Molina Healthcare of Texas
Medicaid and MMP Dual Options Prior Authorization/Pre-Service Review Guide
October 1, 2020

Refer to Molina's website to view the Prior Authorization Code Matrix for specific codes that require authorization and note the limitations listed on the top of that document. Most out of network provider requests require authorization regardless of service. Prior authorization is not a guarantee of payment for services. Only covered services are eligible for reimbursement.

Summary of Services that Require Prior Authorization

- **Anesthesia:**
  - Dental Anesthesia –Medicaid (STAR) child 0-6 years old (Please include DMO Provider Determination Letter)
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)** No PA required with breast cancer diagnosis (Z85.3)
- **Diapers and Incontinence products:** Requests for incontinent supplies contact Longhorn Health Solutions at (877) 394-1860. Requests for incontinence supplies for a provider other than Longhorn will require prior authorization. Providers are unable to request a supplier other than Longhorn on behalf of the member. Members must call Member Services at (866) 449-6849 (Medicaid/CHIP) or (877) 319-6826 (CHIP RSA) to make this request.
- **Durable Medical Equipment**
- **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. (Authorization is required for CHIP Perinate as it is not a standard covered benefit.)
- **Habilitative Therapy –** After initial evaluation **
- **Home Healthcare and Home Infusion including Home PT, OT or ST:** Skilled Nursing after initial evaluation plus six (6) visits per calendar year. PT/OT/ST after initial evaluation.
- **Hyperbaric Therapy**
- **Advanced Imaging and Specialty Tests**
- **Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, All Inpatient Elective Procedures**
- **Long Term Services and Supports (LTSS):** (Not a Medicare covered benefit) All LTSS Services require PA regardless of code(s)
- **Neuropsychological and Psychological Testing**
- **Nursing Facility Membership-** require authorization for all add on services
- **Nutritional Supplements & Enteral Formulas**
- **Non-Par Providers/Facilities:** PA is required for Office visits, procedures, labs, diagnostic studies, inpatient stays except for:
- **Non-Par Providers/Facilities:** (continued)
  - Professional fees associated with ER visit, approved
  - Ambulatory Surgery Center (ASC) or inpatient stay
  - Local Health Department (LHD) service
  - Radiologists, anesthesiologists, and pathologists' professional services when billed for POS 19, 21, 22, 23 or 24 (except for dental anesthesia for STAR children)
  - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting
  - Other services based on state requirements
- **Occupational Therapy:** After initial evaluation
- **Office Visits & Office-Based Procedures for PAR providers <u>do not</u> require authorization, unless specifically included in another category that require authorization even when performed in a PAR provider's office.**
- **Outpatient Hospital Surgery/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures in all settings:** Except trigger point injections
- **Physical Therapy:** After initial evaluation
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery (for selected services only))**
- **Rehabilitation Services:** Comprehensive Outpatient Rehab Facility (CORF) - CORF Services are a benefit for Medicare and CCP only
- **Sleep Studies:** Except Home (POS 12) sleep studies
- **Specialty Pharmacy drugs:** Refer to Vendor Drug Program, TX Medicaid Provider Procedures. Claims payment is dependent on valid National Drug Code during claims submission.
- **Speech Therapy:** After initial evaluation
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization) All transplant related admissions or observation stay require notification, regardless of level of care.
- **Transportation:** Non-emergent ambulance (ground and air) Refer to Molina's Provider website for specific codes that require authorization.
- **Unlisted and Miscellaneous and T (Temporary) 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.

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. (Medicaid benefit only)

Early Childhood Intervention (ECI): An authorization is not required for therapy listed on the ECI Individual Family Service Plan (IFSP) provided by an ECI provider (for children from birth through 35 months of age).

IMPORTANT INFORMATION

Preauthorization is a process to determine "medical necessity" or if a service is "medically necessary." This means health care services determined by a provider, in consultation with Molina Healthcare to be clinically appropriate, or clinically significant, in terms of type, frequency, event, site, according to any applicable generally accepted principles and practices of good medical care, or practice guidelines. These guidelines are developed by the federal government, national, or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by Molina Healthcare consistent with such federal, national, and professional practice guidelines, for the diagnosis, or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

Service requests designated urgent or expedited 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 or non-urgent.
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.

