2025 Annual Notices

for MVP Health Care® Vermont Providers

As part of our commitment to the accreditation standards of NCQA and to comply with state and federal government regulations and mandates, MVP Health Plan, Inc. and MVP Health Services Corp. (collectively, "MVP") publish regulatory and compliance content on **mvphealthcare.com/notices** and direct Participating Providers to this content each year in our Provider digital newsletter, *Healthy Practices*.

Members' Rights and Responsibilities

The MVP Member Rights and Responsibilities policies clearly state:

- Our commitment to treating Members in a manner that respects their rights
- Our expectations of Members' responsibilities

MVP recognizes the specific needs of Members and strives to maintain a mutually respectful relationship. Members are notified of their Rights and Responsibilities in their MVP Member Guide (provided in hard copy after enrollment) and in the Member Annual Notice. To download a PDF of the *Member Annual Notices,* visit **mvphealthcare.com/notices**, select *Legal Notices and Reports* and under *Annual Notices/Reports-Commercial*, select *Member.* To request a printed copy, call the MVP Customer Care Center for Provider Services at **1-800-684-9286** (TTY 711). New and existing Providers can find the MVP Member Rights and Responsibilities statements in the MVP Provider Policies and Payment Policies. To access the MVP Provider Policies and Payment Policies, visit **mvphealthcare.com/policies**. To request a printed copy, call the MVP Customer Care Center for Provider Services at **1-800-684-9286** (TTY 711).

Member Grievance Process

The MVP grievance policies assure that Members' written and oral concerns are registered, investigated, and resolved in a timely manner. Members, or their designated representatives, may call the MVP Customer Care Center or write to the Appeals Department to initiate a formal grievance. Members may appoint their Provider as their designee for the purpose of initiating a grievance. MVP encourages Members to utilize these procedures when necessary and will not retaliate or take any discriminatory action against a Member should he or she file a grievance.

Grievances are analyzed and trended on an aggregate basis and reported regularly to the MVP Service Improvement Committee and the Quality Improvement Committee (QIC). Opportunities to improve the quality of care, access to care, or MVP administrative services are addressed.

After review, analysis, and recommendations are completed, trended grievance information is included in Provider performance measures and considered through the recredentialing process.

Confidentiality and Privacy Policies

Protection of Oral, Written, and Electronic Protected Health Information

All MVP employees are trained in the appropriate use and disclosure of Members' protected health information (PHI) and sign a corporate confidentiality statement annually, committing to uphold our standard of protecting oral, written, and electronic PHI. Access to our physical facilities and information systems is limited to the required minimum necessary to provide services. MVP has established physical, electronic, and procedural safeguards that comply with federal and state regulations to guard PHI. In addition, all MVP Provider and vendor agreements include language regarding the confidential handling of Members' PHI.

The MVP Privacy Notice

The MVP Privacy Notice is provided to all Members at enrollment. Thereafter, Members are notified annually on how to obtain the Privacy Notice. It is also included in the MVP Provider Policies and Payment Policies, and is available at **mvphealthcare.com/notices** for easy access with no login required. To request a printed copy, call the MVP Customer Care Center for Provider Services at **1-800-684-9286** (TTY 711). The Privacy Notice instructs Members regarding our legal duties and health information privacy rules, including:

- Definition of "health information" per the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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- Permitted use and disclosure of health information
- Disclosures to parents (or other third-party representatives) of minors
- Special use and disclosure situations
- Members' rights to request restrictions, confidential communications, and accounting of disclosures
- Members' rights to inspect and obtain copies of their PHI and to amend their health information
- Our commitment not to take retaliatory action against any individual who exercises a right under the HIPAA Privacy and/or Security Rules
- Contact information for MVP

HIPAA Reminder Regarding Faxes

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

Medical Management Decisions

It is the policy of MVP to provide coverage for medically necessary health care services provided to our Members. Providers may contact the Utilization Management (UM) Department, via Provider Services, 24 hours a day, seven days a week at **1-800-684-9286**. After hours, Providers may call the MVP Customer Care Center at the phone number on the Member's MVP Member ID card. It is also the policy of MVP to monitor the impact of the MVP Utilization Management Program to ensure appropriate utilization of services.

The MVP Utilization Management Program does not provide financial incentives to employees or Providers who make utilization management decisions that would create barriers to care and services.

