Clinical Practice Guidelines

Updated clinical practice guidelines can be accessed on the provider section of our website at MDwise.org/providers. All guidelines are in PDF format and are downloadable for printing. Printed copies of the guidelines are also available through your network improvement and provider relations representatives or by calling customer service at 1-800-356-1204 or 317-630-2831.

Guidelines include:

✓ Asthma
✓ Chronic kidney disease
✓ Chronic obstructive pulmonary disease
✓ Congestive heart failure
✓ Coronary artery disease
✓ Diabetes
✓ Pregnancy care

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The Importance of Practitioners Reporting Their Race, Gender and Ability to Speak Another Language

Studies suggest that racial and ethnic minorities and persons with limited English proficiency face barriers to care, despite Medicaid-enabled financial access. MDwise makes efforts to address the observed disparities in access to care for racial, ethnic and linguistic minorities as part of our quality improvement efforts.

Studies show that the physician-patient relationship is strengthened, leading to higher feelings of trust, satisfaction and adherence to treatment when patients feel that their beliefs, values and communication are similar to their health care provider. Factors such as similar perceived race usually lead a patient to feel ethnically similar to their physician while a physician's use of patient-centered communication leads to a patient's belief in perceived personal similarities.

MDwise strives to maintain a practitioner network that can meet the cultural and linguistic needs of all of its eligible members. MDwise collects and shares practitioner race, ethnicity and language data, and regularly assesses the network’s capability to provide linguistically and culturally appropriate care and addresses shortcomings when necessary. MDwise posts a practitioner’s language and race data on the provider directory, which is located at MDwise.org/findadoctor. This information assists eligible individuals to find practitioners who speak their preferred language and who are perceived to be ethnically similar.

MDwise asks that providers share this information with MDwise provider relations staff when requested. Frequently, practitioners are unwilling to share information concerning race and ethnicity. While we understand the reluctance to divulge such information, we only use the information for members to make informed choices about their care.

NDC Codes Required on All Claims For Physician-Administered Drugs

The Federal Deficit Reduction Act of 2005 mandates that all State Medicaid Programs, including Indiana Health Coverage Programs (IHCP), require the submission of National Drug Codes (NDCs) on claims submitted with certain procedure codes for physician-administered drugs. This mandate affects all providers who submit claims for procedure-coded drugs both electronically and on paper.

IHCP is not changing reimbursement policy pertaining to procedure-coded physician-administered drugs at this time. Claims for such drugs will continue to be priced by using the submitted procedure code and procedure code units. The sole exception is that manually priced “J” and “Q” codes will be priced by using the submitted NDC.

Please refer to the IHCP Bulletins BT200713 and BT200731 for specific instructions for completing 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 requirement, please call your MDwise provider relations representative or call MDwise customer service at 1-800-356-1204 or 317-630-2831.
Implications of Poor Health Literacy

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

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

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

Behaviors and responses that may indicate limited literacy are:

- Patient registration forms are incomplete or improperly completed
- Patient frequently misses appointments
- Patient is noncompliant with medication regimens
- Lack of follow-through with laboratory tests, imaging tests or referrals to consultants
- Patient says he/she is taking their medication, but lab tests or physiological parameters do not change in the expected fashion
- Patient responds to receiving written information with statements such as:
  - I forgot my glasses. I’ll read this when I get home.
  - I forgot my glasses, can you read this to me?
  - Let me bring this home so I can discuss it with my children.
- Patient responds to questions about medication regimens with an inability to name medications, inability to explain what medications are for or inability to explain timing of medication administration

Some physicians have found it helpful to add questions about literacy skills to the social history section of patient registration forms. After asking about education and occupation, they may ask:

- How happy are you with the way you read?
- What is the best way for you to learn new things?

These types of questions give the patient an opportunity to discuss the problem if desired.

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

Scheduling an Appointment for a Patient with Poor Health Literacy Skills

When patients call the office to make an appointment, a person should answer the phone. It is preferred over a machine asking the patient to select numerical options. Ideally, the person answering the phone should be able to converse with the patient in the patient’s language.

