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With the changes that have occurred in the transition of Hoosier Healthwise and the Healthy Indiana Plan (HIP), there have been numerous problems with obtaining accurate member eligibility information. MDwise would like providers to know that a provider web portal is available at MDwise.org.

The myMDwise Provider Portal allows providers, including hospitals and ancillary providers, to securely and accurately view member eligibility for the MDwise Hoosier Healthwise, *Care Select* and the Healthy Indiana Plan.

New users must request access by completing the online sign-up form. After you submit your request, it may take up to a week to activate your account; however, we will process as quickly as possible.

The myMDwise Provider Portal is the preferred method for you to check your MDwise member's eligibility.

To get to the online form, go to MDwise.org. Click "Login" in the upper left corner of any page. Look for the link to myMDwise Provider Portal. Follow further instructions to log in. New users should click "Request New Account."

If you have questions, please contact MDwise Customer Service at 1-800-356-1204 or 317-630-2831.

Project ICE Diabetes Education Opportunities via E-Learning

MDwise, the Office of Medicaid Policy and Planning (OMPP), ADVANTAGE Health Solutions, Anthony Wayne Services, Inc. and ASPIN are collaborating on a Project ICE which stands for Integrated Care through Education. Project ICE is a three-year program, funded through the Health Resources and Services Administration (HERSA), designed to improve the health and well-being of persons with mental illness and or intellectual disabilities who also manage diabetes and reside in a rural Indiana county.

The goals of Project ICE are to improve health outcomes through enhanced diabetes management achieved through the cross-training of care-providers on best practices of diabetes management and strategies for working with the targeted population. To further these goals, the Project ICE team developed a series of traditional face-to-face interdisciplinary presentations for care-providers on diabetes, mental illness and intellectual disabilities and how these delivery silos can support coordinated care for the targeted population. Care providers include Direct Support Professionals, Mental Health Case Managers, Clinicians, Certified Diabetes Educators, Psychiatric

Nurses and any other health care professional that touches those impacted by diabetes and a mental illness or intellectual disability.

I should attend a Project ICE training if:

- I work in a Group Home and want to learn more about diabetic complications.
- I am not certain what a HbA1C test indicates.
- I want to learn more about the intellectually disabled population.
- I'm not familiar with the impact of some antipsychotic medications on weight gain.
- I want more information on how a *Care Select* Disease Manager can assist in locating resources for my client who is in the *Care Select* Medicaid program.

The initial, statewide interdisciplinary trainings have been completed and have been converted to an e-learning format. The training topics feature individual subject matter experts delivering presentations on diabetes and intellectual and developmental disabilities and serious mental illness, how to promote nutrition, exercise, and medication management specific to diabetics faced with a mental illness or intellectual disability has been scheduled. These presentations are free and there are continuing education units (CEUs) available per presentation. There is a $20 CEU processing fee for four CEUs. Four presentations are available:

- Understanding Diabetes, Intellectual and Developmental Disabilities, and Serious Mental Illness
- Improving Medication Adherence in Individual Facing an Intellectual Disability and/or Serious Mental Illness and Diabetes
- Increasing Physical Activity to Reduce Diabetes Risks in Individuals with Intellectual Disabilities and/or Serious Mental Illness
- Nutrition for Diabetes Management and Prevention in People with Intellectual Disabilities and/or Serious Mental Illness

Providers interested in improving their diabetes education can view these presentations at www.indianaprojectice.org/elearning. If you have additional questions about the project or e-learning opportunities, go to www.indianaprojectice.org or contact Greg Lorenz, LCSW, ASPIN Clinical Program Development Coordinator at 317-536-4683.

Claims Issues in 2011

Per the IHCP Banner Page BR201112, there have been changes in the eligibility verification systems which affect your ability to verify eligibility for both the Hoosier Healthwise and the Healthy Indiana Plan for the months of January, February and March 2011 only. MDwise has launched the myMDwise Provider Portal which allows you to securely view accurate member eligibility information for MDwise members in the Hoosier Healthwise, Healthy Indiana Plan, and Care Select programs. This portal is the preferred method for you to check your eligibility for MDwise and will allow you to accurately view enrollment and verify which MDwise delivery system to contact to request authorization or to submit claims. If you check the Web Interchange to verify eligibility and MDwise Delivery System, the only system that can guarantee you are using the correct information for January, February and March 2011 is the myMDwise Provider Portal. This system will also be available on an ongoing basis for all dates going forward, for your convenience.

