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

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

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

We will always give you at least 30 calendar days advance notice of any significant change that may affect your office practice or procedures. A significant change in practice is determined by the impact of the policy on such issues as coverage criteria, authorization procedures, referral policies, subcontractors, provider office site standards, medical record standards, or access standards. Notice of all significant changes are also posted on the MDwise website.

If you have questions, concerns, or complaints, you are encouraged to call your delivery system provider relations representative directly at the telephone numbers listed on the Directory. Or, you can always call the toll-free MDwise Customer Service line. MDwise Customer Service Representatives (CSRs) are available Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Standard Time. After regular business hours, MDwise contracts with a telephone answering service who are trained to respond to most provider issues that arise after hours. For instance, the after hours service handles many urgent pharmacy issues. If the answering service representative is unable to respond to a provider call, information is forwarded to a MDwise Customer Service Representative to address the following business day.

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

If you have any questions about the content of this manual, please contact MDwise Customer Service or your MDwise Healthy Indiana Plan provider relations representative.
MDwise is a not-for-profit corporation that began its operation in 1994, when it was established as the Central Indiana Managed Care Organization, Inc. (CIMCO). It was formed specifically to help several major Indianapolis hospitals and their affiliated physicians deliver a provider-directed, cost-effective approach to managed care services for Hoosier Healthwise members. It became the fastest growing organization providing risk-based managed care for Hoosier Healthwise in central Indiana.

In 2001, CIMCO teamed up with IU Health Plan (IUHP), and organized its affiliated providers under a new name, MDwise. In its first year, MDwise providers, through one of the three MDwise delivery systems, served more than 55,000 Hoosier Healthwise members, of which, over eighty-five percent are infants, children, and teenagers. During 2002 and 2003, MDwise expanded into Lake, Porter and LaPorte counties and reached another milestone, with membership topping 100,000 lives. At the close of 2006, MDwise acquired and merged with IU Health Plan, Inc., leaving MDwise as the sole surviving entity to now operate our Healthy Maintenance Organization (HMO) business as a non-profit entity. Today, MDwise continues to grow in membership, serving more than 315,000 members statewide.

In June 2007, MDwise was selected to enter into negotiations with the State of Indiana to serve as a Care Management Organization for the Indiana Care Select Program. Indiana Care Select is 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 can better be addressed by creating an environment that help them organize, make sense of, and navigate the overall health care system. The lack of well-coordinated care plans, multiple comorbidities, and a multitude of psychosocial challenges, dictate we provide a proactive, holistic and all-inclusive care management model, blending disease management, member education/outreach, and care management into one comprehensive program. Our approach involves:

- Comprehensive assessment of member’s medical, social, psychological and functional needs, based on predictive risk modeling, assessment(s), claims history, prior authorization and other records
- Implementation of individual care plans that connect members with evidence-based medical and behavioral health care and increase the members' self-management skills to optimize health status
- Individualized sets of interventions based on unique member needs, led by a variety of “high touch” and “low touch” care plan tasks and interventions
- Coordination of care among medical and other service providers through a multidisciplinary team approach to develop and monitor the member’s plan of care and progress in meeting goals
- Active involvement of member/family/patient advocates at each step of care management process

MDwise is excited to enter into a new endeavor with the State, while continuing to provide high quality health care to Indiana residents.

In August 2007, MDwise was selected to begin negotiations to serve as an insurance provider for the Healthy Indiana Plan. Under the Program, the State of Indiana contracts with statewide, risk-bearing entities 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.

MDwise maintains high community visibility, through ongoing local and statewide involvement as a Hoosier Healthwise resource, both at the legislative and regulatory level as well as the grassroots community level. MDwise focuses exclusively on Indiana Medicaid recipients in the Hoosier Healthwise, Healthy Indiana
Plan and Care Select programs, and is the only locally owned and operated non-profit plan in the State to do so.

MDwise serves its Hoosier Healthwise and Healthy Indiana Plan (HIP) members under a “delivery system model,” as opposed to a model where the managed care entity (MCE) contracts individually with providers. The basis of this model is the localization of health care around a group of providers. These organizations, called “delivery systems” within the MDwise network, are typically comprised of hospital, primary care, specialty care, and ancillary providers who are closely related either in ownership or shared missions. Supplementing these delivery systems are networks for pharmacy services and member transportation that serve members across all delivery systems within MDwise.

Current MDwise delivery system providers for the Hoosier Healthwise and HIP programs include:

- MDwise Methodist Delivery System (Indianapolis Area)
- MDwise Wishard Delivery System (Indianapolis Area)
- MDwise St. Vincent (Indianapolis Area)
- MDwise Saint Margaret Mercy (Hammond, Dyer, Michigan City)
- MDwise Select Health Network (South Bend, Mishawaka, Plymouth)
- MDwise St. Catherine (East Chicago, Munster, Hobart and Portage)
- MDwise Hoosier Alliance (Statewide)
- MDwise Total Care (Fort Wayne area)

MDWISE MISSION

The MDwise Plan is 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 client satisfaction and lower total health care costs by improving the health status of members through the most efficient provision of quality health care services.

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 missions:

- Delivering consistent, high quality care.
- Focusing on families and community in a culturally competent way.
- Shaping health policy and promoting innovation in Medicaid managed care.
- Ensuring financial viability through efficient and cost effective operations.
- Involving providers in key decision making and nurturing local governance of the MDwise product.
Maximizing value in health service delivery includes a focus on quality and access and ultimately depends on the collaborative relationships between the managed care entity, providers and well-informed members. In delivering Hoosier Healthwise, Care Select, and Healthy Indiana Plan services across the full healthcare continuum, a primary focus of MDwise is to link primary care physicians, specialists, hospitals and ancillary providers so all providers can administer and coordinate care more efficiently and effectively.

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

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

MDWISE DEDICATION TO QUALITY

MDwise being a “Medicaid only” plan understands the uniqueness of the underserved and have developed our programs with full attention to guiding quality health care services to the Indiana population. MDwise’s Hoosier Healthwise product line has earned NCQA New Health Plan (NHP) Accreditation. The NHP Accreditation evaluates how well a new health plan manages all parts of its delivery system to continuously improve health care for its members. MDwise will work hard everyday with our providers to help deliver high-quality health care services to our members.
Chapter 2 – Overview of MDwise Programs

On January 1, 2000, the Indiana Medical Assistance Programs were renamed the Indiana Health Coverage programs (IHCP). Hoosier Healthwise, Care Select, Traditional Medicaid, the 590 Program and the Healthy Indiana Program (HIP) are all part of the Indiana Health Coverage Programs.

MDwise participates in the Hoosier Healthwise, HIP and Care Select Programs. The following is an overview of MDwise’s Hoosier Healthwise and HIP Programs. A detailed overview of Care Select can be found in the MDwise Care Select Provider Manual.

The Hoosier Healthwise Program Overview

In 1994, the State of Indiana implemented Hoosier Healthwise, a mandatory managed care program for eligible Medicaid recipients including children, low-income families and pregnant women. OMPP phased in the program and by July 1997, the program was Statewide.

MDwise participates in Hoosier Healthwise, which is Risk-Based Managed Care (RBMC). MDwise receives a capitated rate for members. Under Hoosier Healthwise, Primary Medical Providers (PMPs) are responsible for coordinating all medical care for the members who are assigned to them. Members select a PMP and are then enrolled in the network or managed care plan, chosen by their PMP.

Hoosier Healthwise is designed to meet the following goals:

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

RISK-BASED MANAGED CARE (RBMC)

In the risk-based managed care system, OMPP pays contracted managed care entities (MCEs) a capitated monthly premium for each Hoosier Healthwise member in the MCE’s network. The capitated premium is designed to cover the cost of care and services provided to members in the MCE’s network.

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

For the period January 1, 2011, to December 31, 2014, OMPP has contracted with the following RBMC plans: MDwise, Managed Health Services (MHS), and Anthem. All contracts are statewide.

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

- Family practice
- General practice
- Internal medicine
- Obstetrics/Gynecology
- Pediatrics
The Hoosier Healthwise program provides coverage to children, pregnant women and low-income families. Hoosier Healthwise benefit packages include Packages A, B, C and P.

**Please Note:** Only Packages A, B, C, and P are included in Hoosier Healthwise RBMC. Package E members should never be assigned to a RBMC doctor. If this happens, please call MDwise Customer Service Department at (317) 630-2831 or 1-800-356-1204.

**HOOSIER HEALTHWISE BENEFIT PACKAGES**

**Package A – Standard Plan.** Full coverage for children, low-income families, and some pregnant women.

**Package B – Pregnancy Coverage Only.** Pregnancy-related and emergent/urgent care services for some pregnant women. Pregnancy coverage includes: delivery, family planning services, pharmacy, prenatal and postpartum care, transportation, and treatment of conditions that may complicate the pregnancy. A condition that may complicate the pregnancy is defined as a condition manifesting itself by symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in a deterioration of the patient’s condition or a need for a higher level of care. Following termination of the pregnancy, eligibility begins on the last day of pregnancy and extends through the end of the month in which the last day of the 60-day period ends.

**Package C – Children’s Health Plan.** Preventive, primary, and acute care services for some children ages 19 and under. To be eligible, a child must meet the following criteria:

- The child must be younger than 19 years old.
- The child’s family income must be between 150 and 200 percent of the federal poverty level.
- The child must not have credible health insurance at any time during the three-month period prior to applying for the Hoosier Healthwise program.
- The child’s family must satisfy all cost-sharing requirements.

A child determined eligible for Package C is made conditionally eligible pending a premium payment. The child’s family must pay a monthly premium. Enrollment continues as long as premium payments are received and the child continues to meet the other eligibility requirements. Enrollment is terminated for nonpayment of premiums after a 60-day grace period.

**Package P – Presumptive Eligibility.** Ambulatory prenatal services for some pregnant females. Presumptive Eligibility (PE) is a program that offers temporary coverage of prenatal care services to pregnant women while their Medicaid applications are pending. Ambulatory prenatal care services are defined as outpatient services related to pregnancy including prenatal care services and services related to other conditions that may complicate the pregnancy. Package P does not cover the delivery or inpatient hospital care. To be eligible for presumptive eligibility, a pregnant woman must meet the following eligibility requirements.

- Be pregnant, as verified by a professionally administered pregnancy test
- Not be a current Medicaid member
- Be an Indiana resident
- Be a U.S. citizen or qualified noncitizen
- Not be currently incarcerated
- Have gross family income less than 200 percent of the federal poverty level

The Office of Medicaid Policy and Planning (OMPP) and the Children’s Health Insurance Program (CHIP) work together to set policy for Hoosier Healthwise. The Indiana requirements for the administration of the Medicaid program enacted by the Indiana legislatures are contained in the Indiana Code (IC) and the Indiana Administrative Code (IAC).

The State contracts with a state enrollment broker called Maximus to employ Benefit Advocates who educate and enroll members in the managed care program.
Healthy Indiana Plan (HIP) Overview

The health care coverage plan established under House Bill 1678 (the “Program”) extends health care coverage to certain low-income, uninsured Hoosiers without access to employer sponsored health insurance. The Program represents a groundbreaking attempt to expand coverage while encouraging individuals to take a more proactive role in managing their health and the cost of their health care.

THE PLAN PROVIDES:

- A POWER Account valued at $1,100 per adult to pay for medical costs. Contributions to the account are made by the State and each participant (based on ability to pay). No participant will pay more than 5% of his/her gross family income on the plan.
- A basic commercial benefits package once annual medical cost exceed $1,100.
- Coverage for preventive services up to $500 a year at no cost to participants.

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

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

The Healthy Indiana Plan will provide health insurance for uninsured adult Hoosiers between 19-64 whose household income is between 22 - 200% of the federal poverty level (FPL), who are not eligible for Medicaid. Unlike many other government-sponsored programs, both parental adults and childless adults can participate. Eligible participants must be uninsured for at least 6 months and cannot be eligible for employer-sponsored health insurance. Consolidation of Benefits in Retirement Act (COBRA) coverage is not subject to the six-month provision. If a person has exhausted COBRA benefits, they do not need to wait six months to participate in HIP

The HIP program is not an entitlement program. The number of people who can enroll in the Healthy Indiana Plan is entirely dependent upon available funding. Eligibility will be on a first-come, first-served basis.

HIP requires each participant to make a financial contribution to their coverage. There is a sliding scale for individual contributions (based on % of gross family income):

- 0-100% FPL: 2% contribution
- 101%-125% FPL: 3% contribution
- 126%-150% FPL: 4% contribution
- 151%-200% FPL: 4.5% contribution for parental adults
- 151%-200% FPL: 5% contribution for childless adults

There are no co-pays in the program except for ER use. If all age, sex and pre-existing condition appropriate preventive services are completed, all (State and individual) remaining POWER Account funds will rollover to offset the following year’s contribution. If preventive services are not completed, only the individual’s prorated contribution (not the State’s) to the account rolls over.
If a woman becomes pregnant while on HIP, she will be given an opportunity to switch to Package B of Hoosier Healthwise, and all her pregnancy related medical services will be covered by Package B. Should she elect to remain in HIP, the pregnancy related services are considered non-covered services and she will be required to pay for those services out-of-pocket. Once she chooses to be placed in Hoosier Healthwise Package B, she will be removed from HIP, and she will receive a prorated balance of her POWER account. Following her pregnancy, she may enroll back in the HIP plan. The plan she chooses will be responsible for helping her make the switches to assure seamless coverage.

Uninsured individuals with incomes above 200% FPL may “buy-in” to HIP. Buy-in individuals must be uninsured for at least six months, and cannot have access to health insurance through their employer. The rates will be based on age, sex, and health status, with the participant paying the full cost. Also, if there is a waiting list for HIP, individuals on the waiting list may use buy-in option.

**ENHANCED SERVICES PLAN**

Enhanced Services Plan (ESP) is a special plan for some HIP enrollees with certain high risk medical conditions. The ESP will be administered by the Indiana Comprehensive Health Insurance Association (ICHIA). Applicants will be screened for complex medical conditions such as cancer, HIV/AIDS, hemophilia transplants, and aplastic anemia. Questionnaires will be sent to medical professionals to validate the high risk conditions and qualify members. HIP enrollees, who qualify, will be assigned to ESP. The ESP will provide all HIP benefits in addition to comprehensive disease management services. Affiliated Computer Services (ACS) will process medical claims for the ESP.

**Indiana Care Select Program**

MDwise was awarded a contract to administer a care management program that combined care management and managed care practices by the Office of Medicaid Policy and Planning (OMPP) in order to serve vulnerable Hoosier member populations such as the aged, blind, and disabled. MDwise *Care Select* began operations in November 2007.
Other Indiana Health Coverage Programs

The following Medicaid programs are not part of Care Select, Hoosier Healthwise, or Healthy Indiana, but a description of the programs is included for your reference.

590 PROGRAM
The 590 Program allows for the processing and payment of claims to providers for services provided off-site to individuals who are residents of state owned facilities under the direction of the Family and Social Services Administration (FSSA) Division of Mental Health (DMH), and the Indiana State Department of Health (ISDH). Providers must be enrolled in the 590 Program in order to receive reimbursement for services rendered to members in this program. The program will reimburse services provided to individuals enrolled in the 590 Program when the billed amount is greater than $150. All services totaling $500 or more require prior authorization. HP processes and adjudicates claims for this program.

TRADITIONAL MEDICAID
The Traditional Medicaid Program covers members who are aged, blind, or disabled that are not in a managed care plan like Hoosier Healthwise, Care Select or HIP. These members often have a level of care, are Medicare/Medicaid eligible, or have a Spend down liability. Providers should verify eligibility to determine if a member is in the Traditional Medicaid Program and submit any needed prior authorizations for these members to ADVANTAGE Health Solutions (advantageplan.com). All claims should be submitted to HP for processing and adjudication. The following members are included in the Traditional Medicaid Program.

- Members who are on spend – down,
- Dually eligible for Medicare and Medicaid, members with Qualified Medicare Beneficiaries (QMB) or
- Special Low Income Medicare Beneficiaries (SLMB) only (not in combination with another aid category),
- Members in nursing homes, intermediate care facilities for the mentally retarded (ICF/MR), and State operated facilities,
- Members in the Hospice Program,
- Undocumented aliens,
- Aid to Recipients in County Homes (ARCH) members,
- Members enrolled in the 590 Program, and
- Members enrolled in the Breast and Cervical Cancer Treatment Services Program
Chapter 3 – Hoosier Healthwise Benefit Overview

The MDwise delivery systems arrange for and assure the provision of most Hoosier Healthwise covered services. MDwise members are instructed to contact their PMP for all medical care, including the services listed below. Some services listed below have limitations and/or require prior authorization.

Please Note: In the MDwise system, prior authorization for medical services is handled by the delivery system to which the patient’s doctor belongs. Providers should refer to the MDwise Directory at the front of this manual for the phone numbers of their medical management staff. Out-of-network providers can call the MDwise Customer Service Department at (317) 630-2831 or (800) 356-1204 to be connected to the proper medical management staff.

Covered Services Hoosier Healthwise (general categories):

The following table provides an overview of covered Hoosier Healthwise services available to members receiving benefits in Benefit Packages A: Standard; B: Pregnancy & Pregnancy Related; Package C: Children’s Health Plan; and Package P: Presumptive Eligibility. Package P benefit package covers ambulatory prenatal services, does not cover the delivery or inpatient hospital care, while Package B covered benefits includes pregnancy-related and postpartum care (including prenatal, delivery, and postpartum services. Eligibility for Package B extends up to sixty (60) days postpartum.

Medicaid covered services are outlined in the Indiana Administrative Code 405 IAC 5 and the CHIP Package C covered services in the Indiana Administrative Code at 407 IAC 3. The Indiana Administrative Code at 405 IAC 2-3.2 sets forth the Package P covered services. The Indiana Administrative Code can be found on the State’s website at state.in.us/legislative/iac. Services indicated below as “Carved-out service, not reimbursed under RBMC” are covered (available) services for eligible MDwise members, however the services are not authorized or paid for by MDwise. Further clarification about “carve-out” and “self-referral” services can be found in this chapter.

MDwise provides to its Hoosier Healthwise members, at a minimum, all benefits and services deemed medically reasonable and necessary and covered under the Contract with the State and delivering such covered services sufficient in amount, duration or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services. The table below provides a general summary of the covered services and limitations, outlining under which benefit package each service is covered, and identifying those services that are carved out or excluded and not reimbursed by MCEs.
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<td><strong>Case Management for Persons with HIV/AIDS</strong></td>
<td>Non-covered service</td>
<td>Non-covered service</td>
<td>Non-covered service</td>
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<td>(ICHP Provider Manual, Chapter 8)</td>
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<tr>
<td>Self-referral service</td>
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<td><strong>Case Management for Mentally Ill or Emotionally Disturbed</strong></td>
<td>Targeted case management services limited to those provided by or under supervision of qualified mental health professionals who are employees of a provider agency (CMHC) approved by the Department of Mental Health.</td>
<td>Coverage is limited to services related to as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Non-covered service</td>
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<td>(405 IAC 5-21)</td>
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<tr>
<td>Carved-out service, not reimbursed by MCE</td>
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<tr>
<td><strong>Case Management for Pregnant Women</strong></td>
<td>Non-covered service</td>
<td>Non-covered service</td>
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<td>(405 IAC 5-11)</td>
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<td><strong>Chiropractors</strong></td>
<td>Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 50 therapeutic physical medicine treatments per member per year.</td>
<td>Coverage is limited to services related to as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 14 therapeutic physical medicine treatments per member per calendar year. An additional 36 treatments may be covered if prior approval is obtained based on medical necessity. There is a 50-treatment limit per calendar year.</td>
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<td>(405 IAC 5-12)</td>
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<tr>
<td>Self-referral service</td>
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<td><strong>Dental Services</strong></td>
<td>In accordance with Federal law, all medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered under Package A. Benefit limit $600 per year for ages 21 years and older.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>All medically necessary dental services are provided for children enrolled in Package C even if the service is not otherwise covered under CHIP.</td>
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<tr>
<td>(405 IAC 5-14)</td>
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<tr>
<td>Carved-out services, not reimbursed by MCE</td>
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<td><strong>Diabetes Self Management Training Services</strong></td>
<td>Limited to 16 units per member per rolling calendar year. Additional units may be prior authorized. Current ICHP Provider Manual has it as 8 units per member per year. Additional units may be prior authorized. 1 unit = 30 minutes. IAC has 1 unit = 15 minutes and allow 16 units.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Limited to 16 units per rolling calendar year. Additional units may be prior authorized.</td>
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<tr>
<td>(405-IAC 5-36)</td>
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<td>Self-referral service if provided by self-referral provider</td>
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<td><strong>Drugs – Prescribed (Legend) Drugs</strong></td>
<td>Medicaid covers legend drugs if the drug is approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Medicaid covers legend drugs if the drug is approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid.</td>
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<tr>
<td>(405 IAC 5-24)</td>
<td>Carved out services, not reimbursed by MCE with the exception of physician administered drugs</td>
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<td><strong>Drugs – Over-the-Counter (Nonlegend)</strong></td>
<td>Medicaid covers non-legend (over-the-counter) drugs on its formulary. This is available via a link from the IHCP programs website at indianamedicaid.com/ihcp/index.asp.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Not covered except for insulin.</td>
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<td>Carved out services, not reimbursed by MCE with the exception of physician administered drugs</td>
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<tr>
<td><strong>Early Intervention Services – Early Prevention and Screening, Diagnosis and Treatment (EPSDT)</strong></td>
<td>Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, screening services: vision services, dental services, hearing services, and other necessary health care services in accordance with the HealthWatch EPSDT periodicity and screening schedule. (See Dental – carved out service.)</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Covers immunizations and initial and periodic screenings according to the HealthWatch EPSDT periodicity and screening schedule. Coverage of treatment services is subject to the Package C benefit package coverage limitations.</td>
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<td>(405 IAC 5-15)</td>
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<tr>
<td><strong>Emergency and Post-Stabilization Services</strong></td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
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<td>(IC 12-15-12-15 and -17)</td>
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<td>Self-referral service</td>
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<tr>
<td><strong>Eye Care, Eyeglasses and Vision Services</strong></td>
<td>Coverage for the initial vision care examination is limited to one examination per year for a member under 21 years of age and one examination every two years for a recipient 21 years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, is limited to a maximum of one pair per year for members under 21 years of age and one pair every five years for members 21 years and older. Exceptions are when a specified minimum prescription change makes additional coverage medically necessary or the member’s lenses and/or frames are lost, stolen, or broken beyond repair.</td>
<td>Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Vision care examination is limited to one examination per year for a member under 21 years of age unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, is limited to a maximum of one pair per year for members under 21 years of age except when a specified minimum prescription change makes additional coverage medically necessary or the member’s lenses and/or frames are lost, stolen, or broken beyond repair.</td>
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<tr>
<td><strong>Family Planning Services and Supplies</strong></td>
<td>Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs) if provided during family planning visit; screening and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the US Preventative Services Task Force Guidelines.</td>
<td>Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services. Family planning services are not available under Package P.</td>
<td>Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs) if provided during family planning visit; screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the US Preventative Services Task Force Guidelines.</td>
</tr>
<tr>
<td><strong>Federally Qualified Health Centers (FQHCs)</strong></td>
<td>Coverage is available for medically necessary services provided by licensed health care practitioners.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Coverage is available for medically necessary services provided by licensed health care practitioners.</td>
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<tr>
<td>Food Supplements, Nutritional Supplements, and Infant Formulas (405 IAC S-24-9)</td>
<td>Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs</td>
</tr>
<tr>
<td>Hospital Services – Inpatient (405-IAC S-16)</td>
<td>Inpatient services are covered when the services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition.</td>
<td>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.</td>
<td>Inpatient services are covered when the services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition.</td>
</tr>
<tr>
<td>Hospital Services – Outpatient (405-IAC S-17)</td>
<td>Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition.</td>
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<tr>
<td>Home Health Services (405 IAC S-16)</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
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<tr>
<td>Hospice Care (405 IAC S-34)</td>
<td>RBMC member must be disenrolled from Hoosier Healthwise before benefit can begin. Hospice is available under Medicaid if the recipient is expected to die from illness within six months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days.</td>
<td>Non-covered service</td>
<td>Non-covered service</td>
</tr>
<tr>
<td>Laboratory and Radiology Services (405 IAC S-1; 405 IAC S-27)</td>
<td>Services must be ordered by a physician.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Services must be ordered by a physician.</td>
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<tr>
<td>Long Term Acute Care Hospitalization (IHCP Provider Manual Chapter 14-29)</td>
<td>Long term acute care services are covered. Prior authorization is required. An all inclusive per diem rate is paid based on level of care.</td>
<td>Coverage is limited to services related to pregnancy (including prenata, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services. Available for Package B only.</td>
<td>Long term acute care services are covered up to fifty (50) days per calendar year. Prior authorization is required. An all inclusive per diem rate is paid based on level of care.</td>
</tr>
<tr>
<td>Medical Supplies and Equipment (Includes Prosthetic Devices, Implants, Hearing Aids, Dentures, Etc.) (405 IAC 5-19)</td>
<td>Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.</td>
<td>Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Covered when medically necessary. Maximum benefit of $2,000 per year or $5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased depending on which is more cost efficient.</td>
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<tr>
<td>Mental Health/ Substance Abuse Services – Inpatient (State Psychiatric Hospital) (405 IAC 5-20-1)</td>
<td>Medicaid reimbursement is available for medically necessary inpatient psychiatric services. Covered for individuals under 21 if in a certified wing.</td>
<td>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. Inpatient services available for Package B only.</td>
<td>Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitation as apply to Package A.</td>
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<tr>
<td>Mental Health/ Substance Abuse Services – Inpatient** (Freestanding Psychiatric Facility, 16 Beds or Less) (405 IAC 5-20-1)</td>
<td>Covered. Medicaid reimbursement is available for medically necessary inpatient psychiatric services.</td>
<td>Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services. Inpatient services available for Package B only.</td>
<td>Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitation as apply to Package A.</td>
</tr>
<tr>
<td>Mental Health/ Substance Abuse Services – Inpatient** (Freestanding Psychiatric Facility, More than 16 beds Such as Institution for Mental Diseases) (405 IAC 5-20)</td>
<td>Covered for members under 21 years of age, or under 22 and begun inpatient psychiatric services immediately before his/her 21st birthday.</td>
<td>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. Inpatient services available for Package B only.</td>
<td>Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitation as apply to Package A.</td>
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<tr>
<td>Mental Health/Substance Abuse Services – Outpatient (405 IAC 5-20-8)</td>
<td>Coverage includes medically necessary mental health services, partial hospitalization services, Clinic Option services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology (HSPP). MCEs are responsible for Methadone treatment provided in a clinic setting. Services not reimbursed by MCE include biofeedback, broken or missed appointments, day care and hypnosis (405 IAC 5-21)</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services. MCEs are responsible for Methadone treatment provided in a clinic setting.</td>
<td>Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitation as apply to Package A. MCEs are responsible for Methadone treatment provided in a clinic setting.</td>
</tr>
<tr>
<td>Medicaid Rehabilitation Option (MRO) – Community Mental Health Centers (405 IAC 5-21) Carved-out services. Not reimbursed by MCE.</td>
<td>Coverage includes outpatient mental health services, partial hospitalization (group activity program) and case management. The codes for MRO services are: H0031-HW; H0004-HW; HS-HR or -HQ; H2011-HW; H0033-HW; H2014-HW; H0035-HW; T01016-HW or -TG; 97355-HW or -HQ; 97537-HW or -HQ.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitation as apply to Package A.</td>
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<tr>
<td>Mentally Retarded Services – Intermediate Care Facilities (405 IAC 5-13-2, IHCCH Provider Manual, Chapter 14) Excluded service and not reimbursed by MCE. HH members will be disenrolled from HH once level of care determination made. MCE responsible for up to 60 days while determination is pending.</td>
<td>MCE may be responsible for payment up to 60 days pending and prior to level of care determination made. Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board; mental health services; dental services; therapy and habilitation services; durable medical equipment; medical supplies; pharmaceutical products; transportation; optometric services. Member must be disenrolled from Hoosier Healthwise before benefit can begin.</td>
<td>Non-covered service</td>
<td>Non-covered service</td>
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<tr>
<td>Nurse-Midwife Services (405 IAC 5-22-3)</td>
<td>Coverage is available services rendered by a certified nurse midwife when referred by a PMP. Coverage is restricted to services that the nurse midwife is legally authorized to perform.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Coverage is available services rendered by a certified nurse midwife when referred by a PMP. Coverage is restricted to services that the nurse midwife is legally authorized to perform.</td>
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<td>Nurse Practitioners (405 IAC 5-22-4)</td>
<td>Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.</td>
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<tr>
<td>Nursing Facility Services (Long-Term) (405 IAC 5-31-1, IHCP Provider Manual, Chapter 14)</td>
<td>Excluded service and not reimbursed by MCE. HH members will be disenrolled from HH once level of care determination made. MCE responsible for up to 60 days while determination is pending. MCE may be responsible for payment up to 60 days pending the level of and prior to level of care determination. Requires pre-admission screening for level of care determination and disenrolled from Hoosier Healthwise for long term nursing facility care. Coverage includes room and board; nursing care; medical supplies; durable medical equipment; and transportation.</td>
<td>Non-covered service</td>
<td>Non-covered service</td>
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<tr>
<td>Nursing Facility Services (Short-Term) (405 IAC 5-31-1)</td>
<td>The MCE may obtain services for its members in a nursing facility setting on a short-term basis, i.e. for fewer than 60 calendar days. 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. The MCE can negotiate rates for reimbursing the nursing facilities for these short-term stays.</td>
<td>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. Nursing facility services available for Package B only.</td>
<td>Non-covered service</td>
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<tr>
<td>Occupational Therapy (405 IAC 5-22)</td>
<td>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge. Services authorized upon discharge cannot exceed 12 hours, sessions or visits in 30 calendar days without PA.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year (407 IAC 3-8-2), per type of therapy.</td>
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<tr>
<td><strong>Organ Transplants</strong> (405 IAC 5-3-13)</td>
<td>Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.</td>
<td>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. Organ transplants available for Package B only.</td>
<td>Non-covered service</td>
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<tr>
<td><strong>Orthodontics</strong> (IHCP Provider Manual, Chapter 8) Carve-out services, not reimbursed by MCE</td>
<td>No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.</td>
</tr>
<tr>
<td><strong>Out-of-State Medical Services</strong> (405 IAC 5-5) Reimbursed by MCE with the exception of pharmacy services</td>
<td>Medicaid reimbursement is available for the following services provided outside Indiana: acute hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; and DME and supplies. All out of-state services are subject to the same limitations as instate services.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services. Only outpatient out-of-state services covered under Package P.</td>
<td>Covers acute, general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies. Coverage is subject to any limitations included in the CHIP benefit package.</td>
</tr>
<tr>
<td><strong>Physicians Surgical and Medical Services</strong> (405 IAC 5-25)</td>
<td>Coverage includes reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of four per month or 20 per year per member without prior authorization.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services. Only outpatient physician surgical and medical services covered under Package P.</td>
<td>Coverage includes reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 30 per rolling 12 months per member without prior authorization.</td>
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<tr>
<td><strong>Physical Therapy</strong> (405 IAC 5-22)</td>
<td>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician. Services authorized upon discharge cannot exceed 12 hours, sessions or visits in 30 calendar days without PA.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Services must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year, per type of therapy.</td>
</tr>
<tr>
<td><strong>Podiatrists</strong> (405 IAC 5-26) Self-referral services</td>
<td>Surgical procedures involving the foot, laboratory or X-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Surgical procedures involving the foot, laboratory or X-ray services, and hospital stays are covered when medically necessary. Routine foot care services are not covered.</td>
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<tr>
<td>Psychiatric Residential Treatment Facility (PRTF)</td>
<td>Reimbursement is available for medically necessary services provided to children younger than 21 years old in a PRTF. Reimbursement is also available for children younger than 22 years old who began receiving PRTF services immediately before their 21st birthday. All services require prior authorization.</td>
<td>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. PRTF services available for Package B only.</td>
<td>Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitation as apply to Package A.</td>
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<tr>
<td>Rehabilitation Services – Inpatient*</td>
<td>The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function, or self care activities.</td>
<td>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. Inpatient services available for Package B only.</td>
<td>Covered up to 50 calendar days per calendar year.</td>
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<tr>
<td>Respiratory Therapy**</td>
<td>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, emergency, and oxygen in a nursing facility 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year (407 IAC 3-8-2), per type of therapy.</td>
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<tr>
<td>Rural Health Clinics</td>
<td>Coverage is available for services provided by a physician, physician assistant, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Coverage is available for services provided by a physician, physician assistant, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.</td>
</tr>
<tr>
<td>Smoking Cessation Services</td>
<td>Reimbursement is available for, at minimum, eight (8) counseling sessions per rolling 12 months and 24 weeks of pharmacotherapy treatment per rolling 12 months. (Pending amendment to 405 IAC 5-37)</td>
<td>Reimbursement is available for, at minimum, eight (8) counseling sessions per rolling 12 months and 24 weeks of pharmacotherapy treatment per rolling 12 months. (Pending amendment to 405 IAC 5-37.)</td>
<td>Reimbursement is available for, at minimum, eight (8) counseling sessions per rolling 12 months and 24 weeks of pharmacotherapy treatment per rolling 12 months. (Pending amendment to 405 IAC 5-37.)</td>
</tr>
<tr>
<td>Speech, Hearing and Language Disorders</td>
<td>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge.</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year, per type of therapy.</td>
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**TOBACCO CESSION COVERED SERVICES FOR MDWISE MEMBERS**

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

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

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

The following practitioners cannot obtain an IHCP rendering NPI number and must bill under the supervising practitioner’s NPI number:

- Physician assistant
- Psychologist
- Registered nurse

Covered tobacco cessation services include, upon authorization, at minimum eight (8) sessions of tobacco cessation counseling services per member per rolling twelve (12) months. Covered pharmacy services are reimbursed by Indiana Medicaid FFS under the pharmacy benefit consolidation. Treatment may include prescription of any combination of smoking cessation products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. For the pharmacy to be reimbursed by the IHCP for over-the-counter smoking cessation products, a licensed practitioner must prescribe them.

