West (Roch/Buf)

healthy practices™

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IN THIS ISSUE

New 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. Reward dollars are earned as points; members earn points for things like completing an online health assessment, participating in lifestyle coaching programs and also by **working with you to achieve individual health goals.**

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. A copy of the form is included with this issue of *Healthy Practices*.

"I encourage my patients to complete health screenings as part of routine preventive care. I am excited because now my patients can earn rewards for getting screened and achieving important health goals. This is great because screenings are so important in monitoring health, preventing disease and knowing when I need to work with my patients to get their results into recommended ranges. WellStyle Rewards will help strengthen the team approach I try to foster with my patients."

— Joseph DiPoala, M.D.
Ridgeview Internal Medicine Group, Rochester, New York

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. Once you have signed the form, please return it to your patient. If cholesterol and fasting blood sugar results are not yet available at the time of their office visit, our members will be instructed to attach a copy of their lab results to their form when they submit it.

Health measures like BMI, blood pressure, blood sugar, total cholesterol and tobacco usage can all be changed for the better through lifestyle modification. We hope that completing this screening form not only rewards members for achieving health recommendations, but also helps you and your patient work together to improve their results and their overall health. It is a valuable opportunity for our members to get a more complete picture of their health status and also can help strengthen the team approach that you take with your patients.

We appreciate your participation in this WellStyle Rewards initiative. Thank you for helping MVP members to take on life and live well!

Provider Web portal single sign-on

MVP Health Care is enhancing provider Web portal user accounts to allow access to information on all MVP patients with a single login ID. Once enabled:

- Users can access information for ANY patient with MVP coverage (an MVP ID that begins with a number or a letter) with a single username and password (login ID).
- Users can access all providers associated with the Tax IDs defined by their account.
- Users with access to McKesson's ADM tool for online radiology authorizations will continue to require a separate login for that system.

MVP Health Care's eSupport team will enable access for all existing provider portal users by April 2011. New users will automatically be enabled.

Accounts with many users (100 or more) will be contacted by MVP Professional Relations preceding their migration to kick off the process and help answer any questions. MVP's eSupport team will then work closely with these users to ensure a smooth transition to single sign-on. All other users will receive an e-mail from MVP about 30 days before being transitioned to single sign-on that announces the upcoming change and includes a link to a *Provider Portal Single Sign-on Help* document that shows the changes (go to **www.mvphealthcare.com/provider** and then select *Reference* on the green toolbar).

Users enabled with single sign-on will see a *Provider Snapshot* screen after logging in. If you typically use the provider portal to look up patients with an MVP ID that begins with a number, this will not be a change for you, but it will be an indicator to users who typically log in to look up patients with MVP IDs that begin with a letter that single sign-on is enabled for their account.

MVP HEALTH CARE℠

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Contacting Professional Relations

MVP Corp. Headquarters	(888) 363-9485
Buffalo	(716) 839-1366, x1000
Rochester	Call your representative or Provider Services at (800) 999-3920

Comments

Write to:
Healthy Practices
MVP Health Care, Inc.,
Professional Relations Dept.
PO Box 2207, Schenectady, NY 12301

If you usually use the provider portal to look up patients with an MVP ID that begins with a number, you will notice your account is enabled with single sign-on when the *Provider Snapshot* screen shows your Tax ID instead of an individual provider name, address and/or NPI.

If you have questions about when your account will be transitioned to single sign-on, please contact your Professional Relations Representative. If you have questions about what changes you will find within the provider portal once your single sign-on is enabled, please refer to MVP's *Single Sign-on Help* document at **www.mvphealthcare.com/provider/documents/SSO-Navigation-Overview.pdf.** Users who need assistance after obtaining single sign-on access may e-mail the MVP eSupport Help Desk at **esupport@mvphealthcare.com** or call **1-888-656-5695**.

