Interpretation Services

MDwise members are eligible to receive interpretation services at no cost. This includes foreign language as well as sign language services. The legal foundation for language access lies in Title VI of the 1964 Civil Rights Act. The Health and Human Services (HHS) Office for Civil Rights has responsibility for enforcing the Civil Rights Act and the Americans with Disabilities Act. They have issued guidance for providers to help clarify responsibilities. They suggest that given the nature and importance of health care services, health care providers have a special obligation to ensure language access for their patients. Once a health care provider accepts any federal funds (e.g. Medicare or Medicaid payments), the provider is responsible for providing language access to all of their patients.

Interpretation services can be provided by hiring an interpreter from a local or state organization that provides these services or through a number of language line options, many of which may be available through provider groups or hospital affiliations. Language options all have varied per minute (phone) or per hour (in-person) costs. If you do not have this resource or do not know how to get access for your patients, please contact your MDwise provider relations representative for assistance.

The use of family members and friends as interpreters is not recommended. It raises quality and confidentiality concerns. Here are a few examples of these concerns:

- Breach of confidentiality.
- Patients may be reluctant to disclose information critical to their situation/condition.
- Greater likelihood of medical errors.
- Mistakes in naming body parts.
- Family shame and other issues may interfere.
- If inaccurate history is collected, inadequate treatment recommendations are made.

The use of professional, trained interpreters is critical. MDwise has an interpretation resource guide that provides contact information for foreign language and sign language resources in Indiana. This video from Legal Services of New Jersey gives helpful tips on how to communicate effectively using an interpreter.
MDwise Disease Management Services

MDwise is committed to improving the quality of care that is available to our members suffering from or at risk for chronic disease through research, education, advocacy and the development and application of disease-specific, scientifically-based standards and guidelines.

INcontrol is the MDwise disease management program, specially designed for patients with chronic conditions and special health care needs. The MDwise INcontrol team is here to reinforce the messages you provide in the office. Members may need additional support to stick to their medical regimen. MDwise uses interventions such as counseling, education and appointment reminder systems to support our members who are dealing with chronic conditions.

Participation in the MDwise INcontrol program is voluntary. A member may choose to opt out or decline participation in the program. However, for high-risk members who elect to opt out, the PMP may be contacted to encourage his or her patient to participate.

As a provider, you do not need to do anything to use our disease management services. Members with one of the following qualifying diagnoses are automatically enrolled in the INcontrol program:

- Attention Deficit Hyperactivity Disorder
- Asthma
- Congestive Heart Failure
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Depression
- Diabetes
- Pervasive Developmental Disorder
- Pregnancy

MDwise care managers are responsible for the comprehensive disease-specific assessments, care plan development, treatment plan execution, frequent interactions with the member and the member’s PMP and ongoing monitoring and reassessment. Care managers are available to assist providers with achieving positive health outcomes for our members with chronic conditions through the following interventions:

- Educate members about their disease(s), coping strategies and how they can better self-manage their condition(s).
- Encourage and empower members to understand their condition and monitor their symptoms more effectively, use medications properly and modify their behavior to include healthy lifestyle choices.
- Actively monitor members’ clinical symptoms, treatment plans and implementation of evidence-based guidelines.
- Coordinate care for the member among all providers, including PMP, specialists, behavioral health providers, ancillary providers, hospitals, laboratories and pharmacies.
- Involve members in support groups or organizations that provide continuing education, counseling and fellowship.
- Provide feedback on individual members and support to PMPs about their status between office visits as well as updated information on best practices for disease program components and targeted members.
- Encompass general coordination of care for basic preventive services, such as flu shots.

Members in the INcontrol program are encouraged to develop healthy lifestyle behaviors through disease-specific materials and preventive care reminders via written materials, newsletters, MDwise.org/incontrol and through reinforcement provided by MDwise care managers during health counseling sessions. Provider support is offered through provision of clinical practice guidelines, training opportunities, feedback and comprehensive care coordination of their members.

While members are mainly identified for enrollment in a disease management program through medical and pharmacy claims analysis, as a health care provider we welcome you to refer your MDwise patients to the INcontrol program. You can do so by calling 1-800-356-1204 or by using the online care management referral form at MDwise.org/cmdm-referral.
General Practices for Medical Records

All MDwise participating providers must adhere to the following medical records standards:

Office has defined practice/written guidelines for:

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

Medical Record Review Criteria

1. Patient name or ID 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.
14. Treatment plans and/or 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) or review of under- and over-utilization.
18. Record contains consultant note whenever consultation is requested.
19. Consultation, lab and imaging reports filed in the chart reflect review of ordering practitioner by evidence of such person’s initials on reports.
20. Record includes reports of specialty referrals, inpatient (discharge summary), emergency care and outpatient services (diagnostic and ancillary services).
21. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
22. Immunization record for children is up to date or an appropriate history noted for adults.
23. There is evidence that preventive screening and services are offered in accordance with the practice/preventive care guidelines.
24. Discussion and documentation of advance directives for every patient 21 years and older. If an advance directive has been executed, a copy should be present in the medical record.
25. Missed appointments and any follow-up activities documented in the medical record.
Pharmacy Services for Hoosier Healthwise and HIP