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

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

Finally, help patients prepare for the visit by asking them to bring all their medications and make a list of the questions they wish to ask. Let them know they are welcome to have someone accompany them to the visit and be part of the discussion.
Continuity and Coordination of Care with Primary Care Physicians

Per the current contract with MDwise’s behavioral health network, the Office of Medicaid Policy and Planning requires the following communication with primary care providers:

- For members who are at risk for hospitalization or who have had a hospitalization, the behavioral health provider will provide to the plan and the member’s PMP a summary of the member’s initial assessment session, primary and secondary diagnosis and medications prescribed. This information must be provided after the initial treatment session.

- For members who are not at risk for hospitalization, behavioral health providers must, at minimum, provide a summary of the findings from the member’s initial visit to the plan and PMP. This notification must include the behavioral health provider’s contact information, visit date, presenting problem, diagnosis and a list of any medications prescribed.

- Behavioral health providers must also notify the plan and PMP of any significant changes in the member’s status and/or a change in the level of care.

- Any other relevant information.

MDwise also expects its behavioral health providers to provide periodic updates to primary care beyond the initial evaluation summary as long as the member continues in treatment. It is up to the clinician to decide when an update is appropriate. Suggested times for an update include when medication is changed or when an OTR is submitted for more services, in addition to the situations stipulated in the contract.

MDwise recently completed its annual audit of continuity and coordination of care with primary care. Auditors were looking for evidence of communication with primary care at the start of treatment and periodic updates. The aggregate average of the 14 high volume behavioral health providers audited was 31.4% (140 charts). Many providers do an excellent job of sending out communication at the start of treatment but did not provide periodic updates for those who remained in treatment for some length of time. MDwise has set a goal of 80% in this category.

MDwise appreciates your service to our members and is here to assist you. Please contact Dr. Lynn Bradford at 317-822-7307 or Jennifer Layden, LCSW, LMFT, behavioral health manager, at 317-822-7368 should you have questions.

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Diabetes in Pregnancy

When the physician or practitioner writes “diabetes” in the medical record, be very sure to select the correct code(s). There is a lot of confusion in this area.

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

Gestational diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts a woman at greater risk of developing diabetes after the pregnancy. Gestational diabetes is coded 648.8x abnormal glucose tolerance. Assign code V58.67 also if the gestational diabetes is treated with insulin.

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

Consistent and complete documentation in the medical record is an essential component of quality patient care. MDwise providers are responsible for establishing and maintaining medical records for each member that are consistent with current professional and accreditation standards and requirements as established in 42 CFR 431.305 and 405 IAC 1-5 and MDwise policies and procedures.

Medical records are to be maintained in a manner that is current, detailed, organized and permits effective and confidential patient care and quality review. Medical records are required to reflect all services provided directly by the PMP and are to include all ancillary services, diagnostic tests and therapeutic services ordered or referred by the PMP (e.g., specialty physician’s reports, x-ray reports).

All MDwise participating provider offices must have defined, written practice 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 records 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 number 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 three 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.
General Practices for Medical Records (continued)

14. Treatment plans and 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.

MDwise 90 Day TPL Rule

MDwise has developed a 90 day insurance rule to account for instances when a third-party commercial insurance hasn’t responded to a provider claim within 90 days of the bill date. The information below is a summary of MDwise’s 90 day insurance rule. This information can also be found in the MDwise Provider Manual at MDwise.org.

When the member has other primary insurance, a MDwise provider must submit claims to the other insurance carrier before submitting to the MDwise delivery system. When a third-party insurance carrier fails to respond within 90 days of the provider’s billing date, the claim can be submitted to the MDwise delivery system for payment consideration. However, one of the following must accompany a claim to substantiate attempts to bill the third party or the claim will be denied:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Provider must note the date of the billing attempt and the phrase "no response after 90 days" on an attachment. This information must be clearly indicated.

- Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days from the billing date. The provider is required to boldly make a note of the following on the attachment:
  ✓ Date of the filing attempt
  ✓ The phrase "no response after 90 days"
  ✓ Member identification number (RID) and Provider’s National Provider Identifier (NPI)
  ✓ Name of primary insurance carrier billed

- For claims filed electronically, the following must be documented in the claim note segment of the 837P transaction:
  ✓ Date of the filing attempt
  ✓ The phrase "no response after 90 days"
  ✓ Member identification number (RID) and IHCP provider number
  ✓ Name of primary insurance carrier billed
Presumptive Eligibility Considerations

Verify Eligibility

It is highly recommended that qualified providers for presumptive eligibility (PE) verify eligibility on Web interChange prior to the PE process to determine if the woman is already covered by Medicaid. Women who are already enrolled in Medicaid cannot apply for PE.

