

# **MOLINA<sup>®</sup> HEALTHCARE OF Florida MARKETPLACE**

## **PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE**

### **EFFECTIVE: 07/01/2024**

**REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK UP TOOL/MATRIX FOR  
SPECIFIC CODES THAT REQUIRE AUTHORIZATION  
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT**

**OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS  
DO NOT REQUIRE PRIOR AUTHORIZATION. EMERGENCY SERVICES  
DO NOT REQUIRE PRIOR AUTHORIZATION.**

- **Advanced Imaging and Specialty Tests**
- **All Hospital Outpatient Services (Imaging, Diagnostic procedures, surgical procedures, laboratory, etc.)**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment, Intensive Outpatient above 16 units
  - Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cardiology\***: For adults only, select services are administered by Evolent.
- **Cosmetic, Plastic and Reconstructive Procedures** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment**: Contact Coastal
- **Elective Inpatient Admissions**: Acute Hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing** (Except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)** – Contact Coastal
- **Hyperbaric/Wound Therapy**
- **Inpatient Hospitalization & NICU Admissions including observations:**  
(Except emergency services)
- **Long Term Services and Supports (LTSS)**: Not a covered benefit.
- **Miscellaneous & Unlisted Codes**: Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities**: Except for some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval.
  - Local Health Department (LHD) services;
  - Hospital Emergency services
  - Evaluation and Management services associated with inpatient, ER, and observation stay, or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
  - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23, 24, 51, 52;
  - Other services based on State requirements.
- **Oncology\***: For adults only, select services are administered by Evolent.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures\***
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery\***: For adults only, select services are administered by Evolent.
- **Sleep Studies**
- **Therapy Services at Free standing facility (PT, OT & ST)**: Contact HN1
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation**: All non-emergent transportation.
- **Vision**: Pediatric Low Vision Optical Devices and Services: Please contact VSP (Vision Service Plan) at 1 (800) 877-7195 or visit their website at [www.vsp.com/advantage](http://www.vsp.com/advantage)

<sup>1</sup> Services Provided by Evolent - Cardiology Authorizations for adults 18+ in FL, KY, MI, OH, and WA; Oncology Authorizations for adults 18+ in FL & WA. See below for contact information.

## IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MARKETPLACE PROVIDERS

### Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT, Lab, or X-ray report/results).
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

**The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.**

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax, or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (855) 322-4078.

### Important Molina Healthcare Marketplace Contact Information

Florida (Service hours 8am-5pm local M-F, unless otherwise specified)

#### Prior Authorizations including Behavioral Health

##### Authorizations:

Phone: (855) 322-4078

Fax: (833) 322-1061

##### Vision:

Phone: (800) 877-7195

Website: [www.vsp.com/advantage](http://www.vsp.com/advantage)

##### \*Evolent:

Phone: (888) 999-7713

Cardiology Fax: (877) 370-0963

Medical Oncology Fax: (877) 230-4493

Radiation Oncology Fax: (877) 380-7848

Website: <https://my.newcenturyhealth.com>

#### Progeny Health- NICU Authorizations

Phone: (888) 832-2006

Fax: (866) 365-1062

##### Coastal:

Phone: (855) 481-0505

Fax: (855) 481-0606

#### Pharmacy Authorizations:

Phone: (855) 322-4076

Fax: (866) 236-8531

#### Member Customer Service, Benefits/Eligibility:

Phone: (888) 295-7651/ TTY/TDD 711

#### Radiology Authorizations:

Phone: (855) 714-2415

Fax: (877) 731-7218

##### HN1:

Phone: (888) 550-8800

Fax: (855) 410-0121

#### Transplant Authorizations:

Phone: (855) 714-2415

Fax: (877) 813-1206

#### 24 Hour Nurse Advice Line (7 days/week)

Phone: (888) 275-8750/TTY: 711

Members who speak Spanish can press 1 at the IVR (Interactive Voice Response) prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members.

No referral or prior authorization is needed.

