MDwise
Improving the health of Hoosier Care Connect members

Provider Manual

Hoosier Care Connect
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Introduction

MDwise welcomes you as a provider into the MDwise network. We are supplying you with this Provider Manual to inform you of the 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 providers. Communication is essential to making a partnership work. We update the Provider Manual annually and more frequently, if necessary due to program changes. The manual 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 articles, 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 Care Connect provider relations representative directly at the telephone numbers listed under “Contact Information” at the Provider Page on MDwise.org. Or, you can always call the toll-free MDwise Customer Service line. MDwise Customer Service Representatives (CSRs) are available from 8:00 a.m. to 8:00 p.m. on Monday through Friday.

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

If you have any questions about the content of this manual, please contact MDwise Customer Service or your MDwise Hoosier Care Connect provider relations representative.
Chapter 1 - Welcome to MDwise

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

In 2001, CIMCO teamed up with IU Health Plan (IUHP), and organized its affiliated providers under a new name, MDwise. In 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 by the State of Indiana to serve as a Care Management Organization for the Indiana Care Select Program. In December 2014, MDwise was selected as a successful contractor for the Hoosier Care Connect program. Starting April 1, 2015, this program replaced and expanded upon the Aged, Blind, and Disabled population that MDwise formerly provided administrative services for under the Care Select Program. Hoosier Care Connect is a new coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare. Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s). Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services. Care coordination services will be individualized based on a member’s assessed level of need determined through a health screening. The MDwise care management approach is based on the belief that Hoosier Care Connect 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 co-morbidities, 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

MDwise Hoosier Care Connect Provider Manual • Chapter 1: Welcome to MDwise -2-
• Active involvement of member/family/patient advocates at each step of care management process

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.

MDwise Focus and Goals
Maximizing value in health service delivery includes a focus on quality and access and ultimately depends on the collaborative relationships between the managed care organization, providers and well-informed members. In delivering Hoosier Healthwise, Hoosier Care Connect, 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 Member Advocate program, to focus on the hardest-to-reach and special needs 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, Hoosier Care Connect, Traditional Medicaid, the 590 Program and the Healthy Indiana Program (HIP) are all part of the Indiana Health Coverage Programs.

- Hoosier Healthwise
  - Risk-Based Managed Care
    - MDwise contracts with OMPP
    - Paid capitated rate
  - MDwise subcontracts with Delivery Systems to pay claims and do PA
    - MDwise Delivery Systems contract with PMPs and Specialists

- Hoosier Care Connect
  - Risk-Based Managed Care
    - MDwise contracts with OMPP
    - Paid capitated rate
  - MDwise Inc. manages the program
    - MDwise Inc. administers Care Management, Disease Management and PA for MDwise Hoosier Care Connect Members

- Traditional Medicaid 590 Program
  - Fee for Service
    - Claims paid by HP
    - PA from Advantage Health Services

- Healthy Indiana Plan
  - MDwise contracts with FSSA for the Healthy Indiana Plan
  - MDwise subcontracts with Delivery Systems and other contractors to manage program
Hoosier Care Connect Program Overview

MDwise was selected by the Indiana Family and Social Services Administration as a Managed Care Entity for the Hoosier Care Connect Medicaid program starting April 1, 2015. The Hoosier Care Connect program serves approximately 84,000 aged, blind, and disabled Medicaid beneficiaries.

Members Covered by the Hoosier Care Connect Program

The county Division of Family Resources (DFR) is responsible for determining initial and ongoing eligibility for Hoosier Care Connect. Once the member is determined eligible for Medicaid and the Hoosier Care Connect Program, that member has 60 days from the date of initial eligibility to select a health plan. At the end of this period, if the member does not make a selection, he or she is auto-assigned to a health plan.

Member Eligibility

As Hoosier Care Connect is implemented, the Care Select program will expire. Those Care Select members eligible for Hoosier Care Connect will be transitioned to the new program.

Individuals in the following eligibility categories who do not reside in an institution, are not receiving services through a home and community-based services (HCBS) waiver, and are not in Medicare will be in Hoosier Care Connect:

- Aged (ages 65 and over)
- Blind
- Physically and mentally disabled
- Individuals receiving Supplemental Security Income
- Medicaid for Employees with Disabilities (M.E.D. Works) enrollees
- Wards of the court and foster children (may voluntarily enroll)
- Children receiving adoptive services (may voluntarily enroll)

Provider Enrollment

MDwise invites physicians of all specialties to participate in the MDwise Hoosier Care Connect Primary Care Network as primary medical providers (PMP). Due to the nature of chronic illnesses for some members, specialists can enroll to be PMPs in the Hoosier Care Connect Program. To enroll as a PMP or specialist in the MDwise Hoosier Care Connect Primary Care Network, physicians should complete the Hoosier Care Connect Provider Contract and universal MCE enrollment form located at MDwise.org/providers. Providers should submit completed enrollment forms to their provider relations representative or by mail/fax:

MDwise Provider Relations
1200 Madison Avenue, Suite 400
Indianapolis, Indiana 46225
Fax: 317-822-7535
The Hoosier Care Connect Program is designed by the State to personalize and enhance the care provided by addressing the member’s medical and behavioral health needs holistically and by seeking input from medical providers, behavioral health experts, family members and other care givers. This will result in the improvement of the quality of care and health outcomes for this population. This approach will also include comprehensive care management for members identified for inclusion by the care management staff of each MCE.

- The goal of Hoosier Care Connect is to more effectively tailor benefits to the population by using evidence-based medicine to oversee the provision of services. Through increased coordination across health care services and providers, the program seeks to improve the quality of care and health outcomes for its IHCP members. This includes improved clinical and functional status, enhanced quality of life, improved client safety, client autonomy, adherence to treatment plans, and control of fiscal growth/cost savings. Through this program, the State hopes to address the following concerns:
  - Treatment regimens for chronic illnesses should better conform to evidence-based guidelines.
  - Primary care providers should be more aware of and incorporate knowledge of functional assessments, behavioral changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
  - Care should be less fragmented and more holistic (i.e., in addressing physical and behavioral health care needs and in considering both medical as well as social needs), and there should be more communication across settings and providers.
  - Consumers should have greater involvement in their care management.
**Hoosier Care Connect Claims Processing**

The Hoosier Care Connect Program is a risk-based managed care program like Hoosier Healthwise or Healthy Indiana Plan. Therefore, MDwise will process and reimburse provider claims for the Hoosier Care Connect Program. Questions regarding claim submission guidelines or claim denials can be addressed by contacting MDwise Hoosier Care Connect at 1-800-356-1204.

**Prior Authorization and Medical Management**

MDwise will authorize and manage utilization of services such as physical, behavioral and transportation services for its members. MDwise will also monitor and authorize utilization of pharmacy services. Providers can locate prior authorization request and update forms at MDwise.org that can be used to submit PA requests for services that require PA in the Hoosier Care Connect program.

**MDwise Hoosier Care Connect Scope of Work**

The following table summarizes MDwise’s responsibilities in these areas:

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<th>Service Area</th>
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<td>Member enrollment into Hoosier Care Connect</td>
<td>The State’s enrollment broker will perform all enrollment responsibilities and MDwise will develop member education materials to be distributed by the enrollment broker. MDwise must also obtain appropriate consent for release of member information and use enrollment data and PMP assignment information to inform care management decisions.</td>
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<tr>
<td>Member assignment to Primary Medical Provider (PMP)</td>
<td>Members will select a PMP upon enrollment into the program. If they don’t select a PMP, then the member will be auto-assigned a PMP by MDwise. However, as part of the initial member assessment, MDwise must review PMP assignments with the member and ensure they are comfortable with the selection.</td>
</tr>
<tr>
<td>Claims processing</td>
<td>MDwise will process and reimburse provider claims.</td>
</tr>
<tr>
<td>Prior authorization of member healthcare services and products</td>
<td>MDwise will receive and process (approve or deny) requests for most products and services, including out-of-state placement for traumatic brain injury patients and PRTF placements for MDwise assigned members. MDwise will enter prior authorization requests into the claims system. MedImpact will receive and process all pharmacy PA requests. Also, DentaQuest will receive and process all dental PA requests.</td>
</tr>
<tr>
<td>Care Management</td>
<td>MDwise will provide intensive care management and care coordination services for all assigned members. This will include member assessments, care plan development and implementation, face-to-face interventions, monitoring of progress, and coordination of services the member needs.</td>
</tr>
<tr>
<td>Disease Management</td>
<td>MDwise will administer disease management for our members</td>
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<tr>
<td>Pharmacy services</td>
<td>MedImpact will administer the Hoosier Care Connect pharmacy benefit, including network development and service authorization.</td>
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<tr>
<td>Member grievances and appeals</td>
<td>MDwise will follow all state processes for appeals, grievances, expedited reviews, and the State’s fair hearing system and will provide a full and fair review to any provider or member that wishes to submit an issue for review</td>
</tr>
<tr>
<td>Transportation services</td>
<td>Transportation services remain a benefit for Hoosier Care Connect members. Members can contact MDwise and MDwise will coordinate arrangements with Ride Right, our transportation vendor. Transportation claims will be adjudicated by MDwise.</td>
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<tr>
<td>PMP Network</td>
<td>MDwise is responsible for contracting Hoosier Care Connect Primary Medical Providers.</td>
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Chapter 3 - Hoosier Care Connect Benefits Overview

The following table provides an overview of covered Indiana Hoosier Care Connect Program services. Providers are reminded that Indiana Health Coverage Programs members who are dual-eligible for both IHCP and Medicare, are residents in a long term facility, have institutional Hospice, Individuals receiving Home and Community-Based waiver services, those receiving room and board assistance, Breast and Cervical Cancer Group, Individuals with QMB or SLMB only (not in combination with another aid category), persons in nursing homes, intermediate care facilities for the intellectually disabled (ICF/ID) and state operated facilities, and members with a psychiatric residential treatment facility (PRTF) level of care are not eligible for Indiana Hoosier Care Connect, since they will be covered via Traditional Medicaid.

Providers may also refer to the Indiana Administrative Code, Title 405, Article 5 and Title 407, Article 3 and the IHCP Provider Manual Chapter 2, Section 3 for additional information on covered services and limitations. The Indiana Administrative Code can be found on the State’s website: www.state.in.us/legislative/iac.

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<td>Early Intervention Services (Early Periodic Screening, Diagnosis and Treatment [EPSDT]) (405 IAC 5-15)</td>
<td>Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services in accordance with the HealthWatch EPSDT periodicity and screening schedule. As well as other prior-authorized treatment services that the EPSDT screening Providers determines to medically necessary. No prior authorization is required.</td>
</tr>
<tr>
<td>Emergency Services (IC 12-15-12-15 &amp; -17)</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. An emergency is defined in the IHCP Provider Manual Chapter 8, as A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any organ or part.</td>
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<tr>
<td>Eye Care, Eyeglasses and Vision Services (405 IAC 5-23)</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 member 21 years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, are 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>
</tr>
<tr>
<td>Family Planning Services and Supplies</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.</td>
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process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); 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 United States Preventative Services Task Force Guidelines.

Federally Qualified Health Centers (FQHCs) (405 IAC 5-16-5)

Coverage is available for medically necessary services provided by licensed health care practitioners in an FQHC setting.

Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)

Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs. Prior authorization may be required.

Hospital Services - Inpatient* (405-IAC 5-17)

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. Prior authorization required for elective/planned inpatient admissions at least 48 hours prior to the admission. Emergency admissions, routine vaginal deliveries, C-section deliveries, and newborn admissions will not require PA.

Hospital Services - Outpatient* (405-IAC 5-17)

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. Prior authorization may be required. Non-emergency services provided in a hospital’s emergency room are non-covered.

Home Health Services** (405 IAC 5-16)

Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals. Prior authorization is required unless the member has been discharged from an inpatient admission. Upon discharge from the hospital home health services can be provided without PA up to 120 units within 30 calendar days following the hospital discharge subject to a physician’s written order and the member must be homebound.

Hospice care** (405 IAC 5-34)

Coverage is available for in-home hospice only by MDwise. Institutional hospice is covered by another IHCP program. If institutional hospice, then the member must be disenrolled from the MDwise Hoosier Care Connect Program. Prior Authorization is required.

Laboratory and Radiology Services (405 IAC 5-18; 405 IAC 5-27)

Coverage is available for medically necessary services and must be ordered by a physician.

Long Term Acute Care Hospitalization (IHCP Provider Manual Chapter 14-33)

Long term acute care services are covered. Prior authorization is required. An all inclusive per diem rate is paid based on level of care.
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<th>Service</th>
<th>Hoosier Care Connect Program Benefit</th>
</tr>
</thead>
<tbody>
<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 via purchase or rental because of an illness or injury. PA is required for certain supplies and equipment.</td>
</tr>
<tr>
<td>Mental health services-Inpatient (405 IAC 5-20-1)</td>
<td>Coverage includes mental health services provided in a psychiatric wing of acute care hospitals or psychiatric hospital. Prior authorization is required.</td>
</tr>
<tr>
<td>Mental health services-Inpatient** (Free-standing Psychiatric Facility) (405 IAC 5-20)</td>
<td>Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds or less. Prior authorization is required.</td>
</tr>
<tr>
<td>Mental health services-Outpatient (405 IAC 5-20-8)</td>
<td>Coverage includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology.</td>
</tr>
<tr>
<td>Medicaid Rehabilitation Option (MRO) -Community Mental Health Centers (405 IAC 5-21)</td>
<td>Coverage includes outpatient mental health services, partial hospitalization (group activity program) and case management. Prior authorization is required. MRO services are carved out and paid fee for service through Traditional Medicaid.</td>
</tr>
<tr>
<td>Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) ** (405 IAC 5-13-2, IHCP Provider Manual, Chapter 14)</td>
<td>60 days maximum, pending and prior to level of care determination. Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board, mental health services, dental, therapy, and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services. Coverage is available through Traditional Medicaid and members must be disenrolled from Indiana Hoosier Care Connect for the benefit to begin.</td>
</tr>
<tr>
<td>Nurse-midwife services (405 IAC 5-22-3)</td>
<td>Coverage is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.</td>
</tr>
<tr>
<td>Nurse Practitioners (405 IAC 5-22-4)</td>
<td>Coverage is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.</td>
</tr>
<tr>
<td>Nursing Facility Services** (Long-term) (405 IAC 5-31-1, IHCP Provider Manual, Chapter 14)</td>
<td>Covered in Traditional Medicaid Program. Member must be disenrolled from Hoosier Care Connect. Prior authorization may be required. Requires pre-admission screening for level of care determination. Coverage includes room and board, nursing care, medical supplies, durable medical equipment, and transportation for a maximum of 60 days and prior to level of care determination.</td>
</tr>
<tr>
<td>Nursing Facility Services (Short-term) (405 IAC 5-</td>
<td>MDwise may authorize services for its members in a nursing facility setting on a short-term basis up to 30 calendar days. This may occur if this setting is...</td>
</tr>
</tbody>
</table>
more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. Coverage is available with preadmission diagnosis and evaluation and includes room and board, mental health services, dental, therapy, and habilitation services, medical supplies, durable medical equipment, pharmaceutical products, transportation, and optometric services.

| Occupational Therapy** (405 IAC 5-22-6) | 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. Cannot exceed 30 units in 30 calendar days. PA is required for all members aged 21 and older. |
| Organ Transplants (405 IAC 5-3-13) | Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike. Prior authorization may be required. |
| Orthodontics** (IHCP Provider Manual Chapter 8) | No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate. |

