HEALTHCARE SERVICES

INTRODUCTION

Molina provides care management services to Molina Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated care management model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Elements of the Molina medical management program include Pre-service review and Organization Determination/ Authorization management that includes pre-admission, admission and inpatient review, Medical Necessity review, and restrictions on the use of non-network Providers. You can contact the Molina UM Department toll free at (800) 869-7175. The UM Department fax number is (800) 767-7188.

Utilization Management

Molina's Utilization Management (UM) program ensures appropriate and effective utilization of services. The UM team works closely with the Care Management (CM) team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. To reflect the vital role this process plays in Molina's innovative HCS program, the UM program ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the levels of care needed for a Member. This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes as necessary and is designed to influence Member's care by:

- Identify medical necessity and appropriateness while managing benefits effectively and efficiently to ensure efficiency of the healthcare services provided
- Continually monitor, evaluate and optimize the use of healthcare resources while evaluating the necessity and efficiency of health care services across the continuum of care;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization while monitoring utilization practice patterns of Providers, hospitals and ancillary Providers to identify over and under service utilization;
- Identify and assess the need for Care Management/Health Management through early identification of high or low service utilization and high cost, chronic or long term diseases;
- Promote health care in accordance with local, state and national standards;
- Identify events and patterns of care in which outcomes may be improved through efficiencies in UM, and to implement actions that improve performance by ensuring care is safe and accessible

- Ensuring that qualified health care professionals perform all components of the UM / CM processes while ensuring timely responses to Member appeals and grievances
- Continually seek to improve Member and Provider satisfaction with health care and with Molina utilization processes while ensuring that UM decision tools are appropriately applied in determining medical necessity decision.
- Process authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

The table below outlines the key functions of the UM program. All prior authorizations are based on a specific standardized list of services.

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and Referral Management	Satisfaction evaluation of the UM program using Member and practitioner input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensuring authorized care correlates to Member's medical necessity need(s) & benefit plan	Retrospective Review	Monitor for possible over- or under-utilization of clinical resources
Verifying current Physician/hospital contract status	Referrals for Discharge Planning and Care Transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA, state and health plan UM standards

Medical Necessity Review

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 MCG (formerly known as Milliman Care Guidelines), McKesson InterQual®, other 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.

All Providers must obtain authorization for specific services that require prior authorization, unless the requesting Provider is affiliated with a medical group/IPA granted "delegated" Utilization Management status (For information on contracted medical groups/IPAs that are delegated for UM please see Section 13, Delegation -Medical Group/IPA Operations**.** If you are treating a Member assigned to a PCP in one of the delegated medical groups/IPAs, Molina Providers are required to follow their specific authorization requirements, as they may restrict their referrals to Providers within their group.

Clinical Information

Molina 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 does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations or the Molina Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina 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 prior authorization documents are updated annually and the current documents are posted on the Molina website. You can find the most current copy of the Authorization Request form at http://www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx.

Requests for prior authorizations to the UM Department may be requested by telephone, fax, mail based on the urgency of the requested service, or via the Provider Web Portal. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number, etc.)
- Clinical information sufficient to document the Medical Necessity of the requested service
- Provider demographic information (referring Provider and referred to Provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS, and ICD-10 codes
- Location where service will be performed
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions)
- Pertinent medical history (include treatment, diagnostic tests, examination data)
- Requested Length of stay (for inpatient requests)
- Indicate if request is for expedited or standard processing

Molina will process any non-urgent requests within five (5) calendar days of the receipt of necessary information, but are allowed up to fourteen (14) calendar days, if additional information is required and requested by the Contractor within five (5) calendar days of the original receipt of the request for services. For all urgent requests, the decision must be made within forty-eight (48) hours of receipt of request.

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 does not "retroactively" authorize services that require prior authorization unless the request falls under WAC 284-43-2060 Extenuating Circumstances in Prior Authorization.

