Molina Healthcare of Mississippi Medicaid
Prior Authorization/Pre-Service Review Guide
Effective: 06/01/2021

fRefer to Molina's Provider website or portal 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.

All Non-Par Provider Requests Require Authorization Regardless of Service.

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Crisis Residential Treatment, Partial hospitalization, Day Treatment, **Psychosocial Rehabilitation**; PACT, MYPAC, PRTF Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD). Behavior Identification Assessment (97151) does NOT require prior authorization
  - Community Mental Health Center (CMHC)/Private Mental Health Center (PMCH) services: Evaluations or to exceed the service standard; Prior authorization is required for ALL services provided to individuals under the age of 3; Intensive Community Outreach and Treatment (ICORT).
  - Therapeutic and Evaluative Mental Health services for Expanded EPSDT (T&E): For evaluations **(including developmental evaluations {96112 & 96113})**, or to exceed the service standard. Prior authorization is required for ALL services provided to individuals under the age of 3.
- **Cosmetic, Plastic and Reconstructive Procedures** (in any setting).
- **Dental services**: Prior authorization required for all services including [effective March 1, 2019] outpatient hospital setting, except for emergencies.
- **Durable Medical Equipment/ Medical Supplies**: Refer to Molina's Provider website or portal for specific codes that require authorization. All DME / Supplies must be ordered by a physician.
- **Expanded EPSDT services**
- **Experimental/Investigational Procedures**
- **Eyeglasses (Vision) services:** for children after 2nd pair per FY.
- **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.
- **Hearing services:** Hearing aids (for EPSDT eligible
- **Imaging and Specialty Test. Laboratory and X-Ray services:** For certain outpatient, non- emergency advanced imaging procedures (CT, MRI, PET and Nuclear cardiac studies).
- **Inpatient Admissions:** Elective, Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **Long Term Services and Supports:** Refer to Molina's Provider website or portal for specific codes that require authorization. (Per State benefit)**.**
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** Office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency and Urgently Needed Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Local Health Department (LHD) services;
  - Radiologists, anesthesiologists, and pathologists professional services when billed for 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;
  - Other services based on State Requirements.
- **Occupational & Physical Therapy**: PA not required for initial evaluation. PA required for continued visits.
- **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:** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Pain Management Procedures.** (Except trigger point injections).
- **Pediatric Skilled Nursing (Private Duty Nursing) Services**

members

- **Home Healthcare Services** PA not required for initial evaluation. PA required for visits 1 through 36.
- **Hospice**
- **Hyperbaric Therapy**
- **Prosthetics/Orthotics.** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Radiation Therapy and Radiosurgery** (for selected services only).
- **Sleep Studies.** (Except Home sleep (POS 12) studies).
- **Healthcare Administered drugs.** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Speech Therapy:** PA not required for initial evaluation. PA required for continued visits.
- **Transplants/ Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** Non-Emergent Air Transport. Urgent Air Ambulance (Fixed Wing).
- **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.

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 claim.

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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 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 1 (844) 826-4335

Important Molina Healthcare Medicaid Contact Information

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

Prior Authorizations: Phone: 1 (844) 826-4335 Inpatient Requests Fax: 1 (844) 207-1622 All Non-Inpatient Fax: 1 (844) 207-1620 Outpatient Drug Request: 1 (844) 312-6371	**Behavioral Health Authorizations:** Phone: 1 (844) 826-4335 Inpatient Requests Fax: 1 (844) 207-1622 All Non-Inpatient Fax: 1 (844) 206-4006
Pharmacy Authorizations: Phone: 1 (844) 826-4335 Fax: 1 (844) 312-6371	**Provider Customer Service:** Phone: 1 (844) 826-4335 Fax: 1 (844) 303-5188
Radiology Authorizations: Phone: 1 (855) 714-2415 Fax: 1 (877) 731-7218	**Dental:** Phone: 1 (833) 282-2419
Transplant Authorizations: Phone: 1 (855) 714-2415 Fax: 1 (877) 813-1206	**Transportation:** Phone: 1 (855) 391-2355
NICU Authorizations: Phone: 1 (844) 826-4335 Fax: 1 (844) 207-1622	**Vision:** Phone: 1 (844) 606-2724
Member Customer Service, Benefits/Eligibility: Phone: 1 (844) 809-8438 / TTY/TDD 711 Fax: 1 (844) 305-6408	**24 Hour Nurse Advice Line (7 days/week):** 1 (844) 794-3638 / TTY: 711 **24 Hour Behavioral Health Crisis (7 days/week):** **1 (844) 794-3638 / TTY: 711**

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**

CHIP
Prior Authorization Request Form
Molina Healthcare of Mississippi

MEMBER INFORMATION			
Plan:	☐ CHIP	☐ Other:	
Member Name:		DOB:	/ /
Member ID#:		Phone:	( ) -
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*	

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		☐ Home Health
☐ Surgical procedures	☐ Surgical Procedure	☐ OT ☐ PT ☐ ST	☐ DME*
☐ Admissions	☐ Diagnostic Procedure	☐ Hyperbaric Therapy	☐ Wheelchair*
☐ SNF	☐ Infusion Therapy	☐ Pain Management	☐ In Office
☐ LTAC	☐ Other:	☐ Behavioral Health	
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#:	
*Collaborating Physician Name:		NPI#		*Non-physician practitioners must have a practice agreement with a physician, who is enrolled with the MS DOM, which does not prohibit the ordering of DME and must include the physician's NPI on request.		
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, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.