Changes to the Care Select Program Announced

The Indiana Family and Social Services Administration (FSSA) announced that beginning October 1 the scope of the state’s Care Select program will change to focus on disease management, specifically for members with chronic conditions.

"These changes will allow us to focus on members with chronic conditions, while at the same time providing benefits and services to all of our Medicaid recipients," said Pat Casanova, Director of Indiana Medicaid. "Disease management will help patients with chronic illnesses lead healthier and more productive lives."

Beginning in October, eligible members with asthma, diabetes, congestive heart failure or coronary heart disease, hypertension, chronic kidney disease, severe mental illness and depression will have the option to participate in disease management programs the Care Management Organizations (CMOs) provide for their chronic conditions. Members can choose to opt-out at any time and transfer to traditional Medicaid. Home and Community Based Services (HCBS) waiver members will be enrolled in traditional Medicaid. HCBS waiver individuals receive case management services through the waiver.

About 32,000 Medicaid members will be eligible for the disease management program. Currently, Care Select has 73,000 members. Members who are no longer eligible for Care Select will continue to receive traditional Medicaid. Care Select participants will be notified of changes by the end of August.
What are the Duties of a PMP Who Has a MDwise Member in the Right Choices Program?

It is important to understand that when a member has been placed in the MDwise Right Choices Program they have been identified as over-utilizing, and in some cases abusing, Medicaid services. When a member is placed in the Right Choices Program, they will be assigned to a Care Manager who will communicate with them regularly about their program.

The role of the PMP is to continue to provide health care services to the member. None of the services are limited by being in the Right Choices program. When the PMP determines that a referral to a specialist is appropriate, a written referral is needed for the specialist and the MDwise RCP Administrator. The RCP Administrator will add this specialist to the list of approved providers for this MDwise member. This list of providers, who are authorized to provide services to the member, will be placed on the Web Interchange. The referral can be valid for up to one year, so subsequent referrals do not have to be made. The PMP is encouraged to make referrals to all specialists that he/she feels the member may require.

If the specialist is not on the list, the service will not be paid by MDwise. If an urgent referral is necessary, contact the MDwise RCP Administrator. The MDwise RCP Administrator can be reached at 1-800-356-1204. The fax number is 317-829-5530.

For more information about the Right Choices Program go to www.MDwise.org.

Integrated Care in Indiana Seminar

If you are a Health Care Provider or Representative looking for the latest information on integrated healthcare, you’ll want to attend the Integrated Care in Indiana Seminar on November 12, 2010. Free continuing education units will be provided for mid-level behavioral health providers. For medical providers, free continuing medical education credit will be offered. For more information and to register, please visit www.MDwise.org.

Continuing Education Opportunity


Release Date: Jan 2008
Credit Expiration Date: December 2010

The purpose of this free on-line continuing education program is to assist health professionals in increasing their awareness of the three main factors that affect their communication with patients and how to implement patient-centered communication practices that demonstrate cultural competency and appropriately address patients with limited health literacy and low English proficiency.

- For Physicians: 5 AMA PRA Category 1 Credits™
- For Nurses: 5 Contact Hours
- For Pharmacists: 5 Hour Credits
- For Physician Assistants: 5 Hours of AAPA Category 1 CME
- For Certified Health Education Specialists: 5 Category 1 Contact Hours
- For Health Science Information Professionals: 5 MLA Continuing Education Contact Hours

To register, please visit the Web site, www.ncqa.org/education and select online programs.
Implications of Poor Health Literacy

The limited ability to read and understand health-related information often translates into poor health outcomes. Literacy is one of the strongest predictors of health status. All of the studies that have investigated poor health literacy report that literacy is a stronger predictor of an individual’s health status than income, employment status, education level, and racial or ethnic group.

Patients with limited health literacy have less awareness of preventive health measures and less knowledge of their medical conditions and self-care instructions than patients with more reading and comprehension skills.

While it is difficult to identify patients with poor literacy skills, there are some “red flags” that may provide some clues as to a patient’s comprehension.

