



ProviderLink

Your Quarterly Connection to Smart Solutions For MDwise Providers

MDwise Provides Behavioral Health Continuing Education

The MDwise Behavioral Health Department is now a continuing education provider for licensed social workers, licensed clinical social workers, licensed marriage and family therapists, and licensed mental health clinicians.

The first training was held at MDwise on March 19th. The program was entitled “Treatment Planning: How to Get Paid in a Managed Care Environment.” The topic was selected to educate providers on the importance of utilizing evidenced-based behavioral health care, as well as the importance of using standardized tools to measure progress. In the training, Dr. Lynn Bradford, Ph.D., reviewed the latest evidenced-based practices used for the most prevalent behavioral health diagnoses. Jennifer Layden, LCSW, demonstrated the use of rating scales and how to utilize scores to write meaningful, measurable goals that document client progress.

We are happy to provide this training to clinical provider staff upon request for continuing education credits. For additional information, please contact Jennifer Layden, LCSW, at jlayden@mdwise.org.



IN THIS ISSUE:

MDwise Provides Behavioral Health Continuing Education	1
Culturally Competent Care.....	2
Behavioral Health Quality Improvement Chart Audits	3
Timely Claims Filing for Indiana Care Select and the Impact of Pay for Performance	3
MDwise Hoosier Healthwise 2009 PMP and Office Manager/Nurse Surveys	4
Healthy Indiana Plan Enhanced Services Program	7
Clarification on Reimbursement for Nurse Practitioners	7
Charging Members for Services	8
W-9s Necessary for MDwise Care Select Pay for Performance Reimbursement.....	8
What You Should Know About Hoosier Healthwise Open Enrollment.....	9
MDwise PMP Participation in the New Right Choices Program.....	10
Urgent Care Facility Coordination	11

QUESTIONS?

For questions regarding **ProviderLink**, please contact:

Dan Westlake
Director of Provider Relations & Delivery Systems Manager
317.822.7228

Sherri Miles
Provider Relations Manager
317.822.7139

Culturally Competent Care

The Health & Human Services Office of Minority Health defines culturally competent care as “a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.”

The incorporation of culturally competent approaches within primary healthcare systems remains a great challenge. However, awareness of cultural issues that affect the patient’s care and outcomes is important to develop a care plan that meets the patient’s medical and cultural needs. The cultural gap between you and a patient can be wide or it can be narrow. It is important to be aware of cultural differences between yourself and patients in your ethnic/ racial group as well as patients from other ethnic/racial groups.

Neglecting the member’s cultural issues may result in non-adherence, which can result in unfavorable outcomes and complications. Signs that there may be cultural issues affecting the patient’s understanding of his/her plan of care include:

- Non-adherence with treatment plan
- Resistance to or concerns about recommended care
- Mistrust or conflict
- Failure to return for recommended follow-up care

Cultural beliefs can affect the patient’s attitude regarding nutrition, disease, making eye contact during the exam, and even affect the patient’s willingness to adhere to a treatment plan that is not accepted by his/her culture.

It is important to listen to your patient and acknowledge his/her concerns while developing a plan of treatment that is evidence-based but also considers the patient’s cultural requirements or lifestyle.

Additional information available regarding cultural competency in health care:

- Diversity Rx – www.diversityrx.org
- Office of Minority Health – www.omhrc.gov
- Institute of Medicine – www.iom.edu

Points to Consider

- In many cultures eye contact means different things. In some countries to look someone in the eye is a sign of intimidation and threat.
- Someone who can speak enough English to greet you with, “Hello, doctor,” may not understand everything you explain to him or her in English.
- Children who can speak English and their parent’s native language may not understand either one enough to be effective interpreters. Remember, they are children.
- If you ask someone a question in English and that person nods and smiles, it does not mean he or she understands you. It is embarrassing to many people to have to admit the information is not clear.
- Many people are not fluent in their native language. Make sure that information that has been translated is appropriate for the reading level of your patients.
- Even though someone does not understand English, it does not mean he or she cannot read non-verbal cues. Respect is not only shown through spoken word, but it is also visible through tone and body language.