<table>
<thead>
<tr>
<th>Service</th>
<th>Hoosier Care Connect Program Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-state Medical Services** (405 IAC 5-5)</td>
<td>Medicaid reimbursement is available for the following services provided outside Indiana: acute hospital care; physician services; behavioral health services, dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; and durable medical equipment and supplies. All out-of-state services are subject to the same limitations as instate services. Prior authorization is required.</td>
</tr>
<tr>
<td>Physicians' Surgical and Medical Services* (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 are limited to a maximum of 30 per calendar year, per member, per provider without prior authorization. Prior authorization is required after 30 visits per rolling calendar year per provider as well as any physician service that requires prior authorization by IHCP Program rules.</td>
</tr>
<tr>
<td>Physical Therapy** (405 IAC 5-22-10)</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. Any combination of therapies ordered cannot exceed 30 units in 30 calendar days without prior authorization. Prior authorization is required for all members aged 21 and older.</td>
</tr>
<tr>
<td>Podiatrists (405 IAC 5-26)</td>
<td>Surgical procedures involving the foot, laboratory, X-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered. Prior authorization may be required.</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility (PRTF) (405 IAC 5-20-3.1)</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.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
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<tr>
<td><strong>Rehabilitative Unit Services - Inpatient</strong> (405 IAC 5-32)</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>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong> (405 IAC 5-22-8)</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 hospital when ordered by physician prior to discharge. Prior authorization may be required in other circumstances.</td>
</tr>
<tr>
<td><strong>Rural Health Clinics</strong> (405 IAC 5-16-5)</td>
<td>Coverage is available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.</td>
</tr>
<tr>
<td><strong>Smoking Cessation Services</strong> (405 IAC 5-37)</td>
<td>Reimbursement is available for one 12-week course of treatment per member per calendar year. One or more modalities may be prescribed and counseling may be included in any combination of treatment.</td>
</tr>
<tr>
<td><strong>Substance Abuse Services-Inpatient</strong> (Free-standing Psychiatric Facility) (405 IAC 5-20-3)</td>
<td>Inpatient mental health/substance abuse services are covered when the services are medically necessary for the diagnosis or treatment of the member’s condition except when they are provided in an institution for treatment of mental diseases with more than 16 beds for children under age 21. Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds or less. Prior authorization is required.</td>
</tr>
<tr>
<td><strong>Substance Abuse Services-Outpatient</strong> (405 IAC 5-20-8)</td>
<td>Coverage includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Prior authorization is required.</td>
</tr>
<tr>
<td><strong>Substance Abuse Services-Inpatient</strong> (State Psychiatric Hospital) (405 IAC 5-20-1)</td>
<td>405 IAC 5-20-1(d) states that PA is required for all inpatient psychiatric admissions, including admissions for substance abuse. The IHCP reimburses providers for inpatient psychiatric services provided to an eligible individual between 22 and 65 years old only in a certified psychiatric hospital of 16 beds or less. If the member is 22 years old and began receiving inpatient psychiatric services immediately before his or her 22nd birthday, inpatient psychiatric services are available.</td>
</tr>
<tr>
<td><strong>Speech, Hearing and Language Disorders</strong> (405 IAC 5-22-9)</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 physician prior to discharge. PA is required for all members aged 21 and older.</td>
</tr>
<tr>
<td><strong>Transportation – Emergency</strong> (405 IAC 5-30)</td>
<td>Coverage has no limit or prior approval for emergency ambulance or trips to or from a hospital for inpatient admission or discharge, subject to the prudent layperson standard outlined in the IHCP Provider Manual Chapter 2.</td>
</tr>
</tbody>
</table>
Transportation – Non-emergent (405 IAC 5-30) | Non-emergency travel is available for up to 20 one-way trips of less than 50 miles per rolling 12-month without prior authorization. Interstate transportation or transportation provided by an out-of-state provider, train or bus trips, airline or air bus services require prior authorization.

### Self-Referral Services

MDwise Hoosier Care Connect members may use any IHCP enrolled providers for certain “self referral” services. Federal and state regulations allow members access to certain services outside of MDwise’s network without a referral. Members may access these services from any Indiana Health Coverage Program (IHCP) enrolled provider who is qualified to render the service.

The following are self-referral services in Hoosier Care Connect:

- **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.

Family planning services include birth control pills. MDwise members may obtain birth control pills on a self-referral basis from providers and pharmacies enrolled in the IHCP.

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.

- **Immunizations** are self-referral to any IHCP-enrolled provider and are covered regardless of where they are received (e.g. county health departments).
- **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 Care Connect 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.

Members may self-refer, for behavioral health services, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers. However, they must use...
an in-network MDwise provider. The MDwise mental health providers to which the member may self-refer 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

- **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.

- **Diabetes Self-Management Training Services** - This is a self-referral service rendered by an IHCP enrolled provider as described in the IHCP Provider Manual Ch. 8 pg. 8-175-8-176 who has had specialized training in the management of diabetes that meets community standards. Specific information about this benefit is provided in the IHCP Provider Manual and 405 IAC 5-36.

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

## Emergency 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. Providers should consult the IHCP Provider Manual Chapter 8, Section 2 for submitting claims for true medical emergencies to HP for processing and adjudication.

Hoosier Care Connect covers and reimburses 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 Care Advocate or Care Manager will attempt to contact the member to educate them about appropriate emergency room use.

**Prior Authorization for Emergency Services**

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

- Providers must not advise members to seek non-emergent care in the emergency room as a substitute for their services. Effective July 1, 2009, The IHCP will reimburse hospitals and physicians for a medical screening to determine if the condition is emergent or non-emergent. If the service is emergent, the IHCP will cover those services according to the IHCP guidelines outlined in Chapter 8 of the IHCP Provider Manual. If the service is non-emergent, the IHCP will no longer reimburse non-emergent services provided in an emergency room setting.

- If the member visits the emergency room and is admitted to the hospital, the hospital must notify the member’s assigned primary medical provider (PMP) of the admission to allow for proper post discharge follow-up.

**Non-Emergency Services**

**Facility and Physician Billing of Screening Services**

If the medical screening identifies the member has a non-emergent medical condition, the hospital may only bill Revenue Code 451 – EMTALA-emergency medical screening service and will be reimbursed the lesser of the provider’s submitted charge (usual and customary) or the emergency screening fee of $25. If the screen determines that the member has an emergency condition, the hospital would bill for medically necessary emergency services using the appropriate revenue and any appropriate Healthcare Common Procedure Coding System (HCPCS) codes. Please note that the screening revenue may not be billed in conjunction with emergency room treatment services because the IHCP allows only one unit of
outpatient hospital facility treatment room reimbursement per member per provider (see IHCP Provider Manual Ch. 7, Section 3).

If the physician determines the member has a non-emergent medical condition, the physician may bill only one medical screening CPT code and will be reimbursed the lesser of the provider’s submitted charge (usual and customary) or the IHCP prevailing rate. If the screen determines the member has an emergency condition, the physician may bill the appropriate screening code as well as medically necessary services.

Primary Medical Provider (PMP) authorization is not required for emergency room screening services provided to Hoosier Care Connect members. Effective July 1, 2009, the IHCP will no longer reimburse hospitals and physicians for non-emergency services rendered in the emergency room setting. Hospitals and physicians will be reimbursed for screening services necessary to determine if the member has an emergency condition. Providers should refer to Chapter 8 of IHCP Provider Manual and Provider Bulletin BT200913 for additional guidance regarding this information.

**Out-of-Network Services**

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

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

In accordance with MDwise program rules, all services must be obtained within the MDwise Hoosier Care Connect network, except for the following:

- Self referrals services for Hoosier Care Connect 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 90 days of becoming a member) for services from a provider that is not contracted with MDwise.

**Excluded Services**

The following services are excluded from Indiana Hoosier Care Connect. Individuals requiring these services will be disenrolled from Hoosier Care Connect according to the State’s criteria. MDwise is
responsible for the member’s care until the member is disenrolled, unless stated otherwise. These excluded benefits will remain available under the traditional fee-for-service program.

- **Institutional Hospice.** Terminally ill individuals will be disenrolled from Indiana Hoosier Care Connect Program in order to receive institutional hospice care services through another IHCP program. The hospice provider will notify Maximus, the IHCP enrollment broker, that the Hoosier Care Connect member has elected the institutional hospice benefit. Maximus will then initiate the disenrollment of the member from MDwise Hoosier Care Connect and facilitate hospice coverage. Note: MDwise does cover in-home hospice. We will coordinate care for members that are transitioning into institutional hospice by providing to an IHCP hospice provider any information required to complete the hospice election form, as described in the IHCP Hospice Provider Manual.

- **Psychiatric treatment in a State hospital.** MDwise will coordinate care for members that are transitioning into psychiatric treatment in a State hospital by providing to the State hospital with information about the member’s care plan to date, the member’s care management, treatment, etc..

- **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).** MDwise will coordinate care for members that are transitioning into these facilities by providing the ICF-IID with information about the member’s care plan to date, the member’s care management, treatment, etc.

- **Nursing home.** Members who require either short term or long term nursing home admission must go through the pre-admission screening for an appropriate level of care. If the admission is less than 30 days, MDwise would approve the admission and coordinate with the nursing facility for placement of the member. If the nursing home placement is for a longer than 30 days, the member would be disenrolled from MDwise Hoosier Care Connect and placed into Traditional Medicaid when the level of care is approved and placed into the IndianaAIM System by HP.

**Dual eligibles:** Individuals who are dually eligible will not be enrolled in Hoosier Care Connect. These members will be served by Traditional Medicaid fee-for-service.
Chapter 4 - Member Eligibility

How Members Become Eligible for Hoosier Care Connect

The State of Indiana has sole authority for determining whether individuals or families meet the eligibility criteria for participation in the Hoosier Care Connect 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 Care Connect and submitting documentation to the State so that the State can determine eligibility.

Hoosier Care Connect is a new coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare. Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s). Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services. Care coordination services will be individualized based on a member’s assessed level of need determined through a health screening.

The MDwise ID Card

MDwise issues an ID card to all new members. Family members covered under Hoosier Care Connect each receive their own MDwise Card and cards are not transferable among family members. Members should bring their MDwise ID Card to each visit.

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

- Name
- 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 Care Connect 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 Care Connect 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 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, 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 Care Connect Health Card**

Eligible MDwise members may on occasion need medical care before they receive their Hoosier Care Connect 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 use the HP Web Interchange (https://interchange.indianamedicaid.com) to check eligibility.

**Hoosier Care Connect Eligibility Redetermination**

Eligibility redetermination occurs at intervals determined by the State, normally every six or twelve months. Members whose Hoosier Care Connect eligibility is continuous maintain their health plan 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 60 days to choose a health plan; otherwise they are auto-assigned (see Chapter 5). If the member was
previously enrolled in MDwise they will be auto-assigned by MDwise to their previous PMP to maintain that relationship.

**Hoosier Care Connect Member Disenrollment Process**

Members are disenrolled from MDwise either through PMP change selections (e.g. change to different MCE) or through eligibility terminations provided to MDwise by the state. Maximus, the State’s enrollment broker approves, monitors and tracks all member disenrollment activities, although the FSSA 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.
Chapter 5 - Provider Enrollment & Disenrollment

To participate as a MDwise Primary Medical Provider (PMP), a physician must practice in the field of general practice, family practice, general pediatrics, internal medicine or obstetrics/gynecology. In addition, specialists, such as cardiologists, can serve as PMPs if requested by a member. The specialist must be an IHCP provider, must be able to provide all preliminary and preventive care services (i.e. pap test, acute care visits for viral illness) and may request to limit his/her panel.

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

1. Upon approval, the provider must complete the required Hoosier Care Connect enrollment forms and sign the MDwise Hoosier Care Connect Provider Agreement.

2. MDwise Provider Relations staff reviews the forms for completeness of information and forwards the provider enrollment information to Hewlett Packard (HP) to be uploaded in the state enrollment system.

3. After the enrollment process is complete, all MDwise providers will receive educational training regarding the Hoosier Care Connect Program, including covered services, care management process, disease management, self-referral services, quality improvement requirements, medical records retention and availability, member reassignment, and member grievance procedures.

Hoosier Care Connect PMP Enrollment Updates and Changes

MDwise is responsible for developing a PMP 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.

It is very important that all information in the MDwise Provider Directory provider list is accurate and up-to-date, including PMP specialty, practice limitation, address and office locations.

Any time there is an update to provider enrollment information, please contact your MDwise provider relations staff. You can refer to the Directory in the front of this book for contact information. Please call as soon as you are aware of the change. Your provider relations representative will assist your office in completing the appropriate Hoosier Care Connect Update form and may submit the form to HP on your behalf. 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

**Hoosier Care Connect PMP Disenrollment Procedures**

If a provider plans to disenroll from MDwise Hoosier Care Connect, they should let their provider relations representative know as soon as possible. Similar to the provider enrollment process, the MDwise provider disenrollment process is coordinated by MDwise provider relations personnel. The process works as follows:

1. A PMP may disenroll from the MDwise network by submitting written documentation to MDwise Provider Relations **at least 90 days before the date of disenrollment**.
2. Upon review by MDwise, the disenrollment information will be entered into Indiana AIM or Web interChange.
3. If the provider is disenrolling without reenrolling in another Hoosier Care Connect MCE, the MDwise Provider Relations Department will assist in transitioning the provider’s panel to another MDwise Hoosier Care Connect PMP, if requested in writing. If the provider will be reenrolling in another Hoosier Care Connect MCE, MDwise Provider Relations will coordinate the transfer of the PMP’s existing panel to an existing MDwise Hoosier Care Connect PMP.
4. MDwise provider relation’s staff will monitor the disenrollment process to ensure that the PMP is disenrolled appropriately.

**PMP Panel Size Selection and Changes in Panel Size**

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

- The panel size includes only Hoosier Care Connect enrollees and does not include enrollees in Hoosier Healthwise or HIP (these are separate programs).
- If a physician has multiple 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 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.

For various reasons, it is possible that a PMP will have more members than their selected panel size. For example, a PMP with a full panel will receive auto-assignments of previously assigned Hoosier Care Connect members and auto-assignments of family members (identified by case number) of currently assigned members.

**Panel Modifications and Panel Hold Requests**

MDwise PMPs that wish to increase or decrease their panel size designations can initiate a written, email, or phone request to their MDwise provider relations representative. MDwise will review the request, complete the required paperwork and submit it to OMPP for approval.
A PMP can also request that his/her panel size be temporarily placed on hold in the same manner as above 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).

The reasons for a panel hold request must be documented and are monitored by MDwise to ensure adequate openings to accommodate new MDwise members who self-select or are auto-assigned to a PMP within the program.

**Please Note:** Your provider relations 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 Quick Reference Contact Sheet in the front of this book for contact information.
Chapter 6 - 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. 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 Hoosier Care Connect 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 for Hoosier Care Connect.

- MDwise policies are described in this Provider Manual.
- State requirements can be found on the web at [www.indianamedicaid.com](http://www.indianamedicaid.com).
- If you have any questions about these policies, call MDwise provider relations staff or MDwise Customer Service (see Directory).
- 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: Hoosier Care Connect: 1 – 3,500
- Covered Services: Provide covered PMP services to all MDwise members assigned to PMP.
  - 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.
  - MDwise will not in any way limit a PMP’s ability to advise a member about their health status, medical care, or treatment options, even if MDwise does not cover those treatment options.
- Access to Care: Provide or arrange for coverage of services to assigned members:
  - 24 hours a day, 7 days a week – in person or by an on-call physician.
  - 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.
  - Must answer emergency and urgent phone calls from members within 30 minutes.
• 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 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 HP for each service rendered to MDwise Hoosier Care Connect 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.
  
  o 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 or Hoosier Care Connect, the PMP must first attempt to handle the issue by calling MDwise Customer Service rather than contacting the State directly.

• **Cultural Competency:** PMPs must provide information regarding treatment options in a culturally competent manner. PMPs must ensure that individuals with special needs have effective communications with participants throughout the MDwise system in making decisions regarding treatment options. At the time of enrollment, MDwise respectfully asks that all PMPs report their race, ethnicity, and language on enrollment forms. Should a PMP decline to report
this information, they must document that it is not reported and initial the appropriate enrollment forms.

- **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.

The following sections elaborate on some of the participation requirements outlined above, including provision of covered services, PMP access guidelines, missed appointments, confidentiality of member information, medical records, specialist referrals and cultural sensitivity.

**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. 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.

MDwise complies with 42 CFR 438.102. MDwise must not prohibit or restrict a health care professional from advising a member about his/her health status, medical care or treatment options, regardless of whether benefits for such care are provided under the Hoosier Healthwise, Healthy Indiana Plan, or Hoosier Care Connect Programs as long as the professional is acting within his/her lawful scope of practice. This provision does not require MDwise to provide coverage for a counseling or referral service if the MDwise objects to the service on moral or religious grounds. In accordance with 42 CFR 438.102(a), the MDwise must allow health professionals to advise the 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 will not take punitive action against a provider who requests an expedited resolution or supports a member’s appeal.

