Required Annual Notices

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

MEMBER RIGHTS

The following are specific rights available to MVP members:

1. Members have a right to be treated with dignity. Members have a right to receive quality medical services, in a professional and courteous manner, regardless of their race, sex, religion, age or sexual orientation.
2. Members have a right to confidentiality. All information concerning members' medical histories and enrollment files is privileged and confidential. MVP will release no information regarding any member's care without a written statement or release signed by the member, except as otherwise permitted by law.
3. Members have a right to obtain information. Members have a right to obtain current information on their diagnoses and treatment programs from their doctors or other practitioners in terms they can understand. Members have a right to receive this information in order to give informed consent and to participate in making decisions regarding treatment or care proposed by their doctors. If a member is unable to make medical decisions, this information shall be made available to an authorized person appointed to make medical elections on his/her behalf.
4. Members have a right to know of treatment options. Members have a right to receive complete information regarding all appropriate or medically necessary courses of treatment for their conditions. Members also have a right to discuss all possible treatment plans with their doctors, regardless of cost or benefit coverage levels.
5. If a practitioner with an appropriate specialty is not available within the MVP network to treat a medical condition, members have a right to request out-of-plan services at an in-network level of benefits. All such out-of-plan requests must be made by members' primary care physician (for those plans requiring PCPs) and prior-authorized by MVP.
6. Members have a right to refuse treatment recommended by their doctors or other practitioners, to the extent permitted by law, and with the understanding that they have been informed of the consequences of such refusal.
7. Members have a right to voice complaints or appeals. If a member is not fully satisfied with the medical or administrative services provided by MVP, he/she has a right to a thorough investigation of the complaint or appeal by qualified and impartial staff.
8. Members have a right to be provided with information regarding MVP's policies and procedures, covered services and the names and professional status of health plan practitioners. Members have a right to be provided with MVP's Rights and Responsibilities policy and to make recommendations regarding this policy.

MEMBER RESPONSIBILITIES

The following are responsibilities expected of members of MVP:

1. Where required, members have a responsibility to select a personal participating primary care physician—for themselves and their dependents—who will coordinate their medical care.
2. Members have a responsibility to provide, to the extent possible, complete information needed by their physicians to properly care for them. This includes providing their physicians with accurate information regarding their medical histories; any prescription medications that they are taking; receipt of medical services (such as mammograms and immunizations) through programs at work, school or local health departments; and their general health and safety habits.
3. Members have a responsibility to participate in their health care: to develop good relationships with their physicians and medical practitioners, understand their health problems, develop mutually agreed-upon treatment goals to the degree possible and follow their practitioners' advice for agreed-upon treatments and care.
4. Members have a responsibility to keep all scheduled appointments with their physicians. If a member needs to cancel, he/she should do so at least 24 hours prior to the appointment.
5. Members have a responsibility to notify MVP of any changes in their status, such as adding or deleting dependents, change in marital status, etc.
6. Members have a responsibility to carry their membership cards at all times and never permit anyone else to use them.
7. Members have a responsibility to call MVP within 48 hours or as soon as reasonably possible, if either the member or a dependent is hospitalized for a medical emergency.
8. Members have a responsibility to obtain the necessary referrals, for plans that require referrals, before seeing specialists.
9. Members have a responsibility to pay all applicable copayments, coinsurance and deductibles to their health care providers, as specified in their Subscriber Contract or Certificate of Coverage.

Member Complaint and Appeal Process

MVP's complaint and appeals policies assure that members' written and oral concerns are registered, investigated, and resolved in a timely fashion. Members, or their designated representatives, may call the MVP Member Services department or write to the Appeals Department to initiate a complaint or appeal. Members may appoint their practitioner as their designee for purpose of commencing a complaint or appeal. We encourage members to utilize these procedures when necessary and will not retaliate or

take any discriminatory action against a member should he or she file a complaint or appeal.