Behaviors and responses that may indicate limited literacy are:

- Patient registration forms that are incomplete or improperly completed
- Frequently missed appointments
- Noncompliance with medication regimens
- Lack of follow-through with laboratory tests, imaging tests, or referrals to consultants
- Patients say they are taking their medication, but lab tests or physiological parameters do not change in the expected fashion.

Some physicians have found it helpful to add a question about literacy skills to the social history. After asking about education and occupation, they add “How happy are you with the way you read?” or “What is the best way for you to learn new things?” These types of questions give the patient an opportunity to discuss the problem if desired.

An additional method for identifying patients with limited health literacy is to ask them to bring in all the medications they take at the time of their appointment, both prescription and non-prescription. When the patient comes to the office, the clinician or other medical staff can conduct a medication review by asking the patient to name the medication and explain what it is for and how they take it.

Scheduling an Appointment for a Patient With Poor Health Literacy Skills

When patients call the office to make an appointment, a person should answer the phone – not a machine asking the patient to select numerical options. Ideally, the person answering the phone should be able to converse with the patient in the patient’s language.

Information collected on the phone should include only what is needed to process the appointment and expedite office flow. It should omit nonessential information or information that duplicates what others will ask later.

Ask if the patient needs directions to the office. For first-time patients, offer to send (or fax or email) directions to the office.

Finally, help patients prepare for the visit by asking them to bring all their medications and to make a list of the questions they wish to ask. Let them know that they are welcome to have someone accompany them to the visit and be part of the discussion.
Prior Authorization for Health Care Services

Prior authorizations for health care services can be obtained by contacting the medical management department by phone or fax (information found on the quick contact sheet). Copies of prior authorization forms can be found on the Web site.

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

Authorizations may be required prior to services being rendered to:

- Verify services are covered by the benefit plan.
- Coordinate timely access to appropriate clinical care
- Verify out-of-plan referrals are appropriate.
- Efficaciously manage the utilization of health care services (including limited resources per benefit imitations).
- Implement timely discharge planning and coordination of services.
- Identify members with special health care needs, high risk individuals or populations for care coordination and case management/disease management intervention.

Authorization Procedural Guidelines

Authorization request for those services requiring prior authorization are submitted by calling or faxing the designated form to the delivery system medical management to which the member belongs. Requests should be submitted for review within a reasonable time frame prior to proposed service date.

Information submitted with service request will include demographic information, type of care, frequency and duration if applicable, facility or provider, diagnosis, procedure, date of service or onset date of services, and other pertinent clinical information required to support medical management decisions and benefit coverage determinations.

If additional information is required before the Medical Management staff can make a determination, the prior authorization request will be pended with a request for additional information.

Pre-service (prior authorization/precertification) requests for non-urgent care and retrospective reviews may be denied on the basis of lack of information when unsuccessful in obtaining the necessary information requested to make a decision as outlined in this procedure.

The reply to the prior authorization request will communicate the authorization decision to the PMP and SCP/other provider, as applicable. The communication will note the approved services and the effective time frame or non-authorized services and the reason for denial of service and alternative care options and appeal rights, as applicable.

MDwise Incentive Affirmation Statement

Prior Authorization decisions are based only on appropriateness of care and service and existence of coverage. Compensation plans for physicians and staff
who conduct medical management determinations do not contain incentives or rewards, directly or indirectly, for issuing denials or that encourage decisions that result in underutilization or barriers to care and service.

Qualified Medical Management Staff
Qualifed Medical Management staff with the required knowledge and skills to assess clinical information used to support medical management decisions will perform first-level medical management determinations. MDwise employs current licensed nurse reviewers whose education and experience meet the job qualifications to perform the initial review of the clinical information against criteria.

A specialized behavioral health team of clinical case managers are responsible for the day to day medical management functions surrounding the delivery of behavioral health services including service review determinations and coordination of physical and behavioral health care needs. Behavioral health care managers are comprised of licensed behavioral health care professionals, such as board-certified psychiatrists, psychologists, and master level nurses and clinicians who reach utilization management decisions based on safe and quality driven standards and practices.

A physician, appropriate behavioral health professional, dentist, or clinical pharmacist, as appropriate, reviews any denial of services based on medical necessity. Qualifications for practitioners who review denials of care based on medical necessity include education, training or professional experience in medical or clinical practice and current U.S. license to practice without restriction.

