Provider Frequently Asked Questions

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CLAIMS

Q: What is the filing limit for the initial claim submission?

A: Providers who are contracted with MDwise agree to submit their claims within 90 days of the date of service. Non-contracted providers must submit their claims within 365 days.

Q: Are there circumstances in which the filing limit may be waived or extended?

A: It is required that all providers file claims within the filing time limits. For contracted providers, the MDwise delivery systems will consider waiving the filing limit on a case-by-case basis. For example, if a member has a primary insurer, and the Explanation of Benefits (EOB) indicating that a service is not a covered benefit does not come in time, the contracted provider should call the claims department and explain why the claim is being filed late.

Out-of-network providers (i.e. non-contracted) have 365 days to file a contract. There are not exceptions to this.

Q: What is the process for submitting a corrected/resubmitted claim?

A: When you receive the Explanation of Benefits (EOB) from an MDwise delivery system, and the claim has been denied, or you believe the wrong amount was paid, call the claims inquiry number on the EOB to inform them of your concern. If a mistake was made, they will instruct you on how to resubmit the claim.

Q: What is the filing time limit for submitting a corrected/resubmitted claim?

A: Claims must still be submitted within the claims filing limit unless the delivery system instructs the provider otherwise.

Q: Is the established Medicaid Recipient Identification Number (RID) used to submit claims?

A: Yes. The RID number is used to submit claims. Always check eligibility each time a member presents for services to ensure that the member is eligible for services on the date of service, and, to determine what health plan to submit claims.

Q: Are providers (in-network and out-of-network) issued a separate provider identification number?

A: No.

Q: What information is necessary to process claim received by an out-of-network provider?

A: The provider should submit a W-9 form with a tax ID. The provider must also be enrolled as an IHCP provider in Indiana and possess a National Provider Identifier (NPI) (Note: The NPI is required for all IHCP providers with the exception of non traditional health care providers such as transportation).

Q: Does the plan accept claims electronically from in-network and out-of-network providers?

A: Yes.

Q: What is the plan's Payer ID?

A: MDwise operates on a "delivery system" model, and, as such each delivery system pays its own claims.

MDwise EDI Payer ID Numbers

Delivery System	Professional Claims	Institutional Claims	Family Planning Claims
MDwise Wishard	Emdeon/WebMD: SX172 McKesson/Relay Health: 4481	Emdeon/WebMD: 12K81 McKesson/Relay Health: 4976	Same
MDwise Total Health	Emdeon/WebMD: SX172 McKesson/Relay Health: 4481	Emdeon/WebMD: 12K81 McKesson/Relay Health: 4976	Same
MDwise Methodist	Emdeon/WebMD: SX172 McKesson/Relay Health: 4481	Emdeon/WebMD: 12K81 McKesson/Relay Health: 4976	Same
MDwise SHN	Emdeon/WebMD 64157 RelayHealth/McKesson: 1761	Emdeon/WebMD 64157 RelayHealth/McKesson: 1761	Emdeon/WebMD: Institutional: 12K81 Professional: SX172 McKesson/Relay Health Institutional: 4976 Professional: 4481
MDwise St. Vincent	Emdeon/WebMD: 35199 RelayHealth/MCKesson: 2235	Emdeon/WebMD: 35199 RelayHealth/MCKesson: 2235	Emdeon/WebMD: Institutional: 12K81 Professional: SX172 McKesson/Relay Health Institutional: 4976 Professional: 4481
MDwise Hoosier Alliance	EDI Payor ID 20475	EDI Payor ID 20475	Emdeon/WebMD: Institutional: 12K81 Professional: SX172 McKesson/Relay Health Institutional: 4976 Professional: 4481

MDwise St. Catherine	Emdeon: 35199 RelayHealth/MCKesson: 2235	Emdeon: 35199 RelayHealth/MCKesson: 2235	Emdeon/WebMD: Institutional: 12K81 Professional: SX172 McKesson/Relay Health Institutional: 4976 Professional: 4481
MDwise St. Margaret Mercy	Emdeon: 35199 RelayHealth/McKesson: 2235	Emdeon: 35199 RelayHealth/McKesson: 2235	Emdeon/WebMD: Institutional: 12K81 Professional: SX172 McKesson/Relay Health Institutional: 4976 Professional: 4481

Please Note: MDwise St. Francis and MDwise ProHealth will no longer participate with MDwise effective January 1, 2011. In order to complete the claim runout for these two delivery systems, claims for MDwise St. Francis and MDwise ProHealth members for dates of service **PRIOR** to January 1, 2011 must be submitted MDwise St. Francis and MDwise ProHealth for adjudication. Providers must use the tables below to complete their claim runout with these delivery systems. Please contact the delivery system for claim questions.

MDwise St. Francis

Department	**Contact Information**
Claim Inquiries	317-596-7827 or 1-866-427-3197
Medical Management/Prior Authorization Phone	317-570-6816 or 1-800-2914140
Medical Management/Prior Authorization Fax	317-570-6818
Provider Representative	317-782-6553
Claim Department Address	MDwise St. Francis P.O. Box 502090 Indianapolis, IN 46250
Electronic Claims Payor ID	Emdeon/WebMD: 35199 RelayHealth/McKesson: 2235
Family Planning Claim Address	MDwise Family Planning Claims P.O. Box 68970 Indianapolis, IN 46268-0970 Ph. 317-871-8814
Family Planning Electronic Claims Payor ID	Emdeon/WebMD: Institutional: 12K81 Professional: SX172 McKesson/Relay Health Institutional: 4976 Professional: 4481

MDwise ProHealth

Department	Contact Information
Claim Inquiries	317-621-7565 or 1-800-344-8672
Medical Management/Prior Authorization Phone	317-621-7546 or 1-800-344-8672
Medical Management/Prior Authorization Fax	317-621-7984
Provider Representative	317-621-7581
Claims Department Address	MDwise ProHealth P.O. Box 50407 Indianapolis, IN 46250
Electronic Claims ID Payor ID	NEIC 35161

Any questions that you might have regarding the Electronic Payer ID will need to be directed to the Individual Claims Payers and you may access the phone numbers from the MDwise Quick Contact Sheet or the MDwise website MDwise.org.

Q: What Fields are required on the paper claim forms?

