

Utilization Management (UM) activities include:

- Prospective review/Prior authorizations
- Concurrent review
- Care Advantage
- Discharge planning
- Retrospective review
- Case management
- Care management

Prospective review takes place before a service is provided.

Concurrent review takes place while treatment is in progress.

Retrospective review is performed after treatment has been completed.

Medical Determinations and Utilization Management Criteria

MVP uses InterQual[®] criteria as a guideline for its utilization management decisions for most medical services. MVP also ensures that entities performing delegated UM use nationally accepted criteria that are annually reviewed and approved by MVP's Quality Improvement Committee.

MVP's Behavioral Health Services are managed by different Behavioral Health Management Organizations depending on a member's product:

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 (NYS Medicare Residents)	Authorization Requests	Beacon Health Options	1-800-665-7924
	Provider Relations Contracting Credentialing		1-800-397-1630
NY Medicaid Managed Care NY Child Health Plus NY Health and Recovery Program (HARP)	Authorization Requests	Beacon Health Options	1-844-265-7595
	Provider Relations Contracting Credentialing		1-844-265-7592
NY Essential Plan	Authorization	Beacon Health	1-888-723-

	Requests	Options	7967
	Provider Relations Contracting Credentialing		1-844-265-7592
VT Commercial VT Self-Funded VT Medicare (VT Medicare Residents)	Authorization Requests	PrimariLink	1-800-320-5895
	Provider Relations Contracting Credentialing	MVP Health Care	1-888-687-6277

The vendors' clinical criterion is available on each of the vendor's web site and available upon request to the provider and member.

MVP delegated responsibility for prospective UM review of selected contract's requests for MRI/MRA, PET Scan, Nuclear Cardiology, CT/CTA and 3D rendering imaging services to eviCore healthcare (formerly known as CareCore National, LLC) in Bluffton, South Carolina. eviCore healthcare is also delegated responsibility to perform UM review on Radiation Therapy for selected contracts. eviCore clinical and physician reviewers are licensed clinicians who use nationally recognized clinical protocols to make UM determinations. eviCore utilizes evidence-based guidelines and recommendations for imaging from national and international medical societies and evidenced-based medical research centers. Sources include the American College of Radiology Appropriateness criteria, Institute for Clinical Systems Improvement Guidelines, National Comprehensive Cancer Network Guidelines, and the National Institute for Health and Clinical Excellence Guidelines. To obtain an authorization please call Customer Care Center Provider at **1-800-684-9286** and follow the radiology prompts.

MVP delegated responsibility for UM of chiropractic care, massage therapy and acupuncture for all applicable lines of business to Landmark Healthcare, an eviCore healthcare company, in Sacramento, California. Landmark medical directors, all of whom are licensed chiropractors, massage therapists or acupuncturists, use nationally accepted clinical protocols to make UM determinations. Contact Landmark's UM Department at **1-800-638-4557**.

MVP delegated responsibility for UM of dental services in counties where the dental benefit is offered to Healthplex, Inc., in Uniondale, NY. Healthplex's UM department uses the most current version of Current Dental Terminology published by the American Dental Association. Dentists can reach a Healthplex representative by calling **1-888-468-2183**.

MVP delegated responsibility for prospective and concurrent UM to Connecticut General Life Insurance Company (Cigna) for select self-funded plan and fully insured members who reside or travel outside of the MVP service area, excluding HMO and Medicare members when the care is provided by a CIGNA provider. CIGNA uses nationally accepted clinical protocols as guidelines

to make UM determinations. CIGNA providers outside of the MVP service area may contact Cigna directly. To contact a CIGNA representative, call **1-800-882-4462**.

Effective July 1, 2017, naviHealth, Inc. will provide Utilization Management for Skilled Nursing Facility (SNF), Acute Inpatient Rehabilitation (AIR) and Home Health services for *Medicare Advantage members ONLY*. naviHealth staff will be located in each of MVP's regions to visit facilities and manage the transitions. naviHealth can be reached via the website at **www.naviHealth.us** or **1-844-411-2883**.

Health care providers may request a copy of the specific criteria used to make a UM determination by calling the Customer Care Center - Provider at **1-800-684-9286**. The criteria will be mailed or faxed to the provider's office with a proprietary disclaimer notice. Members may request a copy of the specific criteria used to make a UM determination by contacting the Customer Care Center telephone number on the back of the MVP Member ID card.

MVP uses a Benefits Interpretation Manual (BIM) to determine if a service is medically necessary. Providers may access MVP's BIM online at MVP's website. In addition, providers may offer feedback about the policies to MVP via email. MVP will consider that feedback in future policy development.

MVP uses the Pharmacy Program Administration and various MVP Pharmaceutical Policies to review the medical appropriateness for pharmaceutical therapies.

To access the online BIM, follow these instructions:

1. Go to www.mvphealthcare.com, and click on *Providers*
2. Enter your username and password, then click *Log in* (or click *Register* on the left side of the screen to create a login)
3. Click the *References* tab
4. Select *Benefits Interpretation Manual* from the References page

If you have questions or suggestions, use the email link listed on the introduction page.

At least annually, the health plan requests a review of the utilization management clinical guidelines and criteria by in-plan practitioners and the Medical Management Committee to assure that the criteria used during prospective, concurrent and retrospective reviews are appropriate for all patients in the community.

Providers are notified of new or revised policies via *FastFax* notification and/or through *Healthy Practices*. The new or revised policies are published on MVP's website www.mvphealthcare.com following notification.

For Medicaid Managed Care members, the health plan may apply NYS Medicaid Guidelines (EMedNY and/or State Coverage Question responses found on the State Health Commerce Site) to assist with coverage determinations.

Medical necessity determinations for Medicare Advantage members are rendered using guidance from the Medicare Coverage Database for any pertinent Local Coverage Determination (LCD) or National Coverage Determination (NCD) Policies in addition to MVP's medical policies. The Medicare Coverage Database is available online at: www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Financial Incentives Relating to Utilization Management

It is MVP's policy to facilitate the delivery of appropriate health care to its members and to monitor the impact of the plans UM program to ensure appropriate use of services. MVP's UM program does not provide financial incentives to employees, providers, or providers who make utilization management decisions that would encourage barriers to care and services.

Furthermore,

- Utilization management decisions are based only on appropriateness of care and the benefits provisions of the subscriber's coverage;
- MVP does not reward providers or staff, including medical directors and UM staff, for issuing denials of requested care; and
- MVP does not offer financial incentives, such as annual salary reviews and/or incentive payments, to encourage inappropriate utilization.

Adverse Determinations (Prospective, Concurrent, Retrospective)

When MVP denies a service through the UM processes, this is called an adverse determination. Adverse determinations for prospective, concurrent and retrospective reviews are rendered upon receipt of all necessary medical information. Adverse determination cases are reviewed by the medical director within mandated timeframes.

After an adverse determination is made by the medical director, for non-urgent and urgent requests, the clinical reviewer performing prospective and concurrent reviews contacts the requesting physician or facility by telephone to discuss the adverse determination and to inquire if there is additional medical information available. An opportunity to speak with the medical director is offered. If there is no new information forthcoming, the nurse explains the Appeal process. When the requesting physician is notified in writing of the adverse determination, he/she is, again, advised of their rights (ability to request a reconsideration or appeal of the decision and, if applicable, speak with the medical director who made the decision). For urgent acute hospital services, reconsideration is performed when the hospital submits, during the acute stay, the complete current medical record to the Concurrent Review Unit. Review of the reconsideration request is completed within one (1) business day of receipt of the request, and must be conducted by both the requesting provider and the medical director making the initial determination. Written notification and verbal notification of an adverse determination is generated to the member (or designee) and the requesting physician in accordance with regulatory timeframes.

When new medical information is submitted and services have not been rendered, the case is re-opened in Utilization Management (this is not applicable for Medicare – preservice urgent

and non-urgent reviews, see variation under Reconsiderations section below). The new information is reviewed by the Medical Director who documents the rationale to uphold or reverse the denial. The requesting provider and member are notified of the determination and in writing in accordance with regulatory timeframes.

Verbal and Written Communications on Utilization Review Determinations (Prospective, Concurrent, Retrospective)

MVP notifies members and providers, in accordance with the respective regulations, verbally and / or in writing. Verbal notice is performed on prospective (before service) and concurrent (during service) determinations. For inpatient stays, verbal notice is provided to the facility to communicate the determination to the member. MVP will make one attempt to reach the member and provider for verbal notices. Written notice is provided for all prospective, concurrent and retrospective (after service) determinations.

Written notice of an adverse determination is provided to the member and the requesting provider. For urgent acute hospital services, the health plan notifies the hospital UM/Case Manager, who verbally communicates the adverse determination and provides the member's written notification. The member and the requesting physician's written notification of an adverse determination includes the rationale for the decision; instructions for initiating an appeal; the name of the criteria used in making the determination; and, notice of the availability of the Clinical Criteria used in making the determination (see Medicaid Managed Care Variation below). The member and/or requesting physician may appeal in writing and/or telephone with the Customer Care Center.

Determinations not made within required timelines automatically result in an adverse determination and are subject to appeal. MVP must make a standard appeal determination within 60 calendar days after receipt of the necessary information. Review turnaround times are monitored monthly to ensure requirements are met. In the event that review determination rates drop below requirement/target, a process will be developed to secure timely review determinations.

Expedited and standard appeals will be conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination.

Medicaid Managed Care Variation

For New York State Government Programs (MVP's Medicaid Managed Care, Child Health Plus and HARP programs), a Fair Hearing form accompanies the Initial Adverse Determination letter. For either non-urgent or urgent adverse determinations, the clinical reviewer makes one (1) telephone notification attempt to the physician's office, and member. For urgent acute hospital services, the health plan notifies the hospital UM/Case Manager, who verbally communicates the adverse determination and provides the member's written notification. The member and the requesting physician's written notification of an adverse determination includes the rationale for the decision, instructions for initiating an appeal, the name of the criteria used in making the

determination, and notice of the availability of the Clinical Guidelines used in making the determination. The member and/or requesting physician may appeal in writing and/or telephone with the Customer Care Center.

For NYS Medicaid Managed Care program:

Timeframes for prior authorization and concurrent review determinations, both standard and expedited, may be extended for up to 14 calendar days if:

- The enrollee, the enrollee's designee or the provider requests an extension orally or in writing; or
- MVP can demonstrate or substantiate that there is a need for additional information and how the extension is in the enrollee's best interest. MVP must maintain sufficient documentation of extension determinations to demonstrate, upon DOH request, that the extension was justified.

MVP will make a decision and provide notification to the member and provider by telephone and in writing within 14 calendar days after receipt of the Service Authorization Request.

The written notice of an adverse determination (initial adverse determination) will include:

- A description of Action to be taken,
- Statement that MVP will not retaliate or take discriminatory action if appeal is filed,
- Process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review,
- The enrollee right to contact DOH, with 1-800 number, regarding their complaint,
- The Fair Hearing notice including aid to continue rights statement that notice is available in other languages and formats for special needs and how to access these formats.

Expedited and standard appeals will be conducted by a clinical peer reviewer provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

MVP must send notice of denial on the date review timeframes expire.

Medicare Reconsiderations (Prospective, Concurrent, Retrospective, Urgent and Non-Urgent)

Medicare pre-service and concurrent - any review request received after the initial adverse determination is considered an appeal. MVP Utilization Management will redirect any Medicare appeals to the Appeals unit for processing.

Medicare post-service medical necessity reviews, any payment dispute (or re-review) is processed by the Retrospective Review unit and reviewed within 30 calendar days of the request, *See the Reconsiderations Section below for more information.*

Services that Require a Referral for MVP Medicaid Managed Care

Restricted recipient members—Referrals are required to ALL specialties for members who have a physician restriction. Providers should verify eligibility by using MVP’s website www.mvphealthcare.com, using the MVP ID number (not CIN) presented on the ID card.

Contact MVP’s Customer Care Center - Provider at **1-800-247-6550** to obtain a referral for restricted recipient members.

Out-of-Plan Referral Process (only applies to plans without out-of-network benefits)

The PCP or MVP Participating Specialist must submit a written request to MVP’s UM Department using the Prior Authorization Request Form located at www.mvphealthcare.com under the “Forms” section. The out-of-plan referral will be approved only if MVP does not have a participating physician with the appropriate training or experience needed to treat the member.

Prior Authorization

MVP requires prior authorization for select procedures and health care services. It is the provider’s responsibility to obtain prior authorization no less than five calendar days prior to the procedure. Services requiring prior authorization are not covered benefits until or unless MVP or its UM delegate reviews and grants prior authorization for the service. Providers are responsible for services if rendered without prior authorization. The member is not liable for services rendered without a prior authorization, in accordance with the provider’s contract with MVP and NYS Department of Health laws.

