Molina® Healthcare Marketplace
Pre-Service Review Guide
Effective: 01/01/2025

REFER TO MOLINA'S PROVIDER WEBSITE/PRIOR AUTHORIZATION LOOKUP TOOL 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.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment, Intensive Outpatient above 16 units
  - Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS)
  - Applied Behavioral Analysis (ABA) – for treatment of autism spectrum disorder (ASD)
- **Cardiology**
- **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**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long-Term Services and Supports (LTSS):** Not a covered benefit.
- **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** after initial 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 requires approval.**
  - Local Health Department (LHD) services
  - Hospital Emergency services
  - Evaluation and Management services associated with inpatient, ER, and observation or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
  - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23, 24, 51, 52
  - Other services based on State requirements
- **Occupational, Physical & Speech Therapy:** After the first 12 visits for PT/OT or first 6 visits for ST
- **Oncology**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** All non-emergent transportation
- **Vision:** Pediatric Low Vision Optical Devices and Services: Please contact VSP (Vision Service Plan) at (800) 877-7195 or visit their website at vsp.com/advantage

Important Information for Molina Healthcare 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 are also communicated to the provider by telephone, fax, or electronic notification. Verbal, fax, or electronic denials are given within one business day of 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 (855) 866-5462.

Important Molina Healthcare Marketplace Contact Information

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

Prior Authorizations, including Behavioral Health Authorizations: Phone: (855) 866-5462 Fax: (833) 322-1061	**Vision:** Phone: (800) 877-7195 Website: vsp.com/advantage
Pharmacy Authorizations: Phone: (855) 866-5462 Fax: (855) 365-8112	**Member Customer Service, Benefits/Eligibility** Phone: (833) 644-1623/ TTY/TDD 711
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Provider Customer Service:** Phone: (855) 866-5462
Transplant Authorizations: Phone: (855) 714-2415 Fax: (877) 813-1206	
	24 Hour Nurse Advice Line (7 days/week) Phone: (888) 275-8750/TTY: 711 Members who speak Spanish can press 1 at the IVR (Interactive Voice Response) 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: 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, Inc. Pre-Service Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☒ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (e.g., 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**:_____ ☐ EPSDT/Special Services			

REFERRAL/SERVICE TYPE REQUESTED

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

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

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **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):**	☐**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.

Molina® Healthcare, Inc. BH Pre-Service and Concurrent Review Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☒ **Marketplace**	☐ **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: _____

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):**		☐**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.