A: CMS 1500 (08-05) – Follow same guidelines as fee-for-service (IHCP Provider Manual, chapter 8), with following exceptions:

Form Field 14 – "Date of Current Illness" – Required for payment of pregnancy-related services
Form Field 23 – "Prior Authorization Number" – Required
Form Field 25 – Federal Tax ID Number is required
Form Field 33a – Billing provider NPI

UB 92 – Follow same rules as fee-for-service (IHCP Provider Manual, chapter 8), with these exceptions:

Form Field 5 – Federal Tax ID is required
Form Field 5 – Federal Tax ID is required
Form Field 56 – Pay to NPI
Form Field 57 – "Due from Patient" – not applicable to MDwise patients
Form Field 63a – 63c – Treatment Authorization Codes" – Required by MDwise
Present on Admission or POA unless exempt provider

ELIGIBILITY

Q: Describe how providers should verify eligibility for plan members.

A: The HP Web interChange, the Omni swipe card device, and AVR are the best ways to check member eligibility. It is strongly recommended that member eligibility be checked each time the member presents for services.

Q: How does a provider (in-network and out-of-network) obtain member benefit limitation information?

A: The HP Web interChange will provide this information. Also, a provider can call the claims inquiry number for the MDwise delivery system that the member is enrolled in to see if there has been a claim for a service (e.g. self-referral service). However, this is not a guarantee that the member has not used their benefit limit. The information is based on adjudicated claims data and when a provider calls to ask about whether a member has used up their benefits, there could be a claim on the way or yet to be filed by the provider who rendered the service.

APPEALS/GRIEVANCES

Q: If a claim is denied and the provider disagrees with the denial what is the process for resolution (refile claim, grievance, appeal, etc.)?

A. All MDwise in-network and out-of-network providers 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 provides that persons not involved in making the original decision resulting in the claims dispute or appeal shall review the issue or concern.

MDwise has two tracks for claims dispute resolution, depending on whether the provider has a contact with a delivery system within the MDwise Plan network (In-MDwise network provider) or whether the provider does not hold a contract with a MDwise delivery system (Out-of-MDwise network provider). The two processes are outlined below.

In-MDwise Network Provider Claims Disputes

In-MDwise network providers file a claims dispute directly with the delivery system that the claim was submitted to for payment. Providers should contact the applicable delivery system for information about how to submit a dispute. Claims disputes occurring between a provider and the provider's own delivery system are resolved entirely at the delivery system level.

If however, the dispute is between an MDwise provider and an MDwise delivery system other than the one the provider is affiliated with **and** the provider is not satisfied with the delivery system decision on the disputed claim, the provider may appeal the delivery system determination to MDwise for review. The provider has **60 calendar days** from the date of delivery system claims review resolution response to file an appeal.

Providers may file the objection using the MDwise Provider Claims Dispute Form located at MDwise.org, or send a notice of the dispute, including a detailed explanation of what the provider is objecting to and why. A provider may submit this notice to:

MDwise
Attn: MDwise Grievance Coordinator
1200 Madison Ave., Suite 400
Indianapolis, IN 46225

MDwise will review the dispute and issues a response to the provider within **30 calendar days**. If the in-MDwise network provider is not satisfied with the decision and the dispute does not concern a technical issue (e.g., member not eligible on date of service, claim submitted outside filing limits, etc.), the provider may request review by an Independent Review Organization (IRO) that is certified by the Indiana Department of Insurance.

The provider is given **60 calendar days** from the date of MDwise's claims review resolution response to file and appeal for IRO review. MDwise will issue a written response to the provider appeal within **45 calendar days** of receipt of the request. If the IRO upholds the delivery system determination on the disputed claim, then the provider must pay the IRO reviewer fee. If the IRO overturns the decision on the disputed claims, the fee shall be paid by the delivery system, not the provider.

Out-of-MDwise Network Provider Claims Dispute

An informal claims dispute resolution review precedes the formal claims resolution process. A provider may initiate the informal claims resolution procedure if:

- An informal claims dispute resolution review precedes the formal claims resolution process for Out-of-MDwise network providers.

A provider may initiate the informal claims resolution procedure if:

- The provider objects to a MDwise delivery system's decision regarding payment for a claim, including the payment amount **Or**
- The provider objects to an MDwise delivery system's determination that a claim lacks sufficient supporting information, records or other materials.

A provider may also initiate the informal dispute resolution process if MDwise does not notify the provider of a claims determination (or that claim submitted lacked sufficient documentation) within 30 days of submitting the claim.

Informal Claims Resolution Procedure

The provider must file an informal claims dispute within **60 calendar days** after the provider has received an MDwise delivery system determination on the claim or within **90 calendar days** of when the claim was submitted to MDwise if an MDwise delivery system fails to make a determination on claims payment. Providers may file the objection using the MDwise Provider Claims Dispute Form, or send a notice of the dispute, including an explanation of what the provider is objecting to and why. Providers may send this notice to:

MDwise
Attn: MDwise Grievance Coordinator
1200 Madison Ave., Suite 400
Indianapolis, IN 46225

MDwise will acknowledge, either verbally or 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 response to the provider. This response will be provided within **30 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 Resolution Procedures (Appeal)

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 and appeal. MDwise acknowledges the appeal request in writing within five (5) calendar days of receipt of the request.

Claims appeals are presented to the MDwise Appeal Panel. Individuals who have been involved in any previous consideration of the dispute at issue 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. The provider may appear 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 appeal 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 immediately. If the original decision regarding the claims dispute is upheld, MDwise notifies the provider of their right to submit the case to binding arbitration.

Binding Arbitration

The binding arbitration procedure is conducted according to the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the State of Indiana (IC 34-57-2) unless MDwise and the provider mutually agree to some other binding resolution procedure. A provider may include in a single arbitration proceeding matters from multiple claims that are being disputed through the MDwise appeals process. The non-prevailing party pays the fees and expenses of arbitration.

Primary Medical Providers (PMPs)

Q: What is the process when a member wishes to switch to another PMP within the same plan?

A: According to State policy, an MDwise member may change their PMP within MDwise at any time and for any reason. If an MDwise member wishes to change their PMP, they are first instructed to contact the MDwise Customer Service Line. The MDwise Customer Service Line is 1-(800) 356-1204 or (317) 630- 2831 (Indianapolis area only).

Q: What is the process when a member wishes to switch to another PMP in a different plan?

