Providers with questions regarding this manual can submit those to the MDwise Provider Relations Department at Marketplacerpr@mdwise.org.

Respectfully,

MDwise Provider Relations
# MDwise Marketplace Provider Manual

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Introduction

Welcome to MDwise. We are excited to offer this provider manual to assist providers and their practices as they do business with us on our new Health Insurance Marketplace Product.

The Affordable Care Act offers Hoosiers not covered by a government sponsored health plan (i.e. Medicaid, Children’s Health Insurance Program, or Medicare) or employer sponsored health insurance new choices when it comes to health insurance. The Health Insurance Marketplace is managed by the Centers for Medicare and Medicaid Services (CMS) is designed to help Hoosiers and small employers find and buy health insurance and determine if they are eligible for an insurance subsidy all in one convenient place.

MDwise, Inc. has been an Indiana-based, provider-owned health plan since 1994. The MDwise Marketplace product is designed to offer health coverage, subject to individual premiums and cost sharing, to eligible residents of Indiana. For the first time we now offer our members the advantage of continuity of care by offering a single health plan choice across both government sponsored health plans (i.e. Hoosier Healthwise and Healthy Indiana Plan) and a commercial plan. Members no longer need to worry about having to leave MDwise and the physician they know and trust because a change in income forces them to choose a new health plan and/or choose a new physician because their physician might not be in their new plan’s network. To offer our members the best choice of providers in our service areas no matter the MDwise product they have, providers of all specialties are invited to join the MDwise Marketplace.

MDwise offers a number of benefits to our network providers including:

- Competitive provider reimbursement rates.
- A primary care-based model to better support medical homes and continuity of care.
- MDwise Web Portal with comprehensive member eligibility information across all MDwise products.
- Flexibility in accepting new members
- Case management services to help provider’s patients meet quality health care goals.
- Provider education materials designed to ensure our provider’s practices success in the MDwise family of health plans.

Benefits to our members include:

- A knowledgeable and consumer-focused sales staff that ensures consumers understand the benefits they purchased.
- Quick and easy consumer premium payment processing.
- Access to benefit coverage, health education materials, and other health plan information via the MDwise Web Portal.
- Preventive care screenings and immunizations carved out of the consumer’s cost sharing responsibilities.
Consumers have access to many services including:

- Physician Office Visits
- Inpatient and Outpatient Facility Coverage
- Diagnostic Services
- Prescription Drug Coverage
- Behavioral Health Services
- Family Planning Services
- Vision Benefits (children on all plans, only on select plans for adults)
- And More.

MDwise looks forward to working with our providers to improve the health and well-being of Hoosiers across the state of Indiana. Please call the provider relations department at 1-317-822-7300 ext. 5800 with any questions about MDwise or the Marketplace product. Providers can also visit MDwise.org/providers for more information.

Sincerely,

James Parker
Chief Executive Officer

Ty Sullivan, MD
Chief Medical Officer
Chapter One – Welcome to MDwise

Corporate History

MDwise is a nonprofit corporation that began its operations in 1994, when it was established as the Central Indiana Managed Care Organization, Inc. (CIMCO). The organization was formed specifically to help several major Indianapolis hospitals and their affiliated physicians deliver provider-directed, cost effective approaches to managed care services for Hoosier Healthwise members. It became the fastest growing risk-based managed care plan 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. During 2002 and 2003, MDwise expanded into Lake, Porter, and LaPorte counties and reached a pivotal milestone, with membership topping 100,000 lives. At the end of 2006, MDwise acquired and merged with IU Health Plan, Inc., leaving MDwise as the sole surviving entity to operate as a nonprofit Health Maintenance Organization (HMO) business. Today MDwise continues to grow in membership, serving over 400,000 members in the Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect programs statewide.

In June 2007, MDwise was selected by the State of Indiana to serve as a Care Management Organization for the Indiana Care Select program. Indiana Care Select was comprised of three major components: Care Management, Prior Authorization, and administration of the Indiana Chronic Disease Management Program. The MDwise care management approach is based on the belief that Care Select member needs were better addressed by creating an environment that helped them organize, make sense of, and navigate the overall health care system. The lack of well-coordinated care plans, multiple co-morbidities, and a multitude of psychosocial challenges are why we provide a proactive, holistic and all-inclusive care management model, blending disease management, member education/outreach, and care management into one comprehensive program.

In August 2007, MDwise was selected by the State of Indiana to be a health insurance issuer for the Healthy Indiana Plan. Under this program, the State contracts with health plans to deliver a basic benefit package 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, promote preventative care and healthy lifestyles while encouraging participants to be value-conscious consumers of health care to help promote price and quality transparency.

In January 2014, MDwise launched one of its newest endeavors: operating as an issuer on the Federal Health Insurance Marketplace. Beginning in selected areas around the State, MDwise offers a number of different products to applicants on the Marketplace, including bronze, silver and gold qualified health plans. Unlike our Medicaid plans, members contribute to the cost of their coverage through monthly premiums and cost sharing. Based on income, members may qualify for sliding-scale assistance with their premiums and/or out-of-pocket costs. These products are geared toward providing preventive care and essential health benefits for individuals who cannot get coverage through government programs or employer sponsored plans. MDwise sees these products as a natural extension of our role in supporting the health care safety net and promoting coverage for underserved populations in Indiana. We approach participation in the new Marketplace with our mission in mind – to enhance member satisfaction and lower total health care costs by improving the health status of our members through the most efficient provision of quality health care services.
MDwise Marketplace Delivery System Coverage

MDwise offers the Marketplace product statewide. Product availability is based on a member’s residence.

MDwise Mission
The MDwise Plan offers a delivery system model of managed care, which provides a coordinated, comprehensive approach to managing the cost and utilization of health care services. Our mission is to enhance member satisfaction and lower total health care costs by improving the health status of our members through the most efficient provision of quality health care services.

MDwise is:
The Heart of Compassion
The Star of Excellence
The Torch of Leadership

Our Core values are compassion, excellence, and leadership.

MDwise will accomplish its Core values through five aims:

- Delivering consistent, high quality care.
- Focusing on families and community in a culturally competent way.
- Shaping health policy and promoting innovation in 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.

MDwise Mission, Focus & Goals

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, Hoosier Care Connect, HIP, and our Marketplace products 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 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 Policy Documents, periodic member education materials, as well as ongoing member outreach and education calls when a provider lets us know there is a potential problem.

MDwise Dedication to Quality

MDwise is dedicated to serving the uninsured and under-insured and understands the unique needs of these members. MDwise strives to develop and deploy programs with full attention to guiding quality health care services. MDwise’s Medicaid line of business earned the National Council on Quality
Assurance’s (NCQA) “Commendable” status in its last review. We will also be pursing accreditation for our marketplace products, and are developing all of our programs in accordance with NCQA standards.

The ACA outlines many provisions to improve the quality of health care in America and expands the availability of affordable coverage to millions of Americans. MDwise strives to meet these requirements, specifically in the areas of:

- Local performance on clinical quality measures, such as HEDIS
- Patient experience ratings on standardized CAHPS survey
- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs

MDwise will continue to work diligently with our providers to deliver high-quality health care services to our members.
Chapter Two – Provider Enrollment & Disenrollment

Provider Recruitment

The MDwise Marketplace is a modified delivery system model similar to MDwise Hoosier Healthwise and Healthy Indiana Plan products. Providers can join the MDwise network in a variety of ways including:

1. Submitting a request in writing to the MDwise delivery system provider relations department.
2. Recruitment by MDwise delivery system provider relations in geographic areas where there is a deficit of specific provider types or specialties.
3. MDwise delivery system provider relations responding to requests from primary medical physicians seeking access to particular provider types and/or specialties within a given service area.
4. MDwise, Inc. Provider Relations forwarding a provider's request to contract to the appropriate delivery system(s) operating in the provider’s geographic region.

Becoming a Participating Provider

Participation in a MDwise delivery system’s provider network requires the execution of a provider agreement, provider enrollment, and if applicable, credentialing. This agreement contains the provisions that govern the relationship between the MDwise delivery system and the provider. A clinician or group will be considered a participating provider only upon successful execution of a provider agreement. Additionally, all providers are obligated to screen employees and contractors for excluded individuals and entities prior to hiring or contracting and on a periodic basis, and to review the calculation of overpayments to excluded individuals or entities. Federal law prohibits payments from being made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity while being excluded from participation – unless the claim for payment meets an exception listed in 42 CFR section 1001.1901(c). Any such payments actually claimed for federal financial participation constitute an overpayment under sections 1903(d) (2) (A) and 1903(i) (2) of the Social Security Act, and are therefore subject to recoupment.

The HHS OIG maintains the List of Excluded Individuals and Entities (LEIE), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other federal healthcare programs. The LEIE is located on the HHS OIG website at oig.hhs.gov.

Provider Responsibilities

The provider must notify the MDwise delivery system’s provider relations department of any changes to the information submitted in the initial application request to contract. Material omissions and/or misstatements in the application request to contract will deem the contract voidable. The contract will be effective as of a date determined by the MDwise delivery system, and the provider will be notified accordingly. This is most important: the MDwise delivery system will not reimburse for any services provided prior to the effective date of the contract. Requests for exceptions to this policy must be discussed with MDwise delivery system’s provider relations department prior to the rendering of any care in the form of an out-of-network authorization request. When applicable, credentialing requirements must be met before becoming a contracted provider. Please refer Chapter 4, Credentialing for more information.
Some changes in a provider’s practice may require reconsideration by MDwise delivery system provider relations, up to and including reapplication or recredentialing for continued participation as a network provider. These changes include but are not limited to:

- Change in practice location
- Change in practice specialty
- Change in ownership
- Entering into or exiting from a group practice
- Changes in hospital privileges
- Change in insurance coverage
- Disciplinary and/or corrective action by a licensing or federal agency
- Material changes in the information submitted at the time of contracting

When in doubt, please contact MDwise Provider Relations at 1-317-822-7300 ext. 5800 or via email at MarketplacePR@mdwise.org. Under no circumstances should a provider send Protected Health Information (PHI) or Personally Identifiable Information (PII) through unsecured email.

**Board Certification Requirement for Clinicians**

Physicians participating in a MDwise delivery system provider network are required to obtain board certification for PCP/PMPs and specialty physicians to ensure that the percentage of board-certified primary care providers (PCP or PCP/PMP) and specialty physicians participating in the provider network, at a minimum, is approximately equivalent to the community average for PCP/PMPs and specialty physicians. Participating physicians are required to be either board-certified, board-eligible and to be actively pursuing board certification, or must complete 25 Category 1 continuing medical education (CME) credits per year in order to participate with a MDwise delivery system provider network. During the initial credentialing process and then every three years, MDwise will validate a participating physician’s board certification status. If the participating physician is not board-certified, he/she must provide written documentation that they are board-eligible and are actively pursuing board certification within the required time period as defined by the American Board of Medical Specialties (ABMS) or have completed 25 Category 1 CME per year. Any provider that is not board-certified and not appropriately board-eligible must receive approval and agree to obtain 30 hours of CME to be added to a MDwise delivery system provider network. Please refer to Chapter 4, Credentialing, for more information.

**Role of the Primary Care Provider**

The Primary care provider (PCP/PMP) provides or manages first-contact, continuous and comprehensive health care services for a defined group of assigned members at his/her primary care site. The PCP/PMP is responsible for providing, arranging for and coordinating the provision of covered services to his or her assigned MDwise Marketplace members.

A PCP/PMP can be an individual physician. Registered nurse practitioners, physician assistants, nurse anesthetists who are eligible to practice one of the following specialties can serve as physician extenders:

- Family practice
- General practice
- General internal medicine
- OB/GYN
- Pediatrics
These providers must be directly supervised by a participating PCP/PMP in the MDwise delivery system provider network.

PCPs/PMPs should make best efforts to contact newly assigned members to provide an overview of the practice (such as hours and available services). PCPs/PMPs should also assess any medical needs and, when applicable, schedule an initial appointment.

Specialty Providers
A specialty provider is responsible for the provision of covered specialty care services working in collaboration with the member’s PCP/PMP. MDwise delivery system provider specialty network includes many different physician specialists.

Role of the Specialty Provider
MDwise expects specialty providers to communicate their findings in a timely manner to the member’s PCP/PMP and when applicable, other referring providers. A consultation is not considered complete until the specialist provides a written report to be incorporated by the PCP/PMP’s office into the patient’s medical record.

Provider Enrollment
The following are the four provider classifications MDwise enrolls:

Billing – A practitioner or facility operating under a unique taxpayer identification number (TIN). The TIN may be the practitioner’s Social Security number (SSN) or a Federal Employer Identification Number (FEIN), but a sole proprietor’s TIN may not be shared or used by any other practitioner, group, or facility.

Group – Any practice with one or more practitioners (rendering providers) sharing a common TIN. A group may be a corporation or partnership, or any other legally defined business entity. The group must have one or more rendering providers linked to the group.

Rendering – The provider that performs the services. Reimbursement for these services is paid to the group and reported on the group’s TIN.

Dual – A provider that is a billing and rendering provider. The provider is enrolled as a billing provider at one or more locations, and is also a member of a group or groups at one or more locations. Successful claim processing depends on accurate input of the billing provider information, as well as the rendering provider information, if applicable.

Provider Enrollment Changes
In an effort to keep accurate network provider information, providers must promptly notify the delivery system they are contracted with in writing of relevant changes pertaining to a provider’s practice. Providers are strongly encouraged to notify the delivery system they are contracted with of these changes with a signed document on the provider’s stationery. Verbal requests and/or those submitted by third parties or billing agents not on record as authorized to act on a provider’s behalf cannot be accepted. For providers terminating from a practice, notify the delivery system the provider is contracted with at least 45 days prior to the practitioner’s termination date. This notification must be in writing. The notification must be mailed, emailed, or faxed to the MDwise delivery system provider relations team using the provider’s stationery that includes at a minimum:
• The provider’s name
• National provider identification (NPI) number
• Effective date of termination
• Reason for termination
• If PCP/PMP, panel re-assignment instructions
• Signature and title of the person submitting the notification

Upon receipt of the notification, MDwise delivery system provider relations staff will work with affected members, the provider’s office, and when applicable, specialty providers, to ensure continuity of care.

