West (Roch/Buf)

healthy practices™

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www.mvphealthcare.com

IN THIS ISSUE

New electronic claim submission rules begin January 1, 2012

If you currently submit electronic claims using an ANSI X12 4010 A1 837-P or 837-I format to MVP Health Care, you must switch to an ANSI X12 5010 837-P or 837-I format by January 1, 2012. MVP is already prepared to accept 5010 837-P and 837-I electronic claim submissions.

- If you submit electronic claims directly to MVP, you may contact MVP's EDI Services Department at **1-877-461-4911** to schedule a test of an ANSI X12 5010 837-P or 837-I file. Once a successful test has been completed, EDI Services will schedule your production implementation of 5010 837-P or 837-I claim submissions, which may be prior to January 1, 2012.
- If you currently submit claims to a clearing house, which in turn sends an electronic claim file to MVP, please work with your clearing house to ensure the data you submit will allow the clearing house to send MVP a compliant 5010 837 file.

If you submit a 4010 837-P or 837-I electronic claim file to MVP on or after January 1, 2012, your claim file will be rejected as non-compliant.

Electronic claims experience is an average of 12-15 days faster than paper submissions due to the manual intervention required for paper claims. Please also be aware that rejections for electronically-submitted claims are within 24 hours versus 5 days to receive notice for paper submissions and additional time to resubmit then.

Upcoming updates to MVP ID cards

MVP Health Care recently selected a new vendor partner to facilitate the printing and distribution of ID cards. We are taking this opportunity to update the design and content of all the ID cards we produce to make it easier for health care providers and members to find the information on the cards that pertains to them.

- Updates include a more standardized set of informational components on the ID cards. By making the content more consistent, we can streamline the ID card production process, better ensure card accuracy and reduce language variations that may cause confusion for provider offices.
- Commercial members with a copay/coinsurance cost share will now see "Urgent Care" called out on the front of the card to highlight the cost savings of using urgent care instead of the emergency room when appropriate.
- ID cards for Medicare members have a cleaner look that is easier to read. We paid special attention to making the member ID number as large as possible. Plus, Medicare members with Part D prescription drug coverage will now need only one card for all of their services!
- Information on the back is grouped by audience so that health care providers, pharmacists and members can easily find the information they need on the card.

The updated ID cards will be distributed to Commercial and Medicaid members gradually beginning this fall, as members require or request new cards due to plan changes and regulatory requirements. Medicare members will receive new cards in November and December.

Please be aware that as MVP phases out the current card design, you will see patients with both the "old" and "new" card design. Both are valid for Commercial members. Medicare members' cards will activate automatically on Jan. 1, 2012 for all members. Just remember to log in at **www.mvphealthcare.com/provider** to check each patient's eligibility and ask to see the most current copy of the member's card at every visit.

Samples of the new cards are on the following page.

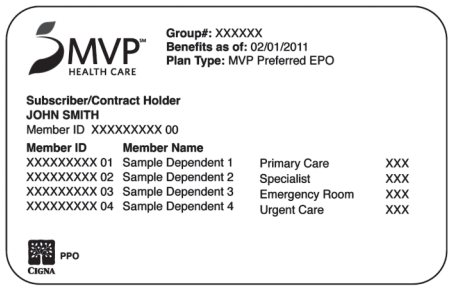
MVP HEALTH CARE

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

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

Commercial


MVP HEALTH CARE

Group#: XXXXXX
Benefits as of: 02/01/2011
Plan Type: MVP Preferred EPO

Subscriber/Contract Holder
JOHN SMITH
Member ID XXXXXXXXX 00

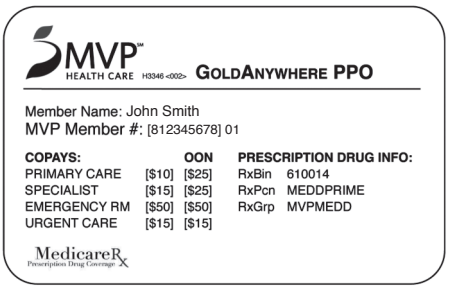
Member ID	Member Name
XXXXXXXXX 01	Sample Dependent 1
XXXXXXXXX 02	Sample Dependent 2
XXXXXXXXX 03	Sample Dependent 3
XXXXXXXXX 04	Sample Dependent 4

Primary Care	XXX
Specialist	XXX
Emergency Room	XXX
Urgent Care	XXX

CIGNA PPO


BENEFITS PROVIDED BY: MVP Health Insurance Co., 625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207
HEALTH CARE PROVIDERS: 1-800-684-9286
PHARMACISTS: Medco (RxBIN 610014 Rx Group MVPCOMM). Member # is first 9 digits of Member ID; Person # is + 01 (00→01). Questions? Call Medco at 1-800-922-1557.
MENTAL HEALTH/SUBSTANCE ABUSE HELP: NY/NH: 1-800-568-0458 VT: 1-800-320-5895
MEMBERS: Refer to your Contract or Certificate of Coverage for an explanation of benefits. CIGNA network available only outside MVP NY, VT, NH Service Area.
Pharmacy Information: 1-800-716-3752
Questions? Call the Customer Care Center at 1-888-687-6277; TTY 1-800-662-1220; www.mvphealthcare.com
MultiPlan
AWAY FROM HOME CARE

