

MEDICAL MANAGEMENT PROGRAM

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.

This section on Referrals, Authorizations, and Utilization Management (UM) describes procedures that apply to directly contracted Molina Healthcare PCPs. All contracted Providers must obtain Molina Healthcare's authorization for specific services that require prior approval, 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 the Medical Group/IPA Operations section of this manual). If you are treating a Member assigned to a PCP in one of the delegated medical groups/IPAs, Molina Healthcare Providers are required to follow their specific authorization requirements, as they may restrict their referrals to Providers within their group.

Referral versus Prior Authorization: Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the specialist. Except for some benefits such as routine eye exams and women's health care needs, Members are required to obtain referrals from their PCPs for specialty care services. Specialists may refer Members to other specialists or for ancillary services. Referrals and authorizations do not have to be routed back through the PCP. **Only certain services require a prior authorization from Molina Healthcare for payment of claims. These services are listed on the WebPortal Prior Authorization by CPT code guide.**

Generally, prior authorization requirements are designed to assure the medical necessity of service, prevent unanticipated denials of coverage, ensure participating Providers are utilized and all services are provided at the appropriate level of care for the Member's needs.

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 will process any non-urgent requests within five (5) 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 (800) 869-7158.

Requesting Prior Authorization

WebPortal/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. You can also click on the following link to take you to the login page:

<https://eportal.molinahealthcare.com/Provider/login>

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*

Online: **<https://eportal.molinahealthcare.com/Provider/login>**

Fax: The Prior Authorization form can be faxed to Molina Healthcare at: (800) 767-7188. If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department.

Phone: Prior Authorizations can be initiated by contacting Molina’s Healthcare Services Department at (800) 869-7188. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior Authorization requests 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

Inpatient Management

Elective Inpatient Admissions- Molina Healthcare requires prior authorization for all elective inpatient admissions to any facility as well as notification at the time of the admission. 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.

Readmission- In compliance with WAC 182-550-2900, Molina Healthcare will not authorize two separate admissions. Specifically, a second stay will not be authorized at the point of the second admission if a member is readmitted to the same or different hospital within seven days and the member's second stay is related to the first. For readmissions occurring on or after July 1, 2014 a second stay will not be authorized within fourteen calendar days. This determination will be based upon a review of all clinical information received. Molina Healthcare will authorize two separate admissions when a member's medical condition at the time of the second admission is unrelated to the first admission, and Molina Healthcare's standard concurrent review process will be followed through discharge.

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

Molina Healthcare Members involved in an "active course of treatment" have the option to complete that treatment with the Provider who initiated the care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina Healthcare and a Provider will not interfere with this option. This option includes the following Members who are:

- In the second or third trimester of pregnancy
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition

For each Member identified in the categories above, Molina Healthcare will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member's needs.

Requests for continued care should be submitted to the Healthcare Services Department at the phone number and address listed at the beginning of this section on page 6-1. All requests will be reviewed by the Medical Director. Molina Healthcare will not approve continued care by a non-participating Provider if:

- The Member only requires monitoring of a chronic condition
- The Provider does not qualify for Molina Healthcare credentialing based on a previous professional review action
- The Provider is unwilling to continue care for the Member

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 and approval 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. 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 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: 800) 869-7185

Fax: (800) 767-7188

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 Washington 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 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 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.

CVS CAREMARK Specialty Pharmacy

In an effort to offer enhanced services, Molina Healthcare has entered into a relationship with CVS/Caremark Specialty Pharmacy to provide an innovative injectable drug delivery program. This service eliminates the cost associated with stocking and billing for office administered specialty injectable drugs for Molina Healthcare Members.

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.

Some of the specialty injectable drugs provided by CVS/Caremark Specialty Pharmacy are:

- Remicade
- Enbrel
- Lupron
- Interferons
- Plus many others

When a Molina Healthcare Member needs an injectable medication, the prescription can be submitted to Molina Healthcare 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 Healthcare 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.

Please contact your Provider Relations Representative with any further questions about the program.

Transitional Care Program

During episodes of illness involving multiple care settings, members 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 Transitional Care program to improve the quality of care for members with complex physical, long-term, and behavioral health care needs as they transition across care settings. Transitional Care programs have been shown to reduce preventable readmissions and Emergency Department use.

Molina defines Transitional 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. During care transitions, Molina's Transitional Care team will confirm and reestablish the member's connection to their medical home and assist in the movement of the member from one care setting to another. The target population for Molina's Transitional Care program are members at 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

Members are initially contacted by a Transitional Care Coach via a face-to-face visit while in the inpatient setting. If members consent to participate in the Transitional Care program, work begins to develop an individual care transition plan and personal health record. Following discharge, the member receives 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. During these contacts, the individual transitional care plan and personal health record are completed and implemented. The Transitional Care staff will assess the safety of the environment, the member's support network and community connections, and will assist the member with obtaining other immediate psychosocial needs such as food, transportation, clothing, social support, advocacy, and other community-based resources.

The Transitional Care Coach will continue to provide care coordination for up to 6 weeks, primarily via telephone, to ensure that the goals of the individual transitional care plan have been met and a member has successfully transitioned to a lower level of care. As the transitional care process nears completion, Molina's Transitional Care staff will identify any on-going needs that a member may have and, if needed, coordinate a referral to the Molina Case Management program or PCP who will work with the member to address those needs going forward.

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

When warranted for HIPAA compliance, Molina Healthcare 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 Healthcare 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 Healthcare 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

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

1. Molina Healthcare 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 Healthcare 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 Healthcare 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 HealthCare'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 Healthcare.

- 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 Healthcare or the medical group/IPA if the requested specialty care Provider or service is not available within the Molina Healthcare network.
- 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 Healthcare 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 Healthcare will not reimburse the providers responsible for the error.