



Required Annual Notices

MARCH 2011

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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*.

MEMBERS' RIGHTS AND RESPONSIBILITIES

MVP's Member Rights and Responsibilities policies clearly state (1) our commitment to treating members in a manner that respects their rights, and (2) MVP's expectations of members' responsibilities. MVP recognizes the specific needs of members and strives to maintain a mutually respectful relationship.

Members are notified of their Rights and Responsibilities in MVP's *Member Guide* (provided in hard copy at enrollment) and in the *Member Annual Notices*, both available on MVP's Web site and in hard copy at any time, by request. New and existing practitioners can find MVP's Member Rights and Responsibilities statements in the *MVP Provider Resource Manual*. They are also available in hard copy with a quick phone call to MVP.

Member Grievance Process

MVP's grievance policies assure that members' written and oral concerns are registered, investigated, and resolved in a timely fashion. Members or their designated representatives may call or write the MVP Customer Care Center to initiate a formal grievance. At the member's request, a practitioner may act on behalf of the member. 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 grievance.

Grievances 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 grievance 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' protected health information (PHI) and sign an annual corporate confidentiality statement in order to uphold MVP's standard of protecting oral, written and electronic PHI. Access to MVP's physical facilities and information systems is limited to the required minimum necessary to provide services. MVP has established physical,

electronic and procedural safeguards that comply with federal and state regulations to guard PHI. In addition, all MVP provider and vendor agreements include language regarding the confidential handling of members' PHI.

MVP's Privacy Notice

MVP's Privacy Notice is provided to all members at enrollment and included in the *MVP Provider Resource Manual*. It is also posted on our Web site at www.mvphealthcare.com for easy access with no log-in required. Hard copies of this notice may be obtained upon request to MVP at any time.

The Privacy Notice instructs members regarding MVP's legal duties and health information privacy rules, including the following:

- Definition of "health information" with respect to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Permitted use and disclosure of health information
- Special use and disclosure situations
- Members' rights to request restrictions, confidential communications and accounting of disclosures
- Members' rights to inspect and obtain copies of their PHI and to amend their health information
- MVP's commitment not to take retaliatory action against any individual who exercises a right under the HIPAA Privacy and/or Security Rules
- Contact information within MVP

Medical Management Decisions

It is MVP's policy to provide benefits for covered medically necessary health care services provided to our members. Physicians may contact VMC at 1-800-639-3881 or MVP's 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.

Pharmacy Benefit Management

MVP utilizes a prescription drug Formulary (a list of covered drugs) for Commercial members. The Formulary is divided into Tiers as determined by our Pharmacy & Therapeutics (P&T) Committee. Most generic drugs are in Tier 1. Tier 2 contains preferred brand drugs and Tier 3 contains non-preferred brand drugs. The most current version of the MVP Formulary is available on the MVP Web site at www.mvphealthcare.com. Visit the site's *Provider* section and under *Pharmacy*, click on *Formulary*.

The MVP Formulary can be downloaded to a PDA device from www.epocrates.com. There is a link to ePocrates® on the MVP Web site. Please update your e-Pocrates account if your computer or PDA is set up to automatically download the Formulary. To request a paper copy of the Formulary, contact your Provider Relations representative.

Medicare Part D Formulary

Formulary updates for Medicare Part D members are updated regularly to MVP's Web site at:

https://www.mvphealthcare.com/medicare/documents/2011_formulary_changes.pdf.

While the most current information can be found online, hard copies of the Part D Formulary are also available. Contact your Provider Relations representative.

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 services. MVP also ensures that entities performing delegated utilization management (VMC, CVPHO) use nationally accepted criteria that are reviewed and approved annually and are available upon request.

MVP has delegated the responsibility for utilization management decisions related to behavioral health services for MVP Vermont members to PrimariLink in Brattleboro, Vermont. PrimariLink uses the following published criteria: LOCUS, CALOCUS/Level of Care Utilization System and the American Society of Addiction Medication (ASAM*) Patient Placement Criteria for the Treatment of Substance-Related Disorders. PrimariLink's behavioral health criteria and their entire provider manual are available for physicians on the PrimariLink Web site. For convenient access, go to www.primarilink.com and click on PrimariLink.

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**.

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 Utilization Management determination by contacting VMC or MVP's 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 utilization management determination or the *Benefit Interpretation Policy* by contacting the Customer Care Center. If an MVP participating practitioner has questions regarding the MVP Utilization Management policies or a specific utilization management decision such as a denial of services, MVP or VMC Medical Directors and appropriately-licensed clinical reviewers are available to discuss any issues. Practitioners requesting to speak with an appropriately-licensed clinical reviewer should contact the Utilization Management staff who will coordinate the contact and the appropriately-licensed clinical reviewer will call the practitioner directly. To speak with an appropriately-licensed clinical reviewer regarding behavioral health care decisions, including denials of service and the submission of additional information, please call PrimariLink in Brattleboro, Vermont.

