MDwise

A McLaren Company

Provider Manual

Hoosier Healthwise and Healthy Indiana Plan (HIP)

Hoosier Healthwise

HIP HEALTHY INDIANA PLAN

Contents

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Welcome to MDwise!

MDwise welcomes you as a provider in the MDwise network. This Provider Manual gives guidance on all the Indiana Health Coverage Programs (IHCP) MDwise manages. In addition to the MDwise guidelines, requirements, policies and procedures, this manual can be a valuable tool for assisting in the care of our members.

MDwise values the on-going partnerships with our network providers. Communication is essential in making these partnerships work. The Provider Manual is updated annually and when the program changes occur throughout the year. Providers will be notified on the MDwise homepage regarding the revisions and updates within the Provider Manual at www.MDwise.org. MDwise provides additional updates throughout the year including quarterly newsletter articles, special mailings and email alerts.

Providers are given 45 calendar days' notice of any significant change that may affect office practices and/or procedures. A significant change in practice is determined by the impact of the policy on such issues as coverage criteria, authorization procedures, referral policies, subcontractors, provider office site standards, medical record standards, or access standards. All significant changes are required to be posted on the MDwise website.

If providers have questions or concerns about a member's care, they are encouraged to call the toll-free MDwise Customer Service line at (800-356-1204). MDwise Customer Service Representatives (CSRs) are available Monday through Friday from 8:00 a.m. to 8:00 p.m.

Eastern Standard Time. After regular business hours, MDwise contracts with a telephone answering service that is trained to respond to most provider issues that arise after hours. Calls received after hours but not resolved are forwarded to the MDwise Customer Service team for follow-up the following business day.

Providers should submit questions regarding this manual to the MDwise Provider Services Department at prenrollment@MDwise.org, or by calling 317-822-7300 option 1.

What is MDwise?

MDwise **(pronounced Em•Dee•wise)** is your local, Indiana-based nonprofit health care company. We were founded in 1994 to help vulnerable populations needing health coverage in Indiana. Our parent organization, McLaren Health Care is a nonprofit integrated health system that believes all Indiana families should have access to high-quality health care regardless of income. Our mission is to provide high-quality health care. We only take care of families in Indiana. MDwise works with the State of Indiana and Centers for Medicare and Medicaid Services to bring you the Hoosier Healthwise and Healthy Indiana Plan health insurance programs.

MDwise Mission and Vision

MDwise provides high-quality, affordable health care services and improves the well-being of our members by bringing together exceptional employees, community leaders and health care professionals. MDwise strives to be the most influential, trusted choice in health plans by doing what is best for the communities we serve.

MDwise five-fold Mission:

- Delivering consistent, high-quality care.
- Focusing on families and community in a culturally competent way.
- Shaping health policy and promoting innovation in Medicaid managed care.
- Ensuring financial viability through efficient and cost-effective operations.
- Involving providers in key decision making and nurturing local governance of the MDwise product.

MDwise Core Values

- **Trust:** We trust each other and act with integrity. We are authentic, empowered to act and communicate openly with candor and caring. We make decisions for the greater good. We earn the trust of those we serve through transparency and accountability. We are dependable – a promise made is a promise kept.
- **Excellence:** We make sound decisions and deliver quality programs with precision. We are subject matter experts and perform to our full potential by working as a team.
- **Stewardship:** We are mission-driven. We are entrusted as stewards of a company that serves members, associates, customers, business partners, and our community. We care deeply about each other and all stakeholders. We are privileged to take care of our members and treat every dollar as if it were our own. We are efficient, set priorities and ensure our processes add value to enhance the member experience.
- **Innovation:** We continuously improve to make it easier to do business with us. We challenge the status quo, generate ideas, collaborate, value diversity and demonstrate agility. We are courageous, learn from experience and adjust quickly.
- **Leadership:** We are industry thought leaders and advocates. We take initiative, are accountable for results and empower those around us to be their best. We roll up our sleeves and dig in to help. We lead by example.

Maximizing value in health service delivery includes a focus on quality and access and ultimately depends on the collaborative relationships between the managed care entity, providers, and well-informed members. In delivering Hoosier Healthwise and Healthy Indiana.

Plan services across the full health care continuum, a primary focus of MDwise is to link primary care physicians, specialists, hospitals, and ancillary providers so all providers can administer and coordinate care more efficiently and effectively.

MDwise emphasizes the role of the primary medical provider (PMP) to guide members to the most appropriate treatment option and place of care. MDwise works to strengthen the link between MDwise members and their PMP medical home by encouraging preventive care, helping coordinate specialty services and preventing potential waste and abuse.

MDwise is focused on ensuring members have access to a full range of cost-effective, quality care. MDwise members are given a Member Handbook, periodic newsletters and mailings, in addition to member outreach and education calls. MDwise focuses outreach on members with diverse medical needs and those residing in underserved areas.

Provider Responsibilities

This chapter contains important information about the role and responsibilities of MDwise providers. Topics covered in this chapter include provider qualifications, network participation process, access and quality standards, and the rights and responsibilities of MDwise providers.

Provider Qualifications & Criteria

To participate in the MDwise Plan under Hoosier Healthwise or Healthy Indiana Plan, providers must first enroll with the State as a participating provider in the Indiana Health Care Programs (IHCP). This means having a valid, current Medicaid provider number and NPI number. This chapter outlines additional participation requirements specific to MDwise.

MDwise follows State policies and procedures related to requests for network participation.

To participate as an in-network MDwise provider, providers must submit all the documentation required on the Universal MCE Enrollment forms to prenrollment@mdwise.org. In addition to the enrollment form(s), providers must also include a W-9 signed within the last calendar year, collaboration agreements for nurse practitioners, and a declaration of ownership form when the request is for a new contract or adding a new location to an existing contract. Detailed steps of the network participation process can be found on the homepage at www.mdwise.org. If you have questions regarding the network participation process, please call your dedicated Provider Relations Representative.

Practitioner Roles & Responsibilities

The primary medical provider (PMP) is an integral part of the MDwise managed health care program. The PMP office functions as the "medical home" for MDwise members. The medical home is a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety. MDwise PMPs coordinate all covered physical and behavioral health care services for their assigned members, except for self-referral and carved-out services.

MDwise offers network participation contracts to all IHCP-enrolled providers once the credentialing process for the provider is established and approved. MDwise guides members to participating specialists and hospitals while maintaining the continuity of each member's health care. MDwise will not limit practitioner's ability to advise a member about their health status, medical care, or treatment options, even if MDwise does not cover those options.

MDwise delivers primary and preventive health care to its members in a personalized and systematic manner through a state-wide network of PMPs and specialists. MDwise encourages providers to give members information about available treatment options regardless of the benefit coverage limitations. In addition, providers should inform members of the scope of the covered benefits under the member's benefit package and how coverage relates to the member's medical needs.

All providers who participate within the MDwise network must agree to the following participation requirements:

- Follow all MDwise Policies and Procedures and Federal and State requirements.
- The MDwise Provider Manual outlines and describes MDwise policies.
- Providers can find state requirements on the web at www.in.gov/medicaid/providers.
- Providers can reach out to MDwise Customer Service or a Provider Relations Specialist with questions about these policies.

Practitioner Participation Criteria

All providers requesting initial and continued participation in the MDwise health plan must meet the following criteria as part of the credentialing process:

- Attested and completed application.
- Hold a current, valid and unrestricted license to practice in Indiana.

DEA: If requesting prescriptive authority, the provider must hold a current, valid and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. ***Note:*** *DEA or CSR certificates are not applicable for chiropractors.*

Education: Graduate of a school recognized by the appropriate Indiana State Boards. Satisfactorily completed a residency program in the appropriate specialty of practice. ***Note:*** *: Residency requirements are not applicable to chiropractors.*

Board Certification: Board certification must come from a recognized Board, such as the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Podiatric Medical Association (APMA), or other recognized specialty boards.

Providers must be Board Certified (or eligible) in the practitioner's specialty used in treating MDwise members. ***Note:*** *Board Certification does not apply to chiropractors.*

Board Certification exception considerations:

- The practitioner has recently completed degree requirements and is in the process of seeking board certification.
- Practitioner has satisfactorily completed a residency program in the appropriate primary specialty of practice and has obtained one of the following (categories):
- Minimum of 25 CMEs (in the previous 12 months/one-year credentialing cycle)
- Minimum of 50 CMEs (in the previous 24 months/two-year credentialing cycle)
- Has a minimum of 75 CMEs (in the previous 36 months/three-year credentialing cycle)
- Physician's specialties are not sufficiently available from board certified or board eligible practitioners within a reasonable commuting distance.
- Current clinical privileges are in good standing at the hospital designated by the practitioner as the primary admitting facility

Note: *If the practitioner has not obtained the required CMEs at the time of initial credentialing or recredentialing, approval for participation may be granted for one year. The practitioner must make up the number of CMEs for which they were deficient, along with obtaining the required 25 Category/CMEs per year. For example, if practitioner has obtained 65 CMEs at time of recredentialing, provider must obtain 35 CMEs during the one-year credentialing cycle.*

Privilege exception considerations:

The physician's practice does not require admitting or practicing privileges at a hospital. These specialties include, but are not limited to radiology, podiatry, pathology, dermatology, emergency medicine, allergy and some behavioral health practitioner specialties (if hospital privileges are available in their specialty).

Current Liability Coverage: Maintains professional liability insurance coverage of $500,000/$1,500,000 with participation in the Indiana Patient Compensation Fund. If the practitioner is not qualified as a provider under the Fund, then they must maintain coverage of $1,000,000 per occurrence, $3,000,000 aggregate, or be a covered employee or contractor of an entity eligible for coverage under the Federal Tort Claims Act.

Malpractice History: Demonstrates acceptable liability history based on the frequency, pattern, and type of settled and pending claims against the practitioner. The practitioner must submit a detailed report of each liability claim filed within the past ten years. The Medical Director will review the claims history for any trends, such as pattern of frequency, date of occurrence, number of open cases, sequential order of patterns and file date.

The peer-review committee will individually review all practitioners with the following:

- Four (4) or more filed malpractice claims or settlements in the last five (5) years
- Any settlement or award of $500,000 or more in the last five (5) years
- Any filed malpractice claims or settlements involving the death of a patient in the last five (5) years

Recredentialing: If there are no additional suits filed against the practitioner since the most recent credentials cycle or if no new information exists on previous cases (e.g., settlement reached, finding of malpractice), individual consideration of liability history is not required.

Impairment: Certifies that a physical or mental dependency (and substance abuse) does not affect the ability to practice.

Sanctions, Disciplinary Action or Criminal Indictment: Must demonstrate absence of Medicare or Medicaid sanctions and disclose:

- All past or pending sanctions under State or other licensing agencies, hospitals and other facilities, or DEA.
- All past or pending disciplinary or professional committee action by a health care entity (e.g., hospital).
- All information concerning any past suspensions, limitations, or termination by any managed care plan, hospital or insurer.
- Any felony convictions. Must demonstrate that history of sanctions/convictions do not demonstrate potential future substandard professional performance.

Work History: Satisfactory five (5) years of professional employment and/or education history.

Initial Office Review: PMPs, obstetricians/gynecologists and high-volume behavioral health specialists must have satisfactory office onsite survey results to participate in the MDwise network.

Attestation Statement: Practitioners must attest to the correctness and completeness of the application.

IHCP Participation: MDwise practitioners must enroll as providers in the Indiana Health Coverage Programs (IHCP). Practitioners who have laboratory testing services onsite must also provide proof of a Clinical Laboratory Improvement Amendments (CLIA) certificate.

Contract: MDwise practitioners must sign an agreement to abide by the terms of the contract.

Physician Extenders

Advanced Nurse Practitioner & Physician Assistant Participation Criteria

MDwise recognizes the value of physician extenders and their vital role in delivering primary and specialty care. With projections of continued shortages in the number of primary care physicians in Indiana, particularly for the underserved population, physician extender importance to providing timely care for our members cannot be understated. These practitioners (including nurse practitioners, nurse midwives, clinical nurse specialists, certified nurse anesthetists and physician assistants) extend the availability of health care and substantially add to physician productivity, allowing the practice site to treat more patients in a timely manner.

MDwise is committed to using physician extenders to increase the availability of primary care offered to current and potential MDwise members. When utilized appropriately, physician extenders offer a cost-effective and valuable clinical resource for providing health care, especially as part of a safety net for underserved populations. Physician extenders in the MDwise network offer opportunities to extend PMP capacity to serve MDwise members and assist in providing more timely access to preventive health care services and acute care for minor illnesses.

Advanced Practice Nurses (Nurse Practitioner, Certified Nurse Midwife, Clinical Nurse Specialist) and Physician Assistants must meet the same credentialing criteria as outlined above for physicians, with the following exceptions:

- **Written Practice Agreement:** Proof of collaboration with a licensed network practitioner, in the form of a written practice agreement.
- **DEA:** If requesting prescriptive authority, current, valid, and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate. Note: DEA or CSR certificates are not applicable for some types of physician extenders.
- **Privileges:** Hospital privileges are not applicable for physician extenders.
- **Education:** Graduate of a school recognized by the appropriate Indiana State Boards. Board certification requirements are not applicable.

Responsibilities of the specialty and ancillary providers include:

- Following the MDwise prior authorization and referral requirements.
- Contacting the PMP to coordinate the member's additional care needs when identified.
- Maintaining contact with the PMP regarding the member's status (e.g., telephone/verbal communication, consultations, written reports).
- Actively participate in coordinating the member's plan of care/treatment plan with the member's PMP and, when applicable, the member's case manager. ***Note:*** *Prior authorization of service is not a guarantee of payment; the member must also be eligible for benefits each date the service is rendered, and claim submission requirements followed, for payment to occur. Providers must verify eligibility for each date that services are rendered. Failure to do so may result in denial of payment.*

Credentialing and Enrollment Process

Provider Credentialing

As a condition of participation in MDwise health plans, licensed independent practitioners, and practitioner groups (including non-physician practitioners) who are contracted with MDwise and provide care for MDwise members, must be credentialed according to MDwise network participation process. Practitioners must complete a standard credentialing application when applying for initial participation and submit other required information (e.g., DEA certificate, malpractice insurance face sheet, curriculum vitae).

The function of the MDwise credentialing process is to support the development and maintenance of credentialing and recredentialing standards for MDwise practitioners based on the Office of Medicaid Policy and Planning (OMPP) and National Committee for Quality Assurance (NCQA) standards. Our provider credentialing and selection policies do not discriminate against providers that specialize in conditions that require costly treatment or provide services to high-risk populations. Our goal is to review the qualifications of potential network practitioners against established standards and to reassess the credentials and performance of network practitioners periodically to ensure that practitioners are qualified to carry out the scope of their duties on behalf of MDwise.

Credentials staff will collect information from recognized monitoring organizations, conduct the required verifications, and review the practitioner's credentials. The credentials staff will notify the practitioner about any information obtained during the credentials process that varies substantially from the information supplied by the practitioner. The practitioner must provide additional information regarding the discrepancy by emailing corrected information to the credentialing department at credentialing@mdwise.org within 48 hours of requesting the additional information.

MDwise processes all network participation requests within 30 calendar days of receipt of a complete application. When all required information and verifications are complete, the MDwise Credentials Committee will consider the practitioner's application (peer-review process). At a minimum, the committee individually reviews the credentials of practitioners who do not meet MDwise established criteria. Committee members are required to abstain from participating in a vote regarding a practitioner if there is a conflict of interest, any professional involvement with the practitioner, or judgment might be otherwise compromised. MDwise will notify practitioners of the credentialing decision within 30 calendar days of the peer-review committee's decision.

Note: *All practitioners have the right to request and receive information regarding the status of their credentialing application. The practitioner may call or write to the MDwise credentialing staff to check the application status. The credentialing staff may share credentialing information with the practitioner except for references, recommendations and/or peer-review protected information.*

All practitioners listed in the MDwise Provider Directory for Hoosier Healthwise and HIP must be credentialed, including:

- Licensed independent medical and behavioral health practitioners or practitioner groups (including non-physician practitioners) who are contracted with MDwise and provide care for MDwise members.
- Practitioners who see members outside the inpatient hospital setting, outside freestanding ambulatory or facility-based settings.
- Practitioners who are hospital-based but who see MDwise members because of their independent relationship with the organization.
- Non-physician practitioners who have an independent relationship with MDwise, as defined above, and who provide care under the Hoosier Healthwise or Healthy Indiana Plan medical or behavioral health benefit.

MDwise maintains the confidentiality of all information developed or presented as part of the credentialing process in accordance with State and Federal regulations. Individuals engaged in credentialing activities ensure that information supplied by the applicant in the application remains confidential.

MDwise secures credentialing files, including confidential records regarding deficiencies found, actions taken, and the recommended follow-up. MDwise provides restricted access information only to those individuals necessary to attain the objectives of the credentials process. MDwise will only distribute confidential information when expressly required by law or with the permission of the practitioner applicant.

Recredentialing

MDwise requires all providers participating in the MDwise health plan to be recredentialed at least every 36 months. The recredentialing process is conducted similarly to the initial credentialing process.

- Practitioners must submit a standard recredentialing application.
- The credentials staff will then collect the necessary information and conduct the required verifications.
- During recredentialing, staff may use data derived from practice experience within the organization as part of the evaluation regarding practitioner retention.
- Credentialing staff would notify the practitioner if information obtained during recredentialing varies substantially from the information that the practitioner supplied to MDwise. The practitioner may then provide additional information regarding the discrepancy.
- When all the required information and verifications are complete, the Credentials Committee will consider the practitioner's application.

The credentialing department is responsible for monitoring practitioner sanctions, member complaints and quality issues between recredentialing cycles. Monitoring helps to ensure that potential quality or safety issues are identified and investigated in a timely manner so that MDwise can implement appropriate actions. Ongoing monitoring between recredentialing cycles includes collecting and reviewing information related to Medicare and Medicaid sanctions, sanctions or limitations on licensure, member complaints about participating practitioners, and information from identified adverse events and quality issues.

Credentialing Appeal Process

MDwise offers an appeal process for credentialing or quality issues when a practitioner is denied participation, suspended, or terminated from the network. The appeals process meets the requirements of the Health Care Quality Improvement Act of 1986. MDwise notifies a provider of appeal rights and procedures in writing within ten (10) business days of the adverse credentialing/recredentialing determination.

Providers have 15 days from the date of the denial letter to submit additional information to the Credentialing Committee for reconsideration. If the committee determines a provider's participation is terminated, the provider has 30 calendar days to request an appeal of network participation. All requests must be made in writing and sent to the credentials staff at credentialing@mdwise.org.

Termination from the network will not be effective until the provider has exhausted the appeal process or chooses not to appeal in the required amount of time.

MDwise is responsible for reporting serious provider quality deficiencies that affect network participation to the appropriate State and/or Federal authority. Concerns relating to quality of care, professional competence or professional conduct are considered reportable actions.

Office Site Visits

MDwise conducts office site visits for the following scenarios:

- During the initial credentialing process for primary medical practitioners, obstetricians/gynecologists, and high-volume behavioral health practitioners.
- When a practitioner claims more than one office location. An onsite review is conducted at each location to ensure that the network participation requirements are met.
- If a MDwise practitioner relocates or opens a new site. An onsite review is conducted following the same procedure as for an initial site visit.
- If the office to which a practitioner is relocating already meets MDwise standards, then a new site visit is not required.

MDwise may also conduct an office site visit for any contracted provider based on a review of member complaints. Provider office sites will be re-evaluated every three (3) years to verify that the location still meets MDwise requirements.

Physician offices must score a minimum of 80% to comply with the office and medical record performance standards. If a site does not meet this threshold, actions for improvement must be implemented and MDwise may visit the site again to ensure the minimum threshold is met.

Provider Enrollment

PMP Enrollment

MDwise Primary Medical Providers (PMPs) for the Hoosier Healthwise and HIP programs are required to be enrolled with Indiana Medicaid. PMPs allowed to open panels for membership include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians and gynecologists and endocrinologists (if the provider's primary specialty is internal medicine). Physician extender providers may also open a panel with MDwise. All PMPs must be fully credentialed according to MDwise standards before enrolling with MDwise.

After becoming a provider in the Indiana Health Coverage Programs, MDwise requires the following PMP enrollment steps to occur:

- The provider submits the completed forms and documents required for the network participation process to prenrollment@mdwise.org.
- The provider enrollment staff reviews the forms for accuracy and ensures all the required information is present. ***Note:*** *Incomplete forms and/or documentation are returned to the provider within five (5) business days with an explanation of what information is missing. If the forms are rejected, the provider must submit all required documents in a new network participation request.*

Once the required documentation is validated, providers are reviewed for credentialing status and contracting needs. Providers and/or provider groups not already participating with MDwise are sent a contract for review and signature.

The provider is enrolled as a PMP upon the completion of the credentialing and contracting activities. Panel sizes and demographics are enrolled separately for Hoosier Healthwise and HIP. Hoosier Healthwise requires a minimum panel size of 150 members. HIP requires a minimum panel size of 25 members unless an exception is approved by MDwise.

After the network participation process is complete, all MDwise providers will receive educational training regarding the Hoosier Healthwise Program and HIP programs, including covered services, self-referral services, quality improvement requirements, medical records retention and availability, member reassignment, member appeals process, provider dispute procedures and POWER Account features (HIP only).

PMP Panel Requirements

Prospective PMPs designate a desired panel size on the Universal MCE Enrollment forms submitted to MDwise during the network participation process. The panel size is the number of MDwise members a PMP agrees to accept. PMPs with two practice locations can designate the panel size at each location separately. The panel status and size are attributed to each individual PMP in a provider group office and may vary by service location. MDwise approves the enrollment of panel sizes below the minimum requirement on a case-by-case basis.

Federal Law mandates an auto-assignment process that ensures members in a managed care program are assigned to primary medical providers. If a PMP has panel slots available, and their panel is not otherwise closed, additional members may be assigned through the auto- assignment process. Full panels or panels on "hold" may still receive an auto-assigned member if they had been assigned to the provider in the past or if they have a sibling/family member currently assigned to the provider.

MDwise PMPs that wish to increase or decrease their panel size can do so at any time by submitting a Universal MCE Enrollment form to prenrollment@mdwise.org. Providers should indicate that the submission is an update to an active panel and not a new participation request. The MDwise enrollment staff will review the forms and update the information in the IHCP

Provider Healthcare Portal and all applicable MDwise databases. Note: A request to lower the panel size to a number that is less than the current number of assigned members will not result in an immediate reduction in panel membership. A reduction in actual panel size can only occur through attrition. Auto-assignment is not considered a justifiable cause for requesting a member be reassigned from a panel.

A PMP can also request that their panel size be temporarily placed on "hold" to prevent new assignments by selection or default auto-assignment. The panel hold does not prevent the assignment of family members with the same case ID as an existing panel member nor members who have had a previous relationship with the PMP.

Panel hold requests are granted with the expectation that the hold be temporary. A panel hold status should not be used to circumvent minimum panel size requirements. The reasons for a panel hold request must be documented and monitored by MDwise to ensure adequate openings to accommodate new MDwise members who self-select or are auto assigned to a PMP within the program.

Note: *Your provider relations representative is available to assist you with selecting an appropriate panel size, completing the required forms, and helping with any panel size changes or hold requests.*

Enrollment Changes and Updates

MDwise is responsible for developing a PMP and specialty provider directory for MDwise members. This directory is based on the information supplied through the provider enrollment process and ongoing provider updates.

MDwise regularly submits a Hoosier Healthwise/HIP provider list to the State, identifying enrolled MDwise PMPs for members to select a PMP. All information in the MDwise Provider Directory and Hoosier Healthwise/HIP provider list must be accurate and include provider specialty, practice limitation, address and office locations. Providers who fail to submit timely and accurate provider enrollment records with MDwise may result in provider directory errors and potential claim denials.

All provider enrollment updates should be sent to prenrollment@mdwise.org within 30 days of a change. Your provider relations representative can assist your office in completing the appropriate Hoosier Healthwise/HIP enrollment form to submit the update.

Note: *Changes in location address, pay to, and specialty additions must be updated on the IHCP Provider Healthcare Portal before they are submitted to MDwise, or our provider enrollment team will not be able to honor the update.*

Some examples of changes that must be updated on the IHCP Provider Healthcare Portal prior to a submission to MDwise include:

- Address/phone number
- Name change
- Age restriction changes or changes in scope of practice
- Change in hours
- Group information, such as addition of new service locations or providers
- Tax ID changes
- CLIA updates
- Ownership changes
- Panel size changes
- Specialty changes/additions
- Board certification status
- Languages spoken
- Adding new physicians to the practice

PMP Disenrollment Procedure

If a provider plans to disenroll from MDwise, the process is outlined as follows:

- A PMP may disenroll from the MDwise network by submitting disenrollment forms at least 90 days before the date of disenrollment.
- Provider relations personnel reviews and transmits the disenrollment information to the IHCP Healthcare Provider Portal.
- If the provider is disenrolling without reenrolling in another location, MDwise will notify members to choose another MDwise PMP.

The disenrolling PMP may request that all members move to another PMP in the MDwise network. The PMP must send a letter to MDwise that specifies why they are no longer willing or able to serve as a PMP. In addition, the PMP must identify a specific MDwise PMP(s) to receive the assignment of panel members. This letter should include the new PMP(s) name, NPI, LPI and group location the members should be transferred.

Members will receive a notification letter from MDwise advising members they can call customer service and request assistance in selecting a new PMP within the MDwise network. If a member does not select another PMP, MDwise will assign the member to another in-network PMP. Members can change PMPs within MDwise if they are dissatisfied with the transfer. The letter provides members instructions on filing a 'just cause' request if the disenrolling PMP has a panel available with another managed care entity

The MDwise provider enrollment staff will monitor the disenrollment process to ensure all updates have been applied and members assigned to an active PMP.

Specialist and Ancillary Provider Enrollment & Disenrollment

The enrollment and disenrollment procedures are the same for all provider types who wish to participate in MDwise. MDwise determines network adequacy for that provider type in their designated region to ensure members have alternate providers they can seek care. All provider types may be required to provide continuity of care services for existing members for up to 30 days after disenrollment or contract termination. For questions on this process, please contact the MDwise Provider Relations department at prenrollment@mdwise.org.

Specialists and ancillary providers who wish to disenroll from MDwise should submit a request for disenrollment to prenrollment@mdwise.org. This request should include the provider's name, tax identification number (TIN), NPI, LPI, group location(s) information and the date the disenrollment should be effective.

Provider Access & Quality Standards

An integral part of patient care is ensuring patients have access to needed medical care. In accordance with the Office of Medicaid Policy and Planning (OMPP) policy and National Committee for Quality Assurance (NCQA) standards, MDwise establishes standards and monitors performance to help ensure that MDwise members receive timely and clinically appropriate access to providers and covered services. MDwise standards address access to emergency and urgent care services, routine preventive care appointments and after-hours care. In addition to physician response time, office appointment waiting and office telephone answering time are also monitored.

The access standards are specific to the type of requested care, referred to as 'appointment category' in the table below. MDwise providers are expected to have procedures in place to see patients within these timeframes. MDwise is responsible for ensuring that MDwise members have the same access to receive care as a provider's non-MDwise population. As an example, MDwise providers are required to offer the same hours of operation for all patients regardless of insurance coverage. Providers may not restrict appointment availability to the type of insurance a member has.

MDwise encourages all new members to have a visit with their PMP within the first 90 calendar days they become effective with MDwise. Establishing a relationship with their assigned provider and receiving preventive care helps ensure members understand who to contact for urgent and/or emergent care needs. The goal is to identify the members' medical needs early so treatment plans can be established, including referrals to MDwise case management or disease management programs. Providers should alert their MDwise provider relations representative if any of the access standards cannot be met at any given time. PMPs should adhere to the following access standards in providing care to MDwise members

PMP Access Standards

Appointment Category	Appointment Standards
Emergent Care Triage	Must be available 24 hours per day**
Urgent Care	Within 48 hours
Non-Urgent Symptomatic	Within 72 hours
Routine Physical Exam	Within three (3) months
Routine Preventive Care	Within five (5) weeks
Initial Appointment (Non-Pregnant Adult)	Within three (3) months
Routine Gynecological Examination	Within three (3) months
New Obstetrical Patient	Within one (1) month
Initial Appointment Well Child	Within one (1) month of member attempting to schedule

Appointment Category	Appointment Standards*
Children with Special Health Care Needs	Within one (1) month

*Appointment standards are from the date the member attempts to schedule an appointment.
**24 hours per day, seven (7) days per week, in-person or by an on-call physician.

Specialist Access

MDwise also requires the following standards to be maintained regarding patient accessibility to specialist referrals

Appointment Category	Appointment Standards*
Emergency	Must be available 24 hours per day**
Urgent	48 hours
Non-Urgent Symptomatic	4 weeks

*Appointment standards are from the date the member attempts to schedule an appointment.
**24 hours per day, seven (7) days per week, in-person or by an on-call physician

Physician Response Time

MDwise members must be able to reach their PMP, or the PMPs qualified clinical staff person, through a toll-free telephone number 24 hours per day, and seven (7) days per week. Live voice coverage must be available after normal business, which may include an answering service, shared-call system with other medical providers, or pager system.

For non-urgent routine telephone messages, the member must receive a return call within one

(1) business day. This includes a minimum of 20 office hours over a 3-day period each week. (The 3-day requirement can be filled by more than one PMP in a group practice).

Office Appointment Waiting Times

Physicians should see each patient within 60 minutes of their scheduled appointment time.

Office Telephone Answering Time

The office telephone should be answered within four (4) rings or 30 seconds. The length of time to be answered by a live voice to schedule an appointment should be less than three (3) minutes.

Accessibility and Availability Audits

MDwise monitors whether participating providers meet these standards through the following mechanisms:

- Ongoing access audits and after-hours availability studies
- Member satisfaction survey
- Analysis of practitioner complaints in arranging referrals to specialists/ancillary providers
- Analysis of member complaints and grievances
- Practice site audits conducted at time of credentialing
- Emergency Services claims/records analysis

Provider Rights and Responsibilities

This section contains important information about the role and responsibilities of MDwise providers. All contracted providers are responsible for providing covered services to MDwise members, as outlined in the provider's contract. Covered services should be provided with the same care and attention customarily provided to all non-MDwise patients seeking care from the office. Providers are expected to provide covered services according to generally accepted clinical, legal, and ethical standards. These standards should be conducted in a manner that is consistent with the physician's license and with the standards of practice for quality care recognized within the medical community in which the physician's specialty aligns. MDwise PMPs are required to coordinate the provision of covered services to members in compliance with MDwise policies and procedures and IHCP requirements. This includes, but is not limited to, admissions to inpatient facilities, referrals to specialty care, and behavioral health care coordination. Providers are responsible for cooperating with ongoing performance audits related to contract requirements.

MDwise provider responsibilities and requirements:

- **Access to Documents:** Make available all books, medical records, and papers directly pertinent to MDwise and its members so that MDwise and authorized government authorities may review and copy them, as allowed by law and reasonable limits on proprietary information. MDwise will give PMPs reasonable notice and conduct reviews within a reasonable timeframe.
- **Claims:** Submit accurate claims and/or supporting claims data, for each service rendered to MDwise members within the required timeframes of the provider agreement.
- **Cooperation with MDwise programs:** Participate in and follow the rules of the MDwise quality improvement, utilization management, credentialing, grievance resolution, provider service and member education/outreach programs.
- **Notify MDwise about changes in licensure status:** PMP must notify MDwise provider relations staff within three (3) business days if the PMP loses or surrenders a professional license, privilege, Drug Enforcement Administration (DEA) provider number and/or of any other action that negatively impacts the PMP's ability to render services.
- **Continuity of Care:** If the PMP disenrolls or otherwise terms the MDwise contract, the PMP must continue to provide care to MDwise members until the members transfer to another PMP. Note: If a member is currently hospitalized, has a chronic or disabling condition, is in the acute phase of an illness, or in the second or third trimester of pregnancy, the PMP must continue to provide services to the member if those obligations are legally required.
- **Communications with the State:** If a PMP has questions or concerns about MDwise, the PMP must first attempt resolution by calling MDwise customer service or provider relations directly as opposed to contacting the State as the avenue for a first level attempt.
- **Cultural Competency:** PMPs must provide guidance about treatment options in a culturally competent manner. Providers must ensure individuals with diverse health needs, whether medical or social, are approached with effective communication methods, cultural sensitivity and appropriate accommodations that promotes understanding when making decisions regarding treatment options.
- **Nondiscrimination:** PMPs shall not discriminate against any MDwise member based on race, religion, color, sex, sexual orientation, disability, national origin, or ancestry.

- **Medical Records:** Maintain medical records for MDwise members assigned to the PMP for the length of ten (10) years from the date the PMP's contract ends or as required by law. Medical records must also be legible, dated and signed by the rendering provider.
- **Confidentiality:** Protect all medical records for MDwise members as required by law and regulation. Agree not to disclose any MDwise information (like contracts, fee schedules, policy and procedure manuals, and software) or use them except in acting as an MDwise PMP.

Eligibility Verification

Providers should verify eligibility before every visit or every time services are rendered, even if eligibility had been checked recently. Enrollment updates can occur daily, and the member's enrollment may have changed since they were last seen. Enrollment changes affect the provider's ability to obtain prior authorization from the appropriate health plan and may affect payment for services rendered.

Eligibility verification should include:

- Verifying the member's enrollment with the IHCP programs on the Indiana Provider Healthcare Portal
- Verifying that the member is assigned to the MDwise plan
- Validating if the member has active primary insurance coverage available
- Reviewing any program restrictions or benefit limitations at the time service is rendered

Verifying member eligibility is available in the IHCP Provider Healthcare Portal at https://in.gov/medicaid/providers. Entering the member's Medicaid ID number for a specific date of service will yield the member's PMP and the Managed Care Entity (MCE) they are assigned, and the phone number to request further information related to prior authorization and claim submission. There may be instances when the IHCP Provider Healthcare Portal does not indicate that the member is assigned to a PMP, but they are still assigned to MDwise. In this scenario, providers can call MDwise customer service for who the member is assigned to and other additional information as it relates to providing the member care.

Note: *Obtaining prior authorization is not a substitute for checking eligibility and does not guarantee reimbursement for services.*

Charging Members

Missed Appointments

State and Federal policies prohibit providers from billing MDwise members for missed appointments. MDwise educates members on the importance of keeping scheduled appointments and providing advanced notice of a cancelation if necessary. Please call the MDwise customer service department regarding a member who regularly misses scheduled appointments. MDwise health advocates will attempt to contact members for educational purposes and to determine if further assistance is needed.

Cultural Sensitivity & Health Equity

MDwise recognizes that effective health care delivery requires identification, appreciation, and integration of members' different cultures and needs. Cultural, racial, socioeconomic, disability status and linguistic differences can present barriers to accessing and receiving quality health

care. The perception of illness and disease and their causes tends to vary by culture. Also, cultural differences often influence help-seeking behaviors, attitudes towards providers and staff, and the expectations that patients and providers have of each other. Language barriers and poor literacy can compound compliance problems with taking prescribed medications and following recommended treatment regimens.

Providers face these issues every day in clinical practice. In addition to addressing concerns regarding language and communications, physicians working with our members often need to distinguish between traditional and/or non-traditional treatment methods that are consistent with the member's cultural background. Language, religious beliefs, cultural norms, socioeconomic conditions, disability status, diet, etc., may make one treatment method more palatable to a member of a particular culture than to another of a differing culture.

MDwise is committed to working to eliminate potential barriers related to cultural differences. Through avenues such as direct member contact, new member telephonic outreach, member and provider satisfaction surveys, and routine compliance audits, MDwise may become aware of a member's diverse health needs. MDwise then attempts to work with the member to address identified barriers and help them access needed care and services.

Health needs assessments and care management interventions help MDwise identify members with potential diverse health care needs. MDwise care managers attempt to learn as much as possible about an individual's or family's cultural norms to understand the different expectations members may have about covered services and how they receive care. MDwise can assist with the coordination between a member, and their PMP, about medically necessary health care services and problem-solving issues related to medical and/or behavioral health care needs.

MDwise also actively works to assist in identifying additional community resources for members facing barriers to receiving quality health care.

Other mechanisms MDwise utilizes to strengthen the Plan's overall cultural sensitivity and disability competencies include:

- Compliance with the Cultural and Linguistically Appropriate Services (CLAS) standards as outlined by the Federal Office of Minority Health
- Interpretive services and language assistance
- Recruitment and retention policies for minority staff (representative of the diverse demographic population of the service area)
- Diversity education and training for staff and provider community
- Distribution of member education materials that are easily understood by diverse audiences including persons of limited English proficiency and varying literacy skills
- Partnerships with community organizations
- Administrative or organizational accommodations

There are several ways in which providers working with multicultural members and families can contribute to a member's positive experience with MDwise and our provider community. An important first step is sensitivity and respect for cultural values and practices when communicating with members about the services they are receiving or being referred. Some members may require interpretive services, either from a provider or clinical staff from the same

ethnic group as the patient during these discussions and/or when services are rendered.

Persons of the same ethnicity may have varying beliefs and practices. It is important to understand the circumstances of a member or member's family as it relates to their place of origin, socioeconomic background, literacy proficiency, and personal expectations concerning health and medical care.

Some examples of ways that you can help members with linguistic or cultural differences include:

- Interview and assess the members with appropriate use of a bilingual/bicultural interpreter.
- Ask questions to increase understanding of a patient's culture regarding health care practices.
- Formulate treatment plans that take consideration of cultural beliefs and practices where appropriate.
- Write instructions or use handouts if available.
- Effectively utilize community resources.
- Request information provided by health care professionals be repeated by the member to verify understanding of the guidance given.
- Explain technical or specialized terminology and concepts and verify that the patient/consumer understands the meaning of the content.
- Clearly communicate expectations and use drawings and gestures to aid communication where appropriate.
- Preserve a member's dignity during physical examinations and offer emotional support to alleviate any fears and anxiety.
- Health care providers should examine their own expectations to understand how this influences their interactions and decision-making. A reflective approach can be a useful tool in identifying any potential unconscious bias that exists.
- Actively seek knowledge related to the impact of cultural differences on the delivery of health care.

Interpretive Services

Interpretive services must be provided to all MDwise members free of charge as requirement of the Americans with Disabilities Act (ADA). This includes oral interpretation and auxiliary aids such as TeleTYpe (TTY), Telecommunications Device for the Deaf (TDD) and American Sign Language (ASL). If a member has limited English proficiency or a member requires interpretive services due to a hearing impairment, the provider must have these resources available onsite through the provider's hospital resources, group practice accommodations, or other mechanisms.

MDwise provides in-person oral interpretation services free of charge to members for covered services. Interpretive services are encouraged to be scheduled in advance to ensure an appropriate interpreter is available for the appointment. The member or provider should call MDwise customer service as soon as the appointment is set up or at least two (2) business days in advance to schedule interpreter services.

To Access the Indiana Relay Service

For communicating telephonically with a hearing-impaired member, MDwise recommends using the Indiana Relay Service for assistance. To access this free service, dial: 1-800-743-3333.

Medical Records

According to Federal and State regulations, MDwise providers must provide Medicaid members a copy of their medical records at no charge. The provider must facilitate the transfer of the member's medical records to another provider or provide the member with a copy of the records upon request. Accurate documentation in the member's medical record is an essential component of quality patient care. MDwise providers are responsible for establishing and maintaining medical records for each member that are consistent with current professional and accreditation standards and requirements as established in 42 CFR 431.305 and 405 IAC 1-1.4- 2 and MDwise policies and procedures.

Medical records must be current, detailed, and organized, permitting effective and confidential patient care and quality review. Medical records are required to reflect all services provided, including prescriptions for medications; inpatient discharge summaries; patient histories (including immunizations) and physicals; and a record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory tests, x-ray tests and findings. Additional signed documentation of member consent must be obtained prior to releasing medical record information to another provider when it pertains to behavioral health conditions such as substance abuse.

The MDwise medical record standards are based on the IHCP published guidelines that can be found at and www.in.gov/medicaid/providers and www.mdwise.org. The MDwise quality improvement staff conduct a review of medical records maintained by contracted PMPs every two (2) years (at minimum) to assess compliance with these standards. After the review is completed, MDwise notifies providers of the review results and whether any corrective actions are necessary based on the findings .

MDwise providers and practitioners are responsible for maintaining medical records to facilitate communication, coordination and continuity of care and promote efficient and effective treatment. Upon request, providers and practitioners must provide copies of patient medical records to CMS, the State, the health plan and their designees at no cost. Sharing medical records for payment, continuity of care, quality of care and monitoring/oversight is a requirement.

Medical Record Standards are outlined by 42 CFR 431.305, provider contracts, IHCP guidelines and NCQA standards. These standards apply to:

- All services provided directly by a practitioner who provide primary care services.
- All ancillary services and diagnostic tests ordered by a practitioner
- All diagnostic and therapeutic services for which a member was referred by a practitioner, including but not limited to:
    - Home Health Nursing
    - Specialty Physician
    - Hospital Discharge
    - Physical Therapy

Providers and practitioners must maintain policies and procedures that address:

- Confidentiality of patient information
- Secure storage that allows access by authorized personnel only
- Medical record content
- Medical record organization (must be consistent)
- Ease of retrieving medical records
- Information documents must meet minimum documentation standards

Minimum health records documentation standards include:

- Allergies and adverse reactions.
- Problem list.
- Medications.
- Documentation of clinical findings and evaluation for each visit.
- Preventive services/risk screening.
- The identity of the patient receiving the services.
- The identity of the provider rendering the service.
- The identity, including date signature or initials, and position of the provider.
- Employee rendering the service, if applicable.
- The date on which the service was rendered.
- The diagnosis of the medical condition of the individual to whom service was rendered.
- The detailed statement describing services rendered, including duration of services rendered.
- The location at which services were rendered.
- Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document the acute medical needs.
- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment and ongoing evaluations as to assess progress and refine goals.
- Ancillary services and diagnostic tests ordered by a practitioner including but not limited to: X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records.

Additional information may be required by the nature of the services provided including but not limited to:

- Prescriptions for medications.
- Inpatient discharge summaries.
- History and physicals including immunizations
- Record of substances used and/or abused, including alcohol, tobacco and legal and illegal drugs.
- Ancillary, outpatient and emergency care provided.

Note: *Individual member authorization is not required for MDwise to perform medical record review. Privacy regulations permit the sharing of medical and behavioral information between health plans and providers for purposes of health plan operations, which includes quality improvement activities.*

According to State and Federal regulations, as well as MDwise standards:

- MDwise must maintain member medical records for at least ten (10) years.
- MDwise providers must provide a copy of a member's medical record upon reasonable request by the member at no charge.
- MDwise members may request that their medical records be corrected or amended.
- Providers must also facilitate the transfer of the member's medical record to another provider at the member's request.
- Any physician receiving payments from IHCP for rendered services may not charge the member for medical record copying/transfer.
- Additional consent and proof of member understanding is required prior to transferring behavioral health information from a member's medical record.

Member Confidentiality

As part of the commitment to members and providers, MDwise recognizes that everyone has the right to privacy and to be treated with respect. MDwise and associated network personnel must always handle all health care issues in a professional and confidential manner.

Confidential information identifies health care services received by or provided to an individual member by any individual provider/group or institutional provider. Confidential information includes, but is not limited to, the patient's medical record, enrollment information, certain data analysis reports and deliberations regarding health care.

MDwise will monitor the following guidelines related to the protection of confidential information:

- Access to confidential information is limited to those employees who need the information to perform their duties.
- Procedures apply to personal knowledge, written materials and information created in other formats, such as electronic records, facsimiles or electronic mail.
- Disclosure of confidential member information is only permitted through signed authorization by the member or authorized representative and as required or permitted by Federal or State laws, court orders or subpoenas.
- All identifiable data used for quality improvement initiatives must be protected from inappropriate disclosure in accordance with this policy and procedure.

Practitioner onsite reviews conducted during the credentialing process include review of the practitioner's informed consent statements and how the practitioners store and protect medical records.

MDwise also requires that participating providers have a documented process for maintaining the confidentiality of patient information that includes:

- Established confidentiality standards for employees.
- Limited release of medical records and information from or copies of records to authorized individuals.
- Assurance that unauthorized individuals cannot gain access to or alter patient records.
- Established levels of authorized user access to data.
- Assurance of timely access to members who wish to examine their medical records.

All MDwise members have the right to file a complaint or grievance regarding concerns related to the use and/or protection of confidential information and/or data. The MDwise member handbook advises members of their right to file a complaint or grievance.

Hoosier Healthwise

Hoosier Healthwise Program Overview

MDwise participates in the Hoosier Healthwise program. Hoosier Healthwise is a health care program for children up to age 19 and pregnant members. The program covers medical care such as doctor visits, prescription medicine, mental health care, dental care, hospitalizations, and surgeries at little or no cost to the member or the member's family.

The Children's Health Insurance Program (CHIP) falls under the Hoosier Healthwise program. CHIP is for children up to age 19 whose families have slightly higher incomes. In CHIP, members are required to pay a low monthly premium for coverage as well as copays for certain services.

There are two benefit packages within Hoosier Healthwise:

- **Package A** - This is a full-service plan for children and pregnant members. Members do not have any cost-sharing obligations.
- **Package C** - This is a full-service plan for children enrolled in CHIP. There is a small monthly premium payment and co-pay for some services based on family income.

A member's assigned primary medical provider (PMP) is responsible for coordinating their medical and behavioral care. Members are required to select a health plan and PMP during an "open enrollment" period, which is within 90 days from the date their eligibility is determined.

Open enrollment periods for Hoosier Healthwise members occur annually during this period and may change when there is a transfer to another managed care entity (MCE).

Hoosier Healthwise is designed to meet the following goals:

- Ensure access to primary and preventive care.
- Improve access to all necessary health care services.
- Encourage quality, continuity, and appropriateness of medical care.
- Provide medical coverage in a cost-effective manner.

The care of Hoosier Healthwise members is managed by the MCE they are enrolled with, through a network of PMPs, specialists and other providers of care contracted directly with the MCE.

The State of Indiana has sole authority for determining whether individuals or families meet the eligibility criteria for participation in Hoosier Healthwise program through the Division of Family Resources (DFR). Enrollment centers staffed by hospital or clinic staff do not determine final eligibility, although they may assist the member applying for benefits and submit documentation to the State for the determination of eligibility.

Members must choose an MCE once they are enrolled in Hoosier Healthwise. If the member does not choose a health plan, the member will be auto assigned to an MCE. Members may choose a PMP once they are enrolled with an MCE; however, if the member does not choose a PMP, the member will be guaranteed an assigned PMP through the MDwise auto-assignment process.

The following provider specialties are eligible to enroll as PMPs with the Hoosier Healthwise program:

Provider	Provider Types	Specialty Codes
Family Practice	31	316
General Practice	31	318
Internal Medicine	31	344
Obstetrics/Gynecology	31	328
Pediatrics	31	345
Advanced Nurse Practitioner	09	090, 091, 092, 093, 095
Physician Assistant	10	100

Hoosier Healthwise Eligibility

The Hoosier Healthwise program provides coverage to children and pregnant members through benefit Packages A and C.

- **Package A:** Provides a full coverage of benefits for children and some pregnant members who meet the income guidelines established by the State.
- **Package C:** Provides preventive, primary, and acute care services for children ages 19 and under who qualify for the Children's Health Insurance Plan (CHIP).

A child must meet the following criteria to be eligible for Package C:

- The child must be younger than 19 years old.
- The child's family income must be between 150 and 250 percent of the federal poverty level (FPL).
- The child must not have credible health insurance or at any time during the three (3) month period prior to applying for the Hoosier Healthwise program.

Package C eligibility is conditional pending the initial monthly premium payment. Continued enrollment is reliant on timely premium payments in addition to the established eligibility requirements. Nonpayment of premiums after a 60-day grace period will result in a termination of Package C enrollment.

Additional information on Hoosier Healthwise Package A and C benefits are found in the IHCP Member Eligibility and Benefit Coverage Module at www.in.gov/medicaid/providers

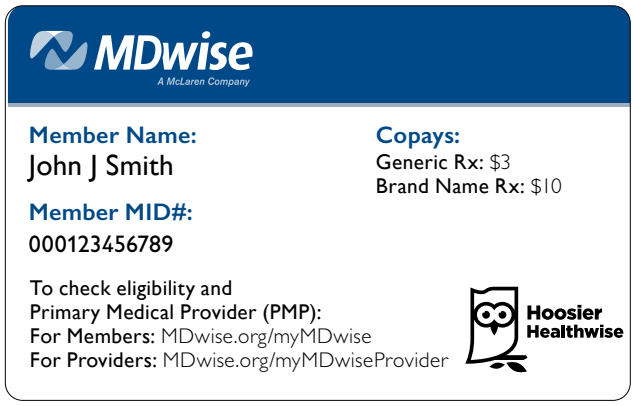
Eligible MDwise members may require medical care prior to receiving their MDwise Hoosier Healthwise ID card or don't have their ID card available when receiving services. Providers must check the member's eligibility even when a card is not available. Eligibility may be verified through the following avenues by using the member's first and last name, date of birth, and/or social security number (SSN):

- The MDwise Customer Service Line at 1-800-356-1204
- The myMDwise Provider Portal at www.MDwise.org
- Indiana Provider Healthcare Portal at provider.indianamedicaid.com

Hoosier Healthwise Member ID Cards

MDwise issues a Hoosier Healthwise Member ID card to all new members. Member ID cards are issued only once automatically; however, members may request a new card be distributed by submitting a request through the MDwise customer service line at 800-356-1204. Family members covered under Hoosier Healthwise receive individual member ID cards, which are not transferable among family members. MDwise encourages all members to bring their individual member ID card to each visit.

Please see a sample card below:



Note: *If a provider suspects a member has presented an identification card belonging to someone else, they should contact the MDwise Compliance department at* **317-822-7400** *immediately.*

Hoosier Healthwise Package C Cost-Sharing & Copayments

Co-pay Amounts

Package C copays must be paid directly to the health care provider or pharmacy at the time of service.

The amounts of the copays are as follows:

Category	Type	Amount
Transportation	Ambulance	$10 (Package C members are covered only for emergency ambulance transportation; nonemergency trips do not apply.)
Pharmacy	Brand Name Drugs	$10
Pharmacy	Generic Drugs	$3

Premium Payments for Package C Members

Federal Poverty Limit (FPL) Income Requirements	Number of Children Enrolled	Monthly Premium Payments
150% to 175% FPL	One (1)	$22.00
	Two (2)	$33.00
175% to 200% FPL	One (1)	$33.00
	Two (2)	$50.00
200% to 225% FPL	One (1)	$42.00
	Two (2)	$53.00
225% to 250% FPL	One (1)	$53.00
	Two (2)	$70.00

Note: *A provider may not deny services to an eligible individual due to the individual's inability to pay the copayment amount at the time services are rendered. This does not restrict the provider's ability to subsequently bill the member for the applicable copayment after a service is provided.*

Hoosier Healthwise Program Benefits

The following table provides an overview of covered Hoosier Healthwise services available to members receiving Package A or C benefits. MDwise provides Hoosier Healthwise members with all medically necessary services that are covered under the Hoosier Healthwise program. The table below provides a general summary of the services covered. For specific service codes that require prior authorization, please refer to the prior authorization section of this manual or on the MDwise website at www.mdwise.org

Benefit	Package A	Package C
Ambulance Transportation (Emergent Only)	Covered	Covered
Chiropractic Manipulation Services**	Covered	Covered
Chronic Disease Management	Covered	Covered
Dental Services	Covered	Covered
Diabetes Self-Management Services	Covered	Covered
Drugs – Over-the-Counter (Non-legend)	Covered	Covered
Drugs – Prescribed (Legend) Drugs	Covered	Covered
Durable Medical Equipment	Covered	Covered
Early Intervention Services (EPSDT)	Covered	Covered
Emergency Services** (Self-referral)	Covered	Covered
Family Planning Services** (Self-referral)	Covered	Covered
Federally Qualified Health Centers (FQHCs)	Covered	Covered
Home- and community-based waiver services	Not Covered	Not Covered

Benefit	Package A	Package C
Home Health Services	Covered	Covered
Hospice Care***	Not Covered	Not Covered
Immunizations (Self-referral)	Covered	Covered
Individualized Education Plan (IEP) ***	Not Covered	Not Covered
Individualized Family Services Plan (IFSP) ***	Not Covered	Not Covered
Inpatient Rehabilitation	Covered	Covered
Long-Term Acute Care Hospitalization	Covered*	Covered*
Long-Term Institutional Care***	Not Covered	Not Covered
Medicaid Rehabilitation Option (MRO)***	Not Covered	Not Covered
Mental Health /Substance Abuse Services – Inpatient **		
(Institution for Mental Disease > 16 beds)	Covered*	Covered*
Mental Health /Substance Abuse Services – Inpatient **		
(Psychiatric Facility < 16 beds)	Covered*	Covered*
Mental Health – Inpatient**	Covered	Covered
(State Psychiatric Hospital)	Not Covered	Not Covered
Non-Emergent Transportation (NEMT)	Covered	Not Covered
Opioid Treatment Program (OTP)	Covered	Covered
Orthodontics	Covered*	Covered*
Out-of-Network Services	Covered	Covered
Out-of-State Medical	Covered	Covered
Pharmacy Services	Covered	Covered
Physical Therapy	Covered	Covered
Podiatrists** (Self-referral)	Covered	Covered
Post-Stabilization Services** (Self-referral)	Covered	Covered
Mental Health /Substance Abuse Services - Inpatient (State Psychiatric Hospital)**	Not Covered	Not Covered
Non-Emergent Transportation	Covered	Not Covered
Orthodontics	Covered	Covered
Out-of-Network Services	Covered	Covered
Out-of-State Medical	Covered	Covered
Pharmacy	Covered	Covered

Benefit	Package A	Package C
Physical Therapy	Covered	Covered
Podiatrists** (Self-referral)	Covered	Covered
Post-Stabilization Services** (Self-referral)	Covered	Covered
	Covered	Covered
Benefit	Package A	Package C
Prosthetics/Orthotics	Covered	Covered
Psychiatric Residential Treatment Facility (PRTF) ***	Not Covered	Not Covered
Psychiatric Treatment in State Hospital***	Not Covered	Not Covered
Respiratory Therapy	Covered	Covered
Rural Health Clinics (RHCs)	Covered	Covered
Tobacco Cessation Treatment (no pharmacy benefit)	Covered*	Covered*
Speech Therapy**	Covered	Covered
Low-intensity residential treatment (ASAM level 3.1) High-intensity residen-	Not Covered	Not Covered
(DMHA Approved SUD Residential Facilities)	Covered	Covered
Surgical Services	Covered*	Covered*
Transplants	Covered	Not Covered
Vision Services, Eyeglasses** (Self-referral)	Covered*	Covered*
Vision Surgical Services	Covered	Covered

**Please refer to the IHCP Member Eligibility and Benefit Coverage Module for service limitations*

***Self-referral services included in these benefits may require authorization. Please see the MDwise prior authorization guide for specific codes.*

****These services may be covered under a different Indiana Health Coverage Program.*

Hoosier Healthwise Service Descriptions

Hoosier Healthwise Self-Referral Services

Federal and State regulations allow Hoosier Healthwise to access certain services outside of MDwise without a referral. Members may access these "self-referral" services from any provider enrolled in Indiana Health Coverage Program (IHCP) qualified to render the service. MDwise is responsible for paying for these services if medically necessary, up to the applicable benefit limits and at 98% of Indiana Medicaid FFS rates.

MDwise does include some self-referral providers in the contracted network. MDwise encourages all PMPs to communicate with self-referral service providers if undertaking any form of medical treatment.

Note: *MDwise may request the use of in-network facilities even when self-referral services are rendered; however, MDwise is required to reimburse the facility and ancillary providers for medically necessary services at IHCP rates, according to IHCP benefit guidelines.*

The following are self-referral services in Hoosier Healthwise:

- **Emergency services:** services rendered for the treatment of an emergency medical condition
- **Chiropractic manipulation services:** IHCP-covered services rendered by a provider enrolled with a specialty 150 (chiropractor) and practicing within the scope of the chiropractic license. Reimbursement is available for covered chiropractic manipulation visits and services associated with such visits in accordance with IC 25-10-1, 846 IAC 1- 1, and 405 IAC 5, Rule 12. Service limits apply on a calendar-year basis. Prior authorization may be required for services.
- **Family planning services:** provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. As outlined in IC 12-15-5-1 and applicable Federal law, reimbursement is available for family planning services.
- **Vision services:** Service limits apply on a calendar-year basis. Prior authorization may be required for services.
- **Podiatry services:** Service limits apply on a calendar-year basis. Prior authorization may be required for services.
- **Immunizations**
- **Diabetes self-management services**
- **Dental services:** Routine dental services (in-network only)

MDwise provides all covered family planning services and supplies, except for the following items which, to the extent included in 405 IAC 5-24 and 405 IAC 9-7 as covered, will be reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation when provided by an Indiana Medicaid enrolled pharmacy or DME provider, as applicable:

- Legend drugs
- Non-legend drugs
- Diaphragms
- Spermicides
- Condoms
- Cervical caps

MDwise remains responsible for reimbursing any provider enrolled with the IHCP for family planning services and supplies so long as they are clinically appropriate or otherwise allowed to provide those services.

Members may self-refer to an in-network behavioral health care provider, or any IHCP-enrolled psychiatrist, without authorization from MDwise or the member's PMP. Members may self-refer to behavioral health services, including mental health, substance use disorder (SUD) services rendered by mental health specialty providers within the MDwise network. The behavioral health providers to which the member may self-refer include:

- Psychiatrists
- Outpatient mental health clinics
- Community mental health centers
- Psychologists
- Health services providers in psychology (HSSP)
- Certified social workers
- Certified clinical social workers
- Psychiatric nurse
- Independent practice school psychologists
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option)

Note: *Refer to the Indiana Health Coverage Program (IHCP) Provider Manual and Bulletins and Banners information related to Self-Referral Services.*

Hoosier Healthwise Emergency Services: Coverage & Prior Authorization

MDwise members may access emergency services 24 hours per day, seven (7) days per week. Members may seek emergency services at the nearest emergency room without referral or authorization when their condition is emergent. MDwise will cover and reimburse all emergency services, including screening services, which are rendered by a qualified IHCP provider to evaluate or stabilize an emergency medical condition. MDwise does not require prior authorization for emergency services or screening exams, regardless of a provider's or facility's contract status with MDwise; however, providers are still required to be actively enrolled with the IHCP to receive reimbursement.

MDwise considers each emergency claim as an emergency medical condition. Since each claim is considered an emergency medical condition, MDwise pays in-network and out-of-network providers at 100% of the IHCP fee schedule.

If a provider or provider's clinical representative advises a member to seek emergency room services, they should notify MDwise medical management staff. This notification is necessary for medical management staff to coordinate care and services to best meet the member's health care needs. The definitions below are referenced regarding emergency services and conditions:

- **Emergency services:** defined in IC 12-15-12- 0.5 as covered inpatient and outpatient services from a qualified provider to provide emergency services necessary to evaluate or stabilize an emergency medical condition.
- **Emergency medical condition:** defined in IC 12-15-12-0.3 as a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
    1. serious jeopardy to the health of the individual, or in the case of a pregnancy, the member or unborn child
    2. serious impairment to bodily functions
    3. serious dysfunction of any bodily organ or part
- **Prudent layperson**: a person without medical training who exercises those qualities of attention, knowledge, intelligence and judgement which society requires of its members for the protection of their own interest and the interest of others. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, based on observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

Note: *Members are always encouraged to call their PMP or the MDwise NURSEon-call (1-800-356-1204), our 24- hour nurse hotline, when they have an urgent health need or are unsure if their need constitutes an emergency. MDwise providers are encouraged to help educate their patients about the appropriate use of the emergency room. The MDwise health advocate team can help provide education about appropriate ER use to members found utilizing the ER for nonemergent situations.*

Hoosier Healthwise Post-Stabilization Services: Coverage & Prior Authorization

MDwise covers post-stabilization without the need for prior authorization. Post-Stabilization care services are defined in IC 12-15-12-0.7 as covered services related to an emergency medical condition provided after a member is stabilized to maintain the stabilized condition or, under the circumstances described in IC 12-15-12-17 (b)(3), to improve or resolve the member's condition. Since MDwise considers each emergency room claim an emergency medical condition, post-stabilization services will pay the contracted rate or 100% of the Medicaid fee schedule.

MDwise Approach to Emergency Room and Post-stabilization Services	
DOES	DOES NOT
Pay contracted rate or Medicaid fee schedule for an observation stay	Limit what constitutes an emergency based on a list of diagnoses or symptoms
Waive ER copayment (if applicable)	Refuse coverage of emergency room coverage if PMP is not notified within ten (10) calendar days
Cover post-stabilization services related to the emergency medical condition	Deny payment for emergency room services
Provide education and care coordination to avoid inappropriate use of ER and avoidance of crisis leading the ER visit	Require medical records to receive payment
Provide NURSEon-call for members and providers regarding condition and need for authorization respectively	Require physician consultation or authorization for continued treatment for post-stabilization services

Out-of-Network Services Hoosier Healthwise

MDwise attempts to provide all care within the MDwise contracted network for coordination, access, and communication purposes. Contracted providers have a better understanding of available resources and have agreed to abide by MDwise policies and procedures according to their provider agreement.

Health care services provided outside of the MDwise network may be authorized for coverage when appropriate contracted providers, services or facilities are unavailable within the member's service area. MDwise will also cover and reimburse authorized routine care provided to members by out-of-network or out-of-area providers. All service authorization requests are subject to clinical practice guidelines and the determination process outlined in the medical management section of this chapter.

In accordance with MDwise program rules, all services must be obtained in-network, except for the following:

- Emergency and self-referrals services
- Medically necessary, covered services not available from an in-network provider within 60 miles of the member's residence
- Services provided under "Continuity of Care" principles (e.g., within 30 days of becoming a member, the recently enrolled MDwise member has an outstanding prior authorization for services from a provider that is not contracted with MDwise)

Reimbursement for the out-of-network, non-emergent claims for authorized services will be at the rate MDwise negotiates with the provider, or the lesser of the following:

- 98% of the IHCP fee schedule rate that existed on the date the service was rendered
- The usual and customary charge made to the public by the provider

Reimbursement for the out-of-network claims for authorized services will be at the rate MDwise negotiates with the provider, or the lesser of the following:

- Medicaid FFS fee schedule rate that existed on the date the service was rendered, or
- The usual and customary charge made to the public by the provider

MDwise requires providers not contracted in the MDwise network to obtain prior authorization to render any non-self-referral or non-emergent services to MDwise members.

MDwise does not require MDwise-assigned provider numbers for out-of-network provider reimbursement.

Hoosier Healthwise Carved Out Services (not paid for by MDwise)

Hoosier Healthwise provides some services that are not included in the MCE capitation and, therefore, are not the responsibility of MDwise. Services that remain under the financial responsibility of the State are reimbursed on a fee-for-service basis and are billed directly to the IHCP.

These certain categories of service covered by IHCP but carved out from the scope of care managed by MDwise for Hoosier Healthwise include:

Carve Out Service	Coverage	MDwise Scope of Care
Medicaid Rehabilitation Option (MRO)	IHCP - FFS	MDwise is responsible for care coordination with physical and other behavioral health services for members receiving MRO services.
Individualized Education Plan (IEP)	IHCP - FFS	MDwise will communicate and coordinate with the school to ensure continuity of care and avoid duplication of services.
Individualized Family Services Plan (IFSP)	IHCP - FFS	MDwise receives a monthly listing from the State of members who actively receive IFSP services. MDwise communicates and coordinates with IFSP providers to avoid duplication of services.

Hoosier Healthwise Excluded Services

The Hoosier Healthwise program excludes some benefits from coverage under managed care. These excluded benefits are available under Fee-for-Service Medicaid or other waiver programs. A MDwise member who requires (or is expected to require) excluded services due to medical necessity, must be disenrolled from the Hoosier Healthwise program to be eligible for those services.

Package A excluded services:

- Long-term institutional care, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Package A members may be placed in a nursing facility on a short-term basis (i.e., for fewer than 60 calendar days) while determinations of medical necessity are reviewed. MDwise may negotiate reimbursement rates with a nursing facility for this short-term stay. Members who require long-term care or whose short-term placement becomes a long-term placement may be disenrolled from managed care if long term care/level of care determinations (LTC/ LOC) are not made within the 60-day timeframe.
- Hospice care
- Home- and Community-Based Waiver Services
- Psychiatric Residential Treatment Facility (PRTF) Services
- Psychiatric treatment in a state hospital

Package C excluded services:

- Institutional care (short and long term) – nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Hospice care
- Home and Community-Based Waiver Services
- Psychiatric Residential Treatment Facility (PRTF) services
- Psychiatric treatment in a state hospital
- Organ transplants
- Routine foot care

Healthy Indiana Plan Member Benefits

Healthy Indiana Plan Program Overview

The Healthy Indiana Plan (HIP) provides health insurance for uninsured adult Hoosiers who are legal US residents ages 19 through 64 whose family income is up to 133% of the FPL. A 5% income disregard is applied to determine eligibility if an individual is found ineligible at 133% FPL but would be income eligible with the disregard. Individuals with Medicare do not qualify.

Members are eligible to remain in HIP if they become pregnant while enrolled in the program. If a member applies for HIP while pregnant, the HIP Maternity package provides Hoosier Healthwise Package A equivalent services, free of cost-sharing. If a member is already enrolled in HIP and becomes pregnant, all cost-sharing is suspended, regardless of which benefit package, and member enrolled with HIP Maternity.

Unless a member is exempt from cost-sharing, HIP members are required to make financial contributions for their coverage or copayments for all applicable services. Members enrolled in HIP Plus or HIP State Plan Plus make a monthly contribution to their coverage based on family income as a percentage of the FPL. The personal health care account, or POWER Account, contribution will not exceed 2% of the family income. See the chart below for more POWER Account Contribution (PAC) information.

