SUMMER 2011
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MDwise

ProviderLink

Your Quarterly Connection to Smart Solutions For MDwise Providers

MDwise **Medical Management**

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.

Reviewer Availability

As an NCQA accredited organization, MDwise complies with NCQA Standard UM 7. Our Delivery System Medical Management Departments have the availability of an appropriate practitioner to discuss medical or behavioral health cases with the treating or attending practitioner. If you or your office receives notification of an impending denial, you should also receive a reminder regarding the availability to have this discussion, also known as a "peer to peer," and how to initiate the discussion.

If you have questions about the peer to peer review or need assistance, please contact the Medical Management Department that you submitted the request to authorize or you may call MDwise Customer Service at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.

IN THIS ISSUE:

Care Select Primary Medical Providers and Members Benefit from Disease Management Support

As a result of changes to the Indiana *Care Select* (ICS) Program, MDwise has focused on providing disease management services and adding value to PMPs and members who opt to remain in the MDwise ICS Program. Many *Care Select* members suffer from chronically poor health and require intensive and often complex treatment regimens. Chronic health conditions and low health literacy often lead to debilitating health issues that acute medical services alone cannot alleviate. MDwise disease management services offer a diverse, intensive and coordinated approach to improving the health outcomes and quality of life for MDwise *Care Select* members.

Member health care is often fragmented and poorly coordinated leaving the member with multiple health providers, case managers and care givers. Often there is not one person who is familiar with the member's overall care and treatment. Our approach is based on the belief that the needs of the member are best met by creating an environment that helps members organize, make sense of and navigate today's complex health care system. A proactive model that is holistic and robust, blending disease management, member education and outreach, and care management into one comprehensive program utilized by the disease management team. This approach benefits the member's health and supports the PMPs who are working for the best health outcomes.

The following are some of the benefits enjoyed by members and their PMPs:

PMPs

- Evidence based member care plans
- Coordination of care including referrals
- Reinforce PMP's plan of care
- Comprehensive disease education
- Manage members collaboratively who require a lot of attention
- Access to transportation network for medical appointments
- Multi-disciplinary disease managers (i.e. medical and behavioral health)
- Quarterly pharmacy reports (medical and behavioral)
- Collaboration leads to improved member health outcomes and lower physician costs to work with *Care Select* membership

Members

- Access to multi-disciplinary care with a "live" disease manager
- Disease managers who build collaborative relationships with members
- Disease self management education
- Care plans designed to meet the member's individual health goals
- Medical decision education and empowerment
- Access to transportation for medical appointments
- Positive progress managing chronic conditions
- Improved health outcomes
- Positive interaction with MDwise

Hoosier Healthwise Member Rights and Responsibilities

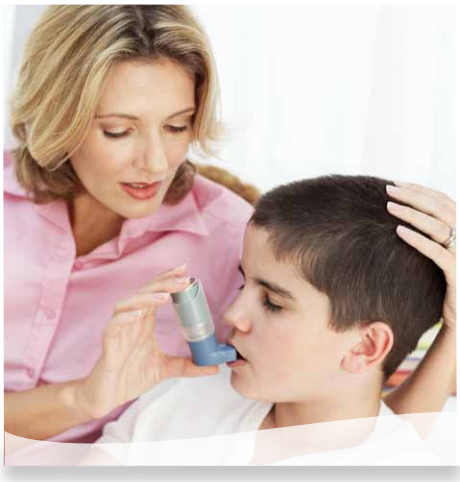
The MDwise Hoosier Healthwise Member Rights and Responsibilities Statement is available at MDwise.org.

For a printed copy of this information, call us at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.

Kids Reap the Benefits of Asthma Camp

Marti Michel, MSN, RN, CNS, AE-C

What could be better than five nights and six days in the beautiful rolling hills of Brown County? Add in great activities like archery, arts and crafts, canoeing and kayaking, creek walks, fishing, challenge courses (low ropes and high ropes), horseback riding and swimming. Now add in a dedicated cadre of health care professionals who volunteer to spend a week at asthma camp, in addition to the counselors and program staff at Happy Hollow Camp (**www.HappyHollowCamp.net**), so that 80–120 children with asthma from Indiana and surrounding states have the opportunity to attend an overnight camp.



