# Provider Newsflash

A fax bulletin for the Molina Healthcare of Washington Provider Network

## Medicaid Prior Authorization/Pre-Service Review Guide
## Effective as of 01/01/2019

**THIS PRIOR AUTHORIZATION/PRE-SERVICE GUIDE APPLIES TO ALL MOLINA HEALTHCARE MEDICAID MEMBERS ONLY**
**REFER TO MOLINA'S PROVIDER WEBSITE OR PORTAL 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**

**ALL NON-PAR PROVIDER REQUESTS REQUIRE AUTHORIZATION REGARDLESS OF SERVICE.**

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment;
  - Electroconvulsive Therapy (ECT);
  - Transcranial magnetic stimulation (TMS)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)** No PA Required with breast CA Dx. (Z85.3)
- **Durable Medical Equipment:** Refer to Molina's Provider website or portal for specific codes that require authorization. **All By Report codes including E1399, will require the MSRP to be send in with the PA Request form.**
- **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.
- **Home Healthcare and Home Infusion (Including Home PT, OT or ST:** All home healthcare services require PA after initial evaluation plus six (6) visits per calendar year.
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty Imaging:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **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 code(s) **(per State benefit)**
- **Neuropsychological and Psychological Testing**
- **Occupational Therapy/Physical Therapy**: After initial evaluation plus twenty-four (24) visits per calendar year for office, and outpatient settings.
- **Office-Based Procedures do not require authorization, unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's Provider website or portal for specific codes that require authorization.
  - Site of Service Authorizations – Some procedures require authorization when performed in an outpatient hospital setting rather than an Ambulatory Surgery Center. Refer to Molina's Provider website or portal for specific codes requiring authorization based on Site of Service.
- **Pain Management Procedures:** except trigger point injections.
- **Prosthetics/Orthotics:** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Radiation Therapy and Radiosurgery (for selected services only):** Refer to Molina's Provider website or portal for specific codes that require authorization.
- **Sleep Studies:** (Except Home (POS 12) 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 six (6) visits for office, and outpatient settings.
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization)
- **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.

MRC PART #19-4303
Approval: MHW-3/12/2019

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| • **Non-Par Providers/Facilities:** PA is required for office visits, procedures, labs, diagnostic studies, inpatient stays except for:<br>o Emergency Department Services;<br>o Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;<br>o Local Health Department (LHD) services;<br>o Radiologists', anesthesiologists', and pathologists' professional services when billed for POS 19, 21, 22, 23 or 24<br>o PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting.<br>o Other services based on State Requirements. | |

**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.**

## IMPORTANT INFORMATION FOR MOLINA HEALTHCARE 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 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 (425) 398-2603.

## Important Molina Healthcare Medicaid Contact Information

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| **Prior Authorizations:**<br>8:00 a.m. – 5:00 p.m. Local Time<br>Phone: (800) 869-7175 Fax: (800) 767-7188 | **Provider Customer Service:**<br>8:00 a.m. – 5:00 p.m. Local Time<br>Phone: (888) 858-5414 Fax: (877) 814-0342 |
| **Member Customer Service Benefits/Eligibility:**<br>Phone: (800) 869-7185 Fax: (800) 816-3378<br>TTY/TDD: 711 | **24 Hour Nurse Advice Line**<br>English: (888) 275-8750 TTY 711<br>Spanish: (866) 648-3537 TTY 711 |
| **Behavioral Health Authorizations:**<br>Phone: (800) 869-7175 Fax: (800) 767-7188 | **Transportation: (Managed by DSHS)** |
| **NICU Authorizations:**<br>Phone: (855) 714-2415 Fax: (877) 731-7220 | **Virtual Urgent Care**<br>(844) 870-6821, TTY 711<br>wavirtualcare.molinahealthcare.com |
| **Pharmacy Authorizations:**<br>Phone: (800) 869-7175 Fax: (800) 869-7791 | **Vision Care:**<br>Phone: (888) 493-4070 Fax: (866) 772-0285 |
| **Radiology Authorizations:**<br>Phone: (855) 714-2415 Fax: (877) 731-7218 | |
| **Transplant Authorizations:**<br>Phone: (855) 714-2415 Fax: (877) 813-1206 | |

**Providers may utilize Molina Healthcare's Website at:**
**https://provider.molinahealthcare.com/Provider/Login**
**Available features include:**

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| • **Authorization submission and status** | • **Claims submission and status** |
| • **Member Eligibility** | • **Download Frequently used forms** |
| • **Provider Directory** | • **Nurse Advice Line Report** |

# Molina Healthcare of Washington
# Medicaid Prior Authorization Request Form

**Phone Number: (800) 869-7175**
**Fax Number: (800) 767-7188**

| MEMBER INFORMATION | | | |
|---|---|---|---|
| **Plan:** | ☐ **Molina Medicaid** | ☐ **Other:** | |
| **Member Name:** | | **DOB:** | / / |
| **Member ID#:** | | **Phone:** | ( ) - |
| **Service Type:** | ☐ Elective/Routine | ☐ Expedited/Urgent* | |

***Definition of Expedited/Urgent service request designation is when the treatment requested 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 should be submitted as routine/non-urgent.**

| REFERRAL/SERVICE TYPE REQUESTED | | | |
|---|---|---|---|
| **Inpatient**<br>☐Surgical procedures<br>☐Admissions<br>☐SNF<br>☐LTAC | **Outpatient**<br>☐Surgical Procedure ☐OT ☐PT ☐ST<br>☐Diagnostic Procedure ☐Hyperbaric Therapy<br>☐Infusion Therapy ☐Pain Management<br>☐Other: _____ | | ☐ **Home Health**<br>☐ **DME**<br>☐ **Wheelchair**<br>☐ **In Office** |
| Diagnosis Code & Description: | | | |
| CPT/HCPC Code & Description: | | | |
| Number of visits requested: | | DOS From: / / to / / | |
| Requested LOS | | | |

**Please send clinical notes and any supporting documentation**

| PROVIDER INFORMATION | | | | | |
|---|---|---|---|---|---|
| Requesting Provider Name: | | NPI#: | | TIN#: | |
| Servicing Provider or Facility: | | NPI#: | | TIN#: | |
| Contact at Requesting Provider's office: | | | | | |
| Phone Number: | ( ) - | Fax Number: | ( ) - | | |
| **For Molina Use Only:** | | | | | |