Refer patients to MVP's Case/ Condition Health Management Programs

For a list of MVP Health Care's case and condition health management programs that you can print for quick reference, visit **www.mvphealthcare.com/provider/documents/CHMReferralGuide.pdf**. We've included details about which patients to consider referring to each program and what information MVP may request from you to help us serve your participating patients – all in an easy-to-follow, single-page grid!

New "return claim" letter to replace remittance advice

As introduced in the November 2010 issue of *Healthy Practices,* please be reminded of the changes to the way certain claims errors will be handled out of MVP's FACETS claims processing system. Several 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 rollout for this change began on December 20 and will take place gradually through January 2011.

Please note that this change only affects 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.

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 submitted as "$0" or left blank
- Line Charges submitted as "$0" or left blank
- 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 some 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

Change in clinical review requirements for GoldCarded procedures

Since 2006, MVP Health Care has allowed authorizations without clinical review (a practice also known as GoldCarding) for the certain procedures when requested by health care providers in MVP's West region (Rochester/Buffalo) who are credentialed on the AMISYS claims processing system.

MVP continues to integrate processes, systems and policies across its service area. In its current form, the GoldCarding policy in the West region is not one that will be effective in other regions. MVP intends to build and then re-introduce a new program that will be common across many regions and be inclusive of more health care providers and procedures. As that work gets underway, however, **MVP will discontinue GoldCarding as of March 1, 2011 and will require that authorizations for these procedures go through the clinical review process.** The new program is slated to launch within a year of discontinuing the current GoldCarding program.

To alleviate some of the added work associated with this change, we are pleased to announce that an online radiology authorization tool — McKesson's Advanced Diagnostics Management (ADM) — will soon be available to you. ADM will streamline the authorization process and minimize additional administrative requirements for you and your staff, drastically reducing the number of phone calls needed to gain authorization and allowing you to focus on the care of your patients. ADM will be in place as of March 1 when GoldCarding is eliminated. With ADM, your office will be able to:

- receive real-time authorizations when criteria are met;
- check authorization status; and
- print approved authorizations.

If you have any questions, please contact Provider Services.

Modifier 22 process changes

McKesson ClaimsXten Clinical Editing Software replaced CodeReview and Patterns on January 1, 2011. ClaimsXten Clinical Editing Software is now used to process claims for members on both of MVP's systems (FACETS and AMISYS). As a result, you will see a change in how modifier 22 claims are processed when submitted without documentation.

For paper claims submitted with modifier 22: If documentation does not accompany the claim, modifier 22 will be removed and the claim will pay at the normal fee schedule with a payment code and description of *WZ – CI – XTEN – CPT modifier disallowed – Medical documentation required.*

If you want to have the claim reviewed for additional reimbursement, the claim must be resubmitted on paper and accompanied by supporting documentation, as well as a completed *Claim Adjustment Review Form* to support the use of modifier 22. Once received, the claim will be reviewed for appropriateness. If approved, the claim will be paid an additional 20 percent.

For electronic claims submitted with modifier 22: Modifier 22 will be removed and the claim will pay at the normal fee schedule with a payment code and description of *WZ – CI – XTEN – CPT modifier disallowed – Medical documentation required.*

If you want the claim reviewed for additional reimbursement, please follow the process outlined above. Upon review, if modifier 22 is deemed to be inappropriate, the modifier will be removed and the claim will remain paid at the normal fee schedule rate with an explanation of payment code of *V2 – CPT modifier documentation does not support additional reimbursement.*

Reminder: check your pharmacy fax number

When faxing pharmacy authorization requests to MVP's pharmacy department, please confirm that you are faxing the information to the correct number. We have been advised that an entity with a similar number is receiving faxes from MVP providers who are mis-dialing. This is a HIPAA violation, as there is Protected Health Information included in pharmacy authorization requests. Please be sure to use the following pharmacy fax numbers:

Commercial Plans: 1-800-376-6373
(HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D: 1-800-401-0915
(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)

Medicaid Update

Changes in effect for MVP Medicaid members

As of January 1, 2011, MVP is maintaining all MVP Option (Medicaid) and MVP Option Family (Family Health Plus) members on our FACETS system. Following is a list of changes that you will see.

