Molina Healthcare of Illinois, Inc. FIDE D-SNP
Prior Authorization/Preservice Review Guide
Effective: 01/01/2026

****FOR DUAL-ELIGIBLE MEMBERS WITH MEDICAID, PLEASE REFER TO THE MEDICAID PA GUIDE FOR ADDITIONAL PA REQUIREMENTS****

REFER TO MOLINA'S PROVIDER WEBSITE/PRIOR AUTHORIZATION LOOKUP TOOL FOR SPECIFIC CODES THAT REQUIRE PRIOR 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 REQUIRE NOTIFICATION, NOT PRIOR AUTHORIZATION.

- **Advanced Imaging and Special Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Partial hospitalization (requires notification and concurrent review)
  - Intensive Outpatient requires review above 16 units
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cardiology[1]:** Select services are administered by Evolent (NCH).
- **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**
  - For Medicare Part B drug provider-administered drug therapies, please direct requests to Novologix via the Availity Essentials Provider Portal. You may also fax a request to (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):** Prior Authorization required after the first three 30-day episodes of care per calendar year.
- **Hyperbaric/Wound Therapy**
- **Long-Term Services and Supports (LTSS):** Not a Medicare-covered benefit*. **(*Per state benefit for dual benefit members.)**
- **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.
- **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 requires approval. Exceptions include:**
  - 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, 23, 31, 32, 33, 51, 52, 61);
  - Dialysis when temporarily absent from service area;
  - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23, 24, 51, 52;
  - 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 12 visits of each discipline
- **Oncology[1]:** Select services are administered by Evolent.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery[1]:** Select services are **administered** by Evolent.
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** Non-emergent air transportation.

[1] Services provided by Evolent (NCH): Cardiology Authorizations for Adults applies to IL, MI. Oncology Authorizations for Adults applies to CT, IL.

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.

Information generally required to support Home Health authorization decision-making includes:

- Signed MD order
- Supporting clinical documentation from the certifying physician and
- A plan of care

Information generally required to support Durable Medical Equipment (DME) authorization decision-making includes:

- Signed MD order
- An itemized quote, and
- An assessment

Information generally required to support Therapy Services (PT, OT, OR ST) authorization decision-making includes:

- Signed MD order
- A therapy evaluation and
- Concurrent evaluations

Information generally required to support Behavioral Health authorization decision-making includes:

- A recent evaluation
- A treatment plan for the requested services

Information generally required to support Ablation/Ligation/Vein Stripping and Sclerotherapy authorization decision-making includes:

- Patient evaluation and complaints
- Diagnosis studies (ultrasound or other imaging test) with results:
- Documentation of vein size and reflux (if applicable)
- Documentation of presence or absence of Deep vein thrombosis (DVT), aneurysm, and or tortuosity
- Conservative treatment(s) tried and duration
- Documentation of pulses
- Treatment plan (include which extremity and vein will be treated)

Information generally required to support Bariatric Surgery authorization decision-making includes:

- Patient evaluation with recent Surgeon's notes:
- Weight, height, BMI
- Past Medical History (Comorbidities)
- Previously unsuccessful with medical treatment for obesity (Patient has tried and has failed to achieve and maintain sufficient weight loss with nonsurgical treatment, including participation in a structured diet program)
- Member is willing to participate and adhere to postoperative instructions

- Patient is appropriate psychological/psychiatric candidate for bariatric surgery (Preoperative Psychological/Psychiatric Evaluation)
- Surgeon Qualifications
- Plan of care

Information generally required to support External Defibrillator authorization decision-making includes:

- Physician order/prescription
- Evaluation and clinical notes, including, but not limited to:
  - Cardiac history (history of cardiac arrest/Ventricular fibrillation or ventricular tachyarrhythmia
  - Familial or inherited conditions
  - History of either prior myocardial infarction or dilated cardiomyopathy, and a measured left ventricular ejection fraction
  - History of a previously implanted defibrillator
  - Coronary artery disease with a documented prior myocardial infarction with a measured left ventricular ejection fraction
  - Beneficiaries with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI)
  - Beneficiaries with nonischemic dilated cardiomyopathy
  - NYHA Class
  - Implantation surgery is contraindicated

Information generally required to support Pneumatic Compressor authorization decision-making includes:

- Physician order/prescription
- Clinical documentation supporting member's diagnosis (Lymphedema/Chronic Venous Insufficiency)
- Symptoms and objective findings, including measurements that establish severity of condition
- A four-week trial of conservative therapy
- Previous treatments (including dates of trial and response to treatment)
- Plan of care, including the reason device is required

Information generally required to support injection authorization decision-making includes:

- Physician order/prescription
- History of lumbar, cervical, and/or thoracic radiculopathy
- History on physical examination and imaging that supports pain due to 1 of the following: Disc herniation, post-laminectomy syndrome, or acute herpes zoster.
- Documentation of pain severe enough to impact quality of life or function and assessed prior to the initial and subsequent injections and at each follow-up
- Documentation of pain with a duration of at least 4 weeks with failure of, or inability to tolerate, noninvasive conservative care.
- Documentation of response to previous injection, if applicable

Information generally required to support Hospital Beds authorization decision-making includes:

- Physician order/prescription
- Documentation showing:
- Condition requires body positioning that cannot be accomplished in ordinary bed
- Condition requires elevation of head of bed due to respiratory issues or risk for aspiration, and pillows and wedges are not sufficient
- Condition requires special equipment that necessitates hospital bed use (e.g., traction equipment)
- Patient/caregiver functional status

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 are also 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 by calling (800) 665-3086.

Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician.

IMPORTANT MOLINA HEALTHCARE CONTACT INFORMATION

Service hours 8 a.m. to 5 p.m. Central Time, Monday through Friday, unless otherwise specified.

Prior Authorizations, including Behavioral Health Availity Essentials Portal provider.molinahealthcare.com	**Provider Services** Phone: (855) 866-5462
Pharmacy Authorizations Part D Fax: (866) 290-1309 J Codes Fax: (800) 391-6437	**Member Services** Phone: (833) 306-3394 or TTY 711
Dental (SKYGEN): Phone: (262) 946-4400 Website: SKYGEN Dental Hub	**Vision (VSP Vision):** Phone: (800) 742-6907, option 3 Website: Be a VSP Doctor
Non-Emergent Transportation (MTM): Phone: (844) 644-6354 Fax: (877) 406-0658	**Healthmap** Chronic Kidney Care Phone: (877) 546-7004
Evolent/New Century Health (NCH) Cardiology and Oncology Authorizations for Adults Phone: (888) 999-7713 Website: my.newcenturyhealth.com	**24-Hour Nurse Advice Line (24/7 year-round)** Phone: (888) 275-8750 or TTY 711 Members who speak Spanish can press 1 at the prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish-speaking members. No referral or prior authorization is needed.
24-Hour Behavioral Health Crisis Line (24/7 year-round) Phone: (833) 657-1982 or TTY 711 No referral or prior authorization is needed.	**National Suicide Lifeline (24/7 year-round)** Phone: 988 No referral or prior authorization is needed.

Providers are strongly encouraged to utilize Molina Healthcare's portal: provider.molinahealthcare.com

Among the many available features are:

- Authorization submission and status
- Member Eligibility
- Provider Directory
- Digital Correspondence Hub
- Claims submission and status
- Download Frequently used forms
- Nurse Advice Line Report
- Much More

Molina Healthcare, Inc. FIDE D-SNP

MEDICAL Preservice and Concurrent Review Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **D-SNP**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e., IL):	ILLINOIS			
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency (**Required**):_____ ☐ Emergent Inpatient Admission – **Date of Admission**: _____ ☐ Special Services			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/Renewal/Amendment**	**Previous Auth No.:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Laboratory Services	☐ Physical Therapy
☐ Inpatient Transplant	☐ Dialysis	☐ LTSS Services	☐ Radiation Therapy
☐ Inpatient Hospice	☐ DME	☐ Occupational Therapy	☐ Speech Therapy
☐ Long-Term Acute Care (LTAC)	☐ Genetic Testing	☐ Outpatient Procedures	☐ Transplant/Gene Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Pain Management	☐ Transportation
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Palliative Care	☐ Wound Care/Hyperbaric
☐ Other Inpatient:_____	☐ Imaging/Special Tests	☐ Pharmacy/Infusion Therapy	☐ Other: _____

CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION ARE REQUIRED TO REVIEW FOR MEDICAL NECESSITY (100 pages or less)

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

Dates Of Service Start	Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

GROUP/FACILITY:

Name:		**NPI:**	**TIN:**	
Phone:	**Fax**:		**Email**:	
Address:		**City:**	**State:**	**ZIP:**
PCP Name:		**PCP Phone**:		
Office Contact Name:		**Office Contact Phone**:		
		Office Contact Fax:		

RENDERING/SERVICING PROVIDER:

Name:				
NPI:	**TIN:**	**Medicaid ID (If Non-Par):**	☐**Non-Par** ☐**COC**	
Phone:	**FAX:**		**Email:**	
Address:		**City:**	**State:**	**ZIP:**

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.

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BEHAVIORAL HEALTH Preservice and Concurrent Review Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **D-SNP**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e., IL):	ILLINOIS			
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____ ☐ Emergent Inpatient Admission			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/Renewal/Amendment**	**Previous Auth No.:**

Inpatient Services:	**Outpatient Services:**	
☐ Inpatient Psychiatric ☐Involuntary ☐Voluntary ☐ Inpatient Detoxification ☐Involuntary ☐Voluntary If Involuntary, Court Date:_____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____

CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION ARE REQUIRED TO REVIEW FOR MEDICAL NECESSITY (100 pages or less)

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

Dates Of Service Start	Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

GROUP/FACILITY:

Provider Name:	**NPI:**	**TIN:**	
Phone:	**Fax**:	**Email**:	
Address:	**City:**	**State:**	**ZIP:**
PCP Name:	**PCP Phone**:		
Office Contact Name:	**Office Contact Phone**:		
	Office Contact Fax:		

RENDERING/SERVICING PROVIDER:

Name:				
NPI:	**TIN:**	**Medicaid ID (If Non-Par):**	☐**Non-Par** ☐**COC**	
Phone:	**FAX:**	**Email:**		
Address:	**City:**	**State:**	**ZIP:**	

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.