

# MOLINA® HEALTHCARE MEDICAID

## PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE

### EFFECTIVE: 01/01/2021

**REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK-UP TOOL/MATRIX 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 Special Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial Hospitalization, Day Treatment, Intensive Outpatient, 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.
- **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)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services & Support (Per State benefit):** All LTSS services require PA regardless of code(s).
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, necessity documentation, pricing and rationale must be submitted with the prior authorization request.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** PA is required for office visits, procedures, labs, diagnostic studies, and inpatient stays except for:
  - Emergency and Urgently Needed Services;
  - Professional fees for Medicaid enrolled providers associated with ER visits and approved Ambulatory Surgery Center (ASC) or inpatient stays;
  - Local Health Department (LHD) services;
  - Radiologists, anesthesiologists, and pathologists professional services when billed in POS 19, 21, 22, 23 or 24;
  - PA is waived for professional component services or services billed from Medicaid enrolled providers with Modifier 26 in ANY place of service setting;
  - Other State mandated services.
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **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 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 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 1 (888) 483-0760.

### Important Molina Healthcare Medicaid Contact Information (Service hours 8am-5pm local M-F, unless otherwise specified)

**Prior Authorizations including Behavioral Health Authorizations:**

Phone: 1 (855) 322-4081  
Fax: 1 (866) 472-0589

**Pharmacy Authorizations:**

Phone: 1 (855) 322-4081  
Fax: 1 (866) 497-7448

**Radiology Authorizations:**

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

**Provider Customer Service:**

Phone: 1 Phone: 1 (855) 322-4081

**Transportation:**

Phone: 1 (801) 538-6155

**24 Hour Behavioral Health Crisis (7 days/week):**

Phone: (844) 800-5154

**Dental:**

Phone: 1 (877) 854-4242  
Website:

**Vision:**

Phone: 1 (844) 350-4089

**Member Customer Service, Benefits/Eligibility:**

Phone: (888)483-0760/ TTY/TDD 711

**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.*

**Transplant Authorizations:**

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

**Providers may utilize Molina Healthcare’s Website at:** <https://provider.molinahealthcare.com/Provider/Login>

Available features include:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Authorization submission and status</li> <li>• Member Eligibility</li> <li>• Provider Directory</li> </ul> | <ul style="list-style-type: none"> <li>▪ Claims submission and status</li> <li>▪ Download Frequently used form</li> <li>▪ Nurse Advice Line Report</li> </ul> |
|---|---|

## Molina® Healthcare, Inc. – Prior Authorization Service Request Form

### MEMBER INFORMATION

<b>Line of Business:</b>	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	<b>Date of Request:</b>
<b>State/Health Plan (i.e. CA):</b>				
<b>Member Name:</b>			<b>DOB (MM/DD/YYYY):</b>	
<b>Member ID#:</b>			<b>Member Phone:</b>	
<b>Service Type:</b>	<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

<b>Request Type:</b>	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	<b>Previous Auth#:</b>
<b>Inpatient Services:</b>	<b>Outpatient Services:</b>		
<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 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: _____

### 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	

### PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:					
<b>Provider Name:</b>	<b>NPI#:</b>	<b>TIN#:</b>			
<b>Phone:</b>	<b>FAX:</b>	<b>Email:</b>			
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>		
<b>PCP Name:</b>			<b>PCP Phone:</b>		
<b>Office Contact Name:</b>			<b>Office Contact Phone:</b>		
SERVICING PROVIDER / FACILITY:					
<b>Provider/Facility Name (Required):</b>					
<b>NPI#:</b>	<b>TIN#:</b>	<b>Medicaid ID# (If Non-Par):</b>	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC		
<b>Phone:</b>	<b>FAX:</b>	<b>Email:</b>			
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>		
<b>For Molina Use Only:</b>					

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.

## Molina® Healthcare, Inc. – BH Prior Authorization Service Request Form

### MEMBER INFORMATION

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

### REFERRAL/SERVICE TYPE REQUESTED

<b>Request Type:</b>	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	<b>Previous Auth#:</b>
<b>Inpatient Services:</b>	<b>Outpatient Services:</b>		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary  <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary  If Involuntary, Court Date: _____	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management		<input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> 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:

<b>Provider Name:</b>		<b>NPI#:</b>	<b>TIN#:</b>
<b>Phone:</b>	<b>FAX:</b>	<b>Email:</b>	
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>PCP Name:</b>		<b>PCP Phone:</b>	
<b>Office Contact Name:</b>		<b>Office Contact Phone:</b>	

#### SERVICING PROVIDER / FACILITY:

<b>Provider/Facility Name (Required):</b>			
<b>NPI#:</b>	<b>TIN#:</b>	<b>Medicaid ID# (If Non-Par):</b>	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
<b>Phone:</b>	<b>FAX:</b>	<b>Email:</b>	
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>

**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