

**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 LOOK-UP TOOL/MATRIX 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.

- **Advanced Imaging and Special 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**
- **Healthcare Administered Drugs**
- **Hearing Aides**
 - Benefit is only available from HearUSA participating providers, Contact HearUSA at (855) 823-4632 to schedule. Hearing aides require prior authorization
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (LTSS):** 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 visits and approved Ambulatory Surgery Center (ASC) or inpatient stays;
 - 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 in 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 (\$2,080 for PT & ST combined and \$2,080 for OT) has been reached for office and outpatient settings.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures:** (Acupuncture is not a Medicare covered benefit).
- **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).
- **Transportation:** non-emergent air transportation.

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 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.

IDAHO (Molina Service Hours: 8am to 5pm local time Monday to Friday, unless otherwise specified)					
	PHONE	FAX		PHONE	FAX
Medical Prior Authorizations	(844) 239-4914	(844) 251-1450	Pharmacy Authorizations	(844) 239-4914	(866) 290-1309
Concurrent, ECT, SNF, LTACS Prior Authorizations	(844) 239-4914	(855) 231-0375	Provider Services	(844) 239-4914	N/A
Member Services Benefits/ Eligibility	Molina Medicare Choice Care: (844) 560-9811 Molina Medicare Complete Care: (844) 239-4913 TTY: 711 7 Days a week, 8 a.m. to 8 p.m. local time		Dental (Delta Dental)	(888) 818-7932 TTY: 711 7 days a week, 8 a.m. to 8 p.m. local time	
Behavioral Health Authorizations	(888) 483-0760	(855) 231-0375	Hearing (HearUSA)	(800) 442-8231 Monday to Friday, 8 a.m. to 8 p.m. EST	
Radiology Authorizations	(855) 714-2415	(877) 731-7218	Vision (March Vision Care)	(844) 416-2724 TTY: 711 or (877) 627-2456	
Transplant Authorizations	(855) 714-2415	(877) 813-1206	Nurse Advice Line (24 hours a day, 7 days a week) (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>		
Transportation (Access2Care (A2C)) <i>Where covered, authorizations are not required unless over the trip limit (over 50 miles one-way). When needed, these authorizations must be approved</i>	(877) 926-4852 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 Monday to Friday: 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.				

*by Molina Healthcare's
Centralized Medicare Utilization
Management (CMU) Department.* Facility Line:
(877) 299-4811

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
 - Member Eligibility
 - Provider Directory
 - Claims submission and status
 - Download Frequently used forms
 - Nurse Advice Line Report
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Molina® Healthcare, Inc. – Prior Authorization 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 <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"/> Rate Code 17 Waiver <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 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: 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:

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:	<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"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary 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"/> 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:	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:

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.