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

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

Confidentiality and Privacy Policies

Protection of Oral, Written, and Electronic PHI

All MVP employees are trained in the appropriate use and disclosure of members' PHI and sign an annual corporate confidentiality statement in order to uphold MVP's standard of protecting oral, written, and electronic PHI. Access to MVP's physical facility and information systems is limited to the required minimum necessary to provide services. MVP has established physical, electronic, and procedural safeguards that comply with federal and state regulations to guard PHI. In addition, all MVP provider and vendor agreements include language regarding the confidential handling of members' PHI. The following privacy notice provides details on MVP's use and disclosure of member PHI.

MVP's Privacy Notice

MVP Health Plan, Inc., MVP Health Services Corp., MVP Health Insurance Company, MVP Health Plan of New Hampshire, Inc. and MVP Health Insurance Company of New Hampshire, Inc., (collectively "MVP") respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, provide you with this notice of our privacy practices and legal duties, and to abide by the terms of this notice.

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and New York State laws and regulations regarding the confidentiality of health information, MVP provides this notice to explain how we may use and disclose your health information to carry out payment and health care operations and for other purposes permitted or required by law. "Health information" is defined as enrollment, eligibility, benefit, claim, and any other information that relates to your past, present or future physical or mental health.

MVP's Duties Regarding Your Health Information

MVP is required by law to:

- Maintain the privacy of information about your health in all forms including oral, written, and electronic;
- Provide you with this notice of our legal duties and health information privacy rules; and
- Abide by the terms of this notice.

We reserve the right to change the terms of this notice at any time, consistent with applicable law, and to make those changes effective for health information we already have about you. Once revised, we will provide the new notice to you by mail and post it on our Web site **(www.mvphealthcare.com)**.

How We Use or Disclose Your Health Information

As a member, you agree to let MVP share information about you for treatment, payment, and health care operations. The following are ways we may use or disclose your health information:

For Treatment: We may share your health information with a physician or other health care provider in order for them to provide you with treatment.

For Payment: We may use and disclose your health information to collect premium payments, determine benefit coverage, or to provide payment to health care providers who render treatment on your behalf.

For Health Care Operations: We may use or disclose your health information for health care operations that are necessary to enable us to arrange for the provision of health benefits, the payment of health claims, and to ensure that our members receive quality service. For example, we may use and disclose your health information to conduct quality assessment and improvement activities, case management and care coordination, licensing, credentialing, underwriting, premium rating, fraud and abuse detection, medical review and legal services.

Appointment Reminders: We may use or disclose your health information to send you a reminder that you have an appointment with your doctor for treatment or medical care.

Health-Related Benefits and Services: We may use or disclose your health information to tell you about alternative medical treatments and programs or about health-related products and services that may be of interest to you.

Disclosures to a Business Associate: We may disclose your health information to other companies that perform certain functions on our behalf. These companies are called "Business Associates." These Business Associates must agree in writing to protect your privacy and follow the same rules we do.

Disclosures to a Plan Sponsor: We may disclose your health information to the plan sponsor of your group health plan (usually your employer) so that the plan sponsor may obtain premium bids, modify, amend or terminate your group health plan and perform enrollment functions on your behalf.

Disclosures to a Third Party Representative: We may disclose to a Third Party Representative (family member, relative, friend, etc.) health information that is directly relevant to that person's involvement with your care or payment for care if we can reasonably infer that the person is involved in your care or payment for care and that you would not object.

Disclosures Authorized by You: We can accept an Authorization to Disclose Information Form if you would like us to share your health information with someone for a reason we have not stated above. Using this form, you can designate who you would like us to share information with, what information you would like us to share, and how long you want us to be able to share your information with that individual. A copy of this form is available by calling our Member Services Department or logging on to the MVP Web site at **www.mvphealthcare.com**. You must complete this form and send it to the address or fax it to the fax number on the form. You can cancel this Authorization at any time in writing and per the requirements on the form.

Special Use and Disclosure Situations

Under certain circumstances, as required by law, MVP would be required to share your information without your permission. Some circumstances include:

Uses and Disclosures required by law: We may use and disclose health information about you when we are required to do so by federal, state or local law.

