West (Roch/Buf)

healthy practices™

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IN THIS ISSUE

Provider Resource Manual updates

The following update to the *Provider Resource Manual* is effective September 1, 2010 and is reflected in the updated 2010 version of the manual that is accessible online when you log in at **www.mvphealthcare.com/provider.**

Hospital Appeals (Section 8 – Appeals Process):

A hospital appeal is a request, submitted by a hospital to MVP, requesting review of a denial of a properly submitted claim on the basis that such services are or were:

a. not medically necessary, or
b. experimental or investigational. MVP provides for two levels of hospital appeals (described below).

The hospitals are appealing on their own behalf and NOT the member. The hospitals are not the member's representative designee for this appeal process.

1. Level One Hospital Appeals

The first step in the hospital appeal process is to initiate a Level One Hospital Appeal, which will be reviewed by MVP's Appeals Department. A hospital may request to initiate a Level One Hospital Appeal by writing to: MVP Health Care, Attn: Appeals Department, 625 State St., Schenectady, NY 12305 within 180 days, (or per the specific contracted payment dispute time frame) from the hospital's receipt of MVP's initial denial notice (either the UM denial letter or the EOB, or MVP's Remittance Advice – whichever comes first). For New York fully insured products, MVP will render a decision on an appeal of a post-service (retrospective) claim denial within 60 days of MVP's receipt of all necessary information to conduct the appeal and will provide written notice of the decision within two business days upon rendering its decision.

2. Level Two Hospital Appeals

If the hospital is not satisfied with the result of the Level One Hospital Appeal, it may commence a Level Two Hospital Appeal, which a third-party arbitrator shall conduct. A hospital may initiate a Level Two Appeal by submitting a written request to the designated third-party arbitrator within 30 days of the hospital's receipt of MVP's Level One Appeals determination notice. Under Chapter 237 of the PHL's Alternative Dispute Resolution (ADR): A facility licensed under Article 28 of the Public Health Law and the MCO may agree to alternative dispute resolution in lieu of an external appeal under PHL 4906(2). This Level II Hospital Appeal conducted by MVP's designated third-party arbitrator is binding on both parties and serves as the final level of appeal. A hospital requesting a Level II Appeal is prohibited from seeking payment from a member for services determined not medically necessary by the designated third-party arbitrator. The party submitting the appeal to a third-party arbitrator is responsible for payment of the processing fee. MVP will reimburse a hospital for the entire processing fee if MVP's denial is reversed in total; and reimburse 50 percent of the processing fee if MVP's denial is reversed in part. In such cases, to obtain reimbursement from MVP for the third-party arbitrator processing fee, the hospital must submit a written request with a copy of the third-party arbitrator decision, to MVP at: MVP Health Care, Attn: Appeals Department, 625 State St., Schenectady, NY 12305.

Hold Harmless: Public Health Law was amended to add a new section 4917. A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable copays, from a member for services determined not medically necessary by the external appeal agent.

Changes for our Medicaid members

Beginning January 1, 2011, MVP will maintain all MVP Option (Medicaid), MVP Option Family (Family Health Plus), and MVP Option Child (Child 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.

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."

MVP HEALTH CARE

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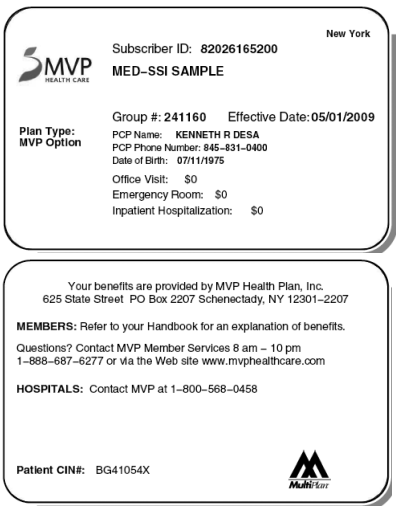
Members will receive a mailing in mid-December which will include a new ID card with their new ID number. We will remind members to show this card at their next visit. You will need to use this new ID number to submit claims or request authorizations starting January 1, 2011. An example of the card is shown below.