Emergency services are not subject to prior authorization. There will be no payment for services determined to be not medically necessary. Emergent Medical Necessity is defined for all plans as health care and services that are necessary to prevent, diagnose, manage or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

Services requiring prior authorization are listed in the UM Policy Guide, which is updated bi-annually. The guide’s most recent version is available on the MVP website www.mvphealthcare.com, or by calling the Customer Care Center – Provider at **1-800-684-9286**. Please be sure to update the UM Policy Guide each time your office receives a new copy with MVP’s *Healthy Practices* newsletter. Providers also may check the website for the online Benefits Interpretation Manual to identify the plans that require prior authorization of services.

In-Office Procedure and Ambulatory Surgery Lists

Participating providers and their office staff can access the In-Office Procedures and Ambulatory Surgery Lists at www.mvphealthcare.com in the *Reference Library* section. Contact your Professional Relations Representative if you prefer a paper copy. Please note:

- The In-Office Procedure List: CPT® codes that MVP requires to be performed in the physician’s office. Claims submitted with a place of service other than the physician’s office will be denied unless prior authorization is obtained.

- The Ambulatory Surgery List: CPT/HCPCS codes that MVP will reimburse when performed in the ambulatory surgery or in-office settings. Claims submitted with an inpatient setting will be denied unless prior authorization is obtained. The Ambulatory Surgery List will be in effect through July 31, 2017, and discontinued thereafter.
- The Inpatient Surgery List: Procedure codes that are not included on the Inpatient Surgical List will require prior-authorization for place of service if being requested to be performed in the inpatient site of service. The Inpatient Surgical List is effective for services performed as of August 1, 2017 and after.
- All procedures are subject to the member’s plan type and benefits.

Durable Medical Equipment Dispensed by Physicians, Podiatrists, Physical Therapists and Occupational Therapists

Physicians and other practitioners (including, but not limited to: podiatrists, physical therapists, occupational therapists and chiropractors) may not act as a DME provider/vendor (exceptions to follow). Basic DME items can be provided for stabilization and safety to prevent further injury, as a convenience to our members without prior authorization. Examples of such items are simple canes, crutches, walkers (for safe ambulation), “off-the-shelf” bracing, air casts and walking boots (for joint/muscle immobilization to prevent further injury). These items must be billed with the office visit, using the appropriate HCPCS code, provided they are not listed on the DME prior authorization code list. All other DME, O&P and specialty equipment and services must be obtained from a participating DME, orthotics, prosthetic or specialty provider/vendor. Physical and Occupational therapists may fabricate and dispense custom hand splints without prior authorization for the following codes:

L3760 L3702 L3710 L3762 L3806 L3807 L3808 L3906 L3908 L3913 L3915 L3917 L3919 L3921 L3923 L3925 L3927 L3929 L3931 L3933 L3935 L3980 L3982 L3984

Podiatrists may provide and bill for:

- Foot orthotics, using the appropriate “L” HCPCS codes, when the member’s contract includes the Foot Orthotic Rider, without prior authorization.
- Shoe inserts and shoes for members who have a diagnosis of diabetes, with or without a Foot Orthotic Rider, using the appropriate “A” HCPCS codes, without prior authorization.
- Ankle Foot orthotics must follow the prior authorization process. Ankle Foot orthotic codes that require prior authorization can be found on the MVP Health Care website, under the Provider section, on the Durable Medical Equipment web page www.mvphealthcare.com/provider/dme.html along with the DME Prior Authorization request form.

Durable Medical Equipment, Orthotics, Prosthetics, and Specialty Vendors

For information regarding DME, prosthetics, orthotics and specialty equipment, visit the MVP Health Care DME web page at www.mvphealthcare.com/provider/dme.html.

- Prior Authorization Request Form (PARF)
- Copies of communications—letters and *FastFaxes*
- Prior Authorization Code lists—with and without descriptions

Verify member eligibility and DME benefits before submitting a prior authorization request by calling the Customer Care Center - Provider at **1-800-684-9286** (Medicaid/CHP/HARP eligibility call **1-800-247-6550**). Completed PARF's are faxed to **1-888-452-5947**. Durable Medical Equipment payment policies can be found in Section 15.

Neuropsychological Testing

Neuropsychological Testing is being managed by the MVP UM department. Questions should be directed to the Customer Care Center - Provider at **1-800-684-9286**. The policy is available on the MVP Health Care website.

Completing the Prior Authorization Request Form (PARF)

- If clinically urgent, call the Customer Care Center - Provider at **1-800-684-9286** to advise that an urgent request has been sent.
- Be sure to fax all relevant medical documentation (e.g., office notes, lab, or radiology reports) with the completed PARF. Do not fax photos – mail them to the appropriate UM department.
- Be sure to indicate a contact name for the UM staff to call.
- Be sure to sign and date the PARF.
- Upon receipt of the PARF, a determination will be made and the provider's office will be notified by phone and mail within the mandated time frames by line of business.

Please note: Faxes received after 4:00pm are considered the next business day's review.

If additional information is needed to make a determination, the appropriate UM department will make one attempt to contact the provider's office to obtain this information. If this attempt is unsuccessful, then a letter will be sent to the provider's office within:

- 24 hours of receipt of an initial urgent request, or
- Three calendar days of receipt of an initial routine request.

When additional information is received and a decision has been made:

- The member and provider will be notified by telephone and in writing within 3 business days of receipt of additional information for all plans.
- For Medicaid Managed Care, notification will be provided by telephone and in writing within three business days of receipt of information but no more than 14 calendar days after receipt of the initial request.
- Additional information must be received within:
 - 48 hours from the receipt of MVP's letter for a urgent request, or
 - 45 calendar days from the receipt of MVP's letter for a routine request
 - Medicaid Managed Care 14 days of the date of the original request for services.

Once the additional information is received, a review will be performed and the request will be forwarded to a medical director for a determination, if necessary. If a provider's office has

questions about whether or not specific services require prior authorization, contact Professional Relations or MVP's UM department.

Note: The above time frames do not apply to MVP Select Care (ASO) groups that follow ERISA mandatory time frames.

Concurrent Review

All inpatient acute medical admissions (excluding normal vaginal and C-section deliveries for all products, except Medicaid Managed Care, Child Health Plus and HARP) require notification to the health plan the next business day following the admission by the facility. Prior notification is still required for admissions or services with non-participating providers or facilities, and for infants who are transferred to the Newborn Intensive Care Unit (NICU) for all MVP Products. Hospital notification is performed by faxing notifications to the Customer Care Center – Provider at **1-800-280-7346**.

Concurrent review occurs when a member is admitted to an inpatient facility on an emergent or an elective basis. An MVP nurse reviewer or an MVP delegate's nurse, reviews select admissions by fax, telephone or electronic medical record. Working in conjunction with the member's attending physician and facility UM staff, the concurrent review nurse obtains clinical information during the member's inpatient stay to determine whether MVP will provide coverage.

Clinical updates should be faxed to **1-888-207-2889**. If sufficient information is provided to demonstrate the medical necessity of the admission and/or continued stay, the UM nurse notifies the facility's UM department of the decision.

In cases where continued care can be safely provided in an alternative setting and the member's care does not require acute care services based on the community standards for care and the member's individual needs, a discussion will occur between the hospital representative and the health plans UM nurse.

If the physician or hospital representative, on behalf of the physician, agrees to discharge the member and the discharge order is written in the chart, the UM nurse or Case Manager is available to work with the facility and to facilitate the post-discharge referrals. This may include contacting the physician, the member and/or the member's family. If the member refuses discharge once the physician has written the discharge order, and the hospital notifies the UM nurse of the member's refusal to leave, the UM nurse will refer the case to the medical director for potential denial. If the medical director denies hospital admission or continued stay and the physician has written a discharge order, then MVP will provide a denial letter for the hospital to deliver to the member resulting in the member's potential financial responsibility for the admission or the continuation of stay. Termination of benefits may occur and the member may be financially liable for continued stay.

If the physician or hospital representative on behalf of the physician disagrees to discharge the member, the UM nurse will refer the case to the medical director. The health plan medical director may authorize a lower level of care for payment purposes. A change in provider reimbursement letter is sent and the member is liable for the copayments/coinsurances applicable to the authorized level of care. If the member's clinical picture changes, reconsideration can be performed as outlined at the end of Section 5.

If there is not sufficient information to demonstrate the medical necessity of the stay, the UM nurse works in conjunction with the facility's UM department and/ or the attending physician for additional information. If information is not provided, then the case will be forwarded to a medical director for review and determination. The medical director, with the assistance of specialist consultants if needed, reviews the available documentation and makes a determination.

- Approval: The UM nurse notifies the facility of the approval in writing or mutually agreed format.
- Denial: The UM nurse verbally notifies the facility / attending physician or facility of the denial and sends written notification.

If the initial admission is not at a coverable level of care, the facility notifies the health plan at the time of admission, following health plan medical director concurrence with the facility/attending physician's determination, an adverse determination letter is sent to the facility and the member is financially liable for the admission and any continued hospital stay.

If ongoing days are not at a coverable level of care, the facility notifies the health plan. For non-Managed Medicare plans and following health plan medical director concurrence, an adverse determination letter is sent to the facility and the member is financially liable for continued hospital stay.

For Medicare Advantage plans, if ongoing days are not at a coverable level of care, the facility issues the CMS "Important Message from Medicare" as directed by CMS to the member and notifies the health plan. If the health plan's medical director does not agree with the issuance of the "Important Message from Medicare," the health plan will issue a letter of reinstatement to the member and fax a copy to the Beneficiary and Family-Centered Care Quality Improvement Organization and the facility.

Medicare Beneficiary Notification forms and instructions can be found on the Beneficiary Notices Initiative (BNI) page at www.cms.gov/BNI.

In instances where the facility, attending physician and MVP disagree on the appropriate level of care or coverage in accordance with MVP's policies and procedures, the facility on behalf of the attending or the attending have the right to dispute the decision and the member is held harmless. Note:

- A medical director determines all denials and changes of care levels. A UM nurse cannot make such determinations.
- Details of the denial(s) will be provided.
- An attending, primary care physician or specialist has the right to speak with the MVP Medical Director reviewing the case at any point in the concurrent review process. Contact the appropriate UM department and request to speak with the medical director.
- All determinations are based upon the available medical documentation provided to the UM department by the facility's UM department and the attending physician.
- The appropriate appeal process can be initiated.

If an adverse concurrent review determination involving inpatient services is made, the facility / attending physician will be notified by phone and mail within 24 hours or the next business day of receipt of request. If the adverse determination has the potential to hold the member financially responsible (i.e. custodial care), the facility will be provided with a denial letter for delivery to the member or the member's representative, advising of the potential for financial responsibility. A letter will also be mailed within 24 hours of the decision.

Levels of care changes require notification to MVP. Examples of level of care changes include, but are not limited to, a change from a medical observation stay to inpatient acute, change from Acute Rehabilitation to Skilled Nursing, normal delivery of a newborn to a medical complication post-delivery or a newborn's stay beyond the mother's hospital stay. This is to ensure medical necessity for the ongoing stay and/or appropriate payment of services. For acute facility to SNF please see section 5.15.

Non-emergent acute to acute facility transfers also require prior authorization from MVP. These transfers will be considered for medical necessity only. Transfers from a facility capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician will not be considered.

Upon receipt of request for a concurrent review service, a determination will be made and the facility's UM Department / attending physician will be notified by phone and mail within:

- One business day for routine requests, or
- 24 hours for urgently needed care

Coverage of ground ambulance or ambulance services may be discussed during these notifications.

Observation Bed Policy:

Purpose

Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to assess a patient's medical condition and provide medically necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours, but may

extend to 48 hours, and the need for an inpatient admission can be determined within this specific period.

Observation level of care services are a critical component in avoiding unnecessary hospital stays. Types of cases vary from region to region, based on a region's community standards of care and availability of non-acute support services. Cases which usually are managed in an urgent observation stay include, but are not limited to, cellulitis, congestive heart failure, dehydration, diabetes mellitus, fever, fractures, gastrointestinal bleeding, general symptoms, ruling out myocardial infarction, pain (chest, abdominal, back, etc.), pain management, pneumonia, syncope and urinary tract infection.

Observation billing is addressed in the online Medicare Claims Processing Manual at Medicare Claims Processing (Pub. 100-04), Chapter 4-Part B Hospital (Including Inpatient Hospital Part B and OPPOS), and Section 290-Outpatient Observation Services and in the New York State Medicaid Update May 2013, Volume 29- Number 5.

