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WellStyle Rewards program encourages preventive care

Members of MVP Preferred EPO and PPO health plans from MVP Health Care can earn up to $300 WellStyle Rewards in 2011 for taking an active role in improving their health.

Members earn rewards for things like completing an online health assessment, participating in lifestyle coaching programs and also by **working with you to achieve individual health goals**.

MVP realizes that this is a new program and has tried to make this program as hassle-free as possible for physicians.

Please work with MVP members who present you with a ***WellStyle Rewards Health Risk Screening Form*** at an office visit to complete the requested screenings and record the results on the form. Once you have signed the form, please return it to your patient.

- If a patient is low risk and has received the necessary screenings within the past 24 months, it is acceptable to list those previous measurement results on the form.
- If cholesterol and fasting blood sugar results are not yet available at the time of their office visit, our members are instructed to attach a copy of their lab results to their form when they submit it.

To view a copy of the *WellStyle Rewards Health Risk Screening Form*, visit **www.mvphealthcare.com/member/documents/WSEscreening_form_providerLTR.pdf**.

Provider portal down for maintenance, updated online CMS-1500 form

Some of MVP's Web portals and tools will not available from 5:00 a.m. Friday, March 25 until 6:00 p.m. on Sunday, March 27. Please plan accordingly.

When the provider portal returns to service on March 27, an updated CMS-1500 form will be available. The new form will be compliant with 5010 EDI and ICD-10 coding, to document diagnosis codes and health care services.

What's new on the Web

Online forms are fast, easy and coming soon

MVP Health Care continues to develop enhancements to our online experience that make it easier to do business with us! Coming soon are electronic versions of five frequently-used forms that can be submitted online (eForms)!

- *Prior Authorization Request Form* (PARF) – Medical
- *Prior Authorization Request Form* (PARF) – Medication (General and Formulary Exceptions)
- *Prior Authorization Request Form* (PARF) – DME / O&P Items and Services
- *Provider Web Site Access Request Form*
- *Provider Web Site Administrator Form*

Note: submitting a PARF online does not constitute an automatic authorization.

How to access eForms

You will access the electronic versions of these documents via the *Forms* page within the *Provider* section of the MVP Web site. You will still have access to the printable PDFs of these forms on this Web page, as well, to submit by fax or mail. Please note: you will be required to log in to access our online PARF forms, using your provider portal username and password. The Web Site Access and Site Administrator forms will not require a log-in.

eForm features

- Fill out and submit your form online.
- Blank or completed, you may print these online forms for your records and/or save a copy to your local computer.
- Our eForm application allows you to upload attachments associated with your submission (if supporting documentation is required).
- When submitting a PARF online, you may select a "fax" option for attachments that automatically generates a fax coversheet, allowing you the ease of submitting the form electronically with the flexibility to fax attachments separately.
- Once submitted, you will get a confirmation screen that your eForm was successfully submitted to MVP.

These user-friendly features will make it easy to quickly submit and save these forms!

David W. Oliker
MVP President & Chief Executive Officer
Healthy Practices is a bi-monthly publication of the Corporate Communications Dept.

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PCP patient rosters now online

MVP Health Care has replaced patient rosters mailed to provider offices with easy, on-demand online access to the roster report.

What the roster report shows

The roster shows the MVP members who have selected you as their primary physician (even for health plans that do not require a designated PCP), as well as members who have been assigned to you.

Please note that the roster will include only those patients with an MVP Member ID that begins with a number. Patients with an MVP Member ID that begins with a letter are not included.

Report options and how to access

Simply log in to the provider portal and click "View PCP Member Roster" on the provider snapshot page. You can customize the report by selecting a date span to look at up to 90 days of data and view new, recurring or termed members. Reports can be generated as a PDF or as an Excel file.

MVP is committed to bringing you online features that add value to your practice!

Online resources now integrated

Resources like MVP's *Provider Resource Manual, Utilization Management Guides, Benefit Interpretation Manual, Custom Claims Edits* and more are now available in one online location rather than being split on different Web pages depending on your patient's MVP Member ID. The new *Online Resources* page features a quick reference grid that indicates whether a posted resource is applicable to MVP members whose ID begins with a number, a letter, or both.

