

# the communicator



WINTER 2010

## RIGHT TO REVIEW

MHS would like to remind practitioners of their right to request the status of their credentialing application with Managed Health Services (MHS) at any time and to review information obtained by MHS to evaluate their credentialing or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank—Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the Department of Regulation and Licensing Medical Examining Board. This allows practitioners to review references, personal recommendations or other information that is peer review-protected.

If you believe any of the information used in the credentialing or recredentialing process to be erroneous or if any information gathered as part of the primary source verification process differ from the submitted, you will have the right to correct erroneous information and to submit your comments and explanations for any other factual information.

To request release of information, submit a written request to the MHS Credentialing Department at 1099 N. Meridian Street, Suite 400, Indianapolis, IN 46204. On receipt of notice from MHS of the presence of apparently adverse information regarding the practitioner, he or she will have 14 days to provide a written response with a detailed explanation for the error or the difference in information. MHS' Credentialing Committee will then include this information to be considered as part of the credentialing or recredentialing process.



## Important Updates

**Revised pharmacy benefits are now in effect.**

**E**ffective December 31, 2009, the Office of Medicaid Policy and Planning (OMPP) assumed responsibility for the administration of the Hoosier Healthwise (HHW) managed care organizations (MCOs) and Healthy Indiana Plan (HIP) pharmacy benefits. Hewlett Packard (formerly EDS) will process all outpatient pharmacy claims and ACS will manage pharmaceutical services for drugs and some drug-related medical supplies and medical devices provided by enrolled Indiana Health Coverage Programs pharmacy or durable medical equipment providers. Please refer to Indiana Health Coverage Programs Bulletin BT200937 ([www.IndianaMedicaid.com](http://www.IndianaMedicaid.com)) for a detailed list of supplies and devices.

Please note that physicians must now utilize the Indiana Medicaid Preferred Drug List (PDL) when prescribing medications for Managed Health Services (MHS) members. The PDL can be found at [www.indianapbm.com](http://www.indianapbm.com). Additionally, MHS members may now have copays for their prescription drugs as follows:

- Presumptive Eligibility (PE) members will not have a copay for drugs.
- HHW members who pay a monthly premium (Package C members) will have a \$3 copay for each generic drug and a \$10 copay for each brand drug.
- HHW members who do not pay a monthly premium (Package A and B members) will follow the same \$3 copay requirements as other FFS members, as outlined in 405 IAC 5-24-7.

Since December 31, 2009, outpatient pharmacy claims that were previously paid by MHS are subject to the Tamper Resistant Prescription Pads (TRPP) requirements.

Refer to Indiana Health Coverage Programs Provider Bulletin BT200929, dated August 26, 2009, for additional information regarding TRPP requirements.

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→ An updated MHS Provider Manual and Provider Quick Reference Guide (QRG) reflecting pharmacy benefit changes is available online at [www.ManagedHealthServices.com](http://www.ManagedHealthServices.com). A comprehensive 2010 edition will be published in March 2010.

MANAGED HEALTH SERVICES  
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## HARD TO SWALLOW

When you're prescribing an antidepressant, keep in mind 30 to 60 percent of patients don't take depression medication as prescribed.

Make compliance a focus of patient education and collaborate with the patient on a treatment plan. You'll gain insight into attitudes and beliefs that may signal future noncompliance. Concerns about cost, side effects, convenience and drug necessity are common reasons for non-compliance.

Most older classes of antidepressants are available in lower-cost generic versions. They're effective, but they produce more adverse effects than the newer classes. Before prescribing an antidepressant, discuss potential side effects and the patient's willingness and ability to tolerate them.

Patients may quit antidepressants prematurely because they think the medication isn't working, or because it is working and they decide they don't need to continue it. Emphasize that several weeks of consistent use of an antidepressant are needed to achieve the drug's main effects. Explain to patients that they shouldn't get frustrated if medication doesn't seem to be working immediately. Dosage changes are frequently required to attain desired effects, and this process could take up to six months. Stopping too soon can lead to a relapse, which may be more severe and less responsive to treatment.

The 2010 HEDIS measure for antidepressant medication looks at the percentage of members 18 years and older newly diagnosed with depression and being treated with antidepressants who remained on the medication during the acute phase treatment of 12 weeks and the continuation phase treatment of at least 180 days.

Encourage the patient to keep appointments and contact you with questions or concerns, especially if he or she is thinking about stopping the medication.

→ **Make it easy for patients to remember instructions by putting them in writing. Also, provide educational handouts for take-home reading.**



## Consumer Assessment

### Member ratings guide improvement efforts.

The 2010 CAHPS survey is scheduled to reach Managed Health Services (MHS) members in March. Members will rate their satisfaction on topics such as doctor-patient communication—particularly regarding smoking cessation and aspirin usage—and overall care from their PMP and specialists. We look forward to commendable CAHPS scores for 2010.

#### Q4 Member Surveys

MHS began conducting semi-formal, intermittent member surveys through SMARI ([www.smari.com](http://www.smari.com)) during third quarter, 2009, seeking member ratings of MHS providers, MHS services and information regarding tobacco cessation.