Member Rights and Responsibilities

The MDwise HHW Member Rights and Responsibilities Statement is available on the MDwise Web site (www.MDwise.org). A printed copy of the information posted to our Web site by is available by calling us at 1-800-356-1204 or 317-630-2831 if you are in the Indianapolis area.

Behavioral Health Quality Improvement Chart Audits

Beginning in April, MDwise will again be conducting chart reviews with a focus on coordination of care, follow-up care for children with ADHD, and access to care. Charts of both behavioral health care and medical providers caring for members with behavioral health issues will be reviewed.

Continuity and Coordination of Care	• Exchange of information between behavioral health and medical providers
	• Referral for appropriate care of either behavioral health or medical issues
	• Exchange of relevant lab or test results
ADHD Follow-up Care	• Use of standardized rating scales used during assessment
	• Follow-up medication check within 30 days after the first prescription
	• Documentation of regular follow-up visits after the first 30 days (at least 2 in the next 9 months)
	• Documentation of behavioral health and physical history, psychosocial assessment, and treatment history
	• Referral to a behavioral health provider for behavior management and parent education
	• Coordination with school personnel
Access Standards	• Non life-threatening emergency appointment within 6 hours
	• Urgent care within 48 hours
	• Routine care within 10 business days
	• 24 hour availability

Timely Claims Filing for Indiana *Care Select* and the Impact of Pay for Performance

To improve the *Care Select* claims data that MDwise receives from HP, we ask providers to submit complete claims to HP as quickly as possible. Providers should always submit claims for Medicaid eligible services even when the member has a third party liability (TPL) insurance. Submitting these claims eliminates the need to do a manual medical chart review to find services that fall into measurable pay for performance measures. *Care Select* claims submitted to HP are the basis for MDwise being able to determine which primary medical providers (PMPs), or the groups/clinics they are employed by, are rendering services related to pay for performance measures as required by our *Care Select* contract with the Office of Medicaid Policy and Planning (OMPP). Services that are measurable by OMPP for Indiana *Care Select* pay for performance include breast cancer screenings, diabetes screening, and adolescent well-child visits. MDwise will be publishing a comprehensive list of services that are measured by the OMPP for eligible pay for performance reimbursement to



MDwise. OMPP mandates that as part of the Indiana *Care Select* contract with MDwise, we pay out a certain percentage of pay for performance funds to MDwise *Care Select* PMPs.

MDwise Hoosier Healthwise 2009 Primary Medical Provider (PMP) Satisfaction Survey and Office Manager/Nurse Survey Summary

MDwise believes a high level of provider satisfaction in the MDwise Hoosier Healthwise program is necessary to develop and maintain an adequate and accessible network of providers to meet the medical and behavioral needs of the members.

The Myers Group (TMG), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, was selected by MDwise to conduct its 2009 Provider Satisfaction Survey. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. Based on the data collected, this article summarizes the results and assists in identifying plan strengths and opportunities.

Target Population

The vendor sent the 2009 Provider Satisfaction Survey to 1,228 Primary Medical Providers (PMP) and called 549 Office Manager/Nurses in the MDwise Hoosier Healthwise program. Responses were received from 266 of the sampled PMPs and 246 responses from Office Managers/Nurses. Results were collected from November through December 2009.

Methodology

MDwise provided TMG with a database of its primary care providers and office managers. TMG mailed a survey to all of the PMPs; Office Managers/Nurses were contacted by telephone.

MDwise decided to make changes to the 2009 survey in an effort to gain a larger response rate. The survey was shorter and two surveys were conducted, one for PMPs and another for the Office Managers/Nurses. MDwise's rationale for conducting the two surveys was that:

- PMPs are uniquely qualified to answer questions on behavioral health and pharmacy and drug benefits.
- Office managers/nurses are sometimes more familiar with questions regarding satisfaction with prior authorization and medical management attributes and finance issues.

