MOLINA® HEALTHCARE MARKETPLACE
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2022

REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK-UP TOOL/MATRIX FOR SPECIFIC CODES THAT REQUIRE 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:**
- Inpatient, Transitional Substance Abuse Residential Treatment, Partial hospitalization.
- Electroconvulsive Therapy (ECT);
- Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting).** No PA Required with breast CA Diagnosis.
- **Durable Medical Equipment**
- **Elective Inpatient Admissions**: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **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**
- **Home Healthcare Services (including home-based OT/PT/ST)**.
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (LTSS)**: Not a covered benefit
- **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:**
  With the exception of some facility based 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;
  - Radiologists, Anesthesiologists, and Pathologists' professional services when billed for POS 19, 21, 22, 23 or 24.
  - Other services based on State requirements.
- **Occupational Physical & Speech Therapy**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies** Except Home (POS 12) sleep studies
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** All non-emergent transportation.
- **Vision:** Pediatric Low Vision Optical Devices and Services: Please contact VSP at 1 (800) 877-7195 or visit their website at www.vsp.com/advantage

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 (866) 814-2221.

Important Molina Healthcare Marketplace Contact Information

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

Prior Authorizations including Behavioral Health: Phone: (844) 557-8434 Fax: (800) 811-4804	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (888) 275-8750
Pharmacy Authorizations: Phone: (855) 322-4075 Fax: (866) 508-6445	**Dental:** Phone: (877) 433-6825 Fax: (949) 830-1655
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Vision:** Phone: (800) 877-7195 (VSP) Website: www.vsp.com/advantage
Transportation: Phone: (855) 322-4075	**Member Customer Service, Benefits/Eligibility:** Phone: (888) 858-2150
Provider Customer Service: Phone: (888) 858-2150 Fax: (562) 499-0619	**Transplant Authorizations:** Phone: (855) 714-2415 Fax: (877) 813-1206
24 Hour Nurse Advice Line (7 days/week): 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. *No referral or prior authorization is needed.*	

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, 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

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:

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 in the most appropriate and cost-effective settings of care.

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: **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 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):**	☐**Non-Par** ☐**COC**
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:** **Zip:**	

For Molina Use Only:

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 in the most appropriate and cost-effective settings of care.