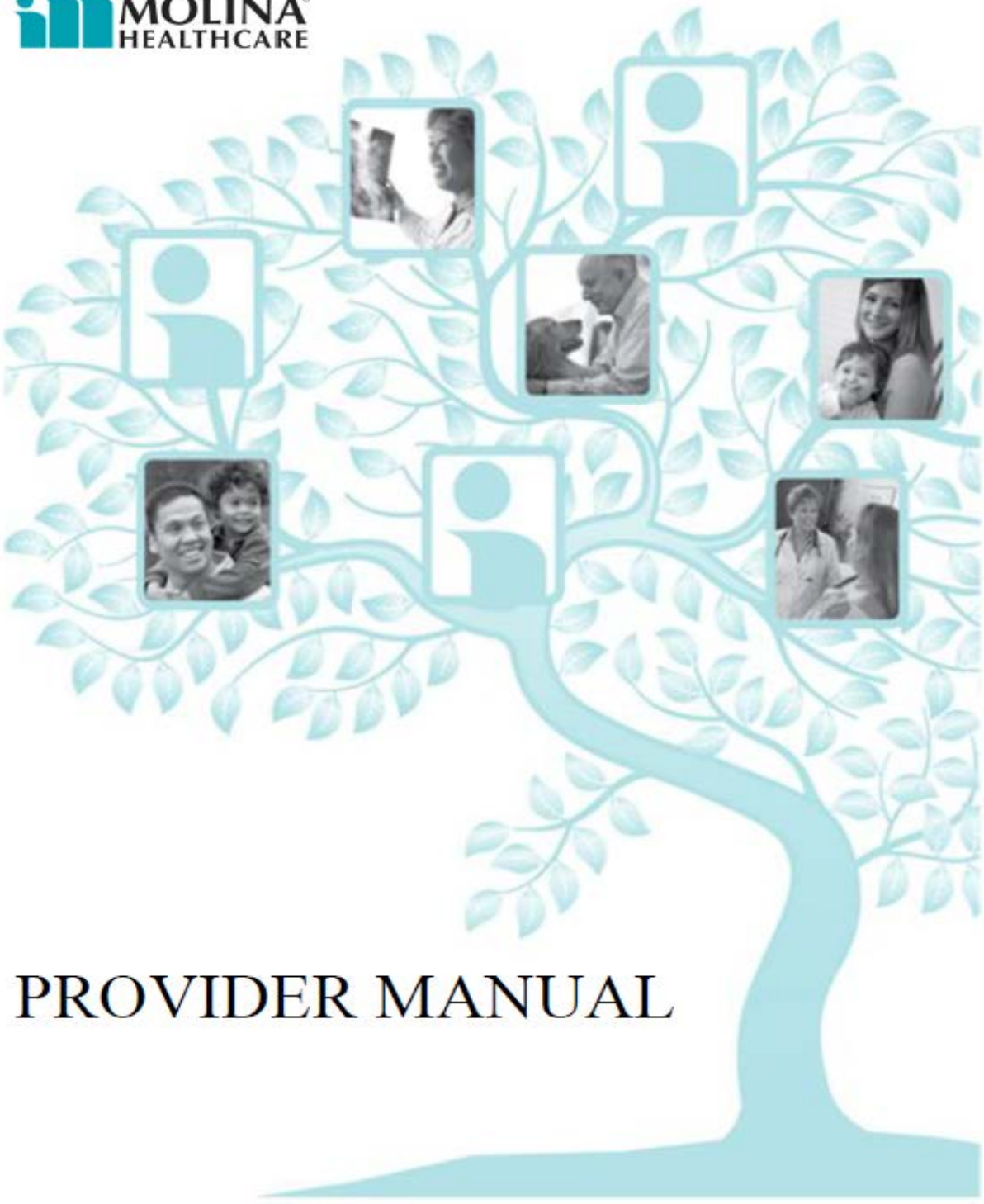
MOLINA HEALTHCARE



PROVIDER MANUAL

PROVIDER MANUAL

Dear Molina Healthcare Provider:

Thank you for participating in the Molina Healthcare network of providers. We are pleased to offer this manual as a communication tool and a reference guide for our program providers and their office staff. It contains basic information about how to work within Molina Healthcare's network. The information contained in the manual is current as of the date of its publication. We will update the online provider manual as often as necessary.

As always, we value your participation and you may contact us at 1-888-898-7969, Option 1 or your assigned Provider Services Representative if you have questions.

Molina Healthcare
www.molinahealthcare.com

CREDENTIALING

PRIMARY CARE PROVIDER RESPONSIBILITIES

COMPLIANCE

INTRODUCTION

Mission

Our mission is to promote health and provide health services to families and individuals who are lower income and covered by government programs.

Vision

Molina Healthcare is an innovative healthcare leader providing quality care and accessible services in an efficient and caring manner.

Core Values:

We strive to be an exemplary organization:

1. We care about the people we serve and advocate on their behalf.
2. We provider quality service and remove barriers to health services.
3. We are healthcare innovators and embrace change quickly.
4. We respect each other and value ethical business practices.
5. We are careful in the management of our financial resources and serve as prudent stewards of the public funds.

About Molina Healthcare

Molina Healthcare, headquartered in Long Beach, California, is a multi-state managed care company focused on providing healthcare services to people who receive healthcare benefits through a Medicare Special Needs Program, Medicare, Medicaid, State Children's Health Insurance Program ("SCHIP"), and other government-sponsored programs. C. David Molina, M.D., founded our company in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. As the need for more effective management and delivery of healthcare services to underserved populations continued to grow, Molina Healthcare became licensed as a Health Maintenance Organization ("HMO") in California.

Today, Molina Healthcare is a multi-state company that provides healthcare services to more than 1.5 million members. Included in Molina Healthcare networks are company-owned and operated primary care clinics, independent physicians and groups, hospitals and ancillary providers.

Our members have distinct social and medical needs and are characterized by their cultural, ethnic and linguistic diversity. From our inception, we have designed our company to work with government agencies to serve low-income populations. Our success has resulted from our expertise in working with government agencies, our extensive experience in meeting the needs of our members, over 30 years of owning and operating primary care clinics, our cultural and linguistic expertise and our focus on operational and administrative efficiency.

CONTACT INFORMATION

The following is a list of contact information to assist you in making the appropriate contact with the Service departments of Molina Healthcare of Michigan.

Claims Status Inquiry ..... www.molinahealthcare.com

.....1-888-898-7969, Option 1 then 2

Claims Appeals (technical denials) Fax to: 1-248-925-1768

Eligibility.....1-888-898-7969

Member Services .....Option 1, 1 then 2
Interactive Voice Response (IVR).....Option 1, 1 then 1
WebPortal (Provider Self Services)..... www.molinahealthcare.com

Pharmacy Services.....1-888-898-7969, Option 1 then 5

Fax Number 1-888-373-3059
email address.....MHMcompliance@molinahealthcare.com

Fraud and Abuse Prevention.....1-877-372-5361

Fax Number 1-248-925-1780

Provider Services 1-888-898-7969, ext.155822

Utilization Management .....1-888-898-7969, Option 1, then 4

Clinical Appeals (Authorization, Readmissions, Medical Necessity, etc)

Referral and Appeals Fax Number 1-800-594-7404

Claims Address:

Molina Healthcare of Michigan, Inc.
P.O. Box 22668
Long Beach CA 90801

Troy, MI Address:

100 West Big Beaver Road, Suite 600
Troy, MI 48084 - 5209

ENROLLMENT INFORMATION

Medicaid

Medicaid is a federal program created by Title XIX of the Social Security Act in 1965. The primary objective of the program is to provide essential medical and health services to those who would not otherwise have the financial resources to purchase them. Public and private agencies work together to administer the Medicaid Program.

Beneficiary eligibility for public assistance is determined by the Department of Human Services (FIA). Michigan Enrolls is the enrollment broker for Michigan's Medicaid and MIChild programs and provides educational materials about the various health plans available in a member's county.

Michigan Enrolls also helps Medicaid beneficiaries pick the health plan of their choice. If members do not choose a health plan, Michigan Enrolls will assign the member to a health plan. Michigan Enrolls' phone number is 1-888-367-6557.

Molina Healthcare is notified each month when Medicaid beneficiaries select our Plan. Members will have two cards, a Molina Healthcare identification card and a Michigan Medicaid identification card (called mihealth card). The State sends a Medicaid identification card (mihealth) to each member. This card contains information on the member's Medicaid eligibility. Members should present both cards each time they receive a service. Here are some eligibility points:

- Members who lose and then regain Medicaid eligibility within 60 days are automatically reassigned to Molina Healthcare and the Primary Care Provider they previously had.

- Newborns are automatically enrolled with the health plan the mother was enrolled in on the date of delivery. Parents may choose a different plan for the newborn within the first 90 days of the newborn's eligibility.

Note: *The newborn's mihealth card may not reflect HMO coverage for 30-60 days.*

MIChild

MIChild is a health insurance program for the uninsured children of Michigan's working families. Eligibility is determined by the following criteria:

- Must be a U.S. citizen (some legal immigrants qualify)
- Must live in Michigan, even for a short period of time
- Must be under the age of 19
- Family must meet income requirements
- Children must not have other insurance coverage
- All eligible children will pay a monthly premium of $10.00 per family

MIChild applicants may submit applications online at www.health4mi.com. Applicants may also submit applications to local health departments, or the Administrative Contractor at MIChild, P.O. Box 30412, Lansing, MI 48909. MIChild questions should be referred to 1-888-988-6300.

Dual Eligibles

Starting **November 1, 2011**, the Department of Community Health will allow beneficiaries dually eligible for Medicaid and Medicare to enroll into Medicaid health plans. Molina Healthcare offers a Medicare Advantage Dual Eligible Special Needs Plan product called **Molina Medicare Options Plus (MMOP).** MMOP is available in:

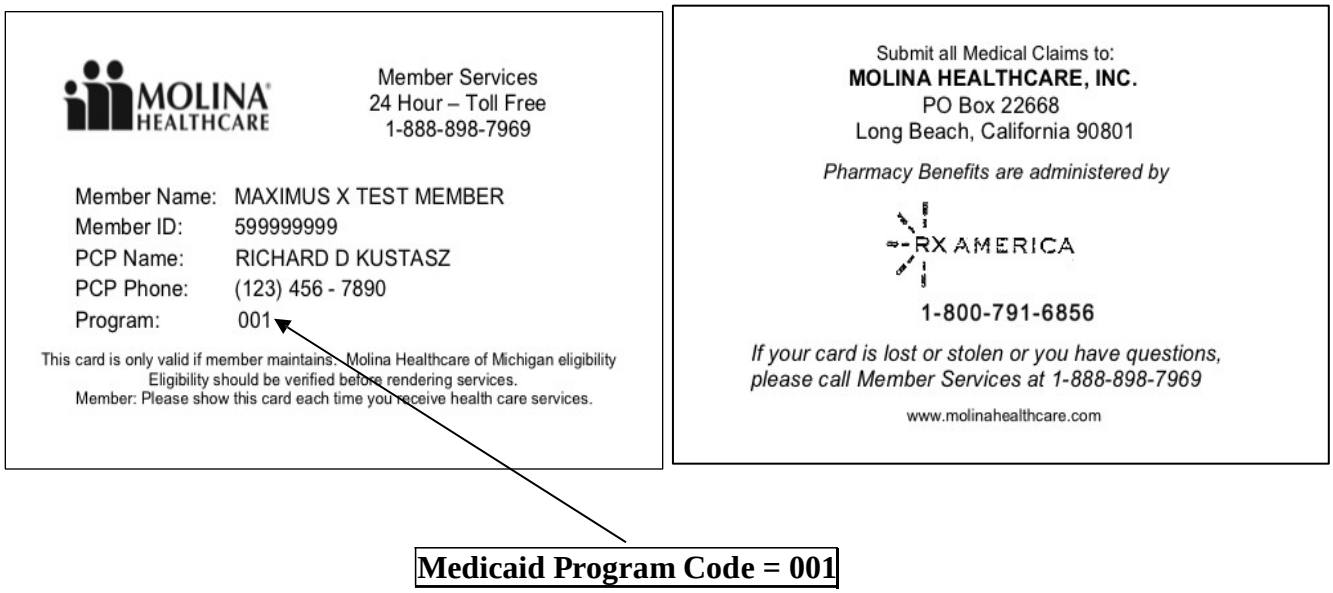
Wayne, Oakland, Macomb, Genesee, Kent, Saginaw, and Montcalm counties.

Molina Healthcare will follow the Medicare eligibility guidelines described in the Michigan Department of Community Health Provider Manual Section 2.6.

Molina Healthcare Identification Cards

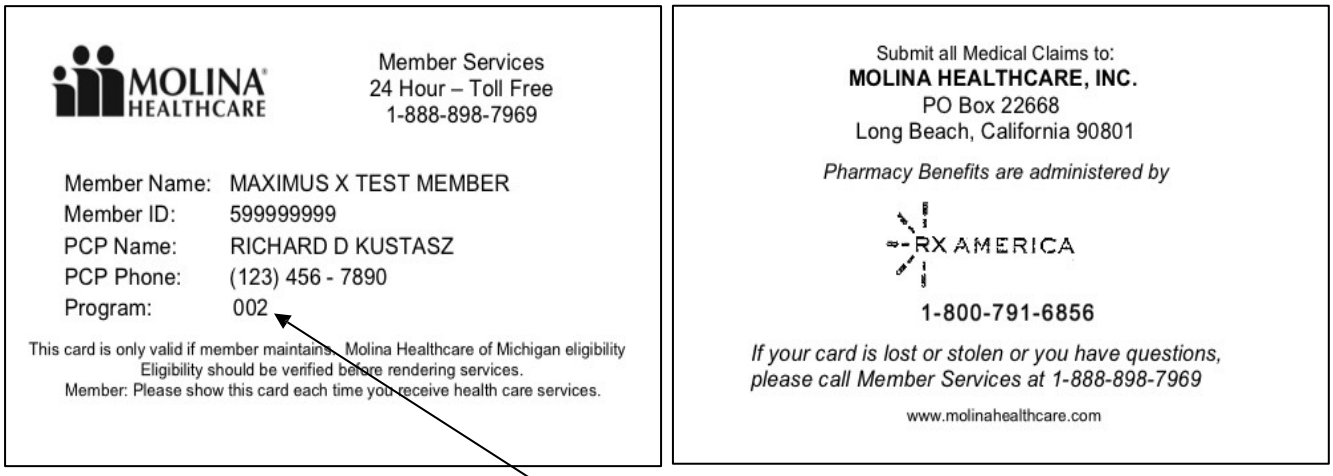
Molina Healthcare identification cards identify which program (Medicaid/MIChild) the member is enrolled in. This information is located in the program field.

Medicaid ID Card



Medicaid Program Code = 001

MIChild ID Card



MIChild Program Code = 002

ELIGIBILITY

The following resources may be utilized to determine whether a patient is eligible to receive Molina Healthcare benefits for Medicaid or MIChild.

Please refer to the Medicaid Provider Manual Directory Appendix at http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf for information on eligibility verification through Medicaid.

WebPortal Eligibility Roster	www.molinahealthcare.com
Interactive Voice Response (IVR) System	1-888-898-7969, Option 1, 1, then 1
Molina Healthcare Member Services	1-888-898-7969, Option 1, 1, then 2
Champs Eligibility Inquiry	1-888-643-2408
Champs Webportal	https://sso.state.mi.us

A member's eligibility may change monthly; therefore, it is the provider's responsibility to verify eligibility prior to rendering services. Services provided when a member is not enrolled with Molina Healthcare will not be covered.

Member Initiated Transfer Requests

Members desiring to change their Primary Care Physician (PCP) must call Member Services at 1-888-898-7969. Generally, requests made on/or before the 15th day of the month will be effective the first of the next month. Requests made after the 15th day of the month will be effective the first of the following month.

Example: *Request made October 10, 2010, change effective November 1, 2010*
Request made October 20, 2010 change effective December 1, 2010

Provider Initiated Transfer Requests

There may be times when a PCP requests a member be transferred to a different PCP. If this situation occurs, the current PCP must inform the member in writing of the reason(s) for terminating the current physician/patient relationship and must also inform the member they have thirty (30) days to choose another PCP. The written correspondence must be mailed by certified or registered letter to the member. A copy of the correspondence must be sent to:

Molina Healthcare
Member Service Department
100 West Big Beaver Road, Suite 600
Troy, Michigan 48084
Fax (248) 925-1765

Providers should use the Molina Healthcare Member Change Information Request Form to notify Member Services of their desire to initiate a member transfer. The form is located in the Forms section of Molina Healthcare's website at www.molinahealthcare.com.
A Member Services Representative can assist the member in reviewing the Provider Directory for available PCP choices.

When the PCP believes an immediate transfer is necessary, the PCP should contact Member Services at 1-888-898-7969 for assistance.

DISENROLLMENT

The Michigan Department of Community Health allows for disenrollment from Medicaid Health Plans via the Special Disenrollment process:

Reasons for Special Disenrollment:

- **Urgent/Life-threatening:** Situations that involve physical acts of violence; physical or verbal threats of violence made against providers, staff or the public; or where stalking situations exist.
- **Fraud/Misrepresentation:** Involves alteration or theft of prescriptions or misrepresentation of plan membership allowing another person to receive healthcare services.
- **Other Actions Inconsistent with Plan Membership:** Examples include, but are not limited to, the repeated use of non-Contractor providers without referral or when in-network providers are available; discharge from multiple practices of available Contractor's network providers; inappropriate use of prescription medication or drug seeking behaviors including inappropriate use of emergency room facilities for drug-seeking purposes.

Documentation for Special Disenrollment:

- Detailed documentation is required to support the disenrollment request.
- Incident Report or summary of member actions is required from provider office.
- Copy of PCP dismissal letter or correspondence to the member.
- Copy of Police Report and reference number given by Police Department.
- Copy of altered/forged prescription.

Completed forms and documentation should be sent to:

Molina Healthcare
Attn: Enrollment Services Supervisor
100 West Big Beaver Road; Suite 600
Troy, MI 48084-5209
Fax: 248-925-1767

CLAIMS

Please submit claims for Molina Healthcare Medicaid and MIChild to:

Billing Address:

Molina Healthcare
P.O. Box 22668
Long Beach, CA 90801

Please do not submit initial claims to the Troy address as this will delay the processing of your claims, and your claim may be returned. Please contact the Provider Call Center for claims status information at 1-888-898-7969, Monday – Friday 8:30 a.m. – 5:00 p.m. EST; you may inquire about 3 claims per call. You can schedule an appointment to assist in claim status or claim resolution when you have multiple claims issues. Please have the Member ID, Date of Service, Tax ID, and/or Claim Number ready when calling to ensure timely assistance.