To access Online Resources:

1. Log in at **www.mvphealthcare.com/provider**
2. Click *Online Resources* in the gray box; you will go to the *Provider Snapshot* screen
3. Click ***Online Resources*** on the left side of the screen

MVP's online resources are updated on continual basis. Be sure to refer to this Web page for the latest version of the materials.

New contact information for Binghamton, NY Professional Relations

MVP's Binghamton Professional Relations staff has relocated. Please update your records to reflect the new contact information.

3660 George F. Highway
Endwell, NY 13760
Phone: 1-800-688-0379
Fax: 1-866-721-9205

E-mail addresses for Binghamton Professional Relations staff have not changed.

Coverage change for gradient compression stockings

Effective March 1, 2011, MVP Health Care will approve payment of claims for gradient compression stockings for the legs only when submitted according to the guidelines below.

Coverage for compression stockings will be available to:

- members of MVP Commercial plans whose coverage includes a Disposable Medical Supplies rider;
- members of MVP's Medicare plans (MVP Gold HMO, GoldAnywhere PPO or GoldValue HMO) who meet coverage criteria, which will be aligned with Medicare guidelines for treatment and diagnosis of **open venous stasis ulcers** (HCPCS codes A6531, A6532 and A6545); and
- members of MVP's Medicaid plans whose claims are billed to an eligible HCPCS code:
  - -A6531, A6532, A6534, A6535, A6537, A6538, A6540, A6541, A6544, A6545, A6549 and A9999 are covered for MVP Option, MVP Option Child and MVP Option Family;
  - -A4500, A4510, A4490, A4495, A6530, A6533, A6536 and A6539 are reimbursed by Fee-for-Service Medicaid for MVP Option and are not covered for MVP Option Child or MVP Option Family.

Prior authorization requirements

- When prescribed for a member of an MVP Medicare or Medicaid plan, durable medical equipment (DME) providers are required to obtain prior authorization for gradient compression stockings.
- No prior authorization is required to prescribe/dispense compression stockings to members of MVP Commercial plans who have a Disposable Medical Supplies rider.

Quantity limits

- Gradient compression stockings are limited to a frequency of two pairs per year; non-elastic gradient compression wraps are limited to one per six months per leg. Additional prior authorization and medical justification are required if limits need to be exceeded.

For more information, please refer to MVP's *Compression Stockings* medical policy. For upper extremity lymphedema treatments, see the *Burn Garments and Lymphedema Sleeves* and the *Lymphedema Pumps, Compression Garments, Appliances* medical policies. Medical policies are accessible online when you log in at **www.mvphealthcare.com/provider**. For DME information and resources, visit **www.mvphealthcare.com/provider/dme.html**.

Upcoming changes to contrast materials reimbursement

MVP Health Care has determined that the cost of *ionic contrast* is included in the fee paid for CT and other contrast enhanced exams. Additional payment for this material is no longer warranted.

Initially, reimbursement for non-ionic contrast was significantly more costly than the ionic contrast agent and its use was to be limited to occasional patients based upon sensitivity to ionic contrast. This basis for payment no longer applies, as the cost of ionic contrast has approached that of non-ionic contrast. In addition, non-ionic contrast material has become routinely used regardless of patient history. Therefore, MVP considers such use of both contrast materials as part of the underlying examination and will consider them inclusive to the primary procedure fee and, therefore, not separately reimbursable.

Effective July 1, 2011, providers will not be reimbursed separately for contrast material for the codes listed below. This will apply to all participating providers (physicians, hospitals and other facilities) for all MVP Commercial and Option (Medicaid) products.

HCPCS Code	Gadolinium
A9579	Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml
HCPCS Code	**Non-Ionic, Low Osmolar Contrast**
Q9951	Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml
Q9965	Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml
Q9966	Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml
HCPCS Code	**Ionic, High Osmolar Contrast**
Q9958	High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9959	High osmolar contrast material, 150-199 mg/ml iodine concentration, per ml
Q9960	High osmolar contrast material, 200-249 mg/ml iodine concentration, per ml
Q9961	High osmolar contrast material, 250-299 mg/ml iodine concentration, per ml
Q9962	High osmolar contrast material, 300-349 mg/ml iodine concentration, per ml
Q9963	High osmolar contrast material, 350-399 mg/ml iodine concentration, per ml
Q9964	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

This policy does not affect reimbursement paid at a global rate. MVP members are not liable for payment of contrast material fees.