The provider portals will be unavailable on the weekend of December 18 and 19. 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 keep you informed of updates in the next edition of *Healthy Practices,* FastFaxes and upcoming provider/facility meetings.



Pulse oximetry reimbursement

Effective January 1, 2011, MVP Health Care will not provide reimbursement for the following pulse oximetry CPT codes:

94760 noninvasive ear or pulse oximetry for oxygen saturation; single determination

94761 noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations

This processing procedure will apply to all claims from all participating providers (physicians, hospitals and other facilities) for all MVP health plans.

In 1999, the Centers for Medicare and Medicaid Services (CMS) ruled that pulse oximetry is no more difficult than taking a patient's temperature, and should be reflected as such. Medicare considers these pulse oximetry codes to be always bundled, not reimbursed with any other procedure code. MVP will not provide reimbursement for these codes when billed in conjunction with other procedures or when billed alone.

MVP members are not liable for payment of these denied services.

Osteopathic manipulations performed by osteopathic physicians

New York State (NYS) mandates that all health plans that provide fully-insured health benefits include coverage for chiropractic care (chiropractic spinal manipulations to correct misalignment or subluxation of the vertebral column) specifically administered by a Doctor of Chiropractics.

CPT codes for the Osteopathic profession are separate and distinct from CPT codes used by Chiropractors. Chiropractic codes are the only manipulation codes that are covered under the mandate.

At present, MVP's West region (Rochester/Buffalo) allows for osteopathic manipulation coverage. To deliver the best possible service to our members and ensure a consistent network of health care providers across the entire MVP service area, coverage will be limited to Doctor of Chiropractics beginning January 1, 2011.

MVP is amending its benefit plans to allow coverage for chiropractic care specifically administered by a Doctor of Chiropractics. MVP's plans will no longer include osteopathic manipulations as a covered benefit in 2011.

Reminder: P.O. box for paper claims submission and attachments

MVP Health Care centralized its paper claims process on January 1, 2010 and discontinued fax lines as a means of submitting claims.

This is a reminder that Rochester P.O. Box 22920 is no longer active. Sending claims to this address will cause some claims to be returned if your envelope is printed with a no-forward notice.

If you have MVP business reply envelopes with the Rochester address on them, please do not attempt to correct the address.

The post office will not accept adjusted address labels, and will return the envelopes to you. Therefore, we request that you discard all old envelopes.

For important mailing addresses, e-mails and phone numbers, please refer to the *Contacting MVP* resource sheet posted on the MVP Health Care Web site at: **www.mvphealthcare.com/provider/documents/buffalo_roch_contact_list.pdf.**

Medicare Updates

Hospice claims processing for Preferred Gold HMO, GoldAnywhere PPO and USA Care products

As of July 15, 2010, MVP Health Care has adopted CMS billing and processing guidelines for Preferred Gold, GoldAnywhere PPO and USA Care members with active hospice elections.

Previously, providers were expected to bill Medicare Fee-for-Service for physician services and hospice for non-physician services related to a member's terminal condition. Services unrelated to that condition were billed to MVP as the sole payer.

Chapter 11, section 40.2.2 of the Medicare Claims Processing Manual states that "Medicare Fee-for-Service retains payment responsibility for all hospice and non-hospice related claims beginning on the date of the hospice election."

Therefore, providers of ***all*** services to members with active hospice elections should submit claims directly to Medicare Fee-for-Service or Hospice. Once payment for claims is received by your office, the Medicare EOMB and a secondary claim should then be submitted to MVP. We will coordinate benefits to pay balances due minus the member's responsibility.

Providers will have up to one year from the date of Medicare's remittance to submit a claim and a copy of the remittance from Medicare to MVP for secondary payment consideration.