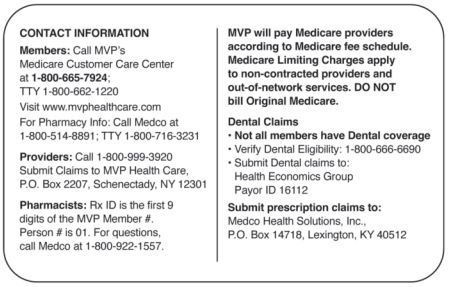
Medicare


MVP HEALTH CARE H3346 <002> GOLDANYWHERE PPO

Member Name: John Smith
MVP Member #: [812345678] 01

COPAYS:		OON	PRESCRIPTION DRUG INFO:
PRIMARY CARE	[$10]	[$25]	RxBin 610014
SPECIALIST	[$15]	[$25]	RxPcn MEDDPRIME
EMERGENCY RM	[$50]	[$50]	RxGrp MVPMEDD
URGENT CARE	[$15]	[$15]	

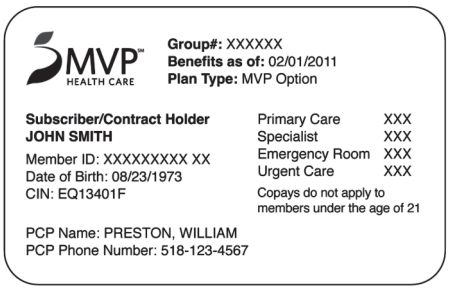
MedicareRx Prescription Drug Coverage


CONTACT INFORMATION
Members: Call MVP's Medicare Customer Care Center at **1-800-665-7924**; TTY 1-800-662-1220
Visit www.mvphealthcare.com
For Pharmacy Info: Call Medco at 1-800-514-8891; TTY 1-800-716-3231
Providers: Call 1-800-999-3920 Submit Claims to MVP Health Care, P.O. Box 2207, Schenectady, NY 12301
Pharmacists: Rx ID is the first 9 digits of the MVP Member #. Person # is 01. For questions, call Medco at 1-800-922-1557.

MVP will pay Medicare providers according to Medicare fee schedule. Medicare Limiting Charges apply to non-contracted providers and out-of-network services. DO NOT bill Original Medicare.
Dental Claims
- **Not all members have Dental coverage**
- Verify Dental Eligibility: 1-800-666-6690
- Submit Dental claims to: Health Economics Group Payor ID 16112

Submit prescription claims to: Medco Health Solutions, Inc., P.O. Box 14718, Lexington, KY 40512

Medicaid


MVP HEALTH CARE

Group#: XXXXXX
Benefits as of: 02/01/2011
Plan Type: MVP Option

Subscriber/Contract Holder
JOHN SMITH
Member ID: XXXXXXXXX XX
Date of Birth: 08/23/1973
CIN: EQ13401F

Primary Care	XXX
Specialist	XXX
Emergency Room	XXX
Urgent Care	XXX

Copays do not apply to members under the age of 21

PCP Name: PRESTON, WILLIAM
PCP Phone Number: 518-123-4567


BENEFITS PROVIDED BY: MVP Health Plan, Inc., 625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207
HEALTH CARE PROVIDERS: 1-800-684-9286
PHARMACISTS: Medco (RxBIN 610014 Rx Group MVPCOMM). Member # is first 9 digits of Member ID; Person # is 01. Questions? Call Medco at 1-800-922-1557.
MENTAL HEALTH/SUBSTANCE ABUSE HELP: NY/NH: 1-800-568-0458 VT: 1-800-320-5895
MEMBERS: Refer to your Handbook for an explanation of benefits.
Pharmacy Information: 1-800-817-8038
Questions? Call the Customer Care Center at 1-800-852-7826; TTY 1-800-662-1220 www.mvphealthcare.com

Professional Relations Updates

Potential HIPAA issues when submitting EOB/EOP to support payment of claims

There are times when MVP requires providers to submit claims with an *Explanation of Benefits (EOB)* or *Explanation of Payment (EOP)* to process a claim. MVP recently noticed that providers are submitting EOB/EOPs for MVP members with other members' protected health information still visible. This may be considered a HIPAA violation, so we are asking for your cooperation in maintaining the protected health information of your patients and our members.

Please be advised when you submit a claim to MVP with an EOB/EOP as an attachment that you need to suppress or black out all other information that does not pertain to the member about which you are inquiring. This will ensure that providers and MVP are keeping our members' protected health information secure and safe. Thank you for your assistance.

MVP completes transition to Facets system January 1

Beginning January 1, 2012, MVP Health Care will maintain all Preferred Gold (Medicare), Commercial and self-insured (ASO) members on its Facets system, completing the transition of all membership to a single claims management platform. Already this year, MVP's Option (Medicaid) members moved to the Facets system.

Membership that will transition to the Facets system for January 1 belong to the following plans:

- Preferred Gold HMO
- GoldValue HMO
- GoldAnywhere PPO
- Preferred EPO and PPO
- USA Care PPO
- TriVantage EPO
- MVP Preferred High-Deductible plans
- Self-insured (ASO) plans administered by MVP

Please be aware that these members will have new MVP Member ID numbers as of January 1, 2012 that must be used when submitting claims or requesting authorization.

