Section 7. Medical Management Program

Introduction
Molina Healthcare maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina Healthcare medical management program also ensures that Molina Healthcare only reimburses for services identified as a covered benefit and medically necessary. Elements of the Molina Healthcare medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network providers.

Medical Necessity Review
In conjunction with regulatory guidance from the Centers for Medicare and Medicaid Services (CMS) and industry standards, Molina Healthcare only reimburses services provided to its members that are medically necessary. Molina Healthcare may conduct a medical necessity review of all requests for authorization and claims, within the specified time frame governed by Federal or State law for all lines of business. This review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively, as long as the review complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement.

Clinical Information
Molina Healthcare requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina Healthcare does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless required by State regulation or the Molina Healthcare Hospital or Provider Services Agreement.

Prior Authorization
Molina Healthcare requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina Healthcare prior authorization documents are updated annually and the current documents are posted on the Molina Healthcare website. Molina Healthcare has included at the end of this section of this manual a copy of the current Authorization Request form. If using a different form, the prior authorization request must include the following information:
- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.)
- Provider demographic information (referring provider and referred to provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS and ICD-9 codes
- Clinical information sufficient to document the medical necessity of the requested service

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State law) are excluded from the prior authorization requirements. Molina Healthcare does not “retroactively” authorize services that require prior authorization.

Molina Healthcare will process any non-urgent requests within fourteen (14) calendar days of receipt of request. Urgent requests will be processed within seventy-two (72) hours.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (801) 858-0429.

Molina Healthcare providers must ensure members receive medically necessary health care services in a timely manner without undue interruption. The member’s PCP is responsible for:

- Providing routine medical care to Molina Healthcare members
- Following up on missed appointments
- Prescribing diagnostic and/or laboratory tests and procedures
- Coordinating Referrals and obtaining Prior Authorization when required

This section on Referrals, Authorizations, and Healthcare services (Utilization Management) describes procedures that apply to directly contracted Molina Healthcare PCPs. All contracted providers must obtain Molina Healthcare’s Authorization for specific services that require prior approval.

**Healthcare Services (Utilization Management)**

Prospective review is a process performed by the Healthcare Services (HCS) staff to evaluate requests for specified services or procedures. Determinations are made by specially trained personnel based on medical necessity and appropriateness, and reflect the application of Molina Healthcare’s approved review criteria and guidelines. Any denial of services may only be issued by the Medical Director (including services denied because of benefit limitations) or his/her designee.

**Referral versus Prior Authorization**

**Referral:** An authorization from Molina is not required to refer a patient to a specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the
Specialist.

**Authorization:** Generally, prior authorization requirements are designed to assure the medical necessity of service, prevent unanticipated denials of coverage, ensure participating providers are utilized and all services are provided at the appropriate level of care for the member's needs.

Providers should send requests for prior authorizations to the Healthcare Services Department by phone or fax. Providers may also submit authorization requests through Molina Healthcare’s e-portal at [www.molinahealthcare.com](http://www.molinahealthcare.com) 24 hours/day 7 days/week. Contact information is listed below.

**Phone:** (888) 483-0760  
**FAX:** (866) 472-0589 Medicaid/CHIP  
(866) 504-7262 Medicare

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Providers are encouraged to use the Molina Healthcare Prior Authorization Request Form (included at the end of this section). If using a different form, the provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, social security number, etc.)
- Provider demographic information (referring provider and referred specialist)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD Code and description)
- Clinical indications necessitating service, pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed
- Requested length of stay (inpatient requests)

Pertinent data and information is required by the Healthcare Services (HCS) staff to enable a thorough assessment for medical necessity and to verify that the diagnosis and procedure codes included in the Prior Authorization Request are appropriate and are incorporated into the Authorization. Authorization is based on medical necessity as well as member eligibility and benefit coverage at the time of service.

Molina Healthcare will process any non-urgent requests within fourteen (14) calendar days of receipt of request. Urgent requests will be processed within (24) hours. Information generally required to support the decision-making process includes:

- Adequate patient history related to the requested services
- Physical examination that addresses the area of the request
- Supporting lab and/or X-ray results to support the request
- Relevant PCP and/or Specialist progress notes or consultations
- Any other relevant information or data specific to the request
Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (801) 858-0429.

**Inpatient Management**

**Elective Inpatient Admissions** - Molina Healthcare requires prior authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

**Emergent Inpatient Admissions** - Molina Healthcare requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. Molina Healthcare requires that notification includes member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements will result in a denial of authorization for the inpatient admission.

**Concurrent Inpatient Review** - Molina Healthcare performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina Healthcare will request updated original clinical records from inpatient facilities at regular intervals during a member’s inpatient admission. Molina Healthcare requires that requested clinical information updates be received by Molina Healthcare from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates will result in denial of authorization for the remainder of the inpatient admission.

**Readmission Policy** - Hospital readmissions within thirty (30) days have been found by CMS to potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare’s Quality Improvement Program to ensure that Molina Healthcare members are receiving hospital care that is compliant with nationally recognized guidelines, Medicare regulations, State Medicaid regulations and CMS.