The MDwise pharmacy benefit for Hoosier Healthwise and the Healthy Indiana Plan (HIP) is administered by the State of Indiana Office of Medicaid Policy and Planning through its pharmacy claims processor, Catamaran Corporation. Members are able to get their prescription supplies of covered pharmacy products through pharmacy providers and durable related medical supply providers that are contracted in the Indiana Health Coverage Program (IHCP) network. Complete details of the State’s pharmacy benefit can be found in Chapter 9 of the IHCP Provider Manual.

The pharmacy benefit is comprehensive and is defined by the State Plan and approved by the Centers for Medicare and Medicaid Services (CMS). The coverage limitations of the pharmacy benefit and reimbursement to pharmacy providers are set out in the IHCP rule 405 IAC 5-24. Prescribing providers are to use the Indiana Medicaid preferred drug list (PDL) when determining prescribing options for the treatment of medical conditions presented in MDwise members.

While the State Plan’s prescription drug benefit is comprehensive, members should always have a medical justification for drug therapy. A prescriber that determines drug therapy is necessary to treat a member’s medical condition should complete a drug order or prescription, regardless of whether or not the service is a legend drug product or an over-the-counter drug product. Legend drug products are covered as long as the drug is:

- Approved by the U.S. Food and Drug Administration (FDA).
- Not designated as a less than effective or identical, related or similar to a less than effective drug.
- Subject to the terms of a rebate agreement between the drug manufacturer and CMS.
- Not specifically excluded from coverage by Indiana Medicaid for being an anorectic or agent used to promote weight loss; topical minoxidil preparation; fertility enhancement drug; or a drug prescribed solely or primarily for cosmetic purposes.

Preferred Drug List

The State’s pharmacy benefit includes coverage of most legend drugs and certain over-the-counter drugs that are listed on the State’s over-the-counter (OTC) drug formulary. Prescribing providers should refer to the most current version of either the PDL or OTC drug formulary on the Indiana Health Coverage Program PBM website at https://inm.providerportal.catamaranrx.com/providerportal/faces/PreLogin.jsp.

While most outpatient prescription and OTC drug products are covered services in the State pharmacy benefit program, other drug-related services may require approval and billing to the MDwise plan directly. Those drug-related services include procedure-coded drugs billed by providers other than the IHCP pharmacy network, most medical supplies and medical devices and enteral or oral nutritional supplements. Providers should contact the MDwise provider relations department for information about requirements surrounding the coverage and submission of claims for these services.

The State’s prescription drug benefit program strives to have system edits in place whenever possible to enforce program policy and parameters. However, it is not systematically possible to have edits for each and every dispensing situation. Pharmacy providers must ensure that services rendered to MDwise members are covered by the program, rendered in accordance with pharmacy practice law and all other applicable laws and do not exceed any established program limits. Payments that may result from a pharmacy provider’s failure to exercise due diligence in this regard are subject to recoupment.

Prior Authorization

Information about authorization requirements for drugs requiring prior authorization (PA) can be found at https://inm.providerportal.catamaranrx.com/providerportal/faces/PreLogin.jsp or by calling 1-855-577-6317. PA request forms are available at provider.indianamedicaid.com. Pharmacy providers and prescribing practitioners should direct any PA-related questions or requests to Catamaran. The Catamaran clinical/technical help desk number is 1-855-577-6317.
Indiana Care Select Pharmacy Benefits

The pharmacy benefit for Care Select members in the MDwise plan includes those drug products that are listed on:

- The Indiana Health Coverage Programs (IHCP) preferred drug list (PDL).
- The over-the-counter (OTC) drug formulary.

The PDL is not intended to show all drugs covered by the IHCP

Some drug classes are purposefully not shown on the PDL and most drugs in those classes are covered by the IHCP and do not require prior authorization. Legend drug products that are listed as non-preferred in the IHCP PDL require prior authorization.

The IHCP PDL and OTC drug formulary can be found on the IHCP PBM website at [https://inm.providerportal.catamaranrx.com/providerportal/faces/PreLogin.jsp](https://inm.providerportal.catamaranrx.com/providerportal/faces/PreLogin.jsp).

MDwise medical management makes prior authorization decisions based on the appropriateness of care and services and the availability of benefits. Practitioners with the authority to make denial decisions are not rewarded for issuing denials of coverage. Financial incentives are not used to encourage medical management decisions that result in under-utilization.