



Required Annual Notices

MARCH 2011

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As part of our commitment to the accreditation standards of the National Committee for Quality Assurance (NCQA) and to comply with state and federal government regulations and mandates, MVP Health Plan, Inc. and MVP Health Insurance Company (MVP) publishes this regulatory and compliance edition of *Healthy Practices*.

MEMBERS' RIGHTS AND RESPONSIBILITIES

MVP's Member Rights and Responsibilities policies clearly state (1) our commitment to treating members in a manner that respects their rights, and (2) MVP's expectations of members' responsibilities. MVP recognizes the specific needs of members and strives to maintain a mutually respectful relationship.

Members are notified of their Rights and Responsibilities in MVP's *Member Guide* (provided in hard copy at enrollment) and in the *Member Annual Notices*, both available on MVP's Web site and in hard copy at any time, by request. New and existing practitioners can find MVP's Member Rights and Responsibilities statements specific to Commercial, Option (Medicaid Managed Care) and Preferred Gold (Medicare Advantage) members in the *MVP Provider Resource Manual*. They are also available in hardcopy with a quick phone call to MVP.

Member Complaint and Appeal Process

MVP's complaint and appeals policies assure that members' written and oral concerns are registered, investigated, and resolved in a timely fashion. Members, or their designated representatives, may call the MVP Customer Care Center or write to the Appeals Department to initiate a complaint or appeal. Members may appoint their practitioner as their designee for the purpose of commencing a complaint or appeal. We encourage members to utilize these procedures when necessary and will not retaliate or take any discriminatory action against a member should he or she file a complaint or appeal.

Complaints and appeals are analyzed and trended on an aggregate basis and reported regularly to the MVP Service Improvement Committee and the Quality Improvement Committee. Issues that identify opportunities to improve the quality of care, access to care, or MVP administrative services are addressed.

After complete evaluation, review, analysis and recommendations, trended complaint information is included in physician performance measures and taken into consideration through the recertification process.

Confidentiality and Privacy Policies

Protection of Oral, Written, and Electronic PHI

All MVP employees are trained in the appropriate use and disclosure of members' protected health information (PHI)

and sign an annual corporate confidentiality statement in order to uphold MVP's standard of protecting oral, written and electronic PHI. Access to MVP's physical facilities and information systems is limited to the required minimum necessary to provide services. MVP has established physical, electronic and procedural safeguards that comply with federal and state regulations to guard PHI. In addition, all MVP provider and vendor agreements include language regarding the confidential handling of members' PHI.

MVP's Privacy Notice

MVP's Privacy Notice is provided to all members at enrollment and included in the *MVP Provider Resource Manual*. It is also posted on our Web site at www.mvphealthcare.com for easy access with no log-in required. Hard copies of this notice may be obtained upon request to MVP at any time. The Privacy Notice instructs members regarding MVP's legal duties and health information privacy rules, including the following:

- Definition of "health information" with respect to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Permitted use and disclosure of health information
- Special use and disclosure situations
- Members' rights to request restrictions, confidential communications and accounting of disclosures
- Members' rights to inspect and obtain copies of their PHI and to amend their health information
- MVP's commitment not to take retaliatory action against any individual who exercises a right under the HIPAA Privacy and/or Security Rules
- Contact information within MVP

Medical Management Decisions

It is the policy of MVP to provide benefits for covered medically necessary health care services provided to our members. Physicians may contact the UM department 24 hours a day, seven days a week at **1-800-568-0458** regarding utilization management concerns. It is also MVP policy to monitor the impact of MVP's utilization management program to ensure appropriate utilization of services.

MVP's Utilization Management Program does not provide financial incentives to employees, providers, or practitioners who make utilization management decisions that would encourage barriers to care and services.

1. Utilization Management decisions are based only on appropriateness of care and the benefit provisions of the member's coverage.
2. MVP does not specifically reward practitioners, providers or staff, including Medical Directors and UM staff, for issuing denials of requested care.
3. MVP does not offer financial incentives to encourage decisions that result in inappropriate utilization.
4. MVP informs those involved in UM decisions of the concerns and risks associated with under-utilization of medical care or services.
5. For Family Health Plus and Medicaid plan types, a member can request a fair hearing through the state if he or she does not agree with a decision MVP makes.

Pharmacy Benefit Management

MVP utilizes a prescription drug Formulary (a list of covered drugs) for Commercial members.

