



# healthy practices<sup>TM</sup>

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## No coverage for FluMist®

There is an ample supply of injectable influenza vaccine available. Therefore, MVP will not provide coverage for the nasally-administered vaccine FluMist® during the 2006-2007 flu season. The MVP *Benefit Interpretation Manual* (BIM) has been updated to note this policy. If an MVP member's benefit plan includes coverage for vaccinations, MVP will reimburse the member for a flu shot from their physician or a flu shot clinic.

## OB/GYN modifier clarification

To receive the \$300 prior to delivery, please place the "TH" modifier on your submitted claim and attach a copy of the member's Prenatal Health Risk Assessment form to the claim. Please note: to be HIPAA compliant, MVP no longer accepts "OB" as the modifier. Effective December 1, 2006, the "TH" modifier must be noted on the claim.

If your office submits claims electronically, please include the "TH" modifier on the claim and fax a completed Prenatal Health Risk Assessment form to Little Footprints Case Manager at **1-800-280-7346**.

## Integration Update

### Preferred Care members can see MVP providers

Starting on January 1, 2007, members of both MVP and Preferred Care health plans can be treated by providers of either health plan. This is the first step since we merged in January of 2006 to integrate our provider networks, including hospitals and ancillary practitioners, into one network that can treat members from both plans.

Providers who have agreed to participate in this new integrated network may be contacted by a Preferred Care member seeking treatment. Below are key points to assist you in providing care to Preferred Care members:

- The frequency of Preferred Care members seeking treatment in MVP service areas should be minimal. Neither MVP nor Preferred Care is actively promoting this initiative to its members or employer groups. Based on historical claims data we anticipate accessed care will be relegated to emergent situations or college students away from home.
- Preferred Care members are not permitted to select a MVP physician as their primary care physician at this time.
- If a Preferred Care member approaches your practice, and you have agreed to treat them, ask to see his or her ID card. We suggest making a copy of the front and back and calling the number listed on the back to make sure the member is eligible. The member's home plan will dictate where claims are sent, and other coverage requirements.
- You will be paid for covered services in accordance with the Preferred Care member's plan benefits. You will be paid your contracted MVP rate for covered services rendered.
- Reference materials and helpful tools to assist providers treating a Preferred Care member can be found on the MVP Web site ([www.mvphealthcare.com](http://www.mvphealthcare.com)). Please visit the MVP Web site and log in. On the provider home page, click on the link that says, "MVP Providers Treating Preferred Care Members". Information about where claims should be submitted, pre-authorization and claim requirements are listed here.

The expertise and quality of both Preferred Care and MVP's networks of healthcare professionals is widely known and highly regarded. We look forward to working with you to provide Preferred Care members the same great care that they are used to getting when they are away from home or attending college in the MVP service area.

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#### Contacting Professional Relations

MVP Corp. Headquarters 1.888.363.9485  
Southern Tier 1.607.651.9141  
Central New York 1.800.888.9635  
Midstate 1.800.568.3668  
Mid-Hudson 1.800.666.1762

#### Comments Write to:

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

[www.mvphealthcare.com](http://www.mvphealthcare.com)



### **MVP is NOW requiring providers' NPI numbers**

Effective May 23, 2007, a HIPAA mandate *requires* all health-care providers who perform standard electronic transactions, including using certain MVP Web site functions, to obtain a 10-digit unique identification number called a National Provider Identifier, or NPI. **MVP is requiring all participating providers to obtain and report an NPI number to the plan by May 23, 2007, regardless of the claim submission format (electronic or paper) or Web site transaction use. It is critical for MVP to have your NPI in order to ensure all members continued access to our entire provider network.**

#### **NPI Impact**

The NPI will replace the MVP provider ID number on all HIPAA standard electronic transactions, however it does not replace your DEA or tax ID number.