Both ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the

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<td>Transportation – Emergency</td>
<td>Coverage has no limit or prior approval for emergency ambulance or trips to/from hospital for inpatient admission/discharge, subject to the prudent layperson standard</td>
<td>Coverage is limited to services related to pregnancy as well as conditions that may complicate the pregnancy or urgent care services.</td>
<td>Covers emergency ambulance transportation using the prudent layperson standard as defined in 407 IAC 1-1-6. $10 copayment applies.</td>
<td>Ambulance services for non-emergencies between medical facilities are covered when requested by a participating physician; $10 copayment applies. Any other non-emergent transportation is not covered.</td>
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<td>Transportation – Non Emergent</td>
<td>Non-emergency travel is available for up to 20 one way trips of less than 50 miles per year without prior authorization.</td>
<td>Coverage is limited to services related to as well as conditions that may complicate the pregnancy or urgent care services.</td>
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<td>(405 IAC 5-30)</td>
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*Prior Approval always required.  **Prior Approval required under certain circumstances.
service itself; this requirement is consistent with existing IHCP policies and regulations.

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

If you choose to counsel members in your office, further billing instructions can be found in the IHCP Provider Manual, Chapter 8. When providers and practitioners furnish a service to the general public at no charge, including smoking cessation counseling services, they cannot receive IHCP reimbursement for that service.

**INDIANA TOBACCO QUITLINE, 1-800-QUIT-NOW**

Providers may refer any Indiana patient to the Indiana Tobacco Quitline, 1-800-QUIT-NOW, which offers education and coaching over the telephone, similar to the toll-free smoking quit lines across the country.

**Self-Referral Services (paid by MDwise)**

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

The MDwise delivery systems do include some self-referral providers in their contracted network. MDwise encourages all PMPs to direct their assigned MDwise members to self-referral services within their hospital delivery system. However, members may not be told they are required to use delivery system providers for these services. MDwise also encourages all PMPs to communicate with self-referral service providers when any form of medical treatment is undertaken.
Please Note: Even in the case of self-referral services, MDwise may request the use of in-network facilities. If the self-referral provider, however, uses facilities outside of the MDwise network, MDwise is required to reimburse the facility and ancillary providers for medically necessary services at IHCP rates, according to IHCP benefit guidelines. Vision care surgeries however, may be required to be provided at an in-network facility, as they are not considered self-referral services in Hoosier Healthwise.

The following are self-referral services in Hoosier Healthwise:

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

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

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

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

According to the IHCP Provider Manual and federal guidelines, initial sexually transmitted disease (STD) diagnosis and treatment, if provided during family planning encounters, are considered part of family planning services. 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.

- Podiatric services are defined as IHCP-covered services rendered by a provider enrolled with a specialty 140 (podiatrist) and practicing within the scope of his or her medical license. Reimbursement is available for covered podiatric visits and services associated with such visits as defined by Indiana law and subject to the limitations set out in 405 IAC 5, Rule 26.
- Psychiatric Services—Hoosier Healthwise covered psychiatric services may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) who has entered into a provider agreement under IC-12-15-11 (IHCP-enrolled provider). A member may self-refer to an IHCP psychiatrist, however the services must be medically necessary for the diagnosis or treatment of the member’s condition.
• Vision care services (except eye care surgeries) are defined as IHCP-covered services for routine and medical eye care rendered by an IHCP provider who is enrolled with vision care specialties 180 (optometrist), 190 (optician), or 330 (ophthalmologist) and practicing within the scope of his or her license. Reimbursement is available for covered eye care visits and services associated with such visits in accordance with 405 IAC Rule 23. Optical supplies are also covered when prescribed by an ophthalmologist or optometrist when dispensed in accordance with this rule. MDwise requires that vision-related surgeries be rendered by providers and facilities within the member’s assigned delivery system, when available and are subject to MDwise authorization protocol.

• Immunization services

IHCP CARE COORDINATION SELF-REFERRAL SERVICES

Diabetes Self-Management Training Services—This is a self-referral service only when rendered by an IHCP enrolled chiropractor, podiatrist, optometrist, or psychiatrist outside the MDwise network who has had specialized training in the management of diabetes. Otherwise, diabetes self-management services must be obtained within the MDwise network. Specific information about this benefit is provided in the IHCP Provider Manual and 405 IAC 5-36.

SELF-REFERRAL SERVICES IN-NETWORK

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

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

Please Note: Refer to the Indiana Health Coverage Program (IHCP) Provider Manual and Bulletins and Banners information related to Self-Referral Services.
MDwise members may access emergency services 24 hours a day, seven days a week. Members are instructed to seek emergency services at the nearest emergency room without authorization when they believe their condition to be an emergency.

MDwise will cover and reimburse all emergency services, including screening services, which are rendered by a qualified IHCP provider to evaluate or stabilize an emergency medical condition, subject to a prudent layperson determination as outlined below. The member’s presenting symptoms upon arrival at the emergency room are the primary factors in determining whether an emergency medical condition exists.

- Emergency services is defined in IC 12-15-12-0.5 as covered inpatient and outpatient services that are provided by a provider qualified to furnish emergency services, and that are necessary to evaluate or stabilize an emergency medical condition.

- Emergency medical condition is defined in IC 12-15-12-0.3 as a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
  1. Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the woman or her unborn child,
  2. Serious impairment to bodily functions, or
  3. Serious dysfunction of any bodily organ or part.

- Prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. A prudent layperson is considered to have acted “reasonably” if other similarly situated laypersons would have believed, based on observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

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

Coverage for Emergency Services

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

- A Level 1 medical screening exam professional fee (99281) will be paid to non-contracted delivery system providers if the service does not meet the definition of emergency medical condition as indicated through prudent layperson and medical management department review.

- If the service does not meet the definition of emergency medical condition, as indicated through the prudent layperson and medical management department review, a facility screening fee of $25.00, or a lesser billed charge, will be paid (revenue code 451).
PRIOR AUTHORIZATION FOR EMERGENCY SERVICES

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

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

COVERAGE OF POST STABILIZATION SERVICES

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

• Prior authorization for the post-stabilization services has been obtained from the member’s PMP or authorized representative in conjunction with the PMP’s medical management department.

• Services are administered to maintain the member’s stabilized condition within one (1) hour of a request to the member’s PMP or authorized representative for prior authorization. The one (1) hour begins at the time the call is placed to the PMP or authorized representative.

• Services are administered to maintain, improve or resolve the member’s stabilized condition if a MDwise delivery system:
  • does not respond to a request for prior authorization within one (1) hour;
  • cannot be contacted; or
  • if the PMP or authorized representative cannot reach an agreement with the member’s treating physician concerning the member’s care, the delivery system shall give the member’s treating physician an opportunity to consult with a MDwise delivery system Medical Director. The member’s treating physician may continue with medically necessary care of the member until the delivery system Medical Director is reached or until one (1) of the following criteria is met:
    • A participating MDwise physician with privileges at the treating hospital assumes responsibility for the member’s care
    • A participating MDwise physician assumes responsibility for the member’s care through transfer to another facility
    • MDwise and the treating physician reach agreement about the member’s care
    • The member is discharged.

Providers must document their request for prior authorization. This documentation should include the member’s PMP, the time of call, the phone number called, and the name of the person answering the phone. The provider must also document the time at which the authorization was given and the authorizing party’s name and institutional affiliation. If the provider is unable to reach the member’s PMP or the applicable delivery system to obtain prior authorization, these requests must also be documented.
MDwise attempts to provide all care within the MDwise contracted network (delivery system, inclusive of MDwise behavioral health network), for coordination, access, and communication purposes, better understanding of available resources within the delivery system, and because MDwise providers have agreed by contract, to abide by MDwise policies and procedures.

Health care services provided outside of the MDwise delivery system may be authorized for coverage when appropriate contracted providers, services, or facilities are not available within the delivery system and/or member’s service area. MDwise will also cover and reimburse authorized routine care provided to members by out-of-network/delivery system or out-of-area providers. These service authorization requests are subject to the medical appropriateness criteria and determination process as outlined in Chapter 13, Medical Management.

In accordance with MDwise program rules, all services must be obtained in-network, and within the member’s delivery system, except for the following:

- Self-referrals services for Hoosier Healthwise members including Emergency services (refer to Self-referral section, page 22)
- Medically necessary, covered services that can’t be obtained from an in-network provider within 60 miles of the member’s residence
- Nurse practitioner services, if they are not available within the member’s service area within the MDwise network
- Services for members traveling out of area who are in need of urgent/emergent services
- Services provided under “Continuity of Care” principles – e.g. individual joins MDwise and has an outstanding prior authorization (within 30 days of becoming a member) for services from a provider that is not contracted with MDwise.

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

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

MDwise requires providers not contracted in the MDwise network to obtain prior authorization from the appropriate MDwise delivery system to render any non-self-referral or non-emergent services to MDwise members. MDwise requires out-of-network providers to coordinate with MDwise with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished in-network.

MDwise does not require an out-of-network provider to acquire a MDwise-assigned provider number for reimbursement. An NPI number is sufficient for out-of-network provider reimbursement.
Hoosier Healthwise provides some services that are not included in the MCE capitation and therefore, are not the responsibility of MDwise. These services remain the financial responsibility of the State, are reimbursed on a fee for service basis and are billed to HP. These service carve-outs include the following:

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

- Medicaid Rehabilitation Option (MRO) services. MDwise is not responsible for MRO services. MDwise is responsible for care coordination with physical and other behavioral health services for members receiving MRO services.

- Dental services. MDwise is not responsible for dental services rendered by providers enrolled in an IHCP dental specialty. Specialties include endodontist, general dentistry practitioner, oral surgeon, orthodontist, pediatric dentist, periodontist, pedodontist, prosthodontist, mobile dentist, and dental clinics. MDwise may be responsible for some associated services related to dental surgery (e.g., anesthesia, post-operative services, pharmaceuticals, transportation). When dental services will be provided in an inpatient or outpatient hospital setting or an ASC for an RBMC member, the dental providers must first contact the member’s MCE before rendering services to determine whether prior authorization is required. When the provider obtains MCE authorization and provides services, the services must be billed as described in the ICHP Provider Manual and applicable bulletins/provider newsletters.

- Individualized Education Plan (IEP). MDwise is not responsible for services provided by a school corporation as part of a student’s IEP. MDwise should communicate and coordinate with the school to ensure continuity of care and avoid duplication of services.

- Individualized Family Services Plan (IFSP). (MDwise is not responsible for services provided under the FSSA First Steps Program. MCEs will receive a monthly list of their members who are receiving First Steps services. MDwise should provide case management to these special needs children and coordinate care with First Steps for these children.

- Pharmacy Services. Under the pharmacy benefit consolidation, these services with some exceptions, are provided to members under the Indiana Medicaid FFS program. FFS reimbursed services include coverage of legend drugs, non-legend drugs included on the Medicaid non-legend drug formulary and identified medical supplies and medical devices.
Excluded Services

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

- Long-term institutional care. (Hoosier Healthwise Package A members and HIP) Nursing Facility or Intermediate Care Facility for Mentally Retarded (ICF/MR)

MDwise may place a member in a nursing facility on a short-term basis, i.e., for fewer than sixty (60) calendar days when determination made for medical necessity care and appropriate place of service. MDwise may negotiate rates for reimbursing the nursing facilities for this short term stay. Members who require long-term care or whose short-term placement becomes a long-term placement will be disenrolled from managed care when long term care/level of care (LTC/LOC) is approved. During the period of level of care determination, up to 60 days, the member remains eligible in MDwise. LTC/LOC services are not eligible to managed care members, and must be disenrolled from MDwise.

- Hospice care
- Home- and community-based waiver services
- Psychiatric Residential Treatment Facility (PRTF) Services
- Psychiatric treatment in a state hospital

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

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

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

Presumptive Eligibility

Presumptive eligibility (PE) allows a pregnant woman to have coverage for ambulatory (outpatient) prenatal services while her application for Medicaid is pending and is under review for eligibility by the Division of Family Resources (DFR). Women determined eligible for PE by a Qualified Provider (QP) may begin receiving pregnancy related services on the day they are determined PE eligible. A Qualified Provider (QP) must complete the PE Application for Pregnant Women for a
woman to be determined eligible for the program. This program became effective with all of the MCEs 7.1.09. Providers are reimbursed for covered services provided during the PE period, beginning on the date a qualified provider (QP) determines the woman to be presumptively eligible. The woman's Hoosier Healthwise/Medicaid eligibility determination is subsequently completed by the DFR.

Women must select a MCE and PMP to activate PE coverage.

Providers will be reimbursed for ambulatory services during the presumptive eligibility period, regardless of whether or not the member ultimately qualifies for the Hoosier Healthwise program. PE coverage is only temporary while the member’s Medicaid application is pending. The member’s PE will be discontinued if the member does not apply for Medicaid by the last day of the month following the month PE was established.

PE Covered Services

The following services are PE covered services

- Outpatient professional services
- Lab work
- Prescriptions (May be 2-3 delay in entering member information in PBM-
- Transportation (Emergency and non emergency-must be pregnancy related)

Non-covered PE services

- Inpatient services
- Labor and delivery/Post Partum Care
- Hospice
- Long Term Care
- Services may be covered if member becomes fully eligible for Package A or B.
- Abortions
- Ectopic pregnancy
- Sterilizations
- Newborn services
- Abnormal products of conception
- Hysterectomies
- Family Planning

*Testing and treatment for STD’s are covered services if the infection/disease will have impact on the health of mom or baby.

** A list of covered codes as well as who can be a Qualified Provider can be found in the Qualified Provider Presumptive Eligibility Manual found at provider.indianamedicaid.com/general-provider-services/manuals.aspx.

MDwise PE members will not receive an ID card during her PE coverage. The PE woman will receive a letter that will serve as identification. The PE members ID number will start with “550”. When checking eligibility, the PE woman Medicaid package will be identified as Package P. If the woman becomes eligible for Hoosier Healthwise she will receive a new ID#.

BILLING REQUIREMENTS FOR PE

- MDwise is responsible for claims payment for MDwise PE covered woman (see MDwise quick contact sheet for list of MDwise Delivery Systems).
- Claims must be billed with the “550” RID number during PE period and billed with the standard Hoosier Healthwise RID during Package A or B periods. * In case of retroactive Medicaid coverage for the member, the Hoosier Healthwise RID must be used.
- Non-covered PE services may become covered if the woman becomes fully eligible for Package A or B.
- Providers should track claims denials during PE period for future submission should the woman become enrolled in Package A or B.
- When the member changes from Package P to Package A or B coverage, new claims must be submitted to the woman’s MDwise Delivery System using the Medicaid RID only for retroactively covered Medicaid coverage.
Chapter 4 – Healthy Indiana Plan Benefits Overview

The MDwise delivery systems arrange for and assure the provision of most Healthy Indiana Plan covered services. MDwise members are instructed to contact their PMP for all medical care, including the services listed below. Some services listed below have limitations and/or require prior authorization.

**Please Note:** In the MDwise system, prior authorization for medical services is handled by the delivery system to which the patient’s doctor belongs. Providers should refer to the MDwise Directory at the front of this manual for the phone numbers of their medical management staff. Out-of-network providers can call the MDwise Customer Service Department at (317) 630-2831 or (800) 356-1204 to be connected to the proper medical management staff.

### Covered Services (general categories):

The following table provides an overview of covered Healthy Indiana Plan benefits. Covered benefits under the Program include physician services, mental health care and substance abuse services, inpatient and outpatient care, emergency room services, urgent care services, preventative care services, family planning services, hospice services, prescription drugs, durable medical equipment, diagnostic services and therapies, disease management and home health. The annual per person benefit maximum is $300,000. The lifetime per person benefit maximum is $1,000,000.

HIP covered services are outlined in IC 12-15-44 and Administrative Code 405 IAC 9-7. As stated in IC 12-15-44-4, the MCE must also comply with any coverage requirements that apply to an accident and sickness insurance plan issued in Indiana. The Indiana Administrative Code can be found on the State’s website at [state.in.us/legislative/iac](http://state.in.us/legislative/iac).

MDwise provides to its Healthy Indiana Plan members, at a minimum, all benefits and services deemed medically reasonable and necessary and covered under the Contract with the State and delivering such covered services sufficient in amount, duration or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services. The table below provides a general list of the HIP covered services and limitations, identifying whether each service is reimbursed by MCEs.

<table>
<thead>
<tr>
<th>Benefit/Description</th>
<th>Limitations/Co-Pay</th>
<th>Subject to POWER Account Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient/Facility</strong></td>
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<tr>
<td><strong>Medical/Surgical</strong></td>
<td>Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse (MH/SA)</strong> (405 IAC 9-7-3)</td>
<td>Covered same as any other illness.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>Excludes custodial care; subject to a 60 day maximum.</td>
<td>Yes</td>
</tr>
<tr>
<td>Benefit/Description</td>
<td>Limitations/Co-Pay</td>
<td>Subject to POWER Account Deductible?</td>
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<tr>
<td><strong>Outpatient Facility</strong></td>
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<tr>
<td><strong>Surgery</strong></td>
<td>Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member’s condition.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Co-pay amounts for ER services:</td>
<td>Use of the Power Account to cover ER co-pay is prohibited. The co-pay amount is included on the member’s ID card.</td>
</tr>
<tr>
<td>(405 IAC 9-2-13 and 405 IAC 9-7-9)</td>
<td><strong>Parents</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Self-referral (405 IAC 9-7-11) | - < 100% federal poverty level (FPL) = $3  
- 100-150% FPL = $6  
- 150-200% FPL = 20% of the cost of services provided during visit or $25.00, whichever is less.                                                                                   |                                      |
| Providers will collect the co-payment from members. | The co-payment must be waived or returned if the parent (member) is found to have an emergency condition or if the member is admitted to the hospital on the same day as the visit.                                                                                       |                                      |
| **Childless Adults/Non-Caretakers** | - $25 regardless of FPL                                                                                                                                                                                                 |                                      |
| | The co-payment must be waived or returned if the member is admitted to the hospital on the same day as the visit.                                                                                                                                                  |                                      |
| | The member must receive an appropriate medical screening examination under section 1867 of the Emergency Medical Treatment and Active Labor Act.                                                                                                                                 |                                      |
| | Assuming a member has an available and accessible alternate non-emergency services provider (i.e. Primary Medical Provider) - and a determination has been made that the individual does not have an emergency medical condition, the hospital must inform the member before providing non-emergency services that: |                                      |
| | - The hospital may require payment of the co-payment before the service can be provided;  
- The hospital provides the name and location of an alternate non-emergency services provider (the member’s PMP) that is actually available and accessible;  
- An alternate provider (the member’s PMP) can provide the services without the imposition of the copayment; and  
- The hospital provides a referral to coordinate scheduling of this treatment.                                             |                                      |
<p>| <strong>Urgent Care</strong>          |                                                                                                                                                                                                                   | Yes                                  |
| <strong>Physical/Occupational/ Speech Therapy</strong> | Requires prior authorization before rendering service.                                                                                                                                                           | Yes                                  |
| (405 IAC 9-7-4)          |                                                                                                                                                                                                                   |                                      |
| <strong>Radiology/Pathology</strong>  |                                                                                                                                                                                                                   | Yes                                  |</p>
<table>
<thead>
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<th>Benefit/Description</th>
<th>Limitations/Co-Pay</th>
<th>Subject to POWER Account Deductible?</th>
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<tbody>
<tr>
<td><strong>Outpatient Facility</strong></td>
<td></td>
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<tr>
<td>Diagnostic Services, Including Pregnancy Testing (405 IAC 9-7-2 (a)(7))</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Pharmacy and Blood</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Cardiovascular</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>FQHC and RHC Services</td>
<td>Yes</td>
<td></td>
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<tr>
<td><strong>Professional Services</strong></td>
<td></td>
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<tr>
<td>Inpatient/Outpatient Surgery</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient/ER Visits</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Office Visits/Consults</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Preventive Care Services (405 IAC 9-2-25)</td>
<td>Includes immunizations, flu shots, annual physicals (including diagnostic services), pap smears, mammograms, routine prostate antigen tests, colorectal cancer exam, laboratory testing). OMPP to publish list of preventive care services annually by age group that member is to obtain.</td>
<td>Preventative services of coverage are not subject to deductible.</td>
</tr>
<tr>
<td>Smoking Cessation Services Reimbursement by MCE with exception of Pharmacy services</td>
<td>Reimbursement is available for, at minimum, eight (8) counseling sessions per rolling 12 months, and 24 weeks of pharmacotherapy treatment per rolling 12 months. (Pending amendment to 405 IAC 5-37.)</td>
<td>No</td>
</tr>
<tr>
<td>Physical/Occupational/Speech Therapy (405 IAC 9-7-4)</td>
<td>Requires prior authorization before rendering service.</td>
<td>Yes</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Radiology/Pathology</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Mental Health/Substance Abuse (405 IAC 9-7-3 Mental Health Parity)</strong> Self-referral within network.</td>
<td>Covered the same as physical illness.</td>
<td>Yes</td>
</tr>
<tr>
<td>Benefit/Description</td>
<td>Limitations/Co-Pay</td>
<td>Subject to POWER Account Deductible?</td>
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<tr>
<td>Ancillary Services</td>
<td></td>
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<tr>
<td>Prescription Drug</td>
<td>(405 IAC 9-7-6)</td>
<td>Yes</td>
</tr>
<tr>
<td>(Not reimbursable by MCE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health/Home IV Therapy, Including Case Management</td>
<td>(405 IAC 9-7-2 (a)(10))</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Emergency ambulance transportation only,</td>
<td>Yes</td>
</tr>
<tr>
<td>Durable Medical Equipment/Supplies/Prosthetics</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Hospice</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Comprehensive Disease Management</td>
<td>(405 IAC 9-7-5)</td>
<td>Yes</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>(405 IAC 9-2-17)</td>
<td>Yes</td>
</tr>
<tr>
<td>(Self-referral)</td>
<td>Lead screening services are covered benefits for individuals 19–20 years of age only.</td>
<td>Yes</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Hearing aids are covered benefits for individuals 19–20 years of age only.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In accordance with (405 IAC 5-28-7) abortions may be provided only in the following situations:

- If the pregnancy is the result of an act of rape or incest; or
- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician place the woman in danger of death unless an abortion is performed. No other abortions, regardless of funding, can be provided as a benefit under the MDwise contract.
Tobacco Cessation Covered Services for MDwise Members

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

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

- Nurse practitioner
- Pharmacist
- Physician
- Psychologist
- Dentist

The following practitioners cannot obtain an IHCP rendering NPI number and must bill under the supervising practitioner’s NPI number:

- Physician assistant
- Psychologist
- Registered nurse

Covered tobacco cessation services include, upon authorization, at minimum eight (8) sessions of tobacco cessation counseling services per member per rolling twelve (12) months. Covered pharmacy services are reimbursed by Indiana Medicaid FFS under the pharmacy benefit consolidation. Treatment may include prescription of any combination of smoking cessation products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. For the pharmacy to be reimbursed by the IHCP for over-the-counter smoking cessation products, a licensed practitioner must prescribe them.

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

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

If you choose to counsel members in your office, further billing instructions can be found in the IHCP Provider Manual, Chapter 8. When providers and practitioners furnish a service to the general public at no charge, including smoking cessation counseling services, they cannot receive IHCP reimbursement for that service.

INDIANA TOBACCO QUITLINE, 1-800-QUIT-NOW

Providers may refer any Indiana patient to the Indiana Tobacco Quitline, 1-800-QUIT-NOW, which offers education and coaching over the telephone, similar to the toll-free smoking quit lines across the country. The services offered by the Quitline are confidential and provided free of charge to Indiana residents.

The Quitline also has online resources at indianatobaccoquitline.net for tobacco users, healthcare providers, family/friends, and employers. The Indiana Tobacco Quitline is a program of the Indiana Tobacco Prevention and Cessation Agency (ITPC). Contact ITPC at 317.234.1787 if you have any questions about the services offered by the Quitline.
The Quitline is designed so you can easily refer clients to the program and is staffed by professionally trained smoking cessation Quit Coaches. The Indiana Tobacco Quitline offers a fax referral program for Indiana residents and physicians. Providers can simply Ask, Advise, and Refer tobacco users to the Indiana Quitline using the fax referral form found at in.gov/quitline/files/QL_ClinicReferralForm_(3).pdf. Instructions are also available at in.gov/quitline/2346.htm.

The Quitline staff will even fax back a report to your office to tell you if the client was reached, enrolled in services, and planned to quit.

CARVED-OUT SERVICES
Healthy Indiana Plan provides some services that are not included in the MCE capitation and therefore, are not the responsibility of the MCE.

• Pharmacy services: Under the pharmacy benefit consolidation, these services with some exceptions, are provided to HIP members under the Indiana Medicaid FFS program. These FFS reimbursed services include coverage of legend drugs, non-legend drugs included on the Medicaid non-legend drug formulary and identified medical supplies and medical devices.

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

• Long-term institutional care HIP members requiring long-term care in a nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR) must be disenrolled from the HIP program and converted to fee-for-service eligibility in the IHCP.

• Home- and community-based services (HCBS) waiver Members who have been approved for these waiver services must be disenrolled from managed care and the MDwise must coordinate care for its members that are transitioning into a HCBS waiver program until the disenrollment from HIP is effective.

• Psychiatric treatment in a state hospital: Psychiatric treatment in a state hospital is an excluded service but HIP members receiving psychiatric treatment in a state hospital shall not be disenrolled from HIP, but should be directed to an alternative inpatient facility.

• Pregnancy Services: HIP excludes pregnancy and related services from its covered services. When a member becomes pregnant, member to enroll in Hoosier Healthwise in order to receive coverage for pregnancy and related services. The woman may be re-enrolled in HIP, providing she remains eligible, after her pregnancy has ended.

MDwise has policies and procedures in place for identifying pregnant members and helping them enroll in Hoosier Healthwise. MDwise will inform both the member and the provider of the procedure to get enrolled in Hoosier Healthwise and also provide the necessary forms to enroll in Hoosier Healthwise. MDwise also has a process for identifying members in their eligibility and claims system to make sure they have successfully obtained Hoosier Healthwise coverage. Once a woman is enrolled in Hoosier Healthwise, she will be disenrolled from HIP but will remain in the MDwise plan unless the MDwise provider network does not provide sufficient access to OB/GYNs. MDwise's liability for covering a HIP pregnant member continues under Hoosier Healthwise throughout the pregnancy and plus sixty (60) calendar days postpartum. MDwise must advise providers that all pregnancy-related claims incurred during the pregnancy discovery period (up to three (3) months) (based on date of service) will be
reimbursed under Hoosier Healthwise once Hoosier Healthwise coverage has been approved. In addition the MDwise must

1) provide a written explanation to providers for any claims determination made during the member’s HIP coverage that informs them that consideration will be made for the claim upon the member’s transfer to Hoosier Healthwise;

2) assist members in obtaining and submitting proof of pregnancy to the State per current Hoosier Healthwise requirements;

3) assure providers are given access to the Medicaid RID number for the member; and

4) complete any other responsibilities that may be required to initiate the transfer of a pregnant member to Hoosier Healthwise.

MDwise will inform members, in writing, that in order to receive coverage for their pregnancy, they must switch coverage to Hoosier Healthwise. MDwise will inform members that in order to qualify for Hoosier Healthwise pregnancy coverage, verification of pregnancy must be provided to DFR. MDwise will facilitate getting the required documentation or the member can take care of it herself. Pregnant members can call the DFR Service Center (or other office as specified by the State) to report the pregnancy. DFR may then send her the change report form that she can attach to her doctor’s statement or she can be given the Document Center’s address to mail or fax the doctor’s statement. DFR will then close the HIP case and approve Hoosier Healthwise. A member shall not be transferred out of HIP if the first pregnancy-related claim incurred is for spontaneous abortion or any expense related to a termination of pregnancy. In this situation, the member shall remain enrolled in HIP and the Contractor shall pay for this expense. Therefore, the State is defining pregnancy-related claims as those indicative of active pregnancies and/or deliveries of a living fetus.

Noncovered Services in the Healthy Indiana Plan

Noncovered services in the Program’s basic benefit package are as follows:

- Maternity and related services (members are requested to enroll in Hoosier Healthwise Package B)
- Dental services including extraction, restoration and replacement of teeth, x-rays, supplies, appliances and all associated supplies with the exception of an accidental traumatic injury to natural teeth. In such cases, treatment must be sought within 48 hours of the injury.
- Conventional or surgical orthodontics or any treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Vision services. (Note: Optometrists may perform covered services under HIP) Per FSSA letter 4/7/09: Please be advised that refraction services are not a covered benefit under the HIP program; however, optometrists may perform covered services for HIP members.
- Elective abortions and abortifacients
- Non-emergency transportation services
- Chiropractic services (Codes 98925, 98926, 98927, 98940, 98941, 98942, and 98943 are NOT covered services under HIP. Chiropractors can, however, provider covered services under HIP that fall within their scope of practice.)
- Long term or custodial care including domiciliary, convalescent care, skilled nursing facilities used for
long-term care, state hospitals and custodial care, nursing home care, home-based respite care, group homes, halfway homes, residential facilities

- Experimental and investigative services. Experimental and investigative services include those procedures and services that are not consistent with accepted standard medical practice or services not approved by the governing bodies. The Plan has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to experimental and investigative services.

- Drugs excluded from the health plan under 405 IAC 9-7-6.

- Any services which are not deemed to be medically necessary as determined by the Plan

- Day care and foster care

- Personal comfort or convenience items

- Cosmetic services, procedures, equipment or supplies. Complications directly relating to cosmetic services, treatment or surgery are not covered. Benefits are available if treatment for reconstructive service is performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or previous medically necessary procedure.

- Hearing aids and associated services for the fitting or prescription of hearing aids. Note: Hearing aids can be covered for members 19 and 20 years old only.

- Safety glasses, athletic glasses and sunglasses

- LASIK and any surgical eye procedures to correct refractive errors

- Vitamins, supplements and over-the-counter medications

- Wellness benefits other than tobacco use cessation

- Diagnostic testing or treatment in relation to infertility

- In vitro fertilization

- Gamete or zygote intrafallopian transfers

- Artificial insemination

- Reversal of voluntary sterilization

- Transsexual surgery

- Treatment of sexual dysfunction including but not limited to medication

- Body piercing

- Over-the-counter contraceptives

- Physician samples dispensed in a physician’s office

- Alternative or complementary medicine including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, massage therapy, herbal, vitamin or dietary products or therapies

- Treatment of hyperhidrosis

- Court ordered testing or care unless medically necessary

- Travel related expenses including mileage, lodging and meal costs, except for mileage paid to emergency transportation providers

- Missed or canceled appointments for which there is a charge

- Services and supplies provided by, prescribed by, or ordered by immediate family members including spouses, parents, siblings, in-laws or self

- Services and supplies for which member has no legal obligation to pay in absence of coverage under the plan

- The evaluation or treatment of learning disabilities

- Routine foot care, with the exception of diabetes foot care

- Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot, and tarsalgia

- Any injury, condition, disease ailment arising out of the course of employment IF benefits are available under any Worker’s Compensation Act or other similar law

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

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

The following are self-referral services in the Healthy Indiana Plan where members may obtain services from any IHCP provider qualified to render the service:

- Services rendered for the treatment of an emergency medical condition. Emergency services are covered without the need for prior authorization or the existence of a provider agreement with the emergency care provider. Emergency services must be available 24 hours a day, seven days a week.
- Family planning services. Federal regulation 42 CFR 431.51(b)(2) requires a freedom of choice of providers and access to family planning services and supplies.
- Immunizations

Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include sexually transmitted disease testing. Elective abortions and abortifacients are not covered family planning services. Reimbursement is available for family planning services, as outlined in IC 12-15-5-1 and applicable federal law.

