MOLINA HEALTHCARE

PROVIDER NEWSLETTER

A newsletter for Molina Healthcare of MI Provider Networks

Second Quarter 2019

Important Message – Updating Provider Information

It is important for Molina Healthcare of Michigan (Molina Healthcare) to keep our provider network information up to date. Up to date provider information allows Molina Healthcare to accurately generate provider directories, process claims and communicate with our network of providers. Providers must notify Molina Healthcare in writing at least 60 days in advance when possible of changes, such as:

- Change in ownership require a new contract request through Provider Contracting
- Practice name change
- A change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location

In this Issue

- When a provider joins or leaves the practice Provider adds should be submitted using the provider addition roster located on the Molina Healthcare website at www.MolinaHealthcare.com/providers under the Forms section.
- Changes should be submitted on the Provider Change Form located on the Molina Healthcare website at www.MolinaHealthcare.com/providers under the Forms section or via the Provider Portal.

Send change forms to:
Email: MHMContractConfig@MolinaHealthcare.com
Fax: 248.925.1757
Mail: Molina Healthcare of Michigan
880 West Long Lake Road, Suite 600
Troy, MI, 48098
ATTN Provider Services Department
Contact your Molina Provider Services Representative at 855.322.4077 if you have questions.

Reminder CHAMPS Registration Required

In accordance to MDHHS Bulletin (MSA 17-48), any individual and entity that provides services, or order and prescribes services, for individuals with Michigan Medicaid coverage must enroll in the Community Health Automated Medicaid Processing System (CHAMPS).

Enrollment in CHAMPS is solely used for screening providers participating in Medicaid and does not enroll providers in Fee-For-Service Medicaid.
Medicaid rules prohibit payment to providers not appropriately screened and enrolled.

Rendering, Ordering, Referring, Attending, Prescribing, and Billing NPI must be enrolled in CHAMPS.

Providers requiring additional information or assistance enrolling in CHAMPS may call the MDHHS Provider Support Help line or visit MDHHS provider websites resources are listed below.

MDHHS Resources

- **Provider Support** Help Line
- **Typical Providers**: 800.292.2550
- **Atypical Providers**: 800.979.4662
- Provider General Information: www.michigan.gov/medicaidproviders
- CHAMPS Provider Enrollment: https://milogintp.michigan.gov

If you have questions regarding your Molina enrollment due to CHAMPS participation, please call Provider Services at 248.729.0905 or email at MHMProviderServicesMailbox@Molinahealthcare.com.

If you receive a denied claim and you are enrolled/registered in CHAMPS with an active or retroactive status from the beginning date of service January 1, 2019, please allow 14 business days before submitting a corrected claim.

Reminder Electronic Funds Transfer (EFT) Registration

Benefits of using EFT for Claims Payment:

- You will receive payment faster
- You can have the ability to have your 835 files routed to your FTP file
- You can search/view/print/download/save the PDF electronic version of your Explanation of Payment -EOP (also known as Remittance Advice).

If you are receiving paper checks and have not registered for EFT for your claim payments, click the following link to begin the registration for EFT: https://providernet.adminisource.com or you can contact Change Healthcare/ProviderNet Services at 877.389.1160. wco.provider.registration@changehealthcare.com. **(this link is to register for EFT for claim payments ONLY).**

Note: If you are already registered and just need to add additional pay to NPI's it can be added through the "Provider Info" screen.

Practitioner Credentialing Rights: What You Need to Know

Molina Healthcare has a duty to protect its members by assuring the care they receive is of the highest quality. One protection is assurance that our providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. Your responsibility, as a Molina Healthcare provider, includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

Molina Healthcare also has a responsibility to its providers to assure the credentialing information it reviews is complete and accurate. As a Molina Healthcare provider, you have the right to:

- Strict confidentiality of all information submitted during the credentialing process
- Nondiscrimination during the credentialing process
- Be notified of information obtained during the credentialing process that varies substantially from what is submitted by you
- Review information submitted from outside primary sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application, with the exception of references, recommendations or other peer-review protected information
- Correct erroneous information
- Be informed of the status of your application upon request by calling the Credentialing Department at 888.898.7969
- Receive notification of the credentialing decision within 60 days of the committee decision
- Receive notification of your rights as a provider to appeal an adverse decision made by the committee
- Be informed of the above rights

For further details on all your rights as a Molina Healthcare provider, please review your Provider Manual. You may also review the provider manual on our website at www.MolinaHealthcare.com/providers under the manual tab. **Note each line of business has its own manual.** Contact your Provider Services Representative if you need additional information 855.322.4077.