A: MDwise may process requests for PMP changes **only** if the member wishes to remain with MDwise and selects another MDwise PMP. If the member wants to select a PMP in a different managed care entity (MCE) outside of the member's open enrollment period, the member must file a grievance with MDwise and allow us to attempt to resolve any concerns the member has. Members have the right to file a grievance either in writing or orally within 60 calendar days of the occurrence of the matter that is the subject of the grievance. MDwise will acknowledge receipt of the grievance within three (3) business days and make a decision on a non-expedited grievance within 20 business days of receipt of the grievance (Please note that an extension of ten (10) business days may be allowed if resolution of the matter requires additional time. Members will be notified of the extension in writing). If the member remains dissatisfied, the member can contact Maximus (1-800-889-9949) to request disenrollment. The member must show a just cause reason for wishing to disenroll from their current MCE. Examples of just cause include lack of access to medically necessary services, member's PMP leaves MDwise to enroll with another health plan or lack of access to providers with experience in treating the member's health care needs. Maximus will review each member MCE disenrollment request and make a final disenrollment decision.

Q: How does a provider increase or decrease the panel size with the plan?

A: To increase or decrease a panel size, a PMP must submit a signed letter to their delivery system provider representative requesting that their panel size be changed. The provider representative will forward the letter and a panel change form to the MDwise Corporate office that will enter the change into the provider database and send the request to HP. HP will make the change in Indiana*AIM*.

Q: How does a provider terminate a member from his/her panel?

A: MDwise would like to assist providers in fostering good relationships with their MDwise members. However, MDwise realizes that there are times when reassignment of a member may be necessary. If this occurs, providers **must**

contact their delivery system provider representative for assistance. MDwise would like to help solve the problem first before having to reassign the member to another provider. To assist with this, there is a form called the "Provider Request for Member Intervention and Education" on the MDwise website. This form **MUST** be filled out as completely as possible. Specially trained staff will attempt to work with the member to resolve the issues. If reassignment is necessary, there is another form on the MDwise website that must be completed and sent to the delivery system provider representative.

The following, developed and finalized by the Hoosier Healthwise Quality Improvement Committee, provides guidelines for approving PMP initiated requests for member reassignment to a different PMP.

Missed appointments – A member may miss at least three scheduled appointments within the last twelve-month period (12) without defensible reasons before a PMP may request for member reassignment. A defensible reason can be defined as a legitimate reason or circumstance (such as unforeseen problems with transportation or the inability to leave work as anticipated) that the member provides that also did not allow the member to notify the PMP's office in advance of the cancellation.

The PMP office should make contact with the member after the first missed appointment to advise them that continued missed appointments are a legitimate reason for requesting a reassignment. The PMP's office must note in the chart, missed appointment details including any contact with the member and the reasons for missed appointment.

If a member has missed two or more appointments, the provider may complete a *Request for Member Intervention or Education Form* (www.mdwise.org) and fax this form to their provider relations representative. An MDwise Member Advocate will then attempt to contact member to provide additional program education regarding missed appointments.

Upon documentation of the third missed appointment for no defensible reasons, MDwise may approve the PMP's request for the member's reassignment within the MCO network.

Member fraud – To use this reason for member reassignment, the provider must refer the case to MDwise for submission to the IHCP Surveillance and Utilization Review (SUR) Unit, so that Indiana Family and Social Services Administration (IFSSA) may investigate the alleged fraud (e.g. drug seeking behavior).

Threatening, abusive, or hostile actions by members – The PMP may request a member reassignment when a member or a member's family displayed actions or behavior towards the PMP or office staff was clearly threatening, abusive, or hostile and attempts at conflict resolution have failed. The PMP or office staff must document the specific actions or behavior in the member's chart and provide that documentation with the reassignment request. The request must be consistent with the PMP's office policies and criteria used to request reassignment of commercial patients.

Before requesting a member reassignment regarding threatening, abusive or hostile behavior, the provider should complete a *Request for Member Intervention or Education Form* (www.mdwise.org) and fax this form to their delivery system provider relations representative. An MDwise Member Advocate will then attempt to contact member to provide education on being more cooperative and acting appropriately in future interactions with a PMP or office staff.

Member's medical needs will be better met by another PMP – A PMP may request that a member be reassigned because he or she feels the member's medical needs would be better handled by another PMP, because of the PMP's proficiencies and/or focus or practice. The PMP must provide documentation on the member's condition along with its severity. MDwise will review the documentation and make a decision based on the disease or severity of a medical condition rather than on a specific patient basis. An example may be a pregnant MDwise member who is assigned to an OB/GYN, however would be better served by an OB/GYN that specializes in high-risk pregnancy. Another example is a member with diabetes that is assigned to a PMP that does not have the expertise and/or supporting programs that a diabetic member may benefit from.

Breakdown of physician/patient relationship – The PMP must provide specific documentation as to the reasons he or she feels the relationship has broken down and cannot be salvaged. The member should also have an opportunity to

share their views on the relationship. MDwise is required to conduct an upper level review to ensure the breakdown in the relationship is mutual between the PMP and the member.

Member accessing care from other than the selected or assigned PMP – A PMP may request a member reassignment when the member consistently seeks primary medical care from another PMP and the member does not request a PMP change. The PMP should make an effort to contact the member to determine why the member is seeking care elsewhere. The PMP should provide documentation of his or her efforts to contact and educate the member.

Misuse of the emergency room is not a valid reason for requesting a member's reassignment. Reassignments will not be approved by OMPP for this reason.

Previously approved termination – The PMP may request a member's reassignment if the member was previously reassigned for an approved reason and became re-linked through error or the auto-assignment process. A request will also be approved if the member is inadvertently placed with another physician within the same practice. A request may also be approved if the PMP had previously received approval for a reassignment but the member's eligibility ended before the reassignment could be completed.

It is expected that most of these situations will be resolved by facilitating the member's selection of another PMP within the same delivery system. Maximus, FSSA's enrollment broker, must authorize provider or MDwise-initiated PMP changes that result in a member's disenrollment from the network.

Previous termination from practice prior to becoming a Hoosier Healthwise member - A PMP may request reassignment for a member who was terminated from his or her practice before the member became eligible for Hoosier Healthwise. Any reason may be accepted with appropriate documentation. The PMP must provide documentation such as a copy of the dated letter terminating the patient. The date must not be within the effective time period of Hoosier Healthwise eligibility.

It is expected that most of these situations will be resolved by facilitating the member's selection of another PMP within the same delivery system. Maximus must authorize provider or MDwise-initiated PMP changes that result in a member's disenrollment from the network.

THIRD PARTY LIABILITY

Q: Will your plan utilize the third party liability data from the HP computer system or will you obtain third party information from other sources?

