



PROVIDER MANUAL

Dear Provider:

Thank you for participating with Molina Healthcare.

This manual provides information about how to work with Molina Healthcare. We will update the online provider manual as often as necessary.

As always, you may contact us at 1-888-898-7969 or your assigned Provider Services Representative if you have questions.

We value your participation

Molina Healthcare

www.molinahealthcare.com

A MICHIGAN FOR PROFIT CORPORATION

Disclaimer:

This Policy & Procedure Manual shall serve as an attachment, referenced thereto and incorporated therein, to the Molina Healthcare of Michigan, Inc. Services Agreement/Amendment. The information contained within this Manual is proprietary to Molina Healthcare. The information is not to be copied in whole or part; nor is the information to be distributed without express written consent of Molina Healthcare.

INTRODUCTION

Mission Vision and Core Values i
 About Molina Healthcare..... i
 Contact Information ii

SECTION 1 ENROLLMENT,ELIGIBILITY & DISENROLLMENT

Enrollment Information1.1
 Eligibility1.2
 Disenrollment Information.....1.3

SECTION 2 CLAIMS

Claims Submission Guidelines2.1
 Claims Policies.....2.2
 Provider National Practitioner Number2.3
 Coordination of Benefits.....2.3
 Appeals2.4

SECTION 3 QUALITY IMPROVEMENT

Quality Improvement Program3.1

SECTION 4 UTILIZATION MANAGEMENT

Utilization Management Program.....4.1
 Authorization Grid4.3
 Admission Review4.6
 Medical Case Management.....4.9
 On-Call Program (After Hours)4.11
 Provider Appeals.....4.12
 Behavioral Health4.14

SECTION 5 PROVIDER APPEALS

Denied Claims Appeals.....5.1
 Administrative Denials5.1
 Medical Necessity5.2

SECTION 6 PHARMACY

Drug Prior Authorization6.1
 Abbreviated Pharmacy Prior Authorization Criteria6.6
 Over the Counter Drug List6.12
 After Hours Pharmacy Services.....6.13

SECTION 7 CREDENTIALING

Credentialing.....7.1

SECTION 8 PRIMARY CARE PROVIDER RESPONSIBILITIES
Access to Care Standards.....8.1
Provider Change Notification Requirements8.1
Facility Staffing Standards.....8.2

SECTION 9 COMPLIANCE
Fraud and Abuse9.1
HIPAA9.4
Deficit Reduction Act9.10

INTRODUCTION

Mission

Our mission is to promote health and provide health services to families and individuals who are lower income and covered by government programs.

Vision

Molina Healthcare is an innovative healthcare leader providing quality care and accessible services in an efficient and caring manner.

Core Values:

We strive to be an exemplary organization:

1. We care about the people we serve and advocate on their behalf.
2. We provider quality service and remove barriers to health services.
3. We are healthcare innovators and embrace change quickly.
4. We respect each other and value ethical business practices.
5. We are careful in the management of our financial resources and serve as prudent stewards of the public funds.

About Molina Healthcare

Molina Healthcare, headquartered in Long Beach, California, is a multi-state managed care company focused on providing healthcare services to people who receive healthcare benefits through a Medicare Special Needs Program, Medicare, Medicaid, State Children's Health Insurance Program ("SCHIP"), and other government-sponsored programs. C. David Molina, M.D., founded our company in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California, 21 of which are in operation today. As the need for more effective management and delivery of healthcare services to underserved populations continued to grow, Molina became licensed as a Health Maintenance Organization ("HMO") in California.

Today, the Company provides medical care in California, Washington, Nevada, Utah, Michigan, Ohio, Missouri, Florida, Texas and New Mexico. Molina Healthcare provides healthcare services to more than one million members.

Included in Molina networks are company-owned and operated primary care clinics, independent physicians and groups, hospitals and ancillary providers.

Our members have distinct social and medical needs and are characterized by their cultural, ethnic and linguistic diversity. From our inception, we have designed our company to work with government agencies to serve low-income populations. Our success has resulted from our expertise in working with government agencies, our extensive experience in meeting the needs of our members, our 25 years of owning and operating primary care clinics, our cultural and linguistic expertise and our focus on operational and administrative efficiency.

CONTACT INFORMATION

The following is a list of contact information to assist you in making the appropriate contact with the Service Departments of Molina Healthcare.

Claims Status Inquiry www.molinahealthcare.com

.....1-888-898-7969, Option 1 then 2

Claims Appeals (technical denials) Fax to:1-248-925-1768

Eligibility1-888-898-7969

Member ServicesOption 1, 1 then 2

Interactive Voice Response (IVR)Option 1, 1 then 1

ePortal (Provider Self Services)..... www.molinahealthcare.com

Pharmacy Services.....1-888-898-7969, Option 1 then 5

Fax Number1-888-373-3059

email address.....MHMcompliance@molinahealthcare.com

CompCare (Behavioral Health Benefit).....1-800-435-5348

Fraud and Abuse Prevention.....1-877-372-5361

Fax Number1-248-925-1780

Provider Services1-888-898-7969, ext.155822

Utilization Management1-888-898-7969, Option 1, then 4

Clinical Appeals (Authorization, Readmissions, Medical Necessity, etc)

Referral and Appeals Fax Number1-800-594-7404

Claims Address:

Molina Healthcare of Michigan, Inc.
P.O. Box 22668
Long Beach CA 90801

Troy Address:

100 West Big Beaver Road, Suite 600
Troy, MI 48084 - 5209

Detroit Address:

409 East Jefferson, Suite 600
Detroit, MI 48226

ENROLLMENT INFORMATION

Medicaid

Medicaid is a federal program created by Title XIX of the Social Security Act in 1965. The primary objective of the program is to provide essential medical and health services to those who would not otherwise have the financial resources to purchase them. Public and private agencies work together to administer the Medicaid Program.

Recipient eligibility for public assistance is determined by the Family Independency Agency (FIA). Michigan Enrolls is the enrollment broker for Michigan's Medicaid program and provides educational materials about the various health plans available in a member's county.

Michigan Enrolls also helps Medicaid members pick the health plan of their choice. If members do not choose a health plan, Michigan Enrolls will assign the member to a health plan. Michigan Enrolls' phone number is 1-888-367-6557.

Molina Healthcare is notified each month when Medicaid recipients select their Plan. Members will have two cards, a Molina Healthcare identification card and a Michigan Medicaid identification card. The State sends a Medicaid identification card (MICard) to each member. This card contains the member's Medicaid eligibility. Members should present both cards each time they receive a service. Here are some eligibility points:

- Members who lose and then regain Medicaid eligibility within 93 days are automatically reassigned to the Plan and the Primary Care Provider they previously had.
- Newborns are automatically enrolled with the Health Plan the mother was enrolled in on the date of delivery. Parents may choose a different plan for the newborn within the first 90 days of the newborn's eligibility.

Note: The newborn's Michigan Medicaid card may not reflect HMO coverage for 30-60 days.

MIChild



MIChild is a health insurance program for the uninsured children of Michigan's working families. Eligibility is determined by the following criteria:

- Must be a U.S. citizen (some legal immigrants qualify)
- Must live in Michigan, even for a short period of time
- Must be under the age of 19
- Family must meet income requirements
- Children must not have other insurance coverage
- All eligible children will pay a monthly premium of \$10.00 per family

MIChild applicants may submit applications online at www.mdch.state.mi.us/msa/mdch_msa/App.htm. Applicants may also submit applications to participating health maintenance organizations (HMO), local health departments, or the Administrative Contractor at MIChild, P.O. Box 30412, Lansing, MI 48909. MIChild questions should be referred to 1-888-988-6300.



Molina Healthcare Identification Cards

Medicaid ID Card

 <p>Member Services 24 Hour – Toll Free 1-888-898-7969</p> <p>Member Name: MAXIMUS X TEST MEMBER Member ID: 599999999 PCP Name: RICHARD D KUSTASZ PCP Phone: (123) 456 - 7890 Program: 001</p> <p><small>This card is only valid if member maintains Molina Healthcare of Michigan eligibility Eligibility should be verified before rendering services. Member: Please show this card each time you receive health care services.</small></p>	<p>Submit all Medical Claims to: MOLINA HEALTHCARE, INC. PO Box 22668 Long Beach, California 90801</p> <p><i>Pharmacy Benefits are administered by</i></p>  <p>1-800-791-6856</p> <p><i>If your card is lost or stolen or you have questions, please call Member Services at 1-888-898-7969</i></p> <p>www.molinahealthcare.com</p>
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Medicaid Program Code = 001

MIChild ID Card

 <p>Member Services 24 Hour – Toll Free 1-888-898-7969</p> <p>Member Name: MAXIMUS X TEST MEMBER Member ID: 599999999 PCP Name: RICHARD D KUSTASZ PCP Phone: (123) 456 - 7890 Program: 002</p> <p><small>This card is only valid if member maintains Molina Healthcare of Michigan eligibility Eligibility should be verified before rendering services. Member: Please show this card each time you receive health care services.</small></p>	<p>Submit all Medical Claims to: MOLINA HEALTHCARE, INC. PO Box 22668 Long Beach, California 90801</p> <p><i>Pharmacy Benefits are administered by</i></p>  <p>1-800-791-6856</p> <p><i>If your card is lost or stolen or you have questions, please call Member Services at 1-888-898-7969</i></p> <p>www.molinahealthcare.com</p>
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MIChild Program Code = 002

ELIGIBILITY

The following resources may be utilized to determine whether a patient is eligible to receive Molina Healthcare benefits for Medicaid or MICHild:

ePortal Eligibility Roster	www.molinahealthcare.com
Interactive Voice Response (IVR) System	1-888-898-7969, Option 1, 1, then 1
Member Services	1-888-898-7969, Option 1, 1, then 2
MDCH Automated Voice Response System	1-888-696-3510 (fee required)
Web-Denis	www.bcbsm.com

A member's eligibility may change monthly; therefore, it is the provider's responsibility to verify eligibility prior to rendering services. Services provided when a member is not enrolled with Molina Healthcare will not be covered.

Member Initiated Transfer Requests

Members desiring to change their Primary Care Physician (PCP) must call Member Services at 1-888-898-7969. Generally, requests made on/or before the 15th day of the month will be effective the first of the next month. Requests made after the 15th day of the month will be effective the first of the following month.

Example: *Request made October 10, 2008, change effective November 1, 2008*
 Request made October 20, 2008 change effective December 1, 2008

Provider Initiated Transfer Requests

There may be times when a PCP requests a member be transferred to a different PCP. If this situation occurs, the current PCP must inform the member in writing of the reason(s) for terminating the current physician/patient relationship and must also inform the member they have thirty (30) days to choose another PCP. The written correspondence must be mailed by certified or registered letter to the member. A copy of the correspondence must be sent to:

Molina Healthcare of Michigan, Inc.
Member Service Department
100 West Big Beaver Road, Suite 600
Troy, Michigan 48084
Fax (248) 925-1765

Providers should use the Molina Healthcare Member Change Information Request Form to notify Member Services of their desire to initiate a member transfer. The form is located in the Forms section of Molina Healthcare's website at www.molinahealthcare.com. A Member Services Representative can assist the member in reviewing the Provider Directory for available PCP choices.

When the PCP believes an immediate transfer is necessary, the PCP should contact Member Services at 1-888-898-7969 for assistance.

DISENROLLMENT

The Michigan Department of Community Health allows for disenrollment from Medicaid Health Plans via the Special Disenrollment process:

Reasons for Special Disenrollment:

- **Urgent/Life-threatening:** Situations that involve physical acts of violence; physical or verbal threats of violence made against providers, staff or the public; or where stalking situations exist.
- **Fraud/Misrepresentation:** Involves alteration or theft of prescriptions or misrepresentation of plan membership allowing another person to receive healthcare services.
- **Other noncompliance situations:** Including failure to follow treatment plan; repeated use or unauthorized use of non-participating providers; no participating provider will see the patient; repeated emergency room use; and those who impede care.

Documentation for Special Disenrollment:

- Detailed documentation is required to support the disenrollment request.
- Incident Report or summary of non-compliance behavior is required from provider office.
- Copy of PCP dismissal letter or correspondence to the member.
- Copy of Police Report and reference number given by Police Department.
- Copy of altered/forged prescription.

Completed forms and documentation should be sent to:

Molina Healthcare of Michigan, Inc.
Attn: Enrollment Services Supervisor
100 West Big Beaver Road; Suite 600
Troy, MI 48084-5209

CLAIMS**Billing Address:**

Molina Healthcare of Michigan, Inc.
 P.O. Box 22668
 Long Beach, CA 90801

Please do not submit initial claims to the Troy address as this will delay the processing of your claims, and your claim may be returned. Please contact the Claims Department with any questions or concerns at 1-888-898-7969.

Claims Submission GuidelinesFiling Limit

- Claims should be sent to Molina Healthcare within 90 days from the date of service.
- For resubmission or secondary claims, Molina Healthcare must receive the claim within 180 days from the date of service.
- If a claim is submitted to Medicaid or another HMO in error prior to the claim being submitted to Molina Healthcare, the submission limit is not extended. Eligibility must be verified prior to rendering services.
- Molina Healthcare responds to claims within State processing guidelines. The Claims determination will be reported to the provider on a Remittance Advice (RA).
- If no response is received within 45 days on a submitted claim, please call the Claims Call Center at 1-888-898-7969 to status the claim(s).
- All claims received beyond the filing limit will be rejected and members may not be billed for the services.

Electronic Claims Submission

Molina Healthcare accepts claims electronically. Electronic submission allows claims to be directly entered into Molina Healthcare's processing system, which results in faster payment and fewer rejections. Contact Molina Healthcare's Help Desk to sign up for ePortal at 1-866-449-6848 or contact your Provider Services Representative.

- ePortal (www.molinahealthcare.com) Provider Self Services
 - submit claims
 - status claims
 - print claims reports
- Molina Healthcare also accepts electronic claims submissions through the following clearing houses:
 - Netwerkes.com
 - Emdeon (formerly WebMD) – Payer Number is 38334.
 - Availity/THIN- Payer Number is 38334
 - Payer Path (HCFA 1500 only) – Payer Number is 38334
 - Practice Insight (HCFA 1500 only) – Payer Number 38334
 - ZirMed Inc – Payer Number 38334
 - SSI Group

Claims Form

- Professional charges must be submitted on a CMS 1500 08-05 version Form
- Facility UB04 Form

- Paper Claim Submission Guidelines
- Must use original forms
- Must be typewritten or computer generated
- Do not use highlighters, white-out or any other markers on the claim
- Avoid script, slanted or italicized type. 12 point type is preferred
- Do not use an imprinter to complete any portion of the claim form.
- Do not use punctuation marks or special characters
- Use a six digit format with no spaces or punctuation for all dates (ex 060101).
- Securely staple all attachments. Attachments should identify patient's name and recipient ID number

Claims Policies

Adjudication

MHM adjudicates claims according to the State of Michigan Medical Services Administration (MSA) policies and procedures. Reference the Uniform Billing Guidelines, ICD-9 Diagnosis Code Book, CPT Code Book, HCPCS and Michigan Department of Community Health (MDCH) website www.michigan.gov when submitting a claim

Payment

- Contracted providers will be paid according to the terms of the agreement between the provider and Molina Healthcare
- Non-Contracted Providers will be paid for covered services according to the MDCH Medicaid fee schedule

Resubmission

- Providers may resubmit claims with correction(s) and/or change(s). The provider should document on the claim that the claim is being resubmitted.
- CMS 1500 claim form: Enter "RESUBMISSION" on the claim in the Remarks section.
- UB04 claim form: Type of bill must be indicated on the form. Enter "RESUBMISSION" in the comments section of the form.

Please send to Original/Resubmission address above. Faxed copies are no longer accepted.

Newborn Care

Newborn care must be submitted on the appropriate claim form using the newborn's Medicaid ID number. The mother's Medicaid ID number may not be used to bill for services provided to a newborn.

Provider National Identification Number (NPI)

Molina Healthcare Required Fields:

CMS 1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Billing Provider Medicaid Number	Yes	Box 33b
Rendering Provider NPI	Yes	Box 24j
Rendering Provider Medicaid Number	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
Taxonomy Code	No	Boxes 24j; 33b and 32b
UB04	Required?	Field Location
Billing Provider NPI	Yes	Box 56
Billing Provider Medicaid Number	Yes	Box 57a
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77j
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79
Taxonomy Code	No	Boxes 57, 76,77,78 and 79

Coordination of Benefits

As a provider treating Molina Healthcare members, your cooperation in notifying Molina Healthcare when any other coverage exists is appreciated. This includes other health care plans or any other permitted methods of third party recovery for coordination of benefits, worker’s compensation and subrogation.

