2020 Annual Notices

for MVP Health Care® New York State Providers

As part of 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 on **mvphealth care.com** and directs Participating Providers to this content each year in our provider newsletter, *Healthy Practices*.

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 onboarding material upon enrollment and in the Member Annual Notices, both available at **mvphealth care.com** and in hard copy at any time by request. New and existing providers can find the MVP Member Rights and Responsibilities statements specific to Commercial, Medicaid Managed Care, and Medicare Advantage Members in the MVP Provider Resource Manual (PRM). To access the PRM go to **mvphealth care.com/PRM**. These are also available in hard copy by contacting MVP.

Member Complaints and Appeals Process

The MVP complaints 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 provider 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 (SIC) and the Quality Improvement Committee (QIC). 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 committing 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, annually, and is included in the MVP PRM. It is also available at **mvphealth care.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 for MVP

HIPAA Reminder About Faxes

Fax communications are not specifically addressed by HIPAA, but information that MVP faxes at the request of a health care provider may contain PHI, to which HIPAA rules apply. Fax machines should be in a secure location with authorized personnel only access.

Medical Management Decisions

It is the policy of MVP to provide benefits for covered, Medically Necessary health care services provided to our Members. Providers may contact the Utilization Management Department, via Provider Services, Monday–Friday, 8:30 am–5 pm (Eastern Time), at **1-800-684-9286** regarding utilization management concerns.

The MVP Utilization Management Program does not provide financial incentives to employees, providers, or practitioners who make utilization management decisions that would create barriers to care and services. Utilization Management decisions are based only on appropriateness of care, treatment and/or services, and the benefit provisions of the Member's coverage.

MVP does not specifically reward practitioners, providers, or staff, including Medical Directors and Utilization management staff, for issuing denials of requested care. MVP does not offer financial incentives to encourage decisions that result in inappropriate utilization.

MVP informs those involved with utilization management decisions of the concerns and risks associated with under-utilization of medical care or services. For Medicaid Managed Care plans, a Member can request a fair hearing through New York State if he or she does not agree with a decision made by MVP.

It is the policy of MVP to monitor the impact of the MVP Utilization Management Program to ensure appropriate utilization of services.

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 and compounds

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 compounds

The Medicaid Managed Care Formulary is a two-tier Formulary:

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

All other drugs and compounds require approval from MVP before they will be covered.

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

- Tier 1 includes preferred generic drugs
- Tier 2 includes generic drugs
- Tier 3 includes preferred brands and nonpreferred generic drugs
- Tier 4 includes non-preferred brands and nonpreferred generic drugs
- Tier 5 includes drugs that cost more than $700 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 follows criteria and Formularies that are 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 clinical reviews on radiology requests for MVP Members in New York State and Vermont to eviCore health care (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:

- American College of Radiology Appropriateness Criteria
- Institute for Clinical Systems Improvement Guidelines
- National Comprehensive Cancer Network Guidelines
- National Institute for Health and Clinical Excellence Guidelines

MVP has also delegated the responsibility for utilization management decisions related to radiation therapy reviews for all lines of business in New York State and Vermont to eviCore. The clinical guidelines for eviCore's radiation therapy 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
- Radiation Therapy Oncology Group

eviCore may be reached at **1-800-918-8924** or at **evicore.com**.

MVP has delegated utilization management of chiropractic care, massage therapy, and acupuncture to Landmark Health care, Inc. DBA eviCore health care MSK Services (Landmark). Landmark uses clinical criteria that have been developed 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 Managed Care, Child Health Plus, and Commercial products, MVP has delegated utilization management for routine dental service to Healthplex, Inc. for all dental services. Healthplex utilizes the most current version of Current Dental Terminology 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 are based on The Professional Guidelines for Review of Services for Medicaid/ Child Health Plus Plans and the MVP contract provisions.

MVP has delegated responsibility for utilization management for Skilled Nursing Facility (SNF), Acute Inpatient Rehabilitation (AIR), and Home Health services for Medicare Advantage Members ONLY to naviHealth, Inc. naviHealth staff will be located in each of MVP's regions to visit facilities and manage the transitions. naviHealth can be reached at **naviHealth.us** or **1-844-411-2883**.