Public Health: We may disclose your health information for public health activities. These activities include preventing or controlling

disease, injury or disability; reporting births or deaths; or reporting reactions to medications or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight: We may disclose your health information to a health oversight agency that monitors the health care system and government programs for designated oversight activities.

Legal Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and, in certain situations, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your health information, so long as applicable legal requirements are met, for law enforcement purposes.

Abuse or Neglect: We may disclose your health information to a public health authority, or other government authority authorized by law to receive reports of child abuse, neglect or domestic violence consistent with the requirements of applicable federal and state laws.

Coroners, Funeral Directors and Organ Donation: We may disclose your health information to a coroner or medical examiner to identify a deceased person, determine a cause of death or as authorized by law. We may also disclose your health information to funeral directors as necessary to carry out their duties. If you are an organ donor, we may release your health information for procurement, banking or transplantation.

Research Purposes: In certain circumstances, we may use and disclose your health information for research purposes.

Criminal Activity: We may disclose your health information when necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Military Activity: We may disclose your health information to authorized federal officials if you are a member of the military (or a military veteran of the military).

National Security: We may disclose your health information to authorized federal officials for national security, intelligence activities and to enable them to provide protective services for the President and others.

Workers' Compensation: We may disclose your health information as authorized to comply with workers' compensation laws and other similar legally established programs.

What Are Members' Rights?

The following are your rights with respect to your health information. Requests for restrictions, confidential communications, accounting of disclosures, amendments to your health information or to inspect or copy your health information, can be made by contacting us at:

MVP Health Care Member Services Department
P.O. Box 2207, 625 State Street, Schenectady, NY 12301
or call 1-888-MVP-MBRS (888-687-6277).

Right to Request Restrictions: You have the right to request a restriction or limitation on your health information we disclose for payment or health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment for your care, such as a family member, relative, or friend. While we will try to honor your request, we are not legally required to agree to restrictions or limitations. If we agree, we will comply with your request or limitations except in emergency situations.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health information in a certain way or at a certain location if the disclosure of information could endanger you. We will require the reason for the request and will accommodate all reasonable requests.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us other than those necessary to carry out treatment, payment, and health care operations, disclosures made to you or authorized by you, or in certain other situations.

Right to Inspect and Obtain Copies of Your Health Information: You have the right to inspect and obtain a copy of certain health information that we maintain. In limited circumstances, we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing of the reason for the denial and if applicable the right to have the denial reviewed.

Right to Amend: If you feel that the health information we maintain about you is incomplete or inaccurate, you may ask us to amend the information. In certain circumstances we may deny your request. If we deny the request, we will explain your right to file a written statement of disagreement. If we approve your request, we will include the change in your health information and tell others that need to know about your changes.

Right to a Copy of the Notice of Privacy Practices: You have the right to obtain a copy of this notice at any time.

Exercising Your Rights

Unless you provide us with a written authorization, we will not use or disclosure your health information in any manner not covered by this notice. If you authorize us in writing to use or disclose your health information in a manner other than described in this notice, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your authorization; however, we will not reverse any uses or disclosures already made in reliance on your authorization before it was revoked.

You have a right to receive a paper copy of this notice at any time. You can also view this notice on our Web site at **www.mvphealthcare.com**.

If you have any questions about this notice, please contact us at:

MVP Health Care Member Services Department
P.O. Box 2207, 625 State Street, Schenectady, NY 12301
or call 1-888-MVP-MBRS (888-687-6277).

If you believe your privacy rights have been violated, you may file a written complaint by contacting us at:

MVP Health Care Complaints Coordinator
P.O. Box 2207, 625 State Street, Schenectady, NY 12301
or you may contact us at 1-888-MVP-MBRS (1-888-687-6277).

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

We will not retaliate in any way if you choose to file a complaint in good faith with us or with the U.S. Department of Health and Human Services. We support your right to the privacy of your medical information.

