HEALTHCARE SERVICES

Introduction

Molina Healthcare maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina Healthcare medical management program also ensures that Molina Healthcare only reimburses for services identified as a covered benefit and medically necessary . Elements of the Molina Healthcare medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network providers.

Delegation to Children's Hospital Organizations

Effective July 1, 2013, Molina Healthcare of Ohio ("Molina Healthcare") partnered with Nationwide Children's Hospital's Partners for Kids (PFK) to delegate Care Management (including Complex, High-Risk and Medium Risk Care Management) for Children with Special Health Care Needs (CSHCN) and CFC children in their assigned counties. Members in Low-Risk Care Management (Disease Management) will continue to be managed by Molina Healthcare. All Utilization Management functions will continue to be handled by Molina Healthcare of Ohio.

PFK Counties: Athens, Belmont, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton, Washington

Effective July 1, 2013, Molina Healthcare also partnered with Health Network by Cincinnati Children's (HNCC) to delegate Care Management (including Complex, High-Risk and Medium Risk Care Management) and Utilization Management for Children with Special Health Care Needs (CSHCN) and CFC children in their assigned counties. Behavioral Health Care Management is currently excluded. Members in Low-Risk Care Management (Disease Management) will continue to be managed by Molina Healthcare. HNCC will handle all Utilization Management functions, including Pre-Certification, Inpatient Concurrent Review, Retro-Authorization and reconsideration of denied services as indicated. Utilization Management of Behavioral Health Services, including both inpatient and outpatient services are currently being managed by Molina Healthcare.

HNCC Counties: Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland and Warren

Each organization will work only with members in their specific regions or counties. Appeals and Grievances for both hospital systems will continue to be managed by Molina Healthcare.

Medical Necessity Review
In conjunction with regulatory guidance from the Centers for Medicare and Medicaid Services (CMS) and industry standards, Molina Healthcare only reimburses services provided to its members that are medically necessary. Molina Healthcare may conduct a medical necessity review of all requests for authorization and claims, within the specified time frame governed by Federal or State law for all lines of business. This review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively, as long as the review complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement.

Clinical Information
Molina Healthcare requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina Healthcare does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless required by State regulation or the Molina Healthcare Hospital or Provider Services Agreement.

Prior Authorization
Molina Healthcare requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina Healthcare prior authorization documents are updated annually and the current documents are posted on the Molina Healthcare website. Molina Healthcare has included at the end of this section of this manual a copy of the current Authorization Request form. If using a different form the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.)
- Provider demographic information (referring provider and referred to provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS and ICD-9 codes
- Clinical information sufficient to document the medical necessity of the requested service

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State law) are excluded from the prior authorization requirements. Molina Healthcare does not "retroactively" authorize services that require prior authorization.

Molina Healthcare and its delegated entity Health Network by Cincinnati Children's will process any non-urgent requests within fourteen (14) calendar days of receipt of request. Urgent requests will be processed within seventy-two (72) hours.

Providers who request Prior Authorization approval for patient services and/or procedures may 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 provider at (855) 322-4079. For Health Network by Cincinnati Children's Members, providers may call 1-855-789-4622 from 8:30 a.m. to 5:00 p.m., Monday through Friday.

Requesting Prior Authorization

Web Portal/Clear Coverage: Providers are encouraged to use the Molina Healthcare WebPortal for prior authorization submission. When submitting a request for outpatient services we have a rules based authorization submission process called Clear Coverage. When you log into the WebPortal choose the drop down option "Create Service Request/Authorization using Clear Coverage" link under the Service Request/Authorization Menu. Currently the rules based authorization submission process is for outpatient services.

Some of the benefits of using Clear Coverage are:

- Many outpatient services can automatically be approved at the time of the authorization submission
- For requests not automatically approved, you can see the real-time status of your request by opening your office's home page directly in *Clear Coverage*
- Receive rapid confirmation for services where no authorization is required. You are notified within a few steps if no authorization is required for the CPT code requested. You can print or paste a copy of that notification showing no authorization required for your records. There is no need for you to take any additional action.