Happy Hollow provides the only overnight camp within the state for boys and girls ages 7–14 who have moderate to severe asthma. Happy Hollow has sponsored a week-long residential camp for 20 years and is a medically supervised camp, with physicians, respiratory therapists, nurses and pharmacists available 24 hours a day. It is sponsored by Indiana University Healthcare, Praxair and IU Health Homecare. I have been privileged to volunteer at asthma camp the last 19 years and the amazing thing is that there are medical staff who have been there much longer. Like InJAC, Happy Hollow Camp wouldn't work without volunteers! One parent wrote on her child's asthma camp application, "It is hard for me to let my child even go outside to play so at first I thought 'No way can she go to asthma camp!' But then last year I talked with another mom who had three kids go to camp and I thought I would give it a try. She had such a great time and learned so much and I rested easy knowing that the staff knew what to do if she had trouble."

We learn a lot about our campers on their camp applications. It is not unusual to see a child who has been to the emergency department multiple times, required hospitalization or has missed many days of school due to asthma. The goal of all asthma camps is to have a camp experience in an environment that also fosters learning about asthma and self-management skills. It promotes feelings of normalcy and allows a child to build life skills such as self-confidence, teamwork, personal responsibility and problem-solving. Camp provides formal asthma education, but within the context of the camp experience. Kids learn about their asthma but they do it while they have fun and may not even realize they are being educated.

There can be lots of firsts at asthma camp—first overnight away from family, first time to be out of the city, first time to paddle a canoe or kayak, first time to swim in a lake, first time to ride a horse, first time to conquer a challenge like completing the high ropes course, overcoming a bout of homesickness or sleeping in a tent under the stars. For some of our kids, it is also the first time they have ever taken their controller medicines on a consistent basis, or been away from second-hand and third-hand smoke. During a week in late June or early July, when the weather is hot and muggy and asthma triggers are literally everywhere, you might expect these kids to have lots of problems but they don't. Over the last ten years we have seen a huge decrease in the number of asthma exacerbations during camp, which is associated with increasing number of children who get appropriately treated with inhaled corticosteroids. According to Debbie Koehl, MS, RRT, AE-C, and a member of InJAC, who serves as Medical Staff Coordinator for Happy Hollow Asthma Camp, it is rare for a child to require emergency care for asthma related symptoms. "Every year we have more children who are on controller-medicines before they come to camp and that has made a huge difference in the numbers of kids who require rescue treatments during activity or at nighttime. Now, we are much more likely to have to see the child in the infirmary or go to the local ER because of a "normal kid" injury such as a need for stitches or a sports-related injury than for asthma."

While Happy Hollow Asthma Camp is the only overnight camp for children in Indiana, according to the Consortium on Children's Asthma Camps (**www.asthmacamps.org**) there are two asthma day camps for children in the state. Camp Nota-Gona-Wheeze is a free day camp offered during spring break for elementary students who have asthma. It serves children from southern Indiana is sponsored by St Mary's Hospital, the Evansville Vanderburgh School Corporation and the University of Southern Indiana. Camp Eeze-the Wheeze is a week long day camp which enrolls campers ages 6–13. It is sponsored by the Thomas Bly Foundation, American Lung Association of Indiana in conjunction with the Indiana University Kokomo School of Nursing and is held in June.