Family planning services include birth control pills but pharmacies are reimbursed under the FFS under the pharmacy benefit consolidation.

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

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

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

- Outpatient mental health clinics
- Community mental health centers
- Psychologists
- Certified psychologists
- Health services providers in psychology
- Certified social workers
- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Person holding a master’s degree in social work, marital and family therapy, or mental health counseling
MDwise members may access emergency services 24 hours a day, seven days a week. Members are instructed to seek emergency services at the nearest emergency room without authorization when they believe their condition to be an emergency.

MDwise will cover and reimburse all emergency services, including screening services, which are rendered by a qualified IHCP provider. Certain co-pays are applicable for members seeking emergency room care, as outlined on page 2 of this chapter and in the following Chapter 6. Providers are required to collect the co-pay at the time the service is provided. MDwise reimburses out-of-network emergency services providers at 100 percent of the Program’s rates (i.e., Medicare rates or 130% of Medicaid rates), minus any applicable co-payments.

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

**PRIOR AUTHORIZATION FOR EMERGENCY SERVICES**

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

**COVERAGE OF POST STABILIZATION SERVICES**

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

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

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

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

Health care services provided outside of the MDwise delivery system may be authorized for coverage when appropriate contracted providers, services, or facilities are not available within the delivery system and/or member’s service area. MDwise will also cover and reimburse authorized routine care provided to members by out-of-network/delivery system or out-of-area providers. These service authorization requests are subject to the medical appropriateness criteria and determination process as outlined in Chapter 13, Medical Management.

Reimbursement for the out-of-network claims will be at the Healthy Indiana Plan reimbursement rate that existed on the date the service was rendered, as follows:
• Medicare reimbursement or
• 130% of Medicaid rates if the service does not have a Medicare reimbursement rate

MDwise requires out-of-network providers to coordinate with MDwise with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished in-network.

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

In accordance with MDwise program rules, all services must be obtained in-network, and within the member’s delivery system, except for the following:
• Family planning services (self-referral)
• Emergency services (self-referral)
• Medically necessary, covered services that can’t be obtained from an in-network provider within 60 miles of the member’s residence
Indiana Health Coverage Program (IHCP) and federal regulations specifically prohibit providers from charging IHCP members for covered services except in specific, limited circumstances as outlined in this Chapter. As a MDwise provider, you are required to accept the final payment determination for covered services as payment in full, except for any copayments and any other patient liability payment allowed by the IHCP. You may not balance bill a member (i.e. charge the member for covered services above the amount paid by MDwise).

Hoosier Healthwise Program

Package A, B, and P members are not required to make co-payments or pay premiums for their health care coverage. Providers must not deny service to these patients, or engage in collection activities, because of non-payment for services.

Package C members are responsible for paying part of the cost of their health care coverage. These payments include premium payments, as well as co-pays for ambulance transportation.

PREMIUM PAYMENTS FOR PACKAGE C MEMBERS

<table>
<thead>
<tr>
<th>Income (%of FPL)</th>
<th>Number of Children Enrolled</th>
<th>Monthly Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>150% to 175% FPL</td>
<td>One</td>
<td>$22.00</td>
</tr>
<tr>
<td></td>
<td>Two</td>
<td>$33.00</td>
</tr>
<tr>
<td>175% to 200%</td>
<td>One</td>
<td>$33.00</td>
</tr>
<tr>
<td></td>
<td>Two</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

CO-PAY AMOUNTS

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

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transporation</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>$10</td>
</tr>
<tr>
<td>(Note: Package C members are only covered for emergency ambulance transportation. Non-emergency trips are not covered)</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Brand Name Drugs</td>
<td>$10.00 COPAY</td>
</tr>
<tr>
<td>Generic/Sole Source drugs</td>
<td>$3.00 COPAY</td>
</tr>
</tbody>
</table>

Please Note: A provider may not deny services to an eligible individual due to the individual’s inability to pay the copayment amount on the date of service. The provider may however, subsequently bill the member for the copayment.
POWER ACCOUNT CONTRIBUTIONS

In the HIP program, members make a financial contribution to their POWER account for coverage. Members contribute no more than 5% of their gross family income to have the security of health insurance. The contribution amount is dependent on income (see below) and family size. The contribution is reduced by the amount of any Hoosier Healthwise contribution (e.g. for Package C members).

- 0-100% FPL: 2% contribution
- 101%-125% FPL: 3% contribution
- 126%-150% FPL: 4% contribution
- 151%-200% FPL: 4.5% contribution for parental adults
- 151%-200% FPL: 5% contribution for childless adults

The State calculates the individual’s POWER Account contribution during the application process. Contributions are also recalculated by the State before a new coverage term begins (during redetermination), to account for any changes in the member’s income. If some or all of a member’s POWER Account balance is rolled over at the end of the coverage term, the amount of the member’s POWER Account contribution for the new coverage term will be reduced.

POWER Accounts are funded in an amount equal to $1,100. The State contributes to the member’s POWER Account, and members are also encouraged to seek contribution assistance from their Employer. An employer is allowed to contribute no more than 50% of the member’s annual POWER Account obligation. Employers interested in providing assistance can seek further information by accessing the MDwise.org or by calling MDwise Customer Service.

HIP members must make their required contribution each month. MDwise provides a wide range of payment options for members to make sure that it easy for them to make their contributions on time. If a member does not make a contribution within 60 calendar days, coverage will be terminated. If a member loses their coverage because they failed to pay their contribution, they may not reapply for HIP for at least 12 months.

CO-PAY AMOUNTS FOR MDWISE HIP MEMBERS

There are no co-pays in the HIP program except for emergency room use. However, the co-pay for parents/caregivers can be waived or returned if the service was a true emergency or if the member is admitted to the hospital on the same day as the emergency room visit...

Providers collect the co-payment from members at the point of service. The member’s copayment amount is indicated on their HIP member ID card. Please note that POWER Account funds cannot be used by the member to pay the co-payment.

Co-pay amounts are as follows:

- Parents/Caregivers
  - < 100% federal poverty level (FPL) = $3
  - 100-150% FPL = $6
  - 150-200% FPL = 20% of the cost of services provided during visit or $25.00, whichever is less.

The co-payment is waived or returned if the parent (member) is found to have an emergency condition, or if the member is admitted to the hospital on the same day as the visit.

- Childless Adults
  - $25 regardless of FPL

The co-payment is waived or returned if the member is admitted to the hospital on the same day as the visit.
Restrictions on Charging MDwise Hoosier Healthwise or HIP Members

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

BILLING FOR COVERED OR NON-COVERED SERVICES

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

- Non-covered benefit: A provider may bill a MDwise member for services that are not covered under Hoosier Healthwise or HIP. It is important to note, however, that for the HIP program, the member’s POWER Account funds may not be used to reimburse providers for non-covered services.

- Member exceeded benefits: Providers may bill the member when the service is a Hoosier Healthwise or HIP covered service for which the member has exceeded the program limits for the particular service. The member must understand before receiving the service that the service is not covered and they will be responsible for the charges incurred. Also, please note it is the provider’s responsibility to verify member benefit limits.

- PA denied and member told why: A provider may bill a member for services that require authorization but for which authorization is denied. However, the provider must establish authorization has been requested and denied before rendering the service. The provider will have an opportunity to request review of the authorization decision by MDwise.

- Outstanding copayments: It is permissible to bill a member for any outstanding copayments, yet providers may not deny services to member due to their inability to pay the copayment amount on the date of service.

OBTAINING A WAIVER

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

- Must include member’s signed statement accepting financial responsibility for the services.

- The waiver is signed only after the member is given the appropriate notification that the service is not covered and why.

- The waiver must be specific about the services to be billed and must be retained as documentation in the patient’s medical record. A waiver must be obtained for each encounter or patient visit that falls under the above scenario.

- The waiver must list the specific services that fall under the waiver’s application, the date the services were rendered and the cost for the services.
The waiver may not contain any language or condition to the effect that if authorization is denied after the service is rendered; the member is responsible for payment.

**Please Note:** For assistance or for sample waiver letters, please contact your delivery system Provider Relations Representative.

**MEMBER BILLING WHEN MEMBER IS ASSIGNED TO A DIFFERENT PMP**

Instead of trying to use the billing waiver process, MDwise providers should try to redirect the member to their assigned PMP. For example, if a member wishes to receive services, however is assigned to a PMP in another MDwise delivery system, you must let the member know they have a different PMP assigned to them and then attempt to redirect the member to their current PMP.

If the member wants to switch PMPs so they can continue seeing you, they need to understand this may not be possible until the PMP change is effective.

**Charging Members for Missed Appointments**

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

**Charging Members for Medical Records**

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

The member should be instructed to call the MDwise Customer Service Line to initiate the PMP change process. This phone call may be made from your office, as long as the member participates in the call.

If you think it is urgent that the member continues seeing you (before the PMP changes happen), a prior authorization will be required from the delivery system the member is assigned to.

If the member insists on receiving the service and authorization is not obtained from the delivery system the member is assigned to, then you must secure a patient waiver as outlined above.

**Please Note:** Providers may not bill the member for a service that could have been covered if the provider had requested authorization to provide the service. If the provider fails to request prior authorization, the provider accepts the risk of non-payment, not the member.
To participate in the MDwise Plan under Hoosier Healthwise, or HIP, providers must first be enrolled as an Indiana Health Coverage Programs (IHCP) provider with the State. In addition, other participation requirements specific to MDwise must be followed as outlined in this chapter. MDwise follows the State’s policies and procedures for handling provider enrollment and disenrollment in the MDwise provider networks.

Please Note: For additional information on the enrollment or disenrollment process, or the process for updating enrollment information, please contact your delivery system provider relation’s representative or MDwise at (317) 630-2831 or 1-800-356-1204

PMP Enrollment Procedure for Hoosier Healthwise and Healthy Indiana Plan (HIP)

To participate as a MDwise Primary Medical Provider (PMP) for the Hoosier Healthwise Program and HIP programs, a physician must practice in the field of general practice, family practice, general pediatrics, internal medicine or obstetrics/gynecology (Hoosier Healthwise only). All PMPs must be fully credentialed according to MDwise standards, before actually enrolling with MDwise. For details on the credentialing process, please contact your delivery system’s provider services representative and see Chapter 9 on Credentialing. Please note, MDwise Delivery Systems make the determination whether they wish to accept new providers into their networks.

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

1. A potential MDwise provider contacts the preferred delivery system provider relation’s staff. If a provider is not affiliated with a delivery system, MDwise can assist the provider in making this connection. All providers in MDwise must be affiliated with a delivery system as a condition of participation. Note: The delivery system provider relation’s staff will coordinate their system’s enrollment and disenrollment process on behalf of their system’s contracted providers.

2. New providers must complete the MDwise credentialing process. (See Chapter 9 for more information concerning the credentialing process.) Upon approval into the respective delivery system, the provider must complete the required Hoosier Healthwise /HIP enrollment forms. The provider must also complete the MDwise Supplemental Enrollment Form and the MDwise Signature Page. Note: The original, signed copy of the PMP signature page must be included.

3. The delivery system provider relation’s staff reviews the forms for completeness of information and forwards the forms to MDwise corporate office for a second level review.

4. After review, MDwise forwards the provider enrollment information to HP, through the Web interChange.

5. After the enrollment process is complete, all MDwise providers will receive educational training regarding the Hoosier Healthwise Program and HIP programs, including covered services, self-referral services, quality improvement requirements, medical records retention and availability, member reassignment, member appeals process, provider dispute procedures, and POWER Account features (HIP only).
Enrollment Changes and Updates

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

MDwise enrolled PMPs are also identified in a Hoosier Healthwise/HIP provider list sent to HP on a regular basis. MDwise members currently use this list to select a PMP.

It is very important that all information in the MDwise Provider Directory and Hoosier Healthwise/HIP provider list is accurate and up-to-date, including provider specialty, practice limitation, address and office locations. Failure to keep updated provider enrollment records with MDwise may result in claim adjudication denials.

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

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

PMP Disenrollment Procedure

If a provider plans to disenroll from MDwise, they should let their delivery system provider relation’s representative know as soon as possible. Similar to the provider enrollment process, the MDwise provider disenrollment process is coordinated by each delivery system’s provider relation’s personnel. The process works as follows:

1. A PMP may disenroll from the MDwise network by submitting written documentation to his or her delivery system at least 90 days before the date of disenrollment.

2. Upon review by the provider’s delivery system’s provider relation’s personnel, these forms are forwarded to the MDwise office where the disenrollment information will be transmitted to HP.

3. If the provider is disenrolling without reenrolling in another Hoosier Healthwise/HIP MCE, the MDwise Provider Relations will assist. The PMPs members will be notified to choose another MDwise PMP.

4. The disenrolling PMP may request that the entire panel of the PMP’s members be moved to another PMP (full-panel transfer). The PMP is required to send a letter to MDwise that specifies the reason he/she is no longer willing or able to serve as a PMP and names a specific MDwise PMP or PMPs who should receive assignment of the current PMP’s members.
5. Members will receive a notification letter from MDwise upon assignment to a new provider. Members are given opportunity to change PMPs within MDwise if they are dissatisfied with the transfer. In the letter, MDwise are also instructed on how to file a just cause request if the disenrolling PMP will be available in another managed care entity.

6. MDwise provider relation's staff will monitor the disenrollment process to ensure that the PMP is disenrolled appropriately.

Specialist and Ancillary Provider Enrollment and Disenrollment

The enrollment and disenrollment procedures for specialists and ancillary providers who wish to participate in MDwise are similar to those for MDwise PMPs, with the following exceptions:

- Before enrollment, the delivery system may conduct an assessment to determine if there is a need for the specialty service offered.
- The delivery system provider relation's representative can assist the specialist in determining which forms need to be completed.
- Upon notification of intent to terminate an agreement, the provider file will be placed in an inactive status in the MDwise database.

PMP Panel Size Selection and Changes to the Panel Size

As part of the enrollment process, a PMP designates his or her desired panel size on enrollment forms submitted to MDwise. The panel size is the number of MDwise members a PMP agrees to accept. Following are various program requirements related to panel size selection and change:

- The minimum panel size is 150 for Hoosier Healthwise or 25 for HIP unless an exception is granted by MDwise. The maximum panel size is 9,999 members. Panel sizes must be designated for each program, Hoosier Healthwise and HIP, since they are reported to HP separately.
- If a physician has two practice locations, the panel size would represent a combination of both sites. For example, if a PMP is enrolled with a panel size of 500 for Hoosier Healthwise, and has two active service locations, the members assigned to him or her may be spread across the two locations.
- The panel size applies to an individual PMP and may not be shared among a group of PMPs.

MDwise can approve the enrollment of a new PMP with a panel size below the minimum requirement on a case-by-case basis due to specific circumstances in an area. This exception generally applies to all PMPs with a specific specialty, such as OB/GYN, in an area where increased access to PMPs with a particular specialty is warranted.
From time to time, PMPs may receive auto-assignments to their existing panel. Auto-assignment is mandated by federal law. This is due to the requirement that members who are in a managed care program have a primary care physician. If a physician has open panel slots and that panel is not full or on hold, they may receive additional members through the auto-assignment process. It should be noted that PMPs that have full panels or panels on hold may still receive auto-assignments. This can happen if the PMP is already treating a member of a family member who is being auto-assigned or has a previous relationship with the member through another IHCP program or previous eligibility segment. PMPs cannot request members be removed from their panel due to the fact that member was auto-assigned.

**Panel Modifications and Panel Hold Requests**

MDwise PMPs that wish to increase or decrease their panel size designations must submit a written request to their delivery system provider relation’s representative. The delivery system will review the request, complete the required paperwork and submit it to MDwise for review and submission to OMPP for approval.

- PMPs may increase their panel size designation at any time.
- PMPs may also request to reduce their panel designation. However, a panel size designation less than the current member of assigned members will not result in an immediate reduction of the panel to the new designation. Members will not be removed; therefore reduction in the panel size can only occur through attrition.

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

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

*Please Note: Your delivery system provider relation’s representative is available to assist you with selecting an appropriate panel size, completing the required forms and helping with any panel size changes or hold requests. Please refer to the Directory in the front of this book for contact information.*
HOW MEMBERS BECOME ELIGIBLE FOR HOOSIER HEALTHWISE

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

THE HOOSIER HEALTH CARD

Once eligibility is confirmed, HP, the state’s fiscal agent for Hoosier Healthwise issues a Hoosier Health card to all new members. Hoosier Health cards are issued only once. A new card is issued only if member loses a card. Family members covered under Hoosier Healthwise each receive their own plastic Hoosier Health Card and cards are not transferable among family members. Members should bring their Hoosier Health Card to each visit.

Information on the front of the card should include the member’s:

- Name and gender
- Date of birth
- Member identification number (RID#)

If you suspect that a member has presented an identification card belonging to someone else, you may request to see a photo ID. If you suspect fraud, please contact the MDwise Compliance Officer at (317) 630-2831 OR (800) 356-1204 immediately.
HOW TO VERIFY ELIGIBILITY

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

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

When you check a member’s eligibility status, you may obtain enrollment information such as:
- Eligibility status
- Availability of other insurance
- Program restriction information

Verifying Eligibility With A Hoosier Health Card

To verify eligibility, the provider has several options from which to choose:
- You can check eligibility through the Automated Voice Response (AVR) system at (317) 692-0819 or 1-800-738-6770, or
- You can also use an OMNI “swipe machine”, or
- You can use the HP Web interChange (https://interchange.indianamedicaid.com) to check eligibility.

At this website, when you enter the member’s RID, you will see the member’s primary physician, the Managed Care Entity (MCE) they are assigned to, their delivery system, where to get prior authorization, and where to send claims. If the member has not yet selected a PMP, you will only see the MCE that the member is assigned to. If Web interChange indicates that the member is assigned to MDwise, but there is not a PMP assignment yet, you can call MDwise Customer Service for additional information about where to get prior authorization and where to send claims.

Please call 1-800-577-1278 for more information about using these options.

VERIFYING ELIGIBILITY WITHOUT A HOOSIER HEALTH CARD

Eligible MDwise members may on occasion need medical care before they receive their Hoosier Health card, or when they forget to bring their card with them. Providers must check the member’s eligibility even though the card is not available, or when a member does not have their card. In these situations, eligibility may be verified by:
- You can check eligibility through the Automated Voice Response (AVR) system at (317) 692-0819 or 1-800-738-6770, and giving the person’s social security number (SSN), or
- You can also use an OMNI “swipe machine”, using the member’s social security number (SSN), or
- You can use the HP Web interChange (https://interchange.indianamedicaid.com) to check eligibility, or
- You can enter the member’s Hoosier Healthwise number in manually on the OMNI “swipe machine” device.
Eligibility redetermination occurs at intervals determined by the State, normally every six or twelve months. Members whose Hoosier Healthwise eligibility is continuous maintain their PMP relationship. However, before eligibility is redetermined, some members may have a gap in eligibility. If there is a gap in coverage, the member may be processed as a new member. The member is then given 30 days to choose a PMP; otherwise they are auto-assigned (See Chapter 8). If the member was previously enrolled in MDwise they will be auto-assigned to their previous PMP to maintain that relationship.

Hoosier Healthwise Member Disenrollment Process

Members are disenrolled from MDwise either through PMP change selections (e.g. member chooses a new PMP in a different MCE) or through eligibility terminations provided to MDwise by the state. Maximus, the State’s enrollment broker approves, monitors and tracks all member movement to other MCEs, although the OMPP has ultimate authority for allowing eligible members to disenroll from the program. Please note, that MDwise will neither terminate enrollment nor encourage an enrollee to disenroll because of a patient’s health needs, change in a patient’s health status or patient’s health care utilization patterns.

How Members Become Eligible for the Healthy Indiana Plan (HIP)

Individuals interested in obtaining Healthy Indiana Plan (HIP) coverage must complete an application. If a parent and child are signing up for health insurance coverage at the same time, a HIP application must be filled out for the parent, and a separate Hoosier Healthwise application must be filled out for the child. Applicants can download and print applications from the internet at hip.in.gov. Applications may also be picked up at various community organizations participating in the V-CAN network, Hoosier Healthwise Enrollment Centers, and the local Division of Family Resources (DFR) office. To find locations, a member can call 877-GET-HIP-9. Completed applications can be submitted to the DFR county office or mailed directly to the FSSA Document Center at PO Box 1630, Marion, IN, 46952. Members may also fax completed applications to 1-800-403-0864 or drop them off at their local FSSA DFR office.

The HIP application will include questions on an individual’s recent health status. Individuals who have high-risk conditions will be assigned to the state’s Enhanced Services Plan (ESP) that will provide enhanced disease management services and will allow access to special networks and providers to assure the individual’s needs are met.

MDwise must accept individuals eligible for enrollment in MDwise in the order in which they apply without restriction.

ELIGIBILITY FOR HIP

Members eligible for HIP include uninsured adult Hoosiers who are legal US residents between the ages of 19 and 64 and who are not eligible for Medicaid. Member’s household income is between 22 - 200% of the federal poverty level (FPL). HIP is only open to Hoosiers who have been uninsured for a minimum of six months and do not have access to health insurance through their employer. Consolidation of Benefits in Retirement Act (COBRA) coverage is not subject to the six-month wait provision, however, all benefits must be exhausted.

A person earning above 200% FPL, who has been uninsured for six-months and does not have access to health insurance through their employer may purchase
the plan at full cost, with no subsidy from the State. Price will vary depending on the age, gender, geographic location and health risk assessment.

Also, if for some reason the plan has reached maximum enrollment, individuals below 200% of the FPL that would normally qualify for HIP can purchase the plan at the discounted Healthy Indiana Plan rates. However, the individual will be responsible for the entire cost and the State will offer no subsidy.

THE HIP CARD
MDwise HIP members will receive a member ID card. Please see a sample card below:

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>FIRST NAME/LAST NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMP Name:</td>
<td>FIRST NAME/LAST NAME</td>
</tr>
<tr>
<td>PMP Phone:</td>
<td>(000) 000-0000</td>
</tr>
<tr>
<td>Delivery System:</td>
<td>Hoosier Alliance</td>
</tr>
<tr>
<td>ER Copay:</td>
<td>$25 OR 20%</td>
</tr>
<tr>
<td>POWER Account Amt:</td>
<td>$1,100</td>
</tr>
<tr>
<td>Rx Bin:</td>
<td>610467</td>
</tr>
<tr>
<td>Rx PCN:</td>
<td>INCAIDPROD</td>
</tr>
</tbody>
</table>

This card does not prove eligibility nor guarantee coverage.

EMERGENCIES: Call 911 or go to the nearest Emergency Room

If you become pregnant, please call Customer Service as pregnancy services are NOT covered under the Healthy Indiana Plan. You may apply for another plan to cover pregnancy care.

Pharmacy:
Pharmacy Prior Authorization Helpline: 1-866-879-0106
Pharmacy Services POS Help Desk: 1-800-577-1278 or 317-655-3240
Member Services Helpline: 1-800-457-4584 or 317-713-9627

MDwise Customer Service for Members and Providers:
1-800-356-1204, Local 317-630-2831, TTY/TDD: 1-800-743-3333

Claims Address: MDwise, P.O. Box 78310, Indianapolis, IN 46268

If you suspect that a member has presented an identification card belonging to someone else, you may request to see a photo ID. If you suspect fraud, please contact the MDwise Compliance Officer at (317) 630-2831 OR 1-877-822-7196 immediately.

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

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

HIP eligibility information is available through MDwise secure web portal. Go to MDwise.org for information on how to access the Provider web portal.

Also, limited information is also available in the IHCP Eligibility Verification Systems (EVS) at https://interchange.indianamedicaid.com. EVS will provide the
The following eligibility information for HIP members:

- The member is eligible for HIP
- The member’s insurer and telephone contact information for member’s benefits

At this website, when you enter the member’s RID, you will see which plan the member is assigned to. If the member is assigned to MDwise HIP please contact our customer service for details on where to submit claims or refer to Quick Contact information on MDwise.org. If you have questions about how to use the eligibility options above, please call 1-800-356-1204 or 317-630-2831 for more information about using these options.

HIP ELIGIBILITY FOR WOMEN WHO BECOME PREGNANT

The Healthy Indiana Plan (HIP) excludes pregnancy services and related services from its covered services. If a member becomes pregnant while in HIP, they have a choice of staying on HIP or moving to Hoosier Healthwise, Package B. However, if the member decides to stay on HIP, pregnancy services will not be covered under the HIP plan.

If a woman becomes pregnant while on HIP and wants to transition to Hoosier Healthwise, she must promptly submit proof of pregnancy to the State Division of Family Resources (DFR). She will then be removed from HIP, and all of her medical services, pregnancy-related and other, will be covered under Package B of Hoosier Healthwise. The Hoosier Healthwise MCE, not the Healthy Indiana Plan, will cover all of the woman’s pregnancy-related services. MDwise is responsible for helping the member with the transition between programs to assure seamless coverage. The member will receive a prorated balance of her POWER Account upon leaving the program. Following her pregnancy, she may enroll back in the HIP plan.

The member must submit to DFR positive proof of pregnancy including member and medical provider contact information along with the Change Report Form. The necessary documentation to initiate enrollment into Hoosier Healthwise for pregnancy coverage may include results of a medical provider’s pregnancy test or a letter from a licensed healthcare provider along with a Report of Change Form, which is accessible at state.in.us/icpr/webfile/formsdiv/44151.pdf.

Please refer to Chapter 12, Claims Submission and Payment Policy, for information on submitting pregnancy related claims for HIP members that are transitioning to Hoosier Healthwise, Package B.

Please Note: If you determine, or suspect that a HIP member is pregnant, please call MDwise Customer Service as soon as possible and let us know. We will then contact the member and assist her with transitioning to Hoosier Healthwise. The member will need proof of pregnancy from a licensed health professional that includes: confirmation of pregnancy, the anticipated date of delivery, and if multiple births are expected.

Before providing any pregnancy-related service to a HIP member, you must:

- Inform member that pregnancy related services are not covered under HIP
- Inform member that they can obtain pregnancy coverage by submitting a change report form to DFR and that MDwise staff is available to assist with the enrollment process
- Provide the member with documentation of positive proof of her pregnancy, including the results of the pregnancy test or a letter from a licensed healthcare provider. Also include the number of births expected, if known.
Assignment to a HIP Health Plan

Individuals will be able to indicate their plan (MCE) preference when they sign up directly on their application or through an enrollment broker. If a choice is not made, the individual will be assigned to a plan. Families, or two individuals in the same household, must choose the same plan. High-risk individuals will be assigned to the Enhanced Services Plan (ESP) that will provide enhanced disease management services as well as provide access to a special network of providers.

Individuals can change plans only before their first POWER Account contribution has been made. After that, they will have to stay with their plan for the duration of their 12-month term. They can only change plans for poor quality of care provided by the plans.

HIP Member Disenrollment

Members will be disenrolled from the Program and MDwise for any one of the following reasons:

- The member fails to make the required monthly POWER Account contribution within 60 calendar days of its due date
- The member is determined ineligible for the Program at redetermination
- The member obtains access to employer sponsored coverage
- The member becomes covered under another health insurance policy or FSSA program, including pregnant women who are transferred into Hoosier Healthwise
- The member is no longer an Indiana resident
- It has been determined that the member was inappropriately enrolled in the plan

The member may also be disenrolled from the MDwise (but not the Program) if, based on a general health questionnaire, physical examination or claims data, the State confirms that a member has a high-risk condition that requires referral into the State’s ESP program.

Poor quality of care is defined as:

- Action, or lack of action, by the Insurer which puts the life of health of the member at risk or jeopardizes the member’s ability to reach and maintain maximum function;
- Unreasonable delay by the Insurer in granting a prior authorization request;
- Failure of the Insurer to provide covered services
- Corrective Action levied against the Insurer by OMPP; or
- Other circumstances determined by FSSA to constitute poor quality of care.

When coverage is terminated for failing to make the required contribution to their POWER account, in addition to losing medical coverage, the individual cannot reapply for 12 months. If an individual chooses not to renew participation after 12 months in the plan, the individual may not reapply for the plan for at least 12 months. They will also face a penalty on the remaining balance of their POWER Account and will not be able to receive the full proportional balance of their contribution.

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

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

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

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

Members who are not satisfied with the results of the MDwise grievance and appeals process may submit a request to change insurers to the enrollment broker. The enrollment broker reviews the request, verifies that the grievance and appeal process at MDwise was exhausted and forwards to FSSA for a determination. If the request is not granted by the FSSA, the member may request an FSSA fair hearing.

If the member’s disenrollment for cause request is approved, MDwise is responsible for providing coverage for the member until it receives notification that the fiscal agent has processed the disenrollment.

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

**HIP Eligibility Redetermination**

Recertification of eligibility in HIP will occur every 12 months and will be based on criteria established by the State. MDwise will assist members in initiating/completing the recertification process, and will begin as early as 60 days prior to the end of the coverage term and in compliance with FSSA processing guidelines. These steps will help prevent interruptions in member care or access to health services.
Many of our members do have a primary medical provider (PMP) when they select MDwise as their Hoosier Healthwise or HIP health plan. For those members that do not have an existing medical home, MDwise Customer Service Representatives help them select a primary care physician after the member has chosen MDwise as their health plan, or, been assigned to MDwise if they did not choose a health plan. Our Customer Service Representatives use the searchable MDwise Provider Directory to help members match their specific needs with a specific MDwise PMP. Once an eligible applicant selects a PMP, they will be assigned to the MDwise Delivery System their PMP is contracted with.

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

Auto-Assignment

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

Because continuity of care is one of the cornerstones of the Hoosier Healthwise and HIP programs, the reassignment of a member to his or her previous PMP takes precedence over all other auto-assignment logic. This rule supersedes the PMP panel size limits, and allows auto-assignment of a member to a PMP with a full panel or a panel on “hold”.

If there is not a previous PMP relationship, the auto-assignment logic next looks for a previous relationship with a PMP, a family member’s current PMP, a family member’s previous PMP, a PMP in a previous provider group, or a PMP in a family member’s current group or previous group.

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

MDwise encourages pregnant members to choose a PMP for their newborn before the baby’s birth. If the member does not preselect a PMP for their newborn, then one will be autoassigned during the enrollment process. If the expectant member is a MDwise member, then the autoassigned PMP for the newborn will also be a MDwise provider, in the same delivery system as the mother.

Physicians are encouraged to discuss the selection of a PMP for their patient’s newborn prior to delivery. Continuity of care can be increased through education of pregnant members about the importance of choosing a doctor for her baby early and the benefits of choosing the baby’s PMP from within the same plan as her PMP. Education may also be directed towards helping members understand the importance of pre-selecting a PMP to:

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

A pre-birth selection may occur at anytime prior to the birth of the infant. The Office of Medicaid Policy & Planning (OMPP) has determined that a pregnant member must select a PMP in the same managed care entity (MCE) as the mother for her unborn child. The mother does have the option to choose a different PMP for their newborn outside of the MDwise Plan network after birth within the open enrollment period (first 90 days). If the newborn is assigned to a PMP who the mother did not choose, a PMP change can be requested by calling MDwise Customer Service at (317) 630-2831 or 1-800-356-1204, or, for a PMP in another health plan, Hoosier Healthwise 1-800-889-9949.

PRE-BIRTH SELECTION FORMS

MDwise has a pre-birth selection form that the provider’s office can use in helping pregnant patients select a physician for their newborn. A copy of this form can be found on the MDwise website at MDwise.org, or it can be obtained from your delivery system provider relations representative.

It is important to note that the expectant mother must select a PMP that is participating in the MDwise network, and with the delivery system the mother is assigned to. The provider’s office may fax the completed pre-birth selection form to either their delivery system provider relations representative or to the MDwise Customer Service Department. An expectant mother may also call MDwise Customer Service directly to pre-select a MDwise PMP for their soon-to-be-born baby.

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

Please Note: Package C newborns should never be retroactively assigned to a PMP. If this occurs, please contact your delivery system’s provider relation’s staff.
Helping Members to Change Doctors (Non-Newborns)

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

However, in accordance with OMPP guidelines, a MDwise member may change their PMP at any time within the MDwise Plan, for any reason. If a MDwise member wishes to change their PMP, they should be instructed to contact the MDwise Customer Service Line at: (317) 630-2831 or 1-800-356-1204. This gives MDwise the opportunity to identify potential issues and assist the member in selecting a new PMP within the MDwise network of physicians. MDwise may process requests for PMP changes only if the member wishes to remain with MDwise and selects another MDwise PMP.

