Molina Healthcare of Washington
Medicaid and Medicare Prior Authorization/Pre-Service Review Guide
Effective: 01/01/2016

Use Clear Coverage 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

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare Medicaid and Medicare Members – excludes Marketplace

Refer to Molina's website or portal for specific codes that require authorization

Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment - (not covered for Medicaid)
  - Electroconvulsive Therapy (ECT) - (not covered for Medicaid)
  - Alcohol and Chemical Dependency Services - (not covered for Medicaid) with the exception Medication Assisted Treatment (MAT) or maintenance therapy for substance use disorders (Medicaid only)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cardiac Rehab**: Limit of 24 visits per calendar year for codes 93797, 93798, G0422, G0423 (covered only for qualifying diagnosis). Limit of 36 visits per calendar year Medicare.
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)**
- **Durable Medical Equipment:** Refer to Molina's provider website or portal for specific codes that require authorization.
  - Medicare Hearing Supplemental benefit: Contact Avesis at 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.
- **Habilitative Therapy – Requires authorization for adults:** Covered only for qualifying diagnosis. Medicaid only
- **Home Healthcare and Home Infusion:** After initial evaluation plus six (6) visits; Home Infusion nursing visits (Medicaid only).
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty Imaging:** Refer to Molina's provider website or portal for specific codes that require authorization
- **Inpatient Admissions: Acute Hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice** (Hospice requires notification only). Hospice covered by traditional Medicare.
- **Long Term Services and Supports:** Refer to Molina's provider website or portal for specific codes that require authorization. Not a Medicare covered benefit **(per state benefit).**
- **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, approved Ambulatory Surgery Center (ASC) or inpatient stay
- **Office Visits and Procedures:** PAR providers do not require prior authorization
- **Outpatient Hospital/ ASC Procedures:** Refer to Molina's provider website or portal for specific codes that require authorization
- **Pain Management Procedures:** Except trigger point injections (Acupuncture is not a Medicare covered benefit).
- **Physical/Occupational Therapy:** Requires prior authorization for adult (Medicaid); after initial evaluation plus 24 visits, Medicare requires notification, Maximum for Medicare is annual cap.
- **Prosthetics/Orthotics:** Refer to Molina's provider website or portal for specific codes that require authorization.
- **Radiation Therapy and Radiosurgery (for selected services only):** Refer to Molina's provider website or portal for specific codes that require authorization.
- **Sleep Studies (Except for Home Sleep Studies)**
- **Specialty Pharmacy Drugs (oral and injectable):** Refer to Molina's provider website or portal for specific codes that require authorization.
- **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
- **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. Medicare will not cover T codes or S codes.

***STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form (HCA 13-364) and the date the sterilization was performed. The consent form must be submitted with claim. (Medicaid benefit only)**

MOLINA HEALTHCARE

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICAID and MEDICARE

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 (425) 398-2603

Important Molina Healthcare Medicaid and Medicare Information

Prior Authorizations: 8:00 a.m. – 5:00 p.m.
Phone: (800) 869-7185 Fax: (800) 767-7188

Medicare All Outpatient and Elective Inpatient
Prior Authorizations: 8:00 a.m. – 5:00 p.m.
Phone: (800) 869-7185 Fax: (844) 251-1450

Medicare & Medicaid SNF/LTAC/Rehabilitation
Phone: (800) 869-7185 Fax: (800) 767-7188

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

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

Pharmacy Authorizations:
Phone: (800) 869-7185 Fax: (800) 869-7791

Behavioral Health Authorizations:
Phone: (800) 869-7185 Fax: (800) 767-7188

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

Member Customer Service Benefits/Eligibility:
Phone: (800) 869-7165 (TTY 711) Fax: (800) 816-3778

Provider Customer Service: 8:00 a.m. – 5:00 p.m.
Phone: (888) 858-5414 Fax: (877) 814-0342

24 Hour Nurse Advice Line
English: (888) 275-8750 (TTY 711)
Spanish: (866) 648-3537

Vision Care:
Phone: (888) 493- 4070 Fax: (866) 772-0285

Transportation:
Phone: (800) 869-7185 Fax: (800) 767-7188

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

- **Electronic authorization submission and status through Clear Coverage application with potential for automatic approval at the time of submission https://eportal.molinahealthcare.com/Provider/Login**
- **Claims Submission and Status**
- **Download Frequently Used Forms**
- **Member Eligibility**
- **Provider Directory**
- **Nurse Advice Line Report**

MOLINA HEALTHCARE

Molina Healthcare of Washington
Medicaid and Medicare Prior Authorization Request Form

Phone Number: (800) 869-7185

MEDICAID & MEDICARE SNF/LTAC/REHABILITATION

Fax Number: (800) 767-7188

MEDICARE ALL Outpatient and Elective Inpatient

Fax Number: (844) 251-1450

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

***Definition of Urgent / Expedited 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 ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Infusion Therapy ☐ Office Based Hospital Procedures ☐ Other: ☐ Speech/Habilitative Therapy ☐ Hyperbaric Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office (excludes hospital based offices)**

ICD10 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:			
Facility Providing Service:			
Contact at Requesting Provider's office:			
Phone Number:	( ) -	Fax Number:	( ) -

For Molina Use Only: