MDwise Medicare Provider Manual 2023

I - Introduction

MDwise (pronounced *Em•Dee•wise*) offers a variety of products and benefits designed to meet the health care needs of each member. To this end, our mission is to partner with providers who offer high-quality, accessible and cost-effective health services throughout our service area.

MDwise Medicare products include:

1. Medicare Advantage Prescription Drug Plans (MAPD)
2. Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)

MDwise combines the resources of independent physicians, multi-specialty groups, ambulatory care centers, ancillary providers and hospitals to offer members access to a comprehensive array of high-quality health care providers. The member's ID card identifies which type of plan they have. MDwise will provide you with updated information through mailings and on our website at www.MDwise.org.

About Managed Care

The objective of managed care is to form effective links between patients and providers, thereby improving access to appropriate health services while containing costs. However, the specific strategies for accomplishing this goal vary widely from one managed care company to another. The MDwise philosophy is to assign as few "rules" as possible so that health care providers can do what they do best - practice medicine. Our Managed Care products require members to select a Primary Care Provider (PCP) at the time of enrollment. Our PCPs will provide both primary care services and act as care coordinators, guiding members to the full range of health services. Staff at MDwise will assist the health care providers in navigating the program and network.

Quick Reference Guides

This Provider Manual contains detailed information regarding the MDwise operations and business practices that are important for you and your staff. We have also summarized this information in the Quick Contact Guide at the end of the manual to provide easy references.

Website

MDwise maintains a website that provides an array of information regarding the health plan's policies, procedures, and general operations. Such information includes the quality programs, preauthorization processes, health management programs, clinical and preventive practice guidelines, pharmaceutical management procedures, the formulary, member rights and responsibilities, the provider appeal process and provider newsletters. Providers can also verify member eligibility and benefit coverage and status claims submitted for payment through the *myMDwise Provider Portal*. Please visit www.MDwise.org frequently for the latest updates and new information. A printed hard copy of any information on the website can be obtained by calling Member Services at 833-358-2140.

Using This Manual

This Provider Manual ("manual") is a guidebook for providers that includes general information and instructions on operational and administrative procedures, which may be revised from time to time. The provisions in this manual should supplement the terms of the provider agreement ("agreement") you entered into with MDwise. In the event of a direct conflict between a provision in this manual and

the Agreement between you and MDwise, the provision in this manual will control unless it conflicts with a term required by law, regulation or a regulatory agency. Or, if your Agreement otherwise specifies that it controls.

II - Department Services

MDwise has several departments available to assist providers and provider staff with their MDwise membership. The following information provides a brief description of the departments that your practice will utilize most frequently.

The MDwise 24-hour toll-free number is (833) 358-2140 (TTY: 711). Access all departments through this number. Normal business hours are 8:00 a.m. to 8:00 p.m., Monday – Friday from April 1st to September 30th. Normal business hours are 8:00 a.m. to 8:00 p.m. 7 days a week from October 1st to March 31st.

Provider Services

The provider services department is responsible for all provider-related issues and requests, including contracting. Territory provider relations representatives are assigned to provider practices based on the county location of the practice. The Provider Relations Representatives act as a liaison between the provider and MDwise. They are available to assist with any of the following:

1. In-services or orientations for you or your staff to learn how best to work with MDwise, including submitting claims, verifying member eligibility or claims via the myMDwise Provider Portal, or discussing any issues you or your office staff may have
2. Providing office materials:
    1. Referral and preauthorization forms
    2. Pharmacy formularies
3. Reporting changes in your practice, such as:
    1. Hospital staff privileges
    2. Office hours
    3. Office address or phone number
    4. Office services
    5. Call coverage
4. A new W-9 form is required to notify us of a change to your:
    1. Federal Tax Identification number
    2. Payment address
    3. Name
5. To discuss any questions regarding your participation in the MDwise Network

Note*: If you are not certain of how to contact your assigned provider relations representative, please call (833) 358-2140 (TTY: 711) or email prenrollment@mdwise.org for assistance.*

Provider Customer Service Unit

MDwise Provider Customer Service Unit (PCSU) is responsible for assisting providers with any questions regarding the MDwise health plans. PCSU representatives are available from 8 a.m. to 6 p.m., Monday – Friday.

Providers are encouraged to use the myMDwise Provider Portal to:

1. Verify member eligibility
2. Status claims
3. View/print provider explanation of benefits (EOB)

For other questions related to claim status providers are encouraged to call (833) 654-9192 for assistance. Questions related to provider enrollment status and contracting should be sent to prenrollment@mdwise.org.

Medical Management

Medical Management supports the needs of both the membership and the provider network. Medical Management offers support to coordinate our members' care and to facilitate access to appropriate services through the resources of our nurse case managers.

Through our case management services, the nurses promote members' health management by focusing on early assessment for chronic disease and special health needs and by providing education regarding preventive services. In addition to this member focus, the nurses are available to assist our provider network with health care delivery to our members. The nurses are available for members 24 hours per day, seven (7) days per week and work under the direction of the MDwise chief medical officer.

Access the Medical Management department by calling (833) 358-2140 and following the prompts. The Medical Management department's business hours are from 8:30 a.m. to 5 p.m., Monday - Friday. Please be aware that you may get voice mail when you call direct numbers due to the large volume of incoming calls. Medical Management checks voice messages frequently throughout the day and returns all calls within one business day. Call Medical Management for information and support with situations such as:

1. Preauthorization requests
2. Inpatient hospital care (elective, urgent, and emergent)
3. Medically necessary determinations of any care, including the criteria used in decision making
4. Case management services
5. Complex case management for members who qualify
6. Disease management: Diabetes, asthma, maternity care and others
7. Preventive health education and community outreach support

Utilization Management

Medical Management, through its utilization management processes, is structured to deliver fair, impartial, and consistent decisions that affect our members' health care. Medical Management coordinates covered services, assisting members and providers to ensure appropriate care is received. Medical Management utilizes nationally recognized, evidence-based criteria when determining the necessity of medical or behavioral health services. The criteria are available to you upon request by calling Medical Management at (833) 358-2140.

If there is a utilization denial, you will be provided with written notification, the specific reason for the denial, and your appeal rights. In addition, the MDwise chief medical officer or an appropriate practitioner will be available by phone to discuss any utilization issues and the criteria utilized in making the decision.

Please call Medical Management at (833) 358-2140 for more information or to schedule a time to speak with the Chief Medical Officer about a utilization denial or any utilization issue.

In addition, regarding incentives, utilization decision-making is based solely on the appropriateness of care and service and the existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives for utilization decision-makers to encourage decisions, resulting in under-utilization.

Case Management Services

MDwise offers case management to all members. A case management nurse is assigned to each PCP's office to assist the physician and staff in managing their MDwise patients. Nurses are available to all members, PCPs and specialty care physicians for management of complex problems or as a resource for any identified issues. Call Case Management toll-free at (833) 358-2140.

Complex Case Management (CCM) nurses are specially trained nurses available to MDwise members with complex care needs. Members considered for CCM include but are not limited to:

1. Members listed for a transplant
2. Frequent hospitalizations
3. Frequent ER visits

Community Outreach

MDwise provides community outreach focusing on support services, such as food programs, housing and utilities, special family services, clothing needs and more. Both Member Services and Medical Management work in tandem to provide outreach, education and ongoing support to our membership.

Many community outreach programs are operational for members such as breast cancer patients, members with asthma and diabetes, members needing preventive screening reminders and much more. For more information about the literature and services that are available, call our toll-free number at (833) 358-2140 (TTY: 711), or for correspondence in writing, send a request to:

MDwise
Attn: Member Services
PO Box 44092
Indianapolis, IN 46244-0092

Interpretation and Translation Services

Interpretation and translation services are free to MDwise members in any setting (ambulatory, outpatient, inpatient, etc.). If MDwise members need help understanding written material or need interpretation services, they can call Member Services at (833) 358-2140 (TTY: 711).

If a member is deaf, hard of hearing or requires speech accommodations, oral interpretation services are available to all MDwise members that require this service. Member materials are available in other languages if needed. Please call Member Services at (833) 358-2140 (TTY: 711) for assistance.

III - MDwise Medicare Plan Definitions

MDwise offers a variety of plans designed specifically to meet the needs of our members and their communities. Our diverse plans offer members varying levels of flexibility in benefit coverage and provider access. See the overview of each plan presented below. For additional information, contact Member Services at (833) 358-2140 (TTY: 711), Monday – Friday, 8:30 a.m. – 8:00 p.m.