**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) and/or FSSA policy, 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 PMP’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 their effective date 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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<thead>
<tr>
<th>ACCESS STANDARDS FOR PMP VISITS</th>
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<tbody>
<tr>
<td>Appointment Category</td>
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<tr>
<td>Urgent/Emergent Care Triage</td>
</tr>
<tr>
<td>Emergency Care</td>
</tr>
<tr>
<td>Urgent Care</td>
</tr>
<tr>
<td>Non-Urgent Symptomatic</td>
</tr>
<tr>
<td>Routine Physical Exam</td>
</tr>
<tr>
<td>Initial Appointment (Non-pregnant Adult)</td>
</tr>
<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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</tbody>
</table>

**Specialist Access**

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

<table>
<thead>
<tr>
<th>ACCESS GUIDELINES FOR SPECIALIST VISITS</th>
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<tbody>
<tr>
<td>Appointment Category</td>
</tr>
<tr>
<td>Emergency</td>
</tr>
<tr>
<td>Urgent</td>
</tr>
<tr>
<td>Non-Urgent Symptomatic</td>
</tr>
</tbody>
</table>

**Physician Response Time**

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

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 emergencies, 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: If you have a MDwise Hoosier Care Connect member who has missed two or more appointments please contact the MDwise Care Management Department for assistance in working with the member to correct this behavior. A MDwise Health Advocate will attempt to contact the member via telephone or letter to help the member understand the importance of keeping scheduled 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 Health Advocate (social worker) 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 the MDwise 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.

Referrals To Specialists

The primary medical provider is responsible for referring a member to specialist physicians as needed. Specialists may not refer a MDwise member to another physician. All referrals must be coordinated through the member’s primary medical provider (PMP).
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 and the National Committee for Quality Assurance (NCQA). MDwise Quality Improvement staff conducts reviews of medical records of contracted PMPs at least every two years to assess compliance with these standards. After the review is completed, providers are notified of the results of the review and whether any corrective actions are necessary, based on results of the assessment.

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

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

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

Cultural Sensitivity

MDwise recognizes that effective delivery of health care requires identification, appreciation, and integration of members’ different cultures and needs. Cultural, racial, socioeconomic, disability status and linguistic differences can present barriers to accessing and receiving quality health care. The perception of illness and disease and their causes tends to vary by culture. Also, cultural differences often influence help-seeking behaviors, attitudes towards providers and staff, and the expectations that patients and providers have of each other. Language barriers and poor literacy can compound compliance problems with taking prescribed medications and following recommended treatment regimens.
Providers face these issues every day in clinical practice. In addition to addressing concerns regarding language and communications, physicians working with our members often need to make distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the member’s cultural background. Language, religious beliefs, cultural norms, socioeconomic conditions, disability status, diet, etc., may make one treatment method more palatable to a member of a particular culture than to another of a differing culture.

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

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

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

- 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 MDwise resources or through the CryaCom language line.

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.

The CryaCom Language Line 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 relations 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

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 relations representative. They will assist in locating resources upon request.

**Use of Physician Extenders**

Nationally, approximately thirty percent of family physicians report utilizing at least one physician extender in their practices. These practitioners are used to extend the availability of health care and improve office productivity. 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.

Physician extenders in the MDwise network, include:

- Nurse practitioners
- Nurse midwives
- Clinical and psychiatric nurse specialists
• Certified registered nurse anesthetists
• Physician assistants
Chapter 7 - Choosing or Changing Doctors

Upon enrollment in Hoosier Care Connect, members must select a primary medical provider (PMP).

In Hoosier Care Connect, the following provider specialties are eligible to enroll as PMPs:

- Family practice
- General practice
- Internal medicine
- Obstetrics/Gynecology
- Pediatrics

In addition, for the Hoosier Care Connect Program, other physician specialties may enroll as PMPs. However, specialist PMPs will not receive auto-assignments. Specialist PMPs will receive members only if the member actively chooses that physician as a PMP.

The PMP serves as a member’s medical home and gatekeeper for most medically necessary care. The PMP is responsible for providing most primary and preventive services, and for reviewing and referring and obtaining authorization for necessary specialty care and hospital admissions.

Helping Members To Change Doctors

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

PMP Change Policy

A MDwise member may change their PMP at any time and for any reason. If a MDwise member wishes to change their PMP, they should be instructed to contact the MDwise Customer Service Line. This gives MDwise the opportunity to identify potential issues and assist the member in selecting a new PMP within the MDwise network of physicians.

For example, if a member wants to change PMPs because they had to wait 30 minutes to see their PMP during a routine office visit, educating the member on the standard approved waiting time is appropriate. If the member understands that 30 minutes falls within the guidelines and that they may encounter the same or longer waiting time with another PMP, they may decide to stay with the existing PMP.

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 – usually 1-5 business days.
- The member will receive a PMP Change 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 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.

**Pregnancy Related Postpartum PMP Change**

MDwise Hoosier Care Connect Care Managers 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 6 weeks post-partum period. Assisting the member to select a new PMP helps to ensure that the member may access necessary primary and preventive care services.

**Please Note:** If you provide OB/GYN services only and have a member that has recently delivered and is in need of a PMP change, please call your MDwise provider relations representative. Please note that a PMP change cannot occur until the member has had their postpartum visit (or after 60 days postpartum). You may refer to the Quick Reference Contact Sheet in the front of this book for contact information.

**Open Enrollment for Hoosier Care Connect Members**

Once Hoosier Care Connect members are assigned to a Managed Care Entity (MCE), they have 90 calendar days to change their MCE. Or if there is just cause, they may change their MCE.
Chapter 8 - Claims and Submission for Hoosier Care Connect

Submitting Claims for Hoosier Care Connect
In and out of network providers must submit Hoosier Hoosier Care Connect claims to MDwise Hoosier Care Connect Claims Department. Providers can determine the member’s eligibility by checking HP Web interChange at indianamedicaid.com. Within the Web interChange system the provider can enter their NPI and the member’s RID number to pull up the member’s eligibility information. The eligibility screen will show the type of coverage the member has (Hoosier Healthwise, Healthy Indiana Plan, Traditional Medicaid, Hoosier Care Connect) and member’s Managed Care Plan.

MDwise Hoosier Care Connect claims may be submitted via paper or electronically. Please remember that all electronic claims must be submitted using HIPAA-compliant transaction and code sets. MDwise Hoosier Care Connect claim address and electronic filing numbers can be found in the MDwise Quick Contact Guide.

MDwise Hoosier Care Connect processes professional and institutional claims, with the exception of carved out services.

MDwise Hoosier Care Connect: P.O. Box 830120 Birmingham, AL 35283-0120

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 Hoosier Care Connect members should be sent to MedImpact.

Dental claims for MDwise Hoosier Care Connect members should be sent to DentaQuest.

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

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

In accordance with MDwise program rules, all services must be obtained within the MDwise Hoosier Care Connect network, except for the following:

- Self referrals services for Hoosier Care Connect 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 90 days of becoming a member) for services from a provider that is not contracted with MDwise.

Claim Submission Deadlines
Contractually all in-MDwise network providers are required to submit claims within 90 days of service. MDwise is responsible for adjudicating clean electronic claims within 21 days of receipt and clean paper claims within 30 days of receipt.

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 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.

Questions about Claims: If you have a question about a specific claim that you submitted, or about an EOB/EOP you received, please call the MDwise Hoosier Care Connect Claims Department at 1-800-356-1204

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

• CMS 1500 (professional claims)
• UB04 form (for institutional claims)
• 837P (HIPAA compliant professional) and/or 8371 (HIPAA compliant institutional) file formats-electronic claims
• The following code sets are to be used when submitting claims electronically or in paper.
  • Current Procedural Terminology – (CPT)
  • HCFA Common Procedure Coding System (HCPCS)
  • National Drug Codes (NDC)

MDwise is required by state and federal regulations to capture specific data regarding services provided to its members. The provider must adhere to all billing requirements to ensure 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.

See chapter 8 of the IHCP Provider Manual for detailed information on required fields. This can be found at indianamedicaid.com

**Third Party Liability**

When the member has other insurance, a MDwise provider must submit claims to the other insurance carrier before submitting to MDwise Hoosier Care Connect Claims. A copy of the third party’s explanation of benefits must be included with a TPL claim. MDwise will then pay the difference between the payment made by the primary insurance carrier and MDwise’s total allowable charge for the covered service. If the primary insurance paid more than MDwise’s total allowable charge the claim will pay zero.

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

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

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

**90 Day Rule**

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

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

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

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

MDwise Medicaid products are the payer of last resort, with the exception of the following two fully state funded programs:
  • Victims Assistance
  • Indiana Children’s Special health Care Services

**Third Party Liability and Prior Authorization**

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

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

**Member Third Party Liability Responsibilities**

MDwise Hoosier Care Connect 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 Third Party Liability Responsibilities**

According to Indiana Health Coverage Program (IHCP) program requirements, providers are responsible for obtaining insurance coverage information from members at the time service is provided. Providers are required to do the following:
• Ask every member if he or she has any insurance coverage and report any available coverage to
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: If you should determine that a member has health coverage through 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 Hoosier Care Connect coverage.

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

Providers must file their initial claim dispute within 60 days of a claims determination or, within 90 days
of submitting a claim if the provider never received a determination on the claim. When submitting a
dispute the provider should include the dispute form, explanation of payment, and an explanation of the
reason for disputing the claim.

MDwise will review all disputes and respond to the provider within 30 calendar days. If the original
decision is upheld the provider will be given information on how to appeal. Please see MDwise.org/for-
providers/forms/claims for more detailed information on in and out of network claims disputes and
appeals.

In Network and Out of Network Provider Claim Disputes for Hoosier Care Connect
Providers who have a claim dispute with a MDwise Hoosier Care Connect should send their disputes to
the MDwise corporate office (shown below). Behavioral health providers should also send all claim
disputes to the MDwise corporate address below.

MDwise
P.O. Box 441423
Indianapolis, IN 46244-1423
Attention: Grievance Coordinator
Chapter 9 - Member Cost Sharing Responsibilities

Hoosier Care Connect Member Copayments

Hoosier Care Connect members do not have co-payments.
Chapter 10 - Care Management for the MDwise Hoosier Care Connect Program

To accomplish the State’s goals for the MDwise Hoosier Care Connect program, the MDwise care management program is centered on an integrated, holistic approach to the member’s care. By addressing medical, physical, and behavioral issues in such a way that the “whole” individual is treated, the MDwise Care Manager helps ensure better outcomes for the member. Our care management approach is based on the belief that MDwise Hoosier Care Connect members’ needs can better be addressed by creating an environment that helps them organize, make sense of, and navigate the overall health care system. The lack of well-coordinated care plans, multiple co-morbidities, and a multitude of psychosocial challenges dictate we provide a proactive, holistic and all-inclusive care management model, blending disease management, member education and 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, needs assessment(s), claims history, prior authorization and other available records. Reassessment is done at established intervals based on the member’s level of care assignment or more frequently, based on information gained by the care management team.

- **Implementation of individual plans of care** aimed at getting members connected with evidence-based medical and behavioral health care designed to increase the members’ self-management skills and optimize their health status. Care plans include prioritized goals, target dates, and manageable interventions. Plans are evaluated and modified over time based on the changing needs of the member. Members, families, PMP, specialists and others are actively involved in the care plan development/implementation process.

- **Individualized set of interventions** based on unique member needs. Care plan interventions include a variety of “low touch” and “high touch” interventions. The care management team maintains frequent telephonic contact with members and draws on a variety of disease management and outreach programs/interventions to assist members in ways to engage and actively participate in their care.

- **Coordination of care among service providers** through a multidisciplinary team approach in the development and monitoring of the member’s plan of care and progress in meeting goals. Ongoing sharing of information among all treating providers ensures services for members are coordinated and duplication is eliminated. Each member has an assigned Complex Case Manager or Care Manager who is responsible for all aspects of coordination – spanning from physical health conditions to substance abuse and/or other behavioral health needs. Coordination is supported through robust information systems that include integrated care management, call tracking and reporting modules.

- **Active involvement of member, family, and Care Management staff** at each step of care coordination. Relationship building occurs over time through frequent and meaningful interactions with the member. Care Management staff provide consistent encouragement to members to become active participants in their plan of care with the goal of empowering members and increasing self-management and functional status over time.
Complementing our intensive care management program is a best practice provider network, strong community partnerships, a comprehensive set of member and provider education and outreach programs, and a vigorous plan for measuring the outcomes of our care management activities.

**Care Management Team**

Our care management team is comprised of experienced and compassionate Complex Case Managers, Care Managers, Health Advocates, and Customer Service Representatives who are trained on active listening skills, relationship-building, member rights, and cultural sensitivity. The MDwise Care Management Team is comprised of the following units:

**Care Management Leadership**

The MDwise Hoosier Care Connect Chief Medical Officer provides medical leadership and clinical oversight for all functional areas of the MDwise Hoosier Care Connect Care Management Program. The Chief Medical Officer has overall responsibility for the quality improvement program, the medical management program and development of clinical policy as it relates to care management and special needs. The Chief Medical Officer actively creates linkage with the provider community and works with community leaders to create programs and guidelines to manage the care received by MDwise Hoosier Care Connect members.

**Complex Case Managers, Care Managers, and Health Advocates**

Complex Case Managers, Care Managers, and Health Advocates (collectively the Care Management Staff) are also responsible for the overall management and coordination of the member’s care. The Care Management Staff is responsible for completing comprehensive assessments, care plan development, treatment plan execution, frequent interactions with members and providers, and ongoing monitoring and reassessment. MDwise Care Management Staff will have diverse skill sets to provide a rich set of resources to meet the needs of the Hoosier Care Connect members. Included in the Care Management Staff will be nurses, social workers, and behavioral health specialists. The staff is supervised by a Registered Nurse under the co-direction of a Psychiatrist and Medical Director. The Complex Case Managers and Care Managers are supported by a team of Health Advocates who generally work to resolve non-clinical issues and triage the member to the appropriate staff member for clinical or social work assistance. Health Advocates make reminder calls about physician appointments to members, assist with transportation, address gaps in care, and complete other tasks that free the Complex Case Managers and Care Managers to concentrate primarily on health care issues.

**MDwise Outreach Call Team**

This specialized team will primarily be responsible for making initial outgoing assessment calls to members. During these calls, the representatives will assist members in understanding their benefits with the MDwise Hoosier Care Connect program, discuss their PMP assignment to be sure that members are satisfied with their selection, encourage a visit with their PMP within 60 days, and also educate members about resources available to them in the community. Member materials that MDwise sends will compliment these outbound call efforts and hopefully reach those that are not available by phone.

**Member Assessment & Stratification**

Health assessment data, claims analysis, referrals submitted through the MDwise website, and other mechanisms are valuable means to identifying members who are currently or have the potential to be at
risk. To have an impact on both member outcomes and healthcare costs, the first step is to identify those members with the greatest need. Subsequently, members are provided with the appropriate interventions to reduce risk, promote healthy outcomes and preventive health care, and avoid acute illness episodes.

Once members are in the MDwise Hoosier Care Connect program, they are assessed and stratified based on past utilization of health care resources, diagnoses, laboratory results, medication profile, and medical history. Members are further stratified based on their acuity and the stability of their progress along the care plan. As part of the ongoing care management process, members are reevaluated at specified intervals with updated information from claims and pharmacy systems as well as findings from follow-up contact.

The guiding principle behind the assessment and stratification logic is to identify members with potentially avoidable episodes of illness. Members with the highest relative risk score and greatest potential for intervention (based on the assessment) in each stratification category are assigned to the highest intervention levels and priority. This method allows MDwise to focus resources on the members who will benefit the most.

