Molina® Healthcare of New Mexico Medicaid
Pre-Service Review Guide
Effective: 01/01/2025

Refer to Molina's Provider Website or Prior Authorization Look-Up Tool for specific codes that require Prior Authorization

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 above 16 units require notification and subsequent concurrent review.
  - Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **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**
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **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 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 requires 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**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **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 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) 322-4078 or for Advanced Imaging discussion contact our toll-free number: (855) 714-2415. Providers can also request peer to peer on the website: https://www.molinahealthcare.com/providers/nm/medicaid/SchedulerForm

IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

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

Prior Authorizations including Behavioral Health Authorizations: Phone: (855) 322-4078 Fax: (833) 558-6769	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (988) Crisis-Line
Pharmacy Authorizations: Phone: (855) 322-4078 Fax: (877) 731-7218	**Dental (DentaQuest):** Phone: (800) 341-8478
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Vision (March Vision):** Phone: (844) 706-2724
Provider Customer Service: Phone: (855) 322-4078	**Member Customer Service, Benefits/Eligibility:** Phone: (844) 862-4543/ TTY/TDD 711
Transportation (Superior Transportation): Phone: (833) 707-7100	**Transplant Authorizations:** Phone: (855) 714-2415 Fax: (877) 813-1206
24 Hour Nurse Advice Line (7 days/week) Phone: (833) 965-1558 /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.*	**Nutrition Consult Program** Phone: (833) 269-7830 Fax: (800) 642-3691

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 of New Mexico, Inc.
Prior Authorization Request Form
Medical/Behavioral Health/Pharmacy

To file electronically, send to:	To file via facsimile, send to:	To contact the coverage review team for Pharmacy and Healthcare Services, please call:
Healthcare Services: https://provider.molinahealthcare.com/provider/login **Pharmacy:** https://www.covermymeds.com/ https://surescripts.com/	**For Medicaid:** Healthcare Services: 1-833-558-6769 Pharmacy : 1-866-472-4578 **For Marketplace:** Pharmacy 1-866-472-4578 Healthcare Services: 1-833-322-1061	1-855-322-4078 Monday through Friday between the hours of 8am and 5pm MST. **For after-hours review, please contact:** 1-855-322-4078

MEMBER INFORMATION

Date of Request:		
Health Plan:		
Member Name		**DOB** (MM/DD/YYYY):
Member ID#:		**Member Phone**:
Street Address:		
City, State, Zip Code		
Priority and Frequency:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – *Clinical Reason for Urgency **Required**:_____ **Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the member.* ☐ Emergent Inpatient Admission	

PROVIDER INFORMATION

Please note: Processing delays may occur if **servicing provide**r does not have appropriate documentation of medical necessity. **Ordering provider** may need to initiate prior authorization.

ORDERING PROVIDER / FACILITY:

Provider Name:			
NPI#:	**TIN#:**	**DEA# if applicable:**	☐ **Non-Par** ☐**COC**
		Medicaid ID# (If Non-Par):	
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#:**	**DEA# if applicable:**	☐ **Non-Par** ☐**COC**
		Medicaid ID# (If Non-Par):	
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

MEDICAL REFERRAL/SERVICE TYPE REQUESTED

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

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital ☐ Inpatient Transplant ☐ Inpatient Hospice ☐ Long Term Acute Care (LTAC) ☐ Acute Inpatient Rehabilitation (AIR) ☐ Skilled Nursing Facility (SNF) ☐ Other Inpatient:_____	☐ 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: _____.

HCPCS/CPT/CDT/Primary ICD-10/Code: **Description:**

DATES OF SERVICE		**PROCEDURE/ SERVICE CODES**	**PROCEDURE / SERVICE CODE DESCRIPTION**	**DIAGNOSIS CODE**	**REQUESTED UNITS/ NUMBER OF VISITS/FREQUENCY**
START	**STOP**				

Molina® Healthcare of New Mexico, Inc.
Prior Authorization Request Form
Medical/Behavioral Health/Pharmacy

BEHAVIORAL HEALTH 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: _____

HCPCS/CPT/CDT/Primary ICD-10/Code: **Description:**

DATES OF SERVICE		**PROCEDURE/ SERVICE CODES**	**PROCEDURE / SERVICE CODE DESCRIPTION**	**DIAGNOSIS CODE**	**REQUESTED UNITS/ NUMBER OF VISITS/FREQUENCY**
START	**STOP**				

PRESCRIPTION DRUG

Diagnosis name and Primary ICD-10 code:

Patient Height (if required):	**Patient Weight (if required):**

Route of administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: Explain:

Administered: ☐ Doctor's Office ☐ Dialysis	Center ☐ Home Health/Hospice ☐ By Patient		
MEDICATION REQUESTED	**STRENGTH (INCLUDE BOTH LOADING AND MAINTENANCE DOSAGE)**	**DOSING SCHEDULE (INCLUDING LENGTH OF THERAPY)**	**QUANTITY PER MONTH OR QUANTITY LIMITS**

Is the patient currently treated with the requested medication(s)? : ☐ Yes* ☐ No
*If "Yes", when was the treatment with the requested medication started? Date:

Anticipated medication start date (MM/DD/YY):

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Prior Authorization Request Form
Medical/Behavioral Health/Pharmacy

General prior authorization request. Explain the clinical reason(s) for the requested medications, including an explanation for selecting these medications over alternatives:

Rationale for drug formulary or step-therapy exception request:

[ ] Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure, specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s).

[ ] Patient is stable on current drug(s), high risk of significant adverse clinical outcome with medication change. Specify anticipated significant adverse clinical outcome below.

[ ] Medical need for different dosage and/or higher dosage, specify below: (1) Dosage(s) used (2) explain medical reason**.**

[ ] Request for formulary exception, specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome.
[ ] Other (explain below)

Required explanation(s):

List any other medications patient will use in combination with requested medication:

List any known drug allergies

Previous services/therapy (including drug, dose, duration, and reason for discontinuing each previous service/therapy)

	Date Discontinued:
	Date Discontinued:
	Date Discontinued:

Attestation

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Requester Signature: **Date:**

DO NOT WRITE BELOW THIS LINE, FIELDS TO BE COMPLETED BY PLAN

Authorization # **Contact Name _**

Contact's credentials/designation