If the member wants to select a PMP in a different managed care entity (MCE), they may only do so during the first 90 days of their open enrollment period, or, if there is just cause to make the reassignment sooner. Under Open Enrollment, members can change health plans only at the following times:
• Anytime during their first 90 days enrolled with a new health plan
• Annually during their open enrollment period
• Anytime there is “just cause”

Just cause reasons are as follows:
• Lack of access to medically necessary services covered by MDwise.
• The MCE does not, for moral or religious objections, cover the service the member seeks.
• The member needs related services performed at the same time and not all related services are available within the MDwise network. The member’s PMP or another provider determines that receiving the services separately would subject the member to unnecessary risk.
• Lack of access to providers experienced in dealing with the member’s health care needs.
• Poor quality of care, including failure to comply with established standards of medical care administration and significant language or cultural barriers.
• The member’s MDwise PMP moves to another MCE.

Maximus, the State’s Enrollment Broker can assist the member to change to another MCE or health plan. MDwise Customer Service representatives can transfer the member to Maximus, if necessary.

The individual who is processing the PMP change request will advise the member of the following:
• If medical care is needed before the PMP change request is effective, the member must continue to seek care from their currently assigned PMP.
• The approximate date the change will be effective
• The member will receive a letter confirming the change and actual effective date of the change once it has been determined.

Certain PMP change requests will receive an upper level review at MDwise and/or by the State, particularly those requests that are related to quality of care or service. In some cases, the member’s request may not be able to be processed (e.g. PMP panel full, doesn’t meet PMP specialty criteria, etc.). The member will then be contacted to select a different PMP.

PMP changes are effective on the first day of the month. Requests for PMP changes entered into the IndianaAIM system by the 25th of the month are effective the first of the following month. Changes entered into the system after the 25th day of the month will not be effective until the first day of the second month.

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

MDwise and the MDwise delivery systems will assist in facilitating the reassignment of a member who is assigned to an OB/GYN (PMP) but is no longer pregnant and whose eligibility will likely continue past the 60 day post-partum period. Assisting the member to select a new PMP helps to ensure that the member may access necessary primary and preventive care services. If the member is a HIP member who was in Hoosier Healthwise Package B for services during pregnancy, MDwise Customer Service will assist the member in being assigned back to her HIP PMP.

Please Note: If you provide OB/GYN services only and have a member that has recently delivered and is in need of a PMP change, please call your delivery system provider relations representative. Please note that a PMP change cannot occur until the member has had their postpartum visit (or after 60 days post partum).
Chapter 9 – Credentialing

As a condition of participation in any of the MDwise Plans, licensed independent practitioners or groups of practitioners (including non-physician practitioners) who are contracted with a MDwise delivery system and provide care for MDwise members, must be credentialed according to MDwise participation criteria and standards.

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

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

The function and goals of the MDwise Credentials Program are:

- to support development and maintenance of credentialing and recredentialing standards for MDwise practitioners, based on the Office of Medicaid Policy and Planning (OMPP) and National Committee for Quality Assurance (NCQA) standards
- to review the qualifications of potential network practitioners against established standards; and,
- to reassess the credentials and performance of network practitioners periodically to ensure that practitioners are qualified to carry out the scope of their duties on behalf of MDwise.

Please Note: In the MDwise Hoosier Healthwise Plan, and MDwise HIP, the credentialing and recredentialing of providers is delegated to the MDwise delivery systems. Behavioral Health providers who are contracted in these programs are credentialed by BHMI. Please contact the corporate Provider Relations Department if you have questions about the credentialing process.

MDwise Practitioner Participation Criteria

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

- Application: Attested and completed application
- State License: Current, valid, and unrestricted license to practice in Indiana. If, however a practitioner only practices and sees members in a neighboring state, practitioner must have current, valid, and unrestricted license to practice in that state.
- DEA: If requesting prescriptive authority, current, valid and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. Note: DEA or CSR certificates are not applicable for chiropractors.
• Education: Graduate of a school recognized by the appropriate Indiana State Boards. Satisfactorily completed a residency program in the appropriate specialty of practice. If Board Certified, residency requirements are met. Note: Residency requirements are not applicable for chiropractors.

• Board Certification: Board certified or board eligible in the specialty in which the practitioner treats MDwise members. Board certification must come from a recognized Board, such as the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Podiatric Medical Association (APMA) or other recognized specialty boards. Note: Board Certification does not apply to chiropractors.

Exceptions may be granted if:

a. The practitioner has recently completed degree requirements and is in process of seeking board certification, or.

b. Practitioner has satisfactorily completed a residency program in the appropriate specialty and has acquired a minimum of 25 Category I CMEs in the previous 12 months (1 year credentialing cycle) or 50 Category I CMEs in the previous 24 months (2 year credentialing cycle), or 75 Category I CMEs in the previous 36 months (3 year credentialing cycle) in his/her primary specialty or

c. The physician’s specific services are not sufficiently available from board certified or board eligible practitioners within a reasonable commuting distance.

• Privileges: Current clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility

Exceptions may be granted if:

a. The physician’s practice does not require admitting or practicing privileges at a hospital. These specialties include, but are not limited to: Radiology, Podiatry, Pathology, Dermatology, Emergency Medicine, and Allergy, some Behavioral Health Practitioner specialties if hospital privileges are available in their specialty.

b. A MDwise primary medical provider (PMP) has a clinical appointment or relationship privileges in good standing at a participating MDwise hospital.

• Current Liability Coverage: Maintains professional liability insurance coverage of $250,000/$750,000 with participation in the Indiana Patient Compensation Fund. If the practitioner is not qualified as a provider under the Fund then they must maintain coverage of $1,000,000 per occurrence, $3,000,000 aggregate or be a covered employee or contractor of an entity that is eligible for coverage under the Federal Tort Claims Act.

• Malpractice History: Demonstrates acceptable liability history based on the frequency, pattern and type of all settled and pending claims against the practitioner. Practitioner must submit detailed report of each liability claim filed within the past ten years. The Medical Director or designee will review the claims history for any trends, such as pattern of frequency, date of occurrence, number of open cases, sequential order of patterns and file date.

The peer-review Committee or designee will individually review all practitioners with the following:

Two (2) or more filed malpractice claims or settlements in the last five (5) years, or

Any settlement or award for $500,000 or more in the last five (5) years, or

Any filed malpractice claims or settlements involving the death of a patient.

Recredentialing - If no additional suits have been filed against the practitioner since the most recent credentials cycle or if no new information exists on previous cases (e.g., settlement reached, finding of malpractice, etc.) individual consideration of liability history is not required.

• Impairment: Certifies that a physical or mental impairment (including absence of chemical
dependency and substance abuse) does not affect his/her ability to practice.

- Sanctions, Disciplinary Action or Criminal Indictment: Must demonstrate absence of Medicare or Medicaid Sanctions. Must disclose 1) all past or pending sanctions under state or other licensing agencies, hospitals and other facilities, or DEA and 2) all past or pending disciplinary or professional committee action by a health care entity (e.g. hospital) 3) all information concerning any past suspensions, limitations or termination by any managed care plan, hospital or insurer and, 4) any felony convictions. Must demonstrate that history of sanctions/convictions does not demonstrate potential future substandard professional performance.

- Work History: Satisfactory five-year professional employment and/or education history.

- Initial Office Review: PMP’s, obstetrician/gynecologists and high volume behavioral health specialists must have satisfactory office onsite survey results to participate in MDwise network.

- Attestation Statement: Practitioner must attest to the correctness and completeness of the application.

- IHCP Participation: MDwise practitioners must be enrolled as providers in the Indiana Health Coverage Programs (IHCP). Practitioners who have laboratory testing services onsite must also provide proof of a Clinical Laboratory Improvement Amendments (CLIA) certificate.

- Contract: Must execute an agreement to abide by the terms of the contract.

Criteria for Advanced Practice Nurses & Physician Assistants

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

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

- DEA: If requesting prescriptive authority, current, valid and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. Note: DEA or CSR certificates are not applicable for some types of physician extenders.

- Privileges: Hospital privileges are not applicable for physician extenders.

- Education: Graduate of a school recognized by the appropriate Indiana State Boards. Board certification requirements are not applicable.
Criteria for Behavioral Health Practitioners

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

- Written Practice Agreement: Proof of collaboration with a licensed network Practitioner, in the form of a written practice agreement
- DEA: If requesting prescriptive authority, current, valid and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. Note: DEA or CSR certificates are not applicable for non-physician behavioral health practitioners
- Education: Graduate of a school recognized by the appropriate Indiana State Boards. Board Certification does not apply some Behavioral Health Practitioner Specialties if not available in their Specialty
- Privileges: Exceptions may be granted if the behavioral health practitioner does not require admitting or practicing privileges at a facility (e.g. psychologist, clinical social workers, psychiatric nurse practitioner, etc.).

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

Initial Credentialing

Practitioners must complete a standard credentialing application when applying for initial participation and submit other required information as required (e.g. DEA certificate, malpractice insurance face sheet, curriculum vitae, etc). Credentials staff will collect information from recognized monitoring organizations, conduct the required verifications, and review the practitioner’s credentials. The credentials staff will notify the practitioner about any information obtained during the credentials process that varies substantially from the information supplied by the practitioner. The practitioner is then given the opportunity to provide additional information regarding the discrepancy.

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

Please Note: All practitioners have the right to request and receive information regarding the status of their credentialing application. The practitioner may call or write 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.
Office Site Visits

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

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

Recredentialing

MDwise requires that all providers participating in the MDwise Plan be recredentialed at least every thirty-six months. Some delivery systems may for the Hoosier Healthwise program or HIP, however, recredential providers every two years. This is generally because their recredentialing cycle coincides with hospital reappointment timeframes.

The recredentialing process is conducted similarly to the initial credentialing process. Practitioners must submit a standard recredentialing application. The credentials staff will then collect the necessary information and conduct the required verifications. In addition, during recredentialing, they may use data derived from practice experience within the organization as part of its evaluation regarding practitioner retention. The practitioner will be notified if any information obtained during recredentialing varies substantially from the information that was supplied to the delivery system. The practitioner will also be given the opportunity to provide additional information regarding the discrepancy. When all required information and verifications have been completed, the practitioner’s application will be considered by the delivery system’s Credentials Committee at outlined above. The practitioner will be notified of the recredentialing decision within sixty (60) calendar days of the peer-review committee’s decision.

Please Note: All practitioners have the right to request and receive information regarding the status of their recredentialing application. The practitioner may call or write 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.

Ongoing Monitoring of Sanctions, Complaints and Quality Issues

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

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

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

**Delegation Oversight**

Even though MDwise delegates the credentialing and recredentialing of providers to subcontractors, MDwise remains responsible for assuring members that the same standards of participation are followed across the MDwise Plan. MDwise ensures that the credentialing policies, procedures, and criteria of the delivery systems meet MDwise standards. MDwise also conducts an annual evaluation of the effectiveness of the delegated credentialing activity (including review of credentials files) and retains final decision-making authority regarding MDwise network participation of the delivery system’s practitioners.

The subcontractors each provide MDwise with a list of practitioners that have been approved through their peer review process. This information is then reviewed by the MDwise Medical Advisory Committee who make recommendations on credentialing and recredentialing to the MDwise Medical Director for final consideration.

**Confidentiality**

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

Credentials files and confidential written records regarding deficiencies found, the actions taken and the recommended follow-up is kept in a secure fashion. Access to information is restricted to those individuals necessary to attain the objectives of the credentials process. Dissemination of any confidential information shall only be made (1) where expressly required by law, or (2) with permission of the practitioner applicant.
Chapter 10 – Provider Responsibilities in Serving MDwise Members

This chapter contains important information about your role and responsibilities as a MDwise provider. Topics covered in this chapter include: the provision of covered services, specialty referrals, MDwise access standards, confidentiality of member information, medical recordkeeping practices, use of physician extenders, notification or pregnancy, provision of interpretive services, and cultural sensitivity.

The Primary Medical Provider’s Role

The Primary Medical Provider (PMP) is an integral part of the MDwise managed health care program. The PMP functions as the central access point for MDwise members. MDwise PMPs coordinate all covered physical and behavioral health care services for their assigned members, except for self-referral and carved-out services, as described in Chapter 3 and Chapter 4. This includes guiding members to participating specialists and hospitals when necessary and maintaining continuity of each member’s health care.

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

SPECIFIC PMP DUTIES

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

• Policies and Procedures: Follow all MDwise policies and procedures and Federal and State requirements.
  1. MDwise policies are described in this Provider Manual.
  2. State requirements can be found on the web at indianamedicaid.com.
  3. If you have any questions about these policies, call MDwise provider relations staff or MDwise Customer Service.

• IHCP Enrollment: Must be enrolled with the State as a participating provider in the Indiana Health Care Programs (IHCP). This means having a valid, current Medicaid provider number and NPI number.

• Panel Size: Designate a panel size upon enrollment:
  4. Hoosier Healthwise – 150 – 3500
  5. HIP – minimum of 25

• Covered Services: Provide covered PMP services to all MDwise members assigned to PMP.
  6. This includes working with the medical management department to obtain all medically necessary referrals (to specialists or other providers) needed by the PMP’s assigned members.

  7. MDwise will not in any way limit a PMP’s ability to advise a member about their health status, medical care, or treatment options, even if MDwise does no cover those treatment options.

• Access to Care: Provide or arrange for coverage of services to assigned members:
  8. 24 hours a day, 7 days a week – in person or by an on-call physician.

  9. Live voice coverage must be available after normal business, which may include an answering service, shared-call system with other medical providers, or pager system.

  10. Must answer emergency and urgent phone calls from members within 30 minutes.

  11. This includes a minimum of 20 office hours over a 3-day period each week. (The 3-day requirement can be filled by more than one PMP in a group practice)
• Billing and Co-payments: Except as allowed under State and program regulations, must not bill or charge co-payments to any MDwise member. Note: Please refer to Chapter 5 of this Provider Manual, and the IHCP Provider Manual, Chapter 4 for specific information on member billing.

• Medical Records: Maintain medical records for MDwise members assigned to the PMP, for the longer of seven (7) years from the date the PMP’s contract ends, or as required by law. Medical records must also be legible, dated, and signed by the rendering provider.

• Confidentiality: Protect all medical records for MDwise members as required by law and regulation. Agree not to disclose any MDwise information (like contracts, fee schedules, policy and procedure manuals, and software) or use them except in acting as an MDwise PMP.

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

• Claims: Submit timely and accurate claims and other data, as required by the State, to the appropriate MDwise delivery system or HIP payer for each service rendered to MDwise members.

• Cooperation with MDwise programs: Participate in and follow the rules of the MDwise quality improvement, utilization management, credentialing, grievance resolution, provider service and member education/outreach programs.

• Notify MDwise about changes in licensure status: PMP must notify MDwise provider relation’s staff within 3 business days if the PMP loses or surrenders a professional license, privileges, or Drug Enforcement Administration provider number, or if any other action negatively impacts the PMP’s ability to render services.

• Continuation of Care: If the PMP contract ends, the PMP must continue to provide care to MDwise members assigned to the PMP until a transition can be made transferring the members to other MDwise PMPs, or other health plans/providers.

12. However, if a member is currently hospitalized, has a chronic or disabling condition, is in the acute phase of an illness, or is in the second or third trimester of pregnancy, PMP must continue to provide services to the member as long as MDwise is required by law or contract to continue that member’s care.

• Communications with the State: If a PMP has questions or concerns about MDwise, the PMP must first attempt to handle the issue by calling MDwise Customer Service or their delivery system provider relations representative rather than contacting the State directly.

• Cultural Competency: PMPs must provide information regarding treatment options in a culturally competent manner. PMPs must ensure that individuals with special needs have effective communications with participants throughout the MDwise system in making decisions regarding treatment options.

• Nondiscrimination: PMPs shall not discriminate against any MDwise member or against any employee or applicant for employment based on race, religion, color, sex, disability, national origin, or ancestry.
Provision of Covered Services

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

Please refer to Chapters 3 and 4 for an overview of Hoosier Healthwise and Healthy Indiana Plan benefits.

Provider Access Guidelines

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

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

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

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

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<th>ACCESS STANDARDS FOR PMP VISITS</th>
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<td>Appointment Category</td>
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<tr>
<td>Urgent/Emergent Care Triage</td>
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<tr>
<td>Non-Urgent Symptomatic</td>
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<tr>
<td>Routine Physical Exam</td>
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<tr>
<td>Initial Appointment (Non-pregnant Adult)</td>
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<tr>
<td>Routine Gynecological Examination</td>
</tr>
<tr>
<td>New Obstetrical Patient</td>
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<tr>
<td>Initial Appointment Well Child</td>
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<tr>
<td>Children with Special Health Care Needs</td>
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SPECIALIST ACCESS

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

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<tr>
<th>ACCESS GUIDELINES FOR SPECIALIST VISITS</th>
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<td>Appointment Category</td>
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<tr>
<td>Emergency</td>
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<tr>
<td>Urgent</td>
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<td>Non-Urgent Symptomatic</td>
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PHYSICIANS RESPONSE TIME

For emergencies and urgent situations, MDwise members must be able to reach their Primary Medical Provider (PMP) or his/her designee by telephone within 30 minutes, 24 hours per day, and 7 days per week.

For non-urgent routine telephone messages, a return call should be made to the member within one working day.

OFFICE APPOINTMENT WAITING TIMES

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

OFFICE TELEPHONE ANSWERING TIME

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

ACCESSIBILITY AND AVAILABILITY AUDITS

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

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

Your assistance with these monitoring efforts is greatly appreciated.
Missed Appointments

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

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

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

Confidentiality of Member Information

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

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

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

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

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

- Established confidentiality standards for employees.
- Limited release of medical records and information from or copies of records to authorized individuals.
- Assurance that unauthorized individuals cannot gain access to or alter patient records.
- Established levels of authorized user access to data.
- Assurance of timely access to members who wish to examine their medical records.
All MDwise members have the right to file a complaint or grievance regarding concerns of use or protection of confidential information or data. The member is advised of the right to file a complaint or grievance in the MDwise member handbook.

**Medical Records**

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

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

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

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

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

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

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

MDwise has joined the other two Hoosier Healthwise Managed Care Entities to participate in the Notification of Pregnancy program. The program was launched in 2009 and already has proven to be beneficial. Through the Notifications of Pregnancy we have been able to identify pregnant Hoosier Healthwise members with histories of high-risk pregnancies or women who are vulnerable to developing a high-risk pregnancy due to existing health conditions and/or psychosocial issues that may potentially impact the birth outcome.

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

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

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

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

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**Cultural Sensitivity**

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

Providers face these issues every day in clinical practice. In addition to addressing concerns regarding language and communications, physicians working with our members often need to make distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the member’s cultural background. Language, religious beliefs, cultural norms, socioeconomic conditions, disability status, diet, etc., may make one treatment method more palatable to a member of a particular culture than to another of a differing culture.
MDwise is committed to working to eliminating potential barriers our members face due to cultural differences. Through avenues such as direct member contact, new member telephone calls, member satisfaction survey, provider information and complaint data, MDwise may become aware of a member’s special needs. MDwise then attempts to work with the member to address identified barriers and help them access needed care and services.

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

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

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

There are several ways in which providers working with multicultural members and families can contribute to a members’ positive experience with MDwise and our provider community. An important first step is to be sensitive to patients’ cultural beliefs and practices and to convey respect for their cultural values through the manner in which you communicate with them and deliver their healthcare. This may require the use of interpretive services, either from a provider or staff from the same ethnic group as the patient, from hospital delivery system resources or through CryaCom language services (see Chapter 18).

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

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

• Interview and assess patients in the target language or via appropriate use of bilingual/bicultural interpreter.
• Ask questions to increase your understanding of the patient’s culture as it relates to health care practices.
• Where appropriate, formulate treatment plans that take into account cultural beliefs and practices.
• Write instructions or use handouts if available.
• Effectively utilize community resources.
• Request the patient to repeat information provided by healthcare professionals to ascertain understanding of message (educational and language barriers).
• Explain technical or specialized terminology and concepts and verify that the patient/consumer understands the content of what is being said.
• Clearly communicate expectations. When appropriate, use drawings and gestures to aid communication.
• Preserve patients’ dignity during physical examinations and offer emotional support to alleviate their fears and anxieties.
• A reflective approach is useful. Health care providers should examine their own biases and expectations to understand how these influence their interactions and decision-making.

• Seek to increase knowledge on the impact of cultural differences on the delivery of healthcare

Interpretive Services

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

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

HEARING IMPAIRED MEMBERS

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

Where sign communication is preferred, a family member or friend of the member can be encouraged to accompany the member to the appointment to aid in communication between the member and the care provider. In cases where the member requests a signor, MDwise providers are encouraged to provide this service through available MDwise resources or a contract service. Please contact your MDwise provider relation’s staff to learn about available resources.

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

To Access the Indiana Relay Service

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

NON-ENGLISH SPEAKING MEMBERS

CryaCom language services are available to assist providers in communicating with members that speak a primary language other than English. CryaCom’s language services are an interpretation resource that is available 24 hours a day, 7 days a week. The service is easily accessible and provides expertise in 140 different languages. These language services can be used to communicate with members by phone or in the office.

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

MDwise recognizes the value of physician extenders and the vital role they play in the delivery of primary and specialty care. With projections of continued shortages in the number of primary care physicians in Indiana, particularly for the underserved population, physician extender importance to the provision of timely care for our members cannot be understated. These practitioners (including nurse practitioners, nurse midwives, clinical nurse specialists, certified nurse anesthetists, and physician assistants) extend the availability of health care and have shown to substantially add to physician productivity, allowing the practice site to treat more patients in a timely manner.

Physician extenders can perform many primary and preventive care services physicians would otherwise have to provide directly. They can take medical histories, perform physicals, order lab tests and x-rays, provide patient education, and perform indirect patient care responsibilities. This frees up the physician’s time to focus their attention and skills on those patients who require a higher level of care and allow the practice to treat more patients daily.

MDwise is committed to the use of physician extenders to increase the availability of primary care offered to current and potential MDwise members. When utilized appropriately, physician extenders offer a cost-effective and valuable clinical resource for providing health care, especially as part of a safety net for underserved populations. Physician extenders in the MDwise network offer opportunities to extend PMP capacity to serve MDwise members and can assist in providing more timely access to preventive health care services and acute care for minor illnesses.
In the MDwise Plan, the administration of Hoosier Healthwise claims is delegated to the MDwise delivery systems. Therefore, providers must submit their claims to the delivery system to which the member receiving services is assigned. For example, if a provider is contacted with MDwise Wishard and has rendered services to a MDwise Wishard member, then the provider would submit their claim to the MDwise Wishard delivery system. However, if that same provider rendered services to a member that is assigned to MDwise Methodist, the provider would submit the claim to the MDwise Methodist delivery system.

If a provider is uncertain about what delivery system the member is assigned to, they may access this information on the HP Web interChange at indianamedicaid.com. At this website, when a member's RID number is entered, along with a provider NPI, you can see what IHCP program (Hoosier Healthwise, Care Select, or HIP) the member is in, what health plan (MCE) they are enrolled in if they are in Hoosier Healthwise, and, if they are in MDwise, what delivery system they are assigned to.

**Claims Submission and Inquiries**

**IN-MDIWSE NETWORK PROVIDERS**

Providers that are contracted with a MDwise delivery system (in-MDwise network providers) must submit their claim to the MDwise delivery system claims department to whom the member is assigned. Providers are encouraged to submit their claims electronically; however, they may also submit paper claims to the applicable delivery system address (see Directory). Please remember that all electronic claims must be submitted using HIPAA-compliant transaction and code sets.

**Please note:** If you have a question about a specific claim that you submitted, or about an EOB/EOP you received, please call the applicable delivery system claims inquiry line, provided on the MDwise website. If you have general questions about claims submission or payment policies, please call your delivery system provider relations representative.

**OUT-OF-MDIWSE NETWORK PROVIDERS**

Out-of-MDwise network providers should send their paper claims to the appropriate MDwise delivery system, or may also submit their claim electronically (see MDwise website). Providers should contact the applicable delivery system claims department, listed in the Directory, for specific instructions on electronic claims submission if problems with transmission occur. Out-of-MDwise network providers who have general questions or concerns about the submission process for claims should contact the MDwise Customer Service Department. If the provider has a specific question about an EOB/EOP they received, then the provider should call the delivery system claims department number listed on the EOB. The delivery system claims department numbers are also provided on the MDwise website, MDwise.org.
Contractually, all in-MDwise network providers are required to submit claims within 90 days of the date of service, unless the claim involves third party liability. The timely filing requirement is also waived in the case of claims for members with retroactive coverage, such as presumptively eligible women and newborns. MDwise is responsible for adjudicating clean electronic claims within 21 days of receipt and clean paper claims within 30 days of receipt. If MDwise fails to adjudicate (pay or deny) a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, interest will be paid on the claims, unless alternate written payment arrangements have been made with the provider.

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

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

**Claims Submission Guidelines**

The MDwise delivery systems process professional and institutional claims, with the exception of those services listed in Chapter 3 as “carve outs” (e.g. routine dental services). Pharmacy claims for MDwise members should be sent to the State’s pharmacy claims vendor, HP.

Providers are required to submit claims on one of the following claim form types:
- CMS 1500 (professional claims)
- UB04 form (for institutional claims)
- 837P (HIPAA compliant professional) and/or 8371 (HIPAA compliant institutional) file formats—electronic claims

The following code sets are to be used when submitting claims electronically or in paper:
- HCFA Common Procedure Coding System (HCPCS)
- National Drug Codes (NDC)

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

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

Following are some basic requirements for claims submission, whether submitted via paper or
electronically. This list is by no means exhaustive. It does however highlight some common submission errors that may lead to a claims denial. Please refer to the IHCP Provider Manual, Chapter 8, for additional information on specific claim form requirements and guidelines.

• An appropriate primary diagnosis code and procedure code must be present to be reimbursed for services.
• A valid authorization number must be included on the claim form for all services requiring prior authorization.
• The most current and specific CPT or HCPCS codes must be used. All applicable diagnosis, procedure and modifier fields must be completed.
• The most specific ICD-9 code must be used. For example, is there a 4th or 5th digit extension, the more general 3rd digit code may not be used.
• On the CMS 1500, “Date of Current Illness” (form field 14) the Last Menstrual Period (LMP) is required for payment of pregnancy-related services.
• Facility claims must include a valid three-digit numeric revenue code. Refer to the IHCP Provider Manual, Chapter 8, for a complete list of revenue codes.
• A federal tax ID number is required on all CMS-1500 and UB-92 forms.
• All claims/encounters must be submitted with the proper provider NPI and complete member RID (Recipient Identification Number).
• All required attachments must be submitted with the claim (e.g. emergency room medical records and nursing notes for emergency services provided, consent form for sterilization, invoices for manually priced items, etc.).
• A copy of the EOB from all third party insurers must be submitted with the original claim form if the member has other insurance. The services billed on the claim form must be the same as the services on the accompanying EOB.
• Any information indicating a work related illness/injury, no fault, or other liability condition, must be included on the claim form.
• All claims forms and documentation must be legible.
• All claims that appear to be altered will be returned.

Claims filed with a MDwise delivery system are subject to the following procedures:

• Verification that all required fields are completed on the CMS 1500 or UB-04 forms
• Verification that all diagnosis and procedure codes are valid for the date of service
• Verification of MDwise member eligibility for services during the time period in which services were provided
• Verification that the services were provided by a contracted provider or that the “out of network” provider had received authorization to provide services to the eligible member (excluding self-referral services).
• Verification that the provider was an IHCP provider at the time of service
• Verification of a valid NPI number on the claim form
• Verification of other third party resources (if applicable) and, if so, verification that MDwise is the “payer of last resort” on all claims submitted (see exceptions outlined below).
• Verification that an authorization has been given for services that require prior authorization

Please Note: All MDwise providers must submit encounter data for every patient visit, even though they may receive a monthly capitation payment.
Each Health Care Provider who participates in a delivery System under MDwise is required to have a national provider identifier, also known as NPI.

The NPI – National Provider Identifier is a unique identifier to be assigned to health care providers as a 10 character alphanumeric identifier. The NPI will identify health care providers in standard electronic transactions. These transactions include claims, eligibility inquiries and response, referral and remittance advices.

The health care provider will be assigned only one NPI; which is indefinite; and will not change over time. The NPI replaces any “legacy” identifiers that are currently being used. The unique identifier is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Health care providers may obtain their NPI by:

- Applying on line at the National Plan and Provider Enumeration System Website at https:\NPPES.cms.hhs.gov.
- Call the NPI Enumerator at 1-800-456-3203 to request a paper NPI application form.
- Apply for a bulk enumeration, which allows an Electronic File Interchange Organization (EFIO) approved by CMS to obtain NPIs for a number of providers.

Third Party Liability

MDwise members’ may have other health care coverage, for example, their spouse may have coverage through their employer or a child may be covered through a parent’s insurance carrier. According to State and Federal regulation, Medicaid and thus, MDwise, is the payer of last resort. This means that if a 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. These other resources include but are not limited to, the following: Commercial health insurance policies, both group and individual:

- Medicare
- TRICARE, Formerly known as CHAMPUS
- Indiana Comprehensive Health Insurance (ICHIA)
- Indemnity policy that pays a fixed per diem for hospital or nursing home services

- Insurance available as a result of an accident or injury (e.g. auto or homeowners liability policy, worker’s compensation, other liability coverage)

MDwise, however is not the payer of last resort for the following as these are fully state-funded programs:

- Victim Assistance
- Children’s Special Health Care Services

If a claim involves third party coverage, MDwise cannot pay the claim until an explanation of benefits/payment has been received from the primary care indicating the amount the carrier will pay. If a provider is aware that the member has other coverage, the provider must bill the proper agency or insurance company before billing MDwise. After receiving a third-party payment or denial, the claim may be submitted to the appropriate
delivery system claims payer. A copy of the third party’s explanation of benefits must be included with the claim. MDwise will then pay the difference between payment made by the primary insurance carrier and MDwise’s total allowable charge for the covered service. If the primary insurance paid more than MDwise’s total allowable charge the claim will pay zero.

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

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

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

AUTHORIZATION OF SERVICES AND TPL

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

Liability Insurance

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

MEMBER TPL RESPONSIBILITIES

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

PROVIDER TPL RESPONSIBILITIES

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

- Ask every member if he or she has any insurance coverage and report any available coverage to the applicable MDwise claims payer through inclusion on a claim form, phone call or written notice. The provider’s reporting duty exists even if the provider obtains knowledge of third party coverage after providing services. The provider should also request that the IHCP member sign an Assignment of Benefits Authorization form.
- Check HP Web interChange before billing MDwise and if available, pursue the TPL resource first. When a provider determines that a member has an available TPL resource, the provider is required to bill that resource before billing MDwise. If a member has other TPL resources and the provider submits a claim to MDwise without documentation that the third party resource was billed, federal regulations require that the claim be denied (see exceptions above).
Please Note: Please refer to the IHCP Provider Manual, Chapter 5, for additional information on third-party liability and Hoosier Healthwise specific program requirements.

Third-Party Payer Fails to Respond (90-Day Provision)
When the member has other insurance, a MDwise provider must submit claims to the other insurance carrier before submitting to the MDwise Delivery System. 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:
  o Date of the filing attempt
  o The words no response after 90 days
  o Member identification number (RID) & Provider’s National Provider Identifier (NPI)
  o Name of primary insurance carrier billed

• For claims filed electronically, the following must be documented in the claim note segment of the 837P transaction:
  o Date of the filing attempt
  o The phrase, “no response after 90 days”
  o The member’s identification (RID) number & IHCP provider number
  o Name of primary insurance carrier billed

Claims Dispute & Appeal Process

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 in the following sections.

IN-MDWISE NETWORK PROVIDER CLAIMS DISPUTES
Except for contracted behavioral health providers, in-MDwise network providers (i.e. contracted) 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. All contracted behavioral health provider claims disputes are processed by MDwise, not the delivery system, as outlined below.

If however, the dispute is between a MDwise provider and a 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 (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
Attention: MDwise Grievance Coordinator
PO Box 441423
Indianapolis, IN 46224-1423

Please Note: If an in-MDwise network provider has not submitted sufficient documentation in order to review the requested dispute, MDwise may return the dispute to the provider along with an explanation of information that must be submitted to process the dispute. If the provider resubmits the dispute with the required documentation, MDwise will proceed through the review process. If a provider does not resubmit the dispute with the requested documentation, the dispute is considered closed.

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 AND MDWISE BEHAVIORAL NETWORK PROVIDER CLAIMS DISPUTES

An informal claims dispute resolution review precedes the formal claims resolution process. 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 a 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 a MDwise delivery system determination on the claim or within 90 calendar days of when the claim was submitted to MDwise if a 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 from 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 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. MDwise offers 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.
Chapter 12 – Claims Submission and Reimbursement for HIP

Claims Submission and Inquiries

For the HIP program, medical and behavioral health providers should submit paper claims to the following address:

**MDwise HIP Claims**
P.O. Box 78310
Indianapolis, IN 46278

MDwise accepts claims in electronic format through the following clearinghouses:

**WebMD/Emdeon**
Institutional Payer ID: 12K81
Professional Payer ID: SX172

**McKesson/Relay Health**
Institutional Payer ID: 4976
Professional Payer ID: 4481

Pharmacy claims for MDwise HIP members should be sent to the State’s pharmacy claims vendor, HP. At HP, the pharmacy benefit is administered in the same manner as it is administered in the Hoosier Healthwise and the Care Select programs. MDwise does maintain a pharmacy benefit for members who “buy-in” to the Healthy Indiana Plan. This program is called the HIP Buy-in program and is managed separately from the State Health Coverage Plans. Providers can identify MDwise HIP Buy-in members from their health insurance card.