Claims Submission Guidelines

Filing Limit

- Claims should be sent to Molina Healthcare within 90 days from the date of service.
- For resubmission or secondary claims, Molina Healthcare must receive the claim within 180 days from the date of service.
- If a claim is submitted to Medicaid or another HMO in error prior to the claim being submitted to Molina Healthcare, the submission limit is not extended. Eligibility must be verified prior to rendering services.
- Molina Healthcare responds to claims within State processing guidelines. The Claims determination will be reported to the provider on a Remittance Advice (RA).
- If no response is received within 45 days on a submitted claim, please call the Provider Call Center at 1-888-898-7969, or use WebPortal to status the claim(s).
- All claims received beyond the filing limit will be rejected and members may not be billed for the services.

Electronic Claims Submission

Molina Healthcare accepts claims electronically, including secondary claims. Electronic submission allows claims to be directly entered into Molina Healthcare's processing system, which results in faster payment and fewer rejections.

- WebPortal (www.molinahealthcare.com) Provider Self Services
  - submit claims
  - status claims
  - print claims reports
- Molina Healthcare also accepts electronic claims submissions through the following clearing houses:
- Netwerkes.com Payor Number is 38334
- Emdeon (formerly WebMD) – Payer Number is 38334.
- Availity/THIN- Payer Number is 38334
- Payer Path (HCFA 1500 only) – Payer Number is 38334
- Practice Insight (HCFA 1500 only) – Payer Number is 38334

- ZirMed Inc – Payer Number is 38334
- SSI Group

Contact Information

- For WebPortal access contact Molina Healthcare's Help Desk at 1-866-449-6848 or contact your Provider Services Representative directly.
- For EDI claim submission issues contact Molina Healthcare's Help Desk at 1-866-409-2935 or submit an e-mail to EDI.Claims@MolinaHealthcare.com. Please include detailed information related to the issue and a contact person's name and phone number.

Claims Form

- Professional charges must be submitted on a CMS 1500 08-05 version form
- Facility UB04 Form

Paper Claim Submission Guidelines

- Must use original forms
- Must be typewritten or computer generated
- Do not use highlighters, white-out or any other markers on the claim
- Avoid script, slanted or italicized type. 12 point type is preferred
- Do not use an imprinter to complete any portion of the claim form.
- Do not use punctuation marks or special characters
- Use a six digit format with no spaces or punctuation for all dates (ex 060101).
- Securely staple all attachments. Attachments should identify patient's name and recipient ID number

Claims Policies

Adjudication

Molina Healthcare adjudicates claims according to the State of Michigan Medical Services Administration (MSA) policies and procedures. Reference the Uniform Billing Guidelines, ICD-9 Diagnosis Code Book, CPT Code Book, HCPCS and Michigan Department of Community Health (MDCH) website www.michigan.gov when submitting a claim.

Payment

- Contracted providers will be paid according to the terms of the agreement between the provider and Molina Healthcare
- Non-Contracted Providers will be paid for covered services according to the MDCH Medicaid fee schedule in effect at the time of service.

Resubmission

- Providers may resubmit claims with correction(s) and/or change(s), either electronically or paper.
- For Paper CMS 1500 claim form: Enter "RESUBMISSION" on the claim in the Remarks section.
- For Paper UB04 claim form: Type of bill must be indicated on the form. Enter "RESUBMISSION in the comments section of the form.

Please send to Original/Resubmission to the address above, or submit electronically when appropriate and with appropriate bill type on UB 04 forms. Faxed copies are not accepted.

Newborn Care

Newborn care must be submitted on the appropriate claim form using the newborn's Medicaid ID number. The mother's Medicaid ID number may not be used to bill for services provided to a newborn.

National Drug Code (NDC)

Effective immediately per the MSA 10-15 and MSA 10-26 Bulletin regarding the billing of drug codes along with the appropriate NDC code for reimbursement. Submitting claims with a missing or invalid NDC drug code will result in delay of payment or denied claim. Please refer to newest NDC coding guidelines for direction regarding appropriate codes. Also refer to the Michigan Department of Community Health's (MDCH) bulletins MSA -7-33 and MSA 07-61 from 2007 and 2008 directing providers to bill accordingly.

This requirement is mandated to ensure MDCH compliance with the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148.

Provider National Identification Number (NPI)

Molina Healthcare Required Fields:

CMS 1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Billing Provider Medicaid Number	Yes	Box 33b
Rendering Provider NPI	Yes	Box 24j
Rendering Provider Medicaid Number	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
Taxonomy Code	No	Boxes 24j; 33b and 32b
UB04	Required?	Field Location
Billing Provider NPI	Yes	Box 56
Billing Provider Medicaid Number	Yes	Box 57a
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77j
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79
Taxonomy Code	No	Boxes 57, 76,77,78 and 79

Coordination of Benefits

As a provider treating Molina Healthcare members, your cooperation in notifying Molina Healthcare when any other coverage exists is appreciated. This includes other health care plans or any other permitted methods of third party recovery for coordination of benefits, worker's compensation and subrogation.

- Claims involving coordination of benefits with primary insurance carriers should be received by Molina Healthcare within 365 days from the date of the primary carrier's explanation/denial of benefits.
- If Molina Healthcare reimburses a provider and then discovers other coverage is primary, Molina Healthcare will recover the amount paid by Molina Healthcare.
- Regardless of the primary payer's reimbursement, Molina Healthcare should be billed as a secondary payer for all services rendered. A copy of the primary payer's EOB showing payment or denial must be attached to the claim when submitting payment, or the claim can be submitted electronically for secondary coordination.
- Molina Healthcare will make payment if the primary insurance payment is less than the Medicaid Fee for Service Rate.
- Molina Healthcare members cannot be billed for any outstanding balance after Molina Healthcare makes payment.
- Molina Healthcare members do not have deductibles, co-pays or co-insurance.

Claims submission guidelines for dual eligible Members

Services provided to patients who are covered by both Molina Medicare Options Plus and Molina Medicaid should follow the guidelines below:

- Submit one authorization request - Molina Healthcare will coordinate authorization requirements, benefits and services between the two products
- Submit one claim to Molina Healthcare - Upon receipt of the claim, we will process under Molina Medicare Options Plus then Molina Medicaid. There is no need to submit two claims. Claims processing information will be reported on two Remittance Advice (RA) forms
    - The 1st will come from Molina Medicare indicating how the claim was processed and informing you that the claim was forwarded to Molina Medicaid for secondary processing
    - The 2nd RA will show how the claim was processed for Molina Medicaid

Interim Billing

Molina Healthcare does not accept claims billed with an interim bill type for outpatient services, containing a 2, 3, or 4 in the 3rd digit. All claims must be billed with the "admit through discharge" information. In the case of continuing or repetitive care, such as with physical therapy, facilities must bill on a monthly basis with all services occurring billed on one claim, with service from and to dates listed separately per line, and as an admit through discharge bill.

Claims Adjustment Request Form Instructions

Please indicate the Line of Business

SECTION 1: General Information

1. If preferred, save the form to your own computer

2. Complete each box in Section 1

3. Use one form per claim number

4. If submitting multiple claim adjustments for the same adjustment type, then complete only one Claims Adjustment Request Form, and leave the following fields blank (these fields will be on each of the claims):
   - Claim Number (can be indicated on each claim or submit the RA)
   - Member Name
   - Member ID#
   - Date of Service

5. Please do not alter this form, as it will not be accepted

SECTION 2: Type of Claim Adjustment
PLEASE CHECK THE MOST APPROPRIATE BOX

1. Appeals:
   - CCI Edits and Timely Filing appeals must be submitted with supporting documentation.

2. COB:
   - Requires a copy of primary payer EOP (explanation of payment).
   - Requires effective date and/or term date, contract/policy number, and name of primary carrier.
   - Or send electronically with completed fields according to the EDI file layout.

3. Member:
   a. Indicate processed under incorrect member of the provider practice.

4. Payment Amount
   - Requires supporting documentation of the calculation/formula used to determine amount of under/overpayment.
   - Indicate if a request for a reversal is to be completed for overpayments.
   - Requires a copy of the claim and supporting documentation for all duplicate claims.
   - Requires a copy of authorization for all authorization related issues.

Please use additional paper attachments if necessary to document comments.
Fax form and documentation attention: Claims Department at (248) 925-1768 or mail to:

Molina Healthcare of Michigan
100 W. Big Beaver Rd, Suite 600
Attention: Claims Department
Troy, MI 48084-5209

Claim Adjustment Form can be found on the website at
http://www.molinahealthcare.com/medicaid/providers/mi/forms/Pages/fuf.aspx

Claim Form Field Requirements

- See Attachment A for CMS HCFA 1500 08-05 claim form requirements
- See Attachment B for CMS 1450 UB-04 claim form requirements

Sample Remittance Advice (RA)

- See Attachment C

CMS HCFA 1500 08-05 claim form requirements

- MANDATORY: Item is required for all claims. If the item is left blank, the claim cannot be processed.
- CONDITIONAL: Item is required if applicable. Your claim may not be processed if blank.

FIELD	STATUS	INFORMATION
1	CONDITIONAL	Insurance
1a	MANDATORY	Medicaid I.D. Number (When billing for a newborn, the newborn's Medicaid ID is required by Molina Healthcare)
2	MANDATORY	Patient's Name
3	MANDATORY	Patient's Birth Date And Sex
4	CONDITIONAL	Insured's Name
5	CONDITIONAL	Patient's Address
6	CONDITIONAL	Patient Relationship To Insured
7	CONDITIONAL	Insured's Address
8	CONDITIONAL	Patient Status
9	CONDITIONAL	Other Insured's Name
9a	CONDITIONAL	Other Insured's Policy Or Group Number
9b	CONDITIONAL	Other Insured's Date Of Birth And Sex
9c	CONDITIONAL	Employer's Name Or School Name
9d	CONDITIONAL	Insurance Plan Name Or Program Name
10a	MANDATORY	Is Patient's Condition Related To Employment?
10b	MANDATORY	Is Patient's Condition Related To Auto Accident?
10c	MANDATORY	Is Patient's Condition Related To Other Accident?
10d	CONDITIONAL	Reserved For Location Use
11	CONDITIONAL	Insured's Policy Group Or Federal Employee Compensation Act (FECA) Number
11a	CONDITIONAL	Insured's Date Of Birth
11b	CONDITIONAL	Employer's Name Or School Name
11c	CONDITIONAL	Insurance Plan Name Or Program Name
11d	CONDITIONAL	Is There Another Health Benefit Plan?
12	CONDITIONAL	Patient's Or Authorized Person's Signature
13	CONDITIONAL	Insured's Or Authorized Person's Signature
14	CONDITIONAL	Date Of Current Illness, Injury Or Pregnancy
15	CONDITIONAL	If Patient Has Had A Same Or Similar Illness, Give First Date
16	CONDITIONAL	Dates Patient Unable To Work In Current Occupation
17	CONDITIONAL	Name Of Referring Physician Or Other Source
17a	CONDITIONAL	I.D. Number Of Referring Physician
17b	CONDITIONAL	10-digit NPI# of Referring Physician or Other Source
18	CONDITIONAL	Hospitalization Dates Related To Current Services
19	CONDITIONAL	Reserved For Local Use - Indicate the additional NDC's and its information in a claim attachment. Report "see attachment" IN THIS FIELD. Please refer to MSA 07-33 for Electronic Billing Information
20	CONDITIONAL	Outside Lab/Charges
21	MANDATORY	Diagnosis Or Nature Of Illness Or Injury

FIELD	STATUS	INFORMATION
22	CONDITIONAL	Medicaid Resubmission Code And Original Reference Number
23	CONDITIONAL	Prior Authorization Number
24a	MANDATORY	Date(S) Of Service
24b	MANDATORY	Place Of Service
24c	CONDITIONAL	Type Of Service
24d	MANDATORY	Procedures, Services Or Supplies - Report the first NDC and its information within the shaded supplemental service line.
24e	MANDATORY	Diagnosis Code (Pointer)
24f	MANDATORY	Charges
24g	MANDATORY	Days Or Units
24h	CONDITIONAL	EPSDT/Family Plan
24I	MANDATORY	EMG-Emergency - Y Or N
24j*	MANDATORY	Rendering Provider ID #, Medicaid # and NPI#
24k	CONDITIONAL	Reserved For Local Use
25	MANDATORY	Federal Tax I.D. Number (Check Box/SSN Or EIN)
26	MANDATORY	Patient's Account Number
27	CONDITIONAL	Accept Assignment
28	MANDATORY	Total Charge
29	CONDITIONAL	Amount Paid
30	MANDATORY	Balance Due
31	MANDATORY	Signature Of Physician Or Supplier Including Degrees Or Credentials
32	CONDITIONAL	Name And Address Of Facility Where Services Were Rendered (If Other Than Home Or Office)
32a	CONDITIONAL	10-digit NPI# of Service Facility Location
33	MANDATORY	Company Name as registered with IRS, Address, Zip Code, Phone # and PIN # (Medicaid ID # without Provider Type). Molina Healthcare requires the name registered with the IRS to be submitted on line one in Box 33.
33a	MANDATORY	10 digit NPI# of Billing Provider
33b*	MANDATORY	Billing provider Medicaid ID#

*Taxonomy code not required

UB-04 claim form requirements

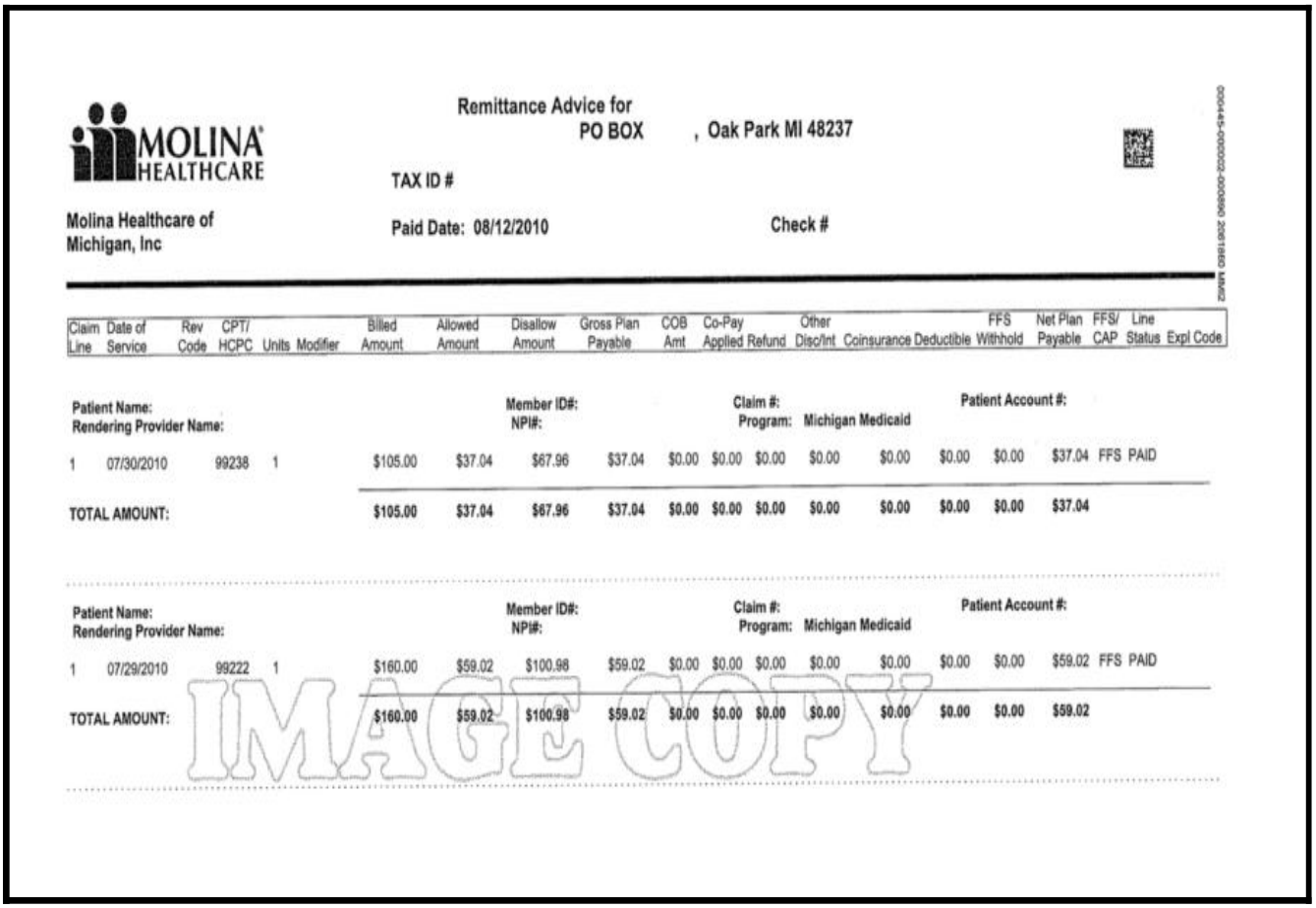
- MANDATORY: Item is required for all claim submissions.
- CONDITIONAL: Item is required if applicable.

