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healthy practices™

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Reminder: *Healthy Practices* is news for your ENTIRE practice

MVP's *Healthy Practices* newsletter for health care providers includes information that's important for doctors, as well as practice managers and office staff. Please circulate each issue throughout your practice; you also may view/download each issue from the News section of MVP's secure Web portal for providers when you log in at **www.mvphealthcare.com/provider**.

New "return claim" letter to replace remittance advice

Beginning in December 2010, Facets paper claim edits that were originally communicated through a remittance advice will instead be communicated through a "Return Claim" letter that indicates submission errors.

The new paper claims processing edits are pursuant to MVP Health Care's initiative to integrate its core system platforms by 2012, as well as ongoing efforts to improve transparency and provider satisfaction.

In the current process, a claim that contains errors is accepted into MVP's claims processing system and run through the adjudication process. Errors are not communicated to provider offices until a remittance batch job is run, which can take several days. Also, the remittances can only list one reason for the denial of a claim, even if multiple errors were found.

The new process will reject claims with fatal errors (errors that preclude the claim from being priced) at the "front door" before they get into the claims system. Notification will be done via a return letter. If the claim is being returned for multiple reasons, the letter will include that level of detail. This will result in quicker turnaround times, since providers will be notified of errors within 24-48 hours, affording a more immediate opportunity to resubmit a new claim with corrected information, rather than receiving actionable notification only after the full end-to-end process is complete.

Please note that this change will only affect paper claims, and only for members with an MVP ID that begins with a number. Paper claims for members with an MVP ID that begins with a letter are not affected. The transition to return letters will take place gradually between December 2010 and January 2011; therefore, provider offices may not be immediately affected.

Fatal Claim errors that will be communicated in a "Return Claim" letter rather than on a remittance:

- Invalid or Blank Date of Service
- Total Charges field left blank (if no charges, submit amount as $0)
- Line Charges field left blank (if no charges, submit amount as $0)
- Invalid or blank Primary Diagnosis Code
- Invalid or blank Procedure Code
- Invalid Modifier Code
- Blank Date of Birth
- Invalid or blank Taxonomy code (multi-specialty providers only)
- Invalid or blank Type of Bill (Facility claims only)
- Invalid or blank Revenue Code (Facility Claims only)
- Invalid or blank Discharge code (Facility Claims Only)
- Quantity field submitted as "0 "or left blank
- Facility claim that is not submitted on a UB-04
- Professional claim that is not submitted on a CMS-1500

Fatal claim errors that are currently communicated via "Return Claim" letter: Practitioners submitting paper claims are already receiving return claim letters for the following errors; however, with the rollout of the new process, the letter verbiage and template will be different.

Member Unknown:

- SSN # submitted rather than a Member ID
- No Member ID
- Incorrect/Invalid Member ID
- Incorrect/Invalid CIN or HIC #s

Provider Unknown:

- Blank or invalid Tax ID
- Blank or invalid NPI

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MVP President & Chief Executive Officer
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Comments
Write to:
Healthy Practices
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Professional Relations Dept.
PO Box 2207, Schenectady, NY 12301

MVP moves to one P.O. Box to simplify paper claims submission

You told us that submitting paper claims to multiple P.O. Boxes was an administrative burden for your offices and we heard you! All paper claims may now be submitted to **P.O. Box 2207, Schenectady, NY 12301.** There will be no delay in processing. We are in the process of updating the forms on our Web site. However, you can begin to use the single P.O. Box immediately. Thank you for your feedback and suggestions!

Reminder: new hours for MVP Rochester Provider Services

MVP Health Care has adjusted staff scheduling within our Rochester call center so that more representatives will be available during the busiest parts of the day. As of July 15, 2010, Rochester Provider Services representatives are available Monday – Friday from 8:30 am – 5:00 pm at **1-800-999-3920**. You may call Provider Services in Rochester for all MVP members, rather than referring to MVP members' identification number to determine which service center to call for eligibility, benefits, or claims inquiries.