Other measures factored into the stratification process, used to proactively find members at risk are especially useful when claims data is not available or the member is new to the MDwise Hoosier Care Connect program. These measures include:

- Health Needs Screening
- Referrals from providers and community partners
- ER and Inpatient utilization
- NURSEoncall
- Disease specific assessments

**Assessment Tools**

MDwise uses a combination of assessment tools to assess, stratify, and identify the needs of members including the Health Needs Screening (HNS) tool initially developed by OMPP. The HNS includes additional questions developed by MDwise and includes special needs screening as well as disease-specific screening questions. Outreach and urgent need identification is the first step in the care management process. Once the member’s immediate needs are addressed, the member is scheduled for a comprehensive assessment by the Complex Case Manager or Care Manager. The comprehensive assessment identifies risk factors and health status by asking questions about the member’s risk behaviors, sense of wellness and ability to care for self.

The comprehensive assessment collects information on the member’s ability to perform activities of daily living, manage health treatments and medications, and connect to providers. This information is used to identify enrollees who may need to be connected to community agencies for additional assistance with transportation or food shopping. The comprehensive assessment also incorporates a review of available data, including ER use, inpatient hospitalizations, PMP visits, and medication refill patterns, as well as members’ knowledge or their chronic illness as part of care plan development activities and determining level of care.
**Member Classification and Prioritization**

Based on the results of the initial screening and mining of historical data, MDwise will stratify members into various subpopulations and initial classifications of Moderate or High risk. This initial stratification will focus on actionable items, such as no history of a PMP visit, recent emergency room encounters and predictive risk score. MDwise staff will create appropriate care plans with High risk members based on individualized stratification. This unique approach identifies opportunities early so interventions can have the maximum positive impact on the cost and quality of care. This process also allows for identification of members with immediate health needs so those individuals can be designated as urgent.

**Care Plan Development & Implementation**

The focus of the MDwise care plans at any level of service is to achieve the following key goals for our MDwise Hoosier Care Connect members:

- Identifying the primary risks that can impact the medical, emotional, social and functional needs of the member,
- Coordinating services to meet members’ needs across these four domains,
- Assuring that members establish an effective working relationship with their providers,
- Identifying members’ and caregivers’ primary concerns related to their current situation and addressing members’ primary healthcare goals.

Care plan 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 to and utilization of appropriate resources.

**Care Plan Development Process**

Each individual care plan developed for High risk MDwise Hoosier Care Connect members will contain prioritized goals with associated target dates, tasks, and interventions for reaching the goals. Tasks or interventions and status updates will be noted in the care management system to monitor the member’s progress toward goals. The Complex Case Manager or Care Manager regularly adjusts the care plan to address the member’s current situation.

The Complex Case Manager’s and Care Manager’s evaluation of the care plan consists of documenting progress toward the goals and integrating new assessment data, physician findings and input from the member/caregiver and other involved health care and community based providers into the overall picture of the member. Complex Case Managers and Care Managers also review claims data and request medical records as needed to evaluate the member’s status. Records may be obtained from the provider office(s), therapists, and home health agencies, in addition to others.

MDwise will utilize a multidisciplinary team approach to develop and review each care plan. Depending on the providers involved in a particular member’s care, the internal process may include review by a pharmacist, therapist consultant, and behavioral health specialist. An external multidisciplinary team may consist of clinical and community providers, the member, and family and support persons the member requests be part of his/her care.
Care plans are evaluated and updated with each member contact, as well as periodically based on the member’s stratification. The timeframe for review of the care plan varies according to the unique situation and care needs of the member. Care plan modification may occur at any time based on the changing status of the member.

As outlined above, the MDwise Care Management Team includes nurses, social workers, and non-medical staff with training in how to coordinate access to both health and social services. This team, combined with the member, providers, family members/caregivers, and other service providers, helps to ensure the plan of care. This multidisciplinary care coordination team strengthens the comprehensive approach to care and an umbrella of services is created for members. The key feature to successfully implementing the full scope of services and avoiding duplication is to have a system in place that feeds information between all involved parties.

Throughout the care coordination process, the MDwise Care Management Staff consistently encourages the member to be an active participant in his/her plan of care with the goal of empowering the member and increasing self-management and functional status over time. The Care Management Staff will assess the member’s readiness to learn and use that knowledge to deliver focused education and promote the development of functions that contribute to enhanced quality of life.

**Member Centered Approach**

The MDwise model allows the member to help define the central focus for as many aspects of care as possible (e.g., ambulatory care, special needs, case management, utilization, pharmacy management and disease-state education). Also, through the practical design of assessments and member input, the Care Management Staff can focus on various activities of daily life that need enhancement (such as the member’s ability to shop for food, get medications, obtain transportation to appointments, etc.). The care management process is designed to be flexible in meeting members’ changing needs.

The process is completely participatory, with the MDwise Care Management Staff involving members in every aspect of the care plan. Placing members at the center of the plan of care ensures that members’ right to self-determination is fully recognized and respected.

**Ongoing Assessment & Evaluation**

Evaluating the effectiveness of the care plan includes case reviews by the Chief Medical Officer and Care Management Staff or through a care conference. Information gathered through supervisory and quality assessment of individual care plans is reviewed with the individual Complex Case Manager or Care Manager. The effectiveness of care plans is also reflected by members’ rates of hospitalization, ER use and compliance with treatment plan. Trends identified through case review or aggregate reporting are incorporated into training programs for the Care Management Staff and used as examples during case rounds.
Chapter 11 - Medical Management

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 Care Connect Program. MDwise works collaboratively with PMPs, behavioral health providers and ancillary service providers, in the development, coordination and evaluation of medical management activities to 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 FSSAcontract, PMP contract, 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 Program Activities

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
- 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
- Interface with MedImpact (pharmacy benefit manager) in order to conduct analysis of claims data and pharmacy utilization and provide recommendations.
- Confidentiality maintenance
- Accessibility/Availability of MM staff
- Quality issues reporting and review according to the Medical Management Program Policies and Procedures
- Data collection and reporting, and annual program review

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.

**Goals and Objectives**

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 goals and objectives of MDwise Medical Management are to:

- Promote safe, efficient, and effective health care services through provider/member education and feedback
- Enhance the value of MDwise's services through the implementation of evidence-based practices, integration of clinical and behavioral health, care management/care coordination, prospective, concurrent and retrospective data analysis and education, and cost-effective service delivery
- Implement ongoing health promotion, disease prevention and disease management activities that reinforce the medical home and reduce avoidable ER and hospitalizations
- Partner with medical and service providers, social agencies and community groups, governmental divisions/departments, members and member advocates in support of holistic, integrated care
- Provide monitoring and oversight to assure 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
- Monitor and analyze relevant data to identify, correct and prevent patterns of potential or actual excessive or under use of health care services or duplication of 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
- Meet or exceed customer expectations

**Integration with QI**

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

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

**MDwise MM Authority, Responsibility and Committee Oversight**

MDwise works collaboratively with hospitals, practicing providers, community agencies, and other service providers and community representatives through its committee structure and affiliations to develop, coordinate, implement, and evaluate our medical management activities and goals that promote the quality and safety of clinical care and service to MDwise members.

The **MDwise Medical Advisory Council**, is delegated the responsibility for reviewing, evaluating the medical management processes and performance improvement issues, coordinating and overseeing functions of the medical management program including data reporting and analysis, monitoring of utilization of health services and member clinical safety issues, and providing organizational strategy to ensure consistent, fair, safe delivery of quality health care.

The Council is given the responsibility to develop, oversee, review and make recommendations regarding medical policy development covering aspects of services (including pharmacy, preventive health and behavioral health services), care management and disease management programs, continuity of care, new technology assessments, clinical practice guidelines and research, interpret and further clarify medical policy guidelines appropriate and applicable to covered services as outlined in the Indiana Health Coverage Programs (IHCP) participation policies and contract obligations. The Medical Advisory Council provides expertise, direction and makes recommendations in the monitoring and improvement of member clinical care and safety issues and utilization.

Council membership includes the MDwise Chief Medical Officer, partner Medical Directors, the MDwise Directors of Pharmacy, participating providers (appropriate specialties), behavioral health, and other related specialties and/or ancillary providers, including ad hoc members necessary to provide the academic and specialty expertise for specific focused policies. Additional staff members include representatives from the Medical Management and Quality Improvement functional areas and, as appropriate, other areas such as Member Outreach, Customer Service, and Compliance/Regulatory.

**Please Note:** Our committee activities will be reported through such means as the MDwise Hoosier Care Connect website and/or Provider Newsletter. Please contact our Provider Relations staff to provide issues you may identify to be discussed.

**Key Medical Management Program Components**

**Physician Involvement in Medical Management Program Implementation**

Prior Authorization and Referral – see last section of this Chapter. The MDwise Chief Medical Officer oversees the medical management program for the MDwise Hoosier Care Connect Program. The MDwise Chief Medical Officer provides overall management of MM functions and provides day to day support to the 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 requires 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.

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 care 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.

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, other IHCP programs or care management organization, service provider, or services. MDwise will also facilitate that the appropriate transfer of patient information occurs to the new provider and/or health plan.

The following types of situations provide the opportunity for the member to continue with current medically necessary care:

- For members with behavioral health care needs who are transitioning from another health plan to MDwise, collaboration and follow-up with the member’s existing medical and behavioral healthcare providers or community based provider including when applicable CMHC, MRO or PRTF case 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 include, but are not limited to the following:

• Members who are hospitalized on the effective date
• Newborn children of members retroactive to the date of birth
• Members that are transitioning into services excluded for managed care but available under Traditional Medicaid fee for service program. Those services include Hospice care, Psychiatric treatment in a state facility, Institutional care facility for the mentally retarded (ICF-MR), and Dual eligibles.

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, and (e) assist in coordinating care and, for example, information gathering to facilitate the member’s transition into Traditional Medicaid.

Please Note: If one of your MDwise patients is transferring in or out of your panel, and because of continuity of care issues requires a transition plan to coordinate necessary clinical care services, please contact Medical Management or Provider Relations.

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 themember. 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 Hoosier Care Connect care management staff will receive daily notification and details of any calls originated by Hoosier Care Connect 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.

Prior Authorization and Referral Process

MDwise Overview
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 IHCP as described in Chapter 2.

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.

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 MM/PA staff and available on the MDwise website to submit request for service authorization. The forms are to be completed by the requesting provider and any additional pertinent 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.
Prior Authorization Requests and Referrals

Prior authorization forms are available on the MDwise website and on indianamedicaid.com

Prior Authorizations for Hoosier Care Connect should be faxed to 1-877-822-7188 or by phone at 1-800-356-1204.

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 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

General Authorization Procedural Guidelines

- Information submitted with service request should include all required elements and other pertinent clinical information required to support medical management decisions and benefit coverage determinations.
- If additional information is required before the Medical Management/PA staff can make a determination, the prior authorization request will be suspended with a request for additional information.
- MDwise Hoosier Care Connect members accessing the Hoosier Care Connect program self-referral providers do not require a referral or authorization to obtain those services from a qualified IHCP provider. Hoosier Care Connect also 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.

Referrals

As a PMP, you may refer a member under your care to another MDwise Hoosier Care Connect participating provider for any medically necessary service. PMPs are responsible for all PMP related services rendered to patients on his/her panel. As a member’s medical case manager, the PMP is responsible for determining whether to authorize, via the referral process, most services provided to members enrolled in the MDwise Hoosier Care Connect Program, if the PMP is not providing the service.

General Referral Guidelines

- Referrals initiated by the PMP must be made to appropriate physicians and other practitioners who are MDwise Hoosier Care Connect providers to ensure that services are furnished to members promptly and without compromise to quality of care.
- Referrals may be given in writing or by telephone.
- All referrals of MDwise Hoosier Care Connect members must be documented in the PMP’s
member medical record. The referral initiated by the PMP must specify which services are covered by the referral and may cover one or multiple visits to complete a plan of care.

- Referrals must be renewed, if necessary, every calendar quarter by the MDwise Hoosier Care Connect PMP.
- The PMP shall refer a member to his/her selected specialist if the member is already an established patient of that physician, and the physician is an MDwise Hoosier Care Connect provider.
- The PMP shall make a referral to an MDwise Hoosier Care Connect provider for a second opinion if requested by the member. This referral shall apply only to the consultation. Any subsequent treatment by the second opinion provider, if necessary, shall require a separate referral.

**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.

**Prior Authorization Request /Referral Procedure Reference Guide**

**PMP Role and Responsibilities**

As a contracted MDwise Hoosier Care Connect Program PMP, you are considered managers of care. In this role, the PMP will provide, or will arrange for the provision of, routine comprehensive preventive services, medically necessary primary care treatment and urgent care services, in keeping with the universally accepted standards as defined by the contract terms. In particular, the PMP will provide, coordinate or seek referrals for the following services:

- Physician services;
- Hospital inpatient and outpatient services; and
- Ancillary services including but not limited to: laboratory and radiology; orthotics/prosthetics; HealthWatch/EPSDT; audiology; and durable medical equipment and supplies specified in the MDwise Hoosier Care Connect Manual and any services added in Provider bulletins amending the Hoosier Care Connect Manual.

The following section outlines the Referral/Authorization procedures adopted from the MDwise Hoosier Care Connect Program requirements:

**Automatic Referrals/Continuity of Care**

As MDwise prior authorization staff will follow the continuity of care rules described in an earlier section of this Chapter, the PMP must also incorporate the following rules when, at the time of PMP assignment, a MDwise member has an established relationship with another MDwise Hoosier Care Connect provider. If the member requires immediate medical attention, the newly assigned MDwise member’s PMP is required to make an automatic referral to that the previous provider in order to maintain continuity of care. Examples of this situation include:

- Members who enroll in MDwise Hoosier Care Connect during late stages of pregnancy (third-trimester), or
- Members who have previously scheduled surgery with a physician other than the PMP
Because members may require care from an MDwise Hoosier Care Connect provider other than the member’s PMP prior to the initial visit with the PMP, PMPs may refer a member to another MDwise Hoosier Care Connect participating provider before performing an initial evaluation on a MDwise Hoosier Care Connect member. PMPs should authorize this care, and the rendering provider should refer the patient back to the PMP for evaluation and follow-up.

**PMP Referral Process**
All PMP services not provided by the MDwise Hoosier Care Connect member’s PMP must be referred by the MDwise member’s PMP in the following manner to another participating MDwise Hoosier Care Connect provider:

- Referrals may be given in writing or by telephone.
- The referral must be documented in the medical record by the PMP.
- The PMP must specify which services are covered by the referral. The PMP referral may cover one or multiple visits to complete a plan of care, but the referral must be renewed at the beginning of each calendar quarter to ensure reimbursement of claims.
- The provider receiving the referral must document the referral in the member’s chart.

**Group Practices and Clinics**
Services provided by MDwise Hoosier Care Connect PMPs and nurse practitioners enrolled under a common billing number, within the same group practice/clinic as the patient’s PMP, do not require a formal referral from the member’s PMP, if services are billed under the same group provider number. In instances where an physician is enrolled in the same group/clinic as the member’s PMP and renders care to the member, the services/care provided must be documented in the member’s chart.

**Self-Referral Services**
MDwise Hoosier Care Connect PMPs are not required to authorize the self-referral services covered by the IHCP requirements. MDwise Hoosier Care Connect members are allowed to access these services without receiving PMP authorization. The following are self-referral services in the Hoosier Care Connect Program:

- Services rendered for the treatment of a true emergency
- Family planning services
- Chiropractic services
- Podiatric services
- Eye care services (except eye care surgeries)
- Psychiatric services by any provider licensed under IC 25-22.5 who has entered into a provider agreement under IC 12-15-11.
- Members may 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 not provided by a psychiatrist, 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:

- Outpatient mental health clinics
• Community mental health centers
• 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
• Immunizations are self referral to any IHCP provider. Immunizations are covered regardless of where they are received.

The following Provider type and IHCP Programs are considered self-referral services:

• School Corporations
• First Steps
• Medical Review Team (MRT)
• Pre-Admission Screening/Resident Review (PASRR)

**Hospital Admissions**

Prior authorization is required for all non-emergency inpatient hospital admissions including all elective or planned inpatient hospital admissions.

It is the responsibility of the Hospital to obtain authorization for all non-emergency inpatient hospital admissions for the MDwise Hoosier Care Connect member.

Once the Hospital obtains the authorization for an inpatient stay, the services rendered as part of the stay do not require separate authorization. All providers of care delivered during the inpatient stay should utilize the Hospital’s admission authorization.