Molina Healthcare's Utilization Management

One of the goals of Molina Healthcare's Utilization Management (UM) department is to render appropriate UM decisions that are consistent with objective clinical evidence. To achieve that goal, Molina Healthcare maintains the following guidelines:

- Medical information received by our providers is evaluated by our highly trained UM staff against nationally recognized objective and evidence-based criteria. We also take individual circumstances and the local delivery system into account when determining the medical appropriateness of requested health care services.

- Molina Healthcare's clinical criteria includes McKesson InterQual® criteria, Hayes Directory, Medicare National and Local Coverage Determinations, applicable Medicaid Guidelines, Molina Medical Coverage Guidance Documents (developed by designated Corporate Medical Affairs staff in conjunction with Molina Healthcare participating physicians serving on the Medical Coverage Guidance Committee) and when appropriate, third party (outside) board-certified physician reviewers.

- Molina Healthcare ensures that all criteria used for UM decision-making are available to practitioners upon request. **To obtain a copy of the UM criteria used in the decision-making process, call our HCS Department at 888.898.7969**.

- As the requesting practitioner, you will receive written notification of all UM denial decisions. The notification will include the name and telephone number of the Molina Healthcare physician that made the decision. You may call him or her to discuss the case. If you need assistance contacting a medical reviewer about a case, please call the HCS Department at 888.898.7969.

It is important to remember that:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.
2. Molina Healthcare does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
3. UM decision makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
4. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
5. Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, Molina Healthcare will arrange for a member to obtain the second opinion out of network at no additional cost to the member than if the services were obtained in-network.
6. Some of the most common reasons for a delay or denial of a request include:
    - Insufficient or missing clinical information to provide the basis for making the decision
    - Lack of or missing progress notes or illegible documentation
    - Request for an urgent review when there is no medical urgency

Molina Healthcare's UM Department staff is available for inbound collect or toll-free calls during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff, please call 888.898.7969.

You may also fax a question about a UM issue to 800.594.7404. The Medical Director is available for more complex medical decision questions and explanations of medical necessity denials.

For information about pre-authorization and the exception process, please refer to the *Drug Formulary and Pharmaceutical Procedures* article.

Molina Healthcare's regular business hours are Monday – Friday (excluding holidays) 8:00 a.m. – 5:00 p.m. Voicemail messages and faxes received after regular business hours will be returned the following business day. Molina Healthcare has language assistance and TDD/TTY services for members with language barriers or with hearing and/or speech problems.

Drug Formulary and Pharmaceutical Procedures

At Molina Healthcare, the Drug Formulary (sometimes referred to as a Preferred Drug List or PDL) and pharmaceutical procedures are maintained by the Pharmacy and Therapeutics (P&T) Committee. This committee usually meets on a quarterly basis, or more frequently if needed.

It is composed of your peers – practicing physicians (both primary care physicians and specialists) and pharmacists from areas Molina Healthcare practitioners are located. The committee's goal is to provide a safe, effective and comprehensive Drug Formulary/PDL. The P&T Committee evaluates all therapeutic categories and selects the most cost-effective agent(s) in each class. In addition, the committee reviews prior authorization procedures to ensure that medications are used safely, and in accordance with the manufacturer's guidelines and FDA-approved indications. The Committee also evaluates and addresses new developments in pharmaceuticals and new applications of established technologies, including drugs. Molina Healthcare has two PDLs, one is for over-the-counter (non-prescription drugs) and the other for prescription drugs.

