MOLINA® HEALTHCARE MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2023

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 Specialty Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial Hospitalization, Day Treatment, Intensive Outpatient Program –after 16th session, Targeted Case Management;
  - Electroconvulsive Therapy (ECT);
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
  - Drug Screening- auth required after 12 units of definitive testing and 24 units of presumptive
- **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)** PA required after initial evaluation plus 6 visits
- **Hyperbaric/Wound Therapy**
- **Inpatient Hospitalization** (Except Emergency and Urgently Needed Services)
- **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 must be submitted with the prior authorization request.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities: 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** PA required after initial evaluation plus 12 visits
- **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 (855) 326-5059.
    - Please review decision in the electronic communication to determine exact contact number to discuss medical necessity decisions.

Important Molina Healthcare Medicaid Contact Information

(Service hours 8am-5pm local M-F, unless otherwise specified)

Inpatient and Outpatient Prior Authorizations including Behavioral Health Authorizations: Phone: (855) 326-5059 Fax: (877) 708-2117	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (414) 257-7222 (Milwaukee County) Website: preventsuicidewi.org
Radiology & Radiation Therapy Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Genetic Testing & Sleep Covered Services and Related Equipment:** Phone: (855) 714-2415 Fax: (877) 731-7218
Pharmacy Authorizations: Phone: (800) 947-9627 (Forward Health) (855) 326-5059 (HMO covered per Forward Health) Fax: (877) 708-2117	**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	**Vision:** Phone: (414) 760-7400 Fax: (414) 462-3103
Dental: Phone: (888) 999-2404	**Transportation:** Phone: (866) 907-1493
Provider Customer Service: Phone: (855) 326-5059	**Member Customer Service, Benefits/Eligibility:** Phone: (888) 999-2404/ TTY/TDD 711

Providers may utilize Molina Healthcare's Website at: https://provider.molinahealthcare.com/Provider/Login

Available features include:

- Authorization submission and status
- Member Eligibility
- Provider Directory
- Claims submission and status
- Download Frequently used forms
- Nurse Advice Line Report

Molina® Healthcare, Inc. – Prior Authorization Request Form

MEMBER INFORMATION

Wisconsin Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	

Service Type:
- ☐ Non-Urgent/Routine/Elective
- ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____
- ☐ Emergent Inpatient Admission
- ☐ EPSDT/Special Services

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:
- ☐ Inpatient Hospital
- ☐ Inpatient Hospital (elective)
- ☐ Maternity/OB Notification (at newborn delivery - include baby stats)
- ☐ Inpatient Transplant
- ☐ Inpatient Hospice
- ☐ Long Term Acute Care (LTAC)
- ☐ Acute Inpatient Rehabilitation (AIR)
- ☐ Skilled Nursing Facility (SNF)
- ☐ Other Inpatient:_____

Outpatient Services:
- ☐ Chiropractic
- ☐ Dialysis
- ☐ DME
- ☐ Genetic Testing
- ☐ Home Health
- ☐ Hospice
- ☐ Hyperbaric Therapy
- ☐ Imaging/Special Tests
- ☐ Office Procedures
- ☐ Infusion Therapy
- ☐ Laboratory Services
- ☐ LTSS Services
- ☐ Outpatient Surgical/Procedures
- ☐ Pain Management
- ☐ Palliative Care
- ☐ Pharmacy J Codes (*Outpatient Hospital/Provider – Refer to Forward Health PAD*)
- ☐ Radiation Therapy
- ☐ Sleep Studies
- ☐ Sleep Equipment
- ☐ Transplant/Gene Therapy
- ☐ Transportation
- ☐ Wound Care
- ☐ Other: _____

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy

# of therapy visits used for current year:

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: (DECISION WILL BE SENT TO THE REQUESTING PROVIDER/FACILITY)

Provider Name:		**NPI#:**	**TIN#:**	
Phone:	**FAX**:	**Email**:		
Address:		**City:**	**State:**	**Zip:**
Office Contact Name:		**Office Contact Phone**:		

SERVICING PROVIDER / FACILITY: (BILLING PROVIDER/FACILITY)

Billing Provider/Facility Name (Required):				
Billing NPI#:	**Billing TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par**	☐**COC**
Phone:		**Email:**		
Address:		**City:**	**State:**	**Zip:**

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.

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

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e., WI):				
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____ ☐ Emergent Inpatient Admission			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**	
☐ Inpatient Psychiatric ☐Involuntary ☐Voluntary ☐ Inpatient Detoxification ☐Involuntary ☐Voluntary If Involuntary, Court Date:_____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ 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: (DECISION WILL BE SENT TO THE REQUESTING PROVIDER/FACILITY)

Provider Name:	**NPI#:**	**TIN#:**	
Phone:	**FAX**:	**Email**:	
Address:	**City:**	**State:**	**Zip:**
Office Contact Name:	**Office Contact Phone**:		

SERVICING PROVIDER / FACILITY: (BILLING PROVIDER/FACILITY)

Billing Provider/Facility Name (Required):			
Billing NPI#:	**Billing TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par** ☐**COC**
Phone:		**Email:**	
Address:	**City:**	**State:**	**Zip:**

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