Passport Health Plan by Molina Healthcare Marketplace
Prior Authorization/Pre-Service Review Guide
Effective: 01/01/2022

PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Refer To Passport's website or portal 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**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Transitional Substance Abuse Residential Treatment, Day Treatment, Partial Hospitalization.
  - Electroconvulsive Therapy (ECT);
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment**
- **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 mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Support (LTSS):** not a covered benefit.
- **Miscellaneous & Unlisted Codes:** Passport 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 Tests**
- **Non-Par Providers/Facilities:** With the exception of 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 stays;
  - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23 or 24;
  - Other services based on State requirements.
- **Occupational, Physical & Speech Therapy**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies:** Except Home (POS 12) sleep studies
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Vision: Pediatric Low Vision Optical Devices and Services:** Please contact VSP at (800) 877-7195 or visit their website at www.vsp.com/advantage

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Passport Health Plan by Molina Healthcare
Prior Authorization Service Request Form

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Important Information For Passport 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.
- Passport has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (800) 578-0775.

Important Passport Marketplace Contact Information

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

Prior Authorizations including Behavioral Health Authorizations: Phone: (800) 578-0775 Fax: (833) 322-1061	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (844) 800-5154
Pharmacy Authorizations: Phone: (800) 578-0775 Fax: (833) 322-1061	**Vision (VENDOR):** Phone: (800) 877-7195
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Member Customer Service, Benefits/Eligibility:** Phone: (833) 644-1621/ TTY/TDD 711
Provider Customer Service: Phone: (800) 578-0775	**Transplant Authorizations:** Phone: (855) 714-2415 Fax: (877) 813-1206
	24 Hour Nurse Advice Line (7 days/week) Phone: (833) 644-1622/ TTY: 711 Members who speak Spanish can press 1 at the IVR prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members. No referral or prior authorization is needed.

Providers may utilize Passport's Website at: http://www.availity.com/

Available features include:

- Authorization submission and status
- Member Eligibility
- Provider Directory
- Claims submission and status
- Download Frequently used form

Passport Health Plan by Molina Healthcare
Prior Authorization Service Request Form

PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Member Information

Line of Business	☐ Marketplace	Date of Request	
State/Health Plan (i.e. KY):			
Member Name:		DOB (MM/DD/YYYY):	
Member ID#:		Member Phone:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required:** _____ ☐ Emergent Inpatient Admission ☐ EPSTD/Special Services		

Referral/Service Type Requested

Request Type:	☐ Initial Request	☐ Extension/ Renewal / Amendment	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Wound Care
☐ Other Inpatient: _____	☐ Hyperbaric Therapy	☐ Pain Management	☐ Other: _____
	☐ Imaging/Special Tests	☐ Palliative Care	

Please send clinical notes and any supporting documentation

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

Dates of Service Start	Stop	**Procedure/ Service Codes**	**Diagnosis Code**	**Requested Service**	**Requested 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):	☐ Non-Par ☐ COC	
Phone:	Fax		Email:	
Address:		City:	State:	Zip:
For Passport 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.

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BH Prior Authorization Request Form

PASSPORT HEALTH PLAN
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Member Information

Line of Business	☐ Marketplace	Date of Request	
State/Health Plan (i.e. KY):			
Member Name:		DOB (MM/DD/YYYY):	
Member ID#:		Member Phone:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required:** _____ ☐ Emergent Inpatient Admission		

Referral/Service Type Requested

Request Type:	☐ Initial Request	☐ Extension/ Renewal / Amendment	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**	
☐ Inpatient Psychiatric ☐ Involuntary ☐ Voluntary ☐ Inpatient Detoxification ☐ Involuntary ☐ Voluntary If involuntary, Court Date:: _____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____

Please send clinical notes and any supporting documentation

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

Dates of Service Start	Stop	**Procedure/ Service Codes**	**Diagnosis Code**	**Requested Service**	**Requested 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):	☐ Non-Par ☐ COC
Phone:	Fax	Email:	
Address:	City:	State:	Zip:
For Passport 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.