Behavioral health practitioners, including psychiatrists, doctoral-level clinical psychologists or certified addiction-medicine specialists review denials of behavioral health care based on medical necessity.

Board-certified physicians may be utilized to provide specialty expertise in the medical necessity review of individual cases.

MDwise requires that all practitioner consultants used in the review of grievances, appeals and claims disputes meet established credentials criteria. The criteria evaluates whether such practitioners have the required knowledge and skills to assess clinical information provided in the review of member and provider appeals of a MDwise determination.

It is a MDwise practice to make the reviewer available to the treating or attending provider to discuss any medical management denial decision. This can be accomplished by calling the appropriate UM Department on the contact sheet or calling MDwise Customer Service and asking to be connected with the Delivery System UM Department. The MDwise Customer Service Department can be reached by calling 800-356-1204 or 317-630-2831.

Please Note: Eligibility must be checked every time a service is rendered. Failure to do so may result in denial of payment. Prior authorization of a referral/service is not a guarantee of payment, for example if benefits expired prior to service date. The practitioner/provider must always check member eligibility at the time of service during the referral/authorization time period to avoid denial of payment for services provided due to member no longer being eligible on date of service.

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MDwise Clinical Practice Guidelines
Clinical Practice Guidelines can be accessed on the provider section of our Web site at www.MDwise.org. A printed copy of the guidelines posted to our Web site is available by calling us at 1-800-356-1204 or 317-630-2831 if you are in the Indianapolis area.

The guidelines include:
- Asthma
- Chronic Kidney Disease*
- Chronic Obstructive Pulmonary Disease*
- Congestive Heart Failure*
- Coronary Artery Disease*
- Diabetes

* New - June 2010
Diabetes in Pregnancy

When the physician or practitioner writes “diabetes” in the medical record, be very sure you select the correct code(s). In auditing practices over the years, there has been a lot of confusion in this area.

For example, consider diabetes mellitus and gestational diabetes—two different conditions with separate diagnosis codes. Diabetes mellitus is a significant complicating factor in a pregnancy. Report diabetes mellitus (defined as diabetic pre-pregnancy) with the primary diagnosis code 648.0x Diabetes mellitus complicating pregnancy, and a secondary code from category 250 Diabetes mellitus, or category 249 Secondary diabetes mellitus to identify the type of diabetes. If the diabetes mellitus is treated with insulin, assign V58.67 Long-term (current) use of insulin, as well.

Gestational diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus.

Don’t Miss an Opportunity to Provide Well Child Care!

While most MDwise members under age 7 are seeing their doctors, some are not receiving well child care – at least as reflected by claims submitted to MDwise.

Some things to remember:

- A well care visit is defined by a preventive medicine evaluation and management (E&M) code (99381-99385, 99391-99395) or a preventive exam diagnosis code (V20.2, V70.0, V70.3, V70.5, V70.6, V70.8).
- The Indiana Health Coverage Programs (IHCP) recently clarified the policy and billing requirements regarding problem-oriented exams rendered on the same date as an EPSDT annual exam or a well-baby exam. According to Banner Page BR200538 released on September 20, 2005, the Health Watch Provider Manual states, “If a patient is evaluated and treated for a problem during the same visit as an EPSDT annual exam or well child service, the problem-oriented exam can be billed separately accompanied by the 25 modifier (separate significantly identifiable E&M service). The problem must require additional moderate level evaluation to qualify as a separate service on the same date.”

Some providers have interpreted this statement from the Manual to mean that Evaluation and Management (E&M) codes 99211, 99212, or 99213 could not be reimbursed if provided on the same date as the EPSDT annual or well-baby exam. This is incorrect.

IHCP (which MDwise follows) will reimburse for all E&M codes billed by a physician who is providing a problem-oriented exam on the same date as the EPSDT annual or well-baby exam. This would include E&M codes 99211 through 99215. These services should be billed with modifier –25 to identify a separate significantly identifiable E&M service.

- Using the 25- modifier does two important things – it gives credit for well care visit provided and it increases reimbursement for a lengthier visit.