Claims submitted to MVP as primary for members with current hospice elections will be denied with instructions to bill Medicare as primary.

We encourage you to reference CMS change request 6778, issued 2/5/10 for additional information. The Change Request and MLN Matters documents can be found at **www.cms.gov/Transmittals/2010Trans/list.asp**.

Medicare risk adjustment reviews continue

As a Medicare Advantage Plan, MVP Health Care is required to meet standards set by The Centers for Medicare and Medicaid (CMS) for data submission and coding accuracy. To confirm this information, the Medicare Risk Adjustment Team continues to work with many offices to scan our Medicare members' medical records. Collecting the medical records allows MVP to verify that serious or chronic medical conditions were reported with the most appropriate diagnosis and coded to the highest level of specificity as noted in the medical record.

This is not an audit of your office. The review will not result in any retroactive adjustments and your practice will not lose any reimbursement.

Thank you for working with us. Together, we are ensuring more consistent, accurate patient data and creating the most up-to-date picture of our Medicare members' health.

SilverSneakers® YogaStretch offers overall fitness for older adults

As a physician, you know that exercise is critical for the health and well-being of your older adult patients, but it may be challenging to find an activity that is reasonable for all ages and fitness levels. Yoga is one form of exercise that is adaptable for all needs and abilities, and can be practiced by children, seniors, and all ages in between. September is National Yoga Month and a great opportunity to encourage your patients to give this gentle but effective physical activity a try.

Yoga makes the body more fit and the mind calmer and more relaxed. Yoga also is beneficial in the prevention and treatment of common health and emotional challenges that can come with advanced age. "Senior citizens can experience profound benefits through yoga posture sequences specifically designed to address the common shifts that occur with age," says Evon Hart, CYI, a yoga instructor and licensed massage therapist in Phoenix.

According to Hart, "The most relevant benefit of the yogic breathing techniques is their ability to access the parasympathetic nervous system, which, when stimulated, calms all of the systems in the human body, including digestive, endocrine, lymphatic, muscular and skeletal." Additionally, yoga can begin to reverse the taxing effect of stress through physical movement, breathing techniques and meditation. Hart adds, "Research shows that regular yoga practice results in lowered levels of cholesterol, blood sugar, blood pressure and cortisol."

As you educate your patients about the importance of including regular physical activity in their weekly routines, be sure to share with them the benefits of yoga. The fact that your MVP Gold, GoldAnywhere and GoldValue patients have access to the SilverSneakers® Fitness Program gives you even more great news to share, especially since the program features a yoga class designed specifically for older adults called YogaStretch. YogaStretch engages participants both physically and mentally with a variety of safe and fun yoga postures and breathing exercises. Using a chair for support, your patients work at their own pace to build flexibility and endurance while learning to relax and think more clearly.

What better time to encourage your older adult patients to try a new physical activity than National Yoga Month? To learn more about the SilverSneakers Fitness Program and YogaStretch, visit **www.silversneakers.com**.

Quality Improvement Update

Chlamydia: educate your female patients about the "silent" STD

You can help prevent pelvic inflammatory disease, infertility, ectopic pregnancies, and other complications for your female patients. Test all sexually active women ages 16 to 25 for Chlamydia. All of these complications and many others can result from having Chlamydia. Teach your patients about the disease, its complications, and how they can be tested.

According to the Centers for Disease Control (CDC), Chlamydia is the most common bacterial sexually transmitted disease in the United States. In a longitudinal study, 4.2 percent of adults ages 18 to 26 had the disease in 2002, and its prevalence is on the rise. Despite this, results from HEDIS 2009 (the Health Plan Employer Data Information Set) indicate that more than 50 percent of women considered at-risk for the disease are not being tested.

Sexually active women ages 16 to 25 are especially at risk for Chlamydia infection. Annual testing is recommended for women in this demographic because the disease frequently has no symptoms. Studies indicate that almost three-quarters of women who are diagnosed had no prior symptoms. Untreated, Chlamydia can lead to pelvic inflammatory disease. In addition, it is a common cause of infertility and can increase a woman's likelihood of contracting HIV.

