A wise choice for you and your family.

MDwise 1st Quarter IHCP Workshop

March 2014
Agenda

• Hoosier Healthwise
• Healthy Indiana Plan
• Care Select
• MDwise is a local, not-for-profit company serving Hoosier Healthwise, Care Select and Healthy Indiana Plan (HIP) members. We have been giving the best possible health care to our neighbors since 1994. In fact, we only take care of families living in Indiana. Our services are provided to more than 280,000 members in partnership with over 1,400 primary medical providers.
• Dismissing a patient
• In and Out of network claims disputes
• Prior authorization appeal process
• Claim Inquiries vs. Claim disputes
• Behavioral health updates
• Top claim denials
• MDwise’s team of health advocate’s and care managers can assist with difficult patients. Please utilize this resource before requesting a member reassignment.

• When there are no other options physicians can dismiss HHW, HIP and CS members from their panel by completing a member reassignment.
• Providers must fill out a member reassignment form. These forms include an explanation as to why the patient is being dismissed. Member reassignment forms are to be submitted to the provider’s delivery system.

• After deciding to terminate the physician patient relationship PMPs must notify the patient and continue care for thirty days or until member has been reassigned and fully transitioned to their new PMP.
Providers may dismiss a patient for one of the following reasons:

- More than three missed appointments in the last rolling calendar year
- Member fraud
- Threatening or abusive behavior
- Members medical needs met better by another PMP
- Breakdown of physician patient relationship
- Member accessing primary care elsewhere
- Previously approved termination
The provider request for member reassignment can be found on the provider member management forms page of our website.
Dismissing a Member From Your Practice

Provider Request for Member Reassignment

Date________

Requesting MDwise Provider_________________________  Provider ID# ____________

We are requesting that the member(s) below be removed from our panel (Members of the same family can be listed on one form BUT please use a separate form for each family.):

Name_________________________  RID#____________________
Name_________________________  RID#____________________
Name_________________________  RID#____________________

Please check reason for request below:

- **Missed appointments** – A member may miss at least three scheduled appointments within the last 12-month period without defensible reasons before a PMP request for member reassignment. Please provide missed appointment dates and documentation from member’s chart. *If you are concerned about less than 3 missed appointments, please contact your Provider Relations Rep to discuss education options for the member.*

- **Member fraud** – Please document the circumstances leading to suspicion. To use this reason for member reassignment, the provider must be prepared to refer the case to the IHCP so that they may investigate the alleged fraud. *(Medical Director review required)*

- **Threatening, abusive, or hostile actions by members** – The PMP may request a member’s reassignment when the member or the member’s family becomes threatening, abusive, or hostile to the PMP or the office staff, after
• Some medical groups and health systems may have additional rules governing when a provider can dismiss a patient, if you are an employed provider please check with your group or system before dismissing a member.

• Member reassignments generally take 30 days to complete. If a reassignment is urgent – because of severe abusive or threatening behavior please mark your reassignment paperwork as such, or contact your delivery system directly!
• A provider within the MDwise network who has a dispute with a claims determination, must first determine what delivery system the dispute is with. If the dispute is with the delivery system that they are contracted or affiliated with, they must file the dispute directly with that delivery system.

• If however, the dispute is between a MDwise provider and a delivery system other than the one the provider is contracted or affiliated with, they must file the dispute with MDwise corporate.
Providers must file initial claim dispute within 60 days of a claims determination or within 90 days of submitting a claim.

When submitting a dispute please include dispute form, explanation of payment, and an explanation of the reason for disputing the claim.

Please see at MDwise.org/providers the claims form page for detailed information on in and out of network claims disputes and appeals.
• Eskenazi, IU Health, and Total Health claim disputes
AND
• Non contracted provider claim disputes

• Send claim disputes to:
  MDwise
  P.O. Box 441423
  Indianapolis, IN 46244-1423
  Attention: Grievance Coordinator
• Eskenazi, IU Health, Total Health, and out of network provider claim dispute form.
For Hoosier Alliance providers, in network claim disputes are to be sent to:

Hoosier Alliance Claims Disputes
200 Stevens Drive, Suite 350
Philadelphia, PA 19113
Select Health, St. Vincent, St. Catherine, and St. Margaret Mercy providers may submit the MDwise claim dispute form to the claim department address of the delivery system.
• To determine the status of an Eskenazi, IU Health, or Total Health claim please call 1-800-356-1204 or fax a claim inquiry form to 317-822-7444
• To determine the status of a Hoosier Alliance claim, please contact their Claims Inquiry Line: 1-800-581-2488

• Hoosier Alliance providers can also research the status of their claims on Navinet the Hoosier Alliance web portal.
To determine the status of a Select Health, St. Vincent, St. Catherine, or St. Margaret Mercy claim please call 1-866-427-3197 or 317-596-7827.
Top Claim Denials

