MOLINA HEALTHCARE | Molina Complete Care

Molina Complete Care Prior Authorization and Pre-service Review Guide

Effective March 3, 2022

Services listed below require prior authorization. Please refer to Molina Complete Care (MCC)'s provider website or prior authorization (PA) lookup tool for specific codes that require authorization. **Please note** – office visits to contracted/participating (PAR) providers, referrals to network specialists and emergency services **don't** require prior authorization.

Please refer to the AHCCCS prior authorization and concurrent review standards during the COVID-19 pandemic for prior authorization guidance. This guidance is subject to change at AHCCCS' discretion at any time.

- Behavioral health – mental health, alcohol and chemical dependency services:
  - Inpatient, residential treatment, partial hospitalization, day treatment, intensive outpatient, targeted care management;
  - Electroconvulsive therapy (ECT);
  - Applied behavioral analysis (ABA) – for treatment of autism spectrum disorder (ASD)
- Cosmetic, plastic and reconstructive procedures – no PA is required for breast cancer diagnoses
- Durable medical equipment (DME)
- Elective inpatient admissions – acute hospital, skilled nursing facilities (SNF), rehabilitation, long-term acute care (LTAC) facility
- Experimental/investigational procedures
- Health care administered drugs
- Home health care services (including home-based physical, occupational and speech therapy (PT/OT/ST)
- Hyperbaric/wound therapy
- Long-term services and supports (LTSS) (per state benefit). All LTSS services require prior authorization regardless of code(s)
- Nursing home/long-term care
- OT/PT/ST
- Orthotics/prosthetics
- Radiation therapy and radiosurgery
- Transportation services – non-emergent air transportation
- Miscellaneous and unlisted codes – MCC requires standard codes when requesting a PA. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the PA request.
- Neuropsychological and psychological testing (see separate specific PA form)
- Non-par providers/facilities – PA is required for office visits, procedures, labs, diagnostic studies and inpatient stays, except for:
  - Emergency and urgently needed services;
  - Professional fees for Medicaid-enrolled providers associated with emergency room visits and approved ambulatory surgery center (ASC) or inpatient stays;
  - Local health department (LHD) services;
  - Radiologists, anesthesiologists and pathologist professional services when billed in POS 19, 21, 22, 23 or 24
  - PA is waived for professional component services or services billed for Medicaid-enrolled providers with modifier 26 in **any** place of service setting
  - Other state-mandated services
- Sleep studies
- Transplant/gene therapy, including solid organ and bone marrow

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 MCC health care providers
Information generally required to support authorization decision making includes: • Current (up to six months) adequate patient history related to the requested service(s) • Relevant physical examination that addresses the problem(s) • 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 as well as additional information regarding the grievance and appeals process. Denials are also 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. • MCC has a full-time medical director available to discuss medical necessity decisions with the requesting provider at (800) 424-5891.

Important MCC contact information	
Prior authorizations, including behavioral health and inpatient authorizations: Phone: (800) 424-5891 Outpatient Fax: (888) 656-7501 Inpatient fax: (888) 656-2201	**24-Hour Behavioral Health Criss Line (available seven days a week)** Phone: (800) 424-5891
Pharmacy authorizations: Phone: (800) 424-5891 Fax: (844)271-6887	**Dental authorizations:** Phone: (800) 440-3048 Fax: (262) 241-7150 (for non-hospital requests) Fax: (262) 834-3575 (for hospital and SPU requests) Website: <www.dentaquest.com>
Advanced Imaging authorizations: Phone: (855) 714-2415 Fax: 877-731-7218	**After-hours prior authorization requests (must be submitted by phone):** Phone: (800) 424-5891
Provider Customer Service: Phone: (800) 424-5891	**Member Services, Benefits and Eligibility:** Phone: (800) 424-5891 (TTY/TDD: 711)
Transportation: Phone: (800) 424-5891	**Transplant authorizations:** Phone: (855) 714-2415 Fax: (877) 813-1206
	Nurse Advice Line (available 24 hours a day, 7 days a week) Phone: (800) 424-5891 (TTY/TDD: 711) Members who speak Spanish can press “1” at the IVR prompt. The nurse will arrange for an interpreter as needed for all non-English/Spanish speaking members. No referral or PA is needed.
Providers may visit the MCC provider portal online at www.availity.com/molinacompletecare**.** Available features include, but aren’t limited to: • Authorization submission and status • Member eligibility • Provider directories • Claims submission and status • Ability to download frequently used forms • Nurse Advice Line report	

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Molina Complete Care 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 ☐ Early and periodic screening, diagnostic and treatment (EPSDT)/special services ☐ Reason for Non-par **required**: _____			

Referral/service type requested			
Request type:	☐ **Initial request**	☐ **Extension/renewal/amendment**	**Previous auth #:**

Inpatient services:	**Outpatient services:**		
☐ Inpatient hospital	☐ Chiropractic	☐ Office procedures	☐ Pharmacy
☐ Inpatient transplant	☐ Dialysis	☐ Infusion therapy	☐ PT
☐ Inpatient hospice	☐ DME	☐ Laboratory services	☐ Radiation therapy
☐ Long-term acute care (LTAC)	☐ Genetic testing	☐ LTSS services	☐ ST
☐ Acute inpatient rehabilitation (AIR)	☐ Home health	☐ OT	☐ Transplant/gene therapy
☐ Skilled nursing facility (SNF)	☐ Hospice	☐ Outpatient surgical/procedures	☐ Transportation
☐ Other inpatient:_____	☐ Hyperbaric therapy	☐ Pain management	☐ Wound care
	☐ Imaging/special tests	☐ Palliative 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(s)**	**Requested service(s)**	**Requested units/visits**

MOLINA HEALTHCARE | Molina Complete Care

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:**

Contact Name:
Contact Phone #:
Contact Fax #:
Contact Email:

Prior authorization isn't a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.

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Molina Complete Care 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 care management *Behavioral Health Psychological/Neuropsychological- see specific Prior Auth Form	☐ Electroconvulsive therapy ☐ Applied behavioral analysis ☐ Non-par outpatient services Reason for Non-par **required**: _____ ☐ 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(s)**	**Requested service(s)**	**Requested units/visits**

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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:**

Contact Name:
Contact Phone #:
Contact Fax #:
Contact Email:

Prior authorization isn't a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.