Utilization Management Program

Molina Healthcare of Michigan’s Utilization Management (UM) program utilizes a care management approach based upon empirically validated best practices, where experience shows that a high touch, member-centric care environment for at-risk members supports better health outcomes. Molina works in partnership with members and practitioners to promote the appropriate use of resources through full integration of physical health, behavioral health, long-term services and support, and social support. Services include:

- Preservice, admission, and concurrent review
- Behavioral Health (BH) Case Management and Utilization Management coordination
- Case Management
- Community Connector services
- Continuity and coordination of member care
- Discharge planning
- Transitional care
- After Hours availability (On Call Program)
- Retrospective review with extenuating circumstance
- Monitoring for over and underutilization of clinical resources
- Monitoring provider and member satisfaction

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 have any questions, please contact our Health Care Services (HCS) Department at:

Molina Healthcare Michigan – Health Care Services Department
Phone: (855) 322-4077
Fax: (800) 594-7404

Business Hours: Monday – Friday (excluding holidays) 8:30am – 5:00pm
After normal business hours: Monday – Friday 5:00pm – 8:30am
Saturday, Sunday and holidays

Visit our website for updates, frequently used forms, and professional resources:

www.MolinaHealthcare.com
Roles
UM activities conducted under the direction and oversight of the Medical Director(s) (Physicians) and the Healthcare Services Vice President and Director. HCS is comprised of both clinical and nonclinical staff.

Multidisciplinary teams may include:

- BH staff (RNs and Social Workers [SWs])
- Care Review Processors
- Care Review Clinicians (RNs and LPNs)
- Case Managers (RNs and SWs)
- Transitions of Care Coaches (RNs, SWs)
- Community Connectors
- Pharmacists
- Medical and BH Medical Directors

This team structure promotes ownership and accountability to providers and members.

Medical Directors:
- Participate in biweekly case review with teams
- Participate as a member of the Integrated Care Team (ICT) to provide medical expertise for care management
- Provides medical oversight in appropriateness and medical necessity for authorizations and manages the denial process
- Development and implementation of medical policy, criteria/guidelines

The Molina Nurse Advice Line (NAL) and On-Call (RN) staff provides clinical support after normal business hours at 1-888-275-8750.

Pre-service and Admission Review/Authorization Requirements

Determining Services that Require Authorization

Examples of services requiring authorization:
- All inpatient admissions
- Select outpatient services
- Select ambulatory surgical/diagnostic procedures
- Potentially cosmetic/experimental/elective procedures
- Home health care (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST))
- Home intravenous (IV) infusion
Requesting a Preservice or Admission Review

There are three ways to request a preservice or admission review:

1. **WebPortal (preservice requests only)**

2. **Fax (preservice and admission)**
   Fax authorization request and clinical information (if required) to Healthcare Services at (800) 594-7404. PCPs/Specialists should use the Molina Healthcare Prior Authorization Request Form or the Michigan Healthcare Referral Form. Forms can be found at [http://www.molinahealthcare.com/providers/mi/medicaid/forms/Pages/fuf.aspx](http://www.molinahealthcare.com/providers/mi/medicaid/forms/Pages/fuf.aspx) Fax requests for Radiology and Transplant authorization to (877) 731-7218.

3. **Telephone (preservice and admission)**
   UM staff can be reached at (855) 322-4077.

**Urgent Requests**

All urgent requests must be submitted by calling HCS staff at (855) 322-4077. Make sure you identify the request as “urgent” to expedite the review process.

**Tips to Help Expedite Authorization Decisions**

- Submit your authorizations electronically through Molina’s WebPortal
- Verify the member’s eligibility and benefits
- Accurately complete the authorization request form (Molina Healthcare Prior Authorization Request Form or the Michigan Healthcare Referral Form)
- Include all appropriate codes (diagnosis code(s) and procedure/item code(s))
- Submit your requests at least 14 days prior for elective services (non-urgent)
- Refer to the Molina Healthcare Medicaid Prior Authorization/Pre-Service Review Guide at [http://www.molinahealthcare.com/providers/mi/medicaid/forms/Pages/fuf.aspx](http://www.molinahealthcare.com/providers/mi/medicaid/forms/Pages/fuf.aspx) since many services may not require an authorization request
- Include pertinent clinical information (progress notes, lab results, photos, imaging studies, leaving against medical advice information, etc.)
- Visit molinahealthcare.com for any changes regarding the authorization process

**Requesting 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 WebPortal. Please include the following information:

- Member’s name, Medicaid beneficiary ID#, date of birth, and age
- Admission date
- Name of admitting facility and fax number
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- Diagnosis and procedure codes
- 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)

Process after Provider Submits Authorization

- Molina staff confirms the member’s eligibility, benefits and provider’s affiliation status.
- Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively.
- If the request does not meet criteria, the Molina staff will contact (via telephone, fax, and/or mail) the provider 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 may be referred to a Molina Healthcare Pharmacist.

Notification of Decision

The decision timeframe is based upon the date in 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 if additional clinical or clarifying information is needed. Our decisions are made in accordance with regulatory and accreditation guidelines.

<table>
<thead>
<tr>
<th>Request</th>
<th>Decision and notification timeframe</th>
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<tbody>
<tr>
<td>Routine (non-expedited) Pre-service</td>
<td>Within 14 business days of receipt of the request</td>
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<tr>
<td>Expedited / Urgent</td>
<td>Within 72 hours of receipt of the request</td>
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<tr>
<td>Urgent Concurrent</td>
<td>Within 24 hours of receipt of request</td>
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Non Urgent Approved Requests

We will call or fax the authorization number of the PCP, requesting physician or facility (if indicated).

Urgent Preservice Approved Requests

We will call with the authorization number to the requestor and facility (if indicated).
Urgent Concurrent Approved Requests
We will call or fax the authorization number to the requestor and facility (if indicated).

Denied Requests
The rationale for denial and the appeals process will be called to the requesting provider and written notification will be mailed or faxed to the member, provider, PCP, and facility (if indicated) within 14 days of the initial request. If an urgent/emergent request is denied, Molina will notify the requesting provider verbally within regulatory and accreditation requirements of the receipt of the request.

Note: Providers may review the UM criteria with Molina Healthcare or they may request a copy of the criteria used to make the medical necessity determination by fax or email.

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

Authorization Submission Guidelines for Dual Eligible Members
For services rendered to patients who are covered by both Molina Medicare Options Plus and Molina Medicaid, submit one authorization request. Molina Healthcare will coordinate authorization requirements, benefits and services between the two products.

Admission Review

Hospitals may request authorization for an urgent/emergent admission by calling (855) 322-4077.
Hospitals can call HCS staff or fax to (800) 594-7404 during normal business hours.
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-hour/day/7 day/week, by providing an On-Call Case Manager during non-business hours.

What type of clinical information should be provided?
Clinical information should include the member’s health history, vital signs, physical assessment, consultations, laboratory or imaging tests, current and previous treatment including those services performed in the ED 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 medical necessity criteria for an inpatient setting, the facility may admit the member to an observation setting. No authorization is required for observation. If the facility does not accept observation setting, the UM staff may request additional information and will forward the case for Medical Director review except for those diagnoses which the Michigan Department of Health and Human Services has deemed payable at a one day/observation payment rate.
Requests for admission that meet Inpatient Criteria but could be treated in an observation setting and there is a likelihood of discharge within 24 hours; an observation stay will be authorized initially with additional clinical information requested for the following diagnoses:

- Acute Abdomen
- Anemia
- Congestive Heart Failure (CHF)
- Deep Vein Thrombosis (DVT)
- Disorders of Fluid Electrolyte and Acid Base Balance
- General Symptoms
- Poisoning/Toxic Ingestions

Effective August 1, 2015, the diagnoses referenced MSA Bulletin-15-32 will be considered payable at the Michigan Department of Health and Human Services one day/observation rate for stays in the observation or inpatient setting for admission and discharge the same date or next calendar day. No approval is required for these cases whether one day inpatient or observation. The diagnoses in the MDHHS policy are listed at http://www.michigan.gov/documents/mdch/MSA_15-32_498744_7.pdf

A post stabilization update will be required 18-24 hours post admission to ensure that the member continues to meet medical necessity criteria for an authorization of an inpatient admission.

When would we contact you?
- If additional clinical information is required.
- If the need for additional medical services is identified post discharge, such as home health care or home infusion.

