HEALTHCARE SERVICES (MEDICAL MANAGEMENT)

Molina Healthcare of Ohio's (Molina Healthcare) mission is to provide quality health services to financially vulnerable families and individuals covered by government programs. The key to achieving this objective is having an established medical home for all of our members.

Each Molina Healthcare member has an assigned primary care provider (PCP) who is responsible for providing routine medical care, following up on missed appointments, prescribing diagnostic or laboratory tests and procedures, coordinating referrals and obtaining prior authorization when required.

REFERRALS

Referrals should be 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. Most referrals to in-network specialists do not require an authorization from Molina Healthcare. When referring a patient, the PCP should forward pertinent patient information to the specialist prior to the first visit.

Members may self refer to:

- Emergency departments
- Urgent care facilities
- Qualified Family Planning Providers
- OB/GYNs
- Certified Nurse Midwives
- Certified Nurse Practitioners
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)
- Community Mental Health Centers
- Ohio Department of Alcohol and Drug Addiction Service (ODADAS) providers
- Dental providers
- Vision providers

Members are encouraged to obtain a referral from a PCP for specialty care, other than those listed above.

Specialists may refer members to other specialists or for ancillary services. Referrals and authorizations by specialty providers do not have to be routed back through the PCP; however, specialists should forward information about the member to the PCP when a plan of care has been determined, when treatment has been changed or when treatment has been completed so the PCP is aware of the care the member has received.

PRIOR AUTHORIZATION

Requests for services on the Molina Healthcare prior authorization list are evaluated by licensed nurses and trained staff that have authority to approve services. When requested services cannot be approved, a

Molina Healthcare Medical Director will review the request. Only a Medical Director can issue a denial, except for services denied due to benefit limitations or eligibility.

Prior authorizations are designed to:

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for members receiving services
- Identify care management and disease management opportunities
- Improve coordination of care

Please use the Standardized Prior Authorization Request Forms available at the Ohio Healthcare Home website. http://ohiohealthcarehome.com/providers/links.cfm. Therse standardized forms are accepted by all Medicaid Managed Care Plans in Ohio in order to reduce your administrative burden
You may also use the Molina Healthcare of Ohio Service Request Form for medical requests and the Behavioral Health Prior Authorization Form for behavioral health service requests. The forms are available online at www.MolinaHealthcare.com.

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)
- Provider demographic information (referring physician and referred-to specialist) including Tax ID or NPI numbers.
- 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)
- The number, frequency and duration of visits (outpatient behavioral health)

The history, prior treatment, test results and other information related to the request is required by the medical or behavioral health staff to thoroughly review the request for medical necessity against appropriate criteria, and to assign appropriate codes in the authorization. This also helps to ensure appropriate claim payment.

Eligibility and benefit coverage are verified by the medical or the behavioral health staff at the time the request is reviewed and approved; however, final authorization for claim payment is based on member eligibility and benefit coverage at the time of the service.

Providers should send requests for prior authorization to the Utilization Management Department via the Molina Healthcare website, www.MolinaHealthcare.com, or by telephone, fax, or mail, based on the urgency of the requested service.

Website Submissions

- Log-in to the Web Portal
- Click on Authorization
- Enter the member's name or ID number, and select the member from the query results
- Enter Referred-to Provider. Providers may be searched using the search function. Select the provider to auto-populate the fields.

- Enter the required information
    - Type of request
    - Diagnosis code(s),procedure code(s)
    - Number of visits
    - Submit

Telephone Submissions
1-800-642-4168
8:00 a.m. to 5:00 p.m., Monday through Friday
Voicemail available after business hours. Messages will be returned the next business day.

