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Important Information About SYNAGIS

Changes have been made for the provision of SYNAGIS, effective through the RSV season from November 1, 2011 to March 31, 2012. SYNAGIS is still a covered IHCP service, but it will only be reimbursed through the pharmacy benefit. Claims using the HCPCs code 90378 will be denied for non-coverage. The Drug Utilization Review Board also approved new authorization criteria for SYNAGIS at their August 2011 meeting. Information about the changes in reimbursement and the new criteria may be found in provider bulletin BT201143 located on the Indiana Medicaid website.
**MDwise HEDIS 2011 Results**

HEDIS® (Healthcare Effectiveness Data and Information Set) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care. HEDIS measures are calculated primarily from medical claims that are submitted by providers or from other administrative data such as the State’s immunization registry. There are a few measures where health plans are allowed to abstract data from the medical record in a provider office and count that data toward its HEDIS rate.

The State of Indiana requires accreditation by the National Committee for Quality Assurance (NCQA) of all participating Medicaid Managed Care Plans. HEDIS® rates make up 50% of a health plan’s accreditation score. The collection of data and reporting of HEDIS rates assess the quality of care members receive. Results from the annual HEDIS® audit are used in collaboration with providers to guide quality improvement initiatives at MDwise.

Notable HEDIS 2011 Well Child Measures results and quality improvement initiatives include:

- **0–15 months, children who turned 15 months of age during 2010; receive six or more well child visits since birth**
  - The rate of 61.8% scores nationally at the 50th percentile of Medicaid plans, which remains unchanged from the prior year.
  - Financial recognition of providers for reaching high levels of performance.
  - Found the 6th visit often occurred just beyond the 15 month time frame. Findings resulted in the MDwise Network Improvement Program (NIP) team creating a new W15 report which will list members 12 months and younger with fewer than 6 well care visits.

- **3–6 years of age as of 12/31/2010; receives one well child visit during 2010**
  - The rate of 72% scores nationally at the 50th percentile of Medicaid plans which remains unchanged from prior year but maintained a 9.2 percentage point improvement achieved calendar year 2009.
  - Financial recognition of providers for reaching high levels of performance.

- **12–21 year of age as of 12/31/2010; receives one adolescent well care visit during 2010**
  - The rate of 65.5% scores nationally at the 90th percentile of Medicaid plans which is a 12.2 percentage point improvement from prior year and is statistically significant. This is in addition to maintaining a 13.1 percentage point improvement achieved calendar year 2009.
  - Financial recognition of providers for reaching high levels of performance.
  - Found ages 18–21 years have the lowest compliance rate of this population and often up to age 21 not recognized as part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program which is the child health component of Medicaid.

The MDwise network improvement (NIP) and provider relations teams will be working corroboratively with MDwise providers to make the American Academy of Pediatrics Bright Futures program available to its providers. Bright Futures includes guidelines for health supervision of infants, children and adolescents. This program is a tool to help providers meet all requirements for both well care and EPSDT.
The HIPAA 5010 Compliance Date is Fast Approaching!

Has your billing software vendor or clearinghouse been approved?

The mandatory compliance date for the American National Standards Institute (ANSI) Health Insurance Portability and Accountability Act (HIPAA) version 5010 for all covered entities is January 1, 2012.

Effective January 1, 2012, the Indiana Health Coverage Programs (IHCP) will reject electronic transactions that are not submitted in the HIPAA-compliant 5010 format. Providers that are unable to submit claims in the compliant 5010 format risk possible delay in claim payment.

The IHCP is in the process of vendor testing 5010 transactions. All software vendors and clearinghouses have been sent testing information and have been encouraged to begin testing. Testing should have been completed by October 31, 2011, to allow plenty of time to convert clients to 5010 before the January 1 deadline. However, as of October 17, 2011, 43% of the software vendors and clearinghouses had begun submitting test transactions. Only 23% of vendors and clearinghouses had been approved for 5010 compliance.

You can find a list of the software vendors and clearinghouses approved for 5010 compliance on www.indianamedicaid.com. If you do not see your software vendor or clearinghouse on the approved list, you must contact your vendor or clearinghouse to ensure that it is in the process of testing with the IHCP.

Additional information about Indiana Medicaid and HIPAA 5010


Submission Summary Report (SSR)—The Submission Summary Report (SSR) will replace the Biller Summary Report that trading partners now receive for 4010A1 transactions. The SSR provides detailed information about claims that reject due to HIPAA compliance errors. The SSR also points the trading partners to the exact claims that caused the rejection, and displays technical and business explanations of the errors. This report will enable trading partners and providers to correct and resubmit rejected claims in a timely manner.

Trading Partner IDs—Trading partners will not be issued new trading partner IDs for submitting version 5010 transactions. You will continue to use your current production trading partner ID.

Web interChange Users—Providers that submit claims, verify eligibility, or view claim inquiry information via Web interChange will not need to test for HIPAA 5010. Web interChange will be updated with the appropriate HIPAA 5010 requirements.

Dual Processing—Indiana Medicaid will not allow dual processing of version 4010A1 and 5010 transactions. When a trading partner begins submitting the HIPAA 5010 version of a transaction, it will not be able to submit the 4010A1 version using the same submitter ID.
Member Rights and Responsibilities

MDwise members are sent a copy of their rights and responsibilities each year. MDwise believes that it is important for providers to know what MDwise staff communicate to its members concerning their rights and responsibilities.

MEMBER RIGHTS AND RESPONSIBILITIES

MDwise provides access to medical care for all its members. We do not discriminate based on your religion, race, national origin, color, ancestry, handicap, sex, sexual preference, or age.

Medical care is based on scientific principles. We provide care through a partnership that includes your doctor, MDwise, other health care staff, and you—our member.

MDwise is committed to partnering with you and your doctor. We will:

• Treat you and your family with dignity and respect.
• Maintain your personal privacy. Keep your medical records confidential as required by law.
• Give you a clear explanation of your medical condition. You have a right to be part of all your treatment decisions. If you understand the options, you can better decide if you want a certain treatment. Options will be discussed with you no matter what they cost or whether they are covered as a benefit.
• Provide you with information about MDwise, its services, its doctors and your rights and responsibilities.

