



Provider Manual

Hoosier Healthwise and Healthy Indiana Plan (HIP)





Contents

Welcome to MDwise

Provider Responsibilities7

- Provider Qualifications
- Credentialing and Enrollment Process
- Access and Quality Standards
- Provider Rights and Responsibilities

Hoosier Healthwise Member Benefits24

- Program Overview
- Eligibility
- Presumptive Eligibility (PE)
- Member Card
- Cost-Sharing and Copayments
- Program Benefits
- Service Descriptions

Healthy Indiana Plan Member Benefits35

- Program Overview
- Eligibility
- Member Card
- POWER Account Contributions and Copayments
- Program Benefits
- Service Descriptions
- Preventive Care Package

Claims49

- Timelines
- Third Party Liability
- Inquiries, Disputes and Appeals

Prior Authorization57

- Services that require Prior Authorization
- PA Process
- Hoosier Healthwise Claim Submission
- Healthy Indiana Plan Claim Submission
- Dental Claims
- Pharmacy Claims
- Billing MDwise Members

Medical Management	59
Care Management	
Disease Management	
Care Coordination	
NURSEon-call	
EPSDT	
Right Choices Program (RCP)	
Quality.....	82
Payment for Outcomes (P4O)	
HEDIS	
Potential Quality Issues (PQI) and Concerns	
Clinical Practice Guidelines	
Preventive Health and Practice Guidelines	
Pharmacy	89
Drug-Related Medical Supplies and Medical Devices	
Pharmacy Claims	
Prior Authorization	
Drug Utilization Review	
Behavioral Health	95
Providers	
Benefits	
Coordination	
Prior Authorization	
Referrals	
Transportation	104
Services and Limitations	
Transport Prior Authorizations	
Transportation Reservations	
Member Rights and Responsibilities	107
Overview	
Choosing and Changing Doctors	
Member Grievances and Appeals	
Outreach and Education	116
Member Education	
Communication Resources	
Community Resources	
Special MDwise Programs	
MDwise Provider Resource Directory	



Welcome to MDwise!

MDwise welcomes you as a provider into the MDwise network. We are supplying you with this Provider Manual to inform you of all the different programs MDwise participates in, as well as MDwise guidelines and requirements, policies and procedures, and answers to questions you may have. MDwise hopes that you will find the manual to be a valuable tool that assists you in caring for our members.

MDwise values its on-going partnership with our network providers. Communication is essential to making a partnership work. We update the Provider Manual annually, and more frequently if necessary, due to program changes. You will be notified via the MDwise Provider webpage as revisions or updates are added to the manual, which is always available on the MDwise website at MDwise.org.

If new procedures and processes take effect after this manual has been published, MDwise will provide updates through other means of distribution including posting on MDwise.org, quarterly newsletter article, special mailings, and email blasts.

We will always give you at least 45 calendar days notice of any significant change that may affect your office practice or procedures. A significant change in practice is determined by the impact of the policy on such issues as coverage criteria, authorization procedures, referral policies, subcontractors, provider office site standards, medical record standards, or access standards. Notice of all significant changes are also posted on the MDwise website.

If you have questions, concerns, or complaints, you are encouraged to call your delivery system provider relations representative directly at the telephone numbers listed in the directory at the end of this manual. Or, you can always call the toll-free MDwise Customer Service line. MDwise Customer Service Representatives (CSRs) are available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Standard Time. After regular business hours, MDwise contracts with a telephone answering service that is trained to respond to most provider issues that arise after hours. For instance, the after-hours service handles many urgent pharmacy issues. If the answering service representative is unable to respond to a provider call, information is forwarded to a MDwise Customer Service Representative to address the following business day.

We look forward to our continued working relationship with you and welcome your comments and suggestions regarding the manual and suggestions on other ways that we can better assist you in providing quality care to our members.

If you have any questions about the content of this manual, please contact MDwise Customer Service or your MDwise Hoosier Healthwise/Healthy Indiana Plan provider relations representative.

Providers with questions regarding this manual can submit those to the MDwise Provider Relations Department at prenrollment@MDwise.org, or by calling **317-822-7300 ext. 5800**.



Who is MDwise?

MDwise is a not-for-profit corporation that began its operation in 1994, when it was established as the Central Indiana Managed Care Organization, Inc. (CIMCO). It was formed specifically to help several major Indianapolis hospitals and their affiliated physicians deliver a provider-directed, cost-effective approach to managed care services for Hoosier Healthwise members. It became the fastest growing organization providing risk-based managed care for Hoosier Healthwise in central Indiana.

In 2001, CIMCO teamed up with IU Health Plan (IUHP) and organized its affiliated providers under a new name, MDwise. In August 2007, MDwise was selected to begin negotiations to serve as an insurance provider for the Healthy Indiana Plan (HIP). Under the HIP program, the State of Indiana contracts with statewide, risk-bearing entities to deliver basic benefit packages offered through a deductible health plan paired with a personal health care account referred to as a POWER (Personal Wellness and Responsibility) Account. The program is designed to foster personal responsibility and promote preventive care and healthy lifestyles while encouraging participants to be value-conscious consumers of health care to help promote price and quality transparency.

In 2018, MDwise was purchased by Michigan based McLaren Health Care. McLaren is a fully integrated health system that includes 14 hospitals, ambulatory surgery centers, imaging centers, and an employed primary care physician network. McLaren Health Plan, a subsidiary, provides health benefits to over 260,000 commercial, Medicaid and Medicare members across Michigan. McLaren's vision and mission are very similar to the MDwise vision and mission. Both MDwise and McLaren are committed to delivering high-quality health care benefits to Indiana Medicaid members.

MDwise Mission

The MDwise Plan is a coordinated, comprehensive approach to managing the cost and utilization of health care services. Our mission is to enhance client satisfaction and lower total health care costs by improving the health status of members through the most efficient provision of quality health care services.

Our Core values are compassion, excellence, and leadership.



MDwise is:

- The Heart of Compassion
- The Star of Excellence
- The Torch of Leadership

MDwise five-fold Mission:

- Delivering consistent, high quality care.
- Focusing on families and community in a culturally competent way.
- Shaping health policy and promoting innovation in Medicaid managed care.
- Ensuring financial viability through efficient and cost-effective operations.
- Involving providers in key decision making and nurturing local governance of the MDwise product.



Maximizing value in health service delivery includes a focus on quality and access and ultimately depends on the collaborative relationships between the managed care entity, providers, and well-informed members. In delivering Hoosier Healthwise and Healthy Indiana Plan services across the full healthcare continuum, a primary focus of MDwise is to link primary care physicians, specialists, hospitals, and ancillary providers so all providers can administer and coordinate care more efficiently and effectively.

MDwise emphasizes the role of the primary medical provider (PMP) to guide members to the most appropriate treatment option and place of care. MDwise works to strengthen the link between MDwise members and their PMPs to coordinate care, prevent unnecessary utilization of services, and ensure access to and utilization of needed medical care, including preventive care.

MDwise is focused on helping physicians and provider networks provide members with a full range of cost-effective, quality care. An equally important function is that MDwise helps members understand their responsibilities in the effective use of the system. This is done through the MDwise member handbook and periodic newsletters and mailings, as well as outgoing member outreach and education calls when a provider lets us know there is a potential problem. MDwise also has a social work-based Health Advocate program to focus on the hardest-to-reach and special needs members.

MDwise Dedication to Quality

MDwise understands the uniqueness of the underserved and has developed our programs with full attention to guiding quality health care services to the Indiana population. MDwise's Hoosier Healthwise and Healthy Indiana Plan product lines are NCQA Accredited. NCQA Health Plan Accreditation evaluates how well a health plan manages all parts of its delivery system to continuously improve health care for its members. MDwise will work hard every day with our providers to help deliver high-quality health care services to our members.

Provider Responsibilities

This chapter contains important information about your role and responsibilities as a MDwise provider. Topics covered in this chapter include: provider qualifications, the credentialing and enrollment process, , access and quality standards, and your Rights and Responsibilities as a MDwise provider.

Provider Qualifications

To participate in the MDwise Plan under Hoosier Healthwise or Healthy Indiana Plan, providers must first be enrolled with the State as a participating provider in the Indiana Health Care Programs (IHCP). This means having a valid, current Medicaid provider number and NPI number. In addition, other participation requirements specific to MDwise must be followed as outlined in this chapter.

MDwise follows the State's policies and procedures for handling provider enrollment and disenrollment in the MDwise provider networks.

Providers who wish to participate as an in-network MDwise provider must first go through the contracting process. To obtain a contract with MDwise, contact your Provider Relations Representative at <http://www.MDwise.org/for-providers/contact-information>. If you have questions regarding the contracting process, please call your dedicated Provider Relations Representative.

Primary Medical Provider Role and Duties

The Primary Medical Provider (PMP) is an integral part of the MDwise managed health care program. The PMP functions as the central access point for MDwise members. MDwise PMPs coordinate all covered physical and behavioral health care services for their assigned members, except for self-referral and carved-out services. Primary Medical Providers (PMP) can only carry a panel with one delivery system at a time.

MDwise offers Medical and Behavioral Health contracts to all IHCP enrolled providers. This includes guiding members to participating specialists and hospitals when necessary and maintaining continuity of each member's health care. MDwise will not in any way limit a PMP's ability to advise a member about their health status, medical care, or treatment options, even if MDwise does not cover those treatment options.

Through the PMP, the MDwise program delivers primary and preventive health care to its members in a personalized and systematic manner. MDwise encourages providers to give members information about available treatment options regardless of the benefit coverage limitations. The member is to be informed of the scope of the covered benefits under the member's benefit package and how coverage relates to the member's medical needs.

Each Primary Medical Provider (PMP) who participates within the MDwise network must agree to the following participation requirements:

Policies and Procedures: Follow all MDwise policies and procedures and Federal and State requirements.

- MDwise policies are described in this Provider Manual.
- State requirements can be found on the web at indianamedicaid.com.
- If you have any questions about these policies, call MDwise provider relations staff or MDwise Customer Service.

Practitioner Participation Criteria

All providers who request initial and continued participation in the MDwise Plan must meet the following criteria as part of the credentialing process:

- Attested and completed application.
 - Hold a current, valid, and unrestricted license to practice in Indiana.
 - **DEA:** If requesting prescriptive authority, current, valid and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. Note: DEA or CSR certificates are not applicable for chiropractors.
 - **Education:** Graduate of a school recognized by the appropriate Indiana State Boards. Satisfactorily completed a residency program in the appropriate specialty of practice. If Board Certified, residency requirements are met. Note: Residency requirements are not applicable for chiropractors.
 - **Board Certification:** Board certified or board eligible in the specialty in which the practitioner treats MDwise members. Board certification must come from a recognized Board, such as the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Podiatric Medical Association (APMA) or other recognized specialty boards.
 - a. **Note:** Board Certification does not apply to chiropractors.
 - **Board Certification exceptions may be granted if:**
 - a. The practitioner has recently completed degree requirements and is in process of seeking board certification, **or**
 - b. Practitioner has satisfactorily completed a residency program in the appropriate specialty of practice and has acquired a minimum of 25 Category I CMEs in the previous 12 months (1-year credentialing cycle) or 50 Category I CMEs in the previous 24 months (2-year credentialing cycle), or 75 Category I CMEs in the previous 36 months (3-year credentialing cycle) in his/her primary specialty **or**
 - c. The physician's specific services are not sufficiently available from board certified or board eligible practitioners within a reasonable commuting distance.
- Please Note:** If practitioner has not obtained the required CME's at the time of initial credentialing or recredentialing, approval for participation may be granted for one year. However, during this time period practitioner is required to make up the number of CMEs for which they were deficient, along with obtaining the required 25 Category I CMEs per year. For example, if practitioner has obtained 65 CMEs at time of recredentialing, provider would be required to obtain 35 CMEs during the one-year credentialing cycle.*
- Current clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility to hold a panel.
 - **Privilege exceptions may be granted if:**
 - a. The physician's practice does not require admitting or practicing privileges at a hospital. These specialties include, but are not limited to: Radiology, Podiatry, Pathology, Dermatology, Emergency Medicine, and Allergy, some Behavioral Health Practitioner specialties if hospital privileges are available in their specialty.
 - b. A MDwise primary medical provider (PMP) has a clinical appointment or relationship privileges in good standing at a participating MDwise hospital.

- **Current Liability Coverage:** Maintains professional liability insurance coverage of \$250,000/\$750,000 with participation in the Indiana Patient Compensation Fund. If the practitioner is not qualified as a provider under the Fund then they must maintain coverage of \$1,000,000 per occurrence, \$3,000,000 aggregate or be a covered employee or contractor of an entity that is eligible for coverage under the Federal Tort Claims Act.
- **Malpractice History:** Demonstrates acceptable liability history based on the frequency, pattern and type of all settled and pending claims against the practitioner. Practitioner must submit detailed report of each liability claim filed within the past ten years. The Medical Director or designee will review the claims history for any trends, such as pattern of frequency, date of occurrence, number of open cases, sequential order of patterns and file date.
- **The peer-review Committee or designee will individually review all practitioners with the following:**
 - a. Two (2) or more filed malpractice claims or settlements in the last five (5) years, **or**
 - b. Any settlement or award for \$500,000 or more in the last five (5) years, **or**
 - c. Any filed malpractice claims or settlements involving the death of a patient.
- **Recredentialing** - If no additional suits have been filed against the practitioner since the most recent credentials cycle or if no new information exists on previous cases (e.g., settlement reached, finding of malpractice, etc.) individual consideration of liability history is not required.
 - a. **Impairment:** Certifies that a physical or mental dependency and substance abuse) does not affect his/her ability to practice.
 - b. **Sanctions, Disciplinary Action or Criminal Indictment:** Must demonstrate absence of Medicare or Medicaid Sanctions. Must disclose **1)** all past or pending sanctions under state or other licensing agencies, hospitals and other facilities, or DEA **and**
 - c. All past or pending disciplinary or professional committee action by a health care entity (e.g. hospital) **3)** all information concerning any past suspensions, limitations or termination by any managed care plan, hospital or insurer and, **4)** any felony convictions. Must demonstrate that history of sanctions/convictions does not demonstrate potential future substandard professional performance.
- **Work History:** Satisfactory five-year professional employment and/or education history.
 - a. **Initial Office Review:** PMP's, obstetrician/ gynecologists and high volume behavioral health specialists must have satisfactory office onsite survey results to participate in MDwise network.
 - b. **Attestation Statement:** Practitioner must attest to the correctness and completeness of the application.
 - c. **IHCP Participation:** MDwise practitioners must be enrolled as providers in the Indiana Health Coverage Programs (IHCP). Practitioners who have laboratory testing services onsite must also provide proof of a Clinical Laboratory Improvement Amendments (CLIA) certificate.
 - d. **Contract:** Must execute an agreement to abide by the terms of the contract.

Physician Extenders

Advanced Nurse Practitioner & Physician Assistant Participation Criteria

MDwise recognizes the value of physician extenders and the vital role they play in the delivery of primary and specialty care. With projections of continued shortages in the number of primary care physicians in Indiana, particularly for the underserved population, physician extender importance to the provision of timely care for our members cannot be understated. These practitioners (including nurse practitioners, nurse midwives, clinical nurse specialists, certified nurse

anesthetists, and physician assistants) extend the availability of health care and have shown to substantially add to physician productivity, allowing the practice site to treat more patients in a timely manner.

Advanced Practice Nurses (Nurse Practitioner, Certified Nurse Midwife, Clinical Nurse Specialist) and Physician Assistants must demonstrate as part of the application process that he/she meets the same credentialing criteria, as outlined above for physicians, with the following exceptions:

- **Written Practice Agreement:** Proof of collaboration with a licensed network Practitioner, in the form of a written practice agreement.
- **DEA:** If requesting prescriptive authority, current, valid and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. Note: DEA or CSR certificates are not applicable for some types of physician extenders.
- **Privileges:** Hospital privileges are not applicable for physician extenders.
- **Education:** Graduate of a school recognized by the appropriate Indiana State Boards. Board certification requirements are not applicable.

Responsibilities of the specialty and ancillary providers include:

- Following the MDwise prior authorization and referral requirements.
- Contacting the PMP to coordinate the member's additional care needs when identified.
- Maintaining contact with the PMP regarding the member's status (i.e., telephone or verbal contacts, consultations, written reports).
- Actively participating in the coordination of the member's plan of care/treatment plan and with the member's PMP and when applicable, the member's case manager.

Please Note: Prior authorization of a service is not a guarantee of payment, for example if benefits expired prior to service date. The practitioner/provider must always check member eligibility at the time of service during the authorization time period to avoid denial of payment for services provided due to member no longer being eligible on date of service. Eligibility must be checked every time a service is rendered. Failure to do so may result in denial of payment.

MDwise is committed to the use of physician extenders to increase the availability of primary care offered to current and potential MDwise members. When utilized appropriately, physician extenders offer a cost-effective and valuable clinical resource for providing health care, especially as part of a safety net for underserved populations. Physician extenders in the MDwise network offer opportunities to extend PMP capacity to serve MDwise members and can assist in providing more timely access to preventive health care services and acute care for minor illnesses.

Credentialing and Enrollment Process

Provider Credentialing

As a condition of participation in any of the MDwise Plans, licensed independent practitioners or groups of practitioners (including non-physician practitioners) who are contracted with MDwise and provide care for MDwise members, must be credentialed according to MDwise participation criteria and standards. Practitioners must complete a standard credentialing application when applying for initial participation and submit other required information as required (e.g. DEA certificate, malpractice insurance face sheet, curriculum vitae, etc.).

The function of the MDwise Credential Program is to support the development and maintenance of credentialing and recredentialing standards for MDwise practitioners, based on the Office of Medicaid Policy and Planning (OMPP) and National Committee for Quality Assurance (NCQA) standards. Our goal is to review the qualifications of potential network practitioners against established standards and, to reassess the credentials and performance of network practitioners periodically to ensure that practitioners are qualified to carry out the scope of their duties on behalf of MDwise. The credentialing and recredentialing of providers is delegated to the MDwise delivery systems.

Credentials staff will collect information from recognized monitoring organizations, conduct the required verifications, and review the practitioner's credentials. The credentials staff will notify the practitioner about any information obtained during the credentials process that varies substantially from the information supplied by the practitioner. The practitioner is then given the opportunity to provide additional information regarding the discrepancy.

When all required information and verifications have been completed, the practitioner's application will be considered by the delivery system's Credentials Committee (peer-review process). At a minimum, the Committee individually reviews the credentials of practitioners who do not meet MDwise established criteria. Committee members abstain from voting on a practitioner if he/she feels there is a conflict of interest, has been professionally involved with the practitioner or feels his/her judgment might be otherwise compromised. Practitioners will be notified of the credentialing decision within sixty (60) calendar days of the peer-review committee's decision.

Please Note: All practitioners have the right to request and receive information regarding the status of their credentialing application. The practitioner may call or write MDwise credentials staff to check his/her application status. Any credentials information may be shared with the practitioner except for references, recommendations or peer-review protected information.

All practitioners listed in the MDwise Provider Directories for Hoosier Healthwise and HIP must be credentialed, including:

- Licensed independent medical and behavioral health practitioners or groups of practitioners (including non-physician practitioners) who are contracted with MDwise and provide care for MDwise members.
- Practitioners who see members outside the inpatient hospital setting or outside freestanding ambulatory or facility-based settings.
- Practitioners who are hospital based but who see MDwise members as a result of their independent relationship with the organization.
- Non-physician practitioners who have an independent relationship with the delivery system, as defined above, and who provide care under the Hoosier Healthwise or Healthy Indiana Plan medical or behavioral health benefit.

MDwise and the MDwise subcontractors maintain the confidentiality of all information developed or presented as part of the credentialing process in accordance with state and federal regulations. Individuals engaged in credentialing activities ensure that information supplied by the applicant in the application remains confidential.

Credentials files and confidential written records regarding deficiencies found, the actions taken and the recommended follow-up is kept in a secure fashion. Access to information is restricted to those individuals necessary to attain the objectives of the credentials process. Dissemination of any confidential information shall only be made (1) where expressly required by law, or (2) with permission of the practitioner applicant.

Recredentialing

MDwise requires that all providers participating in the MDwise Plan be recredentialed at least every thirty-six months. Some delivery systems may for the Hoosier Healthwise program or HLP, however, recredential providers every three years. This is generally because their recredentialing cycle coincides with hospital reappointment timeframes. The recredentialing process is conducted similarly to the initial credentialing process. Practitioners must submit a standard recredentialing application. The credentials staff will then collect the necessary information and conduct the required verifications. In addition, during recredentialing, they may use data derived from practice experience within the organization as part of its evaluation regarding practitioner retention. The practitioner will be notified if any information obtained during recredentialing varies substantially from the information that was supplied to MDwise. The practitioner will also be given the opportunity to provide additional information regarding the discrepancy. When all required information and verifications have been completed, the practitioner's application will be considered by the Credentials Committee at outlined above. The practitioner will be notified of the recredentialing decision within sixty (60) calendar days of the peer-review committee's decision.

Between recredentialing cycles, the credentialing department is responsible for monitoring of practitioner sanctions, member complaints and quality issues. Monitoring helps to ensure that potential quality or safety issues are identified and investigated in a timely manner so that appropriate actions can be implemented. Ongoing monitoring between recredentialing cycles includes collecting and reviewing information related to Medicare and Medicaid sanctions, sanctions or limitations on licensure, member complaints about participating practitioners and information from identified adverse events and quality issues.

Please Note: All practitioners have the right to request and receive information regarding the status of their recredentialing application. The practitioner may call or write MDwise credentials staff to check his/her application status. Any credentials information may be shared with the practitioner except for references, recommendations or peer-review protected information.

Credentialing Appeal Process

MDwise offers an appeals process for circumstances in which it has been determined, based on demonstrated credentialing or quality issues, that a practitioner should be denied participation, suspended or terminated from the network. The appeals process meets the requirements of the Health Care Quality Improvement Act of 1986. A provider is notified of appeal rights and the appeal procedures at the time a notice of an adverse credentialing/recredentialing determination is made. A termination from the network will not be effective until the provider has exhausted the appeal process or chooses not to appeal in the required amount of time.

MDwise is responsible for reporting serious provider quality deficiencies that affect network participation to the appropriate state and/or federal authority. Reportable actions are based on reasons relating to quality of care, professional competence or professional conduct.

Office Site Visits

Office site visits are conducted in conjunction with the initial credentialing process for all primary medical practitioners, obstetricians/gynecologists and high volume behavioral health practitioners. If a practitioner practices at more than one office site, an onsite review is conducted at each location to ensure that MDwise criteria are met. If a MDwise practitioner relocates or opens a new site, an onsite review is conducted following the same procedure as for an initial site visit. If the office to which a practitioner is relocating already meets MDwise standards, then a new site visit is not required. An office site visit may also be conducted for any contracted provider based on review of member complaints. Provider office sites will be re-evaluated every three years to verify the location still meets MDwise requirements.

Physician offices must score a minimum of 80% to comply with the office and medical record performance standards. If a site does not meet this threshold, actions for improvement must be implemented and the delivery system may visit the site again to ensure the minimum threshold is met.

PMP Enrollment

To participate as a MDwise Primary Medical Provider (PMP) for the Hoosier Healthwise Program and HIP programs, a physician must first be enrolled with Indiana Medicaid. Physicians must practice in the field of general practice, family practice, general pediatrics, internal medicine or obstetrics/gynecology. Advanced Nurse Practitioners (APNs), including Nurse Practitioners, nurse midwives and clinical nurse specialists (CNSs) holding the appropriate certification and licensure to practice medicine may also act as a PMP and carry a panel. All PMPs must be fully credentialed according to MDwise standards, before actually enrolling with MDwise. For details on the credentialing process, please contact your Provider Relations Representative.

After becoming a provider in the Indiana Health Coverage Programs, MDwise requires the following PMP enrollment steps to occur:

1. A potential MDwise provider contacts the provider relation's staff.
2. New providers must complete the MDwise credentialing process. Upon approval, the provider must complete the required Hoosier Healthwise /HIP enrollment forms.
3. The provider relation's staff reviews the forms for completeness of information and forwards the forms to the enrollment department for processing and enrollment.
4. After the enrollment process is complete, all MDwise providers will receive educational training regarding the Hoosier Healthwise Program and HIP programs, including covered services, self-referral services, quality improvement requirements, medical records retention and availability, member reassignment, member appeals process, provider dispute procedures, and POWER Account features (HIP only).
5. The minimum panel size is 150 for Hoosier Healthwise and 25 for HIP unless an exception is granted by MDwise. The maximum panel size is 3,500 members. Panel sizes must be designated for each program, Hoosier Healthwise and HIP, since they are reported to DXC separately. For more information on Panel requirements, see the PMP Panel section of this chapter.

PMP Panel Requirements

As part of the enrollment process, a PMP designates his or her desired panel size on enrollment forms submitted to MDwise. The panel size is the number of MDwise members a PMP agrees to accept. If a physician has two practice locations, the panel size would represent a combination of both sites. For example, if a PMP is enrolled with a panel size of 500 for Hoosier Healthwise, and has two active service locations, the members assigned to the PMP may be spread across the two locations. The panel size applies to an individual PMP and may not be shared among a group of PMPs. MDwise can approve the enrollment of a new PMP with a panel size below the minimum requirement on a case-by-case basis due to specific circumstances in an area. This exception generally applies to all PMPs with a specific specialty, such as OB/GYN, in an area where increased access to PMPs with a specialty is warranted.

From time to time, PMPs may receive auto-assignments to their existing panel. Auto-assignment is mandated by federal law. This is due to the requirement that members who are in a managed care program have a primary care physician. If a physician has open panel slots and that panel is not full or on hold, they may receive additional members through the auto-assignment process. It should be noted that PMPs that have full panels or panels on hold may still receive auto-assignments. This can happen if the PMP is already treating a member of a family member who is being auto-assigned or has a previous relationship with the member through another IHCP program or previous eligibility segment. PMPs cannot request members be removed from their panel since member was auto-assigned.

MDwise PMPs that wish to increase or decrease their panel size designations must submit the required form to their Provider Relation's representative. They will review the form and submit for processing in the MDwise and DXC systems. PMPs may increase their panel size designation at any time. PMPs may also request to reduce their panel designation. However, a panel size designation less than the current number of assigned members will not result in an immediate reduction of the panel to the new designation. Members will not be removed; therefore, reduction in the panel size can only occur through attrition.

A PMP can also request that his/her panel size be temporarily placed on hold to prevent new assignments to the practice by selection or default auto-assignment. The panel hold does not stop assignment of members with the same case ID or members who have had a previous relationship with the PMP (auto assignment's case ID and previous PMP logic).

Panel hold requests are usually granted in situations expected to be temporary, and are not to be used to circumvent minimum panel size requirements. The reasons for a panel hold request must be documented and are monitored by MDwise to ensure adequate openings to accommodate new MDwise members who self-select or are auto-assigned to a PMP within the program.

Please Note: Your provider relation's representative is available to assist you with selecting an appropriate panel size, completing the required forms and helping with any panel size changes or hold requests. Please refer to the Directory listed at the end of this Manual for contact information.

Enrollment Changes and Updates

MDwise is responsible for developing a PMP and Specialty Provider Directory for MDwise members. We develop this directory, based on the information that is supplied to us through the provider enrollment process and through ongoing provider updates.

MDwise enrolled PMPs are also identified in a Hoosier Healthwise/HIP provider list sent to DXC on a regular basis. MDwise members currently use this list to select a PMP. It is very important that all information in the MDwise Provider Directory and Hoosier Healthwise/HIP provider list is accurate and up-to-date, including provider specialty, practice limitation, address and office locations. Failure to keep updated provider enrollment records with MDwise may result in claim adjudication denials.

Any time there is an update to provider enrollment information, please contact your provider relation's staff. Please call as soon as you are aware of the change. Your provider relation's representative will assist your office in completing the appropriate Hoosier Healthwise/HIP enrollment information update. **Some examples of changes that must be updated include:**

- Address/Phone Number
- Name Change
- Age Restriction Changes or Change in Scope of Practice
- Change in Hours
- Group Information, such as Addition of New Service Locations or Providers
- Tax ID Changes
- CLIA Updates
- Ownership Changes
- Panel Size Changes
- Specialty Changes/Additions
- Board Certification Status
- Languages spoken
- Adding new physicians to the practice (including specialists)

PMP Disenrollment Procedure

If a provider plans to disenroll from MDwise, they should let their provider relation's representative know as soon as possible. The process works as follows:

1. A PMP may disenroll from the MDwise network by submitting disenrollment forms at least 90 days before the date of disenrollment.
2. Upon review by the provider relations personnel, the disenrollment information will be transmitted to DXC.
3. If the provider is disenrolling without reenrolling in another Hoosier Healthwise/HIP MCE, the MDwise Provider Relations will assist. The PMP's members will be notified to choose another MDwise PMP.
4. The disenrolling PMP may request that the entire panel of the PMP's members be moved to another PMP (full-panel transfer). The PMP is required to send a letter to MDwise that specifies the reason he/ she is no longer willing or able to serve as a PMP and names a specific MDwise PMP or PMPs who should receive assignment of the current PMP's members. This letter should include the new PMP's name, NPI, LPI and location code.

5. Members will receive a notification letter from MDwise upon assignment to a new provider. Members are given opportunity to change PMPs within MDwise if they are dissatisfied with the transfer. In the letter, members are also instructed on how to file a just cause request if the disenrolling PMP will be available in another managed care entity.
6. MDwise provider relations staff will monitor the disenrollment process to ensure that the PMP is disenrolled appropriately

Specialist and Ancillary Provider Enrollment and Disenrollment

The enrollment and disenrollment procedures for specialists and ancillary providers who wish to participate in MDwise are similar to those for MDwise PMPs. However, prior to contracting with Specialist or Ancillary providers, MDwise will determine the network adequacy for that provider type, in their designated region. If it is determined that MDwise is meeting the requirement for network adequacy for that provider type, a contract may not be extended. For questions on this process, please contact the MDwise Provider Relations department at [1-800-356-1204](tel:1-800-356-1204).

Specialists and Ancillary providers who wish to disenroll from MDwise should submit a request for disenrollment to their MDwise Provider Relations representative. This request should include the providers name, tax identification number (TIN), NPI, LPI and the date the disenrollment should become effective.

Provider Access and Quality Standards

An integral part of patient care is making sure patients have access to needed medical care. In accordance with the Office of Medicaid Policy and Planning (OMPP) policy and NCQA standards, MDwise establishes standards and performance monitors to help in ensuring that MDwise members receive timely and clinically appropriate access to providers and covered services. MDwise standards, as outlined below, address access to emergency, urgent and routine care appointments, after-hours care, physician response time, office appointment wait time, and office telephone answering time.

Please keep in mind the following access standards are for differing types of care. MDwise providers are expected to have procedures in place to see patients within these timeframes. Also, in accordance with Medicaid rules and regulations, MDwise is responsible for ensuring that MDwise members are receiving accessible services on an equal basis with a provider's non-MDwise population. For example, ensuring MDwise providers offer the same hours of operation for all patients, regardless of coverage.

MDwise encourages all new members to have a PMP visit within 90 calendar days of when they became effective with MDwise. This helps to ensure that our members receive necessary preventive and well care. It also helps in identifying early, the medical needs of our members so that a plan of treatment can be established, including referrals to MDwise case management or disease management programs. Please help us by accommodating our new members within this 90-day timeframe, if they call for an office visit.

PMP Access Standards

PMPs should adhere to the following access standards in providing care to MDwise members.

Appointment Category	Appointment Standards
Urgent/Emergent Care Triage	24 hours/day*
Non-Urgent Symptomatic	72 hours
Routine Physical Exam	3 months
Initial Appointment (Non-Pregnant Adult)	3 months
Routine Gynecological Examination	3 months
New Obstetrical Patient	Within 1 month of date attempting to schedule an appointment
Initial Appointment Well Child	Within 1 month of calling to schedule an appointment
Children with Special Health Care Needs	1 month

*24 hours a day, 7 days a week – in person or by an on-call physician

Specialist Access

MDwise also requires the following standards to be maintained regarding patient accessibility to specialist referrals.

