Section 7. Medical Management

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 Utilization Management (UM) 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, unless the requesting Provider is contracted with a medical group/IPA granted delegated Utilization Management status (For a list of contracted medical groups/IPAs that are delegated for UM please see section (14) of this manual). If you are treating a Member assigned to a PCP in one of the delegated medical groups/IPAs, Molina Healthcare Providers are required to follow their specific Referral and Authorization requirements, as they may restrict their Referrals to Providers within their group.

Utilization Management – Referral Process

Prospective review is a process performed by the UM staff to evaluate Referrals 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 for services denied because of benefit limitations).

Referral versus Prior Authorization:

Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a Specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the Specialist. Except for some benefits such as routine eye exams and women's health care needs, Members are required to obtain referrals from their PCPs for specialty care services. Specialists may refer Members to other Specialists or for ancillary services. Referrals and authorizations do not have to be routed back through the PCP. Certain Referrals require a prior authorization from Molina Healthcare for payment of claims.

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 Utilization Management Department by phone or fax based on the urgency of the requested service. Providers may also submit authorization requests through Molina Healthcare's e-portal at www.molinahealthcare.com. Contact information is listed below.

Phone: (866) 472-4585 **FAX:** (866) 440-9791

Providers are encouraged to use the Molina Healthcare Service Request Form (included in Appendix B of this manual). 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-9 Code and description**)
- Clinical indications necessitating service or Referral
- 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 UM staff to enable a thorough assessment for medical necessity and assign appropriate diagnosis and procedure codes to the Authorization. Authorization is based on verification of Member eligibility and benefit coverage at the time of service. Claims payment is contingent on eligibility for date of service and appropriate coding and limitations.

Molina Healthcare will process any non-urgent requests within fourteen (14) working days after receiving adequate clinical information. Urgent requests will be processed within (72) hours or three (3) working days. If a Referral has been previously approved, the Specialist or vendor may call Molina Healthcare directly to request an extension of services. 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 (866) 472-4585.

Wrong Site Surgery:

If it is determined a wrong site surgery was performed, Molina Healthcare will not reimburse the Providers responsible for the error. Molina Healthcare will immediately report these types of events that are identified as Critical Incidents to AHCA in addition to reporting a summary on a quarterly basis.

Avoiding Conflict of Interest

The UM 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 UM 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.

Coordination of Care

Molina Healthcare's Utilization Management, Case Management and Disease Management will work with Providers to assist with coordinating services and benefits for Members with complex needs and issues. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

Molina Healthcare staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate Specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina Healthcare staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

Continuity of Care

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 Utilization Management 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 Registered Nurses (RNs) 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: (866) 472-4585 **Fax:** (866) 440-9791

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 for all Members experiencing an emergency medical situation.

Molina Healthcare of Florida 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 member within our service area; Molina Healthcare of Florida, 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, we are prepared to authorize treatment to ensure that the patient is stabilized. This function is also performed by our Utilization Management and Nurse Triage Departments

Medical Necessity Standards

Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered to meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Be 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
- Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- Be 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
- Be furnished in a manner not primarily intended for the convenience of the Member the Member's caretaker or the provider

Medically Necessary services furnished in a Hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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.

CareMark Specialty Pharmaceuticals

Molina Healthcare contracts with CareMark Specialty Pharmacy Services 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.

CareMark operates as a business unit within McKesson Health Solutions. Some of the specialty injectable drugs provided by CareMark 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 (866) 472-9512. CareMark 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.

Molina Healthcare of Florida, Inc.
Prior Authorization/Pre-Service Review Guide
Effective 08-01-10

Authorization for elective services should be requested with supporting clinical documentation at least 14 days prior to the requested service. Authorization for emergent services should be requested within one business day. Information generally required to support decision making includes:

-
- ICD-9 and CPT Codes appropriate for the services requested
- Current (up to 6 months), adequate patient history related to the requested services
- Lab or radiology results to support the request (Including previous MRI, CT Lab or X-ray report/results)
- PCP or Specialist progress notes or consultations
- Any other information or data specific to the request

CLAIMS PAYMENT IS CONTINGENT UPON MEMBER ELIGIBILITY FOR DATE OF SERVICE, APPROPRIATE CODING & BENEFIT LIMITATION

Molina Healthcare will process any "non-urgent" request in no more than 14 calendar days of the initial request. "Urgent" requests will be processed within 72 hours of the initial request.