To help you educate patients about this condition, we sent a letter to female MVP members ages 20 to 24, encouraging them to talk with their physicians about Chlamydia screening. We also enclosed a brochure with information about this screening. A copy of the brochure is available to you in the *MVP Physician Quality Improvement Manual,* along with a poster and pamphlet on *Risky Teen Behaviors*.

Please contact the Quality Improvement Department at **518-388-2602** if you have any questions, or to request copies of these posters or brochures for your office. These materials also may be downloaded from the *Physician Quality Improvement Manual* posted on the MVP Web site at **www.mvphealthcare.com\provider.**

Population Health Management Updates

One phone number for MVP case and condition health management referrals

When your MVP patients are faced with a physical or mental health concern, call **1-866-942-7966** to make a referral to any of our **FREE** case and condition health management programs.

How MVP can help

MVP matches members with programs and resources that can help them manage or improve a medical condition, guide them through a medical event, and learn how to take the best care of themselves. Our programs are staffed by a team of nurses, respiratory therapists, social workers and other health care professionals.

We offer condition health management programs for members living with:

- Asthma
- Cancer (Oncology)
- Chronic Obstructive Pulmonary Disorder (COPD)
- Depression
- Diabetes
- Dialysis
- Heart Events (heart attack or blockages)
- Heart Failure
- Low Back Pain

We also offer services to help members whose needs require different resources than those provided through our condition-specific programs.

- Acute Case Management for members who have complications or other serious health concerns
- Little Footprints℠ for high-risk pregnancies
- The Option Case Management Program for Medicaid members
- Social work services that connect members to community resources and services

What our programs include

Education and Support

Program participants can talk with an MVP clinician who can answer questions and help them find community-based resources and health care solutions. Our clinicians can offer information about healthy eating habits, medication management, symptom monitoring and management, weight monitoring and fitness activities. We'll also send personalized mailings and newsletters with the latest health information!

Health Coaching

If your patient needs extra help to work through a health concern or mental health issue, he or she may be matched with a personal health coach. Health coaches work with both you and your patient to set and work toward goals that are important to their treatment plan.

Call **1-866-942-7966** to trigger an outreach. While not all programs are available to all MVP members, we will connect your patient with the help they need.

Tobacco cessation centers: a resource for physicians

The state of New York funds nineteen tobacco cessation centers as part of its Tobacco Control Program. Each Center's mission is to improve public health by training health care providers to design and implement evidence-based systems to identify tobacco users at every patient encounter and provide brief advice to quit.

By becoming familiar with the tobacco cessation resources and services available to your patients, you can better help them on the road to successfully quitting. Cessation Centers provide brief training (it takes less than an hour to complete) and free resources that enable doctors to quickly and easily refer their patients to cessation services and to the New York State Quitline at **1-866-NY-QUITS (1-866-697-8487)**. To find out more or to schedule training, call the Quitline or call the Cessation Center nearest you. For a listing, visit **www.mvphealthcare.com/provider/qim/documents/nys_smoking_cessation_centers.pdf.**

Additional resources are online at **www.talktoyourpatients.org**.

UM Updates

Execution of clinical criteria

InterQual® criteria, published by McKesson Health Solutions, is used in many of MVP Health Care's medical review processes to support the medical necessity of health care services. The criteria is updated by McKesson Health Solutions to be consistent with evidence-based standards of care and current practices. MVP began using the 2010 InterQual criteria on September 1, 2010.

Modifier 22: suggestions for quicker processing

Modifier 22 (Increased Procedural Services) should only be applied for procedures that require a level of work far more extensive than what is usually necessary for that procedure. Documentation is the key component and must support the reason for this substantial work. MVP Health Care's Utilization Management (UM) team reviews each claim that includes modifier 22 against several criteria, which may include sample size, increased time, technical difficulty of procedure, severity of patient's condition and actual time spent.

