MOLINA® HEALTHCARE OF NEW MEXICO
MEDICARE
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2022

REFER TO MOLINA'S PROVIDER WEBSITE/PRIOR AUTHORIZATION LOOK-UP TOOL/MATRIX FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

OFFICE VISITS TO CONTRACTED/PARTICIPATING PRIMARY CARE PROVIDERS DO NOT REQUIRE PA.

OFFICE VISITS TO NETWORK SPECIALISTS DO NOT REQUIRE A REFERRAL FROM A PARTICIPATING PRIMARY CARE PROVIDER.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

- **Advanced Imaging and Special Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Partial hospitalization;
  - Electroconvulsive Therapy (ECT).
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment and Medical Supplies**
- **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**
  - For Medicare Part B drug provider administered drug therapies, please direct Prior Authorization requests to Novologix via the Molina Provider Portal. You may also fax in a prior authorization at 800-391-6437.
- **Hearing Aids**
  - Benefit is only available from HearUSA participating providers, Contact HearUSA at (855) 823-4632 to schedule. Hearing aids require prior authorization
- **Home Healthcare Services (including home-based PT/OT/ST):** Prior authorization required for any home healthcare in a year beyond the initial 60 day period.
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (LTSS):** Not a Medicare covered benefit*. **(*Per State benefit if MMP)**
- **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**
- **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.**
  - Local Health Department (LHD) services;
  - Hospital Emergency services
  - Evaluation and Management services associated with inpatient, ER, and observation stays
  - Dialysis when temporarily absent from service area;
  - Ambulance services dispatched through 911;
  - Radiologists, anesthesiologists, and pathologists professional services when billed in POS 19, 21, 22, 23 or 24;
  - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting.
- **Occupational, Physical, & Speech Therapy:** PA required after Medicare therapy benefit threshold ($2,150 for PT & ST combined and $2,150 for OT) has been reached for office and outpatient settings.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies:** (Except Home (POS 12) sleep studies)
- **Supervised Exercise Therapy (SET)**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** non-emergent air transportation.

Molina® Healthcare of New Mexico, Inc.
Prior Authorization Request Form

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICARE 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.

IMPORTANT MOLINA HEALTHCARE MEDICARE CONTACT INFORMATION

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

Prior Authorizations including Behavioral Health Authorizations: Phone: (855) 322-4078 Fax: (844) 251-1450	**In-patient Authorizations including Behavioral Health Authorizations:** Phone: (855) 322-4078 FAX: (844) 834-2152
Pharmacy Authorizations: Phone: (800) 665-3086 Fax: (866) 290-1309	**Radiology Authorizations:** Phone: (855) 714-2415 Fax: (877) 731-7218
Transplant Authorizations: Phone: (855) 714-2415 Fax: (877) 813-1206	
Provider Customer Service: Phone: (855) 322-4078	**Member Customer Service, Benefits/Eligibility:** Phone: (866) 440-0127 TTY/TDD 711
PERS Phone: (888) 55.SIGAL (888) 557-4462 TTY: 711 24 hours a day, 7 days a week (Best Buy Health, dba Critical Signal Technologies, Inc. (CST) *Benefit is covered for qualifying members when authorized/ ordered by the Case Manager.*	**Meals** Phone: (866) 224-9485 (Mom's Meals NourishCare PurFoods, LLC dba) *Case Manager must enroll the member in the home delivered meal program giving them access to this benefit*
24 Hour Behavioral Health Crisis (7 days/week): Phone: ((XXX) XXX-XXXX	**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: https://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 of New Mexico, Inc.
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:**

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.

Molina® Healthcare of New Mexico, Inc.
Prior Authorization Request Form
Molina® Healthcare, Inc. – 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.