# MOLINA® HEALTHCARE MEDICARE
# PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
# EFFECTIVE: 01/01/2021

## FOR DUAL MEMBERS WITH MEDICAID, PLEASE REFER TO YOUR STATE MEDICAID PA GUIDE FOR ADDITIONAL PA REQUIREMENTS

**REFER TO MOLINA'S PROVIDER WEBSITE/PRIOR AUTHORIZATION CODE MATRIX/LOOK-UP TOOL FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION**
**ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT**

**OFFICE VISITS TO CONTRACTED/PARTICIPATING PRIMARY CARE PROVIDERS DO NOT REQUIRE PA.**

**OFFICE VISITS TO NETWORK SPECIALISTS DO NOT REQUIRE A REFERRAL FROM A PARTICIPATING PRIMARY CARE PROVIDER.**

**EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.**

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- **Advanced Imaging and Specialty Tests**

- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Partial hospitalization;
  - Electroconvulsive Therapy (ECT).

- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses.

- **Durable Medical Equipment and Medical Supplies**

- **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:**
  - For Medicare Part B drug provider administered drug therapies, please direct Prior Authorization requests to Novologix via the Molina Provider Portal. You may also fax in a prior authorization at 800-391-6437.

- **Hearing Aids**
  - Benefit is only available from HearUSA participating providers, contact HearUSA at (855) 823-4632 to schedule. Hearing aids require prior authorization..

- **Home Healthcare Services (including home-based PT/OT/ST).**

- **Hyperbaric/Wound Therapy.**

- **Long Term Services and Supports:** Not a Medicare covered benefit*. **(*Per State benefit if MMP).**

- **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:**
  PA is required for office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency and Urgently needed Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Dialysis when temporarily absent from service area. Ambulance services dispatched through 911
  - Dialysis when temporarily absent from service area.
  - Ambulance services dispatched through 911
  - PA is waived for all radiologists, anesthesiologists, and pathologists' professional services when billed for POS 19, 21, 22, 23 or 24
  - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting.

- **Occupational, Physical, & Speech Therapy**: PA required after Medicare therapy benefit threshold ($2,110 for PT & ST combined and $2,110 for OT) has been reached for office and outpatient settings.

- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures.**

- **Pain Management Procedures including Acupuncture**

- **Prosthetics/Orthotics.**

- **Radiation Therapy and Radiosurgery**

- **Sleep Studies:** (Except Home (POS 12) sleep studies)

- **Supervised Exercise Therapy (SET).**

- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization). All transplant related admissions or observation stay require notification, regardless of level of care.

- **Transportation:** non-emergent air transportation.

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## IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICARE 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 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.

## IMPORTANT MOLINA HEALTHCARE MEDICARE CONTACT INFORMATION

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

| | PHONE | FAX | | PHONE | FAX |
|---|---|---|---|---|---|
| **Prior Authorizations Outpatient Services: Inpatient Admissions including SNF/Acute Rehab and LTAC: LTSS Authorizations: Nursing Facilities (MMP/Medicare):** | (855) 322-4080<br><br><br><br><br><br>(855) 322-4080 | (844) 251-1450<br>(844) 251-1450<br><br>(833) 994-1960<br><br>(844) 304-7127<br>(866) 420-3639 | **Pharmacy Authorizations**<br><br>**Pharmacy Healthcare Administered Drugs (J-Codes)** | (800) 665-3086<br><br>(800) 665-3086 | (866) 290-1309<br><br>(800) 391-6437 |
| **Member Services Benefits/Eligibility** | (866) 440-0012<br>TTY/TDD: 711<br>7 Days a week,<br>8 a.m. to 8 p.m.,<br>local time | | **Provider Services** | (855) 322-4080 | (281) 599-8916 |
| **Behavioral Health Authorizations** | (866) 449-6849 | (866) 617-4967 | **Dental**<br>(Delta Dental) | (888) 818-7932<br>TTY: 711<br>7 days a week<br>8am to 8pm local time | N/A |
| **Radiology Authorizations** | (855) 714-2415 | (877) 731-7218 | **Meals**<br>(Mom's Meals NourishCare PurFoods, LLC dba)<br>*Case Manager must enroll the member in the home delivered meal program giving them access to this benefit* | Members<br>Case Managers<br>(866) 224-9485<br>M-F,<br>7 am to 6 pm CST<br>+ 24-hour voicemail | N/A |
| **Hearing**<br>(HearUSA) | (800) 442-8231<br>Monday to Friday,<br>8am-8pm EST | N/A | | | |
| **Transplant Authorizations** | (855) 714-2415 | (877) 813-1206 | **PERS**<br>(Best Buy Health, dba Critical Signal Technologies, Inc. (CST)<br>*Benefit is covered for qualifying members when* | (888) 55.SIGAL<br>(888) 557-4462<br>TTY: 711<br>24 hours a day, 7 days a week. | N/A |

