MDwise
A McLaren Company
• Hoosier Healthwise
• Healthy Indiana Plan

ProviderLink

Fall 2020

In This Issue

Provider Appreciation

2020 has provided our world with a big challenge. MDwise wants to thank each of our providers for treating our members with professionalism and compassion. Every day you make a difference by doing what you do. Thank you for being a Hero.

Provider Access Guidelines

An integral part of patient care is making sure patients have access to needed medical care. In accordance with Office of Medicaid Policy and Planning (OMPP) policy and NCQA standards, MDwise establishes standards and monitors performance to help ensure MDwise members receive timely and clinically appropriate access to providers and covered services. For example, an initial appointment for a member, who is not a pregnant adult, should be within three months from the date the member requests the appointment.

MDwise also follows the OMPP-outlined timeframes for provider follow-up to members. For emergencies and urgent situations, members must be able to reach their PMP or designee by phone within 30 minutes, 24 hours a day, 7 days a week. The designee can be a person, or instructions for the member to call 911 if they believe they are experiencing a medical emergency. For non-urgent routine telephone messages, a return call must be made to the member within one working day.

For more information on these access requirements, visit the Quality page on our website.

Population Health Management Practitioner or Provider Support

Behavioral Health Provider Access Standards

It is important to note that our behavioral health providers are held to similar access standards as medical providers. Behavioral health care services include both mental health and substance abuse services for the members.

MDwise Hoosier Healthwise and Healthy Indiana Plan. **Behavioral health providers should adhere to the following time frames:**

- Non-life-threatening Emergency Care within six hours.
- Urgent Care provided within 48 hours.
- Routine Office Visits within 10 working days.
- Provisional access/after-hours care available 24 hours a day.

MDwise performs audits each year per the guidelines established by the State of Indiana, CMS and NCQA. Steps are taken to work with any provider that does not meet access and performance improvement plans are implemented. Services provided via telemedicine would help you meet these requirements during the public health crisis and are a great tool to add to your continuum of treatment options. If you have questions regarding behavioral health access standards, reach out to the MDwise Behavioral Health Specialist.

Medically Frail

Medically Frail is a program that may qualify HIP members for enhanced State Plan benefits if they meet specific criteria established by the state involving:

- Complex medical conditions.
- Disabling behavioral health disorders.
- Chronic substance abuse diagnoses.
- Social Security Disability.
- Impairment of specific activities of daily living.

Most members who qualify as **Medically Frail** are identified automatically through claims processing. Others are identified by a designated team that examines medical and pharmacy records, member interviews, and claims review.

State Plan benefits of a Medically Frail designation include:

- Expanded therapy limits.
- MRO services.
- Non-emergency transportation.
- Vision and dental coverage.

Providers may refer members to the **MDwise Medically Frail** program for assessment or members can self-refer by contacting MDwise customer service at **800-356-1204**. For frequently asked questions access the **FAQ Link**. For the referral form, access the **Referral Form Link**.

MDwise Quality Improvement Program

Areas in which MDwise improved (Measurement Year 2019):

- Lead screening in children.
- Medication management for people with asthma.
- Cervical cancer screenings for Healthy Indiana Plan (HIP) females.
- Controlling blood pressure (HIP adults).

For children, MDwise is still working to make improvements in 2020:

- Children and adolescents getting well visits and immunizations.
- All babies having a test for lead poisoning at 12 months of age and again at 24 months.
- Children having an annual dental visit.

For adults, MDwise is also working to improve in the following areas in 2020:

- All members, especially pregnant women, quitting tobacco use.
- Getting adults in for well care and the health screenings they need every year.
- Getting HIP adult members in for a follow-up appointment within 7 days of a mental health inpatient hospital stay.
- Members using the emergency room wisely.
- Diabetic members getting the tests they need and keeping healthy blood sugar levels and blood pressure.
- Improving early identification of pregnancy to ensure adequate prenatal care.

