



Practitioner Credentialing Rights: What You Need to Know

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

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

- Strict confidentiality of all information submitted during the credentialing process;
- Nondiscrimination during the credentialing process;
- Be notified of information obtained during the credentialing process that varies substantially from what is submitted by you;
- Review information submitted to support your credentialing application, with the exception of references, recommendations or other peer-review protected information;
- Correct erroneous information;
- Be informed of the status of your application upon request by calling Provider Services at 1-800-642-4168;
- Receive notification of the credentialing decision within 60 days of the committee decision;
- Receive notification of your rights as a provider to appeal an adverse decision made by the committee; and,
- Be informed of the above rights.

For further details on all your rights as a Molina Healthcare provider, please review your Provider Manual on our website at www.MolinaHealthcare.com, or call your Provider Services Representative for more details.

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Features at www.MolinaHealthcare.com:

- Clinical practice and preventive guidelines
- Disease management programs for asthma, diabetes and pregnancy
- Quality improvement programs
- Member rights and responsibilities
- Privacy notices
- Claims and denials decision information
- Provider manual
- UM affirmative statement (non incentive for under utilization)
- How to obtain copies of UM criteria

Molina Healthcare of Ohio

Please contact Molina Provider Services for written copies of all information on the website or if you need more information please call Provider Services at 1-800-642-4168.

Molina Healthcare's Utilization Management

One of the goals of Molina Healthcare's Utilization Management (UM) program is to render appropriate UM decisions that are consistent with objective clinical evidence. To achieve that goal, Molina Healthcare maintains the following guidelines:

- Medical information received by our providers is evaluated by our highly trained UM staff against nationally recognized objective and evidence-based criteria. We also take individual circumstances and the local delivery system into account when determining the medical appropriateness of requested health care services.
- Molina Healthcare's clinical criteria includes McKesson InterQual® criteria, Hayes Directory, Medicare National and Local Coverage Determinations, applicable Medicaid Guidelines, Molina Medical Coverage Guidance Documents (developed by designated Corporate Medical Affairs staff in conjunction with Molina Healthcare physicians serving on the Medical Coverage Guidance Committee) and when appropriate, third party (outside) board-certified physician reviewers.
- Molina Healthcare ensures that all criteria used for UM decision-making are available to practitioners upon request. **To obtain a copy of the UM criteria used in the decision-making process, call our UM department at 1-800-642-4168.**
- As the requesting practitioner, you will receive written notification of all UM denial decisions. The notification will include the name and telephone number of the Molina Healthcare physician who made the decision. Please feel free to call him or her to discuss the case. If you need assistance contacting a medical reviewer about a case please call the UM Department at **1-800-642-4168.**

It is important to remember that:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.

2. Molina Healthcare does not reward practitioners or other individuals for denying care.
3. UM decision makers do not receive incentives to encourage decisions that result in underutilization.
4. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
5. Some of the most common reasons for a delay or denial of a request include:
 - Insufficient or missing clinical information to provide the basis for the making the decision,
 - Lack of or missing progress notes or illegible documentation, and/or
 - Requesting an urgent review when there is no medical urgency.

Molina Healthcare's UM Department staff is available during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff, please call **1-800-642-4168**. You may also fax a question to **1-866-449-6843**. The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials.

Molina Healthcare's regular business hours are Monday through Friday (excluding holidays) 8:00 a.m. to 5:00 p.m. Voice messages and faxes received after regular business hours will be returned the following business day.



Complex Case Management

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

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

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

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

If you would like to learn more about this program, speak with a Complex Case Manager and/or refer a patient for an evaluation for this program, please call 1-800-642-4168.



Featured at www.MolinaHealthcare.com:

- Clinical Practice and Preventive Health Guidelines
- Disease Management Programs for Asthma, Diabetes, Hypertension, CAD, CHF & Pregnancy
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Provider Manual
- Information on the Coverage of Prescription Drugs
- Pharmaceutical Management Procedures
- UM Affirmative Statement (re: non-incentive for under-utilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff & Medical Reviewer

PATIENT SAFETY

Patient Safety activities include appropriate safety projects and error avoidance for Molina Healthcare members in collaboration with their primary care providers.

Safe Clinical Practice

The Molina Healthcare Patient Safety activities include the following:

- Member education regarding taking an active role in their own care to reduce the risk of errors.
- Member education about safe medication practices.
- Provider education regarding safe office practices.
- Improving continuity and coordination of care between providers to promote timely sharing of information and avoid miscommunication.
- Investigation and resolution of all potential provider safety issues.

Molina also monitors nationally recognized quality index ratings for facilities from:

Leap Frog Quality Index Ratings (www.leapfroggroup.org)
The Joint Commission Quality Check*
(www.qualitycheck.org)

Providers can also access the following links for additional information on patient safety:

The Leap Frog Group (www.leapfroggroup.org)
The Joint Commission (www.jointcommission.org)



Nurse Advice Line

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

Nurse Advice Line: **1-888-275-8750 (English)**
1-866-648-3537 (Spanish)
1-866-735-2929 (TTY)

Care for Older Adults

Many adults over the age of 65 have co-morbidities which often affect his or her quality of life. As this population ages, it's not uncommon to see decreased physical function and cognitive ability, and increase in pain. Regular assessment of these additional health aspects can help to ensure this population's needs are appropriately met.

- **Advance care planning** – Discussion regarding treatment preferences, such as advance directives should start early before patient is seriously ill.
- **Medication review** – All medications that the patient is taking should be reviewed, including prescription and over the counter medications or herbal therapies.
- **Functional status assessment** – This can include assessments, such as functional independence or loss of independent performance.
- **Pain screening** - A screening including the notation of the presence or absence of pain.

Including these components into your standard well care practice for older adults can help to identify ailments that can often go unrecognized and increase his or her quality of life.



Behavioral Health

Primary care providers provide outpatient behavioral health services, within the scope of their practice, and are responsible for coordinating members' physical and behavioral health care, including making referrals to Behavioral Health providers when necessary. If you need assistance with the referral process for Behavioral Health services, please contact Provider Services at 1-800-642-4168.

Member Rights and Responsibilities

Molina Healthcare wants to inform its providers about some of the rights and responsibilities of Molina Healthcare members.



Molina Healthcare members have the right to:

- Receive the facts about Molina Healthcare, our services, and providers who contract with us to provide services.
- Have privacy and be treated with respect and dignity.
- Participate in decisions about their health care. They may refuse treatment.
- Openly discuss their treatment options in a way they understand. It does not matter what the cost or benefit coverage.
- Voice any complaints or appeals about Molina Healthcare or the care they were given.
- Suggest changes to this policy.
- Request and receive a copy of their medical records or request an amendment or correction.
- Exercise their member rights without fear of intimidation.

Molina Healthcare members have the responsibility to:

- Give, if possible, all facts that Molina Healthcare and providers need to know in order to provide care.
- Follow the plan and instructions for care they agree to with their provider.
- Know their health problems and take part in making agreed upon treatment goals as much as possible.
- Keep appointments and be on time. If members are going to be late or cannot keep an appointment, they are instructed to call their provider.

You can find the complete Molina Healthcare Member Rights and Responsibilities statement on our website (www.MolinaHealthcare.com). Written copies and more information can be obtained by contacting the Provider Services Department at 1-800-642-4168.

Disease Management Programs Improve Member Health

Molina Healthcare offers focused disease management programs that can significantly influence the health of our members and provide a variety of helpful services for those with chronic conditions such as asthma and diabetes.

Molina Healthcare offers the following disease management programs to our members:

- **breathe with easesm** - asthma program for children and adults ages 2 years and older.
- **Healthy Living with Diabetessm** - diabetes program for adults age 18 years and older.
- **Heart Healthy Living** - cardiovascular program for members 18 years and older who have one or more of these conditions: coronary artery disease, congestive heart failure or high blood pressure.
- **Healthy Living with COPD** - COPD program for members 21 years and older who have emphysema and chronic bronchitis.

All disease management program interventions are targeted to the specific needs of each member. Members may be automatically enrolled based on medical claims, or referred by either their provider or self-referred. Program materials include condition specific pamphlets

and brochures, workbooks, patient logs, action plans, newsletters and other tools that educate the patient on how to manage their condition. In addition, nurses or health educators reach out to patients and provide case management to those who will benefit the most from more frequent, in-depth follow-up. Physicians receive results of their patient's self assessments and updates describing interventions and education offered to members. In addition, practitioners receive notifications and patient profiles on all members enrolled in any of the disease management program.

At each point of contact, members are encouraged to discuss their care with their provider and follow their plan of treatment. Other services available to members include having access to the 24-hour Nurse Advice Line. Members can call and speak to a nurse for advice on any health issues. The disease management programs are voluntary and members can stop participating at any time. If you have a Molina Healthcare patient you think will benefit from receiving educational materials or talking with a Case Manager, please refer them to our disease management programs by calling our Member Services Department at 1-800-642-4168.