Medical Management Decisions

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

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

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

Utilization Management Criteria

MVP uses the most current version of InterQual® (ISD-AC adult and pediatric) criteria as a guideline for its Utilization Management decisions for most medical and behavioral health services. For Utilization Management decisions related to alcohol and substance abuse, MVP uses the most current version of the American Society of Addiction Medication (ASAM*) Patient Placement Criteria for the Treatment of Substance-Related Disorders. Pharmacy utilization management utilizes criteria and a formulary developed by the MVP P&T Committee.

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

In service areas where MVP offers participation in Medicaid, Family Health Plus, and Child Health Plus products, MVP has delegated utilization management for routine dental and vision care services to contracted entities. MVP contracted with Healthplex, Inc. to administer utilization management for all dental services. Healthplex utilizes the most current version of "Current Dental Terminology" (CDT) published by the American Dental Association, in addition to internally developed criteria (professional guidelines). MVP has contracted with Davis Vision to administer utilization management for all routine eye care and refractive vision services. Davis Vision holds JCAHO accreditation and the COLTS Laboratories award. All participating providers are required to follow the clinical guidelines of the American Optometric Association and the American Academy of Ophthalmology. Both Healthplex and Davis Vision ensure that approval and denial of services related to MVP's government program members is based on "The Professional Guidelines for Review of Services for Medicaid/Child Health Plus/Family Health Plus Plans" and the MVP contract provisions.

MVP also uses a *Benefit Interpretation Manual* to help determine whether a service is covered. The MVP *Benefit Interpretation Manual* is available for practitioners on MVP's Web site. This online manual provides you with convenient access to information you need. In addition, we hope you will find the e-mail feedback option an easy way to let us know what you think about the policies so we can incorporate that feedback into policy development.

Physicians can view the manual as follows:

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

Practitioners may request a copy of the criteria employed to make a specific Utilization Management determination by contacting the local Utilization Management department. The criteria will be mailed or faxed to the physician's office with a proprietary disclaimer notice. Members may request a copy of the criteria used to make a specific utilization management determination by contacting the Member Services department.

If an MVP participating practitioner has questions regarding the MVP Utilization Management policies or a specific utilization management decision such as a denial of benefit, MVP Medical Directors and appropriately licensed clinical reviewers are available to discuss any issues. Practitioners requesting to speak with a reviewer should contact the Utilization Management staff, who will coordinate the contact and the appropriately licensed clinical reviewers will call the practitioner directly. For all inquiries regarding decisions related to Mental Health and Substance Abuse Services, including denials of benefits, the MVP senior medical director for Behavioral Health is also available at this Schenectady office telephone number: 1-800-568-0458.

**To obtain a complete set of the ASAM criteria contact the ASAM Publications Department directly by phone: (301) 656-3920, fax: (301) 656-3815; e-mail Email@asam.org or mail 4601 North Park Ave, Upper Arcade, Suite 101, Chevy Chase MD 20815.*

Practitioner Appeals

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

1. **Make a Claim Inquiry.** Practitioners may obtain information regarding why a claim was rejected or processed in a certain manner (often resolving any need for any further action) by calling MVP's Provider Claim Services department at 1-800-684-9286 or by filing a Correspondence Adjustment Form and making a Claim Inquiry.
2. **Request a Reconsideration:**

   A. Statutory

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

Pre Service Claims, Urgent Care, and Concurrent Review, the Statutory Reconsideration will occur within one business day of receipt of the request. If MVP upholds the initial denial after completing the Statutory Reconsideration, then you will be provided with written notice of the determination.

B. Supplemental

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

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

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

3. **Practitioner Claim Appeal.** Practitioners may call or write to MVP's Provider Claim Service department to request an appeal of the denial of a properly submitted claim (i.e. "clean claim").
4. **Practitioner Submitting Appeals on Behalf of Members.** Practitioners may also appeal a preservice denial as the designated representative of an MVP member. Except in urgent care situations, MVP shall only accept appeals submitted by practitioners on behalf of members, after the member or appropriate representative of the member has designated the practitioner to act on their behalf. Such designation must be in accordance with MVP's policies and procedures.