MDwise Medicare Inspire (HMO)

Monthly Premium:	$0
Annual Deductible:	$0
Annual Out of Pocket Max:	$3,900
Office Visit Copay:	
PCP	$0
Specialist	$40
Inpatient Hospital Copay (per day):	$295/day (days 1-7)
Prescription Drug Deductible (Part D):	
$0	

MDwise Medicare Inspire Plus (HMO)

Monthly Premium:	$25
Annual Deductible:	$0
Annual Out of Pocket Max:	$4,300
Office Visit Copay:	
PCP	$0
Specialist	$40
Inpatient Hospital Copay (per day):	$290/day (days 1-7)
Prescription Drug Deductible (Part D):	
$0	

MDwise Medicare Inspire Flex (HMO-POS)

Monthly Premium:	$49
Annual Deductible:	$0
Annual Out of Pocket Max:	$10,000 in-network and out-of-network combined; $4,300 in-network
Office Visit Copay:	
PCP	$0
Specialist	$40
Inpatient Hospital Copay (per day):	$310/day (days 1-7)
Prescription Drug Deductible (Part D):	
$0	

MDwise Medicare Inspire Duals (HMO-DSNP)

MDwise Medicare Inspire Duals (HMO-DSNP)

Monthly Premium:	$0
Annual Deductible:	$0
Annual Out of Pocket Max:	$8,300
Office Visit Copay:	
PCP	$0
Specialist	$0
Inpatient Hospital Copay (per day):	$0
Prescription Drug Deductible (Part D):	
$0	

Possession of a MDwise Medicare Advantage member ID card does not guarantee eligibility. Member eligibility should be verified through the myMDwise Provider Portal at www.mdwise.org

MDwise Medicare Evidence of Coverage

The member handbook contains information on emergency and urgent care procedures, out-of-area coverage, benefit limitations and exclusions, the enrollment process, PCP selection, member rights and responsibilities, and the complaint and grievance procedures. MDwise Handbooks are also available at www.MDwise.org. If you or your MDwise members have any questions, please contact Member Services at (833) 358-2140 (TTY: 711).

IV - Provider Network

National Provider Identifier (NPI)

All providers must bill MDwise using their unique rendering and billing (if applicable) NPI for claims to be accepted for processing. Providers can apply for their NPI at the CMS website, https://nppes.cms.hhs.gov.

Participating (Contracted) Providers

MDwise has contracted with an extensive network of quality providers to deliver health care to its members. Unless the member's benefit allows, members must receive health care services from providers in the MDwise network listed in the provider directory. The provider directories for the MDwise Medicare plans can be found at www.MDwise.org. For example, MDwise members needing hospitalization for an elective inpatient procedure must use a network hospital (inpatient hospital care requires preauthorization).

Culturally and Linguistically Appropriate Services (CLAS) Training Requirement

CLAS is a way to improve the quality of services provided to all individuals. By tailoring services to an individual's culture and language preference, health professionals can bring about positive health outcomes for diverse populations.

CLAS training is an NCQA requirement for all providers and staff. MDwise is pleased to offer CLAS training online at www.MDwise.org. The training provides an overview of CLAS standards, legal requirements, communication standards, continuous improvement recommendations and member diversity.

MDwise requests that each provider location completes the CLAS training online and sign the attestation included in the presentation (one per office location). If you have completed CLAS training with another health plan, we will accept their signed attestation. Send your completed attestation to prenrollment@mdwise.org.

V - Role of the PCP

MDwise Medicare members must select a PCP at the time of enrollment. If a member does not choose a PCP, MDwise will assign a PCP to that member. A PCP is a participating physician who has contracted with MDwise to provide primary care services and coordinate and manage the member's access to all health services. Each member must select a PCP, and members have the right to change PCPs.

MDwise recognizes the following groups of providers as PCPs*:

1. Family Practice Physicians
2. General Practice Physicians
3. Internal Medicine Physicians
4. Nurse Practitioners*
5. Physician Assistants*

**Under certain circumstances, a member can request primary care services from a participating specialty care physician. For further information, contact Member Services at (833) 358-2140 (TTY: 711).*

Physician Assistants (PAs) and Nurse Practitioners (NPs)

Except in an emergency, PAs and NPs shall provide medical care services only under the supervision of a physician or properly designated alternative physician (only if those medical care services are within the scope of practice of the supervising physician and delegated by the supervising physician).

PAs and NPs shall conform to the minimal standards of acceptable and prevailing practice for the supervising physician.

The supervising physician must be a contracted in-network provider of MDwise and credentialed by MDwise.

PAs and NPs shall only prescribe drugs as a delegate of a supervising physician in accordance with applicable laws, regulations and rules.

PAs and NPs must comply with all other applicable laws, regulations and rules. Primary care services should be provided to a member by the designated PCP or physician designated to cover for that PCP.

Examples of primary care services are:

1. Annual physical exams
2. Preventive care and screenings
3. Sudden onset of illness
4. Management of chronic conditions
5. Laboratory and diagnostic tests performed routinely in an ambulatory care setting

PCP as the Care Coordinator

The assigned PCP is considered the member's care coordinator. As such, the PCP is expected to coordinate and manage the member's utilization of specialty care, ancillary services and inpatient services. In addition, when a member needs non-emergent inpatient care, MDwise recommends the PCP coordinates the entire episode of care (i.e., initiate the admission or collaborate with the admitting specialist/hospitalist) to ensure timely initiation and appropriate utilization of health services. Contact Case Management nursing staff at (833) 358-2140 (TTY: 711) to assist in this process.

PCP Case Management Program

Case management is a collaborative process that assists the member in accessing care. The MDwise Case Management Program includes the PCP. MDwise proactively assigns a nurse case manager to each PCP to assist the PCP and/or office staff with any member issues (e.g., arranging community services, assisting patients in keeping their appointments, etc.).

The goal of this program is for MDwise to be the physician's advocate. The program has proven successful in many ways, as the PCP has additional resources that can support caseload management and, at the same time, help resolve the individual member's concerns.

Please involve Case Management with the care management of your patients. For further assistance, please contact Medical Management at (833) 358-2140 (TTY: 711). For a member who would benefit from nurse case manager contact, please complete a Referral to Case Management form. Forms are available at www.MDwise.org or obtain by contacting your Provider Services coordinator.

You can supplement your claim data by faxing medical records to MDwise at (810) 733-9653. Supplemental medical records can be sent to MDwise for the following measures:

1. Adult BMI
2. Diabetes care – HbA1c testing, nephropathy testing and eye exams
3. Chlamydia screening
4. Breast cancer screening and any possible exclusion
5. Cervical cancer screening and any possible exclusion

If you have questions, please contact MDwise Member Services at (833) 358-2140 (TTY: 711) and ask for the Quality department.

Accessibility of Care

The established monitoring standards are the minimum guidelines of measurement. The following are the MDwise Medicare plan standards for PCP accessibility to members:

Type of Service	Standard
Urgent Care	Within 48 hours
Routine / Regular Care	Within 14 days
Preventive Care (i.e., physical)	Within 45 days
In-Office Wait Time	Patient seen within 30 minutes of appointment time

The following are the MDwise Medicare plan monitoring standards for high volume* and high impact provider* accessibility to members:

Type of Service	Standard
Initial Visit	Within 45-60 days
Follow-up Care	Within 30-60 days

*High-volume specialty providers are determined based on patient visit volume over a specified period. For example, OB/GYN providers are always deemed high-volume providers. High-impact specialty providers typically treat conditions that have high mortality and morbidity rates, including provider types where treatment requires significant resources. For example, oncology providers are always deemed high-impact specialists.

The following are the MDwise Medicare plan monitoring standards for behavioral health provider accessibility to members:

Type of Service	Standard
Non-life-threatening emergency	Within six (6) hours
Urgent	Within 48 hours
Initial visit for routine care	Within ten (10) days
Routine	Within 30-45 days

Quality Improvement staff conduct an annual evaluation and analysis on the following:

1. Primary care appointment availability for regular, routine and urgent care appointments
2. Primary care after-hours availability
3. Behavioral health care appointment availability (Quality Improvement staff conduct separate analysis for Behavioral Health care providers who prescribe medication and those who do not prescribe medication).

The Quality Improvement committee reviews the reported analysis results. MDwise requires an 80 percent compliance rate for all access measures. Those providers who do not meet the 80 percent requirement will be notified and requested to submit a corrective action plan to MDwise within 30 days. Failure to comply with this requirement may result in provider contract termination.