You can find more information about our programs on the Molina Healthcare website at www.MolinaHealthcare.com



Quality Improvement Program

The Molina Healthcare Quality Improvement Program (QIP) provides the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement in members' health care and service. 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 key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determine further actions
- Designing effective and value-added interventions
- Continuously monitoring performance parameters and comparing to performance standards and benchmarks published by national, regional, or state regulators, accrediting organizations and internal Molina Healthcare standards
- Analyzing information and data to identify trends and opportunities, and the appropriateness of care and services
- Oversight and improvement of delegated functions
- Confirming the quality and adequacy of the provider network through appropriate contracting and credentialing processes

The QIP promotes and fosters accountability of employees, network and affiliated health personnel for the quality and safety of care and services provided to Molina Healthcare members.

The effectiveness of QIP activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the QI work plan quarterly.
- Revising interventions based on analysis, when indicated.
- Evaluating member satisfaction with their experience of care through the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey.
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management.

If you would like more information about our Quality Improvement Program or initiatives, or would like to request a paper copy of our documents, please call Provider Services at 1-800-642-4168. You can also visit our website at MolinaHealthcare.com to obtain more information.

Standards for Medical Record Documentation

Providing quality care to our members is important; therefore, Molina Healthcare has established standards for medical record documentation to help assure the highest quality of care.

Medical record standards promote quality care through communication, coordination and continuity of care, and efficient and effective treatment. Molina Healthcare uses commonly accepted standards for the documentation which must be included in each patient's medical record:

- History and physical
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening

In addition, Molina Healthcare evaluates medical record documentation for the following:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidentiality of patient information
- Standards and performance goals for participating providers

For more information, please call Provider Services at 1-800- 642-4168.

Preventive Health Guidelines

Molina Healthcare adopts preventive healthcare guidelines which are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services depending on the individual needs of the patient.

You can view the guidelines at www.MolinaHealthcare.com. To request printed copies of Preventive Health Guidelines, please contact Provider Services at 1-800-642-4168.



Clinical Practice Guidelines

Clinical practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested as guides for making clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina Healthcare has adopted the following Clinical Practice Guidelines:

- ADHD - Child
- COPD
- Coronary and Other Vascular Disease
- Depression
- Diabetes

You can view the guidelines at www.MolinaHealthcare.com. To request a copy of any guideline, please contact Provider Services at 1-800-642-4168.



Advance Directives

Helping your patients prepare an advance directive may not be as hard as you think. Any person 18 years or older can create an advance directive. Advance directives include a living will document and a durable power of attorney document.

A living will is written instruction that explains your patient's wishes regarding health care in the case of a terminal illness or any medical procedures that prolong life. A durable power of attorney names a person to make decisions for your patient if they become unable to do so. The following links provide you and your patients with free forms to help create an advance directive:

<http://www.nlm.nih.gov/medlineplus/advancedirectives.html>

http://www.nia.nih.gov/HealthInformation/Publications/ClinicianHB/05_sensitive.htm

http://olrs.ohio.gov/ASP/olrs_AdvanceDirect.asp
www.caringinfo.org

For the living will, your patient will need two witnesses. For a durable power of attorney, your patient will need valid notarization.

A patient's advance directive must be honored to the fullest extent permitted under law. Providers should discuss advance directives and provide appropriate medical advice if the patient desires guidance or assistance, including any objections they may have to a patient directive prior to service whenever possible. In no event may any provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an advance directive. Patients have the right to file a complaint if they are dissatisfied with the handling of an advance directive and/or if there is a failure to comply with advance directive instructions.

It is helpful to have materials available for patients to take and review at their convenience. Be sure to put a copy of the completed form in the medical record. The medical record should also document if a patient chooses not to execute an advance directive. Let your patients know that advance care planning is a part of good health care.

Care Coordination and Transitions

Coordination of Care during Planned and Unplanned Transitions for Medicare Members

Molina Medicare is dedicated to providing quality care for our Medicare members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina Medicare member is discharged from a hospital. By working together with providers, Molina Medicare makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is performed to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina Medicare has resources to assist you. Our Utilization Management nurses and Member Services staff are available to work with all parties to ensure appropriate care.