Federal Poverty Level (FPL) %	Monthly PAC Single Individual	PAC Single Individual with Tobacco Surcharge	Monthly PAC Spouses	Spouse PAC when one has Tobacco Surcharge, and other does not	Spouse PAC when both have Tobacco Surcharge (each)
Less than 22%	$1.00	$1.50	$1.00	$1.00 & $1.50	$1.50
23-50%	$5.00	$7.50	$2.50	$2.50 & $3.75	$3.75
51-75%	$10.00	$15.00	$5.00	$5.00 & $7.50	$7.50
76-100%	$15.00	$22.50	$7.50	$7.50 & $11.25	$11.25
101-138%	$20.00	$30.00	$10.00	$10.00 & $15.00	$15.00

The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and is, at minimum, funded with State and individual contributions. Employers and Non-Profit Organizations may contribute as well, with some restrictions. Members use POWER Account funds to meet their health plan deductible. However, POWER Accounts are funded with post-tax dollars and are not considered HSAs or other health spending accounts (e.g., Flexible Spending Accounts, Health Reimbursement Accounts, etc.) under Federal law.

POWER accounts give participants a financial incentive to adopt healthy behaviors that keep them from developing chronic illnesses. When they do seek health care, plan participants seek price transparency so they can make value-conscious decisions. MDwise provides participants with an email account, personalized prevention information, and POWER Account balance and transaction history. MDwise will also provide disease management services and case and care management interventions based on member need.

The POWER Account provides:

- $2,500 per adult to pay for medical costs
- Contributions to the account are made by the State and each participant (based on ability to pay)
- No participant will pay more than 5% of gross family income on the plan
- Coverage for a Non-Affordable Care Act (defined as preventive services) is covered up to $500 per year
- Coverage for Affordable Care Act preventive services do not have a cap

Healthy Indiana Plan Eligibility

Healthy Indiana Plan has several benefit plans. Individuals interested in obtaining Healthy Indiana Plan (HIP) coverage must complete an application. If a parent and child are signing up for health insurance coverage at the same time, only one (a) application must be submitted.

Applicants can apply for benefits online at www.in.gov/medicaid/members or they can download and print out an application for later submission. Completed applications can be submitted to the DFR county office or mailed directly to the FSSA Document Center at **PO Box 1630, Marion, IN, 46952.** Members may also fax completed applications to **1-888-436-9199** or drop them off at their local FSSA DFR office. Applications are also available at various community organizations participating in the V-CAN network, Hoosier Healthwise Enrollment Centers, and the local Division of Family Resources (DFR) offices. To find these locations, a member can call **877-GET-HIP-9**.

The HIP application includes questions about recent health status. MDwise must accept individuals eligible for enrollment by order of application without restriction. Eligible MDwise members may, on occasion, need medical care before receiving the MDwise Healthy Indiana Plan ID card or forgetting to bring the card. Providers must check the member's eligibility even though the card is not available or when a member does not have the card. In these situations, eligibility may be verified by:

- MDwise Customer Service Line at **1-800-356-1204**, Identify the name and social security number (SSN)
- myMDwise Provider Portal at MDwise.org
- Provider Healthcare Portal at portal.indianamedicaid.com

HIP Plus

HIP Plus is the default plan for all HIP members. HIP Plus provides the best value coverage including:

- Members pay an affordable monthly POWER Account Contribution
- No copays (except for non-emergent ER use)
- More extensive pharmacy services
- Dental Services
- Vision Services
- TMJ Coverage
- Bariatric Surgery Coverage
- Chiropractic Manipulation Services (effective 01/01/2018)

Unpaid or missing monthly POWER Account Contributions (PAC) may result in loss of HIP coverage.

HIP Plus members with an income under 100% FPL with unpaid monthly PAC are disenrolled from HIP Plus but will receive HIP Basic. Members with income higher than this threshold will are disenrolled.

HIP Basic

HIP Basic benefits provide (limited) coverage for all required services, but do not provide dental or vision coverage or other benefits. Members do not make a PAC but have copayments for most services.

- $4 for Outpatient Services, including non-preventive office visits
- $4 for Preferred Drugs, $8 for Non-Preferred
- $75 for an Inpatient Stay
- Plan maintains essential health benefits but incorporates reduced benefit coverage (for example, fewer therapy visits)
- TMJ and bariatric surgery not covered
- Dental and vision coverage not included, except for EPSDT services for members ages 19 and 20
- More limited pharmacy options

Note: *Members must understand that HIP Basic can be much more expensive than HIP Plus.*

HIP State Plan (Plus or Basic)

HIP State Plan Plus provides a full set of benefits to members who are particularly at risk, either due to medical conditions (Medically Frail) or have a parent/caretaker. The services are equivalent to those of the Hoosier Healthwise program. Members with this program will either be on Plus or Basic but have access to the State Plan Benefit package. For example, a member on State Plan Basic would have a copay for prescription services, while a member on State Plan Plus would not.

- Hoosier Healthwise-like benefits and limitations
- Dental and vision coverage
- Transportation services coverage

HIP Maternity

Members who become pregnant while enrolled in HIP will be transitioned to the HIP Maternity plan for the duration of their pregnancy and 12-month postpartum period. HIP Maternity members receive all the benefits, and are subject to the same limitations, as a State Plan member. HIP Maternity members also have access to non-emergent transportation (NEMT) for covered services. All cost-sharing requirements are suspended for HIP Maternity members

Section 1931 Parents and Caretaker Relatives

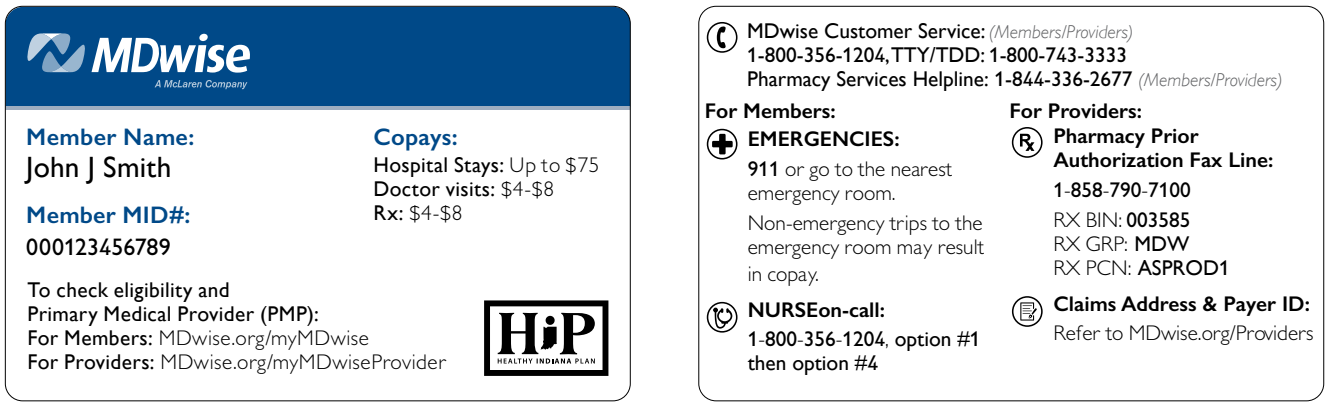
The HIP program includes accommodation for Section 1931 parents and caretaker relatives. These members were eligible prior to the implementation of the HIP program. Section 1931 parents and caretaker relatives are the 'State Plan' member population within the HIP program. State Plan members receive the same benefits as Hoosier Healthwise Package A members. These include non-emergent transportation, enhanced benefit limitations, and other services that may not be covered for non-State Plan HIP recipients.

HIP Eligibility Redetermination

Recertification HIP eligibility will occur annually based on the start date of the current eligibility period and criteria established by the State. MDwise will assist members with the recertification process; reminding members to complete the redetermination process, answer questions and helping members obtain required documentation. FSSA begins the redetermination process approximately 45 days before the end of the certification period. These steps will help prevent interruptions in member care or access to health services.

Healthy Indiana Plan Member ID Card

MDwise Healthy Indiana Plan members will receive a member ID card. Please see a sample card below:



Note: *If you suspect that a member has presented an identification card belonging to someone else, you may request to see a photo ID. If you suspect fraud, please contact the MDwise Compliance Officer at 317-822-7400 immediately.*

POWER Account Contributions & Copayments

POWER Account Contributions

HIP Plus members make financial contributions to their POWER Account that is applied toward medical and pharmacy prescription coverage. HIP Basic members do not contribute to their POWER Accounts. All individual HIP Plus and HIP State Plan Plus members contribute, at minimum, $1.00 (or higher if there is a tobacco surcharge) as a monthly contribution. Married HIP Plus and HIP State Plan Plus members contribute 2% of their gross annual family income. If a HIP member's total annual contribution (including POWER Account contributions and copays) exceeds 5% of their gross annual income, the member will no longer be liable for copayments for the remainder of the calendar quarter; however, the member would still be required to make their established monthly contributions. The POWER Account Contribution amount is dependent on income in relation to the US Federal Poverty Level.

The State calculates the POWER Account contribution during the application process. The State also recalculates contributions throughout a member's benefit period and before a new coverage term begins (during redetermination), to account for any changes in income.

POWER Accounts are funded by both the State and the member in an amount equal to $2,500. The State contributes to the member's POWER Account, and members are also encouraged to seek contribution assistance from a third party. Third parties, such as an employer or non-profit organization, can contribute up to 100% of the member's annual POWER Account obligation.

Third parties interested in aiding can seek further information by accessing MDwise.org or calling MDwise Customer Service at 1-800-356-1204.

HIP Plus members must make their required contribution each month. MDwise provides a wide range of payment options for members to make it easy for them to make contributions on time. Individuals can select or change plans

during the HIP Open Enrollment period between November 1 and December 15 of every year. HIP Plan choice must be made before the member makes their initial POWER Account contribution. Members are assigned to their health plan for the duration of the calendar year. Members with household incomes up to and including 100% FPL not paying the monthly contribution within the allotted time, as a result, will downgrade to the HIP Basic plan. In addition, HIP Basic plan requires copayments for all covered services except preventive care, and members may not transfer to the HIP Plus plan until annual redetermination. ***Note:*** *Native Americans and pregnant members are not subject to POWER Account contributions.*

Copayment Requirements

Providers must attempt to collect applicable copayments for covered services administered to members enrolled in HIP Basic, HIP State Plan Basic, and HIP State Plan Plus Copay (also known as MA-PC). A provider may not deny a service to a member if such member is unable to pay the copayment at the time-of-service delivery. If a member does not pay the copayment at the time services are provided, the member shall still be responsible for paying the copayment and the provider may bill the member for the copayment amount owed. ***Note:*** *Native Americans are pregnant members are not subject to copayments under HIP.*

Copayments for MDwise HIP Plus & Basic Members

Copayments are not required in the HIP Plus plan except for non-emergency use of the ER, which will total $8 for each inappropriate (non-emergency) visit.

The HIP Basic plan will require copayments for all covered services besides preventive care.

Copayment amounts per service type are as follows:

- Maternity services = $0
- Family Planning services = $0
- Preventive care services = $0
- Outpatient services = $4
- Inpatient services = $75
- Preferred drugs = $4
- Non-preferred drugs = $8
- Non-emergency ED visit = $8

Providers collect the member's copayment the point of service. The copayment amount is not indicated on the HIP member ID card. Providers should verify eligibility through the IHCP Provider Healthcare Portal to validate the member's benefit plan, and copays required for the services. **POWER Account funds cannot be used by the member to pay copayments.**

Indiana Health Coverage Program (IHCP) and Federal regulations specifically prohibit providers from charging IHCP members for covered services except in specific, limited circumstances.

MDwise providers must accept the final payment determination for covered services as payment in full, except for any copayments and any other patient liability payment allowed by the IHCP.

Balance-billing is prohibited (i.e., charge the member for covered services above the amount paid by MDwise).

Note: *Individuals incurring out-of-pocket expenses greater than 5% of their household income will be exempt from further cost-sharing for the remainder of the calendar quarter. HIP Basic members, with incomes less than $27 per month, will be automatically suspended from cost- sharing since a single payment would exceed their quarterly threshold.*

Healthy Indiana Plan Program Benefits

MDwise provides Healthy Indiana Plan members, at a minimum, all benefits and services deemed medically reasonable, necessary and covered under the Contract with the State.

HIP Preventive Care Services

OMPP determines which recommended preventive care services apply to a specific HIP member's age and gender, and the member's pre-existing conditions. If a HIP member is redetermined eligible at the end of a benefit period, those HIP members that obtain a recommended preventive care service can roll over their entire POWER Account balance, including monies contributed by the State. Preventative care services can include an annual physical exam or any health screening (e.g., mammogram, colonoscopy, etc.) appropriate for the member's age and gender. HIP members that fail to obtain the recommended preventive care services may only roll over their pro rata share of the POWER Account balance, leaving less money available to reduce the next year's required contribution. The remaining funds must be credited to the State.

POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. During each benefit period, OMPP will determine which recommended preventive services qualify a member for rollover.

Due to complex medical management and health needs, individuals with incomes up to and including 138% FPL meeting the definition of medically frail will be enrolled in HIP but will receive all State health plan services. Consistent with 42 CFR §440.315(f), an individual will be considered medically frail if having one (1) or more of the following:

- Disabling mental disorder
- A chronic substance abuse disorder (SUD)
- Serious and complex medical condition
- Physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living
- A disability determination, based on Social Security Administration criteria

The State anticipates that most of its Serious Mental Illness (SMI) population will be identified and served under the Behavioral and Primary Health Care Coordination (BPHC) program, Indiana's pending 1915(I) State health plan option for adults with SMI.

MDwise may identify individuals as medically frail based on their claim history. MDwise applies Milliman's Medical Underwriting Guidelines (MUGs) to score each member. Members with qualifying conditions or a risk score at or above a defined threshold are considered medically frail and granted the State health plan benefit wrap. Indiana will periodically review claims identifying "medically frail" individuals to verify that all members were categorized appropriately. Individuals no longer qualifying as medically frail will have the option of the HIP Basic or HIP Plus plans.

The following table provides an overview of covered services for HIP Plus, HIP Basic, HIP State Plan (Plus and Basic) and HIP Maternity. HIP-covered services are outlined in IC 12-15-44 and Administrative Code 405 IAC 9-7. As stated in IC 12-15-44-4, the MCE must also comply with any coverage requirements that apply to an accident and sickness insurance plan issued in Indiana. The Indiana Administrative Code is on the State's website at in.gov/legislative/iac/iac_title?iact=405. Additional information on these services listed below can be found in Social Security Act 1 905(a)(1)-(29).

Benefit	HIP Plus	HIP Basic	HIP State Plan and HIP Maternity
Accidental Trauma Treatment	Covered	Covered	Covered
Allergy Testing	Covered	Covered	Covered
Anesthesia	Covered	Covered	Covered
Bariatric Surgery	Covered	Not Covered	Covered
Behavioral and Primary Healthcare Coordination	Covered	Covered	Covered
Behavioral Health Services**	Covered**	Covered**	Covered**
Chemotherapy	Covered	Covered	Covered
Chiropractic Manipulation Services	Covered	Not Covered	Covered
Congenital Abnormalities	Covered	Covered	Covered
Dental Services	Covered	Not Covered	Covered
Diabetes Self-Management Training	Covered	Covered	Covered
Dialysis	Covered	Covered	Covered
Durable Medical Equipment (DME)	Covered	Covered	Covered
Early Periodic Screening Diagnosis and Testing	Covered	Covered	Covered
Emergency Services	Covered	Covered	Covered
Emergency Transportation	Covered	Covered	Covered
(Ambulance and Air Ambulance)	Covered	Covered	Covered
Family Planning Services	Covered	Covered	Covered
General Inpatient Hospital Care	Covered	Covered	Covered
Hearing Aids	Covered	Covered	Covered
Home Health Services	Covered	Covered	Covered
Hospice Care	Covered	Covered	Covered
Imaging – MRI, CT, and PET	Covered	Covered	Covered
Inpatient Physician Services	Covered	Covered	Covered
Inpatient Surgical Services	Covered	Covered	Covered
IV Infusion Services	Covered	Covered	Covered
Laboratory	Covered	Covered	Covered
Long Term Care	Not Covered	Not Covered	Covered
Long Term Services & Supports	Not Covered	Not Covered	Not Covered
Mental/Behavioral Health Inpatient	Covered	Covered	Covered
Mental/Behavioral Health Outpatient	Covered	Covered	Covered
MRO	Not Covered	Not Covered	Covered (Carve Out)

Benefit	HIP Plus	HIP Basic	HIP State Plan and HIP Maternity
Non-Cosmetic Reconstructive Surgery	Covered	Covered	Covered
Non-Emergent Transportation	Not Covered	Not Covered	Covered
Occupational Therapy	Covered	Covered	Covered
Office Visits (PMP/APRN)	Covered	Covered	Covered
Opioid Treatment Program	Covered	Covered	Covered
Outpatient Surgery	Covered	Covered	Covered
Pathology	Covered	Covered	Covered
Physical Therapy	Covered	Covered	Covered
Podiatry Services***	Covered***	Covered***	Covered
Prescription Drugs	Covered	Covered	Covered
Preventive Care Services*	Covered*	Covered*	Covered*
Prosthetics	Covered	Covered	Covered
Radiation Therapy	Covered	Covered	Covered
Rehabilitation	Covered	Covered	Covered
Respiratory Therapy	Covered	Covered	Covered
Skilled Nursing Facility	Covered	Covered	Covered
Specialty Physician Visits	Covered	Covered	Covered
Speech Therapy	Covered	Covered	Covered
Substance Abuse Inpatient Treatment	Covered	Covered	Covered
Substance Abuse Outpatient Treatment	Covered	Covered	Covered
Low-intensity residential treatment (ASAM Level 3.1) High-intensity residential treatment (ASAM Level 3.5) (DMHA Approved SUD Residential Provider)	Covered	Covered	Covered
Temporomandibular Joint Disorders (TMJ)	Covered	Not Covered	Covered
Tobacco Cessation Treatment & Counseling	Covered	Covered	Covered
Transplants	Covered	Covered	Covered
Urgent Care/Emergency Clinics (non- hospital)	Covered	Covered	Covered
Vision Services	Covered	Not Covered	Covered
X-Rays	Covered	Covered	Covered

**Preventive Care Services: Includes services with an "A" or "B" rating from the United States Preventive Task Force, immunizations recommended by the Centers for Disease Control and Prevention, and additional preventive care screenings for women according to the Health Resources and Services Administration guidelines.*

***Behavioral Health Services: Members may self-refer to any IHCP-enrolled psychiatrist or any behavioral health care provider in the MDwise network without a referral from the PMP.*

****Limitations apply and subject to medical necessity*

Healthy Indiana Plan Service Descriptions

Healthy Indiana Plan Self-Referral Services

MDwise HIP members are not restricted to using MDwise contracted providers for certain "self- referral" services. Federal and State regulations allow members access to certain covered services outside of the MDwise network without a referral. Members may access these services

from any Indiana Health Coverage Program (IHCP) enrolled provider qualified to render the service.

Although members can obtain these services out-of-network, MDwise is responsible for paying for these services if medically appropriate. MDwise is responsible for paying out-of-network providers up to the applicable benefit limits and 100% of the program rates.

The following are self-referral services available for Healthy Indiana Plan members. Members may obtain services from any IHCP enrolled provider who is qualified to render the service based on their benefits plan coverage:

- Family planning services: Federal regulation 42 CFR 431.51(b)(2) requires freedom of choice of providers and access to family planning services and supplies. Family planning services are defined as services and supplies provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy and sexually transmitted disease testing.
- Immunizations
- Psychiatric services
- Emergency/Urgent care services
- Vision services:
    - Service limits apply on a calendar-year basis
    - Prior authorization may be required for services
- Chiropractic manipulation services:
    - Service limits apply on a calendar-year basis
    - Prior authorization may be required for services
- Podiatric services:
    - HIP State Plan only
    - Coverage only available for treatment of diabetes and lower extremity circulatory diseases
    - Service limits apply on a calendar-year basis
    - Prior authorization may be required for services

The following are also HIP self-referral services that members must obtain services from a MDwise contracted provider. You may refer them to an in-network provider.

- Dental services
- Behavioral health services
- Diabetes self-management services

Healthy Indiana Plan Emergency Services: Coverage & Prior Authorization

MDwise members may access emergency services 24 hours per day, seven (7) days per week. MDwise will cover and reimburse all emergency services, including screening services, which are rendered by a qualified IHCP provider to evaluate or stabilize an emergency medical condition. MDwise does not require prior authorization for emergency services or screening exams, regardless of whether the IHCP provider contracts with MDwise.

MDwise considers each emergency claim as a service rendered during an emergency medical condition. MDwise pays in-network and out-of-network providers at 100% of the HIP program fee schedule.

If a provider or clinical representative advises a member to seek emergency room services, they must notify MDwise medical management staff. This notification is necessary for medical management staff to coordinate care and services to best meet the member's health care needs.

In the rare event MDwise deemed an emergency room claim not to meet the definition of an emergency medical condition, the claim would be subject to prudent layperson review.

- **Emergency services:** defined in IC 12-15-12- 0.5 as covered inpatient and outpatient services that are provided by a provider qualified to furnish emergency services, and that are necessary to evaluate or stabilize an emergency medical condition.
- **Emergency medical condition:** defined in IC 12-15-12-0.3 as a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
    - jeopardy to the health of the individual, or in the case of a pregnancy, the member or unborn child
    - serious impairment to bodily functions
    - serious dysfunction of any bodily organ or part
- **Prudent layperson:** a person without medical training who exercises those qualities of attention, knowledge, intelligence and judgement which society requires of its members for the protection of their own interest and the interest of others. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, based on observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

Note: *Members are always encouraged to call their PMP or the MDwise NURSEon-call (1-800-356-1204), our 24- hour nurse hotline, when they have an urgent health need or are unsure if it is an emergency.*

MDwise providers are encouraged to help educate their patients about the appropriate use of the emergency room. Also, if you become aware of a member that is inappropriately using the emergency room for primary care services, please let us know and a MDwise health advocate will attempt to contact the members and educate them about appropriate emergency room use.

HIP Post-Stabilization Services: Coverage & Prior Authorization

MDwise covers post-stabilization services without the need for prior authorization.

Post-Stabilization care services is defined in IC 12-15-12-0.7 as covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition or, under the circumstances described in IC 12-15-12-17 (b)(3), to improve or resolve the member's condition. Since MDwise considers each emergency room claim as an emergency medical condition, post stabilization services will pay at the contracted rate or at 100% of the Medicaid fee schedule.

MDwise Approach to Emergency Room and Post-stabilization Services	
DOES	DOES NOT
Pay contracted rate or Medicaid fee schedule for an observation stay	Limit what constitutes an emergency based on a list of diagnoses or symptoms
Waive ER copayment (if applicable)	Refuse coverage of emergency room coverage if PMP is not notified within ten (10) calendar days
Cover post-stabilization services related to the emergency medical condition	Deny payment for emergency room services
Provide education and care coordination to avoid inappropriate use of ER and avoidance of crisis leading the ER visit	Require medical records to receive payment
Provide NURSEon-call for members and providers regarding condition and need for authorization respectively	Require physician consultation or authorization for continued treatment for post-stabilization services

Healthy Indiana Plan Out-of-Network Services

MDwise attempts to provide all care within the MDwise contracted network (inclusive of MDwise behavioral health network) for coordination, access, and communication purposes, better understanding of available resources within the plan, and because MDwise providers have agreed by contract, to abide by MDwise policies and procedures.

Health care services provided outside of the MDwise network may be authorized for coverage when appropriate contracted providers, services, or facilities are not available within the member's service area. MDwise will also cover and reimburse (Medicare rates or 130% of Medicaid rate if no Medicare rate) authorized routine care provided to members by out-of- network or out-of-area providers. These service authorization requests are subject to the medical appropriateness criteria and determination process.

In accordance with MDwise program rules, all services must be obtained in-network, except for the following:

- Family planning services (self-referral)
- Emergency services (self-referral)
- Medically necessary, covered services not available from an in-network provider within 60 miles of the member's residence
- Nurse practitioner services, if they are not available within the member's service area within the MDwise network

- FQHC and RHC services if an FQHC or RHC is not available in the member's service area within the MDwise network
- Services for members traveling out of area needing urgent/emergent services
- Services provided under "Continuity of Care" principles (e.g., Within 30 days of becoming a member, the recently enrolled MDwise member has an outstanding prior authorization for services from a provider that is not contracted with MDwise.)

Note: *MDwise does not require an out-of-network provider to acquire a MDwise-assigned provider number for reimbursement. The NPI number is sufficient for out-of-network provider reimbursement.*

Healthy Indiana Plan Excluded Services

The HIP program excludes some benefits from coverage under managed care. These excluded benefits may be available under traditional Medicaid or other waiver programs. Therefore, a member who is, or will be, receiving excluded services must be disenrolled from managed care to be eligible for the services. MDwise is responsible for the member's care until the member is disenrolled from the plan unless stated otherwise.

Excluded services are:

- Long-term institutional care HIP members: requiring long-term care in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) must be disenrolled from the HIP program and converted to fee-for-service eligibility in the IHCP.
- Home- and community-based services (HCBS) waiver: members approved for these waiver services must be disenrolled from managed care, and MDwise must coordinate care for members transitioning into HCBS waiver program until the disenrollment from HIP is effective.
- Psychiatric treatment in a State hospital: psychiatric treatment in a State hospital is an excluded service, but HIP members receiving psychiatric treatment in a State hospital shall not be disenrolled from HIP but should be directed to an alternative inpatient facility.

Non-Covered Services for the HIP Basic Benefit Package

Non-covered services include, but are not limited to:

- Dental services (including extraction, restoration and replacement of teeth, x-rays, supplies, appliances, and all associated supplies)
- Except for an accidental traumatic injury to natural teeth
- In such cases, they must seek treatment within 48 hours of the injury
- Chiropractic services
- Osteopathic Manipulative Treatment
- Temporomandibular Joint Treatment
- Bariatric surgery
- Vision services

Non-Covered Services for the HIP Basic & HIP Plus Benefit Packages

Non-covered services include, but are not limited to:

- Conventional or surgical orthodontics or any treatment of congenitally missing, mal- positioned, or supernumerary teeth, even if part of a congenital anomaly
- Elective abortions and abortifacients
- Long-term or custodial care, including domiciliary, convalescent care, skilled nursing facilities used for long-term care, State hospitals and custodial care, nursing home care, home-based respite care, group homes, halfway homes, residential facilities
- Daycare and foster care
- Personal comfort or convenience items
- Cosmetic Services, procedures, equipment, or supplies
- Complications directly relating to cosmetic services, treatment or surgery are not covered.
- Benefits are available if treatment for reconstructive service is performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous medically necessary procedure
- Safety glasses, athletic glasses, and sunglasses
- LASIK and any surgical procedures to correct refractive errors
- Vitamins, supplements, and over-the-counter medications
- Wellness benefits other than tobacco use cessation
- Diagnostic testing or treatment in relation to infertility
- In vitro fertilization
- Gamete or zygote intrafallopian transfers
- Artificial insemination
- Reversal of voluntary sterilization
- Treatment of sexual dysfunction, including but not limited to medication
- Body piercing
- Over-the-counter contraceptives
- Physician samples dispensed in a physician's office

Alternative or complementary medicine includes, but is not limited to:

- Treatment of hyperhidrosis
- Court-ordered testing or care unless medically necessary
- Travel-related expenses, including mileage, lodging and meal costs, except for mileage paid to emergency transportation providers
- Missed or canceled appointments for which there is a charge
- Services and supplies for which member has no legal obligation to pay in absence of coverage under the plan
- The evaluation and treatment of learning disabilities
- Routine foot care, except for foot care for individuals with lower extremity circulatory disorders, including diabetes
- Surgical treatment of the feet to correct flat feet, hyperkeratosis, metatarsalgia, subluxation of the foot and Tartaglia
- Any injury, condition, disease ailment arising out of employment IF benefits are available under any Worker's Compensation Act or other similar law
- Examinations for research screening

Early & Periodic Screening, Diagnostic, and Treatment (EPSDT Services

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are a covered benefit for all Hoosier Healthwise members under the age of 21 and for HIP members ages 19 and 20. The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. In addition, EPSDT services include the provision of medically necessary services to members less than 21 years old in institutions of mental disease (IMDs). EPSDT is an essential Medicaid requirement.

The State of Indiana calls its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program "HealthWatch." All MDwise practitioners must participate in "HealthWatch" and offer or arrange for the full range of EPSDT screenings, recommended immunizations, and follow-up care for members in the applicable age range from birth through age 20.

Federal law requires screening for lead poisoning for all children on Medicaid under the age of seven (7). MDwise monitors individual provider compliance with lead screening. Additionally, members between nine (9) and fifteen (15) months of age, or as close as reasonably possible to the patient's appointment, need to receive a blood lead screening test. Children should have another blood lead test between the ages of twenty-one (21) and twenty-seven (27) months, or as close as reasonably possible to the patient's appointment. Any child between twenty-eight (28) and seventy-two (72) months that does not have a record of any prior blood lead test must have a blood lead test performed as soon as possible. Children who screen positive must enroll in case management.

Treatments for diseases, issues or problems found during an EPSDT encounter must be addressed by the provider, subject to the EPSDT Medical Necessity Definition, even if the required services are not covered benefits as defined in the Medicaid Medical Policy, IAC 405. Periodic screenings will be provided in accordance with the EPSDT periodicity schedule if the recipient chooses to participate in the EPSDT program or until the recipient reaches age 21.

Screening services do not require prior authorization. However, treatment services are subject to prior authorizations requirements for services as outlined in the IHCP Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/ HealthWatch Services Module epsdt.pdf (in.gov), MDwise Provider Manual and website.

Notification of Pregnancy (NOP)

Early identification and evaluation of MDwise Hoosier Healthwise and HIP members during pregnancy is important to ensure that these members receive timely and comprehensive prenatal care to minimize maternal complications, limit neonatal complications and improve neonatal outcomes. Through the NOP process, MDwise identifies members with histories of high-risk pregnancies or who are vulnerable to developing a high-risk pregnancy due to existing health conditions and/or psychosocial issues that may potentially impact the birth outcome.
Members identified through a completed NOP form, who have an existing high-risk pregnancy or who are vulnerable to developing high-risk pregnancy, receive numerous services to promote healthy habits during pregnancy and to provide access to supportive services to reduce the effect of psychosocial issues.

Supportive services include but are not limited to:

- High-risk pregnancy case management
- Outreach by a Health Advocate
- Promotion of tobacco cessation
- Assure access to services and supplies necessary to care for the baby after birth

MDwise needs your assistance to ensure that NOP assessments are completed and submitted for all MDwise pregnant members seen for prenatal care. When a MDwise member is determined to be pregnant, a provider can complete the NOP form and electronically submit it via the IHCP Provider Healthcare Portal. NOP forms must be returned within five (5) calendar days of the visit date.

Additional reimbursement of is available for providers that submit the NOP form. Providers may receive an incentive of $60 for one (1) NOP per MDwise member, per pregnancy. The following requirements must be met for a provider to be eligible for reimbursement for submitting an NOP:

- The NOP must be submitted via the IHCP Provider Healthcare Portal no more than five (5) calendar days from the date of the office visit on which the NOP is based.
- The member's pregnancy must be less than 30 weeks gestation at the time of the office visit on which the NOP is based.
- The member must be enrolled with MDwise on the date of service.
- The NOP cannot be a duplicate of a previously submitted NOP.

Once the NOP has been submitted, the date of service on the NOP claim should match the date the provider completed the risk assessment during a visit with the pregnant member. Recognized practitioners can submit claims for NOP reimbursement using the professional claim (CMS-1 500 claim form or the 837P electronic transaction). Hospitals can submit claims for NOP reimbursement using the institutional claim (UB-04 claim form or the 8371 electronic transaction).

Billing guidance for dates of service prior to January 1, 2023:

Professional Claims:

- 99354: Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour {list separately)
- TH: Obstetrical treatment/services. prenatal or postpartum

Institutional Claims:

- 0940 - Other Therapeutic Services in addition to procedure code G9997 with modifier TH.

Billing guidance for dates of service on or after January 1, 2023:

Professional Claims:

- G9997 - Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter
- TH: Obstetrical treatment/services. prenatal or postpartum

Institutional Claims:

- 0940 - Other Therapeutic Services in addition to procedure code G9997 with modifier TH.

MDwise uses the information submitted to determine the health risk level associated with pregnancy and the need for prenatal care coordination. Use the following link for log-in access to the IHCP Provider Healthcare Portal at **IHCP Provider Portal > Home (indianamedicaid.com)**. If you have any questions or need additional assistance regarding Notification of Pregnancy, please contact the MDwise Customer Service Department at **1-800-356-1204** or **317-630-2831** or visit the MDwise website at **www.MDwise.org**.

