MOLINA HEALTHCARE
MEDICAID
PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 1/1/24

Refer to Molina's Provider Website or Prior Authorization Look-Up tool for specific codes that require Prior Authorization

Only covered services will be 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

- **Behavioral Health:** Services including diagnosis, evaluation, and treatment of ASD for beneficiaries 21 years and younger are covered by the PIHP.
- **Cosmetic, Plastic and Reconstructive Procedures** (in any setting)
- **Doula Services: S**ix (6) total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery
- **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):** All home healthcare services require PA after initial evaluation plus six (6) visits.
- **Hyperbaric Therapy**
- **Imaging and Specialty Tests**
- **Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **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 12 visits per calendar year
- **Outpatient Hospital/ASC Procedures:** Refer to Molina's website or provider portal for a specific list of codes that require PA.
- **Pain Management Procedures:** Refer to Molina's website or provider portal for a specific list of codes that require PA.
- **Physical Therapy:** After initial evaluation plus 12 visits per calendar year
- **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:** After initial evaluation plus 12 visits. 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.
- **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.
- **Urine Drug Testing:** After 12 cumulative visits per calendar year. Please refer to Molina's provider website or portal for a specific list of codes that require PA.

Important Information for Molina Medicaid Providers

- 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.

- 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 services to support the request (including previous MRI, CT, Lab, X-ray report/results).
  - Relevant specialty consultation notes.
  - Any other information or data specific to the request.

- If a request is denied, the requesting provider and member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeal process. Denials are also communicated to the provider by telephone, fax or electronic notification.

- Providers and members can request a copy of the criteria used to review requests for medical services. Provider's can also request to speak to a Medical Director to review medical necessity decisions by calling (855) 322-4077.

Important Contact Information 8:00am – 5:00pm local time Monday-Friday		
Service	**Phone**	**Fax**
Authorizations	(855) 322-4077	(800) 594-7404
New Century Health *Cardiology authorizations for Adults	(888) 999-7713	(714) 582-7547
Progeny Health *NICU Authorizations (Medicaid Only)	(888) 832-2006	(866) 890-8857
Imaging Authorizations	(855) 322-4077	(877) 731-7218
Transplant Authorizations	(855) 714-2415	(877) 813-1206
Pharmacy Authorizations	(855) 322-4077	(888) 373-3059
Member Service	(888) 898- 7969 TTY/TDD: 711	
Provider Service	(855) 322-4077	(248) 925-1784
Dental (DentaQuest)	(844) 583-6157	
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	