The submission of a procedure with modifier 22 does not ensure coverage or additional payment. Claims for procedures billed with modifier 22 are determined on a case-by-case basis after careful consideration of all documentation.

To ensure the quickest processing, please take a few moments to add documentation to claims that include modifier 22 that details why the procedure was complicated and additional time spent.

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the August 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 Oct. 1, 2010

Cochlear Implants & Osseointegrated Devices

- Language was added stating that replacement batteries will not be covered unless they are covered in the member's base contract or the member has an appropriate rider.
- *A Medicare and MVP Option Variation* was added to the policy stating that replacement batteries are covered for use with cochlear implant device speech processors for both hip-worn and behind-the-ear.

CT Chest/Small Pulmonary Nodules Follow-up – NEW Policy

- This policy follows the Fleischner Society criteria for low-risk and high-risk patients for follow-up and management of nodules <4 mm to >8 mm in diameter.

CT Kidney – NEW Policy

- This policy was developed following the high-level InterQual criteria for CT Kidney.

Intensity Modulated Radiation Therapy (IMRT)

- The *Indications* follow NCCN Guidelines.
- The *Medicare Variation* was deleted from the policy as there is no longer a national or local coverage determination.
- In the absence of Medicare criteria, the policy follows Commercial criteria for all products.
- Language was added under the policy *Exclusions/Limitations* that individual cases not meeting medical necessity criteria are reviewed on a case-by-case basis.

Laminectomy/Hemilaminectomy – Lumbar Spine

- CPT Codes 63185 & 63190 **will be added** to the policy effective 10/1/10.
- This policy requires prior authorization.

Neuropsychological Testing

- The policy was updated to be in line with the American Academy of Child and Adolescent Psychiatry Guidelines regarding ADHD.

Ventricular Reduction Surgery

- There were no changes to this policy since the last annual review.

Vision Therapy (Orthoptics, Eye Exercises)

- This policy is a non-coverage policy for all products except for MVP Option and MVP Option Family.
- *An MVP Option Variation was added to the policy: Vision therapy is covered to include oculomotor exercises, stereoscopes, vectograms, tracing pictures, completing puzzles, patching/occlusion for amblyopia, prisms to compensate for muscle imbalance and surgery of the eye muscles.*

The policies listed below were presented to the QIC at the August meeting. The policies were recommended for approval without changes. These policies were comprehensively reviewed during 2009. QIC approved the recommendation.

- Continuous Glucose Monitoring
- Continuous Passive Motion Devices
- CT Coronary Arterial Disease
- Deep Brain Stimulation
- Electromyography (EMG) & NCS
- Endovascular Procedures
- High Frequency Chest Wall Oscillation Devices
- Home Care Services
- Home Prothrombin Time Monitoring
- Hospice Care
- Low Vision Aids
- Metal-on Metal Hip Resurfacing
- Oncotype Dx Test/Breast Cancer Prognosis
- Oxygen Therapy for Cluster Headaches
- Prosthetic Devices (Lower Limb)
- Prosthetic Devices (Eye & Facial)
- Radiofrequency Ablation for Spinal Pain/Rhizotomy
- Yttrium-90 Microspheres for Treatment of Liver Cancer

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

Coming Soon

The Healthcare Information Xchange of New York (HIXNY) HIPAA Workgroup will be posting a Web page on the Iroquois Healthcare Alliance (co-founder of HIXNY) Web site at **www.iroquois.org**. The main purpose of this Web page will be to coordinate 5010 information between payers and health care providers. Some of the informational items will include:

- Payer 5010 testing schedules
- Common claim status codes by payer (276/277)
- Common adjustment reason codes by payer (835)

Look for more information in the November issue of *Healthy Practices*. If you have questions, please contact MVP's EDI Services.

