



*"People
helping people
help
themselves"*

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
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INDIANAPOLIS, IN 46207-7083

MEMO

To: Select Joint Commission on Medicaid Oversight
From: Medicaid Managed Care Quality Strategy Committee
Date: October 13, 2010
Re: Committee Recommendations

The 2009 Indiana General Assembly passed House Bill 1572, creating the Medicaid Managed Care Quality Strategy Committee. The Committee was created to provide information on policy issues concerning Medicaid, specifically:

- Emergency room utilization
- Prior authorization
- Standardization of procedures, forms, and service descriptions
- Effectiveness and quality of care
- The number of denials by a managed care organization, the reasons for the denials, and the number of appeals and overturning of denials by a managed care organization.
- How reimbursement rates are determined by a managed care organization, including reimbursement rates for emergency room care and neonatal intensive care

The Committee is required to submit a report to the Select Joint Commission on Medicaid Oversight in October 2010. The Committee respectfully submits its report on the above policy issues for the review of the Select Joint Commission on Medicaid Oversight.



HEA 1572: Medicaid Managed Care Quality Strategy Committee
Report to the State of Indiana Commission on Medicaid Oversight
October 2010

**Report prepared by Office of Medicaid Policy and Planning with approval from
the membership of the Medicaid Managed Care Quality Strategy Committee**

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Section 1: Background and Purpose

The State of Indiana Office of Medicaid Policy and Planning (OMPP) operates the Hoosier Healthwise (HHW) program for children, pregnant women and low-income adults under CMS approved 1115 and 1915b waivers. The program received federal approval in 1993, with the program officially rolling out in mid-1994. The program has evolved over the past sixteen years and currently operates statewide with mandatory managed care enrollment for the population. Effective January 1, 2007, the State contracted with three managed care organizations (MCOs): Anthem, Managed Health Services (MHS), and MDwise.

The 116th Indiana General Assembly passed House Bill 1572 to amend the Indiana Code concerning the Medicaid program. This report focuses on Section 15 of HEA 1572 that established a Medicaid Managed Care Quality Strategy Committee (MCQSC) in order to assist and provide information to the chairman of the Select Joint Commission on Medicaid Oversight in several specific areas as noted below.

“The committee shall study issues related to the following:

- 1) Emergency Room Utilization
- 2) Prior Authorization
- 3) Standardization of procedures, forms, and service descriptions
- 4) Effectiveness and quality of care
- 5) The number of denials by a managed care organization, the reasons for the denials, and the number of appeals and overturning of denials by a managed care organization;
- 6) How reimbursement rates are determined by a managed care organization, including reimbursement rates for emergency care and neonatal intensive care.” (HEA 1572:Section 15, p. 13)

MCQSC Committee Composition

HEA 1572 required that the MCQSC be composed of seven members with appointments made by the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Chairperson of the Legislative Council. The Secretary of the Family and Social Services Agency (FSSA) was required to staff the committee. The members of the committee are as follows:

- 1) Two Individuals Representing Medicaid Providers:
 - a. Kristi Somes, BS, Revenue Cycle Supervisor, Schneck Medical Center
 - b. Stephen Tharp, MD, Public Health Officer, Clinton County
- 2) One Individual Representing Public Hospitals:
 - a. Matt Gutwein, JD, CEO Marion County Health and Hospital Corporation
- 3) Two Individuals Representing Medicaid Managed Care Organizations:
 - a. John Barth, MSW, Vice President of Compliance & Regulatory Affairs, Managed Health Services;
 - b. Amy Brown, MSW, Vice President Government Programs, Advantage Health Solutions
- 4) One Individual Representing Mental Health Professionals:

- a. Josephine Hughes, MSW, Director, NASW
- 5) One Individual from the OMPP who shall act as chairperson for the Committee:
 - a. Doug Elwell, MSA, Acting Deputy Director, Indiana OMPP
 - b. Replaced by Pat Casanova, RN, Director, Indiana OMPP

MCQSC Committee Schedule and Attendance

The MCQSC meeting schedule was arranged so that the voting members of the committee met on an ad hoc basis and the full committee met every other month in a session inclusive of members from the interested public. Meetings were held on the following dates:

- October 26, 2009 (session open to the public)
- November 11, 2009 (ad hoc committee only)
- January 21, 2010 (session open to the public)
- February 18, 2010 (ad hoc committee only)
- March 18, 2010 (session open to the public)
- May 20, 2010 (session open to the public)
- July 15, 2010 (session open to the public)
- August 19, 2010 (session open to the public)
- September 16, 2010 (session open to the public)

	Meeting Dates, Agenda Overview, and Attendance Records								
Dates	Oct 26, 2009	Nov 11, 2009	Jan 21, 2010	Feb 18, 2010	March 18, 2010	May 20, 2010	July 15, 2010	August 19, 2010	Sept 16, 2010
Agenda Items	Opening Comments Emergency Department and PLP Study HEDIS Quality measures Reimbursement Rate Determination	Review of legislation Review of findings from October 2009 meeting 2010 Process and Goals	Welcome, review of minutes and 2010 mtg schedule Prior Authorization Study Results Review of Standard PA form	Follow up from November meeting Structure of Future Meetings Review of Legislation and Focus of the Committee Standardized Forms Approval Process	Welcome, review of minutes Right Choices Program Race, Ethnicity, and Quality Outcomes Audience Q&A	Welcome, review of minutes Update on Standardization of Forms Timeline for Legislative Report development Inpatient stays <24 hours Development of ER triage fee	Welcome, review of minutes Review of Standardized PA Form Update on Inpatient Stays <24 Hours Development of ER Triage Fee Discussion on Draft Report	Welcome, review of minutes Review and Approval of PA Form and Standardized Credentialing Form Report Review Sections 1-3	Welcome, review of minutes Review of Standardized Credentialing Form Report Review Sections 4-7
John Barth	x	x	x	x	x	x	x	x	x
Amy Brown		x	x	x				x	x
Matt Gutwein	x	x		x	x	x		x	x
Josephine	x						x	x	x

Hughes									
Kristi Somes	x	x	x	x	x	x	x	x	x
Steven Tharp	x	x	x	x	x	x	x	x	x
OMPP Leadership	x	x	x	x	x	x	x	x	x

Section 2: Emergency Department Utilization

Overview

The OMPP conducted two separate studies regarding ED utilization and the current prior authorization (PA) processes associated with ED utilization. The first study focused on the Prudent Layperson (PLP) process, including a breakdown of administrative denial reasons for ED facility and physician claims, diagnoses that most commonly did not receive payment, and reports from the MCOs regarding their ED diversion activities. The second study included a clinical review of a random sample of requests for authorization, including approvals and denials. Each MCO was reviewed separately and a clinical summary was presented.

An MCO may conduct a prudent layperson review to determine if a member presenting at an emergency room had an emergency medical condition. Per *IC 12-15-12-0.3* and *42 CFR 438.114*, an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

Regardless of the outcome of the prudent layperson review, both the facility and physician must receive reimbursement for the screening services. Specifically, for physician services billed on a CMS-1500 claim, if a prudent layperson review determines the service was not an emergency, the MCO must reimburse, at minimum, for Current Procedural Terminology (CPT®1) code 99281 – *Emergency department visit – Level 1 screening fee*. Additionally, for facility charges billed on a UB-04, if a prudent layperson review determines the service was not an emergency, the MCO must reimburse for revenue code 451.

With the exception of the physician screening fee and facility fee, the MCO is not required to reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition, unless the MCO authorized this treatment.

Study Methods

Thirty cases were selected from each MCO, including cases that had met PLP approval and those that did not meet PLP approval. The review included Explanation of Benefits forms, and clinical and administrative documentation. Importantly, the ED experience is covered through two claims submissions: a facility (hospital) claim and a provider (physician) claim.

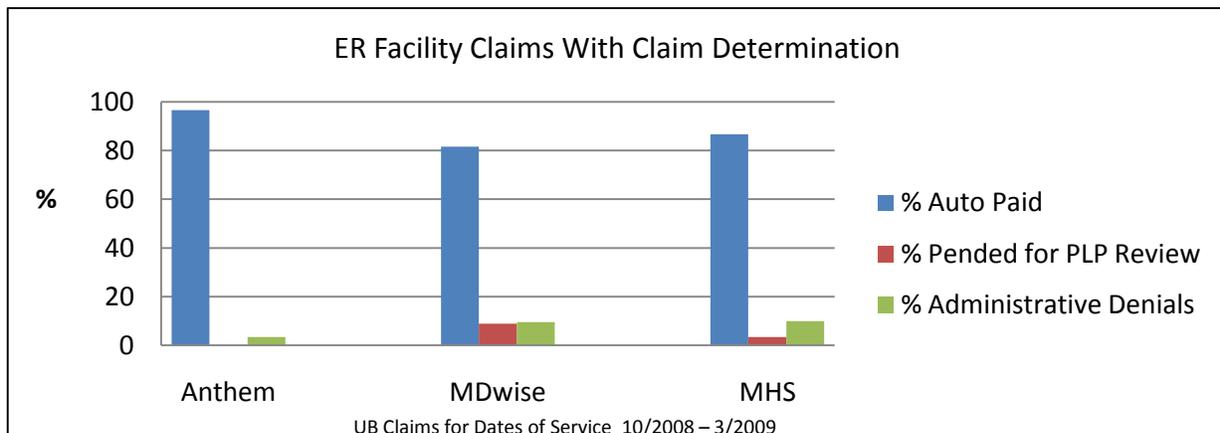
Study Findings

Each MCO has its own process for handling ED claims. Anthem did not participate in a PLP process during the period under review. However, Anthem has subsequently implemented a PLP process.

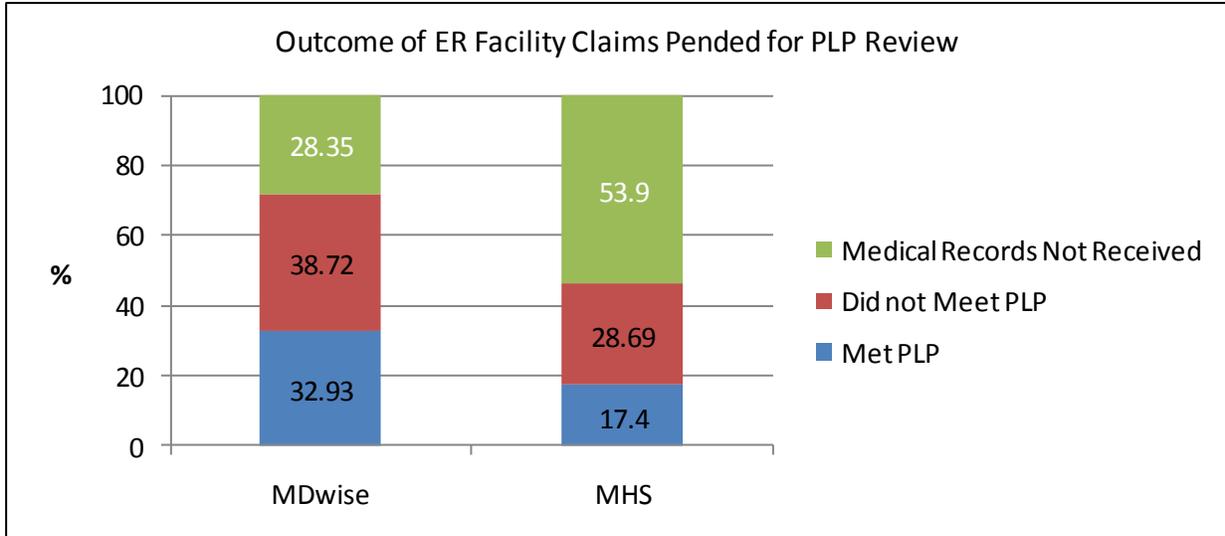
MHS has set up contracting arrangements with hospitals to be part of their ED Claims Program. MHS has a diagnostic listing which is grouped into four categories. These categories range from Level 1 “obvious medical emergencies” to Level 4 in which the presenting signs and symptoms do not meet PLP criteria. Providers participating in the ED Claims Program receive payment for all claims based on the primary diagnosis on the claim. Supporting medical documentation is not required per their contracting arrangements. Participating providers may not appeal the claim payment. Those providers who have opted not to participate in the ED Claims Program are required to submit medical record documentation when the primary diagnosis is a Level 3 or Level 4 on the diagnostic list. These claims undergo formal medical record review, inclusive of the PLP review. Decisions may be appealed. Only facility claims go through the PLP process; physician claims are not pended for medical record review.

MDwise has an auto-pay list. When a diagnosis is not on the auto-pay list, a PLP reviews the presenting symptoms to determine if the standard for PLP is met. If the standard is met, the claim is processed and paid. Those rejected by the PLP processes are paid the screening fee. Some provider groups have set up different billing and payment arrangements through their contract with MDwise and do not participate in the PLP process. All providers have the opportunity to appeal decisions.

Overall, more than 80% of facility ED claims were auto-paid by all three MCOs.



Of those facility claims pended for PLP review, there was a high percentage of medical records not sent in by the provider. Therefore, in these cases the MCO was unable to conduct a clinical review.



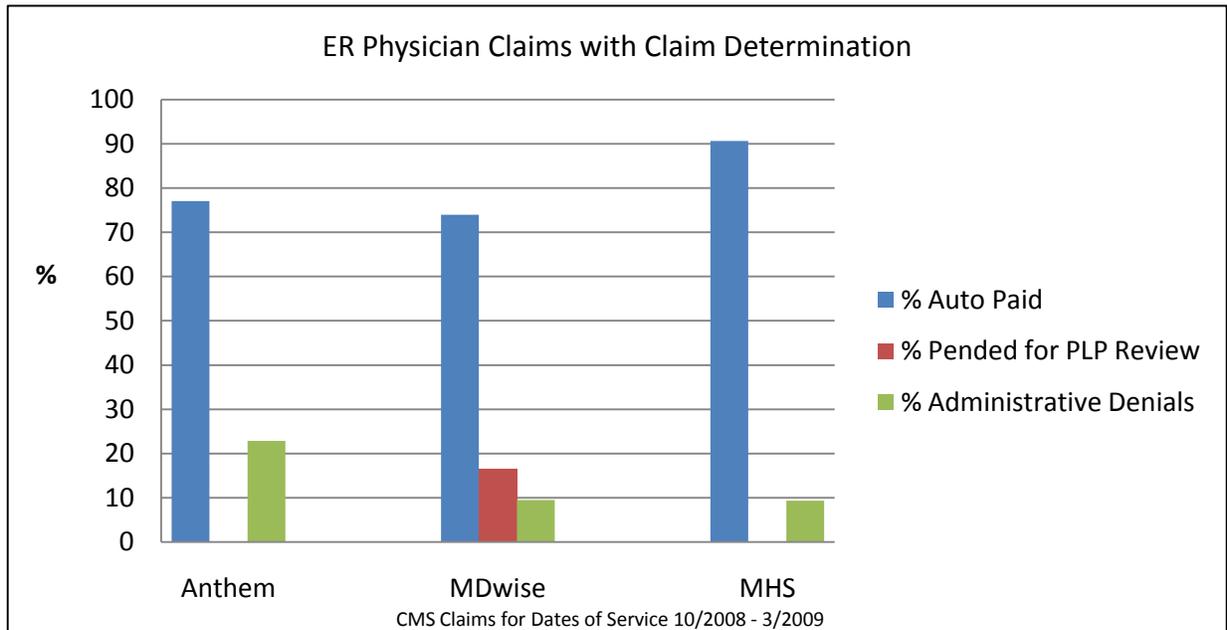
Of those claims denied, the majority were due to administrative reasons versus failure to meet the PLP standard.

MCO	% of Claims Denials Due to Administrative Reasons	% of Claims Denial Due to Not Meeting PLP
Anthem	100%	N/A
MDwise	73.42%	26.58%
MHS	91.1%	8.9%

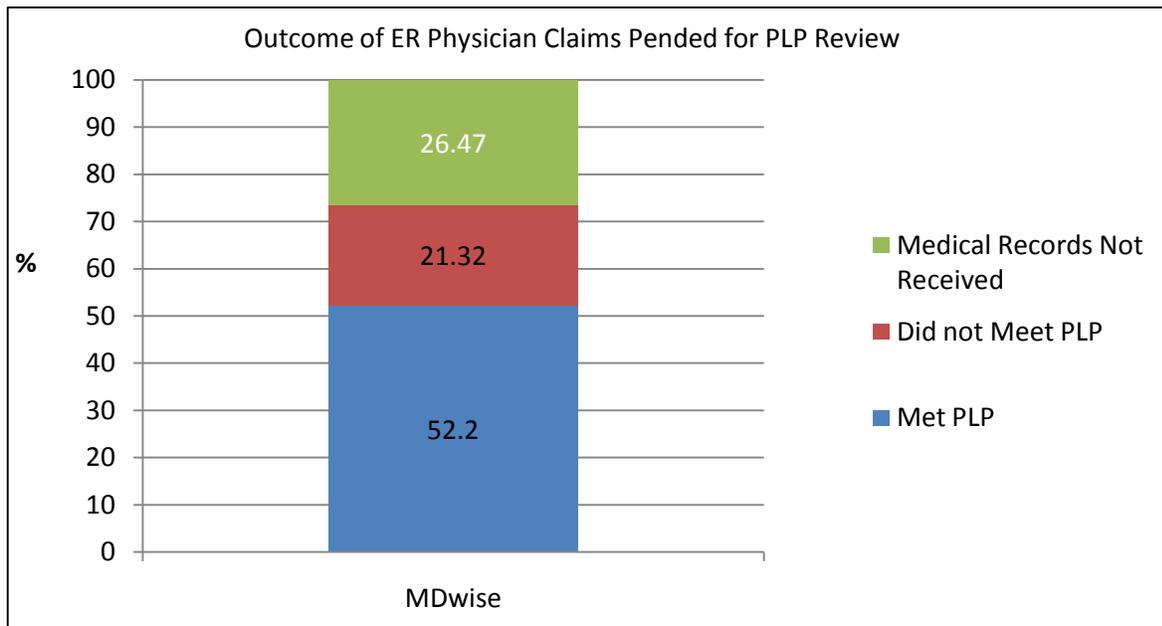
Administrative denials were found to be most commonly the result of improper billing by the provider.

ER Facility Claims – Top Administrative Denials		
Anthem	MDwise	MHS
1. Provider not attested	1. Bundled services	1. Bill primary insurer first
2. Duplicate claim	2. Services not covered	2. Time limit for filing has expired
3. Timely filing	3. Exceeds fee	3. Not a MCO covered benefit
4. Other carriers payment exceeds allowed amount	4. Filing limit	4. Coverage not in effect when service provided
5. Invalid diagnosis	5. Duplicate claim	5. Member name/number/dob do not match

The number of physician claims pending for review by MDwise (the only MCO to conduct a PLP process for physician claims) was greater than the hospital claims.



However, of those claims pended for review, over 50% were paid, and more than 25% were denied because of failure of the provider to submit medical record documentation. Less than 25% were denied due to not meeting the PLP standard. As was found in the facility claims, the majority of physician claim denials were due to administrative reasons.



The clinical review revealed many of the issues salient to the debate regarding use of emergency departments for non-emergent medical services. Importantly, those clinical claims most likely to be denied were those that could have been seen in a primary care, non-emergency setting. The most common of these were for infections, including otitis media (ear infection), pharyngitis (throat infection/sore throat), or bronchitis (upper respiratory tract infection). Clinical review of these claims revealed inconsistencies. In some cases, claims for these common conditions were paid, in others, the claims were denied. Variations in ED practice across facilities were noted. Findings by the medical reviewer include instances of overutilization of radiological procedures (e.g. chest x-rays) and the clinically unwarranted use of narcotic medications (see Appendix 1 for specific case examples).

Each MCO has put ED diversion programs into place, including outreach programs to members with excessive ED utilization, and other educational interventions for their membership as outlined below.

Anthem	<ul style="list-style-type: none"> • ER diversion program with Deaconess Hospital and St. Mary’s Hospital <ul style="list-style-type: none"> • Receive real-time notification of member’s presenting to ER • Outbound calls by case managers for members with more than 3 ER visits • Sends educational information on proper ER use
MDwise	<ul style="list-style-type: none"> • Conducts the Emergency Room Intervention Program <ul style="list-style-type: none"> • Members with ER visits for non-urgent symptoms are contacted by a Member Advocate to educate about appropriate use of the ER • Members with multiple emergency room visits are flagged for case management evaluation • Partnering with Indiana Health Information Exchange (IHIE) to receive timely notification of ER visits • ER diversion program with St. Vincent Hospitals • Implementing IVR calls in the Fall to members with multiple ED visits • Restricted card for members who meet the criteria due to frequent ER visits
MHS	<ul style="list-style-type: none"> • Generates a claims-based Emergency Department diversion report and conducts phone outreach to members and providers • Distributes a "What to do When your Child gets Sick" book and an “when to use the ER” brochure • The restricted card identification process includes ER "frequent flyers" to minimize ER utilization, which triggers case management • 24/7 nurse triage line for members • Distributes cold kits which includes information on URI care

Recommendations:

- 1) A uniform auto-pay list of conditions is not recommended given that the most common cause of denials are for conditions that should be seen in the primary care setting.
- 2) MCOs to develop internal inter-rater reliability procedures to help ensure MCE internal consistency in the PLP determination process. Inter-rater reliability procedures help to

ensure individual reviewers apply consistent standards. Ongoing OMPP monitoring has confirmed that has occurred since this study was conducted. Additionally, the MCOs are conducting a cross-MCO inter-rater reliability study. Cases will be reviewed by staff at each MCO to further study the inter-rater reliability between MCOs.

- 3) Continued monitoring and program development surrounding the monitoring of ED overuse by Medicaid members. For example, the Right Choice Program (Appendix 2).

