



# MOLINA HEALTHCARE MEDICAID/MARKETPLACE PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE EFFECTIVE: 1/1/19

**THIS PRIOR AUTHORIZATION/PRE SERVICE GUIDE APPLIES TO ALL MOLINA HEALTHCARE MEDICAID MEMBERS ONLY  
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**

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment;
  - Electroconvulsive Therapy (ECT);
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD). (Marketplace Only)
- **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.
- **Experimental/Investigational Procedures.**
- **Genetic Counseling and Testing**
- **Home Healthcare and Home Infusion (Including Home PT, OT or ST):** After initial evaluation plus six (6) visits per calendar year.
- **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.
- **Long Term Services and Supports:** All LTSS services require PA regardless of codes. **(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 and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Professional component services or services billed with Modifier 26 in ANY place of service setting
  - Local Health Department (LHD) services;
  - Women's Health, Family Planning and Obstetrical Services
  - Federally Qualified Health Center (FQHC) Rural Health Center (RHC) or Tribal Health Center (THC)
- **Occupational Therapy:** After initial evaluation plus 36 visits per calendar year for office and outpatient settings.
- **Office-Based Procedures do not require authorization, unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office.**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization.
  - Site of Service Authorizations – Some procedures require authorization when performed in an outpatient hospital setting rather than an Ambulatory Surgery Center. Refer to Molina's Provider website or portal for specific codes requiring authorization based on Site of Service
- **Pain Management Procedures:** Refer to Molina's Provider website for specific codes that require authorization. Anesthesia or moderate sedation services associated with pain management procedures are not payable for members over 18 years old. (00300, 00400, 00600, 01935, 01936, 01991, 01992, 99152 and 99153) When billed without a surgical code (10021-69990).
- **Physical Therapy:** After initial evaluation plus 36 visits per calendar year for office and outpatient settings.
- **Prosthetics/Orthotics:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Radiation Therapy and Radiosurgery:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Sleep Studies:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Specialty Pharmacy drugs:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Speech Therapy:** After initial evaluation plus six (6) visits for office, outpatient and home settings. Pediatric cochlear implants – allowed up to 36 visits with prior authorization.
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** non-emergent Air Transport.
- **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. Molina requires PA for all unlisted codes except 90999 does not require PA.

**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 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 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 1 (888) 898-7969

## IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

**Prior Authorizations:**

8:30 a.m. – 5:00 p.m. Local Time  
 Phone: 1 (888) 898-7969      Fax: 1 (800)594-7404

**Member Customer Service Benefits/Eligibility:**

Phone: 1 (888) 898-7969      Fax: 1 (248) 925-1765  
 TTY/TDD: 1 (800) 649-3777

**Behavioral Health Authorizations:**

Phone: 1 (888) 898-7969      Fax: 1 (800) 594-7404

**NICU Authorizations:**

Phone: 1 (855) 714-2415      Fax: 1 (800) 594-7404

**Non-NICU OB Authorizations:**

Phone: 1 (855) 714-2415      Fax: 1 (844) 861-1930

**Pharmacy Authorizations:**

Phone: 1 (888) 898-7969      Fax: 1 (888) 373-3059

**Radiology Authorizations:**

Phone: 1 (855) 714-2415      Fax: 1 (877) 731-7218

**Transplant Authorizations:**

Phone: 1 (855) 714-2415      Fax: 1 (877) 813-1206

**Provider Customer Service:**

8:30 a.m. – 5:00 p.m. Local Time  
 Phone: 1 (855) 322-4077      Fax: 1 (248) 925-1784

**24 Hour Nurse Advice Line**

English: 1 (888) 275-8750 [TTY: 1 (866) 735-2929]  
 Spanish: 1 (866) 648-3537 [TTY: 1 (866) 833-4703]

**Transportation:**

Phone: 1 (866) 712-1063

**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**



## Molina Healthcare Medicaid Prior Authorization Request

**Phone Number: Refer to Number(s) above**  
**Fax Number: Refer to Number(s) above**

MEMBER INFORMATION			
<b>Plan:</b>	<input type="checkbox"/> Molina Medicaid	<input type="checkbox"/> Other:	
<b>Member Name:</b>		<b>DOB:</b>	/ /
<b>Member ID#:</b>		<b>Phone:</b>	( ) -
<b>Service Type:</b>	<input type="checkbox"/> Elective/Routine	<input type="checkbox"/> Expedited/Urgent*	

**\*Definition of Expedited/Urgent 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			
<b>Inpatient</b> <input type="checkbox"/> Surgical procedures <input type="checkbox"/> Admissions <input type="checkbox"/> SNF <input type="checkbox"/> LTAC	<b>Outpatient</b> <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Diagnostic Procedure <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Other: _____	<input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Pain Management	<input type="checkbox"/> Home Health <input type="checkbox"/> DME <input type="checkbox"/> Wheelchair <input type="checkbox"/> In Office
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:		NPI#:	
		TIN#:	
Servicing Provider or Facility:		NPI#:	
		TIN#:	
Servicing Facility Address:			
Contact at Requesting Provider's office:			
Phone Number:	( ) -	Fax Number:	( ) -
<b>For Molina Use Only:</b>			



