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 Covered Services 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-Participating Providers.

Medical Necessity Review

In conjunction with regulatory guidance from Federal and State regulations 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 State or Federal regulations or the Molina Healthcare Hospital or Provider Services Agreement require such documentation to be acceptable.

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; and

- 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 fourteen (14) calendar days of receipt of request. Urgent requests will be processed within seventy-two (72) hours.

Providers who request prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting provider at 855-326-5059.

Requesting Prior Authorization

Web Portal: Providers are encouraged to use the Molina Healthcare Web Portal for prior Authorization submission. Instructions for how to submit a prior Authorization request are available on the Web Portal.

Fax: The prior Authorization form can be faxed to Molina Healthcare at: 877-708-2117. If the request is not on the Molina Healthcare Prior Authorization Request form (see link in the "Prior Authorization Guidelines and Request Form" section below), providers should send the request to the attention of the Healthcare Services Department.

Phone: Prior Authorizations can be initiated by contacting Molina Healthcare's Healthcare Services Department at 855-326-5059. Providers may need 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 Wisconsin, Inc.
Attn: Healthcare Services Dept.
2400 S. 102nd Street
West Allis, WI 53227

Inpatient Management

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

Emergent Inpatient Admissions - Molina Healthcare requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. Molina Healthcare requires that notification includes Member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting

notification and Medical Necessity requirements will result in a denial of Authorization for the inpatient admission.

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

Readmission Policy - Hospital Readmissions within thirty (30) days potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure that Molina Healthcare Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Molina Healthcare will review all hospital subsequent admissions that occur within the time frames allowed by Federal and State law of the previous discharge for all Claims. Reimbursement for Readmissions will be combined with the prior admission unless it meets one (1) of the exceptions noted below, violates State and/or Federal law or violates the terms of the Hospital or Provider Services Agreement between the provider and Molina.

Exceptions:

1. The Readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate Discharge Planning in the first admission necessitated the second admission; or
2. The Readmission is part of a Medically Necessary, prior authorized or staged treatment plan; or
3. There is clear Medical Record documentation that the patient left the hospital against medical advice during the first hospitalization prior to completion of treatment and Discharge Planning.

Definitions

Readmission: A subsequent admission to an acute care hospital within a specified time frame of a prior admission for a related condition or as readmission is defined by State laws or regulations.

Related Condition: A condition that has a same or similar diagnosis or is a preventable complication of a condition that required treatment in the original hospital admission

Non-Participating 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 unless it is for emergency services as defined by Federal law. If there is a need to go to a non-Participating Provider, all care provided by non-Participating Providers must be prior authorized by Molina

Healthcare. Non-Participating Providers may provide emergency 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.

Emergency services for this section is defined as: A) medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Avoiding Conflict of Interest

The Healthcare Services 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. Molina Healthcare also requires its 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 Participating Providers to assess Members, and with the participation of the Member and his/her representative(s), 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 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 is done in partnership with providers and Members to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

It is Molina Healthcare's policy to provide Members with advance notice when a provider they are seeing will no longer be a Participating Provider. Members and providers are encouraged to use this time to transition care to a Participating 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 non-Participating Provider for a given period of time. For additional information regarding continuity of care and transition of Members, please contact Molina Healthcare at 855-326-5059.

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 Care 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, Specialists, 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 (2) weeks of treatment
- Member accessing ER services inappropriately
- Children with Special Health Care Needs

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

Phone: 855-326-5059

Fax: 877-708-2117

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 Care 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; and
- 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 Care Services

Emergency Care services are covered on a twenty-four (24) hour basis without the need for prior Authorization for all Members experiencing a Medical Emergency.

Molina Healthcare of Wisconsin, Inc. accomplishes this service by providing a twenty-four (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 Molina Healthcare.

For Members within the Service Area: Molina Healthcare of Wisconsin, Inc. contracts with vendors that provide twenty-four (24) hour Emergency Care services for ambulance and hospitals.

Medical Record Standards

The provider is responsible for maintaining an electronic or paper Medical Record for each individual Member. Medical 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 the 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 Care 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 the Quality Improvement section 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 or law, 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; and
- 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.

Specialty Pharmaceuticals/Injectables and Infusion Services

Please contact the State of Wisconsin for pharmacy prior Authorizations at 800-291-2002 or by fax at (608) 221-8616.

Prior Authorization Guidelines and Request Form

The Prior Authorization Guidelines can be found at:

http://www.molinahealthcare.com/providers/wi/medicaid/forms/PDF/1558751_3_0_2014%20WI%20PA-Pre-Service%20Review%20Guide%20Medicaid-Medicare%20v8%20corrected%201%207%2014.pdf

The Prior Authorization Request Form can be found at:

http://www.molinahealthcare.com/providers/wi/medicaid/forms/PDF/1558751_1_7_Prior%20Authorization%20Pre%20Service%20Review%20Form%20updated%201%202014.pdf