Molina will administratively deny late notifications (requests for inpatient services greater than 24 hours or next business day from admission) when an extenuating circumstance adversely affects the ability of the participating provider or facility to request prior authorization prior to the service delivery as long as the services are covered benefits for the member and meet Molina medical necessity criteria.

Molina requires a participating provider or facility to submit documentation before a claim is submitted or within 14 days of claims submissions for consideration of prior authorization for extenuating circumstances. Submissions after this time frame will be considered an appeal and follow the timely filing for appeals submissions. When submitting your prior authorization request, clearly document the request is an Extenuating Circumstance and outline the Extenuating Circumstance in this case that prevented the provider from being able to request prior authorization or notification as required.

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 has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (800) 869-7158.

Requesting Prior Authorization

Please indicate if the request is urgent or non-urgent. The Definition of expedited/urgent is when the situation where the standard time frame or decision making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function. If the member is assigned to a delegated Medical Group/IPA, please send the prior authorization request to the Medical Group/IPA.

WebPortal: Providers are required to use the Molina WebPortal for prior authorization submissions whenever possible. Instructions for how to submit a Prior Authorization Request are available on the Portal. You can click on the following link to take you to the login page: **https://eportal.molinahealthcare.com/Provider/login**

Phone:

- Molina Healthcare: (855) 322-4082
- Kaiser Foundation Health Plan of the Northwest: (800) 813-2000
- Confluence Health : (800) 691-1224

Fax: If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department. Please include the supporting documentation needed for Molina to make a determination.

- Molina Healthcare:
  Medical/Behavioral Health (800) 767-7188
  Advanced Imaging (877) 731-7218
  Inpatient Census (800) 413-3806
  NICU (877) 731-7220
  Transplant (877) 813-1206

- Kaiser Foundation Health Plan of the Northwest: (877) 800-5456
- Confluence Health: (509) 665-3606

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

Molina Healthcare of Washington
Attn: Healthcare Services Dept.
PO Box 4004
Bothell, WA 98041-4004

Affirmative Statement about Incentives

Molina requires that all medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns and ensures, through communications to Providers, Members, and staff, that Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Furthermore, Molina affirms that all UM decision making is based only on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care. It is important to remember that:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.

Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Molina and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans or other coverage arrangements.

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina (or by an entity acting on behalf of Molina) and are never delegated:

1. Transplant Case Management - Molina does not delegate management of transplant cases to the medical group. Providers are required to notify Molina's UM Department when the need for a transplant evaluation has been identified. Contracted Providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina conducts medical necessity review. Molina selects the facility to be accessed for the evaluation and possible transplant.
2. Clinical Trials - Molina does not delegate to Providers the authority to determine and authorize clinical trials. Providers are required to comply with protocols, policies, and procedures for clinical trials as set forth in Molina's contracts.
3. Experimental and Investigational Reviews - Molina does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

Delegated Utilization Management Functions

Medical Groups/IPAs delegated with UM functions must be prior approved by Molina and be in compliance with all current Molina policies. Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities depending on their ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual

Communication and Availability to Members and Providers

Molina HCS staff is accessible at (800) 869-7175 during normal business hours, from 7:30 a.m. to 6:30 p.m. Monday – Friday excluding holidays for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, seven days a week at (888) 275-8750. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters. . Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Providers can also utilize fax and the Provider Portal for after-hours UM access, as described later in this section

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff. Callers may also contact staff directly through a private line. All staff Members identify themselves by providing their first name, job title, and organization.

Molina offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

Molina's Provider Portal is available twenty-four (24) hours per day, seven (7) days per week. The Portal can be used for Prior Authorization functions (requests, status checks, etc.) and communication.