To notify you of our decisions:
- When services are approved, we will call or fax 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 you would like to discuss a denial decision with a Medical Director, please call (855) 322-4077.
- For urgent/emergent admissions, we will call or fax you the decision.
- If we are notified retrospectively of an admission and discharge, we will call or fax you.
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Retrospective Authorization*

(*Retrospective Authorization is considered a request for initial authorization after a service has been rendered and/or failure to authorize services according to required timeframes.)

Retrospective authorization is not a Molina Healthcare of Michigan process, except in the event of extenuating circumstances. An extenuating circumstance is defined as:

Provider did not know nor reasonably could have known that patient was a Molina Healthcare Member at the time the service was rendered

- Examples:
  
  Member does not have insurance cards on them at time they arrived
  Eligibility IVR system is offline
  Woman presents in labor and has other insurance, Molina is secondary insurer and card not presented at time of admission
  Member has pending Medicaid at the time of service

Provider did not know nor reasonably could have known that patient needed a service that required authorization prior to the service being rendered

- Examples:
  
  Elective outpatient surgery authorization is obtained for a specific service however; the member presents with an additional and/or different service that requires an authorization.
  Surgery for shoulder repair which turns out to be more extensive than planned
  Member originally requires an Elective surgery that does not require authorization. However, when the member presents an additional and/or different Elective surgery service is needed that requires authorization.
  Planned diagnostic hysteroscopy which results in the removal of a leiomyoma (fibroids)
  Member originally requires an Outpatient service that does not require authorization. However, when the member presents an additional and/or different Outpatient service is needed that requires authorization.
  Member has had a TIA and is need of a Speech Therapy evaluation for swallowing. Evaluation indicates that 12 visits are needed. Evaluation + 6 visits do not require an authorization. The remaining visits would require and authorization.
  Member originally requires an Outpatient service that does not require authorization. However, when the member presents an additional and/or different Outpatient service is needed that requires authorization.
  Member is evaluated for a manual wheelchair which does not require an authorization. The evaluation showed that a power wheelchair was recommended which does require an authorization.

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Documentation to demonstrate extenuating circumstances must be submitted at the time of the request. All requests for retrospective authorization with an extenuating circumstance must be received within 10 calendar days of becoming aware of the extenuating circumstance. Determinations, in this circumstance, will be based on medical necessity guidelines and UM policies and criteria.

There are two ways to request a Retrospective Authorization with extenuating circumstance.

- Fax authorization request and clinical information (if required) to Healthcare Services at (800) 594-7404
- Telephone (855) 322-4077

**Please note if there is a denied claim on file the Provider Appeal process will need to be followed. Refer to the Provider Appeals and Grievances Section.

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

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 routinely as appropriate and medical necessity criteria is used as a guideline in performing review.

How does the process work prior to hospital discharge?
Hospital discharge planning staff is responsible for ensuring authorization is obtained by calling (855) 322-4077. The following select post discharge services may require authorization:

- Home Health Care and Home Infusion
- PT, OT, or ST
- Select durable medical equipment (DME)
- Skilled nursing facility (SNF)
- Rehabilitative services
- Inpatient hospice

Prior to discharge from an inpatient facility, the hospital is responsible for providing the following information to Molina’s UM Department by calling (855) 322-4077 or faxing to (800) 594-7404:
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?
For members with select diagnoses or for those who are identified as high risk, the Molina Healthcare Transitions team may conduct an onsite visit while the member is hospitalized and a post discharge visit to his/her home. A comprehensive assessment is performed during that home visit to determine the member’s needs. In addition, at least three telephone contacts are made to the member to ensure compliance with the discharge plan.

The four critical elements of the transition program include:

Medication Management – Molina staff will assist with coordination of member medications, authorizations (as needed), medication therapy management, and educating members about their medications
Personal Health Record (PHR) – Molina staff will assist in the completion of a PHR that includes pertinent member history, provider information, a discharge checklist, a medication record, and a list of missing preventative services. Members are encouraged to bring the PHR with them to provider visits.
Provider and/or Specialist Appointments – Molina staff will facilitate scheduling and transportation to ensure members keep follow-up appointments.
Knowledge of Warning Signs – Molina staff will ensure the member is educated and aware of signs that their condition is worsening and how to respond.

