



Utilization Management 101



The goal of Utilization Management (UM) is to ensure that health care services delivered to insured patients are a covered benefit, are appropriate in quality and quantity, and are provided through Molina Healthcare's network of practitioners. This is accomplished via the use of prior authorization of certain services and devices, concurrent review of patients during their therapeutic course, and retrospective reviews of the services delivered. In addition, UM encompasses the application of careful discharge planning to assure that patients have appropriate post discharge care, as well as case management of those few patients with complex cases who need short term extra help in managing their illness until stable.

Utilization management at Molina Healthcare includes the following components:

- Collection of data about the patient's symptoms, physical exam findings, diagnosis, and test results.
- Review of the medical information submitted to support the authorization request
- Verification of coverage of benefits.
- Comparison of medical information against nationally recognized medical necessity criteria (i.e. InterQual) and State Medicaid guidelines (if any). If the available guidelines do not address the member's specific situation, then other sources are used such as Hayes Inc On-Line, Up-To-Date, medical

In This Issue

Utilization Management 101	pg 1
Drug Formulary Procedures	pg 3
Practitioner Credentialing Rights	pg 3
NPI Contingency Plan	pg 4
Medicare Member Request	pg 4
Nurse Advice Line	pg 4
Notice of Medicare Non-Coverage	pg 5
Complex Case Management	pg 6

Richard Sanchez, MD
Chief Medical Officer
Molina Healthcare of California

Anne LaSette, RN
Director, Quality Improvement

Katherine Davidson, RN
Director, Utilization Management

Timothy C. Zevnik, MBA
Privacy Official and HIPAA Program Manager
Molina Healthcare, Inc.

Featured at www.molinahealthcare.com:

- Clinical Practice and Preventive Guidelines
- Disease Management Programs for Asthma, Diabetes and Pregnancy
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Provider Manual
- Formulary
- UM Affirmative Statement
(re: non-incentive for under-utilization)
- How to Obtain Copies of UM Criteria

Molina Healthcare of California
Please contact Molina Provider Services for written copies of all information on the website or if you need more information please call Provider Services at 1-888-665-4621.

Utilization Management 101 “Continued”

literature searches, and outside physician expert reviewers. Evidence based medicine criteria are preferred when available.

- Referral of case to the Molina Healthcare Medical Director if criteria are not met with documentation of the above. Only a medical director can deny a request for authorization for requested health care services.
- Communication to all providers and the member of review outcome.
- Communication to all parties of the right to appeal the decision.

Our goal is to make appropriate utilization management decisions that are consistent with the objective clinical evidence. We want to work with you to make this happen. To that end, Molina Healthcare health plans follow these UM guidelines established by NCQA:

- Molina Healthcare ensures that criteria used for UM decision-making is available to practitioners upon request. To obtain a copy of the utilization management criteria used in the decision making process, call our UM department at (800) 526-8196 Ext. 126400.
- As the requesting practitioner, you will receive a written notification of a denial. The notification will always include the name and telephone number of the Molina Healthcare physician that made the decision. He or she will welcome the opportunity to discuss the case with you.
- It's important to remember that:
 1. UM decision making is based only on appropriateness of care and service and existence of coverage
 2. Molina Healthcare does not specifically reward practitioners or other individuals for issuing denials of coverage or care
 3. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

Want faster approval of your Authorization Requests?

1. Don't wait until the last day to request authorizations for routine procedures. An urgent request should be used only when there is medical urgency.
2. Send typewritten progress notes. Poor handwriting may delay the process.
3. Send in sufficient clinical information to provide the basis for decision making. Otherwise we may have to ask for additional information, and this leads to delays or even denials.

Molina Healthcare's UM Department staff is available during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff, please call (800) 526-8196 Ext. 126400. You may also fax a question to (562) 901-9330. The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials.

Molina Healthcare's regular business hours are Monday – Friday (excluding holidays) 8:30am-5:30pm. Voice messages and faxes received after regular business hours will be returned the following business day.



