INPATIENT VS. OBSERVATION

This is an advisory notification to Molina Healthcare of California (MHC) network hospitals regarding MHC’s process on the utilization management evaluation of inpatient and observation reviews.

BACKGROUND
Molina has an established process pertaining to authorization of inpatient admissions. Although our process for evaluating inpatient admission authorizations has not changed, MHC is incorporating a more focused evaluation of these requests in conjunction with observation level criteria. As part of this effort, MHC is providing this communication to assist network hospitals with clarification on how this process is occurring.

PROCESS
The attached Clinical Review Checklist and Prior Authorization Process outlines details of the process for inpatient admissions. All inpatient admissions must meet nationally recognized criteria. MHC has broadened the evaluation of inpatient admission requests to determine if an admission might qualify for an observation level of care, should the initial authorization request not meet nationally recognized inpatient criteria. Documentation back to the hospital will indicate the disposition of the request as either approved or denied. If it is denied, but does meet observation level of care, this information will be included. Should the hospital proceed with placing the member in observation, no further authorization is required. The claim may be submitted as observation and is then eligible for reimbursement under the terms of the provider’s contract. If the hospital wants a reconsideration of the denial, requests for reconsideration, including expedited appeals, can be submitted as indicated on the attached Clinical Review Checklist.

CONSIDERATIONS
MediCal: For the MediCal lines of business, the California Department of Health Care Services (DHCS) does not have a reimbursement rate for observation level of care in a hospital setting. Although DHCS does not have this reimbursement, the expectation is that all inpatient admissions must still meet appropriate inpatient criteria. The attached links are to FAQ documents created by DHCS that include clarification to questions asked about observation and inpatient admissions.

For MHC, to mitigate issues of non-payment for admissions that do not meet inpatient criteria, we are able to contract directly with hospitals to include an observation rate. This will allow for seamless claim processing in the event the inpatient admission does not meet appropriate criteria, but does meet observation level criteria. Claims should be billed in accordance with the contract terms between the hospital and MHC.

*If a hospital does not have or staff is unaware of the hospital having an observation rate for the MediCal lines of business, please contact the MHC Contracting Representative for the hospital’s respective region to discuss existing and potential future contract terms for observation.*

**Medicare:** For the Medicare lines of business, observation level of care is recognized and will be reimbursed in accordance with Medicare reimbursement terms in the contract between the hospital and MHC.

**Marketplace:** For marketplace line of business, observation level of care is recognized and will be covered in accordance with the specific marketplace benefit plan and reimbursed in accordance with the reimbursement terms in the contract between the hospital and MHC.

<table>
<thead>
<tr>
<th>County</th>
<th>Contract Representative</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imperial</td>
<td>Barbara Johnson</td>
<td>(888) 562-5442 ext:121593</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>Jessica Frausto</td>
<td>(888) 562-5442 ext:121028</td>
</tr>
<tr>
<td>Riverside</td>
<td>Jason Valdecantos</td>
<td>(888) 562-5442 ext:121252</td>
</tr>
<tr>
<td>Sacramento</td>
<td>Linda Aquila</td>
<td>(888) 562-5442 ext:128543</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>Jason Valdecantos</td>
<td>(888) 562-5442 ext:121252</td>
</tr>
<tr>
<td>San Diego</td>
<td>Barbara Johnson</td>
<td>(888) 562-5442 ext:121593</td>
</tr>
</tbody>
</table>

**QUESTIONS**
If you have any questions regarding the notification, please contact your Molina Provider Services Representative at (855) 322-4075.
CLINICAL REVIEW CHECKLIST
(All Lines of Business)

- **INITIAL REVIEWS:**
  Clinical Information is needed within twenty-four (24) hours of hospital notification. MHC may extend up to seventy-two (72) hours. The following information is needed for the Initial Review:
  - ER Report
  - History and Physical:
    - To include: PMH, Vital signs and pulse oximetry, abnormal labs
    - Radiology/diagnostic results, an overview of the treatment plan
  - Admitting Orders

- **CONCURRENT REVIEWS (Per Diem Contracts):**
  Clinical information is needed daily for Per Diem contracted facilities. Decision are made within twenty-four (24) hours of receipt of complete information. If a hospital submits the nationally recognized criteria screenshot, it must be accompanied by the following:
  - Daily MD Progress Note
  - Severity of Illness Synopsis, to include:
    - Vital signs, Pulse Oximetry (if related to diagnosis)
    - Abnormal labs, radiology/diagnostic results
    - Other relevant information related to the diagnosis, PT/OT update
  - Intensity of Service Synopsis, to include:
    - IV fluids with rate, IV and PO medications with frequency
    - PRN IV medications with frequency
    - Other relevant treatment related to the admitting diagnosis
    - Continuation of orders relevant to diagnosis (i.e. IV Abx, IVF)
    - New orders relevant to diagnosis (i.e. IV Solumedrol, BiPaP)
    - Treatment(s) related to a change in condition and/or level of care
  - Case Management/Social Work Assessment