Conclusion:

After a review and public discussion of the data and policy information discussed above, the Committee has determined that the MCOs are compliant with state and federal regulations and contract requirements in regard to this ED study. Beyond this the MCOs application of the PLP standard appears to be focused on the type of conditions that are more appropriately treated in the primary care setting. Finally, each MCO has an ED diversion and education program in place to address the issue of ED over-utilization.

Section 3: Prior Authorization, Denials, and Appeals

Overview

OMPP contracted with an external independent entity, Burns and Associates (B&A) to conduct an evaluation of the prior authorization (PA) system for Indiana Medicaid MCOs. There were three main goals of the study:

1. Understand similarities and differences across the MCOs related to authorization policies and procedures
2. Compile results of authorizations completed in calendar year 2008
3. Identify recommendations for improving authorization processes in Hoosier Healthwise

The study included a comparison of the authorization process flows at each MCO, a review of authorization policies and procedures and an audit of a sample of approved and denied authorizations at each MCO.

Findings

MCO PA Policies & Process

When reviewing the PA process, B&A found that all three MCOs follow a similar workflow process for intake and review of authorization requests. Generally, requests are submitted by providers and either approved or denied. The request is reviewed utilizing industry standard criteria such as Milliman or Interqual. Of those that are denied, the provider may submit additional information. The provider can exercise the right to appeal a denial and request a peer review or file a formal appeal. In the peer review process the provider discusses the case with a medical director at the MCO and a decision may be rendered. In the appeal process, the appeal undergoes a formal review by a different clinical staff. If the denial is still upheld, the provider may request an optional independent review of the PA request. If the denial is still upheld, the provider may request a State Fair Hearing on behalf of the member. Additionally, all MCOs were found to employ an inter-rater reliability process for nurses and doctors.

Audit of Approved & Denied Authorizations & Appeals

B&A compiled data from MCO reports on all PA decisions made during 2008. The review of all authorization requests found variation by MCO in the denial rates for inpatient and outpatient services. Additionally, MHS was found to have a higher proportion of denials than Anthem and MDwise overall. However, it should be noted that subsequent monitoring by OMPP through 2009 and 2010 has revealed this trend no longer holds true and all MCOs have comparable denial rates. Finally, very few clinical denials were made by non-clinicians and 11% of the authorizations denied were subsequently approved within 30 days.

The following table provides an overview by MCO of the attributes of the 2008 PA requests.

	Anthem	MHS	MDwise	TOTAL
All Authorizations				
Total	28,290	45,495	91,290	165,075
Approved	26,905 95%	40,296 89%	88,318 97%	155,519 94%
Denied	1,385 5%	5,199 11%	2,972 3%	9,556 6%
Nonclinician Review	6,463 23%	21,267 47%	14,243 16%	41,973 25%
Clinician Review	21,827 77%	24,228 53%	77,047 84%	123,102 75%
Approved Authorizations Only				
Total	26,905	40,296	88,318	155,519
Nonclinician Review	6,460 24%	21,089 52%	14,167 16%	41,716 27%
Clinician Review	20,445 76%	19,207 48%	74,151 84%	113,803 73%
Denied Authorizations Only				
Total	1,385	5,199	2,972	9,556
Nonclinician Review	3 0%	178 3%	76 3%	257 3%
Clinician Review	1,382 100%	5,021 97%	2,896 97%	9,299 97%

B&A developed a study sample based on this report of PA requests for 2008. A 95% confidence interval was required in order to ensure that the sample was representative of the entire population of PA requests. The ultimate sample of 873 cases reviewed was across seven service categories:

1. Ambulatory or Outpatient Surgical
2. Outpatient Diagnostic Procedures, Radiology or Pathology
3. Inpatient Medical/Surgical or Observation
4. Specialist Referrals
5. Physical, Occupational or Speech Therapy
6. Durable Medical Equipment
7. Home Health Visits

The following table outlines the attributes of the sample reviewed.

	Anthem		MHS		MDwise		TOTAL	
	MCO Total	Pct of Total	MCO Total	Pct of Total	MCO Total	Pct of Total	Total	Pct of Total
Final Determination of Authorization Request								
Approved	52	29%	43	12%	125	36%	220	25%
Denied	129	71%	303	88%	221	64%	653	75%
Total	181		346		346		873	
Type of Authorization Request								
Pre Service	98	54%	223	64%	261	75%	582	67%
Concurrent Review	58	32%	72	21%	47	14%	177	20%
Retrospective	23	13%	44	13%	35	10%	102	12%
Cannot be determined from file	2	1%	7	2%	3	1%	12	1%
Total	181		346		346		873	
Number of Days from Request to Determination								
Less than 1 day	40	22%	15	4%	132	38%	187	21%
1 day	41	23%	37	11%	46	13%	124	14%
2 days	14	8%	36	10%	30	9%	80	9%
3 days	7	4%	28	8%	15	4%	50	6%
4 to 14 days	65	36%	171	49%	88	25%	324	37%
More than 14 days	14	8%	59	17%	35	10%	108	12%
Total	181		346		346		873	
Modified Auths	21	12%	10	3%	15	4%	46	5%
Appeals	7	4%	25	7%	21	6%	53	6%

The B&A Clinical Team, which was comprised of five RNs and two MDs, reviewed documentation provided by the MCOs for each of the 873 cases in the sample. Of the 539 clinically denied authorizations reviewed by B&A's Clinical Team, B&A agreed with the denial 58% of the time, disagreed 13% of the time and did not have enough information to make a conclusion (due to lack of medical records provided to B&A) 29% of the time.

The clinical reviewers found that clinical guidelines (e.g., Milliman or Interqual) were usually cited, but there were examples where co-morbidities, age or life situation may merit deviating from clinical guidelines. Additionally, there were numerous situations found where MCOs documented multiple requests from providers for more information before issuing an administrative denial. A review of denial letters also revealed more explanation to providers was sometimes needed.

Finally, review of appeals data indicated that although there was a difference between MCOs in the rates of denials, all MCOs had a similar percentage of overturned decisions upon appeal. The overall average of denials overturned in the sample was 35%.

Recommendations

It is important to note that the B&A study evaluated claims processes for CY2008. By CY2009, many of these processes had been found during ongoing OMPP monitoring to have improved. In areas where it was determined that continued need for improvement remained, the State has integrated findings from the B&A study into 2010 and beyond contract requirements. For example:

- 1) Utilization management and PA process language in the MCO contract warranted strengthening. OMPP incorporated these recommendations in the HIP/HHW rebid request for services for an effective date of January 1, 2011. For the current contract term, OMPP continues to cover these topics during MCO oversight meetings.
- 2) In response to the concern that medical documentation submitted to B&A was not always complete, OMPP established minimum requirements to help ensure more consistent record keeping when denying PA requests. Specifically, for all denials of PA requests, the MCO “shall maintain a record of the following information, at a minimum, in the Contractor’s information system:
 - Name of caller
 - Title of caller
 - Date and time of call
 - Clinical synopsis inclusive of: 1) timeframe of illness or condition; 2) diagnosis; and 3) treatment plan
 - Clinical guideline(s) or other rationale supporting the denial (e.g., insufficient documentation)”

Conclusion

Overall, the study determined that all three MCOs follow a similar workflow process for intake and review of authorization requests while utilizing industry standard criteria such as Milliman or Interqual. As identified within this section, Burns reported that during 2008, MCO PA denial rates ranged from 5%-11%. As of 2009, all MCOs have comparable denial rates, averaging 7% in the second half of the year. The clinical reviewers agreed with the MCOs decision making or did not have enough information to make a determination 87% of the time. Due to the comprehensive and interactive approach that OMPP uses to monitor the MCOs, operational issues that need to be addressed from time-to-time are generally handled in real time.

Section 4: Effectiveness and Quality of Care

Overview

The OMPP presented the HEDIS 2009 results to the committee. HEDIS 2009 represents services provided during calendar year 2008 and reported by the health plans to the OMPP in June 2009.

The following measures were presented:

- Adult Access to Preventive/Ambulatory Care (AAP)
- Children and Adolescents’ Access to PCPs (CAP)
- Well-Child Visits -through 15 months, six or more visits (W15)
- Well-Child Visits, 3 to 6 year olds (W34)
- Well-Child Adolescent Visits (AWC)

- Appropriate Testing for Children with Pharyngitis (CWP)
- Emergency Room Visit Rates (AMB)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Avoidance of Antibiotic for Acute Bronchitis (AAB)
- Pharmacotherapy Management of COPD Exacerbation (PCE)
- Appropriate Use of Imaging Studies for Low Back Pain (LBP)
- Frequency of Myringotomy and Tonsillectomy (FSP)

Study Methods

The National Committee for Quality Assurance (NCQA) maintains and publishes the Healthcare Effectiveness Data and Information Set (HEDIS®) annually. HEDIS is one of the most widely used set of healthcare performance measures in the United States. The OMPP requires Managed Care Organizations (MCOs) to collect and report HEDIS results to the State on an annual basis. Submission of HEDIS results to NCQA is one of the requirements for NCQA Accreditation.

HEDIS data are collected using administrative methods (e.g., claims) and/or hybrid (claims and medical record review). Some services cannot be quantified accurately using only claims data. For example, well-child visits are often coded by office personnel as a general office visit. When auditors review the medical record, the auditor may determine that documentation shows that a well-child visit was performed. If HEDIS specifications call for a hybrid measurement, the general office visit can be counted as a well-child visit during final rate calculation. Details related to sampling methodology and final rate calculation can be located in the HEDIS Technical Specifications (Volume 2).

Each MCO is required to measure HEDIS according to the most current technical specifications. Results are gathered by the MCO and audited by an independent HEDIS-certified auditor. The final results and auditor’s report are submitted to OMPP by July of each year. Results are representative of services provided during the prior calendar year (e.g., July 2010 submission represents services provided during calendar year 2009.)

The use of standardized measures allows OMPP to compare Indiana Medicaid MCOs to each other, as well as performance against national Medicaid managed care benchmarks. Over the past few years, OMPP has incorporated MCO performance on select HEDIS measures into the pay-for-performance program.

Study Findings

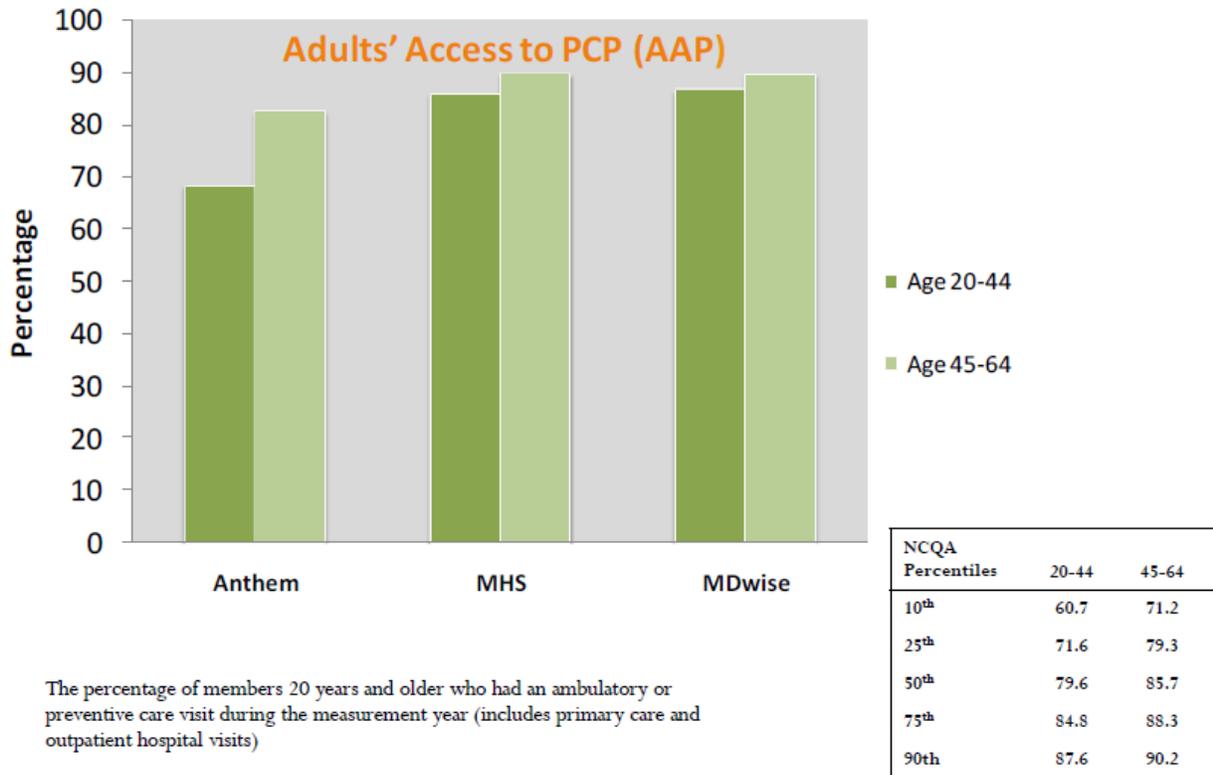
The OMPP presented the HEDIS results for calendar year 2008 to the committee. The following measures were reviewed by the committee.

Measures and Methodology	
Adult Access to Preventive/Ambulatory Care (AAP) –	Administrative Measure
Children and Adolescents’ Access to PCPs (CAP) – Administrative Measure	Administrative Measure
Well-Child Visits –first 15 months, 6 or more	Hybrid Measure

visits (W15) – Hybrid Measure	
Well-Child Visits, 3 to 6 year olds (W34)	Hybrid Measure
Well-Child Adolescent Visits (AWC)	Hybrid Measure
Appropriate Testing for Children with Pharyngitis (CWP)	Administrative Measure
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Administrative Measure
Avoidance of Antibiotic for Acute Bronchitis (AAB)	Administrative Measure
Pharmacotherapy Management of COPD Exacerbation (PCE)	Administrative Measure
Appropriate Use of Imaging Studies for Low Back Pain (LBP)	Administrative Measure
Emergency Room Visit Rates (AMB)	Administrative Measure
Frequency of Myringotomy and Tonsillectomy (FSP)	Administrative Measure

The above listed measures were selected due to the relationship to emergency department and primary care utilization. The selected measures describe access to and appropriate use of preventive services and appropriate treatment of common conditions (e.g., respiratory infections, low back pain). The committee was also involved in reviewing MCO emergency room payment policies, which are discussed in Section 2 of this report.

Access to Primary Care Provider for Preventative Services



Adults' Access to Primary Care Services

For calendar year 2008, the measure of Adults' Access to Primary Care Services is above the 75th percentile for the two MCOs that have longer tenure with the Indiana Medicaid. Anthem began providing services on January 1, 2007; therefore, the slightly smaller membership base and start-up of a new health plan may have resulted in scores between the 25th and 50th percentile nationally. Preliminary results for HEDIS 2010 (represents calendar year 2009) demonstrate significant improvement by Anthem during calendar year 2009 with over 82% of members 20-44 years and 87% of members 45-64 years of age with an ambulatory or preventive care visit during 2009. The below table shows the rates for all three MCOS during calendar year 2009. The 2009 national HEDIS Medicaid percentiles are also shown.

Adults' Access to Primary Care Services – HEDIS 2010 (Calendar Year 2009)			
	Anthem	MHS	MDwise
Ages 20-44 years	82% (>50 th percentile)	86% (> 75 th percentile)	87% (>75 th percentile)
Ages 45- 64 years	87% (>25 th percentile)	89% (>50 th percentile)	90% (>50 th percentile)

Well Child Visits

HEDIS has several measures to evaluate the rate of children receiving well-child check-ups. The following three graphs demonstrate a need for improvement for all age groups and all MCOs. While preliminary results for HEDIS 2010 (calendar year 2009) indicate improvement in the scores for well-child visits, OMPP will engage the MCOs in a collaborative approach focused on further improvement in the area of children’s preventive care. Improvement in the rates in past years can likely be attributed to increased attention by OMPP and the MCOs, with increased pay-for-performance dollars associated with well-child efforts. The MCOs have increased provider education efforts to improve data capture of this important service.

Well-child visits in the first 15 months of life looks for six or more preventive care visits. For calendar year 2008, only one MCO (MDwise) scored above the 50th percentile of 57.5%. Preliminary results for calendar year 2009 showed improvement by MHS and Anthem. MDwise’s rate for this age group dipped slightly from 2008 to 2009.

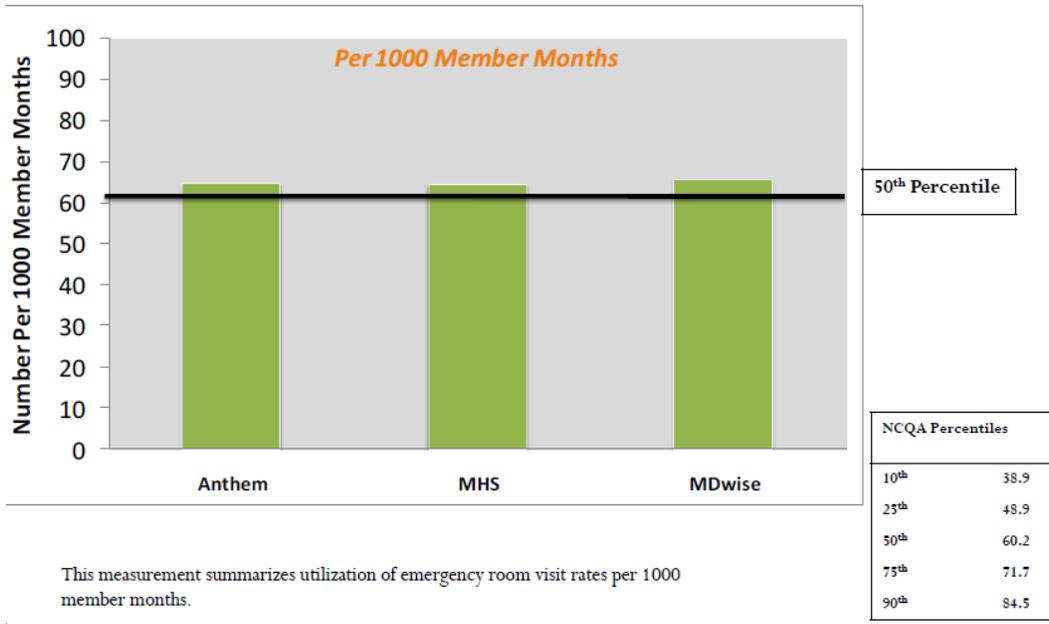
The most striking change from calendar year 2008 to 2009 includes the two measures for well-child visits at ages 3-6 years and 12-21 years. Anthem, MHS and MDwise rates all improved significantly in both age groups, with some rates improving by as much as 10 percentage points from 2008 to 2009.

Well-Child Measures, Calendar Years 2008 vs. 2009						
	Anthem		MHS		MDwise	
	CY2008	CY2009	CY2008	CY2009	CY2008	CY2009
Well-Child, first 15 months, six or more visits	51.4%	50.9%	48.7%	56.9%	61.1%	60.8%
	(>25 th)	(>25 th)	(>10 th)	(>25 th)	(>50 th)	(>50 th)
	44.5%	51.6%	29%	51.6%	57.5%	60.6%
Well-Child, 3-6 years of age	56.0%	65.2%	58.3%	64.5%	62.8%	72.9%
	(>10 th)	(>25 th)	(>10 th)	(>25 th)	(>10 th)	(>50 th)
	52.3%	64%	52.3%	64%	52.3%	70.4%
Adolescent (12-21 years) well-child visit	44.9%	47.9%	37.7%	46.9%	40.2%	53.3%
	(>50 th)	(>50 th)	(>25 th)	(>50 th)	(>25 th)	(>75 th)
	42.1%	45.1%	35.9%	45.1%	35.9%	53.2%

Emergency Department Utilization

Utilization of the emergency department among the three Indiana Medicaid MCOs is only slightly above the national average for other Medicaid health plans.

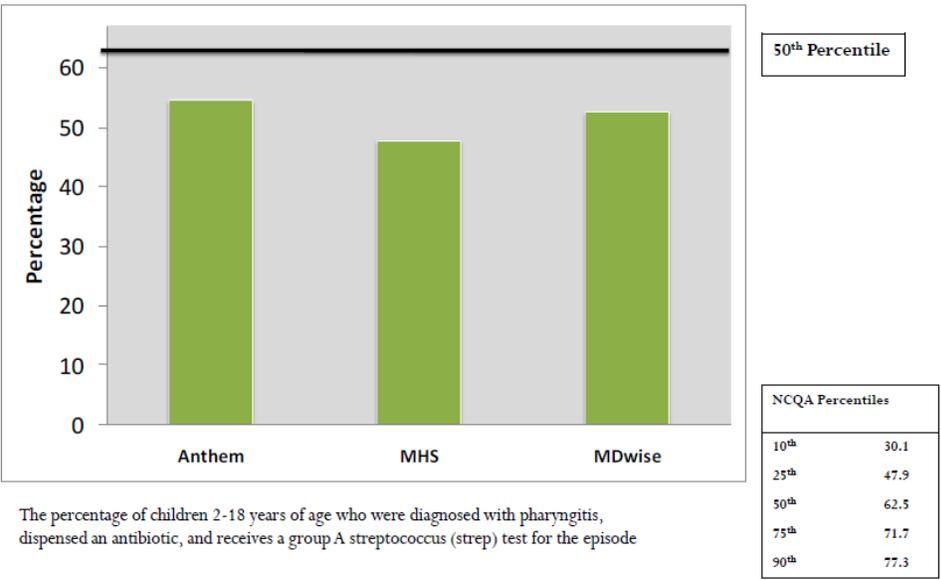
Emergency Room Visit Rates (AMBA)



Appropriate Outpatient Treatment

Treatment of adults and children with pharyngitis, upper respiratory infection, or bronchitis has some room for improvement. The MCOs regularly educate physicians and members regarding appropriate treatment. Still, fewer than 60% of children diagnosed with pharyngitis and dispensed an antibiotic are given a Strep A test.

