Molina Healthcare / Molina Medicare of New Mexico
Prior Authorization / Pre-Service Review Guide
Effective: 04/01/2012

This Prior Authorization / Pre-Service Guide applies to all Molina Salud / Molina Medicare Members.

Referrals to Network Specialists do not require Prior Authorization

Authorization required for services listed below.
Pre-Service Review is required for elective services.
Only covered services will be paid

- **All Non-Par providers/services:** services, including office visits, provided by non-participating providers and facilities and labs, except professional services for ER visits, approved Ambulatory Surgical Center or inpatient stays. ER (and related services) visits do not require PA.
- **Alcohol and Chemical Dependency Services***
- **All Inpatient Admissions:** Acute hospital, SNF, Rehab, LTAC, Hospice (notification only)
- **Behavioral Health Services*:** Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), ECT, and > 12 Office Visits/year for adults and 20 Office visits/year for children
- **Cardiac Rehabilitation, Pulmonary Rehabilitation, and**
- **CORF (Comprehensive Outpatient Rehab Facility services)***
- **Chiropractic Services***
- **Cosmetic, Plastic and Reconstructive Procedures in any setting:** which are not usually covered benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, and surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation or dermabrasion, botox injections, etc
- **Dental General Anesthesia:** > 7 years old or per state benefit (Not a Medicare covered benefit)
- **Dialysis:** notification only
- **Diapers, Incontinence Products and Gloves**
- **Durable Medical Equipment/Orthotics/Prosthetics:**
  - >$500 allowed amount per line item or >$2000 total
  - C-PAP and Bi-PAP
  - All customized orthotics, prosthetics, wheelchairs and braces
  - Hearing Aids – including anchored hearing aids (Medicaid only)
  - Medicare Hearing Supplemental benefit: Contact Avesis at (800) 327-4462*
- **Enteral Formulas & Nutritional Supplements**
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing NOT related to pregnancy**
- **Home Healthcare: after 3 skilled nursing visits**
- **Home Infusion**
- **Outpatient Hospice & Palliative Care:** notification only.
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, intimal media thickness testing, three dimensional imaging
- **Neuropsychological Testing and Therapy**
- **Occupational Therapy, Physical Therapy and Speech Therapy after initial eval plus 6 visits. (Home or outpatient setting)**
- **Office-Based Surgical Procedures do not require auth except for Podiatry Surgical Procedures** (excluding routine foot care)
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures: (see attachment for exceptions)****
- **Pain Management Procedures not rendered in conjunction with surgeries: including sympathectomies, neurotomies,** injections, infusions, blocks, pumps or implants, and acupuncture (Not a Medicare covered benefit)
- **Pregnancy and Delivery:** notification only
- **Sleep Studies**
- **All Specialty Pharmacy including, but not limited to:** Hemophilia drugs, Avastin, Enbrel, Lupron, Remicade, Avonex, Interferon, Xolair, Humira, Raptiva, Amevive, Synagis, Synvisc, growth hormone, monoclonal antibody, genomic preparations, etc. (except for specific state regulatory requirements)
- **Solid Organ and Bone Marrow Transplant Services:** including the evaluation (except Cornea transplants)
- **Transportation:** non-emergent ground and air ambulance
- **Unlisted CPT procedures (all),**
- **Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy**

***Medicare only**

** **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:**

The following procedures do NOT require PA if performed in a participating ASC or Outpatient Hospital setting:

Appendectomy	44950, 44970
Abortion Services	59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866
Arteriovenous Fistula	36831, 36832, 36833
Bladder Tumor	52234, 52235, 52240
Blood Patch	62273
Breast Biopsy	19120
Bronchoscopy	31622, 31623, 31624, 31625, 31626, 31627, 31628, 31629, 31630, 31631, 31632, 31633, 31635, 31636, 31637, 31638, 31640, 31641, 31643, 31645, 31646, 31656
Cardiac Cath	93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464, 93530, 93531, 93532, 93533
Cardiovascular Intra-Arterial/Intra-Aortic Catheter	36100, 36120, 36140, 36147, 36148, 36160, 36200, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248. Also please note that the following associated Aortography/Angiography procedures do not require authorization as well: 75600, 75605, 75625, 75630, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, 75724, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75774, 75791
Cataract	66820, 66821, 66830, 66982, 66983, 66984
Cecostomy tube	49442
Cerclage during Pregnancy	59320
Colonoscopy	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392
Cystourethroscopy	52270, 52275, 52276, 52265, 52260, 52000,52001, 52005
Dialation and Curettage	58120, 59812, 59820, 59821
Endometrial/Endocervical Sampling (biopsy)	58100
Gastrostomy Tube	49440, 49450, 43760, 43761, 49460
Gastrostomy Tube to Jejunostomy Tube	49446, 49452
Gastrointestinal Endoscopy	43234, 43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43257, 43258, 43259, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272
Hardware Removal	20680, 20670
Inguinal Hernia	49505, 49507, 49520, 49521, 49525, 49650, 49651
Jejunostomy Tube	49441, 49451
Lacrimal Duct	68811, 68815, 68816
Lap Cholecystectomy	47563, 47564, 47562
Laryngoscopy	31505, 31510, 31511, 31512, 31513, 31515, 31520, 31525, 31526, 31527, 31528, 31529, 31530, 31531, 31535, 31536, 31540, 31541, 31545, 31546, 31560, 31561, 31570, 31571, 31575, 31576, 31577, 31578, 31579
Malignant Lesion	11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11640, 11641, 11642, 11643, 11644, 11646, 17260, 17261, 17262, 17263, 17264, 17266, 17270, 17271, 17272, 17273, 17274, 17276, 17280, 17281, 17282, 17283, 17284, 17286
Orchiopexy	54640
PICC line placement/ replacement	36568, 36569, 36582, 36584, 36589, 36590, 36598
PORT-A-CATH	36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36576, 36578
Sigmoidoscopy	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345
Sterilization*	55250, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58600, 58605, 58611, 58615, 58671, 58940
Tonsillectomy/Adenoidectomy	42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836
TURP	52601, 52630
Tympanoplasty/Myringotomy	69420, 69421, 69424, 69433, 69436, 69631, 69632, 69633, 69635, 69636, 69637, 69641, 69642, 69643, 69644, 69645, 69646

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE/MOLINA MEDICARE

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 or fax. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition.
- Providers 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

Important Molina Healthcare/Molina Medicare Information

Prior Authorizations: 8:00 a.m. – 5:00 p.m.
Salud: Phone: (877) 262-0187 Fax:(888) 802-5711
Medicare: Phone: (888) 825-9266 Fax:(888) 802-5711
Pharmacy Authorizations:
Salud: Phone: (800) 580-2811 Fax:(866) 472-4578
Medicare: Phone: (866) 440-0127 Fax:(866) 450-3914
Behavioral Health Authorizations:
Salud: Phone: (866) 660-7185 Fax: (888) 760-1879
Medicare: Phone: (888) 825-9266 Fax:(888) 802-5711
Member Customer Service Benefits/Eligibility:
Salud: Phone: (800) 580-2811 Fax: (505) 342-0595
Medicare: Phone: (866) 440-0127 Fax: (801) 858-0409
TTY/TDD: (800) 346-4128
Hearing Exam Benefits Medicare: Avesis: Phone: (800) 327-4462

Provider Customer Service: 8:00 a.m. – 5:00 p.m.
Phone: (888) 825-9266 Fax: (505) 342-4711
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]
Vision Care: March Vision Services
Phone: (888) 493-4070
Dental:
Salud: Phone: (800) 580-2811
Medicare: Avesis: Phone: (855) 214-6779
Transportation:
Salud: ITM: Phone: (888) 593-2052
Medicare: Logisticare:
Reservation Phone: (866) 475-5423
Ride Assist Phone: (866) 474-5331

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com
Available features include:

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

Molina Healthcare / Molina Medicare Prior Authorization Request Form

Phone Number: (877) 262-0187
Fax Number: (888) 802-5711

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare** ☐ **Other:**_____

Member's Name:_____ DOB: ____/____/____

Member's ID#:_____ Member Phone #: ___(____)_____

Service Is: ☐ 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 ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Rehab (PT, OT, & ST) ☐ Diagnostic Procedure ☐ Chiropractic ☐ Wound Care ☐ Infusion Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office**