New Member ID numbers as of January 1, 2011

With the transition to FACETS, the member ID number is a nine-digit number beginning with "82." Members received a mailing in December 2010 with a new ID card that includes the new ID number, along with a reminder to show the new card at their next visit.

New ID required on claims and authorizations

Please remember to use the new ID number that begins with "82" when submitting claims or requesting authorizations.

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. The CIN is located on the back of the member's new MVP ID card.

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. 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.

Quality Improvement Update

HEDIS® and QARR data collection begins

In February 2011, the MVP Quality Improvement (QI) Department will begin its annual Healthcare Effectiveness Data and Information Set (HEDIS); and New York state Department of Health Quality Assurance Reporting Requirements (QARR) data collection.

HEDIS and QARR are sets of standardized performance measures designed to ensure that consumers and purchasers have the information they need to reliably compare managed health care plans. Managed care organizations are required to report their rates to the National Committee for Quality Assurance (NCQA) and the New York state Department of Health.

Every year, the collected HEDIS data is used to guide the design and implementation of our health management activities, measure MVP's health management programs' effectiveness, and measure our performance against other health plans.

MVP has again contracted with Interim Healthcare for registered nurses to help our QI staff collect data from medical records that measure clinical performance in the following areas:

- Adult BMI Assessment
- Adolescent Screening and Counseling
- Immunizations for Adolescents
- Cholesterol Management for patients with Cardiovascular Conditions
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Prenatal and Postpartum Care
- Frequency of Ongoing Prenatal Care

MVP QI staff or an Interim Health Care representative may contact your office to schedule the chart review. We appreciate your cooperation and will make every effort to minimize any impact the review may have on your office operations.

Please note: HEDIS/QARR are part of "health care operations" and, therefore, the Health Insurance Portability and Accountability Act (HIPAA) does not require authorization from the individuals to release their protected health information (PHI) for health care operations activities. MVP has strict standards for the collection and storage of this information.

Thank you in advance for your cooperation and support during these important quality activities. If you have questions, call Betsy LaRose, R.H.I.T. at **518-388-2290** or **1-800-777-4793, ext. 2290**.

Medical Policy Updates

Medical policy updates effective February 1, 2011

Botulinum Toxin Treatment

- The policy has been updated to include XEOMIN® for the treatment of cervical dystonia and blepharospasm. Adults 18 years old and older must have been previously treated with Botox.
- Anesthesiologist was added as an appropriate specialist to order and administer botulinum toxin for neuromuscular indications.
- Gastrointestinal, general surgeon and colorectal surgeon were added as appropriate specialists to order and administer botulinum toxin was added for gastrointestinal indications.

Hearing Aid Services

- The policy has been updated to include hearing aid benefits for the Commercial, MVP Option, Option Child, Option Family, GoldAnywhere PPO and New Hampshire products.
- Medically necessary hearing aids are covered for Commercial members if the benefit is listed in the patient's base contract or if the member has the appropriate rider. Only one hearing aid per ear is considered medically necessary. Ear molds are covered. Disposable ear molds are not covered. Disposable hearing aids and extended wear hearing aids are considered not medically necessary.
- Variations have been added for MVP Option, Option Child, Option Family, GoldAnywhere PPO and New Hampshire. The New Hampshire Variation will be effective January 1, 2011.

Intraoperative Neurophysiologic Monitoring – NEW Policy

- This policy addresses evoked potentials used in surgical intraoperative neurophysiologic monitoring during spinal procedures.

Tumor Markers (OVA1) – NEW Policy

- This policy specifically addresses OVA1™.
- OVA1™ is considered investigational and therefore is not covered.