- Claims involving coordination of benefits with primary insurance carriers should be received by Molina Healthcare within 365 days from the date of the primary carrier’s explanation/denial of benefits.
- If Molina Healthcare reimburses a provider and then discovers other coverage is primary, Molina Healthcare may request the provider to refund the amount paid by Molina Healthcare.
- Regardless of the primary payer’s reimbursement, Molina Healthcare should be billed as a secondary payer for all services rendered. A copy of the primary payer’s EOB showing payment or denial must be attached to the claim.
- Molina Healthcare will make payment if the primary insurance payment is less than the Medicaid Fee for Service Rate.
- Molina Healthcare members cannot be billed for any outstanding balance after Molina Healthcare makes payment.
- Molina Healthcare members do not have deductibles, co-pays or co-insurance.

Appeals

Providers may submit an appeal by following the steps below:

- Contact the Claims Call Center at 1-888-898-7969, Option 1, then 2
- Speak to a Claims Resolution Representative. If you do not agree with the claims determination, then :
- Submit a letter of appeal detailing your reason for appeal along with supporting documentation within 90 days of your of the original claims determination
- Mail your appeal to:
Molina Healthcare of Michigan, Inc.
100 West Big Beaver Road, Suite 600
Troy, MI 48084-5209

Claim Form Field Requirements

- See Attachment A for CMS HCFA 1500 08-05 claim form requirements
- See Attachment B for CMS 1450 UB-04 claim form requirements

Sample Remittance Advice (RA)

- See Attachment C

ATTACHMENT A

CMS HCFA 1500 08-05 claim form requirements

- **MANDATORY:** Item is required for all claims. If the item is left blank, the claim cannot be processed.
- **CONDITIONAL:** Item is required if applicable. Your claim may not be processed if blank.

FIELD	STATUS	INFORMATION
1	CONDITIONAL	Insurance
1a	MANDATORY	Medicaid I.D. Number (When billing for a newborn, the newborn's Medicaid ID is required by MHM)
2	MANDATORY	Patient's Name
3	MANDATORY	Patient's Birth Date And Sex
4	CONDITIONAL	Insured's Name
5	CONDITIONAL	Patient's Address
6	CONDITIONAL	Patient Relationship To Insured
7	CONDITIONAL	Insured's Address
8	CONDITIONAL	Patient Status
9	CONDITIONAL	Other Insured's Name
9a	CONDITIONAL	Other Insured's Policy Or Group Number
9b	CONDITIONAL	Other Insured's Date Of Birth And Sex
9c	CONDITIONAL	Employer's Name Or School Name
9d	CONDITIONAL	Insurance Plan Name Or Program Name
10a	MANDATORY	Is Patient's Condition Related To Employment?
10b	MANDATORY	Is Patient's Condition Related To Auto Accident?
10c	MANDATORY	Is Patient's Condition Related To Other Accident?
10d	CONDITIONAL	Reserved For Location Use
11	CONDITIONAL	Insured's Policy Group Or Federal Employee Compensation Act (FECA) Number
11a	CONDITIONAL	Insured's Date Of Birth
11b	CONDITIONAL	Employer's Name Or School Name
11c	CONDITIONAL	Insurance Plan Name Or Program Name
11d	CONDITIONAL	Is There Another Health Benefit Plan?
12	CONDITIONAL	Patient's Or Authorized Person's Signature
13	CONDITIONAL	Insured's Or Authorized Person's Signature
14	CONDITIONAL	Date Of Current Illness, Injury Or Pregnancy
15	CONDITIONAL	If Patient Has Had A Same Or Similar Illness, Give First Date
16	CONDITIONAL	Dates Patient Unable To Work In Current Occupation
17	CONDITIONAL	Name Of Referring Physician Or Other Source
17a	CONDITIONAL	I.D. Number Of Referring Physician
17b	CONDITIONAL	10-digit NPI# of Referring Physician or Other Source
18	CONDITIONAL	Hospitalization Dates Related To Current Services
19	CONDITIONAL	Reserved For Local Use
20	CONDITIONAL	Outside Lab/Charges
21	MANDATORY	Diagnosis Or Nature Of Illness Or Injury
22	CONDITIONAL	Medicaid Resubmission Code And Original Reference Number

FIELD	STATUS	INFORMATION
23	CONDITIONAL	Prior Authorization Number
24a	MANDATORY	Date(S) Of Service
24b	MANDATORY	Place Of Service
24c	CONDITIONAL	Type Of Service
24d	MANDATORY	Procedures, Services Or Supplies
24e	MANDATORY	Diagnosis Code (Pointer)
24f	MANDATORY	Charges
24g	MANDATORY	Days Or Units
24h	CONDITIONAL	EPSDT/Family Plan
24i	MANDATORY	EMG-Emergency - Y Or N
24j*	MANDATORY	Rendering Provider ID #, Medicaid # and NPI#
24k	CONDITIONAL	Reserved For Local Use
25	MANDATORY	Federal Tax I.D. Number (Check Box/SSN Or EIN)
26	MANDATORY	Patient's Account Number
27	CONDITIONAL	Accept Assignment
28	MANDATORY	Total Charge
29	CONDITIONAL	Amount Paid
30	MANDATORY	Balance Due
31	MANDATORY	Signature Of Physician Or Supplier Including Degrees Or Credentials
32	CONDITIONAL	Name And Address Of Facility Where Services Were Rendered (If Other Than Home Or Office)
32a	CONDITIONAL	10-digit NPI# of Service Facility Location
33	MANDATORY	Company Name as registered with IRS, Address, Zip Code, Phone # and PIN # (Medicaid ID # without Provider Type). MHM requires the name registered with the IRS to be submitted on line one in Box 33.
33a	MANDATORY	10 digit NPI# of Billing Provider
33b*	MANDATORY	Billing provider Medicaid ID#

*Taxonomy code not required

ATTACHMENT B

UB-04 claim form requirements


- **MANDATORY:** Item is required for all claim submissions.
- **CONDITIONAL:** Item is required if applicable.

FIELD	STATUS	INFORMATION
1	MANDATORY	Company Name as registered with the IRS, Address and Telephone Number
2		Blank
3	MANDATORY	Patient Control Number
4	MANDATORY	Type of Bill
5	MANDATORY	Federal Tax Number
6	MANDATORY	Statement Covers Period
7		Blank
8a	MANDATORY	Patient Name
9a-d	MANDATORY	Patient Address
10	MANDATORY	Patient Date of Birth
11	MANDATORY	Patient Sex
12	MANDATORY	Admission Start of Care Date
13	MANDATORY	Admission Hour (for inpatient only)
14	MANDATORY	Type of Admission
15	MANDATORY	Source of Admission (SRC)
16	CONDITIONAL	Discharge Hour
17	MANDATORY	Patient Status (Discharge Status)*
18-28	CONDITIONAL	Condition Codes (if applicable)
29-30	CONDITIONAL	ACDT State
31-34	CONDITIONAL	Occurrence Codes and Dates (if applicable)*
35-37	CONDITIONAL	Occurrence span code
38a-d	CONDITIONAL	Name and Address of the party responsible for the bill
39-41 a-d	CONDITIONAL	Value Codes and Amounts (if applicable)*
42	MANDATORY	Revenue Codes*
43	MANDATORY	Revenue Description
44	MANDATORY	HCPCS Code/Rates (if applicable)
45	MANDATORY	Date of Service for the Line Item
46	CONDITIONAL	Units of Service (if more than 1)
47	MANDATORY	Total Charges (by Revenue Code/HCPCS)
48	CONDITIONAL	Dollar Amount for Any Non-covered Services
49		Blank
50	MANDATORY	Payer Identification
51	MANDATORY	Provider Number: Medicaid ID Number without the Provider Type
52	CONDITIONAL	Assigned Release For Insurance Benefit
53	CONDITIONAL	Assignment Of Benefits
54	CONDITIONAL	Prior Payments (if applicable)
55	MANDATORY	Estimated Amount Due From Payer
56	MANDATORY	Billing Provider NPI#
57	MANDATORY	Billing Provider Medicaid Number

FIELD	STATUS	INFORMATION
58	CONDITIONAL	Name Of Insured
59	CONDITIONAL	Patient's Relationship To Insured
60	MANDATORY	Medicaid Recipient ID Number (When billing for a newborn, the newborn's Medicaid ID is required by MHM).
61	CONDITIONAL	Name Of Group Or Plan Through Which Health Insurance Is Provided
62	CONDITIONAL	Group Policy Number
63	CONDITIONAL	Pre-Cert Or Authorization Number
64	CONDITIONAL	Document Control Number
65	CONDITIONAL	Name Of Employer
66	MANDATORY	ICD-9 Principle Diagnosis
67a-q	CONDITIONAL	Other Diagnosis Codes (if applicable)
68		Blank
69	MANDATORY	Admitting Diagnosis (for Inpatient only)
70 a-c	CONDITIONAL	Patient Reason Diagnosis
71	CONDITIONAL	
72	CONDITIONAL	External Cause Of Injury ICD-9 Diagnosis Code
73		Blank
74	CONDITIONAL	Principle Procedure Code and Date
74 a-e	CONDITIONAL	Other Procedure Codes and Dates
75		Blank
76	CONDITIONAL	Attending Provider NPI#
77	CONDITIONAL	Operating Provider NPI#
78-79	CONDITIONAL	Other Provider NPI#
80	CONDITIONAL	Remarks (if applicable)

*Refer to Uniform Billing Manual for List of Codes

Sample Remittance Advice (RA)



Molina Healthcare, Inc.

Remittance Advice for

TAX ID# _____ Carrier: Molina Healthcare of Michigan

Paid Date: 08/05/2003

Check#

3 Claim Number#

Member: _____

Provider: _____

Member ID# _____

Control# **3008**

Health Plan: Michigan Medicaid

Claim Line	Date of Service	Rev Code	CPT/HCPC	Modifier	Units	Billed Amount	Contract/Allowed Amount	Dis - Allowed	COB/Other Insurance	Other Disc/Int.	Paid Amount	FFS/CAP	Claim Line Message(s)
1	07/18/2003	0	90782		1	10.00	2.47	7.53	0.00	0.00	0.00	CAP	
Summary of Claim #						10.00	2.47	7.53	0.00	0.00	0.00		
Message:													

4 Claim Number#

Member: _____


Provider: _____

Member ID# _____

Control# **3008**

Health Plan: Michigan Medicaid

Claim Line	Date of Service	Rev Code	CPT/HCPC	Modifier	Units	Billed Amount	Contract/Allowed Amount	Dis - Allowed	COB/Other Insurance	Other Disc/Int.	Paid Amount	FFS/CAP	Claim Line Message(s)
1	07/18/2003	0	99394		1	155.00	57.20	97.80	0.00	0.00	0.00	CAP	
2	07/18/2003	0	81025		1	15.00	5.37	9.63	0.00	0.00	0.00	CAP	
3	07/18/2003	0	81002		1	5.00	1.25	3.75	0.00	0.00	0.00	CAP	
4	07/18/2003	0	92551		1	35.00	9.89	25.11	0.00	0.00	0.00	FFS	
5	07/18/2003	0	86580		1	15.00	5.83	9.17	0.00	0.00	5.83	FFS	
6	07/18/2003	0	99173		1	35.00	0.00	35.00	0.00	0.00	0.00	FFS	
Summary of Claim #						260.00	79.54	180.46	0.00	0.00	15.72		
Message: Line 6. - Service not a plan benefit.													



Molina Healthcare, Inc.

Remittance Advice for

TAX ID# _____ Carrier: Molina Healthcare of Michigan

Paid Date: 08/05/2003

Check#

Summary of Check

Billed Amount	\$	540.00
Contract/Allowed Amount	\$	164.02
DisAllowed Amt	\$	35.00
COB/Other Insurance	\$	0.00
Other Disc or Interest	\$	0.00
Paid Amount	\$	31.44

Check Amount
\$31.44

Summary of Advances

Advance Amount Paid on Date:	\$	0.00
Advances Paid to Date	\$	0.00
Amount Applied with this payment	\$	0.00
Balance	\$	0.00

If there are any questions, regarding this payment, please submit a written request within 30 days to:

Molina Healthcare of Michigan, Inc.
100 West Big Beaver, Suite 600
Troy, MI 48084

For telephone inquiries, contact (248) 925-1700 (local) or (888) 898-7969 (toll free).
Appeals must be written and sent within 30 days of receipt.

Molina Healthcare of Michigan is "live" with Netwerkes.com. If you are interested contact Netwerkes.com at (810) 385-1181.

QUALITY IMPROVEMENT

Table of Contents

INTRODUCTION3.1

1. Program Philosophy3.2

2. Quality Improvement Program Goals3.3

3. Quality Improvement Program Objectives3.3

4. Scope of Program Activities3.4

 4.1 Important Aspects of Care3.4

 4.2 Data Sources and Staff Resources3.4

5. Quality Improvement Strategy3.5

 5.1 Quality Improvement Activities3.5

 5.2 Improvement Methodology3.8

6. Organizational Structure Supporting Quality Improvement3.8

 6.1 The Board of Directors3.8

 6.2 Executive QI Committee (QIC)3.8

 6.3 Quality Leadership3.9

 6.4 Quality Improvement Committee Structure3.10

 (1) Peer Review/Credentialing Committees (PRC)

 (2) Quality Improvement Committee (QIC)

 (3) Pharmacy and Therapeutics Committee (P&TC)

 (4) Utilization Management Committee (UMC)

 (5) Compliance Committee (CC)

 (6) Provider and Member Satisfaction Committee

 (7) Policy and Procedure Committee

 6.5 QI Department Roles and Responsibilities3.11

 6.6 Other Departmental Responsibilities for QI3.12

 6.7 Role of Participating Providers3.14

 6.8 Confidentiality3.15

 6.9 Conflict of Interest3.15

7. Delegation Activities3.15

8. Program Evaluation and Revision3.16

9. Governing Body Review and Approval3.16

QUALITY IMPROVEMENT PROGRAM

Introduction

Molina Healthcare serves Medicaid and MICHild members in counties throughout Michigan. Molina Healthcare, also referred to as Molina Healthcare, MH Michigan and “health plan” in this document has served Medicaid patients since 2000. For all plan members, Molina Healthcare emphasizes personalized care that places the physician in the pivotal role of managing healthcare. Molina Healthcare is responsible for managing the provision of accessible, appropriate, cost-effective, high quality health care services for its members throughout the continuum of care. The health plan assists members as they move through the managed care system, reducing barriers to care, and supporting members in reaching optimal health. Molina Healthcare credentials and contracts with individual practitioners, provider organizations, facilities and institutions to deliver health care and service to members. Molina Healthcare delegates the authority to perform specified plan functions and services, while maintaining oversight responsibility for delegated and non-delegated activities.

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and service, and improvement of the health of its members. The QIP assists Molina Healthcare to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan’s customers and the standards established by the medical community, regulatory and accrediting bodies.

The following QI Program Description includes discussion of program philosophy, scope, structure, and methodology.

1. Program Philosophy

Molina Healthcare of Michigan maintains the following values, assumptions, and operating principles for the Quality Improvement Program:

- The QIP provides a structure for promoting and achieving excellence in all areas through continuous improvement.
- Improvements are based on industry “best practice” or on standards set by regulators or accrediting organizations.
- The QIP is applicable to all disciplines comprising the organization, at all levels of the organization.
- Teams and teamwork are essential to the improvement of care and services.
- Data collection and analysis is critical to problem-solving and process improvement.
- Each employee is highly valued as a contributor to quality processes and outcomes.
- Compliance with National Committee for Quality Assurance (NCQA) Standards and achievement of accreditation demonstrates Molina Healthcare's commitment to quality improvement.
- Information about the QIP is available for members and providers upon request.
- Internal and external feedback about Molina Healthcare’s programs and processes is integrated into the improvement efforts.