All providers will be reimbursed for covered services according to payment methodologies outlined in the HIP Reimbursement Manual (See “Manuals” at indianamedicaid.com).

**Please Note:** If you have a question about a specific claim that you submitted, or about an EOB/EOP you received, or if you have general questions about claims submission or payment policies, please call (317) 630-2831 OR (800) 356-1204.

Claims Submission and Processing Timeframes

Contractually, all in-MDwise network providers are required to submit claims within 90 days of the date of service, unless the claim involves third party liability. MDwise claims payers are responsible for adjudicating clean electronic claims within 21 days of receipt and clean paper claims within 30 days of receipt. If our claims payer fails to adjudicate (pay or deny) a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, interest will be paid on the claims, unless alternate written payment arrangements have been made with the provider.

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

As a MDwise provider, you are required to submit complete and accurate claims/encounter data as outlined in your MDwise contract. A corresponding claim or encounter data must be submitted for every service provided, even if a member has other health coverage, with claim detail identical to that required for fee-for-service claims submissions. Providers are encouraged to submit claims electronically as this helps to ensure more timely processing.
Providers are required to submit claims on one of the following claim form types:
- CMS 1500 (professional claims)
- UB-04 form (for institutional claim)
- 837P (HIPAA compliant professional) and/or 837I (HIPAA compliant institutional) file formats—electronic claims

The following code sets are to be used when submitting claims electronically or in paper:
- HCFA Common Procedure Coding System (HCPCS)
- National Drug Codes (NDC)

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

A claim may be rejected if it has invalid or missing data elements, such as the provider tax identification number or member RID number.

Rejected claims are returned to the provider or electronic data interchange (EDI) source without registering in the claim processing system. Since rejected claims are not registered in the claims processing system, the provider must resubmit the corrected claim within the claims timely filing limit. Rejected claims are different than denied claims, which are registered in the claims processing system but do not meet requirements for payment under MDwise guidelines.

Following are some basic requirements for claims submission, whether submitted via paper or electronically. This list is by no means exhaustive. It does however highlight some common submission errors that may lead to a claims denial. Please refer to the IHCP Provider Manual, Chapter 8, for additional information on specific claim form requirements and guidelines.

- An appropriate primary diagnosis code and procedure code must be present to be reimbursed for services.
- A valid authorization number must be included on the claim form for all services requiring prior authorization.
- The most current and specific CPT or HCPCS codes must be used. All applicable diagnosis, procedure and modifier fields must be completed.
- The most specific ICD-9 code must be used. For example, if there a 4th or 5th digit extension, the more general 3rd digit code may not be used.
- Facility claims must include a valid three-digit numeric revenue code. Refer to the IHCP Provider Manual, Chapter 8, for a complete list of revenue codes.
- A federal tax ID number is required on all CMS-1500 and UB-04 forms.
- All claims/encounters must be submitted with the proper IHCP provider number and complete member RID (Recipient Identification Number).
- All required attachments must be submitted with the claim (e.g. emergency room medical records and nursing notes for emergency services provided, consent form for sterilization, invoices for manually priced items, etc.).
- A copy of the EOB from all third party insurers must be submitted with the original claim form if you find that the member has other insurance.
- Any information indicating a work related illness/injury, no fault, or other liability condition, must be included on the claim form.
- All claims forms and documentation must be legible.
- All claims that appear to be altered will be returned.
Claims filed are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-92 forms
- Verification that all diagnosis and procedure codes are valid for the date of service
- Verification of MDwise member eligibility for services during the time period in which services were provided
- Verification that the services were provided by a contracted provider or that the “out of network” provider had received authorization to provide services to the eligible member (excluding self-referral services).
- Verification that the provider was an IHCP provider at the time of service
- Verification of other third party resources (if applicable) and, if so, verification that MDwise is the “payer of last resort” on all claims submitted (see exceptions outlined below).
- Verification that an authorization has been given for services that require prior authorization.

### National Health Care Provider Requirements

Each Health Care Provider who participates in a delivery System under MDwise is required to have a national provider identifier, also known as NPI.

The NPI – National Provider Identifier is a unique identifier to be assigned to health care providers as a 10 character alphanumeric identifier. The NPI will identify health care providers in standard electronic transactions. These transactions include claims, eligibility inquiries and response, referral and remittance advices.

The health care provider will be assigned only one NPI; which is indefinite; and will not change over time. The NPI will replace any “legacy” identifiers that are currently being used. The unique identifier is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The use of the NPI is designed to improve cost efficiency in the health care system by eliminating the need for health care providers to maintain, keep track of, and use multiple identification numbers assigned by the various health plans they bill.

Health care providers may obtain their NPI by:

- Applying on line at the National Plan and Provider Enumeration System Website at https:\NPPES.cms.hhs.gov.
- Call the NPI Enumerator at 1-800-456-3203 to request a paper NPI application form.
- Apply for a bulk enumeration, which allows an Electronic File Interchange Organization (EFIO) approved by CMS to obtain NPIs for a number of providers.

### REQUIRED FIELDS FOR THE UB-04 CLAIMS FORM:

<table>
<thead>
<tr>
<th>Field</th>
<th>Narrative/Description Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name, Address–Enter City State, Zip and phone #</td>
</tr>
<tr>
<td>3</td>
<td>Patient Control Number–Enter the internal patient tracking number.</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill–Enter the code indicating the specific type of bill. This is a three-digit code and all positions must be fully coded.</td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax I.D.–Must be included on the claim form.</td>
</tr>
<tr>
<td>6</td>
<td>Statement covers Period–From/Through–Required on Inpatients/LTC</td>
</tr>
<tr>
<td>8</td>
<td>Patient Name–Last Name, First Name, and Middle Initial</td>
</tr>
<tr>
<td>9A–D</td>
<td>Patients Address–Enter Street, City, State and Zip code</td>
</tr>
<tr>
<td>10</td>
<td>Patients Date of Birth–Enter MMDDYY format.</td>
</tr>
<tr>
<td>11</td>
<td>Patient’s Sex</td>
</tr>
</tbody>
</table>
12 Admission Date—Enter the date the patient was admitted for inpatient care in a MMDDYY format.

13 Admission Hour—Enter the hour during which the patient was admitted for inpatient care.

14 Type of Admission/Visit—Enter the code indicating the priority of this admission.
   1—Emergency
   2—Urgent Care
   5—Trauma Center
   Types 3 and 4 do not apply to HIP program.

17 Patient Discharge Status—Enter the code indicating the member discharge status as of the ending service date of the period covered on this bill. Required for all Inpatient/LTC

18–28 Condition Codes—Enter the applicable code to identify conditions relating to this bill that may affect processing. Required, if applicable

32–35 Occurrence Code and Date—Enter the applicable code and associated date to identify significant events relating to this bill that may affect processing. Required, if applicable

36 Occurrence Span Code, From/Through—Enter the code and associated dates for significant events relating to this bill. The only valid home health overhead Occurrence Span Code is 61. Required, if applicable

42 Revenue Code—Enter the applicable revenue code that identifies the specific accommodation, ancillary service, or billing calculation. Use the specific revenue code when available.

43 Description—Enter a narrative description of the related revenue categories on this bill. Only one description per line.

44 HCPCS/Rates—Use the Healthcare Common Procedure Coding System code applicable to the service provided. Only one service per line is allowed. Required for home health, outpatient, and ASC services. Include all modifiers that are applicable in this field, up to 4 modifiers are allowed for each procedure code.

45 Service Date—Provide the date the indicated outpatient service was rendered. Required for home health, independent laboratories, dialysis, ASC, and outpatient.

46 Units of Service—Provide the number of units corresponding to the revenue code or procedure code submitted. Six digits are allowed. Units must be billed using whole numbers.

47 Total Charges—Enter the total charges pertaining to the related revenue code for the Statement Covers Period. Nine numeric digits are allowed per line, such as 9999999.99.

56 NPI

58 Insured’s Name—Last Name, First Name, Middle Initial

60 Insured’s Unique I.D.—Enter the Member’s RID number.

61 Group Name—Enter HIP

63 Treatment Authorization Codes—Enter the number that indicates the payer authorized the treatment covered by this bill. Required, if applicable

67 Principal Diagnosis Code—Provide the ICD-9-CM code describing the principal diagnosis.

67A–Q Other Diagnosis Codes—Enter the ICD-9-CM codes corresponding to additional conditions that coexist at the time of admissions, or that develop subsequently, and that have an effect on the treatment received or the length of stay.

69 Admit Diagnosis Code—Enter the ICD-9-CM code provided at the time of admission as stated by the physician. Required for Inpatient/LTC

74 Principal Procedure Code/Date—Use the ICD-9-CM procedure code that identifies the principal procedure performed during the period covered by this claim, and the date the principal procedure described on the claim was performed. Required Inpatient Procedures.

74 A–E Other Procedure Code/Date—Use the ICD-9-CM procedure codes identifying all significant procedures other than the principal procedure, and the dates, identified by code, the procedures were performed. Required, when appropriate, for inpatient procedures.
Attending Physician ID–Enter the NPI, qualifier 1D for Medicaid and the IHCP provider number.

Operating Physician–NPI and IHCP Provider ID along with qualifier 1D for Medicaid. Required for inpatient, outpatient, ASC, and LTC.

Other Physician ID–use the NPI, IHCP number for the physician performing the principal procedure.

Quality Code-Quality/Code/Value–If applicable

REQUIRED FIELDS FOR THE CMS1500 CLAIMS FORM:

Field | Narrative/Description | Explanation
---|---|---
1 | Insurance Carrier Selection–Enter X for Other. | 21.1–21.4 Diagnosis or Nature of Illness or Injury–Enter the ICD-9 CM diagnosis codes in priority order. A total of four codes can be entered. At least one diagnosis code is required for all claims.
1A | Insured’s I.D. Number–Enter the member RID number. Must be 12 numeric digits. | 23 Prior Authorization–Required, if applicable.
2 | Patient’s Name–Last Name, First Name, Middle Initial | 24A Date of Service–Provide the FROM and TO dates in MMDDYY format. Up to six dates are allowed per form. FROM and TO dates must be the same-no date ranges are allowed.
3 | Patient’s Birthdate–Enter the member's birth date in MMDDYY format. | 24B Place of Service–Use the POS code for the facility where services are rendered.
5 | Patient’s Address–Street Number, City, State, Zipcode. | 24C Emergency Service–Enter a Y if this was an emergency.
10 | Is Patients Condition Related To–Enter X in the appropriate box in each of the three categories. This information is needed for follow-up third party recovery actions. IF Applicable (Workman’s Comp, Auto Accident) | 24D Procedures, Services, Supplies–CPT/HCPCS Use the appropriate procedure code for the service rendered. Only one procedure code is provided on each claim form service line.
11C | Insurance Plan or Program Name–Enter the HIP program. | 24E Diagnosis Code–Enter 1-4 corresponding to the applicable diagnosis codes in Field 21. With a minimum of 1 and a maximum of 4-diagnosis code references can be entered.
16 | Dates Patient unable to work if Yes in Box 10A | 24F $ Charges–Enter the total amount charged for the procedure performed, based on the number of units indicated in Field 24g. The charged amount is the sum of the total units multiplied by the single unit charge. Each line is computed independently of other lines. This is an eight-digit numeric field.
17 | Name of Referring Physician or Other Source–Enter the name of the referring physician. Required, if applicable | 24G Days or Units–Provide the number of units being claimed for the procedure code. Six digits are allowed, and 999999 units is the maximum that can be submitted. The procedure code may be submitted in partial units, if applicable.
17A | ID number of Referring physician–Enter the IHCP provider number. Required, if applicable. | 24I I.D. qualifier–Enter 1D for Medicaid.
17B | Referring Physician- NPI number–Required, if applicable | 24J Indiana IHCP Provider Number–Enter the nine-digit numerical with the alpha location if applicable. Required at this time. Include NPI # on second line.
18 | Hospitalization Dates Related to Current Services–Enter the requested From and To dates in MMDDYY. Required, if applicable. | 25 Federal Tax I.D. Number–Claims will not be accepted if this field is not completed.
28 | Total Charge–Enter the total of column 24f charges. This is an eight-digit field. |
31 Signature of Physician or Supplier including Degrees or Credentials—An authorized person, designated by the organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not.

32 Name and Address of Facility where Services are Rendered—Enter the provider’s name and address. This allows us to contact the Provider if necessary.

33 Physician’s Supplier’s Billing Name, Address, Zipcode, & phone number—Enter the billing provider number, nine-digit numerical, and location code, one alpha character.

Third Party Liability

HIP members are not eligible for MDwise plan coverage if they have noncomplying health insurance coverage. Non-complying coverage includes medical coverage, such as Medicare, Medicaid, COBRA or insurance under an indemnity plan, health maintenance organization (HMO), preferred provider organization (PPO), individual practice organization (IPO) or point-of-service plan (POS). If a member obtains non-complying coverage, or had non-complying coverage in the six months prior to the member’s application for HIP, the member will be terminated from HIP. If MDwise identifies members who have non-complying coverage, MDwise notifies the State and takes cost avoidance steps such as pending claims and claims recoveries.

When MDwise receives information that a HIP member may have other coverage, MDwise investigates to determine if the coverage is still in effect and whether the coverage is complying or non-complying. If the coverage is complying coverage, MDwise takes steps for cost-avoidance in order to maximize the utilization of the complying coverage. Complying coverage includes coverage by a casualty insurer, such as workman’s compensation insurance or automobile insurance.

If MDwise has determined that a HIP member does have “complying” coverage, MDwise cannot pay the claim until an explanation of benefits/payment has been received from the other insurer indicating the amount the carrier will pay. If a provider is aware that the member has other coverage, the provider must bill the proper agency or insurance company before billing MDwise. After receiving a third-party payment or denial, the claim may be submitted to MDwise. A copy of the third party’s explanation of benefits must be included with the claim. MDwise will then pay the difference between payment made by the other insurance carrier and MDwise’s total allowable charge for the covered service. If the other insurance paid more than MDwise’s total allowable charge the claim will pay zero.

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

Please note: If you should determine that a member has health coverage though another carrier or Medicare (except in case of liability coverage), please let MDwise know immediately. The member will then be disenrolled from the program, as they are no longer eligible for HIP coverage.
LIABILITY INSURANCE

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

Billing Requirements for Pregnancy Services

HIP does not cover pregnancy care. The member has a choice of staying on HIP or moving to Hoosier Healthwise. However, if the member decides to stay on HIP, pregnancy services will not be covered by MDwise.

If a HIP member wants to transition to Hoosier Healthwise, she must promptly report the pregnancy to the Division of Family Resources (DFR) so her eligibility can be transferred. The time period from discovery of the pregnancy until transfer of enrollment from HIP to Hoosier Healthwise is called the Discovery Period. Pregnancy-related services rendered during dates of service in the Discovery Period are the responsibility of HIP, not HIP. Non-pregnancy-related services remain the responsibility of MDwise until transfer of enrollment occurs.

If you are going to provide any pregnancy-related services to a HIP member, you are responsible for:

- Informing the member that pregnancy related services are not covered under HIP
- Informing the member that they can obtain pregnancy coverage by submitting the change report form to DFR and that MDwise Customer Service is available to assist with facilitation of enrollment processes.
- Providing the member with documentation of positive proof of her pregnancy, including the results of the pregnancy test or a letter from a licensed healthcare provider. Also include the number of births expected, if known.

To be transitioned to Hoosier Healthwise, the member must submit to the DFR positive proof of pregnancy including member and medical provider contact information along with a Change Report Form. The necessary documentation to initiate enrollment into Hoosier Healthwise for pregnancy coverage may include results of a medical provider's pregnancy test or a letter from a licensed healthcare provider along with a Report of Change Form. To receive a copy of this form call MDwise customer service at 1-800-356-1204 or (317) 630-2831.

SUBMITTING CLAIMS TO HIP FOR DATES OF SERVICE WITHIN THE DISCOVERY PERIOD

- If claims for pregnancy services are sent to MDwise, they will be denied. HP will also deny claims until the member’s HIP eligibility is end dated and the Hoosier Healthwise eligibility is in place. The provider needs to send these claims to HP after Hoosier Healthwise eligibility is established until the member is enrolled in a Hoosier Healthwise plan.
- Claims payment by HP for pregnancy-related services will be retroactive to allow the member to notify DFR of the pregnancy and for DFR to make the eligibility category change. The Discovery Period is no longer than three months prior to the date when the member’s eligibility changes from HIP to Hoosier Healthwise.
- Providers can bill a member for non-covered services after 90 days from the date of service if Hoosier Healthwise eligibility has not been established. As soon as the member becomes Hoosier Healthwise eligible, she will choose or be auto-assigned to a risk-based managed care entity (MCE). Claims should be submitted to the MCE for dates of service after she has transferred. Providers should continue to verify eligibility to determine where to bill her Hoosier
Healthwise claims. During the Discovery Period, diagnosis codes or CPT procedure codes listed below, will be considered for coverage. All other claims should be submitted to MDwise for reimbursement.

**Please Note:** Once a member’s status has been updated by DFR, she becomes Hoosier Healthwise eligible. Pregnancy services incurred during the Discovery Period while she’s still a HIP member but before her eligibility has been transferred must be submitted to HP as fee for service (FFS). The Discovery Period is effective only through her HIP enrollment.

**ICD-9 CM Diagnosis Codes**

- V22.xx Normal pregnancy
- V23.xx Supervision of high risk pregnancy
- V24.xx Postpartum care and examination
- 640.xx-649.xx Complications mainly related to pregnancy (640.xx-649.xx)
- 650.xx-659.xx Normal delivery and other indications for care in pregnancy, labor, and delivery
- 660.xx-669.xx Complications occurring mainly in the course of labor and delivery
- 670.xx-676.xx Complications of the puerperium
- 647.xx Infectious and parasitic conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium (647.xx). These codes include the listed conditions when complicating the pregnant state, aggravated by the pregnancy, or when a main reason for obstetric care.
- 648.xx Other current conditions in the mother classifiable elsewhere but complicating pregnancy, childbirth, and the puerperium
- 649.xx Other conditions or status of the mother complicating pregnancy, childbirth, or puerperium

**CPT codes—Maternity Care and Delivery**

- 59000 – 59076 Antepartum Services
- 59200 Introduction
- 59300 – 59350 Repair
- 59400-59426 Vaginal Delivery, Antepartum and Postpartum Care
- 59510-59515 Cesarean Delivery
- 59525 Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure). (Use 59525 in conjunction with 59510, 59514, 59515, 59618, 59620, 59622)
- 59610-59622 Delivery After Previous Cesarean Deliver
- 59871-59899 Other procedures

**Please Note:** While MDwise is not responsible for coverage of pregnancy and maternity-related services, MDwise is responsible for covering pregnancy tests.

**BILLING AND BENEFIT COVERAGE FOR THE DISCOVERY PERIOD**

For claims submitted to HP, providers must follow billing procedures as outlined in the IHCP Provider Manual. Billing procedures and details on non-covered services can be found in Chapter 8: Billing Instructions and Chapter 2: Member Eligibility and Benefit Coverage of the IHCP Provider Manual, which is located at [provider.indianamedicaid.com/general-provider-services/manuals.aspx](http://provider.indianamedicaid.com/general-provider-services/manuals.aspx).

Institutional claims must have a principal diagnosis from table 1. Services submitted on professional claims must have a diagnosis from table 1 as the primary code corresponding to each applicable service provided or the appropriate procedure code from table 2. For the Discovery Period providers should only submit a diagnosis from table 1 as the primary diagnosis if it follows correct coding initiatives. Billing guidelines during the Discovery Period defined in this bulletin are not the same as Hoosier Healthwise Package B. Pharmacy dispensed prescription drugs will continue to be the responsibility of MDwise.
PRIOR AUTHORIZATION

Advantage Health Solutions is responsible for processing prior authorization requests and updates for all Traditional Medicaid FFS claims that fall within the Discovery Period. Providers should follow current procedures for submission of prior authorization services. These procedures are available in bulletin BT200723 Instructions for submitting prior authorization requests via Web interChange are available on the IHCP Website at indianamedicaid.com.

CLAIMS DISPUTE AND APPEAL PROCESS

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.

Providers may file the objection using the MDwise Provider Claims Dispute Form (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

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

- The provider objects to a MDwise decision regarding payment for a claim, including the payment amount; or
- The provider objects to a MDwise 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 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.

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 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. 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 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.
Chapter 13 – Medical Management

Introduction

Medical management activities are established to assist both the provider and member in accessing the delivery of timely and appropriate health care over the course of time within the structure of the Hoosier Healthwise benefit plan. MDwise works collaboratively with the delivery systems in the development, coordination and evaluation of medical management activities to:

- Promote efficient, fair and consistent medical management decisions.
- Assure that members have equitable access to care across the MDwise network.

The MDwise Medical Management Program describes the framework, guidelines, structure and accountability designed to promote and support the delivery of quality coordinated healthcare in the most appropriate care setting. MDwise Medical Management (MM) Program elements are further defined in the OMPP contract, delivery system contracts, program and reporting requirements, and MDwise MM Policies and Procedures which include standards and timelines.

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

Scope and Approach

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

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

DELEGATION

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

MEDICAL MANAGEMENT PROGRAM ACTIVITIES

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

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

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

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

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

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

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

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

**Objectives**

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

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

Primary objectives of MDwise Medical Management are to:

- Promote the efficient provision of quality health care services appropriate to the needs of the individual member.
- Provide monitoring and oversight to assure that health care services are delivered at the appropriate level of care in a timely, effective and cost efficient manner.
- Continually examine and improve the quality of health care and resource allocation delivered to members.
- Enhance the overall performance of practitioners and providers in achieving optimal outcomes in the delivery of quality, safe, efficient health care services to members through prospective, concurrent and retrospective data analysis and education.
• Monitor and analyze relevant data to identify, correct and prevent patterns of potential or actual excessive or under use of health care services.
• Facilitate the transition of health care services for members ensuring continuity of care by providing access to continued necessary care and assistance in transitioning to a new care setting, service provider or services, or MCE.

Integration with QI

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

Medical Management prospective, concurrent and retrospective activities provide means by which MDwise can evaluate and promote evaluation of standards of care/practice guidelines, best practices parameters and outcomes on individual cases and by specific populations. Analysis of monitored data is used to develop effective interventions including opportunities for improved medical management interventions, ensuring consistent and appropriate determinations, evaluating the effectiveness of prior authorization requirements, determining member and provider education and interventions, as well as case management and disease management interventions.

MDwise Delivery Systems participate in the state mandated HEDIS measures related to preventive health services. Compliance to screening and immunization schedules is evaluated through the Reaching out for Quality initiative and applicable HEDIS measures.

MDwise MM Authority, Responsibility and Committee Oversight

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

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

Please Note: To contact a committee member representative for your delivery system, please call your delivery system’s provider relations staff, Medical Director or Delivery System Administrator.

Key Medical Management Program Components

Prior Authorization and Referral – see last section of chapter.

Physician Involvement in Medical Management Program Implementation

The MDwise and Delivery System Medical Management Medical Director or designated physician consultant provides clinical expertise and direction to the staff. The delivery system’s Medical Director oversees the medical management program for your delivery system and reviews cases for medical necessity or appropriateness of care for those services not meeting criteria. The Medical Director actively participates in the MDwise Committees as well as the delivery system’s committees.

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

Medical Appropriateness Criteria/Guidelines

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

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

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

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

**CONFIDENTIALITY**

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

- All member and practitioner/provider specific information will be kept confidential in accordance with applicable federal and state laws and regulations (HIPAA) and MDwise Policy. Disclosure of mental health records by the provider to MDwise and to the PMP is permissible under HIPAA and state law (IC 16-39-2-6(a)) without consent of the member because it is for treatment. Consent from the member is necessary for substance abuse records.

- Member specific information is used only for the purpose of medical management functions/activities including case management, disease management and discharge planning and quality assurance/improvement activities. Access is restricted to only those staff that require information to perform their job function. Information obtained during the utilization process is used only for the purposes of medical management functions and is shared only with those agencies that have authority to receive such information.

- Medical Management and Quality Improvement activities comply with applicable federal and state laws and regulations requiring the reporting of quality issues under review.

**MEDICAL MANAGEMENT DETERMINATIONS**

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

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

- When clinical evidence documented in a member’s medical record or provided by the attending physician or behavioral health provider meets the criteria, the nurse reviewer or behavioral health specialist certifies the cases. Timely notification of certification determination is provided outlining the scope of services authorized.

- The nurse reviewer or behavioral health specialist refers cases where clinical information does not
meet the criteria for services requested to the Medical Director, or designee physician reviewer or appropriate behavioral health practitioner. The Medical Director or designee utilizes board certified consultants to assist as needed in making medical necessity determinations.

- The physician or behavioral health practitioner (psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist), or clinical pharmacist reviewing the case makes a determination regarding the medical appropriateness of services and/or care setting, based on clinical information obtained and/or contained in the medical record or obtained from the attending or ordering physician and other providers involved in the member’s care, as needed. A physician reviewer is available by telephone during normal business hours to discuss the case.

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

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

SERVICE REQUESTS NOT MEETING GUIDELINES

- In the event the physician, appropriate health practitioner or pharmacist, determines the services are not medically necessary, the certification is denied.

- A denial of a service request may be generated if information needed to make a decision is not received within a specified time frame as outlined in the timeliness standards for determinations and notifications. Grievance rights also apply to denials due to lack of information.

- The Medical Director or designee will provide alternate options of care if the certification request is denied, when applicable. Such alternatives may be for example, to have the member evaluated by a specialist, receive services in-network.

- The timely notification of a denial clearly communicates the reason for the denial and includes information about the appeal process, including the expedited appeal process, as applicable. The exception to member notification of a denied service applies only to a post-service (retrospective) service denial when the member is at no financial risk.

- The requesting provider is offered the opportunity for a peer to peer discussion with the Medical Director and/or the reviewer’s designee who made a denial determination. The attending or ordering physician is notified via telephone or fax by Medical Management staff of the denial determination. At that time the Medical Management Department assures the requesting provider is advised of the opportunity and the method for requesting a peer to peer discussion.

Please Note: Policies and Procedures are in place describing the medical management functions. Please refer to the Directory at the beginning of the manual to obtain information or ask questions from your provider network medical management staff.

NO FINANCIAL INCENTIVES

Compensation plans for physicians and staff who conduct medical management do not contain incentives, directly or indirectly, that encourage barriers to care and service in making determinations.
CONFLICT OF INTEREST
No person shall participate in the review and evaluation of a MDwise member, practitioner, or provider case in which he/she has a specific conflict due to a relationship or affiliation that could compromise the independence or objectivity of the medical management and quality processes or where judgment may be compromised.

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

TRANSFER TO IN-NETWORK HOSPITAL FROM OUT-OF-NETWORK HOSPITAL
As part of the inpatient concurrent review procedures, the medical management staff implements a review process to determine the appropriateness and safety of transferring a member currently receiving inpatient care at an out-of-delivery system hospital to an in-delivery system facility in order to promote continuity and coordination of care within the member’s delivery system contracted care network. The process includes the following components:

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

- Arranging transfer to in-delivery system facility, when member is medically stable for transfer.

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

- Once all parties agree that the member is medically stable and the situation warrants transfer, the medical management nurse will coordinate the transfer.

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

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

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

- MDwise members with chronic or acute illness undergoing active treatment provided by the member’s current PMP, specialists, ancillary providers or by hospitals prior to member changing to a new MDwise PMP may access continued medically necessary care up through a minimum of 30 days. Active treatment for the purpose of this reference to continuity of care is referred to such treatment that if would be discontinued could cause a reoccurrence or worsening of the condition for which receiving treatment and interfere with anticipated outcomes.

- Authorization for continuation of active treatment past 30 days may be approved as appropriate to the member’s individual situation. A transition plan and coordination and continuity of care responsibilities are implemented according to procedure for those newly enrolled MDwise members undergoing active treatment from an out-of-network/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 or MRO care managers, is begun immediately to ensure that treatment plans and pertinent medical/behavioral information are transferred in a timely manner. An appropriate behavioral health case manager is identified to whom daily contact regarding the member’s care can be communicated and coordinated.

- Women in their third trimester of pregnancy at the time they become your MDwise member may access continued medically necessary care for prenatal, delivery and postpartum care from their previous physicians.

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

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

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

The MDwise continuity and care coordination policy and procedures apply to the various scenarios that
may occur for a member in the Healthy Indiana Plan, including members transitioning into Hoosier Healthwise Package B coverage for their pregnancy care, members transitioning to or from the state’s Enhanced Services Plan (ESP) high risk plan (ICHIA), and members transitioning to another FSSA program or private insurance.

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

**COORDINATION OF MEDICAL AND BEHAVIORAL HEALTH CARE**

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

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

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

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

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

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

• Collaborating in developing and implementing educational forums for providers and medical management departments and case managers regarding coordination of physical and behavioral health care.

• Integrating behavioral health initiatives (i.e. depression) within the disease management and case management process so those members with co-morbid conditions or members who are at higher risk for behavioral health issues are identified and a coordinated approach is implemented to manage their behavioral health and medical care.

• Educating members and providers regarding the incidence of depression with certain chronic health care conditions (i.e. diabetes, CHF, asthma).

• Promoting awareness and encourage treatment for post-partum depression.

• Providing utilization reports to primary care physicians, which include behavioral health treatment and medication information.

Please Note: Refer to Chapter 18 Behavioral Health Care for additional information about mechanisms MDwise utilizes to ensure integration of behavioral health services with medical/physical care services.

SHORT-TERM PLACEMENTS IN LONG-TERM CARE Facilities

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

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

CONCURRENT REVIEW

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

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

DISCHARGE PLANNING

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

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

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

**MEMBER AND PROVIDER INQUIRIES/COMPLAINTS, GRIEVANCES AND APPEALS**

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

**DATA ANALYSIS OF HEALTH SERVICE ACCESS AND UTILIZATION**

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

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

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

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

MDwise receives a daily record from NURSEon-call of the specific calls received throughout the day. The MDwise Care Select care management staff will receive daily notification and details of any calls originated by Care Select members. The primary goal of the nurse triage line is to promote the medical home and refer the member back to the member’s PMP for further assessment/or treatment when appropriate.

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

EPSDT and Related Benefits

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

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

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

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

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

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

- Members with health care needs, acute or chronic, above and beyond those of a normal, healthy persons
- Claims identifying services being utilized, including pharmacy utilization
- Multiple Emergency Room (ER) visits
- Hospital lengths of stay/hospital discharge data
- Readmission for the same diagnosis
- Members with co-morbid conditions
- Multiple specialty referrals
- Multiple therapies
- Health risk screenings and assessments
- Predictive Modeling
- Referrals from NURSEon-call helpline
- High cost or high volume DME
- Data collected through utilization management process

- Referrals from health plan staff including customer service as well as other delivery system staff, and external referrals from physicians, providers, health care delivery staff, members, and family or member’s representative.

The care management process includes:

- Identification and evaluation of member’s needs
- Presentation of member’s needs assessment and ongoing discussion with the member's PMP and development of treatment plan
- Review of clinical information
- Development of goals
- Development of an integrated care plan including behavioral and physical health
- On-going communication with the member or member’s family/caregivers
- Monitoring progress and adjusting care plan accordingly, and
- Transitioning member through levels of case management when appropriate (i.e. goals and needs met, member coverage terminated).

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

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

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

**DISEASE MANAGEMENT**

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

*Please Note:* Refer to Chapter 17, MDwise Disease Management Program for further information.

**Emergency Services**

MDwise members may seek emergency services at the nearest emergency room without authorization when they believe their condition to be an emergency. MDwise will cover and reimburse all emergency services, including screening services, which are rendered by a qualified IHCP provider.

Please refer to Chapter 5, Healthy Indiana Plan Benefits Overview, for emergency services coverage and determinations under the Healthy Indiana Plan, post-stabilization services, co-pays and other details regarding emergency services.

**AUTHORIZATION**

Authorizations are not required prior to the MDwise members seeking emergency services. Emergency services will be covered when authorized by a participating physician or designee or other authorized representative. MDwise covers post-stabilization services. These requirements are outlined in Chapter 5.

*Please Note:* Providers are to notify the delivery system medical management staff in the event he/she, or a representative, have advised a member to seek care in the emergency room or has approved/authorized emergency or post-stabilization services upon contact by the emergency room physician requesting such approval. This notification is necessary in order for medical management to identify member interventions and facilitate claims payment.

**EMERGENCY ADMISSIONS**

If it is determined the member is to be admitted, the hospital must notify the member’s PMP. The admitting hospital is also required to call the medical management department within the required timeframe to provide notification of the admission and the pertinent clinical information and plan of care.

**MONITORING AND MANAGEMENT OF EMERGENCY ROOM UTILIZATION**

Data related to emergency services claims review is analyzed to identify patterns for further investigation and to detect any patterns of potential, questionable, or actual inappropriate under- and over-utilization. Analysis of monitored data is used to develop effective interventions.
Current interventions for members accessing non-emergent services in the emergency room include contacts by Health Advocates, educational efforts and distribution of Use the Emergency Room Wisely brochures, working with hospitals to obtain timely notification of MDwise member visits to their emergency rooms, NURSEon-call line or (Health Connections for MDwise Wishard Delivery System members) access and case management interventions. Members are encouraged to contact their PMP or the NURSEon call phone line (or Health Connections for MDwise Wishard Delivery System members) who are available 24 hours/day if they are uncertain as to whether they need to seek care in the emergency room.

**NURSEon-call (Health Connections for MDwise Wishard Delivery System Members)**

NURSEon-call is a helpline that provides members with 24/7 phone access to a Registered Nurse that can assist them in dealing with health related concerns. The helpline staff follows MDwise approved protocols in educating the member regarding diseases and treatments that have been prescribed and responding to general health questions or questions about situations that are cause for concern by the member. MDwise members also have access to a 24/7 behavioral health triage line in addition to the NURSE-on-call helpline.

The role of the helpline also is to assist members/parents in better understanding the nature and urgency of the situation causing concern, and where to seek care, including emergency care. The NURSEon-call staff has access to member eligibility and will refer the member back to the member’s PMP for further assessment/or treatment, as the situation indicates.

**Self-Referral Services**

Self-referral services are those services that do not require a prior authorization and do not require MDwise members to receive those services from a MDwise contracted provider.

FDederal and state regulations allow members access to certain services outside of the network in which they are enrolled without a referral. MDwise delivery systems are responsible for ensuring that the self-referral services are covered and authorized in advance in accordance with the Indiana Health Plan contract and applicable state and federal regulations.

MDwise may include self-referral providers in its contracted network. The MDwise delivery systems and its PMPs may direct members to seek the services of the contracted self-referral providers however, the delivery system cannot require that members receive services from these providers. Coordination of care efforts promote PMPs to direct their assigned MDwise
members to self-referral services within their hospital delivery system and to receive medical information/communicate with self-referral service providers when any form of medical treatment is undertaken.

Please refer to Chapter 3 & 4, Benefits Overview for a description of self-referral services in the Healthy Indiana Plan.

Prior Authorization and Referral Process

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

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

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

GENERAL INFORMATION

Referral: the label given to the process when the PMP determines that the member’s condition requires additional services provided by a provider other than a primary care physician.

Prior Authorization (PA): the actions taken, including review of benefit coverage and clinical information, to determine if the requested service meets the criteria for authorization.

Authorization Requests: Specific forms are available from medical management to submit for service authorization. The forms are to be completed by the requesting provider and any additional information the provider chooses to provide to support request.

Please Note: Incomplete forms or requests lacking required information to support the specific request will delay the authorization process.

Service Types Requiring Prior Authorization: Such services are grouped according to service type categories that include the following: physician services (in network, out-of-network or non-contracted physicians); inpatient admissions; outpatient services/procedures; pharmacy; therapies, home health care, durable medical equipment; transportation; and self-referral services in accordance with IHCP requirements. (These categories of services are listed in the below MDwise Prior Authorization Reference Guide)
Specific authorizations by federal and state regulations: MDwise follows federal and state regulations related to authorizations of requests for second opinions, access to specialists for members with special needs and access to women’s health specialist for female members.

WHO TO CONTACT TO OBTAIN A REFERRAL /PRIOR AUTHORIZATION

In the MDwise system, prior authorization is handled by the delivery system to which the patient’s doctor belongs. Providers should refer to the Directory at the front of this manual for the phone numbers of their medical management staff.

Out-of-network providers can call the MDwise Customer Service Department at 1-877-822-7196 or (317) 822-7196 to be connected to the appropriate medical management staff.

The Directory at the front of this manual identifies the medical management staff that is specifically dedicated to the medical management activities for your delivery system provider network and your MDwise patients.

QUICK REFERENCES OF SERVICES REQUIRING PRIOR AUTHORIZATION

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

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

To ensure you have the latest and most comprehensive list of services requiring prior authorization, contact your medical management staff (refer to Directory in front of manual).
Prior Authorizations for health care services can be obtained by contacting the medical management department by phone or fax (information found on the contact sheet). Copies of prior authorization forms can be found on the website.

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

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

AUTHORIZATION PROCEDURAL GUIDELINES

- Authorization request for those services requiring prior authorization are submitted by calling or faxing the designated form to the delivery system medical management to which the member belongs. Requests should be submitted for review within a reasonable time frame prior to proposed service date.
- Information submitted with service request should include demographic information, type of care, frequency and duration if applicable, facility or provider, diagnosis, procedure, date of service or onset date of services, and other pertinent clinical information required supporting medical management decisions and benefiting coverage determinations.
- If additional information is required before the Medical Management staff can make a determination, the prior authorization request will be pended with a request for additional information.
- Pre-service (prior authorization/precertification) requests for non-urgent care and retrospective reviews may be denied on the basis of lack of information when unsuccessful in obtaining the necessary information requested to make a decision as outlined in this procedure.
- The reply to the prior authorization request will communicate the authorization decision to the PMP and SCP/other provider, as applicable. The communication will note the approved services and the effective time frame or non-authorized services and the reason for denial of service and alternative care options and appeal rights, as applicable.

Please Note: Eligibility must be checked every time a service is rendered. Failure to do so may result in denial of payment. Prior authorization of a referral/service is not a guarantee of payment, for example if benefits expired prior to service date. The practitioner/provider must always check member eligibility at the time of service during the referral/authorization time period to avoid denial of payment for services provided due to member no longer being eligible on date of service.
Services Requiring Prior Authorization for MDwise Members
Filler to insert PA quick reference lists under review and contacts

REFERRAL PROCESS

Referrals include those to certain specialty and ancillary providers, Out-of-Network/Out-of-Area providers, and reasons that include Continuity of Care, Second Opinions, Specialty Access for Members with Special Health Care Needs, and Women’s Health Specialist access.

Health care services are coordinated through the primary medical physician (PMP); therefore, all referrals must be coordinated through the member’s PMP, with the exception of those specific self-referral services under the Healthy Indiana Plan. Medical management staff assists the PMP, as needed, in identifying and accessing specialty service referrals for MDwise members.

• Health care services provided outside of the MDwise delivery system may be authorized for coverage when appropriate IHCP enrolled providers, services, or facilities are not available within the delivery system. MDwise will also cover and reimburse authorized routine care provided to members by out-of-network/delivery system or out-of-area providers. Out of network service authorization requests are subject to the medical appropriateness criteria and determination process.

Please refer also to Chapter 3 and 4, Benefits Overview, for section regarding Out of Network Services.

• If a PMP wishes to order covered specialty or ancillary services for a MDwise member, the PMP must receive authorization for the referral as outlined by the referral management policies and procedures for the MDwise delivery system to which the member belongs.

REFERRAL PROCEDURAL GUIDELINES

• Referral authorization is obtained by calling or faxing the request to the Medical Management department for review of the proposed service. Referral requests should be submitted for review within a reasonable time frame prior to proposed service date.

• Referrals for certain specialty care services and certain ancillary services procedures and equipment 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.

• MDwise follows our OMPP contracts, RFS, applicable state and federal regulations, IC and IAC and IHCP policies and MDwise policies and procedures regarding MDwise members accessing self-referral services without a MDwise PMP referral authorization, covered services and prior authorization requirements and limitations in reviewing self-referral services.

• Specialists may not refer a MDwise member to another physician. The primary medical provider (PMP) is responsible for referring a member to specialist physicians as needed.
• Information submitted with service request to include demographic information, type of care, frequency and duration if applicable, facility or provider, diagnosis, procedure, date of service or onset date of services, and other pertinent clinical information required supporting medical management decisions and benefiting coverage determinations.

• If additional information is required before the Medical Management staff can make a determination, the prior authorization request will be pended with a request for additional information.

• Pre-service (prior authorization/precertification) requests for non-urgent care and retrospective reviews may be denied on the basis of lack of information when unsuccessful in obtaining the necessary information requested to make a decision as outlined.

• The reply to the referral request will communicate the authorization decision to the PMP and SCP/other provider, as applicable. The communication will note the approved services and the effective time frame or non-authorized services and the reason for denial of service and alternative care options and grievance/appeal rights, as applicable.

• The PMP will provide all pertinent clinical information and services requested to the specialty provider and review correspondence from the Specialist regarding the consultation and/or treatments.

• The approved specialist/ancillary provider must contact the PMP to coordinate any additional services or referrals that require prior authorization.

• Referrals to out-of-delivery system or out-of-MDwise network specialist provider or ancillary provider may be approved for continuity of care reasons, for specialties, providers, including nurse practitioners, or services not available within the network or delivery system.

• Emergency services provided out of network do not require prior authorization. MDwise will cover post-stabilization services when there is an emergency medical condition and prior authorization for the post-stabilization services has been obtained from the member’s PMP or authorized representative in conjunction with the PMP’s medical management department.

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 specialist for female members

• 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-delivery system provider at no cost to the member if the delivery system provider network does not include a provider who is qualified to give a second opinion.

• Access for Members with Special Health Care Needs Medical management must allow members with special needs who are determined to need a course of treatment or regular care monitoring, to directly access a specialist for treatment by an established mechanism such as a standing referral from the member’s PMP or an approved number of visits. Treatment provided by the specialist must be appropriate for the member’s condition and identified needs.

• Access to Women’s Health Specialist Medical management must, in addition to the female member’s designated source of primary care if that source is not a woman’s health specialist, authorize female members to have direct access to a woman’s health specialist within the delivery system for covered care
necessary to provide women’s routine and preventive health care services. Medical management establishes the mechanism to permit female members direct access such as standing referral from the member’s PMP or an approved number of visits.

**SPECIALTY AND ANCILLARY PROVIDER RESPONSIBILITIES**

Responsibilities of the specialty and ancillary providers include:

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

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

The MDwise Right Choice Program (RCP) is a program that identifies members appropriate for assignment and lock-in to one Primary Medical Physician (PMP), one pharmacy and one hospital. This program has been in effect at MDwise since January 2005 under the MDwise Hoosier Healthwise Program and formerly called The Restricted Card. In January 2010 MDwise in conjunction with OMPP and other Medicaid stakeholders redesigned and renamed the program that is now called The Right Choices Program.

OVERVIEW

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

RCP Goals:
The goal of IHCP is to provide quality health care through health care management. Member utilization reviews identify members how use IHCP services more extensively than their peers. Member identified with high utilization are assigned (or locked-in) to one (1) primary medical provider (PMP, one (1) pharmacy, and one (1) hospital. If a member requires specialty services, the PMP must make the referral for those services to be reimbursed.

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

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

MDwise considers multiple factors in enrolling a member into this program. They include, but are not limited to:
- Emergency Room
- Medical records
- Pharmacy utilization
- member compliance
- outcomes of member interventions
- care management activities
- referrals from providers
- referrals from other internal and external sources

MEMBER REFERRALS FOR RIGHT CHOICES PROGRAM

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

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

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

Members that qualify are eligible for a two to five year lock-in to one Primary Medical Provider (PMP), one pharmacy and one hospital.

Members are notified in writing via certified letter of their selection for enrollment into the program and given the opportunity to appeal the decision (10 days from the receipt of their letter to prevent the enrollment from taking place, and 30 days from the receipt of the letter to appeal the enrollment from remaining for the term).

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

PMP SELECTION AND PMP ROLE

Once a member is selected for inclusion into the RCP, the member’s MDwise care manager works with the member and their providers through the end of their enrollment (a period of two to five years). Members are given the opportunity to select their primary lock-in providers. If the member is already established in the MDwise program, their assigned PMP will be asked by MDwise to serve as the members Right Choices PMP. The chosen lock-in hospital, will be one that the PMP has privileges. The PMP is responsible for coordinating all services outside of the PMP medical home. Written referrals are required for RCP members to see a provider outside of the medical home. Without a written referral, services rendered by providers other than the member’s PMP will not be reimbursed. The written referral must be on file at MDwise. Referrals should be faxed or mailed to the member’s assigned care manager. MDwise asks that referrals be kept to a minimum so that the members coordination of care is not jeopardized. As a general rule, written referrals should be created for the shortest duration of time and for only medically necessary services as directed by the PMP. Written referrals are good for the period specified by the PMP or for the term of the restriction, whichever is less.

Written referral requirements:

- The PMP must write the referral on the PMPs letterhead or prescription pad
- The PMP must date and sign the referral
- The referral must include the member’s name and member id
- The referral must include the specialist’s first and last name, and NPI
- The PMP should list the period for which the referral is valid. If no time period is specified on the referral, the referral will be applied for the maximum 1 year allowable.
- It is preferred that a reason for the referral also be communicated for care management support

NON-EMERGENT ER SERVICES

Non-emergent ER services are the financial responsibility of the Right Choices member (Please refer to waiver requirements, Chapter 4 of the Indiana Health Coverage Program Provider Manual to bill the member). It is important that ERs follow this procedure after screening a member, in order for inappropriate use to be deterred and for the Right Choices Program to have its best outcomes.
VERIFICATION OF RESTRICTION

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

- Automated Voice Response (AVR) system
- OmniSwipe card device
- Web interChange

If no restrictions are listed, the member is not restricted to any specific provider. If the eligibility response lists restrictions, the member is restricted to receiving specific types of services only from the specific providers indicated. MDwise will reimburse only the provider to whom the member is restricted unless a referral is on file at MDwise, or if the service is for an emergency condition. If the member receives non-emergency services from providers who are not authorized, MDwise does not cover the services. If a member visits a provider not on the member’s lock-in table and the provider notifies the member before rendering the service that MDwise will not cover the service and the member signs a waiver to that effect, the provider can bill the member for services not eligible for payment due to the RCP restrictions. For more information on billing IHCP members, refer to Chapter 4, Section 5 of the IHCP Manual.

BILLING FOR SERVICES TO RIGHT CHOICE PROGRAM MEMBERS:

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

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

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

MEMBER’S FINANCIAL RESPONSIBILITY WHEN LOCK-IN PROVIDERS ARE NOT USED

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

Please Note: It is important to remember that MDwise does not reimburse providers for services unless these guidelines are followed. For more information on billing IHCP members, refer to Chapter 4, Section 5 of the IHCP Manual.

MDWISE RIGHT CHOICE PROGRAM SUPPORT

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

If you have a MDwise member that you would like considered for the Right Choices Program or if you have specific questions about the program, please call us at:

For MDwise Hoosier Healthwise and Healthy Indiana Plan Members:
1-800-356-1204
Chapter 15 – Quality Improvement

Introduction

MDwise is committed to pursuing opportunities for improvement of MDwise Hoosier Healthwise and MDwise Healthy Indiana Plan members’ general health, health outcomes and service through ongoing comprehensive assessment and quality improvement activities. MDwise establishes and maintains the MDwise 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, service received and member and provider satisfaction.

- MDwise develops and implements an annual QI work plan and policies and procedures to guide the 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.
- Medicaid HEDIS measures and those measures directed by Office of Medicaid Policy and Planning (OMPP) are primary mechanisms through which quality monitoring is reported.
- Pay for Performance (P4P) is a MDwise program developed to implement health system improvements that promote good health and health outcomes for MDwise members. Pay for Performance (P4P) initiatives are designed to be congruent with federal and state priorities for Medicaid, state focus studies and the MDwise QI Work Plan.
- The MDwise QI Program and Work Plan are evaluated annually to measure program effectiveness and to revise and/or establish new program improvement goals and initiatives.

MDwise 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 and their providers in identifying and participating in the QI program activities and initiatives.

CONFIDENTIALITY

Individuals engaged in MDwise QI activities maintain the confidentiality of the information with which they encounter. MDwise recognizes the importance of maintaining the privacy and confidentiality of member identifiable information, verbal or written information generated/utilized in the course of quality improvement activities or associated with activities and performance of network providers, practitioners and/or facilities. All documents and proceedings will be kept in a confidential manner as subject to the State and Federal Statutes regarding confidentiality of peer review material.

- The MDwise QI Program components are compliant with applicable regulatory and accrediting bodies.
- The MDwise QI Program is established in accordance with the Indiana Peer Review Statute and applicable state and federal regulations, including
HIPAA.

• QI activities comply with MDwise policies and applicable federal and state laws and regulations related to the confidentiality of quality improvement activities and the reporting of quality issues under review.

• In compliance with State and Federal regulations, MDwise submits to the State the requested quality improvement data that includes the status and results of performance improvement projects.

• 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, released and the uses and limitations of the data.

Please Note: Your commitment to quality healthcare is greatly appreciated. MDwise sincerely thanks you for your service to our members and for your participation in our quality improvement activities. We will keep you informed of our various quality improvement activities via the Provider Link newsletter and MDwise website.

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/or 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

• Collecting data in support of completion of QI activities

• 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 and State 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 Hoosier Healthwise and Healthy Indiana Plan to MDwise members.
- 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.
- Fosters the MDwise Pay for Performance (P4P) which is a program developed to implement health system improvements that promote good health and healthy outcomes for MDwise members.

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.

Please Note: To contact a MDwise committee member representative for your delivery system, please call your delivery systems’ provider relations staff, Medical Director, or Delivery System Administrator.

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, participate 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 OMP. The MDwise Medical Director or designee coordinates and oversees relationships with the delivery systems to maximize their commitment and cooperation in meeting MDwise 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 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 and reliability of the 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 and OMP 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 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 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 set forth by OMP, and include:

- 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/ESPDT Services and Health Promotion
- 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 case and care management, disease management, and special health care needs assessment and management)
- Clinical Practice Guidelines
PERFORMANCE MONITORING

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 OMPP. 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, and claims administration and member and provider service are monitored.

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.

PAY FOR PERFORMANCE (P4P) PROGRAM

The MDwise Pay for Performance (P4P) program is an incentive program aimed at improving the health status and outcomes of the MDwise member population. P4P measures are selected based on the relevance and importance to improving or maintaining the health status for MDwise members. MDwise recognizes providers for going above and beyond to assist members by providing efficient, quality care.

• The MDwise Quality Management Team Committee is responsible for recommending quality initiatives to the MDwise Board and for overseeing the implementation and evaluating the impact of the initiatives.

• The Pay for Performance (P4P) program is individualized to the specific needs of the MDwise member population. The initiative or measure selection, work plan development, and performance measures are developed through the MDwise quality committees with representation from all delivery systems.

• The areas targeted for improvement and the corresponding measures are those identified by the MDwise Quality Committee as highest priority based on current performance and greatest impact on member outcomes and health status and those areas determined by OMPP. These measures are based on the Healthcare Effectiveness Data and Information.
Set (HEDIS) measures and/or quality improvement goals as established by the State.

- Pay for Performance (P4P) program enhancements include system-wide performance incentives for members and providers based on priorities set by the Quality Committee and OMPP and partnering with Indiana Health Information Exchange (IHIE) to produce community-wide physician or practice level rates.

- The delivery systems are given flexibility in designing their approach, interventions and member and provider incentives towards achieving identified targets, based on the characteristics and needs of their members and contracted providers.

- To assist in reaching the annual P4P targets and OMPP targets, MDwise implements member outreach initiatives and provides technical assistance in methodology, data measurement and analysis, and strategic planning. MDwise compiles the OMPP required HEDIS work plan and status updates that details specific strategies, interventions, time frames and accountability.

Please Note: You will receive information regarding P4P measures in MDwise newsletters as well as through your delivery system administrative staff.

HEDIS (HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SETS)

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

Many of the measures in HEDIS focus on preventive health care services and wellness care as well as monitoring health care of members with specific acute illness (i.e., URI) or chronic diseases (i.e., diabetes, asthma). To determine if the recommended services reported in the annual HEDIS rates to the state were provided to our members, MDwise looks first at its claims (or encounter) data. If MDwise is unable to identify that a particular service was provided from the

claims (or encounter) data, MDwise conducts an annual medical record review to determine if the service was provided but for some reason not in the claims data (perhaps a bill was not submitted).

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

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

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.
PREVENTIVE HEALTH SERVICES/EPSDT

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.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is a federal mandate to Medicaid Programs that is a comprehensive, preventive child health program for individuals under the age of 21. The State of Indiana calls its EPSDT program “HealthWatch.” All MDwise practitioners must participate in “HealthWatch” and offer and arrange for the full range of preventive health services, which the state refers to as “EPSDT screenings”, as well as the recommended immunizations and follow-up care for members in the applicable age range from birth through age 20. Please refer to the Appendix for additional information related to EPSDT.

MDwise Delivery Systems participate in the state mandated HEDIS measures related to preventive health services. Compliance to screening and immunization schedules may be evaluated through the Pay for Performance (P4P) initiative, applicable HEDIS measures and medical record reviews.

POTENTIAL QUALITY CONCERNS/ISSUES

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

- Quality issues are those issues related to health care delivery services, including both medical and behavioral health care, that may have potential impact on the quality of care or services provided. Types of quality issues may include but not limited to the following areas: access, satisfaction, communication/attitude, clinical, service, facility, and internal plan issues.

- If a member or members’ representative initiates the complaint, the member receives a letter confirming the issue as stated by the member and informs the member that the issue is being reviewed.

- Identified potential quality issues/concerns are reported to the 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.

ACCESS TO CLINICAL CARE SERVICES

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

- MDwise establishes access standards and collects and conducts analysis of data to measure its performance against the standards. The established standards for timeliness of access to specified care and services, taking into account the urgency of the need for services, will meet or exceed standards as prescribed by OMPP and applicable accrediting organizations.

- Provider access standards include access to regular routine care appointments, and urgent care
appointments (primary care and specialist referrals), after-hours care, telephone service/physician, or designee response time, and office appointment wait time. Compliance to individual standards is measured against the assigned performance standard. Corrective actions are implemented for performances below the compliance standard.

• MDwise may monitor performance to standards utilizing surveys such as member satisfaction, access or office site surveys; conducting analysis of practitioner complaints in arranging referrals to specialists or other providers/ancillaries, complaints and grievances, appeals, emergency services claims/records analysis, and telephone system audits; and monitoring provider self-reports of appointment and in-office waiting times, supplemented by random calls or audits. The assessment provides data on organization-wide and practice-specific performance. Results are provided to the individual delivery systems to develop actions as appropriate to findings.

Please Note: Refer to the Appendix section for the appointment access standards and additional reference to the access standards in the Credentialing Chapter.

PROVIDER PERFORMANCE FEEDBACK

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

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

• Medical Record Reviews
• Facility Site Reviews
• Member Satisfaction
• Quality of Care Issues
• Accessibility
• Service Indicators
• Preventive Health Screenings/Services
• HEDIS Measures
• Pay for Performance (P4P) 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.

Please Note: Refer to the Credentialing Chapter for further information regarding provider performance monitoring.
MEMBER AND PROVIDER SATISFACTION

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

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

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

Please Note: MDwise member and provider survey results and planned interventions indicated, will be published in the provider newsletter. Specific delivery system results detailing the responses and analysis for your provider network are provided to your delivery system administrator staff.

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:
  • Meet compliance with Federal and State regulations, OMPP contractual obligations and relevant accrediting organization(s).
  • Monitor delegate performance to ensure that members receive equitable access to care and service across all delegated entities.
  • 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 your provider delivery system and have the knowledge and familiarity with your hospital network, primary care, specialty and ancillary providers, as well as the MDwise population and program requirements.
To deliver the best care, obtain optimal outcomes and maintain a healthy state for members, MDwise believes it is essential to maintain an emphasis on prevention-related health services and interventions to assist in management of certain acute and chronic conditions/diseases.

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

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

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

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

Specific preventive health service measures are monitored as part of the MDwise QI Program and Workplan. Preventive health services are also included in the MDwise Pay for Performance (P4P) program which is a quality improvement program aimed at improving the health status and outcomes of the MDwise member. Quarterly HEDIS®-based rates for MDwise and for the MDwise delivery systems are produced for the P4P measures to monitor and evaluate the effectiveness of interventions to achieve the desired performance rate.

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

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

MDwise provides a variety of targeted education and outreach programs to facilitate active member participation in staying healthy and appropriately using clinical services available to MDwise members. Members receive information regarding preventive health services and are encouraged to access those services through member outreach programs and delivery system interventions. Examples include new member materials and member handbooks, member newsletters, the BLUEBELLE beginnings Program (focusing on improving access and care for pregnant members), and specific programs, including the MDwise Rewards Program for members, developed to improve knowledge about the importance of well-care, prenatal care and the importance of health screenings to facilitate access to those services. MDwise outreach and education service efforts encourage members to obtain preventive and health maintenance care. MDwise staff visit schools, neighborhoods and health fairs. In addition, outreach efforts include information regarding behavioral health issues and access to care.

Members identified for disease management programs (i.e. Asthma, Diabetes, Pregnancy, Coronary Artery Disease, Chronic Obstructive Lung Disease, Congestive Heart Failure, Chronic Kidney Disease, ADHD, Depression and Pervasive Development Disease) are contacted by the Case/Care Manager working with members assigned to your provider network. Members are encouraged to actively participate in the management of their condition through disease education, self-management tools, and access to health professionals. Provider support is offered through provision of clinical practice guidelines, training opportunities, feedback, and comprehensive care coordination of their members.

Please Note: Refer to the Case/Care Management Chapter for more information regarding disease management activities.

Preventive Care Benefit Package for the Healthy Indiana Plan (HIP)

OMPP determines which recommended preventive care services apply to a specific HIP member’s age and gender, as well as the member’s pre-existing conditions. If a HIP member is redetermined eligible at the end of a benefit period, those HIP members that obtain a recommended preventive care service are able to roll over their entire POWER Account balance, including monies contributed by the State. This can include an annual physical exam or any health screening (e.g., mammogram, colonoscopy, etc.) appropriate for the member’s age and gender. HIP Members that fail to obtain the recommended preventive care services may only roll over their pro rata share of the POWER Account balance, leaving less money available to reduce the next year’s required contribution. The remaining funds must be credited to the State.

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

SPECIFIC LIST OF GUIDELINES

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

Please Note: See the Appendix for a list of the MDwise Clinical Practice Guidelines.
MDwise promotes empowerment of members with chronic health care needs and support of provider interventions through our disease management programs. Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

MDwise disease management programs are designed to provide member and provider interventions to help meet member health needs and manage chronic conditions, including mechanisms that promote compliance to the program's treatment plan, an understanding about the disease and its treatment, and assisting the member in setting and achieving self-management goals. MDwise disease management programs interact with members and practitioners in various ways including telephone, print, Internet or in person, and often through a combination of these.

Behavioral health and disease management coordination will be provided for members with co-existing behavioral health conditions. Effective treatment for these members requires an integrated plan of care that carefully coordinates both physical and behavioral interventions and caregivers. Our integrated disease management program focuses on preventing the occurrence of a behavioral and/or medical disorder by eliminating causative agents, removing the risk factors, and enhancing member competence in self-care and compliance to treatment.

Provider support is offered through mechanisms such as provision of clinical practice guidelines, training opportunities, feedback, and comprehensive care coordination of their members. Providers are also encouraged to use our Disease Management Platform to access health plan information available for their patients and as a tool for communicating with their patient's assigned Disease Manager.

The goals of the MDwise disease management programs include:

- Promote prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies
- Support the provider and member relationship
- Provide member access to educational resources regarding his/her diagnosis or chronic condition
- Promote healthy lifestyle choices, address barriers to care, and provide access to resources
- Empower the member to actively participate in his/her healthcare management
Program Development

MDwise services the 10 (ten) required conditions of interest cited in the States Hoosier Healthwise and Healthy Indiana Plan contract Scope of Work.

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

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

- Diabetes,
- Coronary artery disease (CAD),
- Chronic obstructive pulmonary disease (COPD),
- Asthma,
- Congestive heart failure (CHF),
- Chronic kidney disease (CKD),
- Depression,
- Attention-Deficit Hyperactivity Disorder (ADHD),
- Pervasive Developmental Disorders (PDD),
- Pregnancy

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

Core Program Elements and Requirements

The disease management programs include these core components:

- Evidence based disease management guidelines
- Identification of members
- Stratification based on individual needs and co-morbidities
- Educational materials for members and providers. All disease management programs include the provision of disease educational materials that meet the readability guidelines established by Indiana Medicaid.
- Phone based interventions including using IVR (interactive voice response) technology for members. Periodic phone based interventions may include, for example, providing reminders about disease specific topics and other member reminders such as timely preventive health care, or the importance of follow-up with the physician, health counseling sessions, or member questionnaire to collect data on health status. An additional component of the disease management programs are access to an audio library, member/provider web portals, texting and email.
- Interventions based on stratification levels, including ongoing case management for high-risk members
- In person intervention as indicated
- Provider interventions
- Performance measures and health outcomes. Analyses to identify strengths, weaknesses, develop additional interventions, diffusion of best practices, and assess for and support member/provider satisfaction.
Member Compliance Interventions

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

MDwise provider relations staff may assist the provider with determining the appropriate expectations/treatment of MDwise members and/or submit a Request for Member Intervention or Education form to MDwise when deemed necessary.

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

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

Upon receipt of a request for member intervention, the MDwise entity providing Case Management services which may be a MDwise Delivery System or MDwise corporate will:

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

Please Note: Please refer to the MDwise website MDwise.org for a copy of the Request for Member Intervention or Education form. You may complete the form and submit it directly to your provider relation’s representative or you can call them and they will help you complete the form. It is very important that you include all efforts you have made to address the behavior at issue with the member. It is important that you document in the member’s record, all attempts to work with the member to resolve perceived areas of noncompliance.

Identification of Program Participants and Interventions

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

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

MDwise conducts stratification of eligible members according to risk, or other clinical criteria based on available clinical data (e.g., claims) or member-provided data, and by following the stratification methodology established by OMPP as required.
In addition to stratification determined by available clinical data (e.g. claims), individual member assessments are conducted. Assessments are typically done on moderate to high-risk members to determine individual needs. A structured clinical assessment is administered to ensure appropriate classification of disease risk and to identify additional health care needs. An in-person intervention may be conducted according to findings.

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

- **Population-based (Low Risk)**—Disease specific materials and preventative care reminders (see care gap alerts), as well as:
  - SMOKE-free information
  - MDwise Newsletter
  - MDwise IVR reminder calls
  - NurseOn-call
  - audio library
  - My WellnessZone

- **Case Management (Moderate Risk)**—Members receive all low-level interventions AND periodic contact with a Health Advocate with specific training in this clinical area. The Health Advocate provides member support and education telephonically. The goal of the Health Advocate is to empower the member to better understand the disorder and self-manage the condition as well as to coordinate care between providers, social services, schools and the community. This intervention will occur on a regular basis until the Health Advocate graduates the member to low-risk based on the members demonstration to the Health Advocate that they understand how to coordinate care for their condition of interest and understand basic self-management techniques.
  - Health Advocates specific activities may include:
    - Focus on education and coaching specific to referral from Care Manager/Provider
    - Refers to Care Manager if member degree of risk is of more complex
    - Arranges education and/or classes as necessary and appropriate
    - Assists with scheduling appointments
    - Promotes access to other population based services including: transportation, nurse triage line
    - Promotes preventive care visits
    - Emergency room notification follow-up

- **Care Management (High Risk)**—Members receive all low-level interventions, AND frequent contact with assigned Care Manager.
  - Care Manager specific activities may include:
    - member specific care plan developed that includes measurable short and long-term goals as well as defined milestones to assess the member's progress and clearly define accountability and responsibilities.
    - coordinates care with the practitioner involved in the member’s care and includes them in the development and execution of the care plan, which is reviewed periodically to adjust for progress or barriers.
    - ensures follow-up with a specialist, if appropriate.
• consults with a clinical pharmacist resource (Butler University/Purdue University/DS Medical Directors/MDwise MTM support) for support, if needed, in making recommendations to practitioner when medications are not consistent with guidelines and member is unable to gain control of symptoms.
• arranges home health visit(s) or education and/or classes as necessary and appropriate.
• conducts detailed education appropriate for stage of disease assisting in member transitioning from inpatient to ambulatory care.
• conducts care conferences with the member and providers as needed.
• assists with scheduling appointments.
• emergency room notification follow-up.
• Right Choices Program if applicable.

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

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

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

**Informing and Educating Providers**

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

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

**Please Note:** For additional information, questions, and/or member referrals, please use the Directory in the front of this manual for your provider delivery system Disease Management staff and Medical Director. Information about disease management programs will also be reported in the provider newsletter.
Chapter 18 – Behavioral Health Care

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

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

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

Behavioral Health Care Providers

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

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

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

All providers must have a valid NPI and IHCP number and be credentialed, prior to rendering services to MDwise members. Please refer to Chapter 10 for information about MDwise credentialing criteria for behavioral health providers.