InJAC
Joint Asthma Coalition
Reducing the burden of asthma in Indiana

Routine *Care Select* Prior Authorization Calls for Providers

Routine Call–Determining Whether a Service Requires PA in Indiana *Care Select*
Providers must check the Indiana Medicaid website at **www.indianamedicaid.com** to determine if a service requires PA in the Indiana *Care Select* and Traditional Medicaid Programs by using the Medicaid fee schedule and the Indiana Health Coverage Programs (IHCP) Provider Manual. Use of these products is free and made public to all providers regardless of enrollment status. It is the provider's responsibility to familiarize themselves with PA requirements that are specific to their specialty service area (IHCP Provider Manual Chapter 6, pages 6–7) rather than rely on the CMO for this information. The IHCP website is the preferred source to share information regarding Medicaid policies including PA. If the provider doesn't have access to the Internet, they will need to discuss adding this capability with their internal management staff in order to comply with IHCP rules previously specified regarding knowledge of PA requirements for their specialty area. Providers should contact the CMO if they require education on how to use the fee schedule or understand basic PA guidelines.

Routine Call–Checking PA Status
HP's Web interChange is the preferred source to check claim status, PA status, and a member's eligibility. Providers have the ability to use HP's Web interChange free of charge to check the status of a PA regardless of the submission method used (i.e. mail, fax, or web or electronic PA submission) and should not rely on the member's CMO to provide them with this information. Enrollment in Web interChange's PA inquiry function can be handled through the provider's assigned database administrator for Web interChange functions or via HP at 1-877-877-5182. Providers should contact the CMO for more complex PA questions such as questions regarding a CMO's suspension of a PA for additional information or clarification of documents necessary to process a PA. If the provider doesn't have access to the Internet, they will need to discuss this issue with their internal management staff so that they can determine PA status.

Providers should contact their HP Provider Relations field representative or HP's Electronic Solutions Helpdesk for questions regarding the use of Web interchange.

Member Eligibility and Coverage for **Hoosier Healthwise Package E Members (Emergency Services Only)**

Health coverage for certain members is limited to treatment for medical emergency conditions. These members are in the FFS delivery system only. The Omnibus Budget Reconciliation Act (OBRA) of 1986 defines an emergency medical condition 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.*

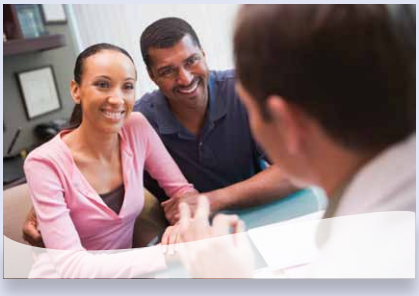
In the case of pregnant women eligible for coverage under Package E, labor and delivery services are also considered emergency medical conditions.

For emergency services rendered to members enrolled in this benefit package, providers must indicate emergency in the proper form locator on the claim form or 837P transaction.

The IHCP does not cover nonemergency services furnished to individuals enrolled in Package E. The patient may be billed for these services if notified of noncoverage prior to rendering care.

Children born to Package E members are eligible for full coverage upon determination of eligibility through the local county office of the DFR or outreach location. Children who are not born in the United States are eligible only under Package E. These children are only eligible for emergency coverage, and are not covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Hoosier Healthwise Package B **Codes Updates**



The Indiana Health Coverage Programs (IHCP) has updated its Package B covered ICD-9-CM Diagnosis Codes to include Family Planning diagnosis codes. Providers providing family planning services to Package B members can now utilize family planning ICD-9-CM Diagnosis Codes for Package B members instead of just a pregnancy related diagnoses (i.e. V22.0). Family planning services are a covered Medicaid service for all Package B members per the IHCP Provider Manual.

Providers may reference Banner page BR201117 dated April 26, 2011 for a list of covered family planning diagnoses located at http://provider.indianamedicaid.com/ihcp/Banners/BR201117.pdf. Based on this banner page and Medicaid guidelines, providers may utilize any of the codes from this list as the primary diagnosis codes for Package B members to convey the provision of a covered service. Therefore, with this update, providers should no longer be required to include a pregnancy code, such as V22.0 (supervise normal pregnancy) as the primary diagnosis code on claims for family planning services.

MDwise is in the process of updating its provider manual and its website at MDwise.org to reflect this update to Package B covered diagnosis codes.

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

MDwise began a new partnership with IU Medical Group-Primary Care (IUMG-PC) for Healthy Indiana Plan (HIP) claims payment processing on April 1, 2011. IUMG-PC is processing HIP claims with DOS April 1, 2011 and forward while Affiliated Computer Systems (ACS) is contining 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.