Involuntary terminations (those initiated by a MDwise delivery system) will include notification to the provider and the practice as needed. Except when a provider’s termination is based upon quality related issues or fraud, MDwise will require continuation of treatment for covered services for:

- Up to 90 days upon the request of a member undergoing active treatment for a chronic or acute medical condition; or through the lesser of the current period of active treatment with the treating provider
- Members in their second or third trimester of pregnancy with the provider treating the member in conjunction with said pregnancy through the initial post-partum visit.

For members who are hospitalized on effective date of the termination, the provider must continue to provide covered services until the earliest of the following: date of member’s discharge, the date member ceases to have coverage, or 90 days after the effective date of termination. Additionally, PCP/PMPs should continue treating members on their panel up to 30 days following the effective date of the termination or until their membership selects or is assigned a new PCP/PMP.

The provider must accept payment at the applicable fee schedule as payment in full and must not seek any payment from the member for covered services, except for any applicable copayments, deductibles, or coinsurance. The provider must adhere to MDwise quality assurance programs and other MDwise policies and procedures including, but not limited to, procedures regarding prior authorization and notification.

For members who will continue receiving care from the provider, MDwise staff will contact the provider to obtain more information including confirmation of any scheduled services to be authorized on an out of network basis, with the provider being notified accordingly. Claims for members who continue to see a terminated provider without the MDwise delivery system’s knowledge will be automatically denied. Disputes in these cases can be addressed through MDwise administrative appeals process and, if the services are approved, the provider will be reimbursed for services rendered at the applicable fee schedule.

Panel Changes
In MDwise Marketplace, Provider Panels have two possible statuses: Open (accepting new members) or Closed (not accepting new members).

If a PCP/PMP should like to change their panel status, they must contact MDwise Provider Relations with that intention. The request may be submitted via email or by mail. The request must contain the name and title of the individual making the request. The request must also include the effective date of the panel closure and the expected duration of such closure. MDwise Provider Relations will make a determination on whether to grant the closed panel request.
Changes to a member’s selected PCP/PMP must be initiated by the member calling the MDwise Member Service Center or submitting a completed Member PCP/PMP Reassignment Request Form bearing the member’s signature. If a PCP/PMP closes their panel, any members who had selected that PCP/PMP prior to the receipt of the PCP/PMP closed panel notification must be allowed assignment to that PCP/PMP’s panel. Once a PCP/PMP’s panel is closed the PCP/PMP will no longer be assigned new members. If a PCP/PMP has a closed panel but would like to accept a new member, the PCP/PMP can open their panel or complete a Provider Request for Member Add form. The only exception to the no member assignment to the closed panel rule is: for terminated MDwise members who reenroll within six months and do not make a new PCP/PMP selection, MDwise will use the last PCP/PMP of record regardless of the PCP/PMP’s panel status at the time of member’s re-enrollment unless contractually agreed otherwise.

The PCP/PMP’s open/closed panel status will be reflected accordingly in the MDwise Provider Directory. The MDwise delivery system provider relations department will review rosters at each provider visit as additional confirmation of panel status, to monitor the duration of closed panels, and to ensure accuracy of provider enrollment information and adequate access.

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**Patient Relations**

**Member Rights and Responsibilities**

MDwise members are entitled to certain rights, including accessing and correcting medical records information as defined within the MDwise Member Rights and Responsibilities documented on the MDwise website. Members must be allowed to freely apply these rights without negatively affecting how they are treated by providers and/or MDwise. In addition, providers will not, and will ensure that no providers under their control will, discriminate against persons, either relative to employment or the provision of covered services under the contract, based upon race, religion, national origin, gender, marital status, sexual orientation, age, health status, disability, or source of payment.

Complaints or grievances reported to MDwise concerning providers whose behaviors are discriminatory, not culturally sensitive to a member and/or perceived by the member as inappropriate are forwarded to MDwise delivery system provider relations department, who will then contact and/or visit the provider, to inform him or her of the registered grievance and when applicable, educate about MDwise policies.

Grievances become part of providers’ file for review at the time of re-credentialing. Additional grievances are reviewed by the MDwise Credentialing Committee and may result in a request for a corrective action plan, suspension and/or termination from the MDwise delivery system provider network.

**Assistance with Interpretation**

MDwise-contracted practices shall provide interpreting services free of charge when necessary or appropriate, including phone communication to members with limited English proficiency. The provision of interpreter services shall comply with applicable state and federal mandates and take into account relevant guidance issued by the Department of Health and Human Services Office of Civil Rights, the Office of Minority Health, NCQA, and the Indiana Department of Insurance.
Privacy Rights
MDwise strongly believes in safeguarding the personal and otherwise protected health information (PHI) of our members. More information on how we protect member privacy is available in our Notice of Privacy Practices. Under no circumstances should a provider send Protected Health Information (PHI) or Personally Identifiable Information (PII) through unsecured email. When faxing PHI, the sender should contact the recipient to verify the appropriate fax number and to confirm receipt.

Behavioral Health Care Integration
MDwise is committed to fully integrating MDwise members’ medical and behavioral health care. MDwise recognizes the importance of working collaboratively to create a coordinated treatment system where all providers work together to support the member in a seamless system of care. To this end, MDwise has worked closely with providers to develop specific programs and provider procedures that standardize communication and linkage between MDwise members’ primary care and behavioral health providers.

Linkage between all providers (primary care, mental health and substance abuse providers, as well as state agencies) supports member access to medical and behavioral health services, reduces the occurrence of over-and-under utilization, and provides coordination within the treatment delivery system.

Communication among providers also improves the overall quality of both primary care and behavioral health services by increasing the early detection of medical and behavioral health problems, facilitating referrals for appropriate services and maintaining continuity of care. It is permissible to disclose mental health records to MDwise and to the member’s PCP/PMP and that such disclosure does not require member consent because the transfer of this record if for treatment purposes (per HIPAA and Indiana State Law [IC 16-29-2-6(a)]. For the disclosure of substance abuse records, the provider needs the members consent to release information to those outside of MDwise. Providers are asked to encourage members to sign a consent that allows coordination with the PCP/PMP.

Provider Rights and Responsibilities
MDwise does not prohibit or restrict network providers acting within the lawful scope of practice from advising or giving treatment options, including any alternative treatment. To ensure effective relationships, and to be consistent with our joint commitment to enhance the quality of life for all MDwise members regardless of MDwise health plan, we require network providers to:

1. Accept MDwise members as patients to the extent other health plan members are accepted.
2. Make members aware of all available care options, including clinical care management through MDwise.
3. Treat MDwise members as equals to all other patients.
4. Be active participants in discharge planning and/or other coordination of care activities.
5. Comply with medical records requirements relative to proper documentation and storage, allowing access for review by individuals acting on MDwise behalf and supporting appropriate medical record information exchange at a provider and/or member’s request.
6. Comply with patient access standards as defined within this manual.
7. Remain in good standing with local and/or federal agencies.
8. Be responsive to the cultural, linguistic and other needs of MDwise members.
9. When applicable, inform members of advanced directive concurrent with appropriate medical records documentation.

10. Coordinate care with other providers through notification of findings, transfer of medical records, etc., to enhance continuity of care and optimal health. Report findings to local agencies as mandated and to MDwise when appropriate.

11. Promptly notify MDwise of changes in their contact information, panel status, and other relevant provider enrollment information.

12. Respect and support MDwise Members Rights and Responsibilities.

13. Of equal importance, MDwise providers have the right to:
   a. Receive written notice of network participation decisions.
   b. Exercise their rights and other options as defined within this manual and/or the MDwise Provider Agreement.
   c. Communicate openly with patients about diagnostic and treatment options.
   d. Expect MDwise adherence to credentialing decisions as defined earlier in this section of the manual.

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**Access and Availability Requirements**

MDwise delivery system provider relations staff regularly evaluates access/availability and the comprehensiveness of the provider network. Access/availability of acute care facilities, PCP/PMPs and obstetricians/gynecologists are evaluated at least quarterly. Access/availability of high volume specialty care practitioners is evaluated at least annually. High-volume specialties are defined as the top five specialties based on claim volume. MDwise strives to ensure the availability of practitioners who are multilingual, understand and comply with state and federal laws requiring that practitioners assist members with skilled medical interpreters and resources, and are responsive to the linguistic, cultural, ethnic, and/or other unique needs of minority groups and special populations.

At least annually, MDwise reviews data on MDwise members’ cultural, ethnic, racial and linguistic needs to define quality initiatives, inform interventions and assess availability of practitioners within defined geographical areas to meet the needs and preferences of our membership. Availability and access standards are defined as follows:

- Provider Access
- Ratio to Members
- Availability by Geographic Standards

**Specialists**

The MDwise specialty network must include at a **minimum two** specialty providers of each type listed below within 60 miles of the member’s residence:

- Anesthesiologists
- Cardiologists
- General surgeons
- OB/GYNs
- Occupational therapists
- Ophthalmologists
- Optometrists
- Orthopedic surgeons
- Physical therapists
- Psychiatrists
- Diagnostic testing
- Speech therapists

The MDwise specialty network must include at a **minimum** one specialty provider of each type listed below within 90 miles of the member's residence:

- Endocrinologists
- Gastroenterologists
- Nephrologists
- Neurologists
- Oncologists
- Pulmonologists
- Urologists
- Cardiothoracic surgeons
- Dentists or Oral Surgeons
- Interventional radiologists
- Non-hospital based anesthesiologist (e.g., pain medicine)
- Pathologists
- Radiation oncologists

The MDwise specialty network must include at a **minimum** one specialty provider of each type listed below within 120 miles of the member's residence:

- Dermatologists
- Infectious disease specialists
- Neurosurgeons
- Rheumatologists
- Prosthetic suppliers

The MDwise specialty network must also include a sufficient number of the following provider specialty types:

- Hematologists
- Orthopedists
- Otolaryngologists

The MDwise ancillary network must also include:

- Two durable medical equipment providers available to provide services to members in at least a contiguous county
- Two home health providers available to provide services to members in at least a contiguous county
In addition to the above specialists, MDwise must:

- Demonstrate the availability of providers with training, expertise, and experience in providing smoking cessation services, especially to pregnant women
- Contract with the Indiana Hemophilia and Thrombosis Center or a similar federally recognized treatment center
- Arrange for laboratory services only through enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates

MDwise will meet or exceed all applicable network adequacy standards for Acute Care, Rehabilitation, and Urgent Care facility requirements.

MDwise delivery systems reserve the right to either expand or limit its provider network according to its business objectives. In determining network expansion needs, MDwise evaluates these availability and access standards along with other criteria.

### Availability and Access Standard for Behavioral Health Services

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Appointment Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>Emergency Services must available 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>Urgent – Members presenting with significant psychiatric or substance abuse history, evidence of psychosis and/or in significant distress.</td>
<td>Urgent care should 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.</td>
</tr>
<tr>
<td>Emergent – Members who have a non-life-threatening emergency.</td>
<td>Emergent care should occur within 6 hours. A care manager will further assess and provide a referral to an appropriate level of care.</td>
</tr>
<tr>
<td>Routine – Members seeking outpatient services who present no evidence of suicidal or homicidal ideation, psychosis, and/or significant distress.</td>
<td>Routine assessments should occur within 10 business days of the request for service.</td>
</tr>
</tbody>
</table>

To ensure up-to-date referral information, providers are required to notify MDwise, Inc. Provider Relations and their contracted delivery system provider relations of any changes or limitations in appointment access up to and including when a clinic or a member of the professional staff:

1. No longer accepts new patients
2. Is available during limited hours or only in certain settings
3. Has any other restrictions on treating members
4. Is temporarily or permanently unable to meet MDwise standards for appointment access

Notification of access limitations may be made by contacting MDwise, Inc. Provider Relations Department at 1-317-822-7300 ext. 5800. Delivery system provider relations contact information can be found on the MDwise Marketplace Quick Contact Guide located at [MDwise.org/quickcontact](http://MDwise.org/quickcontact).
Cultural Competency
MDwise has a diverse membership in terms of linguistic abilities and cultural and ethnic backgrounds. To promote access to providers who have the ability to communicate with the member in a linguistically appropriate and culturally sensitive manner, MDwise uses a number of strategies to capture robust and detailed linguistic, ethnic and cultural data on our members, including the use of health needs assessment tools and querying members upon contact with our customer service department.

MDwise captures linguistic capabilities of providers as part of the contracting and credentialing process for individual clinicians. For access and availability assessment, the member’s self-reported primary language serves as a measure of their linguistic needs and preferences as well as a proxy for cultural and ethnic identity. The providers’ self-report of languages spoken serves as the measure of their linguistic ability and a proxy for cultural and ethnic backgrounds. Language, race, and ethnicity information for physicians helps MDwise to serve a diverse member population in a culturally competent way.

MDwise also employs US Census Data on prevalent non-English languages spoken in Indiana and identifies those languages spoken by more than 10% of individuals, five years and older, within each Indiana County in which MDwise has a Qualified Health Plan. For more information, please see the “Access and Availability Requirements” section of this manual.

Wait Time Access Standards
MDwise providers must ensure the availability of prompt provider consultation, including arrangements to assure coverage for members after hours. MDwise also requires the hours of operation offered for all members to be the same regardless of their coverage. In addition to after-hours access standards, patients should be seen within a reasonable time after their arrival. A reasonable time is defined as within 60 minutes of the appointment time. Patient calls regarding active clinical problems and received during routine office hours should be returned within the hour when clinically appropriate, or within one business day otherwise. Telephone calls regarding routine administrative requests should be returned within two business days.

MDwise is also required to monitor and report on member access to specific primary care and specialty services. Please see the Quality Improvement section of this manual which provides the standards applicable to each of the above services.

Health Care Fraud
Prevention
MDwise expects providers to comply with all federal and state regulations that prohibit fraudulent behavior, including but not limited to:

1. Recording clear and accurate documentation of all services rendered in a timely manner as close as possible to the date of service
2. Not signing blank certification forms that are used by suppliers to justify payment for home oxygen, wheelchairs, and other medical equipment
3. Being suspicious of any vendor offering discounts, free services or cash in exchange for referrals
4. Refusing to certify the need for medical supplies for patients not seen and/or examined
5. Specifying the diagnosis when ordering a particular service (e.g., lab test)
6. Knowing and adhering to the practice’s billing policies and procedures
7. Verifying the identity of patients since insurance cards can be borrowed, stolen and fabricated
8. Carefully scrutinizing requests for controlled substances, particularly with new patients.