EDI 5010: Claims Misc. (837I/837P)

Subscriber/Patient:

The Subscriber/Patient hierarchy has changed to follow the same principles used in other HIPAA transactions, such as Eligibility Request/Response and Claim Status Inquiry/Response. The basic principles are as follows:

- If the patient has a unique identifier assigned by the destination payer in Loop ID-2010BB, the patient is considered to be the subscriber and is sent in the subscriber loop (Loop ID-2000B). The Patient Hierarchical Level (Loop ID-2000C) is not used.
- If the patient is different than the subscriber and the patient does not have a unique identifier, the subscriber information is sent in Loop ID-2000B and the patient information is sent in Loop ID-2000C.

Claim:

- The Total Claim Charge Amount **(CLM02)** now explicitly states that it must be the sum of the service line charge amounts (sum of the **SV203**s).
- The Assignment or Plan Participation Code **(CLM07)** has changed from Situational to Required.

Institutional Claim:

- A Present on Admission Indicator was added to the Other Diagnosis Information **(HI)** segment.
- The Attending Physician Name **(NM1)** segment was renamed to Attending Provider Name.
  - The Attending Provider must be a person; (Loop ID-2310A|NM102 must be a **'1'**).

Professional Claim:

- Twelve diagnoses are allowed. In the Health Care Diagnosis Code **(HI)** segment, **HI09, HI10, HI11** and **HI12** were changed from Not Used to Situational to enable reporting of up to twelve diagnoses.
- The Referring Provider must be a person; (Loop ID-2310A|NM102 must be a **'1'**).

- Ambulance claims must now must include both a pick-up location and address along with drop-off location and address.
- On anesthesia claims, time must be reported in minutes. The use of units is no longer allowed.

  Anesthesia time is counted in minutes from the moment that the practitioner, having completed the preoperative evaluation, starts an intravenous line, places monitors, administers pre-anesthesia sedation, or otherwise physically begins to prepare the patient for anesthesia. Time continues throughout the case and while the practitioner accompanies the patient to the post-anesthesia recovery unit (PACU). Time stops when the practitioner releases the patient to the care of PACU personnel.
- A Place of Service Code is now required.

In the next issue of *Healthy Practices*, learn more about "Eligibility: 270/271" 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 will include 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.**

Engage vendors early

Software vendors are not covered entities; and, therefore, they are not responsible for compliance. However, vendors are critical to provider compliance and any interruption in vendor implementation of compliant products will delay end-to-end testing.

Here are some questions to ask your vendor(s):

- ☐ Will you upgrade your current system to accommodate Versions 5010 transactions?
- ☐ Will the upgrade include acknowledgement of transactions 277CA and 999?
- ☐ Will the upgrade include a "readable" error report produced from 277CA and 999 transactions?
- ☐ When will you be capable of supporting Version 5010 transactions exchange?
- ☐ Will you be able to support both Version 4010A1 and Version 5010 transactions exchange concurrently?
- ☐ When will the current system accommodate both the data collection and transactions conduction for Version 5010?
- ☐ When will the upgrades be available?
- ☐ Will there be a charge for the upgrade?
- ☐ When will the software installation to the systems be completed?
- ☐ Will the transition be completed before the January 1, 2012 compliance date?
- ☐ Will there be sufficient lead time to test the new software before the January 1, 2012 compliance date?

Based on the vendor's responses to the questions above, evaluate the impact to routine operations and begin planning for training and transition.

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

Pharmacy Updates

Policy updates effective October 1, 2010

ACE/ARB

- Table identifying which products require step therapy or prior authorization was added. Also indicated is the tier in which each product is covered.
- Twynsta was added to the policy and is subject to step therapy.

Arthritis, Inflammatory Biologic Drug Therapy

- Actemra was added to the policy. Coverage criteria will mirror Orencia and Remicade.
- For Rituxan, initial and subsequent re-treatments will be on a case-by-case basis.
- Under exclusions, biologic agents will not be covered in combination.

Contraceptive Agents & Family Planning

- Lunelle was removed from the policy; product is no longer on the market.