Drug Formulary and Pharmaceutical Procedures

For each state, the Drug Formulary (sometimes referred to as a Preferred Drug List or PDL) and pharmaceutical procedures are maintained by a Molina Healthcare Pharmacy and Therapeutics (P&T) Committee. This Committee usually meets on a quarterly basis, or more frequently if needed. It is composed of your peers – practicing physicians and pharmacists from areas where Molina Healthcare practitioners are located. The Committee's goal is to provide a safe, effective and comprehensive Formulary/PDL. The P&T Committee evaluates all therapeutic categories and selects the most cost-effective agent(s) in each class. In addition, the Committee reviews prior authorization procedures to ensure that medications are used safely, and in accordance with the manufacturer's guidelines and FDA-approved indications. They also evaluate and address new developments in pharmaceuticals and new applications of established technologies, including drugs.

Medications prescribed for Molina Healthcare members must be listed in the Drug Formulary/PDL. Select medications may require prior authorization, as well as any medication not found on the listing. When there is a medically necessary indication for an exception, such as failure of the formulary choices, providers may request authorization by submitting, via fax, a Medication Prior Authorization Form or by calling the Pharmacy Prior Authorization Department for the plan. Printed copies of the Drug Formulary/PDL may be obtained by calling the Provider Services Department.

Additionally, the listing and prior authorization criteria are posted on the Molina Healthcare website at www.MolinaHealthcare.com.

Practitioner Credentialing Rights: What You Don't Know Can Hurt You

Molina Healthcare has a duty to protect its members by assuring the care they receive is of the highest quality. One protection is assurance that our practitioners have been credentialed according to the strict standards established by the state regulators and NCQA. Your responsibility, as a Molina Healthcare practitioner, includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

Molina Healthcare also has a responsibility to its practitioners to assure the credentialing information it reviews is complete and accurate. As a Molina Healthcare practitioner, you have the right to:

- Strict confidentiality of all information submitted during the credentialing process;
- Nondiscrimination during the credentialing process;
- Be notified of information obtained during the credentialing process that varies substantially from what is submitted by you;

- Review information submitted to support your credentialing application, with the exception of references, recommendations or other peer-review protected information;
- Correct erroneous information;
- Be informed of the status of your application upon request;
- Receive notification of the credentialing decision within 60 days of the committee decision;
- Receive notification of your rights as a practitioner to appeal an adverse decision made by the peer review committee; and,
- Be informed of the above rights.

For further details on all your rights as a Molina Healthcare practitioner, please review your Provider/Practitioner Manual. You may also review the provider/practitioner manual on our website at www.molinahealthcare.com or call your Provider Services Representative for more details.

National Provider ID (NPI) Contingency Plan End Date

Molina Healthcare (Molina) has worked diligently and collaboratively to achieve compliance with the HIPAA NPI requirements by the May 23, 2007 compliance date. In accordance with CMS' NPI Compliance Guidance issued on April 2, 2007, Molina deployed an NPI Contingency Plan in order to help ensure the smooth flow of payments.

Effective May 23, 2008 Molina will end its NPI Contingency Plan and require the NPI as the only provider identifier for HIPAA Transactions.

For up to date information on Molina Healthcare NPI implementation continue to check our NPI web page at www.MolinaHealthcare.com or call our toll-free HIPAA Hotline at 1-866-MOLINA2 (1-866-665-4622).

Are You Ready for the NPI

Get It

To obtain your NPI, health care providers can apply online at the National Plan and Provider Enumeration System (NPPES) website: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

Share It

The most efficient method for submitting your NPI to Molina is through our Provider Self-Services ePortal.

Sign on to the Provider Self-Services ePortal using your existing provider User ID and password: <https://eportal.molinahealthcare.com/eportal/providers/login.aspx>

If you are unable to submit your NPI via the Provider Self-Services ePortal please contact your Provider Services Representative and be prepared to provide your NPI, Tax ID # and Provider ID.

Use It

Molina strongly encourage you to begin using the NPI as the only provider identifier on claims and encounters for both electronic transactions and paper submissions. Effective 5/23/08 Molina will reject paper claims not submitted on the revised CMS 1500 and UB 04 claim forms, and will reject electronic claims that do not use the NPI as the only provider identifier. The TAX ID is the only additional ID permitted.