The Formulary is divided into Tiers as determined by our Pharmacy & Therapeutics (P&T) Committee. Most generic drugs are in Tier 1. Tier 2 contains preferred brand drugs and Tier 3 contains non-preferred brand drugs. The most current version of the MVP Formulary is available on the MVP Web site at www.mvphealthcare.com. Visit the site's *Provider* section and under *Pharmacy*, click on *Formulary*.

The MVP Formulary can be downloaded to a PDA device from www.epocrates.com. There is a link to ePocrates® on the MVP Web site. Please update your e-Pocrates account if your computer or PDA is set up to automatically download the Formulary. To request a paper copy of the Formulary, contact your Provider Relations representative.

Medicare Part D Formulary

Formulary updates for Medicare Part D members are updated regularly to MVP's Web site at:

https://www.mvphealthcare.com/medicare/documents/2011_formulary_changes.pdf.

While the most current information can be found online, hard copies of the Part D Formulary are also available. Contact your Provider Relations representative.

Utilization Management Criteria

MVP uses the most current version of InterQual® (ISD-AC adult and pediatric) criteria as a guideline for its Utilization Management decisions for most medical and behavioral health services. Pharmacy utilization management utilizes criteria and a formulary developed by the MVP P&T Committee.

MVP follows and complies with national coverage decisions, general Medicare coverage guidelines, and written coverage decisions of local Medicare contractors when rendering coverage decisions for Medicare Advantage plan members.

MVP has delegated the responsibility for utilization management decisions related to behavioral health services for MVP members in New York and New Hampshire to ValueOptions. When making Utilization Management decisions, ValueOptions

uses criteria that are either adopted from external sources or developed internally by clinical staff, consultants and providers. Sources for various criteria include the American Psychiatric Association Manual for Peer Review, the DSM-IV-Revised, American Accreditation HealthCare Commission/ URAC Standards, ASAM Standards and Health Management Strategies International, among others. ValueOptions' behavioral health criteria are shared with providers via their provider handbook and newsletters, and are available on the ValueOptions Website. For convenient access, go to www.valueoptions.com. ValueOptions may be reached by phone at 1-800-568-0458 (choose the Behavioral Health prompt).

MVP has delegated utilization management of chiropractic care to Landmark Healthcare, Inc., in Sacramento, CA. Landmark uses clinical criteria that have been developed and based on current referenced professional literature with input and approval from chiropractic specialists and actively practicing chiropractors. Clinical criteria serve as guidelines when making utilization management decisions and are applied by Landmark's Case Managers, all of whom are licensed chiropractors. Landmark's Utilization Review Department can be reached at 1-800-638-4557.

In service areas where MVP offers participation in Medicaid, Family Health Plus, and Child Health Plus products, MVP has delegated utilization management for routine dental service to a contracted entity. MVP contracted with Healthplex, Inc. to administer utilization management for all dental services. Healthplex utilizes the most current version of "Current Dental Terminology" (CDT) published by the American Dental Association, in addition to internally developed criteria (professional guidelines). Healthplex ensures that approval and denial of services related to MVP's government program members is based on "The Professional Guidelines for Review of Services for Medicaid/Child Health Plus/Family Health Plus Plans" and the MVP contract provisions.

MVP also uses a *Benefit Interpretation Manual* to help determine whether a service is covered. The MVP *Benefit Interpretation Manual* is available for practitioners on MVP's Web site.

This online manual provides you with convenient access to information you need. In addition, we hope you will find the e-mail feedback option an easy way to let us know what you think about the policies so we can incorporate that feedback into policy development.

Physicians can view the manual as follows:

1. Go to the MVP Web site at www.mvphealthcare.com
2. Select the *Provider* area, then the *Communications* section.
3. Enter your user ID and password then click to log on.
4. Select "BIM" from the *Communications* page.
5. If you have questions or suggestions please e-mail bim@mvphealthplan.com or use the e-mail link listed on the introduction page.

Practitioners may request a copy of the criteria employed to make a specific Utilization Management determination by contacting the local Utilization Management department. The criteria will be mailed or faxed to the physician's office with a

proprietary disclaimer notice. Members may request a copy of the criteria used to make a specific utilization management determination by contacting the Customer Care Center.

If an MVP participating practitioner has questions regarding the MVP Utilization Management policies or a specific utilization management decision such as a denial of benefit, MVP Medical Directors and appropriately licensed clinical reviewers are available to discuss any issues. Practitioners requesting to speak with a reviewer should contact the Utilization Management staff, who will coordinate the contact and the appropriately-licensed clinical reviewers will call the practitioner directly.