Behavioral Health Providers Communication with Primary Care Physicians

Lynn Bradford, Ph.D.
MDwise Director of Behavioral Health

The State of Indiana continues to emphasize the importance of maintaining regular communication between behavioral health providers and primary care physicians for its Medicaid members. As Medicaid providers who are part of the MDwise Behavioral Network, I would like to remind everyone of the need for this communication.

The new MDwise contract that you signed in 2010 states the following:

"Per the requirements of the RFS, Provider shall 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, psychotherapy prescribed, the visit date and provider's contact information.

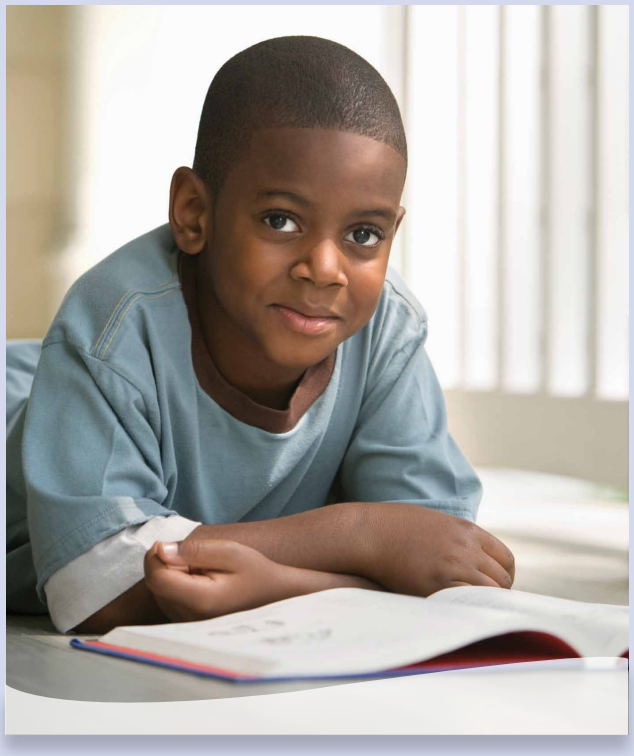
Behavioral health providers must also notify MDwise and the Covered Person's PMP of any significant changes in the Covered Person's status and/or a change in the level of care.

Any other relevant information."

Additionally, on the OTR form, be sure to indicate that you have completed this communication and when it was done. A member can refuse to allow this communication and this can be stated on the form. When at all possible, encourage the member to allow this communication as it improves the coordination of care.

MDwise thanks you for participating in our network and providing care to its members!

Reach Out and Read Annual Fundraiser



Reach Out and Read prepares Indiana's youngest children to succeed in school by partnering with physicians to distribute books and to encourage families to read together. Reach Out and Read Indiana serves over 180,000 Hoosier children at 150 health clinics. Reach Out and Read Indiana's annual fundraising event will be on Friday, September 23, 2011. This is a family friendly event. "An Evening of Authors" includes local Indiana authors, food, a silent auction, and children's activities. Everyone is welcome to attend.

September 23, 2011
5:30 p.m. – 8:30 p.m.

Fairbanks Hall
340 West 10th Street
Indianapolis, IN 46202

Admission Tickets:
$35 Adults, $15 Children

For more information contact Lisa Robertson at lisa.robertson@reachoutandread.org or 317-822-7302.

MDwise Adopts **90 Day Insurance Rule**

At the request of the Office of Medicaid Policy and Planning (OMPP), MDwise has worked with our Hoosier Healthwise delivery systems to develop a 90 Day Insurance Rule to account for instances when a third party commercial insurance hasn't responded to a provider claim within 90 days of the bill date. The information below is a summary of MDwise's 90 Day Insurance Rule. This information will be added to our provider manual at MDwise.org.