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. To view the BIM, providers can visit **mvphealth care.com** and select *Sign In/Register*, then log in using their User ID and Password, then select *Provider Snapshot*, then *Online Resources*, then *Benefit Interpretation Manual*.

Providers may request a copy of the criteria employed to make a specific utilization management determination by contacting the MVP Utilization Management Department at **1-800-568-0458**. The criteria will be mailed or faxed to the provider's office with a proprietary disclaimer notice.

MVP 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 MVP Member ID card.

If an MVP Participating Provider has questions regarding the MVP utilization management policies or a specific utilization management decision, such as a denial of service, MVP Medical Directors and appropriately licensed clinical reviewers are available to discuss the denial. Providers requesting to speak with a clinical reviewer should contact the Utilization Management Department, who will coordinate the discussion. The appropriately licensed clinical reviewers will contact the provider directly. The MVP Utilization Management Department can be contacted at **1-800-568-0458**.

Provider Appeals

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

1. **Make a Claim Inquiry:** Providers may obtain information regarding why a claim was rejected or processed in a certain manner, often resolving the need for any further action, by calling the MVP Customer Care Center for Provider Services at **1-800-684-9286**. If an adjustment is required, providers may file a Correspondence Adjustment Form, which is available by logging into their MVP online account, 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"). Provider appeals denied for "not Medically Necessary" should be mailed to:

   ATTN: Member APPEALS DEPARTMENT
   MVP HEALTH CARE
   625 STATE STREET PO BOX 2207
   SCHENECTADY, NY 12301

   All other appeals should be mailed to:
   OPERATIONS ADJUSTMENT TEAM
   MVP HEALTH CARE
   625 STATE STREET PO BOX 2207
   SCHENECTADY, NY 12301

   Providers may appeal verbally by calling MVP Customer Care Center for Provider Services at **1-800-684-9286**.
3. **Providers Submitting Appeals on Behalf of MVP Members:** Providers may also appeal a pre-service denial as the designated representative of an MVP Member. MVP will only accept appeals submitted by providers on behalf of Members after the Member or appropriate representative of the Member has designated the provider to act on their behalf. Such designation must be in accordance with MVP's policies and procedures.
4. **Request a Reconsideration:** For non-Medicare Products, when the requesting provider is notified of an adverse determination, the provider is advised of the option 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 Medicare Products, all pre-service requests for reconsideration of an initial adverse determination (for Part C request or Part B drugs) and re-determinations (for Part D), are processed as appeals.

Compliance with MVP Protocols

MVP continuously monitors Participating Provider compliance with Credentialing and Re-Credentialing requirements, your provider services agreement and requirements of the Provider Resource Manual including utilization management and claims processing (collectively "MVP Protocols"). Non-compliance with MVP Protocols is identified as a failure to follow such obligations and requirements including but not limited; to breach or non-adherence to the provider services agreement, accessibility, access of care, unauthorized referrals, prior authorization, member non-liability (balance billing) or a general lack of cooperation with MVP.

Utilization Management Processes

MVP offers managed health care products, with the Primary Care Provider (PCP) as the coordinator of care for all medical services (exceptions: MVP Direct Access, PPO, and Non-Group Indemnity plan types).

Out-of-Network Requests

For those plans with in-network benefits only, all requests for out-of-network services require prior authorization to be reviewed by the MVP Medical Director or a Medical Director of an entity to whom MVP has delegated responsibility for utilization management functions. The MVP Member's PCP or MVP Participating Provider must submit a Prior-Authorization Request Form (PARF) to the Utilization Management Department for review before the Member's first appointment with the out-of-network provider. Please attach to the PARF any information substantiating the need for out-of-network services. The PARF is in the back of the Provider Resource Manual or is available by visiting **mvphealthcare.com** and selecting *Providers*, then *Forms*, and then *Prior Authorization*.

