ProviderLink

Your Quarterly Connection to Smart Solutions For MDwise Providers

MDwise Pays Bonus to Top Performing MDwise *Care Select* Primary Medical Providers (PMP)

MDwise is pleased to announce that some PMPs in the MDwise *Care Select* program have earned a bonus for delivering important preventive care to MDwise *Care Select* members. MDwise is committed partnering with PMPs to improve the health of our members and supporting the state's preventive health goals. Last year, three areas in need of improvement were selected for bonus payments:

- Adolescent Well-Care

- Breast Cancer Screening

- LDL–Cholesterol Screening for Diabetics

PMPs were paid a bonus of $25 per well-child visit, breast cancer screening, or cholesterol screening rendered to qualified members on their MDwise *Care Select* panel. The payments are determined based on claims data received by MDwise for eligible members. MDwise appreciates the efforts of PMPs who advance the health and well-being of the *Care Select* population by providing needed preventive care services.

IN THIS ISSUE:

# Free Clinical Presentation at the Annual IHCP Seminar on October 27, 2011

For this year's Indiana Health Coverage Programs (IHCP) Annual Seminar, MDwise has partnered with the Project ICE team to offer a unique Continuing Education Unit (CEU) opportunity for clinical support staff, entitled *Supporting Providers Who Treat Indiana Medicaid Members with Diabetes and Intellectual and Developmental Disabilities*. Project ICE is a three-year program, funded through the Health Resources and Services Administration (HRSA) designed to improve the health and well-being of persons with mental illness and or intellectual disabilities who also manage diabetes. It is directed by a consortium of service providers that includes Anthony Wayne Services, MDwise, ADVANTAGE *Care Select*, and ASPIN. For more information on Project ICE, please visit **www.indianaprojectice.org**.

This educational opportunity will be offered on **Thursday, October 27, 2011 at Indianapolis Marriott East (7202 E. 21st Street, Indianapolis, Indiana 46219). Providers may choose the morning session from 9:30 a.m. to 11:30 a.m., OR the afternoon session from 1:30 p.m. to 3:30 p.m.** This educational opportunity is targeted towards direct support medical professionals, behavioral health case managers, clinicians, certified diabetes educators, nurses and any other health care professional who touches those impacted by diabetes and a mental illness or intellectual disability. Physicians and nurses are encouraged to attend but will not receive continuing medical education credits for their attendance. The training is free and is worth two (2) CEUs, and there is a $20 processing fee for the CEUs earned. Providers who wish to attend this session may sign up by calling MDwise at 317-822-7301.

Program Objectives:

At the end of this program, participants should be able to:

- understand best practices for diabetes management and strategies for patients,

- detect certain factors that cause diabetes complications for patients,

- understand the role the CMO Disease Manager can play in assisting with managing diabetes,

- learn the impact of some antipsychotic medications on weight gain and

- find additional resources to help assist patients in managing their diabetes.
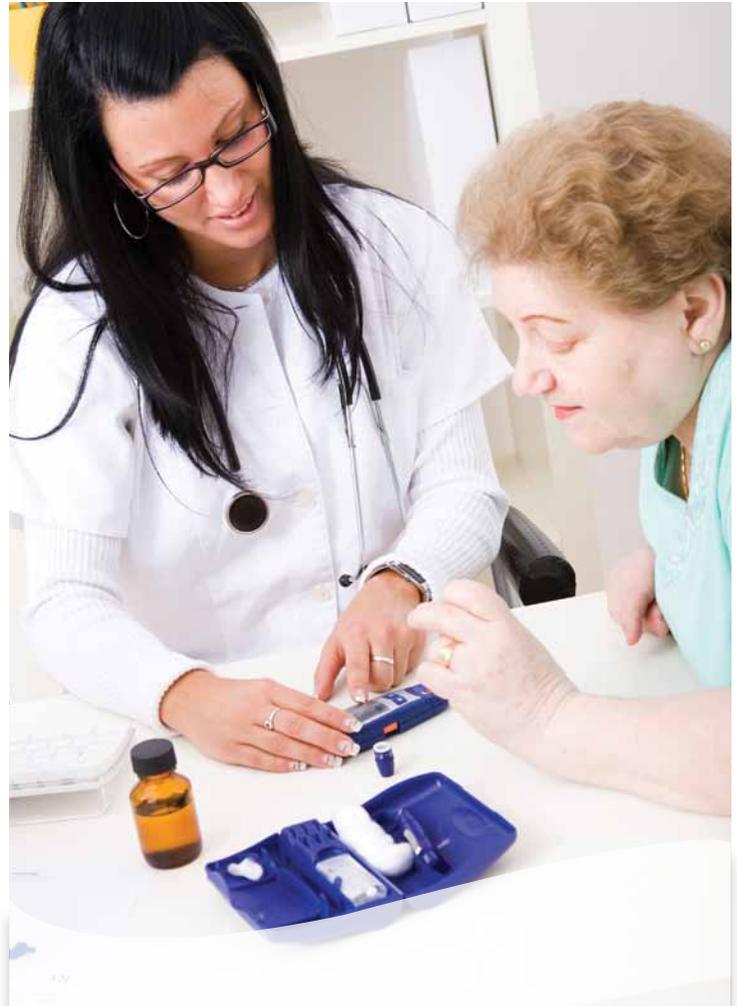
MDwise Behavioral Health Clinical Practice Guidelines Have Been Revised