Women are eligible for PE only one time per pregnancy. There is no PE coverage if the woman, who has been determined to be presumptively eligible, does not select an MCE and PMP by contacting the enrollment broker on the day PE is determined. If an MCE and PMP are not selected the same day that the PE application is approved, the application will fail, a new application must be completed, and the services that were performed on the date of the original application will not be reimbursed.

Claims Submission

While the member is on presumptive eligibility, the provider should bill the appropriate MDwise delivery system using the PE recipient identification number (RID) that begins with 550. Once the Hoosier Healthwise application process has been completed by the Division of Family Resources (DFR), and if the woman is approved, the provider will then submit claims with the woman’s Hoosier Healthwise RID. Web interChange should be checked to see if the benefit package changed from Package P to Package A or B (Hoosier Healthwise). Presumptive eligibility coverage ends on the day after HP receives notification of Hoosier Healthwise eligibility from the DFR, whether approved or denied.

It should be noted, however, that there may be a delay in the time that HP receives notification of Hoosier Healthwise eligibility for the PE member, and when MDwise gets the file from HP with the member’s eligibility date for Hoosier Healthwise. MDwise then submits this information to the payers. Consequently, there may be a short delay of when the information is loaded into the payment system.

If you have questions or concerns about this process, please contact MDwise customer service at 1-800-356-1204 or 317-630-2831 in the Indianapolis area.

Hoosier Healthwise Package B Codes

In 2011, Indiana Health Coverage Programs (IHCP) updated its Package B covered ICD-9-CM diagnosis codes to include family planning diagnosis codes. Those who provide family planning services to Package B members can utilize family planning ICD-9-CM diagnosis codes for Package B members instead of just a pregnancy-related diagnoses (i.e., V22.0). Family planning services are a covered Medicaid service for all Package B members per the IHCP Provider Manual. Providers may reference banner page BR201117 dated April 26, 2011 for a list of covered family planning diagnoses. Based on this banner page and Medicaid guidelines, providers may utilize any of the codes from this list as the primary diagnosis codes for Package B members to convey the provision of a covered service. Therefore, providers are not required to include a pregnancy code, such as V22.0 (supervise normal pregnancy), as the primary diagnosis code on claims for family planning services for Package B members in Hoosier Healthwise.
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. 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 must be submitted within five 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
- Presumptively eligible (PE) pregnant women are eligible for this service

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 five 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.

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
- Federally qualified health center
- Medical clinic
Important Reminders for Completing Notification of Pregnancy

**Tobacco**
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 Quitline (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 in.gov/quitline.

**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 located at 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 members, providers must complete and submit the NOP through Web interChange. The NOP is the only acceptable method of documentation for high-risk pregnancies; the prenatal risk assessment form or other standardized risk-assessment tools are no longer accepted forms of documentation.

Although providers 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 thirtieth 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 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.
Prior Authorization for Health Care Services

Prior authorizations for health care services can be obtained by contacting the medical management department by phone or fax. The contact information can be found in the quick contact guide. Copies of prior authorization forms can be found on MDwise.org.

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

Authorizations may be required prior to services being rendered to:
• Verify services are covered by the benefit plan
• To coordinate timely access to appropriate clinical care
• To verify out-of-plan referrals are appropriate
• To efficaciously manage the utilization of health care services (including limited resources per benefit imitations)
• To implement timely discharge planning and coordination of services
• To identify members with special health care needs, high risk individuals or populations for care coordination and case management/disease management intervention.