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

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

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

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

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

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

Transition of Care for New MVP Members

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

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

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

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

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

Emergency Services

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

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

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

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

Technology Assessment

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

Requests to review new technology or to reassess established technology may originate from providers or institutions outside MVP, or from within the health plan. Assessment and research are completed by MVP's Medical Policy Task Force. The resulting draft policies are distributed to appropriate specialists, MVP Medical Directors, Utilization Management, Claims, Operations, Corporate Communications and Legal Affairs departments for a fourteen business-day review and comment period. The new or revised policy is then presented to the Medical Management Committee (MMC) for consideration. MMC membership includes practicing physicians from representative specialties, including at least one physician from each region within MVP service area and health plan staff.

Formulary recommendations are reviewed by the MVP Pharmacy and Therapeutics Committee (P&T). New drugs, changes in formulation or indications, provider communications, coverage policies and revisions are distributed to P&T members for review and comment prior to each meeting.

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

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

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

MVP Health Care Medical Record Standards and Guidelines

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

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

B. Providers must have an organized medical record keeping system.

1. Medical records must be stored in a secure location not accessible to the public.
2. There is a unique medical record for each member, identified by a medical record identifier on each page.
3. Records are organized with a filing system to ensure easy retrievability. Medical records are available to the treating practitioner whenever the patient is seen at the location at which he/she typically receives care.

C. Primary care medical records must reflect all services provided directly by the PCP, all ancillary services and diagnostic tests ordered by the practitioner, and all diagnostic and therapeutic services for which the practitioner referred the member (e.g. home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports).

D. Confidentiality—Practice sites shall meet or exceed state and federal confidentiality requirements, including HIPAA, and are expected to have implemented procedures that guard against unauthorized or inadvertent disclosure of confidential information.

E. Retention of Medical Records—Providers shall retain medical records according to applicable federal and state laws and regulations.

F. Nondiscrimination in Health Care Delivery—MVP expects health care providers to keep on file and adhere to a documented nondiscrimination policy and procedure that ensures that patients are not discriminated against in the delivery of health care services on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions resulting from acts of domestic violence), genetic information or source of payment. The existence of this policy and adherence to it are also expectations of the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). MVP's Quality Improvement staff will measure compliance with a nondiscrimination policy and procedure at the time of the medical record review.

Specific standards are as follows:

1. The medical record should be organized in such a way that data abstraction can be performed efficiently. Each page in the record should contain the patient's name or ID number.
2. The record should be legible (for example, it can be read by someone other than the writer).
3. Each entry or office note must be dated.
4. All entries in the medical record should contain the author's identification. For all entries dated after July 1, 1999, stamped signatures are not considered appropriate author identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
5. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
6. *Significant illnesses and medical conditions should be indicated on the problem list. A problem list should be completed for each patient, regardless of health status. A flow sheet for health maintenance screening is considered part of the problem list. It is acceptable if the practitioner outlines a problem list at each visit in the progress notes or if the practice site keeps a current ongoing problem list on a computerized system.
7. *Past medical history (for patients seen three or more times) should be easily identified and should include serious accidents, surgeries and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, surgeries and childhood illnesses.
8. Medication list.
9. *Medication allergies and adverse reactions should be prominently noted in the record or on the front cover of the medical record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record, e.g. NKA.