We appreciate your cooperation and partnership throughout this transition process!

Fee integration updates

For claims with a date of service on or after January 1, 2012, MVP will be changing the way particular modifiers/codes are reimbursed. This is a result of a continued effort to integrate pricing practices across the MVP enterprise.

Please review the following information for more detail:

Modifiers

Modifier 52 (Reduced Services) – Will be reimbursed at the lesser of 50% of charges or contracted rate

Modifier 53 (Discontinued Procedure) – Will be reimbursed at the lesser of 50% of charges or contracted rate

Modifier 54 (Surgical Care Only) – Will be reimbursed at the lesser of 80% of charges or contracted rate

Modifier 55 (Post Operative Management Only) – Will be reimbursed at the lesser of 10% of charges or contracted rate

Modifier 56 (Pre Operative Management Only) – Will be reimbursed at the lesser of 10% of charges or contracted rate

Modifier 76 (Repeat Procedure by same physician) – Will be reimbursed at the lesser of 100% of charges or contracted rate.

Modifier 78 (Unplanned return to OR, post-op) – Will be reimbursed at the lesser of 80% of charges or contracted rate

Code 96372 (Intramuscular Injection)

Code 96372 which was previously denied with an office visit, will now be reimbursed.

Medical Policy Updates

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the April, June, and July meetings. Some of the medical 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 medical policy updates. If you have questions regarding the medical 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 medical 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 on **www.mvphealthcare.com** in the *Reference* section.

Imaging policy updates effective August 1, 2011

MVP utilizes InterQual® criteria for many imaging procedures. (see *UM Updates InterQual® Reminder* in this newsletter). The updated 2011 InterQual®criteria were previously made available to providers via the MVP provider Web site. The following imaging policies may reflect InterQual® criteria updates, if applicable, effective August 1, 2011.

MRA Brain

Pre-operative study, carotid endareterectomy planned has been deleted as an indication.

MRA Carotid

There are no changes to this policy.

MRA Kidney

There are no changes to this policy.

MRA Lower Extremity

Peripheral aneurysm by PE/duplex US and angiography not planned has been added as an indication.

MRI Abdomen

There are no changes to this policy.

MRI Chest

For cardiac indications, suspected intracardiac mass "by transthoracic echocardiogram" was added.

MRI Extremity

There are no changes to this policy.

MRI Hip/Knee

There are no changes to this policy.

MRI Neck

There are no changes to this policy.

MRI Pituitary

There are no changes to this policy.

MRI Shoulder/Wrist

There are no changes to this policy.

PET Scan Chest/Cardiac

The policy follows InterQual criteria and contains a Medicare Variation. There are no changes to the policy.

PET Scan Whole Body

This policy was updated to reflect the most recent InterQual indications for PET Whole Body. Multiple myeloma, testicular cancer and baseline part of staging, soft tissue sarcoma and baseline part of staging, and ovarian cancer have been added as indications. The Medicare Variation section was updated to include bone metastasis for cancer. NaF-18 PET imaging is covered Bone Metastasis for Cancer when the member is enrolled in a clinical registry.

Medical policy updates effective October 1, 2011

Continuous Passive Motion Device

Coverage for continuous passive motion device is limited to procedures for the treatment of the knee. Continuous passive motion devices are not covered for the shoulder or elbow.

CT Coronary Arterial Disease

There are no changes to this policy.

Endovascular Procedures

The policy has been updated to reflect that endovascular repair for abdominal aortic aneurysm is covered for patients with a documented unruptured abdominal aortic aneurysm who meet the medical policy criteria. The requirement for patients who are not candidates for open surgical repair has been removed.

Evaluation of New Technology

The policy addresses the process for evaluating new technology or services. There are no changes to this policy.

High Frequency Chest Wall Oscillation Devices

There are no changes to this policy.

Home Care Services

There are no changes to this policy.

Low Vision Aids

The policy has been updated to reflect that due to the lack of data in peer reviewed literature, low vision aids are considered not medically necessary. An Option, Option Family, Option Child Variation has been added that low vision aid services will be considered when criteria are met.

Metal-on-Metal Hip Resurfacing

There are no changes to this policy.

Obstructive Sleep Apnea – Diagnosis (NY) NEW POLICY

The policy addresses obstructive sleep apnea diagnosis criteria for New York State. The Exclusion criteria section has been updated to list diagnoses and conditions not indicated for polysomnography. Home sleep studies are not covered, except for Medicare products.

Obstructive Sleep Apnea – Diagnosis ARCHIVED POLICY

This policy is archived as there are now two new Obstructive Sleep Apnea-Diagnosis policies. Please refer to Obstructive Sleep Apnea – Diagnosis (NY) and Obstructive Sleep Apnea – Diagnosis (Vermont and New Hampshire).

Obstructive Sleep Apnea – Devices

Auto-titrating positive airway pressure (APAP) language was added to the policy. A Medicare Variation for oral appliances was added to the policy. Oral appliances for obstructive sleep apnea are covered when policy criteria are met.