Clinical Practice Guidelines can be accessed on the provider section of our website at MDwise.org.

A printed copy of the guidelines posted to our website is available by calling us at 1-800-356-1204 or 317-630-2831 if you are in the Indianapolis area.

School Immunization Requirements
By Jodi Morgan, Immunization Educator

The Centers for Disease Control and Prevention has identified immunization as one of the top ten public health achievements in the 20th century. School vaccination requirements helped with this accomplishment; in the years since school vaccination requirements were developed and routinely enforced, there has been a significant decline in the incidence of vaccine-preventable diseases among children, demonstrating the effectiveness of this practice. Immunization rates have improved, and this contributes to better community immunity and the overall better health of the population.

Go to **http://www.niaid.nih.gov/topics/pages/communityimmunity.aspx** for more information.

The first school vaccination mandates in the U.S. date back to 1827 when Boston began requiring all children entering public schools to give evidence of smallpox vaccination. Soon, state governments began to implement vaccine mandates for school entry, including Indiana in 1881.

Today, our school immunization requirements are written in the Indiana Code and Administrative Code. School immunization requirements are based on ACIP recommendations and the Indiana State Department of Health (ISDH) helps clarify recommendations for legislative action. (Not every ACIP recommendation becomes a school requirement, and healthcare providers should vaccinate based on ACIP recommendations, not school requirements only.)

Children attending public school in Indiana must be immunized against diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, varicella, and meningococcal disease. In addition, educational information on some vaccines must be distributed to parents/guardians of students.

- Meningococcal disease and vaccine education is required to be distributed to parents/guardians and students at the beginning of each school year.
- HPV vaccine education is required to be sent to parents/guardians of all girls entering grade 6. This is located in the CHIRP Document Center.
  - Also, a request for HPV immunization data from the parent/guardian must be included and that can be found with the HPV educational information.

Each year, the Indiana State Department of Health Immunization Division reviews and updates the immunizations required for school entry. Changes to the 2011–2012 School Immunization Requirements are as follows:

- All requirements implemented in the 2010–2011 school year are still in force.
- The fourth dose of polio vaccine must be administered on or after child's fourth birthday. This applies only to kindergarten and first grade for 2011–2012.
- Two (2) doses of varicella vaccine, or evidence of immunity, will be required for kindergarten and first grade students. This is a "roll-up" requirement from last year's two dose varicella requirement for all kindergarten students.
  - The roll-up of the two dose varicella requirement will continue every year as shown below.
    2010–2011 school year: kindergarten
    2011–2012 school year: kindergarten and first grade
    2012–2013 school year: kindergarten, first grade and second grade, etc…

(This roll-up will continue annually until all grades are required to have two doses of varicella.)

School Immunization Requirements (continued)

Indiana Code does allow for medical or religious exemption to school immunization requirements. A medical exemption must state the specific vaccine is detrimental to the child's health, must be signed by a physician, and must be submitted annually. The ISDH has developed a form that may be used to help with medical exemptions (link below).

A religious exemption must specify the vaccine(s) prohibited by the religious belief, must be signed by the parent/guardian, and must be submitted annually.

