MOLINA HEALTHCARE

Your Extended Family.

Services Covered by Molina Healthcare

Because you are covered by Medicaid, you pay nothing for covered services. As a Molina Healthcare member, you will continue to receive all medically necessary Medicaid-covered services at no cost to you. To learn more about which services are covered, see the table on page 2.

Prior Approval

Prior approval means that Molina Healthcare must approve a service before you get it. You can get most covered services without prior approval.

Some services do need prior approval, also called prior authorization. For a prior approval, a provider must send Molina Healthcare a request for the care they would like you to receive.

We will review the request and let your provider know if it is approved before he or she can give you the service. We do this to make sure you get the right care at the right time and in the right place.

If you have questions about a prior approval request, ask your provider. Or, you can call Member Services. Our prior approval staff is ready to help you between 8 a.m. to 5 p.m., Monday through Friday. After business hours, you can leave a message and your call will be returned the next business day.

Referrals

There are times when your PCP may give you a referral. A referral is a request from a PCP for his or her patient to see a specialist. Although it is not required for you to get a referral from your PCP, your PCP can help you find the right specialist for you. A specialist is a provider who focuses on a particular kind of health care. For example, a podiatrist who specializes in foot care or a cardiologist who specializes in heart health. Molina Healthcare encourages you to see your PCP for referrals so that your care can be coordinated.

Services from Out-of-Network Providers

If there are no network providers available to give you the services you need, Molina Healthcare will cover needed Medicaid-covered services at no cost to you from non-network providers. Your non-network provider will need prior approval before providing you the service, unless it's an emergency.

List of Covered Services

The following list of covered services helps you know which services need prior approval and which do not. Not all services that need prior approval are included in this list. For more information, or if you have any questions, call Member Services.

Covered Services	
Acupuncture	Acupuncture coverage is limited to the pain management of migraine headaches and lower back pain. Prior approval (PA) is required.
Ambulance and wheelchair van transportation	Prior approval is not needed for emergency transportation. Some non-emergency transportation may need a prior approval.
Certified nurse midwife services	Prior approval is not needed.
Certified nurse practitioner services	Prior approval is not needed.

Chiropractic (back) services
• Covered services include:
  • Diagnostic x-rays
  • Adjustments of the spine to correct alignment
	Prior approval is not needed.

Dental services • Routine cleaning and exam once every 6 months • Routine x-rays • Removal of impacted wisdom teeth and emergency tooth re-implantation for adults • Dentures, partial plates and braces	Routine services do not need prior approval. Dental services other than routine care need prior approval.
Developmental therapy services for children aged birth to six years	In an outpatient setting, you can have 30 visits in each 12-month period without needing prior approval. Prior approval is needed to get services after 30 visits in a 12-month period.
Diagnostic services (x-ray, lab)	Selected diagnostic services (including CT Scans, MRIs, MRAs, PET Scans, and SPECT) need prior approval.
Durable medical equipment The equipment you need for certain medical conditions is covered, such as: • Wheelchairs • Oxygen equipment • Canes, crutches and walkers	Some durable medical equipment items need prior approval.
Emergency services An emergency is a medical problem you think is so serious that it must be treated right away by a doctor. Emergency services are always covered. To learn more, see page 11 of your Member Handbook.	Prior approval is not needed.
Family planning services and supplies • Exam and medical treatment • Lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Supplies (condom, foam, film, diaphragm, cap) • Treatment for sexually transmitted infections (STIs)	Prior approval is not needed.

Covered Services	
Federally Qualified Health Center or Rural Health Clinic services • Office visits for primary care and specialists services • Physical therapy services • Speech pathology and audiology services • Dental services • Podiatry services • Vision services • Chiropractic services • Transportation services • Mental health services	Prior approval is not needed.
Free-standing birth center services at a free-standing birth center You can call Member Services to see if there are any qualified centers in your area.	Prior approval is not needed.
Home health services • Home health aide and/or nursing services • Physical therapy, occupational therapy, and speech therapy • Private duty nursing • Home infusion therapy • Medical and social services • Medical equipment and supplies	Prior approval is needed after the initial evaluation plus the first 6 visits.
Hospice care (care for terminally ill, e.g., cancer patients) While you are receiving hospice care, Molina Healthcare will also cover: • Drugs to treat symptoms and pain • Short-term respite care • Home care • Nursing facility care	Prior approval is not needed.
Inpatient hospital services • Semi-private room, or private room if medically-necessary • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care • Drugs and medications • Lab tests • X-rays • Needed surgical and medical supplies • Physical, occupational and speech therapy • Operating and recovery room services • Inpatient substance abuse services	Inpatient hospital services (except for emergency admissions) and elective admissions, including pregnancy delivery services, and all inpatient surgeries, need prior approval. Notification to Molina Healthcare is required within 24 hours of admission or by the next business day for emergency admissions.

