MOLINA® HEALTHCARE MEDICARE
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 04/01/2017

FOR MI HEALTH LINK MEDICAID, PLEASE REFER TO YOUR STATE MEDICAID PA GUIDE FOR ADDITIONAL PA REQUIREMENTS

Refer to Molina's Provider Website/Portal for specific codes that require authorization
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS AND REFERRALS TO NETWORK SPECIALISTS DO NOT REQUIRE PRIOR AUTHORIZATION

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Partial hospitalization;
  - Electroconvulsive Therapy (ECT).
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting).**
- **Durable Medical Equipment**
  - Medicare Hearing Aides [supplemental benefit]. Contact AVESIS at 1 (800) 327-4462.
- **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.
- **Home health care and Home infusion, including Home PT, OT and ST:** After initial evaluation plus six (6) visits per calendar year.
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty Imaging**
- **Inpatient Admissions:** Elective, Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **Long Term Services and Supports:** Not a Medicare covered benefit*. **(*Per State benefit if MMP).**
- **Neuropsychological and Psychological Testing.**
- **Non-Par Providers/Facilities:** Office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency Department Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Local Health Department (LHD) services;
  - Other services based on State Requirements.
- **Occupational & Physical Therapy**: After Medicare therapy benefit cap has been reached for office and outpatient settings.
- **Office-Based Procedures do not require authorization, unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office.**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:**
  - Site of Service Authorizations – Some procedures require authorization when performed in an outpatient hospital setting rather than an Ambulatory Surgery Center. Refer to Molina's Provider website or portal for specific codes requiring authorization based on Site of Service
- **Pain Management Procedures:** except trigger point injections (Acupuncture is not a Medicare covered benefit).
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery (for selected services only)**
- **Sleep Studies:** (Except Home sleep studies).
- **Specialty Pharmacy drugs**
- **Speech Therapy:** After initial evaluation plus six (6) visits for office, outpatient and home settings.
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization.)
- **Transportation:** non-emergent Air Transport.
- **Unlisted & Miscellaneous 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.

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 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.

Important Molina Healthcare Medicare Contact Information

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

	PHONE	FAX		PHONE	FAX
IP Prior Auths **OP Prior Auths**	1 (888) 898-7969 1 (855) 322-4077	1 (888) 295-7665 1 (844) 251-1450	**Pharmacy Authorizations**	1 (888) 665-1328	1 (866) 290-1309
Member Customer Service Benefits/ Eligibility	1 (800) 665-3072	1 (801) 858-0409	**Provider Customer Service**	1 (855) 322-4077	1 (248) 925-1784
Behavioral Health Authorizations	1 (888) 898-7969	1 (888) 295-7665	**Dental**	1 (800) 327-4462	
Radiology Authorizations	1 (855) 714-2415	1 (877) 731-7218	**Transportation**	1 (855) 735-5604	1 (844) 251-1450
Transplant Authorizations	1 (855) 714-2415	1 (877) 813-1206	**Vision** (March Vision)	1 (888) 493-4070	1 (877) 627-2488
NICU Authorizations	1 (855) 714-2415	1 (877) 731-7220	**24 Hour Nurse Advice Line (7 days/week):** English: 1 (888) 275-8750 / TTY: 1 (866) 735-2929 Spanish: 1 (866) 648-3537 / TTY: 1 (866) 833-4703		

Molina Healthcare – Medicare
Prior Authorization Request Form
[Please refer to Contact/FAX numbers above]

MEMBER INFORMATION

Plan: ☐ **Molina Medicare**

Member Name: _____ **DOB:** / /

Member ID#: _____ **Phone:** ( ) -

Service Type: ☐ Elective/Routine ☐ Expedited/Urgent[1]

[1]Definition of Expedited/Urgent service request designation is when the treatment requested 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 should be submitted as routine/non-urgent.

REFERRAL/SERVICE TYPE REQUESTED

Inpatient	**Outpatient**		
☐ Surgical procedures	☐ Surgical Procedure	☐ OT ☐ PT ☐ ST	☐ Home Health
☐ Admissions	☐ Diagnostic Procedure	☐ Hyperbaric Therapy	☐ DME
☐ SNF	☐ Infusion Therapy	☐ Pain Management	☐ Wheelchair
☐ LTAC	☐ Other: _____		☐ In Office

Diagnosis Code & Description: _____

CPT/HCPC Code & Description: _____

Number of visits requested: DOS From: / / to / /

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION

Requesting Provider Name: _____ NPI#: _____ TIN#: _____

Servicing Provider or Facility: _____ NPI#: _____ TIN#: _____

Contact at Requesting Provider's office: _____

Phone Number: ( ) - Fax Number: ( ) -

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 on the date of service (for Molina Marketplace members, this includes grace period status*), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.
*For additional information on a member's grace period status, please contact Molina Healthcare.