

The Primary Care Physician's (PCP) Roles and Responsibilities

The PCP's primary role is to coordinate all the patient's health care needs recommended for their age as outlined by the MVP Quality Improvement (QI) Department. Participating providers agree not to differentiate or discriminate in the treatment of the patient based on race, sex, age, religion, place of residence, handicap, health status or payment source.

Common services include:

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

Additionally, the PCP:

- Maintains the medical records for each patient
- Determines the appropriate plan of treatment
- Authorizes referrals to MVP participating specialists (see *Section 5* for details), when necessary, and
- Meets or exceeds the access standards as set by MVP

Hourly Requirements of PCPs for Government Programs

To be considered a PCP for Government Program members, a provider must practice at least 16 hours a week at that site. Example: if a PCP practices at two sites—the first where he/she practices three days a week for six hours daily and the second where he/she practices one day a week for only eight hours a day— then the first site may be considered a primary care site while the second may be closed to new panel members.

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

Member Selection of a PCP

The following MVP plans require members to select a participating PCP who will coordinate all of their medical care:

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

Types of PCPs

A PCP may be selected from the following types of physicians:

- Family practitioner
- General practitioner
- Internist
- Obstetrician/gynecologist (Members must check the Participating Provider Directory and/or MVP's website to determine if the OB/GYN participates as a PCP. The MVP member may call the Customer Care Center or the OB/GYN prior to selection to ensure the physician agrees with this PCP designation.)
- Pediatrician
- A specialist under conditions listed in this section

Health care providers who have satisfied MVP's credentialing process (see section 11 for all credentialing information) and have a contract with MVP or a Provider Organization (IPA, PHO, PO) will be listed in MVP's participating provider directory. This directory is the primary source by which members select a PCP, and it is essential that the information MVP has on file is accurate. Any changes of address, telephone/fax numbers, tax ID information, additional office location(s), or new billing address should be communicated in writing directly to practitioners' MVP Professional Relations representative.

PCP Panel Listings

Once a member selects a PCP, the member's name will appear on the PCP Member Roster. PCP member rosters can be accessed anytime on MVP's Provider Portal, just go to **www.mvphealthcare.com/provider** and log in with your username and password, then click on *View PCP Member Roster*. Members may change their PCPs as often as they wish by calling the Customer Care Center or through MVP's website.

Member Changing PCP

MVP members have the freedom to change PCPs at any time. To do so members may:

- Contact the Customer Care Center
- Go online to MVP's website **www.mvphealthcare.com**.

The change will take effect immediately. PCPs are notified of their members via the panel listing and/or monthly addition and deletion reports found on MVP's website. Providers can also verify this by calling the Customer Care Center. For Medicaid Managed Care, and Child Health Plus members, the member's PCP is listed on the ID card. For this population, new ID cards will be issued upon a new PCP selection.

PCP Auto Assignments

Members of MVP's Government Programs are asked to select a PCP upon enrollment. MVP contacts members who have not done so within 30 days of enrollment to ensure that all members have a PCP. If MVP is unable to reach a member within this time period, a PCP will be assigned based on the following criteria:

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

A member may also be auto assigned a new PCP if his/her PCP leaves the network and a new PCP is not selected within 30 days of notification of the provider termination.

Specialists' Roles and Responsibilities

A specialist is a participating provider who has agreed to provide specialty services to MVP members. For plans requiring a referral, MVP will provide benefits for the services of specialist provider only when the member's PCP makes an appropriate referral. Please see *Section 5* of this manual for MVP's referral policy. After determining the member's course of treatment, the specialist will submit a report to the member's PCP. The PCP should be provided regular feedback from the specialist during the course of treatment, including any possible hospitalization. Emergency room physicians should provide feedback to the member's PCP regarding any treatment rendered during an emergency room visit and any need for follow-up care. Specialists should also verify an authorization is on file prior to performing any procedures that require authorization. The PCP has the primary responsibility to oversee and coordinate all of the care needed by the MVP member.