Cystic Fibrosis

- Medicare language was updated regarding Part D vs Part B coverage of TOBI based on diagnosis.

Direct Renin Inhibitors

- Name change; previously called Tekturna policy.
- Valturna was added, requiring prior authorization.

Growth Hormone

- Added language that all dose increases require prior authorization.

Hereditary Angioedema

- New policy requiring prior authorization for Cinryze, Berinert and Kalbitor.
- Must be ordered by an allergist or immunologist.
- Member must have a confirmed diagnosis by laboratory results, a contraindication or severe intolerance to attenuated androgens and compliance on preventive therapy.
- Triggers of attacks have been prophylactically treated and severe attacks persist.

Infertility Drug Therapy

- Language added stating any drug used off-label for infertility requires prior authorization.

Leukotriene Modifiers

- Exclusions, including cough, reactive airway disease and intermittent asthma were added.

Mail Order

- Exclusion statement was added that non-self administered injectable drugs are not available from mail.
- Boniva IV, Reclast, Tyvaso and Cayston were added as exclusions.

Orphan Drugs and Biologics

- Folotyn and Ilaris were added.

Osteoporosis Medications (Injectables)

- Osteopenia, also called low bone mass, was defined as T-score between -1 and -2.5.

- Endoscopy was added as objective evidence of ulcer disease.
- Hip location was added as appropriate site for BMD.

Pulmonary Arterial Hypertension

- Explanation of WHO PAH groups vs NYHA functional classes was added.
- Treatment with Revatio requires a step through Adcirca for new starts.
- Treatment with Tracleer requires a step through Letairis for new starts.
- Language regarding vasoreactive testing and the use of calcium channel blockers was updated.
- Extension of therapy, when approved, will be for 12 months.
- Language clarified as to when six-minute walk tests are required.

Samsca

- New policy requiring prior authorization when treating hyponatremia.
- Patient must be 18 years of age or older and have been evaluated for factors contributing to the condition.
- Serum sodium less than 125 mEq/L OR hyponatremic with a serum sodium greater than or equal to 125 mEq/L AND symptomatic AND unable to restrict fluid due to documented disorder or condition that would limit compliance with fluid restriction.
- Unless contraindicated, must be a failure of fluid restriction, saline infusion, drug therapy (e.g. demeclocycline, urea, etc.), and/or sodium restriction (if indicated) or removal of offending medication.
- Medication must be initiated and titrated while in the hospital.

Xolair

- Immunologists as requesting providers were added.
- Added "reduction is ER/hospital/office visits due to asthma" as criteria for an appropriate response to treatment.

Zorbtive

- New policy establishes criteria for use in Short Bowel Syndrome.
- Must be prescribed by a gastroenterologist.

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

- Acromegaly
- Acthar
- Gaucher's Disease Type 1 Treatment
- Intranasal Steroids
- Kuvan
- Patient Medication Safety
- RSV
- Smoking Cessation
- Treatment of Fabry Disease

Medication Therapy Management (MTMP) Program

The MTMP is a CMS-required feature of Medicare Prescription Drug Plans. The program is for qualified MVP Health Care 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 $3,500.

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.

On occasion, laboratory data and/or additional information may be requested from providers so that a comprehensive medication review can be preformed. Your office may receive a request via fax or mail for this information. Your assistance with the program is greatly appreciated. Please call **1-866-942-7754** if you have any questions.

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. Please update your e-Pocrates account if your computer or PDA is set up to automatically download the Formulary. Unless otherwise noted, the following Formulary information is effective **October 1, 2010**.