Coverage Responsibilities

All PCPs contractually commit to providing coverage to MDwise members 24 hours per day, (7) seven days per week. Acceptable after-hours access methods include:

1. An answering service
2. On-call paging system
3. Call forwarding to physician's cell phone or other contact phone
4. Recorded message with instructions directing the member to another provider

There must be a method to talk to a physician 24/7 regarding after-hours care for urgent or non-life-threatening conditions. There must also be instructions to call 911 or go to the emergency department for life-threatening situations.

The message should not direct members to seek after-hours care at the nearest emergency department for non-life-threatening situations.

If the provider utilizes covering physician(s), we recommend that the covering physician also be a participating MDwise physician. It is the PCP's responsibility to ensure that members have access to a covering physician when the PCP is unavailable. In addition, if the PCP is paid on a per member per month basis (capitation), financial reimbursement for services rendered by the covering physician is also the responsibility of the PCP.

MDwise expects the PCP to maintain ultimate responsibility for managing the member's care, even when a covering physician provides a portion of the care.

Non-contracted physicians who are covering a contracted physician must receive preauthorization before rendering services to a member.

Accepting Status of Primary Care Practices

The MDwise Medicare plan products assign members to a PCP upon enrollment. Each contracted PCP is designated to have an open practice unless a request to close a practice has been made and approved.

Changing the Accepting Status of a Practice

Changing the acceptance status of a practice requires the following six (6) steps, completed in the following order:

1. Send the provider updater form or a letter on official letterhead that includes the following:
2. Reason for the request to limit members
3. Attestation that your practice is being closed to all other health plans
4. Anticipated timeframe new enrollment is to be limited
5. Signature of physician making the request
6. Email the document to prenrollment@mdwise.org
7. The provider enrollment representatives review and approve the request following verification of membership assigned to the PCP.
8. The provider enrollment representative will respond in writing to the provider's request within two (2) weeks, indicating approval or denial.
9. If approved, the request for the acceptance status change is effective 30 days from the date of approval.

There are exceptions to the MDwise panel hold policy, which are reviewed on a case-by-case basis. MDwise may make special considerations under the following circumstances:

1. Exit of a partner in the practice
2. Total volume of patient base in direct comparison to office space

3. Leave of absence
4. Provider agreement language

Note: *If MDwise approves a request for panel hold, the length of the status change is limited to six (6) months from the date of approval. After six (6) months, the acceptance status will revert to "open" to accepting new MDwise member.*

Opening a Practice

A participating PCP may open a practice at any time by submitting an enrollment form or a letter, on official letterhead, to prenrollment@mdwise.org, requesting that the practice be open to new MDwise members.

Procedures for Dismissing Members for Disruptive Behavior or Fraud and Abuse

Participating health care providers can request that an MDwise member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include non-compliance with medication schedules, no-show office policies or failure to modify behavior as requested. In addition, any time a member misses three (3) or more consecutive appointments, providers are expected to notify Member Services for assistance.

Providers shall not discriminate when dismissing members from their practice. Involuntary dismissal policies must be designed and implemented in a neutral, non-discriminatory manner.

We strongly recommend that your office make at least three (3) attempts to educate the member about

noncompliant behavior and document them in the patient's record. Please remember that MDwise can assist you in educating the member. After three (3) attempts, providers may initiate the dismissal by following the guidelines below:

1. The provider office must notify the member of the dismissal by certified letter
2. A copy of the letter must be sent to MDwise at the following address:
   ATTN: Member Services
   PO Box 44092
   Indianapolis, IN 46244-0092

For PCPs only, the letter must contain specific language stating that:

1. The member must contact MDwise to choose another PCP
2. The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal

When a member changes to a new PCP, the provider must forward the member's medical records or copies of medical records to the new PCP at no cost within ten (10) calendar days from receipt of a written request.

VI - Emergency and Urgent Care

Patients often find it difficult to distinguish between an urgent health care need and a medical emergency. Therefore, MDwise instructs members to contact their PCP if a medical problem or question arises that the member believes should be taken care of immediately.

Definitions

Emergency care is defined as a sudden and/or unexpected sickness or injury that could result in a serious problem or death if not treated. Examples of emergency conditions include:

1. Serious bleeding
2. Loss of consciousness
3. Convulsions or seizures
4. Severe breathing problems
5. Fracture
6. Chest Pain

Urgent health problems are not life-threatening, but they may require immediate attention. Members are encouraged to contact their PCP if they experience a health problem that they believe requires immediate attention. Examples of common urgent health problems include:

1. Severe sore throat
2. Minor cuts and bruises associated with trauma
3. Sprains
4. Rashes
5. Severe headache
6. High fevers
7. Earache

A PCP or covering physician must be available 24 hours per day, seven (7) days per week, to provide or arrange for coverage of services.

Out-of-Area Emergent Care

If the MDwise member presents to an out-of-area facility for emergency care, the institution providing this emergency care (or emergency admission) must notify MDwise no later than the next business day.

Out-of-Area Non-Emergent Care

MDwise members may be eligible to receive non-emergent or routine covered services while outside the MDwise service area (with prior approval from the Plan) under the following circumstances:

- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Prior authorization must be received from MDwise Medicare prior to using an out-of-network provider in order for the care to be covered under your in-network benefit. In this situation, you will pay the same as you would pay if you got the care from a network provider.

- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

The Inspire Flex plan has a POS benefit that covers services out of network at a higher cost-share.

Member Responsibility

If the member feels they have an emergent medical condition and does not have time to call the PCP, they are instructed to go to the nearest MDwise participating hospital emergency room, the nearest emergency room or call 911.

1. MDwise instructs members who go to urgent care or the emergency room to identify themselves as MDwise members and present their MDwise member identification card.

2. Members should notify their PCP within 24 hours (or the next business day) of an urgent care or emergency room visit to ensure that PCPs may arrange appropriate and immediate follow-up care.

VII - Referral and Prior Authorization Requirements

MDwise promotes the traditional primary care relationship between physicians and their patients. MDwise recommends that the PCP coordinates the entire episode of care to ensure the timely initiation and appropriate utilization of health services. However, we recognize certain situations and circumstances where it would be more appropriate for the specialist provider to request services. Therefore, MDwise also accepts requests for preauthorization from specialist providers.

MDwise uses the Prior Authorization Request Form to obtain prior authorization when certain services are requested. The Prior Authorization Request Form is available electronically for completion and submission to MDwise at https://www.mdwise.org/mdwise-medicare/mdwise-medicare-home. The prior authorization request form also can be printed from the same webpage and submitted via fax to (810) 600-7959.

Contact Medical Management at (833) 358-2140 (TTY: 711) to make an urgent request for prior authorization. MDwise Medical Management strives to respond to provider requests for prior authorization of services efficiently and promptly. MDwise uses the following time frames for timely decision-making for non-behavioral healthcare utilization management:

1. For non-urgent pre-service decisions, MDwise makes decisions within 14 calendar days of receipt of the request
2. For urgent pre-service decisions, MDwise makes decisions within 72 hours of receipt of the request
3. For urgent concurrent review, MDwise makes decisions within 24 hours of the request

Providers receive notification by fax of the utilization management decision.

There is a reference guide of the complete list of service codes requiring prior authorization for each line of business.

MDwise does not require prior authorization for in-network (contracted) specialty consultations or care provided in the specialist office.

In summary, providers must complete the Prior Authorization Request Form and obtain prior authorization for the following:

1. Any care referred to an out-of-network (non-contracted) physician
2. Any service listed on the Preauthorization Code List
3. Certain injections (please call Medical Management for clarification)

In addition, any health care provider not participating with MDwise must obtain preauthorization for all non-emergency services provided unless provider is seeing MDwise Medicare Inspire Flex members.

Please note that prior authorization requirements are subject to change. Please refer to www.MDwise.org for the most current information on services that require prior authorization and the prior authorization process. The MDwise list of service codes requiring prior authorization is available on our website. Updates, changes and clarifications to authorization requirements will be completed quarterly. Any updates, changes or clarifications will be effective in January, April, July and October of each year.

Note: *Prior authorization requests are subject to a medical review by MDwise and may require additional information and/or documentation before a service can be approved.*

The Prior Authorization Request Form requires the following fields:

1. Diagnosis/procedure code
2. Patient information
3. Requesting provider information
4. Rendering provider information
5. Requested service

Note*: MDwise will return incomplete forms to the requesting office and cannot process the request.*

Inpatient Hospital Services: Provider

All patient hospital admissions require preauthorization (except in emergency situations). For Inpatient elective or urgent admissions, the provider must contact Medical Management by calling (833) 358-2140 (TTY: 711) toll-free or by calling your Case Management nurse. For elective admissions, notify MDwise at least seven (7) business days in advance, and for urgent admissions, notify MDwise prior to admission or within 24 hours (or next business day). Include the clinical information that supports the need for inpatient care.