Specialist or Specialty Care Center as a PCP

NY HMO Company Only

For MVP members and new enrollees with a life-threatening, disabling, or degenerative disease or condition that requires prolonged specialized medical care, the specialist or a specialty care center may be considered a PCP. The specialist or specialty care center would assume responsibility to coordinate all primary care services and to authorize referrals for specialty care (see Section 5 for details), lab work, hospitalizations and all other health care needs.

MVP defines specialty care center as such centers that are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated. Examples where this request would be appropriate include, but are not limited to, advanced cancer care, HIV disease, end-stage renal disease and severe cardiac conditions.

In order to evaluate having the specialist act as a PCP, the following must occur:

1. The MVP member, the specialist or the member's current PCP must submit a request to the MVP Utilization Management (UM) department or the Provider Organization UM department asking that the specialist be identified as the new PCP. Both the PCP and the specialist or specialty care center must agree to this request.
2. The request should include pertinent information, including medical documentation, to demonstrate the rationale behind the request and the treatment plan.
3. The request will be reviewed by the appropriate UM department to determine if there is adequate documentation to make a decision. If necessary, the UM department will contact the specialist for additional information.
4. After all of the information is gathered it is sent to the appropriate medical director for a decision.

5. Once the process is complete, the MVP member, the current PCP, and the specialist or specialty care center will be notified in writing by the UM department of the decision.

Medical Health Access Standards

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

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				effort by plan)
Well child care		Within four weeks		
Initial PCP OV for newborns		Within two weeks of discharge from hospital		
Wait in PCP office (max)	30 minutes	one hour	30 minutes	
After-hours care	24/7 availability or coverage	24/7 availability or coverage	24/7 availability or coverage	24/7 availability or coverage
Other Medical Care				
Initial prenatal visit:				
First trimester		Within three weeks		
Second trimester		Within two weeks		
Third trimester		Within one week		
Initial family planning		Within two weeks of request		
Specialist referrals		Within four-six weeks (non-urgent) of request		
Routine lab, x-ray and general optometry				Within 30 days
In-Plan mental health or substance abuse visits (following an emergency or hospital discharge)		Within five days of enrollee request, or as clinically indicated		
In-Plan non-urgent mental health or substance abuse visits		Within two weeks of enrollee request		
Visits to perform assessment of health, mental health, substance abuse for recommendation regarding ability to work as requested by Local DSS		Within 10 days of DSS request		

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

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

Behavioral Health Access Standards—VT Only

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

NY Commercial, Medicare, Essential Health Plans, Managed Medicaid, & Child Health Plus Plans: MVP’s Behavioral Health Services are managed by Beacon Health Strategies. Please contact Beacon Health Strategies for Access Standards at www.beaconhealthoptions.com OR by phone at:

Product	Reason For Call	Who To Call	Phone Number
NY Commercial NY Self-Funded	Authorization Requests	Beacon Health Options	1-888-687-6277
	Provider Relations Contracting Credentialing		1-800-397-1630
NY Medicare	Authorization Requests	Beacon Health Options	1-800-665-7924
	Provider Relations Contracting Credentialing		1-800-397-1630
NY Medicaid NY Child Health Plus	Authorization Requests	Beacon Health Options	1-844-265-7595
	Provider Relations Contracting Credentialing		1-844-265-7592
NY Essential Plan	Authorization Requests	Beacon Health Options	1-888-723-7967

	Provider Relations Contracting Credentialing		1-844-265-7592
VT Commercial VT Self-Funded VT Medicare	Authorization Requests	PrimariLink	1-800-320-5895
	Provider Relations Contracting Credentialing	MVP Health Care	1-888-687-6277

Medicare Variation to Access Standards

MVP Health Care must comply with all requirements of the Centers for Medicare & Medicaid (CMS). The Balanced Budget Act Requirement 422.112(a)(1) mandates that:

The Medicare Advantage organization must ensure that all covered services, including additional or supplemental services contracted for or on behalf of the Medicare enrollee, are accessible under the plan.