Behavioral Health Services

This section of the MDwise Provider Manual provides an overview of Behavioral health care Services. Behavioral Health Care Services include both mental health and substance abuse services for the MDwise Hoosier Healthwise and Healthy Indiana Plan. Additionally, the plan will pay behavioral health service codes billed by a primary care office if they are medically necessary. Clinic Option services are covered by MDwise under these plans, as any non- hospital-based behavioral health covered service delivered for medication management and psychotherapy, not considered MRO services, as outlined below. MDwise Behavioral Health benefits comply with the Mental Health Parity and Additions Equity Act (MHPAEA).

As outlined below, MDwise will work to ensure the integration of mental health and physical health services through activities such as ongoing case management and facilitating information sharing and coordination of care. Together we will work hard to ensure collaboration that promotes a communication "bridge" between PMPs and behavioral health providers.

MDwise members also have the benefit of a 24-hour/7-day nurse helpline. This NURSEon-call (**1-800-356-1204**) triage service is staffed by behavioral and medical health professionals with the expertise to respond appropriately to the needs of our members.

Behavioral Health Providers

MDwise, Inc. is responsible for developing, maintaining and coordinating a comprehensive behavioral health network clinically aligned with the overall needs of our member population. They also provide ongoing provider services to assist MDwise contracted behavioral health providers with clarification of policies and procedures and to address any issues providers have regarding their credentialing status or their contract.

MDwise contracts with a variety of provider types to provide mental health/substance abuse services. MDwise members may self-refer to the providers below within the MDwise network:

- Community Mental Health Centers (CMHC)
- Outpatient mental health clinics
- Psychiatrists
- Psychologists
- Certified psychologists

- Health services providers in psychology
- Substance abuse counselors and facilities
- Certified Social Workers (ACSW, CCSW)
- Licensed Mental Health Counselor (LMHC)
- Licensed Marriage & Family Therapist (LMFT)
- Licensed Clinical Social Workers (LCSW)
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing

All providers must have a valid NPI and IHCP number and be credentialed prior to rendering services to MDwise members. Please refer to the Credentialing chapter for information about MDwise credentialing criteria for behavioral health providers.

In Hoosier Healthwise and HIP, direct reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as health service providers in psychology (HSPP). Midlevel practitioners providing covered services receive reimbursement only if a physician or HSPP directs the services. Midlevel practitioners bill services rendered using the rendering provider number of the supervising practitioner and the billing provider number of the outpatient mental health clinic or facility. Mental health services are limited to a specified number of services or dollars on a rolling 12-month basis. Exceeding this number of dollars or services may require prior authorization (PA) based on medical necessity.

Criteria for Behavioral Health Practitioners

Behavioral health practitioners include doctoral or master's level psychologists (State-certified and State-licensed), master's level clinical social workers, State-certified or State-licensed), master's level clinical nurse specialists or psychiatric nurse practitioners (nationally certified, State-certified, or State-licensed), and other behavioral health care specialists (licensed, certified or registered by the State), to practice independently. Behavioral health practitioners must demonstrate as part of the application process that they meet the same credentialing criteria as outlined above for physicians, with the following exceptions:

- **Written Practice Agreement:** Proof of collaboration with a licensed network practitioner in the form of a written practice agreement.
- **DEA:** If requesting prescriptive authority, current, valid, and unrestricted DEA certificate for prescribing controlled substances and a current Indiana Controlled Substance Certificate.
    - ***Note:*** *DEA or CSR certificates are not applicable to non-physician behavioral health practitioners.*
- **Education:** Graduate of a school recognized by the appropriate Indiana State Boards. Board Certification does not apply for some specialties if certification does not exist.
- **Privileges:**
    - ***Exception:*** *The behavioral health practitioner does not require admitting or practicing privileges at a facility (e.g., psychologist, clinical social worker, psychiatric nurse practitioner).*
    - ***Exception:*** *The provider has a clinical appointment in good standing at a participating MDwise hospital or documented relationship privileges with a participating MDwise provider (e.g., hospitalist).*

Note: *MDwise credentialing or recredentialing decisions may not be based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes.*

Behavioral Health Medical Records

It is a requirement that behavioral health information is shared with the PMP, but there must be the appropriate signed member consent. Therefore, it is important for providers to maintain this consent information in the member's medical record. If providers receive behavioral health information for a member they have yet to see, please create a member record or separate file to store behavioral health information. Once the practice has seen the member, review, initial and place the behavioral health information in the established medical record.

Behavioral Health Access Standards

Behavioral health access standards outlined in the following table:

Type of Service	Appointment Timeframe
Emergency Services	Must be available 24 hours per day, seven (7) days per week.
Urgent: Members presenting with significant psychiatric or substance abuse history, evidence of psychosis and/or significant distress.	Immediately be referred to a BH professional who will further assess and provide referral and direction to an appropriate level of care. Care should occur within 48 hours.
Emergent: Members who have a non-life-threatening emergency.	Care should occur within six (6) hours.
Routine: Members seeking outpatient services presenting no evidence of suicidal or homicidal ideation, psychosis and/or significant distress.	Care should occur within ten (10) business days of the request for service.

Behavioral Health Benefits

Please refer to the Hoosier Healthwise and Healthy Indiana Benefit Overview Chapters for information about mental health covered benefits. Covered behavioral health services generally include the following services (according to the member's benefit package).

- Inpatient psychiatric services
- Emergency/crisis services
- Alcohol and drug abuse services (substance abuse)
- Therapy and counseling, individual, group or family
- Psychiatric drugs included on MDwise PDL
- Laboratory and radiology services for medication regulation and diagnosis
- Screening, evaluation and diagnosis
- Transportation (medically necessary or emergent)

- Neuropsychological and psychological testing
- Partial Hospitalization Services that are not covered include:
    - Biofeedback
    - Broken or missed appointments
    - Day Care
    - Hypnosis
    - State Hospital Placement

Behavioral Health Service Descriptions

Opioid Treatment Program (OTP

Taking care of a member's behavioral health is integral to their health care. Understanding the options for treatment is part of that care. MDwise offers coverage for a continuum of care related to behavioral health and addiction treatment.

MDwise believes that integrated physical and behavioral health services are integral to health care. Our mission is to deliver consistent, high-quality care while focusing on compassion, excellence and leadership.

This program guide outlines the covered benefit for Opioid Treatment Program (OTP) services implemented in accordance with MDwise Medical Management and Behavioral Health policies and procedures and IHCP program requirements for Hoosier Healthwise and Healthy Indiana Plan members.

The Indiana Health Coverage Program (IHCP) defines Opioid Treatment Program (OTP) as a daily bundled service that includes the daily administration of methadone, either at the OTP provider location or as an authorized take-home dose. Using other agents (e.g., Suboxone, Subutex, Vivitrol, etc.) with or without the daily services is not considered OTP programming.

Members enrolled in all IHCP programs have OTP services covered (except for those in the benefit plans identified in BT201744 and BT201755).

For IHCP members who also have Medicare coverage, providers should bypass Medicare billing and bill the IHCP directly for OTP services. Other third-party insurers, however, should be billed before billing the IHCP.

OTPs may enroll under the provider type and specialty that best identify their practice. However, providers wanting to bill for the administration of methadone and other related services exclusive to Opioid Treatment Programs must be credentialed with MDwise and enrolled with IHCP under the Addiction Services/Opioid Treatment Program provider type and specialty (type 35/specialty 835).

The option for an OTP to enroll as other provider types, including Ordering, Prescribing and Referring (OPR) providers, remains unchanged. Providers already enrolled with IHCP as an OPR provider, wanting to bill IHCP for services provided to Medicaid members, must disenroll as an OPR provider and re-enroll as an Addiction Services/ Opioid Treatment Program provider (type 35/835).

All OTP providers enrolling with the IHCP under the Addiction Services/OTP provider type and specialty or as an OPR will be required to have a Drug Enforcement Administration (DEA) license, as well as cer tification from

Indiana's Division of Mental Health and Addiction (DMHA). For additional rules surrounding OTP services, see Indiana Administrative Code 440 IAC 10.

MDwise will recognize the following credentials, under the direction of a physician or Health Service Provider in Psychology (HSPP), for individuals rendering individual, group or family counseling services in an OTP setting:

A licensed psychologist	A physician assistant
A Licensed Clinical Social Worker (LCSW)	A clinical nurse specialist
A Licensed Marriage and Family Therapist (LMFT)	A Licensed Clinical Addiction Counselor (LCAC)
A Licensed Mental Health Counselor (LMHC)	An individual credentialed in addiction counseling by a nationally recognized credentialing body approved by the DMHA*

Note: *The Medication Assisted Treatment Specialist (MATS) credential, not currently recognized by DMHA, will not be allowed by the IHCP.*

Midlevel practitioner claims must be submitted with the appropriate modifier and procedure code when submitting a claim for reimbursement.

OTP Prior Authorization

OTP services for MDwise providers do not require prior authorization; however, providers must maintain documentation demonstrating medical necessity, coverage criteria met and the individual's length of treatment. Providers must register with the IHCP as the provider specialty type Opioid Treatment (specialty 835) and provider type Addiction Services (type 35).

Non-contracted, out-of-network providers that do not obtain required prior authorization for services will be denied for lack of authorization according to MDwise policy, IAC Rules, IHCP policies and bulletins. Claims submitted for providers not registered as provider type/specialty type 35/835, according to MDwise policy and IHCP policies and bulletins will be denied.

MDwise utilizes benefit and medical necessity criteria in determining medical appropriateness of services and care-setting, which includes criteria obtained from current nationally recognized commercial resources such as InterQual, American Society of Addiction Medicine (ASAM), state and federal regulations, OMPP/IHCP manuals, health policy, bulletins, and banners, MDwise medical and benefit administration policies and/or approved internally developed guidelines and protocols.

The American Society of Addiction Medicine (ASAM) provides criteria for medical necessity determinations applied to individual cases. The member's age, comorbidities, complications, the progress of treatment, psychosocial situation, and home environment criteria can apply to the care requested.

When clinical information collected to support the request does not meet the applicable criteria, the MDwise Medical Director or reviewer designee (psychiatrist or behavioral health professional) reviews the request. The MDwise Medical Director or reviewer designee makes any decisions not to authorize a requested service based on medical necessity. MDwise policy guides medical necessity determinations and notifications.

OTP Billing and Reimbursement

OTP providers will be reimbursed at a daily bundled rate, including payment for required opioid treatment services. Providers should bill one unit of Healthcare Common Procedure Coding System (HCPCS) code H0020 - Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program), for each day a member presents for treatment. Providers that allow members take-home doses of methadone must bill code H0020 with modifier UA - Take home Methadone Dose (Medicaid Specific) (H0020 UA) for each date of service for which a take-home dose of methadone is dispensed. Methadone dispensed for unsupervised, take-home use should be dispensed in alignment with federal opioid treatment standards, per Code of Federal Regulations 42 CFR 8.12.

Procedure Code	Service Description
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0020 UA	Take-Home Methadone Dose (Medicaid Specific)

Reimbursement for the above codes is limited to one unit per member per day. Providers must use a professional claim form (CMS 1500) when billing services. OTP services are not eligible for Hospital Assessment Fee (HAF) adjustments. An OTP provider rendering services other than those included in the bundled rate must bill for those additional services using another appropriate IHCP-enrolled provider type and specialty.

For take-home doses, providers must bill each date of service using the UA modifier. The provider may bill the H0020 code (with or without the modifier) once per day. For example, if the provider sees the member in the office twice a week and prescribes three (3) days of take-home doses, they can bill and receive reimbursement for all five (5) days.

Members are not expected to receive weekly or monthly services on each date of service (DOS), only that the services be completed by the end of each week or month, as indicated.

Reimbursement for code H0020, based on a daily bundled rate, includes reimbursement for the following services: Oral medication administration, direct observation, daily	Hepatitis A, B, and C testing, as needed
Methadone, daily	Pregnancy testing, as needed
Drug testing, monthly	Tuberculosis testing, as needed
Specimen collection and handling, monthly	Syphilis testing, as needed
Pharmacologic management, daily	Complete Blood Count, as needed
One hour of case management, weekly	One (1) office visit every 90 days
Four (4) hours of group or individual psychotherapy, monthly	

The daily bundled rate is only billable for individuals receiving daily methadone maintenance treatment. If a member is using an alternative medication for treatment, (e.g., Suboxone or Vivitrol) the medication, and any related services rendered, must be billed separately. Providers enrolled as Addiction Services/OTP providers cannot be reimbursed for alternate medication- assisted treatment. Reimbursement for these services requires an OTP to be enrolled, bill under another IHCP provider type and specialty appropriate for delivering these services and be enrolled with MDwise.

The services below are reimbursable outside the per diem rate. Any services billed outside the bundled rate are subject to post- payment review and must comply with all medical necessity requirements:

Code	Description	Frequency Limitations
90792	Psychiatric diagnostic evaluation, with medical services	Limited to one (1) per rolling year without prior authorization (PA). *May bill additional units after obtaining PA
90832 – 90838 Must be billed with Modifier C (Medically necessary service or supply)	Psychotherapy	Available to individuals in the event of a relapse. Any restrictions regarding service providers and medical necessity as outlined in this policy. Psychotherapy services provided outside of those included in the bundled package are subject to post-payment review. *Must bill with modifier SC

Mental Health Rehabilitation Option (MRO) Services Mental Health Rehabilitation Option (MRO) services are "carved-out" of the Hoosier Healthwise and HIP programs and are not the responsibility of MDwise. These services are covered benefits under the Traditional Medicaid program and are paid for by the State's fiscal agent on a fee-for-service basis. MRO services, defined as community mental health services for members with mental illness, provided through an enrolled mental health center that meets applicable Federal, State, and local laws concerning the operation of community mental health centers (see 405 IAC 5-21).

MRO services are accessible to Medicaid members who have a qualifying MRO diagnosis, and a Level of Need (LON) based on the Child & Adolescent Needs and Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA). Members who do not have a qualifying MRO diagnosis and/or LON may submit PA for MRO services. For an MRO provider to receive reimbursement for the delivery of MRO services, a member must have an assigned MRO service package or prior authorized units of service. In addition, members must have a qualifying diagnosis to be eligible for an MRO service package.

MDwise members who demonstrate a behavioral health need are eligible for Clinic Option Services, such as psychotherapy in a clinical setting. However, only Medicaid consumers with a qualifying diagnosis and Level of Need are eligible for an MRO service package.

Note: *Even though MRO services are carved out of MDwise' payment responsibility for Hoosier Healthwise and HIP, we are responsible for coordinating care and follow-up treatment for our Hoosier Healthwise and HIP members receiving these services. Providers can view the MRO Provider Manual at www.in.gov/medicaid/providers.*

Residential Substance Use Treatment

Taking care of a member's behavioral health is integral to their health care. Understanding the options for treatment is part of that care. MDwise offers coverage for a continuum of care related to behavioral health and addiction treatment.

MDwise believes that integrated physical and behavioral health services are integral to health care. Our mission is to deliver consistent, high-quality care while focusing on compassion, excellence and leadership.

This program guide outlines the covered benefit for Residential substance use treatment implemented in accordance with MDwise Medical Management and Behavioral Health policies and procedures and IHCP program requirements for Hoosier Healthwise and Healthy Indiana Plan members.

The Indiana Health Coverage Program (IHCP) defines *Residential Substance Abuse Treatment* as an inpatient stay for opioid use disorder (OUD) and other substance use disorder (SUD). Admission criteria for inpatient stays for opioid use disorder (OUD) and substance use disorder (SUD) treatment, will be based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria Level 3.1 (clinically Managed Low-intensity Residential Services) which include the following services individual therapy, group therapy, medication training and support, case management, drug testing, and peer recovery supports. American Society of Addiction Medicine (ASAM) Patient Placement Criteria Level 3.5 (clinically Managed High-intensity Residential Services) which include the following services individual therapy, group therapy, medication training and support, case management, drug testing, peer recovery supports, skills training and development. Providers are required to include all appropriate documentation demonstrating medical necessity for residential treatment with the Prior Authorization (PA) request.

Residential substance use treatment facilities may enroll under the provider type and specialty that best identify their practice. However, providers wanting to bill for Residential substance use treatment must be credentialed with MDwise and enrolled with IHCP under the Addiction Services/SUD Residential Addiction Treatment Facility provider type and specialty (type 35/specialty 836). SUD residential addiction treatment providers rendering services other than those included in the per diem payment associated with the residential substance use treatment procedure codes must bill for those additional services using another, appropriate IHCP enrolled provider type and specialty.

All residential substance use treatment facilities enrolling with IHCP under the Addiction Services /SUD Residential Addiction Treatment Facility provider type and specialty will be required to have DMHA certification as a residential (sub-acute stabilization) facility or Department of Child Services (DCS) licensing as a child care institution or private secure care institution and DMHA designation indication approval to offer ASAM Level 3.1 or Level 3.5 residential services (Facilities that have designations to offer both ASAM Level 3.1 and Level

3.5 within the facility must include proof of both with the enrollment application.

SUD Billing and Reimbursement

Low-intensity residential treatment American Society of Addiction Medicine (ASAM level 3.1) and American Society of Addiction Medicine (ASAM level 3.5) will be reimbursed for residential stays for substance use treatment on a per diem basis. Providers are required to bill using a professional claim with the facility NPI located in the rendering provider box. Claims must be billed with the appropriate modifier and appropriate place of service listed in the chart below.

Low-intensity residential Treatment	Modifiers	High-intensity residential treatment	Modifiers
H2034	U1 – Member is an adult (19 years and older	H0010	U1 – Member is an adult (19 years and older
Place of service 55	U2 – Member is a child (18 years and younger	Place of service 55	U2 – Member is a child (18 years and younger

Reimbursement for the residential substance use treatment procedure codes are limited to one unit per member per day.

Services that are reimbursable outside the daily per diem rate include physician visits and Physician administered medications.

Behavioral Health Referrals

Provider Referrals

Providers should refer members needing behavioral health services for a consultation with an appropriate provider. The behavioral health provider can provide an assessment, determine a diagnosis or offer treatment. This includes a member experiencing acute symptoms of a chronic mental disorder (e.g., schizophrenia, bipolar disorders, eating disorders, etc.) or who is in a crisis state or following certain sentinel events, such as a suicide attempt. We also recommend a member referral if the provider is treating a member for such conditions as anxiety and mild depression and symptoms persist or worsen.

An emergency referral for mental health services does not require a referral or authorization; however, PMP-initiated referrals allow for better coordination of care for the member.

Please visit the MDwise Provider website behavioral health link to review the behavior health practice guidelines and provider tools.

To initiate a referral to an MDwise behavioral health provider for a member, access behavioral health provider information via the MDwise website or contact the MDwise Customer Service Line (see the MDwise Directory). Please have available the member's Medicaid ID number (i.e., RID) and date of bir th.

When providers call this number during regular business hours, a trained Customer Service Representative will answer the call. The Customer Service Representative will ask a few brief questions to locate the right therapist or doctor to meet your patient's needs. However, if your patient is having a more serious problem, the Customer Service Representative will connect the member with an appropriate professional.

Note: *If there are questions or concerns regarding the availability of behavioral health services, please contact the MDwise Customer Service Line. Providers may also call the MDwise Behavioral Health Manager to discuss any concerns.*

Behavioral Health Prior Authorization

Behavioral Health Prior Authorization Requirements

A member may self-refer to any MDwise contracted provider for behavioral health care services or any IHCP enrolled psychiatrist. MDwise members are allowed one (1) evaluation and five (5) psychotherapy visits (per rolling 12 months) without prior authorization. Please refer to the Behavioral Health Prior Authorization Quick Reference Guide for the list of required authorizations and number of services allowed without authorization by service type. Request all outpatient authorizations using the forms available on the MDwise website and fax the forms to the appropriate MDwise number for Hoosier Healthwise and HIP. The prior authorization unit will fax a response (approval, denial, modification) back to the provider or a request for additional information.

Hoosier Healthwise and HIP members may self-refer to any IHCP-enrolled psychiatrist regardless of network participation status. All services provided may be subject to medical necessity review post-service. Providers are responsible for keeping track of the number of visits to date and, if necessary, seeking additional visits through the prior authorization process. MDwise does not provide prior authorizations retroactively.

MDwise requires prior authorization for any intensive service, including acute inpatient, detoxification, residential SUD, partial hospital or intensive outpatient treatment. The provider must call to obtain authorization for services except in life-threatening emergencies. However, MDwise may make a retrospective or post-service review to determine payment.

Behavioral Health Prior Authorization Process

The prior authorization process for behavioral health services allows MDwise Care Managers to ensure the member receives the most appropriate and effective treatment based on clinical presentation and ensures that the members have timely access to care.

- Where clinically appropriate, blocks of outpatient care and certain clinically appropriate programs will be authorized. The authorization process for the continuation of sessions beyond the initial authorized block of sessions facilitates the discussion with the provider about the written outpatient treatment plan.
- Inpatient stays are reviewed concurrently after initial authorization to provide opportunities to discuss discharge needs, coordination of services, and after-care treatment.
- Treatment plan goals that are diagnosis-specific and measurable to facilitate the review and approval of services.

MDwise care managers initiate the prior authorization process upon receipt of telephonic and/or written information. Care managers make every effort to obtain all necessary and pertinent clinical information to make medically necessary clinical decisions. The care managers review the service request and any previous treatment, receiving

clinical information from relevant stakeholders in the member's care (e.g., member, family, provider, facility utilization review staff, behavioral health care professionals). Following the guidelines for appropriate privacy and confidentiality set forth by the Federal Health Insurance Portability and Accountability Act (HIPAA), behavioral health care managers, psychiatrists and/or behavioral health specialists,

and providers share member Protected Health Information (PHI) for treatment, payment and health care operations.

Care managers review cases with the Medical Director, Physician Advisors or a contracted psychiatric consultant to discuss medically complex cases or when clinical information does not meet medical necessity. An appropriate behavioral health specialist makes the final determinations. The Medical Director or Physician Advisors are available for peer-to-peer discussions if there is a potential denial or expedited reviews. Please also refer to the Medical Management chapter for additional information regarding service authorization procedures.

Behavioral Health Coordination

Behavioral and Primary Health Care Coordination

The coordination of behavioral and primary care is essential in the provision of quality care. MDwise promotes coordination of behavioral health services with medical care through data analysis, effective exchange of information between the medical and behavioral health providers, service reporting and analysis, follow-up treatment management and integrated case/care management for members with physical and behavioral health care needs. MDwise collaborates with behavioral health and primary health care practitioners to monitor and improve coordination between medical care and behavioral health care.

MDwise achieves this collaborative approach to managing, monitoring, and improving coordination of the member's overall care through the following activities:

- Education of members about behavioral health services and the importance of communicating with their PMP about the services they receive
- Identification of member cases requiring coordinated physical and behavioral health plan (e.g., through data analysis related to medical and behavioral treatment use, screening through health assessments and member or provider referrals)
- Providing periodic member-specific service utilization reports to providers/behavioral health medical profiles
- Informing providers of members receiving emergency and inpatient behavioral health and follow-up care
- Communication between medical and behavioral health Case Managers
- Screening mechanisms to identify members with coexisting medical and behavioral health disorders, including substance abuse disorders (SUD)
- Implementation of primary care guidelines for treating or making referrals for treatment of problems and primary or secondary preventive behavioral health programs
- Medical record audits to confirm communication among medical and behavioral health providers
- Collaborative disease management programs
- Provision of education and training opportunities to MDwise medical and behavioral health care providers and case managers regarding coordination of medical and behavioral health care

Primary Medical Providers and Behavioral Health Care Providers, as directed through your contract and MDwise policies and procedures, will implement the procedures to exchange information, obtain necessary consents and facilitate improved coordination, management, and follow-up for members with coexisting medical and behavioral health care needs.

Behavioral health care providers and PMPs are to document and share the following information with each other and with MDwise for each member receiving behavioral health treatment:

- The provider shall cooperate with MDwise to meet the program's current requirements concerning the treatment plans, diagnosis, medications, and other relevant clinical information.
- The provider shall give timely notification 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 members at risk for or who have had a hospitalization, provide a summary of the member's initial assessment session, primary and secondary diagnoses, medications prescribed, and psychotherapy prescribed. This information must be provided after the initial treatment session.
    - For members not at risk for hospitalization, provide findings from the member's assessment, primary and secondary diagnoses, medication and psychotherapy prescribed.
    - Notify all parties of any significant changes in the member's status and/or a change in the level of care.
    - Any other information relevant to the continuity and coordination of care.

Note: *Disclosure of mental health records by the provider is permissible under HIPAA and State law (IC 16-39-2-6(a) without the patient's consent because it is for treatment. However, consent from the patient is necessary for substance abuse records or information about substance abuse treatment.*

Care Coordination & Case Management

The MDwise Care Management Program is in place for members receiving behavioral health care. The member's needs determine the level of case or care management interventions. As the member's care continues and reassessments occur, care/case management interventions will correlate with the intensity and severity of the member's needs.

MDwise uses the clinical expertise of its care managers and behavioral health clinicians to provide case and care management services. As the member's needs change, the level of service intensity may need to increase or decrease to achieve the best outcomes for the members regarding access to and coordination of services, compliance with the treatment plan, and optimal functioning in the community.

MDwise care managers coordinate care between all providers involved in the member's care. They are responsible for facilitating continuous communication between the behavioral health and medical (physical health) providers.

Some key elements of the MDwise Care Management program administered by the care manager include:

- Developing and implementing a comprehensive, coordinated, collaborative and member- focused plan of care, which meets the member's needs, promotes optimal outcomes, and supports the medical home concept
- Developing and facilitating interventions that coordinate care across the continuum of health care services, decreasing fragmentation, duplication, or lack of services, and promoting access or utilization of appropriate resources
- Facilitation of information sharing among treating providers to ensure services for members are coordinated and duplication is eliminated

- Member appointment compliance
- The case manager monitors the progress and adherence to the plan and collaboration with the member, family/caregiver and providers on the interventions outlined in the treatment plan, including translating the relevant practice guideline standards into tasks to be completed
- Validating outcome measures related to the adequacy and quality of the clinical management (i.e., adherence to medication regime and follow-up medication monitoring visits)

Members at Risk for Acute Services within the General Population

MDwise will also provide case/care management services for members identified as at-risk for inpatient psychiatric or substance abuse hospitalization. MDwise members identified as at-risk for inpatient psychiatric, or substance abuse hospitalization will receive case management follow-up and support to help maintain care in the least restrictive setting possible. Care Management interventions can include contacts with a member's medical provider, behavioral health provider and identified community resources to coordinate treatment and ensure no gaps occur in treatment. A Care Manager will also provide outreach to the members to support, assess needs, and assist in resolving issues that could be related to safety, food, housing, legal problems or transportation. Ongoing monitoring of care continues while the member is in this program to provide care coordination and support by a reliable team of Care Management staff.

For members receiving inpatient psychiatric services, the behavioral health provider must schedule an outpatient follow-up and/or continuing treatment within seven (7) calendar days from the date of the member's discharge. The member receives a reminder call to attend their appointment and to address any issues that may have come up since discharge. Care Managers continue to follow up with members well into the recovery process to ensure treatment compliance and coordination of services between medical and behavioral providers.

Behavioral Health Coordination with the PMP

MDwise and/or the behavioral health clinician or agency providing the services is responsible, according to the contract, for communicating with providers directly regarding the member's care and treatment plan, including any psychotropic medications prescribed. Communication must occur at the beginning, during, and end of treatment. Providers will receive notification regarding any of your MDwise members that may receive inpatient or emergency services.

Providers will receive this information by telephone, mail, or fax. MDwise requires providers to request member consent for information sharing among treating providers, including consent to share substance abuse treatment information to coordinate care with their PMP.

Quarterly, MDwise sends behavioral health profiles to primary medical providers who have members in behavioral health services. These profiles contain information on the types of services received, medications prescribed and who provides the treatment.

MDwise Medical Directors or physician advisors are available as resources for general discussions regarding psychiatric care or for specific case consideration to better manage the patient's treatment.

Transportation Services

Transportation Benefits & Limitations

MDwise provides ambulance and non-emergent transportation (NEMT) to and from offices and facilities that provide medically necessary, covered services. In accordance with Federal Medicaid regulations, MDwise strives to provide our members with "necessary transportation" to and from providers for covered services in the "least expensive mode of transportation that is appropriate."

Non-emergent Transportation (NEMT) Services

Non-emergent transportation, defined as a ride, or reimbursement for a ride, provides an option for MDwise members with no other transportation resources to receive services from a medical provider. Non-emergent transportation does not include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations or facility to facility transfers.

MDwise has a transportation broker that arranges for NEMT services for eligible members. Hoosier Healthwise Package A, HIP State Plan (Plus and Basic), and HIP Maternity are all eligible to receive NEMT services. NEMT is not a covered benefit for Hoosier Healthwise Package C, HIP Plus, nor HIP Basic members.

Transportation Reservations

Eligible MDwise members needing NEMT services, or providers looking to arrange transportation on a member's behalf, should call MDwise Customer Service to schedule a ride. Schedulers should choose the "transportation option" when prompted through the customer service line (1-800-356-1204). Once connected with a transportation specialist, NEMT is scheduled to and/or from a covered service location. All transportation requests must be approved at least two (2) business days before the appointment, except if there is an urgent care need or an emergency. For any transportation service requiring prior authorization, the member should also call in at least two (2) working days before the service is needed. Requests for same-day, urgent care transportation must be made by the provider or provider office staff.

Although members may schedule transportation visits up to two (2) business days in advance of a scheduled appointment, members are encouraged to contact MDwise when the appointment is scheduled, so the appropriate means of transportation can be used.

Emergency & Ambulance Transportation

Emergency transportation and ambulance transportation between facilities is covered for all MDwise members. This includes Advanced Life Support (ALS) and Basic Life Support (BLS) ambulance transportation to both in-state and out-of-state locations. MDwise provides reimbursement for medically necessary emergency and nonemergency ambulance services when the level of service rendered meets the Emergency Medical Services Commission (EMSC) definition of ALS or BLS. Base rate, mileage and wait time are reimbursed. Oxygen and medical supplies used during the trip are based on the level of service rendered.

Level of Service	Base rate includes milage and wait times
Basic Life Support (BLS)	Oxygen and medical supplies are separ ately reimbursable
Advanced Life Support (ALS)	Oxygen and medical supplies **are not** separately reimbursable

Providers billing for transportation services must append both origin and destination modifiers to the base rate and mileage procedure codes. The first character indicates the transport's place of origin, and the second character indicates the destination. Origin and destination modifiers are not used in the prior authorization (PA) requests process; however, the modifiers are required for claim reimbursement.

Package C Transportation Limitations

Package C members are only covered for emergency ambulance transportation, subject to a $10 copay; they are not eligible for NEMT. The inability to pay a copayment at the time of service should not restrict a member's access to care. The ambulance provider may bill the member for the copay amount after the ambulance service is provided but they may not deny the member's benefit.

Note: *Additional information regarding the billing guidelines and covered benefits related to transportation services can be found in the IHCP Transportation Services Module at www.in.gov/medicaid/providers/files/transportation-services*

Prior Authorization for Transportation Services

Certain transportation services require prior authorization:

- Airline or air ambulance services
- Interstate transportation or transportation services rendered by a provider located out-of-state in a nondesignated area
- Train or bus services
- Non-emergent out-of-network services

If a transportation service requires prior authorization, the requests are forwarded to the medical management staff for medical necessity review and determination. Patients with chronic medical conditions should have a PMP-supervised medical care management plan that includes a transportation plan if increasing benefit levels are necessary.

Emergency ambulance services do not require prior authorization; however, claims are subject to retrospective review. Providers not contracted with MDwise transportation must obtain prior authorization to provide these services. Non-contracted providers that do not obtain an authorization for non-emergent transportation will not be reimbursed.

Note: *The MDwise transportation broker is responsible for all MDwise non-emergent transportation and will only pay for non-emergent trips set with the contracted transportation providers.*

Prior Authorization

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 their PMP 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 requests for authorization for primary and preventive care services, if authorization is required, and assists PMPs in providing appropriate referrals for specialty services, second opinions, and diverse health needs.

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.

Services That Require Prior Authorization

Quick reference guides and a specific list of services requiring prior authorization for medical review are distributed to the contracted providers by the MDwise medical management staff. The list of services requiring prior authorization is reviewed annually and continuously updated.

Medical management staff are available to discuss and assist the providers in understanding the prior authorization process. Providers can also access authorization information through the MDwise website, and prior authorization forms.

To obtain the latest and most comprehensive list of services requiring prior authorization, visit MDwise.org/for-providers/forms/prior-authorization.

Contact the medical management department to obtain prior authorizations for health care services by phone or fax (information found on the contact sheet). Copies of prior authorization forms are also located on the website.

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. However, many services and treatments available from MDwise in- network/IHCP providers do not require a medical review.

Authorization may be required prior to services being rendered to:

- Verify services are covered by the benefit plan
- To coordinate timely access to appropriate clinical care
- To verify out-of-plan referrals are appropriate
- To efficaciously manage the utilization of health care services (including limited resources per benefit limitations)
- To implement timely discharge planning and coordination of services
- To identify members with special health care needs, high risk individuals or populations for care coordination and case management/disease management intervention

Service Types Requiring Prior Authorization: Such services are grouped according to service type categories that include:

- 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
- Self-referral services in accordance with IHCP requirements

Note: *These categories of services are listed below in the MDwise Prior Authorization Reference Guide.*

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 health care needs and access to women's health specialists.

