CARTA CIRCULAR PR PROV19-007-001

24 de julio de 2019

A: Solicitud para Registro de Cubierta Especial

Reciba un cordial saludo de parte de la familia de Molina Healthcare de Puerto Rico (MHPR) y el área de Pre Autorizaciones y Registro de Cubierta Especial. Estamos comprometidos con la salud de nuestros beneficiarios así como el servicio a nuestros proveedores del Plan de Salud VITAL.

Para garantizar la continuidad de servicios y cumplir con nuestros beneficiarios, le solicitamos que efectivo a la fecha de este comunicado, descarte cualquier otro formulario de solicitud para Cubierta Especial y utilice el formulario actualizado que se adjunta con esta carta. Toda solicitud de Cubierta Especial recibido con algún formulario que no sea una copia fiel exacta del aquí incluido, será devuelta automáticamente.

Toda solicitud para cubierta especial con información incompleta será evaluada, para determinar si cumple con los criterios de cubierta temporal por un periodo de 30 días. La extensión de este registro estará sujeto al recibo de la información completa que evidencie el diagnóstico y tratamiento de la condición peticionada. Por favor, haga referencia al formulario adjunto el cual contiene la información clínica requerida para cada registro. De esta manera garantizamos la continuidad de servicios cumpliendo así con la necesidad de nuestros beneficiarios.

La solicitud adjunto puede ser enviada al fax al 855-378-3641.

Si tiene alguna pregunta referente a este proceso, puede comunicarse con nuestro Centro de Llamadas de Servicio al Proveedor al (888) 558-5501 de lunes a viernes de 7:00 am a 7:00 pm. Personas audio impedidas pueden comunicarse al TTY (787) 522-8281.

Agradecemos su compromiso con la salud de nuestros beneficiarios.

Cordialmente,

Carmen Gómez RN, MSN
Directora de Operaciones Clínicas

Special Coverage Registration Form

Phone Number: 1-844-633-8350
Fax Number: 1 -855-378-3641

The Special Coverage Benefit is designed to guarantee access to services to members with special health care needs caused by serious illness.

To register a Molina Member in the Special Coverage Registration, please complete and submit the following to GHP Molina Healthcare of Puerto Rico

- Registration form
- All required information listed in the Special Coverage Attachment for the condition

MEMBER INFORMATION			
Member Name:		**Date of birth:**	/ /
Member ID#:		**Phone:**	( ) -

PROVIDER INFORMATION			
Requesting Provider Name:			**NPI:**
Primary Medical Group (PMG):			
Referring to Provider Name :			**NPI:**
Phone Number:	( )	**Fax Number:**	( )
Member Medical History:			

Date was diagnosed:	**Physician's Signature:**
ICD10:	**License:**
Initial ☐ **Extension** ☐	**Date:**

MOLINA HEALTHCARE OF PUERTO RICO, INC.

Attachment: Special Coverage Conditions

Condition:	Supporting Clinical Information:
☐ Aplastic Anemia	Hematological Assessment including, o neutrophil count all < 500/mm3, o Platelet <20,000/mm3, o reticulocyte <1% • Aspiration and/or biopsy of bone marrow Results Certification of diagnosis by **Hematology Oncology** • Treatment Plan
☐ Rheumatoid Arthritis	Certification of diagnosis by Rheumatologist and at least 4 of the following: • Morning numbness periarticular (over 1 hour) for over 6 weeks; • Swelling of soft tissue in > 3 joints for more than 6 weeks; • Swelling of joints in proximal phalanx or metacarpal for more than 6 weeks; • Symmetric arthritis for at least 6 weeks; • Subcutaneous nodules; • Positive Rheumatoid Factor test Laboratory Test – ESR, ANA Test, CRP, RA Factor Evidence of Treatment with DMARDS medicine Treatment Plan
☐ Autism ☐ a) Provisional coverage	The provisional coverage will last for six months. If the evaluation process is not completed, the provisional coverage may be renew for six additional month. (Mark what screening tools where used for evaluation): ☐ <16 months – Ages & Stages Questionnaires: Social Emotional-2 (ASQ-SE-2) or Communication Symbolic Behavior Scales -Developmental Profile (CSBS-DP) ☐ 16-30 months – Modified Checklist for Autism in Toddlers: Revised Follow-Up (M-CHAT R/F) ☐ 31-66 months – Ages & Stages Questionnaire-Social Emotional-2 (ASQ-SE-2) ☐ ≥48 months – Social Communication Questionnaire (SCQ mental age > 2 years) Communication & Symbolic Behavior Scales Developmental Profile (CSBS-DP) ☐ 67 months-11 years – Childhood Asperger Syndrome Test (CAST) ☐ > 11 years – Australian Scale for Asperger Syndrome (ASAS) (See, Protocol of Autism from the Department of Health)