Without prior authorization, MVP will not reimburse out-of-network services, except in emergency situations. You may submit the PARF to MVP via fax or mail. In urgent cases, you may contact the MVP Utilization Management Department 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 provider wishes to end his or her network affiliation with MVP. This is an important part of the MVP Participating Provider contract and helps MVP Members transition their care to a Participating Provider. MVP Members may be eligible to receive transitional care from a provider who has supplied MVP with a termination notice, up to 90 days from the date of the contract termination. However, the provider leaving the MVP network must agree to:

- Accept MVP's established rates as payment in full
- Adhere to the MVP Quality Improvement requirements
- Provide medical information related to care
- Adhere to MVP policies and procedures

If a Member is receiving maternity care and has entered her second or third 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 provider must submit a request for authorization as outlined above to the Utilization Management Department. Transitional care is not available if the provider disenrollment is the result of an MVP determination of imminent harm to patient care, a quality issue, 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 Provider may continue treatment with that provider for up to 60 days from the effective date of the Member's MVP contract if the provider agrees to:

- Accept MVP's established rates as payment in full
- Adhere to MVP's Quality Improvement requirements
- Provide medical information related to care
- Adhere to MVP policies and procedures

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

If an MVP Member is receiving maternity care and has progressed beyond her first 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 requirements listed above.

Transition of care services must receive prior authorization from MVP. To request transition of care services for an MVP 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 reimburse for out-of-network services or treatments that are provided during the transition of care except in emergency circumstances.

Transition from Pediatric to Adult Care

Patients entering adulthood (age 18 and older) may want help to transition from a pediatric 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 **mvphealth care.com** and select *Find a Doctor*.

The MVP Customer Care Center is available to assist with older adolescent Members' transition from a pediatrician and/or pediatric specialists to an adult provider. 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 the MVP Quality Improvement Department at **1-800-777-4793 ext. 42588** for more details.

Specialist as a Primary Care Physician

Individuals with life-threatening, disabling, or degenerative conditions requiring ongoing care may request that a participating specialist or a participating Specialty Care Center be responsible for providing and coordinating their primary and specialty care. The MVP Member or PCP must initiate the process by submitting a written request to the appropriate MVP Utilization Management Department for prior approval. For details regarding submitting a request, please refer to the MVP Provider 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 the required services are not available in-from a Participating Provider..

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 seek emergency treatment without contacting a provider (self-refer). A referral or prior authorization is not needed to seek emergency treatment. Services are covered when a change in a medical or behavioral health condition would lead a prudent layperson to believe a true emergency exists and that the absence of immediate medical attention will result in one or all the following:

- 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
- Serious impairment to the person's bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement of the person

Determination of coverage is based upon the Member's eligibility, contracted benefits, 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.

Behavioral Health Program

MVP sees medical and behavioral health as equal components of a person's overall well-being. MVP recently integrated medical and behavioral health to enable primary care and behavioral health professionals to succeed at integrating patient care, enabling them to support an individual's journey to better health and optimal living. MVP offers behavioral health care management services to manage Members' behavioral health and substance use disorders for all ASO (self-funded) plans, and all fully insured plans in New York State (HMO, POS, EPO, PPO, Indemnity, and government programs including Medicaid Managed Care, Health and Recovery Plans [HARP], and Child Health Plus [CHP]. For questions related to Behavioral Health Services contact MVP at **1-800-684-9286** and listen for the Behavioral Health prompt.

Technology Assessment

MVP follows a formal process to evaluate new technology and reassess existing technologies to determine whether the technology should be covered by MVP when medically appropriate. The results of the evaluation or reassessment are published as policies in the BIM. This includes medical/surgical procedures, drugs, medical devices, and behavioral health treatments. A copy of the policy is available upon 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, Marketing & 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 providers from representative specialties, including at least one provider from each region within the MVP service area, and health plan staff. Formulary recommendations are reviewed by the MVP 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 medical policies undergo review on an annual basis and are updated as new evidence becomes available.

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 technology and policy 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 QIC for final approval. The QIC may approve policies as they are presented, or it may require additional research and revision before considering them again at a future meeting.

Participating Providers are notified of new policies or changes in existing policies through *Healthy Practices*, the MVP provider newsletter, and via MVP FastFax. To view an archive of all MVP FastFax communications, visit **mvphealthcare.com/FastFax**. Full versions of the policies are available on the provider section of **mvphealth care.com**.