• Hoosier Alliance
  – Claim submitted after plan filing limit
  – No pre-certification or authorization on file
  – Duplicate claim
  – EOB from primary carrier required
  – Code not covered
  – No supporting documentation or ambulance run sheet
Top Claim Denials for Eskenazi, IU Health, and Total Health

- Emergency room record required
- Duplicate line
- No authorization for services
- Member not effective for date of service
CMCS
– Duplicate Claim
– No pre-certification or authorization on file
– Additional information required
– Resubmit with primary EOB
• For MDwise, all prior authorizations are handled by the delivery system of the member.

• 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.

• Or see our quick contact guide at MDwise.org/quickcontact
• When a MDwise delivery system makes an adverse prior authorization decision the provider and member are notified. Appeal rights are included in this notification.

• Both providers and members and have the right to appeal adverse prior authorization decisions

• Both providers and members have 33 calendar days from the date of the denial notice to submit an appeal
Providers must submit appeals in writing. All prior authorization appeals regardless of delivery system are sent to:

MDwise Hoosier Healthwise
Attention: Appeals
P.O. Box 441423
Indianapolis, IN 46244

Members may submit in writing, or can contact customer service at 1-800-356-1204 to start an appeal
A panel will be scheduled to review the member’s case. The provider, member, or other individual acting on the member’s behalf may attend in person or by phone.

Both providers and members will be notified with an answer to the appeal within 25 working days from the date MDwise received the appeal.

For emergencies and urgent matters, providers and members can request an expedited appeal. Expedited appeals are handled within 48 hours. Providers and members are notified in 72 hours of the outcome.
• As of February 1, 2014, MDwise will no longer require Prior Authorization for Outpatient Behavioral Health Services for the Hoosier Healthwise and Healthy Indiana Plan:
  
  – Individual Therapy: 90832, 90834, 90837
  – Family Therapy: 90846, 90847, 90849
  – Group Therapy: 90853
• Psychological Testing, Intensive Outpatient Therapy, Partial Hospitalization, ECT, TMS, Vagus Nerve Stimulation, and Inpatient services will still require Prior Authorization. There will be no changes to the Prior Authorization process.

• Out of Network providers are required to obtain Prior Authorization for all services.
Healthy Indiana Plan Agenda

• Billing HIP to HHW for pregnant members
• In and out of network claim disputes
• Prior authorization appeals
• Top claim denials
• If a pregnant Healthy Indiana Plan member arrives in your office, you should encourage the member to switch to Hoosier Healthwise to receive coverage for pregnancy related services, and educate the member about the necessary steps.

• The member will need to take the following steps:
  – Contact the Division of Family Resources (DFR)
  – Provide the DFR with proof of pregnancy
  – Complete a Change Report Form and submit it to their caseworker
The Healthy Indiana Plan covers the initial pregnancy test on the member, that test should be billed to the member’s managed care entity. It is important for the member to continue paying their Healthy Indiana Plan premiums until the member is enrolled in Hoosier Healthwise.

Providers can assist the member in providing proof of their pregnancy. Proof of pregnancy is established by one or more of the following:

- Results of a pregnancy test
- Ultrasound report
- Note from a licensed health care provider
  - Please include the number of expected children, if known
• Discovery Period: the time period from the discovery of the pregnancy until the transfer of enrollment from the Healthy Indiana Plan to the Hoosier Healthwise, not to exceed three months.

• It may take several months for a Healthy Indiana Plan member to become a Hoosier Healthwise member. Providers may continue to render prenatal care to Healthy Indiana Plan members who are transitioning to Hoosier Healthwise.
There are special instructions for billing these claims:

- For pregnancy services rendered during the “discovery period” providers should initially hold their claims.
- During the discovery period all non-pregnancy related services remains the responsibility of the Healthy Indiana Plan until the transfer of enrollment finalized.
- Providers can check Web InterChange to determine the date the member successfully moved to Hoosier Healthwise.
• After Hoosier Healthwise eligibility has been established and the member’s Healthy Indiana Plan coverage has been end dated, the provider may bill the pregnancy related claims from the discovery period to HP as a fee for service claim.
  – Follow IHCP billing guidelines
  – Must have appropriate pregnancy diagnosis
Pregnancy services provided on dates of service after the member has successfully enrolled in Hoosier Healthwise and chosen an MCE, are billed to the MCE as a Hoosier Healthwise claim.
• Both in and out of network providers may file a HIP claim dispute, by submitting the MDwise HIP claims dispute form, the explanation of payment, and an explanation of the reason for the dispute.