## Alternative Level of Care Authorization Form

Phone: 866-449-6828

All Lines of Business Fax: (800) 594-7404

<b>Patient Name:</b>		<b>Molina ID:</b>		<b>DOB/Age:</b>	<b>Today's Date:</b>
<b>Molina LOB:</b>		<input type="checkbox"/> Medicare <input type="checkbox"/> MMP / Duals <input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace			
<b>Level of Care Requested Based on InterQual:</b>				<input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> LTACH <input type="checkbox"/> Custodial/Long term care (MMP only) <input type="checkbox"/> Disenrollment request	
<input type="checkbox"/> SNF Level 1 (1 discipline–1-2 hrs/5 days/wk) <input type="checkbox"/> SNF Level 2 (4 hrs SN <b>OR</b> 1 discipline 2-3hrs/5 days/wk) <input type="checkbox"/> SNF Level 3 (IV abx, wound) (4 hrs SN <b>AND</b> 1 discipline 2-3 hrs/5 days/wk) <input type="checkbox"/> SNF Level 4 (vent/dialysis)					
<b>Nursing Facility Requested:</b>			<b>Hospital:</b>		
<b>Tentative Admission Date:</b>			<b>Hospital Admission Date:</b>		
<b>Facility Contact Information:</b>	CM/RN Name:		<b>Hospital Contact Information:</b>	CM/RN Name:	
	CM/RN Phone:			CM/RN Phone:	
	CM/RN Fax:			CM/RN Fax:	
<b>Active Diagnosis (include ICD10 Codes):</b>			<b>Most Recent Vital Signs:</b>		
1.			BP: _____ T: _____		
2.			P: _____ SpO2: _____		
3.			R: _____ Wt: _____		
<b>Current Clinical Condition:</b>			<b>Past Medical/Surgical History: (Brief, related to current condition):</b>		
<b>Please indicate:</b> <input type="checkbox"/> Smoker <input type="checkbox"/> Alcohol/Substance Use <input type="checkbox"/> DME			<b>Living Arrangements:</b> <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with someone <input type="checkbox"/> Homeless <input type="checkbox"/> Other: _____		
<b>Needs Help With:</b>					
<input type="checkbox"/> Feeding <input type="checkbox"/> Toileting <input type="checkbox"/> Bathing <input type="checkbox"/> Grooming <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Other _____					
<b>Prior Level of Functioning before hospitalization:</b>					
<input type="checkbox"/> Independent <input type="checkbox"/> Contact Guard <input type="checkbox"/> Supervised <input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Other: _____					
<b>Participation Assistance Required while in SNF/IPR:</b>			<b>Daily Participation Level while in hospital:</b>		
PT: <input type="checkbox"/> Max <input type="checkbox"/> Mod <input type="checkbox"/> Min            Contact Guard OT: <input type="checkbox"/> Max <input type="checkbox"/> Mod <input type="checkbox"/> Min            Contact Guard ST: <input type="checkbox"/> Max <input type="checkbox"/> Mod <input type="checkbox"/> Min            Contact Guard Ambulation (Current): _____ ft    Goal: _____ ft			PT: _____ hrs <b>OR</b> _____ min OT: _____ hrs <b>OR</b> _____ min ST: _____ hrs <b>OR</b> _____ min		
<b>IV Medications that will continue post d/c (Must include start/date, dose, frequency):</b>					
<b>Additional Comments:</b>					

**\*\*Therapy/Treatment Notes within 4 days of discharge must be included with this request**



# Molina Healthcare OB Notification Form

**Phone Number: 1-888-898-7969**

**Fax Number: 844-861-1930 (Routine OB – NON - NICU)**

**Fax Number: 800-594-7404 (NICU)**

**\*\*\* 1 FORM PER NEWBORN \*\*\***

Mother's Information					
Plan	<input type="checkbox"/> Medicaid <input type="checkbox"/> MiChild <input type="checkbox"/> Medicare <input type="checkbox"/> Marketplace				
Mother's Name:		Mother's DOB	/ /		
Mother's ID #:		Mother's Phone:	(    )    -		
Mother's Admit Date:	/ /	Mother's Discharge Date	/ /		
Service Type:	NEWBORN NOTIFICATION	<input type="checkbox"/> NICU NICU Level _____ <input type="checkbox"/> Border Baby Hospital Referred to CSHCS? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Newborn Information					
Newborn Name:		Newborn DOB	/ /		
Newborn Admit Date	/ /	Newborn Discharge Date	/ /		
Newborn Admit Date:	From	/ /	TO:	/ /	
Birth Order	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Other _____				
Diagnosis Code & Description:					
Delivery Date:	/ /				
Delivery Type:	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> VBAC <input type="checkbox"/> Repeat C-Section				
Multiples?:	<input type="checkbox"/> No <input type="checkbox"/> Yes              Quantity _____				
Baby's Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female				
Baby's Weight:	_____lb    _____oz				
Apgar Score:	/				
EDD:	/ /				
Gestation:	_____ wks				
Birth Outcome:	<input type="checkbox"/> Discharge with Mom <input type="checkbox"/> Border Baby <input type="checkbox"/> Going to Foster Care  <input type="checkbox"/> Adoption <input type="checkbox"/> Fetal Demise				
Provider Information					
Facility Name		NPI #:		TIN#:	
Attending Provider:		NPI #:		TIN#:	
Contact Information					
Name:					
Phone Number:	(    )    -	Fax Number:	(    )    -		