Medicare Updates

CMS to rate quality of care

The Centers for Medicare & Medicaid Services (CMS) continues to advocate for the nation's older adults by setting expectations for the quality of care and service offered by Medicare Advantage plans and participating physicians.

CMS will now rate MVP's Preferred Gold and GoldAnywhere products on many of the same measures that are already evaluated by HEDIS® , the CAHPS® survey and the Health Outcomes survey (HOS)*. The goal is to ensure that our Medicare members receive excellent clinical care and have positive interactions with their doctors. Additionally, there are measures to ensure that members encounter friendly, knowledgeable and respectful customer service from us.

Look for an ongoing series in *Healthy Practices* about the ratings and how MVP is working with physicians to continually achieve excellence in the quality of health care that our members receive.

*The Healthcare Effectiveness Data & Information Set (HEDIS) is a tool health plans use to evaluate their performance in terms of clinical quality and customer service. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is sent to MVP members annually to ask their opinion about health care experiences with their doctors. Health Outcomes survey (HOS) is sent to a sample of Medicare members to assess their physical and mental health. A baseline survey is completed, then a follow-up survey is sent to the same members after a two-year period.

An opportunity for additional reimbursement

MVP Health Care is proud to announce a new Preventive Health Care Visit Incentive Program for 2011. As an MVP-participating physician who treats our Medicare members, we invite you to find out more about this program.

The goal of the Preventive Health Care Visit Program is to encourage Medicare members who have not had a complete physical examination within the last year to take charge of their health and get that check-up.

Please note that to further encourage our Medicare members to undergo a routine physical exam, there is no copay required. You will bill MVP for the examination as you normally would and **you will receive an additional payment** for any assessments you complete.

We are extremely optimistic about this program; we believe it will benefit many of our Medicare members. If you are interested in this program, please contact Yvonne Monroe in MVP's Medicare Risk Adjustment department at **ymonroe@mvphealthcare.com** or by phone at **585-327-5718**.

Thank you for your commitment to encouraging our members to take advantage of the preventive health care services that are part of their MVP Medicare Advantage plan.

Matrix Medical Network conducting Medicare member HRAs

As you may be aware, MVP Health Care has contracted with Matrix Medical Network to perform Health Risk Assessments (HRAs) for our Medicare members. The assessment is then forwarded to each member's primary care physician (PCP). We understand that reviewing the information will take time. MVP has implemented a program to reimburse you for your review time. MVP will mail a check 4-6 weeks after the HRA is mailed to your office. Look for additional information about this program attached to each Matrix HRA you receive.

Medicaid Updates

Access and availability standards

As a health care provider contracted to see MVP Option members, primary care and obstetric providers are required to maintain the following access and availability standards:

Appointment Type	Standard
Emergency	Immediately upon presentation at site
Urgent Care	Within 24 hours
Non-Urgent Sick	Within 72 hours
Routine Non-Urgent or Preventive	Within 4 weeks
Well Child	Within 4 weeks
Initial Prenatal Visits	Within 2 weeks for initial visit
Initial PCP Visit for Newborns	Within 2 weeks of hospital discharge
Follow up visits (pursuant to an emergency or hospital discharge)	Within 1 week
Adult Baseline Physicals	Within 12 weeks of enrollment

In addition, primary care providers are required to maintain 24-hour, seven-day-a-week telephone access for their members. The standard for returning a member call is 30 minutes. It is not acceptable to have an answering machine in place that does not connect directly to the provider. The message must direct the member to a live voice. The primary care provider is responsible for arranging on-call and after-hours coverage to ensure 24-hour telephone access to all members.

Advise MVP of practice information changes

It is critical for health care providers to notify MVP of panel status changes and phone number updates to ensure that our online and print provider directories include the most current information. You may make changes to your contact or panel status by contacting Professional Relations or by completing the *Provider Change of Information Form*, online at **www.mvphealthcare.com/provider/documents/provider_change_data.pdf.**

Referral requirements for MVP Option members

As of February 1, 2011, referrals for MVP Option (Medicaid) and MVP Option Family products are limited to services provided by the following specialties:

- Oral Surgery
- Dermatology
- Plastic Surgery

Although a referral is not required for most specialty services, please confirm that the servicing provider is participating with MVP's Option products. If a member is referred to a specialist who is not participating with MVP's Option programs, an authorization for a non-participating provider is required even if the provider participates with MVP's other lines of business. Provider participation may be confirmed by accessing **www.mvphealthcare.com** and clicking on *Provider Search*.