Appointment Category	Appointment Standards
Emergency	24 hours
Urgent	48 hours
Non-Urgent Symptomatic	4 weeks

Physician Response Time

For emergencies and urgent situations, MDwise members must be able to reach their Primary Medical Provider (PMP) or his/her designee by telephone within 30 minutes, 24 hours per day, and 7 days per week. Live voice coverage must be available after normal business, which may include an answering service, shared-call system with other medical providers, or pager system.

For non-urgent routine telephone messages, a return call should be made to the member within one working day. This includes a minimum of 20 office hours over a 3-day period each week. (The 3-day requirement can be filled by more than one PMP in a group practice).

Office Appointment Waiting Times

For all appointments except emergency, the physician should see each patient within 60 minutes of the scheduled appointment time.

Office Telephone Answering Time

The office telephone should be answered within four rings or 30 seconds. The length of time to be answered by a live voice to schedule an appointment should be less than three minutes.

Accessibility and Availability Audits

MDwise monitors whether its participating providers meet these standards through the following mechanisms:

- Ongoing access audits and after-hours availability studies
- Member satisfaction survey
- Analysis of practitioner complaints in arranging referrals to specialists, providers/ancillaries.
- Analysis of member complaints and grievances.
- Practice site audits conducted at time of credentialing
- Emergency Services claims/records analysis

Your assistance with these monitoring efforts is greatly appreciated.

Missed Appointments

MDwise is concerned with appointments missed by enrolled members, particularly when initial appointments are missed. It is a MDwise standard that participating providers document missed appointments and any follow-up activities in the medical record.

The provider office is responsible for educating the member about the problems and consequences associated with missed appointments on the first several occurrences. This is particularly important for those members who may have missed a prenatal visit, who have health conditions that can become aggravated without follow-up medical attention, and for children who are in need of immunizations or well-child care.

Please Note: Members may not be charged for missed appointments. If you have a MDwise Hoosier Healthwise or Healthy Indiana Plan member who has missed two or more appointments, please contact the MDwise Customer Service Department for assistance in working with the member to correct this behavior. A MDwise Care Manager will attempt to contact the member via phone or letter to help the member understand the importance of keeping scheduled appointments.

Provider Rights and Responsibilities

This section contains important information about your role as a MDwise provider. MDwise providers are responsible for providing MDwise members with covered services, as outlined in your provider contract, with the same care and attention that are customarily provided to all patients. Each provider is expected to provide covered services according to generally accepted clinical, legal, and ethical standards in a manner that is consistent with the physician's license and with the standards of practice for quality care recognized within the medical community in which the physician practices. As outlined above, MDwise PMPs are expected to coordinate the provision of covered services to members, including admissions to inpatient facilities, in compliance with MDwise policies and procedures. The primary medical provider is responsible for referring a member to specialist physicians if needed. Specialists may not refer a MDwise member to another physician.

The following responsibilities are required of all MDwise providers:

- Access to Documents: Make available all books, medical records, and papers that are directly pertinent to MDwise and its members so that MDwise and authorized government authorities may review and copy them, as allowed by law and reasonable limits on proprietary information. PMPs will be given reasonable notice and reviews conducted at reasonable times.

- Claims: Submit timely and accurate claims and other data, as required by the State, for each service rendered to MDwise members.
- Cooperation with MDwise programs: Participate in and follow the rules of the MDwise quality improvement, utilization management, credentialing, grievance resolution, provider service and member education/outreach programs.
- Notify MDwise about changes in licensure status: PMP must notify MDwise provider relations staff within three (3) business days if the PMP loses or surrenders a professional license, privileges, or Drug Enforcement Administration provider number, or if any other action negatively impacts the PMP's ability to render services.
- Continuation of Care: If the PMP contract ends, the PMP must continue to provide care to MDwise members assigned to the PMP until a transition can be made transferring the members to other MDwise PMPs, or other health plans/providers.
 - However, if a member is currently hospitalized, has a chronic or disabling condition, is in the acute phase of an illness, or is in the second or third trimester of pregnancy, PMP must continue to provide services to the member as long as MDwise is required by law or contract to continue that member's care.
- Communications with the State: If a PMP has questions or concerns about MDwise, the PMP must first attempt to handle the issue by calling MDwise Customer Service rather than contacting the State directly.
- Cultural Competency: PMPs must provide information regarding treatment options in a culturally competent manner. PMPs must ensure that individuals with special needs have effective communications with participants throughout the MDwise system in making decisions regarding treatment options.
- Nondiscrimination: PMPs shall not discriminate against any MDwise member or against any employee or applicant for employment based on race, religion, color, sex, disability, national origin, or ancestry.
- Medical Records: Maintain medical records for MDwise members assigned to the PMP, for the longer of seven (7) years from the date the PMP's contract ends, or as required by law. Medical records must also be legible, dated, and signed by the rendering provider.
- Confidentiality: Protect all medical records for MDwise members as required by law and regulation. Agree not to disclose any MDwise information (like contracts, fee schedules, policy and procedure manuals, and software) or use them except in acting as an MDwise PMP.

Eligibility Verification

When you check a member's eligibility status, you may obtain enrollment information such as:

- Eligibility status.
- Availability of other insurance.
- Program restriction information.

Providers must verify a member's eligibility each time a member presents for services. Eligibility must be verified before rendering services even if eligibility has been checked recently or if the member shows you their ID. It is important to check eligibility again, since system updates may have occurred. Services will not be paid for members who receive medical care but are no longer eligible under the Hoosier Healthwise or Healthy Indiana Plan programs.

Please Note: Obtaining prior authorization for service is not a substitute for checking eligibility. Failure to check eligibility may result in claim denial.



Member eligibility is available in the IHCP Provider Healthcare Portal at <https://in.gov/medicaid/providers>. At this website, when you enter the member's MID, you will see the member's primary physician, the Managed Care Entity (MCE) they are assigned to, where to get prior authorization, and where to send claims. If the Provider Healthcare Portal indicates that the member is assigned to MDwise, but there is not a PMP assignment yet, you can call MDwise Customer Service for additional information about where to get prior authorization and where to send claims. Please call **1-800-577-1278** for more information about using these options.

If the member is a Right Choice Program member and assigned to MDwise, providers will need to log in to the MDwise Provider Portal at [MDwise.org](https://mdwise.org) to see the members assigned PMP, hospital and pharmacy.

Member Confidentiality

As part of MDwise's commitment to its members and providers, it recognizes that everyone has the right to privacy and to be treated with respect. MDwise and associated network personnel must always handle all health care issues in a professional and confidential manner.

Confidential information is defined as any information that identifies health care services received by or provided to an individual member by any individual provider/group or institutional provider. Confidential information includes, but is not limited to, the patient's medical record, enrollment information, certain data analysis reports and deliberations regarding health care.

MDwise will monitor the following guidelines related to the protection of confidential information:

- Access to confidential information is limited to those employees who need the information to perform their duties.
- Procedures apply to personal knowledge, written materials and information created in other formats, such as electronic records, facsimiles, or electronic mail.
- Disclosure of confidential member information is only permitted through the signed authorization of the member or authorized representative and as required or permitted by Federal or State laws, court orders, or subpoenas.
- All identifiable data used for quality improvement initiatives is protected from inappropriate disclosure in accordance with this policy and procedure.
- Practitioner onsite reviews conducted during the credentialing process include a review of the practitioner's informed consent statements and a review of how the practitioners store and protect medical records.

MDwise also requires that participating providers have a documented process for maintaining the confidentiality of patient information that includes the following:

- Established confidentiality standards for employees.
- Limited release of medical records and information from or copies of records to authorized individuals.
- Assurance that unauthorized individuals cannot gain access to or alter patient records.
- Established levels of authorized user access to data.
- Assurance of timely access to members who wish to examine their medical records.

All MDwise members have the right to file a complaint or grievance regarding concerns of use or protection of confidential information or data. The member is advised of the right to file a complaint or grievance in the MDwise member handbook.

Medical Records

Consistent and complete documentation in the medical record is an essential component of quality patient care. MDwise providers are responsible for establishing and maintaining medical records for each member that are consistent with current professional and accreditation standards and requirements as established in 42 CFR 431.305 and 405 IAC 1-5 and MDwise policies and procedures.

Medical records are to be maintained in a manner that is current, detailed, organized and permits effective and confidential patient care and quality review. Medical records are required to reflect all services provided directly by the PMP and are to include all ancillary services, diagnostic tests and therapeutic services ordered or referred by the PMP (e.g., specialty physician's reports, x-ray reports, etc.).

A copy of the MDwise medical record standards can be found in Appendix C and at MDwise.org. The standards are based on published guidelines from OMPP. MDwise Quality Improvement staff conducts reviews of medical records of contracted PMPs at least every two years to assess compliance with these standards. After the review is completed, providers are notified of the results of the review and whether any corrective actions are necessary, based on results of the assessment.

Please Note: Individual member authorization is not required for MDwise to perform medical record review. Privacy regulations permit the sharing of information between health plans and providers for purposes of health plan operations, which includes quality improvement activities.

According to State and Federal regulations, as well as MDwise standards:

- MDwise member medical records must be maintained for at least seven years.
- MDwise providers must provide a copy of a MDwise member's medical record upon reasonable request by the member at no charge.
- MDwise members may request that their medical records be corrected or amended.
- Providers must also facilitate the transfer of the member's medical record to another provider at the member's request.
- Any physician receiving payments from IHCP for rendered services may not charge a MDwise member for medical record copying/transfer.

Cultural Sensitivity

MDwise recognizes that effective delivery of health care requires identification, appreciation, and integration of members' different cultures and needs. Cultural, racial, socioeconomic, disability status, and linguistic differences can present barriers to accessing and receiving quality health care. The perception of illness and disease and their causes tends to vary by culture. Also, cultural differences often influence help-seeking behaviors, attitudes towards providers and staff, and the expectations that patients and providers have of each other. Language barriers and poor literacy can compound compliance problems with taking prescribed medications and following recommended treatment regimens.

Providers face these issues every day in clinical practice. In addition to addressing concerns regarding language and communications, physicians working with our members often need to make distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the member's cultural background. Language, religious beliefs, cultural norms, socioeconomic conditions, disability status, diet, etc., may make one treatment method more palatable to a member of a particular culture than to another of a differing culture.

MDwise is committed to working to eliminating potential barriers our members face due to cultural differences. Through avenues such as direct member contact, new member telephone calls, member satisfaction survey, provider information and complaint data, MDwise may become aware of a member's special needs. MDwise then attempts to work with the member to address identified barriers and help them access needed care and services.

Through assessment and care management interventions, MDwise will become aware of the special needs of individual members. Care managers will attempt to learn as much as they can about an individual's or family's culture and understand the different expectations people may have about the way services are offered. When special medical or behavioral health care needs are identified, MDwise works with the member and their PMP to coordinate the member's health care services and to assist, as appropriate, in problem solving if issues arise. MDwise also actively works to assist in identifying appropriate community resources for members facing special needs or barriers to quality healthcare.

Other mechanisms MDwise utilizes to strengthen the Plan's overall cultural sensitivity and disability competencies include:

- Compliance with the Cultural and Linguistically Appropriate Services (CLAS) standards as outlined by the Federal Office of Minority Health.
- Interpretive services and language assistance.
- Recruitment and retention policies for minority staff (representative of the diverse demographic population of the service area).
- Diversity education and training for staff and provider community.
- Distribution of member education materials that are easily understood by diverse audiences including persons of limited English proficiency and those who have low literacy skills.
- Partnerships with community organizations.
- Administrative or organizational accommodations.

There are several ways in which providers working with multicultural members and families can contribute to a members' positive experience with MDwise and our provider community. An important first step is to be sensitive to patients' cultural beliefs and practices and to convey respect for their cultural values through the way you communicate with them and deliver their healthcare. This may require the use of interpretive services, either from a provider or staff from the same ethnic group as the patient, from hospital delivery system resources or through CyraCom language services.

Because persons of the same ethnicity can have very different beliefs and practices, it is important to also understand the circumstances of the patient or family by obtaining information on their place of origin, socioeconomic background, literacy proficiency, and personal expectations concerning health and medical care.

Some examples of ways that you can help members with linguistic or cultural differences include:

- Interview and assess patients in the target language or via appropriate use of bilingual/bicultural interpreter.
- Ask questions to increase your understanding of the patient's culture as it relates to health care practices.
- Where appropriate, formulate treatment plans that consider cultural beliefs and practices.
- Write instructions or use handouts if available.
- Effectively utilize community resources.

- Request the patient to repeat information provided by healthcare professionals to ascertain understanding of message (educational and language barriers).
- Explain technical or specialized terminology and concepts and verify that the patient/consumer understands the content of what is being said.
- Clearly communicate expectations. When appropriate, use drawings and gestures to aid communication.
- Preserve patients' dignity during physical examinations and offer emotional support to alleviate their fears and anxieties.
- A reflective approach is useful. Health care providers should examine their own biases and expectations to understand how these influence their interactions and decision-making.
- Seek to increase knowledge on the impact of cultural differences on the delivery of healthcare.

Interpretive Services

Interpretive services must be provided to all MDwise members, free of charge. This is a requirement of the Americans with Disabilities Act (ADA) and federal Medicaid law. If a non- English-speaking member or a hearing-impaired member needs interpretive services during a provider encounter, the provider is required to have these resources available on site through the provider's hospital, group or through other mechanisms.

CyraCom language services or the Indiana Relay TDD Line, outlined below, may be used if a member needs interpretative services. However, if a member requests face-to-face oral interpretative services, these services must be made available free of charge, provided the services are scheduled in advance and that an appropriate interpreter is available in the community.

To Access the Indiana Relay Service

For communicating telephonically with a hearing-impaired member, MDwise recommends the use of the Indiana Relay Service for assistance. This is a free service that may be accessed by dialing: **1-800-743-3333**.

Charging Members

Missed Appointments

State and federal policy prohibits providers from billing MDwise members for missed appointments. MDwise educates members on the importance of keeping scheduled appointments and calling in advance to cancel if necessary. Please call the Customer Service Department if you are concerned about a MDwise member who regularly misses scheduled appointments. A MDwise Health Advocate will attempt to contact the member for education purposes and to determine if assistance is needed.

Medical Records

According to federal regulations and OMPP guidelines, MDwise providers are required to provide a copy of the member's medical records upon reasonable request by the member at no charge. The provider is expected to facilitate the transfer of the member's medical records to another provider at the member's request or provide the member with a copy of the records. Federal regulation (42 C.F.R. 447.15) supersedes Indiana Code 16-39-9-1, which establishes maximum amounts that providers may charge patients for copying medical records.

Hoosier Healthwise Member Benefits

MDwise participates in Hoosier Healthwise, which is Risk-Based Managed Care (RBMC). Hoosier Healthwise is a mandatory managed care program for eligible Medicaid recipients including children, low-income families, and pregnant women. Under Hoosier Healthwise, primary medical providers (PMPs) are responsible for coordinating all medical care for the members who are assigned to them. Members select a PMP and are then enrolled in the network or managed care plan chosen by their PMP.

Hoosier Healthwise is designed to meet the following goals:

- Ensure access to primary and preventive care.
- Improve access to all necessary health care services.
- Encourage quality, continuity, and appropriateness of medical care.
- Provide medical coverage in a cost-effective manner.

The care of Hoosier Healthwise members enrolled in the MCE is managed by the MCE through its network of PMPs, specialists, and other providers of care who contract directly with the MCE.

The State of Indiana has sole authority for determining whether individuals or families meet the eligibility criteria for participation in Hoosier Healthwise program through the Division of Family Resources. Enrollment centers staffed by hospital or clinic staff may not determine final eligibility, although they do assist the member in applying for Hoosier Healthwise and submitting documentation to the State so that the State can determine eligibility.

Upon enrollment in Hoosier Healthwise by the Division of Family Resources, a member must choose an MCE. If the member does not choose, the member will be assigned to an MCE. Once assigned to an MCE, the member will choose a PMP. If the member does not choose a PMP, the member will be assigned to a PMP through MDwise's auto-assignment process. **The following provider specialties are eligible to enroll as PMPs:**

Provider	Type	Specialty
Family Practice	31	316
General Practice	31	318
Internal Medicine	31	344
Obstetrics/Gynecology	31	328
Pediatrics	31	345

Eligibility

Hoosier Healthwise Eligibility

The Hoosier Healthwise program provides coverage to children and pregnant women. Hoosier Healthwise benefit packages include Packages A and C.

Package A – Standard Plan. Full coverage for children and pregnant women

Package C – Children's Health Plan. Preventive, primary, and acute care services for some children ages 19 and under.

To be eligible, a child must meet the following criteria:

- The child must be younger than 19 years old.
- The child's family income must be between 158 and 250 percent of the federal poverty level (FPL).
- The child must not have credible health insurance or at any time during the three-month period prior to applying for the Hoosier Healthwise program.
- The child's family must satisfy payment of monthly premiums.

Package C members fall under the Children's Health Insurance Program (CHIP). A child determined eligible for Package C is made conditionally eligible pending a premium payment. The child's family must pay a monthly premium. Enrollment continues as long as premium payments are received and the child continues to meet the other eligibility requirements. Enrollment is terminated for nonpayment of premiums after a 60-day grace period.

For more information on Hoosier Healthwise Package A and C, please refer to the Member Eligibility and Benefit Coverage Module in the IHCP Provider Manual at

provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx.

Eligible MDwise members may on occasion need medical care before they receive their MDwise Hoosier Healthwise ID card, or when they forget to bring their card with them. Providers must check the member's eligibility even though the card is not available, or when a member does not have their card. In these situations, eligibility may be verified by:

- You can check eligibility through the MDwise Customer Service Line at **1-800-356-1204**, and giving the person's name and social security number (SSN).
- myMdwise Provider Portal at MDwise.org.
- DXC Provider Healthcare Portal at provider.indianamedicaid.com.

If you suspect that a member has presented an identification card belonging to someone else, you may request to see a photo ID. If you suspect fraud, please contact the MDwise Compliance Officer at **317-630-2831** or **1-800-356-1204** immediately.

Hoosier Healthwise Member Disenrollment Process

Members are disenrolled from MDwise either through PMP change selections (e.g. member chooses a new PMP in a different MCE) or through eligibility terminations provided to MDwise by the state. Maximus, the State's enrollment broker approves, monitors and tracks all member movement to other MCEs, although the OMPP has ultimate authority for allowing eligible members to disenroll from the program.

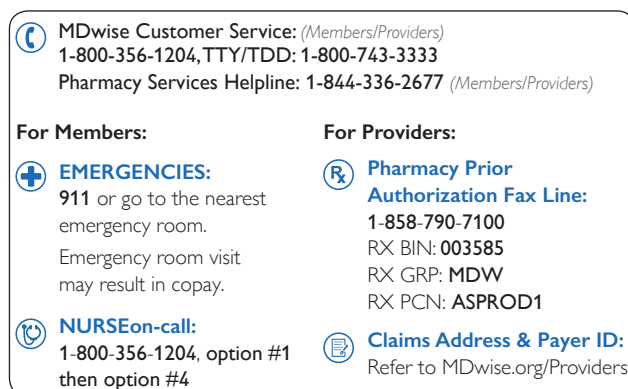


Please note: MDwise will neither terminate enrollment nor encourage an enrollee to disenroll because of a patient's health needs, change in a patient's health status or patient's health care utilization patterns.

Member Card

Once eligibility is confirmed, MDwise issues a Hoosier Healthwise Member ID card to all new members. Member ID cards are issued only once. A new card is issued only if member loses a card. Family members covered under Hoosier Healthwise each receive their own member ID card and cards are not transferable among family members. MDwise PE members will not receive an ID card during her PE coverage. The PE woman will receive a letter that will serve as identification. When checking eligibility, the PE woman Medicaid package will be identified as Package P. If the woman becomes eligible for Hoosier Healthwise she will receive a new ID number. Members should bring their member ID card to each visit.

Please see a sample card below:



Cost-Sharing and Copay

Package A and PE members are not required to pay premiums for their health care coverage. Co-pays may only apply to pharmacy prescription refills (\$3.00) for members 19 years of age or older. Providers must not deny service to these patients or engage in collection activities because of non-payment for services.

Package C members are responsible for paying part of the cost of their health care coverage. These payments include premium payments as well as co-pays for ambulance transportation. A 60-day grace period will be allowed for members to pay their premium after which eligibility will be terminated.

Indiana Health Coverage Program (IHCP) and federal regulations specifically prohibit providers from charging IHCP members for covered services except in specific, limited circumstances. As a MDwise provider, you are required to accept the final payment determination for covered services as payment in full, except for any co-payments and any other patient liability payment allowed by the IHCP. You may not balance bill a member (i.e. charge the member for covered services above the amount paid by MDwise).

Premium Payments for Package C Members

Co-pay Amounts

Package C co-pays must be paid directly to the health care provider or pharmacy at the time of service. **The amounts of the co-pays are as follows:**

Category	Type	Amount
Transportation	Ambulance	\$10 (Package C members are only covered for emergency ambulance transportation; nonemergency trips do not apply.)
Pharmacy	Brand Name Drugs	\$10
Pharmacy	Generic Drugs	\$3

Income (% of FPL)	Number of Children Enrolled	Monthly Payments
150% to 175% FPL	One	\$22.00
	Two	\$33.00
175% to 200% FPL	One	\$33.00
	Two	\$50.00
200% to 225% FPL	One	\$42.00
	Two	\$53.00
225% to 250% FPL	One	\$53.00
	Two	\$70.00

Please Note: A provider may not deny services to an eligible individual due to the individual's inability to pay the co-payment amount on the date of service. The provider may however, subsequently bill the member for the co-payment.

Hoosier Healthwise Program Benefits

The following table provides an overview of covered Hoosier Healthwise services available to members receiving benefits in Benefit Packages A: Standard; Package C: Children's Health Plan; and Package P: Presumptive Eligibility. Covered services are outlined in the Indiana Administrative Code. Medicaid: 405 IAC 5; CHIP Package C: 407 IAC 3. Package P: 405 IAC 2-3.2. The Indiana Administrative Code can be found on the State's website at [in.gov/legislative/iac/iac_title?iact=405](http://www.in.gov/legislative/iac/iac_title?iact=405) and http://www.in.gov/legislative/iac/iac_title?iact=407.

At a minimum, MDwise provides to its Hoosier Healthwise members all benefits and services deemed medically reasonable and necessary and covered under the Contract with the State, and delivers such covered services sufficient in amount, duration, or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services. The table below provides a general summary of the covered services and if prior authorization is required. For specific service codes that require prior authorization, please refer to the Prior Authorization section of this manual, or the Provider page on the MDwise website: mdwise.org/for-providers/forms/prior-authorization.

Benefit	Package A	Package C
Ambulance Transportation (Emergent Only)	Covered	Covered
Chiropractic Services**	Covered	Covered
Chronic Disease Management	Covered	Covered
Dental Services	Covered	Covered
Diabetes Self-Management Services	Covered	Covered
Drugs – Over-the-Counter (Non-legend)	Covered	Covered
Drugs – Prescribed (Legend) Drugs	Covered	Covered
Durable Medical Equipment	Covered	Covered
Early Intervention Services (EPSDT)	Covered	Covered
Emergency Services** (Self-referral)	Covered	Covered
Family Planning Services** (Self-referral)	Covered	Covered
Federally Qualified Health Centers (FQHCs)	Covered	Covered
Home- and community-based waiver services	Not Covered	Not Covered
Home Health Services	Covered	Covered
Hospice Care	Not Covered	Not Covered
Immunizations	Covered	Covered
Individualized Education Plan (IEP)	Not Covered	Not Covered
Individualized Family Services Plan (IFSP)	Not Covered	Not Covered
Inpatient Rehabilitation	Covered	Covered
Long Term Acute Care Hospitalization	Covered	Covered
Long-term Institutional Care	Not Covered	Not Covered
Medicaid Rehabilitation Option (MRO)	Not Covered	Not Covered
Mental Health /Substance Abuse Services - Inpatient (Institution for Mental Disease > 16 beds)**	Covered	Covered
Mental Health /Substance Abuse Services - Inpatient (Psychiatric Facility < 16 beds)**	Covered	Covered
Mental Health /Substance Abuse Services - Inpatient (State Psychiatric Hospital)**	Not Covered	Not Covered
Non-Emergent Transportation	Covered	Not Covered
Orthodontics	Covered	Covered
Out-of-Network Services	Covered	Covered
Out-of-State Medical	Covered	Covered
Pharmacy	Covered	Covered

Benefit	Package A	Package C
Physical Therapy	Covered	Covered
Podiatrists** (Self-referral)	Covered	Covered
Post-Stabilization Services** (Self-referral)	Covered	Covered
Prosthetics/Orthotics	Covered	Covered
Psychiatric Residential Treatment Facility (PRTF)	Not Covered	Not Covered
Psychiatric Treatment in State Hospital	Not Covered	Not Covered
Respiratory Therapy	Covered	Covered
Rural Health Clinics	Covered	Covered
Smoking Cessation Services	Covered	Covered
Speech Therapy**	Covered	Covered
Substance Use Disorder Residential Services (DMHA Approved SUD Residential Facilities)	Covered	Covered
Surgical and Medical Services	Covered	Covered
Transplants	Covered	Not Covered
Vision Services, Eyeglasses** (Self-referral)	Covered	Covered
Vision Services, Surgery** (Self-referral)	Covered	Covered

**Please refer to the IHCP Member Eligibility and Benefit Coverage Module for service limitations*

***Self-referral services included in these benefits may require an authorization. Please see the MDwise prior authorization guide for specific codes.*

Service Descriptions

Hoosier Healthwise Self-Referral Services (paid by MDwise)

MDwise members are not restricted to use MDwise contracted providers for certain “self-referral” services. Federal and state regulations allow members access to certain services outside of MDwise without a referral. Members may access these services from any Indiana Health Coverage Program (IHCP) enrolled provider who is qualified to render the service. Although these services can be obtained out-of-network, MDwise is responsible for paying for these services if medically necessary.

MDwise does include some self-referral providers in the contracted network. MDwise encourages all PMPs to communicate with self-referral service providers when any form of medical treatment is undertaken.

Please Note: Even in the case of self-referral services, MDwise may request the use of in-network facilities. If the self-referral provider, however, uses facilities outside of the MDwise network, MDwise is required to reimburse the facility and ancillary providers for medically necessary services at IHCP rates, according to IHCP benefit guidelines. Vision care surgeries however, may be required to be provided at an in-network facility, as they are not considered self-referral services in Hoosier Healthwise.

The following are self-referral services in Hoosier Healthwise:

- Services rendered for the treatment of an emergency medical condition.
- Chiropractic services: IHCP-covered services rendered by a provider enrolled with a specialty 150 (chiropractor) and practicing within the scope of the chiropractic license. Reimbursement is available for covered chiropractic visits and services associated with such visits in accordance with IC 25-10-1, 846 IAC 1-1, and 405 IAC 5, Rule 12. Prior authorization may be required for services.
- Family planning services: provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Reimbursement is available for family planning services, as outlined in IC 12-15-5-1 and applicable federal law.

MDwise provides all covered family planning services and supplies, except for the following items which, to the extent included in 405 IAC 5-24 and 405 IAC 9-7 as covered, will be reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation when provided by an Indiana Medicaid enrolled pharmacy or DME provider, as applicable:

- Legend drugs.
- Non-legend drugs.
- Diaphragms.
- Spermicides (Hoosier Healthwise only).
- Condoms (Hoosier Healthwise only).
- Cervical caps.

If the family planning services and supplies listed above are provided by a provider type other than a pharmacy or DME provider, the Contractor remains responsible for reimbursing for the service or supply.

Members may also self-refer to an in-network provider for some services without authorization from MDwise or the member's PMP. Members may self-refer, within the MDwise network, for behavioral health services, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers. The mental health providers to which the member may self-refer within the MDwise network include:

- Psychiatrists.
- Outpatient mental health clinics.
- Community mental health centers.
- Psychologists.
- Health services providers in psychology (HSSP).
- Certified social workers.
- Certified clinical social workers.
- Psychiatric nurses.
- Independent practice school psychologists.
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center.
- Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option).

Please Note: Refer to the Indiana Health Coverage Program (IHCP) Provider Manual and Bulletins and Banners information related to Self-Referral Services.

Emergency Services: Coverage and Prior Authorization

MDwise members may access emergency services 24 hours a day, seven days a week. Members are instructed to seek emergency services at the nearest emergency room without authorization when they believe their condition to be an emergency. MDwise will cover and reimburse all emergency services, including screening services, which are rendered by a qualified IHCP provider to evaluate or stabilize an emergency medical condition, subject to a prudent layperson determination as outlined below. The member's presenting symptoms upon arrival at the emergency room are the primary factors in determining whether an emergency medical condition exists.

- Emergency services is defined in IC 12-15-12- 0.5 as covered inpatient and outpatient services that are provided by a provider qualified to furnish emergency services, and that are necessary to evaluate or stabilize an emergency medical condition.
- Emergency medical condition is defined in IC 12-15-12-0.3 as a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
 1. Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the woman or her unborn child,
 2. Serious impairment to bodily functions, or
 3. Serious dysfunction of any bodily organ or part.
- Prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, based on observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

MDwise will cover emergency services as defined above, which are provided to evaluate or stabilize emergency medical conditions.

- A Level I medical screening exam professional fee (99281) will be paid to non-contracted delivery system providers if the service does not meet the definition of emergency medical condition as indicated through prudent layperson and medical management department review.
- If the service does not meet the definition of emergency medical condition, as indicated through the prudent layperson and medical management department review, a facility screening fee of \$25.00, or a lesser billed charge, will be paid (revenue code 451).

MDwise does not require prior authorization for emergency services or screening exams, regardless of whether the IHCP provider is contracted with MDwise or not. However, a retroactive medical necessity review may be performed to determine whether services are covered.

Providers are to notify the MDwise medical management staff in the event he/she, or a representative, have advised a member to seek care in the emergency room or has approved/authorized emergency or post-stabilization services upon contact by the emergency room physician requesting such approval. This notification is necessary so that medical management staff can enter an authorization for such services in the medical management system for claims payment.

Please Note: Members are always encouraged to call their PMP or the MDwise NURSEon-call, our 24-hour nurse hotline, when they have an urgent health need, or are unsure if it is an emergency. MDwise providers are encouraged to help educate their patients about the appropriate use of the emergency room. Also, if you become aware of a member that is inappropriately using the emergency room for primary care services, please let us know and a MDwise Health Advocate will attempt to contact the member to educate them about appropriate emergency room use.

Coverage of Post Stabilization Services

MDwise covers post-stabilization services when there is an emergency medical condition and one of the following occurs:

- Prior authorization for the post-stabilization services has been obtained from the member's PMP or authorized representative in conjunction with the PMP's medical management department.
- Services are administered to maintain the member's stabilized condition within one (1) hour of a request to the member's PMP or authorized representative for prior authorization. The one (1) hour begins at the time the call is placed to the PMP or authorized representative.
- Services are administered to maintain, improve or resolve the member's stabilized condition if a MDwise delivery system:
 - o does not respond to a request for prior authorization within one (1) hour;
 - o cannot be contacted; or
 - o if the PMP or authorized representative cannot reach an agreement with the member's treating physician concerning the member's care, MDwise shall give the member's treating physician an opportunity to consult with the MDwise Medical Director. The member's treating physician may continue with medically necessary care of the member until the Medical Director is reached or until one (1) of the following criteria is met:
 - A participating MDwise physician with privileges at the treating hospital assumes responsibility for the member's care
 - A participating MDwise physician assumes responsibility for the member's care through transfer to another facility
 - MDwise and the treating physician reach agreement about the member's care
 - The member is discharged.

Providers must document their request for prior authorization. This documentation should include the member's PMP, the time of call, the phone number called, and the name of the person answering the phone. The provider must also document the time at which the authorization was given and the authorizing party's name and institutional affiliation. If the provider is unable to reach the member's PMP or the applicable delivery system to obtain prior authorization, these requests must also be documented.

Out-of-Network Services Hoosier Healthwise

MDwise attempts to provide all care within the MDwise contracted network (inclusive of MDwise behavioral health network), for coordination, access, and communication purposes, better understanding of available resources, and because MDwise providers have agreed by contract, to abide by MDwise policies and procedures.

Health care services provided outside of the MDwise network may be authorized for coverage when appropriate contracted providers, services, or facilities are not available within the member's service area. MDwise will also cover and reimburse authorized routine care provided to members by out-of-network or out-of-area providers. These service authorization requests are subject to the medical appropriateness criteria and determination process as outlined in the Medical Management section of this chapter.