Practitioner Appeals

MVP makes it easy for practitioners to obtain information regarding why a claim was rejected or processed in a certain manner (see paragraph 1) as well as to commence an internal review of a claim denial (see paragraphs 2, 3 and 4):

1. **MAKE A CLAIM INQUIRY.** Practitioners may obtain information regarding why a claim was rejected or processed in a certain manner (often resolving any need for any further action) by calling MVP's Customer Care Center at **1-800-684-9286** or by filing a Correspondence Adjustment Form and making a Claim Inquiry.
2. **REQUEST A RECONSIDERATION:**
 - A. *Statutory*

For New York fully insured products, if MVP denies a request for services or a claim for services on the basis that such services are or were not a.) medically necessary or b.) experimental or investigational, and without trying to discuss the denial with the ordering practitioner, then that practitioner may request a Statutory Reconsideration of the claim denial. Statutory Reconsideration is conducted by the member's health care practitioner and the MVP clinical peer review agent who made the initial denial. For Post Service Claims, where the services have already been rendered, the Statutory Reconsideration will occur within 30 business days of the practitioner's request. For Pre Service Claims, Urgent Care, and Concurrent Review, the Statutory Reconsideration will occur within one business day of receipt of the request. If MVP upholds the initial denial after completing the Statutory Reconsideration, then you will be provided with written notice of the determination.

B. *Supplemental*

For all products in both New York and Vermont, MVP offers practitioners a Supplemental Reconsideration process. Practitioners who have received a denial for requested services or a claim denial either for a.) medical necessity or for b.) an experimental or investigational procedure may submit additional information in support of the denied claim without having to formally submit an appeal. MVP will respond to your request for a Supplemental Reconsideration within 30 business days of receipt of the request. A Supplemental Reconsideration is not available after a practitioner has submitted a Statutory Reconsideration (described above), or after a Practitioner Claims Appeal (described below),

has been filed. Moreover, MVP will immediately terminate a Supplemental Reconsideration upon receipt of a Practitioner Claims Appeal. If MVP upholds the initial denial after completion of the Supplemental Reconsideration, then you will be provided with written notice of the determination.

To request either type of Reconsideration described above, you must call the appropriate MVP Utilization Management (UM) department, or the UM departments of delegates, and advise them that you seek Reconsideration. You must submit a request for Reconsideration within 45 business days of receipt of the denial for requested services or the claim denial.

You are not required to submit a request for either a Statutory Reconsideration or a Supplemental Reconsideration in order to submit a Practitioner Claims Appeal, or to submit an appeal on behalf of a member. Additionally, the submission of either type of Reconsideration does not postpone the time period to file either a Practitioner Claims Appeal or Member Appeal.

3. **PRACTITIONER CLAIM APPEAL.** Practitioners may call or write to MVP's Customer Care Center to request an appeal of the denial of a properly submitted claim (i.e. "clean claim").
4. **PRACTITIONER SUBMITTING APPEALS ON BEHALF OF MEMBERS.** Practitioners may also appeal a preservice denial as the designated representative of an MVP member. Except in urgent care situations, MVP shall only accept appeals submitted by practitioners on behalf of members, after the member or appropriate representative of the member has designated the practitioner to act on their behalf. Such designation must be in accordance with MVP's policies and procedures.

Transition of Care for Patients of a Practitioner Leaving the MVP Network

If a practitioner wishes to end his or her network affiliation with MVP, prior written notification must be given. This is an important part of the participating practitioner contract with MVP and helps our members transition their care, should they choose to see another participating provider.

In such an instance, a member may be eligible to receive transition care from a practitioner who has supplied MVP with a termination notice, up to 90 days from the date of the contract termination. However, the practitioner leaving MVP's network must agree to:

- continue to accept reimbursement from MVP at the agreed upon network rates as payment in full;
- adhere to MVP's quality improvement initiatives; and
- perform all network responsibilities including case management, referral and prior authorization requirements.

If a member is receiving maternity care and she has started her second or third trimester at the time the provider has ended his or her participation with MVP, the member may continue her course of care with the same provider through delivery and related post-partum care. The PCP must submit a request for authorization as outlined above to the appropriate Utilization Management department.

Transition care is not available if practitioner disenrollment is the result of MVP's determination of imminent harm to patient care, fraud or action of a state board.

Transition of Care for New MVP Members

New MVP members with life-threatening, disabling, or degenerative conditions who are receiving an ongoing course of treatment from a non-participating practitioner may continue treatment with that provider for 60 days from the date of MVP enrollment providing the provider agrees to:

- adhere to MVP's quality improvement initiatives
- perform all network responsibilities including case management, referral and prior authorization requirements
- accept MVP fees.

New members of the Federal Employees Health Benefits Program have transitional care for 90 days for involuntary change of health plans.

If a member is receiving maternity care and has started her second or third trimester at the time she becomes a member with MVP, the member may continue her course of care with the same provider through delivery and related post-partum care. The provider must adhere to all of the above three bullet points.

Transition of care services must be pre-authorized by MVP. To request transition of care services for a member, please follow the out-of-plan process and state that the need for out-of-plan services is Transition of Care. Without pre-authorization, MVP will not provide benefits for transition of care services except in emergency circumstances.

Emergency Services

Emergency services are those episodes of care provided in an emergency setting when a medical or behavioral condition produces a sudden onset of symptoms of sufficient severity, such that a prudent layperson, possessing an average knowledge of medicine and health, believes a true medical emergency exists.

Members may self refer to seek emergency treatment. A referral or pre-authorization is not needed in order to seek emergency treatment. Services are covered when a change in a medical or behavioral condition would lead a prudent lay person to believe a true emergency exists and that the absence of immediate medical attention, will result in one or all of the following:

1. placing the health of the person afflicted in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or
2. serious impairment to the person's bodily functions; or
3. serious dysfunction of any bodily organ or part; or
4. serious disfigurement of the person.

Determination of coverage is based upon the member's eligibility, benefit coverage, presenting symptoms and clinical findings. Diagnosis upon discharge has no bearing on the coverage determination. A Medical Director reviews all potential denials of services.

Technology Assessment

MVP follows a formal process to evaluate new technology and reassess existing technologies for inclusion in the *Benefit Interpretation Manual*. This includes medical/surgical procedures, drugs, medical devices and behavioral health treatments. A copy of the policy is available on request.

Requests to review new technology or to reassess established technology may originate from providers or institutions outside MVP, or from within the health plan. Assessment and research are completed by MVP's team of Medical Professionals. The resulting draft policies are distributed to appropriate specialists, MVP Medical Directors, Utilization Management, Claims, Operations, Corporate Communications and Legal Affairs departments for a fourteen business-day review and comment period. The new or revised policy is then presented to the Medical Management Committee (MMC) for consideration. MMC membership includes practicing physicians from representative specialties, including at least one physician from each region within MVP service area and health plan staff. Formulary recommendations are reviewed by the MVP Pharmacy and Therapeutics (P&T) Committee. New drugs, changes in formulation or indications, provider communications, coverage policies and revisions are distributed to P&T members for review and comment prior to each meeting.

All existing benefit policies undergo review on an annual basis, with comprehensive updates triggered more often by changes in published medical evidence-based journals. MVP obtains the services of clinical specialists through the MVP network of specialists, academic centers, and contracted experts in selected specialties to ensure that its reviews are thorough. Medical policy language reflects the standard of care.

Policy recommendations that are accepted by the MMC and P&T are then sent to the MVP Quality Improvement Committee (QIC) for final approval. The QIC may approve policies as they are presented, or may send them back through their respective processes for additional research and revision before considering them again at a future meeting.

Participating physicians are notified of new policies or changes in existing policies through the physician newsletter. Full versions of the policies are available on the provider section of MVP's Web site, with paper copies available on request.

MVP Health Care Medical Record Standards and Guidelines

Well-documented electronic or paper medical records improve communication, and promote coordination and continuity of care. In addition, detailed medical records encourage efficient and effective treatment. For these reasons, MVP established standards for record keeping in medical offices that follow the recommendations of NCQA (National Committee for Quality Assurance). The standards are as follows:

- A. Providers must maintain medical records in a manner that is current, detailed, and organized, and permits effective and confidential patient care and quality review.