2. Quality Improvement Program Goals

Molina Healthcare has defined the following goals for the QI Program:

- Design and maintain programs that improve the care and service outcomes within identified member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to members. Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare of Michigan (also referred to as MHM) structure, process, and outcomes.
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals and to ensure participation of community providers in the MH Michigan network.
- Facilitate organizational efforts *which* achieved and maintain regulatory compliance and NCQA Accreditation-Excellent in 2005

3. Quality Improvement Program Objectives

3.1 QIP objectives direct personnel, activities, and resources to achieve Program goals. Written objectives address:

- Activities planned,
- Methodologies,
- Persons responsible, and
- Time frames for meeting each objective

3.2 Objectives are developed and established annually with consideration given to:

- Important aspects of care and service provided by Molina Healthcare.
- Objectives identified from ongoing and annual evaluation.
- Changes in policies, procedures, benefits or product offerings.
- Changes in member demographics and epidemiological characteristics.
- Recommendations made by NCQA, Michigan Department of Community Health (MDCH), practitioners, practitioner groups, and members.
- Contractually mandated improvement activities that address state-wide QI goals
- National, state, and local public health goals.
- Identified "Best Practices".
- Delegated activities and delegates' performance.
- Member and provider satisfaction data.
- Network changes.
- Ability to achieve meaningful improvement with available resources.

- 3.2 QIP objectives are reviewed and revised annually or more frequently as needed. Specific activities are identified to support the achievement of the objectives. These activities are tracked and are recorded in an annual QI Work Plan.
(APPENDIX A)

4. *Scope of Program Activities*

The Molina Healthcare QI Program encompasses the quality of acute, chronic and preventive health care and service provided in both the inpatient and outpatient setting to our population as determined by age, disease categories, risk status and products. The scope of service includes but is not limited to, those provided in institutional settings, ambulatory care, home care and mental health. Contracted provider groups, primary care and specialty practitioners and ancillary providers may render these services.

4.1 Important Aspects of Care

To provide for overall quality functioning as a managed care plan, Molina Healthcare continuously monitors important aspects of care. These aspects or activities of care/service include, but are not limited to:

- Access and Availability
- Continuity and Coordination of Care
- Health Management Systems
- Under and Over Utilization
- Behavioral Health Care
- Chronic and Acute Care
- Member Safety and Error Avoidance
- High-Risk/High-Volume/Problem-Prone Care
- Preventive Care and Services
- Member and Practitioner Satisfaction/Dissatisfaction
- Guideline Management; Clinical Practice and Preventive Guidelines
- Health Plan Service Standards
- Quality of Care Complaint Review and Clinical Case Review
- Pharmacy Services

4.2 Data Sources and Staff Resources

Quality Improvement is a data driven process. Molina Healthcare utilizes multiple data sources to monitor, analyze and evaluate the QI program and planned activities. These sources include, but are not limited to the following:

- Encounter and Claims data
- Pharmacy Benefit Manager data
- Pertinent medical records (minimum necessary)
- Utilization reports and case review data
- Provider and member complaint data obtained through call tracking, Utilization Management (UM), Provider Services and other sources

- Provider and member satisfaction survey results
- Appeal information
- Statistical, epidemiological and demographic member information
- Authorization and denial reporting
- Enrollment; regional, disenrollment
- HEDIS
- Behavioral Health data
- Geo-Access provider availability data and analysis
- Feedback other than complaints regarding services and programs from members and providers.
- CAHPS

QI Staff and Analytical Resources include, but are not limited to:

- Chief Medical Officer (1.0 FTE)
- QI Director (1.0 FTE)
- Health Analyst (3.0 FTE)

Additional QI Expertise resources are in the following functional areas:

- UM
- Case Management
- Pharmacy
- Member Services
- Provider Services
- Government Contracts/Compliance
- Finance
- Credentialing

5.0 Quality Improvement Strategy

5.1 Quality Improvement Activities

To meet the purpose, goals and scope of this program, QI activities as reflected in the QI Work Plan will be focused in the following areas.

1. Improvement of the health status of the health plan membership through:
 - Implementation of programs to address the priority needs associated with the major high-risk, acute and chronic illnesses faced by plan members. These programs will include preventive health, health education, disease management (health management), and care guidelines.
 - Monitoring the outcomes of care against national and available regional practice standards.
 - Utilization of multi-disciplinary and multi-dimensional teams to address process improvements that can enhance care and service, including primary, specialty and behavioral health practitioners.
 - Oversight of delegated processes to ensure delegated organizations MHM standard

2. Identification of appropriate safety and error avoidance initiatives for MHM members in collaboration with the primary care provider through:
 - Evaluation of pharmacy data for provider alerts about drug interactions, recall, and pharmacy over and under-utilization.
 - Education of members regarding their role in receiving safe, error free health care services through the member newsletter and the Molina web site.
 - Education of providers regarding improved safety processes in their practice through the provider newsletter, member profiles and the Molina web site.
 - Dissemination of information regarding important safety activities and Health Delivery Organization (HDO) audit findings for safety concerns to members and providers.
 - Evaluation for safe clinic environments during office site reviews.
 - Education to members regarding safe practices at home through health education and incentive programs.
 - Intervention for identified safety issues as identified through case management, care management and the grievance and clinical case review process.
 - Collection of data regarding hospital activities relating to member safety.
 - Dissemination of information to providers and members regarding activities in the network related to safety and quality improvement.
3. Evaluation of the continuity and coordination of care through annual analysis of data to include:
 - Transition of Care processes and the effectiveness of inter-provider communications and documentation.
 - Medical record audits.
 - Tracking quality of care issues, including adverse events.
 - Focused health management programs.
 - Member and practitioner satisfaction surveys and complaint and appeal review.
 - Identification of chronically ill or complex new patients through assessment processes.
 - Oversight of delegated activities.
4. Monitoring over-utilization and under-utilization through:
 - Tracking quality of care issues, including adverse outcomes and sentinel events.
 - Member complaint and appeal review.
 - Utilization review and case management reports.
 - Practitioner medical, pharmacy and utilization profiles.
 - Performance measures relative to implementation of preventive and clinical practice guidelines

- Oversight of delegated group member satisfaction and utilization.
5. Evaluation of access and availability of care and service through:
 - Measurement and evaluation of geographic access to primary care physicians, key specialists, hospitals and other health care services.
 - Evaluation of appointment access and availability of after-hours care and after hour information offered by practices.
 - Evaluation of MHM Member Services telephone access.
 - Evaluation of all satisfaction measures for availability and access to care.
 - Oversight of delegated activities.
 6. Management of Molina Healthcare's interface with practitioners, providers, members and state agencies to implement programs, including:
 - Inclusion of contracted practitioners and providers in the planning and implementation of clinical programs.
 - Review, approval, and dissemination of preventive health and clinical practice guidelines and measurement of adherence with current recommendations.
 - Review of clinical performance measures including HEDIS results to identify actions for improvement.
 - Identification of legislative and benefit changes that enhance health promotion.
 - Annual review of practitioner surveys and proposed activities for improvement.
 7. Management of health care practitioner and provider credentialing/recredentialing to include:
 - Review of credentialing/recredentialing policies and procedures.
 - Peer review of credentialing/recredentialing decisions.
 - Peer review of investigated quality of care issues and proposed corrective action plans.
 - Oversight of delegated credentialing activities.
 8. Ensure that medical records comply with standards of structural integrity and contain evidence of appropriate medical practices for quality care by:
 - Review of medical record audit results and corrective actions.
 - Practitioner education and corrective action where indicated.
 9. Oversight of member satisfaction measurement and improvement activities:
 - Review of all sources of member satisfaction information including, but not limited to, CAHPS Surveys, disenrollment information, complaints

- and appeals and identify opportunities for improvement.
 - Design and evaluate initiatives to improve satisfaction.
10. Evaluation of the effectiveness of QI activities in producing measurable improvements in the care and service provided to members through:
- Organization of multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
 - Track the progress of quality activities through appropriate quality committee minutes and review/update the QI work plan quarterly.
 - Revise interventions as required based on analysis.

5.2 Quality Improvement Methodology

A cyclic, continuous, systematic process is used to improve performance and communicate clinical and service quality issues. This process is used throughout the organization to help individuals improve procedures, systems, quality, cost, and outcomes related to their areas of responsibility. The model includes the following steps:

- Establish standards and benchmarks
- Collect data
- Analyze data and determine performance levels
- Identify opportunities for improvement
- Prioritize opportunities
- Establish clear improvement objectives
- Design and implement interventions
- Measure effectiveness

6.0 **Organizational Structure Supporting Quality Improvement: Accountability Roles and Responsibilities:**

6.1 The Board of Directors

Molina Healthcare of Michigan's Board has ultimate authority and responsibility for the quality of care and service delivered by MHM. The Board is responsible for the direction and oversight of the QI Program and delegates authority to the Quality Improvement Committee (QIC) under the leadership of the Chief Medical Officer. The President/CEO also serves as a member of the Molina Healthcare of Michigan Board of Directors.

6.2 The Quality Improvement Committee (QIC)

The QIC is responsible for the implementation and ongoing monitoring of the Quality Improvement program. Through the Quality Improvement Sub-committees, the QIC recommends policy decisions, analyzes and evaluates the progress, results and outcomes of all quality improvement activities, institutes needed actions and ensures follow-up.

The QIC sets the strategic direction for all quality activities at Molina Healthcare. The QIC receives reports from all QI sub-committees, advises and directs the committees on the focus and implementation of the QI program and work plan. The QIC reviews data from QI activities to ensure that performance meets standards and makes recommendations for improvements to be carried out by sub-committees or by specific departments.

The QIC is chaired by the Chief Medical Officer, and is composed of management of key health plan functions and network practitioners. The QIC confirms and reports to the Board that plan activities comply with all state, federal, regulatory and NCQA standards. The QIC reports to the Board any variance from quality performance goals and the plan to correct the variance. The QIC submits to the Board approved, signed, minutes reflecting committee decisions and actions of each meeting. In addition it presents an annual QI program, work plan and prior year evaluation, as well as quarterly summaries of important activities to the Board.

6.3 Quality Leadership

1. **The Chief Medical Officer and Director of QI are responsible to plan, design, implement and coordinate QI activities. Their combined responsibilities include but are not limited to:**
 - **Reporting to the Board at the quarterly meetings.**
 - **Demonstration and promotion of the QI Program through communication, practice, and resource allocation.**
 - **Achievement of organizational goals.**
 - **Direct involvement in QI activities to include:**
 - Analysis of UM and QI data
 - Serve as chair of QI committees
 - Ensure effectiveness of quality activities and allocate resources
 - Ensure practitioner participation
2. The Chief Medical Officer is the designated physician who has substantial involvement in the QI Program. This individual is responsible for:
 - Supervision of all of Healthcare Services including operational oversight responsibility for the Quality Improvement, Utilization Management, Credentialing, and Pharmacy departments. Additionally the Chief Medical Officer will evaluate the link between Behavioral Health and MHM on a regular basis.
 - Chairing the Quality Improvement Committee (QIC), and co-chairing the Pharmacy and Therapeutics Committee (P&TC), the Peer Review/Credentialing Committee (PRC), and the Utilization Management Committee (UMC).

- Oversight of development, dissemination, implementation and evaluation of clinical practice guidelines, preventive health guidelines and benefit interpretation guidelines.
 - Communication of information and decisions to network practitioners and providers, and follow-up on corrective action plans implemented for issues regarding quality of care, patient safety, or service.
 - Directs the provision of medical management for health care services, including behavioral health services, in conjunction with the Medical Director, the Clinical Behavioral Health Director and the Pharmacy Director.
3. The Director, QI under the direction of the Chief Medical Officer, leads the QI function and has the following responsibilities:
- Promote and maintain quality as a priority and guiding principle throughout the organization.
 - With the Chief Medical Officer, implements the MHM Safety Strategy.
 - Make available administrative support for planning, oversight, and allocation of resources to establish and maintain an organization-wide system of QI.
 - Serve as a resource for planning, implementation, and evaluation of the QI Program.
 - Provide operational oversight of the QI Program and annual work plan, Health Education, HEDIS, Health Management, Delegation Oversight, and other clinical measurement processes.
 - Coordinate health service activities to provide for measurement and analysis, obtaining needed expertise as needed.
 - Coordinate the organization's ongoing NCQA Accreditation activities.

6.4 Standing Quality Improvement Sub-Committees

The QIC delegates QI functions to specific sub-committees. Each of these sub-committees is guided by a description that outlines its composition, meeting frequency, standards and responsibilities. All MHM Quality Sub-committees meet at a minimum quarterly and all keep contemporaneous minutes using a standard format.

The activities of all quality committees are treated in a confidential manner, as outlined in their policies. (Please refer to attached 2007 Committee Purpose and Meeting Dates, **APPENDIX B** for a full description of sub-committee membership and responsibilities)

- The Quality Improvement Committee (QIC). Information from the QIC is

reported to the Board of Directors on a quarterly basis or more often as appropriate.

- The Peer Review/Credentialing Committee (PRC). The PRC reports to the QIC.
- The Member and Provider Satisfaction Committee. Reports to the QIC.
- The Pharmacy and Therapeutics Committee (P&TC). The P&TC reports to the QIC.
- The Utilization Management Committee (UMC). The UMC reports to the QIC.
- The Compliance Committee (CC). The CC reports to the QIC.
- The Policy and Procedure Committee reports to the QIC

6.5 QI Department Roles and Responsibility

The QI Department is comprised of appropriately credentialed registered nurses, health professionals, and ancillary personnel who are responsible for coordination of the QIP and planned QI activities. These include, but are not limited to:

- Coordination of a health plan wide annual evaluation and planning cycle, resulting in an annual QI work plan that outlines organizational QI objectives with action plans, goals, responsibilities, timeframes and reporting requirements.
- Coordination of clinical and service quality measurement and quarterly reporting to the QIC.
- Management of QI projects, studies and interventions, preparation and submission of QI documents and reports, and recommendations to appropriate quality sub-committees.
- Identification of opportunities for improvement through monitoring and analysis of clinical and satisfaction data.
- Ensuring compliance with MHM and regulatory standards for timely response or resolution of complaints and appeals, in conjunction with UM and Member Services staff.
- Monitoring QI preparations for compliance with regulatory requirements and for future accreditation. Coordinates the preparation of the formal study documentation, including Quality Improvement Activities (QIAs) and Performance Improvement Projects (PIPs).
- Development, adoption, and implementation of relevant health education programs.

- Implementation of the clinical quality of care case review process.
- Membership on appropriate Quality Sub-committees.
- Maintenance of accountability and oversight of delegated administrative functions to include credentialing, utilization management, and claims to contracted provider groups.
- Development, maintenance and implementation of QI policies and procedures.
- Maintenance of necessary QI resources including, but not limited to written materials, software, specialty consultation, analyst and statistical support.
- Identification and interventions for disparities for racially and ethnically diverse populations

6.6 Other Departmental Roles and Responsibilities for QI

All departments have a key role in quality improvement. Departments participate in interdepartmental activities but also focus on intradepartmental opportunities to improve effectiveness or efficiency. All departments participate in one or more of the Quality Improvement Committees.

The UM staff is responsible for:

- Development and maintenance of the UM Program, policies and procedures, annual UM work plan and program evaluation in compliance with NCQA, MHM and other regulatory and accrediting standards.
- Monitoring over and under-utilization, coordination and continuity of care, including access to a nurse advice line.
- Documentation of all potential quality of care, risk management, and member safety issues identified during UM review. The Chief Medical Officer determines the severity of each case and determines if peer review is required.
- Oversight of the coordination of care with healthcare delivery organizations (i.e., facilities) and contracted entities, and with groups delegated for UM functions.
- Implementation of a case management program in collaboration with health management and prevention programs.

The Provider Services staff is responsible for:

- Monitoring practitioner, provider and health delivery organization access and availability, including behavioral health, and implementing improvement plans.
- Review of practitioner satisfaction surveys, practitioner complaints and other forms of practitioner feedback and implementation of improvement plans.

- Dissemination of provider education materials as identified including statements of members' rights and responsibilities.
- Administration of the provider inquiry process for payment issues related to post-service claims and/or authorization denials.
- Monitoring the trends of member concerns, complaints, appeals and disenrollment related to dissatisfaction with provider and provider inaccessibility and identifying opportunities for improvement, in conjunction with Member Services staff and QI.