Medicare Outpatient Services: Section 290.1 states the following:

Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

New York State Medicaid Managed Care Update: May 2013 Volume 29 - Number 5 states the following:

Hospitals may provide observation services for those patients for whom a diagnosis and a determination concerning admission, discharge or transfer cannot be accomplished within eight hours after presenting in the Emergency Department (ED), but can reasonably be expected within 48 hours. In order to be reimbursed for observation services, a patient must be in observation status for a minimum of eight hours (with clinical justification). A patient may remain in observation for up to 48 hours and then the hospital must determine if the patient is to be admitted, transferred to another hospital or discharged from the facility.

Time Frame

Observation bed services are appropriate for stays when care required is greater than six hours (8 hours for Medicaid) and up to a maximum of 48 hours based on InterQual/Medicare criteria. The start time will be when the decision is made for observation status and documentation of such should be on the physician's orders, including the date and time. At the conclusion of the observation stay period the hospital/provider will notify the health plan if the intent is to admit and/or define required alternative services.

Exclusions

Patients who would be considered “inappropriate” for observation bed status are:

1. Patients requiring admission (as defined by InterQual criteria)
2. Services that are not reasonable or necessary for a patient’s diagnosis or treatment, but are provided for the patient’s, their family’s or physician’s convenience.
3. Care that is custodial.
4. Services that are part of another outpatient service, such as ambulatory surgery, routine preparation for diagnostic testing and any post-operative monitoring/recovery periods.
5. Observation stays that are greater than 48 hours for all lines of business.

Availability

Observation beds should be available 24 hours a day, including weekends and holidays. Observation bed assignment and/or approval of this care level is not limited by or restricted to a specific location, unit title, or name of the assigned bed to which observation and care occurs.

Authorization

No prior Authorization or notification is required for observation days. The physician order must indicate the physician’s intent regarding the member disposition either to place the member in observation status or to admit the member to inpatient service. The physician order must identify the date and time of the member’s admission or placement into observation status. Observation stays may be subject to a retrospective clinical review to determine the medical necessity for observation level of care, utilizing InterQual or Medicaid/ Medicare criteria. Observation stays in the absence of clear medical necessity are not covered. If the hospital disagrees with MVP’s level of care decision, the hospital may exercise its normal appeal rights.

Conversion to Inpatient

The facility is required to notify the health plan of the request for conversion from observation to inpatient. This request is subject to review for medical necessity and will be reviewed when all clinical information is received following the standard UM process for concurrent review. If an observation patient is admitted, the entire observation period will convert to inpatient benefit days. When emergency department services precede an observation stay, the emergency department services are incidental to the observation stay and therefore are not reimbursed. All observation days that exceed the 48 hour timeframe prior to conversion to inpatient will not be considered charges in calculating a potential cost outlier.

Discharge Planning

For All Commercial, ASO and Medicaid Plans:

AN MVP UM nurse is available to work with the attending physician, the facilities UM department, discharge planning staff, and others to identify available MVP benefits that are consistent with the member’s discharge planning needs. The hospital personnel responsible for discharge planning will screen all observation-status and acute care patients for potential discharge planning needs. Discharge planning referrals (e.g., for home care evaluation, DME, IV

infusion) may be prior approved by contacting the Concurrent Review nurse assigned to the facility or by contacting MVP's Home Care Unit at **1-800-684-9286**.

For Medicare Advantage Members Only

Effective July 1, 2017, naviHealth, Inc. will provide Utilization Management for Skilled Nursing Facility (SNF), Acute Inpatient Rehabilitation (AIR) and Home Health services

Fax: 1-866-683-6976 for pre-service authorization requests for post-acute care

Fax: 1-866-683-7082 for continued stay authorization requests and "other" (NOMNC, NDMC)

Fax: 1-866-683-9126 is utilized to receive Healthcare MDS from All PAC and Home Health

Tel: 1-844-411-2883

naviHealth hours of operation are 8:00am - 5:00pm Monday through Friday, EST, except for nationally recognized holidays. Prior to July 1, 2017, please continue to contact MVP Provider Customer Care Center at **1-800-684-9286**. To learn more about naviHealth, visit **www.navihealth.us**.

The facilities are required to provide to MVP a daily list of discharges in a mutually agreed upon format.

MVP requires notification of member discharges from the hospital for both elective/planned and unplanned inpatient level of care hospitalizations. Notification of discharge must be made to the health plan within one business day of the member's discharge from the hospital.

The notification may be done by sending a facsimile to **1-800-280-7346**.

The information required from the hospital representative by facsimile includes the following:

- Facility name
- Member (patient) name
- Member contract number
- Date of birth
- Discharge diagnosis, if available
- Admission date
- Discharge date
- Discharge status/ disposition

After discharge notification is received from the hospital, the information is entered into the health plan's information system. Please note that the claim cannot be processed without a valid discharge date in the system.

Medicare Comprehensive Outpatient Rehabilitation Facility

Comprehensive outpatient rehabilitation facility (CORF) services may be a covered benefit under certain medical contracts. CORF consists of an interdisciplinary team of professionals from the field of physical medicine, neuropsychology, physical therapy, occupational therapy, speech

therapy, recreation therapy and clinical social work. It is a multi-level program designed to provide intensive and more frequent rehabilitation therapies to persons with CVA, acquired brain injury and other orthopedic and neurological conditions.

These programs provide a comprehensive approach in order to maximize functional potential, CORF is covered when there is a potential for restoration or improvement of lost or impaired functions. This comprehensive program consists of 4 levels. A referral is made by the Primary Care Physician or hospital attending physician to the CORF program. MVP Health Care does not require notification of this referral. The referral is made to the Physical Medicine Specialist at the CORF program for consultation. The physiatrist performs a consultation and recommends the level of CORF service from which the member can benefit most.

MVP requests the CORF program to refer the program members to the MVP Case Management Department to coordinate and perform case management services. To make this case management referral, providers may call **1-866-942-7966**.

The recommendations will consist of 4 levels of care and must meet the following criteria:

- a. Full day evaluation and/or treatment program*
2-5 days per week (three modalities) and at least 135 minutes total per day
- b. Half day evaluation and/or treatment program*
2-5 days per week (three modalities) and at least 90 minutes total per day
- c. Less than half day 2-5 days per week (2-3 modalities) and at least 90 minutes total per day,
and does not include social work, recreation therapy, or group services.
- d. Single Service

*To bill for half day evaluation the member must require and receive at least two of the following services: social work, group services, or recreational services.

In accordance with Medicare Regulation 42 CFR, §422.624, §422.626, §422.620, effective 1-1-04: The Comprehensive Outpatient Rehabilitation Facility is required to provide MVP's Medicare members advance notice of non-coverage by issuing the Notice of Medicare Non-Coverage (NOMNC). The NOMNC must be issued at least two calendar days prior to the last day of coverage/discharge, signed, and dated by the member (or authorized representative). If there is more than a two day span between services, the NOMNC should be issued on the next to the last time services are provided. The authorized representative may be notified by telephone if personal delivery is not available. The authorized representative must be informed of the content of the notice, the telephone call must be documented, and a copy of the notice must be mailed to the representative. Medicare Regulations do not recognize notification by voicemail. The "valid delivery" of NOMNC must be retained in the member's medical record. A signed (or acknowledged) copy of the NOMNC is faxed to MVP within 24 hours of receiving a NOMNC from MVP. Medicare Beneficiary Notification forms and instructions for the NOMNC can be found on the Beneficiary Notices Initiative (BNI) page at **www.cms.gov/BNI**.

Note: A word document format for the NOMNC may be obtained by contacting a MVP Professional Relations Representative.

When a member requests an appeal with the Beneficiary and Family-Centered Care Quality Improvement Organization, the Comprehensive Rehabilitation Facility is responsible to issue the Detailed Explanation of Non-Coverage upon receipt from MVP. A copy must be retained in the member's medical record.

Skilled Nursing Facilities (SNF):

Prior authorization is required for all lines of business.

Benefit Coverage For All MVP Products

MVP will cover:

1. SNF semi-private room and board whenever such care meets the skilled criteria as defined by Medicare or InterQual.
2. All SNF care or rehabilitation services when provided or referred by the PCP or other appropriate provider and approved by MVP and when criteria outlined in this policy are met.
3. Skilled services are limited to the number of days as defined in the member's subscriber contract, certificate of coverage of Summary Plan Description.

For Commercial, ASO and Medicaid Plans:

Clinical decisions for benefit coverage at SNFs are based on InterQual criteria.

For MVP Medicare Advantage plans:

Through June 30, 2017, clinical decisions for benefit coverage at Skilled Nursing Facilities are based on the MVP BIM for Medicare products. The medical director or designee may review indications for any level of care for medical necessity and appropriateness on an individual basis.

July 1, 2017 and forward, following CMS guidelines clinical decisions for benefit coverage at Skilled Nursing Facilities will be managed by naviHealth, Inc.

SNFs with a Medicare Ban

MVP will not approve an authorization for any MVP member to a skilled nursing facility currently sanctioned under a Denial of Payment for New Admissions (DOPNA) by the Centers for Medicare & Medicaid Services (CMS).

Pharmacy Coverage

Medications received during the paid stay are included in the daily rate and should not be billed to the member's prescription drug plan.

Medicare Advantage Plans: Admission denial for medical necessity

naviHealth, Inc. will issue all admission denials for medical necessity and appropriateness based on the medical director determination.

Key Contacts

To establish benefit eligibility, please refer to the following telephone numbers

Non Medicaid / Commercial Plans	MVP Customer Care Center - Provider	1-800-684-9286
Medicaid /CHP/HARP Plans	MVP Customer Care Center - Provider	1-800-247-6550

For prior authorization, call Customer Care Center - Provider at **1-800-684-9286**. Clinical documentation can be faxed to MVP Skilled Nursing Fax Line: **1-866-942-7826**.

Administrative Guidelines

Documentation, Process, and Quality Standards Requirements

1. SNF stays require prior authorization for all of MVP’s products. Prior authorization is to be obtained by the referring provider or Hospital through the discharge planning process. SNF’s are responsible for ensuring a prior authorization is secured prior to accepting the member to avoid non-payment. SNF’s are required to notify MVP when they have accepted a patient by faxing a Prior Authorization Request Form to MVP.
2. MVP’s Commercial, ASO and Medicaid products may require a three day acute care stay for SNF benefit eligibility. Medicare products do not require a three day acute care stay.

SNF Admission Denials

1. On admission, when there is no qualifying three-day acute care hospital stay (for applicable products) or the member is deemed custodial (applies to all MVP products), the acute care facility and the SNF must notify MVP of the member’s admission. An admission denial will be faxed to the facility. The UR Representative is required to present the verbal and written notice to the member. (Written denial notice is also mailed to the member’s home.)
2. For Managed Medicare products, the acute care facility or the SNF is required to deliver the notice of non-coverage letter and obtain signed acknowledgement of the member’s receipt.

Health plan information must be included on the Medicare NDMC; a Word document with the plan information may be obtained by calling the Skilled Nursing Line. Medicare instructions for the NDMC are available online on the Notices Initiatives page at: **www.cms.gov/BNI**. A word document format for the NDMC may be obtained by contacting a MVP Facility Representative or Contract Manager. Members may appeal the admission denial through Maximus.

- a. Valid Delivery to Member or Authorized Representative: if the member is able to sign the notice or if the authorized representative is present to sign, the Notice

must be signed, dated and faxed back to MVP, via naviHealth, Inc. at **1-866-683-7082**, within 24 hours of the receipt of the Notice.