The 2011–2012 FAQs page can be found in the CHIRP Document Center under School Nurse Documents, and it will answer many questions you may have about school requirements. Every provider is encouraged to read this document. **https://myshare.in.gov/ISDH/LHDResource/immunizations/Immunizations%20Documents/School%20Nurse%20Documents/2011-12%20School%20Immunization%20Requirements%20FAQs.pdf**

Helpful Links:

- Immunization requirements for school:
  IC 20-34-4-2: **http://www.in.gov/legislative/ic/code/title20/ar34/ch4.html**
  410 IAC 1-1-1: **http://www.in.gov/legislative/iac/T04100/A00010.pdf**

- School user information in CHIRP document center:
  https://myshare.in.gov/ISDH/LHDResource/immunizations/default.aspx?RootFolder=%2fISDH%2fLHDResource%2fimmunizations%2fImmunizations%20Documents%2fSchool%20Nurse%20Documents&FolderCTID=&View=%7b76A30483%2dA34-2%2d4582%2d89FD%2dCE9F7ECC5A19%7d

- Meningococcal education links:
  IC 20-30-5-18: **http://www.in.gov/legislative/ic/code/title20/ar30/ch5.html**

- Document center, letter:
  https://myshare.in.gov/ISDH/LHDResource/immunizations/Immunizations%20Documents/Forms/AllItems.aspx?RootFolder=%2fISDH%2fLHDResource%2fimmunizations%2fImmunizations%20Documents%2fSchool%20Nurse%20Documents

- HPV education letter and response form (CHIRP document center):
  https://myshare.in.gov/ISDH/LHDResource/immunizations/Immunizations%20Documents/School%20Nurse%20Documents/2011%20HPV%20Letter%20and%20Fact%20Sheet.pdf

- Exemption from immunizations

  - Religious IC 20-34-3-2:
    http://www.in.gov/legislative/ic/code/title20/ar34/ch3.html

  - Medical IC 20-34-3-3:
    http://www.in.gov/legislative/ic/code/title20/ar34/ch3.html

  - Medical exemption form (CHIRP document center):
    https://myshare.in.gov/ISDH/LHDResource/immunizations/Immunizations%20Documents/VFC%20Provider%20Documents/54648%20R0%204-11%20Vaccine%20Medical%20Exemption.pdf

Updated Provider Bulletin from MDwise
Regarding Claims Issues for Q1 and Q2 for 2011– Extended Filing Limit

MDwise Eligibility and Claim Update

Per the IHCP Banner Page BR201112, there have been changes in the eligibility verification systems which affect your ability to verify eligibility for the Hoosier Healthwise program for the months of January, February and March 2011 only. Because of this, earlier this year MDwise announced that we would extend timely filing, as well as waive network and PA rules, for all first quarter 2011 claims. We did this because we value the providers who have seen our members throughout this issue. However, at MDwise, our efforts to correct our enrollment data due to these issues extended into second quarter. **Therefore, we are announcing an additional claims extension for first and second quarter 2011 claims.** MDwise is extending the timely filing limit for all Hoosier Healthwise claims with dates of service between **1/1/11 and 6/30/11**.

- For all dates of service in this date range, providers will have until 9/30/11 to submit claims (or resubmit if needed).

- Out-of-network providers have 365 days to file claims, so this limit will still apply. MDwise claims payers are currently conducting a mass reprocess of claims that were denied between 1/1/11 and 6/30/11 that were denied due to eligibility issues. **This reprocessing effort is expected to be largely completed in the month of August. This is why we are extending timely filing for all first and second quarter 2011 claims until 9/30/11. Once the reprocessing is complete, you still have time to identify any claims you feel may remain outstanding, and have time to submit them for processing.**

Frequently Asked Questions

Q: How do I know where to send the claims to? What is the accurate source of eligibility information?

A: myMDwise Provider Portal is the best source of information at this time for the months of January, February and March 2011. You can sign up for access to the portal by going to MDwise.org. Click "My MDwise Login" on the left corner of any page on the website. Then click on the myMDwise Provider Portal image. This will take you to the MDwise portal login page. Click "Request an account online" and follow the steps to sign up. We regret that it is not possible to correct the information for January–March 2011 in Web interChange, so your best resource is to check the myMDwise Provider Portal. HP Web interChange can always be used to verify a member's eligible date range and correct MCE assignment. However, due to the issues above, you are always able to use myMDwise Provider Portal to verify PMP and delivery system assignment, for all dates of service past and present.