Providing well care during a sick care visit is often challenging to schedule. If your staff thinks of well child care like they do childhood immunizations, parents calling for sick visit appointments can be scheduled for additional time if their children are also in need of well care. As with immunizations, the key is to never miss an opportunity to provide well child care.

Text4baby

Pregnant women have the opportunity to receive free text messages on their cell phones to help them through their pregnancy and their baby’s first year: All they need to do is text BABY to 511411.

Text4baby is an educational program of the National Healthy Mothers, Healthy Babies Coalition. For more information, please visit www.text4baby.org.

It also puts a woman at greater risk of developing diabetes after the pregnancy. Gestational diabetes is coded 648.8x Abnormal glucose tolerance. Assign code V58.67 also if the gestational diabetes is treated with insulin.

For the preceding examples, you would report two or three ICD-9-CM codes. By coding in this manner, you are providing payers with the most accurate diagnosis on this patient. In some instances, this assists you in obtaining necessary authorizations for serial antepartum testing and other services.”
Provider Access Guidelines

An integral part of patient care is making sure patients have access to needed medical care. In accordance with the Office of Medicaid Policy and Planning (OMPP) policy, MDwise establishes standards and performance monitors to help ensure MDwise members receive timely and clinically appropriate access to providers and covered services. MDwise standards, as outlined below, address access to emergency, urgent and routine care appointments, after-hours care, physician response time, office appointment wait time, and office telephone answering time.

Please keep in mind the following access standards are for differing types of care. MDwise providers are expected to have procedures in place to see patients within these timeframes.

MDwise encourages all new members to have a PMP visit within 90 calendar days of when they became effective with MDwise. This helps to ensure that our members receive necessary preventive and well care. It also helps in identifying the medical needs of our members early so that a plan of treatment can be established, including referrals to MDwise case management or disease management programs.

Please help us by accommodating our new members within this 90-day timeframe if they call for an office visit.

PMP Access Standards

<table>
<thead>
<tr>
<th>Appointment Category</th>
<th>Appointment Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent/Emergent Care Triage</td>
<td>24 hours/day</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>24 hours/day</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>24 hours/day</td>
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<tr>
<td>Non-Urgent Symptomatic</td>
<td>72 Hours</td>
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<tr>
<td>Routine Physical Exam</td>
<td>3 Months</td>
</tr>
<tr>
<td>Initial Appointment (Non-pregnant Adult)</td>
<td>Within 1 month from date calling for appointment/date of assignment notification</td>
</tr>
<tr>
<td>Routine Gynecological Examination</td>
<td>3 Months</td>
</tr>
<tr>
<td>New Obstetrical Patient</td>
<td>3 Months</td>
</tr>
<tr>
<td>Initial Appointment Well Child</td>
<td>Within 1 month from date calling for appointment/date of assignment notification</td>
</tr>
<tr>
<td>Children with Special Health Care Needs</td>
<td>1 month</td>
</tr>
</tbody>
</table>
All MDwise participating providers must adhere to the following medical records standards:

Office has defined practice/written guidelines for:
1. Maintaining confidentiality of patient information
2. Release of information (form/process)
3. Telephone encounters (includes physician notification and documentation in medical record)
4. Filing/tracking of medical records within the office/system
5. Organization of medical records
6. Protection of record from public access
7. Maintenance of record for each individual patient
8. Patient record available at each encounter
9. Requesting records of care received as inpatient (hospital discharge summary), in ER or as outpatient.
10. Providing copy of patient’s medical record upon reasonable request by member at no charge.
11. Facilitating the transfer of patient’s record to another provider at the member’s request.
12. Facilitating communication between primary care physician and behavioral health provider.
13. Maintenance of records for at least seven years.