All elective and urgent hospitalizations must be made to a hospital in the MDwise network unless Medical Management has given prior approval.

Inpatient Hospital Services: Facility

Contracted facilities must notify MDwise of all admissions and provide clinical information within one business day of the admission. Timely facility notification allows us to ensure our members receive care in the most appropriate setting, that our Medical Management nurses are involved in the member's care, including discharge planning, and initiate case management (when appropriate).

Notify us of admissions by telephone or fax:

Telephone: (833) 358-2140 (TTY: 711) (toll-free) | **Fax:** (810) 600-7960 | (810) 733-9645 (direct)

MDwise will give authorization if the clinical information meets the established criteria for admission. If additional information is needed to verify the level of care for any admission, MDwise will fax an *Authorization Process* form to the hospital. After medical review, the form is returned with the final authorization number for reimbursement purposes. In addition, for all inpatient admissions, Medical Management will conduct concurrent reviews. Concurrent review of inpatient admissions requires frequent and comprehensive updates to verify the need for continued stay and to aid in discharge planning. The status of authorization may be adversely affected without adequate and timely information during the concurrent review. MDwise requires notification of inpatient admission prior to a member's discharge and notification of a member's date of discharge. Failure to supply the information necessary may result in nonpayment of hospital admission. The member's Case Management nurse will work with the hospital staff in managing the stay and assist with the planning and determining discharge needs.

Note: *When an admission occurs through the emergency room, we ask the hospital to contact the PCP (before admission) to discuss the member's medical condition and coordinate care.*

If questions arise regarding the appropriateness of any inpatient admission or the course of treatment, a concurrent review nurse or the MDwise chief medical officer will contact the hospital utilization review staff and/or the admitting physician to discuss the case. Please contact Medical Management at (833) 358-2140 (TTY: 711) for further details.

Outpatient/Observation Stay: Facility

Sometimes a facility may request inpatient authorization for an episode of care when outpatient authorization is more appropriate. MDwise considers an episode of care to be more appropriately authorized as outpatient when medical documentation reveals that a patient's presenting symptoms have been stabilized or resolved with emergency room treatment (but still needs additional time for continued short-term treatment/observation).

In addition to the evaluation of the emergency room treatment results, many other factors are also considered, such as the patient's medical history, medical predictability of adverse outcomes with presenting signs and symptoms and the expectation that the episode of care may be resolved in a short period.

Also, to help identify outpatient stays, system edits will identify an episode of care lasting less than 48 hours and members with a specific presenting diagnosis. Examples of diagnoses (not all-inclusive) that may identify for reimbursement as an outpatient include:

1. Asthma
2. Dehydration (gastroenteritis)
3. Bronchitis/bronchiolitis
4. Overdose/alcohol intoxication
5. Cellulitis
6. Pain: e.g., abdominal, head, back
7. Chest pain
8. Pneumonia
9. Closed-head injury without
10. Pyelonephritis loss of consciousness
11. Syncope

If the clinical information suggests that the admission requires outpatient authorization and the hospital is pursuing an inpatient authorization, additional clinical information will be required. The *Authorization Process* form will be faxed to the hospital to aid in the determination of the final authorization for reimbursement. After medical review the form is returned with the final authorization number for reimbursement purposes.

MDwise will respond to a non-contracted facilities request for approval of post-stabilization services within one (1) hour. If MDwise does not respond within one (1) hour, the post-stabilization services (hospitalization or other health care services) will be prior authorized for payment. Payment and

authorization for an inpatient hospitalization in this instance will be for inpatient DRG, not as observation payment.

Additionally, outpatient reimbursement for observation care is not payable in the following situation:

1. After outpatient surgery (reimbursement for recovery room care is included in the outpatient surgical fees)

Readmissions: Facility

MDwise reviews all inpatient readmissions when readmission occurs within 15 days after a member is discharged. We review cases to determine if the readmission is related to the first admission for reasons such as:

1. Premature discharge or a continuity of care issue
2. Lack of, or inadequate, discharge planning
3. A planned readmission
4. Complications from surgery performed on first admission

The outcome of the review may impact the hospital's reimbursement. When providing clinical review for members readmitted to the same hospital within 15 days, please provide a clinical review for the last two days of the first admission, and an admission review for the second, when calling in the second admission. If readmission involves a different facility, MDwise will seek the clinical information from the first admission to determine if either hospital's reimbursement is impacted.

Emergency Care Requires Outpatient Surgery

When a member is transferred from the emergency room for any outpatient surgical procedures, the hospital must call Medical Management at (833) 358-2140 (TTY: 711) to obtain authorization for the services.

VIII - General Information

Physician Office Laboratory Services

MDwise providers who perform laboratory tests in their office must demonstrate that they have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. MDwise has developed a list of laboratory services that are billable when performed in the office by both primary care and specialist. Please see the *MDwise In-Office Laboratory Billable Procedures* form for a complete list of CPT codes that are billable when performed in an office setting.

Clinical Practice Guidelines (MQIC)

MDwise has adopted the Indiana Quality Consortium's (MQIC) Clinical Practice Guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral healthcare services. Locate these guidelines by visiting http://mqic.org and www.MDwise.org/medicaid-provider/provider-guidelines-MDwise.aspx. The guidelines are reviewed every two (2) years for needed updates.

Reference Lab Billing Requirements

As laboratory testing continues to become increasingly specialized, hospital laboratories may need to refer specimens to reference laboratories for testing if they cannot process the specimens in-house. This information pertains to covered laboratory procedures performed by reference laboratories under contractual arrangements with MDwise contracted hospitals. This includes any laboratory procedure covered by CPT codes 80000 – 89999 or applicable HCPCS codes. See Reference Guide "H" for more information on Reference Lab Billing Requirements.

Diabetic Monitors and Supplies – MDwise Medicare Advantage Plans

To request a monitor for a member, give your patient a prescription for one of the following diabetic meters or test strips listed below. Members can take the prescription to their local pharmacy to receive the meter and test strips. MDwise may have specific brand specifications and require prior authorization for suppliers outside of Abbott.

Medical Record Maintenance

State regulations require MDwise participating practitioners and other providers to maintain accurate patient medical records regarding the treatment and diagnostic procedures provided to MDwise members for at least ten (10) years. In addition, CMS requires that practitioners and providers maintain records related to MDwise Medicare or Medicare Advantage members for ten (10) years.

Each provider contracting with MDwise must maintain a medical record for each member served while enrolled in MDwise. These records are to be made available to authorized representatives of MDwise, regulatory agencies, accrediting bodies, and appropriate state and federal agencies.

Medical records of members shall be sufficiently complete and legible to permit subsequent peer review or medical audit.

MDwise requires participating providers to release medical records as directed by the member or authorized representatives of appropriate state and federal agencies.

The provider must maintain medical records of all medical services received by members. Medical records include, but are not limited to, the following:
a) a record of outpatient and emergency care
b) specialist referrals
c) ancillary care
d) diagnostic test findings (including all laboratory and radiology)
e) prescriptions for medications
f) inpatient discharge summaries
g) histories and physicals
h) immunization records
i) all other documentation sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services provided by the provider.

The provider must maintain medical records in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates a system for follow-up treatment. Providers must maintain legibly written or electronic records in English to fully disclose and document the extent of services provided to members. Please maintain legible and complete records to avoid a denial of payment.

Medical records must be legible, signed, dated, and kept during the time required by applicable regulatory agencies. Medical records will be made promptly available, at no cost to MDwise and CMS upon request.

When a member changes PCP, the former PCP must forward copies of the member's medical records to the new PCP within ten (10) working days from receipt of a written request from the new PCP or the member. Medical records must be stored in a manner that ensures compliance with federal and state privacy and security requirements and must be stored securely so that only authorized personnel have access to the records. If the provider is a hospital, the provider must comply with all medical record requirements contained within 42 CFR 456.101-145.

***Note**: The provider will comply with MDwise policies, including any additional medical record standards. Policies are available upon request.*

Medical Record Review Standards

MDwise requires providers to maintain current, detailed, organized medical records that permit effective and confidential patient care and quality review.

MDwise Medical Record Review Standards apply to:

1. All services provided directly by a practitioner who provides primary care services
2. All ancillary services and diagnostic tests ordered by a practitioner
3. All diagnostic and therapeutic services referred by a practitioner

MDwise, on an annual basis, chooses two (2) medical record standards (e.g., patient identification, record content, and continuity and coordination of care) to assess through an on-site visit at 50 percent of our PCPs with >50 members.

