

MOLINA HEALTHCARE MEDICAID/MARKETPLACE PRE-SERVICE REVIEW GUIDE EFFECTIVE: 10/1/22

REFER TO MOLINA’S PROVIDER WEBSITE OR PORTAL FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

OFFICE VISITS OR REFERRALS TO IN NETWORK / PARTICIPATING PROVIDERS DO NOT REQUIRE PRIOR AUTHORIZATION

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| <ul style="list-style-type: none"> ● Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services ● Cardiopulmonary Rehab: PA required after initial (1) visit
Refer to Molina’s Provider website or portal for specific codes that require authorization.
*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): All home healthcare services require PA after initial evaluation plus six (6) visits. ● Hyperbaric Therapy ● Imaging and Specialty Tests ● Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility. ● Neuropsychological and Psychological Testing ● Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stay except for: <ul style="list-style-type: none"> ○ 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) | <ul style="list-style-type: none"> ● Occupational Therapy: After initial evaluation plus 12 visits per calendar year for Medicaid. After initial evaluation plus 12 visits per calendar year (combined benefit with PT and Chiropractic) for Marketplace. ● Outpatient Hospital/ASC Procedures: Refer to Molina’s website or provider portal for a specific list of codes that require PA. ● Pain Management Procedures: Refer to Molina’s website or provider portal for a specific list of codes that require PA. ● Physical Therapy: After initial evaluation plus 12 visits per calendar year for Medicaid. After initial evaluation plus 12 visits per calendar year (combined benefit with PT and Chiropractic) for Marketplace. ● Prosthetics/Orthotics: Refer to Molina’s Provider website or portal for specific codes that require authorization. ● Radiation Therapy and Radiosurgery ● Sleep Studies ● 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. Pediatric cochlear implants – allowed up to 36 visits with prior authorization for Medicaid. After initial evaluation plus 30 visits per calendar year for Marketplace. ● Transplants including Solid Organ and Bone Marrow
*Cornea transplant does not require authorization ● Transportation: Non-Emergent Air.
Marketplace only: Non-Emergent ground transportation. ● 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. ● Urine Drug Testing: After 12 cumulative visits per calendar year for Medicaid only. Please refer to Molina’s provider website or portal for a specific list of codes that require PA. |
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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 (855) 322-4077

MICHIGAN (Service hours 8:00am-5pm local M-F, unless otherwise specified)		
Service	Phone	Fax
Authorizations (Medicaid)	(855) 322-4077	(800) 594-7404
Authorizations (Marketplace)	(855) 322-4077	(833) 322-1061
Imaging Authorizations	(855) 322-4077	(877) 731-7218
Transplant Authorizations	(855) 714-2415	(877) 813-1206
Pharmacy Authorizations	(855) 322-4077	(888) 373-3059
Member Service	(888) 898- 7969 TTY/TDD: 711	
Provider Service	(855) 322-4077	(248) 925-1784
Dental	(800) 327-4462	
Vision (VSP)	(888) 493-4070	
Transportation	(855) 735-5604	
24 Hour Nurse Advice Line (7 days/Week)		
English	1 (888) 275-8750 / TTY: 1 (866) 735-2929	
Spanish	1 (866) 648-3537 / TTY: 1 (866) 833-4703	

Molina Healthcare – 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:				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission <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 <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Other Inpatient: _____	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Imaging/Special Tests	<input type="checkbox"/> Office Procedures <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Laboratory Services <input type="checkbox"/> LTSS Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Outpatient Surgical/Procedures <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Transplant/Gene Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

DATES OF SERVICE		DIAGNOSIS CODES	PROCEDURE CODES	REQUESTED SERVICE	REQUESTED UNITS/VISITS
START	STOP				

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:					

Molina Healthcare – 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:			
Member Name:			DOB (MM/DD/YYYY):
Member ID#:			Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <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 <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary If Involuntary, Court Date: _____	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other: _____	

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION					
Primary ICD-10 Code for Treatment:			Description:		
DATES OF SERVICE		PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
START	STOP				

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:					