**Reporting Health Care Fraud**
Providers who suspect health care fraud should report any suspicions to their organization’s Compliance Office or Executive Director. Suspicions or concerns involving a MDwise member or provider can be reported to MDwise’s compliance department in writing or by email. These concerns can also be reported anonymously to the MDwise Compliance Hotline 24 hours a day, seven days a week at 1-317-822-7400.

Fraudulent acts or suspicions may be reported as follows:
*Mail*
MDwise Compliance Department
1200 Madison Avenue, Suite 400
Indianapolis, Indiana 46225

*Phone*
MDwise Quality & Compliance Office
1-317-822-7400 (then dial 0 to have the call directed) MDWISE Compliance Hotline (anonymous)

Under no circumstances should a provider send Protected Health Information (PHI) or Personally Identifiable Information (PII) through unsecured email.

**Federal False Claims Act**
In complying with our obligations under the Deficit Reduction Act of 2005, MDwise provides detailed information to our employees, contractors and agents regarding the False Claims Act and comparable state anti-fraud statutes, including whistleblower protections. To that end, MDwise has developed and continues to refine our policies and procedures regarding fraud and abuse detection, prevention and reporting including but not limited to the following documents:

1. MDwise Code of Conduct
2. MDwise Compliance and Integrity Plan
3. False Claims Act/Whistleblower Policy

**Preservation of Records and Data**
In accordance with the provider agreement, network providers and MDwise shall each preserve all books, records and data that are required to be maintained under the provisions of the agreement for a period of ten years or longer, as required by law from the date of final payment under the agreement for any specific contract year. These books, records, and data include any that are pertinent to adjudicatory proceedings, audits, or other actions, including appeals.

If any litigation, claim, negotiation, audit, or other action involving the records is initiated before the Expiration of the applicable retention period, all records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the retention period, whichever is later.
Furthermore, any such records shall be maintained upon any allegation of fraud or abuse or upon request by MDwise, its delivery systems or any state or federal government agency, for potential use in a specific purpose or investigation or as otherwise required by law.

These records shall be maintained for a period of time determined by the requesting entity and at least as long as until completion of the action and resolution of all issues that arise from it or until the end of the retention period, whichever is later.

“Hold Harmless” Provision
According to the MDwise Marketplace Provider agreement, a MDwise provider agrees to bill, charge and collect all applicable copayments, coinsurance and deductibles for Marketplace covered services rendered by Provider under their MDwise Marketplace provider agreement. The provider’s Delivery System and MDwise are not liable for any copayments, coinsurance or deductibles the provider doesn’t collect. The provider’s contract also says, “Provider shall not bill or collect payment from a Covered Person for (1) the difference between the amount paid under this Agreement and the amount Provider otherwise charges for such services; or (2) for any amounts denied or not paid by Delivery system due to any reason, including, but not limited to, (i) the insolvency of Delivery System or MDwise, or (ii) Provider’s failure to comply with Delivery System or MDwise policy or procedures, provided however, Provider may collect Copayments, Coinsurance and Deductibles in accordance with the MDwise Exchange Product, as well as fees for Non-Covered Services.” Please see Chapter Three for further information about member financial responsibility.

If there are any questions about this contract provision, please contact the appropriate MDwise delivery system Provider Relations representative directly, or email Provider Relations at MarketplacePR@mdwise.org. Under no circumstances should a provider send Protected Health Information (PHI) or Personally Identifiable Information (PII) through unsecured email.

Provider Enrollments

Providers typically enroll one time and their files are maintained from that time forward. If a provider is enrolled with MDwise for other lines of business they will still need to separately enroll for the Marketplace product. However, we will use a streamlined process for verifying that the information is still current rather than requiring the provider to complete a new application. Providers must report changes in their provider profile information such as NPI, address, tax identification number, provider name, etc. to their contracted delivery system immediately so that those changes can be added to the appropriate MDwise systems (i.e. claims, enrollment, etc.). Failure to report provider enrollment updates or new providers could result in a claim being denied. Providers are ultimately responsible for ensuring their provider file information is up to date.

MDwise only enrolls or updates provider information when the paperwork comes from the delivery system provider representative.

If a physician is out of the network for more than 30 days they must be recredentialed before reentering the MDwise Marketplace Network.
Out-of-network services are not covered unless the service is an emergency or it is authorized. From time to time, it may become necessary for MDwise to grant prior authorization for a non-emergent service performed by an out-of-network provider. Out-of-network providers may request prior authorization by checking member eligibility using the MDwise Web Portal and then contacting the member’s assigned MDwise Delivery System which is indicated on the member’s identification card and on the Web Portal eligibility verification. To contact medical management at the member’s delivery system, providers must use the MDwise Marketplace Quick Contact Guide located at MDwise.org/quickcontact.

During the call to the member’s delivery system medical management department to request prior authorization, contact information for the provider is gathered so that a provider enrollment form and W-9 form can be faxed to the out of network provider. The out-of-network provider must complete the enrollment form and W-9 and fax this information back to the MDwise Provider Enrollment Department so the provider’s information can be loaded into the claims system and if applicable, to the medical management system. Failure to complete the enrollment form and W-9 form and return it to MDwise may cause the provider’s claim to deny.

### Provider Updates

When a provider wishes to update their provider profile, or, if applicable, PCP/PMP panel demographics they must notify their contracted delivery system provider relations department immediately. Once notified, the provider’s contracted delivery system will submit provider file updates on behalf of the provider to MDwise, Inc. MDwise only updates providers when the provider file update information comes from the delivery system provider representative. If MDwise, Inc. is notified of a provider change directly, the update is given to the delivery system provider relations department for appropriate follow-up with the provider contracted with that delivery system. No changes will be made to the provider’s enrollment profile without approval from the provider’s contracted delivery system.

### Provider Disenrollment

If an existing provider wishes to disenroll without re-enrolling in another Delivery System, the provider must send written correspondence to their MDwise delivery system provider relations notifying them of their intent to disenroll. That delivery system will notify MDwise Provider Relations. The correspondence can be either via email or mail to the provider’s contracted delivery system. Providers may use the MDwise quick contact guide to contact their delivery system.

Correspondence stating the disenrollment must contain a typed signature with title, state the physician will no longer be accepting MDwise Marketplace membership or is not signing with the another MDwise Marketplace Delivery System and list who the physician would like to leave the current members with. If all three items are not listed the members cannot be reassigned, the members will be auto assigned.

### Provider Disenrollment with Re-Enrollment

If an existing provider wishes to dis-enroll from one location or MDwise Marketplace Delivery System and re-enroll in another location or MDwise Marketplace Delivery System, the provider must complete
and submit documentation notifying their MDwise delivery system provider relations of the change. The provider must send a letter containing the following:

1. A typed signature with title.
2. The new location/delivery system.
3. Whether the provider’s panel will follow the provider to the new location.
4. If the panel will not follow the provider to the new location, please include a suggested provider to have the panel re-assigned. If this information is not included, the members will be auto-assigned to a new PCP/PMP.
Chapter Three – Member Eligibility

How to Verify Eligibility

Providers must check eligibility at EVERY VISIT
- Providers can access eligibility from the MDwise Marketplace Portal.
- X12 EDI 270 Transaction

Member Premium Payments affect eligibility status

Members who are past-due on their premiums will be indicated as “pending” in regards to eligibility on the MDwise Web Portal. Note: Claims will be pended during the grace period until payment is received, and will be denied at the end of the grace period if not paid in full.

Member Open Enrollment Period

The time period when any eligible individual may enroll into a plan on the Federally Facilitated Marketplace.

Special Enrollment Period

Special Enrollment Period is the timeframe outside of open enrollment when an individual may sign up for new coverage; triggered by a qualifying life event. Qualified Life Event is a change in circumstances that triggers eligibility for a Special Enrollment Period, such as change in income, marital status, having a child or becoming pregnant. Special Enrollment Period selections generally must be made within 60 days of the qualifying event.

MDwise Marketplace Member ID Card

Below is an example of the MDwise Marketplace Member ID Card. Members should present this card at every encounter with a provider but possession of the card is not a guarantee of initial or ongoing eligibility for MDwise Marketplace. Providers must verify member eligibility on each date of service prior to rendering services. The card contains information important to providers so take special note of the following member information:

- MDwise Delivery System
- Member ID numbers
- Subscriber Name and Subscriber Dependents
- Electronic Claim Submission Information
Pharmacy Benefit Manager Contact Information


**Front...**

![Image of MDwise Marketplace card]

Each individual under the same family insurance plan will be listed here. Each member will have their own unique ID number across from their name. Use this number when submitting claims.

**Back...**

This card does not guarantee coverage. To verify benefits, view claims or find a provider, visit MDwiseMarketplace.org or call customer service.

**Member:**
- EMERGENCIES: Call 911 or go to the nearest emergency room; must notify MDwise within 48 hours after admittance.
- Pharmacy member services helpline: 844.336.2684
- VSP Vision Care: 1.855.868.4561

**Provider:**
- (Check member eligibility every visit at MDwise.org/provider)
- Pharmacy: 844.336.2684 • Pharmacy PA Fax Line: 858.790.7100
- RxBIN: 003585 • RxPCN ASPROD1 • RxGRP MDW
- Change Health/Emdeon/WebMD Payer ID: 45627
- Claims Address: Refer to MDwise.org
Chapter Four - Member Financial Responsibility

Additional fees for covered services
Providers may not charge MDwise members fees for covered services beyond copayments, coinsurance or deductibles as described in their benefit plans. Providers may not charge MDwise members retainer, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services they provide that are denied or otherwise not paid due to their failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or otherwise comply with MDwise protocols as required by the provider’s agreement with MDwise, or based on MDwise reimbursement policies and methodologies. This does not prevent providers from charging MDwise members nominal fees for missed appointments or completion of camp/school forms. If a provider wishes to charge a member for these fees, the fees must be outlined in the provider’s practice policy, which must be presented to the member before they can be collected.

Charging Customers for non-covered services
Providers may seek and collect payment from MDwise Marketplace members for services not covered under the applicable benefit plan. A provider should get written consent from a member before rendering any non-covered service(s). The suggested written consent form should include:

1. A good faith estimate of the charges for that service;
2. Type of service(s) to be rendered.
3. A statement of reason for the provider’s belief that the service may not be covered; in the case of a determination by MDwise that planned services are not covered services, include a statement that MDwise has determined that the service is not covered and that the Customer, with knowledge of MDwise determination, agrees to be responsible for those charges.
4. Date and member signature.

A copy of this consent form should be retained in the member’s medical record.

Member financial responsibility (Copayment, Coinsurance, Deductibles)
Members are responsible for the copayments, deductibles and coinsurance associated with their benefit plans. The provider is responsible for collecting copayments, coinsurance, and deductibles. Providers can collect copayments at the time of service; however, to determine the exact member responsibility related to benefit plan deductibles and coinsurance, we recommend that providers submit claims first and refer to the appropriate Explanation of Payment (EOP) when billing members.

If a provider prefers to collect payment at time of service, he or she must make a good faith effort to estimate the member’s responsibility and collect no more than that amount at the time of services. In the event the member pays more than the amount indicated on the medical claim EOP the provider is responsible for promptly refunding the difference to the member.

There are specific services which members are not responsible for copay/coinsurance/deductible when sought in-network. Some of these services include:

- Preventative Care Services
- Pediatric Vision Services
Grace Periods for Member Premium Payments

The ACA permits a grace period for members whose premiums are past due. The grace periods are different depending on whether or not the member gets federal subsidies to help them pay their monthly premiums (Advanced Premium Tax Credits, also known as APTC).

- **For non-subsidized members, the grace period is one month.** This grace period shall not extend beyond the date the member’s policy terminates. Any claims incurred and submitted during the grace period will be pended until premium is received. If premium is not received within the grace period, claims incurred during the grace period will be denied and the member’s coverage will automatically terminate retroactive to the last paid date of Coverage.

- **For subsidized members, the grace period is three months.** MDwise will pay all appropriate claims for services in the first month of the grace period and may pend claims for services in the second and third months of the grace period. Any claims incurred and submitted during the latter two months of the grace period will be pended until the member becomes current on their premiums, or until the end of the grace period, whichever comes first. If payment is not received by the end of the grace period, the member’s coverage will automatically terminate retroactive to the last day of the first month of the grace period.

These grace period rules make it very important for providers to check eligibility on each date of service! MDwise will indicate the member’s eligible (paid) status on our web-based eligibility look-up tool. This web portal tool is our mechanism to notify Participating Providers of the possibility for denied claims when a member is in the second and third months of the Grace Period.

A provider can collect a “pending” member’s copay at the time services are provided and submit a claim to MDwise for payment. Upon receipt of the claim, MDwise will place the claim in suspended status until the member pays the premium due. MDwise will pay no interest on a claim that is placed into “pending” status due to non-payment of premium on the part of the member. If the member pays the premium before the end of the grace period, the claims will be adjudicated. If the member fails to pay their premium, the member’s eligibility will be end dated retroactively. Coverage will end on the last paid date, for unsubsidized members. Coverage will end on the last day of the first month of the grace period, for subsidized members. The provider can then collect their usual and customary for the service(s) provided on a date when coverage is not in effect.

A provider can also treat the member as private pay while the member is in “pending status” and may collect their usual and customary charge for the service(s) provided. If provider chooses to treat the member as private pay and collects the full payment at time of service, the provider would be responsible for returning the member paid portion minus any applicable cost sharing (i.e. copays or deductibles) and submit that claim to MDwise for adjudication if the member’s pending status is removed because they have paid their premium. Providers must be wary of timely filing limits.
Billing for Missed Appointments
The practice and its providers will cooperate and participate with MDwise in programs focused on improving member appointment attendance. Providers are able to do the following based on their office policies:

- Bill members for missed appointments.
- Submit a member reassignment request to MDwise Customer Service for a member due to missed appointments.
- Submit a member reassignment request to MDwise Customer Service because the member has an outstanding balance owed to the practice from a time prior to becoming a MDwise member.

The last two bullets above are reasons a MDwise PCP/PMP may request a member be moved to another PCP/PMP’s panel. Providers can request a member reassignment for a member for missed appointments. It’s the MDwise delivery system’s responsibility to ensure the member has a PCP/PMP within their delivery system. The member will be effective with new PCP/PMP at the beginning for following month following the reassignment request. Refer to Marketplace Provider Request for Member Reassignment located at www.mdwise.org. Providers can contact MDwise Marketplace Customer Service by accessing the MDwise Quick Contact Guide located at MDwise.org/quickcontact.
Chapter Five - Credentialing

Credentialing Overview

MDwise requires credentialing of any licensed medical practitioner (physician or non-physician) either independent or part of a group before reimbursement of any services rendered to MDwise members. Upon finalized credentialing the MDwise provider will be added to the online provider directory under their contracted Delivery System.