In accordance with MDwise program rules, all services must be obtained in-network, except for the following:

- Self-referrals services for Hoosier Healthwise members including Emergency services (refer to Self-referral section of this chapter).
- Medically necessary, covered services that can't be obtained from an in-network provider within 60 miles of the member's residence.
- Nurse practitioner services, if they are not available within the member's service area within the MDwise network.
- Services for members traveling out of area who need urgent/emergent services
- Services provided under "Continuity of Care" principles – e.g. individual joins MDwise and has an outstanding prior authorization (within 30 days of becoming a member) for services from a provider that is not contracted with MDwise.

Reimbursement for the out-of-network claims for authorized services will be at the rate MDwise negotiates with the provider, or the lesser of the following:

- Medicaid FFS fee schedule rate that existed on the date the service was rendered, or
- The usual and customary charge made to the public by the provider

MDwise requires providers not contracted in the MDwise network to obtain prior authorization to render any non-self-referral or non-emergent services to MDwise members.

MDwise does not require an out-of-network provider to acquire a MDwise-assigned provider number for reimbursement. Providers should complete the Non-Contracted Provider Set-up form and submit, with a copy of their W-9 and the first claim, to MDwise. After the initial submission of the Non-Contracted Provider Set-up form, the provider can submit only the claim for adjudication. The Non-Contracted Provider Set-up form can be located on the For Providers page at [MDwise.org](https://www.mdwise.org).

Hoosier Healthwise Carved Out Services (not paid by MDwise)

Hoosier Healthwise provides some services that are not included in the MCE capitation and therefore, are not the responsibility of MDwise. These services remain the financial responsibility of the State, are reimbursed on a fee for service basis and are billed to HP.

These certain categories of service covered by IHCP but carved out from the scope of care managed by MDwise for Hoosier Healthwise include:

Carve Out Service	Coverage	MDwise Scope of Care
Medicaid Rehabilitation Option (MRO)	IHCP - FFS	MDwise is responsible for care coordination with physical and other behavioral health services for members receiving MRO services.
Individualized Education Plan (IEP)	IHCP - FFS	MDwise will communicate and coordinate with the school to ensure continuity of care and avoid duplication of services.
Individualized Family Services Plan (IFSP)	IHCP - FFS	MCEs will receive a monthly list of their members who are receiving First Steps services. MDwise to provide case management to these special needs children and coordinate care with First Steps for these children.

Excluded Services Hoosier Healthwise

The Hoosier Healthwise program excludes some benefits from coverage under managed care. These excluded benefits are available under Traditional Medicaid or other waiver programs. A MDwise member who is, or will be, receiving excluded services must be disenrolled from Hoosier Healthwise to be eligible for the services. These services include:

- Long-term institutional care. (Hoosier Healthwise Package A members and HIP).
 - o Nursing Facility or Intermediate Care Facility for Mentally Retarded (ICF/MR) MDwise may place a member in a nursing facility on a short-term basis, i.e., for fewer than sixty (60) calendar days when determination made for medical necessity care and appropriate place of service.
 - o MDwise may negotiate rates for reimbursing the nursing facilities for this short-term stay. Members who require long-term care or whose short-term placement becomes a long-term placement will be disenrolled from managed care when long term care/level of care (LTC/ LOC) is approved.
 - o During the period of level of care determination, up to 60 days, the member remains eligible in MDwise. LTC/LOC services are not eligible to managed care members, and must be disenrolled from MDwise.
- Hospice care.
- Home- and community-based waiver services.
- Psychiatric Residential Treatment Facility (PRTF) Services.
- Psychiatric treatment in a state hospita.

Healthy Indiana Plan Member Benefits

The Healthy Indiana Plan (HIP) provides health insurance for uninsured adult Hoosiers who are legal US residents the ages of 19 and 64 whose family income is up to 133% of the FPL. A 5% income disregard is applied to determine eligibility if an individual is found ineligible at 133% FPL, but would be income eligible with the disregard. Individuals with Medicare do not qualify.

Pregnant women are eligible to remain in HIP if they become pregnant while enrolled in the program. If a woman applies for HIP while pregnant, she will be enrolled in the HIP Maternity package, which provides Hoosier Healthwise Package A services free of cost sharing. If a woman is already enrolled in HIP when she becomes pregnant, she will have all cost sharing suspended, regardless of which benefit package she is enrolled in. Also, she will receive wraparound benefits that mirror the services provided in Hoosier Healthwise Package A so there is no difference in coverage. If a woman is pregnant when she is due for her annual redetermination, she will be moved to the Hoosier Healthwise program for the duration of her pregnancy.

HIP Plus requires each participant to make a financial contribution to their coverage, unless they are exempt from cost-sharing. The monthly contribution amount is based on family income as a percentage of the FPL. The contribution will not exceed 2% of the family income. See the chart below for more POWER Account Contribution information.

FPL	Monthly PAC Single Individual	Monthly PAC Spouses	PAC with Tobacco Surcharge	PAC with Tobacco Surcharge	Spouse PAC when both have tobacco surcharge (each)
Less than 22%	\$1.00	\$1.00	\$1.50	\$1.00 & \$1.50	\$1.50
23-50%	\$5.00	\$2.50	\$7.50	\$2.50 & \$3.75	\$3.75
51-75%	\$10.00	\$5.00	\$15.00	\$5.00 & \$7.50	\$7.50
76-100%	\$15.00	\$7.50	\$22.50	\$7.50 & \$11.25	\$11.25
101-138%	\$20.00	\$10.00	\$30.00	\$10.00 & \$15.00	\$15.00

The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and will, at minimum, be funded with State and individual contributions. Employers and Non-Profit Organizations may contribute as well with some restrictions. Members use POWER Account funds to meet the deductible of their deductible health plan. However, POWER Accounts are funded with post-tax dollars and are not considered HSAs or other health spending accounts (e.g., Flexible Spending Accounts, Health Reimbursement Accounts, etc.) under federal law.

POWER accounts give participants a financial incentive to adopt healthy behaviors that keep them from developing chronic illnesses. When they do seek health care, plan participants seek price transparency so they can make value conscious decisions. All participants are provided with an email account, personalized prevention information, and POWER account balance and transaction history. MDwise will also provide disease management services and case and care management interventions based on member need.

The POWER account provides:

- A POWER Account valued at \$2,500 per adult to pay for medical costs.
 - Contributions to the account are made by the State and each participant (based on ability to pay).
 - No participant will pay more than 5% of his/her gross family income on the plan.
- Coverage for non-Affordable Care Act preventive services are covered up to \$500 per year.
 - Coverage for Affordable Care Act preventive services do not have a cap.

Eligibility

Healthy Indiana Plan has several benefit plan options. Individuals interested in obtaining Healthy Indiana Plan (HIP) coverage must complete an application. If a parent and child are signing up for health insurance coverage at the same time, a HIP application must be filled out for the parent, and a separate Hoosier Healthwise application must be filled out for the child.

Applicants can download and print applications from the internet at hip.in.gov. Applications may also be picked up at various community organizations participating in the V-CAN network, Hoosier Healthwise Enrollment Centers, and the local Division of Family Resources (DFR) office. To find locations, a member can call **877-GET-HIP-9**. Completed applications can be submitted to the DFR county office or mailed directly to the FSSA Document Center at **PO Box 1630, Marion, IN, 46952**. Members may also fax completed applications to **1-800-403-0864** or drop them off at their local FSSA DFR office.

The HIP application will include questions on an individual's recent health status. MDwise must accept individuals eligible for enrollment in MDwise in the order in which they apply without restriction. Here is a brief description of these benefit plans.

Eligible MDwise members may on occasion need medical care before they receive their MDwise Healthy Indiana Plan ID card, or when they forget to bring their card with them. Providers must check the member's eligibility even though the card is not available, or when a member does not have their card. In these situations, eligibility may be verified by:

- You can check eligibility through the Automated Voice Response (AVR) system at **317-692-0819** or **1-800-738-6770**, and giving the person's social security number (SSN).
- myMdwise Provider Portal at MDwise.org.

If you suspect that a member has presented an identification card belonging to someone else, you may request to see a photo ID. If you suspect fraud, please contact the MDwise Compliance Officer at **317-630-2831** or **1-800-356-1204** immediately.

HIP Plus

The default plan for all HIP members. HIP Plus provides the best value coverage including:

- Members pay an affordable monthly POWER Account Contribution
- No co-pays (except for non-emergent ER use).
- More extensive pharmacy services.
- Dental Services.
- Vision Services.
- TMJ Coverage.
- Bariatric Surgery Coverage.
- Chiropractic Services (effective 1/1/2018).

Members who don't pay or miss their monthly POWER account contributions will lose their HIP Plus coverage.

HIP Plus members with an income under 100% FPL who do not pay their monthly POWER account contribution (PAC) are disenrolled from HIP Plus but will receive HIP Basic. Members with incomes greater than this threshold will lose their coverage.

HIP Basic

HIP Basic benefits provide coverage for all required services but these services are limited and do not provide dental or vision coverage along with other benefits. Members do NOT make a PAC, but have co-payments for services. Co-payments are described in further detail in the chapter on Member Cost-sharing Responsibilities.

- \$4 for Outpatient Services, including non-preventive office visits.
- \$4 for Preferred Drugs, \$8 for Non-Preferred.
- \$75 for an Inpatient Stay.
- Plan maintains essential health benefits, but incorporates reduced benefit coverage (for example, fewer therapy visits). TMJ and bariatric surgery not covered.
- Does not include vision or dental coverage, with the exception of EPSDT services for members aged 19 and 20.
- More limited pharmacy options.

It is important to stress to the member that HIP Basic can be much more expensive than HIP Plus.

HIP State Plan (Plus or Basic)

HIP State Plan Plus provides a full set of benefits to members who are particularly at risk, either due to medical conditions (Medically Frail) or be a parent/caretaker. The services are equivalent to those of the Hoosier Healthwise program. Members on this program will either be on Plus or Basic, but have access to the State Plan Benefit package. For example, a member on State Plan Basic would have a co-pay for prescription services, while a member on State Plan Plus would not.


- Hoosier Healthwise-like benefit package.
- Dental & Vision.

Transportation services are covered.



Member Card

MDwise Healthy Indiana Plan members will receive a member ID card. Please see a sample card below:

		Member MID#: 000123456789	
Member Name: John J Smith			
To check eligibility and Primary Medical Provider (PMP): For Members: MDwise.org/myMDwise For Providers: MDwise.org/myMDwiseProvider			
MDwise Customer Service: <i>(Members/Providers)</i> 1-800-356-1204, TTY/TDD: 1-800-743-3333 Pharmacy Services Helpline: 1-844-336-2677 <i>(Members/Providers)</i>			
For Members:		For Providers:	
 EMERGENCIES: 911 or go to the nearest emergency room. Emergency room visit may result in copay.		 Pharmacy Prior Authorization Fax Line: 1-858-790-7100 RX BIN: 003585 RX GRP: MDW RX PCN: ASPROD1	
 NURSEon-call: 1-800-356-1204, option #1 then option #4		 Claims Address & Payer ID: Refer to MDwise.org/Providers	

POWER Account Contributions and Copayments

POWER Account Contributions

HIP Plus members make a financial contribution to their POWER account that is applied toward medical and pharmacy prescription coverage. HIP Basic members make no contribution to their POWER Accounts. All HIP Plus and HIP State Plan Plus contribute 2% of their gross annual family income to have the security of health insurance. If a HIP member's total annual contribution (including POWER Account contributions and co-pays) exceeds 5% of their gross annual income, the member will no longer be liable for contributions and co-payments for the remainder of the calendar quarter. The POWER Account Contribution amount is dependent on income in relation to the US Federal Poverty Level.

The State calculates the individual's POWER Account contribution during the application process. Contributions are also recalculated by the State throughout a member's benefit period and before a new coverage term begins (during redetermination), to account for any changes in the member's income.

POWER Accounts are funded by both the state and the member in an amount equal to \$2,500. The State contributes to the member's POWER Account, and members are also encouraged to seek contribution assistance from a third party. Third parties, such as an employer or non-profit organization can contribute up to 100% of the member's annual POWER Account obligation. Third parties interested in aiding can seek further information by accessing MDwise.org or by calling MDwise Customer Service at **1-800-356-1204**.

HIP Plus members must make their required contribution each month. MDwise provides a wide range of payment options for members to make sure that it is easy for them to make their contributions on time. Penalties for non-payment of contribution vary for members above or below the 100% FPL. If a member with a household income 101% of the FPL or greater does not make a contribution within 60 calendar days of their due date, coverage will be terminated. Claims will be paid during this 60-day grace period. If a member with a household income 101% of the FPL or greater loses their coverage because they failed to pay their contribution, they may not reapply for HIP for at least 6 months.

Individuals can change plans only before their initial POWER Account contribution has been made and do not already have a calendar year assignment. After that, they will have to stay with their plan for the duration of the calendar year or 12-month term. They can only change plans for poor quality of care provided by the plans. Poor quality of care is defined as:

- The health plan does not, for moral or religious reasons, cover the service that you need.
- You need related services to be performed at the same time; not all related services are available within the health plan network; and your primary medical provider or another provider believes that getting the services separately would subject you to unnecessary risk.
- The health plan is disciplined by the Office of Medicaid Policy and Planning.
- The health plan does not have providers experienced in dealing with your health care needs.
- Poor quality of care. Poor quality of care includes failing to meet established standards of medical care and significant language or cultural barriers.
- The member's primary care provider (PMP) leaves the health plan, and the health plan cannot choose a new PMP suitable for the member's needs.
- The health plan provides limited access to a primary care clinic or other health services within reasonable proximity to the member's home.

Members with household incomes 100% at or below the FPL who fail to make their monthly contribution within the allotted time will be downgraded to the HIP Basic plan. HIP Basic plan requires co-payments for all covered services except preventive care and members may not transfer to the HIP Plus plan until annual redetermination.

Native Americans are not subject to Power Account contributions.

HIP Eligibility Redetermination

Recertification of eligibility in HIP will occur every 12 months and will be based on criteria established by the State. MDwise will assist members in initiating/completing the recertification process, and will begin as early as 60 days prior to the end of the coverage term and in compliance with FSSA processing guidelines. These steps will help prevent interruptions in member care or access to health services.

If a member fails to complete all necessary steps within 90 days to maintain or renew eligibility in HIP during re-determination, the member will not be eligible for HIP for six months. MDwise is required to refund the member's pro rata share of his or her POWER account balance, if any, within sixty (60) days of the member's last date of participation in the plan.

A member may request disenrollment from MDwise in the following circumstances:

- It is the end of the 12-month coverage period and the member requests a plan change.
- Before the first POWER Account contribution is made.
- Member voluntarily chooses to disenroll from the HIP program.
- For cause, at any time.

- If a member wants to disenroll from MDwise “for cause”, they must first exhaust the MDwise grievance or appeals process, depending on the nature of the issue. For cause, according to HIP program regulations is defined as poor quality of health care coverage and includes the following:
 - o Failure of MDwise to provide covered services (appeal).
 - o Failure of MDwise to comply with established standards of medical care administration (grievance).
 - o Significant language or cultural barriers (grievance).
 - o Other circumstances determined by FSSA or its designee to constitute poor quality of care (grievance).

Copayments

In accordance with Federal regulations, as well as 407 IAC 3-10-3 and 407 IAC 3-9-3, it is MDwise policy that providers may not collect copayments for covered services administered to MDwise members, except for those members enrolled in HIP Basic, HIP State Plan Basic or HIP State Plan Plus Copay (also known as MA-PC). Providers must not deny service to these patients, or engage in collection activities, because of non-payment for services.

Please note that if this recoupment pertains to a Healthy Indiana Plan member and the reason for the MCE's recoupment is that the member had other insurance coverage, then the provider must submit this claim(s) following the billing process required by Medicare or other insurance coverage. Under Medicare rules you have 6 months, from date of recoupment notification, to submit such claims. **The provider may not pursue reimbursement from the member per federal rules for covered services under any circumstance.**

Native Americans are not subject to co-pays under HIP. This includes emergency services.

Co-payments for MDwise HIP Plus and Basic Members

There are no co-payments in the HIP Plus plan except for non-emergency use of the ER, which will total \$8 for each inappropriate visit. Pregnant women are excluded from this co-payment and all others.

The HIP Basic plan will require co-payments for all covered services besides preventive care. Pregnant women in this program are exempt from all co-payments. Co-payment amounts per service type are as follows:

- Preventive Care Services = \$0
- Outpatient Services = \$4
- Inpatient Services = \$75
- Preferred drugs = \$4
- Non-preferred drugs = \$8
- Non-emergency ED visit = \$8

Providers collect the co-payment from members at the point of service. The member's co-payment amount is NOT indicated on their HIP member ID card. You will need to verify eligibility before treating a member to know which plan they fit on and if they will owe co-pays for the services you are rendering. Please note that POWER Account funds cannot be used by the member to pay the co-payment.

Indiana Health Coverage Program (IHCP) and federal regulations specifically prohibit providers from charging IHCP members for covered services except in specific, limited circumstances. As a MDwise provider, you are required to accept the final payment determination for covered services as payment in full, except for any co-payments and any other patient liability payment allowed by the IHCP. You may not balance bill a member (i.e. charge the member for covered services above the amount paid by MDwise).

Please Note: Individuals who incur out-of-pocket expenses greater than 5% of their household income will be exempt from further cost-sharing for the remainder of the calendar quarter. HIP Basic with incomes less than \$27 per month will be automatically suspended from cost-sharing, since a single payment would exceed their quarterly threshold.

Pregnant Women and Section 1931 Parents and Caretaker Relatives

Women who become pregnant while enrolled in HIP will be transitioned to HIP Maternity, and receive all State Plan benefits and limitations for the duration of their pregnancy, and 60 day post partum period. This benefit will include enhanced benefit limits for therapy services, access to chiropractic services, and non-emergency transportation. In addition, women who elect to stay in HIP will have all their required cost-sharing suspended for the duration of their pregnancy.

HIP includes Section 1931 parents and caretaker relatives. Section 1931 parents and caretaker relatives participating in HIP will receive the same benefits as on the State Plan, including non-emergency transportation not currently available to HIP members.

Program Benefits

MDwise provides to its Healthy Indiana Plan members, at a minimum, all benefits and services deemed medically reasonable and necessary and covered under the Contract with the State and delivering such covered services sufficient in amount, duration or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services.

Due to complex medical management and health needs, individuals with incomes up to and including 138% FPL who meet the definition of medically frail will be enrolled in HIP but will receive all State Plan services. Consistent with 42 CFR §440.315(f), an individual will be considered medically frail if he or she has one or more of the following: 1) disabling mental disorder; 2) a chronic substance abuse disorder; 3) serious and complex medical condition; 4) physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activity of daily living; or 5) a disability determination, based on Social Security Administration criteria. The State anticipates that most of its severely mentally ill population will be identified and served under the Behavioral and Primary Health Care Coordination (BPHC) program, Indiana's pending 1915(l) State Plan option for adults with serious mental illness.

MCEs may identify individuals as medically frail based on their claims history. The MCEs must apply Milliman's Medical Underwriting Guidelines (MUGs) to score each member. Members with qualifying conditions or a risk score at or above a defined threshold are considered medically frail and granted the State Plan benefit wrap. Indiana will periodically look at claims for identified "medically frail" individuals to verify all members were categorized appropriately. Individuals who no longer qualify as medically frail will have the option of the HIP Basic or HIP Plus plans.

The following table provides an overview of covered services for HIP Plus, HIP Basic, HIP State Plan (Plus and Basic) and HIP Maternity. HIP covered services are outlined in IC 12-15-44 and Administrative Code 405 IAC 9-7. As stated in IC 12-15-44-4, the MCE must also comply with any coverage requirements that apply to an accident and sickness insurance plan issued in Indiana. The Indiana Administrative Code can be found on the State's website at in.gov/legislative/iac/iac_title?iact=405. Additional information on these services listed below can be found in Social Security Act 1905(a)(1)-(29).

Benefit	HIP Plus	HIP Basic	HIP State Plan and HIP Maternity
Accidental Trauma Treatment	Covered	Covered	Covered
Allergy Testing	Covered	Covered	Covered
Anesthesia	Covered	Covered	Covered
Bariatric Surgery	Covered	Not Covered	Covered
Behavioral Health Services**	Covered**	Covered**	Covered**
Chemotherapy	Covered	Covered	Covered
Chiropractic Services †	Covered	Not Covered	Covered
Congenital Abnormalities	Covered	Covered	Covered
Dental Services	Covered	Not Covered	Covered
Dialysis	Covered	Covered	Covered
Durable Medical Equipment	Covered	Covered	Covered
Early Periodic Screening Diagnosis and Testing (EPSDT)	Covered	Covered	Covered
Emergency Services	Covered	Covered	Covered
Emergency Transportation (Ambulance and Air Ambulance)	Covered	Covered	Covered
Family Planning Services (Includes Birth Control Pills) 42 CFR 431.51(b)(2)	Covered	Covered	Covered
General Inpatient Hospital Care	Covered	Covered	Covered
Hearing Aids	Covered	Covered	Covered
Home Health Services	Covered	Covered	Covered
Hospice Care	Covered	Covered	Covered
Imaging – MRI, CT, and PET	Covered	Covered	Covered
Inpatient Physician Services	Covered	Covered	Covered
Inpatient Surgical Services	Covered	Covered	Covered
IV Infusion Services	Covered	Covered	Covered
Laboratory	Covered	Covered	Covered
Long Term Care	Not Covered	Not Covered	Covered
Long Term Care	Not Covered	Not Covered	Covered

Benefit	HIP Plus	HIP Basic	HIP State Plan and HIP Maternity
Long Term Services & Supports	Not Covered	Not Covered	Not Covered
Mental/Behavioral Health Inpatient	Covered	Covered	Covered
Mental/Behavioral Health Outpatient	Covered	Covered	Covered
MRO	Not Covered	Not Covered	Covered (Carve Out)
Non-Cosmetic Reconstructive Surgery	Covered	Covered	Covered
Non-Emergent Transportation	Not Covered	Not Covered	Covered
Occupational Therapy	Covered	Covered	Covered
Office Visits (PMP/APRN)	Covered	Covered	Covered
Outpatient Surgery	Covered	Covered	Covered
Pathology	Covered	Covered	Covered
Physical Therapy †	Covered	Covered	Covered
Podiatry Services	Covered	Covered	Covered
Prescription Drugs	Covered	Covered	Covered
Preventive Care Services*	Covered*	Covered*	Covered*
Prosthetics	Covered	Covered	Covered
Radiation Therapy	Covered	Covered	Covered
Rehabilitation	Covered	Covered	Covered
Respiratory Therapy	Covered	Covered	Covered
Skilled Nursing Facility	Covered	Covered	Covered
Specialty Physician Visits	Covered	Covered	Covered
Specialty Physician Visits	Covered	Covered	Covered
Speech Therapy †	Covered	Covered	Covered
Substance Abuse Inpatient Treatment	Covered	Covered	Covered
Substance Abuse Outpatient Treatment	Covered	Covered	Covered
Add Substance Use Disorder Residential Services (DMHA Approved SUD Residential Provider)	Covered	Covered	Covered
Temporomandibular Joint Disorders (TMJ)	Covered	Not Covered	Covered
Tobacco Cessation Drugs	Covered	Covered	Covered
Transplants	Covered	Covered	Covered
Urgent Care/Emergency Clinics (non-hospital)	Covered	Covered	Covered
Vision Services †	Covered	Not Covered	Covered
X-Rays	Covered	Covered	Covered

*Preventive Care Services: Includes services with an "A" or "B" rating from the United States Preventive Task Force, immunizations recommended by the Centers for Disease Control and Prevention, and additional preventive care screenings for women as provided in the Health Resources and Services Administration guidelines.

**Behavioral Health Services: The behavioral health providers to which the member may self-refer within the MDwise network include:

- Outpatient mental health clinics.
- Community mental health centers.
- Psychologists.
- Certified psychologists.
- Health services providers in psychology.
- Certified social workers.
- Certified clinical social workers.
- Psychiatric nurses.
- Independent practice school psychologists.
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center.
- Person holding a master's degree in social work, marital and family therapy, or mental health counseling.

† *Self-referral services included in these benefits may require an authorization. Please see the MDwise prior authorization guide for specific codes.*

Self-Referral Services Healthy Indiana Plan (paid by MDwise)

MDwise HIP members are not restricted to use MDwise contracted providers for certain "self-referral" services. Federal and state regulations allow members access to certain covered services outside of MDwise without a referral. Members may access these services from any Indiana Health Coverage Program (IHCP) enrolled provider who is qualified to render the service.

Although these services can be obtained out-of-network, MDwise is responsible for paying for these services if medically necessary. When members choose to receive self-referral services from providers who are not contracted with MDwise, MDwise is responsible for payment to these providers up to the applicable benefit limits and at Program rates (i.e., Medicare rates).

The following are self-referral services in the Healthy Indiana Plan where members may obtain services from any IHCP enrolled provider qualified to render the service, based on their benefit plan coverage:

- Family planning services. Federal regulation 42 CFR 431.51(b)(2) requires a freedom of choice of providers and access to family planning services and supplies (i.e. birth control pills).
 - o Services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy and sexually transmitted disease testing.
 - o Reimbursement is available for family planning services, as outlined in IC 12-15-5-1 and applicable federal law.

- Immunizations.
- Emergency/Urgent Care Services.
- Vision Services.
- Chiropractic Services.
- Dental Services.

The following are also HIP self-referral services; however, members must obtain services from a MDwise contracted provider. You may refer them to an in-network provider.

- Psychiatric services.
- Behavioral health services.
- Podiatric services – HIP coverage only available for diabetic foot care.
- Diabetes self-management service.

Healthy Indiana Plan Emergency Services and Post Stabilization

MDwise members may access emergency services 24 hours a day, seven days a week. Members are instructed to seek emergency services at the nearest emergency room without authorization when they believe their condition to be an emergency. MDwise will cover and reimburse all emergency services, including screening services, which are rendered by a qualified IHCP provider. There are co-pays for inappropriate use of emergency room services, as outlined on the benefit coverage table above (see page 49).

MDwise reimburses out-of-network emergency services providers at 100 percent of the Program's rates (i.e., Medicare rates or 130% of Medicaid rates), minus any applicable co-payments.

MDwise does not require prior authorization for emergency services or screening exams, regardless of whether the IHCP provider is contracted with MDwise or not. However, a retroactive medical necessity review may be performed to determine whether services are medically necessary. Providers should notify the MDwise medical management staff in the event he/she, or a representative, have advised a member to seek care in the emergency room or has approved/authorized emergency or post-stabilization services upon contact by the emergency room physician requesting such approval.

MDwise covers post-stabilization services when there is an emergency medical condition and one of the following occurs:

- Prior authorization for the post-stabilization services has been obtained from the member's PMP or authorized representative in conjunction with the PMP's medical management department.
- Services are administered to maintain the member's stabilized condition within one (1) hour of a request (begins at the time the call is placed) to the member's PMP or authorized representative for prior authorization.
- Services are administered to maintain, improve or resolve the member's stabilized condition if MDwise:
 - o Does not respond to a request for prior authorization within one (1) hour
 - o Cannot be contacted
 - o If the PMP or authorized representative cannot reach an agreement with the member's treating

physician concerning the member's care, MDwise shall give the member's treating physician an opportunity to consult with the MDwise Medical Director. The member's treating physician may continue with medically necessary care of the member until the Medical Director is reached or until one (1) of the following criteria is met:

- A participating MDwise physician with privileges at the treating hospital assumes responsibility for the member's care.
- A participating MDwise physician assumes responsibility for the member's care through transfer to another facility.
- MDwise and the treating physician reach agreement about the member's care
- The member is discharged.

Providers must document their request for prior authorization. This documentation should include the member's PMP, the time of call, the phone number called, and the name of the person answering the phone. The provider must also document the time at which the authorization was given and the authorizing party's name and institutional affiliation. If the provider is unable to reach the member's PMP or the applicable delivery system to obtain prior authorization, these requests must also be documented.

Please Note: Members are always encouraged to call their PMP or the MDwise NURSEon-call, our 24-hour nurse hotline, when they have an urgent health need, or are unsure if it is an emergency. MDwise providers are encouraged to help educate their patients about the appropriate use of the emergency room. Also, if you become aware of a member that is inappropriately using the emergency room for primary care services, please let us know and a MDwise Health Advocate will attempt to contact the member to educate them about appropriate emergency room use.

Healthy Indiana Plan Out-of-Network Services

MDwise attempts to provide all care within the MDwise contracted network (, inclusive of MDwise behavioral health network), for coordination, access, and communication purposes, better understanding of available resources within the delivery system, and because MDwise providers have agreed by contract, to abide by MDwise policies and procedures.

Health care services provided outside of the MDwise network may be authorized for coverage when appropriate contracted providers, services, or facilities are not available within the member's service area. MDwise will also cover and reimburse (Medicare rates or 130% of Medicaid rate if no Medicare rate) authorized routine care provided to members by out-of-network or out-of-area providers. These service authorization requests are subject to the medical appropriateness criteria and determination process.

In accordance with MDwise program rules, all services must be obtained in-network, except for the following:

- Family planning services (self-referral).
- Emergency services (self-referral).
- Medically necessary, covered services that can't be obtained from an in-network provider within 60 miles of the member's residence.
- Nurse practitioner services, if they are not available within the member's service area within the MDwise network.
- FQHC and RHC services if an FQHC or RHC is not available in the member's service area within the

MDwise network.

- Services for members traveling out of area who need urgent/emergent services.
- Services provided under "Continuity of Care" principles – e.g. individual joins MDwise and has an outstanding prior authorization (within 30 days of becoming a member) for services from a provider that is not contracted with MDwise.

MDwise does not require an out-of-network provider to acquire a MDwise-assigned provider number for reimbursement. An NPI number is sufficient for out-of-network provider reimbursement.

Healthy Indiana Plan Excluded Services

The HIP program excludes some benefits from coverage under managed care. These excluded benefits may be available under traditional Medicaid or other waiver programs. Therefore, a member who is, or will be, receiving excluded services must be disenrolled from managed care to be eligible for the services. MDwise is responsible for the member's care until the member is disenrolled from the plan unless stated otherwise. Excluded services are:

- Long-term institutional care HIP members requiring long-term care in a nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR) must be disenrolled from the HIP program and converted to fee-for-service eligibility in the IHCP.
- Home- and community-based services (HCBS) waiver Members who have been approved for these waiver services must be disenrolled from managed care and the MDwise must coordinate care for its members that are transitioning into a HCBS waiver program until the disenrollment from HIP is effective.
- Psychiatric treatment in a state hospital: Psychiatric treatment in a state hospital is an excluded service but HIP members receiving psychiatric treatment in a state hospital shall not be disenrolled from HIP, but should be directed to an alternative inpatient facility.

Non-Covered Services for the HIP Basic Benefit Package

- Dental services including extraction, restoration and replacement of teeth, x-rays, supplies, appliances and all associated supplies with the exception of an accidental traumatic injury to natural teeth. In such cases, treatment must be sought within 48 hours of the injury.
- Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Elective abortions and abortifacients.
- Long term or custodial care including domiciliary, convalescent care, skilled nursing facilities used for long term care, state hospitals and custodial care, nursing home care, home-based respite care, group homes, halfway homes, residential facilities.
- Day care and foster care.
- Personal comfort or convenience items.
- Cosmetic Services, procedures, equipment, or supplies. Complications directly relating to cosmetic services, treatment or surgery are not covered. Benefits are available if treatment for reconstructive service is performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or previous medically necessary procedure.
- Safety glasses, athletic glasses and sunglasses.

