New Disease Management Program Starts April 1

Effective April 1, 2003, beneficiaries with asthma, diabetes, or hypertension will be enrolled in the Mississippi Medicaid Disease Management Program. The program is managed by McKesson Health Solutions and its partners, including Health Alliance, the University of Mississippi Medical Center, Mississippi Primary Health Care Association, Jackson Medical Mall Foundation, Specialty Disease Management Services, and Hinds County Health Alliance.

House Bill 1200, passed during the 2002 Legislative Session, mandated development of disease management programs for individuals with asthma, diabetes, or hypertension. In response to this legislation, the Division of Medicaid developed a Request for Proposals, and McKesson and its partners were selected from among the submitted proposals. Medicaid, Medicare, and other third party payers around the country are implementing similar programs to improve the quality of care and control health care costs. Our goal is to treat these chronic diseases and prevent or delay complications that minimize the beneficiary's quality of life.

This comprehensive disease management program will provide a package of services that includes beneficiary and provider education, case management, and home visits. The program will be statewide, and beneficiaries with asthma, diabetes, or hypertension will be enrolled. Medicare beneficiaries, those in hospice program, residents of a long-term care facility, PRTF, or ICF-MR, and those enrolled in a Home and Community Based Waiver Program will be excluded from the program. Nurses will contact beneficiaries by telephone and through home visits. These nurses will work with both beneficiaries and providers to ensure that nationally recognized standards of care are met. There is no provider network or lock-in to certain providers. Beneficiaries will continue to have the freedom of choice of providers, including hospitals, physicians, pharmacies, durable medical equipment, and other participating Medicaid providers.

Over the next few weeks, providers will receive additional mailings with information about this new program. McKesson and its partners will be actively involved in working with Medicaid providers to provide information, answer questions, and facilitate beneficiaries' access to services. Beneficiaries will also receive mailings and phone calls from McKesson explaining the program and providing them with information about their chronic diseases. If at any point you have questions, concerns, or need further information about the disease management program, please call Alicia Crowder or LaKeshia Robertson at the Division of Medicaid, Bureau of Medical Services, at (601) 359-5683.

TAN Procedure Outlined

In an effort to improve the quality of service offered to providers, Division of Medicaid (DOM), ACS, and HealthSystems of Mississippi (HSM) have worked collaboratively to refine the process by which neonatal care is certified for reimbursement.

Effective March 1, 2003, the procedure for issuing treatment authorization numbers for infants born to Medicaid mothers (known as K-babies), was modified. This modification was designed to ensure the timely and complete communication of all authorization and billing information required for provider reimbursement.

Prior to March 1, when a provider secured certification approval for K-baby services, HSM transmitted written confirmation of the approval to the provider.

Beginning March 1, HSM will continue to issue written confirmation of certification approvals but the Treatment Authorization Number (TAN) issued in that approval letter will not be transmitted to the fiscal intermediary until the infant's own Medicaid number is added to the file and all name information is verified as correct.

HSM will distribute to providers a revised bi-weekly newborn listing. This listing will contain two dedicated data fields, one to validate the infant's name and a second field designated to record any name correction.

Once the infant's name and Medicaid number are verified as correct, HSM will transmit the TAN to the fiscal intermediary for provider billing/reimbursement. At that time HSM will reissue the approval notification to both the provider and the attending physician, completing the authorization procedure.

By correlating and validating complete and correct information for K-babies, the certification information transmitted by HSM will be consistent for billing/reimbursement procedures.

Updates to the Pharmacy Program

This notice contains information for **all providers** about changes to the Medicaid Pharmacy Program.

Drugs/Drug Classes Removed from the PA List effective April 7, 2003

H2 Antagonists: PA is no longer required for H2 Antagonists. Appropriate prescribing and usage will be monitored via the retrospective drug utilization review process.

New Drugs/Drug Classification added to the PA List effective April 7, 2003

Oral Transmucosal Fentanyl Citrate (ACTIQ)

Actiq is indicated only for the management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking at least 60 mg morphine/day, 50 mcg transdermal fentanyl/hour, or an equianalgesic dose of another opioid for a week or longer.

Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, Actiq is contraindicated in the management of acute or postoperative pain. This product must not be used in opioid non-tolerant patients.

The FDA recommends Actiq to be used only in the care of cancer patients and only by oncologists and pain specialists who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain.[1]

The appropriate dosing and safety of Actiq in opioid tolerant children with breakthrough cancer pain have not been established below the age of 16 years.[2]

Prior Authorization (PA) is required for Actiq. PA requests must include documentation of:

- Management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy
- Diagnosis of cancer (ICD-9 codes 141.0-208)

Contraindications:

- Hypersensitivity to opiates
- Respiratory depression/hypoxia/hypercarbia
- Severe asthma or COPD
- Paralytic ileus
- Treatment of acute or postoperative pain
- Treatment of opioid non-tolerant patients
- Use in children below the age of 16 years

Duration of Prior Authorization: Approval may be granted for up to 6 months.