Medicare/Medicaid Updates

Upcoming changes for MVP Medicaid members

Beginning January 1, 2011, MVP will maintain all MVP Option (Medicaid) and MVP Option Family (Family Health Plus) members on our Facets system. We are currently working to move members enrolled in these products in the Rochester area (Genesee, Livingston, Monroe and Ontario counties) from our AMISYS system to Facets. Following is a list of changes that you will see.

Member ID numbers will change as of January 1, 2011

Currently, in AMISYS, we use the member's Client Identification Number (CIN) as their member ID. With the transition to FACETS, the member ID# will be a 9-digit number beginning with "82."

Members will receive a mailing in mid-December which will include a new ID card with their new ID number. We will remind members to show this card at their next visit.

New ID required on claims and authorizations

You will need to use the new ID number that begins with "82" to submit claims or request authorizations starting January 1, 2011.

Accessing member information

- For information on a member for a date of service **prior to January 1, 2011**, log in with your *easyLink*[sm] ID. We will notify you when you will be able to log in using your HealthWeb ID to view this information.
- For information on a member for a date of service **on or after January 1, 2011**, log in with your HealthWeb ID.
- To view member eligibility information, you can search by name, date of birth, social security number, or the new ID number beginning with "82." You can use the CIN to narrow your search results.

For our ValueOptions® providers

If you have any open or pending authorizations, ValueOptions® will be able to recognize the new member number, so there will be no interruption in service to our members and no need to resubmit authorizations with the new member ID.

The provider portals will be unavailable on the weekend of December 10 and 11. At that time, our IT department will be working on moving records from AMISYS to Facets. However, you should continue to use *easyLink* to access information for these members until December 31, 2010.

We will continue to keep you informed of updates with FastFaxes, during office visits by our Provider Relations representatives, and during upcoming provider/facility meetings.

Matrix Medical home visits for select Medicare members

Medicare requires MVP to submit appropriate, accurate, and detailed diagnostic documentation about each Medicare patient. To ensure that the most complete and comprehensive diagnostic picture of each plan member is submitted to Medicare, MVP Health Care will be working with a doctor or nurse practitioner from Matrix Medical Network to conduct a home visit for selected members. Not all of your MVP Medicare patients will be contacted by Matrix. We are only selecting MVP members with certain chronic conditions.

If your patient is selected for the home visit, he or she will receive a call from a Matrix representative to schedule a visit. ***Participation is optional and there is no charge for the visit.***

This visit is not a quality or billing audit, nor is it meant to take the place of their existing doctor appointments or replace the care they receive from you.

The results of any home visit assessment will be shared with you and also will be forwarded to Medicare. The results include a list of observations made by the clinician who visited your patient. MVP realizes that the home visit was made without the benefit of reviewing your medical record of this member, and therefore the information may not be entirely applicable.

If you receive an assessment from Matrix Medical for one of your patients and would like to "opt-out" of receiving the documents in the future, the contact information will be included in the cover letter of the assessment. Please request the "opt-out" at that time.

Matrix Medical has completed approximately 4,000 home assessments in 2010; MVP expects Matrix to complete an additional 4,000 assessments by the end of 2010.

Matrix Medical Network serves MVP Health Care in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA). As defined by HIPAA, Matrix Medical Network's role as a "Business Associate" of a "Covered Entity" is ethically and legally bound to protect, preserve and maintain the confidentiality of all Protected Health Information (PHI) it obtains pursuant to its contractual obligations to MVP Health Care.

New York Medicaid's patient-centered medical home incentive program

The New York State Department of Health has implemented an initiative to promote the development of patient-centered medical homes for Medicaid members receiving primary care services. Upon required federal approval, health care providers that meet New York's medical home standards will be eligible to receive additional payment for primary care services to Medicaid members. New York

has adopted the National Committee for Quality Assurance (NCQA) Physician Practice Connections® – Patient Centered Medical Home™ (PPC®-PCMH™) program as the standards for this initiative. Health care providers who are recognized by the PPC-PCMH program will be eligible for additional payments.

The PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes. There are nine standards, including 10 must-pass elements, which can result in one of three levels of recognition. For each level of NCQA recognition, reimbursement amounts are based on an average payment per visit.