Medications prescribed for Molina Healthcare members must be listed in the Drug Formulary/PDL. The Drug Formulary/PDL also includes an explanation of limits or quotas, any restrictions and medication preferences, and the process for generic substitution, therapeutic interchange and step-therapy protocols. Select medications listed on the Drug Formulary/PDL may require prior authorization, as well as any medication not found on the listing. When there is a medically necessary indication for an exception, such as failure of the formulary choices, providers may request authorization by submitting, via fax, a Medication Prior Authorization Form or by calling the Pharmacy Prior Authorization Department for the plan. The Drug Formulary/PDL is available online at www.MolinaHealthcare.com and printed copies may be obtained by calling the Provider Services Department at 888.898.7969.

The Michigan Department of Health and Human Services has worked with its health plan partners to create a list of drugs that all Medicaid health plans must cover. This list is called the Michigan Medicaid Managed Care Common Formulary. The 2019 Molina Healthcare of MI Preferred Drug List (Formulary) includes everything on the Michigan Medicaid Managed Care Common Formulary and some additional products that Molina has chosen to cover for its members.

The drug formulary/drug listing, processes for requesting an exception request and generic substitutions, therapeutic interchanges and step-therapy protocols are distributed to our network providers through fax and/or mail, and/or the Molina website once updates are made.
These changes and all current documents are posted on the Molina Healthcare website at www.MolinaHealthcare.com.

When there is a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing practitioners are notified by Molina Healthcare within 30 calendar days of the Food and Drug Administration notification.
An expedited process is in place to ensure notification to affected members and prescribing practitioners of Class I recalls as quickly as possible. These notifications will be conducted by fax, mail and/or telephone.

Complex Case Management

Molina Healthcare offers you and your patients the opportunity to participate in our Complex Case Management Program. Patients appropriate for this voluntary program are those who have the most complex service needs. This may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

The purpose of the Molina Healthcare Complex Case Management Program is to:

- Conduct a needs assessment of the patient, patient's family, and/or caregiver
- Provide intervention and care coordination services within the benefit structure across the continuum of care
- Empower our patients to optimize their health and level of functioning
- Facilitate access to medically necessary services and ensure that they are provided at the appropriate level of care in a timely manner
- Provide a comprehensive and on-going care plan for continuity of care in coordination with you, your staff, your patient, and the patient's family

If you would like to learn more about this program, speak with a Complex Case Manager and/or refer a patient for an evaluation for this program, please call toll-free 888.898.7969.

Preventive Health Guidelines

Preventive Health Guidelines can be beneficial to the provider and his/her patients. Guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services depending on the individual needs of the patient.

To request printed copies of Preventive Health Guidelines, please contact Provider Services at 888.898.7969. You can also view all guidelines at www.MolinaHealthcare.com.

Website

Featured at www.MolinaHealthcare.com:

- Clinical Practice and Preventive Health Guidelines
- Health Management Programs for Asthma, Diabetes, Hypertension, CAD, CHF & Pregnancy
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Claims/Denials Decision Information
- Provider Manual
- Current Formulary & Updates
- Pharmaceutical Management Procedures
- UM Affirmative Statement (re: non-incentive for under-utilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff & Medical Reviewer
- New Technology
- How to access language services

If you would like to receive any of the information posted on our website in hard copy, please call 888.898.7969.

Patient Safety

Patient Safety activities encompass appropriate safety projects and error avoidance for Molina Healthcare members in collaboration with their primary care providers.

Safe Clinical Practice

The Molina Healthcare Patient Safety activities address the following:

- Continued information about safe office practices
- Member education; providing support for members to take an active role to reduce the risk of errors in their own care
- Member education about safe medication practices
- Cultural competency training
- Improvement in the continuity and coordination of care between providers to avoid miscommunication
- Improvement in the continuity and coordination between sites of care such as hospitals and other facilities to assure timely and accurate communication
- Distribution of research on proven safe clinical practices

Molina also monitors nationally recognized quality index ratings for facilities from:

- Leapfrog Quality Index Ratings (www.leapfroggroup.org)
- The Joint Commission Quality Check® (www.qualitycheck.org)

Providers can also access the following links for additional information on patient safety:

- The Leapfrog Group (www.leapfroggroup.org)
- The Joint Commission (www.jointcommision.org)

Health Risk Assessment (HRA)

The HRA is a health survey for Healthy Michigan members to evaluate their health risks and quality of life. It is designed to identify healthy behavior goals and is intended to be completed during a member's annual well care visit.