Alternative Level of Care Authorization Form

Phone: 866-449-6828

All Lines of Business Fax: (800) 594-7404

Patient Name:		Molina ID:		DOB/Age:	Today's Date:
Molina LOB:		<input type="checkbox"/> Medicare <input type="checkbox"/> MMP / Duals <input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace			
Level of Care Requested Based on InterQual:				<input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> LTACH <input type="checkbox"/> Custodial/Long term care (MMP only) <input type="checkbox"/> Disenrollment request	
• SNF Level 1 (1 discipline – 1-2 hrs/5 days/wk) • SNF Level 2 (4 hrs SN OR 1 discipline 2-3 hrs/5 days/wk) • SNF Level 3 (IV abx, wound) (4 hrs SN AND 1 discipline 2-3 hrs/5 days/wk) • SNF Level 4 (vent/dialysis)					
Nursing Facility Requested:			Hospital:		
Tentative Admission Date:			Hospital Admission Date:		
Facility Contact Information:	CM/RN Name:		Hospital Contact Information:	CM/RN Name:	
	CM/RN Phone:			CM/RN Phone:	
	CM/RN Fax:			CM/RN Fax:	
Active Diagnosis (include ICD10 Codes):			Most Recent Vital Signs:		
1.			BP: _____ T: _____		
2.			P: _____ SpO2: _____		
3.			R: _____ Wt: _____		
Current Clinical Condition:			Past Medical/Surgical History: (Brief, related to current condition):		
Please indicate: • Smoker • Alcohol/Substance Use • DME			Living Arrangements: • Lives alone • Lives with someone • Homeless • Other: _____		
Needs Help With: • Feeding • Toileting • Bathing • Grooming • Meal Preparation • Other: _____					
Prior Level of Functioning before hospitalization: • Independent • Contact Guard • Supervised • Wheelchair bound • Other: _____					
Participation Assistance Required while in SNF/IPR: PT: • Max • Mod • Min • Contact Guard OT: • Max • Mod • Min • Contact Guard ST: • Max • Mod • Min • Contact Guard Ambulation (Current): _____ ft Goal: _____ ft			Daily Participation Level while in hospital: PT: _____ hrs OR _____ min OT: _____ hrs OR _____ min ST: _____ hrs OR _____ min		
IV Medications that will continue post d/c (Must include start/date, dose, frequency):					
Additional Comments:					

****Therapy/Treatment Notes within 4 days of discharge must be included with this request**



Molina Healthcare OB Notification Form

Phone Number: 1-888-898-7969

Fax Number: 844-861-1930 (Routine OB – NON - NICU)

Fax Number: 800-594-7404 (NICU)

***** 1 FORM PER NEWBORN *****

Mother's Information					
Plan	<input type="checkbox"/> Medicaid <input type="checkbox"/> MiChild <input type="checkbox"/> Medicare <input type="checkbox"/> Marketplace				
Mother's Name:			Mother's DOB	/ /	
Mother's ID #:			Mother's Phone:	() -	
Mother's Admit Date:	/ /		Mother's Discharge Date	/ /	
Service Type:	NEWBORN NOTIFICATION		<input type="checkbox"/> NICU NICU Level _____ <input type="checkbox"/> Border Baby Hospital Referred to CSHCS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Newborn Information					
Newborn Name:			Newborn DOB	/ /	
Newborn Admit Date	/ /		Newborn Discharge Date	/ /	
Newborn Admit Date:	From	/ /	TO:	/ /	
Birth Order	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Other _____				
Diagnosis Code & Description:					
Delivery Date:	/ /				
Delivery Type:	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> VBAC <input type="checkbox"/> Repeat C-Section				
Multiples?:	<input type="checkbox"/> No <input type="checkbox"/> Yes Quantity _____				
Baby's Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female				
Baby's Weight:	_____lb _____oz				
Apgar Score:	/				
EDD:	/ /				
Gestation:	_____ wks				
Birth Outcome:	<input type="checkbox"/> Discharge with Mom <input type="checkbox"/> Border Baby <input type="checkbox"/> Going to Foster Care <input type="checkbox"/> Adoption <input type="checkbox"/> Fetal Demise				
Provider Information					
Facility Name			NPI #:		
Attending Provider:			NPI #:		
Contact Information					
Name:					
Phone Number:	() -		Fax Number:	() -	