FIELD	STATUS	INFORMATION
1	MANDATORY	Company Name as registered with the IRS, Address and Telephone Number
2		Blank
3	MANDATORY	Patient Control Number
4	MANDATORY	Type of Bill
5	MANDATORY	Federal Tax Number
6	MANDATORY	Statement Covers Period
7		Blank
8a	MANDATORY	Patient Name
9a-d	MANDATORY	Patient Address
10	MANDATORY	Patient Date of Birth
11	MANDATORY	Patient Sex
12	MANDATORY	Admission Start of Care Date
13	MANDATORY	Admission Hour (for inpatient only)
14	MANDATORY	Type of Admission
15	MANDATORY	Source of Admission (SRC)
16	CONDITIONAL	Discharge Hour
17	MANDATORY	Patient Status (Discharge Status)*
18-28	CONDITIONAL	Condition Codes (if applicable)
29-30	CONDITIONAL	ACDT State
31-34	CONDITIONAL	Occurrence Codes and Dates (if applicable)*
35-37	CONDITIONAL	Occurrence span code
38a-d	CONDITIONAL	Name and Address of the party responsible for the bill
39-41 a-d	CONDITIONAL	Value Codes and Amounts (if applicable)*
42	MANDATORY	Revenue Codes*
43	MANDATORY	Revenue Description plus (First NDC & its supplemental information) Please refer to MSA 07-61 for Electronic Claim Format Information
44	MANDATORY	HCPCS Code/Rates (if applicable)
45	MANDATORY	Date of Service for the Line Item
46	CONDITIONAL	Units of Service (if more than 1)
47	MANDATORY	Total Charges (by Revenue Code/HCPCS)
48	CONDITIONAL	Dollar Amount for Any Non-covered Services
49		Blank
50	MANDATORY	Payer Identification
51	MANDATORY	Provider Number: Medicaid ID Number without the Provider Type
52	CONDITIONAL	Assigned Release For Insurance Benefit
53	CONDITIONAL	Assignment Of Benefits
54	CONDITIONAL	Prior Payments (if applicable)
55	MANDATORY	Estimated Amount Due From Payer
56	MANDATORY	Billing Provider NPI#

FIELD	STATUS	INFORMATION
57	MANDATORY	Billing Provider Medicaid Number
58	CONDITIONAL	Name Of Insured
59	CONDITIONAL	Patient's Relationship To Insured
60	MANDATORY	Medicaid Recipient ID Number (When billing for a newborn, the newborn's Medicaid ID is required by Molina Healthcare).
61	CONDITIONAL	Name Of Group Or Plan Through Which Health Insurance Is Provided
62	CONDITIONAL	Group Policy Number
63	CONDITIONAL	Pre-Cert Or Authorization Number
64	CONDITIONAL	Document Control Number
65	CONDITIONAL	Name Of Employer
66	MANDATORY	ICD-9 Principle Diagnosis
67a-q	CONDITIONAL	Other Diagnosis Codes (if applicable)
68		Blank
69	MANDATORY	Admitting Diagnosis (for Inpatient only)
70 a-c	CONDITIONAL	Patient Reason Diagnosis
71	CONDITIONAL	
72	CONDITIONAL	External Cause Of Injury ICD-9 Diagnosis Code
73		Blank
74	CONDTIONAL	Principle Procedure Code and Date
74 a-e	CONDITIONAL	Other Procedure Codes and Dates
75		Blank
76	CONDITIONAL	Attending Provider NPI#
77	CONDITIONAL	Operating Provider NPI#
78-79	CONDITIONAL	Other Provider NPI#
80	CONDITIONAL	Remarks (if applicable)

*Refer to Uniform Billing Manual for List of Codes

Sample Remittance Advice (RA)



MOLINA HEALTHCARE

Remittance Advice for
PO BOX , Oak Park MI 48237

TAX ID #

Molina Healthcare of Michigan, Inc

Paid Date: 08/12/2010 Check #

Claim Line	Date of Service	Rev Code	CPT/ HCPC	Units	Modifier	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amt	Co-Pay Applied	Refund	Other Disc/Int	Coinsurance	Deductible	FFS Withhold	Net Plan Payable	FFS/ CAP	Line Status	Expl Code
Patient Name:								Member ID#:				Claim #:				Patient Account #:				
Rendering Provider Name:								NPI#:				Program:	Michigan Medicaid							
1	07/30/2010		99238	1		$105.00	$37.04	$67.96	$37.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37.04	FFS	PAID	
TOTAL AMOUNT:						$105.00	$37.04	$67.96	$37.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37.04			
Patient Name:								Member ID#:				Claim #:				Patient Account #:				
Rendering Provider Name:								NPI#:				Program:	Michigan Medicaid							
1	07/29/2010		99222	1		$160.00	$59.02	$100.98	$59.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.02	FFS	PAID	
TOTAL AMOUNT:						$160.00	$59.02	$100.98	$59.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.02			

No check voucher
Cash Advance-Balance ($1.91)

000712-000001-001423 2065358 1060CKD12
Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

Temporary Return Service Requested

VPA DIAGNOSTICS PC
PO BOX 1500
Novi MI 48376

Page 1 of 4

DATE: 09/28/2010
TAX ID #: 383176990
CHECK NO.: No Check

MEDICAL REMITTANCE ADVICE

SUMMARY OF CHECK

Billed Amount:	$14.00	Refunds:	$0.00
Contract/Allowed Amt:	-$1.91	Interest:	$0.00
Disallow Amount::	$15.91	Coinsurance:	$0.00
Gross Plan Payable:	-$1.91	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	-$1.91

Advance Recovery

Advance Date:	09/28/2010
Advance Amount:	$1.91
Total Amount Recovered From This Payment:	$0.00
Remaining Balance:	$1.91

Total Check Amount: -$1.91

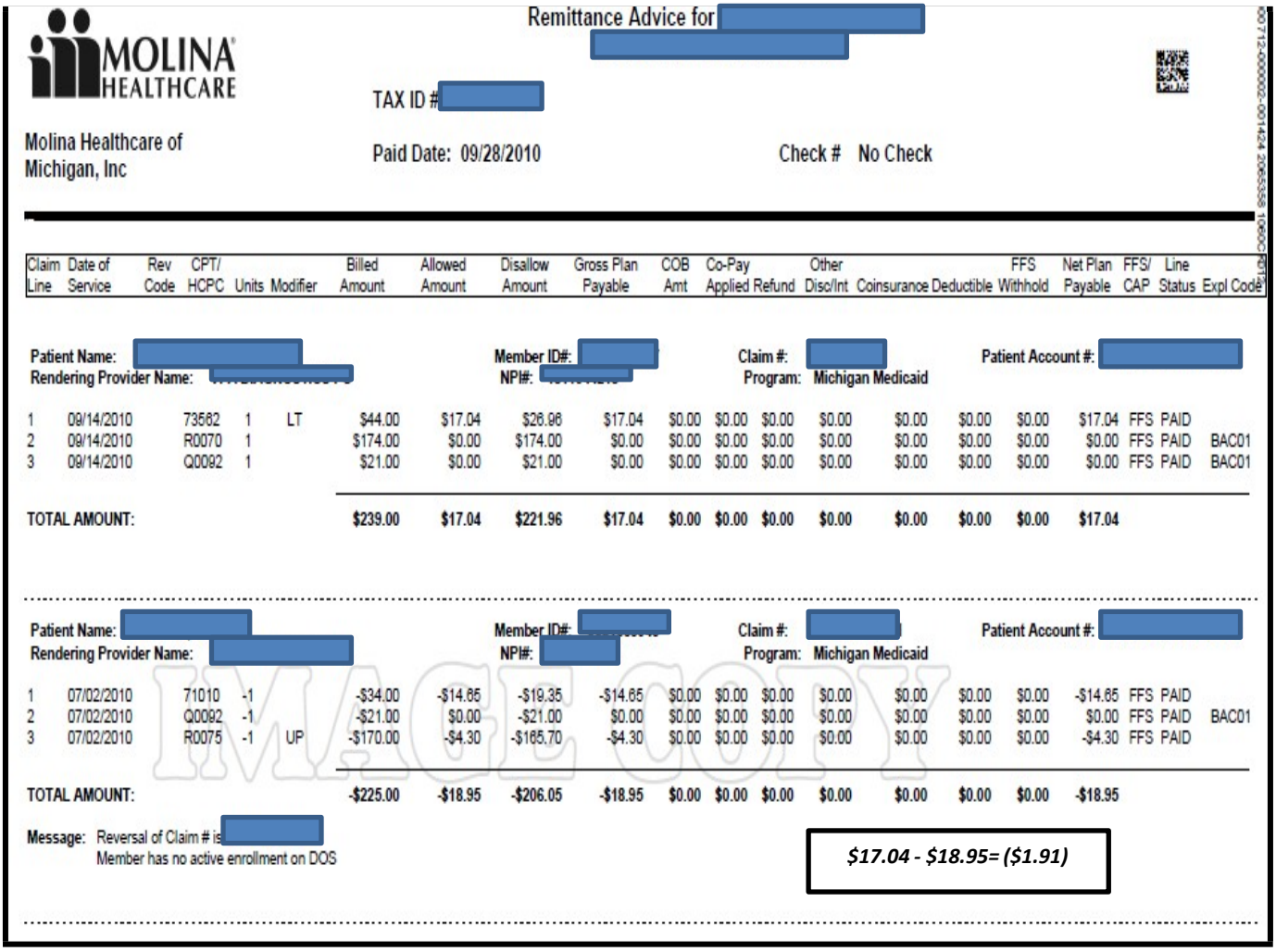
Confidential Protected Health Information

This document contains confidential Protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information should be safeguarded at all times and should be securely destroyed when no longer needed. This information is intended only for use by the authorized recipient. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare.

To file a provider claim reconsideration, please see the reconsideration procedure on the back of this page.

Exciting COB Enhancement: Molina can now accept COB claims through the standard 837 EDI file format.

Detail of no check voucher
Cash advance of ($1.19)



MOLINA HEALTHCARE

Remittance Advice for [redacted]

TAX ID # [redacted]

Molina Healthcare of Michigan, Inc

Paid Date: 09/28/2010 Check # No Check

Claim Line	Date of Service	Rev Code	CPT/ HCPC	Units	Modifier	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amt	Co-Pay Applied	Refund	Other Disc/Int	Coinsurance	Deductible	FFS Withhold	Net Plan Payable	FFS/ CAP	Line Status	Expl Code
Patient Name: [redacted] Member ID#: [redacted] Claim #: [redacted] Patient Account #: [redacted] Rendering Provider Name: [redacted] NPI#: [redacted] Program: Michigan Medicaid																				
1	09/14/2010		73562	1	LT	$44.00	$17.04	$26.96	$17.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04	FFS	PAID	
2	09/14/2010		R0070	1		$174.00	$0.00	$174.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
3	09/14/2010		Q0092	1		$21.00	$0.00	$21.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
TOTAL AMOUNT:						$239.00	$17.04	$221.96	$17.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04			
Patient Name: [redacted] Member ID#: [redacted] Claim #: [redacted] Patient Account #: [redacted] Rendering Provider Name: [redacted] NPI#: [redacted] Program: Michigan Medicaid																				
1	07/02/2010		71010	-1		-$34.00	-$14.65	-$19.35	-$14.65	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$14.65	FFS	PAID	
2	07/02/2010		Q0092	-1		-$21.00	$0.00	-$21.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
3	07/02/2010		R0075	-1	UP	-$170.00	-$4.30	-$165.70	-$4.30	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$4.30	FFS	PAID	
TOTAL AMOUNT:						-$225.00	-$18.95	-$206.05	-$18.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$18.95			

Message: Reversal of Claim # is [redacted]
Member has no active enrollment on DOS

$17.04 - $18.95= ($1.91)

Voucher Summary and Check

Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

Temporary Return Service Requested

Page 1 of 3

DATE: 08/12/2010
TAX ID #:
CHECK NO.:

MEDICAL REMITTANCE ADVICE

SUMMARY OF CHECK

Billed Amount:	$265.00	Refunds:	$0.00
Contract/Allowed Amt:	$96.06	Interest:	$0.00
Disallow Amount::	$168.94	Coinsurance:	$0.00
Gross Plan Payable:	$96.06	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	$96.06

Total Check Amount: $96.06

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IMAGE COPY

Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

USBank
Havre, MT
usbank.com
93-455/929

08/12/2010

VOID AFTER 90 DAYS

PAY Ninety-Six and 06/100 **$96.06

TO THE ORDER OF
PO BOX
Oak Park MI 48237

QUALITY IMPROVEMENT PROGRAM

Introduction

Molina Healthcare of Michigan serves Michigan members in counties throughout Michigan. Molina Healthcare of Michigan has served Medicaid patients since 2000. For all plan members, Molina Healthcare emphasizes personalized care that places the physician in the pivotal role of managing healthcare. Molina Healthcare is responsible for managing the provision of accessible, appropriate, cost-effective, high quality health care services for its members throughout the continuum of care. The health plan assists members as they move through the managed care system, reducing barriers to care, and supporting members in reaching optimal health. Molina Healthcare credentials and contracts with individual practitioners, provider organizations, facilities and institutions to deliver health care and service to members. Molina Healthcare delegates the authority to perform specified plan functions and services, while maintaining oversight responsibility for delegated and non-delegated activities.

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and service, and improvement of the health of its members. The QIP assists Molina Healthcare 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 following QI Program Description includes discussion of program philosophy, scope, structure, and methodology.

Program Philosophy

Molina Healthcare of Michigan maintains the following values, assumptions, and operating principles for the Quality Improvement Program:

- The QIP provides a structure for promoting and achieving excellence in all areas through continuous improvement.
- Improvements are based on industry "best practice" or on standards set by regulators or accrediting organizations.
- The QIP is applicable to all disciplines comprising the organization, at all levels of the organization.
- Teams and teamwork are essential to the improvement of care and services.
- Data collection and analysis is critical to problem-solving and process improvement.
- Each employee is highly valued as a contributor to quality processes and outcomes.
- Compliance with National Committee for Quality Assurance (NCQA) Standards and achievement of accreditation demonstrates Molina Healthcare's commitment to quality improvement.
- Information about the QIP is available for members and providers upon request.
- Internal and external feedback about Molina Healthcare's programs and processes is integrated into the improvement efforts.

Quality Improvement Program Goals

Molina Healthcare of Michigan has defined the following goals for the QI Program:

- Design and maintain programs that improve the care and service outcomes within identified member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to members. Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare of Michigan (also referred to as MHM) structure, process, and outcomes.
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals and to ensure participation of community providers in the MH Michigan network.
- Facilitate organizational efforts which achieved and maintain regulatory compliance and NCQA Accreditation-Excellent in 2005.

Quality Improvement Program Objectives

QIP objectives direct personnel, activities, and resources to achieve Program goals. Written objectives address:

- Activities planned,
- Methodologies,
- Persons responsible, and
- Time frames for meeting each objective

Scope of Program Activities

The Molina Healthcare QI Program encompasses the quality of acute, chronic and preventive health care and service provided in both the inpatient and outpatient setting to our population as determined by age, disease categories, risk status and products. The scope of service includes but is not limited to, those provided in institutional settings, ambulatory care, home care and mental health. Contracted provider groups, primary care and specialty practitioners and ancillary providers may render these services.

Important Aspects of Care

To provide for overall quality functioning as a managed care plan, Molina Healthcare continuously monitors important aspects of care. These aspects or activities of care/service include, but are not limited to:

- Access and Availability
- Continuity and Coordination of Care ,
- Health Management Systems
- Under and Over Utilization
- Behavioral Health Care
- Chronic and Acute Care
- Member Safety and Error Avoidance
- High-Risk/High-Volume/Problem-Prone Care
- Preventive Care and Services
- Member and Practitioner Satisfaction/Dissatisfaction
- Guideline Management; Clinical Practice and Preventive Guidelines
- Health Plan Service Standards
- Quality of Care Complaint Review and Clinical Case Review
- Pharmacy Services

Data Sources

Quality Improvement is a data driven process. Molina Healthcare utilizes multiple data sources to monitor, analyze and evaluate the QI program and planned activities. These sources include, but are not limited to the following:

- Encounter and Claims data
- Pharmacy Benefit Manager data
- Pertinent medical records (minimum necessary)
- Utilization reports and case review data
- Provider and member complaint data obtained through call tracking, Utilization Management (UM), Provider Services and other sources
- Provider and member satisfaction survey results
- Appeal information
- Statistical, epidemiological and demographic member information
- Authorization and denial reporting
- Enrollment; regional, disenrollment
- HEDIS
- Behavioral Health data
- Geo-Access provider availability data and analysis
- Feedback other than complaints regarding services and programs from members and providers.
- CAHPS

Quality Improvement Strategy

Quality Improvement Activities

To meet the purpose, goals and scope of this program, QI activities as reflected in the QI Work Plan will be focused in the following areas.

- Improvement of the health status of the health plan membership through:
- Implementation of programs to address the priority needs associated with the major high-risk, acute and chronic illnesses faced by plan members. These programs will include preventive health, health education, disease management (health management), and care guidelines.
- Monitoring the outcomes of care against national and available regional practice standards.
- Utilization of multi-disciplinary and multi-dimensional teams to address process improvements that can enhance care and service, including primary, specialty and behavioral health practitioners.
- Oversight of delegated processes to ensure delegated organizations MHM standard.
- Identification of appropriate safety and error avoidance initiatives for MHM members in collaboration with the primary care provider through:
- Evaluation of pharmacy data for provider alerts about drug interactions, recall, and pharmacy over and under-utilization.
- Education of members regarding their role in receiving safe, error free health care services through the member newsletter and the Molina web site.
- Education of providers regarding improved safety processes in their practice through the provider newsletter, member profiles and the Molina web site.
- Dissemination of information regarding important safety activities and Health Delivery Organization (HDO) audit findings for safety concerns to members and providers.
- Evaluation for safe clinic environments during office site reviews.
- Education to members regarding safe practices at home through health education and incentive programs.
- Intervention for identified safety issues as identified through case management, care management and the grievance and clinical case review process.
- Collection of data regarding hospital activities relating to member safety.
- Dissemination of information to providers and members regarding activities in the network related to safety and quality improvement.
- Evaluation of the continuity and coordination of care through annual analysis of data to include:
- Transition of Care processes and the effectiveness of inter-provider communications and documentation.
- Medical record audits.
- Tracking quality of care issues, including adverse events.
- Focused health management programs.
- Member and practitioner satisfaction surveys and complaint and appeal review.
- Identification of chronically ill or complex new patients through assessment processes.