Practitioners that require credentialing include:

- Licensed independent medical and behavioral health practitioners or groups of practitioners (including non-physician practitioners) who are contracted with and have an independent relationship with a MDwise delivery system and provide care for MDwise members. An independent relationship exists when the delivery system selects and directs its members to see a specific practitioner or group of practitioners, including all practitioners whom members can select as a primary care provider (PCP/PMP).
- Most hospital-based practitioners who treat MDwise members.
- Non-physician practitioners who have an independent relationship with a delivery system.

The Goals of the MDwise Credential System include:

- Supporting development/maintenance of credentialing and recredentialing standards based upon the guidelines of the National Committee for Quality Assurance (NCQA).
- Upholding fair review of the qualifications of practitioners against established standards.
- Ensuring ongoing monitoring through performance reviews and credential reassessment to maintain a network of high quality healthcare providers for our members.

Credentialing Process

A standard credentialing application (e.g. CAQH application) must initially be completed by all providers along with submission of additional credentialing materials (e.g. DEA certificate, malpractice insurance face sheet, CV, etc.). Verification of the accuracy of the materials will be conducted by credentialing staff utilizing data from recognized monitoring organizations. Any discrepancies between materials submitted by providers and the data viewed during verification will be conveyed to providers giving the practitioner a chance to resolve the discrepancy.

Upon completion of the initial credentialing process an appointed committee of a particular delivery system will review the materials to determine entry into the program. At a minimum, the committee individually reviews the credentials of practitioners who do not meet MDwise established criteria. An objective review will be enforced thereby omitting any committee member from making any voting decisions if he/she feels there is a conflict of interest, has been professionally involved with the practitioner, or feels his or her judgment has been compromised. Practitioners will be notified within sixty (60) calendar days of the peer-review committee's decision.

It should be noted that credentialing for behavioral health providers will be performed at MDwise Corporate and not the delivery system.
Please Note: All practitioners have the right to request information concerning the status of his/her credentialing application. This request can be made via telephone or writing by contacting the particular MDwise delivery system credentialing staff. A contact list for MDwise delivery systems can be found at our website MDwise.org/quickcontact. Information exempt from being requested includes references, recommendations, or peer-review protected information.

In addition, office site visits are conducted in conjunction with the initial credentialing process for primary care providers, obstetricians/gynecologists, and high volume behavioral health practitioners. Providers practicing at multiple locations will require onsite visits at all sites to ensure MDwise criteria is met. Relocation to a new site or opening of a new location will be subject to an initial onsite visit as well. If a relocation site has already satisfied MDwise standards an initial screening will not be necessary.

Furthermore, consistent member complaints could possibly warrant onsite reviews for quality assurance. Please refer to Appendix C for a copy of the MDwise Office Site Standards. At minimum, physician offices must score 80% to comply with office and clinical standards. Below this threshold an improvement plan will be implemented and a supplementary site visit will be conducted to ensure threshold attainment.

### Required Credentialing Materials

To participate in the MDwise network the following criteria must be met by practitioners:

- **Attestation:** Attested to completion and accuracy of the application.
- **State License:** Current, valid, and unrestricted license to practice in Indiana or a neighboring state.
- **DEA:** Current, valid and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate.
- **Educational Requirements:** Graduate school recognized by Indiana State Boards. Satisfactorily completed a residency program in the appropriate specialty of practice.
- **Board Certification:** Board certified in the specialty in which the practitioner treats MDwise patients. Certification must be through a recognized board such as ABMS, AOA, APMA etc. Exceptions may be granted if:
  a) If the physician is not board certified in the appropriate specialty of practice MDwise must ensure the appropriate CME documentation has been submitted that verifies the physician has received a minimum 25 Category I CME’s in the last 12 months, 50 Category I CME’s in the last 24 months, or 75 Category I CME’s in the last 36 months.
- **Privileges:** Clinical privileges in good standing at practitioner’s primary admitting hospital. If the practitioner is a PCP/PMP or behavioral health practitioner and does not have admitting privileges at an in network hospital, the practitioner must have relationship privileges with another in network practitioner to admit a MDwise member and follow the member while the member is in the hospital. Additionally, the practitioner may have a clinical appointment to an in network hospital that designates covering practitioner relationship(s).
• **Liability Coverage:** Professional liability coverage of $250,000/$750,000 and participation in the Indiana Patient Compensation Fund. If not under the fund then there must be 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:** Acceptable liability history must be presented based upon pattern, frequency, and type of settle and pending claims against the practitioner. A historical report within the last ten years of any liability claims filed must be submitted for review by the medical director or designee.

A peer-review Committee or designee will review all practitioners with:

a) Two (2) or more filed malpractice claims or settlement in the past five (5) years.
b) Any settlement for $500,000 or more in the past five (5) years.
c) A closed claim with a payment or settlement involving a death.

Note: If no additional suits have been filed against the practitioner since the most recent credentials cycle or no new information arises on previous cases (e.g. settlement reached, finding of malpractice, etc.) liability history review is not required.

• **Work History:** Comprehensive five-year professional employment and/or education history

• **Initial Office Review:** PCP/PMP’s, OB/GYNs, and high volume behavioral health specialists must have satisfactory office onsite survey results.

• **CLIA:** Practitioners with laboratory testing services onsite must also provide proof of a Clinical Laboratory Improvement Amendments (CLIA) certificate.

• **Contract:** Must confirm an agreement to abide by contract terms.

• **Impairment:** Attests that physical or mental impairment cannot affect ability to practice, which includes absence of chemical dependency or substance abuse.

• **Sanctions:** Must report past disciplinary action or criminal indictment. Must demonstrate an absence of Medicare or Medicaid sanctions. It must be demonstrated that sanctions outside of Medicare of Medicaid will not permit future subpar performance.

**Providers Must Disclose:**

a) All past or pending sanctions under state or other licensing agencies, hospitals, DEA, or other facilities.
b) All past or pending disciplinary or professional committee action by a healthcare entity (e.g. hospital).
c) Information regarding past suspensions, limitations, or termination from a managed care plan, hospital, or insurer.
d) Any felony convictions.

**Recredentialing**

MDwise requires all practitioners participating in the MDwise plan to be recredentialed at least every thirty-six (36) months.
Recredentialing will be similar to the initial credentialing process as a standard recredentialing application (e.g. CAQH application) will be completed and verified using recognized monitoring organizations. In addition, data obtained during the provider’s tenure in the plan will be evaluated for quality assurance or clinical effectiveness. The data regarding practice experience can take part in the peer-review committee review of a recredentialing provider. Practitioners will be notified of any discrepancies between recredentialing applications and the delivery system’s review of the information allowing them a chance of submission of additional materials to resolve the issue. After verification of materials a delivery system’s committee will comprehensively review the candidate and notify the practitioner of the decision within sixty (60) calendar days. MDwise Corporate will follow a similar process for behavioral health provider credentialing.

**Please Note:** All practitioners have the right to request information concerning the status of his/her credentialing application. This request can be made via telephone or writing by contacting the particular MDwise delivery system credentialing staff. A contact list for MDwise delivery systems can be found at our website MDwise.org/quickcontact. Information exempt from being requested includes references, recommendations, or peer-review protected information.

**Monitoring of Sanctions, Complaints & Quality Issues**

MDwise is committed to providing its members with consistent, high-quality healthcare. To maintain its commitment, ongoing monitoring of sanctions, member complaints, and quality issues is conducted by the credentialing staff. Between recredentialing cycles the credentialing staff will strive to identify any significant quality or safety issues in a timely manner so that an improvement plan can be implemented. Monitoring can include, but is not limited to reviewing Medicare or Medicaid sanctions, limitations on licensures, member complaints, and information regarding adverse events or quality issues.

**Appeals Process**

In accordance with the Health Care Quality Improvement Act of 1986, an appeals process is available to practitioners in the event that he or she should be denied participation, suspended, or terminated from the program due to a credentialing review or quality issues. At the time of notice of an adverse credentialing/recredentialing decision, the provider will be notified of the appeal rights and procedures. Except for the following reasons, termination from the program will not occur until the appeals process is exhausted by the provider or the provider chooses not to appeal in the required time period.

Providers are terminated immediately from the MDwise network, for any of the following confirmed reasons:

- Loss or surrender of license.
- Loss of sufficient liability coverage.
- Exclusion or suspension from Medicare or Medicaid program.

MDwise is responsible for reporting provider quality deficiencies that affect network participation to the appropriate state and/or federal organizations. Reportable deficiencies may be related to professional competence or conduct as well as quality of care.
Delegation Oversight

MDwise retains ultimate responsibility for maintaining that all standards of participation are consistent across all providers regardless of delegation of the credentialing/recredentialing process to subcontractors. As such, MDwise ensures that the credentialing policies, procedures, and criteria of the delivery systems meets MDwise standards through a review process such as an annual evaluation of the delegated credentialing activity (including review of credentials files). Final decision-making regarding practitioner participation will be upheld by MDwise if deemed necessary.

A central MDwise Medical Advisory Committee will review a list of practitioners sent by each respective delivery system so that suggestive input can be provided for the final consideration.

Confidentiality

In adherence to state and federal regulations MDwise and MDwise subcontractors maintain confidentiality of all information collected, developed or presented as part of the credentialing process. Credentialing files and written records of quality deficiencies and improvement plans are kept in a secure location. Access to information is restricted only to individuals that are necessary to attain credentialing process objectives. Dissemination of any confidential information shall only be made (1) where expressly required by law, or (2) with permission of the provider applicant.
Chapter Six – Claims Submission & Reimbursement
Billing, Reimbursement, and Claims Submission

Submitting a Claim
MDwise is committed to processing clean claims within 45 days for paper claims and 30 days for electronic. The claim receipt’s date is embedded in the MDwise claim number as shown on the Explanation of Payment (EOP).

A clean claim is defined as one that includes the following information:

- Full member name
- Member’s date of birth
- Full MDwise member identification number
- Date(s) of service
- Valid diagnosis code(s)
- Valid procedure code(s) and modifier codes(s) if applicable
- Valid place of service code(s)
- Charge information and units
- National provider identifier (NPI) group number
- National provider identifier (NPI) rendering provider number, when applicable
- Vendor name and address (including zip+4)
- Provider’s federal tax identification number

Claim Submission Guidelines
When using a billing agent or clearinghouse, providers are responsible for meeting all MDwise claim submission requirements.

MDwise requires the submission of all paper and electronic claims within 120 days of the date of service for in-network providers, and 180 days for non-contracted providers unless contracted differently.

EDI (Electronic) Claims

MDwise:
Medical and behavioral health claims submitted electronically are subject to the claim edits established by MDwise. MDwise Marketplace Electronic Claims Change Health/ Emdeon / WebMD Payer ID: 45627

For questions regarding electronic claims submissions, please contact MDwise Marketplace Customer Service Center at 1-855-417-5615.

Paper claims must be submitted on the proper forms either a CMS 1500 or UB-04, within the aforementioned time frames. Claim forms other than those noted above cannot be accepted. MDwise front end edits apply to both EDI and paper claim submissions.
Corrected Claims

MDwise accepts corrected claims for reconsideration. Please submit corrected claims within the 120 day filing limit for in network providers, 180 day filing limit for out of network providers. Please include the notation “Corrected Claim” on the top of the claim. Corrected facility claims can be submitted electronically however corrected professional claims must be submitted on paper.

Pharmacy - MedImpact:
MedImpact Pharmacy BIN: 003585
RxPCN: ASPRODI
MedImpact Provider Line: 1-844-336-2684
MedImpact PA Fax Line: 1-858-790-7100
Note: Please contact MedImpact directly for instructions on claim submission, corrected claims, claim status, etc.

VSP Vision Care (Child benefit on all plans, but only on select plans for adults):
VSP Customer Service: 1-855-868-4561
VSP Provider Services: 1-800-852-7600
Note: Please contact VSP directly for instructions on claim submission, corrected claims, claim status, etc.

Pended Claims Due to Non Payment of Member Premium
The ACA permits a grace period for members whose premiums are past due. The grace periods vary dependent on whether the member receives federal premium subsidies (Advanced Premium Tax Credits, also known as APTC):

- For non-subsidized members, the grace period is 30 days. This grace period shall not extend beyond the date the member’s policy terminates. Any claims incurred and submitted during the grace period will be pended by MDwise until the premium is received. If the premium is not received within the grace period, claims incurred during the grace period will be denied and the member’s coverage will automatically terminate retroactive to the last paid date of Coverage. Members will then be considered self-pay for those claims incurred during the grace period.

- For subsidized members, the grace period is 90 days. MDwise will pay all appropriate claims for services in the first month of the grace period. Any claims incurred and submitted during the latter two months of the grace period will be pended until the member becomes current on their premiums, or until the end of the grace period, whichever comes first. If payment is not received by the end of the grace period, the member’s coverage will automatically terminate retroactive to the last day of the first month of the grace period. The member will then be considered self-pay for claims incurred during the grace period.

These grace period rules make it very important for providers to check eligibility on each date of service. MDwise will indicate the member’s eligible (paid) status on our provider portal eligibility look-up tool.
Claims Inquiries

All MDwise in-network and out-of-network providers may inquire about the processing of a claim directly with MDwise and expect a timely response and an explanation of the outcome of the review process. Providers may submit claims inquiries through an online form available on MDwise.org/forms, or call MDwise Customer Service. Providers must not use the claim inquiry form to file claim disputes.

Claims research inquiries regarding administrative, coding, prior authorization, or billing issues are processed by the MDwise Claims department.

Administrative Issues:

- Eligibility Issues
- Claim not filed within filing limits
- Benefit coverage issues
- Claim sent to wrong address/payer
- Claim paid wrong amount
- Coding/billing issue (denial because of lack of modifier, NCCI edits, etc.).
- COB issues
- Identified system errors
- Prior Authorization

All claims research inquiries are logged in the Claims customer service system and tracked through resolution to ensure that processing guidelines and timeframes are maintained.

Claim Disputes

Overview

All MDwise in-network and out-of-network providers regardless of provider specialty have the right to dispute a decision or action concerning a claim and expect a timely response about the outcome of the review process. MDwise disputes are reviewed by the claims research team, not the processors of the claim.

