Molina Healthcare of Texas
Medicaid/CHIP Prior Authorization/Pre-Service Review Guide
January 1, 2025

Refer to Molina's website to view the Medicaid Behavioral Health and Medical Prior Authorization (PA) Code Matrix/ Medicaid Prior Authorization Code Matrix for Outpatient Drug Services/Look-Up Tool for specific codes that require authorization and note the limitations listed on the top of that document. Most out of network provider requests require authorization regardless of service. Prior authorization is not a guarantee of payment for services. Only covered services are eligible for reimbursement. Office visits to contracted/participating providers and referrals to network specialists do not require prior authorization. Emergency services do not require prior authorization. Prior authorization for services not currently listed as a Medicaid benefit may be considered for coverage under the case-by-case exception or DME Exceptional Circumstance Provision when prior authorized and medically necessary.

Summary of Services that Require Prior Authorization (PA)

- **Advanced Imaging and Specialty Tests**
- **Anesthesia:**
  - Dental Anesthesia –Medicaid (STAR) child 0-6 years old (Please include DMO Provider Determination Letter)
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment, Intensive Outpatient, Targeted Case Management
  - 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 diagnosis
- **Durable Medical Equipment** requests for services that exceed quantity limits or frequency replacement limits must be submitted for prior authorization.
- **Elective Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facility, All Inpatient Elective Procedures and NICU.
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing**
- **Healthcare Administered Drugs:** Refer to Vendor Drug Program, TX Medicaid Provider Procedures. Claims payment is dependent on valid National Drug Code during claims submission.
- **Home Healthcare and Home Infusion:** Skilled Nursing: No prior authorization required for the initial plus six (6) visits per calendar year. PA required for all subsequent visits.
- **Hyperbaric/Wound Therapy**
- **Inpatient Hospitalization:** (Except emergency and urgently needed services)
- **Long Term Services and Supports (LTSS):** All LTSS Services require PA regardless of code(s)
- **Miscellaneous 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:** 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.
  - Hospital Emergency Services
  - Evaluation and Management services associated with inpatient, ER visits and observation stays
  - Local Health Department (LHD) service
  - Evaluation and Management services associated with inpatient, ER, and observation stays or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
  - Radiologist, anesthesiologist, and pathologist professional services when billed in POS 19, 21, 22, 23 or 24; (except for dental anesthesia for STAR children)
  - Other services based on state requirements
- **Nursing Home/Long Term Care**
- **Nutritional Supplements & Enteral Formulas**
- **Obstetric Admissions for Delivery:** Starting 3/1/2024 No prior authorization required for 3 day vaginal delivery or a 5 day ceasaren delivery; any additional days would need to have a prior authorization for claims payment
- **Occupational and Physical Therapy including Home Health:** No prior authorization required for the initial evaluation per calendar year. PA required for all subsequent visits.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Speech Therapy including Home Health:** For adults no prior authorization required for the initial evaluation per calendar year. Authorization required for all subsequent visits. For ages 20 and under, PA required after initial evaluation.
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization) All transplant related admissions require prior authorization.
- **Transportation:** Non-emergent ambulance (ground and air)

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)

Early Childhood Intervention (ECI): An authorization is not required for therapy listed on the ECI Individual Family Service Plan (IFSP) provided by an ECI provider (for children from birth through 35 months of age).

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 are 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, for Advanced Imagining discussion contact our toll-free number: 855-714-2415, or for Star/StarPlus NICU contact toll-free number: 888-832-2006.

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. Member is notified through written communication of a denial decision within one business day of the decision.

Preauthorization is an approval by Molina that confirms that a requested service has been determined to be Medically Necessary and is covered under the plan. Preauthorization is not a guarantee of payment for services.
Payment is made based upon the following:

- · Benefit limitations;
- · Exclusions;
- · Member eligibility at the time the services are provided; and
- · Other applicable standards during the claim review process.

Pharmaceutical Services
Molina Healthcare has a list of drugs that we will cover. The list is known as the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community. Certain drugs on the Drug Formulary require preauthorization. Molina also has a process to allow you to request and gain access to clinically appropriate drugs that are not covered under the plan. Molina Healthcare may cover specific non-formulary drugs when the prescriber documents in the medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of the Member's disease or condition, or the Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member. The drug formulary which indicates the drugs requiring preauthorization can be found here.

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 Contacts
Hours of Operations Medicaid/CHIP 7:00 a.m. – 6:00 p.m.

Prior Authorizations:
Medicaid/CHIP Phone: 855-322-4080
Outpatient Services Fax: 866-420-3639
Inpatient Admissions Fax: 833-994-1960
LTSS Authorizations: Fax: 866-420-3639
Nursing Facilities (Medicaid/CHIP):
Phone: 855-322-4080 Fax: 866-420-3639

NICU Admissions (Starting 3/4/2024)
CHIP:
Phone: 855-322-4080 Fax: 833-994-1960
Star/Star+Plus:
Phone: 888-832-2006 Fax: 888-358-4011

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

Pharmacy Prior Authorizations:
Medicaid/CHIP Prescription and most Healthcare Administered Drugs Requests:
Phone: 855-322-4080
Fax: 888-487-9251

Behavioral Health Authorizations:
Phone: 866-449-6849 Fax: 866-617-4967

Transplant Authorizations:
Phone: 855-714-2415 Fax: 877-813-1206

STAR+PLUS Service Coordination Line:
Phone: 866-409-0039

24 Hour Nurse Advice Line (24 hours a day, 7 days a week)
Phone: 888-275-8750 or TTY:711
Member who speak Spanish can press 1 at the IVR prompt; the nurse will arrange for an interpreter, as needed, for non-English speaking members.
No referral or prior authorization is needed.

Member Customer Service including Benefits/Eligibility/Prior Authorization Assistance:
Medicaid: 866-449-6849 Fax: 281-599-8916
TTY/TDD: Relay Texas
English: 800-735-2989 OR 711
Spanish: 800-662-4954

Provider Customer Service: 8:00 a.m. – 5:00 p.m.
Phone: 855-322-4080 Fax: 281-599-8916

Vision Care:
VSP
Toll-Free Number: 844-859-5870
https://www.vsp.com/medicaid

Medicaid Dental (VAS):
DentaQuest Phone: (833) 479-0206
Fax: (262) 834-3589

Transportation:
Non-Emergent Medical Transport/Non-Medical Transport (NEMT/NMT)
Access2Care
Medicaid: 866-462-4857
MMP: 866-462-4856