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.

Radiopharmaceutical policy

Beginning January 1, 2012, MVP will be changing our Radiopharmaceutical Policy as follows:

Any Radiopharmaceutical Codes that are billed **less than $50** will be reimbursed at 100% of charges per standard MVP policy.

The following Radiopharm codes will be paid at 100% of charges up to $100 dollars:

- **A9541**
- **A9560**

The following Radiopharm codes will be paid at 100% of charges up to $160 dollars:

- **A9500**
- **A9502**
- **A9505**
- **A9538**
- **A9552**

The following Radiopharm codes will be paid at 100% of charges up to $250 dollars:

- **A9562**
- **A9556**

Any other Radiopharm codes or any Radiopharm codes that do not meet the criteria above will require an invoice.

This policy applies to physician claims only, for all lines of business except Medicare.

Web Updates

Provider portal enhancement: benefits display

Benefits Display offers users of MVP's Web portals quick and comprehensive access to benefit information, improving users' ability to self-serve.

In January, 2011, *Benefits Display* became available to Web portal users — members, employers, brokers and health care providers — to allow access to benefit information for members of select Facets-based products (the Federal Government plan, the New York State Health Insurance Plan [NYSHIP], the Finger Lakes Consortium and Medicare).

By the end of 2011, nearly all members' Facets-based health plans will be linked to a *Benefits Display*, offering an enhanced view of your patients' coverage and payment responsibilities.

To access the *Benefits Display* for a patient, log in at **www.mvphealthcare.com/provider**, perform a patient inquiry and select a patient, then go to *Patient Information*. If the patient search is for a member whose health plan is configured for *Benefits Display*, the patient's health plan name in the *Subscriber and Policy Details* section will be underlined and blue – a hotlink that will bring up the *Benefits Display*.

We think that your practice will find the *Benefits Display* a valuable addition to MVP's Web portal for providers; we are pleased to make this feature more widely available by year-end!

Disabling default provider portal accounts

In the last issue of *Healthy Practices*, we announced that, to ensure the highest level of security for our Web portal users, as of July 5, 2011 we would no longer allow provider portal login usernames to be the same as provider IDs and would disable any accounts with matching usernames/provider IDs.

Based on your feedback, we have extended the timeframe during which portal users may complete the necessary steps to ensure that every user in your practice has a unique login. Accounts with matching usernames/provider IDs will not be disabled until October 1, 2011.

If your MVP provider Web portal username contains part or all of your last name, no action is required. If, however, your MVP provider Web portal username is the same as your practice's MVP payee ID, please follow these action steps to retain your access to the provider portal after October 1:

1. Designate a site administrator through MVP's online portal registration process **(www.mvphealthcare.com/provider/register.html)**
2. Request usernames and passwords for staff, also through the online registration process.

Please note that staff usernames and passwords cannot be set up without the site administrator request form or without an existing site administrator.

If you have any questions, please contact MVP eSupport (**esupport@mvphealthcare.com** or **1-888-656-5695**).

Not yet registered for an online account?

By registering for an account at **mvphealthcare.com** allows you a fast, easy way to get information you need about your MVP patients, our policies and procedures, newsletters and much more. If your practice has Internet access, visit **www.mvphealthcare.com/provider/register.html** to set up accounts for your staff. New features are constantly in development to make your online account a valuable tool for your practice!

Update your provider account profile

If your online account profile includes an outdated or personal e-mail address, take a moment to update it with your current business e-mail address. As MVP continues to explore ways of getting you the information you need via the technology you prefer, your valid e-mail address and profile information will enable you to quickly and easily be part of our advancements! You can update your e-mail address, password and security question at any time by clicking the *Change Profile* link (under your name) just after logging in at **www.mvphealthcare.com/provider.**

UM Updates

DMEPOS provider auditing program underway

Effective September 1, 2011, MVP Health Care's DME Utilization Management Unit will begin conducting audits of durable medical equipment (DMEPOS) claims.

The purpose of these audits is to:

- substantiate claims for medical necessity, appropriate coverage/applicable benefits and justification of charges;
- identify adverse utilization trends;
- identify inappropriate claims submission; and
- assess aberrant billing methods that affect copayments for MVP members.

The DME audits will be conducted for HCPCS codes billed to MVP that are not included on the DME Prior Authorization Code List. Action(s) resulting from the audits may include further investigation, possible claim adjustments, feedback to vendors and provider education.

If you have questions about the auditing program, please contact Dan Flanagan, DME Supervisor, at **518-388-2281**.

Effective January 1: new clinical editing knowledge pack

MVP Health Care will enhance its clinical editing application, McKesson® ClaimsXten™, an industry-recognized software program, with a new **Waste and Abuse Knowledge Pack** on January 1, 2012.

McKesson ClaimsXten ensures that payment policies are applied consistently while providing additional transparency for providers.

The sources of ClaimsXten's correct coding standards include but are not limited to:

- National Correct Coding Initiative (NCCI)
- American Medical Association (AMA)
- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)

These standards are currently used for facility and non-facility claims.

If you have any questions about these changes, please contact your Professional Relations Representative.