Authorization Procedural Guidelines

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

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

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

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

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

MDwise Incentive Affirmation Statement

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

Qualified Medical Management Staff

Qualified medical management staff with the required knowledge and skills to assess clinical information used to support medical management decisions will perform first-level medical management determinations. MDwise employs current licensed nurse reviewers whose education and experience meet the job qualifications to perform the initial review of the clinical information against criteria.
A specialized behavioral health team of clinical case managers are responsible for the day to day medical management functions surrounding the delivery of behavioral health services, including service review determinations and coordination of physical and behavioral health care needs. Behavioral health care managers are comprised of licensed behavioral health care professionals, such as board-certified psychiatrists, psychologists and master’s-level nurses and clinicians who reach utilization management decisions based on safe and quality driven standards and practices.

A physician, appropriate behavioral health professional, dentist or clinical pharmacist, as appropriate, reviews any denial of services based on medical necessity.

Qualifications for practitioners who review denials of care based on medical necessity include education, training or professional experience in medical or clinical practice and current U.S. license to practice without restriction. Behavioral health practitioners, including psychiatrists, doctoral-level clinical psychologists or certified addiction-medicine specialists review denials of behavioral health care based on medical necessity.

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

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

It is a MDwise practice to make the reviewer available to the treating or attending provider to discuss any medical management denial decision. This can be accomplished by calling the appropriate UM department on the quick contact guide or calling MDwise customer service and asking to be connected with the delivery system UM department. The MDwise customer service department can be reached by calling 1-800-356-1204 or 317-630-2831.

A provider may request a copy of the criteria or guideline used to make a prior authorization denial decision by calling the telephone number on the denial letter and asking the MDwise delivery system medical management staff for a copy of the criteria.

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

### WIC Formulary

Please note that the Indiana WIC Formulary may be accessed via the Indiana State Department of Health website at in.gov/isdh/19691.htm. On the left side of the page, under WIC Home, click on WIC Approved Foods & Formula, then select Formulas Chart. The formulary was recently updated in August 2012 and is now posted for viewing. All future formulary revisions will be posted to this site and available for your reference. Alternate access can also be obtained by going to in.gov and search for ISDH WIC.
Provider Access Guidelines

An integral part of patient care is making sure patients have access to needed medical care. In accordance with the Office of Medicaid Policy and Planning (OMPP) policy, MDwise establishes standards and performance monitors to help ensure 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 time frames.

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

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

**PMP Access Standards**

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<thead>
<tr>
<th>Appointment Category</th>
<th>Appointment Standards</th>
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<td>24 hours/day</td>
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<td>Emergency Care</td>
<td>24 hours/day</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>24 hours/day</td>
</tr>
<tr>
<td>Non-Urgent Symptomatic</td>
<td>72 hours</td>
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<tr>
<td>Routine Physical Exam</td>
<td>3 months</td>
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<td>Initial Appointment (Non-pregnant Adult)</td>
<td>3 months</td>
</tr>
<tr>
<td>Routine Gynecological Examination</td>
<td>3 months</td>
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<td>New Obstetrical Patient notification</td>
<td>Within 1 month from date calling for appointment/date of assignment</td>
</tr>
<tr>
<td>Initial Appointment Well Child notification</td>
<td>Within 1 month from date calling for appointment /date of assignment</td>
</tr>
<tr>
<td>Children with Special Health Care Needs</td>
<td>1 month</td>
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</tbody>
</table>
Restrictions on Charging MDwise Hoosier Healthwise or HIP Members

As outlined below, there are very specific circumstances in which a provider can bill members for covered or non-covered services.

Billing for Covered or Non-covered Services

According to MDwise policy, a provider may bill a member for Hoosier Healthwise or HIP covered or non-covered benefits only when the following conditions have been met:

- **Non-covered benefit**: A provider may bill a MDwise member for services that are not covered under Hoosier Healthwise or HIP. It is important to note, however that for the HIP program, the member’s POWER Account funds may not be used to reimburse providers for non-covered services.

- **Member exceeded benefits**: Providers may bill the member when the service is a Hoosier Healthwise or HIP covered service for which the member has exceeded the program limits for the particular service. The member must understand before receiving the service that the service is not covered and they will be responsible for the charges incurred. Also, please note it is the provider’s responsibility to verify member benefit limits.