#### Provider Customer Service:

Phone: (855) 322-4078

**Providers may utilize Molina Healthcare's Website at:** <https://provider.molinahealthcare.com/Provider/Login>

Available features include:

- Authorization submission and status
- Member Eligibility
- Provider Directory
- ♦ Claims submission and status
- ♦ Download Frequently used forms
- ♦ Nurse Advice Line Report

## Molina® Healthcare, Inc. – Prior Authorization Request Form

### MEMBER INFORMATION

|                               |                                                                                                                                                                                                                                                             |                                      |                                   |                   |
|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------|-------------------|
| Line of Business:             | <input type="checkbox"/> Medicaid                                                                                                                                                                                                                           | <input type="checkbox"/> Marketplace | <input type="checkbox"/> Medicare | Date of Request:  |
| State/Health Plan (i.e., CA): |                                                                                                                                                                                                                                                             |                                      |                                   |                   |
| Member Name:                  |                                                                                                                                                                                                                                                             |                                      |                                   | DOB (MM/DD/YYYY): |
| Member ID#:                   |                                                                                                                                                                                                                                                             |                                      |                                   | Member Phone:     |
| Service Type:                 | <input type="checkbox"/> Non-Urgent/Routine/Elective<br><input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____<br><input type="checkbox"/> Emergent Inpatient Admission<br><input type="checkbox"/> EPSDT/Special Services |                                      |                                   |                   |

### REFERRAL/SERVICE TYPE REQUESTED

|                                                                                                                                                                                                                                                                                                                                                                                   |                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| Request Type:                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Initial Request | <input type="checkbox"/> Extension/ Renewal / Amendment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Previous Auth#: |
| Inpatient Services:                                                                                                                                                                                                                                                                                                                                                               |                                          | Outpatient Services:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                 |
| <input type="checkbox"/> Inpatient Hospital<br><input type="checkbox"/> Inpatient Transplant<br><input type="checkbox"/> Inpatient Hospice<br><input type="checkbox"/> Long Term Acute Care (LTAC)<br><input type="checkbox"/> Acute Inpatient Rehabilitation (AIR)<br><input type="checkbox"/> Skilled Nursing Facility (SNF)<br><input type="checkbox"/> Other Inpatient: _____ |                                          | <input type="checkbox"/> Chiropractic<br><input type="checkbox"/> Dialysis<br><input type="checkbox"/> DME<br><input type="checkbox"/> Genetic Testing<br><input type="checkbox"/> Home Health<br><input type="checkbox"/> Hospice<br><input type="checkbox"/> Hyperbaric Therapy<br><input type="checkbox"/> Imaging/Special Tests<br><input type="checkbox"/> Office Procedures<br><input type="checkbox"/> Infusion Therapy<br><input type="checkbox"/> Laboratory Services<br><input type="checkbox"/> LTSS Services<br><input type="checkbox"/> Occupational Therapy<br><input type="checkbox"/> Outpatient Surgical/Procedures<br><input type="checkbox"/> Pain Management<br><input type="checkbox"/> Palliative Care<br><input type="checkbox"/> Pharmacy<br><input type="checkbox"/> Physical Therapy<br><input type="checkbox"/> Radiation Therapy<br><input type="checkbox"/> Speech Therapy<br><input type="checkbox"/> Transplant/Gene Therapy<br><input type="checkbox"/> Transportation<br><input type="checkbox"/> Wound Care<br><input type="checkbox"/> Other: _____ |                 |

### PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

**Primary ICD-10 Code:**
**Description:**

| DATES OF SERVICE<br>START | STOP | PROCEDURE/<br>SERVICE CODES | DIAGNOSIS<br>CODE | REQUESTED SERVICE | REQUESTED<br>UNITS/VISITS |
|---------------------------|------|-----------------------------|-------------------|-------------------|---------------------------|
|                           |      |                             |                   |                   |                           |
|                           |      |                             |                   |                   |                           |
|                           |      |                             |                   |                   |                           |

### PROVIDER INFORMATION

#### REQUESTING PROVIDER / FACILITY:

|                      |  |       |                       |        |      |
|----------------------|--|-------|-----------------------|--------|------|
| Provider Name:       |  | NPI#: |                       | TIN#:  |      |
| Phone:               |  | FAX:  |                       | Email: |      |
| Address:             |  | City: |                       | State: | Zip: |
| PCP Name:            |  |       | PCP Phone:            |        |      |
| Office Contact Name: |  |       | Office Contact Phone: |        |      |