- MVP Health Care will reimburse MVP Option providers who achieve level 1, 2 or 3 recognition from NCQA according to the State-recommended reimbursement levels of $2, $4 and $6 per member, per month (PM/PM), based on the number of Option and Option Family members assigned to the provider's panel.
- MVP is currently processing initial reimbursements, which will be retrospective to either July 1, 2010 or the date on which New York State identified you as eligible for the NCQA payment.
- After initial reimbursements are made, MVP will make reimbursement payments on a quarterly basis.

Details about the incentive program are online at **www.nyhealth.gov/health_care/medicaid/program/update/2009/2009-12spec.htm**. For more information about the PPC-PCMH standards, go to **www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf.**

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the September meeting. Some of the benefit interpretation policies may reflect new technology while others clarify existing benefits. All policy updates are listed online in the *Benefits Interpretation Manual (BIM)*. Visit MVP online at **www.mvphealthcare.com**. Providers can directly access the online BIM through the *Reference* section of the provider portal. The *Current Updates* page of the BIM lists all policy updates. If you have questions regarding the policies or wish to obtain a paper copy of a policy, contact your Professional Relations representative.

Healthy Practices and/or FastFax will continue to inform your office about new and updated policies. MVP encourages your office to look at all of the revisions and updates on a regular basis in the *Benefit Interpretation Manual (BIM)* located at **www.mvphealthcare.com** in the *Reference* section.

Medical policy updates effective December 1, 2010

Biofeedback Therapy

- Dysfunctional voiding in children has been added as an indication for biofeedback therapy.
- Pediatric migraine and tension-type headache have been added as an indication for biofeedback therapy.

Bone Growth Stimulator

- Language regarding high-risk patients was updated Electric Bone Growth Stimulator (Invasive and Non-invasive) use in spinal fusion patients. Patients who are smokers, take medications effecting healing, have glycohemoglobin greater than or equal to 7, or have renal disease are considered high risk.

Burn Garments & Lymphedema Sleeves – NEW Policy

- Previously, burn garments were addressed in the Pressure Garments (TED or Jobst), Compression Garments, and Elastic Stockings medical policy.
- This policy address burn garments and lymphedema sleeves and follows Medicare criteria.
- Compression burn garments are covered when they are used to reduce hypertrophic scarring and joint contractures following a burn injury.
- A lymphedema sleeve is considered medically necessary to reduce or control pooling of fluids to an affected limb after a mastectomy or when the member has chronic lymphedema.

Canaloplasty & Viscocanaloplasty – NEW Policy

- This is a non-coverage policy.
- There is insufficient evidence in the peer reviewed literature to support long-term safety and efficacy of canaloplasty for the treatment of open angle glaucoma and it is, therefore, considered investigational for all indications.
- There is insufficient evidence in the peer reviewed literature that viscocanalostomy results in proven beneficial outcomes that are superior to conventional trabeculectomy in reducing intraocular pressure for the treatment of open angle glaucoma and it is, therefore, considered not medically necessary for all indications.

Compression Stockings – NEW Policy

- Previously, compression stockings addressed in the Pressure Garments (TED or Jobst), Compression Garments, and Elastic Stockings medical policy.
- Coverage for compression stockings is not allowed for members without a disposable rider.
- A Medicare variation allows coverage for Medicare members for gradient compression below the knee stockings when used to treat open venous stasis ulcers.

Cosmetic & Reconstructive Surgery

- Dermal injections for the treatment of facial lipodystrophy syndrome are not covered for Commercial members. They are considered cosmetic and are not medically necessary.
- A Medicare variation has been added regarding dermal injections for the treatment of facial lipodystrophy syndrome.

Genetic Counseling & Testing

- Criteria for Cowden's Syndrome genetic testing were added.
- Criteria for HER2 testing were added.
- The Cowden's Syndrome & HER2 testing criteria follow NCCN Guidelines.
- Language regarding drug metabolizing enzyme genotyping systems (e.g., Amplichip™) was added to the policy. Drug metabolizing enzyme genotyping systems are considered experimental/investigational and, therefore, are not covered.