Fax Submissions
Medical pre-service requests: 1-866-449-6843
Medical admission notification/continued stay review: 1-866-553-9219
Behavioral health requests: 1-866-553-9262

Hard Copy Submissions
Molina Healthcare of Ohio, Inc**.**
Attn: Authorizations
P.O. Box 349020
Columbus, Ohio 43234-9020

To check on the status of an authorization submitted online:

- Log-in to the Web Portal
- Click on Authorization
- Select the search criteria
- Click Search
- Click on View Details

For information about a specific request or to obtain copies of medical necessity criteria used for making a specific utilization management decision:
1-800-642-4168
8:00 a.m. to 5:00 p.m., Monday through Friday
Voicemail available after business hours. Messages will be returned the next business day.

TIMEFRAMES FOR PROCESSING PRIOR AUTHORIZATION REQUESTS

Molina Healthcare will process non-urgent requests as expeditiously as the member's health condition requires, but no later than 14 calendar days of receipt of the request.

Providers may make urgent requests based on the member's health status or condition. A request is considered urgent if delay would seriously jeopardize the member's life, health or ability to maintain or regain maximum function. Urgent requests will be expedited and the decision made as quickly as possible, but no later than 72 hours of receipt of the request.

Members, providers and Molina Healthcare may request an extended timeframe of up to 14 additional days to complete the review. If requested by Molina Healthcare, the request must be submitted to ODJFS for prior approval.

PRE-SERVICE REQUEST DECISIONS

Upon approval, the requestor will receive an authorization number provided by telephone or fax.

If a request is denied, providers are notified by fax within 24 hours of the decision or sooner if necessary due to the member's condition or health status. A copy of the member letter is mailed to the requesting provider simultaneously with the final decision.

ADMISSION AND CONTINUED STAY DECISIONS

Upon approval, the requestor will receive an authorization number provided by telephone or fax
If a request is denied, the requestor will receive a letter explaining the reason for the denial along with information regarding the reconsideration process. Denial information is communicated to the provider by telephone if at all possible and always by fax if contact by telephone was not possible.

Telephonic and fax denial decisions are given within 24 hours of the provider request for approval if adequate clinical information is received to make a decision. The denial letter will be mailed within 3 days of the faxed/telephonic denial notification.

EXTENSIONS OF AUTHORIZATIONS

Once a service has been approved, the specialist or vendor may call Molina Healthcare directly to request an extension of services prior to the service end date. Information required to support the request includes:

- Adequate patient history and physical examination information related to the requested services
- Supporting test results
- Relevant PCP and/or specialist progress notes or consultations
- Any other information to support the requested extension
- For behavioral health services you may use the appropriate section of the Behavioral Health Prior Authorization Form to request an extension.

Availability Of Reviewer

A physician reviewer is available to discuss authorization decisions with providers upon request.
1-800-642-4168
8:00 a.m. to 5:00 p.m., Monday through Friday
Voicemail available after business hours. Messages will be returned the next business day.

APPEALS OF DENIED PRE-SERVICE REQUESTS

Providers dissatisfied with a pre-service authorization decision may appeal that decision on the member's behalf by submitting the following information, in writing, no later than 90 days after the denial decision was made. If the provider appeals a denied pre-service decision, the provider must submit all pertinent information including:

- The denial letter
- Supporting medical records
- Any new information pertinent to the request that was not originally submitted

Submit appeals along with the completed Appeal Representative Form to:

Molina Healthcare of Ohio, Inc.
Attn: Provider Services Department
PO Box 349020
Columbus, Ohio 43234-9020

A copy of the Appeal Representative Form can be found in the Forms section of this manual.

Information about the appeals process is also included in each denial letter and provider appeal response letters, on the remittance advice, and it is described on the Molina Healthcare website.
For more information about appeals, including the claim appeal process, please refer to the Appeals and Grievances (Complaints) section of this manual.

RECONSIDERATIONS OF ADMISSION, DELAY OF SERVICE AND CONTINUED STAY DENIALS

An admission, delay of service or continued stay denial may or may not impact your claim payment. Please submit your reconsideration after you have filed your claim and have received payment.

