Services that Require Prior Authorization

A Guide for Members

What is Prior Authorization?

Prior authorization is the approval that your doctor must get from MVP Health Care® (MVP) before you receive certain outpatient, medical, or surgical procedures, durable medical equipment, home care and professional services, as well as certain prescription drugs. MVP reviews information about your medical condition and the services to determine whether such services are medically necessary, covered services. It also is the approval that you need from MVP before you receive any services from a non-participating (often referred to as "out-of-network") health care provider.

To receive prior authorization, your provider will contact MVP on your behalf with the necessary medical information if the service, drug or supply requires prior authorization.

When prior authorization is properly obtained by your MVP participating provider for services included in your certificate of coverage (contract) with MVP, you will only need to pay the copay, coinsurance or deductible that is required by your health plan. If you are using a non-participating provider, it is your responsibility to confirm there is prior authorization on file when needed.

If you pay out-of-pocket for a drug without the required authorization, you will be financially responsible for that drug regardless of whether the pharmacy is participating or non-participating. It is best to use a pharmacy in the MVP network for drugs covered under the prescription rider to ensure the appropriate benefit is applied.

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Prescription Drugs

MVP's drug formulary is an approved list of covered medications—those that are proven safe and effective and those that provide clinical value to treat your condition. The formulary also lists medications that require prior authorization or are subject to step therapy (when certain drugs to treat a medical condition are tried before a different drug for that condition will be covered) or quantity limits (for certain drugs, the health plan may limit the amount of a drug that will be covered), as well as whether they are available through mail service.

For a complete, up-to-date list of drugs that are subject to prior authorization, quantity limits or step therapy, refer to the MVP formulary online at **mvphealthcare.com**, click *Manage Prescriptions* and then *MVP Prescription Drug Formulary*.

Coverage for prescription drugs may be different based on your specific health plan. Programs used by MVP to enhance safety and control costs also may affect coverage. Out- of-pocket costs may vary based upon the drug your doctor prescribes. Work with your doctor to make sure that you get the best and most cost-effective drugs available. Not all MVP health plans offer prescription drug coverage. Check your plan materials for your coverage details.

Behavioral Health Services

MVP will manage all New York members' behavioral (mental) health and substance use treatment services. The behavioral health services that require prior authorization include: Assertive Community Treatment (ACT); Transcranial Magnetic Stimulation (TMS); Home and Community Based Services (HCBS); and Applied Behavior Analysis (ABA). Notification of admission is required within two (2) business days for Mental Health and Substance Use Inpatient and Residential Treatment Center admissions. Community Oriented Recovery & Empowerment service providers must notify MVP within three (3) business days after the first date of initiating a new CORE Service. If you have any questions concerning coverage for behavioral health benefits, please refer to the Mental Health/Substance Use Disorder Help number located on the back of your member ID card.

Going out of network for your health care? Call MVP first.

If you are considering receiving health care services from a provider outside of MVP's network and your health plan includes out-of-network benefits, please call us first.

Out-of-network providers are not under contract to deliver covered services to you and so can set their own fees for services. The charges from an out-of-network provider may be much higher than the charges from a provider within MVP's network.

In addition, some services will not be covered by your health plan if you use an out-of-network health care provider without calling MVP first for prior authorization. An approved prior authorization request means that your benefits will be applied to the cost of the service.

Before receiving out-of-network care, call MVP's Customer Care Center at the phone number shown in the Member section on the back of your ID card. The Customer Care Representative can provide you with prior authorization requirements and information about your health plan's out-of-network benefits. You may want to consider using an in-network provider rather than going out-of-network.

If Your Health Plan Does Not Include Out-Of-Network Benefits, you will not be covered for any service performed by an out-of-network provider, except in the following circumstances:

A. COVERED EMERGENCY CARE SERVICES, when emergency care services are utilized, you must notify MVP as soon as possible after the emergency admittance. Many times, in emergency situations, the services are provided by out-of-network providers. You're covered for emergency medical care, including services by an out-of-network provider, when you are outside of the service area or in the event that a life- threatening emergency requires that medical attention be provided by the nearest medical provider. Please consult your Certificate of Coverage for information regarding emergency care coverage under your plan.

B. COVERED NON-EMERGENCY CARE SERVICES, in circumstances where a qualified participating provider with the appropriate training and experience to meet the needs of the member is not available to provide covered services to a member, MVP may provide benefits for covered services provided by a non-participating provider. When you want to ask for benefits from a non-participating provider in these circumstances, your physician must provide MVP with information about your condition, a medical opinion as to why services cannot be provided by a participating provider and the name and qualifications of the proposed non-participating provider.

If you are admitted to a hospital for emergency services, you or your doctor must notify MVP as soon as possible (this is called "concurrent notice") so that MVP can review the services that you received and determine your coverage.