There is **no change** in the process for submitting member referrals, which may be done by faxing the MVP referral form or through MVP's online referral form. To access these forms, please visit **www.mvphealthcare.com/provider** and follow the steps below:

Fax Referral Form:

- Click on the *Forms* tab at the top of the MVP *Provider* home page
- Under the *Prior Authorization and Referral* section click on the link for *Referral Form*
- Print out the *Referral Form* and fax the form to **1-888-819-2103**

Online Referral Form:

- Log in to MVP's Web portal for health care providers at **www.mvphealthcare.com/provider**
- Click on the gray box to go to the *Provider Snapshot* page
- Under *Manage Patients* on the right side of the screen, click *Submit Referral*
- Complete the online form and then click Submit

Please note: Service specific prior authorization requirements have not changed for these products and there is no change to the referral requirements for MVP's CompCare product. Please refer to MVP's Benefits Interpretation Manual to determine if a procedure requires an authorization based on the member's product.

Quality Improvement Updates

2011 Physician *Quality Improvement Manual* is now available

The *2011 Physician Quality Improvement* manual is now available on the provider home page of MVP's Web site under the *Quality Programs* tab (at **www.mvphealthcare.com/provider/qim/index.html**)

This manual contains all MVP-endorsed clinical guidelines and tools. Guidelines most recently updated in 2010 included Asthma, End Stage Renal Disease, Anti-infective Otitis Media, ADHD,

Oncology, CVD secondary prevention, COPD, Osteoporosis and Perinatal Care. To receive a paper copy of the guidelines or the manual, call **1-800-777-4793, ext. 2602**.

MVP updates its clinical guidelines at least every two years. The review process is initiated on a more frequent basis when new scientific evidence or national standards are published. These guidelines are not intended to replace the role of the clinical judgment by the physician in the management of any disease entity. They are educational guidelines to help assist in the delivery of good medical care. All treatment decisions are ultimately determined by the physician.

Osteoporosis guideline approved for *Quality Improvement Manual* (QIM)

The Quality Improvement Committee (QIC) recently approved an enterprise-wide clinical guideline for the **Prevention and Treatment of Osteoporosis.**

This guideline, adopted from the National Osteoporosis Foundation (NOF) Prevention and Treatment of Osteoporosis, contains recommendations applicable to post-menopausal women and men age 50 and older. The entire guideline, along with an executive summary, is online at **www.nof.org/sites/default/files/pdfs/NOF_ClinicianGuide2009_v7.pdf.** An additional resource for physicians within the QI manual is the World Health Organizations Fracture Assessment tool (FRAXX).

Paper copies of these recommendations are available by calling MVP's Quality Improvement (QI) department at **1-800-777-4793, ext. 2602**. The recommendations also are available in the online *QI Manual* at **www.mvphealthcare.com/provider/qim/index.html.**

UM Update

Financial incentives relating to utilization management policy

It is the policy of all of the operating subsidiaries of MVP Health Care, Inc. to facilitate the delivery of appropriate health care to our members and to monitor the impact of the Plan's Utilization Management program to detect and correct potential under- and over-utilization of services.

MVP's Utilization Management Program does not provide financial incentives to employees, providers or practitioners who make utilization management decisions that would encourage barriers to care and services.

Utilization management decisions are based only on appropriateness of care and the benefits provisions of the member's coverage. MVP does not specifically reward practitioners, providers or staff, including Medical Directors and UM staff, for issuing denials of requested care.

Financial incentives, such as annual salary reviews and/or incentive payments do not encourage decisions that result in underutilization.

Medical Policy Updates

Medical policy updates effective April 1, 2011

Dermabrasion

- Dermabrasion is considered to be a cosmetic procedure; therefore, it is considered not medically necessary.
- There have been no changes to the policy.

Indirect Calorimeter – NEW Policy

- This is a new policy. There is insufficient evidence in the peer-reviewed literature that the handheld device provides superior outcomes when compared to the use of established conventional methods. It is considered not medically necessary.

Laminectomy, Hemilaminectomy Lumbar Spine

- The policy follows InterQual® criteria.
- There have been no criteria changes to the policy.