Authorization Procedural Guidelines

- Submit authorization requests for services requiring prior authorization by calling or faxing the designated form to MDwise medical management. Requests should be submitted for review within a reasonable time frame prior to the proposed service dates. Forms are available on the MDwise website to submit for service authorization. The requesting provider completes the forms and includes any additional information the provider chooses to provide to support the request. To access the PA forms, go to MDwise.org/for-providers/forms/prior-authorization.
- Information submitted with service requests should include demographic information, type of care, frequency, duration if applicable, facility or provider, diagnosis, procedure, date of service or onset date of services, and other pertinent clinical information required supporting medical management decisions and benefiting coverage determinations.
- If Medical Management requires additional information to decide, the prior authorization request will be pending with a request for additional information. Incomplete forms/requests lacking the required information to support the specific request will delay the authorization process.
- Prior authorization requests for non-urgent care and retrospective reviews may be denied based on lack of information.
- Prior authorization determinations are communicated to the member, requesting provider and the member's PMP. Approval notifications will include the services considered medically necessary and the date(s) the service can be provided. Authorization Denials will include listing of the denied service(s), the denial reason, member appeal rights and alternative care options.

Note: *Prior authorization is a determination of medical necessity and is not a guarantee of payment. Changes in enrollment status, Managed Care Entity, and/or IHCP benefit package can affect the member's eligibility to receive a particular service. Therefore, checking for eligibility ensures the member is still eligible for coverage each time a service is rendered, Failure to do so may result in denial of payment.*

Claims

Hoosier Healthwise & Healthy Indiana Plan Claims

MDwise is required by State and Federal regulations to capture specific data regarding services provided to its members. By adhering to all billing requirements, the provider ensures timely claims processing. It is important to complete all required data fields on the claim form. Missing or invalid data elements or incomplete forms causes processing delays, rejections or denials.

Providers are required to submit MDwise medical claims on one of the following claim forms:

- CMS 1500 (professional claims)
- UB04 form (for institutional claims)
- 837P (HIPAA compliant professional) and/or 837I (HIPAA compliant institutional) file formats-electronic claims

The following code sets are to be used when submitting medical claims electronically or on paper:

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM)
- Current Procedural Terminology – (CPT)
- HCFA Common Procedure Coding System (HCPCS)
- National Drug Codes (NDC)

Submitting Claims

MDwise medical claims can be submitted via paper or electronic transaction.

Electronic medical claims: Claims should be sent via electronic transaction for expedited processing and payment. Electronic medical claims should be submitted through the following clearinghouses:

Hoosier Healthwise Claims:	Optum/Change Health/Emdeon/WebMD Payer ID: 3519M
Healthy Indiana Plan Claims:	Optum/Change Health/Emdeon/WebMD Payer ID: 3135M

Note: *All electronic claims must be submitted using HIPAA-compliant transaction and code sets.*

Paper claims: Medical claims that require an attachment, such as a consent form or cost invoice, must be sent via paper submission. Paper claims should be submitted to the following address:

MDwise/McLaren Health Plans

P.O. Box 1575

Flint, Michigan 48501

Rejected Claims

Claims may be rejected if it has invalid or missing data elements, such as the provider tax identification number or member Medicaid number. Rejected claims are returned to the provider or electronic data interchange (EDI) source without registering in the claim processing system. Rejected claims are different than denied claims, which are registered in the claims processing system but do not meet requirements for payment under MDwise guidelines. MDwise does not register rejected claims in the claims processing system, the provider must resubmit the claim within the claim's timely filing limit.

See the IHCP Claims Submission and Processing Module for detailed information on required fields at www.in.gov/medicaid/providers.

Note: *MDwise follows the IHCP-applied National Correct Coding Initiative (NCCI) editing to medical services billed on professional and outpatient institutional claims. For more information on NCCI edits, please refer to the IHCP Provider Reference Module on the National Correct Coding Initiative.*

Dental Claims

Dental claims (paper and electronic for Hoosier Healthwise and Healthy Indiana members should be sent directly to Delta Dental.

Delta Dental
P.O. Box 9085
Farmington Hills, MI 48333-9085

To submit a claim to Delta Dental of Indiana, you can use the Dental Office Toolkit (DOT or a clearinghouse:

Delta Dental Clearinghouse Payer ID: DDPIN

Pharmacy Claims

See Pharmacy Benefit section of this manual

Corrected Claim Submission

In the case of a denied claim due to a provider's incorrect claim information, the provider should review the claim and resubmit with corrections. To submit a corrected claim, providers must include the resubmission code, or the resubmission will be denied as a duplicate claim submission. Corrected claims must be submitted within 90 days of the Explanation of Benefit (EOB) date.

Further directions on submitting corrected claims can be found in the IHCP Provider Modules Claim Submission and Processing and Claim Adjustments.

Claim Timelines

Claim Submission Type	Submission Deadline (calendar days)
MDwise Contracted Providers	90 days from the date of service
Non-Contracted Providers	180 days from the date of service
Secondary Claims	90 days from the date of the primary EOB
Claim Adjustments	60 days from the date of EOB
Claim Dispute	90 days from the date of EOB
Newborn Claims	365 days from the date of service within the first 30 days of life

Adjudication	Response Time
Clean Electronic Claim	21 business days from the date of receipt
Clean Paper Claim	30 business days from the date of receipt
Dispute Resolution	30 calendar days from the date of receipt

According to 42 CFR § 447.45, the Centers for Medicare & Medicaid Services (CMS) define a clean claim as one submitted by a provider for payment and processed without obtaining additional information from the provider of service or a third party. The receipt date of a claim is the date that MDwise receives either written or electronic notice of the claim. All hard copy claims are stamped with date of receipt.

MDwise providers must submit complete and accurate claims/encounter data as outlined in your MDwise contract. If a member has other health coverage, the provider submits a corresponding claim or encounter data for every service provided, with claim detail identical to that required for fee-for-service claims submissions. Providers are encouraged to submit claims electronically as this helps to ensure more timely processing.

Questions about Claims: *If you have a question about a specific claim submitted or about an EOB you received, please contact MDwise at* ***1-833-654-9192****.*

Inquiries, Adjustments & Disputes

Claim Inquiries

Providers may inquire about a claim at any time during the adjudication process. Providers are encouraged to use the myMDwise Provider Portal (www.mdwise.org) prior to contacting MDwise Provider Customer Service (1-833-654-9192) when trying to determine the status of the claim.

Claim Adjustment Requests

Providers who need to correct a claim may complete a Provider Claim Adjustment Request Form.

The Provider Claim Adjustment Form must be received by MDwise within 60 calendar days from the date of the explanation of payment (EOP). A copy of the corrected claim and/or any supporting documentation for the adjustment must be attached to the form.

The claims adjustment process is not available to a provider if the formal claim dispute process has already been initiated. Providers may not utilize the Provider Claim Adjustment Form as an avenue to have the claim reviewed nor to extend the claim dispute timeframes.

Claim Dispute Requests

All in-network and out-of-network providers have the right to dispute a claim decision or action. If the provider remains dissatisfied with the reimbursement after reasonable attempts to correct or adjust a claim, the provider should submit a formal claims dispute.

Providers must file their claims dispute within 90 calendar days of the initial EOP determination. When submitting a dispute, the provider should include the Claims Dispute Form, explanation of payment, and a summary of the reason for disputing the claim.

Examples of denials that may constitute a dispute include:

- Timely Filing
- Coding Issues

The following do not constitute a dispute:

- New Claims
- Corrected Claims
- Medical Records
- Attachments (Consent forms, Invoices)
- Recoupments

Readmission Dispute Information

A Readmission Dispute Form can be utilized to dispute claims denied due to a previous inpatient stay being paid within 14 calendar days prior to the admission date of the claim in question. Providers must file their readmission claims dispute within 90 calendar days of the initial EOP determination. The description should include, but not be limited to the following items:

- Medical reason the 2nd claim should be considered
- Medical records for both admissions
- Claim date of service and claim number for both admissions

Filing a Dispute

All claim forms (Adjustments and Disputes) can be found on the MDwise website at MDwise.org/for-providers/forms/claims. Each claim adjustment and/or dispute requires a separate form and supporting documentation.

- **Claim Adjustment Forms** and supporting documentation can be submitted via email (preferred method) to MDwiseClaims@MDwise.org, or faxed to 463-426-5854.
- **Claim Readmission Dispute Forms** and supporting documentation can be submitted via email (preferred method) to Readmission@mdwise.org.
- **Claims Dispute Forms** can be submitted via email (preferred method) at cdticket@MDwise.org.
- **Claim Readmission and Claim Dispute Forms** and supporting documentation can also be submitted via mail to:
  MDwise
  P.O. Box 441423
  Indianapolis, IN 46244-1423
  Attention: Dispute Department

In-Network & Out-of-Network Provider Claim Disputes

In-network and out-of-network providers who have a claim dispute follow the same process and timeframes. MDwise will review all disputes and respond to the provider within 30 business days. If the original decision is upheld the provider will be given information on how to file a second level dispute.

Third-Party Liability

When the member has other insurance, providers must submit claims to the other insurance carrier before submitting to MDwise. Providers include a copy of the third-party's explanation of benefits (EOB) with a TPL claim, within 90 days of the date of the primary explanation of benefits. MDwise pays the difference between the payment made by the primary insurance carrier and the MDwise total allowable charge for the covered service. If the primary insurance paid more than MDwise total allowable charge, the claim would pay zero.

If the provider finds out about TPL after they bill MDwise, they are responsible for billing the other carrier. If MDwise has already paid the provider and the provider subsequently obtains TPL payment, the provider must submit a refund to MDwise.

In some cases, even if there is third-party coverage involved, MDwise must first pay the provider and then coordinate with the liable third party.

This applies when the claim is for:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program and preventive pediatric services covered by the Medicaid Program
- Coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider has not received payment from the third- party within 30 calendar days after the date of service

90-Day Rule

When a third-party insurance carrier fails to respond within 90 days of the provider's date of service, providers may submit the claim to MDwise 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.
- The provider must note the date of the billing attempt and the words ***"no response after 90 days"*** clearly indicated on an attachment.

Note: *For contracted providers, MDwise must still receive claims within the 90-day filing limit.*

Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days from the last date of service on the claim. 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's Medicaid ID number (also known as RID) and provider's National Provider Identifier (NPI)
- Name of primary insurance carrier billed

For claims filed electronically, include the following documentation in the claim note segment of the 837P transaction date:

- The phrase, ***"no response after 90 days"***
- Name of primary insurance carrier billed

MDwise Medicaid products are the payer of last resort, except for the following two fully State- funded programs:

- Victims Assistance
- Indiana Children's Special Health Care Services

Third-Party Liability & Prior Authorization

If a covered service is to be provided that requires prior authorization by MDwise, and the member has third-party coverage, the provider is still responsible for obtaining prior authorization for the service and any authorization required by the third-party payer. Without prior authorization, the claim may be denied.

If a provider is aware that a member has been in an accident, however, does not yet know who the liable third party is, the provider can bill MDwise. If billing MDwise, the provider must note that the claims are for accident-related services on the applicable claim form. If a provider initially pursues payment from the liable third party and submits the claim to MDwise after the filing time limit, the claim may be denied.

Provider Third Party Liability Responsibilities

According to Indiana Health Coverage Program (IHCP) program requirements, providers are responsible for obtaining insurance coverage information from members at the time service is provided.

IHCP requires the following:

- Ask every member if they have any insurance coverage and report any available coverage to MDwise through inclusion on a claim form, phone call or written notice.
- Check the MDwise Provider Portal before billing MDwise and if available, pursue the TPL resource first.
- When a provider determines that a member has an available TPL resource, the provider must bill that resource before billing MDwise.
- If a member has other TPL resources and the provider submits a claim to MDwise without documentation that the third-party resource was billed, Federal regulations require that the claim be denied.

Billing MDwise Members

Billing for Covered or Non-Covered Services

IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered IHCP service. Provider acceptance of payment from MDwise as payment in full is a condition of participation in the IHCP. As outlined below, there are specific circumstances in which a provider can bill members for covered or non-covered services.

According to MDwise policy, a provider may bill a member for Hoosier Healthwise or HIP covered or non-covered benefits only when all the following conditions have been met:

Non-covered benefit*: A provider may bill a MDwise member for services not covered under Hoosier Healthwise or HIP.

HIP program member POWER Account funds may not be used to reimburse providers for non- covered services.

The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the MDwise did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed and the member signs the consent before receiving the service.

Member exceeded benefits*: Providers may bill the member when the service is a Hoosier Healthwise or HIP-covered service for which the member has exceeded the program limits. The member must understand before receiving the service that the service is not covered, and they will be responsible for the charges incurred. Note: it is the provider's responsibility to verify member benefit limits.

PA denied, and member informed*: A provider may bill a member for services that require authorization but for which authorization is denied. However, the provider must establish authorization has been requested and denied with member before rendering the service. The provider can request review of the authorization decision by MDwise. If MDwise maintains the

decision to deny an authorization, the provider must inform the member that the service requires authorization, if and why authorization has been denied, and that they may appeal this decision directly with MDwise. The provider must

inform the member that covered services may be available without cost, from the appropriate provider in the MDwise network. The provider must inform the member of their responsibility for payment if they choose to or insist on receiving the service without authorization.

Member did not tell provider they were eligible*: A provider may bill the member when the provider has taken appropriate action to identify a responsible payer and the member has failed to inform the provider of Hoosier Healthwise or HIP eligibility. However, if the provider then finds that the member had Hoosier Healthwise or HIP coverage, the provider must submit the bill to MDwise (and cannot require the member to pay) if it is still within the claim timeliness filing limits.

Outstanding copayments*: It is permissible to bill a member for any outstanding copayments, yet providers may not deny services due to the member's inability to pay the copayment amount on the date of service.

Prior to receiving the service, the member must understand (verbally and in writing) that the service(s) are not covered, and they will be personally responsible for the charges incurred.

Obtaining a Waiver

When a member chooses to receive a service that MDwise does not cover, they may only be billed if a waiver is obtained prior to the service being rendered. The provider must ensure that the member understands that they are choosing to receive the service voluntarily, knowing that MDwise will not pay for it. The signed waiver can be used as the member's acknowledgement that they understand and will be responsible for the charges.

The waiver must meet all the following requirements:

- Must include a member's signed statement accepting financial responsibility for the services.
- The waiver is signed only after the member is appropriately notified that the service is not covered and the reason.
- The waiver must be specific about the services to be billed and retained as documentation in the patient's medical record. A waiver must be obtained for each encounter or patient visit that applies.
- The waiver must list the specific services that fall under the waiver application, including the date and cost of services rendered.
- The waiver may not contain any language or condition to the effect that if authorization is denied (after the service is rendered) the member is responsible for payment.

Pharmacy Benefits

Pharmacy Benefit Overview

To deliver quality care, MDwise believes it is necessary to establish procedures for pharmaceutical management to promote clinically appropriate and optimal therapeutic use of pharmaceuticals. MDwise pharmacy management follows procedures based on sound clinical evidence, reviewed by pharmacists and actively practicing clinicians (at least annually) to ensure procedures are updated. This is an essential step in meeting the National Committee on Quality Assurance (NCQA) accreditation standards.

The MDwise Medical Advisory Council oversees the pharmaceutical management of MDwise Hoosier Healthwise and HIP members. The Preferred Drug List and other policy decisions regarding the MDwise pharmacy benefits are determined by the MDwise Medical Advisory Council. This committee of local practicing clinicians in the medical and pharmacy fields represents the MDwise network.

In cooperation with its Pharmacy Benefit Manager (PBM, MedImpact), MDwise offers MTM (medication therapy management) services to Hoosier Healthwise and HIP enrollees, which enhance therapeutic outcomes through improved medication use and reduced risk of adverse events. The PBM's network of MTM clinicians will primarily provide these services.

Several criteria target appropriate members for MTM services, including those with multiple chronic diseases, those taking multiple medications, and those whose costs must exceed a specific dollar threshold annually. Participants and prescribers can access interventions after meeting the targeting criteria and enrolling in the MTM program (MTMP). In addition, both the beneficiary and prescriber can access interventions independently or in combination to promote coordinated care. Pharmacists and other qualified providers, experienced in medication management and certified in geriatric medication management, provide MTM services. MTMP services are free of charge to MTMP enrollees. Maintenance medications (90-day supplies) are available for patients enrolled in the HIP Plus Plan. For appropriate medications, IHCP-enrolled network pharmacies may dispense 90-day supplies upon request.

Hoosier Healthwise & Healthy Indiana Plan Prescriptions

MDwise maintains the prescription drug benefit for the Hoosier Healthwise and Healthy Indiana Plan programs. Members in the HIP program can obtain prescription and over-the-counter (OTC) drugs from MDwise participating pharmacies and drug stores, prescribed only by a licensed Indiana prescriber. The prescription drug benefit utilizes a preferred drug list available on the MDwise website (MDwise.org). MDwise members who present their prescription to a pharmacy must show the pharmacist their Hoosier Healthwise/HIP identification card. If a member chooses to go to a non-participating pharmacy, the member will be responsible for paying the full retail cost for the prescription out of pocket.

A prescription written by a valid practitioner is required for all over-the-counter products regardless of the member's Benefit Package. Pharmacies will communicate with the members and attempt to contact the prescriber or the Pharmacy Help Desk when the prescribed medication is not part of the preferred drug list.

Hoosier Healthwise and HIP Pharmacy Help Desk Information:

A 72-hour temporary supply of medication is available in emergency situations when the PBM clinical staff is unavailable

MedImpact (PBM) Pharmacy Customer Service: **1-844-336-2677**

MDwise Pharmacy Customer Service: **1-800-356-1204**

Pharmacy Network

The PBM's contracted network delivers pharmacy services to MDwise members. The PBM provides MDwise with a list of participating providers that is updated monthly. The PBM access standard is as follows: all members must have access to two (2) pharmacies (the closer of) 30 miles or 30 minutes from their home.

MDwise PBM also conducts an aggressive network auditing program and educational system designed to increase the overall effectiveness and quality of the pharmacy network. The audit program includes statistical system audits, desk audits, onsite audits and audit follow-up.

Note: *To view a listing of the network pharmacies, visit the Providers or Members Page on MDwise.org.*

Hoosier Healthwise and HIP Pharmacy Copays

Members on the HIP Basic or HIP State Plan Basic Plan options will owe copays for non-preventive prescriptions. The copays are $4 for Preferred and $8 for Non- preferred medications. MDwise members enrolled in the Children's Health Insurance Program (CHIP) have set copays at $3 for each covered generic drug and $10 for each covered brand drug. For a breakdown of the applicable category for each covered drug, please visit MDwise.org.

Preferred Drug List Exceptions Policy

MDwise administers a pharmacy benefit for Hoosier Healthwise and HIP programs with a closed Preferred Drug List. Members and prescribers have the right to request a timely review for coverage of a non-Preferred Drug List pharmaceutical based on medical necessity determined by the member's clinical needs. This request may occur before the pharmaceutical is denied and can possibly resolve the request before it may become a formal appeal.

MDwise criteria and medical policy, member benefits, MDwise pharmaceutical and PBM procedures, State and Federal regulatory standards, and the MDwise Member Grievance Policy and Procedure collectively guide the evaluation of requests and determinations.

Pharmacy Appeals

MDwise notifies Hoosier Healthwise and HIP members, and providers of the appeals process if there is a decision to deny a medication based on medical necessity.

Pharmacy Inquiry Registering and Resolution

The PBM is responsible for maintaining a provider inquiry reporting and resolution process that includes MDwise notification and interaction as needed. PBM reporting to MDwise includes an inquiry report that identifies the type and outcome of MDwise provider inquiries.

Provider staff should forward pharmacy-related inquiries to the MDwise Customer Service Department. In addition to the MDwise Medical Advisory Council, other MDwise committees may discuss pharmacy-related issues (committees overseeing corporate quality, quality improvement, medical management, member services and provider services). Representatives from the PBM are present or available at the meetings as needed or upon request.

MDwise members and providers have access to the MDwise customer service representatives to file inquiries regarding pharmacy issues as outlined in the MDwise policies. MDwise QI efforts focus on the timely resolution of inquiries and regular analysis of inquiries to improve services to MDwise customers.

The MDwise Director of Pharmacy and QI Director are the principal contacts between PBM and MDwise for daily operations.

Pharmacy Prior Authorization

MDwise Pharmacy Benefit Manager, MedImpact, handles the prior authorization process. MedImpact utilizes qualified health care professionals, including clinical pharmacists, to make utilization management decisions. MedImpact will request documentation to determine the medical necessity of the requested drug or treatment in accordance with their usual procedures. Proactively working with the prior authorization entity on requests for prior authorization will expedite the process for the provider and the member. Therefore, providing written documentation (i.e., records supporting requests for prior authorization) is essential to a valid, consistent and expedient review process.

Upon electronic submission of the prescription claim for adjudication, a message will appear notifying the pharmacy that prior authorization is required. The technician or pharmacist will call the PBM at the pharmacy help desk number. If it is a clinical authorization, the prescriber is to submit clinical information and rationale to support the request. The following steps occur:

- The prescriber should locate the appropriate prior authorization medication request form (MRF) from the MDwise website.
    - The completed form should be faxed to the number on the form.
- The reviewer can approve the prescription immediately if criteria are met and enter the approval into the electronic claims processing system.
- The reviewer will refer requests to the Medical Director or designee if the prescriber is not able to substantiate medical necessity for the drug in question based on the guidelines (criteria).
- If the Medical Director or designee denies the prior authorization request due to lack of medical necessity, the prescribing physician will be notified of the reason for denial.
    - The physician and member will be notified of appeal rights.
- If the prior authorization or medical necessity override is denied due to lack of information, communication will be sent to both the requesting prescriber and the affected member stating clearly what additional information is necessary to make a valid and consistent determination.
- Once received, a decision will be made on the request within 24 hours. If a situation arises that the decision cannot be made within 24 hours a temporary supply can be obtained as outlined below.

Prior Authorization & Emergency Supply Pending Review

If a non-Preferred Drug List medication or medication requiring prior authorization is prescribed in an emergent situation (as ascertained by the dispensing pharmacist) when the review process cannot be implemented promptly or during off-hours, a 72-hour supply of the medication may be provided for a member (extensions can be granted under certain circumstances).

The prescriber must submit a request for prior authorization to the prior authorization entity within the 72-hour period for continuation of the drug. In cases where a therapeutic equivalent exists on the MDwise Preferred Drug List, the prior authorization entity may request the medication be substituted with a medication found on the PDL.

If a change in medication could be detrimental to the member, every effort to ensure continuation of appropriate therapy set out by clinical guidelines will be made.

If the request for continuation of medication is denied, MDwise will notify the physician and member of their right to proceed with the grievance/appeals process and/or exceptions policy as appropriate.

Pharmacy Claims

MedImpact is the pharmacy benefit manager (PBM) for MDwise Hoosier Healthwise and Healthy Indiana Plan members.

MedImpact is responsible for:

- Processing pharmacy and compound claims
- Adjudicating claims according to the MDwise State-approved formulary
- Implementing and managing plan-approved utilization management rules (e.g., step therapy, quantity limits, etc.)
- Processing prior authorization requests
- Auditing Pharmacy providers
- Managing Specialty pharmacy claims
- Managing pharmacy encounter claims submissions/corrections

Hoosier Healthwise and Healthy Indiana Plan pharmacy claims questions to the Pharmacy Help Desk at 1-844-336-2677. Obtain Pharmacy Prior Authorizations by calling 1-800-788-2949 or faxing your request to 1-858-790-7100. Fax Pharmacy Appeals to 1-844-759-8548.

MDwise Hoosier Healthwise and Healthy Indiana Plan Pharmacy Group Information:

RxBIN: 003585

PCN: ASPROD1

RxGroup: MDW

Medical Management

Medical Management Overview

Medical Management functions include, but are not limited to, coordination of care and care plan activities as applicable, authorization of services as appropriate, monitoring utilization of services/medical necessity as appropriate, facilitating improved continuity of care, and assisting in transitioning members into other care options.

MDwise medical management must coordinate care for its members transitioning into long-term institutional care, hospice, or a Home and Community-Based Services (HCBS) waiver.

Coordination efforts include:

- Working with the long-term care facility to ensure timely submission of the request for a Pre-Admission Screening Resident Review (PASRR). MDwise is responsible for payment for up to 60 calendar days for members placed in a long-term care facility while the level of care determination is pending.
- Providing the IHCP hospice provider with any information required to complete the hospice election form.
- Coordinating care for members transitioning into a HCBS waiver until the disenrollment is effective.

MDwise Medical Management (MM) Program elements are further defined in the OMPP contract, program, and reporting requirements. MDwise Medical Management Policies and Procedures include standards and timelines. The Medical Management Program components are compliant with the applicable regulatory and accrediting bodies. MDwise conducts medical management activities respecting the importance and obligation of maintaining the member privacy, security, and confidentiality of personally identifiable health information.

Note: *While MDwise does not cover long-term institutional care, MDwise can place a member in a nursing facility on a short-term basis. Members who require long-term care or whose short- term placement becomes a long-term placement will be disenrolled from managed care when LTC/LOC is approved and entered the Provider Healthcare Portal. While a Medicaid-eligible individual in a Hoosier Healthwise-eligible aid category is awaiting placement in an LTC/ LOC facility, they could be auto-assigned to MDwise before completing the placement paperwork.*

Medical Management Scope and Approach

Medical Management focuses on the outcome of treatment with an emphasis on the following:

- Appropriate screening activities
- Reasonableness and necessity of all services
- Quality of care reflected by the choice of services provided, type of provider involved, and the setting for services provided
- Prospective and concurrent care management
- Evaluation of standards of care and guidelines for the provision of care
- Best practice monitors

Medical Management Objectives

Medical Management Program objectives are supported through a coordinated plan involving MDwise medical directors, associate medical directors and administrative staff.

MDwise Medical Management Program emphasizes the role of the Primary Medical Provider (PMP) and the establishment of a medical home to provide, coordinate, or guide members to the most appropriate treatment option and place of care. MDwise medical management works to strengthen the link between the MDwise member, PMP and behavioral health provider if applicable, to coordinate care, prevent unnecessary utilization of services, and ensure access to and utilization of needed medical care, including behavioral health and preventive care.

Primary objectives of MDwise Medical Management:

- Promote the efficient provision of quality health care services appropriate to the individual member's needs.
- Provide monitoring and oversight to ensure the delivery of health care services at the appropriate level of care in a timely, effective, and cost-efficient manner.
- Continually examine and improve health care quality and resource allocation delivered to members.
- Enhance the overall performance of practitioners and providers in achieving optimal outcomes in delivering quality, safe and efficient health care services to members through prospective, concurrent and retrospective data analysis and education.
- Monitor and analyze relevant data to identify, correct and prevent patterns of potential or actual excessive or underuse of health care services.
- Facilitate the transition of health care services for members ensuring continuity of care by providing access to continued necessary care and assistance in transitioning to a new care setting, service provider, services or MCE.
- Implement case management services that assess, monitor, plan, and coordinate care options for members with health conditions such as resource-intensive illness, multiple diagnoses of mental illness, substance abuse and physical illness, (have or at increased risk for) a chronic physical, developmental, behavioral, or emotional condition.
- Meet or exceed customer expectations.

Medical Management Program Activities

Medical Management service authorization activities conducted by the medical management staff include:

- Preauthorization of inpatient and selected outpatient services, including pharmaceuticals
- Concurrent review
- Retrospective review of selected inpatient and outpatient services
- Authorization and Denial notification
- Supplemental activities to assist the provider and member in accessing and receiving appropriate services to meet the member's needs include:
- Discharge planning
- Identification of members with special health care needs
- Continuity and coordination of care
- Case and Care management
- Disease management

The MDwise Medical Management Program also addresses the following components or activities:

- Defined structure, processes, qualified health professionals, and assigned responsibilities
- PBM interface
- Participation in the review of medical management grievances
- Confidentiality maintenance
- Accessibility/Availability of Medical Management staff
- Quality issues reporting and review according to the Medical Management Program Policies and Procedures
- Data collection, reporting and annual program review

The MDwise Medical Director and QI staffs work together in developing, implementing, and evaluating medical management program components that include policies and procedures, audits, application of criteria, data reports and analysis, member and provider satisfaction issues and corrective actions and evaluation.

MDwise recognizes the integral role of medical management in developing and managing opportunities to provide preventive and health maintenance care to MDwise members.

Therefore, MDwise provides outreach and education services to MDwise members encouraging preventive care that includes newsletters, focused member initiatives, visits to schools, neighborhoods, and health fairs to teach children and adults how to ensure basic good health.

Medical Management Integration with QI

MDwise Medical Management standards integrate the QI process in measuring, monitoring, and evaluating its activities and provider practice patterns. Quality of care is evaluated by analyzing information related to the management of care, treatments, practice patterns (e.g., referrals), authorization and denial decisions, case outcomes, and other data analysis for under- or over- utilization patterns. Potential quality of care issues, adverse outcomes, questionable treatment plans and/or complications that require further investigation are directed to the MDwise QI Director.

Medical Management prospective, concurrent, and retrospective activities provide means by which MDwise can evaluate and promote evaluation of standards of care/practice guidelines, best practices parameters and outcomes on individual cases and by specific populations.

MDwise uses analysis of monitored data to develop effective interventions, including opportunities for improved medical management interventions, ensuring consistent and appropriate determinations, evaluating the effectiveness of prior authorization requirements, determining member and provider education and interventions, case management, and disease management interventions.

MDwise participates in the State mandated HEDIS measures related to preventive health services. Compliance with screening and immunization schedules is evaluated through applicable HEDIS measures.

MDwise Medical Management Authority, Responsibility and Committee Oversight

The MDwise Medical Advisory Council (MAC), as directed by the MDwise Quality Management Team, is delegated the responsibility for reviewing and evaluating the medical management processes and performance improvement issues, coordinating and overseeing functions of the medical management program, including data reporting and analysis, and monitoring the utilization of health care services by MDwise members. The MAC is responsible for medical policy development covering aspects of services (including pharmacy, preventive health and behavioral health services), case management and disease management programs, continuity of care, new technology assessments, clinical practice guidelines and research, interpret and further clarify medical policy guidelines appropriate and applicable to covered services as outlined in the Indiana Health Coverage Programs (IHCP) participation policies and contract obligations. The MAC also provides expertise, direction and makes recommendations in the monitoring and improving of member clinical care, safety issues and utilization.

This committee comprised of MDwise clinical staff, medical directors, clinical experts in pharmacy, behavioral health and other related specialties (including ad hoc members) is necessary to provide the academic and specialty expertise for specific, focused policies.

The Medical Advisory Council also reviews and makes recommendations regarding the organization's management of pharmaceutical benefits, utilization, and pharmacy-related issues and makes recommendations for quality improvement pharmacy activities, including drug utilization information and drug formulary.

Note: *To contact a council member representative, please call your provider relations staff or Medical Director.*

Key Medical Management Personnel

Physician Involvement in Medical Management Program Implementation

The MDwise Medical Management Medical Director or designated physician consultant provides clinical expertise and direction to the staff. The Medical Director oversees the medical management program and reviews cases for medical necessity or appropriateness of care for those services not meeting criteria. In addition, the Medical Director actively participates in the MDwise Committees.

Note: *The Medical Director or designee is available to discuss Hoosier Healthwise and HIP benefit coverage and/or medical necessity decisions prior to the service request and/or in the event a service request cannot be authorized.*

Medical Management Appropriateness Criteria & Guidelines

Medical Management evaluates nationally recognized and internally developed guidelines to adopt and utilize the criteria for evaluating the necessity of medical services. The criteria from commercial resources and internally developed criteria will be reviewed and evaluated at least annually prior to approval for initial or continued use in the medical appropriateness determination process. The guidelines are reviewed and individually revised as necessary to ensure consistency with MDwise clinical practice guidelines, medical policy, and current

standards of practice in the community, as well as the Indiana Health Care Program Manuals, applicable Federal regulations, and Indiana Code (IC) and Indiana Administrative Code (IAC) policy, and OMPP Medical Policies. Participating practitioners are involved in developing, revising, approving and applying the criteria/guidelines.

Note: *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 medical management staff for a copy of the criteria.*

Medical Management Determinations

Medical Management bases decisions on the appropriateness of care and service and the existence of coverage. Qualified health professionals collect and assess the clinical information used to support medical management decisions and benefit coverage determinations utilizing the approved clinical guidelines for medical necessity/appropriateness, Medical Policy, Policies and Procedures. Medical Management bases determinations on the Indiana Health Coverage Programs manuals, IAC, IC, RFS medical necessity references, Medicaid Medical Policies, and applicable State and Federal guidelines. Medical Management may delegate pharmaceutical reviews and determination functions to the PBM employing licensed, qualified pharmacists.