Covered Services	
Medical supplies	Some medical supplies need prior approval.
Mental health and substance abuse services • Counseling and therapy • Assessment • Crisis intervention • Alcohol/drug screening analysis/lab urinalysis • Methadone administration	Prior approval is not needed to begin getting services at a Community Mental Health Center, an Ohio Department of Mental Health and Addiction Services (MHAS) facility, or other network providers. Prior approval is only needed for intensive services such as partial hospitalization or to receive services beyond the annual Medicaid limits for psychology or community behavioral health services. Contact your provider or Molina Healthcare for more information.
Nursing facility services for a short-term rehabilitative stay • A semi-private room, or a private room if medically-necessary • Meals, including special diets • Nursing services • Physical, occupation and speech therapy • Drugs you get as part of your plan of care • Medical and surgical supplies • Lab tests • X-rays • Equipment, such as wheelchairs Nursing facility stays are covered unless ODM determines that you will return to fee-for-service. If you are in need of nursing services, call Member Services for information on available providers.	Nursing facility services need prior approval.
Obstetrical (maternity care: prenatal and postpartum including at-risk pregnancy services) and gynecological services • Prenatal care • Postpartum care • At-risk pregnancy care management • Pelvic exam and pap test	Prior approval is not needed.
Outpatient hospital services • Services in an emergency department or outpatient clinic • Outpatient surgery • Chemotherapy • Lab and diagnostic tests • Mental health care • X-rays • Medical supplies, such as splits and casts	Some outpatient services need prior approval.

Covered Services	
Physical and occupational therapy	In an outpatient setting, you can have 30 visits in each 12-month period for any physical and occupational therapy services without needing prior approval. Prior approval is needed to get services after 30 visits in a 12-month period.
Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source	Prior approval is not needed.
Podiatry (foot) services • Diagnosis of injuries and diseases of the foot • Surgical treatment • Routine foot care	Prior approval is not needed.
Prescription drugs, including certain prescribed over-the-counter drugs Your provider will write a prescription for any drugs you need. You can fill the prescription at a network pharmacy. See the Prescription Drugs section on page 25 of your Member Handbook to learn more.	Selected drugs, including injectables and some over-the-counter drugs, need prior approval.
Preventive mammogram (breast) and cervical cancer (Pap smear) exams	Prior approval is not needed.
Primary care provider services Your PCP will provide all routine care services, such as: • Yearly well exams • Healthchek • Preventive screenings • Immunizations • Colds/flu • Sore throat • Earache • Rash • Joint pain • Pregnancy tests	Prior approval is not needed.
Renal dialysis (kidney disease) • Inpatient and outpatient dialysis treatments • Home dialysis supplies	Prior approval is not needed.
Respite services for Supplemental Security Income (SSI) members under the age of 21, as approved by CMS within the applicable 1915(b) waiver and as described in OAC rule 5160-26-03. Respite services offer short-term, temporary relief to the informal, primary caregiver of a Supplemental Security Income (SSI) member under the age of 21 in order to support and preserve the primary care giving relationship.	Respite services need prior approval.
Screening and counseling for obesity	Prior approval is not needed. Screening and counseling for obesity requires a referral by a provider.

Covered Services	
Services for children with medical handicaps (Title V)	Prior approval is not needed.
Shots (immunizations) • Vaccines for children under age 21 • Flu shots • Hepatitis B vaccine	Prior approval is not needed.
Specialist services Consultation, diagnosis and treatment by specialist provider	Office visits to see a specialist do not need prior approval. Some specialist services do need prior approval.
Speech and hearing services, including • Hearing and balance tests • Hearing aids, batteries and accessories • Speech therapy	In an outpatient and home setting, you can have 30 visits in each 12-month period for any combination of speech and audiology therapy services without needing prior approval. Prior approval is needed to get services after 30 visits in a 12-month period. Some hearing aids may need prior approval.

Vision (optical) services, including eyeglasses
• Eye Exams
  • One every 12 months
• Eyeglasses – One complete frame and pair of lenses, just lenses or just frames, or contact lenses with prior approval. We also offer an expanded selection of frames to choose from at no cost to you.
  • One every 12 months
	Prior approval is not needed.

Well-child (Healthchek) exams for children under the age of 21 • Checkups, immunizations and other services for children under age 21. See page 27 of your Member Handbook to learn more.	Prior approval is not needed.
Yearly well-adult exams	Prior approval is not needed.