The medical record shall pass with a minimum of 80 percent for the entire review and for each section. If any section is below 80 percent, a corrective action plan (CAP) is required to be submitted within 30 days. If the medical record score is below 80 percent, a CAP is required within 30 days with a re-visit in 60 days.

The following documentation should be in each patient's medical record:

1. PATIENT IDENTIFICATION

Identification sheet or demographic data must be documented and current.

AN IDENTIFICATION SHEET, WHICH INCLUDES ALL OF THE FOLLOWING INFORMATION PERTAINING TO THE PATIENT/ENROLLEE:

1. Name
2. Address
3. Date of birth or age
4. Gender (Except Obstetrics and Gynecology)
5. Emergency contact person
6. Home and work telephone numbers
7. Employer
8. Marital status

2. RECORD CONTENT

The following documentation should be in each patient's medical record:

1. ALLERGIES AND ADVERSE REACTIONS TO MEDICATIONS PROMINENTLY DISPLAYED

   Medications may be displayed on front cover, inside cover, medication sheet, patient information sheet.

2. ALL ENTRIES IN MEDICAL RECORDS CONTAIN THE WRITER'S ID (INCLUDING FLOW SHEETS)

   All writers in the patient record (including flow sheet) must be identified. If initials or signature stamp is used, then a signature list is available. A written policy and procedures are required for use of the signature stamp, and the stamp must be locked or kept with the practitioner at all times.

3. ALL PAGES CONTAIN PATIENT ID

   If pages are not secured in the record, each page must have an ID# (e.g., DOB, member ID number, etc.) in addition to the name.

4. RECORD LEGIBLE

   Record can be read by at least two (2) people other than the writer.

5. ALL ENTRIES DATED

6. UPDATED PROBLEM LIST

   Pediatric records should include any acute or recurrent problems.

7. UPDATED MEDICATION LIST

   Medication list must be separate from progress notes.

8. IMMUNIZATION RECORD PRESENT

   Is there a centralized form present in the record for recording all immunizations?

9. ADVANCE DIRECTIVES

   The Indiana Legislature authorized the use of Durable Power of Attorney for Health Care in our state. The member can appoint another individual to make decisions concerning care, custody and medical treatment when the member is unable to participate in medical treatment decisions. Need to have evidence of inquiry of Advance Directives prominently located. (Adults age 18 and older).

10. APPROPRIATE MEASURES TAKEN TO ENSURE CONFIDENTIALITY OF PATIENT MEDICAL RECORDS

    Measures include storage, accessibility of records (must not be accessible to patients), release of information, a written policy and procedure, and a signed confidentiality statement.

11. MEDICAL/TREATMENT RECORD ORGANIZED IN A CONSISTENT MANNER

    All labs, x-ray reports, consults, etc., organized in the record in a consistent manner.

3. HEALTH HISTORY

Comprehensive health assessment completed or offered. If the patient refuses to complete the form, documentation should be present. Checklists are acceptable as long as they include the following:

1. MEDICAL HISTORY DOCUMENTED (UPDATED WITH A PHYSICAL)
   The patient can complete, but practitioner must review, date and sign. Delivery data must be included for children,

2. FAMILY HISTORY DOCUMENTED (UPDATED WITH A PHYSICAL)

   (As listed above.) For children, if in foster care or adopted, it must be documented.

3. SOCIAL HISTORY DOCUMENTED

   Documentation marital status, number of children, sexual activity and contraceptive usage.

4. SUBSTANCE USE DOCUMENTED

   Includes documentation of smoking habits and history of patient alcohol use, according to the health plan's preventive guidelines.

5. SAFETY EDUCATION

   Documentation evidence of inquiry regarding use of seat belts, helmets, smoke detectors, etc.

6. COMPLETE PHYSICAL EXAMINATION

   A completed physical exam should be documented or offered in timeframes according to the health plan's preventive guidelines.

7. ABUSE INQUIRY

   Documentation of evidence of inquiry regarding present or previous mental, physical, sexual abuse.

4. PROGRESS NOTES

1. REASON FOR VISIT

Documentation of the reason patient came to see the practitioner.

2. OBJECTIVE PHYSICAL FINDINGS

Documentation of physical findings according to patient presenting complaints.

3. DIAGNOSIS/PHYSICAL FINDINGS

4. TREATMENT RENDERED

Documentation of what was done for the patient relative to the patient's presenting complaints.

5. FOLLOW UP PLANS

Documentation of date for next visit, return as needed, etc.

6. PREVIOUS UNRESOLVED PROBLEMS ADDRESSED

5. REFERRALS/CONSULTANTS

1. REPORT DATED UPON REVIEW BY PHYSICIAN
2. SIGNED OR INITIALED UPON REVIEW BY PHYSICIAN
3. CONSULTANT/REFERRAL REPORTS IN RECORD
4. REFERRALS ISSUED APPROPRIATELY

6. LAB/X-RAY REPORTS

1. DATED UPON REVIEW BY PHYSICIAN (CAP Required if not passed)
2. SIGNED OR INITIALED UPON REVIEW BY PHYSICIAN (CAP required if not passed)
3. FOLLOW-UP TO ABNORMAL FINDINGS

   Need documentation of patient notification of abnormal findings and plan to address findings (CAP required if not passed)

7. PREVENTIVE SERVICES

Preventive healthcare services should be offered and documented accordingly.

1. IMMUNIZATIONS APPROPRIATE FOR AGE

   Documentation of immunizations, according to the health plan's preventive guidelines.
2. BREAST CANCER SCREENING
3. CERVICAL CANCER SCREENING
4. PSA

   Performed in accordance with the health plan's preventive guidelines.
5. COLORECTAL CANCER SCREENING
6. PATIENT EDUCATION

   Based on diagnosis and the health plan's preventive guidelines.
7. SMOKING INQUIRY ON EACH VISIT Inquiry recommended on each visit; may be noted on vital signs sheet.
8. SMOKING COUNSELING ON EACH VISIT (if required)

8. CONTINUITY AND COORDINATION OF CARE

1. EVIDENCE OF CONTINUITY AND COORDINATION OF CARE BETWEEN PRIMARY AND SPECIALTY PHYSICIANS?

   Documentation of the exchange of information in an effective, timely and confidential manner, including patient-approved communications between medical practitioners, behavioral health practitioners and other specialist providers.

2. EVIDENCE OF DISCHARGE SUMMARIES FROM HOSPITALS
3. EVIDENCE OF DISCHARGE SUMMARIES OR PROGRESS NOTES FROM SKILLED NURSING FACILITIES/HOME HEALTH PROVIDERS

Confidentiality

MDwise guarantees its members the right to privacy of information through its policies and procedures. A privacy notice is available to all members. In addition, every MDwise employee signs a statement stating that they must keep member information private when hired. Each year, MDwise trains employees on policies and procedures for keeping information private and only allow employees authorized with password access to electronic information.

Providers must ensure that all information relating to, or identifying specific patients, shall be kept strictly confidential. Each MDwise participating provider is responsible for maintaining the confidentiality of medical, social, and economic information contained in the member's medical record. Storage of medical and confidential files shall be subject to physical security measures during non-working hours.

Quality Improvement Activities

The MDwise contracted provider network must comply with all MDwise quality improvement activities. These activities include utilization review, quality management, care coordination, peer review, and other programs established by MDwise to promote quality health care and cost containment.

The MDwise provider network collects performance data with quality improvement activities. This data is collected through, but not limited to, claims history and HEDIS chart review. This data is utilized in a variety of ways. For example, individual provider performance is reported and compiled into the health plan's overall performance. Using the data, work plans, and opportunities for action, MDwise develops provider incentives to help increase quality outcomes and member satisfaction.

Non-Discrimination

In connection with the performance of services under the contract between MDwise and the provider, the provider agrees to comply with the American Disability Act, 42 USLA 12112 (ADA) and Section 1557. Additionally, the provider agrees with the Civil Rights Act of 1964 (78 stat. 252).

Discussing Treatment Options

MDwise providers may freely communicate with patients about treatment options, including medication treatment options, regardless of benefit coverage limitations. In addition, providers may advocate on behalf of a member in any grievance or utilization review process or individual authorization process to obtain necessary health care services.

Member Complaint, Grievance and Appeal Procedure

We want to hear member comments so that we can make our services better. We want our members to receive answers to questions they have about MDwise. We will do our best to fairly resolve any problems members may have with us. Please contact us with any member comments or concerns. We are here to help complete forms and take other steps. Interpreter and TTY services are available.

STANDARD GRIEVANCES

If a member is unhappy with any aspect of the operations, activities or behavior of a plan or its providers in the provision of health care items, services, or prescription drugs, they may file a grievance. The member can call Member Services if they have questions or concerns and MDwise staff will try to resolve concerns during the first contact. If members are still unhappy with the response from MDwise, they may file a formal grievance.