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

Drug Name	Indication
Lumizyme *(medical benefit)*	Pompe Disease
Mirapex ER	Parkinson's disease
Natazia	Contraception
Oleptro	Major depressive disorder
Oravig	Oropharyngeal candidiasis
Pancreaze	Exocrine pancreatic insufficiency
Prolia *(obtain from CuraScript, medical benefit)*	Osteoporosis
Provenge *(medical benefit)*	Prostate cancer
Vimovo	OA, RA and AS
Zortress *(obtain from CuraScript, medical benefit)*	Prevent organ rejection (kidney)
Zyclara	Actinic keratosis
Zymaxid	Conjunctivitis

Generic drugs added to Formulary (Tier 1)

amoxicillin clavulan (Augmentin XR)	anastrazole (Arimidex)
Gianvi (Yaz)	famotidine (Pepcid Susp)
imipramine pamoate (Tofranil-PM)	adapalene (Differin Gel)
naratriptan (Amerge)	venlafaxine XR (Effexor XR)
omepraz/sod bicarb (Zegerid)	rivastigmine (Exelon)
trandolapril/verapamil (Tarka)	azelastine (Astelin Nasal)

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

Bepreve	Metozolv ODT
Embeda *(step therapy and quantity limit)*	Zyprexa Relprevv† *(medical benefit)*
Fanapt	Twynsta *(step therapy)*
Intuniv	Zenpep
Istodax† *(medical benefit)*	Vibativ† *(medical benefit)*
Welchol Packets	Fibricor
Zipsor	Arzerra† *(medical benefit)*
Zirgan	

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

*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.

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

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

Arimidex	Effexor XR

Formulary updates for Medicare Part D members

You can now access and download the MVP Medicare Part D Formulary 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.htm.**

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

Drug Name	Tier	Prior Authorization Required
azelastine (Astelin Nasal)	1	No
methamphetamine 5mg (Desoxyn)	1	No
Norvir 100mg	2	No
trandolapril/verapamil (Tarka)	1	No
Zirgan	3	No
Zortress	Specialty	Yes

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

Drug Name	Reason for Change	Effective Date
Cardizem LA Tabs 180mg, 240mg, 300mg, 360mg, 420mg	Generic equivalent is available	10/1/2010
Cozaar	Generic equivalent is available	10/1/2010
Hyzaar	Generic equivalent is available	10/1/2010
Evoclin	Generic equivalent is available	10/1/2010
Skelaxin	Generic equivalent is available	10/1/2010
Desoxyn	Generic equivalent is available	11/1/2010
Alacol drops	Deemed as a non-Part D drug by CMS	10/1/2010
Alenaze-D liquid	Deemed as a non-Part D drug by CMS	10/1/2010
Atropine drops and ointment 1%	Deemed as a non-Part D drug by CMS	10/1/2010
Brovex PB tablets/ PEB liquid	Deemed as a non-Part D drug by CMS	10/1/2010
Cetacaine gel	Deemed as a non-Part D drug by CMS	10/1/2010
J-Tan D	Deemed as a non-Part D drug by CMS	10/1/2010
Levulan	Deemed as a non-Part D drug by CMS	10/1/2010
nitroglycerin capsules 6.5mg	Deemed as a non-Part D drug by CMS	10/1/2010
Respahist-II	Deemed as a non-Part D drug by CMS	10/1/2010
Tanabid SR	Deemed as a non-Part D drug by CMS	10/1/2010
phenazopyridine 100mg, 200mg	Deemed as a non-Part D drug by CMS	10/1/2010
Pramoxine-HC	Deemed as a non-Part D drug by CMS	10/1/2010
Pyridium 100mg, 200mg	Deemed as a non-Part D drug by CMS	10/1/2010
Zotane-HC	Deemed as a non-Part D drug by CMS	10/1/2010
Seradex-LA	Deemed as a non-Part D drug by CMS	10/1/2010
Pramozone-E cream	Deemed as a non-Part D drug by CMS	11/01/2010
isoxsuprine 20mg	Deemed as a non-Part D drug by CMS	11/01/2010
Oticin-HC drops	Deemed as a non-Part D drug by CMS	11/01/2010
Otirx drops	Deemed as a non-Part D drug by CMS	11/01/2010
trimethobenzamide 250mg capsules	Deemed as a non-Part D drug by CMS	11/01/2010