**Medical Record Review Criteria**

1. Patient name or ID# on each page of record.
2. Personal/biographical data are present in record (address, employer, home and work phone number, marital status).
3. Entries are signed by authorized personnel. (Author identification may be handwritten signature, unique electronic identifier or initials.)
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses & medical conditions are indicated on problem list.
7. Current medication list is maintained and easily accessible.
8. Allergies & adverse reactions are prominently noted in record. If member has no known allergies or adverse reactions, notation of such is documented in record.
9. Past medical history (for patients seen 3 or more times) is noted and easily identified. History notation includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), history relates to prenatal care, birth, operations and childhood illnesses.
10. Information regarding use of tobacco, alcohol and substance abuse for patients 10 years and older is documented in record.
11. Record (history and physical exam) identifies appropriate subjective & objective information pertinent to presenting complaint(s).
12. Labs and other studies are ordered as appropriate.
13. Working diagnoses are consistent with findings.
14. Treatment plans/plans of action are consistent with diagnoses.
15. Encounter form or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time is noted in days, weeks, months, or as needed.
16. Unresolved problems from previous visits are addressed in subsequent visits.
17. There is evidence of appropriate utilization of consultants (specialists)(review of under- and over- utilization).
18. Record contains consultant note whenever consultation is requested.
19. Consultation, lab and imaging reports filed in the chart reflect review of ordering practitioner by evidence of such person’s initials on reports.
20. Record includes reports of specialty referrals, inpatient (discharge summary), emergency care and outpatient services (diagnostic and ancillary services)
21. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
22. Immunization record for children is up to date or an appropriate history noted for adults.
23. There is evidence that preventive screening and services are offered in accordance with the practice/preventive care guidelines.
24. Discussion and documentation of Advance Directives for every patient 21 years and older. If an advance directive has been executed, a copy should be present in the medical record.
25. Missed appointments and any follow-up activities are documented in the medical record.
Grievance and Appeal Procedure For Hoosier Healthwise and HIP Members

Any MDwise member that does not agree with an answer they receive to a complaint or a MDwise decision, has the right to ask for further review of the issue. A member can request review of any health care decision and/or personal treatment received.

The MDwise review system includes a grievance and appeal process as well as expedited review procedures and access to the State’s fair hearing system. MDwise also offers members the opportunity to request an expedited review of their grievance or appeal and has an external review procedure in cases where members are not satisfied with the appeal resolution. Grievances and appeals are processed in accordance with State and Federal law and OMPP guidelines. In the processing of member grievances and appeals, MDwise assists members in completing the necessary procedural steps. This includes providing interpretive services and the toll-free MDwise customer service line.

All MDwise member grievances and appeals are reviewed by individuals who were not involved in making the original decision resulting in the grievance or appeal. As necessary, input on the grievance/appeal is obtained by a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment (medical necessity grievances only).

According to federal regulations, MDwise may not take punitive action against a provider who requests an expedited resolution or supports a member’s appeal.

Definitions

Appeal – The term appeal is defined as a request for review of an action. An action, as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, as defined by the State
- Failure of an MCO to act within the required timeframes.
- For the resident of a rural area where MDwise is the only contractor, the denial of the member’s request to exercise his or her right, under CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable).

Grievance – The term grievance, as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an “action” as defined above.

Response Time Frames

All Grievances must be resolved and communicated to members in writing within 20 days. If the Grievance involves an adverse decision (e.g. Member is not permitted to change their PMP) the member may then appeal the grievance decision and must be provided with appeal rights in their follow-up letter. If the member is not happy with that adverse decision they can appeal. It is then processed as an appeal according to MDwise Policy # MS 02.

In the event of a clinically urgent situation, MDwise makes every attempt to resolve the matter as quickly as possible, but no longer than 48 business hours with a grievance and 72 hours with an appeal. These are considered “Expedited” grievances and appeals.

An appeal will be resolved as expeditiously as possible and with regard to the clinical urgency of the appeal.

- MDwise responds to all oral and written appeals with three (3) business days of receiving the request. The appeal must be resolved within 20 business days of appeal receipt and written notification of the appeal resolution must be sent to the member within five (5) business days after the decision is made. If the member requests an extension, or if MDwise is unable to make a decision within twenty (20) business days because additional information is needed either from the provider or member that has been requested, but not provided, the member is notified before the 20th day of the delay. MDwise provides the member with written notice of the delay, demonstrating in the notice that the extension is in the member’s best interest and that a decision will be granted within ten (10) additional business days.

