Molina Healthcare Of Illinois
Prior Authorization/Pre-Service Review Guide
Effective: 01/01/2016

Use the Molina web portal for faster turnaround times.
Contact Provider Services for details

Referrals to Network Specialists and office visits to contracted (par) providers do not require Prior Authorization

Prior Authorization/Pre-Service Guide applies to all Molina Healthcare of Illinois Members
Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)**
- **Durable Medical Equipment**
- **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
- **Habilitative Therapy –** After initial evaluation plus six (6) visits for outpatient and home settings **(per state benefit)**
- **Home Healthcare and Home Infusion:** After initial evaluation plus six (6) visits
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty Imaging**
- **Inpatient Admissions: All Acute Hospital, Skilled Nursing Facility (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility** Always require Prior Authorization
- **Long Term Services and Supports:** Not a Medicare covered benefit. (per state benefit)
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities: All Out of Network Office visits, procedures, labs, diagnostic studies, inpatient stays require Prior Authorization except for:**
  - Emergency Department services
  - Professional fees associated with ER visit, Ambulatory Surgery Center (ASC) or inpatient stay
  - Women's Health, Family Planning, Obstetrical services
  - Local Health Department (LHD) services
  - Other services based on state requirements
- **Office-Based Procedures do not require authorization**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures:** except trigger point injections (Acupuncture is not a Medicare covered benefit)
- **Pregnancy and Delivery:** notification upon delivery only
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery (for selected services only)**
- **Rehabilitation Services:** Including Pulmonary, and Comprehensive Outpatient Rehab Facility (CORF). CORF Services for Medicare only
- **Sleep Studies –** Allow one sleep study per calendar year without authorization
- **Specialty Pharmacy drugs (oral and injectable)**
- **Speech Therapy:** After initial evaluation plus six (6) visits for outpatient and home settings
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization)
- **Transportation:** Non-emergent Air transport
- **Unlisted, Miscellaneous and T (Temporary) 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.

***STERILIZATION NOTE: Federal guidelines require that at least 30 days, not to exceed 180 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 claim. (Medicaid benefit only)**

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE OF ILLINOIS

- By requesting prior authorization, the provider is affirming that the services are medically necessary and a covered benefit under Medicare or Illinois Medicaid programs.
- As a condition of authorization, the servicing provider agrees to accept no more than 100% of traditional reimbursement under Medicare minus any copayments, co-insurance and deductibles plus what Medicaid would have paid up to the Medicare allowable amount for the coordination of benefits between Medicare and Medicaid programs.
- When the service is only covered under Medicare, the servicing provider agrees to accept no more than 100% of traditional reimbursement under Medicare minus any copayments, co-insurance and deductibles for any covered services.
- When the service is only covered under Medicaid, the servicing provider agrees to accept no more than 100% of the Illinois Medicaid fee schedule for any covered services.
- Molina Healthcare will not reimburse services that not deemed medically necessary.
- Servicing providers also recognize that Molina Healthcare Members are not to be balanced billed for any uncollected monies for covered services pursuant to Medicare and Medicaid billing guidelines.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE OF ILLINOIS

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 the enrollee's 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) 866-5462

Prior Authorization Contact Information

Prior Authorizations 8 a.m. – 5 p.m.
Phone: (855) 866-5462
Fax: (866) 617-4971
Radiology Authorizations
Phone: (855) 714-2415
Fax: (877) 731-7218
NICU Authorizations
Phone: (855) 714-2415
Fax: (877) 731- 7218
Pharmacy Authorizations
Medicaid Phone: (855) 866-5462
Medicaid Fax: (855) 365-8112
MMP Phone: (877) 901-8181
MMP Fax: (866) 290-1309
Behavioral Health Authorizations
Phone: (855) 866-5462
Fax: (866) 617-4971
Transplant Authorizations:
Phone: (855) 714-2415
Fax: (877) 731-7218

Member Services
Integrated Care Program Phone: 855-766-5462
Family Health Plan Phone: (855) 687-7861
MMP Phone: (877) 901-8181
TTY:711
Provider Services 8 a.m. – 5 p.m.
Phone: (855) 866-5462
24 Hour Nurse Advice Line
English: (888) 275-8750 [TTY: (866) 735-2929]
Spanish: (866) 648-3537 [TTY: (866) 833-4703]
Vision Care
Phone: (844) 456-2724
Dental
Medicaid Phone: (866) 857-8124
MMP Phone: (855) 701-0433
Transportation
Medicaid Phone: (844) 644-6354
MMP Phone: (844) 644-6353

Providers may utilize Molina Healthcare's eWeb at: www.molinahealthcare.com
Available features include:

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