Benchmark

TMG developed the 2009 Provider Satisfaction Survey utilizing input from several health plans and health industry professionals. The survey has been used for over 250 projects and has consistently updated with provider feedback over eight years. There are currently no publicly reported benchmarks available for comparison to the TMG Provider Satisfaction Survey. MDwise compares the applicable results to past year results and also to all other plans in the market.

Goal

The goal of this exercise was to see if there was improvement in provider Summary Rate satisfaction levels. A Summary Rate is the proportion of respondents who selected the most positive options for a given attribute. The positive satisfaction rates represent the following responses:

- Excellent or Very Good
- Yes
- Definitely yes or Probably yes
- Very satisfied or Somewhat satisfied



Summary Findings

The charts below present 2009 Summary Rates for MDwise's overall satisfaction attributes. In the survey, respondents were asked to rate MDwise and all other health plans in the market in which the provider participates. A comparison between these scores is displayed in the charts below.

PMP Summary Rate Comparison

PMP Responses (266) Composite/Attribute	MDwise		Other Plans		Significance Testing
	n	2009 SRS	n	2009 SRS	
Provider Relations		34.9%		21.5%	Sig. Higher
Responsiveness of health plan's provider relations representative	218	43.1%	185	24.9%	Sig. Higher
Usefulness of practitioner educational meetings/in-services	165	37.0%	135	20.0%	Sig. Higher
Usefulness of written communications, manuals	231	27.3%	197	18.3%	Sig. Higher
Responsiveness of health plan's medical director	158	32.3%	135	23.0%	Not Sig.
Behavioral Health					
Usefulness of behavioral health reports	123	31.7%	75	21.3%	Not Sig.
Pharmacy and Drug Benefits		19.7%		14.2%	Not Sig.
Ease of referencing the plan's preferred drug list	233	19.7%	189	15.3%	Not Sig.
Helpfulness of health plan's Pharmacy Benefit Call Center	178	19.7%	146	13.0%	Not Sig.

Office Manager/Nurse Summary Rate Comparison

Office Manager/Nurse (246) Composite/Attribute	MDwise		Other Plans		Significance Testing
	n	2009 SRS	n	2009 SRS	
Provider Relations		34.8%		21.6%	Sig. Higher
Responsiveness of health plan's provider relations representative	229	43.2%	201	26.4%	Sig. Higher
Timeliness to answer questions and/or resolve complaints	233	29.2%	206	22.8%	Not Sig.
Adequacy of provider orientation by the health plan's provider relations staff	206	35.0%	181	18.8%	Sig. Higher
Usefulness of practitioner educational meetings/in-services	172	37.2%	151	21.9%	Sig. Higher
Usefulness of written communications, manuals	223	29.6%	197	18.3%	Sig. Higher
Prior Authorization and Medical Management		24.4%		15.5%	Sig. Higher
Phone access to medical management staff for prior authorization	226	28.3%	199	18.6%	Sig. Higher
Timeliness of prior authorization process	224	25.4%	197	17.8%	Not Sig.
Extent to which medical management staff share review criteria and reasons for adverse determinations	203	22.7%	179	12.3%	Sig. Higher
Consistency of review decisions	194	19.1%	172	14.0%	Not Sig.
Appropriateness of Prior authorization for services relative to other health plans	213	23.0%	191	13.6%	Sig. Higher
Availability of care/case managers by phone	208	27.9%	177	16.9%	Sig. Higher
Finance Issues		27.6%		18.3%	Sig. Higher
Accuracy of claims processing	183	29.5%	164	19.5%	Sig. Higher
Timeliness of claims processing	175	32.6%	159	22.0%	Sig. Higher
Resolution of claims payment problems or disputes	155	20.6%	143	13.3%	Not Sig.

Valid n is the number of respondents who gave a rating for the attribute. Summary Rate Scores (SRS) are the sum of the two most favorable response options.

Trend Comparison Overall Satisfaction

All Respondents	MDwise Overall Satisfaction Summary Rate		
	2009	2008	2007
	72.4%	58.5%	63.4%

Composite/Attribute	2009	2008	2007
All Respondents	72.4%	58.5%	63.4%

When the overall satisfaction scores for 2009 are combined, the Summary Rate has increased significantly from both 2007 and 2008.

Summary Rate Comparison by Survey Type

All Respondents (512) Composite/Attribute	MDwise Valid n & Summary Rate Score					
	Aggregate		Physician		Office Manager	
MDwise Overall Satisfaction						
Please rate your overall satisfaction with MDwise	500	72.4%	257	66.1%	243	79.0%
Provider Relations						
Responsiveness of health plan's provider relations representative	447	43.2%	218	43.1%	229	43.2%
Usefulness of practitioner educational meetings/in-services	337	37.1%	165	37.0%	172	37.2%
Usefulness of written communications/manuals	454	28.4%	231	27.3%	223	29.6%
Network						
Specialist network has adequate number of specialists	462	50.2%	233	45.9%	229	54.6%

Overall, the scores for the 2009 Provider Satisfaction Survey were up. The goal of improving provider satisfaction levels was achieved.

The survey pointed out some areas that correlate with satisfaction where MDwise needs to focus resources on:

1. Usefulness of educational meetings/in-services
2. Responsiveness of the health plan's medical director
3. Resolution of claims payment problems or disputes
4. Timeliness to answer questions and/or resolve complaints
5. Availability of care/case managers by phone

Even though the scores for the 2009 Survey improved when compared to the previous two years, MDwise would like to see more participation in future surveys. If you have suggestions on how to improve the return rate for the provider satisfaction survey, please contact Dan Westlake at dwestlake@mdwise.org.

Healthy Indiana Plan Enhanced Services Program

Healthy Indiana Plan members with certain diagnoses identified by the State may qualify for the Enhanced Services Program (ESP). For members who qualify, this program provides additional services not available to the member in Healthy Indiana Plan and may mitigate costs and worry for members with certain catastrophic diseases. The diseases that qualify for investigation of ESP include, but are not limited to, cirrhosis, cancer, hepatitis, and diabetic complications like diabetic retinopathy.

In order for MDwise to determine whether the member qualifies for ESP, we must secure clinical information through an ESP questionnaire that must be completed and signed by the treating provider. These questionnaires are vital to the process of referring members who may benefit from additional resources to ESP. The questionnaires should be completed, signed and faxed back to the number indicated on the form.

We would appreciate your assistance in helping us assure qualified members have access to the ESP services by filling out the questionnaire your office may receive and sending it back in a timely manner.



MEDICATION MADE EASY

YOUR SOLUTION. DailyMed™



Covered by
Indiana
Medicaid

EASY

No more worrying with multiple pill bottles or confusing pill reminders

ORGANIZED

A month of medications organized into pre-sorted packets

SIMPLE

Medication packets are marked with the time you need to take them

DELIVERED

DailyMed™ is delivered every month right to your home

STAY AT HOME

No more running to the pharmacy or waiting in long lines at the counter

For assistance in enrolling, call DailyMed™ today!

DailyMed™

1.800.973.1955

DailyMedRx.com

Clarification On Reimbursement for Nurse Practitioners

1. Independently practicing nurse practitioners (not linked to a group) who have their own IHCP provider number.

The NPI for the independent nurse practitioner is billed in both the rendering (Box 24J) and the billing (Box 33A) fields on the claim. Reimbursement should be reduced to 75% of the allowed amount for the service being billed.

