THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

☒ Imperial
☒ Riverside/San Bernardino
☒ Los Angeles
☒ Orange
☒ Sacramento
☒ San Diego

LINES OF BUSINESS:

☒ Molina Medi-Cal Managed Care
☒ Molina Medicare Options Plus
☒ Molina Dual Options Cal MediConnect Plan (Medicare-Medicaid Plan)
☒ Molina Marketplace (Covered CA)

PROVIDER TYPES:

☐ **Medical Group/ IPA/MSO**

Primary Care
☐ IPA/MSO
☐ Directs
☐ MMG

Specialists
☐ Directs
☐ IPA

☒ **Hospitals**

Ancillary
☐ CBAS
☐ SNF/LTC
☐ DME
☐ Home Health
☐ Other

FOR QUESTIONS CALL PROVIDER SERVICES:
(855) 322-4075, Extension:

Los Angeles County

122233	114378	117079
111131	127307	120104
127685	127657	

Riverside/San Bernardino Counties

128010	110092	126556
123251	127709	128007
120021	120210	127684

Sacramento County

127140	121360
126232	121031

San Diego County

120056	121151
121180	121740

Imperial County

121740	120153
125682	121146

INPATIENT CLINICAL REVIEW / RECONSIDERATIONS
(All Lines of Business)

This is an advisory notification to Molina Healthcare of California (MHC) network hospitals regarding MHC's process on the utilization management evaluation of inpatient reviews and revised reconsideration process timeframes.

- Hospital must notify MHC within 24 hours of inpatient admission, including pre-authorized surgeries/procedures. Clinical information is required within twenty-four (24) hours of hospital notification of admission, including pre-authorized surgeries/procedures. MHC may extend up to seventy-two (72) hours.
- The MHC telephonic Concurrent Review Clinician (CRC) RN will review the admission applying nationally recognized criteria for medical necessity. Ultimately, denial decisions are made by MHC Medical Director using sound clinical judgment.
- **DRG facilities:** Admissions that meet criteria will be authorized per DRG. MHC will require clinical updates every seven (7) days identifying member condition change and discharge planning/needs. **Complete medical records are not required for this clinical update.**
- **Per Diem facilities:** Admissions that meet criteria will be authorized for day of admission. Clinical information is required daily (via Electronic Medical Records (EMR) or FAX). Decisions are made within twenty-four (24) hours of receipt of complete information. Ultimately, denial decisions are made by MHC Medical Director using sound clinical judgment.
- **MHC will not accept criteria screenshot in lieu of clinical documentation**

**** Non-compliance with timely, adequate clinical submission will be reviewed by the MHC Medical Director and will be subject to denial.***

- **REVIEWS (DRG Contracts):**

After the initial notification and authorization, clinical information is required at least every seven (7) days during the hospital stay. Discharge planning begins upon admission. MHC will continue to follow for coordination of discharge needs. The following information is required for the review:

- Physician Orders
- Specialty Consultations
- Supporting Clinical Documentation

LATE NOTIFICATION

When the Hospital fails to notify MHC of an admission within 24 hours, the authorization request may become subject to administrative denial. The MHC CRC will review the admission. If the admission meets criteria and is approved, the MHC CRC will review for continued stay. If the member was discharged prior to late notification of **less than 30 days**, MHC UM staff will notify the hospital. If EMR is unavailable, please submit via fax, *ER Report, H&P, Admitting orders, dictated specialty consultations, documentation supporting the inpatient admission and continued stay, D/C orders, and D/C Summary* for Retro Review to:

FAX: 800-811-4804

If the member was discharged prior to late notification of 60 days or more, please submit a claim to MHC via **Change Healthcare with payer ID 38333**. ***You will be notified of the specific medical records required to support the request for inpatient stay by the Retro Review team.***

DISCHARGE PLANNING

The MHC CRC is available to assist with Complex Discharge Planning. Hospital to provide the following:

- Prior level of function and living arrangements
- Required Level of Care
- Skilled need
- Follow-up Care/Services required
- **Upon discharge, please submit the Discharge Summary and/or patient Discharge instructions to MHC**

RECONSIDERATIONS *UPON DENIAL*

- ***Medi-Cal and Marketplace* Reconsideration:** Upon denial, MHC allows **30 calendar days (7 calendar days for hospitals allowing MHC EMR access)** for the hospital to submit ***minimal*** additional clinical information to support medical necessity, or to request a peer to peer review. For Reconsideration, please submit specific documentation requested to support approval of the admission or continued stay to:

  FAX: 800-811-4804

  To request a Peer to Peer review, within 5 calendar days of denial, please call:
  Toll Free: 844-557-8434

- ***Medicare* does not allow reconsiderations, including Peer to Peer review after a denial decision is made.** The hospital must follow the Medical Claims Review process for **Medicare,** which is outlined in the MHC Provider Manual. Please submit ***minimal*** additional clinical information to support medical necessity with the claim via the MHC Provider Portal at https://provider.molinahealthcare.com/

RETROSPECTIVE REVIEW

When notification of a **Medi-Cal** or **Marketplace** (Covered California) member admission is not submitted to MHC timely, but in **less than 30 days**, the hospital should utilize the Retrospective Review Process. Please submit, via fax, a service request form to:

FAX: 800-811-4804

You will be notified of the specific medical records required to support the request for inpatient stay by the Retro Review team.

- There is no Retrospective Review process for Medicare and MMP; therefore, please submit a medical claim and ***minimal*** medical records supporting medical necessity of the admission and continued stay, *ER Report, H&P, Admitting orders, dictated specialty consultations, documentation supporting the inpatient admission and continued stay, D/C orders, and DC Summary* via the MHC Provider Portal at https://provider.molinahealthcare.com/

MEDICARE AND DUAL OPTIONS CAL MEDICONNECT:

As of May 23, 2016 all MHC Medicare and Dual Options Cal MediConnect prior authorizations for services listed below should be sent to the toll free fax number **844-251-1450.** Phone number **855-322-4075**.

- Elective Surgeries (outpatient and inpatient)
- Outpatient Behavioral Health
- Durable Medical Equipment (DME)
- Pharmacy (Part B only)
- Supplemental Benefits
- Home Health
- All Outpatient Therapy Services (Physical therapy, Occupational therapy, Speech therapy or Chiropractic therapy)
- Dialysis Notifications

PRIOR AUTHORIZATION PROCESS

Hospitals must complete a ***Prior Authorization Request Form*** with all pertinent information and medical notes as applicable. The ***Prior Authorization Request Form*** is conveniently located on the MHC website at www.molinahealthcare.com. Simply click on "Forms" and "Frequently Used Forms". Hospitals may also access the form by following this link: http://www.molinahealthcare.com/providers/common/medicare/PDF/CA-PAreview-2015.pdf

If you have any questions, please feel free to call MHC Utilization Management **Toll Free: 844-557-8434**