Providers dissatisfied with a decision may request reconsideration by submitting the following information, in writing, no later than 90 days after the claim payment notification date.
The provider must submit all pertinent information including:

- The original claim and denial letter
- Supporting medical records
- Any new information pertinent to the request that was not originally submitted

Reconsideration requests should be submitted to:

Molina Healthcare of Ohio, Inc.
PO Box 349020
Columbus, Ohio 43234-9020
Attention: Healthcare Services
Medical Necessity Denial Reconsiderations

Information about the reconsideration process is also included in each denial letter.

SECOND MEDICAL/SURGICAL OPINION

Molina Healthcare members may request a second opinion through their assigned PCP or through Molina Healthcare member services. A member services representative will assist the member in coordinating the second opinion request with the PCP or participating specialist.

If the requested second opinion for medically-necessary covered services is not available from a contracted provider, Molina Healthcare will assist in locating the needed service with a non-participating provider at no cost to the member.

AVOIDING CONFLICT OF INTEREST

The Molina Healthcare Healthcare Services Department (UM) affirms that its decision making is based only 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 decisions that result in under-utilization or denial.

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 mental health providers and the PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

POST-STABILZATION SERVICES

Molina Healthcare has designated a telephone line to receive provider requests for coverage of post-stabilization care services. The Molina Healthcare Nurse Advice Line (1-888-275- 8750 or 1-866-648-3537 Español) is available 24 hours a day.

EMERGENCY DEPARTMENT DIVERSION PROGRAM

Molina Healthcare has implemented an Emergency Department Diversion (EDD) Program for members who frequently utilize the emergency department inappropriately. The goal of the program is to direct the member away from episodic care at the emergency department and to reinforce the relationship between the member and the PCP or managing specialist.

The EDD Program:

- Monitors emergency department utilization
- Identifies frequent emergency department utilizers
- Reaches out to high utilizers to reduce avoidable emergency department utilization

Molina Healthcare's EDD Program addresses those emergency department visits which could have been prevented through improved education, health care access, quality or care management approaches. Molina Healthcare encourages members to access primary, specialist and urgent care in the most appropriate settings to minimize frequent, preventable utilization of emergency department services.

There is often an assumption that frequent emergency department visits are solely the result of a preference on the part of the member and that education will remedy the situation; however, it is also important to ensure that a member's frequent emergency department utilization is not due to problems, such as a PCP's lack of accessibility or failure to make appropriate specialist referrals. Therefore, Molina Healthcare's EDD Program also includes the identification of providers who serve as PCPs for a substantial number of frequent emergency department utilizers. Molina Healthcare works with those providers to determine if there are access issues and, if so, develops approaches to addressing them.

Molina Healthcare realizes that this requirement does not replace their responsibility to inform and educate all members about the appropriate use of the emergency department. The Molina Healthcare member handbook clearly educates members on the appropriate use of the emergency department. In addition, Molina Healthcare members may access the Molina Healthcare 24-Hour Nurse Advice Line for assistance with determining the appropriate place for treatment of medical problems.

CARE MANAGEMENT

Molina Healthcare provides a comprehensive Care Management program to all members who meet the criteria for services. Care management focuses on procuring and coordinating the care, services, and resources needed by members with complex health care issues through a continuum of care.

Molina Healthcare adheres to Case Management Society of America (CMSA) Standards of Practice Guidelines for our Care Management Program. Molina Healthcare Care Managers are licensed Registered Nurses and Licensed Social Workers who are educated, trained, and experienced in the care management process.

The services offered by the Molina Healthcare Care Management Team are individualized to accommodate each member's needs with collaboration and approval from the member's PCP. The Molina Healthcare Care Management Team will coordinate services for members who have complex health care needs or difficulty maneuvering through the health care system as evidenced by frequent admissions or inappropriate utilization of services. This may include ongoing medical care, home health care, hospice care, rehabilitation services, and preventive services.