The Member Services staff is responsible for:

- Administration of the members' rights and responsibilities.
- Monitoring member access to Molina Healthcare and compliance with contractual and regulatory standards for timely response or resolution of all issues, in conjunction with Provider Services.
- Monitoring trends of member complaints, appeals and disenrollment and identification of opportunities for improvement.
- Review of member satisfaction surveys and other forms of member feedback, identification of opportunities for improvement, and implementation of improvement activities.
- Reporting all potential quality of care and risk management issues that are reported by members following policy and procedure.
- Administration of the member complaint and appeal policy, ensuring timelines met per policy.

Compliance Manager is responsible for:

- Coordination of compliance audits.
- Oversight of compliance with all applicable statutory, regulatory and contractual requirements.
- Review of draft and final regulations and statutes.
- Education and training for Molina Healthcare staff regarding contract provisions and new law/regulation.
- Liaison with the state of Michigan.
- Coordination of contract renewal activities.
- Implementation and monitoring of the Compliance Plan.
- Maintenance of approved policies and procedures, ensuring annual review and approval.
- Preparation and review of member communications and submission to the state for approval as required, including member handbook and mailings.
- Management and review of confidentiality issues and provision of training

as needed.

- Coordinate organizational compliance for HIPAA (Health Insurance Portability and Accountability Act).

The Credentialing staff is responsible for:

- Implementation of a credentialing and recredentialing program that includes completion of office site visits to ensure a safe environment for members and appropriate practices, development and maintenance of provider profiles including available data from health plan functions and staffing the PRC.
- Implementation of the medical record-keeping audit program.
- Delegation Oversight

The Pharmacy staff is responsible for:

- Identification of key processes to evaluate pharmacy safety and effectiveness.
- Maintenance of notification system for drug alerts.
- Development and maintenance of operational policy and procedures for effective formulary management, authorizations processes and safe practices.
- Oversight of Pharmacy Benefit Manager to ensure practices meets MHM's standards.

6.7 Role of Participating Providers

Participating practitioners serve on all clinical committees including, QIC, UMC, P&TC and PRC. Through this committee activity, participating providers may:

- Review and provide feedback on proposed practice guidelines, preventive health standards, clinical protocols, health management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures.
- Review proposed QI study designs.
- Participate in the development of action plans and interventions to improve levels of care and service.

In cases where specific specialty feedback or assistance is needed, community specialists are used to review cases and to provide feedback on proposed

interventions or programs. As needed, focus groups of practitioners may be used for assisting with the design or evaluation of specific programs.

6.8 **Confidentiality**

Molina Healthcare of Michigan is authorized by specific regulatory agencies and by members to obtain and review medical records, including member and practitioner identities. Authorization is subject to all state and federal laws and regulations, including Title 42 Code of Federal Regulations, Molina Corporate Employee Handbook, Section B, Security and Confidentiality. Use of Protected Health Information (PHI) is outlined in a privacy notice distributed to all members.

All Molina Healthcare personnel sign a Confidentiality Agreement and a Code of Conduct and Employee Handbook Acknowledgment form. Signed documents are on file in the Human Resources Department. In addition, non-Molina Healthcare members of QI committees sign a confidentiality statement when attending committee meetings and are protected from being required, with some exceptions, to testify in civil actions related to specific committee activities and actions.

As an approved Coordinated QI Program by MDCH, information and documents created specifically for, and collected and maintained by an approved program receive protections from public disclosure. Molina Healthcare's QI documents are maintained in compliance with all legal requirements and include, but are not limited to, internal reviews, including patient care review studies, QI studies and reports, minutes of QI committees and administrative (i.e., non-clinical) processes having a direct impact on the provision of care or service. The findings of all Molina Healthcare QI committees are part of the QI Program. Such findings will not be released to any outside agency without the express permission of the originating agency and assurance that confidentiality will be maintained.

The Board assigns the responsibility of managing and reviewing confidentiality issues to the Government Contracts and Compliance Department. A Compliance Committee has been formed as directed by the Compliance Plan. This committee addresses issues of confidentiality.

6.9 **Conflict of Interest**

No reviewing physician may perform a review on one of his/her patients, the patients of his/her partners, or cases in which the reviewing physician has a proprietary financial interest in the site providing care.

7. ***Delegation Activities***

Molina Healthcare of Michigan may delegate Credentialing, UM, and Claim activities to provider groups that meet delegation requirements. Prior to delegation, Molina Healthcare conducts on-site delegation pre-assessments to determine compliance with regulatory and accrediting requirements. The health plan monitors ongoing compliance with review of monthly reports and annual on-site assessments.

The QIC monitors ongoing delegate compliance with regulatory and accrediting requirements. The committee requires corrective action of delegates when necessary. MHM's Director, QI is responsible for the delegation oversight process, which includes coordinating and conducting annual on-site assessments, monitoring credentialing reports, overseeing the corrective action process, and providing staff support.

MHM currently delegates the following:

- Credentialing
- Quality Improvement for Behavioral Health
- Utilization Management for Behavioral Health

8. *Program Evaluation and Revision*

The Quality Improvement Program Description and Work Plan govern the program structure and activities for a period of one calendar year. At least annually, the QI Department will facilitate a formal evaluation of the QI Program. Evaluation of all quality activities will include a description of limitations and barriers to improvements.

The annual QI evaluation identifies the outcomes and includes the following areas:

- Evaluates the results of each QI activity implemented during the year and identifies quantifiable improvements in care and service.
- Where available, includes a trended indicator report and brief analysis of changes in trends and improvement actions taken as a result of the trends.
- Identifies opportunities to strengthen member safety activities.
- Evaluates resources, training, scope, and content of the program and practitioner participation.
- Identifies limitations and barriers and makes recommendations for the upcoming year, including the identification of activities that will carry over into next year.
- Evaluates the overall effectiveness of the QI Program.

9. *Governing Body Review and Approval*

Molina Healthcare of Michigan's QI Program is accountable to and reports activities to the Board of Directors through the Quarterly and Annual Reports. The Quality Improvement Program Evaluation, the QIP and the Work Plan are submitted to the Board of Directors for review and approval.

10. Glossary

BH:	Behavioral Health
CAHPS:	Consumer Assessment of Health Plans
ED:	Emergency Department
HCA:	Health Care Authority
HDO:	Health Delivery Organization
HEDIS:	Health plan Employer Data and Information Set
MDCH:	Michigan Department of Community Health
NCQA:	National Committee for Quality Assurance
PRC:	Peer Review Committee
P&T:	Pharmacy and Therapeutics
PHI:	Protected Health Information
PCP:	Primary Care Provider
QIC	Quality Improvement Committee
QIP:	Quality Improvement Program
UM:	Utilization Management
UMC:	Utilization Management Committee

UTILIZATION MANAGEMENT PROGRAM

Introduction

Utilization Management Department Services

Call us: 888-898-7969, Option 1, then 4

Fax us: 800-594-7404

Visit our website www.molinahealthcare.com

for updates, frequently used forms, and professional resources

Molina Healthcare is happy to provide you with the enclosed “Provider’s Guide” which highlights the programs and initiatives offered by our Utilization Management (UM) Department. We hope this guide will help you gain insight of what we do, and what we can do to assist you in caring for our members.

Our UM Program facilitates quality, cost-effective and medically appropriate services across a continuum of care that integrates a range of services appropriate to meet individual member needs. Our services include: preservice and admission review; concurrent review; discharge planning; continuity and coordination of member care post hospital discharge; after hours clinical availability (On-Call Program); retrospective review; medical case management for specific conditions and specialized clinical programs; clinical policy and criteria development; provider appeal processing; utilization data analysis including monitoring for over and underutilization; evaluating member and provider satisfaction; staff education and quality oversight.

Our UM staff is available to meet with you, your office staff and/or your physician group to address your concerns and provide education about our programs. If you would like to schedule a meeting at your office or have any questions, please call our UM Department at 1-888-898-7969 or your contact your Provider Services representative.

Thank you for continuing to provide the quality care on which our members depend. We are always looking for ways to support the most effective healthcare for our members, and improved service to our providers.

Who are we?

UM activities are coordinated and conducted under the direction of the Medical Director(s) (Physicians) and the UM Director.

- Managers (Registered Nurses (RN) and Supervisors (RN) oversee the daily functions.
- Multidisciplinary teams are assigned to a population of members divided by geographic area and/or provider group. The teams are composed of:
 - Complex Case Managers (RN)
 - Clinical Case Managers (RN)
 - Utilization Management Specialists (Licensed Practical Nurses (LPN)
 - Utilization Management Coordinators
- The team structure promotes ownership and accountability to providers and members.
 - An RN is assigned as lead to coordinate work.
 - Productivity reporting and expectations are monitored.
- Medical Director Physician Support includes:
 - Weekly case review with teams.
 - Case discussion of complex or chronic illness case management cases.
 - Case discussion of members with frequent emergency department (ED) use.
 - Review of cases that cannot be approved by a nurse.
 - Development of criteria/guidelines.
- Pharmacist Support
- Nurse Advice Line (NAL) and On-Call staff provide clinical availability after normal business hours.
- Health Services Support includes:
 - Medical Social Worker (MSW)
 - Registered Health Information Administrator (RHIA)
 - Healthcare Data Analyst
 - UM Clinical Trainer
 - Quality Nurse Reviewer
 - Telephonic Triage Team
 - Administrative and Clerical Support

What do we do?

- Preservice and admission review
- Concurrent review
- Discharge planning
- Continuity and coordination of member care
- Case management
- Retrospective review
- Clinical policy and criteria development
- Provider appeal processing
- Utilization data analysis including monitoring for over and under utilization
- Evaluate member and provider satisfaction with the UM Program
- Staff education and oversight.

How to contact us?

The Telephonic Triage Team answers incoming phone calls. If you have a question or would like to contact a multidisciplinary team that is assigned to you, call the Telephonic Triage Team at 1-888-898-7969.

- Department Phone 1-888-898-7969
- Department Fax 1-800-594-7404

Preservice and Admission Review / Authorization Requirements

How to decide if a service requires authorization?

The Molina Healthcare Authorization Requirements Grid can be found on the Molina Healthcare website at www.molinahealthcare.com.

Review the 3 columns on the Molina Healthcare Authorization Requirements Grid

1. Authorization Not Required Column:

- Service may be performed upon physician order
- Service may be performed by a contracted (preferred) provider or facility

2. Notification Required Column:

- Molina Healthcare must be notified of service (prior for elective services)
- Authorization is required for claim payment
- Clinical information does not need to be provided

3. Clinical Review Required Column:

- Molina Healthcare must be notified of service (prior for elective services)
- Authorization required for claim payment
- Clinical information is required and reviewed utilizing InterQual®, Medicaid or Molina Healthcare criteria.

Examples of services requiring authorization:

- Selected outpatient services require authorization
- Select ambulatory surgical/diagnostic procedures
- Potentially cosmetic/experimental procedures
- Medical benefit review
- Home health care (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST))
- Home intravenous (IV) infusion
- Authorization is required for all inpatient admissions
- Molina Healthcare utilizes InterQual® criteria to determine medical necessity

Should a referral be issued?

A referral is a request by a Primary Care Physician (PCP) for a member to receive specialty services from another physician, another healthcare professional or a facility. PCPs are able to refer a member to a provider/specialist for consultation without submitting a authorization request to Molina Healthcare.

Three easy ways to request a preservice or admission review

- **Fax** your authorization request, and clinical information if required, to the UM Department at 1-800-594-7404. PCPs / Specialists should use the Molina Healthcare Referral Form or the Michigan HealthCare Referral Form. You may locate the forms at molinahealthcare.com.
- **Electronically** submit your request using our web based program, e-Portal.
- **Telephone** the UM Department at 1-888-898-7969.

Urgent requests

All urgent requests must be submitted by calling UM Department at 1-888-898-7969. Make sure you identify the request as “urgent” to expedite the review process.

What if we did not know the service required authorization or the authorization was not obtained?

- **Fax** your authorization request, and clinical information if required, to the UM Department at 1-800-594-7404. PCPs / Specialists should use the Molina Healthcare Referral Form or the Michigan HealthCare Referral Form. You may locate the forms at molinahealthcare.com.
- **Electronically** submit your request using our web based program, e-Portal.
- **Telephone** UM Department at 1-888-898-7969.

Notification of our decision will be given within 14 days of the receipt of the request.

Tips to help expedite authorization decisions

- ✓ Submit your authorizations electronically (e-Portal)
- ✓ Verify the member's eligibility and benefits
- ✓ Accurately complete one of the authorization request forms (Molina Healthcare Referral Form or the Michigan HealthCare Referral Form)
- ✓ Include the CPT and ICD-9 codes
- ✓ Submit your requests at least 14 days prior for elective services
- ✓ Refer to the Molina Healthcare Authorization Requirements Grid, since many services may not require you to submit a authorization request
- ✓ Include pertinent clinical information (progress notes, lab results, photos, imaging studies)
- ✓ Visit molinahealthcare.com for any changes regarding the authorization process

How do we request an elective admission?

For *all elective admissions*, the PCP, specialist, or facility must request authorization prior to the scheduled admission. Authorizations may be requested by *phone, fax or e-Portal*. Please include the following information:

- Member's name, Medicaid recipient ID #, date of birth, and age
- Admission date
- Name of admitting facility and fax number
- ICD-9 and CPT code
- Member's current medical condition including date of onset, duration of symptoms, and treatment rendered to date
- Proposed treatment plan
- Requesting physician's fax number
- Pertinent clinical documentation (progress notes, x-ray reports, lab results).

What happens after you submit your request for authorization?

- We confirm the member's eligibility, benefits, and provider's affiliation status.
- If the request is submitted with complete and accurate information, then if appropriate the request is reviewed against medical appropriateness criteria. The criteria sources used are one or more of the following:
 - InterQual®
 - The Hayes Directory for New Medical Technologies
 - Comprehensive Medicaid guidelines for Michigan
 - Internally developed medical necessity criteria
 - Algorithms and guidelines from recognized professional societies
 - Advice from authoritative review articles and textbooks
 - Medicare guidelines
- If the request does not meet criteria, the UM staff will contact (via telephone, fax, and/or mail) the requestor for clarification or additional clinical information, or refer the case to a Molina Healthcare Medical Director. In the case of a pharmacy request the case is referred to a Molina Healthcare Registered Pharmacist.

When and how will you be notified of your decision?

The decision time frame is based upon the date on which we receive your request and the supporting clinical information. To ensure a timely decision, please provide all supporting clinical information with the initial request. We will contact you when additional clinical or clarifying information is needed. Our decisions are made in accordance with regulatory and accreditation guidelines.

- **Urgent approved requests** – we will call the authorization number to the requestor and facility (if indicated) within seventy-two (72) hours of the initial request.
- **Nonurgent approved requests** – we will call or fax the authorization number to the PCP, requesting physician or facility (if indicated) within fourteen (14) days of the initial request.
- **Urgent denied requests** – The denial rationale for denial and appeals process will be called to the requesting provider and written notification will be mailed to the member, provider, PCP, and facility (if indicated) within seventy-two (72) hours of the request.
- **Nonurgent denied requests** - The denial rationale for denial and appeals process will be called to the requesting provider and written notification will be mailed to the member, provider, PCP, and facility (if indicated) within fourteen (14) days of the initial request.

Note: Providers may review the UM criteria at Molina Healthcare or they may request a copy of the criteria of interest by telephone, fax, or email.

A Molina Healthcare Medical Director is available to discuss the denial decision with any treating practitioner.

Admission Review

How do we request authorization for an urgent/emergent admission?

Call **1-888-898-7969**. During normal business hours, the hospital can call the UM Department or fax to 1-800-594-7404.

For **all urgent/emergent admissions**, the hospital is required to provide clinical information once the determination is made to admit the member. Molina Healthcare ensures availability 24 hours per day, 7 days a week, by providing an On-Call Case Manager (RN) during non business hours. If Molina Healthcare fails to respond within one (1) hour, the admission will be automatically approved.

What type of clinical information should be provided?

Clinical information should include the member's health history, vital signs, physical assessment, consultations, current and previous treatment including those services performed in the emergency room and outpatient settings and the member's response to treatment. Please include any anticipated discharge needs.

How does MHM perform clinical review of urgent/emergent inpatient admissions?

If the admission does not meet InterQual® medical necessity criteria as an inpatient setting, the facility may admit the member to an observation setting, no authorization is required. If the facility does not accept observation setting, the UM staff will forward the case for Medical Director review.