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- B. Providers must have an organized medical record keeping system.
1. Medical records must be stored in a secure location not accessible to the public.
 2. There is a unique medical record for each member, identified by a medical record identifier on each page.
 3. Records are organized with a filing system to ensure easy retrievability. Medical records are available to the treating practitioner whenever the patient is seen at the location at which he/she typically receives care.
- C. Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the practitioner, and all diagnostic and therapeutic services for which the practitioner referred the member (e.g. home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports).
- D. Confidentiality—Practice sites shall meet or exceed state and federal confidentiality requirements, including HIPAA, and are expected to have implemented procedures that guard against unauthorized or inadvertent disclosure of confidential information.
- E. Providers must retain medical records in accordance with contractual obligations and applicable federal and state laws and regulations.
- (a) For providers participating in all NY Commercial and NY State Government Program Products: Medical Record Retention is required for a period of six (6) years after date of service rendered to the enrollee, and for a minor, three years after majority or six years after the date of the service, whichever is later; and
- (b) For providers participating in Medicare Products: Medical Record Retention is required for a period of ten (10) years after the date of service rendered to the enrollee.
- F. Nondiscrimination in Health Care Delivery—MVP expects health care providers to keep on file and adhere to a documented nondiscrimination policy and procedure that ensures that patients are not discriminated against in the delivery of health care services on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions resulting from acts of domestic violence), genetic information or source of payment. The existence of this policy and adherence to it are also expectations of the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). MVP's Quality Improvement staff will measure compliance with a nondiscrimination policy and procedure at the time of the medical record review.
- Specific standards are as follows:
1. The medical record should be organized in such a way that data abstraction can be performed efficiently. Each page in the record should contain the patient's name or ID number.
 2. The record should be legible (for example, it can be read by someone other than the writer).
 3. Each entry or office note must be dated.
 4. All entries in the medical record should contain the author's identification. For all entries dated after July 1, 1999, stamped signatures are not considered appropriate author identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
 5. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
 6. *Significant illnesses and medical conditions should be indicated on the problem list. A problem list should be completed for each patient, regardless of health status. A flow sheet for health maintenance screening is considered part of the problem list. It is acceptable if the practitioner outlines a problem list at each visit in the progress notes or if the practice site keeps a current ongoing problem list on a computerized system.
 7. *Past medical history (for patients seen three or more times) should be easily identified and should include serious accidents, surgeries and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, surgeries and childhood illnesses.
 8. Medication list.
 9. *Medication allergies and adverse reactions should be prominently noted in the record or on the front cover of the medical record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record, e.g. NKA.
 10. For patients age 14 years and older, there should be appropriate notation concerning the use of cigarettes, alcohol and other substances. For patients who have been seen three or more times, there should be a record of asking about any substance abuse history.
 11. For all patients 18 and younger, there should be a completed immunization record. For patients over 18, there should be a note in the history of immunizations. Because most adults may not have an immunization record, appropriate notation should be made of Flu vaccine, Pneumococcal vaccine (if appropriate), and tetanus/diphtheria (Td) vaccine every 10 years.
 12. Unresolved problems from previous office visits should be addressed and documented in subsequent visits.
 13. Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.
 14. No-shows or missed appointments must be documented with follow-up efforts to reschedule appointment.
 15. Consultation, lab, and imaging reports filed in the chart should be initialed by the practitioner who ordered them to signify review. If the reports are presented electronically or
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by some other method, there should also be representation of review by the ordering practitioner. Consultation, abnormal lab, and imaging study results should have an explicit notation in the record of follow-up plans.

16. If a consultation/referral is requested, there should be a note from the consultant in the record.
17. Lab and other studies ordered should reflect consideration of the reported signs/symptoms and recorded diagnoses.
18. *Documentation of clinical findings and evaluation for each visit. Working diagnoses should be consistent with findings.
19. When indicated by diagnosis, plans of action should include the consultation of specialists. Treatment plans should reflect consideration of recorded diagnoses and reported signs/symptoms.
20. There should be no evidence that the patient was placed at inappropriate risk by a diagnostic or therapeutic procedure.
21. *For members over the age of 18, documentation of whether or not the patient has executed an advance directive. Documentation of any advance directive should be maintained in a prominent part of the member's medical record and should be kept up-to-date. Advance Directives can be found in the QI manual.
22. Preventive care/Risk assessment—There is evidence that preventive screening and services are offered in accordance with MVP's practice guidelines.

**These elements are required for Medicare and Medicaid members.*

To assess compliance with the standards, MVP conducts an annual ambulatory medical record review at the offices of Primary Care Physicians (PCP) with HMO member panel sizes of 150 or more on the following six core elements:

- Problem list
- Allergy information
- History & physical noted for each visit
- Medication list
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening offered

Additional core elements are reviewed for Medicare patients age 65 and over:

- Advance directives
- Pain assessment
- Functional assessment
- Fall assessment.