Pressure Garments (TED or Jobst), Compression Garments, and Elastic Stockings – DELETED

- Burn garments and lymphedema sleeves are addressed in the new Burn Garments and Lymphedema Sleeves medical policy.
- Compression stockings are addressed in the new Compression Stockings medical policy.

Prophylactic Mastectomy Oophorectomy

- Requirement for a psychological evaluation regarding the prophylactic mastectomy was removed from the policy.
- NCCN criteria for Prophylactic Mastectomy and Bilateral Oophorectomy were added.

The policies listed below were presented to the QIC at

he September and October meetings. The policies were recommended for approval without changes. These policies were comprehensively reviewed during 2009. QIC approved the recommendation.

September

- Genetic Testing for Susceptibility to Breast and Ovarian Cancer (BRCA1 and BRCA2)
- Hip Surgery (Arthroscopic) for Femoroacetabular Impingement (FAI)

October

- Autologous Chondrocyte Implantation (ACI)
- Durable Medical Equipment
- Obstructive Sleep Apnea (Devices)
- Private Duty Nursing
- Septoplasty
- Speech Therapy (Outpatient

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.

UM Updates

Coming soon! Advanced diagnostic management (ADM) for online authorizations

MVP has partnered with McKesson Provider Technologies to bring health care providers a more efficient way of submitting radiology authorizations. Advanced Diagnostic Management (ADM) is an online tool that will allow providers to submit radiology and diagnostic authorizations for MVP members and receive immediate, real-time responses without having to make a phone call.

The benefits for providers are:

- ***Self Service*** – provider offices do not have to call MVP for an authorization and can submit these requests outside of business hours.
- ***Rapid response to authorization requests*** – some requests may be auto-authorized immediately without manual clinical review, giving you an immediate authorization number.
- ***Centralized Location*** – provider offices can submit an authorization and check the status of pended requests in one location any time of day without a phone call.
- ***Printable Authorizations*** – authorizations can be downloaded in PDF format and printed out for proof of authorization.

MVP will roll out this initiative during the first half of 2011. MVP will reach out to providers to sign them up for this program. If you are interested in this program, please contact your Professional Relations Representative.

Coverage change for gradient compression stockings

Effective February 1, 2011, gradient compression stockings will only be covered for MVP Medicare members with one specific diagnosis, and for Commercial members who have a Disposable Rider. Coverage criteria will follow Medicare guidelines for the treatment of open venous stasis ulcers only. A new *Compression Garment* Benefit Interpretation will be effective and online on February 1, 2011. Coverage will be unavailable for those members who do not meet Medicare criteria for gradient compression stockings.

Applicable HCPCS codes for open venous stasis ulcers are: A6531, A6532 and A6545 – gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

If you have questions regarding this change, please contact Professional Relations at **1-800-999-3920**. For more information regarding DME, visit MVP's DME Web page at **www.mvphealthcare.com/provider/dme.html.**

EDI Updates

5010 eligibility (270/271) highlights

270 Eligibility Request

Same basic data content. Generic request performed using Service Type 30 (Health Benefit Coverage) minimum.

271 Eligibility Response

Subscriber (2000C loop)

The subscriber is a person who can be uniquely identified to an information source by a unique Member Identification Number (which may include a unique suffix to the primary policy holder's identification number such as: 00, 01, 02, etc.). The subscriber may or may not be the patient.

Payer Must Return

Must include patient demographic information that is necessary to identify the patient for other EDI transactions.

- First and Last Name
- Date of Birth
- Member ID
- Address
- Other new requirements:
  - Primary care provider
  - Other payers
  - If the individual has active coverage, the Plan Begin date must be returned.

Coverage Information

If an information source receives a Service Type Code "30" submitted in the 270 EQ01 or a Service Type Code that they do not support, the following 2110C/D EB03 values must also be returned if they are a covered benefit category at a plan level.