Molina Healthcare will review all hospital subsequent admissions that occur within thirty 30 days of the previous discharge for all Medicaid claims. If the subsequent hospital admission is determined to be a Readmission, Molina Healthcare will deny the subsequent admission or pay for the subsequent admission and seek money from the first Provider if they are different Provider, unless it meets one of the exceptions noted below, violates State and/or Federal law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina.

**Exceptions:**

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission
2. The readmission is part of a medically necessary, prior authorized or staged treatment plan

3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Definitions:

Readmission: A subsequent admission to an acute care hospital within a specified time frame of a prior admission for a related condition or as readmission is defined by State laws or regulations.

Related Condition: A condition that has a same or similar diagnosis or is a preventable complication of a condition that required treatment in the original hospital admission.

Non-Network Providers: Molina Healthcare maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare members. Molina Healthcare requires members to receive medical care within the participating, contracted network of providers. All care provided by non-contracted, non-network providers must be prior authorized by Molina Healthcare. Non-network providers may provide emergent/urgent care and dialysis services for a member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State laws or regulations.

Avoiding Conflict of Interest

The HCS Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Also, we require our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Continuity of Care and Transition of Members

Molina Healthcare members involved in an active course of treatment have the option to complete treatment with the provider who initiated care. The lack of a contract with the provider of a new member or terminated contracts between Molina Healthcare and a provider will not interfere with this option. This option includes members who are:

- Pregnant
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition
For each member identified in the categories above, Molina Healthcare will work with the treating provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the member’s needs.

Requests for continued care should be submitted to the HealthCare Services Department at the phone number and address listed at the beginning of this section. All requests will be reviewed by the Medical Director. Molina Healthcare will not approve continued care by a non-contracted provider if:

- The member only requires monitoring of a chronic condition
- The provider does not qualify for Molina Healthcare credentialing based on a previous professional review action
- The provider is unwilling to continue care for the member
- The provider has never seen the member prior to enrolling with Molina Healthcare

Continuity and Coordination of Provider Communication

Molina Healthcare stresses the importance of timely communication between providers involved in a member’s care. This is especially critical between specialists, including behavioral health providers, and the member’s PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Case Management

Molina Healthcare provides a comprehensive Case Management (CM) program to all members who meet the criteria for services. The CM program focuses on procuring and coordinating the care, services, and resources needed by members with complex issues through a continuum of care. Molina Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Healthcare case managers are licensed professionals and are educated, trained and experienced in the case management process. The CM program is based on a member advocacy philosophy, designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The CM program is individualized to accommodate a member’s needs with collaboration and approval from the member’s PCP. The Molina Healthcare case manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare case manager is responsible for assessing the member’s appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff,
discharge planners, specialist providers, ancillary providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the member being referred.

Members with the following conditions may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation:

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- Children with Special Health Care Needs

Referrals to the CM program may be made by contacting Molina Healthcare at:

**Phone:** (888) 483-0760

**Fax:** (866) 472-0589 Medicaid/CHIP
(866) 504-7262 Medicare

**PCP Responsibilities in Case Management Referrals**

The member’s PCP is the primary leader of the health team involved in the coordination and direction of services for the member. The case manager provides the PCP with reports, updates, and information regarding the member’s progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

**Case Manager Responsibilities**

The case manager collaborates with all resources involved and the member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, providers, and the member are responsible for implementing the plan of care. Additionally the case manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource to team members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
• Coordinates appropriate education and encourages the member’s role in self-help
• Monitors progress toward the member’s achievement of treatment plan goals in order to determine an appropriate time for the member’s discharge from the CM program

Health Education and Disease Management Programs

Molina Healthcare’s Health Education and Disease Management programs will be incorporated into the member’s treatment plan to address the member’s health care needs. Primary prevention programs may include smoking cessation and wellness.

Emergency Services

Emergency services are covered on a (24) hour basis without the need for prior authorization for all members experiencing an emergency medical situation.

Molina Healthcare of Utah accomplishes this service by providing Utilization Management during business hours and a (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all members at the onset of any call to the plan.

For members within our service area: Molina Healthcare of Utah, Inc. contracts with vendors that provide (24) hour emergency services for ambulance and hospitals. In the event that our member is outside of the service area, Molina Healthcare is prepared to authorize treatment to ensure that the patient is stabilized.

Medical Record Standards

The provider is responsible for maintaining an electronic or paper medical record for each individual member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable federal and state regulations. The provider must ensure his/her staff receives periodic training regarding the confidentiality of member information.

The provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the member was referred to the provider.

At a minimum, each medical record must be legible and maintained in detail with the
documentation outlined in section 8 (Quality Improvement) of this manual.

Medical Necessity Standards

Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs
- Consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
- Furnished in a manner not primarily intended for the convenience of the member, the member’s caretaker, or the provider

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Specialty Pharmaceuticals

Molina Healthcare contracts with a Specialty Pharmacy Services vendor to provide an innovative injectable drug delivery program. This service eliminates the cost associated with stocking and billing for office administered specialty injectable drugs for Molina Healthcare members.

Some of the specialty injectable drugs provided by the vendor are:

- Remicade
- Enbrel
- Depot - Lupron
- Interferons

When a Molina Healthcare member needs an injectable medication, the Prior Authorization request can be submitted to Molina Healthcare by fax at 801-245-3879. Molina’s pharmacy vendor will coordinate with Molina Healthcare and ship the prescription directly to your office or the member’s home. All packages are individually marked for each member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.