Reminder: InterQual criteria use began August 1

InterQual® criteria, published by McKesson® Health Solutions, are used in many of MVP Health Care's medical review processes to support the medical necessity of health care services. The criteria are updated by McKesson Health Solutions to be consistent with evidence-based standards of care and current practices. Please be aware that MVP began using the 2011 InterQual Criteria on August 1, 2011.

To access 2011 InterQual criteria, log in at **www.mvphealthcare.com/provider**.

Questions? Call the Customer Care Center for Provider Services.

Vitamin D testing recommendations

Are you wondering what to tell your patients who are concerned about their Vitamin D level and ask to have it tested?

The Monroe County Medical Society's practice guideline, "Community-wide Vitamin D Recommendations" provides sound advice on this topic. The guideline is based on a November 2010 report from the Institute of Medicine (IOM) entitled *Dietary Reference Intakes for Calcium and Vitamin D* which summarizes the IOM's study of health outcomes compared to Vitamin D and calcium levels. After assessing more than 1,000 studies, the IOM concluded that information about the health benefits tied to these two nutrients were from studies that provided often mixed and inconclusive results and could not be considered reliable. Only bone health was tied to having sufficient levels of Vitamin D and calcium.

The conclusions outlined in the Monroe County Medical Society's practice guideline are:

- There is no conclusive evidence supporting routine Vitamin D testing for healthy adults or for children.
- Nearly all Americans obtain sufficient Vitamin D from their diet without supplementation for bone health.
- There are special populations identified as being at risk for Vitamin D deficiency (immigrant populations, those with dark skin, the elderly who are institutionalized or who are obese). Individuals in these groups may benefit from Vitamin D testing and supplementation.

The Local Coverage Determination for Vitamin D Assay Testing (L29510) indicates that, for Medicare beneficiaries:

- The level of 25-hydroxyvitamin D may be measured. Measurement of other metabolites is generally not medically necessary.
- Vitamin D testing may not be used for routine screening.

Once a beneficiary is shown to be vitamin D deficient, further testing is medically necessary only to ensure adequate replacement has been accomplished. Thereafter, annual testing may be appropriate depending upon the indication and other mitigating factors.

Pharmacy Updates

Pharmacy policy and formulary updates

Enteral Therapy

Effective October 1, 2011 for non-Medicare members, enteral nutrition must be obtained at an MVP participating pharmacy and adjudicate through the MVP pharmacy benefits manager (PBM). Copays and/or coinsurances are subject to the member's enteral product benefit. Home infusion vendors that also participate with MVP as a pharmacy provider must bill using a valid NDC/UPC product number. Enteral products indicated for inherited diseases of metabolism (ie: PKU, MSUD) will adjudicate without prior authorization. All other products require prior authorization to determine medical necessity as established in MVP policy.

Tamiflu Dosing Change

When flu season arrives this fall, a liquid form of Tamiflu will be available in a new, lower concentration to reduce the possibility of medication errors. The change applies to the oral suspension form of Tamiflu and not the capsule. The Tamiflu packaging of its oral suspension product says "new strength" because the concentration of medicine in the liquid has been changed from 12 mg/mL to 6 mg/mL. This change in concentration means that the amount of medicine that must be taken has also changed.

Effective September 1, 2011

Advanced Agents for Pulmonary Arterial Hypertension

- Indications for Adcirca and Flolan were updated
- Exclusion section updated to indicate Letairis is contraindicated in pregnancy

Contraceptive Agents and Family Planning

- Lo Seasonique was added to the policy

Cystic Fibrosis

- Cayston was added to the policy
- Criteria for extension of therapy was added

Gaucher's Disease

- Vpriv was added to the policy

Infertility

- Fertinex was removed from the policy as it is no longer on the market
- Follistim AQ is preferred over Gonal-F
- Specific lab documentation criteria was added

Intranasal Corticosteroids

- Nasarel was removed from the policy as it is no longer on the market

Multiple Sclerosis, Select Oral Agents

- Name changed from Ampyra
- Gilenya and Ampyra criteria are similar

Orphan Drugs

- Soliris and Lumizyme were added to the policy

Effective October 1, 2011

ACE/ARB

- Prior authorization will be required for Azor, Tribenzor and Twynsta
- Option and Option Family variation was added. Losartan/HCTZ and Diovan/HCT are the preferred ARBs for these products

Acthar

- New indication for infantile spasms was added

Androgens/Anabolic Steroids

- This is a new policy for MVP Option and MVP Option Family members only. Prior authorization is required and is limited to FDA approved indications only

Antineoplastic Enzyme Inhibitors

- MVP Option and MVP Option Family variation was added that require prior authorization for Gleevec. Established criteria in the policy applies

Direct Renin Inhibitors

- Tekamlo and Amturnide were added to the policy

Enteral Therapy New York

- MVP Option and MVP Option Family variation was added. In addition to criteria established in the policy, these members would also need to be fed via nasogastric, gastrostomy or jejunostomy tube

Gout

- New policy requiring quantity limits of 60/30 for Colcrys and step therapy or prior authorization for Uloric and Krystexxa

Growth Hormone

- Option and Option Family variation was added. Tev-Tropin and Humatrope are the preferred growth hormones for these products

Mail Service

- Pradaxa was added as excluded from mail order

Proton Pump Inhibitors

- MVP Option and MVP Option Family variation was added. Generic PPIs are preferred for these products

Quantity Limits

- MVP Option and MVP Option Family variation was added. Subutex, Suboxone and generic equivalents are limited to 60 units per 30 days

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

- Acromegaly
- Fabry's Disease
- Hereditary Angioedema
- Kuvan
- Leukotriene Modifiers
- RSV
- Samsca
- Smoking Cessation Medications
- Xolair
- Zorbtive

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.