Spinal Fusion – Lumbar

- The policy follows InterQual criteria.
- Degenerative disc disease has been added to the *Indications/Criteria* section.

Varicose Veins of the Lower Extremity (Surgical Treatment)

- There have been no criteria changes to the policy.

The following imaging policies have been updated to include the most recent InterQual criteria:

CT Abdomen

- The policy was updated to include aldosterone producing adrenal tumor/bilateral adrenal hyperplasia.

CT Abdomen/Pelvis

- The policy was updated to include acute abdominal pain of unknown etiology.
- Suspected renal calculi has been deleted.

CT Cervical, Thoracic, Lumbar Spine

- Follow-up primary bone tumor and myelopathy have been deleted under the *Thoracic Spine Indications/Criteria* section.
- The following are changes to the *Lumbar Spine Indications/Criteria* section:
  - Follow-up primary bone tumor, myelopathy, suspected neurocompression by tumor and suspected lumbar radiculopathy have been deleted.
  - Suspected nerve root compression by lumbar disc herniation/foraminal stenosis has been added.
  - Suspected cauda equine compression has been changed to cauda equine syndrome.

CT Sinuses

- "Sinusitis" has been replaced with "rhinosinusitis."
- Recurrent acute rhinosinusitis > 2 episodes within one year has been added to the *Indications/Criteria* section

MRA Brain

- Screening study for cerebral aneurysm, known cerebral aneurysm, has been deleted from the *Indications/Criteria* section.

MRI Brain

- Dementia and suspected subdural hematoma have been added to the *Indications/Criteria* section.

MRI Breast

- Breast cancer has been added to the *Indications/Criteria* section.

MRI Cervical Thoracic Spine

- Suspected disc space infection has been deleted from the *Cervical Spine Indications/Criteria* section.

MRI Lumbar Spine

- Degenerative disc disease by x-ray has been added to the Indications/Criteria section.

MRI TMJ

• Suspected implant failure/device recall has been deleted from the Indications/Criteria section.

PET Scan Brain

- Dementia was added to follow mental status changes in the *Indications/Criteria* section.
- Suspected Alzheimer's disease was deleted from the *Indications/Criteria* section.
- The *Medicare Variation* section has been updated to reflect the Initial Anti-Tumor Treatment Strategy and Subsequent Anti-Tumor Treatment Strategy language utilized by Medicare.

The policies listed below were presented to the QIC at the January meeting. The policies were recommended for approval without changes. QIC approved the recommendation.

- Breast Reconstruction Surgery
- Erectile Dysfunction
- Lenses for Medical Conditions of the Eye
- Penile Implants for Erectile Dysfunction
- PET Scan Whole Body

Please refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy. Each policy grid defines the prior authorization requirements for a specific product.

EDI Updates

Real-time eligibility

MVP has implemented Real-Time eligibility via our new vendor relationship with Post-n-Track®. Post-n-Track will be hosting our EDI eligibility inquiry (270/271) for all MVP members whose ID begins with an "8." MVP's plans call for Real-Time eligibility to be available for all MVP members by March. Any questions concerning this transaction can be directed to MVP's EDI Services Unit. This is a free service from MVP.

Real-time claim status

MVP has implemented Real-Time claim status via our new vendor relationship with Post-n-Track. Post-n-Track will be facilitating our EDI claim status (276/277) for all MVP members whose ID begins with an "8." For connectivity, please contact Post-n-Track at **860-257-2030** or **www.post-n-track.com**. Any questions concerning this transaction can also be directed to MVP's EDI Services Unit. This is a free service from MVP.

Post-n-Track

Post-n-Track (PNT) provides a secure, reliable, no-cost solution for transmission of EDI transactions. You may want to consider using PNT if:

- you currently send claims using a modem;
- you are looking for a reliable transfer mechanism;
- you are looking to change clearinghouses;
- you need more detailed reporting;
- you are looking for Human Readable Reports; or
- you need a cost-free method of submitting claims to MVP.

The next issue of *Healthy Practices* will cover the changes in the 835 (Health Care Claim Payment/Advice) for 5010 and more EDI Helpful Tips.

EDI helpful tip

When submitting claims for members whose MVP member ID starts with the letter "A," remember that the next character in the member ID is a zero and NOT the letter "O."