Please mail grievances to the following mailing address:

MDwise
ATTN: Appeals & Grievances
P.O. Box 44092
Indianapolis, IN 46244-0092

Phone number: (833) 358-2140 (TTY: 711)
Fax number: 855-325-8041
Email: medicareappeals@mdwise.org

Note: *Grievances do not include appeals. See the Appeals section for more information. Member Services staff can help members document and file a grievance. MDwise will acknowledge receipt of the grievance in writing within five (5) days of receipt. Standard grievances are processed as quickly as your health requires, but no later than 30 calendar days from receipt. We may extend the time frame by up to 14 calendar days if you ask for an extension or if we need additional information and delaying our response is in your best interest. Grievances received orally will be responded to orally. If the grievance is submitted in writing, we will respond in writing with our decision. All grievances must be submitted within 60 calendar days of the event or incident. Any grievance submitted outside this time frame cannot be accepted. Individuals who make decisions on the grievance will not be involved in a previous level of review. They will also not be the direct subordinate of a review team member. If required, the appropriate clinical individuals will be members of the review team.*

EXPEDITED GRIEVANCES

You or your representative may request an expedited grievance if we extend the time frame to make an organization or coverage determination, extend the time frame to make a reconsideration or redetermination, deny your request for an expedited appeal, or deny your request for an expedited organization determination. If you wish to file an expedited grievance contact Member Services (phone numbers are printed on the back cover of this booklet). Expedited grievances will be responded to verbally within 24 hours of receipt.

If upon review of your expedited request we see that delaying our decision will not seriously harm you medically, we will not accept the expedited request. We will handle the request as a standard grievance and process within 30 days of receipt. We will notify you of this decision verbally and a written notice will be mailed within three (3) calendar days after the verbal notification.

Members may file an appeal of an expedited grievance with MDwise. Members may file a request for an expedited external review while filing a request for an expedited internal grievance. If the member files a request for an expedited external review, they may have exhausted the internal grievance process available through MDwise.

STANDARD INTERNAL APPEALS

Members may file an appeal of an adverse pre-service determination with MDwise. Note that an untimely response to a request may become an adverse determination. The member or their authorized representative has 60 days from the date of the adverse pre-service determination notice to file an appeal.

Members can have someone act as their authorized representative to file an appeal. However, the member will need to complete the authorized representative form available at www.MDwise.org or MDwise Member Services is available to mail a hard copy.

Members may appoint an authorized representative at any step of the appeals process. If the member is deceased, the estate representative may be the authorized representative. The appeals process will begin with the signed authorized representative form. Please ensure it is sent to us as soon as possible.

The member or their authorized representative can appeal in writing or verbally. Send appeal requests along with any added information to:

MDwise
ATTN: Appeals & Grievances
P.O. Box 44092
Indianapolis, IN 46244-0092

Phone Number: (833) 358-2140 (TTY: 711)
Fax Number: 855-325-8041

Email: MDwiseApeals@MDwise.org or Medicareappeals@mdwise.org

When a MDwise decision is subject to appeal, MDwise will give a written adverse determination notice to the member and the requesting provider, if applicable. Adverse determination notices for the suspension, reduction or termination of services must occur at least ten (10) days prior to the change in services. MDwise will continue member benefits if all the following conditions apply:

1. The appeal is filed timely, meaning on or before the later of the following:
2. Within ten (10) days of MDwise mailing the notice of action
3. The intended effective date of proposed action from MDwise
4. The appeal involves the termination, suspension or reduction of the previously authorized course of treatment
5. An authorized provider ordered the services

6. The authorization period has not expired
7. The member requests an extension of benefits

If MDwise continues or reinstates member benefits while the appeal is pending, the services continue until one of the following occurs:

Level 1 – MA Reconsideration

Level 2 – Independent Review Entity

Level 3 – Administrative Law Judge Hearing

Level 4 – Medicare Appeals Council

Level 5 - Federal District Court

If we reverse the adverse action decision or if a State Fair Hearing reverses it, we will pay for services provided while the appeal is pending and authorize or provide the disputed services. MDwise will do this as fast as the member's health requires, (at most) 72 hours after we receive notice of a reversal.

If an adverse State Fair Hearing decision is made, you may be required to pay the cost of your services. However, MDwise may only do this as allowed by state policy.

A member may request copies of information relevant to their appeal, free of charge, by contacting MDwise Member Services. MDwise will provide members with any new or added information considered, relied upon or generated by us related to the appeal. This is free of charge to the member. We will also provide the member with any new or added rationale for a claim denial or appeal, giving the member a reasonable opportunity to respond.

A person not involved in the initial decision will review the appeal. The person will not be a subordinate of anyone who previously made a decision on the appeal. If the appeal is based in whole or in part on medical judgment, the person who reviews the appeal will be of the same or similar specialty as would typically manage the case.

We will decide as fast as the member's health condition needs. Normally we have 30 days to complete the appeal process but may extend this time period up to 14 additional days. We will call the member if we need to request an extension, but the extension must be in the member's best interest. We will also send a letter telling the member of the delay. If they disagree with the extension, they may file an appeal.

The member will receive a written letter telling them of our final determination within three (3) days after the decision is made. In addition, MDwise may call the member to tell them the decision.

EXPEDITED INTERNAL APPEALS

If a physician believes that due to a member's medical status, a resolution of the appeal within normal time frames would seriously jeopardize their life or health or ability to regain maximum function, MDwise may expedite the appeals process.

To request an expedited appeal, a member can call MDwise at (833) 358-2140 (TTY: 711) or make this request in writing. Expedited appeals are only available for pre-service adverse determinations. This includes requests concerning admissions, continued stay or other health care services if they have

received emergency services but have not been discharge from a facility. MDwise may decide not to treat the appeal as expedited. In this case, we will make efforts to call the member and mail a letter within two (2) days of the request informing the member that the appeal is not expedited but will be treated as a standard appeal.

If MDwise accepts the appeal as expedited, we will tell the member and their physicians of our decision as fast as their medical condition requires. This will be no later than 72 hours after we receive their request. Generally, MDwise will notify the member and their physician of the decision by phone and will send the member and their physician a written letter of the decision within two (2) days of the request informing the member that the appeal is expedited. The member's physician may confirm by phone or writing that they have a medical condition that the timeframe for completing an expedited internal appeal would seriously jeopardize their life, health or ability to regain maximum function.

Allowable Amount

MDwise reimburses all providers of care, for all lines of business, at applicable facilities and professional fee schedule rates and methodologies. Reimbursement is payment in full at the lesser of billed charges or 100 percent of the allowed amount less any deductibles, copayments or coinsurance amounts that are the member's responsibility.

Mid-Level Providers

MDwise reimburses mid-level providers according to industry standard methodology. The mid-level provider reimbursement rate is 85 percent of the standard professional fee schedule, applicable to each line of business, less any deductibles, copayments or coinsurance amounts that are the member's responsibility. Mid-level providers are classified as:

1. Physician Assistant (PA)
2. Nurse Practitioner (NP)
3. Certified Nurse Midwife (CNM)
4. Certified Nurse Specialist (CNS)

Multiple Surgical Procedures

When submitting claims for multiple surgical procedures performed during the same surgical session (for both professional and facility charges), report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier 51.

The multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice. MDwise reimburses up to 100 percent of the fee screen for the most complex surgical procedure and up to 50 percent (of the fee screens) for the second through fifth surgical procedures. Providers must provide an operative report with the claim for more than five (5) procedures.

Telemedicine

To enhance our members' access to care, MDwise has made available the use of telemedicine. Telemedicine is using telecommunication technology to connect a patient with a health care professional in a different location. It allows real-time interaction between the patient and health care professional via the telecommunication system at the originating and distant sites. Telemedicine use is primarily for when travel is prohibitive for the beneficiary, or there is an imminent health risk justifying immediate medical need for services. Telemedicine is often limited to specialty consults with an ER physician or low-complexity visits that will not require a follow-up encounter. Telemedicine is never used for physician convenience.

Providers must ensure the member's privacy and the security of any information shared via telemedicine. In addition, the technology used must comply with current regulations and industry standards for audio and visual equipment and software.

There are no preauthorization requirements when in-network providers provide telemedicine services to MDwise members. However, providers must submit all allowable telemedicine services with the appropriate telemedicine modifier, GT. Always use the GT modifier for services billed only via telemedicine. Failure to include the GT modifier for these services will result in denial of the service.