The Health Risk Assessment form can be submitted and viewed in the CHAMPS system via the Health Risk Assessment questionnaire web page. See the link below for instructions.
https://www.michigan.gov/documents/mdhhs/Provider_Instructions_for_Completing_the_Health_Risk_Assessment_620500_7.pdf

Molina rewards provider the incentive bonus is $25.00 for annual and timely completion of the HRA. An additional $25.00 if completed within 150 days of enrollment.

FAX completed HRAs to:
Maximus at 517.763.0200
OR
Molina Healthcare of MI at
855.671.1283

MAIL completed HRAs to:
Molina Healthcare of MI
ATTN: Healthcare Services
800 W Long Lake Rd, Suite 600
Troy, MI 48098

If you have additional questions, please contact your Provider Service Representative at 855.322.4077 or email MHMProviderServicesMailbox@MolinaHealthcare.com

Care for Older Adults

Many adults over the age of 65 have co-morbidities that often affect their quality of life. As this population ages, it is not uncommon to see decreased physical function and cognitive ability and increase in pain. Regular assessment of these additional health aspects can help to ensure this population's needs are appropriately met.

- **Advance care planning** – Discussion regarding treatment preferences, such as advance directives, should start early before patient is seriously ill.
- **Medication review** – All medications that the patient is taking should be reviewed, including prescription and over-the-counter medications or herbal therapies.
- **Functional status assessment** – This can include assessments, such as functional independence or loss of independent performance.
- **Pain screening** - A screening may comprise of notation of the presence or absence of pain.

Including these components in your standard well care practice for older adults can help to identify ailments that can often go unrecognized and increase their quality of life.

Hours of Operation

Molina Healthcare requires that providers offer Medicaid members hours of operation no less than hours offered to commercial members.

Non-Discrimination

As a Molina Healthcare provider, you have a responsibility to not differentiate or discriminate in providing covered services to members because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, socioeconomic status, or participation in publicly financed health care programs. Providers are to render covered services to Members in the same location, in the same manner, in accordance with the same standards and within the same time availability regardless of payer.

Member Rights and Responsibilities

Molina Healthcare wants to inform its providers about some of the rights and responsibilities of Molina Healthcare members.

Molina Healthcare members have the right to:
Receive information about Molina Healthcare, its services, its practitioners and providers and member rights and responsibilities.

- Be treated with respect and recognition of their dignity and their right to privacy.
- Help make decisions about their health care.
- Participate with practitioners in making decisions about their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about Molina Healthcare or the care it provides.
- Make recommendations regarding Molina Healthcare's member rights and responsibilities policy.

Molina Healthcare members have the responsibility to:
Supply information (to the extent possible) that Molina Healthcare and its practitioners and providers need to provide care.

- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Keep appointments and be on time. If members are going to be late or cannot keep an appointment, they are instructed to call their practitioner.

You can find the complete Molina Healthcare Member Rights and Responsibilities statement for your state at our website (**www.MolinaHealthcare.com**). Written copies and more information can be obtained by contacting the Provider Services Department at 888.898.7969.

Quality Improvement Program

The Molina Healthcare Quality Improvement Program (QIP) provides the structure and key processes that enable the health plan to carry out our commitment to ongoing improvement in members' health care and service. The Quality Improvement Committee (QIC) assists the organization to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies.

The key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determination of further actions
- Design of effective and value-added interventions
- Continuous monitoring of performance parameters and comparing to performance standards and benchmarks published by national, regional, or state regulators, accrediting organizations and internal Molina Healthcare threshold
- Analysis of information and data to identify trends and opportunities, and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: Claims, UM and/or Credentialing
- Confirmation of the quality and adequacy of the provider and Health Delivery Organization network through appropriate contracting and credentialing processes

The QIP promotes and fosters accountability of employees, network and affiliated health personnel for the quality and safety of care and services provided to Molina Healthcare members.