In Hoosier Healthwise and HIP, direct reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as health service providers in psychology (HSPP). Covered services provided by other midlevel practitioners outlined above, are reimbursed, however the services must be directed by a physician or HSPP. Services rendered by a mid-level practitioner must be billed using the rendering provider number of the supervising practitioner and the billing provider number of the outpatient mental health clinic or facility.
Please refer to the Hoosier Healthwise and Healthy Indiana Benefit Overview Chapters (Chapter 3 & 4) for information about mental health covered benefits. Covered behavioral health services generally include the following services. The services are covered according to the member’s benefit package.

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

Services that are not covered include:

- Biofeedback
- Broken or missed appointments
- Day Care
- Hypnosis

MRO SERVICES

As outlined is Chapter 3 & 4, Mental Health Rehabilitation Option (MRO) services are “carved-out” of the Hoosier Healthwise and HIP programs and are not the responsibility of MDwise. These services are covered benefits under Traditional Medicaid program, and, are paid for by the State’s fiscal agent on a fee-for-service basis. MRO services are defined as community mental health services for members with mental illness, provided through an enrolled mental health center that meets applicable federal, state and local laws concerning the operation of community mental health centers (see 405 IAC 5-21).

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

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

Please Note: Even though MRO services are carved out of MDwise’s payment responsibility for Hoosier Healthwise and HIP, we are responsible for coordinating care and follow-up treatment for our Hoosier Healthwise and HIP members who are receiving these services. Providers can view the MRO Provider Manual at indianamedicaid.com.
MDwise Hoosier Healthwise members may self-refer to any IHCP Psychiatrist for behavioral health care services. HIP members may self refer to any Psychiatrist within the MDwise network. MDwise Hoosier Healthwise or HIP members may also self-refer to any behavioral health provider that is contracted with MDwise to provide services to MDwise members.

**PMP REFERRALS**

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

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

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

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

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

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

**MEMBER REFERRAL**

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

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

Although a member may self-refer to any MDwise contracted provider for behavioral health care services, after the initial outpatient referral, 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 Behavioral Health Prior Authorization Quick Reference Guide for the list of required authorizations and number of services allowed without authorization by service type. All outpatient authorizations are requested using the OTR forms available on the MDwise website. These forms must be faxed to the appropriate MDwise delivery system for Hoosier Healthwise and HIP. The prior authorization unit will fax a response back to the provider, or, if more information is required to make a decision, will request additional information.

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

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

PRIOR AUTHORIZATION PROCESS

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

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

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

Care managers review cases with the Medical Director, Physician Advisors or with a contracted psychiatric consultant to discuss medically complex cases or when clinical information does not meet medical necessity. An appropriate behavioral health specialist makes the final determinations. The Medical Director or Physician Advisors are available for peer-to-peer discussions if there is a potential denial or for expedited reviews. Please also refer to the Medical Management Chapter for additional information regarding service authorization procedures.
The coordination of behavioral and physical care is essential in the provision of quality care. MDwise promotes coordination of behavioral health services with medical care through data analysis, effective exchange of information between the medical and behavioral health providers, service reporting and analysis, follow-up treatment management and integrated case/care management for members with physical and behavioral health care needs. MDwise collaborates with behavioral health and physical health practitioners to monitor and improve coordination between medical care and behavioral healthcare.

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

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

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

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

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

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

**CARE COORDINATION AND CASE MANAGEMENT**

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

Role of Care Manager 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 PMP**

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

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

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

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

**Medical Records**

As outlined above, it is a requirement that behavioral health information be shared with the PMP, with appropriate member consent. It is important for you to maintain this information in the member’s medical record. If you receive behavioral health information for a member whom you have not yet seen, please create a member record or separate file to house the behavioral health information. Once the member has been seen by your practice, place the behavioral health information in the established medical record. In addition, all behavioral health information received should be reviewed and initialed prior to placement in the medical record.
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>
</tr>
</tbody>
</table>
The MDwise Pharmacy Benefit for the Hoosier Healthwise and Healthy Indiana Plan is administered by the State of Indiana, Office of Medicaid Policy and Planning through its pharmacy claims processor, HP. Members are able to get their prescription supplies of covered pharmacy products through pharmacy providers and durable related medical supply providers that are contracted in the Indiana Health Coverage Program (IHCP) network. Complete details of the State’s pharmacy benefit can be found in Chapter 9 of the IHCP Provider Manual.

The pharmacy benefit is comprehensive and is defined by the State Plan and approved by the Centers for Medicare and Medicaid Services (CMS). The coverage limitations of the pharmacy benefit and reimbursement to pharmacy providers are set out in the IHCP rule at 405 IAC 5-24. Prescribing providers are to use the Indiana Medicaid Preferred Drug List (PDL) when determining prescribing options for the treatment of medical conditions presented in MDwise members.

While the State Plan’s prescription drug benefit is comprehensive, members should always have a medical justification for drug therapy. A prescriber that determines drug therapy is necessary to treat a member’s medical condition should complete a drug order or prescription, regardless of whether or not the service is a legend drug product or an over-the-counter drug product. Legend drug products are covered as long as the drug is:

- Approved by the US FDA
- Not designated as a less than effective, or identical related or similar to a less than effective drug
- Subject to the terms of a rebate agreement between the drug manufacturer and CMS, and
- Not specifically excluded from coverage by Indiana Medicaid for being an anorectic or agent used to promote weight loss; topical minoxidil preparation; fertility enhancement drug, or a drug prescribed solely or primarily for cosmetic purposes.

The State’s prescription drug benefit program strives to have system edits in place whenever possible to enforce program policy and parameters. However, it is not systematically possible to have edits for each and every dispensing situation. Pharmacy providers must ensure that services rendered to MDwise members are covered by the program, rendered in accordance with pharmacy practice law and all other applicable laws, and do not exceed any establish program limits. Payments that may result from a pharmacy provider’s failure to exercise due diligence in this regard are subject to recoupment.

PREFERRED DRUG LIST

The State’s pharmacy benefit includes coverage of most legend drugs and certain over-the-counter drugs that are listed on the State’s OTC Drug Formulary. Prescribing providers should refer to the most current version of either the PDL or OTC Drug Formulary on the Indiana Health Coverage Programs – PBM website at indianapbm.com.

While most outpatient prescription and OTC drug products are covered services in the State pharmacy benefit program, other drug-related services may require approval and billing to the MDwise Plan directly. Those drug-related services include procedure coded drugs billed by providers other than the IHCP pharmacy network, most medical supplies and medical devices, and enteral or oral nutritional supplements. Providers should contact the MDwise Provider Relations department for information about requirements surrounding the coverage and submission of claims for these services.

PRIOR AUTHORIZATION

Information about authorization requirements for drugs requiring PA can be found at indianapbm.com, or by calling the ACS Clinical Call Center at 1-866-879-0106. ACS provides services for pharmacy-related PA. PA request forms are available at provider.indianamedicaid.com. Providers should direct all questions about pharmacy-related PA requests to ACS at 1-866-879-0106.
Certain drug products and therapeutic classes may have clinical edits applied to them that are juried through a set of automated rules and managed by the State’s clinical edit application, Smart PA. SmartPA is an application that enables the inclusion of member medical evidence that comes from professional and institutional claims into comprehensive pharmacy adjudication edits to prove the medical need for drug therapies in an automated fashion. If information in a member’s medical claims history produces evidence of a diagnostic requirement to a rule for a drug, the claim for the drug would continue through the pharmacy claims processing system without interruption. If medical claims history does not support criteria needs of the clinical edit, the claim denies and the provider will receive notification to contact the ACS Indianapolis Clinical Call Center to determine whether preferred drug therapy alternatives are appropriate or an authorization request needs to be initiated. All clinical edits and criteria used in SmartPA are approved by the State’s DUR Board.

**DRUG UTILIZATION REVIEW EDITS THAT REQUIRE PA**

The following drug utilization review edits will post a denial and require a PA to override:

- Drug-Drug interactions of severity level 1
- Overutilization/Early Refill
- 34-Day Supply Limit for non-maintenance medications

A provider requesting an authorization override for a drug-drug interaction involving a drug therapy that has been discontinued should contact the ACS Clinical Call Center at 1-866-879-0106. A request for an authorization override for a drug-drug interaction in which both medications are taken concurrently requires the prescriber to call and provide medical necessity justification. Overrides for overutilization edits can be performed by the pharmacist through a call to the ACS Clinical Call Center at 1-866-879-0106.

**MANDATORY GENERIC SUBSTITUTION/BRAND MEDICALLY NECESSARY**

Under the State pharmacy benefit program, prescribers and pharmacy providers should know that generic substitution of drug products is mandated by Indiana Code (IC 16-42-22-10). Failure to dispense wholly in accordance with the law can result in recoupment of payment that was paid in excess as a result. Pharmacy providers should be aware of, and dispense in accordance with, the brand medically necessary provisions of the Medicaid rule at 405 IAC 5-24-8, and view IC 16-32-22 Drugs: Generic Drugs.

A prescriber’s specification of brand medically necessary requires a prior authorization request. Currently, the following drug products are exempted from the PA requirement associated with brand medically necessary:

- Dilantin
- Coumadin
- Lanoxin
- Premarin
- Tegretol
- Provera
- Synthroid
- Mental Health medications as defined by State statute

Please be alert to OMPP correspondence, Bulletins and Banners published to stay current.

**EMERGENCY SUPPLY**

In circumstances in which prior authorization cannot be immediately obtained, a pharmacist may dispense a 72 hour supply of the prescribed drug product for a covered outpatient drug as an “emergency supply” with the assurance of reimbursement by the State’s pharmacy claims processor, HP.

In addition, emergency supplies are allowed to cover for holidays, weekends, and times when prior authorization offices are closed for up to 4 days of supply of a covered outpatient drug with the assurance of reimbursement by the State’s pharmacy claims processor, HP.
For drug products whose packaging cannot be broken down to a four day or less supply, the pharmacy should dispense the smallest quantity possible that is adequate for the “emergency supply”. Pharmacy providers are responsible for internally documenting the quantities dispensed due to manufacturing constraints in dosage forms as the least amount able to be dispensed while meeting the patient’s needs for the “emergency supply”.

100-DAY SUPPLY FOR MAINTENANCE MEDICATIONS

Drugs that are designated and maintenance medications are limited in quantity per claim to no more than a 100-day supply. A maintenance medication is a drug that is prescribed for a chronic medical condition, and is taken on a regular, recurring basis. Non-maintenance medications are limited to quantities of no more than a 34-day supply per claim.

TAMPER RESISTANT PRESCRIPTION PADS

Because the pharmacy benefit utilizes the State Plan, prescribers must use Tamper Resistant Prescription Pads (TRPPs), when ordering pharmacy benefit services for MDwise members. The Indiana Board of Pharmacy security prescription blanks meet all TRPP requirements and can be obtained from the Board of Pharmacy to support prescribing drug therapies to MDwise members.

DRUG COPAYMENT

Members in the Hoosier Healthwise Program are required to pay and pharmacy providers are required to collect a copayment for legend and nonlegend drugs and insulins under the following circumstances:

• The copayment that is paid by the member should offset the reimbursement amount that is paid by the State Plan to the pharmacy provider.
• The pharmacy provider shall not deny services to any member based on the member’s ability to pay the copayment amount.

• The copayment amount is $3 for each prescription supply.

The following services are exempt from the pharmacy copayment requirement:

• Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.
• Prescription supplies dispensed to members less than 18 years of age.
• Prescription supplies dispensed to pregnant women if the drug therapies are related to pregnancy or any other medical condition that may complicate the pregnancy.
• Prescription supplies dispensed to members who are hospital inpatients, nursing facility residents, intermediate care facility residents for the mentally retarded, or residents of other medical institutions.
• Prescription supplies for family planning to members of child bearing age.

MDwise members enrolled in the Children’s Health Insurance Program (CHIP) have a $3 copayment for each covered generic drug dispensed and $10 copayment for each covered brand drug dispensed.

DRUG-RELATED MEDICAL SUPPLIES AND MEDICAL DEVICES

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

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

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

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

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

HIP Buy-In Pharmacy Helpdesk Information:
• PBM clinical representatives are available 8:30am to 6:00pm est. Monday through Friday
• The claims processing agent is available 24 hours per day, 365 days per year to assist in claims adjudication issues
• A 72-hour temporary supply of medication is available in emergency situations when the PBM clinical staff is not available.

• Physician and Provider Support Number: 1-800-558-1655
• Pharmacy Customer Service: 1-800-558-1655

HIP BUY-IN PROGRAM PHARMACY BENEFIT-PRIOR AUTHORIZATION & EMERGENCY SUPPLY PENDING REVIEW
The prior authorization process is handled by MDwise’s Pharmacy Benefit Manager, PerformRx. The Pharmacy Benefit Manager utilizes qualified health care professionals including PharmD’s to make utilization management decisions. These functional units are hereafter referred to as the “prior authorization entity”. The prior authorization entity will request the documentation to determine the medical necessity of the requested drug or treatment in accordance with their usual procedures. Proactively working with the prior authorization entity on requests for prior authorization will expedite the process for the provider and the member. Provision of written documentation i.e. records supporting requests for prior authorization are essential to a valid, consistent and expedient review process.

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

The prescriber must submit a request for prior authorization to the prior authorization entity within the 72-hour period for continuation of the drug. In cases where a therapeutic equivalent exists on the MDwise Preferred Drug List, the prior authorization entity may request the medication be substituted with a medication found on the PDL.
If a change in medication could be detrimental to the member, every effort to insure continuation of appropriate therapy set out by clinical guidelines will be made.

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

**HIP BUY-IN PROGRAM PHARMACY BENEFIT–PRIOR AUTHORIZATION**

Upon entering the drug in the computer, a message will appear notifying the pharmacy that prior authorization is required. The technician or pharmacist will call the PBM at the pharmacy help-desk number. If it is a clinical authorization, the prescriber is to submit clinical information and rationale to support the request. The following steps occur:

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

**HIP BUY-IN PROGRAM PHARMACY BENEFIT–EXCEPTIONS POLICY**

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

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

**HIP BUY-IN PROGRAM PHARMACY BENEFIT–APPEALS**

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

**HIP BUY-IN PROGRAM PHARMACY BENEFIT–INQUIRY REGISTERING AND RESOLUTION**

The PBM is responsible for maintaining a provider inquiry reporting and resolution process that includes MDwise notification and interaction as needed. PBM reporting to MDwise includes an inquiry report that identifies type and outcome of MDwise provider inquiries.
Delivery system staff should be directed to forward pharmacy-related inquiries to the MDwise Customer Service Department. In addition to the MDwise Medical Advisory Council, pharmacy related issues may also be discussed at other MDwise committees, including committees overseeing corporate quality, quality improvement, medical management, member services and provider services. Representatives from the PBM are present or available at the meetings as needed or upon request.

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

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

HIP BUY-IN PROGRAM–PHARMACY NETWORK
Pharmacy services are delivered through the PBM’s contracted network. The PBM provides MDwise with a list of participating providers that is updated monthly. The PBM access standard is as follows: At least 95% of MDwise members will have a retail network pharmacy within a five-mile radius of their residence if there is an existing pharmacy within that radius.

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

Please Note: A listing of the network pharmacies can be found on the MDwise website, MDwise.org, Providers or Members Page.
Transportation to and from the facility where medically necessary covered services are provided is a necessary condition for access to care. MDwise has a transportation vendor that arranges for non-emergency transportation services for the members in the MDwise Hoosier Healthwise program. Transportation is not a covered benefit for the Healthy Indiana Plan (HIP).

Members that are in need of transportation services are instructed to call MDwise Customer Service. When a member calls, they are prompted to select the “transportation option”. They will then be connected with a transportation specialist who can schedule their transport to and from a covered service.

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

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

Transportation services managed by MDwise include:
- Processing requests for transportation from members
- Verifying eligibility for services
- Scheduling transportation with vendor
- Billing and management reporting
- Contracting with local transportation vendors

Transportation Reservations

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

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

Please Note: To assist a member in arranging a ride, please have the member call MDwise Customer Service at: (800) 356-1204 or (317) 630-2831 (Indianapolis area)

Urgent Trips: Someone from the provider’s office staff (this does not have to be a nurse) must call MDwise to authorize an urgent trip (same day service), or the member will be denied a ride.
Certain transportation services require prior authorization:

- Trips of fifty (50) miles or more one way
- Airline, air ambulance, interstate transportation or transportation services from a provider located out-of-state,
- Trips exceeding twenty (20) one-way trips per recipient, per rolling twelve (12) month period, excluding those transportation services exempt from the 20-trip limit.

If a transportation service requires prior authorization the member must call at least two (2) working days before the service is needed. This gives the Transportation Specialists time to get the required authorization from the medical management department.

Prior authorization for transportation services beyond the 20-trip limit are granted for trips for medically necessary services. Upon verification of a scheduled visit/service, a Transportation Specialist will authorize a request for the following services:

- PMP visits and prenatal care visits
- After hours services
- Cancer therapy
- Renal Dialysis
- Dental visits
- ER – non-ambulance

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

Emergency ambulance services do not require prior authorization but claims are subject to retrospective review (Please refer to Chapter 3, for an overview of emergency services coverage). MDwise covers both basic and advanced life support emergency ambulance services; however, advanced life support ambulance services are covered only when this level of service is medically necessary and a basic emergency ambulance is not appropriate due to the medical condition of the member being transported.

Transportation Considerations

**TRIP LIMITS**

Members in Packages A, B, and P are covered for 20 one-way trips per year without authorization. The year is counted starting on the date of the first trip. When a member has 7 or fewer trips left, the member is encouraged to contact their PMP to discuss the need for additional transportation. The PMP may then contact their delivery system medical management department to discuss a member’s need for additional trips (e.g. reoccurring therapy visits, treatment of chronic medical condition, etc.). Members must obtain prior authorization for transportation services beyond the 20-trip limit.

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

**TRANSPORTATION LIMITS**

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

HIP members, similar to Package C members, are not covered for routine transportation. They are only covered for emergency transportation and for inter-hospital transfers that are deemed to be medically necessary.

For all members, transportation is not provided to pharmacies or for visits for non-covered medical services.
Chapter 21 – Member Outreach and Education Programs

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

New Member Materials

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

- A member handbook with a phone card listing MDwise telephone numbers
- An introductory/welcome letter with a magnet that members can personalize with their doctor’s name, phone and hospital information (arrives two weeks after the handbook)
- Information on how to obtain a MDwise Provider Directory
- HIP members - POWER Account/ID Card

Each new MDwise member is also instructed in his/her new member materials to call a toll-free number to activate his/her “Extra Benefits.” This may enhance our ability to reach all new members within the first 30 days to complete a health risk screener and confirm or assist in PMP selection. This call provides MDwise with the opportunity to link the member with any targeted or enhanced services, identify any special needs he/she may have and to educate him/her on the importance of scheduling an appointment to see his/her PMP within 90 days.

Toll-Free Member Phone Line

MDwise has a toll-free customer service telephone line to assist members with any questions he/she may have about MDwise or their health care coverage. You can call MDwise at 1-800-356-1204 or 317-630-2831 in the Indianapolis area. There are representatives who can help you 24 hours a day, 7 days a week. If you get an automated message, please leave your name and number and someone will return your call no later than the next business day. You can also go to MDwise.org for news and information. MDwise CSRs are available Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Standard Time.

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

Both during regular business hours and after hours, members that phone in will be advised to contact their PMP or will be provided assistance in contacting the PMP for issues necessitating the PMP’s response or intervention such as care management issues.
**Member Newsletter**

The MDwise member newsletter is sent out quarterly (languages other than English, including Spanish, are available as requested) and includes information about timely health topics, preventive health services, new program information, inquiry and grievance procedures, MDwise policies and special children’s features. The newsletter is also posted on the MDwise website.

*Please Note:* Providers are invited to submit topics for inclusion in the newsletter. Suggestions or newsletter articles may be submitted to the MDwise Director of Marketing.

**Special MDwise Programs**

MDwise has a number of extra programs for members that will help members get healthy and stay healthy. Members can call MDwise Customer Service or visit the MDwise website at MDwise.org to learn more about these programs.

| **NURSEon-call** | NURSEon-call provides members with 24/7 access to a Registered Nurse. NURSEon-call, is MDwise’s nurse triage service for members. The triage service is operated by trained nurses and is designed to help our members access the most appropriate resources and information for their needs. Members (or their parents) can call NURSEon-call at any time, day or night with a health question or concern and talk directly to a nurse. They can receive answers to questions about illness, medications, medical tests, or procedures or they may receive help in determining if they need to seek professional care, including emergency care. NURSEon-call may also help members or their parents gain a better understanding of the nature and urgency of the situation causing concern. NURSEon-call staff always refers the member back to their PMP for further assessment and/or treatment to reinforce the importance of the member’s medical home. To access the NURSEon-call, the member can call MDwise Customer Service at (800) 356-1204 or (317) 630-2831 (In the Indianapolis area). |
| **Ms. Bluebelle’s club for kids** | Ms. Bluebelle’s club for kids offers special activities and mailings that teach kids to make healthy choices. Kids can also call the Ms. Bluebelle hotline to hear a fun health message or leave a personal message for Ms. Bluebelle. Kids can reach Ms. Bluebelle by calling 1-800-356-1204. |
| **RIDEwise** | MDwise covers transportation to doctor appointments for Hoosier Healthwise members on Package A, B, and PE. More information regarding ambulance transportation for Package C and Healthy Indiana Plan members are provided in Chapter 18. |
| **TEENconnect** | TEENconnect is a resource for teens to find health information. They can access information on being a healthy teenager. For example, they can read about dealing with peer pressure, sex, tobacco, drugs and alcohol, depression and/or changes happening with their body. Some of this is done through interactive games. |
The MDwise BLUEBELLEbeginnings program was launched in 2004 to improve access and care for pregnant women and to improve the likelihood of a healthy baby. The program includes a wide range of interventions including health education materials, community referrals, access to health education classes, telephonic outreach, and high-risk case management. MDwise will also assist the member in selecting a doctor for their baby. Members stay enrolled in the program until after delivery.

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

For participating in BLUEBELLEbeginnings, the member currently receives a package of prenatal information. As an added incentive to the pregnant member for making and keeping her appointments, the MDwise Rewards program specifically rewards points for prenatal and postpartum exams. As the pregnant member accumulates points, she can redeem her points for a gift.

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

WEIGHTwise is a nutrition and exercise resource. MDwise members are provided with access to important information on eating right and being active. WEIGHTwise also has a food and exercise diary as well as other resources.

Through WELLNESSchats, MDwise offers educational meetings/forums for our members at various community and/or clinic sites. These forums are open to MDwise members and their families as well as the general community. Before the WELLNESSchats take place, efforts are made to survey patients in that area to determine what health topic, date and time is of importance/convenience to them. The forums may focus on clinical topics, such as asthma or diabetes or on parenting, wellness, or other topics of interest to our members. If you are interested in holding a WELLNESSchat at your office or clinic site, please call the MDwise Outreach Department and this can be arranged. Transportation is made available for MDwise members, as well as childcare if possible.

MDwise can answer member questions about health and community services, as well as family issues or almost anything else. We will link members to people who can help with their question or problem. For more information call Customer Service at: 1-800-356-1204 or 317-630-2831 in the Indianapolis area.
MDwise launched an incentive program that uses points and financial rewards to encourage member participation in MDwise programs. Our goal is to increase member participation in making positive health care decisions for themselves and their families. The program will incentivize members across the plan with one central approach. The program engages members in taking greater responsibility for their health care decisions, become better educated health care consumers, and improve their health.

The program “rewards” members with incentives for completing targeted health and wellness activities. Members earn points that are deposited into a personalized rewards account. The member can then redeem the points, once they reach a designated level, for a MDwise gift. After the member “cashes in” their reward points, they can begin accumulating new ones. We are hopeful that this approach will be more successful in realizing ongoing healthy actions and behavior change.

The MDwise Rewards Program is tailored to achieve a number of goals. Initially, we would like to reward members with “points” for the following behaviors:

- Sign up for myMDwise Member Portal (member must supply an email address)
- Sign up to receive Healthy Indiana Plan monthly statements online through the myMDwise Member Portal
- Completion of a Health Risk Screener (HRS) online via secure website, via phone call with MDwise Customer Service or by mail
- Completion of an annual physical exam or well-child visits
- Getting recommended mammogram screenings
- Getting recommended prenatal visits
- Completing a postpartum exam
- Diabetics obtaining and LDL and A1C test

For each of these actions, MDwise awards the member predetermined weighted points. For example, a well child visit may be worth 20 points (3 points for the first year to equal 21 points for the year), while each prenatal exam would be worth 2 (potential to earn up to 32 points through the course of the pregnancy) and joining the myMDwise Member Portal may be worth 10 points.

Members are able to access their rewards account via a secure member portal. Accumulated points and the activity for which the member earned those points, is displayed. MDwise Customer Service has access to this information for those that do not have access to a computer. Once a member accumulates a certain level of points, he/she can choose to either continue saving the points to earn a larger reward, or “spend” their points on a smaller gift. This allows us to address the needs of those members who need more immediate gratification in order to stay engaged in the process. There will be prizes determined for point intervals up to 75, such as gift cards or store coupons.

On at least an annual basis, MDwise will review the Rewards program and make decisions about behaviors to add to the list. In order to keep members engaged, we will eventually plan to advertise a member’s ability.
to earn “bonus” points, via the member newsletter and other OMPP-approved communication materials.

Earn and cash in points in the program. Educational materials also serve to reinforce important health and wellness messages.

Comprehensive educational materials have been developed and distributed to help members understand MDwise Reward Program features and how they can earn and cash in points in the program. Educational materials also serve to reinforce important health and wellness messages.

Emergency Room Use

MDwise closely monitors member participation rates and utilization rates of targeted services.

As with any new program MDwise implements, results will be analyzed and used to refine and improve program features so we can be assured of meeting goals for the MDwise Rewards Program. Reports on the MDwise Rewards Program progress will be published in the ProviderLink and the MDwise website.

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

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

Emergency treatment plans will include:

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

Additionally, through our Pay for Performance (P4P) program, MDwise focuses on well care visits and encouraging new members to visit their PMP within 90 days of enrollment in order to establish a relationship with their PMP. At these visits, the PMP can reinforce the medical home concept and the availability to contact their PMP or the NURSEon-call nurse line 24/7 if they are unsure if they need to be seen in an ER for their symptoms, etc.
Following is a brief summary of specific strategies MDwise employs to reduce inappropriate ER utilization:

<table>
<thead>
<tr>
<th>ER Initiative</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Frequent ER Visitors</strong></td>
<td>Members who visit the emergency room more than three times in a 90 day period as indicated by claims analysis receive educational outreach and screening to educate the member on the role of the PMP, care options, and appropriate use of the emergency room. During these conversations, MDwise outreach staff will determine whether the member is experiencing any barriers to primary care and will work with the member to overcome such barriers. Members may also be referred to their care manager who conducts an additional assessment of the medical condition and reviews and updates the individual care plan.</td>
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<tr>
<td><strong>Physician Profiling</strong></td>
<td>PMP profiles will be generated that include emergency room utilization. Profile data is risk-adjusted to compensate for differences in acuity among members. Profiles can be used as a tool to indicate when high-risk members have failed to obtain necessary services from their PMP, and whether members who have a specialist serving as their PMP have higher utilization of the emergency room for non-emergency care. Care managers and providers will supplement the physician profiling strategy to help identify high-risk members for over or under ER utilization.</td>
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| **Access Surveys**                                | Bi-annually, a portion of the PMP network, including all PMPs with non-standard ER utilization results, will be monitored to evaluate access for urgent and after-hours care.  
  - To assess urgent care access, the office will be contacted with a request for an urgent appointment; the scheduler’s response, including duration from date of call to the first available appointment, is documented.  
  - To assess after-hours access, the offices are called after business hours with a request to speak to a physician. PMPs who do not meet the required access standards receive follow-up education from a MDwise provider representative and are automatically included in the sample for the next survey. |
| **Member Outreach and Timely Feedback**            | Pilot project with Hoosier Healthwise members. In the program, St. Vincent ERs provide immediate, 24/7 notification to MDwise via facsimile any time a MDwise member has been to their emergency room. Upon receipt of the notification and review of the initial ER visit documentation, MDwise makes a determination about the most appropriate intervention for each member situation. This project will expand, as MDwise is able to obtain agreements with additional hospitals to provide timely ER information on members seen in the emergency room. MDwise has also executed an agreement with the Indiana Network for Patient Care (INPC) to supply MDwise with similar notification for all INPC participating hospital emergency rooms. Similar to the St. Vincent project, notification from INPC will provide MDwise with the opportunity to contact members in a timely manner to provide “just-in-time” education and to address any barriers that might be resulting in emergency room visits. |
| **NURSEon-call Nurse Triage and Member Education Service** | Members will have access to 24 hour NURSEon-Call service when they are unsure of the most appropriate place to get services for their problems. |

*Please Note:* MDwise has an educational brochure for members regarding the appropriate use of the Emergency Room. You can distribute this brochure to your members. Please call your delivery system provider relations representatives if you would like a supply of these brochures to distribute.
MDwise is proud to be a founding sponsor of the Indiana Reach out and Read (ROR) program, which is a provider office based pediatric literacy program that targets communities with limited resources and low literacy rates. ROR promotes early literacy by bringing into the pediatric exam room the gift of new books and advice on the importance of reading aloud. For parents with limited literacy skills, this may involve looking at and talking about the pictures with children. Doctors and nurses give new books to children at each well child visit from 6 months through 5 years of age, along with developmentally appropriate advice to parents about reading aloud with their child. MDwise collaborates with the American Academy of Pediatrics, the Indiana Literacy Foundation, and the Riley Memorial Foundation, to promote the expansion of the Indiana ROR program. The number of MDwise provider sites that implement this program has grown from 19 sites in 2003 to approximately 80 sites in 2010. The number of provider sites that implement this program has grown to 144 sites across the State of Indiana. The Executive Director’s office is located at MDwise.

**Please Note:** Reach out and Read (ROR) is currently offered to members at approximately 80 MDwise provider sites. MDwise hopes to expand this program to all community health centers and hospitals that serve MDwise members. If you have an interest in learning more about the program or are interested in setting up ROR in your office, please contact your MDwise Provider Relations representative or Lisa Robertson, Executive Director of Reach Out and Read Indiana, via lisa.robertson@reachoutandread.org.

**MDwise Website**

The MDwise website is an important source of information for MDwise members and families. Some of the information and tools currently found at MDwise.org include:

- myMDwise member portal
- How members can earn MDwise Rewards points
- Health risk screening survey online
- MDwise member handbook
- MDwise member newsletters
- Information related to MDwise outreach and education programs
- Appropriate use of the emergency room tips for members
- New member information
- MDwise contact information
- Member rights and responsibilities
- Privacy policies
- How members can access transportation and medical care
- Participating pharmacies
Special Needs of MDwise Members

MDwise is committed to serving all of its members equally, making extra attempts to serve the needs of members who have special health care needs or require other services in order to access needed services.

The following sections lists a variety of programs and medical management activities intended to serve that purpose. However, if a MDwise member requires other special services beyond those listed here, please contact your provider relations representative or the MDwise Customer Service Department for further assistance in locating appropriate resources. Please also refer to Chapter 12: Medical Management for additional information regarding programs and assistance for meeting the needs of these members.

If you have questions about a special health care needs member and want to speak with someone at MDwise please call 317-630-2831 (Indianapolis Area) or 1-800-356-1204.

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

Language Services

Effective communication with members is a key component in our ability to effectively coordinate and deliver appropriate health care services. MDwise is committed to ensuring that members seeking health care services from MDwise providers or requiring information about health care services from MDwise have free oral interpretive and language translation services available when needed. MDwise is also responsible for ensuring that members have telephone access to their PMP in English and Spanish 24-hours-a-day, seven-days-a-week. Provider responsibilities for interpretive services are outlined in Chapter 9.

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

- As outlined earlier in this chapter, MDwise has a statewide toll-free customer service line that is available 24-hours a day, seven days a week. If a member cannot speak English, MDwise utilizes CryaCom language services to assist in communicating with the caller. Interpreters speaking over 140 languages are available through this service and are available to assist callers 24 hours a day, 7 days a week.
- MDwise also employs bilingual Customer Service Representatives (CSR) when there is a significant concentration of MDwise members (10% of membership) for whom English is not their native language. Currently MDwise employs CSRs who speak Spanish and Burmese. These representatives are available to assist Spanish- and Burmese-speaking members during regular business hours. MDwise also offers telephone-automated messaging in English and Spanish.
- Members who are hearing impaired may access MDwise by calling Relay Indiana at 1-800-743-3333. This number can be used anywhere in Indiana. The operator will connect the caller to the MDwise customer service line and relay the text typed by the member to the MDwise CSR, as well as typing back to the member the CSR’s verbal response. The service is available 24-hours a day, seven days a week.