2. Nurse practitioners who are linked to a physician group who do not have their own IHCP provider number.

The NPI for the supervising physician is billed in the rendering field (Box 24J) and the group NPI number is billed in the billing (Box 33A). The service should also be billed with an SA modifier to indicate that the service was actually performed by a nurse practitioner. The services in this situation should be reimbursed at 100% of the allowed amount.

3. Nurse practitioners who have their own IHCP provider number but are employed by a physician group.

The NPI for the nurse practitioner is billed in the rendering field (Box 24J) and the physician group NPI is entered in the billing provider (Box 33A). The services in this situation should be reimbursed at 100% of the allowed amount.



Charging Members for Services

Federal and state regulations prohibit providers from charging any Indiana Health Coverage Programs (IHCP) member, or the family of a member, for any amount not paid following a reimbursement determination by the IHCP. See Code of Federal Regulations, Title 42, Part 447, Subpart A, Section 447.15; Indiana Administrative Code, Title 405, Article 1, Rule 1, Sections 3(i). Furthermore, the IHCP Provider Agreement contains the following provision:

“To accept payment as payment in full the amounts determined by Indiana Family and Social Services Administration or its fiscal agent, in accordance with the Federal and State statutes as the appropriate payment for Medicaid or CHIP members (recipients). Provider agrees not to bill members, or any member of a recipient’s family, for any additional charge for Medicaid or any member of a recipient’s family, for any additional charge for Medicaid or CHIP covered services, excluding any copayment permitted by law.”

The clear intent of this provision is to ensure that no member or family of a member is billed in excess of the amount paid by the IHCP.

As a condition of the provider’s participation in the IHCP, the provider must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If the provider disagrees with the Medicaid determination of payment, the provider’s right of recourse is limited to an adjustment request, administrative review, and appeal as provided in 405 IAC 1-1-3. Violation of this section constitutes grounds for the termination of the provider agreement and decertification of the provider, at the option of the Indiana Family and Social Service Administration (IFSSA).

Billing Exceptions

An IHCP provider can bill an IHCP member only when the following conditions are met:

- The service must be an IHCP noncovered service or a covered service for which the member has exceeded the program limitations for the particular service.
- The member is a qualified Medicare beneficiary (QMB) only or a specified low income Medicare beneficiary (SLMB) only, and the IHCP pays only the coinsurance and deductible, but does not provide medical coverage.
- The IHCP member must understand, before receiving the service, that the service is not covered under the IHCP and that the member is responsible for the service charges.

Note: If a waiver is used to document that a member has been informed that a service is not covered, the waiver must not include conditional language such as “if the service is not covered by the IHCP, or not authorized by the member’s primary medical provider (PMP), then the member is responsible for payment.” This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or PA as needed.

The provider must maintain documentation in the member’s file that the member voluntarily chose to receive the service, knowing the IHCP did not cover it.

W-9s Necessary for MDwise Care Select Pay for Performance Reimbursement

MDwise has embarked on a series of pay for performance programs for physicians enrolled as primary medical providers (PMPs) in the MDwise *Care Select* Program. As we continue to make payments to providers (a sole proprietor, group provider, or organization that owns a provider group or clinic), we must first receive a W-9 from the provider. Once the W-9 is received, we will release payment for any pay for performance funds earned by the provider. Many providers participate in other MDwise lines of business such as Hoosier Healthwise and may have provided that MDwise delivery system with their W-9. MDwise *Care Select* must pay providers for pay for performance separately from those delivery systems and must have the provider’s W-9 on file prior to making payment. We appreciate providers submitting a W-9 so that we may begin to pay providers for earned pay for performance funds. Please submit a W-9 to MDwise at the following address:

MDwise, Inc.
Attention: Finance Department
1200 Madison Avenue, Suite 400
Indianapolis, IN 46225

What You Should Know About Hoosier Healthwise Open Enrollment

Under Open Enrollment, members can change health plans only at the following times:

- Anytime during their first 90 days enrolled with a new health plan
- Annually during their open enrollment period
- Anytime there is “just cause”

Just cause reasons are as follows:

1. Lack of access to medically necessary services covered under the MCO’s contract with the State.
2. The MCO does not, for moral or religious objections, cover the service the enrollee seeks.
3. The enrollee needs related services performed at the same time and not all related services are available within the MCO’s network. The enrollee’s primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
4. Lack of access to providers experienced in dealing with the enrollee’s health care needs.
5. Poor quality of care, including failure to comply with established standards of medical care administration and significant language or cultural barriers.



If a provider wants to add a member to his full or hold panel:

The member must be within their fee-for-service window, or the 90-day open enrollment period, or be active within the same MCO as the provider that is completing the full-panel add form. Full-panel add forms must be fully processed before the end of the 90-day open enrollment period.

Another exception to the Open Enrollment rules:

A provider’s panel can follow when the PMP decides to transfer to another MCO. For example, a provider decides to leave MCO A and enroll only in MCO B. The provider’s entire panel enrolled in MCO A would follow the provider to MCO B.

Remember: A member can change doctors within his/her MCO at any time. If a member wants to change MCOs after the Open Enrollment period, a grievance may be filed with that member’s MCO. The MCO will try to resolve any “just cause” issue. If the member remains dissatisfied, the grievance will then be forwarded to the enrollment broker.

myMDwise Provider Portal

myMDwise Provider Portal is an online tool available 24 hours a day, 7 days a week at www.MDwise.org that helps MDwise Healthy Indiana Plan (HIP) providers to:

- Check member eligibility
- View the member’s delivery system



MDwise PMP Participation in the New Right Choices Program

In January 2010, the Office of Medicaid Policy and Planning (OMPP) announced the Right Choices Program which replaced the Restricted Card Program. Indiana Health Coverage Programs (IHCP) has redesigned the program to safeguard against unnecessary or inappropriate use of Medicaid services. Effective January 1, 2010, the RCP is administered by MDwise and its three IHCP programs, Hoosier Healthwise, *Care Select*, and Healthy Indiana Plan (HIP) using uniform criteria and policies established by the State.

The RCP case managers, in partnership with the member's PMP, provide intensive member education, care coordination, and utilization management for members enrolled in the RCP. Case managers also support providers in the management of their RCP members.

To achieve the goal of delivering quality health care for RCP members, RCP stakeholders (i.e. the health plan's case manager and the member's primary medical provider) collaborate to create a medical home for RCP members. RCP members are assigned and "locked in" to a team of experts consisting of one primary medical provider (PMP), one pharmacy, and one hospital. If a member requires specialty services or needs to see any practitioner other than the PMP (including any physicians in the same clinic or group), the PMP must make a written referral for those services to be authorized for reimbursement. This includes situations of self-referral (for example, dentists and psychiatrists). Referrals must include the following:

- The IHCP member's name and recipient identification number (RID)
- The first and last name of the referring physician (member's assigned PMP)
- The first and last name of the referral physician
- The referral physician's National Provider Identifier (NPI)
- Date of the referral
- Dates of service for which the referral is valid
- PMP's manual or electronic signature

MDwise is seeking PMP buy-in and support for the objectives of the new Right Choices Program which are to:

- Improve the individual's health status by increasing the level of care coordination and utilization control for members enrolled in the RCP.
- Reduce inappropriate outpatient hospital use, especially use of the emergency room.
- Reduce inappropriate use of pharmacy services, especially controlled substances and other items with potential for misuse or abuse.
- Reduce medical expenditures related to inappropriate use and/or overuse of services.
- Increase provider participation and improve provider satisfaction with RCP.