For providers, MDwise worked on the following projects in 2019:

- MDwise developed a Quality Toolkit for providers which is available on the MDwise Website (For Providers/Quality Toolkit).
- MDwise developed a Provider HEDIS manual also available on the MDwise Website (For Providers/HEDIS/Provider HEDIS Manual).

MDwise will work on the following for providers in 2020:

- Increase promotion of the Member Profile to all providers.
- Promote Lead testing education and testing kit options.
- Increase quality focus during provider visits through further integration with Provider Relations and Outreach staff.
- Continue outreach to behavioral health providers by assimilating into Provider Relations Department activities.
- Ensure antipsychotics are not being prescribed off-label for non-FDA approved indications
- A Provider CAHPS tip sheet (member experience with providers).

HEDIS Tips for Providers

The Healthcare Effectiveness Data and Information Set (HEDIS) 2020 project has officially come to an end. Thank you to all of our providers and office staff that sent in requested medical records. The HEDIS project would not be a success without your help!

We will be sharing HEDIS tips in quarterly ProviderLink newsletters to help you maximize your efforts. **This edition will focus on general tips and those for children.**

For all patients:

- Contact patients who are due for an annual preventive visit (physical, well-child visit, etc.) or are new to your practice. If you use Electronic Health Records (EHRs), consider using a flag to track patients due or overdue for visits or immunization(s). If you do not use EHRs, consider how you could create a manual tracking system.
- When possible, call patients several hours before appointments as a reminder, and include information about anything they might need to bring with them to the appointment. Ask for a commitment to make the appointment.
- The HEDIS measures related to blood pressure are ones that frequently prompt a medical record request since blood pressure is often not coded on claims. However, the HEDIS measure does count CPT II codes 3074F, 3075F, 3078F, 3079F and 3080F through claims. This can potentially decrease the number of record requests. Look for appropriate opportunities to code claims with the corresponding CPT II codes.

For children:

- Schedule six or more well-child visits before child turns 15 months old. It may also help to schedule the next visit at each appointment.
- Schedule two or more well-child visits after the child turns 15 months plus one day old and before the child turns 30 months old. It may also help to schedule the next visit at each appointment.
- For patients three-21 years of age, you do not need to wait 12 months between well-child/preventive visits. The start of a new calendar year marks the beginning of a new measurement year and all members are non-compliant.
- Consider making nutritional and weight management questioning and counseling routine and "document any advice given." Note nutritional behavior like appetite or meal patterns and eating/dieting habits. Note behaviors like exercise routines, participation in sports activities or bike riding.
- Make sure your records include height, weight and the BMI percentile as a value (e.g. 50th percentile) or plotted on an BMI growth chart for members younger than 20 on the date of service. BMI ranges and thresholds do not count towards HEDIS measure compliance; the measure requires a specific value (percentile).
- The HEDIS measure related to BMI percentile is one that frequently prompts a medical record request since BMI percentile is often not coded on claims. However, the HEDIS measure will count the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes Z68.51, Z68.52, Z68.53 and Z68.54 as compliant through claims, which decreases the number of record requests. Look for appropriate opportunities to code claims with the corresponding Z code.
- Consider creating a standing order for in-office lead testing for children ages 12 months to six years who haven't received previous lead screening. Note, a lead risk assessment questionnaire is not a compliant substitute for the lead screening HEDIS measure. Make sure records reflect both the date of the test and results or findings. Educate parents about the importance of testing, lead poisoning, potential sources of lead, pathways of exposure, how to avoid exposure and testing schedules. Develop a process to check medical records for lab results to follow-up on previously ordered lead screenings. Sick and well-child visits may also serve as chances to encourage parents to have their child tested.
- Recommend immunizations to parents. It is believed that parents are more likely to agree with vaccinations when supported by their providers. Address common misconceptions about vaccinations.
- Consider whether it would be appropriate to create standing orders for nurses and physician assistants in your practice to allow staff to identify opportunities to immunize.