Levels of Administrative and Clinical Review

Molina reviews and approves or denies plan coverage for various services—inpatient, outpatient, medical supplies, equipment, and selected medications. The review types are:

- Administrative (e.g., eligibility, appropriate vendor or Participating Provider, covered services) and
- Clinical (e.g., Medically Necessary)

The overall review process begins with administrative review followed by initial clinical review if appropriate. Specialist review may be needed as well. All Determination/Authorization requests that may lead to denial are reviewed by a heath professional at Molina (medical directory, pharmacy director, or appropriately licensed health professional).

All staff involved in the review process has an updated Determination/Authorization requirements list of services and procedures that require Pre-Service Organization Decision/Authorization.

The Determination/Authorization requirements, timelines and procedures are published in the Provider Manual and are available on the www.molinahealthcare.com website.

In addition, Molina's Provider training includes information on the UM processes and Determination/Authorization requirements.

Hospitals

Emergency Services

Emergency Services means: a medical screening examination, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that Emergency Medical Condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

Emergency or Emergency Medical Condition means: the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including sever pain, which in the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in jeopardy to the person's health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or disfigurement to the person; in in the case of a pregnant woman, serious jeopardy to the health of the fetus.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Services rendered to the Member do not require prior authorization from Molina.

Members accessing the emergency department inappropriately will be contacted by Molina Case Managers whenever possible to determine the reason for using Emergency Services. Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Admissions

Hospitals are required to notify Molina within twenty four (24) hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. Prior authorization is required for inpatient or outpatient surgeries.

Certified Public Expenditure (CPE) Hospitals

If your facility is identified as a CPE hospital your hospital is eligible to be compensated for inpatient services provided to the Apple Health Blind and Disabled (AHBD) or Integrated Managed Care Blind and Disabled (IMCBD) population through the certified public expenditure program. You will need to bill all inpatient services for AHBD and IMCBD members to Washington State Medicaid. In order to be compensated for services you must obtain prior authorization from the members' health plan in advance of providing the service. When you bill Washington State Medicaid you will need to include the health plan authorization number in the comments or notes section on the claim. The professional component is the responsibility of the health plan and should be billed directly to the health plan.

Inpatient Management

Elective Inpatient Admissions

Molina 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 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. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina 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 or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

- Member eligibility;
- Member covered benefits;
- The service is not experimental or investigation in nature;
- The service meets Medical Necessity criteria (according to accepted, nationally-recognized resources);
- All covered services, e.g. test, procedure, are within the Provider's scope of practice;
- The requested Provider can provide the service in a timely manner;
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition;
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor;
- The service is provided at the appropriate level of care in the appropriate facility; e.g. outpatient versus inpatient or at appropriate level of inpatient care;
- Continuity and coordination of care is maintained; and
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

Inpatient Review

Molina 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 will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, for those stays where there is a clear expectation, and the medical record supports that reasonable expectation of an extended stay, or where observation has been tried, in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed.

Inpatient Status Determinations

Molina's UM staff determine if the collected medical records and clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or

injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements. To determine Medical Necessity, the criteria outlined under "Medical Necessity Review" will be used.

Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

Concurrent Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The concurrent review nurses review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Post Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do not require authorization. Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

Failure to obtain authorization when required will result in denial of payment for those services, unless the request falls under WAC 284-43-2060 Extenuating Circumstances in Prior Authorization.

Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, CMS Medical Coverage Guidelines, Local and National Coverage Determinations, CMS Policy Manuals, regulation and guidance and evidence based criteria sets.

Specific Federal or State requirements or Provider contracts that prohibit administrative denials supersede this policy.

Readmission

Effective 01/01/2018 HCA is implementing a new readmission policy. All Medicaid health plans and FFS will follow a common policy which contains specific provider requirements in discharge and follow-up planning. Determination and recoupment will be retroactive and applies only to medically necessary readmissions. Critical Access hospitals are excluded from this policy.

