MOLINA® HEALTHCARE MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 07/01/2020

REFER TO MOLINA'S PROVIDER WEBSITE OR PORTAL FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION
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.

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment, IOP
  - UDT (once 12 units of definitive testing and 24 units of presumptive testing have been reached annually)
  - Electroconvulsive Therapy (ECT);
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting).** No PA Required with breast CA Dx. (Z85.3)
- **Durable Medical Equipment**
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing**[1] (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 Services (including home-based OT/PT/ST)** All home healthcare services require PA after initial evaluation plus six (6) visits per calendar year.
- **Hyperbaric Therapy**
- **Imaging and Specialty Tests**[1]
- **Elective Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **Long Term Services and Supports (per State benefit).** All LTSS services require PA regardless of code(s).
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** PA is required for office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency and Urgently Needed Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Local Health Department (LHD) services;
  - Radiologists, anesthesiologists, and pathologist professional services when billed for POS 19, 21, 22, 23 or 24
- **Non-Par Providers/Facilities (continued):**
  - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting.
  - Other services based on State Requirements.
- **Occupational & Physical Therapy**: After initial evaluation plus twenty-four (24) visits per calendar year for office and outpatient settings for each specialty.
- **Office-Based Procedures do not require authorization, unless specifically included in another category that requires authorization even when performed in a participating provider's office**
- **Referrals required for certain specialty services in FL ONLY (i.e. from PCP to specialist)**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures.** (Except trigger point injections).
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery (for selected services only).**[1]
- **Sleep Studies** (Except Home (POS 12) sleep studies)[1].
- **Healthcare Administered drugs**
- **Speech Therapy:** After initial evaluation plus six (6) visits for office and outpatient settings.
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** Non emergent air transportation.
- **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.

[1]**Services provided by eviCore apply to IL/MI/NY/OH/WI only. See below 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 (888) 999-2404

Important Molina Healthcare Medicaid Contact Information

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

SERVICE AREA	PHONE	FAX	SERVICE AREA	PHONE	FAX
Prior Authorizations	(855) 326-5059	(877) 708-2117	**Pharmacy Authorizations**	(800) 947-9627	
Member Customer Service Benefits/ Eligibility	(888) 999-2404	(414) 214-2489	**Provider Services**	(855) 326-5059	(877) 708-2117
Behavioral Health Authorizations	(855) 326-5059	(877) 708-2117	**Dental**	(888) 999-2404	
eviCore Services	(888) 333-8144	(800) 540-2406	**Transportation**	(866) 907-1493	
Transplant Authorizations	(855) 714-2415	(877) 813-1206	**Vision**	(414) 760-7400	(414) 462-3103
			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.*		

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

Available features include:

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

Molina® Healthcare - Medicaid
Prior Authorization Request Form
Refer to Contact/FAX Numbers above

MEMBER INFORMATION			
State/Plan:		☐ **Other:**	
Member Name:		**DOB:**	/ /
Member ID#:		**Phone:**	( ) -
Service Type:	☐Elective/Routine	☐Expedited/Urgent*	

***Definition of Expedited/Urgent service request designation is when the treatment requested 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 should be submitted as routine/non-urgent.**

REFERRAL/SERVICE TYPE REQUESTED		
Inpatient ☐Surgical procedures ☐Admissions ☐SNF ☐LTAC	**Outpatient** ☐Surgical Procedure ☐OT ☐PT ☐ST ☐Diagnostic Procedure ☐Hyperbaric Therapy ☐Infusion Therapy ☐Pain Management ☐Other: _____	☐ Home Health ☐ DME ☐ Wheelchair ☐ In Office

Diagnosis Code & Description:			
CPT/HCPC Code & Description:			
Number of visits requested:		DOS From: / / to / /	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION					
Requesting Provider Name:		NPI#:		TIN#:	
Servicing Provider or Facility Name:		NPI#:		TIN#:	
Contact at Requesting Provider's office:					
Provider Phone Number:	( ) -	Provider Fax Number:	( ) -		
For Molina Use Only:					

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.