Provider Claims Issues/ Dispute Process

All in- and out-of-network providers have the right to dispute a claim decision or action. The initial claim dispute must be filed within 60 days of the explanation of payment (EOP). When submitting a dispute, the dispute form, explanation of payment, and an explanation of the reason for disputing the claim should be submitted to **cdticket@mdwise.org**.

As of 1/1/2019 MDwise began utilizing a **Claim Adjustment Request Form** to lessen the rigidity of the dispute process. The Claim Adjustment Request form allows providers 90 days from the latest EOP to submit for reconsideration of a claim.

This does not replace the dispute process and is not a form that is all-encompassing for issues for reconsideration. This form is not available to providers for claims that have already initiated the dispute process. Providers may use this form for payment reconsideration if the claim was paid inappropriately or was denied. Providers who wish to request an adjustment should resubmit the claim on paper form along with supporting documentation and a completed Claims Adjustment Request form.

Supporting documentation is required when the claim was denied for a lack of authorization, member having primary insurance, claim being denied as duplicate or responding to an MDwise request for medical records. Once submitted, you will receive notification only if the denial will be upheld. If the Claim Adjustment Request Form has all necessary information to correct the initial outcome of the claim, it will re-adjudicate for appropriate payment.

Reminder: The following items are not considered a claim dispute and should not be sent via the dispute process: new claims, corrected claims, a MDwise request for medical records or attachments or a provider recoupment request.

For more information on the dispute process and to locate the Provider Dispute Form, go to **MDwise.org/for-providers/claims** and select the member program. You can also call **1-800-356-1204** to speak to a claims dispute representative.

Patient-Centered Medical Home

The Agency for Healthcare Research and Quality recognizes that revitalizing the nation's primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans. The **primary care medical home**, also referred to as the **patient centered medical home** (PCMH), **advanced primary care**, and the **healthcare home**, is a promising model for transforming the organization and delivery of primary care.

5 Attributes of a PCMH:

1. Comprehensive Care.
2. Patient-Centered.
3. Coordinated Care.
4. Accessible Services.
5. Quality and Safety.

Shifting your practice toward a PCMH may seem daunting, but help is available! The **Agency for Healthcare Research and Quality's PCMH Resource Center** includes free tools, white papers and resource guides about implementing a PCMH.

Want to do a deep dive into implementing a PCMH? Check out **pcmh.ahrq.gov** for more information.

References:
Agency for Healthcare Research and Quality (2020). Defining the PCMH

Distribution of Member Rights

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

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 members have the right to:

- Be treated with dignity and respect.
- Personal privacy. We keep medical records confidential as required by law.
- Be provided with information about MDwise, its services, its doctors and other health care providers and members' rights and responsibilities.
- A clear explanation of their medical condition. The member has a right to be part of all treatment decisions. Options should be discussed with the member no matter what they cost or whether they are covered as a benefit.