1. Utilization Management decisions are based only on appropriateness of care, treatment and/or services, and the benefit provisions of the Member's coverage.
2. MVP does not specifically reward Providers or staff, including Medical Directors and Utilization Management staff, for issuing denials of requested care.
3. MVP does not offer financial incentives to encourage decisions that result in inappropriate utilization.
4. MVP informs those involved with utilization management decisions of the concerns and risks associated with under-utilization of medical care or services.

Pharmacy Benefit Management

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

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

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

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

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

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

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

- Tier 1 includes preferred generics
- Tier 2 includes generics
- Tier 3 includes preferred brands and non-preferred generics
- Tier 4 includes non-preferred brands and non-preferred generics
- Tier 5 includes drugs that cost more than $950 for a 30-day supply

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

Utilization Management Criteria

MVP uses the most current version of InterQual® criteria as a guideline for its utilization management decisions for inpatient services and certain medical services. In addition, MVP utilizes evidence-based proprietary medical policies, outlined in the MVP Benefit Interpretation Manual (BIM), as a guideline to render medical necessity determinations for select requests.

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

MVP follows and complies with national coverage decisions, general Medicare coverage guidelines, and written coverage decisions of local Medicare contractors when rendering coverage decisions for Medicare Advantage Plan Members.

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

MVP has delegated the responsibility for utilization management decisions related to clinical reviews on radiology requests for MVP Members across all lines of business except for Medicare to eviCore Healthcare (eviCore). eviCore reviews MRI/MRA, PET scans, Nuclear Cardiology, and CT/CTA.

When making utilization management decisions, eviCore utilizes evidence-based guidelines and recommendations for imaging from national and international medical societies and evidenced-based medicine research centers. Sources include:

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

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

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

Effective May 1, 2024, MVP has delegated responsibility for utilization management for outpatient medical oncology treatments for MVP Members* to Optum Health Solutions (Optum). Oncologists will submit prior authorization requests through Optum's online portal. Optum will review requests for the treatment of Members with a cancer diagnosis for drugs on the MVP Prior Authorization list when being delivered in an outpatient setting (e.g., performed in a doctor's office, other outpatient facility, or at home). If you have questions, please contact the Optum Oncology Customer Care Center for Provider Services at **1-866-654-7432** from 7 am–7 pm Eastern Time.

The MVP UM Policy Guides and BIM will help determine whether a service is covered and requires prior authorization. These online manuals provide convenient access to needed information. To view both documents, Providers can Sign In to their online account at **mvphealthcare.com/providers** and select *Benefits Interpretation Manual*. Or, select *Other Resources* and then *New York* or *Vermont*.

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

MVP Members may request a copy of the criteria used to make a specific utilization management determination by contacting the MVP Customer Care Center at the number on the back of their MVP Member ID card.

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

To speak with an appropriately-licensed clinical reviewer regarding behavioral health care decisions, including denials of service and the submission of additional information, please call the MVP Customer Care Center for Provider Services at **1-800-684-9286**.

To obtain a complete set of the American Society of Addiction Medicine (ASAM) criteria, contact the ASAM Publications Department at **301-656-3920**, by fax at **301-656-3815**, by email to **email@asam.org**, or by mail to:

AMERICAN SOCIETY OF ADDICTION MEDICINE
4601 N PARK AVE
UPPER ARCADE STE 101
CHEVY CHASE MD 20815

Provider Appeals

Providers should follow the steps below to obtain information regarding why a claim was rejected or processed in a certain manner (see item 1 below) or to initiate an internal review of denials (see items 2, 3, and 4 below):

1. **Make a Claim Inquiry**
   Providers may obtain information regarding why a claim was rejected or processed in a certain manner, often resolving any need for any further action, by calling the MVP Customer Care Center for Provider Services at **1-800-684-9286**. If an adjustment is required, Providers may file a Claim Adjustment Request form (CARF). To download the form, visit **mvphealthcare.com/providers** select *Resources*, then *Forms*, then *Claim Adjustment Forms*, or submit

*Excludes MVP Dual Eligible Special Needs Plan (D-SNP) Members. May exclude MVP Self-Funded Members.

a HIPAA standard EDI adjustment transaction for electronic adjustments.