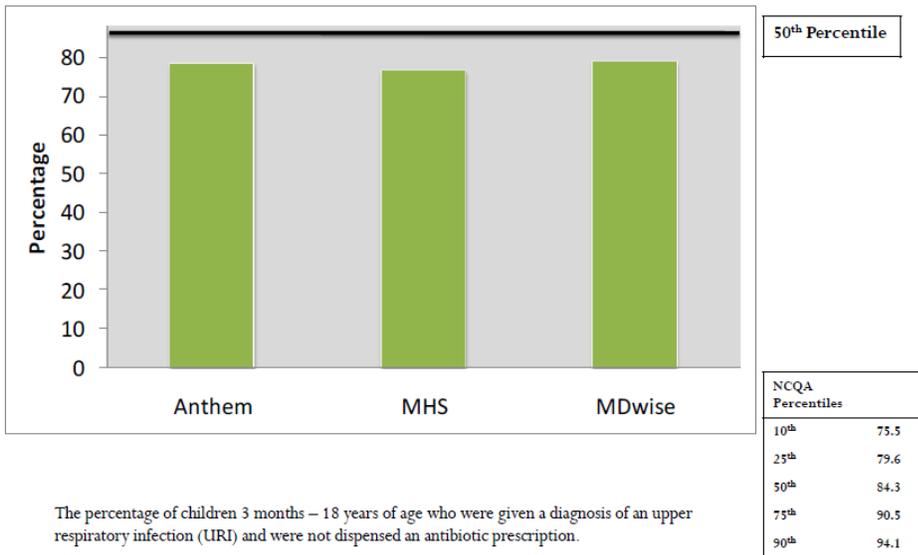
Appropriate Testing for Children with Pharyngitis (CWP)



The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and receives a group A streptococcus (strep) test for the episode

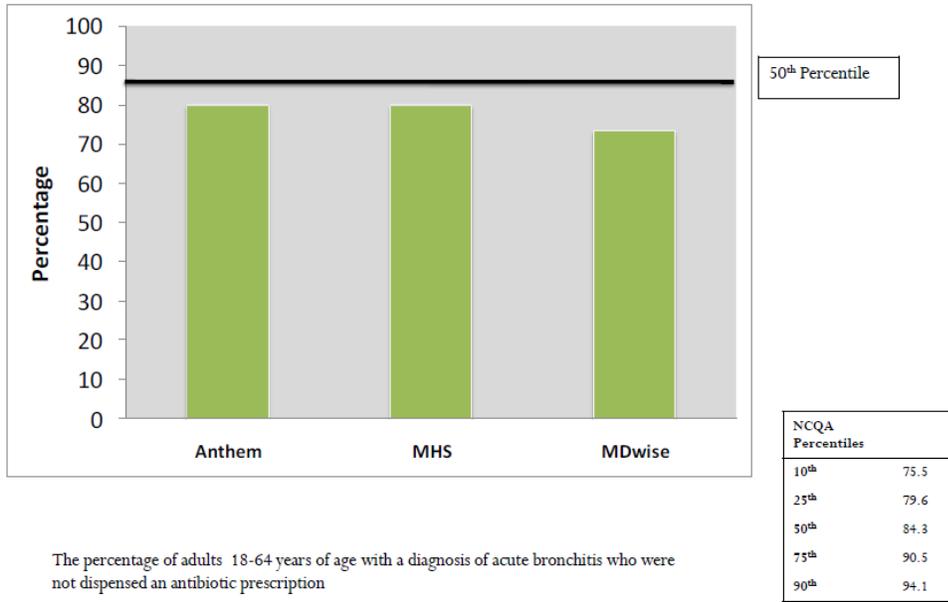
Similarly, approximately 25% of children diagnosed with a viral upper respiratory infection (URI) are dispensed antibiotic prescription, which is not the appropriate course of treatment for a URI. Similar results are shown for adults with acute bronchitis, with nearly 20% dispensed an antibiotic.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)



The percentage of children 3 months – 18 years of age who were given a diagnosis of an upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Avoidance of Antibiotic for Acute Bronchitis (AAB)



Additional results for select HEDIS measures can be found in Appendix xx.

Recommendations:

1. OMPP to work with the MCOs to develop a Collaborative Quality Improvement Project for Well-Child visits in 2010-2011.
2. MCOs to continue education for patients and physicians related to appropriate use of the Emergency Department and medically appropriate treatment for common conditions treated in primary care.

Section 5: Reimbursement Rates

Overview

The Hoosier Healthwise MCOs presented to the Medicaid Managed Care Quality Strategy Committee on their authorization and reimbursement practices. Similarities were observed across the entities. Specifically, all MCOs reimburse providers according to the Medicaid fee schedule unless a provider has negotiated an alternate reimbursement rate and/or methodology. Additionally, the MCOs do not require prior authorization for ER services and require notification within 2 business days of an emergency admission.

The MCOs all follow the same general flow for claims reimbursement. For services which require PA (as outlined in the MCO Provider Manual and contracts), the provider submits the necessary clinical documentation for review. This information is then reviewed as outlined in the Prior Authorization, Denials and Appeals section of this report. When an incoming claim is submitted, the MCO claims processing system determines if an authorization was approved and is on file for the requested service. Additionally, the MCO claims system will confirm various factors to ensure appropriate reimbursement such as:

- Member eligible on the date of service
- Covered benefit under plan or package
- Provider enrolled in the IHCP
- Claim filed timely

If the above factors are present and all other required claims fields are completed appropriately, the claim pays according to the Medicaid fee schedule or negotiated rate. The Committee noted that low Medicaid reimbursement rates remain of concern, but acknowledged that this is the result of fiscal constraints and outside the Committee’s scope. If data on the claim is missing or incomplete when submitted by the provider, this will cause processing delays, rejections or denials.

The MCOs are required to process electronic claims within 21 days of receipt and paper claims within 30 days of receipt. If the MCO fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the MCO must also pay interest as required under IC 12-15-13-1.7(d).

If a provider disagrees with a claims determination, a claims dispute may be filed as outlined in the provider contract. If the provider is not contracted with the MCO, a dispute may be filed as outlined in 405 IAC 1-1.6-1. This process includes an informal objection, formal appeal and binding arbitration.

The following chart demonstrates the MCO’s performance on claims payment processing. There were only two minor instances of non-compliance over four quarters. In both cases the MCO was one percentage point from the target.

Performance Measure	Target	Quarter	Anthem	MDwise	MHS
UB-04 Claims Paid: Percent of adjudicated UB-04 claims that were paid	≥ 85%	Q2-09	94%	94%	91%
		Q3-09	92%	95%	92%
		Q4-09	92%	96%	92%
		Q1-10	91%	95%	93%
CMS 1500 Claims Paid: Percent of adjudicated CMS 1500 claims that were paid	≥ 85%	Q2-09	84%	94%	90%
		Q3-09	85%	95%	90%
		Q4-09	86%	96%	91%

		Q1-10	85%	95%	91%
	≤ 15%	Q2-09	6%	6%	9%
		Q3-09	8%	5%	8%
		Q4-09	8%	4%	8%
		Q1-10	9%	5%	7%
CMS 1500 Claims Denied: Percent of adjudicated CMS 1500 claims that were denied	≤ 15%	Q2-09	16%	6%	10%
		Q3-09	15%	5%	10%
		Q4-09	14%	4%	9%
		Q1-10	15%	5%	9%
Claims Adjudicated: Percent of all clean claims adjudicated within aging targets	98%	Q2-09	100%	98%	100%
		Q3-09	100%	97%	100%
		Q4-09	100%	98%	100%
		Q1-10	100%	99%	100%

Recommendations

OMPP should continue to monitor the MCO's claims payment performance. Currently these are monitored through regular reporting and corrective action implemented when contract standards are not met.

Section 6: Standardization of Forms

Overview

A Forms Committee was convened with representation from OMPP, provider groups, Healthy Indiana Plan (HIP), Care Select and Hoosier Healthwise (HHW) Managed Care Entities. The Forms Committee goal was to review forms currently utilized by the various Medicaid contractors and to develop standardized forms where feasible. After review of the various forms currently in use, the Forms Committee concluded the Prior Authorization (PA) forms and Credentialing and Enrollment Forms could be standardized.

Prior Authorization Form

After review of the PA forms used by all of the health coverage programs, the Forms Committee made revisions to ensure that providers could use a single PA form when requesting services that require PA. The Forms Committee sent the revised PA form to the following provider associations for their review and comments:

- AIHMES (DME)
- Home Health Association
- Indiana Hospital Association
- IN Psych Society and Psychological Society

- Indiana State Medical Association
- Transportation

The Forms Committee incorporated feedback from the provider associations and revised the PA form with the following changes:

- Changed “Ordering Provider” to “Rendering Provider”
- Changed “Diagnosis” to “Dx1, Dx2, and Dx3”
- Added “Notes” to the lines section at the bottom of the request form

The PA form was then sent to the Medicaid Managed Care Quality Strategy Committee for review and approval. Approval was granted on August 19, 2010. Following this approval, the OMPP will send publications to all providers advising them of the changes made to the PA form and will post the form to the IHCP website and websites of the HIP, HHW and Care Select vendors.

Standardized Provider Enrollment Form

To reduce the need for providers to complete multiple enrollment and credentialing forms for participation with the Care Select, HHW and HIP managed care entities, the Forms Committee developed the Hoosier Healthwise, Healthy Indiana Plan and Care Select Provider Enrollment Form.

All practitioners must complete the Hoosier Healthwise, Healthy Indiana Plan and Care Select Provider Enrollment Form. This form includes the relevant information necessary to enroll a provider with a managed care entity such as contact information, scope of practice, hospital privileges and claims payment information. Providers can complete the form one time and submit to the various entities with whom they are interested in enrolling.

To further reduce the paperwork required to enroll, providers are encouraged to participate in the Council for Affordable and Quality Healthcare (CAQH). CAQH is a credentialing data warehouse that allows practitioners to keep all credentialing information in a central location. This information can be accessed by a variety of credentialing entities and can save practitioners time when seeking to participate with multiple health plans. If a provider participates in CAQH, no additional paperwork is required to become credentialed with an ICHP managed care entity. If a provider does not participate in CAQH, he or she must also complete and submit a credentialing application. For further standardization, the Forms Committee opted to utilize the paper CAQH application.

Facilities such as hospitals and home health agencies are not eligible to participate in CAQH. As such, the Forms Committee developed the Hoosier Healthwise, Healthy Indiana Plan and Care Select Provider Enrollment Form for hospitals to complete. This form includes basic demographic, billing and liability insurance information.

The credentialing form was sent to various provider associations for review and comment. Additionally, the form is being utilized by the MCOs for a trial period to further allow for the incorporation of provider feedback. The Forms Committee incorporated this feedback and presented the final draft to the Medicaid Managed Care Quality Strategy Committee for review and approval.

Section 7: Conclusions/Next Steps

In summary, no major areas of MCO non-compliance were noted in any of the study areas. In regards to emergency room reimbursement, the MCOs were found to be compliant with state and federal regulations and contract requirements. A review of prior authorization practices revealed comparability across MCOs and alignment with industry standards. Additionally, quality of care rendered to Indiana Medicaid members continues to be a focus of the MCOs and OMPP through pay for performance and other quality improvement initiatives. Finally, the Committee accomplished standardization of enrollment and credentialing forms, thus reducing administrative burden for providers.

The Medicaid Managed Care Quality Strategy Committee was a productive forum to discuss the issues raised by HEA 1572. The OMPP has responded to provider concerns and issues of note discovered through this process through contract language revision and continued MCO oversight through regular reporting and monthly onsite monitoring visits. It is recommended that these strategies continue and are adapted as additional issues are identified.

The Committee also has the following recommendations: 1) that the legislature consider the impact and benefit of electronic signature for the use of all clinical and operational Medicaid issues as well as 2) NCQA's credentialing standards are designed to ensure that an MCO thoroughly evaluates the practitioners approved for its provider panels. To that end, NCQA requires MCOs to have written policies and procedures that define their credentialing and recredentialing process. The Indiana Code and the contract with the State of Indiana (beginning in 2011) require the MCOs to be accredited by the National Committee for Quality Assurance (NCQA). NCQA Credentialing and Recredentialing (CR) standards requires each plan to have its own credentialing committee (CR 2) and each MCO cannot delegate this portion of the process. Therefore, it is our recommendation that this objective has been fulfilled to the greatest extent possible.

And finally, the Committee recommends that continued partnership with the provider community and other interested members of the public should be garnered through the existing Quality Strategy Committee, a group focused on the overarching Medicaid quality strategy.



"People
helping people
help
themselves"

MITCHELL E. DANIELS, JR., GOVERNOR
STATE OF INDIANA

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

September 29, 2010

Dear Committee Members,

Thank you again for your time, review, knowledge, and input on the analysis and final report under the Medicaid Managed Care Quality Strategy Committee. We believe that because of your active participation, it has been a very successful exercise and output of findings.

Attached, please find a final draft with the revisions requested in the September 16th meeting red-lined. In addition, please find all appendixes, the approved PA form (with instructions), and the approved credentialing form. As discussed in our meeting, the PA form will be available October 11th, there will be a transition period from October 11 through January 1, and after January 1, we will no longer accept the old PA form. As also mentioned, the credentialing form has been used as a pilot in recent months - effective November 11, it will be used officially.

Please note specifically that the following recommendation has been added:

The Committee also has the following recommendations: 1) that the legislature consider the impact and benefit of electronic signature for the use of all clinical and operational Medicaid issues as well as 2) NCQA's credentialing standards are designed to ensure that an MCO thoroughly evaluates the practitioners approved for its provider panels. To that end, NCQA requires MCOs to have written policies and procedures that define their credentialing and recredentialing process. The Indiana Code and the contract with the State of Indiana (beginning in 2011) require the MCOs to be accredited by the National Committee for Quality Assurance (NCQA). NCQA Credentialing and Recredentialing (CR) standards requires each plan to have its own credentialing committee (CR 2) and each MCO cannot delegate this portion of the process. Therefore, it is our recommendation that this objective has been fulfilled to the greatest extent possible.

Many of you were also interested in the impact of healthcare reform. There is a survey available right now at our Indiana website: nationalhealthcare.in.gov. We encourage you to complete. You can also submit written feedback to feedback@nationalhealthcare.in.gov. Information will be added to this website in order to inform and provide most recent activities.

The final changes are few, but worthwhile. Please review and provide your approval of the document. Please respond by COB Thursday so that we can submit on Friday.

It truly has been a pleasure working with all of you.

Thank you and kind regards,
Peggy Novotny



Approvals:

From: Somes, Kristi [mailto:KSomes@schneckmed.org]
Sent: Thursday, September 30, 2010 4:11 PM
To: Richardson, Anita
Subject: FW: 1572 - Final

I recommend approving the document.

Kristi Somes
Revenue Cycle Supervisor
Schneck Medical Center
Seymour, IN
812-524-4285
812-522-0524 (fax)
ksomes@schneckmed.org

From: Amy Brown [mailto:abrown@advantageplan.com]
Sent: Thursday, October 07, 2010 8:46 PM
To: Richardson, Anita; Barth, John; Tharp, Stephen; Marion Co. - Matt Gutwein
Subject: RE: 1572 - Final

Please note the typo on page 19 "Calendar Year 208". Otherwise, I approve. Thank you for the opportunity to review and be a part of this group.

Thanks,

Amy

From: Tharp, Stephen D [mailto:SDTharp@stvincent.org]
Sent: Friday, October 08, 2010 2:20 PM
To: Richardson, Anita
Subject: RE: 1572 - Final

Ms. Richardson,
I have reviewed the report and give my approval for submission.
Thanks,
Stephen D. Tharp, M.D.

From: John Barth [mailto:JBARTH@CENTENE.COM]
Sent: Friday, October 08, 2010 3:56 PM
To: Brown, Amy (Advantage); Richardson, Anita; Tharp, Stephen; Marion Co. - Matt Gutwein
Subject: RE: 1572 - Final

Approve to send.

From: MGutwein@HHC Corp.org [mailto:MGutwein@HHC Corp.org]
Sent: Friday, October 08, 2010 3:59 PM
To: Barth, John; Brown, Amy (Advantage); Richardson, Anita; Tharp, Stephen
Subject: Re: 1572 - Final

I concur as well.



INSTRUCTIONS FOR ENROLLMENT AND CREDENTIALING WITH HOOSIER HEALTHWISE (HHW), HEALTHY INDIANA PLAN (HIP) AND CARE SELECT MANAGED CARE ENTITIES

To reduce the need for practitioners to complete multiple enrollment and credentialing forms for participation in multiple IHCP Managed Care MCO/CMOs, the following forms have been developed. ***Please complete all applicable forms and return to the MCO/CMO with which you seek participation.***

PRACTITIONERS (HHW, HIP AND CARE SELECT):

All practitioners must complete the ***IHCP MCO/CMO Provider Enrollment Form***. If you participate in the Council for Affordable Quality Healthcare (CAQH), the Provider Enrollment Form is the only form you will be required to submit for the enrollment/credentialing process. Please add the appropriate IHCP MCO/CMO as an authorized plan, giving permission to print a provider CAQH application.

CAQH is a credentialing data warehouse that allows you to keep all of your credentialing information in a central location. This information can be accessed by a variety of credentialing entities and can save you time when seeking participation with multiple health plans.

If you do not participate in CAQH, you must also complete and submit a credentialing application. OMPP will require utilization of the CAQH application as the universal credentialing application. You may obtain the application through a link at the OMPP Web site at www.indianamedicaid.com or directly from the CAQH Web site at <https://upd.caqh.org>.

PROVIDERS (HHW, HIP AND CARE SELECT):

Facilities such as hospitals, home health agencies, etc, are not eligible to participate in CAQH. As such, you must fill out the ***Hoosier Healthwise Managed Care Organization Hospital/Ancillary Credentialing/Enrollment Form*** and return to the appropriate MCO/CMO with the required documentation

If you have any questions about the enrollment or credentialing process, please contact the appropriate MCO/CMO at:

ADVANTAGE Health Solutions

Phone: 1-866-504-6708

Web: www.advantageplan.com

Anthem

Phone: 1-800-455-6805

Web: www.anthem.com

Managed Health Services

Phone: 1-877-647-4848

Web: www.managedhealthservices.com

MDwise

Phone: 1-800-356-1204

Web: www.mdwise.org



HOOSIER HEALTHWISE, HEALTHY INDIANA PLAN AND CARE SELECT PROVIDER ENROLLMENT FORM

This form is for use in enrolling as a participating provider with one of the IHCP MCO/CMOs.

Please select the program(s) for which this form applies:

- Healthy Indiana Plan (HIP)
 Hoosier Healthwise (HHW)
 Care Select

- New Enrollment**
 Update (Fill in only updated info)

PRACTITIONER DATA

CAQH Number			
Provider First Name	MI	Last Name	Suffix
Degree (check one): <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DMD <input type="checkbox"/> DPM <input type="checkbox"/> CRNA <input type="checkbox"/> NP <input type="checkbox"/> CNM <input type="checkbox"/> Other: _____			
SSN	Date of Birth	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
NPI	Taxonomies (list all)		
DEA #	CSR #		
License Number & State	UPIN	LPI (Medicaid) Number	
Enrolling as: <input type="checkbox"/> PMP with Panel <input type="checkbox"/> Physician Specialist <input type="checkbox"/> NP-supporting a PMP <input type="checkbox"/> Other: _____ <input type="checkbox"/> NP-supporting a Specialty <input type="checkbox"/> Certified Mid-Wife <input type="checkbox"/> Prenatal Care Coordinator			
Primary Specialty	Secondary Specialty	NP - specialty supported	
Are you: <input type="checkbox"/> A Locum Tenem <input type="checkbox"/> Hospital-based Physician <input type="checkbox"/> Hospitalist			
The National Committee for Quality Assurance (NCQA) requires that health plans assess the cultural, ethnic, racial and linguistic needs of members to the practitioners in the network. Please provide the following information:			
Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> African-American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other (please specify) _____			
Practitioner E-mail	Fax	Phone	
Maximum membership accepted (PMPs only) - panel size			

Scope of Practice (OB/GYN PMPs only)
All Women (OB/GYN) includes pregnant and non-pregnant members, <i>Family Practitioners cannot render to All Women</i> <input type="checkbox"/> YES <input type="checkbox"/> NO
OB Only <input type="checkbox"/> YES <input type="checkbox"/> NO

Age Restrictions (PMPs only) check one					
<input type="checkbox"/>	None Internal Med & OB/GYN Practitioners <u>cannot</u> select this category (Only Family Practitioners and General Practitioners can select this category)				
<input type="checkbox"/>	0 – 2 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 12 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 17 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 20 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	3+ years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	<input type="checkbox"/> 13+ years	<input type="checkbox"/> 13 – 17 years	<input type="checkbox"/> 13 – 20 years	<input type="checkbox"/> 17+ years	<input type="checkbox"/> 21+ years <input type="checkbox"/> 65+ years

PRACTITIONER DATA – cont'd

Hospital Privileges YES NO

Name	Address
------	---------

Name	Address
------	---------

Name	Address
------	---------

If you do not have Hospital Privileges, state relationship privileges below:

Relationship Privileges YES NO

Physician	Hospital	Address
-----------	----------	---------

Any Primary Medical Provider (PMP) who renders OB services must have delivery privileges and/or relationship privileges to deliver

Delivery Privileges YES NO

Name	Address
------	---------

If you do not have Delivery Privileges, state relationship privileges below

Delivery Privileges YES NO

Physician	Name	Address
-----------	------	---------

ARE YOU ENROLLING AS:

- Individual
 Group
 FQHC
 RHC
 Clinic (Type: _____)
 Urgent Care
 Health Department

PRIMARY PRACTICE INFORMATION

Practice Group Name

Does this location utilize Nurse Practitioner or Physician Assistant? NP PA

Service Location Address (include ZIP + 4)

Primary Phone	Primary Fax	If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO
---------------	-------------	---

Office Contact Name	Office Contact E-mail
---------------------	-----------------------

County	Group IHCP Number (including Alpha suffix)
--------	--

Group NPI	Taxonomies
-----------	------------

Medicare Group Number

Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
---------------	-----	-----	-----	-----	-----	-----	-----

Is this office: Handicap accessible YES NO On a bus route YES NO

Does the site offer: Weekend hours YES NO Evening hours YES NO CSHCN (Children w/Special Needs) YES NO

Our office is fluent in the following languages other than English:

- Spanish
 Chinese
 French
 Burmese, dialect _____
 Russian
 Other (please specify) _____

PAY TO INFORMATION

Billing Name	TIN
--------------	-----

Billing (Pay To) Address

Billing Phone	Billing Contact Name	Billing Contact E-mail
---------------	----------------------	------------------------

MAILING ADDRESS

Mailing Address same as Primary Practice Address

Mailing Address

OTHER PRACTICE LOCATIONS

Please list up to two additional Practice Locations in which you will see IHCP members

Practice Group							
Does this location utilize Nurse Practitioner or Physician Assistant? <input type="checkbox"/> NP <input type="checkbox"/> PA							
Service Location Address (include ZIP + 4)							
Primary Phone		Primary Fax		If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO			
Office Contact Name				Office Contact E-mail			
County			Group IHCP Number (including Alpha suffix)				
Group NPI			Taxonomies				
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible <input type="checkbox"/> YES <input type="checkbox"/> NO On a bus route <input type="checkbox"/> YES <input type="checkbox"/> NO							
Does the site offer: Weekend hours <input type="checkbox"/> YES <input type="checkbox"/> NO Evening hours <input type="checkbox"/> YES <input type="checkbox"/> NO CSHCN (Children w/Special Needs) <input type="checkbox"/> YES <input type="checkbox"/> NO							
Our office is fluent in the following languages other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Burmese, dialect _____ <input type="checkbox"/> Russian <input type="checkbox"/> Other (please specify) _____							

Practice Group							
Does this location utilize Nurse Practitioner or Physician Assistant? <input type="checkbox"/> NP <input type="checkbox"/> PA							
Service Location Address (include ZIP + 4)							
Primary Phone		Primary Fax		If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO			
Office Contact Name				Office Contact E-mail			
County			Group IHCP Number (including Alpha suffix)				
Group NPI			Taxonomies				
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible <input type="checkbox"/> YES <input type="checkbox"/> NO On a bus route <input type="checkbox"/> YES <input type="checkbox"/> NO							
Does the site offer: Weekend hours <input type="checkbox"/> YES <input type="checkbox"/> NO Evening hours <input type="checkbox"/> YES <input type="checkbox"/> NO CSHCN (Children w/Special Needs) <input type="checkbox"/> YES <input type="checkbox"/> NO							
Our office is fluent in the following languages other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Burmese, dialect _____ <input type="checkbox"/> Russian <input type="checkbox"/> Other (please specify) _____							

For additional addresses, please copy and complete this page and submit with application.