In addition, YOU have the right to:

• Change your doctor by calling the MDwise customer service department.
• Timely access to covered services.
• Appeal any decisions we make about your health care. You can also complain about personal treatment you get.
• Get copies of your medical records or limit access to these records, according to state and federal law.
• Amend your medical records that we keep.
• Get information about your doctor.
• Request information about the MDwise organization and operations.
• Refuse care from any doctor.
• Ask for a second opinion.
• Make complaints about MDwise, its services, doctors and policies.
• Get timely answers to your complaints 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 our physician incentive plan.
• Be told about changes to your benefits and doctors.
• Be told how to choose a different health plan.
• Health care that makes you comfortable based on your 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. This means that your doctor cannot restrain or seclude you because it is the easiest thing to do. The doctor cannot make you do something that you do not want to do. The doctor cannot try to get back at you for something that you may have done.
• When you exercise these rights, you will not be treated differently.
• Provide input on MDwise member rights and responsibilities.
Member Rights and Responsibilities (continued)

- Participate in all treatment decisions that affect your care.
- If MDwise closes or becomes insolvent, you are not responsible for our debts. Also, you would not be responsible for services that were given to you because the State does not pay MDwise, or that MDwise does not pay under a contract. Finally in the case of insolvency, you do not have to pay any more for covered services than what you would pay if MDwise provided you the services directly.

You are responsible for:

- Contacting your doctor for all of your medical care.
- Treating the doctor and their staff with dignity and respect.
- Understanding your health problems to the best of your ability and working with your doctor to develop treatment goals that you can both agree on.
- Telling your doctor everything you know about your condition and any recent changes in your health.
- Telling your doctor if you do not understand your care plan or what is expected of you.
- Following the plans and instructions for care that you have agreed upon with your doctor.
- Keeping scheduled appointments.
- Notifying your doctor 24 hours in advance if you need to cancel an appointment.
- Telling us about other health insurance that you have.

Important Tip:

If you do not follow your doctor’s advice, this may keep you from getting well. It is your job to talk with your doctor if you have any questions about your medical care. Don’t ever be afraid to ask your doctor questions. It is your right!

Behavioral Health Updates

Behavioral Health OTRs: Please check our website at MDwise.org, under the behavioral health tab for the revised OTR form that was approved by the State recently for use in Hoosier Healthwise and HIP. If you are using non-clinical office staff to complete OTRs, please be sure to have the clinician providing the services review it for accuracy. This will save time on having to send additional information at the request of MDwise utilization management due to incorrect or confusing information. Accurate clinical information will expedite the approval process.

Many behavioral health providers are now seeing MDwise members who are involved with the Department of Child Services and have been referred by them for behavioral health services. This new program looks to have services covered by Medicaid where appropriate and medically necessary. Services that are denied either for prior authorization or on a claim should then be submitted to DCS for payment.
Revised MDwise Clinical Care Guidelines for Diabetes

OBJECTIVE
Guide the appropriate diagnosis and management of Diabetes.

GUIDELINE
Care to be provided in accordance with the current recommendation from the American Diabetes Association (ADA)
American Diabetes Association (ADA) Standards of Medical Care in Diabetes 2011

ASSESSMENT & DIAGNOSIS
CRITERIA FOR DIABETES MELLITUS DIAGNOSIS:

• Hemoglobin A1C ≥ 6.5%; OR
• Fasting Plasma Glucose (FPG) ≥ 126mg/dL (7.0mmol/L); OR
  o Fasting = no caloric intake for > 8 hours
• 2-hour plasma glucose ≥ 200mg/dL (11.1mmol/L) during an Oral Glucose Tolerance Test (OGTT); OR
  o OGTT is defined by the WHO as using a 75g load of anhydrous glucose dissolved in water
• Patient presentation with classic symptoms of hyperglycemia or hyperglycemic crisis, accompanied by a random plasma glucose ≥ 200mg/dL (11.1mmol/L)

**Repeat testing necessary to confirm diagnosis

**Once a diagnosis of diabetes mellitus has been confirmed, it is imperative that the patient be evaluated for comorbidities and potential complications of hyperglycemia including: cardiovascular disease (hypertension, dyslipidemia, coagulation disorders, coronary heart disease); thyroid dysfunction; nephropathy; retinopathy; and neuropathy.

GLYCEMIC CONTROL:

• Self Monitoring of Blood Glucose (SMBG)
  o Patients receiving multiple insulin injections or using an insulin pump should test their blood glucose ≥ 3 times/day.
    » Target Preprandial Plasma Glucose: 70–130mg/dL (3.9–7.2mmol/L)
    » Target Peak Postprandial Plasma Glucose < 180mg/dL (<10.0mmol/L)
      – Generally 1–2 hours after start of a meal
  o Patients treated with less frequent insulin injections, or non-insulin therapies should strongly consider using SMBG.
• Hemoglobin A1C should be obtained twice a year for well-controlled diabetic patients, and four times a year for patients undergoing therapy change(s) or those not meeting their glycemic goals.
  o Target A1C < 7%
    » Use of a lower goal A1C may be considered if it can be achieved without causing significant hypoglycemia or other adverse effects.
    » Use of a higher goal A1C may be considered in patients with a history of severe hypoglycemia, limited life expectancy, advanced micro- or macrovascular complications, extensive comorbid conditions, and those with long-standing diabetes who are unable to attain the standard goal despite DSME, SMBG, and effective doses of multiple hypoglycemic agents including insulin.
TREATMENT

NON-PHARMACOLOGIC:

• Diabetic patients should receive Diabetes Self-Management Education (DSME) upon diagnosis, and as needed thereafter.
• Diabetic patients should receive individualized Medical Nutrition Therapy (MNT) from a registered dietician.
• Weight loss (if necessary) and at least 150 minutes/week of moderate-intensity aerobic exercise should be encouraged.
  ◦ Patients receiving insulin or insulin secretagogue therapy should ingest additional carbohydrates prior to exercising if their pre-exercise glucose levels are < 100mg/dL (5.6mmol/L).
• Bariatric surgery may be considered for Type II diabetic patients with a BMI > 35kg/m², who are unable to achieve proper glycemic control through lifestyle modification and pharmacologic therapy.

