2018 Annual Notices

for MVP Health Care Vermont Providers

As part MVP Health Care's 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 regulatory and compliance content online at **mvphealthcare.com** and directs health care providers to this content each year in our *Healthy Practices* provider newsletter.

Members' Rights and Responsibilities

The MVP Member Rights and Responsibilities policies clearly state:

1. Our commitment to treating members in a manner that respects their rights.
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 their MVP Member Guide (provided in hard copy after enrollment) and in the Member Annual Notices, both available at **mvphealthcare.com** and in hard copy at any time by request. New and existing practitioners can find the MVP Member Rights and Responsibilities statements in the MVP Provider Resource Manual. These are also available in hard copy by calling MVP.

Member Complaint and Appeal Process

The MVP complaint and appeals policies assure that members' written and verbal concerns are registered, investigated, and resolved in a timely manner. 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. MVP encourages 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 considered through the recredentialing process.

Confidentiality and Privacy Policies Protection of Oral, Written, and Electronic Protected Health Information

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 available at **mvphealthcare.com** for easy access with no login required. Printed 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:

- 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

HIPAA Reminder About Faxes

Fax communications are not specifically addressed by HIPAA, but information that MVP faxes upon the request

of a health care provider may contain PHI, to which HIPAA rules apply. Fax machines should be in a secure location where non-authorized personnel cannot access faxes.

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 Utilization Management Department 24 hours a day, seven days a week at **1-800-684-9286** regarding utilization management concerns. After hours, physicians may call the MVP Customer Care Center at the phone number on the member's ID card. 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 service and the existence of benefit provisions of the member's coverage.
2. MVP does not specifically reward practitioners, providers, or staff, including Medical Directors and Utilization Management 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 Utilization Management decisions of the concerns and risks associated with under-utilization of medical care or services.
5. For Medicaid Managed Care plans, a member can request a fair hearing through the state if he or she does not agree with a decision made by MVP.

Pharmacy Benefit Management

MVP utilizes prescription drug Formularies (lists of covered drugs) for Commercial, Marketplace, Medicaid Managed Care, and Medicare Part D members.

The Commercial Formulary is divided into three Tiers as determined by our Pharmacy and Therapeutics (P&T) Committee:

- Tier 1 contains most generic drugs
- Tier 2 contains preferred brand drugs
- Tier 3 contains non-preferred brand drugs

The Marketplace Formulary is divided into three Tiers as determined by our P&T Committee:

- Tier 1 contains all preferred generic drugs
- Tier 2 contains preferred brand-name drugs and select high-cost generic drugs
- Tier 3 contains non-preferred brand-name drugs and all compounds

The Medicare Part D Formulary is a six-tier Formulary:

- Tier 1 includes preferred generics,
- Tier 2 includes generics
- Tier 3 includes preferred brands and non-preferred generics
- Tier 4 includes non-preferred brands and non-preferred generics
- Tier 5 includes drugs that cost more than $600 for a 30-day supply
- Tier 6 includes select vaccines

To access the most current versions of the MVP Formularies and regular updates, visit **mvphealthcare.com** and select *Providers*, then *Pharmacy*.

Utilization Management Criteria

MVP uses the most current version of InterQual® criteria as a guideline for its Utilization Management decisions for most medical services.

Pharmacy utilization management utilizes criteria and Formularies are developed by the MVP P&T Committee.

MVP also ensures that entities performing delegated utilization management use nationally accepted criteria that are reviewed and approved annually and are available upon request.

MVP has delegated the responsibility for utilization management decisions related to behavioral health services for MVP members in Vermont to PrimariLink in Brattleboro, Vermont. PrimariLink uses the following published criteria: LOCUS, CALOCUS/Level of Care Utilization System and the American Society of Addiction Medication (ASAM*) Patient Placement Criteria for the Treatment of Substance-Related Disorders. PrimariLink's behavioral health criteria and their entire provider manual are available for physicians by visiting **brattlebororetreat.org** and selecting *Programs*, then *Primarilink*, then *Provider-Home*.

MVP has delegated the responsibility for utilization management decisions related to clinical reviews on radiology requests for MVP members in New York and Vermont to eviCore healthcare (eviCore). eviCore reviews MRI/MRA, PET scans, Nuclear Cardiology, and CT/CTA.