ICD-9 Code & Description: _____

CPT/HCPC Code & Description: _____

Number of visits requested:_____ Date(s) of Service:_____

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name:_____

Facility Providing Service:_____

Contact @ Requesting Provider's: _____

Phone Number: _____ Fax Number: _____

For Molina Use Only:

CARE COORDINATION/CASE MANAGEMENT REFERRAL

Molina Healthcare Toll Free Fax Number (866) 472-4575
Customer Service Toll Free Telephone Number (800) 580-2811

Referral Date:_____

Referral Source:_____Telephone #:_____ Sender's fax #:_____ DOB:_____

Patient Name: _____ Parent Name if Child:_____SS #:_____

Patient Address: _____ Patient telephone #:_____

City: _____County:_____ State: _____ Zip: _____

PCP: _____ PCP telephone #:_____Fax#: _____ OB Provider:_____

Reason for Referral (Be specific; this will help CC/MCM develop the Plan of Care):

To be completed by MHNM CC/MCM

ISHCN Yes No

Level of Risk Stratification: Low Medium High

Is this Member:

Waiver enrolled? Yes No
Waiver Case Manager:_____
Telephone #:_____

CYFD Involved? Yes No
CYFD Case Manager:_____
Telephone #:_____

Targeted Case Management: Yes No

Receiving Special Education? Yes No
School:_____ IEP ☐IFSP ☐ Contact:_____

Currently receiving BH Services? Yes No
If NO:
Does the member require a Mental Health Assessment? Yes No

Created: 12/21/00
Revised: 6/08, 4/10

Disease Management Referral

☐ **Diabetes** ☐ **Asthma** ☐ **Pregnancy** ☐ **Heart Disease**
☐ **Coronary Obstructive Pulmonary Disease (COPD)**

(Referrals for other medical conditions can be made to Care Coordination/Case Management)

Member Information:

Date: _____ Name: _____

ID#: _____ DOB: _____ Telephone: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Primary Care Practitioner (PCP) Information:

Name: _____ Telephone: _____

Clinic/Address: _____

_____

City: _____ State: _____ Zip: _____

Other Information:

Line of business: Molina Salud! _____ Molina SCI_____ Molina UNM SCI _____

Does the member have a Case Manager with another agency/organization? ❒ Yes ❒ No
If yes, with what agency/organization: _____
Name of Case Manager: _____ Telephone:_____

Does the member have a Case Manager with Molina Healthcare? ❒ Yes ❒ No
If yes, with what Department: _____
Name of Case Manager: _____ Telephone:_____

Has Member had any hospitalizations? ❒ Yes ❒ No
If yes, what were the dates? _____

Has Member frequently used the ER? ❒ Yes ❒ No
If yes, what were the dates? _____

List any other co-morbidities: _____

Is the Member compliant (ie. medication or treatment plan)? ❒ Yes ❒ No
Comments: _____

Name of person/agency making this referral: _____
Title: _____ Telephone:_____Fax:_____

Return completed referral to:

Molina Healthcare of New Mexico, Inc.
Disease Management Program
P. O. Box 3887
Albuquerque, New Mexico 87190-9859
In Albuquerque (505)342-4660 ext 182618 or toll free (800) 377-9594 ext 182618
FAX: (877) 553-6508

Revised 2/12

Molina Healthcare of New Mexico
Medication Prior Authorization Request Form

Fax: (866) 472-4578
Toll free telephone: (800) 580-2811

To ensure a timely response, please fill out form completely and legibly.

