Member Rights and Responsibilities

Medical care is based on scientific principles and on partnerships among the member, doctor, MDwise and other health care staff. MDwise is committed to developing these partnerships and recognizes that there are certain member rights and responsibilities that are critical to the success of this partnership and the provision of appropriate medical care. Please review the MDwise member rights and responsibilities statements:

Hoosier Healthwise, HIP and Hoosier Care Connect member rights and responsibilities

MDwise Marketplace member rights and responsibilities

We appreciate you!

MDwise appreciates your hard work and dedication as part of our provider network. MDwise values your participation as you provide quality care to our MDwise members throughout 2016 and for years to come.
Cut, Copy and Paste Functionality in Electronic Health Records

Maintaining a legally sound health record covers a vast territory from the content of the health record and how entries are recorded to the functionality in the system to access, audit trails and security. While the electronic age brings new variables to an old and complex problem, the foundation remains the same: health records must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards and legal standards.

An important documentation issue in Electronic Health Records (EHRs) is the cut, copy and paste functionality. Organizations must consider whether they will allow cutting and pasting and how they will handle cut-and-paste content from one entry to another.

AHIMA recommends the following guidelines for the cut, copy and paste functionality. The primary issue with the cut, copy and paste functionality in the EHR is one of authorship—who is the author and what is the date of origination for a copied entry?

Cutting and pasting saves time; however, it also poses several risks:

- Cutting and pasting the note to the wrong encounter or the wrong patient record.
- Lack of identification of the original author and date.
- The acceptability of cutting and pasting the original author’s note without his or her knowledge or permission.

Organizations should develop policy and procedures related to cutting, copying and pasting documentation in their EHR systems. By following these guidelines and training clinical staff, providers can allow cutting and pasting within certain boundaries.

- In general, the original source author and date must be evidenced in copied information. If users are allowed to copy forward from a previous entry by another person, an attribution statement referring to the original document, date, and author should be attached or incorporated where applicable.
- Cutting, copying and pasting must not be perceived as “OK unless proven otherwise” but instead should be considered “not OK until proven otherwise.”
- Each potential function must be evaluated for policy or procedure acceptance or rejection by a practice.
- In some settings, copy and paste may be acceptable for legal record purposes but not for others (clinical trials data, quality assurance data, pay-for-performance data).
- In the hybrid environment, audit tracking of copy and paste may not be available because it involves different systems.
- In some contexts, it is never legitimate, including settings where the actual function takes personal health information outside the security environment.
- Some systems have an intermediate step allowing information to be brought forward but require another validation step.
- As a mitigation step, boilerplate text or libraries may be devised to describe common or routine information as agreed upon by the organizational standards.
Applied Behavioral Analysis (ABA) Therapy

ABA therapy is the behavioral health treatment used to treat members diagnosed with Autism Spectrum Disorder. ABA involves breaking skills down into their most basic components, rewarding the demonstration of appropriate behavior with praise and positive reinforcement and then "generalizing” skills in a naturalistic setting. ABA is the design, implementation and evaluation of environmental modifications to produce socially significant improvement in human behavior. MDwise has provided coverage for ABA therapy for the past 3 years and has an adequate network of ABA providers throughout the state. We continue to enroll providers based on need in a given area of the state as well as ensuring that the providers have proper certification. To provide ABA therapy providers need to have the following certifications:

- HSPP
- Licensed or Board Certified Behavioral Analyst (BCBA)
  - Master’s level
- BCBA Bachelor’s level
- BCBA-D Doctoral level
- Credentialed Registered Behavioral Technician (RBT)

It is the provider’s responsibility to pursue these certifications. ABA services rendered by a BCBA-D, BCBA, BCaBA, or RBT must be billed under the National Provider Identifier (NPI) of an IHCP-enrolled physician or HSPP, because behavior analysts are not currently enrolled independently. Prior authorization is required for these services to ensure that medical necessity criteria are met. For additional information, please see Bulletin BT201606.

Requesting and Obtaining an Authorization for MDwise Marketplace

Quick reference guides and specific lists of services requiring prior authorization for medical review are distributed to the contracted providers by delivery system medical management staff and can also be found at MDwise.org/forms/priorauthorization.

The list of services requiring prior authorization is reviewed at least annually and updated as needed. For the most up-to-date and comprehensive list of services requiring prior authorization providers should contact their delivery system medical management department. See the MDwise Marketplace quick contact guide at MDwise.org/quickcontact for contact information for each delivery system or call the MDwise provider relations department at 317.822.7300 ext. 5800.

Authorizations can be obtained from each delivery system by phone, fax, mail or delivery system online authorization tool (if available). Delivery system medical management contact information can be found on the MDwise Marketplace quick contact guide at MDwise.org/quickcontact.

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Valid Prior Authorization Requests

A valid prior authorization request is defined as one where:

- The request is initiated by the primary care provider (PCP/PMP), treating specialist, the treating provider or member.
- The member is enrolled with MDwise Marketplace at the time of the service.
- The appropriate authorization form is completed for service requests.
- A physician prescription is included with a request for enteral formulas, infusion therapy and DME that requires authorization accompanies the request.
- Clinical documentation to support medical necessity is included in the request.

Authorization Submission

For specific service requirements, see the MDwise prior authorization guidelines at [MDwise.org/forms/priorauthorization](http://MDwise.org/forms/priorauthorization).

For faxed or mailed submission physical health providers should use the MDwise Marketplace prior authorization form, found on [MDwise.org/forms/priorauthorization](http://MDwise.org/forms/priorauthorization). There will be a separate MDwise Marketplace outpatient treatment request form for behavioral health providers. See the MDwise Marketplace quick contact guide for medical management phone and fax numbers.