Molina's Medical Necessity Screening Criteria is objective, clinically valid, compatible with established principles of health care, and flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

- Cases meeting screening criteria are approved by licensed clinician (nurse/therapist);
- Cases not meeting the screening criteria are forwarded to the Medical Director for review.

Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 866-449-6849 x206660 or for Advanced Imagining discussion contact our toll-free number: 855-714-2415.

If medical necessity is not established, Molina will send the requesting provider and the member 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 and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition. Member is notified through written communication of a denial decision within one business day of the decision.

Preauthorization is an approval by Molina that confirms that a requested service has been determined to be Medically Necessary and is covered under the plan. Preauthorization is not a guarantee of payment for services.
Payment is made based upon the following:

- · Benefit limitations;
- · Exclusions;
- · Member eligibility at the time the services are provided; and
- · Other applicable standards during the claim review process.

Pharmaceutical Services
Molina Healthcare has a list of drugs that we will cover. The list is known as the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community. Certain drugs on the Drug Formulary require preauthorization. Molina also has a process to allow you to request and gain access to clinically appropriate drugs that are not covered under the plan. Molina Healthcare may cover specific non-formulary drugs when the prescriber documents in the medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of the Member's disease or condition, or the Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member. The drug formulary which indicates the drugs requiring preauthorization can be found here.

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com Available features include:

- Authorization submission and status
- Claims submission and status (EDI only)
- Download frequently used forms
- Member Eligibility
- Provider Directory
- Nurse Advice Line Report

Important Molina Contacts
Hours of Operations Medicaid/CHIP 8:00 a.m. – 5:00 p.m.
Medicare/MMP 8:00 a.m. – 8:00 p.m.

Prior Authorizations:
Medicaid/CHIP Phone: [855-322-4080]
Outpatient Services Fax: [866-420-3639]
Inpatient Admissions Fax: [833-994-1960]
Medicare/MMP Phone: [855-322-4080]
Outpatient Services Fax: 1 [844-251-1450]
Inpatient Admissions Fax: [833-994-1960]
LTSS Authorizations: Fax: 1 [844-304-7127]
Nursing Facilities (Medicaid/CHIP/MMP/Medicare):
Phone: 1 [855-322-4080] Fax: 1 [866-420-3639]

Radiology Authorizations:
Phone: 1 [855-714-2415] Fax: 1 [877-731-7218]

NICU Authorizations:
1 [855-322-4080] Fax: 1 [866-420-3639]

Pharmacy Prior Authorizations:
Medicaid/CHIP Prescription and J Code Request:
1 [855-322-4080] Fax: 1 [888-487-9251]
MMP/Medicare Prescriptions
1 [800-665-3086] Fax: 1 [866-290-1309]
Medicare J Code Requests Fax: 1 [844-251-1450]
MMP J Code Requests Fax: 1 [844-251-1451]

Behavioral Health Authorizations:
Phone: 1 [866-449-6849] Fax: 1 [866-617-4967]

Transplant Authorizations:
Phone: 1 [855-714-2415] Fax: 1 [877-731-7218]

STAR+PLUS Service Coordination Line:
Phone: 1 [866-409-0039]

24 Hour Nurse Advice Line (24 hours a day, 7 days a week)
Phone: 1 [888-275-8750] or [TTY:711]
Member who speak Spanish can press 1 at the IVR prompt; the nurse will arrange for an interpreter, as needed, for non-English speaking members.
No referral or prior authorization is needed.

Member Customer Service including Benefits/Eligibility/Prior Authorization Assistance:
Medicaid: 1 [866-449-6849] Fax: 1 [281-599-8916]
TTY/TDD: Relay Texas
English: 1 [800-735-2989 OR 711]
Spanish: 1 [800-662-4954]

Provider Customer Service: 8:00 a.m. – 5:00 p.m.
Phone: 1 [855-322-4080] Fax: 1 [281-599-8916]

Vision Care: (www.opticarevisionplans.com)
provrel@opticare.net
CHIP 1 [800-368-4790]
STAR 1 [866-492-9711]
STAR+PLUS 1 [877-832-4118]
Fax: [800-980-4002]
Dental:
Dental: *Medicaid* Liberty Dental
1 [888-359-1084]

Transportation:
Medicaid: Medical Transportation Program *(MTP)*
Dallas: 1 [855-687-3255] Houston: 1 [855-687-4786]
All other areas: 1 [877-633-8747 (877-MED-TRIP)]