- LASIK and any surgical procedures to correct refractive errors.
- Vitamins, supplements and over-the-counter medications.
- Wellness benefits other than tobacco use cessation.
- Diagnostic testing or treatment in relation to infertility.
- In vitro fertilization.
- Gamete or zygote intrafallopian transfers.
- Artificial insemination.
- Reversal of voluntary sterilization.
- Transsexual surgery.
- Treatment of sexual dysfunction including but not limited to medication.
- Body piercing.
- Over-the-counter contraceptives.
- Physician samples dispensed in a physician's office.
- Alternative or complementary medicine including, but not limited to: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reiket therapy, massage therapy, herbal or dietary products or therapies.
- Treatment of hyperhidrosis.
- Court ordered testing or care unless medically necessary.
- Travel related expenses including mileage, lodging and meal costs, except for mileage paid to emergency transportation providers.
- Missed or cancelled appointments for which there is a charge.
- Services and supplies for which member has no legal obligation to pay in absence of coverage under the plan
- The evaluation and treatment of learning disabilities.
- Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot and tarsalgia.
- Any injury, condition, disease ailment arising out of the course of employment IF benefits are available under any Worker's Compensation Act or other similar law.
- Examinations for research screening.

Preventive Care Package

OMPP determines which recommended preventive care services apply to a specific HIP member's age and gender, as well as the member's pre-existing conditions. If a HIP member is redetermined eligible at the end of a benefit period, those HIP members that obtain a recommended preventive care service can roll over their entire POWER Account balance, including monies contributed by the State. This can include an annual physical exam or any health screening (e.g. mammogram, colonoscopy, etc.) appropriate for the member's age and gender. HIP Members that fail to obtain

the recommended preventive care services may only roll over their pro rata share of the POWER Account balance, leaving less money available to reduce the next year's required contribution. The remaining funds must be credited to the State.

POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. Each benefit period, OMPP will determine which recommended preventive services qualify a member for roll over.

Claims

Compensation for services rendered by IHCP providers will follow all IHCP Provider Guidelines, including the IHCP Fee Schedule, attendant to the Hoosier Healthwise and the CMS fee schedule for Healthy Indiana Plan.

Claims Submission Forms

Providers are required to submit claims on one of the following claim form types:

- CMS 1500 (professional claims)
- UB04 form (for institutional claims)
- 837P (HIPAA compliant professional) and/or 837I (HIPAA compliant institutional) file formats-electronic claims

The following code sets are to be used when submitting claims electronically or in paper:

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM)
- Current Procedural Terminology – (CPT)
- HCFA Common Procedure Coding System (HCPCS)
- National Drug Codes (NDC)

MDwise is required by state and federal regulations to capture specific data regarding services provided to its members. The provider must adhere to all billing requirements to insure timely processing of claims. It is important to complete all required data fields on the claim form. Missing or invalid data elements or incomplete forms will cause processing delays, rejections, or denials.

A claim may be rejected if it has invalid or missing data elements, such as the provider tax identification number or member MID number. Rejected claims are returned to the provider or electronic data interchange (EDI) source without registering in the claim processing system. Rejected claims are different than denied claims, which are registered in the claims processing system but do not meet requirements for payment under MDwise guidelines. Since rejected claims are not registered in the claims processing system, the provider must resubmit the claim within the claims timely filing limit.

See the IHCP Claims Submission and Processing Module for detailed information on required fields. This can be found at indianamedicaid.com.

Please note: MDwise follows the IHCP applied National Correct Coding Initiative (NCCI) editing to medical services billed on professional and outpatient institutional claims. For more information on NCCI edits, please refer to the Provider Reference



Module on the [National Correct Coding Initiative](#).

Claim Timelines

Claim Submission Type

MDwise Contracted Providers
Non-Contracted Providers
Secondary Claims
Claim Dispute
Corrected Claim
Newborn Claims

Submission Deadline

90 calendar days from date of service
180 calendar days from date of service
90 calendar days from date of Primary EOP
60 calendar days from date of EOB
90 calendar days from date of EOB
365 days from date of service

Adjudication

Clean Electronic Claim
Clean Paper Claim
Dispute Resolution

Response Time

21 business days from date of receipt
30 business days from date of receipt
30 calendar days from date of receipt

According to this Indiana Statute, a clean claim is a claim submitted by a provider for payment that can be processed without obtaining additional information from the provider of service or a third party. The receipt date of a claim is the date that MDwise receives either written or electronic notice of the claim. All hard copy claims are stamped with date of receipt.

As a MDwise provider, you are required to submit complete and accurate claims/encounter data as outlined in your MDwise contract. A corresponding claim or encounter data must be submitted for every service provided, even if a member has other health coverage, with claim detail identical to that required for fee-for-service claims submissions. Providers are encouraged to submit claims electronically as this helps to ensure more timely processing.

Questions about Claims: *If you have a question about a specific claim that you submitted, or about an EOB/EOP you received, please contact MDwise at [1-800-356-1204](tel:1-800-356-1204). If you have general questions about claims submission or payment policies, please call your provider relations representative.*

Corrected Claim Submission

When a claim is denied due to a provider's incorrect claim information, the provider should review the claim and resubmit with corrections. To submit a corrected claim, be sure to include the resubmission code, or the resubmission will be denied as a duplicate claim submission. Corrected claims must be submitted within 90 days of the date of the EOB.

Further direction on submitting corrected claims can be found in the IHCP Provider Modules [Claim Submission and Processing](#) and [Claim Adjustments](#).

Third Party Liability

When the member has other insurance, a MDwise provider must submit claims to the other insurance carrier before submitting to MDwise. A copy of the third party's explanation of benefits (EOB) must be included with a TPL claim, within 90 days of the date of the primary explanation of benefits. MDwise will then pay the different between the

payment made by the primary insurance carrier and MDwise's total allowable charge for the covered service. If the primary insurance paid more than MDwise's total allowable charge the claim will pay zero.

If the provider finds out about TPL after they bill MDwise then they are responsible for billing the other carrier. If the provider has already been paid by MDwise and the provider subsequently obtains TPL payment, the provider must submit a refund to MDwise.

In some cases, even if there is third party coverage involved, MDwise must first pay the provider and then coordinate with the liable third party. This applies when the claim is for:

- Prenatal care for a pregnant woman.
- Preventative pediatric services (EPSDT) that are covered by the Medicaid program.
- Coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the providers has not received payment from the third party within 30 calendar days after the date of service.

90 Day Rule

When a third-party insurance carrier fails to respond within 90 days of the provider's date of service, the claim can be submitted to MDwise for payment consideration.

However, one of the following must accompany a claim to substantiate attempts to bill the third party or the claim will be denied:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Provider must note the date of the billing attempt and the words **no response after 90 days** on an attachment. This information must be clearly indicated. Note: For contracted providers, claims must still be received by MDwise within the 90-day filing limit.
- Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days from the date of service. The provider is required to boldly make a note of the following on the attachment:
 - o Date of the filing attempt.
 - o The words **no response after 90 days**.
 - o Member identification number (MID) and provider's National Provider Identifier (NPI).
 - o Name of primary insurance carrier billed.

For claims filed electronically, the following must be documented in the claim note segment of the 837P transaction:

- Date of the filing attempt.
- The phrase, "no response after 90 days."
- The member's identification (MID) number and IHCP provider number.
- Name of primary insurance carrier billed.

MDwise Medicaid products are the payer of last resort, with the exception of the following two fully state funded programs:

- Victims Assistance
- Indiana Children's Special Health Care Services

Third Party Liability and Prior Authorization

If a covered service is to be provided that requires prior authorization by MDwise, and the member has third party coverage, the provider is still responsible for obtaining prior authorization for the service in addition to any authorization required by the third-party payer. If prior authorization is not obtained, the claim may be denied.

If a provider is aware that a member has been in an accident, however does not yet know who the liable third party is, the provider can bill MDwise. If MDwise is billed, the provider must note the claims are for accident-related services on the applicable claim form. If a provider initially pursues payment from the liable third party and the claim is submitted to MDwise after the filing time limit, the claim may be denied.

Provider Third Party Liability Responsibilities

According to Indiana Health Coverage Program (IHCP) program requirements, providers are responsible for obtaining insurance coverage information from members at the time service is provided. Providers are required to do the following:

- Ask every member if he or she has any insurance coverage and report any available coverage to MDwise through inclusion on a claim form, phone call or written notice.
- Check the MDwise Provider Portal before billing MDwise and if available, pursue the TPL resource first.
- When a provider determines that a member has an available TPL resource, the provider is required to bill that resource before billing MDwise.
- If a member has other TPL resources and the provider submits a claim to MDwise without documentation that the third-party resource was billed, federal regulations require that the claim be denied.

Notification of Pregnancy (NOP)

Early identification and evaluation of pregnant Hoosier Healthwise members is important to assuring that these members receive timely and comprehensive prenatal care to minimize maternal complications, limit neonatal complications, and improve neonatal outcomes.

Through the Notifications of Pregnancy, we have been able to identify pregnant Hoosier Healthwise members with histories of high-risk pregnancies or women who are vulnerable to developing a high-risk pregnancy due to existing health conditions and/or psychosocial issues that may potentially impact the birth outcome.

Women identified through a completed Notification of Pregnancy (NOP) form who have an existing high-risk pregnancy or who are vulnerable to developing high-risk pregnancy receive numerous services to promote healthy habits during pregnancy and to provide access to supportive services to reduce the effect of psychosocial issues. Examples include but are not limited to:

- High-risk pregnancy case management.
- Outreach by a Health Advocate (Social Worker).
- Promotion of tobacco cessation.
- Assure access to services and supplies necessary to care for the baby after birth.



As a PMP, MDwise needs your assistance to assure that Notifications of Pregnancy (NOPs) assessments are completed and submitted for all MDwise pregnant members seen in your office for prenatal care. When a Hoosier Healthwise eligible woman is determined to be pregnant, a provider can complete the NOP form and electronically submit it via the Provider Healthcare Portal. NOP forms must be returned within five (5) days. Additional reimbursement is available for providers that submit the NOP form. The submitted information will be used by MDwise to determine her health risk level associated with the pregnancy and the need for prenatal care coordination. You may access the following link to log on to the Provider Healthcare Portal at

<https://portal.indianamedicaid.com/hcp/provider/Home/tabid/135/Default.aspx>.

If you have any questions or need additional assistance regarding Notification of Pregnancy, please contact the MDwise Customer Service Department at **1-800-356-1204** or **317-630-2831** or visit the MDwise website at **MDwise.org**.

Inquiries and Disputes

Claim Inquiries

Providers may submit an inquiry on a claim at any time during the adjudication process. However, MDwise requests that the provider first checks the MDwise Provider Portal and contact customer service prior to submitting an inquiry form.

To submit an inquiry, utilize the Claims Provider Inquiry Form located at MDwise.org/for-providers/forms/claims. Once the form is complete, please send to the fax number located at the top right-hand side of the inquiry form. If you have additional questions on an inquiry, please call **1-800-356-1204** or **317-630-2831**.

General Dispute Information

All in and out of network providers have the right to dispute a claim decision or action. MDwise provides that persons not involved in making the original claim decision shall review the issue or concern upon dispute.

Providers must file their initial claim dispute within 60 days of a claims determination. When submitting a dispute, the provider should include the dispute form, explanation of payment, and an explanation of the reason for disputing the claim.

MDwise will review all disputes and respond to the provider within 30 business days. If the original decision is upheld the provider will be given information on how to file a 2nd level dispute. Please see MDwise.org/for-providers/forms/claims for more detailed information on in and out of network claims disputes.

Examples of denials that may constitute a dispute include:

- Timely Filing
- Coding Issues
- Prior Authorization



The following do not constitute a dispute:

- New Claims
- Corrected Claims
- Medical Records
- Attachments (Consent forms, Invoices)
- Recoupments

Filing a Dispute

To file a claim dispute, completely fill out the Claims Dispute Form located at [MDwise.org/ MediaLibraries/MDwise/Files/For%20Providers/Forms/Claims/claims_dispute_form.pdf](https://MDwise.org/MediaLibraries/MDwise/Files/For%20Providers/Forms/Claims/claims_dispute_form.pdf). Each claim dispute requires a separate claims dispute form. Completed forms should be submitted to the Claims Dispute team via email (preferred method) at cdticket@MDwise.org, or mail to:

MDwise

P.O. Box 441423
Indianapolis, IN 46244-1423
Attention: Dispute Department

In Network & Out of Network Provider Claim Disputes

Providers who have a claim dispute should send their disputes to the MDwise corporate office. Behavioral health providers should also send all claim disputes to the MDwise address below.

MDwise

P.O. Box 441423
Indianapolis, IN 46244-1423
Attention: Grievance Coordinator

Hoosier Healthwise & Healthy Indiana Plan Claims

Submitting Claims

Providers can determine the member's eligibility by checking Core MMIS at indianamedicaid.com. Within the Core MMIS system the provider can enter their NPI and the member's MID number to pull up the member's eligibility information. The eligibility screen will show the type of coverage the member has (Hoosier Healthwise, Healthy Indiana Plan and Traditional Medicaid) and the Managed Care Plan the member is assigned to.

Claims may be submitted via paper or electronically. Please remember that all electronic claims must be submitted using HIPAA-compliant transaction and code sets.

MDwise processes professional and institutional claims, with the exception of carved out services. Pharmacy claims from MDwise members should be sent to the state's pharmacy claims vendor.

Providers can determine the member's eligibility by checking Core MMIS at indianamedicaid.com. Within the Core MMIS system the provider can enter their NPI and the member's MID number to pull up the member's eligibility information. The eligibility screen will show the type of coverage the member has (Hoosier Healthwise, Healthy



Indiana Plan or Traditional Medicaid) and the Managed Care Plan the member is assigned to.

Medical and behavioral health providers should submit their claims to MDwise at:

MDwise/McLaren Health Plans

P.O. Box 1575

Flint, Michigan 48501

MDwise accepts claims in electronic format through the following clearinghouses:

Hoosier Healthwise Claims:	Optum/Change Health/Emdeon/WebMD Payer ID: 3519M
Healthy Indiana Plan Claims:	Optum/Change Health/Emdeon/WebMD Payer ID: 3135M

Dental Claims

Dental claims for Hoosier Healthwise and Healthy Indiana members should be sent directly to DentaQuest.

DentaQuest of IN – Claims

P.O. Box 2906

Milwaukee, WI 53201

Electronic DentaQuest claims should be sent directly to dentaquest.com or via clearinghouse:

DentaQuest Clearinghouse Payer ID: CX014

Billing MDwise Members

Billing for Covered or Non-Covered Services

As outlined below, there are very specific circumstances in which a provider can bill members for covered or non-covered services.

According to MDwise policy, a provider may bill a member for Hoosier Healthwise or HIP covered or non-covered benefits only when all the following conditions have been met:

- Non-covered benefit: A provider may bill a MDwise member for services that are not covered under Hoosier Healthwise or HIP. It is important to note, however that for the HIP program, the member's POWER Account funds may not be used to reimburse providers for non-covered services.
- Member exceeded benefits: Providers may bill the member when the service is a Hoosier Healthwise or HIP covered service for which the member has exceeded the program limits for the particular service. The member must understand before receiving the service that the service is not covered and they will be responsible for the charges incurred. Also, please note it is the provider's responsibility to verify member benefit limits.
- PA denied and member told why: A provider may bill a member for services that require authorization but for which authorization is denied. However, the provider must establish authorization has been requested and denied with member before rendering the service. The provider will have an opportunity to request review of the authorization decision by MDwise. If MDwise maintains the decision to deny an

authorization the provider must inform the member that the service requires authorization, that the authorization has been denied and why, and that they may appeal this decision directly with MDwise. The provider must also inform the member that covered services may be available without cost if the member gets them from the appropriate provider in the MDwise network. The provider must inform the member of their responsibility for payment if they choose to or insist on receiving the service without authorization.

- Member did not tell provider they were eligible: A provider may bill the member when the provider has taken appropriate action to identify a responsible payer and the member has failed to inform the provider of Hoosier Healthwise or HIP eligibility. However, if the member tells the provider later that he/she had Hoosier Healthwise or HIP coverage, and it is still within the claims timeliness filing limits, the provider must submit the bill to MDwise and so cannot require the member to pay.
- Outstanding co-payments: It is permissible to bill a member for any outstanding co-payments, yet providers may not deny services to member due to their inability to pay the co-payment amount on the date of service.

Obtaining a Waiver

In the situations outlined above, when the member chooses to receive a service that is not covered by MDwise they may only be billed, if the provider obtains documentation (i.e. waiver), that the member voluntarily chose to receive the service, knowing that MDwise will not pay for it and they are responsible for the charges. The waiver must meet all the following requirements:

- Must include member's signed statement accepting financial responsibility for the services.
- The waiver is signed only after the member is given the appropriate notification that the service is not covered and why.
- The waiver must be specific about the services to be billed and must be retained as documentation in the patient's medical record. A waiver must be obtained for each encounter or patient visit that falls under the above scenario.
- The waiver must list the specific services that fall under the waiver's application, the date the services were rendered and the cost for the services.
- The waiver may not contain any language or condition to the effect that if authorization is denied after the service is rendered; the member is responsible for payment.

MDwise claim submission guidelines can be found in the IHCP Provider Manual under the [Claim Submission and Processing](#) module.

Prior Authorization

MDwise emphasizes the role of the primary medical provider (PMP) to guide members to the most appropriate treatment option and place of care. The PMP coordinates and oversees referrals to specialty care providers. MDwise medical management works to strengthen the link between the MDwise member and their PMP in an effort to coordinate care, prevent unnecessary utilization of services and ensure access to and utilization of needed medical care, including preventive care.

MDwise medical management facilitates the PMPs' requests for authorization for primary and preventive care services, if an authorization is required, and assists the PMPs in providing appropriate referral for specialty services, second opinions, special needs and women's services.

MDwise medical management functions are guided by specific policies and procedural steps to facilitate the review of a referral/authorization request based on the appropriateness of care and services for that individual member.

Services That Require Prior Authorization

Quick reference guides and a specific list of services requiring prior authorization for medical review are distributed to the contracted providers by your medical management staff. The list of services requiring prior authorization is reviewed at least annually and updated as needed.

Medical management staff is available to discuss and assist the providers in understanding the prior authorization process. Providers can also access authorization information through the MDwise website as well as prior authorization forms.

To ensure you have the latest and most comprehensive list of services requiring prior authorization, visit MDwise.org/for-providers/forms/prior-authorization.

Prior authorizations for health care services can be obtained by contacting the medical management department by phone or fax (information found on the contact sheet). Copies of prior authorization forms can be found on the website.

MDwise medical management identifies specific services and treatments that require prior authorization for medical necessity review based on several criteria, including federal and state regulations and policy. Many services and treatments available from MDwise in-network/delivery system providers do not require a medical review.

Authorizations may be required prior to services being rendered to:

- Verify services are covered by the benefit plan.
- To coordinate timely access to appropriate clinical care.
- To verify out-of-plan referrals are appropriate.
- To efficaciously manage the utilization of health care services (including limited resources per benefit limitations).
- To implement timely discharge planning and coordination of services.
- To identify members with special health care needs, high risk individuals or populations for care coordination and case management/disease management intervention.

Service Types Requiring Prior Authorization: Such services are grouped according to service type categories that include the following: physician services (in network, out-of-network or non-contracted physicians); inpatient admissions; outpatient services/procedures; pharmacy; therapies, home health care, durable medical equipment; transportation; and self-referral services in accordance with IHCP requirements. (These categories of services are listed in the below MDwise Prior Authorization Reference Guide).

Specific authorizations by federal and state regulations: MDwise follows federal and state regulations related to authorizations of requests for second opinions, access to specialists for members with special needs and access to women's health specialist for female members.

Authorization Procedural Guidelines

- Authorization request for those services requiring prior authorization are submitted by calling or faxing the designated form to MDwise medical management. Requests should be submitted for review within a reasonable time frame prior to proposed service date. Forms are available on the MDwise website to submit for service authorization. The forms are to be completed by the requesting provider and any additional information the provider chooses to provide to support request. To access the PA forms, go to MDwise.org/for-providers/forms/prior-authorization.
- Information submitted with service request should include demographic information, type of care, frequency and duration if applicable, facility or provider, diagnosis, procedure, date of service or onset date of services, and other pertinent clinical information required supporting medical management decisions and benefiting coverage determinations.
- If additional information is required before the Medical Management staff can make a determination, the prior authorization request will be pended with a request for additional information. Incomplete forms or requests lacking required information to support the specific request will delay the authorization process.
- Pre-service (prior authorization/precertification) requests for non-urgent care and retrospective reviews may be denied based on lack of information when unsuccessful in obtaining the necessary information requested to make a decision as outlined in this procedure.
- The reply to the prior authorization request will communicate the authorization decision to the PMP and SCP/other provider, as applicable. The communication will note the approved services and the effective time frame or non-authorized services and the reason for denial of service and alternative care options and appeal rights, as applicable.

Please Note: Eligibility must be checked every time a service is rendered. Failure to do so may result in denial of payment. Prior authorization of a referral/service is not a guarantee of payment, for example if benefits expired prior to service date. The practitioner/provider must always check member eligibility at the time of service during the referral/authorization period to avoid denial of payment for services provided due to member no longer being eligible on date of service.

Medical Management

Medical Management functions include, but not limited to coordination of care and care plan activities as applicable, authorization of services as appropriate, monitor utilization of services/medical necessity as appropriate, facilitate improved continuity and care coordination and outcomes, and assist in transitioning member into other care options.

MDwise medical management must coordinate care for its members that are transitioning into long-term institutional care, Hospice or a home and community-based waiver services. Coordination efforts include:

- Working with the long-term care facility to ensure timely submission of the request for a Pre- Admission Screening Resident Review (PASRR). MDwise is responsible for payment for up to sixty (60) calendar days for its members placed in a long-term care facility while the level of care determination is pending.
- Providing to an IHCP hospice provider any information required to complete the hospice election form.
- Coordinating care for members that are transitioning into a HCBS waiver until the disenrollment is effective.

MDwise Medical Management (MM) Program elements are further defined in the OMPP contract, program and reporting requirements, and MDwise Medical Management Policies and Procedures which include standards and timelines. The Medical Management Program components are compliant with the applicable regulatory and accrediting bodies. MDwise conducts medical management activities respecting the importance and obligation of maintaining the privacy, security and confidentiality of member personal identifiable health information.

Please Note: While long-term institutional care is not covered by MDwise, MDwise can place a member in a nursing facility on a short-term basis. Members who require long-term care or whose short-term placement becomes a long-term placement will be disenrolled from managed care when LTC/LOC is approved and entered into the Provider Healthcare Portal. It could also happen that while a Medicaid eligible individual in a Hoosier Healthwise-eligible aid category is awaiting placement in a LTC/LOC facility they could auto-assigned to MDwise before the placement paperwork is completed. Again, LTC/LOC services are not eligible to managed care members, and must be disenrolled from MDwise.

Scope and Approach

Medical Management focuses on the outcome of treatment with an emphasis on:

- Appropriate screening activities.
- Reasonableness and necessity of all services.
- Quality of care reflected by the choice of services provided, type of provider involved, and the setting in which the care was delivered.
- Prospective and concurrent care management.
- Evaluation of standards of care/guidelines for provision of care.
- Best practice monitors.

Delegation

MDwise delegates medical management functions to the individual hospital delivery systems. Medical management activities are performed by qualified health professionals, including the Medical Director, who have the knowledge and familiarity with your hospital network, primary care, specialty and ancillary providers, as well as the MDwise population and program requirements.

Medical Management Program Activities

Medical Management service authorization activities conducted by the medical management staff include:

- Preauthorization of inpatient and selected outpatient services, including pharmaceuticals.
- Concurrent review.
- Retrospective review on selected inpatient and outpatient services.
- Authorization and Denial notification.

Supplemental activities to assist the provider and member in accessing and receiving appropriate services to meet the member's needs include:

- Discharge planning.
- Identification of members with special health care needs.
- Continuity and coordination of care.
- Case and Care management.
- Disease management.

The MDwise Medical Management Program also addresses the following components or activities:

- Defined structure, processes, qualified health professionals and assigned responsibilities.
- PBM interface.
- Participation in the review of medical management grievances.
- Confidentiality maintenance.
- Accessibility/Availability of Medical Management staff.
- Quality issues reporting and review according to the Medical Management Program Policies and Procedures.
- Data collection and reporting, and annual program review.

The MDwise Medical Director and QI staffs work together in developing, implementing and evaluating medical management program components that include policies and procedures, audits, application of criteria, data reports and analysis, member and provider satisfaction issues and corrective actions and evaluation.

MDwise recognizes the integral role for medical management in developing and managing opportunities to provide preventive and health maintenance care to MDwise members. MDwise provides outreach and education services to MDwise members encouraging preventive care that includes newsletters, focused member initiatives, visits to schools, neighborhoods and health fairs to teach children and adults how to ensure basic good health.

Objectives

Medical Management Program objectives are supported through a coordinated plan involving MDwise medical directors or associate medical directors, and administrative staff.

MDwise Medical Management Program emphasizes the role of the primary medical provider (PMP) and establishment of a medical home to provide, coordinate, or guide members to the most appropriate treatment option and place of care. MDwise medical management works to strengthen the link between the MDwise member and their PMP, and behavioral health provider if applicable, in an effort to coordinate care, prevent unnecessary utilization of services, and ensure access to and utilization of needed medical care, including behavioral health and preventive care.

Primary objectives of MDwise Medical Management are to:

- Promote the efficient provision of quality health care services appropriate to the needs of the individual member.
- Provide monitoring and oversight to assure that health care services are delivered at the appropriate level of care in a timely, effective and cost-efficient manner.
- Continually examine and improve the quality of health care and resource allocation delivered to members.
- Enhance the overall performance of practitioners and providers in achieving optimal outcomes in the delivery of quality, safe, efficient health care services to members through prospective, concurrent and retrospective data analysis and education.

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- Continually examine and improve the quality of health care and resource allocation delivered to members.
- Enhance the overall performance of practitioners and providers in achieving optimal outcomes in the delivery of quality, safe, efficient health care services to members through prospective, concurrent and retrospective data analysis and education.
- Monitor and analyze relevant data to identify, correct and prevent patterns of potential or actual excessive or under use of health care services.
- Facilitate the transition of health care services for members ensuring continuity of care by providing access to continued necessary care and assistance in transitioning to a new care setting, service provider or services, or MCE.
- Implement case management services that assess, monitor, plan, and coordinate care options for members with such conditions as a chronic or resource intensive illness, multiple diagnoses of mental illness, substance abuse and physical illness, or have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition.
- Meet or exceed customer expectations.

Integration with QI

MDwise Medical Management standards integrate the QI process in measuring, monitoring and evaluating its activities and provider practice patterns. Quality of care is evaluated by analyzing information related to management of care, treatments, practice patterns (for example referrals), authorization and denial decisions, case outcomes, and other analysis of data for under or over utilization patterns. Potential quality of care issues, adverse outcomes, and questionable treatment plan and/or complications that require further investigation are directed to the delivery system QI Director.

Medical Management prospective, concurrent and retrospective activities provide means by which MDwise can evaluate and promote evaluation of standards of care/practice guidelines, best practices parameters and outcomes on individual cases and by specific populations. Analysis of monitored data is used to develop effective interventions

including opportunities for improved medical management interventions, ensuring consistent and appropriate determinations, evaluating the effectiveness of prior authorization requirements, determining member and provider education and interventions, as well as case management and disease management interventions.

MDwise participates in the state mandated HEDIS measures related to preventive health services. Compliance to screening and immunization schedules is evaluated through applicable HEDIS measures.

MDwise Medical Management Authority, Responsibility and Committee Oversight

The MDwise Medical Advisory Committee, as directed by the MDwise Quality Management Team, is delegated the responsibility for reviewing and evaluating the medical management processes and performance improvement issues, coordinating and overseeing functions of the medical management program including data reporting and analysis, and monitoring the utilization of health care services by MDwise members. The Committee is given the responsibility to develop, oversee, review and make recommendations regarding clinical determination criteria/guidelines, medical policy development covering aspects of services (including pharmacy, preventive health and behavioral health services), case management and disease management programs, continuity of care, new technology assessments, clinical practice guidelines and research, interpret and further clarify medical policy guidelines appropriate and applicable to covered services as outlined in the Indiana Health Coverage Programs (IHCP) participation policies and contract obligations. The Medical Advisory Council provides expertise, direction and makes recommendations in the monitoring and improvement of member clinical care and safety issues and utilization.

This committee is comprised of MDwise clinical staff, medical directors and clinical experts in pharmacy, behavioral health, and other related specialties, including ad hoc members necessary to provide the academic and specialty expertise for specific focused policies.

The Medical Advisory Council also reviews and makes recommendations regarding the organization's management of pharmaceutical benefits, utilization, and pharmacy related issues and makes recommendations for quality improvement pharmacy activities, including drug utilization information and drug formulary.

Please Note: To contact a council member representative, please call your provider relations staff or Medical Director.

Key Medical Management Program Components

Physician Involvement in Medical Management Program Implementation

The MDwise Medical Management Medical Director or designated physician consultant provides clinical expertise and direction to the staff. The Medical Director oversees the medical management program and reviews cases for medical necessity or appropriateness of care for those services not meeting criteria. The Medical Director actively participates in the MDwise Committees.

Please Note: The Medical Director or designee is available to discuss Hoosier Healthwise and HIP benefit coverage and/or medical necessity decisions prior to the service request and/or in the event a service request cannot be authorized.

Medical Appropriateness Criteria/Guidelines

Medical Management evaluates nationally recognized guidelines and internally developed guidelines to adopt and utilize the criteria in evaluating the necessity of medical services. The criteria from commercial resources and internally developed criteria will be reviewed and evaluated at least annually prior to approval for initial or continued use in the medical appropriateness determination process.

The guidelines are reviewed and individually revised as necessary to ensure consistency with MDwise's clinical practice guidelines, medical policy, and current standards of practice in the community as well as the Indiana Health Care Program Manuals, applicable Federal regulations and Indiana Code (IC) and Indiana Administrative Code (IAC) policy, and OMPP Medical Policies. Participating practitioners are involved in the development, revision, approval and application of the criteria/guidelines.

Please Note: A provider may request a copy of the criteria or guideline used to make a prior authorization denial decision by calling the telephone number indicated on the denial letter and asking the medical management staff for a copy of the criteria.

Medical Management Access and Availability

The Medical Management staff is available telephonically via a toll-free number, which is also TDD/TTY compliant. Medical Management staff is available at least eight hours a day during normal business days for practitioners/providers and members regarding medical management issues, questions regarding the prior authorization process or specific questions regarding a prior authorization. Language assistance is provided free of charge for members calling the toll free Medical Management number who need interpretation. The Medical Management Department ensures the availability of a telephone system capable of accepting and recording incoming telephone calls after business hours. Callers are prompted with instructions for leaving voice mail message including their contact information. All Medical Management Department messages are returned on the next business day.

Please Note: Please refer to the Directory in the end of this book for contact information for your provider network medical management staff.

Informing and Educating Providers

Care management supports the practitioner-member relationship and plan of care. MDwise provides practitioners with verbal and written disease management program information and follow-up including:

- Disease management program materials including clinical guidelines.
- Educational materials that reinforce the principles of the disease management program.
- Instructions on how to use the disease management program services.
- How the disease management staff works with the PMP and their member's in the program.
- Procedures for PMP receiving updates regarding the member's progress meeting his/her self-management goals, modifying the care plan, and determining the appropriate time to transition the member to a lower risk group.
- Information regarding the PMP's patients identified as having the disease and their specific health data profile and patients who have been contacted and agreed to participate in program.

Please Note: For additional information, questions, and/or member referrals, please use the Directory at the end of this manual for Disease Management staff and Medical Director. Information about disease management programs will also be reported in the provider newsletter.

Confidentiality

MDwise recognizes the importance of maintaining confidentiality of member identifiable information, verbal or written information generated/utilized during medical management and quality improvement activities and/or information associated with activities and performance of network practitioners/providers and/or facilities.

- All member and practitioner/provider specific information will be kept confidential in accordance with applicable federal and state laws and regulations (HIPAA) and MDwise Policy. Disclosure of mental health records by the provider to MDwise and to the PMP is permissible under HIPAA and state law (IC 16-39-2-6(a)) without consent of the member because it is for treatment. Consent from the member is necessary for substance abuse records.
- Member specific information is used only for medical management functions/activities including case management, disease management and discharge planning and quality assurance/ improvement activities. Access is restricted to only those staff that require information to perform their job function. Information obtained during the utilization process is used only for the purposes of medical management functions and is shared only with those agencies that have authority to receive such information.
- Medical Management and Quality Improvement activities comply with applicable federal and state laws and regulations requiring the reporting of quality issues under review.

