Molina® Healthcare Medicaid
Prior Authorization/Pre-Service Review Guide
Effective: 01/01/2024

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, Residential Treatment, Partial hospitalization, Day Treatment, Intensive Outpatient above 16 units require notification and subsequent concurrent review
  - Targeted Case Management;
  - Electroconvulsive Therapy (ECT);
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- **Cardiology**
- **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 or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST/SN)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (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 should be submitted with the prior authorization request.
- **Neuropsychological and Psychological Testing** after initial 4 hours of 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 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**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** Non- Emergent: Please contact the local Transportation Manager; Medical Answering Services (All of NY except Nassau or Suffolk County) or ModivCare (Long Island Region); Emergency Transportation is covered by Fee for service by the state.
  * Child Health Plus Emergency transportation services covered by plan.

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 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 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 (877) 872-4716.

IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

(Service hours 8am-6pm local M-F, unless otherwise specified)

Prior Authorizations including Behavioral Health Authorizations: Phone: (877) 872-4716 Fax: (866) 879-4742	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (844) 819-5977
Pharmacy Authorizations: (including J-code requests) Phone: (877) 872-4716 Fax: (844) 823-5479	**Dental:** Phone: (888) 308-2508 Website: www.dentaquest.com
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Vision:** Phone: (866) 819-4298 Website: www.superiorvision.com
Provider Customer Service: Phone: (877) 872-4716	**Member Customer Service, Benefits/Eligibility:** Phone: (800) 223-7242/ TTY/TDD 711
Progeny: (NICU Admissions) Phone: (888) 832-2006 Fax: (833) 734-1510	**Transplant Authorizations:** Phone: (855) 714-2415 Fax: (877) 813-1206
	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.*

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
Your Extended Family.

Molina® Healthcare, Inc. – Pre-Service and Concurrent Review Request Form

Fax completed form with clinical to : 1-866-879-4742
Fax number for Pharmacy J-code requests: 1-844-823-5479

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Essential Plan**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e. CA):				
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	☐ Imaging/Special Tests	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Office Procedures	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Infusion Therapy	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ Laboratory Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health(Short Term) # of visits used to date: _____	☐ LTSS Services (CDPAS/PCS/PDN)	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Occupational Therapy	☐ Transportation(CHP Only)
☐ Other Inpatient:_____	☐ Hyperbaric Therapy	☐ Outpatient Surgical/Procedures	☐ Wound Care
		☐ Pain Management	☐ Other: _____
		☐ Palliative Care	

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/BILLING PROVIDER / FACILITY:

Provider/Facility Name (Required):

NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par** ☐**Continuity of Care (COC)*** **Accepts 100% Medicaid rate** ☐ Yes ☐ No **Out of Network Reason**:_____

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.

- Please refer to the provider manual for definition of Continuity of Care

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MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Essential Plan**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e. CA):				
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 ☐ Inpatient Rehabilitation ☐Stabilization ☐Rehabilitative ☐Reintegration If Involuntary, Court Date:_____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management ☐ Home and Community Based Services- Adult ☐ Home and Community Based Services-Children	☐ 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** ☐**Continuity of Care (COC) *** **Accepts 100% Medicaid rate** ☐ Yes ☐ No **Out of Network Reason**:_____
Phone:	**FAX:**		**Email:**
Address:	**City:**	**State:**	**Zip:**

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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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