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

Drug Name	Indication
Axiron	Testosterone deficiency
Benlysta† (medical)	Systemic lupus erythematosus
Banzel susp	Lennox-Gastaut syndrome
Butrans	Moderate-to-severe chronic pain
Corifact† (medical)	Factor XIII deficiency
Daliresp	COPD
Dificid	Diarrhea caused by *c.difficile*
Edarbi	Hypertension
Edurant	HIV-1 infection
Horizant	Restless leg syndrome
Incivik+	Chronic hepatitis C
Krystexxa† (medical)	Gout
Lastacaft	Allergic conjunctivitis
Nexiclon XR	Hypertension
Nulojix	Prophylaxis for organ rejection
Phoslyra	Reduction of serum phosphorus
Rezira	Cough and cold
Staxyn	Erectile dysfunction
Sylatron	Melanoma
Tradjenta	Type 2 diabetes mellitus
Victrelis+	Chronic hepatitis C
Viramune XR	HIV-1 infection
Xerese	Treatment and prevention of cold sores
Yervoy† (medical)	Metastatic melanoma
Zictifa	Thyroid cancer
Zutripto	Cough and cold
Zytiga+	Prostate cancer

Generic drugs added to Formulary (Tier 1)

budesonide oral
carbamazepine 12 hour (generic Carbatrol)
epinastine
letrozole
methylphenidate (generic Concerta)
fondaparinux
triamcinolone nasal
levofloxacin
Loryna (generic Yaz)
cyclobenzaprine (generic Amrix)

Brand drugs added to Formulary (Tier 2)

Follistim AQ
Pulmicort Respules
Nitrostat
Ventolin HFA

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

Atelvia
Beyaz
Bromday
Egrifta
Halaven^
Iprivask
Kapvay
Kombiglyze ER
Latuda
Lo Loestrin FE
Nuedexta
Suprep
Teflaro†

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

Carbatrol
Concerta
Femara
Proventil HFA (effective 9/1/2011)

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

†*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.*

ST*Subject to step therapy*

QL*Subject to quantity limits*

+*Curascript mandatory*

Medication recalls and withdrawals

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

- In June, Endo Pharmaceutical announced a nationwide consumer recall of Endocet because some bottles may contain different strengths. MVP has notified 163 members who might have been impacted by this recall.
- In June, Qualitest announced a recall of specific lots of butalbital/APAP/caffeine and hydrocodone/APAP due to the possibility that the bottles may contain incorrect tablets. MVP has notified 61 members who might have been impacted by this recall.

Medicaid Updates

MVP to cover pharmacy benefits for MVP Option and MVP Option Family

Beginning October 1, 2011, MVP will administer the prescription drug and medical supply benefit for our MVP Option (Medicaid) and MVP Option Family (Family Health Plus) members. Copays for prescription drugs, OTC drugs and medical supplies, when administered by MVP Health Plan, Inc., will remain the same. MVP will re-issue our current ID cards that reflect pharmacy coverage to all Option and Option Family members prior to October 1. As new members enroll in our Option and Option Family plans, they will receive a new ID card.

There will be a unique MVP Option and MVP Option Family formulary that promotes generic utilization. Prescribing practitioners will be able to access this formulary on our Web site at **www.mvphealthcare.com/provider/pharmacy.html** on or about September 1, 2011. Note that there are variations from the MVP Commercial formulary in certain drug classes. MVP will be notifying all MVP Option and MVP Option Family members if the medication they are currently taking is not on the formulary or requires step therapy or is subject to quantity limits. The health care professional who wrote the prescription also will be notified and will receive an impacted member list to assist in changing to a MVP covered medication.

MVP Option and MVP Option Family members will be required to use CuraScript for specialty drugs. MVP will reach out to CuraScript to assist in transitioning specialty prescription from retail pharmacies. Impacted members and providers will also be notified. Members may use any MVP participating pharmacy for non-specialty drugs. A mail order benefit will not be available and retail and specialty prescriptions will be limited to a 30-day supply of medication.

The prior authorization process is the same as for MVP Commercial business, including all forms. Any pharmacy policy that has an MVP Option and MVP Option Family variation will be updated accordingly and posted in the Medical Policy Manual and in the *Provider Resource Manual* on or before October 1, 2011.

Medicaid changes affect MVP Option and MVP Option Family

MVP has been making changes to its MVP Option (Medicaid) and MVP Option Family (Family Health Plus) products as a result of the decision by New York State to have managed care plans assume coverage of some benefits previously handled by fee-for-service Medicaid.

We've summarized the current and future changes below and provided important information about how MVP is handling the changes that you will need to know.

MVP is updating all its systems to accurately reflect changes that are already in place and will update its systems appropriately as additional service changes become effective.