Health Information Designs (HID) handles PA requests. The form for requesting Actiq is included in this bulletin on page 6. You may also download it from the HID web site at www.hidmsmedicaid.com.

[1] ©2002 Cephalon, Inc. Boxed Warning on Prescribing Information for Actiq
[2] ©2002 Cephalon, Inc. Prescribing Information for Actiq

FAX TO : 1-800-459-2135
Health Information Designs, Inc.
P.O. Box 320506
Flowood, MS 39232
Phone 800-355-0486

ACTIQ
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid # _____

DOB: _____ City_____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ Medicaid ID # _____

City_____ State _____ Phone #: _____

FAX #: _____

_____
Physician's signature and date

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider # _____

City_____ State _____ Phone #: _____

DRUG/CLINICAL INFORMATION

Drug Name & Strength: _____ Quantity /Month _____ Frequency:_____

Diagnosis with ICD-9: _____ NDC#:_____ Indicate asymmetrical dosing (if needed) ____am ____pm

Additional Medical Justification: _____

List prior drug use:
1. _____ Length of therapy_____ days Reason for d/c:_____

2. _____ Length of therapy_____ days Reason for d/c:_____

According to manufacturers guidelines and FDA indications Actiq is indicated only for the management of breakthrough cancer pain in patients with malignancies.

Indicate type of pain: ___Acute___Chronic Indicate severity of pain: ___Mild___Moderate ___Severe

Does the patient have a history of substance abuse or addiction? Yes No

Does the patient have a history of the following?
- Hypersensitivity to opiates
- Respiratory depression/hypoxia/hypercarbia
- Severe asthma or COPD
- Paralytic ileus

FOR HID USE ONLY
Eligibility Verified by _____
Approved _____
Denied/Code:_____
From Date _____ Thru Date_____
Reviewed by_____
HID#_____ PA#_____

Revised PA Criteria effective April 7, 2003

Proton Pump Inhibitors (PPI)

Prior authorization criteria for PPIs must include each of the following:

1. Beneficiary must have one of the following diagnoses.
   - Heartburn
   - H. Pylori
   - Gastroesophageal Reflux Disease (GERD)
   - Esophagitis
   - Peptic Ulcer Disease (PUD)
   - Gastric Ulcer
   - Barrett's Esophagus
   - Zollinger-Ellison Syndrome
   - Laryngopharyngeal Reflux (LPR)
   - Other Hypersecretory condition (diagnosis with medical justification attached to the request)

2. Beneficiary must have failed two 30-day trials of Antacids, H2 Antagonists, or other PPI. Multiple antacids will be considered as one trial only.

3. Beneficiary must have documentation of testing supporting the diagnosis.

Approved length of therapy varies depending upon diagnosis.

Health Information Designs (HID) handles PA requests. The form for requesting PPIs is included in this bulletin on page 8. You may also download it from the HID web site at www.hidmsmedicaid.com.

Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Policy Manual and must be placed behind Tab 88 of the manual. All providers are held accountable for all policies in the monthly Mississippi Medicaid Bulletins.

FAX TO : 1-800-459-2135
Health Information Designs, Inc.
P.O. Box 320506
Flowood, MS 39232
Phone 800-355-0486

ANTI-SECRETORY THERAPY
PROTON PUMP INHIBITORS
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid # _____

DOB: _____ City_____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ Medicaid ID # _____

City_____ State _____ Phone #: _____

FAX #: _____

_____
Physician's signature and date

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider # _____

City_____ State _____ Phone #: _____

FAX #:

DRUG/CLINICAL INFORMATION

Drug Name: _____ Quantity /Month _____ Daily Dose:_____ mg/day

Diagnosis: _____ NDC#:_____

Additional Medical Justification: _____

List prior drug use:
1. _____ Length of therapy_____ days Reason for d/c:_____

2. _____ Length of therapy_____ days Reason for d/c:_____

CIRCLE DIAGNOSIS:
Laryngopharyngeal reflux
Peptic Ulcer Disease:
Duodenal Ulcer
Gastric Ulcer
Barrett's Esophagus
GERD
Heartburn/Dyspepsia
Erosive esophagitis
Non-erosive esophagitis
Zollinger-Ellison Syndrome

Type of Testing	Positive	Negative
Endoscopy	x	x
UGI/Barium Swallow	x	x
H. Pylori	x	x
Ph Probe	x	x
Fiberoptic exam	x	x

Date of last Test:
_____
month day year

Combination Therapy for H. Pylori? yes no

Lifestyle Modifications recommended? yes no

FOR HID USE ONLY
Eligibility Verified by _____
Approved _____
Denied/Code:_____
From Date _____ Thru Date_____
Reviewed by_____
HID#_____ PA#_____