Providers must file an objection by completing and submitting the claim dispute form and include a detailed explanation of what the provider is objecting to and why within 60 calendar days after they receive the MDwise claim adjudication. Providers must use the MDwise Dispute form and not the Claim Inquiry form to submit their dispute. The Claim Dispute form can be found at MDwise.org/forms.

Providers must send all 2016 claim disputes to:

MDwise, Inc.
P.O. Box 441423
Indianapolis, IN 46244-1423
Attn: MDwise Grievance Coordinator
Claim disputes with a date of service of 1/1/2017 or after can now be submitted via email. Providers must complete the Claim Dispute Form found at MDwise.org/For-Provider/Forms. This completed form along with all supporting documentation should be submitted securely to cdticket@mdwise.org.

The received email is routed to a Claims Dispute work queue where a ticket number will be assigned and an email notification will be sent back immediately. The Claims Dispute team will review the submitted dispute and work the cases to resolution (uphold or overturn). Once a resolution is reached, the claims payer will be notified of the need to reprocess the claim, if necessary. An email notification will then be sent to the provider, referencing the dispute and ticket number, on the resolution determination.

**Informal Claims Dispute**

**MDwise:**
The provider must file an informal claims dispute within 60 calendar days after the provider has received a MDwise determination on the claim or within 90 calendar days of when the claim was submitted to MDwise, and MDwise fails to make a determination on claims payment.

MDwise will acknowledge, in writing, the receipt of a request for a claim resolution review within 5 calendar days of receiving the dispute. MDwise will review the dispute and provide a written response to the provider. This response will be provided within 45 calendar days of the date the provider initiated the dispute. If it is determined that additional documentation is required, then the provider has 30 calendar days to submit the required documentation. If the original decision is upheld, the provider is given instructions regarding submitting a formal appeal. If the original decision is overturned, the claim will be reprocessed within 30 calendar days of the determination date.

**Formal Claims Dispute**

**MDwise:**
If a provider is not satisfied with the resolution of the informal claim dispute, they may submit a written request for the matter to be reviewed in the formal claims dispute process. The request must specify the basis of the provider’s dispute with MDwise. The provider is given 60 calendar days from the date of MDwise’s initial claims review resolution response to file a formal claims dispute. MDwise acknowledges the dispute request in writing within five (5) calendar days of receipt of the request.
Claims disputes are presented to the MDwise Dispute Panel. Individuals who have been involved in any previous consideration of the dispute cannot serve on the panel. The MDwise Medical Director or another physician designed by the Medical Director serves as a consultant to the panel if the matter involves a question of medical necessity or appropriateness. MDwise offers the provider the option of appearing before the panel or may communicate with the panel through other appropriate means (e.g. teleconference) if the provider is unable to appear in person. An attorney may represent the provider, but is not required. MDwise will issue a written reply to the provider’s dispute within 45 calendar days of receipt of the written request. If MDwise fails to deliver the panel’s written determination within 45 calendar days, this failure shall have the effect of an approval and the claim will be processed for payment within 30 business days. If the original decision regarding the claims dispute is upheld, MDwise notifies the provider of their right to submit the case to binding arbitration.

**Billing for Professional Services, Durable Medical Equipment, and Supplies**

Professional charges, as well as DME and supplies must be billed on a CMS-1500 claim form and include all pertinent and/or required information (e.g. invoice, MSRP). Missing, incomplete, or invalid information can result in claim denials.

In addition, the group and the rendering clinician’s NPI numbers are required on professional claim submissions. Claims submitted without a valid NPI number will be denied by MDwise.

**Billing for Inpatient and Outpatient Facility Services**

Institutional charges must be billed on a UB-04 claim form and include all pertinent and/or required information. Where appropriate, use valid ICD-9/ICD-10, revenue (REV), CPT and/or HCPCS, and standard three-digit type of bill codes are required on institutional claims.

MDwise requires the facility’s NPI on all institutional claim submissions. Claims submitted without a valid NPI number will be denied by MDwise.

**Itemization**

Itemization of inpatient charges is required upon request with each day of service separately reported.

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**Coordination of Benefits (COB) Guidelines**

**Coordination of Benefits**

Individuals who purchase a MDwise Marketplace health plan may have another government or private insurance policy. MDwise Marketplace coordinates benefits with other insurance policies held by members.

**Order of Benefit Rules**

If there is a basis for benefits under the member’s MDwise Marketplace plan and another Plan, MDwise Marketplace is the Secondary Plan unless (1) the other Plan has rules coordinating its benefits with those set forth by MDwise Marketplace in this document, and (2) the rules of MDwise Marketplace and the other Plan requires MDwise Marketplace to be the Primary Plan.

MDwise Marketplace will apply the following rules in the order they appear to determine whether the MDwise Marketplace health plan is primary or secondary to the other health plan based on the below:
(1) **Non-dependent or dependent**
The Plan that covers the individual as an active employee or inactive employee (i.e., laid-off or retired) rather than as a dependent is the Primary Plan except in the following situation. The Plan that covers the individual as a dependent is Primary to the Plan that covers the individual as an employee if the individual is also a Medicare beneficiary, and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is Secondary to the Plan covering the individual as a dependent and Primary to the Plan covering the individual as an employee.

(2) **Dependent Child or Parents not Separated or Divorced**
If two Plans cover the same child as a dependent of his parents, the Plan of the parent whose birthday falls earlier in a calendar year will be Primary. If both parents have the same birthday, then the Plan that has covered one parent longer will be the Primary Plan. However, if the other Plan has a rule based on gender instead of this birthday rule and, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

(3) **Dependent Child or Separated or Divorced**
If two or more Plans cover the same child as a dependent of divorced or separated parents the following rules apply unless a qualified medical child support order ("QMCSO"), as defined in ERISA, specifies otherwise:

a. the Plan of the parent with custody of the Child is Primary;

b. the Plan of the spouse of the parent with custody of the child is the next Plan to be Primary; and

c. the Plan of the parent without custody of the child is the last Plan to be Primary.

If a QMCSO states that a parent is responsible for the health care expense of a child that parent's Plan is Primary as long as the administrator of the Plan has actual knowledge of the QMCSO. The plan of the other parent is the Secondary Plan. Until the plan administrator has actual knowledge of the QMCSO, then the rules stated in (a), (b), and (c) above apply for any Claim Determination Period or Plan Year during which benefits are paid or provided.

(4) **Joint Custody**
If a court order states that a child's parents have joint custody of the child but does not specify that one parent is responsible for the health care expenses of the child, the order of benefit rules in Paragraph (2), Dependent Child or Parents not Separated or Divorced will apply.

(5) **Active or Inactive**
A Plan that covers an individual as an active employee is Primary to a Plan that covers the individual as an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(6) **Dependent of Active or Inactive Employee**
A Plan that covers an individual as a dependent of an active employee is Primary to a Plan that covers an individual as a dependent of an inactive employee (i.e., laid-off or retired). This rule
will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(7) **Continuation Coverage**
If an individual has Continuation Coverage under MDwise Marketplace and also has coverage under another Plan as an employee or dependent, the other Plan is Primary. This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(8) **Longer or Shorter Length of Coverage**
If none of the above rules determines the order of benefits, the benefits of the Plan that has covered the individual longer will be Primary to the Plan that has covered the individual for a shorter term.

**Effect on the Benefits**
Member benefits under MDwise Marketplace will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period:

1. The benefits that would be payable for the Allowable Expenses under this Contract in the absence of this coordination of benefits provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of coordination of benefits provisions like this Contract’s coordination of benefits provisions, whether or not a claim is made.

The benefits of this plan will be reduced so that the combination of this plan’s benefits and the payable benefits under the other Plans do not exceed the Allowable Expenses. Each benefit will be proportionally reduced and then charged against any applicable benefit limit of this plan.

**Facility of Payment**
If another Plan provides a benefit that should have been paid or provided under the member’s MDwise Marketplace Contract, MDwise Marketplace may reimburse the Plan for the benefit. We may then treat the amount as if it were a benefit provided under the member’s MDwise Marketplace contract and will not be responsible for providing that benefit again. This provision applies to the payment of benefits as well as to providing services. If services are provided, then MDwise Marketplace will reimburse the other Plan for the reasonable cash value of those services.

**Right of Recovery**
If MDwise Marketplace provides a benefit that exceeds the amount of benefit it should have provided under the terms of these coordination of benefits provisions, MDwise Marketplace may seek to recover the excess of the amount paid or the reasonable cash value of services provided from the following.

1. The individuals MDwise Marketplace plan have paid or for whom MDwise Marketplace plan have provided the benefit;
2. Insurance Companies; or
3. Other Organizations.

**Third-Party Liability Claims**
When a MDwise member is involved in an automobile accident, providers should make the proper notation on submitted claims.

**Workers Compensation (WC) Claims**
When a MDwise member is injured on the job, the employer’s workers compensation carrier should be billed directly for the services. Only upon denial from the workers compensation carrier will MDwise consider additional claims.

**Reconciling MDwise Explanation of Payment (EOP)**

Each EOP claim line reflects the specific service codes billed to MDwise. Denied claim lines will have corresponding “Remarks” explaining the reason for the denial.

A claim line can be denied for many reasons, including but not limited to:

- The payment submitted is included in the allowance for another service/procedure
- The service code submitted is not a covered benefit
- The member was not effective for some or all dates of service
- The time limit for filing the claim has expired
- An authorization is required and not on file

Providers with questions or concerns on the disposition of a denied claim should first validate that all reasons for the claim denial have been considered before inquiring or disputing the claim to MDwise.

Providers are strongly encouraged to reconcile the EOP timely or at least within 30 days of receipt. Requests for adjustments or corrections received beyond the 120 day timely filing limit or 60 day from the date of EOP will not be considered for reprocessing.

**Provider Reimbursement**

With the exception of an applicable copayment, coinsurance or deductible, contracted providers may not seek or accept payment from a MDwise member for any covered service rendered. Providers should look solely to MDwise for payment with respect to MDwise covered services rendered.

Furthermore, a provider may not maintain any action at law or in equity against any member to collect any sums that are owed to the provider by MDwise for any reason, up to and including MDwise failure to pay, insolvency, or otherwise breach of the terms and conditions of the MDwise Provider Agreement.

**Payment Guidelines**

MDwise’s payment guidelines are designed to help with claim submissions by promoting accurate coding and by clarifying coverage.

Updates to Payment Guidelines are announced through our quarterly e-newsletter MDwise Provider Link. To sign up, visit MDwise.org/providerlink or contact your MDwise Provider Relations Representative.
Chapter Seven – Medical Management

Medical Management

MDwise Medical Management (MM) program is established to assist both the provider and member in accessing the delivery of timely and appropriate health care within the structure of the Marketplace plan. MDwise works collaboratively with the delivery systems in the development, coordination, and evaluation of medical management activities.

The Medical Management Program components are compliant with applicable regulatory and accrediting bodies. MDwise and their delivery systems conduct medical management activities respecting the importance and obligation of maintaining the privacy, security, and confidentiality of member personal identifiable health information.

Medical Management focuses on:

- Evaluating requests for services by determining the medical necessity, appropriateness and efficiency of the requested services.
- Promoting continuity of patient care through the facilitation and coordination of patient services to ensure a smooth transition for members across the continuum of health care.
- Facilitating communication among members, families, medical providers and MDwise clinical staff.
- Analyzing utilization statistics to identify trends and opportunities for improvement.
- Reviewing, revising and developing medical coverage policies to ensure that MDwise members have appropriate access to new and emerging technologies.

Prior authorization, authorization and denial notification, and concurrent review are all elements of MDwise medical management program.

MDwise Medical Management Program emphasizes the role of primary care provider (PCP/PMP) and establishment of a medical home to provide, coordinate, or guide members to the most appropriate treatment option and place of care.

MDwise recognizes that underutilization of medically appropriate services has the potential to adversely affect our members’ health and wellness. MDwise medical management decisions are based only on appropriateness of care and service and existence of coverage. MDwise does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does MDwise provide financial incentives to MM decision makers to encourage decisions that result in underutilization.

The treating provider, in conjunction with the member or designee, is responsible for making all clinical decisions regarding the care and treatment of the member.
Delegation

MDwise may delegate medical management functions to the individual delivery systems. Medical management activities are performed by qualified health professionals, including the Medical Director, who has the knowledge and familiarity with the appropriate hospital network, primary care, specialty, and ancillary providers.

MDwise works collaboratively with its delivery systems in the development, coordination, and evaluation of medical management activities that promote efficient, fair, and consistent medical management decisions to assure that members have equitable and optimal access to covered health care services across the network.

The MDwise Medical Advisory Committee, as directed by the MDwise Quality Management Team, is delegated the responsibility for reviewing and evaluating the medical management process and performance improvement issues, coordinating and overseeing function of the medical management program including data reporting and analysis, and monitoring the utilization of health care services by MDwise members.

Integration with Quality Improvement

The MDwise Medical Management standards integrate with the Quality Improvement process in measuring, monitoring and evaluating provider practice patterns, 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 retroactive activities provide the means by which MDwise can evaluate and promote standards of care/practice guidelines, best practices parameters and outcomes on individual cases and by specific populations. Monitored data is used to develop improved medical management interventions, ensuring consistent and appropriate determinations, evaluate the effectiveness of prior authorization requirements, determining member and provider education, and case management and disease management interventions.

Requesting and Obtaining an Authorization

Quick reference guides and specific lists of services requiring prior authorization for medical review are distributed to the contracted providers by delivery system medical management staff, and can also be found at MDwise.org/for-providers/forms/prior-authorization/.

The list of services requiring prior authorization is reviewed at least annually and updated as needed. For the most up to date and comprehensive list of services requiring prior authorization providers should contact their delivery system medical management department. See the MDwise Quick Contact Guide at MDwise.org/quickcontact for contact information for each delivery system, or, call the MDwise Provider Relations department at 1-317-822-7300 ext. 5800.
Authorizations can be obtained from each delivery system by phone, fax or mail. Delivery system Medical Management contact information can be found on the MDwise Quick Contact Guide at MDwise.org/quickcontact.

**Valid Prior Authorization Requests**
A valid prior authorization request is defined as one where:

- The request is initiated by the primary care provider (PCP/PMP), treating specialist, the treating provider, or member.
- The member is enrolled with MDwise at the time of the service.
- The appropriate authorization form is completed for service requests.
- A physician prescription is included with a request for enteral formulas, infusion therapy and DME that requires authorization accompanies the request.
- Clinical documentation to support medical necessity is included in the request.