- Oversight of delegated activities.
- Monitoring over-utilization and under-utilization through:
- Tracking quality of care issues, including adverse outcomes and sentinel events.
- Review of clinical performance measures including HEDIS to indentify actions for improvement oversite of member satisfaction.
- Review all sources of member satisfaction including but not limted to CAHPS Survey disenrollment information, complaints and appeals to identify opportunities for improvement.
- Member complaint and appeal review.
- Utilization review and case management reports.
- Practitioner medical, pharmacy and utilization profiles.
- Performance measures relative to implementation of preventive and clinical practice guidelines
- Oversight of delegated group member satisfaction and utilization.
- Evaluation of access and availability of care and service through:
- Measurement and evaluation of geographic access to primary care physicians, key specialists, hospitals and other health care services.
- Evaluation of appointment access and availability of after-hours care and after hour information offered by practices.
- Evaluation of MHM Member Services telephone access.
- Evaluation of all satisfaction measures for availability and access to care.
- Oversight of delegated activities.
- Management of Molina Healthcare's interface with practitioners, providers, members and state agencies to implement programs, including:
- Inclusion of contracted practitioners and providers in the planning and implementation of clinical programs.
- Review, approval, and dissemination of preventive health and clinical practice guidelines and measurement of adherence with current recommendations.
- Review of clinical performance measures including HEDIS results to identify actions for improvement.
- Identification of legislative and benefit changes that enhance health promotion.
- Annual review of practitioner surveys and proposed activities for improvement.
- Management of health care practitioner and provider credentialing/recredentialing to include:
- Review of credentialing/recredentialing policies and procedures.
- Peer review of credentialing/recredentialing decisions.
- Peer review of investigated quality of care issues and proposed corrective action plans.
- Oversight of delegated credentialing activities.
- Ensure that medical records comply with standards of structural integrity and contain evidence of appropriate medical practices for quality care by:
- Review of medical record audit results and corrective actions.
- Practitioner education and corrective action where indicated.
- Oversight of member satisfaction measurement and improvement activities:

- Review of all sources of member satisfaction information including, but not limited to, CAHPS Surveys, disenrollment information, complaints and appeals and identify opportunities for improvement.
- Design and evaluate initiatives to improve satisfaction.
- Evaluation of the effectiveness of QI activities in producing measurable improvements in the care and service provided to members through:
- Organization of multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
- Track the progress of quality activities through appropriate quality committee minutes and review/update the QI work plan quarterly.
- Revise interventions as required based on analysis.

Quality Improvement Methodology

A cyclic, continuous, systematic process is used to improve performance and communicate clinical and service quality issues. This process is used throughout the organization to help individuals improve procedures, systems, quality, cost, and outcomes related to their areas of responsibility. The model includes the following steps:

- Establish standards and benchmarks
- Collect data
- Analyze data and determine performance levels
- Identify opportunities for improvement
- Prioritize opportunities
- Establish clear improvement objectives
- Design and implement interventions
- Measure effectiveness

Organizational Structure Supporting Quality Improvement: Accountability

The Board of Directors

Molina Healthcare of Michigan's Board has ultimate authority and responsibility for the quality of care and service delivered by MHM. The Board is responsible for the direction and oversight of the QI Program and delegates authority to the Quality Improvement Committee (QIC) under the leadership of the Chief Medical Officer. The President/CEO also serves as a member of the Molina Healthcare of Michigan Board of Directors.

The Quality Improvement Committee (QIC)

The QIC is responsible for the implementation and ongoing monitoring of the Quality Improvement program. Through the Quality Improvement Sub-committees, the QIC recommends policy decisions, analyzes and evaluates the progress, results and outcomes of all quality improvement activities, institutes needed actions and ensures follow-up.

The QIC sets the strategic direction for all quality activities at Molina Healthcare. The QIC receives reports from all QI sub-committees, advises and directs the committees on the focus and implementation of the QI program and work plan. The QIC reviews data from QI activities to ensure that performance meets standards and makes recommendations for improvements to be carried out by sub-committees or by specific departments.

The QIC is chaired by the Chief Medical Officer, and is composed of management of key health plan functions and network practitioners. The QIC confirms and reports to the Board that plan activities comply with all state, federal, regulatory and NCQA standards. The QIC reports to the Board any variance from quality performance goals and the plan to correct the variance. The QIC submits to the Board approved, signed, minutes reflecting committee decisions and actions of each meeting. In addition it presents an annual QI program, work plan and prior year evaluation, as well as quarterly summaries of important activities to the Board.

Standing Quality Improvement Sub-Committees

The QIC delegates QI functions to specific sub-committees. Each of these sub-committees is guided by a description that outlines its composition, meeting frequency, standards and responsibilities. All MHM Quality Sub-committees meet at a minimum quarterly and all keep contemporaneous minutes using a standard format.

The activities of all quality committees are treated in a confidential manner, as outlined in their policies. (Please refer to attached 2005 Committee Purpose and Meeting Dates, APPENDIX B for a full description of sub-committee membership and responsibilities)

- The Quality Improvement Committee (QIC). Information from the QIC is reported to the Board of Directors on a quarterly basis or more often as appropriate.
- The Peer Review/Credentialing Committee (PRC). The PRC reports to the QIC.
- The Member and Provider Satisfaction Committee. Reports to the QIC.
- The Pharmacy and Therapeutics Committee (P&TC). The P&TC reports to the QIC.
- The Utilization Management Committee (UMC). The UMC reports to the QIC.
- The Compliance Committee (CC). The CC reports to the QIC.

Confidentiality

Molina Healthcare of Michigan is authorized by specific regulatory agencies and by members to obtain and review medical records, including member and practitioner identities. Authorization is subject to all state and federal laws and regulations, including Title 42 Code of Federal Regulations, Molina Corporate Employee Handbook, Section B, Security and Confidentiality. Use of Protected Health Information (PHI) is outlined in a privacy notice distributed to all members.

All Molina Healthcare personnel sign a Confidentiality Agreement and a Code of Conduct and Employee Handbook Acknowledgment form. Signed documents are on file in the Human Resources Department. In addition, non-Molina Healthcare members of QI committees sign a confidentiality statement when attending committee meetings and are protected from being required, with some exceptions, to testify in civil actions related to specific committee activities and actions.

As an approved Coordinated QI Program by MDCH, information and documents created specifically for, and collected and maintained by an approved program receive protections from public disclosure. Molina Healthcare's QI documents are maintained in compliance with all legal requirements and include, but are not limited to, internal reviews, including patient care review studies, QI studies and reports, minutes of QI committees and administrative (i.e., non-clinical) processes having a direct impact on the provision of care or service. The findings of all Molina Healthcare QI committees are part of the QI Program. Such findings will not be released to any outside agency without the express permission of the originating agency and assurance that confidentiality will be maintained.

The Board assigns the responsibility of managing and reviewing confidentiality issues to the Government Contracts and Compliance Department. A Compliance Committee has been formed as directed by the Compliance Plan. This committee addresses issues of confidentiality.

Conflict of Interest

No reviewing physician may perform a review on one of his/her patients, the patients of his/her partners, or cases in which the reviewing physician has a proprietary financial interest in the site providing care.

Delegation Activities

Molina Healthcare of Michigan may delegate Credentialing, UM, and Claim activities to provider groups that meet delegation requirements. Prior to delegation, Molina Healthcare conducts on-site delegation pre-assessments to determine compliance with regulatory and accrediting requirements. The health plan monitors ongoing compliance with review of monthly reports and annual on-site assessments.

The QIC monitors ongoing delegate compliance with regulatory and accrediting requirements. The committee requires corrective action of delegates when necessary. MHM's Director, QI is responsible for the delegation oversight process, which includes coordinating and conducting annual on-site assessments, monitoring credentialing reports, overseeing the corrective action process, and providing staff support.

MHM currently delegates the following:

- Credentialing
- Quality Improvement for Behavioral Health
- Utilization Management for Behavioral Health

Program Evaluation and Revision

The Quality Improvement Program Description and Work Plan govern the program structure and activities for a period of one calendar year. At least annually, the QI Department will facilitate a formal evaluation of the QI Program. Evaluation of all quality activities will include a description of limitations and barriers to improvements.

The annual QI evaluation identifies the outcomes and includes the following areas:

- Evaluates the results of each QI activity implemented during the year and identifies quantifiable improvements in care and service.
- Where available, includes a trended indicator report and brief analysis of changes in trends and improvement actions taken as a result of the trends.
- Identifies opportunities to strengthen member safety activities.
- Evaluates resources, training, scope, and content of the program and practitioner participation.
- Identifies limitations and barriers and makes recommendations for the upcoming year, including the identification of activities that will carry over into next year.
- Evaluates the overall effectiveness of the QI Program.

Governing Body Review and Approval

Molina Healthcare of Michigan's QI Program is accountable to and reports activities to the Board of Directors through the Quarterly and Annual Reports. The Quality Improvement Program Evaluation, the QIP and the Work Plan are submitted to the Board of Directors for review and approval.

Glossary

BH	Behavioral Health
CAHPS	Consumer Assessment of Health Plans
ED	Emergency Department
HCA	Health Care Authority
HDO	Health Delivery Organization
HEDIS	Health plan Employer Data and Information Set
MDCH	Michigan Department of Community Health
NCQA	National Committee for Quality Assurance
PRC	Peer Review Committee
P&T	Pharmacy and Therapeutics
PHI	Protected Health Information
PCP	Primary Care Provider
QIC	Quality Improvement Committee
QIP	Quality Improvement Program
UM	Utilization Management
UMC	Utilization Management Committee

UTILIZATION MANAGEMENT PROGRAM

Introduction

Utilization Management Department Services

Call us: **1**-888-898-7969, Option 1, then 4

Fax us: **1**-800-594-7404

Business hours: Monday – Friday (excluding holidays), 8:30 am to 5:00 pm
After normal business hours: Monday – Friday 5:00 pm – 8:30 am
Saturday, Sunday and holidays

Visit our website www.molinahealthcare.com
for updates, frequently used forms, and professional resources

Molina Healthcare is happy to provide you with the enclosed "Provider's Guide" which highlights the programs and initiatives offered by our Utilization Management (UM) Department. We hope this guide will help you gain insight of what we do, and what we can do to assist you in caring for our members.

Our UM Program facilitates quality, cost-effective and medically appropriate services across a continuum of care that integrates a range of services appropriate to meet individual member needs. Our services include: preservice and admission review; concurrent review; transitional care; discharge planning; continuity and coordination of member care post hospital discharge; after hours clinical availability (On-Call Program); retrospective review; medical case management for specific conditions and specialized clinical programs; clinical policy and criteria development; provider appeal processing; utilization data analysis including monitoring for over and underutilization; evaluating member and provider satisfaction; staff education and quality oversight.

Our UM staff is available to meet with you, your office staff and/or your physician group to address your concerns and provide education about our programs. If you have any questions, please call our UM Department at 1-888-898-7969 or your contact your Territory Manager.

Thank you for continuing to provide the quality care on which our members depend. We are always looking for ways to support the most effective health care for our members, and improved service to our providers.

Who are we?

UM activities are coordinated and conducted under the direction of the Medical Director(s) (Physicians) and the Vice President of Health Care Services.

- Managers (Registered Nurses (RN)) and Supervisors (RN) oversee the daily functions.
- Multidisciplinary teams are assigned to a population of members divided by geographic area and/or provider group. The teams are composed of:
    - Complex Case Managers (RN)
    - Clinical Case Managers (RN)
    - Utilization Management Specialists (Licensed Practical Nurses (LPN)
    - Utilization Management Coordinators
- The team structure promotes ownership and accountability to providers and members.
    - An RN is assigned as lead to coordinate work, perform planning, and monitor team functions.
    - Productivity reporting and expectations are monitored.
- Medical Director Physician Support includes:
    - Biweekly case review with teams.
    - Case discussion of complex or chronic illness case management cases.
    - Case discussion of members with frequent emergency department (ED) use.
    - Review of cases that cannot be cannot be approved be a nurse.
    - Development of criteria/guidelines.
- Pharmacist Support
- Nurse Advise Line (NAL) and On-Call (RN) staff provide clinical availability after normal business hours.
- Health Services Support includes:
    - Medical Social Workers (MSW)
    - Registered Health Information Administrator (RHIA)
    - Healthcare Data Analysts
    - UM Clinical Trainer
    - Quality Nurse Reviewers (RN)
    - Administrative and Clerical Support

What do we do?

- Preservice and admission review
- Concurrent review
- Facilitate care transitions
- Discharge planning
- Continuity and coordination of member care
- Case management
- Retrospective review
- Clinical policy and criteria development
- Provider appeal processing
- Utilization data analysis including monitoring for over and under utilization
- Evaluate member and provider satisfaction with the UM Program
- Staff education and oversight.

How to contact us?

The UM Department has designated staff to answer incoming phone calls. If you have a question or would like to contact a multidisciplinary team that is assigned to you:

- Department Phone 1-888-898-7969
- Department Fax 1-800-594-7404

Business hours: Monday – Friday (excluding holidays), 8:30 am to 5:00 pm
After normal business hours: Monday – Friday 5:00 pm – 8:30 am
Saturday, Sunday and holidays

Preservice and Admission Review / Authorization Requirements

How to decide if a service requires authorization?

The Molina Healthcare Authorization Requirements Grid can be found on the Molina Healthcare website at www.molinahealthcare.com. The Authorization Requirements Grid pertains to both the Molina Healthcare of Michigan Medicaid and MIChild membership.

Review the 3 columns on the Molina Healthcare Authorization Requirements Grid

1. **Authorization Not Required Column:**
   - Service may be performed upon physician order
   - Service may be performed by a contracted (preferred) provider or facility
2. **Notification Required Column:**
   - Molina Healthcare must be notified of service (prior for elective services)
   - Authorization is required for claim payment
   - Clinical information does not need to be provided
3. **Clinical Review Required Column:**
   - Molina Healthcare must be notified of service (prior for elective services)
   - Authorization required for claim payment
   - Clinical information is required and reviewed utilizing InterQual®, Medicaid or Molina Healthcare criteria.

Examples of services requiring authorization:

- Selected outpatient services require authorization
- Select ambulatory surgical/diagnostic procedures
- Potentially cosmetic/experimental procedures
- Medical benefit review
- Home health care (Physical Therapy (PT), Occupational Therapy (OT)) (Speech Therapy (ST) – only a MIChild covered benefit)
- Home intravenous (IV) infusion
- Authorization is required for all inpatient admissions
- Molina Healthcare utilizes InterQual® criteria to determine medical necessity

Should a referral be issued?

A referral is a request by a Primary Care Physician (PCP) for a member to receive specialty services from another physician, another health care professional or a facility. PCPs are able to refer a member to a provider/specialist for consultation without submitting an authorization request to Molina Healthcare.

Specialty Network Access (SNA)

The Michigan Department of Community Health, the Medicaid Health Plans and the four Public Entities, University of Michigan Health System, Wayne State University, Hurley Hospital, and Michigan State University, have worked on a joint initiative to increase access to specialty care services to Michigan Medicaid recipients. We have developed a process to allow Medicaid beneficiaries access to the specialty care services that are unavailable through the Health Plan's contracted network.

Please be advised that Molina Healthcare has a contract with one of the above providers (Wayne State University). Our provider network is robust and contains specialists able to meet your needs. We strongly encourage you to utilize Molina Healthcare's Provider Network for specialty care.

However, if you determine that a specialist referral is needed for a member to access a specialty care service at one of the above Public Entities that is not available within our network, please contact our UM Department at 1-888-898-7969 and we will assist you with obtaining a referral to an appropriate affiliated specialty care provider of the four Public Entities. A referral is not necessary for Wayne State University.

When calling, please have patient demographic information, primary care provider and referring specialty provider information available. Also, please have all pertinent information regarding the service being requested and the patient's medical information, including but not limited to specialty required, number of visits, start and end date and diagnosis to facilitate appointment scheduling.

It is our hope that this process will increase the care and access to necessary specialty care to the Michigan Medicaid program beneficiaries. If you have any questions, please contact Molina Healthcare Provider Services at 1-866-449-6828, ext. 155822.

Three easy ways to request a preservice or admission review

- **Fax** your authorization request, and clinical information if required, to the UM Department at 1-800-594-7404. PCPs / Specialists should use the Molina Healthcare Service Request Form or the Michigan Healthcare Referral Form. You may locate the forms at molinahealthcare.com.
- **Electronically** submit your request using our web based program, WebPortal.
- **Telephone** the UM Department at 1-888-898-7969.

Urgent requests

All urgent requests must be submitted by calling UM Department at 1-888-898-7969. Make sure you identify the request as "urgent" to expedite the review process.

What if we did not know the service required authorization or the authorization was not obtained?

- **Fax** your authorization request, and clinical information if required, to the UM Department at 1-800-594-7404. PCPs / Specialists should use the Molina Healthcare Service Request Form or the Michigan Healthcare Referral Form. You may locate the forms at molinahealthcare.com.
- **Electronically** submit your request using our web based program, WebPortal.
- **Telephone** UM Department at 1-888-898-7969.

Notification of our decision will be given within 14 days of the receipt of the request.

Tips to help expedite authorization decisions

- ✓ Submit your authorizations electronically (WebPortal)
- ✓ Verify the member's eligibility and benefits
- ✓ Accurately complete one of the authorization request forms (Molina Healthcare Service Request Form or the Michigan Healthcare Referral Form)
- ✓ Include all appropriate codes (diagnosis code(s) and procedure / item code(s))
- ✓ Submit your requests at least 14 days prior for elective services
- ✓ Refer to the Molina Healthcare Authorization Requirements Grid, since many services may not require you to submit a authorization request
- ✓ Include pertinent clinical information (progress notes, lab results, photos, imaging studies)
- ✓ Visit molinahealthcare.com for any changes regarding the authorization process

How do we request an elective admission?

For ***all elective admissions***, the PCP, specialist, or facility must request authorization prior to the scheduled admission. Authorizations may be requested by ***phone, fax or WebPortal***. Please include the following information:

- Member's name, Medicaid beneficiary ID #, date of birth, and age
- Admission date
- Name of admitting facility and fax number
- Diagnosis and Procedure codes
- Member's current medical condition including date of onset, duration of symptoms, and treatment rendered to date
- Proposed treatment plan
- Requesting physician's fax number
- Pertinent clinical documentation (progress notes, x-ray reports, lab results).

What happens after you submit your request for authorization?

- We confirm the member's eligibility, benefits, and provider's affiliation status.
- If the request is submitted with complete and accurate information, if appropriate, the request is reviewed against medical appropriateness criteria. The criteria sources used are one or more of the following:
    - Applicable Federal or State mandates and guidelines
    - McKesson InterQual® Criteria
    - The Hayes Directory for New Medical Technologies
    - Internally developed medical necessity criteria
    - Algorithms and guidelines from recognized professional societies
    - Advice from authoritative review articles and textbooks
- If the request does not meet criteria, the UM staff will contact (via telephone, fax, and/or mail) the requestor for clarification or additional clinical information, or refer the case to a Molina Healthcare Medical Director. In the case of a pharmacy request the case may be referred to a Molina Healthcare Registered Pharmacist.

When and how will you be notified of your decision?

The decision time frame is based upon the date on which we receive your request and the supporting clinical information. To ensure a timely decision, please provide all supporting clinical information with the initial request. We will contact you when additional clinical or clarifying information is needed. Our decisions are made in accordance with regulatory and accreditation guidelines.