Providers receive a notification letter when they have been selected by the member to participate on the member's medical home team. Information regarding the member's authorized providers is also available via Web interChange. Members are notified in writing of their selection and enrollment into the RCP program. The letter indicates the member's assigned or chosen PMP, pharmacy, and hospital. RCP member enrollment information is entered into Web interChange so providers can identify the individual as a member of the Right Choices Program when they check a patient's Medicaid eligibility. A member's RCP enrollment stays intact, regardless of member movement between programs or health plans.

For additional information, contact MDwise Customer Service. Please do not contact medical management or prior authorization for questions or assistance regarding the Right Choices Program as they do not maintain information for the Right Choices Programs. Providers can always check member eligibility on Web interChange at www.indianamedicaid.com to determine the member's Right Choices Program status indicator and a list of approved Right Choices Program providers for that member.

MDwise Customer Service

Care Select..... 1-866-440-2449
Hoosier Healthwise..... 1-800-356-1204
Healthy Indiana Plan..... 1-877-822-7196

Urgent Care Facility Coordination With MDwise Primary Medical Providers

An urgent care facility that sees MDwise Hoosier Healthwise, Healthy Indiana Plan, or *Care Select* members may contact the member's primary medical provider (PMP) to discuss the member's care at the urgent care facility. It may also share protected health information (PHI) with the member's PMP or health plan (i.e. prior authorization requests) for purposes of health plan operations, member continuity of care and any necessary follow-up services needed by the member's assigned PMP once the member leaves the urgent care facility. The disclosure of PHI can be related to physical health records or mental health records governed by Health Insurance Portability and Accountability (HIPAA) and state law for purposes of treatment. However, consent is required from the member prior to releasing substance abuse records. All providers must be aware of and follow established privacy and HIPAA guidelines governing the release of any medical records. The urgent care facility may not charge the member for copying needed medical records to send to the member's assigned PMP according to 42 C.F.R. 447.15. Providers can find more information governing member medical records in the MDwise Provider Manual located at www.MDwise.org. Prior to rendering any non-emergent service to a MDwise member, providers must ensure that any prior authorization protocols are met.

Urgent care facilities are reminded that if they are not in network (i.e. not a contracted provider) with a MDwise Hoosier Healthwise or Healthy Indiana Plan delivery system, prior to rendering services to the member, they must contact the member's assigned MDwise Hoosier Healthwise or Healthy Indiana Plan delivery system to receive authorization. Failure to obtain authorization prior to rendering services may result in a claim denial. The urgent care facility must contact the delivery system it received authorization from for claim submission guidelines. If the urgent care facility is in network (i.e. contracted) with a MDwise Hoosier Healthwise or Healthy Indiana Plan delivery system, the facility needs to be certain of that delivery system's authorization rules prior to rendering services to its



members. The urgent care facility must contact the delivery system for claim submission guidelines. Contact information for all MDwise delivery systems is located at www.MDwise.org.

Urgent care facilities are not required to be in network with MDwise before rendering services to MDwise *Care Select* members. At this time, the Office of Medicaid Policy and Planning (OMPP) has not mandated that these specialty providers be in network with the care management organization (CMO) to see *Care Select* members. However, OMPP does require urgent care facilities to seek authorization from the member's assigned MDwise *Care Select* PMP prior to rendering services. If the member's PMP approves the services to be rendered by the urgent care facility, the PMP will release to the urgent care facility their two character certification code and national provider identifier (NPI). Failure to obtain the certification code and the NPI prior to rendering services to a MDwise *Care Select* member could result in the claim being denied by HP, OMPP's fiscal intermediary that processes all *Care Select* claims. Providers must consult the IHCP Provider Manual for appropriate claim submission guidelines or contact HP for further assistance. This information is located at www.indianamedicaid.com.



1200 Madison Ave., Suite 400
Indianapolis, IN 46225

Contact Us:

Dan Westlake
317.822.7228

Sherri Miles
317.822.7139

www.MDwise.org

Customer Service Department

317.630.2831 or

1.800.356.1204

Fax: 317.829.5530