Effective May 23, 2007, the following HIPAA covered transactions will require an NPI:

- 270 — eligibility inquiry (single transaction)
- 271 — eligibility response (single transaction)
- 276 — claim status inquiry
- 277 — claim status response
- 278 — referral submission
- 835 — remittance advice
- 837 — claim submission

Effective May 23, 2007, the following MVP Web site transactions defined under HIPAA will require an NPI:

- online claim submission
- online referral submission
- online eligibility inquiry
- online claim status inquiry

#### **Apply for your NPI**

If you have not done so, please apply to the Centers for Medicare and Medicaid Services (CMS) for your NPI. CMS has contracted with Fox Systems, Inc. to serve as the NPI Enumerator. You can apply online at <http://nppes.cms.hhs.gov/NPPES/Welcome.do>.

#### **Report your NPI to MVP**

All participating providers must report their NPIs to MVP online using the MVP Web site. Please visit [www.mvphealthcare.com](http://www.mvphealthcare.com) and follow these steps:

- Select *Providers Home* from the Providers drop down box
- Click on the *NPI* link in the top right corner
- Click on the *Report Your NPI* link at the top of the page
- There are two options for reporting your NPI
- Please follow the instructions provided

To alleviate potential claim issues, please report your NPI to MVP prior to submitting claims

#### **Transition to NPI**

MVP has adopted the CMS dual strategy approach and prefers providers to submit claims as follows:

- From December 1, 2006 to May 22, 2007, providers submit both their MVP provider ID number and their NPI number. This timeline is a recommended approach only and is not mandatory. During this timeframe, claims adjudication will be based on the MVP provider ID number.
- Beginning May 23, 2007, in compliance with the HIPAA mandate, MVP will require providers to use their NPI number as mandated by HIPAA. If an electronic claim is submitted to MVP without an NPI, it will be rejected as incomplete.
- MVP will accept NPIs on paper claims, however we do not require it.

Up-to-date NPI information, revised EDI Companion Guides and a link to the CMS Web site are available on the MVP Web site ([www.mvphealthcare.com](http://www.mvphealthcare.com)). MVP will continue to publish NPI updates in *Healthy Practices*.

#### **MVP Gold update**

Providers that have joined the new MVP Gold Medicare Advantage network may begin seeing MVP Gold patients on January 1, 2007.

Our dedicated MVP Gold Service Center is now available to answer questions about eligibility, claims, benefit questions, etc. at **1-800-671-7527** from 8:00 a.m. to 5:00 p.m.

Providers in the MVP Gold network recently received a mailing that included the following items:

- MVP Gold/Medicare section of the *MVP Provider Manual*
- MVP Gold Quick Reference Guide
- List of MVP Gold Frequently Asked Questions (FAQ)
- MVP Gold Abridged Formulary

If you need additional copies of any of the items from the mailing, or you do not currently participate in the MVP Gold provider network and would like to, please call Professional Relations. Also, many of the items from the mailing are available on the MVP Web site at [www.mvphealthcare.com](http://www.mvphealthcare.com).

MVP Gold is offered to Medicare-eligible individuals and through employer groups in Albany, Dutchess, Montgomery, Onondaga, Rensselaer, Saratoga, Schenectady and Ulster counties. It is offered exclusively to employer groups in Broome and Cayuga counties. Please note: to participate in the MVP Gold network, providers must practice in at least one of the 10 counties listed above or in an adjacent county.

## Pregnancy Notifications

Participating OB/GYNs are required to notify MVP of all pregnancies by completing a Prenatal Health Risk Assessment form. Physicians can use the ACOG form or their own Health Risk Assessment form. Please fax the form to the Little Footprints Case Manager at **(518) 388-2201** or **1-800-280-7346** or submit the form with your paper claim.

It is important that MVP is notified about pregnancies early so members can be evaluated for participation in our Little Footprints program. To obtain the notifications early, participating OB/GYNs are entitled to a \$300 reimbursement of their global fee upon MVP's receipt of a claim and a completed Prenatal Health Risk Assessment form. Please note: This \$300 payment is part of the global fee but is paid to your office earlier. MVP will pay you the \$300 once the notification is received instead of the total reimbursement being given after the delivery. This is a great way for your office to receive some of the global fee prior to submitting the delivery claim.

## Credentialing Update

Due to high provider participation rates, the MVP Credentials Committee recently approved replacing the MVP credentialing application with the CAQH Universal Credentialing DataSource application for credentialing and recredentialing. This free, online service allows providers to complete one application to meet the credentialing needs of multiple organizations.