When making utilization management decisions, eviCore utilizes evidence-based guidelines and recommendations for imaging from national and international medical societies and evidenced-based medicine research centers. Sources include the American College of Radiology Appropriateness criteria, Institute for Clinical Systems Improvement Guidelines, National Comprehensive Cancer Network Guidelines, and the National Institute for Health and Clinical Excellence Guidelines.

MVP has also delegated the responsibility for utilization management decisions related to radiation therapy treatment reviews for all lines of business in New York and Vermont membership to eviCore. The clinical guidelines for eviCore's radiation therapy treatment are derived from evidence-based guidelines and recommendations, sourced from national and international medical societies and medical research centers, including American College of Radiology Appropriateness criteria, American Society for Radiation Oncology, National Comprehensive Cancer Network Guidelines, and Radiation Therapy Oncology Group. eviCore may be reached at **1-888-684-9286** or at **evicore.com**.

MVP has delegated utilization management of chiropractic care to Landmark Healthcare, Inc. DBA eviCore healthcare MSK Services (Landmark) 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**.

MVP also uses a *Benefit Interpretation Manual* (BIM) to help determine whether a service is covered. This online manual provides convenient access to needed information. 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. To view the BIM, physicians can visit **mvphealthcare.com** and select *Sign In/Register*, then log in with your *User ID* and *Password* and select *Sign In*, then select the gray box to go to the *Provider Snapshot* page, then *Online Resources*, then *Benefit Interpretation Manual*.

Practitioners may request a copy of the criteria employed to make a specific utilization management determination by contacting the local Utilization Management Department at **1-800-568-0458**. 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 MVP Customer Care Center at the number on the back of their Member ID card.

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 contact the practitioner directly. The Utilization Management Department can be contacted at **1-800-568-0458.**

To speak with an appropriately-licensed clinical reviewer regarding behavioral health care decisions, including denials of service and the submission of additional information, please call PrimariLink at **1-800-320-5895**.

To obtain a complete set of the American Society of Addiction Medicine (ASAM) criteria contact the ASAM Publications Department at **301-656-3920**, by fax at **301-656-3815**, by email to **Email@asam.org**, or by mail to 4601 North Park Ave, Upper Arcade, Suite 101, Chevy Chase MD 20815.

Practitioner Appeals

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

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 the MVP Customer Care Center at **1-800-684-9286**. If an adjustment is required, practitioners may file a *Correspondence Adjustment Form* available on the MVP Provider Portal, or by using a HIPAA standard EDI adjustment transaction for electronic adjustments.

2. **Practitioner Claim Appeal**

   Practitioners may call or write to the MVP Customer Care Center to request an appeal of the denial of a properly submitted claim (i.e. "clean claim").

3. **Practitioners Submitting Appeals on Behalf of MVP Members**

   Practitioners may also appeal a pre-service denial as the designated representative of an MVP member. MVP will 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.

4. **Request a Reconsideration**

   For non-Medicare lines of business, when the requesting physician is notified of an adverse determination, he/she is advised of the ability to request a reconsideration of the decision and speak with the MVP Medical Director who made the decision. Review of the reconsideration request is completed within one business day for urgent and concurrent review requests and must be conducted by both the requesting provider and the Medical Director making the initial determination.

   For the Medicare lines of business, all pre-service or concurrent requests for reconsideration (for Part C request or Part B drugs) and redeterminations (for Part D), following the initial denial, are processed as appeals.

MVP Non-Compliance Policy

MVP objectively and systematically monitors provider compliance with MVP policies and procedures. The following categories represent potential physician non-compliance issues that are reviewed and investigated by MVP.

1. **Contractual Violations Issues**—violations of MVP, Physician-Hospital Organizations, direct, or Independent Practice Association contracts
   (a) Accessibility of care issues involving MVP members.
   (b) Balance billing of members by MVP practitioners and/or providers.
2. **Utilization Management Issues**
   (a) Unauthorized non-emergent surgical procedures and procedures pre-certified in less than the five business day time frame.
   (b) Unauthorized out-of-plan referrals.
   (c) Failure to obtain prior authorization for services when required by MVP policy.
   (d) Refusal to cooperate with the Utilization Management/Quality Improvement process. Examples: (1) refusal to speak with the MVP Medical Director or UM/QI staff or (2) verbal abuse of the UM/QI staff.

The MVP Credentialing Department follows occurrences of non-compliance. Non-compliance information is reviewed during the MVP re-credentialing process.