It is the responsibility of the hospital to coordinate billing authorization, if required, among the various departments and professional service groups that render care to the MDwise Hoosier Care Connect members.

**Emergency Room**

**Prudent Layperson Standard**

The Federal Balanced Budget Act (BBA), Section 4704, defines “Emergency Services” as covered inpatient and outpatient services furnished by a qualified Medicaid provider that are necessary to evaluate or stabilize an emergency medical condition. It goes on to define an “Emergency Medical Condition” as follows:

• A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part.
Referrals for Emergency Room Services
In accordance with federal requirements, MDwise Hoosier Care Connect members are allowed to obtain emergency services without prior approval. Members are encouraged to call their PMP for advice if they are unsure about whether or not they have an emergency situation. PMPs should advise their patients, accordingly, to go to the emergency room or to visit the PMP’s office that day or the next day.

Additionally, the MDwise Hoosier Care Connect member can contact the 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 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 PMP assignment and will refer the member back to the member’s PMP for further assessment/or treatment, as the situation indicates.

MDwise has various initiatives designed to educate members about situations for which it would be appropriate to go to the emergency room for treatment and when it would be better to obtain care from their PMP.

The emergency department staff must contact the member’s PMP within 48 hours of an emergency room visit or emergency admission. The prudent layperson standard in the above definition of an emergency medical condition is based on the member’s symptoms at the time of presentation to the emergency department.

Reimbursement for Services Provided in the Emergency Room
Pursuant to Indiana Code 12-15-15-2.5, MDwise Hoosier Care Connect will reimburse emergency room physicians for services rendered to members according to the following provisions:

- Emergency room physicians will be reimbursed for federally required medical screening examinations that are necessary to determine the presence of an emergency without authorization by the member’s PMP.
- All physician services provided to the Medicaid Select member in the emergency department, other than the federally required medical screening, that are authorized, either prospectively or retrospectively, by the member’s PMP, will be deemed as meeting the prudent layperson standard and will be paid. Claims submitted for these services without PMP authorization may be suspended for review.
- Reimbursement for physician services provided in the emergency department must be at 100% of IHCP rates.

If a MDwise Hoosier Care Connect member seeks treatment in an emergency room for an emergency medical condition, the emergency department may provide treatment to stabilize the patient without PMP authorization.

Emergency department claims submitted with emergency diagnoses will be paid. Claims submitted without an emergency diagnosis code, but with PMP authorization, will be deemed as meeting the prudent layperson standard and will be paid. Claims for emergency department services that do not include an emergency diagnosis and do not have PMP authorization may be suspended for review to
determine if the prudent layperson standard has been met. If the review results in a determination that the prudent layperson standard has not been met, the claim will be denied.

**Post-Stabilization Care**
Care and treatment provided to a MDwise Hoosier Care Connect member after the member is stabilized is not considered emergency care. Pursuant to I.C. 12-15-12-17, MDwise Hoosier Care Connect will reimburse providers for post-stabilization care services for members according to the following provisions:

- The services are pre-approved by the member’s PMP;
- The services are not pre-approved by the member’s PMP, but are administered to maintain the member’s stabilized condition within one hour of a request for pre-approval; or
- The services are not pre-approved by the member’s PMP, but are administered to maintain, improve, or resolve the enrollee’s stabilized condition if: (a) the PMP does not respond to a request for regarding approval within one hour; (b) the PMP cannot be contacted; or (c) the PMP and the treating physician cannot reach an agreement concerning the enrollee’s care.

**Non-Emergent/Routine Care**
MDwise Hoosier Care Connect members are encouraged to seek routine, non-emergent care from their PMP. If the emergency department renders services to a MDwise Hoosier Care Connect member, and the PMP denies authorization because the member’s condition was not an emergency based on the prudent layperson standard, Hoosier Care Connect Program will reimburse the emergency physician for the federally required screening exam, in accordance with state law. However, MDwise Hoosier Care Connect Program may suspend and review the hospital’s claim for rendered outpatient non-emergency charges that are not authorized by the member’s PMP, to determine if the prudent layperson standard was met. If the claim review results in a determination that the prudent layperson standard was not met, payment will be denied.

If the member’s condition is not an emergency, based on the prudent layperson standard, and the PMP denies authorization for further services, the member may choose to assume financial responsibility for those services beyond the physician’s screening exam.

Before the member can be held financially responsible for emergency department services, the following must occur:

The emergency department must contact the PMP prior to delivery of services beyond the screening exam and document that the PMP denied authorization for further non-emergent care; and

The member must be advised of the following:

- The PMP did not authorize further out-patient care,
- The Hoosier Care Connect Program does not cover non-emergent care rendered in the emergency department,
- The member may be responsible to pay for the charges, and
- The services are available in the PMP’s office at no charge to the member.
Hospitals are strongly encouraged to require written verification by the member of the member’s understanding that (1) the services to be received are not covered by the Hoosier Care Connect Program if rendered in the emergency department; (2) the services could be rendered in the PMP’s office at no charge to the member; and (3) by receiving the services at the emergency department, the member agrees to be financially responsible for the non-screening exam charges.

Second Opinions
If a member requests a second opinion, this must be honored and arranged by the PMP. MDwise Hoosier Care Connect members may choose a qualified MDwise Hoosier Care Connect provider (other than another PMP) from whom they desire to seek a second opinion. Regardless of which provider is chosen, the member’s PMP must provide a referral for this second opinion.

Transportation and Pharmacy Services
Transportation and pharmacy services do not require PMP authorization in the Hoosier Care Connect Program. However, providers of these types of service must continue to complete Prior Authorization requests according to the policies as defined in the IHCP Manual for members in Hoosier Care Connect.

The MDwise has contracted with MedImpact to serve as the Pharmacy Benefits Manager for the MDwise Hoosier Care Connect members. MedImpact will process pharmacy-related prior authorization requests and other clinically oriented services. Pharmacy claims will be processed and paid by our pharmacy benefit manager.

MDwise will be participating in analyzing the pharmacy claims data and pharmacy utilization to provide findings and recommendations to OMPP regarding policy decisions.

Family Planning
Members may seek family planning services from any qualified MDwise Hoosier Care Connect provider without PMP authorization. However, if a family planning provider diagnoses a particular condition in a member and subsequently initiates treatment, (i.e., sexually-transmitted diseases) the family planning provider must refer the patient back to the PMP if treatment continues for more than one month. At that time, the PMP will assume case management and determine whether or not further treatment is medically necessary. If additional treatment is required, the PMP may either continue treatment at the PMP site or authorize the family planning provider to do so.

Home Health Services
Home health services in excess of 30 days or 120 hours post hospital discharge for MDwise Hoosier Care Connect members also require Prior Authorization from MDwise as defined in the Indiana Health Coverage Programs Manual.

Hospice Benefits
In-home hospice is covered under Hoosier Care Connect. However, if electing institutional hospice benefits, a member effectively waives Hoosier Care Connect coverage for:

- All other forms of health care for the treatment of the terminal illness for which hospice care was elected or a condition related to the terminal illness,
- Any services provided by another provider which are equivalent to the care provided by the hospice provider, and
- Hospice services other than those provided by the elected hospice provider and its contractors.

Therefore, when a MDwise Hoosier Care Connect member elects Medicaid institutional hospice benefits, the member must be disenrolled from the Hoosier Care Connect program in order for an appropriate level of care to be entered into IndianaAIM for that member. This level of care designation identifies the member as a hospice beneficiary and no longer a part of Hoosier Care Connect program. Before the hospice authorization is approved, the member must elect hospice services, the attending physician must make a certification of terminal illness and a plan of care must be in place.

MDwise will review hospice elections. Upon approval of institutional hospice benefits for the MDwise Hoosier Care Connect member, Maximus must be notified so the member can be disenrolled from the Hoosier Care Connect program and moved to the fee – for – service Traditional Medicaid Program. Disenrollment will be effective the next calendar day. MDwise will provide the member’s PMP in writing of the member’s disenrollment and effective data.

**Provider Responsibilities upon Receiving Referral**

Responsibilities of the specialty and other type of provider receiving a referral from the MDwise Hoosier Care Connect PMP include:

- Following the MDwise Hoosier Care Connect 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.
Chapter 12 - Disease Management Program

MDwise promotes empowerment of members with chronic health conditions 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 imperative to maintaining good health.

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 with treatment plans, understanding of conditions and their treatments, 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 physical health coordination will be provided for members participating in disease management programs who have co-morbid conditions. Effective treatment for these members requires an integrated plan of care that carefully coordinates both physical and behavioral interventions. Our integrated disease management program focuses on reducing the negative impact of behavioral and/or medical disorders by identifying causative agents, addressing barriers and risk factors, and enhancing member competence in self-care and compliance with treatment.

Provider support is available in the form 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 patients; assigned Care Management Staff person.

The goals of the MDwise disease management programs are to:

- Promote prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies;
- Support the provider-member relationship;
- Provide members access to educational resources regarding their diagnoses or chronic conditions;
- Promote healthy lifestyle choices, address barriers to care, and provide access to resources;
- Empower members to actively participate in their healthcare management.

Program Development

MDwise services the required conditions of interest cited in the State’s Hoosier Care Connect Plan contract Scope of Work.

Eligible members are those who have been diagnosed with or are at risk for specific conditions. MDwise utilizes pharmacy and medical claims history data to confirm relevant chronic conditions in the MDwise population, as well as the State’s mandated Health Needs Screener (HNS) for members new to MDwise.

MDwise has the following disease management programs available to its Hoosier Care Connect Plan members:
Diabetes
Pregnancy
Hypertension
Coronary Artery Disease (CAD)
Asthma
Congestive Heart Failure (CHF)
Chronic Pulmonary Obstructive Disease (COPD)
Chronic kidney disease (CKD)
Depression
Attention deficit hyperactivity disorder (ADHD)
Autism/pervasive developmental disorder
Severe Emotional Disturbance (SED)
Serious Mental Illness (SMI)

MDwise also makes Care Management services available to members who have other conditions and who are identified as either 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 through stratification based on individual needs and co-morbidities
- Educational materials for members and providers. All disease management programs include disease educational materials that meet the readability guidelines established by Indiana Medicaid.
- Phone-based interventions for members including IVR (interactive voice response) technology. Periodic phone-based interventions may include health counseling sessions, member questionnaires to collect data on health status, and providing reminders about disease-specific topics, timely preventive health care, or the importance of follow-up with providers or. 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 care management for high risk members
- In-person intervention as needed
- Provider interventions
- Performance measures and health outcomes. Analyses will identify strengths and weaknesses, develop additional interventions and assess for and support member/provider satisfaction.

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 or complete the referral form at MDwise.org to initiate enrollment of the member.

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

In addition to stratification determined by available clinical data, individual member assessments are conducted. Assessments are typically completed with Moderate and 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 if needed.

Member interventions are specific to the member’s stratification based on assessment outcomes. Interventions will be tailored to meet the individual member’s needs. All members receive the following interventions based on their stratification: (NCQA QI8, Element F)

Population-based (Low Risk)—Disease specific materials and preventive care reminders (see care gap alerts), as well as:

- SMOKE-free information
- MDwise Newsletter
- MDwise IVR reminder calls
- NURSEon-call
- Audio library
- Wellness tools

Care Management (Moderate Risk)—Members receive all low-level interventions AND periodic contact with a Care Manager. The Care Manager provides member support and education telephonically. The goal of the Care Manager’s involvement is to empower members to better understand their conditions and improve self-management. The Care Manager will also assist with coordinating care between providers, social services, schools and the community. These interventions will occur regularly until the Care Manager graduates members to Low risk. Graduation is based on members’ demonstrated ability to coordinate care for their condition(s) of interest and understand basic self-management techniques.

Care Managers’ specific activities may include:

- Education and coaching specific to referral from Complex Case Manager/Provider
- Referrals to Complex Case Managers if member’s degree of risk is more complex
- Arranging education and/or classes as needed
- Assisting with scheduling appointments
- Promoting access to other population-based services such as transportation and NURSEon-call
- Promotes preventive care visits
- Following up with members after receiving emergency room notification
Complex Case Management (High Risk)— Members receive all low-level interventions, AND frequent contact with assigned Complex Case Manager.

Complex Case Managers’ specific activities may include:

- Member-specific care plan development that includes measurable and defined milestones to assess members’ progress and clearly define accountability and responsibilities
- Coordinating care with providers involved in members’ care and including them in the development and execution of the care plan
- Periodically reviewing care plans to adjust for progress or barriers
- Ensuring follow-up with specialists, if appropriate
- Consulting with a clinical pharmacist resource for support in making recommendations to prescribers when medications are not consistent with guidelines and member is unable to gain control of symptoms
- Arranging home health visit(s) or education as needed
- Conducting detailed education appropriate for stage of disease
- Assisting in member transitions from inpatient to ambulatory care
- Conducting care conferences with the member and providers as needed
- Assisting with scheduling appointments
- Following up with members after receiving emergency room notification Right Choices Program management if applicable

MDwise may periodically adjust the intervention plan as member needs change or new knowledge about interventions develops.

Indicators are established as a mechanism to determine when members have achieved the maximum benefit from their level of intervention and should therefore transition to a lower level of intervention. A transition plan is developed to ensure that members continue with their self-management activities. Changes identified in members’ risks will result in notification to the Care Manager or Complex Case Manager and disease management services may be resumed.

**Short-Term Placements in Less Acute Settings**

Arrangements for MDwise members to receive services in a nursing, rehab, or long-term care facility on a short-term basis is a care option if this setting, as evaluated through the discharge planning process, is the most appropriate setting than other options for the member to obtain the care and services needed.

Disease Management staff is responsible for monitoring the member’s care during the stay in the nursing facility and coordinating discharge planning. A member requiring longer-term nursing facility placement will be disenrolled from Hoosier Care Connect and placed into the fee for service Traditional Medicaid plan. Eligibility and placement in a nursing home is handled with the assistance of the AAA and IndianaOptions. The member’s assigned care manager also works with the aforementioned agencies in order to assure the best care setting is achieved.
Discharge Planning

MDwise implements procedures to ensure that members are evaluated for necessary clinical and support services to meet their needs. The intent of the process is that members are safely placed in the most appropriate and least restrictive setting with the necessary services. As such, our plan development process begins with an assessment of each of the four domains of care – medical psychological, social and functional – to insure that the plan addresses the comprehensive needs of our members.

The collaborative partnership between the PMP and the medical management/care manager, and the Medical Management staff/Care management team interactions and discharge plan development with other health providers, family members/caregivers, and other service providers, community support agencies, and MDwise care advocates, enable us to promote and achieve objectives of timely, effective discharge planning, providing the most appropriate services in the most appropriate setting along the continuum of care.

The MDwise Care Manager will keep you informed of the progress of the discharge planning process for your MDwise Hoosier Care Connect member and, ongoing once implemented.

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, community based providers and member’s history using claim, authorization and assessment information available.

MDwise Hoosier Care Connect will work with you and the facility discharge planners and other appropriate health care staff to identify potential candidates for referral to IndianaOPTIONS. For those members being evaluated for transition into or out of a nursing home, MDwise and the Area Agencies on Aging (AAAs) will work together to ensure that each individual is fully aware of his/her care alternatives through IndianaOPTIONS and that the member is directed to an environment that can optimize the member’s quality of life in the most appropriate setting.

Please Note: Contact the care management staff to alert them to patients with potential discharge needs. The care 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.

Coordination of Medical and Behavioral Health Care

MDwise promotes integration of behavioral health services with medical care in all of our IHCP Programs, which provides a holistic approach to meeting the member’s needs. 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, and integrated care management for members with physical and behavioral health care 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.

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 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, referrals from providers. 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 care managers regarding coordination of physical and behavioral health care.

• Integrating behavioral health initiatives (i.e. depression) within the disease management and care management process so that 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).

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

• Promoting care management and coordination of MDwise Hoosier Care Connect members with both behavioral and physical needs through the assignment of an experienced behavioral health Care Manager with the responsibility for the development, and implementation of an integrated, coordinated, member-focused plan of care accessible to the medical and behavioral health providers and conducting care conferences.