2. **Providers Claim Appeal**

   Providers may call or write to the MVP Customer Care Center to request an appeal of the denial of a properly submitted claim (i.e., "clean claim"). Provider appeals denied for "not medically necessary" should be mailed to:

   MEMBER APPEALS DEPARTMENT
   MVP HEALTH CARE
   PO BOX 2207
   SCHENECTADY NY 12301

   All other appeals should be mailed to:

   OPERATIONS ADJUSTMENT TEAM
   MVP HEALTH CARE
   PO BOX 2207
   SCHENECTADY NY 12301

   Providers may appeal verbally by calling the MVP Customer Care Center for Provider Services at **1-800-684-9286**.

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

   Providers may also appeal a pre-service denial as the designated representative of an MVP Member. MVP will only accept appeals submitted by Providers on behalf of Members after the Member or appropriate representative of the Member has designated the Provider to act on their behalf. Such designation must be in accordance with our policies and procedures.

4. **Request a Reconsideration**

   For non-Medicare lines of business, when the requesting Provider is notified of an adverse determination, the Provider is advised of the option to request a reconsideration of the decision and speak with the MVP Medical Director who made the decision.

   Review of the reconsideration request is completed within one business day for urgent and concurrent review requests and must be conducted by both the requesting Provider and the Medical Director making the initial determination.

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

MVP Noncompliance Policy

MVP objectively and systematically monitors Provider compliance with MVP policies and procedures. The following categories represent potential Provider noncompliance issues that are reviewed and investigated by MVP.

1. **Contractual Violations Issues**

   Violations of MVP, Provider-Hospital Organizations, direct, or Independent Practice Association contracts

   a. Accessibility of care issues involving MVP Members.
   b. Balance billing of Members by MVP Participating Providers.

2. **Utilization Management Issues**

   a. Unauthorized non-emergent surgical procedures and procedures pre-certified in less than the five business day time frame.
   b. Unauthorized out-of-plan referrals.
   c. Failure to obtain prior authorization for services when required by MVP policy.
   d. Refusal to cooperate with the Utilization Management/Quality Improvement process.

Examples: (1) refusal to speak with the MVP Medical Director or UM/QI staff or (2) verbal abuse of the UM/QI staff.

The MVP Credentialing Department monitors occurrences of non-compliance. Non-compliance information is reviewed during the MVP recredentialing process.

Utilization Management Processes

MVP expects that the Member's Primary Care Provider (PCP) or their appropriate Specialty Care Provider will manage the coordination of care as it relates to services requiring prior authorization.

Services Requiring Prior Authorization or Out-of-Network Requests

Providers must submit a Prior Authorization Request Form (PARF) with any information substantiating the service, item or procedure, or use of an out-of-network Provider (for Members without out-of-network benefits) to the MVP Utilization Management Department (unless the service is delegated to another entity as noted under the Utilization Management Criteria section). Providers can submit a PARF by signing in to their MVP Provider Online Account at **mvphealthcare.com/providers** and completing the online form.

Providers can also download and print the PARF by visiting **mvphealthcare.com/providers** and selecting *Resources*, then *Forms*, and then *Admissions and Prior Authorization*. The completed hard copy can be faxed or mailed to MVP. Without prior authorization, MVP will not reimburse services. MVP will not reimburse out-of-network services, except in emergency situations. In urgent cases, you may contact the MVP Utilization Management Department at **1-800-568-0498** and request an expedited review. Services that require prior authorization are reviewed by licensed clinicians and/or Medical Directors as appropriate.

Transition of Care for Members of a Provider Leaving the MVP Provider Network

Prior written notification must be given if a Provider wishes to end his or her network affiliation with MVP Health Care.

As stated in the Participating Provider contract with MVP notification of termination helps MVP Members transition their care to another Participating Provider. In some Provider termination situations, the Member may be eligible to receive transitional care from a Provider for up to 90 days from the date of the contract termination. The terminating Provider leaving the MVP network must agree to:

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

If a Member is receiving maternity care at the time the Provider has ended participation with MVP, the Member may continue their course of care with the same provider throughout their pregnancy, delivery, and through the completion of their postpartum care directly related to their pregnancy. The Provider must submit a request for authorization as outlined above to the Utilization Management Department. Transitional care is not available if the Provider disenrollment is the result of an MVP determination of imminent harm to member care, fraud, or action of a state board.