Administrative Days

Hospitals requesting authorization of administrative days must submit a separate authorization request from the inpatient hospital stay. Molina requires the following information be included in the request for authorization:

- Current clinical data
- Submission of documented discharge/placement efforts
- Documentation of phone call and fax responses regarding placement to include specific information of contacted providers
- Documentation of specific rationale for declines related to placement
- Plan of care including specific needs and long term goals

If during the continuation of administrative days the member's condition is such that custodial care may be appropriate, you will be directed to Home and Community Services (HCS) for future discharge and placement needs. If the member's diagnosis includes chemical dependency issues, you must refer the member to Department of Social and Health Services (DSHS) for possible chemical dependency treatment.

Administrative days must be billed on a separate claim form:

- For acute care stay paid under DRG - revenue code 0191 must be billed on the claim for administrative days and the acute care stay claim must be billed with inpatient status code 30 to indicate a separate claim will be submitted for administrative days
- For per-diem - paid services bill with revenue code 0169

Non-Network Providers

Molina maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Members. Molina requires Members to receive medical care within the participating, contracted network of providers unless it is for emergent/urgent services. Non-network providers may provide emergent/urgent services for a member without prior authorization or as otherwise required by Federal or State laws or regulations.

If there is a non-emergent need to go to a non-contracted provider, all care provided by the non-contracted, non-network provider must be prior authorized by Molina.

Avoiding Conflict of Interest

The HCAS Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Molina does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision

makers to make determinations that result in under-utilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

Molina's Health Care Services (HCS) includes Utilization Management and Care Management. HCS works with Providers to assist with coordinating services and benefits for Members with complex needs. 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 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 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'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 and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to ninety (90) days or longer if necessary for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.

It is also Molina's policy to allow continuity of care for new Members who become effective with Molina and meet the above conditions. All requests will be reviewed by the Medical Director. For additional information regarding continuity of care and transition of Members, please contact Molina at (800) 869-7175.

Organization Decisions

A decision is any determination (e.g., an approval or denial) made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination);

- Determination to deny requests (adverse benefit determination);
- Discontinuation of a service;
- Payment for temporarily out-of-the-area renal dialysis services;
- Payment for Emergency Services, post stabilization care or urgently needed services;

All Medical Necessity requests for authorization determinations must be based on nationally recognized criteria that are supported by sound scientific, medical evidence. Clinical information used in making determinations include, but are not limited to, review of medical records, consultation with the treating Providers, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

Clinical criteria does not replace State regulations when making decisions regarding appropriate medical treatment for Molina Members. Molina covers all services and items required by State.

Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of medical necessity.

Board certified licensed Providers from appropriate specialty areas must be utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal regulatory requirements and NCQA standards.

Providers can contact Molina's Healthcare Services department at (800) 869-7175 to obtain Molina's UM Criteria.

Reporting of Suspected Abuse of an Adult

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

Molina reports suspected or potential abuse, neglect or exploitation of vulnerable adults as required by state and Federal law. A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental/behavioral or emotional condition. Mandatory reporters include:

- Molina employees who have knowledge or suspect the abuse, neglect, or exploitation;
- Law enforcement officer;
- Social worker; Professional school personnel; Individual Provider; an employee of a facility; an operator or a facility; and/or

- An employee of a social service, welfare, mental/behavioral health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or healthcare Provider.

A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina UM Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.

The following are the types of abuse which are required to be reported:

- Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
- Sexual abuse is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- Mental/behavioral mistreatment is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.
- Neglect occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.
- Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.
- Exploitation occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
- Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care.

In the event that an employee of Molina or one of its contracted Providers encounters potential or suspected abuse as described above, a call must be made to:

Office of the Attorney General’s Vulnerable Adult Abuse reporting line at:
(866) 363-4276 (866-END-HARM).

All reports should include:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Any safety concerns.

Molina’s HCS team will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities or

other clinical personnel. Under State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Utilization Management Committee and the proper state agency.

Emergency Services

Emergency Services means: a medical screening examination, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

Emergency services are covered on a (24) hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Molina Healthcare of Washington accomplishes this service by providing 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 of Washington 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 is prepared to authorize treatment to ensure that the patient is stabilized.