MVP 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 support efficient and effective treatment. MVP established standards for recordkeeping and retention in medical offices that follow the recommendations of NCQA. The standards are as follows:

- Providers must maintain medical records in a manner that is current, detailed, organized, and permits effective and confidential patient care and quality review.
- Providers must have an organized medical record-keeping system:
  - Medical records must be stored in a secure location that is inaccessible by the public.
  - A unique patient identifier is used for each Member. The identifier is included on each page of the medical record.
  - Records are organized with a filing system or search capability to ensure easy retrieval. Medical records are available to the treating provider whenever the patient is seen at the location at which he/she typically receives care.
- Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the provider, and all diagnostic and therapeutic services for which the provider referred the Member (e.g., home health nursing reports, specialty physician reports, hospital discharge reports, physical therapy reports).
- Confidentiality: Providers/Practice sites shall comply with current state and federal confidentiality requirements, including HIPAA, and are expected to adopt policies and procedures that guard against unauthorized or inadvertent disclosure of PHI.
- Retention of Medical Records: Providers shall retain medical records in accordance with contractual obligations, and current applicable federal and state laws and regulations.

Specific medical records 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 include the patient's full name and identification number. In addition, home address, phone number(s), employer, marital status, and emergency contact information is maintained.
2. The record is legible to someone other than the writer.
3. Each entry or 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 or an electronic 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. Problem List: Documents all chronic, serious, or disabling conditions, and active, acute medical, and psychosocial problems. A problem list should be completed for each patient, regardless of health status and updated as necessary. A flow sheet for health maintenance screening is considered part of the problem list. It is acceptable if the provider 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 include serious injury, surgical

procedures, and illnesses. For children and adolescents (18 years of age and under), past medical history relates to prenatal care, birth, surgical procedures, and childhood illnesses.

8. Medication List: Documents all medications, updated as necessary with dosage changes and the date the change was made. All medications (prescribed, over-the-counter herbal therapies, vitamins, and supplements) must be noted. Dates of initial and refill prescriptions must be included.
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, NKDA).
10. For patients age 12 and older, there should be appropriate notation concerning tobacco, alcohol, and substance use. For patients who have been seen three or more times, substance abuse history is assessed.
11. For patients age 18 and younger, there should be a complete immunization record. For patients age 19 and older, an immunization history is maintained (e.g., influenza, pneumococcal, tetanus/diphtheria immunizations).
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 frame for return is noted (e.g., weeks, months, or as needed).
14. No-shows or missed appointments must be documented with follow-up efforts to reschedule the appointment.
15. Specialist, laboratory, and imaging reports should be initialed by the provider 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 provider. Specialist, abnormal laboratory, and imaging study results should have an explicit notation in the record of follow-up plans.
16. If a specialist referral is requested, there should be a note from the consultant in the record.
17. Laboratory 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. The 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. Preventive Care/Risk Assessment: There is evidence that preventive screening and services are offered in accordance with MVP's practice guidelines.
22. Depression Screening: May be assessed on a comprehensive physical examination, review of systems, patient health questionnaire, or a formal screening tool (e.g., PHQ-9, Beck Depression Inventory) or any part of the following questions, 1) Little interest or pleasure in doing things? 2) Feeling down, depressed, or hopeless?
23. Advance Care Planning for Patients Age 65 and Older: Notation of an advance care planning discussion and date, and/or copy of an executed Advance Directive form. Current Advance Directive forms should be maintained in a prominent part of the Member's medical record. Advance Directive forms are available in the MVP Provider Quality Improvement Manual.
24. Annual Medication Review for Patients Age 65 and Older: Conducted by a prescribing provider and the date the review was performed.
25. Functional Status Assessment for Patients Age 65 and Older: Components include vision, hearing, mobility, continence, nutrition, bathing, use of phone, preparing meals, and managing finances. Functional assessment may be found on a specific tool.
26. Fall Risk Assessment for Patients Age 65 and Older: Components include age, fall history, gait, balance, mobility, muscle weakness, osteoporosis risk, impairments related to vision, cognitive or neurological deficits, continence, environmental hazards, and number and type of medication.
27. Monitoring of Physical Activity for Patients Age 65 and Older: Includes annual assessment of level of exercise or physical activity, and counseling related to begin exercising or increase/maintain their level of exercise or physical activity.
28. Pain Screening for Patients Age 65 and Older: Includes character, severity, location, and factors that improve or worsen pain. Pain assessment may be found on a specific tool such as a pain scale, visual pain scale, or diagram.