- **Urgent approved requests** – we will call the authorization number of the requestor and facility (if indicated) within 72 hours of the initial request.
- **Non-urgent approved requests** – we will call or fax the authorization number of the PCP, requesting physician or facility (if indicated) within 14 days of the initial request.
- **Urgent denied requests** – The denial rationale for denial and the appeals process with be called to the requesting provider and written notification will be mailed to the member, provider, PCP, and facility (if indicated) within 72 hours of the request.
- **Non-urgent denied requests** - The denial rationale for denial and the appeals process with be provided by telephone to the requesting provider and written notification will be mailed to the member, provider, PCP, and facility (if indicated) within 14 days of the initial request.

Note: Providers may review the UM criteria at Molina Healthcare or they may request a copy of the criteria of interest by telephone, fax, or email.

A Molina Healthcare Medical Director is available to discuss the denial decision with any treating practitioner.

Authorization submission guidelines for dual eligible Members

For services rendered to patients who are covered by both Molina Medicare Options Plus and Molina Medicaid, **submit one authorization request** - Molina Healthcare will coordinate authorization requirements, benefits and services between the two products.

Admission Review
How do we request authorization for an urgent/emergent admission?

Call ***1-888-898-7969.*** During normal business hours, the hospital can call the UM Department or fax to 1-800-594-7404.

For ***all urgent/emergent admissions,*** the hospital is required to provide clinical information once the determination is made to admit the member. Molina Healthcare ensures availability 24 hours per day, 7 days a week, by providing an On-Call Case Manager during non business hours. If Molina Healthcare fails to respond within one hour, the admission will be automatically approved.

What type of clinical information should be provided?

Clinical information should include the member's health history, vital signs, physical assessment, consultations, current and previous treatment including those services performed in the emergency department (ED) and outpatient settings and the member's response to treatment. Please include any anticipated discharge needs.

How does Molina Healthcare perform clinical review of urgent/emergent inpatient admissions?

If the admission does not meet InterQual® medical necessity criteria as an inpatient setting, the facility may admit the member to an observation setting, no authorization is required. If the facility does not accept observation setting, the UM staff may request additional information and will forward the case for Medical Director review.

Requests for admission that meet InterQual® Inpatient Criteria, but could be treated in an observation setting (such as, rule out Myocardial Infarction/Chest Pain, Asthma, Congestive Heart Failure) and there is a likelihood of discharge within 24 hours an observation stay will be authorized initially for the following diagnoses:

- Acute Abdomen
- Acute Coronary Syndrome
- Acute Bronchitis
- Anemia
- Asthma
- Bronchiolitis
- Cellulitis or Abscess
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Deep Vein Thrombosis (DVT)
- Dehydration
- Diabetes
- Disorders of Fluid, Electrolyte, and Acid-base Balance (Nausea, Vomiting)
- Gastroenteritis / Esophagitis
- General Symptoms

- Pneumonia, Organism Unspecified or Simple
- Poisoning / Toxic Ingestions
- Seizures
- Syncope or Decreased Responsiveness
- Unstable Angina

When would we contact you?

- If additional clinical information is required
- If the need for additional medical services are identified post discharge, such as home health care or home infusion
- To notify you of our decisions
    - When services are approved, we will call you with an authorization number and next review date
    - When services are not approved, we 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 would like to discuss a denial decision with a Medical Director, please call 1-888-898-7969.
    - For urgent/emergent admissions, we will call you within 72 hours of the receipt of the request.
    - If we are notified retrospectively of an admission and discharge, notification of our decision will be given within 14 days of the receipt of the request.

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

Why concurrent review / discharge planning / continuity and coordination of care?

Concurrent review is performed to determine medical necessity and appropriateness of a continued inpatient stay, to identify appropriate ***discharge planning needs***, 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 once or twice a week as appropriate and InterQual® is used as a guideline in performing review.

How does the process work prior to discharge?

Hospital discharge planning staff is responsible for ensuring authorization is obtained by calling 1-888-898-7969. The following select post discharge services require authorization:

- Home health care (including hospice, IV therapy, PT, OT, etc.)
- Infusion therapy
- Select durable medical equipment (DME)
- Skilled nursing facility (SNF)

- Rehabilitative services
- Hospice

Prior to or upon discharge from an inpatient facility, the hospital is responsible for providing the following information by calling 1-888-898-7969 or faxing to 1-800-594-7404:

- Discharge date
- Discharge plan (medications, appointments, ancillary service needs, etc.)
- Place of discharge
- Member phone number
- Alternative phone number and contact

How does the process work post hospital discharge?

Molina Healthcare UM staff (RN) will contact the member post discharge to evaluate if prescriptions were filled and the member is taking accurately, if post discharge appointments are scheduled, and if the member is following the discharge plan. If it is determined the member requires additional services that were not ordered at discharge, the UM staff will contact the member's PCP and/or attending physician to discuss the member needs. The UM staff will arrange home care services or equipment as necessary.
In summary, the program provides:

- Three phone attempts over two week period following discharge
- Letters to members and their PCPs
- Nursing assessment tool
- Assistance with follow-up appointments
- Medication compliance monitoring
- Evaluation of compliance with discharge instructions
- Evaluation of current clinical condition
- Education on disease process

Medical Case Management

Who are we?

Our Complex Case Managers (CM) are RNs with specialized training in the management of specific diseases. We also have a clinical social worker on our team to provide psychosocial support to members.

What services do the CMs provide?

Their role is to improve the health and well-being of each member by educating, assisting and facilitating access to the most appropriate health care services available. The CM has the responsibility to coordinate medical services throughout the member's continuum of care, while effectively reducing costs. The CMs assist:

- Identifying members who will benefit the most from case management services
  - Accept referrals from all Molina Healthcare areas and from physicians, hospital staff, etc.
- Developing a plan of care including problem identification, goals (including discharge from the program) and plan of care.
- Implementing interventions and service coordination within the benefit structure.
- Ensuring all services are medically necessary and provided at the appropriate level of care and in a timely manner.
- Coordinating such services as home health and hospice care, home infusion therapy, inpatient rehabilitation and skilled nursing care.
- Monitoring progress towards the goals.
- Reassessment and close the member to case management when appropriate.

The CMs are available to physicians, utilization review staff, discharge planners, the patient and patient's family to answer questions, attend care conferences and assist in facilitating a discharge plan or coordinating care.

Who is eligible for case management?

All Molina Healthcare members *are* eligible for case management and some members may be eligible for select case management programs. Members that may be referred for case management include those with:

- A known chronic disease
- Risk for developing chronic disease
- Multidisciplinary needs requiring case management intervention/support
- Multiple hospital admissions with one more of the following conditions:
  - Cardiovascular Disease
  - Congestive Heart Failure
  - Chronic Obstructive Pulmonary Disease
  - End Stage Renal Disease
  - Asthma

- Diabetes
- Sickle Cell
- AIDS/HIV
- Cancer
- High Risk Obstetrics/Newborns

The following select case management programs are also available to support member's health care needs:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease
- End Stage Renal Disease
- High Risk Obstetrics
- Pediatrics
- Skilled Nursing Facility and Rehabilitation
- Transplant / Oncology
- Social Work Services
- Frequent ED Use

If you would like to learn more information, speak with a CM and/or refer a member for an evaluation, please call our UM Department at 1-888-898-7969.

How to refer a member for case management?

During normal business hours call the UM Department at 1-888-898-7969.

How will you know if the member is accepted into case management?

You will receive a letter from a CM with their direct phone number.

When will you hear from us?

Our CMs perform an individualized member assessment. Following the assessment, the CM will send a letter informing you of the member's acceptance into the Case Management Program. The CM may periodically contact you regarding the member's progress.

Our CMs may contact you for other reasons:

- Coordinate a plan of care
- Confirm a diagnosis
- Verify appropriate follow up
- Identify member compliance issues
- Discuss other problems and issues that may affect the member care

On-Call Program (After Hours)

Who are we and how should you contact us?

Molina Healthcare requests inpatient facilities to contact Molina Healthcare once a determination is made to admit a member from the ED but prior to the admission. By using the On-Call Program (After Hours) service the facility can obtain authorization prior to the admission. This service can also be used for discharge planning for hospitalized members.

Your call is answered by the Molina Healthcare Nurse Advice Line (NAL) Operator. The NAL Operator verifies eligibility for the patient and contacts the On-Call Case Manager (RN).

What do we do?

We provide clinical staff availability 24 hours per day, 7 days per week to members, providers, and hospital, including after normal business hours Monday – Friday 5:00 PM – 8:30 AM, Saturday – Sunday, and holidays.

The On-Call Case Manager 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 InterQual® Medical Appropriateness Guidelines.

The On-Call Case Manager will facilitate one of the following:

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

When will you hear from us?

The On-Call Case Manager will contact the facility within one hour maximum.

How can you reach us?

You can reach the On-Call Case Manager by calling 1-888-898-7969

PROVIDER APPEALS

The UM Appeals/Denials area coordinates the provider appeals and Molina Healthcare Medical Directors review all appeals of denied decisions. All providers have the right to appeal any denial decision made by Molina Healthcare. Our appeal process is objective, thorough, fair and timely. A Molina Healthcare Medical Director may determine that a same specialty physician review may be needed. There are two types of provider appeals, administrative decisions and medical review.

Administrative Denials

Molina Healthcare has a one (1) level appeal process for the practitioner appeal of post-service administrative denials. **Examples of administrative denials** are failure to authorize services according to required timeframes.

Level 1

A. A practitioner must submit a written appeal within 90 days of the denial notification to:
   Molina Healthcare of Michigan
   Utilization Management Appeals
   100 West Big Beaver, Suite 600
   Troy, MI 48084
B. The appeal must include new supporting evidence and/or documentation justifying the service, care or treatment being appealed, and reason for notification outside of Molina Healthcare notification timeframes. Portions of the medical record may be submitted.
C. Upon receipt of the appeal, the Medical Director, or other qualified physician, will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
D. The Medical Director, or other qualified physician, will/may consult with a physician of the same or similar specialty as the case in review.
E. A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

Expedited Appeal: Molina Healthcare will expedite an appeal and render a decision within 72 hours of the request if a longer timeframe could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is subject of the request.

Rights to copies of documents: A practitioner may request Molina Healthcare to furnish all documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A practitioner may request Molina Healthcare to furnish the names, titles and qualifications of any medical experts whose advice was obtained on behalf of Molina Healthcare in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.

Medical Necessity Denials

Molina Healthcare of Michigan has a two (2) level appeal process for the practitioner appeal of post-service medical necessity denials. **Examples of medical necessity denials** are inpatient admission which did not meet InterQual® criteria, or a request which did not meet medical criteria guidelines.

Level 1

A. A practitioner must submit a written appeal within 90 days of the denial notification to:
   Molina Healthcare of Michigan
   Utilization Management Appeals
   100 West Big Beaver, Suite 600
   Troy, MI 48084
B. The appeal must include new supporting evidence and/or documentation justifying the service, care or treatment being appealed. Portions of the medical record may be submitted.
C. Upon receipt of the appeal, the Medical Director, or other qualified physician, will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
D. The Medical Director, or other qualified physician, will/may consult with a physician of the same or similar specialty as the case in review.
E. A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

Level 2

A. If you disagree with the decision at Level 1, a practitioner must submit a second written appeal within 90 days of the date of the Level 1 denial notice to the same address as listed in Level 1. The request must clearly state it is for a Level 2 review.
B. The written request must include additional supporting documentation justifying the need for the denied service.
C. The appeal will/may be reviewed by a Medical Director or by a consultant of same or similar specialty.
D. The Medical Director will render a decision and written notification will be provided within 30 calendar days of the receipt of a post-service appeal.

Expedited Appeal: Molina Healthcare of Michigan will expedite an appeal and render a decision within 72 hours of the request if a longer timeframe could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is subject of the request.

Rights to copies of documents: A practitioner may request Molina Healthcare of Michigan to furnish all documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A practitioner may request Molina Healthcare to furnish the names, titles and qualifications of any medical experts whose advice was obtained on behalf of Molina Healthcare in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.

Timely Filing Appeals

Providers may submit an appeal for timely filing and/or coding edit (CCI edit denials) by following the steps below:

- Timely Filing appeals must be submitted with supporting documentation showing claim was filed in a timely manner.
- Complete a Claims Adjustment Request Form, or submit an appeal letter with supporting documentation.
- **Mail your Timely Filing appeal to:**

  Molina Healthcare
  Attention: Claims Department
  100 W. Big Beaver Road, Suite 600
  Troy, MI 48084-5209
- **Or fax to : 248- 925- 1768 Attention Timely Filing appeal**

Code Edit Appeals (CCI Edits)

- CCI Edit appeals must be submitted with supporting documentation and medical notes/reports.
- Only submit non corrected claims as appeals
- Complete a Claims Adjustment Request Form, or submit an appeal letter with supporting documentation.

  Mail your CCI Edit appeal to:

  Molina Healthcare
  Attention: Claims Department
  100 W. Big Beaver Road, Suite 600
  Troy, MI 48084-5209
- **Or fax to : 248- 925- 1768 Attention CCI Edit appeal**

Rapid Dispute Resolution

Plan supports the Michigan Department of Community Health (MDCH) Rapid Dispute Resolution Process (RDRP) for hospitals under the MDCH Access Agreement. The purpose of this policy and procedure is to ensure Provider disputes are processed in a timely and efficient manner with adherence to State/Federal Regulations. Provider disputes will be reviewed to determine the appropriate resolution.

Request for Binding Arbitration

A request for arbitration may be submitted in writing to MHM's Provider Inquiry Research and Resolution Department after all MHM appeal processes have been exhausted. Arbitration must be initiated within one year of the earlier of the date the claim or controversy arose, was discovered or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. MHM's Legal department will coordinate the binding arbitration process in accordance with the American Arbitration Association rules for Arbitration for Non Contracted providers, and pursuant to the provisions of the Provider Agreement for Contracted providers. Arbitration disputes will be processed in a timely and efficient manner with adherence to State/Federal Regulations.

Send All Written Requests for Arbitration to:
Molina Healthcare of Michigan
Attention: Provider Inquiry Research and Resolution (Arbitration)
100 W. Big Beaver Rd. Suite 600 Troy, Michigan, 48084-5209

PHARMACY

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. The goal of Molina Healthcare is to provide our members high quality, cost effective drug therapy.

At Molina Healthcare, medications can fall into the following categories. Information on procedures to obtain these medications is described in detail within this document and also available on the website.

1. **Formulary Medications** - These medications do not require Prior Authorization (PA). Molina Healthcare covers up to a 30 day supply of medication. In some cases, your patients may only be able to receive certain quantities of medication. Information on quotas are included in this document and can also be found in the Formulary documents.

2. **Formulary Medications with Prior Authorization** -These medications may require the use of first line medications before they are approved. Information on PA criteria is included in this document.

3. **Non Formulary Medications**- These medications can be considered for exception when Formulary medications are not appropriate for a particular patient or have proven ineffective. Requests for Formulary exceptions are completed on the Molina Healthcare Prior Authorization form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity**.**

4. **Drugs available but not covered by the Health Plans** - These medications are often called "carved out drugs" because they are a covered benefit but provided outside of the health plan. In Michigan, behavioral health drugs and drugs used to treat HIV are carved out from health plan coverage. Prior Authorization requests are made directly to Fee For Service through Magellan Medicaid Administration at**:** ***www.michigan.fhsc.com***

5. **Medications not covered by Medicaid** - These medications are not covered under the Medicaid benefit and therefore are excluded from coverage. For example, drugs used in the treatment of fertility are not part of the benefit. These exclusions are determined by the Michigan Department of Community Health.

Formulary Documents: Information on medication coverage is sent to providers throughout the year both by mail and via FAX. These documents are also available on the Molina Healthcare website under Providers, Michigan, Drug list or Forms:

1. Drug formulary book
2. Condensed formulary "*At a Glance*"
3. "*Ez Rx*" newsletters which address a variety of important information about formulary medications and other medication therapy issues
4. "*Just the Fax*" newsletters which address formulary additions and changes

Important Contact Numbers:

1. Rx PA Hotline: (888) 898-7969, Providers-Option 1, Pharmacies - Option 5
2. RX PA Fax Line: (888) 373-3059
3. For a 24 hour pharmacy over ride: Please call Rx PA Hotline and you will be transferred to after hour help desk.
4. Magellan Medicaid Administration information for carved out drugs:
    a. www.michigan.fhsc.com/Providers/Drug Information
    b. Magellan Medicaid Administration Clinical Call Center: (877) 864-9014

Drug Prior Authorization (PA) Procedures

This summary is intended to provide a quick reference to the Prior Authorization (PA) procedures for Formulary medications that require Prior Authorization

1. Please familiarize yourself with the Molina Healthcare Drug Formulary to learn which drugs require prior authorization. You also have access to the latest Drug Formulary information at www.molinahealthcare.com and ePocrates. If you need additional copies of the Molina Healthcare Drug formulary, please call your Territory Manager.
2. If a drug requires Prior Authorization you must fax a Molina Healthcare Prior Authorization Drug Request form to (888) 373-3059.
3. Drug prior authorizations are always processed in the order in which they are received. However, antibiotics and other urgent requests are given expedited attention. If all necessary information is presented, expect a response within two hours and not longer than one business day. If forms are NOT filled out completely, you may expect a FAX back with a request for additional information.
4. Once received, your PA request is reviewed by the Molina Healthcare Pharmacy Team to determine if it meets the Molina Healthcare PA criteria. The team can either APPROVE or PEND your request. If your request is PENDED, please submit the requested documentation to substantiate your request or choose one of the formulary alternatives indicated on the form.
5. Expect a written communication from Pharmacy personnel the following business day if you have not responded to the formulary suggestions or request for additional information. Molina Healthcare follows up on these requests to ensure that the member receives their medication in a timely fashion.
6. If your request is DENIED by the Medical Director or Pharmacy Director, you and the member will receive written documentation with the reason the request was denied. Providers and members can appeal this decision. Information regarding the appeal process will be provided in the letter.
7. Considerations when reviewing a request for Prior Authorization:
    - First line Formulary prescription or OTC Drugs take precedence over non-formulary drugs.
    - Prescription requests for medications requiring Prior Authorization or for medications not included on the Molina Healthcare Drug Formulary may be approved when medically necessary and when Formulary alternatives have proven ineffective. When these exceptions arise, the provider must FAX a completed PA form to Molina Healthcare Pharmacy Department at (888) 373-3059.
    - All non-FDA approved ("off label") drug requests will be DENIED and are subject to the review of the Medical or Pharmacy Director only.
    - The use of manufacturer's samples of non-formulary or "Prior Authorization Required" medications does not override Formulary requirements.

