Healthcare Services (HCS)

Introduction

Healthcare Services is comprised of Utilization Management (UM) and Care Management (CM) Departments that work together to achieve an integrated 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. Molina provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (UM)

- Molina ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level 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 as well as integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes in the member's condition and is designed to influence member's care by managing available benefits effectively and efficiently while ensuring quality care is provided;
- Evaluating the medical necessity and efficiency of health care services across the continuum of care;
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization;
- Implementing comprehensive processes to monitor and control the utilization of health care resources;
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness;
- Reviewing processes to ensure care is safe and accessible;
- Ensuring that qualified health care professionals perform all components of the UM and CM processes.
- Ensuring that UM decision making tools are appropriately applied in determining medical necessity decision.

Key Functions of the UM Program

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 Provider input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensure authorized care correlates to Member's medical necessity need(s) & benefit plan	Post service/post claim audits	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

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM program, including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina's website or by calling the UM Department.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Molina's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina at least annually.

UM 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 payment of request (adverse determination);
- Discontinuation of a payment for a service;
- Payment for temporarily out-of-the-area renal dialysis services; and,
- Payment for Emergency Services, post stabilization care or urgently needed services.

Molina follows a hierarchy of medical necessity decision making with Federal and State regulations taking precedence. Molina covers all services and items required by State and Federal regulations.

Board certified licensed Providers from appropriate specialty areas are 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.

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, 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.

Providers can contact Molina's Healthcare Services department at (855) 322-4077 or fax (800) 594-7404 to obtain Molina's UM Criteria.

Medical Necessity

"Medically Necessary" or "Medical Necessity" means a denial of covered medical benefits as defined by Molina Healthcare, including hospitalization and emergency services, as listed in the Evidence of Coverage-Summary of Benefits, or care or service that could be considered a covered benefit depending on the circumstances.

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.

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively.

To determine medical necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized evidence based guidelines, third party guidelines CMS guidelines, state guidelines, guidelines from nationally recognized standards, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Molina review process begins with administrative review followed by clinical review if appropriate.

The administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage.

- Verifying Member eligibility.
- Requested service is a covered benefit.
- Requested service is within the Provider's scope of practice.
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor.

The Clinical review includes medical necessity and level of care.

- Requested service is not experimental or investigation in nature.
- Servicing 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.
- Medical necessity criteria (according to accepted, nationally-recognized resources) is met.
- 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.
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

All UM requests that may lead to a denial are reviewed by a healthcare professional at Molina (medical director, pharmacy director, or appropriately licensed health professional).

Molina's Provider training includes information on the UM processes and Authorization requirements.

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 allows 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 customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at www.MolinaHealthcare.com.

Providers are encouraged to use the Molina prior authorization form provided on the Molina web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
  - Pertinent medical history (include treatment, diagnostic tests, examination data).
  - Requested length of stay (for inpatient requests).
  - Rationale for expedited processing.

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. Prior Authorization is not a guarantee of payment. Payment is contingent upon medical necessity and member eligibility at the time of service.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation.

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, the health or safety of the member or others, due to the member's psychological state, or in the opinion of the provider with knowledge of the enrollee's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the enrollee's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited request for authorization, a determination is made as promptly as the member's health requires and no later than seventy-two (72) hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provides notification within fourteen (14) calendar days.

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 (855) 322-4077.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Molina, Molina may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the www.MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix
- Prior Authorization Guide

Provider Portal: Participating Providers are encouraged to use the Molina Provider Portal for prior authorization submissions whenever possible.

Instructions for how to submit a prior authorization request are available on the Molina Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.

Fax: The Prior Authorization Request Form can be faxed to Molina at: (800) 564-7404.

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services Department at (855) 322-4077. 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 Michigan
Attn: Healthcare Services Dept.
880 W. Long Lake Road
Troy, MI 48098

Emergency Services

Emergency Services means: healthcare services needed to evaluate, stabilize, or treat an Emergency Medical Condition.

Emergency Medical Condition or Emergency means: the sudden onset of a medical, psychiatric, or substance abuse condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily functions, or serious dysfunction of any bodily organ or part.

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.

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

Molina accomplishes this service by providing a twenty-four (24) hour Nurse Advise 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 contracts with vendors that provide twenty-four (24) hour Emergency Services for ambulance and hospitals.

An out of network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member will be responsible for payment.