For a list of all currently participating organizations, please go to [www.caqh.org](http://www.caqh.org). Providers who have not applied with CAQH will be phased in during the recredentialing process. Effective January 1, 2007, all credentialing applicants will need to utilize the online CAQH application to apply for participation with MVP. Effective April 1, 2007, all recredentialing applicants will need to use the online CAQH application to apply for participation with MVP.

### CAQH Recredentialing Application Completion Process:

1. CAQH should have already sent you a CAQH Provider ID. If you do not have a record of your CAQH Provider ID, please call the MVP Professional Relations department at **1-888-363-9485**. MVP will access your CAQH Provider ID for you or you can call the CAQH Help Desk at **1-888-599-1771**.
2. With your CAQH Provider ID, visit CAQH online at [www.caqh.org/cred](http://www.caqh.org/cred) to register and begin using the Universal Credentialing Application.
3. Please make sure you have authorized MVP to access your information by individually selecting MVP from the list of plans or by providing global authorization by selecting "any current or future users of CAQH."
4. If you are unable to complete CAQH application online, please contact the CAQH Help Desk to obtain information on submitting the CAQH paper application.
5. Should you need assistance to complete the CAQH application, please call the CAQH Help Desk at **1-888-599-1771**.

Please call the MVP Professional Relations department at **1-888-363-9485** if you have any questions. For more information about the Universal Credentialing DataSource, visit [www.caqh.org/cred](http://www.caqh.org/cred). You can also call the CAQH Help Desk at **1-888-599-1771** or e-mail [help@caqh.geoaccess.com](mailto:help@caqh.geoaccess.com).

## Find NCQA-recognized physicians online

A new feature has been added to the doctor search function on the MVP Web site. A participating physician who has successfully completed any of the National Committee for Quality Assurance (NCQA) certification programs will have the corresponding NCQA seal next to his or her name.

Descriptions of the NCQA certification programs appear below:

- The Physician Practice Connections program (PPC) recognizes a physician practice that has demonstrated application of clinical information systems, patient education and support, and care management to improve the health care delivered to patients.
- The Diabetes Physician Recognition Program (DPRP) recognizes physicians who demonstrate that they provide high quality care to their patients with diabetes.
- The Heart Stroke Recognition Program (HSRP) recognizes physicians who demonstrate that they provide high quality care to patients with cardiac conditions or who have had a stroke.

Evidence of NCQA recognition appears directly to the right of an eligible physician's name. A sample is below.

John Doe, M.D.  
Main Street  
Anytown, NY 01234



## Behavioral Health

### Authorizations expired at the end of 2006

A reminder to participating psychiatrists, psychologists and social workers:

- All Behavioral Health authorizations (both counseling and medication management) that were obtained through the MVP Behavioral Health Access Center expired at the end of 2006.
- Any unused approved visits in 2006 may only be carried over into 2007 by submitting the End of the Year Continuing Treatment Log to MVP.
- Providers do not need to call MVP to obtain a new authorization for 2007.

Exception: Psychiatrists providing medication management (CPT® code 90862) may call the Behavioral Health Access Center at **1-800-568-0458** to obtain a new authorization for 2007. Psychiatrists who use billing codes other than 90862 should submit the *End of the Year Continuing Treatment Log*.

An *End of Year Continuing Treatment Log* was enclosed in the November 2006 issue of *Healthy Practices*. The log is also posted on the MVP Web site at [www.mvphealthcare.com/provider](http://www.mvphealthcare.com/provider). Click on *Important Provider Information and Forms* and scroll down to the *End of Year Continuing Treatment Log*.

## Introducing MVP's Healthy NY High Deductible Plan

MVP now offers a Healthy NY High Deductible Health Plan. There are two main differences with new High Deductible Plan:

- The Healthy NY High Deductible plan has deductibles for members, current Healthy NY coverage does not. The Healthy NY plan has an out-of-pocket individual deductible of \$1,150, and a family deductible of \$2,300 for the plan year. Once these deductibles are met, the member's applicable copayment will be required for covered services and/or treatment.
- The Healthy NY High Deductible Plan uses a Health Savings Account (HSA). A Health Savings Account is a personal, interest-bearing account set up by the subscriber at a bank to cover expenses such as the deductible and copayments associated with a High Deductible Health Plan.