1 - Medical Care
33 - Chiropractic
35 - Dental Care
47 - Hospital
86 - Emergency Services
88 - Pharmacy
98 - Professional (Physician) Visit - Office
AL - Vision (Optometry)
MH - Mental Health
UC - Urgent Care

Patient Responsibility must be indicated when applicable on the 271 by using the following codes:

- Coinsurance
- Copay
- Deductible
- Stop Loss
- Cost Containment
- Spend down

Subscriber Search Methods Required

Primary Search
- Member ID
- Patient First Name
- Patient Last Name
- Date of Birth

Alternate Search A
- Member ID
- Patient Last Name
- Date of Birth

Alternate Search B
- Member ID
- Patient First Name
- Patient Last Name

MVP's tentative 5010 test schedule

Internal Testing Completed:	12/31/2010
Trading Partner Testing:	2011
837 Compliance/ Business Edits (999/277CA)	Q1 2011
270/271 & 276/277	May 2011
835	June 2011
837/835 (Complete cycle)	July 2011
5010 Production:	Post April 2011 (TBA)

In the next issue of *Healthy Practices*, learn more about "Claim Status 276/277" and EDI 5010.

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 issue of this newsletter, with a listing of questions to ask your vendors. We'll be including a segment of the checklist in this and the next several newsletters. 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**

Communicate with clearinghouses, billing services, and payers

Contact clearinghouses or billing services and health insurance payers early to learn about their implementation plans. Some questions to ask your clearinghouses, billing services, and payers are:

- ☐ Will you be upgrading your systems to accommodate Version 5010 transactions?
- ☐ When will the upgrades be completed?
- ☐ Will you change your fees for Version 5010 transactions?
- ☐ How will we need to register in order to conduct 5010 transactions?
- ☐ When can we send you our test transactions to ensure the system works correctly?

Based on the responses to the questions above, you will know if your clearinghouses and billing service can continue to support your business. This information will assist you with planning budget needs and help you develop a time frame for testing and implementation.

Source: *Centers for Medicare & Medicaid Services Provider Action Checklist for a Smooth Transition*

Pharmacy Updates

Fluzone High-Dose

For the 2010/2011 flu season, MVP Health Care will cover one dose of Fluzone High-Dose in adults 65 years of age and older. Payment will be provided under CPT code *90662: Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use.* It should be noted that there have been no controlled clinical studies demonstrating a decrease in influenza incidence after vaccination with Fluzone High-Dose when compared to standard-dose flu vaccines.

Pharmacy policy and formulary update effective December 1, 2010

Alpha-1 Antitrypsin Inhibitor Therapy

- Prolastin-C was added requiring prior authorization and subject to the same criteria as Prolastin.

Ampyra

- EDSS category description was added.
- For initial requests, EDSS language changed to "EDSS score between 5.0-6.5 OR documentation supporting the disability within that range." For continuation of therapy, two T25FW tests will be required.

Antineoplastic Enzyme Inhibitors

- Votrient and Afinitor were added. EGFR and HER2 status requirements were also added.

Mozobil

- Use in leukemia exclusion statement and the drug mechanism of action were added.

Multiple Sclerosis Self-Injectables

- Extavia was added; no prior authorization is required.

Select Biologic Chemotherapy Agents

- Arzerra was added; no prior authorization is required. NCCN guidelines will continue to be followed for all drugs in this policy.

Thrombopoiesis-Stimulating Proteins

- An exclusion for the use in chronic liver disease was added.

The following policies were archived and no longer require prior authorization:

- Abraxane
- Restasis (effective January 1, 2011)

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

- Actimmune
- Formulary Exception for Non-Covered Drugs
- Myelodysplastic Syndrome Selected Agents
- Thalidomide and Thalidomide Derivatives
- Tysabri for Multiple Sclerosis

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 December 1, 2010.

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

Drug Name	Indication
Dulera	Asthma
Jalyn	BPH
Jevtana *(medical benefit)*	Prostate cancer
Rybix ODT	Pain
Silenor	Insomnia
Tribenzor	Hypertension
Zuplenz	Nausea and vomiting

Brand drugs added to Formulary (Tier 2)

Aricept 23

Generic drugs added to Formulary (Tier 1)

azelastine (Optivar)
chlorzoxazone (Parafon Forte DSC)
enoxaparin (Lovenox)
trospium (Sanctura)

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

Chenodal
Pennsaid
Victoza

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

Lovenox
Optivar

*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).

