

**Molina® Healthcare Medicaid**  
**Prior Authorization/Pre-Service Review Guide**  
**Effective: 01/01/2024**

**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 per DMAS MHS and ARTS Doing Business Spreadsheet**
- **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 or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (per State benefit).**
- **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.
- **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.
- **Occupational, Physical & Speech Therapy**
- **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.

## 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 also are communicated to the provider by 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 800-424-0061

## IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

Service hours are 8 a.m. to 6 p.m. Monday through Friday, unless otherwise specified

<b>Service authorization requests</b>	Phone: (800) 424-4461 Inpatient physical health fax: (866) 210-1523 Outpatient physical health fax: (855) 769-2116 LTSS fax: (800) 614-8207 Behavioral health fax: (855) 339-8179 Care coordination fax: (800) 614-7934 Pharmacy fax: (844) 278-5731
<b>24-hour behavioral health crisis (7 days/week):</b>	Phone: (800) 424-4518
<b>Radiology authorizations</b>	Phone: (855) 714-2415 Fax: (877) 731-7218
<b>Vision: VSP:</b>	Phone: (800) 877-7195
<b>Provider Services</b>	Phone: (800) 424-4461
<b>Member Services (Benefits/eligibility)</b>	Phone: (800) 424-4518 TTY, 711
<b>Transportation: MTM (non-emergency)</b>	Phone: (877) 790-9472
<b>24-hour Nurse Advice Line (7 days/week)</b>	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. <i>No referral or prior authorization is needed.</i>
<b>Transplant authorizations</b>	Phone: (855) 714-2415 Fax: (877) 813-1206

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

Available features include:

<ul style="list-style-type: none"> <li>• Authorization submission and status</li> <li>• Member Eligibility</li> <li>• Provider Directory</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Claims submission and status</li> <li><input type="checkbox"/> Download Frequently used forms</li> <li><input type="checkbox"/> Nurse Advice Line Report</li> </ul>
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Molina® Healthcare, Inc. – Pre-Service Request Form

## MEMBER INFORMATION

<b>Line of Business:</b>	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<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

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:**

<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"/> COC	
<b>Phone:</b>	<b>FAX:</b>	<b>Email:</b>		
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>

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.



## Your Extended Family

Molina® Healthcare, Inc. – BH Pre-Service and Concurrent Review 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"/> 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: _____	
If Involuntary, Court Date: _____					

**PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION**

**Primary ICD-10 Code for Treatment:**

### 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:

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.