The Molina Healthcare Care Manager is responsible for assessing whether the member is appropriate for the Care Management Program and for notifying the PCP of the evaluation. The PCP is consulted for recommendations for a plan of care. This request by the Care Manager can be made by phone, written request or during a point of care conference at a member office visit where the Care Manager is in attendance. The PCP is encouraged to include the Care Manager in any point of care opportunities with the member in order to provide collaboration in the development of a plan of care and to discuss benefit and resource information. In some cases, it may be appropriate to initiate a standing referral to a specialist who would become the member's managing specialist. This would be initiated in consultation with the member's PCP.

The Care Manager works collaboratively with all members of the health care team, including:

- The PCP
- Hospital UM staff
- Discharge planners
- Specialists
- Ancillary providers
- The local health department and other community resources
- Community Mental Health Centers

REFERRAL TO CARE MANAGEMENT

Members with high-risk medical conditions and special health care needs as evidenced by high utilization of health care services should be referred to the Molina Healthcare Care Management Program. An assessment is completed by a Care Manager within thirty days of identifying the member has a need for care management. Through assessment and evaluation of the individual needs, Molina Healthcare Care Management can provide guidance and assistance in navigating physical, behavioral, and socio-economic delivery systems. The goal of collaboration is to identify the tools and resources needed and arrange for cost effective services provided at the right setting which will help the member regain optimum health.

All providers in the Molina Healthcare network are encouraged to make referrals for care management by contacting Molina Healthcare at 1- 866 -774 -1510 or Fax 1-866-553-9212 or 614-785-0736.

COORDINATION WITH OTHER AGENCIES AND RESOURCES

Molina Healthcare Care Managers coordinate with other support agencies to coordinate interventions, minimize redundancy of activity and reduce confusion for the member. Care Managers will also make referrals to agencies, support groups and community resources for members who may benefit from such services.

PCP/MANAGING SPECIALIST RESPONSIBILITIES IN CARE MANAGEMENT REFERRALS

The PCP is responsible for the provision of preventive services and for the primary medical care of members. The Care Manager will create an initial care plan and will send it to the PCP and/or managing specialist for input. The PCP and managing specialist may provide input at any time while the member is in the care management program. Care Managers will provide PCPs with reports, updates, and information regarding a member's progress through the case management plan. Care Managers are available to accompany members to office visits if the provider and member are in agreement..

CARE MANAGER RESPONSIBILITIES

The Care Manager collaborates with all parties involved to develop a plan of care, which includes a multidisciplinary plan of action, a link to the appropriate institutional and community resources and a statement of expected outcomes.
Additionally the Care Manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource throughout the implementation of the plan and makes revisions to the plan as needed.
- Coordinates education and encourages the member's role in self-help.
- Monitors progress toward achievement of care plan goals to determine an appropriate time for discharge from the Care Management Program.
- Assists in arranging needed services.

DISEASE MANAGEMENT (HEALTH MANAGEMENT)

Molina Healthcare offers a comprehensive Health Management Program for members with the following chronic conditions that have been identified as relevant to our member population.

- Asthma
- Diabetes
- Hypertension
- Coronary Artery Disease
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Pregnancy

The goal of the program is to improve clinical outcomes through continual (rather than episodic) care. The program focuses on enabling our members to manage their symptoms optimally and empower them to share responsibility in their health care by adopting behaviors which may prevent disease and complications.

Members can be referred for disease management program participation from multiple sources, including:

- Claims data
- Pharmacy data
- Lab results
- Member self-referral
- Practitioner referral
- Nurse Advice Line
- Interdepartmental referral

Outreach to members enrolled in disease management includes both educational mailings specific to their condition and telephonic contact from Care Managers. The intensity of outreach increases with the severity of the member’s condition.

Providers are encouraged to make referrals for Health Management programs as appropriate for their patients by contacting Molina Healthcare at 1-800-642-4168.