MDwise also produces member materials in a foreign language when required by OMPP, or if it can be determined that there is a significant concentration of MDwise members (10% of membership) who do not speak English as their native language. Currently all member materials are available in both English and Spanish. Burmese member handbooks are also available.
Agency and Community Service Providers

ABOUT SPECIAL KIDS! ASK: 1-800-964-4746
ABOUTSPECIALKIDS.ORG
About Special Kids is a place for families and professionals in Indiana to go to “ASK” questions about children with special needs and to access information and resources about a variety of topics such as health insurance, special education, community resources and medical homes. The mission of About Special Kids is: Supporting children with special needs and their families by providing information, peer support, and education, and building partnerships with professionals and communities. ASK also conducts a variety of workshops, in-services, and conferences for parents, family members, service providers, educators and policymakers. Some of the topics include special education rules and regulations, and health care.

(CSHCS) FIRST STEPS PROGRAM: 1-800-545-7763 (STEP)
IN.GOV/FSSA/DDRS/2633.HTM
This program provides services for children up to age 3. The children must have a disability or be developmentally vulnerable. The services include:
• Screenings and assessments.
• Help to access medical care and other resources
• Coverage for some health care services that are not covered by Hoosier Healthwise.
• Support services.
• Family education and special training.

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

CHILDREN’S SPECIAL HEALTH CARE SERVICES (CSHCS) PROGRAM: 1-800-475-1355
IN.GOV/ISDH/19613.HTM
This program provides health care services for children through age 21. The children must have a severe, chronic medical condition that does at least one of the following:
• Has lasted or is expected to last at least 2 years.
• OR - Will produce disability, disfigurement, or limits on function
• OR - Requires special diet or devices.
• OR - Without treatment, would produce a chronic disabling condition.

A Care Coordinator will help a member obtain medical services they may need. For children under 3 years old, the CSHCS Program will also work with First Steps to coordinate patient care.
When new members call to activate their “extra benefits,” they will be asked about any special services they might need. MDwise will attempt to provide members with information on community resources that may address identified needs.

**Linking Members with Additional Community Resources**

MDwise also has staff that can assist members with difficult issues or finding other services, like a parent support group. The Health Advocates can help if the member needs suggestions or information about other services available in their community.

**Please Note:** Access to Health Advocates can be accomplished by calling 317-630-2831 (Indianapolis Area) or 1-800-356-1204 or through the link HELPlink on the MDwise website MDwise.org. HELPlink links the member with a MDwise Health Advocate who can answer questions about health and community services, as well as family issues or other concerns. More about the MDwise Health Advocate program is provided in the Member Outreach and Education Chapter.

Please refer to this section in the Member Outreach and Education Chapter for information regarding interpretive and language translation services and services available for the hearing impaired. In that chapter section you will find detailed instructions in how to access these services for your patients.

MDwise also produces member materials in a foreign language when required by OMPP, or if it can be determined that there is a significant concentration of MDwise members (10% of membership) who do not speak English as their native language. Currently all member materials are produced in both English and Spanish.

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

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

Each member assessment is categorized according to the individual’s condition and needs including the type and level of functional limitations, intensity and scope of service utilization, and type and duration of the on-going health condition as it affects the member’s physical, developmental and behavioral or emotional status. MDwise also assists the member in identifying, assessing and using community resources and coordinating the services to meet the individual health care needs that affect the member’s health. The specific interventions are developed to meet the member’s needs and promote optimal outcomes.
Mechanisms are in place to allow members identified as having special needs to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member’s condition and identified needs.

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

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

**Please Note:** Contact the MDwise Health Advocates or your delivery system case management/medical management staff to refer your members that have special health care needs and may need additional assistance. Your Delivery System may have other additional resources they will share with you.
Medical care is based on scientific principles and on partnerships among the member, doctor, MDwise, and other health care staff. MDwise is committed to developing these partnerships and recognizes that there are certain member rights and responsibilities that are critical to the success of this partnership and the provision of appropriate medical care. Following is the MDwise Member Rights and Responsibilities Statement.

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

MDwise members have the right to:
• Be treated with dignity and respect.
• Personal privacy. Keep medical records confidential as required by law.
• A clear explanation of their medical condition. The member has a right to be part of all treatment decisions. Options should be discussed with the member no matter what they cost or whether they are covered as a benefit.
• Be provided with information about MDwise, its services, its doctors and other health care providers and members’ rights and responsibilities.

In addition, members have the right to:
• Change their doctor by calling the MDwise Customer Service Department.
• Timely access to covered services.
• Appeal any decisions we make about their health care. The member can also complain about personal treatment they received.
• Get copies of their medical records or limit access to these records, according to state and federal law.
• Amend their medical records.
• Get information about their doctor.
• Request information about the MDwise organization and operations.
• Refuse care from any doctor.
• Ask for a second opinion, at no cost.
• Make complaints about MDwise, its services, doctors, and policies.
• Get timely answers to grievances or appeals.
• Take part in member satisfaction surveys.
• Prepare an advance directive.
• Get help from the Indiana Family and Social Services Administration (FSSA) about covered services, benefits, or complaints.
• Get complete benefit information. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered services.
• Request information about the MDwise physician incentive plan.
• Be told about changes to benefits and doctors.
• Be told how to choose a different health plan.
• Health care that makes the member comfortable based on their culture.
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with Federal regulations.
• When a member exercises these rights, the member will not be treated differently
• Provide input on MDwise member rights and responsibilities.
• Participate in all treatment decisions that affect the member’s care.
• If MDwise closes or becomes insolvent, members are not responsible for MDwise debts. Also, members would not be responsible for services that were given to a member because the State does not pay MDwise, or that MDwise does not pay under a contract. Finally in the case of insolvency, members do not have to pay any more for covered services than what they would pay if MDwise provided the services directly.
Members are responsible for:

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

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

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

- MDwise provides access to medical care without regard for religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age for all members.
- MDwise does not prohibit or restrict a health care professional from advising a MDwise member about his/her health status, medical care, or treatment options. This policy applies, so long as the professional is acting within the lawful scope of practice, regardless of whether benefits for such care are provided under the provider’s contract or under the Hoosier Healthwise or Healthy Indiana Plan program.
- In accordance with 42 CFR 438.102(a), MDwise allows health professionals to advise a member on alternative treatments that may be self-administered, and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits and consequences of treatment or non-treatment.
- MDwise does not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods.
- MDwise may not take punitive action against a provider who requests an expedited resolution or supports a member’s appeal.
Any MDwise member that is dissatisfied with a service they received or does not agree with an answer they receive to a complaint or a MDwise decision, has the right to ask for further review of the issue.

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

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

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

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

A member who wishes to file an appeal or a grievance by telephone should call MDwise Customer Service at (317) 630-2831, or if outside the greater Indianapolis area, 1-800-356-1204. A member or member’s representative who wishes to file a grievance or appeal in writing should send a letter to:

MDwise Customer Service Department
Attn: Grievances OR Appeals
PO Box 44236
Indianapolis, IN 46244-0236

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

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

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

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

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

APPEAL

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

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

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

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

- Standard Appeals MDwise responds to all oral and written appeals with three (3) business days of receiving the request. The appeal must be resolved within 20 business days of appeal and written notification of the appeal resolution must be sent to the member within five (5) business days after the decision is made. If the member requests an extension, or if MDwise is unable to make a decision within twenty (20) business days because additional information is needed either from the provider or member that has been requested, but not provided, the member is notified before the 20th day of the delay. MDwise provides the member with written notice of the delay, demonstrating in the notice that the extension is in the member’s best interest and that a decision will be granted within ten (10) additional business days.

- Expedited appeals MDwise resolves expedited appeals meeting MDwise criteria within 48 hours of receiving the request and the attending physician
and member are notified immediately by telephone. This time frame can be extended pursuant to 42 CFR 438.408(c). A written confirmation of the decision is also sent by mail to the member within 48 hours of notification.

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

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

**LEVELS OF EXTERNAL REVIEW IF MEMBER IS NOT SATISFIED WITH APPEAL DECISION**

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

- **Independent Review Organization (IRO)** A member may pursue review by an IRO if they are not satisfied with the MDwise appeal decision (must be filed within 45 calendar days of receiving appeal determination). The IRO is available for appeals that involve an adverse utilization review determination, an adverse determination of medical necessity or a determination that a proposed service is experimental or investigational. A member may also pursue an expedited external review. Requests for excluded benefits or exceed benefits are not eligible for independent review.

MDwise responds to requests for external review, within three (3) business days of receiving the request for an IRO review. A standard external review must be resolved within 15 business days after the review is requested. An expedited external review must be resolved within 48 hours of receipt of the request. For a standard external review, the member is notified within 72 hours of the IRO panel’s decision. For an expedited external review, the member must be notified within 24 hours of the IRO panel decision.

The member is informed that he/she is not required to bear costs of the IRO, including any filing fees. An IRO determination is binding on MDwise.

The resolution notification of an IRO denial decision includes the member’s appeal rights to request a FSSA fair hearing.

- **FSSA Fair Hearing** The member may choose to request the FSSA fair hearing by submitting a written request directly to FSSA within 30 days of either:
  - Receipt of appeal denial notification from MDwise by submitting a request in writing to FSSA.
  - Receipt of an IRO review determination and is not satisfied with the IRO decision.

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

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

To access the Indiana Health Coverage Program (IHCP) manual for HealthWatch Early Periodic Screening, Diagnosis, and Treatment Provider Manual, please go to the Indiana Medicaid website: provider.indianamedicaid.com/ihcp/manuals/epsdt_healthwatch.pdf. The information in this supplemental provider manual is specifically HealthWatch/EPSDT services provided to Indiana Health Coverage Programs (IHCP) members younger than 21 years old.

HealthWatch (EPSDT)

The federally mandated Early Periodic Screening, Diagnosis, and Testing (EPSDT) Program, referred to as HealthWatch in Indiana, is a preventive health care program designed to promote early detection and treatment of health problems among IHCP eligible infants, children, and adolescents.

Special emphasis is given to early detection and treatment of health issues because these efforts can reduce the risk of more costly treatment or hospitalization that can result when detection is delayed. HealthWatch/EPSDT services are available to IHCP members from birth to 21 years old (subject to the limitations of each benefit package). Individuals enrolled in Hoosier Healthwise Package C are eligible for these services; however, treatment may be subject to benefit limitations. EPSDT is a federally mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid.

All IHCP-covered preventive and treatment services are provided, as well as other treatment services determined to be medically necessary by the HealthWatch/EPSDT screening provider and prior authorized as required.

• HealthWatch/EPSDT includes periodic screening, vision, dental, and hearing services. In addition, the program requires that any medically necessary health care service determined as necessary by the screening exam must be provided to the Medicaid enrollee even if the service is not normally available under the State’s Medicaid plan. This rule applies to IHCP members from birth to 21 years old. Package C members’ treatment may be subject to benefit limitations.

• HealthWatch/EPSDT includes the usual components of a well child exam including periodic screening, vision, dental, and hearing services, and anticipatory guidance and health education.

• The importance of HealthWatch/EPSDT is that any treatment found necessary as a result of a diagnosis pursuant to or found during an EPSDT screening may be provided by Hoosier Healthwise, HIP or Care Select.
  - If it is a covered service that normally requires prior authorization, this rule will still apply for EPSDT-identified services.
  - Additionally, if a service is not covered by Indiana Hoosier Healthwise, it is still available to EPSDT eligible members subject to prior authorization requirements if it passes the following test: “The service is necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.” (See 405 IAC 5)

WHO PARTICIPATES IN HEALTHWATCH/EPSDT?

• Any IHCP member from birth to 21 years of age may participate in the HealthWatch/EPSDT program. MDwise will inform each member about the program in accordance with federal regulations. Participation in HealthWatch/EPSDT by MDwise members is voluntary.

• Individual physicians, physician group practices, hospitals, or physician-directed clinics that are enrolled as Medicaid providers must participate and as needed for their patients, may provide a complete HealthWatch/EPSDT screen. Further, any enrolled Medicaid provider may provide HealthWatch/EPSDT diagnostic and/or treatment services within


Because HealthWatch/EPSDT screenings include more components than a typical well-child office visit, reimbursement rates for HealthWatch screens are higher than the rates paid for well-child exams. Any provider enrolled in the IHCP, licensed to perform an unclothed physical exam, and providing the components of HealthWatch/EPSDT is eligible to offer HealthWatch/EPSDT screens for infants, children, and adolescents.

**Program Goals**

Ensuring that all children in the IHCP receive age-appropriate, comprehensive, preventive services is the primary goal of the HealthWatch/EPSDT program. Through initial and periodic examinations and evaluations, it enables early detection and diagnosis and treatment of health problems, before they become more complex and their treatment more costly.

The HealthWatch/EPSDT program consists of two mutually supportive, operational goals:

- Assuring the availability and accessibility of required health care resources; and
- Helping Medicaid recipients and their parents or guardians effectively use these resources.

**HealthWatch Screening Examinations**

Periodicity schedules for Periodic Screening, Vision, and Hearing services must be provided at intervals that meet reasonable standards of medical practice. Dental services must also be provided at intervals determined to meet reasonable standards of dental practice.

To provide quality assurance for members to participate in the HealthWatch/EPSDT program and to claim a higher level of reimbursement for HealthWatch/EPSDT screens, the following components of the screen must be provided and documented:

- Comprehensive health and developmental history, including assessment of both physical and mental health development.
- Comprehensive unclothed physical exam: A comprehensive unclothed physical exam is required at each EPSDT visit. Guidelines for evaluating the general physical and mental health status for infants, children, and youth to the age of 21 years are described in the Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.
- Nutritional assessment: A nutritional assessment is required at each EPSDT visit. Assessment is based on the child’s health history, physical exam including oral dental exam, growth pattern and appropriate blood work. It is also recommended that providers plot body mass index (BMI) beginning at age 2.
- Developmental assessment: A developmental assessment is required at each EPDST visit. The detection of developmental delays is an integral component of well-child care. Developmental surveillance\(^1\) should be incorporated into every EPSDT visit; while structured developmental screening\(^2\) should be administered regularly during the 9 month, 18 month, and 30 month visits.”

\(^1\)Developmental surveillance: The process of recognizing children who may be at risk of developmental delays.

\(^2\)Developmental screening: The use of standardized tools to identify and refine the risk of developmental delays.
- Vision screening: Vision screening is required at each EPSDT visit (the objective screen is not separately billable). Direct referral to an optometrist or ophthalmologist starting when objective screen methods indicate a referral is warranted.

- Hearing screening: Hearing screening is required at each EPSDT visit. Objective testing with audiometer at 4 years old, should be administered in the PMP’s office (the simple hearing observation screening is not separately billable) or referred to a hearing specialist.

- Dental observation: Dental observation is required at each EPSDT visit. Preventive dental services are recommended every six months or as medically indicated. PMPs are to perform oral dental observations and examinations as part of the EPSDT visit to identify children who require further evaluation and treatment.

- Laboratory tests appropriate for age and risk factors required at corresponding EPSDT visit.

- Immunizations administered or referred, if needed at time of the screen.

- Health education: Patient health education is a required component of EPSDT services, which should include documented and appropriate anticipatory guidance. Education and guidance should be conveyed to parents (or guardians) and children, and designed to assist in understanding what to expect in terms of the child’s development, healthy lifestyle choices and accident and disease prevention. At the outset, the physical and/or dental screenings provide the initial context for providing health education.

Documentation for the HealthWatch/EPSDT screen may be incorporated into the documentation routinely kept for well child check-ups. Because only a few activities differentiate HealthWatch/EPSDT screen components and well-child services, it is imperative that those differences be reflected in the member’s health record.

When screenings reveal the need for more frequent health exams or monitoring than recommended by the periodicity schedule, inter-periodic screens may be performed. Inter-periodic office visits and EPSDT screening exams are covered by the IHCP up to the 30 office visit maximum per individual, per year.

**CDC GUIDELINES REQUIRE LEAD SCREENING FOR ALL CHILDREN ON MEDICAID**

Lead screening is required for all children on Medicaid REGARDLESS OF THEIR RISK FACTORS! Current CDC guidelines call for:

- Testing all children at 12 months and 24 months of age.
- Testing all children 36 months and 72 months of age, if they have never been tested for lead poisoning.

**REQUIRED EPSDT REFERRALS**

All lead screening results are now reportable to the State and those results are now posted along with a child’s immunization history in CHIRP, the State’s immunization registry. Providers may want to consider adding Lead Screening to their Well Child assessment forms as a reminder that Lead Screening is required for all children on Medicaid.

HealthWatch providers are responsible for completing the following screenings as part of every EPSDT visit, at indicated ages:

- Developmental surveillance and structured screening
- Dental observation and screening
- Vision observation and screening
- Hearing observation and screening
- Blood Lead screening

**HEALTH EDUCATION**

Health education is a required component of EPSDT services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children/adolescents is required and designed to assist in understanding what to expect in terms of the child’s/adolescent’s development, the benefits of healthy lifestyles and practices, and accident and disease prevention.
**DIAGNOSIS**

When a screening examination indicates the need for further evaluation of an individual’s health, the primary medical provider must assist in setting appointments on behalf of HealthWatch participants who need diagnostic services or follow-up treatment when screening results point toward a problem. The referral should be made without delay and follow-up to make sure that the member receives a complete diagnostic evaluation. If the member is receiving care from a continuing care provider, diagnosis may be part of the screening and examination process.

**TREATMENT**

Health care must be made available for treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services.

**OTHER NECESSARY HEALTH CARE**

Other necessary health care, diagnosis services, treatment, and other measure described in section 1905(a) of the Act must be provided to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

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**General Billing Information**

Indiana does not require providers to bill EPSDT screens on a separate EPSDT medical claim form when submitting claims on paper or in an 837P transaction, if submitting electronically.

HealthWatch/EPSDT providers must adhere to screening and documentation procedures to claim the higher rate of reimbursement for HealthWatch/EPSDT screens. Providers must furnish all components of the EPSDT examination in accordance with the HealthWatch/EPSDT Periodicity and Screening Schedule, document services performed/referred, and include all applicable diagnosis codes (up to four) on the medical claim form if sending on paper, or 837P transaction if submitting electronically, for each HealthWatch/EPSDT screening exam.

To ensure adherence to EPSDT requirements, the IHCP will monitor the following:

- Timely screening as recommended by the HealthWatch/EPSDT Periodicity and Screening Schedule and the immunization schedule
- Timely administration of immunizations
- Hematocrit/hemoglobin testing
- Blood lead testing
- Urinalysis
- Audiometric testing
- Children receiving follow-up treatment for diagnosed conditions

The following billing procedures must be followed to permit correct and prompt reimbursement.

Every claim for a HealthWatch/EPSDT visit must be coded with the following:

- The appropriate patient examination code (99381-99385, 99391-99395) must be included on the first detail line of the medical claim form if sending on paper or 837P transaction if submitting electronically
- The preventive health diagnosis code, V20.2, must be used as the primary diagnosis
Specific Billing Procedures

• Physicians are strongly encouraged to include all applicable diagnosis codes (up to four) and procedure codes on the claim form if sending on paper, or on the 837P transaction if submitting electronically, for each HealthWatch/EPSDT visit.

• The appropriate EPSDT reimbursement rate for the initial or established patient exam billed. The appropriate reimbursement rate should also be indicated, $75 for codes 99381-99385, and $62 for codes 99391-99395.

Providers must report on the medical claim form if sending on paper or 837P transaction if submitting electronically all screens and immunizations administered during HealthWatch/EPSDT visits.

Billing for EPSDT Visits and Office Visits at the Same Time

If a patient is evaluated and treated for a problem during the same visit as a HealthWatch/EPSDT annual exam the problem-oriented exam can be billed separately accompanied by the -25 modifier (separate significantly identifiable E/M service).

The problem must require additional moderate level evaluation to qualify as a separate service on the same date. This includes E&M codes 99203 through 99215. These services should be billed with modifier -25 to identify a separate significantly identifiable E&M service.

The provider can bill usual and customary charges. IHCP reimbursement is allowed at the lesser of the submitted charge or the maximum fee for each code. However, the total billed charge must not be more than the provider charges for similar services provided to private-pay patients.
All MDwise participating providers must adhere to the following medical records standards.

**GENERAL PRACTICES FOR MEDICAL RECORDS**

Office has defined practice/written guidelines for:

1. Maintaining confidentiality of patient information (personal health information-PHI) in accordance with HIPAA and all other applicable State and Federal requirements. Includes periodic training for staff.
2. Release of information (form/process)
3. Telephone encounters (includes physician notification and documentation in medical record)
4. Filing/tracking of medical records within the office/system
5. Organization of medical records
6. Protection of record from public access
7. Maintenance of record for each individual patient
8. Patient record available at each encounter
9. Requesting records of care received as inpatient (hospital discharge summary), in ER or as outpatient.
10. Providing copy of patient’s medical record upon reasonable request by member at no charge.
11. Facilitating the transfer of patient’s record to another provider at the member’s request.
12. Facilitating transfer, at the request of the OMPP or MDwise, a summary or copy of the member’s medical records to another PMP if the member is reassigned.
14. Maintenance of records for at least seven years.

**MEDICAL RECORD DOCUMENTATION ELEMENTS**

1. Patient name or ID# on each page of record.
2. Personal/biographical data are present in record (address, employer, home and work phone number, marital status).
3. Entries are signed by authorized personnel. (Author identification may be handwritten signature, unique electronic identifier or initials.)
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses & medical conditions are indicated on problem list
7. Current medication list is maintained and easily accessible.
8. Allergies & adverse reactions are prominently noted in record. If member has no known allergies or adverse reactions, notation of such is documented in record.
9. Past medical history (for patients seen 3 or more times) is noted and easily identified. History notation includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), history relates to prenatal care, birth, operations and childhood illnesses.
10. Information regarding use of tobacco, alcohol and substance abuse for patients 10 years and older is documented in record.
11. History and physical exam identifies appropriate subjective & objective information pertinent to presenting complaint(s) / health maintenance concerns.
12. Labs and other studies are ordered as appropriate.
13. Working diagnoses are consistent with findings.
14. Treatment plans/plans of action are consistent with diagnoses.
15. Encounter form or notes have a notation regarding follow-up care, calls or visits, when indicated. The specific time is noted in days, weeks, months, or as needed.
16. Unresolved problems from previous visits are addressed in subsequent visits.

17. There is evidence for under-or over-utilization of consultants.

18. Record contains consultant note whenever consultation is requested.

19. Consultation, lab and imaging reports filed in the chart reflect review of ordering practitioner by evidence of such person’s initials on reports. If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

20. Record includes reports of specialty referrals, inpatient (discharge summary), emergency care and outpatient services (i.e. diagnostic and ancillary services, therapies.

21. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

22. Immunization record for children is up to date or an appropriate history noted for adults.

23. There is evidence that preventive screening and services are offered in accordance with the practice/preventive care guidelines/ EPSDT.

24. Discussion and documentation of Advanced Directives for every patient 21 years and older. If an advance directive has been executed, a copy should be present in the medical record. Written instructions for a living will or durable power of attorney for health care when the patient is incapacitated and has such a document.

25. Missed appointments and any follow-up activities are documented in the medical record.
Appendix C: Physician Office Site Standards

ACCESSIBILITY:
1. Adequate parking is available, including handicap parking.
2. Office or office building is handicap accessible (e.g. ramp, elevator available for > 1 floor)
3. Restrooms are available to patients and wheelchair/rail equipped.

APPEARANCE:
1. Clean, well maintained environment.
2. Waiting room space & seating adequate for number of patients.
3. Corridors and hallways are clear

EXAM/TREATMENT ROOMS MEET THE FOLLOWING CRITERIA:
1. Individual areas maintain patient privacy
2. Exam table paper changed or appropriate cleaning methods are used between patients.
3. Lighting is adequate in exam and treatment rooms.
4. Disposable gloves are readily accessible.
5. Soap dispenser/paper towels are in close proximity to patient care areas.
6. Sharps containers are present in all exam and treatment rooms.
7. No syringes, medications, RX pads within patient reach
8. Adequate number of exam rooms

INFECTION CONTROL:
A. Office staff has the knowledge and practices Indiana Universal Precautions Law.
B. The office observes OSHA Exposure Control Measures (Biohazardous Waste).
C. Appropriate sterilization procedures are followed.
D. Autoclave operational and staff follows procedures for use, servicing and monitoring equipment.
   Sterilized packs are dated for expiration
   Monthly cleaning/equipment checks are conducted and log maintained.
   Monthly spore counts are performed
E. Cold Sterilization
   All containers are dated & labeled with name of solution
   Solution is changed routinely as directed per policies
   Log of changes maintained
F. Specified office workspace is designated as clean and dirty areas.
G. Disinfectant/Cleaning solution containers are labeled.
H. Separate refrigerator in office for medications and specimens from employee personal use.
I. Thermometer is in place in medication refrigerator.

FIRE AND SAFETY:
1. Smoke detectors are in place and operational.
2. Fire extinguishers are visible and maintained.
3. Adequate number of exits and clearly marked.
4. Disaster evacuation plan is written/displayed.
5. Passageways are clear
6. Oxygen/Therapeutic gases are secured & labeled.
7. Equipment is calibrated/checked for electrical safety (i.e., EKG machine).
**EMERGENCY PREPAREDNESS**
1. Office emergency procedure is documented.
2. Emergency cart/equipment are available or if not, medical emergency protocol in place.
3. Emergency cart check conducted regularly and documented.
4. Follow-up procedure is in place to address “canceled”/“no show” appointments.
5. Access standards are in place that meet or exceed State and MDwise standards.

**MEDICATIONS:**
1. All medications are stored in secure place away from patient access.
2. Narcotics are maintained in a locked area and are properly logged for medication dispensing.
3. Medications (multi-dose vials/injectables) are properly labeled and dated when opened.
4. Procedure is in place for checking expired drugs.
5. Process is in place to discard drugs.
6. Prescription pads are not accessible to patient.

**ON-SITE ANCIllARY SERVICES (IF APPLICABLE):**
1. Lab is licensed/certified/or has a CLIA certificate of waiver.
2. Instruments are calibrated and maintained consistent with manufacturer’s recommendations.
3. Procedure manual lists procedures for all tests conducted.
5. Equipment and Personnel are currently licensed.
6. Badges are worn and exposure rates are monitored.
7. Warning for pregnant women is displayed.
8. Scheduled maintenance cycle is adhered to according to manufacturer’s recommendations.
9. Number of patients scheduled per hour allows adequate time for patient care.
10. Average office-waiting time performance standard in place meets or exceeds MDwise standards (60 minutes).
11. Telephone response procedure indicates that a clear policy is in place for reaching the physician.
12. Formal office telephone hours’ policy exists and is communicated to the patient.
13. Telephone should be answered within four rings or 30 seconds.
14. Length or time it takes to reach a live voice via telephone to schedule an appointment should be less than 3 minutes.
15. Telephone coverage provides ability for member to reach PMP or designee by phone within 30 minutes in an emergency or urgent situation.

<table>
<thead>
<tr>
<th>Appointment Category:</th>
<th>Appointment Standards:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent/Emergent Care Triage</td>
<td>24 hours/day</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>24 hours/day</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>24 hours/day</td>
</tr>
<tr>
<td>Non-Urgent Symptomatic</td>
<td>72 hours</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>5 weeks</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>
</tr>
<tr>
<td>New Obstetrical Patient</td>
<td>Within 5 business days of attempting to schedule an appointment</td>
</tr>
<tr>
<td>Initial Appointment Well Child</td>
<td>Within 1 month of date of assignment notification</td>
</tr>
<tr>
<td>Children with Special Health Care Needs</td>
<td>1 month</td>
</tr>
</tbody>
</table>

**PHYSICIAN ACCESS/SCHEDULING:**
1. Call schedule provides physician coverage 24 hrs/day, 7 days/wk.
2. Urgent & Emergent services are provided during and after hours.
3. Procedures for follow-up of abnormal tests or labs are in place.
13. Routine, non-urgent calls are returned to the patient within one working day.

14. Mechanisms are in place to access language translation services for patients who are in need of interpretive services.

MEDICAL RECORD KEEPING PRACTICES/PATIENT RIGHTS:

1. Office has policies and procedures in place to preserve patient confidentiality:
   a. Release of information (form/process) in place
   b. Medical records protected from public access

2. Individual record established for each patient

3. Record available at each encounter

4. Patient Education Materials are available

5. Process in place to provide copy of medical record to patient upon reasonable request (no charge) for MDwise members and other Medicaid patients.

6. Process in place to facilitate the transfer of patient’s record to another provider at the member’s request.

7. Maintenance of records for at least seven years

8. Appeals/Grievance rights and phone number are posted

9. Record format is conducive to recording subjective & objective information, and plan of treatment pertaining to presenting complaints during each visit.

10. Medical record is organized for easy identification of:
    a. Medication record
    b. Allergies and Adverse reactions or indication no known allergies/adverse reactions
    c. Problem list
    d. Preventive health services (e.g. immunizations)
    e. Personal/biographical data
    f. Progress notes
    g. Treatment plan pertaining to presenting complaints during each visit
Appendix D: HIPAA

The Department of Health and Human Services (HHS) crafted regulations for the Health Insurance Portability and Accountability Act (HIPAA) to guarantee patients’ new rights and protections against the misuse or disclosure of their health records. The final rule took effect on April 14, 2001 and entities covered under this rule have until April 14, 2003 to comply with the rule’s provisions.

The final rule gives covered entities the flexibility to design their own policies and procedures to meet the standards. The requirements are flexible and scalable to account for the nature of each entity’s business, and its size and resources. Covered entities will generally have to:

- Adopt written privacy procedures. These include who has access to protected information, how it will be used within the entity, and when the information may be disclosed. Covered entities will also need to take steps to assure that heir business associates protect the privacy of health information.
- Covered entities will need to train their employees in their privacy procedures, and must designate an individual to be responsible for ensuring the procedures are followed.
- Providers will be required to give patients a clear written explanation of how the covered entity may use and disclose their health information.

To get more information concerning HIPAA and the privacy regulations go to these websites:

[http://hhs.gov/ocr/hipaa](http://hhs.gov/ocr/hipaa)
[http://indianamedicaid.com](http://indianamedicaid.com)
Appendix E: MDwise Practice Guidelines

TYPE: PREVENTIVE HEALTH GUIDELINES
- Guidelines for Childhood and Adolescent Immunization
- Guidelines for Health Supervision and EPSDT/Healthwatch in Children and Adolescents
- Guidelines for Adult Health Supervision
- Guidelines for Pregnancy Care

TYPE: CLINICAL HEALTH GUIDELINES
- Asthma
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure (CHF)
- Coronary Artery Disease
- Diabetes

TYPE: BEHAVIORAL HEALTH GUIDELINES
- Attention Deficit Hyperactivity Disorder
- Anxiety Disorders in Children and Adults
- Bipolar Disorder in Adults
- Depression in Children and Adolescents
- Developmental Testing
- Eating Disorders
- Major Depression in Adults
- Metabolic Status
- Neuropsychological Testing
- Pervasive Developmental Disorders
- Psychological Testing
- Substance Use Disorders in Adults

To view the most current MDwise Clinical Guidelines go to MDwise.org or call MDwise Customer Service at 1-800-356-1204 or (317) 630-2831 (Indianapolis Area).
Appendix F: The Vaccine for Children (VFC) Program

The federal Vaccine for Children (VFC) Program is administered by the Indiana Immunization Program within the Indiana State Department of Health (ISDH).

ELIGIBLE MEMBERS

The VFC Program is intended to help raise childhood immunization levels in the United States by supplying health care providers with free vaccine to administer to children 18 years old and under who meet one or more of the following:

- Enrolled in Medicaid*
- Without health insurance
- Identified by parent or guardian as American Indian or Alaskan native
- Underinsured, for example, children with health insurance that does not cover immunizations.
- Underinsured patients who have health insurance that does not cover immunizations are eligible to
- Receive VFC vaccines only at a FQHC or RHC.

*Through a special arrangement with the Indiana Children's Health Insurance Program (CHIP or Package C), VFC vaccines are also available for immunizing children enrolled in Package C.

PROVIDER ENROLLMENT IN THE VFC PROGRAM

The Indiana State Department of Health (ISDH) handles VFC provider enrollment and education as well as VFC vaccine orders and distribution. To participate in the VFC Program, providers should follow the following steps:

- Contact the ISDH and request VFC provider enrollment forms
- Complete and mail the provider enrollment forms
- Receive appropriate training and technical assistance
- Order vaccines periodically, as needed, and maintain appropriate vaccine supply records

Providers may contact the ISDH about the VFC at the following address:

Indiana Immunization Program
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Telephone: (317) 233-7704 or 1-800-701-0704
Fax: (317) 233-3719

Additional information about the VFC Program can be found on the ISDH website: in.gov/isdh/17203.htm