

Provider Notification

Notification Date: 07/01/25

To: Hospitals

From: MDwise Provider Relations

Subject: Prudent Lay Process

Effective Date: 07/01/2025

Summary

7/1/25 MDwise will be using the Prudent Lay Process (PLP) for all emergency Services.

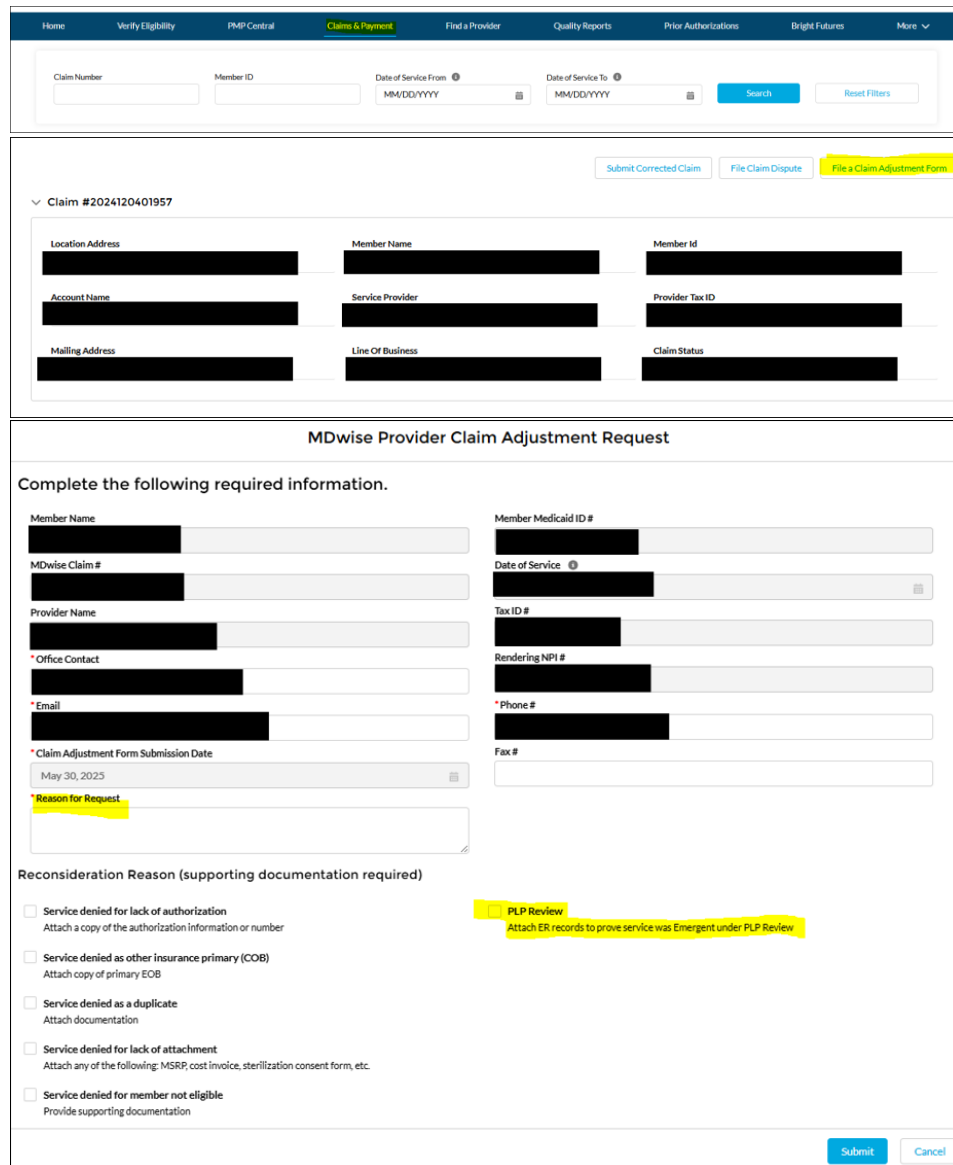
Impact

- Hospital providers billing for ER services.

Action

1. Claim will match against ER auto pay list (list of dx codes to indicate if the visit is emergent or non-emergent)
2. If dx code on claim does not match a dx code on the ER auto pay list, the claim will only pay a screening fee
3. If the provider disagrees and feels the service should meet the emergency requirements outside of the ER auto pay list, the provider can request a PLP review

- To request a PLP review, the provider will need to send a copy of medical records through the MDwise portal via a claims adjustment form to be reviewed within 90 calendar days from the date of the most recent Explanation of Benefits (EOB)



The screenshot shows the MDwise Provider Claim Adjustment Request form. At the top, there is a navigation bar with links: Home, Verify Eligibility, PMP Central, **Claims & Payment**, Find a Provider, Quality Reports, Prior Authorizations, Bright Futures, and More. Below the navigation bar is a search section with fields for Claim Number, Member ID, Date of Service From (MM/DD/YYYY), and Date of Service To (MM/DD/YYYY), along with Search and Reset Filters buttons.

Below the search section, there are buttons: Submit Corrected Claim, File Claim Dispute, and **File a Claim Adjustment Form**. A dropdown menu shows "Claim #2024120401957".

The form is titled "MDwise Provider Claim Adjustment Request". It asks to "Complete the following required information." and lists several fields: Member Name, MDwise Claim #, Provider Name, * Office Contact, * Email, * Claim Adjustment Form Submission Date (May 30, 2025), * Reason for Request, Member Medicaid ID #, Date of Service, Tax ID #, Rendering NPI #, * Phone #, and Fax #.

Below these fields is a section for "Reconsideration Reason (supporting documentation required)" with several checkboxes:

- ☐ Service denied for lack of authorization (Attach a copy of the authorization information or number)
- ☐ Service denied as other insurance primary (COB) (Attach copy of primary EOB)
- ☐ Service denied as a duplicate (Attach documentation)
- ☐ Service denied for lack of attachment (Attach any of the following: MSRP, cost invoice, sterilization consent form, etc.)
- ☐ Service denied for member not eligible (Provide supporting documentation)

At the bottom right, there are Submit and Cancel buttons. A yellow highlight is placed over the "PLP Review" option in the Reconsideration Reason section, with a note: "Attach ER records to prove service was Emergent under PLP Review".

- Upon review by the prudent layperson, the claim can be deemed emergent and will be adjusted to pay in accordance with the IHCP fee schedule or determined to remain paid at the screening fee as non-emergent

*If a member calls the 24-hour nurse hotline and is told to go to the emergency department, the claim will be treated as an emergency.