Requests for admission that meet InterQual® Inpatient Criteria, but could be treated in an observation setting (specifically, rule out Myocardial Infarction/Chest Pain, Asthma, Congestive Heart Failure) and there is a likelihood of discharge within 24 hours an observation stay will be authorized initially for the following diagnoses:

When would we contact you?

- If additional clinical information is required
- If the need for additional medical services are identified post discharge, such as home health care or home infusion
- To notify you of our decisions
 - When services are approved, we will call you with an authorization number and next review date
 - When services are not approved, we will call you. Written notification is also sent at the time of the decision giving you the reason for the denial. Member and provider appeal rights are included with the notification. If you would like a copy of the criteria that was used to make a denial determination, or would like to discuss a denial decision with a Medical Director, please call 1-888-898-7969.
 - For urgent/emergent admissions, we will call you within 72 hours of the receipt of the request.
 - If we are notified retrospectively of an admission and discharge, notification of our decision will be given within 14 days of the receipt of the request.

Concurrent Review / Discharge Planning / Continuity and Coordination of Care Post Hospital Discharge

Why concurrent review / discharge planning / continuity and coordination of care?

Concurrent review is performed to determine medical necessity and appropriateness of a continued inpatient stay, to identify appropriate *discharge planning needs*, facilitate discharge to an appropriate setting in a timely manner and ensure *continuity and coordination* of the member's care. Our staff collaborates with the physician, hospital discharge planning, practitioners and their representatives.

Concurrent reviews are conducted once or twice a week as appropriate and InterQual® is used as a guideline in performing review.

How does the process work prior to discharge?

Hospital discharge planning staff is responsible for ensuring authorization is obtained by calling 1-888-898-7969. The following select post discharge services require authorization:

- Home health care (including hospice, Infusion (IV) therapy, PT, OT, etc.)
- Infusion therapy
- Select durable medical equipment (DME)
- Skilled nursing facility (SNF)

- Rehabilitative services
- Hospice

Prior to or upon discharge from an inpatient facility, the hospital is responsible for providing the following information by calling 1-888-898-7969:

- Discharge date
- Discharge plan (medications, appointments, ancillary service needs, etc.)
- Place of discharge
- Member phone number
- Alternative phone number and contact

How does the process work post hospital discharge?

Molina Healthcare UM staff (RN) will contact the member post discharge to evaluate if prescriptions were filled and the member is taking accurately, if post discharge appointments are scheduled, and if the member is following the discharge plan. If it is determined the member requires additional services that were not ordered at discharge, the UM staff will contact the member's PCP and/or attending physician to discuss the member needs. The UM staff will arrange home care services or equipment as necessary.

In summary, the program provides:

- Three phone attempts over two week period following discharge
- Letter if unable to reach
- Nursing assessment tool
- Assistance with follow-up appointments
- Medication compliance monitoring
- Evaluation of compliance with discharge instructions
- Evaluation of current clinical condition
- Education on disease process

Medical Case Management

Who are we?

Our Complex Case Managers (CM) are registered nurses with specialized training in the management of specific diseases. We also have a clinical social worker on our team to provide psychosocial support to members.

What services do the CMs provide?

Their role is to improve the health and well-being of each member by educating, assisting and facilitating access to the most appropriate health care services available. The CM has the responsibility to coordinate medical services throughout the member's continuum of care, while effectively reducing costs. The CMs assist:

- Identifying members who will benefit the most from case management services
 - Accept referrals from all Molina Healthcare areas and from physicians, hospital staff, etc.
- Developing a plan of care including problem identification, goals (including discharge from the program) and plan of care.
- Implementing interventions and service coordination within the benefit structure.

- Ensuring all services are medically necessary and provided at the appropriate level of care and in a timely manner.
- Coordinating such services as home health and hospice care, home infusion therapy, inpatient rehabilitation and skilled nursing care.
- Monitoring progress towards the goals.
- Reassessment and close the member to case management when appropriate.

The CMs are available to physicians, utilization review staff, discharge planners, the patient and patient's family to answer questions, attend care conferences and assist in facilitating a discharge plan or coordinating care.

Who is eligible for case management?

All Molina Healthcare members *are* eligible for case management and some members may be eligible for select case management programs. Members referred for case management include those with known chronic disease, those at risk for developing chronic disease, those with multiple hospital admissions, or those with needs for multidisciplinary outpatient care.

The following select case management programs are also available to support member's health care needs:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease
- End Stage Renal Disease
- High Risk Obstetrics
- Pediatrics
- Skilled Nursing Facility and Rehabilitation
- Transplant / Oncology
- Social Work Services
- Frequent Emergency Department Use

If you would like to learn more information, speak with a Complex Case Manager and/or refer a member for an evaluation, please call our Utilization Management Department at 1-888-898-7969.

How to refer a member for case management?

During normal business hours call the UM Department at 1-888-898-7969.

How will you know if the member is accepted into case management?

You will receive a letter from a CM with their direct phone number.

When will you hear from us?

Our CMs perform an individualized member assessment. Following that assessment, the CM will send a letter with the long term goals and a form asking you to let us know if there are any other needs. The CM will periodically call you regarding the member's progress.

Our CMs may contact you for other reasons:

- Coordinate a plan of care
- Confirm a diagnosis
- Verify appropriate follow up
- Identify member compliance issues
- Discuss other problems and issues that may affect the member care

On-Call Program (After Hours)

Who are we and how should you contact us?

Molina Healthcare requests inpatient facilities to contact Molina Healthcare once a determination is made to admit a member from the emergency department but prior to the admission. By using the On-Call Program (After Hours) service the facility can obtain authorization prior to the admission. This service can also be used for discharge planning for hospitalized members.

Your call is answered by the Molina Healthcare NAL Operator. The NAL Operator verifies eligibility for the patient and contacts the On-Call Case Manager (RN).

What do we do?

We provide clinical staff availability 24 hours per day, 7 days per week to members, providers, and hospital, including non-business hours Monday – Friday 5:00 PM – 8:30 AM, Saturday – Sunday, and holidays.

The On-Call Case Manager contacts the facility to obtain clinical criteria (signs and symptoms, vital signs, lab results, diagnostic test results, medications with response, past medical history, plan of care) and applies InterQual® Medical Appropriateness Guidelines.

The On-Call Case Manager will facilitate one of the following:

- Approve inpatient admission in which an authorization number is provided along with the next review date
- Approve 23 hour observation
- Pend for additional clinical information, in which the facility has 48 hours in which to supply Molina Healthcare with the requested information
- Discharge to home
- Discharge to home with home care, home infusion, and / or DME

When will you hear from us?

The On-Call Case Manager will contact the facility within one hour maximum.

How can you reach us?

You can reach the On-Call Case Manager by calling 1-888-898-7969.

Provider Appeals

Who handles provider appeals?

The UM Appeals/Denials area coordinates the provider appeals and Molina Healthcare Medical Directors review all appeals of denied decisions.

What do we do?

All providers have the right to appeal any denial decision made by Molina Healthcare. Our appeal process is objective, thorough, fair and timely. A Molina Healthcare Medical Director may determine that a same specialty physician review may be needed. There are 2 types of provider appeals, medical review and administrative decisions.

1. Medical review denial decisions. Providers have a period of ninety (90) days after denial notification of a denial decision in which to submit a written appeal. Appeal rationale needs to include supporting clinical documentation. Two levels of appeal are available. Examples of clinical denials are inpatient admission which did not meet InterQual® criteria or a request which did not meet medical criteria guidelines.
2. Administrative denial decisions. Providers have a period of ninety (90) days after the denial determination to submit a written appeal request. Appeal documentation needs to include rationale for failure to comply with Molina Healthcare's requirements and supporting clinical documentation. One level of appeal is available. Examples of administrative denials are failure to authorize services according to required timeframes and DRG validation determinations.

If Molina Healthcare receives an appeal request after the designated time frame, Molina Healthcare is not obligated to review the case.

Expedited appeal for urgent services

Providers may request an expedited appeal for services that have not been rendered and are urgently needed when the delay in a decision may jeopardize the life or health of the member by calling the Member Services Department at 1-888-898-7969, Appeal and Grievance Unit.

How to request an appeal of a denial decision?

Send all requests to UM Department with all the new, clarifying supporting documentation within ninety (90) days of receipt of the initial denial determination.

Address: Molina Healthcare of Michigan, Inc.
Attn: Utilization Management Appeals
100 West Big Beaver, Suite 600
Troy, MI 48084

A Molina Healthcare Medical Director is available to discuss the denial decision with any treating practitioner by calling 1-888-898-7969 and asking for the UM Appeals/Denials area. In addition, you may request a copy of the criteria used to make the denial decision.

When can you expect to hear from Molina Healthcare?

We will notify you in writing within 30 calendar days of the receipt of the appeal request.

Expedited appeals: We will notify you within 72 hours of the receipt of your appeal request.

Appeals decisions are final.

Coordination of medical and behavioral health care

Who are we?

Molina Healthcare clinical staff, which includes RNs, CMs, a clinical Social Worker and Medical Directors, routinely assess all Molina Healthcare members for potential behavioral health issues. In cooperation with our behavioral health vendor, Comprehensive Care (CompCare), we coordinate the Molina Healthcare membership behavioral health care needs.

What do we do?

The mechanisms used to assess members include:

- Direct member contact (phone)
- Indirect contact through inpatient review including assessment of “trigger” diagnosis and patient events.

In addition, behavioral medicine assessment and referral occurs for all members assessed for case management services.

If a member is identified with a potential need for behavioral health assessment or an intervention is identified, UM staff encourage them to seek care through CompCare and offer the telephone number 1-800-435-5348. Molina Healthcare staff can also contact CompCare directly to refer members (three-way call).

More about CompCare and Molina Healthcare member’s behavioral health benefits

CompCare manages the outpatient mental health benefit only. Members have 20 mental health appointments a year for outpatient counseling with a therapist as well as medication management with a psychiatrist. When a member has a chronic mental health issue or have used their 20 visits CompCare refers them to the community mental health agency in their area for treatment. Inpatient treatment is managed by the state. CompCare does not manage the substance abuse benefit; however, they can assist members by providing them with the resources for treatment. Below are specific situations where CompCare can assist Molina Healthcare members:

- Any member that requires an MMPI for Bariatric surgery or psychological tests can be referred to CompCare. CompCare has specific providers that they use for these tests. Contact CompCare at 1-800-435-5348 extension 4520 for a referral to these providers.
- PCP’s can also contact CompCare for assistance in finding a specific mental health provider. When a PCP contacts Molina Healthcare for this information they should be directed to talk to CompCare at 1-800-435-5348.
- Pervasive developmental disorder (PDD), autism and retardation are carved out to the community mental health by the state. CompCare can provide education to the members and refer them to Michigan Department of Community Health for services.

Provider Appeals

- CompCare has some providers that will perform home visits for members that are homebound. Evaluations will be done by CompCare on a case by case basis. Contact CompCare at 1-800-435-5348 extension 4320 to arrange this.
- CompCare's normal business hours are 8:30 to 6:30 p.m. Members requiring urgent services after hours are referred to the nearest access center otherwise; the members will receive a call the following business day.
- If there are any issues with CompCare please contact Molina Healthcare's Social Worker at 1-888-898-7969.

PHARMACY

Contact Information

RX PA Hotline: 1-(888) 669878-43227969 Option 1 for Providers, Option 5 for Pharmacies

RX PA Fax Line: 1-(888) 373-3059

General Telephone Number: 1-(866) 449-6828

Drug Formulary is published
on the Molina Healthcare of Michigan, Inc. (MHM) Website:
www.molinahealthcare.com

*Please check coverage and prior authorization requirements for psychotropic medications(including ADD Drugs) on the State of Michigan Website:
www.michigan.fhsc.com*

Drug Prior Authorization (Pa) Procedures

1. First please review your Molina Healthcare of Michigan, Inc. (MHM) Drug Formulary to learn which drugs are highlighted or italicized medications require prior authorization. You may also have access to the latest Drug Formulary information at www.molinahealthcare.com and ePocrates. If you need additional copies of the MHM Drug formulary, please call your Provider Services Representative.
2. If a drug requires prior authorization you must fax a MHM Prior Authorization Drug Request form to (888) 373-3059.
3. Drug prior authorizations are always processed in the order in which they are received. If all necessary information is presented, expect a response usually within two hours or less and not later than one business day. If forms are NOT filled out completely, you may expect a call fax back with a request for additional information.
4. Once received, your drug PA is reviewed by the MHM Pharmacy Team to determine if your request meets the MHM PA criteria. The team can either APPROVE or PEND your request. If your request is PENDED, please fax back the requested documentation or additional information to substantiate your request.
5. Expect a call or written communication from Pharmacy personnel the next day if you have not responded to the formulary suggestions. MHM wants to follow up on these issues to ensure that the member received their medication in a timely fashion.
6. If your request is DENIED by the Medical Director or Pharmacy Director, you may appeal this decision.
7. Drug PA Review Considerations:

- First line Formulary prescription or OTC Drugs take precedent over nonformulary drugs.
 - All non-FDA approved "off label" drug requests will be DENIED and are subject to the review of the Medical or Pharmacy Director only.
 - The use of manufacturer's samples of non-formulary or "Prior Approval Authorization Required" medications does not override prescribing requirements.
 - Prescriptions Requests for medications requiring prior approval authorization or for medications not included on the MHM Drug Formulary may be approved when medically necessary and when formulary alternatives have demonstrated ineffectiveness. When these exceptions arise, the provider may must fax a completed drug prior authorization form to MHM Pharmacy Department at (888) 373-3059. Trials of pharmaceutical samples do not guarantee or override prior authorization approval.
8. To assure excellent customer service, all drug authorization requests received by 5:00 PM EST will be processed the same day.



Drug Prior Authorization Form

Phone: (888) 669-4322

Fax: (888) 373-3059

Date of Request:		Time:	
Pt. Name: (Last)		(First)	Pt's DOB
Pt. ID (Medicaid ID)			
Provider's/Mid Level Provider's Name		Specialty Name:	
Phone #: (Area Code)	(Number)	Fax #: (Area Code)	(Number)

(*Required for confirmation/ Please print clearly. *)

- Drug Requested: (Name, strength, dose, sig, quantity) **MAX 2 DRUGS PER FORM**
- Estimated length of need:
- Diagnosis/medical indications for RX: (Send all pertinent test results and/or reports with this fax.)
- Previous medications prescribed and outcome:

For Molina Healthcare of Michigan use ONLY!!	
<input type="checkbox"/> Approved _____ <input type="checkbox"/> Pending <input type="checkbox"/> Denied	Pharmacist's comments:
Note: We will assume your concurrence with our formulary recommendation if we have not received a response from the provider within two business days.	

A for Profit Company

Rev. 12/09/2009

Drug Prior Authorization (Pa) Helpful Hints

• Prevent Rx Delays

Make extra copies of RX PA forms and keep them readily available. This will save time expediting your request. You may also download a RX PA form from our website:

www.molinahealthcare.com

• Save Telephone Calls

Get to know your Provider Representative. They can provide: extra copies of prior authorization request forms, PA procedures, copies of formularies and a list of OTC drugs that do not require prior authorization.

• Save Time - Save Calls From Pharmacies

Use alphabetical listing in your formulary book index to look up which drugs require a PA.

• Be Informed - Be Patient Oriented

Please familiarize yourself with the MHM Drug Formulary. Please refer to the MHM website and ePocrates for the most up-to-date Drug Formulary information. Drugs shaded in gray require a PA. Knowledge of this will save you calls from pharmacies and complaints from your patients. For your convenience we have included MHM DRUG PA Guidelines.

• Save Time - Save Calls From Us

Fill out drug PA form completely; make sure you note your office phone and fax number with area code, member name, and recipient ID number, physician name and name of person completing the form..

• Save Aggravation on Pain Management Drugs

Allow for dosage titration in the high acuity patients in the amount of drug/dose requested. Once entered into the pharmacy computer, PA must be manually modified if the dosage is changed. This will help prevent calls from pharmacies, patients, caregivers and filling out and faxing us another drug PA form.

• Important - Please Note

Any questions or concerns may be directed to our pharmacy Pharmacy voice mail system/Department. Please do not hesitate to request extra copies of formularies, PA forms, status of claims etc. Messages from our pharmacy voice mail system or direct calls(888) 669-4322 are retrieved answered promptly throughout the day. Your voice mail message/call is important to us and all calls are returned no later than the same business day.

