Molina® Healthcare Medicaid Pre-Service Review Guide Effective: 01/01/2025

Refer to Molina's Provider website or Prior Authorization Look-Up Tool for specific codes that require Prior Authorization (PA)
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 requires notification and subsequent concurrent review.
  - Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - Transcranial Magnetic Stimulation (TMS)
  - Presumptive (PA required after 12 tests) and Definitive UA Drug Testing (PA required after 8 tests)
  - Applied Behavioral Analysis (ABA) for treatment of Autism Spectrum Disorder (ASD)
- **Cardiology[1]:** For adults (21 years and older), select services are administered by Evolent.
- **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**
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based Physical Therapy (PT)/ Occupational Therapy (OT)/Speech Therapy (ST))** All skilled nursing home healthcare services require PA after the initial evaluation plus six (6) visits per calendar year. PA after the first episode of MSW per calendar year. HH Aide covered in conjunction with a covered skilled home health service (SN, PT, OT, ST).
- **Hyperbaric/Wound Therapy**
- **Inpatient Hospitalization** (Except Emergency and Urgently Needed Services)
- **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**
  - Psychological testing is limited to twelve units of any combination of CPT® codes 96130, 96131, 96136, 96137, 96138, or 96139 without PA per client, per lifetime
  - Developmental testing after initial 4 units of 96112 and 96113 combined
  - Neuropsych Testing 96132 and 96133
- **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 or 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**
  - OT/PT: No PA required for members 20 years and younger. PA required after the first 12 combined visits for members 21 years and older
  - ST Evaluations:
    - Children (20 and younger): No PA required - Unlimited evaluations
    - Adults (21 and older): PA required after 1 evaluation per calendar year
  - ST Visits:
    - Children (20 and younger): 12 no authorization needed (NAN) visits per calendar year
    - Adults (21 and older): 12 NAN visits for codes 92507/92508 per calendar year, and 6 NAN visits for codes 92526/92609/97129/97130 per calendar year
    - Home Health 12 NAN visits per calendar year
- **Oncology[1]:** For adults (21 years and older), select services are administered by Evolent.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures[1]**
- **Pain Management Procedures:** Except trigger point injections.
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery[1]:** For adults select services are administered by Evolent.
- **Sleep Studies:** Except Home (POS 12) sleep studies.
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** Carved out and managed by Washington State Health Care Authority.

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.

[1] Services provided by Evolent - Cardiology Authorizations for adults 21+ in WA. Oncology Authorizations for adults 21+ in WA. See following page for contact information.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE 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 (425) 398-2603 or toll free (844) 658-8540.

Important Molina Healthcare Medicaid Contact Information	
(Service hours 8 a.m. - 5 p.m. local M-F, unless otherwise specified)	
Prior Authorizations: Phone: (800) 869-7175 Fax: Physical Medicine: (800) 767-7188 Behavioral Health (833) 552-0030	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (800) 869-7175 Fax: (833) 552-0030
Pharmacy Authorizations: Phone: (855) 322-4082 Fax: (800) 869-7791	**Dental:** Managed by DSHS
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Vision:** Phone: (888) 493-4070 Fax: (866) 772-0285
Provider Customer Service: Phone: (855) 322-4082 Fax: (877) 814-0342	**Member Customer Service, Benefits/Eligibility:** Phone: (800) 869-7185/ TTY: 711 Fax: (800) 816-3378
Transportation: Managed by HCA	**Transplant Authorizations:** Phone: (855) 714-2415 Fax: (877) 813-1206
New Century Health (NCH): Cardiology and Oncology Authorizations for adults. Phone: (888) 999-7713 Website: my.newcenturyhealth.com	**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:
provider.MolinaHealthcare.com/Provider/Login

Available features include:

- Authorizations submission and status
- Member Eligibility
- Provider Directory
- Claims submission and status
- Download frequently used forms
- Nurse Advice Line Report

Molina® Healthcare, Inc. - Pre-Service Request Form

Member Information

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (e.g.,WA):				
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone:**	

Service Type:
- ☐ Non-Urgent/Routine/Elective
- ☐ Urgent/Expedited – **Clinical Reason for Urgency Required** _____
- ☐ EPSDT/Special Services

Referral/Service Type Requested

Request Type: ☐ **Initial Request** ☐ **Extension / Renewal / Amendment** **Previous Auth#:**

Inpatient Services:
- ☐ Inpatient Hospital
- ☐ Inpatient Transplant
- ☐ Inpatient Hospice
- ☐ Long Term Acute Care (LTAC)
- ☐ Acute Inpatient Rehabilitation (AIR)
- ☐ Skilled Nursing Facility (SNF)
- ☐ Other Inpatient: _____

Outpatient Services:
- ☐ Chiropractic
- ☐ Dialysis
- ☐ DME
- ☐ Genetic Testing
- ☐ Home Health
- ☐ Hospice
- ☐ Hyperbaric Therapy
- ☐ Imaging/Special Tests
- ☐ Office Procedures
- ☐ Infusion Therapy
- ☐ Laboratory Services
- ☐ LTSS Services
- ☐ Occupational Therapy
- ☐ Outpatient Surgical/Procedures
- ☐ Pain Management
- ☐ Palliative Care
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Radiation Therapy
- ☐ Speech Therapy
- ☐ Transplant/Gene Therapy
- ☐ Transportation
- ☐ Wound Care
- ☐ Other: _____

PLEASE send clinical notes and any supporting documentation

Primary ICD-10 Code: **Description:**

Dates of Service Start	Dates of Service 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**	☐ **COC**
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.