- b. Valid Delivery to Authorized Representative by Telephone: if the member is unable to sign, and notice of denial is delivered to the authorized representative over the phone the facility representative delivering the notice must sign the Notice with their signature, phone number, date and time the Notice was given. They must also document on the notice, who they spoke to (authorized representative) and their phone number. Documentation must also contain a statement that in the writer's opinion the authorized representative understood the contents of the Notice. The Notice then needs to be mailed to the authorized representative. The Notice with the above information must be faxed back to MVP, via naviHealth, Inc. at **1-866-683-7082**, within 24 hours of the receipt of the Notice.
- c. Valid Delivery to Authorized Representative by Certified Mail, Return Receipt: if the member is unable to sign, and you cannot reach the member's authorized representative by phone, the Notice must be sent to the authorized representative by Certified Mail, Return Receipt requested. The date that someone at the authorized representative's house signs or refuses to sign the receipt is the date received. Place a copy of the Notice in the member's medical file, and document the attempted telephone contact to the member's authorized representative. The documentation must include: the name, organization and contact number of the staff person initiating the contact, the name of the authorized representative you attempted to contact, the date and time of the attempted call, and the telephone number called. When the Return Receipt is returned by the post office with no indication of a refusal date, then the member's liability starts on the second working day after the mailing date. The Return Receipt of delivery of the Notice and the Notice itself with above information written on it must be faxed to MVP, via naviHealth, Inc. at **1-866-683-7082**, within 24 hours of the Return Receipt delivery to your facility.
- d. Valid Delivery if Member or Authorized Representative Refuses to Sign: if the member or authorized representative refuses to sign the Notice, the facility representative must document on the Notice, the member's and/or authorized representative's refusal to sign. The facility representative delivering the Notice must sign the Notice with their signature date and time the Notice was given. The Notice must be faxed back to MVP, via naviHealth, Inc. at **1-866-683-7082**, within 24 hours of receipt of the Notice.

3. A copy of the acknowledgement form must be kept in the member's medical record. The SNF will be responsible for services rendered prior to notification of non-coverage to the member. The SNF can only bill the member after appropriate notification that the benefits criteria and/or medical necessity are not met. The SNF is responsible for any associated grace days and cannot bill the member until this requirement is met.

SNF Continued Stay

1. Continued stay services require prior authorization, using MVP criteria (Medicare guidelines for Medicare Advantage members or InterQual criteria for all other lines of business) in consideration of the member's individual needs and the local delivery system.

For Commercial, ASO and Medicaid: Continued stay reviews may be conducted via medical record review by MVP UM staff at the facility and/ or by review of clinical documentation submitted to MVP via fax. Documentation submitted to MVP must include the reason for submission of the clinical documentation – i.e., whether the facility is seeking a termination of benefits or an authorization for an extension of stay. If the reason for submission of the clinical documentation is to request a termination of benefits, the facility must also indicate the date on which it is requesting the termination to be effective.

For Medicare Advantage Members Only

Effective July 1, 2017, naviHealth, Inc. will provide Utilization Management for Skilled Nursing Facility (SNF),

Fax number: **1-866-683-7082** for continued stay authorization requests and "other" (NOMNC, NDMC)

Fax number: **1-866-683-9126** is utilized to receive Healthcare MDS from All PAC and Home Health. Phone number is **1-844-411-2883**

naviHealth hours of operation are 8:00am - 5:00pm Monday through Friday, EST, except for nationally recognized holidays. Prior to July 1, 2017, please continue to contact MVP Provider Customer Care Center at **1-800-684-9286**. To learn more about naviHealth, visit **www.navihealth.us**.

2. Reviews conducted at MVP or naviHealth, Inc.; require clinical documentation to be received at MVP between one and three business days prior to the next review date. Submitted clinical documentation must be current, reflecting the past week's clinical interventions, and member progress relative to each discipline providing care;

Required documentation for determining inpatient SNF continued stay authorizations is the facility's responsibility and must be supplied upon request. Required documentation includes, but is not limited to:

- a. Members Name and MVP I D Number
 - b. Medical orders
 - c. Medical progress notes
 - d. Nursing notes and care plan including measurable member goals (includes member/ family teaching needs for discharge plan)
 - e. Medication records
 - f. Therapy progress notes
 - g. Discharge planning/ social work notes
 - h. Hospital therapy notes
 - i. Skilled service progress notes must reflect the daily administration of those skilled services and the member's daily status/progress in response to the skilled services
3. Failure to obtain appropriate authorizations for admission and/or continued stay or level of care changes will result in non-payment for the unauthorized days and the member will be held harmless.
 4. For continued stays, the SNF is required to notify MVP when the member's level of care changed from skilled to custodial. MVP will perform a review to verify medical necessity of the ongoing stay and issue a medical necessity denial notice (for non-Managed Medicare members) or a notice of non-coverage (for Managed Medicare members), if applicable.
 5. Failure to notify MVP of level of care changes and faxing the corresponding clinical documentation within 24 hours of the change will result in non-payment for non-skilled (see "Description" section of this policy for "skilled services" definitions) days.
 6. The same denial notification process is followed on concurrent review stays as above under SNF Admission Denials.

For all Medicare Advantage members: The SNF must deliver the Notice of Medicare Non-Coverage 2 calendar days prior to discharge in accordance with Medicare Regulation 42 CFR, §422.624, §422.626. The member has the right to appeal the denial with the Medicare the Beneficiary and Family-Centered Care Quality Improvement Organization.

The notice must identify MVP along with MVP's address and MVP member service phone number. Failure to deliver the notice properly may result in non-payment for any overturned days by an appeal organization and the member will be held harmless.

Health plan information must be included on the NOMNC; a word document with the plan information may be obtained by calling the Skilled Nursing Line. The Medicare NOMNC and instructions for the NOMNC are available online on the Beneficiary Notices Initiative (BNI) page at www.cms.gov/BNI. A word document format for the NOMNC may be obtained by contacting a MVP Professional Relations Representative.

When a member requests an appeal with the Beneficiary and Family-Centered Care Quality Improvement Organization, the Detailed Explanation of Non-Coverage will be issued to the Home Care Agency by naviHealth, Inc. The SNF is responsible to issue the Detailed Explanation of Non-Coverage to the member upon receipt from MVP Health Care, via naviHealth, Inc... A copy must be retained in the member's medical record.

Member appeals: While a member appeal is in process with a Quality Improvement Organization (Livanta), for the state of New York) the SNF should notify MVP Health Care via phone or fax of any level of care change which may change the member's eligibility status for SNF coverage. MVP Health Care will review for reinstatement of the members skilled nursing facility benefit.

7. The facility is responsible for notifying MVP of the member's discharge date from the SNF and the member's disposition upon discharge, within two business days of the discharge. Such notification may be communicated by phone, fax, or other electronic notification as specifically agreed upon by the facility and MVP.
8. Requests for a Medicare Swing Beds require prior authorization and will be reviewed on a case by case basis for medical necessity using the following criteria:
 - a. The member must have skilled needs as defined above as well as Medicare Guidelines.
 - b. Requesting facility must provide written documentation from in-plan SNFs (that have beds available) of inability to accept the member. Requests for Swing Beds will not be covered if there are in-plan SNF beds available.
 - c. When a hospital is providing extended care services (Swing Beds), it will be treated as a SNF for purposes of applying coverage rules. SNF level of care days in a Swing Bed are to be counted against total SNF benefit days available.
 - d. If there is an available SNF bed in the geographic region (all contracted SNFs within 50 miles of the hospital), the extended care patient (swing bed) must be transferred within five days of the availability date (excluding weekends and holidays) unless the patient's physician certifies, within the 5 day period, that transfer of that patient to that facility is not medically appropriate on the availability date.

Exclusions and Limitations

Skilled care does not mean custodial care, intermediary care, domiciliary care, or convenience care. Under this policy, the following are not usually considered benefits:

1. Custodial care (assisting with activities of daily living such as ambulating, bathing, dressing, feeding, toileting, preparing special diets, and supervising medication that would ordinarily be self-administered).
2. Maintenance care or services.
3. Intermediary care (institutional care in addition to board and lodging in functionally independent persons).

4. Domiciliary care (room, board, laundry, and housekeeping services for health-stable persons).

The above listing should not be considered all-inclusive. The medical director or designee may review indications for any level of care on an individual basis for medical necessity and appropriateness.

MVP Medicaid Managed Care

It is the responsibility of the SNF to complete the appropriate paperwork upon determination that an MVP Medicaid Managed Care member is changing to a permanent (Long Term Nursing Home) status. Permanent placement will only be allowed to MVP participating providers. (If the SNF facility does not contract with MVP for long term placement, the member must change to a plan that the facility contracts with for long term placement.) The request for permanent placement must first be prior authorized by MVP by sending the request along with the PRI, 3559, MD Statement of Need and MDS forms. Upon MVP approval, it is the facilities responsibility to complete the application and submit to the Local Department of Social Services (LDSS) Office in the county where the member resides.

MVP Health Care Process for Hospice Care:

Description

An interdisciplinary program of palliative care and supportive services addressing the physical, spiritual, social, and economic needs of terminally ill patients and their families provided in the home or a hospice center.

Indications / Criteria

Hospice service is a covered benefit that does not require prior authorization.

- Member must have a terminal illness with a life expectancy of less than six months.
- All aggressive forms of treatment for their illness must have stopped, except for radiation therapy for palliative measures.
- A recognized hospice provider must administer hospice services.
- Coverage shall include home care and outpatient services provided by the community hospice agency.

Variations for Hospice

Medicare Advantage Members

Members with an active hospice election must select a Medicare-certified hospice provider. Hospice claims are sent directly to Medicare. Providers of all services to those on hospice must submit their claims directly to Medicare Fee-For-Service for Hospice. Once payment for claims has been received, the Medicare EOMB and a secondary claim should be submitted. MVP will then coordinate benefits to pay the balance due minus the member's responsibility. Coverage includes medical supplies related to the hospice care and use of DME equipment, per hospice contracts. All DME must be provided through a participating provider or hospice vendor. Drugs traditionally covered under Part B and Part D are covered under the Medicare Part A per-diem

payment to the hospice program. For prescription drugs to be covered outside of the Part A per diem and under the member's Part D benefit, the hospice provider must provide documentation identifying why the drug is unrelated to the terminal illness or related condition. Prescribers who are unaffiliated with the hospice provider should also attest that they have coordinated with the hospice provider and the hospice provider confirmed that the drug is unrelated to the terminal illness or related condition. With the exception of payment for physician services, payment for hospice care is made at one of four predetermined prospective rate depending on level of care. The four levels of care are: Routine Home Care (Revenue Code 0651); Continuous Home Care (Revenue Code 0652); Inpatient Respite Care (Revenue Code 0655); and General Inpatient Care (Revenue Code 0656). Medical justification for continuous home hospice and all inpatient care must be documented in the member's hospice medical record.

Discharge for Medicare Advantage members from Hospice must follow the CMS guidelines for the NOMNC. Medicare Beneficiary Notification forms and instructions can be found on the Beneficiary Notices Initiative (BNI) page at www.cms.gov/BNI.

Note: A Word document format for the NOMNC may be obtained by contacting a MVP Professional Relations Representative.

Palliative Care through Hospice

The Palliative Care Program is to be considered for members with a serious illness who may have a prognosis of more than six months and may be pursuing curative interventions. The diagnosis to be considered but not limited to AIDS, cancer, heart disease, lung disease, renal disease, or a progressive neurological disease. Referrals to the Palliative Care program are accepted from multiple resources: physician, UM staff, home care agency, hospital discharges planners and hospice.

MVP Medicaid Managed Care, Child Health Plus and HARP -children are allowed to receive hospice services while receiving any medically necessary curative services.

MVP Health Care Home Care Referral Process:

Overview

MVP provides home care services in accordance with Medicare guidelines; the Home Care BIM and MVP contracted benefits. Home care benefits under the supervision of an RN are available to members upon meeting eligibility requirements and criteria established to determine medical necessity for skilled services to homebound patients. Short-term, intermittent services by home health aides; physical, occupational, and speech therapists; and durable medical equipment (DME) are available to eligible members when medically necessary.

Initial Requests for Services

1. The PCP or specialist must initiate home care requests. A discharge planner may act as a physician's agent to initiate a care request.

2. Select In-Network Home Care Providers (Nursing, PT/OT/SLP & HHA services) do not require prior authorization. Please contact the MVP Home Care Unit for a provider list at **1-800-684-9286**
3. All out-of-network services do require prior authorization, which can be obtained by contacting the MVP Home Care Unit at **1-800-684-9286**
4. A facility discharge planner may act as a physician's agent to initiate a request for care. The case manager will review the information. If additional services are approved, the member's MVP case is updated. The agency is contacted and a follow-up letter is sent and/or a response to a standard EDI transaction (ANSI 278). Requests for authorization extensions may be obtained by calling MVP's Home Care Unit at **1-800-684-9286**.

Requests for Continuing Services

The home care agency will provide updates, using a standard EDI transaction (ANSI 278), or by phone or fax on a concurrent basis for each case in which additional home care services are requested prior to completion of care or the approved time frame for home services. The PCP, attending physician, or specialist treating the patient must initiate requests for home care services.

Variation for Home Care Services

Medicare Advantage

Effective July 1, 2017, naviHealth, Inc. will provide Utilization Management for Home Health services for Medicare Advantage members only.