**Authorization Submission**
For specific service requirements, see Prior Authorization List and Quick Reference Guide at MDwise.org/providers.

For faxed or mailed submission physical health providers should use the MDwise Marketplace Prior Authorization Form, found on MDwise.org/providers. The MDwise Marketplace Outpatient Treatment Request Form should be used for behavioral health providers. See the MDwise delivery system quick contact list for Medical Management phone and fax numbers.

Information submitted with a 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
- other pertinent clinical information to benefit coverage determinations

**Confirmation of Requested Authorizations**
Network providers will obtain confirmation of received authorization requests and an authorization letter via fax or mail. Information provided will include the authorization identification number, authorization decision, number of days/visits, and the duration approved or denied.

Only those requests made by the requesting servicing provider may be viewed by the requesting servicing provider. All requests are assigned an authorization identification number for tracking purposes independent of the approval status. It is imperative that providers validate the status of a specific authorization request.

All authorization decisions resulting in an adverse determination are also communicated to the requesting provider by phone and in writing.
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 delivery system 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.

Medical Management Methods

Prior Authorization (Prospective Review)

Prior authorization allows for the efficient use of covered health care services and helps to ensure that members receive the most appropriate level of care in the most appropriate setting. MDwise follows federal and state regulations related to authorization of requests for second opinions, access to specialists for members with special needs, and access to women’s health specialists for female members.

Certain requested services, procedures, or admissions require prior authorization. Prior authorizations are based on medical necessity and are not a guarantee of payment. Requests for services requiring prior authorization must be submitted prior to delivery of service. Providers must request an authorization for services at least two business days prior to the scheduled service, per the IDOI (IC 27-8-17-15(a)(3).

For elective services, MDwise requires at a minimum, submission five business days prior to the admission to ensure adequate time for review and process and may take up to 14 calendar days to complete. (See “Time Frame for Decision-making and Notification.”)

Prior authorization is not required for emergency room care, post emergency room stabilization, and emergency acute inpatient admissions; if the condition being treated qualifies as an emergency medical condition. For these services, providers are to submit an authorization request within 2 business days of an emergency inpatient admission.

MDwise reviews emergency room claims that do not have a prior authorization. Medical conditions that fail to meet a prudent layperson’s definition of an emergency medical condition may be denied, and the member may be financially responsible for co-pays and claims payment.
Second Opinions
The Medical Management staff will authorize a request by a MDwise member for a second opinion from a qualified professional. Medical management will authorize a visit to an out-of-network provider at no cost to the member if the network does not include a provider who is qualified to give a second opinion.

Durable Medical Equipment (DME)
DME purchases and rentals must be requested by the member’s PCP/PMP, MDwise treating provider, or an approved vendor.

DME supply requests are submitted through to MDwise delivery systems through phone, fax or mail. The physician’s prescription and supportive documentation for the requested DME are attached to the electronic request. A valid authorization request, supportive documentation, and a physician's prescription are required before a requested service can be approved.

Providers need to submit requests including supporting information and a prescription directly to the participating vendor. MDwise staff works directly with the vendors to ensure efficient and timely filling of requests.

Authorization Decision Time Frames
Authorizations are made as expeditiously as possible but no later than the designated time frames:

- Non-urgent preservice: within 2 business days of receiving all necessary information
- Urgent preservice: within 72 hours of receiving all necessary information
- Concurrent Review: within 1 business day of receiving all necessary information
- Retrospective review: within 30 calendar days

Concurrent Review
MDwise performs concurrent review of both acute medical and behavioral facility inpatient stays and ongoing outpatient services. Concurrent review includes utilization management, discharge planning, and quality of care activities that take place during an inpatient stay, an ongoing outpatient course of treatment or ongoing home care course of treatment (for example, acute hospital, skilled nursing facilities, outpatient therapy, skilled home care, and continuous DME supplies/equipment).

Concurrent review is required for subsequent days of care or visits beyond the initial authorization. Requests for concurrent services are submitted through the appropriate delivery system. All concurrent requests must be supported by clinical documentation to determine medical necessity.

Concurrent review may be conducted by phone or fax.

Medical Management Time Frame for Decision Making and Notification
Authorizations are made as expeditiously as possible but no later than within the designated time frames.
<table>
<thead>
<tr>
<th>Request Type</th>
<th>Allowed Turnaround Time for Determination</th>
<th>Timeframes for Notification of Determination To Provider and Member or Member Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non Urgent Preservice Approval</strong></td>
<td>Within 2 business days of receiving request that includes all necessary information.</td>
<td>Within 2 business days allowed for determination.</td>
</tr>
<tr>
<td><strong>Non Urgent Preservice Resulting in Denial</strong></td>
<td>Within 2 business days of receiving request that includes all necessary information.</td>
<td>Written notification mailed to member and/or member representative, guardian or parent and to provider, (or if any party requests/agrees to receive written notification electronically, i.e. faxed) within 2 business days allowed for determination.</td>
</tr>
<tr>
<td><strong>Urgent Preservice Approval</strong></td>
<td>Within 1 business day of receipt of request that includes all necessary information, not to exceed 2 business days from receipt of request.</td>
<td>Within 1 business day of the request.</td>
</tr>
<tr>
<td><strong>Urgent Preservice Resulting in Denial</strong></td>
<td>Within 1 business day of receipt of request that includes all necessary information, not to exceed 2 business days from receipt of request.</td>
<td>Must notify member and provider how to initiate expedited appeal at time they are notified of denial. Verbal notification within 1 business day and written notification within 1 business day of the request is mailed to member (and/or member representative, guardian or parent) and to provider, or if any party requests/agrees to receive written notification electronically (i.e. faxed), provide within the 1 business day.</td>
</tr>
<tr>
<td><strong>Concurrent Review Urgent Approval</strong></td>
<td>Within 1 calendar day</td>
<td>Within 1 calendar day</td>
</tr>
<tr>
<td><strong>Concurrent Review Urgent Resulting in Denial</strong></td>
<td>Within 1 calendar day.</td>
<td>Must notify member and provider how to initiate expedited appeal at time they are notified of denial. Verbal notification within 1 calendar day and written notification within 1 calendar day of the request is mailed to member (and/or member representative, guardian or parent) and to provider, or if any party requests/agrees to receive written notification electronically (i.e. faxed), provide within the 1 calendar day.</td>
</tr>
<tr>
<td><strong>Retrospective Review</strong></td>
<td>Within 2 business days of obtaining all necessary information that falls within the 30 calendar days of receipt of the request.</td>
<td>Within 2 working days allowed for determination that falls within the 30 calendar days of receipt of the request - member written notification occurs if member held any financial risk. Provider written notification can be via EOP/EOB message</td>
</tr>
</tbody>
</table>
Emergency Services
MDwise members may seek emergency services at the nearest emergency room. Prior authorization is not required for emergency room care, post emergency room stabilization, and emergency acute inpatient admissions; if the condition being treated qualifies as an emergency medical condition. For these services, providers are to submit an authorization request within 2 business days of an emergency inpatient admission, per the IDOI (IC 27-8-17-15(a)(3)).

MDwise reviews emergency room claims that do not meet the MDwise Marketplace emergency room auto-pay list. Medical conditions that fail to meet a prudent layperson’s definition of an emergency medical condition may be denied, and the member may be financially responsible for co-pays and claims payment.

Members requiring the services of an air ambulance do not require a prior authorization. A retrospective authorization, including medical records, must be requested and submitted within 30 days of the date of service. Providers should submit the request via the Prior Authorization form and directions located at MDwise.org/for-providers/forms/prior-authorization/.

Contracted Provider Network
Contracted providers have agreed to provide covered services to MDwise members. Contracted providers are not employees, agents or representatives of MDwise.

The MDwise contracted Provider Directory is available by visiting our website at MDwise.org/providers. Customer Service Representatives are also available to help PCP/PMP offices locate a contracted provider.

Out-of-Network Authorization Request Exceptions
MDwise works with members and providers to provide continuity of care for members and to ensure uninterrupted access to medically necessary covered services. MDwise makes provisions for members to access an out-of-network provider with the same training, experience and specialization as an in-network provider for medically necessary covered services under some circumstances. Non-authorized, non-emergent out of network services will be denied.

Medical Management Decision-Making
MDwise intention is that all medical necessity decisions are made in a consistent and impartial manner. Clinical criteria and guidelines are used to facilitate fair and consistent medical necessity decisions.

Medical management evaluates nationally recognized guidelines and internally developed guidelines in the creation of criteria for evaluating the necessity of medical services. Criteria are reviewed at least annually before being approved for initial or continued use. These guidelines and criteria are developed and amended by MDwise clinicians under the direction of the Chief Medical Officer, the Medical Advisory Committee, and the delivery system Medical Affairs Oversight committee.
Medical Management decisions are based on appropriateness of care and service and health existence of healthcare coverage. Current Indiana licensed nurse reviewers and behavioral health professionals, perform the initial review of the clinical information against approved criteria. Nurse reviewers or behavioral health professional/practitioners collect and assess additional information from the provider as necessary. A physician, appropriate behavioral health specialist, clinical pharmacist, or dentist, as appropriate reviews any denial of services based on medical necessity.

The clinical guidelines are applied to individual cases, but in those instances where criteria/guidelines are not applicable to an individual’s case, the review follows the process outlined or the case is referred to the delivery system 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 with applying criteria to the care requested, along with available services in the member’s delivery system.

**Definition of Medical Necessity**
Medical necessity or medically necessary means health care services consistent with generally accepted principles of professional medical practice, as determined by whether the service/intervention is:

- The most appropriate available supply or level for the insured in question, considering potential benefits and harms to the individual.
- Known to be effective, based on scientific evidence, professional standards and expert opinion in improving health outcomes.
- For services and interventions not in widespread use, are based on scientific evidence.

**Collection of Clinical Information for MM Decision-making**
The MDwise delivery system Medical Management staff requests only that clinical information which is relevant and necessary for decision-making. MDwise uses relevant clinical information and consults with appropriate health care providers when making a medical necessity decision.

When the provided clinical information does not support an authorization for medical necessity coverage, medical management will request additional information. A decision will be made based on the available information if the treating practitioner does not respond within the time frame specified. All clinical information is collected in accordance with applicable federal and state regulations regarding the confidentiality of medical information.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), MDwise is entitled to request and receive protected health information for purposes of treatment, payment and health care operations, without the authorization of the member.

**Medical Necessity Denials**
A medical necessity denial is a decision made by MDwise to deny, terminate, modify or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care.

In the event the physician, appropriate behavioral health practitioner, or pharmacist determines the services are not medically necessary, the certification is denied.
A denial of service request may be generated if information needed to make a determination is not received within the time frame as outlined in the timeliness standards for determinations and notifications. Appeal rights apply to denials due to lack of information.

Written notifications of medical necessity denials contain the following information:

- The specific information upon which the denial was made.
- The member’s presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical necessity review criteria.
- Alternative treatment options that are available, such as having the member evaluated by a specialist or receive services in-network.
- A summary of the applicable medical necessity review criteria and applicable clinical practice guidelines.
- How the provider may contact a physician reviewer to discuss the denial.
- A description of MDwise internal appeals process, the mechanism for instituting the appeals process, expedited appeal process, and external review process.

**Administrative Denials**

Administrative denials for authorization of requested services or payment for services rendered may be made when:

- A service is explicitly excluded as a covered benefit under the member’s benefit plan.
- The requested benefit has been exhausted.
- A service was provided without obtaining the required prior authorization.
- A description of MDwise formal appeals process, the mechanism for instituting the appeals process, expedited review process, and external review process.

**Appealing Medical Necessity and Administrative Denials**

In the event there is a decision by MDwise Marketplace to issue an adverse benefit determination, the member or provider can request an internal appeal. An adverse benefit determination includes a decision to deny, reduce or terminate payment in whole or part for a benefit. MDwise Marketplace Medical Management will issue a written Notice of Adverse Benefit Determination to you and the member. This notification includes an overview of the two levels of appeals.

Appeals concerning adverse benefit determinations that may place the member’s health in serious jeopardy or may place the member in danger of failing to regain maximum function may be processed as an expedited internal appeal.

Internal appeals must be filed with MDwise within 180 days of receiving the Notice of Adverse Benefit Determination. Standard or non-expedited appeals can be requested in writing and mailed to MDwise Marketplace Medical Management at:

MDwise Marketplace  
Attn: Marketplace Medical Management  
PO Box 441099  
Indianapolis, IN 46244-1099
Non-expedited appeals will be resolved within 30 calendar days for pre-service authorization decisions and within 45 calendar days for post-service decisions (where the member has already received services).

An expedited internal appeal can be requested by calling MDwise Marketplace Medical Management at 1-855-417-5615. Expedited appeals will be resolved within 48 hours or less. If the situation is urgent and qualifies for an expedited internal appeal, you or the member may request an external review at the same time as the expedited internal appeal request.

Once the internal appeal is resolved and if the original decision is upheld, you and the member are notified in writing via the Final Internal Adverse Benefit Determination, which includes the right and process to file an external review. A written request for an external review must be initiated within 120 calendar days of receiving the Final Internal Adverse Benefit Determination letter unless it is expedited and an expedited request for external review can be submitted verbally.

Upon receipt of the written request for an external review, MDwise will forward the case file documentation and any additional documentation submitted with the internal appeal to an Independent Review Organization (IRO). The non-expedited external review will be resolved no later than 15 calendar days after receiving the request unless it is expedited and expedited external reviews will be resolved within 72 hours.

Members can be directed to MDwise Marketplace Medical Management at 1-855-417-5615 for additional directions and assistance regarding their appeal rights.

**Technology Assessment**
The Chief Medical Officer or Medical Directors are responsible for making medical necessity decisions on urgent requests for new technologies that have not been evaluated and approved by MDwise. The Medical Advisory Committee is responsible for approving new and emerging technologies.

