



MOLINA[®] HEALTHCARE MARKETPLACE
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2021

REFER 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.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
 - Inpatient, Transitional Substance Abuse Residential Treatment, Day Treatment, Partial Hospitalization.
 - Electroconvulsive Therapy (ECT);
 - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- **Cardiac Rehab/Therapy**
- **Cosmetic, Plastic and Reconstructive Procedures:** No prior authorization 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):** Prior Authorization required after the evaluation and first 7 visits, per calendar year.
- **Hospice (Inpatient Care):** Notification only, prior authorization is not required.
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Support (LTSS):** not a covered benefit.
- **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/Facilities:**

Prior Authorization is required for office visits, procedures, labs, diagnostic studies, inpatient stays except for:

 - Emergency and Urgently Needed Services;
 - Professional fees associated with ER visits and approved Ambulatory Surgery Center (ASC) or inpatient stays;
 - Local Health Department (LHD) services;
 - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting;
 - Radiologists, Anesthesiologists, and Pathologists professional services when billed in POS 19, 21, 22, 23 or 24.
 - Other services based on State requirements.
- **Occupational, Physical & Speech Therapy:** Prior Authorization required after the evaluation and first 7 visits.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Pregnancy and Delivery:** Notification only, Prior Authorization is not required.
- **Prosthetics/Orthotics**
- **Pulmonary Rehab/Therapy**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies:** Except Home (POS 12) sleep studies
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** All non-emergent transportation.
- **Vision:** Pediatric Low Vision Optical Devices and Services: Please contact VSP at 1 (800) 877-7195 or visit their website at www.vsp.com/advantage

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MARKETPLACE 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 (855) 237-6178

IMPORTANT MOLINA HEALTHCARE MARKETPLACE CONTACT INFORMATION

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

SERVICE AREA	PHONE	FAX	SERVICE AREA	PHONE	FAX
Prior Authorizations including Behavioral Health Authorizations:	(855) 237-6178	(866) 423-3889	Vision (VSP):	(800) 877-7195	Website: www.vsp.com/advantage
Pharmacy Authorizations:	(855) 237-6178, option 2	(855) 571-3011	Member Customer Service, Benefits/ Eligibility:	(855) 885-3176 TTY: 711	N/A
Radiology Authorizations:	(855) 714-2415, press 72 for South Carolina	(877) 731-7218	Transplant Authorizations:	(855) 237-6178	(866) 423-3889
Transportation:	Contact Molina Prior Authorization Department to arrange	N/A	Provider Customer Service:	(855) 237-6178	N/A
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
- Claims submission and status
- Member Eligibility
- Download Frequently used forms
- Provider Directory
- Nurse Advice Line Report

**MEMBER INFORMATION**

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:				DOB (MM/DD/YYYY):
Member ID#:				Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission <input type="checkbox"/> EPSDT/Special Services			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Other Inpatient: _____	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic/Genomic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Imaging/Special Tests	<input type="checkbox"/> Office Procedures <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Laboratory Services <input type="checkbox"/> LTSS Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Outpatient Surgical/Procedures <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Transplant/Gene Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: _____

J Code Drug Requests (Include J Code, Drug Name, Dosage, and Frequency)

J Code:	Drug Name:	Dosage:	Frequency:
J Code:	Drug Name:	Dosage:	Frequency:
J Code:	Drug Name:	Dosage:	Frequency:
J Code:	Drug Name:	Dosage:	Frequency:

Please send clinical notes and any supporting documentation

Primary ICD-10 Code:

Description:

DATES OF SERVICE		PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
START	STOP				

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):	<input type="checkbox"/> Non-Par <input type="checkbox"/> 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.