10. For patients age 14 years and older, there should be appropriate notation concerning the use of cigarettes, alcohol and other substances. For patients who have been seen three or more times, there should be a record of asking about any substance abuse history.
11. For all patients 18 and younger, there should be a completed immunization record. For patients over 18, there should be a note in the history of immunizations. Because most adults may not have an immunization record, appropriate notation should be made of Flu vaccine, Pneumococcal vaccine (if appropriate), and tetanus/diphtheria (Td) vaccine every 10 years.
12. Unresolved problems from previous office visits should be addressed and documented in subsequent visits.
13. Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.
14. No-shows or missed appointments must be documented with follow-up efforts to reschedule appointment.
15. Consultation, lab, and imaging reports filed in the chart should be initialed by the practitioner who ordered them to signify review. If the reports are presented electronically or by some other method, there should also be representation of review by the ordering practitioner. Consultation, abnormal lab, and imaging study results should have an explicit notation in the record of follow-up plans.
16. If a consultation/referral is requested, there should be a note from the consultant in the record.
17. Lab and other studies ordered should reflect consideration of the reported signs/symptoms and recorded diagnoses.
18. *Documentation of clinical findings and evaluation for each visit. Working diagnoses should be consistent with findings.
19. When indicated by diagnosis, plans of action should include the consultation of specialists. Treatment plans should reflect consideration of recorded diagnoses and reported signs/symptoms.
20. There should be no evidence that the patient was placed at inappropriate risk by a diagnostic or therapeutic procedure.
21. *For members over the age of 18, documentation of whether or not the patient has executed an advance directive. Documentation of any advance directive should be maintained in a prominent part of the member's medical record and should be kept up-to-date. Advance Directives can be found in the QI manual.
22. Preventive care/Risk assessment—There is evidence that preventive screening and services are offered in accordance with MVP's practice guidelines.

*These elements are required for Medicare and Medicaid members.

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

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

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

Actions for improving medical records:

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

1. Receive a letter with recommendations for improvement with a copy sent to the Regional/IPA/PO Medical Director.
2. Receive notification that a re-review will be performed in six months on the elements that did not meet standards.

Practitioners who continue to score below 80 percent upon re-review will be contacted for a written corrective plan of action within 30 days. A copy of the request will be sent to the Regional/IPA/PO Medical Director. Upon receipt, a copy of the corrective action plan will also be forwarded to the Regional/IPA/PO Medical Director.

Failure to cooperate with MVP QI activities or to correct deficiencies noted during the medical record review process will also result in notification of the IPA/PO Medical Director.

Results of the ambulatory medical record review program will be reported to the Quality Improvement Committee.

Advance Directives

As part of our medical records review, MVP assesses whether providers' offices document advance directives for members age 18 and older. MVP urges all primary care physicians (PCPs) and other participating providers, as appropriate, to inform members of their right to execute advance directives. If the member chooses to do so, the provider should document the decision and place signed copies of the form or other documents in a prominent place in the medical record. If the member decides not to execute an advance directive, this also should be documented in the medical record. A NYSDOH Health Care Proxy form is located under the preventive care section of the *Quality Improvement Manual* at http://tinyurl.com/2fxkvq. For additional information concerning advance directives, please call the MVP Quality Improvement department at **1-800-777-4793, ext. 2290**.

MVP's Quality Improvement Program

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

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

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

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

- Collect and utilize information to enhance the credentialing, peer review, performance assessment and recredentialing processes.
- Promote a system of timely, thorough and appropriate resolution of member complaints and appeals.
- Develop initiatives that will enhance patient safety in various professional care settings.

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

Invitation to Join MVP's Quality Improvement Program

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

Practitioner Review of Credentialing Information

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

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

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

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

Report Suspected Insurance Fraud/Abuse

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

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

- Falsification of procedure codes
- Falsification of diagnosis codes
- Manipulation of modifiers
- Up-coding
- Over utilization of diagnostic procedures and tests; and
- Over utilization of treatment modalities.

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

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

Self-Treatment and Treatment of Immediate Family Members

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

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

- The practitioner's personal feelings may influence his/her professional medical judgment, thereby interfering with the care being delivered.
- Practitioners may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the practitioner is an immediate family member.
- Practitioners may be inclined to treat problems that are beyond their expertise or training.
- If tensions develop in a practitioner's professional relationship with a family member, perhaps as a result of a negative medical outcome, these difficulties may extend into their personal relationship as well.
- Concerns regarding patient autonomy and informed consent may arise when practitioners attempt to treat members of their immediate family.
- Family members may be reluctant to state their preference for another practitioner or decline a recommendation for fear of offending the practitioner. Practitioners may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.