At a minimum, each provider must meet the following standards to ensure accessibility to our members. The following accessibility standards apply to all primary care physicians (PCPs), specialists, and ancillary providers:

1. Office waiting room time cannot exceed 30 minutes.
2. Provider should be accessible 24 hours a day, 365 days a year.
 - a. Providers must have a published after-hours phone number that may be included in a phone directory, on office business cards, or on insurance cards. This number must connect patients to an answering service, a hospital switchboard, an emergency department, or a paging system.
 - b. An office announcement directing patients to leave a message is unacceptable.

Medicare Quarterly Demographic Review

The Centers for Medicare and Medicaid Services regulation 42 CFR 422.111(b)(3) and (h)(2)(ii), 422.112, 423.128(d)(2) requires that all health plans work with their provider network on a quarterly basis to confirm that the provider demographic information in the online directory is accurate. Providers are required to review their demographic information in the MVP directory and notify MVP of any inaccuracies in order for the directory to be updated.

MVP is requesting on a quarterly basis that all Participating Providers follow these steps:

Step 1 – Go to www.mvphealthcare.com and click on *Find a Doctor* and then *Search by Provider*

Step 2 – Search for the provider(s) in your practice and review the following demographic information for accuracy:

- Ability to accept new patients;
- Street address, missing addresses, phone numbers; and
- Other changes that affect availability to patients. (e.g., handicap accessibility, specialty changes)

Step 3 – If demographic information is identified as incorrect, please use the change form to submit the correct information to MVP (This form can be found at www.mvphealthcare.com/providers/forms). Submit the form to the appropriate email or fax number on the form.

Step 4 – If the update applies to multiple providers in the group, please attach a roster of all providers the changes apply to, including the provider's name and NPI.

Step 5 - Fax or email the form to the appropriate regional fax or email address on the demographic change form based on the provider's location.

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

Note: If a provider determines that their demographic information is correct, then no action is needed on the part of the provider.

Medicaid Managed Care and Child Health Plus Variation to Access Standards

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

Coverage Arrangements

Participating primary care physicians must ensure that there is 24/7 coverage for members. Physicians may use a back-up call service, provided that a physician is available at all times to back up the call service. Participating physicians agree that, in the case of an absence, they will arrange for patient care to be delivered by another provider. They will make every effort to ensure that the covering provider participates with MVP. If arrangements are made with a non-participating physician*, it is the responsibility of the participating physician to ensure that the non-participating physician will:

- Accept MVP's fee as full payment for services delivered to MVP member patients
 - Accept the MVP peer-review procedures
 - Seek payment only from MVP for covered services provided to members and at no time bill or otherwise seek compensation for covered services from MVP members, except for the applicable copayments
 - Comply with MVP utilization management and quality improvement procedures
- *Note:** providers who are not contracted for Government Program lines of business are considered non-participating for Government Program plan types (Medicaid Managed Care and Child Health Plus).

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

Advance Directives

In accordance with state and federal law, individuals have the right to control their own medical care. Under these laws, MVP is obligated to provide our members with specific information regarding self-determination so that every competent adult may accept or refuse any recommended medical treatment. Members have the right to make advance directives about their medical care in the event that they may later lack the capacity to make such decisions. Providers are responsible for ensuring that the member's medical record incorporates information regarding the member's wishes with respect to the advance medical directives.

The Patient Self-determination Act (PSDA) requires that HMOs provide members with a statement of the patient's rights to make an advance directive. The New York State Department of Health defines advance directives as verbal or written instructions made by a patient before an incapacitating illness or injury that communicate the patient's wishes about treatments to be followed if the patient is too sick or unable to make decisions about care. Advance directives include but are not limited to: a health care proxy, consent to a Do-Not-Resuscitate (DNR) order, and a living will. The law requires that caregivers honor legally enforceable advance directives made by competent patients.