The following is a list of MVP Utilization Management contact information, by geographical location for VMC practitioners:

VMC **1-800-639-3881**

Schenectady, NY **1-800-568-0458**

PrimariLink (for Behavioral Health UM) **1-800-320-5895**

*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 Customer Care Center at **1-800-684-9286** or by filing a Correspondence Adjustment Form and making a Claim Inquiry.

2. REQUEST A RECONSIDERATION: 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 Customer Care Center 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.

Utilization Management Processes

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

Out-of-Plan Requests

For those plans with in-network benefits only, all requests for out-of-plan services require prior authorization from the MVP Medical Director or a Medical Director of an entity to whom MVP has delegated utilization management duties.

The member's PCP must submit a *Pre-Authorization Request Form* (PARF) to the Utilization Management department for authorization prior to the member's first appointment with the out-of-plan physician. Please attach any information substantiating the need for out-of-plan services to the PARF. The PARF can be located in the back of your *Practitioner Resource Manual* or on MVP's Web site (www.mvphealthcare.com) on the "Important Provider Information and Forms" page.

Without pre-authorization, MVP will not provide benefits for out-of-plan services except in emergency situations. You may submit the request form to MVP via fax or mail. In urgent cases, you may contact your Utilization Management department by phone and request an expedited review. VMC physicians please contact VMC for all expedited review requests at **1-800-639-3881**. All other providers please contact the MVP Utilization Management department at **1-800-568-0458**.

For non-urgent cases, if all necessary information is received with the request form, MVP will notify you of its decision within three working days. In the event of an adverse determination, MVP will notify you by telephone of its decision, followed by a written notice within 24 hours of the telephone notice. If all necessary information is not received at the time of the request, MVP will notify you within 15 days what additional information is required to complete its review of the request. You and the member will have 45 days from the receipt of the notice to submit further information. In such instances, MVP will notify you in writing of its decision:

- a) within three working days after our receipt of the missing information; or
- b) within 15 days after the expiration of your time to provide the missing information, whichever is sooner.

For urgently needed care, MVP will notify you of its decision within 24 hours of receiving the request. If all necessary information is not received at the time of the request, MVP will notify you within 24 hours of the need for additional information. You and the member will have 48 hours after the receipt of our notice to submit further information for review. In such cases, we will notify you by telephone and in writing of our decision within 48 hours after:

- a) our receipt of the missing information, or
- b) the expiration of your time to provide the missing information, whichever is sooner.

Pre-Authorization Requests

MVP does require pre-authorization for a select number of treatments, procedures, and medications. Without pre-authorization, MVP will not provide benefits for services requiring pre-authorization. The out-of-plan form also serves as a *Pre-Authorization Request Form* (or PARF). You must follow the steps outlined above for out-of-plan requests before ordering a service or medication that requires prior authorization. A list of services and medications requiring pre-authorization is outlined in the most recent edition of the *UM Policy Guide*, which can be found at the back of the participating *Practitioner Resource Manual*. The *UM Policy Guide* can also be sent to you upon request.

MVP reviews pre-authorization in accordance with the time frames outlined in the out-of-plan process noted above.

Concurrent Review

Utilization Management nurses may review the medical records of all members requiring hospitalization. To assist with this review process, nationally recognized criteria are utilized along with the consultation of the Medical Directors. You may receive a copy of the review criteria by contacting the Utilization Management department.

Retrospective Review

There are times MVP performs a utilization review of services after treatment has been provided, such as in the event MVP is not notified of a member's hospital stay prior to discharge. In addition, all claims are reviewed retrospectively. If all necessary information is received at the time of the request for review or claim, MVP will notify you of its decision within 30 days. If all information required for review is not received at the time of the request for review, MVP will notify you that more information is needed. You will have 45 days from the receipt of the notice to submit the additional information for review. In such instances, we will notify you of an adverse determination, in writing, within 15 days after:

- (a) our receipt of the missing information; or
- (b) the expiration of your time to provide us with the missing information, whichever is sooner.

MVP Non-Compliance Policy

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

- I. Contractual Violations Issues – violations of MVP, PHO, direct, and IPA contracts
 - A. Accessibility of care issues involving MVP members.
 - B. Balance billing of members by MVP practitioners and/or providers.
- II. Utilization Management Issues
 - A. Unauthorized non-emergent surgical procedures and procedures precertified in less than the five (5) 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 co-operate with the UM/QI Process.
Examples:
 1. Refusal to speak with the MVP Medical Director or UM/QI staff.
 2. Verbal abuse of UM/QI staff.