Provider action checklist for a smooth transition to 5010

The Centers for Medicare & Medicaid Services (CMS) has developed a checklist to help providers move to the 5010 version of electronic data interchange (EDI).

We started the checklist in the September 2010 issue of this newsletter. Here, we continue the checklist. Take a moment now to read through the suggested action items and check each off as you complete it so that you will be ready when 5010 arrives.

To view the entire checklist, go to: **www.cms.gov/Versions5010andD0/ Downloads/w5010PvdrActionChklst.pdf**

☐ **Identify staff training needs**

Training staff ensures that transactions continue to be submitted, received, interpreted, and responded to correctly using Versions 5010 transactions.

Some questions to consider regarding staff training are:

- Who should be trained on the transaction changes?
- How long will it take to train staff on the changes?
- What resources are needed for training?

Pharmacy Updates

Pharmacy policy and formulary update effective March 1, 2011

Blood Modifiers-Excluding RBC Agents

- For Commercial members only, prior authorization* will be removed from Neulasta.

Erythropoietic Agents

- For Commercial members only, prior authorization* will be removed from Epogen, Procrit and Aranesp when billed from a place of service other than a pharmacy.

Oforta

- New policy which establishes prior authorization criteria for B-cell chronic lymphocytic leukemia. The medication must be prescribed by an oncologist, the member must be >18 years old and progression on or non-responsive to at least one alkylating agent regimen.

Pharmacy Programs Administration

- The Brand/Generic Difference Program language was updated. New RxCare PDP language was added. For Medicare, tier language was updated to reflect coverage for 2011 and the Coverage Gap Discount Program description was added

The following policies were reviewed and approved without any changes to criteria:

- Cosmetic Agents
- Dermatologicals for Inflammation

*For members whose ID# begins with "A," submit a request for authorization until further notice. No clinical review will be required unless for off-label use.

Formulary updates for Commercial members

The MVP Formulary is updated after each Pharmacy and Therapeutics Committee meeting. The most current version is available online at **www.mvphealthcare.com**. Simply visit the site's *Provider* section and under *Pharmacy*, click on *Formulary*. The MVP Formulary can be downloaded to a PDA device from **www.epocrates.com**. There is a link to ePocrates® on the MVP Web site. Unless otherwise noted, the following Formulary information is effective March 1, 2011.

New drugs* *(recently approved by the FDA, prior authorization required, Tier 3)*

Drug Name	Indication
Alsuma	Migraine
Beyaz	Oral contraceptive
Gilenya	Multiple sclerosis
Glassia (medical benefit)	Emphysema
Suprep	Colon cleanser

Generic drugs added to Formulary (Tier 1)

donepezil (Aricept/Aricept ODT)
levocetirizine (Xyzal)
zifirlukast (Accolate)

Drugs added to Formulary (Tier 2)

Chantix

Drugs removed from prior authorization* (all medications are non-formulary, Tier 3 unless otherwise noted above)

Cambia (quantity limits)
Livalo
Lysteda

Drugs removed from the Formulary† (change from Tier 2 to Tier 3)

Aricept/Aricept ODT (effective 7/1/2011)
Pacnex

*Drugs indicated as "medical," when provided in a physician office or outpatient facility, are a covered Medicare Part B benefit and are subject to MVP commercial policies.

†Affected members will receive a letter if further action is required (i.e. contacting the prescriber for a formulary alternative)

Formulary updates for Medicare Part D members

Medicare Part D Formulary Available From ePocrates®

You can now access and download the MVP Medicare Part D Formulary for 2011 from ePocrates®. Simply follow the instructions on our Web site at **www.mvphealthcare.com/provider/pharmacy.html.**

The tier and prior authorization status of the following medications have been approved. Policies, where applicable, can be found on our Web site at **www.mvphealthcare.com/medicare/2011MedicarePARTDPAlist.html.**

The following drugs were added to the Medicare Part D Formulary:

Drug Name	Tier	Prior Authorization Required
Latuda	3 or Specialty	Yes
Zymaxid	3	No
Natazia	3	No
Vimovo	3	No

A complete list of formulary changes may be found at **www.mvphealthcare.com/medicare/documents/Formulary.pdf**

Health Care Reform & Preventive Drug Coverage Guidelines*

The Patient Protection and Affordable Care Act (ACA) allows for coverage in full for select employer groups as follows:

Aspirin: The use of aspirin is covered when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage in men ages 45 – 79 years & women ages 55 – 79 years.