A: MDwise delivery system claims payers do use the TPL data obtained from the HP's Indiana*AIM* System. In addition, the delivery system claims payers also learn about other coverage through the claims payment process, through interactions with providers, review of emergency room claims data, member interviews, hospital admissions, etc. It is the policy at MDwise for the delivery systems to forward any information regarding other insurance coverage to MDwise. This information is then forwarded to HP so that it can be placed in the Indiana*AIM* System.

Q: If the third party liability information in Indiana*AIM* is different than the information in your system, how should the provider proceed?

A: Call the delivery system's payer. The claims inquiry numbers can be found on the Quick Reference Sheet or on the MDwise website at MDwise.org. Since the IHCP is the payer of last resort by law, providers are responsible for obtaining insurance coverage information from members at the time service is provided. When a provider determines that a member has an available TPL resource, the provider is required to bill that resource before billing MDwise. If a member has other coverage, this information must then be provided in the applicable sections of the claim forms (e.g. fields 11 a–d on CMS 1500).

Q: If the third party liability data is not sufficient for the other insurer to adjudicate the claim and provide a written payment or denial to the provider how can the provider resolve this with your plan to obtain payment?

A: Providers are responsible for obtaining insurance coverage information from members at the time service is provided. When a provider determines that a member has an available TPL resource, the provider is required to bill that resource before billing MDwise. If for some reason, the third party does not adjudicate the claim, then you may call and/or submit the information from the other party to the applicable MDwise delivery system. MDwise delivery system claims payers, however will work with contracted providers on a case-by-case basis to attempt to resolve the issue. Providers must provide documentation of efforts employed to communicate with the primary insurer. Providers should call the claims inquiry number for the delivery system that the member is enrolled.

When a third-party insurance carrier fails to respond within 90 days of the provider's billing date, the claim can be submitted to the MDwise Delivery System for payment consideration. However, one of the following must accompany a claim to substantiate attempts to bill the third party or the claim will be denied:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Provider must note the date of the billing attempt and the words **no response after 90 days** on an attachment. This information must be clearly indicated.
- Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days from the billing date. The provider is required to boldly make a note of the following on the attachment:
    - Date of the filing attempt
    - The words ***no response after 90 days***
    - Member identification number (RID) & Provider's National Provider Identifier (NPI)
    - Name of primary insurance carrier billed
- For claims filed electronically, the following must be documented in the claim note segment of the 837P transaction:
    - Date of the filing attempt
    - The phrase, "no response after 90 days"
    - The member's identification (RID) number & IHCP provider number
    - Name of primary insurance carrier billed

Q: If the member's primary insurer provides payment to the member instead of the provider, how does the provider obtain secondary payment from your plan?

A: When a provider has proof that an MDwise member received reimbursement from an insurance carrier, the provider should follow these steps:

- Contact the insurance carrier and advise them that payment was made to the member in error. Request a correction and reimbursement to be made to the provider.
- If unsuccessful, contracted providers should contact the delivery system claims payer to inform them of the problem. MDwise delivery system claims payers will work with contracted providers on a case-by-case basis to attempt to resolve the issue. Providers must provide documentation of efforts employed to communicate with the primary insurer.
- In future visits with the MDwise member, the provider should request that the member sign an assignment of benefits authorization form. The form states the member authorizes the insurance carrier to reimburse the provider.

Q: If the provider has submitted a claim to the member's primary insurance and has not received a response, what is the process to obtain payment from you plan?

A: When a third-party insurance carrier fails to respond within 90 days of the provider's billing date, the claim can be submitted to the MDwise Delivery System for payment consideration. However, one of the following must accompany a claim to substantiate attempts to bill the third party or the claim will be denied:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Provider must note the date of the billing attempt and the words no response after 90 days on an attachment. This information must be clearly indicated.
- Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days from the billing date. The provider is required to boldly make a note of the following on the attachment:
    - Date of the filing attempt
    - The words *no response after 90 days*
    - Member identification number (RID) & Provider's National Provider Identifier (NPI)
    - Name of primary insurance carrier billed
- For claims filed electronically, the following must be documented in the claim note segment of the 837P transaction:
    - Date of the filing attempt
    - The phrase, "no response after 90 days"
    - The member's identification (RID) number & IHCP provider number
    - Name of primary insurance carrier billed

Q: Are providers required to submit claims to the plan that have been paid in full by the member's primary insurance?

A: Yes. MDwise uses the information from the claim for our Reach Out for Quality program and for calculating our HEDIS rates. This information is also used by the State to track utilization and for setting future Medicaid rates for managed care. These claims should be submitted just like actual claims, but show the amount paid by the primary insurer. MDwise recommends all PMPs participating across all MDwise Programs follow this guidance for appropriate tracking of the delivery of HEDIS recommended preventative services to its membership.

Q: What is the process for submitting prenatal care, delivery, and postpartum care claims when the member is covered by primary care insurance? The primary insurer generally requires the global OB code and historically Medicaid has required these services to be unbundled.

A: There are services that CMS states are exempt from third party liability cost avoidance requirements. For the Hoosier Healthwise program, these include pregnancy care, prenatal care and preventive pediatric care (EPSDT). Providers who render these exempted services are still permitted, but not required, to bill available third party resources. Claims for these services are identified by the diagnostic codes identified below, and bypass the normal cost-avoidance process.

MDwise

The following diagnoses codes must be primary on a *UB-92* or *837I,* or listed as the first diagnosis code on a *CMS-1500* or *837P*.

Prenatal Care	**Preventive Pediatric Care**
V22.0	V01.0-V01.9
V22.1	V02.0-V02.9
V23.0-V23.9	V03.0-V06.9
V28.0-V28.9	V07.0-V07.9
V23.0-V23.9	
V28.0-V28.9	
Pregnancy Related Diagnosis Codes**	V72.0-V72.3
**Claims with the following diagnosis codes are first paid as long as the fifth digit of the diagnosis code is 3 such as 640.03.	V73.0-V75.9
640	V77.0-V77.7
630-648.9	V78.2-V78.3
650.0	V79.2-V79.3
651.0-658.9	V79.8
671.0-671.9	V82.3-V82.4
673.0-673.8	
675.0-676.9	

***** Diagnosis codes for which MDwise first pays provider and then seeks payment from liable third party

Secondly, MDwise follows the IHCP claims filing requirements and procedures. A provider is required to file claims in the manner specified by IHCP, even though a primary insurer may require a different process. In this case, the provider would have to contact the primary insurer to determine what the postnatal charges would have been and then distribute the remainder to the prenatal and pregnancy charges. The EOB from the primary insurer should accompany the claim.