**Informing and Educating Providers**

Disease management supports the practitioner-member relationship and plan of care. MDwise provides practitioners with verbal and/or 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

• Explanation of how the Care Management Staff work with PMPs and their members in the program

• Procedures for PMPs receiving updates regarding members’ progress meeting their self-management goals, modifying care plans, and determining the appropriate time to transition members to a lower risk group

• Information regarding the PMP’s patients who have been identified as having a specific condition of interest and their specific health data profiles

• Patients who have been contacted and agreed to participate in program. Patients may opt out of participating in disease management programs.
Chapter 13 - 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 Hoosier Care Connect program.

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 Inc. is responsible for the development, maintenance, and coordination of a comprehensive behavioral health network which is clinically aligned with the overall needs of our member population. MDwise also provides 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. The network includes a variety of provider types and settings to meet the needs of this diverse Hoosier Care Connect population.

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 the Hoosier Care Connect program, 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. Hoosier Care Connect members who receive services through Hoosier Care Connect are also eligible for State of Indiana funded services such as Medicaid Rehabilitation Option services providing wrap around community care for individuals meeting appropriate levels of need. These are described below.

**Behavioral Health Care Benefits**

Please refer to the Hoosier Care Connect Benefit Overview Chapters for information about mental health covered benefits. Covered behavioral health services generally include the following services. The services are covered according to the member’s benefit package:

- Inpatient psychiatric services
- Emergency/crisis services
- Alcohol and drug abuse services (substance abuse)
- Behavioral health care management
- 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 and 1915(i) Services**

As outlined is Chapter 3 & 4, Mental Health Rehabilitation Option (MRO) services and 1915(i) home and community based services are “carved-out” of the Hoosier Care Connect program and are not the responsibility of MDwise. 1915(i) services include Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health and Habilitation (AMHH) and Children’s Mental Health Wraparound (CMHW). 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. Prior authorization for these services is handled by Advantage. 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).
services and 1915(i) services are restricted to those provided through designated Community Mental Health Centers (CMHCs), as approved by the Family and Social Services Administration, Division of Mental Health.

**Please Note:** Even though MRO and 1915(i) services are carved out of MDwise’s prior authorization responsibilities, MDwise is responsible for coordinating care and follow-up treatment for our Hoosier Care Connect members who are receiving these services. CMHCs can view the MRO Provider Manual at www.indianamedicaid.com. The MDwise care management unit is available to assist members in coordinating on-going services.

**Behavioral Health Care Referrals**

MDwise Hoosier Care Connect members may self-refer to any IHCP behavioral health providers enrolled in the MDwise Behavioral Health Network for behavioral health care services. This includes psychiatrists, psychologists, and mid-level providers such as social workers and clinical nurse specialists. (Please refer to page 1 of this chapter for a complete list). Members may self refer to any IHCP enrolled psychiatrist.

**PMP Referrals**

PMPs should refer members who may be in need of behavioral health services 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 a MDwise member calls this number during regular business hours, a trained Customer Service Representative will answer the call. The Customer Service Representative will ask a few brief questions in order to locate the right therapist or doctor to meet your patient’s needs. However, if your patient is having a more serious problem the Customer Service Representative will connect the member with an appropriate professional.
**Please Note:** If you have questions or concerns regarding the availability of behavioral health services for your patients, please contact the MDwise Customer Service Line. You may also call the MDwise Behavioral Health Manager to discuss any concerns that you have.

**Member Referral**

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

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

**Behavioral Health Care Authorization**

**Prior Authorization Requirements**

A member may self-refer to any MDwise contracted provider or IHCP psychiatrist for behavioral health care services. For outpatient therapy services, prior authorization is not required for individual therapy, family therapy or group therapy. Medication management services also do not require prior authorization. Psychological Testing, Intensive Outpatient Therapy, Partial Hospitalization, ECT, TMS, Vagus Nerve Stimulation, and Inpatient services will still require Prior Authorization. Out of Network providers are required to obtain Prior Authorization for all services. For Hoosier Care Connect, providers need to use the Universal Prior Authorization form that is available on the MDwise Website. Along with the form, please submit a current treatment plan, signed by the supervising MD or HSPP and progress notes indicating necessity and effectiveness of treatment.

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. Complete the 1261A form within 14 days of phone authorization to ensure that authorization is made. In the event of life threatening emergencies, prior authorization is not needed. However, a retrospective or post-service medical necessity review may be made for determination of payment.

Please refer to the Behavioral Health Prior Authorization Quick Reference Guide for information on how to submit the forms. Submission is available via fax, the web and by mail.

**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.

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.

**Behavioral and Physical Health Coordination**

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

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

• Education of members about behavioral health services and importance of communicating with their PMP about the services they receive;

• Identification of member cases requiring coordinated physical and behavioral health plan (e.g. through data analysis related to medical and behavioral treatment use, screening through health assessments, member or provider referrals);

• Providing periodic member specific service utilization reports to providers/ behavioral health-medical profiles;
• Informing providers of members receiving emergency and inpatient behavioral health or substance abuse services and follow-up care;
• Communication between medical and behavioral health Case Managers;
• Screening mechanisms to identify members with coexisting medical and behavioral disorders, including substance abuse;
• Implementation of primary care guidelines for treating or making referrals for treatment of problems and primary or secondary preventive behavioral health programs;
• Medical record audits to confirm communication among medical and behavioral health providers;
• Collaborative disease management programs; and
• 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. The Indiana FSSA supports the following types of information sharing:

• Provider shall cooperate with 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 the content of psychotherapy notes as well as 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 by incorporating behavioral, medical and social needs
- 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. 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.

All members who have had an inpatient admission for a behavioral or substance abuse/dependence condition are required to be enrolled in care management for 90 days following discharge. The care management must be arranged and/or coordinated with the member’s delivery system. The member may be moved to a lower level of disease management (e.g. case or population management) only after the 90 days has been completed.

**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**

Behavioral health access standards are outlined in the following table:

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>APPOINTMENT TIME FRAME</th>
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<tbody>
<tr>
<td><strong>Emergency Services</strong></td>
<td>Emergency Services must be available 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td><strong>Urgent</strong> – 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><strong>Emergent-Members who have a non-life threatening emergency</strong></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><strong>Routine</strong> – Members seeking outpatient services who present no evidence of suicidal or homicidal ideation, psychosis, and/or significant distress.</td>
<td>Routine assessments should occur within 10 business days of the request for service.</td>
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Chapter 14 - Pharmacy Services for Hoosier Care Connect Members

The Pharmacy Benefit for the Hoosier Care Connect Program is administered by MedImpact for MDwise under the review of the State of Indiana, Office of Medicaid Policy and Planning. 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 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 MDwise Preferred Drug List (PDL) when determining prescribing options for the treatment of medical conditions presented in Hoosier Care Connect members. The State’s pharmacy benefit includes coverage of certain over-the-counter drugs that are listed on the MDwise OTC Drug Formulary. Prescribing providers should refer to the most current versions of the PDL and OTC Drug Formulary on MDwise’s website at www.mdwise.org.

While the State’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; erectile dysfunction drug; fertility enhancement drug, or a drug prescribed solely or primarily for cosmetic purposes

Preferred Drug List

The pharmacy benefit includes coverage of most legend drugs and certain over-the-counter drugs that are listed on the MDwise PDL/OTC Formulary. Prescribing providers should refer to the most current version found on the MDwise website at www.mdwise.org.

MDwise’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 Hoosier Care Connect members are covered by the program, rendered in accordance with pharmacy practice law and all other applicable laws, and do not exceed any established program limits. Payments that may result from a pharmacy provider’s failure to exercise due diligence in this regard are subject to recoupment.
Prior Authorization

Information about authorization requirements for drugs requiring PA can be found at www.mdwise.org/providers, or by calling the MedImpact Clinical Call Center at 1-800-788-2949. PA request forms are available at www.mdwise.org.

Certain drug products and therapeutic classes may have clinical edits applied to them that are adjudicated through a set of automated rules.

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
- 30-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 MedImpact Clinical Call Center at 1-800-788-2949. 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 MedImpact Clinical Call Center at 1-800-788-2949.

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 in addition to the statutory requirement for the words “brand medically necessary” to appear on the prescription. Once each of these steps are complete, pharmacies should submit a dispense code of ‘6’ or ‘9.’

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 MDwise pharmacy claims processor, MedImpact.

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 MDwise.
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”.

90-Day Supply for Maintenance Medications

Drugs that are designated and maintenance medications are limited in quantity per claim to no more than a 90-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 30-day supply per claim.

Tamper Resistant Prescription Pads

Prescribers must use Tamper Resistant Prescription Pads (TRPPs), when ordering pharmacy benefit services for Hoosier Care Connect 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 Hoosier Care Connect members.

Drug Copayment

Members in the Hoosier Care Connect Program are not required to pay a copayment for legend and non-legend drugs and insulins which are covered under the Program.
Chapter 15 - Preventive Health and Practice Guidelines

Health Care Decisions for Preventive Health and Clinical Services

To deliver the best care, obtain optimal outcomes and maintain a healthy state for members, MDwise believes it is essential to maintain an emphasis on prevention-related health services. Obtaining regular preventive care services enables early detection, diagnosis, and treatment of health problems before they become more complex and their treatment more costly.

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 national 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.

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.

MDwise notifies practitioners of approved new and/or revised preventive health guidelines and clinical practice guidelines. Guidelines are distributed to 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, and specific programs developed to improve knowledge about the importance of immunizations and well-care and 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.

Please Note: Refer to Chapter 21 Member Outreach and Education for more information regarding MDwise Outreach and Education Programs.

Members identified for disease management programs (i.e. Asthma, Diabetes, Congestive Heart Failure, Chronic Kidney Disease, Hypertension, SMI, Depression and SED) are contacted by the Disease Manager working with members. 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 Disease Management Chapter for more information regarding disease management activities.

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.
Chapter 16 - Quality Improvement

MDwise is committed to pursuing opportunities for improvement of MDwise 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, including the development and monitoring of key performance indicators and quality activities.
- 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 Hoosier Care Connect 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, MDwise key indicators, and those measures directed by FSSA, are the primary mechanisms through which quality monitoring is reported. Key indicators are objective, measurable indicators that encompass the scope of health plan administration, services and care provided by MDwise.
- 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 participating providers and care partners in the development, coordination, and evaluation of QI activities that promote the quality and safety of clinical care and service to MDwise members.

Confidentiality

Individuals engaged in MDwise QI activities shall 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 HIPPA.
• QI activities will 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 will submit 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, releases 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. Please also contact our Provider Relations staff if you are interested in participating

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 our care partners, 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 Committee including Quality Management Team, Medical Advisory Council and their subcommittees.
• Clinical Policy and Quality Committees.
• Participating in QI Committees and subcommittee meetings and functions.
• Developing, implementing, and evaluating corrective actions.
• Reviewing potential quality issues and reporting/analysis of issues.
• Completing projects within the established time frames and submitting required reports in accordance with MDwise and State requirements.
• Incorporating the Culturally and Linguistically Appropriate Services (CLAS) standards throughout the organization and at all levels of service provision.

Contractually, MDwise agrees to provide the quality reports and updates to FSSA as required, and agrees to participate in focus studies to be determined by the State. The participating providers and care partners, through contractual agreements, agree to cooperate with MDwise QI activities to meet the obligations and the standards under the terms of the State contract and in implementing the components of the MDwise Quality Improvement Program.
QI Program Scope

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 the Hoosier Care Connect program to MDwise members.
- The MDwise QI Program actively involves the providers and care partners with emphasis on a collaborative and multidisciplinary approach to coordinate opportunities for improvement including accurate data submission, improvement interventions, and systems change.
- QI initiatives include the integration of behavioral health and physical health care and service quality improvement initiatives to promote and sustain improved coordination of care for members with behavioral health care needs.
- Effective care coordination and information sharing programs are implemented to integrate all health services enabling a more holistic approach to maximizing member function and independence while also recognizing their right to self-determination. MDwise supports members in taking responsibility for their health and health care, for example, by providing education, case management monitoring, disease management interventions, motivating improved treatment compliance, and access to preventive care services.

QI Program Goals

The overall goals of the MDwise QI Program are:

- To demonstrate measurable and meaningful improvements in physical and behavioral health, functional status, service delivery, access to care, quality of life and member satisfaction.
- To enhance the value of MDwise's services through the implementation of evidence-based practices, integration of clinical and behavioral health, care management/care coordination, and cost-effective service delivery.
- To implement ongoing health promotion, disease prevention and disease management activities that reinforce the medical home and reduce avoidable ER and hospitalizations.
- To tailor benefits to the individual’s and population’s needs through care management, care coordination and community integration.
- Promote safe and effective health care services through ongoing review of clinical appropriateness and outcomes of care, and through provider/member education and feedback.
- To promote member autonomy, and accountability.
- To partner with medical and service providers, social agencies and community groups, governmental divisions/departments, members and member advocates in support of holistic, integrated care.
- To promote culturally competent care and comply with the CLAS Standards established by the Department of Health and Human Services.

QI Program Oversight

The MDwise Board of Directors has the authority and responsibility for the MDwise QI Program within the organization and retains the overall accountability for the QI Program. The MDwise 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 QI Program Authority and Responsibility and Committee(s) structure, role and functions are further described in the MDwise Quality Improvement Program document.

**QI Program Approach and Implementation**

QI Program objectives are supported through a coordinated plan involving MDwise administrative staff responsible for medical management, quality improvement, member services and provider relations staff, local practitioners, pharmacists, clinicians, and community health care leaders.

MDwise providers and care partners participate in the development and implementation of MDwise QI initiatives that are based on the needs of the MDwise membership and as required by OMPP. Input and participation is solicited through our quality committee structure.

MDwise requires the MDwise partners and participating providers to cooperate with MDwise QI activities, maintain the confidentiality of member information and records, and allow MDwise access to data and medical records to be in compliance with QI Program elements and MDwise and state contract obligations to the extent permitted by state law. Activities shall demonstrate compliance to the MDwise QI Program components and policies and procedures and applicable regulatory and accrediting organization standards.

QI Program objectives are supported through a coordinated plan involving MDwise and partner staff that includes Medical Directors or associate Medical Directors, administrative staff responsible for medical management, quality improvement, member services and provider relations, local practitioners, pharmacists and clinicians and community health care leaders. Contracted systems agree to comply with MDwise policies and procedures and MDwise and state data collection and reporting requirements. The MDwise Chief Medical Officer or designee coordinates and oversees relationships with the partners to maximize their commitment and cooperation in meeting MDwise objectives.

The results of MDwise quality monitors and initiatives are reported through the applicable committees to the Quality Committee for comment and recommendations. The MDwise participating Hoosier Care Connect providers and care partners are informed of findings and recommendations, which may illustrate organization-wide, or provider specific findings.

**QI Program Activities/Initiatives**

Quality study initiatives, relevant to the MDwise membership and in compliance with OMPP 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.

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 contract requirements set forth by FSSA, and include:

• Identification and monitoring of key clinical and service activities
• Measurement, intervention and follow-up activities
• Evaluation of effectiveness of program 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 Satisfaction
• Member Incentive and Provider Pay for Performance Programs
• Health Information Technology and Data Sharing
• Health Management (including chronic care, care management, disease management, and special health care needs assessment and management)
• Clinical Practice Guidelines
• HEDIS Measures and reporting
• Member and Provider Customer Service
• Member Education and Outreach Programs
• Provider Education and Management Activities
• Clinical Care and Service Safety
• Network Development, Practitioner/Provider contracting/CLAS activities

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 FSSA. 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 and pharmacy utilization analysis, care management, disease management, access, and transportation. In addition, other health plan functional service area monitors include but are not limited to enrollment, provider access, customer service, member and provider complaints/disputes, grievances and appeals, financials, network development, and reporting.

Performance measure 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 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 provider and partner 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 resulting outcomes by interventions implemented by MDwise, MDwise providers, and or MDwise care partners are shared on an organization wide basis.

**HEDIS (Healthcare Effectiveness Data and Information Sets)**

MDwise collects data to complete the annual HEDIS report. Results from the annual HEDIS report 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 at its claims (or encounter) data.

*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.

**Clinical Practice Guidelines**

The MDwise Medical Advisory Council 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 FSSA 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

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 Note: Refer to the Appendix for further information regarding the practice and preventive health guidelines. The Appendix also contains information about the Vaccines for Children Program and CHIRP.