Members over-utilizing the emergency department will be contacted by Molina Care Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

Care 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.

Inpatient Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective/scheduled inpatient admissions and procedures to any facility. Facilities are required to also notify Molina within 24 hours or by the following business day once the admission has occurred for concurrent review. 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 Following business day. 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 sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

If the admission does not meet medical necessity criteria for an inpatient setting, the facility may admit the member to an observation setting. No authorization is required for observation. If the facility does not accept observation setting, the UM staff may request additional information and will forward the case for Medical Director review except for those diagnoses which the Michigan Department of Health and Human Services has deemed payable at a one day/observation payment rate. Requests for admission that meet Inpatient Criteria but could be treated in an observation setting

and there is a likelihood of discharge within 24 hours; an observation stay will be authorized initially with additional clinical information requested for the following diagnoses:

- Acute Abdomen Anemia
- Congestive Heart Failure (CHF)
- Deep Vein Thrombosis (DVT)
- Disorders of Fluid Electrolyte and Acid Base Balance
- General Symptoms
- Poisoning/Toxic Ingestions

Effective August 1, 2015, the diagnoses referenced MSA Bulletin-15-32 will be considered payable at the Michigan Department of Health and Human Services one day/observation rate for stays in the observation or inpatient setting for admission and discharge the same date or next calendar day. No approval is required for these cases whether one day inpatient or observation. The diagnoses in the MDHHS policy are listed at http://www.michigan.gov/documents/mdch/MSA_15-32_498744_7.pdf

A post stabilization update will be required 18-24 hours post admission to ensure that the member continues to meet medical necessity criteria for an authorization of an inpatient admission.

When would we contact you?

If additional clinical information is required.

If the need for additional medical services is identified post discharge, such as home health care or home infusion.

To notify you of our decisions:

- When services are approved, the UM staff will call or fax you with an authorization number and next review date.
- When services are not approved, the UM staff will call you.
- Written notification is also sent at the time of the decision giving you the reason for the denial. Member and provider appeal rights are included with the notification
- If you would like a copy of the criteria that was used to make a denial determination, or you would like to discuss a denial decision with a Medical Director, please call (855) 322-4077.
- For urgent/emergent admissions, the UM staff will call or fax you the decision.
- If we are notified retrospectively of an admission and discharge, the UM staff will call or fax you.

Inpatient at time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not covered services.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure 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 clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. 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, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that 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. Upon discharge the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Molina's UM staff follow CMS guidelines to determine if the collected 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 (refer to the Medical Necessity Standards section).

Discharge Planning

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.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Concurrent Review/Discharge Planning/Continuity and Coordination of Care/Post Hospital Discharge/ Managing Care Transition

Concurrent review is performed to determine medical necessity and appropriateness of a continued inpatient stay, identify appropriate discharge planning needs.

Also to facilitate discharge to an appropriate setting in a timely manner and ensure continuity and coordination of the member's care. Our staff collaborates with the physician, hospital discharge planning, practitioners and their representatives.

Concurrent reviews are conducted routinely as appropriate and medical necessity criteria is used as a guideline in performing review.

A Molina Healthcare Medical Director is available for peer-to-peer consultation to discuss the denial decision with any treating practitioner regarding medical necessity.

Listed below are the timeframe requirements by line of business and service type:

Timeframe Requirements for Peer to Peer Note: One peer to peer is allowable per each adverse determination.		
	Medicaid/ Marketplace	**Medicare**
Pre-service	Requesting provider has ten (10) business days from receipt of the denial notification to initiate a Peer to Peer. If no formal appeal has been filed If a formal appeal is filed, the appeal process must be followed.	Requesting provider can request a Peer to Peer any time **PRIOR** to an adverse determination being made. ***Scheduling Exceptions*:** None
Inpatient	A Peer to Peer can be initiated at any time up until 1 business day after discharge or until 1 day after notification, whichever is later.	An adverse determination can be changed during a Peer to Peer conversation to an approval at any time while the member is still inpatient.
SNF/IPR/LTAC	For the initial authorization request, a peer to peer regarding an adverse determination can occur at any time while the member is still inpatient. For concurrent requests the peer to peer regarding an adverse can occur while the member is still in the facility (SNF/IPR/LTAC).	An adverse determination can be changed during a Peer to Peer conversation to an approval at any time while the member is still inpatient.
Pharmacy	Requesting provider has ten (10) business days from receipt of the denial notification to schedule a P2P. Call 888-898-7969.	N/A