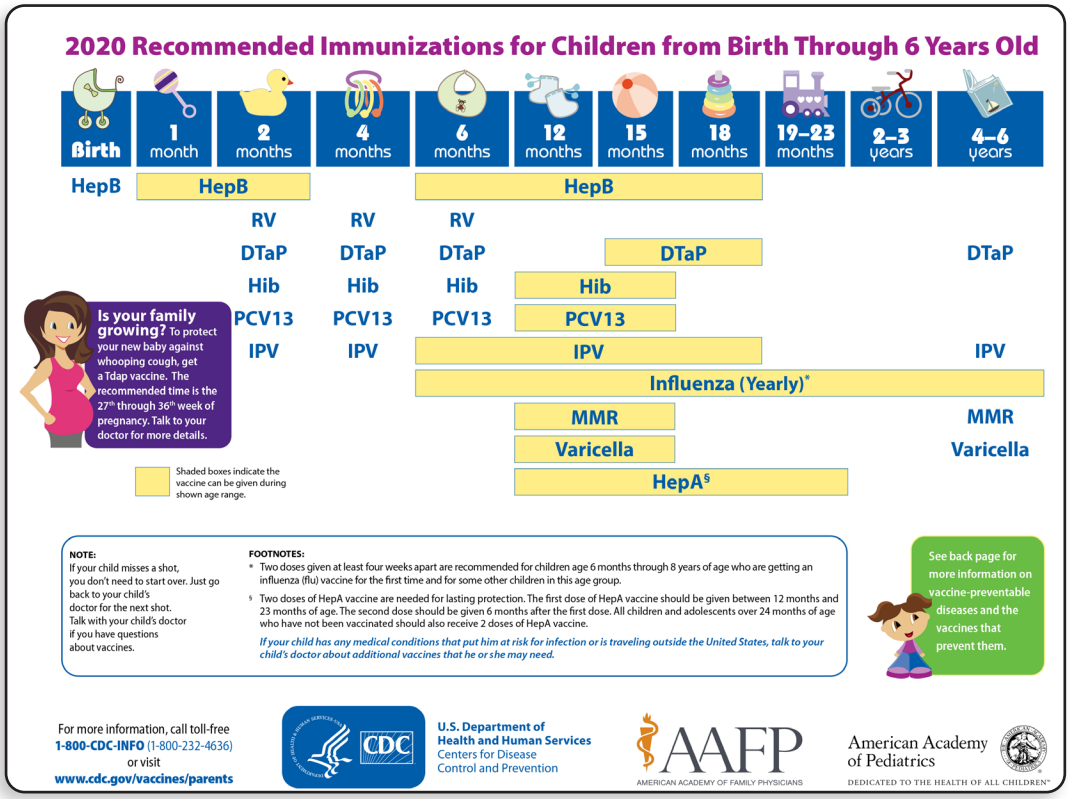
In addition, members have the right to:

- Change their doctor by calling the MDwise customer service department.
- Timely access to covered services.
- Appeal any decisions we make about their health care. The member can also complain about personal treatment they received.
- Get 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.
- Request information about the MDwise organization and operations.
- Refuse care from any doctor.
- Ask for a second opinion, 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 to get services 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, in the case of insolvency, members do not have to pay any more for covered services than what they would pay if MDwise provided the services directly.

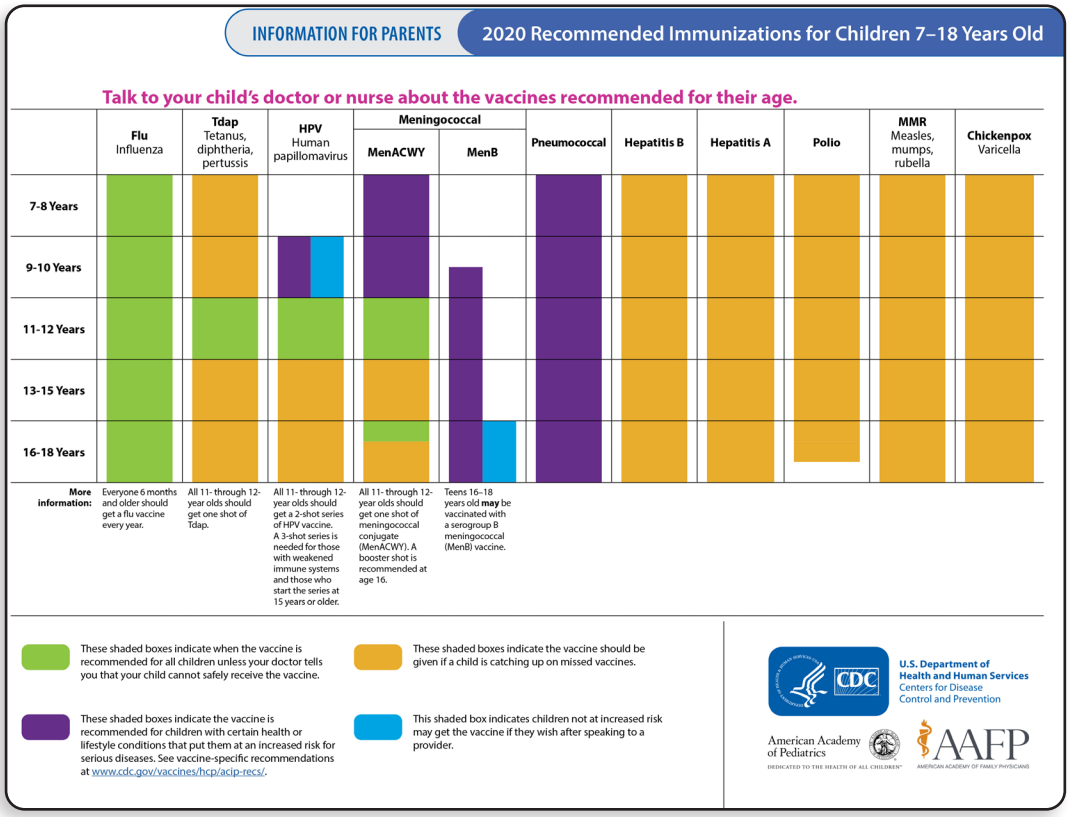
Through the MDwise member handbook and member newsletter, each MDwise member is advised of his or her rights and responsibilities. When the MDwise member is a child, the above list of rights and responsibilities apply both to the child and the child's parent or guardian. All of the above rights also apply to the designated personal representative of the member.

