MOLINA HEALTHCARE
MEDICAID
PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 7/1/24

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

- **Cosmetic, Plastic and Reconstructive Procedures** (in any setting)
- **Doula Services:** Six (6) total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery
- **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 or OT):** All home healthcare services require PA after initial evaluation plus six (6) visits. ***CSHCS members are eligible for ST visits with prior authorization.**
- **Hyperbaric Therapy**
- **Imaging and Specialty Tests**
- **Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **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)
- **Occupational Therapy:** After initial evaluation plus 12 visits per calendar year
- **Outpatient Hospital/ASC Procedures:** Refer to Molina's website or provider portal for a specific list of codes that require PA.
- **Pain Management Procedures:** Refer to Molina's website or provider portal for a specific list of codes that require PA.
- **Physical Therapy:** After initial evaluation plus 12 visits per calendar year
- **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:** After initial evaluation plus 12 visits. Pediatric cochlear implants – allowed up to 36 visits with prior authorization.
- **Transplants including Solid Organ and Bone Marrow** *Cornea transplant does not require authorization
- **Transportation:** Non-Emergent Air.
- **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.
- **Urine Drug Testing:** After 12 cumulative visits per calendar year. Please refer to Molina's provider website or portal for a specific list of codes that require PA.

Additional Information:

- 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.
- 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) 322-4077

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 theproblem.
- 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.

MICHIGAN (Service hours 8:00am 5pm local M F, unless otherwise specified)		
Service	**Phone**	**Fax**
Authorizations Non-NICU OB Deliveries	(855) 322-4077	(800) 594-7404 (844) 861-1930
New Century Health *Cardiology authorizations for Adults	(888) 999-7713	(714) 582-7547
Progeny Health *NICU Authorizations (Medicaid Only)	(888) 832-2006	(866) 890-8857
Imaging Authorizations	(855) 714-2415	(877) 731-7218
Transplant Authorizations	(855) 714-2415	(877) 813-1206
Pharmacy Authorizations	(855) 322-4077	(888) 373-3059
Member Service	(888) 898- 7969 TTY/TDD: 711	
Provider Service	(855) 322-4077	(248) 925-1784
Dental (DentaQuest)	(844) 583-6157	
Vision (VSP)	(888) 493-4070	
Transportation	(855) 735-5604	
24 Hour Nurse Advice Line (7 days/Week)		
English	1 (888) 275-8750 / TTY: 1 (866) 735-2929	
Spanish	1 (866) 648-3537 / TTY: 1 (866) 833-4703	

Molina Healthcare – Alternate Level of Care Request Form

Phone: 855-322-4077 Fax: 800-594-7404

Member Information	
Member Name:	**DOB:**
Member ID:	**Today's Date:**
Hospital Name:	**Hospital Admit Date:**
Facility Requested:	**Tentative Admit Date:**

Level of Care Requested:

☐ SNF/SAR ☐ Inpatient Rehabilitation ☐ LTAC

Hospital Contact Information:	CM/RN Name:	**Facility Contact Information:**	CM/RN Name:
	CM/RN Phone: **Confidential V/M?** ☐ Yes ☐ No		CM/RN Phone: **Confidential V/M?** ☐ Yes ☐ No
	CM/RN Fax:		CM/RN Fax:

Most Recent Vitals:		**Active Diagnosis (Include ICD-10 codes):**
BP:	**T:**	**1.**
P:	**Sp02:**	**2.**
	L RA / 02:	
R:		**3.**
Vent Settings:		**4.**
Current IV Meds:		**Pertinent Labs:**
End date:	**Frequency:**	
Restraints: ☐ Yes ☐ No		

Living Arrangements: ☐ Lives alone ☐ Lives with someone ☐ Homeless ☐ Other

Prior Level of Functioning before hospitalization: ☐ Independent ☐ Contact Guard ☐ Supervised ☐ W/C Bound ☐ DME ☐ Other

DOCUMENTS REQUIRED with this completed form for submission:

- Facesheet/Demographics
- H&P + Most recent attending MD progress notes
- OT & PT notes – no older than 48h from date of request
- PM&R note – no older than 48h from date of request (IPR only)
- Pt's prior level of function (DME used, level of assist needed and who assisted pt.)
- Pt's prior living arrangements
- LTAC: SPECIFIC documentation as to why pt. required LTAC level of care

****Therapy/Treatment notes within 3 days of discharge must be included with this request**

Molina Healthcare – Behavioral Health Prior Authorization Request Form

Phone: 855-322-4077 Fax: 800-594-7404

Member Information

Member Name:		**DOB**:	
Member ID#:		**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited		

Service Requested

Outpatient Services:

☐ Applied Behavioral Analysis
☐ Electroconvulsive Therapy
☐ Non-PAR Outpatient Services
☐ Psychological/Neuropsychological Testing
☐ Other: _____

☐ **Continuation of Care (COC)** – Non par provider requesting services for COC

Note:
Inpatient Psychiatric and Detoxification services are rendered through the PIHPs.

Outpatient Treatment, Partial Hospitalization, Intensive O/P, Day Treatment and Assertive Community Treatment Programs are rendered through the PIHPs.

Date of Service	Diagnosis Code	Procedure/HCPC Code	Service Description	Requested Units/Visits

Provider Information

Requesting Provider/Facility: (Decision will be sent to the requesting provider/facility)

Provider Name:	**NPI#:**	**TIN#:**	
Phone:	**Fax:**		
Address:	**City:**	**State:**	**Zip:**
Office Contact Name:	**Office Contact Phone**:		

Servicing Provider/Facility:

Provider/Facility Name:	**NPI#:**	**TIN#:**	
Phone:	**Fax:**		
Address:	**City:**	**State:**	**Zip:**

For Transcranial Magnetic Stimulation (TMS) requests, please also indicate the following:

☐ No presence of acute or chronic psychotic symptoms or disorders (i.e., schizophrenia or schizoaffective disorder)

☐ No cochlear implant or deep brain stimulator

☐ No metallic hardware or implanted magnetic-sensitive medical device implanted within 30cm of the discharging coil

☐ Treatment parameters use either high frequency or low frequency (less than 1 Hz to 20 Hz) and taper over course of treatment

☐ Request is for a continuation course of treatment after an acute treatment course

Medication history including adherence, duration and side effects must be included with request

Molina Healthcare – Prior Authorization Request Form

Phone: 855-322-4077 Fax: 800-594-7404

Member Information

Member Name:		**DOB**:	
Member ID#:		**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited		

Service Requested

Inpatient Services:	**Outpatient Services:**		
☐ Surgical Procedure ☐ Transplant	☐ Chiropractic ☐ Dialysis ☐ DME ☐ Genetic Testing ☐ Home Health ☐ Hyperbaric Therapy ☐ Imaging/Special Tests ☐ Infusion Therapy ☐ Non-Par Provider Request ☐ Occupational Therapy	☐ Office Procedures ☐ Pain Management ☐ Physical Therapy ☐ Radiation Therapy ☐ Sleep Study ☐ Speech Therapy ☐ Surgical Procedures ☐ Transplant ☐ Wound Care ☐ Other: _____	☐ **Continuation of Care (COC)** – Non par provider requesting services for COC ☐ **Home care** - Eval + 6 visits have been used this calendar year ☐ **PT/OT/ST** – Eval + 12 visits have been used this calendar year

Date of Service	Diagnosis Code	Procedure/HCPC Code	Service Description	Requested Units/Visits

Provider Information

Requesting Provider/Facility: (Decision will be sent to the requesting provider/facility)

Provider Name:	**NPI#:**	**TIN#:**	
Phone:	**Fax:**		
Address:	**City:**	**State:**	**Zip:**
Office Contact Name:	**Office Contact Phone**:		

Servicing Provider/Facility:

Provider/Facility Name:	**NPI#:**	**TIN#:**	
Phone:	**Fax:**		
Address:	**City:**	**State:**	**Zip:**

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.