MOLINA HEALTHCARE
MEDICARE / MMP
PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 7/1/22

REFER TO MOLINA'S PROVIDER WEBSITE OR PORTAL FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

OFFICE VISITS OR REFERRALS TO IN NETWORK / PARTICIPATING PROVIDERS DO NOT REQUIRE PRIOR AUTHORIZATION

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services**
- **Cosmetic, Plastic and Reconstructive Procedures** (in any setting)
- **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):** Medicare will not require PA for first 60-day episode of home care in a year. For continued home care beyond 60 days an authorization will be required.
- **Hyperbaric Therapy**
- **Imaging and Specialty Tests**
- **Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **Long Term Services and Supports:** All LTSS services require PA regardless of codes.
  *LTSS benefits only apply to MMP
- **Neuropsychological and Psychological Testing**
- **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)
  - Place of Service: 21, 22, 23, 31, 32, 33, 51, 52 or 61.
- **Occupational Therapy:** PA required after benefit CAP of $2,150 has been met.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Pain Management Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Physical Therapy:** PA required after therapy CAP of $2,150 has been met for combined benefits PT and ST.
- **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:** PA required after therapy CAP of $2,150 has been met for combined benefits PT and ST.
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** non-emergent Air Transport.
- **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.

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 claim.

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 at 1 (888) 898-7969

MICHIGAN (Service hours 8am-5pm local M-F, unless otherwise specified)		
Service	**Phone**	**Fax**
Prior Authorizations (inc. Behavioral Health)	(855) 322-4077	(844) 251-1450 (Medicare)
		(844) 251-1451 (MMP)
Imaging Authorizations	(855) 322-4077	(877) 731-7218
Inpatient Admit & Discharge Authorizations	(855) 322-4077	(844) 834-2152
Transplant Authorizations	(855) 714-2415	(877) 813-1206
Pharmacy Authorization	(888) 665-3086	(866) 290-1309
Member Service	(888) 898- 7969 TTY/TDD: 711	
Provider Service	(855) 322-4077	(248) 925-1784
Dental	(800) 327-4462	
Vision (VSP)	(888) 493-4070	
Transportation	(855) 735-5604	
24 Hour Nurse Advice Line (7 days/Week)		
English Spanish	1 (888) 275-8750 / TTY: 1 (866) 735-2929 1 (866) 648-3537 / TTY: 1 (866) 833-4703	

Molina Healthcare – 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:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Other Inpatient:_____	☐ Hyperbaric Therapy	☐ Pain Management	☐ Wound Care
	☐ Imaging/Special Tests	☐ Palliative Care	☐ 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:

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:				

Molina Healthcare – 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:	**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		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):**		☐ **Non-Par** ☐ **COC**
Phone:	**FAX:**		**Email:**	
Address:		**City:**	**State:**	**Zip:**
For Molina Use Only:				

MOLINA HEALTHCARE

Alternative Level of Care Authorization Form

Phone: 866-449-6828
All Lines of Business Fax: (800) 594-7404

Patient Name:	**Molina ID:**	**DOB/Age:**	**Today's Date:**
Molina LOB:	· **Medicare** · **MMP / Duals** · **Medicaid** · **Marketplace**		

Level of Care Requested Based on InterQual:

- SNF Level 1 (1 discipline – 1-2 hrs/5 days/wk)
- SNF Level 2 (4 hrs SN **OR** 1 discipline 2-3 hrs/5 days/wk)
- SNF Level 3 (IV abx, wound) (4 hrs SN **AND** 1 discipline 2-3 hrs/5 days/wk)
- SNF Level 4 (vent/dialysis)
- Inpatient Rehab
- LTACH
- Custodial/Long term care (MMP only)
- Disenrollment request

Nursing Facility Requested:		**Hospital:**	
Tentative Admission Date:		**Hospital Admission Date:**	
Facility Contact Information:	CM/RN Name:	**Hospital Contact Information:**	CM/RN Name:
	CM/RN Phone:		CM/RN Phone:
	CM/RN Fax:		CM/RN Fax:

Active Diagnosis (include ICD10 Codes):	**Most Recent Vital Signs:**
1.	**BP:**_____ **T:** _____
2.	**P:**_____ **SpO2:** _____
3.	**R:**_____ **Wt:** _____

Current Clinical Condition:	**Past Medical/Surgical History: (Brief, related to current condition):**

Please indicate:	**Living Arrangements:**
· Smoker · Alcohol/Substance Use · DME	· Lives alone · Lives with someone · Homeless · Other: _____

Needs Help With:
· Feeding · Toileting · Bathing · Grooming · Meal Preparation · Other_____

Prior Level of Functioning before hospitalization:
· Independent · Contact Guard · Supervised · Wheelchair bound · Other: _____

Participation Assistance Required while in SNF/IPR:	**Daily Participation Level while in hospital:**
PT: · Max · Mod · Min · Contact Guard OT: · Max · Mod · Min · Contact Guard ST: · Max · Mod · Min · Contact Guard Ambulation (Current):_____ft Goal:_____ft	PT:_____hrs **OR**_____min OT:_____hrs **OR**_____min ST:_____hrs **OR**_____min

IV Medications that will continue post d/c (Must include start/date, dose, frequency):

Additional Comments:

****Therapy/Treatment Notes within 4 days of discharge must be included with this request**

Molina Healthcare
OB Notification Form
Phone Number: 1-888-898-7969
Fax Number: 844-861-1930 (Routine OB – NON - NICU)
Fax Number: 800-594-7404 (NICU)

****** 1 FORM PER NEWBORN ******

Mother's Information			
Plan	☐ Medicaid ☐ MiChild ☐ Medicare ☐ Marketplace		
Mother's Name:		Mother's DOB	/ /
Mother's ID #:		Mother's Phone:	( ) -
Mother's Admit Date:	/ /	Mother's Discharge Date	/ /
Service Type:	NEWBORN NOTIFICATION	☐ NICU NICU Level_____ ☐Border Baby Hospital Referred to CSHCS? ☐Yes ☐No	

Newborn Information			
Newborn Name:		Newborn DOB	/ /
Newborn Admit Date	/ /	Newborn Discharge Date	/ /

Newborn Admit Date:	From / / TO: / /
Birth Order	☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐Other _____
Diagnosis Code & Description:	
Delivery Date:	/ /
Delivery Type:	☐ Vaginal ☐ C-Section ☐ VBAC ☐ Repeat C-Section
Multiples?:	☐ No ☐ Yes Quantity _____
Baby's Gender:	☐ Male ☐ Female
Baby's Weight:	_____lb _____oz
Apgar Score:	/
EDD:	/ /
Gestation:	_____ wks
Birth Outcome:	☐ Discharge with Mom ☐ Border Baby ☐ Going to Foster Care ☐Adoption ☐Fetal Demise

Provider Information					
Facility Name		NPI #:		TIN#:	
Attending Provider:		NPI #:		TIN#:	

Contact Information			
Name:			
Phone Number:	( ) -	Fax Number:	( ) -