In order to appropriately coordinate care, Molina Medicare will need the following information in writing from the facility *within one business day* of the transition from one setting to another:

- Initial notification of admission within 24 hours of the admission
- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information can be faxed to Molina Medicare at 1-801-858-0409.

To assist with the discharge planning of Molina Medicare members, please note the following important phone numbers:

- **Medicare Member Services & Pharmacy 1-866-472-4584.**
- **Behavioral health** services and substance abuse treatment for Molina Medicare members can be arranged by contacting **Medicare Member Services at 1-866-472-4584.**

- **Transportation** services for Molina Medicare Options Plus Members may be arranged by calling **MTM at 1-866-867-3208.**
- The **Nurse Advice Line** is available to members 24 hours a day, 7 days a week at **1-888-275-8750.**

Important information you need to know about Molina Medicare Options Plus:

- All beneficiaries have rights that are defined in our provider manual. They are also available in the member EOC posted on our website at **www.MolinaMedicare.com.**
- Molina Medicare Options Plus members have both Medicare and Medicaid benefits to meet their special needs. The state agency or its designated health plans have the responsibility for coordinating care, benefits and co-payments. Please be aware of your patients' status & Medicaid benefits and bill the correct entity.
- Health plans and providers can never charge members more than they would have paid under original Medicare and Medicaid. Members can also call the Medicaid agency for details and have specific rights with regard to their Medicaid benefits.
- Providers are responsible for verifying eligibility and obtaining approval for services that require prior authorization as outlined in the provider contract. Our Medicare Member Services department can assist you in this regard.

Please contact the UM Department at 1-800-642-4168 or Medicare Member Services 1-866-403-8293 if you have questions regarding planned or unplanned transitions.

New ACOG Practice Bulletin on Cervical Cytology Screening

In December 2009 the American College of Obstetricians and Gynecologists (ACOG) revised the recommendations for cervical cancer screening for women who are low risk. A woman is low risk if she has had three consecutive negative cytologic tests and does not have HIV, compromised immunity, a personal history of grade 2 or 3 cervical intraepithelial neoplasia, or exposure to diethylstilbesterol in utero. The changes to the guidelines are:

Age	Previous Guidelines	Revised Guidelines
Under 21 yrs	Screen annually if sexually active for 3 yrs	Avoid Screening
21 – 29 yrs	Screen annually if sexually active and have a cervix	Screen every 2 yrs if sexually active and have a cervix
30 – 65 or 70 yrs	Screen every 2-3 yrs with 3 or more normal annual Pap tests	May screen every 3 yrs with 3 or more normal consecutive Pap tests
Between 65 – 70 yrs	Discontinue if 3 or more normal consecutive Pap tests in last 10 yrs	May discontinue screening 3 or more normal consecutive Pap tests in last 10 yrs

Screening before age 21 should be avoided because it may lead to unnecessary and harmful evaluation and treatment in women at very low risk of cancer. These risks include cervical stenosis, cervical incompetence, anxiety, labeling, and extended surveillance procedures.

- The American Cancer Society, U.S Preventative Services Task Force, and the American College of Obstetrics and Gynecology all support the guideline that it is now reasonable to discontinue screening in women 65-70 years of age who have had three or more consecutive normal test and no abnormal results within the past 10 years.
- Women who have had a history of CIN 2 or CIN 3, or cancer and have undergone hysterectomy with removal of the cervix should continue to be screened annually for a period of time for at least 20 years. Unfortunately, there are no good data to refute or support when to discontinue screening in this population.
- Those women who have had a hysterectomy with removal of the cervix for benign indications and without a history of high grade CIN should stop routine screening.
- Women who have received the HPV vaccine should continue to be screened in the same fashion as nonimmunized women.
- Both liquid-based and conventional methods of cervical cytology are acceptable for screening.
- Testing using the combination of both cytology plus HPV DNA testing is appropriate for women over the age of 30. A woman who tests negative for both cytology and HPV should be re-screened no sooner than 3 years.

Molina Healthcare encourages its providers to continue to perform annual gynecologic examinations (including STD screening, contraceptive maintenance, mammogram screening, etc.) regardless of the frequency of cervical cytology screening. We also encourage providers to follow the new ACOG guidelines to give the best possible care to their patients. For full information about these guidelines, please review the ACOG Practice Bulletin #109, Cervical Cytology Screening at http://journals.lww.com/greenjournal/documents/PB109_Cervical_Cytology_Screening.pdf. Further information about preventive health guidelines is available at our website www.MolinaHealthcare.com.