When the member has other insurance, a MDwise provider must submit claims to the other insurance carrier before submitting to the MDwise Delivery System. When a third-party insurance carrier fails to respond within 90 days of the provider's billing date, the claim can be submitted to the MDwise Delivery System for payment consideration. However, one of the following must accompany a claim to substantiate attempts to bill the third party or the claim will be denied:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Provider must note the date of the billing attempt and the words no response after 90 days on an attachment. This information must be clearly indicated.
- Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days from the billing date. The provider is required to boldly make a note of the following on the attachment:
  - ✔ Date of the filing attempt
  - ✔ The words no response after 90 days
  - ✔ Member identification number (RID) & 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 & IHCP provider number
  - ✔ Name of primary insurance carrier billed

Cultural Competency and Behavioral Health Care

Lynn Bradford, PhD, HSPP
Director of Behavioral Health

MDwise is responsible, per its contract with the State of Indiana, for ensuring that its behavioral health network providers are trained about and are aware of the cultural diversity of the Medicaid population served by the Hoosier Healthwise and Healthy Indiana Programs. To that end, MDwise is notifying the members of its behavioral health network of free continuing education programs available on the web.

The Office of Minority Health offers this program.:

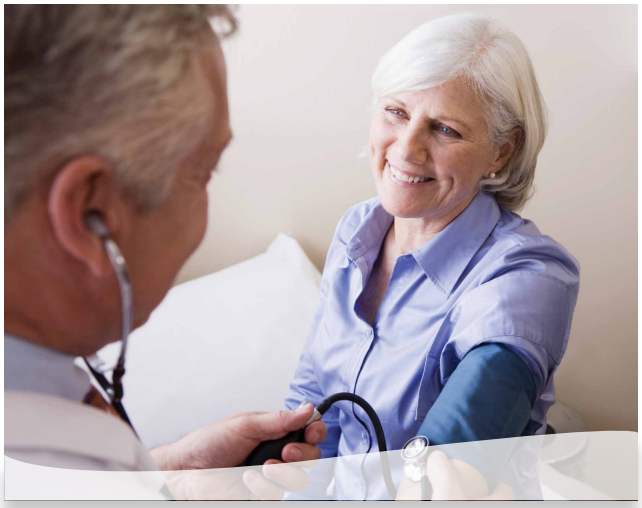
MDwise.org/providers-continuingedcredits.html

You do have to register and there is a link to that service:

https://cccm.thinkculturalhealth.hhs.gov/default.asp

The Office of Minority Health has also issued National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. To read more about these standards, follow the link below:

www.omhrc.gov/clas/



Preventive Health Guidelines

Preventive Health Guidelines can be accessed on the provider section of MDwise.org.

For a printed copy of this information, call us at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.

MDwise Hoosier Healthwise **2010 Primary Medical Provider (PMP) Satisfaction Survey and Office Manager/Nurse Survey**

The Myers Group (TMG), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, was selected by MDwise to conduct its 2010 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 report summarizes the results and assists in identifying plan strengths and opportunities.

The vendor sent the 2010 Provider Satisfaction Survey to 1,301 Primary Medical Providers (PMP) and called 687 Office Manager/Nurses in the MDwise Hoosier Healthwise program. Responses were received from 252 of the sampled PMPs, and, 278 responses from Office Managers/Nurses. Results were collected from December 2010 through January 2011.

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

The 2009 TMG Medicaid Book of Business is a benchmark containing data from all eligible Medicaid Provider Satisfaction Surveys TMG collected data for in 2009. Plans were included in the Book of Business only if they contained at least 12 of the benchmark questions. As a result, the 2009 TMG Medicaid Book of Business is comprised of 34 plans encompassing 9,901 respondents. Attributes were included in the 2009 TMG Medicaid Book of Business if at least 11 of the plans included the question in their survey.

The 2009 TMG Medicaid Respondent-Level Benchmark contains the respondent-level data from the 34 Provider Satisfaction Surveys included in 2009 TMG Medicaid Book of Business in addition to Office Manager Satisfaction Surveys which represent results from respondents. This benchmark segments results by Survey Respondent (Physician versus Office Manager) and is shown on the respondent-level, meaning that ratings from the respondents (9,901 Provider Survey respondents plus Office Manager Survey respondents) are averaged to compute the Summary Rate.