**Care and Disease Management**
MDwise members are offered care and disease management programs where members are encouraged to actively participate in the management of their condition through disease education, self-management tools, care coordination 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. For more information see the Care and Disease Management chapter.
Chapter Eight – Quality Improvement

Quality Introduction

MDwise establishes and maintains the Quality Improvement (QI) Program, which is designed to lead to improvements in the delivery of health care and services, inclusive of both physical and behavioral health, to its members, as well as in all health plan functional areas. The MDwise quality improvement initiatives strive to achieve significant improvement over time in identified clinical care and non-clinical care service areas that are expected to have a favorable effect on health outcomes, services received and member and provider satisfaction:

- MDwise develops and implements an annual QI work plan and policies and procedures to guide implementation of the quality improvement program initiatives in accordance with the National Committee for Quality Assurance (NCQA).
- 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 both health outcomes and the delivery of health care services across the continuum of services available to MDwise members.
- 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 works collaboratively with the delivery systems in the development, coordination and evaluation of QI activities that promote the quality and safety of clinical care and service to MDwise members. The QI Program and MDwise policies and procedures and contract agreements indicate the dual involvement of MDwise Administration and the delivery systems in identifying and participating in the QI program activities and initiatives.

Confidentiality

Individuals engaged in MDwise healthcare activities maintain the privacy and confidentiality of the information with which they encounter, in accordance with HIPAA, HITECH, and other applicable laws. MDwise recognizes the importance of maintaining the privacy and confidentiality of member identifiable information, verbal or written information generated/utilized in the course of healthcare activities or associated with activities and performance of network providers, practitioners and/or facilities. All such documents will be kept confidential and in compliance with State and Federal laws and regulations, including peer review material:

- MDwise is compliant with applicable regulatory and accrediting bodies.
- MDwise is established in accordance with the Indiana Peer Review Statute and applicable state and federal regulations, including HIPAA and HITECH.
- All healthcare activities comply with MDwise policies and applicable federal and state laws and regulations related to the confidentiality of healthcare activities and reporting.
• MDwise protects the confidentiality of provider and member specific data in compliance with
MDwise and state and federal confidentiality policies.

Components of Quality Improvement Program

QI Program Responsibility
The MDwise QI Program represents a collaborative and multidisciplinary approach to coordinate
opportunities for improvement at all levels of the organization. MDwise staff, in collaboration with
participating practitioners and delivery system staff will comply with the QI process by:

• Developing, implementing, overseeing, and evaluating specific annual activities designed to
achieve the organization’s quality improvement goals and objectives.
• Reviewing and evaluating results of quality key indicators, performance measures, studies and
HEDIS results.
• Providing regular reports to MDwise management and QI Program Committees including
Quality Management Team, Medical Advisory Council and their subcommittees.
• Participating in QI Committees and subcommittee meetings and functions.
• Developing, implementing and evaluating corrective actions.
• Reviewing potential quality issues and reporting/analysis of issues.
• Incorporate improving patient safety activities into existing quality improvement initiatives.
• Completing projects within the established time frames and submitting required reports in
accordance with MDwise, State, and Federal requirements.

QI Program Scope
The overall goal of the QI Program is to demonstrate the effectiveness of meaningful improvements in
the quality and safety of clinical care and service, and administrative services delivered to MDwise
members. The scope of the program is comprehensive and includes both the monitoring and evaluation
of the delivery of clinical health care services inclusive of both physical and behavioral health in
institutional and non-institutional settings, and administrative service issues relevant to MDwise
members:

• The QI Program monitors performance and seeks opportunities for improvement across the
range of health care services available through MDwise.
• The MDwise QI Program actively involves the providers and delivery systems with emphasis on
data submission and analysis, improvement interventions, and systems change.
• Includes the integration of behavioral health and physical health care and service quality
improvement initiatives to address the medical, psychological, functional, and social needs of
members.
• Addresses the cultural and linguistic needs of members through assessment, education and
training, collaboration, outreach and communication, and actions that best meet the needs of
members.
• Addresses serving members with complex health needs by helping members regain optimum
health or improved functional capability, in the right setting and in a cost-effective manner.
QI Program Oversight

The MDwise Board of Directors has the authority, responsibility, and overall accountability for the MDwise QI Program. The Board periodically reviews MDwise QI activities, provides feedback and recommendations and approves the QI Program, Annual Work Plan and Evaluation. Responsibility for ensuring development, implementation, monitoring and evaluation of the QI Program is delegated to the MDwise Quality Management Team. Quality oversight encompasses all functional units within MDwise with individual subcommittees, teams and/or functional units providing reports to the Quality Management Team, and Executive Committee as applicable.

The MDwise Quality Management Team may establish working subcommittees. The MDwise Quality Management Team and its subcommittees are composed of practitioners and staff, with additional clinical and administrative representatives from the delivery systems, ancillary providers and community representatives, as applicable to the specific functional area. The QI Program Authority and Responsibility and Committee(s) structure, role and functions are further described in the MDwise Quality Improvement Program document.

QI Program Approach and Implementation

QI Program objectives are supported through a coordinated plan involving MDwise and delivery systems staff that include delivery system medical directors or associate medical directors, administrative staff responsible for medical management, disease management, quality improvement, member services and provider relations staff, local practitioners, pharmacists and clinicians and community health care leaders.

Delivery system staff, including the MDwise behavioral health delivery system, participates in the development and implementation of MDwise QI initiatives that are based on the needs of the MDwise delivery systems’ membership and as required by State and Federal guidelines. The MDwise Medical Director or designee coordinates and oversees relationships with the delivery systems to maximize their commitment and cooperation in meeting MDwise goals and objectives.

MDwise requires the delivery systems and participating providers to cooperate with MDwise QI activities and allow MDwise access to data and medical records to be in compliance with QI Program elements and State and Federal contract obligations. Activities shall demonstrate compliance to the MDwise QI Program components and policies and procedures and applicable regulatory and NCQA accrediting organization standards. MDwise and the delivery systems implement procedures for collecting and validating the accuracy of data related to the QI activities. Adherence to data submission requirements by delivery systems is guided by contract agreement and MDwise policy and procedures.

The Delivery Systems are required to have a process for analyzing and evaluating data provided by MDwise and taking action and/or assist in interventions to improve results/outcomes for their provider network.

The results of MDwise quality monitors and initiatives are reported through the applicable committees to the Quality Management Team Committee for comment and recommendations. The appropriate delivery system and its providers are informed of findings and recommendations, which may illustrate organization wide, delivery system and/or provider specific findings.
QI Program Activities/Initiatives

Quality study initiatives, relevant to the MDwise membership and in compliance with NCQA, Federal, and State requirements/focus studies, will be determined annually. These projects are designed to:

- Assess care and service issues.
- Include mechanisms to assess continuity and coordination of care and potential or actual underutilization and overutilization of services.
- Assess quality and appropriateness of care furnished to members with special health care needs.
- Identify areas for improvement, and achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in those identified clinical care and non-clinical care/service areas that are expected to have a favorable effect on health outcomes, service received and member satisfaction.
- Include member-targeted or PCP/PMP targeted programs that result from identified areas for improvement.
- Promote the delivery of services in a culturally competent manner to all members.
- Analyze and implement interventions based on complaint and satisfaction data.

Components of the MDwise quality improvement processes include those listed below. The MDwise QI Program components, including program documents and policies and procedures, are compliant with NCQA standards and contract requirements:

- Identification and monitoring of key clinical and service activities
- Credentialing and Recredentialing process
- Monitoring of Access and Availability of Practitioners/Providers and Services
- Medical Record Reviews
- Medical Management
- Preventive Health and Well-Care
- Continuity and Coordination of Care
- Member and Provider Satisfaction
- Member Incentive and Provider Pay for Performance Programs
- Health Information Technology and Data Sharing
- Health Management (including complex case management, disease management, and special health care needs assessment and management)
- Clinical Practice Guidelines
- Delegation and Oversight
- HEDIS Measures and reporting
- Member and Provider Customer Service
- Member Education and Outreach Programs
- Provider Education and Management Activities
- Claims Administration and Reporting
- Clinical Care and Service Safety
- Health Information Technology and data sharing
- Network Development, Practitioner/Provider contracting
- Cultural Competency training and education
Performance Monitoring and Reporting

MDwise establishes an internal system for monitoring key performance indicators and quality improvement activities, including the assessment of special needs populations and other quality measures requested by State and federal regulators. Objective, measurable quality indicators that encompass the scope of care and service provided to MDwise members are defined to provide a consistent means to evaluate internal performance and demonstrate quality of care and service to members and improvements that positively affect the quality of care and services members receive.

Performance monitors are comprehensive in the ability to assess health care delivery service activities, including but not limited to, inpatient and outpatient service utilization, emergency services, pharmacy, care management, care/case management, access, and transportation. Additionally, enrollment, provider access, customer service, member and provider complaints/disputes, grievances and appeals, financials, network development, claims administration, and member and provider service are monitored.

On a regular basis, primary care sites are provided with reports outlining their performance in areas including but not limited to:

- Emergency room utilization
- Asthma
- Diabetes
- Member satisfaction
- Cost and utilization
- Well care visits for children
- Prenatal care
- Postpartum care
- Well care visits for adults

Performance measures are reported to the MDwise Quality Committee(s) for review and recommendations, including the development of corrective action and/or performance improvement plans which may occur at various levels (for example, organization wide or delivery system or specific practice site). The Committee(s) receives periodic status reports of the performance measures, evaluates the effectiveness of interventions for improvement and recommends subsequent follow-up.

Improvement activities can occur at the MDwise corporate level or at the delivery system levels, or both, and are determined by the type of intervention planned. Best practices related to MDwise performance measures, as found in the literature and as identified by the outcome of the MDwise delivery systems’ interventions, are shared with all delivery systems and posted to the MDwise website on an ongoing basis.

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 a provider’s members are selected for medical review, representatives from MDwise will conduct a chart review to collect necessary information. One or more of a participating provider’s patients may be randomly selected for review and MDwise asks for full cooperation in collecting this important information.

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**Clinical Practice Guidelines**

The MDwise Medical Advisory Council Committee oversees the development and implementation of clinical practice guidelines consistent with current acceptable practice standards to assist MDwise practitioners and members in making medical and behavioral health care decisions:

- Clinical practice guidelines are developed for preventive health services and specific clinical circumstances (acute and chronic medical care) and behavioral health care conditions relevant to the MDwise membership and in compliance with OMPP medical care standards and practice guidelines.
- MDwise will periodically measure performance against specific aspects of a guideline. Results will be used to improve health system and practitioner performance or to improve the guidelines as applicable.

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**Preventive Health Services**

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. Please refer to Chapter 16, Preventive Health and Practice Guidelines, for further information regarding the preventive health guidelines.

MDwise Delivery Systems participate in HEDIS measures related to preventive health services. Compliance to screening and immunization schedules may be evaluated through the applicable HEDIS measures and medical record reviews.

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**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 or 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 healthcare 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 Delivery System’s 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.

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**Access to Clinical Care Services**

MDwise has responsibility for ensuring MDwise members have information and timely access to an adequate network of qualified practitioners, behavioral health providers, and specialty providers available that meet their clinical need, 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, taking into account the urgency of the need for services, will meet or exceed standards as prescribed by 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 with individual standards is measured against the assigned performance benchmark. 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.
**Primary Care Access Standards**

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

**Specialist Access**

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<thead>
<tr>
<th>Appointment Category</th>
<th>Appointment Standards</th>
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<tbody>
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<td>Emergency</td>
<td>24 hours</td>
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<tr>
<td>Urgent</td>
<td>48 hours</td>
</tr>
<tr>
<td>Non-Urgent Symptomatic</td>
<td>4 weeks</td>
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**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 PCP/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.

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

- Medical Record Review
- Facility Site Reviews
- Member Satisfaction
- Quality of Care Issues
- Accessibility
- Service Indicators
- Preventive Health Screenings/Services
- HEDIS 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 delivery system 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, Consumer Assessment of Healthcare Providers and Systems (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 also conducts an annual survey of providers to assess provider (PCP/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.

**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 across the MDwise Delivery Systems (delegates) and that the delegate 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, CMS Marketplace 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 within the individual delivery system. These activities are performed by qualified health professionals, including the Medical Director, who work within the provider’s delivery system and have the knowledge and familiarity with the provider’s hospital network, primary care, specialty and ancillary providers, as well as the MDwise population and program requirements.
Chapter Nine – Behavioral Health Care

Behavioral Health Overview

This section provides an overview of the MDwise provision of Behavioral Health Care Services. Behavioral health care services include both mental health and substance abuse services for the MDwise Marketplace. Additionally, behavioral health service codes billed by a primary care office will be paid by the plan if they are medically necessary.

MDwise will work to ensure integration of behavioral 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 communications “bridge” between PCP/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 NURSEon-call, and is staffed by behavioral health professionals with the expertise to respond appropriately to the needs of our members.

MDwise 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.

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

- Community Mental Health Centers (CMHC)
- Inpatient facilities, free standing and hospital based
- Other behavioral health professionals

All providers must have a valid NPI and be credentialed, prior to rendering services to MDwise members. Please refer to Chapter 4 for information about MDwise credentialing criteria for behavioral health providers.

Direct reimbursement is available for behavioral health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, licensed addiction counselors, psychologists endorsed as health service providers in psychology (HSPP) licensed clinical social workers, licensed marriage and family therapists, and licensed mental health counselors.

Please refer to the MDwise Marketplace Benefit Overview Chapters for information about behavioral 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 outpatient
- Psychiatric drugs included on MDwise PDL
- Laboratory and radiology services for medication regulation and diagnosis
- Screening and evaluation and diagnosis
- Neuropsychological and psychological testing
- Partial Hospitalization
- Intensive Outpatient Programs

Services that are not covered include:
- Broken or missed appointments
- Long term custodial nursing care
- Hypnosis and other experimental therapies

**PCP/PMP Referrals**

PCP/PMPs should refer members who may be in need of behavioral health services to an appropriate provider for consultation. 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 a provider is currently treating a member for such conditions as anxiety and mild depression and the symptoms persist or become worse.

Behavioral health services do not require a referral or authorization; however, PCP/PMP initiated referrals allow for better coordination of care for the member. Please visit the MDwise Provider website behavioral health link to review the behavior health practice guidelines and provider tools.

To initiate a referral to a MDwise behavioral health provider for one of their members, a provider can also access behavioral health provider information via the MDwise website at MDwise.org/marketplace/findadoctor. The provider should have the member’s ID number and date of birth available. 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 the patient’s needs.

However, if the patient is having a more serious problem the Customer Service Representative will connect the member with an appropriate professional. Please Note: If a provider has questions or concerns regarding the availability of behavioral health services for their patients, they should contact the MDwise Customer Service Line. Providers may also call the MDwise Behavioral Health Manager to discuss any concerns that they have.

