Molina Complete Care prior authorization/pre-service review guide

Refer to Molina Complete Care's (MCC's) provider website or prior authorization (PA) look-up tool/matrix for specific codes that require authorization. Only covered services are eligible for reimbursement**.**

Office visits to contracted/participating (PAR) providers and referrals to participating (PAR) specialists do not require prior authorization. Emergency services do not require prior authorization.

Services requiring prior authorization

- Advanced imaging and special tests
- Behavioral health: Mental health, alcohol and chemical dependency services
    - Inpatient, residential treatment, partial hospitalization, day treatment, intensive outpatient, targeted case management
    - Electroconvulsive Therapy (ECT)
    - Applied Behavioral Analysis (ABA)
- Cosmetic, plastic and reconstructive procedures—no PA required with breast cancer diagnoses
- Durable medical equipment
- Elective inpatient admissions—acute hospital, Skilled Nursing Facilities (SNF), acute inpatient rehabilitation, Long Term Acute Care (LTAC) facilities
- 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)
- Health care administered drugs
- Home healthcare services (including home-based physical therapy [PT], occupational therapy [OT] or speech-language therapy [ST])
- Hyperbaric/wound therapy
- Inpatient hospitalization (except emergency and urgently needed services)
- Long Term Services and Supports (LTSS) per state benefit—all LTSS services require PA regardless of code(s)
- Miscellaneous and unlisted codes—Molina requires standard codes when requesting authorization. Should you use an unlisted or miscellaneous code with your request,

medical necessity documentation and rationale must be submitted with the prior authorization request.

- Neuropsychological and psychological testing
- Non-par providers—with the exception of some facility-based professional 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 or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
    - Radiologists, anesthesiologists, and pathologists professional services when billed in POS 19, 21, 22, 23, 24, 51, 52
    - Other state mandated services
- Nursing home/long term care
- Occupational, physical and speech therapy
- Outpatient hospital/Ambulatory Surgery Center (ASC) procedures
- Pain management procedures
- Prosthetics/orthotics
- Radiation therapy and radiosurgery
- Sleep studies
- Transplants/gene therapy, including solid organ and bone marrow (cornea transplant does not require authorization)
- Transportation services—non-emergent air transportation

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 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 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 providing information about the grievance and appeals process. Denials are communicated to the provider by telephone or fax. We provide verbal or faxed denials within two business days 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 Complete Care has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician. Call Provider Services to contact them:
    - Commonwealth Coordinated Care Plus (CCC Plus): (800) 424-4524
    - Medallion 4.0: (800) 424-4518

MCC Medicaid contact information

Service hours are 8 a.m. to 6 p.m. Monday through Friday, unless otherwise specified.

Service authorization requests	Phone: CCC Plus: (800) 424-4524 Medallion 4.0: (800) 424-4518 Inpatient physical health fax: (866) 210-1523 Outpatient physical health fax: (855) 769-2116 LTSS fax: (800) 614-8207 Behavioral health fax: (855) 339-8179 Pharmacy fax: (844) 278-5731
24-hour behavioral health crisis (7 days/week):	Phone: CCC Plus: (800) 424-4524 Medallion 4.0: (800) 424-4518
Radiology authorizations	Phone: (855) 714-2415 Fax: (877) 731-7218
Vision: VSP	Phone: (800) 877-7195
Provider Services	Phone: CCC Plus: (800) 424-4524 Medallion 4.0: (800) 424-4518
Member Services (Benefits/eligibility)	Phone: CCC Plus (800) 424-4524 TTY, 711 Medallion 4.0 (800) 424-4518 TTY, 711
Transportation: VEYO (non-emergency)	Phone: (877) 790-9472
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.*
Transplant authorizations	Phone: (855) 714-2415 Fax: (877) 813-1206

Providers should utilize MCC's provider portal at https://provider.molinahealthcare.com/Provider/Login.

Available self-service features include:

- Authorization submission and status
- Member eligibility
- Provider directories
- Claims submission and status
- Download frequently used forms
- Nurse Advice Line report