Benefits for covered services for the High Deductible Health Plan are the same as your current Healthy NY plan. A copy of the Healthy NY High Deductible ID card is shown below.

	Subscriber ID: <b>81234567800</b> <b>New York</b>
	<b>JOSEPH SAMPLE</b>
	Member #:      Member Name
	81234567801      EDIE SAMPLE
	81234567802      ALAINA SAMPLE
<b>Plan Type:</b>	
<b>High Deductible Healthy NY</b>	Group #: <b>214347</b> Effective Date: <b>01/01/2007</b>
	<b>Referral Required</b>
	Coverage is subject to a deductible.
	Rx Group #: <b>MVPCOMM</b> Rx Bin #: <b>610014</b>



Your benefits are provided by MVP Health Plan, Inc.  
625 State Street, PO Box 2207, Schenectady, NY 12301-2207

**MEMBERS:** Refer to your Contract or Certificate of Coverage for an explanation of benefits.  
Questions? Contact MVP Member Services 8 am – 10 pm  
1-888-687-6277 or via the Web site [www.mvphealthcare.com](http://www.mvphealthcare.com)

**Mental Health/Substance Abuse:** NY/NH: 1-800-568-0458

**HOSPITALS:** Contact MVP at 1-800-568-0458

**Medco contact information:**  
Members, to locate participating Pharmacies: 1-800-716-3752  
Pharmacies, to verify eligibility: 1-800-922-1557

Outside NY, NJ, CT      Outside MVP service area in NY, NJ, CT only

## Healthy NY News

Effective January 1, 2007, members will have the following additional benefits for their Healthy NY coverage:

- Up to 40 Home Health Care visits per calendar year following a hospital stay or surgical procedure, when medically necessary. A \$20 copayment per visit will apply;
- Up to 30 Physical Therapy visits per calendar year following a hospital stay or surgical procedure, when medically necessary. A \$20 copayment per visit will apply; and
- Diagnostic screenings for prostate cancer when ordered by your Primary Care Physician. A \$20 copayment will apply.

These additions are part of the overall benefit package required by New York State Department of Insurance. All health insurance plans offering Healthy NY must include these benefit enhancements.



## Pharmacy Updates

### New Pharmacy Benefits Manager

Medco Health Solutions, Inc. became MVP's new pharmacy benefit manager (PBM) for all retail and mail order pharmacy programs effective January 1, 2007. This change applies to all MVP products with prescription drug coverage.

A new prescription will be needed for controlled substances or compounded prescriptions being filled by Medco's mail-order pharmacy. Other refillable prescriptions have been transferred from our previous pharmacy mail-order vendor, Express Scripts, to Medco with no new prescription required. The transfer of current claims history and preauthorization information occurred between NMHC, our previous retail pharmacy vendor, and Medco.

Medco offers MVP members an extensive network, expertise in mail-order pharmacy programs, and online services such as a medication-pricing tool, the ability to check and track prescriptions filled by mail order, and a complete mail order and retail prescription history and expense summary. Medco's network includes many of the same pharmacies you and your MVP patients have become accustomed to using. In the event that a pharmacy is not in Medco's network, you can find one that is online at [www.medco.com](http://www.medco.com).

Please note: There is no change to MVP's specialty injectable pharmacy program. CuraScript™ will continue as our vendor. MVP requires New York HMO members to obtain certain injectable drugs through CuraScript, however it is voluntary for Vermont HMO members.

### New Prescription Drug Formulary

The enclosed abridged 2007 MVP Prescription Drug Formulary represents the top therapeutic classes and displays the most widely prescribed drugs in their respective tiers. It also indicates whether a drug requires pre-authorization, is subject to step therapy edits or if it is available through mail service. The Formulary will be effective on January 1, 2007 and applies to all members with pharmacy plan coverage except MVP Indemnity and some MVP Select Care (ASO) members.