**Member Referral**

MDwise does not require members to receive a “PCP/PMP referral” to use MDwise 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 member names and phone numbers of the providers to call or the Customer Service Representative will 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.

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 a provider’s members appears to be in crisis, is suicidal, or a danger to others, they should not hesitate to call 911 or send (as appropriate) to the nearest emergency room or mental health center. We want to make sure their patient gets the emergency care they need.

**Prior Authorization Requirements**

Although a member may self-refer to any MDwise contracted provider for behavioral health care services, after the initial outpatient evaluation, a limited number of outpatient sessions can be provided before authorization is required. This means that any services being rendered to the member by a behavioral health professional must have an authorization in place prior to services rendered, if the initial number of sessions is exceeded. Please refer to the Prior Authorization Quick Reference Guide on MDwise.org/providers for the list of required authorizations and number of services allowed without authorization by service type.

For contracted MDwise behavioral health providers, in addition to a 90791 or 90792 (see D.1.2.1), members can receive up to twelve (12) therapy sessions without prior authorization per billing provider. This includes CPT codes: 90832, 90834, 90837, 90846, and 90847. When appropriate, CPT code 90785, interactive complexity may be reimbursed in addition to the CPT codes outlined above but does not require a separate prior authorization as it is an add-on to the services that do require prior authorization. All other therapy visits and psychological, neurological, and developmental testing require prior authorization. All services for out-of-network providers require prior authorization.

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. Providers risk non-payment if the approved visit number is exceeded or time frame expires.

All outpatient authorizations are requested using the Behavioral Health Outpatient Treatment forms available on the MDwise website. These forms must be faxed to the appropriate MDwise delivery system. 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.

Prior authorization is also required for any intensive service, including acute inpatient, detoxification, and all substance abuse inpatient and outpatient services, partial hospitalization, and intensive outpatient programs. The provider must 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 medical management staff 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 medical management staff member’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 medical management staff reviews the service request and any previous treatment. Clinical information is received from the provider requesting services after evaluating the patient and speaking with relevant stakeholders in the member’s care. 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, medical management staff, psychiatrists and/or behavioral health specialists, and providers share member Protected Health Information (PHI) for treatment, payment, and health care operations.

Medical management staff reviews 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.

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 PCP/PMP about the services they receive.
- Identification of member cases requiring coordinated physical and behavioral health plans (e.g., through data analysis related to medical and behavioral treatment use, screening through health assessments, member or provider referrals).
- 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 behavioral health problems and primary or secondary preventive behavioral health programs.
• Collaborative disease management programs.
• Medical record audits to confirm communication among medical and behavioral health providers.

Primary care providers and Behavioral Health Care Providers, as directed through the provider 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 PCP/PMP to the extent possible, based on the Covered Person’s willingness to sign a consent to release behavioral health information, if such consent is required:

• A written summary of each Covered Person’s treatment session;
• Primary and secondary diagnoses;
• Findings from assessment;
• Medication(s) prescribed; and
• All other relevant and appropriate information, including any known Psychiatric Residential Treatment Facility services the member has received, in order to facilitate coordination of these services with the member.

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 continuity of 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 PCP/PMP
MDwise and/or the behavioral health clinician or agency actually providing the services is responsible, according to contract, for communicating with the PCP/PMP directly regarding the member’s care and treatment plan, primary and secondary diagnosis, and any medications that have been prescribed. 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.

Likewise, MDwise PCP/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. MDwise Medical Directors or physician advisors are available as resources for general discussions regarding psychiatric care or for specific case consideration to help in better managing the patient’s treatment.
Medical Records

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

Behavioral health access standards are outlined in the following table:

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>APPOINTMENT TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>Emergency Services must be available 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>Urgent – Members presenting with significant psychiatric or substance abuse history, evidence of psychosis and/or in significant distress.</td>
<td>Urgent care should 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.</td>
</tr>
<tr>
<td>Emergent – Members who have a non-life-threatening emergency</td>
<td>Emergent care should occur within 6 hours. A Care Manager will further assess and provide a referral to an appropriate level of care.</td>
</tr>
<tr>
<td>Routine – Members seeking outpatient services who present no evidence of suicidal or homicidal ideation, psychosis, and/or significant distress.</td>
<td>Routine assessments should occur within 10 business days of the request for service.</td>
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</table>
Chapter Ten – Pharmacy Services

Pharmacy & Formulary

In the MDwise Formulary, clinicians can search our database about MDwise drug coverage. A searchable formulary is available on our website, MDwise.org/providers. The formulary should be used to find the following:

- Drug coverage under a member’s plan
- Step Therapy
- Prior Authorization
- Mail order Program

We encourage providers to use the Formulary to become familiar with MDwise approved medications. MDwise formulary is regularly reviewed, evaluated and revised by our Medical Advisory Committee. The MDwise Medical Advisory Committee is composed of local practicing clinicians in the medical and pharmacy fields, representing each of the delivery systems in the MDwise network.

To ensure the most current information, please go to our website at: MDwise.org.

Prescription Drug Member Identification

MedImpact is the MDwise pharmacy benefit manager and processes all pharmacy claims on behalf of MDwise.

All MDwise Marketplace members have a pharmacy benefit. The pharmacy member identifier is the same as their MDwise Marketplace ID, which can be seen on the Member Identification Card in the “Member Information” section of this manual.

Pharmacy co-payments vary by contract and are noted on the member’s identification card.

MDwise Pharmacy Coverage

Over-the-counter Benefit
MDwise does cover several over-the-counter products. Please review the MDwise Marketplace searchable formulary to review these products.

Generic Policy
MDwise has a mandatory generic substitution policy. The generic equivalent must be dispensed when available. Multi-source brand name drugs are not covered when a clinically equivalent lower cost generic is available. Brand name medications may be covered only when a generic is not available. Brand names may also be covered over a generic when a provider has a medically necessary reason for the brand name. This situation should be resolved through the prior authorization process.
Prior Authorization:
MDwise delegates to our pharmacy benefit manager, MedImpact, clinical and administrative prior authorization responsibility. Refer to the Formulary for medications requiring prior authorization. Prescribers can request clinical reviews by calling the MedImpact Provider Contact Center at 1-844-336-2684. The clinical criteria for prior authorizations are reviewed annually by MDwise Medical Advisory Committee and are available on our website at: MDwise.org/providers.

To request a Prior Authorization by Fax, Providers may utilize the appropriate number below:
- Standard Prior Authorization: 1-858-790-7100
- Urgent Prior Authorization: 1-858-790-7100

The Form to request a Prior Authorization by Fax can be accessed on the MDwise Marketplace website.

In order to appeal any decision made by MedImpact to deny, terminate, or modify or suspend a requested health care benefit based on failure to meet medical necessity, please contact MDwise Marketplace Customer Service at 1-855-417-5615.

Step-Therapy Programs:
The step therapy programs require use of specific, lower cost, therapeutically equivalent medications within a therapeutic class before higher cost alternatives are approved. Prescriptions for “first-line” medication(s) are covered; prescriptions for “second-line” medications process automatically if the member has previously received first-line medication(s) in the past 6-12 months of MDwise enrollment. Look-back period depends upon the particular program. Providers may submit an override request to prescribe a second-line medication prior to using a first-line medication or if the member has previously failed a first-line medication outside of the drug look-back period. Submit request by calling the MedImpact Provider Contact Center at 1-844-336-2684.

Mail-Order Program
MDwise members can order a 90-day supply of certain prescription medicines at a reduced cost. Certain maintenance medications (i.e. drugs for asthma, hypertension, high cholesterol and arthritis) are available through the MedImpact Mail Service Program. MedImpact contracts with Postal Prescription Services for our Marketplace members.

Members must mail their prescription, completed Postal Prescription Service order form, and copay to Postal Prescription Services. Or they can order by phone at 1-800-552-6694.

Providers can access the Postal Prescription Services order form at MDwise.org/for-providers/forms/pharmacy.

Customer Care can be reached at 1-800-552-6694. For additional pharmacy information, including a list of preferred drugs providers can visit our website at MDwise.org/for-providers/tools-and-resources/pharmacy-resources/mdwise-marketplace/.
Chapter Eleven – Provider Relations

MDwise Marketplace Provider Relations Representative

General Information
MDwise Provider Relations serves as the liaison between the provider and member communities. Provider Relations offers providers avenues for resolving claims processing matters and conducting information maintenance activities.

Every contracted provider is assigned a dedicated Provider Relations Representative early in the contracting process, often before the provider sees his/her first MDwise patient. The Provider Relations Representative serves as the primary liaison between MDwise and our providers. Provider Relations Representatives work in partnership with MDwise delivery systems in administering contractual provisions of the MDwise Marketplace Provider Contract and/or to ensure contract compliance.

Provider Relations Representatives schedules meetings with designated staff within their provider territories to:

- Coordinate and conduct on-site training and educational programs.
- Respond to inquiries related to policies, procedures and operational issues.
- Facilitate problem resolution.
- Manage the flow of information to and from provider offices.
- Ensure contract compliance.
- Monitor performance patterns.
- Maintain day-to-day network provider enrollment and disenrollment’s.
- Market MDwise in efforts to recruit providers and develop the MDwise provider Network.
- Represents MDwise in all provider association, regional workshops/training sessions and industry tradeshows.
- Handles all provider inquiries claims and Web Portal inquiries.
- Assist in credentialing MDwise Providers within the MDwise Marketplace network.

Claims
MDwise Provider Relations will assist with inquiries about claims denials. Inquires about processing, policy, and covered services are addressed in the claims department. For more information, please see Chapter 6: Claims – above.

To assist with timely processing of inquiries, Providers should consider following these guidelines when contacting MDwise Provider Relations:

- Providers should not inquire about the status of a specific claim until at least 30 business days after submission. For general claim status inquiries, refer to the explanation of payment (EOP).
- For claims inquiries, call MDwise Marketplace Customer Service at 1-855-417-5615.
When requesting information about a claim denial, provide the following information:

- Name of person calling
- Office name
- Provider name
- Billing provider’s NPI
- Claim Number
- Member name and member identification number
- Dates of service (including specification of the claim type, such as inpatient, outpatient, medical, dental and so forth)
- Amount billed
- An outline of the question or problem

**Site Visits**

Provider Relations conducts initial site visits to make sure MDwise criteria are met and to provide education. On site reviews are also conducted for a provider who relocates or opens a new site.

**Credentialing**

MDwise utilizes delivery system credentialing for providers enrolling in the Marketplace plan. Participation is contingent upon all credentialing and recredentialing activities being completed. Providers should not provide services to MDwise Marketplace members without credentialing being authorized by the relevant MDwise Marketplace Delivery System. Providers who render services without credentialing being completed run the risk of those claims being denied.

**Provider Link**

Each quarter an electronic newsletter is sent to Providers in providing resource information regarding all aspects of MDwise.

For more information or assistance in a specific area, to request a MDwise orientation or to schedule an appointment with a MDwise Provider Relations Representative, please contact MDwise Provider Relations Department at 1-317-822-7300 ext. 5800.

**Provider Notification and Training**

The MDwise Marketplace delivery system and MDwise, Inc. provider relations department works in partnership with provider offices to build and maintain positive working relationships and respond to the needs of both providers and members. MDwise believes in keeping providers informed and so uses direct mail, clinical and administrative newsletters, and other vehicles for communicating policy or procedural changes and/or pertinent, updates and information. The provider network’s implementation
and adherence to communicated procedural changes is monitored with internal reports, provider site visits, reported member grievances, and other resources.

Providers receive a minimum of 30 days advanced notice on any changes that may affect how they do business with MDwise. Where a policy or procedure change results in modification of payments or covered services or otherwise substantially impacts network providers, notification will be made at least 60 days prior to the effective date unless mandated sooner by state or federal agencies. In addition to our administrative and clinical newsletters, MDwise Provider Newsletter is our quarterly e-newsletter for notifying our network of important changes and updates, including revisions to the MDwise Provider Payment Guidelines and the Provider Manual. Providers are strongly encouraged to sign up to receive MDwise updates by visiting the Provider section of our website at MDwise.org. Provider relations representatives incorporate provider notifications into their agenda for provider visits to reiterate MDwise provider notifications and to address any need for clarification. MDwise also hosts periodic forums for network providers, focusing on administrative and clinical topics, as well as policy and procedural changes. Providers can join these forums in person or with a “webinar” option.

Role of the MDwise Provider Relations Representative
Every contracted provider is assigned a dedicated Provider Relations Representative early in the contracting process, often before the provider sees his/her first MDwise patient. The Provider Relations Representative serves as the primary liaison between MDwise and our provider network. Provider Relations Representatives work in partnership with MDwise, Inc. and other staff in administering contractual provisions of the Provider Agreement and/or to ensure contract compliance.

Provider Relations Representatives meet regularly with designated staff within their provider territories to:

- Coordinate and conduct on-site training and educational programs
- Respond to inquiries related to policies, procedures and operational issues
- Facilitate problem resolution
- Manage the flow of information to and from provider offices
- Ensure contract compliance
- Monitor performance patterns.

For more information or assistance in a specific area, to request a MDwise orientation or to schedule an appointment with a MDwise delivery system provider relations representative, please use the provider quick contact guide at MDwise.org/quickcontact.
myMDwise Provider Web Portal

Provider Sign-Up Steps, visit MDwise.org/providers to get started!

Getting Started
Step 1: Licensing Agreement

Review and click on **Agree**

Step 2: Personal Information

Complete required fields and click on **Next**
Step 3: Provider Information

Complete the fields and click on Next

Step 4: Additional Information
Step 5: Create Username and Password

Complete required fields and click on Finish

Step 6: Verification

Verify the information entered is correct and click Finish.

After submitting you will be taken to your myMDwise home screen. This is the same screen you will see whenever you log into the myMDwise web portal.

Please note: Until your access is approved you will not be able to view eligibility and claims. Please allow up to three days for MDwise Provider Relations to process your request.
Home Page (prior to approval)

Home Page (after approval)
Eligibility and Claims Data

- Providers have access to the following portal data:
  - Member eligibility data for all MDwise Marketplace Members.
  - Member claims data for ONLY members whose claim matches the Provider’s Tax ID number.
  - Providers can add additional Tax ID’s under their Profile tab in Portal:

Claim Search Filters

- Providers can search by Claim Number, Member Identification Number (ID) and Date of Service or Group NPI and Date of Service.