Continuity and Coordination of Provider Communication

Molina 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.

Care Management

Molina Care Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services.

PCP Responsibilities in Care 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 Care Management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care 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 Management

Molina's Health Management programs can be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation and weight management and disease-specific health management programs for Asthma and Depression. Refer to "Benefits and Covered Services" section for detailed information regarding these services.

Case Management (CM)

Molina 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 needs through a continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina 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 and approval from the member's PCP. The Molina case manager will arrange individual services for

members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina 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. 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 provides 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 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 at:

Phone: 800) 869-7185
Fax: (800) 767-7188

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 records shall be maintained in accordance with State and Federal law, and for a period not less than ten (10) years.

Medical Necessity Standards

"**Medically Necessary**" or "**Medical Necessity**" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

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 a vendor, designated by Molina.

CVS/Caremark Specialty Pharmacy operates as a business unit within CVS/Caremark Corporation. The Member and Provider dispensing capabilities of McKesson Specialty Pharmaceuticals complement McKesson's existing patient relationship and disease management businesses, which hold market-leading positions.

When a Molina Member needs an injectable medication, the prescription can be submitted to Molina by fax at (800) 869-7791. Specialized request forms can be obtained by calling (800) 237-2767 or at http://www.molinahealthcare.com/providers/wa/medicaid/forms/PDF/forms_wa_Specialtydrugrequestform.pdf.

CVS/Caremark Specialty Pharmacy will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each

patient, 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.

Transitions of Care

During episodes of illness involving multiple care settings, patients are at increased risk of poor health outcomes and avoidable re-admissions resulting from fragmented care if care transitions are not well executed. Molina designed its patient-centered Transitions of Care (ToC) program to improve the quality of care for patients with complex physical, long-term, and behavioral health care needs as they transition across care settings. Transitions of Care programs have been shown to reduce preventable re-admissions, emergency department use, and to improve health outcomes.

Molina defines Transitions of Care to include all services required to ensure the coordination and continuity of care from one care setting to another as the member's health status changes. This includes members discharging from medical, psychiatric, and chemical dependency inpatient treatment facilities and others. Molina's Transitions of Care team will confirm and re-establish the patient's connection to their medical home/Primary Care Physician/Specialist and assist with the coordination of care as the patient moves from one care setting to another. The target populations for Molina's Transitions of Care program are patients that are at a high risk of re-admission, based on medical literature and 30 years of experience serving the Medicaid population. These include members with a diagnosis of:

- Asthma
- Cellulitis
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes
- Pneumonia
- Chronic mental illness
- Substance abuse disorder
- Additional secondary criteria will be considered based on acuity and may include, but are not limited to, the following:
    - Member history of re-admission and poor adherence to follow-up treatment
    - Alzheimer's disease
    - Parkinson's disease
    - Multiple co-morbid conditions

Molina's ToC program focus is patient-centered collaborative care coordination. Our Transitions team works closely with Case Management, In-Patient Review Discharge Planners, Disease Management, Health Home staff, Community Health Workers, Pharmacy, providers, and care givers. This proactive collaboration helps assess for and remove barriers prior to discharge. This interdisciplinary approach ultimately results in improved health outcomes and reduced re-admissions. The ToC Team provides oversight to assure appropriate collaboration and confirms the members identified needs have been addressed. Weekly case review meetings led by a Molina Medical Director allow for discussion and planning for complex and difficult transitions.