Timeframe Requirements for Peer to Peer Note: One peer to peer is allowable per each adverse determination.		
	Medicaid/ Marketplace	**Medicare**
Out of timeframe for the Peer to Peer	Pre-service: The requesting provider is instructed to file an appeal on behalf of the member; for additional information regarding member appeals please see policy MIRR-002 Processing Member Appeals. Post-Service: The requesting provider is instructed to submit a claim and follow the provider appeal/ reconsideration/ dispute process; for additional information regarding post service provider appeals please see policy RT-002 Post-Service Provider Appeals.	Requesting provider is instructed to file an appeal on behalf of the member or submit a claim and follow the provider appeal/reconsideration/dispute process.

Timeframe Requirements for Submission of Additional Information Following the Peer to Peer		
	Medicaid/ Marketplace	**Medicare**
	Pre-Service	
After discussing the case with requesting provider, Molina Medical Director requests that additional information be submitted to Molina, following the Peer to Peer:	Additional information must be received by the requesting provider within **1 business day** following the peer to peer	Prior to an adverse determination being made, additional information must be received by the requesting provider within **1 business day** following the peer to peer. Once an adverse determination has been made, additional information cannot be accepted.
	If the provider does not meet the above timeframe for submitting additional information: Molina will notify the provider stating that: ✓ The initial decision will be upheld and ✓ Instruct the provider to file an appeal on behalf of the member or submit a claim and file a claims dispute/reconsideration.	Prior to an adverse determination being made, if the additional information is received **AFTER 1 business day** following the peer to peer Molina will notify the provider stating that ✓ The information cannot be accepted. ✓ The adverse determination will be issued, and the provider may file an appeal on behalf of the member or submit a claim and file a claims dispute/reconsideration.
	Inpatient	
	Prior to discharge, see non highlighted row of Preservice section immediately above.	Prior to discharge, see non highlighted row of Preservice section immediately above.

There are circumstances where peer to peer conversations will not be initiated. These are listed below:

Medicaid/ Marketplace	Medicare
✓ A request was administratively denied (e.g. non-covered benefit or exhaustion of benefits) ✓ An appeal has been submitted and filed ✓ A peer to peer, for the same denial, has already occurred. ✓ Post Service requests: services have been rendered (provided) ✓ Concurrent requests (concurrent review): The member has been discharged ✓ If the peer to peer is requested after 10 business days from receipt of the denial notification	✓ Concurrent requests (concurrent review): The member has been discharged ✓ A request was administratively denied (e.g. non-covered benefit or exhaustion of benefits) ✓ An appeal has been submitted and filed
If any of the above apply Molina will notify the provider that: ✓ The initial decision will be upheld at this time; ***and*** ✓ Instruct the provider that a member appeal or claims dispute may be filed	

Readmissions

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Molina will conduct readmission reviews for participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates. There are two situations for Readmissions: Readmissions occurring within 24 hours from discharge (same or similar diagnosis); and Readmissions occurring within 2-30 days of discharge (same or similar diagnosis PLUS preventable).

When a subsequent admission to the same facility with the same or similar diagnosis occurs within twenty-four (24) hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital;
- Issues with transition or coordination of care from the initial admission;
- For an acute medical complication plausibly related to care that occurred during the initial admission.

Readmissions that are excluded from consideration as preventable readmissions include:

- Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
- Neonatal and obstetrical Readmissions.
- Initial admissions with a discharge status of “left against medical advice” because the intended care was not completed.
- Behavioral Health readmissions.
- Transplant related readmissions.

Post Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error, a Medical Necessity review will be performed.

Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance and evidence-based criteria sets.

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

There are two ways to request a Retrospective Authorization with an extenuating circumstance as described above.

Fax authorization request and clinical information (if required) to Healthcare Services at (800) 594-7404.

Telephone (855) 322-4077

**Please note if there is a denied claim on file the Provider Appeal process will need to be followed. Refer to the Provider Appeals and Grievances Section.

On Call Program (After Hours)

Inpatient facilities are requested to contact Molina Healthcare once a determination is made to admit a member from the ED but prior to the admission. Outside of business hours, the On-Call service can be contacted to obtain authorization prior to the admission.

Clinical staff are available 24 hours a day/7 days a week to members, providers, and hospital staff, including after normal business hours (Monday through Friday 5:00 p.m.-8:30 a.m., Saturday – Sunday and holidays).

