UTILIZATION MANAGEMENT PROGRAM
Introduction
Health Care Services

Call us: 1-888-898-7969, Option 1, then Option 4
Fax us: 1-800-594-7404
Business hours: Monday – Friday (excluding holidays), 8:30 a.m. to 5:00 p.m.
After normal business hours: Monday – Friday 5:00 p.m. – 8:30 a.m.
Saturday, Sunday and holidays
Visit our website 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.

Molina Healthcare's Integrated Care Management Program uses an integrated care management approach based on empirically validated best practices. Research and experience show that a higher-touch, member-centric care environment for at-risk members supports better health outcomes. We strive for full integration of physical health, behavioral health and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. The Integrated Care Management Program consists of Case Management, Care and Access Monitoring, and the Care Transitions Program. Our services include: preservice, admission, and concurrent review; transitional care; discharge planning; continuity and coordination of member care post hospital discharge; after hours clinical availability (On-Call Program); retrospective review; 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 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 your Provider Services Representative or 1-866-449-6828 extension 155216

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 health care for our members, and improved service to our providers.

Who are we?

UM medical and behavioral health activities are coordinated and conducted under the direction of the Medical Director(s) (Physicians) and the Vice President of Health Care Services.

- Director (Registered Nurse (RN)
- Managers (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:
    - o Complex Case Managers (RN)
    - o Clinical Case Managers (RN)
    - o Utilization Management Specialists (Licensed Practical Nurses (LPN))
    - o Utilization Management Coordinators
- The team structure promotes ownership and accountability to providers and members.
    - o An RN is assigned as lead to coordinate work, perform planning, and monitor team functions.
    - o Productivity reporting and expectations are monitored.
- Medical Director Physician Support includes:
    - o Biweekly case review with teams.
    - o Case discussion of complex or chronic illness case management cases.
    - o Review of cases that cannot be cannot be approved be a nurse.
    - o Development of criteria/guidelines.
- Pharmacist Support
- Nurse Advise Line (NAL) and On-Call (RN) staff provide clinical availability after normal business hours.
- Health Services Support includes:
    - o Medical Social Workers (MSW)
    - o Registered Health Information Administrator (RHIA)
    - o Healthcare Data Analysts
    - o UM Clinical Trainers (RN)
    - o Quality Nurse Reviewer (RN)
    - o Administrative and Clerical Support

What do we do?

- Preservice and admission review
- Concurrent review
- Facilitate care transitions
- 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 UM Department has designated staff to answer incoming phone calls. If you have a question or would like to contact a multidisciplinary team that is assigned to you for medical and behavioral health services:

- Department Phone 1-888-898-7969 (option 1, option 4)
- Department Fax 1-800-594-7404

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

Preservice and Admission Review / Authorization Requirements

How to decide if a service requires authorization?

The Molina Healthcare Authorization Requirements Guide can be found on the Molina Healthcare website at www.molinahealthcare.com. The Authorization Requirements Guide pertains to both the Molina Healthcare of Michigan Medicaid and MIChild membership.

Examples of services requiring authorization:

- Select outpatient services require authorization
- Select ambulatory surgical/diagnostic procedures
- Select behavioral health services
- Potentially cosmetic/experimental procedures
- Medical benefit review
- Home health care
- Home intravenous (IV) infusion
- 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 health care professional or a facility. PCPs are able to refer a member to a provider/specialist for consultation without submitting an authorization request to Molina Healthcare. Members may self refer to a behavioral health provider. Members can also directly access women health specialists and pediatric providers for routine and preventative health care services without a referral.

Specialty Network Access (SNA)

The Michigan Department of Community Health, the Medicaid Health Plans and the five Public Entities, University of Michigan Health System, Wayne State University, Hurley Hospital, Michigan State University and Oakland University (Beaumont), have worked on a joint initiative to increase access to specialty care services for Michigan Medicaid recipients. We have developed a process to allow Medicaid beneficiaries' access to the specialty care services that are unavailable through the Health Plan's contracted network.

Please be advised that Molina Healthcare has a contract with two of the above providers (Wayne State University and Oakland University (Beaumont). Our provider network is robust and contains specialists able to meet your needs. We strongly encourage you to utilize Molina Healthcare's Provider Network for specialty care.

However, if you determine a specialist referral is needed for a member to access a specialty care service at one of the above Public Entities that is not available within our network, please contact our UM Department at 1-888-898-7969 (option 1, option 4) and we will assist you with obtaining a referral to an appropriate affiliated specialty care provider of the four Public Entities. A referral is not necessary for Wayne State University nor Oakland University.

When calling, please have patient demographic information, primary care provider and referring specialty provider information available. Also, please have all pertinent information regarding the service being requested and the patient's medical information, including but not limited to specialty required, number of visits, start and end date and diagnosis to facilitate appointment scheduling.