MVP will continue to encourage generic drug use and add new generics to the formulary as available. In general, multi-source drugs or those drugs that have an FDA approved generic equivalent will be made non-formulary. MVP will grandfather any member currently prescribed a single source brand product. An exception to this grandfathering protocol will be in the PPI and ARB drug classes. Members currently prescribed a non-formulary PPI or ARB will be notified in writing and advised to speak with their physician about taking a formulary agent. Prescribing practitioners will receive a notification and a list of their patients impacted by these formulary changes.

The Formulary is accessible online at [www.mvphealthcare.com](http://www.mvphealthcare.com) and can be downloaded to a PDA device at [www.epocrates.com](http://www.epocrates.com). Printed copies are available from your Professional Relations representative. Updates to the Formulary will continue to be communicated to you through this newsletter and are available online at [www.mvphealthcare.com](http://www.mvphealthcare.com).

## Pharmacy updates effective January 1, 2007

### Prevnar Policy

- Policy deleted.
- MVP will follow immunization guidelines as recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.

### OTC Coverage for Government Programs Policy

- The list of covered over-the-counter medications was revised to more closely follow the New York State Medicaid Program Pharmacy Fee Schedule Section 4.1.

### Pulmonary Hypertension Policy

- Policy description was updated to include NYHA Functional Classification chart.
- Medical necessity criteria was expanded to include more detailed requirements and limitations.

### GnRH Agonists Medications

- Plenaxis® was removed from the policy.
- Medicare Part D language was added.

### ACE/ARB Policy

- Pre-authorization is required for all non-formulary ARBs.
- Criteria added to include failure on all formulary agents before a non-formulary agent will be approved.
- Diabetic edit was removed.

### Thalidomide and Thalidomide Derivatives Policy

- Description, indications and criteria sections were updated.
- Initial approval will be for three months with documentation of clinical response necessary prior to continuation of coverage.

### Vidaza® Policy

- New policy.
- Established retrospective review criteria for appropriate use.

### Zyvox Policy

- Initial approval will be for 14 days.
- Specialists edit is not applicable for Medicare Part D members.

### Proton Pump Inhibitor Policy

- H2-antagonist language removed.
- Pre-authorization is required for all non-formulary proton pump inhibitors.
- Criteria added to include failure on all formulary agents before a non-formulary agent will be approved.
- Medicare language added.

### Smoking Cessation Policy

- Chantix® was added to the policy requiring pre-authorization.
- Quantity limit of 60 tablets per month. Formulary Update

## Formulary Update

Effective January 1, 2007, select medications will become non-formulary. Impacted members and their prescribing physicians have been notified. For MVP members that have a three-tier prescription drug rider, non-formulary medications are still covered however the member is responsible for the highest tier copayment. The angiotensin receptor blockers and proton pump inhibitors are exceptions and pre-authorization is required for non-formulary drugs in these classes.

The MVP Formulary is updated after each Pharmacy and Therapeutics committee meeting. The most current version is available online at [www.mvphealthcare.com](http://www.mvphealthcare.com). Simply log on to the Provider section of the site and click on Rx Formulary in the navigation bar (located on the left side). The MVP Formulary can be downloaded to a PDA device from [www.epocrates.com](http://www.epocrates.com). There is a link to ePocrates® on the MVP Web site.

Drug	F/C	PA	QL	Page	Mail
<b>fentanyl lozenges</b>	<b>F1</b>	<b>ST</b>	<b>QL</b>	<b>N</b>	
<b>Opana®</b>	<b>N3</b>			<b>N</b>	
<b>Opana ER®</b>	<b>N3</b>	<b>ST</b>	<b>QL</b>	<b>N</b>	
<b>Quasense®</b>	<b>F1</b>			<b>Y</b>	
<b>Jolessa®</b>	<b>F1</b>			<b>Y</b>	
<b>Seasonale®</b>	<b>N3</b>			<b>Y</b>	
<b>Seasonique®</b>	<b>N3</b>			<b>Y</b>	
<b>Oracea®</b>	<b>N3</b>			<b>N</b>	
<b>Elaprase®</b>	<b>N3</b>	<b>PA</b>		<b>N</b>	
<b>Myozyme®</b>	<b>N3</b>	<b>PA</b>		<b>N</b>	
<b>Chantix®</b>	<b>N3</b>	<b>PA</b>		<b>N</b>	
<b>Apidra®</b>	<b>D</b>			<b>Y</b>	
<b>Myozyme®</b>	<b>M</b>	<b>PA</b>		<b>N</b>	
<b>Elaprase®</b>	<b>M</b>	<b>PA</b>		<b>N</b>	