To assure excellent customer service, all authorization requests received before 5:00 PM EST will be processed the same day.

Drug Prior Authorization (PA) Helpful Hints

Prevent Rx Delays

Make extra copies of PA forms and keep them readily available. This will save time expediting your request. You may also download the PA form from our website: **www.molinahealthcare.com, Michigan, Providers, Forms**

Save Telephone Calls

Get to know your Territory Manager. They can provide: extra copies of Prior Authorization request forms, PA procedures, copies of formularies and other general assistance related to medication questions.

Save Time - Save Calls from Pharmacies

Use alphabetical listing in your formulary book index to look up which drugs require a PA.

Be Informed - Be Patient Oriented

Please familiarize yourself with the Molina Healthcare Drug Formulary. Please refer to the Molina Healthcare website and ePocrates for the most up-to-date Drug Formulary information. Drugs shaded in gray require a PA. Knowledge of this will save you calls from pharmacies and complaints from your patients. For your convenience we have included the abbreviated Prior Authorization criteria within this document.

Save Time - Save Calls or Faxes from Molina Healthcare

Fill out drug PA form completely; make sure you note your office phone and fax number with area code, member name, and recipient ID number, physician name and name of person completing the form and include use of any previous therapy.

Important - Please Note

Any questions or concerns may be directed to our pharmacy voice mail system. Please do not hesitate to request PA forms, status of requests, etc. Messages from our pharmacy voice mail system or direct calls at (888) 669-4322 are retrieved and answered promptly throughout the day. Your voice mail message/call is important to us and all messages are returned as soon as possible and no later than the same business day. If you or your staff are leaving for the day and will not be available when we return your call, please indicate who we should contact in the event you are out of the office.

Non Formulary Medication Prior Authorization Criteria

Prescriptions for Non-Formulary medications, whose drug class is represented on the Drug Formulary with other agents, may be approved if the drug(s) will be used within these guidelines:

1. Documented failure or intolerance to all Formulary agents of same drug class.
   - Eg., a request for the statin drug Crestor will require failure on Formulary agent simvastatin or pravastatin.

   - If the Formulary agents/drug class should require Prior Authorization, member will need to meet the Prior Authorization requirements for specific medication/drug class before it can be used.

OR,

2. Medication is being used for a unique treatment/condition that is not indicated for Formulary agents in same drug class.

OR,

3. All Formulary agents from same drug class are contraindicated for member per manufacturer recommendations.

OR,

4. Medication request is for a new member who is continuing therapy started while in another health plan. May be asked to provide documentation of previous use. A transition supply may be approved until the members can be started on a Formulary agent

Formulary alternatives will be recommended to requesting physician if any of the following apply:

A) Above criteria (1-4) are not met.
B) Pharmaceutical samples were dispensed to member before all Formulary agents within same drug class were tried.

Prior Authorizations generally will be denied if Formulary alternatives are not accepted by prescriber.

These guidelines for prior authorization approval are for reference only. They do not replace the professional judgment of the prescribing physician and do not necessarily apply to all patient-specific situations.

ABBREVIATED PRIOR AUTHORIZATION CRITERIA

Prior Authorization criteria is reviewed and approved by the Molina Healthcare Pharmacy and Therapeutics Committee. Medications under review are evaluated and compared to medications available on the formulary. Clinical evidence used to make decisions is evaluated from journals, medical associations, and from good scientific information. Changes to the PA criteria can be found in the formulary on the website, "At a Glance", or faxed or printed newsletters: *EZ Rx* newsletters and *Just the Fax.*

IMPORTANT NOTE: For these important medications, please complete a PA request before hospital discharge and before member takes Rx to pharmacy

ABBREVIATED PRIOR AUTHORIZATION/QUOTA CRITERIA ANTIBIOTICS

BRAND NAME	GENERIC NAME	CRITERIA
AUGMENTIN	Amoxicillin/ clavulanate	Quantity Limit - #20/fill. Suspension form – No PA for members <12
AVELOX	Moxifloxacin	Failure on first-line antibiotic, as indicated by nature of infection.
BIAXIN	Clarithromycin	Failure on first-line antibiotic, as indicated by nature of infection. OK as first-line for MAC and H. Pylori. Suspension form – No PA for members <12
CECLOR CD	Cefaclor	Failure on first-line antibiotic, as indicated by nature of infection. Suspension form – No PA for members <12
CEFZIL	Cefprozil	Failure on first-line antibiotic, as indicated by nature of infection. Suspension form – No PA for members <12
CIPRO	Ciprofloxacin	Quantity Limit - #20/fill. Suspension form – No PA for members <12
CLEOCIN	Clindamycin	150mg capsules only – No PA required
FLOXIN	Ofloxacin	Failure on 1st-line antibiotic, as indicated by nature of infection.
KETEK	Telithromycin	Failure on first-line antibiotic, as indicated by nature of infection.
LEVAQUIN	Levofloxacin	Failure on first-line antibiotic, as indicated by nature of infection.
OMNICEF	Cefdinir	Failure on first-line antibiotic, as indicated by nature of infection.
SUPRAX	Cefixime	Failure on first-line antibiotic, as indicated by nature of infection.
ZITHROMAX	Azithromycin	Zithromax Powder Pack – No PA required when billed as 1 day stat dose for STD treatment. 250mg-Quantity limit #6/14 days, 500mg #3/14 days

FORMULARY MEDICATIONS

BRAND NAME	GENERIC NAME	CRITERIA
ACCOLATE	Zafirlukast	Moderate to severe asthma; failure on inhaled steroids and Singulair (PA required).
ACTOPLUS	Pioglitazone/Metformin	Treatment of Type II diabetes with HbA1c > 6.0 and ≤8.5; Failed or intolerant to max doses of sulfonylureas and/or metformin,
ACTOS	Pioglitazone	Treatment of Type II diabetes with HbA1c > 6.0 and ≤8.5; Failed or intolerant to max doses of sulfonylureas and/or metformin,
ADVAIR	Fluticasone/ Salmeterol	Moderate to severe asthma or COPD. Failure on inhaled steroids.
ALINIA	Nitazoxanide	For the treatment of diarrhea caused by *Giarda lamblia* or *Cryptosporidium parvum*

BRAND NAME	GENERIC NAME	CRITERIA
ALLEGRA, -D	Fexofenadine Fexofenadine / pseudoephedrine	Treatment of allergic rhinitis/urticaria. Failure of OTC antihistamines (Including Claritin and Zyrtec) and nasal steroids.
AMITIZA	Lubiprostone	For the treatment of chronic idiopathic constipation or IBS in adults.
APRISO	Mesalamine	Maintenance of remission. Quantity limit - #120/month
ARTHROTEC	Diclofenac / misoprostol	Treatment of arthritis in patients at high risk for ulcers. Failure of formulary preferred Voltaren and Mobic.
BARACLUDE	Entecavir	For the treatment of chronic HBV infection in adults with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease
BENICAR,-HCT	Olmesartan,-HCTZ	For the treatment of hypertension; failure or intolerant to ACE inhibitor, losartan.
CHANTIX	Varenicline	Failure or intolerant to Nicotine patches, gum, and Zyban.
LIPITOR	Atorvastatin	Failure or intolerant to simvastatin. Step Therapy – No PA required after 3 consistent months of maximum dose simvastatin
DAYPRO	Oxaprozin	Use in patients with documented treatment failure on at least three generic NSAIDs, each treatment course being at least 2 weeks.
DETROL LA	Tolterodine	Treatment of overactive bladder. Failure/contraindication to oxybutynin, -XL. Rx'd by Urologist.
DIFLUCAN	Fluconazole	Quantity Limit - #2/fill. 150mg tablet only
DURICEF	Cefadroxil	Failure on first-line antibiotic, as indicated by nature of infection.
ELIDEL	Pimecrolimus	Treatment of short-term and intermittent long-term therapy in the treatment of mild to moderate atopic dermatitis in patients >2 years of age; failure of topical steroids, unless treated area is on face.
ESTRADERM	Estradiol Transdermal	Failure of formulary oral estradiol
EVISTA	Raloxifene	Failure of formulary Fosamax.
EXELON	Rivastigmine	For the treatment of mild to moderate dementia of the Alzheimer type; failure of formulary oral alternatives
FLOMAX	Tamsulosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure/intolerance Hytrin/Cardura
FORADIL	Fomoterol	Failure on inhaled corticosteroids (ICS). Approved in conjunction with ICS
GLUCOMETER	TRUE TRACK / RESULT & supplies	Quantity limit #200/month for members actively filling insulin or prenatal vitamins. Quantity limit #50/month for all other members
HALOG, -E	Halcinonide	Use in patients with documented treatment failure on non-Prior Auth Formulary high potency (Group II) steroids (e.g, Lidex, Valisone, Topicort, Diprosone).
INSULIN PEN DEVICES	All insulins	Insulin Pen Delivery systems to be authorized when member is either blind or disabled. Will not be authorized for convenience purposes.
JANUMET	Sitagliptin/ Metformin	Treatment of Type II diabetes with HbA1c > 6.0 and ≤8.5; Failed or intolerant to max doses of sulfonylureas and/or metformin,
JANUVIA	Sitagliptin	Treatment of Type II diabetes with HbA1c > 6.0 and ≤8.5; Failed or intolerant to max doses of sulfonylureas and/or metformin,
LAMISIL	Terbinafine HCl	Quantity Limit - #30 TABLETS / fill
LOVENOX	Enoxaparin	≤ 7 day supply at retail; continued use – Caremark Specialty Pharmacy
KADIAN	Morphine Sulfate CR	Failure or intolerant to formulary Morphine Sulfate (MsContin and/or MSIR), Methadone and Dilaudid
MIACALCIN SPRAY	Calcitonin Salmon	Failure of formulary Fosamax.
MIGRANAL	Dihydroergotamine Nasal Spray	Acute treatment of migraine with or without aura; failure or intolerance of Formulary agents. Prophylactic therapy needed in patients with 2 or more attacks per month.
MULTAQ	Dronedarone	Step Therapy – Three month consistent use of amiodarone
NAMENDA	Memantine	Failure of formulary Aricept
NICORETTE GUM (OTC)	Nicotine polacrilex	For smoking cessation. Treatment course limited to 3 months. For continued use member must be enrolled in the American Cancer Society Smoking Cessation program. Step Therapy – Trial and failure of Zyban and Nicotine Patches
NICOTROL PATCH (OTC)	Nicotine transdermal	For smoking cessation. Treatment course limited to 3 months. For continued use member must be enrolled in American Cancer Society Smoking Cessation program

BRAND NAME	GENERIC NAME	CRITERIA
NORGESIC, NORGESIC FORTE	Orphenadrine/ ASA/Caffeine	Failure of non-Prior Auth Formulary skeletal muscle relaxants (e.g., Flexeril, Soma, Lioresal, Norflex)
NOXAFIL	Posaconazole	For the treatment of oropharyngeal candidiasis, including oropharyngeal candidiasis refractory to itraconazole and/or fluconazole.
ORAMORPH SR	Morphine Sulfate CR	Failure or intolerant to formulary Morphine Sulfate (MsContin and/or MSIR), Methadone and Dilaudid
ORUVAIL	Ketoprofen CR	Use in patients with documented treatment failure on at least three generic NSAIDs, each treatment course being at least 2 weeks.
PENTASA	Mesalamine	Treatment of active Ulcerative Colitis. Failure or intolerant to Asacol
PRECOSE	Acarbose	Treatment of mealtime blood sugar spikes. Failure or intolerant to Metformin. A1c < 8.5
PREVACID	Lansoprazole	Treatment of GERD, Duodenal/Gastric Ulcer, Erosive Esophagitis, Hypersecretory conditions. Failure on Omeprazole 20mg. Authorizations provided will be for Prevacid OTC. No PA required for members under 12. Up to #30/month
PROTONIX	Pantoprazole	Treatment /maintenance of healing of erosive esophagitis associated with GERD, and treatment of pathological hypersecretory conditions; documented failure of Omeprazole 20mg and Prevacid OTC 15mg.
PROTOPIC	Tacrolimus	For short-term and intermittent long-term treatment of moderate to severe atopic dermatitis. Must fail topical corticosteroids first, unless affected area is face/neck.
PULMICORT	Budesonide	Respules: No PA required for members 9 and under. Inhaler: Failure of inhaled corticosteroids. Exception: Pregnancy.
RANEXA	Ranolazine	For the treatment of chronic angina. Failure of nitrate monotherapy.
RAZADYNE	Galatamine	Failure of formulary Aricept
RELAFEN	Nabumetone	Use in patients with documented treatment failure on at least three generic NSAIDs, each treatment course being at least 2 weeks.
SEREVENT	Salmeterol	Failure of ICS monotherapy. Approved in conjunction with ICS.
SINGULAIR	Montelukast	Moderate to severe asthma; Recent failure on inhaled steroids. Not covered for diagnosis of allergies. Chew tab – No PA required for members 9 and under
SYMBICORT	Budesonide/ Formoterol	Failure on inhaled corticosteroids
TORADOL (tablets)	Ketoralac tromethamine	Use in patients with documented treatment failure on at least three generic NSAIDs, each treatment course being at least 2 weeks.
UROXATRAL	Alfuzosin	Treatment of Benign Prostatic Hyperplasia (BPH); failure /intolerance to Hytrin/Cardura and Flomax.
VIVELLE	Estradiol transdermal	Failure of formulary oral estradiol
VOLMAX	Albuterol ER	Failure of formulary Albuterol tabs
VYTORIN	Ezetimibe/ Simvastatin	Failure of formulary simvastatin and Lipitor as monotherapy.
ZOFRAN tabs	Ondansetron	Quantity limit - #12/ month
ZYBAN	Bupropion SR	For smoking cessation. Treatment course limited to 3 months. For continued use member must be enrolled in American Cancer Society Smoking Cessation program
ZYMAR	Gatifloxacin	Treatment of bacterial keratitis, endophthalmitis, or prophylaxis for ocular surgeries; prescribed by ophthalmologist. Failure of formulary alternatives.

NON-FORMULARY

Requests for non formulary medications must be submitted on a Molina Healthcare Prior Authorization form. Requests for non formulary medications will be evaluated on an individual basis. In order to evaluate the request, providers must submit information on prior use and failure of Formulary medications unless unique indications exist. Listed below is a table that contains important information when submitting a request for a non formulary medication exception.

BRAND NAME	GENERIC NAME	CRITERIA
ACIPHEX	Rabeprazole	Documented failure of Omeprazole 20mg and Prevacid OTC 15mg & Protonix
ACTONEL	Risedronate	Documented failure / intolerance to Fosamax
APIDRA	Insulin Glulisine	Documented failure / intolerance to both Long Acting (Humulin, Lantus etc) & Short Acting (Humalog/Novolog)
ARAVA	Leflunomide	Treatment of active rheumatoid arthritis; failure on/intolerance to methotrexate and sulfasalazine. Prescribed by rheumatologist.
AVODART	Dutasteride	Documented failure / intolerance to Proscar. Diagnosis of BPH with enlarged prostate
BONIVA	Ibandronate	Documented failure / intolerance to Fosamax, Actonel and Miacalcin
BYETTA	Exenatide	Documented failure / intolerance to Lantus, maximum dose Metformin, TZD (Actos) and/or sulfonylurea. A1c < 8.0
BYSTOLIC	Nebivolol	Documented failure / intolerance to at least two formulary beta blockers. Coreg, Lopressor, Tenoretic, Tenormin, Toprol XL
CELEBREX	Celecoxib	Treatment of signs and symptoms of osteoarthritis or rheumatoid arthritis in patients with documented risk of ulcer dz or bleeding disorder. Etodolac and sulindac are Formulary options for GI upset/GERD on other NSAIDs.
CRESTOR	Rosuvastatin	Documented failure of Zocor and Lipitor.
DETROL	Tolterodine	Documented failure to formulary agents. Tx of overactive bladder. Failure/contraindication to oxybutynin. Rx'd by Urologist.
DIOVAN	Valsartan	Documented failure / intolerance to ACE, Losartan and Benicar.
DITROPAN XL	Oxybutynin ER	Treatment of overactive bladder. Documented failure on regular oxybutynin.
DURAGESIC	Fentanyl transdermal	Treatment of severe chronic pain with documented failure on / intolerance to oral formulary long-acting analgesics; documented evaluation/recommendation by pain management specialist or oncology
FORTEO	Teriparatide	Documented failure / intolerance to Fosamax, Actonel and Miacalcin
IMITREX Inj & nasal spray	Sumatriptan Succinate	Abortive treatment of migraine attacks. Documented failure on oral Imitrex.
KYTRIL	Granisetron	Prevention of nausea/vomiting associated with initial and repeat courses of emetogenic chemotherapy, including high dose cisplatin; nausea and vomiting associated with radiation.
LEVEMIR	Insulin Detemir	Documented failure / intolerance to Lantus, maximum dose Metformin, TZD (Actos) and/or sulfonylurea
LOVAZA	Omega-3	Documented triglycerides ≥ 500 mg/dL or documented triglycerides ≥ 350 mg/dL following at least three consistent months treatment with fenofibrate.
MIGRANAL	Dihydroergotamine Nasal Spray	Acute treatment of migraine with or without aura; documented failure or intolerance of Formulary agents. Prophylactic therapy needed in patients with 2 or more attacks per month.
NICOTROL NASAL SPRAY	Nicotine nasal spray	For smoking cessation. Treatment course limited to 3 months. For continued use member must be enrolled in American Cancer Society Smoking Cessation program
Non-Formulary GLUCOMETER & Supplies		Documented failure/inability to use True Track Glucometer (True Track Test Strips) AND True Result Glucometer (True Test Test Strips). Approved for confirmed diabetic patients.
OXYCONTIN	Oxycodone CR	Treatment of severe chronic pain with documented failure on other formulary long-acting analgesics; documented evaluation/recommendation by pain management specialist/oncology. Only approved QD or BID dosing, no prn use
PROSCAR	Finasteride	Diagnosis of BPH with enlarged prostate

BRAND NAME	GENERIC NAME	CRITERIA
STADOL NASAL SPRAY	Butorphanol	Treatment of acute pain; failure or intolerance to Formulary narcotics. If used for migraines member must have documented failed Formulary Triptans
STARLIX	Nateglinide	Documented failure / intolerance to Precose.
SYMLIN	Pramlintide	Documented failure / intolerance to Lantus, maximum dose Metformin
Testosterone	Testosterone	Treatment of hypogonadism (primary and secondary). Documented Total Testosterone deficiency. Will not be approved for the treatment Erectile Dysfunction.
TRICOR	Fenofibrate	Treatment of hypertriglyceridemia when patient is at risk of pancreatitis. Lofibra generic fenofibrate covered.
VFEND	Voriconazole	Treatment of invasive aspergillosis; treatment of serious fungal infections caused by *Scedosporium apiospermum* or *Fusarium sp*, in patients intolerant of, or refractory to other therapy.
WEIGHT LOSS MEDICATIONS	Various FDA-approved	After failure on structured weight loss and diet programs, member must have a BMI ≥33 plus two or more of the following risk factors: poorly controlled HTN, diabetes, uncontrolled dyslipidemia, significant cardiac disease, symptomatic sleep apnea, restrictive lung disease, or DJD/osteoarthritis of the hip and/or knee.
WELCHOL	Colesevelam	Documented failure / intolerance to Zetia. Documented elevated LFTs and/or myalgia on statin
XOPENEX	Levalbuterol	Documented unexpected cardiac side effects while on regular nebulized albuterol; in clinical trials, Xopenex has not been shown to be more effective than equipotent doses of albuterol on an outpatient basis.
ZETIA	Ezetimibe	Documented elevated LFTs and/or myalgia on statin

To request a copy of a prior authorization request form, or to request full-length criteria for a medication listed above (if applicable), call (888) 669-4322.