Fax: **1-866-683-6976** for pre-service authorization requests

Fax number: **1-866-683-7082** for continued stay authorization requests and "other" (NOMNC, NDMC)

Fax number: **1-866-683-9126** is utilized to receive Healthcare MDS from All PAC and Home Health.

All NOMNCs should be faxed to naviHealth at 1-866-683-7082

Tel: 1-844-411-2883

naviHealth hours of operation are 8:00am - 5:00pm Monday through Friday, EST, except for nationally recognized holidays. Prior to July 1, 2017, please continue to contact MVP Provider Customer Care Center at **1-800-684-9286** To learn more about naviHealth, visit **www.navihealth.us**.

In accordance with Medicare Regulation 42 CFR, §44.624, §422.626, §422.620, effective 01/01/2004 for MVP Medicare members:

The Home Care Agency is required to provide MVP Medicare members advance notice of non-coverage by issuing the Notice of Medicare Non-Coverage (NOMNC). The NOMNC must be issued at least two days prior to the last day of coverage/discharge, signed, and dated by the member (or authorized representative). If there is more than a two day span between services,

the NOMNC should be issued on the next to the last time services are provided. The authorized representative may be notified by telephone if personal delivery is not available. Medicare Regulations do not recognize notifications by voicemail. The authorized representative must be informed of the content of the notice, the telephone call must be documented, and a copy of the notice must be mailed to the representative. The "valid delivery" of NOMNC must be retained in the member's medical record. A signed (or acknowledged) copy of the NOMNC is faxed to MVP Health Care within 24 hours of receiving a NOMNC from MVP Health Care.

Medicare Beneficiary Notification forms and instructions for the NOMNC can be found on the Beneficiary Notices Initiative (BNI) page at www.cms.gov/BNI.

A Word document format for the NOMNC may be obtained by contacting a MVP Professional Relations Representative.

When a member requests an appeal with the Beneficiary and Family-Centered Care Quality Improvement Organization, the Detailed Explanation of Non-Coverage will be issued to the Home Care Agency by naviHealth, Inc. The Home Care agency is responsible to issue to the member the Detailed Explanation of Non-Coverage upon receipt from MVP via naviHealth, Inc.

MVP Medicaid Managed Care Variation for Personal Care Services

Effective August 1, 2011, MVP Health Plan, Inc. covers personal care services for Medicaid Managed Care members. Personal care services must be prescribed by a participating physician and services must be performed by a participating Personal Care agency. A personal care assessment must be completed and submitted to the health plan for prior authorization before the initiation of Personal Care Services. Level I (nutritional and environmental support functions) will be considered for coverage based on medical necessity. There will be a limit of up to eight hours per week for Level I personal care services. Prior authorization is obtained by calling **1-914-372-2433**.

Special Requirements for Home Health Agencies Providing Personal Care Assistant Services to NYS Medicaid Recipients:

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

- a. The level of personal care services provided and title of those providing services
- b. The criteria for selection of persons providing personal care services
- c. Compliance with the requirements of the Criminal History Record Check Program (NYCRR Part 402)
- d. That training, approved by the NYS DOH, is provided to each person performing personal care services, other than household functions

- e. The agency assigns appropriate staff to provide personal care services to a member according to MVP's authorization for the level, amount, frequency and duration of services to be provided
- f. There is administrative and nursing supervision of all persons providing personal care services
- g. The agency's administrative supervision assures that personal care services are provided according to MVP's authorization for the level, amount, frequency and duration of services to be provided.
- h. The administrative supervision includes the following activities:
 - i. Receipt of the initial referrals from MVP, including its authorization for the level, amount, frequency and duration of the personal care services to be provided
 - ii. Notifying the MVP when the agency providing services accepts or rejects a patient
 - iii. When accepted, the arrangements made for providing personal care services; and
 - iv. When rejected, the reason for such rejection
- i. The agency promptly notifies MVP when the agency is unable to maintain case coverage.
- j. The agency provides nursing supervision to assure member's needs are being met.

MVP Health Care Home Infusion Services

Refer to MVP's payment policy: Home Infusion Policy.

Infusion therapy requires a prescription from a qualified physician who is overseeing the care of the patient and is designed to achieve physician-defined therapeutic endpoints. The infusion therapy must be initiated on time within the stipulations of the physicians' orders for 100 percent of cases.

Most home infusion services do not require prior authorization. The health plan reserves the right to audit the vendor's records to ensure compliance with MVP Policies. Prior authorization may be required prior to the administration of specific medications. Refer to the MVP website for a list of specific medications requiring prior authorization. The vendor will work with the prescriber to coordinate the prior authorization.

Home Infusion Services are covered when deemed medically necessary. Coverage of services may vary by member contract. Home Infusion nursing services are in some instances applied to a member's home health care benefit. Some prescription drugs are not a part of the base medical benefit. Coverage may exist under member or employer riders. MVP reserves the right to limit the availability of certain medications to a specialty pharmacy vendor. For providers with electronic access, further information surrounding specific benefits / riders may be obtained on the provider portal, on the MVP website. For providers without electronic access, contact the Customer Care Center.

The home infusion vendor must report any adverse outcomes (due to wrong dose, administration, faulty equipment or other issues) within 24 hours of occurrence by contacting MVP's Home Care Unit at 1-800-684-9286.

Home Infusion and Home Health Care Agency Nursing Visits

All efforts will be made between the infusion vendor and home care agency to coordinate the delivery of care to the member. When the member is under the oversight of and opened to a home care agency for non-infusion related care, the home care agency shall administer the medication on the dates the agency is scheduled to have a nurse in the home. Home infusion vendors may subcontract with another agency for all or part of the nursing services. In these instances, the home infusion vendor:

- Assumes responsibility and oversight of care provided;
- Bills MVP Health Care for their services; and
- Is responsible to pay for all subcontracted services.

Insulin Infusion and DME

External Subcutaneous Insulin Pumps and Supplies may be covered under the member's Diabetic Care Benefit with a participating DME vendor. Supplies may also be obtained through a network pharmacy and should be billed online to the Pharmacy Benefits Manager (PBM) for members with a pharmacy benefit through MVP.

Home Infusion and Hospice Services

When a member elects hospice, all services and respective charges related to the hospice diagnosis are global to the hospice payment. No separate reimbursement is made to the home infusion vendor.

Home Infusion and Skilled Nursing Facility (SNF) Care

When a member is in a Skilled Nursing Facility at a skilled (non-custodial) level of care, all services under CMS's consolidated billing and the respective charges are global to the SNF payment. No separate reimbursement is made to the home infusion vendor. If the member becomes custodial and remains at the SNF for residential purposes, the home infusion vendor may be reimbursed by MVP for the home infusion services. The drugs administered in the SNF for custodial members must be billed to MVP's PBM and may be subject to a Medicare Part B or Part D determination review.

In accordance with Medicare Regulation 42 CFR, §44.624, §422.626, §422.620, effective 1-1-04 for MVP Medicare members:

The Home Infusion Agency is required to provide MVP Medicare members advance notice of non- coverage by issuing the Notice of Medicare Non Coverage (NOMNC). See above under Home Care.

MVP Medicaid Managed Care

As of October 1, 2011 all pharmacy benefits are covered by MVP. Please refer to the MVP Medicaid Managed Care Formulary for more information.

Retrospective Review

Retrospective review is conducted based on specified type of review by a Registered Nurse (RN), Certified Coding Specialist (CCS) or Certified Professional Coder (CPC). Reviews can be conducted to verify level of care, place of service assignment, length of stay, services rendered, validation of inpatient/outpatient coding, and accuracy of claim data including submitted charges that impact reimbursement. MVP utilizes facility/provider medical records, in conjunction with clinical review criteria, utilization review/coding guidelines, and when applicable invoices, itemized bills. Consultations with MVP's Associate Medical Director occur based on case complexity. All medical denials and Level of Care changes are determined by an Associate Medical Director. Coding Denials are reviewed by Certified Coders. A retrospective case that is identified as a potential Quality Improvement, Coordination of Benefits, or Case Management trigger, will be referred to the appropriate unit. The applicable policies address regulatory turnaround timeframes, clinical information collection, assessment and appeal rights. These reviews are all performed after the service has been rendered and may be pre or post payment. Types of retrospective reviews may include but are not limited to:

Post-Service Inpatient Review

Retrospective review of charts is performed on all inpatient hospital admissions where the claim indicates the following:

- a. The approved Length of Stay (LOS) days do not match between the claim and the authorization
- b. Required match fields (i.e. level of care) on a claim submitted do not match the authorization.
- c. No authorization or pended authorization (includes participating provider claims with date of service after 06/30/2013).

MVP Health Care may reverse a pre-authorized treatment upon retrospective review of relevant medical information presented at the time of the Utilization Review if it is materially different from the information presented during the pre-authorization, the information existed at the time of the pre-authorization and was withheld or not available or the Utilization Reviewer was not aware of the existence of the information, and if the information was available the requested service or procedure would not have been authorized.

If a claim is received from a participating facility, and MVP has not been notified of the admission, the claim will deny administratively "No Admit Notification by PAR Facility." There will be no clinical review performed at that time and the member cannot be held liable. The facility will be able to appeal the administrative denial through the normal administrative denial process. For complete Appeal Rights see Section 8.

The administrative denial process for no notification of the inpatient admit will NOT apply to any Non-Participating facilities, Cigna, URN/Transplant, maternity or well newborn admits. A medical necessity review will be performed on all Non Par claims. When a retrospective review decision is communicated to the facility, the facility has the right to appeal and or bill for the appropriate Level of Care. For complete Appeal Rights see Section 8.

Based on regulatory guidelines providers/facilities will receive written notification on retrospective adverse determinations.

DRG Validation

DRG Validation is performed post payment (within six months of paid claim date) on claims submitted by those facilities that have a contractual agreement with MVP for a DRG payment methodology. DRG validation is performed by certified RN coders (CCS) who utilize ICD-9 CM/ICD-10 CM Coding Guidelines/Conventions and coding software which is consistent with industry and regulatory standards. Charts are reviewed for validation of all ICD-9 CM/ICD-10 CM/PCS codes impacting DRG as well as the sequencing of principal and secondary diagnoses. Additional clinical resources used in DRG validation include but are not limited to American Hospital Association Coding Clinics, Faye Brown Coding Handbook, and Merck Manual etc.

Other DRG reimbursement drivers that can be reviewed are birth weights, discharge disposition, transfers, short stay payments, long stay outliers, cost outliers and readmissions reviews as per the individual facility contracts or regulatory requirements. When the coder disagrees with the hospital's coding and subsequent DRG assignment, the hospital is notified, in writing, of the DRG reassignment, with rationale, references cited and appeal rights. The claim will be adjusted to the DRG identified in the notification letter

MVP may request at any time in this process that a physician query be initiated to clarify diagnoses and/or procedures. The format used for submitting this query shall adhere to the nationally recognized guidelines set forth by AHIMA. The expectation is that the facility will submit the documented physician query/response along with all other medical record documentation that substantiates the diagnosis/procedures to MVP within 30 calendar days from the date of the request/letter for the facility to initiate a physician query.

If the facility is not in agreement with MVP's decision and wishes a reconsideration, the facility may submit the entire medical record (if not submitted prior to reconsideration) and/or any additional supporting documentation no later than thirty calendar (30) days from the date of MVP's letter. If, upon review of the facility's reconsideration letter and supporting documentation, MVP Health Care's RN CCS coder determines the facility's original DRG was appropriate an agree letter is sent and the claim is readjusted to pay the originally submitted DRG. For those reconsiderations that the RN CCS coder upholds the MVP Health Care DRG assignment a letter will be sent to the facility notifying as such and will include additional rationale, and references

If a hospital is not satisfied with the result of the DRG reconsideration, it may commence with a level Two Hospital Appeal, if allowed by contract, which a third party arbitrator shall conduct. Per the instructions in the closing of the reconsideration letter, the hospital will submit a written request to the designated arbitrator within 30 calendar days from the date of MVP's Level one appeal (reconsideration) determination notice. According to the contractual agreement between the hospital and MVP, the subscriber/member cannot be held financially responsible for any balance billing.

Other Types of Retrospective Claim Reviews:

Transfer Payment: is based on contract and/or Medicaid or CMS regulations. An acute care transfer is considered a discharge of a hospital inpatient from an acute care non-exempt facility to another acute care non-exempt facility. The total payment to the transferring facility will not exceed the amount that would have paid if the patient had been discharged. If on review, the health plan finds either the discharging or the transferring facility incorrectly billed a transfer case, payment will be adjusted.