Prior Authorization Procedures/Services List

The following procedures/services may require prior authorization from MVP. To verify the procedures/services that may require prior authorization, call the Customer Care Center at the phone number shown in the Member section on the back of your ID card.

If you are interested in learning more about the treatments and services listed here, try looking them up in our online Health Encyclopedia. Visit the MVP website at **mvphealthcare.com**, click *Live Healthy* and then *Health Encyclopedia A-Z*.

Acute Inpatient Rehabilitation
Advanced Imaging (Radiology) Services
Advanced Infertility Services including In Vitro Fertilization (IVF)
Air Medical Transport/Air Ambulance (non-emergency transport)
Applied Behavior Analysis (ABA)
Assertive Community Treatment (ACT)
Atrial Fibrillation Ablation, Catheter based
Autologous Chondrocyte Implantation
Automatic External Defibrillators
Benign Prostatic Hyperplasia (BPH) Treatments
Biventricular Pacing - Cardiac Resynchronization Therapy
Bone Growth Stimulator
Breast Reduction Surgery
Cancer Gene Expression Genetic Tests
Cochlear Implants & Osseointegrated (BAHA) Devices
Cold Therapy Devices
Colorectal Cancer Susceptibility Genetic Testing
Continuous Glucose Monitoring
Cosmetic vs Reconstructive Services
Court Ordered Services
DME/Prosthetics/Orthotics
Enteral Therapy
Erectile Dysfunction
Fertility Preservation Services
Gaucher's Disease Treatment
Gender Affirming Treatment
Genetic and Molecular Diagnostic Testing
Gynecomastia Treatment
Hepatitis C Drug Treatment
Hereditary Angioedema
Home and Community Based Services (HCBS)
Home Care Services
Hyperbaric Oxygen Therapy (HBO)
Hyperhidrosis Treatments
Idiopathic Scoliosis Surgery
Immunoglobulin Therapy
Infertility Drug Therapy
Infertility Services (Advanced) including In Vitro Fertilization (IVF)
Insulin Pumps
Inpatient/Residential Mental Health (Notification of admission within 2 business days)
Inpatient/Residential Substance Use (Notification of admission within 2business days)
Interventional Pain Management
Joint Replacement and Implant for Hallux Rigidus
Laser Treatment for skin lesions
Mechanical Stretching Devices
Negative Pressure Wound Therapy Pumps
New Technology

Obstructive Sleep Apnea Surgical
Oncotype DX Testing and Cancer Gene Expression Tests
Oral/Orthognathic Surgery
Orphan Drugs
Orthotic Devices (Braces and Splints)
Panniculectomy and Abdominoplasty
Pectus Excavatum
Penile Implant for Erectile Dysfunction
Percutaneous Left Atrial Appendage (LAA) Closure Devices
Personal Care and Consumer Directed Services
Pneumatic Compression Devices
Power Mobility Devices
Private Duty Nursing
Prosthetic Devices (External)
Rhinoplasty
Sacral Nerve Stimulation
Sacroiliac Joint Fusion
Sinus Surgery – Endoscopic
Speech Generating Devices (SGD)
Spinal Cord Stimulator for Chronic Pain
Stereotactic Radiosurgery Body
Stereotactic Radiosurgery Brain
Synagis (Injectable agents for RSV)
Temporomandibular Joint Dysfunction (TMJ)
Thoracic Electrical Bioimpedance
Total Artificial Heart
Transcranial Magnetic Stimulation (TMS)
Transplants
Uvulopalatopharyngoplasty (UPPP) Surgery
Ventricular Assist Device (Left)
Wheelchairs

Oncology Medications

MVP has delegated utilization management for oncology medications billed under the medical benefit to Optum. MVP Health Care is making this change as part of our commitment to working with care providers to help support improved population health outcomes, affordable evidence-based treatment and leverage Optum's expertise in the oncology and specialty fields. The Optum portal is not used for requesting prior authorization for the following: CAR-T therapies, chemotherapy drug(s) for non-oncology diagnosis, chemotherapy ordered and/or administered as part of inpatient or home care, drugs without prior authorization requirements, oral drug authorizations and stem-cell or bone marrow transplant regimens. For a list of prior authorization requirements, please call the Customer Care Center at the phone number shown in the Member section on the back of your ID card.

We are here to help.

MVP has attempted to capture all prior authorization requirements in this document. However, benefit plans are subject to change. If you have questions about your benefit coverage, services or procedures in this document, or about any services that are not included, please call the Customer Care Center at the phone number shown in the Member section on the back of your ID card.

Visit the MVP website at mvphealthcare.com to see the MVP Prescription Drug Formulary that identifies pharmacy covered drugs that require prior authorization.