Molina Healthcare of Iowa, Inc. (MHIA)

Prior Authorization

June 2024

MHIA: Utilization Management Overview

Utilization Management

- A process that evaluates requests for medical and behavioral health services
- Clinical providers send the requests to Molina Healthcare and our clinical team begins the process

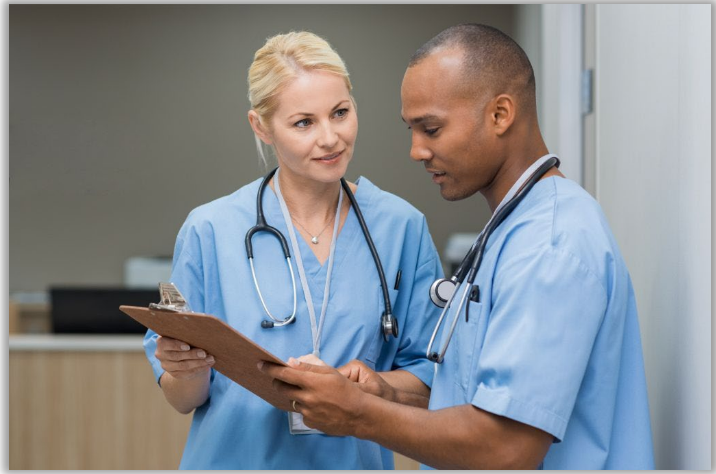
Review process begins with:

- Verification of member eligibility
- Verification of provider contracting status
- Verification of benefit coverage
- Verification of appropriate vendor
- Prior Authorization requirements for the services being requested

Clinical Review Process Includes:

- Evaluation of medical necessity criteria
- Specialist reviews are conducted when appropriate
- All potential denials are reviewed by appropriate health professionals
- For MLTSS: Services determinations are made based on the member's assessed needs and the person-centered service plan

MHIA: Levels of Reviews



Initial Clinical Review: Completed by Registered Nurses

- RN's (Registered Nurses) complete the initial clinical review of service requests
- Our nurses are licensed in the State of Iowa and have both clinical experience as well as experience in medical necessity reviews

Physician Level Review: Completed by our Medical Doctors

- Our Medical Doctors are licensed and board certified in various specialties
- Our Medical Doctors have many years of clinical practice experience in addition to experience evaluating requests for medical necessity reviews
- Our Doctors complete reviews when the Registered Nurse is not able to approve based off initial information.
- This team has access to specialists, as needed, and when needed, will also outreach to the attending clinical provider for additional information

MHIA: Review Criteria Summary

Molina Healthcare utilizes nationally recognized clinical review criteria*.

- **This is based on:**
  - sound medical evidence for making decisions concerning medical necessity;
  - and appropriateness of services.

The appropriate use of criteria is incorporated into all phases of the UM decision making process by licensed staff and Medical Directors.

- **HCS staff follow the appropriate hierarchy of decision according to policy and procedure. The criteria sources used may include:**
  - Federal/State Rules & Guidelines;
  - Pharmacy Guidelines;
  - Technology assessments approved by Federal agencies and Clinical Associations;
  - and MLTSS Assessments.

*MCG Criteria: Magellan Care Guidelines
*ASAM: American Society of Addiction Medicine

MHIA: A Partnership

Our UM and Prior Authorization is built on our partnership and collaboration with clinical providers.

- Our processes are more efficient when we receive:
  - all of the clinical information needed to efficiently and effectively make a decision;
  - timely notice of the request for services;
  - and availability of clinical staff to answer additional questions/provide additional clarification.

Our UM Team is available to answer questions!

- Easiest to reach us through our Provider Relations Contact Center: **(844) 236-1464**
- Our team is available **7:30am to 6pm CST**, Monday through Friday to assist with:
  - ✓ answering questions;
  - ✓ provide guidance;
  - ✓ help schedule a peer-to-peer conversation; and/or
  - ✓ help clinical providers navigate our prior authorization process.