The Public Health Law of New York State requires that when an advance directive is given to a health care provider:

- The advance directive must be included in the member's medical record.
- The health care provider is required to comply with the health care decisions made by an agent under the advance directive to the same extent as the provider would comply with the member's decisions.
- The law does not require health care providers to honor health care decisions that are contrary to the provider's religious beliefs or sincerely held moral convictions. Under these circumstances, the provider must promptly inform the health care agent and transfer responsibility for the member to another provider.
- For Preferred Gold members age 18 and older, the medical record chart should contain a notation that there is an advance directive, or that the member was asked about completing one. This documentation should be prominently noted in the medical chart.
- MVP Health Care will monitor compliance through the Quality Assurance review process for medical records.

Emergency Care

Immediate patient access is the standard for emergency care.

In **New York**, a medical emergency is defined as a medical or behavioral condition, when onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- A. Placing the health of the afflicted person in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy;
- B. Serious impairment to the person's bodily functions;

- C. Serious dysfunction of any bodily organ or part of the person; or
- D. Serious disfigurement of the person.

In **Vermont**, emergency care is defined as medically necessary covered services to evaluate and treat an emergency medical condition. Further, 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 possesses an average knowledge of health and medicine, to result in:

- A. Placing the member’s physical or mental health in serious jeopardy; or
- B. Serious impairment to bodily functions; or
- C. Serious dysfunction of any bodily organ or part.

Emergency Services

“Emergency Services” are covered inpatient and outpatient procedures, treatments or services that are furnished by a qualified provider to evaluate or stabilize an emergency medical condition including psychiatric stabilization and medical detoxification from drugs or alcohol. Enrollees who need emergency services should call 911 and/or go to the nearest emergency room.

To the extent possible, the Enrollee should inform emergency room staff of his or her affiliation with MVP and notify his or her PCP of the visit.

If a member is in urgent need of medical advice or services, or if a member is in need of medical advice or services after regular business hours, but the member does not believe the need to be emergent, the member should call his or her PCP for advice.

Out-of-Network Emergency Services

If an MVP member is outside the Plan’s service area and requires emergency services as defined above are covered in the emergency room by non-participating providers and out-of-network hospitals.

Physicians Treating Self or Family Members

A look at the AMA’s regulation regarding self-treatment and treatment of family members.

The American Medical Association (AMA) has stringent guidelines regarding practitioner self-treatment or treatment of immediate family members. The AMA Code of Ethics E-8.19 addresses this issue in detail.

Practitioners should not write prescriptions for themselves or their family members except in a true emergency. Continued writing of narcotic prescriptions can lead to abuse and addiction with potentially fatal consequences to the practitioner or their relative.

MVP endorses the AMA's position regarding practitioner self-treatment and treatment of immediate family members. MVP will not provide reimbursement for such care and this is noted in the member's contract.

Change in Demographic Information or Termination of Participation

The provider's participation agreement is directly with MVP or through a Provider Organization (IPA, PHO, PO). Accordingly, the termination conditions are dictated by the specific contract. Participating providers are required to provide prior written notice to MVP to announce their termination of participation in MVP's network. Participating providers are asked to refer to their provider agreement for the amount of prior notice required. For Preferred Gold, CMS requires that a provider give at least 60 days' notice for termination without cause. MVP's provider contracts may require more than 60 days' notice; therefore, refer to the provider contract for the agreed-upon notice requirement. If a provider voluntarily terminates his/her contract, MVP will make a good faith effort to notify all affected members of the termination within 30 days of receiving notice.

Participating providers should notify MVP of any demographic changes per their contractual agreement. Failure to update demographic information may result in claim denials. Providers should contact MVP regarding the demographic changes via email or complete the demographic change form found on MVP's website at <https://www.mvphealthcare.com/providers/forms/>, click on Provider Demographic Change Forms and click on [Contracted/Non-Contracted Provider Change of Information Form \(All Regions\)](#) follow the instructions on the form on how to submit the form to MVP.

In addition per NYS Out of Network Surprise Bill; providers are required to review their hospital affiliations and languages spoken on a yearly basis and update the plan when this has been completed. Providers may make the change on their CAQH application and attest the information is correct per CAQH standards. MVP will review all changes made on the CAQH application and contact the provider with any questions.