- **PA denied and member told why**: A provider may bill a member for services that require authorization but for which authorization is denied. However, the provider must establish authorization has been requested and denied before rendering the service. The provider will have an opportunity to request review of the authorization decision by MDwise. If the MDwise delivery system maintains the decision to deny an authorization the provider must inform the member that the service requires authorization, that the authorization has been denied and why and that they may appeal this decision directly with MDwise. The provider must also inform the member that covered services may be available without cost if the member gets them from the appropriate provider in the MDwise network. The provider must inform the member of their responsibility for payment if they choose to or insist on receiving the service without authorization.

- **Member did not tell provider they were eligible**: A provider may bill the member when the provider has taken appropriate action to identify a responsible payer and the member has failed to inform the provider of Hoosier Healthwise or HIP eligibility. However, if the member tells the provider later that he/she had Hoosier Healthwise or HIP coverage, and it is still within the claims timeliness filing limits, the provider must submit the bill to MDwise and therefore cannot require the member to pay.

- **Outstanding copayments**: It is permissible to bill a member for any outstanding copayments, yet providers may not deny services to members due to their inability to pay the copayment amount on the date of service.

Obtaining a Waiver

In the situations outlined above, when the member chooses to receive a service that is not covered by MDwise, they may only be billed if the provider obtains documentation (i.e., waiver) that the member voluntarily chose to receive the service, knowing that MDwise will not pay for it and they are responsible for the charges. The waiver must meet the following requirements:

- Must include member’s signed statement accepting financial responsibility for the services.
- The waiver is signed only after the member is given the appropriate notification that the service is not covered and why.
- The waiver must be specific about the services to be billed and must be retained as documentation in the patient’s medical record. A waiver must be obtained for each encounter or patient visit that falls under the above scenario.
- The waiver must list the specific services that fall under the waiver’s application, the date the services were rendered and the cost for the services.
- The waiver may not contain any language or condition to the effect that if authorization is denied after the service is rendered, the member is responsible for payment.

*Please Note: For assistance or for sample waiver letters, please contact your delivery system provider relations representative.*
Clinical Care Guidelines for:  
Major Depression in Children and Adolescents

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

DIAGNOSIS & ASSESSMENT

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

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

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

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

Symptoms cause significant distress or impairment in functioning.

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

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

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

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

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

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

• Treatment with medication should always include acute and continuation phases. Some children may require maintenance treatment.
• May be seen more frequently during the first month and subsequent two months based on the needs of the child and the family.
• Each phase of treatment should include psychoeducation, supportive management, family and school involvement.
• Education, support, and case management appear to be sufficient for treatment of uncomplicated or brief depression.
• For children and adolescents who do not respond to the above or have more complicated depression, a trial of CBT and/or medication is indicated.
• Kennard, et. al. (2009) found that adolescents treated with a combination of an anti-depressant and CBT will remit earlier than those who receive either treatment alone and improvement is superior to that of both monotherapies.
• To consolidate the response to acute treatment and avoid relapse, treatment should always be continued for 6–12 months.
• Treatment should include the management of comorbid conditions.
• Progress in treatment should be monitored with rating scales such as the Beck Depression Inventory, Children’s Depression Inventory or Reynolds Adolescent Depression Inventory.
• Abrupt discontinuation of anti-depressants is not recommended.

REFERENCES

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

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

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

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

Definitions

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

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

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

**Response Time Frames**

All grievances must be resolved and communicated to members in writing within 20 days. If the grievance involves an adverse decision (e.g., member is not permitted to change their PMP) the member may then appeal the grievance decision and must be
Grievance and Appeal Procedure for Hoosier Healthwise and HIP Members (continued)

provided with appeal rights in their follow-up letter. If the member is not happy with that adverse decision they can appeal. It is then processed as an appeal according to MDwise Policy # MS 02.

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

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

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

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

- MDwise responds to all requests for external review, within three business days of receiving the request for an IRO review. A standard external review must be resolved within 15 business days after the review is requested. An expedited external review must be resolved within 48 hours of receipt of the request. For a standard review, the member is notified within 72 hours of the IRO panel decision. For an expedited review, the member must be notified within 24 hours of the IRO panel decision.

- FSSA fair hearing members submit a request directly to FSSA for a fair hearing and time frames are according to those rules that govern the FSSA in conducting the FSSA fair hearing. MDwise responds to all information requests by the FSSA fair hearing officer or designee within the required format and time frame.

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

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

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

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