PHARMACOLOGIC:

• Type I Diabetes Mellitus
  ◦ Successful management of Type I DM consists of the following:
    » Multiple dose insulin injections (3–4 injections per day of basal and prandial insulin), or Continuous Subcutaneous Insulin Infusion.
      – Insulin analogs are often used in order to minimize hypoglycemia.
    » Calculation of prandial insulin dosing based upon carbohydrate intake, premeal plasma glucose, and anticipated activity.

• Type II Diabetes Mellitus
  ◦ Upon initial diagnosis, initiation of metformin along with lifestyle modifications (exercise and MNT) is recommended first-line.
  ◦ It is recommended that additional hypoglycemic agents, including insulin, are added to the treatment regimen in a stepwise fashion as needed in order to achieve and maintain glycemic goals.
    » Additions to the treatment regimen should consist of agents from different pharmacological classes.
    » Emphasis should be placed on the achievement and maintenance of glycemic goals; rather than the selection of specific medications and their particular sequencing.
    » It is recommended that patients presenting with weight loss or other severe hyperglycemic signs/symptoms begin insulin therapy upon diagnosis.

• Management of Hypoglycemia
  ◦ If patient is conscious, administer 15–20g of oral glucose (carbohydrate)
  ◦ Should their plasma glucose level still indicate hypoglycemia 15 minutes post-treatment, re-administer treatment.
  ◦ Once plasma glucose normalizes, patient should be instructed to eat a snack/meal to prevent further hypoglycemia.
  ◦ Glucagon rescue kits should be prescribed to all diabetic patients at high risk for developing hypoglycemia.

• Immunizations
  ◦ All diabetic patients > 6 months of age should receive an annual influenza vaccine.
  ◦ All diabetic patients ≥ 2 years of age should receive the pneumococcal polysaccharide vaccine.
    » Revaccination is recommended for individuals > 64 years of age who were previously immunized when they were < 65 years of age, or if it has been > 5 years since their previous vaccination.

REFERENCES

American Diabetes Association (ADA) Standards of Medical Care in Diabetes 2011
MDwise Medical Advisory Council — Approval Date: 6/1/08, Reviewed/Approved 6/10/09, 03/10/10, 6/8/11  P0515 (05/10)
Revised MDwise Clinical Care Guidelines for Chronic Obstructive Pulmonary Disease

OBJECTIVE
Guide the appropriate diagnosis and management of Chronic Obstructive Pulmonary Disease (COPD)

GUIDELINE
Consistent with the National Institutes of Health’s (NIH) National Heart, Lung, and Blood Institute (NHLBI) and the World Health Organization (WHO), MDwise references the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines when administering its COPD programs.

GOLD—the Global Initiative for Chronic Obstructive Lung Disease

ASSESSMENT & DIAGNOSIS

PATIENT FACTORS FOR CONSIDERATION OF A COPD DIAGNOSIS
• Diagnosis of COPD should be considered if any of the following patient-specific factors are present in an individual > 40 years of age:
  ○ Dyspnea that is: progressive, persistent, worsens with exercise, and described by the patient as an “increased effort to breathe,” “heaviness,” “air hunger,” or “gasping”
  ○ Chronic cough: possibly intermittent or unproductive
  ○ Chronic sputum production
  ○ History of exposure to risk factors: tobacco smoke, occupational dusts and chemicals, and smoke from home cooking and heating fuel

**Definitive diagnosis confirmed via spirometry.

DIFFERENTIAL DIAGNOSIS OF COPD
• COPD
  ○ Mid-life onset
  ○ Slow, progressive symptom development
  ○ Long history of smoking
  ○ Exercise-induced dyspnea
  ○ Airflow limitation largely irreversible

• Asthma
  ○ Early onset (typically childhood)
  ○ Daily symptom variation
  ○ Nighttime/early morning symptoms prevalent
  ○ Allergy, rhinitis, and/or eczema also present
  ○ Family history of asthma
  ○ Airflow limitation largely reversible

**Utilize bronchodilator reversibility testing to rule out asthma diagnosis
STAGES OF COPD

- **Stage I: Mild COPD**—Characterized by mild airflow limitation (FEV\(_1\)/FVC < 0.70; FEV\(_1\) ≥ 80% predicted). Symptoms of chronic cough and sputum production may be present, but not always.

- **Stage II: Moderate COPD**—Characterized by worsening airflow limitation (FEV\(_1\)/FVC < 0.70; 50% ≤ FEV\(_1\) < 80% predicted), with shortness of breath typically developing on exertion and cough/sputum production sometimes also present. Many patients typically seek medical care at this stage due to chronic respiratory symptoms or an exacerbation of their disease.

- **Stage III: Severe COPD**—Characterized by further worsening of airflow limitation (FEV\(_1\)/FVC < 0.70; 30% ≤ FEV\(_1\) < 50% predicted), greater shortness of breath, reduced exercise capacity, fatigue, and repeated exacerbations that almost always have an impact on patients’ quality of life.

- **Stage IV: Very Severe COPD**—Characterized by severe airflow limitation (FEV\(_1\)/FVC < 0.70; 30% < FEV\(_1\) predicted or FEV\(_1\) < 50% predicted plus the presence of chronic respiratory failure). Patients may have Stage IV: Very Severe COPD even if FEV\(_1\) is > 30% predicted, whenever these complications are present.

1Values are post bronchodilator

TREATMENT

PHARMACOLOGIC THERAPY

- Bronchodilators
  - Represent the cornerstone of COPD symptom management therapy for patients with stable COPD.
  - The selection of which therapeutic agent to use (\(\beta_2\)-agonist, anticholinergic, theophylline, or combination) depends largely upon the individual patient response regarding symptom relief and tolerability of side effects.
  - Short-acting bronchodilators (i.e. albuterol, levalbuterol, ipratropium bromide) are prescribed on an ”as needed” basis to provide acute symptomatic relief.
  - Long-acting bronchodilators (i.e. formoterol, salmeterol, tiotropium) are prescribed for maintenance use in order to prevent or reduce persistent symptoms.
  - Combining bronchodilators (one short & one long-acting) of different pharmacological classes may improve efficacy and decrease the risk of side effects compared to increasing the dose of a single bronchodilator.
    - Exception: Short and long-acting inhaled anticholinergic agents should not be combined.
Revised MDwise Clinical Care Guidelines for Chronic Obstructive Pulmonary Disease (continued)

- **Glucocorticosteroids**
  - Prolonged continuous use of inhaled glucocorticosteroids is only appropriate for symptomatic patients with an FEV₁ < 50% predicted and repeated exacerbations.
  - Regular treatment with inhaled glucocorticosteroids has been shown to decrease exacerbation frequency, but does not modify the long-term decline in FEV₁.
  - The combination of an inhaled glucocorticosteroid and a long-acting β₂-agonist has been shown to be more effective than the individual components in reducing exacerbation frequency and improving lung function.
  - Only the 250/50mcg strength of Salmeterol/Fluticasone (Advair®) is FDA-approved for the treatment of COPD.
  - Prolonged treatment with oral glucocorticosteroids for COPD is not recommended.