Transition of Care

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

Transitional care applies to all members whose provider leaves MVP's network and is receiving an active course of treatment for an acute episode of chronic illness or acute medical condition.

Transitional care also applies to all members whose provider leaves MVP's network and is receiving an ongoing course of treatment for a life-threatening, disabling, or degenerative disease or condition. MVP members will not be offered the opportunity to continue care if the provider's departure is due to:

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

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

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

Members requesting transition care should contact the Customer Care Center to obtain the necessary documentation.

Continuation of Care

NY HMO Company Only

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

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

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

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

Cultural and Health-related Considerations

All providers must ensure that services are provided to all members in a culturally competent manner, including services for those members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds and physical or mental disabilities or conditions.

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

TRAINING PROGRAM OVERVIEW – Medicaid Only

In collaboration with Beacon Health Options, we are developing materials and a training curriculum specific to the HARP program. Many of the materials will be developed in collaboration with OMH and the RPCs. This program will offer providers the skills, and expertise to comply with the requirements under managed care. This program will transition as a foundation for ongoing new provider credentialing and recredentialing.

Overview of HCBS including:

- Overview and purpose of the waiver services
- Medical necessity
- Prior authorization process
- Care planning – person-centered planning process
- Independent evaluations
- Qualifications for providers
- What is a critical incident and what are the reporting requirements
- Cultural Competencies

Beacon will reach out all providers required to take this training to provide a schedule of offered training sessions. Most training will either be live webinars or self-paced web training.

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

MVP requires that all MRI/MRA, CT/CTA and PET machines used to render services to MVP members have accreditation from the American College of Radiology (ACR) or from the Intersocietal Accreditation Commission (IAC). This aligns MVP's protocol with Medicare guidelines that required machines to be ACR-accredited as of January 1, 2012.

Provider offices that are approved to perform these high-tech imaging services are required to submit proof of ACR or IAC accreditation to MVP for all MRI/MRA, CT/CTA, and PET equipment utilized for MVP members. Providers' offices that are not accredited and do not submit proof of ACR or IAC accreditation to MVP may not perform these services to MVP members in their office, and will not be reimbursed for such services.

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

MVP Mid-Level and Ancillary Practitioner Registration or Contracting Requirements

Registration Requirements. Mid-level and Ancillary Practitioners who provide services in an MVP participating physician’s practice must be registered with MVP. Mid-level and Ancillary practitioners subject to this registration requirement include all office-based physician extenders, including but not limited to: Nurse Practitioners (NP)*; Physician Assistants (PA); Certified Registered Nurse Anesthetists (CRNA); Certified Nurse Midwives (CNM)*; Advanced Practice Register Nurses (APRN)**; Anesthesia Assistants (AA) (VT only); Clinical Nutritionists and Certified Dietitians.

Only mid-level and ancillary practitioners whose collaborating physicians are MVP **participating providers** are eligible for registration. Mid-Level and ancillary practitioners must have the same specialty as their collaborating physician. If an ancillary practitioner is a **hospital employee** who practices in the Inpatient- and/or Outpatient hospital setting, then registration with MVP is **not required**.

Billing and Payment Rules. MVP payments for services rendered by registered mid-level practitioners will be made to the participating MVP physician’s billing address under that collaborating physician’s Tax ID #. No claims will be paid to the registered mid-level practitioner directly.

Services rendered by MVP registered mid-level and ancillary practitioners must be billed using their individual type 1 NPI number **and** their collaborating MVP participating physician’s Tax ID number. Mid-levels may not bill using their collaborating physicians’ NPI number. Please refer to MVP’s website for information on billing with an NPI Number.

Mid-levels must also bill with the specialty taxonomy associated with their collaborating physician. If a Mid-level Please refer to MVP’s website for information on billing with an NPI Number.

Mid-level and Ancillary Practitioners who have opted out of Fee-for- Service (FFS)

Medicare may not render services to MVP Medicare Gold patients. This rule applies to all mid-level and ancillary practitioners who have opted out of Medicare FFS, regardless of whether the MVP participating physician with whom they practice has opted in to FFS Medicare and is a participating provider with the MVP Medicare Gold products.