Post-Acute Care Transfer: A discharge of a Medicare hospital inpatient is considered to be a transfer when the discharge is assigned as outlined in the CMS Manual (Post-Acute Care Transfer Policy per Center for Medicare & Medicaid Services) to one of the qualifying diagnosis related groups (DRG) and discharge is made under any for the following circumstances:

- To a hospital or distinct hospital unit excluded from the prospective payment system.
- To a skilled nursing facility
- To home under a written plan of care with a provision of home health services from a home health agency and those services begin within 3 calendar days after the date of discharge.

If, on review, the health plan determines that the submitted claim had an incorrect discharge disposition the payment will be adjusted accordingly. The provider may submit documentation for reconsideration to the attention of MVP's Retrospective DRG Unit.

Short-Stay Payments are cases in which the total length of stay is below the low trim point of the DRG; a short-stay payment is made per the hospital contract and/or DRG methodology. Cases in which the length of stay is equal to or one day greater than the low trim point will be reviewed for medical necessity. If any days are determined as not medically necessary, these days will be cut from the total length of stay, therefore, decreasing the hospital's reimbursement if the adjusted length of stay falls below the low trim point.

Long-Stay Outliers are cases in which the total length of stay is above the high trim point for a DRG based on contract and/or DRG methodology. These cases are reviewed to ensure all days above the high trim are medically necessary. If any days are determined as not medically necessary, these days will be eliminated from the total length of stay, therefore decreasing the hospital's reimbursement if the adjusted length of stay falls below the high trim point.

Cost Outliers require the hospital to submit all itemized charges for any case in which a cost outlier review is requested. The hospital receives the DRG payment plus additional payment for cases that exceed the DRG threshold for excessive cost to the hospital as based on the contracted DRG methodology. The case is reviewed to verify accuracy, appropriateness of charges and services billed along with DRG validation. In addition any days that were not reviewed for medical necessity concurrently may be reviewed retrospectively and if any days are determined to not be medically necessary, those associated charges will be removed from the total allowable charges, which may affect the hospitals final reimbursement.

Readmission is defined when a patient is discharged and readmitted to the same non-exempt hospital within 30/31 days, for the same or a related condition for which the patient was treated at the time of the original discharge and the second admission is the result of an inappropriate/premature discharge or for patient/facility convenience or scheduling difficulties. Reviews will be performed In accordance with facility contract and/or CMS/ Medicaid/ New York State regulations. Days between the original discharge and the subsequent admission will not be considered in the calculation of the total length of stay for payment.

Based on the review of the applicable medical records, MVP may identify a second admission as a "readmission" for purposes of reimbursement, if MVP's RN reviewer or Medical Director determines that the first discharge was inappropriate/ premature(i.e. discharged in an unstable medical condition and did not meet standard/established discharge criteria), or was for patient/ facility convenience. For Medicaid members the New York State Regulation for readmissions will be followed. This includes but not limited to a readmission which could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period (i.e. home care appropriate following discharge but none ordered resulting in readmission). In addition any discharge with subsequent readmission due to a delay in service or due to facility or member convenience would fall under these readmission requirements.

In the case of readmissions the Hospital shall be reimbursed the lesser of:

- i. the total of the case rate payments for the two separate admissions; or
- ii. the payment which would have been received pursuant to this Rate Sheet and Addendum by billing MVP for a single case rate by combining, according to the principal reason for Member admission, those diagnoses and procedures of the readmission with the diagnoses and procedures of the original admission, and total medically necessary days in the combined admission.

If MVP does not consider the case a "Readmission", MVP will pay each discharge separately in accordance with the facility contract/MVP Agreement. Discharges and subsequent admissions between acute care unit and a behavioral health unit or a physical rehabilitation unit in the same hospital are not considered a "readmission" for purposes of this paragraph.

When a readmission is identified the hospital is notified in writing that MVP Health Care is combining the said DOS, citing the resulting DRG assignment, provide rationale, references and reconsideration/appeal rights.

If a Hospital disagrees with MVP's decision regarding a readmission, Hospital may ask for reconsideration as directed within the Readmission letter by submitting a reconsideration request letter with supporting documentation within 30 calendar days from the date of the initial readmission letter.

If a hospital is not satisfied with the result of the readmission reconsideration, it may (as allowed by contract) commence with a level Two Hospital Appeal, with the designated third party arbitrator. The instructions and timeframe of thirty (30) calendar days from the date of MVP Health Care's response letter are provided in the closing of MVP Health Care's reconsideration response letter. According to the contractual agreement between the hospital and MVP, the subscriber/member cannot be held financially responsible for any balance billing.

Never Events/Hospital Acquired Conditions (HAC's): The National Quality Forum, CMS, New York State Medicaid and other entities maintain different listings of Never Events/ Serious Reportable Adverse Events/HACs. MVP will not pay for the cost of care associated with a Never Event. For a detailed summary of the MVP Never Event Policy, refer to the end of this section. MVP reviews all never events to facilitate accurate coding, billing and reimbursement based on individual contracts.

High Cost Claim Audits are conducted per MVP hospital contracts for the following but not limited to high cost drugs, level of care/room charges, high cost services, implants etc. An itemized bill along with the medical record may be requested to verify charges being billed. The facility will be notified by letter of any changes to charges along with the rationale for changes. Facility may request reconsideration per instructions in the closing of the high cost change letter. If the facility disagrees with adjustment the facility may submit a reconsideration letter with rationale within thirty calendar days of receipt of initial letter.

High Cost Claim Audits are conducted per MVP hospital contracts for the following but not limited to high cost drugs, level of care/room charges, high cost services, implants etc. An itemized bill along with the medical record may be requested to verify charges being billed. The facility will be notified by letter of any changes to charges along with the rationale for changes. Facility may request reconsideration per instructions in the closing of the high cost change letter. If the facility disagrees with adjustment the facility may submit a reconsideration letter with rationale within thirty calendar days of receipt of initial letter.

Physician Claims Review (PCR): MVP provides equitable and consistent reimbursement for all MVP participating and non-participating physicians and facilities while managing health care costs by conducting post service claim review. PCR performs medical necessity and coding reviews on post service, pre-payment claims, as well as on appeals received for finalized (i.e. paid or denied) claims. The PCR CPC staff reviews the claim to determine the accuracy of the coding,

modifiers and place of service and verifies that the billed procedures are coded appropriately based on review of the documentation provided. Current Procedural Terminology (CPT) Guidelines, American Medical Association (AMA), National Correct Coding Initiative (NCCI) edits, McKesson ClaimsXten Clinical Editing and MVP Policy guidelines are utilized for determinations. The PCR staff reviews and evaluates claims for potential cosmetic and experimental/investigational procedures to determine medical necessity. All medical necessity denials and level of care changes are determined by an associate medical director.

MVP may turn off specific subsets of edits. MVP monitors trending data to identify changes in coding practices. MVP will execute audits on specific providers or turn the edit on if a trending change warrants. Providers to be audited will be offered advanced notice of initiated audits. MVP will request all documentation to support the coding on the claim.

Providers and facilities may appeal any payment changes as a result of clinical editing, medical necessity or level of care denials by submitting a Claim Adjustment Request Form with the clinical and/or coding rationale explaining why the denial is incorrect. Please make sure to include any medical reports and/or coding documentation that will substantiate the appropriateness of the appeal. If documentation was originally submitted with the initial denial, providers need to send additional supporting documentation with the CARF that may not have been provided with the initial denial.

MVP may reverse a pre-authorized treatment, service or procedure on retrospective review, pursuant to section 4905 (5) of the NYS Public Health Law, when: relevant medical information presented to MVP upon retrospective review is materially different from the information that was presented during the pre-authorization review; the information existed at the time of the pre-authorization review but was withheld or not made available; and MVP was not aware of the existence of the information at the time of the pre-authorization review; and had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Medical Audit: Medical audits are performed by MVP or a contracted recovery audit vendor to ensure providers are following MVP's clinical and coding guidelines when providing services or care. Medical auditing is a cost effective approach to review/respond to utilization trends for medical services not managed through the traditional Prospective, Concurrent, or Retrospective review processes.

Medical auditing is performed on health services where MVP has elected to relax prior authorization guidelines for those targeted services and for services where MVP has chosen to perform limited post service review. Audits are performed to ensure services are provided in accordance with MVP policies, contracts and billing guidelines. Examples of services audited include but are not limited to FDA approved implantables, home care, home infusion, select DME, coding and clinical trials.

When MVP or a contracted recovery vendor performs a medical audit, the provider will be required to supply clinical notes within 30 calendar days of the request. Clinical notes are faxed to **1-888-656-5691**. Failure to provide the requested notes may result in recovery of claims paid to the provider.

If a medical necessity adverse determination is made following audit review of clinical notes, the provider may appeal the determination following the appeal process in the notice of denial. If the documentation review results in a coding or payment adjustment, the provider may file dispute reconsideration and provide any additional documentation to the Medical Audit unit within contracted timeframes. MVP will recover any monies paid to the provider and the members will be held harmless.

Case Management/Health Management (Disease Management)

Caring for members with acute and/or chronic health conditions sometimes takes an extra helping hand. That's why MVP has a team of nurses, respiratory therapists and social workers certified in case management and/or health coaching and other health care professionals to help you to ensure that your patients achieve the best health outcomes possible.

MVP offers integrated telephonic programs:

- Case Management: which includes Complex and Catastrophic Case Management, Transition Care, Transplant, Social Work and Little FootprintsSM for High Risk Pregnancy;
- Health Management (Disease management) which includes programs for the following conditions: Asthma, COPD, Cardiac, Depression (managed by Beacon Health Options), Diabetes, Heart Failure and Low Back Pain.

Additional information about these programs is provided below. To refer to any of the MVP programs contact our central triage number at **1-866-942-7966** or email **PHMReferrals@mvphealthcare.com**.

Case Management

The Case Management program was created to ensure that the highest quality of care is provided to members who have multiple or complex health care needs. The goal of Case Management is to help members regain optimum health, or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with self-management goals, monitoring, and follow-up.

Case Management

For members who have complications or other serious health concerns. This includes management of members with transplant needs, hemophilia or high-risk pregnancy, high emergency room utilization and a variety of other health concerns or conditions (such as stroke, complex wound care, social work needs, and more). Case managers utilize the principles of case management and health coaching to increase the effectiveness of communication with plan members. In addition to providing support to members in the form of care coordination and facilitating access to needed resources, Case Management aims to achieve the following objectives:

- Ensure cost effective solutions through appropriate utilization and coordination of health care resources and application of health care benefits.
- Identify gaps in services or communication and create systems to correct them.
- Improve the continuity of care received by members by providing a contact person for physicians, staff, patients and families throughout the episode of care.
- Provide impartial advocacy, facilitation and education to members and their families.
- Be aware of the financial needs of members and maximize benefits and health care resources to limit out-of-pocket expenses.
- Improve medication adherence, safety and quality of life.

Transplant Case Management

Transplantation involves complex and highly specialized care and requires time-intensive coordination for multiple health concerns. MVP's Case Management department has dedicated Case Managers that specialize in Transplant Case Management. A transplant referral occurs when the PCP or specialist requests a transplant evaluation and/or prior authorization for a transplant.

The Transplant Case Manager should be consulted for benefit questions or other transplant-related issues. An individual case manager follows up with each transplant recipient by phone and/or correspondence for up to one year post-transplant.

Procedure for Transplant

Following the request for prior authorization, the MVP Case Manager will begin gathering the medical information for review.

Upon identification of a potential transplant candidate, the attending provider is required to submit a request to MVP's Case Management Department by calling **1-866-942-7966** for prior authorization of non-urgent evaluations for transplant. If it is an urgent request, that should be stated during the phone call. Regardless of transplant facility, before a transplant evaluation or transplant procedure can be performed, an approval must be obtained. If after the transplant evaluation a transplant is planned, the results of the evaluation are sent to the case manager to ensure the review is complete prior to any additional services rendered.

In addition to MVP's contracted facilities, MVP uses the Optum HealthCare (formerly known as United Resource Network [URN] Transplant Network) to access centers of excellence for transplant services and to provide information and resources on centers of excellence for specific types of transplant. For information about Optum HealthCare participating facilities, providers may call the case manager at **1-866-942-7966** or visit Optum Health Care's website at: **www.myoptumhealthcomplexmedical.com**.

Little FootprintsSM for high-risk pregnancies:

MVP offers a high-risk prenatal care program called Little FootprintsSM. Little FootprintsSM provides additional clinical expertise for expectant mothers

The goal of the Little FootprintsSM program is to promptly identify female members at risk of a high-risk pregnancy (multiple births, infertility, history of miscarriage, etc.) and provide the member with care coordination and prenatal education. The program involves monthly telephonic contact with an MVP Case Manager or bilingual Maternity Care Coordinator (for Spanish speaking members). The Case Manager follows each member individually and develops an education plan in conjunction with the pregnancy assessments and screenings.