The effectiveness of QIP activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the QI work plan quarterly.
- Revising interventions based on analysis, when indicated.
- Evaluating member satisfaction with their experience of care through the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey.
- Reviewing member satisfaction with their experience with behavioral health services through a focused survey and evaluation of behavioral health specific complaints and appeals.
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management.

Molina Healthcare would like to help you to promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the Molina Healthcare website, please contact the Quality Improvement Department at 888.898.7969.

If you would like more information about our Quality Improvement Program or initiatives and the progress toward meeting quality goals or would like to request a paper copy of our documents, please call the Quality Improvement Department at 888.898.7969. You can also visit our website at www.MolinaHealthcare.com to obtain more information.

Health Management Programs Improve Member Health

Molina Healthcare offers focused Health Management Programs that can significantly influence the health of our members and provide a variety of helpful services for those with chronic conditions such as asthma and diabetes.

Molina Healthcare offers the following Health Management Programs to our members:

- Asthma management
- Depression management

All Health Management Program interventions are targeted to the specific needs of each member. Members are automatically enrolled based on medical and pharmacy claims. Program materials include condition specific pamphlets and brochures, workbooks, patient logs, action plans, newsletters and other tools that educate the patient on how to manage his or her condition. In addition, nurses or health educators reach out to patients and provide case management to those who will benefit the most from more frequent, in-depth follow-up. Physicians receive results of their patient's self-assessments and updates describing interventions and education offered to members. In addition, practitioners receive notifications and patient profiles on all members enrolled in any of the Health Management Programs.

At each point of contact, members are encouraged to discuss their care with their provider and follow their plan of treatment. Other services available to members include having access to the 24-hour nurse advice line. Members can call and speak to a nurse for advice on any health problems. All Health Management Programs are voluntary, and members can stop participating at any time. If you have a Molina Healthcare patient you think will benefit from receiving educational materials or talking with a Case Manager, please refer them to our Health Management Programs by calling the Health Management Department at 866.891.2320.

You can find more information about our programs on the Molina website at www.MolinaHealthcare.com.

Behavioral Health

Primary Care Providers provide outpatient behavioral health services, within the scope of their practice, and are responsible for coordinating members' physical and behavioral health care, including making referrals to Behavioral Health providers when necessary. If you need assistance with the referral process for Behavioral Health services, please contact the Member Services Department at 888.483.0760.

Standards for Medical Record Documentation

Providing quality care to our members is important; therefore, Molina Healthcare has established standards for medical record documentation to help assure the highest quality of care. Medical record standards promote quality care though communication, coordination and continuity of care, and efficient and effective treatment.

Molina Healthcare's medical record documentation standards include:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information
- Standards and performance goals for participating providers

Below are commonly accepted standards for documentation in medical records and must be included in each medical record:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening

For more information, please call the Credentialing Department at 888.898.7969.

2019 Health Effectiveness Data and Information Set (HEDIS) Provider Manual

Molina's HEDIS provider manual is developed by the National Committee for Quality Assurance (NCQA). HEDIS is a widely used set of performance measures in the managed care industry, and an essential tool in ensuring that our members are getting the best healthcare possible. It is vitally important that our providers understand HEDIS specifications and guidelines.

Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs, and we want to do everything we can do to make this process as easy possible. The HEDIS manual is intended to be an easy to follow guide that covers all the HEDIS measures applicable to Medicaid and Medicare.

The 2019 HEDIS Manual is available on the provider portal under the forms tab see link below.
https://provider.molinahealthcare.com/Provider/ProviderForms.

Translation Services

We can arrange for an interpreter to help you speak with our members in their primary language. We also provide written materials in different languages and formats. If you need an interpreter or written materials in a language other than English, please contact Molina's Member Services Department at 855.322.4077. You can also call TTD/TTY: 711, if a member has a hearing or speech disability.

Advance Directives

Helping your patients prepare Advance Directives may not be as hard as you think. Any person 18 years or older can create an Advance Directive. Advance Directives include a living will document and a durable power of attorney document.