**Bolded = effective 1/1/07**  
 QL = Quantity limits apply – see MVP policy  
 ST = Step therapy edits apply  
 C = Available from CuraScript  
 N = Available from Nova Factor  
 NL = Not listed  
 D = Diabetic Copay  
 M = Medical copay



## Quality Improvement Updates

### New Disease Management Program for Depression

MVP now offers a new Disease Management (DM) program for individuals with depression. The program, developed with input from practicing psychiatrists, psychologists, social workers and family practice physicians, is based on current standards of care for the management of depression. Additionally, it has been modeled after other MVP DM programs for chronic illness that have demonstrated a positive impact on members' health status, utilization and costs.

Goals of the DM program are as follows:

- Improve members' knowledge of depression and related triggers
- Improve members' self-management and coping skills
- Improve members' functional status and quality of life
- Increase the appropriate use of antidepressant medications
- Improve adherence to prescribed treatment plans including follow-up visits
- Increase referrals to specialized behavioral health treatment, as appropriate
- Decrease the number of hospitalizations and ER visits for the defined population
- Decrease the impact of depression on comorbid illnesses
- Reduce lost productive work time due to physical or mental illness
- Reduce the stigma associated with mental illness

To achieve these goals members will receive a biannual newsletter with helpful articles related to depression and mental wellness as well as other educational materials and tools to manage health. Members will be encouraged to complete a Health Risk Assessment (HRA) survey that includes the Patient Health Questionnaire (PHQ-9) questions to assess depression severity.

Members with moderate to severe depression may also participate in telephonic health coaching. Health coaching reinforces the care plans developed by the member's providers and empowers the member to bring about personal change and engage the health care system in a more constructive manner. Following the providers' treatment plan, the health coach will:

- Educate the member on depression and how it is treated
- Encourage adherence to prescribed treatment plans including medications and psychotherapy
- Help the member identify his/her personal health concerns and set goals
- Identify barriers to personal goals and methods for overcoming them. Progress toward goals will be reviewed during each call.
- Teach problem-solving skills
- Help the member recognize triggers and symptoms of depression
- Ensuring the member attends follow-up visits with their provider(s)

Call MVP at **1-888-357-4687** for additional program information or to refer a patient.

### Resource Management Report and Physician Quality Report

In January, the MVP Resource Management Report (RMR) and Physician Quality Report (PQR) will be mailed to primary care physicians (PCPs) with a commercial member panel size of 150 or greater. These reports contain statistical data in graph format and compare the PCP with peer groups in key areas of care. The RMR will focus on CAT Scans, MRIs, specialist visits, ER visits and pharmacy. The PQR will focus on member satisfaction, access to care and quality of care information.

Upon review of these reports, please forward your comments and suggestions to David Phelps, M.D., MVMA Medical Director at **518-388-2647**, via fax at **518-388-2090** or via email to [dphelps@mvphealthcare.com](mailto:dphelps@mvphealthcare.com). A PowerPoint presentation can be viewed online at [www.mvma.net](http://www.mvma.net) on the "Clinical Reporting" page. Dr. Phelps and Sarah Ghent, R.N., MVMA Professional Liaison conduct personal meetings with physicians to discuss these reports and welcome the opportunity to provide information regarding other IPA initiatives.

### HEDIS® and QARR data collection begins

In February 2007, the MVP Quality Improvement department will begin its annual Health Employer Data 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, collected HEDIS data is used to guide the design and implementation of our health promotion activities, measure MVP's health programs effectiveness and measure our performance against other health plans.

MVP has again contracted with Interim Health Care for registered nurses to assist our Quality Improvement Staff in collecting data from medical records measuring clinical performance in the following key areas:

- cervical cancer screening
- controlling high blood pressure
- cholesterol management for patients with cardiovascular conditions
- comprehensive diabetic care
- prenatal and postpartum care
- adolescent screening and counseling measures.