Transition of Care for New MVP Members

Newly enrolled MVP Members with life-threatening, disabling, or degenerative conditions who are receiving an ongoing course of treatment from a non-Participating Provider may continue treatment with that Provider for up to 60 days from the date of MVP enrollment if the Provider agrees to:

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

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

If a Member is receiving maternity care and is in their second or third trimester of pregnancy at the time they become a Member with MVP, the Member may continue their course of care with the same Provider throughout their pregnancy, delivery, and through the completion of their postpartum care directly related to their pregnancy. The Provider must adhere to all of the above requirements.

Transition of care services must be prior-authorized by MVP. To request transition of care services for an MVP Member, please follow the out-of-plan process and state that the need for out-of-plan services is Transition of Care. Without prior authorization, MVP will not reimburse for out-of-network services or treatment provided during the transition of care except in emergency circumstances.

Transition from Pediatric to Adult Care

Members entering adulthood (age 18) can request assistance to transition from a pediatrician to an adult care Provider. The MVP online Provider directory enables Members to identify an adult care Provider by several preferences such as location, board certification, gender, or language spoken. Visit **mvphealthcare.com/findadoctor**.

The MVP Customer Care Center is available to assist older adolescent Members' transition from a pediatrician and/or pediatric specialists to an adult care Provider. Members can reach the MVP Customer Care Center by calling the phone number on the back of their MVP Member ID card.

MVP offers a template letter to use when contacting your Members age 18 and older to help make the transition from your practice to an adult care practice. Call the MVP Accreditation and Quality Regulatory Compliance Department at **518-991-3609** for more details.

Specialist as a Primary Care Provider

Individuals with life-threatening, disabling, or degenerative conditions requiring ongoing care may request a Participating Specialist or a Participating Specialty Care Center coordinate their primary and specialty care. The MVP Member or PCP must initiate the process by submitting a written request to the MVP Utilization Management Department for prior approval. For details on submitting a request, please refer to the MVP Provider Polices and Payment Policies.

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

Members may not elect to use a non-participating specialist or Specialty Care Center as their PCP unless the services are not available from a Participating Provider.

Emergency Services

Emergency services are those episodes of care provided in an emergency setting that are required to evaluate and treat an emergency medical or behavioral condition. An emergency medical or behavioral condition means the

sudden, and at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine to result in:

- Placing the Member's physical or mental health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement of the person

A referral or prior authorization is not needed to seek emergency treatment. Members may seek emergency treatment without contacting a Provider (self-refer). Determination of coverage is based upon the Member's eligibility, contracted benefits, presenting symptoms, and clinical findings. Diagnosis upon discharge has no bearing on the coverage determination. An MVP Medical Director reviews all potential denials of services.

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 and surgical procedures, drugs, medical devices, and behavioral health treatments. A copy of the policy is available upon request.

Requests to review new technology or to reassess established technology may originate from providers or institutions outside MVP, or from within the health plan.

Assessment and research are completed by our team of Medical Professionals. Draft versions of policies are distributed to appropriate specialists, MVP Medical Directors, Utilization Management, Claims, Operations, Marketing and Communications, and Legal Affairs Departments for a 14 business-day review and comment period.

The new or revised policy is then presented to the Medical Management Committee (MMC) for consideration.

MMC membership includes practicing Providers from representative specialties, including at least one Provider from each of the MVP service region, and health plan staff. Formulary recommendations are reviewed by the MVP P&T Committee.

New drugs, changes in formulation or indications, provider communications, coverage policies, and revisions are distributed to P&T members for review and comment prior to each meeting.

All medical policies undergo review on an annual basis with interim updates indicated by changes in published medical evidence-based journals.

MVP obtains the services of clinical specialists through the MVP network of specialists, academic centers, and contracted experts in selected specialties to ensure that its reviews are thorough. Medical policy language reflects the standard of care.

Policy recommendations that are accepted by the MMC and P&T are then sent to the MVP Quality Improvement Committee (QIC) for final approval. The QIC may approve policies as they are presented, or it may require additional research and revision before considering approval.