MDwise is responsible for the costs incurred by the member with respect to care and services which are included in MDwise's capitation rate, but which are not covered or payable under the health or casualty insurer's plan. When it is determined that MDwise is a secondary payer, the MDwise delivery systems shall reduce claims payment so that the total benefits paid or provided by all payers during a claim determination period are not more than 100% of the total Medicaid allowable expenses. Savings are calculated by subtracting the amount that a delivery system paid as a secondary payer from the amount it would have paid had it been primary.

Q: How does a provider obtain reimbursement from the plan if a non-custodial parent holds the primary insurance on the member but is unable or unwilling to provide the coverage information to the provider?

A: According to State and Federal regulation, Medicaid and thus, MDwise, is the payer of last resort. This means that if an MDwise member has any other resources available to pay for, or help pay for, the cost of his or her medical care, that resource must be used before any payment by MDwise. If a member refuses to provide this information, you can call MDwise Customer Service and they will attempt to work with the member to get this information.

In a case where coverage is held by a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider has not received payment from the third party payer within 30 calendar days after the date of service, MDwise must first pay the provider and then coordinate with the liable third party.

Q: Describe the appropriate procedures for filing a claim that is past the filing limit because of a delay caused by the member's primary insurance.

A: When a provider determines that a member has an available TPL resource, the provider is required to bill that resource before billing MDwise. If a member has other TPL resources and the provider submits a claim to MDwise without documentation that the third party resource was billed, federal regulations require that the claim be denied. When a claim is cost avoided, the provider must bill the appropriate third party. If, for any reason, that source denies payment or pays less than MDwise would have paid, the provider can resubmit the claim to MDwise. The time-filing limit begins when the provider receives notification form the primary insurer.

REFERRALS/AUTHORIZATIONS

Q: What services require a referral from a PMP?

A: Referrals for certain specialty care services, certain ancillary services procedures and equipment, out-of-network/out-of-area providers, continuity of care, second opinions, specialty access for members with special health care needs and women's health specialist access, must originate with the PMP and be submitted prior to the member receiving the service. Such referrals may also be requested by a participating specialty care provider or other specialty care provider as noted in an existing authorization with the PMP approval. Many services provided within the delivery system network of contracted providers do not require a referral. In addition, those specific "self-referral" services under the Hoosier Healthwise program do not require a referral or authorization.

Q: Describe the referral process.

A: In-network providers should call the delivery system medical management department to see what services require a referral. Out-of-network (non-contracted) will always require a referral authorization, unless the provider is a "self-referral" provider. Out-of-network providers can call the MDwise Customer Service Line and ask to be connected with the appropriate medical management department. The Customer Service Line number is (800) 356-1204 or (317) 630-2831 (Indianapolis area only).

Q: What services require prior authorization (PA) from the plan?

A: Typically, selected services for PA include the services listed below. Because Hoosier Healthwise and Healthy Indiana Plan are risk based managed care programs, MDwise may elect to require PA for services in its benefits offering that typically does not require PA in Traditional Medicaid. The list is not all-inclusive and updates are made to the list as deemed necessary. Please contact the member's MDwise delivery system's medical management department or visit MDwise's website at MDwise.org for the latest list and for any questions you may have regarding prior authorization procedures. See the MDwise Quick Reference Sheet for the phone numbers for each delivery system, or, call the MDwise Customer Service Line at (800) 356-1204 or (317) 630-2831 (Indianapolis area only). Medical providers must use the new OMPP mandated Universal PA form located at www.indianamedicaid.com for medical services which require PA. Behavioral health providers must continue to use the Outpatient Therapy Request form located at MDwise.org for outpatient behavioral health services that require PA. In general, providers can expect the following services to require PA:

- Out-of-network providers or services
- Inpatient admissions
- Observation stays
- Outpatient Services/Procedures including the following:
    - Speech, Physical and Occupational Therapy services
    - Pain management
    - Home Health services
    - Certain diagnostic testing, for example MRI
- Surgical services including the following:
    - Cochlear implant
    - Bariatric surgery
    - Reduction mammoplasty
    - Reconstructive or plastic surgery
- Durable Medical Equipment (DME) over a determined dollar amount (call med management)
- Transplants
- Other specific services including oxygen, enteral nutritional products, hearing aids, augmentation communication devices
- Assistant surgeons
- Transportation services (if over 50 miles or out-of-state and in excess of 20 one-way trips per calendar year)
- Designated pharmaceuticals (see PDL at MDwise.org)
- Facility and anesthesia fees for dental procedures performed in an outpatient setting

Certain routine laboratory, radiology and medical services do not require authorization and are paid automatically if obtained and processed within the network. A detailed list is maintained by the medical management staff from each delivery system and available to providers.

MDwise follows Indiana Administrative Code (IAC) and IHCP policies regarding MDwise members accessing self-referral services including emergency services without an MDwise PMP referral authorization and the covered services and prior authorization requirements and limitations in reviewing self-referral services.

Q: How does an Out-of –Network provider obtain a prior authorization?

A: In the MDwise system, prior authorization is handled by the delivery system to which the patient's doctor belongs. This information can be found by checking the member's IHCP eligibility on the HP web interchange, the Omni swipe machine or the AVR. Out-of-network providers can call the MDwise Customer Service Department at (800) 356-1204

or (317) 630-2831 to be connected with the proper medical management staff. Non-contracted providers must use the appropriate PA form as described in the previous question and answer section.

Q: What is the turn-around time for prior authorization requests?

A: MDwise establishes timeliness standards for medical management decisions and notification of decisions and monitors performance in meeting the standards. The timeliness standards are based on NCQA standards, Indiana Department of Insurance requirements for Utilization Review Agent Licensure as indicated in IC 27-8 and OMPP requirements. As per the Indiana Department of Insurance, within (2) business days of receiving all *information necessary* to complete the requested utilization review determination, the member and/or provider will be notified of the determination either orally, in writing, or electronically.

Q: How is continuity of care referrals/authorizations handled?