Molina patients may be contacted by a Transitions of Care Coach via a face-to-face or telephonic visit while in the inpatient setting. The Transitions of Care coach with the facility care team works to develop an individual care transition plan and personal health record. Following discharge, the patient may receive a follow-up phone call within 2-3 days after discharge, and a face-to-face visit in their place of residence within one week after discharge if needed. The Transitions of Care Coach will assess the patient's ability to make and attend all needed follow up appointments, complete medication reconciliation, nutrition management, patients understanding of illness and how to recognize worsening symptoms, when to call their Primary Care Physician, and develop a sick day plan, assess home safety, the member's support network and community connections, and will assist the member with obtaining immediate psychosocial needs such as food, transportation, clothing, social support, advocacy, and other community-based resources. The Transitions of Care Coach will continue to provide care coordination for 4 weeks, primarily via telephone, to ensure that the goals of the individual have been met and a member has successfully transitioned to a lower level of care. As the transitions of care process nears completion, Molina's Transitions of Care coordinator will identify any on-going needs that a member may have and, if needed, coordinate a referral to the Molina Case Management program or Primary Care Physician who will work with the member to address those needs going forward.

Molina's standard of care for Transitions of Care include the following and requires these elements be completed by the facilities, Primary Care Provider, Molina Contracted Staff, Case Managers, or Molina Transitions of Care coach for each patient as they transition between care settings.

- Assess and stratify patients into levels of risk for re-admission
- Create an individual patient plan to mitigate readmission to include:
    - Patient education to support discharge care needs for example: Medication management, ensure follow up appointments are attended, self-management of conditions, when and how to seek medical care. Planning is to include caregivers as needed,
    - Written discharge plan must be given to patient/caregiver and Primary Care Provider upon discharge,
    - Provider will ensure access to follow up appointment within 7 days of discharge.
    - Schedule follow up outpatient mental health or PCP appointments within 7 calendar days of discharge or ensure Home Care services are delivered within 7 days of discharge,
    - Organize post discharge services, home care services, and therapies, etc.,
    - Telephonic reinforcement of discharge plan and needed problem solving within 2-3 business days from time of discharge,
    - Information on what to do if a problem arises following discharge,
    - For patients at high risk of re-hospitalization, provide onsite care coordinator at time of discharge (Molina may have ToC coach or contracted staff round at facility),
    - For patients at high risk of re-hospitalization, Primary Care Provider or Molina (Molina contracted staff) will visit patient residence or secondary facility such as skilled nursing facility or residential mental health facility within 7 calendar days

post discharge as needed to support discharge instructions, assess environment safety, conduct medicine reconciliation, assess adequacy of support network and services, link to appropriate referrals.

Planning activity should include patient's family and caregivers and support network in assessing needs.

Members engaged in Health Homes program will receive Transitions of Care services from Health Homes Care Coordinator.

To prevent duplication of services Molina will coordinate required elements with admitting facilities and assist in providing required elements that admitting facilities are unable to provide. Molina has developed operational agreements with Regional Support Networks, targeted substance use disorder treatment facilities, long-term care facilities, and behavioral and physical health facilities to communicate and collaborate on members' transitions through different levels of care. These operational agreements include guidelines for sharing the following information:

- Notification to Molina and Primary Care Physician of member admission.
- Written discharge plan provided to both the member and Primary Care Physician.
- Discharge planning including scheduled follow-up visits.
- Coordination of services needed upon discharge.
- Notification to Molina and Primary Care Physician of discharge.

When warranted for HIPAA compliance, Molina will obtain releases from members to allow sharing of data.

Health Home Services

Health Home implementation is authorized by Section 2703 of the federal Patient Protection and Affordable Care Act, the managed fee-for-service demonstration model, and the Substitute Senate Bill 5394 from the 2011 legislative session. Under Washington State's approach, Health Homes (HH) is the bridge to integrate care within existing health delivery systems.

A Health Home is the central point for directing patient-centered care for high-risk, high-cost beneficiaries in a specified geographic coverage area. The Health Home is accountable for reducing avoidable healthcare costs, specifically preventable hospital admissions/re-admissions, and avoidable emergency room visits. The Health Homes will provide timely post-discharge follow-up with the goal to improve patient outcomes by providing intensive care coordination services to high-cost, high-need Medicaid and Medicaid/Medicare beneficiaries to ensure that services are integrated and coordinated across medical, mental health, chemical dependency, long-term services and supports, and community support services.