Q: What if I have already submitted a claim and it was denied or rejected?

A: For denied claims:

- MDwise claims payers will be conducting a mass reprocess of claims that were denied between 1/1/11 and 6/30/11 due to eligibility issues.

- If your claim was denied because it was submitted to the wrong delivery system, MDwise asks that you submit your denied claims to the correct MDwise delivery system for Hoosier Healthwise members. The correct MDwise delivery system will be found only in the myMDwise Provider Portal.

A: For rejected claims:

- If you submitted claims between 1/1/11 and 6/30/11 and they were rejected by a MDwise payer, please resubmit the claims in order to ensure processing. This is necessary because rejected claims are not stored by claims systems; we apologize for this inconvenience. Please use the Provider Portal to verify delivery system before resubmitting. MDwise and our payers will not be applying out-of-network restrictions for dates of service between 1/1/11 and 6/30/11. Medical necessity and coverage/benefit rules will still apply and can be appealed through the usual routes.

Q: What if I sent the claim to the correct claim shop, but it was still denied?

A: If you sent the claims to the proper MDwise delivery system but still got a denial due to eligibility, this is likely because eligibility was wrong at the time of original submission and has now been corrected. MDwise will mass reprocess these claims and you do NOT need to resubmit them.

Q: What if I already got authorization to provide a service, but now the claim is denied because it was the wrong MDwise delivery system (i.e. network)?

A: If you got a prior authorization for service, but now find that the PA was from an incorrect MDwise delivery system, you should submit this PA number as proof of good faith attempt to get PA. The claim will be honored as long as proof of a PA number is provided.

Q: What if I provided a service to a MDwise member but I am not contracted with a MDwise delivery system and considered out-of-network?

A: Out-of-network restrictions (including out-of-delivery system) will not be applied for 1/1/11 through 6/30/11 dates of service. However, Hoosier Healthwise benefit/coverage rules and medical necessity will still apply.

THANK YOU!

MDwise appreciates your service to our Hoosier Healthwise, Healthy Indiana Plan, and *Care Select* members. We are pleased to be continuing our programs in support of Indiana's health care safety net, and we look forward to many years working together with you. If you have any questions about this process, please feel free to call us at 1-800-356-1204.

HIP Claims Submission

Effective 8.1.11, all HIP claims regardless of date of service should be mailed to:

MDwise HIP Claims
P.O. Box 78310
Indianapolis IN 46278

ACS EDI Clearinghouses IUMG EDI Clearinghouses
Emdeon, TK Software and ACS Gateway
Payer ID for all EDI clearinghouses: MDWIS

WebMD/Emdeon
Institutional Payer ID – 12K81
Professional Payer ID – SX172

McKesson/Relay Health
Institutional Payer ID – 4976
Professional Payer ID – 4481

*Paper claims submitted to the above address should be submitted on **red** claim form for HIP. This allows the form to be scanned into the claims system thus reducing errors and getting the claims processed faster. A black form can be used, but the form is entered into the system manually and generally takes a little longer.*

Notification of Pregnancy

The Office of Medicaid Policy and Planning (OMPP) developed the Notification of Pregnancy (NOP) assessment to improve birth outcomes for pregnant women in the Hoosier Healthwise program. MDwise Hoosier Healthwise delivery system providers participate in NOP. NOP is a risk assessment completed on Web interChange that identifies potential health risks that contribute to poor birth outcomes. The risk assessment includes questions about maternal and obstetrical history, mental health, substance abuse and social risk factors. MDwise will use this information to identify pregnant women and connect them with case and care management services that will provide education and care coordination to improve their birth outcome. Our case and care management staff can assist with giving support to the provider and the plan of care they've developed with the member.

Frequently Asked Questions:

What is the reimbursement?
Recognized MDwise providers are eligible for reimbursement of $60 upon submission of the NOP via Web interChange. Presumptively Eligible (PE) pregnant women are eligible for this service. In order to receive reimbursement from MDwise the following must be met:

- The pregnant woman must be enrolled in MDwise Hoosier Healthwise.
- The woman's pregnancy must be less than 30 weeks gestation.
- The NOP must be submitted via Web interChange.
- The NOP is required to be submitted within 5 CALENDAR DAYS from the date the risk assessment was completed in the provider's office.
- Only one NOP can be submitted per member, per pregnancy to be eligible for reimbursement.