Immunization Schedule

Birth to 6 years.



7 to 18 years.



Pay for Outcomes

Physician Pay for Value (P4V) Program

MDwise is committed to providing high quality, cost-effective health care to our members. By establishing our P4V Program, MDwise will maintain a strong partnership with our PMPs, resulting in improved quality and access to health care services. The goal of the program is to improve access and health outcomes for all members.

Effective January 1, 2019 the **MDwise Pay for Outcomes** (P4O) program was replaced with the **MDwise Pay for Value Program** (P4V).

MDwise is preparing payments to eligible provider groups. This is for their performance in 2019. The awards for 2019 performance recognized eligible provider groups who **performed well on these key measures:**

1. Well-Child (W34)
2. Behavioral Health (FUH)
3. Timeliness of Prenatal Care (PPC)
4. Pharmacy (GDR-BH)
5. Ambulatory Care (AMB)
6. Preventive Care (AAP)
7. Postpartum (PPC)

Availability of Utilization Management Criteria

MDwise is an NCQA-accredited organization and complies with all NCQA Utilization Management (UM) standards including UM 2 regarding criteria availability. Please remember that if you receive notification of an adverse decision, which includes the determination to deny, modify or reduce the services for which you requested authorization, you may request the clinical guideline or criteria that was applied to make the decision by calling the **Medical Management** department. The **Medical Management** staff will work with you to provide you with the guideline or criteria in the method that is most acceptable via fax, email, phone or mail.

HHW-HIPP0675 (8/20)

Vision Eligibility Form

MDwise has a new way of sending in the vision eligibility request forms. You can email the request forms to visioneligibility@mdwise.org. Please allow up to two business days for response. Your responses will be worked in the order they were received. To avoid duplicate requests, please allow up to the maximum days for response. If you have not received a response, you may contact our MDwise Customer Service team at 1-800-356-1204 and select the appropriate prompts for vision eligibility requests.

HIP Power Account Contribution and Copayments

Your patients are not responsible for their copays or POWER Account payments during the COVID-19 pandemic. They will receive a 60 day notice before their payments or copays are due.

1-800-356-1204 or 317-630-2831
Hoosier Healthwise and HIP

MDwise.org/providers

Visit MDwise.org/providers for additional information and tools for providers.

HIP HEALTHY INDIANA PLAN

Hoosier Healthwise
Support & Services for Pregnant Women, Babies, Children & Teens

MDwise
A McLaren Company
MDwise.org

Connect with us!

facebook.com/MDwise
linkedin.com/company/MDwise-inc-
twitter.com/MDwiseInc
@MDwiseInc