Attachment: Special Coverage Conditions

Condition	Requirements
☐ b) Permanent registration	For **permanent registration** is required any of the following: Diagnosis certification by a • Clinical Psychologist, • School Psychologist, • Counselor Psychologist, • Neurologist, • Psychiatrist, • Pediatrician development specialist. Professionals should have training or experience in the area of Autism, as required by the Protocol of Autism from the Department of Health of PR. After 21, to continue in the special coverage registration, a certification by a neurologist or psychiatrist establishing the need for the condition management and treatment as an adult is required.
☐ Cancer	• Certification of diagnosis with staging by Hematologist/oncologist • Treatment plan including start and completion dates. • Biopsy results • Diagnostic Studies (CT, MRI, PET scan, etc.) Treatment Plan
☐ Skin Cancer Carcinoma ☐ IN SITU	• Positive Biopsy • Treatment Plan
☐ Skin Cancer as:	• Melanoma invasive or squamous cell carcinoma with evidence of Metastasis • Positive Pathology or biopsy • Diagnostic Studies (CT, MRI, PET scan, etc.) • Certification by dermatologist or medical oncologist/hematologist • Treatment Plan
☐ Chronic Renal Disease	Glomerular filtration (GFR) BUN and Creatinine • Level 3 - 30-59 GFR • Level 4 - 15-29 GFR • Level 5 - < 15 GFR • Treatment Plan

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Condition	Requirements
☐ Scleroderma	Evidence of ANA Test Positive ≥ 1:80 Positive Skin biopsy Certification of diagnosis by Rheumatologist Must meet at least Major or Minor Criteria • Major criteria: Proximal Scleroderma Loss of elasticity of the skin Hyperpigmentation and Hypopigmentation of the skin in "salt and pepper" pattern • Minor criteria: Sclerodactyly Loss of substance of finger pad Pulmonary fibrosis in both bases
☐ Multiple Sclerosis and Amyotrophic Lateral Sclerosis	Two (2) different episodes of verified neurological symptoms by neurologist Symptoms that indicate damage or injury in more than one region of the Central Nervous System. Absence of another illness or condition that may cause symptoms or lab findings. • Certification of the diagnosis by a neurologist confirming condition and plan of treatment. • Evidence such: MRIs, EMG, Evoked potentials, NCS, lumbar punction, Genetic studies, etc .
☐ Cystic Fibrosis	• Sweat test • Evidence of treatment • Certification of diagnosis by Pulmonologist
☐ Hemophilia	Hematology Assessment: • Severe – Factor VIII level < 1% • Moderate – Factor VIII level < 1-5% • Slight – Factor VIII level 5-25% with manifestations of severe bleeding Results for levels of coagulation Certification of diagnosis by Hematology or Hemophilia Clinic
☐ Leprosy	• Skin biopsy results • Culture results • Certification of diagnosis by infectious disease specialist or dermatologist • Treatment Plan
☐ Systemic Lupus	• Certification of diagnosis by Rheumatologist • Lab results – ANA Test, DS-DNA, Anti-Sm, and Anti Phospholipids • Treatment Plan
☐ Children with Special Healthcare Needs	• Medical evidence • Lab results • Diagnostic certifications • Treatment Plan

Attachment: Special Coverage Conditions

Condition	Requirements
☐ Obstetrics	Certification of pregnancy by OB-GYN • Estimated Date of Conception • Estimated date of birth • Result laboratory positive, Sonogram
☐ Tuberculosis	• Tuberculin test results • Chest x-rays • Lab and Culture results • Biopsy results • HIV test results
☐ HIV/AIDS	One of the following lab results: • Positive Western Blot • Viral Load HIV • 4 generation lab positive with antibodies or antigens for and acute infection.
☐ Adults with phenylketonuria (PKU)	• The registry has to be request by the geneticist and shall include a treatment history and evidence of the result of the genetic study.
☐ Pulmonar Hypertension	• Diagnosis certification and treatment plan by the Pneumologist or Cardiologist and evidence of supporting test(s).