Fax: The Prior Authorization form can be faxed to Molina Healthcare at: 866-449-6843. If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department.

For Health Network by Cincinnati Children's Members, Providers may fax to 1-877-402-8646

Phone: Prior Authorizations can be initiated by contacting Molina's Healthcare Services Department at 855-322-4079. It may be necessary to submit additional documentation before the authorization can be processed.

For Health Network by Cincinnati Children's Members, Providers may call 1-855-789-4622 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday.

Mail: Prior Authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:

Molina Healthcare of Ohio
Attn: Healthcare Services Dept.
P.O. Box 349020
Columbus, OH 43234

Inpatient Management

Elective Inpatient Admissions- Molina Healthcare requires prior authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions-Molina Healthcare requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. Molina Healthcare requires that notification includes member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements will result in a denial of authorization for the inpatient admission.

Concurrent Inpatient Review- Molina Healthcare performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina Healthcare will request updated original clinical records from inpatient facilities at regular intervals during a member's inpatient admission. Molina Healthcare requires that requested clinical information updates be received by Molina Healthcare from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates will result in denial of authorization for the remainder of the inpatient admission.

Inpatient Observation Policy

Molina Healthcare has implemented inpatient utilization review policy changes effective Oct. 1, 2013. Our goal is to ensure members receive medically necessary services in the appropriate and most efficient and cost effective setting. All inpatient admissions require prior authorization. Similar to Ohio Administrative Code (OAC) 5101:3-2, Molina Healthcare will review and evaluate covered medical services to ensure procedures are medically necessary and provided in the most appropriate setting.

- If inpatient admission InterQual® criteria are not met and observation InterQual® criteria are met, Molina Healthcare will authorize an observation stay. For stays of one day or less, when InterQual® is met for inpatient and observation, we will review and consider these for observation level of care. If you disagree with the decision and believe inpatient admission is necessary, a Molina Healthcare Medical Director will review the case and make a determination.
    - **Important Note: Hospitals participating in Molina Healthcare's network are not required to seek authorization for observation days.**
- If both observation and inpatient criteria are met, Molina Healthcare will initially authorize an observation stay for the following conditions:

    - Acute Abdomen
    - Acute Appendicitis (adult)

- Acute Bronchitis
- Acute Coronary Syndrome/Chest Pain
- Acute Kidney failure
- Acute Pancreatitis
- Anemia Asthma Bronchiolitis
- Cardiac Dysrhythmia
- Cellulitis or Abscess
- Cholelithiasis
- Chronic Ischemic Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Deep Vein Thrombosis (DVT) Dehydration
- Diabetes/DKA
- Disorders of Fluid, Electrolyte, and Acid base balance (Nausea, Vomiting)
- Gastroenteritis/Esophagitis
- General Symptoms
- Hypotension
- Pneumonia, Organism Unspecified or simple
- Poisoning/Toxic Ingestions
- Seizures
- Septicemia
- Syncope or Decreased Responsiveness
- Unstable Angina

These conditions are often evaluated and treated within one day or less and rapid improvement of the member's condition is anticipated. If the member remains hospitalized past one day and continues to meet InterQual® criteria, Molina Healthcare will approve the inpatient admission authorization request. If inpatient admission InterQual® are met, Molina Healthcare will approve an inpatient admission based upon clinical criteria at the time of admission, excluding the above listed conditions. For instructions on submitting a prior authorization request, visit www.MolinaHealthcare.com.

Non-Network Providers- Molina Healthcare maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare members. Molina Healthcare requires members to receive medical care within the participating, contracted network of providers. All care provided by non-contracted, non-network providers must be prior authorized by Molina Healthcare. Non-network providers may provide emergent/urgent care and dialysis services for a member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State laws or regulations.