It is our hope that this process will increase the care and access to necessary specialty care to the Michigan Medicaid program beneficiaries. If you have any questions, please contact Molina Healthcare Provider Services at 1-866-449-6828, ext. 155822 or MhmProviderservices@molinahealthcare.com.

Three easy ways to request a pre-service 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 Request Form(s). You may locate the forms at www.molinahealthcare.com/medicaid/providers/mi/forms.aspx
- **Electronically** submit your request using our web based program, WebPortal.
- **Telephone** the UM Department at 1-888-898-7969 (option 1, option 4).

Urgent requests

All urgent requests must be submitted by calling UM Department at 1-888-898-7969 (option 1, option 4). Make sure you identify the request as "urgent" to expedite the review process.

Dual Eligible Authorization Guidelines

Services provided to patients who are covered by both Molina Medicare Options Plus and Molina Medicaid should follow the guidelines below:

- Submit one authorization request - Molina Healthcare will coordinate authorization requirements, benefits and services between the two products
- Submit one claim to Molina Healthcare - Upon receipt of the claim, we will process under Molina Medicare Options Plus then Molina Medicaid. There is no need to submit two claims. Claims processing information will be reported on two Remittance Advice (RA) forms
    - The 1st will come from Molina Medicare indicating how the claim was processed and informing you that the claim was forwarded to Molina Medicaid for secondary processing
    - The 2nd RA will show how the claim was processed for Molina Medicaid

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 Request Form(s). You may locate the forms at www.molinahealthcare.com/medicaid/providers/mi/forms.aspx.
- **Electronically** submit your request using our web based program, WebPortal.
- **Telephone** UM Department at 1-888-898-7969 (option 1, option 4).

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 (WebPortal)
- ✓ Verify the member's eligibility and benefits
- ✓ Accurately complete the appropriate authorization request form (Molina Healthcare Request Form)
- ✓ Include all appropriate codes (diagnosis code(s) and procedure / item code(s))
- ✓ Submit your requests at least 14 days prior for elective services
- ✓ Refer to the Molina Healthcare Authorization Requirements Guide, since many services may not require you to submit a authorization request
- ✓ Include pertinent clinical information (progress notes, lab results, photos, imaging studies)
- ✓ Visit www.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 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
- 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)

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, if appropriate, the request is reviewed against medical appropriateness criteria. The criteria sources used are one or more of the following:
    - Applicable Federal or State mandates and guidelines
    - McKesson InterQual® Criteria
    - The Hayes Directory for New Medical Technologies
    - Internally developed medical necessity criteria
    - Algorithms and guidelines from recognized professional societies
    - Studies published and referenced in medical literature with relevant clinical evidence for efficacy
- 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 may be 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 of the requestor and facility (if indicated) within 72 hours of the initial request.
- **Non-urgent approved requests** – we will call or fax the authorization number of the PCP, requesting physician or facility (if indicated) within 14 days of the initial request.
- **Urgent denied requests** – The rationale for denial and the appeals process with be called to the requesting provider and written notification will be mailed to the member, provider, PCP, and facility (if indicated) within 72 hours of the request.
- **Non-urgent denied requests** - The rationale for denial and the appeals process with be provided by telephone to the requesting provider and written notification will be mailed to the member, provider, PCP, and facility (if indicated) within 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 mail.
- 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 (option 1, option 4).*** 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 during non business hours. If Molina Healthcare fails to respond within one 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 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 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 may request additional information and will forward the case for Medical Director review.

Requests for admission that meet InterQual® 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 for the following diagnoses:

- Acute Abdomen
- Acute Coronary Syndrome
- Acute Bronchitis
- Anemia
- Asthma
- Bronchiolitis
- Cellulitis or Abscess
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Deep Vein Thrombosis (DVT)
- Dehydration
- Diabetes
- Disorders of Fluid, Electrolyte, and Acid-base Balance (Nausea, Vomiting)

- Gastroenteritis / Esophagitis
- General Symptoms
- Pneumonia, Organism Unspecified or Simple
- Poisoning / Toxic Ingestions
- Seizures
- Syncope or Decreased Responsiveness
- Unstable Angina

When would Molina Healthcare 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/or 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 (option 1, option 4).
    - 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 / Managing Care Transitions / Discharge Planning / Continuity and Coordination of Care Post Hospital Discharge

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.