Fluoride: Clinicians should prescribe oral fluoride supplementation at recommended doses to preschool children older than 6 months of age whose primary water source is

deficient in fluoride. Combination products that include multiple vitamins with fluoride are not covered in full.

Folic Acid: All women planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid. Combination products that include multiple vitamins with folic acid are not covered in full.

Iron: Routine iron supplementation is recommended for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Combination products that include multiple vitamins with iron are not covered in full.

Smoking Cessation Medications: Clinicians are recommended to ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. For non-pregnant adults (>18 years), therapy includes nicotine replacement therapy (gum, lozenge, patch, inhaler and nasal spray) and sustained release bupropion (Zyban) & varenicline (Chantix).

Smoking Cessation Counseling includes but is not limited to certified and/or community, telephonic or Web-based programs. Examples include **Freedom from Smoking** (American Lung Association), **New York State Smokers Quitline, Vermont Quit Network** and the **Try to Stop Smokers Helpline** (New Hampshire).

Prior notification must be received from a provider before claims for smoking cessation medications will adjudicate at the pharmacy. Prior notification requests should be submitted to MVP.

Members* who participate in smoking cessation counseling will be reimbursed in full for smoking cessation medications. For reimbursement, members must present a prescription to their pharmacy and pay-out-of-pocket for over-the-counter products or their prescription copay when applicable. Members should then submit the claim to MVP by following the member claim submission process available on our Web site at **www.mvphealthcare.com/pharmacy/documents/health-care-reform-guidelines.pdf.**

*Not all members are eligible for the above coverage. ASO grandfathered plans do not have this coverage. In addition, select groups may have chosen to modify this coverage.

Medication recalls and withdrawals

In the past several months, the Food and Drug Administration (FDA) has issued important medication warning, withdrawals and recalls. Highlights of the FDA activity include:

- In January 2011, Bristol-Myers Squibb Co said it has recalled 64 million tablets of the blood pressure medicine Avalide in the United States and Puerto Rico due to the potential for reduced effectiveness. The move, which Bristol-Myers said was undertaken as a precautionary measure. It is expected that there will be a shortage of Avalide in the first quarter 2011.
- One January 6, 2011, Teva Pharmaceuticals, voluntarily recalled Metronidazole Tablets USP, 250mg, lot 312566, expiration date 05/2012. This product lot is being recalled due to the presence of underweight tablets.
- On December 30, 2010, the Ritedose Corporation conducted a voluntary recall of 0.083% Albuterol Sulfate Inhalation Solution, 3 mL (in 25, 30, and 60 unit dose vials). This product is an inhalation solution, administered via a nebulizer, for the treatment and maintenance of acute asthma exacerbations and exercise induced asthma in children and adults. This product is being recalled because the 2.5 mg/3 mL single use vials are embossed with the wrong concentration of 0.5 mg/ 3 mL and therefore, represents a potential significant health hazard.

Medication Therapy Management Program (MTMP)

The MTMP is a CMS-required feature of Medicare Prescription Drug Plans. The program is for qualified MVP members who:

- have a minimum of 3 of 7 of the following targeted chronic diseases: congestive heart failure, diabetes, chronic obstructive pulmonary disease, dyslipidemia, hypertension, depression and osteoporosis;
- take more than eight Part D medications as determined by our Pharmacy Benefit Manager (PBM) in conjunction with the MVP Health Care Pharmacy and Therapeutics Committee; and
- are likely to incur annual costs for covered Part D drugs that exceed $3,000.

Each qualified member will be offered a comprehensive medication review (CMR) which will be preformed by an MVP clinical pharmacist. The purpose of the review is to reduce medication errors, optimize the patient's medication use and refer members to MVP case and disease management if needed. A summary of the CMR will be provided to the member and provider as appropriate. Follow-up with the member and provider also may be performed, depending on the intervention.

The 2011 MTMP is starting and your office may be receiving requests for current chart notes and/or laboratory data in writing from MVP for participating members so that a comprehensive medication review may be performed. Your office may receive request forms from MVP via fax or mail for lab data. Your assistance with the program is greatly appreciated.