A: The medical management departments for each MDwise delivery system implements procedures to provide authorizations for continued access to necessary care and assist in transitioning the care as needed for the MDwise members that are assigned to their specific delivery system. The following types of situations provide the opportunity for the member to continue with current medically necessary care:

- MDwise must honor the previous health plan's service authorizations and scheduled covered services that were not completed for a member prior to transferring from another plan into MDwise, for a maximum of 30 calendar days from the effective date of enrollment. This authorization extends to any service or procedure previously authorized within the Hoosier Healthwise program, including but not limited to physician services, pharmacy, a specific procedure such as surgery, or for ongoing procedures or services authorized for a specified duration such as therapies or home health care.
- MDwise members with chronic or acute illness undergoing active treatment provided by the member's current PMP, specialists, ancillary providers or by hospitals prior to member changing to a new MDwise PMP may access continued medically necessary care up through a minimum of 30 days. (Active Treatment for the purpose of this reference to continuity of care is referred to such treatment that if discontinued, the member could experience a reoccurrence or worsening of the condition.
- Authorization for continuation of active treatment past 30 days may be approved as appropriate to the member's individual situation. A transition plan and coordination and continuity of care responsibilities are implemented according to procedure for those newly enrolled MDwise members undergoing active treatment from an out-of-network/delivery system PMP and members changing delivery systems within MDwise.
- For members with behavioral health care needs who are transitioning from another health plan to MDwise, collaboration and follow-up with the member's existing medical and behavioral healthcare providers or community based provider including when applicable CMHC, MRO, or PRFT care managers, is begun immediately to ensure that treatment plans and pertinent medical/behavioral information are transferred in a timely manner. An appropriate behavioral health case manager is identified to whom daily contact regarding the member's care can be communicated and coordinated.
- Women in the third trimester of pregnancy at the time they become a MDwise member may access continued medically necessary care for prenatal, delivery and postpartum care from their previous physicians.

In-network providers should call the delivery system medical management department for the delivery system that the member is assigned. Out-of-network providers can call the MDwise Customer Service Line and ask to be connected with the appropriate medical management department. The Customer Service Line number is (800) 356-1204 or (317) 630-2831 (Indianapolis area only).

MDwise

BEHAVIORAL HEALTH

Q: Please describe the plan's behavioral health coverage.

A: MDwise covers behavioral health benefits in accordance with State requirements and OMPP guidelines. Coverage guidelines are included in the table below.

MDwise (Hoosier Healthwise) Program Behavioral Health Benefit Packages

	Package A	**Package B**	**Package C**
Population	**Children, Pregnant women and low-income families (TANF)**	**Pregnant Women Only**	**CHIP**
Age	All ages	All ages	0 through 18 years of age
Deductibles	$0.00	$0.00	$0.00
Co pays	$0.00	$0.00	$0.00
Inpatient Mental Health and Substance Abuse Services (Prior approval required)	Coverage is available for medically necessary inpatient psychiatric services in an acute care hospital and in a freestanding psychiatric facility to members under 21 years of age. (or if the member had begun receiving services immediately before their 21st birthday). Inpatient services provided in a freestanding psychiatric facility to a member between 22 and 65 years of age are covered only if the facility has 16 beds or less.	Coverage is limited to pregnancy (including post-partum services), as well as conditions that may complicate the pregnancy or emergent/urgent care services.	Coverage is available for medically necessary inpatient psychiatric services in an acute care hospital. Inpatient mental health services in a freestanding psychiatric facility are only covered for Package C members when provided in an institution for mental diseases with less than 16 beds.

	Package A	Package B	Package C
Population	**Children, Pregnant women and low-income families (TANF)**	**Pregnant Women Only**	**CHIP**
Mental Health and Substance Abuse Outpatient Services	Coverage includes medically necessary mental health services (including laboratory, radiology, and facility charges) provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology (HSPP). Coverage is also available for physician or HSPP directed outpatient mental health services to certain midlevel practitioners. *Members can self-refer to in-network providers without authorization. The first visit is automatically paid. However, additional sessions will require prior authorization. Out-of-network benefits are only available to members seeking services with a psychiatrist, unless continuity of care provisions apply, or if prior authorized (see following exception), or if services not available from in-network provider. Services provided by an out-of-network psychiatrist do not require a prior authorization for the first 20 visits, per rolling 12-month period. All services after 20 visits require prior authorization.* Non-covered services include biofeedback, broken or missed appointments, day care, and hypnosis.	Coverage is limited to pregnancy (including post-partum services), as well as conditions that may complicate the pregnancy or emergent/urgent care services.	Coverage includes medically necessary mental health services (including laboratory, radiology, and facility charges) provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology (HSPP). Coverage is also available for physician or HSPP directed outpatient mental health services to certain midlevel practitioners. Office visits limited to a maximum of 50 per a rolling 12 months per member per year. *Members can self-refer to in-network providers without authorization. The first visit is automatically paid. However, additional sessions will require prior authorization. Out-of-network benefits are only available to members seeking services with a psychiatrist, unless continuity of care provisions apply, or if prior authorized (see following exception), or if services not available from in-network provider. Services provided by an out of network psychiatrist do not require a prior authorization for the first 20 visits, per rolling 12-month period. All services after 20 visits require prior authorization.* Non-covered services include biofeedback, broken or missed appointments, day care, and hypnosis.

	Package A	Package B	Package C
Population	**Children, Pregnant women and low-income families (TANF)**	**Pregnant Women Only**	**CHIP**
Out-of-State services	Acute behavioral health services only. Emergency services are also covered as outlined below.	Coverage is limited to pregnancy (including post-partum services), as well as conditions that may complicate the pregnancy or urgent care services. Emergency services are also covered as outlined below.	Acute behavioral health services only. Emergency services are also covered as outlined below.
Emergency services ***Covered by MDwise delivery system– except for psychiatric evaluation by a behavioral health provider or if ER visit results in emergency admission***	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.

	Package A	Package B	Package C
Population	**Children, Pregnant women and low-income families (TANF)**	**Pregnant Women Only**	**CHIP**
Emergency Admissions	Available for reimbursement only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms as outlined in 405, IAC 5-20-6.	*Coverage is limited to pregnancy (including post-partum services), as well as conditions that may complicate the pregnancy or emergent/urgent care services.*	Available for reimbursement only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms as outlined in 405, IAC 5-20-6
Home Health **Services for mental illness/substance abuse diagnosis** (*405 IAC 5-16*)	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.
Nursing Facility **Services for mental illness/substance abuse diagnosis.** **(Long-term)** (405 IAC 5-31-1, IHCP Provider Manual, Chapter 14)	MCO may be responsible for payment up to 60 days pending and prior to level of care determination. Member must be disenrolled from Hoosier Healthwise managed care before benefit can begin. Requires pre-admission screening for level of care determination. Coverage includes room and board; nursing care; medical supplies; durable medical equipment; and transportation.	Non-covered services.	Non-covered services.