Medical policy updates effective March 1, 2011

Compression Stockings – NEW Policy

- Previously, compression stockings was addressed in the Pressure Garments (TED or Jobst), Compression Garments and Elastic Stockings medical policy.
- Coverage for compression stockings is not allowed for Commercial products 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.
- For MVP Option products, support hose, as well as surgical stockings with compression factors between 18 mm/hg and 30 mm/Hg, are considered medical supplies. Gradient compression surgical stockings are considered DME. For Medicaid managed care, support hose and single compression surgical stockings are covered by fee-for-service Medicaid while gradient compression surgical stockings are the responsibility of the plan.

Pressure Garments (TED or Jobst), Compression Garments, and Elastic Stockings – Archived Policy Effective 3/1/11

- Burn garments and lymphedema sleeves are addressed in the new Burn Garments and Lymphedema Sleeves medical policy which became effective 12/1/10.
- Compression stockings are addressed in the new Compression Stockings medical policy. Effective 3/1/11.

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

5010 claim status

The following changes will occur in the 5010 version of the Claim Status Inquiry (276/277):

- As with Eligibility and Claims, the patient is considered the subscriber, so there is no need for dependent loops.
- Provides support for Prescription Number.
- Requesters are required to evaluate the necessity of sending certain information. If it is not needed for search refinement, the data is not to be sent. (Minimum Necessary)
- Information Receiver must be identified by an ETIN (Electronic Transmitter Identification Number).
- Provider Name: 5010 allows for Billing or Rendering. MVP Health Care requires Rendering Provider.
- MVP plans to return Claim Status at both the claim and service line level.

Real-time eligibility

Effective December 6, 2010, MVP has implemented Real-Time eligibility via our new vendor relationship with Post-n-Track. Post-n-Track is now hosting MVP's EDI eligibility inquiry (270/271) for all MVP members whose ID begins with an "8". MVP's plans

to make Real-Time eligibility available for all of its members in January 2011. Any questions concerning this transaction may be directed to MVP's EDI Services Unit.

EDI helpful tips

Tip #1: After sending your electronic claim file, be sure to download your 277U or your Confirmation and Edit reports that are created for you by MVP. These reports are the ONLY place where you will see an alert if any of your claims have been RETURNED, as well as the reason for the return. If a claim has been RETURNED, this means it will NOT be processed and must be corrected and re-sent.

If you are using a clearinghouse or billing service, they should return two reports: a billing service or clearinghouse rejection report, as well as a translation of the MVP rejections. Please be sure to contact the clearinghouse or billing service if you are not receiving these reports.

Tip #2: When a claims returned for Gender Mismatch and you are sure that you have the correct gender, please check to be sure you have the correct member suffix. You can check the member suffix online when you log in to MVP's Web portal for providers at **www.mvphealthcare.com/provider**.

Post-n-Track

During MVP's provider seminars, we introduced you to Post-n-Track (PNT). 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.

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 changes to data reporting requirements

The data reporting requirements for Version 5010 transactions differ from the current transactions. These changes may require the collection of additional data or reporting data in a different format. For example, with Version 5010, the billing provider address can no longer be reported as a P.O. Box or lockbox address. Some questions to consider regarding data reporting requirements:

- Can we identify the data reporting changes for the transactions we use?
- Can we find the resources to assist us in identifying the data reporting changes and if so, what is the cost of the resources?
- Can this new data be stored in our current system or will it require a system upgrade to store it?
- Will we need to purchase additional hardware for the new reporting requirements?

☐ Identify possible modifications to current workflow and business processes

Once data reporting changes have been identified, workflow modifications may be necessary. Some questions to consider:

- What workflow processes do we need to change or add to capture the new data?
- What additional costs will we incur from new data collection methods?

Based on the responses to these questions, you will know what changes in your data reporting may be needed to support 5010 and how those changes translate to your business processes and expenses.