Prior Authorization Criteria**DRUG (S): ALL NON-FORMULARY WITH CLASS REPRESENTATION ON DRUG FORMULARY FDA-APPROVED INDICATION(S):**

As directed by the FDA

PRIOR AUTHORIZATION APPROVAL:

Prescriptions for Non-Formulary medications, whose drug class is represented on the Drug Formulary with other agents, may be approved if the drug(s) will be used within these guidelines:

1. Documented failure or intolerance to all Formulary agents of same drug class.
 - Eg., a request for the lipid drug Pravachol will require failure on Formulary agent Lipitor.
 - If the Formulary agents/drug class should require Prior Authorization, member will need to meet the Prior Authorization requirements for specific medication/drug class before it can be used.

OR,

2. Medication is being used for a unique treatment/condition that is not indicated for Formulary agents in same drug class.

OR,

3. All Formulary agents from same drug class are contraindicated for member per manufacturer recommendations.

OR,

4. Medication request was for a new member who is continuing therapy started while in another health plan. May be asked to provide documentation of previous use.

Formulary alternatives will be recommended to requesting physician if any of the following apply:

- A) Above criteria (1-4) are not met.
- B) Pharmaceutical samples were dispensed to member before all Formulary agents within same drug class were tried.

Prior Authorizations generally will be denied if Formulary alternatives are not accepted by physician.

These guidelines for prior authorization approval are for reference only. They do not replace the professional judgment of the prescribing physician and do not necessarily apply to all patient-specific situations.

**ABBREVIATED PHARMACY PRIOR AUTHORIZATION CRITERIA
MOLINA HEALTHCARE OF MICHIGAN**

BRAND NAME	GENERIC NAME	CRITERIA
ACCOLATE	Zafirlukast	Moderate to severe asthma; failure on inhaled steroids. Can not be authorized as steroid replacement.
ACTOS	Pioglitazone	Treatment of Type II diabetes with HbA1c > 7; Failed or intolerant to max doses of sulfonylureas/metformin, or in addition to insulin in patients using >60units daily.
ADDERALL XR (FOR AGES ≥18)	Amphetamine, mixed salts	Treatment of ADHD, with documented ADHD diagnosis by psychiatry. Prior Authorization is not required for ages <18.
ALDARA cream NF	Imiquimod	Treatment of external genital and perianal warts/condyloma acuminata in adults; treatment of clinically typical, non-hyperkeratotic/non-hypertrophic actinic keratoses on face or scalp; treatment of biopsy-confirmed, primary superficial basal cell carcinoma, with maximum tumor diameter of 2cm. Treatment course must be consistent with product label.
ALLEGRA, -D	Fexofenadine Fexofenadine / pseudoephedrine	Treatment of allergic rhinitis/urticaria. Failure of OTC antihistamines (Including Claritin and Nolahist), Semprex-D, and nasal steroids. Not for use in combination with nasal steroids (combo no more effective than single agent)
ARAVA _{NF}	Leflunomide	Treatment of active rheumatoid arthritis; failure on/intolerance to methotrexate and sulfasalazine. Prescribed by rheumatologist.
ARTHROTEC	Diclofenac / misoprostol	Treatment of arthritis in patients at high risk for ulcers.
AUGMENTIN tablets	Amoxicillin / clavulanate	Failure on first-line antibiotic, as indicated by nature of infection. OK as first-line for animal bites and abscess.
AVANDIA	Rosiglitazone	Treatment of Type II diabetes with HbA1c > 7; recently failed or intolerant to max doses of sulfonylureas/metformin (authorized as add-on tx), or in addition to insulin in patients using >60units daily.
AVANDAMET	Rosiglitazone/ metformin	Treatment of Type II diabetes with HbA1c > 7; recently failed or intolerant to max doses of metformin.
BEXTRA _{NF}	Valdecoxib	Treatment of signs and symptoms of osteoarthritis or rheumatoid arthritis in patients with documented risk of ulcer dz or bleeding disorder. Etodolac and sulindac are Formulary options for those with GI upset/GERD on other NSAIDs.
BIAXIN	Clarithromycin	Failure on first-line antibiotic, as indicated by nature of infection. OK as first-line for MAC and <i>H. Pylori</i> . For <i>H. Pylori</i> , use Prevpac.
CEFZIL	Cefprozil	Failure on first-line antibiotic, as indicated by nature of infection.
CELEBREX _{NF}	Celecoxib	Treatment of signs and symptoms of osteoarthritis or rheumatoid arthritis in patients with documented risk of ulcer dz or bleeding disorder. Etodolac and sulindac are Formulary options for those with GI upset/GERD on other NSAIDs.
CIALIS _{NF}	Tadalafil	Treatment in male patients of documented organic erectile dysfunction. Therapy initiated by a Urologist. Psychogenic causes must be ruled out. Max 6 tablets per month.
CIPRO	Ciprofloxacin	Failure on first-line antibiotic, as indicated by nature of infection. CIPRO "HC" is non-Formulary (see FLOXIN OTIC, CIPRODEX)
CIPRODEX	Ciprofloxacin/ dexamethasone	Treatment of acute otitis media in pediatric patients with tympanostomy tubes; treatment of otitis externa after failure/intolerance to Cortisporin.
COMBIVENT	Ipratropium/	Tx of chronic obstructive pulmonary disease (COPD) as single drug tx (no

BRAND NAME	GENERIC NAME	CRITERIA
	Albuterol	separate rescue medication needed); or compliance issue related to manual dexterity.
COREG _{NF}	Carvedilol	Treatment of mild to severe congestive heart failure (CHF); to reduce cardiac mortality in post-MI patients with left ventricular dysfunction (ejection fraction $\leq 40\%$). For treatment of hypertension, other Formulary beta blockers and other medication classes are available.
DAYPRO	Oxaprozin	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
DDAVP	Desmopressin	Short-term treatment of nocturnal enuresis. Failure of behavioral modification. Max treatment course of 6 months. Also for central diabetes insipidus.
DERMATOP	Prednicarbate	Use in patients with documented treatment failure on non-Prior Auth Formulary medium potency (Group III) steroids (e.g, Kenalog, Synalar, Topicort LP, Westcort).
DETROL _{NF}	Tolterodine	Tx of overactive bladder. Failure/contraindication to oxybutynin. Rx'd by Urologist.
DIFLUCAN	Fluconazole	Treatment of oropharyngeal, esophageal, or other forms of serious candidiasis; also cryptococcal meningitis. Single-dose 150mg tablet is available without prior authorization for vaginal candidiasis.
DIPROLENE	Augmented betamethasone	Failure on lower potency steroids, unless indicated by specific condition.
DITROPAN XL _{NF}	Oxybutynin ER	Treatment of overactive bladder. Failure on regular oxybutynin. Rx'd by Urologist.
DOVONEX	Calcipotriene	Treatment of moderate plaque psoriasis.
DURAGESIC	Fentanyl transdermal	Treatment of severe chronic pain with documented failure on / intolerance to oral formulary long-acting analgesics; documented evaluation/recommendation by pain management specialist or oncology
DURICEF (suspension only)	Cefadroxil	Failure on first-line antibiotic, as indicated by nature of infection.
EFUDEX	Fluoruracil topical	Treatment of Actinic or Solar Keratoses
ELIDEL	Pimecrolimus	Treatment of short-term and intermittent long-term therapy in the treatment of mild to moderate atopic dermatitis in patients > 2 years of age; failure of topical steroids, unless treated area is on face. 30g quantity max for face tx, 60 g for other areas.
ELOCON	Mometasone	Use in patients with documented treatment failure on non-Prior Auth Formulary medium potency (Group III) steroids (e.g, Kenalog, Synalar, Topicort LP, Westcort).
FLOMAX	Tamsulosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure/intolerance Hytrin/Cardura.
FLORONE, -E	Diflorasone Diacetate	Failure on lower potency steroids, unless indicated by specific condition.
FLOXIN	Ofloxacin	Failure on 1st-line antibiotic, as indicated by nature of infection. OK as 1st-line for STDs.
FLOXIN OTIC	Ofloxacin	Chronic suppurative OM with perforated tympanic membrane or acute OM with tympanostomy tubes. For otitis externa patients, Cortisporin is first-line agent.
GEODON	Ziprasidone	Treatment of schizophrenia; <i>*NOTE- In LA, San Bernardino, Riverside, Yolo, and GMC counties, Geodon is billed to Medi-Cal Fee-For-Service for all Medi-Cal members</i>
GLEEVEC	Imatinib msylate	Newly diagnosed adult patients with Philadelphia chromosome positive (Ph+) chronic myeloid leukemia (CML); (CML) in blast crisis, accelerated phase or chronic phase after failure of interferon therapy; treatment of patients with Kit-(CD 117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GISTs); Treatment of pediatric patients with (Ph+) chronic myeloid leukemia (CML) in chronic phase, and for children whose disease has recurred after stem cell transplant or who are resistant to

BRAND NAME	GENERIC NAME	CRITERIA
		interferon alpha therapy.
HALOG, -E	Halcinonide	Use in patients with documented treatment failure on non-Prior Auth Formulary high potency (Group II) steroids (e.g, Lidex, Valisone, Topicort, Diprosone).
HESPERA	Adefovir	Treatment of chronic Hepatitis B in adults with evidence of active viral replication and either evidence of persistent elevations in LFTs or histologically active disease; failure of Epivir HBV
HIV MEDICATIONS	Miscellaneous	Most HIV medications are to be billed to Medi-Cal Fee-For-Service on-line for all Medi-Cal members. This applies to members residing in LA, San Bernadino, Riverside, Yolo, and GMC-Sacramento counties. For all others, medication will be authorized once Molina Medical Case Management is notified of member's condition.
IMITREX Injection, nasal spray	Sumatriptan Succinate	Abortive treatment of migraine attacks. Failure on oral Imitrex. Prophylactic therapy needed in patients with 2 or more attacks per month. Quantity limits - Inject. - 1 kit per month; 20 mg NS - 6 per month.
INSULIN PEN DEVICES _{NF}	All insulins	Insulin Pen Delivery systems to be authorized when member is either blind or disabled. Can not be authorized for convenience purposes.
KEPPRA	Levetiracetam	Treatment of seizures, with therapy initiated by neurology; not approved for psychiatric use.
KYTRIL tablets	Granisetron	Prevention of nausea/vomiting associated with initial and repeat courses of emetogenic chemotherapy, including high dose cisplatin; nausea and vomiting associated with radiation.
LAMICTAL	Lamotrigine	Treatment of seizures, with therapy initiated by neurology; Maintenance treatment of adults with Bipolar Disorder, with therapy managed by psychiatry.
LAMISIL (tablets only)	Terbinafine HCl	Tx of onychomycosis with (+) KOH/PAS stain; member must be experiencing pain that interferes with normal activity, or be diabetic, have peripheral vascular dz, or be immunocompromised; normal baseline LFTs required
LEVAQUIN	Levofloxacin	Failure on first-line antibiotic, as indicated by nature of infection. Dosage for Uncomplicated UTI (with failure to first-line abx) is 250mg QD x 3 Days.
LEVITRA _{NF}	Vardenafil	Treatment in male patients of documented organic erectile dysfunction. Therapy initiated by a Urologist. Psychogenic causes must be ruled out. Max 6 tablets per month.
LODINE XL	Etodolac CR	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
LOPROX	Ciclopirox	Treatment of dermatomycosis; failure on Formulary OTC antifungals.
LOTRISONE	Clotrimazole / betamethasone	Treatment of dermatomycosis; failure on Formulary OTC antifungals or when an additional steroid is required.
LOTRONEX _{NF}	Alosetron	Treatment of women with severe diarrhea-predominant IBS who have chronic symptoms (duration 6 months or more) that are not due to an anatomic or metabolic abnormality, and who have failed to respond to conventional therapy; diagnosis confirmed by GI.
MIGRANAL	Dihydroergotamine Nasal Spray	Acute treatment of migraine with or without aura; failure or intolerance of Formulary agents. Prophylactic therapy needed in patients with 2 or more attacks per month.
NICORETTE GUM (OTC)	Nicotine polacrilex	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in Molina "Free and Clear" program or equivalent. Max #96 pieces/month.
NICOTROL 15mg PATCH (OTC)	Nicotine transdermal	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in Molina "Free and Clear" program or equivalent.
NICOTROL NASAL SPRAY	Nicotine nasal spray	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in Molina "Free and Clear" program or equivalent. Max #4 boxes/month.

BRAND NAME	GENERIC NAME	CRITERIA
NIZORAL	Ketoconazole	<i>Oral</i> - Treatment of systemic fungal infections and severe recalcitrant cutaneous dermatophyte infections not responding to topical therapy or griseofulvin. <i>Topical</i> - Treatment of dermatomycosis; failure on Formulary OTC antifungals. <i>Shampoo</i> - Failure of selenium sulfide.
NON-FORMULARY DRUGS_{NF}	Miscellaneous	Failure on <u>all</u> Formulary drugs within same drug class, unless unique indication exists that is not treatable with those agents or other Formulary alternatives.
NORGESIC, NORGESIC FORTE	Orphenadrine/ASA/Caffeine	Failure of non-Prior Auth Formulary skeletal muscle relaxants (e.g., Flexeril, Soma, Lioresal, Norflex)
NORVASC _{NF}	Amlodipine	Treatment of hypertension, ischemic heart disease, angina (stable and vasospastic), or CHF; failure of Formulary calcium channel blockers (CCBs) that share same indication.
OMNICEF	Cefdinir	Failure on first-line antibiotic, as indicated by nature of infection.
ORUVAIL	Ketoprofen CR	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
OXYCONTIN	Oxycodone CR	Treatment of severe chronic pain with documented failure on other formulary long-acting analgesics; documented evaluation/recommendation by pain management specialist or oncology; Approved only for QD or BID dosing, no prn use
PAXIL	Paroxetine	Treatment of Depression, OCD, Panic Disorder, Social Anxiety. Failure on Prozac (Fluoxetine) required for treatment of depression, panic disorder, or OCD.
PRANDIN	Repaglinide	Treatment of type 2 diabetes, after failure on sulfonylureas and metformin
PREVACID _{NF}	Lansoprazole	Treatment of GERD, Duodenal/Gastric Ulcer, Erosive Esophagitis, Hypersecretory conditions. Failure on all Formulary PPIs. BID dosing allowed only in extreme circumstances. For <i>H. pylori</i> , use Prevpac. Exceptions may be made for children not tolerant to Formulary PPI dosage forms.
PROSOM	Estazolam	Failure on non-Prior Auth Formulary sedatives/hypnotics (e.g, Dalmane, Restoril)
PROTONIX	Pantoprazole	Treatment /maintenance of healing of erosive esophagitis associated with GERD, and treatment of pathological hypersecretory conditions; documented failure (via pharmacy claims history) of OTC Prilosec 2-month trial for Medi-Cal members, H2 blocker trial for Healthy Families members.
PROTOPIC	Tacrolimus	For short-term and intermittent long-term treatment of moderate to severe atopic dermatitis. Must fail topical corticosteroids first, unless affected area is face/neck.
PSORCON	Diflorasone diacetate	Failure on lower potency steroids, unless indicated by specific condition.
REGRANEX _{NF}	Becaplermin	Tx of lower-extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply, in addition to debridement, pressure relief and infection control. Ulcer must be <10cm ² and diabetes must be under control (HgA1c≤10). Must be prescribed by an orthopedic surgeon/podiatrist. Max 15g/month x 5 months.
RELAFEN	Nabumetone	Use in patients with documented treatment failure on at least two generic NSAIDs, each treatment course being at least 2 weeks.
RELENZA _{NF}	Zanamivir	Treatment of influenza within 48 hours of onset. Member must have pre-existing medical condition that would be significantly worsened by influenza. Must be >7 years old.
RESTASIS	Cyclosporine ophthalmic	To increase tear production in patients diagnosed with condition keratoconjunctivitis sicca; Prescribed by ophthalmology
RISPERDAL	Risperidone	Treatment of psychotic disorders; Prescribed by psychiatrist. *NOTE- In LA, San Bernardino, Riverside, Yolo, and GMC counties, Risperdal is billed to Medi-Cal Fee-For-Service for all Medi-Cal members.