	Package A	Package B	Package C
Population	**Children, Pregnant women and low-income families (TANF)**	**Pregnant Women Only**	**CHIP**
Nursing Facility **Services for mental illness/substance abuse diagnosis.** **(Short-term)** (405 IAC 5-31-1)	The MCO may obtain services for its members in a nursing facility setting on a short-term basis - 30 days maximum. This may occur if setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. Refer to Nursing Facility Services (Long-term) above for description of covered services pending a level of care determination.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	The MCO may obtain services for its members in a nursing facility setting on a short-term basis - 30 days maximum. This may occur if setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility.

MDwise Coverage Exclusions:

- State Psychiatric hospital admissions
- Psychiatric Residential Treatment Services (PRTF), Effective January 1, 2011, Hoosier Healthwise (HHW) members receiving PRTF services will be disenrolled from HHW and moved to fee-for-service while in the PRTF. To facilitate appropriate claims payment, a level of care will be established for members receiving PRTF services. PRFT providers will need to contact ADVANTAGE Health SolutionsSM (800-269-5720) when they have an HHW member who is going to be admitted, so ADVANTAGE can assign a level of care. Once the level of care is assigned, the member will be disenrolled from HHW. Upon discharge from the PRTF, the PRTF should notify ADVANTAGE so the member will be re-enrolled immediately into the most applicable IHCP program.
- Service for the Mentally retarded
- MRO Services – Codes: H0002; H0004-HW, -HS, -HR or –HQ; H0031-HW; H0033-HW; H0035-HW; H0040 HW; H2011-HW; H2014-HW; T01016-HW or –TG; 97535-HW or –HQ; 97537-HW or –HQ (all services for SPMI and DD members). Services are rendered through the CMHC, however requires care coordination for members receiving MRO services.
- Case Management for SPMI/DD members is covered by Community Mental Health Centers.
- MRO Services are NOT available for members in Package C or the Healthy Indiana Plan

Note: All Providers must possess an Indiana Medicaid ID Number or IHCP Number, including out-of-state providers.

Q: How are behavioral health services billed?

A: MDwise provides and coordinates behavioral and medical health services for MDwise members in Hoosier Healthwise. Reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as health services providers in psychology (HSPP). Covered services provided by other midlevel practitioners (i.e. certified social workers, substance abuse counselors, certified clinical social workers, psychiatric nurses, independent practice school psychologists and advanced practice nurses credentialed in psychiatric or mental health nursing) are reimbursed,

however a physician or HSPP must direct the services. Services rendered by a mid-level practitioner must be billed using the rendering provider number of the supervising practitioner and the billing provider number of the outpatient mental health clinic or facility. All providers must have a valid IHCP number and be credentialed by MDwise prior to rendering services to MDwise members.

Charges for outpatient services should be submitted on a CMS 1500 claim form. Charges for inpatient services and facility charges should be submitted on a UB 92 claim form. All claims should be authorized and submitted to the member's delivery system identified on the eligibility verification system (i.e. web interChange, OMNI, or automated voice response system) the provider verifies eligibility.

Q: How are behavioral health services defined for the purposes of the plan, by primary diagnosis code or procedure code?

A: Behavioral health services are defined by a combination of diagnosis code and provider type.

GENERAL

Q: If a member self refers to an out-of-network physician and this is not discovered until the date of service, what process should the out-of-network physician follow?

A: In general, all out-of-network providers, except providers of "self-referral" services require PA before a service is rendered. Providers should check the member's IHCP eligibility to determine if the member is eligible for services, and, if so, what MDwise delivery system the member is enrolled in. The provider should call the medical management department of the appropriate delivery system to get authorization to provide services. This can be done by calling the MDwise Customer Service Line at (800) 356-1204 or (317) 630-2831 (Indianapolis area only).

If the PA is denied, inform the member that MDwise has denied the service at this location and inform them to call the MDwise Customer Service Line for assistance in locating an in-network provider. If the member insists on being treated, you can have them sign a waiver letter and then, they can be billed for the service. If a member chooses to receive a service that is not covered under the Hoosier Healthwise program or not authorized by MDwise, the provider must obtain a patient waiver that meets the following requirements:

- Must include member's signed statement accepting financial responsibility for the services.
- The waiver is signed only after the member is given the appropriate notification that the service is not covered and why.
- The waiver must list the specific services that fall under the waiver's application, the date the services were rendered and the cost for the services.
- The waiver may not contain any language or condition to the effect that if authorization is denied after the service is rendered, the member is responsible for payment.

Q: Does the plan allow payment to an in-network or out-of-network provider for a screening exam in the emergency room?

A: MDwise will cover emergency services, which are provided to evaluate or stabilize emergency medical conditions, whether provided by an in or out-of-network provider. According to Indiana statute (IC 12-15-12-0.7), emergency services are defined as covered inpatient and outpatient services that are provided by a provider qualified to furnish emergency services, and that are necessary to evaluate or stabilize an emergency medical condition. IC 12-15-12-0.3 defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the woman or her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

MDwise refers to this as a "prudent layperson" standard.

Q: How should a provider identify the provision of an emergency service provided in a place other than the emergency room?

A: These are unusual cases and most times providers would refer patients to the ER. MDwise would handle these instances on a case-by-case basis. Providers should call the medical management department of the delivery system that the member is enrolled to inform them of the situation. The numbers for the medical management departments can be found on the Quick Reference Sheet, MDwise.org, or by calling the Customer Service line at (800) 356-1204.

Q: How are newborn claims billed?

A: When a MDwise member gives birth, the newborn will also be covered under the MDwise plan. MDwise is responsible for medically necessary services from in-network and out-of-network providers for up to 30 days or until IHCP eligibility can be verified in the Indiana*AIM* database. Claims cannot be submitted until the newborn's RID number can be verified in the HP Web interhange, the Omni swipe device or AVR. Once eligibility has been verified in Indiana*AIM*, prior authorization must be obtained in order for services from out-of-network providers to be covered. When a newborn has a RID number, claims should be submitted to the delivery system that the member is assigned to.

An MDwise member can select a MDwise PMP for her child prior to giving birth. She is not able to pre-select a PMP in another plan. Once the RID number is in the Indiana*AIM* database, this linkage will be made by the system. After the MDwise mom gives birth and the newborn is assigned a RID number, the mother has 90 days to choose another plan for the baby if she so desires.

Q: Please describe any claim requirements for billing family planning services for Package A and Package B members.

A: Family Planning is a self-referral service for members in Hoosier Healthwise. Members can receive services from any family planning provider who is enrolled in the IHCP. Providers must include an appropriate primary diagnosis code and procedure code to be reimbursed for family planning services. If both codes are not included, MDwise claims payers will deny the claim with explanation that both ICD-9 code and procedure code must be present to process the claim.