As in the 2009 TMG Medicaid Book of Business, plans were included in the TMG Respondent-Level Benchmark only if they contained at least 12 of the benchmark questions. Attributes were included in the 2009 TMG Medicaid Respondent-Level Benchmark if at least 11 of the plans included the question in their survey.

The 2009 TMG Medicaid Respondent-Level Benchmark is shown to provide a comparison of how Physician respondents from MDwise compare to Physician Benchmark respondents and how Office Manager respondents from MDwise compare to Office Manager Benchmark respondents.

The MDwise goal 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

The charts below presents 2010 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 (252) Composite/Attribute	MDwise n	MDwise 2010 SRS	MDwise 2009	Other Plans n	Other Plans 2010 SRS	Significance Testing
Provider Relations		**35.2%**	**34.9%**		**26.6%**	**Not Sig.**
Responsiveness of the provider relations representative	220	43.6%	43.1%	185	29.7%	Sig. higher
Usefulness of practitioner educational meetings/in-services	169	31.4%	37.0%	133	26.3%	Not sig.
Usefulness of written communications, manuals	224	28.6%	27.3%	181	23.8%	Not sig.
Responsiveness of health plan's Medical Director	150	7.3%	32.3%	128	26.6%	Not sig.
Continuity/Coordination of Care						
Frequency of feedback/reports from Specialists for patients in your care	193	42.0%	New for 2010	164	39.6%	Not sig.
Behavioral Health						
Quality of the behavioral health reports	141	31.9%	New for 2010	105	23.8%	Not sig.

Office Manager/Nurse Summary Rate Comparison

Office Manager/Nurse (278) Composite/Attribute	MDwise n	MDwise 2010 SRS	MDwise 2009	Other Plans n	Other Plans 2010 SRS	Significance Testing
Provider Relations		**38.7%**	**34.8%**		**23.3%**	**Sig. higher**
Responsiveness of the provider relations representative	232	48.7%	43.2%	214	30.4%	Sig. higher
Timeliness to answer questions or resolve complaints	226	41.2%	29.2%	213	22.5%	Sig. higher
Adequacy of provider orientation by the health plan's provider relations staff	207	37.7%	35.0%	191	25.1%	Sig. higher
Usefulness of educational meetings/in-services	184	32.1%	37.2%	164	17.7%	Sig. higher
Usefulness of written communications and manuals	218	33.9%	29.6%	206	20.9%	Sig. higher
Prior Authorization and Medical Management		**26.2%**	**24.4%**		**15.0%**	**Sig. higher**
Process of obtaining pre-certification/ referral/authorization information	221	30.8%	New for 2010	202	20.3%	Sig. higher
Phone access to medical management staff for prior authorization	220	30.5%	28.3%	201	16.4%	Sig. higher
Timeliness of prior authorization process	220	28.6%	25.4%	202	16.8%	Sig. higher
Extent to which medical management staff share review criteria and reasons for adverse determinations	192	25.0%	22.7%	185	15.1%	Sig. higher
Consistency of review decisions with other plans	184	17.9%	19.1%	173	11.0%	Not sig.

Office Manager/Nurse (278) Composite/Attribute	MDwise n	MDwise 2010 SRS	MDwise 2009	Other Plans n	Other Plans 2010 SRS	Significance Testing
Timeliness of UM appeals process	154	17.5%	New for 2010	146	11.0%	Not sig.
Availability of care/case managers by phone	194	33.0%	27.9%	172	14.5%	Sig. higher
Case Management/Disease Management						
Satisfaction with the referral process of patients to disease management programs	187	27.3%	New for 2010	171	20.5%	Not sig.
Finance Issues		**27.2%**	**27.6%**		**19.9%**	**Not sig.**
Accuracy of claims processing	169	27.2%	29.5%	155	20.6%	Not sig.
Timeliness of claims processing	168	31.5%	32.6%	154	23.4%	Not sig.
Resolution of claims payment problems or disputes	162	22.8%	20.6%	147	15.6%	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

	MDwise Overall Satisfaction Summary Rate		
All Respondents	**2010**	**2009**	**2008**
	72.7%	72.4%	58.5%

When the overall satisfaction scores for 2010 are combined, the Summary Rate has increased significantly from 2008 but only slightly increased from 2009.