**VACCINES**

- It is recommended that all COPD patients receive an annual influenza vaccine; reduces risk of serious illness/death by 50%.
- COPD patients > 65 years of age, or < 65 years of age with an FEV₁ < 40% predicted should receive the pneumococcal polysaccharide vaccine.

**REHABILITATION / OXYGEN THERAPY**

- All COPD patients, regardless of their disease stage, achieve improvements in exercise tolerance and symptoms of dyspnea and fatigue following completion of at least a six week exercise rehabilitation program.
- Long-term oxygen therapy should be considered in Stage IV COPD patients who meet certain laboratory criteria.
- Goal is to produce an SaO₂ of > 90% so as to preserve vital organ function and adequate delivery of oxygen.

**REFERENCES**

GOLD—the Global Initiative for Chronic Obstructive Lung Disease
MDwise Medical Advisory Council – Approval Date: 06/09/10; 06/08/11; P0531 (06/10)

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**NDC Codes Required on All Claims for Physician-Administered Drugs**

**Effective 1/1/2012**

Beginning in 2012, professional claims submitted to the Medicaid managed care entities containing procedure codes for physician administered drug components must include the NDCs of the drug products administered. Currently, professional claims for drugs administered in physician practice settings are adjudicated by the managed care plans using the “J” and “Q” codes without a NDC. However, the claim systems of the Medicaid Health Plans will be modified in 2012 to deny a professional claim that contains a “J” or “Q” code if it does not include the NDC of the drug product. The reimbursement for these procedure codes paid by the managed care entities will not change.

Please refer to the IHCP Bulletins BT200713 and BT200731 for instructions on how to complete the CMS 1500 and UB 04 paper claims, as well as electronic billing. Tables listing the procedure codes can also be found in these bulletins.

If you have questions regarding this billing requirement, please call your MDwise provider relations representative or call MDwise customer service at 1-800-356-1204 or 317-630-2831.
Changes to the **MDwise HIP Buy-In Pharmacy Benefit**

Providers who care for MDwise members enrolled in the HIP Buy-In program should be aware of changes to the preferred drug list that will be in effect on January 2, 2011.

The MDwise HIP Buy-In Pharmacy benefit pertains to only those HIP members purchasing health insurance through the Buy-In program. The PDL changes are listed below. Copies of the MDwise HIP Buy-In Preferred Drug List as well as information about the pharmacy benefit are available on the MDwise website at [MDwise.org/healthyindiana/providers/buyin-pharmacy.html](http://MDwise.org/healthyindiana/providers/buyin-pharmacy.html)

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cefpodoxime</td>
<td>Added to Preferred Drug List with a step edit therapy requirement of a First-line Antibiotic to be filled in the last 35 days.</td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>Losartan, Losartan HCT</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td><strong>TEKTURNA, TEKTURNA HCT</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of an ACE inhibitor or Losartan product in the last 60 days.</td>
</tr>
<tr>
<td><strong>VALTURNA</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of an ACE inhibitor or Losartan product in the last 60 days.</td>
</tr>
<tr>
<td><strong>TEKAMLO</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of an ACE inhibitor or Losartan product in the last 60 days.</td>
</tr>
<tr>
<td>AZOR</td>
<td>Removed from the Preferred Drug List. PDL alternatives include DIOVAN, DIOVAN HCT, EXFORGE, EXFORGE HCT.</td>
</tr>
<tr>
<td><strong>BENICAR, BENICAR HCT</strong></td>
<td>Removed from the Preferred Drug List. PDL alternatives include DIOVAN, DIOVAN HCT, EXFORGE, EXFORGE HCT.</td>
</tr>
<tr>
<td>SIMCOR</td>
<td>Removed from the Preferred Drug List. PDL alternative includes LIPITOR 80mg Tablet.</td>
</tr>
<tr>
<td><strong>VYTORIN 10/80</strong></td>
<td>Removed from the Preferred Drug List. PDL alternative includes LIPITOR 80mg Tablet.</td>
</tr>
<tr>
<td>SLO-NIACIN</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>NIASPAN</td>
<td>Removed from the Preferred Drug List. PDL alternative includes SLO-NIACIN.</td>
</tr>
<tr>
<td>MEBARAL</td>
<td>Removed from the Preferred Drug List. PDL alternative includes Phenobarbital.</td>
</tr>
<tr>
<td><strong>DIASTAT, DIASTAT ACUDIAL</strong></td>
<td>Added to Preferred Drug List with Prior Authorization.</td>
</tr>
<tr>
<td>INVEGA</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>LATUDA</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>SAPHRIS</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>Granisetron</td>
<td>Added to Preferred Drug List with Quantity Limit of 8 tablets per 30 days.</td>
</tr>
<tr>
<td>Hydrocodone w/ Acetaminophen</td>
<td>Remove 5/500, 7/5/500, and 10/650 dosages. PDL alternatives include tablet strengths of 5/325, 7.5/325, 10/325, and 10/650, and capsule strength 5/500.</td>
</tr>
<tr>
<td><strong>MIRAPEX ER</strong></td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td><strong>MIRAPEX</strong></td>
<td>Removed from Preferred Drug List, PDL alternative includes MIRAPEX ER.</td>
</tr>
<tr>
<td>Lindane shampoo</td>
<td>Added to Preferred Drug List.</td>
</tr>
</tbody>
</table>
Changes to the **MDwise HIP Buy-In Pharmacy Benefit** (continued)

