

**MOLINA[®] HEALTHCARE MEDICARE
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2022**

FOR DUAL MEMBERS WITH MEDICAID, PLEASE REFER TO YOUR STATE MEDICAID PA GUIDE FOR ADDITIONAL PA REQUIREMENTS

**REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK-UP TOOL/MATRIX FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT**

OFFICE VISITS TO CONTRACTED/PARTICIPATING PRIMARY CARE PROVIDERS DO NOT REQUIRE PA.

OFFICE VISITS TO NETWORK SPECIALISTS DO NOT REQUIRE A REFERRAL FROM A PARTICIPATING PRIMARY CARE PROVIDER.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
 - Inpatient, Partial hospitalization;
 - Electroconvulsive Therapy (ECT).
- **Chiropractic Care²**
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment & Medical Supplies**
- **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**
 - For Medicare Part B drug provider administered drug therapies, please direct Prior Authorization requests to Novologix via the Molina Provider Portal. You may also fax in a prior authorization at 800-391-6437.
- **Hearing Aids**
 - Benefit is only available from HearUSA participating providers, Contact HearUSA at (855) 823-4632 to schedule. Hearing aids require prior authorization.
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (LTSS):** Not a Medicare covered benefit*. (*Per State benefit if MMP)
- **Miscellaneous & 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.
 - Local Health Department (LHD) services;
 - Hospital Emergency Services;
 - Evaluation and Management services associated with inpatient, ER, and observation stays
 - Dialysis when temporarily absent from service area;
 - Ambulance services dispatched through 911;
 - Radiologists, anesthesiologists, and pathologists' professional services when billed in 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.
- **Occupational, Physical, & Speech Therapy:** PA required after Medicare therapy benefit threshold (\$2,150 for PT & ST combined and \$2,150 for OT) has been reached for office and outpatient settings.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures; including acupuncture¹**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Supervised Exercise Therapy (SET)**
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services :** non-emergent air transportation.

¹ Acupuncture services provided by American Specialty Health (ASH) in applicable states. Applies to Molina Medicare Plans in the following states (FL/ID/IL/NM/ OH (D-SNP Only)/SC/TX/UT/WA/WI) See below for contact information. Contact plan directly to determine if supplemental acupuncture benefits are covered.

² Chiropractic services provided by American Specialty Health (ASH) in applicable states. Applies to all Molina Medicare Plans (ID/NM/ OH (D-SNP only)/SC (D-SNP only)/TX/UT/WA) See below for contact information.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICARE 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.

IMPORTANT MOLINA HEALTHCARE MEDICARE CONTACT INFORMATION

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

IP Authorizations, including Behavioral Health

Phone: (855) 326-5059
Fax: (844) 834-2152

24 Hour Behavioral Health Crisis (7 days/week):

Phone: (888) 275-8750/TTY: 711

Prior Authorizations, including Behavioral Health

Phone: (855) 326-5059
Fax: (844) 251-1450

**Imaging & Special Tests:
(MRI, CT, PET, Ultrasounds, Cardiac imaging)**

Phone: (855) 714-2415
Fax: (877) 731-7218

Pharmacy Authorizations:

Phone: (855)-315-5663
Fax: (866) 290-1309

Dental (Delta Dental)

Phone: (888) 818-7932

Vision (March Vision Care):

Phone: (855) 516-2724
TTY: 711 or (877) 627-2456

Hearing (HearUSA)

Phone: (800) 442-8231

Transplant Authorizations:

Phone: (855) 714-2415
Fax: (877) 813-1206

Provider Customer Service:

Phone: (855) 326-5059

Member Customer Service, Benefits/Eligibility:

Phone: (855) 315-5663 / TTY/TDD 711

Transportation:

Phone: (888) 616-4841 TTY: 711

¹American Specialty Health (ASH):

Phone: (888) 979-2746
Fax: (877) 304-2746
Web www.ASHLink.com
P.O. Box 509001
San Diego, CA 92150-9001

24 Hour Nurse Advice Line (7 days/week)

No referral or prior authorization is needed

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.

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

Available features include:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Authorization submission and status • Member Eligibility • Provider Directory | <ul style="list-style-type: none"> ■ Claims submission and status ■ Download Frequently used forms ■ Nurse Advice Line Report |
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Molina® Healthcare, Inc. – Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission <input type="checkbox"/> EPSDT/Special Services			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Other Inpatient: _____	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Imaging/Special Tests	<input type="checkbox"/> Office Procedures <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Laboratory Services <input type="checkbox"/> LTSS Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Outpatient Surgical/Procedures <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Transplant/Gene Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code:	Description:			
DATES OF SERVICE START	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:
PCP Name:			PCP Phone:		
Office Contact Name:			Office Contact Phone:		
SERVICING PROVIDER / FACILITY:					
Provider/Facility Name (Required):					
NPI#:		TIN#:		Medicaid ID# (If Non-Par):	
				<input type="checkbox"/> Non-Par <input type="checkbox"/> 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.

Molina® Healthcare, Inc. – BH Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary If Involuntary, Court Date: _____	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other: _____	

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment:

Description:

DATES OF SERVICE START	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):	<input type="checkbox"/> Non-Par <input type="checkbox"/> 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.