How do providers bill MDwise for NOP?
Providers must bill the pregnant woman's assigned MDwise delivery system for reimbursement of a successfully completed NOP. Providers should use CPT code 99354 and modifier TH. The date of service should reflect the date the provider completed the risk assessment with the pregnant woman.

Who can be a Qualified Provider?
- Family or general practitioner
- Pediatrician
- Internist
- Obstetrician or gynecologist
- Neonatologist
- Certified nurse midwife
- Advanced practice nurse practitioner
- Federally qualified health center
- Medical clinic
- Rural health clinic
- Outpatient hospital
- Local health department
- Family planning clinic
- Nurse practitioner clinic

Can hospitals bill for NOP?
Hospitals can bill the pregnant woman's assigned MDwise delivery system for reimbursement using the UB-04 claim form. NOP claim forms must be coded with the following:
- Revenue Code 960
- CPT code 99354 and modifier TH

How much time does it take to complete and submit an NOP on Web interChange?
Completing an NOP takes less than 10 minutes. Most of the questions only require a "Yes" or "No" answer. Providers can also consider completing a paper form for entry into Web interChange at a later time. However, NOP must be submitted within 5 CALENDAR DAYS from the date of the assessment.

What are the benefits of using NOP?
The Notification of Pregnancy can help MDwise enhance your plan of care. NOP is used by MDwise to identify moderate to high risk pregnancies and provide education, care coordination and link pregnant women to additional community resources. The goal of MDwise is to work with our practitioners and members to improve birth outcomes across all MDwise delivery systems. It is critical that practitioners complete the entire NOP. This provides MDwise vital information such as the member's tobacco use, psychosocial history, body mass index (BMI), obstetrical history, medical history and most importantly whether or not the pregnancy is high risk or low risk.

Notification of Pregnancy (continued)

NOPs Help Identify Women with High Risk Pregnancies
Current tobacco or substance abuse stratifies pregnancies into a high risk category. Members who have a history of tobacco or substance abuse are at moderate risk for their pregnancy. Refer tobacco users to smoking cessation resources. The Indiana Tobacco Quit Line (1-800-QUIT-NOW) is a free phone based counseling service that helps Indiana smokers quit. A trained quit coach will work with the member and provide solutions tailored to their needs. MDwise has partnered with the Indiana Tobacco Prevention and Cessation Agency to help our members quit smoking. For more information on the benefits of becoming a preferred provider or to download the fax referral forms please visit:
http://www.in.gov/quitline/index.htm.

Social History
There are several social risk factors that automatically put MDwise pregnant members at high risk. These include learning disability, mental retardation, homelessness, food insecurity, domestic violence and current pregnancy due to rape. MDwise case and care managers will work with the member to obtain additional resources that can help her outside of the normal scope of a physician's office.

Body Mass Index (BMI)
Body mass index can be problematic for pregnancies if it is either too high or too low. MDwise members with a BMI greater than 30 or less than 19 are considered high risk. Please be sure to accurately complete the BMI section on the NOP. MDwise will use this information to identify health risks for the member and provide additional assistance.

The National Heart Lung and Blood Institute has a free BMI calculator. Please visit the following link for access to this information: **http://www.nhlbisupport.com/bmi/bminojs.htm**.

Automatic High Risk (18 or younger)
The stratification guideline adopted by the Neonatal Quality Committee classifies a pregnant member 18 years of age and younger as high risk.

High-risk Pregnancy Documentation for Hoosier Healthwise Members
To document medically high-risk pregnancies for Hoosier Healthwise (HHW) members, providers must complete and submit the Notification of Pregnancy (NOP) through Web interChange. The NOP is the only acceptable method of docu-mentation for high-risk pregnancies; the Prenatal Risk Assessment Form or other standardized risk-assessment tools are no longer accepted forms of documentation.

Although they must use the NOP to document every high-risk pregnancy, providers are encouraged to use the NOP to document and monitor conditions of all pregnancies, regardless of risk category. The initial NOP must be completed before the 30th week of pregnancy—preferably during the initial visit—to receive the one-time $60 payment. Regardless, if at any time during the pregnancy, a normal pregnancy becomes high-risk, providers must use the NOP to document the high-risk factors.