#### SERVICING PROVIDER / FACILITY:

|                                    |  |       |  |                            |      |
|------------------------------------|--|-------|--|----------------------------|------|
| Provider/Facility Name (Required): |  |       |  |                            |      |
| NPI#:                              |  | TIN#: |  | Medicaid ID# (If Non-Par): |      |
| Phone:                             |  | FAX:  |  | Email:                     |      |
| Address:                           |  | City: |  | State:                     | Zip: |

#### For Molina Use Only:

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

## Molina® Healthcare, Inc. – BH Prior Authorization Request Form

### MEMBER INFORMATION

|                               |                                                                                                                                                                                                          |                                      |                                   |                   |
|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------|-------------------|
| Line of Business:             | <input type="checkbox"/> Medicaid                                                                                                                                                                        | <input type="checkbox"/> Marketplace | <input type="checkbox"/> Medicare | Date of Request:  |
| State/Health Plan (i.e., CA): |                                                                                                                                                                                                          |                                      |                                   |                   |
| Member Name:                  |                                                                                                                                                                                                          |                                      |                                   | DOB (MM/DD/YYYY): |
| Member ID#:                   |                                                                                                                                                                                                          |                                      |                                   | Member Phone:     |
| Service Type:                 | <input type="checkbox"/> Non-Urgent/Routine/Elective<br><input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____<br><input type="checkbox"/> Emergent Inpatient Admission |                                      |                                   |                   |

### REFERRAL/SERVICE TYPE REQUESTED

|                                                                                                                                                                                                                                                                                                        |                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| Request Type:                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Initial Request | <input type="checkbox"/> Extension/ Renewal / Amendment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Previous Auth#: |
| Inpatient Services:                                                                                                                                                                                                                                                                                    |                                          | Outpatient Services:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                 |
| <input type="checkbox"/> Inpatient Psychiatric<br><input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary<br><br><input type="checkbox"/> Inpatient Detoxification<br><input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary<br><br>If Involuntary, Court Date: _____ |                                          | <input type="checkbox"/> Residential Treatment<br><input type="checkbox"/> Partial Hospitalization Program<br><input type="checkbox"/> Intensive Outpatient Program<br><input type="checkbox"/> Day Treatment<br><input type="checkbox"/> Assertive Community Treatment Program<br><input type="checkbox"/> Targeted Case Management<br><br><input type="checkbox"/> Electroconvulsive Therapy<br><input type="checkbox"/> Psychological/Neuropsychological Testing<br><input type="checkbox"/> Applied Behavioral Analysis<br><input type="checkbox"/> Non-PAR Outpatient Services<br><input type="checkbox"/> Other: _____ |                 |

### PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment:

Description:

| DATES OF SERVICE<br>START | STOP | PROCEDURE/<br>SERVICE CODES | DIAGNOSIS<br>CODE | REQUESTED SERVICE | REQUESTED<br>UNITS/VISITS |
|---------------------------|------|-----------------------------|-------------------|-------------------|---------------------------|
|                           |      |                             |                   |                   |                           |
|                           |      |                             |                   |                   |                           |
|                           |      |                             |                   |                   |                           |

### PROVIDER INFORMATION

#### REQUESTING PROVIDER / FACILITY:

|                      |  |                       |        |      |
|----------------------|--|-----------------------|--------|------|
| Provider Name:       |  | NPI#:                 | TIN#:  |      |
| Phone:               |  | FAX:                  | Email: |      |
| Address:             |  | City:                 | State: | Zip: |
| PCP Name:            |  | PCP Phone:            |        |      |
| Office Contact Name: |  | Office Contact Phone: |        |      |

#### SERVICING PROVIDER / FACILITY:

|                                    |       |                            |                                                               |  |
|------------------------------------|-------|----------------------------|---------------------------------------------------------------|--|
| Provider/Facility Name (Required): |       |                            |                                                               |  |
| NPI#:                              | TIN#: | Medicaid ID# (If Non-Par): | <input type="checkbox"/> Non-Par <input type="checkbox"/> COC |  |
| Phone:                             | FAX:  | Email:                     |                                                               |  |
| Address:                           | City: | State:                     | Zip:                                                          |  |
| For Molina Use Only:               |       |                            |                                                               |  |

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.