Indiana Health Coverage Program Managed Care Organization and or Care Management Organization (IHCP MCO/CMO)

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Indiana Health Coverage Program Managed Care Organization and/or Care Management Organization (IHCP MCO/CMO), its representatives, agents or designees, to obtain from any source, information and/or documents regarding my professional credentials and qualification related to this application for new or continued network provider privileges (hereinafter referred to as “Credentialing Information”).

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any IHCP MCO/CMO contracted network, and grants me no rights or privileges of participation until such time as I receive actual written notice of acceptance and participating provider status. Termination of my request for application is not an adverse action within the reporting requirements of the National Practitioner Data Bank and does not entitle me to any appeal or hearing.

I understand that the IHCP MCO/CMO will conduct an independent verification of this Credentialing Information and such information will be used to evaluate my credentials according to the IHCP MCO/CMO standards. I hereby consent to the release of Credentialing Information to the IHCP MCO/CMO, its agents, representatives or designees. This authorization to release Credentialing Information shall include, but not be limited to, sources such as the medical staff office and/or Chief(s) of clinical Departments of any hospital or facility with which I have at any time been affiliated, all National Practitioner Data Bank and/or Peer Review Committee information and reports, including utilization review information, and information from professional boards, state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which I have obtained professional liability insurance. I hereby release all third party sources of Credentialing Information from any and all liability related to the release of such information that is provided in good faith and without malice.

I hereby release and hold harmless from any and all liability all members of the IHCP MCO/CMO, the Board of Directors, it officers, agents, peer review committee members and employees, for all activities executed in good faith and without malice regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any IHCP MCO/CMO contracted network or the IHCP MCO/CMO.

A photocopy of this authorization will serve as an original. I understand that the IHCP MCO/CMO, the Credentialing Committee and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. I understand the IHCP MCO/CMO, its Credentialing Committee and their designees will treat this information as confidential.

The undersigned certifies and attests that the forgoing is truthful, correct and complete in all respects, and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information is grounds for denial or immediate termination from the IHCP MCO/CMO provider networks. The undersigned hereby agrees to report to IHCP MCO/CMO any changes in the above information within thirty (30) days of change.

Printed Name _____ Title _____

Signature _____ Date _____

During the credentialing and re-credentialing process, the IHCP MCO/CMO will obtain information from various outside sources (e.g., state licensing agencies, National Practitioner Data Bank) to evaluate your application. You have the right to review any primary source information that the IHCP MCO/CMO collects during this process. These rights do not include information obtained as references, recommendations or other information that is peer review protected.

Should you believe any of the information used in the credentialing and re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by you, as the practitioner, you will have the right to correct any information and submit your comments and explanations for any other factual information.

Please keep a copy for your records.



HOOSIER HEALTHWISE HEALTHY INDIANA PLAN HOSPITAL/ANCILLARY CREDENTIALING/ENROLLMENT FORM

Please select the program(s) for which this form applies:

Healthy Indiana Plan (HIP) Hoosier Healthwise (HHW)

APPLICATION INSTRUCTIONS In order to be considered complete:

1. All information must be legible (please print or type)
2. Application must be completed in its entirety
3. Application must be signed and dated
4. Use a separate sheet of paper to provide additional information, if necessary
5. Current copies of all documents applicable to your organization **MUST** be submitted with this application:
 - State License
 - Copy of Medicaid certification letter
 - CMS site evaluation - if state site survey is not available
 - Liability coverage Face sheet
 - Indiana Department of Health Accreditation Certificate with site survey
 - TIN W-9
 - Copy of Medicare certification letter
 - CLIA
 - DEA

DEMOGRAPHIC INFORMATION

Entity Name		Medicaid Number
DBA Name or Legal Name	Indiana State License No.	Fed. Tax ID Number
NPI	Taxonomy Number	Medicare Number
Address	City, St., ZIP	County
Contact Name	Contact Title	

- Accreditation Type:
- Joint Commission of Accreditation of Healthcare Organizations (JCAHO)
 - National Commission of Quality Assurance (NCQA)
 - Health Care Finance Administration (HCFA)
 - Indiana State Department of Health (ISDH)
 - Other _____

BILLING INFORMATION (if different from above)

Pay to:		
Street	City, St., ZIP	Phone
Contact Person	Fax	

COMPREHENSIVE/GENERAL/PROFESSIONAL LIABILITY

Liability Carrier	Coverage Limits
Policy Number	Expiration Date

ATTESTATION QUESTIONS

Please answer the following questions **YES** or **NO**. If **YES**, please provide full details on a separate sheet.

A. Has your organization's malpractice insurance ever been terminated or revoked except with your consent or request? YES NO

B. Is your organization currently or has been in the last five years under investigation by any government entity or peer review? YES NO

C. Has your organization been sanctioned by Medicaid or Medicare? YES NO

**HOOSIER HEALTHWISE MANAGED CARE ORGANIZATION
HOSPITAL/ANCILLARY CREDENTIALING/ENROLLMENT FORM - page 2**

Indiana Health Coverage Program Managed Care Organization and or Care Management Organization (IHCP MCO/CMO)

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Indiana Health Coverage Program Managed Care Organization and/or Care Management Organization (IHCP MCO/CMO), its representatives, agents or designees, to obtain from any source, information and/or documents regarding our entity's qualifications related to this application for new or continued network provider privileges (herein after referred to as "Credentialing Information"). We understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any IHCP MCO contracted network, and grants no rights or privileges of participation until such time as we receive actual written notice of acceptance and participating provider status. Termination of this request for application is not an adverse action within the reporting requirements of the Healthcare Integrity and Protection Data Bank and does not entitle us to any appeal or hearing. We understand that the IHCP MCO/CMO will conduct an independent verification of this Credentialing Information and such information will be used to evaluate our credentials according to the IHCP MCO/CMO standards. I hereby consent to the release of Credentialing Information to the IHCP MCO/CMO, its agents, representatives or designees. This authorization to release Credentialing Information shall include, but not be limited to, all Healthcare Integrity and Protection Data Bank and information from state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which we have obtained professional liability insurance.

We hereby release all third party sources of Credentialing Information from any and all liability related to the release of such information that is provided in good faith and without malice. We hereby release and hold harmless from any and all liability all members of the IHCP MCO/CMO, the Board of Directors, IT officers, agents, peer review committee members and employees, for all activities regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any IHCP MCO/CMO contracted network or the IHCP MCO/CMO. A photocopy of this authorization will serve as an original. We understand that the IHCP MCO/CMO, the Credentialing Committee and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. We understand the IHCP MCO/CMO, its Credentialing Committee and their designees will treat this information as confidential.

The undersigned certifies and attests that the forgoing is truthful, correct and complete in all respects, and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information is grounds for denial or immediate termination from the IHCP MCO/CMO provider networks. The undersigned hereby agrees to report to IHCP MCO/CMO any changes in the above information within thirty (30) days of change. During the credentialing and re-credentialing process, the IHCP MCO/CMO will obtain information from various outside sources (e.g., state licensing agencies, Healthcare Integrity and Protection Database) to evaluate your application. You have the right to review any primary source information that the IHCP MCO/CMO collects during this process. These rights do not include information obtained as references, recommendations or other information that is peer review protected.

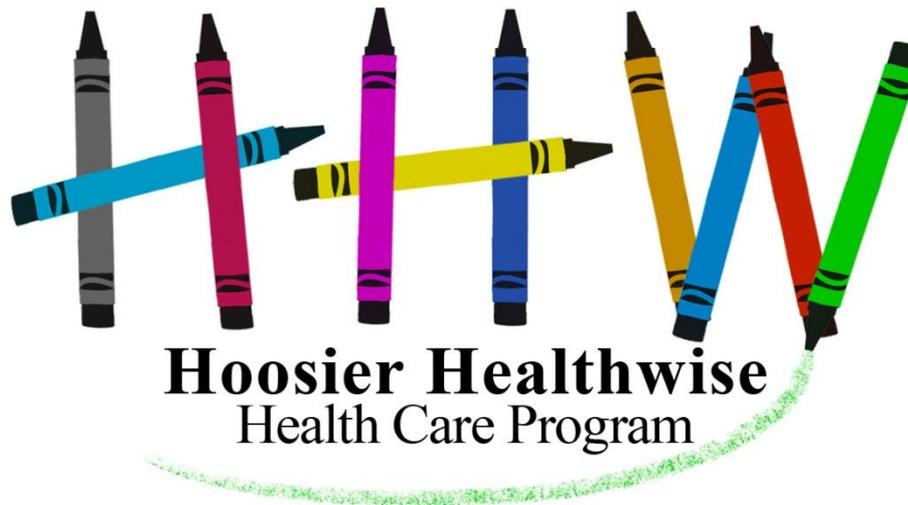
Printed Name _____ Title _____

Signature _____ Date _____

Should you believe any of the information used in the credentialing and re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by you, as the practitioner, you will have the right to correct any information and submit your comments and explanations for any other factual information.

Please keep a copy for your records.

OMPP Audit of Hoosier Healthwise MCO Prudent Layperson Review Process



Medicaid Managed Care Quality Strategy Committee
October 26, 2009

Prudent Layperson Review Process



- From April – July 2009 OMPP conducted a review of the Hoosier Healthwise MCO prudent layperson process inclusive of:
 - Comprehensive review of MCO policies and procedures on prudent layperson to ensure compliance with contract requirements and State and Federal law
 - Data pull and analysis regarding ER claims adjudication, prudent layperson outcomes and appeals for October 2008 – March 2009 dates of service
 - In addition to data analysis, a review of 30 cases from each MCO that went through the PLP process

Prudent Layperson Case-Level Review Methodology



- OMPP requested all cases pended for PLP review
- Thirty cases were selected from each MCO
 - The sample was representative across diagnoses
 - The sample included cases that had “met PLP” and “did not meet PLP”
- Documentation was reviewed for each case, inclusive of:
 - Final decision EOB/EOP
 - Clinical/medical documentation
 - Appeals documentation
 - Provider ER notes
- A sampling of all MDwise delivery systems was included

Overview of MDwise PLP Process



- Diagnoses on incoming claims are compared against an auto pay list. All delivery systems use the same auto-pay list. If the diagnosis is on the auto-pay list the claim processes and is paid. If the diagnosis is not on the auto-pay list, a request for medical records is sent to the provider.
- Upon receipt of medical records, a “prudent layperson” reviews the presenting symptoms to determine if the standard for prudent layperson is met. If the standard is met, the claim is processed and paid.
- If the initial reviewer determines the PLP standard has not been met, the case is reviewed by a physician.

Overview of MDwise PLP Process



- If the physician determines the PLP standard was met, the claim processes and is paid. If the standard has not been met, the claim is paid for the ER screening fee.
- This process applies to both facility and physician claims.
- Some providers via their provider contract have opted to forego the ER PLP process.
- This process would still be applicable for all non-participating providers.
- Providers have the right to dispute any denials.

Overview of MHS PLP Process



- Contracted facilities have the option to participate in the MHS Indiana ED Claims Program
- Diagnoses are grouped into 4 categories for both par & non-par facilities:
 - Category 1: Diagnoses of obvious medical emergencies such as status asthmaticus, fractured femur, and trauma. (Auto – Pay)
 - Category 2: Diagnoses of significant medical problems (e.g. chronic/severe illnesses) that may indicate the presence of a medical emergency. (Auto – Pay)
 - Category 3: Presenting signs and symptoms indicating the presence of conditions that meet the PLP definition of an emergency, but do not actually require immediate, emergent medical attention/intervention. (Pend for PLP review)
 - Category 4: Presenting signs and symptoms that do not fall into any of the above 3 categories and do not meet the PLP guidelines. (Pend for PLP review)

Overview of MHS PLP Process



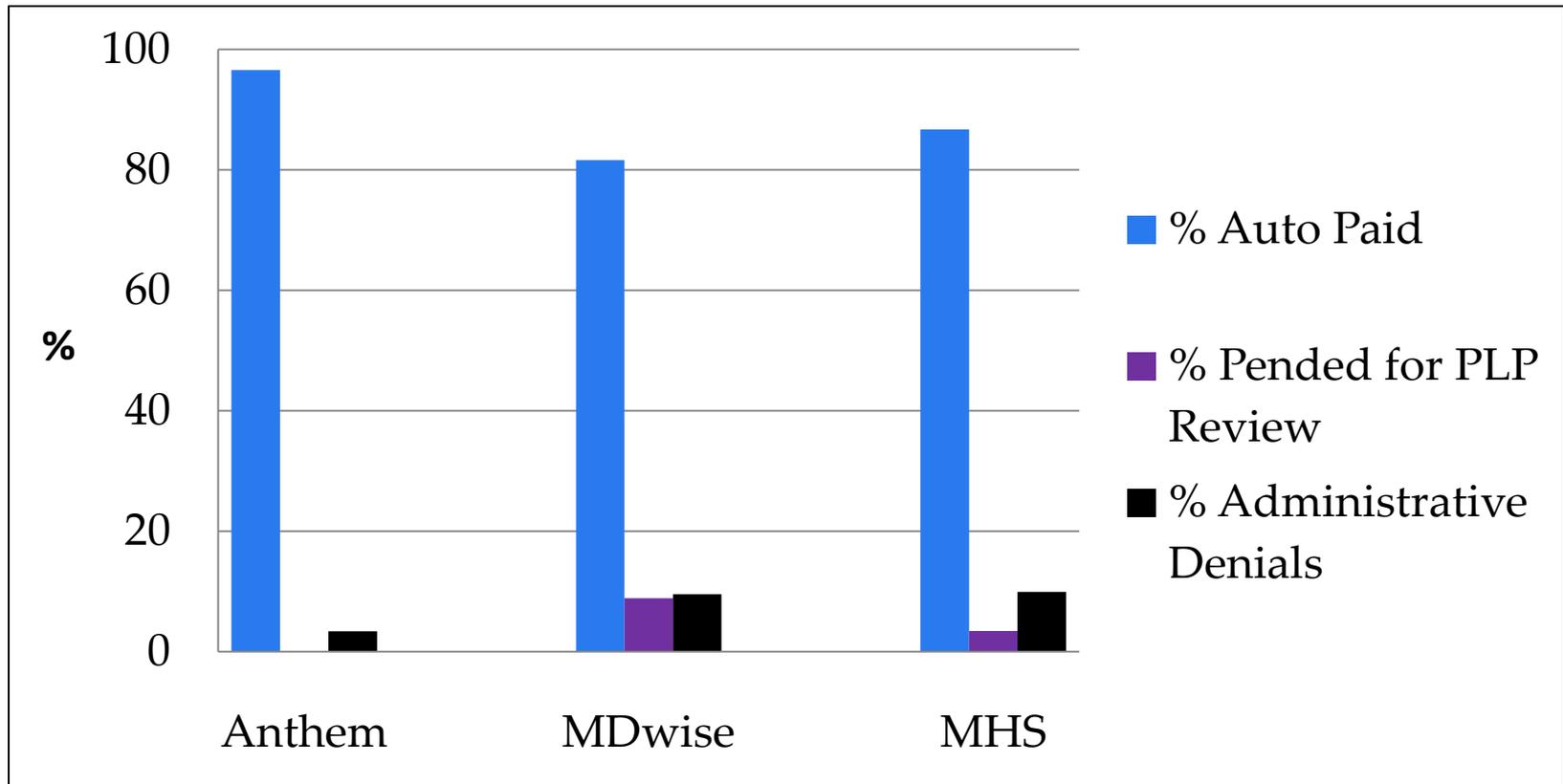
- The claim is adjudicated based on the primary diagnosis on the claim.
- For a non-participating provider, claims with primary diagnoses in categories 3 & 4 are pended with a request for medical records. A prudent layperson review is then conducted.
- In network providers who have opted to participate in the ED Claims Program have their claims paid with no medical record review. Participating providers receive claims payment for all four levels.
- The PLP review is conducted only for facility claims.
- Only non-participating providers may appeal the claim determination.

Anthem PLP Process



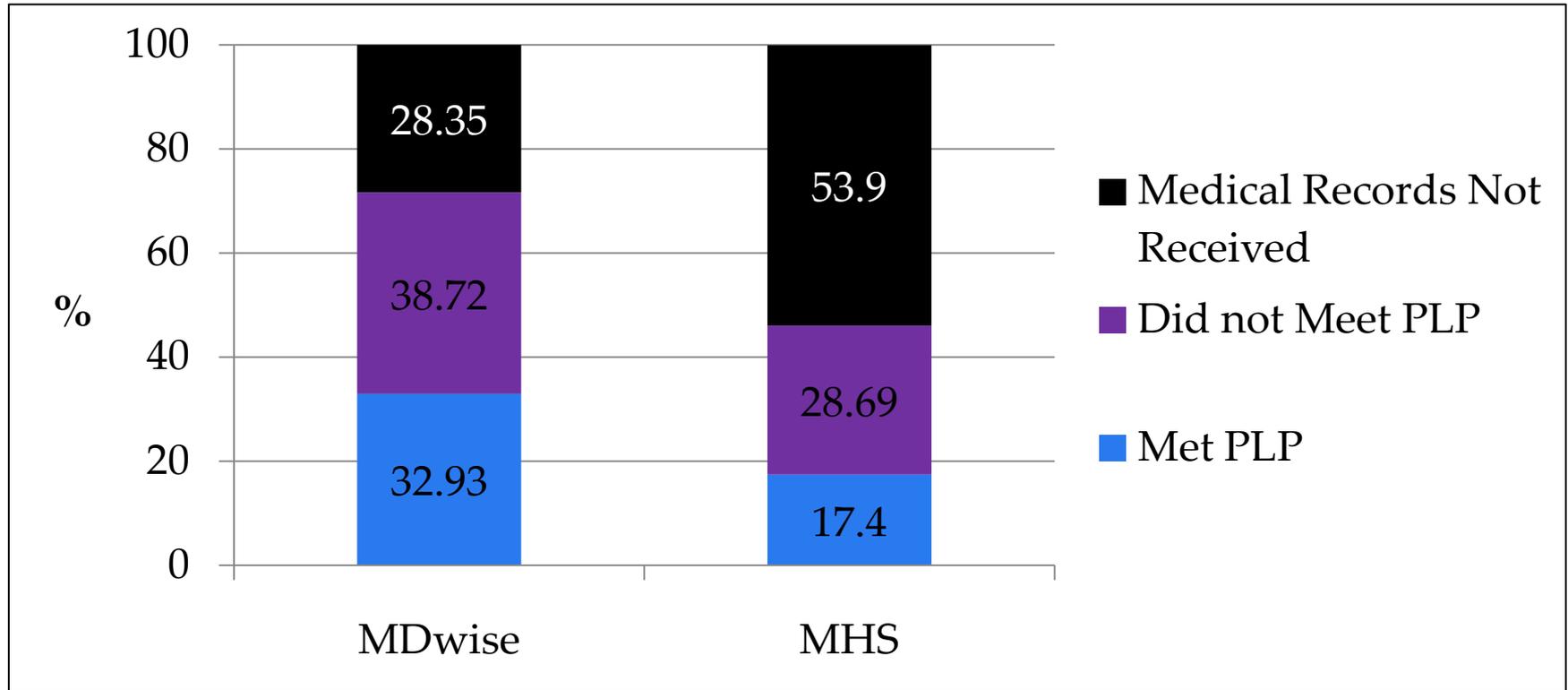
- Anthem does not currently conduct a prudent layperson review
- Data on Anthem's ER claims adjudication and appeals rate for October 2008 – March 2009 was reviewed by OMPP in this study

ER Facility Claims with Claim Determination



UB-04 claims for dates of service 10/2008 – 3/2009
Anthem does not conduct a prudent layperson review.