• Providers must file initial claim dispute within 60 days of a claims determination or within 90 days of submitting a claim.

• Disputes should be mailed to:
  MDwise
  P.O. Box 441423
  Indianapolis, IN 46244-1423
  Attn: MDwise Grievance Coordinator
HIP In and Out of Network Claim Disputes

Provider Claims Dispute Form

Providers Name: ____________________________ Date: ____________________________
Telephone Number: ____________________________ Fax Number: ____________________________
Member Name: ____________________________ Date of Service: ____________________________
RD #: ____________________________ MDwise Participating Provider: Yes No
Service(s) Disputed: ____________________________

Describe disputed claim. Description should include, but not be limited to the following items: reason given for denial and position statement that explains why this claim should be paid.

Please attach a copy of the red lined claim, Explanation of Benefits and/or denial letter and any documentation that you believe may be relevant to support this request.

Form Completed By: ____________________________ Date: ____________________________

Please send completed form to:
MDwise
P.O. Box 441423
Indianapolis, IN 46244-4223
Attn: MDwise Grievance Coordinator
• Providers wanting to check the status of a MDwise HIP claim may call 1-800-356-1204 or submit a claim inquiry form to 317-822-7444.
• When a MDwise delivery system makes an adverse prior authorization decision the provider and member are notified. Appeal rights are included in this notification.

• Both providers and members have the right to appeal adverse prior authorization decisions.

• Both providers and members have 33 calendar days from the date of the denial notice to submit an appeal.
• Providers must submit appeals in writing. All prior authorization appeals regardless of delivery system are sent to:

  MDwise Healthy Indiana Plan
  Attention: Appeals
  P.O. Box 441423
  Indianapolis, IN 46244

• Members may submit in writing, or can contact customer service at 1-800-356-1204 to start an appeal
A panel will be scheduled to review the members case, the provider, member, or other individual acting on the member’s behalf may attend in person or by phone.

Both providers and members will be notified with an answer to the appeal within 25 working days from the date MDwise received the appeal.

For emergencies and urgent matters providers and members can request an expedited appeal. Expedited appeals are handled within 48 hours. Providers and members are notified in 72 hours of the outcome.
Healthy Indiana Plan Top Claim Denials

- No authorization for services
- Member not effective on date of service
- Duplicate claim
- Timely filing limit exceeded
- Not covered by plan
Care Select Agenda

- New contract
- Member intervention, Care Management, and Disease Management referral form
- How to dismiss a patient from your practice
- Billing Care Select members
- Claims
MDwise is excited to have been chosen once again by the state to participate as a Care Management Organization for Care Select
• MDwise now offers our popular Member Intervention, Care Management, and Disease Management referral form online

• Visit MDwise.org/cmdm-referral

• Providers, office staff, caregivers and others can use this form to notify MDwise of members needing additional education and assistance
Case Management/Disease Management Referral Form

This form is for members, providers and caregivers to request Care Management, Case Management and specific Disease Management services.

Member Information (All fields are required)
RID ___________________ First Name ___________________ Last Name ___________________

Referring Person's Information (All fields are required)
Relationship to Member: Caregiver
First Name ___________________ Last Name ___________________
Address ___________________ City ___________________ State: IN ___________________ Zip ___________________
Phone ___________________ Fax ___________________
Reason for Referral: Coordination of Care
Summary of Current Problem: (2,000 characters allowed: 2000 characters left)

Case Management/Disease Management Programs
Member Interventions

• A MDwise health advocate will reach out to the member, assess their needs, provide education, and report back to the provider.

• Members in need of additional disease or case management will be added to the appropriate program for long term guidance and assistance.
MDwise’s team of health advocate’s and care managers can assist with difficult patients. Please utilize this resource before reassigning a member.

When there are no other options, PMPs can dismiss members from their panel.

After deciding to terminate the physician patient relationship, PMPs must notify the patient and continue care for thirty days or until member has been reassigned and established care with their new PMP.
• Providers must fill out a member reassignment form to explain why the patient is being dismissed.

• Requests to reassign a Care Select Member should be sent to MDwise via fax at: 317-822-7519

• Urgent reassignment requests due to severe threatening or abusive behavioral can be marked as urgent. Or please call MDwise customer service directly.
• Please remember it is against State and Federal law to bill a Medicaid member without a waiver signed prior to the member receiving the service. Please see the IHCP manual for detailed information about waivers.

• Care Select claims are billed to HP. Please note you have 365 days to submit Care Select claims.
Thank you for seeing our members!

Contact information:

• Matthew McGarry mmcgarry@mdwise.org
• Marvin Davis mdavis@mdwise.org
• Meredith Edwards meedwards@mdwise.org
• Jacquie Marsalis jmarsalis@mdwis.org