Information submitted with a service request should include:

- Demographic information.
- Type of care.
- Frequency and duration (if applicable).
- Facility or provider.

- Diagnosis.
- Procedure.
- Date of service or onset date of services.
- Other pertinent clinical information to benefit coverage determinations.

Confirmation of Requested Authorizations

Network providers will obtain confirmation of received authorization requests and an authorization letter via fax or mail. Information provided will include the authorization identification number, authorization decision, number of days/visits and the duration approved or denied.

Only those requests made by the requesting servicing provider may be viewed by the requesting servicing provider. All requests are assigned an authorization identification number for tracking purposes independent of the approval status. It is imperative that providers validate the status of a specific authorization request.

All authorization decisions resulting in an adverse determination are also communicated to the requesting provider by phone and in writing.

A provider may request a copy of the criteria or guideline used to make a prior authorization denial decision by calling the telephone number indicated on the denial letter and asking the delivery system medical management staff for a copy of the criteria.
Prior Authorization and Referral Process for Hoosier Healthwise, HIP and Hoosier Care Connect

MDwise emphasizes the role of the primary medical provider (PMP) to guide members to the most appropriate treatment option and place of care. The PMP coordinates and oversees referrals to specialty care providers. MDwise medical management works to strengthen the link between the MDwise member and his or her PMP in an effort to coordinate care, prevent unnecessary utilization of services and ensure access to and utilization of needed medical care, including preventive care.

MDwise medical management facilitates PMP’s requests for authorization for primary and preventive care services, if an authorization is required, and assists PMPs in providing an appropriate referral for specialty services, second opinions, special needs and women’s services.

MDwise medical management functions are guided by specific policies and procedural steps to facilitate the review of a referral/authorization request based on the appropriateness of care and services for that individual member.

General Information

Referral: The label given to the process when the PMP determines that the member’s condition requires additional services provided by a provider other than a primary care physician.

Prior Authorization (PA): The actions taken, including review of benefit coverage and clinical information, to determine if the requested service meets the criteria for authorization.

Authorization Requests: Specific forms are available from medical management to submit for service authorization. The forms are to be completed by the requesting provider and any additional information the provider chooses to provide to support request.

Please Note: Incomplete forms or requests lacking required information to support the specific request will delay the authorization process.

Service Types Requiring Prior Authorization: Such services are grouped according to service type categories that include the following: physician services (in-network, out-of-network or non-contracted physicians); inpatient admissions; outpatient services/procedures; pharmacy; therapies, home health care, durable medical equipment; transportation; and self-referral services in accordance with IHCP requirements. These categories of services are listed in the MDwise prior authorization quick reference guides.

Specific Authorizations by Federal and State Regulations:

MDwise follows federal and state regulations related to authorizations of requests for second opinions, access to specialists for members with special needs and access to women’s health specialists for female members.

Who To Contact To Obtain a Referral or Prior Authorization

In the MDwise system, prior authorization is handled by the delivery system to which the patient’s doctor belongs. Providers should refer to the quick contact guide at MDwise.org/quickcontact for the phone numbers of their medical management staff.

Out-of-network providers can call the MDwise customer service department at 1.877.822.7196 or 317.822.7196 to be connected to the appropriate medical management staff.

Quick Reference of Services Requiring Prior Authorization

Quick reference guides and specific lists of services requiring prior authorization for medical review are distributed to the contracted providers by your delivery system medical management staff. The list of services requiring prior authorization is reviewed at least annually and updated as needed.

Medical management staff is available to discuss and assist the providers in understanding the prior authorization process. Providers can also access authorization information through the MDwise website as well as prior authorization forms at MDwise.org/forms/priorauthorization.

To ensure you have the latest and most comprehensive list of services requiring prior authorization, contact your medical management staff.

Prior authorizations for health care services can be obtained by contacting the medical management department by phone or fax. This information can be found in the quick contact guide at MDwise.org/quickcontact.

MDwise medical management identifies specific services and treatments that require prior authorization for medical necessity review based on several criteria, including federal and state regulations and policy. Many services and treatments available from MDwise in-network/delivery system providers do not require a medical review.
Interpretation Services

MDwise members are eligible to receive interpretation services at no cost. This includes all foreign languages as well as sign language services. The legal foundation for language access lies in Title VI of the 1964 Civil Rights Act. The Health and Human Services (HHS) Office for Civil Rights has responsibility for enforcing the Civil Rights Act and the Americans with Disabilities Act. They have issued guidance for providers to help clarify responsibilities. They suggest that given the nature and importance of health care services, health care providers have a special obligation to ensure language access for their patients. Once a health care provider accepts any federal funds (e.g., Medicare or Medicaid payments), the provider is responsible for providing language access to all of their patients.

There are several ways that appropriate language access can be provided. Interpretation services can occur:

- Face-to-face by hiring an interpreter from a local or state organization that provides these services in-person at the provider office
- Telephonically through language line options, many of which may be available through provider groups or hospital affiliations

These language options all have varied per hour (in-person) or per minute (phone) costs. If you do not have this resource or do not know how to obtain interpretation services for your patients, please contact your MDwise provider relations representative for assistance.

The use of family members and friends as interpreters is not recommended! It raises quality and confidentiality concerns. Here are a few examples:

- Breach of confidentiality
- Patients may be reluctant to disclose information critical to their situation/condition
- Greater likelihood of medical errors
- Mistaken naming of body parts
- Family shame and other issues that may interfere
- Inaccurate history collection can result in inadequate treatment recommendations

The use of professional, trained interpreters is critical. If you need additional information about accessing or use of interpretation services, please access the MDwise Provider Toolkit on Culturally and Linguistically Appropriate Services, here.