For a pregnancy to be considered high-risk, the pregnant woman must have at least two medical risk factors in her current pregnancy or obstetrical history that place her at risk for a preterm birth or poor pregnancy outcome. The IHCP recognizes that the care of pregnant women in the medical high-risk category requires greater physician management. The IHCP provides higher reimbursement for prenatal office visits only for patients who present with medical high-risk factors when the provider documents the existence of the high-risk factors through the NOP. When billing, providers must indicate the high-risk diagnoses on the claim.

Please refer to Process for Completion of the Notification of Pregnancy in Chapter 8 of the *IHCP Provider Manual* for more specific guidelines.

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 2010 QI PROGRAM

- MDwise Network Improvement Program (NIP) team provided assistance to our providers and delivery systems. The Well-Child First Campaign provided educational tools and performance reporting at the provider and member level. The impact of NIP was evident in the significant increase in HEDIS 2010 scores for well-child 3–6 years of age and adolescent well care.
- ManagedCare.com (MCC), the web-based comprehensive reporting application, was expanded as development work was both challenged and enhanced by the transition of ownership to Transunion, a company that brought important processing capability and experience to the ManagedCare.com platform.
- Primary care–behavioral health integration grants awarded by MDwise continued across the state which engaged growing numbers of providers in transforming how behavioral health care is delivered; integration efforts within medical management at the delivery system level were highly successful and focus has transitioned to promoting communication between behavioral health and primary care providers.
- Member Satisfaction (HEDIS CAHPS) Child maintained its favorable survey results and was especially pleased with our increase in Customer Service score by 10% which has been a focus over the past few years.
- Scores for the 2010 Provider Satisfaction Survey was

spilt into two components providing an opportunity for feedback from both the provider and office managers.
- Groundwork was completed 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; implementation of the system occurred at the end of 2010.

PROGRAM GOALS FOR 2011 ARE TO:
- Expand the scope and role of Network Improvement Program team to include the Well-Child 0–15 Months measure, pregnancy measures including C-Section rates and NOP completion rates, and Physicians Advising Patients to Quit Smoking.
- Continue outreach to BH inpatient and outpatient provider on 7-day follow-up following Inpatient Behavioral Health Stay.
- Incorporate preventive care gaps into new CRM and develop/update corresponding scripts.
- Incorporate preventive and clinical care gaps into ManagedCare.com PMT (disease management/disease management system).
- Develop new reporting to address new ER Bounce Back Measure—both for delivery systems to support work with hospital ERs and providers to support member interventions.
- Implement MDwise Rewards program, incenting preventive/wellness exams and screenings.
- Explore and implement use of automated dialer calls for preventive care reminders.
- Complete build-out of disease registries, care management/policies/procedures, and performance metrics for disease management, Special Needs, Right Choices and ensure compliance with RFS 10-40 and NCQA Standards.
- Implementation of a CLAS strategic plan; improve provision of culturally sensitive/competent care.

Information on the QI program and evaluation report is available on the website at **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.

> 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.

General Practices for Medical Records

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 and medical conditions are indicated on problem list.
7. Current medication list is maintained and easily accessible.
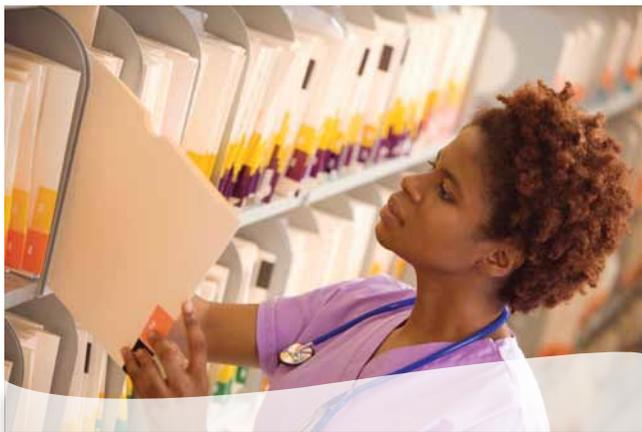
8. Allergies and adverse reactions are prominently noted in record. If member has no known allergies or adverse reactions, notation of such is documented in record.
9. Past medical history (for patients seen 3 or more times) is noted and easily identified. History notation includes serious accidents, 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 and 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 Advanced 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.