| | | | |
|---|---|---|---|
| | | | *authorized/ ordered by the Case Manager.* |
| **Vision**<br>(March Vision Care) | (844) 976-2724<br>TTY: 711 or<br>(877) 627-2456<br>Monday to Friday,<br>7 am to 8 pm EST | N/A | **Nurse Advice Line**<br>(24 hours a day, 7 days a week)<br>(888) 275-8750 (TTY: 711)<br>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.* |
| **Transportation**<br>(Access2Care)<br>*Where needed, Authorizations are not required unless over the trip limit (over 50 miles one-way). When needed, these authorizations must be approved by Molina Healthcare's Centralized Medicare Utilization Management (CMU) Department.* | (888) 616-4846 TTY: 711 or (866) 874-3972 or Press 1 for Ride Assist; otherwise stay on the line for assistance 24 hours a day, 7 days a week, 365 days a year for **URGENT**/ same day appointments, facility DISCHARGES, and RIDE ASSIST<br><br>Monday to Friday:<br>8 a.m. to 8 p.m. local time for **ROUTINE** reservations.  Requests for ROUTINE reservations will not be accepted on national holidays. This does not apply to URGENT same day appointments, facility DISCHARGES, and RIDE ASSIST – these calls are 24 hours a day, 7 days a week, 365 days a year.<br><br>Facility Line: (877) 299-4811<br><br> Facility line is dedicated for use by plan representatives and/or facilities. Same hours as above. | | |

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

**Available features include:**

- **Authorization submission and status**
- **Claims submission and status**
- **Member Eligibility**

- **Provider Directory**
- **Frequently used forms**
- **Nurse Advice Line Report**

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

## MEMBER INFORMATION

| Line of Business: | ☐ Medicaid | ☐ Marketplace | ☐ Medicare | Date of Request: |
|---|---|---|---|---|

**State/Health Plan (i.e. CA):**

**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 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
☐ Occupational Therapy
☐ Outpatient Surgical/Procedures
☐ Pain Management
☐ Palliative Care

☐ Pharmacy
☐ Physical Therapy
☐ Radiation Therapy
☐ Speech Therapy
☐ Transplant/Gene Therapy
☐ Transportation
☐ Wound Care
☐ 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 |
|---|---|---|---|---|---|
| | | | | | |
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## 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): | ☐Non-Par  ☐COC |
|---|---|---|---|
| Phone: | FAX: | Email: | |
| Address: | City: | State: | Zip: |

**For Molina Use Only:**

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.

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

## MEMBER INFORMATION

| Line of Business: | ☐ Medicaid | ☐ Marketplace | ☐ Medicare | Date of Request: |
|---|---|---|---|---|

**State/Health Plan (i.e. CA):**

**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:**

☐ Inpatient Psychiatric
  ☐ Involuntary    ☐ Voluntary

☐ Inpatient Detoxification
  ☐ Involuntary    ☐ Voluntary

If Involuntary, Court Date:_____

**Outpatient Services:**

☐ 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 |
|---|---|---|---|---|---|
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## 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): | ☐Non-Par  ☐COC |
|---|---|---|---|

| Phone: | FAX: | Email: |
|---|---|---|

| Address: | City: | State: | Zip: |
|---|---|---|---|

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