A practitioner's medical records are considered to meet MVP's standards when the score for each of the core elements is 80 percent or greater. Practitioners who scored 100 percent on each element in the previous year will not be reviewed for the six core elements in the following year.

Actions for improving medical records:

Practitioners who score below 80 percent on any one of the six elements will:

1. Receive a letter with recommendations for improvement with a copy sent to the Regional/IPA/PO Medical Director.

2. Receive notification that a re-review will be performed in six months on the elements that did not meet standards. Practitioners who continue to score below 80 percent upon re-review will be contacted for a written corrective plan of action within 30 days. A copy of the request will be sent to the Regional/IPA/PO Medical Director. Upon receipt, a copy of the corrective action plan will also be forwarded to the Regional/IPA/PO Medical Director.

Failure to cooperate with MVP QI activities or to correct deficiencies noted during the medical record review process will also result in notification of the IPA/PO Medical Director. Results of the ambulatory medical record review program will be reported to the Quality Improvement Committee.

Advance Directives

As part of our medical records review, MVP assesses whether providers' offices document advance directives for members age 18 and older. MVP urges all primary care physicians (PCPs) and other participating providers, as appropriate, to inform members of their right to execute advance directives. If the member chooses to do so, the provider should document the decision and place signed copies of the form or other documents in a prominent place in the medical record. If the member decides not to execute an advance directive, this also should be documented in the medical record. A NYSDOH Health Care Proxy form is located under the preventive care section of the *Quality Improvement Manual* at <https://www.mvphealthcare.com/provider/qim/index.html>. For additional information concerning advance directives, please call the MVP Quality Improvement department at 1-800-777-4793, ext. 2290.

MVP's Quality Improvement Program

MVP is dedicated to providing quality health care and services to our members. For that reason, a Quality Improvement (QI) Program is in place to ensure that the care and services provided meet our standards. Specific components of MVP's QI Program include Preventive Health, Medical Records, Utilization Management, Behavioral Health, Credentialing, Delegation, Member Connections and Member Rights and Responsibilities.

MVP's Quality Improvement Committee (QIC) and Board of Directors oversee the QI Program. The QIC is chaired by MVP's Vice President of Medical Quality Management and includes community physicians from various specialties representing the different provider organizations that participate with MVP.

The objective of MVP's Quality Improvement Program is to provide a structured process to objectively and systematically monitor and improve the quality and appropriateness of care and services provided to members. Activities include the following:

- Develop studies and measurements that are statistically meaningful to track, evaluate and analyze quality improvement.
- Design and promote health management programs that will improve the health status of members with chronic conditions and promote the use of those services to members and physicians.

- Develop, implement and monitor programs that will improve the quality of behavioral health care services and improve the continuity of behavioral health care with medical care.
- Collect and utilize information to enhance the credentialing, peer review, performance assessment and recredentialing processes.
- Promote a system of timely, thorough and appropriate resolution of member complaints and appeals.
- Monitor member satisfaction with the health plan, identify opportunities for improvement and implement appropriate interventions to improve member satisfaction.
- Develop initiatives that will enhance patient safety in various professional care settings.

Each year MVP reports on its progress toward achieving the goals of the QI Program to the Quality Improvement Committee and to the Board of Directors. To receive a copy of the Executive Summary of the most recent annual evaluation, or a copy of the QI Program, please call the Quality Improvement department at **1-800-777-4793, extension 2602**.

Invitation to Join MVP's Quality Improvement Program

The main focus of MVP's Quality Improvement and Health Management programs is to ensure member access and quality/continuity of care. The objective behind our health management program is to enhance members' identification, treatment, and management of particular medical conditions. MVP invites physicians and other health care providers to participate in the development, implementation and evaluation of MVP's QI processes and programs. For more information, or to comment on MVP's QI programs, please call **1-800-777-4793, extension 2602**.

Practitioner Credentialing and Recredentialing Process

MVP will execute a participation agreement and complete the initial credentialing (including primary source verification of information submitted) for practitioners applying for participation in MVP's provider network. Practitioners must be credentialed before being listed in MVP's Participating Provider Directory. Practitioners are required to undergo recredentialing at least every three years. MVP does not make credentialing or recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation. MVP does not make credentialing or recredentialing decisions based solely on the types of procedures performed, or the types of patients the practitioner sees. MVP will retain all verification information for credentialing and recredentialing purposes, pursuant to state and federal data retention requirements.

