

What is Prior Authorization?

Prior authorization is the approval that your doctor must get from MVP Health Care[®] before you receive certain outpatient, home care and professional services, as well as certain prescription drugs. MVP reviews information about your medical condition and the services to determine whether such services are medically necessary, covered services. It also is the approval that you need from MVP before you receive any services from a non-participating (often referred to as “out-of-network”) health care provider.

To receive prior authorization, your provider will contact MVP on your behalf with the necessary medical information if the service, drug or supply requires prior authorization.

When prior authorization is properly obtained by your MVP participating provider for services included in your certificate of coverage (contract) with MVP, you will only need to pay the copay, coinsurance or deductible that is required by your health plan. If you are using a non-participating provider, it is your responsibility to confirm there is prior authorization on file when needed.

If you pay out-of-pocket for a drug without the required authorization, you will be financially responsible for that drug regardless of whether the pharmacy is participating or non-participating. It is best to use a pharmacy in the MVP network for drugs covered under the prescription rider to ensure the appropriate benefit is applied.

Services that Require Prior Authorization

Prescription Drugs

MVP’s drug formulary is an approved list of covered medications—those that are proven safe and effective and those that provide clinical value to treat your condition. The formulary also lists medications that require prior authorization or are subject to step therapy (when certain drugs to treat a medical condition are tried before a different drug for that condition will be covered) or quantity limits (for certain drugs, the health plan may limit the amount of a drug that will be covered), as well as whether they are available through mail service.

For a complete, up-to-date list of drugs that are subject to prior authorization, quantity limits or step therapy, refer to the MVP formulary online at www.mvphealthcare.com, click *Manage Prescriptions* and then *MVP Prescription Drug Formulary*.

Coverage for prescription drugs may be different based on your specific health plan. Programs used by MVP to enhance safety and control costs also may affect coverage. Out-of-pocket costs may vary based upon the drug your doctor prescribes. Work with your doctor to make sure that you get the best and most cost-effective drugs available. Not all MVP health plans offer prescription drug coverage. Check your plan materials for your coverage details.

Behavioral Health Services

MVP has entrusted Beacon Health Options to manage our New York members' behavioral health care (mental health and substance abuse) services. PrimariLink manages our Vermont members' behavioral health (mental health and substance abuse) services.

The behavioral health services that require prior authorization include:

Chemical Dependency, Mental Health Services, Methadone Maintenance/Opioid Substitution Therapy and Psychological Testing. To verify the procedures/services that may require prior authorization, call the Customer Care Center at the phone number shown in the Member section on the back of your ID card.

Advanced Imaging (Radiology) Services

MVP's partner, eviCore Healthcare, manages our members' use of radiology services to improve the quality, affordability and safety of the services you receive. eviCore Healthcare reviews authorization requests from your physician for the following services: MRI/MRA, PET scans, Nuclear Cardiology, CT/CTA scans, 3D rendering imaging services and radiation therapy. If you have a question about eviCore Healthcare, please call MVP's Customer Care Center at the phone number shown in the Member section on the back of your ID card.

Going out of network for your health care? Call MVP first.

If you are considering receiving health care services from a provider outside of MVP's network and your health plan includes out-of-network benefits, please call us first.

Out-of-network providers are not under contract to deliver covered services to you and so can set their own fees for services. The charges from an out-of-network provider may be much higher than the charges from a provider within MVP's network.

In addition, some services will not be covered by your health plan if you use an out-of-network health care provider without calling MVP first for prior authorization. An approved prior authorization request means that your benefits will be applied to the cost of the service.

Before receiving out-of-network care, call MVP's Customer Care Center at the phone number shown in the Member section on the back of your ID card. The Customer Care Representative can provide you with prior authorization requirements and information about your health plan's out-of-network benefits. You may want to consider using an in-network provider rather than going out-of-network.

IF YOUR HEALTH PLAN DOES NOT INCLUDE OUT-OF-NETWORK BENEFITS, you will not be covered for any service performed by an out-of-network provider, except in the following circumstances:

- A. COVERED EMERGENCY CARE SERVICES, when emergency care services are utilized, you must notify MVP as soon as possible after the emergency admittance. Many times, in emergency situations, the services are provided by out-of-network providers. You're covered for emergency medical care, including services by an out-of-network provider, when you are outside of the service area or in the event that a life threatening emergency requires that medical attention be provided by the nearest medical provider. Please consult your Certificate of Coverage for information regarding emergency care coverage under your plan.