- **REVIEWS (DRG Contracts):**
  After the initial notification and authorization, clinical information is needed after seven (7) days, if the patient is still admitted. If the hospital submits the nationally recognized criteria screenshot it must be accompanied by the following information. Otherwise, Discharge Planning is started at admission and tracked for progress.
  - Daily MD Progress Note
  - Severity of Illness Synopsis, to include:
    - Vital signs, Pulse Oximetry (if related to diagnosis)
    - Abnormal labs, radiology/diagnostic results
    - Other relevant information related to the diagnosis, PT/OT update
  - Intensity of Service Synopsis, to include:
    - IV fluids with rate, IV and PO medications with frequency
    - PRN IV medications with frequency
    - Other relevant treatment related to the admitting diagnosis
    - Continuation of orders relevant to diagnosis (i.e. IV Abx, IVF)
    - New orders relevant to diagnosis (i.e. IV Solumedrol, BiPaP)
    - Treatment(s) related to a change in condition and/or level of care
  - Case Management/Social Work Assessment

- **DISCHARGE PLANNING:**
  - Members lives with family, friends, alone, hotel or homeless
  - PCP access
  - DME or oxygen needs
  - Medically necessary transportation needs
  - Upon Discharge send the Discharge Summary and/or patient discharge instruction sheet to the plan

To opt out of Just the Fax: Call (855) 322-4075, ext. 127413.
Please leave provider name and fax number and you will be removed within 30 days.
PRIOR AUTHORIZATION PROCESS

Hospitals must complete a Prior Authorization Request Form with all pertinent information and medical notes as applicable. The Prior Authorization Request Form is conveniently located on the MHC website at www.molinahealthcare.com. Simply click on “Forms” and “Frequently Used Forms.” Hospitals can also access the form by following this link: http://www.molinahealthcare.com/providers/common/medicare/PDF/CA-PAreview-2015.pdf

- CLINICAL TIMEFRAMES:
  - Inpatient clinical information is required for pre-authorized surgeries and/or procedures within twenty-four (24) hours of admission.
  - For Per Diem Contracted Hospitals, ongoing (concurrent) daily reviews are required contracted hospitals up to and including the day of discharge.
  - DRG contracted hospitals are required to provide information upon admission and after seven (7) days, if patient is still admitted.
  - Clinical information not received within the seventy-two (72) hour timeframe will be sent to the MHC Medical Director for review and may be denied.

- RECONSIDERATIONS FOR DENIED AUTHORIZATIONS:
  - Medi-Cal: After denial issued, hospital has five (5) business days to submit new clinical information or request a peer to peer review for reconsideration and possible overturn of the denial. To request a peer to peer review, the hospital should contact 888.562.5442 Ext 127288 to schedule.
  - Medicare: MHC does not process reconsiderations for Medicare. CMS states that once the plan denies a requested service, in whole or in part, an adverse organization determination has occurred and the plan must issue a written denial notice. Once the plan has phoned the member or provider advising them of the adverse decision, the appeals process then must be utilized. A peer-to-peer request cannot be offered to hospitals once the plan has made a decision regarding any Medicare Organizational Determination or appeal. Please refer to the Medicare Provider Manual at www.molinahealthcare.com for the Medicare line of business appeal process.
  - Marketplace: After a denial is issued, the hospital has five (5) business days to submit new clinical information or request a peer-to-peer review for reconsideration and possible overturn of the denial. To request a peer-to-peer review, the hospital should contact 888.562.5442 Ext 127288 to schedule.

- RETRO REVIEW OF AUTHORIZATIONS
  - MediCal: If MHC did not receive notification of a MediCal admission within the required timeframe, the hospital has thirty (30) days post discharge to submit clinical information for a retro review for authorization. It would be necessary to provide clinical information as stated above in the clinical review checklist.
  - MediCare: CMS does not allow retrospective reviews for authorization.
  - Marketplace: If MHC did not receive notification of a Marketplace admission within the required timeframe, the hospital has thirty (30) days post discharge to submit clinical information for a retro review for authorization. It would be necessary to provide clinical information as stated above in the clinical review checklist.