Miscellaneous Benefits – effective April 1, 2011

The following benefits and limitations were effective on 4/1/11:

Limitation on the prescription footwear benefit:

- Includes orthopedic shoes, shoe modifications or shoe additions
- Benefit coverage is limited to children under 21 years of age, when a shoe is attached to a lower limb orthotic brace or as a component of a comprehensive diabetic treatment plan limited to shoes, inserts and/or modifications for diabetics only
- Limitation on compression and support stockings

Refer to the *Benefit Interpretation Manual* located in the Online Resources section of the provider portal for additional information.

- Smoking Cessation Counseling.
- Expanded to 6 sessions per calendar year for all Medicaid members over the age of 9.

Personal Care – effective August 1, 2011

Managed care plans will be responsible for covering personal care services that have historically been carved out to the fee-for-service Medicaid program. Under our MVP Option plan, we started managing coverage for personal care services as of 8/1/11.

- Personal care is defined as the provision of some or total assistance with personal hygiene, dressing and feeding; and nutritional and environmental support (meal preparation and housekeeping).
- Such services must be essential to the maintenance of the member's health and safety in his or her own home.
- The service must be ordered by a physician, and there has to be a medical need for the service.
- Licensed home care service agencies, as opposed to certified home health agencies, are the primary providers of personal care services (PCS).
- Members receiving PCS must have a stable medical condition and generally be expected to receive services for an extended period of time (years).
- MVP has several participating personal care agencies. These agencies act as assessment agencies and personal care agencies and can perform either service.
- Members and health care providers can find a personal care agency through the *Provider Search* tool located at **www.mvphealthcare.com**.
- In order for a member to obtain personal care services, MVP requires:
  -A completed *Prior Authorization Form*
  -Physician Orders with DOH form 4359
  -A completed personal care assessment from an assessment agency submitted with the prior authorization form.
- The required forms to request personal care services, as well as billing instructions, can be found on our provider portal.

Physical Therapy/Occupational Therapy/Speech Therapy – effective October 1, 2011

There will be a limit on the number of physical therapy, occupational therapy, and speech therapy visits allowed.

- Each member will be allowed 20 visits for each service in a calendar year (January 1 through December 31).
- The limitation will take effect on 10/1/11; however a retro review will be done to see how many visits a member has already used since 1/1/11.
- If a member has used 20 visits of any of these services prior to 10/1/2011, they will not be allowed any additional visits in the service category until 1/1/2012. (Example – if the member has used 20 PT visits prior to 10/1/11, they will not be able to receive any additional PT visits in 2011, however, they can still receive additional OT and ST visits unless they have also reached the 20-visit limit in those service categories as well.)
- You can find information on how many visits a member has used for these benefits beginning 10/1 when you log in at **www.mvphealthcare.com/provider** and go to the *Patient Inquiry* section.

On August 1, 2011, MVP assumed responsibility for the Medicaid Restricted Recipient Program

On March 31, the New York State 2011-2012 budget was passed, including a cost savings program titled Medicaid Redesign. Beginning **August 1, 2011** the management of Medicaid's fee-for-service **Restricted Recipient program** was transferred to managed care health plans including MVP Health Plan, Inc. (MVP).

Members identified as restricted recipients are assigned to specific health care providers for treatment. Usually, these members are assigned to specific pharmacies or physicians because of evidence of abuse or fraudulent behavior.

Since August 1, MVP has upheld current restrictions put in place by the Office of the Medicaid Inspector General (OMIG). Moving forward, MVP will be responsible for identifying members that have abusive or fraudulent patterns and restricting their access to certain health care providers for their care.

Therefore, when treating MVP Option members, please keep these important things/processes in mind:

- If a member has a restriction and you are not the health care provider that has been assigned to care for the person, you will not receive payment for any services you may render.
- The restricted member must go to their assigned health care provider for treatment. Members in a restricted status have been told which provider they can go to. They are notified in writing, and the provider they are assigned to is told as well.
- To avoid non-payment of services to restricted recipients, you should verify if an Option member is a restricted recipient.
- To do so, please continue to verify eligibility by using MVP's Web site **(www.mvphealthcare.com)**, using the MVP ID number (not CIN) presented on the ID card. MVP's Web site will inform you if the member is restricted and instruct you to call the Customer Care Center for Providers for additional information on the restriction. Doing so will help ensure that the member has coverage for the date of service and that the member is eligible to see you.

We **strongly recommend** you follow the above steps for all Medicaid members. If you currently treat Medicaid members, the Medicaid Restricted Recipient Program may not be a new process for you. What has changed is that MVP and other health plans are now managing the program and not Fee-for-Service Medicaid.

MVP is working closely with the New York State Department of Health and the Office of the Medicaid Inspector General to obtain more information about restricted recipients, and administration of the program. We will keep you informed about changes that affect you.