Outcome of ER Facility Claims Pended for PLP Review



UB-92 claims for dates of service 10/2008 – 3/2009
Anthem does not conduct a prudent layperson review process.

ER Facility Claims - Administrative Denials



MCO	% of Claims Denials Due to Administrative Reasons	% of Claims Denial Due to Not Meeting PLP
Anthem	100%	N/A
MDwise	73.42%	26.58%
MHS	91.1%	8.9%

UB-04 claims for dates of service 10/2008 – 3/2009

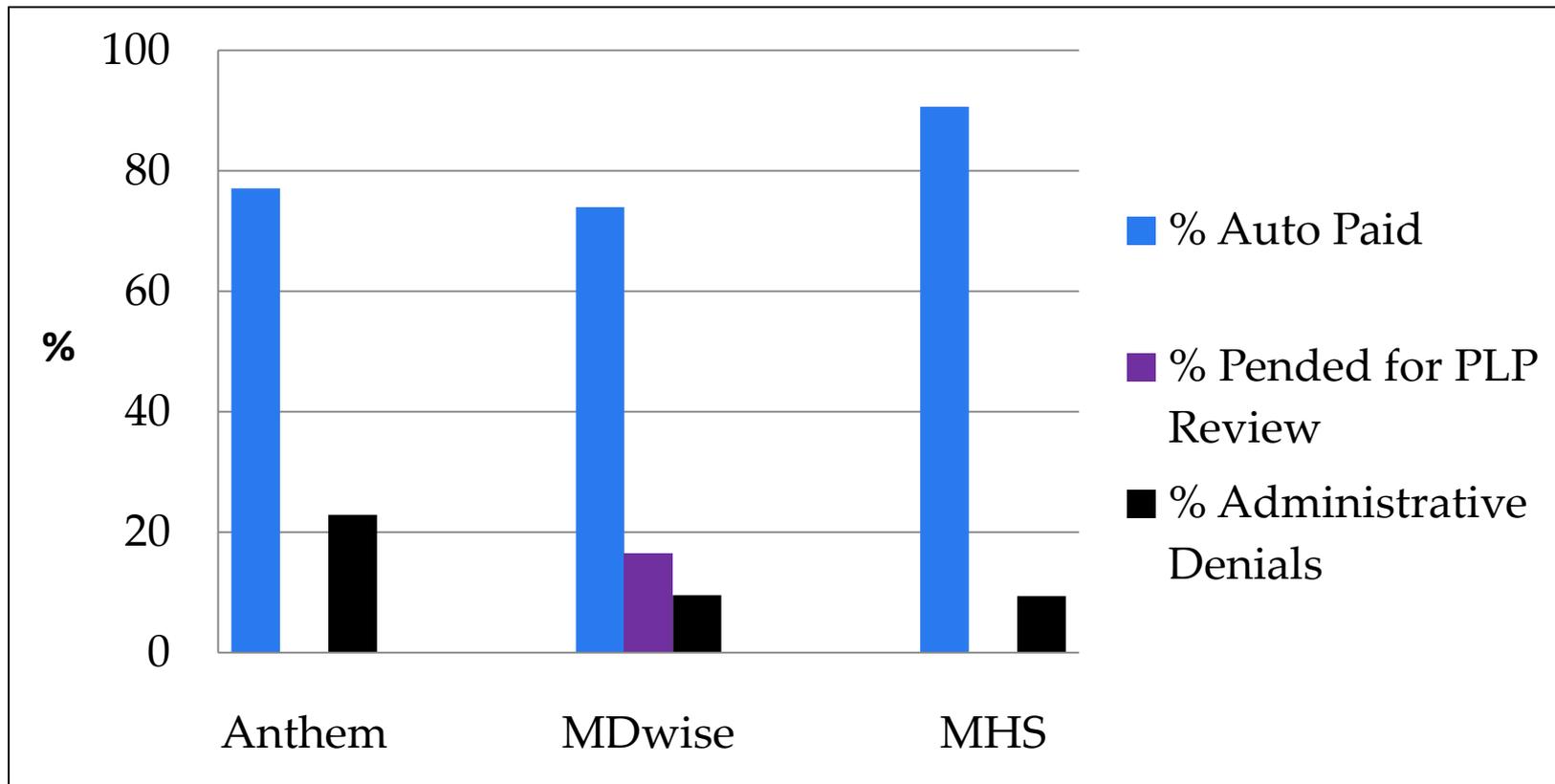
ER Facility Claims – Top Administrative Denials



Anthem	MDwise	MHS
<ol style="list-style-type: none"> 1. Provider not attested 2. Duplicate claim 3. Timely filing 4. Other carriers payment exceeds allowed amount 5. Invalid diagnosis 	<ol style="list-style-type: none"> 1. Bundled services 2. Services not covered 3. Exceeds fee 4. Filing limit 5. Duplicate claim 6. Incorrect billing 	<ol style="list-style-type: none"> 1. Bill primary insurer first 2. Time limit for filing has expired 3. Not a MCO covered benefit 4. Coverage not in effect when service provided 5. Member name/number/dob do not match

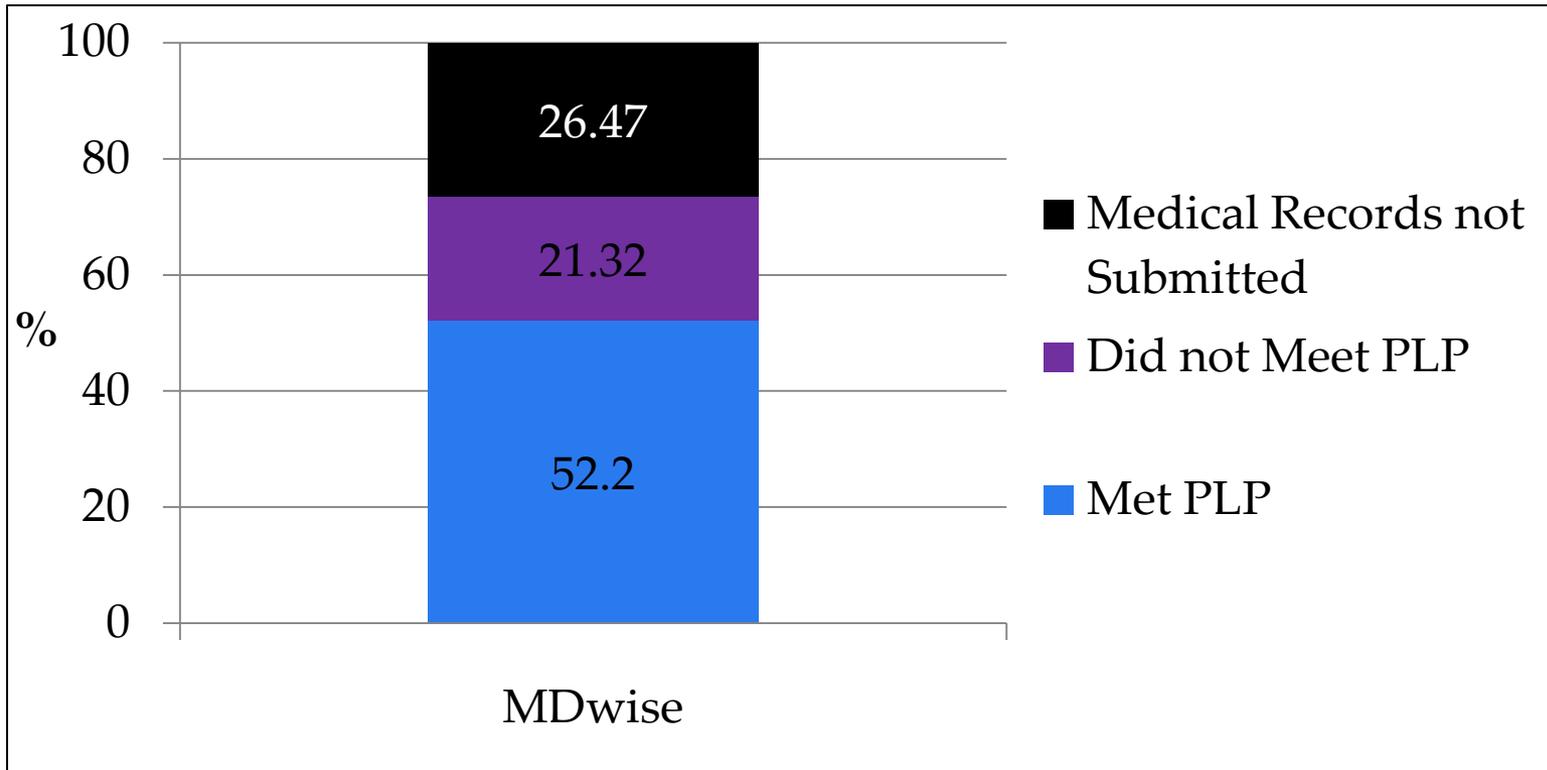
Administrative denials may be disputed through the MCO's claims dispute process. This process is outlined in the provider's contract with the MCO. For non-contracted providers, providers have 60 days from the receipt of written notification from the MCO on the claim determination to file an informal dispute. Providers then have 60 days following the outcome of the informal dispute to file a formal written claims dispute.

ER Physician Claims with Claim Determination



CMS 1500 claims for dates of service 10/2008 – 3/2009
Anthem does not conduct a prudent layperson review.
MHS does not conduct a prudent layperson review on ER Physician claims.

Outcome of ER Physician Claims Pended for PLP Review



CMS 1500 claims for dates of service 10/2008 – 3/2009
Anthem does not conduct a prudent layperson review process.
MHS does not conduct a prudent layperson review on physician claims.



ER Physician Claims - Administrative Denials

MCO	% of Claims Denials Due to Administrative Reasons	% of Claims Denial Due to Not Meeting PLP Criteria
Anthem	100%	N/A
MDwise	72.9%	27.1%
MHS	100%	N/A

MHS & Anthem do not conduct a PLP review on physician claims.

ER Physician Claims – Top Administrative Denials



Anthem	MDwise	MHS
<ol style="list-style-type: none"> 1. Provider not attested 2. Duplicate claim 3. Timely filing 4. NPI not on claim 5. Invalid diagnosis 	<ol style="list-style-type: none"> 1. Duplicate claim 2. Filing limit 3. Services not covered 4. Incorrect billing 5. Bundled services 	<ol style="list-style-type: none"> 1. Bill primary insurance first 2. Time limit for filing has expired 3. Coverage not in effect when service provided 4. Member name/number/dob do not match 5. Code was denied by code auditing software

Administrative denials may be disputed through the MCO's claims dispute process. This process is outlined in the provider's contract with the MCO. For non-contracted providers, providers have 60 days from the receipt of written notification from the MCO on the claim determination to file an informal dispute. Providers then have 60 days following the outcome of the informal dispute to file a formal written claims dispute.

Top Ten Diagnoses on Cases That Did Not Meet PLP Standard



NOTE: The prudent layperson review is conducted based on the member's presenting symptoms, not diagnosis. Providers should note in the medical record if the member's PMP referred to the ER to ensure appropriate reimbursement.

MDwise	MHS
1. Acute URIs of Unspecified Site	1. Unspecified Otitis Media
2. Unspecified Otitis Media	2. Acute URIs of Unspecified Site
3. Acute Pharyngitis	3. Acute Pharyngitis
4. UTI Site Not Specified	4. Fever
5. Vomiting Alone	5. Headache
6. Lumbago	6. Abdominal Pain, Unspecified Site
7. Unspec Viral Inf CCE & UNS Site	7. UTI Not Specified
8. Acute Bronchitis	8. Unspecified Site Ankle Sprain & Strain
9. UNS Noninf Gastroenteritis & Colitis	9. Contus Face Scalp & Neck Except Eye
10. Abdominal Pain, Unspecified Site	10. Vomiting Alone

PLP Disputes



	MDwise	MHS
PLP Disputes Processed	444	178
Dispute Rate	6.24%	22.68%
Decisions Overturned	129	3
Overturn Rate	29.1%	1.69%

Includes PLP disputes for UB-04 & CMS 1500 denials for dates of service 10/2008 – 3/2009.

Anthem does not conduct a PLP review.

Participants in the MHS Indiana ED Claims Program cannot dispute or appeal the outcome of an ER claims payment determination, per their contract with MHS. Additionally, MHS does not conduct a PLP review on Professional Claims.

MCO Auto-Pay Lists



- OMPP conducted a review of the MCO's auto-pay lists
- MHS auto-pays for 5,017 diagnosis codes
- MDwise auto-pays for 3,288 diagnosis codes
- The top diagnoses among all MCOs for cases that have been denied for not meeting the PLP standard include:
 - Acute Upper Respiratory Infection
 - Otitis Media
 - Pharyngitis
- OMPP does not currently intend to mandate a uniform auto-pay list
- The creation of a uniform auto-pay list would not include these non-emergent conditions

MCO ER Diversion Activities



<p>Anthem</p>	<ul style="list-style-type: none"> •ER diversion program with Deaconess Hospital and St. Mary’s Hospital <ul style="list-style-type: none"> •Receive real-time notification of member’s presenting to ER •Outbound calls by case managers for members with more than 3 ER visits •Sends educational information on proper ER use
<p>MDwise</p>	<ul style="list-style-type: none"> •Conducts the Emergency Room Intervention Program <ul style="list-style-type: none"> •Members with ER visits for non-urgent symptoms are contacted by a Member Advocate to educate about appropriate use of the ER •Members with multiple emergency room visits are flagged for case management evaluation •Partnering with Indiana Health Information Exchange (IHIE) to receive timely notification of ER visits •ER diversion program with St. Vincent Hospitals •Implementing IVR calls in the Fall to members with multiple ED visits •Restricted card for members who meet the criteria due to frequent ER visits
<p>MHS</p>	<ul style="list-style-type: none"> •Generates a claims-based Emergency Department diversion report and conducts phone outreach to members and providers •Distributes a "What to do When your Child gets Sick" book and an “when to use the ER” brochure •The restricted card identification process includes ER "frequent flyers" to minimize ER utilization, which triggers case management •24/7 nurse triage line for members •Distributes cold kits which includes information on URI care

PLP Clinical Review



Study Overview

- Two plans conducted PLP
- Charts sampled from Oct 2008-March 2009
- Sixty unique members
- 104 episodes of care

Multiple Visits are Common



# of Visits	1	2	3	4	5
Cases	31	20	4	4	1

Who is a Prudent Layperson?



- Reviewer to put self in the mindset of average, reasonable, non-medical person
- Typically high school graduate
- Reviewer to assess whether symptoms could lead to any serious health consequences

PLP Standard: What is Serious?



- Acuteness of Symptoms
 - Sharp or severe pain
 - Rapid onset of symptoms
 - Sudden, or severe worsening of chronic symptoms

Prudent Layperson Standard



- Seriousness of Symptoms
 - Did the symptom place the health of the individual in serious jeopardy?
 - If a pregnant woman, did the symptom place the health of woman or unborn child in serious jeopardy?
 - Was there a serious impairment to body functions?
 - Was there a serious dysfunction of any bodily organ or part?

Who Typically Conducts PLPs?



- Review suggests that clinically trained personnel conduct PLP reviews
- Second line review at physician/medical director level

Overall Approvals and Denials Reviewed



PLP or physician approved, n=48

PLP denied, n=51

Insufficient records/no clinical notes, n=5

Common Cases

Infections

Pregnancy-related

Behavioral Health

Infections



- 23 Cases
- Otitis media, n=11
- Pharyngitis
- Bronchitis/Cough
- Sinusitis
- Gastritis

Infections



- Common to see CXR in pharyngitis and bronchitis cases, regardless of history
- Fever present in only two cases at time of presentation in ED
- PLP most inconsistent for otitis and pharyngitis
 - Approx. one-half approved and one-half denied
 - Weekend/evening hours
 - “Serious” rarely met
 - Stated reason “could be seen in PCP office”

Pregnancy



- Nine cases
 - Seven cases PLP met
 - One post-partum “incisional pain” seen during regular business hours denied
 - One case confirming pregnancy seen during regular business hours denied

Behavioral Health



- Eight cases in sample
- Two denials
 - One denial occurred in adolescent case brought to ED by police, child calm at arrival

Other Findings



- Ondansetron (Zofran) and narcotics delivered to same patient with pharyngitis on two separate occasions
- >90% cases described as No Apparent Distress (NAD)
- >90% reported some level of pain

Other Findings



- 26/104 cases received BZD or narcotics
 - One hospital accounted for 1/3 cases
 - Narcotics to three year old with otitis, no evidence of other pain meds (e.g. ibuprofen) delivered in pharmacy records included in chart
- One case review noted that 15-20 ED visits in last several months, but indicated that case management was not needed

Other Findings



- Common use of imaging is concerning
 - CXR for one day of cough to six weeks cough
 - Does this need to be done in ER setting?
 - Head CT for six weeks of headache absent neurological findings

Conclusions



- Review of cases highlighted the complex nature of ED utilization
 - Social factors
 - Scheduling issues
 - Lack of standardization in review process
 - Questionable use of therapies and testing in ER setting

Conclusions



- Majority of denials occurred in pharyngitis and otitis cases—no consistency in pattern of denials/approvals
- Majority of PLP denials reasonable given that conditions could/should have been seen in office setting
- Caveats may include arrival by police (conduct disorder) or ambulance (toddler sprayed Static Guard in mouth)

Recommendations



- Health plans need consistent policies on common conditions (e.g. otitis) or emergent cases (e.g. police)
- Health plans need to consider other options when primary care not readily available
- Health plan call centers should have access or collaboration with PCP scheduling in order to assure non-ED access to care

Recommendations



- Hospitals need to develop true triage criteria and/or other venues of care
- Hospitals need to evaluate work-ups and refer back to primary care or urgent care
- Hospitals need to evaluate use of imaging
- Hospitals to evaluate use of BZD and narcotics



Emergency Department Strategies

OMPP Managed Care Quality Strategy
Oversight Committee (HEA 1572)

March 18, 2010



Emergency Department Strategies

- ▶ Literature Review
- ▶ Internal Analyses
 - ▶ NYU ED groupers show that substantial proportion of visits are not emergent in HHW adult population
- ▶ Few number of enrollees represent most of the largest share of “over” or “inappropriate” utilization



How to Change Behavior?

- ▶ Understanding reasons for over- or inappropriate utilization
- ▶ Overarching program to target all members not likely to succeed
- ▶ Targeted programs directed at outliers have been most successful



Basic Tenets

- ▶ Program must look the same across all Medicaid programs
- ▶ Intervention must function the same across all Medicaid MCO's, CMO's, and FFS programs
- ▶ Program must be based in collaboration between health plan, member, and primary care provider
- ▶ Planning, design, and implementation must involve all units at OMPP as well as health plans
- ▶ Must complement existing, successful programs
 - ▶ E.g. Open enrollment



Right Choices Program

- ▶ Effective January 1, 2010, Restricted Card Program has been renamed and revamped
- ▶ Program redesigned to be interventional not punitive
- ▶ Increased emphasis on member education and case management
- ▶ Uniform criteria and policies established by the OMPP
- ▶ Administered by each of the health plans for their own members –
 - ▶ Hoosier Healthwise (RBMC): Anthem, MHS, MDwise
 - ▶ *Care Select: Advantage, MDwise*
 - ▶ Traditional Medicaid: Advantage



Right Choices Program

- ▶ Care coordination and collaboration among health plan and primary providers
- ▶ Member education in the benefits available and how to use them in most appropriate manner
- ▶ Member care is overseen by a primary physician (PMP), pharmacy and hospital
- ▶ PMP is the gatekeeper and responsible to provide referrals for specialty care and prescription services



Right Choices Program

- ▶ **Initial Review Criteria** - to identify members potentially eligible for RCP
 - ▶ **Utilization Analysis** - for a six month period, members whose utilization meets or exceeds the established threshold (~3 std. dev.) in these categories:
 - ▶ Number of ER visits
 - ▶ Number of Prescribers
 - ▶ Number of Pharmacies
 - ▶ Number of PMP changes



Right Choices Program

- ▶ **Initial focus for review**
 - ▶ Members at 3 standard deviations or more above the mean in ER utilization
 - ▶ Starting with members above 3 SD in more than one criteria
 - ▶ ER criteria plus 1 or more other criteria equates to less than 1% of population
 - ▶ Between 1.3% to 2.2% of the health plan's total population is to be reviewed by mid-summer



Right Choices Program

- ▶ RCP Administrator and primary provider information is available in Eligibility Verification Systems (e.g., AVR, WebInterchange)
- ▶ In order for the pharmacy to get paid for a RCP prescription, the prescriber NPI must be on the referral provider list. This includes “self-referral” services, such as dental, podiatry, vision, family planning, behavioral health.
- ▶ Referrals are not required for emergency services but in RBMC, “prudent layperson” still applies



Right Choices Program

- ▶ After utilization analysis, the next step may be
 - ▶ referral to case/care management, or
 - ▶ clinical review
- ▶ Clinical Review - Review of clinical and other information available to determine whether to enroll the member into RCP or not
 - ▶ Medication Therapy Management Analysis
 - ▶ Drug Class and Polypharmacy data
 - ▶ Number of Filled Prescriptions
 - ▶ Number of Filled Controlled Substance Prescriptions
 - ▶ 5 or more psychotropic medications in a recent 45 day period
 - ▶ Benzodiazepines from 3 or more prescribers in recent 90 days
 - ▶ Allegations of suspected fraudulent activity

Results of External Quality Review of Hoosier Healthwise Authorizations

Review Period – CY 2008

Presented to the Medicaid Managed Care
Quality Strategy Committee
January 21, 2010

Goals of the Authorization Review

- 1) Understand similarities and differences across the MCOs related to authorization P&Ps
- 2) Compile results of authorizations completed in CY 2008 to understand differences in timeliness, denial rates, and appeals
- 3) Identify recommendations for improving authorization processes in Hoosier Healthwise

Burns & Associates, Inc., EQR for HHW

- No affiliation with any Indiana MCO or providers
- Clinical Team included two MDs and five RNs
- Non-clinical team compiled statistics on data provided by the MCOs and results from clinical team's case file review

B&A Tasks in Authorization Study

- Interview MCO staff with specific knowledge of PA processes
- Compare authorization process flows at each MCO
- Review and critique authorization P&Ps
- Compare MCO strategies with respect to staffing in UM/PA (qualifications, training, IRR)
- Collect and tabulate statistics related to MCO authorizations in 2008
- Audit a sample of approved and denied authorizations at each MCO within pre-defined service categories



Statistics Compiled for CY 2008 Auth Requests

	Anthem	MHS	MDwise	TOTAL
--	---------------	------------	---------------	--------------

All Authorizations

Total	28,290	45,495	91,290	165,075
Approved	26,905 95%	40,296 89%	88,318 97%	155,519 94%
Denied	1,385 5%	5,199 11%	2,972 3%	9,556 6%
Nonclinician Review	6,463 23%	21,267 47%	14,243 16%	41,973 25%
Clinician Review	21,827 77%	24,228 53%	77,047 84%	123,102 75%

Approved Authorizations Only

Total	26,905	40,296	88,318	155,519
Nonclinician Review	6,460 24%	21,089 52%	14,167 16%	41,716 27%
Clinician Review	20,445 76%	19,207 48%	74,151 84%	113,803 73%

Denied Authorizations Only

Total	1,385	5,199	2,972	9,556
Nonclinician Review	3 0%	178 3%	76 3%	257 3%
Clinician Review	1,382 100%	5,021 97%	2,896 97%	9,299 97%

Findings from Review of all Auth Requests

- 1) All data self-reported by the MCOs
- 2) MHS had higher proportion of denials than Anthem and MDwise overall
- 3) Variation by MCO in denial rates for IP and OP services
- 4) Very few clinical denials made by non-clinicians
- 5) 11% of auths denied for a member had subsequent approval within 30 days
- 6) Appeals per 1,000 denials by MCO:
 - Anthem: 118 appeals/1,000 denials
 - MHS: 171 appeals/1,000 denials
 - MDwise: 31 appeals/1,000 denials

Constructing the Sample for Review

- The sample was constructed using the following variables:
 - Service category (7 in all)
 - Determination status- approved or denied
 - Reviewer status- non clinical or clinical
 - Appeal status- Yes or No
- Denied auths were oversampled (75% of the total)
- Ensured at least 75% of sample were cases reviewed by MCO clinical staff

Constructing the Sample for Review (cont.)