Ongoing telephone calls are scheduled with the member to encourage healthy behavior and provide education on topics such as fetal development, diet, nutrition and exercise. "Face to Face" visits may be coordinated for high risk Medicaid members identified with psycho-social issues and/or behavioral health diagnoses. Members are followed post-delivery and are assessed for post-partum depression. In addition, a newborn assessment is completed. Members are advised to follow up with their physicians post-delivery and verify that an appointment with the pediatrician has been scheduled. Expectant mothers are mailed educational information packets upon enrollment and delivery. Those members who are not eligible or declined the Little FootprintsSM program are referred to the Healthy Starts program for an educational packet via mail. The Healthy Starts program gives mothers-to-be information that helps them stay healthy, learn about pregnancy, and prepare for delivery. Medicaid members who are not eligible or decline the Little Footprints program will receive the same packets as those enrolled in the Little Footprints program.

Rochester providers caring for members enrolled in the Medicaid Managed Care program are encouraged to notify MVP of all pregnancies (not limited to high risk) by faxing a copy of the member's Prenatal Health Risk Assessment form to the Customer Care Center - Provider at **1-800-247-6550**. This process provides prompt referral of a pregnant member to the Little FootprintsSM program.

The maternity management program follows the evidence-based guidelines published by the American Academy of Pediatrics ("AAP") and the American College of Obstetricians and Gynecologists ("ACOG") Guidelines for Perinatal Care, Sixth Edition.

Breastfeeding

MVP recognizes the importance of breastfeeding babies and we are committed to ensuring that breastfeeding support is available for every mom and baby we cover. We have a new, comprehensive lactation support program providing breastfeeding support and equipment

through Corporate Lactation Services. Through this relationship with Corporate Lactation Services, MVP is able to offer nursing mothers state-of-the-art breastfeeding equipment and access to internationally board certified lactation consultants and registered nurses 365 days-a-year. This support program includes outreach calls placed at specific times to provide mothers with information appropriate for the age of the infant/baby. Members can call in with questions or concerns until weaning. All of these services are offered at no additional charge to our members. To enroll, members can visit www.corporatelactation.com and click on subsidy login then enter the pass code MVP2229 or call **1-888-818-5653**.

Social Work Services

Social Work services are available to connect members to community resources and services and assist with addressing member specific social and economic needs. The social work team can assist members with the following:

- Department of Social Services: fee-for-service Medicaid, food stamps and the Home Energy Assistance Program (HEAP)
- Housing: Section 8, Housing Authority, home modification/weatherization and homelessness
- Copayment relief: prescription assistance programs and facility copayments for things like hospital stays
- Social Security Administration: disability and Medicare
- Senior support programs
- Cancer resources
- Advance directives
- Transportation

Health Management (Disease Management)

MVP's telephonic Health Management (Disease Management) programs are structured to empower the member to bring about lifestyle and behavior change, provide condition-specific education and assist members with achieving evidence-based care guideline outcomes. Clinical interventions are aimed at collaborative care planning and/or goal setting that continuously evaluates clinical, humanistic and economic factors affecting overall health. The health management programs provide two service options:

1. Information mailed to the member's home, including bi-annual condition specific newsletters and health screening reminders; and
2. Telephonic one-on-one outreach by a clinician. The telephonic outreach program focuses on prevention of exacerbations and complications, self-management strategies and helping members to make positive lifestyle changes and better control their condition. In addition, health management programs assist with connecting members with appropriate community resources and services.

MVP's health management programs identify and outreach to members living with:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression

- Diabetes
- Heart Disease Heart Failure
- Low Back Pain

Transition Care

The transition care team consists of clinicians focused on helping to support members after a hospital admission. Services include assisting the member with understanding discharge instructions, encouraging prompt provider follow-up and coordination of care, assessing risks post-discharge in the home environment and providing the patient with self-management tools and coaching.

A quick reference summary of the programs and contact information can be found on the MVP www.mvphealthcare.com/provider/documents/CHMReferralGuide.pdf. The following programs provide outbound member newsletter mailings: Asthma, COPD, Diabetes, Cardiac, Heart Failure and Low Back Pain. MVP clinicians utilize a variety of strategies aimed at:

- Conducting outbound calls to engage members in telephonic management including assessment and data collection of pertinent health information
- Guiding members toward evidence based practice outcomes aimed at improving overall quality of life and health outcomes (thereby improving likelihood of achieving provider performance metrics)
- Helping members to better understand their condition and better manage their overall health
- Assisting members with setting realistic actionable health and wellness goals aimed at lifestyle modification and preventative care
- Encouraging the member to effectively communicate with all members of their health care team

These programs are offered at no cost to the member and there are no copayments for these services. Member may choose to opt-out at any time.

Member Identification

There are three ways a member may be identified as a candidate for one of the MVP Case or Condition Management programs:

1. A health care provider may refer a member to the program.
2. The member (or designated care giver) may self-refer to the program.
3. Using a variety of data points (health risk assessment data, claims, authorization data, laboratory data, predictive modeling and more). Upon identification, a clinician will reach out to the member to engage in a telephonic program.

How to Refer a Member to a Program

The process for referral is simple. Call our central triage number at **1-866-942-7966**. Let us know how we can help. MVP will reach out to the member by telephone. We will match the member to the most appropriate program and services. This telephone line is secure and you

may leave a secure message at this number. To assist providers with the referral process, a one-page referral guide is available on the MVP website at www.mvphealthcare.com/provider/documents/CHMReferralGuide.pdf.

Communication between MVP and Providers

MVP recognizes the importance of communication between the clinicians and the provider/provider offices. That is why we may be in contact with the office (by fax, letter or phone) in an effort to alert you to a change in status and to collect pertinent medical data that may assist us with management of the member. For example, the following data elements may be requested to assist with the overall management of the member:

Asthma/COPD: stage (based on pulmonary function outcomes), controller medication, FEV1 or PFT, inhaled corticosteroids, use of spacer and asthma action plan

Diabetes: date and result of last HbA1c, LDL, total cholesterol, date of most recent foot exam, dilated eye exam, date and result of urine microalbumin

Cardiac: most recent lab results of HDL, LDL, total cholesterol, blood pressure, triglycerides

Heart Failure: ejection fraction, blood pressure, dosing of an ACE, ARB or substitute most recent labs HDL, LDL, total cholesterol

All of the MVP case and health management (disease management) programs offer multiple-risk stratification dimensions; tailored member-centric interventions; program components that are integrated and coordinated with multiple delivery models; two-way information exchange with providers (inbound and outbound); and outcome measures that assess overall effectiveness and impact. Providers are encouraged to refer members to the programs provided.

MVP offers a number of provider tools, including clinical guidelines and assessment tools, to help providers identify members requiring specialized services. The tools and guidelines are available on the MVP website at

<https://content.mvphealthcare.com/provider/onlineresources.html>

A sample list of guidelines follows:

- Adolescent health
- Back Pain (Low Back program)
- Behavioral Health (Depression program)
- Cardiac Care (Cardiac and Heart Failure programs)
- Careful antibiotic usage
- Infectious disease
- Kidney care (ESRD program)
- Oncology/Cancer (Oncology program)
- Preventive health (adult/childhood preventive care guidelines)

- Quality Improvement in the clinical setting
- Respiratory (Asthma/COPD programs)
- Women’s Health

In addition to the guidelines, MVP offers assessment tools to assist with the identification of potential alcohol abuse. These tools, also found on MVP’s website, include the:

- CAGE questionnaire for assessment of potential alcohol abuse in adults
- CRAFFT questionnaire for assessment of potential alcohol abuse in adolescents

Case Management for Government Program Members (Medicaid Managed Care, Child Health Plus, HARP)

Health Homes is a care management service model whereby all of a member’s caregivers communicate with one another to ensure that all of the member’s needs are addressed in a comprehensive manner. This is done primarily through a “care manager” who oversees and provides access to all of the services the member needs to stay healthy, out of the emergency room, and out of the hospital.

MVP is contracted with multiple Health Homes in our service area. The contracted providers are listed on the MVP website. Upon enrolling in any of MVP’s Government Programs, MVP’s Member Service Department performs New Member Orientation calls and gathers pertinent medical history information from our new members. Additionally, members are asked to complete a health risk assessment (HRA). When an HRA is returned, this is reviewed for case management opportunities. MVP’s case managers will identify any special needs or barriers to receiving treatment. The member’s PCP may be contacted to coordinate and review health concerns which are identified on the health risk assessment form. MVP Medicaid members identified with two chronic conditions or one serious persistent mental health condition or as HIV positive are referred to a Health Home by utilizing the MVP Health Home Upward Referral Form. This form is available on the MVP website.

In addition, MVP’s Medicare Services and Supports team will review claims history and authorizations to monitor and identify a member’s need for care management services based on:

Diagnostic Eligibility

- two or more chronic conditions, or
- one serious persistent mental health condition, or
- HIV/ AIDS

Frequent Utilization Eligibility

- No primary Care provider
- No connection or inadequate connectivity with specialty doctor
- High utilization of Emergency Department (3-6 visits in previous year)
- Repeated recent hospitalizations (2-3 inpatient stays in previous year)
- Recent discharge from psychiatric hospitalization
- Assertive Community Treatment (ACT)

MVP's Clinical, Behavioral, Member Services and Provider Services teams who interact with our members, providers, hospitals and pharmacies will refer an enrollee upon identification or notification for the above reasons and/or one of the qualifying factors below:

- No connection or inadequate connectivity with specialty doctor
- Recent release from incarceration
- Poor compliance with treatment or medications or difficulty managing medications
- Homeless or inadequate social/family/housing support
- Learning or cognition issues
- Deficits in activities of daily living such as dressing, eating, etc.
- Cannot be effectively treated in an appropriate resourced patient centered medical home
- Court Ordered Assisted Outpatient Treatment

Members are referred to a Health Home by utilizing the MVP Health Home Upward Enrollment Referral Form.

PCPs for MVP Government Programs have additional responsibilities including:

Services for Foster Care Children

Participating providers must work with local department of social services (LDSS) staff to provide comprehensive medical assessment for children in foster care as specified in 18 NYCRR §441.22 and 507.

Child Protective Services

Participating providers must comply with lead screening follow-up as specified in 18 NYCRR §432.

Care Advantage

The Care Advantage Program is available to ASO employer groups as an add-on. The focus of this program is to promote health, wellness, informed decision-making, preventive care, healthy lifestyle choices and complex case management while optimizing quality and efficiency. This program provides a proactive, integrated, member-centric approach utilizing the nurse as the primary point of contact. Registered nurse case managers, known as Care Coordinators, are dedicated and assigned to the employees of the organization as well as to their covered dependents. The Care Coordinators provide direct assistance to participants and their treating physicians with the management of the enrollee's health care, as well as provide and/or coordinate a wide array of healthcare-related support and educational services. They are available to discuss treatment options and provide resource information with the enrollee, all in coordination with the treating physician. They act as proactive partners with the members and are available to help them navigate through the healthcare delivery system, understand their benefit coverage, and coordinate with other relevant providers and care managers involved in

their treatment, such as EAP providers, behavioral health providers, disease management coordinators, etc.

The Care Coordinators, in addition to being registered nurses, are certified case managers with advanced training or certification in health coaching. Their duties and responsibilities include, but are not limited to, proactive outreach based on biometric and personal health assessment triggers, identification and outreach based on care gaps, and high cost outreach to evaluate alternatives discharge planning.

24/7 Nurse Advice Line

MVP members have access to a 24/7 Nurse Advice Line operated by CitraHealth, f/k/a SironaHealth, Inc. The 24/7 Nurse Advice Line allows members to obtain the health information and education they need to make better health care decisions. Members and providers may call the Customer Care Center on their ID card or via email through the MVP website.

Bariatric Surgery Network

MVP established a network of hospitals that are approved sites for MVP members to receive bariatric surgery. To obtain a list of the hospitals participating in MVP's Bariatric Surgery Network, visit **www.mvphealthcare.com**. For members enrolled in a Medicare Plan, services must be obtained at an approved Medicare facility. A listing of facilities certified by the American Society for Bariatric Surgery (ASBS) may be found at: **www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp**.

For MVP's Medicaid Managed Care, providers must follow the MVP Medical Policy. Medicaid Managed Care and HARP members are not restricted to the CMS approved and ASBS facilities. MVP also requires that the surgical team (including surgeons, anesthesiologists, and radiologists) be MVP-participating physicians.