Hospital-Based Mid-Levels: Mid-level providers listed above that are hospital employees and whose services are billed under a hospital Tax ID, and whose services are provided within the inpatient (POS 21) or outpatient (POS 22 and 23) setting, do require registration in order to receive payment if contractually applicable. Mid-level hospital employees (billing under the hospital Tax ID) who provide services **must** have a supervising physician who is participating with MVP.

Registered Nurse First Assistants (RNFA) who work exclusively in the hospital and are credentialed and privileged by the hospital are required to be registered with MVP. MVP will

not reimburse RNFAs for services provided to an MVP Medicare member. RNFAs that are not working exclusively in the hospital please see section 11 for MVPs credentialing requirements.

If you have any questions regarding Mid-levels employed by the hospital and their registration requirements please contact your contracting manager or professional relations representative.

Clinical Nutritionists and Dietitians: Mid-levels with this specialty must be credentialed and contracted with MVP. The credentialing and contracting process includes satisfying MVP's current credentialing requirements outlined in Section 11. These providers are not required to have a collaborating physician and can bill with their own TIN #. Contracts can be obtained by contacting the regional office at the email address provided in *Section 1*. Clinical Nutritionists and Dietitians who are employed by a hospital are subject to the Hospital Based Mid-level rules detailed in the above paragraph and must be registered. If you have any questions regarding contracting or registration requirements please contact your contracts representative or professional relations representative. Contact information can be found in the contact information in *Section 1* under Credentialing.

***Certified Nurse Midwives/Nurse Practitioners: Nurse Practitioners and Certified Nurse Midwives in the state of New York who do not render services in an MVP participating physician's office are *not eligible for registration with MVP*.** Such independently practicing nurse practitioners and certified nurse midwives must be **credentialed by and complete a contract** with MVP. The credentialing and contracting process includes satisfying MVP's current credentialing requirements outlined in Section 11. Certified Nurse Midwives who are employed by a hospital are subject to the Hospital Based Mid-level rules detailed above. Nurse Practitioners who do not meet the credentialing requirements must be registered with MVP and follow all registration requirements outlined above. In order for MVP to approve the services of a non-participating nurse midwife in compliance with a State mandate, the nurse midwife must satisfy MVP's current liability insurance requirements and must have an arrangement with a collaborating physician.

****Advanced practice registered nurse registration and/or contracting subject to MVP credentialing policies and criteria.**

Ancillary providers not listed here should refer to *Section 11* to determine if they are required to be credentialed with MVP. Mid-levels that are unsure if a contract is required with MVP should contact their regional contracting representative with any questions. Contact information can be found in the contact information in *Section 1*.

Note: Contracting, credentialing, and registration requirements may vary by state and product. Providers should review their MVP contract to determine if they have a contractual variation which will supersede this policy.

Provider Complaints

MVP is committed to ensuring that health care providers have a positive experience with the plan. Providers may formally voice concerns on any issue that they have not been able to get resolved in a timely matter. Providers can voice a complaint by contacting the Customer Care Center for Provider Services or their Professional Relations Representative. Providers also may submit a complaint in writing to:

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

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

Non-Participating Provider Joining a Participating Group

To remain compliant with the New York state law, any health care provider who joins a participating provider group is loaded as a non-participating provider. New providers joining a participating group should contact MVP to begin the credentialing process. New providers are considered non-participating until they have been fully reviewed and approved by MVP's Credentialing Committee.

Provider Communication

MVP will notify providers of all policy and procedure changes in a timely matter as stated in the provider's contract. All updates will be communicated with providers by one of the following means:

- *Healthy Practices*—Issued six times a year in January, March, May, July, September and November
- Email – Providers who have opted in to receiving email communications will receive *Healthy Practices* via email. In addition, MVP may utilize the email options to send policy updates to providers.
- *FastFaxes*—MVP may utilize the option to fax communications to providers' offices.
- MVP website—MVP may announce upcoming changes at **www.mvphealthcare.com/provider**
- Direct Mailings—MVP may send direct mailings to physicians regarding changes to contracts and policies.

