



2021 Provider Resource Manual

Your guide to working with MVP Health Care®.

Updated December 1, 2020



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The Provider Resources Manual will be amended as the MVP operational polices change.

Contacting MVP Health Care

Contacting MVP Health Care

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Claims

Claims Submission

Sending Claims Electronically

- MVP offers several options for submitting claims electronically using an Electronic Data Interchange (EDI).
- MVP's Payee ID is 14165.
- For EDI questions, call MVP's EDI coordinators at **1-877-461-4911** or via email at ediservices@mvphealthcare.com.

Sending Claims Manually (CMS-1500 or UB-04)

Submit claims for all products and members to the following address:

MVP Health Care
Attn: Claims Department
PO Box 2207
Schenectady, NY 12301

Claims Adjustments or Appeal Requests

- Call MVP's Provider Services at **1-800-684-9286**.
 - For faster processing, go to mvphealthcare.com to submit claim adjustment requests. The status of online claim adjustments is also available through the provider portal.
- Initial *Claim Adjustment* forms should be submitted to the following address for all products and members:

MVP Health Care
Attn: Claims Department
PO Box 2207
Schenectady, NY 12301
- Second *Clinical Review Claims Adjustment* forms should be submitted to the following address:

MVP Health Care
Attn: Operations Adjustment Team
PO Box 2207
Schenectady, NY 12301
- Appeals should be submitted to the following addresses:

MVP ID #	Address
Not Medically Necessary	MVP Health Care Attn: Member Appeals Department 625 State Street Schenectady, NY 12305
No Prior Authorization obtained/Eligibility (excludes medical necessity appeals)	MVP Health Care Attn: Member Appeals Department 625 State Street Schenectady, NY 12305
Claims exceeding timely filing limits/ Contractual denials per MVP Policy	MVP Health Care Attn: Member Appeals Department 625 State Street Schenectady, NY 12305

Coordination of Benefits (COB)

Call **1-800-556-2477**

Credentialing

Providers who would like to become a participating provider should complete the Provider Credentialing Application Request form found at mvphealthcare.com, then select *Providers*, then select *Join MVP*, and click on *How do I apply?* Once you have completed the form, include state and county in the subject line and email it to ProviderEnrollment@mvphealthcare.com.

Customer Care Center for Members

To find the appropriate Customer Care Center phone number for a member, please refer to the back of their member ID card.

Providers can verify member eligibility and benefits online at mvphealthcare.com or by calling MVP's Provider Services at **1-800-684-9286**.

Durable Medical Equipment (DME)

For all MVP plan types, call **1-800-452-6966** or fax **1-888-452-5947**.

Hospital Billing Questions

Call MVP's Provider Services at **1-800-684-9286**, or contact us via mail at:

MVP Health Care
Hospital Billing Coordinator
PO Box 2207
Schenectady, NY 12301-2207

Pharmacy

- The MVP Formulary is available online at mvphealthcare.com, select *Provider*, then *Pharmacy*, then *MVP Formularies*.
- The Medicare Formularies are available online at mvphealthcare.com, select *Provider*, then *Pharmacy*, then *MVP Formularies*, then *2019 Formularies*, then select the appropriate formulary.
- For formulary exception and prior authorization requests, a *Medication Prior Authorization Request* form should be submitted.
- All medication request forms can be found online at mvphealthcare.com, then *Provider*, then *Forms*, then *Prior Authorizations* and choose the appropriate form.
 - a. For non-Medicare members, fax the form to **1-800-376-6373**.
 - b. For all Medicare members (Preferred Gold, GoldValue, GoldAnywhere, and USA Care) and MVP Managed Medicaid and Child Health Plus members, fax the form to **1-800-401-0915**.

Professional Relations

Providers who wish to update their demographic or payment information with MVP should use the Online Demographic Change Form available at mvphealthcare.com/demographics.

To contact MVP Professional Relations, email MVPPR@mvphealthcare.com.

To contact Behavioral Health Professional Relations, email ihprovidercontracting@mvphealthcare.com.

Utilization and Case Management

Members	Please call the number on the back of their ID card. For Case Management, call 1-866-942-7966
Providers may call or fax their UM requests to MVP	<p>Call MVP's Provider Services at 1-800-684-9286</p> <p>Faxes may be directed to the following numbers:</p> <ul style="list-style-type: none"> • Prior Authorization Request Forms or Out-of-Network Requests: 1-800-280-7346 • Acute Inpatient Concurrent Review: 1-888-207-2889 • SNF or Acute Rehabilitation: 1-866-942-7826 • Commercial, ASO, and Medicaid Plans: 1-866-942-7826 • Medicare, please contact naviHealth, Inc: 1-844-411-2883

Please reference the Utilization and Case Management section of this manual for all other numbers related to Utilization and Case Management.

Services That Require a Referral for MVP Medicaid Managed Care

Restricted recipient members—referrals are required to all specialties for members who have a physician restriction. Providers should verify eligibility by calling Provider Services at **1-800-684-9286**.

Behavioral Health

Product	Who to call	Reason for call	Phone number
NY Commercial NY Self-Funded	MVP Health Care	• Authorization Requests	1-888-687-6277
		• Provider Relations • Contracting • Credentialing	1-800-684-9286
NY Medicare	MVP Health Care	• Authorization Requests	1-800-665-7924
		• Provider Relations • Contracting • Credentialing	1-800-684-9286
MVP Managed Medicaid MVP Child Health Plus MVP Harmonious Health Care Plan	MVP Health Care	• Authorization Requests	1-800-684-9286
		• Provider Relations • Contracting • Credentialing	1-800-684-9286
		• Authorization Requests	1-888-723-7967
NY Essential Plan	MVP Health Care	• Provider Relations • Contracting • Credentialing before January 1, 2020	1-800-684-9286
		• Authorization Requests	1-800-684-9286
VT Commercial VT Self-Funded VT Medicare	MVP Health Care	• Authorization Requests	1-800-684-9286
		• Provider Relations • Contracting • Credentialing	1-800-684-9286
		• Authorization Requests	1-800-684-9286

MVP Plan Type Information

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Overview

These products will be administered according to their respective MVP Certificates/Contracts of Coverage, including the MVP medical management requirements and the MVP claims adjudication processes.

The majority of network physicians and facilities will receive services and claims payment from the Schenectady office. On the following pages you will find brief overviews of the plans offered by MVP. For additional benefit details, please log into your Provider account.

Essential Plan

In New York, the Essential Plan (Basic Health Program) is an Insurance Affordability Program that offers qualified individuals and families a choice of plans through the New York State of Health Marketplace. To be eligible, individuals must be ages 19-64, reside in New York State, and not be eligible for Medicaid or Child Health Plus. These plans were built based on an HMO (Health Maintenance Organization) model, where members are required to use participating MVP physicians, hospitals, and other providers for all covered services.

MVP VT and Plus

The VT and Plus plans, which are available through Vermont Health Connect, were built based on an HMO model, where members are required to use participating MVP physicians, hospitals, and other providers for all covered services. Upon enrollment, members are encouraged to select a Primary Care Physician (PCP) who is responsible for providing or coordinating and overseeing the member's covered medical services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP. These plans include Telemedicine coverage. These plans feature a wide variety of deductibles, co-payments, and/or co-insurance at the various metal levels (Bronze, Silver, Gold, and Platinum).

All Vermont Plus Plans include \$600 WellBeing Rewards Program.

THESE PLANS HAVE NO OUT-OF-NETWORK BENEFITS. Members who receive covered services from non-participating providers will pay 100 percent of the actual costs.

MVP VT and Plus plans have access to the CIGNA national provider network outside the MVP service area for in-network benefits. Members are still required to use participating MVP physicians, hospitals, and other providers for all covered services.

MVP VT HDHP and Plus HDHP

The VT HDHP plans are high-deductible HMO plans available through Vermont Health Connect and qualified according to federal regulations. These plans can be offered alongside an optional Health Savings Account (HSA). The plans are designed with deductibles, co-insurance, and annual out-of-pocket maximums that apply to all benefits, including prescription drugs, consistent with federal guidelines. They are available at three metal levels (Bronze, Silver, and Gold). These HDHP plans also cover preventive care services in full. As an HMO product, these HDHPs suggest a PCP selection; however, referrals are not necessary for specialty care.

All Vermont Plus Plans include \$600 WellBeing Rewards Program.

THESE PLANS HAVE NO OUT-OF-NETWORK BENEFITS. Members who receive covered services from non-participating providers will pay 100 percent of the actual costs.

MVP VT HDHP and Plus HDHP plans have access to the CIGNA national provider network outside the MVP service area for in-network benefits. Members are still required to use participating MVP physicians, hospitals, and other providers for all covered services.

MVP Premier and Premier Plus

The NY Premier plans, which are available for individuals directly from MVP and on the New York State of Health Marketplace, were built based on an HMO model, where members must use participating MVP physicians, hospitals, and other providers for all covered services. Upon enrollment, members are encouraged to select a PCP, who is responsible for providing or coordinating and overseeing the member's covered medical services. If specialty care is required, these plans do not require the PCP to submit a referral to MVP. These plans feature a wide variety of deductibles, co-payments, and/or co-insurance at the various metal levels (Bronze, Silver, Gold, and Platinum).

MVP Premier Plus plans have Preferred Provider Facilities for Advance Imaging, Laboratory Procedures, Diagnostic Radiology Services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery.

MVP Premier and Premier Plus plans include the \$600 WellBeing Rewards Program.

THESE PLANS HAVE NO OUT-OF-NETWORK BENEFITS. Members who receive covered services from non-participating providers will pay 100 percent of the actual costs.

MVP Premier Plus plans include Up to \$1,000 in out-of-service-area covered benefits per Member, up to the age of 26, per plan year (outside MVP's network of providers), subject to preauthorization (except for emergency care). Services received out-of-area are subject to the applicable in-network member cost-share.

MVP Premier Plus HDHP

The MVP Premier Plus HDHP plans are High-Deductible HMO plans. They are available for Individuals directly from MVP and on the New York State of Health Marketplace and are qualified according to federal regulations. These plans can be offered alongside an optional HSA. The plans are designed with deductibles, co-insurance, and annual out-of-pocket maximums that apply to all benefits, including prescription drugs, consistent with federal guidelines and are available at three metal levels (Bronze, Silver, and Gold). These HDHP plans also cover preventive care services not subject to the deductible; these services are covered in full. As an HMO product, these HDHPs suggest a PCP selection; however, referrals are not necessary for specialty care.

THESE PLANS HAVE NO OUT-OF-NETWORK BENEFITS. Members who receive covered services from non-participating providers will pay 100 percent of the actual costs.

MVP Premier Plus HDHP plans include a dependent child(ren) benefit of \$1,000 out-of-area (outside MVP's network of providers), subject to preauthorization (except for emergency care). Services received out-of-area are subject to the applicable in-network member cost-share. The portfolio includes a HMO+Cigna Network HDHP plan at the Bronze level Off Exchange. This plan is identified with "National" in the plan name.

MVP Premier Plus HDHP plans have Preferred Provider Facilities for Advance Imaging, Laboratory Procedures, Diagnostic Radiology Services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery.

MVP Premier Plus HDHP plans include the \$600 WellBeing Rewards Program.

MVP EPO, MVP PPO, MVP HMO

These plans are available to small groups directly from MVP and are available as either an EPO (Exclusive Provider Organization/Plan) or PPO (Preferred Provider Organization/Plan) or HMO (Health Maintenance Organization). Members who receive covered services from non-participating providers will pay 100 percent of the actual costs. MVP EPO/MVP PPO plans do not require PCP selection. MVP HMO plans are required to select a PCP, who is responsible for providing or coordinating and overseeing the member's covered medical services. These plans have preferred provider facilities for advance imaging, laboratory procedures, diagnostic radiology services, therapeutic radiology, and out-patient hospital surgery. The HMO plans include integrated ACA-required pediatric dental benefits. These plans include the \$600 WellBeing Rewards Program.

THESE PLANS HAVE NO OUT-OF-NETWORK BENEFITS. Members are required to use participating MVP physicians, hospitals, and other providers for all covered services as well as the Cigna national provider network outside the MVP network area for in-network benefits.

These plans feature a wide variety of deductibles (some of which are high), co-payments, and/or co-insurance at the various metal levels (Bronze, Silver, Gold, and Platinum).

MVP EPO, MVP PPO, MVP HMO HDHP

The HDHP plans are High-Deductible EPO/PPO and HMO plans that are available to Small Groups directly from MVP and are qualified according to federal regulations. These plans can be offered alongside an optional HSA. The plans are designed with deductibles, co-insurance, and annual out-of-pocket maximums that apply to all benefits, including prescription drugs, consistent with federal guidelines and are available at three metal levels (Bronze, Silver, and Gold). The EPO or PPO HDHP products do not require PCP selection or referrals for specialty care. The HMO plans are required to select a PCP, who is responsible for providing or coordinating and overseeing the member's covered medical services. These Small Group plans have Preferred Provider Facilities for Advance Imaging, Laboratory Procedures, Diagnostic Radiology Services, Therapeutic Radiology, Ambulatory Surgery, and Out-Patient Hospital Surgery. Also, these plans include integrated ACA Required Pediatric Dental and Vision benefits.

MVP Premier Plus HDHP plans include the \$600 in WellBeing Rewards Program

MVP Secure NY and VT

The Secure plans are catastrophic policies that are available on the New York State of Health Marketplace and Vermont Health Connect. They were built based on an HMO model. Members are required to use participating MVP physicians, hospitals, and other providers for all covered services. Upon enrollment, members are required to select a PCP, who is responsible for providing or coordinating and overseeing the member's covered medical services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP. These plans feature three PCP visits and preventive care services covered in full; all other covered benefits are subject to deductible and/or applicable cost-share (co-pay/co-insurance).

THESE PLANS HAVE NO OUT-OF-NETWORK BENEFITS. Members who receive covered services from non-participating providers will pay 100 percent of the actual costs.

MVP Secure VT plans have access to the CIGNA national provider network outside the MVP service area for in-network benefits. Members are still required to use participating MVP physicians, hospitals, and other providers for all covered services.

MVP HMO (VT)

This is MVP's traditional HMO plan. Members are required to use participating MVP physicians, hospitals, and other providers for all covered services. Upon enrollment, members are encouraged to select a PCP, who is responsible for providing or coordinating and overseeing the member's covered medical services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP.

THIS PLAN HAVE NO OUT-OF-NETWORK BENEFITS. Members who receive covered services from non-participating providers will pay 100 percent of the actual costs.

MVP Healthy NY

MVP offers a comparable "Off-Exchange" Commercial HMO metal level plan (Gold Plan) directly to small groups. MVP offers a comparable "Off-Exchange" Commercial HMO Gold metal level plan (Gold Plan) directly to small

MVP Plan Type Information

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groups which is Marketplace certified beginning January 2020. Eligible Small Groups can purchase this plan from MVP and still receive a Small Business Health Care Tax Credit. Individuals and sole proprietors are able to choose from several plans both “on” and “off” of the exchange.

MVP POS

Available in New York only.

The MVP POS adds an “out-of-network” benefit to the traditional MVP HMO plan. “Out-of-network” means the member can receive covered services from a non-participating provider. Out-of-network benefits are subject to deductible and co-insurance payments by the members instead of co-payments (as in the HMO). For “in-system” coverage, members are required to use participating MVP physicians, hospitals, and other providers for all covered services. If specialty care is required, this plan does not require the PCP to submit a referral to MVP.

MVP EPO – Large Group

Available in New York only.

The MVP EPO plan does not require PCP selection or referrals for specialty care. Members have access to the entire MVP network, as well as to the Cigna national provider network outside the MVP network area for in-network benefits. This plan type features a wide variety of deductibles (some of which are high), co-payments, and/or co-insurance.

Most of the MVP EPO plans include MVP’s WellBeing Rewards, which provides members with access to an online personal health assessment and other tools and services that promote wellness, healthy behaviors and lifestyles, including a Health Risk Screening Form that members may bring to an office visit. Members can earn rewards for getting health screenings and having optimal or borderline results (detailed on the form). In addition, Members can earn reimbursements for the purchase of tools, programs, and applications that enhance their well-being as well as earn dollars for meeting quarterly activity/step goals.

MVP EPO plans for 2020 now have Preferred Provider Facilities for Advance Imaging, Laboratory Procedures, Diagnostic Radiology Services, Therapeutic Radiology, and Out-Patient Hospital Surgery.

These plans include the \$600 in WellBeing Rewards Program.

THIS PLAN HAS NO OUT-OF-NETWORK BENEFITS. Members who receive covered services from non-participating providers will pay 100 percent of the actual costs.

MVP EPO HDHP–Large Group

Available in New York only.

MVP’s High-Deductible EPO plans are qualified according to federal regulations to be offered alongside an HSA. The MVP HDHP EPO plans are designed with co-insurance and/or co-pays after deductibles and annual out-of-pocket maximums that apply to all benefits, including prescription drugs, consistent with federal guidelines. These HDHP plans also cover certain preventive care services not subject to the deductible, and in some plans are covered in full. As an EPO product, these HDHP EPOs do not require PCP selection or referrals for specialty care. Members have access to the entire MVP network, as well as to the Cigna national provider network outside the MVP network area for In Network benefits.

The MVP HDHP EPO includes MVP’s WellBeing Rewards, which provides members with access to an online personal health assessment and other tools and services that promote wellness, healthy behaviors, and lifestyles, including a Health Risk Screening Form that members may bring to an office visit. Members can earn rewards for getting health screenings and having optimal or borderline results (detailed on the form).

THIS PLAN HAS NO OUT-OF-NETWORK BENEFITS. Members who receive covered services from non-participating providers will pay 100 percent of the actual costs.

MVP Level Funding

MVP Level Funding is a self-insured product offering for small to mid-size employers (approximately 50 to 250 employees) that combines the cost advantages and stop loss protections of a self-insured plan with the stability and predictable cash flow of a fixed monthly expense plan like an insured premium. MVP partners with Health Plans, Inc. (HPI), a leading national third party administrator (TPA), for the administration of this product offering. MVP receives and prices claims, then send claims to HPI. HPI performs eligibility checks, benefit determinations, utilization management, claims finalization, and Provider payments. HPI administers the Member and Provider call center and web service portals. Members enrolled in these plans have access to MVP's regional network in New York and Vermont, as well as Cigna's national medical network and the First Health/MagnaCare national behavioral health network. MVP Level Funding members use MVP's pharmacy program through CVS, including MVP's commercial formulary, policies, and clinical rules.

MVP PPO – Large Group

Available in New York only.

The MVP PPO plan is an insurance plan offering members in-network and out-of-network benefits. In-network providers (preferred providers) are participating MVP physicians, hospitals, and other health care providers and include the Cigna national network. Members do not select a PCP nor obtain referrals for specialty care. Members can self-refer to a preferred or non-preferred provider for covered services. Members who receive covered services from non-preferred providers will pay higher out-of-pocket costs. Some services may be limited with non-preferred providers or covered through preferred providers only. The MVP PPO includes WellBeing Rewards (described under MVP EPO).

MVP PPO HDHP

Available in New York only.

MVP's High-Deductible Health Plan (HDHP) PPO plans are qualified according to federal regulations to be offered alongside an HSA. The MVP HDHP PPO plans are designed with co-insurance and/or co-pays after deductible and annual out-of-pocket maximums that apply to all benefits, including prescription drugs, consistent with federal guidelines. These HDHP PPO plans also cover certain preventive care services that are not subject to the deductible and in some plans are covered in full. As a PPO plan, the MVP HDHP PPO plan is an insurance plan offering members in-network and out-of-network benefits. In-network providers are participating MVP physicians, hospitals, and other health care providers and the Cigna national network. Members do not select a PCP, nor must they obtain referrals for specialty care. Members can self-refer to a preferred or non-preferred provider for covered services. Members who receive covered services from non-preferred providers will pay higher out-of-pocket costs. Some services may be limited with non-preferred providers or covered through preferred providers only.

The MVP HDHP PPO includes WellBeing Rewards, which provides members with access to an online personal health assessment and other tools and services that promote wellness, healthy behaviors, and lifestyles, including a Health Risk Screening Form that members may bring to an office visit. Members can earn rewards for getting health screenings and having optimal or borderline results (detailed on the form). In addition, Members can earn reimbursements for the purchase of tools, programs, and applications that enhance their well-being as well as earn dollars for meeting quarterly activity/step goals.

MVP Student Health Plan

MVP's Student Health Plans (SHPs) are health insurance plans that are offered to college students in MVP's service area through their college. Members do not need to select a PCP or obtain referrals for specialty care. These plans are regulated by the New York State Department of Financial Services and run on a plan year basis (not calendar year basis). These plans are Individual PPO plans that meet ACA guidelines. Pediatric dental and vision coverage are embedded into MVP's SHPs. MVP's SHPs cover students only and do not offer dependent coverage. Enrolled students have access to MVP's regional network in New York and Vermont, as well as access to the Cigna national network of 500,000+ providers.

This plan includes Telemedicine—24/7 Online Doctor Visits and the \$600 WellBeing Rewards Program.

MVP Select Care

Available in New York and Vermont.

MVP Select Care is the MVP company that provides fee-based administrative services to companies who self-insure their employee health benefits. Employers have the flexibility of choosing and customizing the standard plan types including PPO, EPO, HDHPs, and Indemnity plans. Members may be responsible for co-payments, deductibles, and co-insurance based on the plan type chosen.

Riders

Riders are available for the Commercial group plans described above to enhance or alter the standard core plan benefits. Some common riders include:

- Changing visit/day limits on certain benefits
- Dental or vision benefits
- Co-payment changes for in-patient/out-patient hospital surgery/emergency room services
- Prescription drug coverage options

MVP Medicare Preferred Gold (HMO-POS), MVP Medicare Secure(HMO-POS), and MVP Medicare Secure Plus (HMO-POS)

MVP Medicare Preferred Gold (HMO-POS), MVP Medicare Secure(HMO-POS), and MVP Medicare Secure Plus (HMO-POS) are Medicare Advantage HMO-POS plans specifically designed for Medicare-eligible individuals. Members are required to select a PCP. These plan options are offered with Part D prescription drug coverage. These members have a limit on how much they must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. When a member reaches the maximum out-of-pocket payment amount, they will not have to pay any out-of-pocket costs for the remainder of the calendar year for covered Part A and Part B services. Routine eEyewear, routine dental (if covered by the plan), hearing aid benefit, and acupuncture services do not apply to the out-of-pocket maximum.

Gold PPO, GoldAnywhere PPO, MVP Mediare WellSelect PPO, MVP Medicare WellSelect Plus (PPO), MVP® Medicare Patriot PlanSM (PPO)

Gold PPO, GoldAnywhere PPO, MVP Mediare WellSelect PPO, MVP Medicare WellSelect Plus (PPO), MVP® Medicare Patriot PlanSM (PPO) are Medicare Advantage PPO plans specifically designed for Medicare-eligible individuals. They offer members the option of using out-of-network providers for a higher cost sharing. These plans are only offered with Part D prescription drug coverage. PPO members have separate in-network and catastrophic out-of-network

limits on how much they must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. The catastrophic out-of-pocket maximum is the maximum amount a member must pay during the calendar year for covered Part A and Part B services received from both in-network and out-of-network providers. Once they have reached the maximum for covered services, they will have 100 percent coverage and will not have any out-of-pocket costs for the remainder of the year for covered Part A and Part B services. Routine eyewear, routine dental (if covered by the plan), hearing aid benefit, and acupuncture services do not apply to the out-of-pocket maximum.

USA Care PPO

USA Care is a Medicare Advantage PPO plan specifically designed for Medicare-eligible individuals. USA Care offers members the option of using out-of-network providers anywhere in the United States. This plan's options are only offered with Part D prescription drug coverage. Members may also reside permanently outside the MVP service area. PPO members have separate in network and catastrophic limits on how much they must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. The catastrophic out-of-pocket maximum is the maximum amount a member must pay during the calendar year for covered Part A and Part B services received from both in-network and out-of-network providers. Once they have reached the maximum for covered services, they will have 100 percent coverage and will not have any out-of-pocket costs for the remainder of the year for covered Part A and Part B services. Eyewear and acupuncture services do not apply to the out-of-pocket maximum.

MVP SmartFund MSA

MVP's SmartFund is a High-Deductible Health Plan paired with a Medical Savings Account. It is offered to both Individuals and Employer Group Medicare Eligible. The plan covers only Medicare Part A and Part B services. The MSA product does not cover Part D prescription drugs. Members must purchase a separate PDP for Rx coverage. MVP Medicare-participating providers participate with this product because it is a Medicare Advantage product, yet members may utilize any Medicare-approved provider who agrees to see the member. For Medicare A/B services, the member pays 100 percent of the costs until they reach the deductible, then MVP pays 100 percent of the A/B services. MVP makes an annual contribution to the member's MSA account upon enrollment.

MVP RxCare PDP

The MVP RxCare PDP is a stand-alone prescription drug plan (PDP) for employer group members with Medicare Parts A and B. PDP Members enrolled in MVP RxCare may or may not have Commercial medical coverage through their employer group. This plan covers Medicare Part D drugs only. Any medications or supplies that are considered Part B must be billed to Original Medicare. PDP members with a Commercial medical product through MVP will have limited coverage for Diabetic Testing and Insulin Pump Supplies, as mandated by the state.

MVP Medicaid Managed Care

MVP's Medicaid Managed Care (MMC) Product is offered through New York State for Medicaid-eligible members residing in counties within MVP's Medicaid licensed service area. Members are required to select a PCP upon enrollment. Members must use MVP providers who have contracted to provide services to Government Program (Medicaid and Child Health Plus) enrollees unless MVP gives prior authorization for the service. MVP providers not contracted for Government Programs must obtain Prior Authorization before treating an MVP MMC Member. This Product has benefit coverage established by the New York State Medicaid Managed Care program. There are no deductibles or co-insurance associated with this Product. There are minimal co-payments for prescription drugs and supplies.

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MVP Child Health Plus

Child Health Plus is a Product for children under 19 years of age who do not have insurance, are Medicaid-ineligible, and reside in counties within MVP's licensed Child Health Plus service area. Members are required to select a PCP upon enrollment. Members must use MVP Network Providers who have contracted to provide services to Government Program (Medicaid, HARP, and Child Health Plus) members unless MVP gives prior authorization for the service. MVP providers not contracted for government programs must obtain prior authorization before treating an MVP CHP member. This Product has no co-payments, deductibles, or co-insurance. There are some visit limits for select benefits.

MVP Harmonious Health Care Plan

The MVP Harmonious Health Care Plan is available to existing MMC members aged 21 and over. These members have been identified by New York State as suffering from serious mental illness and/or substance use disorders and may benefit from additional treatment and community-based support. The MVP Harmonious Health Care Plan includes traditional MMC benefit coverage in addition to comprehensive Behavioral Health Home and Community Based Services (BH-HCBS) for additional, specialized, and integrated physical and behavioral health support and treatment. These services must be prior-authorized by MVP following an assessment of the member as well as the submission and review of a member's plan of care that detail the provision of BH-HCBS and goals of the member.

Plan Type ID Cards

Essential Plan

MVP
HEALTH CARE

Essential Plan 1

Subscriber Name JOHN SAMPLE	Group#: 620011
Subscriber ID Number 812345678 99	RxBIN: 004336
	RxPCN: ADV
	RxGRP: MVPMRKT

Primary Care:	\$15
Specialist:	\$25
Urgent Care:	\$25
Emergency Room:	\$75

Cigna

mvphealthcare.com
Member Customer Care Center: **1-888-723-7967**
TTY: **1-800-662-1220**
Pharmacy Information: **1-800-378-9295**
Mental Health/Substance Use Disorder Help: **1-888-723-7967**
24/7 Online Doctor Visits: **myvisitnow.com**

Provider Services Department: **1-800-684-9286**
Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/provider

Send Claims to:
MVP Health Services Corp.
625 State Street
P.O. Box 2207
Schenectady, NY 12301-2207

AWAY FROM HOME CARE

HMO

MVP
HEALTH CARE

MVP HMO

Subscriber Name JOHN Q. MVPMEMBER	Group#: 600000
Subscriber ID Number 12345678900	RxBIN: 004336
	RxPCN: ADV
	RxGRP: MVPMRKT

Primary Care:	\$15
Specialist:	\$30
Urgent Care:	\$30

Cigna

mvphealthcare.com
Member Customer Care Center: **1-800-348-8515**
TTY: **1-800-662-1220**
Pharmacy Information: **1-800-378-9295**
Mental Health/Substance Use Disorder Help: **1-800-348-8515**
24/7 Online Doctor Visits: **myvisitnow.com**

Provider Services Department: **1-800-684-9286**
Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/provider

Send claims to:
MVP Health Plan, Inc.
PO Box 2207
Schenectady, NY 12301-2207

AWAY FROM HOME CARE

- Primary Care Physician required
- No referral required
- Co-payments for PCP and Specialist listed
- No out-of-network benefits

MVP Plan Type Information

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ASO

EMPLOYER LOGO

High Deductible EPO
 Subscriber Name
JOHN SAMPLE
 Subscriber ID Number
 812345678 99

MVP HEALTH CARE

Group#: 123456
 RxBIN: 004336
 RxPCN: ADV
 RxGRP: MVPCOMM

Coverage is subject to a deductible.

OPEN ACCESS PLUS Cigna

mvphealthcare.com
 Member Customer Care Center: 1-800-229-5851
 TTY: 1-800-662-1220
 Pharmacy Information: 1-866-284-7134
 Mental Health/Substance Use Disorder Help: 1-800-229-5851
 24/7 Online Doctor Visits: myvisitnow.com

Prior Authorization: Fax a prior authorization request form to MVP at 1-800-280-7346

Provider Services Dept. or Urgent Prior Auth. Requests: 1-800-684-9286
 Pharmacies | CVS Caremark | 1-800-364-6331
mvphealthcare.com/provider

Send Claims to:
 MVP Select Care, Inc.
 P.O. Box 2207
 Schenectady, NY 12301

First Health Network MultiPlan
 MAGNACARE AWAY FROM HOME CARE

- MVP Administrative Services Only (ASO) for self-funded employer groups
- No referral required
- Benefits unique to each employer group
- Employer name appears on the card

Point of Service (POS)

MVP HEALTH CARE

Point of Service

Subscriber Name
John Doe
 Subscriber ID Number
 XXXXXXXX XX

Group#: XXXXXX
 RxBIN: XXXXXXXX
 RxPCN: XXXX
 RxGRP: XXXXXXXX

Primary Care:
 Specialist:
 Urgent Care:
 Emergency Room:

MVP PRO Cigna

mvphealthcare.com
 Member Customer Care Center: 1-888-687-6277
 TTY: 1-800-662-1220
 Pharmacy Information: 1-866-284-7134
 Mental Health/Substance Use Disorder help: 1-800-568-0458
 24/7 Online Doctor Visits: myvisitnow.com
 CIGNA networks available outside of MVP NY & VT Service Area only for covered urgent/emergency or prior authorized out of network care

Provider Services Department: 1-800-684-9286
 Pharmacies | CVS/caremark: 1-800-364-6331
mvphealthcare.com/provider

Send Claims to:
 MVP Health Plan, Inc.
 625 State Street
 P.O. Box 2207
 Schenectady, NY 12301-2207

MultiPlan
 AWAY FROM HOME CARE

- Point of Service (POS) plan
- Co-payments for PCP and Specialist listed
- Primary Care Physician required

MVP Secure HMO

MVP HEALTH CARE

MVP Secure

Subscriber Name
JANE SAMPLE
 Subscriber ID Number
 812345678 00

Group#: 600000
 RxBIN: 004336
 RxPCN: ADV
 RxGRP: MVPMRKT

Member ID Member Name
 812345678 01 JOHN SAMPLE

Coverage is subject to a deductible.

MVP PRO Cigna

mvphealthcare.com
 Member Customer Care Center: 1-800-348-8515
 TTY: 1-800-662-1220
 Pharmacy Information: 1-800-378-9295
 Mental Health/Substance Use Disorder Help: 1-800-348-8515
 24/7 Online Doctor Visits: myvisitnow.com

Provider Services Department: 1-800-684-9286
 Pharmacies | CVS Caremark: 1-800-364-6331
mvphealthcare.com/provider

Send Claims to:
 MVP Health Plan, Inc.
 625 State Street
 P.O. Box 2207
 Schenectady, NY 12301-2207

First Health Network MultiPlan
 MAGNACARE AWAY FROM HOME CARE

- Primary Care Physician coordinated care
- No referral required
- No out-of-network benefits

MVP Plan Type Information

[Plan Type Table of Contents](#) [Main Table of Contents](#)


Individual versus Small Group Identification

MVP HEALTH CARE **MVP Premier**

Subscriber Name: **JOHN SAMPLE**
Subscriber ID Number: **812345678 99**

Group#:	123456
RxBIN:	004336
RxPCN:	ADV
RxGRP:	MVPMRKT

Primary Care:	\$15
Specialist:	\$35
Urgent Care:	\$55
Emergency Room:	\$100





mvphealthcare.com

Member Customer Care Center: **1-877-742-4181**
TTY: **1-800-662-1220**
Pharmacy Information: **1-800-378-9295**
Mental Health/Substance Use Disorder Help: **1-877-742-4181**
24/7 Online Doctor Visits: **myvisitnow.com**
CIGNA networks available outside of MVP NY & VT Service Area only for covered urgent/emergency or prior authorized out of network care

Provider Services Department: **1-800-684-9286**
Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/provider
Type: Individual

Send Claims to:
MVP Health Plan, Inc.
625 State Street
P.O. Box 2207
Schenectady, NY 12301-2207


 
MAGNACARE **AWAY FROM HOME CARE**

MVP HEALTH CARE **MVP EPO**

Subscriber Name: **JOHN SAMPLE**
Subscriber ID Number: **812345678 99**

Group#:	4XXXXX
RxBIN:	004336
RxPCN:	ADV
RxGRP:	MVPMRKT

Member ID	Member Name	Primary Care:	\$15
812345678 91	JANE SAMPLE	Urgent Care:	\$50
812345678 92	JAKE SAMPLE	Emergency Room:	\$300





mvphealthcare.com

Member Customer Care Center: **1-877-742-4181**
TTY: **1-800-662-1220**
Pharmacy Information: **1-800-378-9295**
Dental Information: **1-800-480-5640**
Mental Health/Substance Use Disorder Help: **1-877-742-4181**
24/7 Online Doctor Visits: **myvisitnow.com**

Provider Services Department: **1-800-684-9286**
Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/provider
Type: Small Group

Send Claims to:
MVP Health Services Corp.
P.O. Box 2207
Schenectady, NY 12301-2207
→Dental Claims: use P.O. Box 763

 
MAGNACARE **AWAY FROM HOME CARE**

MVP Level Funding

High-Deductible EPO **MVP HEALTH CARE**


COMPANY NAME

Member ID Number **HHZ010001 00**

GEORGESMITH

Group#:	014Z01
RxBIN:	004336
RxPCN:	ADV
RxGRP:	MVPLF

Coverage is subject to a deductible.






mvphealthcare.com/MVPElevelfunding

Member Customer Care Center: **1-844-260-9900**
Mental Health/Substance Use Disorder Help: **1-844-260-9900**
Pharmacy Information: **1-866-284-7134**

Provider Services: **1-844-260-9900**
Prior Authorizations: obtain form at **mvphealthcare.com/MVPElevelfunding/Forms**
Pharmacies | CVS Caremark: **1-800-364-6331**
For pharmacy authorizations, fax to: **1-800-376-6373**
mvphealthcare.com/MVPElevelfunding

Send claims to:
MVP Select Care, Inc.
PO Box 2207
Schenectady, NY 12301-2207
MVP EDI Payer ID: 14165

Powered by:  | Health Plans, Inc.

 
MAGNACARE **AWAY FROM HOME CARE**


MVP Student Health Plans (SHPs)

MVP HEALTH CARE **PPO Student Plan**

Subscriber Name: **College**
Subscriber ID Number: **123456789 00**

Group#:	490430
RxBIN:	004336
RxPCN:	ADV
RxGRP:	MVPMRKT

Member ID	Member Name	Primary Care:	\$25
123456789 01	SUNSHINE PLATINUM	Specialist:	\$25
		Urgent Care:	\$25
		Emergency Room:	\$100



mvphealthcare.com

Member Customer Care Center: **1-888-687-6277**
TTY: **1-800-662-1220**
Pharmacy Information: **1-800-378-9295**
Dental Information: **1-800-480-5640**
Mental Health/Substance Use Disorder Help: **1-888-687-6277**
24/7 Online Doctor Visits: **myvisitnow.com**

Provider Services Department: **1-800-684-9286**
Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/provider

Send Claims to:
MVP Health Services Corp.
625 State Street
P.O. Box 2207
Schenectady, NY 12301-2207
→Dental Claims: use P.O. Box 763



 
MAGNACARE **AWAY FROM HOME CARE**

- Preferred Provider Organization (PPO) plan
- No Primary Care Physician or referral required
- Out-of-network benefits available at greater cost
- Access to Cigna HealthCare’s PPO national provider network
- Pediatric dental coverage included
- Vision coverage included

MVP Plan Type Information

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MVP EPO (Large Group)

		MVP EPO	
Subscriber Name JOHN Q. MVPMEMBER		Group#:	123456
Subscriber ID Number 123456789 00		RxBIN:	004336
		RxPCN:	ADV
		RxGRP:	MVPCOMM
Member ID	Member Name	Primary Care:	\$30
123456789 01	HENRY S MVPMEMBER	Specialist:	\$50
123456789 02	JANEE MVPMEMBER	Urgent Care:	\$30
123456789 03	BONNIE D MVPMEMBER	Emergency Room:	\$200
			

mvphealthcare.com
Member Customer Care Center: 1-888-687-6277
TTY: 1-800-662-1220
Pharmacy Information: 1-866-284-7134
Mental Health/Substance Use Disorder Help: 1-888-687-6277
24/7 Online Doctor Visits: [myvisitnow.com](#)



Provider Services Department: 1-800-684-9286
Pharmacies | CVS Caremark: 1-800-364-6331
[mvphealthcare.com/providers](#)

Send claims to:
MVP Health Services Corp.
PO Box 2207
Schenectady, NY 12301-2207



- Exclusive Provider Organization (EPO) plan
- No referral required
- No out-of-network benefits
- No Primary Care Physician required


MVP PPO (Large Group)

		MVP PPO	
Subscriber Name SALLY R SAMPLE		Group#:	123456
Subscriber ID Number 820123456 00		RxBIN:	004336
		RxPCN:	ADV
		RxGRP:	MVPCOMM
Member ID	Member Name	Primary Care:	\$30
820123456 01	HENRY S SAMPLE	Specialist:	\$50
820123456 02	JANE E SAMPLE	Urgent Care:	\$30
820123456 03	BONNIE O SAMPLE	Emergency Room:	\$200
			

mvphealthcare.com
Member Customer Care Center: 1-888-687-6277
TTY: 1-800-662-1220
Pharmacy Information: 1-866-284-7134
Mental Health/Substance Use Disorder Help: 1-888-687-6277
24/7 Online Doctor Visits: [myvisitnow.com](#)


Provider Services Department: 1-800-684-9286
Pharmacies | CVS Caremark: 1-800-364-6331
[mvphealthcare.com/provider](#)

Send Claims to:
MVP Health Services Corp.
625 State Street
P.O. Box 2207
Schenectady, NY 12301-2207



- Preferred Provider Organization (PPO) plan
- No Primary Care Physician or referral required
- Out-of-network benefits available at greater cost
- Access to Cigna HealthCare's PPO national provider network

MVP Medicaid Managed Care

		Plan Type: MVPM	
Member Name JOHN Q. MVPMEMBER		Group#:	241160
Member ID Number 800000XXX 00		RxBIN:	004336
		RxPCN:	ADV
		RxGRP:	MVP625
PCP Name:	Dr. PCP	Primary Care:	\$0
PCP Phone:	123-456-7890	Specialist:	\$0
PCP Office:	PCP Primary Medical	Emergency Room:	\$0
		Urgent Care:	\$0

For Members:
mvphealthcare.com
Member Services/Customer Care Center: 1-800-852-7826
TTY: 1-800-662-1220
Pharmacy Info: 1-866-832-8007
Mental Health/Substance Use Disorder Help: 1-800-852-7826
24/7 Online Doctor Visits: [myvisitnow.com](#)

For medical advice, call your Primary Care Provider (see front of card for name and number). Emergency: call 911 or go directly to the nearest hospital emergency room.

Send claims to:
MVP Health Plan, Inc.
625 State Street
PO Box 2207
Schenectady, NY 12301-2207

For Providers:
Provider Services Department: 1-800-684-9286
Pharmacies | CVS Caremark: 1-800-364-6331
[mvphealthcare.com/providers](#)

- Primary Care Physician required
- Pre-authorization required
- Minimal co-payments may apply for pharmacy and medical supplies
- Care must be rendered by a participating MVP Government Programs provider
- Pharmacy services through MVP Health Plan, Inc.— special formulary exists
- Outpatient imaging pre-authorization required through MVP
- Dental Care through Healthplex

MVP Plan Type Information

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Medicaid Managed Care SSI

		DOB: 02/01/1996 CIN: XX12345X	Plan Type: MVPMS
Member Name JOHN Q. MVPMEMBER Member ID Number 800000XXX 00	Group#: 241160 RxBIN: 004336 RxPCN: ADV RxGRP: MVP625		
PCP Name: Dr. PCP PCP Phone: 123-456-7890 PCP Office: PCP Primary Medical	Primary Care: \$0 Specialist: \$0 Emergency Room: \$0 Urgent Care: \$0		

For Members:

mvphealthcare.com
 Member Services/Customer Care Center: **1-800-852-7826**
 TTY: **1-800-662-1220**
 Pharmacy Info: **1-866-832-8007**
 Mental Health/Substance Use Disorder Help: **1-800-852-7826**
 24/7 Online Doctor Visits: **myvisitnow.com**

For medical advice, call your Primary Care Provider (see front of card for name and number). Emergency: call 911 or go directly to the nearest hospital emergency room.


Send claims to: MVP Health Plan, Inc.
 625 State Street
 PO Box 2207
 Schenectady, NY 12301-2207

For Providers:

Provider Services Department: **1-800-684-9286**
 Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/providers

- Primary Care Physician required
- Preauthorization required
- Minimal co-payments may apply for pharmacy and medical supplies
- Care must be rendered by a participating Government Programs provider
- Dental Care through Healthplex
- Pharmacy services through MVP Health Plan, Inc.—special formulary exists
- Outpatient imaging preauthorization required through MVP

Medicaid Restricted Member

		DOB: 02/01/1996 CIN: XX12345X	Plan Type: MVPM
Member Name JOHN Q. MVPMEMBER Member ID Number 800000XXX 00	Group#: 241160 RxBIN: 004336 RxPCN: ADV RxGRP: MVP625		
PCP Name: Dr. PCP PCP Phone: 123-456-7890 PCP Office: PCP Primary Medical	Primary Care: \$0 Specialist: \$0 Emergency Room: \$0 Urgent Care: \$0		

RESTRICTED (Providers call 1-800-684-9286)

For Members:

mvphealthcare.com
 Member Services/Customer Care Center: **1-800-852-7826**
 TTY: **1-800-662-1220**
 Pharmacy Info: **1-866-832-8007**
 Mental Health/Substance Use Disorder Help: **1-800-852-7826**
 24/7 Online Doctor Visits: **myvisitnow.com**

For medical advice, call your Primary Care Provider (see front of card for name and number). Emergency: call 911 or go directly to the nearest hospital emergency room.

Send claims to: MVP Health Plan, Inc.
 625 State Street
 PO Box 2207
 Schenectady, NY 12301-2207

For Providers:

Provider Services Department: **1-800-684-9286**
 Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/providers

If the card says “Restricted” in red print, then the member is part of the NYS DOH Restricted Recipient Program. Please call MVP’s Provider Services Department for additional information if you see this on an ID card. Restricted recipients require a referral from their PCP to see a specialist.

MVP Plan Type Information

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MVP Child Health Plus

	DOB: 02/01/2012	Plan Type: MVPC
Member Name JOHN Q. MVPMEMBER	Group#: 241160	RxBIN: 004336
Member ID Number 800000XXX00	RxPCN: ADV	RxGRP: MVPCOMM
PCP Name: Dr. PCP	Primary Care: \$0	Specialist: \$0
PCP Phone: 123-456-7890	Emergency Room: \$0	Urgent Care: \$0
PCP Office: PCP Primary Medical		

For Members:
mvphealthcare.com
Member Services/Customer Care Center: **1-800-852-7826**
TTY: **1-800-662-1220**
Pharmacy Info: **1-866-284-7134**
Mental Health/Substance Use Disorder Help: **1-800-852-7826**
24/7 Online Doctor Visits: **myvisitnow.com**


For medical advice, call your Primary Care Provider (see front of card for name and number). Emergency: call 911 or go directly to the nearest hospital emergency room.

Send claims to:
MVP Health Plan, Inc.
625 State Street
PO Box 2207
Schenectady, NY 12301-2207

For Providers:
Provider Services Department: **1-800-684-9286**
Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/providers

- Primary Care Physician required
- Pre-authorization required
- No co-payments
- Care must be rendered by a participating Government Programs provider
- Dental Care through Healthplex
- MVP Commercial Formulary applies
- Outpatient imaging pre-authorization required through MVP

MVP Harmonious Health Care Plan

	DOB: 02/01/1996 CIN: XX12345X	Plan Type: MVPH
Member Name JOHN Q. MVPMEMBER	Group#: 241160	RxBIN: 004336
Member ID Number 800000XXX00	RxPCN: ADV	RxGRP: MVP625
PCP Name: Dr. PCP	Primary Care: \$0	Specialist: \$0
PCP Phone: 123-456-7890	Emergency Room: \$0	Urgent Care: \$0
PCP Office: PCP Primary Medical		

For Members:
mvphealthcare.com
Member Services/Customer Care Center: **1-844-946-8002**
TTY: **1-800-662-1220**
Pharmacy Info: **1-866-832-8007**
Mental Health/Substance Use Disorder Help: **1-844-946-8002**
24/7 Online Doctor Visits: **myvisitnow.com**

For medical advice, call your Primary Care Provider (see front of card for name and number). Emergency: call 911 or go directly to the nearest hospital emergency room.

Send claims to:
MVP Health Plan, Inc.
625 State Street
PO Box 2207
Schenectady, NY 12301-2207


For Providers:
Provider Services Department: **1-800-684-9286**
Pharmacies | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/providers

- Managed Care Medicaid Program for members identified by NYS with behavioral health needs
- Primary Care Physician required
- Pre-authorization required
- Minimal co-payments may apply for pharmacy and medical supplies
- Care must be rendered by a participating MVP Government Programs provider
- Pharmacy services through MVP Health Plan, Inc.—special formulary exists
- Outpatient imaging pre-authorization required through MVP
- Dental Care through Healthplex
- Home and Community Based benefits are available after assessment and prior authorization

MVP Plan Type Information

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Medicare Products WITH Part D


 **MVP**
HEALTH CARE H9615 802 GoldAnywhere PPO

Member Name
JOHN Q. MVPMEMBER

Member ID Number
123456789 00

IN-NETWORK		OUT-OF-NETWORK	
Primary Care:	\$10	Primary Care:	\$25
Specialist:	\$15	Specialist:	\$25
Emergency Room:	\$65	Emergency Room:	\$65
Urgent Care:	\$15	Urgent Care:	\$15

RxBIN: 004336
RxPCN: MEDDADV
RxGRP: MVPMEDD

 Medicare Rx
Prescription Drug Coverage

mvphealthcare.com
Medicare Customer Care Center: **1-800-665-7924**
TTY: **1-800-662-1220**
Pharmacy Info: **1-866-494-8829** | TTY: **711**
24/7 Online Doctor Visits: myvisitnow.com


Provider Services Department: **1-800-684-9286**
Pharmacists | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/providers

Send claims to:
MVP Health Plan, Inc.
PO Box 2207
Schenectady, NY 12301-2207

Prescription claims to:
CVS Caremark
PO Box 52066
Phoenix, AZ 85072-2066

MVP will pay Medicare providers according to Medicare fee schedule. Medicare Limiting Charges apply to non-contracted providers and out-of-network services. DO NOT bill Original Medicare.

Medicare Products WITHOUT Part D


 **MVP**
HEALTH CARE H3305 021 Preferred Gold HMO-POS

Member Name
JOHN Q. MVPMEMBER

Member ID Number
123456789 00

Primary Care:	\$15
Specialist:	\$40
Emergency Room:	\$90
Urgent Care:	\$50

RxBIN: 004336
RxPCN: MEDDADV
RxGRP: MVPMEDD

 Medicare Rx
Prescription Drug Coverage

mvphealthcare.com
Medicare Customer Care Center: **1-800-665-7924**
TTY: **1-800-662-1220**
Pharmacy Info: **1-866-494-8829** | TTY: **711**
24/7 Online Doctor Visits: myvisitnow.com

Provider Services Department: **1-800-684-9286**
Pharmacists | CVS Caremark: **1-800-364-6331**
mvphealthcare.com/providers

Send Claims to:
MVP Health Plan, Inc.
625 State Street
P.O. Box 2207
Schenectady, NY 12301-2207

Prescription Claims to:
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066

MVP will pay Medicare providers according to Medicare fee schedule. Medicare Limiting Charges apply to non-contracted providers and out-of-network services. DO NOT bill Original Medicare.

Credentialing

Credentialing

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Review of Practitioner Credentialing and Recredentialing Information

MVP will execute a Participation Services Agreement only upon the successful completion the initial Credentialing (including primary-source verification of submitted information) for practitioners applying for participation or continued participation (Recredential) in the MVP Network. Practitioners must be Credentialed and contracted before being reimbursed for seeing a Member and being listed in MVP's Participating Provider Directory.

Participation in the MVP Network is at MVP's sole discretion. Credentialing or Recredentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or 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 requirements. Credentialing and Recredentialing applications will only be reviewed upon the receipt of a Complete Credentialing/Recredentialing Application.

Who We Credential and Recredential

Consistent with NCQA guidelines and MVP shall Credential and Recredential Participating Providers every three years.

Practitioner Types

MVP contracts with and credentials the following practitioner types:

- Physicians (MDs and DOs)
- Naturopaths (ND) (Vermont only)
- Podiatrists
- Chiropractors
- Neuropsychologists
- Oral Surgeons (providing services under the medical benefit)

Ancillary and Mid-Level practitioners: including, but not limited to, Optometrists, Physical Therapists, Occupational Therapists, Certified Nurse Midwives, Lay Midwives (Vermont), Diabetes Educators, Massage Therapists, Acupuncturists, Speech/Language Pathologists, Audiologists, Dieticians/ Nutritionists, Nurse Practitioners (NP) independent in specialty areas approved by New York State Public Health Law, NPs in a physician practice with a PCP specialty who wish to practice as a primary care provider (PCP) (NY Only), Registered Nurse First Assistants (NY Only-excludes Medicare line of business) working in an outpatient setting, and behavioral health practitioners as defined below.

In New York

- Alcohol and Drug Counselors
- Applied Behavioral Analysts
- Assistant Behavioral Analysts
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselors (LMHC), based on MVP's network need
- Licensed Psychologists (PsyD, PhD, or EdD)
- Licensed Psychoanalysts
- Independent Psychiatric Nurse Practitioners

NYS Behavioral Health Participating Providers in the Medicaid line of business must certify that they will not seek reimbursement from MVP for Conversion Therapy as defined by the Medicaid Model Contract.

In Vermont

- Licensed Clinical Mental Health Counselors (LCMHC)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Clinical Social Workers (LICSW)
- Master's-Prepared Psychologists (MA, MS, or MACP)
- Licensed Alcohol and Drug Counselors (LADC)
- Licensed Psychologists (PsyD, PhD, or EdD)
- Applied Behavioral Analysts (PhD, MA, MS)
- Assistant Behavioral Analysts (BA, BS)

Psychiatric Advanced Practice Registered Nurses (APRN) approved for solo practice by the state of Vermont may be considered for credentialing based on network need.

CAQH Application Process

MVP is a member of the Council for Affordable Quality Healthcare (CAQH) credentialing initiative and uses the CAQH Universal Credentialing DataSource application for Credentialing and Recredentialing to streamline Credentialing and Recredentialing processes for our Participating Providers.

The CAQH Universal Credentialing DataSource is a free online service that allows practitioners to fill out one application to meet the Credentialing and Recredentialing data needs of multiple health plans. Once the online application is complete, practitioners only need to update information that has changed or expired and attest to the accuracy of the data three times per year.

To register with CAQH or learn more about the Universal Credentialing DataSource, visit proview.caqh.org and select the *Register Now* link.

Registered Practitioners

MVP is not required to Credential all practitioner types per state and federal regulations and/or accreditation standards but are subject to MVP's Registration Process. Certain Mid-Level practitioner types, such as non-independent Nurse Practitioners (NP) or APRNs, Certified Nurse Midwives (CNM) who do not wish to be listed in the MVP directories, Physicians Assistants (PA), Certified Registered Nurse Anesthetist (CRNA), and Registered Nurse First Assistant (RNFA) are may be Registered in lieu of Credentialing. Variations may exist regarding Mid-Level Registration, depending on individual state laws and/or IPA bylaws as below.

NYS/VT

The following hospital-based inpatient practitioner types must be Registered:

- Hospitalists* (Internal Medicine, Pediatric, and Family Medicine)
- Emergency Department Physicians*
- Pathologists
- Anesthesiologists*
- Neonatologists*

- Intensivists*
- Certified Registered Nurse Anesthetists
- Non-independent Nurse Practitioners
- Registered Nurse First Assistants
- Physician’s Assistants
- Licensed Master Social Workers (LMSW)

***Exceptions:** Anesthesiologists who want to be designated as a Pain Medicine specialist; Neonatologists and Intensivists who will provide services outside of the NICU or ICU; and Hospitalists who provide outpatient services must be Credentialed. Emergency Physicians who also provide services in an urgent care center, or any other outpatient setting, must be Credentialed. Exceptions may vary based on contractual requirements. Registration forms may be found in the provider section of the MVP website at mvphealthcare.com/providers/join-mvp.

For more information, see [Provider Responsibilities](#).

Locum Tenens

Please refer to [Payment Policies](#) for information referring to the locum tenens payment policy.

Emergency Response Credentialing

During a declared State of Emergency (SOE), to ensure adequate access to Members, MVP may expedite the Credentialing of health care providers as set forth by State/Federal authorities or NCQA. Such expedited Credentialing may include Provisional Credentialing or providers with temporary licensing due to such SOE or other such licensing as directed by the State/Federal authorities or NCQA.

Emergency Response Providers, designated by State/Federal authorities or NCQA as a team of practitioners deemed appropriate to provide care to MVP Members in a specific state or locality, shall not be required to be Credentialed prior to providing services to MVP Members unless required by State/Federal authorities or NCQA. Emergency Response Providers will be advised to follow the established MVP Locum Tenens policy (see Locum Tenens).

Excluded and Precluded Individuals

If Medicare or Medicaid has sanctioned a Participating Provider, MVP may in its sole discretion, suspend or terminate such Participating Provider from the applicable lines of business. If Medicare or Medicaid has excluded or precluded the Participating Provider, MVP will administratively deny or terminate the Participating Provider from MVP’s Medicare/Medicaid Network, as applicable. Participating Provider appeal rights may apply.

New York State Medicaid Program Enrollment

Participating Providers who bill for services for Medicaid Members must be enrolled in the [New York State Medicaid Management Information System \(“MMIS”\)](#) with the exception of Licensed Master Social Workers, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Certified Registered Nurse Anesthetists, and Registered Dietitians unless they are also Certified Diabetes Educators. Additional information regarding enrollment in the New York State Medicaid Program is available at eMedNY.org.

Criteria for Admission and Continued Participation

To participate with MVP, the following are required:

- The appropriate education to obtain state licensure in the relevant practice area and completion of one of the following residency programs: Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the Royal College of Family Physicians of Canada (RCFPC), or the Royal College of Physicians and Surgeons of Canada (RCPSC), as applicable to the profession. Physicians who were trained outside of the U.S. and Canada, or whose training was not accredited by one of the entities, will be subject to additional review. MVP recognizes abdominal transplant fellowships accredited by the American Society of Transplant Surgeons/ Transplant Accreditation and Certification Council (TACC).
- Specialty listings will also be granted based on completion of one of the following recognized fellowship programs: ACGME, AOA, RCFPC, RCPSC, or TACC, as applicable to the profession.
- Board certification is not required of applicants unless it is a prerequisite for state licensure/certification. However, applicants claiming board certification must be certified in accordance with the definition of their specialty board. MVP recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), the Royal College of Family Physicians of Canada (RCFPC) and the Royal College of Physicians and Surgeons (RCPSC) boards for physicians and other appropriate boards for Certified Nurse Midwives, Lay Midwives, Diabetes Educators, Registered Dietitians/Nutritionists, Podiatrists, Nurse Practitioners, Registered Nurse First Assistants, Oral Surgeons, and Behavioral Analyst.
- A valid license to practice medicine in the state where MVP Members are seen.
- A valid Drug Enforcement Agency (DEA) Certificate or Controlled Dangerous Substances (CDS) Certificate is required for physicians (MD, DO), Naturopaths (ND) who prescribe controlled substances, Podiatrists (DPM), Oral Surgeons, Nurse Practitioners (NP-NY only), Independent Advanced Practice Registered Nurses (APRN- VT only), and Certified Nurse Midwife (CNM) applicants for all states in which they treat MVP Members. Naturopaths (ND) who do not prescribe medications must submit a description of their scope of practice to be considered for an exception to this requirement.
- Any Participating Provider whose specialty scope of practice includes prescribing medications must have the ability to write prescriptions, including controlled substances, as applicable. Practitioners with prescription limitations will be denied participation in MVP's Network. Participating Providers with a suspended, revoked, or restricted DEA Certificate or who have prescribing restrictions placed on their ability to provide a full scope of care to MVP Members, may be suspended or removed from the Network and will not be considered for Recredential until such limitation has been removed.
- Provide a minimum of five years' work history. The practitioner must clarify employment gaps of six months or longer. Any gaps in work history of greater than one (1) year must be fully documented in writing on the CV, the CAQH application, MVP Re-Entry Plan form, or via email and signed by the applicant.
- A complete history of professional liability claims, including claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner.
- Proof of current malpractice insurance coverage with minimum coverage amounts of \$1 million per incident and \$3 million annual aggregate and the absence of excessive malpractice claims for the area and type of practice as determined by the MVP Credentialing Committee.
- A completed CAQH application containing a signed attestation statement and release that includes:
 - A. A history of loss of license and/or felony convictions.
 - B. History of loss or limitation of privileges or disciplinary activity.

- C. Reasons for any inability to perform the essential functions of the position, and that could impact the ability to deliver adequate care to MVP Members, with or without accommodation.
 - D. Certification that physician/practitioner is free of any physical or mental conditions that could impact his/her ability to deliver adequate care to MVP Members.
 - E. Certification of a lack of present illegal drug use.
 - F. Current malpractice insurance coverage.
 - G. The correctness and completeness of the application.
- Reasonable office hours in order to maintain adequate access to care. PCPs for MVP Medicaid Members must maintain a minimum of 16 hours per week at one location.
 - MDs/DOs, Oral Surgeons, DPMs, NPs, and CNMs must maintain clinical privileges in good standing, as appropriate to their specialty, on the medical staff of an MVP participating hospital designated by the practitioners as their primary admitting facility, or demonstrate proof of coverage for admissions and/or inpatient coverage as outlined in MVP criteria.
 - Oral Surgeons must possess a valid and current anesthesia certificate and proof of current Advanced Cardiac Life Support (ACLS) certification.
 - Dentists who provide conscious sedation, deep sedation, or general anesthesia outside of a hospital setting must provide a copy of the appropriate certificate(s) issued by the state for the level of sedation and age of the patients being treated.
 - Comply with MVP medical record, accessibility, and office site standards.

If the Participating Provider in an area where MVP contracts with an Independent Practice Association, then participation with MVP may be contingent upon (1) the contractual relationship between MVP and the IPA; (2) the provider's admission into the IPA; and (3) the specific criteria for admission such as IPA.

The criteria as outlined in the section above may change periodically. Contact your Professional Relations representative for the most current criteria.

Notification Time Frames for New Applicants

MVP will comply with the state regulatory notification time frames in processing applications for participation as specified by the state in which the practitioner is located.

New York State

- MVP shall complete review of the health care professional's application to participate in MVP's network and shall, within 60 days of receiving a Completed File and all required documentation to participate in the MVP's network, notify the health care professional as to:
 - A. Credentialing approval or denial; or
 - B. Additional documentation is required. MVP may require additional time to decide due to the failure of a third party to provide necessary documentation ("incomplete file"). 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 Completed Credentialing/Recredentialing Application.

Note: For applicants that are (1) newly licensed health care professionals or (2) a health care professional who has recently relocated to New York from another state and has not previously practiced in New York, and who are joining a participating group in which all members of the group currently participate with MVP, (3) New York State

physicians who are employed by MVP Network licensed general hospital, licensed diagnostic and treatment center or Mental Health Law licensed facility whose other employed physicians are Participating Providers in the MVP Network or, (4) newly trained Medicare practitioners that are contracting with MVP in the Medicare line of business and have completed all appropriate training and education within the last twelve months, the applicant shall be eligible for provisional Credentialing as of the 61st day of the application if:

- The applicant has submitted a Complete Application and any requested supporting documentation; and
- The applicant provided written notification to the MVP Senior Leader, Credentialing, including a statement that in the event the applicant is denied, the applicant or the applicant's group practice:
 - A. Shall refund any payments made for in-network services provided during the period of provisional Credentialing that exceed the Member's out-of-network benefits; and
 - B. Shall not pursue reimbursement from the Member, except to collect the co-payment or co-insurance that otherwise would have been payable had the Member received services from a Participating Provider.

Vermont

- MVP shall notify a practitioner applicant concerning an incomplete Credentialing Application not later than 30 business days after MVP receives the Completed File.
- MVP shall notify a practitioner concerning the status of the practitioner's Completed Credentialing Application not later than:
 - A. 60 days after the MVP receives the Completed File: and
 - B. Every 30 days after the notice is provided until the MVP makes a final Credentialing determination concerning the practitioner.

Delegated Credentialing

MVP may, in its sole discretion delegate its Credentialing to a third-party delegate to act on its behalf in matters of approval, termination, and appeal. MVP shall remain accountable for the overall Credentialing delegation oversight and retains the right to approve, suspend, or terminate individual Participating Providers.

Directory Listing

Prior to being listed in MVP's Directories and/or marketing or Member materials, the following must be in place:

- An executed Participation Services Agreement with MVP or with an affiliated IPA/PO/PHO.
- A completed Credentialing Application reviewed and approved by the MVP Credentialing Committee.

Physician applicants who are not ABMS, AOA, RCFPC, or RCPSC board-certified or have not completed an accredited training program recognized by MVP requesting specialty listings must supply additional information in support of such request for a specialty listing.

MVP only lists the ABMS/AOA specialties and the ABMS/AOA sub-certificates of the specialties in physician specialty listings. MVP also recognizes transplant surgery as a sub-specialty for physicians trained at a TACC-accredited fellowship. MVP may recognize other specialties if mandated to do so by state and/or federal regulations.

Confidentiality of Practitioner Information

MVP complies with all applicable state and federal laws regarding the confidentiality of practitioner data and information. Steps taken to safeguard practitioner information include, but are not limited to, maintenance of files in

locked cabinets, password-protected databases, limiting access to data to appropriate personnel, and confidentiality/conflict of interest statements signed by MVP personnel and Credentials Committee members annually. MVP has policies and procedures surrounding how Credentialing information is stored, modified, and secured in compliance with NCQA requirements.

General Practitioner Rights

Right of Practitioners to Be Informed of Application Status

Applicants have the right to be informed of the status of their credentialing or recredentialing application. MVP, upon direct verbal or written request from the applicant, will notify the applicant of their application's status.

Right of Practitioners to Review Information

Applicants have the right to review the information obtained from any outside primary source that is presented to the Credentials Committee in support of their credentialing and/or recredentialing application. Upon written request, MVP will make its Credentialing and recredentialing criteria available to all applicants. Release of information obtained from a third party will be subject to the consent of the third party. Recommendations, letters of reference, and other peer review protected information are not subject to this disclosure. MVP also acknowledges that information obtained from the National Practitioner Data Bank or other outside entity that is not allowed to be released will not be released to the practitioner.

Right to Correct Erroneous Information Submitted by Another Party

MVP will notify the applicant of any information obtained during the credentialing and/or recredentialing process that varies substantially from the information given to MVP by the practitioner. The applicant will have seven (7) calendar days from notification to clarify and/or correct such discrepancies.

Change in Information

MVP requires applicants and Participating Providers to immediately notify MVP in writing of any change in information relative to their application. This information includes, but is not limited to, demographic changes to their practice, malpractice coverage, new malpractice actions, or updated information on a previously pending actions, as well as any adverse actions taken by state or federal agencies, hospitals, or other health plans.

Non-compliance with Recredentialing

Failure to meet Recredentialing criteria or non-compliance with the Recredentialing process will result in termination of participation in MVP's Network. Non-compliance with the Recredentialing process includes, but it's not limited not responding to or returning requests for the Recredentialing application (a CAQH application that has been re-attested to within the past 90 days and to which MVP has been authorized access) and all supplemental information within 14 calendar days from the date of request.

Compliance with MVP Protocols

MVP monitors Participating Provider compliance with MVP Protocols. Non-compliance is identified as failure to follow MVP Protocols including but not limited to, prior authorization, unauthorized out of plan referrals, balance billing of Members, and general lack of cooperation with MVP staff.

Performance Monitoring

To ensure Participating Providers continue to meet MVP guidelines, MVP tracks performance through three-year Recredentialing cycle. Information related to Participating Provider's performance is collected by the QI

and includes site visit scores, QI investigations, Member complaints, and issues related to non-compliance with MVP Protocols, as well as various quality metrics as determined by the QI Department. Data is reported to the Credentials Committee at the time a Participating Provider is Recredentialed and such data is used by the Committee in its decision-making process. In some cases, the QI Department will perform immediate intervention, including, but not limited to, a request for a Corrective Action Plan or early review by the Credentials Committee. As an example, any two complaints regarding record keeping practices or office conditions will trigger a site assessment, regardless of specialty.

Participating Providers receiving five or more complaints of any type, and from any source, within a three-year period will be subject to review by the Credentials Committee. In addition to the data gathered for the review of Participating Provider, the data collected by the QI Department is presented to the Credential Committee in a semi-annual aggregate report. Further details regarding the quality metrics used in performance monitoring quality can be found in [Quality Improvement](#).

Ongoing Monitoring

Ongoing monitoring is the monitoring of Participating Providers between Recredentialing cycles and the assessment of adverse events such as readmissions, unexpected death, accessibility issues, and complications of therapy pertaining to performance. This activity includes, but is not limited to, the monitoring of state license sanctions, Medicare and/or Medicaid sanctions, Medicare opt out reports, Medicare precluded practitioners, adverse events, a determination of fraud, and/or other criminal charges/convictions.

MVP Credentialing Committee – Processes and Procedures

The MVP Credentialing Committee, reports to the MVP Quality Improvement Committee and reviews Credentialing and Recredentialing applications for participation in the Network and may considers recommendations any applicable IPA Credentials/membership committees.

Notification of Credentialing Committee Decision

Credentialing Approval. Upon approval of the Participating Provider MVP shall:

- Assign a provider number.
- Notify the applicant of the approval decision, within 60 calendar days of the approval date through a “welcome letter.”
- Add the Participating Provider’s name to the MVP Directory at the next publishing date.
- Provide Participating Provider and office staff orientation to MVP procedures, as appropriate.

Recredentialing Approval. Upon Participating Provider’s Recredentialing approval, Participating Provider shall continue to be listed in the Provider Directory.

Credentialing Denial. Upon denial of a new Credentialing applicant MVP shall:

- Notify the applicant and/or any affiliated IPA in writing within 60 calendar days of the denial decision by the MVP Chief Medical Officer or his/her designee.
- If the applicant is licensed and practicing in Vermont, the physician/practitioner will have appeal rights as outlined in Vermont Rule 10.203(F)(9) and 10.203(I).
- If the physician applicant applied for participation with a Medicare product, the physician will be permitted to request a review of the decision by presenting information and views on the decision.

Recredentialing Denial. Upon termination of a Participating Provider, MVP shall:

- Notify the Participating Provider and/or any affiliated IPA in writing of the termination decision by the MVP Chief Medical Officer or his/her designee.
- Advise Participating Provider of any applicable right to a hearing or review.

Termination Process for Participation with MVP

If the MVP Credentials Committee proposes to suspend or terminate a Participating Provider such Participating Provider will be notified in writing of the decision. Such notice will state:

- The MVP Credentials Committee's decision.
- The nature of the basis for the Committee's decision. For Medicare Advantage Participating Providers, the reason shall include, if relevant, the standards and data used to evaluate the Participating Provider and the numbers and mix of practitioners needed for the MVP Network.
- The Participating Provider's right to request a hearing or review of the decision before a hearing panel appointed by MVP.
- A time limit of 30 calendar days to request a hearing or review and a description of the way a request may be properly made to MVP.

Upon receipt of the notice of proposed termination, the Participating Provider has 30 calendar days to request a hearing before the hearing panel. Failure to request a hearing or review within 30 calendar days shall result in termination of a Participating Provider's participation or contract with MVP. If a hearing is requested during the 30-day notice period, MVP will notify the Participating Provider of the scheduled hearing date. The hearing must be held within 30 calendar days of receipt of the request. The 30-day time limit may be extended by agreement of MVP and the Participating Provider.

If such an extension is agreed to, Participating Provider shall sign a waiver evidencing his or her consent to such extension. The hearing panel shall be composed of at least three persons appointed by MVP, the majority of whom shall be clinical peers in the same discipline and the same or similar specialty as the Participating Provider under review. The hearing panel will render a decision, and a copy of such decision will be memorialized in writing and mailed to the Participating Provider in a timely manner. Decisions will include one of the following: reinstatement, provisional reinstatement with conditions set forth by MVP, or termination. The effective date of the termination shall be not less than 30 days after Participating Provider's receipt of the hearing panel's decision. In no event shall termination be effective earlier than 60 days from the Participating Provider's receipt of the notice of termination.

Summary Suspension/Termination of Participation

MVP may Summarily Terminate or Summarily Suspend a Participating Provider's participation in the Network immediately for the reasons defined below.

Summary Suspension:

- Cases involving actions or accusations that may represent imminent harm to patient care.
- A charge of fraud by a competent state or federal legal authority.
- Cases where the actions raise the potential for financial or administrative damage to MVP.
- A preliminary disciplinary action or pending investigation by the New York State Office of Professional Medical Conduct, other state licensing board, or other governmental agency that might impair the Participating Provider's ability to practice.
- Physical or behavioral impairment that may impede or limit the Participating Provider's ability to provide appropriate medical care.

Summary Termination:

- Cases involving actual or imminent harm to patient care.
- Cases involving a determination of fraud by a competent state or federal legal authority.
- A determination of fraud by the MVP Special Investigation Unit.
- A final disciplinary action that has been taken against the Participating Provider by a state licensing board or other governmental agency that impairs the Participating Provider's ability to practice.
- Participating Provider's license in the state where they see MVP Members is expired or showing as not registered.

A Participating Provider does not have the right to appeal a summary suspension/summary termination. Summary Suspension/Summary Termination of a Participating Provider's participation in the Network shall be effective immediately upon notice to the Participating Provider. Participating Provider contracted for the Medicare Advantage Plan network have the right to appeal a Summary Suspension or Summary Termination. The requirement to hold the hearing within thirty (30) days of the Participating Provider's request does not apply in the case of a Summary Suspension.

Vermont Participating Provider are entitled to request a review of a decision to reduce, suspend, or terminate privileges.

A Participating Provider's suspension may not exceed thirteen (13) months. When the Participating Provider reaches a twelve (12) month period of suspension, they will be notified of the pending termination upon reaching a thirteen (13) month period of suspension and will be offered the right to appeal the termination.

Reasons MVP May Not Terminate

MVP may not terminate a contract or Participating Provider solely because the Participating Provider has:

- Advocated on behalf of an enrollee;
- Filed a complaint against MVP;
- Appealed any MVP decision;
- Provided information or files a report pursuant to Section 4406-c of the Public Health Law of the State of New York;
- Requested a hearing or review pursuant to Section 4406-d of the Public Health Law of the State of New York;
- Discussed treatment options with Members; or
- Reported, in good faith, to state or federal authorities any act or practice by MVP that jeopardizes patient health or welfare.

Reporting Requirements

MVP shall report to state professional disciplinary agencies and/or the federal National Practitioner Data Bank (NPDB) as per applicable state and/or federal laws.

Review Process for Medicare Advantage Physicians

Physicians denied participation who have applied for participation with a Medicare product are permitted to present information and their views on the decision. The physician must request the review within 30 days of receipt of the denial notification letter.

Reapplication for Participation

- Practitioners who are denied participation must wait one year before they may reapply.
- Participating Provider whose participation is involuntarily terminated (except for non-compliance with recredentialing) must wait a minimum of three years or as required by regulatory bodies. If terminated due to a license action, the action must be fully resolved before reapplication will be allowed.
- Participating Provider who voluntarily resign their participation due to an unwillingness to meet criteria or due to contractual issues will be required to wait one year before they will be allowed to reapply.
- Participating Provider who were suspended and/or terminated due to pending criminal charges that were resolved in the Participating Provider's favor (charges that were dismissed/dropped or the Participating Provider was acquitted of all charges) will not be subject to a waiting period for reapplication.

Practitioner Leave of Absence

Participating Provider shall notify MVP prior to taking a leave of absence (LOA) that will last more than 90 days. The following guidelines apply to Participating Provider taking a LOA longer than 90 days:

- LOA may be contingent upon MVP or IPA approval, if applicable.
- Participating Provider must complete the MVP Leave of Absence form and return it to their Professional Relations Representative at least 30 days prior to the start of their leave except in urgent or emergent circumstances. The *Leave of Absence* form can be found [here](#).
- The covering practitioner must be a Participating Provider.
- The specialty of the covering practitioner must fall within the MVP accepted covering rules.
- The Participating Provider's membership will be voluntarily suspended at the beginning of the leave.
- Participating Provider returning from a LOA of less than 13 months will be reinstated as a Participating Provider if there has been no change to their specialty, spectrum of services provided, physical or mental health, nor any other substantive change in the Participating Provider's ability to provide care to MVP Members.
- Participating Provider must provide proof of current malpractice coverage prior to reinstatement.
- Participating Provider' LOA may not extend beyond 13 months. Practitioners returning from a LOA of more than 13 months must reapply for participation via the Credentialing process.
- An "indefinite" LOA shall be regarded as an LOA exceeding 13 months.
- When a LOA extends beyond 13 months, the Participating Provider will be notified of pending termination and will be offered appropriate appeal rights as per state and federal regulations.

Facility/Organizational Provider Credentialing Guidelines

To be compliant with NCQA credentialing guidelines and MVP policy, MVP Credentials and Recredentials participating organizational providers every three years. MVP Credentials the following organizational Participating Provider:

- Adult Day Care programs
- Ambulatory mental health and alcohol/substance use disorder treatment facilities
- Bariatric surgery centers*
- Clinical laboratories
- Federally Qualified Health Centers (FQHC)
- Free-standing ambulatory surgery centers (ASC)

- Free-standing dialysis centers
- Free-standing radiology centers
- Free-standing rehabilitation centers (mental rehab and physical rehab only)
- HIV/AIDS Day Care programs
- Home health/infusion agencies/home health agencies providing Personal Care Assistant Services
- Hospice
- Hospitals
- Hyperbaric Medicine Treatment Centers
- Long-term care facilities
- Portable/Mobile X-ray Suppliers
- Psychiatric hospitals
- Residential alcohol/substance use disorder treatment facilities
- Skilled nursing facilities (SNF)
- Transplant programs*
- Urgent Care Centers (UCC)
- Ventricular Assisted Device Facilities (LVAD)*

*Indicates Center of Excellence Program

Criteria for Facility/Organizational Provider Participation with MVP

To participate with MVP the Facility/Organization Provider must meet the following requirements:

- Operating Certificates/Licensure/Certification. A current and active operating certificate or licensure in the state where MVP Members are serviced is required, where applicable.
- Participation in Medicare (Title XVIII of the Social Security Act) and Medicaid (Title XIX of the Social Security Act) If contracted for services to Medicare and/or Medicaid members, documentation of participation in those programs is required, where applicable.
- General Liability and Professional Malpractice Insurance Proof of general liability and professional malpractice insurance coverage is required with minimum coverage amounts of \$1 million per incident and \$3 million aggregate.
- Malpractice History MVP will obtain written confirmation from the applicant for the past 10 years of malpractice settlements (three years at time of recredentialing). Applicants with any history of malpractice cases are required to fully document, in writing, the case specifics. As per New York State Public Health Law, hospitals are not required to disclose information regarding malpractice claims.
- Application and Attestation. A completed MVP application (excluding CAQH application) containing a signed attestation statement is required for initial Credentialing and at Recredentialing.

Accreditation

Organizational providers must provide proof that they have been reviewed and are accredited by one of the following:

Entity	Abbreviation	Facility Type
The Joint Commission	TJC	Hospitals/SNFs/Home Health/FQHCs/SBHCs, ASCs, Urgent Care Centers, Ventricular Assisted Devices
The American Osteopathic Association Healthcare Facilities Accreditation Program	HFAP	Hospitals/FQHCs/SBHC
Accreditation Association of Ambulatory HealthCare	AAAHC	Freestanding Ambulatory Surgery Centers
American College of Radiologists	ACR	Free Standing Radiology Centers
Det Norske Veritas Health Care Inc.	DNV	Hospitals/SNFs/FQHCs/SBHCs
Community Health Accreditation Program	CHAP	Home Health Care and Hospice
Clinical Laboratory Certification/Amendment Certification	CLIA	Lab
Comprehensive Bariatric Surgery Center as designated by the <i>American College of Surgeons</i> and the <i>American Society for Metabolic and Bariatric Surgeons (ASMBS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)</i>	MSBAQIP	Bariatric Surgery Centers
Foundation for the Accreditation of Cellular Therapy (FACT) for bone marrow transplants	FACT	Bone Marrow Transplants
Accreditation as a Level 1, 2, or 3 Hyperbaric Treatment Center by the Undersea and Hyperbaric Medical Society	UHMS	Hyperbaric Treatment Centers
Commission on the Accreditation of Rehabilitation Facilities	CARF	Day Treatment Health Centers (Adult and HIV/AIDS) and Rehabilitation Facilities
National Dialysis Accreditation Commission	NDAC	Dialysis Centers
Urgent Care Association of America	ACAOA	Urgent Care Centers
National Urgent Care Center Accreditation	NUCCA	Urgent Care Centers
Council on Accreditation	COA	Behavioral Health and Substance Use Disorder facilities/Private and public behavioral health and community-based social service agencies

Non-accredited organizational providers will be considered for participation based on Network need as defined by MVP. Non-accredited organizational providers must supply MVP with a copy of their CMS or state review and meet any additional requirements. The organizational provider must demonstrate satisfactory completion of an on-site quality assessment using MVP-developed assessment criteria.

Site Visit

The organizational provider must meet MVP's facility site standards. The facility reviews focus on patient safety, access and availability, confidentiality, emergency services, Credentialing processes, and quality-improvement processes. The corresponding medical record review is tailored to address the specific needs of each of these facility types. For a copy of the criteria for any of these facilities, contact the Credentialing Department at Credentialing@mvphealthcare.com.

A CMS or state review may be substituted for an MVP-conducted site review. If MVP is using a state review in lieu of an MVP-conducted site visit, MVP must verify that the review was completed within the time limits and meets MVP's site visit standards. In this instance, organizational provider applicants must provide a copy of the CMS or state review report performed within the previous 36 months and a copy of the organization's QI Plan and Credentialing Process. MVP is not required to conduct a site visit if the state or CMS has not conducted a site review of critical access hospitals and the hospital is in a rural area, as defined by the U.S. Census Bureau.

Access Standards

The facility must meet MVP Access Standards for appointment availability, as applicable. (See QI policies and procedures on Access Standards).

Special Requirements for Home Health Agencies Providing Personal Care Assistant Services to New York State Medicaid Recipients

Home health agencies that provide Personal Care Assistant services are required to attest that the agency has policies, procedures, programs, and protocols to demonstrate compliance with NYS Medicaid Standards for the following:

- A. The level of personal care services provided and title of those providing services
- B. The criteria for selection of persons providing personal care services
- C. Compliance with the requirements of the Criminal History Record Check Program (NYCRR Part 402)
- D. That training, approved by the NYS DOH, is provided to each person performing personal care services, other than household functions
- E. The agency assigns appropriate staff to provide personal care services to a Member according to
- F. MVP's authorization for the level, amount, frequency, and duration of services to be provided
- G. There is administrative and nursing supervision of all persons providing personal care services
- H. The agency's administrative supervision assures that personal care services are provided according to the MVP's authorization for the level, amount, frequency, and duration of services to be provided
- I. The administrative supervision includes the following activities:
 - Receipt of the initial referrals from MVP, including its authorization for the level, amount, frequency, and duration
 - Notifying MVP when the agency providing services accepts or rejects a Member
 - When accepted, the arrangements made for providing personal care services iv. When rejected, the reason for such rejection
- J. The agency promptly notifies the MVP when the agency is unable to maintain case coverage
- K. The agency provides nursing supervision to assure member's needs are being met

Exemptions for NYS-Approved Children’s Managed Care Transition Program and Health Home Program

Effective October 1, 2019, when contracting with organizations or facilities approved by the New York State Department of Health for services provided to medically fragile children and Health Home program recipients, MVP shall not perform separate Credentialing of Behavioral Health or other health care practitioners employed by organization or designated as an approved provider by the Department of Health.

Exemptions to Credentialing Process for HARP HCBS Designated Providers and OMH and OASAS Certified Organizations and Facilities

- When credentialing HARP, HCBC designated providers and NYS licenced OMH-certified, and OASAS-certified organizations, MVP shall accept OMH and OASAS licenses, operations, and certifications in place of, and not in addition to, any Credentialing process for individual employees, subcontractors, or agents of such organizations.
- MVP shall collect and accept program integrity-related information (fraud, waste and abuse) as part of the licensing and certification process.
- MVP requires that such providers shall not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government or otherwise excluded from participation in the Medicare or Medicaid program. Refer to the [Provider Responsibilities](#) section of this document for additional information.
- A New York State mental health facility that participates in the Medicaid lines of business must certify that it will not seek reimbursement from MVP for Conversion Therapy provided to any member.
- MVP reports to the State of New York OMH and OASAS at least quarterly regarding provider performance deficiencies and corrective actions related to performance issues. In addition, MVP reports any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

MVP Credentialing Committee

The MVP Credentials Committee, which reports to the MVP QI Committee, reviews the credentials of organizational providers for participation in the MVP Network.

Change in Information

MVP requires organizational Credentialing and Recredentialing providers to immediately notify MVP in writing of any change in information relative to their application or any other information that is being verified as part of Credentialing or Recredentialing.

Non-compliance with Recredentialing

Failure to meet Recredentialing or non-compliance with the Recredentialing may result in termination of participation. Non-compliance is defined as not responding to or returning requests for the recredentialing application and all supplies.

Compliance with MVP Protocols

MVP monitors Participating Provider compliance with company policies and procedures. Non-compliance is identified as failure to follow MVP Protocols for prior authorization of services, unauthorized out of plan referrals, balance billing of Members, and general lack of cooperation with MVP.

Notification of Credentialing Committee Decision

Following a complete review of the organizational provider's credentials application, the MVP Credentialing Committee will approve or deny the organizational provider.

- Upon approval of a new organizational provider applicant, MVP will notify the applicant of the approval decision and assign a provider number.
- Upon denial of a new organizational provider applicant, MVP will notify the applicant in writing of the decision.
- Upon termination of a Participating Provider, MVP will notify the Participating Provider in writing of the decision.

Denial or termination of organizational providers will not be subject to appeal.

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Participating Provider Responsibilities Overview

This Section is an overview of MVP Participating Provider roles and responsibilities for which all Participating MVP Providers are accountable and designed to help make working with MVP simple, we have created this Provider Resource Manual (PRM) with direction and guidance around the basic operational processes of Participating Providers. Please note that Participating Provider Groups and facilities are responsible for providing access to this PRM to their in-network Participating Providers. Please refer to your Provider Services Agreement (individually and collectively “Provider Agreement”), Facility Services Agreement or contact a Provider Relations representative for further information or questions.

Participating Provider Training

All Participating Providers are required to provide appropriate training for employees and applicable subcontractors within 90 days of hire and annually. Such training shall cover compliance programs that may include, but are not limited to, Fraud, Waste, and Abuse (FWA), Potential Quality Issues (PQI), and the HIPAA. Provider Review Requirements Where applicable, Participating Providers must agree to permit DOH, DFS, or any other regulatory body as required, to conduct on-site evaluations periodically in accordance with the current state and federal laws and regulations and to comply with the agency’s recommendations, if any. [Additional trainings may be required](#) depending on Product participation (for example, Cultural Competency, HARP, HCBS and CHCBS training for Government Programs). Participating Providers must give DFS, HHS, the GAO, any Peer Review Organization (PRO) or accrediting organizations, their designees, and other representatives of regulatory or accrediting organizations the right to audit, evaluate, or inspect books, contracts, medical records, patient care documentation, other records of contractors, subcontractors or related entities for services provided on behalf of MVP for the time period required by applicable law following the termination of the contract or the completion of an audit, whichever is later.

Participating Provider Insurance Requirements

Throughout the term of the Provider Agreement, Participating Providers must maintain a malpractice, general liability and any other insurance and bond in the amounts usual and customary for Covered Services provided with a licensed managed care company admitted to do business in the State or New York (or Vermont as applicable) and acceptable to MVP. In the event Participating Provider procure a “claims made” policy as distinguished from an occurrence policy, providers must procure and maintain prior to termination of such insurance, continuing “tail” coverage or any other insurance for a period of not less than five (5) years following such termination. Participating Providers must immediately notify MVP of any material changes in insurance coverage or self-insurance arrangements and must provide a certificate of insurance coverage to MVP upon MVP’s request. Copies of insurance policies and/or evidence of self-insurance must be provided to MVP upon request.

Compliance with the Americans with Disabilities Act (ADA)

MVP employees, business partners and contracted Providers must comply with ADA requirements, including compliance with Section 504 of the Rehabilitation Act which requires that electronic and information technology be accessible to people with disabilities and special needs. Web pages, portals and other electronic forms of communication are compliant with these standards. Any documents provided on member-based portals are compliant with the Section 504 standards allowing the use of assistive reading programs.

Language Assistance for Limited English Proficiency (LEP)

MVP assesses the linguistic needs of its Members to ensure Members have access to translation and interpretation services for medical services, customer service, and health plan administrative documentation, as needed and according to state regulations. MVP also ensures Member access to translated or alternative format documents and communication as necessary, including for the visually and hearing impaired.

Confidentiality and Protected Health Information (PHI)

MVP and its Participating Providers are considered “Covered Entities” under the Privacy Rule, implemented pursuant to HIPAA and must comply with the strictest applicable federal and state standards for the use and disclosure of PHI. MVP and its Participating Providers are required by federal and state laws to protect a Member’s PHI and are also required to report any breach in confidentiality immediately. MVP maintains physical, administrative, and technical security measures to safeguard PHI; it is important that any delegated entities maintain these safeguards of PHI as well.

MVP Provider Directory

Health care providers who have satisfied MVP’s Credentialing requirements and have executed a Provider Services Agreement with MVP or a Provider Organization (IPA, PHO, PO) will be listed in MVP’s Participating Provider Directory. MVP’s Provider Directory may be searched for in-Network Participating Providers, Specialists, lab facilities and more.

The Primary Care Physician’s Roles and Responsibilities

The Primary Care Physician’s (“PCP”) primary role is to coordinate all the Member health care needs recommended for their age as outlined by the Participating Provider’s Provider Services Agreement and the MVP Quality Improvement (QI) Department. Participating Providers agree not to differentiate or discriminate in the treatment of the Member based on race, sex, age, religion, place of residence, handicap, health status, or payment source.

A PCP may be selected from the following types of Participating Providers:

- Family practitioner
- General practitioner
- Internist
- Obstetrician/Gynecologist
- Pediatrician
- Credentialed Nurse Practitioner (see Credentialing specific requirements)
- A specialist under the conditions as set forth in this section

Common PCP services include:

- Initial examinations, including screenings, history, and lab/diagnostic procedures
- Patient and parent counseling
- Immunizations

Additionally, the PCP:

- Maintains the medical records for each patient
- Determines the appropriate plan of treatment
- Authorizes referrals to MVP participating specialists (see [Utilization and Case Management](#) for details), when necessary
- Behavior Health Screening for all Medicaid, CHP, and HARP Members, and
- Meets or exceeds the access standards as set by MVP

Hourly Requirements of PCPs for Government Programs (Medicaid, HARP, CHP)

- To be considered a PCP for Government Program Members, a Participating Provider must practice at least 16 hours a week at that site.

Member Ratio Requirements for Government Programs (Medicaid HARP and CHP)

- MVP reports the ratio of Medicaid Managed Care and Child Health Plus Members to PCP on a quarterly basis. Any PCP exceeding the enrollment ratio of 1,500 Members/provider will have their panel closed to new Members until the number falls below the accepted ratios. Any credentialed Nurse Practitioner exceeding the enrollment ratio of 1,000 Members/provider will have their panel closed to new Members until the number falls below the accepted ratios. PCPs must provide Government Program Members with access to care via face-to-face or on-call coverage 24/7. PCPs may not routinely refer Members to emergency rooms for after-hours care. PCPs using an answering machine for after-hours coverage must direct members how to access a live person.

Member Selection of a PCP

The following MVP Products require Members to select a participating PCP to provide primary care services to Members and who is responsible for maintaining continuity of care provided to Members:

- MVP HMO – Including all exchange products
- MVP POS
- Medicaid Managed Care
- HARP
- MVP Select Care (ASO) POS
- Preferred Gold
- Child Health Plus
- MVP Select Care (ASO) HMO

Types of PCPs

A PCP may be selected from the following types of Participating Providers:

- Family practitioner
- General practitioner
- Internist
- Obstetrician/Gynecologist
- Pediatrician
- Credentialed Nurse Practitioner (See [Credentialing](#) for those requirements)
- A specialist under conditions listed in this section

Health care providers who have satisfied MVP's credentialing process and have a Provider Services Agreement with MVP or a Provider Organization (IPA, PHO, PO) will be listed in MVP's Participating Provider directory.

PCP Member Roster

Once a Member selects a PCP, the Member's name will appear on the PCP Member Roster. PCP Member Rosters can be accessed anytime by logging onto your Provider account [here](#) (click on *View PCP Member Roster*).

Specialist or Specialty Care Center as a PCP

Certain MVP Products allow for a Specialist or a Specialty Care Center to be designated as a Member's PCP. MVP defines Specialty Care Center as centers accredited or designated by an agency of the state or federal government

or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition.

- **NY HMO, Medicaid, CHP and HARP Only.** Current MVP Members and newly enrolled Members with a life-threatening, disabling, or degenerative disease or condition that requires prolonged specialized medical care, the specialist or a Specialty Care center may be considered a PCP. If a Member is using a Behavioral Health Clinic that also provides primary care services, the Member may select his or her lead Participating Provider to be a PCP.
- The specialist or Specialty Care Center assumes the responsibility to coordinate all primary care services and to authorize referrals for specialty care (see [Utilization Management](#) for details), lab work, hospitalizations, and all other health care needs.

Member Changing PCP

MVP Members have the freedom to change their PCP at any time. Medicaid Managed Care, HARP and Child Health Plus ID Cards list the Member's PCP. A new Member ID card will be issued upon a new PCP selection.

PCP Auto Assignments

Government Programs Members may select a PCP upon enrollment. If a Member has not selected a PCP within 24 hours of enrollment a PCP will be assigned based on the following criteria:

- Member's geographic location
- Specific health considerations
- Language and age, if appropriate

A Member will also be auto assigned a new PCP within 15 business days of notification from a PCP who will no longer participate with MVP.

PCP Referrals to Specialists

For MVP Products requiring a referral, MVP will provide pay for the Covered Services of a specialist only if the Member's PCP makes an appropriate in-network referral after determining the Member's course of treatment, the specialist will submit a report to the Member's PCP. The PCP has the primary responsibility to oversee and coordinate all the care needed by the MVP Member. Please see [Utilization Management](#) for MVP's referral policy.

Specialists Roles and Responsibilities

MVP requests specialists provide regular feedback to the PCP during the course of treatment.

Emergency room physicians Participating Providers should provide feedback to the Member's PCP regarding any treatment rendered during an emergency room visit and any need for follow-up care. Specialists should verify an authorization is on file before performing any non-emergent procedures that require authorization.

Specialist or Specialty Care Center as a PCP

MVP defines Specialty Care Center as centers accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition.

- **NY HMO, Medicaid, CHP and HARP Only.** Current MVP Members and newly enrolled Members with a life-threatening, disabling, or degenerative disease or condition that requires prolonged specialized

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medical care, the specialist or a Specialty Care enter may be considered a PCP. If a Member is using a Behavioral Health Clinic that also provides primary care services, the Member may select his or her lead Participating Provider to be a PCP

- The specialist or Specialty Care Center assumes the responsibility to coordinate all primary care services and to authorize referrals for specialty care (see [Utilization Management](#) for details), lab work, hospitalizations, and all other health care needs.

Health Access Standards

MVP requires the following Health Access Standards as required by Product, law and regulation:

Type of Service – NYS DOH Guidance Commercial	MVP	New York State DOH: Medicaid Managed Care ,Child Health Plus and HARP**	CMS: Medicare Advantage Product	Vermont Rule 9-03B
Emergent Medical (Read further for definitions of “emergency”)	Immediate access	Immediate access	Immediate access	Immediate access
Urgent Medical (Read further for definitions of “urgent”)	Within 24 Hours	Within 24 Hours	Within 24 Hours	Within 24 Hours
PRIMARY CARE Within 48-72hours				
Non-urgent “sick” visit		(Measure within three calendar days)		
Routine symptomatic: Non-urgent, non-emergent	Within two weeks	Within two weeks	Within one week	Within two weeks with prompt F/U, including referrals as needed
Routine asymptomatic: Non-urgent and preventive care appointments (NYSDOH) routine and preventive (CMS)		Within four weeks	Within 30 days	
Preventive care, wellness visits including routine physicals (CM, VT) adult (>21) baseline and routine physical (NYSDOH)	Within 90 days			Within 90 days
Initial assessment		Within 12 weeks of enrollment		Within 90 days of enrollment (good faith effort by plan)
Well-children		Within four weeks		
Initial PCP OV for newborns		Within two weeks of discharge from hospital		

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Type of Service – NYS DOH Guidance Commercial	MVP	New York State DOH: Medicaid Managed Care ,Child Health Plus and HARP**	CMS: Medicare Advantage Product	Vermont Rule 9-03B
Wait in PCP office (max)	30 minutes	one hour	30 minutes	
After-hours care	24/7 availability or coverage	24/7 availability or coverage	24/7 availability or coverage	24/7 availability or coverage
OTHER MEDICAL CARE				
Initial prenatal visit:				
First trimester		Within three weeks		
Second trimester		Within two weeks		
Third trimester		Within one week		
Initial family planning		Within two weeks of request		
Specialist referrals		Within four-six weeks (non-urgent) of request		
Routine lab, x-ray, and general optometry				Within 30 days
In-Plan mental health or substance abuse visits (following an emergency or hospital discharge)		Within five days of enrollee request, or as clinically indicated		
In-Plan non-urgent mental health or substance abuse visits		Within one week of enrollee request		
Visits to perform assessment of health, mental health, substance abuse for recommendation regarding ability to work as requested by local DSS		Within 10 days of DSS request		

* The NYS DOH considers it a violation of the Medicaid Contract Standard Clauses to require Medicaid enrollees to provide a medical record or health questionnaire as a condition of scheduling an appointment.

** After-hours availability, if the telephone in provider’s office is answered in an automated manner (e.g., an answering machine), Members must be directed to call a second telephone number which is answered by a live person.

Behavioral Health Access Standards

Type of Service	MVP Commercial	Vermont Rule 9-03B
Behavioral health: Emergency: Life-threatening/non-life-threatening	Immediate access	
Urgent BH	Within 48 Hours	Within 24 Hours
Routine BH	Within 10 business days	
Routine follow-up: Licensed to Prescribe BH Providers	30 days	
Non License to Prescribe BH Providers	20 days	
MH of SA follow-up: Post emergency/post inpatient admissions	1 week	
Non-urgent MH or SA Health, MH and SA assessment for purpose of making recommendation RE: Member's ability to work when required by LDSS	1 week	

Medicare Variation to Access Standards

MVP must comply with all CMS requirements and ensure that all Covered Services including additional or supplemental service contracted for on behalf of the Medicare Member are accessible. At a minimum, all PCPs, specialists, and Ancillary Providers must meet the following standards to ensure accessibility to Members:

1. Office waiting room time cannot exceed 30 minutes.
2. Participating Provider should be accessible 24 hours a day, 365 days a year.
 - a. Such assess must include an after-hours phone number published in a phone directory, on office business cards, or on insurance cards which connects the Member to an answering service, a hospital switchboard, an emergency department, or a paging system.
 - b. An office announcement directing Members to leave a message is unacceptable.

Medicaid Managed Care, HARP and Child Health Plus Variation to Access Standards

Access and availability studies are routinely conducted by both the New York State Department of Health and MVP to ensure that the access and availability standards as described above are met for all Medicaid, HARP and CHP Managed Care plans. Representatives from the local Department of Social Services or DOH or their designee may contact a provider's office and attempt to schedule appointments for various types of services. It is important that all staff members are knowledgeable of both MVP requirements and the standards described above. In the event that DOH contacts a provider office in this manner, the staff person who answers the telephone will be informed by the state representative at the conclusion of the conversation that he or she has just been tested on the standards. The DOH will also conduct tests to ensure that PCPs are available 24 hours a day by contacting providers after business hours to verify that an appropriate live voice "on-call" telephone system is in place. An after-hours voicemail message advising patients to call 911 in an emergency is not acceptable. In addition, as part of MVP's participation in the New York State Medicaid Managed Care program, MVP is required to conduct an annual survey on appointment availability and 24-hour access to our Government Programs network.

Children’s Home and Community Based Services (“CHCBS”) Variation to Access Standards

Effective, 10/1/19, Children who have received a 1915(c) will be moved into Medicaid Managed Care programs. Children with a 1915(c)-waiver moved into MVPs Medicaid Plan will receive all current Medicaid along with CHCBS.

Medical Health Access standards listed above must be adhered to for CHCBS. In addition to the Medical Health Access Standards, Members receiving CHCBS will be provided comprehensive and preventive health care services to ensure they receive appropriate preventive, dental, mental health, developmental and special services. MVP contracts with providers with expertise in caring for medically fragile children, to ensure that medically fragile children, including children with co-occurring developmental disabilities. In the event MVP does not have Participating Providers for such Covered Services, the referring provider must submit a prior authorization for an out of network provider. Refer to [Utilization and Case Management](#) for the process on how to obtain a prior authorization to an out-of- network provider. The following access standards must be met by all providers

Foster Care Initial Health Services Variation to Access Standards

The following services must be performed by a Participating Provider who is not a Behavioral Health Specialist in the designated timeframes of a child being placed in foster care.

Initial Health Services Time Frames

Activity	Time Frame	Who Performs
Initial screening/screening for abuse/neglect	Within 24 hours of request	Health Practitioner (preferred) or Child Welfare Caseworker/ health staff
Initial determination of capacity to consent for HIV risk assessment & testing	Within 5 days of request	Child Welfare Caseworker or designated staff
Initial HIV risk assessment for child without capacity to consent	Within 5 days of request	Child Welfare Caseworker or designated staff
Request consent for release of medical records & treatment	Within 10 days of request	Child Welfare Caseworker or designated staff
Initial medical assessment	Within 30 days of request	Health Practitioner
Initial dental assessment	Within 30 days of request	Health Practitioner
Initial mental health assessment	Within 30 days of request	Mental Health Practitioner
Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)	Within 30 days of request	Health Practitioner
HIV risk assessment for child with possible capacity to consent	Within 30 days of request	Child Welfare Caseworker or designated staff
Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	30 days	Child Welfare Caseworker or designated staff
Initial developmental assessment	45 days	Health Practitioner
Initial substance abuse treatment	45 days	Health Practitioner

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Activity	Time Frame	Who Performs
Follow-up health evaluation	60 days	Health Practitioner
Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	60 days	Child Welfare Caseworker or health staff
Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	60 days	Child Welfare Caseworker or health staff

Coverage Arrangements

Participating PCPs must ensure that there is 24/7 coverage for Members. PCPs may use a back-up call service, provided that a physician is always available to back up the call service. PCPs agree that, in the case of an absence, they will arrange for patient care to be delivered by another provider and ensure the covering provider participates with MVP. If arrangements are made with a non-participating physician*, it is the responsibility of the participating physician to ensure that the non-participating physician will:

- Accept MVP's fee as full payment for services delivered to MVP Member patients
- Accept the MVP peer-review procedures
- Seek payment only from MVP for covered services provided to Members and at no time bill or otherwise seek compensation for covered services from MVP Members, except for the applicable co-payments
- Comply with MVP utilization management and quality improvement procedures

Note: Providers who are not contracted for Government Program lines of business are considered non-participating for Government Program plan types (Medicaid Managed Care, HARP and Child Health Plus).

When submitting the insurance claim to MVP, the covering provider should indicate "covering for Dr. 'X'" in box 19 of the CMS-1500 claim form.

Provider Directory Policy

MVP is committed to ensuring our Members have access to the care they need. In order to do this MVP requires all individual Providers that have gone through MVPs credentialing process to be listed in MVPs online and paper directories.

Policy Exceptions

Physicians who are registered with MVP or has a specialty in which a Member does not require a follow up appointment for care, including:

- Individual Diagnostic Radiologists (except for Interventional Radiologists) – Radiology Facilities are listed.
- Anesthesiologists (except those credentialed as Pain Management Specialists)
- Hospitalists (Hospital only based providers with the specialties of Internal Medicine, Family Practice, and Pediatrics)
- Critical Care Specialists
- Pathologists
- Neonatologists
- Emergency Medicine Providers

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- Providers practicing in an Urgent Care setting with the following specialists (Internal Medicine, General Practice, Family Practice, Emergency Medicine or Pediatrics)
- Primary Care Physicians who are covering at a location 1x a week or less or does not meet the 16-hour PCP requirements for a location.
- Providers who practice in a Skilled Nursing Facility only.
- Individual Behavioral Health Providers practicing in an OMH/OASES certified/licensed facility or program are not listed in the directory; however, the facilities are listed in the directory.

Mid-Level Providers who are registered with MVP, including:

- Nurse Practitioners (NP or Advanced Practice Registered Nurse (APRN) that do not meet MVPs credentialing requirements)
- Certified Nurse Midwives (CNM) that do not meet MVPs credentialing requirements
- Physician Assistants
- Registered Nurse First Assistants (RNFA)
- Licensed Master Social Worker (LMSW).

Changes in Demographic Information or Termination of Participation

Termination

MVP requires Participating Providers to provide prior written notice of termination of participation in MVP's network. Termination notice requirements are dictated by the Participating Provider's Service Agreement may be directly with MVP or through a provider organization (IPA, PHO, PO). MVP Preferred Gold requires that a Participating Provider give at least 60 days' notice of termination without cause. Some provider service agreements may require more than 60 days' notice. Providers should refer to their Provider Service Agreement for notice requirements. If a Participating Provider voluntarily terminates his/her contract, MVP will make a good faith effort to notify all affected Members of the termination within 15 days of receiving notice. Participating Providers terminating of Government Programs (Medicaid, CHP, and HARP) must notify Members of the change in status and the impact of such change on the Member.

Transition of Care

When an MVP Member is under the care of a Participating Provider who leaves MVP's network, the Member may be offered Continuation of Care with the provider for 90 days from the effective date of the termination of the provider's participation in the MVP network, assuming the provider has not been terminated due to quality issues, is willing to accept the MVP fee schedule as payment in full, is in the area, is able to provide care, and agrees to follow MVP policies and procedures.

Continuation of Treatment: NY HMO Company Only

At the time of enrollment, new MVP Members may be undergoing treatment with a non-participating provider. MVP will provide benefits for covered services and will not deny coverage of an ongoing course of care for 60 days from the date of enrollment or until accepted by a new provider (whichever is sooner), if the new Member is undergoing treatment for:

- A life-threatening disease or condition
- A disabling or degenerative disease or condition

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MVP also will provide benefits for covered services if the new member has entered the second or third trimester of pregnancy at the effective date of enrollment. Care will be covered through the completion of postpartum care related to the delivery. MVP will provide benefits only if the non-participating provider:

- Accepts MVP's established rates as payment in full
- Adheres to MVP's QI requirements
- Adheres to MVP's policies and procedures
- Provides MVP with medical information related to care

Continuation of Care will not be offered if the provider's departure is due to:

- A determination of fraud
- Final disciplinary action by a state licensing board that impairs the provider's ability to practice
- Medicare or Medicaid exclusion
- Imminent harm to a patient

Transitional Care

Transitional care applies to all Members whose provider leaves MVP's network and is receiving an active course of treatment for an acute episode of chronic illness or acute medical condition, or for a life-threatening, disabling, or degenerative disease or condition.

If a pregnant MVP Member has entered her second or third trimester at the time of the provider's departure, Transition of Care will be allowed until the completion of postpartum care related to the delivery. Upon notification of the termination of a Member's provider, the Professional Relations representative will forward a letter to the provider outlining the transition of care requirements. If the practitioner agrees to the following stipulations, the signed transition of care letter is returned to the Professional Relations Representative for implementation. The provider must agree to:

- Continue to treat the Member for an appropriate period based on the written transition plan goals
- Accept MVP's established rates as payment in full and not charge the Member for amounts beyond
- Adhere to MVP's QI requirements
- Provide medical information related to care
- Adhere to MVP policies and procedures

New York State Confidentiality Law and HIV

The following information is excerpted from the New York State Department of Health AIDS Institute website at hivguidelines.org.

New York State Public Health Law (Article 27-F):

- Requires that information about AIDS and HIV is kept confidential
- Requires that anyone receiving a voluntary HIV test must first sign a consent form
- Strictly limits disclosure of HIV-related information
- Requires that when disclosure of HIV-related information is authorized by a signed special HIV release, the person receiving the information must keep it confidential
- Only applies to people and facilities providing health or social services, or who obtain the information pursuant to a special HIV release

The law also requires that physicians and laboratories report the following results to the New York State Department of Health:

- AIDS
- Positive HIV tests
- Viral load tests
- Diagnoses of HIV-related illnesses
- Tests showing t-cell counts under 500

Only tests completed at certified anonymous test sites are exempted from reporting.

Demographic Changes

Participating Providers must notify MVP of any demographic changes; failure to do so may result in claim denials. Providers should use the Online Demographic Form for such updates. Go to mvphealthcare.com/demographics. Complete the appropriate fields and submit the form. A reference number will be generated for your records; use the reference number when checking on the status of a change.

NYS Out-of-Network Surprise Bill requires Providers to review and update MVP regarding their hospital affiliations and languages spoken yearly. Providers may make the change on their CAQH application and attest the information is correct per CAQH standards. MVP will review all changes made on the CAQH application and contact the Provider with any questions.

Quarterly Demographic Review

CMS requires MVP to perform a quarterly review of demographic information of MVP's online directory. MVP requires all Participating Providers to review demographic information and ensure that it is accurate and up to date, notify MVP of any demographic changes and your CAQH profile as applicable.

To review and verify provider information on a quarterly basis:

Step 1 – Visit mvphealthcare.com and select *Members*, and then *Find a Doctor*, and then search by *Find a Doctor*.

Step 2 – On the provider search tool, click on *Guest* and choose one of the products the provider(s) in your practice participates with. Search for the Participating Provider(s) in your practice and review the following demographic information for accuracy:

- Ability to accept new Members
- Street address or missing addresses
- Phone number
- Other changes that affect availability to Members (e.g., handicapped accessible, specialty changes)

Step 3 – If demographic information is incorrect, please access the Online Provider Change of Information form and submit the correct information to MVP. This form can be found [here](#). Delegated providers, please contact your delegate administrator to update your demographic information.

Step 4 – If the update applies to multiple Participating Providers in the group, choose contracted group on the form and attach a roster of all Participating Providers the change applies to, including the Participating Provider's name and NPI.

Step 5 – Once the form is complete, click submit. A reference number will be generated; please keep this for your records and use when requesting status of your change.

Step 6 – Log in to CAQH and make any demographic updates to your CAQH profile so it matches the information you are submitting to MVP and re-attest your CAQH.

Advance Directives

An Advanced Directive(s) is a legal document where a Member makes provisions for future health care decisions in the event, they are unable to make such decisions themselves. Participating Providers are required by law to provide information to Members about Advance Directives. MVP requires Participating Providers to adhere to all applicable laws and regulations, and requires information shared with Members and their treatment options be easily understood by the Member. Participating Providers may not require Members to sign or waive an Advance Directive as a condition of care. Participating Providers must comply with all applicable law and regulation when an Advance Directive is given to a Participating Provider, by the Member. Such requirements include but may not be limited to:

- Including the Advanced Directive in the Member’s medical record.
- Complying with the health care decisions made by an agent under the Advance Directive to the same extent as the provider would comply with the Member’s decisions.
- Participating Provider must promptly inform the health care agent and transfer responsibility for the Member to another Participating Provider if the Member’s health care decisions are contrary to the Participating Providers religious beliefs or sincerely held moral convictions.
- MVP Preferred Gold Members age 18 and older, requires documentation be prominently noted in the medical record chart to contain a notation of the Advance Directive, or that the Member was asked about completing one.
- MVP will monitor compliance through the Quality Assurance medical record review.

Emergency Care

Participating Providers shall provide Members with immediate access to care is the standard for an emergency condition. An Emergency Condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

Physicians Treating Self or Family Members

The American Medical Association (AMA) has stringent guidelines regarding practitioner self-treatment or treatment of immediate family members. The AMA Code of Ethics E-8.19 addresses this issue in detail. MVP endorses the AMA’s position regarding practitioner self-treatment and treatment of immediate family members and will not reimburse such care.

Cultural and Linguistic Competency

All Participating Providers must ensure that services are provided to all Members in a culturally competent manner. Cultural and Linguistic competency in healthcare is the ability of providers to understand social, ethnic, religious, and linguistic characteristics of a population and use this understanding to improve the quality of care providers deliver. MVP is committed to ensuring that our Members are treated with dignity and respect and that their cultural needs are considered when interacting with Participating Providers.

The socio-cultural differences between Members and healthcare professionals influence many aspects of the medical encounter that can impact patient satisfaction, adherence to medical advice, and health outcomes. For example, Members respond better when care instructions are delivered in their own language. Moreover, knowledge of, and sensitivity to, cultural issues can impact the way Members communicate their medical needs, and how physicians and nurses can enhance diagnosis and treatment. Cultural education for providers can not only accomplish the goal of culturally sensitive care but can also help address ethnic disparities in healthcare.

Regulations prohibit MVP Health Care and its contracted health care providers from discrimination based on health status.

MVP Participating Providers may access [E-learning](#) offered by the Uniform Network Provider Training. Services free of charge and equips providers with the necessary competencies to improve the quality of treatment for our diverse Member population. This training is required by Participating Providers serving our Government Programs Members and encouraged for all others.

High-Tech Imaging Services Provided in an Office or Free-Standing Radiology Center

MVP requires that all MRI/MRA, CT/CTA, and PET machines have accreditation from the American College of Radiology (ACR) or from the Intersocietal Accreditation Commission (IAC). Provider offices that are approved to perform these high-tech imaging services are required to submit proof of ACR or IAC accreditation to MVP. Providers' offices that are not accredited and do not submit proof of ACR or IAC accreditation to MVP may not perform these services to MVP Members in their office and will not be reimbursed for such services.

MVP currently has a moratorium on the addition of such high-tech radiology equipment. MVP will not add new high-tech radiology equipment to its network unless a demonstrated access need is identified (at MVP's sole discretion).

Telehealth

Providers supplying Telehealth services must adhere to MVP Protocols and all applicable laws and regulations. For additional information on payment for Telehealth services refer to MVP's Telehealth Payment Policy or MVP's Telemental Health Payment Policy.

- Providers providing services via Telehealth must be licensed or certified, currently registered in accordance with NYS Education Law or other applicable law.
- Providers providing services via Telehealth to Medicaid, HARP, and/or CHP Members must be and enrolled in NYS Medicaid, with an MMIS number.
- Telehealth services must be delivered by providers acting within their scope of practice.
- Reimbursement will be made in accordance with existing and applicable MVP payment policies and all applicable federal and state regulations related to supervision and billing rules and requirements.
- When services are provided by an Article 28 facility, the Telehealth Provider must be credentialed and privileged at both the originating and distant sites in accordance with Section 2805-u of PHL. The law can be viewed at <http://public.leginfo.state.ny.us/lawsrch.cgi?NVLWO>: and select PBH; select Article28; select 2805u)

Confidentiality

All services delivered via Telehealth must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to: 45 CFR Parts 160 and 164 (HIPAA

Security Rules); 42 CFR, Part 2; PHL Article 27-F; and MHL Section 33.13. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. Additionally:

- HIPAA requires that a written “business associate agreement” (BAA), or contract that provides for privacy and security of protected health information (PHI) be in place between the Telehealth provider and the supporting Telehealth vendor.
- Privacy must be maintained during all patient-Provider interactions.
- All existing confidentiality requirements that apply to medical records (including, but not limited to: 45 CFR Part 160 and 164; 42 CFR Part 2; PHL Article 27-F, and MHL Section 33.13) shall apply to services delivered by Telehealth, including the actual transmission of service, any recordings made during the Telehealth encounter, and any other electronic records.

Patient Rights and Consents

The Provider shall provide the Member with basic information about the services that he/she will be receiving via telehealth and the Member shall provide his/her consent to participate in services utilizing this technology. Telehealth sessions/services shall not be recorded without the Member’s consent. Culturally competent translation and/or interpretation services must be provided when the member and distant Provider do not speak the same language. If the Member is receiving ongoing treatment via telehealth, the Member must be informed of the following patient rights policies at the initial encounter.

Documentation in the medical record must reflect that the Member receiving telehealth services are informed of their rights as outlined below:

- Have the right to refuse to participate in services delivered via telehealth and must be made aware of alternatives and potential drawbacks of participating in a telehealth visit versus a face-to-face visit;
- Are informed and made aware of the role of the Provider at the distant site, as well as qualified professional staff at the originating site who are going to be responsible for follow-up or ongoing care;
- Are informed and made aware of the location of the distant site and all questions regarding the equipment, the technology, etc., are addressed;
- Have the right to have appropriately trained staff immediately available to them while receiving the telehealth service to attend to emergencies or other needs;
- Have the right to be informed of all parties who will be present at each end of the telehealth transmission; and
- Have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit.

MVP Physician, Mid-Level, and Ancillary Provider Registration or Contracting Requirements

Certain physicians, mid-levels, and Ancillary Providers are not required by MVP to be fully Credentialed, but instead may be subject to MVP’s registration process. Registration requires MVP to confirm that the proper licensure, education, insurance requirements, and required regulatory sanction checks are met and is contingent upon the provider being fully credentialed by their employer (collectively “Provider Registration”). Provider Registration is available to the following providers:

- Nurse Practitioners (NP)
- Physician’s Assistants (PA)
- Certified Registered Nurse Anesthetist (CRNA)

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- Certified Nurse Midwives (CNM)
- Advanced Practice Registered Nurses (APRN) – Vermont only
- Anesthesia Assistants – Vermont only
- Opticians
- Registered Nurse First Assistants (RNFA)
- Licensed Masters Social Workers (LMSW)
- Locum Tenens - At MVPs Sole Discretion when provider is identified in a medically underserved area. For additional details please review MVPs Locum Tenens Payment Policy (see Locum Tenens Payment Policy in the Payment Policies)
- Physicians in the following specialties:
 - Family Practice, Internal Medicine, & Pediatrics in the Inpatient Hospital Setting Only
 - Anesthesiology
 - Critical Care
 - Neonatology
 - Emergency Medicine
 - Pathology

Upon Provider Registration, MVP shall set the date of participation date and inform the Registered Provider of their participation status (“Par Date”). MVP does not allow retro-activation of Registered Providers. Participation status is at MVP’s discretion and such determination is based on the successful Provider Registration and an executed Provider Agreement with MVP (as applicable). A Registered Provider will not be reimbursed for services provided to MVP Members prior to their Par Date. Providers in the specialties outlined below must notify MVP as soon as they are aware

that they will be providing services to MVP Members. Applications with future effective dates will be accepted, and the provider will be set up with the future effective date upon their successful Provider Registration. Provider Registration may take up to 60 days from the date the executed MVP Provider Agreement (as applicable) and complete registration application are received.

1. **Internal Medicine, Family Practice and Pediatrics.** Physicians with a specialty of Internal Medicine, Family Practice, and Pediatrics that are solely practicing in the hospital as a hospitalist in an MVP participating Hospital (or facility) must be bound by the hospital’s Provider Agreement with MVP and complete Provider Registration. Physicians with practicing in the specialty of Internal Medicine, Family Practice and/or Pediatrics outside the hospital setting must be fully [Credentialed](#),
2. **Emergency Medicine, Hospital Based Anesthesiology, Critical Care, Neonatology and Pathology.** Physicians with a specialty of Emergency Medicine, Hospital Based Anesthesiology, Critical Care, Neonatology, and/or Pathology must be contracted with MVP and complete Provider Registration. Anesthesiologists and Pathologists that have practices outside the hospital setting must be fully [Credentialed](#).
3. **Mid-Levels and Ancillary Providers.** Mid-level and Ancillary Providers providing Covered Services in an MVP Participating Provider’s practice are subject to Provider Registration. Mid-level and Ancillary Providers are eligible for Provider Registration if they have (1) collaborating physicians (defined as Physician services include making medical diagnoses, prescribing medications and other treatments, and ordering diagnostic tests. Collaboration is defined by each state, and usually means providing direction and oversight and being available for consultation by telephone or other means) who is an MVP Participating Provider in the same specialty; or (2) in a substantially similar specialty (defined as Provider of patient care provides assessment, treatment, and clinical management which is substantially similar in

function or capability) in an integrated clinical practice (defined as a patient-centered approach in which behavioral health and medical providers work together to provide care. Often, this takes the form of two models of care: 1) primary care practices integrating behavioral health providers and 2) behavioral health clinics integrating primary care providers) and are bound by the terms of an MVP Provider Agreement. If an Ancillary Provider is a hospital employee billing under the hospital's Tax ID and practices in the in-patient and/or out-patient-hospital setting, Provider Registration is not required. Mid-level and Ancillary Providers subject to this registration requirement include all office-based physician extenders, including, but not limited to:

- Nurse Practitioners (NP) and Certified Nurse Midwives (CNM).
 - NPs and CNMs in the state of New York, practicing independently must be Credentialed and individually contracted with MVP.
 - CNMs employed by a hospital are subject to the hospital based Mid-Level rules detailed below.
 - NPs are required to have 5 years' experience in the specialty area requested for credentialing to be contracted and credentialed independently. NPs and CNMs to who do not meet individual Credentialing requirements may not be individually contracted and are subject to Provider Registration.
 - MVP may approve the services of a non-participating CNM in compliance with the NY State mandate, when such the CNM has satisfied MVP's current liability insurance requirements and has a written agreement with a collaborating physician.
- Physician's Assistants (PA)
- Certified Registered Nurse Anesthetist (CRNA).
 - A CRNA determined by MVP to be in an underserved area may use a MVP participating surgeon in the practice (instead of an Anesthesiologist) as their collaborating physician only if they have a written agreement with an MVP Participating anesthesiologist outside the practice who can provide oversight if needed. All other CRNAs in non-underserved areas, as determined by MVP, must follow Provider Registration requirements including an MVP participating anesthesiologist as their collaborating physician.
- Advanced Practice Register Nurses (APRN)
 - An APRN practicing in Vermont may use a doctorate level APRN who is credentialed and participating with MVP as their collaborating.
 - APRNs in the state of Vermont, practicing independently must be Credentialed and individually contracted with MVP and are required to have 5 years' experience in the specialty area requested for credentialing to be contracted and credentialed independently.
- Anesthesia Assistants (AA) – Vermont Only.
- Opticians
 - Opticians do not require a collaborating provider
 - Opticians do not require a DEA
- Registered Nurse First Assistants: Working exclusively in an MVP Participating Facility and are credentialed and privileged by the hospital.
 - Medicare does not recognize and reimburse separately for RNFA's. These providers may not participate with MVP Medicare products.

4. **Mid-Level and Ancillary Providers in an Integrated Health Practice** - The following provider types are required to be registered with MVP when practicing in an Integrated Clinical Practice:
- **Nurse Practitioner (NP)** - Nurse Practitioners in an Integrated Clinical Practice who will be practicing psychiatry must have a collaborating provider that is credentialed and participating with MVP and has the same or substantially similar specialty. In this situation a Primary Care Physician may be considered at MVPs sole discretion, a substantially similar specialty for a collaborating provider. The collaborating provider can be under the same TIN or outside the TIN; however, an NP cannot practice independently unless they meet the [credentialing requirements](#).
 - **Advanced Practice Registered Nurse (APRN) VT Only** – APRNs in an Integrated Clinical Practice who will be practicing psychiatry must have a collaborating provider that is credentialed and participating with MVP and has the same or substantially similar specialty. In this situation a Primary Care Physician at MVPs sole discretion, may be considered a substantially similar specialty for a collaborating provider. Providers may also have a Doctoral Level APRN under the same specialty act as a collaborating provider, if they are credentialed by MVP.
 - APRNs in the state of Vermont, practicing independently must be Credentialed and individually contracted with MVP and are required to have 5 years’ experience in the specialty area requested for credentialing to be contracted and credentialed independently.
 - **Licensed Masters Social Worker (LMSW)** – Providers who are LMSW do not meet MVPs requirements for credentialing and must be registered. LMSW providers must have a supervising provider that is credentialed and participating with MVP and have one of the following specialties: Psychiatry Psychology, or Licensed Clinical Social Workers with “R” certification (LCSW-R).

Ancillary Providers not listed herein should refer to the [Credentialing](#) for Credentialing requirements. Mid-levels who are unsure if a contract is required with MVP should contact MVPPR@mvphealthcare.com to determine if they require a contract.

Exceptions to Provider Registration Requirements

MVP shall accept state issued HCBS provider, OMH and OASAS certified providers with an OASAS license and certifications in place of MVP Credentialing or Registration for individual employees, subcontractors or agents of such Participating Providers. MVP will not separately Credential or Register individual staff members in their capacity as employees, but is still required to collect and accept program integrity-related information from such providers as required by the Medicaid Model Contract and will require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government or otherwise excluded from participation in the Medicare or Medicaid program (collectively, MVP State Registration Process”). These providers can be submitted on MVPs required roster format and should be reviewed and update quarterly. These rosters should be submitted to MVP via email to BHproviderroster@mvphealthcare.com.

Billing and Payment Rules

Mid-Levels in a Private Practice with Collaborating Physician

MVP will make payments for Covered Services rendered by registered Mid-Level Providers to the physician’s billing address under that groups tax ID. No claims will be paid to the registered Mid-Level practitioner directly.

Covered Services rendered by MVP registered Mid-Level and Ancillary Providers must be billed using their individual type 1 NPI number and the groups Tax ID number. Mid-levels may not bill using their collaborating physicians’ NPI number.

Mid-levels must bill with the specialty taxonomy associated with their collaborating physician.

Mid-level and Ancillary Providers who have opted out of Fee-for-Service (FFS) Medicare may not render services to MVP Medicare Gold patients. This rule applies to all Mid-Level and Ancillary Providers who have opted out of Medicare FFS, regardless of whether the MVP participating physician with whom they practice has opted in to FFS Medicare and is a participating provider with the MVP Medicare Gold products.

Hospital-Based Mid-Levels

Mid-level providers listed above who are hospital employees and whose services are billed under a hospital Tax ID, and whose services are provided within the inpatient (POS 21) or outpatient (POS 22 and 23) setting, require Provider Registration to receive payment if contractually applicable. Mid-level hospital employees (billing under the hospital Tax ID) providing Covered Services must have a supervising physician participating with MVP.

Registered Nurse First Assistants (RNFA) who work exclusively in the hospital and are credentialed and privileged by the hospital require Provider Registration. MVP will not reimburse RNFAs for Covered services provided to an MVP Medicare member. RNFAs that are not working exclusively in the hospital, please see MVP's credentialing requirements.

If you have any questions regarding Mid-levels employed by the hospital and their registration requirements, please contact your contracting manager or Professional Relations Representative.

Opticians

Opticians must be contracted and complete Mid-Level/Ancillary Provider Registration. All opticians must have a valid New York State License (or Vermont, as applicable) to practice, and a copy of such license must be included with the Provider Registration. Opticians must receive registration approval before they see MVP Members. Opticians who will be billing independently for services do require an NPI for billing purposes. The Mid-Level/Ancillary Provider Registration form can be found [here](#) (click on *JoinMVP*).

Clinical Nutritionists and Dietitians

Clinical Nutritionists and Dietitians must be Credentialed and contracted with MVP, as outlined in the Credentialing section. These providers are not required to have a collaborating physician and can bill with their own TIN number. To request participation, complete the Provider Credentialing Application Request form found [here](#) (click on *JoinMVP*). Contracting is at the discretion of MVP. Clinical Nutritionists and Dietitians who are employed by a hospital are subject to the Hospital Based Mid-level rules detailed in this Section and require Provider Registration. If you have any questions regarding contracting or Provider Registration requirements, please contact your contracts representative or Professional Relations Representative.

OASAS Registration of Behavioral Health Providers

Behavioral Health Providers that are OMH licensed and OASAS certified program may be registered but shall still be subject to program integrity related information.

New York State Medicaid Enrollment Requirement

Federal law requires that all providers ordering, prescribing, referring, or certifying eligibility for services for members eligible to receive Managed Care Medicaid, HAPR and Child Health Plus to enroll in the New York State Medicaid Program. Providers must have an active Medicaid Management Information System (MMIS) number effective 7/1/18 or have applied for a MMIS number in order to be registered participating providers in MVP's Medicaid, HARP and Child Health Plus programs. Providers who do not obtain an MMIS Number will not be reimbursed for Covered Services provided to such members. If an MVP Participating Provider is terminated from, not accepted to, or fails to submit a designated enrollment application to the New York State Medicaid Program and obtain a MMIS number, the Provider shall be terminated from all Government Programs Plans. Please visit emedny.org to obtain an MMIS number.

Note: Contracting, Credentialing, and Provider Registration requirements may vary by state and product and are at the discretion of MVP. Providers should review their MVP Provider Services Agreement to determine if they have a contractual variation that will supersede this policy. Please refer to MVP Provider Toolkit for additional details on the contracting, Credentialing, and Provider Registration process, found [here](#).

Provider Complaints

MVP is committed to ensuring that Participating Providers have a positive experience with the MVP. Providers may formally voice concerns on any issue that has not been resolved in a timely matter. Providers can voice a complaint by contacting the Customer Care Center for Provider Services or their Professional Relations Representative.

Providers also may submit a complaint in writing to:

MVP Health Care
Provider Complaints
625 State Street
Schenectady, NY 12305

All Providers who formally voice a concern will receive a letter acknowledging that the complaint was received and will receive a resolution within 30 working days of MVP's receipt of the complaint.

Non-Participating Provider Joining a Participating Group

New providers joining a participating group should contact MVP to begin the credentialing process. New providers are considered non-participating until they have been fully reviewed and approved by MVP's Credentialing or have completed the MVP registration process.

Provider Communication

MVP will notify providers of all policy and procedure changes in a timely matter as stated in the provider's contract committee or have completed the MVP registration process.

Collecting Patient Responsibility

A Member's Co-payment is due at the time of service. Providers may collect Member's Co-insurance and Deductible only if the amount due is known to the Provider and the Member. The Provider should wait to collect Co-insurance and Deductible amounts until Claim and received the Remit from MVP indicating Member's Responsibility. Providers can check the Member's Deductible accumulator in the patient eligibility section of MVP's Provider Portal to determine if they will be responsible for the Deductible or if the Deductible has been met.

Providers can determine a Member's cost share by accessing the benefits display tool on the MVP Provider Portal. The MVP Provider Portal will indicate if the Member is responsible for a Co-payment, Co-insurance, or Deductible.

Participating Providers may only collect Members Co-pay, Co-insurance, or Deductible. Providers are contractually prohibited from billing Member surcharges if cost share is not collected at the time of visit.

Additional Provider Requirements for New York Medicaid

Pursuant to Federal and State law, the NYS DOH Standards Clauses and the Medicaid Model Contract, the following submissions and attestations are required for Medicaid Participating Providers:

Ownership and Disclosure Requirements

Facility Ownership and Disclosure Form

As required by federal law and the Medicaid Model Contract, all Medicaid Participating Provider facilities must complete and submit to MVP the NYS DOH Ownership and Disclosure Certification Form (“Facility O&D Form”) within five days of contracting with MVP.

The Facility O&D Form must be updated any time there is a change in direct or indirect ownership or controlling interest of five percent (5%) or more and/or a change in any directors, officers, agents, or managing employees of the facility within thirty-five (35) days of such change.

Participating Provider Owner/Manager Disclosure Certification Form

Pursuant to applicable federal and state law, and the NYS SOD Standard Clauses all Medicaid Participating Providers must complete and submit to MVP NYS DOH Owner/Manager Disclosure Certification Form within five (5) days of contract execution.

Participating Provider Attestation of Cultural and Linguistic Competency.

As required by OMH, OASAS, DOH, and the MMC, Participating Providers must demonstrate cultural competence and certify, on an annual basis, the completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers’ staff who have regular and substantial contact with Medicaid Members.

Disclosure Certification form. The Participating Provider Owner/Manager Disclosure Certification form can be found here ([click on Professional Relations Disclosure Forms](#)).

Disclosure of Criminal Activity Requirements

Medicaid Participating Providers must complete the Disclosure of Criminal Activity form found [here](#) (click on *Professional Relations Disclosure Forms*) within five days of contracting with MVP and updated any time there is a change regarding health care related criminal convictions of persons affiliated with the provider within five (5) days of becoming aware of a criminal conviction.

MVP shall report this criminal activity information to NYS DOH within twenty (20) days of being notified by a Medicaid Participating Provider of a criminal conviction. MVP will follow applicable regulatory requirements associated with the disclosure of this information, up to and including not executing a contract, or non-renewal or termination of any contracts with entities found not to be in compliance with this requirement.

Exclusion Database Monitoring Requirements

All Medicaid Participating Providers must have procedures in place to identify and determine the exclusion status of employees and staff associated with a Medicaid Participating Provider through checks of the following exclusionary databases and must routinely monitor exclusion status of such employees and staff:

MVP requires all Medicaid participating providers to monitor all employees and staff associated with the Medicaid participating provider against the following exclusionary databases on a monthly basis:

- U.S. Office of Inspector General’s List of Excluded Individuals and Entities (OIG-LEIE): [exclusions.oig.hhs.gov](https://www.exclusions.oig.hhs.gov)
- U.S. General Service Administration’s System for Award Management (GSA-SAM) (formerly known as the Excluded Parties List System (EPLS)): [sam.gov](https://www.sam.gov)
- New York State Office of the Medicaid Inspector General List of Restricted and Excluded Provider (OMIG Exclusion List): omig.ny.gov/search-exclusions

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- U.S. Department of the Treasury’s Office of Foreign Assets Control (OFAC) Sanction Lists (including the Specially Designated Nationals (SDN) List as well as the Non-SDN Palestinian Legislative Council List (NS-PLC List), the Part 561 List, the Non-SDN Iran Sanctions Act List (NS-ISA List), the Foreign Sanctions Evaders List (FSE List), the Sectoral Sanctions Identifications List (SSI List), and the List of Persons Identified as Blocked Solely Pursuant to Executive Order 13599 (13599 List)): treasury.gov/resource-center/sanctions/SDN-List/Pages/fuzzy_logic.aspx

MVP requires that all Medicaid participating providers complete an Attestation Regarding Monitoring of Exclusionary Databases annually. The Exclusionary Database Attestation can be found [here](#) (click on *Professional Relations Disclosure Forms*). Participating Providers must notify MVP any time an employee(s) or staff associated with the Participating Provider shows up on the exclusionary databases or as soon as the Participating Provider becomes aware of the change in the exclusion status. MVP will follow applicable regulatory requirements associated with the disclosure of this information, up to and including not executing a contract, or non-renewal or termination of any contracts with entities found not to be in compliance with this requirement.

MVP requires all Medicaid participating providers to monitor all employees and staff associated with the Medicaid participating provider against the following exclusionary databases on an annual basis:

- U.S. Centers for Medicare and Medicaid Services National Plan and Provider Enumeration System (NPPES): npiregistry.cms.hhs.gov/
- U.S. Social Security Administration Death Master File (Death Master): ssdmf.com

Note that the website addresses provided above are accurate at the time of publication but are subject to change from time to time by the respective controlling regulatory agencies.

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Overview

MVP and its Participating Facility Providers use industry-standard billing formats, which allow for efficient claims processing and an expedited adjudication of cleanly submitted claims. Facility Providers should refer to the rate sheet documents contained in their most current MVP agreement for the methodologies specific to that facility Provider's reimbursement.

Inpatient Hospital Services

The following represent the majority of inpatient stay categories for which payment rates may be distinguished:

- Medical/surgical
- ICU/CCU
- Obstetrical delivery
- Obstetrical-related care; non-delivery
- Newborn
- Neonatal intensive care
- Licensed, hospital-based skilled nursing facility
- Tertiary care exclusions
- Skilled nursing level
- Physical rehab
- Sub-acute level

Note: Payment rates are “all inclusive,” meaning that all services provided during the inpatient stay, including all pre-admission testing, will be paid at one rate. Except as defined in the agreement, MVP does not reimburse hospitals separately for any service provided during the inpatient stay. The hospital may elect to include the physician component in the inpatient per diem or case rates. The effective date of a hospital's rates is indicated on its rate sheet. Newborn reimbursement includes payment for the New York State-required newborn hearing screening.

Per diem services that overlap contract periods will be paid based on the rate effective on the applicable date of service. DRG and case rates will be paid based on the Member's admission date. MVP considers the member's inpatient hospital admission date to be the date and time the physician writes the order to admit to an inpatient level of care. MVP, in conjunction with facilities that have rate agreements, has reimbursement methodologies in place to process and pay different levels of inpatient care, as appropriate, within a hospital stay.

DRG Reimbursement Payment Methodology

DRG reimbursement is a payment methodology that reimburses select hospitals a lump sum payment for the entire admission to the facility. Facility pre-admission testing or outpatient services provided three (3) or more days immediately preceding and including the date of admission are included in the inpatient payment. MVP utilizes the NYS Department of Health All Payer Revised DRG reimbursement rules and methodologies in addition to MS DRG methodology reimbursement for MVP Medicare as outlined in the hospital's rate sheet documents. If Members require hospital services during the covered admission which are not available at the hospital, the hospital will be responsible for all costs of covered services provided at other facilities, including transportation to those facilities unless the member is discharged from the hospital prior to treatment. A hospital must notify MVP of all Member admissions within 24 hours of each admission or the first business day after each admission if the admission takes place on a weekend or MVP-recognized holiday (see [Concurrent Review](#) in *Utilization Management* for more details).

Outpatient Hospital Services

Examples of outpatient service types for which payment rates may be distinguished include:

- Ambulatory surgery/major
- Ambulatory surgery/minor
- Laparoscopic surgery
- Scope procedures
- Angioplasty
- Cardiac catheterization
- Observation stays
- Emergency room
- Electrophysiology studies
- Sleep studies
- Physical, occupational, and speech therapy
- Non-capitated lab services
- Non-capitated radiology services
- MRI/MRA
- PET and PET/CT
- Lithotripsy
- Hyperbaric chamber
- Wound care
- Other special case rates
- Other referred ambulatory services
- Other referred ambulatory services without CPT or HCPCS procedure code

“Per Visit” Outpatient Service Format

All surgeries, scope procedures, cardiac catheterization, lithotripsy, emergency room, observation bed, PT/OT/ST, sleep study services, and other services are subject to a “per visit” payment methodology. This methodology assumes that the payment rates are all-inclusive, which means all services provided during the outpatient visit are included in one case rate, including preadmission testing. Except as defined in the Agreement, MVP will not reimburse hospitals separately for any service provided during the outpatient visit. The hospital may elect to include the physician component in the “per visit” rates.

Hospital-Based Ambulatory Surgery

Hospital-based ambulatory surgery services are determined by the principal CPT procedure codes. CPT and HCPCS codes designated as ambulatory surgery are updated annually.

The payment rates for hospital-based ambulatory surgical procedures are all-inclusive and include all facility services directly related to the procedure within 24 hours of the surgery.

Reimbursement for hospital-based ambulatory surgical procedures is defined by the Provider contract. If the patient is admitted following the surgery, the hospital's ambulatory surgery services are inclusive to the payment terms of the inpatient service category.

Observation Status

Please refer to [Payment Policies](#), under *Observation Services for Facilities and Providers*.

Emergency Room

Emergency room services are defined by the applicable revenue codes 0450-0459 (excluding 0456). One of MVP's emergency room methodologies is a four-level program based upon diagnosis severity of an ER visit. The principal diagnosis submitted on the UB04 or Standard EDI Transaction (ANSI 837) will determine the ER level and thus the payment rate. The MVP Emergency Room classification system is updated annually to add new codes and remove deleted codes. If a patient is approved for an inpatient admission, ambulatory surgery, or observation of the ER, services are inclusive to the payment terms of those service categories.

Multiple Surgery Protocol – VT only

Refer to [Payment Policies](#) for information.

Other Referred Ambulatory Procedures

The laboratory, radiology, and other referred ambulatory procedures are defined as referred care not part of a “per visit” service type. MVP will only reimburse these procedures if they are not covered as part of an existing capitation agreement or other contract. It is important that hospitals follow the guidelines for billing and claims submission relative to the contract that is in place for these services. Under a fee schedule agreement, if a laboratory, radiology, or other referred ambulatory procedure is not covered as part of an existing contract, these procedures are to be reimbursed on a fee-max-based system. The fee-max-based system is based upon the resource-based relative value scale (RBRVS) for physician payment format. The RBRVS uses the federal system that assigns a relative value unit to CPT or HCPCS procedure codes multiplied by a negotiated “conversion factor” dollar amount.

The RBRVS RVUs MVP uses as well as the Clinical Lab Fee Schedule can be accessed at National Physician Fee Schedule Relative Value File from Medicare at [cms.gov](https://www.cms.gov). In the event that Medicare has not published an RVU for a given code, MVP will pay these codes at the all other referred ambulatory rates without CPT/HCPCS code at reasonable charges. Please refer to your rate agreement for further details. Under a fee-max-based system, the amount allowed shall not exceed billed charges.

On or about January 1 of each year, MVP will update the MVP Fee Schedule to be consistent with the regionally or nationally adjusted Medicare Fee Schedule most recently updated during the immediately preceding calendar year. Such updates shall not be retroactive.

Free-Standing Ambulatory Surgical Centers

Services provided at free-standing ambulatory surgical centers are determined by the principal CPT procedure code detailed on the CMS-1500 claim form or the Standard EDI Transaction (ANSI 837). CPT and HCPCS codes designated as ambulatory surgery are updated annually.

Reimbursement for free-standing ambulatory surgical center procedures is defined by the Provider contract. Unless specifically contracted, reimbursement for professional services is not included.

Urgent Care Centers

Services provided at urgent care centers are determined by the place of service code detailed on the CMS-1500 claim form or the Standard EDI Transaction (ANSI 837). CPT and HCPCS codes are updated annually.

Reimbursement for urgent care center procedures is defined by the Provider Agreement.

OMH-licensed or OASAS-certified ambulatory behavioral health services

Notwithstanding anything to the contrary in a Participating Provider’s provider services agreement, Participating Providers shall be reimbursed in accordance with the applicable ambulatory patient group (“APG”) rate-setting methodology or other government rates established and published by the New York State Office of Mental Health (“OMH”) or New York State Office of Alcoholism and Substance Abuse Services (OASAS) as required for certain services, including OMH licensed or OASAS certified ambulatory behavioral health services and outpatient mental health services at Article 28 hospital-based and free-standing clinics, Article 31 and Article 32 outpatient clinics, and rehabilitation and Opioid Treatment Programs, regardless of billed charges and/or any other rates identified in the Participating Provider’s fee schedules. Therefore, any requirement, in either Participating Provider’s provider services agreement or fee schedules, that participating Provider be paid the lesser of billed charges or the rates set forth in the Provider services agreement or fee schedules, is not applicable to claims for those certain services which are required to be reimbursed using the APG methodology or other required government rates.

Laboratory Data

Overview

Laboratory data is essential to MVP’s HEDIS, risk and clinical operations and analytics. A secure file transfer process will be established to allow for seamless transfer of laboratory data to MVP.

Required Data Requirements

Table 1 contains the rules for the data elements that must be sent to MVP.

Table 1 Required Data Requirements

Area	Definitions	Comments
Content/File data Format	List of Data elements E.g. Date of Service, Member ID, LOINC, etc.	See Table 2 below
Naming Convention	Vendor name and date	
File Frequency Requirement	How often/what date file is sent to MVP.	Monthly
Transmission Schedule	Date and time the file sent.	Suggest 20th of the month at 9 am
Transmission Requirements	Protocol by which the data will be sent.	SFTP
Encryption	Encryption to be used.	PGP Encryption
Aggregation/Compression	Type of compression to be used	Zip

Area	Definitions	Comments
General file characteristics	Encoding of the file.	All upper case, ASCII Tilde (~) delimited, cr/lf line terminations
Sensitivity	Does this file contain PHI; PII; STI/Substance Abuse data, or other information requiring special handling?	

Required Data Elements

The following fields must be submitted in laboratory data feeds transmitted to MVP. MVP wants to receive all laboratory tests conducted on their Members in their monthly submissions.

Table 2 Required Data Elements

FIELD	DESCRIPTION	FILE FORMAT
Member ID		String (11)
Name	(Last Name, First Name MI)	String (<255)
Date of Birth	Date of birth formatted as 'MM/DD/YYYY'	String (10)
Lab ID	Site of Service location	String (<255)
Ordering Provider	If known, formatted as Last Name, First Name, MI, Credential: e.g. Smith, John, A, MD	String (<255)
DOS	Date of service formatted as 'MM/DD/YYYY'	String (10)
CPT/HCPCS Procedure Code	CPT or HCPCS Procedure Code	String (10)
LOINC	LOINC	String (20)
Result	Test results	String (<255)
Principal diagnosis code	If available	String (<255)
Lab test panel code	Two sample values: 52142E, 15981X	String (20)
Lab test panel name	Two sample values: "HETEROPHILE, MONO SCREEN", "CELIAC DISEASE COMP PANEL"	String (<255)
Lab test code	Two sample values: 4011, 5620	String (<255)
Lab test desc	Two sample values: "HETEROPHILE, MONO SCREEN", "TISSUE TRANSGLUTAM AB IGA"	String (<255)
Reference range desc	Two sample values: Negative, <5	String (20)
Reference range low value	Two sample values: 0000011000000, 0000003800000	String (<255)
Reference range high value	Two sample values: 0000011000000, 0000003800000	String (<255)

MVP Laboratory Contact

Should you have questions about the process to establish a laboratory feed or its content, please contact Ruth Leslie at rleslie@myhealthcare.com or **518-388-2026**.

Pharmacy Benefits

Pharmacy Benefits

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Pharmacy Benefits Manager

CVS Caremark is MVP's pharmacy benefit manager (PBM) for all retail and mail order prescriptions. This applies to all MVP products that offer prescription drug coverage. The CVS Mail Order Pharmacy, part of the CVS Caremark family of pharmacies, is the mail order pharmacy vendor MVP uses to fill prescriptions for maintenance medications for MVP products that have a mail order benefit.

Prescription Drug Benefits

MVP offers multiple different prescription drug benefit options. The CVS Caremark claims system is configured to adjudicate these different benefits as well as program-mandated prescription drug coverage. Most drug plans have prior authorization, step therapy, or quantity limit requirements on select medications. Refer to the MVP formularies on the website for a complete list of drugs that are subject to pharmacy management programs.

Pharmacy and Therapeutics (P&T) Committee

MVP's P&T Committee is composed of physicians from multiple specialties and primary care, practicing pharmacists, and MVP staff. The committee uses utilization, pharmacoeconomic, and clinical information to develop drug inclusion/exclusion criteria. Each new drug* requires prior authorization for at least six months. For the Medicare Part D formulary, new drugs may be excluded until the next benefit year. The P&T Committee evaluates the value of adding or excluding a new drug to the formulary based upon whether or not the new drug offers significant clinical and therapeutic advantages over current formulary drugs. The committee also designates in which coverage tier a specific drug is placed and reviews all policies and drug classes at least annually.

*A "new drug" is defined as a new molecular entity or biosimilar; a new route of administration; a new dosage form, formulation, or delivery system; a combination of currently approved drugs; a drug with potential safety and/or efficacy issues; and a drug that has the potential for inappropriate utilization.

Formularies

The formulary is a guide to use when prescribing medications for members. The drugs listed on the formulary are intended to provide sufficient therapeutic options for most situations. The formulary is available in several formats:

- The most current printed version is available on the MVP website at mvphealthcare.com.
- Periodic updates are published in the *Healthy Practices* newsletter and/or sent to provider offices via FastFax. Updates also can be found on the MVP website.

Commercial Prescription Drug Formulary

The MVP Commercial formulary applies to members with employer-sponsored large group or select self-funded (ASO) prescription drug coverage, and children covered under the Child Health Plus plan (CHP).

The formulary is divided into three tiers:

- Tier 1 generally includes preferred generic drugs.
- Tier 2 includes covered brand name drugs chosen for their overall value.
- Tier 3 includes all other covered prescription drugs and all new drugs* that are under review. Tier 3 is non-formulary for CHP and requires prior authorization for coverage.

The Federal Employee Health Benefits (FEHB) Program is divided into four tiers:

- Tier 1 includes most generic drugs.
- Tier 2 includes preferred brand name drugs, select high cost generic drugs, and preferred specialty drugs.
- Tier 3 includes non-preferred brand name drugs.
- Tier 4 includes non-preferred specialty drugs.

MVP Marketplace Prescription Drug Formulary

The MVP Marketplace formulary applies to members with employer-sponsored small group or individual-purchased through MVP or the state Exchange, or Essential Health Plan prescription drug coverage.

The formulary is divided into three tiers:

- Tier 1 generally includes preferred generic drugs.
- Tier 2 includes covered non-preferred generics and brand name drugs chosen for their overall value.
- Tier 3 includes all other covered prescription drugs and all new drugs* that are under review.

Members in select Essential Health Plan pharmacy benefits may have coverage of some over-the-counter medications.

MVP Medicaid Prescription Drug Formulary

This Formulary is a guide to use when prescribing medications for MVP Medicaid/HARP members. This formulary promotes the use of generic medications. The formulary is available in several formats.

The MVP Medicaid formulary is divided into two tiers:

- Tier 1 includes all generic medications.
- Tier 2 includes formulary brand medications selected for their overall value.

Non-formulary drugs require prior authorization from MVP. Some drug classes such as erectile or sexual dysfunction drugs, weight loss drugs, drugs used to treat infertility (except tamoxifen, letrozole, bromocriptine, and clomiphene), cough and cold products, cosmetic, marked “sample” or “not for sale,” DESI drugs, non-FDA approved drugs (NDA/ANDA/BLA), used for radiological testing, packaged in unit dose when bulk packaging is available, regularly supplied to public free of charge, and viscosupplementation products are excluded from coverage. Drugs (legend and OTC) and supplies which are not covered under the NYS Medicaid Formulary is not covered.

Atypical antipsychotics, antidepressants, anti-rejection, anti-retroviral, select endocrine (including but not limited to growth hormones, diabetic drugs, and insulin and pancreatic enzymes), hematological, multiple sclerosis, and anti-seizure agents will be subject to Prescriber Prevails provisions. This enables the prescriber’s reasonable professional judgment to prevail in the prior authorization process for atypical antipsychotics. When the plan is unable to complete a prior authorization due to missing information or because the prescriber’s reasonable professional judgment has not been adequately demonstrated, either by consistency with FDA approved labeling or use supported in at least one of the Official Compendia as defined in federal law under the Social Security Act section 1927 (g)(1)(B)(i), the plan will issue a Notice of Action to the provider and member.

The MVP Medicaid benefit includes coverage for select over-the-counter medications, diabetic management supplies, enteral products, and some medical supplies. Coverage is limited to a 30-day supply of medications at a participating retail pharmacy. Mail order is not a covered benefit. Specialty medications may be obtained from CVS Specialty Pharmacy, MVP’s specialty pharmacy vendor, or a contracted specialty retail pharmacy.

The formulary exception and prior authorization process are the same as for Commercial, Marketplace, and Medicaid members. Prescribing Providers should use existing MVP prior authorization forms found on our website.

All prior authorization and formulary exception requests for MVP Medicaid members can also be submitted on the Medicaid standardized prior authorization form. This form can be found on our website at mvphealthcare.com/providers/forms.

Formulary Indicators

These indicators are common across multiple formularies. Each formulary may also contain additional indicators. Please refer to the descriptions noted within the formulary for additional information.

- **Mail** – Those medications listed with an asterisk (*) are available via mail order.
- **Step Therapy (ST)** – Certain drugs requiring prior authorization have a step therapy edit in place to systematically allow a claim to process if certain criteria are met. These edits are supported by MVP benefit interpretations that are available in the MVP's Provider Portal. Prior authorization is required if step therapy edits are not met. Step therapy clinical reviews will use recognized evidenced-based and peer-reviewed clinical review criteria that is appropriate for the medical condition.
- **Prior authorization (#)** – Requests for drugs requiring a prior authorization must be submitted through the Pharmacy Department using the Medication Prior Authorization Request form and faxing it to **1-800-376-6373** for Commercial, Marketplace, and Medicaid members. Benefit interpretations containing applicable prior authorization criteria are available from MVP and are available in the MVP Provider Portal.
- **Quantity Limit (q)** – Certain drugs have quantity limitations or durations. Benefit interpretations containing the applicable prior authorization criteria are available from MVP.
- **Specialty Medications (+)** – Certain drugs must be obtained from the MVP specialty pharmacy vendor or contracted specialty pharmacy.
- **Medical (M)** – A prescription drug rider is not required for coverage. If the provider does not buy and bill, the drug must be obtained from CVS Specialty or other contracted Specialty provider.
- **Excluded Drug (EX)** – Excluded drug; medical exception approval required.

The above indicators are common across multiple formularies. Each formulary may also contain additional indicators. Please refer to the descriptions noted within the formulary for additional information.

MVP Medicare Part D Prescription Drug Formulary

There are two MVP Medicare Part D formularies which apply to all members with Part D prescription drug coverage. There is a formulary for Medicare Advantage plans with coverage through a former employer and a formulary for Individual Medicare Advantage Plans (plans purchased directly by the member). The Part D formularies are a guide to use when prescribing medications for members. The drugs listed in the formularies are intended to provide sufficient therapeutic options for most situations.

The Part D formulary is divided into five tiers:

- Tier 1 includes select generic drugs for diabetes, blood pressure control, bone health, heartburn, and ulcers. The drugs in Tier 1 are provided at little to no cost.
- Tier 2 includes non-preferred generic drugs.
- Tier 3 includes non-preferred generics and preferred brand drugs that have the lowest cost share for brand name drugs.

- Tier 4 includes non-preferred brand name and non-preferred generic drugs. In addition, Part D drugs excluded from the formulary must go through an exception process in order for MVP to cover them. If they are approved, they will be covered in Tier 4.
- Tier 5 (Specialty tier) includes most drugs (brand name and generic) that cost \$670 or more for a 30-day supply. All drugs in this tier are restricted to a 30-day supply at retail and are excluded from the mail order program.

The Medicare Part D formularies exclude most new drugs and most drugs with a generic equivalent (as determined by the FDA). These drugs may be obtained through the Formulary Exception Procedure (see below). Medicare regulations also require that certain drug classes not be covered: DESI drugs, unapproved drugs (approved via NDA/ANDA/BLA), drugs used to treat sexual dysfunction (including erectile dysfunction), and drugs used to promote weight gain or loss. Brand name drugs manufactured by companies that did not sign the Medicare Coverage Gap agreement are not eligible to participate in the Medicare Part D program. Some enhanced Part D riders may include coverage of Medicare Part D excluded drugs, including drugs for weight loss or weight gain, or erectile dysfunction medications. Prior authorization criteria and quantity limits for these medications follow the Commercial pharmacy policies.

Members and providers may view MVP's Medicare Part D Pharmacy Management programs on the MVP website at content.mvphealthcare.com/medicare/index.html. Requests for Prior Authorization and Formulary Exceptions should be submitted using the MVP Prior Authorization form or the Medicare Part D Coverage Determination form and faxing the completed form, including the physician supporting statements, to **1-800-401-0915**.

Formulary (Medicare Part D) Indicators

- **Prior Authorization (PA)** – MVP requires prior authorization for certain drugs.
- **Quantity Limits (QL)** – For certain drugs, MVP limits the amount of the drug that we will cover. For example, MVP covers one tablet per day for Linzess®. This limit may be applied to a standard one-month or three-month supply.
- **Step Therapy (ST)** – In some cases, MVP requires certain drugs to treat a medical condition to be tried before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, MVP may not cover Drug B unless Drug A is tried first. If Drug A does not work, MVP will then cover Drug B.
- **Dispensing Limits (DL)** – Certain drugs are limited to a 30-day supply through a retail pharmacy and are not available through the mail order pharmacy.
- **Limited Availability (LA)** – Some medications are available only through a designated Specialty Pharmacy because of manufacturer limited distribution.
- **Part B versus Part D drug coverage (B/D)** – Some drugs could be covered under the Part B or Part D benefit, depending on the specific member situation. This means that a request must be submitted to MVP to determine, based on Medicare guidelines, if the drug will be covered as Part B or Part D.
- **Not available at mail-order (NM)** – Certain drugs are not available through the mail order pharmacy.

Medicare Medical Injectables and Vaccines

Most injectable medications, including all vaccines (**except Part D vaccines for Medicare members), administered in a provider's office must be obtained by the provider and billed to MVP on the appropriate billing code (i.e., J-code), unless otherwise specified. Office-administered injectable medications should not be purchased at the retail

pharmacy by the member and transported back to the office; these medications are not covered under the member's prescription drug benefit when obtained at a retail pharmacy. Physician-administered injectables may be covered under the member's Medicare Part B benefit and applicable co-insurance. Review the Medicare Part D formulary at mvphealthcare.com, which includes injectable medications that may be covered under the Medicare Part D benefit. Most home infusion medications are covered under the Medicare Part D benefit and billed to the PBM.

****For Medicare members:** All commercially available vaccines will be covered under the Part D pharmacy benefit only (unless excluded as a Part B benefit, such as pneumococcal and influenza vaccines). This also includes the administration fees associated with the vaccinations. **All Part D vaccines and vaccine administration fees must be billed through CVS Caremark.** Since physician offices may not be able to bill CVS Caremark directly, Medicare members with a Part D rider may need to pay the provider for the vaccine and administration fee and then submit a reimbursement claim directly to CVS Caremark. Members will be reimbursed the negotiated rate minus their applicable co-payment for these vaccines. Reimbursement forms are available at mvphealthcare.com.

Providers now have an online option for processing Medicare Part D vaccine claims electronically. **TransactRx Part D Vaccine Manager**, a product of Dispensing Solutions Inc., provides physicians with real time claims processing for in-office administered vaccines. This new online resource helps to reduce the current challenges in providing Medicare Part D vaccines and vaccine administration reimbursement to our members. Enrollment in TransactRx is available at no cost to providers. Simply complete the one-time online enrollment process at mytransactrx.com/ws_enroll.

For questions related to enrollment or claims processing, contact Vaccine Manager Support at **1-866-522-3386**.

When to Contact MVP's Pharmacy Department

The following are examples of when to contact the Pharmacy Department under either urgent or routine circumstances:

- Medications requiring prior authorization (including medical drugs listed on the formulary)
- Medications that are not on the formulary, on MVP's excluded drug list, or when requesting coverage of a non-formulary drug when the member has a two-tier prescription drug benefit*
- Medications subject to step therapy when criteria are not systematically met
- Medications that are subject to quantity limitations or durations
- Member with an existing authorization and changes to a different MVP benefit will require a new authorization (e.g., Essential Health Plan to Medicaid, Commercial to Medicare, etc.)

*For members with a two-tier prescription drug benefit (MVP Medicaid or MVP Child Health Plus), a prior authorization for non-formulary agents will be considered in accordance with criteria listed in the Formulary Exception Policy and noted below. The form must be completed and the request approved before the member fills the prescription at the pharmacy. Medicare members requesting a formulary exception request for non-formulary drugs or drugs with a quantity limit will follow the Medicare Formulary Exception process.

Incomplete information on the request may result in a decision delay or denials. The provider must fax the completed form to the appropriate fax number listed on the form. Forms must include the signature of the prescriber or an attestation from the prescriber attesting that the information on the submitted form is complete, accurate, and available for review if requested. All urgent requests must be marked "Urgent" at the top of the form. The turn-around time for urgent requests is typically 1 business day from MVP's receipt of the request and 3 business days for non-urgent requests. Medicaid retail pharmacy requests are reviewed within 24 hours of receipt of a completed request. See Coverage Determination for Medicare Members below for the applicable Medicare Part D timeframes.

For NY Commercial, NY Marketplace: A Step Therapy protocol determination will be made within 24 hours (urgent) or 72 hours (standard) of the receipt of a supporting rationale and documentation. Marketplace and Large Group requests for non-formulary drugs: a determination will be made within 24 hours (urgent) or 72 hours (standard) of the receipt of a supporting rationale and documentation.

Only the prescriber responsible for the treatment and evaluation of the member, an authorized agent, member, or member's authorized representative may initiate a prior authorization or coverage determination. An authorized agent is someone who is an employee of the prescribing practitioner and has access to the member's medical records (e.g., nurse, medical assistant, etc.). An authorized representative is someone who has been designated by the member to represent them for a specific healthcare decision via a Power of Attorney (POA) or Authorization of Representation (AOR) form. Pharmacists, pharmacies, third-party vendors, or other patient advocacy personnel are not eligible to initiate a prior authorization or coverage determination. Requests from these providers will not be accepted or acknowledged as received. Prescribers excluded by CMS, OIG, OMIG, or other regulatory entity will be deemed "excluded" and prescriptions will reject at the PBM.

No payment will be made for prescriptions filled or services rendered prior to the approval of a prior authorization request. Members may be allowed a 72-hour emergency supply of medication while awaiting review for a prior authorization or formulary exception request or receive a seven-day emergency supply of a substance use medication (Medicaid/HARP members).

For information on lost/stolen/damaged medications and vacation overrides, please refer to the Pharmacy Programs Management Policy.

Pharmacy Forms

All pharmacy-related prior authorization forms are available at mvphealthcare.com on the Provider page under Forms. Forms should be faxed to the phone number on the bottom of each form.

Formulary Exception Process

There may be occasions when a non-formulary medication is medically necessary. In such cases, the appropriate medication may be obtained through the MVP Formulary Exception Process as follows:

1. The provider completes the *Prior Authorization Request Form for Medication* before the member fills the prescription at the pharmacy.
2. The provider faxes the completed form and all necessary clinical documentation to support the medical necessity for the exception to the appropriate fax number listed on the form. A letter containing the decision to approve/deny the request is sent to the provider and the member, preceded by a phone call. Although circumstances may vary, reasons for approving an exception may include documented:
 - Allergic/adverse reaction to all formulary agents
 - Therapeutic failure of all clinically appropriate formulary agents
 - Patient therapy stability issues where a formulary agent is contraindicated or a change in therapy is inadvisable
 - Patient-specific contraindication or reason formulary agents are inappropriate
 - Policy and/or benefit interpretation
 - Member contract and/or prescription drug rider
3. "Sample" use alone does not satisfy criteria.

Step Therapy Program (NY Commercial, NY Exchange, and NY Medicaid)

Prior authorization requests for drugs requiring Step Therapy will use recognized evidenced-based and peer-reviewed clinical review criteria that is appropriate for the medical condition of the member.

Supporting rationale and documentation: A step therapy protocol override prior authorization request will be granted when it includes supporting rationale and documentation from a requesting health care professional, demonstrating that:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the member
- The required prescription drug is expected to be ineffective based on the member's known clinical history, condition, and prescription drug regimen
- The member has tried the required prescription drug while covered by MVP, or under previous health insurance coverage, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event
- The member is stable on a prescription drug selected by the requesting health care professional for the medical condition, unless the required prescription drug is an AB-rated generic equivalent
- The required prescription drug is not in the member's best interest because it will likely cause a significant barrier to adherence to or compliance with the member's plan of care, will likely worsen a comorbid condition, or will likely decrease the member's ability to achieve or maintain reasonable functional ability in performing daily activities

Coverage Determination Procedure for Medicare Members

Coverage determination requests may be submitted on one of the MVP Prior Authorization Request forms or by using the Medicare Part D Coverage Determination Request form and faxed to **1-800-401-0915** or submitted via the online Medicare Coverage Determination form. Coverage determinations are requests required for:

- Drugs that require prior authorization
- Drugs subject to Step Therapy
- Part D drugs that are excluded from the formulary
- Quantity limits that are in excess of the formulary allowed amount
- Tier exceptions (requests to cover a drug at a lower tier co-pay than what is listed on the formulary)

Coverage determination requests for drugs that require prior authorization or step therapy will be reviewed and a decision made within 72 hours of the receipt of the request unless the request is marked "URGENT," in which case the request will be reviewed and a decision made within 24 hours.

Coverage determination requests to cover an excluded Part D drug, a quantity that exceeds the allowed amount, or a request to cover a drug at a lower-tier co-pay must be accompanied by a supporting statement from the prescriber. Requests submitted without the supporting statement will be placed on a "pending" status for a decision until the information is received, but no longer than 14 days from the receipt of the request. Supporting statements may include:

- Rationale why all other drugs included on the formulary have not been or would not be as effective, or would cause adverse effects compared to the non-formulary (higher tier) drug, formulary excluded drug, or drug requiring step therapy. (Tier exceptions to generics only cost share tier and drugs within the specialty tier to a lower cost share tier are excluded. Approved formulary exceptions are also

exempt from tier exceptions.) The number of doses available has not been effective, would likely not be effective, or would adversely affect the drug's effectiveness.

Mail Order Pharmacy

MVP members (excluding MVP Medicaid, MVP Child Health Plus, some MVP Marketplace and Essential Health Plan, and some MVP Select Care [ASO] members) may use the mail service option when filling prescriptions. Mail service includes home delivery of medications. In most cases, there are member co-payment savings by ordering a 90-day supply. When prescribing a drug eligible for the mail order program for the initial order, the MVP member may ask the provider to send two electronic prescriptions. One is for up to 30 days to be filled at a local pharmacy. The other can last up to 90 days, with refills for up to one year, and can be filled through the CVS Health Mail Order Pharmacy, part of the CVS Health family of pharmacies.

MVP recommends that an order be placed two to three weeks before medications are needed to save on rush delivery charges and avoid possible problems if the shipment is delayed. Not all prescription drugs are eligible to be filled through the Mail Order Pharmacy. Please refer to the MVP formularies to determine if the drug is eligible to be filled through the Mail Order Pharmacy.

Brand/Generic Difference Program

When a health care provider writes a prescription for a brand name drug and indicates “dispense as written” and there is a Food and Drug Administration (FDA) approved generic equivalent, the member will be responsible for paying the generic co-pay plus the difference between the cost of the brand and generic drug. This Brand/Generic Difference program helps encourage the use of generic drugs over brand name drugs. This does not apply to all MVP prescription benefits. Please refer member to their prescription rider to determine if a co-pay penalty applies.

Note: Co-payment reduction for medical necessity for Commercial and Marketplace members may be submitted for medications subject to the brand/generic penalty only. Criteria must meet that listed in the MVP Co-payment Adjustments for Medical Necessity policy. Requests should be submitted on the *Medication Prior Authorization* form and specifically marked “Co-payment Adjustment.”

CVS Specialty Pharmacy

CVS is MVP's specialty pharmacy provider for select self-injectable and oral medications. Many specialty medications require prior authorization, which is obtained directly from MVP through the process described above. Prescription orders may be placed with CVS Specialty via fax, phone, or mail. Use CVS Specialty's toll-free fax at **1-800-323-2445**, or call **1-866-444-5883**. Refer to the MVP Formularies to determine if a medication must be obtained from CVS Specialty. Once the order is placed, CVS Specialty will contact the member to set up an account and arrange for delivery. Free delivery is available to the member's home or provider's office. CVS Specialty also offers educational support, compliance monitoring, adherence counseling, and coordinated care with the provider's office regarding these medications. Ancillary supplies, such as syringes and needles, may be provided to members at no additional charge.

Compounded Prescriptions

For all lines of business except Medicare Part D, compounded prescriptions more than \$100 require prior authorization from MVP. Compound medications containing bulk powders and non-covered medications are not covered. In addition, these prescriptions are non-formulary and tier 3 (Commercial and Marketplace members). Bulk powders and non-covered drugs (OTC, excluded, etc.) are not covered. Refer to the MVP Compounded Medication BIM for additional information.

Onco360

For those unique situations where a physician is administering an oncology drug in the office setting and is not able to obtain the medication through their supplier, MVP has contracted with Onco360 to provide a select list of oncology medications. More information on Onco360 and the medications they can deliver can be obtained from your Professional Relations representative.

Benefit Coverage (Commercial, Exchange, and Medicaid unless otherwise noted)

Most contracts and prescription drug riders allow for coverage of legend (prescription required), FDA-approved medications (FDA approved via NDA/ANDA/BLA) that are reasonably self-administered. The PBM system is configured to process these medications at the pharmacy point-of-service and for the claim to take the appropriate co-pay, co-insurance, deductible etc. Some contracts and/or riders prohibit coverage for certain drugs classes (i.e., cosmetic agents, drugs used to treat erectile dysfunction). The PBM system is also configured to deny coverage for these drugs as appropriate.

1. OTC Equivalent Program

Legend drug products that have an over-the-counter (OTC) equivalent are not a covered pharmacy benefit unless medically necessary. Examples of drugs that are subject to this program include but are not limited to: ammonium lactate topical, benzoyl peroxide, diphenhydramine, meclizine, butenafine topical, ketotifen fumarate, fluticasone nasal spray, and polyethylene glycol 3350.

2. Physician Administered Medications

- a. Generally, it is the physician's responsibility to "buy-and-bill" medications that are administered in the office or another similar place-of-service unless other specified. The CVS Caremark system is not configured to allow physician administered medications to process at a pharmacy. This includes chemotherapy drugs and vaccines (except for Medicare Part D vaccines, see Medicare Part D section). In rare circumstances when a physician is unable to obtain a drug, he/she should contact the Plan for a case-by-case determination and applicable override. The Plan reserves the right to determine whether a medication is usually physician administered and reimbursable under the medical benefit. Physician administered medications that are mandated to the Plan's Specialty Pharmacy vendor should be billed on-line to CVS Caremark directly by the Specialty Pharmacy.
- b. Generally, when a physician gives a patient an oral medication, these drugs are excluded from coverage since the form of the drug is self-administered. Similarly, if a physician gives a patient an injection that is usually self-injected this drug is excluded from coverage, unless administered to the patient in an emergency situation.

3. Diabetic Drugs and Supplies

These drugs (including oral and injectable hypoglycemics and insulin) and supplies (including test strips, lancets and insulin pump supplies) are generally covered under the Commercial member's medical plan per applicable state mandates. The PBM system is configured to process these drugs and supplies and therefore claims should be billed online to CVS Caremark. The applicable diabetic co-payment(s) will apply. Preferred diabetic insulins, meters and test strips may apply. Refer to the applicable formulary for a list of preferred products.

4. Preferred Home Infusion Vendors

Select medications may be required to be obtained through a preferred home vendor. Access and medical exception requests for use of an alternative vendor must be submitted to the Plan for medical necessity review.

5. Drugs used in coordination with a medical procedure

Drugs used in coordination with a medical procedure will be deemed to be inclusive of the procedure billing, unless the sole purpose of the procedure is the administration of the drug.

6. Oral or self-administered drugs part of a Medicare transitional add-on payment arrangement

Oral or self-administered drugs which are included in a Medicare transitional add-on payment arrangement (e.g., ESRD PPS) are subject to member's Part B co-insurance/co-pay (commensurate with the co-payment associated with dialysis services) and the member's selection of the site of service for the provision of these drugs. Drugs which are covered under a Medicare consolidated billing arrangement cannot be billed to the member or the plan separately.

7. Emergency supply of a medication

Members may be eligible for a 72-hour emergency supply of a medication when an emergency condition, including an emergency behavioral health condition, exists and access to an emergency seven-day supply (seven-day supply for Medicaid and HARP members) of a medication for the management of opioid withdrawal and/or stabilization. Medicaid Members will be eligible to receive a 72-hour emergency supply of a medication for an emergency behavioral health condition.

Pharmacy Network

An extensive network, including thousands of pharmacies throughout the United States, is available to most Members; while a more limited network of pharmacies is available to those Members enrolled in the MVP Medicaid/HARP and Essential Plan products. Covered drugs filled at a participating pharmacy are subject to the Member's applicable co-pay(s) as defined by his/her pharmacy benefit. For information on Plan-participating pharmacies, refer to mvphealthcare.com/Medicare.

Opiate Management Programs

Prescribers should review prescription claims in the state Prescription Monitoring Program (e.g., iSTOP) prior to prescribing opiate prescriptions. Use of an opiate prescription for greater than 3 months requires a current provider-patient treatment agreement and documented pain management treatment plan. Cancer patients not in remission, patients receiving hospice or end-of-life care, or being treated as part of a palliative care service are exempt from this requirement.

Behavioral Health

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Behavioral Health Management Overview

MVP's new model of care is focused on integrating medical and behavioral health as equal components of a person's overall wellbeing. MVP's Integrated Health initiative is designed 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
- All fully insured plans in Vermont and New York (HMO, POS, EPO, PPO, Indemnity, and government programs including Medicaid Managed Care, HARP, Child Health Plus, and Medicare)

For questions related to Behavioral Health Services contact us at **1-800-684-9286** and listen for the Behavioral Health prompt.

Communication and Coordination of Care with PCPs

MVP strongly encourages behavioral health Participating Providers to communicate with the Member's PCP. This allows both health care providers to have a complete overview of the Member's health issues and concerns, in addition to coordinating any medications the Member might receive.

MVP recognizes that, after a discussion of the importance of coordination of care, some Members may not allow their behavioral health information to be shared with their PCP. This declination should also be documented in the Member's medical record.

MVP's Mental Health Consultation form for behavioral health providers should be used to communicate with Member's PCPs. The *Mental Health Consultation* form can be downloaded by visiting mvphealthcare.com/providers and selecting *Forms*, or by calling your local Professional Relations department.

MVP requires contracted Behavioral Health providers to review a release of information (ROI) with Members prior to the onset of treatment and that any communication between a Behavioral Health provider and PCP is documented in the Member's medical record.

Behavioral Health Services Programs

MVP Behavioral Health Advocates

MVP offers its Members the services of behavioral health Advocates, who are trained to assist MVP Members in accessing their behavioral health benefits, by supplying them detailed, accurate, and current information regarding treatment options in the Member's area, Utilization Review determinations and processes, Medical Necessity criteria, and Appeals.

Medicaid Health Homes

MVP's Health Home Program provides care management to all HARP and qualified adult and children Medicaid Members. HARP and qualified Medicaid Members will be assigned to Health Homes that will be responsible for coordinating all their care. Health Homes facilitate the development of a Plan of Care that integrates all aspects of a Member's health. For detailed information on Medicaid Health Homes, please see the Health Home Program in the [Government Programs](#) Section.

Health and Recovery Plan

Health and Recovery Plan (“HARP”) offered through MVP’s Harmonious Health Care Plan is designed to meet the unique needs of adult Medicaid Members living with a serious mental illness or Substance Use Disorder by integrating physical health, Behavioral Health and Substance Use Disorder services. For detailed information on Health and Recovery Program, please see the Health and Recovery Program in the [Government Programs](#) Section.

Children’s Home and Community Based Services

Children’s and Family Services and Supports, Medicaid Managed Care Children’s Home and Community Based Services (“CHCBS”) provide opportunities for Medicaid Members under the age of 21 that have Behavioral Health needs and/or medically complex conditions to receive Covered Services in their own home or community. For detailed information on CHCBS, please see the CHCBS in the [Government Programs](#) Section.

Harm Reduction Services

Harm Reduction Services (“HRS”) are provided for Medicaid Members addressing overdose prevention and response and preventing transmission of HIV, Hepatitis B and C, and other illnesses in members with Substance Use Disorders. For detailed information on HRS, please see HRS in the [Government Programs](#) Section.

Behavioral Health Utilization Management (UM)

Medical Necessity

MVP’s Medical Necessity Criteria for behavioral health consists of InterQual and Clinical Criteria guidelines provided by New York State (for ACT, PROS, Adult HCBS, Children’s HCBS & CFTSS). For NY Members receiving substance use services, MVP uses the most current version of the New York State Office of Addiction and Services Support (“OASAS”) Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) for Medicaid, HARP, Commercial, CHP and Essential Plan Members for all levels of care when treatment is provided within New York state. For all other lines of business and when treatment is provided outside of New York state, InterQual criteria is utilized for substance use.

For ASO and fully-insured plans, MVP provides, subject to medical necessity, unlimited benefits for inpatient and outpatient Behavioral Health care, as well as for residential treatment for Behavioral Health conditions, except for family counseling services, which may be capped at 20 visits per year.

For Medicare plans, MVP provides, subject to medical necessity inpatient and outpatient behavioral health care services. There are some limits to inpatient mental health care based on place of service. There is a 190-day lifetime limit of inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Otherwise all inpatient and outpatient services are unlimited days. The Medicare portfolio does not provide coverage for residential behavioral health services.

The criteria for Medical Necessity determinations made by MVP regarding behavioral health benefits are made available: (i) on a website accessible by MVP Participating Providers; and (ii) upon request, to any current or potential participant, beneficiary, or contracting provider.

Authorization/Notification Requirements

For all lines of business, excluding self-funded plans, MVP requires notification for all Inpatient and Residential Mental Health and Substance Use Treatment admissions. Providers are expected to notify MVP within two business days of admission by completing the necessary forms and when indicated, submitting supporting clinical information. Forms may be accessed by visiting mvphealthcare.com/providers and selecting *Forms*, then *Behavioral Health*.

Please contact MVP directly at **1-800-684-9286** to determine authorization requirements and for Plan of Care submissions.

The following behavioral health services require an authorization:

- ECT–Electroconvulsive Therapy
- TMS–Transcranial Magnetic Stimulation
- PROS–Personalized Recovery Oriented Services
- ACT–Assertive Community Treatment
- All Home and Community Based Services (HCBS)
- ABA–Applied Behavior Analysis (for Commercial, Medicare and Child Health Plus members)
- Mental Health Residential
- Elective (planned) inpatient admissions

The following Behavioral Health Services require notification only:

- Inpatient Mental Health
 - Inpatient Mental Health Treatment for Members under 18 at MVP Network facilities Licensed by the Office of Mental Health (OMH): Inpatient mental health treatment at a MVP Network OMH-licensed Hospital is not subject to preauthorization or concurrent review for the first 14 days of the inpatient admission if the OMH-licensed facility notifies MVP of both the admission and the initial treatment plan within 2 business days of the admission. After the first 14 days of the inpatient admission, MVP may review the entire stay to determine whether it is Medically Necessary, and MVP will use clinical tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, the Member is only responsible for the in-network cost sharing that would otherwise apply to the inpatient admission.
 - Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities: Inpatient Detoxification, Inpatient Rehabilitation, Stabilization Services in a Residential Setting and Rehabilitative Services in a Residential Setting at a participating OASAS-certified Facility is not subject to preauthorization or concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies MVP of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, MVP may review the entire stay to determine whether it is Medically Necessary, and MVP will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, the Member is only responsible for the in-network Cost-Sharing, if applicable, that would otherwise apply to the inpatient admission.

Notification/Authorization Request Forms

Notification/Authorization Request Forms may be accessed by visiting mvphealthcare.com/providers/forms, then select Behavioral Health. All requests for services can be faxed to **1-855-853-4850** or e-mailed to BHServices@mvphealthcare.com.

For HARP HCBS

MVP's HARP clinicians will ensure that the NYS established Medical Necessity criteria for each HCBS, as well as Member's goals and preferences, will weight into decisions made regarding services. MVP will ensure that the Plan of Care is developed based upon all assessment documentation with the assistance of the Member, the service provider(s), and any individual the Member wishes to participate in service planning and delivery of services

that are delivered in home and community based settings. In addition, the Plan of Care and Member’s chart will be reviewed to ensure that it identifies strengths, capacities, and preferences of the Member and that resources are available to meet these needs. When services are temporarily unavailable, MVP will work with the Case Management Agency (CMA) on a back-up plan to ensure that needed assistance or services are provided.

Behavioral Health Case Management

MVP offers dedicated Case Management programs to Members at a variety of service levels. Drawing on the combined strength of registered nurses, behavioral health clinicians, pharmacists, physicians and community health care providers, the Behavioral Health case management program offers an integrated member centric approach in helping Members regain optimal health, well-being and/ or improved functional capability in the right setting and in a safe, cost-effective manner. As part of our business agreement, representatives of the MVP Care Management team will at times need to contact your practice to obtain health information and/ or contact information regarding our Members. To assure that we provide the best care possible, it is important Participating Providers furnish MVP with the requested information in a timely manner. Working together with Participating Providers, we ensure Members with chronic conditions understand the best course of action to address their needs, and everyone understands that the emergency room is often not the best solution. Your cooperation allows us to educate Members to provide the highest quality care. Sharing data and keeping the lines of communication open will help us both give Members additional guidance in navigating the health care continuum.

The MVP Behavioral Health Case Management Program ensures that Members identified with mental health or Substance Use disorder needs can access and obtain the highest quality of care possible. The process includes comprehensive assessment of the Member’s condition, determination of available benefits and resources, and development and implementation of a case management plan with self-management goals, monitoring and follow-up. If you have a Member in crisis, contact MVP Health Care at **1-800-684-9286**

For Behavioral Health Referrals, call MVP at **1-800-684-9286**

Behavioral Health Prescription Drugs

Please refer to the [Pharmacy Benefits](#) section for more information.

Behavioral Health Access Standards

Behavioral health providers must adhere to appointment availability Standards by behavioral health service type as set forth below:

Service Type	Standard	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to emergency or hospital discharge	Follow-up to jail/prison discharge
MH Outpatient Clinic/ PROS Clinic		Within 24 hrs. of	Within 1 wk.		Within 5 days of	Within 5 days of
ACT		Within 24 hrs. of			Within 5 days of	
PROS		Within 24 hrs. of request		Within 2 wks.	Within 5 days of request	Within 5 days of request
Continuing Day Treatment				Within 2 wks.		Within 5 days of request

Behavioral Health

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Service Type	Standard	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to emergency or hospital discharge	Follow-up to jail/prison discharge
IPRT				2-4 wks.		
Partial Hospitalization					Within 5 days of	
Inpatient Psychiatric Services	Upon presentation					
CPEP	Upon presentation					
Crisis Intervention	Upon presentation	Within 24 hours for short term respite			Immediate	
Community Mental Health Services (These are 599 clinic services offered in the community)		Within 24 hrs.				
of request	Within 1 wk.		Within 5 days of request	Within 5 days of request		
OASAS Outpatient Clinic		Within 24 hrs. of request	Within 1 wk. of request		Within 5 days of request	Within 5 days of request
Detoxification	Upon presentation					
SUD Inpatient Rehab	Upon presentation	Within 24 hrs.				
of request						
Opioid Treatment Program		Within 24 hrs. of request			Within 5 days of request	
Residential Addiction Services		Within 24 hrs. of request		2-4 wks.	Within 5 days of request	
Routine Behavioral Health Appointment	Within 10 business days					
Behavioral Health Home and Community Based Services						
Psychosocial Rehabilitation, CPST Habilitation, and Family Support and Training	n/a	n/a	Within 2 weeks of request		Within 5 days	
Short Term and Intensive Crisis Respite	Immediately	Within 24 hours	n/a		Immediate	

Service Type	Standard	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to emergency or hospital discharge	Follow-up to jail/prison discharge
Educational and Employment Support Services	n/a	n/a	Within 2 weeks of request		n/a	
Peer Supports	n/a	Within 24 hours for symptom management	Within 1 week of request		Within 5 days	

For Vermont, the access standards are:

Type of Service	Standard
Emergency Care	Immediate access
Urgent Behavioral Health Problem	Within 24 hours
Routine Behavioral Health Appointment	Within 10 business days

Mental Health Parity

The Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) and New York state law (“Timothy’s Law”) requires health insurance plans to cover mental health and Substance Use Disorder the same manner in which medical treatment is covered, ensuring “parity” between the coverage of mental health or Substance Use Disorder and physical illness.

MVP provides broad-based coverage for the diagnosis and treatment of behavioral health conditions, equal to the coverage provided for other physical health conditions. Behavioral health conditions include mental health and Substance Use Disorders. There is no day or visit limitation for Members who have a behavioral health benefit and meet medical necessity criteria. Prior approval requirements are applicable. The utilization review conducted by MVP for each request or claim for behavioral health benefits is comparable to, and applied no more stringently than, the utilization review conducted by MVP for each request or claim for similar Medical/Surgical benefits. Any annual or lifetime limits on behavioral health benefits for MVP plans are no stricter than such limits on medical/surgical benefits. MVP does not apply any cost-sharing requirements that are applicable only to behavioral health benefits. MVP does not apply any treatment limitations that are applicable only to behavioral health benefits, except for family counseling services, which may be capped at 20 visits per year. Where an MVP Product covers medical/surgical benefits provided by out-of-network providers, the Product also covers Behavioral Health benefits provided by out-of-network providers.

Where an MVP Product has a deductible, MVP charges a single deductible for all benefits, whether Covered Services rendered are for medical/surgical or Behavioral Health conditions, with the exception that MVP charges a separate deductible for prescription drugs.

Behavioral Health Medical Record Standards

MVP requires behavioral health specialists to meet standards for medical record keeping. The core elements relating to behavioral health to be included in BH Medical Records are:

1. Documentation of suicidality or other risk of harm (history and present assessment including suicidality)

2. Recorded treatment plans/goals
3. Evidence of communication with the Member's PCP and other appropriate providers. If none, evidence that the Member did not consent to communicate with the PCP*
4. Inclusion of a signed "MVP Permission to Exchange Information" form or other comparable form in the chart or documentation of the revocation of such consent.
5. Allergies and adverse reactions to medications are prominently displayed for those behavioral health care specialists who prescribe medications
6. Clear listing of psychotropic medications prescribed to the Member

**These two elements are used in the recredentialing process.*

To assess compliance with these standards, MVP conducts annual record reviews at the offices of high-volume behavioral health providers. These reviews are HIPAA-compliant in that the Privacy Rule permits health care providers to disclose a patient's personal health information (PHI) to a health plan for the purpose of conducting health care operations. Each year, MVP determines the specific number of Participating Providers to be reviewed and ensures that the sample covers at least 50 percent of Members being seen by all behavioral health specialists. If there are concerns about quality of care or access to care, a behavioral health provider (regardless of MVP participation) could be subject to a medical record review of the above-listed core elements.

For a copy of MVP's medical record standards for behavioral health providers, call the QI Department at **1-800-777-4793** ext. 12247 or review the [Quality Improvement](#) section.

Confidentiality of Behavioral Health and Substance Use Disorder

Providers are required to develop policies and procedures to ensure the confidentiality of behavioral health and Substance Use Disorder information. Comprehensive policies must include:

1. Initial and annual in-service education of staff, contractors
2. Identification of staff allowed access and limits of access
3. Procedure to limit access to trained staff (including contractors)
4. Protocol for secure storage (including electronic storage)
5. Procedures for handling requests for BH/SUD information protocols to protect persons with behavioral health and/or substance use disorder from discrimination.

Cultural Competency

All Participating Providers must ensure that services are provided to Members in a culturally competent manner. For more information on the MVP policy, please review the *Provider Responsibilities* section.

MVP's New York State Government Programs

MVP's New York State Government Programs

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MVP's New York State Government Programs (Medicaid, Health Recovery Plan and Child Health Plus)

MVP's New York State Government Program Plans types offer more health plan choices for individuals and families. MVP's high quality, affordable health plan options include:

Medicaid Managed Care is a health insurance program for low-income children and adults. Eligibility is based on income and family size, as well as citizenship and immigration status. Medicaid is also available to people of any age who are blind or disabled. There are no monthly premiums for Medicaid.

Child Health Plus is a health plan for kids that don't qualify for Medicaid. Almost all children, under age 19, qualify for health coverage with Child Health Plus regardless of family income or immigration status. Depending on income, a small monthly premium may be all that is needed to enroll a child.

MVP Harmonious Health Care Plan is a managed care product called a Health and Recovery Plan (HARP) that combines physical health, mental health, and substance use services in an integrated way, helping members find housing, live independently, get an education, find a job, manage stress, and more. Eligibility for HARP services is determined by New York State.

Member Rights and Responsibilities

Members have rights pursuant to Federal and State law and the applicable program contract. These rights are summarized below. Additionally, Member rights and responsibilities are outlined in the MVP Health Care Member Handbook provided to all Members upon enrollment.

An MVP Member has the right to:

- Receive information about MVP Health Care, our services, our providers, and Member rights and responsibilities
- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation.

An MVP Member has the responsibility to:

- Work with providers to guard and improve health.
- Use the MVP complaint system to settle any complaints, or contact the New York State Department of Health or the local Department of Social Services
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

MVP's New York State Government Programs Plan Types

The following plan types are printed on the Member's MVP ID card:

- MVP Medicaid Managed Care (MVPM)
- MVP Medicaid Managed Care SSI (MVPMS)
- MVP Child Health Plus (MVPC)
- MVP Harmonious Health Care Plan Health and Recovery Program (MVPH)

Member-initiated PCP Changes

A member may change his/her PCP by contacting the Customer Care Center. Upon selecting a new PCP, the member will be issued a new MVP ID card. These changes will also appear on mvphealthcare.com. Providers are encouraged to verify members' enrollment at every visit.

PCP-initiated Changes

In the event that a PCP believes that he/she can no longer manage the member's care, the physician should submit a letter to their local Professional Relations Department documenting the reasons necessitating the change. Reasons for a PCP to request a change might include:

- Consistent physical or verbal abusiveness to a provider and/or the providers' staff
- Fraudulent activity
- Repeated non-compliance with treatment plan or keeping appointments
- Repeated non-compliance with MVP administrative guidelines

Providers should include documentation of events and any follow-up taken by the provider and the providers' staff. Additionally, the documentation should show:

- The physician has ruled out any underlying medical conditions that may be impacting the member's behavior
- Any special considerations the office may be able to address regarding any disabilities the member might have
- Any cultural issues that might impact the physician's ability to work effectively with the member
- Any additional training delivered or necessitated for staff to be able to work more effectively with the member

Self-referral and Free Access

MVP Medicaid Managed Care (MMC) Members may self-refer for the following services:

- Unlimited Mental Health and substance abuse assessment services from Participating Provider and BH-HCBS applicable to HARP Members (exceptions: ACT, inpatient psychiatric hospitalization, and partial hospitalization.)
- Routine vision screening with a Participating Provider every two years
- Diagnosis and treatment of tuberculosis by public health agency facilities
- Family planning and reproductive health services from any Participating Provider or any
- Medicaid provider

Restricted Recipient Program

Restricted Recipients are Members identified by OMIG and assigned to specific pharmacies or physicians in the MVP Network. Usually, these members are "restricted" due to evidence of abuse or fraudulent behavior.

The following procedures should be followed when treating MVP MMC Members.

- Verify eligibility by visiting mvphealthcare.com, using the MVP Member ID (not CIN) presented on the ID card. The word "Restricted" may be present on the Member's ID card. MVP's website will inform you if the Member is restricted and instruct you to call the Customer Care Center for Providers for additional information on the restriction to ensure coverage and confirm referral requirements.
- MVP shall not pay for any services rendered to a Restricted Member by a Provider that has not been assigned unless MVP has issued a referral to you as requested by the designated provider.
- Participating Providers Assigned to care for Restricted Members may submit specialist referrals using MVP's online referral system or by faxing a referral request.

- Specialty referrals and changes to restricted pharmacy are required for all Restricted Recipient Members with a physician restriction.
- Restricted Members are notified of such restriction in writing and must go to their assigned health care provider for treatment.

Members in a restricted status have been told which provider they can go to. They are notified in writing, and the provider they are assigned to is told as well.

Public Health

Tuberculosis (TB) Screening, Diagnosis and Treatment

Testing

PCPs are expected to perform tuberculin screening of adults in high-risk groups. This includes persons who have signs or symptoms of clinically active TB. TB screening guidelines can be found within the age-specific MVP Preventive Care Guidelines.

Required reporting to local department of health

to the local County Department of Health (CDOH), as required by state health codes. MVP also expects the PCP and other providers to cooperate with the CDOH to identify case contacts and arrange for or provide services and follow-up care. MVP encourages all physicians to consult with their respective CDOH on TB treatment and preventive therapy. Physicians should call their local county department of social services for the appropriate contact number.

Reporting cases to MVP

MVP requires providers to report active TB cases to the MVP supervisor of case management to ensure that: (1) case management is initiated; and (2) Appropriate referrals are made to providers within the MVP network, when required (See Utilization Management for MVP's referral policy).

Preventive therapy and treatment for active TB

In the absence of HIV or other complications, the PCP or specialist managing the case should provide preventive treatment to Members who have a positive skin test, following the Centers for Disease Control (CDC) guidelines or other accepted treatment protocols. MVP encourages PCPs to refer active cases, including drug-resistant cases, to hospital-based programs or specialized TB clinics.

HIV-Positive TB Patients

MVP encourages the physician to refer HIV-positive individuals with TB to providers in designated AIDS centers who have TB treatment expertise. An individual with a dual diagnosis of TB and mental illness may require a referral to a specialized clinic or program.

Members who are non-compliant with Drug Therapy

If there is a need for Directly Observed Therapy (DOT), the case will be referred by the PCP to the city or county DOH for assessment. Providers are required to report positive TB cases to their local public health agency. Refer to the list of Important Numbers at the end of this section for phone numbers to report TB and other communicable diseases.

Sterilization and Hysterectomy

Sterilization and hysterectomy procedures for MVP's NYS Government Programs Members require an administrative Prior Authorization for all procedures, not a medical necessity review. For sterilization procedures performed on

male and female members, the New York State Sterilization Consent Form (DSS-3134) must be attached to the Prior Authorization request form.

For hysterectomies, New York State Hysterectomy Information Form (DSS-3113) must be attached to the prior authorization request form.

Prior authorization requests with the required consent form must be faxed to MVP's Provider Services Department at fax number **585-327-5759**.

Informed Consent for Sterilization and Hysterectomy

Participating Providers and certified nurse-midwives must comply with documentation, possess and quality standard requirements including informed consent procedures for hysterectomy and sterilization as specified in 42 CFR, Part 441, sub-part F, and 18 NYCRR §505.13. Participating Providers are required to keep on file copies of the sterilization consent form and/or acknowledgement of the Hysterectomy Information Form for MVP MMC Members who receive these services.

The Member must:

- Be at least 21 years old
- Be informed of the risks and benefits of sterilization
- Sign the mandated sterilization consent form (LDSS-3134) not less than 30 days or more than 180 days prior to performance of the procedure

Sterilization

Documentation, Process, and Quality Standards Requirements

1. Medicaid Management Information System (MMIS) in conjunction with the above noted Federal and State citations for Medicaid members seeking a sterilization procedure includes the following requirements to be completed by the servicing provider:

- a. **Informed Consent** – The person who obtains consent for the sterilization procedure must offer to answer any questions the member may have concerning the procedure, provide a copy of the New York State Sterilization Consent Form (DSS-3134), and provide verbally all the following information or advice to the member to be sterilized:
 - Advise that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right for future care or treatment and without loss or withdrawal of any federally funded program benefits to which the member might be otherwise entitled. Give a description of available alternative methods of family- planning and birth control
 - Advise that the sterilization procedure is irreversible
 - A thorough explanation of the specific sterilization procedure to be performed
 - A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used
 - A full description of the benefits or advantages that may be expected because of the sterilization
 - Advise that the sterilization will not be performed for a least 30 days except in the circumstances specified below under “Waiver of 30-day Waiting Period”

In addition to provision of this information at the initial counseling session, the physician who performs the sterilization must discuss the above with the member shortly before the procedure, usually during the preoperative examination.

- b. **Waiting Period** – The member to be sterilized must have voluntarily given informed consent not less than 30 days or more than 180 days prior to sterilization.
- c. **Waiver of 30-Day Waiting Period** – The only exception to the 30-day waiting period is in cases of premature delivery when the sterilization was scheduled for the expected delivery date of emergency abdominal surgery. In both cases, informed consent must have been given at least 30 days before the intended date of sterilization. Since premature delivery and emergency abdominal surgery are unexpected but necessary medical procedures, sterilizations may be performed during the same hospitalization, if 72 hours have passed between the original signing of the informed consent and the sterilization procedure.
- d. **Minimum Age** – The member to be sterilized must be at least 21 years old at the time of giving voluntary, informed consent to sterilization.
- e. **Mental Competence** – The member must not be a mentally incompetent individual. For the purpose of this restriction, “mentally incompetent individual” refers to an individual who has been declared mentally incompetent by a Federal, State, or Local court of competent jurisdiction for any purposes unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
- f. **Institutionalized Individual** – The member to be sterilized must not be an institutionalized individual. For the purposes of this restriction, “institutionalized individual” refers to an individual who is (1) involuntarily confined or detained, under a civil or criminal stature, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or (2) confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
- g. **Restrictions on Circumstances in Which Consent is Obtained** – Informed consent may not be obtained while the member to-be-sterilized is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the member’s state of awareness.
- h. **Foreign Languages** – An interpreter must be provided if the member to-be-sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.
- i. **Handicapped Persons** – Suitable arrangements must be made to insure that the sterilization consent information is effectively communicated to deaf, blind, or otherwise handicapped individuals.
- j. **Presence of Witness** – The presence of a witness is optional when informed consent is obtained.

One copy of the completed New York State Sterilization Consent Form (DSS-3134) or Acknowledgment of Receipt of Hysterectomy Information Form (DSS-3113) must be given to the member and one copy of the completed form must be kept in the member’s medical record.

Hysterectomy

Federal regulations prohibit reimbursement for hysterectomies which are performed solely for the purpose of rendering the member permanently incapable of reproducing; or if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing. Approved procedures will be reimbursed by MVP only if the member (and her representative, if any) has been informed verbally and in writing prior to surgery that a hysterectomy will render her permanently incapable of reproduction. In addition, the member (or her representative, if any) must sign a written acknowledgment of receipt of that information. The requirements for the member’s written acknowledgment can be waived if:

- a. The woman was sterile prior to the hysterectomy.

- b. The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible. This must be documented by the surgeon who performs the surgery.
- c. Acknowledgment of receipt of Hysterectomy Information Form (DSS-3113). This form documents the receipt of hysterectomy information by the member or the surgeon's certification of reasons for waiver of the acknowledgment. It also contains the surgeon's statement that the hysterectomy was not performed for the purpose of sterilization.

Copies of the New York State Sterilization Consent form or the Acknowledgement of Receipt of Hysterectomy Information form (DSS -3113) can be requested from:

New York State Department of Health
Corning Tower, Room 2029
Empire State Plaza
Albany, NY 12237
Attention: Michael Margiasso

Lead Screening

Providers must comply with lead screening follow-up as specified in 10NYCRR, Sub-par 67.1. MVP will reimburse for "point-of-care" blood lead testing of children under age 6 years and pregnant women when performed by practitioners operating Physician Office Laboratories (POLs) that hold appropriate CLIA certification, and clinics that operate Limited Service Laboratories (LSLs) registered by Wadsworth Center for blood lead analysis. These changes also require properly certified physicians with in-office labs and clinics that operate limited services laboratories to report blood lead test results to the NYS Department of Health (NYSDOH) and the Local Public Health Agency (LPHA).

Child/Teen Health Program

MVP participates in the high-priority New York State Child/Teen Health Program (C/THP) for Medicaid-eligible children under age 21 years, which promotes the provision of early and periodic screening services (Well Care Exams), with diagnosis and treatment of any physical, mental, or dental health problems identified during the conduct of well care, to be consistent with nationally recognized standards.

MVP follows the recommendations of the American Academy of Pediatrics (AAP) for preventive care for children and adolescents and promotes the guidelines including the AAP periodicity schedule with plan providers who care for MVP children and adolescents. MVP assesses provider adherence to guideline recommendations through HEDIS-NYS QARR reporting.

MVP also takes steps to identify Members who do not access preventive care services, including Well Care Exams, immunizations and blood lead testing. MVP offers assistance with appointment setting and transportation coordination and works to address any barriers that exist to ensure Medically Necessary and preventative care is delivered.

MVP includes pediatric preventive care guidelines in its Physician Quality Improvement Manual. For a paper copy, call the QI Department at **1-800-777-4793, ext. 12247**. The manual also is available by visiting mvphealthcare.com.

Immunizations for Medicaid Managed Care and Child Health Plus Members

MVP is taking steps to identify Members who do not access certain preventive care services, including immunizations. A list of these Members will be generated monthly and sent to the appropriate PCP. To ensure children are receiving necessary services, PCPs may be asked to cross reference the information MVP provides with their own records and, if necessary, contact the Member and encourage a preventive care visit.

The New York State Vaccines for Children (NYS VFC) immunization program provides free vaccines to physicians who are program participants. Children under 18 who are members of the Medicaid Managed Care and Child Health Plus coverage programs receive vaccines through the NYS VFC program. Physicians may call **1-800-KID-SHOTS (1-800-543-7468)** for more information and to register with this program.

Rehabilitative Service Coverage

Including the evaluation, MVP will cover 40 Physical Therapy visits per covered member per calendar year. MVP will also cover 20 visits each, including the evaluation, for Speech Therapy and Occupational Therapy services. The visit limitations for all three service lines do not apply for:

- Members under the age of 21 (depending on medical necessity)
- Services rendered in a hospital inpatient setting, skilled nursing facility, or through a certified Home Health Agency
- Members with traumatic brain injury
- Members determined to be developmentally disabled by the Office for People with Developmental Disabilities (OPWDD)

Prevention of Sexually Transmitted Diseases

Providers are responsible for the screening, treatment, and education of members regarding the risks of sexually transmitted diseases. Providers are also responsible for reporting cases of sexually transmitted diseases to local public health agencies and cooperating with contact investigations in accordance with all existing state and local regulations

Breast Cancer Surgery Facilities

See the [Utilization Management](#) section.

New York State Title 10 Rules and Regulations Section: 85-40 Prenatal Care Services

MVP has adopted New York State's 2009 updated Prenatal Care Standards as set forth in Title 10, Part 85.40 of the New York Code, Rules & Regulations. Please refer to the DOH Medicaid Prenatal Care Standards for New York State available [online](#). Participating Providers must adhere to all requirements, practice and care standards. Obstetric providers must establish and educate patients regarding arrangements for availability of after-hours, on-call and emergency consultation.

Requirements

1. General requirements:
 - a. Prenatal care providers shall create and maintain records and reports that are complete, legible, retrievable and available for review by representatives of the Commissioner of Health upon request. Such records and reports shall include the following:
 - i. a comprehensive prenatal care record for each pregnant woman which documents the provision of care and services received and which is maintained in a manner consistent with medical confidentiality requirements.
 - ii. special reports and data submissions as necessary for the Commissioner of Health;
 - iii. records of internal quality assurance;
 - iv. all written policies and procedures required by this section; and

- v. data submissions in electronic form as requested by the Commissioner of Health in compliance with the most current Department of Health policies for health information exchange in New York State.
 - b. Prenatal care providers shall comply with all federal, state and local laws and regulations regarding the disclosure of protected medical information when sharing or transferring medical information with other healthcare providers or facilities. Providers shall therefore obtain written informed consent from patients prior to transfer of medical records or information where required by law.
 - c. Prenatal care providers shall comply with the requirements to obtain informed consent for all services described herein, in accordance with all applicable laws and regulations.
 - d. Any subcontracts between the prenatal care providers and other agents or agencies providing care and services shall:
 - i. be available for review and inspection by the Department of Health; and
 - ii. require that subcontractors provide contracted care and services that meet the minimum standards established in this section and are provided in accordance with generally accepted standards of practice and patient care services.
 - e. Prenatal care providers shall participate in quality improvement initiatives as requested by the Commissioner of Health.
- 2. Provider/Staff requirements:
 - a. Prenatal care services, including prenatal diagnostic and treatment services, provided to pregnant women and postpartum women shall meet generally accepted standards of care as described by the most current American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) guidelines for perinatal care and shall be provided by a qualified provider practicing as:
 - i. a licensed physician practicing in accordance with Article 131 of the New York State Education Law and must be either an obstetrical care physician (MD/DO), Board Certified or Board Eligible in their area of specialty, or have completed an accredited residency program in Family Practice or Obstetrics/Gynecology;
 - ii. a nurse practitioner practicing in accordance with Article 139 of the New York State Education Law;
 - iii. a licensed Midwife practicing in accordance with Article 140 of the New York State Education Law; or
 - iv. a registered physician's assistant practicing in accordance with Part 94 of this Title, Article 37 of the NYS PHL and article 131 of the NYS Education Law.
 - b. Prenatal care providers shall promote the delivery of prenatal care services in a culturally sensitive/competent manner to all pregnant women including those with limited English proficiency and diverse cultural and ethnic backgrounds. Interpretation services must be offered to patients whose primary language is not English, in person when practical, or via telephone if a translator is not immediately available.
 - c. Prenatal care providers must either have admitting privileges at one or more hospitals or shall develop agreements with planned delivery sites including a system for sharing patient information for continuity and follow-up care.
- 3. Provider/Specialist/Consultation Requirements:

Prenatal care providers shall provide pregnant women timely access and referral to appropriate levels of prenatal care, (basic, specialty, and subspecialty), based on her assessed risk status in order to prevent, recognize and treat conditions associated with maternal and infant mortality and morbidity.

 - a. Management of pre-existing medical conditions - Providers shall provide or arrange for the provision of care for the specific needs of a pregnant woman with a pre-existing medical condition, according to current standards of practice.

- b. Transfer of care - Practices shall develop criteria requiring transfer of primary responsibility for patient care from a family medicine practice physician, physician's assistant, licensed midwife or nurse practitioner to an obstetrician and/or maternal-fetal medicine specialist (high risk obstetrician or perinatologist).
- c. Specialty physician consultation/referral - Prenatal care providers shall develop criteria for consultation and referral for care to a maternal-fetal medicine specialist, perinatologist, high risk obstetrician, specialty physician, behavioral health specialist, including licensed social worker or other health care specialist as necessary based on the identification of specific risk factors or medical conditions requiring additional specialty monitoring and management. Prenatal care providers should follow AAP/ACOG's early and on-going pregnancy risk specific recommendations for consultation³. Referrals for specialty provider consultations should include:
 - i. description of the indication for the consult,
 - ii. the role of the consultant during the initial consult
 - iii. the role of the consultant during the follow-up care throughout the stages of pregnancy, and
 - iv. the sharing of patient/clinical information between the primary care obstetrical provider and the special care consultant.

Access to Care

1. Any pregnant woman who presents for prenatal care should begin receiving care as quickly as possible, preferably the same day. All prenatal care service providers must provide prenatal care services to recipients determined to be presumptively eligible for medical assistance but are not yet enrolled in Medicaid.
2. Prenatal care providers shall assist or refer women for assistance with application for medical assistance and managed care plan selection in accordance with procedures established by the Commissioner.
3. Prenatal care practices must provide or arrange for the provision of 24 hour/7 day week coverage (after hours and weekend/vacation number to call that leads to a person or message that can be returned by a health care professional within one hour). Pregnant women shall have access to unscheduled or emergency visits on a 24 hour basis⁵.
4. Prenatal care providers must develop systems or arrange for reminder/call backs to patients needing continued or follow-up services, and for visits requiring follow-up for abnormal test results. Prenatal care providers shall outreach to patients to reschedule missed appointments in a manner that maintains patient confidentiality.
5. Prenatal care providers shall schedule prenatal care visits for an uncomplicated pregnancy consistent with AAP/ACOG recommendations. Pregnant women with medical, obstetrical and/or psychosocial problems may require more frequent visits. The need for increased surveillance is best determined by the prenatal care provider based on the individual needs of the woman, and the nature and severity of her problems.

Prenatal Risk Assessment, Screening and Referral for Care

Prenatal care (PNC) providers shall conduct a comprehensive prenatal care risk assessment for both maternal and fetal risks, at the earliest prenatal care visit, on all pregnant women.

1. The risk assessment shall include but not be limited to an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, environmental, behavioral health, psychosocial and history of previous and current obstetrical/fetal and medical/surgical risk factors. Historical obstetric risk assessment shall include an evaluation of prior preterm birth, risk for recurrent preterm birth and eligibility for progesterone supplementation as per ACOG recommendations. Prenatal care providers are encouraged to use a standardized written risk assessment tool, such as the ACOG, Hollister or POPRAS form. Using established criteria for determining high risk pregnancies, the prenatal care provider shall determine the woman's risk status based on generally accepted standards of practice. The risk assessment shall be:

- a. reviewed at each visit;
 - b. repeated formally early in the third trimester;
 - c. used to form the basis for the development of the care plan and;
 - d. documented clearly in the medical record.
2. Based on results of the risk assessment and the individual woman's increased risk for a poor pregnancy outcome, the prenatal care provider shall refer the pregnant woman for follow-up care. Referrals for such care may include but are not limited to: prenatal case management programs provided by managed care plans, other case management programs, home visitation agencies, or community-based programs for prenatal care coordination.
 3. In accordance with Public Health Law section 2530-a 2.3. Prenatal care providers shall complete a standardized New York State Prenatal Care Risk Screening Form, which summarizes the results of the comprehensive risk assessment (as described in C.1.) for each new pregnancy. The completion of this risk screening form once during the pregnancy and reporting of the information shall be with the pregnant woman's informed written consent and shall be in a format to be developed by the Commissioner. If consent and voluntary participation is obtained, prenatal care providers shall complete the New York State Prenatal Care Risk Screening Form at the earliest prenatal care visit and transmit the information in a confidential manner to be determined by the Commissioner.

Psychosocial Risk Assessment, Screening, Counseling and Referral for Care

Prenatal care providers shall conduct a psychosocial risk assessment of all pregnant women during the first prenatal care visit. The assessment should be reviewed at each visit and formally repeated early in the third trimester and postpartum to identify important issues that may have developed over time. The assessment shall include a broad range of social, economic, psychological and emotional problems. Screening should include but not be limited to assessment of barriers to care, unstable housing, communication barriers (i.e. language and /or cultural barriers), nutrition, tobacco use, substance use, depression or other psychiatric illness, safety, domestic abuse, sexual abuse, and stress. Based on the results of this assessment the providers shall identify areas of concern, validate major issues with the patient, provide information, and if indicated, provide treatment or make appropriate referral(s).

The psychosocial risk assessment shall include but not be limited to screening for the following

1. Tobacco Use-Prenatal care providers shall assess all pregnant women about their past and present use of tobacco and exposure to secondhand smoke. All pregnant women should be advised to avoid or minimize time spent in the presence of tobacco smoke. The patient who smokes should be strongly advised to stop smoking and be provided with tailored counseling to assist in smoking cessation. Patients who smoke shall be offered a referral to an appropriate smoking cessation education and/or treatment program.
2. Substance Use-Prenatal care providers shall assess all pregnant women about their past and present use of all substances, including drugs, alcohol, or the use of any prescription or nonprescription medications, including herbal supplements. The possible effects of any substances used before or during pregnancy should be discussed. A woman who acknowledges the use of any substances should be counseled about the implications of their use during pregnancy, and strongly encouraged to refrain from use of any substances that may negatively affect her or her fetus. If appropriate the woman should be offered a referral to a treatment program.
3. Domestic Violence-Prenatal care providers shall screen all pregnant women for domestic violence. Descriptions of domestic abuse from the patient should be documented in the patient's medical record, safety of the patient and family shall be ascertained, and referrals made to appropriate counseling, legal and social-service advocacy programs.
4. Depression-Prenatal care providers shall screen pregnant and postpartum women for depression utilizing an appropriate screening tool, and should have a system in place to ensure that positive screening results

are followed by accurate diagnosis, implementation of treatment, and follow-up either within the practice or through referral. Prenatal care providers should refer to information on maternal depression, including current evidence and guidelines, evidence-based screening tools and available follow-up support resources provided on the Department's website

Nutritional Screening, Counseling and Referral for Care

Prenatal care providers shall provide or arrange for the provision of nutritional and physical activity screening, counseling and referral which includes:

1. Individual nutritional risk assessment including an assessment of pre-pregnancy BMI, weight gain to date, if any, and specific nutritional risks at the initial prenatal care visit and continuing reassessments as needed.
2. Documentation of the nutritional assessment, risk status and the plan of care in the patient's medical record.
3. Referral of pregnant women identified as being at nutritional risk for specific nutritional counseling, monitoring and follow-up;
4. Provision of basic nutrition education and counseling for each pregnant woman which includes:
 - a. appropriate dietary intake and recommended dietary allowances during normal pregnancy;
 - b. recording of height and weight at the initial prenatal visit to allow for the calculation of the BMI and sequential weight monitoring at each visit. Parameters of appropriate weight gain should be made based on the pre-pregnancy BMI categories recommended in the 2009 Institute of Medicine (IOM) guidelines
 - c. focused approach to nutrition counseling based on AAP/ACOG guidelines which includes exercise and lifestyle changes for all women, but particularly for women with a BMI in the obese (BMI>30) or underweight (BMI<18.5) range; and
 - d. counseling and education regarding infant feeding choices discussed with the woman during prenatal visits and immediately postpartum. Prenatal care providers should support breast feeding by counseling the patient regarding the nutritional advantages of human breast milk and should provide her with information regarding the benefits of breast feeding for both the mother and infant. Exclusive breastfeeding is recommended for the first 6 months of life and should be continued along with supplemental foods through the second half of the first year of life and for as long as desired thereafter. Breastfeeding is not recommended for HIV positive women and may be medically contraindicated in other situations. Income eligible women considering breastfeeding should be referred to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for breastfeeding education and support.
5. Referral of pregnant women identified as needing to access proper nutrition and assistance in obtaining supplemental food to programs such as the Supplemental Nutritional Assistance Program (SNAP) or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
6. Special considerations for underweight and/or overweight/obese women:
 - a. Prenatal care providers shall assess, and counsel underweight and overweight/obese women regarding the increased risk for pregnancy complications related to their weight and encourage these women to participate in a lifestyle improvement program, including diet, exercise, and behavior modification.
 - b. Prenatal care providers shall consider screening obese patients for gestational diabetes upon presentation or in the first trimester, and repeat screening later in the pregnancy if results are initially negative

Health Education

Prenatal care providers shall provide or arrange for the provision of health and childbirth education based on an assessment of the pregnant woman's individual needs. Prenatal care providers should focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and

language needs of the patient as well as her gestational history. Such services shall be provided by professional staff, documented in the medical record and shall include but not be limited to the following:

1. Rights and responsibilities of the pregnant woman;
2. Signs and symptoms of complications of pregnancy;
3. Physical activity, exercise and recommended weight gain during pregnancy;
4. Avoidance of harmful behaviors including the use of alcohol, drugs, non-prescribed medications and nicotine;
5. Sexuality during pregnancy;
6. Occupational and environmental concerns including lead exposure;
7. Risks of HIV infection and risk reduction behaviors;
8. Signs of labor;
9. Labor and delivery process and availability of various delivery options;
10. Relaxation techniques in labor;
11. Obstetrical anesthesia and analgesia;
12. Preparation for parenting including infant development and care, options for feeding and the benefits of breastfeeding;
13. Newborn screening program, including the distribution of newborn screening literature;
14. Family planning and optimum inter-pregnancy interval.

Development of a Care Plan and Care Coordination

Prenatal care providers shall develop a care plan jointly with each pregnant woman which addresses the problems identified as a result of the initial and ongoing risk assessments. The care plan shall describe the implementation and coordination of all services required by the pregnant woman, be routinely updated and implemented jointly by the pregnant woman, her family and the appropriate members of the health care team.

1. Care shall be coordinated to:
 - a. Ensure that relevant information is exchanged between the prenatal care provider and other providers, health plan case managers or sites of care including the anticipated delivery site.
 - b. Ensure that the pregnant woman and her family or other designated representative, with her consent, have continued access to information resources and are encouraged to participate in the decisions involving the care and services being provided.
 - c. Encourage and assist the pregnant woman in obtaining necessary medical, dental, nutritional, psychosocial, drug and substance abuse services appropriate to her identified needs.
 - d. Provide the pregnant woman with an opportunity to receive prenatal and postpartum home visitation when medical and/or psychosocial benefits may be derived from the visits.
 - e. Provide to or refer the pregnant woman for needed services as identified in the risk assessment.
 - f. Obtain special tests and services that may be recommended or required by the Commissioner of Health, when necessary to protect maternal and/or fetal health. Pregnant women shall be provided appropriate medical care, counseling and education based on test results.
2. The prenatal care provider shall coordinate labor and delivery services by developing agreements with planned delivery sites which address, at a minimum, the following:
 - a. a system for sharing prenatal medical records, including HIV test results;

- b. pre-booking of women for delivery by 36 weeks gestation for low risk pregnancies and by 24 weeks gestation for high risk pregnancies;
 - c. scope of services; and
 - d. sharing of delivery/birth outcome information.
3. The prenatal care provider shall arrange for postpartum home visitation care as necessary and available when the mother and/or newborn may derive medical, physical and/or psychosocial benefits from such visits.

Prenatal Care Services

Prenatal care providers shall provide or make arrangements for the provision of comprehensive prenatal care services in accordance with generally accepted standards of professional practice, as outlined by the AAP and ACOG.

1. Prenatal diagnostic and treatment services shall include but not be limited to the following:
 - a. Comprehensive assessment - An initial comprehensive assessment including history, review of systems, and physical examination.
 - b. Standard and special laboratory tests - Based on AAP/ACOG recommendations, standard and special laboratory tests and procedures should be performed at the recommended gestational age.
 - c. Follow-up, evaluation of results and referral - Follow-up shall be conducted as indicated based on abnormal findings from the comprehensive assessment, results of preliminary abnormal laboratory test findings and repeat testing of women considered to be at high risk. Prenatal care providers shall discuss the following with the pregnant woman:
 - i. findings from the comprehensive assessment,
 - ii. results of all laboratory tests,
 - iii. recommendations for additional testing,
 - iv. treatment options and obtaining informed consent for treatment,
 - v. technological support and referrals as necessary.

2. HIV Services

a. Prenatal HIV Counseling and Testing

Prenatal care providers shall provide HIV counseling to all pregnant women as early as possible in the pregnancy without regard to risk. Counseling shall be provided, and informed consent obtained prior to HIV testing and shall be consistent with the requirements described in Article 27F of the Public Health Law and NYCRR Title 10 Section 63.3. A repeat third trimester test, preferably at 34 - 36 weeks should be routinely recommended to all pregnant women who tested negative early in prenatal care to identify sero-conversion after an initial negative prenatal HIV test. The New York State Department of Health Informed Consent to Perform HIV Testing (DOH Form - 2556), allows the pregnant woman to receive counseling for both tests at the initial counseling and to sign for both tests at that time.

The pregnant woman should be counseled about benefits to knowing her HIV status, specifically the significant reduction in risk of mother-to-child HIV transmission with the provision of antiretroviral (ARV) prophylaxis to HIV-positive women during pregnancy, at delivery and to the newborn. The pregnant woman should be informed that if she does not have a prenatal test, she will be HIV-counseled again when she presents for delivery, and that expedited testing will be done on her, with her consent, or on the newborn, without her consent. She should also be told that all newborns are routinely screened for HIV as part of the Newborn Screening Program, as a final safety net to identify exposed infants.

Pregnant women who receive negative test results should be provided with their results and if at continued risk for developing HIV, encouraged to access HIV prevention programs and services appropriate to their risk(s). Pregnant women who receive positive HIV test results should be provided with post-test counseling

consistent with Public Health Law section 2781 and Part 63 regulations and will be provided necessary care and/or appropriate referrals for services.

Prenatal care providers should transfer information regarding a prenatal patient's HIV counseling and testing status, including a copy of the result, if one exists, to the delivery setting. Routine consent procedures for the transfer of medical records are sufficient to authorize the transfer of HIV-related information to health care providers.

b. Care of an HIV-Positive Pregnant Woman

Management of antiretroviral (ARV) medications during pregnancy should be done by, or in consultation with, an experienced HIV specialist familiar with state and federal clinical guidelines for the care of HIV-positive pregnant women and the prevention of mother-to-child HIV transmission. Breastfeeding is not recommended for HIV-positive women where there are good alternatives.

3. Dental care

The prenatal care provider shall conduct an assessment of the woman's oral health care needs at the first prenatal care visit. The assessment shall include but not be limited to interviewing the patient regarding current oral health problems, previous dental problems, and the availability of a dental provider. Pregnant women identified as having a current oral health problem or not having a dental visit in the past six months should be referred to a dentist as soon as possible, preferably before 20 weeks gestation. The prenatal care provider shall educate the pregnant woman about the importance of oral health and that dental care is safe during pregnancy. Oral health care should be coordinated between the prenatal care provider and the dentist.

4. Immunizations

Pregnancy is not an absolute contraindication to any vaccination. Some vaccines are strongly recommended for pregnant women during the prenatal period. Many women will not be up-to-date, and each pregnant woman should be evaluated for immunization status. Prenatal care providers should reference current guidelines for immunizations and be alert for updated recommendations. Guides for immunizing during and after pregnancy are available from the Centers for Disease Control and Prevention (CDC) and the New York State Department of Health Bureau of Immunization.

- a. All pregnant women shall be evaluated for serologic evidence of immunity to rubella at their first prenatal visit, unless known to be immune by documentation of a previous test. Varicella immunity shall also be assessed by either a reliable history of disease, laboratory evidence of previous disease or documented receipt of two doses of vaccine.
- b. Influenza vaccine is strongly recommended for all pregnant women due to the increased risk of influenza-related complications among pregnant women. Providers should advocate for influenza vaccination and provide the influenza vaccine to their pregnant patients. Pregnant women should only receive the trivalent inactivated influenza vaccine (TIV), and not the live attenuated influenza vaccine (LAIV), the nasal spray.
- c. The following immunizations are recommended for women at risk for these diseases and who do not have a history of immunity:
 - i. Hepatitis B - A pregnant woman's risk of acquiring Hepatitis B Virus (HBV) should be assessed along with her risk of acquiring other sexually transmitted infections. Pregnant women who have been identified as being at risk for HBV infection should be vaccinated. Pregnancy is not a contraindication for HBV vaccination, and limited evidence does not suggest any fetal harm from the HBV vaccine.
 - ii. Tetanus, Diphtheria/Tetanus, Diphtheria, Pertussis booster (Td/Tdap) - Pregnant women who have not received a Td booster within the last 10 years and require immediate protection against tetanus and diphtheria (i.e. wound prophylaxis) should be vaccinated with Td based on the severity of the risk of tetanus and the need to be immunized. Immunization with Td during pregnancy is preferred in the 2nd or 3rd trimester.

- iii. Due to the burden of pertussis disease in vulnerable newborns, pregnant women should receive a dose of Tdap during each pregnancy, regardless of prior immunization history, optimally between 27 weeks and 36 weeks gestation. Tdap may be given at any time during pregnancy and there is no evidence of adverse fetal effects from administering inactivated viral or bacterial vaccines or toxoids during pregnancy. For women who have not previously received Tdap, if Tdap was not administered during pregnancy, Tdap should be administered immediately postpartum. By providing Tdap vaccine to women during pregnancy, infants will gain pertussis antibodies during the time they are most vulnerable-before three months of age. The infant's immune response to DTaP may not be as strong; however, based on a recent study looking at this issue, this interference does not seem to cause any problems when it comes to protecting infants. Researchers are still working to better understand this issue. The benefits of vaccinating during pregnancy and protecting a newborn during the most vulnerable time outweigh the potential risk of blunting an infant's response to DTaP vaccine.
- d. Other pregnancy related immunization issues:
 - i. New York State Public Health Law 2500-e requires that every pregnant woman be tested for the presence of hepatitis B surface antigen (HBsAg) and that the test results and the date are documented in the prenatal record. It also requires that infants of women who are hepatitis B surface antigen positive or whose test results are unknown receive treatment at birth with hepatitis B vaccine and hepatitis B immunoglobulin (HBIG).
 - ii. New York State Public Health Law 2112 (effective July 1, 2008) prohibits the administration of vaccines containing more than trace amounts of thimerosal, a mercury-containing preservative, to pregnant women, unless the supply is insufficient. There is no evidence that thimerosal causes harm to the pregnant woman or her fetus.
- e. Postpartum Period - The following vaccinations or a history of immunity are recommended for all postpartum women: influenza, MMR (measles, mumps, rubella), Tdap, varicella and human papilloma virus. An adult schedule should be checked for appropriate indications in regard to age, previous history of disease or prior history of vaccination.

Women who plan to breastfeed can and should receive vaccinations as no evidence exists of any risk to a mother or her infant if she is vaccinated while breastfeeding. Breastfeeding is not a contraindication to any vaccination, with the exception of vaccinia vaccine.

5. Lead Poisoning Prevention, Testing and Management

As required by NYS Public Health Law and Regulations (NYCRR Subpart 67-1.5), prenatal health care providers (HCPs) shall provide all pregnant women with anticipatory guidance on preventing lead poisoning, information on the major sources of lead and the means to prevent exposure while pregnant. At the initial prenatal visit, each pregnant woman shall be assessed for exposure to lead by using a risk assessment questionnaire recommended by the State Commissioner of Health. If the pregnant woman responds "yes" to even one of the questions, or the provider suspects lead exposure, she is considered to be at risk, and should have a blood lead test and be counseled on how to eliminate lead exposure. HCPs are also required to provide anticipatory guidance on the prevention of childhood lead poisoning at the woman's first postpartum visit.

The New York State Department of Health (NYSDOH) is in the process of updating the NYSDOH Lead Poisoning Prevention Guidelines for Prenatal Care Providers. During the interim, please utilize the 2010 Centers for Disease Control and Prevention "Guidelines for the Identification and Management of Lead Exposure in Pregnant and Lactating Women." These guidelines are based on the best available scientific information and provide practical considerations regarding preventing lead exposure during pregnancy, assessment and blood lead testing during pregnancy, medical and environmental management to reduce fetal exposure, breastfeeding, and follow-up of infants and children exposed to lead in utero. Highlights include pregnant or lactating women with a confirmed venous BLL:

- a. 5 micrograms per deciliter ($\mu\text{g}/\text{dL}$) or greater, should receive risk reduction counseling and follow-up testing
 - i. prenatal HCP and pediatrician must communicate to ensure newborn has a lead test at birth and follow-up testing is done as needed
 - ii. encourage breastfeeding and monitor infant's BLL
- b. $10\mu\text{g}/\text{dL}$ or greater, who may have been occupationally exposed to lead, should be medically removed from the workplace exposure
 - i. Refer the pregnant woman to the local health department for an evaluation of available services
 - ii. Contact a Regional Lead Resource Centers (RLRC) for consultation
- c. $15\mu\text{g}/\text{dL}$ or greater, assist local health department with complete exposure source assessment
- d. $45\mu\text{g}/\text{dL}$ or greater, should be referred to a RLRC for medical management and possibly chelation therapy

6. Use of Ultrasound

Prenatal care providers must document the medical indication for performing an ultrasound examination of a pregnant patient based on identified need. Ultrasound for gestational dating is recommended, especially before 20 weeks, if there is a size-date discrepancy or imprecise menstrual dates. Ultrasonography shall be provided only by physicians or technologists who have undergone training and only when there is a valid medical indication for the examination documented in the woman's medical record by a qualified prenatal care provider. AAP/ACOG guidelines should be followed when recommending an ultrasound exam. Common indications for ultrasound include but are not limited to evaluation for gestational age, fetal number, viability, placenta location, abnormal amniotic fluid volume, fetal growth disturbances, fetal anomalies and aneuploidy screening.

7. Screening for Genetic Disorders

Prenatal care providers shall offer all pregnant women additional maternal/fetal screenings to identify fetal abnormalities/genetic problems as follows:

- a. Birth defects - Prenatal care providers shall offer all pregnant women screening tests to identify birth defects at specific times throughout the prenatal period based on AAP/ACOG recommendations.
- b. invasive diagnostic testing for aneuploidy should be available to all women regardless of maternal age. Early amniocentesis (at less than 15 weeks gestation) should not be performed.
- c. Pregnant women should be counseled regarding the differences between screening and invasive diagnostic testing for aneuploidy including a discussion of the risks and benefits of the invasive test compared with other available screening tests. Pregnant women who choose not to undergo invasive diagnostic testing for aneuploidy shall be offered aneuploidy screening before 20 weeks gestation regardless of maternal age.
- d. Prenatal care providers should offer information on cystic fibrosis screening to all couples and cystic fibrosis carrier screening should be offered to all couples regardless of race or ethnicity.
- e. Prenatal genetic screening or diagnosis should be offered to pregnant women based on personal and family history. Genetic screening and counseling criteria should be based on AAP/ACOG recommendations. This includes screening for genetic disorders based on racial and ethnic background, such as hemoglobinopathies (sickle cell, α -thalassemia, β -thalassemia), Tay-Sachs disease, Canavans disease and familial dysautonomia, cystic fibrosis and other genetic disorders based on family history.

8. Fetal Well- Being

Tests of fetal well- being are indicated in the presence of specific maternal and pregnancy-related conditions and shall be performed based on the judgment of a qualified prenatal care provider according to individual patient need. There are several tests used in clinical practice to assess fetal status, each test has advantages, disadvantages as well as risks. The prenatal care provider based on clinical judgment and recommended

AAP/ACOG guidelines should choose the test that best meets the needs of the pregnant woman and her fetus and initiate testing at the appropriate gestational age. The test results and the interpretation shall be discussed with the pregnant woman, documented in the medical record and appropriate referrals initiated as soon as possible.

Postpartum Services

The prenatal care provider shall schedule a postpartum visit based on the woman's identified needs and in accordance with AAP/ACOG's recommended schedule, (approximately 4 - 6 weeks after delivery but no later than eight weeks after delivery; women with a complicated gestation or delivery by cesarean section should have a visit scheduled within 7 - 14 days of delivery). The visit should include an interval history and a physical examination to evaluate the patient's current status and her adaptation to the newborn.

1. The visit shall include but not be limited to the following:
 - a. identify whether any medical, dental, psychosocial (including depression), nutritional (including breastfeeding), tobacco/smoking cessation needs, alcohol and drug treatment needs of the mother or infant are being met;
 - b. provide anticipatory guidance on the prevention of childhood lead poisoning;
 - c. refer the mother or other infant caregiver to resources available for meeting identified needs and provide assistance in meeting such needs where appropriate;
 - d. assess family planning/contraceptive needs and provide advice and services or referral when indicated;
 - e. provide appropriate inter-conception counseling including information such as recommended preconception daily intake of folic acid (400 mcg) as per CDC and ACOG guidelines and encourage a preconception visit prior to subsequent pregnancies;
 - f. refer the infant to preventive and special care services appropriate to his/her needs;
 - g. advise the mother/caregiver of the availability of Medicaid eligibility for infants; and
 - h. advise or refer the mother for assistance with an application for on-going medical care assistance for herself, in accordance with her financial status, health assistance program eligibility and the policies and procedures established by the Commissioner of Health and the State of New York.
 - i. recommend that overweight/obese women continue a nutrition and exercise regimen after pregnancy to encourage weight loss before attempting another pregnancy.
2. The prenatal care provider shall arrange for postpartum home visitation as necessary when the mother and/or newborn may derive medical, physical and/or psychosocial benefits from such visits.
3. Postpartum documentation by the prenatal provider shall include: delivery outcome, maternal physical exam, health status of the mother/infant including medical, nutritional, psychosocial needs with referrals.

Welfare Documentation

Upon Member consent, providers are required to supply medical documentation of health, mental health, and chemical dependence assessments as follows:

- Within 10 days of request from a Member or former Member currently receiving or applying for public assistance, the PCP or specialist provider must provide medical documentation concerning the Member or former Member's health or mental health status to the local department of social services (LDSS) or the LDSS's designee.
- Within 10 days of request of a Member or former Member who has already undergone or is scheduled to undergo an initial LDSS-required mental and /or physical exam, the Member's PCP shall provide a health, mental health, or chemical-dependence assessment exam or other services as appropriate to identify or quantify a Member's level of incapacitation.

Claim Encounters

Providers are required to submit all claim encounters for Medicaid Managed Care (Medicaid, SSI, HARP) and Child Health Plus products following the claim submission guidelines outlined in the [Claims Section](#) of this manual

Special Networks

Healthplex, Inc.

Healthplex, Inc., administers all dental services for the Medicaid, HARP and CHP, Lines of business. This includes a full range of preventive, prophylactic, diagnostic, and other routine dental care, services, and supplies as well as limited orthodontia services for children enrolled in MVP Medicaid Managed Care and MVP Child Health Plus. If a Healthplex dental provider identifies a medical issue, he/she will refer the Member back to his/her PCP for coordination of the appropriate medical care or referrals.

Pharmacy Services

Refer to the [Pharmacy](#) section of this manual for information on pharmacy benefits and services for MVP State Government Programs Members.

Consumer-Directed Fiscal Intermediary Authorization

To comply with Title 18 NYCRR §505.28, fiscal Intermediaries are required to submit an Authorization application to the NYS Department of Health. MVP is expected to follow contract termination protocols as identified in the Consumer Directed Personal Assistant Services Administrative Agreement MVP has with the Fiscal Intermediary if an Authorization application is not on file.

Fair Labor Standards Act

Licensed Home Care Services Agencies (LHCSA), Certified Home Health Agencies (CHHA) and Fiscal Intermediaries (FI) are required to comply with all applicable provisions of the Fair Labor Standards Act (FLSA) per section 35.11 of the Medicaid Model Contract. Providers must develop protocols to demonstrate compliance with requirements of the FLSA. Such protocols shall include appropriate record keeping methodologies, tracking of aide travel time, hours worked on live-in cases, and appropriate rate of reimbursement.

Critical incidents

Critical Incidents are a subset of Serious Reportable Events (SRE) applicable to MVP Members receiving Long Term Services and Supports (LTSS) including:

- Private Duty Nursing
 - Skilled Nursing
- Home Health Services
- Personal Care Services
 - Consumer Directed Personal Assistance Services
 - Adult Day Health Care
 - AIDS Adult Day Health Care
 - Institutional services including long term placement in Residential Health Care Facilities

An MVP Participating Provider must report Critical Incidents within 24 hours of their knowledge of the event to the MVP Customer Care Center for Provider Services at **1-800-684-9286**.

The following categories of events constitute a Critical Incident as defined by New York Department of Health regulations (10.38).

A. Wrongful Death: Any cessation of life due to other than natural causes, including deaths determined to be due to abuse, neglect, or exploitation.

B. Use of Restraints: Restraint is defined as the act of limiting or controlling a person's actions or behavior through the use of any device which prevents the free movement of any limb; any device or medication

which immobilizes a person; any device which is ordered by a physician for the expressed purpose of controlling behavior in an emergency; or any medication as ordered by a physician which renders the participant unable to satisfactorily participate in services, community inclusion time or other activities.

C. Medication errors that resulted in injury: Any situation in which a participant experiences marked adverse reactions which threaten his/her health and welfare due to refusing to take prescribed medication; taking medication in an incorrect dosage, form, or route of administration; taking medication on an incorrect schedule; taking medication which was not prescribed; or, the failure

on the part of the staff of a provider of waiver services to properly follow the plan for assisting the participant in self-medication.

D. Instances of abuse of enrollees: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The abuse may be physical, psychological, or sexual.

E. Instances of neglect of enrollees: Failure to provide an enrollee with goods and services that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes inconsistent or inappropriate services, treatment or care which does not meet their needs, or failure to provide an appropriate and/or safe environment.

F. Instances of exploitation of enrollees: The illegal or improper use of an individual's funds, property, or assets. Includes taking advantage of an Enrollee for personal gain using manipulation, intimidation, threats, or coercion.

G. Crimes committed against enrollee: An illegal act that is punishable by law that is committed against an enrollee.

H. Crimes committed by enrollee: An illegal act that is punishable by law that is committed by an enrollee.

I. Other incident resulting in hospitalization: Any incident that results in an unplanned admission to the hospital. Does NOT include a planned overnight for a procedure.

J. Other incident resulting in medical treatment other than hospitalization: Any incident that requires medical intervention(s) provided as a direct result of an accident/injury or non-accident to the participant, regardless of whether hospitalization is required or not. DOES include the use of an Emergency Room.

Deficit Reduction Act (DRA) of 2005

The Deficit Reduction Act (DRA) of 2005 instituted a requirement for health care entities that receive Medicaid funds in excess of \$5 million annually to establish written policies informing and educating their contractors about federal and state anti-fraud statutes. As a Medicaid Managed Care contractor, MVP is subject to this DRA requirement. In

In addition, Participating Providers in MVP's Medicaid Managed Care program are contractors and as such are required to adopt MVP's policy for Detecting and Preventing Fraud, Waste and Abuse. This policy provides information regarding several important anti-fraud statutes, such as the False Claims Act, and MVP's policies and procedures for compliance with these laws. This policy is available by visiting mvphealthcare.com, select Providers, then Reference Library, then Learn About MVP Policies, then select Detecting and Preventing Fraud, Waste and Abuse.

Non-Emergent Transportation (NY)

Non-emergent transportation for MMC and HARP Members is coordinated by the NYS transportation vendor, Medical Answering Services (MAS).

Providers may also order transportation services via the Medical Answering Services website at medanswering.com; phone or fax. Location specific phone number and contact details can be found on the MAS website.

Benefit Coverage

Transportation expenses are covered for MMC Members when essential to obtain Medically Necessary Covered services.

Travel Exclusions and Limitations

- Travel for non-authorized care.
- Travel to a PCP that the Member has selected that is outside the 30-minute, 30-mile travel standard, unless no provider is available within travel standard.

Hemophilia Blood Clotting Factor Program

MVP covers blood clotting factor drugs and treatment rendered by Participating Providers for MMC and CHP Members. Services and supplies must be obtained by practitioners in the MVP Network.

Prior Authorization is required for CHP members. Participating Providers should follow MVP protocols for Prior Authorization.

Prior Authorization is not required for MMC Members. However, the prescribing Participating Provider must complete a Clotting Factor Individual Service Plan (ISP) form as a Member starts blood clotting factor treatment or becomes covered by MVP while in treatment. This requirement allows MVP to collect information from the prescriber and the vendor supplying the drug and develop a person-centered service plan that is designed to meet all the member's potential treatment needs. A new ISP for the member should be sent to MVP every 180 days. Quarterly updates from the supplier of the drug are also required. Participating Providers should consult MVP's Benefit Interpretation Manual regarding coverage criteria.

Health Home Program

A Health Home is a care management service model whereby all of a member's caregivers communicate with one another, so all needs are addressed comprehensively, and physical and behavioral health services are integrated. MVP's Health Home Program provides Care Management services to qualified adult and children Members using an integrative model to support the Member's recovery. The Health Home Program is designed to minimize gaps in care, maximize early intervention and improve health outcomes.

Health Home Program services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, increased patient and family support. For adult Health Home members enrolled

in a Health and Recovery Plan (HARP), and for children enrolled in a Health Home, a care manager can assist with assessing for Adult Behavioral Health Home and Community Based Services (BH-HCBS) or Children's Home and Community Based Services (CHCBS) and Social Support Services (collectively "Health Home Services").

New York State's Health Home eligibility criteria

Determining Eligibility for Health Home Services

Step One

Step One is to determine Medicaid eligibility. Medicaid reimbursement for Health Home services can only be provided for individuals who are enrolled in Medicaid that is also compatible with Health Home services (refer to Guide to Coverage Codes and Health Home Services). The Health Home Care Management Agency (CMA)/Health Home Care Manager (HHCM) must confirm Medicaid eligibility required for enrollment. It is also important to note that a client's Medicaid eligibility may change frequently. The care manager should continually verify Medicaid eligibility and work with eligible Members to assist them in enrolling or renewing Members for Medicaid benefits as required. It is important to note that Medicaid coverage may be granted retroactively.

Step Two

Step Two is to determine if the Member is eligible for Health Home services. To be eligible for Health Home services, an individual must have two chronic conditions or one single qualifying condition. Having one chronic condition (other than the single qualifying conditions below) and being at risk of developing another condition does not qualify an individual as Health Home eligible in New York State.

Medicaid Members eligible to be enrolled in a Health Home must have:

- Two or more chronic conditions
- OR
- One single qualifying chronic condition:
 - HIV/AIDS or
 - Serious Mental Illness (SMI) (Adults) or
 - Serious Emotional Disturbance (SED) or Complex Trauma (Children)

Substance use disorders (SUDS) are considered chronic conditions, but do not by themselves qualify an individual for Health Home services. Individuals with SUDS must have another chronic condition (as described below) to qualify.

Diagnostic eligibility criteria verifying the individual's current condition(s) must be confirmed and maintained in the record. Information may be accepted from any one of these sources: Plan referrals, medical records or assessments, written verification by the individual's physician or treating healthcare provider, the Regional Health Information Organization (RHIO), or the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES).

MCOs and medical providers may provide the Health Home Care Management Agency (CMA) or Health Home with a Clinical Discretion of Diagnostic Requirements, to allow the CMA/HH to service the Member without documentation and verification of qualifying conditions.

Qualifying chronic conditions are any of those included in the "Major" categories of the 3MTM Clinical Risk Groups (CRGs) as described in the list below.

Major Category: Alcohol and Substance Use Disorder

- Alcohol and Liver Disease
- Chronic Alcohol Abuse

- Cocaine Abuse
- Drug Abuse – Cannabis/NOS/NEC
- Substance Abuse
- Opioid Abuse
- Other Significant Drug Abuse

Major Category: Mental Health

- Bi-Polar Disorder
- Conduct, Impulse Control, and Other Disruptive Behavior Disorders
- Dementing Disease
- Depressive and Other Psychoses
- Eating Disorder

Major Personality Disorders

- Psychiatric Disease (Except Schizophrenia)
- Schizophrenia

Major Category: Cardiovascular Disease

- Advanced Coronary Artery Disease
- Cerebrovascular Disease
- Congestive Heart Failure
- Hypertension
- Peripheral Vascular Disease

Major Category: Developmental Disability

- Intellectual Disability
- Cerebral Palsy
- Epilepsy
- Neurological Impairment
- Familial Dysautonomia
- Prader-Willi Syndrome
- Autism

Major Category: Metabolic Disease

- Chronic Renal Failure
- Diabetes

Major Category: Respiratory Disease

- Asthma
- Chronic Obstructive Pulmonary Disease

Major Category: Other

Step Three

Step three is to determine appropriateness for Health Home services. Individuals who are Medicaid eligible and have active Medicaid and meet diagnostic eligibility criteria are not necessarily appropriate for Health Home care

management. An individual can have two chronic conditions and be managing their own care effectively. An individual must be assessed and found to have significant behavioral, medical, or social risk factors that require the intensive level of Care Management services provided by the Health Home Program. Appropriateness for Health Home services must be determined for MAPP HHTS Referral Portal referrals, as well as community or bottom up referrals. An assessment must be performed for all individuals to evaluate whether the person has significant risk factors.

Additionally, currently enrolled Members should be evaluated to determine whether they remain appropriate for the Health Home Program. Can the Member manage their condition(s) using existing services and family/natural supports without evidence of risk that supported their HH enrollment? Can the Member be disenrolled or transitioned to a lower level of care management?

Determinants of medical, behavioral, and/or social risk can include:

- Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement).
- Lack of or inadequate social/family/housing support, or serious disruptions in family relationships.
- Lack of or inadequate connectivity with healthcare system.
- Non-adherence to treatments or medication(s) or difficulty managing medications.
- Recent release from incarceration, detention, psychiatric hospitalization or placement.
- Deficits in activities of daily living, learning or cognition issues; OR
- Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

NOTE: When evaluating appropriateness for the enrollment of the adult population, there are varying factors that must be considered. HHs, CMAs and MCPs must follow NYS DOH guidance provided in the Eligibility Requirements: Identifying Potential Members for Health Home Services – Appropriateness Criteria, which supplements this policy by providing examples of determinants of risk identified in the above list.

If you have any questions, please contact MVP's Health Home Program at HealthHome@mvphealthcare.com.

MVP Behavioral Health Case Management

MVP offers behavioral health care management services to manage Members' behavioral health care needs (both behavioral health and substance use disorders.) This service is available to:

- All Medicaid Managed Care, Child Health Plus, and Medicare Members
- Children and Adults

In collaboration with the Member, MVP Behavioral Health Care Management offers direct support in addressing individual needs and navigating available services and supports. For Members with high risk behavioral or substance use conditions that require more extensive use of resources intensive case management services are available.

For questions related to behavioral health services contact us at **1-800-684-9286** and listen for the behavioral health prompt.

Health and Recovery Plan – (MVP Harmonious Health Care Plan)

A Health and Recovery Plan (HARP) is a special needs product that focuses on adults with significant behavioral health needs. The plan addresses these needs through the integration of physical health, mental health, and substance use services. MVP's HARP product is called the MVP Harmonious Health Care Plan. This product is

designed to promote person-centered, collaborative care which focuses on recovery.

The MVP Harmonious Health Care Plan will:

- Manage the Members Medicaid Services
- Manage an enhanced benefit package of Adult Behavioral Health Home and Community-Based Services (BHHCBS)
- Provide enhanced care management for Members to help them coordinate all their physical health, behavioral health and non-Medicaid support needs

Eligibility for HARP

To join the MVP Harmonious health Care Plan, individuals must be 21 or older, be insured only by Medicaid and be eligible for Medicaid managed care. NYS identifies individuals eligible for HARP based on a number of factors which includes prior Medicaid use. Those that are found eligible will receive a notice from New York Medicaid Choice.

HARP is not mandatory. As part of the State's passive enrollment process, these individuals will be informed about HARP eligibility, benefits as well as their ability to stay in their existing mainstream plan, choose another HARP or opt out of HARP. Individuals are given 30 days to opt out or switch to a new HARP. Once enrolled in their desired Plan, Members are given an additional 90 days to choose another HARP or return to Mainstream. Following this 90 day period, Members are locked in to their selected HARP for 9 additional months (after which they may change plans at any time.)

join the MVP Harmonious health Care Plan, individuals must be 21 or older, be insured only by Medicaid and be eligible for Medicaid managed care. NYS identifies individuals eligible for HARP based on a number of factors which includes prior Medicaid use. Those that are found eligible will receive a notice from New York Medicaid Choice. HARP is not mandatory. As part of the State's passive enrollment process, these individuals will

be informed about HARP eligibility, benefits as well as their ability to stay in their existing mainstream plan, choose another HARP or opt out of HARP. Individuals are given 30 days to opt out or switch to a new HARP. Once enrolled

in their desired Plan, Members are given an additional 90 days to choose another HARP or return to Mainstream.

Following this 90-day period, Members are locked into their selected HARP for 9 additional months (after which they may change plans at any time.)

HARP Model of Care

The HARP model of care is a recovery model. This model emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self-direction, social inclusion, and coping skills.

Providers working with HARP eligible members, and especially those providing Adult BH-HCBS Services, must implement processes to ensure clinical work adheres to recovery-based principles including but not limited to:

- Self-direction: Consumers determine their own path to recovery.
- Individualized and person-centered: There are multiple pathways to recovery based on individuals' unique strengths, needs, preferences, experiences and cultural backgrounds.
- Empowerment: Consumers can choose among options and participate in all decisions that affect them.
- Holistic: Recovery focuses on people's entire lives, including mind, body, spirit and community.
- Nonlinear: Recovery isn't a step-by-step process, but one based on continual growth, occasional setbacks and learning from experience.

- Strengths-based: Recovery builds on people's strengths.
- Peer support: Mutual support plays an invaluable role in recovery.
- Respect: Acceptance and appreciation by society, communities, systems of care and consumers themselves are crucial to recovery.
- Responsibility: Consumers are responsible for their own self-care and journeys of recovery.
- Hope: Recovery's central, motivating message is a better future — that people can and do overcome obstacles.

MVP will evaluate the use of Recovery Principles in care during both utilization management activities, quality evaluations and chart review processes.

To join the MVP Harmonious health Care Plan, individuals must be 21 or older, be insured only by Medicaid and be eligible for Medicaid managed care. NYS identifies individuals eligible for HARP based on a number of factors which includes prior Medicaid use. Those that are found eligible will receive a notice from New York Medicaid Choice. HARP is not mandatory. As part of the State's passive enrollment process, these individuals will be informed about HARP eligibility, benefits as well as their ability to stay in their existing mainstream plan, choose another HARP or opt out of HARP. Individuals are given 30 days to opt out or switch to a new HARP. Once enrolled in their desired Plan, Members are given an additional 90 days to choose another HARP or return to Mainstream. Following this 90-day period, Members are locked into their selected HARP for 9 additional months (after which they may change plans at any time.)

HARP Covered Benefits and Services

Members enrolled in the MVP Harmonious Health Care Plan have access to the following Behavioral Health benefits for all Medicaid participants 21 and older.

- Medically supervised outpatient withdrawal
- Outpatient clinic and opioid treatment program (OTP) services
- Outpatient clinic services
- Comprehensive psychiatric emergency program
- Continuing day treatment
- Partial hospitalization
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment (ACT)
- Home Care Coordination and Management
- Inpatient hospital detoxification
- Inpatient medically supervised inpatient detoxification
- Inpatient treatment
- Rehabilitation services for residential SUD treatment supports
- Inpatient psychiatric services
- Rehabilitation services for residents of community residences
- Adult Crisis Residence

Additionally, Members meeting eligibility requirements may access Adult BH-HCBS.

- Psychosocial Rehabilitation

- Community Psychiatric Support and Treatment (CPST)
- Habilitation Services
- Family Support and Training
- Short-Term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Peer Support Services
- Non-medical Transportation
- Pre-vocational Services
- Transitional Employment
- Intensive Supported Employment
- On-going Supported Employment

HARP Care Management

Care management for HARP Members is offered by Health Homes designated by NYS. Upon enrollment into the MVP Harmonious Health Care Plan, Members are screened for BH-HCBS eligibility by their Health Home Care Manager or a State Designated Entity. Once eligibility is established Members work with their health Home

care manager to develop a comprehensive person-centered Plan of Care (POC.) This POC is used to identify and document appropriate services and supports to meet each Members unique needs including the array of available BH-HCBS. This document is shared with MVP and includes the scope, type, and duration of services the Member is eligible to receive. BH-HCBS is a voluntary program. HARP Care Management may be provided regardless of BH-HCBS utilization.

Adult Behavioral Health Home and Community Based Services (BH-HCBS)

Adult Behavioral Health Home and Community Based Services (BH-HCBS) enhance access to Behavioral Health and substance use treatment and recovery services for eligible Medicaid Members. BH-HCBS provides alternatives to hospital based, inpatient or other institutional care settings. This program is designed to empower Members to take an active role in their health care and through an integrated approach support Members in maintaining success in the community. The array of services includes opportunities for Members to be served in the community setting or within their own homes in many cases.

Core Principles of BH-HCBS include:

- **Person-Centered Care:** Care should be self-directed whenever possible and emphasize shared decision- making approaches that empower Members, provide choice, and minimize stigma.
- **Recovery-Oriented:** The system should include a broad range of services that support recovery from mental illness and/or substance use disorders.
- **Integrated:** Service providers should attend to both physical and behavioral health needs of Members, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met.
- **Data-Driven:** Providers and plans should use data to define outcomes, monitor performance, and promote health and well-being.

BH-HCBS Eligibility

Eligibility for BH-HCBS is assessed annually for all HARP Members using the following screening tools:

- NYS Community Mental Health Eligibility Assessment (Initial assessment)
- NYS Community Mental Health Assessment

Upon enrollment into the MVP Harmonious Health Care Plan Members are offered enrollment in a State designated Health Home who will provide HARP Care Management as described above. To be assessed for BH-HCBS eligibility, Members must either participate with a Health Home or Recovery Coordination Agency (RCA*) who will complete the screening tools and POC development in compliance with conflict free case management requirements. All HARP Members are screened for BH-HCBS eligibility annually.

The assessment identifies level of need associated to the following functional areas:

- Employment/Education
- Stress and Trauma
- Cognitive Skills
- Co-morbid Conditions
- Social Relations
- Engagement
- Substance Use
- Risk of Harm
- Instrumental Activities of Daily Living (IADL)

BH-HCBS has two tiers of service eligibility. The NYS Community Mental Health Eligibility Assessment is an initial assessment used to determine overall BH-HCBS and Tier eligibility. Members may be found non eligible.

Tier 1 services include:

- Peer supports
- Employment
- Education
- Crisis respite

Tier 2 Services include (in addition to above):

- Psychosocial rehabilitation
- Community psychiatric supports and treatment

Once Members qualify for BH-HCBS and Tier eligibility is established, the NYS Community Mental Health Assessment is completed. This assessment is used to develop a comprehensive POC which includes all eligible and appropriate BH-HCBS and recovery goals. Members will work with their HARP Care Manager (or RCA) in conjunction with the Health Plan to identify and refer to BH-HCBS providers within the MVP network.

*Recovery Coordination Agencies (RCAs) are State Designated Entities (SDEs) who assist HARP members who are not enrolled or do not wish to be enrolled in a Health Home in accessing Behavioral Health Home and Community Based Services (BH HCBS). These providers work with the MCO to conduct NYS Eligibility Assessments, referrals and Person-Centered Care Planning for Adult Behavioral Health HCBS.

BH-HCBS Descriptions

Many of the BH-HCBS are designed to be provided in clusters which promote recovery along a spectrum.

Psychosocial Rehabilitation (PSR)

PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive Member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

Community Psychiatric Support and Treatment (CPST)

CPST includes time-limited goal directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

Pre-vocational Services

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Transitional Employment (TE)

This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Intensive Supported Employment (ISE)

This service assists individuals with MH/SUD to obtain and keep competitive employment. These services consist of

intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence-based principles of the Individual Placement and Support (IPS) model. This service is based on Individual Placement Support (IPS) model which is an evidence-based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or

above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by

the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting. Ongoing Supported Employment: This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain

their paid employment positions. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive

not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's

Ongoing Supported Employment

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain

a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Short-term Crisis Respite

This is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support

- When there is an indication that a person's symptoms are beginning to escalate Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Short-Term Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

Intensive Crisis Respite

This is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety. Individuals in need of ICR are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Intensive Crisis

Educational Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support

Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Empowerment Services – Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to

the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

Habilitation/ Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist participants with developing skills necessary for community

living and, if applicable, to continue the process of recovery from a SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant.

Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are

all primary members of the recovery team. For purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. “Family” does not include individuals who are employed to care for the participant. Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery Plan and shall include updates, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual’s recovery plan and for the benefit of the Medicaid covered participant.

For more information on BH-HCBS services and eligibility please refer to the NYS HARP BH HCBS Provider Manual:

<https://omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf>

Children’s Behavioral Health Services

Covered Benefits and Services

Members enrolled in the MVP Medicaid Managed Care Plan have access to following Children’s Behavioral Health benefits for all Medicaid participants under 21 years of age.

- Assertive Community Treatment (ACT) (minimum age is 18)
- Children’s Day Treatment
- Comprehensive Psychiatric Emergency Program including Extended Observation Bed
- Continuing Day Treatment (minimum age is 18)
- Inpatient Psychiatric Services
- Licensed Behavioral Health Practitioner (LBHP) Service
- Licensed Outpatient Clinic Services
- Medically Managed Detoxification (hospital-based)
- Medically Supervised Inpatient Detoxification

- Medically Supervised Outpatient Withdrawal
- OASAS Inpatient Rehabilitation Services
- OASAS Outpatient and Residential Addiction Services
- OASAS Outpatient Rehabilitation Programs
- OASAS Outpatient Services
- OMH State Operated Inpatient West
- Partial Hospitalization
- Outpatient Clinic and Opioid Treatment Program (OTP) services
- Personalized Recovery Oriented Services (PROS) (minimum age is 18)
- Rehabilitation Services for residents of community residences
- Residential Rehabilitation Services for Youth (RRSY)
- Residential supports and services (Early Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)
- Residential Treatment Facility (RTF)
- Children's Crisis Residence

Members meeting applicable medical necessity criteria may access Children and Family Treatment and Support Services (CFTSS)

- Other Licensed Practitioner (OLP)
- Crisis intervention
- Community Psychiatric Supports & Treatment (CPST)
- Psychosocial Rehabilitation Services
- Family peer Support Services
- Youth Peer Advocacy and Training

Additionally, Members meeting CHCBS Eligibility may access Children's home and Community Based Services (CHCBS)

- Respite (Planned / Crisis)
- Community Habilitation
- Day habilitation
- Caregiver/Family support and Services
- Supported Employment
- Prevocational Services
- Community Self-Advocacy Training and Supports
- Non-Medical Transportation
- Adaptive and Assistive Equipment
- Vehicle Modifications
- Environmental Modifications
- Palliative Care

- Expressive therapy ◦ Massage therapy
- Bereavement Service
- Pain and Symptom management

Children and Family Treatment and Support Services

Children and Family Treatment and Support services (CFTSS) are available to all MVP Medicaid Managed Care enrolled children under the age of 21 meeting applicable medical necessity criteria. These services focus on provision of individualized Behavioral Health interventions which promote greater care flexibility and include family and community provider integration. Medical Necessity criteria can be found on the NYS Office of Mental

Health (OMH) website. The following is a description of the various CFTSS. These services should be provided using the principles of recovery orientation, person-centeredness, strengths-based, evidence-based, and delivered in the community and the most integrated settings whenever possible.

Other Licensed Practitioner

Non-physician licensed behavioral health practitioner (NP-LBHB) who is licensed in the State to prescribe, diagnose, and/or treat individuals with a physical, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in State law and in any setting permissible under State practice law (i.e., services can be delivered in the community outside the four walls of the agency). NP-LBHPs include individuals licensed and able to practice independently or are under the supervision or directions of a licensed clinical social worker, a licensed psychologist, or a psychiatrist. Activities would include:

Recommending treatment that also considers trauma-informed, cultural variables, and nuances

- Developing recovery or treatment plan
- Activities within the scope of all applicable state laws and their professional license including counseling, individual, or family therapy
- Developing recovery-oriented treatment plans

Crisis Intervention

Crisis intervention services are provided to all children/youth who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it.

Community Psychiatric Support & Treatment (CPST)

Community Psychiatric Support & Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the child's treatment plan. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings but can benefit from community-based onsite rehabilitative services.

Psychosocial Rehabilitation

Psychosocial Rehabilitation Services (PRS) are designed to work with children and their families to implement interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environment barriers associated with a child/youth's behavioral health needs.

Family Peer Support Services

Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provided a structure, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/ caregiver for the benefit of the child/ youth.

Youth Peer Support

Youth Peer Support (YPS) services are formal and informal services and supports provided to youth and families raising an adolescent who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community-centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

Children's Home and Community Based Services (CHCBS)

Children's Home and Community-Based Services (CHCBS) is a State operated 1915c Children's Waiver which provides opportunities for Medicaid Member's under 21 that have Behavioral Health needs and/or medically

complex conditions to receive services in their own home or community. The array of available services supports children with significant need who are at risk for hospitalization or institutionalization care to support them maintaining within their home and community setting. MVP, Health Home Care Managers (*Children Youth Evaluation Services (CYES), service providers, plan members, and their chosen supporters/caregivers, help Members prevent, manage, and ameliorate chronic health conditions and improve health outcomes.

MVP's strategies to promote behavioral health-medical integration for children, including at-risk populations, include:

- Provider access to rapid consultation from child and adolescent psychiatrists
- Provider access to education and training
- Provider access to referral and linkage support for child and adolescent patients

*The Children and Youth Evaluation Service (C-YES) is a statewide program that determines whether a child/youth (under age 21) is eligible for Home and Community Based Services (HCBS).

Children's Home and Community Based Services Eligibility Criteria

Children and youth must be under 21 years of age and eligible for Medicaid to receive CHCBS. Eligibility is established using the HCBS/LOC Eligibility Determination tool housed within the Uniform Assessment system (UAS) along with the Child and Adolescent Needs and Strengths – NY (CANS-NY) Assessment. Only a Health Home Care Manager, Children and Youth Evaluation Services (C-Yes) or the OPWDD Developmental Disabilities Regional Office (DDRO) are given access within the UAS to complete the HCBS/LOC Eligibility Determination. Members may opt

to use either the HHCM/C-Yes to complete the assessment and subsequent POC development. As made available through the State operated Children's Waiver, the Member must also be provided a CHCBS Waiver slot, appointed by NYS DOH prior to accessing services.

CHCBS eligibility is comprised of three components:

- Target Criteria
- Risk Factors

- Functional Criteria

These three components are evaluated using the HCBS/LOC Eligibility Determination to establish which CHCBS eligibility group the child or youth is eligible for (if any). There are two CHCBS eligibility Groups

- Level of care (LOC): Children that meet institutional placement criteria

There are 4 subgroups within the LOC group:

- a. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
- b. Children with a Developmental Disability in Foster Care
- c. Children who are Medically Fragile
- d. Children who are Medically Fragile with a Developmental Disability

- Level of Need (LON): Children at risk of instructional placement (expected to be implemented 2021)

There are two subgroups within the LON group

- a. Children with Serious Emotional Disturbance (SED) with or without co-occurring Substance Use Disorders (SUD)
- b. Abuse, Neglect and Maltreatment or Health Home Complex Trauma

The HCBS/LOC Eligibility Determination is completed annually and remains active for a 12-month period with the following exceptions:

- Significant life event
 - If there is a significant life event for a child/youth while receiving HCBS, a new HCBS/LOC Eligibility Determination may be needed. A significant life event is something that occurs in child's/youth's life that impacts their functioning, daily living situation or those that care for the child/youth.
- The Member is found HCBS/LOC eligible but initially declines CHCBS. A new assessment is needed if the active determination is not utilized within six (6) months of the date of the eligibility outcome.

If a child/youth is found HCBS/LOC ineligible and there is a change in circumstances, the child/youth can be reassessed at any time, as there is no wait period between assessments.

Capacity Management

Capacity Management is the process by which New York State manages the combined slots for the 1915c Children's Waiver. Slot capacity is tracked by NYS using target population regionally. Upon completion of the HCBS/LOC Eligibility Determination within the UAS the NYS Capacity Management team will review the Eligibility report by the next business day and provide notification to the HHCM (or C-YES) of slot assignment. The Capacity Management team will also send a Notice of Decision to the Member. Once assigned, the Member will maintain the Waiver slot until discharged from the waiver.

Review Guidelines

Once LOC has been established (or LON once implemented) the HHCM (or C-YES) will work with the Member to develop a person-centered Plan of Care (POC) inclusive of all eligible and appropriate Services. The HHCM will work to refer the Member to all applicable CHCBS providers within the plans network.

Once referred CHCBS provider(s) will conduct service specific evaluation(s) and forward additional information to Health Home Care Manager regarding intensity and duration of services which is captured within the POC shared with MVP.

HCBS providers will be required to submit a notification to MVP when a Member has been accepted and a first appointment scheduled. Notification will allow for authorization of specific CHCBS interventions as well as collaborative monitoring to assure timely and appropriate care coordination. MVP utilization management will ensure the Member's plan of care reflects the Member's individual, assessed, and self-reported needs and is aligned with concurrent review protocols.

MVP will oversee and support the Health Homes and CHCBS providers via identified quality and utilization metrics and clinical review to ensure adherence with program specifications as defined by NYS-established criteria. The program oversight includes effectively partnering and engaging with contracted Health Home and HCBS providers to ensure that program operations and service delivery have a consistent focus on key factors that result in quality and efficacious treatment for eligible enrollees.

All eligible Members will additionally be provided access to an MVP Care Manager who will serve as the contact with the Health Home, review clinical information, and collaborate on coordination of care, as appropriate.

These review guidelines provide a framework for discussion between HCBS providers and MVP. The review process is a collaboration between all pertinent participants including but not limited to, the Health Home Care Manager, HCBS provider and Member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the Member's chosen goals. Conversations will focus on the Member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all Members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

Children's Home and Community-Based Services Descriptions

Respite (Planned and Crisis)

Respite focuses on short-term assistance and/or relief for children with disabilities (developmental, physical and/or behavioral), and family/ caregivers which can be provided in a planned mode or delivered in a crisis environment. To the extent that the skilled nursing is provided as a form of respite, this service must be ordered by a physician. This service may be provided in a one-to-one, individual session, or group session. The need for crisis respite may be identified because of a Medicaid State Plan crisis intervention or may come from referrals from the emergency room, the community, LDSS/LGU/SPOA, school, self-referrals, or as part of a step-down plan from an inpatient setting. Crisis respite should be included on the plan of care to the extent that it is an element of the crisis plan or risk mitigation strategy.

Caregiver/Family Supports and Services

These services are designed to enhance the child's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child in the home and/or community. Note: this service differs from the State Plan series of Family Peer Support Services, which is delivered by credentialed/certified Family Peer Specialist with lived experience

Prevocational Services

Prevocational services are individually designed to prepare a youth age 14 or older to engage in paid work, volunteer work or career exploration. Prevocational services are structured around teaching concepts such as compliance, attendance, task completion, problem solving, and safety based on a specific curriculum related to youth with disabilities (developmental, physical, and/or behavioral). In addition, prevocational services

assist facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements. Prevocational services are not job-specific, but rather are geared towards facilitating success in any work environment for children whose disabilities do not permit them access to other prevocational services. The service will be reflected in a participant's service plan directed to teaching skills rather than explicit employment objectives.

Supportive Employment

Supported employment services are individually designed to prepare individuals with disabilities (developmental, physical, and/or behavioral) age 14 and older to engage in paid work. Supported employment services provide assistance to participants with disabilities as they perform in a work setting. Supported employment provides ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in a competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but no

less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Community Self-Advocacy Training and Support

These services aim to improve the child's ability to gain from the community experience and enables the child's environment to respond appropriately to the child's disability and/or health care issues. The use of this service may appropriately be provided to prevent problems in community settings as well as when the child experiencing difficulty. The plan of care objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the

plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child. This service may be provided in an individual session or in a group setting.

Habilitation (Day & Community)

These services focus on helping children with developmental, medical, and behavioral disabilities who are eligible for HCBS to be successful in the home, community, and school by acquiring both social and environmental skills associated with his/her current developmental stage. This service assumes that the child has never had skills being acquire. Habilitation services assist children who have never acquired a particular skill with the self-help, socialization and adaptive skills necessary for successful functioning in the home and community when other types of skill-building services are not appropriate. This service may be delivered in an individual or group setting.

Habilitation is provided to the child and the child's family/caregiver to support the development and maintenance of skill sets.

Palliative Care Services

Palliative care is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life-threatening illness. The goal is to improve quality of life for both the child/youth and the family. Palliative care is provided by a specially trained team of doctors, nurses, social workers, and other specialists who work together with a child/youth's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life-threatening illness and can be provided along with curative treatment. There are several distinct Palliative care Services available:

- Expressive therapy
- Massage therapy

- Bereavement service
- Pain and Symptom management

Adaptative and Assistive Equipment

This service provides technological aids and devices identified within the child/youth's Plan of Care (POC) which enable the accomplishment of daily living tasks that are necessary to support the health, welfare, and safety of the child/youth.

Vehicle Modifications

This service provides physical adaptations to the primary vehicle of the enrolled child/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence.

Environmental Modifications

Environmental Modifications provides internal and external physical adaptations to the home or other eligible residences of the enrolled child/youth which, per the child/youth's POC, are identified as necessary to support the health, welfare, and safety of the child/youth or that enable the child/youth to function with greater independence in the home and without which the child/youth would require an institutional and/or more restrictive living setting.

Additional Coverage for Children with Non-Supplemental Security Income (SSI) Medicaid Managed Care (MMC) Children with non-Supplemental Security Income (SSI) Medicaid Managed Care (MMC) will have additional coverage so they can take advantage of additional behavioral health treatment and support services for their families.

These services place strong emphasis on early identification and access to treatment. The intention is to prevent the

onset or progression of behavioral health conditions and a need for long-term or more expensive services. Some of these services will allow the child to be treated in the home and other natural, community-based settings where children/youth and their families live. This includes the following services:

1. **Other Licensed Practitioner (OLP)** – lets children get individual, group, or family therapy where they are most comfortable.
2. **Psychosocial Rehabilitation (PSR)** – helps children relearn skills to help them in the community.
3. **Psychiatric Supports and Treatment (CPST)** – helps children stay in their home and communicate better with family, friends, and others.
4. **Family Peer Support Services (FPSS)** – provides support to families caring for or raising a child experiencing social, emotional, medical developmental, substance use, and/or behavioral challenges.
5. **Crisis Intervention (CI)** – works towards resolving serious acute psychological/emotional problems a child/youth may be facing.
6. **Youth Peer Support and Training (YPST)** – provides support and training to youth experiencing social, emotional, medical developmental, substance use, and/or behavioral challenges

Transition of Children in Voluntary Foster Care into Medicaid Managed Care

Effective July 1, 2021 children placed in voluntary foster care will transition into Medicaid Managed Care. Voluntary Foster Care Agencies (VFCAs) who obtain Article 29-I licensure and provide mandatory Core Limited Health-Related Services to foster care children while they are in active placement. VFCAs may also provide Other Limited-Health

Related Services (as outlined in the agency’s licensure) to children in active foster care placement and up to one-year post discharge.

Core Limited Health-Related Services (residual per diem):

- Skill building
- Nursing supports and medication management
- Medicaid treatment planning and discharge planning
- Clinical consultation and supervision
- Managed Care Liaison/administration

Other Limited Health-Related Services may include:

- Screening, diagnosis, and treatment related to physical/developmental/behavioral health
- Children and Family Treatment and Support Services (when designated a children’s provider)
- Children’s Home and Community Based Services (when designated a children’s provider)

Behavioral Health Provider Training

MVP provides resources for provider training regarding Behavioral Health services and special populations including HARP, CHCBS and CFTSS. The training is available online at mvphealthcare.com/providers/education. All Participating Providers in MVPs Medicaid Managed Care program are required to complete this training. The training outlines information including the following:

- Determining a child’s eligibility for the CHCBS program (e.g. Targeting Criteria, Risk Factors, Functional Limitations)
- How to work with MVP on developing and reviewing a Plan of Care (POC) for these members.
- How to determine if an MVP member is enrolled in this program as they will not have a different line of business, only additional benefits.
- How to determine the additional benefits for these members.
- Utilization and Case Management Requirements regarding required specialized services.
- Any special billing and coding requirements, data interface, documentation requirements, Provider profiling programs, and for these members.

Benefit Overview for NYS Government Programs

The table below outlines the benefits covered by each MVP Government program plan. An “X” in a box indicates that service is covered.

SERVICE	MEDICAID	SSI	MVP Harmonious Health Care Plan (HARP)*	CHPlus
Adult Day Health Care	X Covered with Prior Authorization	X Covered with Prior Authorization	X Covered with Prior Authorization	Not Covered
AIDS Adult Day Care	X Covered with Prior Authorization	X Covered with Prior Authorization	X Covered with Prior Authorization	Not Covered

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SERVICE	MEDICAID	SSI	MVP Harmonious Health Care Plan (HARP)*	CHPlus
Audiology services: hearing aids and follow-up visits	X	X	X	One hearing exam/ calendar year and any medically necessary follow-up
Chiropractic services	Not covered	Not covered	Not covered	Not covered
Custodial Nursing Home Care	X – Covered with approval from the County LDSS	X – Covered with approval from the County LDSS	Not covered	Not Covered
Clinical Laboratory Certification/ Amendment Certification	CLIA	Lab		
Dental*	X*	X*	X*	X*
Doctor visits	X	X	X	X
Durable medical equipment(DME)	X	X	X	X
Emergency room services	X	X	X	X
Emergency transport	X Covered under FFS Medicaid	X Covered under FFS Medicaid	X Covered under FFS Medicaid	X ground only (air ambulance not covered)
Family planning and reproductive care	X	X	X	X
Foot care	Medically necessary non-routine foot care	Medically necessary non-routine foot care	Medically necessary non-routine foot care	Medically necessary non-routine foot care
Harm Reduction Services	X	X	X	
Home Delivered meals	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	
Hospice	X	X	X	X
Immunizations	X Immunizations for children under age 18 are covered by the NYS VFC program	X Immunizations for children under age 18 are covered by the NYS VFC program	X	X Immunizations for children under age 18 are covered by the NYS VFC program

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SERVICE	MEDICAID	SSI	MVP Harmonious Health Care Plan (HARP)*	CHPlus
Infertility Services	X	X	X	Not covered
EPSDT services through the Child/Teen Health Program and Adolescent Preventive Services	X	X		X
Inpatient Hospital Services	X	X	X	X
Inpatient mental health	X*	X*	X*	X*
Laboratory services	X	X	X	X
Low vision and medical eye care	X	X	X	X
Medically managed inpatient detoxification	X*	X*	X*	X*
Occupational therapy	X	X	X	X
Mobile Crisis Intervention Services	X	X	X	Not covered
Medical Social Services	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for members who transitioned from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	
Orthodontia	X* Covered with prior authorization	X* Covered with prior authorization	X* Covered with prior authorization	X* Covered with prior authorization
OTC Drugs <i>See Section 9- Pharmacy</i>	X	X	X	Not covered except with prescription. Must be for therapeutic and preventive purposes
Outpatient Mental Health	X*	X*	X*	X*
Outpatient Substance Abuse Services	X*	X*	X*	X*
Personal Care – Level 1	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered
Personal Care – Level 2	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered
Consumer Directed Personal Assistance	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered

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SERVICE	MEDICAID	SSI	MVP Harmonious Health Care Plan (HARP)*	CHPlus
Physical therapy	X	X	X	X
Prenatal Care	X	X	X	X
Prescription Drugs <i>See Section 9 – Pharmacy</i>	X Use MVP Medicaid Managed Care formulary	X Use MVP Medicaid Managed Care formulary	X Use MVP Medicaid Managed Care formulary	X Use MVP Commercial formulary
Preventive Health Services	X	X	X	X
Private Duty Nursing	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Not covered
Prosthetics and Orthotics	X	X	X	Covered as medically necessary w/ exception of wigs, dental prostheses and orthotics prescribed for sports
Radiology services	X	X	X	X
Other preventive services	X	X	X	X
Renal dialysis	X	X	X	X
Routine eye care and glasses	X	X	X	X
Routine transportation	Covered by fee-for-service Medicaid, contact Medical Answering Services	Covered by fee-for-service Medicaid, contact Medical Answering Services	Covered by fee-for-service Medicaid, contact Medical Answering Services	Not covered
Home health care	X	X	X	Up to 40 visits/year as medically necessary
Smoking cessation counseling	X	X	X	Not covered
Smoking cessation products	X Use MVP Medicaid Managed Care formulary	X Use MVP Medicaid Managed Care formulary	X Use MVP Medicaid Managed Care formulary	Not covered
Specialist care	X	X	X	X
Speech therapy	X	X	X	X
Substance Use Disorder services Mandated by LDSS	X*	X*	X*	

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SERVICE	MEDICAID	SSI	MVP Harmonious Health Care Plan (HARP)*	CHPlus
Substance Use Disorder (SUD) Inpatient Rehabilitation and Treatment Services	X*	X*	X*	X*
SUD Residential Addiction Treatment Services	X*	X*	X*	
SUD Outpatient (includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	X*	X*	X*	X*
SUD Medically Supervised Outpatient withdrawal	X*	X*	X*	X*
Buprenorphine Prescribers	X	X	X	X
Crisis Intervention Services	X*	X*	X*	X*
Children's Crisis Residence	X	X	Not covered	Not covered
Adult Crisis Residence	X*	X*	X	Not covered
Adult HCBS Psychosocial Rehabilitation (PSR)	Not covered	Not covered	X*	Not covered
Children's HCBS Psychiatric Support and Treatment (PSR)	X*	X*	Not covered	Not covered
Adult HCBS Community Psychiatric Support and Treatment (CPST)	X* Not covered	X* Not covered	X*	Not covered
Children's Community Psychiatric Support and Treatment (CPST)	X*	X*	Not covered	Not covered
Adult HCBS Habilitation Services	Not covered	Not covered	X*	Not covered
Children's HCBS Community Habilitation Services	X*	X*	Not covered	Not covered
Children's HCBS Day Habilitation Services	X*	X*	Not covered	Not covered
Adult HCBS Family Support and Training	Not covered	Not covered	X*	Not covered
Children's HCBS Caregiver/Family Supports and Services	X*	X*	Not covered	Not covered
Children's Family Peer Supports and Services (FPSS)	X*	X*	Not covered	Not covered
Children's HCBS Community Self-Advocacy Training and Supports	X*	X*	Not covered	Not covered

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SERVICE	MEDICAID	SSI	MVP Harmonious Health Care Plan (HARP)*	CHPlus
Adult HCBS Short-term Crisis Respite	Not covered	Not covered	X*	Not covered
Children's HCBS Crisis Respite	X*	X*	Not covered	Not covered
Adult HCBS Intensive Crisis Respite	Not covered	Not covered	X*	Not covered
Children's HCBS Planned Respite	X*	X*	Not covered	Not covered
Adult HCBS Education Support Services	Not covered	Not covered	X*	Not covered
Adult HCBS Peer Supports/ Empowerment Services	Not covered	Not covered	X*	Not covered
Children's Youth Peer Support and Training (YPST)	X*	X*	Not covered	Not covered
Adult HCBS Pre-vocational Services	Not covered	Not covered	X*	Not covered
Children's HCBS Pre-vocational Services	X*	X*	Not covered	Not covered
Adult HCBS Transitional Employment	Not covered	Not covered	X*	Not covered
Adult HCBS Intensive Supported Employment (ISE)	Not covered	Not covered	X*	Not covered
Adult HCBS Ongoing Supported Employment	Not covered	Not covered	X*	Not covered
Children's HCBS Supported Employment	X*	X*	Not covered	Not covered
Care Coordination for the HARP Program	Not covered	Not covered	X*	Not covered
Children's Other Licensed Practitioner (OLP)	X*	X*	Not covered	Not covered
Children's HCBS Palliative Care	X* Prior authorization is required	X* Prior authorization is required	Not covered	Not covered
Children's HCBS Assistive and Adaptive Equipment	X* Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	X* Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	Not covered	Not covered

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SERVICE	MEDICAID	SSI	MVP Harmonious Health Care Plan (HARP)*	CHPlus
Children's HCBS Vehicle Modifications	X* Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	X* Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	Not covered	Not covered
Children's HCBS Environmental Modifications	X* Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	X* Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	Not covered	Not covered
Children's HCBS Non-Medical Transportation	X* Covered by fee-for-service Medicaid	X* Covered by fee-for-service Medicaid	Not covered	Not covered
Assistive Technology	X** Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	X** Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	Not covered	Not covered
Environmental Modifications	X* Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	X* Prior authorization is required. One-time expense not to exceed \$15,000 without prior authorization.	Not covered	Not covered
Article 29-I VFCA Core Limited Health-Related Services	X***	X***	Not covered	Not covered
Article 29-I VFCA Other Limited Health-Related Services	X***	X***	Not covered	Not covered

*Refers to special network information

**Refers to Children's services effective 1/1/2020

***Refers to Children's services effective 7/1/2020

Important Phone Numbers

MVP GOVERNMENT PROGRAMS

MVP After Hours	1-888-MVP-MBRS (687-6277)
MVP Customer Care Center	1-800-852-7826
MVP Harmonious Health Care Customer Care Center	1-844-946-8002
Provider Claims	1-800-684-9286
MVP Medical and Behavioral Health Case Management	1-800-666-1762
MVP Behavioral Health Services	1-800-666-1762
CVS Caremark	1-866-832-8077
Healthplex, Inc. (dental benefits administrator)	1-800-468-9868

ALBANY COUNTY

Albany County Department of Social Services (DSS)	518-447-7492
Transportation for MMC members, Medical Answering Services	1-855-360-3549

COLUMBIA COUNTY

Columbia Department of Social Services (DSS)	518-828-9411
Transportation for MMC members, Medical Answering Services	1-855-360-3546

DUTCHESS COUNTY

Dutchess County Department of Social Services (DSS)	845-486-3000
Transportation for MMC members, Medical Answering Services	1-866-244-8995

GENESEE COUNTY

Genesee Department of Social Services (DSS)	585-344-2580
Transportation for MMC members, Medical Answering Services	1-855-733-9404
Child Lead Poisoning Prevention Program	585-344-2580, ext. 5000

GREENE COUNTY

Greene Department of Social Services (DSS)	518-719-3700
Transportation for MMC members, Medical Answering Services	1-855-360-3545

JEFFERSON COUNTY

Jefferson County Department of Social Services	315-782-9030
Transportation for MMC members, Medical Answering Services	1-866-558-0757

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LEWIS COUNTY

Lewis County Department of Social Services (DSS) **315-376-5400**

Transportation for MMC members,
Medical Answering Services **1-800-430-6681**

LIVINGSTON COUNTY

Livingston Department of Social Services (DSS) **585-243-7300**

Transportation for MMC members,
Medical Answering Services **1-888-226-2219**

Child Lead Poisoning Prevention Program **585-243-7299**

MONROE COUNTY

Monroe Department of Human Services **585-753-6440**

Transportation for MMC members,
Medical Answering Services **1-866-932-7740**

Child Lead Poisoning Prevention Program **585-753-5087**

Department of Health Tuberculosis Control Program **585-753-5161**

ONEIDA COUNTY

Oneida County Department of Social Services (DSS) **315-798-5700**

Transportation for MMC members,
Medical Answering Services **1-855-852-3288**

ONTARIO COUNTY

Ontario County Department of Social Services (DSS) **585-396-4599**

Transportation for MMC members,
Medical Answering Services **1-855-733-9402**

Child Lead Poisoning Prevention Program **585-396-4854**

ORANGE COUNTY

Orange County Department of Social Services (DSS) **845-291-4000**

Transportation for MMC members,
Medical Answering Services **1-855-360-3543**

PUTNAM COUNTY

Putnam County Department of Social Services (DSS) **845-808-1500**

Transportation for MMC members,
Medical Answering Services **1-855-360-3547**

RENSSELAER COUNTY

Rensselaer County Department of Social Services (DSS) **518-266-7991**

Transportation for MMC members,
Medical Answering Services **1-855-852-3293**

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ROCKLAND COUNTY

Rockland County Department of Social Services (DSS) **845-364-2000**

Transportation for MMC members,
Medical Answering Services **1-855-360-3542**

SARATOGA COUNTY

Saratoga County Department of Social Services **518-884-4148**

Transportation for MMC members
Medical Answering Services **1-855-852-3292**

SCHENECTADY COUNTY

Schenectady County Department of Social Services **518-388-4470**

Transportation for MMC members
Medical Answering Services **1-855-852-3291**

SULLIVAN COUNTY

Sullivan County Department of Social Services (DSS) **845-292-0100**

Transportation for MMC members,
Medical Answering Services **1-866-573-2148**

ULSTER COUNTY

Ulster County Department of Social Services (DSS) **845-334-5000**

Transportation for MMC members,
Medical Answering Services **1-866-287-0983**

WASHINGTON COUNTY

Washington County Department of Social Services (DSS) **518-746-2300**

Transportation for MMC members,
Medical Answering Services **1-855-360-3544**

WARREN COUNTY

Warren County Department of Social Services **518-761-6321**

Transportation for MMC members,
Medical Answering Services **1-855-360-3541**

WESTCHESTER COUNTY

Westchester County Department of Social Services (DSS) **1-800- 549-7650**

Transportation for MMC members,
Medical Answering Services **1-866-883-7865**

NEW YORK STATE

HIV Confidentiality Hotline **1-800-962-5065**

NY State Department of Health AIDS Institute **1-518-402-6814**

NYS Domestic Violence Hotline **1-800-942-6906**

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NYS Domestic Violence Hotline (Spanish) **1-800-942-6906**

WIC Hotline **1-800-522-5006**

NYS Smokers Quit line **1-866-697-8487**

New York State Vaccines for Children Program **1-800-543-7468**

MVP's Medicare Advantage Plans

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Medicare Advantage Plan Overview

MVP Medicare Preferred Gold HMO-POS, MVP Medicare Secure HMO-POS, MVP Medicare Secure Plus HMO-POS, Gold PPO, GoldAnywhere PPO, USA CareSM PPO, MVP Medicare WellSelect PPO, SmartFund MSA, and MVP RxCare PDP

MVP Health Care's Medicare Advantage plans are specifically designed for Medicare-eligible individuals. These plans take the place of Original Medicare. To enroll, prospective members must have Medicare Parts A and B and have residency qualifications specific to the product. MVP Medicare Preferred Gold HMO-POS, GoldAnywhere PPO and USA Care PPO are offered with and without prescription drug coverage (Part D). All other HMO POS and PPO plans have Part D coverage included. MVP Rx Care is a stand-alone prescription drug plan offered to members with a commercial medical plan through their employer group. SmartFund MSA is a medical-only plan that does not offer Part D prescription drug coverage.

MVP's HMO-POS plans feature a large network of doctors and health care providers locally and across New York State and Vermont. No specialist referrals are required, and the plans provide a point of service benefit that covers members for routine care with non-participating providers. MVP PPO plans offer all the benefits of the HMO-POS plans, plus the freedom to see any doctor or provider anywhere in the U.S., anytime for both routine and non-routine care. USA Care members live across the country and may see any provider in the country who accepts Medicare. SmartFund members can utilize the MVP network or may see any provider in the country that accepts Medicare. MVP Rx Care members have access to more than 66,000 pharmacies in our national network.

Contact Information

See the [Contacting MVP Health Care](#) section for contact information

Claims Submission

NOTE: Per CMS requirements, "Original Medicare (not MVP plans) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial." Based on this requirement, any claims that are part of a clinical trial should be sent directly to Original Medicare and not to MVP Health Care.

Submit all MVP Medicare Advantage plan claims, correspondence and appeals to:

MVP Health Care
Medicare Advantage Plans
PO Box 2207
Schenectady, NY 12301

Claims may also be submitted electronically to MVP.

Identifying MVP Medicare Advantage Providers in the Provider Directory

Providers appearing in red in this resource manual participate with MVP Medicare Advantage plans. Be certain to refer HMO POS plan members to only those providers for non-routine services. PPO members may be referred to non-participating providers,

though their cost share may be higher. USA Care and SmartFund MSA members may see any provider in the country who accepts Medicare.

Visit mvphealthcare.com for the most current listings.

Marketing

MVP's Medicare Sales marketing staff can answer questions and help Medicare-eligible individuals with enrollment. Our experienced Medicare Sales Representatives use Medicare-approved materials and are specifically trained in Medicare marketing rules. For details, call MVP Medicare Sales at **1-800-324-3899** (TTY: 1-800-662-1220).

Prompt Payment and Claims Submission

Claims will be processed according to the contractual guidelines stipulated in each provider's contract. Refer to this manual's [Claims](#) section for details.

Beneficiary Financial Protection

MVP Medicare Advantage members are protected for the duration of the contract period for which premium payments have been made. For members who are hospitalized on the date MVP Medicare Advantage contract with CMS terminates, they will be covered through discharge.

Plan-Directed Care

When a participating provider furnishes non-covered services or refers a Medicare Advantage member to a non-contracted provider for services the member believes are covered, Federal law prohibits holding the member financially liable for the service. In these circumstances, the service may be referred to as "Plan Directed Care."

A member will generally be deemed to believe the service is covered unless the member received an adverse organization determination from MVP. Therefore, MVP requires the following:

- Participating Providers should not refer to out-of-network providers without prior authorization from MVP (See Utilization Management, Prior Authorization section).
- If a participating Provider knows or believes an item or service the out-of-network provider will furnish is not covered, the member or provider must request a pre-service or organization determination from MVP. **As noted below, an ABN may not be used.** In the case of a member who routinely receives the same non-covered service, one organization determination (denied authorization) received at the beginning of the course of service may be used, as long as it is clear that the member understands that the services will never be covered.

Pursuant to law, if a Participating Provider fails to follow these authorization requirements, MVP may decline to pay the claim, in which case the provider will be held financially responsible for services received by the member.

For more information on Plan-Directed Care, Balance Billing and other topics, refer to Chapter 4 of the [Medicare Managed Care Manual](#).

PLEASE NOTE—AN MVP-PARTICIPATING MEDICARE ADVANTAGE PROVIDER MUST NEVER USE AN ADVANCE BENEFICIARY NOTICE (ABN) WITH A MEDICARE ADVANTAGE ENROLLEE.

Services of Non-contracting Providers and Suppliers

MVP must make timely and reasonable payment to or on behalf of the MVP Medicare Advantage plan member for services obtained from provider or supplier who does not contract with the Medicare Advantage organization. Such services include, but are not limited to, emergency and urgently needed care and renal dialysis services for members outside the service area for less than six months.

Balance Billing

Participating providers cannot balance bill MVP's Medicare members when furnishing covered services. Balance billing is the practice of billing the patient for the difference between what MVP Health Care pays for covered services and the "retail" price you charge uninsured patients for these services.

Balance Billing Rules Under Medicare

The **Medicare Managed Care Manual, Chapter 4**, Section 170, states in part: Medicare Advantage members are responsible for paying only the plan-allowed cost-sharing (co-payments or co-insurance) for covered services.

- MVP Health Care as the Medicare Advantage Organization (MAO), not the Medicare member, is obligated to pay limited balance billing amounts to non-par providers; see below.
- If a member inadvertently pays a bill which is MVP's responsibility, we must refund the amount to the enrollee.

Limited Balance-billing Payments to Non-participating Providers— Medicare Contracts Only

Please see below for definitions of provider types:

- **Contracted providers and non-contracting, Original Medicare participating providers**
Balance billing is not allowed.
- **Non-contracting, non-(Medicare)-participating providers**
Bill the MAO [MVP Health Care] the difference between the member's co-payment or co-insurance and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider.
- **Non-contracting, non-participating DME suppliers**
Bill the MAO (MVP Health Care) the difference between the member's cost-sharing (co-payment or co-insurance) and your charges. **Please note that this applies only to members with out-of-network DME coverage**
- According to the *Medicare Managed Care Manual, Chapter 6*, and Section 100, Special Rules for Services Furnished by Non-Contract Providers:
 - **Non-contract providers [including non-contract facilities]** must accept as payment in full payment amounts applicable in Original Medicare (provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare).
 - **Non-contract providers** may not balance bill Medicare Advantage plan enrollees for other than their plan cost-sharing amounts.

Balance Billing Prohibited for Qualified Medicare Beneficiaries (QMBs)

MVP must make timely and reasonable payment to or on behalf of the MVP Medicare Advantage plan member for services obtained from provider or supplier who does not contract with the Medicare Advantage organization. Such services include, but are not limited to, emergency and urgently needed care and renal dialysis services for members outside the service area for less than six months.

Federal law bars Medicare providers from billing a QMB beneficiary (also known as “dual- eligible”) under any circumstances. QMBs are entitled to Medicare Part A, eligible for Medicare Part B, have income below 100 percent of the Federal Poverty Level, and have been determined to be eligible for QMB status by the State Medicaid Office. Medicaid is responsible for deductibles; co-insurance and co-payment amounts for Medicare Part A and B covered services. Further, all original Medicare and Medicare Advantage (MA) providers - not only those that accept Medicaid - must refrain from charging QMB individuals for Medicare cost sharing.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Access to Care

MVP ensures that its provider network is adequate to provide access to covered services.

MVP will arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs.

Health Assessment

MVP will assess new and existing Medicare Advantage plan members for complex or serious medical conditions. Determination is based on a score indicating a complex or serious medical condition by using a tested and accepted health-risk assessment tool, claims data, or other available information.

- For new members, MVP must complete the assessment within 90 days of the member's enrollment date.
- The health care provider who has primary responsibility for the patient's well-being will complete and implement a treatment plan consistent with CMS guidelines.
- Health care providers and MVP will provide member communication regarding the importance of follow-up and self-care consistent with the patient's medical status.

Provision of Care

MVP participating providers should note that decisions made by MVP concerning covered and non-covered services shall in no way affect the health care providers' responsibility to provide services in a manner consistent with professionally recognized standards of care.

Appeal Procedures

MVP and its providers must follow the Medicare appeals/expedited appeals procedures for Medicare Advantage enrollees, including gathering and forwarding information on appeals to MVP and/or MAXIMUS, as necessary. Following are the variations for the provider appeal process:

1. All appeal types will have one level of dispute. The provider cannot go on to a second level with the NYS DFS or the VT DFR for an external appeal of a CMS product. The decision of the health plan will be final and binding for the provider appeal process.
2. Only the provider will receive an acknowledgment letter(s). No copies of outcome letters will be sent to the member.

3. The provider can appeal as the member's appointed authorized representative or on behalf of the member. The member may appoint a representative:
 - a. In writing, the member must provide their name, Medicare number, and a statement that appoints an individual as the member's representative. (Ex: I [name] appoint [representative's name] to act as my representative in requesting an appeal from (policy type) regarding [service description/claim].)
 - b. The member and the representative must sign and date the statement.
 - c. The authorization statement must be submitted with the appeal. If the provider is the member's appointed authorized representative, then the appeal will follow the member appeal path allowing the case to go to MAXIMUS also, if applicable.
4. The provider can appeal as the member's appointed authorized representative or on behalf of the member for Part D.

Medicare Part D

Some of MVP's Medicare Advantage products will be offered with the Medicare Part D benefit. See the Pharmacy Benefits section for additional information on MVP's Medicare Part D benefits and MVP's Part D formulary.

Medication Therapy Management

MVP Medicare Advantage plan members with a Medicare Part D benefit may be eligible to participate in MVP's Medication Therapy Management program (MTM). This program is designed to improve patient safety and adherence to medication therapy for individuals who meet CMS enrollment requirements. For more details, visit mvphealthcare.com and select *Members*, then *Medicare*.

How to Refer a Member to a Program

The process for referral is simple. Call our central triage number: **1-866-942-7966**. Let us see how we can help. MVP will reach out to the member by phone. We will match the member to the most appropriate program and services. This phone line is secure, and you may leave a secure message at this number.

Program Compliance

MVP requires providers to cooperate in and abide by all of MVP's programs, protocols, rules, and regulations, including MVP's QI program, credentialing process, peer-review systems, member grievance system, and Utilization Management program.

Medicare Advantage regulations require MVP to make quality improvement a priority and engage in activities and efforts that demonstrably improve MVP's performance.

Providers are also required to take all actions necessary to permit compliance by MVP with applicable law and the standards of regulatory and other external review agencies, such as NCQA.

Laws and Regulations

All MVP Medicare Advantage providers are paid by MVP from federal funds and must comply with all applicable Federal laws and rules.

Disclosure of Information

MVP will collect and submit information to CMS that will help administer and evaluate MVP Medicare Advantage contracting entities, and the Medicare Advantage program. MVP will collect and provide information to CMS and to Medicare beneficiaries that will help them exercise choice in obtaining Medicare services.

Auditing

To ensure compliance, the Department of Health and Human Services, the Government Accounting Offices, or their designees have the right to audit, evaluate, and inspect books, contracts, medical records, patient care documentation, other MVP Medicare Advantage records, contractors, subcontractors, or related entities for 10 years from the date of service.

Accountability

MVP and its contracting entities are accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations and Medicare laws. MVP retains ultimate responsibility to ensure regulations and laws are satisfied.

Medicare Advantage Regulatory Issues

This policy contains the statements as required in the *Medicare Managed Care Manual*, Chapter 11 and the *Prescription Drug Benefit Manual*, Chapter 6.

Documentation, Process, and Quality Standards Requirements

Auditing

The Department of Health and Human Services, the Government Accounting Offices, or their designees have the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, and other records of MVP Medicare products, MVP's contractors, subcontractors, or related entities for 10 years or periods exceeding six years or completion of an audit, whichever is later to ensure compliance.

Marketing

MVP has a Medicare marketing staff available to answer questions and assist Medicare Beneficiaries with enrollment. Our marketing staff utilizes Medicare-approved materials and they have been specially trained in Medicare marketing rules.

Access to Care

MVP ensures that the provider network is adequate to provide access to covered services.

Cultural and Health-Related Considerations

Providers shall ensure that services are provided in a culturally competent manner to all enrollees, including services for those members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities or conditions.

Non-discrimination

Regulations prohibit MVP and its contracted health care providers from discrimination in the delivery of health care services consistent with the benefits covered in our contracts based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical, disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

Participating providers are required to have practice policies and procedures that demonstrate that they accept for treatment any member in need of the health care services they provide.

Beneficiary Financial Protection

Enrollees are protected for the duration of the contract period for which the Centers for Medicare and Medicaid Services (CMS) payments have been made and, for enrollees who are hospitalized on the date MVP's contract with CMS terminates or in the event of insolvency, through discharge.

Disclosure of Information

MVP will collect and submit to CMS information that will help to administer and evaluate MVP, MVP contracting entities, and the Medicare Advantage program. MVP will collect and provide information to CMS and to Medicare beneficiaries that will assist them in exercising choice in obtaining Medicare services. Examples include satisfaction survey results, disenrollment statistics, disenrollment survey results, health outcomes survey results, statistics regarding beneficiary appeals and their disposition, provider payment mechanisms, and various other regulatory reports or data.

Provider Termination

Although CMS requires that a provider or MVP give at least a 60-day notice for termination without cause, the actual amount of days is identified in your contract. If a provider voluntarily terminates his or her contract, we will make a good-faith effort to notify all affected members of the termination of the provider contract within 30 days of receiving notice about the termination. MVP will notify a provider in writing of reasons for denial, suspension or termination of his or her contract. (See administrative policy, entitled Suspension and Termination of Practitioners.)

Accurate Encounter Data

Providers must make every effort to code patient encounters accurately and to the highest level of specificity for each encounter. Encounter data is submitted to CMS and is used for multiple purposes such as statistics for HEDIS reporting.

Excluded Individuals

MVP and its contracted entities are prohibited from employing or contracting with an individual who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act for the provision of any of the following: health care, utilization review, medical social work, or administrative services.

Program Compliance

CMS requires that providers cooperate with an independent quality review and improvement organization's activities. Medicare Advantage regulations require plans to implement improvement activities each year. Also, providers must comply with our medical policy, QA program, and medical management program. All standards and guidelines are created in consultation with network providers.

Accountability

MVP and its contracting entities are accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations and Medicare laws. MVP retains ultimate responsibility to ensure regulations and laws are satisfied.

Prompt Payment

Claims will be processed according to the provider contracts. Refer to the [Claim Submission and Adjustment Guidelines](#) section for detailed information on how to submit claims.

Requirements of Other Laws and Regulations

All providers are ultimately paid from Federal Funds and must comply with Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Americans With Disabilities Act; and other laws applicable to recipients of Federal funds; and all other applicable laws and rules.

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Utilization and Case Management

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Utilization and Case Management (UM) Activities

UM activities include:

- Prospective review/Prior authorizations
- Concurrent review
- Care Advantage
- Discharge planning
- Retrospective review
- Case management
- Care management

Prospective review takes place before a service is provided.

Concurrent review takes place while treatment is in progress.

Retrospective review is performed after treatment has been completed.

Medical Determinations and Utilization and Case Management Criteria

MVP utilizes nationally recognized and Medicare guidelines as well as MVP published criteria (including the MVP Formulary) to conduct prospective, concurrent and retrospective reviews for medical necessity. The InterQual® Criteria software program, MVP's Benefit Interpretation Manual (BIM) and Medicare Guidelines are used as guidelines to determine medical necessity. The guidelines and criteria are reviewed annually and approved by the Medical Management Committee (MMC) and Quality Improvement Committee (QIC), which consists of physicians from all MVP service regions. Copies of criteria and guidelines are available to MVP Member Participating Providers request.

Site of Service Guidelines are derived from CMS and InterQual. These are inpatient surgery list and physician office guidelines and are adopted by MVP. These guidelines are utilized to determine whether the procedure should be provided in an outpatient setting or within a physician's office. The Site of Service guidelines are reviewed annually by the MMC and approved by the QIC. Copies of guidelines are available to MVP Providers upon request.

For the Managed Medicaid medically fragile children and foster care children, MVP utilizes the NYS Medicaid guidance into the prior authorization, concurrent or retrospective review.

Specifically, MVP incorporates the following into the policies:

OMH Clinical Standards of Care	omh.ny.gov/omhweb/clinic_standards/care_anchors.html
OASAS Clinical Guidance	oasas.ny.gov/AdMed/recommend/recommendations.cfm
OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013	health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf
OCFS Working Together: Health Services for Children/ Youth in Foster Care Manual	ocfs.ny.gov/main/publications/Pub5011.pdf
OHIP Principles for Medically Fragile Children	Provided by the NYS DOH Children's Health and Behavioral Health Benefit Administration, July 31, 2017

Utilization and Case Management

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MVP delegated responsibility for prospective UM review of selected contract's requests for MRI/MRA, PET Scan, Nuclear Cardiology, CT/CTA and 3D rendering imaging services to eviCore healthcare (formerly known as CareCore National, LLC) in Bluffton, South Carolina. eviCore healthcare is also delegated responsibility to perform UM review on Radiation Therapy for selected contracts. eviCore clinical and physician reviewers are licensed clinicians who use nationally recognized clinical protocols to make UM determinations. eviCore utilizes evidence-based guidelines and recommendations for imaging from national and international medical societies and evidenced-based medical 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. To obtain an authorization, please call Customer Care Center Provider at **1-800-684-9286** and follow the radiology prompts.

MVP delegated responsibility for UM of chiropractic care, massage therapy, and acupuncture for all applicable lines of business to Landmark Healthcare, an eviCore healthcare company, in Sacramento, California. Landmark medical directors, all of whom are licensed chiropractors, massage therapists, or acupuncturists, use nationally accepted clinical protocols to make UM determinations. Contact Landmark's UM Department at **1-800-638-4557**.

MVP delegated responsibility for UM of dental services in counties where the dental benefit is offered to Healthplex, Inc., in Uniondale, NY. Healthplex's UM department uses the most current version of Current Dental Terminology published by the American Dental Association. Dentists can reach a Healthplex representative by calling **1-888-468-2183**.

MVP delegated responsibility for prospective and concurrent UM to Connecticut General Life Insurance Company (Cigna) for select self-funded plan and fully insured Members who reside or travel outside of the MVP service area, excluding HMO, Medicare, and Medicaid Members when the care is provided by a CIGNA Provider. CIGNA uses nationally accepted clinical protocols as guidelines to make UM determinations. CIGNA Providers outside of the MVP service area may contact Cigna directly. To contact a CIGNA representative, call **1-800-882-4462**.

naviHealth, Inc. provides Utilization and Case Management for post-acute care services including Skilled Nursing Facility (SNF), Acute Inpatient Rehabilitation (AIR), and Home Health services for *Medicare Advantage Members ONLY*. naviHealth staff will travel to each of MVP's regions to visit facilities and manage the transitions. naviHealth can be reached via the website at naviHealth.us or **1-844-411-2883**.

MVP delegated responsibility for Prospective UM review for non-emergent musculoskeletal (MSK) procedures to National Imaging Associates (NIA), a subsidiary of Magellan Healthcare. This program will require prior authorization for MVP Members for select non-emergent MSK procedures including outpatient interventional pain management services (IPM), inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries. This program will include all lines of business including select self-funded plans administered by MVP. Please contact Provider Services to verify if the self-funded plan requires review by Magellan. The validity period (authorization time span) for all MSK procedures will be 90 days from the requested date of service. This is a change from MVP's current process. Providers can contact Magellan Healthcare through their RadMD website at RadMD.com or call toll free **1-866-249-1578**.

Participating Providers may request a copy of the specific criteria used to make a UM determination by calling the Customer Care Center - Participating Provider at **1-800-684-9286**. The criteria will be mailed or faxed to the Provider's office with a proprietary disclaimer notice. Members may request a copy of the specific criteria used to make a UM determination by contacting the Customer Care Center telephone number on the back of the MVP Member ID card.

MVP uses the Pharmacy Program Administration and various MVP Pharmaceutical Policies to review the medical appropriateness for pharmaceutical therapies.

At least annually, MVP requests a review of the Utilization Management clinical guidelines and criteria by in-plan Participating Providers and the MVP MMC to assure that the criteria used during prospective, concurrent and retrospective reviews are appropriate for all patients in the community.

Participating Providers are notified of new or revised policies via *FastFax* notification, provider newsletter, *Healthy Practices*, or other similar electronic means including MVP's online portal. The new or revised policies are published on MVP's website, myphealthcare.com, following notification.

For MMC and HARP Members, MVP may apply NYS Medicaid Guidelines (EMedNY and/or State Coverage Question responses found on the State Health Commerce Site) to assist with coverage determinations.

Medical Necessity determinations for Medicare Advantage Members are rendered using guidance from the Medicare Coverage Database for any pertinent Local Coverage Determination (LCD) or National Coverage Determination (NCD) Policies in addition to MVP's medical policies. The Medicare Coverage Database is available online at cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Benefits Interpretation Manual (BIM)

MVP uses a BIM to determine whether a requested service is Medically Necessary. The BIM is the online repository for all MVP medical and pharmacy policies. These benefit interpretations provide medical criteria to be used in determining Medical Necessity for Covered Services. The criteria are based upon a review of currently available peer-reviewed medical literature, regulatory status of the technology, evidence-based guidelines, and positions of leading national health professional organizations. Practicing physicians with expertise relevant to each policy are consulted and relied upon. We welcome feedback and supporting studies from participating practitioners. A Member's Product (health benefit plan) may contain exclusions or other benefit limits applicable to the policy. Some benefit plans exclude coverage for services or supplies that MVP considers Medically Necessary.

Participating Providers are responsible for checking the BIM's Current Update Section for policy updates each time they access the BIM before going into the policies. Refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy. Providers should review the grid at the end of each policy for specific prior authorization requirements for the specific Member's contract.

Participating Providers may access MVP's BIM online at MVP's website by following these instructions:

1. Visit myphealthcare.com/Providers and *Sign In* to your online account. Or select *Register Now for Access* to create an online account.
2. Select *References* and then *Benefits Interpretation Manual*.

If you have questions or suggestions, use the email link listed on the introduction page. In addition, Providers may offer feedback about the policies to MVP via email. MVP will consider that feedback in future policy development.

Financial Incentives Relating to Utilization and Case Management

It is MVP's policy to facilitate the delivery of appropriate health care to its Members and to monitor the impact of the MVP UM program to ensure appropriate use of services. MVP's Utilization management decisions are based only on appropriateness of care and the benefit provisions of the Member's Subscribers Contracts:

- MVP does not provide financial incentives to employees, Providers, or delegates who make Utilization Management decisions that would encourage barriers to care and services;
- MVP does not reward Providers or staff, including medical directors and UM staff, for issuing denials of requested care; and

- MVP does not offer financial incentives, such as annual salary reviews and/or incentive payments, to encourage inappropriate utilization.

Adverse Determinations (Prospective, Concurrent, Retrospective)

When MVP denies a service through the UM processes, this is called an adverse determination. Adverse determinations for prospective, concurrent, and retrospective reviews are rendered upon receipt of all necessary medical information. Adverse Determination cases are reviewed by the medical director within regulatory mandated timeframes.

After an adverse determination is made by the medical director, for non-urgent and urgent requests, the clinical reviewer performing prospective and concurrent reviews contacts the requesting physician or facility by telephone to discuss the adverse determination and to inquire if there is additional medical information available. An opportunity to speak with the medical director is offered. If there is no new information forthcoming, the clinical reviewer explains the Appeal process. When the requesting physician is notified in writing of the adverse determination, he/she is, again, advised of their rights (ability to request a reconsideration or appeal of the decision and, if applicable, speak with the medical director who made the decision). For urgent acute hospital services, reconsideration is performed when the hospital submits, during the acute stay (prior to the Member's discharge and within 45 days of discharge), the complete current medical record to the Concurrent Review Unit. Review of the reconsideration request is completed within one (1) business day of receipt of the request when the member is confirmed and within 15 days of discharge. It must be conducted by both the requesting Provider and the medical director making the initial determination. Written notification and verbal notification of an adverse determination is provided to the Member (or designee) and the requesting physician in accordance with regulatory timeframes.

When new medical information is submitted, and services have not been rendered, the case is re-opened in Utilization and Case Management for Transplants (this is not applicable for Medicare – preservice urgent and non-urgent reviews; see variation under Reconsiderations section below). The new information is reviewed by the Medical Director who documents the rationale to uphold or reverse the denial. The requesting Provider and Member are notified of the determination in writing in accordance with regulatory timeframes.

Verbal and Written Communications on Utilization Review Determinations (Prospective, Concurrent, Retrospective)

MVP notifies Members and Providers, in accordance with applicable regulations, verbally and/or in writing. Verbal notice is provided on prospective (before service) and concurrent (during service) determinations. For inpatient stays, verbal notice is provided to the facility to communicate the determination to the Member. MVP will make two (2) attempts to reach the Member and Provider for verbal notices. Written notice is provided for all prospective, concurrent, and retrospective (after service) determinations.

Written notice of an Adverse Determination is provided to the Member and the requesting Provider. For urgent acute hospital services, MVP notifies the hospital UM/Case Manager, who verbally communicates the adverse determination and provides the Member's written notification. The Member and the requesting physician's written notification of an adverse determination includes the rationale for the decision; instructions for initiating an appeal; the name of the criteria used in making the determination; and, notice of the availability of the Clinical Criteria used in making the determination (see Medicaid Managed Care Variation below). The Member and/or requesting physician may appeal in writing and/or by telephone with the Customer Care Center.

Determinations not made within required timeframes automatically result in an Adverse Determination and are eligible to appeal. Please see the Appeals Section of this manual for appeal determination timeframes. Review turnaround times are monitored monthly to ensure requirements are met. In the event that review determination rates drop below requirement/target, a process will be developed to secure timely review determinations.

Expedited and standard appeals will be conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination.

For either non-urgent or urgent Adverse Determinations, the clinical reviewer makes two (2) telephone notification attempt to the physician's office and Member. For urgent acute hospital services, MVP notifies the hospital UM/Case Manager, who verbally communicates the Adverse Determination and provides the Member's written notification. The Member and the requesting physician's written notification of an adverse determination includes the rationale for the decision, instructions for initiating an appeal, the name of the Clinical Guidelines or criteria used in making the determination, and notice of the availability of the Clinical Guidelines or criteria used in making the determination. The Member and/or requesting physician may appeal in writing and/or by telephone with the Customer Care Center.

For NYS Medicaid Managed Care Program

The ordering physician has the right for a peer-to-peer review with the MVP Medical Director. In general, denials, grievances, and appeals must be peer-to-peer — that is, the credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician. In addition, the reviewer should have clinical experience relevant to the denial (e.g., a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist).

In addition:

- A physician board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21.
- A physician certified in addiction treatment must review all inpatient LOC/continuing stay denial for SUD treatment.
- Any appeal of a denied BH medication for a child should be reviewed by a board-certified child psychiatrist.
- A physician must review all denials for services for a medically fragile child and such determinations must take into consideration the needs of the family/caregiver.

(Early Prevention Services, Diagnostic and Treatment) and HCBS (Home and Community Based Services).

Timeframes for prior authorization and concurrent review determinations, both standard and expedited, may be extended for up to 14 calendar days if:

- The Member, the Member's designee, or the Provider requests an extension orally or in writing; or
- MVP can demonstrate or substantiate that there is a need for additional information and how the extension is in the Member's best interest. MVP must maintain sufficient documentation of extension determinations to demonstrate, upon DOH request, that the extension was justified.

MVP will render decisions in accordance with established timeframes out lined in the Medicaid Managed Care Model Contract; ("OHIP") Principles for Medically Fragile Children; under (Early Prevention Services, Diagnostic and Treatment), HCBS (Home and Community Based Services ("HCBS") and (Community First Choice Option) rules; and with consideration for extended discharge planning.

MVP will provide notification to the Member and Provider by telephone and in writing within 14 calendar days after receipt of the Service Authorization Request.

The written notice of an adverse determination (initial adverse determination) will include:

- An Appeal Request Form

- Process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review
- The enrollee right to contact DOH, with 1-800 number and how to file a grievance or complaint
- A Non-Discrimination Notice, including a statement that notice is available in other languages and formats for special needs and how to access these formats

Expedited and standard appeals will be conducted by a clinical peer reviewer provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. MVP must send notice of denial on the date review timeframes expire.

Medicare Reconsiderations (Prospective, Concurrent, Retrospective, Urgent, and Non-Urgent)

Medicare pre-service and concurrent – any review request received after the initial adverse determination is considered an appeal. MVP Utilization and Case Management will redirect any Medicare appeals to the Appeals unit for processing.

Medicare post-service medical necessity reviews, any payment dispute (or re-review) is processed by the Retrospective Review unit and reviewed within 30 calendar days of the request. See the Reconsiderations Section below for more information.

Services that Require a Referral for MVP Medicaid Managed Care

Restricted recipient Members—Referrals are required to ALL specialties for Members who have a physician restriction. Providers should verify eligibility by using MVP’s website mvphealthcare.com, using the MVP ID number (not CIN) on the MVP Member ID card.

Contact MVP’s Customer Care Center - Provider at **1-800-247-6550** to obtain a referral for restricted recipient Members.

Home and Community Based Services

Home and Community Based Services- Referrals to HCBS, functional assessments, HCBS eligibility determinations and plans of care for medically fragile children/ youth are submitted to MVP by faxing the request to **1-855-853-4850** or communityservices@mvphealthcare.com.

Once assessments and plans of care are received, MVP will evaluate services requested and will send the level of service determination to meet regulatory requirements. MVP will work collaboratively with Health Homes, Behavioral Health vendors, Providers, MVP internal Utilization and Care Management and BH Case Manager staff in order to evaluate the Member’s level of care; adequacy of service plans; Provider qualifications; Member’s health and safety and financial accountability and compliance. The review and approval of services will be person centered.

Out-of-Plan Referral Process (only applies to plans without out-of-network benefits)

The PCP or MVP Participating Specialist must submit a written request to MVP’s UM Department using the Prior Authorization Request Form which can be found by visiting mvphealthcare.com, then *Providers*, then *Forms*, then *Prior Authorization*. The out-of-plan referral will be approved only if MVP does not have a participating Provider with the appropriate training or experience needed to treat the Member.

For continuity of care purposes, MVP will allow children to continue with their care Providers, including medical, BH, and HCBS Providers, for a continuous episode of care. This requirement will be in place for the first 24 months of the transition of children from FFS to MVP. These children will not be required to change Health Homes or the

Health Home Care Management Agency at the time of the transition. MVP will reimburse on a single case basis for children enrolled in a Health Home if they are not under contract with MVP.

For Managed Medicaid Children's Physical Health services, network Providers will refer to appropriate community and facility Providers to meet the needs of the child or seek authorization from MVP for out-of-network Providers when participating Providers cannot meet the child's needs. MVP considers the network availability with the appropriate training / experience to meet the Member's needs and confirm the medically necessary service is not available through Network Providers.

Managed Medicaid Foster Care Transition

The Transition of Care process is enhanced for foster care children to ensure continuity of care is achieved. MVP will allow the child to transition to a new primary care Provider and other health care Providers without disrupting the care plan that is in place. Transition of Care needs including the plan of care must be communicated to MVP by the referring Provider, Voluntary Foster Care Agency (VFCA) or Health Home.

Members under the foster care program who transition from Medicaid Fee-For-Service to managed care could experience a disruption of care when the Member moves from county to county when MVP is not operating in the new county. MVP permits the Member to access Providers with expertise treating children involved in foster care in non-MVP contracted counties as needed to ensure continuity of care for their medically necessary services. The Member may transition to a new primary care Provider and other health care Providers in the non-MVP county to ensure the care plan is carried out and the benefits are received.

In the case of a long-term foster care placement outside of MVP's service area and solely at the discretion of the LTSS or VFCA, MVP will coordinate with the LDSS or VFCA to ensure a smooth transition of enrollment.

Prior Authorization

MVP requires prior authorization for select procedures and health care services. It is the Provider's responsibility to obtain prior authorization no less than five (5) calendar days prior to the procedure. Services requiring prior authorization are not covered benefits until or unless MVP or its UM delegate reviews and grants prior authorization for the service. Providers are responsible for services if rendered without prior authorization. The Member is not liable for services rendered without a prior authorization, in accordance with the Provider's contract with MVP and NYS Department of Health laws.

Emergency services are not subject to prior authorization. There will be no payment for services determined to be not medically necessary. Emergent Medical Necessity is defined for all plans as health care and services that are necessary to prevent, diagnose, manage or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

Services requiring prior authorization are listed in the UM Policy Guide, which is updated bi-annually. The guide's most recent version is available on mvphealthcare.com, or by calling the Customer Care Center – Provider at **1-800-684-9286**. Please be sure to update the UM Policy Guide each time your office receives a new copy with MVP's *Healthy Practices* newsletter. Providers also may check the website for the online Benefits Interpretation Manual to identify the plans that require prior authorization of services.

In-Office Procedure and Inpatient Surgery Lists

Participating Providers and their office staff can access the In-Office Procedures and Inpatient Surgery Lists at mvphealthcare.com in the *Reference Library* section. Contact your Professional Relations Representative if you prefer a paper copy. Please note:

- The In-Office Procedure List: CPT® codes that MVP requires to be performed in the physician’s office. Claims submitted with a place of service other than the physician’s office will be denied unless prior authorization is obtained.
- The Inpatient Surgery List: Procedure codes that are not included on the Inpatient Surgical List will require prior-authorization for place of service if being requested to be performed in the inpatient site of service.
- All procedures are subject to the Member’s plan type and benefits.

Durable Medical Equipment Dispensed by Physicians, Podiatrists, Physical Therapists, and Occupational Therapists

Physicians and other practitioners (including, but not limited to, podiatrists, physical therapists, occupational therapists, and chiropractors) may not act as a DME Provider/vendor (exceptions to follow). Please refer to your Provider Contract to determine if you are eligible to dispense DME products from your office. Basic DME items can be provided for stabilization and safety to prevent further injury, as a convenience to our Members without prior authorization. Examples of such items are simple canes, crutches, walkers (for safe ambulation), “off-the-shelf” bracing, air casts, and walking boots (for joint/muscle immobilization to prevent further injury). These items must be billed with the office visit, using the appropriate HCPCS code, provided they are not listed on the DME prior authorization code list. All other DME, O&P and specialty equipment and services must be obtained from a participating DME, orthotics, prosthetic or specialty Provider/vendor. Physical and Occupational therapists may fabricate and dispense custom hand splints without prior authorization for the following codes:

L3702	L3806	L3901	L3915	L3923	L3931	L3982
L3710	L3807	L3906	L3917	L3925	L3933	L3984
L3760	L3808	L3908	L3919	L3927	L3935	
L3762	L3900	L3913	L3921	L3929	L3980	

Podiatrists may provide and bill for:

- Foot orthotics, using the appropriate “L” HCPCS codes, when the Member’s contract includes the Foot Orthotic Rider, without prior authorization.
- Shoe inserts and shoes for Members who have a diagnosis of diabetes, with or without a Foot Orthotic Rider, using the appropriate “A” HCPCS codes, without prior authorization.

Ankle Foot orthotics must follow the prior authorization process. Ankle Foot orthotic codes that require prior authorization can be found on the MVP Health Care [website](#).

Durable Medical Equipment, Orthotics, Prosthetics, and Specialty Vendors

For information regarding DME, prosthetics, orthotics, and specialty equipment, visit MVP Health Care:

- Prior Authorization Request Form (PARF) mvphealthcare.com/Providers/forms/#prior-authorization
- Prior Authorization Code lists—with and without descriptions mvphealthcare.com/Providers/reference-library/#utilization

Verify Member eligibility and DME benefits before submitting a prior authorization request by calling the Customer Care Center - Provider at **1-800-684-9286** (Medicaid/CHP/HARP eligibility call **1-800-247-6550**). Completed PARF’s are faxed to **1-888-452-5947**. Durable Medical Equipment payment policies can be found in the Payment Policies Section.

Completing the Prior Authorization Request Form (PARF)

- If clinically urgent, call the Customer Care Center - Provider at **1-800-684-9286** to advise that an urgent request has been sent.
- Be sure to fax all relevant medical documentation (e.g., office notes, lab, or radiology reports) with the completed PARF. Do not fax photos – mail them to the appropriate UM department.
- Be sure to indicate a contact name for the UM staff to call.
- Be sure to sign and date the PARF.
- Upon receipt of the PARF, a determination will be made, and the Provider's office will be notified by phone and mail within the mandated time frames by line of business.

Processing of services/items that require Prior Authorizations

Please note: With the exception of Medicare and Medicaid, faxes received after 4 pm are considered the next business day's review. The start time for a Medicare and Medicaid request is considered the date and time the request is received by the plan.

If additional information is needed to make a determination, the appropriate Utilization and Case Management department will make up to three (3) attempts to contact the Provider's office to obtain this information. If this attempt is unsuccessful, then a letter requesting the specific information required to make the determination will be sent to the Provider's office within:

- 24 hours of receipt of an initial urgent request; or
- Three calendar days of receipt of an initial routine request.

When additional information is received, and a decision has been made:

- The Member and Provider will be notified by telephone and in writing within 3 business days of receipt of additional information for all plans.
- For Medicaid Managed Care, notification will be provided by telephone and in writing within three business days of receipt of information but no more than 14 calendar days after receipt of the initial request.
- Additional information must be received within:
 - 48 hours from the receipt of MVP's letter for an urgent request, or
 - 45 calendar days from the receipt of MVP's letter for a routine request
 - Medicaid Managed Care 14 days of the date of the original request for services.

Once the additional information is received, a review will be performed, and the request will be forwarded to a medical director for a determination, if necessary. If a Provider's office has questions about whether or not specific services require prior authorization, contact Professional Relations or MVP's UM department.

Note: The above time frames do not apply to MVP Select Care (ASO) groups that follow ERISA mandatory time frames.

Managed Medicaid

MVP reviews the Home and Community Based Services (HCBS) requests and plan of care (POC) to ensure the following are accounted for:

- HCBS must be managed in compliance with CMS HCBS Final Rule and any applicable state guidance

- ensures the plan of care was developed in person-centered manner; compliant with federal regulations and state guidance and meets the Members individual needs;
- validates the HCBS service is provided in accordance with the POC; and
- to develop a data driven approach to identify serve utilization patterns that deviate from any approved plan of care, conduct outreach will be performed to review any deviations, and require appropriate adjustment to either the service provided or the plan of care.

MVP will continue to cover HCBS and LTSS services as authorized as a part of the NYS 1915(c) waiver for at least 180 days following the date of transition of children's specialty services newly carved into managed care. This coverage includes service frequency, scope, level, quantity and existing Providers at the time of the transition unless the Member requests changes or the Provider refuses to work with the plan. At the close of the transition period, a new POC is developed. During the transition period, MVP will authorize any newly carved in children's specialty services that are added to the POC under a person-centered process without conducting utilization review.

For 24 months from the date of transition of the children's specialty services carve-in, for Fee-For Service children in receipt of HCBS at the time of enrollment. MVP will continue to authorize covered HCBS and LTSS according to the most recent POC. This coverage includes service frequency, scope, level, quantity and existing Providers at the time of the transition unless the Member requests changes or the Provider refuses to work with the plan. At the close of the transition period, a new POC is developed.

To ensure a smooth transition of HCBS and LTSS Members from NYS Fee-for-Service to Managed Care, for children receiving HCBS services, MVP will begin accepting POC's as outlined below:

- 1) On October 1, 2019 for:
 - a. The newly enrolled Members or
 - b. Children for whom the Health Home or Independent Entity has obtain consent to share the POC with MVP and the family has selected MVP as their plan through the selection process.
- 2) On October 1, 2019, for a child in the care of a LDSS/ licensed VFCA where MVP has been confirmed by the LDSS/VFCA.
- 3) MVP will continue to accept POC's for children in receipt of HCBS in advance of the effective date of enrollment when MVP is notified by another plan, a Health Home Care Manager or the Independent Entity that consent was received to share the POC with MVP and the family has selected MVP through the selection process, or the child on je case of LDSS/ Licensed VFCA and MVP is confirmed by the LDSS/ VFCA

POC's are to be faxed to **1-800-280-7346**. Authorizations will be entered once the Member is enrolled in the MVP systems.

Concurrent Review

All inpatient acute medical admissions (excluding normal vaginal and C-section deliveries for all products, except Medicaid Managed Care, Child Health Plus and HARP) require notification to the health plan the next business day following the admission by the facility. Prior notification is still required for admissions or services with non-participating Providers or facilities, and for infants who are transferred to the Newborn Intensive Care Unit (NICU) for all MVP Products. Hospital notification is performed by faxing notifications to the Customer Care Center – Provider at **1-800-280-7346**.

Concurrent review is performed when a Member is admitted to an inpatient facility on an emergent or an elective basis. An MVP UM Clinical Reviewer or an MVP delegate's clinical review, reviews select admissions by fax, telephone, or electronic medical record. Working in conjunction with the Member's attending physician and

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facility UM staff, the concurrent Clinical Reviewer obtains clinical information during the Member's inpatient stay to determine whether MVP will provide coverage.

Clinical updates should be faxed to **1-888-207-2889**. If sufficient information is provided to demonstrate the medical necessity of the admission and/or continued stay, the UM Clinical Reviewer notifies the facility's UM department of the decision.

In cases where continued care can be safely provided in an alternative setting and the Member's care does not require acute care services based on the community standards for care and the Member's individual needs, a discussion will occur between the hospital representative and MVP's UM Clinical Reviewer.

If the physician or hospital representative, on behalf of the physician, agrees to discharge the Member and the discharge order is written in the chart, the UM Clinical Reviewer or Case Manager is available to work with the facility and to facilitate the post-discharge referrals. This may include contacting the physician, the Member and/or the Member's family. If the Member refuses discharge once the physician has written the discharge order, and the hospital notifies the UM Clinical Reviewer of the Member's refusal to leave, the UM Clinical Reviewer will refer the case to the medical director for potential denial. If the medical director denies hospital admission or continued stay and the physician has written a discharge order, then MVP will provide a denial letter for the hospital to deliver to the Member resulting in the Member's potential financial responsibility for the admission or the continuation of stay. Termination of benefits may occur, and the Member may be financially liable for continued stay.

If the physician or hospital representative on behalf of the physician disagrees to discharge the Member, the UM Clinical Reviewer will refer the case to the medical director. The health plan medical director may authorize a lower level of care for payment purposes. A change in Provider reimbursement letter is sent and the Member is liable for the co-payments/co-insurances applicable to the authorized level of care. If the Member's clinical picture changes, a reconsideration can be performed as outlined at the [end of this section](#).

If there is not sufficient information to demonstrate the medical necessity of the stay, the UM Clinical Reviewer works in conjunction with the facility's UM department and/or the attending physician for additional information. If information is not provided, then the case will be forwarded to a medical director for review and determination. The medical director, with the assistance of specialist consultants if needed, reviews the available documentation and makes a determination.

- Approval: The UM Clinical Reviewer notifies the facility of the approval in writing or mutually agreed format.
- Denial: The UM Clinical Reviewer verbally notifies the facility/attending physician or facility of the denial and sends written notification.

If the initial admission is not at a coverable level of care, the facility notifies the health plan at the time of admission, following health plan medical director concurrence with the facility/attending physician's determination, an adverse determination letter is sent to the facility and the Member is financially liable for the admission and any continued hospital stay.

If ongoing days are not at a coverable level of care, the facility notifies the health plan. For non-Managed Medicare plans and following health plan medical director concurrence, an adverse determination letter is sent to the facility and the Member is financially liable for continued hospital stay.

For Medicare Advantage plans, if ongoing days are not at a coverable level of care, the facility issues the CMS "Important Message from Medicare" as directed by CMS to the Member and notifies the health plan. If the health plan's medical director does not agree with the issuance of the "Important Message from Medicare," the health plan will issue a letter of reinstatement to the Member and fax a copy to the Beneficiary and Family-Centered Care Quality Improvement Organization and the facility.

Medicare Beneficiary Notification forms and instructions can be found on the Beneficiary Notices Initiative (BNI) page at [cms.gov/BNI](https://www.cms.gov/BNI).

In instances where the facility, attending physician, and MVP disagree on the appropriate level of care or coverage in accordance with MVP's policies and procedures, the facility on behalf of the attending or the attending have the right to dispute the decision and the Member is held harmless. Note:

- A medical director determines all denials and changes of care levels.
- Details of the denial(s) will be provided.
- An attending, primary care physician, or specialist has the right to speak with the MVP Medical Director reviewing the case at any point in the concurrent review process. Contact the appropriate UM department and request to speak with the medical director.
- All determinations are based upon the available medical documentation provided to the UM department by the facility's UM department and the attending physician.
- The appropriate appeal process can be initiated.

If an adverse concurrent review determination involving inpatient services is made, the facility/attending physician will be notified by phone and written correspondence within 24 hours or the next business day of receipt of request. If an adverse determination involving patient services could result in Member financial responsible (i.e., custodial care), the facility will be provided written adverse determination y fax for delivery to the Member or the Member's representative, advising of the potential for financial responsibility. A letter will also be mailed within 24 hours of the decision.

Levels of care changes require notification to MVP. Examples of level of care changes include, but are not limited to, a change from a medical observation stay to inpatient acute, change from Acute Rehabilitation to Skilled Nursing, normal delivery of a newborn to a medical complication post-delivery or a newborn's stay beyond the mother's hospital stay. This is to ensure medical necessity for the ongoing stay and/or appropriate payment of services. For transfer from acute facility to SNF, please see the [Skilled Nursing Facilities](#) section.

Non-emergent acute to acute facility transfers also require prior authorization from MVP. These transfers will be considered for medical necessity only. Transfers from a facility capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician will not be considered.

Upon receipt of clinical information for a concurrent review service, a determination will be made, and the facility's UM Department/attending physician will be notified by phone and mail within:

- One business day for routine requests; or
- 24 hours for urgently needed care

Coverage of ground ambulance or ambulance services may be discussed during these notifications.

Observation Bed Policy

Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to assess a patient's medical condition and provide medically necessary services to a Member whose diagnosis and treatment are not expected to exceed 24 hours, but may extend to 48 hours, and the need for an inpatient admission can be determined within this specific period.

Observation level of care services are a critical component in avoiding unnecessary hospital stays. Types of cases vary from region to region, based on a region's community standards of care and availability of non-acute support services. Cases which usually are managed in an urgent observation stay include, but are not limited to, cellulitis, congestive heart failure, dehydration, diabetes mellitus, fever, fractures, gastrointestinal bleeding, general symptoms, ruling out myocardial infarction, pain (chest, abdominal, back, etc.), pain management, pneumonia, syncope, and urinary tract infection.

Observation billing is addressed in the online Medicare Claims Processing Manual at Medicare Claims Processing (Pub. 100-04), Chapter 4-Part B Hospital (Including Inpatient Hospital Part B and OPPTS), and Section 290-Outpatient Observation Services and in the New York State Medicaid Update May 2013, Volume 29- Number 5.

Medicare Outpatient Services

Section 290.1 states the following: Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

New York State Medicaid Managed Care Update

May 2013 Volume 29 - Number 5 states the following: Hospitals may provide observation services for those patients for whom a diagnosis and a determination concerning admission, discharge or transfer cannot be accomplished within eight hours after presenting in the Emergency Department (ED), but can reasonably be expected within 48 hours. In order to be reimbursed for observation services, a patient must be in observation status for a minimum of eight hours (with clinical justification). A patient may remain in observation for up to 48 hours and then the hospital must determine if the patient is to be admitted, transferred to another hospital or discharged from the facility.

Time Frame

Observation bed services are appropriate for hospital stays when care required is greater than six hours (8 hours for Medicaid) and the need for an acute inpatient level of care is not established. The start time will be when the decision is made for observation status and documentation of such should be on the physician's orders, including the date and time. At the conclusion of the observation stay period the hospital/Provider will notify the health plan if the intent is to admit and/or define required alternative services.

Exclusions

Patients who would be considered "inappropriate" for observation bed status are:

1. Patients requiring admission
2. Services that are not reasonable or necessary for a patient's diagnosis or treatment, but are provided for the patient's, their family's or physician's convenience
3. Care that is custodial
4. Services that are part of another outpatient service, such as ambulatory surgery, routine preparation for diagnostic testing and any post-operative monitoring/recovery periods
5. Observation stays that are greater than 48 hours for all lines of business

Availability

Observation beds should be available 24 hours a day, including weekends and holidays. Observation bed assignment and/or approval of this care level is not limited by or restricted to a specific location, unit title, or name of the assigned bed to which observation and care occurs.

Authorization

No prior Authorization or notification is required for observation days. The physician order must indicate the physician's intent regarding the Member disposition either to place the Member in observation status or to admit the Member to inpatient service the physician order must identify the date and time of the Member's admission or placement into observation status. Observation stays may be subject to a retrospective clinical review to determine

the medical necessity for observation level of care, utilizing InterQual or Medicaid/Medicare criteria. Observation stays in the absence of clear medical necessity are not covered. If the hospital disagrees with MVP's level of care decision, the hospital may exercise its normal appeal rights.

Conversion to Inpatient

The facility is required to notify the health plan of the request for conversion from observation to inpatient. This request is subject to review for medical necessity and will be reviewed when all clinical information is received following the standard UM process for concurrent review. If an observation patient is admitted, the entire observation period will convert to inpatient benefit days. When emergency department services precede an observation stay, the emergency department services are incidental to the observation stay and therefore are not reimbursed. All observation days that exceed the 48-hour timeframe prior to conversion to inpatient will not be considered charges in calculating a potential cost outlier.

Discharge Planning

For All Commercial, ASO, and Medicaid Plans

An MVP UM Clinical Reviewer is available to work with the attending physician, the facilities UM department, discharge planning staff, and others to identify available MVP benefits that are consistent with the Member's discharge planning needs. The hospital personnel responsible for discharge planning will screen all observation-status and acute care patients for potential discharge planning needs. Discharge planning referrals (e.g., for home care evaluation, DME, IV infusion) may be prior approved by contacting the Concurrent Review Clinical Reviewer assigned to the facility or by contacting MVP's Home Care Unit at **1-800-684-9286**.

For Medicare Advantage Members Only

naviHealth, Inc. provides Utilization and Case Management for post-acute care services including Skilled Nursing Facility (SNF), Acute Inpatient Rehabilitation (AIR) and Home Health services.

Fax: 1-866-683-6976 for pre-service authorization requests for post-acute care

Fax: 1-866-683-7082 for continued stay authorization requests and "other" (NOMNC, NDMC)

Fax: 1-866-683-9126 for Healthcare MDS from All PAC and Home Health

Tel: 1-844-411-2883

naviHealth hours of operation are 8:00 am - 5:00 pm Monday through Friday EST, except for nationally recognized holidays. To learn more about naviHealth, visit navihealth.us.

The facilities are required to provide to MVP a daily list of discharges in a mutually agreed upon format.

MVP requires notification of Member discharges from the hospital for both elective/planned and unplanned inpatient level of care hospitalizations. Notification of discharge must be made to the health plan within one business day of the Member's discharge from the hospital.

The notification may be done by sending a facsimile to **1-800-280-7346**.

The information required from the hospital representative by facsimile includes the following:

- Facility name
- Member (patient) name
- Member contract number
- Date of birth

- Discharge diagnosis, if available
- Admission date
- Discharge date
- Discharge status/disposition

After discharge notification is received from the hospital, the information is entered into the MVP information system. Please note that the claim cannot be processed without a valid discharge date in the system.

Medicare Comprehensive Outpatient Rehabilitation Facility

Comprehensive outpatient rehabilitation facility (CORF) services may be a covered benefit under certain medical contracts. CORF consists of an interdisciplinary team of professionals from the field of physical medicine, neuropsychology, physical therapy, occupational therapy, speech therapy, recreation therapy, and clinical social work. It is a multi-level program designed to provide intensive and more frequent rehabilitation therapies to persons with CVA, acquired brain injury, and other orthopedic and neurological conditions.

These programs provide a comprehensive approach in order to maximize functional potential, CORF is covered when there is a potential for restoration or improvement of lost or impaired functions. This comprehensive program consists of 4 levels. A referral is made by the Primary Care Physician or hospital attending physician to the CORF program. MVP Health Care does not require notification of this referral. The referral is made to the Physical Medicine Specialist at the CORF program for consultation. The physiatrist performs a consultation and recommends the level of CORF service from which the Member can benefit most.

MVP requests the CORF program to refer the program Members to the MVP Case Management Department to coordinate and perform case management services. To make this case management referral, Providers may call **1-866-942-7966**.

The recommendations will consist of 4 levels of care and must meet the following criteria:

1. Full day evaluation and/or treatment program*
2-5 days per week (three modalities) and at least 135 minutes total per day
2. Half day evaluation and/or treatment program*
2-5 days per week (three modalities) and at least 90 minutes total per day
3. Less than half day 2-5 days per week (2-3 modalities) and at least 90 minutes total per day, and does not include social work, recreation therapy, or group services
4. Single Service

*To bill for half day evaluation the Member must require and receive at least two of the following services: social work, group services, or recreational services.

In accordance with Medicare Regulation 42 CFR, §422.624, §422.626, §422.620, effective 1-1-04: The Comprehensive Outpatient Rehabilitation Facility is required to provide MVP's Medicare Members advance notice of non-coverage by issuing the Notice of Medicare Non-Coverage (NOMNC). The NOMNC must be issued at least two calendar days prior to the last day of coverage/discharge, signed, and dated by the Member (or authorized representative). If there is more than a two-day span between services, the NOMNC should be issued on the next to the last time services are provided. The authorized representative may be notified by telephone if personal delivery is not available. The authorized representative must be informed of the content of the notice, the telephone call must be documented, and a copy of the notice must be mailed to the representative. Medicare Regulations do not recognize notification by voicemail. The "valid delivery" of NOMNC must be retained in the Member's medical record. A signed (or acknowledged) copy of the NOMNC is faxed to MVP within 24 hours of receiving a NOMNC from MVP. Medicare

Beneficiary Notification forms and instructions for the NOMNC can be found on the Beneficiary Notices Initiative (BNI) page at cms.gov/BNI.

Note: A word document format for the NOMNC may be obtained by contacting a MVP Professional Relations Representative.

When a Member requests an appeal with the Beneficiary and Family-Centered Care Quality Improvement Organization, the Comprehensive Rehabilitation Facility is responsible to issue the Detailed Explanation of Non-Coverage upon receipt from MVP. A copy must be retained in the Member's medical record.

Skilled Nursing Facilities (SNF)

Prior authorization is required for all lines of business.

Benefit Coverage for All MVP Products

MVP will cover:

1. SNF semi-private room and board whenever such care meets the skilled criteria as defined by Medicare or InterQual.
2. All SNF care or rehabilitation services when provided or referred by the PCP or other appropriate Provider and approved by MVP and when criteria outlined in this policy are met.
3. Skilled services are limited to the number of days as defined in the Member's subscriber contract, certificate of coverage of Summary Plan Description.

For Commercial, ASO, and Medicaid Plans

Clinical decisions for benefit coverage at SNFs are based on InterQual criteria.

For MVP Medicare Advantage plans

Following CMS guidelines, clinical decisions for benefit coverage at Skilled Nursing Facilities will be managed by naviHealth, Inc.

SNFs with a Medicare Ban

MVP will not approve an authorization for any MVP Member to a skilled nursing facility currently sanctioned under a Denial of Payment for New Admissions (DOPNA) by the Centers for Medicare and Medicaid Services (CMS).

Pharmacy Coverage

Medications received during the paid stay are included in the daily rate and should not be billed to the Member's prescription drug plan.

Medicare Advantage Plans: Admission Denial for Medical Necessity

naviHealth, Inc. will issue all admission denials for medical necessity and appropriateness based on the medical director determination.

Key Contacts

To establish benefit eligibility, please refer to the following telephone numbers:

Non-Medicaid / Commercial Plans

MVP Customer Care Center - Provider

1-800-684-9286

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Medicaid /CHP/HARP Plans

MVP Customer Care Center - Provider

1-800-247-6550

For prior authorization, call Customer Care Center - Provider at **1-800-684-9286**.

Clinical documentation for non-Medicare Members can be faxed to MVP Skilled Nursing Fax Line: **1-866-942-7826**.

Clinical Documentation for Medicare Advantage Members can be faxed to naviHealth, Inc. at:

Fax: 1-866-683-6976 for pre-service authorization requests for post-acute care

Fax: 1-866-683-7082 for continued stay authorization requests and “other” (NOMNC, NDMC)

Fax: 1-866-683-9126 for Healthcare MDS from All PAC and Home Health

Tel: 1-844-411-2883

Administrative Guidelines

Documentation, Process, and Quality Standards Requirements:

1. SNF stays require prior authorization for all of MVP’s products. Prior authorization is to be obtained by the referring Provider or Hospital through the discharge planning process. SNF’s are responsible for ensuring a prior authorization is secured prior to accepting the Member to avoid non-payment. SNF’s are required to notify MVP when they have accepted a patient by faxing a Prior Authorization Request Form to MVP.
2. MVP’s Commercial, ASO, and Medicaid products may require a three-day acute care stay for SNF benefit eligibility. Medicare products do not require a three-day acute care stay.

SNF Admission Denials

1. On admission, when there is no qualifying three-day acute care hospital stay (for applicable products) or the Member is deemed custodial (applies to all MVP products), the acute care facility and the SNF must notify MVP of the Member’s admission. An admission denial will be faxed to the facility. The UR Representative is required to present the verbal and written notice to the Member. (Written denial notice is also mailed to the Member’s home.)
2. For Managed Medicare products, the acute care facility or the SNF is required to deliver the Notice of Denial of Medical Coverage (NDMC) to the Member or Member representative.

Health plan information must be included on the Medicare NDMC; a Word document with the plan information may be obtained by calling MVP. Medicare instructions for the NDMC are available online on the Notices Initiatives page at [cms.gov/BNI](https://www.cms.gov/BNI). A word document format for the NDMC may be obtained by contacting an MVP Facility Representative or Contract Manager. Appeal Rights are available in the NDMC.

SNF Continued Stay

1. Continued stay services require prior authorization, using MVP criteria (Medicare guidelines for Medicare Advantage Members or InterQual criteria for all other lines of business) in consideration of the Member’s individual needs and the local delivery system.

For Commercial, ASO and Medicaid:

Continued stay reviews may be conducted via medical record review by MVP UM staff at the facility and/ or by review of clinical documentation submitted to MVP via fax. Documentation submitted to MVP must include the reason for submission of the clinical documentation – i.e., whether the facility is seeking a termination of benefits or an authorization for an extension of stay. If the reason for

submission of the clinical documentation is to request a termination of benefits, the facility must also indicate the date on which it is requesting the termination to be effective.

For Medicare Advantage Members Only

naviHealth, Inc. provides Utilization Management for Skilled Nursing Facility (SNF),
Fax number: **1-866-683-7082** for continued stay authorization requests and “other”
(NOMNC, NDMC)

Fax number: **1-866-683-9126** for Healthcare MDS from All PAC and Home Health.

Tel: **1-844-411-2883**

naviHealth hours of operation are 8:00 am - 5:00 pm Monday through Friday EST, except for nationally recognized holidays. To learn more about naviHealth, visit navihealth.us.

2. Reviews conducted at MVP or naviHealth, Inc., require clinical documentation to be received at MVP between one and three business days prior to the next review date. Submitted clinical documentation must be current, reflecting the past week’s clinical interventions, and Member progress relative to each discipline providing care.

Required documentation for determining inpatient SNF continued stay authorizations is the facility’s responsibility and must be supplied upon request. Required documentation includes, but is not limited to:

- a. Members Name and MVP ID Number
 - b. Medical orders
 - c. Medical progress notes
 - d. Nursing notes and care plan including measurable Member goals (includes Member/ family teaching needs for discharge plan)
 - e. Medication records
 - f. Therapy progress notes
 - g. Discharge planning/social work notes
 - h. Hospital therapy notes
 - i. Skilled service progress notes must reflect the daily administration of those skilled services and the Member’s daily status/progress in response to the skilled services
3. Failure to obtain appropriate authorizations for admission and/or continued stay or level of care changes will result in non-payment for the unauthorized days and the Member will be held harmless.
 4. For continued stays, the SNF is required to notify MVP when the Member’s level of care changed from skilled to custodial. MVP will perform a review to verify medical necessity of the ongoing stay and issue a medical necessity denial notice (for non-Managed Medicare Members) or a notice of non-coverage (for Managed Medicare Members), if applicable.
 5. Failure to notify MVP of level of care changes and faxing the corresponding clinical documentation within 24 hours of the change will result in non-payment for non-skilled (see “Description” section of this policy for “skilled services” definitions) days.
 - a. Valid Delivery of the NOMNC to Member or Authorized Representative: if the Member is able to sign the notice or if the authorized representative is present to sign, the Notice must be signed, dated and faxed back to MVP, via naviHealth, Inc. at **1-866-683-7082**, within 24 hours of the receipt of the Notice.

- b. Valid Delivery to Authorized Representative by Telephone: if the Member is unable to sign, and notice of denial is delivered to the authorized representative over the phone the facility representative delivering the notice must sign the Notice with their signature, phone number, date and time the Notice was given. They must also document on the notice, who they spoke to (authorized representative) and their phone number. Documentation must also contain a statement that in the writer's opinion the authorized representative understood the contents of the Notice. The Notice then needs to be mailed to the authorized representative. The Notice with the above information must be faxed back to MVP, via naviHealth, Inc. at **1-866-683-7082**, within 24 hours of the receipt of the Notice.
- c. Valid Delivery to Authorized Representative by Certified Mail, Return Receipt: if the Member is unable to sign, and you cannot reach the Member's authorized representative by phone, the Notice must be sent to the authorized representative by Certified Mail, Return Receipt requested. The date that someone at the authorized representative's house signs or refuses to sign the receipt is the date received. Place a copy of the Notice in the Member's medical file, and document the attempted telephone contact to the Member's authorized representative. The documentation must include: the name, organization and contact number of the staff person initiating the contact, the name of the authorized representative you attempted to contact, the date and time of the attempted call, and the telephone number called. When the Return Receipt is returned by the post office with no indication of a refusal date, then the Member's liability starts on the second working day after the mailing date. The Return Receipt of delivery of the Notice and the Notice itself with above information written on it must be faxed to MVP, via naviHealth, Inc. at **1-866-683-7082**, within 24 hours of the Return Receipt delivery to your facility.
- d. Valid Delivery if Member or Authorized Representative Refuses to Sign: if the Member or authorized representative refuses to sign the Notice, the facility representative must document on the Notice, the Member's and/or authorized representative's refusal to sign. The facility representative delivering the Notice must sign the Notice with their signature date and time the Notice was given. The Notice must be faxed back to MVP, via naviHealth, Inc. at **1-866-683-7082**, within 24 hours of receipt of the Notice.

A copy of the acknowledgement form must be kept in the Member's medical record. The SNF will be responsible for services rendered prior to notification of non-coverage to the Member. The SNF can only bill the Member after appropriate notification that the benefits criteria and/or medical necessity are not met. The SNF is responsible for any associated grace days and cannot bill the Member until this requirement is met.

- 6. For all Medicare Advantage Members: The SNF must deliver the Notice of Medicare Non-Coverage 2 calendar days prior to discharge in accordance with Medicare Regulation 42 CFR, §422.624, §422.626. The Member has the right to appeal the denial with the Medicare the Beneficiary and Family-Centered Care Quality Improvement Organization.

The notice must identify MVP along with MVP's address and MVP Member service phone number. Failure to deliver the notice properly may result in non-payment for any overturned days by an appeal organization and the Member will be held harmless.

Health plan information must be included on the NOMNC; a word document with the plan information may be obtained by calling the Skilled Nursing Line. The Medicare NOMNC and instructions for the NOMNC are available online on the Beneficiary Notices Initiative (BNI) page at [cms.gov/BNI](https://www.cms.gov/BNI). A word document format for the NOMNC may be obtained by contacting an MVP Professional Relations Representative.

When a Member requests an appeal with the Beneficiary and Family-Centered Care Quality Improvement Organization, the Detailed Explanation of Non-Coverage will be issued to the Home Care Agency by naviHealth, Inc. The SNF is responsible to issue the Detailed Explanation of Non-Coverage to the Member upon receipt from MVP Health Care, via naviHealth, Inc. A copy must be retained in the Member's medical record.

Member appeals: While a Member appeal is in process with a Quality Improvement Organization (Livanta, for the state of New York) the SNF should notify MVP Health Care via phone or fax of any level of care change which may change the Member's eligibility status for SNF coverage. MVP Health Care will review for reinstatement of the Members skilled nursing facility benefit.

7. The facility is responsible for notifying MVP of the Member's discharge date from the SNF and the Member's disposition upon discharge, within two business days of the discharge. Such notification may be communicated by phone, fax, or other electronic notification as specifically agreed upon by the facility and MVP.
8. Requests for a Medicare Swing Bed requires prior authorization and will be reviewed on a case by case basis for medical necessity using the following criteria:
 - a. The Member must have skilled needs as defined above as well as Medicare Guidelines.
 - b. Requesting facility must provide written documentation from in-plan SNFs (that have beds available) of inability to accept the Member. Requests for Swing Beds will not be covered if there are in-plan SNF beds available.
 - c. When a hospital is providing extended care services (Swing Beds), it will be treated as a SNF for purposes of applying coverage rules. SNF level of care days in a Swing Bed are to be counted against total SNF benefit days available.
 - d. If there is an available SNF bed in the geographic region (all contracted SNFs within 50 miles of the hospital), the extended care patient (swing bed) must be transferred within five days of the availability date (excluding weekends and holidays) unless the patient's physician certifies, within the 5-day period, that transfer of that patient to that facility is not medically appropriate on the availability date.

Exclusions and Limitations

Skilled care does not mean custodial care, intermediary care, domiciliary care, or convenience care. Under this policy, the following are not usually considered benefits:

1. Custodial care (assisting with activities of daily living such as ambulating, bathing, dressing, feeding, toileting, preparing special diets, and supervising medication that would ordinarily be self-administered).
2. Maintenance care or services.
3. Intermediary care (institutional care in addition to board and lodging in functionally independent persons).
4. Domiciliary care (room, board, laundry, and housekeeping services for health-stable persons).

The above listing should not be considered all-inclusive. The medical director or designee may review indications for any level of care on an individual basis for medical necessity and appropriateness.

MVP Medicaid Managed Care

It is the responsibility of the SNF to complete the appropriate paperwork upon determination that an MVP Medicaid Managed Care Member is changing to a permanent (Long Term Nursing Home) status. Permanent placement will only be allowed to MVP participating Providers. (If the SNF facility does not contract with MVP for long term

placement, the Member must change to a plan that the facility contracts with for long term placement.) The request for permanent placement must first be prior authorized by MVP by sending the request along with the PRI, 3559, MD Statement of Need and MDS forms. Upon MVP approval, it is the facilities responsibility to complete the application and submit to the Local Department of Social Services (LDSS) Office in the county where the Member resides.

MVP Health Care Process for Hospice Care

Description

An interdisciplinary program of palliative care and supportive services addressing the physical, spiritual, social, and economic needs of terminally ill patients and their families provided in the home or a hospice center.

Indications/Criteria

Hospice service is a covered benefit that does not require prior authorization.

- Member must have a terminal illness with a life expectancy of less than six months.
- All aggressive forms of treatment for their illness must have stopped, except for radiation therapy for palliative measures.
- A recognized hospice Provider must administer hospice services.
- Coverage shall include home care and outpatient services provided by the community hospice agency.

Variations for Hospice: Medicare Advantage Members

Members with an active hospice election must select a Medicare-certified hospice Provider. Hospice claims are sent directly to Medicare. Providers of all services to those on hospice must submit their claims directly to Medicare Fee-For-Service for Hospice. Once payment for claims has been received, the Medicare EOMB and a secondary claim should be submitted. MVP will then coordinate benefits to pay the balance due minus the Member's responsibility. Coverage includes medical supplies related to the hospice care and use of DME equipment, per hospice contracts. All DME must be provided through a participating Provider or hospice vendor. Drugs traditionally covered under Part B and Part D are covered under the Medicare Part A per-diem payment to the hospice program. For prescription drugs to be covered outside of the Part A per diem and under the Member's Part D benefit, the hospice Provider must provide documentation identifying why the drug is unrelated to the terminal illness or related condition. Prescribers who are unaffiliated with the hospice Provider should also attest that they have coordinated with the hospice Provider and the hospice Provider confirmed that the drug is unrelated to the terminal illness or related condition.

With the exception of payment for physician services, payment for hospice care is made at one of four predetermined prospective rates depending on level of care. The four levels of care are:

1. Routine Home Care (Revenue Code 0651)
2. Continuous Home Care (Revenue Code 0652)
3. Inpatient Respite Care (Revenue Code 0655)
4. General Inpatient Care (Revenue Code 0656).

Medical justification for continuous home hospice and all inpatient care must be documented in the Member's hospice medical record.

Discharge for Medicare Advantage Members from Hospice must follow the CMS guidelines for the NOMNC. Medicare Beneficiary Notification forms and instructions can be found on the Beneficiary Notices Initiative (BNI) page at [cms.gov/BNI](https://www.cms.gov/BNI).

Note: A Word document format for the NOMNC may be obtained by contacting an MVP Professional Relations Representative.

Palliative Care through Hospice

The Palliative Care Program is to be considered for Members with a serious illness who may have a prognosis of more than six months and may be pursuing curative interventions.

The diagnoses to be considered include, but not limited to, AIDS, cancer, heart disease, lung disease, renal disease, or a progressive neurological disease. Referrals to the Palliative Care program are accepted from multiple resources: physician, UM staff, home care agency, hospital discharges planners and hospice.

MVP Medicaid Managed Care, Child Health Plus, and HARP.

Children are allowed to receive hospice services while receiving any medically necessary curative services.

MVP Health Care Home Care Referral Process

Overview

MVP provides home care services in accordance with Medicare guidelines, the Home Care BIM and MVP contracted benefits. Home care benefits under the supervision of an RN are available to Members upon meeting eligibility requirements and criteria established to determine medical necessity for skilled services to homebound patients. Short-term, intermittent services by home health aides; physical, occupational, and speech therapists; and durable medical equipment (DME) are available to eligible Members when medically necessary.

Initial Requests for Services

1. The PCP or specialist must initiate home care requests. A discharge planner may act as a physician's agent to initiate a care request.
2. Select In-Network Home Care Providers (Nursing, PT/OT/SLP and HHA services) do not require prior authorization for Commercial, Medicaid and ASO. Please contact the MVP Home Care Unit for a Provider list at **1-800-684-9286**.
3. All out-of-network services do require prior authorization, which can be obtained by contacting the MVP Home Care Unit at **1-800-684-9286**.
4. A facility discharge planner may act as a physician's agent to initiate a request for care. The case manager will review the information. If additional services are approved, the Member's MVP case is updated. The agency is contacted, and a follow-up letter is sent and/or a response to a standard EDI transaction (ANSI 278). Requests for authorization extensions may be obtained by calling MVP's Home Care Unit at **1-800-684-9286**.

Requests for Continuing Services

The home care agency will provide updates, using a standard EDI transaction (ANSI 278), or by phone or fax on a concurrent basis for each case in which additional home care services are requested prior to completion of care or the approved time frame for home services. The PCP, attending physician, or specialist treating the patient must initiate requests for home care services.

Variation for Home Care Services: Medicare Advantage

naviHealth, Inc. provides Utilization Management for Home Health services for Medicare Advantage Members only.

Fax: 1-866-683-6976 for pre-service authorization requests

Fax number: 1-866-683-7082 for continued stay authorization requests and "other" (NOMNC, NDMC)

Fax number: 1-866-683-9126 is utilized to receive Healthcare MDS from All PAC and Home Health

All NOMNCs should be faxed to naviHealth at **1-866-683-7082**

Tel: 1-844-411-2883

naviHealth hours of operation are 8:00 am - 5:00 pm Monday through Friday EST, except for nationally recognized holidays. Prior to July 1, 2017, please continue to contact MVP Provider Customer Care Center at **1-800-684-9286**. To learn more about naviHealth, visit navihealth.us.

In accordance with Medicare Regulation 42 CFR, §44.624, §422.626, §422.620, effective 01/01/2004 for MVP Medicare Members:

The Home Care Agency is required to provide MVP Medicare Members advance notice of non-coverage by issuing the Notice of Medicare Non-Coverage (NOMNC). The NOMNC must be issued at least two days prior to the last day of coverage/discharge, signed, and dated by the Member (or authorized representative). If there is more than a two-day span between services, the NOMNC should be issued on the next to the last time services are provided. The authorized representative may be notified by telephone if personal delivery is not available. Medicare Regulations do not recognize notifications by voicemail. The authorized representative must be informed of the content of the notice, the telephone call must be documented, and a copy of the notice must be mailed to the representative. The “valid delivery” of NOMNC must be retained in the Member’s medical record. A signed (or acknowledged) copy of the NOMNC is faxed to MVP Health Care within 24 hours of receiving a NOMNC from MVP Health Care.

Medicare Beneficiary Notification forms and instructions for the NOMNC can be found on the Beneficiary Notices Initiative (BNI) page at cms.gov/BNI.

A Word document format for the NOMNC may be obtained by contacting a MVP Professional Relations Representative.

When a Member requests an appeal with the Beneficiary and Family-Centered Care Quality Improvement Organization, the Detailed Explanation of Non-Coverage will be issued to the Home Care Agency by naviHealth, Inc. The Home Care agency is responsible to issue to the Member the Detailed Explanation of Non-Coverage upon receipt from MVP via naviHealth, Inc.

MVP Medicaid Managed Care Variation for Personal Care Services

MVP Health Plan, Inc. covers personal care services for Medicaid Managed Care Members. Personal care services must be prescribed by a participating physician and services must be performed by a participating Personal Care agency. A personal care assessment must be completed and submitted to the health plan for prior authorization before the initiation of Personal Care Services. Level I (nutritional and environmental support functions) will be considered for coverage based on medical necessity. There will be a limit of up to eight hours per week for Level I personal care services. Prior authorization is obtained by calling **1-914-372-2433**.

Special Requirements for Home Health Agencies Providing Personal Care Assistant Services to NYS Medicaid Recipients

Home Health Agencies that provide Personal Care Assistant Services are required to attest that the agency has policies, procedures, programs and protocols to demonstrate compliance with NYS Medicaid Standards for the following:

- a. The level of personal care services provided and title of those providing services
- b. The criteria for selection of persons providing personal care services
- c. Compliance with the requirements of the Criminal History Record Check Program (NYCRR Part 402)
- d. That training, approved by the NYS DOH, is provided to each person performing personal care services, other than household functions

- e. The agency assigns appropriate staff to provide personal care services to a Member according to MVP's authorization for the level, amount, frequency and duration of services to be provided
- f. There is administrative and nursing supervision of all persons providing personal care services
- g. The agency's administrative supervision assures that personal care services are provided according to MVP's authorization for the level, amount, frequency and duration of services to be provided
- h. The administrative supervision includes the following activities:
 - i. Receipt of the initial referrals from MVP, including its authorization for the level, amount, frequency and duration of the personal care services to be provided;
 - ii. Notifying the MVP when the agency providing services accepts or rejects a patient;
 - iii. When accepted, the arrangements made for providing personal care services; and
 - iv. When rejected, the reason for such rejection.
- i. The agency promptly notifies MVP when the agency is unable to maintain case coverage
- j. The agency provides nursing supervision to assure Member's needs are being met

MVP Health Care Home Infusion Services

Refer to MVP's payment policy: Home Infusion Policy.

Infusion therapy requires a prescription from a qualified physician who is overseeing the care of the patient and is designed to achieve physician-defined therapeutic endpoints. The infusion therapy must be initiated on time within the stipulations of the physicians' orders for 100 percent of cases.

Most home infusion services do not require prior authorization. The health plan reserves the right to audit the vendor's records to ensure compliance with MVP Policies. Prior authorization may be required prior to the administration of specific medications. Refer to the MVP website for a list of specific medications requiring prior authorization. The vendor will work with the prescriber to coordinate the prior authorization.

Home Infusion Services are covered when deemed medically necessary. Coverage of services may vary by Member contract. Home Infusion nursing services are in some instances applied to a Member's home health care benefit. Some prescription drugs are not a part of the base medical benefit. Coverage may exist under Member or employer riders. MVP reserves the right to limit the availability of certain medications to a specialty pharmacy vendor. For Providers with electronic access, further information surrounding specific benefits/riders may be obtained on the Provider portal, on the MVP website. For Providers without electronic access, contact the Customer Care Center.

The home infusion vendor must report any adverse outcomes (due to wrong dose, administration, faulty equipment or other issues) within 24 hours of occurrence by contacting MVP's Home Care Unit at **1-800-684-9286**.

Home Infusion and Home Health Care Agency Nursing Visits

All efforts will be made between the infusion vendor and home care agency to coordinate the delivery of care to the Member. When the Member is under the oversight of and opened to a home care agency for non-infusion related care, the home care agency shall administer the medication on the dates the agency is scheduled to have a nurse in the home. Home infusion vendors may subcontract with another agency for all or part of the nursing services. In these instances, the home infusion vendor:

- Assumes responsibility and oversight of care provided;
- Bills MVP Health Care for their services; and
- Is responsible to pay for all subcontracted services.

Insulin Infusion and DME

External Subcutaneous Insulin Pumps and Supplies may be covered under the Member's Diabetic Care Benefit with a participating DME vendor. Supplies may also be obtained through a network pharmacy and should be billed online to the Pharmacy Benefits Manager (PBM) for Members with a pharmacy benefit through MVP.

Home Infusion and Hospice Services

When a Member elects hospice, all services and respective charges related to the hospice diagnosis are global to the hospice payment. No separate reimbursement is made to the home infusion vendor.

Home Infusion and Skilled Nursing Facility (SNF) Care

When a Member is in a Skilled Nursing Facility at a skilled (non-custodial) level of care, all services under CMS's consolidated billing and the respective charges are global to the SNF payment. No separate reimbursement is made to the home infusion vendor. If the Member becomes custodial and remains at the SNF for residential purposes, the home infusion vendor may be reimbursed by MVP for the home infusion services. The drugs administered in the SNF for custodial Members must be billed to MVP's PBM and may be subject to a Medicare Part B or Part D determination review.

In accordance with Medicare Regulation 42 CFR, §44.624, §422.626, §422.620, effective 1-1-04 for MVP

Medicare Members: The Home Infusion Agency is required to provide MVP Medicare Members advance notice of non-coverage by issuing the Notice of Medicare Non Coverage (NOMNC). See above under Home Care.

MVP Medicaid Managed Care

Please refer to the *MVP Medicaid Managed Care Formulary* for more information.

Retrospective Review

Retrospective review is conducted based on specified type of review by a Registered Nurse (RN), RN Certified Coding Specialist (CCS), or RN Certified Professional Coder (CPC). Reviews can be conducted to verify level of care, place of service assignment, length of stay, services rendered, validation of inpatient/outpatient coding, and accuracy of claim data including submitted charges that impact reimbursement. MVP utilizes facility/Provider medical records, in conjunction with clinical review criteria, MVP Medical Policy utilization review/coding guidelines, and when applicable invoices, itemized bills. Consultations with MVP's Associate Medical Director occur based on case complexity. All medical denials and Level of Care changes are determined by an Associate Medical Director. Coding Denials are reviewed by Certified Coders. A retrospective case that is identified as a potential Quality Improvement, Coordination of Benefits, or Case Management trigger, will be referred to the appropriate unit. The applicable policies address regulatory turnaround timeframes, clinical information collection, assessment and appeal rights. These reviews are all performed after the service has been rendered and may be pre or post payment. Types of retrospective reviews may include but are not limited to:

Post-Service Inpatient Review

Retrospective review of medical records is performed on all inpatient hospital admissions where the claim indicates the following:

- a. The approved Length of Stay (LOS) days do not match between the claim and the authorization.
- b. Required match fields (i.e., level of care) on a claim submitted do not match the authorization.
- c. No authorization or pending authorization.

Post-Service Outpatient Review

Retrospective review of outpatient medical records may include but are not limited to the following:

- a. Cosmetic procedures or services
- b. Experimental and investigational procedures or services
- c. Injury to sound natural teeth services/procedures
- d. Services identified in MVP's medical policy as requiring a retrospective review

MVP Health Care may reverse a pre-authorized treatment upon retrospective review of relevant medical information presented at the time of the Utilization Review if it is materially different from the information presented during the pre-authorization, the information existed at the time of the pre-authorization and was withheld or not available or the Utilization Reviewer was not aware of the existence of the information, and if the information was available the requested service or procedure would not have been authorized.

Based on regulatory guidelines Providers/facilities will receive written notification on retrospective adverse determinations.

DRG Validation

DRG Validation is performed post payment (within six months of paid claim date) on claims submitted by those facilities that have a contractual agreement with MVP for a DRG payment methodology. DRG validation is performed by certified RN coders (CCS) who utilize ICD-10 CM Coding Guidelines/Conventions and coding software which is consistent with industry and regulatory standards. Charts are reviewed for validation of all ICD-10 CM/PCS codes impacting DRG as well as the sequencing of principal and secondary diagnoses. Additional clinical resources used in DRG validation include but are not limited to American Hospital Association Coding Clinics, Faye Brown Coding Handbook, and Merck Manual etc.

Other DRG reimbursement drivers that can be reviewed are birth weights, discharge disposition, transfers, short stay payments and readmissions reviews as per the individual facility contracts or regulatory requirements. When the coder disagrees with the hospital's coding and subsequent DRG assignment, the hospital is notified, in writing, of the DRG reassignment, with rationale, references cited and appeal rights. The claim will be adjusted to the DRG identified in the notification letter.

MVP may request at any time in this process that a physician query be initiated to clarify diagnoses and/or procedures. The format used for submitting this query shall adhere to the nationally recognized guidelines set forth by AHIMA. The expectation is that the facility will submit the documented physician query/response along with all other medical record documentation that substantiates the diagnosis/procedures to MVP within 30 calendar days from the date of the request/letter for the facility to initiate a physician query.

If the facility is not in agreement with MVP's decision and wishes a reconsideration, the facility may submit the entire medical record (if not submitted prior to reconsideration) and/or any additional supporting documentation no later than thirty calendar (30) days from the date of MVP's letter. If, upon review of the facility's reconsideration letter and supporting documentation, MVP Health Care's RN CCS coder determines the facility's original DRG was appropriate an agree letter is sent and the claim is readjusted to pay the originally submitted DRG. For those reconsiderations that the RN CCS coder upholds the MVP Health Care DRG assignment a letter will be sent to the facility notifying as such and will include additional rationale, and references.

If a hospital is not satisfied with the result of the DRG reconsideration, it may commence with a level Two Hospital Appeal, if allowed by contract, which a third-party arbitrator shall conduct. Per the instructions in the closing of the reconsideration letter, the hospital will submit a written request to the designated arbitrator within 30 calendar days from the date of MVP's Level one appeal (reconsideration) determination notice. According to the contractual

agreement between the hospital and MVP, the subscriber/Member cannot be held financially responsible for any balance billing.

Other Types of Retrospective Claim Reviews

Transfer Payment

Transfer Payment is based on contract and/or Medicaid or CMS regulations. An acute care transfer is considered a discharge of a hospital inpatient from an acute care non-exempt facility to another acute care non-exempt facility. The total payment to the transferring facility will not exceed the amount that would have paid if the patient had been discharged. If on review, the health plan finds either the discharging or the transferring facility incorrectly billed a transfer case, payment will be adjusted.

Post-Acute Care Transfer

A discharge of a Medicare hospital inpatient is considered to be a transfer when the discharge is assigned as outlined in the CMS Manual (Post-Acute Care Transfer Policy per Center for Medicare and Medicaid Services) to one of the qualifying diagnosis related groups (DRG) and discharge is made under any for the following circumstances:

- To a hospital or distinct hospital unit excluded from the prospective payment system.
- To a skilled nursing facility.
- To home under a written plan of care with a provision of home health services from a home health agency and those services begin within 3 calendar days after the date of discharge.

If, on review, the health plan determines that the submitted claim had an incorrect discharge disposition the payment will be adjusted accordingly. The Provider may submit documentation for reconsideration to the attention of MVP's Retrospective DRG Unit.

Cost Outliers

Cost Outliers require the hospital to submit all itemized charges for any case in which a cost outlier review is requested. The hospital receives the DRG payment plus additional payment for cases that exceed the DRG threshold for excessive cost to the hospital as based on the contracted DRG methodology. The case is reviewed to verify accuracy, appropriateness of charges and services billed along with DRG validation. In addition, any days that were not reviewed for medical necessity concurrently may be reviewed retrospectively and if any days are determined to not be medically necessary, those associated charges will be removed from the total allowable charges, which may affect the hospital's final reimbursement.

Readmission

Readmission is defined when a patient is discharged and readmitted to the same non-exempt hospital within 30/31 days, for the same or a related condition for which the patient was treated at the time of the original discharge and the second admission is the result of an inappropriate/premature discharge or for patient/facility convenience or scheduling difficulties. Reviews will be performed in accordance with facility contract and/or CMS/Medicaid/New York State regulations. Days between the original discharge and the subsequent admission will not be considered in the calculation of the total length of stay for payment.

Based on the review of the applicable medical records, MVP may identify a second admission as a "readmission" for purposes of reimbursement, if MVP's RN reviewer or Medical Director determines that the first discharge was inappropriate/premature (i.e. discharged in an unstable medical condition and did not meet standard/established discharge criteria), or was for patient/facility convenience. For Medicaid Members the New York State Regulation for readmissions will be followed. This includes but is not limited to a readmission which could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period (i.e., home care appropriate following discharge but none ordered resulting in

readmission). In addition, any discharge with subsequent readmission due to a delay in service or due to facility or Member convenience would fall under these readmission requirements.

In the case of readmissions, the Hospital shall be reimbursed the lesser of:

- i. the total of the case rate payments for the two separate admissions; or
- ii. the payment which would have been received pursuant to this Rate Sheet and Addendum by billing MVP for a single case rate by combining, according to the principal reason for Member admission, those diagnoses and procedures of the readmission with the diagnoses and procedures of the original admission, and total medically necessary days in the combined admission.

If MVP does not consider the case a “Readmission,” MVP will pay each discharge separately in accordance with the facility contract/MVP Agreement. Discharges and subsequent admissions between acute care unit and a behavioral health unit or a physical rehabilitation unit in the same hospital are not considered a “Readmission” for purposes of this paragraph.

When a readmission is identified the hospital is notified in writing that MVP Health Care is combining the said DOS, citing the resulting DRG assignment, provide rationale, references and reconsideration/appeal rights.

If a Hospital disagrees with MVP’s decision regarding a readmission, Hospital may ask for reconsideration as directed within the Readmission letter by submitting a reconsideration request letter with supporting documentation within 30 calendar days from the date of the initial readmission letter.

If a hospital is not satisfied with the result of the readmission reconsideration, it may (as allowed by contract) commence with a level Two Hospital Appeal, with the designated third-party arbitrator. The instructions and timeframe of thirty (30) calendar days from the date of MVP Health Care’s response letter are provided in the closing of MVP Health Care’s reconsideration response letter. According to the contractual agreement between the hospital and MVP, the subscriber/Member cannot be held financially responsible for any balance billing.

Never Events/Hospital Acquired Conditions (HAC’s)

The National Quality Forum, CMS, New York State Medicaid and other entities maintain different listings of Never Events/Serious Reportable Adverse Events/HACs. MVP will not pay for the cost of care associated with a Never Event. For a detailed summary of the MVP Never Event Policy, refer to the end of this section. MVP reviews all never events to facilitate accurate coding, billing and reimbursement based on individual contracts.

High Cost Claim Audits

High Cost Claim Audits are conducted per MVP hospital contracts for the following but not limited to high cost drugs, level of care/room charges, high cost services, implants etc. An itemized bill along with the medical record may be requested to verify charges being billed. The facility will be notified by letter of any changes to charges along with the rationale for changes. Facility may request reconsideration per instructions in the closing of the high cost change letter. If the facility disagrees with adjustment the facility may submit a reconsideration letter with rationale within thirty calendar days of receipt of initial letter.

Physician Claims Review (PCR)

MVP provides equitable and consistent reimbursement for all MVP participating and non-participating physicians and facilities while managing health care costs by conducting post service claim review. PCR performs coding reviews on post service, pre-payment claims, as well as on appeals received for finalized (i.e., paid or denied) claims. The PCR CPC staff reviews the claim to determine the accuracy of the coding, modifiers and place of service and verifies that the billed procedures are coded appropriately based on review of the documentation provided. Current Procedural Terminology (CPT) Guidelines, American Medical Association (AMA), National Correct Coding Initiative (NCCI) edits, McKesson Claims ten Clinical Editing and MVP Policy guidelines are utilized for determinations.

MVP may turn off specific subsets of edits. MVP monitors trending data to identify changes in coding practices. MVP will execute audits on specific Providers or turn the edit on if a trending change warrants. Providers to be audited will be offered advanced notice of initiated audits. MVP will request all documentation to support the coding on the claim.

Providers and facilities may appeal any payment changes as a result of clinical editing, medical necessity or level of care denials by submitting a Claim Adjustment Request Form (CARF) with the clinical and/or coding rationale explaining why the denial is incorrect. Please make sure to include any medical reports and/or coding documentation that will substantiate the appropriateness of the appeal. If documentation was originally submitted with the initial denial, Providers need to send additional supporting documentation with the CARF that may not have been provided with the initial denial.

MVP may reverse a pre-authorized treatment, service or procedure on retrospective review, pursuant to section 4905 (5) of the NYS Public Health Law, when: relevant medical information presented to MVP upon retrospective review is materially different from the information that was presented during the pre-authorization review; the information existed at the time of the pre-authorization review but was withheld or not made available; and MVP was not aware of the existence of the information at the time of the pre-authorization review; and had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Medical Audit

Medical audits are performed by MVP or a contracted recovery audit vendor to ensure Providers are following MVP's clinical and coding guidelines when providing services or care. Medical auditing is a cost-effective approach to review/respond to utilization trends for medical services not managed through the traditional Prospective, Concurrent, or Retrospective review processes.

Medical auditing is performed on health services where MVP has elected to relax prior authorization guidelines for those targeted services and for services where MVP has chosen to perform limited post service review. Audits are performed to ensure services are provided in accordance with MVP policies, contracts and billing guidelines. Examples of services audited include but are not limited to FDA approved implantables, home care, home infusion, select DME, coding and clinical trials.

When MVP or a contracted recovery vendor performs a medical audit, the Provider will be required to supply clinical notes within 30 calendar days of the request. Clinical notes along with any other supporting documentation can be faxed to **1-518-386-7417** or mailed to Medical Audit, 625 State Street, Schenectady, NY 12305. Failure to provide the requested notes may result in recovery of claims paid to the Provider.

If a medical necessity adverse determination is made following audit review of clinical notes, the Provider may appeal the determination following the appeal process in the notice of denial. If the documentation review results in a coding or payment adjustment, the Provider may file dispute reconsideration and provide any additional documentation to the Medical Audit unit within contracted timeframes. MVP will recover any monies paid to the Provider and the Members will be held harmless.

Care Management Programs

MVP Health Care with internal and external Members of the health care delivery team to provide comprehensive Case Management. MVP's care management programs aim to maintain and/or improve the physical and psychological well-being of our Members through tailored and cost-effective health solutions. MVP strives to address the health needs of its Members at all points along the continuum of health and well-being, through participation of, engagement with, and targeted interventions for the population. These programs are offered at no cost to the Member and there are no co-payments for these services. Member may choose to opt-out at any time.

Caring for Members with acute and/or chronic health conditions sometimes takes an extra helping hand. That's why MVP has a team of registered nurses (RN), respiratory therapists, licensed social workers, licensed mental health professionals (LMHP), health coaches and patient engagement specialists to help ensure that your patients achieve the best health outcomes possible.

Additional information about these programs is provided below. To refer to any of the MVP programs contact our central triage number at **1-866-942-7966** or email PHMReferrals@mvphealthcare.com.

Case Management-Complex/Catastrophic Programs

The Case Management program was created to ensure that the highest quality of care is provided to Members who have multiple or complex health care needs. The goal of Case Management is to help Members regain optimum health, or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the Member's condition, determination of available benefits and resources, and development and implementation of a case management plan with self-management goals, monitoring, and follow-up.

The Catastrophic Care Program supports Members with serious illnesses or injuries such as hemophilia, HIV, complex cancer treatment, ALS, end stage renal disease and stroke. Case Managers provide care coordination to ensure that MVP Members are effectively accessing the appropriate outpatient and Provider services. Members will be transferred to Complex Care after an acute episode, if ongoing self-management support is needed. The Complex Care Program assists with the coordination of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate appropriate delivery of care and services. Case Managers provide self-management support to Members with multiple chronic conditions (CHF, COPD, CAD, Diabetes and Asthma); ensuring the Member/caregiver is able to independently self-manage their conditions. In addition, MVP Medicaid Members are often found to have significant medical and social needs that drive their health care utilization. MVP has case managers dedicated to meeting these Members' needs especially those Members enrolled in the HARP program and/or a Health Home. Clinicians also work collaboratively with Health Homes (HH) and our Behavioral Health team to support complicated medical and psychosocial Member needs.

Case managers utilize the principles of case management and health coaching to increase the effectiveness of communication with plan Members. In addition to providing support to Members in the form of care coordination and facilitating access to needed resources, Case Management aims to achieve the following objectives:

- Ensure cost effective solutions through appropriate utilization and coordination of health care resources and application of health care benefits.
- Identify gaps in services or communication and create systems to correct them.
- Improve the continuity of care received by Members by providing a contact person for physicians, staff, patients and families throughout the episode of care.
- Provide impartial advocacy, facilitation and education to Members and their families.
- Be aware of the financial needs of Members and maximize benefits and health care resources to limit out-of-pocket expenses.
- Improve medication adherence, safety and quality of life.

Transplant Case Management

Transplantation involves complex and highly specialized care and requires time-intensive coordination for multiple health concerns. MVP's Case Management department has dedicated Case Managers that specialize in Transplant Case Management. A transplant referral occurs when the PCP or specialist requests a transplant evaluation and/or prior authorization for a transplant.

The Transplant Case Manager should be consulted for benefit questions or other transplant-related issues. An individual case manager follows up with each transplant recipient by phone and/or correspondence for up to one-year post-transplant.

Procedure for Transplant

Following the request for prior authorization, the MVP Case Manager will begin gathering the medical information for review.

Upon identification of a potential transplant candidate, the attending Provider is required to submit a request to MVP's Case Management Department by calling **1-866-942-7966** for prior authorization of non-urgent evaluations for transplant. If it is an urgent request, that should be stated during the phone call. Regardless of transplant facility, before a transplant evaluation or transplant procedure can be performed, an approval must be obtained. If after the transplant evaluation a transplant is planned, the results of the evaluation are sent to the case manager to ensure the review is complete prior to any additional services rendered.

In addition to MVP's contracted facilities, MVP uses the Optum HealthCare to access centers of excellence for transplant services and to provide information and resources on centers of excellence for specific types of transplant. For information about Optum HealthCare participating facilities, Providers may call the case manager at **1-866-942-7966** or visit Optum Health Care's website at: myoptumhealthcomplexmedical.com.

Little FootprintsSM for High-Risk Pregnancies

MVP offers a high-risk prenatal care program called Little Footprints, which provides additional clinical expertise for expectant mothers.

The goal of the Little Footprints program is to promptly identify female Members at risk of a high-risk pregnancy (multiple births, infertility, history of miscarriage, etc.) and provide the Member with care coordination and prenatal education. The program involves telephonic contact with an MVP Case Manager or bilingual Maternity Care Coordinator (for Spanish speaking Members). The Case Manager follows each Member individually and develops an education plan in conjunction with the pregnancy assessments and screenings.

Ongoing telephone calls are scheduled with the Member to encourage healthy behavior and provide education on topics such as fetal development, diet, nutrition and exercise. Members are followed post-delivery and are assessed for post-partum depression. Members are advised to follow up with their physicians post-delivery and verify that an appointment with the pediatrician has been scheduled. Expectant mothers are mailed educational information packets upon enrollment and delivery. Those Members who are not eligible or declined the Little Footprints program are referred to the Healthy Starts program for an educational packet via mail. The Healthy Starts program gives mothers-to-be information to help them stay healthy, learn about pregnancy, and prepare for delivery. Medicaid Members who are not eligible or decline the Little Footprints program will receive the same packets as those enrolled in the Little Footprints program.

Rochester Providers caring for Members enrolled in the Medicaid Managed Care program are encouraged to notify MVP of all pregnancies (not limited to high risk) by faxing a copy of the Member's Prenatal Health Risk Assessment form to the Customer Care Center - Provider at **1-800-247-6550**. This process provides prompt referral of a pregnant Member to the Little Footprints program.

The maternity management program follows the evidence-based guidelines published by the American Academy of Pediatrics ("AAP") and the American College of Obstetricians and Gynecologists ("ACOG") Guidelines for Perinatal Care, Seventh Edition, October 2012.

Breastfeeding Support

MVP recognizes the importance of breastfeeding babies and we are committed to ensuring that breastfeeding support is available for every mom and baby we cover. We have a comprehensive lactation support program providing breastfeeding support and equipment through Corporate Lactation Services. Through this relationship with Corporate Lactation Services, MVP is able to offer nursing mothers state-of-the-art breastfeeding equipment and access to internationally board-certified lactation consultants and registered nurses 365 days-a-year. This support program includes outreach calls placed at specific times to provide mothers with information appropriate for the age of the infant/baby. Members can call in with questions or concerns until weaning. All of these services are offered at no additional charge to our Members. To enroll, Members can visit corporatelactation.com and click on *subsidy login*, then enter the pass code **MVP2229** or call **1-888-818-5653**. Additional breast-feeding support is available by video using the myVisitNowSM video platform through American Well.

Social Work Services

Social Work services are available to connect Members to community resources and services and assist with addressing Member specific social and economic needs. The social work team can assist Members with the following:

- Department of Social Services: fee-for-service Medicaid, food stamps and the Home Energy Assistance Program (HEAP);
- Housing: Section 8, Housing Authority, home modification/weatherization and homelessness;
- Co-payment relief: prescription assistance programs and facility co-payments for things like hospital stays;
- Social Security Administration: disability and Medicare;
- Senior support programs;
- Cancer resources;
- Advance directives, written plans documenting the Member's wishes in terms of health care treatment in the event that they cannot speak for themselves; and
- Transportation.

Health Management (Disease Management) and Health Coaching

MVP's telephonic Health Management (Disease Management) programs are structured to empower the Member to bring about lifestyle and behavior change, provide condition-specific education and assist Members with achieving evidence-based care guideline outcomes. Clinical interventions are aimed at collaborative care planning and/or goal setting that continuously evaluates clinical, humanistic and economic factors affecting overall health. The health management programs provide two service options:

1. Information mailed to the Member's home, including bi-annual condition specific newsletters and health screening reminders; and
2. Telephonic one-on-one outreach by a health coach. The telephonic outreach program focuses on prevention of exacerbations and complications, self-management strategies and helping Members to make positive lifestyle changes and better control their condition. In addition, condition health management programs assist with connecting Members with appropriate community resources and services.

MVP's health management programs identify and outreach to Members living with:

- Asthma

- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- Low Back Pain

Transition Care

The Transition Care Program is an intensive program for Members recently discharged from the hospital to provide education and support to reduce their risk for readmission. Outreach is provided through home visits, video or telephonic. The MVP Transition Care team consists of clinicians focused on helping to support Members after a hospital admission. Services include assisting the Member with understanding discharge instructions, medication adherence, encouraging prompt Provider follow-up and coordination of care, assessing risks post-discharge in the home environment and providing the patient with self-management tools and coaching. Visits are conducted telephonically, within the home or video.

Care Advantage

The Care Advantage Program is available to ASO employer groups as an add-on. The focus of this program is to promote health, wellness, informed decision-making, preventive care, healthy lifestyle choices and complex case management while optimizing quality and efficiency. This program provides a proactive, integrated, Member-centric approach utilizing the nurse as the primary point of contact. Registered nurse case managers, known as Care Coordinators, are dedicated and assigned to the employees of the organization as well as to their covered dependents. The Care Coordinators provide direct assistance to participants and their treating physicians with the management of the enrollee's health care, as well as provide and/or coordinate a wide array of healthcare-related support and educational services. They act as proactive partners with the Members and are available to help them navigate through the healthcare delivery system, understand their benefit coverage, and coordinate with other relevant Providers and care managers involved in their treatment, such as EAP Providers, behavioral health Providers, disease management coordinators, etc.

Member Identification

There are three ways a Member may be identified as a candidate for one of the MVP Case or Condition Management programs:

1. A health care Provider may refer a Member to the program.
2. The Member (or designated care giver) may self-refer to the program.
3. The Population Health Analytics team at MVP may identify a Member for management using a variety of data points (health risk assessment data, claims, authorization data, laboratory data, predictive modeling and more). Upon identification, a clinician will reach out to the Member to engage in a telephonic program.

How to Refer a Member to a Program

The process for referral is simple. Call our central triage number at **1-866-942-7966**. Let us know how we can help. MVP will reach out to the Member by telephone. We will match the Member to the most appropriate program and services. This telephone line is secure, and you may leave a secure message at this number. To assist Providers with the referral process, a one-page [referral guide](#) is available on the MVP website.

Communication between MVP and Providers

MVP recognizes the importance of communication between the clinicians and the Provider/Provider offices. That is why we may be in contact with the office (by fax, letter, or phone) in an effort to alert you to a change in status and to collect pertinent medical data that may assist us with management of the Member.

The MVP case and health management (disease management) programs offer multiple-risk stratification dimensions as well as tailored Member-centric interventions. Providers are encouraged to refer Members to the programs provided.

MVP offers a number of Provider tools, including clinical guidelines and assessment tools, to help Providers identify Members requiring specialized services. The [tools and guidelines](#) are available on the MVP website.

A sample list of guidelines follows:

- Adolescent health
- Back Pain (Low Back program)
- Behavioral Health
- Depression program
- Cardiac Care (Cardiac and Heart Failure programs)
- Careful antibiotic usage
- Caring for older adults
- Diabetes
- Infectious disease
- Kidney care
- Oncology/Cancer Prevention
- Preventive health (adult/childhood preventive care guidelines)
- Quality Improvement in the clinical setting
- Respiratory (Asthma/COPD programs)
- Women's Health

In addition to the guidelines, MVP offers assessment tools to assist with the identification of potential alcohol abuse. These tools, also found on MVP's website, include the:

- CAGE questionnaire for assessment of potential alcohol abuse in adults
- CRAFFT questionnaire for assessment of potential alcohol abuse in adolescents

Health Home Services for Government Program Members (Medicaid Managed Care, Child Health Plus, HARP)

Health Homes are a care management service model whereby all a Member's caregivers communicate with one another to ensure that all the Member's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all the services the Member needs to stay healthy, out of the emergency room, and out of the hospital. Health Home participation is voluntary.

MVP is contracted with multiple Health Homes in our service area. The contracted Providers are listed on the MVP website. Upon enrolling in any of MVP's Government Programs, MVP's Member Service Department performs New Member Orientation calls and gathers pertinent medical history information from our new Members. Additionally, Members are asked to complete a health risk assessment (HRA). When an HRA is returned, this is reviewed for case

management opportunities. MVP's case managers will identify any special needs or barriers to receiving treatment. The Member's PCP may be contacted to coordinate and review health concerns which are identified on the health risk assessment form. MVP Medicaid Members identified with two chronic conditions or one serious persistent mental health condition or as HIV positive are referred to a Health Home by utilizing the MVP Health Home Upward Referral Form. This form is available on the MVP website.

In addition, MVP's Medicare Services and Supports team will review claims history and authorizations to monitor and identify a Member's need for care management services based on:

Diagnostic Eligibility

- two or more chronic conditions; or
- one serious persistent mental health condition; or
- HIV/ AIDS.

Frequent Utilization Eligibility

- No primary Care Provider
- No connection or inadequate connectivity with specialty doctor
- High utilization of Emergency Department (3-6 visits in previous year)
- Repeated recent hospitalizations (2-3 inpatient stays in previous year)
- Recent discharge from psychiatric hospitalization
- Assertive Community Treatment (ACT)

MVP's Clinical, Behavioral, Member Services, and Provider Services teams who interact with our Members, Providers, hospitals, and pharmacies will refer a Member to a Health Home who meet the criteria above and/or one of the qualifying factors below:

- No connection or inadequate connectivity with specialty doctor
- Recent release from incarceration
- Poor compliance with treatment or medications or difficulty managing medications
- Homeless or inadequate social/family/housing support
- Learning or cognition issues
- Deficits in activities of daily living such as dressing, eating, etc.
- Cannot be effectively treated in an appropriate resourced patient centered medical home
- Court Ordered Assisted Outpatient Treatment

Providers can make referrals to a Health Home by utilizing the MVP Health Home Upward Enrollment Referral Form located on the MVP website.

PCPs for MVP Government Programs have additional responsibilities including:

Services for Foster Care Children

Participating Providers must work with local department of social services (LDSS) staff to provide comprehensive medical assessment for children in foster care as specified in 18 NYCRR §441.22 and 507.

Child Protective Services

Participating Providers must comply with the [Statewide Central Register of Child Abuse and Maltreatment](#).

24/7 Nurse Advice Line

MVP Members have access to a 24/7 Nurse Advice Line operated by CareNet Health, Inc. The 24/7 Nurse Advice Line allows Members to obtain the health information and education they need to make better health care decisions. Members and Providers may call the Customer Care Center on their ID card or via email through the MVP website.

Online Doctor Visits

MVP now offers myVisitNowSM to fully insured Commercial, Medicare, Medicaid, and Essential Health Plans. MyVisitNow is a smart phone application that supports a video chat service connecting a Member to a doctor or other health care professional. The service is intended for use with non-emergent situations that will benefit from the expertise of a clinical professional. Since the inception of the program, myVisitNow has included Behavioral Health Therapy, Lactation Consultations, and Nutrition and Diet in addition to the core Urgent Care offerings. Psychiatry and Spanish mobile experience was also added to the platform. Since the interaction occurs via video, the health care professional may be able to offer diagnoses, treatment plans or a prescription. Members are provided with a post-visit summary that can be shared with their Primary Care Physician. As with the 24-hour Nurse Advice line, this service is not intended to replace the relationship between a Member and his or her Primary Care Physician or health care professional. Additionally, all interactions are encrypted and secure, providing privacy and confidentiality.

Bariatric Surgery Network

MVP established a network of hospitals that are approved sites for MVP Members to receive bariatric surgery. To obtain a list of the hospitals participating in MVP's Bariatric Surgery Network, visit mvphealthcare.com. For Members enrolled in a Medicare Plan, services must be obtained at an approved Medicare facility. A listing of facilities certified by the American Society for Bariatric Surgery (ASBS) may be found at cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp.

For MVP's Medicaid Managed Care, Providers must follow the MVP Medical Policy. Medicaid Managed Care and HARP Members are not restricted to the CMS approved and ASBS facilities. MVP also requires that the surgical team (including surgeons, anesthesiologists, and radiologists) be MVP-participating physicians.

Before referring an MVP patient for bariatric surgery and before obtaining prior authorization, call Customer Care Center - Provider at **1-800-684-9286** to determine if the Member's benefits require him/her to have the surgery performed in one of the hospitals in MVP's Bariatric Surgery Network. Coverage is subject to each Member's specific MVP benefit plan as indicated in his/her subscriber contract or certificate of coverage.

MVP Breast Cancer Surgery Facilities

In accordance with NYS DOH requirements for Medicaid Managed Care programs, MVP may no longer authorize inpatient or outpatient mastectomy and lumpectomy procedures for its Medicaid Managed Care Members at hospitals and ambulatory surgery centers identified as low volume by the New York State Department of Health. A listing of the designated approved and unapproved facilities may be found at nyhealth.gov/health_care/medicaid/quality/surgery/cancer/breast. Please note that the facility must be contracted for MVP Government Program Members as well as on the approved list in order to be authorized to treat MVP Medicaid Managed Care Members.

Medical Affairs

New Technology Assessment

MVP follows a formal process to evaluate new technology and reassess existing technologies to determine whether such technologies are covered services and/or should be addressed in the Benefit Interpretation Manual. This

includes medical/surgical procedures, drugs, medical devices, and behavioral health treatments. A copy of this policy is available on request.

MVP's technology policies are reviewed at least annually, with comprehensive updates triggered more often by changes in published medical evidence-based journals. Requests to review new technology or to reassess established technology are received from participating Providers, MVP medical directors, UM staff and other MVP personnel.

Our team of medical professionals conducts research of the published scientific evidence, information from government regulatory bodies, and prepares a draft of the technology assessment/benefit interpretation policy. The new/updated technology is considered for its impact on health outcomes, health benefits and risks, and effectiveness compared to existing procedures and/or products. The draft policy is presented to the Medical Policy Task Force for review and forwarded to practicing physician consultants from appropriate specialties for review and comment. Policies are then distributed to MVP medical directors and key UM staff, Professional Relations, Claims, Corporate Affairs and Legal Affairs for a 14-day review and comment period. The Medical Policy Task Force reviews the recommendations from the above and appropriate recommendations are incorporated into the proposed policy. The revised policy is then presented to the Medical Management Committee (MMC) Work Group for review and discussion. Once approved the policy is forwarded to the MMC for consideration. Comments are considered and as appropriate incorporated into the medical policy. MMC Membership includes practicing physicians from representative specialties, including at least one physician from each of the MVP service areas and MVP staff. MVP's Pharmacy and Therapeutics (P&T) Committee reviews all new drugs including new chemical entities, new formulation and combination products. Prior to each meeting, new drug coverage policies and policy revisions are distributed to P&T Members for review and comment.

Policy recommendations that are accepted by the MMC and P&T are presented to the Quality Improvement Committee (QIC) for final approval. The QIC may approve the policies when they are presented or send them back through their respective processes for additional research and revision before reconsidering them at a future meeting. Once the QIC approves a medical policy, Providers are informed through the Healthy Practices newsletter or online at www.mvphealthcare.com of the new/revised medical policy and effective date. The policy is then posted in the online BIM for Providers. Formulary and pharmacy policy updates also are found online.

Serious Reportable Adverse Events (SRAE) (Formerly referred to as “Never Events”) and Hospital Acquired Conditions (HACs)-By Product.

MVP's policy is consistent with those defined by the National Quality Forum (NQF), CMS, New York State Department of Health (DOH) and other entities that maintain different lists of SRAE/HAC's. These lists are not intended to capture all of the SRAE and HAC's that could possibly occur in hospital facilities, outpatient/office based surgery centers, and ambulatory practice settings/office-based practice, long term/skilled nursing facilities but are intended to provide guidance as to what would likely be considered SRAEs and HACs. The actual Never Events/SRAE/HAC's governed under this policy will change over time, as dictated by federal and/or state mandate, and the needs of our customers and Members. The SRAE and HAC criterion utilized, to which this policy applies, is listed below:

1. MVP Commercial/ASO Products

MVP will deny a claim submitted with a SRAE and MVP will reduce payment on a claim billed with a HAC diagnosis and a Present-on-Admission (POA) indicator of “N”. For hospitals billing with APR DRG's for commercial business, MVP shall reference the then current New York State DOH SRAE and or HAC lists as published by the NYS DOH. For hospitals billing with MS DRGs for commercial business, MVP shall reference the then current CMS list published by CMS. Providers shall bill MVP according to the applicable CMS rules relating to SRAEs and HACs. The applicable NYS DOH or CMS list utilized will be determined by the date services were rendered.

Facility/Providers notification/claims submission related to Never Event/SRAE for Commercial ASO Members:

- a) Facility/Provider will notify MVP if an SRAE occurs by contacting MVP Provider Service Representative.
- b) Facility/Provider will bill MVP for these Inpatient and Outpatient services, according to the standard process.
- c) MVP will deny a claim if an SRAE is identified upon medical record review.
- d) Should the facility disagree with MVP's denial of the claim, the hospital may appeal to MVP within 30 days of the date of the denial letter.
- e) Subsequent Inpatient or Outpatient readmissions to the same facility caused by the SRAE and admission is related to the SRAE will also be denied by MVP.
- f) SRAEs and HACs are non-reimbursable services and Members may not be balanced billed.

2. Medicare Advantage Products

MVP will deny a claim submitted with an SRAE and MVP will reduce payment on a claim billed with a HAC and a Present-on-Admission indicator of "N". For SRAEs and HACs MVP shall reference the then current CMS SRAE and HAC lists published by CMS. MVP follows standard CMS reimbursement practices for SRAEs and/or HAC's, which may include payment adjustments or non-payment for CMS specific SRAE and/or HACs. The lists of SRAEs and HAC's may be adjusted by CMS periodically and MVP will follow CMS practices. The applicable CMS list will be determined by the date services were rendered.

Facility/Provider Notification/claims submission related to Never Events/SRAE on a Medicare Patient:

- a) Facility/Provider will notify MVP if an SRAE occurs by contacting MVP Provider Service Representative.
- b) Facility/Provider will bill MVP for these Inpatient and Outpatient services, according to the standard CMS billing process.
- c) MVP will deny a claim if a SRAE is identified upon medical record review. Should the facility disagree with MVP's denial of the claim, the facility may appeal to MVP within 30 days of the date of the denial letter.
- d) Subsequent Inpatient or Outpatient readmissions to the same facility as a result of, or related to the SRAE will also be denied by MVP.
- e) These are non-reimbursable services and Members may not be billed.

3. New York State Government Programs Products (Medicaid Managed Care, Child Health Plus and HARP)

MVP will deny a claim submitted with an SRAE and MVP will reduce payment on a claim billed with a HAC and a Present-on-Admission indicator of "N". For SRAEs and HAC's MVP shall reference the then current Medicaid SRAE and HAC lists published by DOH. MVP follows standard New York State Medicaid reimbursement practices for SRAEs and /or HACs for its New York Government Programs products. The applicable DOH list will be determined by the date services were rendered.

Facility/Provider Billing Related to SRAE and for Medicaid Managed Care, Child Health Plus and HARP

- a) Facility/Provider will notify MVP if an SRAE occurs by contacting MVP Provider Service Representative.
- b) Facility will bill MVP for these Inpatient and Outpatient services, according to the standard process as defined by NYS Medicaid Managed Care, Child Health Plus or HARP Members.
- c) MVP will deny a claim submitted with an SRAE or reduce payment on a claim submitted with a HAC and a Present-on-Admission indicator of "N".

- d) Should the facility disagree with MVP's denial of the claim, the facility may appeal to MVP within 30 days from the date of the denial letter. Subsequent Inpatient or Outpatient readmissions to the same facility as a result, or related to the SRAE will also be denied by MVP.
- e) These are non-reimbursable services and Members may not be billed.

New York State Essential Plans

MVP will deny a claim submitted with an SRAE and MVP will reduce payments on a claim submitted with a HAC and a Present-on- Admission indicator of "N". For SRAE's and HACs, MVP shall reference the then current Medicaid SRAE and HAC lists as published by NYS DOH. MVP follows standard Medicaid reimbursement practices for SRAEs and/or HACs for its New York Essential Plans.

Facility/Provider notification/claims submission related to SRAE for New York State Essential Plans

- a) Facility/Provider will notify MVP if an SRAE occurs by contacting MVP Provider Service Representative.
- b) Facility will bill MVP for these Inpatient and Outpatient services, according to the standard process as defined by NYS Medicaid Managed Care, Child Health Plus or HARP Members.
- c) MVP will deny a claim submitted with an SRAE or reduce payment on a claim submitted with a HAC and a Present-on-Admission indicator of "N".
- d) Should the facility disagree with MVP's denial of the claim, the facility may appeal to MVP within 30 days from the date of the denial letter. Subsequent Inpatient or Outpatient readmissions to the same facility as a result of, or related to the SRAE will also be denied by MVP.
- e) These are non-reimbursable services and Members may not be billed.

4. Physician Billing Related to Never Events

Commercial/ASO Products

- a) Physicians will notify MVP by contacting MVP Provider Services if one of the SRAE occurs as defined by the appropriate regulatory list as noted above.
- b) Should MVP determine that SRAE occurred; Providers who were causatively linked to the event will have their bills denied. Members may not be billed.
- c) Physicians who provided services ancillary to the Never Events (i.e., radiologists, pathologists, consultants) will not have their bills denied.
- d) Physicians whose bills are denied may appeal such denials in accordance with their MVP contracts.

Medicare Products

- a) MVP will follow Medicare protocols related to payments of physicians for Never Events.

New York Government Programs Products Medicaid Managed Care, Child Health Plus and HARP

MVP will follow NYS Medicaid Managed Care protocols related to payment of physicians.

NY Essential Plan Products

- a) Physicians will notify MVP by contacting MVP Provider Services if one of the SRAE occurs as defined by the appropriate regulatory list as noted above.
- b) Should MVP determine that SRAE occurred; Providers who were causatively linked to the event will have their bills denied. Members may not be billed.
- c) Physicians who provided services ancillary to the Never Events (i.e., radiologists, pathologists, consultants) will not have their bills denied.

- d) Physicians whose bills are denied may appeal such denials in accordance with their MVP contracts.

Reconsiderations Statutory

For New York fully insured products, if MVP denies a claim for services on the basis that such services are or were:

- a. Not medically necessary; or
- b. Experimental or investigational, without offering to discuss the denial with the Provider who specifically recommended the health care service, procedure or treatment under review, then that Provider may request a statutory reconsideration of the claim denial. The Provider and the MVP clinical peer reviewer who made the initial denial will conduct a statutory reconsideration.

For post-service claims, the statutory reconsideration will occur within 30 business days of the Provider's request. For pre-service claims, Urgent Care, and Concurrent Review, the statutory reconsideration will occur within one business day of receipt of the request. If MVP upholds the initial denial after completing the statutory reconsideration, then the Provider will be sent a written notice of the determination.

Supplemental

For all MVP health insurance and HMO products in New York, and Vermont, MVP offers hospitals a supplemental reconsideration process. If MVP denies a claim for services on the basis that such services were:

- a) Not medically necessary; or
- b) Experimental or investigational, then the hospital may request a supplemental reconsideration of the claim denial and submit additional information in support of the denied claim without having to formally submit a hospital appeal.

MVP will respond to requests for supplemental reconsideration within 30 business days of receipt. If MVP upholds the initial denial after completion of the supplemental reconsideration, then the hospital will receive written notice of the determination. Supplemental reconsideration is not available after a hospital has submitted a statutory reconsideration or filed a hospital appeal. Moreover, MVP will immediately terminate its review of the supplemental reconsideration upon receipt of a hospital appeal.

Commencement of a Statutory or Supplemental Reconsideration

To request either type of reconsideration described above, a hospital must call the appropriate MVP UM department and advise them that reconsideration is sought. A hospital must submit its reconsideration request within 45 calendar days of receipt of the claim denial or MVP's remittance advice. A hospital is not required to submit either a statutory or supplemental reconsideration in order to submit a hospital appeal or to submit an appeal on behalf of a Member. Additionally, the submission of either type of reconsideration does not postpone the time period to file either a hospital appeal or an appeal on behalf of a Member.

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When to Call the Customer Care Center

Providers may check the status of all claims submitted to MVP online at mvphealthcare.com.

Providers who have additional questions about claims or remittance advices may contact the Customer Care Center for Provider Services at **1-800-684-9286** or **1-800-999-3920**.

When to Resubmit a Claim

Providers may resubmit a claim directly to MVP electronically if it was not processed on MVP's system. If you are correcting a claim that was already processed, you may resubmit electronically or with a Claims Adjustment Request form, to:

MVP Health Care
PO Box 2207
Schenectady, NY 12301

When resubmitting a claim directly, use the following guide to determine if a claim adjustment form is required:

Claim Adjustment Form IS NOT REQUIRED...	<ul style="list-style-type: none">• for a different or corrected:<ul style="list-style-type: none">- Date of service- ID number- Service provider- Procedure or revenue code- Date of birth
Claim Adjustment Form IS REQUIRED... (UNLESS sending electronic EDI Request)	<ul style="list-style-type: none">• for any other change to the information on the 02/12 1500 claim form, UB-04 form, or a Standard EDI Transaction (ANSI 278)• for a different or corrected name• for claims appeals• for claims denied for no EOB from primary carrier and provider submitting EOB• for a different or corrected place of service

Claim Requirements

Claim information must be entered in the designated field for all claims submitted. MVP uses state-of-the-art optical imaging and optical character recognition (OCR) for all paper claims. Therefore, print quality and data alignment for paper claims must be of high quality for optimum clarity when scanned into the computer system.

Providers are required to use the most current version of the 02/12 1500 available.

The *CMS Medicare Billing: Form CMS-1500 and the 837 Professional* booklet is available [here](#).

The *CMS Medicare Claims Processing Manual - Completing and Processing the Form CMS-1450 Data Set* (also known as the UB-04) is located [here](#).

Important NPI Reminder

HIPAA mandates that all health care providers performing standard electronic transactions obtain a National Provider Identifier (NPI). MVP requires NPIs on paper claims. Up to date NPI information, revised EDI Companion Guides, and a link to the CMS website are available at mvphealthcare.com.

Providers must report their NPIs to MVP at the time they are requesting to become a participating provider. MVP will not Credential or register a new Provider without verifying they have an active NPI.

Clean Claim Processing Timeframes

Clean Claim Definition

A Complete and Accurate Claim or “Clean Claim” is defined as a completed and accurate UB-04 or 02/12 1500 claim form which does not include any erroneous or conflicting information) bill containing all data necessary for processing. It must be submitted no more than 180 days after the date of discharge or 180 days after a service is rendered.

Clean Claim Processing

If the provider submits a Clean Claim including all requisite information to process the claim at the time of submission, MVP will:

1. Pay the claim or any undisputed portion of the claim within applicable Regulatory timeframes.
2. Notify the provider of any adverse determination, in writing, within 30 days after MVP’s receipt of the claim. However, if a claim is denied for lack of medical records, requested information must be resubmitted within 180 days from receipt of MVP’s notice. If the Provider receives an adverse determination, the Provider may request reconsideration or appeal the denial on the member’s behalf as described in this manual’s Appeals Section.

If the Provider does not submit a Clean Claim, it will be rejected and returned to the provider.

Hospital Inpatient Claim Itemized Bill Requirement

Providers must submit an itemized bill for all inpatient hospital claims with billed charges greater than or equal to \$50,000. Inpatient claims that are reimbursed solely at the inlier DRG methodology will be excluded. MVP will suspend all claims that do not include an itemized bill. MVP will send the provider notice of the pended claim, along with a request for the required itemized bill. Provider must submit such itemized bill with MVP’s request letter for claim to be processed. Failure to provide an itemized bill may result in a claim denial.

Equian Claim Review Guidelines

MVP utilizes Chapter 22, CMS 2202.6 policy for **all lines of business** when reviewing charges for specified claims that are included in the general cost of room and board or associated surgery and are considered non-billable for separate reimbursement.

The general cost of the room where services are being rendered includes routine services and supplies. As such, these items are considered non-billable for separate reimbursement and are not eligible to be included in outlier calculations for additional reimbursement.

Timely Claims Submission Reminder

MVP applies a timely filing limitation of 180 days, or as specified in your contract, from the date(s) of service for the filing of claims. All claims received after the time period will be denied. MVP members cannot be billed for services denied because of timely filing issues.

There are two exceptions to the timely filing limitation:

- Claims that involve Coordination of benefits where MVP is the secondary payer have a timely filing limitation of 180 days, or as specified in your Agreement, from the date of the primary’s EOB but no more than two (2) years after the date of service.
- Claims for Worker’s Compensation or No Fault are not subject to the timely filing limitation of two (2) years after the date of service, provided that MVP receives the claim with appropriate denials/documentation no later than the contracted filing limit.

In addition to filing claims in a timely manner, MVP imposes the timely filing limit on adjustment requests. An adjustment is defined as a request to correct a processing error, whether the claim was denied or modified by MVP erroneously, or the Provider has amended the claim for a billing error or omitted data. Providers may request an adjustment within 180 days, or as specified in your Agreement, from the date of MVP's denial or incorrect payment to submit an Adjustment request. For all timely filing reconsiderations, we require supporting documentation to overturn a denial.

For inquiries of Workers' Compensation, No Fault, or Coordination of Benefits (COB) claims, call MVP's COB Unit at **1-800-556-2477, option 2** for Benefits, and **option 3** for No Fault or Worker's Compensation.

Electronic Claim Submission

Optical Scanning Instructions

Providers that are enabled to submit claims electronically must do so. If you cannot initiate electronic submission of claims with MVP via standard EDI Transactions (ANSI 837) for institutional, professional claims, Providers may create and submit medical and behavioral health claims online to MVP by accessing <https://mvphealthcare.transshuttle.axiom-systems.com>. This website is hosted and powered by AXIOM and the services available therein are offered by AXIOM to providers on behalf of MVP Health Care. AXIOM may require that users agree to AXIOM's site requirements and certain terms of use before accessing AXIOM's services. If you are unable to submit electronically, mail scannable paper claims.

Providers must submit paper claims on the official Drop-Red-Ink 02/12 1500 forms. Claims that are black-and-white, faxed or photocopied may not scan as cleanly, requiring manual keying. Providers who pre-print their names and addresses in field 33 should use a 10- or 12-point font size.

- ✓ Use UPPERCASE characters only
- ✓ The print should be 10- or 12-point font size. Do not use multiple font sizes on a claim. This includes re-submissions with corrected information.
- ✓ Use standard fonts – typewritten (Courier). Do not use unusual fonts such as sans serif, script, italics, etc.
- ✓ Claims that are too light cannot be scanned.
- ✓ Enter all information on the same horizontal line.
- ✓ Enter all information within the designated field.
- ✓ Avoid handwriting anything on the claim form.
- ✓ Avoid folding claims.
- ✓ A maximum of six line-items are allowed per claim in field 24.
- ✓ Do not use special characters such as slashes, dashes, decimal points, dollars signs, or parentheses.
- ✓ Make sure the claim is aligned correctly and the data is within the box. If information is not contained within the intended field, it may be returned.
- ✓ Staple any multiple page claims (with or without attachments)

Providers that are enabled to submit claims electronically must do so. If you are unable to submit electronically, mail scannable paper claims.

EDI Transactions

MVP is prepared to receive standard EDI Transactions (ANSI 837) for institutional, professional claims. Refer to the MVP EDI Companion Guide for additional information. Contact MVP's EDI Services Department toll-free at

1-877-461-4911 or **1-800-933-3920, ext. 2239** to initiate electronic submission of claims with MVP. Please refer to the following documents for additional information related to electronic claim submission:

- Companion Guides on MVP’s website for information specific to MVP electronic claim submissions are located [here](#).
- The HIPAA Technical Report Type 3 (TR3) guides, which contains complete information for each of the mandated EDI transactions. You can obtain copies of these guides from Washington Publishing Company at wpc-edi.com.

Electronic Replacement and Void Claims Submission

Claims processing system recognizes claim frequency codes on professional electronic claim transactions (ANSI 837P) and institutional electronic claim transactions (ANSI 837I). Using the appropriate code indicates that the claim is an adjustment of a previously adjudicated (approved or denied) claim. The claim frequency codes are as follows:

Claim Frequency Code	Description
1	Indicates the claim is an original claim.
7	Indicates the new claim is a replacement or corrected claim – the information present on this bill represents a complete replacement of the previously issued bill.
8	Indicates the claim is a voided/canceled claim.

Direct Electronic Options

MVP offers the following electronic transactions in the approved HIPAA standard format:

- 837P – Professional Claims
- 837I – Institutional Claims
- 837D – Dental Claims
- 835 – Electronic Remittance Advice
- 270/271 – Electronic Eligibility and Benefits Request and Response
- 276/277 – Electronic Claim Status Request and Response
- 278 – Electronic Authorization Request

When submitting claims electronically to MVP, the Provider should refer to MVP’s HIPAA EDI Companion Guide. For questions about electronic claims submission, contact MVP’s EDI Services Department at **1-877-461-4911** or at ediservices@mvphealthcare.com.

Electronic Claim Filing Tips

When filing claims electronically, please review the “Payer Reports” to ensure MVP has accepted the claim. When billing claims electronically through a clearinghouse, the claim is checked by clearinghouse edits to ensure that all required fields are complete and the format is correct. If the claim passes the clearinghouse edits, it is then forwarded to MVP. MVP also performs edits prior to processing claims.

837 Professional Claim Submission

The CMS *Medicare Billing: Form CMS-1500* and the *837 Professional* booklet is available [here](#).

Replacement Claims

Replacement claims (sometimes referred to as corrected claims or recall claims) submitted electronically will help MVP process the claim promptly and accurately. A replacement claim is any claim that has a change to the original claim (e.g., changes or corrections to charges, procedure or diagnostic codes, dates of service, member name). Corrected claims may be submitted immediately. When a replacement claim is being submitted, Providers may submit the correction electronically with a “7” as the frequency code.

Quick Review Grid

Question	Definition	Examples	How to Submit Claims
<p>What is a replacement (or corrected or recall) claim? (Type of bill ending in 7)</p>	<p>A replacement claim is sent when data on the claims was either missed or needs to be corrected.</p>	<ul style="list-style-type: none"> • Incorrect date of service(DOS) • Incorrect units • Procedure code missing • Diagnosis code change or addition • Revenue code changes • Line being added • Change to injury date • Change to related cause code • Change to place of service • Change to rendering provider with no billing provider change 	<p>If claim was previously processed on Facets and was billed via paper, send in CARF.</p> <p>If claim was previously processed on Facets and billed electronically, follow EDI/MVP replacement claim submission guidelines.</p> <p>Claims that require timely filing review or additional documentation need to be submitted via CARF.</p>
<p>What is a voided claim? (Type of bill ending in 8)</p>	<p>When identifying elements change, a void submission is required to eliminate the previously submitted claim.</p>	<ul style="list-style-type: none"> • Payer information change • Subscriber information change • Billing provider change • Patient information change • Statement covers period • Patient did not want insurance billed • Bill type changes from IP to OP or OP to IP. 	<p>Whether original claim was submitted by paper or electronically, the void may be sent electronically. The void should be sent along with the new original claim.</p> <p>Follow EDI/MVP submission guidelines.</p>

Coordination of Benefits—EDI

When MVP is not the Member’s primary payer, claims can be submitted via an 837 transaction. Please be sure to include the following information from the other payer:

- Total Charge
- Primary Approved Amount
- Primary Paid Amount
- Patient Responsibility
- Other Payer Information

Please contact MVP’s EDI Services Department for more information at ediservices@myphealthcare.com or at **1-877-461-4911**.

Claim Returned to Provider Letters

Providers that receive a “claim returned to provider” letter, which indicates that all required fields have not been populated for a Clean Claim, must respond to the letter or submit a corrected claim within the provider’s contractual adjustment guidelines. The receipt date for a Corrected Claim or contact date for a call made to MVP, beyond the contractual adjustment timeframe, will be subject to timely filing requirements as outlined in the providers Agreement and subject to denial.

Non-Liability

Providers may not bill Members for Covered Services, except for the collection of permitted Deductibles, Co-insurance, or Co-payments a specifically provided in the Subscriber Contract and as set forth in the terms and conditions of the Agreement.

YME/YUV Denials

A claim denied for remark code “YME – Provider Tax ID/Address discrepancy” or “YUV – The tax ID and/or address billed are not on file for the NPI billed” indicate that the demographic information billed on the Provider claim form does not match the demographic information on file with MVP. Providers must update your demographic information, address, tax ID information, new billing locations, or additional office locations with MVP by submitting a change request through MVP’s *Online Demographic* form, found [here](#).

Facilities needing to make a change to demographic information should complete the PDF version of the *Provider Change of Information* form, found [here](#).

Ambulance Mileage Billing

When submitting a chargeable transport service for payment, the transport distance quantity field in Loop 2300:CR106 of an electronic claim must be greater than 0 but less than or equal to 9,999 (miles). Claims submitted with values in excess of 9,999 will be denied, stating “Transport Distance Quantity (CR106) exceeds 9,999.”

Interim Bills

Interim bills are required once a Member has been an inpatient for 120 days, and then every 120 days thereafter. Once the 120-day threshold is met, the facility must submit an interim bill to MVP within 30 days of the 120th inpatient day. Claims will be adjusted to pay the difference as an interim payment for each submission until final discharge.

Imaging Payment Policy

When imaging studies are performed on certain contiguous adjacent body part(s), within a family of codes but not across families of codes (as defined by CMS), provided during the same session on the same date of service, MVP will reimburse the technical component only as follows:

- First Code: 100 percent of Fee Schedule
- Subsequent Codes: 75 percent of Fee Schedule
- The First Code is defined as the code with the highest RVU as defined by CMS.

This is acceptable to all MVP Products for the technical component only regardless of the setting (i.e., outpatient or physician operated setting) excluding Case Rates or when a Medicaid APG or Medicare APC methodology is used.

Modifiers

For more information regarding modifier payment, please refer to the *Modifier Payment Policy* in the [Payment Policies](#) section.

Clinical Edits

MVP uses Change Healthcare (formerly known as McKesson) Claims Xten™ Clinical Editing software to facilitate efficient and consistent claim processing and payment. This software applies a predetermined set of rules to each claim so that as many claims as possible can be automatically approved or denied rather than manually reviewed. Clinical edit updates and enhancements are sourced to nationally recognized correct coding standards.

Custom Clinical/Claim Edits

- CPT® codes 20985, 0054T and 0055T as global to orthopedic codes.
- CPT® code 99173 denied as global to all Evaluation and Management (E/M) codes.
- HCPCS codes Q0091 and G0101 are denied as a subset to sick visits. The denial can be reconsidered with proper medical documentation as to a separate service from the problem visit.
- MVP will reimburse separately for a venipuncture when the Lab work is sent to an external lab and billed with a modifier CG.
- Infusion billed with 96410-96414 and J9000-J9999 is only allowed if billed with Modifier 59.
- CRNA billing with place of service 21/22 and with a hospital TIN is considered global to Surgery.
- Allergy testing/treatment is only allowed when performed by allergists, ENTs and Dermatologists.
- Percutaneous tests will be denied when more than 80 units are billed. Percutaneous tests billed with food allergy diagnosis will be denied when more than 65 units are billed. Intradermal tests will be denied when more than 40 units are billed.
- IP professional charges (visits, consults, anesthesia, etc.) billed by providers employed/staffed by a hospital will be denied “global” (subject to exceptions).
- Effective 9/1/2018 Surgical Trays (A4550) are not reimbursable.
- Surgical procedures that can only be performed in an office/IP/ER setting are defined on the MVP In-Office Procedure list and are not subject to an enhanced fee.
- Heparin and saline will be denied “global” when billed with home infusion.
- B-12 injections billed under injection administration codes will be denied to resubmit with HCPCS code.
- When two IP physician visits are billed for the same date of service by the same provider for the same/related condition, only one visit will be approved.
- When the same lab test is billed multiple times on the same date of service, only one test will be approved.
- Lab services that must be performed in office are documented on the MVP Regional In-Office Lab List and are not subject to enhanced fees.
- Mental health codes billed with a quantity greater than one will be denied.
- More than one mental health session billed on the same date of service will be denied.
- For pelvic and abdominal procedures on the same date of service – the major procedure is reimbursed at 100 percent, minor procedure reimbursed at 50 percent (Mid-Hudson Region).

- Pap Smear code Q0091 will be denied “subset” when billed with an E&M code (including preventive care codes).
- If the first prenatal office visit is billed with a TH modifier but not a prenatal form, the claim will be denied.
- If a prenatal form is submitted after 90 days, the first prenatal visit will be denied.
- Telephone calls from physicians to patients, etc., are not covered and will be denied “incidental to other procedures”.
- Therapeutic codes billed with non-chemo J codes must be billed with modifier 59 when billed in addition to chemo admin, chemo J codes, Q codes or E&M codes.
- Specimen handling is not covered and will be denied “incidental to other procedures”.
- Testing (including hearing and vision testing) is not allowed when billed during a Well Care visit and will be denied “incidental to other procedures” or “included in global fee”.
- If 99070 is billed with a description of a supply and a valid HCPCS code exists for the supply, it will be denied to resubmit with valid HCPCS code.
- Local anesthesia charges billed by providers other than anesthesiologists with office surgery will be denied.
- Dental Injectables billed with Arthrocentesis are not allowed and will be denied “global”.
- If two breast ultrasounds are billed for the same date of service, MVP will approve one and deny the other as “global”.
- If a Biophysical Profile is billed on the same date of service as a fetal or obstetrical ultrasound, the ultrasound should be reimbursed at 100 percent of allowable, the Biophysical Profile should be reimbursed at 50 percent of allowable (applies to Central Region).
- OB ultrasounds performed by OB/GYNs in the office will be denied “global” to the OB delivery claim (applies to Mid-state Region).
- New York State Physicians Pelvic and Transvaginal Ultrasound Policy – codes 76830 and 76817 will be reimbursed at 100 percent of allowable, other codes will be reimbursed at 50 percent of allowable when billed with 76830, 76817.
- Unless otherwise specified in your MVP contract, MVP will not make payment on drug screenings (AMA CPT code range 80300 – 80377). In lieu of a code in this range, the appropriate CMS approved HCPCS G-code should be billed.

Appealing Any Clinical Editing Denial

Providers may Appeal a clinical edit denial by using a Claims Adjustment Request Form with the clinical and/or coding rationale supporting the Adjustment Request. Any medical records/and/or operative reports that will substantiate the appropriateness of the Appeal must be included. Information about MVP policies and procedures is available online [here](#) or from an MVP Professional Relations representative.

Modifiers Effect on Payment

Please see the [Payment Policies](#) section.

Anesthesia

- MVP reimburses in accordance with ASA guidelines.
- Anesthesia Participating Provider Groups must submit anesthesia-specific claims with ASA codes, not surgical codes.

- Anesthesia Participating Provider Groups must submit claims with the total time minutes in the quantity field. MVP automatically calculates the base units from the ASA code billed, and then adds the time units by using the information in the quantity field.
- MVP reimburses based upon 15-minute time units, and will calculate the time units automatically based upon the total time minutes billed by group. MVP reviews all claims submitted with P modifiers. The diagnosis must justify billing of these modifiers/codes.
- Deleted code 01997 should no longer be used. Per CPT guidelines, use the appropriate evaluation and management (E&M) code.
- MVP reimburses 01996 once per day at three units.

Invoice Requirement for Radiopharmaceuticals (Contrast Materials)

See the [Payment Policies](#) section for these requirements.

Coordination of Benefits (COB) Determination

COB/Coinsurance determines the order in which benefits are paid when a Member is covered by insurance policy or contractual entitlement issued by a payer other than MVP (“Other Payer”). MVP will coordinate its benefits with the Other Payer to prevent overpayment and duplicate payments for the same service. Contact the COB Department at **1-800-556-2477**, option 2 for Benefits, and option 3 for No Fault or Worker’s Compensation.

If MVP is the Secondary Payer, the rules and procedures of MVP as stated in the Member’s Subscriber Contract must be followed before MVP will make payment and MVP shall not pay more than it would have paid if it were the Primary Payer.

When billing MVP as the secondary Payer, all MVP primary billing requirements and codes must be followed for the services provided according to specific coding requirements in the Agreement and MVP Protocols, regardless of what was billed to the Other Payer. MVP will not act as secondary payer on a services not covered in a Member’s Subscriber Contract.

MVP As Secondary Payer

If a Member has an accident and is covered for accident-related expenses under any of the following types of coverage, the Other Payer is primary, and MVP may be secondary:

- No-fault auto insurance
- MedPay Insurance
- Group auto insurance
- Traditional fault-type auto insurance that you
- Workers’ compensation
- Other property/liability insurance providing medical payment benefits
- Personal injury protection insurance
- Financial responsibility insurance
- Homeowner’s insurance
- Uninsured/underinsured motorists insurance
- Automobile-medical payment insurance
- Medical reimbursement insurance coverage that you did not purchase

Note: The above list varies by state.

Effect of Medicare

Members must enroll in Medicare Part B upon eligibility when Medicare is determined to be the member's primary plan. If the Member fails to enroll in Part B when eligible and Medicare is primary, MVP will reduce Product benefits by the amount Medicare would have paid for the services or care. The reduction in benefits will occur even if the Member fails to enroll in Medicare, does not pay premiums or charges to Medicare, or receives services at a hospital or from a provider that cannot bill Medicare.

Medicare is considered the Secondary Payer if the Member is:

- A. Medicare-eligible by reason of age and the subscriber is currently employed by an employer group with 20 or more employees.
- B. Medicare-eligible by reason of end-stage renal disease (ESRD) and there is a waiting period before Medicare becomes effective.
- C. Disabled (by reason other than ESRD) and the subscriber is currently employed by an employer group with 100 or more employees.

MVP-Contracted Vendors

MVP contracts with several vendors who may reach out to providers for additional information. These vendors are:

Xerox Recovery Services, Inc. (formerly known as ACS)

1301 Basswood Road, Suite 105
Schaumburg, IL 60173

Xerox reviews MVP claims and eligibility data extracts monthly, for possible Primary Payers. This is a second review after the MVP COB team's review. They use various methods to analyze the data to determine which Members to investigate for other insurance. While not the only focus of their attention, Medicare makes up much of their investigations, end stage renal disease and disability cases in particular. Xerox also has been contracted to provide the additional services of Credit Balance Audits, Hospital Bill Audits, and Data Mining Services.

CDR

307 International Circle, Suite 300
Hunt Valley, MD 21030

CDR receives monthly paid claims extracts to perform bill audits on end stage renal disease facilities.

Trover Solutions, Inc.

9390 Bunsen Parkway
Louisville, KY 40220

Trover Solutions, Inc. receives claims and eligibility data extracts from MVP on a monthly basis. They use software that sorts and analyzes the data compiling high probability cases for investigation. Trover Solutions, Inc. concentrates on Workers Compensation, No Fault, and Third Party Liability cases.

Equian

300 Union Blvd Suite 200
Lakewood, CO 80228

Remittance Advice

An MVP Remittance Advice Statement (RA), explaining approved and denied claims, accompanies each check. If the claim is denied or adjusted, the appropriate claim adjustment code is provided.

Recoveries on Overpayments

All applicable state and federal recovery overpayment guidelines are adhered to by MVP, as well as MVP's Contracted Recovery Vendors.

MVP is regularly audited by external auditing agencies, such as the New York State Department of Financial Services, CMS, and ASO group audits. MVP is required to comply with time limits established by these auditing agencies. Audits may include up to three years of claim data. MVP has no time limit for provider-initiated refunds to MVP. In the event of an overpayment to a Provider, identified by MVP or other applicable auditing agency, MVP may pursue recovery efforts as permitted by law and in accordance with the following timeframes:

1. Medicare, Medicaid, CHP, HARP, Essential Plan Products

MVP shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was received by a Provider.

2. For Self-Insured Products

MVP shall initiate overpayment recovery efforts in accordance to the employer group's contract or twenty-four (24) months after the original payment was received by the health care Provider which includes Medicare primary claims.

3. For New York Providers

MVP shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was received by a health care Provider; provided, however, that no such time limit shall apply to overpayment recovery efforts that:

- Involve fraud, wast, or abuse; or
- Are required by, or initiated at the request of, a self-insured plan; or
- Are required or authorized by a state or federal government program or coverage that is provided by New York State or a New York municipality or its respective employees, retirees, or members; or
- The claims payment was incorrect because the provider was already paid for the services.

4. For Vermont providers

MVP shall not initiate overpayment recovery efforts more than twelve (12) months after the original payment was received by a Provider; provided, however, that the retrospective denial of payment shall be allowed beyond the twelve (12) month period if:

- MVP has a reasonable belief that fraud or other intentional misconduct occurred; or
- Provider was already paid; or
- The health services identified in the claims were not in fact delivered by the provider; or
- The claim payment is subject of adjustment by an Other Payer; or
- The claim payment is the subject of litigation.

Services Provided Free of Charge

MVP will not Pay for Covered services provided to our members free of charge, or when those Covered Services are at no cost to the provider as they are subsidized through a Government or related program, i.e., vaccinations. Covered Services that are provider free of charge should be billed to MVP with the modifier SL.

New CMS Code and Relative Value Units (RVU) Updates

CMS creates new medical codes and assigned RVUs on a quarterly basis. MVP will begin updating fee schedule with the appropriate assigned RVU to all CMS codes on a quarterly basis. Applicable Provider Agreements will still be reimbursed at the agreed upon percentage of Medicare as stated in the Agreement Fee schedule.

Claim Auditing

MVP audits a random sampling of 3-5 percent of all processed claims to ensure processing accuracy.

Special Investigations Unit (SIU)

Special Investigations Unit Insurance laws require MVP to establish and maintain a process to investigate potential occurrences of health care fraud, waste and/or abuse. The Special Investigations Unit's (SIU) mission is to assist MVP in detecting and addressing situations where fraud and/or abuse may have occurred.

SIU uses a formal process for detecting, investigating, and preventing these types of activities. The investigation process includes investigators and nurses with backgrounds in insurance fraud investigations and medical claim reviews. The SIU staff surveys and evaluates claim data— including provider/facility history, specialty profiles, common fraud schemes, waste, and/or abuse, and claim patterns that differ from past history or peer norms for a given condition or specialty.

SIU's investigative process also includes the use of high-tech software, STAR Sentinel™ to detect, track, analyze, and report instances of health care fraud, abuse, or misrepresentation.

It may be necessary for SIU to obtain medical records in order to complete its investigation as efficiently and accurately as possible. However, if SIU requests information from your practice, it does not necessarily indicate a problem exists. MVP also relies on our participating facilities, providers, and their office staff to help us fight insurance fraud, waste and/or abuse.

Please report any suspicious activity by calling MVP's Special Investigations Unit (SIU) toll-free at **1-877-TELL-MVP (1-877-825-5687)**. All information will be kept confidential.

Quality Improvement

Quality Improvement

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MVP's Quality Improvement Program

The MVP Quality Improvement (“QI Program”) has been established to develop, implement, evaluate, and report on the various interventions and programs designed to improve clinical quality, to maximize safe clinical practices and to enhance the MVP Member’s experience. The purpose of the program is to ensure that MVP has the necessary infrastructure to coordinate care and promote quality performance and efficiency on an ongoing basis.

MVP’s QI Program includes components from across all functional areas that relate to Quality Improvement. Some of these activities include Preventive Health, Member Experience, Population Health and Complex Case and Disease Management, Utilization Management, Behavioral Health, Credentialing, Delegation, and Member Rights and Responsibilities.

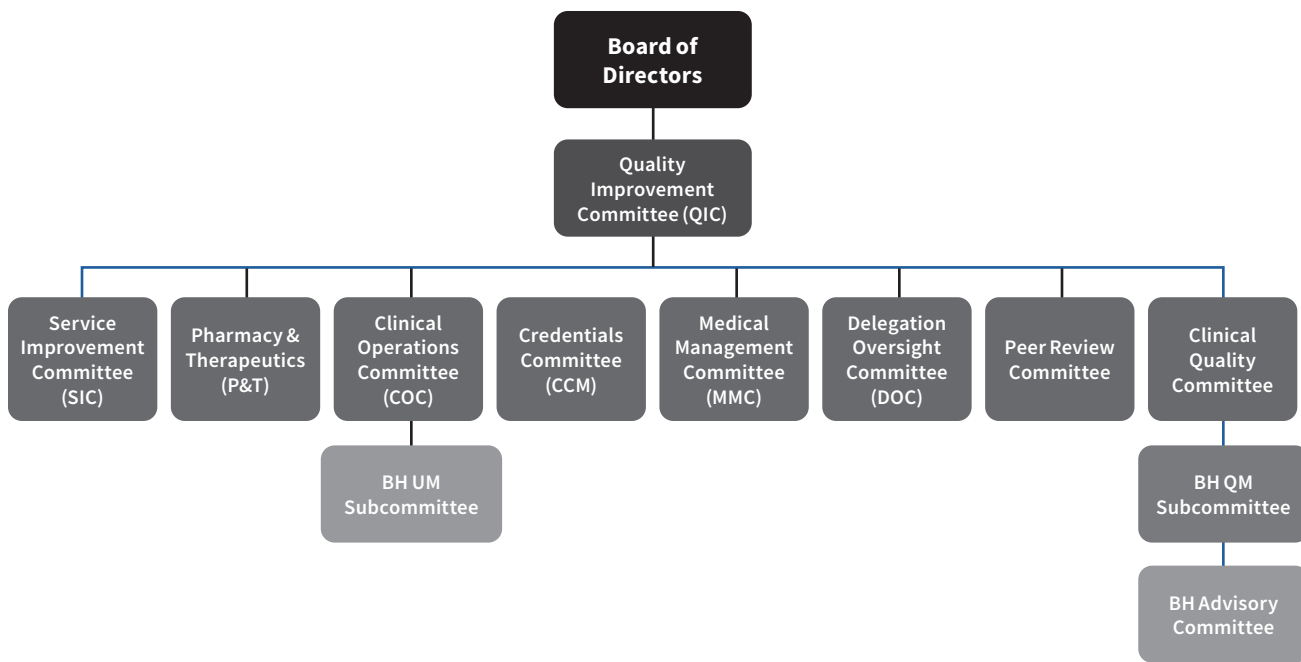
The QI Program’s objective is to provide a structured process to objectively and systematically monitor and improve the quality, appropriateness of care, and services provided to Members. Please see the complete QI Program description at mvphealthcare.com/providers/quality-programs.

The QI Committee (“QIC”) and MVP’s Board of Directors oversee the QI Program. The QIC is chaired by the Senior Leader, Health Management Clinical Strategy and includes community physicians from various specialties who represent the different Participating Providers and Participating Provider Groups in MVP’s Network. Participating Providers interested in participating in QIC are invited to contact the QI Department.

The QI Program is evaluated annually, and the report is sent to the QIC and Board of Directors for approval. For a copy of the Executive Summary of the annual evaluation, call the MVP Customer Care number on the Member ID card.

Members and Participating Providers may participate in the development, implementation, and evaluation of the QI Program. MVP invites Participating Providers to comment on its QI process via the website or by calling Customer Care.

MVP's Quality Committee Structure



MVP's Quality Reporting Structure

MVP has established, in compliance with NYS Department of Health requirements for Government Programs including HARP, Medicaid and CHP regulations, Quality Management (QM) and Utilization Management (UM) committees, subcommittees and advisory groups, which are specific to Behavioral Health, to ensure that MVP's policies, procedures and interventions are effective and relevant. Please see the MVP Quality Improvement Program Description at mvphealthcare.com/providers/quality-programs for the detail regarding each committee and subcommittee.

MVP's Quality and Utilization Management Subcommittees

Behavioral Health UM Subcommittee

- Is co-chaired by:
 - MVP Senior Leader, Medical Affairs
 - MVP Senior Leader, Behavioral Health Medical Director
 - MVP Senior Leader, Health Management Clinical Operations (Lead Role)
- Has membership that includes internal MVP staff including behavioral health staff, which includes but is not limited to:
 - MVP Senior Medical Director, Medicaid and Mid-Hudson
 - MVP Senior Leader Behavioral Health Clinical Operations
 - MVP Behavioral Health Program Manager
- Is responsible for reviewing/analyzing data, variances and outcomes and developing and/or approving interventions
- Ensures interventions have measurable outcomes and are included in meeting minutes
- Meets at least quarterly
- Reports regularly to the MVP Quality Improvement Committee
- Maintains records documenting attendance, findings, recommendations, and actions
- Reviews:
 - Under-utilization and over-utilization
 - Avoidable admission and readmission rates and Average Length of Stay (ALOS) for medical inpatient facilities.
- Outpatient civil commitments (Assisted Outpatient Treatment)
- ED utilization and crisis services use
- Use of crisis diversion services
- Prior authorization/denial and notices of action
- Substance Use Disorder (SUD) initiation and engagement rates
- First Episode Psychosis (FEP) initiation and engagement rates
- Pharmacy utilization including physical health, psychotropic and addiction medications
- BH Home and Community-Based Services (HCBS) utilization
- All physical health measures required by the MCO Model Contract

- Health Home engagement rates for HARP and Medicaid populations
- For Mental Health and SUD inpatient and residential reviews:
 - A. Readmission rates and trends;
 - B. ALOS;
 - C. Post discharge follow-up.

Behavioral Health Quality Management Subcommittee

The BH QM subcommittee addresses all populations served by MVP with a focus on the needs of HARP, Medicaid and CHP Members within the framework of the meeting. Each population is documented separately on the agendas and meeting minutes in accordance with New York State requirements.

- Is co-chaired by:
 - MVP Senior Leader, Quality Performance and Operations
 - MVP Senior Leader, Behavioral Health Operations
 - MVP Senior Leader, Behavioral Health Quality Management
- Has membership that includes peer Specialists, Participating Providers, plans subcontractors, Regional Planning
- Consortia participants and other Member-serving agencies as appropriate
- Membership also includes:
 - MVP Senior Medical Director, Medicaid and Mid-Hudson
 - MVP Senior Leader Behavioral Health Clinical Operations and other MVP staff as determined by MVP
 - MVP Behavioral Health Program Manager
- Uses surveys, focus groups and other mechanisms as appropriate to obtain input on QIAs from stakeholders, including Members, family members, peer Specialists, Participating Providers, plans subcontractors, Regional Planning Consortia participants and other Member-serving agencies
- Meets at least quarterly
- Reports regularly to the MVP QIC
- Separately tracks, trends, and reports Complaints, Grievances, Appeals, and Denials
- Will report to the OMH and the OASAS any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified or designated providers
- Will report on recovery measures employment, housing, criminal justice status
- Maintains records documenting attendance, findings, recommendations, and actions
- Will track and report on compliance with:
 - HCBS assurances and sub-assurances
 - Protocols for expedited and standard appeals regarding plan of care denials for HCBS
 - Protocols for the identification and prompt referral of individuals with First Episode Psychosis (FEP) to programs and services.
- Oversees the development and implementation of BH-specific QIAs, performance improvement projects and focused studies

- Will conduct an annual consumer perception survey (supplementary to Consumer Assessment of Healthcare Providers and Systems [CAHPS])

Behavioral Health Advisory Committees

- Is chaired by:
 - Sr. Leader, Quality Performance and Operations
 - Sr. Leader, Behavioral Health Operations
 - AVP, Westchester Medical BH CM Services
 - Sr. Leader, Behavioral Health Quality Management
- Membership includes:
 - MVP BH staff
 - MVP contracted BH providers
 - Peer specialists
 - Members
 - Local government unit (LGU) Representatives
 - MVP Senior Medical Director, Medicaid and Mid-Hudson
 - MVP Senior Leader, Behavioral Health Clinical Operations
 - Other MVP staff as determined by MVP
- Meet at least quarterly
- Report regularly to the MVP QIC via the Behavioral Health QM Subcommittee
- Will review and consider recommendations of the Regional Planning Consortia regarding improved integration of BH and PH
- Maintain records documenting attendance, findings, recommendations, and actions

Hourly Requirements of PCPs for Government Programs

MVP provides performance information to Participating Providers and PCPs to help them deliver high quality, cost-effective care. We collect performance information from annual CAHPS surveys, HEDIS data, and submitted claim data. For more information concerning Participating Provider performance reporting, please see the complete QI Program description at myphealthcare.com.

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 the National Committee for Quality Assurance (“NCQA”). The standards are as follows:

- Participating Providers must maintain medical records in a manner that is current, detailed, and organized, and permits effective and confidential patient care and quality review.
- Participating Providers must have an organized medical record keeping system.
 1. Medical records must be stored in a secure location inaccessible to the public.

2. A unique patient identifier is used for each Member. The identifier is included on each page of the medical record.
 3. Records are organized with a filing system or search capability to ensure easy retrieval. Medical records are available to the treating practitioner 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 Participating Provider, and all diagnostic and therapeutic services for which the Participating Provider referred the Member (for example, home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports).
 - Confidentiality: Participating Providers/ shall comply with current state and federal confidentiality requirements, including HIPAA and are expected to have implement policies and procedures that guard against unauthorized or inadvertent disclosure of Protected Health Information.
 - Retention of Medical Records – Participating Providers must retain medical records in accordance with contractual obligations and current applicable federal and state laws and regulations.
 - Non-discrimination in Health Care Delivery – MVP, as per CMS and NCQA, expects Participating Providers to have a documented non-discrimination 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.”

Specific standards are as follows:

1. The medical record should be organized in such a way that data abstraction can be performed efficiently. Each page in the record should include the patient’s full name and identification number. In addition, home address, telephone number(s), employer, marital status, and emergency contact information is maintained.
2. The record is legible to someone other than the writer.
3. 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 electronic signature, unique electronic identifier or initials.
4. The history and physical exam identifies appropriate subjective and objective information pertinent to the Member’s presenting complaints.
5. Problem list: Documents all chronic, serious or disabling conditions and active, acute medical and psychosocial problems. A problem list should be completed for each Member, 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 Participating 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.
6. Past medical history (for Members seen three or more times): Should be easily identified and include serious injuries, surgical procedures and illnesses. For children and adolescents (≤ 18 years of age), past medical history relates to prenatal care, birth, surgical procedures, and childhood illnesses.
7. Medication list: Documents all medications including dosage changes and includes the date changes were made. All medications (prescribed and over the counter), herbal therapies, vitamins and supplements must be noted. Dates of initial and refill prescriptions must be included.
8. Medication allergies and adverse reactions: should be prominently noted in the record or on the front cover of the medical record. If the Member has no known allergies or no history of adverse reactions, this is appropriately noted in the record (for example, NKA, NKDA).

9. For patient's ≥ 12 years of age, there should be appropriate notation concerning the use of tobacco, alcohol, and substance use. For Members who have been seen three or more times, an assessment of substance abuse history is included.
10. For all Members ≤ 18 years of age, there should be a complete immunization record. For Members over 18, an immunizations history is maintained (for example, influenza, pneumococcal, tetanus/diphtheria ("Td") immunizations).
11. Unresolved problems from previous office visits should be addressed and documented in subsequent visits.
12. Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls or visits. The specific timeframe for return is noted (ex. weeks, months, or as needed).
13. No shows or missed appointments must be documented with follow-up efforts to reschedule appointment.
14. Specialist, laboratory, and imaging reports should be initialed by the Participating 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 Participating Provider. Specialist, abnormal laboratory, and imaging study results should have an explicit notation in the record of follow-up plans.
15. If a specialist referral is requested, there should be a note from that Participating Provider in the medical record.
16. Laboratory and other studies ordered should reflect consideration of the reported signs/symptoms and recorded diagnoses.
17. Documentation of clinical findings and evaluation for each visit. The working diagnoses should be consistent with findings.
18. 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.
19. There should be no evidence that the Member was placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. Preventive care/Risk assessment: There is evidence that preventive screening and services are offered in accordance with MVP's practice guidelines.
21. Depression screening: May be assessed on a comprehensive physical examination, review of systems, patient health questionnaire, or a formal screening tool (ex. PHQ-9, Beck Depression Inventory) or any part of the following questions: a) Little interest or pleasure in doing things? B) Feeling down, depressed, or hopeless?
22. Advance Care Planning for ages ≥ 65 : Notation of an advance care planning discussion and date 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 Provider Quality Improvement Manual on the Provider Portal of the MVP website.
23. Annual medication review for ages ≥ 65 : Conducted by a Participating Provider and the date performed.
24. Functional status assessment for ages ≥ 65 : Components include vision, hearing, mobility, continence, nutrition, bathing, use of telephone, meal preparation, and managing finances. Functional status assessments may be found on a specific tool.
25. Fall risk assessment for ages ≥ 65 : Components include age, fall history, gait, balance, mobility, muscle weakness, osteoporosis risk, impairments related to vision, cognitive or neurological deficits, continence, environmental hazards, number and type of medication.
26. Monitoring of physical activity for ages ≥ 65 : Includes annual assessment of level of exercise or physical activity and counseling related to begin exercise or increasing/maintaining their level of exercise or physical activity.

Pain screening for ages ≥ 65 : Includes character, severity, location, and factors that improve or worsen pain. Pain assessments may be found on a specific tool such as a pain scale, visual pain scale, or diagram. To assess compliance with the standards for Commercial membership, MVP conducts an annual ambulatory medical record review at the office of PCPs with high volume Member panel sizes of 250 or more on the following two core elements:

- Are records current, detailed, organized, and permit effective and confidential patient care and quality review
- Depression screening

In accordance with your Provider Agreement, medical records must be provided to MVP when requested. The medical records must be received within 10 business days of the request. If a medical record vendor is used, the Participating Provider is responsible for ensuring that the vendor provides the medical records within 10 business days at no cost to MVP or as otherwise explicitly required by the terms of your Provider Agreement. MVP can work with Participating Provider Groups to identify a process to obtain charts, which can include one of the following:

- MVP can set up remote access with Participating Providers to obtain the records electronically
- MVP can perform an onsite review of the charts
- Records can be phased in using our secure electronic RightFax
- Records can be uploaded via MVP's Provider Portal
- Records can be mailed in an encrypted thumb drive or CD

Access to Medical Records

In accordance with your Provider Agreement, medical records must be provided to MVP when requested. The medical records must be received by 10 business days of the request. If a medical record vendor is used, the Participating Provider is responsible to assure that the vendor provides the medical records within the 10 business days at no cost to MVP or as otherwise explicitly required by the terms of your contract. MVP can work with Participating Provider Groups on the best option for them to obtain charts which can include one of the following:

- MVP can set up remote access with Participating Provider offices to obtain the records electronically.
- MVP can perform an onsite review of the charts.
- Records can be phased in using our secure electronic RightFax
- Records can be uploaded via MVP's Provider Portal or can be mailed in an encrypted thumb drive or CD

Clinical Practice Guidelines

MVP encourages Participating Providers to use acute and chronic care management clinical practice guidelines and preventive care guidelines to assist in the management of specific conditions. MVP endorses recommendations for preventive care and acute and chronic care management clinical practice guidelines based on nationally recognized sources.

All of MVP's clinical practice and preventive care guidelines are maintained in the Provider Quality Improvement Manual ("PQIM"). A paper copy of the manual is available by calling Customer Care. The manual is available online at mvphealthcare.com. MVP updates its clinical guidelines at least every two years unless required annually or as sources are updated. Participating Providers are encouraged to check the PQIM periodically for updates and changes. Guideline updates also are published in MVP's Healthy Practices newsletter.

MVP's guidelines are not intended to replace the Participating Provider's clinical judgment in the management of any condition or disease. They are educational guidelines to assist in the delivery of good medical care. Treatment decisions are left to the discretion of the Participating Provider.

MVP Health Care’s New York State Child/Teen Health Program

MVP participates in the high priority New York State Child/Teen Health Program (“C/THP”), a program of early and periodic screening, including inter-periodic, diagnostic and treatment services that New York State offers all Medicaid-eligible children under twenty-one (21) years of age. Care and services are provided in accordance with the periodicity schedule and guidelines developed by the DOH. C/THP includes administrative services designed to help families obtain services for children including outreach, information, appointment scheduling, administrative case management, and transportation assistance, to the extent that transportation is included in the MVP Product or Benefit Plan. C/THP promotes the provision of early and periodic screening services (well care exams), with diagnosis and treatment of any physical, mental or dental health problems identified during the conduct of well care, to be consistent with nationally recognized standards.

MVP follows the recommendations of the American Academy of Pediatrics (AAP) for preventive care for children and adolescents and promotes the guidelines including the AAP periodicity schedule. MVP promotes these guidelines by working with our providers consistently to ensure our members receive the best quality outcomes. MVP assesses provider adherence to guideline recommendations through HEDIS-NYSQARR reporting.

MVP also takes steps to identify Members who do not access preventive care services, including well care visits, immunizations and blood lead testing and notifies and offers assistance to such Members through mailed reminders and telephonic outreach. MVP helps with appointment setting and transportation coordination and works to address any barriers that exist to ensure medically necessary care is delivered.

MVP Health Care’s New York State Children’s Transformation Program

The New York State Children’s Medicaid Redesign fundamentally restructures and transforms the health care delivery system for individuals under 21 that have behavioral health (BH) needs and/or medically complex conditions. The MVP Medicaid BH and Children’s programs include, in an advisory capacity, Members, family members, youth and family peer support specialists, and child-serving providers. The QM/UM Program activities, to include the Children’s Transformation Program will be managed and advanced by the Medicaid BH / Medical QM and BH / Medical UM committees. The activities will be tabulated and tracked in a work plan. The QIC will assess progress toward annual goals and evaluate the effectiveness of the program. The QIC will recommend revisions as appropriate to further advance improved integration and coordination of BH and PH clinical care and services to mainstream Medicaid Members. Outcomes will be summarized annually and presented to the Board of Directors via the QIC.

Member Rights and Responsibilities

MVP members have specific rights and responsibilities with regard to their health care. You can review the [Commercial Member Rights and Responsibilities](#), [Medicare Members Rights and Responsibilities](#), and [Medicaid Member Rights and Responsibilities](#) by clicking on each of these items.

Confidentiality and Privacy Policies

MVP’s Network of Participating Providers rendering care and services to MVP Members share responsibility for protecting PHI. In compliance with HIPAA privacy and security rules, MVP has established policies describing how and by whom MVP Members’ PHI is handled. Please see the Notice of Privacy Practices and Compliance at mvphealthcare.com.

Continuity of Care

Communication is an essential component for quality medical care. Written or verbal communication between PCPs, Specialists, and other Participating Providers helps provide effective follow-up care and improves patient safety.

MVP collects and analyzes data in order to identify opportunities to improve the continuity of care our Members receive from Participating Providers. MVP is studying the differences between Participating Providers that have achieved Patient Centered Medical Home (“PCMH”) certification and/or the usage of an electronic medical record and those that have not taken these steps, to see if these efforts had an impact on Member utilization of emergency rooms for non-emergent and non-urgent care.

Improving the All-Cause Hospital Readmission Rate

MVP is working to reduce readmissions through various projects across the service area.

Hospital Quality Report

MVP offers the Healthgrades rating tool as part of our online directory of Participating Providers to help Members make educated decisions about their care. Healthgrades assigns up to five stars to rate the quality of clinical services and patient safety at hospitals and other health care facilities nationwide. It also offers estimated costs for medical procedures and treatments at each facility. A link to these reports is available on mvphealthcare.com, the Provider Portal and Member pages. Or call MVP at **1-800-777-4793**, ext. 12069 to request a copy of a specific report.

HIV-Related Information

New York State Public Health Law (Section 2782 – Confidentiality and Disclosure of HIV-related information) requires that all health care providers develop and implement policies and procedures as follows:

- Initial and annual in-service education of staff and contractors on HIV-related information and maintenance of a list of those who received training
- Identification of staff by job title and their specific functions who are allowed access to HIV-related information and limits of access
- A requirement that only full-time or part-time employees, contractors, and medical, nursing or health-related students who have received such education on HIV confidentiality, or can document that they have received such education or training, shall have access to confidential HIV-related information while performing the authorized functions listed under paragraph
- Protocol for secure storage of HIV-related information (including electronic storage)
- Procedures for handling requests from other parties for HIV-related information
- Protocols to protect persons with, or suspected of having, HIV infection from discrimination by employees/agents/contractors
- Review of the policies and procedures on at least an annual basis

Reference: HIV/AIDS TESTING, REPORTING AND CONFIDENTIALITY OF HIV-RELATED INFORMATION (Statutory Authority Public Health Law, section 2786 and Article 21, Title III (section2139) Part 63.[8]9 Health care provider and health facility policy and procedures (health.ny.gov/professionals/ems/pdf/srgpart63.pdf).

Behavioral Health and Substance Use Information

New York State and Federal law requires health care providers to develop policies and procedures to assure confidentiality of Behavioral Health and Substance Use Disorder related information. These policies and procedures must include:

- Initial and annual in-service education of staff and contractors on Behavioral Health and Substance Use Disorder information
- Identification of staff allowed access to Behavioral Health and Substance Use Disorder information and limits of access
- Procedure to limit access of Behavioral Health and Substance Use Disorder information to trained staff (including contractors)
- Protocol for secure storage of Behavioral Health and Substance Use Disorder information (including electronic storage)
- Procedures for handling requests for Behavioral Health and Substance Use Disorder information and protocols to protect Members with Behavioral Health and Substance Use Disorder from discrimination

Quality Improvement

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Introduction

MVP Health Care takes great pride in providing our Members with the highest quality health care and customer service. However, on occasion, misunderstandings and differences of opinion may occur. The MVP appeal and complaint procedures provide Members with a dignified and confidential process to resolve these differences. MVP's subscriber contract, certificate of Coverage, or Summary Plan Description will prevail in cases of any dispute or question concerning coverage or rules of eligibility, enrollment, or participation in an MVP health plan.

MVP is committed to resolving all appeals and complaints fairly and amicably, and to assure a high level of quality care and service for Members. MVP encourages Members to use the appeal and complaint procedures when necessary. MVP will not retaliate or take any discriminatory action against a Member who files an appeal or complaint.

Appeal

An appeal is a request for MVP to change a decision that has been made. It may concern whether or not a requested service is a benefit covered by MVP, or the way a complaint has been resolved.

An External Appeal is the review of MVP's denial based on Not Medically Necessary, Experimental/Investigational or Out of Network determination by an independent third party not related to MVP.

Appeal Reviewers

For all levels of internal appeal, appeals are reviewed by persons who are not subordinate to those who made prior adverse benefit determinations. Appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified, or registered healthcare professionals who were not involved in the initial determination, at least one of whom will be a clinical peer reviewer. For any Medicaid Behavioral Health grievances or appeals, a peer-to-peer review will be conducted prior to a decision being made and are subject to specific Behavioral Health requirements including:

- A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment
- A physician board certified in addiction treatment must review all inpatient level of care denials for Substance Use Disorder (SUD)

Provider Submitting Appeals on a Member's Behalf

A provider may appeal a request for a service or claim denial as the designated representative of an MVP Member. MVP shall only accept appeals submitted by providers on a Member's behalf after the Member or appropriately appointed Member representative has designated the provider to act on their behalf. Such designation must be in accordance with MVP's policies and procedures. (A provider filing an appeal on their own behalf for a retrospective UM denial should follow the provider appeals process.)

Expedited Appeals Provider/Hospital on Member's Behalf

An expedited appeal is used whenever a Member or Member's designee appeals a denial of services that:

- Could seriously jeopardize the Member's life or health or the Member's ability to regain function, as determined by MVP applying the prudent layperson standard.
- In the opinion of the provider/hospital with knowledge of the Member's medical condition would subject the Member to severe pain that cannot adequately be managed without the care or treatment that is the claim's subject.

- Involves MVP's review of continued or extended health care services or additional services when the Member is undergoing a course of continued treatment prescribed by the health care provider.

Providers/hospitals can initiate an expedited appeal on a Member's behalf prior to the provider/hospital being appointed the Member's designated representative, if the provider/hospital does the following:

- Calls the MVP Customer Care Center and indicates that he/she would like to submit an expedited Member appeal on the Member's behalf.
- Confirms to MVP's Customer Care Center that it is his/her reasonable belief that an expedited Member appeal is appropriate in this case.
- Advises MVP's Customer Care Center that it is his/her reasonable belief that any further delay in submitting an appeal could have a detrimental effect on the Member's health.

First level expedited appeals

An expedited External Appeal for Medical Necessity or experimental/investigational services can be made simultaneously with an expedited first level of internal appeal. Members requesting an expedited External Appeal must still pursue all internal appeal options. The Member Appeals Coordinator responsible for the disposition of the appeal investigates the situation thoroughly, including contacting the Member, provider, MVP medical director, or clinical peer, who are available 24/7, for clarification of issues or additional information when necessary.

MVP will make the expedited appeal determination and notify the Member and practitioner(s) by telephone as expeditiously as the medical condition requires, but no later than 24 hours after the request is received; for MVP Medicaid Managed Care (Medicaid), MVP Harmonious Health Care Plan (HARP), and NY State of Health Members, as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the appeal or two business days of receipt of the information necessary to conduct the Appeal whichever is earlier. **For Medicaid and HARP Members, this time may be extended for up to 14 days upon the Member's or the provider's request; or if MVP demonstrates that more information is needed and the delay is in the best interest of the Member. The Member and/or provider will be notified of this verbally and in writing.**

Any Medical Necessity-related appeal not conducted within the required timeframes shall be deemed a reversal of the determination. (For Medicaid and HARP Members, any administrative appeal requests in which the Member submits an appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from MVP within State-specified timeframes or the appeal resolution or extension notice does not meet noticing requirements, the Member is eligible to file a state Fair Hearing.) The Member is also sent written confirmation of the decision within two working days of rendering the decision. A written notice of final adverse determination concerning an expedited Utilization Review appeal will be transmitted to the Member within 24 hours of the decision being rendered.

To submit an expedited appeal on the Member's behalf, the provider/hospital must contact the Customer Care Center at 1-888-687-6277, Medicaid at **1-800-852-7826**, or **HARP at 1-844-946-8002**, between 8 am and 6 pm Monday through Friday; or FAX the appeal to MVP Member Appeals Department at 518-386-7600. Appeals should be filed within 180 days (60 calendar days for Medicaid and HARP Members) of the Member's receipt of a denial notice.

Member Appeals (Excludes Medicare Members)

MVP has two levels of internal appeal:

- The first level of appeal must be initiated within 180 days of the initial denial (60 calendar days for Medicaid, HARP).
- The second level of appeals must be initiated within 180 days of the date of denial of the first level of appeal as applicable.

Appeals Process

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Vermont Members have 90 days to request a second level appeal, NY State of Health Members under a group policy only have 45 days.

Medicaid and HARP Members have 60 calendar days to file a first level of appeal. (Medicaid and HARP do not have a second level of appeal; NY State of Health Individual and Vermont Non-Group Indemnity Individual policies have only one level of internal appeal per Federal Health Care Reform.)

A full investigation of each appeal, including any aspects of clinical care involved, is conducted and completed within 15 calendar days of receipt of the appeal or as expeditiously as the Member's condition requires (NY State of Health appeals are completed within the following timeframes, small group, pre-service/pre-authorization 15 calendar days, individual policy, 30 calendar days, small group, post-service/retrospective 30 calendar days, individual policy, 60 calendar days, Medicaid and HARP 30 calendar days). Any Medical Necessity-related appeal not conducted within the required timeframes shall be deemed a reversal of the determination.

For Medicaid and HARP, the Members are eligible to file a state Fair Hearing. A written acknowledgement is sent to the Member within five calendar days of the appeal receipt (15 calendar days for Medicaid and HARP). Within two days of rendering the decision, MVP sends the Member written confirmation of the appeal decision, including an explanation of the Member's right to appeal further or to proceed directly to external review, if applicable.

For expedited appeals, MVP will make a determination and notify the Member and practitioner by telephone as expeditiously as the medical condition requires, but no later than 24 hours after the request is received.

For Medicaid and HARP Members, this time may be extended for up to 14 days upon the Member's or the Provider's request; or if MVP demonstrates that more information is needed and the delay is in the best interest of the Member. The Member and/or Provider will be notified of this verbally and in writing.

Expedited appeals not resolved to the satisfaction of the Member and/or Provider who filed the appeal may be re-appealed through the external appeal process. For group health insurance only, the Member and/or Provider may also re-appeal through the standard first level of appeal process.

A Member or his/her representative, or a Provider acting on behalf of a Member, may file an appeal verbally or in writing. (See policies for acceptance of verbal and written appeals filed by a Member representative or Provider acting on behalf of a Member). An appeal may be filed verbally by contacting the Customer Care Center at **the number on the back of their ID card**, Monday through Friday from 8 am to 6 pm. (Refer to Member Services Policy and Procedure: Accepting Verbal Appeals.) If the Member calls after hours, the MVP Answering Service will accept the Member's name and telephone number, and a Customer Care Center representative will return the call during the next working day. If the Member does not speak English, either a bilingual MVP employee will speak with the Member or MVP will use the services of the AT&T language line, which provides interpreters in 150 different languages.

Appeals should be filed within 180 days (60 calendar days for Medicaid and HARP Members) after receipt of the denial notice. An appeal may be filed in writing to the following address:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, New York 12301

Written requests for appeal submitted by a Member will be accepted into the Member appeals process. For written requests for appeal submitted by a designated representative acting on behalf of the Member, the appeals coordinator will first send a Third-Party Authorization form to the Member to verify that the Member authorizes this representative to act on the Member's behalf. The appeal will initiate once this authorization is obtained. (For Medicaid and HARP Members, MVP will begin the appeal process while waiting for the authorization to be

returned and respond only to the Member.) A Medicaid or HARP Member filing an appeal within 10 days of notice of the Action or by the intended date of an Action, whichever is later, that involves the reduction, suspension, or termination of previously approved services will receive Aid Continuing. To keep the services the same, the Member must ask for an Appeal within 10 days of the date of the Initial Adverse Determination, or by the effective date of the decision, whichever is later. If the Member does not want Aid Continuing, they must say they do not want to do this.

If the Member loses the appeal, they may have to pay for the services they received while waiting for a decision.

If the Member asks for a timely Fair Hearing, the Office of Administrative Hearings will order MVP to keep the Member's services the same, unless the Member says they do not want to do this.

MVP must also provide Aid Continuing if the Office of Administrative Hearings (OAH) orders MVP to do so.

For appeals submitted by a provider acting on the Member's behalf, refer to the Member Appeals section.

Department policies and procedures: Providers Submitting Appeal Requests

If a Medicaid or HARP Member files a verbal appeal, the Customer Care Center will accept the appeal, and also request that the Member submit a written summary of the verbal appeal. (For verbally requested expedited appeals, the appeal does not need to be confirmed in writing.)

If additional information is needed in order to complete the appeal, MVP will also notify the provider and Member in writing, as soon as possible but within 15 days of receipt of the appeal, of such request for information. In the event that only a portion of the information is received, MVP will request the missing information, in writing, within five business days of receipt of the partial information. If the appeal is expedited, this request for information will be made by telephone, followed by written notification to the Member and provider.

For Medicaid and HARP Members, MVP will send the appeal case file with all of the information about the appeal request to the Member, provider and/or representative prior to a decision being made on the appeal. MVP will provide all Members with reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. If the appeal is expedited, MVP will inform the Member of the limited time to present such evidence. MVP will allow the Member or Member's designee, both before and during the appeal process, to examine the Member's case file, including medical records and any other documents and records considered during the appeal process. MVP will consider the Member, Member's designee, or legal representative of a deceased Member a party to the appeal.

A written response is sent to a Member on MVP letterhead within two business days of the appeal determination. The letter includes:

- The date the appeal was filed, a summary of the appeal, the appeal coordinator's name and telephone number
- The Member's coverage type
- The name of the provider or facility, as applicable
- The date the appeal process was completed
- The disposition of the appeal, in clear terms, with contractual (benefits) and/or clinical (Medical Necessity) rationale if appropriate
- The Member's right to appeal further (MVP's Second Level Appeals Committee or to external review if appropriate, including relevant written procedures to do so, and relevant reference to attached standard description of the external appeals process)
- If an adverse determination is rendered

- A list of titles and qualifications of the individuals participating in the review of the appeal including the name and address of the UR agent and the contact person's name and phone number.
- A statement of the reviewer's understanding of the pertinent facts of the appeal
- Reference to the evidence or documentation used as the basis for the decision (such as the Medical Policy Criteria, Subscriber Contract, Member Handbook, Summary Plan Description, Certificate of Coverage, or clinical criteria, including either a copy of the specific rule, guideline, protocol, or criterion, or a statement that such rule, guideline, protocol, or criterion is available upon request, free of charge)
- A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's claim for benefits by contacting a Customer Care Center Representative at the number on the back of their ID card, between 8:00 am and 6:00 pm Monday through Friday. Members may also write to us at: MVP Health Care, Attn: Member Appeals Department, 625 State Street, Schenectady, New York 12305
- A statement of the Member's right to bring civil action under section 502 (a) of ERISA (excluding Federal Government Members, Medicaid, HARP, CHP and New York State Members)

For Medicaid and HARP Members, this written response will include the right of the Member to contact the New York State Department of Health (including the Department's toll-free number), and a statement that the notice is available in other languages and formats for special needs, and how to access these formats. It will also include a description of the Members' fair hearing rights. New York State allows Members the right to request a review by a State-approved External Appeal agent if MVP has denied coverage on the basis of Medical Necessity or because the service is experimental and/or investigational.

Fair Hearings (MVP Medicaid, Medicaid SSI, and HARP only)

A Member may request a fair hearing after completing MVP's internal appeals process.

A Member may request a fair hearing and an External Appeal; if both requests are made, the fair hearing decision is the one that will be binding.

A Member may ask for a fair hearing from New York State:

- After receiving an appeal resolution that an adverse benefit determination has been upheld (Final Adverse Determination)
- The Member is deemed to have exhausted MVP's appeal process when notice and timeframe requirements under 42 CFR 438.408 have not been met; (42 CFR 438.408 provides that the Member has no less than 120 days from the date of the appeal resolution to request a state fair hearing)
- The Member asked for a plan appeal and received an inadequate notice of the appeal decision
- The Member asked for an expedited appeal and the timeframe for the decision has expired (no notification that the request for the expedited appeal was denied and being handled as a standard appeal)
- The Member asks for an appeal about an adverse benefit determination and MVP refuses to accept or review the appeal
- The appeal process is "deemed exhausted"
- The Member requests an appeal, verbally or in writing, and does not receive an appeal resolution letter or extension letter from MVP
- The Member requests an appeal, verbally or in writing, and does not receive an appeal resolution letter or extension letter from MVP within the state specified timeframes

- MVP's appeal resolution letter or extension letter does not meet the noticing requirements in 42 CFR 438.408

The Member can use one of the following ways to request a Fair Hearing:

- Phone: **1-800-342-3334**
- Fax: **518-473-6735**
- Online: otda.state.ny.us/oah/forms.asp
- Mail: NYS Office of Temporary and Disability Assistance
Fair Hearings
PO Box 22023
Albany, NY 12201-2023

A Member also may make a complaint to the New York State Department of Health at any time by calling **1-800-206-8125**.

For New York Members (this does not apply to MVP's self-insured policies or federal government policies), denials for Medical Necessity and experimental/investigational natures of appeal will include a statement of Final Adverse Determination (FAD). The Member must first request a level one of internal appeal through MVP or the Member and MVP must have jointly agreed to waive the internal appeal process. The letter agreeing to a waiver must contain all the applicable elements issued in a final adverse determination letter and must be provided to the Member within 24 hours of the agreement to waive MVP's internal appeal process. The Member has four months from the date of MVP's FAD to request an External Appeal.

If the requested health care service has already been provided and the Member appealed, the physician may file an External Appeal application on the Members behalf, but only if the Member consents to this in writing. The FAD also will include a statement written in bolded text stating that the four-month timeframe for requesting an External Appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the Member to request an External Appeal.

For Commercial Members, the Member does not need to exhaust both level of appeals and the Member has 45 days from the final adverse determination to request and external appeal. Requesting a second level of appeal may cause the time to file and external appeal to expire.

For Vermont Members, the External Appeal request can be requested either after a standard level one or voluntary level two appeal, unless the request is for an expedited appeal; please refer to the Expedited Appeals section.

The Member's Right to Appeal a Determination that a Health Care Service Is Not Medically Necessary

If MVP denies benefits on the basis that the health care service is not Medically Necessary, the Member may appeal to an External Appeal Agent if they can satisfy the following three criteria:

- a) The service, procedure, procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), or treatment must otherwise be a Covered Service under this Contract;
- b) They must have received a Final Adverse Determination through MVP's internal appeal process and MVP must have upheld the denial or the Member and MVP must agree in writing to waive any internal appeal; and
- c) The appeal is an expedited appeal in which case the Member can choose to file an internal expedited appeal at the same time as the external expedited appeal.

An “Out-of-Network Denial” means a denial of a request for prior authorization to receive a particular health service from an out-of-network provider, which is based on the determination that the requested service is not materially different from a service available in-network. (A denial of a referral to an in-network provider is available to provide the requested service is not an Out-of-Network Denial.) To appeal an Out-of-Network Denial, you must submit the following items with your appeal:

- a) A written statement from the Member’s attending physician certifying that the requested out-of-network service is materially different from that which is available in-network; and
- b) Two documents citing medical and scientific evidence that the requested out-of-network service is likely to be more clinically beneficial to the Member than the in-network service and that the requested out-of-network service is not likely to increase the adverse risk to the Member substantially.

The Member’s Right to Appeal a Determination that a Health Care Service Is Experimental or Investigational

If the Member has been denied benefits on the basis that the health care service is an experimental or investigational treatment, they must satisfy the following three criteria:

- a) The service must otherwise be a Covered Service under this Contract;
- b) They must have received a Final Adverse Determination through MVP’s internal appeal process and MVP must have upheld the denial or the Member and MVP must agree in writing to waive any internal appeal; and
- c) The appeal is an expedited appeal in which case the Member can choose to file an internal expedited appeal at the same time as the external expedited appeal.

In addition, the attending physician must certify that the Member has a life-threatening or disabling condition or disease.

- A “life-threatening condition or disease” is one in which, according to the current diagnosis of the attending physician, has a high probability of death.
- A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders the Member unable to engage in any substantial gainful activities.
- In the case of a child under the age of 18, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

The attending physician must also certify that the Members life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by MVP or one for which there exists a clinical trial (as defined by law). In addition, the attending physician must have recommended one of the following:

- a) A service, procedure, or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – the attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- b) A clinical trial for which the Members are eligible (only certain clinical trials can be considered).

For the purposes of this Section, the physician must be a licensed, board-certified, or board-eligible physician qualified to practice in the area appropriate to treat the Member's life-threatening or disabling condition or disease.

The external review agent will render a decision within 30 days of receiving the Member's application for a standard appeal, or within three days for an expedited appeal. The agent's decision is final and binding for both the Member and MVP. In cases where the external review agent overturns MVP's decision, MVP will provide written notification to the Member. Commercial Members are eligible to file an external appeal without having to exhaust the second level of internal appeal.

The Member's Right to Appeal a Determination to Allow an Out-of-Network Referral

If MVP denies an Out-of-Network Referral (OON referral), these denials are eligible for further appeal through the New York State External Appeal process. The Member or his/her designee can appeal an out-of-network referral denial by submitting a written statement from the Member's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the Member for the health care service sought. The written statement must:

- 1) specify that the in-network health care provider(s) recommended by MVP does not have the appropriate training and experience to meet the particular health care needs of the Member; and
- 2) identify an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the Member, who is able to provide the requested service.

The External Appeal agent will consider the training and experience of the in-network health care provider, the training and experience of the OON provider, the clinical standards of the plan, the information provided concerning the Member, the attending physicians' recommendation, the Member's medical record, and any other pertinent information. The External Appeal agent will overturn MVP's denial if they determine that MVP does not have a provider with the appropriate training and experience to meet the particular health care needs of the Member who is able to provide the requested service, and that the OON provider has the appropriate training and experience to meet the health care needs of the Member who is able to provide the requested service and is likely to produce a more clinically beneficial outcome.

The change is effective for HMO and EPO policies that require a referral from their Primary Care Physician for denials issued on or after March 31, 2015.

When the Department of Financial Services receives an External Appeal application for an OON referral denial MVP will be contacted to determine the eligibility of the application. MVP will be required to provide the type of policy providing the coverage and the renewal date of the policy. Similar to other requests for information on an External Appeal, MVP will be required to provide this information within 24 hours for a standard appeal or 1 hour for an expedited appeal.

ASO External Appeals

External Appeals

External appeals of certain adverse benefit determinations are only available to Members of non-grandfathered self-funded plans. Members who have questions about their plan's status may contact their employer's human resources personnel or MVP's Customer Care Center at **1-800-229-5851**.

Standard External Appeals

Under the following circumstances, Members may request a standard External Appeal:

- a) If they have completed all levels of internal appeal of an adverse benefit determination (for reasons other than eligibility) and the adverse benefit determination was upheld; and/or
- b) If, at any point during the internal claim or appeal process, the plan fails to adhere to the requirements outlined in this attachment.

Expedited External Appeals

Under the following circumstances, Members may be eligible to file an expedited External Appeal:

- a) If they receive an adverse benefit determination (claim denial) that: involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize their life or health, or that would jeopardize their ability to regain maximum function, and they have filed a request for an expedited internal appeal.
- b) If a Member receives a final adverse benefit determination (claim denial upheld on internal appeal) and:
 - they have a medical condition for which the timeframe for completion of a standard External Appeal would seriously jeopardize their life or health, or that would jeopardize their ability to regain maximum function, or;
 - if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which they have received emergency services but have not been discharged from a facility.

How to File an External Appeal

An External Appeal request must be received by MVP within 120 days or four (4) months after the receipt of a notice of a final adverse benefit determination (the denial of the internal appeal).

A Member (or their authorized representative) may file an appeal either verbally or in writing as follows:

- To file an appeal, Members can call MVP's Customer Care Center at **1-800-229-5851**. They should have their claim denial notice, ID card and any other information they would like to have considered in connection with the appeal with them when they make the call.
- To file a written appeal, Members can write a letter to MVP's Appeal Department stating their position.

The letter must be sent to:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

Whether filing a verbal request for an External Appeal or filing a written request, the External Appeal application form must be submitted. A filing fee of \$25 must accompany the application form. There is an annual limit for any Member of \$75 per year. (A filing fee needs to have been imposed.) If the external agent overturns MVP's denial the \$25 filing fee is returned to the Member. If the external review agent agrees with MVP's denial then MVP will retain the check which will be credited back to the employer group. For an expedited External Appeal, a filing fee of \$25 must be submitted within 30 days. For more information on how to file an appeal, including how to designate an authorized representative, Members can contact MVP's Customer Care Center at **1-800-229-5851**.

The Decision Makers

Within five business days from the receipt of the standard External Appeal, MVP will complete a preliminary review of the request in order to determine a Member's eligibility for an External Appeal. Within one business day after completion of the preliminary review, MVP will issue the Member and/or the authorized representative (and the IRO) a written notification of the Member's eligibility for an External Appeal. If the request is complete but not eligible for External Appeal, the notice will include the reasons for ineligibility. If the request is incomplete, the notice will describe the information or materials needed to make the request complete and the Member will have an opportunity to complete the request. MVP will assign an eligible and complete External Appeal request to an independent review organization (IRO) to conduct the appeal. Please note that the IROs are independent from MVP and MVP does not make External Appeal determinations. MVP will maintain contracts with no fewer than three (3) IROs for assignments, and the assignments will be made in a random and unbiased fashion.

The External Appeal Process

Standard External Appeals

Within five business days after the External Appeal request has been assigned to an IRO, MVP must provide to the IRO the documents and any information considered in making the adverse benefit determination. If MVP fails to provide the information in a timely manner, the IRO may terminate the External Appeal and reverse the adverse benefit determination in the Member's favor. The IRO will review all of the information and documents received in a timely manner and it will not be bound by any decisions or conclusions reached during the claims and internal appeal processes. The IRO also will, to the extent the information and documents are available and the IRO considers them appropriate, consider other sources of information including, but not limited to, the Member's medical records, the health care professional's recommendations, the terms of the plan, appropriate practice guidelines and clinical review criteria. The IRO will provide, to Members and the plan, written notice of its decision within 45 days after it receives the request for the External Appeal. Upon receipt of a notice of a final External Appeal decision reversing the adverse benefit determination, the plan immediately will provide coverage or payment for the claim.

Expedited External Appeals

Immediately upon receipt of the request for an expedited External Appeal, MVP will complete a preliminary review of the request in order to determine the Member's eligibility for an External Appeal. Immediately after completion of the preliminary review, MVP will issue the Member and/or the authorized representative a written notification of the Member's eligibility for an External Appeal. If the request is complete but not eligible for External Appeal, the notice will include the reasons for ineligibility. If the request is incomplete, the notice will describe the information or materials needed to make the request complete and the Member will have an opportunity to complete the request. Upon the determination that a request is eligible for an expedited external review, MVP will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO will provide notice, to the Member and the plan of the final External Appeal decision as expeditiously as possible, but in no event no later than 72 hours after the IRO receives the request for the expedited External Appeal. Upon receipt of a notice of a final External Appeal decision reversing the final adverse benefit determination, the plan immediately will provide coverage or payment for the claim.

For both standard and expedited External Appeals, please note that the determination of the assigned IRO is final and binding on the plan, the Member and MVP.

Right to Legal Action

When an initial claim denial is upheld after the appeals process and a Member has complied in full with the plan's claim and appeal procedures as well as any time limits for taking legal action, they may bring a civil action under Section 502(a) of the federal law commonly known as "ERISA" regarding the denied claim. Any questions relative to this right should be addressed to a Member's own legal advisor.

For Assistance

For further questions about a Member's appeal rights or for assistance, New York Members can contact the Employee Benefits Security Administration at **1-866-444-3272**; Vermont Members can contact Vermont Legal Aid at **1-800-917-7787**.

Member Complaints

A complaint is a written or verbal expression of dissatisfaction with MVP. If the Member submits a complaint, it will be investigated thoroughly, and the Member will be sent a response within 30 calendar days (15 calendar days for Vermont Members). A full investigation of each complaint is conducted and completed within 30 calendar days of receipt of the complaint. A written acknowledgment is sent to the Member within five calendar days of the complaint receipt and written confirmation of the complaint decision within two business days of rendering the decision. All quality of care issues are fully investigated and responded to by MVP's Complaints Coordinator.

A Member or his/her representative, or a provider acting on behalf of a Member as the designated representative, may file a complaint verbally or in writing.

A complaint may be filed verbally by contacting the Customer Care Center at **the number on the back of their ID card**, between 8:00 am and 6:00 pm Monday through Friday.

A complaint may also be filed in writing to:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

For Medicaid and HARP Members:

- Medicaid and HARP Members have 60 calendar days after notice of MVP's determination to file an appeal.
- They can do these themselves or ask someone they trust to file the appeal for them. They can call the Customer Care Center at the number listed on the back of their ID card if they need help filing an appeal.
- We will not treat them differently or badly because they file an appeal.
- The appeal can be made by phone or in writing. If they make an appeal by phone it must be followed up in writing.

Inpatient Hospital Appeal Process

For the reconsideration process, please refer to [Utilization Management](#) (UM).

Definitions

1. Hospital

For the purpose of MVP's Reconsideration and Appeal Process, a hospital shall mean a facility that has an agreement with MVP to provide services to MVP's Members, and is licensed pursuant to Articles 28, 36, 44 or 47

of the New York State Public Health Law or licensed pursuant to Articles 19, 31 or 32 of the Mental Hygiene Law or applicable Vermont or New Hampshire law. If a facility is licensed outside of New York State, then comparable legislation of the state where licensure has been obtained will be reviewed to determine if the facility meets the definition of a hospital.

2. New York, Vermont, and Fully-Insured Products

For the purpose of MVP's Reconsideration and Appeal Process, the reference to "New York, Vermont, Fully-Insured Products" refers to health insurance or HMO products issued by MVP Health Plan, Inc., MVP Health Insurance Company, MVP Health Services Corp., which are subject to Article 49 of the New York State Public Health Law, Article 49 of the New York State Insurance Law, or applicable Vermont Law.

3. Provider

For the purpose of MVP's Hospital Reconsideration and Appeal Process, provider shall mean a hospital (as defined above) or other appropriately licensed health care professional.

Services Deemed Not Medically Necessary or Experimental or Investigational

A hospital appeal is a request submitted by a hospital to MVP requesting review of a denial of a properly-submitted claim on the basis that such services were not Medically Necessary.

Levels of Hospital Appeals

MVP provides two levels of hospital appeals (described below). Eligibility requires that the hospitals are appealing on their own behalf (NOT the Member); therefore, the hospitals are not the Member's representative designee for this appeal process.

1. Level One Hospital Appeals

The first step in the hospital appeal process is to initiate a Level One Hospital Appeal, which will be reviewed by MVP's Health Services Inpatient Department.

A hospital may request to initiate a Level One Hospital Appeal by writing within 180 days, (or per the specific contracted payment dispute time frame) from the hospital's receipt of MVP's initial denial notice (either the UM denial letter or the EOB, or MVP's Remittance Advice – whichever comes first) to:

MVP Health Care
Attn: Utilization Management Inpatient Provider Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

For New York fully insured products, MVP will render a decision on an appeal of a post-service (retrospective) claim denial within 60 days of MVP's receipt of all necessary information to conduct the appeal and will provide written notice of the decision within two business days upon rendering its decision.

2. Level Two Hospital Appeals

Unless otherwise contracted, if the hospital is not satisfied with the result of the Level One Hospital Appeal, it may commence a Level Two Hospital Appeal, which a third-party arbitrator shall conduct. A hospital may initiate a Level Two Appeal by submitting a written request to the designated third-party arbitrator within 30 days of the hospital's receipt of MVP's Level One Appeals determination notice.

Under Article 49 Title 1 Section 4906: A facility licensed under Article 28 of the Public Health Law and the MCO may agree to alternative dispute resolution in lieu of an External Appeal under PHL 4906(2). This Level II Hospital Appeal conducted by MVP's designated third-party arbitrator is binding on both parties and serves as the final level

of appeal. A hospital requesting a Level II Appeal is prohibited from seeking payment from a Member for services determined not medically necessary by the designated third-party arbitrator.

The party submitting the appeal to a third-party arbitrator is responsible for payment of the processing fee. MVP will reimburse a hospital for the entire processing fee if MVP's denial is reversed in total; and reimburse 50 percent of the processing fee if MVP's denial is reversed in part. In such cases, to obtain reimbursement from MVP for the third-party arbitrator processing fee, the hospital must submit a written request with a copy of the third-party arbitrator decision to MVP at:

MVP Health Care
Attn: Utilization Management Inpatient Provider Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

Facilities not subject to the third-party arbitrator may have External appeal rights with the New York State Department of Financial Services (DFS) (for New York fully insured products). If the facility is subject to this option, they will be sent the External appeal application packet with the letter of final adverse determination. The completed application along with the filing fee of \$50 (make checks payable to MVP Health Care) should be sent to the address listed in the packet within 60-days of the date of the letter.

Hold Harmless: Public Health Law was amended to add a new section 4917. A provider requesting an External Appeal of a concurrent adverse determination, including a provider requesting the External Appeal as the Member's designee, is prohibited from seeking payment, except applicable co-pays, from a Member for services determined not medically necessary by the External Appeal agent.

Participating Provider Claims Appeals

A Participating Provider claims appeal is a request submitted by the Participating Provider, on their own behalf, to have MVP review a denial of a properly submitted Clean Claim. Participating Provider have only one level of internal appeal. An appeal must be submitted within 180 days of the date on MVP's remittance advice. Appeals can be submitted in writing by letter with supporting documentation.

Participating Provider appeals denied for "not Medically Necessary" should be mailed to:

MVP Health Care
Attn: Member Appeals Department
PO Box 2207, 625 State Street
Schenectady, NY 12301

All other appeals should be mailed to:

MVP Health Care
Operations Adjustment Team
PO Box 2207
Schenectady, NY 12301

Providers may appeal verbally by calling the Customer Care Center for Provider Services at **1-800-684-9286**. They may also call this number for more information about initiating an appeal.

MVP will make a determination on appeals within 60 days of receipt of all necessary information. MVP will mail a written notice of the determination within two business days of the determination. If the services being appealed are approved, the claim(s) in question will be adjusted.

For New York fully insured products, if you are appealing a post-service claim denial based upon Medical Necessity or because the service was determined to be experimental or investigational in nature, then the written notice will include instructions on how to submit an External Appeal with the state of New York.

MVP staff who were not involved in the initial claims denial process will review the appeal. Likewise, appropriate clinical peer reviewers who also were not involved in the initial claim denial process will review claims based on clinical criteria.

Medicare Member Appeals and Complaints (grievance)

A “**general issue**” is a type of expressed dissatisfaction that does not involve attitude, access, or quality of services received. It does not involve an initial determination (e.g., denied claim or referral) and there is no further financial liability from the Member or the Member’s representative. MVP will document and investigate all general issues brought to our attention either by phone or mail. All findings and actions taken will be reported to the Member as expeditiously as necessary, but no later than 30 days by either phone or mail.

A “**Grievance**” is a complaint a Member makes **if they have any other type (except for an appeal) of problem with MVP or Network Provider. Appeal determinations are not considered grievances.** For example, they would file a grievance regarding things such as:

- The quality of their care;
- Waiting times for appointments or in the waiting room;
- The way their doctors or others behave;
- Being able to reach someone by phone or get the information they need; or
- The cleanliness or condition of the doctor’s office.

An “**appeal**” is a Member request for **MVP to reconsider and change a decision made about what services are covered or what will be paid for a service.** Specifically, the Member has the right to appeal if:

- MVP refuses to cover or pay for services they think should be covered;
- MVP or one of their plan providers refuses to give them a service they think should be covered;
- MVP or one of their plan providers reduces or cuts back on services they have been receiving; or
- The Member thinks MVP is stopping coverage of a service too soon.

Medicare Grievance Process

If the Member has a Grievance regarding attitude, access, or quality of service received, MVP encourages them to call the MVP Medicare Customer Care Center, **1-800-665-7924**. MVP will try to resolve their Grievance over the phone. If the Grievance cannot be resolved over the phone, a formal procedure called the “Grievance Procedure” is used to review the Grievance. The Member may also submit a grievance in writing to the Member Service - Grievances Department, 220 Alexander Street, 5th floor, Rochester, NY 14617. The grievance must be filed within 60 calendar days of the incident and include a description of the incident or events that led to the Grievance. The Grievance will be investigated by MVP’s Quality Improvement Department.

A Member may file his or her own Grievance or the Member may appoint a representative. To appoint a representative:

- In writing, the Member must provide their name, Medicare number, and a statement that appoints an individual as their representative. For example, “I [member name] appoint [name of representative] to act as my representative in requesting a grievance from MVP regarding (service/claim).”

- The Member and the representative must sign and date the statement.
- The authorization statement must be submitted with the grievance.

Medicare Standard Grievances

MVP will acknowledge the Grievance within 3 days of receipt. MVP will respond to the Member's concern within 30 days from receipt of the grievance, by letter. In some instances, MVP may need more than 30 days to properly address the Member's concern. If more than 30 days is necessary, MVP will notify the Member and explain why additional time is required.

Expedited “Fast” Grievances

A Member may file an expedited grievance if they disagree with MVP's decision not to expedite an appeal, not to expedite a request for approval made by a provider or if they disagree with MVP's request for more time to complete an appeal or request for more time to approve a service requested by a provider. MVP will respond to these requests within 24 hours.

Quality Improvement Organization (QIO) Complaint Process

If Members are concerned about the quality of care they receive, including care during a hospital stay, they may file a Grievance through MVP, or a complaint with Livanta BFCC-QIO. Livanta is a Quality Improvement Organization (QIO) for the States of New York and Vermont that is paid to handle this type of complaint from Medicare patients. The QIO review process is designed to allow an external review organization to investigate health care issues. To contact Livanta, Members may call **866-815-5405**. TTY users may call **1-866-868-2289**. USA Care Members must contact the QIO within the state in which he/she resides.

Five Possible Steps for Requesting Care or Payment from MVP

If the Member has problems getting care, or payment for care, there are five possible steps they can take. At each step, their request is considered and a decision is made. If they are unhappy with the decision there may be an additional step they can take.

- In Step one the Member makes their request directly to MVP. It is reviewed and the decision is communicated.
- In Steps two through five, people in organizations that are not connected to MVP make the decisions. To keep the review independent and impartial, those who review the request and make the decision in Steps two through five are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The five possible steps are summarized below:

Step One: Appealing the Initial Decision by MVP

If the Member disagrees with the initial decision one, they may ask MVP to reconsider the decision. This is called an **“appeal”** or a **“request for reconsideration”**. The Member can ask for a **“fast or expedited appeal”** if their request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing the appeal, MVP will decide whether to stay with the original decision, or change this decision and give the Member some or all of the care or payment they want.

Step Two: Review of the Request by an Independent Review Organization (IRO)

If MVP turns down part of the request or the entire request (step one), MVP is then **required** to send the request to an independent review organization that has a contract with the federal government and is not part of MVP. This organization will review the request and make a decision about whether the Member is granted the care or payment they requested. MVP staff who were not involved in the initial claims denial process will review the appeal. Likewise, appropriate clinical peer reviewers who also were not involved in the initial claim denial process will review claims based on clinical criteria.

Step Three: Review by an Administrative Law Judge (ALJ)

If the Member is unhappy with the decision made by the organization that reviews their case in step two, they may ask an Administrative Law Judge to consider their case and make a decision. The Administrative Law Judge works for the federal government. To qualify for review by an ALJ, the amount in controversy must meet a minimum amount to be determined by the ALJ. The amount in controversy must be at least \$160.00 and this minimum amount is incrementally increased annually by CMS, based on increases in the consumer-pricing index.

Step Four: Review by a Departmental Appeals Board

If the Member or MVP are unhappy with the decision made in step three, either party may be able to ask the **Medicare Appeals Council (MAC)** to review the case. This Board is part of the federal department that runs the Medicare program.

Step Five: Federal Court

If the Member or MVP are unhappy with the decision made by the Medicare Appeals Council in step four, either party may be able to take the case to a Federal Court. The dollar value of the contested medical care must be at least \$1,760.00.

Pre-Service and Post-Service Appeals Process

All appeals must be completed as expeditiously as the Member's health requires, but no later than the times indicated. If the Member wants to file a pre-service or post-service appeal, the following steps must be taken:

- File the request verbally by contacting MVP's Medicare Customer Care Center. If the Member calls after hours, the MVP Answering Service will accept the Member's name and telephone number, and a Customer Care Representative will return the call during the next working day. If the Member does not speak English, either a bilingual MVP employee will speak with the Member or MVP will use the services of the AT&T language line, which provides interpreters in 150 different languages. Members may also submit the request in writing to MVP at the following address: MVP Health Care, Attn: Member Appeals Department, 625 State Street, Schenectady, NY, 12305. Alternatively, the request may be filed with an office of the Social Security Administration or the Railroad Retirement Board (if the Member is a railroad retiree). Even though the Member may file a request with the Social Security Administration or Railroad Retirement Board office, that office will transfer the request to MVP for processing.
- Mail, FAX, or deliver the request in person. Use the address above or FAX the appeal to MVP Member Appeals Department at **585-327 5724** or **1-800-398-2560**.
- The request must be filed within 60 calendar days from receipt of the initial denial notice.

MVP will gather all necessary information, including referral notes, medical records, and all information used in the initial determination and any new information that may be relevant to the appeal. Appeal decisions that do not involve Medical Necessity are made by a reviewer(s) trained and experienced in interpreting contracts, policies,

benefits, Member eligibility, and health care regulations. Decisions that involve Medical Necessity will be made by a licensed provider in the same or similar specialty as the health care provider who typically manages the medical condition or disease, or provides the service or treatment under review. In addition, the appeal decision is made by a reviewer who was not involved in the initial determination, and is not a subordinate of any person involved in the initial determination.

To protect the Member's privacy and ensure an unbiased review of the appeal, all personally identifiable health and financial information will be removed from the record unless a business associate's agreement is in effect between MVP and the health care provider reviewing the appeal.

A Member may request free of charge, a copy of all documents relevant to the appeal, including the clinical criteria; internal policy, guidelines, protocol or rule relied upon to make the appeal decision by contacting a Medicare Customer Care Center Representative at the number on the back of their ID card, Monday – Friday, 8am – 8pm, Saturday 8am – 4pm Eastern Time. From October 1 – February 14, call seven days a week, 8am – 8pm. Members may also write to us at:

MVP Health Care
Attn: Member Appeals Department
625 State Street
Schenectady, New York 12305

A Member is given the opportunity to submit written comments, documents or other information related to the appeal.

A decision must be provided to the Member within 30 calendar days from receipt of a pre-service appeal and within 60 calendar days of a post-service appeal. However, if the Member requests it, or if MVP finds that some information is missing which can help them, MVP can take up to an additional 14 calendar days to make the decision for a pre-service appeal. No extension is allowed for post service appeals. The substance of the appeal and any actions taken are documented in the Member's file. If MVP does not notify the Member of the decision within 30 calendar days or by the end of the extended time period for a pre-service appeal, or within 60 calendar days for a post-service appeal, the request will automatically go to Medicare's External Review Organization, currently Maximus Federal Services for review of the case. The Member is notified in writing within three (3) calendar days of the decision. If the decision is unfavorable, the notice will also include information advising them that the case has been forwarded to Maximus Federal Services who will render an appeal decision.

Expedited Appeals Process

An expedited appeal may be initiated verbally or in writing by the Member, the Members appropriately appointed representative or a provider acting on behalf of the Member. If any party requests an expedited decision, he or she must do the following:

- File a verbal or written request for an expedited (fast) appeal, specifically stating that they want an expedited appeal, fast appeal, or 72-hour appeal, or that they believe that their health could be seriously harmed by waiting 30 days for a standard appeal.
- To file a verbal request, the Member or the Members appropriately appointed representative can call MVP's Medicare Customer Care Center at **1-800-665 7924** (TTY: 1-800-662-1220).
- A hand delivered request can be received at the following addresses:

220 Alexander Street
Rochester, NY 14607; or
625 State Street
Schenectady, NY 12305

Members can also mail their request to:

625 State Street
Schenectady, NY 12305

The 72-hour review time will begin when the request for appeal is received by MVP.

- To FAX a request, our FAX number is **585-327-5724**, or **1-800-398-2560**. If the Member is in a hospital or a nursing facility, he or she may request assistance in having the written appeal transmitted to MVP by use of a FAX machine.
- The Member must file the request within 60 calendar days of the date of the initial denial.
- The Expedited Appeal process applies only to **pre-service** appeals.

If a Member requests a 72-hour expedited (fast) appeal, MVP's Medical Director will decide if an expedited appeal is appropriate. If it is not appropriate, the appeal will be processed within 30 days. MVP will notify the Member verbally and in writing of the decision not to expedite the appeal within 72 hours. If any physician supports the need for a fast appeal, it must be granted. For this process, Medicare defines a physician as any Medical Doctor, Doctor of Osteopathic Medicine, or a Doctor of Podiatry.

MVP will make a decision and notify the Member and Participating Provider within 72 hours or sooner if the Member's health condition requires, from receipt of the expedited request. A written confirmation of the decision will be sent to the Member and Participating Provider within 24 hours from the date of the appeal decision. However, if the Member requests it, or if MVP finds that some information is missing which can help them, MVP can take up to an additional 14 calendar days to make the decision. If MVP does not inform the Member or the provider of the decision within 72 hours (or by the end of the extended time period), their request will automatically go to Medicare's External Review Organization, currently Maximus Federal Services for review of the case. The Member is notified in writing within 24 hours that the decision was unfavorable and the case has been forwarded to Maximus Federal Services who will render an appeal decision.

If the decision is not fully in favor of the Member's request, MVP will automatically forward the appeal to Maximus Federal Services for an independent review decision. Maximus will notify the Member and MVP of their decision within 72 hours from receipt of the appeal. If necessary, Maximus may require an extension up to 14 additional days.

Inpatient Hospital Appeals

When a Member is hospitalized, they have the right to get all the hospital care covered by MVP that is necessary to diagnose and treat their illness or injury. The day they leave the hospital (discharge date) is based on when their stay in the hospital is no longer medically necessary.

If a Member is inpatient at a hospital the facility on behalf of MVP will provide them with the *Notice of Discharge and Medicare Appeal Rights* notice, they have the right by law to ask for a review of their discharge date. As explained in the *Notice of Discharge and Medicare Appeal Rights*, if they act quickly, they can ask an outside agency called the Livanta BFCC-QIO to review whether their discharge is medically appropriate. The *Notice of Discharge and Medicare Appeal Rights* gives the name and telephone number of Livanta and tells them what they must do.

Livanta is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of MVP or the hospital. The doctors and other health experts in Livanta review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon.

The Member must be sure that they have made their request to Livanta **no later than noon** on the first working day after they are given written notice that they are being discharged from the hospital. This deadline is very important.

If they meet this deadline, they are allowed to stay in the hospital past their discharge date without paying for it themselves, while they wait to get the decision from Livanta.

Livanta will make this decision within one full working day after it has received their request and all of the medical information it needs to make a decision.

- If Livanta decides that the Member's discharge date was medically appropriate, the Member will not be responsible for paying the hospital charges until noon of the calendar day after Livanta gives them its decision.
- If Livanta agrees with the Member, then MVP will continue to cover their hospital stay for as long as medically necessary.

If the Member requests a Livanta appeal, he/she cannot subsequently request an appeal for the same denial through MVP.

Skilled Nursing Home (SNF), Home Health Care, and CORF Appeals

When the Member is a patient in a SNF, home health agency, or Comprehensive Outpatient Rehabilitation Facility (CORF), they have the right to get all SNF, home health or CORF care covered by MVP that is necessary to diagnose and treat their illness or injury. The day MVP ends their SNF, home health agency or CORF coverage is based on when their stay is no longer Medically Necessary.

If MVP decides to end coverage for a Member's SNF, home health agency, or CORF services, they will receive a written notice from their provider at least two (2) calendar days in advance of MVP ending the coverage. The Member (or someone they authorize) may be asked to sign and date this document to show that they received the notice. Signing the notice does not mean that they agree that coverage should end – it only means that they received the notice.

Review of the Termination of Your Coverage by Livanta BFCC

The Member has the right, by law, to ask for an appeal of MVP's termination of their coverage. They can ask Livanta to review whether MVP terminating their coverage is medically appropriate and this is explained in the notice they get from their provider.

Getting the Livanta review

If the Member wants to have the termination of their coverage appealed, they must act quickly to contact Livanta. The written notice they get from their provider gives the name and telephone number of Livanta and tells them what they must do.

- If they get the notice two days before coverage ends, they must be sure to make their request **no later than noon** of the day after they get the notice from their provider.
- If they get the notice and they have more than two days before coverage ends, then they must make their request **no later than noon** the day before the date that their Medicare coverage ends.
- Livanta will make this decision within one full day after it receives the information it needs to make a decision.
- If Livanta decides that the decision to terminate coverage was medically appropriate, the Member will be responsible for paying the SNF, home health or CORF charges after the termination date on the advance notice they got from their provider.
- If Livanta agrees with the Member, then MVP will continue to cover the SNF, home health, or CORF services for as long as medically necessary.

If the Member does not ask Livanta for a “fast appeal” of their discharge by the deadline, they can ask MVP for a “fast appeal” of their discharge.

If the Member asks for a fast appeal of their termination and they continue getting services from the SNF, home health agency, or CORF, they run the risk of having to pay for the care they received past their termination date. Whether they have to pay or not depends on the decision MVP makes.

- If MVP decides, based on the fast appeal, that the Member needs to continue to get services covered, then MVP will continue to cover their care for as long as medically necessary.
- If MVP decides that they should not have continued getting coverage of their care, then MVP will **not** cover any care they received if they stayed after the termination date.

If the Member does not ask Livanta by noon after the day they are given written notice that MVP will be terminating coverage for their SNF, home health or CORF services, and if they continue to receive services from the SNF, home health agency or CORF after this date, they run the risk of having to pay for the SNF, home health or CORF care received on and after this date. However, the Member can appeal any bills for the SNF, Home Health or CORF care received using the appeals process.

Medicare Appeals

The following information applies to all Medicare Appeals:

Support for an Appeal

The Member is not required to submit additional information to support their appeal. MVP is responsible for gathering all necessary medical information, however, it may be helpful for the Member to include additional information to clarify or support their position. For example, the Member may want to include information such as medical records or physician opinions in support of their appeal. MVP will provide an opportunity for the Member to submit additional information in person or in writing.

Providers are required to abide by CMS guidelines. If a Member requests an Expedited Appeal, MVP will request that the provider fax (or expedite mailing) all pertinent medical records to the Appeals Department. This will allow MVP to meet the required 72-hour time frame.

Who May File an Appeal

1. The Member may file their own appeal.
2. The Member may appoint a representative. To appoint a representative:
 - a. In writing, the Member must provide their name, Medicare number, and a statement that appoints an individual as their representative. For example, “I [name] appoint [name of representative] to act as my representative in requesting an appeal from MVP regarding (service/claim).”
 - b. The Member and the representative must sign and date the statement.
 - c. The authorization statement must be submitted with the appeal.
3. A non-contract provider may file a post-service appeal only if the provider completes a waiver of liability statement, which says they will not bill the Member regardless of the outcome of the appeal.
4. A court appointed guardian or an agent under a health care proxy to the extent provided under state law.
5. If the Member is unable to appoint a representative due to their mental status, the appeal must be signed by a legal representative as determined by state law.

6. If the Member is deceased, the appeal must be filed by a legal representative as determined by state law.
7. The Member's treating physician may also file an expedited or pre-service appeal on behalf of the Member without appointment of representation.

Part D Appeals Only

MVP must provide a decision to the Member within seven calendar days from receipt of a pre-service or post-service request. If MVP does not notify the Member of the decision within seven calendar days, the request will automatically go to Medicare's External Review Organization, currently MAXIMUS Federal Services, for review of the case. For Part D denials, Members must request a review by MAXIMUS Federal Services except as noted above, MVP does not automatically send these appeals.

MVP Network Vendors

MVP Network Vendors

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Cigna HealthCare

Under MVP’s national alliance with Cigna HealthCare, Cigna members may access MVP’s Upstate New York Participating Provider Network to receive medical care. Likewise, MVP EPO and PPO Members with national coverage have access to Cigna’s national network to receive medical care.

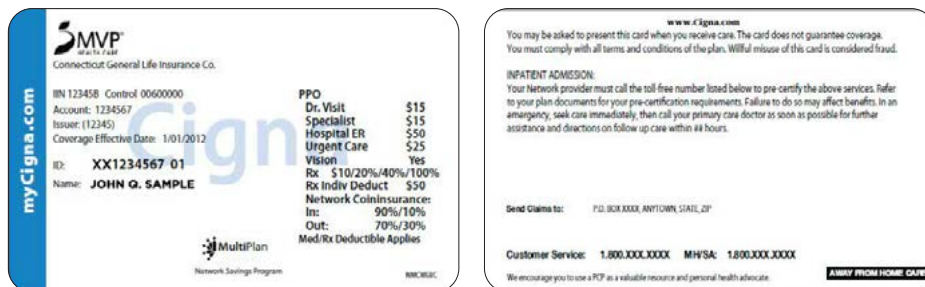
MVP Members with New York HMO and POS plans use Cigna as their national network for covered urgent/emergency care, as well as elective out-of-area care when prior-authorized. However, Cigna members must continue to use the Cigna HealthCare provider network for the following services:

- Behavioral Health
- Dental Care
- Pharmacy
- Routine and non-routine Vision Services

MVP Members with New York HMO and POS plan do not have access to Cigna HealthCare provider network for Behavior Health and must access MVP’s network.

ID Card Sample

Cigna members seeking health care services should present this or a similar Cigna ID card to their providers at every visit.



Cigna Contact Information

Call Cigna to confirm eligibility, obtain benefit coverage information or prior authorization requirements, or for any claim submission/coverage questions:

1-800-CIGNA24 (244-6224)

Visit [Cigna for Health Care Professionals](#) for online tools that can help answer questions and provide other information for any health care professionals treating Cigna members. An online demo shows providers how to register and use the site’s other tools.

[cignaforhcp.com](#)

Where to submit claims

NPI numbers must be included on all claims submitted to Cigna to help ensure timely processing. Submit paper claims to the address on the back of the member’s ID card.

For information on EDI claim submission, you may either visit [cignaforhcp.com](#) or call **1-800-CIGNA24 (244-6224)**.

Cigna will pay Participating Providers for Covered Services rendered to Cigna members provided all prior authorization and claim requirements are met. Participating Providers’ MVP reimbursement schedule will be used

to process claim payment for these services. When payment is received, Participating Providers cannot bill the Cigna member for any amounts above and beyond the member's cost share as identified on Cigna's remittance advice.

Cigna's Other Alliances and Cigna Payer SolutionsSM

Cigna's alliance with MVP, Cigna maintains alliances with other health plans, including Tufts Health Plan, HealthPartners, and Health Alliance Plan. Additionally, Cigna administers benefits for a number of Third Party Administrators through its Cigna Payer SolutionsSM subsidiary.

Members of these plans will have the Cigna logo on their member ID card, and will typically have the MVP logo on their card as well. These members should be treated no differently than MVP and Cigna Members.

If a member of one of these health plans presents for services with an MVP Participating Provider, they should contact that health plan directly by calling the toll-free number on the back of the member's ID card to verify benefits and eligibility, and submit claims directly to that health plan either electronically or on paper to the claim address found on the back of the ID card.



HealthPartners[®]

TUFTS  Health Plan



First Health

First Health serves as MVP's primary out-of-network 'wrap' network. This network is utilized if the Provider or Facility is in MVP's Service Area but is not contracted with MVP, or if the provider or facility is not contracted with Cigna. Additionally, First Health provides a Behavioral Health network to MVP. First Health is used for Commercial and ASO products; government plans do not utilize the First Health network. Providers or facilities that are contracted with First Health and which have a primary specialty of Behavioral Health, mental health, or Substance Use Disorder are considered In-Network with MVP. Outside of the specialties listed above, MVP does not direct Members to First Health-contracted providers, thus the provider search function on the MVP website does not specifically identify these providers.

Contact Information

Providers that are contracted with First Health should contact MVP to confirm Member eligibility, obtain benefit coverage information or Prior Authorization requirements, or for any claim submission/coverage questions.

Claims Submission

Providers that are contracted with First Health should submit claims to MVP either electronically or on paper to the claim address found on the back of the Member ID card. Additional information on claims submission can be found at mvphealthcare.com.

Upon submission to MVP, out-of-network claims will be routed to First Health. If the submitting provider is found to be contracted with First Health, the claim will be priced and sent back to MVP for payment. First Health-contracted Providers will receive payment from MVP and may not bill the MVP Member for any amounts above and beyond the Member's cost share as identified on MVP's remittance advice.