Potential Quality Concerns/Issues

Potential quality care and service concerns are appropriately researched and evaluated consistently using MDwise’s documented quality 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 Director 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 QI Manager 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 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 FSSA and applicable accrediting organizations.
Provider access standards include access to regular routine care appointments, 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 member satisfaction surveys, access or office site surveys, analysis of practitioner complaints in arranging referrals to specialists or other providers/ancillaries, complaints and grievances, emergency services claims/records analysis, and telephone system audits. Provider self-reports of appointment and in-office waiting times are monitored and supplemented by random calls or audits. The assessment provides data on organization-wide and practice-specific performance. Results provide the opportunity to develop actions as appropriate to findings.

Provider Performance Feedback

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

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

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

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

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

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

**Member and Provider Satisfaction**

MDwise may periodically conduct a member satisfaction survey through a contracted external research organization. The purpose of is to evaluate members satisfaction and identify opportunities for improvements. The survey measures member satisfaction with the MDwise health plan and the health care services provided. 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 may participate in 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.

MDwise also tracks key performance indicators to monitor service levels and as a result can quickly identify areas requiring interventions for improvements or best practices to continue or implement in other areas.

**Please Note:** MDwise member and provider survey results and planned interventions indicated, will be published in the provider newsletter.
Chapter 17 – Transportation Services

Non-Emergent Transportation

Hoosier Care Connect covers non-emergent medical transportation to doctor and dentist appointments for MDwise Hoosier Care Connect members. Non-emergent medical transportation is defined as a ride, or reimbursement for a ride, provided so that a MDwise member with no other transportation resources can receive services from a medical provider. By definition, non-emergent medical transportation does not include transportation provided on an emergent basis, such as trips to the emergency room in life-threatening situations. Non-emergent medical transportation services are to be provided in the most cost effective manner that can be identified that meets the medical needs of the member.

Transportation Considerations

Members in Hoosier Care Connect are covered for 20 one-way trips per rolling calendar year.

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

Transportation is not provided to pharmacies or for visits for medical services not covered by Medicaid.

Transportation Reservations

Although members may schedule transportation visits up to two (2) business days in advance of a scheduled appointment, members are encouraged to contact MDwise Transportation when their appointment is set, so the appropriate transportation can be scheduled.

The member’s PMP or PMP office staff may call to arrange for same day transportation if a member needs urgent care. If a member calls MDwise Transportation to set up urgent transportation, a MDwise Transportation agent will call the PMP office to verify that it is an urgent visit.

If you would like to assist a member in arranging transportation, you may call (800) 356-1204 or (317) 630-2831 (Indianapolis area) and follow the appropriate IVR prompts to access a MDwise Transportation agent. Please inform the agent that you are calling from a medical office and you are assisting the member in scheduling transportation.

Prior Authorization (PA) for Transportation Services

Transportation is limited to 20 one-way trips per member, per rolling calendar year. If a member needs PA for transportation, they must call at least two (2) working days before the service is needed. This gives the MDwise Transportation Specialist time to get the required authorization from the appropriate medical management department.

If a PA is required, it will be created by a MDwise Transportation Specialist at the time of the transportation request. A MDwise Transportation Specialist will forward the PA to the appropriate medical management team for review. The MDwise Transportation Specialist will schedule the transportation if the PA is approved or will contact the member if the PA is denied.
Certain transportation services that require prior authorization are:

- 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 (see below).
- Trips of fifty (50) miles or more one way

Prior authorization for transportation services beyond the 20-trip limit are automatically granted for trips for medically necessary services. Upon verification of a scheduled visit/service, a MDwise Transportation Specialist can authorize certain transportation requests.

Certain transportation services that do not require prior authorization and are exempt from the twenty (20) trip limit are:

- PMP Visits and Prenatal Care Visits
- After Hours Services
- Cancer Therapy
- Renal Dialysis
- Emergency Room– Non-Ambulance

**Emergent Transportation**

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). Indiana Medicaid 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.
Chapter 18 - 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 personalized with their doctor’s name, phone and hospital information (arrives two weeks after the handbook)
- Information on how to obtain a MDwise Provider Directory

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.” However, this may enhance our ability to reach all new members within the first 30 days to complete a health needs screener and confirm or assist in PMP selection. The call also gives MDwise staff the opportunity to help ensure that the member is linked to any targeted or enhanced services that may be of benefit, to identify any special needs of new members, and to educate them on the importance of scheduling an appointment to see their PMP within 90 days.

Toll-Free Member Phone Line
MDwise has a toll-free customer service telephone line to assist members with any questions they have about MDwise or their health care coverage. Members are also encouraged to call this toll-free line with any complaints or concerns they may have. MDwise CSRs are available from 8:00 a.m. to 8:00 p.m. Monday through Friday, Eastern 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 produced quarterly (in both English and Spanish) and includes information about timely health topics, preventive health services, new program information, inquiry and grievance procedures, MDwise policies, and special children’s features (Ms. Bluebelle club for kids). The newsletter is 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 Marketing Department.

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**

Speak with a nurse 24 hours a day

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) and select option 3.

**BLUEBELLE beginnings**

Give your newborn a healthy start

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 prenatal assessment (in addition to care management assessment) conducted by MDwise Customer Service. 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 prenatal 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 BLUEBELLE beginnings, 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.

The Ms. Bluebelle club for kids offers special activities and mailings that teach kids to make healthy choices. Ms. Bluebelle has a special kids page in every member newsletter. This page delivers a health message just for kids, along with a fun game or puzzle. 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 and selecting option #4.

MDwise members get free rides to and from doctor’s visits. More about the transportation benefit is provided in Chapter 18.

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, in the SMOKE-free program members may be linked with a smoking cessation class offered through MDwise, Inc. The program also informs members that many smoking cessation aids such as nicotine gum and patches, as well as bupropion (WELLBUTRIN) are covered.

WEIGHTwise is a nutrition and exercise resource. MDwise members are provided with access to important information on eating right and being active. In the WEIGHTwise program, kids can color fun pages about fruits and vegetables. Teens can take a quiz on food portions and adults can use a health calculator to check their body mass. 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. 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 WELLNESS chat at your office or clinic site, please call the MDwise Outreach Department and this can be arranged.

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.

**Emergency Room Use**

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, disease management may be initiated to avoid future medical or behavioral health crises resulting in an ER visit. MDwise will identify case-by-case emergency treatment options for all appropriate members with high ER utilization. Emergency treatment plans will include:

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

Additionally, through our Reach Out for Quality 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>Frequent ER Visitors</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 then 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</td>
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### ER Initiative | Description
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**Physician profiling** | 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.

**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 MDwise, Inc provider relations representatives if you would like a supply of these brochures to distribute.
Reach Out and Read (ROR) Program

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 to 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 77 sites in 2010. The Executive Director’s office is located at MDwise.

Please Note: Reach out and Read (ROR) is currently offered to members at approximately 77 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 317-630-2831

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 relation’s 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 network providers
- Behavior that presents a security risk to others
- Consistently not following medical recommendations in a manner that endangers the members health
- Utilization patterns of controlled substances

Upon receipt of a request for member intervention, a MDwise Health Advocate or Care Manager 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 care advocate/care 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 web site 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.

MDwise Website
The MDwise website is an important source of information for MDwise members and families. Some of the information currently found at MDwise.org includes: new member information, MDwise contact information, member rights and responsibilities, privacy policies, how to access transportation and medical care, participating pharmacies, MDwise Member Handbook, MDwise member newsletters, Ms. Bluebelle club activities, and information related to MDwise outreach and education programs and appropriate use of the emergency room.

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 the CryaCom Language Line 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. These representatives are available to assist Spanish-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 (3% of membership) who do not speak English as their native language. Currently all member materials are produced in both English and Spanish.

**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 11: 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 a MDwise member advocate please call 317-630-2831 (Indianapolis Area) or 1-800-356-1204.

**Agency and Community Service Providers**

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.

**About Special Kids! ASK: 1-800-964-4746**

[http://www.aboutspecialkids.org](http://www.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: 1-800-441-7837 (STEP)**

[http://www.in.gov/fssa/first_step/](http://www.in.gov/fssa/first_step/)

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
http://www.in.gov/isdh/programs/cshcs/

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.

**Linking Members with Additional Community Resources**

When new members call to activate their “extra benefits,” they will be asked about any special services they might need. MDwise will attempt to provide members with information on community resources that may address identified needs. In addition, special needs information will be sent to the member’s PMP so the PMP can provide specialized services as needed.

**MDwise Health Advocates**

MDwise also has staff that can assist members with difficult issues or finding other services, like a parent support group. The Member Advocates can help if the member needs suggestions or information about other services available in their community.

**Please Note:** Access to Member 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 Member Advocate who can answer questions about health and community services, as well as family issues or other concerns. More about the MDwise Member Advocate program is provided in the Member Outreach and Education Chapter.

**Coordinating Care for Members with Special Health Needs**

MDwise has also established procedures to identify MDwise members with special needs or at-risk members and to 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. All calls where special needs are identified receive a follow-up call by a MDwise Member Advocate to evaluate the special needs and either work with the member directly or refer the member for a case management evaluation.

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 Member Advocates, MDwise 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 Member Advocates as care plans are developed and implemented.

**Please Note:** Contact the MDwise Member Advocates to refer your members that have special health care needs and may need additional assistance.
Chapter 19 - Member Rights and Responsibilities

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.

Member Rights

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, and doctors.

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.

**Member Responsibilities**

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.
Chapter 20 - Member Grievance and Appeals

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, TTY/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.

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 MCO 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. 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.
Urgent Grievances must be resolved within 48 hours. A MDwise representative must contact the member with a resolution within that time frame.

**Appeals**

All prior authorization appeals must be filed at the address or telephone number listed below:

**MDwise Inc.**  
**Attn: Appeals**  
**PO Box 44236**  
**Indianapolis, IN 46244-0236**  
**1-800-356-1204**

The term *appeal* is defined as a request for review of an action. 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.

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 must respond 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 we are 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. The member receives a 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 FSSA 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.
Levels of further appeal resolution 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.

External Review

- 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 120 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.

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 33 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.

Office of Hearings and Appeals
402 West Washington, Room W392
Indianapolis, IN 46204

Please Note: At all levels of the grievance and appeal process, MDwise allows the member the opportunity for representation by anyone he or she chooses, including an attorney or provider. Members
are also offered the opportunity to send notes, medical records or other documents that will help in the review.
Chapter 21 - 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.

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 and the State, will collaborate to create a medical home for RCP members. The RCP encourages 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 Note: Please expect that a MDwise care manager will outreach to you in consultation for identified members. Your input and participation are valuable to the enrollment process.

Members that qualify are eligible for a two to five year lock-in to one Primary Care Physician (PCP), 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 restricted benefits.

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 outside of the PMP medical home 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. Referrals are good for the period specified by the PCP or for the term of the restriction, whichever is less.
Referral requirements

- The PCP 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 restricted, 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 Restricted Card 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.

**MDwise Right Choices 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 restricted 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

For MDwise Hoosier Care Connect Members:
1-800-356-1204
Chapter 22 - Dental Services

The Dental Benefit for the MDwise Hoosier Care Connect Program is administered by DentaQuest.

DentaQuest Eligibility Systems

Participating Providers may access Member eligibility information through DentaQuest’s Interactive Voice Response (IVR) system or through the “Providers Only” section of DentaQuest’s website at www.dentaquest.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest’s Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

Access to eligibility information via the Internet

DentaQuest’s Internet currently allows Providers to verify a Member’s eligibility as well as submit claims directly to DentaQuest. You can verify the Member’s eligibility on-line by entering the Member’s date of birth, the expected date of service and the Member’s identification number or last name and first initial. To access the eligibility information via DentaQuest’s website, simply log on to the website at www.dentaquest.com. Once you have entered the website, click on “Dentist”. From there choose your ‘State” and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest’s Customer Service Department at 855.398.8411. Once logged in, select “eligibility look up” and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest’s Customer Service Department at 855.398.8411 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member by entering your 6 digit DentaQuest location number, the Member’s recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient’s eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

The health plan eligibility phone number for patients assigned to MDwise is:

844.231.8310
Dental Treatment Requiring Authorization

Authorization is a utilization tool that requires Participating Providers to submit “documentation” associated with certain dental services for a Member. Participating Providers will not be paid if this “documentation” is not provided to DentaQuest.

Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest’s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria section). Please review these criteria as well as the Benefits covered to understand the decision making process used to determine payment for services rendered.

Authorization and documentation submitted before treatment begins (Non-emergency) treatment.

Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Member, the Plan and/or DentaQuest.

Your submission of “documentation” should include:

- Radiographs, narrative, or other information where requested (See Exhibits for specifics by code)
- CDT codes on the claim form

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits) contain a column marked Authorization Required. A “Yes” in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

After the DentaQuest dental director reviews the documentation, the submitting office shall be provided an authorization number. The authorization number will be provided within two business days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

Submitting Authorization Requests and X-Rays

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the “Learn More” button. To register, click the “Provider Registration” button in the middle of the home page.
• Submission of duplicate radiographs (which we will recycle and not return)
• Submission of original radiographs with a self addressed stamped envelope (SASE) so that we may return the original radiographs.

Note that determinations will be sent separately and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs be mounted when there are 5 or more radiographs submitted at one time. If 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2006 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:
• Radiographs duplicated and displayed in proper order on a piece of duplicating film.
• Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:
• Cut out radiographs taped or stapled together.
• Cut out radiographs placed in a coin envelope.
• Multiple radiographs placed in the same slot of a radiograph holder or mount.

All radiographs should include member’s name, identification number and office name to ensure proper handling.

Authorization and documentation submitted with claim (Emergency treatment)
DentaQuest recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations services that require authorization, but are rendered under emergency conditions, will require the same “documentation” be provided with the claim when the claim is sent for payment. It is essential that the Participating Provider understand that claims sent without this “documentation” will be denied.

Payment for Non-Covered Services
Participating Providers shall hold Members, DentaQuest, Plan and Agency harmless for the payment of non-Covered Services except as provided in this paragraph. Provider may bill a Member for non-Covered Services if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:
• The services to be provided;
• DentaQuest, Plan and Agency will not pay for or be liable for said services; and
• Member will be financially liable for such services.
**Electronic Attachments**

DentaQuest accepts dental radiographs electronically via FastAttach™ for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to [www.nea-fast.com](http://www.nea-fast.com) or call NEA at: 800.782.5150

**Dispute Resolution /Provider Appeals Procedure**

Participating Providers that disagree with determinations made by the DentaQuest dental directors may submit a written Notice of Appeal to DentaQuest that specifies the nature and rationale of the disagreement. This notice and additional support information must be sent to DentaQuest within 60 days from the date of the original determination to be reconsidered by DentaQuest’s Peer Review Committee.

**DentaQuest, LLC**  
**Attention: Utilization Management/Provider Appeals**  
**12121 N. Corporate Parkway**  
**Mequon, WI 53092**

All notices received shall be submitted to DentaQuest’s Peer Review Committee for review and reconsideration. The Committee will respond in writing with its decision to the Provider.

**Participating Hospitals**

Upon approval, Participating Providers are required to administer services at Plan’s participating hospitals. Provider should submit services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Provider should contact the plan below for facility authorization at the number below.

**MDwise: 844.231.8310**

Participating Hospitals may change. Please contact plan for current listing.

**Claim Submission Procedures (claim filing options)**

DentaQuest receives dental claims in four possible formats. These formats include:

- Electronic claims via DentaQuest’s website ([www.dentaquest.com](http://www.dentaquest.com)).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims.
Submitting Authorization or Claims with X-Rays

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the “Learn More” button. To register, click the “Provider Registration” button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs be mounted when there are 5 or more radiographs submitted at one time. If 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2006 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:
- Radiographs duplicated and displayed in proper order on a piece of duplicating film.
- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:
- Cut out radiographs taped or stapled together.
- Cut out radiographs placed in a coin envelope.
- Multiple radiographs placed in the same slot of a radiograph holder or mount.

All radiographs should include member’s name, identification number and office name to ensure proper handling.

Electronic Claim Submission Utilizing DentaQuest’s Internet Website

Participating Providers may submit claims directly to DentaQuest by utilizing the “Dentist” section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member’s eligibility prior to providing the service.