Before referring an MVP patient for bariatric surgery and before obtaining prior authorization, call Customer Care Center - Provider at **1-800-684-9286** to determine if the member's benefits require him/her to have the surgery performed in one of the hospitals in MVP's Bariatric Surgery Network. Coverage is subject to each member's specific MVP benefit plan as indicated in his/her subscriber contract or certificate of coverage.

MVP Breast Cancer Surgery Facilities

In accordance with NYS DOH requirements for Medicaid Managed Care programs, MVP may no longer authorize inpatient or outpatient mastectomy and lumpectomy procedures for its Medicaid Managed Care members at hospitals and ambulatory surgery centers identified as low volume by the New York State Department of Health. A listing of the designated approved and unapproved facilities may be found at **www.nyhealth.gov/health_care/medicaid/quality/surgery/cancer/breast**. Please note that the facility must be contracted for MVP Government Program members as well as on the approved list in order to be authorized to treat MVP Medicaid Managed Care members.

Benefits Interpretation Manual (BIM)

The BIM is the online repository for all MVP medical and pharmacy policies. These benefit interpretations provide medical criteria to be used in determining medical necessity for services covered under the members benefit. The criteria are based upon a review of currently available peer-reviewed medical literature, regulatory status of the technology, evidence-based guidelines, and positions of leading national health professional organizations. Practicing physicians with expertise relevant to each policy are consulted and relied upon. We welcome feedback and supporting studies from participating practitioners. A member's benefit plan may contain exclusions or other benefit limits applicable to the policy. Some benefit plans exclude coverage for services or supplies that MVP considers medically necessary.

Providers are responsible for checking the BIM's Current Update Section for policy updates each time they access the BIM before going into the policies. Refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy. Providers should review the grid at the end of each policy for specific prior authorization requirements for the specific member's contract.

Medical Affairs

New Technology Assessment

MVP follows a formal process to evaluate new technology and reassess existing technologies to determine whether such technologies are covered services and/or should be addressed in the Benefit Interpretation Manual. This includes medical/surgical procedures, drugs, medical devices, and behavioral health treatments. A copy of this policy is available on request.

MVP's technology policies are reviewed at least annually, with comprehensive updates triggered more often by changes in published medical evidence-based journals. Requests to review new technology or to reassess established technology are received from participating providers, MVP medical directors, UM staff and other MVP personnel.

Our team of medical professionals conducts research of the published scientific evidence, information from government regulatory bodies, and prepares a draft of the technology assessment/benefit interpretation policy. The new/updated technology is considered for its impact on health outcomes, health benefits and risks, and effectiveness compared to existing procedures and/or products. The draft policy is presented to the Medical Policy Task Force for review and forwarded to practicing physician consultants from appropriate specialties for review and comment. Policies are then distributed to MVP medical directors and key UM staff, Professional Relations, Claims, Corporate Affairs and Legal Affairs for a 14-day review and comment period. The Medical Policy Task Force reviews the recommendations from the above and appropriate recommendations are incorporated into the proposed policy. The revised policy is then presented to the Medical Management Committee (MMC) Work Group for review and discussion. Once approved the policy is forwarded to the MMC for consideration. Comments are considered and as appropriate incorporated into the medical policy. MMC membership includes

practicing physicians from representative specialties, including at least one physician from each of the MVP service areas and MVP staff. MVP's Pharmacy and Therapeutics (P&T) Committee reviews new drugs including new chemical entities as well as new formulation and combination products. Prior to each meeting, new drug coverage policies and policy revisions are distributed to P&T members for review and comment.

Policy recommendations that are accepted by the MMC and P&T are presented to the Quality Improvement Committee (QIC) for final approval. The QIC may approve the policies when they are presented or send them back through their respective processes for additional research and revision before reconsidering them at a future meeting. Once the QIC approves a medical policy, providers are informed through the Healthy Practices newsletter or online at www.mvphealthcare.com of the new/revised medical policy and effective date. The policy is then posted in the online BIM for providers. Formulary and pharmacy policy updates also are found online.

Serious Reportable Adverse Events (SRAE) (Formerly referred to as "Never Events") and Hospital Acquired Conditions (HACs)-By Product.

MVP's policy is consistent with those defined by the National Quality Forum (NQF), CMS, New York State Department of Health (DOH) and other entities that maintain different lists of SRAE/HAC's. These lists are not intended to capture all of the SRAE and HAC's that could possibly occur in hospital facilities, outpatient/office based surgery centers, and ambulatory practice settings/office based practice, long term /skilled nursing facilities but are intended to provide guidance as to what would likely be considered SRAEs and HACs.. The actual Never Events/SRAE/HAC's governed under this policy will change over time, as dictated by federal and/or state mandate, and the needs of our customers and members. The SRAE and HAC criteria utilized, to which this policy applies, is listed below.

1. MVP Commercial/ASO Products

MVP will deny a claim submitted with a SRAE and MVP will reduce payment on a claim billed with a HAC diagnosis and a Present-on-Admission (POA) indicator of "N". For hospitals billing with APR DRG's for commercial business, MVP shall reference the then current New York State DOH SRAE and or HAC lists as published by the NYS DOH. For hospitals billing with MS DRGs for commercial business, MVP shall reference the then current CMS list published by CMS. Providers shall bill MVP according to the applicable CMS rules relating to SRAEs and HACs. The applicable NYS DOH or CMS list utilized will be determined by the date services were rendered.

Facility notification/claims submission related to Never Event/SRAE for Commercial ASO Members:

- a) Facility/Provider will bill MVP for these Inpatient and Outpatient services, according to the standard process
- b) MVP will deny a claim if an SRAE is identified upon medical record review. .
- c) Should the facility disagree with MVP's denial of the claim, the hospital may appeal to MVP within 30 days of the date of the denial letter. .
- d) Subsequent Inpatient or Outpatient readmissions to the same facility caused by the SRAE and admission is related to the SRAE will also be denied by MVP.
- e) SRAEs and HACs are non-reimbursable services and members may not be balanced billed.

2. Medicare Advantage Products

MVP will deny a claim submitted with an SRAE and MVP will reduce payment on a claim billed with a HAC and a Present-on-Admission indicator of "N". For SRAEs and HACs MVP shall reference the then current CMS SRAE and HAC lists published by CMS. MVP follows standard CMS reimbursement practices for SRAEs and/or HAC's, which may include payment adjustments or non-payment for CMS specific SRAE and/or HACs. The lists of SRAEs and HAC's may be adjusted by CMS periodically and MVP will follow CMS practices. The applicable CMS list will be determined by the date services were rendered.

Facility Notification/claims submission related to Never Events/SRAE on a Medicare Patient

- a) Facility/Provider will bill MVP for these Inpatient and Outpatient services, according to the standard CMS billing process.
- b) MVP will deny a claim if a SRAE is identified upon medical record review. Should the facility disagree with MVP's denial of the claim, the facility may appeal to MVP within 30 days of the date of the denial letter.
- c) Subsequent Inpatient or Outpatient readmissions to the same facility that caused the SRAE and admission is related to the SRAE will also be denied by MVP.
- d) These are non-reimbursable services and members may not be billed.

3. New York State Government Programs Products (Medicaid Managed Care, Child Health Plus and HARP)

MVP will deny a claim submitted with an SRAE and MVP will reduce payment on a claim billed with a HAC and a Present-on-Admission indicator of "N". For SRAEs and HAC's MVP shall reference the then current Medicaid SRAE and HAC lists published by DOH. MVP follows standard New York State Medicaid reimbursement practices for SRAEs and /or HACs for its New York Government Programs products. The applicable DOH list will be determined by the date services were rendered.

Facility Billing Related to SRAE and for Medicaid Managed Care, Child Health Plus and HARP

- a) Facility will bill MVP for these Inpatient and Outpatient services, according to the standard process as defined by NYS Medicaid Managed Care, Child Health Plus or HARP members.
- b) MVP will deny a claim submitted with an SRAE or reduce payment on a claim submitted with a HAC and a Present-on-Admission indicator of "N".
- c) Should the facility disagree with MVP's denial of the claim, the facility may appeal to MVP within 30 days from the date of the denial letter. Subsequent Inpatient or Outpatient readmissions to the same facility that caused the SRAE and admission is related to the SRAE will also be denied by MVP.
- d) These are non-reimbursable services and members may not be billed.

New York State Essential Plans

MVP will deny a claim submitted with an SRAE and MVP will reduce payments on a claim submitted with a HAC and a Present-on- Admission indicator of "N". For SRAE's and HACs, MVP shall reference the then current Medicaid SRAE and HAC lists as published by NYS DOH. MVP follows standard Medicaid reimbursement practices for SRAEs and/or HACs for its New York Essential Plans.

Facility notification/claims submission related to SRAE for New York State Essential Plans

- a) Facility will bill MVP for these Inpatient and Outpatient services, according to the standard process as defined by NYS Medicaid Managed Care, Child Health Plus or HARP members.
- b) MVP will deny a claim submitted with an SRAE or reduce payment on a claim submitted with a HAC and a Present-on-Admission indicator of "N".
- c) Should the facility disagree with MVP's denial of the claim, the facility may appeal to MVP within 30 days from the date of the denial letter. Subsequent Inpatient or Outpatient readmissions to the same facility that caused the SRAE and admission is related to the SRAE will also be denied by MVP.
- d) These are non-reimbursable services and members may not be billed.

4. Physician Billing Related to Never Events

Commercial/ASO Products

- a) Physicians will notify MVP if one of the SRAE occurs as defined by the appropriate regulatory list as noted above. Should MVP determine that SRAE occurred; providers who were causatively linked to the event will have their bills denied. Members may not be billed.
- b) Physicians who provided services ancillary to the Never Events (i.e. radiologists, pathologists, consultants) will not have their bills denied.

- c) Physicians whose bills are denied may appeal such denials in accordance with their MVP contracts.

Medicare Products

- a) MVP will follow Medicare protocols related to payments of physicians for Never Events.

New York Government Programs Products Medicaid Managed Care, Child Health Plus and HARP

MVP will follow NYS Medicaid Managed Care protocols related to payment of physicians.

NY Essential Plan Products

- a) Physicians will notify MVP if one of the SRAE occurs as defined by the appropriate regulatory list as noted above. Should MVP determine that SRAE occurred; providers who were causatively linked to the event will have their bills denied. Members may not be billed.
- b) Physicians who provided services ancillary to the Never Events (i.e. radiologists, pathologists, consultants) will not have their bills denied.
- c) Physicians whose bills are denied may appeal such denials in accordance with their MVP contracts.

RECONSIDERATIONS Statutory

For New York fully-insured products, if MVP denies a claim for services on the basis that such services are or were:

- a) Not medically necessary; or
- b) Experimental or investigational,

without offering to discuss the denial with the provider who specifically recommended the health care service, procedure or treatment under review, then that provider may request a statutory reconsideration of the claim denial. The provider and the MVP clinical peer reviewer who made the initial denial will conduct a statutory reconsideration.

For post-service claims, the statutory reconsideration will occur within 30 business days of the provider's request. For pre-service claims, Urgent Care, and Concurrent Review, the statutory reconsideration will occur within one business day of receipt of the request. If MVP upholds the initial denial after completing the statutory reconsideration, then the provider will be sent a written notice of the determination.

Supplemental

For all MVP health insurance and HMO products in New York, and Vermont, MVP offers hospitals a supplemental reconsideration process. If MVP denies a claim for services on the basis that such services were:

- a) Not medically necessary; or
- b) Experimental or investigational, then the hospital may request a supplemental reconsideration of the claim denial and submit additional information in support of the denied claim without having to formally submit a hospital appeal.

MVP will respond to requests for supplemental reconsideration within 30 business days of receipt. If MVP upholds the initial denial after completion of the supplemental reconsideration, then the hospital will receive written notice of the determination. Supplemental reconsideration is not available after a hospital has submitted a statutory reconsideration or filed a hospital appeal. Moreover, MVP will immediately terminate its review of the supplemental reconsideration upon receipt of a hospital appeal.

Commencement of a Statutory or Supplemental Reconsideration

To request either type of reconsideration described above, a hospital must call the appropriate MVP UM department and advise them that reconsideration is sought. A hospital must submit its reconsideration request within 45 calendar days of receipt of the claim denial or MVP's remittance advice. A hospital is not required to submit either a statutory or supplemental reconsideration in order to submit a hospital appeal or to submit an appeal on behalf of a member. Additionally, the submission of either type of reconsideration does not postpone the time period to file either a hospital appeal or an appeal on behalf of a member.