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ULESFIA</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of three weeks of treatment with permethrin or pyrethrin/piperonyl butoxide in the past 45 days.</td>
</tr>
<tr>
<td><strong>EURAX</strong></td>
<td>Removed from Preferred Drug List. PDL alternatives include permethrin products, pyrethrin/piperonyl butoxide products, OVIDE, lindane shampoo, and ULESFIA.</td>
</tr>
<tr>
<td>Lindane lotion</td>
<td>Removed from Preferred Drug List. PDL alternatives include permethrin products, pyrethrin/piperonyl butoxide products, OVIDE, lindane shampoo, and ULESFIA.</td>
</tr>
<tr>
<td><strong>CIPRODEX</strong></td>
<td>Removed from Preferred Drug List. PDL alternatives include ofloxacin and neomycin/polymixin/hydrocortisone.</td>
</tr>
<tr>
<td><strong>NASONEX</strong></td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>Flunisolide nasal spray</td>
<td>Removed from Preferred Drug List, PDL alternatives include fluticasone nasal spray and NASONEX.</td>
</tr>
<tr>
<td><strong>RHINOCORT AQUA</strong></td>
<td>Removed from Preferred Drug List, PDL alternatives include fluticasone nasal spray and NASONEX.</td>
</tr>
<tr>
<td><strong>ONGLYZA</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of 2 prescriptions for insulin or metformin in the last 75 days.</td>
</tr>
<tr>
<td><strong>STARLIX</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of 2 prescriptions for insulin or metformin in the last 75 days.</td>
</tr>
<tr>
<td><strong>KOMBIGLYZE XR</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of 2 prescriptions for insulin or metformin in the last 75 days.</td>
</tr>
<tr>
<td><strong>APIDRA</strong></td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td><strong>HUMULIN 50/50</strong></td>
<td>Removed from Preferred Drug List. PLD alternatives include APIDRA, HUMALOG, HUMALOG MIX 75/25, HUMULIN 70/30, HUMULIN R, HUMULIN N, LANTUS, LEVEMIR.</td>
</tr>
<tr>
<td><strong>ACTOS</strong></td>
<td>Requires Prior Authorization.</td>
</tr>
<tr>
<td><strong>ACTOSPLUS MET</strong></td>
<td>Requires Prior Authorization.</td>
</tr>
<tr>
<td><strong>AVANDAMET</strong></td>
<td>Requires Prior Authorization.</td>
</tr>
<tr>
<td><strong>AVANDARYL</strong></td>
<td>Requires Prior Authorization.</td>
</tr>
<tr>
<td><strong>AVANDIA</strong></td>
<td>Requires Prior Authorization.</td>
</tr>
<tr>
<td><strong>DUETACT</strong></td>
<td>Requires Prior Authorization.</td>
</tr>
<tr>
<td>Nizatidine</td>
<td>Removed from Preferred Drug List. PLD alternatives include cimetidine, famotidine, and ranitidine.</td>
</tr>
<tr>
<td><strong>PREVACID-24 OTC</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of 21-days of first line therapy in the past 60 days.</td>
</tr>
<tr>
<td><strong>ZEGERID OTC</strong></td>
<td>Added to Preferred Drug List with a step edit therapy requirement of 21-days of first line therapy in the past 60 days.</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>Pantoprazole</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td><strong>GENOTROPIN</strong></td>
<td>Added to Preferred Drug List with a prior authorization requirement.</td>
</tr>
<tr>
<td><strong>PEG-INTRON</strong></td>
<td>Added to Preferred Drug List with a prior authorization requirement.</td>
</tr>
</tbody>
</table>
Changes to the MDwise HIP Buy-In Pharmacy Benefit (continued)

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORENCIA</td>
<td>Added to Preferred Drug List with a prior authorization requirement.</td>
</tr>
<tr>
<td>REMICADE</td>
<td>Added to Preferred Drug List with a prior authorization requirement.</td>
</tr>
<tr>
<td>SIMPONI</td>
<td>Added to Preferred Drug List with a prior authorization requirement.</td>
</tr>
<tr>
<td>STELARA</td>
<td>Added to Preferred Drug List with a prior authorization requirement.</td>
</tr>
<tr>
<td>KINERET</td>
<td>Removed from Preferred Drug List. PDL alternatives include ENBREL, ORENCIA, REMICADE, SIMPONI.</td>
</tr>
<tr>
<td>Colchicine</td>
<td>Removed from Preferred Drug List. PDL alternatives include allopurinol and probenacid.</td>
</tr>
<tr>
<td>Prenatal Vitamins</td>
<td>Approved only for pregnant members.</td>
</tr>
<tr>
<td>TRAVATAN Z</td>
<td>Removed from Preferred Drug List. PDL alternatives include brimonidine 0.15%, dorzolamide, iopidine, latanaprost.</td>
</tr>
<tr>
<td>PANTANOL</td>
<td>Removed from Preferred Drug List. PDL alternatives include ALAWAY OTC, ZADITOR OTC, ketotifen, pheniramine/naphazoline, and PATADAY.</td>
</tr>
<tr>
<td>VIGAMOX</td>
<td>Added to Preferred Drug List with a prior authorization requirement.</td>
</tr>
<tr>
<td>Ofloxacin 0.3% Ophthalmic Soln</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>DULERA</td>
<td>Added to Preferred Drug List.</td>
</tr>
<tr>
<td>NICOTROL</td>
<td>Removed from Preferred Drug List. PDL alternatives include nicotine gum, nicotine lozenges, and nicotine patches.</td>
</tr>
</tbody>
</table>

If your members have had prescriptions filled for diabetic medications like ACTOS, ACTOPLUS MET, AVANDAMET, AVANDARYL, AVANDIA, and DUETACT within the 3-month period before January 2, 2012, they will be allowed to continue those medicines without having to receive an authorization. Other medications affected by the change may require providers to contact MDwise for an approval.

MDwise Medical Management Program Evaluation 2010

Introduction

The Medical Management Program serves to assist members and providers/practitioners to access the delivery of timely and appropriate health care in a manner that complies with applicable regulatory and accrediting organizations. The Medical Management Department reviews the core medical management activities to evaluate the primary processes related to prior authorizations, denials, and appeals including but not limited to timeliness, consistency of gathering information and applying criteria, peer to peer availability, denial letter appropriateness, and appropriate/timely handling of appeals.
Core Medical Management Activities

While MDwise delegates the majority of medical management activities to our delivery system partners, MDwise maintains a fully comprehensive delegation oversight program of all delegated functions including prior authorization, concurrent review, and retrospective review. MDwise maintains the sole responsibility for member appeals, review of denial letter notifications prior to their mailing or faxing, provision of member access to a medical and behavioral health triage line, and availability of an MDwise clinical contact to perform post-stabilization authorization requests due to an emergency room visit.