DME, Prosthetics, and Orthotics Benefits

As a reminder, MDwise members in any line of business have benefits for DME, prosthetics, and orthotics*. Certain authorization requirements apply, differing for specific lines of business. (Please see the authorization requirements listed by service code at www.MDwise.org). In addition to authorization requirements, there are quantity limits, age parameters and rental caps that MDwise applies when considering reimbursement of medically necessary, covered services. If you have any questions, please contact Member Services at (833) 358-2140 (TTY: 711).

**Orthotics are only covered by providers who have facility accreditation through the American Board for Certification in Orthotics, Prosthetics and Pedorothics, Inc., to furnish and bill for custom-fabricated P&O appliances. Providers must maintain their ABC accreditation and be able to provide accreditation proof upon request. Coverage for orthotics is not available when received from a podiatrist.*

Clinical Editing System (CES) Implementation

MDwise implemented a CES in 2019, focusing on professional claims. The CES is designed to automatically check each claim on a pre-payment basis for errors, omissions and questionable coding relationships, by testing the data against industry rules, regulations and policies governing health care claims.

The CES will also detect coding errors, including but not limited to the following:

- Errors relating to unbundling
- Incidental procedures
- Modifier appropriateness
- Diagnoses
- Duplicate claims

IX - Submitting a Claim

MDwise follows the claims reimbursement policies and procedures established by the CMS. MDwise accepts both paper (CMS 1500 and UB-04 claim forms) and electronic claims. All claims must be submitted and received by MDwise no later than one (1) year from the date of service to be eligible for reimbursement. Claims received that exceed this filing limit may be denied.

Use a CMS 1500 Form for:	Use a UB-04 Form for:
Professional services provided by physicians, behavioral health providers, DME providers, laboratories, ambulances, etc.	Services provided by hospitals (inpatient/outpatient), ambulatory surgery centers, hospices, home health care companies, skilled nursing facilities and dialysis facilities.

Paper Claims

All claims, including coordination of billing claims, should be submitted electronically. However, if you do submit them on paper, all paper claims should be mailed to the following address:

MDwise/McLaren Health Plans
P.O. Box 1575
Flint, MI 48501

Note: *MDwise does not accept handwritten claims. Paper claims must be typed and mailed to the address provided above.*

Paper claim submissions must use the most current form version, designated by the CMS and the National Uniform Claim Committee (NUCC). If you are submitting paper claims, you need to contact your Provider Services Coordinator for assistance with submitting electronic claims.

Note: *You must submit your appropriate NPI on the claim form. If you have any questions, contact Provider Services or access www.MDwise.org.*

Electronic Claims Submission

For claims filed electronically through MDwise Electronic Data Interchange (EDI) vendors, the claims payment process does not differ from paper claim submissions. However, electronic claims may require providers to put the information in different "fields" or "loops". Refer to the Clearinghouse Information section for detailed instructions for submitting electronic claims.

Payer IDs for electronic claims:

MDADV

Clearinghouse Information (both Professional and Facility)

MDwise receives EDI claims from our clearinghouse, ENS Optum Insight. Since you may contract with a different clearinghouse, ensure your clearinghouse has a forwarding arrangement with ENS Optum Insight. A forwarding arrangement allows your clearinghouse to pass claims to ENS Optum Insight so that MDwise will receive them. Please visit www.MDwise.org for an updated listing of ENS Optum Insight affiliated clearinghouses.

Claims Data Validation

EDI claims (submitted to us) will be validated at several points before they are loaded into our claims payment system for review by a claims analyst.

1. Your clearinghouse validates your data
2. Our clearinghouse validates your data
3. Pre-Edit: Our system validates the subscriber and billing provider

The following suggestions will improve your ability to submit a claim for processing:

Your Clearinghouse

Your clearinghouse should provide rejection reports for claims we do not receive. MDwise does not receive a copy of your rejection reports. Please understand that we have no control over or knowledge of the validation that your clearinghouse performs.

Pre-Edit

Your claim must contain the rendering and the billing NPI to be processed.

Subscriber Identification

We will not process a claim that contains an invalid subscriber/member ID. The correct subscriber ID can be found on the MDwise member ID card. If you are unsure of the number, call Customer Services at (833) 358-2140 (TTY: 711).

Billing Provider Identification:

We will not process a claim that contains an invalid billing NPI. Be sure to submit the rendering provider's NPI as assigned by CMS. The tax ID number is not acceptable in place of this field but included as the *Billing Provider Secondary Identifier*. Additionally, the billing address cannot contain a P.O. Box or Department Number for electronic claims, as specified by 5010 billing requirements.

EDI Contacts

If you have questions about becoming a customer at ENS Optum Insight or have problems with ENS Optum Insight claim rejections, contact: http://enshealth.com; (866) 367-9778

If you have questions about the instructions in this document or would like the status of a claim you have submitted to us:

1. Access the myMDwise Provider Portal at www.MDwise.org
2. Contact Member Services at (833) 358-2140 (TTY: 711)

Clean Claims

MDwise is required to **process** your clean claims within 45 days of MDwise receiving the claim. Clean claims not processed in this period are eligible for interest payments at 12 percent per annum in compliance with Indiana's prompt payment legislation.

Billing for Physician Administered Drugs and NDC Reporting

Providers must report the National Drug Code (NDC) supplemental information in addition to the procedure code (CPT or HCPCS) when billing for a physician-administered drug on the electronic and paper claim formats. This requirement is mandated to ensure MDwise compliance with the Patient Protection and Affordable Care Act (PPACA). The PPACA requires Medicaid to collect rebates for certain drugs.

When billing MDwise for physician-administered drugs, in addition to the appropriate CPT or HCPCS codes, providers must report the following on the claim:

1. 11-digit NDC number
2. Unit price (EDI only)
3. 2-digit unit of measure code (GM/gram, ML/milliliter, UN/unit)
4. Quantity dispensed
5. Prescription number

Due to the implementation of the HIPAA X12 version 5010, only one LIN segment is used to report the supplemental NDC information along with the HCPCS Code. The prescription number must be reported for electronic and DDE claims, to link multiple service lines together for the same procedure code.

Note*: If billing multiple lines for the same injectable medication due to different NDC numbers, a 59 modifier is required.*

Coordination of Benefits (COB)

MDwise does not pay a claim when it is unclear as to whether MDwise is the primary or secondary payer. Therefore, we recommend that you always ask patients when they register if they have coverage from more than one insurance carrier or if their injury is the result of an accident.

COB claims should be submitted electronically to MDwise within 12 months from the date of service or 90 days from the date of the primary payer's EOB. To ensure appropriate adjudication of secondary claims, providers must report the primary insurance payment at the line level, not the claim level.

MDwise has an active Coordination of Benefits Agreement (COBA) with CMS. COBA standardizes the way that Medicare eligibility and claims payment information is exchanged with a claims crossover. In the case of a patient with Medicare primary and MDwise coverage secondary, submit the claim to Medicare. Once Medicare adjudicates the claim, it will be forwarded, by CMS, to MDwise. MDwise will then process the claim for secondary benefits. Therefore, you will not need to submit a secondary claim directly to MDwise when a patient has Medicare primary.

COB Provider Payment Reports (PPR)

When a claim is submitted to MDwise for coordination of benefits, the primary payer may have been paid more than the plan's allowable amount. When this happens, the provider will see a provider discount amount on the PPR, but no ineligible code. Subtracting the discounted amount from the charge gives you the health plan's allowed amount. The primary payer's amount is listed in the "Other Carrier" column of the PPR and will be more than the health plan's allowed amount.

Checking the Status of Claims or Requesting a Claims Adjustment

All claim inquiries and adjustments must be submitted to MDwise within 90 calendar days of the administrative action, excluding COB/subrogation claims. MDwise does not consider inquiries and requests for adjustments after 90 calendar days. Verify a claim status in our system by accessing the myMDwise Provider Portal. The myMDwise Provider Portal is HIPAA compliant and will allow the following:

1. Providers or (provider-designated representatives) may status any claims they have submitted and verify member eligibility and coverage
2. Providers must register for access (and a password) to myMDwise Provider Portal at www.MDwise.org

Providers who wish to request a claims adjustment to correct a previously submitted claim, believe a service was denied inappropriately or a claim did not pay correctly, are encouraged to do one of the following:

1. Complete the *Provider Claim Adjustment Form*, attach a paper copy of the corrected claim (or claim in dispute) and supporting documentation for the adjustment, and fax it to Customer Service at (833) 540-8648 for processing.
2. Contact Member Services at (833) 358-2140 (TTY: 711) to request a claim adjustment.