Providers who request prior authorization approval for patient services and/or procedures can 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 physician at (866) 472-4585.

Important Molina Healthcare Numbers and Website

Prior Authorizations (UM): 8:00 am – 5:30 pm
Phone: (866) 472-4585
Fax: (866) 440-9791

Pharmacy Authorizations:
Phone: (866) 472-4585
Fax: (866) 236-8531

Behavioral Health Authorizations: Magellan Health Services:
Phone: (800) 297-7821

Member Customer Service Benefits/Eligibility:
Phone: (866) 472-4585
Fax: (866) 422-6445

Provider Customer Service: 8:00 am – 7:00 pm
Phone: (866) 472-4585
Fax: (866) 422-6445

24 Hour Nurse Advice Line:
English: 1 (888) 275-8750 [TTY: 1-866/735-2929]
Spanish: 1 (866) 648-3537 [TTY: 1-866/833-4703]

Vision Care: March Vision Care:
Phone: (888) 493-4070

DentaQuest: Authorizations
Phone: (888) 696-9541
Fax: (262) 241-7150 or (888) 313-2883

Medical Transportation Management:
(Broward County only)
Phone: (888) 240-6596

Providers may utilize Molina Healthcare's ePortal at www.molinahealthcare.com

Available features include:
- **Authorization submission and status**
- **Claims submission and status** (EDI only)
- **Download Frequently used forms**
- **Member Eligibility**
- **Provider Directory**
- **Nurse Advice Line Report**

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare Members.

<table>
<tr><td colspan="2">For the following programs:
Medicaid</td></tr>
<tr><td>Prior Authorization/Pre-Service Review is required for:</td><td>Prior Authorization/Pre-Service Review is required for:</td></tr>
<tr><td>
• <u>All non-participating providers</u>
• Alcohol and Chemical Dependency Treatment - refer to Magellan Health Services
• Behavioral Health – refer to Magellan Health Services
• C-PAP and Bi-Pap devices
• Chiropractic Care > 24 visits/year < age 21
• Durable Medical Equipment/Medical Supplies: if >$250 reimbursement per line item
• Experimental/investigational services/cosmetic procedures
• Formula & Nutritional Supplements
• Genetic testing and counseling
• Glucometers
• Hearing aids in excess of 1 every 3 years
• Home Healthcare, Home Infusion
• Imaging – CT, MRIs, PET and SPECT
• Injectable drugs Refer to drug formulary for list of injectable medications requiring prior authorization on the Molina website at www.molinahealthcare.com. Go to Florida specific page. (Examples are: Botox, Myozyme, Flolan, Remoudulin, Synagis, Xolair, injectable medications supplied from pharmacies)
</td><td>
• Inpatient Hospitalizations/Surgeries (including Acute Rehab, Skilled Nursing Facility, Observation Stays)
• Negotiated Rates for Ground & Air Transportation
• Neuropsychological testing
• Orthotic and prosthetics: if >$250 reimbursement per line item
• Outpatient Surgery & Procedures in Hospital or Ambulatory Surgery Center (ASC) -
Note: cardiac catheterizations, nerve blocks, sterilizations*, tonsillectomy, adenoidectomy, myringotomy, tympanoplasty, and all endoscopic procedures do not require authorization.
• Pain Management Programs
• Physical/Occupational/Speech Therapy – except for evaluations
• Pregnancy ultrasound > 3 regardless of diagnosis
• All pregnancy transvaginal ultrasounds
• Sleep Studies
• Transplant Evaluation or Procedures
• Unclassified drugs (J3490, J3590, J9999)
• Unlisted procedures
• Voluntary Termination of Pregnancy* (covered only in cases of rape/incest or danger of death to the mother)
</td></tr>
<tr><td colspan="2">• *Sterilizations require consent form signed 30 days prior to surgery.
• *Abortion certificate form must be submitted with the claim.
• *Hysterectomy form must be submitted with the claim.</td></tr>
</table>

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