MOLINA® HEALTHCARE MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2022

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.

ALWAYS REQUEST SERVICES FROM PRIMARY INSURANCE CARRIER BEFORE SECONDARY MEDICAID, UNLESS MEDICAID WAIVERED SERVICE OR NON-COVERED MEDICARE SERVICE.

- **Advanced Imaging and Special Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial Hospitalization, Day Treatment, Intensive Outpatient, Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **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 mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services & Support (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, pricing and rationale must be submitted with the prior authorization request.

- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** PA is required for office visits, procedures, labs, diagnostic studies, and inpatient stays except for:
  - Emergency and Urgently Needed Services;
  - Professional fees for Medicaid enrolled providers associated with ER visits and approved Ambulatory Surgery Center (ASC) or inpatient stays;
  - Local Health Department (LHD) services;
  - 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 from Medicaid enrolled providers with Modifier 26 in ANY place of service setting;
  - Other State mandated services.
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow:** (Cornea transplant does not require authorization).
- **Transportation Services:** Non-emergent air transportation.

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.

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 1 (844) 239-4914.

Important Molina Healthcare Medicaid Contact Information
(Service hours 8am-5pm local M-F, unless otherwise specified)

Prior Authorizations including Behavioral Health Authorizations:
Phone: 1 (844) 239-4914
Fax: 1 (855)231-0375

24 Hour Behavioral Health Crisis (7 days/week):
Phone: (844) 800-5154

Pharmacy Authorizations:
Phone: 1 (844) 239-4913
Fax: 1 (866) 290-1309

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

Vision:
Phone: 1 (844) 416-2724
Fax: 1 (877) 627-2488

Provider Customer Service:
Phone: 1 (844) 239-4914

Member Customer Service, Benefits/Eligibility:
Phone: 1 (844) 239-4913/ TTY/TDD 711

Transportation:
Phone: 1 (844) 368-1501

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.

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

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 form
- Nurse Advice Line Report

![Molina Healthcare logo - Your Extended Family]

Molina® Healthcare, Inc. – Prior Authorization Service 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:		
☐ Rate code 17 Waivered Service Nursing Facility LTC *verify PASRR submitted to state ☐ Other Inpatient:_____	☐ DME ☐ Hospice	☐ LTSS Services- Do not use this form. Email MHIDCaseManagement@molinahealthcare.com if you are unsure of how to request rate code 15 services.	☐ Transportation ☐ 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:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.