To submit claims via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the “Dentist” icon. From there choose your ‘State” and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest’s Customer Service Department at 855.398.8411. Once logged in, select “Claims/Pre-Authorizations” and then “Dental Claim Entry“. The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you have questions on submitting claims or accessing the website, please contact our Systems
Electronic Authorization Submission Utilizing DentaQuest’s Internet Website

Participating Providers may submit Pre-Authorizations directly to DentaQuest by utilizing the “Dentist” section of our website. Submitting Pre-Authorizations via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member’s eligibility prior to providing the service.

To submit pre-authorizations via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the “Dentist” icon. From there choose your “State” and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest’s Customer Service Department at the numbers below:

MDwise: 844.231.8310

Once logged in, select “Claims/Pre-Authorizations” and then “Dental Pre-Auth Entry”.

The Dentist Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the pre-authorization.

Electronic Claim Submission via Clearinghouse
DentaQuest works directly with Emdeon (1-888-255-7293), Tesia 1-800-724-7240, EDI Health Group 1-800-576-6412, Secure EDI 1-877-466-9656 and Mercury Data Exchange 1-866-633-1090, for claim submissions to DentaQuest.

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest’s Payor ID is CX014.

HIPAA Compliant 837D File
For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider’s practice management system. Please email EDITeam@dentaquest.com to inquire about this option for electronic claim submission.
NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest.

- Providers must register for the appropriate NPI classification at the following website [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependant upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI’s. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable provider signature.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist’s name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.
- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist’s NPI is entered in field 54 and the billing entity’s NPI is entered in field 49.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
• List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (ex Extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

• Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

DENTAQUEST of Indiana, LLC-Claims
12121 N. Corporate Parkway
Mequon, WI 53092

Coordination of Benefits (COB)
When DentaQuest is the secondary insurance carrier, a copy of the primary carrier’s Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier’s payment meets or exceeds a provider’s contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

Filing Limits
Each provider contract specifies a specific timeframe after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the timely filing limit specified in the contract will be denied for “untimely filing.” If a claim is denied for “untimely filing”, the provider cannot bill the member. If DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

DentaQuest Address and Telephone Numbers:
Provider Services
12121 N. Corporate Parkway
Mequon, WI 53092
855.453.5286

Claims Questions:
denclaims@dentaquest.com

Eligibility or Benefit Questions:
Customer Service/Member Services
12121 N Corporate Parkway
Mequon, WI 53092
denelig.benefits@dentaquest.com
844.231.8310

Hearing Impaired/TTY

MDwise Hoosier Care Connect Provider Manual • Chapter 22: Dental Services -122-
Credentialing
12121 N. Corporate Parkway
Mequon, WI 53092
Credentialing Hotline: 800.233.1468

Authorizations should be sent to:
DENTAQUEST of OH-Authorizations
12121 N. Corporate Parkway
Mequon, WI 53092

Claims should be sent to:
DENTAQUEST of IN-Claims
12121 N. Corporate Parkway
Mequon, WI 53092

Electronic Claims should be sent:
Direct entry on the web
www.dentaquest.com Or,
Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
12121 N Corporate Parkway
Mequon, WI 53092
Appendix A: EPSDT Screening Schedule

To access the Indiana Health Coverage Program (IHCP) manual for EPSDT HealthWatch Early Periodic Screening, Diagnosis, and Treatment Provider Manual, please go to the Indiana Medicaid website: http://provider.indianamedicaid.com/media/23429/epsdt_healthwatch.pdf. The information in this supplemental provider manual is specifically 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 because these efforts can reduce the risk of more costly treatment or hospitalization that can result when detection is delayed. HealthWatch services are available to IHCP members from birth to 21 years old (subject to the limitations of benefit package). EPSDT is a required component of care for Hoosier Care Connect members.

All IHCP-covered preventive and treatment services are provided, as well as other treatment services determined to be medically necessary by the EPSDT screening provider and prior authorized as required.

- 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 Hoosier Care Connect members.
- 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 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 Care Connect.
  - 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 Hoosier Care Connect, 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 EPSDT?
- Any Hoosier Care Connect member under twenty-one (21) years of age may participate in the EPSDT program. MDwise will inform each member about the program in accordance with federal regulations. Participation in EPSDT by MDwise members in Hoosier Care Connect 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 EPSDT screen. Further, any enrolled Medicaid provider may provide EPSDT diagnostic
and/or treatment services within the scope of his or her practice upon referral from the screening provider.

Because 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. To be a HealthWatch provider, the provider must be enrolled in the IHCP and be licensed to perform an unclothed physical exam, as well as perform other components of the HealthWatch screen.

Program Goals
Ensuring that all children in the IHCP receive age-appropriate, comprehensive, preventive services is the primary goal of the HealthWatch/EPSDT program.

The EPSDT program consists of two mutually supportive, operational goals:

- Assuring the availability and accessibility of required health care resources; and
- Helping members and their parents or guardians effectively use these resources.

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.

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 care for participants in the HealthWatch program and for the provider to claim a higher level of reimbursement for EPSDT screens, the following components of the screen must be provided and documented:

- A health and developmental history, including assessment of both physical and mental health development
- An unclothed physical exam
- A nutritional assessment
- A developmental assessment
- Vision observation at each screen and direct referral to an optometrist or ophthalmologist starting when objective screen methods indicate a referral is warranted
- Hearing observation at each screen and objective testing with audiometer at four years, administered or referred
- Dental observation at each screen; direct referral to a dentist starting at 24 months old. Dental referrals may be made as early as 12 months old when indicated.
- Laboratory tests, including blood lead level assessment appropriate for age and risk factors
- Immunizations administered or referred, if needed at time of the screen
- Health education, including anticipatory guidance
Documentation for the HealthWatch screen may be incorporated into the documentation routinely kept for well child check-ups. However, when the patient receives HealthWatch screen components or when the patient is referred elsewhere to receive components, it is imperative that the patient record reflects the components that were given and also the components, if any that were referred elsewhere.

If a child needs more frequent screening than recommended by the periodicity schedule, interperiodic screens may be performed.

**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 1 and 2 years of age.
- Testing all children 3 to 6 years of age, if they have never been tested.

For more information: [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5809a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5809a1.htm)

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.

**Required EPSDT Referrals**
HealthWatch providers are responsible for making the following required referrals at indicated ages or when screening results indicate a problem:

- Dental
- Vision
- Hearing
- Lead screening

**Health Education**
Health education is a required component of screening 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 is designed to assist in understanding what to expect in terms of the child’s/adolescent’s development and to provide information about the benefits of healthy lifestyles and practices as well as 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 provide or coordinate the diagnostic services. 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.

General Billing Information
Indiana no longer requires providers to bill EPSDT screens on a separate EPSDT claim form; however, HealthWatch providers must adhere to EPSDT billing and screening procedures to participate in this program.

To claim the higher rate of reimbursement for EPSDT screens, HealthWatch providers must furnish all components of the EPSDT in accordance with the EPSDT Periodicity and Screening Schedule, document services performed/referred, and include all applicable diagnosis codes (up to four) on the claim form for each EPSDT screening exam.

Specific Billing Procedures
The following billing procedures must be followed to permit correct 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.
- The preventive health diagnosis code, V20.2, as the primary diagnosis.
- Physicians are strongly encouraged to include all applicable diagnosis codes (up to four) and procedure codes on the claim form 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 99381-5, and $62 for codes 99391-5.

Providers must report on the claim form 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 an EPSDT annual exam or well child service, 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.

The IHCP reimburses for all E&M codes billed by a physician who is providing a problem-oriented exam on the same date as the EPSDT annual or well-baby exam. 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 IHCP does not currently require that the charge be reduced, as is required by Medicare. 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.
Appendix B: Medical Records Audit Guidelines

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. Record to reflect services provided directly by PMP, ancillary services and diagnostic tests ordered by PMP and diagnostic and therapeutic service referrals.
10. Requesting records of care received as inpatient (hospital discharge summary), in ER or as outpatient.
11. Providing copy of patient’s medical record upon reasonable request by member at no charge.
12. Facilitating the transfer of patient’s record to another provider at the member’s request.
13. 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.
15. 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 overutilization 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

MDwise 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
   o Sterilized packs are dated for expiration
   o Monthly cleaning/equipment checks are conducted and log maintained
   o Monthly spore counts are performed
E. Cold Sterilization
   o All containers are dated & labeled with name of solution
   o Solution is changed routinely as directed per policies
   o 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 if not, medical emergency protocol in place
3. Emergency cart check conducted regularly and documented

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
4. Radiology
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

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
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
<table>
<thead>
<tr>
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<td>Urgent Care</td>
<td>24 hours/day</td>
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<td>Non-Urgent Symptomatic</td>
<td>72 hours</td>
</tr>
<tr>
<td>Routine Physical Exam</td>
<td>3 months</td>
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<tr>
<td>Routine Preventive Exam</td>
<td>5 weeks</td>
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<tr>
<td>Initial Appointment (Non-pregnant Adult)</td>
<td>3 months</td>
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<tr>
<td>Routine Gynecological Examination</td>
<td>3 months</td>
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<tr>
<td>New Obstetrical Patient</td>
<td>Within 5 business days of attempting to schedule an appointment</td>
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<tr>
<td>Initial Appointment Well Child</td>
<td>Within 1 month of date of assignment notification</td>
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<tr>
<td>Children with Special Health Care Needs</td>
<td>1 month</td>
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6. Number of patients scheduled per hour allows adequate time for patient care
7. Average office-waiting time performance standard in place meets or exceeds MDwise standards (60 minutes)
8. Telephone response procedure indicates that a clear policy is in place for reaching the physician
9. Formal office telephone hours' policy exists and is communicated to the patient
10. Telephone should be answered within four rings or 30 seconds.
11. Length or time it takes to reach a live voice via telephone to schedule an appointment should be less than 3 minutes.
12. Telephone coverage provides ability for member to reach PMP or designee by phone within 30 minutes in an emergency or urgent situation.
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.
Appendix D: HIPAA

Medical Recordkeeping 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

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 web sites:

www.hhs.gov/ocr/hipaa

www.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: CHIRP - Children and Hoosiers Immunization Registry Program

For information regarding CHIRP, please go to the CHIRP website: https://chirp.in.gov/home.jsp

What is CHIRP?
CHIRP is a statewide computer-based system designed to keep track of immunization records of your patients. CHIRP is Internet-based, providing real-time access. Immunization records from multiple providers are consolidated into one comprehensive record.

CHIRP . . .
Provides immediate access to immunization records of new patients previously seen elsewhere
- Decreases staff time spent retrieving immunization records
- Reduces costs: staff time, paperwork and vaccine use
- Flags opportunities to give needed vaccinations
- Provides reminder cards and letters resulting in fewer missed appointments
- Maintains immunization data in a confidential and secure system
- Provides easy access to records needed for school, licensed child care, and HEDIS
- Generates automatic reminders to help keep children’s immunizations on schedule
- Reduces costs (and discomfort to child) of unnecessary duplicate immunizations

CHIRP captures immunization data from all the Indiana Health Departments, from Regenstrief, and from Medicaid claims. Providers are encouraged to sign up for CHIRP for easy web-based access to their patient’s immunization history.

To sign up for CHIRP, check the CHIRP website at https://chirp.in.gov/home.jsp
For more information about CHIRP you can contact:

Indiana State Department of Health
Immunization Program, 6A-22
2 North Meridian Street
Indianapolis, IN 46204
Phone: (888) 227-4439
Fax: (317) 233-8827
Appendix G: Behavioral Health Symptoms Identification

This Behavioral Health Symptom identification tool lists the core diagnostic criteria and associated features of common behavioral health disorders. At a glance, you are able to see unique symptoms for a specific disorder, and clusters of symptoms that overlap from one disorder to another. This tool addresses only the symptoms of behavioral disorders and does not address criteria related to duration and functional impairment. When patients exhibit these symptoms, you should refer the member for behavioral health evaluation and treatment. This tool is not a substitution for seeing a health care provider, and is only to be used to help direct the user toward seeking assistance from a qualified professional.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>ADHD</th>
<th>Major Depressive Episodes</th>
<th>Generalized Anxiety Disorder</th>
<th>Bipolar Manic Episodes</th>
<th>Schizophrenia</th>
<th>Substance Use/Abuse</th>
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<td>Misplaces or loses necessary items</td>
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<td>Difficulty organizing</td>
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<td>Fails to give close attention to detail, makes careless mistakes</td>
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<td>Lack of follow-through/fails to finish tasks</td>
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<td>Blurs out answers before questions are completed</td>
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<td>Difficulty engaging in leisure activities quietly</td>
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<td>On the go, as driven by a motor</td>
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<td>Does not seem to listen</td>
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<td>Avoids tasks that require sustained mental effort</td>
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<td>Forgetfulness or memory problems</td>
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<td>Depressed mood: reported as feeling sad or empty or by other as tearfulness</td>
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<td>Change in appetite and related weight changes</td>
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<td>Psychomotor retardation (slowed movement, speech, thinking)</td>
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<td>Indecisiveness</td>
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<td>Symptoms</td>
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<td>Feelings of worthlessness</td>
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<td>Excessive or inappropriate guilt</td>
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<td>Recurrent thoughts of death or suicide</td>
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<td>Decreased sexual interest</td>
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<td>Body aches and pains</td>
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<td>Slowed, uninflected, or absent speech</td>
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<td>Diminished interest or pleasure in usual activities</td>
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<td>Insomnia/hypersomnia/sleep disturbance</td>
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<td>Fatigue or loss of energy</td>
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<tr>
<td>Feelings of anxiety or phobias</td>
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<td>Excessive worry</td>
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<td>Muscle tension</td>
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<td>Trembling, twitching, feeling shaky, muscle aches associated with muscle tension</td>
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<td>Somatic symptoms (sweating, nausea, diarrhea)</td>
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<td>Exaggerated startle response</td>
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<td>Conditions associated with stress (irritable bowel syndrome, headaches)</td>
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<td>Worry may interfere with attention to tasks</td>
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<td>Perfectionism or worry about quality of performance</td>
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<td>Alcohol or substance abuse</td>
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<td>Potential for psychotic features</td>
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<tr>
<td>Delusions</td>
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<td>Risk of suicidal behavior</td>
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<td>Occupational problems</td>
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<td>Academic problems</td>
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<td>Difficulty concentrating or sustaining attention to tasks</td>
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<td>Agitation/restlessness</td>
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<td>Irritability/temper outbursts</td>
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<td>Marital/family problems</td>
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<td>Distractibility</td>
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<td>Talking excessively</td>
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<td>Difficulty awaiting turn</td>
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<td>Impulsiveness</td>
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<td>Poor judgment</td>
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<td>Euphoria</td>
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<td>Inflated self-esteem or grandiosity</td>
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<td>Decreased need for sleep</td>
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<td>Flight of ideas or racing thoughts</td>
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<td>Increase in goal-directed activity/excessive planning</td>
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<td>Increased sociability</td>
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<td>Excessive spending/foolish investments</td>
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<td>Sexual indiscretion/excessive sexual interest</td>
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<td>Disorganized or bizarre social behavior</td>
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<td>Disregard for ethical concerns</td>
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<td>Hostility or threats to others</td>
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<td>Labile mood</td>
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<td>Disorganized speech</td>
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<td>Grossly disorganized or catatonic behavior</td>
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<td>Potential for assaultive</td>
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<td>Symptoms</td>
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<td>Hallucinations</td>
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<td>Negative symptoms (affective flattening, avolition)</td>
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<td>Recurrent substance use resulting in a failure to fulfill major role obligations at work/school/home</td>
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<td>Repeated absences from or poor work, neglect of children or household</td>
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<td>Recurrent substance use in situations in which it is physically hazardous (driving an automobile, etc)</td>
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<td>Recurrent substance-related legal problems (arrests for substance-related disorderly conduct)</td>
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<td>Continued substance use despite having persistent/recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (i.e. Arguments, with spouse about consequences of intoxication, physical flights)</td>
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<td>Need a markedly increased amounts of the substance to achieve intoxication or desired effect</td>
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<td>Withdrawal is manifested by avoiding withdrawal symptoms</td>
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<td>Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption.</td>
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