

## ***Chapter 6***

### ***Prior Authorizations and Utilization Management***

#### **A. Utilization Management (UM)**

Utilization Management is an on-going process of assessing, planning, organizing, directing, coordinating, monitoring and evaluating utilization of health care services for Molina members. The UM process utilizes a multidisciplinary, comprehensive approach to support the continuum of care by evaluating the necessity and efficiency of health care through systematic monitoring of the medical necessity and quality, and by maximizing the cost effectiveness of the care and service provided to members.

The UM Program encompasses all services and practitioners who have an impact on the provision of health care. This includes the evaluation of medical necessity and the efficient use of medical services, procedures, facilities, specialty care, inpatient, outpatient, home care, skilled nursing services, ancillary services and pharmaceutical services. In addition decisions are made within the scope of the benefit plan. A team of physicians and nurses, who hold unrestricted licenses in the state of Texas, perform utilization activities within their scope of practice and utilize InterQual, Milliman, and Medicaid criteria to determine medical necessity. Other resources include clinical practice guidelines recommended and adopted by national professional physician organizations, the Hayes Directory, and available scientific medical evidence.

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

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

- Molina Healthcare does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.
- 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 1-877-665-4622.

The Utilization Management Department maintains a process for gathering pertinent clinical information, applying criteria/guidelines during the utilization review decision making process based on individual needs, age, co-morbidities, complications, progress of treatment, psychosocial situation, home environment, when applicable, and assessment of the local delivery system. Each medical decision must be case specific regardless of available practice guidelines.

***The authorization process is comprehensive and, includes the following review processes:***

- Direct Referral
- Prospective Review
- Concurrent Authorization
- Retrospective review

The Utilization Management Department adheres to the HHSC and TDI approved standards for processing referrals, providing authorizations or denial decisions and the notification time frames. These standards are applied to urgent or routine requests for prospective, concurrent and retrospective service. Practitioners / providers and members may obtain urgent services twenty-four (24) hours a day, seven (7) days a week. Molina Healthcare of Texas maintains a toll-free (800) number that is staffed by Telephone Advice Nurses to assist in obtaining services. UM Staff is available eight hours a day during normal business hours for calls regarding UM issues. Staff can receive inbound communication regarding UM issues after normal business hours. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. Staff member identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. The toll free number to reach UM staff for any/all inquiries or questions of the UM process is 866-449-6849 and you will be prompted to the UM department.

Potential or actual cases of over or underutilization of healthcare services for members will be identified by the Medical Director and the UM staff during all components of UM:

- Prior Authorization (Referrals/Denials to specialty care providers)
- Concurrent Review (Bed-days in comparison to the community standard, length of stay)
- Emergency Room Visits (Frequency of ER use based on community standards)
- Pharmacy Utilization (Outpatient prescription patterns, Brand fill rate)
- Member Satisfaction Survey (Referral process, Obtaining needed care)
- Re-admissions to an acute care facility based on same or similar diagnosis within 30 days following discharge.

## **B. Prior Authorizations**

**This Prior Authorization (PA) Guide applies to all Molina Healthcare Members.**

**PLEASE NOTE:** Authorization requests should be submitted by the PCP or Specialist ordering the service.

### ***Procedures / Services Requiring Prior Authorization***

- **Referral to any Non-Participating Physician**
- Ambulance transfer (non-emergent)
- All Admissions – elective, urgent, or emergent (i.e., Hospital, OB deliveries, Physical Rehabilitation, Skilled Nursing Facilities, or LTAC)
- Bariatric Surgery
- Breast Reconstruction, Reduction, or Augmentation
- Chemotherapy – Initial Therapy and Changes in Protocol

- Cosmetic Procedures
- Dialysis
- Durable Medical Equipment if cost/rental is greater than \$250 per line item
- Home Health Care
- Outpatient Rehabilitation Services – Physical, Occupational, Speech, Pulmonary, and Cardiac Rehabilitation
- Orthotics and Prosthetics
- Outpatient MRI, MRA, SPECT and PET scans
- OB Prenatal Care: Notification after first prenatal visit to facilitate coverage of newborn and any case management needs
- All Outpatient and Ambulatory Surgery Center Procedures *except* bronchoscopy, colonoscopy, herniorrhaphy, myringotomy and tympanoplasty, GI endoscopy, biopsies and sterilization (signed consent form 30 days prior to procedure is still required)
- Pain Management Program
- Transplant Evaluation and/or Procedures
- Day Activity and Health Services
- Attendant Care/Personal Assistance Services
- Adult Foster Care
- Assisted Living/Residential Care Services
- Home Delivered Meals
- Minor Home Modifications
- Respite Care Services
- Transition Assistance Services

### ***How to Request an Authorization***

Current (up to 6 months), adequate patient history related to the requested services should be submitted when seeking prior authorization. Examples of information needed include:

- Physical examination that addresses the problem
- Lab or X-ray results to support the request
- PCP or Specialist progress notes or consultations
- Any other information or data specific to the request

To obtain a prior auth, please fill out form attached (in appendix IX) completely and fax to number located on top of Service request form. Fax # 866-420-3639. If you have an urgent request, please mark on fax “URGENT”. Urgent requests are usually processed within 24-48 hours. If it needs to be processed Stat, please call 866-449-6849.

### ***Hospital Admissions***

**All admissions must notify Molina Healthcare of current admission within next business day.**

Once the complete information is received, Molina Healthcare will process any “non-urgent” requests within two (2) business days. “Urgent” requests will be processed within one (1) business day. Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 866-449-6849.

### **C. Notification of Denied Services**

Molina will notify the Member, the Member’s Authorized Representative, or the Member’s Provider of Record of the Determination. A licensed nurse will verbally notify a provider of the offer for a Peer to Peer and provide information on how to reach the MHT Medical Director within 24hrs prior to issuing a denial. If, after the treating and/or attending physician discusses the case with the CMO/Medical Director, and the decision for a denial is made, an adverse determination letter is generated and mailed to the member, physician and facility within 24 hours of the determination.

### **D. Continuity of Care**

Molina Members who are involved in an “active course of treatment” have the option to complete that treatment with the practitioner who initiated the care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina and a Provider will not interfere with this option. This option includes the following Members who are:

- have pre-existing conditions
- In the 24th week of pregnancy (STAR only)
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition
- Receiving care for a life threatening illness, and
- Receiving care for a disability

For each Member identified in the categories above, Molina will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member’s needs.

#### ***What if a member moves?***

If a member moves out of the service area, Molina will continue to cover medically necessary care through the end of the month.