Just the Fax

A fax bulletin from Molina Healthcare of Michigan (MHM) • July 2, 2019

Molina Home Care Authorization Change Notification Effective July 1st 2019

Frequently Asked Questions (FAQ)

What is the anticipated turnaround time for authorizations?	Molina strives to turn around authorizations as quickly as possible. To assure prompt hospital discharge, Molina has added a separate fax number for Hospital Discharge Requests. See Hospital Discharge Fax Numbers on pg. 2 Hospital Discharge: If Home Care Prior Authorization is required for Hospital Discharge, please mark the request as **Urgent-Hospital Discharge and indicate the expected date of discharge so these cases can be expedited.** The request will be complete on an expedited basis. Home Care Prior Authorization Requests: are processed as expeditiously as possible. If services are needed urgently, please indicate "urgent" on the authorization request. Please submit the requests for continued services as soon as you become aware that the member will need additional services to ensure no interruption of care. It is critical to review these requirements to assure complete information on the authorization request.
What is the authorization process for services performed late in June and required in July?	For members receiving services in June who need continued services in July, all services rendered in July will require authorization, therefore, Molina recommends requesting authorization prior to the beginning of July.
Will an authorization be given by visits or per episode?	Authorizations are provided in number of visits.
Do any variations in the authorization process exist by Lines of Business and services provided?	Molina follows the MDHHS and CMS guidelines in processing authorizations.
Does the home care provider need to request separate authorizations when PT, OT, and/or ST are performed during the same episode of care?	All authorizations can be included in the same request Please provide appropriate CPT codes and number of visits for each discipline.
Will unique authorization numbers be given for each service type or will one authorization cover all services (PT, OT, and ST)?	PT, OT and ST services can be covered in one (1) authorization during the same episode of care.
What if a member requires services while waiting for an authorization determination?	Molina understands the member may require treatment on a weekend or holiday before you have an opportunity to call. Molina will review the request for medical necessity, and if criteria are met, will honor the start of care.
When should providers note Urgent on the authorization request?	Providers should mark the authorization urgent in two instances: 1. Hospital discharge requests should be notated **Urgent-Hospital Discharge** & sent to the fax number on page 2. 2. Other requests: when a treatment is required to prevent serious deterioration in the member's health or could jeopardize the

	enrollee's ability to regain maximum function should be notated as **Urgent** and sent to the fax number on page 2**.**
If a member requires services beyond the original authorization, how does the home health agency request additional visits?	Services need to be requested as soon as the provider determines that additional Home Care visits (including PT/OT/ST) will be required. Additional clinical information and other documentation per the MDHHS or CMS guidelines will be required to determine medical necessity.

Prior Authorization Request Fax Numbers

Medicaid/Marketplace	Medicare/MMP MI Health Link
(800) 594-7404	(844) 251-1450

Provider Portal Request

https://provider.molinahealthcare.com/Provider/Login

Hospital Discharge Fax Number

Medicaid/Marketplace	Medicare/MMP MI Health Link
(800) 594-7404	(844) 834-2152

If a service is denied what is the provider's responsibility?

Medicaid / Marketplace	Medicare / MI Health Link / MMP
Molina will advise the provider of their appeal rights on behalf of the member. A new authorization with same episode of care, diagnosis and CPT code may not be submitted within the 60 days following the initial authorization request. **Molina follows the MDHHS and CMS guidelines**	
	For Medicare/MMP MI Health Link Continuation of Care, the provider must issue a Notice of Medicare None Coverage (NOMNC). NOMNC must be delivered at least two (2) calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. NOMNC Form: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

What is the process to dispute an authorization denial for home care service by LOB, during or before services are rendered?

Medicaid / Marketplace	Medicare / MI Health Link / MMP
The opportunity to speak to a Medical Director**)** is granted for a period of 5 business days after receipt of denial notification. The discussion must be between the ordering physician and the Molina Medical Director. The provider may file a formal appeal as outlined in the denial letter.	Molina offers the opportunity for a peer to peer discussion if the denial letter has not yet been mailed out. After that point, a formal appeal must be initiated. For a Continuation of Care denial, member will be issued a Notice of Medicare None Coverage (NOMNC) and may appeal to the QIO.