#### → Notable findings for Q4 2009:

1. Overall high satisfaction rates for MHS providers and services.
2. 86 percent report being happy or somewhat happy with doctors and specialists.
3. Lower satisfaction levels with providers were due to long wait times, unhelpful office staff and inability to have medical questions addressed.
4. 66 percent of reported smokers were offered help from their doctor to quit.

Key opportunities for practitioner improvement, based on member perceptions provided on the SMARI surveys, indicated that MHS and practitioners can work more diligently to address member perceptions of poor patient-doctor communication and long wait times.

We appreciate the care and services you provide to MHS members. If you have any questions or comments regarding the SMARI survey or how to improve SMARI or CAHPS scores, please contact us.

#### 2010 Member Rights and Responsibilities

MHS members have certain rights and responsibilities listed in their handbook, provided to them on enrollment and available on the MHS website. These rights and responsibilities changed January 1, 2010. We encourage MHS providers to be aware of these items and observe them, as applicable. Please visit our website at [www.ManagedHealthServices.com](http://www.ManagedHealthServices.com) to download a copy of the Member handbook. Or, you can call Member Services to request a copy.

## Practitioners' Rights Prior to an Appeal

Before a provider files an appeal, he or she may call MHS to ask for a "peer-to-peer" phone meeting with the MHS doctor who reviewed the case. The patient or provider may still file a Grievance or an Appeal if in disagreement with the result.

To arrange a meeting with MHS, call Provider Services at (877) 647-4848 to request a "peer-to-peer" meeting.

# Information Building Blocks

## Do your diabetic patients know how to manage their disease?

For healthcare providers, the results of yearly screenings completed for the HEDIS comprehensive diabetes care measures reveal a health snapshot of adult patients with diabetes. For most patients, however, the picture isn't very clear. Studies reveal that patients with diabetes have a considerable lack of understanding about their disease.

Discussing test results offers a useful opportunity for patient education. Why not talk to patients not only about what the individual screening numbers mean, but also how they fit together? In particular, adults with diabetes need to know why their heart-related numbers—cholesterol and blood pressure—are as important as their glucose numbers.

The challenge of helping patients achieve and maintain good control is complicated by the fact that most Americans under-exercise and overeat, two unhealthy lifestyle practices. In a

recent study of Americans with diabetes, published in the *Journal of the American Dietetic Association*, most consumed fat, saturated fats and sodium in excess of recommended amounts and didn't eat enough fruits, vegetables, dairy and grains. Consider findings like those a clarion call for more effective, lifelong patient education and guidance on diabetes self-management.

As you review results of blood pressure and LDL cholesterol screenings with patients, explain the link between diabetes and cardiovascular disease (CVD). CVD is the leading cause of premature death among people with diabetes. In one study published in the *Journal of the American College of Cardiology*, only 17 percent of patients with diabetes were

aware that CVD is a serious complication of diabetes.

Fortunately, healthy lifestyle modifications that contribute to glycemic control—diet, exercise and stress reduction—also help in the management of CVD, so your patient education efforts are doubly important.

**Listen and learn.** Ask your patients to walk you through a typical day of managing their diabetes. This helps them to “own” their role as manager of their condition. You get to listen for clues to what's working and what's a problem. When they're done, offer encouragement and reinforce their strengths. Address their frustrations and concerns. If you pick up on lack of family support or cultural obstacles, be sensitive when talking about them with your patients.

**7%** Hemoglobin A1c levels lower than 7 percent indicate good glycemic control.



## The Skinny on BMI

As part of the outpatient visit, practitioners should enter the Body Mass Index (BMI) of all patients ages 18 to 74 into the medical record. It's for the Adult Body Mass Index assessment, a HEDIS measure introduced in 2009 that assesses the percentage of health plan members ages 18 to 74 who had an outpatient visit and had their BMI documented during the current or prior measurement year.

An indirect measure of body fat, BMI is a weight-to-height index. The measurement is a convenient opener to a straight-talk discussion of the patient's weight, any health risks and weight-management strategies. Tailor your message to the patient's weight and readiness for behavior change.

Surprising numbers of Americans are unaware—or in denial—of their condition: In a 2006 Thomson Medstat study, 80 percent of overweight people and 64 percent of morbidly obese people described their eating habits as very or somewhat healthy; 40 percent of obese people reported that they exercise vigorously for 20 minutes a day, three times a week.

→ **If you don't use an electronic health record that calculates BMI (kg/m<sup>2</sup>), you can run the numbers using a BMI calculator at <http://cdc.gov/healthyweight/assessing/bmi/>.**

Classification	BMI (kg/m <sup>2</sup> )
Underweight	Below 18.5
Healthy weight	18.5–24.9
Overweight	25.0–29.9
Obese	30.0 and above
Morbid/ Extreme obesity	40.0 or higher

Source: CDC, 2009

## On Our Website

MHS has adopted clinical practice guidelines, which are available for review on the MHS website at [www.ManagedHealthServices.com](http://www.ManagedHealthServices.com). References that are utilized for the creation of these guidelines include National Guidelines Clearinghouse, AHCPR, AAP, NHLBI, ACOG and others that are specific to the disease entity.

These guidelines are for reference purposes and may not contain all updated information. They are reviewed and approved by the Clinical and Service Quality Improvement Committee at least every two years to ensure appropriateness and current content.

→ **Request printed copies of these items and any other information from MHS by calling (877) 647-4848.**