The On-Call Care Review Clinician (RN) contacts the facility to obtain clinical criteria (signs and symptoms, vital signs, lab results, diagnostic test results, medications with response, past medical history, plan of care) and applies medical appropriateness criteria.

The On-Call Care Review Clinician will facilitate one of the following:

- Approve inpatient admission in which an authorization number is provided along with the next review date
- Pend for additional clinical information, in which the facility has 48 hours in which to supply Molina Healthcare with the requested information
- Participate in the discharge planning process and facilitation for home care, home infusion, and/or DME

When will you hear from us?

The On-Call Care Review Clinician will contact the facility within one hour of the request.

How can you reach us?

You can reach the On-Call Care Review Clinician by calling (888) 275-8750.

Affirmative Statement about Incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Molina requires that all utilization-related decisions regarding member coverage and/or services are based solely on appropriateness of care and service and existence of coverage.

Molina does not specifically reward practitioners or other individuals for issuing denials of coverage or care. And, Molina does not receive financial incentives or other types of compensation 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.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements.

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 322-4077 during normal business hours, Monday through Friday (except for Holidays) from 8:30 a.m. to 5:00 p.m. 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.

After business hours, Providers can also utilize fax and the Provider Portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers twenty-four (24) hours a day, seven (7) days a week at (888) 275-8750. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

Out of Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to Molina Members.

Molina 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-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network 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.

Coordination of Care and Services

Molina HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment or referral such as, self-referral, provider referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.

Molina staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member, 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, Members and/or their authorized representative(s) 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.

For additional information regarding continuity of care and transition of Members, please contact Molina at(855) 322-4077.

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.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is receiving or may be in need of receiving 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. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or child care givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers.

Suspected abuse and/or neglect should be reported as follows:

Child Abuse:

Michigan Department of Health and Human Services, Child Protective Services, (855) 444-3911

Adult Abuse:

Michigan Department of Health and Human Services, Adult and Children Services, (855)444-3911

Molina's HCS teams 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 Healthcare Services Committee and the proper State agency.

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 the members' ICP, interdisciplinary care team (ICT) updates, and information regarding the Member's progress through the ICP when requested by the PCP. 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 the Member and any additional participants as directed by the member to develop an ICP that includes recommended interventions from Member's ICT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the case manager:

- Assesses the member to determine if the members' needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the members' ICT, as Member needs warrant.
- Serves as a coordinator and resource to the Member, their representative and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.

Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members.

Health Education/Disease Management

Molina offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs.

Members can request to be enrolled or dis-enrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation
- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder
- Maternity Screening and High Risk Obstetrics

Member Newsletters

Member Newsletters are posted on the www.MolinaHealthcare.com website at least two (2) times a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members can access our easy-to-read materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, Members are directed to ask their doctor or visit our website.

Program Eligibility Criteria and Referral Source

Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis.

Identified Members will receive targeted outreach such as educational newsletters, telephonic outreach or other materials to access information on their condition.

Members can contact Molina Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy Claims data for all classifications of medications.
- Encounter Data or paid Claims with a relevant CMS accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members.
- External referrals from Provider(s), caregivers or community-based organizations.
- Internal referrals from Nurse Advice Line, Medication Management or Utilization Management.
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications.

Provider Participation

Contracted Providers are notified as appropriate, when the Member is enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs.
- Clinical Practice Guidelines.
- Preventive Health Guidelines.

Additional information on health management programs is available from your local Molina Healthcare Services Department toll free at (855) 322-4077.

Members may qualify for Molina's ICM program based on confirmed diagnosis or specified criteria. The comprehensive program is are available for all Members that meet the criteria for services.

Care Management (CM)

Molina provides a comprehensive ICM program to all Members who meet the criteria for services. The CM program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care.

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

The Molina care managers may be licensed professionals and are educated, trained and experienced in Molina's ICM program. The ICM 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 ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina care manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services.

The Molina care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the members' ICP.

Referral to Care Management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, such as, discharge planners, ancillary Providers, the local Health Department or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care and social data about the Member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue transplants, End Stage Renal Disease)
- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, CHF, etc.)
- Preterm births
- High-technology home care requiring more than 2 weeks of treatment
- Member accessing Emergency Department services inappropriately
- Children with Special Health Care Needs

Referrals to the ICM program may be made by contacting Molina at:
Phone: (855) 322-4077
Fax: (248) 925-1732