Date of Request:

MEMBER INFORMATION

Last Name:	First Name:	Date of Birth:
ID Number:		

PROVIDER INFORMATION

Name:	Specialty:
Telephone Number:	Fax Number:

- **Medication Requested** (Include name, strength, directions & quantity):

- **Estimated duration of therapy:**

- **Diagnosis/medical indications for Rx** (Send all pertinent clinical documentation with this fax. Use of pharmaceutical samples cannot be accepted as justification.):

- **Previous formulary medication trials** (Length of treatment/outcome with dates):

☐ **Reauthorization of current medication** (recent clinical documentation required)

For Molina Use Only

☐ Approved ☐ Pending ☐ Denied
Duration _____

Reviewer Comments:

Pharmacy and Therapeutics Committee
Formulary Addition Request Form

Generic name:

Brand name and manufacturer:

Dosage forms and strengths:

Pharmacologic/therapeutic category:

FDA-approved indications:

List the therapeutic advantages of this drug over the formulary drugs in current use for similar conditions:

List the therapeutic disadvantages of this drug over the formulary drugs in current use for similar conditions:

List any safety issues that need to be considered relative to this drug:

Cite or attach published peer-reviewed literature references in support of the above statements:

Which formulary drugs could be deleted in conjunction with the addition?

Date requested: _____ Requested by: _____
(PLEASE PRINT CLEARLY)

Fax to: (866) 472-4578 or call toll free (800) 580-2811

Facet Joint Injections

***(FOR SALUD/SCI REQUESTS ONLY)**
Fax: (888) 802-5711
Phone (505) 342-4660 Ext 180783

INITIATION OF THERAPY (Use this section for NEW requests- Skip to Continuation for follow-up injections.)

Duration of symptoms: _____

Average pain level on a scale of 0 (zero pain) to ten (10) (extreme pain): _____

Conservative treatment:

- **Activity Modification** (please describe activity and dates of treatment)

  Activity: _____

  Activity Dates: _____

- **NSAIDS /Pain Medication** (what medication(s) and treatment dates):

  Medication(s): _____

  Date(s): _____

- **Physical Therapy** (PT) - (please note dates of PT or if contraindicated, why):

  Dates PT completed: _____

- **IF NOT APPLICABLE PLEASE EXPLAIN HERE: _____**

  _____

  _____

Response to diagnostic block(s):

- What percent (%) of symptom or pain relief achieved (using visual analog scale or verbal descriptor scale) within one (1) hour using short acting local anesthetic or two (2) hours with longer-acting anesthetic: _____%

CONTINUATION OF THERAPY (Request for authorization of follow-up injections)

- ❑ Response to diagnostic block(s):
  - What percent (%) of symptom or pain relief achieved (using visual analog scale or verbal descriptor scale) within one (1) hour using short acting local anesthetic or two (2) hours with longer-acting anesthetic: _____%

Please complete (include latest available clinical notes) and fax with your prior authorization request toll free (888) 802-5711.

If you have questions please call (505) 342-4660 extension 180783.

Epidural Steroid Injection

***(FOR SALUD/SCI REQUESTS ONLY)**
Fax: (888) 802-5711
Phone: (505) 342-4660 Ext 180783

INITIATION OF THERAPY (Use this section for NEW requests- Skip to Continuation for follow-up injections)

Is there a documented cervical or lumbar nerve root compression/radiculopathy confirmed by CT, MRI or nerve conduction velocity testing? (please circle) **YES** **NO**

Conservative treatment (If this is not feasible, please explain why below):

- **Activity modification** (please describe activity and dates of treatment)

  Activity: _____

  Activity Dates: _____

- **NSAIDS /Pain Medication** (what medication(s) and treatment dates):

  Medication(s): _____

  Date(s): _____

- **Physical Therapy (PT)** (please note dates of PT or if contraindicated, why):

  Dates PT completed: _____

- **IF NOT APPLICABLE PLEASE EXPLAIN HERE: _____**

  _____

  _____

CONTINUATION OF THERAPY (Request for authorization of follow-up injections)

Response to diagnostic phase or previous injection

Diagnostic Phase: A total of two (2) injections for diagnosis may be given no less than one (1) week apart, preferably two (2) weeks apart. Please note percent (%) symptom or pain relief (using visual analog scale or verbal descriptor scale) and how long this relief lasted.

- Date of last injection: _____
- Percent (%) pain or symptom relief: _____%
- How long did pain or symptom relief last from the date of the last injection? _____

Please complete (include latest available clinical notes) and fax with your prior authorization request toll free (888) 802-5711.

If you have questions please call (505) 342-4660 extension 180783.