Due to the enrollment issues that providers experienced in January through March of 2011, MDwise is waiving the timely filing limit for all Hoosier Healthwise claims with dates of service between 1/1/11 and 1/31/11. For January dates of service, in-network providers will have until 5/30/11 to resubmit claims if needed. For February and March dates of service, providers will have until 7/1/11 to resubmit claims if needed. Out of network providers have 365 days to file claims, so this limit will still apply.

MDwise claims payers will be conducting a mass reprocess of claims that denied between 1/1/11 and 3/31/11 that were denied due to eligibility issues.Providers do not need to resubmit paper claims that were denied during this period, unless the claim was submitted to the wrong delivery system initially.If you submitted claims between 1/1/11 and 3/31/11 and they were rejected by a MDwise payer, please resubmit the claims in order to ensure processing. This is because rejected claims are not stored by claims systems; we apologize for this inconvenience. Please use the Provider Portal to verify the proper Delivery System before resubmitting. MDwise and our payers will not be applying out of network restrictions for dates of service between 1/1/11 and 3/31/11.

If a provider determines through reviewing the myMDwise Provider Portal that they obtained prior authorization (PA) from the wrong MDwise delivery system, please submit the PA number received as proof of good faith attempt to obtain PA.

As always, all other regular Indiana Medicaid payment rules will continue to apply, such as member eligibility on the date of service, coverage limits, prior authorization requirements, etc. Any appeals due to these reasons can be pursued through the normal process. Per our State mandated oversight responsibilities, MDwise may conduct random, periodic audits on all claims. As with all Medicaid claims, please remember to keep all claims information, prior authorization approval numbers, and back-up documentation for audit purposes.

Universal Prior Authorization and Provider Enrollment/Credentialing Forms

Overview

The Office of Medicaid Policy and Planning (OMPP) mandated the use of two new forms effective January 1, 2011 for Traditional Medicaid (TM), Indiana *Care Select* (ICS), Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP). These forms are the universal Prior Authorization (PA) form and the universal Provider Enrollment and Credentialing form. The purpose of these new universal forms is to reduce duplicate and redundant forms, simplify IHCP program operations, and encourage participation among various IHCP Programs. Providers are encouraged to use these new forms immediately as the old provider enrollment and prior authorization forms were phased out January 1, 2011. Please direct questions regarding these new forms to MDwise Customer Service at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.

New Universal PA Form

The universal prior authorization (PA) form is required for all IHCP services (except pharmacy and dental) that require PA by MDwise (HHW and HIP) or by the OMPP (ICS and TM) regardless of the IHCP program the member is in. With the adoption of this form, there are no changes to the IHCP PA regulations outlined in the Indiana Administrative Code (IAC) or the IHCP Provider Manual Chapter Six. There are also no changes to MDwise PA policy outlined in the MDwise provider manual located at MDwise.org. Providers who provide services to ICS or TM members can determine if a service requires PA by viewing the IHCP fee schedule and the IHCP Provider Manual Chapter Six located at www.indianamedicaid.com. Providers who provide services to MDwise members in HHW and HIP can contact the delivery system they are contracted with to determine what services require PA or consult the PA information located in the MDwise Provider Manual or on the website at MDwise.org. Providers may obtain the universal PA form and instructions by going to MDwise.org. Providers can obtain the pharmacy and dental PA forms at www.indianamedicaid.com.

New Universal Provider Enrollment Form

Providers who wish to participate in Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) or Indiana *Care Select* (ICS) with MDwise must complete the universal provider enrollment form. Providers may begin to use these two new forms and MDwise will accept them for provider enrollment and credentialing immediately for all its lines of business (HHW, HIP and ICS). With the adoption of this form, there are no changes to IHCP provider enrollment regulations outlined in the IAC or the IHCP Provider Manual Chapter Four (i.e. being and enrolled Medicaid provider with HP, possessing a National Provider Identifier, etc.). There are also no changes to MDwise provider enrollment and credentialing policies for HHW, HIP, and ICS outlined in the MDwise Provider Manual and mandated by the OMPP located at MDwise.org. Physicians who wish to serve as a PMP or a specialist in the MDwise HHW and HIP network must meet all MDwise credentialing guidelines and be approved by the MDwise Medical Advisory Committee (MAC) which is made up of all the MDwise delivery system Medical Directors. Physicians who wish to serve as a PMP in the MDwise ICS PMP network must meet all MDwise credentialing guidelines and be approved by the MDwise MAC. The universal provider enrollment and credentialing form can be obtained at MDwise.org.