A living will is written instruction that explains your patient's wishes regarding health care in the case of a terminal illness or any medical procedures that prolong life. A durable power of attorney names a person to make decisions for your patient if he or she becomes unable to do so.

The following links provide you and your patients with free forms to help create an Advance Directive:
http://www.nlm.nih.gov/medlineplus/advancedirectives.html
https://order.nia.nih.gov/sites/default/files/2017-07/End_of_Life_508.pdf
http://www.hsdaas.utah.gov/advance_directives.htm
www.caringinfo.org

For the living will document, your patient will need two witnesses. For a durable power of attorney document, your patient will need valid notarization. A patient's Advance Directive must be honored to the fullest extent permitted under law. Providers should discuss Advance Directives and provide appropriate medical advice if the patient desires guidance or assistance, including any objections they may have to a patient directive prior to service whenever possible. In no event may any provider refuse to treat a patient or otherwise discriminate against a patient because the patient has completed an Advance Directive. Patients have the right to file a complaint if they are dissatisfied with the handling of an Advance Directive and/or if there is a failure to comply with Advance Directive instructions.

It is helpful to have materials available for patients to take and review at their convenience. Be sure to put a copy of the completed form in a prominent section of the medical record. The medical record should also document if a patient chooses not to execute an Advance Directive. Let your patients know that advance care planning is a part of good health care.

Clinical Practice Guidelines

Clinical practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested as guides for making clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina Healthcare has adopted the following Clinical Practice Guidelines which include but are not limited to:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Asthma
- Depression
- Diabetes
- Hypertension
- Chronic Obstructive Pulmonary Disease (COPD)

To request a copy of any guideline, please contact Molina Healthcare's Provider Services Department at 888.898.7969. You can also view all guidelines at www.MolinaHealthcare.com.

Care Coordination & Transitions

Coordination of Care during Planned and Unplanned Transitions for Medicare Members
Molina Medicare is dedicated to providing quality care for our Medicare members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina Medicare member is discharged from a hospital. By working together with providers, Molina Medicare makes a special effort to coordinate care during transitions. This coordination of specific aspects of the member's transition is performed to avoid potential adverse outcomes.

To ease the challenge of coordinating patient care, Molina Medicare has resources to assist you. Our Utilization Management nurses and Member Services staff are available to work with all parties to ensure appropriate care.

In order to appropriately coordinate care, Molina Medicare will need the following information in writing from the facility *within one business day* of the transition from one setting to another:

- Initial notification of admission within 24 hours of the admission
- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information can be faxed to Molina Medicare at: 866.594.7404
To assist with the discharge planning of Molina Medicare members, please note the following important phone numbers:

- **Medicare Member Services & Pharmacy:** 866.553.9494
- **Behavioral health services and substance abuse treatment** for Molina Medicare members can be arranged by contacting: 888.898.7969
- **Transportation services** for Molina Medicare Options Plus members may be arranged by calling **LogistiCare** at: 866.475.5423
- The **Nurse Advice Line** is available to members 24 hours a day, 7 days a week at: 888.275.8750

Important information you need to know about Molina Medicare Options Plus:

- All beneficiaries have rights that are defined in our provider manual. They are also available in the member EOC posted on our website at **www.MolinaHealthcare.com/Medicare**.
- Molina Medicare Options Plus members have Medicare and Medicaid benefits designed to meet their special needs, therefore the state agency or its designated health plans have the responsibility for coordinating care, benefits and co-payments. Please be aware of your patients' status and Medicaid benefits and bill the correct entity.
- Health plans and providers can never charge these members more than they would have paid under Original Medicare and Medicaid. Members can also call the Medicaid agency for details and have specific rights with regard to their Medicaid benefits.
- Providers are responsible for verifying eligibility and obtaining approval for services that require prior authorization as outlined in the Provider contract. Our Medicare Member Services department can assist you in this regard.

Please contact the UM Department or Medicare Member Services if you have questions regarding planned or unplanned transitions at:

UM Department: 888.898.7969 **Member Services:** 800.665.3072