- Expedited appeals meeting MDwise criteria are reviewed by the Medical Director and resolved within 48 hours of receiving the request and the attending physician and member are notified immediately by telephone. A written confirmation of the decision is also sent by mail to the member within 48 hours of notification.

- MDwise responds to all requests for external review, within three business days of receiving the request for an IRO review. A standard external review must be resolved within 15 business days after the review is requested. An expedited external review must be resolved within 72 hours of receipt of the request. For a standard review, the member is notified within 72 hours of the IRO panels’ decision. For an expedited review, the member must be notified within 24 hours of the IRO panel decision.

Members are provided with information on how to submit a grievance or appeal in the MDwise member handbook given to each member upon enrollment. In accordance with State law, MDwise also requires providers to post a brief statement of the member’s right to file a grievance with MDwise (including the toll free telephone number) in each location where health care services are provided by or on behalf of MDwise.

A member may request continuation of services during the grievance and appeal process if an authorized service is being terminated, reduced or suspended before the expiration of the original authorization date.

Please Note: You may request additional information regarding MDwise’s member grievance and appeal procedure by calling the MDwise Customer Service Department or by referring to the MDwise Provider Manual, Chapter 26, at www.mdwise.org. MDwise will not penalize providers in any way for requesting an expedited grievance/appeal resolution or supporting a member’s appeal.
MDwise Quality Improvement Program

MDwise has a Quality Improvement (QI) Program to monitor and evaluate the health care services used by our members. Services are monitored to see that they meet quality guidelines, are appropriate, are efficient and are effective. The Quality Management Team (QMT) with input from the Medical Advisory Council and the various QI Program Subcommittees oversee the QI Program. The QMT is made up of executive leadership and health care professionals. Each year, the QI Program sets goals to improve member health outcomes and services, and conducts activities to meet the goals.

Goals
The overall goal of the QI Program is to provide high quality and safe clinical and behavioral care and services to all members. To meet this goal, the QI program manages and analyzes data and takes action to manage risks.

Evaluation
Each year, MDwise evaluates the QI Program to see how well it meets its goals. We look at all parts of the QI Program, including clinical, behavioral and service activities. The evaluation includes suggestions to improve the QI Program and goals for the next year. It also identifies the resources needed to meet the goals and objectives.

Accomplishments for 2009 QI Program:
- NCQA New Health Plan (NHP) Accreditation was earned by MDwise’s Hoosier Healthwise product line.
- MDwise Network Improvement Program (NIP) Team was created and immediately began providing needed and desired assistance to our providers. NIP is a comprehensive program designed to improve the quality and utilization of healthcare services rendered to MDwise members.
- MDwise maintained its Reach Out for Quality (ROQ) incentive program for its delivery systems in 2009. Delivery systems met 81% of their goals among 14 measures (HEDIS Measures) for the ROQ year, most at the 100% level which was an improvement.
- ManagedCare.com (MCC), the web-based comprehensive reporting application, was put into operation and utilized to manage and track member populations.
- Primary care-behavioral health integration grants were awarded by MDwise across the state engaged growing numbers of providers in transforming how behavioral health care is delivered.
- Member Satisfaction (HEDIS CAHPS) Adult and Child showed significant improvement in health plan satisfaction when compared to its 2008 Summary Rate.
- Scores for the 2009 Provider Satisfaction Survey were up by nearly 14%.
- Groundwork was established for the new Customer Relationship Management (CRM) system that will house member and provider data to support functions within Customer Service and Outreach, Provider Relations, Medical Affairs and Quality Improvement, Compliance, and Information Services departments.
- MDwise, with assistance from the Indiana Health Information Exchange (IHIE), identified members seeking ER services for non-emergent reasons or for services that could have been managed by the PMP. MDwise employed Member Advocate interventions which demonstrated a reduction of ER usage when interaction and education with the member occurred.
- Metrics used by MDwise to measure the efficacy of our asthma and diabetes programs trended upward.