MVP Quality Improvement staff or an Interim Health Care representative may contact your office to schedule a time to conduct the chart review. We appreciate your cooperation and strive to impact your office operations as little as possible.

Please note that HEDIS/QARR are part of "health care operations" and the Health Insurance Portability and Accountability Act (HIPAA) does not require authorization from individuals to release 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 in this process and for your support of these important quality activities. If you have any questions, call Betsy LaRose, R.H.I.T., at **(518) 388-2290** or toll free at **1-800-777-4793, extension 2290**.

## Physicians achieve PPC certification

MVP and MVMA have continued to work with the National Committee for Quality Assurance's (NCQA) evaluation program, Physician Practice Connections (PPC), to recognize physician practices that use clinical information and technology to positively impact patient care.

For practices interested in achieving certification, process assistance is available from MVP. Assistance is also available for offices seeking to achieve a higher level of certification. If you are interested in learning more about the program or the assistance available, contact Sue Bornt at (518) 388-2023 or via e-mail at [sbornt@mvphealthcare.com](mailto:sbornt@mvphealthcare.com).

Additional information regarding the NCQA physician recognition program, including how to apply, can be found online at <http://www.ncqa.org/ppc/>.

The following pediatricians recently achieved PPC certification:

- Ligaya Cosico, M.D.
- Edward Sessa, M.D.
- Karen Spinelli, M.D.
- Margaret Woods, M.D.
- Norbert Woods, M.D.
- Richard Yan, M.D.

## New York state insurance law changes

Effective January 1, 2007 the New York State Insurance Law will require health plans to:

- accept and process all claims submitted by a physician providing services to a member covered under a New York certificate of coverage using current AMA CPT® and Medicare/Medicaid common HCPCS codes for physician billed services
- publish the name of the claims editing software used, and any custom edits made, on our Web site and in our provider newsletter. We must also make this information available to any participating physician providing services to a member covered under a New York certificate of coverage upon written request
- notify physicians 30 days in advance of any payment recovery related to services provided to a member covered under a New York certificate of coverage (subject to certain exclusions)
- not begin such payment recovery efforts more than 24 months from when the physician received the original claims payment (subject to certain exclusions and to the terms of the physician's MVP or IPA/PO/PHO contract)
- complete New York state physician credentialing within 90 days (subject to exceptions).

In addition to our FACETS clinical edits software, MVP uses National Correct Coding Initiative (NCCI), American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) code guidelines and Deloitte & Touche claim edits to accurately process claims. To ensure accurate claims processing and reimbursement, MVP continues to test and make adjustments to the claims system.

## Custom claim edits

MVP has made the following custom claim edits to our FACETS clinical edits software:

- The following CPT® codes will be denied if submitted for reimbursement with a preventive care diagnosis code or a preventive care CPT code: 92015, 92081, 92551, 92552, 92553, 92555, 92556, 92557, 92567, 96110, 99172, 99173, 95930, 0065T. This rule applies to both participating and non-participating providers.
- CPT® code 0056T as global to orthopedic codes
- CPT® code 99173 denied as global to all Evaluation and Management (E/M) codes
- HCPCS Codes Q0091 and G0101 are denied as a subset to sick visits. The denial can be reconsidered with proper medical documentation as to a separate service from the problem visit.

Beginning in January 2007, MVP will publish all present and future custom claim editing and significant claims editing information online at [www.mvphealthcare.com/provider](http://www.mvphealthcare.com/provider). Click on the *Communications* link in the navigation bar and select the *Claim Edits* link. Information about our policies and procedures can also be obtained on the MVP Web site or from your Professional Relations representative.