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

Pharmacy Updates

Propoxyphene withdrawal

On November 19, 2010, the Food and Drug Administration (FDA) announced that Xanodyne Pharmaceuticals Inc. agreed to voluntarily withdraw its pain medication Darvon® and Darvocet-N® (propoxyphene and propoxyphene/acetaminophen) from the U.S. market because of new clinical trial data indicating potentially serious or even fatal heart rhythm abnormalities. The FDA recommends that prescribers should not issue any further prescriptions for propoxyphene-containing products and pharmacists should stop dispensing the drug and patients should discontinue taking the medication. MVP has sent letters to members who have been prescribed propoxyphene-containing products and advised them to contact their health care providers as soon as possible. If you have any questions or require further information regarding the market withdrawal of propoxyphene, contact Xanodyne's Medical Information department at **1-877-773-7793.**

Pharmacy policy and formulary update effective January 1, 2011

Chronic Hepatitis C

- For Pegasys & Copegus, language regarding reported red cell aplasia and use with azathioprine was added
- Information regarding duration of treatment for Rebetol and expanded indication for Infergen also was added

Constipation and IBS Medications

- An overview section was added that details the disorder and associated symptoms

Crohn's Disease and Ulcerative Colitis

- Name changed from Select Agents for Inflammatory Bowel Disease
- For Remicade, members who have fistulating disease must have failed or be intolerant to immunosuppressants and antibiotic therapy
- Step through Humira is not required for members <18 years of age
- For Remicade and Tysabri, documentation must include CDAI-defined symptoms

Enteral Therapy New York

- Statement added requiring all providers, including pharmacies, home infusion and DME, to bill through the pharmacy benefits management system

Immunoglobulin Therapy

- Criteria were updated and/or clarified for use in primary humoral immunodeficiency, ITP, CLL and bone marrow transplant patients
- Hizentra (SQ immunoglobulin) was added to the policy

Proton Pump Inhibitors

- The overview section was updated to include possible increased risk of osteoporosis-related fractures with high-dose, long-term PPI therapy
- Information about the use of PPIs with clopidogrel also was added

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

- Government Programs OTC
- Quantity Limits

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 January 1, 2011.

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

Drug Name	Indication
Iprivask	Prophylaxis of deep vein thrombosis
Suboxone Film	Opioid dependence
Tekamlo	Blood pressure
Veltin	Acne
Xeomin *(medical benefit)*	Cervical dystonia

Generic drugs added to Formulary (Tier 1)

adapalene gel & cream 0.1% (Differin)
azelastine (Astelin Nasal Spray)
diazepam rectal gel (Diastat)
hydrocodone/chlorpheniramine (Tussionex)
lansoprazole tablets[QL] (Prevacid Solutabs)
oxymorphone (Opana)
rivastigmine capsules (Exelon)
zolpidem CR[QL] (Ambien CR)

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

Exalgo (subject to step therapy and quantity limits)

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

Astelin Nasal Spray
Differin Gel & Cream 0.1%
Exelon Capsules

*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 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
Oforta	Specialty	Yes
Vpriv	Specialty	Yes

Coverage Gap Discount Program

Beginning January 1, 2011, most pharmaceutical manufacturers will provide 50-percent discounts on the cost of covered brand-name prescription drugs for non-LIS beneficiaries in the Medicare Part D coverage gap (donut hole). Only those drugs covered by the manufacturer discount agreement will be covered under the Part D program. Medicare has determined that compounds are not applicable drugs for purposes of the Coverage Gap Discount Program. In addition, the following drugs will not be covered under the Part D program on and after January 1, 2011:

Acetadote	Lithostat
Alferon N	Myobloc
Cardene Sr	Sucraid
Estrogel	Thiola
Flebogamma	Tindamax
Flebogamma Dif	Vivotif Berna
Fusilev	

A complete list of formulary changes may be found at **www.mvphealthcare.com/medicare/rochester/partd_drug_lists.html.**