Passport by Molina® Healthcare Of Kentucky
Marketplace Prior Authorization/Pre-Service Review
Guide Effective: 01/01/2024

REFER TO PASSPORT'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 (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, Transitional Residential Treatment for Substance Use, 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**: For adults only, select services are administered by New Century Health (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** (Except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Inpatient Hospitalization and NICU Admissions:** (Except emergency services)
- **Long Term Services and Supports (LTSS):** Not a covered benefit.
- **Miscellaneous & Unlisted Codes:** Passport 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:** **Except for 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 stay, 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 evaluation and first 12 visits for PT/OT or first 6 visits for ST
- **Oncology**: For adults only, select services are administered by New Century Health (NCH).
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**: For adults only, select services are administered by New Century Health (NCH).
- **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 1 (800) 877-7195 or visit their website at www.vsp.com/advantage

Services Provided by New Century Health (NCH) - Cardiology Authorizations for adults 18+ in KY and WA; Oncology Authorizations for adults 18+ in WA. See below for contact information.

PASSPORT BY MOLINA HEALTHCARE

IMPORTANT INFORMATION FOR PASSPORT MARKETPLACE 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.
- Passport has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (855) 322-4077.

Important Passport Marketplace Contact Information

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

Prior Authorizations including Behavioral Health Authorizations: Phone: (855) 322-4077 Fax: (833) 322-1061	**Vision:** Phone: (800) 877-7195 Website: www.vsp.com/advantage
Pharmacy Authorizations: Phone: (855) 322-4077 Fax: (888) 373-3059	**Member Customer Service, Benefits/Eligibility:** Phone: (888) 898-7969/ TTY/TDD 711
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Provider Customer Service:** Phone: (855) 322-4077
Transplant Authorizations: Phone: (855) 714-2415 Fax: (877) 813-1206	
New Century Health (NCH): Cardiology and Oncology Authorizations for adults over 18 only Phone: (888) 999-7713 Website: https://my.newcenturyhealth.com	**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 the Availity Essentials portal: www.Availity.com

Available features include:

- Authorization submission and status
- Member Eligibility
- Provider Directory
- Claims submission and status
- Download Frequently used forms
- Nurse Advice Line Report

PASSPORT BY MOLINA HEALTHCARE

Passport by Molina® Healthcare – Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e., CA):				
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 ☐ EPSDT/Special Services			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

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:**

		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:**

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.

PASSPORT BY MOLINA HEALTHCARE

Passport by Molina® Healthcare – BH Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e., CA):				
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#:**

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:**

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.