Some MDwise delivery systems do not pay family planning claims due to moral objections. Family planning claims for members in these delivery systems must be sent to a different payer. Please refer to the Quick Reference Sheet on the MDwise website for this information.

Contraceptive pills, devices, and supplies, including Norplant, **that have NDCs** must be billed by physicians and family planning clinics using the appropriate NDC and the NDC description. Services and supplies **without an NDC** can be billed using the CMS-1500 or 837P claim form. These services must be billed using appropriate CPT and HCPCS codes and appropriate ICD-9 CM diagnoses for services provided or conditions treated.

When using CPT code 99070 for supplies dispensed during a family planning visit, the name of the ***item*** dispensed and ***BCP*** (birth control pill or patch) or ***STD*** (sexually transmitted disease) **must** be identified below the line item being billed on the CMS-1500 or 837P claim form. The quantity (number of packages) dispensed must be identified in field 24G. The amount billed must reflect the appropriate cost of the contraceptive item and must not exceed the NDC packaging price. CPT code 99070 may not be substituted if a HCPCS II code exists for the item dispensed (e.g. Appropriate A code must be used for condoms and foams/jellies, J code for vaginal ring or patch).

According to the IHCP Provider Manual and federal policy, initial STD diagnosis and treatment, **if** provided during

family planning encounters, are considered part of family planning services. Therefore, initial STD diagnosis and treatment services provided by a **family planning provider** (not member's PMP) may be denied if such services were not provided during a family planning visit.

Ongoing follow-up of STDs and visits for treatment of chronic STDs are not considered part of family planning services and should be provided, as necessary, by the member's PMP. If a family planning provider diagnoses a sexually transmitted disease in a member and subsequently initiates treatment, the family planning provider must refer the patient back to the PMP. At that time, the PMP will determine whether further treatment is medically necessary. If additional treatment is required, the PMP may either continue treatment at the PMP site or authorization may be obtained for the family planning provider to do so.

According to *405 IAC 5-28-7,* sterilization can be reimbursed only when a consent form accompanies the claim connected with the service for both men and women. A sterilization form is **not necessary** when a patient is rendered sterile because of an illness or injury. The physician must attach a certification to the claim indicating that the sterilization occurred due to an illness or injury when prior acknowledgement was not possible. At least 30 days but not more than 180 days must pass following the date the informed consent is given and the date the sterilization procedure is performed. The exception to this policy is for premature delivery or emergency abdominal surgery: (Premature delivery is defined as labor before 37 weeks gestation.) In these situations, informed consent must be signed 72 hours before the sterilization. The physician must indicate the reason for the surgery being performed early and the individual's expected date of delivery.

Q: Are there any specific forms required by the plan?

A: MDwise has a number of forms, all of which can be found on the MDwise website at MDwise.org. They include:

- Standardized Prior Authorization form for medical services
- Standardized OTR form for behavioral health services
- Standardized enrollment form for PMPs and Specialists
- Claims Dispute form
- MDwise Provider Forms:
    - Full Panel Add Request
    - Hold Panel Add Request
    - PMP Change/Pre-Birth Selection – English and Spanish
    - Provider Request for Member Reassignment
    - Request for Member Intervention or Education
    - Doctor/Patient Agreement and Guide for completion
    - MDwise OB-Only PMPs
- Hoosier Healthwise Forms:
    - RBMC Primary Medical Provider Disenrollment without Reenrollment
    - RBMC Primary Medical Provider Disenrollment with Reenrollment
    - RBMC Primary Medical Provider Panel Limit and Panel Hold

Q: Please provide a brief overview of the credentialing process.

A: The MDwise delivery systems are responsible for credentialing and recredentialing all of their contracted practitioners (including non-physician practitioners). The exceptions to this policy include:

- Practitioners who practice exclusively within the inpatient setting and provide care for MDwise members only as a result of members being directed to the hospital or other inpatient setting (e.g. pathologists, radiologists, emergency room physicians, etc)
- Practitioners who practice exclusively within freestanding facilities and who provide care for MDwise members

only because of members being directed to the facility (e.g. urgent care centers, surgi-centers, etc.)
- Pharmacists who work for a pharmacy benefits management organization
- Practitioners who do not care for members in a treatment setting (e.g. board-certified consultants)
- Covering practitioners (e.g. locum tenums)

MDwise follows the credentialing standards established by the National Committee on Quality Assurance (NCQA). Practitioners must complete a standard credentialing application when applying for initial or continued participation in a MDwise delivery system. Participating practitioners are re-credentialed at least every thirty-six months. Between re-credentialing cycles, a process is implemented for the ongoing monitoring of practitioner sanctions, member complaints and quality issues.

Provisional credentialing status may be granted to a practitioner who is applying to the MDwise network for the first time. Provisional status may only be granted in accordance with verification requirements and can only be granted one time and cannot be granted longer than sixty (60) days.

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

In the credentialing/re-credentialing process, the following credentials information is obtained and verified from primary sources:

(1) License to practice
(2) Hospital admitting privileges
(3) DEA Certificate
(4) Malpractice insurance
(5) Professional liability claims history
(6) Board Certification or highest level of medical training

All of the above information must be current when presented to the peer review committee. Practitioner information is requested directly from recognized monitoring organizations including the National Practitioner Data Bank (NPDB) and the appropriate State Licensing Board.

All MDwise practitioners must also be enrolled as providers in the Indiana Health Coverage Programs (IHCP).

All practitioners must be notified of the organizations credentialing/re-credentialing decisions within sixty (60) calendar days of the peer-review committee's decision.

Please Note: *In the MDwise Plan, the credentialing and re-credentialing of providers is delegated to the MDwise delivery systems. A provider will be credentialed for initial and ongoing participation in the MDwise Plan by the delivery system they are contracted with. A provider should contact their delivery system provider relations representative if they have questions about the delivery system's credentialing process.*

Q: Does the plan credential non-physician practitioners such as nurse practitioners and physicians?

A: Yes, if included in the MDwise Provider Directory or if MDwise directs its members to see a specific practitioner then, Advanced Practice Nurses (Nurse Practitioner, Certified Nurse Midwife, Clinical Nurse Specialist) and Physician Assistants must demonstrate as part of the application process that he/she meets the credentialing criteria.

Q: Does the plan follow established guidelines for billing a Medicaid member, as outlined on page 4–35 of the *Indiana Health Coverage Programs Provider Manual*?

A: Yes