Appeals

In 2010, the Office of Medicaid Policy and Planning (OMPP) revised the definition of a grievance, which had previously been defined as the first level of an appeal. As a result, in July 2010 a grievance was defined as an expression of dissatisfaction about any matter other than an action. An appeal was defined as a written request from a member or a provider on a member’s behalf to change a previous action or decision (i.e. denial or modification) by the MCE. As a result, there was variability to the definitions for the first part of 2010 versus the latter part of 2010. In addition to changing the definitions of a grievance, OMPP also revised the appeals process to include only one internal level of appeal at the MCE with any subsequent level of appeal occurring by the Administrative Law Judge or through an Independent Review Organization (IRO). The potential financial impact of members requesting to proceed immediately to IRO was a concern. However, MDwise continued to work with our delivery system partners to stress the importance of making sound initial determinations that are based on clinical guidelines that would be supported on appeal to an IRO.

MDwise is responsible for processing all appeals filed by the member or by the provider on the member’s behalf. As noted earlier, in 2010 OMPP revised the definition of a grievance which removed the two levels that MDwise previously administered to reconsider an adverse decision. Appeals are performed in a timely manner as established by OMPP, the scope of work and Indiana Department of Insurance, which is documented in MDwise appeals policy. The timeliness of appeals is monitored on a daily basis and reports are provided to OMPP reflecting the number of appeals received and the average time to resolve appeals.

Appeal activity is also monitored to evaluate the initial reviews decisions to identify patterns of denial and identify opportunities for improvement, which may include but are not limited to policy and procedure revision or development, member education, provider education and education of Medical Management staff.

Biannually, appeal activity is reported to the MDwise Quality Management Team (QMT) and the Medical Advisory Committee (MAC). The QMT consists of MDwise executive management, directors and managers. The QMT reviews the appeal activity to analyze additional interventions that may be necessary to address any patterns or concerns related to denials and the appeals process. The MAC also reviews the appeal activity to oversee the interventions addressed and implemented via the QMT.

In 2010, MDwise noted a decrease in the number of appeals filed compared to 2009. 371 were filed in 2009 compared to 162 in 2010. MDwise believes this reduction is partly due to several initiatives including but not limited to:

- Education and outreach efforts to promote consistent application of criteria among our delivery system medical management departments
- Across delivery system inter-rater reliability audits facilitated by MDwise
- Review of denial letters prior to their mailing and intervening in those instances where an impending denial appears problematic or inappropriate
- Training of delivery system medical directors on the appropriate hierarchy of criteria application
Based on the analysis of 2010 appeal activity, MDwise plans additional initiatives in 2011 including but not limited to:

- Add behavioral health reviews to across delivery system inter-rater reliability audits
- Train medical management staff and medical directors on members with special needs and the implication for prior authorization determinations

**Timeliness of PA Decisions**

Medical management determinations are made in a timely manner to accommodate the clinical urgency of the situation. Timeliness standards for medical management determinations and notification of determinations are established and performance is monitored to be in compliance with applicable regulatory agencies and accrediting organizations standards.

The timeliness standards are based on Indiana Department of Insurance requirements for Utilization Review Agent Licensure as indicated in IC 27-8-17, OMPP, RFS and federal requirements and NCQA standards. Indiana Code and regulatory standards may preclude the NCQA timeliness standards. The time frame standards are maximum time frames, as decisions shall be made as soon as possible, taking into account the medical urgency of the situation.

The timeliness of medical management determinations is monitored through annual delegation oversight audits, appeals of denied services and reporting measurements. Issues identified with regard to timeliness are addressed and corrective action plans developed to assure that any issues with timely decision making is resolved.

In 2010, MDwise delivery systems resolved non-behavioral health authorization decisions in a timely manner 99.67% of the time and behavioral health authorization decisions in a timely manner 100% of the time.

MDwise did not identify any trends or patterns of concern regarding timeliness of decision making in 2010 and will continue to monitor timeliness in 2011 via quarterly reporting, appeal file review, complaints/grievances and annual delegation oversight audits.

**Denial Activity**

A physician, appropriate behavioral health specialist, clinical pharmacist or dentist, as appropriate, reviews any denial of service based on medical necessity. Board-certified consultants are utilized to assist the medical director or physician reviewer designee in making medical necessity determinations and the review of grievances, appeals and claims disputes.

Denial determinations are monitored to assure that denials are made according to the policies and procedures established by MDwise. Denial activity is monitored through inter-rater reliability audit, appeals, annual delegation oversight audits, and denial letter review.

In 2010, MDwise delivery systems fully denied 5.19% of medical authorization requests and fully denied less than 1% of behavioral health authorization requests. Denial activity is monitored to identify any patterns or trends that may indicate the necessity of additional clinical guidelines or criteria, revisions to existing guidelines/criteria, and education opportunities for medical management staff regarding the application of criteria.

**Inter-Rater Reliability**

In accordance with MDwise policy and procedure and NCQA standards, each MDwise delivery system performs an inter-rater reliability audit among all reviewers including physicians and nurses. Historically, MDwise has facilitated an inter-rater reliability audit across all of our participating delivery systems. The purpose is to evaluate the consistency of decision-making across all the delivery systems while monitoring for opportunities to provide training, revise existing guidelines, develop new guidelines, and facilitate in general discussion among the delivery system medical directors and their physician reviewers.
Cases are randomly selected by MDwise and redacted so that the medical director cannot identify the original reviewing physician or the member’s respective delivery system. The entire file that was reviewed for original denial is submitted to each medical director along with a tool to complete as he/she reviews the file. The results are assimilated and reported at the Medical Advisory Committee (MAC).

**Care Management/Disease Management**

In 2010 MDwise began working on the requirements of the RFS 10-40 to implement the new case, care and disease management program for Hoosier Healthwise and Healthy Indiana Plan. All members receive disease management touches. The program is designed to emphasize the prevention of exacerbation and complications of specific disease processes identified by the OMPP. Assessments are completed which guide the assigned intervention levels. Members receive less intensive to more intensive levels of interventions dependent on member’s identified care needs and may transition between levels depending on assessments and leveling protocols. MDwise is responsible for the overall case, care and disease management oversight based on NCQA standards across all delivery systems. The program was implemented January 1, 2011.