- B. COVERED NON-EMERGENCY CARE SERVICES, in circumstances where a qualified participating provider with the appropriate training and experience to meet the needs of the member is not available to provide covered services to a member, MVP may provide benefits for covered services provided by a non-participating provider. When you want to ask for benefits from a non-participating provider in these circumstances, your physician must provide MVP with information about your condition, a medical opinion as to why services cannot be provided by a participating provider and the name and qualifications of the proposed non-participating provider.

If you are admitted to a hospital for emergency services, you or your doctor must notify MVP as soon as possible (this is called “concurrent notice”) so that MVP can review the services that you received and determine your coverage.

Prior Authorization Procedures/Services List

The following procedures/services may require prior authorization from MVP. To verify the procedures/services that may require prior authorization, call the Customer Care Center at the phone number shown in the Member section on the back of your ID card.

If you are interested in learning more about the treatments and services listed here, try looking them up in our online Health Encyclopedia. Visit the MVP website at **www.mvphealthcare.com**, click *Live Healthy* and then *Health Encyclopedia A-Z*.

- Air Medical Transport/Air Ambulance
(For non-emergency transport)
- Amniotic Membrane Transplant
- Autologous Chondrocyte Implantation
- Bariatric Surgery
- Blepharoplasty
- Botox Injections (Office procedure only)
- BRCA 1/BRCA 2 (Genetic testing for breast cancer)
- Breast Implantation
- Breast Reduction Surgery
- Capsule Endoscopy
- Cochlear Implants & Osseointegrated Devices
- Continuous Glucose Monitoring
- Cosmetic vs. Reconstructive Surgery
- Court Ordered Services (coverage for MVP Care)
- Deep Brain Stimulation
- Dental Services (Accidental Injury to Sound Teeth, Outpatient Services, Prophylactic)
- DME/Prosthetics/Orthotics
- Endovascular Treatment for AAA and Carotid Artery Disease
- Gaucher’s Disease Treatment
- Gender Reassignment Surgery
- Genetic Testing/Chromosomal Studies
- Hereditary Angioedema
- Hip Surgery for FAI

- Hyperbaric Oxygen Therapy
- Hyperhidrosis Treatment
- Immunoglobulin Therapy
- Implantable Cardiac Defibrillators
- IMRT
- Infertility (Advanced and/or Secondary), available with Rider
 - Including drugs (e.g., Follitropins, Menotropins)
 - GIFT/ZIFT are not covered
- Interstim(Sacral Nerve Stimulator)
- Intraoperative Neurophysiological Monitoring
- Laser Treatment of Port Wine Stains
- Left Ventricular Assist Device
- Lumbar Laminectomy (Discectomy)
- MSLT – Multiple Sleep Latency Testing
- Nasal Sinus Endoscopy
- Neuropsychological Testing
- New Technology
- Oncotype Diagnostic Testing
- Oral Surgery/Orthognathic Surgery
- Organ Donor
- Orphan Drugs
- Panniculectomy/Abdominoplasty
- Pectus Excavatum
- Penile Implants
- Percutaneous Vertebroplasty/Kyphoplasty
- Private Duty Nursing
(Coverage for MVP Care, FHP, CHP only)
- Prolotherapy
- Rhinoplasty
- Rhizotomy/Radiofrequency Ablation
- Sclerotherapy
- Septoplasty
- Shoulder Resurfacing
- Skin Endpoint Titration
- Sleep Studies (Facility based)
- Speech Generating Devices
- Speech Therapy – Selected Contracts
- Spinal Fusion - Lumbosacral
- Spinal Stimulator
- Synagis (Injectable for RSV)
- Thoracic Electrical Bioimpedance
- TMD/TMJ
- Treatment of Obstructive Sleep Apnea (Policies A & B)
- UPPP Surgery
- Virtual Colonoscopy thru EviCore
- VNUS/EVLT
- Wound Vacs

We are here to help.

MVP has attempted to capture all prior authorization requirements in this document. However, benefit plans are subject to change. If you have questions about your benefit coverage, services or procedures in this document, or about any services that are not included, please call the Customer Care Center at the phone number shown in the Member section on the back of your ID card.

Visit the MVP website at **www.mvphealthcare.com** to see the *MVP Prescription Drug Formulary* that identifies pharmacy covered drugs that require prior authorization.