Participating Providers are notified of new policies or changes in existing policies through *Healthy Practices*, the MVP Provider digital newsletter, and via MVP FastFax. To view an archive of all MVP FastFax communications, visit **mvphealthcare.com/FastFax**. To view full versions of the policies, visit **mvphealthcare.com/providers** and select *Resources*, then select *Medical Policies*.

MVP Medical Record Standards and Guidelines

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

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

B. Providers must have an organized medical record keeping system:
   - Medical records must be stored in a secure location inaccessible to the public
   - A unique patient identifier is used for each Member—the identifier is included on each page of the medical record
   - Records are organized with a filing system or search capability to ensure easy retrieval—medical records are available to the treating Provider whenever the Member 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 Provider, and all diagnostic and therapeutic services for which the Provider referred the Member (e.g., home health nursing reports, specialty provider reports, hospital discharge reports, physical therapy reports, etc.).

D. **Confidentiality:** Providers/Practice sites shall comply with current state and federal confidentiality requirements, including HIPAA, and are expected to adopt policies and procedures that guard against unauthorized or inadvertent disclosure of PHI.

E. **Retention of Medical Records:** Providers shall retain medical records in accordance with contractual obligations, and current applicable federal and state laws and regulations.

Specific medical records standards are:

1. The medical record should be organized in such a way that data abstraction be performed efficiently. Each page in the record should include the Member's full name and identification number. In addition, home address, phone number(s), employer, marital status, and emergency contact information is maintained.
2. The record is legible to someone other than the writer.
3. Each entry or note must be dated.
4. All entries in the medical record should contain the author's identification and credential. For all entries dated after July 1, 1999, stamped signatures are not considered appropriate author identification. Author identification may be handwritten, or an electronic signature is acceptable.
5. The history and physical exam identify appropriate subjective and objective information pertinent to the Member presenting complaints.
6. **Problem List:** Documents all chronic, serious, or disabling conditions, active and 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. The Provider may outline a problem list at each visit in the progress note or keep a current ongoing problem list in an electronic health record (EHR) system.
7. **Past Medical History (for Members seen three or more times):** Should be easily identified and include serious injury, surgical procedures, and illnesses. For children and adolescents (18 years of age and younger), past medical history relates to prenatal care, birth, surgical procedures, and childhood illnesses.
8. **Medication List:** Documents all medications, updated as necessary with dosage changes and the date the change was made. All medications (prescribed, over-the-counter, herbal therapies, vitamins, and supplements) must be noted. Dates of initial and refill prescriptions must be included.
9. Medication allergies and adverse reactions should be prominently noted in the record or on the front cover of the medical record. If the Member has no known allergies or history of adverse reactions, this is also appropriately noted in the record (e.g., NKA, NKDA).
10. Screening and assessment of tobacco, alcohol, and substance use for Members 12 years of age and older who have been seen three or more times, including substance abuse history.
11. **Immunization Record:** Include the complete immunization record for Members 18 years of age and younger. An immunization history is maintained for Members age 19 and older to include influenza, pneumococcus, tetanus/diphtheria, pertussis, and varicella zoster immunizations, among others.
12. Unresolved problems from previous office visits should be addressed and documented in subsequent visits.
13. Encounter forms or notes should indicate followup care, calls, or visits. The specific time frame for return to office is noted (e.g., weeks, months, or as needed).
14. No-shows or missed appointments must be documented with follow-up efforts to reschedule the appointment.
15. Specialist, laboratory, and imaging reports should be marked by the ordering Provider to signify review. If the reports are presented electronically or by some other method, there should also be representation of review by the ordering Provider. If follow up is indicated, the record should include an explicit notation of the plan.
16. If a specialist referral is requested, there should be a note from the consultant in the record.
17. Laboratory and other studies ordered should reflect consideration of the reported signs/symptoms and recorded diagnoses.
18. Documentation of clinical findings and evaluation shall be included for each visit. The working diagnoses should be consistent with findings.
19. When indicated by diagnosis, plans of action should include the consultation of specialists. Treatment plans should reflect consideration of recorded diagnoses and reported signs/symptoms.
20. There should be no evidence that the Member was placed at inappropriate risk by a diagnostic or therapeutic procedure.