Strategies to Avoid Out-of-Network Claims Denials

There are a few best practices to utilize to avoid out-of-network claims denials for Hoosier Healthwise and the Healthy Indiana Plan (HIP). These include:

✔ Checking eligibility each time a patient comes for a visit.

- Is the member eligible for services today?
- In what IHCP Plan are they enrolled? (Hoosier Healthwise, Medicaid Select, Traditional Medicaid)
- If the member is in Hoosier Healthwise or HIP what MCO are they assigned? (MDwise, Anthem, MHS)
- If the member is enrolled in Hoosier Healthwise, what services are they eligible to receive? (Package A, B, or C)
- Who is their Primary Medical Provider (PMP)?
- Does the member have primary health insurance other than Medicaid? (Frequently seen with package B moms)

✔ All Out-of-Delivery System providers require authorization for services prior to being rendered.

- Authorization or denial of services is handled by the Medical Management department in the MDwise delivery system where the member's PMP belongs. If you are unsure about what MDwise Delivery System to call, MDwise Customer Service can connect you with the appropriate department (1-800-356-1204 or 317-630-2831 in the Indianapolis area).

✔ Contractually, all in-MDwise network providers are required to submit claims within 90 days of the date of service, unless the claim involves third party liability. The timely filing requirement is also waived in the case of claims for members with retroactive coverage, such as presumptively eligible women and newborns. Out-of-network providers have 365 days to submit claims.

- MDwise is responsible for adjudicating clean electronic claims within 21 days of receipt and clean paper claims within 30 days of receipt. If MDwise fails to adjudicate (pay or deny) a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, interest will be paid on the claims, unless alternate written payment arrangements have been made with the provider.

MDwise HIP Specialty Network to Close Effective April 1, 2011

MDwise will be closing our specialist and facility provider network effective April 1, 2011. Starting on this date, all non-contracted providers who render specialty services must obtain an authorization to be paid for services provided to MDwise Healthy Indiana Plan members.

Prior authorization will be granted only if a contracted network provider isn't located within the designated geographical region. Please refer to the MDwise website for a copy of our prior authorization form at MDwise.org.

Primary Medical Provider (PMP) **First Amendment to the IHCP PMP Addendum Announced in Provider Bulletin BT201043**

PMPs who participate in the MDwise ICS PMP network must notify MDwise of their intent to continue to participate after January 1, 2011 by signing and returning the First Amendment to the PMP Participation Addendum to the IHCP Provider Agreement as quickly as possible. IHCP specialty providers, ancillary providers, and hospital providers do not have to sign this First Amendment. PMP offices can obtain the First Amendment to the PMP Participation Addendum at MDwise.org. Select Providers, then *Care Select*, then forms. Providers may also fax completed amendments to Provider Relations at 317-822-7301 or mail to MDwise, P.O. Box 44214 Indianapolis, IN 46244-0214.

MDwise requests PMPs who wish to continue participating in the MDwise *Care Select* PMP network to complete the First Amendment and return it to MDwise right away in order to continue with their current panel of MDwise *Care Select* members. PMPs who have questions about completing the First Amendment to the PMP Addendum to the IHCP Provider Agreement should contact MDwise Customer Service at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.

Changes to MDwise Healthy Indiana Plan **Effective April 1, 2011**

MDwise will begin a new partnership with IU Medical Group-Primary Care (IUMG-PC) for Healthy Indiana Plan (HIP) claims payment processing effective April 1, 2011. IUMG-PC will begin processing HIP claims with DOS April 1, 2011 and forward while Affiliated Computer Systems (ACS) will continue to process claims with dates of service through March 31, 2011.

The electronic submission payer IDs and paper claims addresses for the HIP program for both claims payers are listed below for your convenience:

Dates of Service March 31, 2011 and Prior	Dates of Service April 1, 2011 Forward
Paper Claims	Paper Claims
MDwise P.O. Box 33049 Indianapolis, IN 46203-0049	MDwise HIP Claims P.O. Box 78310 Indianapolis IN 46278
ACS EDI Clearinghouses	IUMG EDI Clearinghouses
Emdeon, TK Software and ACS Gateway Payer ID for all EDI clearinghouses: MDWIS	WebMD/Emdeon Institutional Payer ID: 12K81 Professional Payer ID: SX172 McKesson/Relay Health Institutional Payer ID: 4976 Professional Payer ID: 4481

MDwise will also issue new member identification cards to all MDwise HIP members to reflect the new claims payment address.

If you have questions about the transition, please call MDwise Customer Service at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.