Medical Management Determinations

Medical Management decisions are based on appropriateness of care and service and existence of coverage. Qualified health professionals collect and assess the clinical information used to support medical management decisions and benefit coverage determinations utilizing the approved clinical guidelines for medical necessity/appropriateness, Medical Policy and Policies and Procedures. Determinations are also based on the Indiana Health Coverage Programs manuals, IAC, IC, RFS medical necessity references, and Medicaid Medical Policies and applicable state and federal guidelines. Specific pharmaceutical reviews and determination functions may be delegated to the PBM employing current licensed qualified pharmacists.

The guidelines are applied to individual cases, but in those instances where criteria/guidelines are not applicable to an individual's case, the reviewer follows the process outlined or the case is referred to the medical director, appropriate behavioral health specialist, and/or the appropriate committee. The member's age, co-morbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable, are considered when applying criteria to the care requested.

- When clinical evidence documented in a member's medical record or provided by the attending physician or behavioral health provider meets the criteria, the nurse reviewer or behavioral health specialist certifies the cases. Timely notification of certification determination is provided outlining the scope of services authorized.
- The nurse reviewer or behavioral health specialist refers cases where clinical information does not meet the criteria for services requested to the Medical Director, or designee physician reviewer or appropriate behavioral health practitioner. The Medical Director or designee utilizes board certified consultants to assist as needed in making medical necessity determinations.
- The physician or behavioral health practitioner (psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist), or clinical pharmacist reviewing the case makes a determination regarding the medical appropriateness of services and/or care setting, based on clinical information obtained and/or

contained in the medical record or obtained from the attending or ordering physician and other providers involved in the member's care, as needed. A physician reviewer is available by telephone during normal business hours to discuss the case.

- Medical management determinations are made in a timely manner to accommodate the clinical urgency of the situation. Timeliness standards for medical management determinations and notification of determinations are established and performance is monitored to be in compliance with applicable regulatory agencies and accrediting organizations standards.

Please Note: Providers requesting service authorization are responsible for submitting the necessary relevant information for the Medical Management staff to make a certification determination. Providers are asked to submit authorized service requests in sufficient time prior to the start date of the requested service. Timely submission of the request along with the necessary information to process and support the service will facilitate the response time by the medical management staff.

Service Requests Not Meeting Guidelines

- In the event the physician, appropriate health practitioner or pharmacist, determines the services are not medically necessary, the certification is denied.
- A denial of a service request may be generated if information needed to make a decision is not received within a specified time frame as outlined in the timeliness standards for determinations and notifications. Grievance rights also apply to denials due to lack of information.
- The Medical Director or designee will provide alternate options of care if the certification request is denied, when applicable. Such alternatives may be for example, to have the member evaluated by a specialist, receive services in-network.
- The timely notification of a denial clearly communicates the reason for the denial and includes information about the appeal process, including the expedited appeal process, as applicable. The exception to member notification of a denied service applies only to a post-service (retrospective) service denial when the member is at no financial risk.
- The requesting provider is offered the opportunity for a peer to peer discussion with the Medical Director and/or the reviewer's designee who made a denial determination. The attending or ordering physician is notified via telephone or fax by Medical Management staff of the denial determination. At that time the Medical Management Department assures the requesting provider is advised of the opportunity and the method for requesting a peer to peer discussion.

Please Note: Policies and Procedures are in place describing the medical management functions. Please refer to the directory at the end of the manual to obtain information or ask questions from medical management staff.

No Financial Incentives

Compensation plans for physicians and staff who conduct medical management do not contain incentives, directly or indirectly, that encourage barriers to care and service in making determinations.

Conflict of Interest

No person shall participate in the review and evaluation of a MDwise member, practitioner, or provider case in which he/she has a specific conflict due to a relationship or affiliation that could compromise the independence or objectivity of the medical management and quality processes or where judgment may be compromised.

Monitoring and Management of Emergency Room Utilization

Data related to emergency services claims review is analyzed to identify patterns for further investigation and to detect any patterns of potential, questionable, or actual inappropriate under- and over-utilization. Analysis of monitored data is used to develop effective interventions.

Current interventions for members accessing non-emergent services in the emergency room include contacts by Health Advocates, educational efforts and distribution of Use the Emergency Room Wisely brochures, working with hospitals to obtain timely notification of MDwise member visits to their emergency rooms, NURSEon-call line or access and case management interventions.

Members are encouraged to contact their PMP or the NURSEon call phone line who are available 24 hours/day if they are uncertain as to whether they need to seek care in the emergency room.

Care Management/Disease Management

Care Management

MDwise promotes empowerment of members with chronic health care needs and support of provider interventions through our care management programs. Care management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. MDwise identifies case/care management as an integral component of medical management.

- Care management involves the development and implementation of a coordinated, member-focused plan of care, which meets the member's needs and promotes optimal outcomes.
- Care management objectives include developing and facilitating interventions that coordinate care across the continuum of health care services; decreasing fragmentation or duplication of services; and promoting access or utilization of appropriate resources.

Case/Care management referrals may include those members with multiple, complex, frequent or special needs, which may be due to an individual's catastrophic, high risk or potential risk, behavioral health diagnoses, co-morbidities or chronic health problems. There are several avenues by which members may be identified and referred to care managers to be evaluated for implementation of case management.

Examples of specific triggers to identify members who are screened for case/care management interventions include but are not limited to:

- Members with health care needs, acute or chronic, above and beyond those of a normal, healthy person.
- Claims identifying services being utilized, including pharmacy utilization.
- Multiple Emergency Room (ER) visits.
- Hospital lengths of stay/hospital discharge data.
- Readmission for the same diagnosis.
- Members with co-morbid conditions.
- Multiple specialty referrals.
- Multiple therapies.

- Health needs screenings and assessments.
- Predictive Modeling.
- Referrals from NURSEon-call helpline.
- High cost or high volume DME.
- Data collected through utilization management process.
- Referrals from health plan staff including customer service, physicians, providers, health care delivery staff, members, and family or member's representative.

Eligible members are members diagnosed with or at risk for such condition(s). MDwise utilizes pharmacologic and medical claims history data to confirm relevant chronic conditions in the MDwise population, as well as the State's mandated Health Needs Screener (HNS) for members new to MDwise.

MDwise has available to its Hoosier Healthwise and Healthy Indiana Plan members the following disease management programs:

- Diabetes.
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).
- Asthma.
- Congestive heart failure (CHF).
- Chronic kidney disease (CKD).
- Depression.
- Attention-Deficit Hyperactivity Disorder (ADHD).
- Autism Spectrum Disorder (ASD).
- Pregnancy.
- Post-Traumatic Stress Disorder (PTSD).
- Hypertension.

MDwise also makes these services available to members who have other conditions and are identified as underutilizing or overutilizing services.

The care management process includes:

- Identification and evaluation of member's needs.
- Presentation of member's needs assessment and ongoing discussion with the member's PMP and development of treatment plan.
- Review of clinical information.
- Development of goals.
- Development of an integrated care plan including behavioral and physical health.
- On-going communication with the member or member's family/caregivers.

- Monitoring progress and adjusting care plan accordingly, and
- Transitioning member through levels of case management when appropriate (i.e. goals and needs met, member coverage terminated).
- Performance measures and health outcomes, including analyses to identify strengths and weaknesses, develop additional interventions, diffuse best practices, and assess for and support member/provider satisfaction.

Other benefits of the involvement of a Case/Care Manager for both the member and provider include having:

- An advocate in coordinating care and services across continuum of care versus episodic care.
- A communication link to medical providers regarding care plans and goals.
- A voice to provide consistent messages related to benefits and available services and guidelines for referrals.
- An overseer of utilization of services, alternative care, accessing preventive health care services, member and provider satisfaction and outcomes.

Please Note: Contact the Care Management department or complete the electronic CM/DM Referral Form located on the MDwise website and in the MDwise provider portal, to refer any of your MDwise members who are at risk, or, could benefit from being connected to a care manager. The care manager will work with you, the member and his/her family and caregivers, and other providers involved in the member's care to implement and monitor the treatment/care plan for your member.

Disease Management

MDwise members are offered disease management programs that address conditions in which patient self-care efforts and empowerment are significant. Members are encouraged to actively participate in the management of their condition through disease education, self-management tools, and access to health professionals. Provider support is offered through provision of clinical practice guidelines, training opportunities, feedback, and comprehensive care coordination of their members.

Identification of Program Participants and Interventions

Types of data MDwise may use for identification of members includes claims and encounter data, diagnosis codes, lab results, pharmacy, member chart data, physician referrals, and self-referral solicitation responses.

Please Note: While members are mainly identified for enrollment in a disease management program through medical and pharmacy claims analysis, providers may also identify members for enrollment in a disease management program and are encouraged to contact MDwise to initiate enrollment of his/her member. See also referral form at [MDwise.org](https://www.mdwise.org).

MDwise conducts stratification of eligible members according to risk, or other clinical criteria based on available clinical data (e.g., claims) or member-provided data, and by following the stratification methodology established by OMPP as required.

In addition to stratification determined by available clinical data (e.g. claims), individual member assessments are conducted. Assessments are typically done on moderate to high-risk members to determine individual needs. A structured clinical assessment is administered to ensure appropriate classification of disease risk and to identify additional health care needs. An in-person intervention may be conducted according to findings.

Member interventions are specific to the member's stratification based on the assessments performed. Interventions will be tailored to meet the individual member's needs, as necessary. In general, all members receive the following interventions based on the outcome of their assessment: (NCQA QI8, Element F).

- **Population-based (Low Risk)** – Disease specific materials and preventive care reminders (see care gap alerts), as well as:
 - o SMOKE-free information.
 - o MDwise Newsletter.
 - o MDwise IVR reminder calls.
 - o NURSE on-call.
 - o Audio Library.
 - o My WellnessZone.
- **Care Management (Moderate Risk)** – Members receive all low-level interventions AND periodic contact with a Health Advocate or Care Manager with specific training in this clinical area. The Health Advocate/Care Manager provides member support and education telephonically. The goal of the Health Advocate/Care Manager is to empower the member to better understand the disorder and self-manage the condition as well as to coordinate care between providers, social services, schools and the community. This intervention will occur on a regular basis until the Health Advocate graduates the member to low-risk based on the members demonstration to the Health Advocate/Care Manager that they understand how to coordinate care for their condition of interest and understand basic self- management techniques.
 - o Health Advocates/Care Managers specific activities may include:
 - Focus on education and coaching specific to referral from Provider.
 - Refers to Case Manager if member's degree of risk is of more complex.
 - Arranges education and/or classes as necessary and appropriate.
 - Assists with scheduling appointments.
 - Promotes access to other population based services including: transportation, nurse triage line.
 - Promotes preventive care visits.
 - Emergency room notification follow-up.
- **Complex Case Management (High Risk)** – Members receive all low-level interventions, AND frequent contact with assigned Case Manager.
 - o Case Manager specific activities may include:
 - Member specific care plan developed that includes measurable short and long- term goals as well as defined milestones to assess the member's progress and clearly define accountability and responsibilities.
 - Coordinates care with the practitioner involved in the member's care and includes them in the development and execution of the care plan, which is reviewed periodically to adjust for progress or barriers.
 - Ensures follow-up with a specialist, if appropriate.

- Consults with a clinical pharmacist resource (Butler University/Purdue University/DS Medical Directors/MDwise MTM support) for support, if needed, in making recommendations to practitioner when medications are not consistent with guidelines and member is unable to gain control of symptoms.
- Arranges home health visit(s) or education and/or classes as necessary and appropriate.
- Conducts detailed education appropriate for stage of disease assisting in member transitioning from inpatient to ambulatory care.
- Conducts care conferences with the member and providers as needed.
- Assists with scheduling appointments.
- Emergency room notification follow-up.
- Right Choices Program if applicable.

MDwise may periodically adjust the plan of care as member needs change or new knowledge about the member's needs develops.

The phone-based intervention will attempt to reach all MDwise identified program eligible members through the application of interactive voice response (IVR), or live person.

Indicators are established as a mechanism to determine the member has achieved the maximum benefit from the level of intervention and therefore transitioned into a lower level of care. A transition plan is developed to ensure the member continues with his/her self-management activities. Changes identified in the member's risk will result in continuation of disease management services.

Coordination of Care

The MDwise continuity and care coordination policy and procedures apply to the various scenarios that may occur for a member in the Healthy Indiana Plan, including, members transitioning to another FSSA program or private insurance.

Please Note: Access to Health Advocates can be accomplished by calling **317-630-2831** (Indianapolis Area) or **1-800-356-1204** or through the link HELPlink on the MDwise website [MDwise.org](https://www.mdwise.org). HELPlink links the member with a MDwise Health Advocate who can answer questions about health and community services, as well as family issues or other concerns.

Coordination and Continuity of Care

Core elements of the MDwise medical management functions include ensuring identification and appropriateness of services, coordination of those services, and continuity of care over the continuum of care for both physical and behavioral health conditions. MDwise implements procedures to provide access to continued necessary care and assistance in transitioning to a new care setting, service provider or services. The following types of situations provide the opportunity for the member to continue with current medically necessary care:

- MDwise must honor the previous health plan's service authorizations and scheduled covered services that were not completed for a member prior to transferring from another plan into MDwise, for a minimum of 30 calendar days from the effective date of enrollment. This authorization extends to any service or procedure previously authorized within the Hoosier Healthwise program, including, but not limited to, physician services, pharmacy, a specific procedure such as surgery, or for ongoing procedures or services authorized for a specified duration such as therapies or home health care.

- MDwise members with chronic or acute illness undergoing active treatment provided by the member's current PMP, specialists, ancillary providers or by hospitals prior to member changing to a new MDwise PMP may access continued medically necessary care up through a minimum of 30 days. Active treatment for the purpose of this reference to continuity of care is referred to such treatment that if would be discontinued could cause a reoccurrence or worsening of the condition for which receiving treatment and interfere with anticipated outcomes.
- Authorization for continuation of active treatment past 30 days may be approved as appropriate to the member's individual situation. A transition plan and coordination and continuity of care responsibilities are implemented according to procedure for those newly enrolled MDwise members undergoing active treatment from an out-of-network PMP.
- For members with behavioral health care needs who are transitioning from another health plan to MDwise, collaboration and follow-up with the member's existing medical and behavioral healthcare providers or community based provider including when applicable CMHC or MRO care managers, is begun immediately to ensure that treatment plans and pertinent medical/behavioral information are transferred in a timely manner. An appropriate behavioral health case manager is identified to whom daily contact regarding the member's care can be communicated and coordinated
- Women in their third trimester of pregnancy at the time they become your MDwise member may access continued medically necessary care for prenatal, delivery and postpartum care from their previous physicians.

Other special considerations that require coordinating and providing medically necessary care during the transition from another network or delivery system include, but are not limited to the following:

- Newborn child of a Package A MDwise-enrolled mother from the newborn's date of birth.
- Newborn children of members retroactive to the date of birth.
- Members who are hospitalized when the effective date occurs.
- Members that are transitioning into services excluded for managed care but available under Traditional Medicaid or other waiver programs: those members undergoing the Pre-Admission Screening Resident Review (PASSR) process for long-term care placement, electing hospice benefit and those transitioning into a home and community-based waiver service (HCBS).

Medical management performs a variety of interventions to promote continuity and coordination of care based on the individual member's plan of care or needs including but not limited to (a) obtaining information from the member's previous health plan or PMP regarding his/her treatment plan, (b) development of a transition of care plan, (c) notifies new health plan or PMP of change in assignment during course of hospitalization or active treatment regimen, (d) honors previous health plan's authorizations for a minimum of 30 calendar days and (e) assist in coordinating care and, for example, information gathering (PASRR), to facilitate the member's transition into Traditional Medicaid or other waiver programs.

Please Note: *If one of your MDwise patients is transferring in or out of your panel, to ensure continuity of care through a transition plan, please contact your medical management staff who will assist in coordinating necessary clinical care services.*

Coordination of Medical and Behavioral Health Care

MDwise promotes integration of behavioral health services with medical care in all three of its IHCP Program contracts. This provides a holistic approach to meeting the member's needs. Integration of behavioral health and medical care is accomplished through communication among the providers as well as a collaborative approach to managing the member's overall care.

Medical management performs a variety of interventions to promote continuity and coordination of care based on the individual member's plan of care or needs including but not limited to:

- Obtaining information from the member's previous health plan or PMP regarding his/her treatment plan,
- Providing information to the new health coverage plan case manager and/or PMP regarding, for example, authorizations, current care management / treatment plans, disease management participation, other care providers involved in current care plan, utilization of applicable preventive care services,
- Development of a transition of care plan,
- Notifying new health plan or PMP of change in assignment during course of hospitalization or active treatment regimen, promote discharge planning, coordinating and authorizing medically necessary care during the transition from or to another health plan when the member is hospitalized until the new effective date occurs,
- Interfacing with the case managers/medical management staff to ensure appropriate access, authorizations, and coordination of care for those members who become pregnant and are transitioning to Hoosier Healthwise,
- Assisting in coordinating care and gathering information to facilitate the member's transition into one of the other IHCP programs (e.g. Hoosier Healthwise or Medicaid waiver programs) when disenrollment is necessary due to medical reasons, change in income, or as required by program rules.

Please Note: *If one of your MDwise patients is transferring in or out of your panel, please contact your medical management staff to ensure the member receives a transition plan for continuity of care.*

MDwise implements several methods to promote coordination of care among medical and behavioral health providers including:

- Facilitating communication (written and verbal) among the medical and behavioral providers and auditing for such documentation during medical record reviews.
- Identifying of member cases requiring coordinated physical and behavioral health plan of care by various means, including for example, data analysis related to medical and behavioral treatment use, screening through health assessments or risk questionnaires, joint planning meetings between behavioral health providers and the delivery system care management departments and MDwise Behavioral Health Director, as well as (when applicable) the CMHC case manager(s) or MRO staff for members requiring additional services. The Behavioral Health Director has access to additional referral sources, i.e., customer service calls; Health Advocate contacts/interventions; health needs screening; records of ER visits; and reports of contacts with our NURSEon-call service.
- Collaborating in developing and implementing educational forums for providers and medical management departments and case managers regarding coordination of physical and behavioral health care.
- Integrating behavioral health initiatives (i.e. depression) within the disease management and case

management process so those members with co-morbid conditions or members who are at higher risk for behavioral health issues are identified and a coordinated approach is implemented to manage their behavioral health and medical care.

- Educating members and providers regarding the incidence of depression with certain chronic health care conditions (i.e. diabetes, CHF, asthma).
- Promoting awareness and encourage treatment for post-partum depression.
- Providing utilization reports to primary care physicians, which include behavioral health treatment and medication information.

Please Note: Refer to the chapter on Behavioral Health Care for additional information about mechanisms MDwise utilizes to ensure integration of behavioral health services with medical/physical care services.

Coordinating Care for Members with Special Health Needs

MDwise has also established procedures to identify MDwise members with special needs or at-risk members and to assess their needs, and as a result, provide outreach and assistance with managing their needs, including member advocacy, care coordination, case management, and/ or disease management as deemed appropriate. Health management activities are coordinated with the member/member's family or caregiver, member's PMP, and other providers caring for the member.

In addition to various member mailings and customer service contacts to obtain information to identify members, MDwise has also implemented use of Interactive Voice Response (IVR) technology to both identify and reach out to its members in an effort to assist members with special needs. IVR calls use a prerecorded script to interact with a member (or parent/ guardian) to both inform the member about services at MDwise, the importance of regular visits with the member's PMP, as well as ask questions to which the member can respond.

Each member assessment is categorized according to the individual's condition and needs including the type and level of functional limitations, intensity and scope of service utilization, and type and duration of the on-going health condition as it affects the member's physical, developmental and behavioral or emotional status. MDwise also assists the member in identifying, assessing and using community resources and coordinating the services to meet the individual health care needs that affect the member's health. The specific interventions are developed to meet the member's needs and promote optimal outcomes.

Mechanisms are in place to allow members identified as having special needs to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

The health management program for MDwise members with special health care needs is accomplished through collaborative services provided by MDwise, MDwise Health Advocates, Medical Management, MDwise affiliates and arrangements with community service providers/agencies.

You will receive information about case management/ care coordination services for members with special health care needs through contacts with MDwise Health Advocates and your delivery system case management/ medical management staff as care plans are developed and implemented.

Please Note: To refer your members that have special health care needs and may need additional assistance, submit a CM/DM Referral on the MDwise Provider Portal. This referral will be routed the appropriate MDwise Health Advocate or case management/medical management staff.

Transition to Other Care

In the event that coverage of services ends under the benefit plan provisions and the member is still in need of care, the medical management staff offers to educate the member of alternative care options available in the community or through a local or state funded program or information may be outlined in the notification to the member.

Transfer to In-Network Hospital from Out-of-Network Hospital

As part of the inpatient concurrent review procedures, the medical management staff implements a review process to determine the appropriateness and safety of transferring a member currently receiving inpatient care at an out-of-network hospital to an in-network facility in order to promote continuity and coordination of care. The process includes the following components:

- Notification of an inpatient admission to an out-of-network hospital.
- Obtaining clinical information, treatment plans and estimated length of stay.
- Applying medically necessary criteria to determine appropriateness of admission/continued care.
- Determination that member's condition is sufficiently stable to allow for safe transfer, as determined by physicians.
- Verifying in-network facility has similar care capacity/capability to receive member for continued treatment.
- Arranging transfer to in-network facility, when member is medically stable for transfer.

The determination whether the member's condition meets the criteria for transfer to an in-network hospital is a group effort and consensus, led by the Medical Director. The Medical Director works in collaboration with the member's PMP and/or attending physician and/or specialists as needed to provide continued treatment in in-network facility, and the attending physician at the out-of-network hospital.

- Once all parties agree that the member is medically stable and the situation warrants transfer, the medical management nurse will coordinate the transfer.
- If the member's condition is determined not to be medically stable for transfer or it is determined that treatment plan and length of stay/planned discharge does not warrant need for transfer to in-network hospital, the medical management nurse will continue to receive reviews/updates from the UR department and/or attending physician until a determination of medical stability for transfer or discharge is made.

Short-Term Placements in Long-Term Care Facilities

Arrangements for MDwise members to receive services in a nursing or long-term care facility on a short-term basis (no more than 30 days for Hoosier Healthwise and up to the benefit maximum for HIP) is a care option if this setting, as determined by the PMP, is the most appropriate setting than other options for the member to obtain the care and services needed. Short-term placement charges from the nursing facility are MDwise's responsibility.

Medical Management staff is responsible for monitoring the member's care during the stay in the nursing facility and coordinating discharge planning. A member requiring long-term nursing facility placement will be disenrolled from their MDwise managed care plan and converted to Traditional fee-for-service eligibility in the IHCP. The medical management staff will help coordinate the member's disenrollment from MDwise by working with the nursing facility and the enrollment broker.

Concurrent Review

MDwise performs concurrent review of both acute medical and behavioral facility inpatient stays and ongoing outpatient services to gain pertinent clinical information and assess current needs to facilitate continuity and coordination of services, discharge planning and the authorization of the appropriate services and member access to those services. Concurrent reviews evaluate the effectiveness of the current care plan in meeting the member's individual needs and the appropriate utilization of services, identify and facilitate transition to alternate levels of care when appropriate and promote delivery of quality care on a timely basis. Additionally, concurrent review is performed in order to develop a safe and appropriate discharge plan to the most appropriate setting for the member, preferably in the home or community-based setting when able.

The concurrent review process and gathering of pertinent current health information will also be utilized to facilitate referrals for services appropriate to the member's health status, for example, disease management programs, case or care management.

Discharge Planning

Medical management implements procedures to evaluate and coordinate the resources necessary to meet the needs of the member upon discharge of care and/or transfer to less acute care setting or services.

Discharge planning will be initiated as soon as possible after admission or initiation of services utilizing information obtained from various sources including the medical record, physician, member and/or representative, hospital-based staff or ancillary provider.

Please Note: Contact the medical management staff to alert them to patients with potential discharge needs. The medical management staff can coordinate the discharge planning activities, be in contact with the involved parties till discharge, and monitor arranged services after discharge, as applicable.

Member and Provider Inquiries/Complaints, Grievances and Appeals

The Medical Management program for physical and behavioral health care applies MDwise's Member and Provider Inquiry, Complaint, and Grievance and Appeals process to address member and provider complaints, grievance and appeals. MDwise monitors grievance and appeal activity to identify possible fraud or abuse issues as well as to identify opportunities for member interventions (i.e. education, disease management, case management) and provider interventions (i.e. education regarding access, service utilization).

Data Analysis of Health Service Access and Utilization

To ensure delivery of appropriate health care service and coverage for MDwise members, reporting and monitoring activities are in place. All medical management decisions are based only on appropriateness of care and service.

MDwise has established processes to collect, report, and analyze access and utilization of specific health services, including preventive care services, pharmacy, behavioral health services, and emergency room utilization: to identify patterns for further investigation; identify potential members with special health care needs or at risk: and to detect and correct any patterns of potential or actual inappropriate under-and-over utilization of services. Analysis of monitored data is used to develop effective interventions including opportunities for improved medical management interventions, member and provider education and interventions, as well as case management and disease management interventions.

The effectiveness of the functions of the Medical Management Program are evaluated through the monitoring and analysis of measures such as performance standards, utilization data, HEDIS® rates, underutilization and over utilization monitors, quality referrals, complaints, activity reports, denials and grievance and appeals reports and analysis, consistency/interrater reliability audits, and member and provider satisfaction surveys. Where opportunities for improvement are identified during the evaluation process, the organization takes action to achieve/ maintain the objective to meet or exceed the customer expectations.

Member Compliance Interventions

Providers are encouraged to call their provider relations contact when, in their judgment, the behavior of their MDwise member is non-compliant. MDwise care management staff will investigate the issue further to determine appropriate member/provider intervention(s).

MDwise provider relations staff may assist the provider with determining the appropriate expectations/treatment of MDwise members and/or submit an electronic Case Management/Disease Management Referral form on the MDwise website when deemed necessary.

Some examples of areas of concern in member behavior are presented below but are not meant to be all-inclusive.

- Missing multiple appointments.
- Pregnant members or infants missing the first scheduled appointment.
- Members not seeking provider-recommended or other necessary medical/preventive care.
- Inappropriate use of the emergency room.
- Obtaining medical treatment without a referral from the PMP.
- Inappropriate use of out-of-network providers.
- Behavior that presents a security risk to others.
- Consistently not following medical recommendations in a manner that endangers the members health.
- Utilization patterns of controlled substances.

Upon receipt of a request for member Case/Disease Management, MDwise corporate, will:

- Review the request and conduct additional investigation on the issue if necessary.
- Attempt to contact the member to determine appropriate action.
- As necessary, provide counseling/education on the behavior at issue.
- Care Manager or Health Advocate may conduct targeted member education regarding missed appointments.
- Referral procedures, use of out-of-network services, inappropriate emergency room utilization, and/or the importance of seeking necessary medical/preventive care.

Please Note: Please refer to the electronic Case Management/Disease Management Referral Form on the MDwise website, MDwise.org. You can call your provider relations representative and they will help you complete the electronic form. It is very important that you include all efforts you have made to address the behavior at issue with the member. It is important that you document in the member's record all attempts to work with the member to resolve perceived areas of noncompliance.

NURSEon-call

NURSEon-call is a helpline that provides members with 24/7 phone access to a Registered Nurse that can assist them in dealing with health-related concerns. The helpline staff follows MDwise approved protocols in educating the member regarding diseases and treatments that have been prescribed and responding to general health questions or questions about situations that are cause for concern by the member. The role of the helpline can also assist members/parents in better understanding the nature and urgency of the situation causing concern, and where to seek care, including emergency care. The NURSEon-call staff has access to member eligibility and will refer the member back to the member's PMP for further assessment/or treatment, as the situation indicates.

NURSEon-call will also educate members on HIP co-payment amounts for emergency room use. Members will be educated that an emergency room visit will cost \$8 for the co-pay if the service is determined to be non-emergent. If the member is admitted as a true medical emergency the co-pay will be waived.

The primary goal of the nurse triage line is to promote the medical home and refer the member back to the member's PMP for further assessment/or treatment when appropriate.

To access the NURSEon-call, the member can call MDwise Customer Service at **1-800-356-1204** or **317-630-2831** (in the Indianapolis area) and select option 3.

EPSDT and Related Benefits

The State of Indiana calls its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program "HealthWatch." All MDwise practitioners must participate in "HealthWatch" and offer or arrange for the full range of EPSDT screenings, recommended immunizations and follow-up care for members in the applicable age range from birth through age 20.

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT services are a covered benefit for HIP members ages 19 and 20, and for all HHW members under the age of 21. EPSDT is an extraordinarily important Medicaid requirement. Treatments for diseases, issues or problems found in the course of an EPSDT encounter **MUST BE** provided by MDwise, subject to the EPSDT Medical Necessity Definition, even if the required services are not covered benefits as defined in the Medicaid Medical Policy, IAC 405.

Periodic screenings will be provided in accordance to the EPSDT periodicity schedule as long as the recipient chooses to participate in the EPSDT program, or until the recipient reaches his or her 21st birthday. Prior authorization is not required for screening services. Treatment services are subject to prior authorizations requirements for services as outlined in the IHCP Modules, Policies and Procedures and MDwise policies and procedures.

Right Choices Program

The MDwise Right Choices Program (RCP) is a program that identifies members appropriate for assignment and lock-in to one Primary Medical Physician (PMP), one pharmacy and one hospital.

RCP Mission:

To safeguard against unnecessary or inappropriate use of Medicaid services and against excessive payment by identifying members who use Indiana Health Coverage Programs (IHCP) services more extensively than their peers, and to ensure the right service is delivered at the right time in the right place for each member.

RCP Goals:

The goal of IHCP is to provide quality health care through health care management. Member utilization reviews identify members who use IHCP services more extensively than their peers. Members identified with high utilization are assigned (or locked-in) to one (I) primary medical provider (PMP), one (I) pharmacy, and one (I) hospital. If a member requires specialty services, the PMP must make the referral for those services to be reimbursed.

RCP Philosophy:

In order to achieve the goal of delivering quality health care for RCP members, RCP stakeholders, including members, providers, RCP Administrators (including MDwise) and the State, will collaborate to create a medical home for RCP members. The RCP Administrators encourage and will participate in any coordination efforts available to ensure that RCP processes and guidelines are carried out appropriately while members receive medically necessary care.

Identification and Referral of Members for Restriction

MDwise members are considered candidates for restriction if they continue to misuse their benefits despite efforts on the part of MDwise and its provider(s) to educate and assist the member in modifying misuse patterns.

MDwise considers multiple factors in enrolling a member into this program. They include, but are not limited to:

- Emergency room visits.
- Medical records.
- Pharmacy utilization.
- Member compliance.
- Outcomes of member interventions.
- Care management activities.
- Referrals from providers.
- Referrals from other internal and external sources.

MDwise accepts referrals from internal and external resources. Common referral reasons for the program include the member being treated by several physicians for the same medical condition, purchasing the same medications from several different pharmacies, or frequently using the hospital emergency department for services that are not considered an emergency.

All referrals are forwarded to the member's care manager. The care manager and/or PMP is responsible for instituting or overseeing the institution of interventions that are intended to assist the member in behavior modification and improving communications between the member and their IHCP providers.

If the member continues to misuse their benefits despite these efforts, the member's care manager in coordination with the PMP presents a case to a clinician reviewer for consideration for enrollment into the Right Choices Program. Please expect that a MDwise care manager will reach out to you in consultation for identified members. Your input and participation are essential to the enrollment process.

Members that qualify are enrolled for up to two years and are locked-in to one Primary Medical Provider (PMP), one pharmacy one hospital, and approved specialty providers as needed. Members are notified in writing via certified letter of their selection for enrollment into the program and given the opportunity to appeal the decision (10 days from the receipt of their letter to prevent the enrollment from taking place, and 30 days from the receipt of the letter to appeal the enrollment from remaining for the term).

Once the member's initial appeals period expires, the member's lock-in PMP, hospital ER and billing departments, and pharmacy are notified in writing of the member's enrollment into the program.

PMP Selection and PMP Role

Once a member is selected for inclusion into the RCP, the member's MDwise care manager works with the member and their providers through the end of their enrollment (a period of up to two years). Members are given the opportunity to select their primary lock-in provider. If the member is already established in the MDwise program, their assigned PMP will be asked by MDwise to serve as the member's Right Choices PMP. The chosen lock-in hospital will be one in which the PMP has privileges.