Molina’s Transitions of Care staff will identify any ongoing needs that a member may have and, if needed, will refer members to Molina Case Management Program to address those needs going forward.

Case Management

Who are we? Our Case Managers are RNs and SWs with specialized training in the management of chronic diseases. Molina SWs, in collaboration with Molina’s BH department, provide psychosocial support to members.

The Community Connector is an extender to the RN or SW Case Manager and plays a highly visible role in connecting the member with appropriate health care services. A unique quality of the program is the high touch, face to face approach in the member’s home, medical and community settings. The Community Connector is the “eyes and ears” of the Case Manager. While present in the home, the Community Connector is able to assess immediate needs, access resources and coordinate the individual plan of care with the member and Case Manager, in a person centered, recovery focused, environment.
What services do the Case Managers provide? The Case Manager’s role is to improve the health and well-being of each member by educating members on managing their health conditions, assisting members with obtaining appropriate resources, and facilitating access to the most appropriate health care services available. The Case Manager has the responsibility to coordinate services throughout the member’s continuum of care. The Case Managers assist with:

Identifying members who will benefit from case management services:
- Accept referrals from all Molina Healthcare staff, physicians, hospital staff, and/or members who can self-refer.
- Review data collected and/or supplied from claims, hospital discharge, UM process, members, caregivers, practitioners.

Develop a plan of care including problem identification, establishment and prioritization of goals, identification of barriers, and implementing interventions to promote achievement of goals.

Coordinate services within the benefit structure.
Ensure that services are medically necessary and provided at the appropriate level of care and in a timely manner.

Coordinate such services as home health and hospice care, home infusion therapy, inpatient rehabilitation and skilled nursing care, and others.

Monitor progress towards goals.
Ongoing reassessment of member needs and modification of the plan of care as needed until the member meets their goals or is no longer eligible for case management.

Provide support to the Integrated Care Team (ICT).

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

Who is eligible for case management? All Molina Healthcare members who need assistance in managing their health conditions are eligible for case management. Members who have frequent ED visits or hospital admissions or members with a newly diagnosed condition may benefit from case management. Members may be referred for case management for reasons such as:

- A known chronic disease
- Risk for developing chronic disease
- Multidisciplinary needs requiring case management intervention support
- Multiple hospital admissions with one more of the following conditions:
  - Asthma
  - AIDS/HIV
  - Cardiovascular Disease
  - CHF
  - COPD
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- Diabetes
- End Stage Renal Disease
- High Risk Obstetric/Newborns
- Sickle Cell

If you would like more information, speak with a Case Manager and/or refer a member for an evaluation, please call Molina Healthcare Services at (855) 322-4077.

You will receive a copy of a member welcome letter from a Case Manager with his/her direct phone number once a member is enrolled in case management.

When will you hear from us? Our Case Managers perform an individualized member assessment. Following the individualized member assessment, the Case Manager will send a letter informing you of the member’s acceptance into the case management program. The Case Manager may periodically contact you to:

- Coordinate a plan of care
- Confirm a diagnosis
- Identify member compliance issues
- Discuss other problems and issues that may affect the member’s care
- Participate on the ICT

On Call Program (After Hours)
Inpatient facilities are requested to contact Molina Healthcare once a determination is made to admit a member from the ED but prior to the admission. Outside of business hours, the On-Call service can be contacted to obtain authorization prior to the admission.

Clinical staff are available 24 hours a day/7 days a week to members, providers, and hospital staff, including after normal business hours (Monday through Friday 5:00 p.m. – 8:30 a.m., Saturday – Sunday and holidays).

The On-Call Care Review Clinician (RN) 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 medical appropriateness criteria.

The On-Call Care Review Clinician will facilitate one of the following:

- Approve inpatient admission in which an authorization number is provided along with the next review date
- Pend for additional clinical information, in which the facility has 48 hours in which to supply Molina Healthcare with the requested information
- Participate in the discharge planning process and facilitation for home care, home infusion, and/or DME
When will you hear from us?
The On-Call Care Review Clinician will contact the facility within one hour of the request.

How can you reach us?
You can reach the On-Call Care Review Clinician by calling (888) 275-8750.

Appeals
For information on submitting an appeal for an authorization denial, please refer to the Appeals and Grievances section of the Molina Healthcare of Michigan Provider Manual.