Molina Healthcare of Texas
Marketplace Prior Authorization /Pre-Service Review Guide
Effective: January 01, 2021

Refer to Molina's website to view the Prior Authorization (PA) Code Matrix/Look-Up Tool for specific codes that require authorization. Please note the limitations listed on the top of that document. Please also note that prior authorization is not a guarantee of payment for services. Only covered services are eligible for reimbursement. Most out of network provider requests require authorization regardless of service.

Summary of Services that Require Prior Authorization

- **Advanced Imaging and Special Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Transitional Substance Abuse, Residential Treatment, Partial hospitalization
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures**: No PA required with breast cancer diagnoses.
- **Durable Medical Equipment**
- **Elective Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility and NICU.
- **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
- **Healthcare Administered Drugs (oral and injectable)**
- **Home Healthcare and Home Infusion including Home PT, OT or ST:** All home healthcare services require PA after initial evaluation plus six (6) visits per calendar year. (maximum allowed is 60 visits a year for all modalities)
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Support (LTSS):** Not a covered benefit
- **Miscellaneuous and Unlisted 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.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** PA is required for office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency Department and Urgently Needed Services
  - Professional fees associated with ER visit, and approved Ambulatory Surgery Center (ASC) or inpatient stay
  - Local Health Department (LHD) services
  - Other services based on state requirements
  - Radiologists, anesthesiologists, and pathologists' professional services when billed for POS 19, 21, 22, 23 or 24.
  - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting.
- **Observation stays longer than 48 hours**
- **Occupational and Physical Therapy:** PA required after initial evaluation plus 12 visits.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies:** Except Home (POS 12) sleep studies
- **Speech Therapy:** After initial evaluation plus six (6) visits for office, outpatient and home settings.
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization) All transplant related admissions or observation stay require notification, regardless of level of care.
- **Transportation:** All non-emergent transportation.
- **Vision:** Pediatric Low Vision Optical Devices and Services: Please contact VSP at (800) 877-7195 or visit their website at www.vsp.com/advantage

Molina publishes internal pre-authorization screening criteria on its website. Proprietary and copyrighted criteria as applicable to the specific service request is available to providers upon request via fax or phone call.

IMPORTANT INFORMATION -

Preauthorization is a process to determine "medical necessity" or if a service is "medically necessary." This means health care services determined by a provider, in consultation with Molina Healthcare to be clinically appropriate, or clinically significant, in terms of type, frequency, event, site, according to any applicable generally accepted principles and practices of good medical care, or practice guidelines. These guidelines are developed by the federal government, national, or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by Molina Healthcare consistent with such federal, national, and professional practice guidelines, for the diagnosis, or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

Service requests designated urgent or expedited 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 or non-urgent.

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.

Molina's Medical Necessity Screening Criteria is objective; clinically valid; compatible with established principles of health care; and flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

- Cases meeting screening criteria are approved by licensed clinician (nurse/therapist);
- Cases not meeting the screening criteria it will be forwarded to the Medical Director for review.

Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 855-322-4080 or for Advanced Imagining discussion contact our toll-free number: 855-714-2415.

If a covered service is medically necessary, Molina will send written notification regarding the approval of the service. If medical necessity is not established, Molina will send the requesting provider and the member 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 and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition.

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

Important Molina Healthcare Marketplace Contact Information

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

SERVICE AREA	PHONE	FAX	SERVICE AREA	PHONE	FAX
Outpatient Prior Authorizations:	(855) 322-4080	(866) 420-3639	**Member Customer Service Benefits/ Eligibility:**	(888) 560-2025	(800) 735-2989
Inpatient Admission Prior Authorizations:	(855) 322-4080	(833) 994-1960	**Provider Services:**	(855) 322-4080	(281) 599-8916
Behavioral Health Authorizations:	(855) 322-4080	(866) 617-4967	**Vision:** (VSP)	(800) 877-7195	www.vsp.com/advantage
Radiology Authorizations:	(855) 714-2415	(877) 731-7218	**Nurse Advice Line** (24 hours a day, 7 days a week) (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.*		
Transplant Authorizations:	(855) 714-2415	(877) 813-1206			
Pharmacy Authorizations:	(855) 322-4080	(888) 487-9251			