Program Goals for 2010 are to:
- Maintain momentum with the MDwise Well Child First Campaign
- Develop an analogous prenatal/postpartum campaign
- Continued outreach to BH inpatient and outpatient providers on FUH
- Redouble efforts to impact diabetes measures through provider and member interventions
- Incorporate care gaps into new CRM
- Expand role of MDwise Network Improvement Program Team
- Disease management
- Prenatal/postpartum care
- CAHPS and smoking cessation
- ER utilization
- Practice management
- Quality improvement tools (PDSA)
- Pilot and roll-out of provider access through ManagedCare.com
- Develop disease registries including stratification criteria and outcomes measures in ManagedCare.com
- Coordination with Behavioral Health providers in roll-out of MRO Benefit packages
- Implementation of Customer Relationship Management (CRM) System
- Develop disease registries including stratification criteria and outcomes measures in ManagedCare.com
- Coordination with Behavioral Health providers in roll-out of MRO Benefit packages
- Implementation of Customer Relationship Management (CRM) System

Information on the QI Program and evaluation report is available on the Web site at www.MDwise.org. A paper copy of the QI Program information is available upon request by contacting MDwise Customer Service at 1-800-356-1204 or 317-630-2831.
Chances are as a PMP, you may be treating many children with ADHD in your practice.

MDwise knows that a majority of children currently being treated for ADHD receive medication from their primary care provider. It is vital that PMPs begin utilizing evidenced based practices for ADHD in order to effectively assist these children.

Where can I find information about best practices for diagnosing and treating ADHD?

MDwise has established a one page Clinical Care Guideline for ADHD that is similar to the guide established by the American Academy of Pediatrics (AAP). You can find the MDwise guideline at www.MDwise.org/hoosierhealthwise/providers/behavioral.html.

Additional resources can be found on the American Academy of Pediatrics Web site at www.aap.org/healthtopics/adhd.cfm. The AAP offers an ADHD toolkit for primary care physicians. It includes school communication forms, an ADHD treatment plan, and Vanderbilt Rating Scales.

One best practice is the use of standardized rating scales in diagnosing ADHD, as well as for checking medication effectiveness. MDwise has posted the Vanderbilt Parent and Teacher Rating Scales on our Web site at www.MDwise.org/hoosierhealthwise/providers/behavioral.html. We plan on adding additional resources for treating ADHD in the near future.

When should a PMP refer a child with ADHD to a Behavioral Health Provider?

Many children with ADHD respond very well both at home and school when taking stimulant medication alone. These children typically come from stable homes, are free of other behavioral health diagnoses such as oppositional defiant disorder, anxiety disorder, or depression, and do not have learning disabilities or other psychosocial issues.

If a child does not seem to be responding well to medication alone, it may be time to refer to a behavioral health provider.

Most of the MDwise Behavioral Health providers have additional resource staff such as clinical social workers, case managers, and psychologists. These staff provide additional best practice services such as parent training and behavior management. They often work closely with the school system to meet the needs of these children. If your practice includes many ADHD children, you might consider collaborating with a behavioral health provider to provide these services in your office setting.

How do I find a Behavioral Health Provider close to my practice?

MDwise has recently updated the HHW Behavioral Health provider directory on the Web site. It is separate from the medical provider directory and can be accessed at www.MDwise.org/hoosierhealthwise/providers/behavioral.html on the behavioral health page or at www.MDwise.org/hoosierhealthwise/providerssearch/index.cfm on the provider search page. There is now a separate search (like the dentist directory) for behavioral health. If your staff has any difficulty using the directory, they can always contact customer service (1-800-356-1204 or in Indianapolis at 317-630-2831) for further assistance.
Clinical Care Guidelines for Major Depression in Children and Adolescents

Objective
To guide the appropriate diagnosis and treatment of Major Depression in children and adolescents.

Diagnosis & Assessment
DSM-IV-TR Diagnostic Criteria
>5 or more symptoms present during a 2 week period; (1) depressed mood and (2) loss of interest or pleasure and any three of the following:

1. Significant weight loss or decrease in appetite
2. Insomnia or hypersomnia
3. Psychomotor agitation or retardation
4. Fatigue or lack of energy
5. Feelings of worthlessness or guilt
6. Decreased concentration or indecisiveness
7. Recurrent thoughts of death or suicide

In addition to the above DSM-IV criteria, children and adolescents may also have some of the following symptoms:

- Persistent sad or irritable mood
- Frequent vague, non-specific physical complaints
- Frequent absences from school or poor performance in school
- Being bored
- Alcohol or substance abuse
- Increased irritability, anger or hostility
- Reckless behavior

Symptoms cause significant distress or impairment in functioning.