The PMP is responsible for coordinating all services outside of the PMP medical home. Written referrals are required for RCP members to see a provider outside of the medical home. Without a written referral, services rendered by providers other than the member's PMP will not be reimbursed. The written referral must be on file at MDwise. Referrals should be faxed or mailed to the member's assigned care manager or the MDwise RCP Administrator. MDwise asks that referrals be kept to a minimum so that the members' coordination of care is not jeopardized. As a general rule, written referrals should be created for the shortest duration of time required and for only medically necessary services as directed by the PMP. Written referrals are good for the period specified by the PMP or for up to one year if no time period is specified.

Written referral requirements:

- The PMP must write the referral on the PMP's letterhead or prescription pad.
- The PMP must date and sign the referral (electronic or stamp signatures are acceptable but signatures of office staff for the PMP are not acceptable).
- The referral must include the member's name and MID.
- The referral must include the specialist's first and last name, and NPI.
- The PMP should list the period for which the referral is valid. If no time period is specified on the referral, the referral will be applied for the maximum 1 year allowable.
- It is preferred that a reason for the referral also be communicated for care management support.

Certain services can be accessed by the member on a self-referral basis. However, the PMP is encouraged to submit a referral to the MDwise RCP Administrator to ensure better coordination of care among providers. If a self-referral provider will be writing a prescription that will be dispensed at a pharmacy, a referral is necessary for the prescription claim to be paid. If no prescriptions will be written, self-referral services do not require a written referral from the PMP to the MDwise RCP Administrator.

Providers can refer members to the RCP program by completing the Right Choices Program Panel Add Form on the MDwise website at [MDwise.org/for-providers/manual-and-overview/right-choices-program](https://www.mdwise.org/for-providers/manual-and-overview/right-choices-program).

Billing Requirements

Verification of Restriction

Once enrolled in RCP, the member's eligibility is tagged and should be checked like any IHCP member before services are rendered. This can be done via:

- Automated Voice Response (AVR) system.
- OmniSwipe card device.
- Provider Healthcare Portal.

If no restrictions are listed, the member is not restricted to any specific provider. If the eligibility response lists restrictions, the member is restricted to receiving specific types of services only from the specific providers indicated. MDwise will reimburse only the provider to whom the member is restricted unless a referral is on file at MDwise, or if the service is for an emergency condition. If the member receives non-emergency services from providers who are not authorized, MDwise does not cover the services. If a member visits a provider not on the member's lock-in table and the provider notifies the member before rendering the service that MDwise will not cover the service and the member signs a waiver to that effect, the provider can bill the member for services not eligible for payment due to the RCP restrictions. For more information on billing IHCP members, refer to The Provider Reference Module for Claims and Billing.

Billing for Services to Right Choice Program Members

Physicians and other non-acute care providers—After MDwise adds a provider to a member's lock-in table, the provider files the claim in the usual manner.

Hospitals—A hospital that is the member's lock-in hospital can file claims in the same manner followed for non-RCP members. If a PMP or specialist wants a member to go to a hospital that is not their assigned lock-in hospital for non-emergent care, then a written referral from the PMP will first have to be on file with MDwise or the claim will deny.

Pharmacies—For pharmacy claims to be processed successfully for an RCP member, the prescription must be written by the primary lock-in provider or a valid referring doctor and be presented at the lock-in pharmacy. Claims can be submitted through point-of-sale (POS), electronic batch, or paper. If a member in the RCP is locked-in to a pharmacy and presents a prescription from a prescriber that is not the primary lock-in provider or a valid referral provider, the claim denies. If the pharmacy does receive a denial indicating the prescriber is not a valid lock-in provider, and the member insists he or she has a valid referral for that prescriber, the lock-in pharmacy should contact MDwise to confirm the referral.

Member's Financial Responsibility When Lock-In Providers Are Not Used

The RCP member is responsible for payment of services if the member chooses to receive services from providers for whom they are not authorized to receive service. Prior to rendering the service, the provider must inform the RCP member orally and in writing that MDwise does not cover the service. A prior written statement signed by the member is sufficient documentation to substantiate member awareness that the service was not covered and the member is responsible for payment.

Please Note: It is important to remember that MDwise does not reimburse providers for services unless these guidelines are followed. For more information on billing IHCP members, refer to the IHCP Claims and Billing Procedure Module.

Non-Emergent ER Services

Non-emergent ER services are the financial responsibility of the Right Choices Program member (please refer to waiver requirements in the IHCP Right Choices Module to bill the member). It is important that ERs follow this procedure after screening a member, in order for inappropriate use to be deterred and for the Right Choices Program to have its best outcomes.

Right Choices Program Support

Every MDwise Right Choices Program member has an assigned care manager. The member's assigned care manager is responsible for communication, monitoring, and managing a member's care plan and coordinating all aspects of the member's Right Choices services including monitoring emergency room use and pharmacy utilization patterns, collaborating with the member's assigned pharmacy and PMP, updating the care plan as necessary, coordinating behavioral health care plans, and continuity of care. At regular intervals, member compliance is monitored by reviewing treatment plans, utilization of services, and care coordination conferences between the member and the member's care manager. The member's PMP and Pharmacist will also be involved from time to time in care conferences. At the end of a member's RCP enrollment period, a decision to graduate the member from the RCP may be made based on member compliance with the program and their treatment plan. Providers should contact the member's care manager with questions regarding that member's participation in the MDwise RCP. In addition, if a Right Choices PMP encounters any issues that may affect the care of an RCP member, the PMP is STRONGLY encouraged to contact the member's care manager in efforts to coordinate a meaningful intervention. MDwise supports its PMPs participating in the Right Choices Program.

If you have a MDwise member that you would like considered for the Right Choices Program or if you have specific questions about the program, please call us at [1-800-356-1204](tel:1-800-356-1204). You may also reference the IHCP's Right Choices Program Provider Reference Module for more information.

Quality Improvement

MDwise is committed to improvement of Hoosier Healthwise and Healthy Indiana Plan outcomes through ongoing comprehensive assessment and quality improvement activities. MDwise establishes and maintains the MDwise Quality Improvement (QI) Program, which improves the delivery of both physical and behavioral health care. MDwise leverages our extensive experience with Indiana Medicaid in collaboration with our robust provider network to identify areas of success and replicate those best practices throughout our network.

Our annual QI work plan and policies and procedures are used to guide the implementation of our QI program initiatives in accordance with the National Committee for Quality Assurance (NCQA) and the Office of Medicaid Policy and Planning (OMPP)

- The MDwise QI Program and policies and procedures provide the framework and structure by which the organization can identify aspects of clinical care and service issues relevant to MDwise members.
- The annual MDwise QI Work Plan prioritizes and defines health and clinical care and service activities to be monitored and evaluated in the calendar year. The QI Work Plan is specific to the MDwise member population, monitoring activities and interventions for improving health outcomes for MDwise members.
- NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) measures and those measures directed by OMPP are the primary mechanisms through which quality is measured.
- Pay for Outcomes (P4O) is a MDwise program developed to encourage positive health outcomes for MDwise members. P4O initiatives are designed to be congruent with federal and state priorities for Medicaid, state focus studies, and the MDwise QI Work Plan.
- The MDwise QI Program and Work Plan are evaluated annually to measure program effectiveness and to revise and/or establish new program improvement goals and initiatives.

MDwise conducts an annual CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey to determine member satisfaction with the plan and network providers. MDwise is focused on providing services to members that are culturally and linguistically appropriate. The national CLAS standards that are developed by the Office of Minority Health are used as a guide in ongoing activities and in developing improvement projects.

The MDwise QI Program developed a P4O program to award providers that achieve high quality performance in a defined set of measures, established annually. The established measures are typically preventive in nature and are geared towards increasing the wellness of the MDwise population through engagement in healthy activities. The provider P4O program details can be found at MDwise.org/Quality.

The MDwise QI Program has developed tools and resources for the provider network to help ensure the quality performance measures are met and members receive the required care.

Our reporting tools to provide virtually real-time information to the provider network both online and in person during Quality Performance Visits regarding progress, performance, and specific member activity. A primary medical provider (PMP) office can request access to the MDwise provider portal to view quality reports, track and trend their quality performance, and view the members in need of service for the annually defined set of quality measures. The list of members in need of a service can be utilized for outreach and identifying gaps in care for a member assigned to a PMP or provider office. To request a new account to obtain access to the tools, go to MDwise.org/for-providers.

The online quality reports provide a coversheet with the annual performance measures and rates for each requested provider location, PMP panels, members in need of a service for each performance measure on the coversheet, ER utilization, and panel rosters. The quality performance reports are updated monthly on the provider portal under the Quality Reports tab. Additionally, a MDwise Provider Relations Team Member can provide the following quality reports to track and trend the provider's quality performance: Monthly HEDIS Progress Reports, Missed Opportunity Reports, or Year Over Year Comparison Reports. Progress reports compare similar groups to one another, ranking their performance. Missed Opportunity reports identify members that have been seen at the provider office and remain in need of a preventive service. Year over Year reports compare performance from the previous year with a similar timeframe. All reports are processed including paid and denied claims.

During the education process to provider offices, quality reports and member lists are reviewed to ensure members are being outreached to for needed services and that the claims provided are received by MDwise. At times during the process, medical records are reviewed or requested due to missing services, rejected claims, or third-party liability (TPL). Contracted providers are required to provide a copy of a Member's medical record at no charge upon reasonable request by such Member or by MDwise and shall facilitate the transfer of the Member's medical record to another provider at the request of the Member or MDwise.

Additionally, the MDwise Fax Back program ensures provider offices receive credit for all services rendered and that all quality performance reports are accurate. The Fax Back program accepts claims, superbills, and medical records when a claim is not submitted to MDwise for processing. The fax back process and forms can be found on MDwise.org/for-providers/Quality.

As provider offices work with members on the annual quality measures, MDwise members earn points for identified healthy activities through the MDwise REWARDS program. The rules for the Hoosier Healthwise and HIP REWARDS programs are available on MDwise.org/for-members.

HEDIS (Healthcare Effectiveness Data and Information Sets)

MDwise collects data to complete the annual HEDIS audit. Results from the annual HEDIS audit are used to guide various quality improvement efforts at MDwise.

Many of the measures in HEDIS focus on preventive health care services and wellness care as well as monitoring health care of members with specific acute illness (i.e., URI) or chronic diseases (i.e., diabetes, asthma). To determine if the recommended services reported in the annual HEDIS rates to the state were provided to our members, MDwise looks first at its claims (or encounter) data. If MDwise is unable to identify that a particular service was provided from the claims (or encounter) data, MDwise conducts an annual medical record review to determine if the service was provided but for some reason not in the claims data (perhaps a bill was not submitted).

If any of your members are selected for medical review, representatives from MDwise will conduct a chart review to collect necessary information. As a participating MDwise provider, one or more of your patients may be randomly selected for review and MDwise asks for your cooperation in collecting this important information.

Please Note: *If you have any questions relating to the specific HEDIS measures and/how to ensure the claims submitted by your office capture the necessary information to count towards these elements, contact your provider relation's or QI staff.*

Potential Quality Concerns/Issues

Potential quality care and service concerns are appropriately researched and evaluated through the delivery system's documented procedures consistent with MDwise policies and procedures. Potential quality issues ("PQIs") may be identified/referred from multiple sources including specific predefined indicators or monitors, quality studies/data analysis, customer service, medical management, quality improvement and network development/provider services departments, grievance and appeals, physicians, providers, members/ member representatives, office staff or facility staff and MDwise QI Manager or designee.

- Quality issues are those issues related to health care delivery services, including both medical and behavioral health care, that may have potential impact on the quality of care or services provided. Types of quality issues may include but not limited to the following areas: access, satisfaction, communication/attitude, clinical, service, facility, and internal plan issues.
- If a member or members' representative initiates the complaint, the member receives a letter confirming the issue as stated by the member and informs the member that the issue is being reviewed.
- Identified potential quality issues/concerns are reported to the Director of QI or designee to conduct and coordinate the investigation, evaluation and implementation of actions as deemed appropriate. Identified quality issues are referred for review to the designated peer review committee. Tracking and trending reports and outcomes of interventions are periodically reported to the Quality Committee or designated physician/staff committee. The Quality Committee responsible for credentialing of providers will be notified of confirmed quality concern issues pertaining to a practitioner.

Clinical Practice Guidelines

MDwise has responsibility for ensuring MDwise members information and timely access to an adequate network of qualified practitioners, behavioral health providers, and other providers available to meet the clinical needs of the MDwise members, as well as to promote the delivery of services in a culturally competent manner to all members.

- MDwise establishes access standards and collects and conducts analysis of data to measure its performance against the standards. The established standards for timeliness of access to specified care and services, considering the urgency of the need for services, will meet or exceed standards as prescribed by OMPP and applicable accrediting organizations.
- Provider access standards include access to regular routine care appointments, and urgent care appointments (primary care and specialist referrals), after-hours care, telephone service/physician, or designee response time, and office appointment wait time. Compliance to individual standards is measured against the assigned performance standard. Corrective actions are implemented for performances below the compliance standard.
- MDwise may monitor performance to standards utilizing surveys such as member satisfaction, access or office site surveys; conducting analysis of practitioner complaints in arranging referrals to specialists or other providers/ancillaries, complaints and grievances, appeals, emergency services claims/ records analysis, and telephone system audits; and monitoring provider self-reports of appointment and in-office waiting times, supplemented by random calls or audits. The assessment provides data on organization-wide and practice-specific performance. Results are provided to the individual delivery systems to develop actions as appropriate to findings.

Provider Performance Feedback

Objective, measurable, clinical, service, and facility quality indicators are defined to provide a consistent means to evaluate and report information to a MDwise PMP related to their individual performance and/or performance of their practice site. Periodic monitoring and analysis is conducted to measure performance against goals and identification of opportunities for continuous quality improvement.

PMP and practice site clinical and service performance monitoring indicators, may include, but are not be limited to:

- Medical Record Reviews.
- Facility Site Reviews.
- Member Satisfaction.
- Quality of Care Issues.
- Accessibility.
- Service Indicators.
- Preventive Health Screenings/Services.
- HEDIS Measures.
- Pay for Value (P4V) Measures.
- Clinical Indicators.
- Utilization Monitors (for example, continuity of care, over/under utilization, pharmacy, services for members with special health care needs).

Federal and state laws govern responsibility and liability for quality improvement activities. All quality assessment/peer review activities/documents will be kept confidential and privileged as subject to the state and federal statutes regarding confidentiality of peer review material.

MDwise protects the confidentiality of provider and member specific data in compliance with MDwise confidentiality policies and follows policies/agreements on how provider specific data is collected, verified, releases and the uses and limitations of the data.

When a quality of care issue occurs or performance standard is not met by a participating provider, the MDwise QI staff or Medical Director may consult with the Medical Director and/or individual provider to discuss, educate, and develop an action plan to address the specific issue as necessary. If the provider fails to resolve the issue appropriately, additional levels of action may be instituted. These actions may include a site visit and counseling by the appropriate MDwise personnel or presentation of the case to Quality Committee and/or Credentials Committee or an Ad Hoc Peer Review Committee for recommendations and follow-up.

Member and Provider Satisfaction

Annually, MDwise conducts a member satisfaction survey through a contracted external research organization. The survey tool, CAHPS, is the NCQA accreditation required questionnaire. This survey evaluates member satisfaction and identifies opportunities for improvement; the survey looks at the MDwise health plan and the health care services provided by its delivery systems. The survey study is also used to ascertain demographic characteristics and general health status of our membership to better establish the context in which our services are sought, and through which they are communicated and provided.

MDwise conducts an annual survey of providers to assess provider (PMP) satisfaction with various operations within the managed care system, including overall satisfaction with the health plan, access to specialists, medical management and other functions related to member and provider services to identify opportunities for improvement.

MDwise seeks information from providers to identify their concerns, needs and expectations on an ongoing basis through such avenues as the office site visits, contacts with the provider relations staff, education seminars, and provider calls.

Please Note: MDwise member and provider survey results and planned interventions indicated, will be published in the provider newsletter.

Delegation

In certain contractual agreements, upon completion of the pre-delegation evaluation and approval process MDwise may delegate to the contracted entities the authority to perform specific functions involving quality improvement, preventive health, medical record review, credentialing, medical management, member service activities, provider services and network development and claims processing.

- Delegation may occur only when the program functions of the delegated entity meet or exceed MDwise standards.
- MDwise is responsible for ensuring that consistent procedures are adhered to and that the MDwise fulfills all State and Federal requirements appropriate to the services or activities delegated under the subcontract.

- MDwise remains accountable for these functions and must have appropriate structures and mechanisms to oversee delegated activities. MDwise delegation oversight program is designed to:
 - o Meet compliance with Federal and State regulations, OMPP contractual obligations and relevant accrediting organization(s).
 - o Monitor delegate performance to ensure that members receive equitable access to care and service across all delegated entities.
 - o Ensure delegates comply with the MDwise health plan policies and procedures, medical and benefit policies and meet established standards.

As a result of the delegation oversight approval and ongoing monitoring processes, MDwise is able to maintain these functions. These activities are performed by qualified health professionals, including the Medical Director, who have the knowledge and familiarity with your hospital network, primary care, specialty and ancillary providers, as well as the MDwise population and program requirements.

Preventive Health and Practice Guidelines

Health Care Decisions for Preventive Health and Clinical Services

To deliver the best care, obtain optimal outcomes and maintain a healthy state for members, MDwise believes it is essential to maintain an emphasis on prevention-related health services and interventions to assist in management of certain acute and chronic conditions/ diseases.

MDwise adopts evidence-based preventive health guidelines and clinical practice guidelines for specific clinical circumstances relevant to the MDwise membership and in compliance with CMS or OMPP medical or behavioral health care standards and practice guidelines. The guidelines address preventive health services, acute and chronic medical care, and preventive and non-preventive behavioral health services to effectively improve health outcomes. Clinical practice guidelines also serve as the clinical basis for disease management programs. Obtaining regular preventive care services enables early detection, diagnosis, and treatment of health problems before they become more complex and their treatment costlier.

The guidelines are implemented to assist MDwise practitioners and members in making appropriate health care decisions for specific clinical circumstances. The guidelines address preventive health services, acute and chronic medical care, and preventive and non-preventive behavioral health services.

Development and Monitoring

The MDwise Medical Advisory Committee has the responsibility for development or adoption of evidence-based guidelines and oversight of preventive health guidelines and clinical practice guidelines for specific clinical and behavioral health circumstances relevant to the MDwise membership. Committee members solicit input and feedback from participating providers. Upon approval by the committee, providers are notified and the guidelines are distributed for implementation.

Periodically, the guidelines will be evaluated to assess practice patterns, member compliance and patient outcomes. Results will be used to improve practitioner performance and/or member compliance as applicable. Guidelines will be reviewed and updated as appropriate at the time new scientific evidence or national standards are published, or at minimum, every two years.

Specific preventive health service measures are monitored as part of the MDwise QI Program and Workplan. Preventive health services are also included in the MDwise Pay for Value (P4V) program which is a quality improvement program aimed at improving the health status and outcomes of the MDwise member. Quarterly HEDIS®-based rates for MDwise are produced for the P4V measures to monitor and evaluate the effectiveness of interventions to achieve the desired performance rate.

MDwise notifies practitioners of approved new and/or revised preventive health guidelines and clinical practice guidelines. Guidelines are distributed to delivery system/ appropriate existing practitioners for implementation. MDwise distributes existing guidelines to appropriate new practitioners. Printed copies of guidelines are accessible on MDwise website and are provided upon request. Notification may be accomplished through:

- Direct Mailing.
- Electronic transmission of notification/guideline.
- Newsletter.
- Provider Manual.
- Orientation and Training materials.
- Website.

As indicated, key focus of the MDwise QI Program initiatives is to ensure members have access to and receive age and gender specific preventive health care services. MDwise participates in the state mandated HEDIS measures related to preventive health services. Compliance to screening and immunization schedules may be evaluated through the Pay for Value (P4V) initiative, applicable HEDIS measures and medical record reviews.

Specific List of Guidelines

For the most current versions of the guidelines, please go to MDwise.org. You may print the guidelines from the website to insert in the manual.

Pharmacy Benefits

MDwise believes to deliver quality care, it is necessary to establish procedures for pharmaceutical management to promote clinically appropriate and optimal therapeutic use of pharmaceuticals. MDwise pharmacy management follows procedures based on sound clinical evidence that are reviewed by pharmacists and actively practicing clinicians at least annually to ensure procedures are updated. This is an essential step in meeting the National Committee on Quality Assurance (NCQA) accreditation standards.

The MDwise Medical Advisory Council oversees pharmaceutical management of MDwise Hoosier Healthwise and HIP members. Preferred Drug List and other policy decisions regarding the MDwise pharmacy benefit is the responsibility of the MDwise Medical Advisory Council. This committee is composed of local practicing clinicians in the medical and pharmacy fields, representing the MDwise network.

In cooperation with its Pharmacy Benefit Manager (PBM, MedImpact), MDwise offers MTM (medication therapy management) services to Hoosier Healthwise and HIP enrollees which are intended to enhance therapeutic outcomes through improved medication use and reduced risk of adverse events. These services will be primarily provided by the PBM's network of MTM clinicians.

Several criteria are used to target appropriate members for MTM services including those with multiple chronic diseases, those taking multiple medications, and those whose costs for medications are expected to exceed a specific dollar threshold on an annual basis. Upon meeting the targeting criteria and enrolling into the MTM program (MTMP), interventions will be offered to the participant and his/her prescriber(s). These beneficiary and prescriber interventions may be provided independently or in combination to promote coordinated care. MTM services may be furnished by pharmacists as well as other qualified providers who are experienced in medication management and certified in geriatric medication management. MTMP services are free of charge to MTMP enrollees.

Ninety-day supplies of maintenance medications are available for patients enrolled in the HIP Plus Plan. For appropriate medications, IHCP-enrolled network pharmacies may dispense 90-day supplies upon request.

Hoosier Healthwise and Healthy Indiana Plan

MDwise maintains the prescription drug benefit for the Hoosier Healthwise and Healthy Indiana Plan programs. Members in the HIP program are able to obtain prescription or Over-the-Counter (OTC) drugs from MDwise participating pharmacies and drug stores as long as the drugs are prescribed by a licensed Indiana prescriber. The prescription drug benefit utilizes a preferred drug list that is available on the MDwise website at MDwise.org. MDwise members who present their prescription to a pharmacy must show the pharmacist their Hoosier Healthwise/HIP identification card. If a member chooses to go to a pharmacy other than a MDwise participating pharmacy, the member will be responsible for paying out of pocket the full retail cost for the prescription. A prescription written by a valid practitioner is required for all over-the-counter products regardless of the member's Benefit Package.

Pharmacies will communicate with the member and attempt to contact the prescriber, or the Pharmacy Help-Desk when the prescribed medication is not part of the preferred drug list.

Hoosier Healthwise and HIP Pharmacy Helpdesk Information:

- A 72-hour temporary supply of medication is available in emergency situations when the PBM clinical staff is not available.
- MedImpact (PBM) Pharmacy Customer Service: **1-844-336-2677**
- MDwise Pharmacy Customer Service: **1-800-356-1204**

Hoosier Healthwise and HIP Pharmacy Copays

Members on the HIP Basic, HIP Presumptive Eligibility or HIP State Plan Basic Plan options will owe co-copays for their non-preventive prescriptions. These co-pays are set at \$4 for Preferred and \$8 for Non-preferred medications. MDwise members enrolled in the Children's Health Insurance Program (CHIP) have a \$3 copay for each covered generic drug dispensed and a \$10 copay for each covered brand drug dispensed. For a breakdown of the applicable category for each covered drug, please visit the MDwise website at www.MDwise.org

Preferred Drug List Exceptions Policy

MDwise administers a pharmacy benefit for Hoosier Healthwise and HIP programs with a closed Preferred Drug List. Members and prescribers are given the right to request a timely review for coverage of a non-Preferred Drug List pharmaceutical based on medical necessity as determined by the member's clinical needs. This request may occur before the pharmaceutical is denied and can possibly resolve the request before it may become a formal appeal.

Requests are evaluated and determinations made in accordance with MDwise criteria and medical policy, member benefits, MDwise pharmaceutical and PBM procedures, state and federal regulatory standards and the MDwise Member Grievance Policy and Procedure.

Appeals

MDwise Hoosier Healthwise and HIP members and providers are notified of the appeals process at the time they are notified of a decision to deny a medication based on medical necessity.

Inquiry Registering and Resolution

The PBM (MedImpact) is responsible for maintaining a provider inquiry reporting and resolution process that includes MDwise notification and interaction as needed. PBM reporting to MDwise includes an inquiry report that identifies type and outcome of MDwise provider inquiries.

Delivery system staff should be directed to forward pharmacy-related inquiries to the MDwise Customer Service Department. In addition to the MDwise Medical Advisory Council, pharmacy related issues may also be discussed at other MDwise committees, including committees overseeing corporate quality, quality improvement, medical management, member services and provider services. Representatives from the PBM are present or available at the meetings as needed or upon request.

MDwise members and providers have access to the MDwise customer service representatives to file inquiries regarding pharmacy issues as outlined in the MDwise policies. MDwise QI efforts focus on timely resolution of inquiries and regular analysis of inquiries to improve services to MDwise customers.

The MDwise Director of Pharmacy and QI Director are the principal contacts between PBM and MDwise for daily operations.

Pharmacy Network

Pharmacy services are delivered through the PBM's contracted network. The PBM provides MDwise with a list of participating providers that is updated monthly. The PBM access standard is as follows: all members must have access to two pharmacies the closer of thirty (30) miles or thirty (30) minutes from their home, where two pharmacies exist.

MDwise's PBM also conducts an aggressive network auditing program and educational system designed to increase the overall effectiveness and quality of the pharmacy network. The audit program includes statistical system audits, desk audits, on-site audits, and audit follow-up.

Please Note: A listing of the network pharmacies can be found on the MDwise website, MDwise.org, Providers or Members Page.

Drug-Related Medical Supplies and Medical Devices

There are certain drug-related medical supplies that are covered through the State Plan and not covered by MDwise. A table is provided that lists those drug-related medical supplies and medical devices that are to have their claims submitted to HP for reimbursement. These claims are to be billed on the CMS-1500 claim form or an 837P transaction. These services must be provided by an IHCP enrolled pharmacy or DME provider.

Drug-Related Medical Supplies and Medical Devices that are to be submitted to HP:

Code	Description
A4210	Needle free injection device
A4211	Supplies for self-administered injection
A4245	Alcohol wipes, per box
A4206	Syringe with needle; sterile, 1 cc or less, each
A4207	Sterile 2cc, each
A4208	Sterile 3cc, each
A4209	Sterile 5cc or greater, each
A4213	Syringe, sterile, 20cc or greater, each
A4215	Needle, sterile, any size, each
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient,
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each
A4244	Alcohol or peroxide, per pint
A4250	Urine test or reagent strips or tablets (100 tablets or strips)
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4256	Normal, low, and high calibrator solutions/chips
A4258	Lancet device
A4259	Lancets, per box of 100
A4261	Cervical cap for contraceptive use
A4266	Diaphragm for contraceptive use
A4267*	Contraceptive supply, condom, male, each
A4268*	Contraceptive supply, condom, female, each
A4269*	Contraceptive supply, spermicide (e.g., foam, gel), each
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler
A7018	Water, distilled, used with large volume nebulizer, 1000 ml
E0607	Home blood glucose monitor
E2100	Blood glucose monitor with integrated voice synthesizer
E2101	Blood glucose monitor with integrated lancing/blood sample
S8101	Holding chamber or spacer for use with an inhaler or nebulizer; with mask
S8100	Holding chamber or spacer for use with an inhaler or nebulizer without mask

*covered service in Hoosier Healthwise only

Pharmacy providers billing these drug-related medical supplies and medical devices, as well as procedure coded drug services, should know that the Federal Deficit Reduction Act of 2005 mandates that the IHCP require submission of National Drug Codes (NDCs) where they exist for all professional claims involving procedure coded drug and drug-related services.

Pharmacy Claims

MedImpact is the pharmacy benefit manager (PBM) for MDwise Hoosier Healthwise and Healthy Indiana Plan members. MedImpact is responsible for:

- Processing pharmacy and compound claims.
- Maintaining the formulary.
- Processing prior authorization requests.
- Auditing Pharmacy providers.
- Managing Specialty pharmacy claims.

All Hoosier Healthwise and Healthy Indiana Plan pharmacy claims questions should be directed to the Pharmacy Help Desk at **1-844-336-2677**. Pharmacy Prior Authorizations can be obtained by calling **1-800-788-2949** or faxing your request to **1-858-790-7100**. All Pharmacy Appeals must be faxed to **1-844-759-8548**.

MDwise Hoosier Healthwise and Healthy Indiana Plan Pharmacy Group Information:

RxBIN: 003585

PCN: ASPRODI

RxGroup: MDW

Prior Authorization

The prior authorization process is handled by MDwise's Pharmacy Benefit Manager, MedImpact. The Pharmacy Benefit Manager utilizes qualified health care professionals including clinical pharmacists to make utilization management decisions. These functional units are hereafter referred to as the "prior authorization entity". The prior authorization entity will request the documentation to determine the medical necessity of the requested drug or treatment in accordance with their usual procedures. Proactively working with the prior authorization entity on requests for prior authorization will expedite the process for the provider and the member. Provision of written documentation, i.e. records supporting requests for prior authorization, are essential to a valid, consistent and expedient review process.

Upon electronic submission of the prescription claim for adjudication, a message will appear notifying the pharmacy that prior authorization is required. The technician or pharmacist will call the PBM at the pharmacy help-desk number. If it is a clinical authorization, the prescriber is to submit clinical information and rationale to support the request. The following steps occur:

- The prescriber should locate the appropriate prior authorization medication request form (MRF) from the MDwise website.
 - o The completed form should be faxed to the number on the form.

- The reviewer can approve the prescription immediately if criteria are met and enter the approval into the electronic claims processing system.
- The reviewer will refer requests to the Medical Director or designee if the prescriber is not able to substantiate medical necessity for the drug in question based on the guidelines (criteria).
- If the Medical Director or designee denies the prior authorization request due to lack of medical necessity, the prescribing physician will be notified of the reason for denial.
 - The physician and member will be notified of appeal rights.
- If the prior authorization or medical necessity override is denied due to lack of information, communication will be sent to both the requesting prescriber and the affected member stating clearly what additional information is necessary to make a valid and consistent determination.
- Once received, a decision will be made on the request within 24 hours. If a situation arises that the decision cannot be made within 24, hours a temporary supply can be obtained (as outlined below).

Prior Authorization & Emergency Supply Pending Review

If a non-Preferred Drug List medication or medication requiring prior authorization is prescribed in an emergent situation (as ascertained by the dispensing pharmacist) when the review process cannot be implemented promptly or during off-hours, a 72-hour supply of the medication may be provided for a member (extensions can be granted under certain circumstances).

The prescriber must submit a request for prior authorization to the prior authorization entity within the 72-hour period for continuation of the drug. In cases where a therapeutic equivalent exists on the MDwise Preferred Drug List, the prior authorization entity may request the medication be substituted with a medication found on the PDL.

If a change in medication could be detrimental to the member, every effort to ensure continuation of appropriate therapy set out by clinical guidelines will be made.

If the request for continuation of medication is denied, the physician and member are informed of their right to proceed with the grievance/appeals process and/or exceptions policy as appropriate.

Behavioral Health Care

This section of the MDwise Provider Manual provides an overview of MDwise's provision of Behavioral Health Care Services. Behavioral health care services include both mental health and substance abuse services for the MDwise Hoosier Healthwise and Healthy Indiana Plan. Additionally, behavioral health service codes billed by a primary care office will be paid by the plan if they are medically necessary. Clinic Option services are covered by MDwise under these plans and are defined as any non-hospital based behavioral health covered service delivered for medication management and psychotherapy that are not considered MRO services, as outlined below. MDwise Behavioral Health benefits comply with the Mental Health Parity and Additions Equity Act (MHPAEA).