NYS online Practitioner Notification Program (PNP)

The New York State Bureau of Narcotic Enforcement (BNE) is responsible for protecting the public health by combating the illegal use and trafficking of prescription controlled substances. The PNP is now in place to allow any New York State prescriber who holds a valid DEA registration to see whether a patient they are treating is receiving controlled substances from another practitioner. Each prescriber must have an individual Health Commerce System (HCS) account to gain access. To find out how to set up an account, go to **https://commerce.health.state.ny.us/pub/**. For more information about this valuable tool, go to **www.nyhealth.gov/professionals/narcotic/practitioners/online_notification_program/online_csi_practitioner_notification_program.htm.**

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 2010 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/2010MedicarePARTDPAlist.html.**

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

Drug Name	Tier	Prior Authorization Required
chlorzoxazone	1	No
azelastine ophthalmic 0.05%	1	No
enoxaparin	1	No (quantity limits)
trospium	1	No
Jevtana	Specialty	Yes
Victoza	3	No
Xifaxan	3	No

The following drugs will be removed from the Medicare Part D Formulary on the dates indicated below:

Drug Name	Reason for Change	Effective Date
Dritho-Scalp Cream 0.05%	Deemed as a non-Part D drug per CMS	12/1/2010
Saltropine Tablet 0.4mg	Deemed as a non-Part D drug per CMS	12/1/2010

Quality Improvement Updates

Quality Improvement Manual (QIM): clinical guidelines re-endorsed

The Quality Improvement Committee (QIC) recently approved the following enterprise-wide clinical guidelines:

Chronic Obstructive Pulmonary Disease (COPD): MVP Health Care adopted the Global Initiative for Chronic Kidney Disease: Evaluation, Classification, and Stratification. The GOLD Guideline for COPD, entitled Global Strategy for the Diagnosis, Management, and Prevention of COPD, can be found on the GOLDCOPD Web site at **www.goldcopd.com**. Click *Guidelines & Resources*, located under the Home icon on the GOLDCOPD Internet home page.

Attention Deficit Hyperactivity Disorder (ADHD): The practice parameter for the evaluation and treatment of ADHD was endorsed based on the recommendations of the American Academy of Child and Adolescent Psychiatry (AACAP)'s Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention Deficit/Hyperactivity Disorder (ADHD). Included in the guideline is a link to the AACAP Web site at **www.aacap.org**, along with educational materials from the National Initiative for Children's Healthcare Quality (NICHQ) toolkit. The ADHD toolkit can be accessed at **www.nichq.org/adhd.html.**

Asthma: MVP has recently re-endorsed recommendations for asthma care that are derived from the National Institutes of Health's (NIH) Third Expert Panel 3 Report (EPR3). This is a result of a collaborative effort led by the New York State Department of Health (NYSDOH) and the New York City Department of Health and Mental Hygiene. The collaborative group also included professional organizations, MVP and other health plans from across the state. The guidelines are based on the National Institutes of Health's (NIH) most recent recommendations. For an update summary, go to **www.health.state.ny.us/diseases/asthma/pdf/2009_asthma_guidelines.pdf.**

Secondary Prevention of Cardiovascular Disease: MVP continues to endorse the American Heart Association/American College of Cardiology's recommendations for secondary prevention of cardiovascular disease. The guidelines are available on the American Heart Association's Web site at **www.americanheart.org** and the American College of Cardiology's Web site at **www.acc.org** by clicking the *Quality and Science* icon.

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 will be available in an update to the *MVP Physician Quality Improvement Manual.* The current edition of the manual is located on the provider home page of the MVP Web site at **www.mvphealthcare.com/provider**. Offices interested in receiving a CD-ROM or paper edition of the updated manual should call the QI department at the number above.