Notice to Molina Provider Self-Services ePortal Users

Effective May 23, 2008 Molina Healthcare will require that practitioner/provider Pay-To, Rendering and Subpart NPIs be registered with Molina in order to conduct Claims and Service Request transactions via the Provider Self-Services ePortal. Providers who have not registered their NPI will be prohibited from conducting such transactions.

Medicare Member Requests for Services

CMS regulations allow Molina Medicare members to request medical services directly from the health plan. When this occurs Molina must initially handle the request as an expedited or urgent request requiring a 72 hour decision turnaround. When Molina receives these requests we may contact the member's physicians to obtain clinical information in support of the member's request. Molina needs the cooperation of its providers in obtaining relevant clinical information such as chart notes, labs, imaging reports and hospital records under these circumstances. Molina Healthcare appreciates the cooperation shown by our provider network in helping us obtain clinical information for medical decision making.



Nurse Advice Line

1-888-275-8750 (English) 1-866-648-3537 (Spanish)

The Nurse Advice Line is here to help. Bilingual Registered Nurses are available to serve your patients 24 hours a day, seven days a week. If your patients have any concerns about their health, our specially trained triage nurses are available to listen to their symptoms, provide nursing care advice and make referrals to an appropriate care setting. Encourage your patients to call our Nurse Advice Line for assistance.

Important Molina Medicare notice for Home Health Agency (HHA), Skilled Nursing Facility (SNF) and Comprehensive Outpatient Rehabilitation Facility (CORF) providers



Notice of Medicare Non-Coverage (NOMNC)

The NOMNC is an OMB-approved standardized notice. The NOMNC is a written notice designed to inform Medicare enrollees that their covered SNF, HHA, or CORF care is ending. The NOMNC meets the notice requirements set forth at 42 CFR 422.624(b)(2).

Molina Healthcare will deliver the approved NOMNC to the facility upon authorization of the SNF, HHA or CORF services. All enrollees receiving covered SNF, HHA or CORF services must receive a NOMNC upon termination of services, even if they agree that services should end. The notice may be delivered earlier, but must be delivered no later than 2 days prior to the proposed termination of services. Although Medicare health plans are responsible for either making or delegating the decision to end services, SNFs, HHAs, and CORFs are responsible for delivering the notices to enrollees.

The notice must identify and provide the telephone number of the appropriate QIO. All other required elements of the notice are included in the standardized material on the notice. The provider also has the option to include (or an agent to include) additional information in the space provided on the notice. Note that completion of this section of the standardized notice is optional, and does not substitute for delivery of a Detailed Explanation of Non-Coverage (DENC) which is required when an enrollee invokes his or her appeal rights.

The NOMNC is not to be used when a Medicare health plan determines that an enrollee's services should end based on the exhaustion of Medicare benefits (such as the 100-day SNF limit), when a single service that does not end the skilled stay ends, and the enrollee disagrees with that determination, or when an admission to SNF, home health or CORF services is not covered. Instead, Medicare health plans must issue the Notice of Denial of Medical Coverage (NDMC) in these cases.

Complex Case Management

Molina Healthcare offers you and your patients the opportunity to participate in our Complex Case Management Program. Patients appropriate for this voluntary program are those that have the most complex service needs and may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

The purpose of the Molina Healthcare Complex Case Management Program is to:

- Conduct a needs assessment of the patient, patient's family, and/or caregiver
- Provide intervention and care coordination services within the benefit structure across the continuum of care
- Empower our patients to optimize their health and level of functioning

- Facilitate access to medically necessary services and ensure that they are provided at the appropriate level of care in a timely manner
- Provide a comprehensive and on-going care plan for continuity of care in coordination with you, your staff, your patient, and the patient's family.

If you would like to learn more about this program, speak with a Complex Case Manager and/or refer a patient for an evaluation for this program, please call 1-800-526-8196, Ext. 127604.

