

# Molina® Healthcare Medicaid

## Prior Authorization/Pre-Service Review Guide

### Effective: 10/1/2024

**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 above 16 units require notification and subsequent concurrent review
  - Targeted Case Management;
  - Electroconvulsive Therapy (ECT);
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- **Cardiology**
- **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**
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST/SN)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (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, medical necessity documentation and rationale should be submitted with the prior authorization request.
- **Neuropsychological and Psychological Testing** after initial 4 hours of testing
- **Non-Par Providers:** With the exception of some facility-based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval.
  - 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.
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy**
- **Oncology**
- **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: Please contact the local Transportation Manager; Medical Answering Services (All of NY except Nassau or Suffolk County) or ModivCare (Long Island Region); Emergency Transportation is covered by Fee for Service by the state.  
\* Child Health Plus Emergency transportation services covered by plan.

**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 are also 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 (877) 872-4716.

## IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

(Service hours 8am-6pm local M-F, unless otherwise specified)

**Prior Authorizations including Behavioral Health**

**Authorizations:**

Phone: (877) 872-4716  
Fax: (866) 879-4742

**Pharmacy Authorizations: (including J-code requests)**

Phone: (877) 872-4716  
Fax: (844) 823-5479

**Radiology Authorizations:**

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

**Provider Customer Service:**

Phone: (877) 872-4716

**Progeny: (NICU Admissions)**

Phone: (888) 832-2006  
Fax: (833) 734-1510

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

Phone: (844) 819-5977

**Dental:**

Phone: (888) 308-2508  
Website: [www.dentaquest.com](http://www.dentaquest.com)

**Vision:**

Phone: (866) 819-4298  
Website: [www.superiorvision.com](http://www.superiorvision.com)

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

Phone: (800) 223-7242/ TTY/TDD 711

**Transplant Authorizations:**

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

**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:

- |                                       |   |
|---------------------------------------|---|
| • Authorization submission and status | <input type="checkbox"/> Claims submission and status   |
| • Member Eligibility                  | <input type="checkbox"/> Download Frequently used forms |
| • Provider Directory                  | <input type="checkbox"/> Nurse Advice Line Report       |

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

**Fax completed form with clinical to (866) 879-4742**

**Fax number for Pharmacy J-code requests: (844) 823-5479**

**MEMBER INFORMATION**

<b>Line of Business:</b>	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Essential Plan	<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 <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(Short Term) # of visits used to date: _____ <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 (CDPAS/PCS/PDN) <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(CHP Only) <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/BILLING 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"/> Continuity of Care (COC)* Accepts 100% Medicaid rate <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Out of Network</b> <b>Reason:</b> _____
<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:**

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.

- Please refer to the provider manual for definition of Continuity of Care

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

**Fax completed form with clinical to (866) 879-4742**

**Fax number for Pharmacy J-code requests: (844) 823-5479**

### MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Essential Plan	<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  <input type="checkbox"/> Inpatient Rehabilitation <input type="checkbox"/> Stabilization <input type="checkbox"/> Rehabilitative <input type="checkbox"/> Reintegration  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"/> Home and Community Based Services- Adult <input type="checkbox"/> Home and Community Based Services- Children  <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:

Provider Name:		NPI#:		TIN#:	
Phone:		FAX:		Email:	
Address:			City:		State:
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"/> Continuity of Care (COC) * Accepts 100% Medicaid rate <input type="checkbox"/> Yes <input type="checkbox"/> No Out of Network Reason: _____		
Phone:		FAX:		Email:	
Address:			City:		State:

#### 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.

- Please refer to the provider manual for definition of Continuity of Care