OVER THE COUNTER (OTC) DRUG LIST

Over-the-counter (OTC) medications are a covered benefit with no out-of-pocket expense to members only when a prescription is written by a provider. The following is a list of covered OTC medications. Please consider these OTC medications as First Line Therapy when treating your patients. Please remember that generic medications will be dispensed when available.

Category	Generic Name	Brand Name
1. Anti-Acne Medications	Benzoyl peroxide lotion 5%, 10%	
2. Antibiotics and Antibiotic Combinations	Bacitracin ointment	
3. Antidiarrheal Preparations	Attapulgite	Parapectolin/Kaopectate
4. Antidiarrheal Preparations	Bismuth Subsalicylate	Pepto Bismol
5. Antifungal-Vaginal Anti-infective	Clotrimazole	Mycelex-G, Gyne-Lotrimin, Lotrimin, Mycelex
6. Antihistamines	Diphenhydramine 25mg	Benedryl
	Loratadine & Loratadine	Claritin & Claritin-D
7. Antihistamines Single-Entity Products	Pseudoephedrine	Nolahist
8. Antihistamines Single-Entity Products	Phenindamine	Chlor-Trimeton
9. Antitussives & Expectorants	Cholrpheniramine	Robitussin
10. Antitussives & Expectorants	Guaifenesin	Robitussin DM
11. Decongestant Products	Guaifenesin/Dextromethorphan Pseudoephedrine	Sudafed Tabs, Syrup
12. Digestants/Stool Softeners	Docusate sodium	Colace
13. Digestants/Stool Softeners	Psyllium	Matamucil
14. Digestants/Stool Softeners	Bisacodyl	Dulcolax
15. Insulins/supplies	Glucose Test Strips	True Track/True Test
16. Insulins/Supplies	Insulin Syringes, Lancets	
17. Miscellaneous	Condoms (max 12)	
18. Miscellaneous	Spermicidal Jelly/foam	
19. Miscellaneous	Vaporizer	
20. Miscellaneous Nasal Products	Cromolyn-nasal inhaler	Nasalcrom
21. Miscellaneous OTIC Products	Carbamide peroxide 6.5%	Debrox
22. Non-Narcotic Analgesic	Aspirin-Tabs, enteric coated Tabs	Aspirin
23. Non-Narcotic Analgesic	Acetaminophen	Tylenol
24. Non-Steroidal Anti-Inflammatory Drugs	Ibuprofen	Motrin
25. Nutritional Products-Other	Calcium Carbonate	Os-Cal, Tums
26. Nutritional Products-Other	Ferrous Gluconate	Fergon
27. Nutritional Products-Other	Ferrous Sulfate	Feosol Tabs, solution
28. Nutritional Products-Other	Ped. Electrolyte Solution	Pedialyte solution
29. Other Anti-Ulcer Products, Antacids	Antacid Liquid	Maalox/Maalox TC
30. Other Anti-Ulcer Products, Antacids	Antacid Liquid	Mylanta/Mylanta II
31. Other Anti-Ulcer Products, Antacids	Simethicone	Mylicon
32. Other CNS Drugs	Nicotine Gum	Nicorette Gum (PA required)
33. Other CNS Drugs	Nicotine Transdermal	Nicotrol Patch
34. Respiratory Medications-Combination	Bromphen/Decongestant	Dimetapp Tabs, Elixir
35. Respiratory Medications-Combination	Chlortimeton/Decongestant	Contac-12 Hour Caps
36. Respiratory Medications-Combination	Tripolidine/Pseudophedrine	Actifed Tabs, Syrup
37. Scabicides/Pediculocides	Permethrin	NIX
38. Scabicides/Pediculocides	Pyrethens combo	RID, A-200
39. Topical Anti-Fungal	Tolnaftate cream	Tinactin
40. Topical Anti-infective	Polysporin ointment	
41. Topical Anti-infective	Triple Antibiotic Ointment	
42. Ulcer Therapy-H2 Antagonists	Famotidine	Pepcid AC
43. Ulcer Therapy-PPI	Omeprazole	Prilosec OTC

Member After Hours Pharmacy Services

POLICY
After normal business hours, which are defined as after the close of Molina Healthcare Pharmacy Department (Monday-Friday), 8:00am-6:00pm EST, network pharmacies are to contact the after hour Help Desk at (800) 791-6856 to obtain an override to fill an emergency three day (72 hour) supply of medication, which "when not given may cause the member's condition to worsen".

PURPOSE
This policy establishes the infrastructure and procedures for plan members to obtain medications on an emergency basis and on a 24-hour/day/7day/week basis.

SCOPE
This policy applies to CVS/Caremark contracted pharmacy providers dispensing medications to Molina Healthcare members after Molina Healthcare's normal business hours.

PROCEDURE

1. After normal business hours as defined in the POLICY statement, CVS/Caremark / Molina Healthcare contracted pharmacy providers are required to exercise professional judgment in the dispensing of medications to members requiring after hours pharmacy services.

2. Members have the ability to obtain prescription drugs on a 24-hour/day/7 day/week basis.

3. Pharmacists are instructed to contact the CVS/Caremark Help Desk at (800) 770-8014 to obtain an override code. This will assure the timely adjudication of prescription claims.

4. Members, pharmacists or medical providers requiring medication assistance after normal business hours should call (888) 898-7969. The answering service will refer callers to CVS/Caremark for assistance.

MEMBER AND PROVIDER PATIENT SAFETY NOTIFICATION

Molina Healthcare has a process to notify members and providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization. Letters are sent to members instructing them to obtain an additional supply of the medication. Included in this document is a State of Michigan approved member notification letter which is sent to Molina Healthcare members. In all cases, providers are notified at the same time. If you have any questions regarding this safety initiative, please contact the pharmacy department.

Medication Recall Notification

Month day, year

Dear Member:

Please read this letter carefully. It contains information about a medicine that you or your family member received from a pharmacy under the Molina Healthcare Plan.

The name of the medicine is:

The medicine listed above is being removed from the market because of a safety problem. The safety problem comes only from the company that made the product. The medicine should not be used. This letter is being sent to you only about the company listed. It does not apply to any other company or product with the same name.

Molina members are asked to do the following:

- Stop using the medicine as soon as possible
- If you have any medicine left, please return to it to your pharmacy
- If the medicine is still needed, get a new supply at the pharmacy

If you have any questions or concerns, please talk with the provider. You can also call Member Services at 1-888-898-7969 if you need help or have questions about this letter.

Thank you,

Member Services Department

MIC-PH02-revised 8/5/09

STATE OF MICHIGAN CARVE OUT

Effective October 2004, the State of Michigan enacted a Carve out for all Psychotropic and HIV/AIDS related medications. Effective April 2010, additional classes of medication have been added to the Carve Out. These classes include ADHD, Anti-Depressive, Sedative, Anti-Anxiety and Anti-Convulsant medications. Claims for these medications must be submitted directly to the State of Michigan, Magellan Medicaid Administration. Molina members may be responsible for $1.00-$3.00 co-pay on these medications as indicated by State rules.

Effective 10/1/2004	STELAZINE	DIASTAT, ACUDIAL	PHENOBARBITAL
ABILIFY	SUBOXONE	DILANTIN	PHENYTEK
AGENERASE	SUSTIVA	DORAL	PRISTIQ
AKINETON	SYMBYAX	EDLUAR	PROSOM
APTIVUS	THORAZINE	EFFEXOR, XR	PROVIGIL
ARTANE	TRILAFON	ELAVIL	PROZAC, WEEKLY
ATRIPLA	TRIZIVIR	EMSAM	REMERON
CAMPREL	TRUVADA	FELBATOL	RESTORIL
CLOZARIL	VIDEX, -EC	FOCALIN, XR	RITALIN, SR, LA
COGENTIN	VIRACEPT	GABITRIL	ROZEREM
COMBIVIR	VIRAMUNE	HALCION	SARAFEM
CRIXIVAN	VIREAD	INTUNIV	SECONAL SODIUM
EMTRIVA	ZERIT	KEPPRA, XR	SERAX
EPIVIR	ZIAGEN	KLONOPIN	SERZONE
EPZICOM	ZYPREXA, ZYDIS	LAMICTAL, ODT, XR	SINEQUAN
FAZACLO	**Effective 4/1/2010**	LEXAPRO	SOMNOTE, NOCTEC
FORTOVASE	ADDERALL, XR	LIBRIUM	SONATA
FUZEON	AMBIEN CR	LIMBITROL, DS	STAVZOR
GEODON	ANAFRANIL	LUDIOMIL	STRATTERA
HALDOL	APLENZIN, ER	LUMINAL	SURMONTIL
HIVID	ASENDIN	LUNESTA	TEGRETOL, XR
INAPSINE	ATIVAN	LUVOX, CR	TOFRANIL, PM
INVIRASE	BANZEL	LYRICA	TOPAMAX
KALETRA	BUSPAR, VANSPAR	MARPLAN	TRANXENE T-TAB
KEMADRIN	BUTISOL SODIUM	MEBARAL	TRIAVIL, ETRAFON
LEXIVA	CARBATROL	METADATE ER, CD	TRILEPTAL
LOXITANE	CELEXA	MILTOWN	VALIUM
MELLARIL	CELONTIN	MYSOLINE	VIMPAT
MOBAN	CEREBYX	NARDIL	VIVACTIL
NAVANE	CONCERTA	NEURONTIN	VYVANSE
NORVIR	CYMBALTA	NIRAVAM	WELLBUTRIN, SR, XL
ORAP	DALMANE	NORPRAMIN	XANAX, -XR
PROLIXIN	DAYTRANA	NUVIGIL	ZARONTIN
RESCRIPTOR	DEPAKENE	PAMELOR	ZOLOFT
RETROVIR	DEPAKOTE, ER	PARNATE	ZONEGRAN
REYATAZ	DESYREL	PAXIL, CR	
RISPERDAL	DEXEDRINE	PEGANONE	
SEROQUEL	DEXTROSTAT	PEXEVA	

Caremark Specialty Pharmacy

Molina Healthcare of Michigan has an exclusive contractual arrangement with *Caremark Specialty Pharmacy* to be the provider of specialty bio-pharmaceutical medications. This program allows our health plan to obtain the best possible price and at the same time, obtain other services to assist in the overall healthcare management of the member. These specialty medications may be delivered directly to the patient or to your office. **All medications on this list require Prior Authorization and the Molina Healthcare PA form must be submitted to obtain authorization.** This information should be faxed to Molina Healthcare Pharmacy.

IMPORTANT NOTE: *Caremark Specialty Pharmacy* requires the patient's telephone number to verify certain information such as insurance eligibility and availability to sign for the package. Listed below are the medications handled by *Caremark Specialty Pharmacy.* Please see below for a list of some of the preferred medications handled by Caremark Specialty Pharmacy. **Other medications are non-formulary.**

If you have any questions, please call Pharmacy Services at (888) 898-7969. The pharmacy FAX line is (888) 373-3059. This list is subject to change as new medications become available.

ACTIMMUNE	GLEEVEC	NEXAVAR	SANDOSTATIN
ADVATE	HELIXATE	NOVANTRONE	SPRYCEL
ALPHANATE	HERCEPTIN	NOVOSEVEN	STIMATE
ALPHANINE	HUMATE P	OCETREOTIDE	SUTENT
APLIGRAF	HUMATROPE	PEGASYS**	SYNAGIS
ARIXTRA	HUMIRA	PEG-INTRON**	SYNAREL
ARANESP	INCRELEX	PROCRIT	TEMODAR
AUTOPLEX	INFERGEN	PROFILNINE	TEVTROPIN**
AVONEX	INTRON A	PROPLEX	THALOMID
BEBULIN	KOATE	PULMOZYME	THROMATE
BENEFIX	KOGENATE	RAPTIVA	THYROGEN
COPAXONE	LEUKINE	REBETOL	TOBI
COPEGUS	LOVENOX	REBETRON	TRACLEER
DDAVP	LUCENTIS	RECOMBINATE	TYKERB
ELAPRASE	LUPRON	REFACTO	TRELSTAR
ENBREL	MONARCH M	REMODULIN	VIDAZA
EPOGEN	MONCLATE	REVATIO	VANTAS
EXTAVIA**	MONONINE	REVLIMID	VISUDYNE
EUFLEXXA	MYOBLOC	RHOGAM	WHINRHO
FEIBA-VH	NEUMEGA	RIBAVIRIN	XELODA
FORTEO	NEULASTA	REFERON	XOLAIR
FRAGMIN	NEUPOGEN	SAIZEN	ZOLADEX

**** Formulary Preferred**

All medications on this list require a Prior Authorization, which must be faxed to Molina Healthcare of Michigan.

MIChild Formulary Information

MIChild provides prescription drug coverage which includes medications on the Molina Healthcare Formulary with a few exceptions. Please refer to the Molina Healthcare website at: www.molinahealthcare.com/Providers/Michigan/Drug list for the most up to date and comprehensive information on MIChild prescription coverage. In addition, Formulary questions may be directed to Molina Healthcare pharmacy services: 1-888-898-7969 Monday through Friday 8 am to 5 pm (EST).

Differences between Molina MIChild Drug formulary and Molina Medicaid drug formulary:

Antibiotics – Formulary antibiotic suspensions are covered without age limitations. Quantity limits still apply. Please refer to the Formulary for a complete list of Formulary medications in this category.

Asthma Therapy - Molina Healthcare encourages the use of inhaled corticosteroids (QVAR preferred) as an important component of treatment of asthma. However, if necessary, Singulair chew tabs and tablets are covered without age limitations. Quantity limits still apply.

Anticonvulsants - Covered under MIChild but require Prior Authorization

Community Mental Health Prescriptions - Prescriptions written by Community Mental Health providers are not covered by Molina Healthcare MIChild. This would include medications such as ADHD, anticonvulsant and antidepressants. Therefore, these medications require Prior Authorization.

Digoxin solution - Digoxin solution is covered without age limits.

Drugs "carved out" of the health plan benefits - Drugs that have been carved out of the health plan prescription coverage are included for MIChild members. This includes psychotropic and anticonvulsants. However, Prior Authorization is required for these categories.

Estrogen Replacement Therapy - These medications are not covered as part of the MIChild Formulary.

Insulin Pens - Medications available as an insulin pen are covered and do not require authorization for this dosage form. Quantity limits still apply.

Narcotics - Prescriptions for narcotics require Prior Authorization.

CREDENTIALING

Based on standards set forth by the National Committee for Quality Assurance (NCQA) all Providers listed in literature for Molina Healthcare will be credentialed.

Molina Healthcare will credential designated Practitioners prior to granting Provider status. All mid-level professionals, as defined above, must be credentialed prior to allowing them to provide services to Molina Healthcare members. The plan requires initial credentialing of all practitioners and mid-level professionals who seek reinstatement after having a break in service beyond 30 calendar days.

Molina Healthcare does not make credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients the practitioner discipline of care.

Who Should Be Credentialed
Credentialing standards must apply to all licensed independent practitioners or groups of practitioners who provide care for Molina Healthcare members. NCQA standards do not address the types of practitioners with whom Molina Healthcare may contract.

Practitioners who must be credentialed
NCQA required Molina Healthcare to credential the following types of practitioners:

- Practitioners who have an independent relationship with the organization. An independent relationship exists when the organization selects and directs its members to see a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities.
- Practitioners who are hospital based, but see Molina Healthcare's members as a result of their independent relationship with the organization.
- Pharmacists who work for a pharmacy benefit manager (PBM) to which the organization delegates utilization management.
- Covering practitioners (e.g. locum tenens)
- Practitioners who do not provide care for members in a treatment setting (e.g. board certified consultants)

Documents Required For Credentialing
Molina Healthcare must verify that the following elements are present and within the prescribed time limits:

- A valid Drug Enforcement Agency (DEA) certificate
- Verification of education
- Verification of training
- If a provider states on the application that he or she is Board Certified, verification of board certification.
- Verification of work history
- A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioners
- Verification of license

Credentialing Application

The applicant will have the responsibility of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and ability to provide services without limitations including physical and mental health status as allowed by law, and the responsibility of resolving any doubts about these or any of the other basic qualifications required by Molina Healthcare.

Network Development sends an unsigned contract and an application packet to each requesting practitioner, mid-level professional, and/or IPS/medical group with whom Molina Healthcare has chosen to pursue a business relationship.

The application packet will contain the application form, release and consent forms and instructions for completing and submitting credentialing information to Molina Healthcare. Although the applicant's contracted medical group or IPA may return the completed application to the Credentialing Coordinator, the applicant is responsible for completing all of the information and providing the supporting documentation. The contract is fully executed once the applicant has completed the Peer Review/Credentialing Review process.

Application Form

The applicant shall complete the Application (see attachment A at the end of this section). Each application for Molina Healthcare Provider or mid-level professional status shall provide current information, be submitted on the written application form prescribed by the Governing Board and be signed by the applicant. The application shall request at least the following:

- A current, valid Michigan license or certificate to practice his/her profession, including a copy of such license or certificate.
- A current, valid DEA certificate, including a copy of such certificate, as applicable.
- Documentation of professional liability insurance at a minimum amount of $100,000 per occurrence and $300,000 aggregate coverage appropriate to the medical practice under contractual consideration. This coverage shall extend to Molina Healthcare members and the applicant's activities on Molina Healthcare's behalf. The name of the insurance carrier and date of expiration must be included.
- A list of all malpractice actions for at least the last ten (10) years, with explanations of the actions and current status.
- Education.
- Board Certification status, if applicable.
- Educational background, including professional school, graduation date and degree.

