Behavioral Health Prior Authorization Reference Guide

Prior Authorization Submission Preparation

- Member comes in for services or calls to schedule services with Provider.
- Provider confirms benefit eligibility with Molina Healthcare through the e-portal or by contacting Member Services.
- Provider completes initial assessment with member and determines the Level of Care needed.
- Provider completes the Molina Prior Authorization form requesting appropriate Level of Care with all relevant clinical information included.
- Provider sends the appropriate completed Molina Prior Authorization form to the Molina Healthcare of Ohio Prior Authorization Team:

  Fax (866) 553-9262; **Phone** (855) 322-4079

  Web Portal: https://eportal.molinahealthcare.com/Provider/Login

After the Prior Authorization Request form is submitted

Next steps:

- Form may be faxed back to the provider with authorization number and time frame included on form.
- Provider may receive a call with authorization information.
- Provider may receive a request (via fax or phone) for additional clarifying clinical information for further authorization consideration.
- Provider may receive verbal notification and will receive written notification of denial of request with information on denial reasoning and how to have request reconsidered if desired.
- Turnaround times for authorization processing and response:

  Emergent (Inpatient BH or other higher LOC) - NO PA REQUIREMENT FOR ANY EMERGENCY INPATIENT SERVICES. Cases will be reviewed within 24 hours.

  Expedited/Urgent Outpatient Services - **72 hours**

  Routine (All Outpatient LOC) - **14 days**

  **For questions or concerns regarding continuity of care for new Molina members, contact the Molina Healthcare Prior Authorization Team at (855) 322-4079.

- Initial Authorization Average Timeframes. (Actual time authorized is based on adequate clinical information and medical necessity.)
    - Inpatient Admission:
        - **2 to 3 days**
        - AUTHORIZATIONS ARE ENTERED WITHIN 24 to 48 HOURS AFTER RECEIVING CLINICAL INFORMATION.
    - Partial Hospitalization/Intensive Outpatient:
        - **2 weeks**
    - Alternative Outpatient Services (Community-Based Behavioral Health Services):
    - **Authorization timeframe is based on medical necessity** Traditional Outpatient (Individual, Group, and Family Psychotherapy) up to 12 visits authorized per initial request – can list multiple codes on a single authorization (to cover multiple time frames):
        - **6 months for participating provider; 3 months for non-participating provider**
            - Provider can request separate authorization for family (up to 12 visits per initial request) and group (up to 12 visits per initial request). Clinical information provided for review and all services rendered by the Provider must meet Medical Necessity. Authorizations will be provided for covered services ONLY.

After Hours Requests

For Outpatient/Community BH Service Requests – Providers may submit request forms after hours. Providers may follow up with the Molina Care Access and Monitoring Team the next business day for authorization status.

For Emergent Admissions – Follow local Medical Necessity Guidelines and submit the appropriate Level of Care Request form. The request will be processed the next business day. Providers may follow up with the Molina Care Access and Monitoring Team the next business day for authorization status.

Providers do have the option of contacting the Molina Healthcare 24-Hour Nurse Advice Line for admission notification prior to request submission. Clinical information from the Provider is still required to be submitted to the Molina Healthcare Utilization Management Team for review