# Provider Bulletin

Molina Healthcare of California
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June 13, 2025

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## 2025 Annual Clinical Hierarchy

This is an advisory notification to Molina Healthcare of California (MHC) network providers applicable to all lines of business.

### What you need to know:

MHC medical necessity criteria are based on the most current available clinical evidence supporting safety and efficacy. The following are considered approved and acceptable resources for clinical criteria. The order in which they are listed is regarded as the acceptable hierarchy for use.

MHC's Delegation Oversight shall incorporate these standards as a part of Utilization Management (UM) oversight activities.

**1. Medicare Hierarchy**

When benefits are covered by Medicare, clinicians follow this hierarchy of decision making:

i. Applicable Federal mandates/regulations and National Coverage Determinations (NCDs).
ii. General coverage guidelines included in original Medicare manuals (e.g., Medicare Benefit Policy Manual, etc.) and instructions (e.g., CMS transmittals, MLN articles, HPMS memos, etc.) unless superseded by regulation or related instructions.
iii. Local Coverage Determinations (LCDs) as published by the applicable Medicare Administrative Contractor (MAC) for the jurisdiction where services are being rendered and any applicable Local Coverage Articles.
iv. Licensed external decision-making criteria, including MCG as applicable.
v. Corporate guidance documents and policies, including Molina Clinical Policy (MCP) or if applicable, Delegated 3rd party clinical criteria guidelines
vi. The following specialty clinical decision aids, where applicable:
    - American Society of Addiction Medicine (ASAM) Criteria
    - Level of Care Utilization Systems (LOCUS);
    - National Comprehensive Cancer Network (NCCN) guidelines
        – Level of Evidence 2A or above is considered recommended.

## Provider Action

Please review and familiarize yourself with the Annual Clinical Hierarchy and criteria expectations based on your contracted lines of business. No further action is required.

vii. Hayes Technology Assessments
- Hayes Rating of B or better for the treatment/technology may be considered for approval.
- Hayes Rating of C or below for the treatment/technology demonstrates unproven benefit. Some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, substantial uncertainty remains about safety and/or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns.

viii. All internal coverage criteria utilized by Molina and its delegated entities must be reviewed and approved for UM use by the Medicare Advantage UM committee.

**2. Medi-Cal Hierarchy**

When benefits are covered by Medi-Cal, clinicians follow this hierarchy of decision making:

i. Federal Law on Medicaid (Social Security Act)
ii. State Law (Health and Safety Code, Welfare and Institutions Code)
iii. State Regulations Governing Medi-Cal (California Code of Regulations, Title 22)
iv. Medi-Cal Provider Manuals
v. Department of Health Care Services (DHCS) Medi-Cal Managed Care AND Department of Managed Health Care (DMHC) directives
- All Plan Letters, Policy Letters, and related

**3. Molina Marketplace (Covered California) Hierarchy**

When benefits are covered by Molina Marketplace, clinicians follow this hierarchy of decision making:

i. Federal Law on Insurance Exchanges (as per Affordable Care Act)
ii. Member's Marketplace Evidence of Coverage
- Corporate, evidence-based guidance documents addressing new or existing technology.
- McKesson InterQual® Criteria, MCG Health Criteria, MCP, DRG, American College of Radiology (ACR) guidelines for imaging services, or comparable clinical decision support criteria.
- Hayes Technology Assessments or comparable evidence-based review products.
- UpToDate
- Apollo's Managed Care Guidelines
- Technology assessments established by nationally accepted governmental agencies, physician specialty societies, associations, or academies and published in peer-reviewed medical literature.
- Well-controlled or prospective cohort/comparison studies published and referenced in medical or scientific literature with relevant clinical evidence supporting the assertion that the requested modality would provide benefit to the member and a clinical advantage over its competitors. (Two independent studies are preferred).
- Specialty consultations by independent, certified, third-party review organizations

**<u>When decision support criteria are not available, delegated entities may do one of the following:</u>**

1. Adhere to the existing process for ad hoc review of current literature for urgent needs.
2. Request two (2) independent scientific or medical documents with relevant clinical evidence supporting the assertion that the requested treatment would benefit the patient and be a clinical advantage over its competitors from the provider.

- Reliable evidence may be obtained from good-quality randomized controlled trials or minimally biased prospective cohort/ comparison studies.
- Case reports, retrospective studies, and abstracts are not sufficient.
- A technology considered an established standard of medical practice that has published data with evidence supporting its effectiveness may be considered (e.g., transplantation with donor bank data supporting increased life expectancy).

3. When published evidence is not available on topics that are considered standard of care, the Delegated Entity's evidence-based policies may be used for UM determinations.
4. Delegates shall consider the individual healthcare needs of each member when applying the criteria for coverage and prior to making coverage decisions. These factors shall include, at minimum, but may not be limited to:
    - Age
    - Comorbidities
    - Complications
    - Progress of treatment
    - Psychosocial situations
    - Home environment, when applicable
    - Local hospitals' ability to provide all recommended services within the estimated length of stay
    - Availability of any local delivery systems in the organization's service area as needed to support the patient after hospital discharge (e.g., skilled nursing facilities, Sub-acute care facilities, and home care agencies).
    - Coverage of benefits for Subacute or skilled nursing facilities, home care, or other local delivery systems as needed.

**Delegates shall use clinical information to make UM determinations that include but may not be limited to:**

1. Office and hospital records history of the presenting problem.
2. History of the presenting problem.
3. Clinical exam.
4. Diagnostic testing results.
5. Treatment plan and progress notes.
6. Patient psychosocial history.
7. Information and consultations with the treating practitioner.
8. Evaluations from other health care practitioners and providers.
9. Photographs.
10. Operative and pathological reports.
11. Rehabilitation evaluations.
12. A printed copy of the criteria related to the request.
13. Information regarding benefits for services or procedures.
14. Information regarding the local delivery system.
15. Patient characteristics and information.
16. Information from responsible family members.

## What if you need assistance?

If you have any questions regarding the notification, please contact your Molina Provider Relations Representative below.

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If you are not contracted with Molina and your fax number is not shared with a contracted provider, and you wish to opt out of receiving the MHC Provider Bulletin, please email mhcproviderbulletin@molinahealthcare.com.

Please include the provider's name, NPI, county, and fax number, and you will be removed within 30 days.