

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.

Office visits to contracted/participating (par) providers & referrals to network specialists do not require prior authorization.

Emergency services do not require prior authorization.

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| <ul style="list-style-type: none"> • Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services: <ul style="list-style-type: none"> ◦ Inpatient, Residential Treatment, Partial hospitalization, Day Treatment, Intensive Outpatient above 16 units, Targeted Case Management; ◦ Applied Behavioral Analysis (ABA) ◦ Assertive Community Treatment (ACT) ◦ Electroconvulsive Therapy (ECT) ◦ MRSS Stabilization Service (more than 6 weeks) ◦ Psychological Testing / Neuropsychological Testing ◦ SBIRT ◦ Transcranial Magnetic Stimulation Therapy (TMS) ◦ Alcohol or Drug Assessment ◦ Peer Support (more than four hours on same day) ◦ Psychiatric Diagnostic Evaluations Inpatient, residential treatment, partial hospitalization • Cardiology¹: For adults 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) | <ul style="list-style-type: none"> • Hyperbaric/Wound Therapy • Imaging and Specialty Tests • Inpatient Hospitalization (Except Emergency and Urgently Needed Services) • Long Term Services and Supports (per State benefit). All LTSS services require PA regardless of code(s). • Miscellaneous & Unlisted Codes: Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale should 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 require approval. <ul style="list-style-type: none"> ◦ 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) ◦ Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23 or 24, 51, 52; ◦ Other State mandated services. • Nursing Home/Long Term Care • Occupational, Physical & Speech Therapy • Oncology¹: For adults select services are administered by New Century Health (NCH). • Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures¹ • Pain Management Procedures • Prosthetics/Orthotics • Radiation Therapy and Radiosurgery¹: For adults select services are administered by New Century Health (NCH). • Transplants/Gene Therapy, including Solid Organ and Bone Marrow (Cornea transplant does not require authorization). • Transportation Services: Non-emergent air transportation. |
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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 the claim.

¹ Services provided by New Century Health (NCH) - Cardiology Authorizations for Adults: Effective 1/1/21 applies to KY. Effective 10/1/21 applies to WA. Effective 2/1/22 applies to NV. Effective 4/1/22 applies to OH. Oncology Authorizations for Adults: Effective 10/1/22 applies to KY, NV. Effective 11/1/22 applies to WA.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICAID 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.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (855) 322-4079.

Important Molina Healthcare Medicaid Contact Information

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

Prior Authorizations including Behavioral Health Authorizations:

Phone: (855) 322-4079
Fax: (866) 449-6843

24-Hour Behavioral Health Crisis (7 days/week):

Phone: (888) 275-8750 (TTY: 711)

Dental (SKYGEN):

Phone: (888) 818-7932 (TTY: 711)
Hours: 7 days a week, 8 a.m. to 8 p.m. ET

Member Services, Benefits/Eligibility:

Phone: (800) 642-4168 (TTY: 711)
Hours: Monday to Friday, 7 a.m. to 8 p.m.

New Century Health (NCH):

Cardiology and Oncology Authorizations for adults.
Phone: (888) 999-7713
Website: my.newcenturyhealth.com

Pharmacy Authorizations:

Phone: (855) 322-4079
Fax: (800) 961-5160

Progeny Health (NICU)

Phone: (888) 832-2006
Fax: (866) 519-1259

Provider Customer Service:

Phone: (855) 322-4079
Fax: (888) 296-7851

Radiology Authorizations:

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

Transplant Authorizations (Kidney Only)

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

Transportation:

Phone: (866) 642-9279
Hours: Monday to Friday, 8 a.m. to 8 p.m. local time for ROUTINE reservations. Requests for ROUTINE reservations will not be accepted on national holidays. This does not apply to URGENT same day appointments, facility DISCHARGES, and RIDE ASSIST – these calls are 24 hours a day, 7 days a week, 365 days a year.

Transplant Authorizations (All Others):

Phone: (855) 322-4079
Fax: (866) 449-6843

Vision (March Vision Care):

Phone: (844) 756-2724 (TTY: 711) or
(877) 627-2456

24-Hour Nurse Advice Line (7 days/week)

Phone: (888) 275-8750 (TTY: 711)
Members who speak Spanish can press 1 at the IVR 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 at:

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
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Member Information

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:				DOB (MM/DD/YYYY):
Member ID#:				Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission <input type="checkbox"/> EPSDT/Special Services			

Referral/Service type requested

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension / Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Other Inpatient: _____	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Imaging/ Special Tests	<input type="checkbox"/> Office Procedures <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Laboratory Services <input type="checkbox"/> LTSS Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Outpatient Surgical/Procedures <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Transplant/ Gene Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: _____

Please send clinical notes and any supporting documentation

Primary ICD-10 Code for Treatment:			Description:		
Dates of Service		Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits
Start	Stop				

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):	<input type="checkbox"/> Non-Par
			<input type="checkbox"/> 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.

Member Information

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:				DOB (MM/DD/YYYY):
Member ID#:				Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission			

Referral/Service type requested

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension / Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary Court Date, if applicable: _____	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Level 3.5 <input type="checkbox"/> Level 3.1 <input type="checkbox"/> Partial Hospitalization Program Number of days per week _____ <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management		<input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/ Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Transcranial Magnetic Stimulation Therapy (TMS) <input type="checkbox"/> Other _____

Please send clinical notes and any supporting documentation

Primary ICD-10 Code for Treatment:			Description:		
Dates of Service		Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits
Start	Stop				

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):	<input type="checkbox"/> Non-Par
			<input type="checkbox"/> 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.