BRAND NAME	GENERIC NAME	CRITERIA
SINGULAIR	Montelukast	Moderate to severe asthma; Recent failure on inhaled steroids. Can not be authorized as steroid replacement, must be given concurrently with steroid. For allergies, many other Formulary alternatives are available and should all be tried first, as Singulair has been shown to be no more effective in clinical trials than any Formulary agent.
SONATA	Zaleplon	Short-term treatment of insomnia. Failure/intolerance to Formulary agents including Restoril, Elavil, Dalmane. Quantity limit #14/month, #30/month for special circumstances when prescribed by psychiatrist.
SPIRIVA	Tiotropium	Maintenance treatment of COPD-induced bronchospasm; must be either prescribed or recommended by pulmonary specialist.
SPORANOX	Itraconazole	Tx of onychomycosis with (+) KOH/PAS stain; member must be experiencing pain that interferes with normal activity, or be diabetic, have peripheral vascular dz, or be immunocompromised; normal baseline LFTs required
STADOL NASAL SPRAY	Butorphanol	Treatment of acute pain; failure or intolerance to Formulary narcotics. If used for migraines member must have failed Formulary Triptans and will be on prophylaxis while on Stadol.
STRATTERA (FOR AGES ≥18)	Atomoxetine	Treatment of ADHD, with documented ADHD diagnosis by psychiatry. **QD dosing only. 1 capsule max/day for all strengths except 40mg. 2 capsules max/day for 40mg. No Prior Auth Required for ages <18.
SUPRAX	Cefixime	Failure on first-line antibiotic, as indicated by nature of infection.
TAMIFLU _{NF}	Oseltamivir	Treatment of influenza within 48 hours of onset. Member must have pre-existing medical condition that would be significantly worsened by influenza.
TARCEVA	Erlotinib	Tx of patients with locally advanced or metastatic non-small cell lung cancer as monotherapy after failure of platinum-based chemotherapies; requested by Oncology.
TAZORAC GEL	Tazarotene	Treatment of stable plaque psoriasis. Treatment of cystic acne, prescribed by dermatologist (0.1% only).
TESTODERM PATCH	Testosterone transdermal	Treatment of hypogonadism (primary and secondary). Max #30/month. Must be prescribed by endocrinologist.
TOPAMAX	Topiramate	Treatment of seizures, with therapy initiated by neurology; not approved for psychiatric use.
TRICOR	Fenofibrate	Treatment of hypertriglyceridemia, when patient is at risk of pancreatitis. Failure or intolerance to Lopid.
TRILEPTAL	Oxcarbazepine	Treatment of seizures, with therapy initiated by neurology; not approved for psychiatric use.
ULTRAVATE	Halobetasol	Failure on lower potency steroids, unless indicated by specific condition.
UROXATRAL	Alfuzosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure /intolerance to Hytrin/Cardura.
VFEND	Voriconazole	Treatment of invasive aspergillosis; treatment of serious fungal infections caused by <i>Scedosporium apiospermum</i> or <i>Fusarium sp</i> , in patients intolerant of, or refractory to other therapy.
VIAGRA _{NF}	Sildenafil	Treatment in male patients of documented organic erectile dysfunction. Therapy initiated by a Urologist. Psychogenic causes must be ruled out. Max 6 tablets per month.
WEIGHT LOSS MEDICATIONS _{NF}	Various FDA-approved	After failure on structured weight loss and diet programs, member must have a BMI ≥33 plus two or more of the following risk factors: poorly controlled HTN, diabetes, uncontrolled dyslipidemia, significant cardiac dz (except for Meridia), symptomatic sleep apnea, restrictive lung disease, or DJD/osteoarthritis of the hip and/or knee.
WELLBUTRIN SR	Bupropion	Treatment of depression. Not for smoking cessation (see ZYBAN).
XOPENEX _{NF}	Levalbuterol	PRN "Rescue" treatment of asthma; significant, unexpected cardiac side effects while on regular nebulized albuterol; in clinical trials, Xopenex has not been shown to be more effective than equipotent doses of albuterol on an

BRAND NAME	GENERIC NAME	CRITERIA
		outpatient basis.
ZITHROMAX	Azithromycin	Failure on first-line antibiotic, as indicated by nature of infection. OK as first-line for STDs.
ZELNORM _{NF}	Tegaserod	Short-term treatment of women with irritable bowel syndrome (IBS) whose primary symptom is constipation; diagnosis by GI; history of 6 month failure on conventional treatment; two 4-6 week courses maximum, when approved.
ZOFRAN tabs	Ondansetron	Prevention of nausea/vomiting associated with initial and repeat courses of emetogenic chemotherapy, including cisplatin; prevention of post-operative nausea/vomiting; prevention of nausea/vomiting associated with radiotherapy.
ZOLOFT	Sertraline	Treatment of depression, panic disorder, OCD, PTSD. Failure on Prozac (Fluoxetine) required for treatment of depression, panic disorder, or OCD. 50mg daily dose approved as 100mg ½ tab
ZYBAN	Bupropion SR	For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in Molina “Free and Clear” program or equivalent.
ZYMAR	Gatifloxacin	Treatment of bacterial keratitis, endophthalmitis, or prophylaxis for ocular surgeries; prescribed by ophthalmologist.
ZYPREXA	Olanzapine	Treatment of psychotic disorders and bipolar mania; Prescribed by psychiatrist. <i>*NOTE- In LA, San Bernardino, Riverside, Yolo, and GMC counties, pharmacy is to bill Medi-Cal Fee-For-Service on-line for all Medi-Cal members..</i>
ZYRTEC, -D	Cetirizine, Cetirizine/Pse	Treatment of allergic rhinitis/urticaria; Failure of OTC antihistamines (Including Claritin and Nolahist), Semprex-D, and nasal steroids. Not for use in combination with nasal steroids (combo no more effective than single agent)

To request a copy of a prior authorization request form, or to request full-length criteria for a medication listed above (if applicable), call (888) 669-4322.

OVER THE COUNTER (OTC) DRUG LIST

Over-the-counter (OTC) medications are a covered benefit with no out-of-pocket expense to members when prescription is written by a provider. The following is a list of covered OTC medications. Please consider these OTC medications as First Line Therapy when treating your patients. Please remember that generic medications will be dispensed when available.

Category	Generic Name	Brand Name
1. Anti-Acne Medications	Benzoyl peroxide lotion 5%, 10%	
2. Antibiotics and Antibiotic Combinations	Bacitracin ointment Attapulgit	Parapectolin/Kaopectate Pepto Bismol
3. Antidiarrheal Preparations	Bismuth Subsalicylate	Mycelex-G, Gyne-Lotrimin,
4. Antidiarrheal Preparations	Clotrimazole	Lotrimin, Mycelex
5. Antifungal-Vaginal Anti-infective		Benedryl
6. Antihistamines	Diphenhydramine 25mg Loratadine & Loratadine Pseudoephedrine	Claritin & Claritin-D Nolahist
7. Antihistamines Single-Entity Products	Phenindamine	Chlor-Trimeton
8. Antihistamines Single-Entity Products	Chlorpheniramine	Robitussin
9. Antitussives & Expectorants	Guaifenesin	Robitussin DM
10. Antitussives & Expectorants	Guaifenesin/Dextromethorphan	Sudafed Tabs, Syrup
11. Decongestant Products	Pseudoephedrine Loratidine	Claritin-OTC (PA Required) Colace
12. Digestants/Stool Softeners	Docusate sodium	Matamucil
13. Digestants/Stool Softeners	Psyllium	Dulcolax
14. Digestants/Stool Softeners	Bisacodyl	True Trade
15. Insulins/supplies	Glucose Test Strips	
16. Insulins/Supplies	Insulin Syringes, Lancets	
17. Miscellaneous	Condoms (max 12)	
18. Miscellaneous	Spermicidal Jelly/foam	
19. Miscellaneous	Vaporizer	Nasal Crom
20. Miscellaneous Nasal Products	Cromolyn-nasal inhaler	Debrox
21. Miscellaneous OTIC Products	Carbamide peroxide 6.5%	Aspirin
22. Non-Narcotic Analgesic	Aspirin-Tabs, enteric coated Tabs	Tylenol
23. Non-Narcotic Analgesic	Acetaminophen	Motrin
24. Non-Steroidal Anti-Inflammatory Drugs	Ibuprofen	Os-Cal, Tums
25. Nutritional Products-Other	Calcium Carbonate	Fergon
26. Nutritional Products-Other	Ferrous Gluconate	Feosol Tabs, solution
27. Nutritional Products-Other	Ferrous Sulfate	Pedialyte solution
28. Nutritional Products-Other	Ped. Electrolyte Solution	Maalox/Maalox TC
29. Other Anti-Ulcer Products, Antacids	Antacid Liquid	Mylanta/Mylanta II
30. Other Anti-Ulcer Products, Antacids	Antacid Liquid	Mylicon
31. Other Anti-Ulcer Products, Antacids	Simethicone	Nicorette Gum
32. Other CNS Drugs	Nicotine Gum	Nicotrol Patch
33. Other CNS Drugs	Nicotine Transdermal	Naldecon DX Children's syrup drops
34. Pediatric Cough/Cold Products	PPA/guaifenesin/dextromethorphan	Naldecon Pediatric Syrup, Ped
35. Pediatric Cough/Cold Products	PPA/phenyleph/chorphen/phenyltolox	Pedia-Care Cough Cold Liquid
36. Pediatric Cough/Cold Products	Pseudochlorphen/dextromethorphan	Dimetapp Tabs, Elixir
37. Respiratory medications-Combination	Bromphen/Decongestant	Contact-12 Hour Caps
38. Respiratory Medications-Combination	Chlortimeton/Decongestant	Actifed Tabs, Syrup
39. Respiratory Medications-Combination	Tripolidine/Pseudophedrine	NIX
40. Scabicides/Pediculocides	Permethrin	RID, A-200
41. Scabicides/Pediculocides	Pyrethens combo	Tinactin
42. Topical Anti-Fungal	Tolnaftate cream	
43. Topical Anti-infective	Polysporin ointment	
44. Topical Anti-infective	Triple Antibiotic Ointment	Pepcid AC
45. Ulcer Therapy-H2 Antagonists	Famotidine	Prilosec OTC
46. Ulcer Therapy-PPI	Omeprazole	

Member After Hours Pharmacy Services

POLICY

After normal business hours, which is defined as after the close of MHM Pharmacy Department (Monday-Friday), 8:00AM-6:00PM EST, network pharmacies are to contact the Rx America Help Desk at (800) 770-8014 to obtain an override code to fill an emergency three day (72 hour) supply of medication, which “when not given may cause the member’s condition to worsen”.

PURPOSE

This policy establishes the infrastructure and procedures for plan members to obtain medications on an emergency basis and on a 24-hour/day/7day/week basis.

SCOPE

This policy applies to Rx America contracted pharmacy providers dispensing medications to MHM members after MHM’s normal business hours.

PROCEDURE

1. After normal business hours as defined in the POLICY statement, Rx America / MHM contracted pharmacy providers are required to exercise professional judgment in the dispensing of medications to members requiring after hours pharmacy services.
2. Members have the ability to obtain prescription drugs on a 24-hour/day/7 day/week basis.
3. Pharmacists are instructed to contact the Rx America Help Desk at (800) 770-8014 to obtain an override code. This will assure the timely adjudication of prescription claims.
4. Members, pharmacists or medical providers requiring medication assistance after normal business hours should call (888) 898-7969. The answering service will refer callers to Rx America for assistance.

CREDENTIALING

Based on standards set forth by the National Committee for Quality Assurance (NCQA) all Providers listed in literature for Molina Healthcare of Michigan, Inc. (MHM) will be credentialed.

All designated practitioners, including physicians (DO's and MD's), podiatrists (DPM's), dentists (DMD's), and chiropractors (DC's), as well as mid-level professionals such as Physician Assistants (PA's), Nurse Practitioners (NP's), and Certified Nurse Midwives (CNM's) will have their credentials reviewed in a manner that is non-discriminatory, objective and uniform. This will assure that care is rendered to MHM members by qualified practitioners. This also includes behavioral health practitioners, such as Psychologists, Psychiatrists, Social Workers and Counselors who are credentialed by CompCare, an NCQA accredited Managed Behavioral Health Organization delegate.

MHM will credential designated Practitioners prior to granting Provider status. All mid-level professionals, as defined above, must be credentialed prior to allowing them to provide services to MHM members. The plan requires initial credentialing of all practitioners and mid-level professionals who seek reinstatement after having a break in service beyond 30 calendar days.

MHM does not make credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients the practitioner discipline of care.

Who Should Be Credentialed

Credentialing standards must apply to all licensed independent practitioners or groups of practitioners who provide care for MHM's members. NCQA standards do not address the types of practitioners with whom MHM may contract.

Practitioners who must be credentialed

NCQA required MHM to credential the following types of practitioners:

- Practitioners who have an independent relationship with the organization. An independent relationship exists when the organization selects and directs its members to see a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities.
- Practitioners who are hospital based, but see MHM's members as a result of their independent relationship with the organization.
- Dentists who provide primary dental care only under a dental plan rider.
- Pharmacists who work for a pharmacy benefit manager (PBM) to which the organization delegates utilization management.
- Covering practitioners (e.g. locum tenens)
- Practitioners who do not provide care for members in a treatment setting (e.g. board certified consultants)

Documents Required For Credentialing

MHM must verify that the following elements are present and within the prescribed time limits:

- A valid Drug Enforcement Agency (DEA) certificate
- Verification of education
- Verification of training
- If a provider states on the application that he or she is Board Certified, verification of board certification.
- Verification of work history
- A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioners
- Verification of license

Credentialing Application

The applicant will have the responsibility of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and ability to provide services without limitations including physical and mental health status as allowed by law, and the responsibility of resolving any doubts about these or any of the other basic qualifications required by MHM.

Network Development sends an unsigned contract and an application packet to each requesting practitioner, mid-level professional, and/or IPS/medical group with whom MHM has chosen to pursue a business relationship.

The application packet will contain the application form, release and consent forms and instructions for completing and submitting credentialing information to MHM. Although the applicant's contracted medical group or IPA may return the completed application to the Credentialing Coordinator, the applicant is responsible for completing all of the information and providing the supporting documentation. The contract is fully executed once the applicant has completed the Peer Review/Credentialing Review process.

Application Form

The applicant shall complete the Application (see attachment A at the end of this section). Each application for MHM Provider or mid-level professional status shall provide current information, be submitted on the written application form prescribed by the Governing Board and be signed by the applicant. The application shall request at least the following:

- A current, valid Michigan license or certificate to practice his/her profession, including a copy of such license or certificate.
- A current, valid DEA certificate, including a copy of such certificate, as applicable.
- Documentation of professional liability insurance at a minimum amount of \$100,000 per occurrence and \$300,000 aggregate coverage appropriate to the medical practice under contractual consideration. This coverage shall extend to MHM members and the applicant's activities on MHM's behalf. The name of the insurance carrier and date of expiration must be included.
- A list of all malpractice actions for at least the last ten (10) years, with explanations of the actions and current status.
- Education.
- Board Certification status, if applicable.
- Educational background, including professional school, graduation date and degree.

The credentialing process will be completed with 60 working days of application submission unless extenuating circumstances exist (i.e. Verification of education is delayed), assuming the information submitted by the applicant is determined by the Peer Review/Credentialing Committee to be sufficient to make a determination of the mid-level professional's qualifications or current competence. If any time sensitive application information and/or verification, as defined by current NCQA guidelines, becomes over one hundred and eighty (180) calendar days old prior to a final decision by the Peer Review/Credentialing Committee regarding the applicant, updated information must be obtained and included in the review of the application.

Credentialing Site Visits

As part of the credentialing process, MHM must assess the quality, safety and accessibility of the office sites where care is delivered. In addition MHM sets standards for medical/treatment record practice. MHM contracts with Medical Site Reviewers (MSR) to conduct office site visits.

1. A standard site visit survey form that is completed at the time of the site visit (See attachment B at the end of this section)
2. A set of criteria for the office review, which include an assessment of:
 - Physical accessibility
 - Physical appearance
 - Adequacy of waiting and exam room space
 - Availability of appointments
 - Adequacy of medical/treatment record keeping
 - Standards and thresholds for acceptable performance

Practitioner office sites must pass with an 80% in order to be considered to enter the MHM network.