Utilization Management Processes

MVP is a managed care system with the Primary Care Physician (PCP) as the coordinator of care for all medical services (exceptions: PPO and Non-Group Indemnity plan types).

Out-of-Plan Requests

For those plans with in-network benefits only, all requests for out-of-plan services require prior authorization from the MVP Medical Director or a Medical Director of an entity to whom MVP has delegated utilization management duties. The member's PCP or MVP-participating provider must submit a *Prior Authorization Request Form (PARF)* to the Utilization Management Department for authorization prior to the member's first appointment with the out-of-plan physician. Please attach any information substantiating the need for out-of-plan services to the PARF. The PARF can be located in the back of your *Practitioner Resource Manual* or by visiting **mvphealthcare.com** and selecting *Providers*, then *Forms*, and then *Prior Authorization*.

Without prior authorization, MVP will not provide benefits for out-of-plan services except in emergency situations. You may submit the request form to MVP via fax or mail. In urgent cases, you may contact the Utilization Management Department by phone at **1-800-568-0458** and request an expedited review.

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

Prior written notification must be given if a practitioner wishes to end his or her network affiliation with MVP Health Care. 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 the MVP network (assuming the provider has not been terminated due to a quality issue) 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
- 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 trimester of the pregnancy at the time the provider has ended participation with MVP, the member may continue her course of care with the same provider through delivery and related postpartum care. The physician must submit a request for authorization as outlined above to the appropriate Utilization Management Department. Transition care is not available if the 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 postpartum care. The provider must adhere to all of the above three requirements.

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 prior authorization, MVP will not provide benefits for transition of care service,s except in emergency circumstances.

Transition from Pediatric to Adult Care

Patients entering adulthood (ages 18 and older) may want help or need encouragement to transition from a pediatrician to an adult care provider. MVP offers resources to help you serve your adolescent patients. MVP's online provider directory enables members to search for and choose an adult provider by several preferences such as location, board certification, gender, or language spoken. Visit **mvphealthcare.com** and select *Find a Doctor.*

The MVP Customer Care Center is available to assist older adolescent members' transition from a pediatrician and/or pediatric specialists to an adult provider when they wish to make the change. Members can reach the MVP Customer Care Center by calling the phone number on the back of their MVP Member ID card. MVP offers a template letter to make it easy for you to contact your patients age 18 and older to help make the transition from your practice to an adult practice. Contact your MVP Clinical Reporting Coordinator for more details.

Specialist as a PCP

Individuals with life-threatening, disabling, or degenerative conditions requiring ongoing care may request a participating Specialist or a participating Specialty Care Center be responsible for providing and coordinating their primary and specialty care. The member or PCP must initiate the process by submitting a written request to the appropriate MVP Utilization Management Department for prior approval. For details on submitting a request please refer to your Practitioner Resource Manual.

MVP will need to collect information regarding the specialist's ability to provide access to care, the member's medical needs in relation to the current condition, the plan of care, and a written agreement from the specialist to assume the role of the member's PCP. Once all information has been received, the request will be reviewed by the MVP Medical Director and the Utilization Management supervisor. The member, the PCP, and the specialist will be notified in writing of MVP's decision.

Members may not elect to use a non-participating specialist or Specialty Care Center as their PCP unless these services are not available in-plan.

Emergency Services

Emergency services are those episodes of care provided in an emergency setting that are required to evaluate and treat an emergency medical condition. An emergency medical condition means the sudden, and at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the

prudent layperson, who possess an average knowledge of health and medicine to result in:

- placing the member's physical or mental health in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- serious disfigurement of the person.

Members may self-refer to seek emergency treatment. A referral or prior authorization is not needed to seek emergency treatment. 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. An MVP 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 14 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 the 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 it 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 MVP provider newsletter, *Healthy Practices*. Full versions of the policies are available on the provider section of the MVP website. Paper copies are 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.

The standards are:

1. Providers must maintain medical records in a manner that is current, detailed, and organized, and permits effective and confidential patient care and quality review.
2. Providers must have an organized medical record keeping system.
   (a) Medical records must be stored in a secure location not accessible to the public.
   (b) There is a unique medical record for each member, identified by a medical record identifier on each page.
   (c) Medical records are organized with a filing system to makes them easy to retrieve. Medical records are available to the treating practitioner whenever the patient is seen at the location at which he/she typically receives care.
3. Primary care medical records must reflect all services provided directly by the physician, 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).