21. **Preventive Care/Risk Assessment:** There is evidence that preventive screening and services are offered in accordance with our practice guidelines.
22. **Depression Screening:** May be assessed during a comprehensive physical examination or review of systems, or using a patient health questionnaire or formal screening tool (e.g., PHQ-9, Beck Depression Inventory) or any part of the following questions, 1) Little interest or pleasure in doing things? 2) Feeling down, depressed, or hopeless?
23. **Advance Care Planning for Members Age 65 and Older:** Notation of an advance care planning discussion and date, and/or copy of an executed Advance Directive form. If the Member decides not to execute an Advance Directive, this also should be documented in the medical record. Current Advance Directive forms should be maintained in a prominent part of the Member's medical record.
24. **Annual Medication Review for Members Ages 65 and Older:** Conducted by a prescribing Provider and include the date the review was performed.
25. **Functional Status Assessment for Members Age 65 and Older:** Components include vision, hearing, mobility, continence, nutrition, bathing, use of phone, preparing meals, and managing finances. Functional assessment may be found on a specific tool.
26. **Fall Risk Assessment for Members Age 65 and Older:** Components include age, fall history, gait, balance, mobility, muscle weakness, osteoporosis risk, impairments related to vision, cognitive or neurological deficits, continence, environmental hazards, and number and type of medication.
27. **Monitoring of Physical Activity for Members Age 65 and Older:** Includes annual assessment of level of exercise or physical activity, and counseling related to begin exercising or increase/maintain their level of exercise or physical activity.
28. **Pain Screening for Members Age 65 and Older:** Includes character, severity, location, and factors that improve or worsen pain. Pain assessment may be found on a specific tool such as a pain scale, visual pain scale, or diagram.

Nondiscrimination in Health Care Delivery

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

Advance Directives

MVP strongly encourages all PCPs and other Participating Providers, as appropriate, to inform Members of their right to execute advance directives. If the Member chooses to do so, the Provider should document the decision and place signed copies of the form or other documents in a prominent place in the medical record. If the Member decides not to execute an advance directive, this also should be documented in the medical record. Vermont Advanced Directives forms are available by visiting **vtethicsnetwork.org** and selecting *Forms*.

For additional information concerning advance directives, please call the MVP Accreditation and Quality Regulatory Compliance Department at **518-991-3609**.

MVP Quality Improvement Program

The MVP Quality Improvement (QI) Program provides the framework to improve the quality, safety, and efficiency of clinical care, enhance satisfaction, and improve the health of MVP Members and the communities it serves. The QI Program Description defines the authority, scope, structure, and content of the QI Program, including the roles and responsibilities of committees and individuals supporting program implementation.

MVP is a quality-driven organization that adopts continuous quality improvement as a core business strategy for the entire health plan. MVP develops and implements a quality management strategy that is embedded within every staff role and department function, approaching quality assurance, quality management, and quality improvement as a culture, integral to all daily operations. Each MVP operational area has defined performance metrics with accountability to the Quality Improvement Committee (QIC) and Board of Directors.

MVP acknowledges its obligation to provide Members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate setting. MVP provides for the delivery of quality care with the primary goal of improving the health status of Members by supporting Providers, who know what is best for their patients.

The MVP leadership team is committed to focusing clinical, network, and operational processes toward improving the health of Members (including all demographic groups and those with special health care needs), enhancing

each Member's experience of care and service, lowering the per capita cost of their health care, and improving the work life of Participating Providers and their staff, as well as their experience and satisfaction. The MVP QI Program applies a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care systems and processes. Methods such as the Plan-Do-Study-Act (PDSA) and other validated, data driven approaches to quality improvement, are used to monitor performance and measure effectiveness of quality improvement initiatives.

Our Board of Directors delegates the operating authority of the QI Program to the QIC. MVP executive management, clinical staff, and Participating Providers including, but not limited to, primary, specialty, behavioral, dental, and vision health care providers, are involved in the implementation, monitoring, and directing of the relative aspects of the QI Program through the QIC, which is directly accountable to the Board of Directors.

The QIC is a senior management led committee accountable directly to the Board of Directors and reports QI Program activities, findings, recommendations, actions, and results to the Board of Directors no less than annually. MVP ensures ongoing Member, Provider, and stakeholder input into the QI Program through a strong QIC, and subcommittee structure focused on Member and Provider experience. The MVP QIC structure is designed to continually promote information, reports, and improvement activity results, driven by the Quality Work Plan, throughout the organization and to Providers, Members, and stakeholders. The QIC serves as the umbrella committee through which all subcommittee activities are reported and approved. The QIC directs subcommittees to implement improvement activities based on performance trends, and Member, Provider, and system needs. Additional committees may also be included as needed, including regional level committees as needed based on distribution of Membership. These committees assist with monitoring and supporting the QI Program.