***Note**: Providers cannot submit requests for claim adjustments electronically. The completed Provider Claim Adjustment Form must accompany a paper claim to avoid it from being automatically denied as a duplicate claim.*

Submitting a Claim

In general, MDwise follows the claim reimbursement policies and procedures set forth by CMS for Medicare Advantage plans. Providers shall comply with MDwise payment policies. Please contact MDwise for details.

Data Reporting

All providers must submit claims to MDwise for every encounter or consultation provided to a member. MDwise encourages providers to submit claims within 60 days of the date of service to document service utilization. MDwise needs encounter data to document the amount of work health care providers perform on a member's behalf. This data tracks utilization (the content, type, and timing of services) monitors over-utilization and under-utilization of services and is used for required documentation to state regulators, the Healthcare Effectiveness Data and Information Set (HEDIS), and accrediting bodies. MDwise assumes that if it does not receive encounter data, no visit or consultation has taken place, which could negatively impact your future reimbursement rates.

1. MDwise expects all providers to submit claims even when MDwise is the secondary payer, and no reimbursement is due from MDwise.

2. Please report professional services on a standard CMS 1500 form to report all encounters and billable services provided.

Claims Recovery

MDwise identifies opportunities to recover payments made to providers. The claims recovery process will include adjustments on the following types of previously paid claims including, but not limited to:

1. COB
2. Subrogation
3. Clinical inpatient review
4. Fraud, waste or abuse
5. Overpayments due to billing, clerical error and termination of a member's coverage COB includes the following:
    1. MDwise paid primary and then found out at a later date that MDwise should have paid secondary or tertiary
    2. MDwise paid primary/secondary and then found out at a later date that MDwise should not have paid at all

Overpayments

Providers are required to report overpayments to MDwise promptly. Please contact MDwise as soon as possible if you have identified an overpayment. Federal law requires you to notify MDwise (in writing) of the reason for an overpayment. We will work with you to ensure the overpayment is promptly returned to MDwise. In some cases, this may include offsetting future claims. However, please note that for overpayments related to the MDwise Medicaid/Healthy Indiana Plan line of business, federal law requires that if overpayment is identified, then the overpayment is returned within 60 days. If MDwise cannot recover an overpayment by either offsetting future claims or direct reimbursement from the provider, MDwise will seek reimbursement through collections.

The following table outlines the timeframes for MDwise to request funds or do take-backs.

Type of Corrective Adjustment	Timeframe
COB	The longer of 12 months from the date of service or 90 days after MDwise receives information confirming the primary carrier
Subrogation	24 months from the initial date of reimbursement
Inpatient Clinical Review	24 months from the initial date of reimbursement
Gross Negligence, Billing Errors, Fraud by Provider	No time-limit
Clerical Overpayments by MDwise	No time-limit
Termination of Member's Coverage	12 months from the date of service

835 and EFT Options

To add efficiency and speed to the payment of claims, MDwise offers EFT/ACH, virtual card payment options and 835 remittance delivery options. For more information on these payment options and 835 remittance delivery options, please contact Member Services at (833) 358-2140 (TTY: 711).

X - Fraud, Waste and Abuse

Health care fraud and abuse are both state and federal offenses. The HIPAA Act of 1996 indicates a dishonest provider or member is subject to fines or imprisonment (of not more than ten (10) years) or both. In addition to fines, probation, or incarceration, fraudulent or abusive activities may result in a denial, suspension or termination of the provider's license.

MDwise asks that providers and members partner with us to identify and eliminate fraud, waste and abuse. As part of that partnership, the provider, while contracted with us, warrants that the provider and its employees:

1. Have not been listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in federal or state health care programs or in administering health care
2. Have not been convicted of any crime related to defrauding any health care benefit program

The provider will also routinely screen its employees for the above-noted participation issues. The provider must notify MDwise in writing immediately if the provider or any employees are listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in federal or state health care programs or if the provider or any of its employees are convicted of any crime related to defrauding any health care benefit program.

Fraud is intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit. It includes any act that constitutes fraud under applicable federal and state law (42 CFR § 455.2).

Waste is the overuse of services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not caused by criminally negligent actions but rather by misuse of resources.

Abuse is provider practices that are inconsistent with sound fiscal, business or medical practices resulting in unnecessary costs to the Medicaid program, or commercial health care program, or resulting in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes recipient practices resulting in unnecessary costs to the Medicaid program (42 CFR § 455.2), or commercial health care program.

Examples of fraud, waste and abuse include, but are not limited to:

1. Billing more than once for the same service
2. Billing for services never performed or provided
3. Performing inappropriate or unnecessary services
4. Providing lower cost or used equipment and billing for higher cost or new equipment
5. Using someone else's identity
6. Altering or falsifying pharmacy prescriptions

Reporting Fraud, Waste and Abuse

To report Fraud, Waste and Abuse, please contact MDwise at (866) 866-2135. This can be done anonymously. Report a Fraud, Waste and Abuse claim in writing to SIU@MDwise.org

False Claims Act

The Deficit Reduction Act of 2005 requires information about both the federal False Claims Act and other laws, including state laws dealing with fraud, waste, and abuse and whistleblower protection for reporting those issues.

Federal law prohibits employers from discriminating against an employee, in the terms or conditions of employment, because the employee initiated or otherwise assisted in a false claims action. Please direct employees to report a possible violation by contacting MDwise at (317) 822-7400.

XI - Medicare Member Rights

MDwise providers have a responsibility to recognize the specific needs of the membership, treat members in a mutually respectful manner, and ensure that members' rights and responsibilities are followed accordingly.

MDwise Members have:

1. The right to confidentiality.
2. The right to be treated with respect and dignity, including freedom from restraint and seclusion.
3. The right to a primary care provider at all times.
4. The right to receive culturally and linguistically appropriate services.
5. The right to receive covered benefits consistent with the MDwise contract with the state, and state and federal regulations.
6. The right to a current listing of network providers and access to a choice of specialists within the network that can treat chronic problems.
7. The right to get covered routine and preventive OB-GYN and pediatric covered services without a referral if the OB-GYN or pediatric specialist is a participating provider.
8. The right to receive Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC) services.
9. The right to be free from any form of restraint or seclusion used as coercion, discipline, convenience or retaliation.
10. The right to continue receiving services from a specialty provider who is no longer in the MDwise network if it is medically necessary.
11. The right for pregnant members to continue coverage with a provider who is no longer in the MDwise network, including up to six (6) weeks after they have their baby.
12. The right to no "gag rules" from MDwise. Doctors are free to discuss all medical treatment even if they are not covered services.
13. The right to participate in decision-making regarding their health care.
14. The right to refuse treatment, to get a second opinion and express preferences about treatment options.
15. The right to receive a copy of their medical record upon request, and request amendments or corrections.
16. The right to know how MDwise pays its providers, including incentive arrangements or financial risk.
17. The right to be provided with a telephone number and address to obtain additional information about payment methods, if desired.
18. The right to tell MDwise if they have a complaint about the care provided and the right to appeal a decision to deny or limit coverage.
19. The right to know that they or a provider cannot be penalized for filing a complaint or appeal about care.

20. The right to receive beneficiary information and information about the structure and operation of MDwise, including the services, providers of care and member rights and responsibilities.
21. The right to make suggestions regarding MDwise members' rights and responsibilities.
22. The right to have their medical record kept confidential by MDwise and their provider.
23. The right to be free from other discrimination is prohibited by state and federal regulations.
24. The right to be free to exercise their rights without adversely affecting the way MDwise, providers or the state treats them.

Members of MDwise have the following responsibilities:

1. To schedule appointments in advance and be on time. If a member needs to cancel an appointment with any doctor's office, call as soon as possible.
2. To use the hospital emergency room only for emergency care. If possible, a member should call their provider before going to the emergency room.
3. To give all the information that the member can to their providers and MDwise so they can be cared for in the best way.
4. To ask questions if the member does not understand the care they will be receiving.
5. To talk about their care and help their doctors plan what they will be receiving.
6. To complete the treatments that the member has agreed to and follow all plans of care.
7. To tell the MDHHS and Customer Service right away if there is any change in address or telephone number.
8. To help MDwise assist with the members' health care by telling us of any problems with services.
9. To tell MDwise suggestions in writing or by contacting Customer Service for assistance.
10. To carry the MDwise Member ID card at all times.

XII - HIPAA Notice of Privacy Practices

Members are notified of privacy practices as required by HIPAA. This notice includes a description of how and when medical information about members is used or disclosed and how members can access it. In addition, we take measures across our organization internally to protect members' oral, written, and electronic personal health information.

Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with regulation 45 CFR 164. For example, health care providers may disclose patient information to us for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank you for your assistance in providing the requested information to us in a timely manner.