2009-2010 NYSDOH Medicaid Managed Care Performance Improvement Project: Appropriate Weight Gain During Pregnancy and the Benefits of Exclusive Breastfeeding

The New York State Department of Health (NYSDOH) is overseeing a statewide two-year collaborative Performance Improvement Project (PIP) focused on pediatric obesity for all Medicaid Managed Care Plans for implementation in 2009-2010. Local PIP collaborators include Excellus Blue Cross Blue Shield, The Monroe Plan for Medical Care, MVP Health Care and the Perinatal Network of Monroe County. The objectives of this regional quality improvement effort are to encourage women to gain appropriate weight during pregnancy, to encourage nutrition referrals for overweight and obese pregnant women and to encourage more women to exclusively breastfeed their babies.

Appropriate weight gain during pregnancy

Are you routinely assessing the weight that your pregnant patients are gaining?

The weight assessment should include documentation of pre-pregnancy BMI with recommendations made for appropriate weight gain during pregnancy. Counseling regarding exercise and lifestyle changes should be provided as indicated. Special considerations should be taken for overweight and obese pregnant women.

The amount of weight a woman needs to gain during pregnancy is based on her pre-pregnancy body mass index (BMI), which compares weight to height. The Institute of Medicine (IOM) issued revised guidelines on weight gain during pregnancy in May of 2009. Depending on how much a woman weighed before getting pregnant, the IOM weight gain guidelines for pregnant women now are, Underweight: weight range 28-40 pounds; normal weight: weight range 25-35 pounds; overweight: weight range 15-25 pounds; and obese: weight range 11-20 pounds.

Researchers concluded that based on a woman's pre-pregnancy BMI, overweight women were more likely to have a target gain above the IOM's guidelines. According to a recent news release from the American College of Obstetricians and Gynecologists (ACOG), while a woman's pre-pregnancy BMI was the strongest predictor of maternal target weight gain, her health care provider's recommendation also was an important factor. In one study, 33% of subjects reported receiving no advice on gestational weight gain from their provider.

Recent research indicates that children of mothers who gain more than the recommended amount of weight during pregnancy are more likely to be overweight at age seven. Children of mothers who are obese prior to pregnancy and gain excessive weight are at the greatest risk. Adherence to pregnancy weight gain recommendations may be a new and effective way to prevent childhood obesity, since currently almost half of U.S. women exceed these recommendations.

ACOG's Guidelines for Prenatal Care (sixth edition, 2007) state that nutritional assessment during pregnancy should include the following:

- individual nutrition risk assessment including screening for specific nutritional risk conditions at the initial prenatal care visit and continuing reassessment as needed;
- arrangements for services with funded nutrition programs available in the community including provision for enrollment of all eligible women and infants in the Supplemental Food Program for Women, Infants and Children (WIC), at the initial visit; and
- provision of basic nutrition education and counseling for each pregnant woman which includes appropriate dietary intake and recommended dietary allowances during normal pregnancy; appropriate weight gain; and infant feeding choices including individualized counseling regarding the advantages of breastfeeding.

What can you do?

Record height and weight for all women at the initial prenatal visit to allow BMI calculation; offer nutrition consultation to overweight and obese women and encourage them to follow a nutrition and exercise program.

Resources:
www.nyhealth.gov/prevention/nutrition/wic/index.htm

Breastfeeding recommendations

What message do you provide to your pregnant patients on the benefits of breastfeeding?

Discuss the nutritional advantages of breastfeeding. Exclusive breastfeeding is recommended during the baby's first 6 months of life. Breastfeeding is not recommended for HIV positive women and may be medically contraindicated in other situations.

Did you know?

Scientific literature indicates a positive relationship between breastfeeding and positive birth outcomes, including the impact on childhood overweight/obesity. Babies who have been exclusively fed breast milk for an extended period are less likely to become overweight or obese as children. This finding is proven in several evidence-based studies.

Resources:
www.nal.usda.gov/wicworks/Learning_Center/LS/success.pdf
www.nal.usda.gov/wicworks/Learning_Center/LS/MBOL/mombrochure_eng.pdf

MVP adheres to the Americans with Disabilities Act

MVP Health Care assists members with different cultural or linguistic needs. MVP has developed a brief overview of the Americans with Disabilities Act for its internal use that also includes information on diversity and sensitivity and the services that MVP offers to members who have a language barrier or who are visually or hearing impaired. To request a copy of this information, please contact the QI Department at **1-800-777-4793, ext 2602.**

Congratulations to NCQA-recognized physicians

MVP Health Care is pleased to announce that the following physicians have been recognized by NCQA for one or more of its physician recognition programs. Included here is a description of each of the five NCQA programs and the names of health care providers recognized with that certification.

