CENTRAL HEALTH MEDICARE PLAN

Molina® Healthcare Medicare
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE

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

NOTE: For Molina Medicare Members with Molina Medicaid (Including FIDE/CA EAE Plans), Please Refer to Your State Molina Medicaid PA Look-Up Tool for Additional Medicaid Benefit PA Requirements

OFFICE VISITS TO CONTRACTED /PARTICIPATING PRIMARY CARE PROVIDERS DO NOT REQUIRE PA
OFFICE VISITS TO NETWORK SPECIALIST DO NOT REQUIRE A REFERRAL FROM A PARTICIPATING PRIMARY CARE PROVIDER
EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION

Important Information for Molina Healthcare Medicare Providers

Information generally required to support authorization decision making includes:

- Completed PA Form
- 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:
- Completed PA Form
- 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:
- Completed PA Form
- Signed MD order
- An itemized quote, and
- An assessment.

Information generally required to support Therapy Services (PT, OT, OR ST) authorization decision making includes:
- Completed PA Form
- Signed MD order,
- A therapy evaluation and
- Concurrent evaluations

Information generally required to support Behavioral Health authorization decision making includes:
- Completed PA Form
- 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:
- Completed PA Form
- Patient evaluation and complaints
- Diagnosis studies (ultrasound or other imagining 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 (including which extremity and vein will be treated)

Information generally required to support Bariatric Surgery authorization decision making includes:
- Completed PA Form
- Patient evaluation with recent Surgeon's notes:
  - Weight, height
  - BMI
- Past Medical History (Comorbidities)
- Previously unsuccessful 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 an 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:
- Completed PA Form
- MD's order/prescription
- Patient's evaluation and clinical notes include, 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:
- Completed PA Form
- MD's 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 of treatment)
- Plan of care including reason device is required

Information generally required to support Injections authorization decision making includes:

- Completed PA Form
- MD's orders/prescription
- Offices notes:
  - Patient's history of Lumbar, Cervical, or Thoracic radiculopathy (As applicable)
  - Patient's history on physical examination and imaging that supports pain due to 1 of the following: Discherniation, post-laminectomy syndrome, or acute herpes zoster.
  - Patient's pain severe enough to impact quality of life or function and assessed prior to the initial and subsequent injections and at each follow up.
  - Patient's pain with a duration of at least 4 weeks with failure of, or inability to tolerate noninvasive conservative care.
  - Patient's response to previous injection, if applicable.

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

- Completed PA Form
- MD's orders/prescription
- Offices notes:
  - Patient's condition requires body positioning that cannot be accomplished in ordinary bed
  - Patient's condition requires elevation of head of bed due to respiratory issues or risk for aspiration
  - Patient's condition requires special equipment that necessitates hospital bed use (e.g., traction equipment)
  - Patient/patient's caregiver 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 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 by calling (800) 665-3086.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decision with the requesting physician.

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IMPORTANT MOLINA HEALTHCARE MEDICARE CONTACT INFORMATION

(Service Hours: 8am to 5pm local time Monday to Friday, unless otherwise specified)

In-patient (IP) (Includes Behavioral Health Authorizations)
Phone: (800) 665-3086
Fax: (844) 834-2152
Peer to Peer: (866) 425-0786

For all Post-Acute requests (SNF, LTAC, Acute Rehab)
Phone: (800) 665-3086
Fax to: (833)912-4454
Peer to Peer: (866) 425-0786

Prior Authorizations (Includes Planned Inpatient and Behavioral Health Authorizations)
Phone: (800) 665-3086
Medicare Fax: (844) 251-1450
FIDE/CA EAE Fax: (844) 251-1451
Peer to Peer: (866) 425-0786

Pharmacy Authorizations Part D
Phone: (800) 665-3086
Fax: (866) 290-1309

Part B Healthcare Administered Drugs
Fax: (800) 391-6437

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

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

24 Hour Nurse Advise Line
(7 days/week)
888-275-8750 (follow prompts)
TTY: 711
Members who speak Spanish can press 1 at the IVR prompt.