- Results of this sampling methodology:
 - Sample reflects denial rates of each MCO (Anthem: 11 denials/1,000 members, MHS: 31 denials/1,000 members, MDwise: 11 denials/1,000 members)
 - Sample cases proportional to an MCO's denials within a service category
 - Anthem 20% of sample, MHS 40% of sample, MDwise 40% of sample
 - Confidence test for denied auths: B&A has 95% confidence that the sample results are accurate to within +/- 3.29% of the actual results in the universe.

Final Sample



	Anthem		MHS		MDwise		TOTAL	
	MCO Total	Pct of Total	MCO Total	Pct of Total	MCO Total	Pct of Total	Total	Pct of Total
Ambulatory or Outpatient Surgical	8	4%	35	10%	44	13%	87	10%
Diagnostic Outpt Proc, Radiology, or Pathology	38	21%	91	26%	153	44%	282	32%
Inpatient Med/Surg or Observation	93	51%	129	37%	79	23%	301	34%
Specialist Referrals	8	4%	3	1%	16	5%	27	3%
Physical, Occupational or Speech Therapy	2	1%	33	10%	22	6%	57	7%
Durable Medical Equipment	23	13%	51	15%	27	8%	101	12%
Home Health Visits	9	5%	4	1%	5	1%	18	2%
Total	181		346		346		873	



Attributes of the Sample Reviewed

	Anthem		MHS		MDwise		TOTAL	
	MCO Total	Pct of Total	MCO Total	Pct of Total	MCO Total	Pct of Total	Total	Pct of Total
Final Determination of Authorization Request								
Approved	52	29%	43	12%	125	36%	220	25%
Denied	129	71%	303	88%	221	64%	653	75%
Total	181		346		346		873	
Type of Authorization Request								
Pre Service	98	54%	223	64%	261	75%	582	67%
Concurrent Review	58	32%	72	21%	47	14%	177	20%
Retrospective	23	13%	44	13%	35	10%	102	12%
Cannot be determined from file	2	1%	7	2%	3	1%	12	1%
Total	181		346		346		873	
Number of Days from Request to Determination								
Less than 1 day	40	22%	15	4%	132	38%	187	21%
1 day	41	23%	37	11%	46	13%	124	14%
2 days	14	8%	36	10%	30	9%	80	9%
3 days	7	4%	28	8%	15	4%	50	6%
4 to 14 days	65	36%	171	49%	88	25%	324	37%
More than 14 days	14	8%	59	17%	35	10%	108	12%
Total	181		346		346		873	
Modified Auths	21	12%	10	3%	15	4%	46	5%
Appeals	7	4%	25	7%	21	6%	53	6%

Attributes of Sample of Clinically Denied Auths

	Anthem		MHS		MDwise		TOTAL	
	MCO Total	Pct of Clinical Denied	MCO Total	Pct of Clinical Denied	MCO Total	Pct of Clinical Denied	Total	Pct of Clinical Denied
Service Category								
Ambulatory or Outpatient Surgical	4	3%	28	11%	21	12%	53	10%
Diag Outpt Proc, Radiology, or Path	10	9%	72	29%	110	63%	192	36%
Inpatient Med/Surg or Observation	74	64%	87	35%	20	11%	181	34%
Specialist Referrals	0	0%	0	0%	2	1%	2	0%
Physical, Occup or Speech Therapy	0	0%	30	12%	6	3%	36	7%
Durable Medical Equipment	22	19%	29	12%	14	8%	65	12%
Home Health Visits	6	5%	3	1%	1	1%	10	2%
Total	116		249		174		539	
Type of Authorization Request								
Pre Service	50	43%	165	66%	159	91%	374	69%
Concurrent Review	44	38%	56	22%	9	5%	109	20%
Retrospective	21	18%	23	9%	6	3%	50	9%
Cannot be determined from file	1	1%	5	2%	0	0%	6	1%
Total	116		249		174		539	
Number of Days from Request to Determination								
Less than 1 day	13	11%	2	1%	41	24%	56	10%
1 day	31	27%	26	10%	18	10%	75	14%
2 days	9	8%	28	11%	18	10%	55	10%
3 days	4	3%	21	8%	8	5%	33	6%
4 to 14 days	50	43%	141	57%	63	36%	254	47%
More than 14 days	9	8%	31	12%	26	15%	66	12%
Total	116		249		174		539	
Modified Auths								
	19	16%	10	4%	8	5%	37	7%
Appeals								
	7	6%	21	8%	20	11%	48	9%
Upheld	4		19		7		30	63%
Overturned	3		2		13		18	38%



Authorization Denial Rates

	Anthem	MHS	MDwise	TOTAL
Total	5%	11%	3%	6%
Ambulatory or Outpatient Surgical	4%	10%	7%	8%
Diagnostic Outpt Proc, Radiology, or Pathology	2%	22%	2%	8%
Inpatient Med/Surg and Observation	6%	9%	1%	4%
Specialist Referrals	3%	1%	1%	1%
Physical, Occupational, or Speech Therapy	3%	15%	2%	8%
Durable Medical Equipment	10%	13%	4%	8%
Home Health Visits	4%	4%	1%	3%

B&A's Evaluation of Denial Decisions

- Of the 539 clinically denied authorizations reviewed by B&A's Clinical Team
 - B&A agreed with denial decision 58% of time
 - Disagreed 13% of time
 - Not enough info to conclude (lack of medical records) 29%
- Overall average of denials overturned in sample was 35%

Clinical Team Observations from Study Sample



- 1) Clinical guidelines or IAC usually cited, but examples were found where co-morbidities, age or life situation may merit deviating from clinical guideline.
- 2) Numerous situations found where MCOs documented multiple requests from providers for more information before issuing an administrative denial.
- 3) Other examples where limited clinical records, consult notes prohibited B&A from issuing an opinion on MCO's decision.
- 4) IP stays < 72 hours routinely denied by two MCOs.
- 5) Denial letters could provide more explanation to providers.

Clinical Team Observations from P&P Review



- 1) All MCOs follow a similar workflow process for intake and decisions on auth requests.
- 2) Terminology used differently by MCOs, specifically *approved* and *denied* on multiple auth request.
- 3) All MCOs utilize Milliman, InterQual or both plus IAC.
- 4) Documentation of staff training on guidelines limited.
- 5) All MCOs employ an IRR process for nurses and doctors.
- 6) All MCOs monitor over/under utilization, but vary in how this information informs auth decisions.

B&A Recommendations

Related to Policies and Procedures:

- Strengthen Utilization Management and PA process in Scope of Work.
- Monitor MCO's approach to training staff making auth decisions on the use of clinical guidelines.

OMPP Response:

- OMPP strengthened requirements regarding UM, PA processes and demonstration of training materials for new employees and "refresher" training within the HHW/HIP Rebid Request for Services released 1/6/10. In addition, these topics will be covered during monthly onsite oversight meetings conducted by OMPP staff at each of the MCOs.

Related to Documentation:

- Determine when medical records/notes are required for authorization decision.
- Audit the MCO records for evidence of records, when applicable.

OMPP Response:

- OMPP established minimum requirements to help ensure more consistent record keeping when denying PA requests. These minimum requirements were established as a part of the HHW/HIP Rebid RFS released 1/6/10, with an effective date of 1/1/11.

Related to Documentation:

- MCO clinical staff should sign their notes, even on the computer, and use their correct suffix (LPN, RN, MD) when making decisions on PA/UM requests.
- Consistency and quality of denial letters to providers and members could be improved.

OMPP Response:

- OMPP supports this recommendation and will monitor in 2010.

Related to Data Reporting:

- Require MCOs to use standardized terminology when submitting reports for tracking/trending data.
- Results of this study at the service category level could use further scrutiny due to differing definitions and categorizations by MCOs.

OMPP Response:

- OMPP staff are leading efforts through the current reporting manual process to establish a crosswalk of definitions amongst the MCOs to help ensure consistency of data submission to OMPP. This will include defining partial approvals vs. partial denials. NCQA and other nationally recognized sources are being consulted.

Related to Inpatient Authorizations:

- Inpatient denials for LOS <72 hours should be analyzed further.
- Clarify to providers opportunity to submit request for approval for Inpatient Stays <24 hours as retrospective review.

OMPP Response:

- OMPP is currently reviewing this issue further and will provide direction and clarification to MCOs and/or providers, as needed.

Related to Appeals:

- MCOs should be reminded of the absolute requirement that an appeal cannot be done by the same physician reviewer who did the original denial (CFR 438.406)

OMPP Response:

- OMPP supports this recommendation, has reminded the MCOs of this requirement and will monitor during the monthly onsite process.

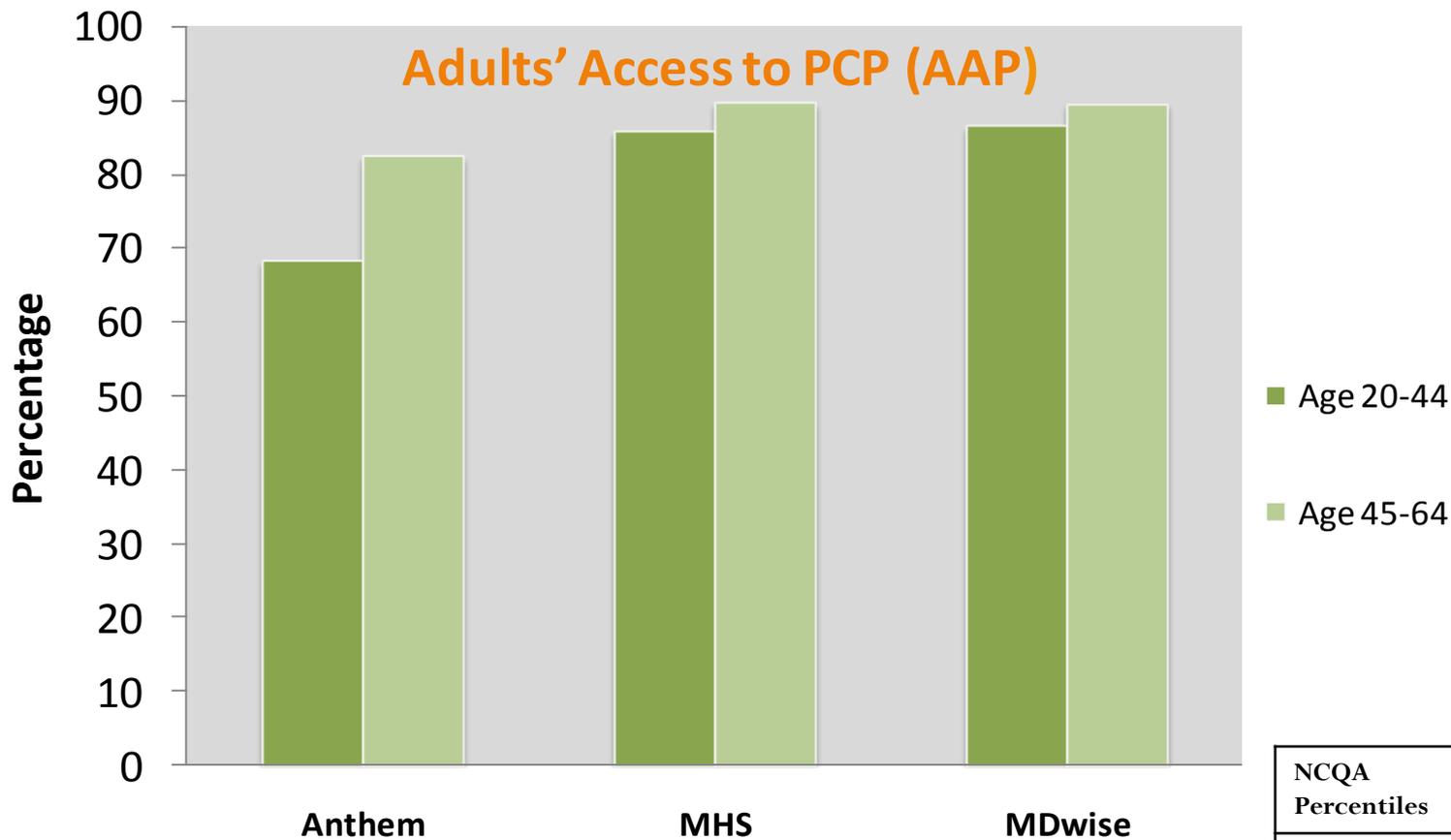
HEDIS® 2009 Hoosier Healthwise

Review of Select HEDIS® 2009 Results

HEDIS® 2009

- Represent data collected for dates of service through 12/31/2008
 - Measures can be reported as Administrative (claims-only) or Hybrid (combination of claims and record review)
 - When applicable, the rate shown is the Hybrid rate
 - All results have been reviewed by an NCQA-certified independent auditor
- Selected measures look at access to and appropriate use of preventive services; and appropriate treatment of common conditions

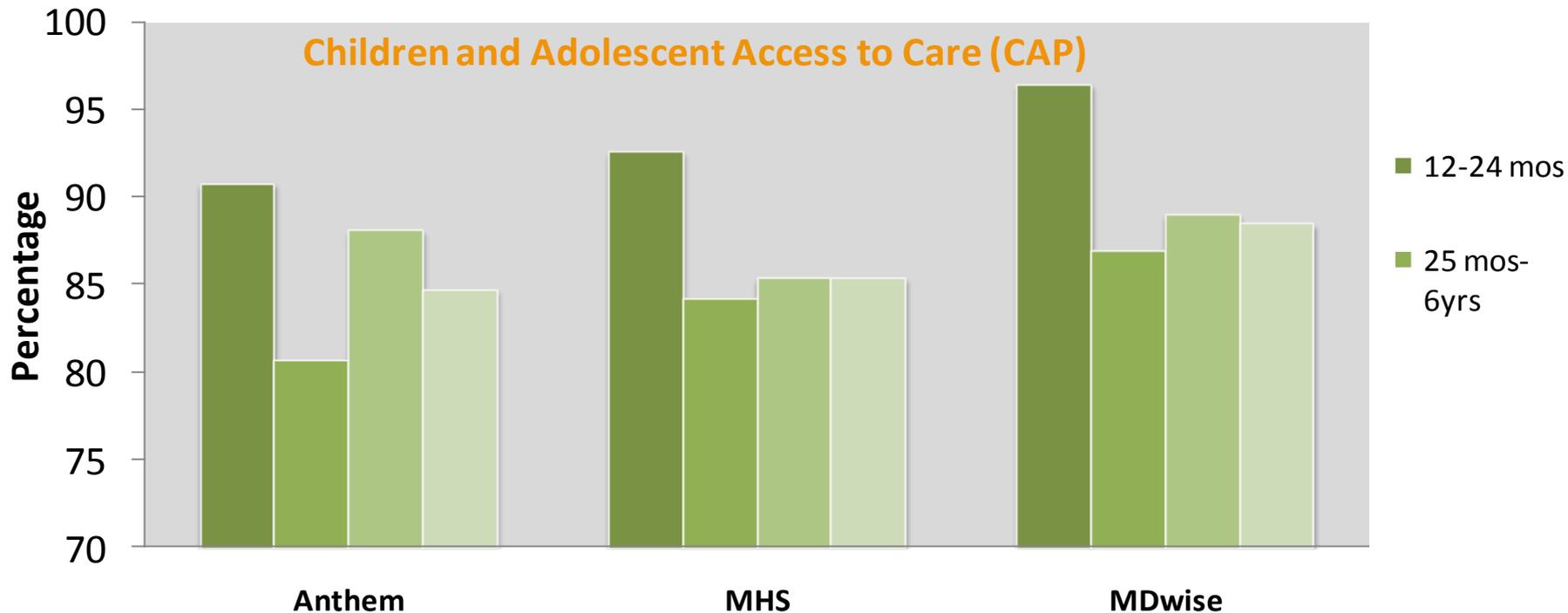
Access to Primary Care Provider for Preventative Services



The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year (includes primary care and outpatient hospital visits)

NCQA Percentiles	20-44	45-64
10 th	60.7	71.2
25 th	71.6	79.3
50 th	79.6	85.7
75 th	84.8	88.3
90 th	87.6	90.2

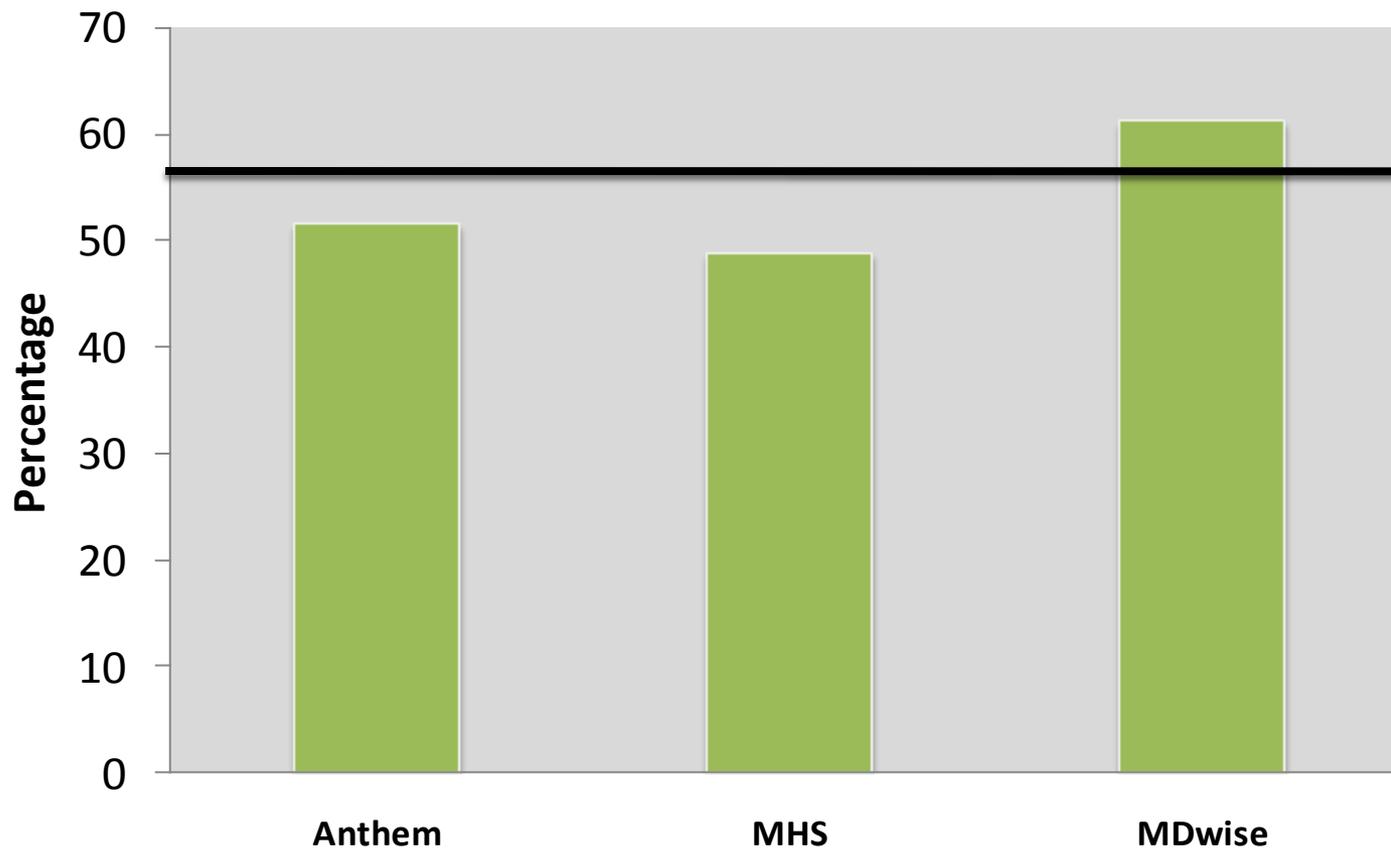
Access to Primary Care Provider for Preventative Services



NCQA Percentiles	12-24 mos.	25 mos. – 6yrs	7 yrs – 11 yrs	12yrs – 19yrs
10 th	87.7	74.2	75.5	70.6
25 th	93.2	82.3	82.2	78.1
50 th	95.8	86.5	87.8	84.5
75 th	97.4	89.4	91.2	90.0
100 th	98.4	92.0	94.1	91.9

The percentage of members 12 months – 6 years of age who had a visit with a PCP during the measurement year; ages 7 yrs – 19 yrs who had at least 1 visit with a PCP during a two year measurement period.