The transition process included development of specific program descriptions for each condition of interest, stratification criteria and the development of the Program Management Tool (PMT) in ManagedCare.com. PMT development remains on-going.

Evaluation measures for 2011, including satisfaction and outcomes, will be established and monitored through regularly scheduled data reporting analysis, and mechanisms such as, but not limited to, member and provider complaints, utilization and appeals.

**Pharmacy**

In 2009, the State of Indiana announced to the Managed Care Entities (MCEs) its intent to carve the pharmacy benefit out from the MCEs’ contract and implement the benefit into its existing State contracted PBM and claims processing vendors, which were already managing the pharmacy benefit for the Care Select program. The transition happened at the end of 2009 and on January 2010 the pharmacy benefit was solely supported and managed by the State’s PBM contractor, ACS, and it claims processor, HP. Since January 2010, MDwise no longer processes the pharmacy benefits for the Hoosier Healthwise or Healthy Indiana Plan programs. All aspects involved in the support of the pharmacy benefit is now under the management of the Office of Medicaid Policy and Planning, including, network support, claims processing, prior authorization of the pharmacy benefit, maintaining a preferred drug list and payment to the pharmacy provider network for services rendered to MDwise membership. MDwise is responsible for working with its provider network to monitor and address the utilization and cost of the pharmacy benefit, and to encourage the use of generic drug regimens for its member drug regimens. A monetary incentive was set aside by the State designed to reward those MCEs that are effective in controlling the utilization and cost of the pharmacy benefit. Those MCEs that meet the pay-for-performance targets are paid a percentage of the incentives. Over the course of 2010, MDwise has performed very well in controlling utilization and generic fill rates.

Oversight of the pharmacy benefit by MDwise is conducted and reported monthly to delivery system leadership and the MDwise executive team. Copies of the encounter data paid by the State’s PBM is routinely shared with the MCEs. The claims encounter files are used to support clinical call centers and applications, as well as care management initiatives.
Comparing the utilization and cost of the pharmacy benefit from 2009, when MDwise managed the benefit, to 2010, when the State of Indiana took over the benefit management, the following patterns have been demonstrated:

1. Utilization in the Hoosier Healthwise program has shown a 9% reduction whereas the average cost per claim has exhibited a 13% increase. The overall net effect is that the pharmacy benefit experienced a program cost ($PMPM) of 3%.

2. Utilization in the Healthy Indiana Plan has shown no change from 2009 to 2010, although the average cost per claim has increased 24%.

3. The generic fill rate for the Hoosier Healthwise program has maintained a status well above 80% for the calendar year 2010.

4. The generic fill rate for the Healthy Indiana Plan has maintained a rate above 82%.

**Training**

MDwise facilitates training on medical management topics at the corporate MDwise office as well as communicates training opportunities in the community and via managed care related organizations including but not limited to Association for Community Affiliated Plans (ACAP), Indiana Perinatal Network (IPN), About Special Kids (ASK), Milliman and the Indiana Minority Health Coalition.

In 2010, several training opportunities were made available to our delivery system partners on a variety of medical management related topics:

- Hierarchy of applying criteria
- Right Choices program
- Autism: A parent’s perspective
- Fraud and abuse
- Medical Rehabilitation Option (MRO)
- Best practices in case management patient contact, monitoring and follow-up
- Case management: Identifying, monitoring and managing target populations
- Promote smoke free pregnancy
- Educating consumers on mental health services
- Serving the deaf and hard of hearing community
- Indiana newborn developmental care conference
- Serving refugees in Indiana
- Addressing racial disparities in infant sleep practice

In 2011, MDwise will continue to facilitate training opportunities including regarding NCQA UM standards, NCQA care/case/disease management standards and Milliman criteria application.


Each year MDwise contracts with The Myers Group (TMG) to conduct Consumer Assessment of Health Care Providers and Systems (CAHPS®) surveys on its Hoosier Healthwise adult and child members and HIP members. The overall objective of the CAHPS® study is to capture accurate and complete information on MDwise members’ reported experiences with health care. Specifically, the objectives are to measure how well MDwise is meeting our members’ expectations and goals; to determine which areas of service have the greatest effect on our members’ overall satisfaction; and to identify areas of opportunity for improvement. The majority of the ratings involve member feedback on their interaction with MDwise providers.

The Myers Group collected valid surveys from the eligible member population for HHW and HIP from January through May of 2011. Survey questions were based on services received by members in 2010. MDwise chose a mixed survey administration that included both mail and telephone. Once the survey is complete, The Meyers Group generates reports comparing MDwise to prior years, The Myers Group Medicaid book of business, and (CAHPS®) databases and Quality Compass. The Meyers Group also analyzes the data.
to identify those questions that are most highly correlated with member satisfaction with MDwise and with the health care they received. The CAHPS® benchmark and threshold reports are also important because The National Committee for Quality Assurance (NCQA) utilizes these CAHPS® scores in determining Accreditation status and Health Plan Ranking.

Corporate results from the 2011 CAHPS® Survey are presented here. Performance varied by delivery system and product line. The complete reports for all surveys, including all the detail behind each question, were distributed to each MDwise delivery system in July 2011.

Highlights from the Surveys

**Overall Scoring**
MDwise received the highest scores in the Hoosier Healthwise child survey. HIP survey scores were fairly close to the Hoosier Healthwise survey child scores. Our lowest scores were on the Hoosier Healthwise adult survey. MDwise is in the process of developing quality improvement strategies across all three programs to improve member satisfaction.