The Back Pain Recognition Program (BPRP) recognizes physicians who provide high-value, patient-centered care for patients with low back pain.

DAVID L. HEFFER, DC
ANDREW A. VELARD, DC

The Diabetes Recognition Program (DRP) recognitions physicians who demonstrate that they provide high quality care to their patients with diabetes.

ROBERT J. AGOSTINELLI, MD
DIANE E. AHLMAN, MD
THOMAS J. ARNONE, DO
MARITZA Y. BAEZ, MD
ROBIN S. BAINES, MD
JOHN T. BANK, MD
JOSEPHINE BARRETT, MD
WILLIAM H. BAYER, MD
JUDITH K. BORBAS, MD
MATTHEW J. BROWN, MD
CLARK W. BRYANT, MD
ENRICO CAIOLA, MD
ELIAS CHRISTIDIS, MD
ROBERT E. COLE, MD
MELANIE R. CONOLLY, MD
LETITIA M. DEVOESICK, DO
BERNARD J. FARNAND, MD
ELIZABETH J. FELTNER, MD
JOSEPH C. FINETTI, MD
DANIEL J. FLAHERTY, DO
DOUGLAS J GOLDING, MD
CHERYL HERRMANN, MD
SHERYL R. HOLLEY, MD
SRINIVAS JONNALA, MD
STEFENIE L. KING, MD
RICHARD F. MITTEREDER, MD
MICHAEL NAZAR, MD
TIMOTHY L. NOLAN, MD
THOMAS J. PASTOR, MD
WILLIAM D. PUM, MD
MARK REIFENSTEIN, MD
BRETT W. ROBBINS, MD
STEVEN M. SCOFIELD, MD
LEO F. STORNELLI, MD
SCOTT A. STRATTON-SMITH, MD
MATTHEW T. WIZA, DO

The Heart Stroke Recognition Program (HSRP) recognizes physicians who demonstrate that they provide high quality care to patients with cardiac conditions or who have had a stroke.

BERTHOLLET M. BAVIBIDILA, MD
ROBERT E. COLE, MD
DANIEL J. FLAHERTY, DO
JAMES A. SLOBARD, MD
LEO F. STORNELLI, MD

The Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) program recognizes physician practices that function as medical homes, using systematic, patient-centered and coordinated care management processes.

MARITZA Y. BAEZ, MD
DEBORAH BALL CORNELL, MD
JOHN T. BANK
WILLIAM H. BAYER
SUNITHA BOLLINENI, MD
REENA BOSE, MD
ROBERT A. CAIFANO
MARK COHEN
JOSEPH A. DIPOALA JR
DAVID M. DOBRZYNSKI
SHAZIA JANMUHAMMAD, MD
SHERYL R. HOLLEY
SHELLY M. KANE
HARNEET R. KOHLI
ARIANE MARIE-MITCHELL, MD
CATHERINE MCPHEE
GEOFFREY G. MORRIS
MICHAEL NAZAR
SUE ANN NOVAK
WILLIAM D. PUM
ANN R. SHAMASKIN
NANCY G. SHEDD
ROBERT L. SMITH
SCOTT A. STRATTON-SMITH
ROBERT C. THOMSON
WAYMAN C. MCCOY, MD
BHASKARA REDDY, MD
KELLIE L REED, MD
VIKAS SINGLA, MD
MICHAEL D. TRAYLOR, MD

The Physician Practice Connections Program (PPC) recognizes a physician practice that has demonstrated application of clinical information systems, patient education and support, and care management to improve the health care delivered to his or her patients. Although there are no MVP providers recognized by this program to date at this time, we plan to include those who achieve this distinction in a future newsletter.

For more information about any of NCQA's physician recognition programs, visit **www.ncqa.org/tabid/74/Default.aspx.**