Nondiscrimination in Health Care Delivery

MVP, as per The Centers for Medicare and Medicaid Services (CMS) and NCQA, expect that providers have a documented nondiscrimination policy and procedure on file "to ensure that Members are not discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment."

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 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. To obtain a New York State Department of Health (DOH) Health Care Proxy form, visit **mvphealth care.com** and select *Providers*, then *Forms*, then *Patient Forms*.

For additional information concerning Advance Directives, please call the MVP Quality Improvement Department at **1-800-777-4793 ext. 42588**.

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 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 providers 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.

QIC activities 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 QIC 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 MVP QI Department at **1-800-777-4793 ext. 42588**.

Invitation to Join the MVP Quality Improvement Program

The main focus of MVP's QI 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. 42588**.

Practitioner Credentialing and Recredentialing Process

MVP will complete the initial Credentialing, including primary source verification of information submitted, for providers applying for participation in the MVP provider network, prior to the execution of a Participating Provider Agreement.

Providers must have an executed Participating Provider Agreement and be credentialed to be listed in the MVP Participating Provider Directory. Providers 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 provider 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 by applicable federal law, state law, regulation, or contract), directly or indirectly, any confidential information obtained during the Credentialing or Recredentialing process to any nonauthorized individual. MVP will notify the applicant of the status of the application upon verbal or written request directly from the applicant.

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

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

Provisional Credentialing Requirements for New York State Providers

MVP shall complete a review of the health care professional's application to participate in the MVP network and shall, within 60 days of receiving a Completed Application* to participate in the MVP network, notify the health care professional as to whether:

- They are Credentialed.
- Additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, MVP shall make every effort to obtain such information as soon as possible and shall make a final determination within 21 days of receiving the necessary documentation.

For applicants that 1) are newly licensed health care professionals, or 2) are health care professionals who have recently relocated to New York State from another state and have not previously practiced in New York State, and who are joining a participating group in which all Members of the group already currently participate with MVP, the applicant shall be eligible for provisional Credentialing as of the 61st day of the application if the applicant has submitted the following:

1. Completed Application and any requested supporting documentation.
2. Written notification to the MVP Director of Credentialing including a statement that in the event the applicant is denied, the applicant or their group practice shall:
    a. 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.
    b. Not pursue reimbursement from the insured, except to collect the co-payment or co-insurance that otherwise would have been payable had the insured received services from an MVP Participating Provider.

**Completed Application for Credentialing and Re-credentialing includes: A complete and accurate CAQH application, re-attested to within the last 90 days, with all supporting documentation including, but not limited to, malpractice insurance certificate, continuity of care arrangements that meet MVP criteria for specialty, explanation of any affirmative responses including malpractice suits, an explanation of any work history gaps of more than six months, and a re-entry plan for all gaps of more than one year (the provider is obliged to provide MVP with information sufficiently detailed to render an opinion regarding any affirmative response); MVP's receipt of all verifications from third party sources.*

Report Suspected Insurance Fraud, Waste, and 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 Providers, facilities, and their office staff to help us fight insurance fraud and/or abuse. Please report any suspicious activity by calling the SIU at **1-877-TELL-MVP (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. Providers 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.

MVP Meets Members' Special, Cultural, and Linguistic Needs

MVP assists Members with different cultural or linguistic needs. MVP has developed a comprehensive diversity and cultural competency training that includes the Americans with Disability Act. 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 MVP QI Department at **1-800-777-4793 ext. 42588**.

MVP Provider Directory

To access the MVP online provider search tool, visit **mvphealth care.com** and select *Find a Doctor*, and 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**.