MOLINA HEALTHCARE
MEDICAID/MARKETPLACE PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 10/1/19

THIS PRIOR AUTHORIZATION/PRE-SERVICE GUIDE APPLIES TO ALL MOLINA HEALTHCARE MEDICAID MEMBERS ONLY
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

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment;
  - Electroconvulsive Therapy (ECT);
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD). (Marketplace Only)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting).**
- **Durable Medical Equipment:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Experimental/Investigational Procedures.**
- **Genetic Counseling and Testing**
- **Home Healthcare and Home Infusion (Including Home PT, OT or ST):** All home healthcare services require PA after initial evaluation
- **Hyperbaric Therapy.**
- **Imaging, Advanced and Specialty Imaging:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **Long Term Services and Supports:** All LTSS services require PA regardless of codes. **(per State benefit)**
- **Neuropsychological and Psychological Testing.**
- **Non-Par Providers/Facilities:** Office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency Department Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Professional component services or services billed with Modifier 26 in ANY place of service setting
  - Local Health Department (LHD) services;
  - Women's Health, Family Planning and Obstetrical Services
  - Federally Qualified Health Center (FQHC) Rural Health Center (RHC) or Tribal Health Center (THC)
- **Occupational Therapy**: After initial evaluation plus 36 visits per calendar year for office and outpatient settings.
- **Office-Based Procedures do not require authorization, unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office.**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization.
  - Site of Service Authorizations – Some procedures require authorization when performed in an outpatient hospital setting rather than an Ambulatory Surgery Center. Refer to Molina's Provider website or portal for specific codes requiring authorization based on Site of Service
- **Pain Management Procedures:** Refer to Molina's Provider website for specific codes that require authorization. Anesthesia or moderate sedation services associated with pain management procedures are not payable for members over 18 years old. (00300, 00400, 00600, 01935, 01936, 01991, 01992, 99152 and 99153) When billed without a surgical code (10021-69990).
- **Physical Therapy:** After initial evaluation plus 36 visits per calendar year for office and outpatient settings.
- **Prosthetics/Orthotics:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Radiation Therapy and Radiosurgery:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Sleep Studies:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Specialty Pharmacy drugs:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Speech Therapy:** After initial evaluation plus six (6) visits for office, outpatient and home settings. Pediatric cochlear implants – allowed up to 36 visits with prior authorization.
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** non-emergent Air Transport.
- **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. Molina requires PA for all unlisted codes except 90999 does not require PA.

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.

Molina Healthcare
Medicaid Prior Authorization Request
Phone Number: Refer to Number(s) above
Fax Number: Refer to Number(s) above

MEMBER INFORMATION			
Plan:	☐ **Molina Medicaid**	☐ **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 the enrollee's 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 ☐ Diagnostic Procedure ☐ Infusion Therapy ☐ Other: ___________	☐ OT ☐ PT ☐ ST ☐ Hyperbaric Therapy ☐ Pain Management	☐ **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:		NPI#:		TIN#:	
Servicing Facility Address:					
Contact at Requesting Provider's office:					
Phone Number:	( ) -	Fax Number:	( ) -		
For Molina Use Only:					

Alternative Level of Care Authorization Form

Phone: 866-449-6828

All Lines of Business Fax: (800) 594-7404

Patient Name:	**Molina ID:**	**DOB/Age:**	**Today's Date:**
Molina LOB:	▪ **Medicare** ▪ **MMP / Duals** ▪ **Medicaid** ▪ **Marketplace**		

Level of Care Requested Based on InterQual:

- ☛ SNF Level 1 (1 discipline – 1-2 hrs/5 days/wk)
- ▪ SNF Level 2 (4 hrs SN **OR** 1 discipline 2-3 hrs/5 days/wk)
- ▪ SNF Level 3 (IV abx, wound) (4 hrs SN **AND** 1 discipline 2-3 hrs/5 days/wk)
- ▪ SNF Level 4 (vent/dialysis)
- ▪ Inpatient Rehab
- ☛ LTACH
- ▪ Custodial/Long term care (MMP only)
- ▪ Disenrollment request

Nursing Facility Requested:		**Hospital:**	
Tentative Admission Date:		**Hospital Admission Date:**	
Facility Contact Information:	CM/RN Name:	**Hospital Contact Information:**	CM/RN Name:
	CM/RN Phone:		CM/RN Phone:
	CM/RN Fax:		CM/RN Fax:

Active Diagnosis (include ICD10 Codes):	**Most Recent Vital Signs:**
1.	BP:__________ T: __________
2.	P:__________ SpO2: __________
3.	R:__________ Wt: __________

Current Clinical Condition:	**Past Medical/Surgical History: (Brief, related to current condition):**

Please indicate:	**Living Arrangements:**
▪ Smoker ▪ Alcohol/Substance Use ▪ DME	▪ Lives alone ▪ Lives with someone ▪ Homeless ▪ Other: ____________________

Needs Help With:

▪ Feeding ▪ Toileting ▪ Bathing ▪ Grooming ▪ Meal Preparation ▪ Other________________________________

Prior Level of Functioning before hospitalization:

▪ Independent ▪ Contact Guard ▪ Supervised ▪ Wheelchair bound ▪ Other: ____________________________

Participation Assistance Required while in SNF/IPR:	**Daily Participation Level while in hospital:**
PT: ▪ Max ▪ Mod ▪ Min ▪ Contact Guard OT: ▪ Max ▪ Mod ▪ Min ▪ Contact Guard ST: ▪ Max ▪ Mod ▪ Min ▪ Contact Guard	PT:______________hrs **OR**____________min OT:______________hrs **OR**____________min ST:______________hrs **OR**____________min
Ambulation (Current):____________ft Goal:______ft	

IV Medications that will continue post d/c (Must include start/date, dose, frequency):

Additional Comments:

****Therapy/Treatment Notes within 4 days of discharge must be included with this request**

Molina Healthcare
OB Notification Form
Phone Number: 1-888-898-7969
Fax Number: 844-861-1930 (Routine OB – NON - NICU)
Fax Number: 800-594-7404 (NICU)

****** 1 FORM PER NEWBORN ******

Mother's Information			
Plan	☐ Medicaid ☐ MiChild ☐ Medicare ☐ Marketplace		
Mother's Name:		Mother's DOB	/ /
Mother's ID #:		Mother'sPhone:	( ) -
Mother's Admit Date:	/ /	Mother's Discharge Date	/ /
Service Type:	NEWBORN NOTIFICATION	☐ NICU NICU Level________ ☐Border Baby Hospital Referred to CSHCS? ☐Yes ☐No	

Newborn Information			
Newborn Name:		Newborn DOB	/ /
Newborn Admit Date	/ /	Newborn Discharge Date	/ /

Newborn Admit Date:	From / / TO: / /
Birth Order	☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐Other ______
Diagnosis Code & Description:	
Delivery Date:	/ /
Delivery Type:	☐ Vaginal ☐ C-Section ☐ VBAC ☐ Repeat C-Section
Multiples?:	☐ No ☐ Yes Quantity _______
Baby's Gender:	☐ Male ☐ Female
Baby's Weight:	________lb _________oz
Apgar Score:	/
EDD:	/ /
Gestation:	_________ wks
Birth Outcome:	☐ Discharge with Mom ☐ Border Baby ☐ Going to FosterCare ☐Adoption ☐Fetal Demise

Provider Information					
Facility Name		NPI #:		TIN#:	
Attending Provider:		NPI #:		TIN#:	

Contact Information			
Name:			
Phone Number:	( ) -	Fax Number:	( ) -