Well-Child Visits – through 15 months, six or more visits (W15)



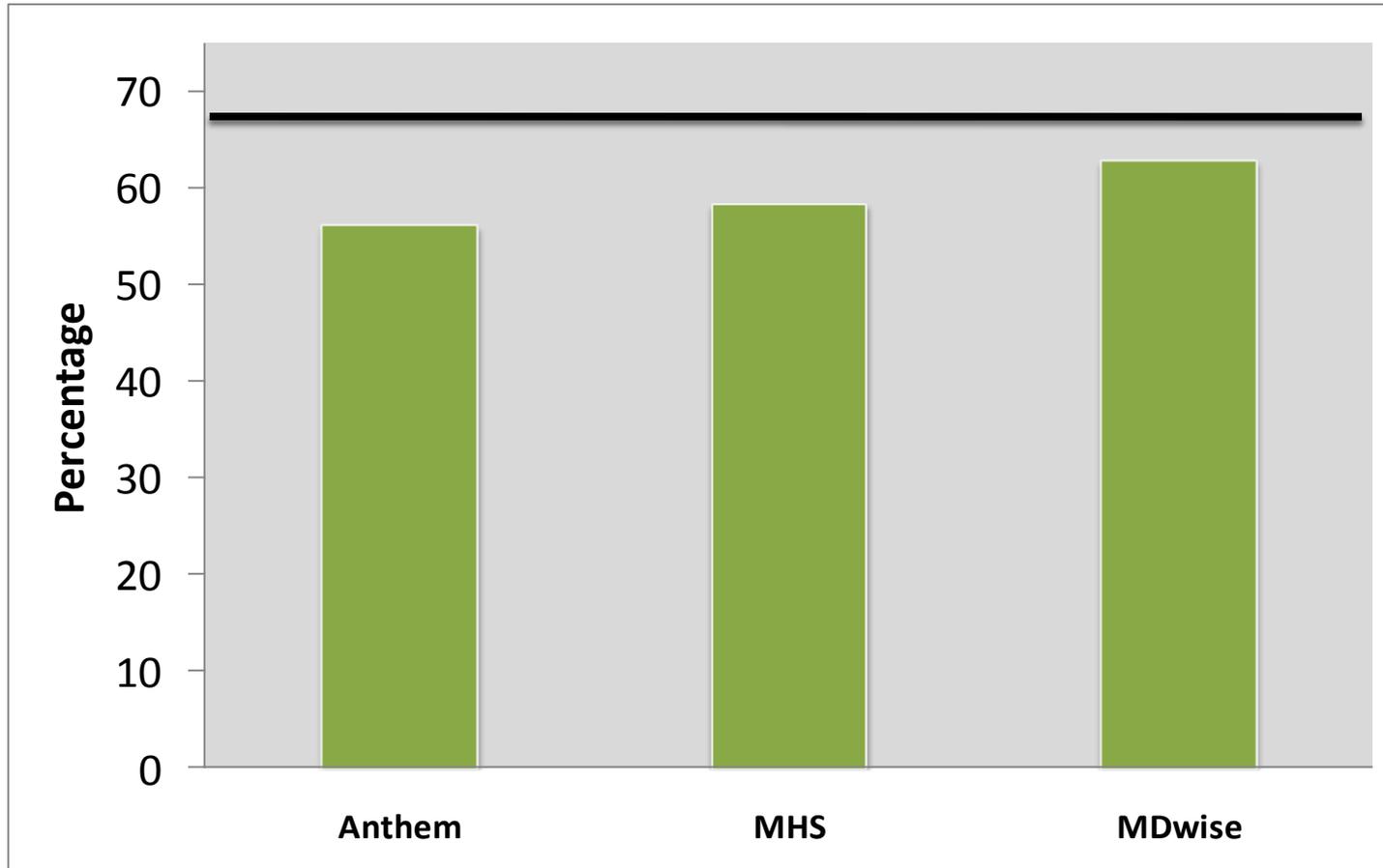
50th Percentile

NCQA Percentiles

10 th	29.0
25 th	44.5
50 th	57.5
75 th	65.4
90 th	73.7

The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life

Well-Child Visits, 3 to 6 year olds (W34)

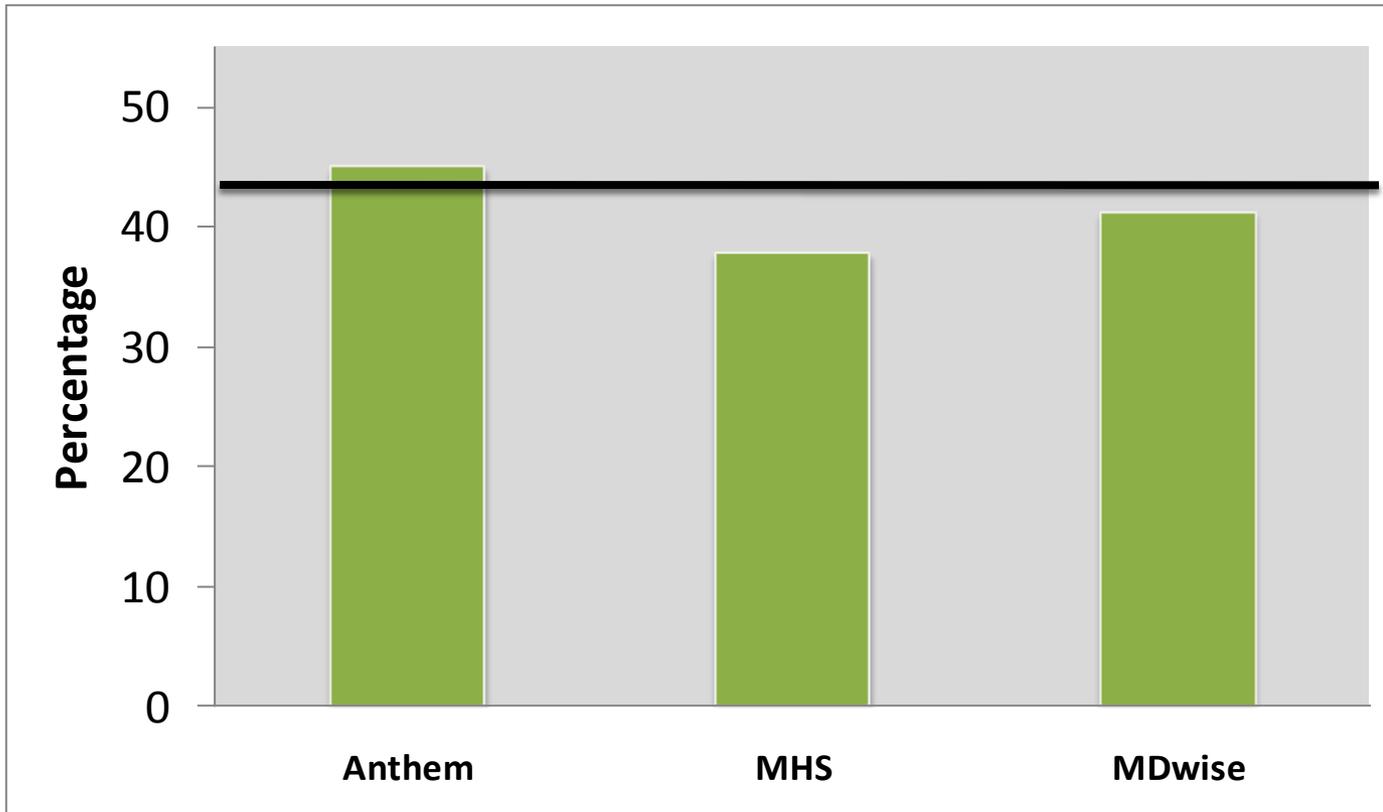


50th Percentile

NCQA Percentiles	
10 th	52.3
25 th	59.8
50 th	68.2
75 th	74.0
90 th	78.9

The percentage of members 3 – 6 years of age who received one or more well-child visits with a PCP during the measurement year.

Adolescent Well-Child Visits (AWC)

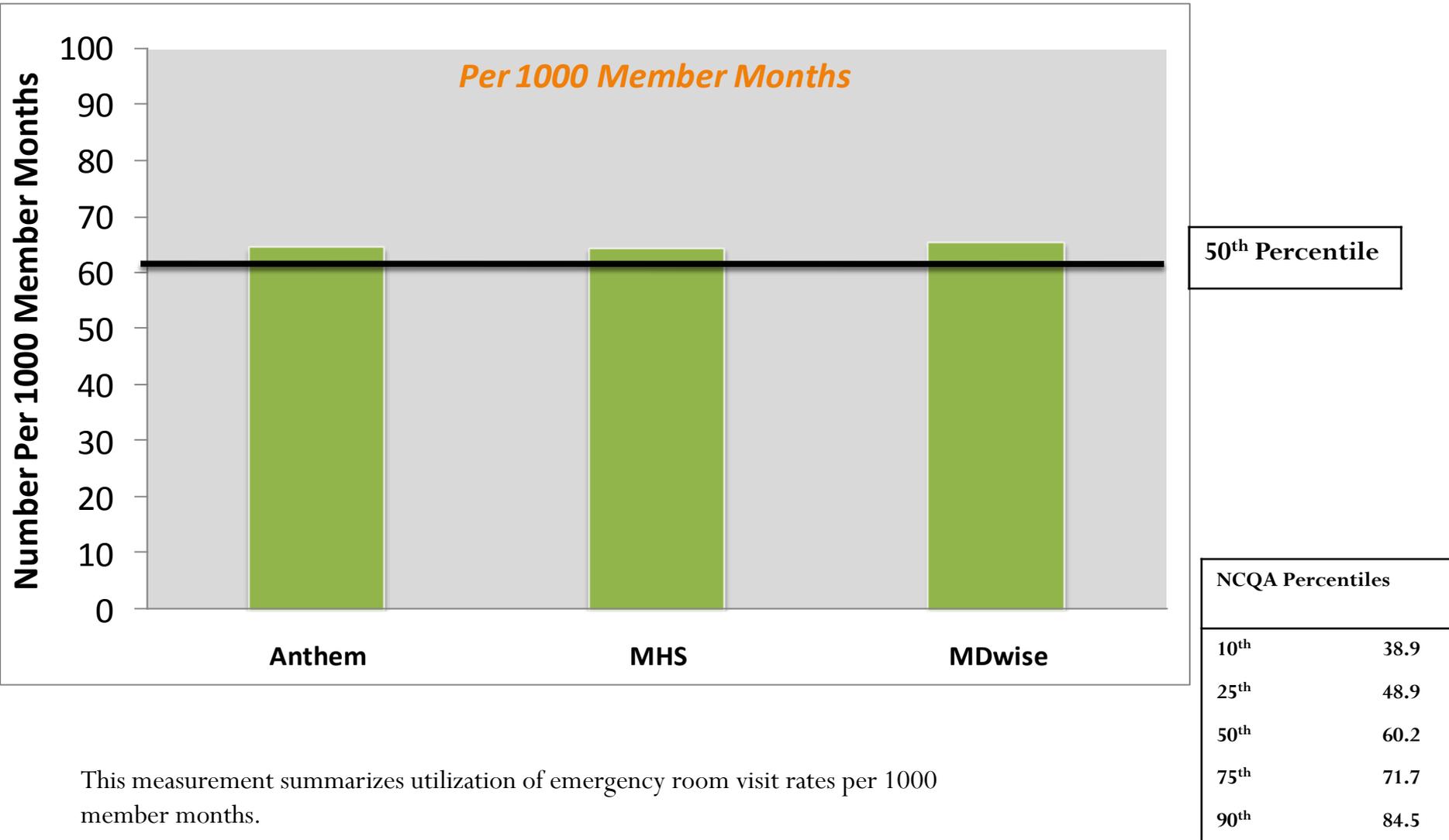


50th Percentile

NCQA Percentiles	
10 th	27.2
25 th	35.9
50 th	42.1
75 th	51.4
90 th	56.7

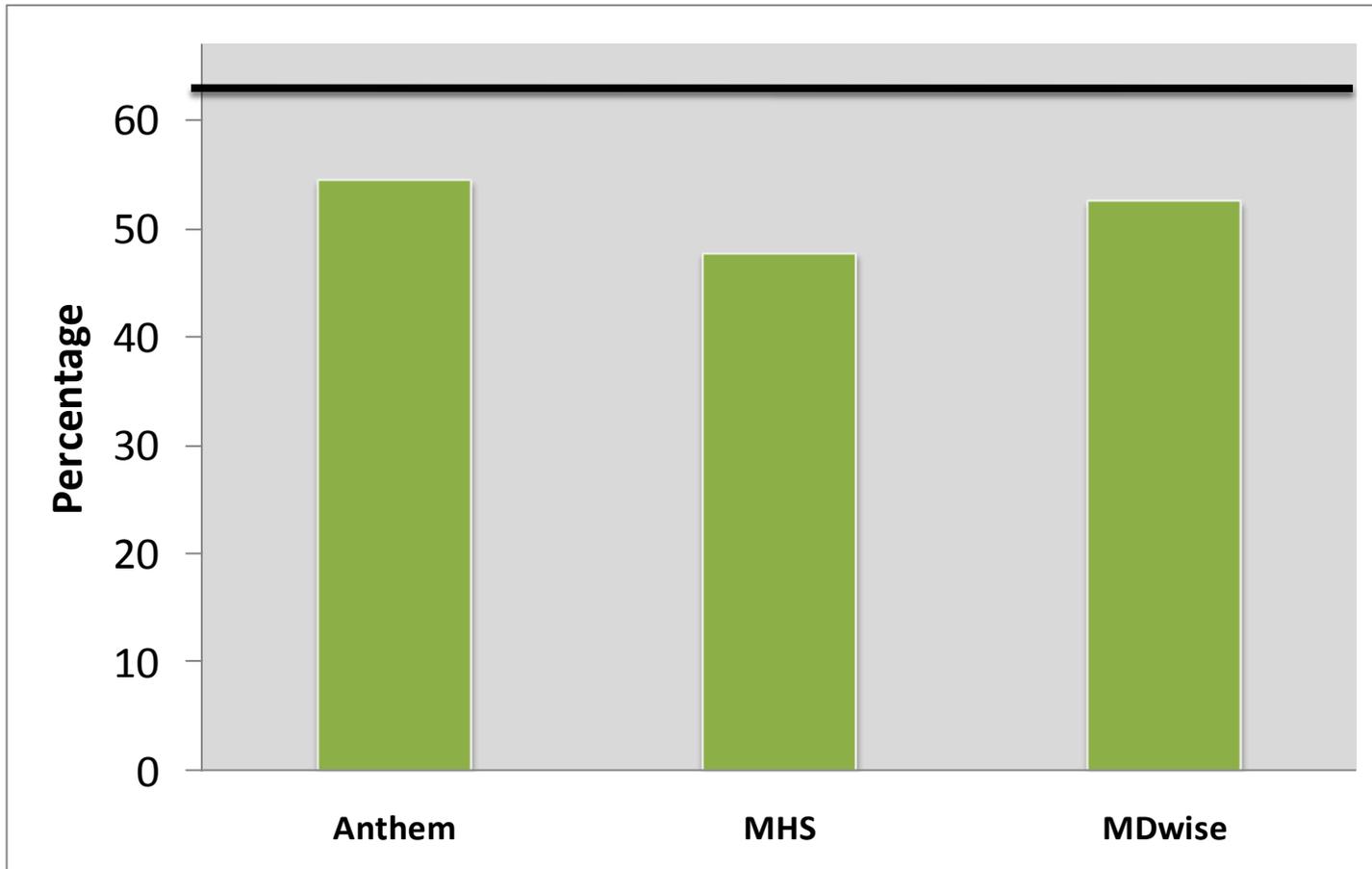
The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Emergency Room Visit Rates (AMBA)



This measurement summarizes utilization of emergency room visit rates per 1000 member months.

Appropriate Testing for Children with Pharyngitis (CWP)



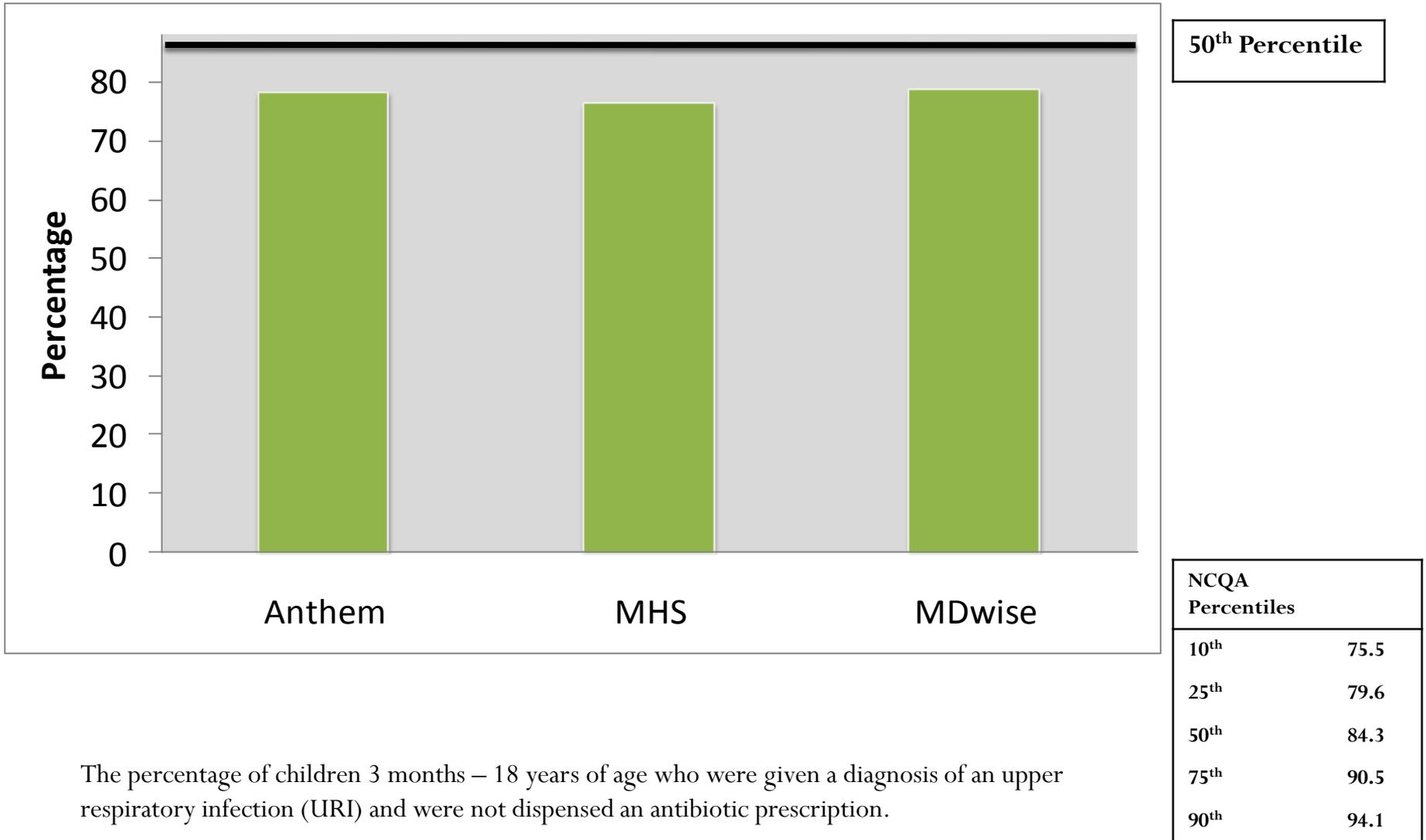
50th Percentile

NCQA Percentiles

10 th	30.1
25 th	47.9
50 th	62.5
75 th	71.7
90 th	77.3

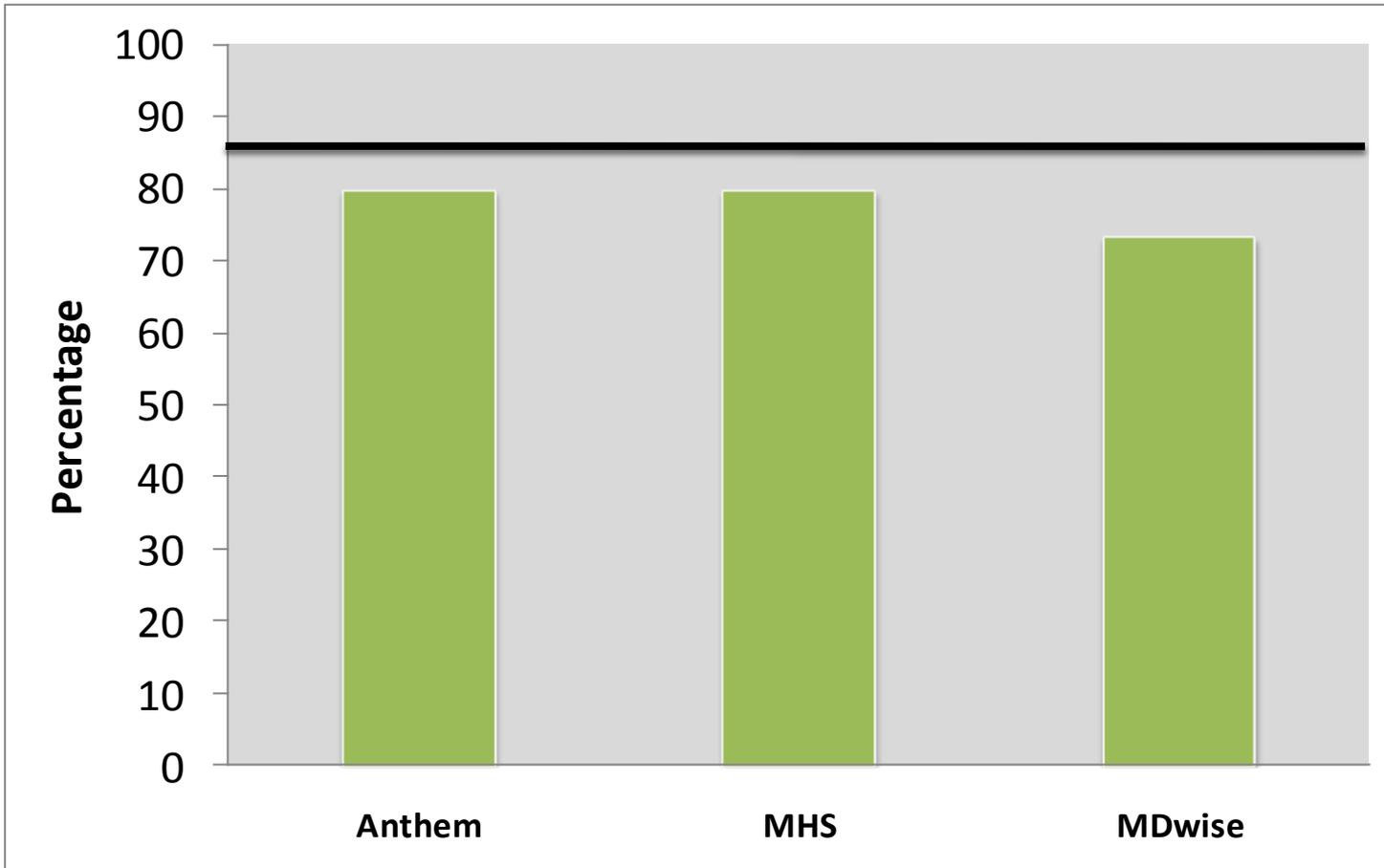
The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and receives a group A streptococcus (strep) test for the episode

