



MOLINA HEALTHCARE MEDICARE PRE-SERVICE REVIEW GUIDE EFFECTIVE: 1/1/22

REFER TO MOLINA'S PROVIDER WEBSITE OR PORTAL FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

*INDICATES CODES ARE DELEGATED TO EVICORE FOR AUTHORIZATION

OFFICE VISITS OR REFERRALS TO IN NETWORK / PARTICIPATING PROVIDERS DO NOT REQUIRE PRIOR AUTHORIZATION

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services**
- **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):** Medicare will not require PA for first 60-day episode of home care in a year. For continued home care beyond 60 days an authorization will be required.
- **Hyperbaric Therapy**
- **Imaging and Specialty Tests***
- **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.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** Office visits, procedures, labs, diagnostic studies, inpatient stay 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:** PA required after benefit CAP of \$2,080 has been met.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Pain Management Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Physical Therapy:** PA required after therapy CAP of \$2,110 has been met for combined benefits PT and ST.
- **Prosthetics/Orthotics:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Radiation Therapy and Radiosurgery***
- **Sleep Studies***
- **Specialty Pharmacy drugs:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Speech Therapy:** PA required after therapy CAP of \$2,110 has been met for combined benefits PT and ST.
- **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.

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

MICHIGAN (Service hours 8am-5pm local M-F, unless otherwise specified)		
Service	Phone	Fax
Prior Authorizations (inc. Behavioral Health)	(855) 322-4077	(844) 251-1450 (Medicare)
		(844) 251-1451 (MMP)
Imaging Authorizations	(855) 322-4077	(877) 731-7218
Inpatient Admit & Discharge Authorizations	(855) 322-4077	(844) 834-2152
Transplant Authorizations	(855) 714-2415	(877) 813-1206
Pharmacy Authorization	(888) 665-3086	(866) 290-1309
Member Service	(888) 898- 7969 TTY/TDD: 711	
Provider Service	(855) 322-4077	(248) 925-1784
Dental	(800) 327-4462	
Vision (VSP)	(888) 493-4070	
Transportation	(855) 735-5604	
24 Hour Nurse Advice Line (7 days/Week)		
English	1 (888) 275-8750 / TTY: 1 (866) 735-2929	
Spanish	1 (866) 648-3537 / TTY: 1 (866) 833-4703	



Molina Healthcare – Prior Authorization Request Form

MEMBER INFORMATION				
Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	
Service Type:				
<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			
Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:		Outpatient Services:	
<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	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS	
START	STOP				

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):	
				<input type="checkbox"/> Non-Par <input type="checkbox"/> COC	
Phone:		FAX:		Email:	
Address:			City:		State:
					Zip:
For Molina Use Only:					



Molina Healthcare – BH Prior Authorization Request Form

MEMBER INFORMATION

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

REFERRAL/SERVICE TYPE REQUESTED

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

DATES OF SERVICE		PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
START	STOP				

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):		<input type="checkbox"/> Non-Par <input type="checkbox"/> COC	
Phone:		FAX:		Email:	
Address:			City:	State:	Zip:
For Molina Use Only:					



Alternative Level of Care Authorization Form

Phone: 866-449-6828

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

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

****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 #:		
Attending Provider:			NPI #:		
Contact Information					
Name:					
Phone Number:	() -		Fax Number:	() -	