Practitioner Appeal Rights

Procedural rights provided to Molina Healthcare of Michigan, Inc's (MHM) practitioners when an action or recommendation of a MHM Quality Improvement Committee, Peer Review/Credentialing Committee or the Board will, if it becomes a final action, result in a report to the Michigan State Board of Medicine. This applies to practitioners with MHM active status as well as those who are applicants for MHM.

Grounds for a Hearing

Grounds for a Hearing exist whenever the MHM Quality Improvement Committee or Peer Review/Credentialing Committee take or recommend any of the following Adverse Actions:

- Denial of initial application for MHM Provider status;
- Revocation or termination of, or expulsion from MHM participation;
- Reduction or revocation of authority to provide care to MHM patients;
- Suspension or restriction of authority to provide care to MHM patients for a cumulative period of more than thirty (30) days in any twelve (12) month period;
- Summary suspension of authority to provide care to MHM patients for more than fourteen (14) consecutive days.

Notice of Action

If the MHM Quality Improvement Committee or Peer Review/Credentialing Committee has recommended an Adverse Action as defined above, the Committee taking or recommending the adverse action shall give written notice to the Provider by certified mail with appropriate return receipt. This notice shall:

- Describe the nature of the proposed action or recommendation; and
- State that the proposed action or recommendation, if adopted, must be reported to the National Practitioners Data Bank; and the State Licensing Board within fifteen (15) days from the date the adverse action is taken.
- Advise the Provider that he/she has the right to request a Hearing on the proposed action or recommendation; and
- Inform the Provider that any request for Hearing must be made in writing within thirty (30) days following receipt of the Notice of Action and must be sent to the Medical Director; and
- Contain a summary of the Provider's hearing rights.

Request for a Hearing

If the Provider has not requested a Hearing within the time and manner described above, the Provider shall be deemed to have accepted the action or recommendation, and such action or recommendation shall become the MHM Quality Improvement Committee's or Peer Review/Credentialing Committee's final action or recommendation, which shall be forwarded to the Board for their information. In the event that a timely written request for a Hearing is received, a Hearing Panel shall be appointed and the practitioner shall be provided a Notice of Hearing and Statement of Charges consistent with this policy.

PRIMARY CARE PROVIDER RESPONSIBILITIES

Access to Care Standards

A Primary Care Provider (PCP) may be any of the following type of provider: family or general practice, internal medicine, OB/Gyn, pediatric, physician assistant and/or nurse practitioner.

A PCP must be accessible 24 hours a day, seven days a week, either personally or through coverage arrangements with a designated contracted primary care physician.

The PCP must make every effort to schedule members for appointments using the following recommendations:

1. Office Hours. Primary Care Providers must be available at least 20 hours per week. The PCP must provide staffing patterns, which are adequate for caseload, inclusive of healthcare support staff, paraprofessionals, and other healthcare professionals.
2. Emergent Appointments. Emergencies must be handled immediately or the member be referred to a hospital emergency room.
3. Urgent Appointments. Urgent appointments scheduled on the same day or referred to urgent care facility.
4. Routine Appointments. Routine appointments scheduled within seven (7) to ten (10) days.
5. Health Assessment. Well examination and physical scheduled within four (4) to six (6) weeks after the initial request.
6. After-Hours Care. Primary Care Providers must provide member access and availability to physician services, 24 hours per day, seven days a week. Members can access medical services after-hours by calling (888) 898-7969.

Provider Change Notification Requirements

Providers must notify Molina Healthcare in writing at least **60 days** in advance when possible of changes in physician staffing, after hours and/or vacation coverage, practice location changes, billing address and tax ID changes.

Facility Staffing Standards

The Facility Staffing Standards are divided into the following types of Primary Care Centers:

1. **Multi-specialty Centers** – consist of Internists, Family/General Practitioners and Pediatricians all on-site at the same location. In addition, Multi-Specialty Centers should have a referral OB/Gyn physician.
2. **Family Practice Centers** – consist of two (2) Family Practitioners or two (2) General Practitioners or one of each. In addition, Family Practice Centers should have a referral OB/GYN and referral Pediatrician.
3. **Multi-Specialty Multi-Location Centers** – consist of Internists, General/Family Practitioners and Pediatricians located in different locations within 20 minutes from each other.

Realizing that different staffing may be necessary based upon the number of members being serviced; Molina Healthcare of Michigan, Inc. (MHM) has established standards for large and small centers. The standards, therefore, change based upon the following numbers of members.

- 0 – 349 Members
- 350 – 999 Members
- 1000 – 1999 Members
- 2000 – 3999 Members
- 4000+ Members

Primary Care Provider Services

1. Multi-Specialty Centers

Less than 349 Members

One Internist, Family Practitioner, Or General Practitioner on site	4 days/week 20 hours/week 2 hours/day minimum
One Referral OB/Gyn Within 30 minutes travel time	3 days/week 20 hours/week
One Pediatrician on site Access to private office on alternate days	3 days/week 20 hours/week 2 hours/day minimum

350 – 999 Members

One Internist, Family Practitioner, Or General Practitioner on site	4 days/week 20 hours/week 2 hours/day minimum
One Pediatrician on site Access to private office on alternate days	3 days/week 20 hours/week 2 hours/day minimum

1000 – 1999 Members

Two Internists, Family Practitioners Or General Practitioners on site	4 days/week 22 hours/week 4 hours/day minimum
One Pediatrician on site Access to private office on alternate days	5 days/week 22 hours/week 4 hours/day minimum

2000 – 3999 Members*

Three Internists, Family Practitioners, Or General Practitioners on site	4.5 days/week 30 hours/week 6 hours/day minimum
Two Pediatricians on site Access to private office on alternate days	4 days/week 22 hours/week 4 hours/day minimum

****Note: MHM will review and determine annually the Facility Standards for those centers with memberships over 4,000.***

Primary Care Provider Services

2. Family Practice Centers

Less than 349 Members

One Family Practitioner, General Practitioner, or Internist on site	4 days/week 20 hours/week 2 hours/day minimum
One Referral OB/GYN* within 30 minutes travel Time from other specialties	3 days/week 20 hours/week
One Referral Pediatrician* within 30 minutes Travel time from other specialties	3 days/week 20 hours/week

350 – 999 Members

One Family Practitioner, General Practitioner, or Internist on site	4 days/week 20 hours/week 2 hours/day minimum
One Family Practitioner, General Practitioner, or Internist on site	4 days/week 20 hours/week 2 hours/day minimum
One Referral OB/GYN* within 30 minutes travel Time from other specialties	3 days/week 20 hours/week
One Referral Pediatrician* within 30 minutes Travel time from other specialties	3 days/week 20 hours/week

1000 – 1999 Members

One Family Practitioner, General Practitioner or Internist on site	4 days/week 22 hours/week 2 hours/day minimum
One Family Practitioner, General Practitioner or Internist on site	4 days/week 22 hours/week 2 hours/day minimum
One Referral OB/GYN* within 30 minutes travel Time from other specialties	5 days/week 22 hours/week
One Referral Pediatrician* with 30 minutes Travel time from other specialties	5 days/week 22 hours/week

Primary Care Provider Services

2000 – 3999 Members **

One Family Practitioner, General, Practitioner or Internist on site	4.5 days/week 30 hours/week 6 hours/day minimum
One Family Practitioner, General Practitioner or Internist on Site	4.5 days/week 30 hours/week 6 hours/day minimum
One Family Practitioner, General Practitioner or Internist on Site	4.5 days/week 22 hours/week 6 hours/day minimum
Two Referral OB/Gyn's* within 30 minutes Travel time from other specialties	4.5 days/week 30 hours/week
Two Referral Pediatricians* within 30 minutes Travel time from other specialties	4 days/week 22 hours/week

****NOTE: OB/Gyn is a self referral provider and Pediatrician will sign referral Agreement and be listed as a referral of the Center. However, the Family Practitioner, General Practitioner or Internist will be the “gatekeeper” and will evaluate whether the patient should be seen by a Pediatrician.***

*****NOTE: MHM will review and determine annually the Facility Standards for those centers with memberships over 4,000.***

Primary Care Provider Services

3. MULTI-LOCATION CENTERS

Less than 349 Members

One Internist, Family Practitioner, Or General Practitioner on site	4 days/week 20 hours/week 2 hours/day minimum
One OB/GYN within 30 minutes travel Time from other specialties	3 days/week 20 hours/week 2 hours/day minimum
One Pediatrician within 30 minutes Travel from other specialties	3 days/week 20 hours/week 2 hours/days minimum

350- 999 Members

Two Internists, Family Practitioners, Or General Practitioners on site	4 days/week 20 hours/week 2 hours/day minimum
One OB/GYN within 30 minutes travel Time from other specialties	3 days/week 20 hours/week 2 hours/day minimum
One Pediatrician with 30 minutes Travel time from other specialties	3 days/week 20 hours/week 2 hours/day minimum

1000 - 1999 Members

Two Internists, Family Practitioners, Or General Practitioners on site	4 days/week 22 hours/week 4 hours/day minimum
One OB/GYN within 30 minutes travel Time from other specialties	5 days/week 22 hours/week 4 hours/day minimum
One Pediatrician within 30 minutes Travel time from other specialties	5 days/week 22 hours/week 4 hours/day minimum

Primary Care Provider Services

2000 - 3999 Members

Three Internists, Family Practitioners.	4.5 days/week 6 hours/day minimum
Two OB/GYN's within 30 minutes travel time From other specialties	4.5 days/week 30 hours/week 4 hours/day minimum
Two Pediatricians within 30 minutes travel Time from other specialties	4 days/week 22 hours/week 4 hours/day minimum

****NOTE: MHM will review and determine annually the Facility Standards for those centers with membership over 4,000.***

****NOTE: OB/GYN and Pediatrician can be a self referral provider and will sign a Specialist Agreement and be listed as a referral of the Center. However, the Family Practitioner, General Practitioner or Internist will be the "gatekeeper" and will evaluate whether the patient should be seen by the Pediatrician.***

MHM reserves the right to modify staffing after review of Member Complaints, Member Satisfaction Survey, Utilization Reports, Member Transfers, and can make adjustments to these staffing standards.

COMPLIANCE

Molina Healthcare of Michigan ("Molina") seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members, and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

Definitions:

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR §455.2)

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Federal False Claims Act, 31 USC Section 3279

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Health care fraud is:

Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

Examples of Fraud and Abuse

By a Member	By a Provider
Lending an ID card to someone who is not entitled to it.	Billing for services, procedures and/or supplies that have not been actually been rendered.
Altering the quantity or number of refills on a prescription.	Providing services to patients that are not medically necessary.
Making false statements to receive medical or pharmacy services.	Balancing Billing a Medicaid member for Medicaid covered services.
Using someone else’s insurance card.	Double billing or improper coding of medical claims.
Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits.	Intentional misrepresentation of manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, “unbundling” of procedures, non-covered treatments to receive payment , “upcoding”, and billing for services not provided.
Pretending to be someone else to receive services.	Concealing patients misuse of Molina Health card.
Falsifying claims.	Failure to report a patient’s forgery/alteration of a prescription.

Other Provider Crimes

- Knowingly and willfully solicits or receives payment of kickbacks or bribes in exchange for the referral of Medicare or Medicaid patients.
- A physician knowingly and willfully referring Medicare or Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)
- Balance billing – asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider’s usual and customary fees.

Preventing Fraud and Abuse

Healthcare fraud is rising higher and higher every year. Molina and other State and Federal agencies are working together to help prevent fraud. Here are a few helpful tips on how you can help prevent healthcare fraud and abuse:

- Do not give you Molina ID card or number to anyone except your doctor, clinic, hospital or other healthcare provider.
- Do not let anyone borrow your Molina ID card.
- Never lend your social security card to anyone.
- When you get a prescription make sure the number of the pills in the bottle matches the number on the label.
- Never change or add information on a prescription.
- If your Molina ID card is lost or stolen, report it to Molina immediately.

Reporting Fraud and Abuse

You may report suspected cases of fraud and abuse to Molina's Compliance Officer. You have the right to report your concerns anonymously to Molina or the Michigan Department of Community Health Program Investigation Section. When reporting an issue, please provide as much information as possible. The more information provided the better the chance the situation will be successfully reviewed and resolved. Remember to include the following information when reporting suspected fraud or abuse:

- Nature of complaint
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

You may report suspected fraud and abuse to Molina through one of the following:

TELEPHONE

Call the Toll-Free number of the Molina Healthcare of Michigan, Compliance
Hotline: **(877) 372-5361**

FAX (248) 925-1780

E-MAIL

Molina Healthcare of Michigan Compliance:
MHMCompliance@MolinaHealthcare.com

REGULAR MAIL

Write (marked confidential) to:
Compliance Officer
100 W. Big Beaver Road
Suite 600
Troy, MI 48084

You may report suspected fraud and abuse to the Michigan Department of Community Health Program Investigation Section by calling (866) 428-0005 or sending a memo or letter to:

Program Investigation Section
Michigan Department of Community Health
Capitol Commons Center
400 S. Pine Street, 6th Floor
Lansing, MI 48909

SECTION 27: HIPAA REQUIREMENTS AND INFORMATION

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI).

Provider/Practitioner Responsibilities

Molina Healthcare expects that its contracted Providers/Practitioners will respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Applicable Laws

Providers/Practitioners must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers/Practitioners must comply with. In general, most Michigan healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
 - HIPAA
 - Medicare and Medicaid laws
2. Michigan Medical Privacy Laws and Regulations

Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/Practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the Provider/Practitioner's own TPO activities, but also for the TPO of another covered entity.¹ Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that

includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of “services.”²

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality improvement;
- Disease management;
- Case management and care coordination;
- Training Programs; or
- Accreditation, licensing, and credentialing

Importantly, this allows Providers/Practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare Providers/Practitioners must allow patients to exercise any of the below-listed rights that apply to the Provider/Practitioner’s practice:

1. *Notice of Privacy Practices*

Providers/Practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient’s privacy rights and the process the patient should follow to exercise those rights. The Provider/Practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

¹ See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.

² See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

2. *Requests for Restrictions on Uses and Disclosures of PHI*

Patients may request that a healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

3. *Requests for Confidential Communications*

Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

4. *Requests for Patient Access to PHI*

Patients have a right to access their own PHI within a Provider/Practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider/Practitioner includes both the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

5. *Request to Amend PHI*

Patients have a right to request that the Provider/Practitioner amend information in their designated record set.

6. *Request Accounting of PHI Disclosures*

Patients may request an accounting of disclosures of PHI made by the Provider/Practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity—such as health insurance information—without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers/Practitioners are encouraged to submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at www.molinahealthcare.com for additional information.

National Provider Identifier

Provider/Practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider/Practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider/Practitioner. The Provider/Practitioner must report its NPI and any subparts to Molina Healthcare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina Healthcare within 30 days of the change. Provider/Practitioners must use its NPI to identify itself on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers/Practitioners

Providers/Practitioners that are delegated for claims and utilization management activities are the “business associates” of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers/Practitioners must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.

**MOLINA HEALTHCARE OF MICHIGAN, INC.
AUTHORIZATION FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Name of Member: _____

Date of Birth: _____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

2. Name of persons/organizations authorized to receive the protected health information:

3. Specific description of protected health information that may be used/disclosed:

4. The protected health information will be used/disclosed for the following purpose(s):

5. Will the person/organization authorized to use/disclose the protected health information receive compensation for doing so?
Yes ____ No ____

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:

- a) action has been taken in reliance on this authorization; or
- b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

11. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.

13. This authorization expires on/upon: _____ .

Signature of Member or Member's Personal Representative

Date

Printed Name of Member's Personal Representative, if applicable

Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare

Deficit Reduction Act (DRA)

On February 8, 2006, President Bush signed into law the Deficit Reduction Act (“DRA”). The law, which became effective on January 1, 2007 aims to cut fraud, waste and abuse from the Medicare and Medicaid programs over the next five years.

Health care entities like Molina who receive or pay out at least \$5 million in Medicaid funds per year must comply with DRA. As a contractor doing business with Molina, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protected rights as whistleblowers.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it;
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use;
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program;
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer’s inappropriate actions.

Compliance

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare of Michigan will take steps to monitor Molina contracted providers to ensure compliance with the law.

For more information on this legislation, please contact your Molina Healthcare of Michigan Provider Services Representative at 1-866-449-6828.