Summary Rate Comparison by Survey Type

All Respondents (530) Composite/Attribute	MDwise Valid n & Summary Rate Score					
	Aggregate		Physician		Office Manager	
MDwise Overall Satisfaction						
Please rate your overall satisfaction with MDwise	477	72.7%	234	64.5%	243	80.7%
Provider Relations						
Responsiveness of health plan's provider relations representative	452	46.2%	220	43.6%	232	48.7%
Usefulness of practitioner educational meetings/in-services	353	31.7%	169	31.4%	184	32.1%
Usefulness of written communications/manuals	442	31.2%	224	28.6%	218	33.9%

ANALYSIS/RECOMMENDED IMPROVEMENT ACTIVITIES: Overall, the scores for the 2010 Provider Satisfaction Survey were up slightly from 2009. The goal of improving provider satisfaction levels was achieved.

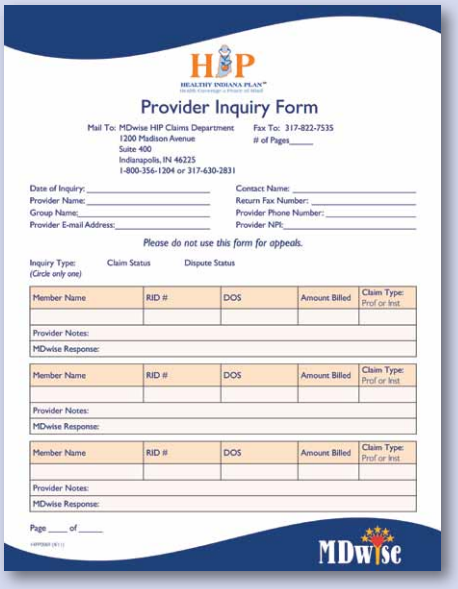
The survey pointed out some areas that correlate with satisfaction where MDwise needs to focus resources on:

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

If you have suggestions or comments related to this article, pleased call Dan Westlake at 317-822-7228.

HIP Claims Inquiry Form for Providers and Billing Offices

MDwise now offers providers a new tool to check claims status for Healthy Indiana Plan claims. The new fax inquiry form can be used by all provider types. Faxes can be sent to a confidential fax number at 317-822-7535. Claims inquiry received before 4:00 p.m. ET are responded to daily.



Provider Inquiry Form

Mail To: MDwise HIP Claims Department
1200 Madison Avenue
Suite 400
Indianapolis, IN 46225
1-800-356-1204 or 317-630-2831

Fax To: 317-822-7535
# of Pages____

Date of Inquiry: _____
Provider Name: _____
Group Name: _____
Provider E-mail Address: _____

Contact Name: _____
Return Fax Number: _____
Provider Phone Number: _____
Provider NPI: _____

Please do not use this form for appeals.

Inquiry Type: (Circle only one) Claim Status Dispute Status

Member Name	RID #	DOS	Amount Billed	Claim Type: Prof or Inst
Provider Notes:				
MDwise Response:				
Member Name	RID #	DOS	Amount Billed	Claim Type: Prof or Inst
Provider Notes:				
MDwise Response:				
Member Name	RID #	DOS	Amount Billed	Claim Type: Prof or Inst
Provider Notes:				
MDwise Response:				

Page ____ of ____

MDwise

To find the form online, got to MDwise.org/healthyindiana/providers/forms.html. Scroll down to the bottom of the page and click on, "HIP Claims Provider Inquiry Form" under "Claims Forms."

MDwise

Contact Us:

Customer Service Department
1.800.356.1204 or 317.630.2831

MDwise.org