Molina Healthcare of Washington is a qualified Health Home (AKA "lead entity") for geographic area 1 (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston Counties); area 2 (Island, San Juan, Skagit, and Whatcom Counties); and area 6 (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens,

and Whitman Counties). Molina is contracted with qualified lead entities in 3 other areas across the state to provide Health Home services. King and Snohomish counties are not participating in the Health Home demonstration. As a qualified lead entity, Molina is responsible for providing (or contracting for) the following six (6) specific care coordination services functions:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitions care from inpatient to other settings, including appropriate follow-up
- Individual and family support, including authorized representatives
- Referral to community and social support services
- Use of health information technology to link services, as feasible and appropriate

bAs a lead entity, Molina has created integrated provider networks in the above areas to ensure physical health, mental health, chemical dependency, long term services and social support needs can be met through an integrated collaborative approach.
Molina has contracted with various qualified Care Coordination Organizations (CCO) who will hire a team of care coordination staff responsible for delivery of face-to-face interactions with qualified Health Home enrollees. Molina is also functioning as a direct (CCO) to provide direct member interactions in limited areas.

The care coordination staff will be a combined team of clinical Case Managers and non-clinical community health workers. The dedicated care coordination staff will provide individual enrollee interactions aimed at delivery through six (6) Health Home elements of care coordination (see previous description).
The Health Care Authority will determine eligibility for the Health Home program and passively enroll eligible beneficiaries into the contractor's Health Home program. Those determined eligible for Health Home must have at least one chronic condition and be at-risk of a second, as determined by a minimum predictive risk score (PRISM) of 1.5.

Every member will have the ability to consent to Health Home services, withdraw from Health Home services, or opt-out of Health Home services.

The Clinical care coordinator will be responsible for informing and coordinating services with a member's current medical team and other community support services. When your client is receiving Health Home services you will be notified by the care coordinator.

If you would like more information about Health Homes and Molina's Health Home program, information can be found at Molinahealthcare.com, click on the "for healthcare professionals" tab. Open the "Health Resources" tab and click the Health Home category (or follow the attached link):

http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/healthhomes.aspx

Cancellation of Prior Authorized Services

Molina has implemented a process of canceling prior authorized services if the Member has lost eligibility. Molina's process is as follows:

1. Molina limits the authorization time frame to the current calendar month (i.e., all services will need to be rendered during the calendar month in which the authorization is issued); or
2. Molina sends a written notice that a Member's eligibility will be terminating at the end of a given month, and any previously issued authorization(s) will be cancelled as of the last day of the month if services are not rendered by the last day of the month. This notice is sent to the rendering Provider, Member's PCP and the Member.

Second Medical/Surgical Opinion

A Member may request a second medical/surgical opinion at any time during the course of a particular treatment, in the following manner:

- Molina Members may request a second opinion about the care they are receiving at any time.
- The member may request the Second Opinion through their assigned PCP or through Molina's Member Service Department.
- Second opinion consultations with participating practitioners, arranged by the member's PCP, do not require review or prior approval by Molina.
- A Member Services representative can assist the Member in coordinating the second opinion request with the Member's PCP, specialist and/or medical group/IPA.
- An approval to a non-participating Provider will be facilitated by Molina or the medical group/IPA if the requested specialty care Provider or service is not available within the Molina network.
- The appointment for the second opinion will occur within thirty (30) days of the request. The Member may request to postpone the second opinion to a date later than 30 days.
- The Medical Director may request a second opinion at any time on any case deemed to require specialty Provider advisor review.

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 has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (425) 424-1100 or (800) 869-7175.

Wrong Site Surgery

If it is determined a wrong site surgery was performed, Molina will not reimburse the providers responsible for the error.