Guidelines apply to individual cases, but when criteria/guidelines are not applicable to an individual's case, the reviewer follows the process outlined, or the case is referred to the medical director, appropriate behavioral health specialist and/or the appropriate committee. When applying criteria to the care requested, consider the member's age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment (when applicable).

Medical Management Determination Process:

When clinical evidence documented in a member's medical record (or provided by the attending physician or behavioral health provider) meets the criteria, the nurse reviewer or behavioral health specialist certifies the cases. The reviewer provides timely notification of certification determination, outlining the scope of services authorized.

The nurse reviewer or behavioral health specialist refers cases to the Medical Director (or designee physician reviewer or appropriate behavioral health practitioner) when clinical information does not meet the criteria for services requested. The Medical Director (or designee) utilizes board-certified consultants to assist as needed in making medical necessity determinations.

The physician or behavioral health practitioner (psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist) or clinical pharmacist reviewing the case decides regarding the medical appropriateness of services and/or care setting based on clinical information obtained and/or contained in the medical record or obtained from the attending or ordering physician and other providers involved in the member's care, as needed. A physician reviewer is available by telephone during regular business hours to discuss the case.

Medical management provides timely notification of medical determinations to accommodate the clinical urgency of the situation. Timeliness standards (for medical management determinations and notification of determinations) monitor that performance follows applicable regulatory agencies and accrediting organizations standards.

Note: *Providers requesting service authorization are responsible for submitting the necessary relevant information for the Medical Management staff to make a certification determination. Providers are asked to submit authorized service requests in sufficient time prior to the start date of the requested service. Timely submission of the request, and necessary information to process and support the service, will facilitate the response time by the medical management staff.*

Service Requests Not Meeting Guidelines

If the physician, appropriate health practitioner, or pharmacist determines the services are not medically necessary, the certification is denied.

Medical Management staff may generate a denial-of-service request if information needed to decide is not received within a specified time frame, as outlined in the timeliness standards for determinations and notifications. Grievance rights also apply to denials due to a lack of information.

The Medical Director or designee will provide alternate care options if the certification request is denied, when applicable. Such alternatives may be to have the member evaluated by a specialist and receive services in-network.

The timely notification of a denial clearly communicates the reason for the denial and includes applicable information about the appeal process, including the expedited appeal process. The exception to member notification of a denied service applies only to a post-service (retrospective) service denial when the member is at no financial risk.

The requesting provider has the opportunity for a peer-to-peer discussion with the Medical Director and/or the reviewer's designee who made a denial determination. The attending or ordering physician is notified via telephone or fax by Medical Management staff of the denial determination. At that time the Medical Management Department advises the requesting provider of the opportunity and the method for requesting a peer-to-peer discussion.

Note: *Policies and procedures describe the medical management functions. Please refer to the directory at the end of the manual to obtain information or ask questions from medical management staff.*

No Financial Incentives

Compensation plans for physicians and staff who conduct medical management do not contain incentives, directly or indirectly, that encourage barriers to care and service in making determinations.

Conflict of Interest

Medical Management staff shall not participate in reviewing and evaluating a member, practitioner, or provider case in which a specific conflict is present due to a relationship or affiliation that could compromise the independence or objectivity of the medical management and quality processes or where judgment may be compromised.

Data Analysis of Health Service Access and Utilization

Reporting and monitoring activities are in place to ensure delivery of appropriate health care services and coverage for MDwise members. All medical management decisions are based only on the appropriateness of care and service.

MDwise has established processes to collect, report, and analyze access and utilization of specific health services, including preventive care services, pharmacy, behavioral health services, and emergency room utilization. These processes identify patterns for further investigation, identify potential members with special health care needs (or are at risk), detect and correct any patterns of potential or actual inappropriate utilization of services. Analysis of monitored data is used to develop effective interventions, including opportunities for improved medical management interventions, member and provider education interventions, case management and disease management interventions.

The effectiveness of the functions of the Medical Management Program are evaluated through the monitoring and analysis of performance standards, utilization data, HEDIS rates, appropriate utilization monitors, quality referrals, complaints, activity reports, denials/grievance/appeals report and analysis, consistency/interrater reliability audits, and member/provider satisfaction surveys. Opportunities for improvement are identified during the evaluation process, and the organization takes action to achieve/maintain the objective to meet or exceed customer expectations.

Monitoring and Management of Emergency Room Utilization

Data related to emergency services claims review is analyzed to identify patterns for further investigation and to detect any patterns of potential, questionable, or actual inappropriate under- and over-utilization. Analysis of monitored data is used to develop effective interventions.

Current interventions for members accessing non-emergent services in the emergency room include contacts by Health Advocates, educational efforts, and distribution of Use the Emergency Room Wisely brochures, working with hospitals to obtain timely notification of MDwise member visits to their emergency rooms, NURSEon-call line or access and case management interventions.

Members are encouraged to contact their PMP or the NURSEon-call phone line (available 24 hours per day) if they are uncertain whether they need to seek care in the emergency room.

Medical Management Access and Availability

The Medical Management staff is available telephonically via a toll-free number, which is also TDD/TTY compliant. Medical Management staff is available at least eight (8) hours per day during normal business days for practitioners/ providers and members regarding medical management issues, questions regarding the prior authorization process or questions regarding a specific prior authorization. Language assistance is provided free of charge for members calling the toll-free Medical Management number who need interpretation. The Medical Management Department ensures the availability of a telephone system capable of accepting and recording incoming telephone calls after business hours. Instructions for leaving voice mail, prompts callers to include their contact information. The Medical Management Department returns all messages on the next business day.

Member and Provider Inquiries/Complaints, Grievances and Appeals

The Medical Management program for physical and behavioral health care applies the MDwise Member and Provider Inquiry, Complaint, Grievance and Appeals process to address member and provider complaints, grievances and appeals. The *Member Rights and Responsibilities* section of this manual outlines the grievance and appeal process. MDwise monitors grievance and appeal activity to identify possible fraud or abuse issues as well as to identify opportunities for potential intervention.

Confidentiality

MDwise recognizes the importance of maintaining confidentiality of member identifiable information, verbal or written information generated/utilized during medical management, and quality improvement associated with activities and performance of network practitioners, providers and facilities.

All member and practitioner/provider-specific information will be kept confidential in accordance with applicable Federal and State laws and regulations (HIPAA) and MDwise Policy. Disclosure of mental health records by the provider to MDwise and the PMP is permissible under HIPAA and State law (IC 16-39-2-6(a)) without the consent of the member because it is for treatment. In addition, consent from the member is necessary for substance abuse records.

Member-specific information is used only for medical management functions/activities, including case management, disease management, discharge planning, and quality assurance/ improvement activities. Only staff who require information to perform their job function can access restricted information. Information obtained during the utilization process is used only for medical management functions and is shared only with those agencies that have the authority to receive such information.

Medical Management and Quality Improvement activities comply with applicable Federal and State laws and regulations requiring the reporting of quality issues under review.

Care Management/Disease Management

Care Management

MDwise promotes the empowerment of members with chronic health care needs and support of provider interventions through our care management programs. Care management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. MDwise identifies case/care management as an integral component of medical management.

Care management involves developing and implementing a coordinated, member-focused plan of care that meets the member's needs and promotes optimal outcomes.

Care management objectives include:

- Developing and facilitating interventions that coordinate care across the continuum of health care services
- Decreasing fragmentation or duplication of services
- Promoting access or utilization of appropriate resources

Case/Care management referrals may include those members with multiple, complex, frequent, or diverse health needs, which may be due to an individual's catastrophic, high risk or potential risk, behavioral health diagnoses, co-morbidities or chronic health problems. There are several avenues to identify and refer members to care managers for evaluation and implementation of case management.

Examples of specific triggers to identify members screened for case/care management interventions include, but are not limited to:

- Members with health care needs, acute or chronic, above and beyond those of a normal, healthy person
- Claims identifying services being utilized, including pharmacy utilization
- Multiple Emergency Room (ER) visits
- Hospital lengths of stay/hospital discharge data
- Readmission for the same diagnosis
- Members with co-morbid conditions
- Multiple specialty referrals and/or therapies
- Health needs screenings and assessments
- Predictive Modeling
- Referrals from NURSEon-call helpline
- High-cost or high-volume DME
- Data collected through the utilization management process
- Referrals from health plan staff, including customer service, physicians, providers, health care delivery staff, members, and family or member's representative

Eligible members are members diagnosed with (or at risk for) such conditions. MDwise utilizes pharmacologic and medical claims history data to confirm relevant chronic conditions in the MDwise population, and the State's mandated Health Needs Screener (HNS) for members new to MDwise.

MDwise has the following disease management programs available to Hoosier Healthwise and Healthy Indiana Plan members:

- Diabetes
- Sickle Cell Disease
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Congestive Heart Failure (CHF)
- Chronic Kidney Disease (CKD)
- Depression
- Attention-Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder (ASD)
- Pregnancy
- Post-Traumatic Stress Disorder (PTSD)
- Substance Use Disorder (SUD)
- Hypertension

MDwise also makes these services available to members with other conditions identified as underutilizing or overutilizing services.

The care management process includes the following:

- Identification and evaluation of member's needs
- Presentation of member's needs assessment and ongoing discussion with the member's PMP and development of treatment plan
- Review of clinical information
- Development of goals
- Development of an integrated care plan including behavioral and physical health
- Ongoing communication with the member or member's family/caregivers
- Monitoring progress and adjusting care plan accordingly\
- Transitioning members through levels of case management when appropriate (e.g., goals and needs met, member coverage terminated)
- Performance measures and health outcomes, including analyses to identify strengths and weaknesses, develop additional interventions, diffuse best practices, and assess for and support member/provider satisfaction

Other benefits of Case/Care Management for both the member and provider include the following:

- An advocate in coordinating care and services across continuum of care versus episodic care
- A communication link to medical providers regarding care plans and goals
- A voice to provide consistent messages related to benefits, available services and guidelines for referrals
- An overseer of the utilization of services, alternative care, accessing preventive health care services, member and provider satisfaction and outcomes

Note: *Contact the Care Management department or complete the electronic CM/DM Referral Form located on the MDwise website and in the MDwise provider portal to refer any of your MDwise members who are at risk or could benefit from being connected to a care manager. The care manager will work with you, the members, family/caregivers, and other providers involved in the member's care to implement and monitor the treatment/care plan.*

Disease Management

Disease management guides the care of members with chronic health conditions to improve the quality of care, adherence to care and control health care costs. Our disease management program emphasizes prevention of the exacerbation of the condition and its complications using evidence-based practice guidelines. MDwise offers members disease management programs that address conditions in which patient self-care efforts and empowerment are significant.

MDwise encourages members to actively participate in managing their condition through disease education, self-management tools and access to health professionals. We encourage all new members to have a preventive care visit within 60 calendar days of the member's effective date of enrollment. Providers offer support through provisions of clinical practice guidelines, training opportunities, feedback, and comprehensive care coordination of their members.

MDwise disease management services address each member's medical and health concerns, specific medical information, and available community resources. Services typically result in brief, short-term encounters. MDwise reaches out to members and providers during the initial assessment period and on an ongoing basis via phone, in-person, and written notification.

Community health workers will physically make contact when disease management via phone is not successful. Members in disease management services are provided with the MDwise phone numbers to call with questions.

Identification of Program Participants & Interventions

Types of data MDwise utilizes to identify members includes claims and encounter data, diagnosis codes, lab results, pharmacy, member chart data, physician referrals and self-referral solicitation responses.

Note: *While member identification is primarily for enrollment in a disease management program through medical and pharmacy claims analysis, providers may also identify members for enrollment in a disease management program and are encouraged to contact MDwise to initiate member enrollment. To view the referral form, visit www.MDwise.org.*

MDwise conducts stratification of (assesses) eligible members according to risk, or other clinical criteria based on available clinical data (e.g., claims) or member-provided data and follows the required stratification methodology established by OMPP.

In addition to stratification determined by available clinical data (e.g., claims), individual member assessments are conducted. Assessments are typically done on moderate to high-risk members to determine individual needs. A structured clinical assessment is administered to ensure appropriate disease risk classification and to identify additional health care needs. MDwise may conduct an in-person intervention according to findings.

MDwise individualizes interventions specifically to the member's stratification based on the assessments performed. Interventions will be tailored to meet the individual member's needs. In general, all members receive the following interventions based on the outcome of their assessment: (NCQA QI8, Element F).

Population-based (Low Risk) – Disease-specific materials, preventive care reminders (see care gap alerts) and:

- SMOKE-free information
- MDwise Newsletter
- MDwise IVR reminder calls
- NURSE on-call
- Audio Library
- My WellnessZone

Care Management (Moderate Risk) – Members receive all low-level interventions AND periodic contact with a Health Advocate or Care Manager with specific training in this clinical area. The Health Advocate/Care Manager provides member support and education telephonically. The goal of the Health Advocate/Care Manager is to empower the member to better understand and self-manage the condition, coordinate care between providers, social services, schools, and the community. This intervention will occur regularly until the Health Advocate graduates the member to low-risk based on the member's demonstration to the Health Advocate/Care Manager that they understand how to coordinate care for their condition of interest and understand basic self-management techniques.

Health Advocate/Care Manager specific activities may include:

- Focus on education and coaching specific to referral from Provider
- Refers to Case Manager if member's degree of risk is more complex
- Arranges education and/or classes as necessary and appropriate
- Assists with scheduling appointments
- Promotes access to other population-based services, including transportation, and nurse triage line
- Promotes preventive care visits
- Emergency room notification follow-up

Complex Case Management (High Risk) – Members receive all low-level interventions AND frequent contact with assigned Case Manager.

Case Manager-specific activities may include:

- Member-specific care plan developed that includes measurable short- and long-term goals and defined milestones to assess the member's progress and clearly define accountability and responsibilities
- Coordinates care with the practitioner involved in the member's care and includes them in the development and execution of the care plan (reviewed periodically to adjust for progress or barriers)
- Ensures follow-up with a specialist, if appropriate
- Consults with a clinical pharmacist resource (Butler University/Purdue University/DS Medical Directors/MDwise MTM support) for support, if needed, in making recommendations to practitioner when medications are not consistent with guidelines and member is unable to gain control of symptoms
- Arranges home health visit(s) or education and/or classes as necessary and appropriate\

- Conducts detailed education appropriate for stage of disease, assisting in member transitioning from inpatient to ambulatory care
- Conducts care conferences with the members and providers as needed\
- Assists with scheduling appointments
- Ensures transportation is available to HIP Maternity and HIP State Plan members attending the appointment
- Emergency room notification follow-up
- Right Choices Program if applicable

MDwise may periodically adjust the plan of care as needs change or new knowledge about the member's needs develops.

The phone-based intervention will attempt to reach all MDwise identified program eligible members through the application of interactive voice response (IVR) or live person.

Established indicators determine that the member has achieved maximum benefit from the level of intervention and can transition into a lower level of care. Developing a transition plan ensures that the member continues self-management activities. Changes identified in the member's risk will result in continuation of disease management services.

Informing & Educating Providers

Care management supports the practitioner-member relationship and plan of care.

MDwise provides practitioners with verbal and written disease management program information and follow-up including:

- Disease management program materials, including clinical guidelines
- Educational materials that reinforce the principles of the disease management program Instructions on how to use the disease management program services
- How the disease management staff works with the PMP and their members in the program Procedures for PMP receiving updates regarding the member's progress in meeting self- management goals, modifying the care plan and determining the appropriate time to transition the member to a lower-risk group
- Information regarding the PMP's patients identified as having the disease, their specific health data profile, and patients who have been contacted and agreed to participate in program

Note: *For additional information, questions, and/or member referrals, please use the disease management staff and medical director in the directory at the end of this manual. The provider newsletter will also report information about disease management programs.*

**covered service in Hoosier Healthwise only*

Member Compliance Interventions

Providers are encouraged to call their provider relations contact when, in their judgment, the behavior of their MDwise member is non-compliant. MDwise care management staff will investigate the issue further to determine appropriate member/provider intervention(s).

MDwise provider relations staff may assist the provider with determining the appropriate expectations/treatment of MDwise members and/or submit an electronic Case Management/Disease Management Referral form on the MDwise website when necessary.

Some examples of areas of concern in member behavior include, but are not limited to, the following:

- Missing multiple appointments
- Pregnant members or infants missing the first scheduled appointment
- Members not seeking provider-recommended or other necessary medical/preventive care
- Inappropriate use of the emergency room
- Obtaining medical treatment without a referral from the PMP
- Inappropriate use of out-of-network providers
- Behavior that presents a security risk to others
- Consistently not following medical recommendations in a manner that endangers the member's health
- Utilization patterns of controlled substances
- Upon receipt of a request for member Case/Disease Management, MDwise corporate will:
- Review the request and conduct an additional investigation on the issue if necessary
- Attempt to contact the member to determine appropriate action
- Provide counseling/education on behavior at issue if necessary

Care Manager or Health Advocate may conduct targeted member education regarding missed appointments, referral procedures, use of out-of-network services, inappropriate emergency room utilization and/or the importance of seeking necessary medical/preventive care

Missed Appointments

MDwise understands it interrupts operations when enrolled members miss appointments. MDwise encourages providers to notify customer service when they notice members missing multiple scheduled appointments. MDwise can help educate members on the importance of keeping scheduled appointments and help determine whether there are social or economic barriers that affect a member's ability to adhere to scheduled appointment times. Access to transportation is a common barrier that MDwise customer service can solve and help prevent future missed appointments. Providers are required to document missed appointments and any follow-up activities in the medical record.

The provider office is responsible for educating members on the consequences of missing appointments; however, MDwise can also provide ongoing outreach and education to encourage positive behavior patterns. This is particularly important for those members who may have missed a prenatal visit, who have health conditions that can become dangerous without ongoing medical attention, as well as children who need timely preventive care and scheduled immunizations.

Members may not be charged for missed appointments. If a Hoosier Healthwise or Healthy Indiana Plan member has missed two (2) or more appointments, please contact the MDwise customer service for assistance in outreach and education for the member and/or member's guardian. MDwise will attempt to contact the members, to help them understand the importance of keeping scheduled appointments. Three (3) outreach attempts are made via phone. If the member cannot be reached telephonically, a letter is sent directly to the member's residence on file.

Note: *Please refer to the electronic Case Management/Disease Management Referral Form on the MDwise website, MDwise.org. Call your provider relations representative for help completing the electronic form. It is very important that you include all efforts you have made to address the behavior at issue with the member. It is important that you document in the member's record all attempts to work with the member to resolve perceived areas of noncompliance.*

Care Coordination

The MDwise continuity and care coordination policy and procedures apply to the various possible scenarios for a member in the Healthy Indiana Plan, including members transitioning to another FSSA program or private insurance.

Note: *Access to Health Advocates can be accomplished by calling* ***1-800-356-1204*** *or visit the HELPlink at* **www.MDwise.org**. *HELPlink links the member with a MDwise Health Advocate who can answer questions about health and community services, family issues or other concerns.*

Coordination and Continuity of Care

Core elements of the MDwise medical management functions include ensuring identification and appropriateness of services, coordination of those services, and continuity of care over the continuum of care for both physical and behavioral health conditions. MDwise implements procedures to provide access to continued necessary care and assistance in transitioning to a new care setting, service provider or services. The following types of situations provide the opportunity for the member to continue with current medically necessary care:

MDwise must honor the previous health plan's service authorizations and scheduled covered services that were not completed for a member prior to transferring from another plan into MDwise (for a minimum of 90 calendar days from the effective date of enrollment). This authorization extends to any service or procedure previously authorized within the Hoosier Healthwise and Healthy Indiana programs, including, but not limited to, physician services, pharmacy, a specific procedure such as surgery, ongoing procedures or services authorized for a specified duration (e.g., therapies, home health care).

MDwise members with chronic or acute illness undergoing active treatment provided by the member's current PMP, specialists, ancillary providers or by hospitals prior to member changing to a new MDwise PMP may access continued medically necessary care up to a minimum of 30 days. Active treatment (referring to continuity of care) is a treatment that, if discontinued, could cause a recurrence or worsen the condition and interfere with anticipated outcomes.

Authorization for continuation of active treatment past 30 days may be approved if appropriate to the member's individual situation. A transition plan for coordination and continuity of care responsibilities is implemented according to procedure for newly enrolled MDwise members undergoing active treatment from an out-of-network PMP.

For members with behavioral health care needs who are transitioning from another health plan to MDwise, collaboration and follow-up with the member's existing medical and behavioral healthcare providers or community-based provider, including (when applicable) CMHC or MRO care managers, is begun immediately to ensure timely transfer of treatment plans and pertinent medical/behavioral information. A behavioral health case manager can communicate/coordinate daily contact regarding the member's care.

Members in their third trimester of pregnancy at the time they become a MDwise member may access continued medically necessary care (prenatal, delivery and postpartum care) from their previous physicians.

Other special considerations that require coordinating and providing medically necessary care during the transition from another network or program include, but are not limited to, the following:

- Newborn child of a Package A MDwise-enrolled mother from the newborn's date of birth
- Newborn children of members retroactive to the date of birth
- Members who are hospitalized when the effective date occurs

Members who are transitioning into services excluded for managed care but available under Traditional Medicaid or other waiver programs: those undergoing the Pre-Admission Screening Resident Review (PASSR) process for long-term care placement, electing hospice benefit and those transitioning into a home and community-based waiver service (HCBS)

Medical management performs a variety of interventions to promote continuity and coordination of care based on the individual member's plan of care or needs including, but not limited to, the following:

- Obtaining information from the member's previous health plan or PMP regarding the treatment plan
- Development of a transition of care plan
- Notifies new health plan or PMP of change in assignment during course of hospitalization or active treatment regimen
- Honors previous health plan's authorizations for a minimum of 90 calendar days
- Assists in coordinating care and, for example, information gathering (PASRR) to facilitate the member's transition into Traditional Medicaid or other waiver programs

Note: *If a MDwise patient is transferring in or out of your panel, to ensure continuity of care through a transition plan, please contact your medical management staff, who will assist in coordinating necessary clinical care services.*

Coordination of Medical & Behavioral Health Care

MDwise promotes integration of behavioral health services with medical care in all our IHCP programs. This provides a holistic approach to meeting member needs. Integration of behavioral health and medical care is accomplished through communication among the providers and a collaborative approach to managing the member's overall care.

Medical management performs a variety of interventions to promote continuity and coordination of care based on the individual member's plan of care or needs including, but not limited to, the following:

- Obtaining information from the member's previous health plan or PMP regarding the treatment plan
- Providing information to the new health coverage plan case manager and/or PMP regarding, for example, authorizations, current care management/treatment plans, disease management participation, other care providers involved in current care plan, utilization of applicable preventive care services

- Development of a transition of care plan
- Notifying new health plan or PMP of change in assignment during course of hospitalization or active treatment regimen, promoting discharge planning, coordinating, and authorizing medically necessary care during the transition from or to another health plan (when the member is hospitalized) until the new effective date occurs
- Interfacing with the case managers/medical management staff to ensure appropriate access, authorizations, and coordination of care for those members who become pregnant and are transitioning to Hoosier Healthwise
- Assisting in coordinating care and gathering information to facilitate the member's transition into one of the other IHCP programs (e.g., Hoosier Healthwise or Medicaid waiver programs) when disenrollment is necessary due to medical reasons, change in income or as required by program rules.

Note: *If a MDwise patient is transferring in or out of your panel, please contact your medical management staff to ensure the member receives a transition plan for continuity of care.*

MDwise implements several methods to promote coordination of care among medical and behavioral health providers including:

- Facilitating communication (written and verbal) among the medical and behavioral providers and auditing such documentation during medical record reviews
- Identifying member cases requiring coordinated physical and behavioral health plan of care by various means (e.g., data analysis related to medical and behavioral treatment use, screening through health assessments or risk questionnaires, joint planning meetings between behavioral health providers and the MDwise Care Manager and Behavioral Health Director, and CMHC case manager(s) or MRO staff for members requiring additional services)
- The Behavioral Health Director has access to additional referral sources (e.g., customer service calls, Health Advocate contacts/interventions, health needs screening, records of ER visits and reports of contacts with our NURSEon-call service)
- Collaborating in developing and implementing educational forums for providers, medical management departments and case managers regarding coordination of physical and behavioral health care
- Integrating behavioral health initiatives (e.g., depression) within the disease management and case management process to identify members with co-morbid conditions or members at higher risk for behavioral health issues to implement a coordinated approach for managing behavioral health and medical care
- Educating members and providers regarding the incidence of depression with certain chronic health care conditions (e.g., diabetes, CHF, asthma)
- Promoting awareness and encouraging treatment for post-partum depression
- Providing utilization reports to primary medical providers, which include behavioral health treatment and medication information.

Note: *Refer to the Behavioral Health Care section of the MDwise manual for additional information to ensure the integration of behavioral health services with medical/physical care services.*

Coordinating Care for Members with Special Health Care Needs

MDwise has also established procedures to identify MDwise members with special health needs or at-risk members to assess individual needs. The results provide outreach and assistance with managing special health needs, including member advocacy, care coordination, case management, and/ or disease management as appropriate. Additionally, MDwise coordinates health management activities with the member/member's family or caregiver, PMP and other providers caring for the member.

In addition to various member mailings and customer service contacts to obtain information to identify members, MDwise has also implemented the use of Interactive Voice Response (IVR) technology to identify and reach out to assist members with special health needs. IVR calls use a prerecorded script to interact with a member/guardian to inform the member about services at MDwise, the importance of regular visits with the member's PMP and ask the member individualized questions.

Each member assessment is categorized according to the individual's condition and needs, including the type and level of functional limitations, intensity and scope of service utilization, and type and duration of the ongoing health condition as it affects the member's physical, developmental, behavioral or emotional status. MDwise also assists the member in identifying, assessing and using community resources, and coordinating the services to meet the individual health care needs that affect the member's health. MDwise develops specific interventions to meet member needs and promote optimal outcomes.

Mechanisms are in place to allow MDwise members with special health needs to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

The health management program for MDwise members with special health care needs is accomplished through collaborative services provided by MDwise, MDwise Health Advocates, Medical Management, MDwise affiliates and arrangements with community service providers/agencies.

You will receive information about case management/care coordination services for members with special health care needs through contacts with MDwise Health Advocates and case management/medical management staff as care plans are developed and implemented.

Note: *To refer your members with special health care needs and may need additional assistance, submit a CM/DM Referral on the MDwise Provider Portal. The appropriate MDwise Health Advocate or case management/medical management staff will receive the referral.*

Transition to Other Care

If benefit coverage of services ends under the plan provisions and the member is still in need of care, the medical management staff offers to educate the member of alternative care options available. Alternative care options may be available in the community, through a local or State funded program, or further outlined information included in the notification to the member.

Transfer to In-Network Hospital from Out-of-Network Hospital

As part of the inpatient concurrent review procedures, the medical management staff implements a review process to determine the appropriateness and safety of transferring a member receiving inpatient care (at an out-of-network hospital) to an in-network facility to promote continuity and coordination of care.

The process includes the following components:

- Notification of inpatient admission to an out-of-network hospital
- Obtaining clinical information, treatment plans and estimated length of stay
- Applying medically necessary criteria to determine the appropriateness of admission/continued care
- Determination that the member's condition is sufficiently stable to allow for safe transfer, as determined by physicians
- Verifying that the in-network facility has similar care capacity/capability to receive member for continued treatment
- Arranging transfer to in-network facility when member is medically stable for transfer

The determination of whether the member's condition meets the criteria for transfer to an in- network hospital is a group effort and consensus, led by the Medical Director. The Medical Director works in collaboration with the member's PMP, attending physician, and specialists (as applicable) to provide continued treatment in an in-network facility, and with the attending physician at the out-of-network hospital.

Once all parties agree that the member is medically stable and the situation warrants transfer, the medical management nurse will coordinate the transfer.

If the member's condition is not medically stable for transfer, or there is a determination that the treatment plan and length of stay/planned discharge will not warrant transferring to an in- network hospital. In that case, the medical management nurse will continue to receive reviews and updates from the UR department and/or attending physician until the member is medically stable for transfer or discharge.

Short-Term Placements in Long-Term Care Facilities

Arrangements for MDwise members to receive services in a nursing or long-term care facility on a short-term basis (no more than 30 days for Hoosier Healthwise and up to the benefit maximum for HIP) is a care option if this setting, as determined by the PMP, is the most appropriate setting compared to other options, for the member to obtain the care and services needed. Short-term placement charges from the nursing facility are MDwise responsibility.

Medical Management staff is responsible for monitoring the member's care during the stay in the nursing facility and coordinating discharge planning. A member requiring long-term nursing facility placement will be disenrolled from their MDwise managed care plan and converted to Traditional fee-for-service eligibility in the IHCP. The medical management staff will help coordinate the member's program disenrollment from MDwise by working with the nursing facility and the enrollment broker.

Concurrent Review

MDwise performs concurrent reviews of acute medical and behavioral facility inpatient stays and ongoing outpatient services to gain pertinent clinical information and assess current needs to facilitate continuity and coordination of services, discharge planning and the authorization of the appropriate services and member access to those services. Concurrent reviews evaluate the effectiveness of the current care plan in meeting the member's individual needs and the appropriate utilization of services, identify and facilitate the transition to alternate levels of care when appropriate and promote timely delivery of quality care. Additionally, a concurrent review develops a safe and appropriate discharge plan to the most appropriate setting for the member, preferably in the home or community-based setting when able.

In addition, the concurrent review process and gathering pertinent current health information assists in facilitating referrals for services appropriate to the member's health status (e.g., disease management programs, case/care management).

Discharge Planning

Medical management implements procedures to evaluate and coordinate the resources necessary to meet the member's needs upon discharge of care and/or transfer to a less acute care setting or services.

Medical management will initiate discharge planning as soon as possible after admission or initiation of services utilizing information obtained from various sources, including the medical record, physician, member and/or representative, hospital-based staff or ancillary provider.

Note: *Contact the medical management staff to alert them to patients with potential discharge needs. The medical management staff can coordinate the discharge planning activities, contact involved parties until discharge, and monitor arranged services after discharge, as applicable.*

Right Choices Program

The MDwise Right Choices Program (RCP) is a program that identifies members appropriate for assignment and lock-in to one Primary Medical Physician (PMP), one pharmacy and one hospital.

RCP Mission, Goals & Philosophy

RCP Mission

To safeguard against unnecessary or inappropriate use of Medicaid services and excessive payment by identifying members who use Indiana Health Coverage Programs (IHCP) services more extensively than their peers and to ensure the right service is delivered at the right time in the right place for each member.

RCP Goals

The goal of IHCP is to provide quality health care through health care management. Member utilization reviews identify members who use IHCP services more extensively than their peers. Members identified with high utilization are assigned to one (1) primary medical provider (PMP), one (1) pharmacy and one (1) hospital. If a member requires specialty services, the PMP must make the referral for reimbursement of services.

RCP Philosophy

To achieve the goal of delivering quality health care for RCP members, RCP stakeholders, including members, providers, RCP Administrators (including MDwise) and the State, will collaborate to create a medical home for RCP members. The RCP Administrators encourage and will participate in any coordination efforts available to ensure the appropriate RCP processes and guidelines, while members receive medically necessary care.

Identification and Referral of Members for Restriction

MDwise members are candidates for restriction if they continue to misuse their benefits despite efforts on the part of MDwise and its provider(s) to educate and assist the member in modifying misuse patterns. Before enrolling a member in the RCP, MDwise ensures a physician, pharmacist or nurse confirms the appropriateness of the enrollment.

MDwise considers multiple factors in enrolling a member into this program including, but not limited to, the following:

- Emergency room visits
- Medical records
- Pharmacy utilization
- Member compliance
- Outcomes of member interventions
- Care management activities
- Referrals from providers
- Referrals from other internal and external sources

MDwise accepts referrals from internal and external resources. Common referral reasons for the program include the member being treated by several physicians for the same medical condition, purchasing the same medications from several different pharmacies, or frequently using the hospital emergency department for services that are not considered an emergency.

The member's care manager receives all referrals. The care manager and/or PMP is responsible for instituting or overseeing interventions intended to assist the member in behavior modification and improving communications between the member and their IHCP providers.

If the member continues to misuse their benefits despite these efforts, the member's care manager, in coordination with the PMP, presents a case to a clinician reviewer for consideration for enrollment into the Right Choices Program. MDwise care managers contact the PMPs in consultation for identified members. PMP input and participation are essential to the enrollment process.

Members that qualify are enrolled for up to two (2) years and are locked-in to one (1) Primary Medical Provider (PMP), one (1) pharmacy one (1) hospital and approved specialty providers as needed. Members are notified in writing via certified letter of their selection for enrollment into the program and given the opportunity to appeal the decision (ten (10) days from the receipt of their letter to prevent the enrollment from taking place, and 30 days from the receipt of the letter to appeal the enrollment from remaining for the term).

Once the member's initial appeals period expires, the member's lock-in PMP, hospital ER and billing departments, and pharmacy are notified in writing of the member's enrollment into the program.

