



## 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](http://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 Advise 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](http://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](http://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](http://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](http://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 Molina Healthcare 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.
- 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.