Collecting Patient Responsibility

Providers can determine a member's cost share by accessing the benefits display tool on the MVP Provider Portal. The MVP Provider Portal will indicate if the member is responsible for a co-payment, coinsurance, or deductible, which are defined as follows:

Copayment – means the charge for covered services not covered by premiums, paid by or on behalf of members, directly to physician pursuant to the terms of the subscriber Contract. Copayment fees are normally paid at the point of service when the service is rendered. Examples of co-payment fees include fees charged for office visits, home visits, outpatient prescriptions and emergency room visits. Copayment levels or amounts are contained in the MVP Subscriber Contract for the plan in which the member is enrolled and include:

- A set amount the patient will be responsible to pay for services provided
- Coinsurance – means a cost sharing arrangement in which members are required to pay a specified percentage of Physician's charges for covered services directly to Physician. Coinsurance levels or amounts are set forth in the MVP subscriber contract for the plan in which the member is enrolled in a set percentage of the allowed amount the patient will be responsible for services provided.
- Deductible – means a cost sharing arrangement in which members are required to pay a specified amount for covered services before MVP is required to make payment therefore. Deductible levels or amounts are set forth in the MVP Subscriber Contract for the plan in which the member is enrolled. The patient is responsible for the full contracted allowed amount for a service provided until they have reached their deductible. Some products do not have a cost share after the deductible has been met while others have a coinsurance or copay. This can be determined by checking the member's benefits online.

A member's copayment is due at the time of service; therefore, providers may collect member's copayment amount at the time of service. Providers may collect member's coinsurance and deductibles only if the amount due is known to the Provider and the member. Provider should wait to collect coinsurance and deductible amounts until the provider has submitted the claim and received the remit from MVP indicating the member's responsibility. Providers can check the member's deductible accumulator in the patient eligibility section of MVP's Provider Portal to determine if they will be responsible for the deductible or if the deductible has been met.

Participating providers with MVP are entitled to only collect the members copay, coinsurance, or deductible. Providers cannot bill a member a surcharge if they do not pay their cost share at the time of visit based on MVP contractual obligations.

Ownership and Disclosure Requirements – New York Only/Medicaid Only

Pursuant to applicable federal and state law, including specifically 42 CFR 455.104, 42 CFR 455.105, Section 18.6 of the MMC Contract, and Section B(9)(j) of the New York State Department of Health Standard Clauses (effective May 1, 2015), all Medicaid participating provider facilities must disclose to MVP their complete ownership, control, and relationship information. Accordingly, MVP requires that all Medicaid participating provider facilities complete an Ownership and Disclosure form. The Ownership and Disclosure form can be found <https://www.mvphealthcare.com/providers/join-mvp/> and click on Professional Relations Disclosure Forms. The Ownership and Disclosure form must be completed by the facility and include disclosure of complete ownership, control, and relationship information of the entity and all individuals or organizations having a direct or indirect ownership or controlling interest of

five percent (5%) or more and any directors, officers, agents, or managing employees of the entity. The term “facilities” as used in this paragraph includes without limitation Hospitals, Free Standing Ambulatory Surgery Centers, Skilled Nursing Facilities, Dialysis Centers, Laboratory’s, Durable Medical Equipment Facilities, Home Health Care Facility, Urgent Care Centers and Federally Qualified Health Centers. The Ownership and Disclosure form must be completed at the time a Medicaid participating provider facility first contracts with MVP. Thereafter, each Medicaid participating provider facility is responsible for updating MVP any time there is a change in direct or indirect ownership or controlling interest of five percent (5%) or more and/or a change in any directors, officers, agents, or managing employees of the entity each Medicaid participating provider facility is required to resubmit the Ownership and Disclosure form within thirty-five (35) days of the change. MVP will follow applicable regulatory requirements associated with the disclosure of this information, up to and including not executing a contract, or non-renewal or termination of any contracts with entities found not to be in compliance with this requirement. Note that this requirement does not apply to individual physicians or ancillary practitioners or groups of physicians or ancillary practitioners.