Clinical Practice Guidelines

Updated Clinical Practice Guidelines can be accessed on the provider section of our website at **MDwise.org**. All guidelines are in PDF format and are downloadable for printing. Printed copies of the guidelines posted to our website are also available through your Network Improvement and Provider Relations Representatives, as well as by calling us at 1-800-356-1204 or 317-630-2831.

Updated guidelines include:
- Asthma
- COPD
- Diabetes
- Coronary Artery Disease
- Chronic Kidney Failure
- Congestive Heart Failure

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 in ensuring that 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 early, the medical needs of our members 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

Appointment Category	Appointment Standards
Urgent/Emergent Care Triage	24 hours/day
Emergency Care	24 hours/day
Urgent Care	24 hours/day
Non-Urgent Symptomatic	72 hours
Routine Physical Exam	3 months
Initial Appointment (Non-pregnant Adult)	3 months
Routine Gynecological Examination	3 months
New Obstetrical Patient	Within 1 month from date calling for appointment/date of assignment notification
Initial Appointment Well Child	Within 1 month from date calling for appointment /date of assignment notification
Children with Special Health Care Needs	1 month

Member Satisfaction CAHPS Survey (Performed Annually)

Topics	Questions Asked of Adults/Guardians
Getting Care Quickly	In the last 6 months: • When you or your child needed care right away, how often did you get care as soon as you thought you needed? • Not counting the times you or your child needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
How Well Doctors Communicate	In the last 6 months, how often did you or your child's personal doctor: • Explain things in a way that was easy to understand? • Listen carefully to you? • Show respect for what you had to say? • Spend enough time with you?
Shared Decision Making	In the last 6 months: • Did a doctor or other health care provider talk with you about the pros and cons of each choice for you or your child's treatment or health care? • When there was more than one choice for you or your child's treatment or health care, did a doctor or other health care provider ask you which choice you thought was better for you or your child?
Health Promotion and Education	• In the last 6 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness?
Advising Smokers and Tobacco Users to Quit	• In the last 6 months, on how many visits were you advised to quit smoking or using tobacco products by a doctor or other health provider in your plan? • On how many visits was medication recommended or discussed to assist you with quitting smoking or using tobacco products (for example: nicotine gum, patch, nasal spray, inhaler, prescription medication)? • On how many visits did your doctor or health provider recommend or discuss methods and strategies (other than medication) to assist you with quitting smoking or using tobacco products?
Rating of Health Care Rating of Personal Doctor Rating of Specialist Coordination of Care (with other doctors)	In the last 6 months: • Using any number from 0 to 10, where 0 is the worst and 10 is the best, what number would you use to rate you or your child's health care? • Rate your personal doctor. • Rate any specialists seen. • How often did you or your child's personal doctor seem informed and up to date about the care you got from these doctors or other health care providers?

MDwise Prior Authorization for Infant Formula

Providers follow the following process for prescribing formula for their infant patients:

- Request prior authorization of formula using the Universal Prior Authorization form via fax to the MDwise delivery system medical management department in which the member is enrolled. The form can be found at **MDwise.org.**

- The medical management staff reviews the request to determine if all necessary clinical information was submitted. The medical management staff will contact the provider if more information is needed.

- If the criteria are met, the request is given a prior authorization number. The provider will be notified of the approval and assistance will be provided as needed with the DME contractor who will provide the formula to the member.

MDwise Delivery System Preferred Providers For Formula

Delivery System	Preferred Formula Provider
Methodist (IU Health)	IU Home Health Apria
St. Catherine	Fairmeadows Home Health Center American Medical Oxygen Sales
Saint Margaret Mercy/ Saint Anthony	Apria Fairmeadows Home Health Center
St. Vincent	Apria
Wishard	Home Respiratory Services Clarian Homecare
Total Health	Apria Clarian Homecare Lincare
Hoosier Alliance	No preferred providers, they will coordinate and arrange with the IHCP provider that the requesting physician refers the member to.

For WIC participants in Hoosier Healthwise, Medicaid is the primary payer for WIC eligible exempt infant formulas and medical foods. WIC can provide a temporary supply of the approved formula if necessary. The WIC clinic must receive a copy of the authorization or denial.

MDwise

Contact Us:

Customer Service Department
1.800.356.1204 or 317.630.2831

MDwise.org