Avoiding Conflict of Interest
The HCS Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.
Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Also, we require our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care
Molina Healthcare's Integrated Care Management, which includes Utilization Management, Case Management and Disease Management, will work with providers to assist with coordinating services and benefits for members with complex needs and issues. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.
Molina Healthcare staff assists providers by identifying needs and issues that may not be verbalized by providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina Healthcare staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members
It is Molina Healthcare's policy to provide members with advance notice when a provider they are seeing will no longer be in network. Members and providers are encouraged to use this time to transition care to an in-network provider. The provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the provider(s) assuming care. Under certain circumstances, members may be able to continue treatment with the out of network provider for a given period of time. For additional information regarding continuity of care and transition of members, please contact Molina Healthcare at 855-322-4079

Continuity and Coordination of Provider Communication
Molina Healthcare stresses the importance of timely communication between providers involved in a member's care. This is especially critical between specialists, including behavioral health providers, and the member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Case Management
Molina Healthcare provides a comprehensive Case Management (CM) program to all members who meet the criteria for services. The CM program focuses on procuring and coordinating the care, services, and resources needed by members with complex issues through a continuum of

care. Molina Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Healthcare case managers are licensed professionals and are educated, trained and experienced in the case management process. The CM program is based on a member advocacy philosophy, designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The CM program is individualized to accommodate a member's needs with collaboration from the member's PCP. The Molina Healthcare case manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare case manager is responsible for assessing the member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program, in addition case management accepts referrals from hospitals, nursing homes, and other health care providers as well as internal referrals . The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist providers, ancillary providers, the local Health Department and other community resources. The referral source may provide the case manager with demographic, health care and social data about the member being referred.

Members with the following conditions may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation:

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- Children with Special Health Care Needs

Referrals to the CM program may be made by contacting Molina Healthcare at:

Phone: (855) 322-4079
Fax: (866) 553-9260

PCP Responsibilities in Case Management Referrals
The member's PCP is the primary leader of the health team involved in the coordination and direction of services for the member. The case manager provides the PCP with reports, updates, and information regarding the member's progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

Case Manager Responsibilities
The case manager collaborates with all resources involved and the member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, providers, and the member are responsible for implementing the plan of care. Additionally the case manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource to team members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
- Coordinates appropriate education and encourages the member's role in self-help
- Monitors progress toward the member's achievement of treatment plan goals in order to determine an appropriate time for the member's discharge from the CM program.

Health Education and Disease Management Programs
Molina Healthcare's Health Education and Disease Management programs will be incorporated into the member's treatment plan to address the member's health care needs. Primary prevention programs may include smoking cessation and wellness.

Emergency Services
Emergency services are covered on a (24) hour basis without the need for prior authorization for all members experiencing an emergency medical situation.
Molina Healthcare of Ohio accomplishes this service by providing Utilization Management during business hours and a (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all members at the onset of any call to the plan.

For members within our service area: Molina Healthcare of Ohio, Inc. contracts with vendors that provide (24) hour emergency services for ambulance and hospitals. In the event that our member is outside of the service area, Molina Healthcare is prepared to authorize treatment to ensure that the patient is stabilized.

Medical Record Standards
The provider is responsible for maintaining an electronic or paper medical record for each individual member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable federal and state regulations. The provider must ensure his/her staff receives periodic training regarding the confidentiality of member information.

The provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the member was referred to the provider.
At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in section 8 (Quality Improvement) of this manual.

Medical Necessity Standards
Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain

- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs

- Consistent with the generally accepted professional medical standards as determined by applicable Federal and State regulation, and not be experimental or investigational

- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide

- Furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider

- The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Specialty Pharmaceuticals/Injectables and Infusion Services
Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases they will be made available through Molina Healthcare's vendor, Caremark Specialty Pharmacy. More information about our Prior Authorization process, including a PA request form, is available in Section 7 of this manual.

Molina's pharmacy vendor will coordinate with Molina Healthcare and ship the prescription directly to your office or the member's home. All packages are individually marked for each member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

Prior Authorization Guidelines and Request Form
Visit the Molina Healthcare website at www.MolinaHealthcare.com for guidelines and the prior authorization request form. Click on "For Health Care Professionals" at the top of the page, then select "Forms" and scroll down to "Medical Services" to find the Service Request Form and Instructions.