As outlined below, MDwise will work to ensure integration of mental health and physical health services through activities such as ongoing case management and facilitating information sharing and coordination of care. Together we will work hard to ensure collaboration that promotes a communication “bridge” between PMPs and behavioral health providers.

MDwise members, also have the benefit of a 24-hour/365-day nurse helpline. This triage service function is referred to as NURSE on-call, and is staffed by behavioral health professionals with the expertise to respond appropriately to the needs of our members.

Behavioral Health Providers

MDwise, Inc. is responsible for the development, maintenance, and coordination of a comprehensive behavioral health network which is clinically aligned with the overall needs of our member population. They also provide ongoing provider services to assist MDwise contracted behavioral health providers with clarification of policies and procedures and to address any issues providers have regarding their credentialing status or their contract.

MDwise contracts with a variety of provider types to provide mental health/substance abuse services, including:

- Community Mental Health Centers (CMHC).
- Outpatient mental health clinics.
- Psychiatrists.
- Psychologists.
- Certified psychologists.
- Health services providers in psychology.
- Substance abuse counselors and facilities.
- Certified social workers (ACSW, CCSW).
- Licensed Mental Health Counselor (LMHC).
- Licensed Marriage & Family Therapist (LMFT).
- Licensed clinical social workers (LCSW).
- Psychiatric nurses.
- Independent practice school psychologists.
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing.

All providers must have a valid NPI and IHCP number and be credentialed, prior to rendering services to MDwise members. Please refer to the chapter on Credentialing for information about MDwise credentialing criteria for behavioral health providers.

In Hoosier Healthwise and HIP, direct reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as health service providers in psychology (HSPP). Covered services provided by other midlevel practitioners outlined above, are reimbursed, however the services must be directed by a physician or HSPP. Services rendered by a mid-level practitioner must be billed using the rendering provider number of the supervising practitioner and the billing provider number of the outpatient mental health clinic or facility.

Behavioral Health Access Standards

Behavioral health access standards are outlined in the following table:

Type of Service	Appointment Timeframe
Emergency Services	Must be available 24 hours a day, 7 days a week.
Urgent: Members presenting with significant psychiatric or substance abuse history, evidence of psychosis and/or in significant distress.	Immediately be referred to a Care Manager who will further assess and provide referral and direction to an appropriate level of care. Care should occur within 48 hours.
Emergent: Members who have a non-life-threatening emergency.	Care should occur within 6 hours.
Routine: Members seeking outpatient services who present no evidence of suicidal or homicidal ideation, psychosis, and/or significant distress.	Care should occur within 10 business days of the request for service.

Medical Records

As outlined above, it is a requirement that behavioral health information be shared with the PMP, with appropriate member consent. It is important for you to maintain this information in the member's medical record. If you receive behavioral health information for a member whom you have not yet seen, please create a member record or separate file to house the behavioral health information. Once the member has been seen by your practice, place the behavioral health information in the established medical record. In addition, all behavioral health information received should be reviewed and initialed prior to placement in the medical record.

Criteria for Behavioral Health Practitioners

Behavioral health practitioners include: doctoral or master's level psychologists who are state certified and state licensed, master's level clinical social workers, who are state certified or state licensed, master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or state licensed, and other behavioral healthcare specialists who are licensed, certified, or registered by the state to practice independently. Behavioral health practitioners must demonstrate as part of the application process that he/ she meets the same credentialing criteria, as outlined above for physicians, with the following exceptions:

- Written Practice Agreement: Proof of collaboration with a licensed network Practitioner, in the form of a written practice agreement.

- DEA: If requesting prescriptive authority, current, valid and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. Note: DEA or CSR certificates are not applicable for non-physician behavioral health practitioners.
- Education: Graduate of a school recognized by the appropriate Indiana State Boards. Board Certification does not apply some Behavioral Health Practitioner Specialties if not available in their specialty.
- Privileges:
 - a. Exceptions may be granted if the behavioral health practitioner does not require admitting or practicing privileges at a facility (e.g. psychologist, clinical social workers, psychiatric nurse practitioner, etc.).
 - b. Exceptions may be granted if a provider has a clinical appointment in good standing at a participating MDwise hospital or documented relationship privileges with a MDwise provider (e.g. hospitalist).

Please Note: MDwise credentialing or recredentialing decisions may not be based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or patients in which the practitioner specializes.

Behavioral Health Care Referrals

MDwise Hoosier Healthwise members may self-refer to any IHCP Psychiatrist for behavioral health care services. HIP members may self-refer to any Psychiatrist within the MDwise network. MDwise Hoosier Healthwise or HIP members may also self-refer to any behavioral health provider that is contracted with MDwise to provide services to MDwise members.

PMP Referrals

PMPs should refer members, who may be in need of behavioral health services for consultation, to an appropriate provider. The behavioral health provider can provide an assessment, determine diagnosis, or offer treatment. This includes a member who is experiencing acute symptoms of a chronic mental disorder (e.g. schizophrenia, bipolar disorders, eating disorders, etc.) or who is in a crisis state or following certain sentinel events, such as a suicide attempt. We also recommend a member referral if you are currently treating a member for such conditions as anxiety and mild depression and the symptoms persist or become worse.

An emergency referral for mental health services does not require a referral or authorization; however, PMP-initiated referrals allow for better coordination of care for the member. Please refer to Appendix J for a Behavioral Health Symptom Identification Grid. This tool lists the core diagnostic criteria and associated features of common behavioral health disorders and can help in determining when a member should be referred for behavioral health evaluation and treatment.

Please visit the MDwise Provider website behavioral health link to review the behavior health practice guidelines and provider tools.

To initiate a referral to an MDwise behavioral health provider for one of your members, you can also access behavioral health provider information via the MDwise website or contact the MDwise Customer Service Line (see Directory). Please have the member's MID number and date of birth available.

When you call this number during regular business hours, a trained Customer Service Representative will answer the call. The Customer Service Representative will ask a few brief questions in order to locate the right therapist or doctor to meet your patient's needs. However, if your patient is having a more serious problem the Customer Service Representative will connect the member with an appropriate professional.

Please Note: *If you have questions or concerns regarding the availability of behavioral health services for your patients, please contact the MDwise Customer Service Line. You may also call the MDwise Behavioral Health Manager to discuss any concerns that you have.*

Member Referral

MDwise does not require members to receive a "PMP referral" to use MDwise's behavioral health services. A member or member representative, as stated earlier, can self-refer for behavioral health services or can contact MDwise Customer Services to obtain assistance in obtaining behavioral health care. The Member will talk to a Customer Service Representative who will give the names and phone numbers of the providers to call or assist the members in identifying behavioral health care providers using the MDwise website. The Customer Service Representative will verify the Member's eligibility as provided by MDwise. The Customer Service Representative will ask a few brief questions in order to locate the right behavioral healthcare professional to meet the Member's needs.

Please Note: *Members have access to the 24-hour nurse on call line, 365 days a year, as well as MDwise Customer Service via toll-free number. The member will also be instructed regarding actions to take if an emergency or crisis exists. If one of your members appears to be in crisis, is suicidal, or a danger to others, please do not hesitate to call 911 or send (as appropriate) to the nearest emergency room or mental health center. We want to make sure your patient gets the emergency care they need.*

Behavioral Health Benefits

Please refer to the Hoosier Healthwise and Healthy Indiana Benefit Overview Chapters for information about mental health covered benefits. Covered behavioral health services generally include the following services. The services are covered according to the member's benefit package.

- Inpatient psychiatric services.
- Emergency/crisis services.
- Alcohol and drug abuse services (substance abuse).
- Therapy and counseling, individual, group or family.
- Psychiatric drugs included on MDwise PDL.
- Laboratory and radiology services for medication regulation and diagnosis.
- Screening and evaluation and diagnosis.
- Transportation (medically necessary or emergent).
- Neuropsychological and psychological testing.

- Partial Hospitalization Services that are not covered include:
 - Biofeedback.
 - Broken or missed appointments.
 - Day Care.
 - Hypnosis.
 - State Hospital Placement.

MRO Services

Mental Health Rehabilitation Option (MRO) services are “carved-out” of the Hoosier Healthwise and HIP programs and are not the responsibility of MDwise. These services are covered benefits under Traditional Medicaid program, and, are paid for by the State’s fiscal agent on a fee-for-service basis. MRO services are defined as community mental health services for members with mental illness, provided through an enrolled mental health center that meets applicable federal, state and local laws concerning the operation of community mental health centers (see 405 IAC 5-21).

MRO services are accessible to Medicaid members who have a qualifying MRO diagnosis and a Level of Need (LON) based on the Child & Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA). Members who do not have a qualifying MRO diagnosis and/or LON may submit PA for MRO services. For an MRO provider to receive reimbursement for the delivery of MRO services, a member must have an assigned MRO service package or prior authorized units of service. A member must have a qualifying diagnosis to be eligible for an MRO service package.

MDwise members who demonstrate a behavioral health need are eligible for Clinic Option Services, such as psychotherapy in a clinic setting. However, only Medicaid consumers with a qualifying diagnosis and Level of Need are also eligible for an MRO service package.

Please Note: Even though MRO services are carved out of MDwise’s payment responsibility for Hoosier Healthwise and HIP, we are responsible for coordinating care and follow-up treatment for our Hoosier Healthwise and HIP members who are receiving these services. Providers can view the MRO Provider Manual at indianamedicaid.com.

Behavioral Health Coordination

Behavioral and Physical Health Coordination

The coordination of behavioral and physical care is essential in the provision of quality care. MDwise promotes coordination of behavioral health services with medical care through data analysis, effective exchange of information between the medical and behavioral health providers, service reporting and analysis, follow-up treatment management and integrated case/care management for members with physical and behavioral health care needs. MDwise collaborates with behavioral health and physical health practitioners to monitor and improve coordination between medical care and behavioral healthcare.

This collaborative approach to managing, monitoring, and improving coordination of the member's overall care is achieved through such activities as:

- Education of members about behavioral health services and importance of communicating with their PMP about the services they receive.
- Identification of member cases requiring coordinated physical and behavioral health plan (e.g. through data analysis related to medical and behavioral treatment use, screening through health assessments, member or provider referrals).
- Providing periodic member specific service utilization reports to providers/ behavioral health-medical profiles;
- Informing providers of members receiving emergency and inpatient behavioral health or substance abuse services and follow-up care;
- Communication between medical and behavioral health Case Managers.
- Screening mechanisms to identify members with coexisting medical and behavioral disorders, including substance abuse;
- Implementation of primary care guidelines for treating or making referrals for treatment of problems and primary or secondary preventive behavioral health programs.
- Medical record audits to confirm communication among medical and behavioral health providers.
- Collaborative disease management programs.
- Provision of education and training opportunities to MDwise medical and behavioral health care providers and case managers regarding coordination of medical and behavioral health care.

Primary Medical Providers and Behavioral Health Care Providers, as directed through your contract and MDwise policies and procedures, will implement the procedures to exchange information, obtain necessary consents and facilitate improved coordination, management and follow-up for members with coexisting medical and behavioral health care needs.

Behavioral health care providers are to document and share the following information for each member receiving behavioral health treatment with MDwise medical management/case or care manager and the member's PMP:

- Provider shall cooperate with Delivery System and MDwise in meeting current requirements of the program with respect to the treatment plans, diagnosis, medications and other relevant clinical information.
- Provider shall timely notify MDwise and the Covered Person's PMP and submit information about the treatment plan, the member's diagnosis, medications and other relevant information about the member's treatment needs as follows:
 - o For Covered Persons who are at risk for hospitalization or who have had a hospitalization, the behavioral health provider will provide a summary of the Covered Person's initial assessment session, primary and secondary diagnosis, medications prescribed and psychotherapy prescribed. This information must be provided after the initial treatment session.
 - o For Covered Persons who are not at risk for hospitalization, behavioral health providers must, at a minimum, provide findings from the Covered Person's assessment, primary and secondary diagnoses, medication prescribed, and psychotherapy prescribed.

- o Behavioral health providers must also notify MDwise and the Covered Person's PMP of any significant changes in the Covered Person's status and/or a change in the level of care.
- o Any other information relevant to the continuity and coordination of care.

Please note: Disclosure of mental health records by the provider is permissible under HIPAA and state law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance abuse records or information about substance abuse treatment. Please obtain the consent.

Care Coordination and Case Management

The MDwise Care Management Program is in place for members receiving behavioral health care. The member's needs determine the level of case or care management interventions. As the member's care continues and reassessments occur, care or case management interventions will correlate with the intensity and severity of the member's needs.

MDwise uses the clinical expertise of its care managers and behavioral health clinicians to provide case and care management services. As the member's needs change, the level of service intensity may need to increase or decrease to achieve the best outcomes for the members regarding access to and coordination of services, compliance with the treatment plan, and optimal functioning in the community.

MDwise care managers coordinate care between all providers involved in the members care. They are responsible for facilitating continuous communication between the behavioral health and medical (physical health) providers.

Some key elements of the MDwise Care Management program administered by the care manager include:

- Developing and implementing a comprehensive, coordinated, collaborative and member-focused plan of care, which meets the member's needs, promotes optimal outcomes and supports the medical home concept.
- Developing and facilitating interventions that coordinate care across the continuum of health care services; decreasing fragmentation, duplication, or lack of services, and promoting access or utilization of appropriate resources.
- Facilitation of information sharing among treating providers to ensure services for members are coordinated and duplication is eliminated.
- Member appointment compliance.
- Collaboration with the member/family or caregiver and providers on interventions outlined in the treatment plan, the case manager monitors the progress and adherence to the plan, including translating the relevant practice guideline standards into tasks to be completed.
- Validating outcome measures related to the adequacy and quality of the clinical management, i.e., adherence to medication regime and follow-up medication monitoring visits, etc.

Members at Risk for Acute Services within the General Population

MDwise will also provide case/care management services for members identified as at-risk for inpatient psychiatric or substance abuse hospitalization. MDwise members identified as at-risk for inpatient psychiatric or substance abuse hospitalization will receive case management follow-up and support to help maintain the members' care in the least restrictive setting possible. Care Management interventions can include contacts with a member's medical provider,

behavioral health provider, and identified community resources to coordinate treatment and to ensure no gaps occur in treatment. Contacts are also made to the member to provide support, assess needs and assist in resolving issues that could be related to safety, food, housing, legal problems or transportation. Ongoing monitoring of care is continued while the member is in this program to provide care coordination and support by a reliable team of Care Management staff.

Upon inpatient discharge, an outpatient follow-up care appointment is set for the member to see a behavioral health professional within 7 days. Inpatient providers are responsible for making this appointment. The member receives a call to remind him/her to attend his/her appointment and to address any issues that may have come up since discharge. Care Managers continue to follow-up with members well into the recovery process to ensure treatment compliance and coordination of services between medical and behavioral providers.

Behavioral Health Coordination with the PMP

MDwise and/or the behavioral health clinician or agency actually providing the services is responsible, according to contract, for communicating with you directly regarding the member's care and treatment plan, including any psychotropic medications that have been prescribed. Communication is to occur at the beginning, during, and at the end of treatment. You will also receive notification regarding any of your MDwise members that may receive inpatient or emergency services. You will receive this information by telephone, mail, or fax. MDwise also strongly encourages behavioral health providers to obtain consent from members who are in substance abuse treatment so that care can be coordinated with their primary care physician. Additionally, behavioral health providers must provide the primary care physician with a summary of a member's primary and secondary diagnosis, and medications prescribed for those who are at risk of an inpatient hospitalization.

Likewise, MDwise PMPs are expected, with informed member consent, to provide behavioral health providers with any relevant health status information. This helps to ensure the member's medication management remains safe, therapeutic interventions are effective, and overall healthcare is efficient and unduplicated.

On a quarterly basis, Behavioral Health profiles are sent out to primary care physicians who have members in behavioral health services. These profiles contain information on types of services received, medications prescribed and who is providing the treatment.

MDwise Medical Directors or physician advisors are available as resources to you for general discussions regarding psychiatric care or for specific case consideration to help in better managing the patient's treatment.

Behavioral Health Care Prior Authorization

Prior Authorization Requirements

A member may self-refer to any MDwise contracted provider for behavioral health care services. The member is allowed a limited number of initial evaluations per calendar year (2). After the initial evaluation, there is no limit for outpatient therapy and no prior authorization is required. Please refer to the Behavioral Health Prior Authorization Quick Reference Guide for the list of required authorizations and number of services allowed without authorization by service type. All outpatient authorizations are requested using the OTR forms available on the MDwise website. These forms must be faxed to the appropriate MDwise delivery system for Hoosier Healthwise and HIP. The prior authorization unit will fax a response back to the provider, or, if more information is required to make a decision, will request additional information.

As outlined above, services provided by a psychiatrist are self-referral for Hoosier Healthwise members. Therefore, for out of network psychiatrist services, up to 20 visits (including the diagnostic evaluation) per member, per rolling 12-month period may be provided without authorization. Services are subject to medical necessity review, post-service. Providers are responsible for keeping track of the number of visits to date and if necessary, seeking additional visits through the prior authorization process. MDwise does not provide prior authorizations retroactively.

Prior authorization is also required for any intensive service, including acute inpatient, detoxification, residential, partial hospital, or intensive outpatient treatment. The provider must call to obtain authorization for services. In the event of life threatening emergencies, prior authorization is not needed. However, a retrospective or post-service review may be made for determination of payment.

Prior Authorization Process

The prior authorization process for behavioral health services allows MDwise Care Managers to ensure the member receives the most appropriate and effective treatment based on clinical presentation and ensures that the members have timely access to care.

- Where clinically appropriate, blocks of outpatient care and certain clinically appropriate programs will be authorized. The authorization process for the continuation of sessions beyond the initial authorized block of sessions facilitates the discussion with the provider about the written outpatient treatment plan.
- Inpatient stays are reviewed on a concurrent basis after initial authorization to provide opportunities to discuss discharge needs, coordination of services, and after-care treatment.
- Treatment plan goals that are diagnosis specific and measurable facilitate the review and approval of services.

The prior authorization process is initiated upon a care manager's receipt of telephonic and/or written information. Every effort is made to obtain all necessary and pertinent clinical information on which to make medically necessary clinical decisions. The care managers review the service request and any previous treatment. Clinical information is received from relevant stakeholders in the member's care; i.e., member, family, provider, facility utilization review staff, behavioral health care professionals, etc. Following the guidelines for appropriate privacy and confidentiality set forth by the federal Health Insurance Portability and Accountability Act (HIPAA), the behavioral health care managers, psychiatrists and/or behavioral health specialists, and providers share member Protected Health Information (PHI) for treatment, payment, and health care operations.

Care managers review cases with the Medical Director, Physician Advisors or with a contracted psychiatric consultant to discuss medically complex cases or when clinical information does not meet medical necessity. An appropriate behavioral health specialist makes the final determinations. The Medical Director or Physician Advisors are available for peer-to-peer discussions if there is a potential denial or for expedited reviews. Please also refer to the Medical Management Chapter for additional information regarding service authorization procedures.

Transportation

Transportation to and from a facility where medically necessary covered services are provided is a necessary condition for access to care. MDwise has a transportation broker that arranges for non-emergent transportation services for the members of the MDwise Hoosier Healthwise program, who are covered under Package A. Non-emergent transportation is a covered benefit for Healthy Indiana Plan members who are in a HIP Maternity, or a HIP State Plan. Transportation is not a covered benefit under HIP Basic and HIP Plus.

Members need transportation services, or providers who are looking to schedule transportation for a member, are instructed to call MDwise Customer Service. When a member or provider calls, they are prompted to select the "transportation option". They are then connected with a transportation specialist who can schedule their transport to and from a covered service.

Non-emergent transportation is defined as a ride, or reimbursement for a ride, provided so that a MDwise member with no other transportation resources can receive services from a medical provider. By definition, non-emergent transportation does not include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations.

To assist a member in arranging a ride, please call MDwise Customer Service at [1-800-356-1204](tel:1-800-356-1204), or [317-630-2831](tel:317-630-2831).

Services and Limitations

Services

Transportation services are to be provided in the most cost-effective manner that can be identified that meets the medical needs of the member. In accordance with Federal Medicaid regulations MDwise strives to provide our members with "necessary transportation" to and from providers for covered services, in the "least expensive mode of transportation that is appropriate."

Transportation services managed by the MDwise transportation broker include:

- Processing transportation requests for transportation from members and providers.
- Verifying eligibility for services.
- Scheduling non-emergent transportation with the appropriate provider.
- Billing and management reporting.
- Contracting with local transportation providers.

Trip Limits

Hoosier Healthwise members with Package A are covered for 20 one-way trips per rolling calendar year without authorization as well as HIP members in the HIP State Basic, HIP State Plus and HIP Maternity Plan. The year is counted starting with the member's first day of eligibility.

For HIP members, the 20 one-way trips are covered during the member's benefit period. The HIP member benefit period follows a calendar year.

Transportation services for the purposes of transporting a member to a hospital for admission, for transporting the member home following discharge from the hospital, for renal dialysis purposes, and/or transportation by an emergency ambulance are exempt from the 20-trip limit.

Transportation Limits

Pregnancy package members' emergency and non-emergency transportation coverage is limited to services related to pregnancy (including, prenatal and postpartum services) as well as conditions that may complicate the pregnancy or urgent care services.

Package C members are not covered for routine transportation. They are only covered for emergency ambulance transportation, and a co-pay of \$10 will apply. However, emergency ambulance service may not be denied due to a Package C member's failure to pay the co-payment. The ambulance provider may bill the member for the co-pay amount after the ambulance service is provided.

For all members, transportation is not provided to pharmacies or for visits for non-covered medical services.

Prior Authorization for Transportation Services

Certain transportation services require prior authorization:

- Trips of fifty (50) miles or more one way.
- Airline, air ambulance, interstate transportation or transportation services from a provider located out-of-state.
- Trips exceeding twenty (20) one-way trips per recipient, per rolling twelve (12) month period for Hoosier Healthwise members, and per twelve (12) month calendar year for Healthy Indiana Plan members, excluding those transportation services exempt from the 20-trip limit (see below).
- If a transportation service requires prior authorization the member should call at least two (2) working days before the service is needed. This gives the Transportation Specialists time to get the required authorization from the medical management department.

There are prior authorization exemptions that are granted for transportation services beyond the 20-trip limit. Upon verification of a scheduled visit/service, a Transportation Specialist will automatically authorize a request for the following services:

- PMP visits and prenatal care visits.
- After hours services.
- Cancer therapy.
- Renal Dialysis.
- Emergency Room – Non-Ambulance.

All other requests for services are forwarded to the medical management staff for medical necessity review and determination. Patients with chronic medical conditions should have a PMP supervised medical care management plan that includes a transportation plan, if benefit levels are to be exceeded.

Emergency ambulance services do not require prior authorization but claims are subject to retrospective review. MDwise covers both basic and advanced life support emergency ambulance services; however, advanced life support ambulance services are covered only when this level of service is medically necessary and a basic emergency ambulance is not appropriate due to the medical condition of the member being transported.

Non-emergent transports must be reserved through the MDwise transportation vendor. Providers who are not contracted with the transportation vendor must obtain a prior authorization to provide these services. Provider who are not contracted and do not obtain an authorization for non-emergent transportation, will not be reimbursed.

Transportation Reservations

MDwise members must make transportation reservations in advance. All transportation requests must be approved at least two (2) business days in advance of the appointment, except if there is an urgent care need or an emergency. For any transportation service that requires prior authorization (e.g. trips beyond 20 one-way trips and trips over 50 miles) the member should also call in at least two (2) working days before the service is needed.

For urgent care, the member's PMP or PMP office staff must call to arrange for same day transportation (urgent care only). Although members may schedule transportation visits up to two (2) business days in advance of a scheduled appointment, members are encouraged to contact MDwise when their appointment is scheduled, so the appropriate means of transportation can be used.

Please note: The MDwise transportation broker is responsible for all MDwise non-emergent transportation and will only pay for non-emergent trips set with their contracted transportation providers.

Member Rights and Responsibilities

MDwise is committed to developing partnerships among the member, doctor, MDwise, and other health care staff. MDwise also recognizes that there are certain member rights and responsibilities that are critical to the success of this partnership and the provision of appropriate medical care. Following is the MDwise Member Rights and Responsibilities Statement.

MDwise provides access to medical care for all its members. We do not discriminate based on religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age.

MDwise members have the right to:

- Be treated with dignity and respect.
- Personal privacy – We keep medical records confidential as required by law.
- A clear explanation of their medical condition. The member has a right to be part of all treatment decisions. Options should be discussed with the member no matter what they cost or whether they are covered as a benefit.
- Be provided with information about MDwise, its services, its doctors and other health care providers and members' rights and responsibilities.
- Change their doctor by calling the MDwise Customer Service Department.
- Timely access to covered services.
- Appeal any decisions we make about their health care. The member can also complain about personal treatment they received.
- Get copies of their medical records or limit access to these records, according to state and federal law.
- Amend their medical records.
- Get information about their doctor.
- Request information about the MDwise organization and operations.
- Refuse care from any doctor.
- Ask for a second opinion, at no cost.
- Make complaints about MDwise, its services, doctors, and policies.
- Get timely answers to grievances or appeals.
- Take part in member satisfaction surveys.
- Prepare an advance directive.
- Get help from the Indiana Family and Social Services Administration (FSSA) about covered services, benefits, or complaints.
- Get complete benefit information. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered services.
- Request information about the MDwise physician incentive plan.
- Be told about changes to benefits and doctors.

- Be told how to choose a different health plan.
- Health care that makes the member comfortable based on their culture.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with Federal regulations.
- When a member exercises these rights, the member will not be treated differently.
- Provide input on MDwise member rights and responsibilities.
- Participate in all treatment decisions that affect the member's care.
- If MDwise closes or becomes insolvent, members are not responsible for MDwise debts. Also, members would not be responsible for services that were given to a member because the State does not pay MDwise, or that MDwise does not pay under a contract. Finally, in the case of insolvency, members do not have to pay any more for covered services than what they would pay if MDwise provided the services directly.

Members are responsible for:

- Contacting their doctor for all their medical care.
- Treating the doctor and their staff with dignity and respect.
- Understanding their health problems to the best of their ability and working with their doctor to develop treatment goals that both can agree on.
- Telling their doctor everything you know about their condition and any recent changes in your health.
- Telling their doctor if they do not understand their care plan or what is expected of them.
- Following the plans and instructions for care that they have agreed upon with their doctor.
- Keeping scheduled appointments.
- Notifying their doctor 24 hours in advance if they need to cancel an appointment.
- Appropriately utilizing benefits and services.
- Telling MDwise of any third-party coverage or changes in coverage at the time services are rendered.

Through the MDwise Member Handbook and Member Newsletter, each MDwise member is advised of his or her Rights & Responsibilities. When the MDwise member is a child, the above list of rights and responsibilities apply both to the child and the child's parent or guardian. All the above rights also apply to the designated personal representative of the member.

In addition to these rights and responsibilities, MDwise complies with the following federal and state regulations:

- MDwise provides access to medical care without regard for religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age for all members.
- MDwise does not prohibit or restrict a health care professional from advising a MDwise member about his/her health status, medical care, or treatment options. This policy applies, so long as the professional is acting within the lawful scope of practice, regardless of whether benefits for such care are provided under the provider's contract or under the Hoosier Healthwise or Healthy Indiana Plan program.

- In accordance with 42 CFR 438.102(a), MDwise allows health professionals to advise a member on alternative treatments that may be self-administered, and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits and consequences of treatment or non-treatment.
- MDwise does not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods.
- MDwise may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

Emergency Room Use

MDwise provides many activities directed at reducing inappropriate emergency room utilization, including educational initiatives and ER related care coordination or case management.

Educational interventions are designed to promote access and availability to the member's PMP and medical home or behavioral health provider, and to the MDwise NURSEon-call for health information. For members whose ER utilization results from inadequate management of an acute or chronic disease or behavioral health condition, care management may be initiated to avoid future medical or behavioral health crises resulting in an ER visit. MDwise will identify case-by-case emergency treatment options for all appropriate members with high ER utilization. Emergency treatment plans will include:

- History and physical information to help emergency care givers treat the member most appropriately.
- Transportation coordination to ensure the safest emergency transport.
- Care location options depending on the condition and time of day.

Choosing or Changing Doctors

Many of our members do have a primary medical provider (PMP) when they select MDwise as their Hoosier Healthwise or HIP health plan. For those members that do not have an existing medical home, MDwise Customer Service Representative help them select a primary care physician after the member has chosen MDwise as their health plan, or, been assigned to MDwise if they did not choose a health plan. Our Customer Service Representatives use the searchable MDwise Provider Directory to help members match their specific needs with a specific MDwise PMP.

Only members age 18 or older, or a designated parent or court appointed legal guardian may make a PMP selection or request a PMP change. Pregnant members under the age of 18 may make a PMP selection or change if they are no longer living with their parent or guardian and are making their own decisions about care and other aspects of daily living.

Auto-Assignment

Hoosier Healthwise and HIP members, with the exception of newborns, have a 30-day period within which to choose a PMP. However, sometimes the member fails to make this choice within the required timeframe. If this happens, the member will be auto-assigned by MDwise, according to auto assignment logic developed by the State and MDwise, consistent with federal regulations.

Because continuity of care is one of the cornerstones of the Hoosier Healthwise and HIP programs, the reassignment of a member to his or her previous PMP takes precedence over all other auto-assignment logic. This rule supersedes the PMP panel size limits, and allows auto-assignment of a member to a PMP with a full panel or a panel on “hold”. If there is not a previous PMP relationship, the auto-assignment logic next looks for a previous relationship with a PMP, a family member’s current PMP, a family member’s previous PMP, a PMP in a previous provider group, or a PMP in a family member’s current group or previous group.

In the absence of a previous PMP, or family member relationship, the primary consideration under the auto assignment process is matching the member to a PMP located within 30 miles of the member’s residence. MDwise members who are auto-assigned to a PMP not of their choosing can request a change by calling MDwise Customer Service at **317-630-2831** or **1-800-356-1204**.

Member Third Party Liability Responsibilities

Members are required to sign an assignment of rights form, which allows third party payment to be made directly to MDwise. Each member also agrees to cooperate in obtaining payment from these resources, including authorizing providers and insurers to release necessary information to pursue third party payment. Members are also responsible for informing providers of any third-party coverage or changes in coverage at the time services are rendered.

Choosing a Newborn’s Doctor

MDwise encourages pregnant members to choose a PMP for their newborn before the baby’s birth. If the member does not preselect a PMP for their newborn, then one will be autoassigned during the enrollment process. If the expectant member is a MDwise member, then the autoassigned PMP for the newborn will be the same as the mother. Physicians are encouraged to discuss the selection of a PMP for their patient’s newborn prior to delivery. Continuity of care can be increased through education of pregnant members about the importance of choosing a doctor for her baby early and the benefits of choosing the baby’s PMP from within the same plan as her PMP. Education may also be directed towards helping members understand the importance of pre-selecting a PMP to:

- Help prepare for the baby and ensure timely newborn care.
- Keep all siblings with the same doctor.
- Avoid auto-assignment to a doctor that they did not select.

A pre-birth selection may occur at any time prior to the birth of the infant. The Office of Medicaid Policy & Planning (OMPP) has determined that a pregnant member must select a PMP in the same managed care entity (MCE) as the mother for her unborn child. The mother does have the option to choose a different PMP for their newborn outside of the MDwise Plan network after birth within the open enrollment period (first 90 days).

If the newborn is assigned to a PMP who the mother did not choose, a PMP change can be requested by calling MDwise Customer Service at **317-630-2831** or **1-800-356-1204**, or, for a PMP in another health plan, Hoosier Healthwise **1-800-889-9949**.

Pre-Birth Selection Forms

MDwise has a pre-birth selection form that the provider’s office can use in helping pregnant patients select a physician for their newborn. A copy of this form can be found on the MDwise website at MDwise.org.

The provider’s office may fax the completed pre-birth selection form to the MDwise Customer Service Department. An expectant mother may also call MDwise Customer Service directly to pre-select a MDwise PMP for their soon-to-be-born baby.

Unfortunately, Package C newborns cannot be enrolled before birth. However, the baby can be enrolled as soon as it is born. Eligibility begins on the first day of the month in which their application was approved and the first month's premium was paid.

Please Note: Package C newborns should never be retroactively assigned to a PMP. If this occurs, please contact the Customer Service department at [1-800-356-1204](tel:1-800-356-1204).

Helping Members Change Doctors (Non-Newborns)

Members are encouraged to build long term relationships with their Primary Medical Providers (PMP) through appropriately scheduled visits and good communication.

However, in accordance with OMPP guidelines, a MDwise member may change their PMP at any time within the MDwise Plan, for any reason. If a MDwise member wished to change their PMP, they should be instructed to contact the MDwise Customer Service Line at [317-630 2831](tel:317-630-2831) or [1-800-356-1204](tel:1-800-356-1204). This gives MDwise the opportunity to identify potential issues and assist the member in selecting a new PMP within the MDwise network of physicians. MDwise may process requests for PMP changes only if the member wishes to remain with MDwise and selects another MDwise PMP. If the member wants to select a PMP in a different managed care entity (MCE), they may only do so during the first 90 days of their open enrollment period or if there is just cause to make the reassignment sooner. Under Open Enrollment, the members can change health plans on at the following times:

- Any time during their first 90 days enrollment with a new health plan.
- Annually during their open enrollment period.
- Any time there is "just cause."

Just cause reasons are as follow:

- Lack of access to medically necessary services covered by MDwise.
- The MCE does not, for moral or religious objections, cover the service the member seeks.
- The member needs related services performed at the same time and not all related services are available within the MDwise network. The member's PMP or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- Lack of access to providers experience in dealing with the member's health care needs.
- Poor quality of care, including failure to comply with established standards of medical care administration and significant language or cultural barriers.
- The member's MDwise PMP moves to another MCE. Maximus, the State's Enrollment Broker can assist the member to change to another MCE or health plan. MDwise Customer Service representatives can transfer the member to Maximus, if necessary.

Certain PMP change requests will receive an upper level review at MDwise and/ or by the State, particularly those requests that are related to quality of care or service. In some cases, the member's request may not be able to be processed (e.g. PMP panel full, doesn't meet PMP specialty criteria, etc.). The member will then be contacted to select a different PMP. PMP changes are effective on the first day of the month. Requests for PMP changes entered into the Indiana AIM system by the 25th of the month are effective the first of the following month. Changes entered into the system after the 25th day of the month will not be effective until the first of the second month.

Providers should continue to check a member's eligibility prior to rendering service or requesting prior authorization. A PMP could disenroll from MDwise and enroll in another MCE. The PMP's panel will NOT follow the PMP to the new plan, unless the member chooses to follow the PMP to the new MCE. In this scenario, the member who moved with the PMP when the PMP contracted with a different Plan would have another 90-day period in which to change MCEs if they wish.

Pregnancy Related Postpartum PMP Change

MDwise will assist in facilitating the reassignment of a member who is assigned to an OB/GYN (PMP) but is no longer pregnant and whose eligibility will likely continue past the 60-day post-partum period. Assisting the member to select a new PMP helps to ensure that the member may access necessary primary and preventive care services.

Please Note: *If you provide OB/GYN services only and have a member that has recently delivered and is in need of a PMP change, please call your provider relations representative. Please note that a PMP change cannot occur until the member has had their postpartum visit (or after 60 days post-partum).*

Member Grievances and Appeals

Any MDwise member that is dissatisfied with a service they received or does not agree with an answer they receive to a complaint or a MDwise decision has the right to ask for further review of the issue.

The MDwise review system includes the member rights to a grievance and appeal process. The review system also includes expedited review procedures and access to external reviews including Independent Review Organization and the State's fair hearing system. An expedited review is a request to change an adverse determination for urgent care in where a nonurgent care determination could result in seriously jeopardizing the life or health of the member's ability to attain, maintain, or regain maximum function or subject member to severe pain. For expedited appeals, MDwise must allow a health care practitioner with knowledge of the member's condition (e.g., a treating practitioner) to act as the member's authorized representative.

Grievances and appeals are processed in accordance with State and Federal law and OMPP guidelines. According to federal regulations, MDwise may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

All MDwise member grievances and appeals are reviewed by individuals who were not involved in making the original decision resulting in the grievance or appeal. As necessary, input on the grievance or appeal is obtained by a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment (medical necessity appeals only).

Members are provided with information on how to submit a grievance or appeal in the Member Handbook, on the MDwise website, in member newsletters, and in medical management determination letters sent to members when a service is denied. At all levels of the grievance and appeal process, MDwise assists members in completing the necessary procedural steps. This includes providing interpretive services, TYY/TDD capability, and the toll-free MDwise customer service line. Members may file a grievance or appeal in writing or they may call MDwise customer service directly and a Customer Service Representative will assist the member in filing.



A member who wishes to file an appeal or a grievance by telephone should call MDwise Customer Service at 1-800-356-1204. A member or member's representative who wishes to file a grievance or appeal in writing should send a letter to:

MDwise Customer Service Department

Attn: Grievances OR Appeals

PO Box 44236

Indianapolis, IN 46244-0236

The letter should include:

- Member name, address, telephone number, and MDwise card number.
- Date and description of the service/issue.
- Additional information that can help in the review.

In accordance with 760 IAC 1-59-7, MDwise also requires providers to post a brief statement of the member's right to file a grievance and appeal with MDwise, including the toll-free telephone number, in each location where health care services are provided by or on behalf of MDwise.

The MDwise grievance and appeals system is an integral part of the MDwise Medical Management Program. All levels of appeals are recorded so MDwise may systematically and objectively evaluate, track, and trend member issues and take appropriate action (e.g. improvement opportunities), or update its policies and procedures accordingly.

Processing Grievances and Appeals

Grievances

Grievances are defined by 42 CFR 43.8.400 (b) as any dissatisfaction expressed by the member, or a representative on behalf of a member, about any matter other than an action, as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, rudeness of a provider or employee, or the failure to respect member's rights. Grievances are further defined in 760 IAC 1-59-3 as any dissatisfaction expressed by or on behalf of a member regarding the availability, delivery, appropriateness or quality of health care services and matters pertaining to the contractual relationship between an enrollee and a MCE group individual contract holder for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.

Grievances may be submitted by the member or by a representative of the member's choice, such as a family member, friend, guardian, or health care provider. This must be done within 60 days of the event or incident. MDwise acknowledges receipt of each grievance within 3 business days. Urgent Grievances must be resolved within 48 hours. A MDwise representative must contact the member with a resolution within that time frame. MDwise notifies the member in writing within 20 days (except if grievance is expedited), when the issue is resolved and informs them of their right to appeal an adverse decision if applicable.

Appeals

The term appeal is defined as a request for review of an action and/or request to change a previous decision. An action, as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined the State; or
- Failure of an MCE to act within the required timeframes.
- For the resident of a rural area where MDwise is the only contractor, the denial of the member's request to exercise his or her right, under CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable).

An appeal must be filed within 33 calendar days from the date of action notice. Members may file the appeal orally, however must follow the oral filing with a written, signed appeal, unless the member or provider requests an expedited appeal.

Authorized representatives may act on behalf of members with respect to requesting an appeal and the procedures involved, including medically frail decisions. The member is allowed the opportunity for representation by anyone he or she chooses, including a provider or attorney. For expedited appeals, a health care practitioner with knowledge of the member's condition (e.g., a treating practitioner) may act as the member's authorized representative. The member and member representative may present evidence or testimony in person as well as in writing.

- Standard Appeals MDwise responds to all oral and written appeals with three (3) business days of receiving the request. The appeal must be resolved within 20 business days of appeal and written notification of the appeal resolution must be sent to the member within five (5) business days after the decision is made. If the member requests an extension, or if MDwise is unable to make a decision within twenty (20) business days because additional information is needed either from the provider or member that has been requested, but not provided, the member is notified before the 20th day of the delay. MDwise provides the member with written notice of the delay, demonstrating in the notice that the extension is in the member's best interest and that a decision will be granted within ten (10) additional business days.
- Expedited appeals MDwise resolves expedited appeals meeting MDwise criteria within 48 hours of receiving the request and the attending physician and member are notified immediately by telephone. This time frame can be extended pursuant to 42 CFR 438.408(c). A written confirmation of the decision is also sent by mail to the member within 48 hours of notification.

A member may request continuation of services during the appeal process if an authorized service is being terminated, reduced or suspended before the expiration of the original authorization date. The member is informed of the financial obligations if received continued services during the appeal process and the final decision is adverse to the member.

MDwise also offers members the opportunity, at any time during the appeal process, reasonable access and ability to examine the relevant contents in the appeal file, including medical records and any other supporting documentation considered by MDwise. MDwise informs members of these rights in all communications about the appeal process and in all correspondence generated for a specific appeal.

External Review for Denied Appeal

If the standard appeal or expedited appeal results in upholding the denial, additional external appeal procedure options are available to the member. The member (or member's representative or the provider on the member's behalf) may choose either an external review by an Independent Review Organization or a State Fair Hearing as a next review level.

- A member may pursue review by an Independent Review Organization (IRO) if they are not satisfied with the MDwise appeal decision (must be filed within 45 calendar days of receiving appeal determination). The IRO is available for appeals that involve an adverse utilization review determination, an adverse determination of medical necessity or a determination that a proposed service is experimental or investigational. A member may also pursue an expedited external review. Requests for excluded benefits or exceed benefits are not eligible for independent review.
- MDwise responds to requests for external review, within three (3) business days of receiving the request for an IRO review. A standard external review must be resolved within 15 business days after the review is requested. An expedited external review must be resolved within 48 hours of receipt of the request. For a standard external review, the member is notified within 72 hours of the IRO panel's decision. For an expedited external review, the member must be notified within 24 hours of the IRO panel decision.
- The member is informed that he/she is not required to bear costs of the IRO, including any filing fees. An IRO determination is binding on MDwise.
- The resolution notification of an IRO denial decision includes the member's appeal rights to request a FSSA fair hearing.
- FSSA Fair Hearing The member may choose to request the FSSA fair hearing by submitting a written request directly to FSSA within 30 days of either:
 - o Receipt of appeal denial notification from MDwise by submitting a request in writing to FSSA.
 - o Receipt of an IRO review determination and is not satisfied with the IRO decision.

Members submit a request directly to FSSA for a fair hearing and time frames are according to those rules that govern the FSSA in conducting the FSSA fair hearing. MDwise responds to all information requests by the FSSA fair hearing officer or designee within the required format and timeframe.

Office of Hearings and Appeals

402 West Washington, Room W392
Indianapolis, IN 46204

Please Note: At all levels of the grievance and appeal process, MDwise allows the member the opportunity for representation by anyone he or she chooses, including an attorney or provider. Members are also offered the opportunity to send notes, medical records or other documents that will help in the review.

Outreach and Education

MDwise provides many education and outreach programs to better educate its members and their families about staying healthy and appropriately using medical and behavioral health services in a managed care system. The goal of these activities is to educate, support and encourage MDwise members to be informed, responsible and active participants in their own health care and well-being.

Member Education

New Member Materials

Welcome materials are sent to all new MDwise members. This gives MDwise the opportunity to begin establishing a meaningful connection with our members. Welcome materials include:

- A member handbook with a phone card listing MDwise telephone numbers.
- An introductory/welcome letter with their doctor's name, phone and hospital information.
- Information on how to obtain a MDwise Provider Directory.
- HIP members - POWER Account Debit Card/ID Card.

Each new MDwise member is also instructed through their new member materials to call MDwise to complete a Health Needs Assessment and confirm or assist in PMP selection. This call provides MDwise with the opportunity to link the member with any targeted or enhanced services, identify any special needs they may have and to educate them on the importance of scheduling an appointment to see his/her PMP within 90 days.

Member Newsletter

The MDwise member newsletter is sent out quarterly to each delivery system and includes information about timely health topics, preventive health services, new program information, inquiry and grievance procedures, MDwise policies and special children's features. Members receive a postcard informing them that the newsletter is posted on the website. The newsletter is available in languages other than English, including Spanish, upon request.

Please Note: Providers are invited to submit topics for inclusion in the newsletter. Suggestions or newsletter articles may be submitted to marketing@MDwise.org.

Outreach to Members

MDwise provides a variety of targeted education and outreach programs. These programs encourage members to stay healthy and use clinical services appropriately. MDwise outreach and education service efforts encourage members to obtain preventive and health maintenance care. MDwise outreach visits schools, neighborhoods and health fairs. In addition, outreach efforts include sharing information about behavioral health issues and access to care. Members receive information regarding preventive health services and are encouraged to access those services through member outreach programs. Examples include new member materials, member handbooks and member newsletters. Information is also mailed regarding special programs including BLUEBELLEbeginnings, focused on improving access and care for pregnant members, and MDwiseREWARDS focused on improving member knowledge about the importance of well-care, prenatal care and health screenings.



Members identified for disease management programs (i.e. asthma, diabetes, pregnancy, Coronary Artery Disease, Chronic Obstructive Lung Disease, Congestive Heart Failure, Chronic Kidney Disease, ADHD, depression and Pervasive Development Disease) are contacted by the Case/Care Manager working with members assigned to their provider network. Members are encouraged to actively participate in the management of their condition through disease education, self-management tools, and access to health professionals. In order to facilitate effective and efficient treatment of the most common medical disorders of our members, MDwise's Medical Advisory Committee has approved and provided clinical health guidelines. These are available to providers as a quick reference for diagnosis, treatment and prevention parameters.

Communication Resources

MDwise is available by phone to help members and potential members understand the health plans and benefits we offer.

For Hoosier Healthwise and Healthy Indiana Plan, MDwise customer service is available at **1-800-356-1204** or **317-630-2831** in the Indianapolis area. Help is available from 8 a.m. to 8 p.m., Monday through Friday.

If you call outside of open hours, you will get an automated message. Leave your name and phone number. A MDwise representative will follow up with you by the next business day.

Hoosier Healthwise, HIP Maternity and HIP State Plan members: If you call about transportation for an immediate need such as hospital discharge, urgent trip or trip home from the emergency room, you can call and talk to someone 24 hours a day, seven days a week.

Toll-Free Member Phone Line

MDwise Customer Service can be reached at **1-800-356-1204** or **317-630-2831** in the Indianapolis area. There are representatives who can help 24 hours a day, seven days a week. If you get an automated message, please leave your name and number and someone will return your call no later than the next business day. You can also go to MDwise.org for news and information. MDwise customer service representatives (CSRs) are available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Standard Time.

After regular business hours, MDwise contracts with a telephone answering service. The staff is trained to respond to most member and provider issues. For instance, the after-hours service handles many urgent transportation calls and pharmacy issues. If the answering service representative is unable to respond to a member or provider call, information is forwarded to a MDwise CSR to address the following business day.

During regular business hours and after hours, members who call in will be advised to contact their PMP or will be aided in contacting their PMP for issues necessitating the PMP's response or intervention such as care management issues.

Language Services

Effective communication with members is a key component in our ability to effectively coordinate and deliver appropriate health care services. MDwise is committed to ensuring that members have access to free oral interpretive and language translation services at appointments with MDwise providers. MDwise is also responsible for ensuring members have telephone access to their PMP in English and Spanish 24 hours a day, seven days a week.

Language and interpretive services are provided to members through the following:

- MDwise has a statewide toll-free customer service line that is available 24-hours a day, seven days a week. If a member cannot speak English, MDwise utilizes SpectraCorp language services to assist in communicating with the caller. Interpreters speaking more than 200 languages are available.
- MDwise also employs bilingual CSR's when there is a significant concentration of MDwise members (10% of membership) for whom English is not their native language. Currently MDwise employs CSRs who speak Spanish and Burmese. These representatives are available to assist Spanish- and Burmese-speaking members during regular business hours. MDwise also offers telephone-automated messaging in English and Spanish.
- Members who are hearing impaired may access MDwise by calling Relay Indiana at **1-800-743-3333**. The operator will connect the caller to MDwise customer service and relay the text typed by the member to the MDwise CSR. The CSR will respond verbally and a typed message is relayed back to the member. The service is available 24-hours a day, seven days a week.
- MDwise also produces member materials in a foreign language when required by OMPP, or if it can be determined that there is a significant concentration of MDwise members (10% of membership) who do not speak English as their native language. Currently all member materials are available in both English and Spanish. Burmese member handbooks are also available.

Please Note: *If you are unable to offer or procure translation services for MDwise members or need information on the Language Line, please contact your MDwise provider relation's representative. They will assist in locating resources upon request.*

Hearing Impaired Members

All providers within the MDwise network must provide a reasonable means of communication for the hearing impaired during in-person contacts. Based upon specific needs and individual circumstances, members may use basic communication aids such as hand-written notes or computer-aided communication.

Where sign communication is preferred, a family member or friend of the member can be encouraged to accompany the member to the appointment to aid in communication between the member and provider. In cases where the member requests an ASL interpreter, MDwise providers are encouraged to offer this service through available MDwise resources or a contract service. For more information about available resources, please contact the MDwise provider relations representative in your region.

The Indiana Relay Service may also be used to help providers communicate via phone with hearing impaired members. Instructions are listed below.

To Access the Indiana Relay Service

To communicate by phone with hearing impaired members, MDwise recommends using of the Indiana Relay Service for assistance. This is a free service that may be accessed by dialing: **1-800-743-3333**.

Community Resources

Tobacco Cessation Covered Services for MDwise

Providers are encouraged to discuss tobacco cessation with members. Indiana Medicaid programs cover tobacco cessation counseling and prescription cessation aids. Pharmacotherapy treatment is reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation.

Treatment services must be prescribed by an IHCP licensed practitioner within the scope of license under Indiana law. The IHCP reimburses for smoking cessation treatment services rendered by the following licensed practitioners participating in the IHCP:

- Nurse practitioner
- Pharmacist
- Physician
- Physician's assistant
- Psychologist
- Registered nurse
- Dentist

The following practitioners cannot obtain an IHCP rendering NPI number and must bill under the Supervising practitioner's NPI Number:

- Physician assistant
- Psychologist
- Registered nurse

Covered tobacco cessation services include, upon authorization, at minimum eight sessions of tobacco cessation counseling services per members per rolling 12 months. Covered pharmacy services are reimbursed by Indiana Medicaid FFS under the pharmacy benefit. Treatment may include prescription of any combination of smoking cessation products and counseling. Providers can prescribe one or modalities of treatment. Providers must include counseling in any combination of treatment. For the pharmacy to be reimbursed by the IHCP for over-the-counter products, a licensed practitioner must prescribe them.

Both ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself; this requirement is consistent with existing IHCP policies and regulations.

Please Note: Only patients who agree to participate in smoking cessation counseling may receive prescriptions for smoking cessation products. As the prescribing practitioner you may want to have the patient sign a commitment to establish a "quit date" and to participate in counseling as the first step in smoking cessation treatment. A prescription for such products serves as documentation that the prescribing practitioner has prescribed or obtained assurance from the patient that counseling occurs concurrently with the receipt of smoking cessation products.

If you choose to counsel members in your office, further billing instructions can be found in the IHCP Provider Reference Module. When providers and practitioners furnish a service to the general public at no charge, including smoking cessation counseling services, they cannot receive IHCP reimbursement for that service.

Indiana Tobacco Quitline, I-800-QUIT-NOW

Providers may refer any Indiana patient to the Indiana Tobacco Quit line, **I-800-QUIT-NOW**, which offers education and coaching over the telephone. This is similar to the toll-free smoking quit lines across the country.

The Quitline also has online resources at indianatobaccoquitline.net for tobacco users, healthcare providers, family/friends and employers. The Indiana Tobacco Quitline is a program of the Indiana Tobacco Prevention and Cessation Agency (ITPC). Contact ITPC at **317-234-1787** if you have any questions about the services offered by the Quitline.

The Quitline is designed so providers can easily refer clients to the program and is staffed by professionally trained smoking cessation Quit Coaches. The Indiana Tobacco Quitline offers a fax referral program for Indiana residents and physicians. Providers can simply ask, advise, and refer tobacco users to the Indiana Quitline using the fax referral form found at [in.gov/quitline/files/QL_ClinicReferralForm_\(3\).pdf](http://in.gov/quitline/files/QL_ClinicReferralForm_(3).pdf). Instructions are also available at in.gov/quitline/2346.htm. The Quitline staff will fax back a report to your office to tell you if the client was reached, enrolled in services, and planned to quit.

Linking Members with Additional Community Resources

When new members call to activate their “extra benefits,” they will be asked about any special services they might need. MDwise will attempt to provide members with information on community resources that may address identified needs.

The following organizations assist children and families of children with special health care needs. MDwise does not run these programs. The information is provided for your reference.

Agency and Community Service Providers:

ABOUT SPECIAL KIDS! ASK: **I-800-964-4746**

AboutSpecialKids.org

About Special Kids is a place for families and professionals in Indiana to go to “ASK” questions about children with special needs and to access information and resources about a variety of topics such as health insurance, special education, community resources and medical homes. According to the About Special Kids website, the organizations’ mission is, “Helping children with special needs live better lives by educating, empowering and connecting their families.”

(CSHCS) FIRST STEPS PROGRAM:

I-800-387-7837

<https://www.in.gov/fssa/4655.htm>

This program provides services for children up to age 3. The children must have a disability or be developmentally vulnerable. The services include:

- Screenings and assessments.
- Help to access medical care and other resources.
- Coverage for some health care services that are not covered by Hoosier Healthwise.

- Support services.
- Family education and special training.

Please Note: MDwise members with special needs may also be able to get other services. These programs are operated by the State of Indiana, not MDwise. So, even if a member is no longer in MDwise, they may still be able to get these services.

Children's Special Health Care Services (CSHCS) Program:

1-800-475-1355

<https://www.in.gov/isdh/19613.htm>

This program provides health care services for children through age 21. The children must have a severe, chronic medical condition that does at least one of the following:

- Has lasted or is expected to last at least two years.
- OR - Will produce disability, disfigurement, or limits on function.
- OR - Requires special diet or devices.
- OR - Without treatment, would produce a chronic disabling condition.

A Care Coordinator will help a member obtain medical services they may need. For children under 3 years old, the CSHCS Program will also work with First Steps to coordinate patient care.

Special MDwise Programs

MDwise has many extra programs to help members get healthy and stay healthy. Members can call MDwise Customer Service or visit the MDwise website at MDwise.org to learn more about these programs.

NURSEon-call

NURSEon-call provides members with 24/7 access to a Registered Nurse. NURSEon-call, is MDwise's nurse triage service. The triage service is operated by trained nurses and is designed to help members access the most appropriate resources and information for their needs.

Members (or their parents) can call NURSEon-call at any time, with health questions or concerns and talk directly to a nurse. Nurses can answer questions about illness, medications, medical tests, or procedures. Nurses can also help in determine if the member needs to seek professional care, including emergency care. NURSEon-call may also help members or their parents gain a better understanding of the nature and urgency of the situation causing concern. NURSEon-call staff always refers the member back to their PMP for further assessment and/or treatment to reinforce the importance of the member's medical home.

To access the NURSEon-call, the member can call MDwise Customer Service at **1-800-356-1204** or **317- 630-2831**.

RIDEwise

RIDEwise covers transportation to doctor appointments for Hoosier Healthwise members on Package A and PE. More information regarding ambulance transportation for Package C and Healthy Indiana Plan members are provided in the chapter on Transportation.

TEENconnect

TEENconnect is a resource for teens to find health information. They can access information on being a healthy teenager. For example, they can read about dealing with peer pressure, sex, tobacco, drugs and alcohol, depression and/or changes happening with their body. Some of this is done through interactive games.

BLUEBELLEbeginnings

The MDwise BLUEBELLEbeginnings program was launched in 2004 to improve access and care for pregnant women and to improve the likelihood of a healthy baby. The program includes a wide range of interventions including health education materials, community referrals, access to health education classes, telephone calls, and high-risk case management. MDwise assists members in selecting a doctor for their baby. Members stay enrolled in the program until after delivery.

The program includes a Health Needs Assessment as well as an additional assessment completed by Care Management. Information obtained during this contact is used to help determine what additional services are needed to support the member throughout her pregnancy. The telephonic contact also provides an opportunity to encourage members to obtain prenatal care and maintain healthy behaviors. The information from the assessment is passed on to an appropriate care manager. Other interventions include educating the expectant mother on early warning signs of complications, healthy lifestyle choices, and early identification of potentially high-risk complications. Close contact with the member's obstetric provider is maintained.

Members who participate in BLUEBELLEbeginnings receive a package of prenatal information. Additionally, pregnant members receive MDwiseREWARDS points for keeping appointments as well as for prenatal and postpartum exams. Members can use their accumulated points to redeem gift cards.

SMOKEfree

The SMOKEfree program is for members who want to stop smoking or chewing tobacco. We offer informational brochures and links to web pages that help members get answers to their questions and link them to pertinent resources. In addition, the SMOKEfree program links members with a smoking cessation class offered through their delivery system or other community organizations. The program also informs members that MDwise will cover many smoking cessation aids such as nicotine gum and patches, as well as bupropion (WELLBUTRIN).

Members who smoke or use tobacco can earn MDwiseREWARDS points for trying to quit. By completing a cessation program (i.e. Indiana's Tobacco Quitline, Baby and Me Tobacco Free, a program through a hospital or clinic) the member can earn points. Members must ask for a certificate or letter saying the program was completed. To earn the points, the member must mail, email or fax a copy to MDwise. Mail to **MDwiseREWARDS**, P.O. Box 441423, Indianapolis, IN 46244. Fax to (toll-free) **1-844-759-8551**. Email to rewards@MDwise.org.

WEIGHTwise

WEIGHTwise is a nutrition and exercise resource. MDwise members are provided with access to important information on eating right and being active. WEIGHTwise also has a food and exercise diary as well as other resources.

WELLNESSchats

Through WELLNESSchats, MDwise offers educational meetings/forums for members at various community and/or clinic sites. These forums are open to MDwise members and their families as well as the general community. Before the WELLNESSchats take place, efforts are made to survey patients in that area to determine what health topic, date and time is of importance/convenience to them. The forums may focus on clinical topics, such as asthma or diabetes or on parenting, wellness, or other topics of interest to members. If you are interested in holding a WELLNESSchat at your office or clinic site, please call the MDwise Outreach Department.

HELPlink

HELPlink is a MDwise program that connects members to various organizations in their community. These organizations can help with housing, utilities, job placement and more. HELPlink is available to all members. It is a free resource that can help members overcome the obstacles of daily life, and help members on their pathway to success. MDwise is working with the State to build out HELPlink to complement the Gateway to Work program.

INcontrol

INcontrol is the MDwise program for members with certain health conditions. The INcontrol program does not take the place of the doctor. Rather, the goal of the program is to help members control health conditions such as asthma, ADHD, Congestive Heart Failure (CHF), Chronic Kidney Disease (CKD), Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), depression, diabetes, pregnancy and Pervasive Disease (COPD).

MDwiseREWARDS

MDwise launched MDwiseREWARDS to encourage members to make positive health care decisions for themselves and their families. This incentive program uses points and financial rewards to increase member participation in MDwise programs. The program incentivizes members across plans with one central approach. The program engages members in taking greater responsibility for their health care decisions, becoming better educated health care consumers and improving their health.

The program “rewards” members with incentives for completing targeted health and wellness activities. Members earn points that are deposited into a personalized rewards account. The member can then redeem the points, once they reach a designated level, for a MDwise gift. After the member “cashes in” their reward points; they can begin accumulating new ones. We are hopeful that this approach will be more successful in realizing ongoing healthy actions and behavior change.

MDwiseREWARDS is tailored to achieve many goals. MDwise rewards member for the following activities:

- Join myMDwise.
- Sign up to get electronic communications through myMDwise.
- Answer questions about their health (Health Needs Screening) Completion of an annual physical exam or well-child visits.
- Complete an annual physical exam.
- Getting annual mammogram.
- Attend recommended prenatal appointments.
- Complete a postpartum exam.
- Complete follow-up appointment after a mental health inpatient hospital stay.



For each of these actions, MDwise awards the member predetermined weighted points. For example, a well child visit may be worth 2 points and joining the myMDwise Member Portal may be worth 5 points.

Members can access their rewards account via a secure member portal. Accumulated points and the activity for which the member earned those points, is displayed. MDwise Customer Service has access to this information for those who do not have access to a computer. Once a member accumulates a certain level of points, they can choose to either continue saving the points to earn a larger reward, or “spend” their points on a smaller gift. This allows us to address the needs of those members who need more immediate gratification in order to stay engaged in the process.

On at least an annual basis, MDwise will review the Rewards program and make decisions about behaviors to add to the list. In order to keep members engaged, we will eventually plan to advertise a member’s ability to earn “bonus” points, via the member newsletter and other OMPP-approved communication materials.

Comprehensive educational materials have been developed and distributed to help members understand MDwise REWARDS program features and how they can earn gift cards in points in the program. Educational materials also serve to reinforce important health and wellness messages.

MDwise Provider Resource Directory

Provider Relations

Our MDwise Provider Relations Representatives are available to work with providers of all types. MDwise has developed a comprehensive quick contact guide that includes contact information for all MDwise departments. Please visit www.MDwise.org for the most up to date version of the contact guides.

To credential, enroll, disenroll or update a current provider, please utilize the forms on the provider enrollment page at MDwise.org/for-providers/forms/provider-enrollment.

For contracting, credentialing or enrollment questions, you can email your inquiry to prenrollment@MDwise.org or call **317.822.7300 ext. 5800** for assistance.

Prior Authorization

To file a prior authorization, send the required PA request form to the appropriate fax number:

Hoosier Healthwise Fax: **1-888-465-5581**

Healthy Indiana Plan Fax:

- Inpatient: **1-866-613-1631**
- Outpatient: **1-866-613-1642**

The MDwise Prior Authorization request form and current PA list can be found at MDwise.org/for-providers/forms/prior-authorization.

If you wish to inquire on a current authorization request, please call the Hoosier Healthwise/Healthy Indiana Plan PA line at **1-888-961-3100**.



Claims

Claim submission information can be found on the MDwise website, on the claims page. If you would like an update on a claim status, or if you have a question on a process or denial, please call **1-800-356-1204** and follow the prompts for the claims department, or you can complete the claim inquiry form located at MDwise.org/for-providers/forms/claims, and fax to the designated number on the form. You are also encouraged to review your claim online by using the myMDwise Provider Portal.

Claim Disputes & Appeals

Claim disputes can be sent to MDwise at cdticket@MDwise.org (recommended) or mail to:

MDwise, Inc.
P.O. Box 441423
Indianapolis, IN 46225
ATTN: Claim Dispute Team

Only one claim is allowed per claim dispute form, and each form should be emailed individually to the email address above.

Medical Management

Care Management

If you have a member who could benefit from a more personalized insurance program, please contact our Care Management department to refer the member to the Right Choice Program. Referrals can be made by completing the form at MDwise.org/for-providers/forms/care-management, through the myMDwise Provider Portal.

Member Management

To add a member to your closed or full panel, please refer to the Member Management page at MDwise.org/for-providers/forms/member-management. This webpage provides the forms required to add members, change your panel size and status, pre-birth selection, add a Right Choices Program member or request reassignment for a member.

Behavioral Health

Behavioral Health providers can utilize the MDwise Behavioral Health webpage to locate PMP toolkits, prior authorization information, member resources, and clinical practice guidelines. A behavioral health poster is also available with contact information and prior authorization guidelines.

For the behavioral health provider page, visit MDwise.org/for-providers/behavioral-health. For behavioral health forms, go to MDwise.org/for-providers/forms/behavioral-health.

Pharmacy

Pharmacy benefits are managed through MedImpact. Pharmacy resources are broken down based on the members program. Go to MDwise.org/for-providers/pharmacy-resources and select Hoosier Healthwise or Healthy Indiana Plan for more information on pharmacy prior authorization and pharmacy documents.



To mail order a prescription, view the prior authorization reference guide or download a medication request form, visit MDwise.org/for-providers/forms/pharmacy.

Member Resources

The MDwise website is an important source of information for MDwise members and families. Some of the information and tools currently found at MDwise.org include:

- myMDwise member portal.
- How members can earn MDwise Rewards points.
- Health Needs Screening survey online.
- MDwise member handbook.
- MDwise member newsletters.
- Information related to MDwise outreach and education programs.
- Appropriate use of the emergency room tips for members.
- New member information.
- MDwise contact information.
- Member rights and responsibilities.
- Privacy policies.
- How members can access transportation and medical care.
- Participating pharmacies.
- CM/DM Referral Form to request help from a care manager.