MVP has made the following custom claim edits to our Deloitte & Touche claims editing software:

- Infusion billed with 96410-96414 and J9000-J9999 is only allowed if billed with modifier 59
- CRNA billing with place of service 21/22 and with a hospital TIN is considered global to surgery
- Venipunctures billed with blood labs without a modifier 90 will be denied
- Allergy testing/treatment is only allowed when performed by allergists, ENTs and dermatologists
- Established patient E&M codes, IP physician and ER physician CPT codes must be billed with modifier 25 if billed on the same day as allergy injections/immunotherapy, PUVA, UVA, UBA treatments or Surgery
- Percutaneous tests will be denied when over 50 units are billed. Percutaneous tests billed with food allergy diagnosis will be denied when over 65 units are billed. Intradermal Tests will be denied when over 50 units are billed.
- IP professional charges (visits, consults, anesthesia, etc.) billed by providers employed/staffed by a hospital will be denied "global" (subject to exceptions)
- Surgical Trays are not covered when billed by anesthesiologists (exception: unless billed in conjunction with pain management)
- Osteopathic manipulation is not a covered benefit
- Surgical procedures that can only be performed in an office/IP/ER setting are defined on the MVP In Office Procedure list
- Heparin and saline will be denied "global" when billed with home infusion
- Immunization Administration codes billed without a V-code diagnosis to describe the immunization being administered are denied for "insufficient medical documentation"
- B-12 injections billed under injection administration codes will be denied to resubmit with HCPCS code

*Continued*

- When two IP physician visits are billed for the same date of service by the same provider for the same/related condition, only one visit will be approved
- When the same lab test is billed multiple times on the same date of service, only one test will be approved
- Lab services that must be performed in office are documented on the MVP Regional In Office Lab list
- Radiology services that cannot be performed in office are documented on the MVMA In Office Radiology list and the South Central Radiology list
- Mental health codes billed with a quantity greater than one will be denied
- More than one mental health session billed on the same date of service will be denied
- For pelvic and abdominal procedures on the same date of service — the major procedure is reimbursed at 100 percent, minor procedure reimbursed at 50 percent (Mid Hudson Region)
- Pap Smear code Q0091 will be denied “subset” when billed with an E&M code (including preventative care codes)
- If the first prenatal office visit is billed with a TH modifier but not a prenatal form, the claim will be denied
- If a prenatal form is submitted after 90 days, the first prenatal visit will be denied
- If \$300 is paid on the first prenatal visit, but the allowable amount of the total OB code is less than \$300, the claim will be denied “global”
- Antepartum care codes billed without the number of prenatal visits that occurred will be denied
- Two E&M codes billed on the same date of service will not be allowed even if billed with a 25 modifier and multiple diagnosis codes (preventative vs. medical)
- After Hours visit codes are denied when billed by Emergency Med Physicians
- Telephone calls from physicians to patients, etc. are not covered and will be denied “incidental to other procedures”
- Therapeutic codes billed with non-chemo J codes must be billed with modifier 59 when billed in addition to chemo admin, chemo J codes, Q codes or E&M codes
- Specimen handling is not covered and will be denied “incidental to other procedures”
- Testing (including hearing and vision testing) is not allowed when billed during a Well Care visit and will be denied “incidental to other procedures” or “included in global fee”
- Tympanometry billed by a PCP in addition to a Well Child Visit will be denied “incidental to other procedures” or “global” (applies to all regions)
- If 99070 is billed with a description of a supply and a valid HCPCS code exists for the supply, will be denied to resubmit with valid HCPCS code
- Local anesthesia charges billed by providers other than anesthesiologists with office surgery will be denied
- Caine Injectables billed with Arthrocentesis are not allowed and will be denied “global”
- If two breast ultrasounds are billed for the same date of service, MVP will approve one and deny the other as “global”
- If a Biophysical Profile is billed on the same date of service as a fetal or obstetrical ultrasound, the ultrasound should be reimbursed at 100 percent of allowable, the Biophysical Profile should be reimbursed at 50 percent of allowable (applies to Central Region)
- OB ultrasounds performed by OB/GYNs in the office will be denied “global” to the OB delivery claim (applies to Midstate Region)
- New York State Physicians Pelvic and Transvaginal Ultrasound Policy — codes 76830 and 76817 will be reimbursed at 100 percent of allowable, other codes will be reimbursed at 50 percent of allowable when billed with 76830, 76817
- Urgent care claims will be denied “ER criteria not met” when billed with routine diagnoses or routine services.