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

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

If a practitioner wishes to end his or her network affiliation with VMC, prior written notification must be given. This is an important part of the participating practitioner contract with

VMC 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; and
- 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 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 that 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.

Specialist as a PCP

Individuals with life-threatening, disabling or degenerative conditions requiring ongoing care, may request a participating Specialist or a participating Specialty Care Center be responsible for providing and coordinating their primary and specialty care.

The member or Specialty Care Physician can initiate the request for the Specialist to act in the capacity of the PCP. This request

may be directed to MVP's Customer Care Center or directly to a VMC Care Coordinator. For details on submitting a request please refer to your *Practitioner Resource Manual*. MVP will need to collect information regarding the specialist's ability to provide access to care, the member's medical needs in relation to the current condition, the plan of care, and a written agreement from the specialist to assume the role of the member's PCP. Once all information has been received, the request will be reviewed by the Medical Director and the Utilization Management supervisor. The member, the PCP, and the specialist will be notified in writing of MVP's or VMC's decision. Members may not elect to use a non-participating specialist or Specialty Care Center as their PCP unless these services are not available in-plan.

Emergency Services

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

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

Members may self refer to seek emergency treatment. A referral or pre-authorization is not needed in order to seek emergency treatment.

Determination of coverage is based upon the member's eligibility, benefit coverage, presenting symptoms and clinical findings. Diagnosis upon discharge has no bearing on the coverage determination. 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 team of Medical Professionals. The resulting draft policies are distributed to appropriate specialists, MVP Medical Directors, Utilization Management, Claims, Operations, Corporate Communications and Legal Affairs departments for a 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 (P&T) Committee. New drugs, changes in formulation or indications, provider communications, coverage policies and revisions are distributed to P&T members for review and comment prior to each meeting.

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

Policy recommendations that are accepted by the MMC and P&T are then sent to the MVP Quality Improvement Committee (QIC) for final approval. The QIC may approve policies as they are presented, or 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 in accordance with contractual obligations and applicable federal and state laws and regulations.

- a) In Vermont, providers are required to retain record for six (6) years after the date of service and, in the case of minors, until six (6) years after the age of majority.
- b) For providers participating in Medicare products, medical record retention is required for a period of ten (10) years after the date of service rendered to the enrollee.

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

Additional core elements are reviewed for Medicare patients age 65 and over:

- Advance directives
- Pain assessment
- Functional assessment
- Fall assessment.

A practitioner's medical records are considered to meet MVP's standards when the score for each of the core elements is 85 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 85 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 <https://www.mvphealthcare.com/provider/qim/index.html>. 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 ensuring that network providers give 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 Vice President of Medical Quality Management 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, implement and monitor programs that will improve the quality of behavioral health care services and improve the continuity of behavioral health care with medical care.
- Collect and utilize information to enhance the credentialing, peer review, performance assessment and recredentialing processes.
- Promote a system of timely, thorough and appropriate resolution of member complaints and grievances.
- Monitor member satisfaction with the health plan, identify opportunities for improvement and implement appropriate interventions to improve member satisfaction.
- Develop initiatives that will enhance patient safety in various professional care settings.

Each year, MVP reports on its progress toward achieving the goals of the QI Program to the Quality Improvement Committee and to the Board of Directors. To receive a copy of the Executive Summary of the annual evaluation for 2006, 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 Credentialing and Recredentialing Process

As MVP's delegate, VMC will execute a participation agreement and complete the initial credentialing (including primary source verification of information submitted) for practitioners applying for participation in MVP's provider network. MVP remains accountable for the overall credentialing function, including the right to approve, suspend or terminate individual providers. Practitioners must be credentialed before being listed in MVP's *Participating Provider Directory*. Practitioners are required to undergo recredentialing at least every three years. MVP does not make credentialing or recredentialing decisions based on an applicant's race, 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 the 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 if MVP receives information that differs substantially from the information submitted to MVP in the credentialing application. Also, practitioners will be permitted, upon request, to review information obtained during the credentialing process 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.

MVP Meets Members' Special, Cultural and Linguistic Needs

MVP Health Care assists members with different cultural or linguistic needs. MVP has developed a brief overview of the Americans with Disability Act for its internal use that also includes information on diversity and sensitivity and the services that MVP offers to members who have a language barrier or who are vision- or hearing-impaired. To request a copy of this information, please contact the QI Department at **1-800-777-4793, ext. 12602**.