The credentialing process will be completed with 60 working days of application submission unless extenuating circumstances exist (i.e. Verification of education is delayed), assuming the information submitted by the applicant is determined by the Peer Review/Credentialing Committee to be sufficient to make a determination of the mid-level professional's qualifications or current competence, If any time sensitive application information and/or verification, as defined by current NCQA guidelines, becomes over one hundred and eighty (180) calendar days old prior to a final decision by the Peer Review/Credentialing Committee regarding the applicant, updated information must be obtained and included in the review of the application.

Provider Disclosure Information (FY2010)
The Medicaid Managed Health Plans are expected to solicit the following information from their providers/contractors:

1. Ownership information. For specifics see **42 CFR §455.104.**
2. Managing employee, including name and social security number. For specifics see **42 CFR §455.106.**
   Once the ownership and managing employee information are obtained, the Medicaid health plan must check the EPLS on these individuals.
3. Information on criminal conviction by querying: Has any person who has ownership or control interest in the provider or is an agent or managing employee of the provider ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the title XX services program since the inception of those programs? For specifics see **42 CFR §455.106.** If the answer is "yes," to this question the provider/disclosing entity, must list these individuals. Then, the plan must report these individuals to the HHS/Office of Inspector General (OIG) within 20 days of disclosure and also to our department. Please See **42 CFR §455.106.**

For definitions, including definition of Managing Employee, please see **42 CFR §455.101.**

Credentialing Site Visits
As part of the credentialing process, Molina Healthcare must assess the quality, safely and accessibility of the office sites where care is delivered. In addition Molina Healthcare sets standards for medical/treatment record practice. Molina Healthcare contracts with Medical Site Reviewers (MSR) to conduct office site visits.

1. A standard site visit survey form that is completed at the time of the site visit (See attachment B at the end of this section)

2. A set of criteria for the office review, which include an assessment of:
   - Physical accessibility
   - Physical appearance
   - Adequacy of waiting and exam room space
   - Availability of appointments
   - Adequacy of medical/treatment record keeping
   - Standards and thresholds for acceptable performance

Practitioner office sites must pass with an 80% in order to be considered to enter the Molina Healthcare network.

Practitioner Appeal Rights
Procedural rights provided to Molina Healthcare practitioners when an action or recommendation of a Quality Improvement Committee, Peer Review/Credentialing Committee or the Board will, if it becomes a final action, result in a report to the Michigan State Board of

Medicine. This applies to practitioners with Molina Healthcare active status as well as those who are applicants for Molina Healthcare.

Grounds for a Hearing
Grounds for a Hearing exist whenever the Molina Healthcare Quality Improvement Committee or Peer Review/Credentialing Committee take or recommend any of the following Adverse Actions:

- Denial of initial application for Molina Healthcare Provider status;
- Revocation or termination of, or expulsion from Molina Healthcare participation;
- Reduction or revocation of authority to provide care to Molina Healthcare patients;
- Suspension or restriction of authority to provide care to Molina Healthcare patients for a cumulative period of more than thirty (30) days in any twelve (12) month period;
- Summary suspension of authority to provide care to Molina Healthcare patients for more than fourteen (14) consecutive days.

Notice of Action
If the Molina Healthcare Quality Improvement Committee or Peer Review/Credentialing Committee has recommended an Adverse Action as defined above, the Committee taking or recommending the adverse action shall give written notice to the Provider by certified mail with appropriate return receipt. This notice shall:

- Describe the nature of the proposed action or recommendation; and
- State that the proposed action or recommendation, if adopted, must be reported to the National Practitioners Data Bank; and the State Licensing Board within fifteen (15) days from the date the adverse action is taken.
- Advise the Provider that he/she has the right to request a Hearing on the proposed action or recommendation; and
- Inform the Provider that any request for Hearing must be made in writing within thirty (30) days following receipt of the Notice of Action and must be sent to the Medical Director; and
- Contain a summary of the Provider's hearing rights.

Request for a Hearing
If the Provider has not requested a Hearing within the time and manner described above, the Provider shall be deemed to have accepted the action or recommendation, and such action or recommendation shall become the Molina Healthcare Quality Improvement Committee's or Peer Review/Credentialing Committee's final action or recommendation, which shall be forwarded to the Board for their information. In the event that a timely written request for a Hearing is received, a Hearing Panel shall be appointed and the practitioner shall be provided a Notice of Hearing and Statement of Charges consistent with this policy.

PRIMARY CARE PROVIDER RESPONSIBILITIES

Access to Care Standards

A Primary Care Provider (PCP) may be any of the following types of provider: family or general practice, internal medicine, OB/Gyn, pediatric, physician assistant and/or nurse practitioner.

A PCP must be accessible 24 hours a day, seven days a week, either personally or through coverage arrangements with a designated contracted primary care provider. After Hours coverage must meet the requirements below.

- ✓ Provides instructions for an emergency situation
- ✓ Provides means of reaching an on-call physician

The PCP must make every effort to schedule members for appointments using the following recommendations:

1. Office Hours. Primary Care Providers must be available at least 20 hours per week. The PCP must provide staffing patterns, which are adequate for caseload, inclusive of healthcare support staff, paraprofessionals, and other healthcare professionals.

2. Emergent Appointments. Emergencies must be handled immediately or the member be referred to a hospital emergency room.

3. Urgent Appointments. Urgent appointments scheduled on the same day or referred to urgent care facility.

4. Routine Appointments. Routine appointments scheduled within seven (7) to ten (10) days.

5. Health Assessment. Well examination and physical scheduled within four (4) to six (6) weeks after the initial request.

6. After-Hours Care. Primary Care Providers must provide member access and availability to physician services, 24 hours per day, seven days a week. Members can access medical services after-hours by calling (888) 898-7969.

Provider Change Notification Requirements

Providers must notify Molina Healthcare in writing at least **60 days** in advance when possible of changes in physician staffing, after hours and/or vacation coverage, practice location changes, billing address and tax ID changes. Changes should be submitted on the "Molina Healthcare Provider Change Form" located on the Molina Healthcare website at www.molinahealthcare.com in the Provider Forms section. Please submit completed forms and supporting documentation by mail, fax or email to: Molina Healthcare of Michigan, Systems Configuration, 100 W. Big Beaver Road, Suite 600, Troy, MI 48084 or Fax to (248) 925-1757, or e-mail to MHMProviderChangeForm@molinahealthcare.com. Please direct questions to the Provider Call Center at (888) 898-7969.

Facility Staffing Standards
The Facility Staffing Standards are divided into the following types of Primary Care Centers:

1. **Multi-specialty Centers** – consist of Internists, Family/General Practitioners and Pediatricians all on-site at the same location. In addition, Multi-Specialty Centers should have a referral OB/GYN physician.

2. **Family Practice Centers** – consist of two (2) Family Practitioners or two (2) General Practitioners or one of each. In addition, Family Practice Centers should have a referral OB/GYN and referral Pediatrician.

3. **Multi-Specialty Multi-Location Centers** – consist of Internists, General/Family Practitioners and Pediatricians located in different locations within 20 minutes from each other.

Realizing different staffing may be necessary based upon the number of members being serviced; Molina Healthcare has established standards for large and small centers. The standards, therefore, change based upon the following numbers of members.

- 0 – 349 Members
- 350 – 999 Members
- 1000 – 1999 Members
- 2000 – 3999 Members
- 4000+ Members

1. Multi-Specialty Centers

Less than 349 Members

One Internist, Family Practitioner,	4 days/week
Or General Practitioner on site	20 hours/week
	2 hours/day minimum
One Referral OB/Gyn	3 days/week
Within 30 minutes travel time	20 hours/week
One Pediatrician on site	3 days/week
Access to private office on alternate days	20 hours/week
	2 hours/day minimum

350 – 999 Members

One Internist, Family Practitioner,	4 days/week
Or General Practitioner on site	20 hours/week
	2 hours/day minimum
One Pediatrician on site	3 days/week
Access to private office on alternate days	20 hours/week
	2 hours/day minimum

1000 – 1999 Members

Two Internists, Family Practitioners	4 days/week
Or General Practitioners on site	22 hours/week
	4 hours/day minimum
One Pediatrician on site	5 days/week
Access to private office on alternate days	22 hours/week
	4 hours/day minimum

2000 – 3999 Members*

Three Internists, Family Practitioners,	4.5 days/week
Or General Practitioners on site	30 hours/week
	6 hours/day minimum
Two Pediatricians on site	4 days/week
Access to private office on alternate days	22 hours/week
	4 hours/day minimum

Note: Molina Healthcare will review and determine annually the Facility Standards for those centers with memberships over 4,000.

2. Family Practice Centers

Less than 349 Members

One Family Practitioner, General Practitioner, or Internist on site	4 days/week 20 hours/week 2 hours/day minimum
One Referral OB/GYN* within 30 minutes travel Time from other specialties	3 days/week 20 hours/week
One Referral Pediatrician* within 30 minutes Travel time from other specialties	3 days/week 20 hours/week

350 – 999 Members

One Family Practitioner, General Practitioner, or Internist on site	4 days/week 20 hours/week 2 hours/day minimum
One Family Practitioner, General Practitioner, or Internist on site	4 days/week 20 hours/week 2 hours/day minimum
One Referral OB/GYN* within 30 minutes travel Time from other specialties	3 days/week 20 hours/week
One Referral Pediatrician* within 30 minutes Travel time from other specialties	3 days/week 20 hours/week

1000 – 1999 Members

One Family Practitioner, General Practitioner or Internist on site	4 days/week 22 hours/week 2 hours/day minimum
One Family Practitioner, General Practitioner or Internist on site	4 days/week 22 hours/week 2 hours/day minimum
One Referral OB/GYN* within 30 minutes travel Time from other specialties	5 days/week 22 hours/week
One Referral Pediatrician* with 30 minutes Travel time from other specialties	5 days/week 22 hours/week

2000 – 3999 Members **

One Family Practitioner, General,	4.5 days/week
Practitioner or Internist on site	30 hours/week
	6 hours/day minimum
One Family Practitioner, General	4.5 days/week
Practitioner or Internist on Site	30 hours/week
	6 hours/day minimum
One Family Practitioner, General	4.5 days/week
Practitioner or Internist on Site	22 hours/week
	6 hours/day minimum
Two Referral OB/Gyn's within 30 minutes	4.5 days/week
Travel time from other specialties	30 hours/week
Two Referral Pediatricians within 30 minutes	4 days/week
Travel time from other specialties	22 hours/week

_____

***NOTE: Molina Healthcare will review and determine annually the Facility Standards for those centers with memberships over 4,000.**

3. MULTI-LOCATION CENTERS

Less than 349 Members

One Internist, Family Practitioner, Or General Practitioner on site	4 days/week 20 hours/week 2 hours/day minimum
One OB/GYN within 30 minutes travel Time from other specialties	3 days/week 20 hours/week 2 hours/day minimum
One Pediatrician within 30 minutes Travel from other specialties	3 days/week 20 hours/week 2 hours/days minimum

350- 999 Members

Two Internists, Family Practitioners, Or General Practitioners on site	4 days/week 20 hours/week 2 hours/day minimum
One OB/GYN within 30 minutes travel Time from other specialties	3 days/week 20 hours/week 2 hours/day minimum
One Pediatrician with 30 minutes Travel time from other specialties	3 days/week 20 hours/week 2 hours/day minimum

1000 - 1999 Members

Two Internists, Family Practitioners, Or General Practitioners on site	4 days/week 22 hours/week 4 hours/day minimum
One OB/GYN within 30 minutes travel Time from other specialties	5 days/week 22 hours/week 4 hours/day minimum
One Pediatrician within 30 minutes Travel time from other specialties	5 days/week 22 hours/week 4 hours/day minimum

2000 - 3999 Members

Three Internists, Family Practitioners.	4.5 days/week 6 hours/day minimum
Two OB/GYN's within 30 minutes travel time From other specialties	4.5 days/week 30 hours/week 4 hours/day minimum
Two Pediatricians within 30 minutes travel Time from other specialties	4 days/week 22 hours/week 4 hours/day minimum

NOTE: Molina Healthcare will review and determine annually the Facility Standards for those centers with membership over 4,000.

Molina Healthcare reserves the right to modify staffing after review of Member Complaints, Member Satisfaction Survey, Utilization Reports, Member Transfers, and can make adjustments to these staffing standards.

COMPLIANCE

Molina Healthcare seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members, and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

Definitions:

”Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR §455.2)

”Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Federal False Claims Act, 31 USC Section 3279

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term ”knowing” is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Health care fraud is:

Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

Examples of Fraud and Abuse

By a Member	By a Provider
Lending an ID card to someone who is not entitled to it.	Billing for services, procedures and/or supplies that have not been actually been rendered.
Altering the quantity or number of refills on a prescription.	Providing services to patients that are not medically necessary.
Making false statements to receive medical or pharmacy services.	Balancing Billing a Medicaid member for Medicaid covered services.
Using someone else's insurance card.	Double billing or improper coding of medical claims.
Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits.	Intentional misrepresentation of manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment , "upcoding", and billing for services not provided.
Pretending to be someone else to receive services.	Concealing patients misuse of Molina Health card.
Falsifying claims.	Failure to report a patient's forgery/alteration of a prescription.

Other Provider Crimes

- Knowingly and willfully solicits or receives payment of kickbacks or bribes in exchange for the referral of Medicare or Medicaid patients.
- A physician knowingly and willfully referring Medicare or Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)
- Balance billing – asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.

Preventing Fraud and Abuse

Health care fraud is rising higher and higher every year. Molina Healthcare and other State and Federal agencies are working together to help prevent fraud. Here are a few helpful tips on how you can help prevent healthcare fraud and abuse:

- Verify eligibility at each patient visit.
- Keep a copy of the patient's photo identification in the medical record.
- Bill according to standard billing guidelines.

Reporting Fraud and Abuse
You may report suspected cases of fraud and abuse to Molina Healthcare's Compliance Officer. You have the right to report your concerns anonymously to Molina Healthcare or the Michigan Department of Community Health Program Investigation Section. When reporting an issue, please provide as much information as possible. The more information provided the better the chance the situation will be successfully reviewed and resolved. Remember to include the following information when reporting suspected fraud or abuse:

- Nature of complaint
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

You may report suspected fraud and abuse to Molina Healthcare through one of the following:

TELEPHONE
Call the Toll-Free number of the Molina Healthcare, Compliance Hotline: **(877) 372-5361**

FAX (248) 925-1780

E-MAIL
Molina Healthcare Compliance:
MHMCompliance@MolinaHealthcare.com

REGULAR MAIL
Write (marked confidential) to:
Compliance Officer
100 W. Big Beaver Road
Suite 600
Troy, MI 48084

You may report suspected fraud and abuse to the Michigan Department of Community Health Program Investigation Section by calling (866) 428-0005 or sending a memo or letter to:

Program Investigation Section
Michigan Department of Community Health
Capitol Commons Center
400 S. Pine Street, 6th Floor
Lansing, MI 48909

HIPAA REQUIREMENTS AND INFORMATION

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI).

Provider/Practitioner Responsibilities

Molina Healthcare expects that its contracted Providers/Practitioners will respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Applicable Laws

Providers/Practitioners must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers/Practitioners must comply with. In general, most Michigan healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
   - HIPAA
   - Medicare and Medicaid laws
2. Michigan Medical Privacy Laws and Regulations

Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/Practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the Provider/Practitioner's own TPO activities, but also for the TPO of another covered entity.[1] Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that

includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services.[2]"

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality improvement;
- Disease management;
- Case management and care coordination;
- Training Programs; or
- Accreditation, licensing, and credentialing

Importantly, this allows Providers/Practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare Providers/Practitioners must allow patients to exercise any of the below-listed rights that apply to the Provider/Practitioner's practice:

1. *Notice of Privacy Practices*
   Providers/Practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider/Practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

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[1] See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

2. *Requests for Restrictions on Uses and Disclosures of PHI*
   Patients may request that a healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

3. *Requests for Confidential Communications*
   Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

4. *Requests for Patient Access to PHI*
   Patients have a right to access their own PHI within a Provider/Practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider/Practitioner includes both the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

5. *Request to Amend PHI*
   Patients have a right to request that the Provider/Practitioner amend information in their designated record set.

6. *Request Accounting of PHI Disclosures*
   Patients may request an accounting of disclosures of PHI made by the Provider/Practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers/Practitioners are encouraged to submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at www.molinahealthcare.com for additional information.

National Provider Identifier

Provider/Practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider/Practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider/Practitioner. The Provider/Practitioner must report its NPI and any subparts to Molina Healthcare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina Healthcare within 30 days of the change. Provider/Practitioners must use its NPI to identify itself on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers/Practitioners

Providers/Practitioners that are delegated for claims and utilization management activities are the "business associates" of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers/Practitioners must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

MOLINA HEALTHCARE
AUTHORIZATION FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Name of Member: _____ **Date of Birth:** _____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

_____

2. Name of persons/organizations authorized to receive the protected health information:

_____

_____

3. Specific description of protected health information that may be used/disclosed:

_____

_____

4. The protected health information will be used/disclosed for the following purpose(s):

_____

_____

5. Will the person/organization authorized to use/disclose the protected health information receive compensation for doing so? Yes____ No ____
6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.
7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.
8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.
9. I understand that I have a right to receive a copy of this authorization, if requested by me.
10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:
    a) action has been taken in reliance on this authorization; or
    b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.
11. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.
13. This authorization expires on/upon: _____.

_____ _____
Signature of Member or Member's Personal Representative | Date

_____ _____
Printed Name of Member's Personal Representative, if applicable | Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare

Deficit Reduction Act (DRA)

On February 8, 2006, President Bush signed into law the Deficit Reduction Act ("DRA"). The law, which became effective on January 1, 2007 aims to cut fraud, waste and abuse from the Medicare and Medicaid programs over the next five years.

Health care entities like Molina who receive or pay out at least $5 million in Medicaid funds per year must comply with DRA. As a contractor doing business with Molina, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protected rights as whistleblowers.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it;
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use;
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program;
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare of Michigan will take steps to monitor Molina contracted providers to ensure compliance with the law.

For more information on this legislation, please contact your Molina Healthcare of Michigan Territory Manager at 1-866-449-6828.