Molina Healthcare of New Mexico
Medicaid and Medicare Prior Authorization/Pre-Service Review Guide
Effective: 09/06/2016

Use Clear Coverage for faster turnaround times
Contact Provider Services for details

Referrals to Network Specialists and office visits to contracted (par) providers do not require Prior Authorization

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare Medicaid and Medicare Members – excludes Marketplace

Refer to Molina's website or portal for specific codes that require authorization

Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient and Residential Treatment
  - Treatment Foster Care
  - Group Home
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)**
- **Diapers/Incontinence supplies** (not a Medicare covered benefit)
- **Durable Medical Equipment:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- Medicare Hearing Supplemental benefit: Contact Avesis at 1-800-327-4462
- **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 mandated by state regulations
- **Home Healthcare and Home Infusion:** After initial evaluation plus six (6) visits **
- **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) FacilityLong Term Services and Supports:** Refer to Molina's Provider website or portal for specific codes that require authorization. Not a Medicare covered benefit. **(per state benefit)**
- **Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stays except for:**
  - Emergency Department services
  - Professional fees associated with ER visit, approved Ambulatory Surgery Center (ASC) or inpatient stay
  - Local Health Department (LHD) services
  - Other services based on state requirements
- **Occupational Therapy**: After initial evaluation plus twenty-four (24) visits for office, outpatient and home 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
- **Pain Management Procedures:** except trigger point injections (Acupuncture is not a Medicare covered benefit)
- **Physical Therapy:** After initial evaluation plus twenty-four (24) visits for office, outpatient and home settings. **
- **Pregnancy and Delivery:** notification only
- **Prosthetics/Orthotics:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Radiation Therapy and Radiosurgery (for selected services only):** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Sleep Studies:** (Except Home sleep studies)
- **Specialty Pharmacy drugs (oral and injectable):** 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. **
- **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.

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. (Medicaid benefit only)

**** Please be aware that Alternative Benefit Plan members may have restrictions and/or benefit limitations. Please call Molina Healthcare for additional information.**

MOLINA HEALTHCARE

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICAID and MEDICARE 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 (800) 377-9594 ext. 180284

Important Molina Healthcare Medicaid and Medicare Contact Information

Prior Authorizations: 8:00 a.m. – 5:00 p.m. (Local time, M-F) Toll Free Phone: 1 (877) 262-0187
Medicaid: Fax: 1 (888) 802-5711
Medicare: Fax - Local (505) 924-8258 Toll Free: 1 (855) 278-0310

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

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

Pharmacy Authorizations:
Medicaid:1 (800) 377-9594 ext. 186336
Medicaid Fax: 1 (866) 472-4578
Medicare Phone: 1 (888) 665-1328
Medicare Fax: 1 (866) 290-1309

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

Member Customer Service Benefits/Eligibility:
Medicaid: 1 (800) 580-2811 Fax: (505) 342-0595
Medicare: 1 (866) 440-0127 Fax: 1 (801) 858-0409
TTY/TDD: 1 (800) 346-4128

Behavioral Health Authorizations:
Phone: 1 (855) 315-5677
Toll Free Fax: 1 (888) 295-5494
Local Fax: (505) 924-8237
Secure Email: BHRequests@Molinahealthcare.com

Provider Customer Service: 8:00 a.m. – 5:00 p.m.
Phone: 1 (888) 825-9266

24 Hour Nurse Advice Line
English: 1 (888) 275-8750 [TTY: 1-866/72935-29]
Spanish: 1 (866) 648-3537 [TTY: 1-866/833-4703]

March Vision Care:
Phone: 1 (888) 493-4070 [TTY: 1-877-627-2480]

Dental:
Medicaid (Scion): 1 800-580-2811
Medicare (Avesis): 1 855-214-6779 [TTY: 711]

Transportation:
Medicaid & Medicare: ITM 1 (888)593-2052

Providers may utilize Molina Healthcare's eWeb at:
https://provider.molinahealthcare.com/Provider/Login

Available features include:

- **Authorization submission and status**
- **Claims submission and status**
- **Download Frequently used forms**
- **Member Eligibility**
- **Provider Directory**
- **Nurse Advice Line Report**

Molina Healthcare of New Mexico
Medicaid and Medicare Prior Authorization Request Form
Phone: 1 (877) 262-0187

MEMBER INFORMATION				
Plan:	☐ **Molina Medicaid** **Fax: 1 (888) 802-5711**	☐ **Molina Medicare** **Fax: 1 (505) 924-8258** **Or 1 (855) 278-0310**	**BH Fax: 1 (505) 924-8237** ☐ **or 1 (888) 295-5494** **Secured email BHRequests@Molinahealthcare.com**	
Member Name:			**DOB:**	/ /
Member ID#:			**Phone:**	( ) -
Service Type:	☐Elective/Routine		☐Expedited/Urgent*	

***Definition of Urgent / Expedited 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 (all types) ☐SNF ☐LTAC	**Outpatient** ☐Surgical Procedure ☐OT ☐PT ☐ST ☐Diagnostic Procedure ☐Hyperbaric Therapy ☐Infusion Therapy ☐Other: _____		☐ Home Health ☐ DME ☐ In Office (Non-Par)
Diagnosis Code & Description:			
CPT/HCPC Code & Description:			
Number of visits requested for code:		DOS From / / to / /	
Number of visits requested for code:		DOS From / / to / /	
Number of visits requested for code:		DOS From / / to / /	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:			
Provider/Facility Providing Service:			
Provider/Facility NPI number:			
Contact at Requesting Provider's office:			
Phone Number:	( ) -	Fax Number:	( ) -
For Molina Use Only:			