Depression Scales such as the Beck Depression Inventory, Children's Depression Inventory or the Reynolds Adolescent Depression Inventory can be used to establish severity, baseline functioning, and to monitor the progress of treatment.

Screening and Evaluation
Clinicians should screen all children for key depressive symptoms including sadness, irritability and a loss of pleasure in previously enjoyed activities. If these symptoms are present most of the time, affect psychosocial functioning and are not developmentally appropriate, refer for a full evaluation.

A thorough evaluation for depression should include determining the presence of other co-morbid psychiatric and medical disorders, interviews with the child and parents/caregivers, and if an adolescent, try to meet with him/her alone. Additionally, collect information from teachers, primary care physician, and other social service professionals.

- Assess for Suicidal Ideation/Crisis
  1. If the patient has a plan, the means or has recently attempted, hospitalize.
  2. If the situation is unclear, refer to a behavioral health practitioner.
  3. Evaluate level of impulsivity and if patient can commit to not harming himself; seek help if the ideation becomes overwhelming.
  4. Refer to a psychiatrist or behavioral health professional if symptoms are severe, there are co-morbid conditions, there are significant psychosocial stresses, and/or substance abuse.

- Assess for presence of on-going or past exposure to negative events such as abuse, neglect, family psychopathology, family dysfunction, and exposure to violence.

- If a child or adolescent is discharged from an inpatient hospitalization, s/he needs to be seen by an outpatient behavioral health clinician within 7 days of discharge.

Treatment
- Treatment with medication should always include acute and continuation phases. Some children may require maintenance treatment.
• Each phase of treatment should include psychoeducation, supportive management, family and school involvement.

• Education, support, and case management appear to be sufficient for treatment of uncomplicated or brief depression.

• For children and adolescents who do not respond to the above or have more complicated depression, a trial of CBT and/or medication is indicated.

• Kennard, et. al. (2009) found that adolescents treated with a combination of an anti-depressant and CBT will remit earlier than those who receive either treatment alone and improvement is superior to that of both monotherapies.

• To consolidate the response to acute treatment and avoid relapse, treatment should always be continued for 6–12 months.

• Treatment should include the management of comorbid conditions.

• Progress in treatment should be monitored with rating scales such as the Beck Depression Inventory, Children’s Depression Inventory or Reynolds Adolescent Depression Inventory.

References

MDwise Welcomes New Chief Medical Officer

MDwise is pleased to announce that Dr. Caroline Carney-Doebbeling, MD, MSc, FAPM, has joined MDwise as Chief Medical Officer

In her role as CMO, Dr. Carney Doebbeling serves on the MDwise executive team and oversees several departments including Quality and Outcomes, Medical Management, Provider Relations, Care Management, and Clinical Data. Dr. Carney Doebbeling will develop new clinical and quality programs, set the strategic direction for member and provider engagement, and ensure that MDwise meets federal and state standards for all Medicaid programs. She serves as the liaison to clinical leaders in the MDwise delivery systems, and oversees prior authorization and clinical reviews and appeals.

Dr. Carney Doebbeling earned her medical and masters degrees at the University of Iowa College of Medicine. She is board certified in Psychiatry, Psychosomatic Medicine, and Internal Medicine. She has a longstanding academic career, with numerous peer reviewed publications, clinical and teaching awards, and editorial board activities. She served as the behavioral health consultant to Wellmark Blue Cross Blue Shield of Iowa and South Dakota, and most recently as Indiana Medicaid Medical Director overseeing quality and outcomes until 2010. She holds adjunct associate professorships of internal medicine and psychiatry at IU School of Medicine, is an affiliated investigator at the Regenstrief Institute, and an adjunct associate professor of epidemiology at the University of Iowa College of Public Health.

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