RCP PMP Selection & PMP Role

Once a member is selected for inclusion into the RCP, the member's MDwise care manager works with the member and their providers through the end of their enrollment (a period of up to two (2) years). Members can select their primary lock-in provider. If the member is already established in the MDwise program, MDwise will ask their assigned PMP to serve as the member's Right Choices PMP. The chosen lock-in hospital will be one in which the PMP has privileges.

The PMP is responsible for coordinating all services outside of the PMP medical home. Written referrals are required for RCP members to see a provider outside the medical home. Services rendered by providers other than the member's PMP need a written referral for reimbursement. The written referral must be on file at MDwise. Referrals should be faxed or mailed to the member's assigned care manager or the MDwise RCP Administrator. MDwise asks that referrals be kept to a minimum, not jeopardizing the member's coordination of care. As a rule, written referrals should be created for the shortest duration of time required and for only medically necessary services as directed by the PMP. Written referrals are good for the period specified by the PMP or for up to one year if no time is specified.

RCP Written referral requirements:

- The PMP must write the referral on the PMP's letterhead or prescription pad.
- The PMP must date and sign the referral (electronic or stamp signatures are acceptable, but signatures of office staff for the PMP are not acceptable).
- The referral must include the member's name and MID.
- The referral must include the specialist's first and last name and NPI.

- The PMP should list the period for which the referral is valid. Without a specified date range on the referral, the referral applies for the maximum one (1) year allowable.
- The PMP should communicate a reason for referral for care management support.

RCP members can access certain services on a self-referral basis. However, the PMP is encouraged to submit a referral to the MDwise RCP Administrator to ensure better coordination of care among providers. If a self-referral provider will be writing a prescription that will be dispensed at a pharmacy, a referral is necessary for the prescription claim to be paid. If a provider will not be writing prescriptions, self-referral services do not require a written referral from the PMP to the MDwise RCP Administrator.

Providers can refer members to the RCP program by completing the Right Choices Program Panel Add Form on the MDwise website at MDwise.org/for-providers/manual-and- overview/right-choices-program.

RCP Billing Requirements

Verification of Restriction

RCP member eligibility should be checked before rendering services. Providers must verify their provider information is listed in the restricted section of the member's enrollment profile prior to rendering services.

Eligibility and RCP restrictions can be verified via:

- Automated Voice Response (AVR) system
- IHCP Provider Healthcare Portal

If the eligibility response lists restrictions, the member can receive specific types of services only from the specific providers indicated. MDwise will reimburse only the provider to whom the member is restricted unless a referral is on file at MDwise, or if the service is for an emergency condition. If the member receives non-emergency services from providers who are not authorized, MDwise does not cover the services. If a member visits a provider not on the member's lock-in table and the provider notifies the member before rendering the service that MDwise will not cover the service and the member signs a waiver to that effect, the provider can bill the member for services not eligible for payment due to the RCP restrictions. For more information on billing IHCP members, refer to The Provider Reference Module for Claims and Billing.

Billing for Services to Right Choice Program Members

Physicians and other specialty care providers: Providers must be added to a member's lock- in table by MDwise for an approved date range. Once this is complete, the provider may file claims in the usual manner.

Hospitals: The member's lock-in hospital can file claims in the same manner followed for non- RCP members. If a PMP or specialist wants a member to go to a different hospital that is not currently on their assigned lock-in list, the PMP must send a written referral as validation of the approved visit.

Pharmacies: For pharmacy claims to be processed successfully for an RCP member, the prescription must be written by the primary lock-in provider or a valid referring doctor and be present at the lock-in pharmacy. Claims can be submitted through point-of-sale (POS), electronic batch, or paper. If a member in the RCP is locked-in to a pharmacy and presents a prescription from a prescriber that is not the primary lock-in provider or a valid referral provider, the claim denies. If the pharmacy does receive a denial indicating the prescriber is not a valid lock-in provider, and the member insists that they have a valid referral for that prescriber, the lock-in pharmacy should contact MDwise to confirm the referral.

RCP Member Financial Responsibility When Lock-In Providers Are Not Used

RCP members are only able to receive services from providers on their lock-in list or they may be held liable for payment. Per 405 IAC 5-6-2, exceptions to using a nonapproved provider include emergency services and certain urgent referral circumstances, otherwise, the provider should not be rendering services to that member. Prior to rendering the service, the provider must inform the RCP member orally and in writing that MDwise does not cover the service. A prior written statement signed by the member is sufficient documentation to substantiate member awareness that the service was not covered, and the member is responsible for payment.

Note: *It is important to remember that MDwise does not reimburse providers for services unless these guidelines are followed. For more information on billing IHCP members, refer to the IHCP Claims and Billing Procedure Module.*

RCP Non-Emergent ER Services

Non-emergent ER services are the financial responsibility of the Right Choices Program member (please refer to waiver requirements in the IHCP Right Choices Module). ERs must follow this procedure after screening a member to deter inappropriate use and for the Right Choices Program to have its best outcomes.

Right Choices Program Support

Every MDwise Right Choices Program member has an assigned care manager. The care manager is responsible for communication, monitoring, and managing a member's care plan and coordinating all aspects of the member's Right Choices services, including monitoring emergency room use and pharmacy utilization patterns, collaborating with the member's assigned pharmacy and PMP, updating the care plan as necessary, coordinating behavioral health care plans, and continuity of care. At regular intervals, member compliance is monitored by reviewing treatment plans, utilization of services, and care coordination conferences between the member and the member's care manager. The member's PMP and Pharmacist will also be involved from time to time in care conferences. At the end of a member's RCP enrollment period, providers may decide to graduate the member from the RCP based on member compliance with the program and their treatment plan. Providers should contact the member's care manager with questions regarding that member's participation in the MDwise RCP. In addition, if a Right Choices PMP encounters any issues that may affect the care of an RCP member, the PMP is strongly encouraged to contact the member's care manager to coordinate a meaningful intervention. MDwise supports PMPs participating in the Right Choices Program.

To consider a MDwise member for the Right Choices Program or if you have specific questions about the program, please call 1-800-356-1204. Reference the IHCP Right Choices Program Provider Reference Module for more information.

Quality Improvement

Quality Improvement Overview

MDwise is committed to improving Hoosier Healthwise and Healthy Indiana Plan outcomes through ongoing comprehensive assessment and quality improvement activities. MDwise establishes and maintains the MDwise Quality Improvement (QI) Program, which improves the delivery of both physical and behavioral health care. In addition, MDwise leverages our extensive experience with Indiana Medicaid in collaboration with our robust provider network to identify areas of success and replicate those best practices throughout our network.

Our annual QI work plan, policies and procedures guide the implementation of our QI program initiatives in accordance with the National Committee for Quality Assurance (NCQA) and the Office of Medicaid Policy and Planning (OMPP).

- The MDwise QI Program and policies and procedures provide the framework and structure by which the organization can identify aspects of clinical care and service issues relevant to MDwise members.
- The annual MDwise QI Work Plan prioritizes and defines health and clinical care and service activities to be monitored and evaluated in the calendar year. The QI Work Plan is specific to the MDwise member population, monitoring activities and interventions for improving health outcomes for MDwise members.
- NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) measures and those measures directed by OMPP are the primary mechanisms used to measure quality.
- MDwise developed a program, Pay for Value (P4V), to encourage positive health outcomes for MDwise members. P4V initiatives are congruent with Federal and State priorities for Medicaid, State focus studies, and the MDwise QI Work Plan. You may see OMPP refer to this program as Pay for Outcomes.
- Annual Evaluation of the MDwise QI Program and Work Plan measures program effectiveness to revise and/or establish new program improvement goals and initiatives.

MDwise conducts an annual CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey to measures member satisfaction with the plan and network providers. MDwise focuses on providing services to members that are culturally and linguistically appropriate. The national CLAS standards, developed by the Office of Minority Health, guide ongoing activities and the development of improvement projects.

The P4V program awards providers that achieve high-quality performance in a defined set of measures, established annually. The established measures are typically preventive in nature and geared towards increasing the wellness of the MDwise population through engagement in healthy activities. To view the provider P4V program details, visit MDwise.org/Quality.

The MDwise QI Program has developed tools and resources for the provider network to help ensure the meeting of quality performance measures and care requirements for all members.

Our reporting tools provide virtual real-time information to the provider network both online and in person during Quality Performance Visits regarding progress, performance, and specific member activity. A primary medical provider (PMP) office can request access to the MDwise provider portal to view quality reports, track their quality performance, and view the members needing service for the (annually defined) set of quality measures. The list of members needing service can be utilized for outreach and identifying gaps in care for a member assigned to a PMP or provider office. To request a new account or to access repor ting tools, visit MDwise.org/for-providers.

The online quality reports provide a cover sheet with the annual performance measures and rates for each requested provider location, PMP panels, members needing service per performance measure on the cover sheet, ER utilization, and panel rosters. The quality performance reports are updated monthly on the provider portal under the Quality Reports tab.

MDwise Provider Relations Team members can provide the following quality reports to track and trend the provider's quality performance:

- Monthly HEDIS Progress Reports - compare similar groups to one another, ranking performance
- Missed Opportunity Reports - identify members that have been seen at the provider's office and remain in need of a preventive service
- Year Over Year Comparison Reports - compare performance from the previous year with a similar timeframe

Note: *All reports are processed including paid and denied claims.*

During the education process, provider offices, quality reports and member lists are reviewed to ensure members are being contacted for needed services and that MDwise receives the claims provided. During the process, medical records are reviewed or requested due to missing services, rejected claims, or third-party liability (TPL). Contracted providers are required to provide a copy of a member's medical record at no charge upon reasonable request by the member or by MDwise and shall facilitate the transfer of the medical record to another provider at the request of the member or MDwise.

Additionally, the MDwise Fax Back program ensures that provider offices receive credit for all services rendered and that all quality performance reports are accurate. When a claim is not submitted to MDwise for processing, the Fax Back program accepts claims, superbills and medical records. To view the Fax Back process and forms, visit MDwise.org/for-providers/Quality.

As provider offices work with members on the annual quality measures, MDwise members earn points for identified healthy activities through the MDwise REWARDS program. The rules for the Hoosier Healthwise and HIP REWARDS programs are available on MDwise.org/for-members.

Healthcare Effectiveness Data & Information Set (HEDIS)

Healthcare Effectiveness Data and Information Set (HEDIS) is the measurement tool used by health plans to evaluate their performance in terms of clinical quality including measuring well- child visits. MDwise collects data to complete the annual HEDIS audit. Results from the annual HEDIS audit guide various quality improvement efforts at MDwise.

Many of the measures in HEDIS focus on preventive health care services and wellness care as well as monitoring the health care of members with specific acute illnesses (e.g., URI) or chronic diseases (e.g., diabetes, asthma). MDwise first looks at claims (or encounter) data to determine if members received the recommended services reported in the annual HEDIS rates to the State. If MDwise is unable to identify that a particular service was provided from the claims (or encounter) data, MDwise conducts an annual medical record review to determine the reason for any missing records/claims data (e.g., bill was not submitted).

Note: *For HEDIS well-child measures, documentation collected in the patient's chart serves as evidence of health education and anticipatory guidance. Handouts in the record alone do not count as documentation of health education or anticipatory guidance.*

Examples of the specific anticipatory guidance to include in the member's chart:

- Nutrition
- Oral health
- Immunizations explained
- Infant care
- Behavior and development
- Parent-infant interaction
- Injury/illness prevention

Examples of specific health education to include in the member's chart:

- Injury and illness prevention
- Nutrition
- Oral health
- Mental health
- Sexuality
- Social competence
- Substance use and abuse prevention
- Responsibility
- School or vocational achievements
- Family
- Community

Documentation that does not count as anticipatory guidance/health education for well- child measures:

- Allergies, medications, or immunizations alone
- "Appropriate for age" without mentioning the type of physical and mental development
- "Well-developed/appearing well-nourished"
- "Neurological exam" or "Appropriately responsive" for development
- Vital signs alone for the physical exam
- Health education/anticipatory guidance related to medications or immunizations or the side effects

Representatives from MDwise will conduct a chart review to collect necessary information on any members selected for medical review. As a participating MDwise provider, one or more of your patients may be randomly selected for review and MDwise asks for your cooperation in collecting this important information.

Note: *If providers have any questions related to the specific HEDIS measures and/or how to ensure the claims submitted capture the necessary information to count towards these elements, contact the MDwise provider relations or QI staff.*

Provider Performance

MDwise has the responsibility for ensuring MDwise members have information and timely access to an adequate network of qualified practitioners, behavioral health providers, and other providers available to meet the clinical needs of the MDwise members, as well as to promote the delivery of services in a culturally competent manner to all members.

- MDwise establishes access standards and collects and conducts an analysis of data to measure its performance against the standards. The established standards for timeliness of access to specified care and services, considering the urgency of the need for services, will meet or exceed standards as prescribed by OMPP and applicable accrediting organizations.
- Provider access standards include access to routine care appointments, urgent care appointments (primary care and specialist referrals), after-hours care, telephone service/physician or designee response time, and office appointment wait time. Compliance with individual standards measures against the assigned performance standard. There is corrective action for performances below the compliance standard.
- MDwise may monitor performance standards related to member satisfaction, access to care, office site demographics and productivity, practitioner difficulty in arranging referrals to other providers, member complaints/grievance/appeals, emergency service utilization, telephonic system response, and provider self-reporting of appointment and in-office waiting times. In addition, these surveys are enhanced by ad hoc audits throughout the year if there is any indication of member or provider dissatisfaction. The assessment provides data for organization-wide and practice-specific performance. Results are shared with the individual provider(s) to develop action plans appropriate to the survey/audit findings.

Provider Performance Feedback

Objective, measurable, clinical, service, and facility are quality indicators defined to provide a consistent means to evaluate and report information to MDwise PMPs related to their individual performance and/or performance of their practice site. Periodic monitoring and analysis are conducted to measure performance against goals and identify opportunities for continuous quality improvement.

PMP and practice site clinical and service performance monitoring indicators may include, but are not limited to:

- Medical Record Review
- Facility Site Reviews
- Member Satisfaction
- Quality of Care Issues
- Accessibility
- Service Indicators
- Preventive Health Screenings/Services
- HEDIS Measures
- Pay for Value (P4V) Measures
- Clinical Indicators
- Utilization Monitors (e.g., continuity of care, over/under utilization, pharmacy, services for members with diverse health care needs)

Federal and State laws govern responsibility and liability for quality improvement activities. Therefore, all quality assessment/peer review activities/documents will be confidential and privileged as subject to the State and Federal statutes regarding the confidentiality of peer review material.

MDwise protects the confidentiality of provider-specific and member-specific data in compliance with MDwise confidentiality policies and follows policies/agreements on how provider-specific data is collected, verified, released, uses of and limitations of the data.

When a quality-of-care issue occurs or a participating provider does not meet performance standards, the MDwise QI staff or Medical Director may consult with the Medical Director and/or individual provider to discuss, educate and develop an action plan to address the specific issue as necessary. If the provider fails to resolve the issue appropriately, additional levels of action may follow. These actions may include a site visit and counseling by the appropriate MDwise personnel, presentation of the case to Quality Committee and/or Credentials Committee, or an Ad Hoc Peer Review Committee for recommendations and follow-up.

Member and Provider Satisfaction

MDwise conducts a member satisfaction survey annually through a contracted external research organization. The survey tool, CAHPS, is the NCQA accreditation-required questionnaire. This survey measures member experience and identifies opportunities for improvement; the survey helps evaluate the MDwise health plan and the health care services provided by its network. The survey study is also ascertaining our membership demographic characteristics and general health status, establishing the context in which members seek services and how services are communicated and provided.

MDwise conducts an annual survey of provider satisfaction with various operations within the managed care system, including overall experience with the health plan, access to specialists, medical management and other functions related to member and provider services to identify opportunities for improvement.

MDwise seeks information from providers to identify their concerns, needs, and expectations on an ongoing basis through such avenues as office site visits, contacts with the provider relations staff, education seminars and provider calls.

Note: *MDwise member and provider survey results and planned interventions will be published in the provider newsletter.*

Delegation

In certain contractual agreements, upon completion of the pre-delegation evaluation and approval process MDwise may delegate to the contracted entities the authority to perform specific functions involving quality improvement, preventive health, medical record review, credentialing, medical management, member service activities, provider services and network development and claims processing.

Delegation may occur only when the program functions of the delegated entity meet or exceed MDwise standards.

MDwise is responsible for ensuring that consistent procedures are adhered to and that MDwise fulfills all State and Federal requirements appropriate to the services or activities delegated under the subcontract.

MDwise remains accountable for these functions and must have appropriate structures and mechanisms to oversee delegated activities. MDwise delegation oversight program is designed to:

- Meet compliance with Federal and State regulations, OMPP contractual obligations, and relevant accrediting organization(s)
- Monitor delegate performance to ensure that members receive equitable access to care and service across all delegated entities
- Ensure that delegates comply with the MDwise health plan policies and procedures, and that medical and benefit policies meet established standards

MDwise performs delegation oversight and ongoing monitoring to maintain compliance with State and Federal program requirements. Oversight and monitoring activities are performed by qualified health professionals, including our Medical Director, primary care physicians, and specialty/ancillary providers, who know and are familiar with our provider network and the covered services for our members.

Potential Quality Issues (PQIs) & Concerns

MDwise policies and procedures guide the research and evaluation of potential quality care and service concerns. Potential quality issues (PQIs) may be identified/referred from multiple sources including specific predefined indicators or monitors, quality studies/data analysis, customer service, medical management, quality improvement, network development/provider services departments, grievance and appeals, physicians, providers, members/member representatives, office/faculty staff and MDwise QI Manager or designee.

Quality issues related to health care delivery services (including medical and behavioral health care) and have the potential to impact quality of care or services provided. Examples of a PQI related to health care delivery could include available access to care, office staff communication/attitude, clinical and facility services and overall member satisfaction. If a member/member representative initiates a complaint, the member receives a letter confirming that MDwise is reviewing the issue (as stated by the member).

The Director of QI or designee receives identified PQIs to conduct and coordinate the investigation, evaluation and implementation of actions as deemed appropriate. Designated peer review committees review the identified quality issues. Tracking and trending reports and outcomes of interventions are periodically reported to the Quality Committee or designated physician/staff committee. Notification of a confirmed quality concern issue pertaining to practitioners transfers to the Quality Committee responsible for credentialing providers.

Preventive Health & Clinical Practice Guidelines

Health Care Decisions for Preventive Health and Clinical Services

To deliver the best care, obtain optimal outcomes and maintain a healthy state for members, MDwise believes it is essential to maintain an emphasis on prevention-related health services and interventions to assist in management of certain acute and chronic conditions/diseases.

MDwise adopts evidence-based preventive health guidelines and clinical practice guidelines for specific clinical circumstances relevant to the MDwise membership and in compliance with CMS or OMPP medical or behavioral health care standards and practice guidelines. The guidelines address preventive health services, acute and chronic medical care, and preventive and non- preventive behavioral health services to effectively improve health outcomes. Clinical practice guidelines also serve as the clinical basis for disease management programs. Obtaining regular preventive care services enables early detection, diagnosis, and treatment of health problems before they become more complex and their treatment costlier.

The guidelines are implemented to assist MDwise practitioners and members in making appropriate health care decisions for specific clinical circumstances. The guidelines address preventive health services, acute and chronic medical care, and preventive and non-preventive behavioral health services.

Development & Monitoring

The MDwise Medical Advisory Committee is responsible for developing or adopting evidence- based guidelines and oversight of preventive health guidelines and clinical practice guidelines for specific clinical and behavioral health circumstances relevant to the MDwise membership. Committee members solicit input and feedback from participating providers. Providers are notified upon approval by the committee, and the guidelines are distributed for implementation.

Periodically, MDwise will evaluate the guidelines to assess practice patterns, member compliance and patient outcomes. Results will guide the improvement process for practitioner performance and/or member compliance as applicable. Guidelines will be reviewed and updated as appropriate as new scientific evidence or national standards are published, or at minimum, every two (2) years.

The MDwise QI Program and Workplan includes monitoring specific preventive health service measures. The MDwise Pay for Value (P4V) program includes preventive health services as a quality improvement program aimed at improving the health status and outcomes of the MDwise member. MDwise produces quarterly HEDIS-based rates for the P4V measures to monitor and evaluate the effectiveness of interventions to achieve the desired performance rate.

MDwise notifies practitioners of approved, new and/or revised preventive health guidelines and clinical practice guidelines. MDwise distributes guidelines to appropriate new and existing practitioners for implementation. Printed copies of guidelines are accessible on MDwise website and are provided upon request.

Notification may be accomplished through:

- Direct Mailing
- Electronic transmission of notification/guideline
- Newsletter
- Provider Manual
- Orientation and Training materials
- Website

As indicated, the key focus of the MDwise QI Program initiatives is to ensure members have access to and receive age/gender-specific preventive health care services. MDwise participates in the State mandated HEDIS measures related to preventive health services. The Pay for Value (P4V) initiative, applicable HEDIS measures and medical record reviews may evaluate compliance to screening and immunization schedules.

Specific List of Guidelines

For the most current versions of the guidelines, please visit MDwise.org.

Member Rights & Responsibilities

Member Rights & Responsibilities Overview

MDwise is committed to developing partnerships among the members, providers, MDwise and other health care staff. However, MDwise also recognizes that certain member rights and responsibilities are critical to this partnership's success and the provision of appropriate medical care. Following is the MDwise Member Rights and Responsibilities Statement.

MDwise provides access to medical care for all its members. We do not discriminate based on religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age. MDwise guarantees to uphold member rights protected under 42 CFR 438.100 and will not treat members differently when they exercise these rights.

MDwise member rights, including rights protected under 42 CFR 438.100:

- Be treated with dignity and respect.
- Personal privacy – We keep medical records confidential as required by law.
- A clear explanation of their medical condition. The member has a right to be part of all treatment decisions. MDwise Providers should discuss options with the members no matter what those services cost nor whether they are covered as a benefit.
- MDwise provides information about its services, its doctors and other health care providers and members' rights and responsibilities.
- Receive information in a manner that is easily understood, readily accessible, and available in alternative formats free of charge when requested in paper form.
- Change their doctor by calling the MDwise Customer Service Department.
- Timely access to covered services.
- Ongoing care and coordination of services with other service providers (e.g., FFS Medicaid, community and social supports, hospital).
- Receive Family planning services in a manner that protects and enables members the freedom to choose the method of family planning.
- Appeal any decisions we make about their health care. The members can also complain about personal treatment they received.
- Obtain copies of their medical records or limit access to these records, according to State and Federal law.
- Amend their medical records.
- Get information about their doctor.
- Get information about how to report suspected fraud or abuse.
- Request information about the MDwise organization and operations.
- Refuse care from any doctor.
- Ask for a second opinion (at no cost).
- Request interpretation services and auxiliary aids (at no cost).
- Make complaints about MDwise, its services, doctors, and policies.

- Get timely answers to grievances or appeals.
- Take part in member satisfaction surveys.
- Prepare an advance directive.
- Get help from the Indiana Family and Social Services Administration (FSSA) about covered services, benefits, or complaints.
- Get complete benefit information. This includes how and where to get services (including any cost sharing) during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered services.
- Request information about the MDwise physician incentive plan.
- Be told about changes to benefits and doctors.
- Be told how to choose a different health plan.
- Health care that makes the member comfortable based on their culture.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation in accordance with Federal regulations.
- When a member exercises these rights, the member will not be treated differently.
- Provide input on MDwise member rights and responsibilities. Participate in all treatment decisions that affect the member's care.
- If MDwise closes or becomes insolvent, members are not responsible for MDwise debts. Also, members would not be responsible for services that were given to a member because the State does not pay MDwise, or that MDwise does not pay under a contract. Finally, for covered services provided to members under contract or referral, members only must pay what they would pay if MDwise covered the services directly.

Members are responsible for:

- Contacting their doctor for all their medical care.
- Treating the doctor and their staff with dignity and respect.
- Understanding their health problems to the best of their ability and working with their doctor to develop treatment goals that both can agree on.
- Telling their doctor everything they know about their condition and any recent changes in their health.
- Telling their doctor if they need help understanding their care plan or what is expected of them.
- Following the plans and instructions for care that they have agreed upon with their doctor.
- Keeping scheduled appointments.
- Notifying their doctor 24 hours in advance if they need to cancel an appointment.
- Appropriately utilizing benefits and services.
- Telling MDwise of any third-party coverage or changes in coverage at the time services are rendered.

The MDwise Member Handbook and Member Newsletter advise members of their Rights and Responsibilities. When the MDwise member is a child, the above list of rights and responsibilities apply both to the child and the child's parent or guardian. Additionally, all the above rights also apply to the designated personal representative of the member.

In addition to these rights and responsibilities, MDwise complies with the following Federal and State regulations:

- MDwise provides all members access to medical care without regard for religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age.
- MDwise does not prohibit or restrict a health care professional from advising MDwise members about health status, medical care, or treatment options. This policy applies under the condition that the professional acts within the lawful scope of practice, regardless of whether benefits for such care are provided under the provider's contract or under the Hoosier Healthwise or Healthy Indiana Plan program.
- In accordance with 42 CFR 438.102(a), MDwise allows health professionals to advise a member on alternative treatments that may be self-administered and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits and consequences of treatment or non-treatment.
- MDwise does not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods.
- MDwise may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

Emergency Room Use

MDwise provides many activities to reduce inappropriate emergency room utilization, including educational initiatives and ER-related care coordination or case management.

MDwise Educational interventions promote access and availability to the member's PMP, medical home or behavioral health provider, and the MDwise NURSEon-call (800-365-1204 option #4) for health information. For members whose ER utilization results from inadequate management of an acute or chronic disease or behavioral health condition, MDwise may initiate care management to avoid future medical or behavioral health crises resulting in an ER visit.

MDwise will identify case-by-case emergency treatment options for all appropriate members with high ER utilization.

Emergency treatment plans will include:

- History and physical information to help emergency caregivers treat the member most appropriately.
- Transportation coordination to ensure the safest emergency transport.
- Care location options depend on the condition and time of day.

Choosing or Changing Doctors

Many of our members do have a primary medical provider (PMP) when they select MDwise as their Hoosier Healthwise or HIP health plan. For those members that do not have an existing medical home, MDwise Customer Service Representatives can help them select a PMP. Our Customer Service Representatives use the searchable MDwise Provider Directory to help members match their specific needs with a specific MDwise PMP.

Only members aged 18 or older, or a designated parent or court-appointed legal guardian may make a PMP selection or request a PMP change. Pregnant members under the age of 18 may make a PMP selection or change if they are no longer living with their parent or guardian and are making their own decisions about care and other aspects of daily living.

Auto-Assignment

Hoosier Healthwise and HIP members, except for newborns, have a 30-day period to choose a PMP. However, sometimes the member fails to make this choice within the required timeframe. If this happens, the member will be auto-assigned by MDwise, according to auto-assignment logic developed by the State and MDwise, consistent with Federal regulations. We notify the member in writing of the auto-assigned provider, the member's right to change PMP, and the process by which the member may change PMP.

Because continuity of care is one of the cornerstones of the Hoosier Healthwise and HIP programs, the reassignment of a member to a previous PMP takes precedence over all other auto-assignment logic. This rule supersedes the PMP panel size limits and allows auto- assignment of a member to a PMP with a full panel or a panel on "hold". If there is not a previous PMP relationship, the auto-assignment logic next looks for a previous relationship with a PMP, a family member's current PMP, a family member's previous PMP, a PMP in a previous provider group, or a PMP in a family member's current group or previous group.

In the absence of a previous PMP or family member relationship, the primary consideration under the auto-assignment process is matching the member to a PMP located within 30 miles of the member's residence. MDwise members who are auto assigned to a PMP, not of their choosing, can request a change by calling MDwise Customer Service at 317-630-2831 or 1-800-356-1204.

Member Third Party Liability Responsibilities

Members are required to sign an assignment of rights form, which allows third-party payment to be made directly to MDwise. Each member also agrees to cooperate in obtaining payment from these resources, including authorizing providers and insurers to release necessary information to pursue third-party payment. Members are also responsible for informing providers of any third-party coverage or changes in coverage when rendering services.

Choosing a Newborn's Doctor

MDwise encourages pregnant members to choose a PMP for their newborn before the baby's birth. If the member does not preselect a PMP for their newborn, one will be auto assigned during the enrollment process. In this case, MDwise auto-assigns the PMP to be the same as the mother. Physicians are encouraged to discuss the selection of a PMP for their patient's newborn prior to delivery. Education of pregnant members can increase the continuity of care, placing importance on choosing a doctor early and the benefits of choosing the baby's PMP from within the same plan as the expectant member's PMP. In addition, physicians may educate members to understand the importance of preselecting a PMP to:

- Help prepare for the baby and ensure timely care for the newborn.
- Keep all siblings with the same doctor.
- Avoid auto-assignment to a doctor that they did not select.

A pre-birth selection may occur at any time prior to the birth of the infant. The Office of Medicaid Policy and Planning (OMPP) has determined that a pregnant member must select a PMP for the newborn member in the same managed care entity (MCE). The mother has the option to choose a different PMP for the newborn outside of the MDwise Plan network after birth within the open enrollment period (first 90 days).

Call MDwise Customer Service to request a PMP change for a newborn member at **1-800-356-1204**, or for a PMP in another health plan, Hoosier Healthwise **1-800-889-9949**.

Pre-Birth Selection Forms

MDwise provider offices can use the pre-birth selection form to help pregnant patients select a physician for their newborn. To obtain a copy of this form, visit the MDwise website at MDwise.org.

The provider's office may fax the completed pre-birth selection form to the MDwise Customer Service Department. An expectant member may also call MDwise Customer Service directly to preselect a PMP for the newborn member.

Unfortunately, Package C newborns cannot be enrolled before birth. Eligibility for Package C newborns begins on the first day of the month in which the newborn member's application was approved and the first month's premium is paid.

Note: *Package C newborns should never be retroactively assigned to a PMP. If this occurs, please contact the Customer Service department at* ***1-800-356-1204*****.**

Pregnancy-Related Postpartum PMP Change

MDwise will assist in facilitating the reassignment of a member assigned to an OB/GYN (PMP) but no longer pregnant and whose eligibility will likely continue past the 12-month post-partum period. Assisting the member in selecting a new PMP helps to ensure that the member may access necessary primary and preventive care services.

Note: *If you provide OB/GYN services only and have a member that has recently delivered needing a PMP change, please call your provider relations representative.*

Helping Members Change Their MDwise PMP

Members are encouraged to build long-term relationships with their Primary Medical Providers (PMP) through appropriately scheduled visits and good communication.

However, in accordance with OMPP guidelines, MDwise members may change PMPs at any time within the MDwise health plan, for any reason. Any member wishing to change PMPs should contact the MDwise Customer Service Line at **1-800-356-1204**. This allows MDwise the opportunity to identify potential issues and assist the member in selecting a new PMP within the MDwise network of physicians. MDwise may process requests for PMP changes only if the member wishes to remain with MDwise and selects another MDwise PMP .

Members Disenrollment Requests

If the member wants to disenroll from MDwise and change to a PMP in another managed care entity (MCE), they may only do so during the first 90 days of their open enrollment period. If the member is outside of their open enrollment period, they can still submit a disenrollment request through MDwise if the change is for "just cause" reasons in accordance with the Code of Federal Regulations 42 CFR 438.56.

The reasons considered "just cause" are as follows:

- Lack of access to medically necessary services covered by MDwise.
- MDwise does not, for moral or religious objections, cover the service the member seeks.
- The member needs related services performed simultaneously, and not all related services are available within the MDwise network. The member's PMP or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- Lack of access to providers experienced in dealing with the member's health care needs.
- Poor quality of care, including failure to comply with established standards of medical care, administration, and significant language or cultural barriers.

The member's MDwise PMP moves to another MCE. The State's Enrollment Broker, Maximus (1-800-457-4584), can assist the member in changing to another MCE or health plan. MDwise Customer Service representatives can transfer members to the State's Enrollment Broker if necessary.

MDwise will attempt to resolve the member's concerns during an internal grievance and appeal process before the change request is sent to Maximus Health Services Inc., the State's enrollment broker. Maximus approves, monitors, and tracks all member movement to other MCEs; however, OMPP has ultimate authority to allow eligible members to disenroll from the program.

Certain PMP change requests will receive an upper-level review at MDwise and/or by the State, particularly those related to the quality of care or service. In some cases, the member's request may not be able to be processed (e.g., PMP panel full, doesn't meet PMP specialty criteria), then MDwise will contact the member to select a different PMP. PMP changes are effective on the first day of the month. Requests for PMP changes that are submitted by the 25th of the month are effective the first of the following month. Changes submitted after the 25th day of the month will be effective on the first day of the second month.

Providers should continue checking a member's eligibility before rendering service or requesting prior authorization. If a PMP disenrolls from MDwise and enrolls in another MCE, the PMP's panel will not follow the PMP to the new plan unless the member chooses to follow the PMP to the new MCE. In this scenario, the member who moved with the PMP when the PMP contracted with a different health plan, would have another 90-day period to change MCEs.