Under the **Care Transitions Program,** Molina Healthcare will coordinate the Care Transitions Plan with you. Our team will facilitate authorizations and serve as a resource for health plan benefits. You may contact the Molina Healthcare UM Department by phone at 1-866-898-7969 (option 1, option 4) or fax 1-800-594-7405 to:

- Inform Molina Healthcare of member hospital admission within one business day of admission
- Arrange post discharge home care and supplies
- Notify Molina Healthcare of potential discharge

The Care Transition Program features four critical elements of services that are a foundation to prepare members through their transition and help them after discharge:

- Medication Management
- A Personal Health Record
- Facilitation of PCP and Specialist Follow-Up
- Education regarding Red Flags

Our dedicated Care Transitions team will:

- Call or visit the member in the hospital as appropriate
- Provide a home visit as appropriate
- Make three post discharge phone calls

The **Discharge Planning** process is initiated by hospital discharge planning staff. Authorization is obtained by calling 1-888-898-7969 (option 1, option 4) or faxing to 1-800-594-7404. The following select post discharge services may require authorization:

- Home health care (including hospice, IV therapy, PT, OT, etc.)
- Hospice
- Outpatient behavioral health visits
- Infusion therapy
- Rehabilitative services
- Select durable medical equipment (DME)
- Skilled nursing facility (SNF)

Prior to or upon discharge from an inpatient facility, the hospital is responsible for providing the following information:

- Discharge date
- Discharge plan (medications, appointments, ancillary service needs, etc.)
- Place of discharge
- Member phone number
- Alternative phone number and contact

Case Management

Our Complex Case Managers (CM) are RNs with specialized training in the management of specific diseases. We also have clinical social workers 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 and behavioral health services throughout the member's continuum of care, while effectively reducing costs. The CMs:

- **Identify** at-risk members who will benefit the most from case management services
  - Accept referrals from all Molina Healthcare areas and from physicians, hospital staff, or from members themselves
- **Assess** members to determine member needs
- **Develop a plan of care** with prioritized goals
- **Implement interventions** through ongoing member contact
  - Focus on health education and coaching to promote self-management
- **Assist with care coordination** including medical health and mental health
  - Coordinate interdisciplinary approach involving internal staff, providers, member/family and community resources
  - Coordinate with community-based organizations and services
- **Assist with service coordination**
  - Scheduling appointments and attaining DME

The CMs are available to physicians, utilization review staff, discharge planners, the member and member's family/caregiver (with applicable member consent) 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 that may be referred for case management include those with:

- Multidisciplinary needs requiring case management intervention/support
- Multiple hospital admissions and ED visits within the last six months with one more of the following conditions:
  - Asthma
  - AIDS/HIV
  - Cancer (other than chemotherapy admissions)
  - Cardiovascular Disease
  - CHF

- COPD
- Diabetes
- End Stage Renal Disease (ESRD)
- Sickle Cell Anemia
- High Risk Obstetrics/Newborns

If you would like to learn more information, speak with a CM and/or refer a member for an evaluation, please call our UM Department at 1-888-898-7969 (option 1, option 4).

How to refer a member for case management?

During normal business hours call the UM Department at 1-888-898-7969 (option 1, option 4).

How will you know if the member is accepted into case management?

Our CMs perform an individualized member assessment. Following the assessment, the CM will send a letter informing you of the member's acceptance into the Case Management Program, with their direct phone number.

The CM may periodically contact 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 ED 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 Nurse Advice Line (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 after normal business hours Monday – Friday 5:00 p.m. – 8:30 a.m., 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
- Observation services
- 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 (option 1, option 4).

Coordination of Medical and Behavioral Health Care

Coordinating member's behavioral and medical health care is essential to providing appropriate care for our members.

Molina Healthcare recognizes that a members' emotional and physical well being can significantly affect their ability to participate in their treatment plan. As part of a comprehensive member treatment plan for all conditions, Molina Healthcare expects behavioral health and medical providers coordinate care for members they treat.

Molina Healthcare clinical staff is available to assist in the coordination of care

Molina Healthcare case managers identify members for potential behavioral health issues during contact with the member. When members are identified as having a potential behavioral health/substance abuse condition, Molina clinical staff will:

- Notify the PCP and the attending physician, when applicable, to coordinate appropriate care.
- Assist in the coordinate of care between providers.

Expectations of behavioral health providers

To promote the appropriate coordination of care between the providers involved in the member's care, behavioral health providers are expected to communicate the following information to the member's PCP:

- Member's diagnosis
- Dates of clinical evaluation and types of treatment
- List of medications
- Dates of any related hospitalizations
- Any medical conditions that require attention
- Dates of aftercare/follow-up appointments

Behavioral health providers are asked to:

- Consult with the clinicians who treated the member prior to the current episode of care, if applicable
- Refer the member for follow-up with community and psychosocial support services, when appropriate

Expectations of non-behavioral health providers

When a PCP or other non-behavioral health practitioner encounters a member who may benefit from behavioral health services, the member should be referred to an appropriate behavioral health provider for care. Molina clinical staff is available to assist with this coordination.