# Molina Healthcare of Nebraska Medicaid
## Prior Authorization/Pre-Service Review Guide
### Effective: 01/01/2024

**Refer to Molina's Provider Website or Prior Authorization Look-Up Tool for specific codes that require Prior 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, Residential Treatment, Partial hospitalization, Day Treatment, Intensive Outpatient require notification and subsequent concurrent review.
  - Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses for certain procedures.
- **Durable Medical Equipment:** DME over $750 requires PA.
- **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 or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services:** PA required after 6 visits per calendar year.
- **Hyperbaric/Wound Therapy**

- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale should be submitted with the prior authorization request.
- **Non-Par Providers:**  Receipt of ALL services or items from a non-contracted provider in all places of service require prior authorization approval with the exception of:
  - Local Health Department (LHD) services
  - Hospital Emergency services
  - Evaluation and Management services associated with inpatient, ER, and observation stays or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
  - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23 or 24, 51, 52
  - Other State mandated services
- **Occupational, Physical & Speech Therapy (including home-based PT/OT/ST):** PA Required after 12 visits of each therapy type per calendar year. Benefit limits apply.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics:** DME over $750 requires PA.
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** Non-emergent air transportation.

**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 the claim.**

## IMPORTANT INFORMATION FOR MOLINA 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 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 8 am to 5 pm Monday through Friday at (844) 782-2678.

## IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION
### (Service hours 8am-5pm central time M-F, unless otherwise specified)

**Prior Authorizations including Behavioral Health Authorizations:**
Phone: (844) 782-2678
Fax: (833) 832-1015

**24 Hour Behavioral Health Crisis (7 days/week):**
CareNet
Phone: (207) 228-6513

**Pharmacy Authorizations:**
Phone: (844) 782-2678
Fax: (877) 281-5364

**Dental:** Skygen
Provider Services phone: (885) 806-5192
Member Services phone: (855) 806-5191
Website: https://app.dentalhub.com/app/login

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

**Transplant Authorizations:**
Phone: (855) 714-2415
Fax: (877) 813-1206

**Provider Services:**
Phone: (844) 782-2678
7am-6pm Monday - Friday

**Member Customer Service, Benefits/Eligibility:**
Phone: (844) 782-2018/ TTY/TDD 711
8am – 6pm Monday - Friday

**Transportation:** MTM
Phone: (888) 889-0421
Fax: (636) 561-2962
24 hours a day (7 days/week)
Website: https://memberportal.net/

**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:

- Prior Authorization submission and status
- Member Eligibility
- Provider Directory

☐ Claims submission and status
☐ Download Frequently used forms
☐ Nurse Advice Line Report

## Molina Healthcare of Nebraska, Inc. – Pre-Service Request Form

### MEMBER INFORMATION

| | |
|---|---|
| **Line of Business:** ☐ **Medicaid**  ☐ **Marketplace**  ☐ **Medicare** | **Date of Request:** |
| **State/Health Plan (i.e. CA):** | |
| **Member Name:** | **DOB** (MM/DD/YYYY): |
| **Member ID#:** | **Member Phone:** |

**Service Type:**
☐ Non-Urgent/Routine/Elective
☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____
☐ Emergent Inpatient Admission
☐ EPSDT/Special Services

### REFERRAL/SERVICE TYPE REQUESTED

**Request Type:**  ☐ **Initial Request**  ☐ **Extension/ Renewal / Amendment**  | **Previous Auth#:**

**Inpatient Services:**
☐ Inpatient Hospital
☐ Inpatient Transplant
☐ Inpatient Hospice
☐ Long Term Acute Care (LTAC)
☐ Acute Inpatient Rehabilitation (AIR)
☐ Skilled Nursing Facility (SNF)
☐ Other Inpatient:_____

**Outpatient Services:**

| | | |
|---|---|---|
| ☐ Chiropractic | ☐ Office Procedures | ☐ Pharmacy |
| ☐ Dialysis | ☐ Infusion Therapy | ☐ Physical Therapy |
| ☐ DME | ☐ Laboratory Services | ☐ Radiation Therapy |
| ☐ Genetic Testing | ☐ LTSS Services | ☐ Speech Therapy |
| ☐ Home Health | ☐ Occupational Therapy | ☐ Transplant/Gene Therapy |
| ☐ Hospice | ☐ Outpatient Surgical/Procedures | ☐ Transportation |
| ☐ Hyperbaric Therapy | ☐ Pain Management | ☐ Wound Care |
| ☐ Imaging/Special Tests | ☐ Palliative Care | ☐ Other: _____ |

### PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

**Primary ICD-10 Code:**          **Description:**

| Dates of Service Start | Stop | Procedure/ Service Codes | Diagnosis Code | Requested Service | Requested Units/Visits |
|---|---|---|---|---|---|
| | | | | | |
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### 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):** | ☐Non-Par  ☐COC |
| **Phone**: | **FAX:** | **Email**: | |
| **Address:** | **City:** | **State:**  **Zip:** | |

**For Molina Use Only:**

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

# Molina® Healthcare, Inc. – BH Pre-Service and Concurrent Review Request Form

## MEMBER INFORMATION

| Line of Business: | ☐ Medicaid | ☐ Marketplace | ☐ Medicare | Date of Request: |
|---|---|---|---|---|

| State/Health Plan (i.e. CA): | |
|---|---|

| Member Name: | | DOB (MM/DD/YYYY): |
|---|---|---|

| Member ID#: | | Member Phone: |
|---|---|---|

**Service Type:**
☐ Non-Urgent/Routine/Elective
☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____
☐ Emergent Inpatient Admission

## REFERRAL/SERVICE TYPE REQUESTED

| Request Type: | ☐ Initial Request | ☐ Extension/ Renewal / Amendment | Previous Auth#: |
|---|---|---|---|

| **Inpatient Services:** | **Outpatient Services:** | |
|---|---|---|
| ☐ Inpatient Psychiatric<br>   ☐Involuntary ☐Voluntary<br><br>☐ Inpatient Detoxification<br>   ☐Involuntary ☐Voluntary<br><br>If Involuntary, Court Date:<br>_____ | ☐ Residential Treatment<br>☐ Partial Hospitalization Program<br>☐ Intensive Outpatient Program<br>☐ Day Treatment<br>☐ Assertive Community Treatment Program<br>☐ Targeted Case Management | ☐ Electroconvulsive Therapy<br>☐ Psychological/Neuropsychological Testing<br>☐ Applied Behavioral Analysis<br>☐ Non-PAR Outpatient Services<br>☐ Other: _____ |

## PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

**Primary ICD-10 Code for Treatment:**       **Description:**

| Dates of Service Start | Stop | Procedure/ Service Codes | Diagnosis Code | Requested Service | Requested Units/Visits |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## 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): | ☐Non-Par<br>☐COC |
|---|---|---|---|

| Phone: | FAX: | Email: |
|---|---|---|

| Address: | City: | State: | Zip: |
|---|---|---|---|

| **For Molina Use Only:** |
|---|
| |

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.