Please visit MDwise.org for a copy of our prior authorization form and for more information about the transition of claims payors. Thank you for your continued service to MDwise and our members.

Open Enrollment

Following enrollment with an MCO, in accordance with federal requirements, members maintain the right to change MCOs during the first 90 days of enrollment. Following this 90-day period, eligible members remain enrolled with the same MCO for nine months unless they have "just cause."

Enrollees are permitted to request a transfer from an MCO for just cause during the 12 month lock-in period. Just cause reasons are as follows:

- Lack of access to medically necessary services covered under the MCO's contract with the State.
- The MCO does not, for moral or religious objections, cover the service the enrollee seeks.
- 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.
- Lack of access to providers experienced in dealing with the enrollee's health care needs.
- Poor quality of care. Poor quality of care includes failure to comply with established standards of medical care administration and significant language or cultural barriers.

Recent Changes to "Just Cause:"

- Maximus will refer issues to MDwise for resolution if the member is not in the "free-change" period.
- If a member formally requests a plan change outside of the free-change period, Maximus will confirm grievance process was completed and request documentation from MDwise.
- A new just cause reason was established for a member requesting a move when the member's PMP leaves MDwise to go to another plan.
- Maximus will review and make a final determination on approval or denial of just cause change.

Primary Medical Provider (PMP) Certification Codes for MDwise *Care Select* Program

PMPs are reminded that OMPP discontinued the use of PMP certification codes and National Provider Identifier (NPI) to authorize medically necessary referrals from the member's PMP to specialist or ancillary providers, including inpatient hospital admissions, effective for dates of service after January 1, 2011. Specialty physician and inpatient services provided prior to January 1, 2011 will still require the PMP's certification code and NPI.

Primary Medical Provider **Requirements**

MDwise PMPs must provide or arrange for coverage of services 24 hours a day, seven days a week. They must offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number 24 hours a day, seven days a week. Each PMP must be available to see members at least three days per week for a minimum of 20 hours per week. For life-threatening situations, the PMP must provide appropriate direction to the member to contact 911 or the nearest emergency department. The PMP must provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers.

MDwise Medical Management makes prior authorization decisions based on appropriateness of care and coverage rules. MDwise Medical Management staff and our delegates who perform prior authorization DO NOT receive incentives or rewards, financial or otherwise, for making denial decisions and are not rewarded for making UM decisions decrease utilization of services by MDwise members.

Prior Authorization Required for Elective Inpatient Admissions

Effective January 1, 2011, the Office of Medicaid Policy and Planning (OMPP) requires Prior Authorization (PA) for all nonemergent inpatient admissions for Traditional Medicaid and Indiana *Care Select members*. This applies to medical and surgical inpatient admissions. Emergency admissions, routine vaginal deliveries, C-section deliveries, and newborn stays will not require PA. Observation will not require PA. For MDwise *Care Select* members, providers must contact MDwise Customer Service at 1-800-356-1204 or 317-630-2831 in the Indianapolis area at least two business days prior to admission. All inpatient hospital PAs will be requested via telephone. The facility must call prior to the admission and provide criteria for medical necessity. If information given by the provider over the phone is not sufficient to make an immediate determination, additional information may be requested and the PA will be suspended for this required information. It should also be noted that concurrent review and discharge information of the non-emergent admission is not required once the PA has been obtained.

The Indiana Health Coverage Programs (IHCP) follows Milliman guidelines for all non-emergent and urgent care inpatient admissions. If IHCP criteria already exists, use that criteria first when determining if admissions are appropriate. If criteria are not available within Milliman or IHCP policy, the IHCP will rely on medical necessity determination of current evidence-based practice. To assure a 48 hour turnaround, the PA request should be made by a clinical staff person. For non-emergent and urgent care admissions that occur outside normal business hours, including weekends and holidays, providers will have 48 hours from the time of admission to request PA.

When requesting a prior authorization, providers must provide the following information:

- Member name and recipient identification number (RID)
- Procedure requested, including Current Procedural Terminology (CPT®1) code
- Location service is to be performed (facility)
- Medical condition being treated, including International Classification of Diseases, Ninth/Tenth Edition, Clinical Modification (ICD-9/10-CM) code
- Medical necessity of the procedure
- Admitting physician or surgeon
- Date of admission
- The estimated length of stay (LOS)
- National Provider Identifier (NPI)

With this new requirement that all non-emergent/elective inpatient medical admissions require PA, there have been no changes to the IHCP PA regulations outlined in the Indiana Administrative Code (IAC) or the IHCP Provider Manual Chapter Six, in regards to procedures or surgeries that may or may not require PA. The procedures/surgeries that require PA remains the same and will continue to be processed accordingly. There will be the continued need for the provider to submit the proper documentation for review as has always been the requirement, i.e. bariatric surgery, transplants, hysterectomies, etc. When the provider faxes the PA request for the procedure/surgery he/she should also request the inpatient stay at that time on the Universal PA Form; the MDwise PA staff will not automatically add the inpatient stay.

Primary Medical Provider (PMP) Responsibilities for MDwise *Care Select* Members in the Right Choices Program

MDwise *Care Select* PMPs who provide primary care services to MDwise *Care Select* members enrolled in the Right Choices Program (RCP) serve an important function in coordinating member care and improving health outcomes while reducing inappropriate utilization of Medicaid services that can harm members and cause wasteful use of program resources. To help PMPs better understand the RCP Program as they work with MDwise *Care Select* RCP members, the following information outlines a few of the key roles RCP PMPs play as they work with MDwise Disease Managers and other IHCP specialty providers (i.e. specialists or hospitals). PMPs who have questions about these roles or would like further clarification may consult the IHCP Provider Manual, Chapter 13, Section 4 located at www.indianamedicaid.com or contact MDwise Customer Service at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.

PMP roles:

1. **Referrals**–PMPs must use referrals if the RCP member requires evaluation or treatment by a specialist or another doctor. The purpose of the referral is to ensure the PMP has authorized the visit to the referral provider. The referral should be sent to the RCP administrator to ensure that claims from referral providers will be processed for payment. Referrals should include IHCP member's name, IHCP member's recipient identification number (RID), first and last name of the referring physician (the second physician), first and last name of the referral physician (the third physician), new rendering provider's National Provider Identifier (NPI) and the group the rendering provider is linked to, date of the referral, date(s) of service for which the referral is valid and the PMP's manual or electronic signature. (NOTE: Signatures of office staff for the physician are unacceptable). PMPs are encouraged to provide referrals for all Medicaid services, including self-referral services, to ensure that any prescriptions written by the providers will be reimbursed appropriately at the pharmacy.

2. **RCP Member Termination**–PMPs may opt to terminate a member's care for specific reasons outlined in the provider's internal office policies and the administrator's provider manuals, such as noncompliance with treatment recommendations and abusiveness to office staff. If this situation should transpire for a RCP member, the following MUST occur:

   • The provider should give a letter to the member, with 30 days notice, stating that the member's care (by the PMP) is being terminated.

   • A copy of this letter should be mailed or faxed to the MDwise RCP administrator with any applicable reassignment request forms. The MDwise RCP administrator will work with the member to select another PMP. PLEASE NOTE: Referrals made by the terminating provider will expire 30 calendar days after the MDwise RCP administrator's receipt of the dismissal. Upon approval from the MDwise RCP administrator's medical director, the expiration date may be extended by MDwise under the following extenuating circumstances: (1) New provider is unable to see member within 30 calendar days. (2) RCP member eligibility terminates during the process of changing the PMP and the member is auto-assigned to dismissing provider.

3. **RCP PMP Services**–RCP PMPs are not required to furnish all medically necessary services for RCP members. RCP members who need specialty services (i.e. cardiology, endocrinology, etc) that are medically necessary can be referred to the appropriate specialty provider by the RCP PMP. No certification codes are required for referrals, but the RCP PMP must authorize those services by following the guidelines specified in the first bullet above and submit the referral to the MDwise RCP administrator. Specialty services which require PA from MDwise must be completed by the specialty physician who is providing that service.

The MDwise RCP Program is designed to assist the member's PMP in coordinating care and improving member compliance and behavior. RCP PMPs are encouraged to contact the MDwise RCP Program and allow the RCP administrator to work with the member to remove barriers to following the PMP's plan of care or improve member compliance or inappropriate behavior. It is the role of the MDwise RCP Program to support and assist the PMP in improving the member's health, locating additional community and social services, finding access to appropriate specialty care, removing transportation or language barriers, reinforcing the PMP's plan of care, and improving medication adherence.

MDwise is actively seeking PMPs in the MDwise *Care Select* PMP network to participate in the MDwise RCP Program due to a shortage of RCP PMPs. Please contact the MDwise RCP administrator if you would like to participate. PMPs can determine the extent to which they accept new RCP members into their practice by discussing this with the MDwise RCP administrator.

Contact Us:

Customer Service Department
1.800.356.1204 or 317.630.2831

MDwise.org