In 2011, the scores indicate that there are opportunities in:

- How well doctors communicate
- Rating of specialist
- Advising smokers and tobacco users to quit
- Customer service
- Health promotion and education

<table>
<thead>
<tr>
<th>Type</th>
<th>Measure Focus</th>
<th>Category</th>
<th>Child HHW 2011</th>
<th>Adult HHW 2011</th>
<th>Adult HIP 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite Summary</td>
<td>Provider</td>
<td>Getting Needed Care</td>
<td>85.3%</td>
<td>76.0%</td>
<td>80.6%</td>
</tr>
<tr>
<td>Rates</td>
<td>Provider</td>
<td>Getting Care Quickly</td>
<td>89.0%</td>
<td>79.9%</td>
<td>83.6%</td>
</tr>
<tr>
<td></td>
<td>Provider</td>
<td>How Well Doctors</td>
<td>88.1%</td>
<td>86.1%</td>
<td>90.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communicate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MDwise</td>
<td>Customer Service</td>
<td>75.6%</td>
<td>67.9%</td>
<td>79.4%</td>
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<tr>
<td></td>
<td>Provider</td>
<td>Shared Decision Making</td>
<td>72.2%</td>
<td>58.2%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Global Ratings</td>
<td>Provider</td>
<td>Rating of Personal Doctor</td>
<td>85.2%</td>
<td>74.1%</td>
<td>78.8%</td>
</tr>
<tr>
<td></td>
<td>Provider</td>
<td>Rating of Specialist</td>
<td>82.7%</td>
<td>70.8%</td>
<td>75.0%</td>
</tr>
<tr>
<td></td>
<td>Provider</td>
<td>Rating of Health Care</td>
<td>80.8%</td>
<td>63.8%</td>
<td>73.3%</td>
</tr>
<tr>
<td></td>
<td>MDwise</td>
<td>Rating of Health Plan</td>
<td>84.9%</td>
<td>67.6%</td>
<td>75.5%</td>
</tr>
<tr>
<td></td>
<td>Responses</td>
<td></td>
<td>854</td>
<td>470</td>
<td>608</td>
</tr>
<tr>
<td></td>
<td>Response Rate</td>
<td></td>
<td>32.10%</td>
<td>21.5%</td>
<td>48.0%</td>
</tr>
</tbody>
</table>

Another important question on the adult member CAHPS® survey is whether the member smokes cigarettes or uses tobacco. On the 2011 survey 43.6% of HHW adult members and 39.1% of HIP members reported that they smoked “every day” or “some days.”
The survey also asks the member what their provider has discussed with them regarding tobacco cessation. The following are the survey questions that are asked of members:

In the last six months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

In the last six months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting (e.g. nicotine patch, gum, prescription medications, etc)?

In the last six months, how often did your doctor or health provider discuss methods or strategies other than medication to assist you with quitting (e.g. telephone helpline, individual or group counseling, etc.)?

On the 2011 survey, MDwise members had the following responses:

<table>
<thead>
<tr>
<th>Category</th>
<th>Adult HHW 2011</th>
<th>Adult HIP 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advising Smokers and Tobacco Users to Quit</td>
<td>70.2%</td>
<td>76.3%</td>
</tr>
<tr>
<td>Discussing Cessation Medications</td>
<td>35.3%</td>
<td>55.1%</td>
</tr>
<tr>
<td>Discussing Cessation Strategies</td>
<td>35.9%</td>
<td>48.1%</td>
</tr>
</tbody>
</table>

The responses to these questions are considered when a health plan is accredited by NCQA. In addition, the Indiana Office of Medicaid Policy and Planning has set this as a Pay for Performance measure for the Hoosier Healthwise and HIP programs.

**When to Refer to a Behavioral Health Provider**

**Complex Behavioral & Emotional Issues**

If a member:
- Has behavior or emotions that pose a threat of harm to the safety of self, a child or others (e.g. suicidal behavior, severe aggressive behavior, an eating disorder that is out of control, self-destructive behavior)
- Has had a significant disruption in day-to-day functioning or loss of contact with reality
- Has been recently hospitalized for treatment of a psychiatric illness
- Has complex diagnostic issues
- Has a mood disorder and would benefit from CBT

**Complex Social & Environmental Issues**

If a member:
- Has a caretaker with serious emotional issues or a substance abuse problem, or there are other serious environmental issues such as a hostile divorce situation
- Has a history of abuse, neglect and/or removal from the home and has significant issues related to the abuse or neglect
- Has a significant change in emotions or behavior for which there is no obvious precipitant e.g. sudden onset of school avoidance, a suicide attempt in a previously well functioning individual

**Complex Medical Issues**

If a member:
- Has only a partial response to a course of medications or is being treated with more than one psychotropic medication
- Has a family history that suggests treatment with psychotropic medications may have an adverse effect. (e.g. prescribing stimulants to a child with a family history of schizophrenia or bipolar disorder; children under the age of 5 who require on-going use of a psychotropic medication)
- Has a chronic medical condition and behavior or emotions prevent the medical condition from being treated properly
- Has had a course of treatment for 6–8 weeks with no meaningful improvement
When to Refer to a Behavioral Health Provider (continued)

The Referral for Behavioral Health Services form can be found at MDwise.org/docs/providerbehavioralhealth/bh-referralform.pdf

Dear Colleague:

I am the primary care physician for the above-named member, who has expressed concern about the issues checked below. A course of treatment ___has ___has not been started under my care.

Current concerns:
- [ ] Depressed symptoms
- [ ] Anxiety Symptoms
- [ ] ADHD Symptoms
- [ ] Eating Disorder
- [ ] Other

- [ ] Substance Use
- [ ] Behavioral Problems
- [ ] Developmental Delays
- [ ] Head Injury
- [ ] Parenting
- [ ] Learning Problems

- [ ] Hallucinations/Delusions
- [ ] Mania
- [ ] Other

Current Medications:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Length of time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| See attached list

Medical Problems:
- [ ] Diabetes
- [ ] Asthma
- [ ] Other

Attached lab results:
- [ ] CBC
- [ ] Thyroid Studies
- [ ] Chem. Profile
- [ ] EKG
- [ ] Lipid Profile
- [ ] Serum drug level

Diagnostic Tests:

- [ ] Medical problem
- [ ] Hospital
- [ ] Date of admission

Recent Hospitalizations:

<table>
<thead>
<tr>
<th>Medical/problem</th>
<th>Hospital</th>
<th>Date of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PMP Information:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Phone:</th>
<th>Fax:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Referral for Behavioral Health Services form can be found at MDwise.org/docs/providerbehavioralhealth/bh-referralform.pdf

We appreciate you!

MDwise appreciates your hard work and dedication as a part of our provider network as you continue to provide quality of care to our MDwise members throughout 2011 and for years to come.

Contact Us:
Customer Service Department
1.800.356.1204 or 317.630.2831
MDwise.org