Invitation to Join the MVP Quality Improvement Program

MVP invites all health care providers to participate in the development, implementation, and evaluation of our QI processes and programs. For more information, or to comment on our QI programs, please call the MVP Accreditation and Quality Regulatory Compliance Department at **518-991-3498**.

How to Request Quality Program Documentation

To receive a copy of the most recent QI Annual Evaluation and/or the QI Program Description, please call the MVP Accreditation and Quality Regulatory Compliance Department at **518-991-3498**.

Provider Credentialing and Recredentialing Process

MVP completes the initial credentialing, including primary source verification of information submitted, for Providers applying for participation in the MVP Provider Network, prior to the execution of a Participating Provider Agreement.

Providers must have an executed Participating Provider Agreement to be listed in the MVP Participating Provider Directory. Providers are required to undergo recredentialing at least every three years. MVP does not make credentialing or recredentialing decisions based on an applicant's race, religion, ethnic/national identity, gender, age, or sexual orientation. MVP does not make credentialing or recredentialing decisions based solely on the types of procedures performed, or the types of Members treated by the Provider.

MVP retains all information used for credentialing and recredentialing purposes, pursuant to state and federal data retention requirements. MVP will make the criteria for credentialing and/or recredentialing available to all applicants upon written request. MVP will not disclose (except when permitted or required by applicable federal law, state law, regulation, or contract), directly or indirectly, any confidential information obtained during the credentialing or recredentialing process to any non-authorized individual. MVP will notify the applicant of the status of the application upon verbal or written request directly from the applicant.

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

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

Report Suspected Insurance Fraud, Waste, and Abuse

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

analyze, and report instances of health care fraud, abuse, or misrepresentation.

The SIU staff uses FraudScope 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.

FraudScope identifies suspicious claims for:

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

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

Please report any suspicious activity by calling the MVP SIU at **1-877-TELL-MVP** (1-877-835-5687). Providers can also report fraud and/or abuse by visiting **mvphealthcare.com** and navigating to the very bottom of the page, selecting *Fraud and Abuse*, and completing the Report Insurance Fraud form. 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, **Treating Self or Family**. Providers generally should not treat or write prescriptions for themselves or members of their immediate families, with the exception of emergency situations. MVP does not provide reimbursement for such care.

MVP Meets Members' Special, Cultural, and Linguistic Needs

MVP recognizes the necessity to have Providers who are best able to meet the complete needs of Members and eliminate barriers to access. Numerous factors beyond network adequacy analyses are considered, such as patterns of care, cultural and linguistic needs, and social determinants of health. MVP collects Member demographic and linguistics characteristic data, as well as provider demographic, cultural, and linguistics data for analysis to ensure MVP meets Members' Special, Cultural, and Linguistic needs. MVP also offers specialized services through the MVP Customer Care Center for Members who have language barriers, or vision or hearing impairment.

Online Provider Demographic Information Review

The No Surprises Act (NSA) requires all Participating Providers to review and confirm their publicly listed information once every 90 days to ensure that Members have access to the most up-to-date Provider information.

Providers can review their demographic information by visiting **mvphealthcare.com/searchproviders**. Select *Search by Location & Plan Type*. Then, click *Choose a location and plan* and enter a zip code for your desired search. Select *Browse a list of plans*, then select *All Plans* at the bottom of the page. If all information is accurately displayed in the Provider directory, then no further action is required.

If the listed demographic information is incorrect, Providers can *Sign In* and update their information online using the "Provider Change of Information" form at **mvphealthcare.com/demographics**. Delegated providers should contact their delegate administrator to update their demographic information.

MVP Provider Directory

To access the MVP online provider search tool, visit **mvphealthcare.com/findadoctor** and follow the prompts for a targeted search. In addition, you may request a copy of the full MVP directory in print or electronic format at any time by calling the MVP Customer Care Center for Provider Services at **1-800-684-9286**.