Quality Updates

Clinical guidelines re-approved

MVP's Quality Improvement Committee (QIC) recently re-approved the following existing clinical guidelines:

MVP Health Care, as part of its continuing Quality Improvement Program, has adopted Adult Preventive Care Guidelines. These adult prevention guidelines reflect the most current recommendations of the United States Preventive Services Task Force (USPSTF). For adult immunizations, MVP continues to endorse the current recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

Smoking Cessation:

MVP continues to endorse the Health and Human Services (HHS) smoking cessation guideline. The HHS recommendations include tips for assessing a patient's readiness to quit and suggested medications for patients who want to stop smoking. Additionally, there is a tear sheet containing tips for patients to improve their chances of quitting successfully.

Adult Low Back Pain:

MVP's low back pain guideline is from the Institute of Clinical Systems Improvement (ICSI). ICSI is an independent non-profit organization that provides health care quality improvement to medical organizations. A copy of the guideline is available online from ICSI at: **www.icsi.org/guidelines_and_more/guidelines_order_sets_protocols/musculo-skeletal/low_back_pain/low_back_pain__adult_5.html.** There is an executive summary included along with an easy to follow algorithm. The guideline is 74 pages long, although the first 24 pages are most relevant to MVP's membership. The remaining pages offer annotations that support the specific recommendations of the algorithm.

Paper copies of these recommendations are available by calling MVP's Quality Improvement (QI) department at **1-800-777-4793, ext 2602.** The current edition of the manual online at **www.mvphealthcare.com/provider/qim/index.html.** Offices interested in receiving a paper copy of the updated guidelines should call the QI Department at the number above.

Caring for Your Older Adult Patients

Continue to emphasize preventive care

MVP Health Care now has over 101,000 Medicare members. We are very fortunate in our service area to have so many good physicians who care for them. There are many physicians who have already begun transforming their practices into Patient Centered Medical Homes, implementing strategies to draw patients into their offices for preventive care services.

An annual visit is a covered benefit for our Medicare members at no cost to them. This exam will give you the opportunity to assess your patient, to keep them healthy and to identify any problems that may be starting to develop. It is an opportune time to talk about and put in place a plan of care (with input from your patient and his or her representative, when necessary) that identifies the services they should receive throughout the year. As noted in the "Clinical Guidelines Re-Approved" article in this issue, MVP's Adult Preventive Care guidelines contain key USPSTF recommendations in an easy-to-follow table format. There is a special section for people ages 65 and older that includes additional tips, as the recommendations are tailored to this age group. You will see that many of these tips relate to the Stars measures shown below.

CMS Star measures point the way to a 5-star member experience

Articles in the last two issues of *Healthy Practices* have introduced the Star program and the expectations that the Centers for Medicare and Medicaid Services (CMS) has of MVP and the physicians who contract with MVP to care for our Medicare members. CMS is now rating the MVP Preferred Gold HMO and GoldAnywhere PPO products based on clinical outcome measures, member satisfaction (access and service) and administrative oversight. Currently, the list includes 53 measures.

For many of these clinical measures, MVP and our physicians are rated at a 5-star level across our contracts. This is the highest CMS rating (star ratings are 1 – 5). Our current ratings, though, also point out opportunities for improvement in a number of clinical measures, which are listed here.

In the coming months, MVP will be working with physicians and members to improve these results. Please think about ways to improve these results within your own practice. If you are interested in getting further information about these clinical measures or if you have suggestions as to how we might improve, please contact Mary Orr, Associate Director, Medical Quality Management, Government Programs, at **1-585-327-2284** or **morr@mvphealthcare.com**.

CMS Star Program: Clinical Measures on which MVP is Focusing for Improvement

CLINICAL MEASURE (SOURCE)	DESCRIPTION
Annual Flu Vaccine (Member survey data)	Percent of plan members aged 65+ who got a vaccine (flu shot) prior to flu season.
Breast Cancer Screening (Claims data)	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.
Cardiovascular Care – Cholesterol Screening (Claims data)	Percent of plan members with heart disease who have had a test for "bad" (LDL) cholesterol within the past year.
Controlling High Blood Pressure (Medical record review data)	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
Diabetes Care – Kidney Disease Monitoring (Claims & medical record review data)	Percent of diabetic MA enrollees who either had a urine micro-albumin test during the measurement year, or who had received medical attention for nephropathy during the measurement year.
Drug Plan – members 65 and older receive a prescription for certain drugs with a high risk of side effects (CMS & pharmacy claims data)	Percent of Medicare Part D beneficiaries 65 years or older who received at least one prescription for a drug with a high risk of serious side effects in the elderly.
Improving Bladder Control (Member survey data)	Percent of members with a urine leakage problem who discussed the problem with their doctor and got treatment for it within 6 months.
Improving or Maintaining Mental Health (Member survey data)	Percent of all plan members whose mental health was the same or better than expected after two years.
Improving or Maintaining Physical Health (Member survey data)	Percent of all plan members whose physical health was the same or better than expected after two years.
Monitoring Physical Activity (Member survey data)	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.
Osteoporosis Management (Claims data)	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.
Reducing the Risk of Falling (Member survey data)	Percent of Medicare members 65 years of age or older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.
Rheumatoid Arthritis Management (Claims data)	Percent of plan members with Rheumatoid Arthritis who got 1 or more prescription(s) for an anti-rheumatic drug.
Using the kind of blood pressure medication that is recommended for people with diabetes (CMS & pharmacy claims data)	Percent of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication.

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