MOLINA HEALTHCARE
MEDICAID PRIOR AUTHORIZATION/PRE-SERVICE
REVIEW GUIDE
EFFECTIVE: 3/1/18

THIS PRIOR AUTHORIZATION/PRE SERVICE GUIDE APPLIES TO ALL MOLINA HEALTHCARE MEDICAID MEMBERS ONLY
REFER TO MOLINA'S PROVIDER 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

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment;
  - Electroconvulsive Therapy (ECT);
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD). (Marketplace Only)

- **Cosmetic, Plastic and Reconstructive Procedures (in any setting).**

- **Durable Medical Equipment:** Refer to Molina's Provider website or portal for specific codes that require authorization.

- **Experimental/Investigational Procedures.**

- **Genetic Counseling and Testing**

- **Home Healthcare and Home Infusion (Including Home PT, OT or ST):** After initial evaluation plus six (6) visits per calendar year.

- **Hyperbaric Therapy.**

- **Imaging, Advanced and Specialty Imaging:** Refer to Molina's Provider website or portal for specific codes that require authorization.

- **Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.

- **Long Term Services and Supports:** All LTSS services require PA regardless of codes. **(per State benefit)**

- **Neuropsychological and Psychological Testing.**

- **Non-Par Providers/Facilities:** Office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency Department Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Professional component services or services billed with Modifier 26 in ANY place of service setting
  - Local Health Department (LHD) services;
  - Women's Health, Family Planning and Obstetrical Services Federally Qualified Health Center (FQHC) Rural Health Center (RHC) or Tribal Health Center (THC)

- **Occupational Therapy**: After initial evaluation plus 36 visits per calendar year for office and outpatient settings.

- **Office-Based Procedures do not require authorization, unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office.**

- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization.
  - Site of Service Authorizations – Some procedures require authorization when performed in an outpatient hospital setting rather than an Ambulatory Surgery Center. Refer to Molina's Provider website or portal for specific codes requiring authorization based on Site of Service

- **Pain Management Procedures:** Refer to Molina's Provider website for specific codes that require authorization. Anesthesia or moderate sedation services associated with pain management procedures are not payable for members over 18 years old. (00300, 00400, 00600, 01935, 01936, 01991, 01992, 99152 and 99153) When billed without a surgical code (10021-69990).

- **Physical Therapy:** After initial evaluation plus 36 visits per calendar year for office and outpatient settings.

- **Prosthetics/Orthotics:** Refer to Molina's Provider website or portal for specific codes that require authorization.

- **Radiation Therapy and Radiosurgery:** Refer to Molina's Provider website or portal for specific codes that require authorization.

- **Sleep Studies:** Refer to Molina's Provider website or portal for specific codes that require authorization.

- **Specialty Pharmacy drugs:** Refer to Molina's Provider website or portal for specific codes that require authorization.

- **Speech Therapy:** After initial evaluation plus six (6) visits for office, outpatient and home settings. Pediatric cochlear implants – allowed up to 36 visits with prior authorization.

- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).

- **Transportation:** non-emergent Air Transport.

- **Unlisted & Miscellaneous 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. Molina requires PA for all unlisted codes except 90999 does not require PA.

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 claim.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICAID 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 the enrollee's 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 1 (888) 898-7969

IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

Prior Authorizations:
8:30 a.m. – 5:00 p.m. Local Time
Phone: 1 (888) 898-7969   Fax: 1 (800)594-7404

Member Customer Service Benefits/Eligibility:
Phone: 1 (888) 898-7969   Fax: 1 (248) 925-1765
TTY/TDD: 1 (800) 649-3777

Behavioral Health Authorizations:
Phone: 1 (888) 898-7969   Fax: 1 (800) 594-7404

NICU Authorizations:
Phone: 1 (855) 714-2415   Fax: 1 (800) 594-7404

Non-NICU OB Authorizations:
Phone: 1 (855) 714-2415   Fax: 1 (844) 861-1930

Pharmacy Authorizations:
Phone: 1 (888) 898-7969   Fax: 1 (888) 373-3059

Radiology Authorizations:
Phone: 1 (855) 714-2415   Fax: 1 (877) 731-7218

Transplant Authorizations:
Phone: 1 (855) 714-2415   Fax: 1 (877) 813-1206

Provider Customer Service:
8:30 a.m. – 5:00 p.m. Local Time
Phone: 1 (855) 322-4077   Fax: 1 (248) 925-1784

24 Hour Nurse Advice Line
English: 1 (888) 275-8750 [TTY: 1 (866) 735-2929]
Spanish: 1 (866) 648-3537 [TTY: 1 (866) 833-4703]

Transportation:
Phone: 1 (866) 712-1063

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
Medicaid Prior Authorization Request
Phone Number: Refer to Number(s) above
Fax Number: Refer to Number(s) above

MEMBER INFORMATION		
Plan:	☐ **Molina Medicaid**	☐ **Other:**
Member Name:		**DOB:** / /
Member ID#:		**Phone:** ( ) -
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*

*Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

REFERRAL / SERVICE TYPE REQUESTED			

Inpatient
☐ Surgical procedures
☐ Admissions
☐ SNF
☐
   LTAC

Outpatient
☐ Surgical Procedure
☐ Diagnostic Procedure
☐ Infusion Therapy
☐ Other: _____

☐ OT ☐ PT ☐ ST
☐ Hyperbaric Therapy
☐ Pain Management

☐ **Home Health**
☐
☐ **DME**
   Wheelchair
☐ **In Office**

Diagnosis Code & Description:	
CPT/HCPC Code & Description:	
Number of visits requested:	DOS From: / / to / /

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:		NPI#:	TIN#:
Servicing Provider or Facility:		NPI#:	TIN#:
Servicing Facility Address:			
Contact at Requesting Provider's office:			
Phone Number: ( ) -		Fax Number: ( ) -	
For Molina Use Only:			