Molina® Healthcare South Carolina Medicaid
Pre-Service Review Guide
Effective: 01/01/2026

Refer to Molina's Provider Website or Prior Authorization Look-Up Tool for specific codes that require Prior 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 (requires notification and concurrent review), Residential Treatment, Partial hospitalization, Day Treatment
  - Intensive Outpatient requires review after 16 units
  - Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cardiology[1]:** Select services are administered by Evolent.
- **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**
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale should be submitted with the prior authorization request.
- **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 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 or 24, 51, 52
  - Other State mandated services
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy**
- **Oncology[1]:** Select services are administered by Evolent.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** Non-emergent air transportation.

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.

[1] **Services provided by Evolent - Cardiology Authorizations for Adults: applies to FL, IA, IL, KY, MI, MS, NV, OH, SC, WA, WI. Oncology Authorizations for Adults: applies to FL, IA, IL, KY, MS, NV, OH, SC, WA.**

IMPORTANT INFORMATION FOR MOLINA 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 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 are typically communicated to the provider electronically and sometimes via fax. 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 MEDICAID CONTACT INFORMATION

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

Prior Authorizations including Behavioral Health Authorizations: Phone: (855) 237-6178	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (844) 800-5154
Pharmacy Authorizations: Phone: (855) 237-6178, option 2	**Dental:** Phone: (888) 307-6552 Website: www.dentaquest.com
Radiology Authorizations: Phone: (855) 714-2415	**Vision:** Phone: (844) 946-2724
Provider Customer Service: Phone: (855) 237-6178 / TTY /TDD: 711	**Member Customer Service, Benefits/Eligibility:** Phone: (855) 882-3901/ TTY/TDD 711
Transportation: Phone: (855) 882-3901	**Transplant Authorizations:** Phone: (855) 714-2415
Evolent: Cardiology and Oncology Authorizations for adults Phone: (888) 999-7713 Portal: https://my.newcenturyhealth.com	**24 Hour Nurse Advice Line (7 days/week)** Phone: (844) 800-5155/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 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. – Pre-Service Request Form