Note: *MDwise will neither terminate enrollment nor encourage an enrollee to disenroll because of a patient's health needs, a change in a patient's health status, or health care utilization patterns.*

Member Grievances & Appeals

The quality of service MDwise members receive is important to us. Any MDwise member dissatisfied with a service they received. or the quality of service can file a grievance by calling customer service or submitting their complaint in writing. In addition, any MDwise member has the right to file an appeal when they are dissatisfied with a decision considered an "action" from MDwise. This may occur after MDwise notifies a requesting provider and member of a decision to deny.

Processing Grievances & Appeals

Grievances

Members may file a grievance at any time. If a member is dissatisfied with a service they **receive** or the quality of service, an MDwise customer service representative can file file a grievance for them if they call or submit the complaint in writing. MDwise also has an interpreter and TTY services available to the member during this process. MDwise will inform the member that the grievance has been filed, either verbally or in writing within three days of receipt. The customer service representative will try to resolve the concern right away. If they are unable to resolve the concern, they will request further review. MDwise will follow up with the member with a letter within 30 calendar days.

If MDwise is not able to complete the review of the member grievance or the member requests an extension, the time frame may be extended an additional 14 calendar days. MDwise will notify the member in writing, within two days of the extension and tell the member why the extension is needed and their right to file a grievance if they don't agree with the extension.

In an emergency, grievances will be handled quickly. This is called an "expedited" grievance. An expedited grievance would be any service or concern that could seriously harm the members health or life. If the member's case can be expedited, MDwise will review the case and verbally notify the member of a decision within two calendar days and in writing within five business days. If the member does not agree, they can file an appeal.

Requesting a "Just Cause" Exemption

If the member files a grievance asking to switch from MDwise to a different managed care company and the member disagrees with the proposed resolution of their grievance, the member may ask the State's enrollment broker for a "Just Cause" exemption.

The member's request for the Just Cause exemption can be submitted by calling the Enrollment Broker at:

- HIP Members: 877-GET-HIP9 (877-438-4479)
- HHW Members: 800-889-9949

If the member needs help preparing or filing their request for a Just Cause exemption, they may call MDwise Customer Service for assistance at 1-800-356-1204 (TTY/TTD: 711).

Appeals

If a member does not agree with the decision made on their health care benefits, they have the right to ask for further review of the problem. This is called an "appeal". The member can file an appeal about health care decisions. The provider can do this on their behalf.

The member must file an appeal within 60 calendar days of the date that the decision was made. When the member files an appeal, they may be able to continue getting a service that has been denied. This can only happen if the member is getting those services already. If the decision on the appeal is not in the member's favor, they may have to pay the cost of the denied benefits.

How to File an Appeal:

Step 1. Submit appeal

The member may write a letter or call MDwise Customer Service to request an appeal. If they choose to write a letter; they may call the MDwise Customer Service department for help writing their letter. MDwise Customer Service can also file the appeal for the member. MDwise also has interpreter and TTY services available to the member during this process. The letter should include the following:

- Member name, address, telephone number and MDwise identification number ending in "99" (located on Member ID card)
- What service was denied and the date it was denied
- The reason for the appeal
- Any other information the member feels may be helpful in the review
- Signature of the member

The member should keep a copy of the letter and mail the original letter to:

For Medication Service Appeals:
MDwise Pharmacy Department
PO Box 441423
Indianapolis, IN 46244-0236
OR Fax it to 317-822-7582 or toll-free to 1-844-759-8548
OR Email it to: pharmacyappeals@mdwise.org

For Dental Service Appeals:
MDwise Customer Service Department, Attention: Appeals
PO Box 44236
Indianapolis, IN 46244-0236
OR Fax it to 866-613-1631
OR Email it to: dentalappeal@mdwise.org

For All Other Service Appeals:
MDwise Customer Service Department, Attention Appeals
PO Box 44236
Indianapolis, IN 46244-0236
OR Fax it to 866-613-1631
Or Email it to: padept@mdwise.org

MDwise will send an acknowledgment letter within three business days after receiving the Service Appeal

The member appeal must be filed by mail or by telephone within 60 calendar days of the date the decision was made. They may ask someone else to file an appeal on their behalf. For example, the member can ask their doctor to file an appeal on their behalf. The member may also send in written comments or information.

The MDwise Appeals Panel will review the member issue. MDwise will send the member a letter with the date and time the Appeals Panel will meet. The member can speak to the panel or they can have someone else speak for them. Participation in the Appeal Panel can be done by telephone. MDwise will send the member a letter with an answer to their appeal within 30 calendar days from the time they receive the appeal. The member has the right to review copies of documents that are related to their appeal. This includes records that were used in making the decision such as benefit information and state rules and guidelines. The member may call MDwise if they want to review these records. MDwise will provide copies of this information free of charge upon request. Under certain circumstances, the member benefits will continue if they file an appeal or request an FSSA Fair Hearing within the specified time. MDwise will continue the member's benefits if:

- The member or provider files the appeal within 10 days of MDwise mailing notice or the intended effective date, whichever is later
- The appeal involves the termination, suspension, or reduction of a previously authorized service
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired; and
- The member requests extension of benefits

The member may be required to pay the cost of the services given during the appeal if the final decision is not in their favor.

Other Notes: *In an emergency, appeal will be handled quickly. This is called an "expedited" appeal. If the member's case can be expedited, MDwise will review the member case and notify them of a decision in 48 hours. The member may call MDwise Customer Service to see if this can be done.*

Step 2. Request an external appeal review

If the member does not agree with the MDwise Appeal Panel decision, they may request an external appeal review. There are two options for an external appeal review. The member may choose (1) an external review by a State Fair Hearing panel and/or (2) an external review by an Independent Review Organization. If the member chooses the Independent Review Organization option first, they may still request a State Fair Hearing if the Review Organization upholds the denial. The member may also request a State Fair Hearing at the same time as the external review by an Independent Review Organization.

For an Independent Review Organization

The member must request an external review by an Independent Review Organization within 120 calendar days of the MDwise appeal denial by sending a letter to:

MDwise
Attention: Appeals
PO Box 44236
Indianapolis, IN 46244-0236
Phone number 1-800-356-1204

The decision made by the Independent Review Organization is binding and MDwise will authorize the service promptly, but no later than 72 hours if the decision is made in the member's favor. The IRO will make a decision within 15 business days for a standard appeal. If at any time, the member has a question about the MDwise internal appeal panel process or either State Fair Hearing and/or Independent Review Organization process, they may call MDwise Customer Service for help.

If a member selects an Independent Review Organization external review and the decision is not in their favor, they may request a State Fair Hearing panel The member must request the State Fair Hearing within 120 days of the MDwise appeal decision letter. *See "For a State Fair Hearing" below.*

Other Notes: *In an emergency, Independent Reviews will be handled quickly. This is called an "expedited" appeal. If the member's case can be expedited, the IRO will review the case and notify the member of a decision within 72 hours. Members can call MDwise Customer Service to see if this can be done.*

For a State Fair Hearing

The member must request the State Fair Hearing withing 120 days of the MDwise appeal decision letter or the Independent Review Organization decision letter. To request a State Fair Hearing, the member must contact the State directly in writing at:

Office of Administrative Law Proceedings
100 N. Senate Avenue, Room N802
Indianapolis, IN 46204

The State Office of Administrative Law Proceedings will respond to the member directly regarding their request. The member can choose to attend the State Fair Hearing themselves or send a representative on their behalf. Once a decision is made, the member will be notified of the outcome. If the State Fair Hearing finds in the member's favor, MDwise will authorize denied services promptly. If the appeal is not in the member's favor, they may be required to pay the cost of the service given during the appeal.

Outreach & Education

MDwise provides many education and outreach programs members and their families about staying healthy and appropriately using medical and behavioral health services in a managed care system. These activities aim to educate, support and encourage MDwise members to be informed, responsible and active participants in their health care and well-being.

Member Education

New Member Materials

MDwise sends welcome materials to all new MDwise members. This allows MDwise to begin establishing a meaningful connection with our members.

Welcome materials include:

- A member handbook with a phone card listing MDwise telephone numbers
- An introductory/welcome letter with their doctor's name, phone and hospital information
- Information on how to obtain the MDwise Provider Directory
- (HIP members) POWER Account Debit Card/ID Card

The new member materials also provide instructions for each new MDwise member to call MDwise to complete a Health Needs Assessment and confirm or assist in PMP selection. This call provides MDwise with the opportunity to link members with any targeted or enhanced services, identify any diverse health needs they may have, and educate them on the importance of scheduling an appointment to see their PMP within 90 days.

Member Newsletter

The MDwise member newsletter is sent out quarterly and includes information about timely health topics, preventive health services, new program information, inquiry and grievance procedures, MDwise policies and special children's features. Members receive a postcard informing them that MDwise posts the newsletter on the website. The newsletter is available in English, Spanish, and other languages upon request.

Note: *MDwise invites providers to submit topics for inclusion in the newsletter. Submit suggestions for newsletter articles to marketing@MDwise.org.*

Outreach to Members

MDwise provides a variety of targeted education and outreach programs. These programs encourage members to stay healthy and use clinical services appropriately. MDwise outreach and education efforts encourage members to obtain preventive and health maintenance care. MDwise outreach visits schools, neighborhoods, and health fairs. In addition, outreach efforts include sharing information about behavioral health issues and access to care. Members receive information regarding preventive health services and are encouraged to access those services through member outreach programs. Examples include new member materials, member handbooks and member newsletters. MDwise mails information regarding special programs including, BLUEBELLEbeginnings, focused on improving access and care for pregnant members, and MDwiseREWARDS, focused on improving member knowledge about the importance of well-care, prenatal care and health screenings.

A Case/Care Manager contacts members identified for disease management programs (e.g., asthma, diabetes, pregnancy, Coronary Artery Disease, Chronic Obstructive Lung Disease, Congestive Heart Failure, Chronic Kidney Disease, ADHD, depression, and Pervasive Development Disease). Members are encouraged to actively participate in managing their condition through disease education, self-management tools and access to health professionals. To facilitate effective and efficient treatment of the most common medical disorders for our members, the MDwise Medical Advisory Committee has approved and provided clinical health guidelines. These are available to providers as a quick reference for diagnosis, treatment and prevention parameters.

Communication Resources

Toll-Free Member Phone Line

MDwise Customer Service can be reached at **1-800-356-1204**. Representatives are available 24 hours per day, seven (7) days per week. After regular business hours, MDwise contracts with a telephone answering service staff, trained to respond to most member and provider issues. If the caller receives an automated message, they should leave their name and number. A representative will return the call no later than the next business day. MDwise Customer Service Representatives (CSRs) are available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Standard Time.

Language Services

Effective communication with members is a key component in our ability to effectively coordinate and deliver appropriate health care services. MDwise is committed to ensuring that members have access to free oral interpretive and language translation services at appointments with MDwise providers. MDwise is also responsible for ensuring members have telephone access to their PMP, in any language, 24 hours per day, seven (7) days per week.

Language and interpretive services are provided free of charge to members through the following:

- MDwise has a statewide toll-free customer service line that is available 24 hours per day, seven (7) days per week. If a member has limited English proficiency, MDwise utilizes SpectraCorp language services to assist in communicating with the caller. All interpreter services, whether telephonic or face-to-face, are provided free of charge to members.
- MDwise employs bilingual CSRs when there is a significant concentration of MDwise members (3% of membership) with limited English proficiency. Currently, MDwise employs CSRs who speak Spanish and Burmese. These representatives are available to assist Spanish- and Burmese-speaking members during regular business hours. MDwise also offers telephone-automated messaging in English and Spanish.
- Members who are hearing impaired may access MDwise by calling Relay Indiana at **800-743-3333**. The operator will connect the caller to MDwise customer service and relay the text typed by the member to the MDwise CSR. The CSR will respond verbally, and a typed message is relayed back to the member. The service is available 24-hours a day, seven days a week MDwise also produces member materials in a foreign language

when required by OMPP, or if it can be determined that there is a significant concentration of MDwise members (3% of membership) who do not speak English as their native language. Currently all member materials are available in any language.

Note: *Contact MDwise Provider Relations if you are seeking to offer or obtain translation services for MDwise members, or if you need information on the Language Line. Provider relations representatives will assist in locating resources upon request.*

All providers within the MDwise network must provide a reasonable means of communication for members of the deaf and hard of hearing (DHH) community, during in-person contacts. Based upon specific needs and individual circumstances, members may use basic communication aids such as hand-written notes or computer-aided communication.

If sign language is the member's preferred communication, a family member or friend can be encouraged to accompany the member to the appointment to aid in communication between the member and provider. In cases where the member requests an American Sign Language (ASL) interpreter, MDwise providers are encouraged to offer this service through available MDwise resources or a contract service. For more information about available resources, please contact the MDwise provider relations representative in your region.

The Indiana Relay Service may also be used to help providers communicate via phone with DHH members. Instructions are listed below.

To Access the Indiana Relay Service

To communicate by phone with members who are deaf or hard of hearing (DHH), MDwise recommends using the Indiana Relay Service for assistance. This is a free service that may be accessed by dialing: 1-800-743-3333.

- Access MDwise by phone, using Indiana Relay Service. Call 1-800-743-3333.
- The operator will connect the caller to MDwise Customer Service and relay the text typed by the member to the MDwise CSR.
- The CSR will respond verbally, and a typed message is relayed to the member.
- The service is available 24 hours per day, seven (7) days per week.

Tobacco Cessation Services

Tobacco Cessation Covered Services for MDwise

Providers are encouraged to discuss tobacco cessation with members. MDwise covers tobacco cessation counseling and prescription cessation aids.

Treatment services must be prescribed by an IHCP licensed practitioner within the scope of the license according to Indiana law. The following licensed practitioners participating in the IHCP:

Nurse Practitioner*	Clinical Nurse Specialist
Pharmacist	Dentist
Physician	Optometrists
Physician Assistant*	Clinical Social Workers (LCSW)*
Health Services Provider in Psychology (HSPP)	Marital/Family Counselors (LMFT)*
Clinical Psychologist*	Mental Health Counselors (LMHC)*
Registered Nurse (RN)	Licensed Clinical Addiction Counselors (LCAC)*
Certified Nurse Mid-Wife	

***Note:** A service performed by one of the (* practitioners above, who is not IHCP-enrolled, is eligible for reimbursement. For reimbursement, the supervising physician should bill the claim using the National Provider Identifier (NPI with the appropriate modifier.*

Covered tobacco cessation services include tobacco dependence counseling services billed with procedure code(s) 99406 and 99407. Tobacco dependence counseling sessions greater than three (3) minutes, up to ten (10) minutes, utilizing code 99406; sessions of ten (10) minutes or more, utilizing code 99407. Providers should bill for the counseling with the most appropriate diagnosis code for the services provided.

MDwise reimburses covered tobacco cessation pharmacy services under the pharmacy benefit. Treatment may include a prescription of any combination of tobacco cessation products and counseling. Providers can prescribe one or more treatment options but must include counseling. MDwise will reimburse the pharmacy for over-the-counter products only if a licensed practitioner prescribes them.

Both ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and the provision of the service itself. This requirement is consistent with existing IHCP policies and regulations.

Note: *Only patients who agree to participate in tobacco cessation counseling may receive prescriptions for tobacco cessation products. As the prescribing practitioner, providers may want to have the patient sign a commitment to establish a "quit date" and to participate in counseling as the first step in tobacco cessation treatment. A prescription for such products serves as documentation that the prescribing practitioner has prescribed or obtained assurance from the patient that counseling occurs concurrently with the receipt of tobacco cessation products.*

When providers and practitioners furnish a service to the public at no charge, including tobacco cessation counseling services, they cannot receive reimbursement for that service.

Quit Now Indiana, 1-800-QUIT-NOW

Quit Now Indiana (QNI) is the frontline tool for helping Hoosiers break their addiction to tobacco. Providers may refer any Indiana patient to the Indiana Quitline, 1-800-QUIT-NOW. QNI allows providers to easily refer clients to the program and is staffed by professionally trained tobacco cessation Quit Coaches.

In addition to the Indiana Quitline, QNI offers an online option to refer patients through the Quit Now Indiana Referral Portal. The portal can be accessed at www.quitenowindiana.com for tobacco users, healthcare providers, family/friends and employers.

QNI is a program of the Indiana Tobacco Prevention and Cessation Agency (ITPC). Contact ITPC at 317-234-1787 if you have any questions about the services offered by Quit Now Indiana.

Additional Resources

When new members call to activate their "extra benefits," they will be asked about any special services they might need. MDwise will attempt to provide members with information on community resources that may address identified needs.

The following organizations assist children and families of children with diverse health care needs. MDwise does not run these programs, but this information is provided for your reference.

Agency and Community Service Providers:
ABOUT SPECIAL KIDS! ASK: 1-800-964-4746
AboutSpecialKids.org

About Special Kids is a place for families and professionals in Indiana to go to "ASK" questions about children with diverse health needs and to access information and resources on a variety of topics such as health insurance, special education, community resources and medical homes. According to the About Special Kids website, the organization's mission is "Helping children with diverse health needs live better lives by educating, empowering and connecting their families."

(CSHCS) FIRST STEPS PROGRAM:
1-800-387-7837
https://www.in.gov/fssa/4655.htm
This program provides services for children up to age three (3) who have a disability or who are developmentally vulnerable.

The services include:

- Screenings and assessments
- Help to access medical care and other resources
- Coverage for some health care services that Hoosier Healthwise does not cover
- Support services
- Family education and special training

Note: *MDwise members with diverse health needs may also be able to get other services. These programs are not operated by MDwise, they are operated by the State of Indiana. Therefore, even if a member is no longer enrolled with MDwise, they may still be able to access these services.*

Children's Special Health Care Services (CSHCS) Program:
1-800-475-1355
https://www.in.gov/isdh/19613.htm
This CSHCS program provides health care services for children through age 21 who have at least one (1) of the following severe, chronic, medical conditions that:

- have lasted or is expected to last at least two (2) years
- will produce disability, disfigurement, or limits on function
- requires special diet or devices
- without treatment, would result in a chronic disabling condition

Note: *A Care Coordinator will help a member obtain medical services they may need. For children under three (3) years old, the CSHCS Program will also work with First Steps to coordinate patient care.*

Special MDwise Programs

MDwise has many extra programs to help members get healthy and stay healthy. Members can call MDwise Customer Service or visit the MDwise website at MDwise.org to learn more about these programs.

NURSEon-call

NURSEon-call provides members with 24/7 access to a Registered Nurse. NURSEon-call is the MDwise nurse triage service. The triage service, operated by trained nurses, helps members to access the most appropriate resources and information for their needs.

Members (or their parents) can call NURSEon-call anytime, with health questions or concerns, to talk directly to a nurse. Nurses can answer questions about illness, medications, medical tests or procedures. Nurses can also help determine if the member needs to seek professional care, including emergency care. NURSEon-call may also help members (or their parents) better understand the nature and urgency of the situation causing concern. NURSEon-call staff always refer the member back to their PMP for further assessment and/or treatment to reinforce the importance of the member's medical home. To access the NURSEon-call, the member can call MDwise Customer Service at **1-800-356-1204**.

RIDEwise

RIDEwise covers transportation to doctor appointments for Hoosier Healthwise members on Package A and PE. The chapter on Transportation provides more information regarding ambulance transportation for Package C and Healthy Indiana Plan members.

TEENconnect

TEENconnect is a resource for teens to access information on being a healthy teenager. For example, they can read about dealing with peer pressure, sex, tobacco, drugs and alcohol, depression and/or changes happening with their body. TEENconnect provides some health information through interactive games.

BLUEBELLEbeginnings

The MDwise BLUEBELLEbeginnings program was launched in 2004 to improve access and care for pregnant members and increase the likelihood of a healthy baby. The program includes various interventions, including health education materials, community referrals, access to health education classes, telephone calls and high-risk case management. MDwise assists members in selecting a doctor for their baby, and members stay enrolled in the program until after delivery.

The program includes a Health Needs Assessment and an additional assessment completed by Care Management. Information obtained during this contact determines additional services needed to support the member throughout pregnancy. Telephonic contact also provides an opportunity to encourage members to obtain prenatal care and maintain healthy behaviors. The appropriate care manager receives the information from this assessment. Other interventions include educating expectant members on early warning signs of complications, healthy lifestyle choices and early identification of potentially high-risk complications. In addition, the BLUEBELLEbeginnings program assists in maintaining close contact with the member's obstetric provider.

Members who participate in BLUEBELLEbeginnings receive a package of prenatal information. Additionally, pregnant members receive MDwiseREWARDS points for keeping appointments, and for prenatal and postpartum exams. Members can use their accumulated points to redeem gift cards.

SMOKE-free

The SMOKE-free program is for members who want to stop smoking or chewing tobacco. We offer informational brochures and links to web pages that help members get answers to their questions and link them to pertinent resources. In addition, the SMOKE-free program links members with a tobacco cessation class offered through community organizations. The program also informs members that MDwise will cover many tobacco-cessation aids, such as nicotine gum and patches, and bupropion (WELLBUTRIN).

Members who smoke or use tobacco can earn MDwiseREWARDS points for trying to quit. The member can earn points by completing a cessation program (e.g., Indiana's Tobacco Quitline, Baby and Me Tobacco Free, a program through a hospital or clinic). Members must ask for a certificate or letter saying they have completed the program. To earn the points, the member must mail, email or fax a copy to MDwise at the following address.

MDwiseREWARDS
P.O. Box 441423
Indianapolis, IN 46244.
Fax to (toll-free) 1-844-759-8551
Email to rewards@MDwise.org

WEIGHTwise

WEIGHTwise is a nutrition and exercise resource. MDwise members obtain access to important information on eating well and being active. WEIGHTwise provides a food and exercise diary, and other resources.

WELLNESSchats

Through WELLNESSchats, MDwise offers educational meetings/forums for members at various community and/or clinic sites. These forums are open to MDwise members, their families and the general community. Before the WELLNESSchat takes place, patients participate in a survey to determine what health topic, date and time is of importance/convenience to them. The forums may focus on clinical topics, such as asthma, diabetes, parenting, wellness or other topics of interest to members. If you are interested in holding a WELLNESSchat at your office or clinic site, please call the MDwise Outreach Department.

HELPlink

The MDwise program HELPlink, connects members to various organizations in their community. These organizations can help with housing, utilities, job placement and more. HELPlink is available to all members. It is a free resource that can help members overcome life's daily obstacles, helping members on their pathway to success.

INcontrol

INcontrol is the MDwise program for members with certain health conditions. The INcontrol program does not take the place of the doctor. Instead, the goal of the program is to help members control health conditions such as asthma, ADHD, Congestive Heart Failure (CHF), chronic kidney disease (CKD), Chronic Obstructive Pulmonary Disease (COPD), coronary artery disease (CAD), depression, diabetes, pregnancy and Pervasive Disease (COPD).

MDwiseREWARDS

MDwise launched MDwiseREWARDS to encourage members to make positive health care decisions for themselves and their families. This incentive program uses points and financial rewards to increase member participation in MDwise programs. The program incentivizes members across plans with one central approach. The program engages members in taking greater responsibility for their health care decisions, becoming better-educated health care consumers and improving their health.

The program "rewards" members with incentives for completing targeted health and wellness activities. Members earn points and deposit them into a personalized rewards account. The member can then redeem the points once they reach a designated level, for a gift from MDwise. After the member "cashes in" their reward points; they can begin accumulating new ones. We are hopeful that this approach will be more successful in realizing ongoing healthy actions and behavior change.

MDwiseREWARDS tailors to members to achieve many goals. MDwise rewards members for the following activities:

- Joining myMDwise
- Signing up to get electronic communications through myMDwise
- Answering questions about their health (Health Needs Screening)
- Completing an annual physical exam or well-child visits
- Getting an annual mammogram
- Attending recommended prenatal appointments

- Completing a postpartum exam
- Having a follow-up appointment after a mental health inpatient hospital-stay

For each of these actions, MDwise awards the member predetermined weighted points. For example, a well-child visit may be worth two (2) points and joining the myMDwise Member Portal may be worth five (5) points.

Members can access their rewards account via a secure member portal. Accumulated points and the activity for which the member earned those points are displayed. MDwise Customer Service has access to this information for those who do not have access to a computer. Once a member accumulates a certain level of points, they can choose to either continue saving the

points to earn a larger reward or "spend" their points on a smaller gift. This allows us to address the needs of those members who need more immediate gratification to stay engaged in the process.

At least annually, MDwise will review the Rewards program and make decisions about behaviors to add to the list. To keep members engaged, we will eventually plan to advertise a member's ability to earn "bonus" points via the member newsletter and other OMPP-approved communication materials.

MDwise develops and distributes comprehensive educational materials to help members understand MDwise REWARDS program features and how they can earn gift cards in points in the program. Educational materials also serve to reinforce important health and wellness messages.

WISEinstitute

WISEinstitute is a training program for MDwise providers. MDwise offers online training to assist our providers in caring for our members by offering a library of training materials. We will add presentations, videos and other training documentation as they are available.

Frequently Asked Questions

When and how should I contact MDwise Provider Relations?

Our MDwise Provider Relations Representatives are available to work with providers of all types. In addition, MDwise has developed a comprehensive quick contact guide that includes contact information for all MDwise departments. Please visit www.MDwise.org for the most up- to-date version of the contact guides.

To credential, enroll, disenroll or update a current provider, please utilize the forms on the provider enrollment page at MDwise.org/for-providers/forms/provider-enrollment.

For contracting, credentialing or enrollment questions, you can email your inquiry to prenrollment@MDwise.org or call 317-822-7300 option 1 for assistance.

How do I submit a Prior Authorization?

To file a prior authorization, send the required PA request form to the appropriate fax number:

- Hoosier Healthwise Fax: 1-888-465-5581
- Healthy Indiana Plan Fax:
- Inpatient: 1-866-613-1631
- Outpatient: 1-866-613-1642

To view the MDwise Prior Authorization request form and current PA list, visit MDwise.org/for-providers/forms/prior-authorization

If you wish to inquire about a current authorization request, please call the Hoosier Healthwise/Healthy Indiana Plan PA line at 1-888-961-3100.

How do I submit a Claim?

For claim submission information, visit the claims page on the MDwise website. If you would like an update on a claim status, or if you have a question on a process or denial, please call 1-883- 654-9192 and follow the prompts for the claims department, or you can complete the claim inquiry form located at MDwise.org/for-providers/forms/claims, and fax to the designated number on the form. You are also encouraged to review your claim online using the myMDwise Provider Portal.

How do I submit Claim Disputes & Appeals?

Email claims disputes to MDwise at cdticket@MDwise.org (recommended) or mail to the following address:

MDwise, Inc.
P.O. Box 441423
Indianapolis, IN 46225 ATTN: Claim Dispute Team

Note: *Only one claim is allowed per claim dispute form. Each form should be emailed individually to the email address above.*

How do I request Care Management for a member?

Care Management

If you have a member who could benefit from a more personalized insurance program, please contact our Care Management department to refer the member to the Right Choice Program. Make a referral by completing the form at MDwise.org/for-providers/forms/care-management through the myMDwise Provider Portal.

How do I adjust my panel size?

Member Management

To add a member to your closed or full panel, please refer to the Member Management page at MDwise.org/for-providers/forms/member-management. This webpage provides the forms required to add members, change your panel size and status, pre-birth selection, add a Right Choices Program member or request reassignment for a member.

Are there tools and resources specific to Behavioral Health?

Behavioral Health providers can utilize the MDwise Behavioral Health webpage to locate PMP toolkits, prior authorization information, member resources, and clinical practice guidelines. A behavioral health poster is also available with contact information and prior authorization guidelines.

For the behavioral health provider page, visit MDwise.org/for-providers/behavioral-health. For behavioral health forms, visit MDwise.org/for-providers/forms/behavioral-health.

Where can I find Pharmacy resources?

MedImpact manages pharmacy benefits. Pharmacy resources are broken down based on the member's program. Go to MDwise.org/for-providers/pharmacy-resources and select Hoosier Healthwise or Healthy Indiana Plan for more information on pharmacy prior authorization and pharmacy documents.

To mail order a prescription, view the prior authorization reference guide, or download a medication request form, visit MDwise.org/for-providers/forms/pharmacy.

What resources are available to MDwise members

The MDwise website is an important source of information for MDwise members and families. Some of the information and tools currently found at MDwise.org include:

- myMDwise member portal
- How members can earn MDwise Rewards points
- Health Needs Screening survey online
- MDwise member handbook
- MDwise member newsletters

- Information related to MDwise outreach and education programs
- Appropriate use of the emergency room tips for members
- New member information
- MDwise contact information
- Member rights and responsibilities
- Privacy policies
- How members can access transportation and medical care
- Participating pharmacies

How do I contact the State?

Family and Social Services Administration
Address: 402 W. Washington Street, Indianapolis, IN 46204 General Phone Number: 800-403-0864
Medicaid Complaint Number: 800-403-0864
Medicaid Recipient Information Number: 800-457-4584

Office of Medicaid Policy & Planning
Address: 402 W. Washington Street, Room W382, Indianapolis, IN 46204 Phone: 800-403-0864

MDwise Quick Contact Guide

MDwise Product Information

Indiana Health Coverage Program (IHCP) Member Enrollment	
Hoosier Healthwise Hoosier Healthwise Member Website: www.in.gov/medicaid/members	Healthy Indiana Plan (HIP) Healthy Indiana Plan Member Website: www.in.gov/fssa/hip
IHCP Enrollment Broker: Maximus, Inc.	
Hoosier Healthwise Helpline: 1-800-889-9949	HIP Enrollment Helpline: 1-877-GET-HIP-9 (877-438-4479)

General Information

MDwise Member Customer Service & Transportation Reservations	
Member Customer Service	
Phone Toll Free: 1-800-356-1204 Fax Toll Free: 1-877-822-7190	Phone Local: 1-317-630-2831 Fax Local: 1-317-829-5530
MDwise Provider Services	
Provider Customer Service Unit (PCSU)	Phone: 1-833-654-9192
MDwise Provider Services 2955 N Meridian St. Ste. 201 Indianapolis, IN 46208	MDwise Provider Enrollment Email: prenrollment@mdwise.org Phone: 317-822-7300 option 1 Fax: 1-317-822-7310
Provider Relations Territory Representatives www.mdwise.org/for-providers/contact-information	Provider Credentialing Email: credentialing@mdwise.org
MDwise Health Services & Medical Prior Authorization	
Phone & Fax Authorization Requests Phone: 1-888-961-3100 Main Fax: 1-888-465-5581 Inpatient Fax: 1-866-613-1631 Outpatient Fax: 1-866-613-1642	Prior Authorization Portal Requests www.mdwise.org/for-providers/prior-authorization E-Mail Inquiry: padept@mdwise.org
Prior Authorization Appeals Attention; Medical Management P.O. Box 44236 Indianapolis, IN 46244-0236 Member Appeals Phone Inquiry: 1-800-356-1204	Right Choice Program (RCP) Phone: 1-800-356-1204 Fax: 1-317-822-7500

MDwise Claim Contact Information

Medical Claims

Paper Claim Submissions
MDwise/McLaren Health Plans
P.O. Box 1575
Flint, MI 48501

Electronic Claim Submissions
Clearinghouse: Optum Financial
www.optum.com/eps
Hoosier Healthwise Payer ID: 3519M
Healthy Indiana Plan Payer ID: 3135M

Claim Status Verification

myMDwise Provider Portal: www.mdwise.org/for-providers/mymdwise-provider-portal

Provider Customer Service Unit (PCSU): 1-833-654-9192

Claim Inquiry, Adjustments & Disputes

MDwise, Inc.
Attention: Claim Dispute Team
P.O. Box 441423
Indianapolis, IN 46225

Email: CDticket@mdwise.org
Claim Adjustment, Dispute, Readmission Dispute and Refund Readmittance forms can be found at:
www.mdwise.org/for-providers/forms/claims

Pharmacy Claims

Pharmacy Information
RxBIN: 003585
PCN: ASPRODI
RxGRP: MDW

Pharmacy Help Desk: 1-844-336-2677
Prior Authorization Phone: 1-800-788-2949
Prior Authorization Fax: 1-858-790-7100
Pharmacy Appeals Fax: 1-844-759-8548

Preferred Drug List (PDL): www.mdwise.org/for-providers/pharmacy-resources

Dental Claims

Paper Claims Submissions
Delta Dental Indiana- Claims
P.O. Box 9085
Farmington Hills, MI 48333-9085

Electronic Claims Submissions
Clearinghouse: Dental Office Toolkit
www.dentalofficetoolkit.com
Payer ID: DDPIN

Subrogation Information & Recovery

Multiplan
535 Diehl Road Ste. 100
Naperville, IL 60563

Phone: 1-866-223-9974
Fax: 1-866-297-3112
Website: http://www.multiplan.us

MDwise Program Integrity

MDwise Special Investigation Unit (SIU)
Toll Free Phone: 1-800-356-1204
Local Phone: 1-317-822-7400
E-mail: SIU@MDwise.org

OMPP Program Integrity
Phone: 1-800-457-4515
Email: programintegrity.FSSA@fssa.in.gov
www.in.gov/medicaid/providers/business-transactions

MDwise.org/Providers