Appropriate Treatment for Children with Upper Respiratory Infection (URI)



The percentage of children 3 months – 18 years of age who were given a diagnosis of an upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Avoidance of Antibiotic for Acute Bronchitis (AAB)

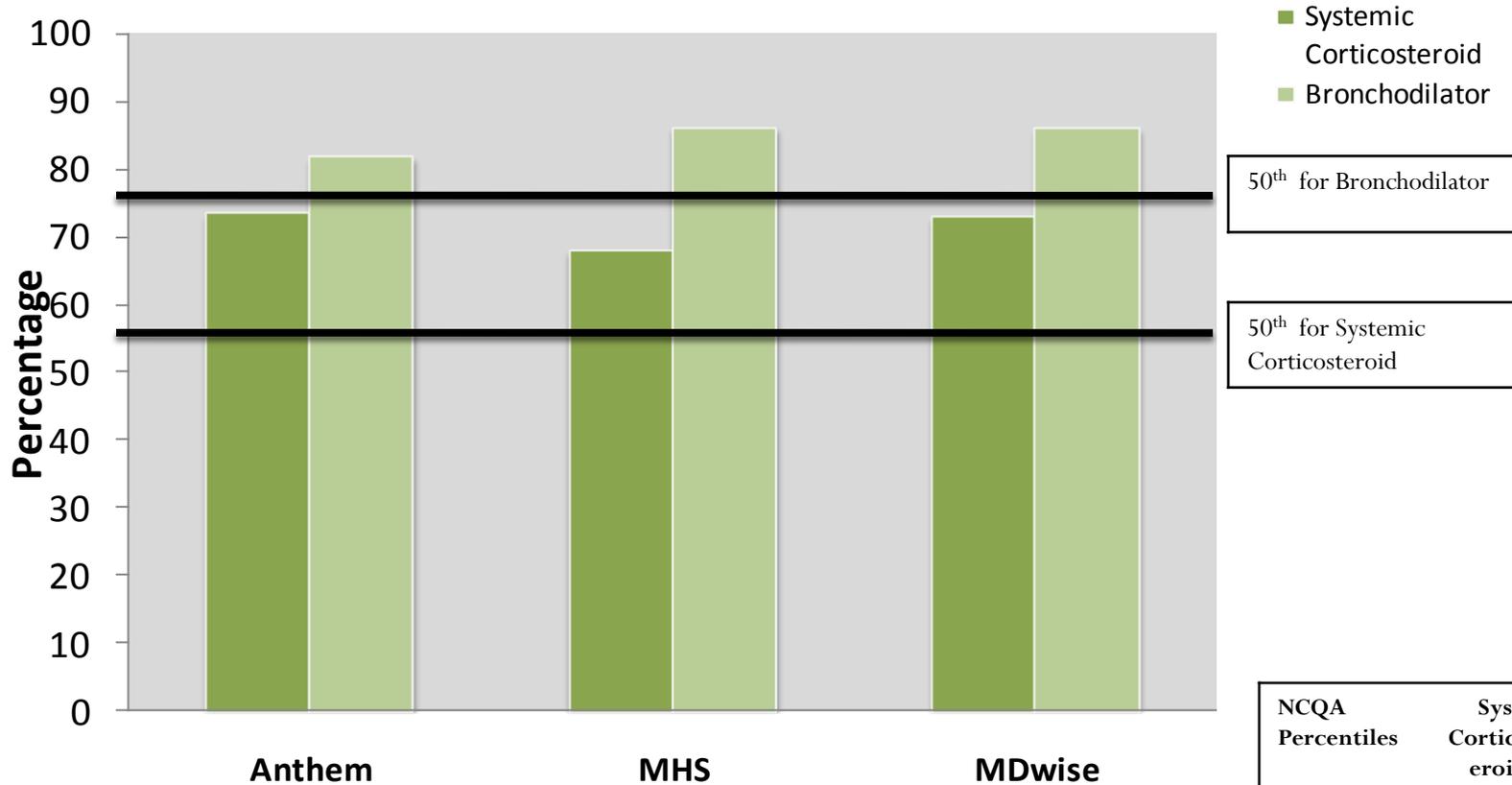


50th Percentile

NCQA Percentiles	
10 th	75.5
25 th	79.6
50 th	84.3
75 th	90.5
90 th	94.1

The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

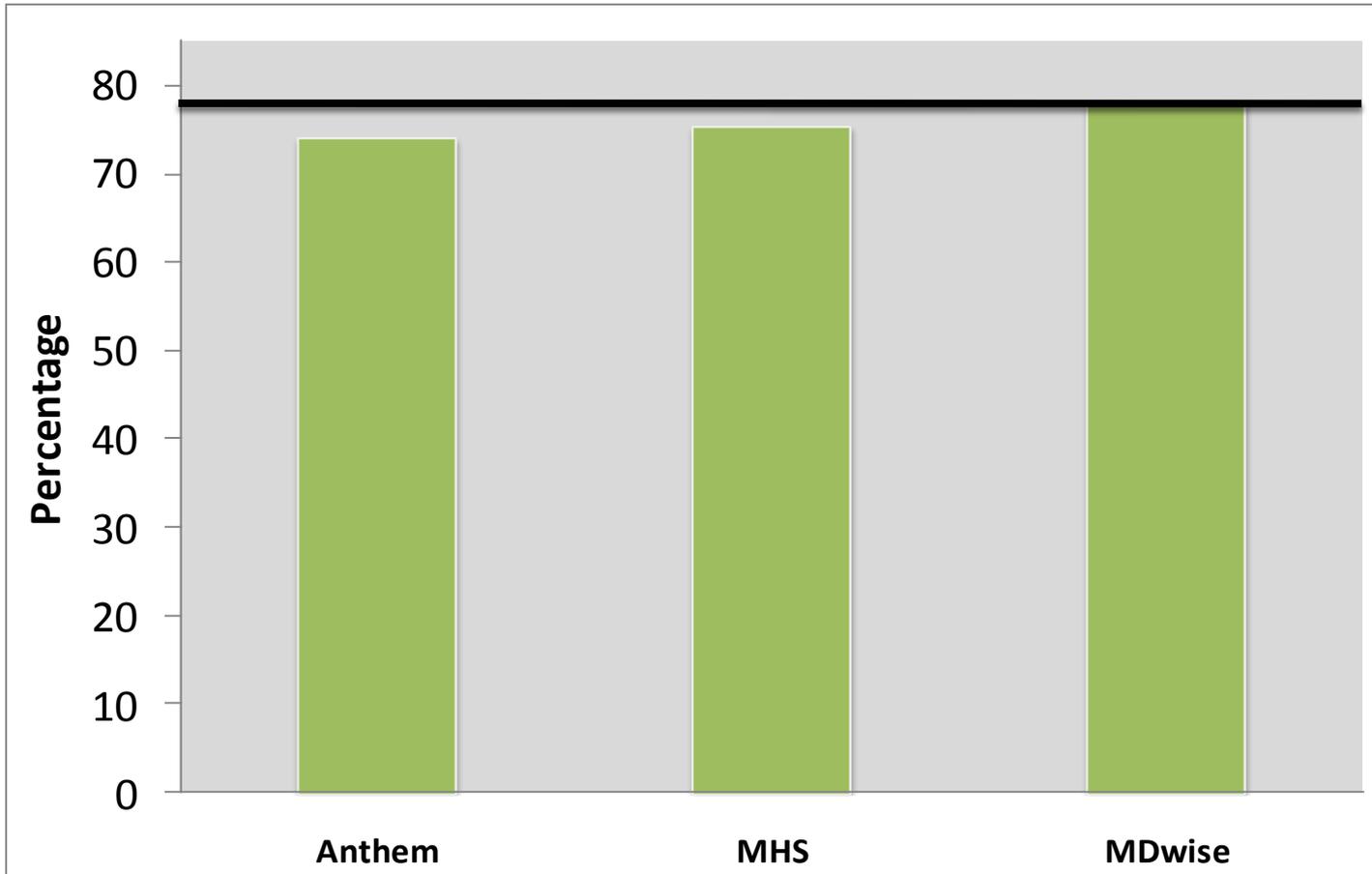
Pharmacotherapy Management of COPD Exacerbation (PCE)



The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1 – November 30 of the measurement year and who were dispensed appropriate medications (systemic corticosteroid within 14 days of event or bronchodilator within 30 days of the event)

NCQA Percentiles	Sys. Corticosteroid	Bronchodilator
10 th	36.8	65.1
25 th	48.0	70.4
50 th	54.1	77.9
75 th	60.9	82.2
90 th	68.6	86.2

Appropriate use of Imaging Studies for Low Back Pain (LBP)

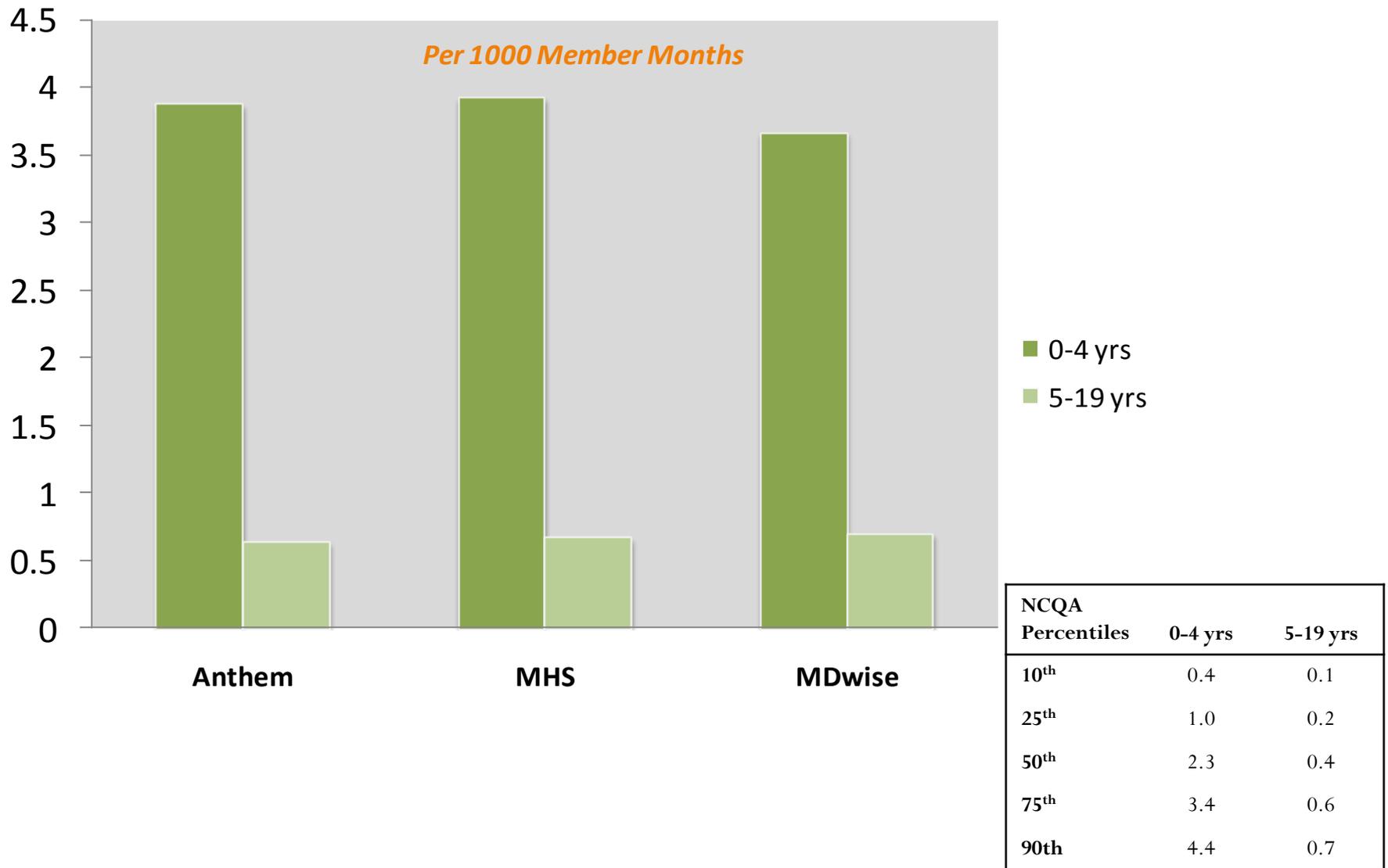


50th Percentile

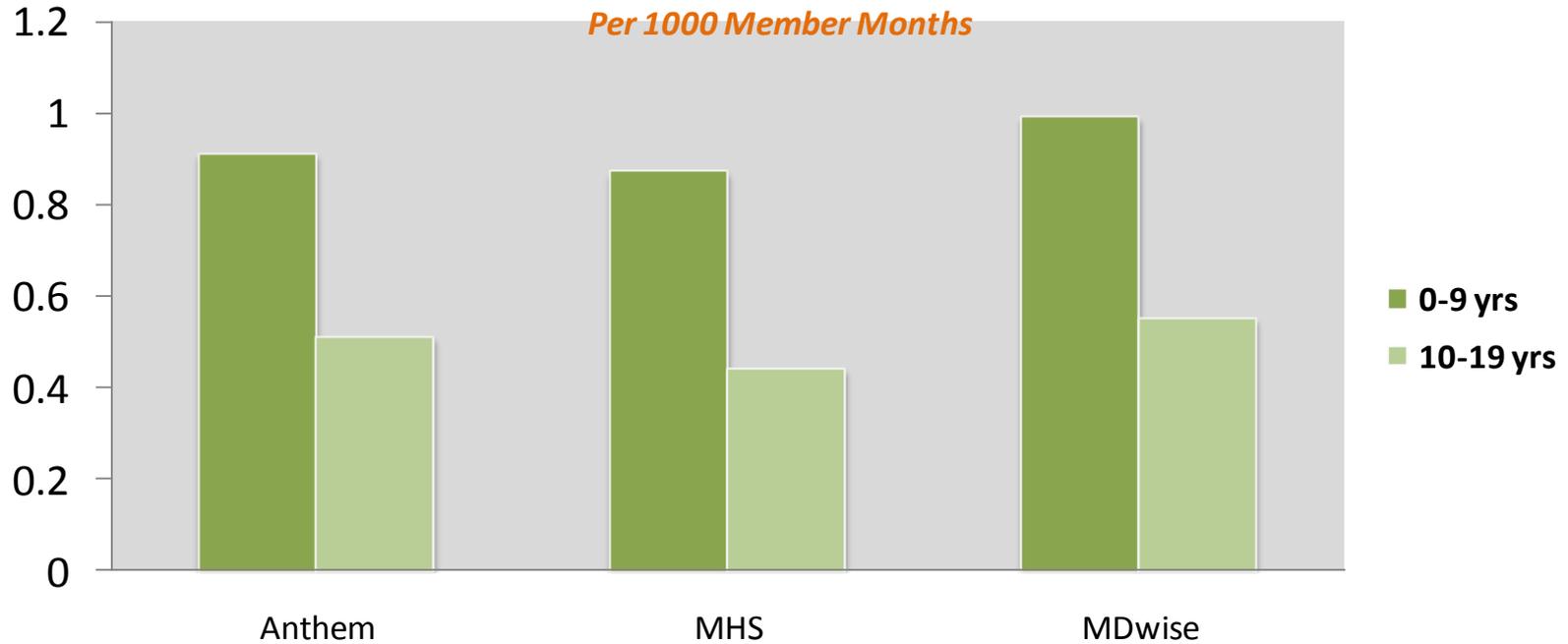
NCQA Percentiles	
10 th	70.7
25 th	74.1
50 th	78.2
75 th	80.4
90 th	82.9

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

Frequency of Myringotomy (FSP)



Frequency of Tonsillectomy (FSP)



NCQA Percentiles	0 - 9 yrs	10-19 yrs
10 th	0.2	0.0
25 th	0.4	0.2
50 th	0.7	0.3
75 th	0.9	0.5
90 th	1.1	0.6

Descriptions of Measures

Adult Access to Preventive/Ambulatory Care (AAP)

The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year

Children and Adolescents' Access to PCPs (CAP)

The percentage of members 12 months – 19 years of age who had a visit with a PCP during the measurement year.

Well-Child Visits - through 15 months, six or more visits (W15)

The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life

Well-Child Visits, 3 to 6 year olds (W34)

The percentage of members 3 – 6 years of age who received one or more well-child visits with a PCP during the measurement year

Descriptions of Measures

Well-Child Adolescent Visits (AWC)

The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

Appropriate Testing for Children with Pharyngitis (CWP)

The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and receives a group A streptococcus (strep) test for the episode

Emergency Room Visit Rates (AMB)

This measurement summarizes utilization of ambulatory care in the areas of Outpatient Visits, ED Visits, Ambulatory Surgery/Procedures, and Observation Room Stays

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The percentage of children 3 months – 18 years of age who were given a diagnosis of an upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Descriptions of Measures

Avoidance of Antibiotic for Acute Bronchitis (AAB)

The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

Appropriate Use of Imaging Studies for Low Back Pain (LBP)

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

Pharmacotherapy Management of COPD Exacerbation (PCE)

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1 – November 30 of the measurement year and who were dispensed appropriate medications (systemic corticosteroid within 14 days of event or bronchodilator within 30 days of the event)

Frequency of Myringotomy and Tonsillectomy (FSP)

This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization

Indiana Health Coverage Programs Prior Authorization Request Form

Check the box of the plan in which the member is enrolled.

Traditional	<input type="checkbox"/> Advantage Traditional	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	<input type="checkbox"/> Anthem Hoosier Healthwise	P: 866-408-7187	F: 866-406-2803
	<input type="checkbox"/> MDwise Hoosier Healthwise	See www.mdwise.org	
	<input type="checkbox"/> MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan	<input type="checkbox"/> Anthem HIP	P: 866-408-7187	F: 866-406-2803
	<input type="checkbox"/> MDwise HIP	See www.mdwise.org	
Care Select	<input type="checkbox"/> Advantage Care Select	P: 800-784-3981	F: 800-689-2759
	<input type="checkbox"/> MDwise Care Select	P: 866-440-2449	F: 877-822-7186

Please complete all appropriate fields.

Patient Information			
Medicaid ID/RID#:			
DOB:			
Patient Name:			
Address:			
City/State/Zip:			
Patient/Guardian Phone:			
PMP Name:			
PMP NPI:			
PMP Phone:			
Medical Diagnosis (Use of ICD-9 Diagnostic Code is Required)			
Dx1		Dx2	
Dx3			

Requesting Provider Information:
NPI#:
Tax ID #:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID #:
Name:
Address:
City/State/Zip:
Phone:
Fax:
Preparer's Information:
Name:
Phone:
Fax:

Please check requested assignment category below:

- | | | |
|---|---|---|
| <input type="checkbox"/> DME | <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> <i>Purchased</i> | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> <i>Rented</i> | <input type="checkbox"/> Observation | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Transportation |
| | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |

Dates of Service		Procedure/ Service Codes	Modifier(s)	Requested Service	Taxonomy	POS	Units	Dollars
Start	Stop							

Notes: _____

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____