MOLINA® HEALTHCARE OF FLORIDA
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 06/01/2022

REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK-UP TOOL
HTTPS://WWW.MOLINAHEALTHCARE.COM/MEMBERS/FL/EN-US/HEALTH-CARE-PROFESSIONALS/HOME.ASPX OR
MATRIX FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION
HTTPS://WWW.MOLINAHEALTHCARE.COM/PROVIDERS/FL/MEDICAID/FORMS/FUF.ASPX
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 Special Tests (MRIs, CT Scans, PET scans, etc)**
- **All Hospital Outpatient Services (Imaging, Diagnostic procedures, surgical procedures, laboratory, etc)**
- **Allergy Testing (except for specialist – Allergy, Allergy & Inmunology, ENT, Pulmonology)**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial Hospitalization, Day Treatment, Intensive Outpatient, Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
  - Medication Assisted Treatment
  - Psychological Testing
  - Statewide Inpatient Psychiatric Program Services
- **Cosmetic, Plastic and Reconstructive Procedures:**
- **Durable Medical Equipment (for Comprehensive contact Molina, for MMA, Specialty, MKP, and Medicare contact Coastal)**
- **Elective Inpatient Admissions:** Acute Hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Expanded Services for Comprehensive and Specialty Members**
- **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**
- Hearing Aids
- Housing Assistance
- **Home Healthcare Services (including home-based PT/OT/ST) (for Comprehensive contact Molina, for MMA, Specialty, MKP, and Medicare contact Coastal)**
- **Hyperbaric/Wound Therapy**
- **In lieu of Services for Comprehensive and Specialty Members**
- **Inpatient Hospital Services including Observation (**Except Emergency Department Services, Professional fees associated with ER visits and approved services, Local Health Department Services)
- **Long Term Acute Care (LTAC)**
- **Long Term Services & Support (Per State benefit):** All LTSS services require PA regardless of code(s).
- **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:** **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 State mandated services.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures (except for trigger point injections)**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Skilled Nursing Facilities**
- **Therapy Services at Free standing facility (for MMA/Comprehensive, Specialty, MKP, and Medicare contact HN1)**
- **Therapy Services for EIS members**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow:** (Cornea transplant does not require authorization)
- **Transportation Services:** Air transportation
- **Unlisted codes and Miscellaneus codes**

STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with the claim.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE OF FLORIDA 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.

Important Molina Healthcare of Florida Contact Information

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

Prior Authorizations including Behavioral Health Authorizations:
Phone: (855) 322-4076

Fax: (866) 440-9791- Medicaid
(833) 322-1061- Marketplace
(844) 834-2152 - Medicare Inpatient
(844) 251-1450- Medicare Prior Auth

Coastal Care: Phone: (855)-481-0505
Fax: (855)-481-0606

HN1: Phone: (888)-550 8800
Fax: (855)-410-0121

Pharmacy Authorizations (Including J-Codes):
Phone: (855) 322-4076
Fax: (866) 236-8531

Radiology Authorizations:
Phone: (855) 714-2415
Fax: (877) 731-7218

Vision (Managed by iCare):
Phone: (855) 373-7627 Fax: (305) 675-8195

MCG Auto Auth (Advanced Imaging):
https://provider.molinahealthcare.com/Provider/Login

- MCG Website: http://www.mcg.com/
- MCG Phone: 888-464-4746

Provider Customer Service:
Phone: (855) 322-4076

Member Customer Service, Benefits/Eligibility:
Phone: (866) 472-4585/ TTY/TDD 711

Transportation (Managed by A2C):
Phone: (888) 298-4781
Fax: (866) 515-0865

24 Hour Nurse Advice Line (7 days/week)
Phone: (888) 275-8750/ 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.

Transplant Authorizations:
Phone: (855) 714-2415
Fax: (877) 813-1206

Providers may utilize Molina Healthcare's Web Portal 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 form
- Nurse Advice Line Report

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

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e. FL):				
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 ☐ EPSDT/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/Genomic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Other Inpatient:_____	☐ Hyperbaric Therapy	☐ Pain Management	☐ Wound Care
	☐ Imaging/Special Tests	☐ Palliative Care	☐ Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **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 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 Service Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e. FL):				
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 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.