MVP will make the criteria for credentialing and/or recredentialing available to all applicants upon written request. MVP will not reveal, disclose or divulge (except when permitted or required under federal, state law or contract), directly or indirectly, any confidential information obtained during the credentialing or recredentialing process to any non-authorized individual. Upon verbal or written request directly from the applicant, MVP will

notify the applicant of the status of the application.

Practitioners are required to immediately notify MVP in writing of any changes in credentials information submitted to MVP as part of the application process.

Practitioners will be notified if MVP receives information that differs substantially from the information submitted to MVP in the credentialing application. Also, practitioners will be permitted, upon request, to review information obtained during the credentialing process and any data that differ(s) substantially from the information the practitioner submitted to MVP in the initial application. MVP will, at that time, inform practitioners of their right to correct erroneous information. MVP will then verify the corrected information.

Provisional Credentialing Requirements for NYS Physicians

New York State Applicants who are joining a participating group in which all members of the group already participate with MVP Health Care, are eligible for provisional credentialing on the 91st day that the complete application has been in process in the following circumstances:

- The applicant has submitted a completed credentialing application along with any requested supporting documentation.
- The applicant has submitted a written request for provisional credentialing to the MVP Associate Director of Credentialing and stated that, should the application be denied, the applicant or his/her group practice:
 - i. Shall refund any payments made for in network services provided during the period of provisional credentialing that exceed out of network benefits under the insured's contract with MVP Health Care; and
 - ii. Shall not pursue reimbursement from the insured, except to collect the copayment or coinsurance that otherwise would have been payable had the insured received services from a participating MVP provider.

Report Suspected Insurance Fraud/Abuse

Each year, fraudulent and/or abusive health insurance claims increase health care costs. To help combat insurance fraud and abuse, MVP's Special Investigations Unit (SIU) uses high-tech software to detect, track, analyze, and report instances of health care fraud, abuse, or misrepresentation.

The SIU staff uses STARSentinel software to survey and evaluate claims data - including provider/facility history, specialty profiles, common fraud schemes and/or abuse, and claim patterns that differ from past history or peer norms for a given condition or specialty. STARSentinel™ identifies suspicious claims for:

- falsification of procedure codes;
- falsification of diagnosis codes;
- manipulation of modifiers;
- up-coding;
- over-utilization of diagnostic procedures and tests; and
- over-utilization of treatment modalities.

The SIU staff also works closely with state agencies responsible for identifying and investigating potential insurance fraud and/or abuse, other insurance companies, and law enforcement agencies. MVP also relies on our participating facilities, providers and their office staff to help us fight insurance fraud and/or abuse.

Please report any suspicious activity by calling MVP's Special Investigations Unit (SIU) toll-free at **1-877-TELL-MVP (1-877-835-5687)**. All information will be kept confidential.

Self-Treatment and Treatment of Immediate Family Members

MVP concurs with and endorses the position of the American Medical Association (AMA) as stated in the Code of Ethics guideline, E-8.19: Self-Treatment or Treatment of Immediate Family Members. Practitioners generally should not treat or write prescriptions for themselves or members of their immediate families (exception: emergency situations). MVP does not provide reimbursement for such care.

Professional objectivity may be compromised when an immediate family member or the practitioner is the patient, as:

- The practitioner's personal feelings may influence his/her professional medical judgment, thereby interfering with the care being delivered.
- Practitioners may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the practitioner is an immediate family member.

- Practitioners may be inclined to treat problems that are beyond their expertise or training.
- If tensions develop in a practitioner's professional relationship with a family member, perhaps as a result of a negative medical outcome, these difficulties may extend into their personal relationship as well.
- Concerns regarding patient autonomy and informed consent may arise when practitioners attempt to treat members of their immediate family.
- Family members may be reluctant to state their preference for another practitioner or decline a recommendation for fear of offending the practitioner. Practitioners may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

MVP Meets Members' Special, Cultural and Linguistic Needs

MVP Health Care assists members with different cultural or linguistic needs. MVP has developed a brief overview of the Americans with Disability Act for its internal use that also includes information on diversity and sensitivity and the services that MVP offers to members who have a language barrier or who are vision- or hearing-impaired. To request a copy of this information, please contact the QI Department at **1-800-777-4793, ext. 12602**.