Disclosure of Criminal Activity Requirements – New York Only/Medicaid Only

Pursuant to applicable federal and state law, including specifically 42 CFR 455.106, Section 18.12(b) of the MMC Contract, and Section B (9) (h) of the New York State Department of Health Standard Clauses (effective May 1, 2015), all Medicaid participating providers must ensure that all persons affiliated with the provider, including but not limited to owner/person with controlling interest, agent, or managing employee, have been screened for health care related criminal conviction. Accordingly, MVP requires that all Medicaid participating providers complete a Disclosure of Criminal Activity form. The Disclosure of Criminal Activity form can be found on <https://www.mvphealthcare.com/providers/join-mvp/> and click on Professional Relations Disclosure Forms. This Disclosure of Criminal Activity form must be completed by all facilities, physician/physician groups, and ancillary practitioner/ancillary practitioner groups that are participating with MVP. The Disclosure of Criminal Activity form must be completed at the time a Medicaid participating provider first contracts with MVP. Thereafter, each Medicaid participating provider is responsible for updating MVP any time there is a change regarding health care related criminal convictions of persons affiliated with the provider within five (5) days of becoming aware of a criminal conviction. MVP will be responsible for reporting this criminal activity information to New York State Department of Health within twenty (20) days of being notified by a Medicaid participating provider of a criminal conviction. MVP will follow applicable regulatory requirements associated with the disclosure of this information, up to and including not executing a contract, or non-renewal or termination of any contracts with entities found not to be in compliance with this requirement.

Exclusion Database Monitoring Requirements – New York Only/Medicaid Only

Pursuant to applicable federal and state law, including specifically Section 18.9(d) of the MMC Contract and Section B(9)(i) of the New York State Department of Health Standard Clauses (effective May 1, 2015), all Medicaid participating providers must have procedures in place to identify and determine the exclusion status of employees and staff associated with a Medicaid participating provider through checks of exclusionary databases listed below and must monitor

exclusion status of such employees and staff with the frequency listed below. Accordingly, MVP requires that all Medicaid participating providers complete an Attestation Regarding Monitoring of Exclusionary Databases. The Attestation Regarding Monitoring of Exclusionary Databases can be found on <https://www.mvphealthcare.com/providers/join-mvp/> and click on Professional Relations Disclosure Forms. The Attestation Regarding Monitoring of Exclusionary Databases must be completed by all facilities, physician/physician groups, and ancillary practitioner/ancillary practitioner groups that are participating with MVP. The Attestation Regarding Monitoring of Exclusionary Databases must be completed each year. Additionally, each Medicaid participating provider is responsible for updating MVP any time any of its employees or staff associated with the Medicaid participating provider shows up on the exclusionary databases as soon as the Medicaid participating provider becomes aware of the change in the exclusion status. MVP will follow applicable regulatory requirements associated with the disclosure of this information, up to and including not executing a contract, or non-renewal or termination of any contracts with entities found not to be in compliance with this requirement.

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

- U.S. Office of Inspector General's List of Excluded Individuals and Entities (OIG-LEIE): <http://exclusions.oig.hhs.gov>
- U.S. General Service Administration's System for Award Management (GSA-SAM) (formerly known as the Excluded Parties List System (EPLS)): <https://www.sam.gov>
- New York State Office of the Medicaid Inspector General List of Restricted and Excluded Provider (OMIG Exclusion List): <https://www.omig.ny.gov/search-exclusions>
- U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists (including the Specially Designated Nationals (SDN) List as well as the Non-SDN Palestinian Legislative Council List (NS-PLC List), the Part 561 List, the Non-SDN Iran Sanctions Act List (NS-ISA List), the Foreign Sanctions Evaders List (FSE List), the Sectoral Sanctions Identifications List (SSI List), and the List of Persons Identified as Blocked Solely Pursuant to Executive Order 13599 (13599 List)): https://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/fuzzy_logic.aspx

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

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

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