4. 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.
5. Providers must retain medical records in accordance with contractual obligations and applicable federal and state laws and regulations.
   (a) For providers participating in Vermont, medical record retention is required for a period of six years after the date of service rendered to the MVP member, and for a minor, until six years after the age of majority.
   (b) For providers participating in Medicare products, medical record retention is required for a period of 10 years after the date of service rendered to the MVP member.
6. 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 nondiscrimination in health care delivery policy and adherence to it are also expectations of the Centers for Medicare & Medicaid Services (CMS) and the NCQA. MVP's Quality Improvement staff will measure compliance with a nondiscrimination policy and procedure at the time of the medical record review.

Specific medical record standards are:

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; someone other than the writer must be able to read it.
3. Each entry or office note must be dated.
4. All entries in the medical record should contain the author's identification. Stamped signatures are not considered appropriate author identification for entries dated after July 1, 1999. 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 and older, there should be appropriate notation concerning the use of tobacco, alcohol, and other substances. For patients who have been seen three or more times, there should be a record of asking about any substance use history.
11. For all patients age 18 and younger, there should be a completed immunization record. For patients age 19 and older, 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.

* Required for MVP Medicare and Medicaid Managed Care members.

15. Consultation, lab, and imaging reports filed in the medical chart should be initialed by the practitioner who ordered them to signify review. If the reports are presented electronically or 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 age 19 and older, 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. There is evidence that preventive care/risk assessment screening and services are offered in accordance with MVP's practice guidelines.
23.* Evidence of an annual medication review and date on which it was performed; at least one annual medication review conducted by a prescribing practitioner and the date on which it was performed.
24.* Functional status assessment documented. Components of functional assessment: vision, hearing, mobility, continence, nutrition, bathing, phone use, meals preparation, and management of finances. Functional assessment may be found on a specific tool.
25.* Pain screening assessment documented. Pain assessment usually consists of questions asked by the physician that can be found on the physical. Patient is usually asked the character, severity, location, and factors that improve or worsen the pain. Pain assessment may be found on a specific tool such as a pain scale, visual pain scale, or diagram.

To assess compliance with the standards, MVP conducts an annual ambulatory medical record review at the offices level of physicians with HMO and EPO/PPO member panel sizes of 250 or more on these six core elements:

- Problem list
- Allergy information
- History and 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%or greater. Practitioners who scored 100%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%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% 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 MVP Quality Improvement Committee.

* Required for MVP Medicare and Medicaid Managed Care members.

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 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. Vermont Advanced Directives forms are available by visiting **vtethicsnetwork.org** and selecting *Forms*. For additional information concerning advance directives, please call the MVP Quality Improvement Department at **1-800-933-3920** ext. 12463.

The MVP 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 the MVP QI Program include Preventive Health, Medical Records, Utilization Management, Behavioral Health, Credentialing, Delegation, Member Connections, and Member Rights and Responsibilities.

The MVP Quality Improvement Committee (QIC) and Board of Directors oversee the QI Program. The QIC is chaired by the MVP Senior Medical Director for Medical and Quality Management, and includes community physicians from various specialties representing the different provider organizations that participate with MVP. The objective of the MVP QI 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 Quality Improvement Committee include:

- 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 MVP 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** ext. 42343.

Invitation to Join the MVP 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** ext. 42343.

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 the MVP provider network.

Practitioners must be credentialed before being listed in the MVP 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, religion, 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 law, state law or contract), directly or indirectly, any confidential information obtained during the credentialing or recredentialing process to any non-authorized individual. MVP will notify the applicant of the status of the application upon verbal or written request directly from the applicant.

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.

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, the MVP 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
- over-utilization of treatment modalities

The SIU staff also works closely with federal and 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 the MVP Special Investigations Unit 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, with the exception of 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, such 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 comprehensive diversity and cultural competency training that highlights the Americans with Disability Act for internal use. This training focuses on creating a climate for diversity and cultural competence, outlining services that support 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. 42343.

MVP Provider Directory

To access the MVP online provider search tool, visit **mvphealthcare.com** and select *Find a Doctor*, then follow the prompts for a targeted search. In addition, you may request a copy of MVP's full directory in print or electronic format at any time by calling the MVP Customer Care Center at **1-888-687-6277**.