



Services Requiring Authorization

The following list includes all services that require prior authorization. Any services not on this list and performed by a participating provider DO NOT require prior authorization. For your convenience, a list of procedure codes that require prior authorization can be found at www.MolinaHealthcare.com by selecting the Resource tab and Service Request Resources link. To request a hardcopy of this list, please call (800) 642-4168.

Services Requiring Prior Authorization

- Ambulatory surgical services
 - Cosmetic/Plastic procedures
 - Dermatologic procedures
 - ENT except T & A and Myringotomy
 - Oral Maxillofacial procedures
 - Pain Management procedures, including all injections
 - Reductive Mammoplasty
 - Uvulopalatopharyngoplasty (UPPP)
 - Visual Correction surgery, Blepharoplasty

Specific services in an office setting (place of service 11) will require authorization; see link above for the list of specific CPT/HPCS codes.

- Bariatric procedures and treatment related to obesity
- Durable Medical Equipment follow ODJFS guidelines
- Experimental/Investigational procedures (excluded from coverage)
- Home Health Care
- Home Infusion

- Injectible Medications and Immunoglobulins (examples include: Enbrel, Lupron, Remicade, Interferon, Xolair, Humira, Raptiva, Amevive, blood or blood factors, Synagis).
 - Unlisted injectible codes with charges exceeding \$500
- Inpatient Admissions (Skilled Nursing Facility, surgical, medical, obstetric, rehabilitative)
- Radiology: MRI, MRA, PET SCAN, SPECT
- Referrals to Any Non-Participating Providers including second opinions
- Transplant Evaluations, Transplants and Related Procedures

For Alcohol and Chemical Dependency Treatment (except at ODADAS facilities) and Mental Health Services (except at Community Mental *Health Centers*) – *Providers or Members may inquire about these* services by calling Molina Healthcare of Ohio at (800) 642-4168.

PLEASE NOTE: Abortions, Hysterectomies and Sterilizations do not require clinical review. However, claims for these services cannot be paid until the appropriate **ODJFS Consent Form** is received.

Elective Admissions require prior authorization. All emergent admissions require notification within 24 hours of admission or next business day.

Prior Authorization Request Submission

Requests for service requests to the Utilization Management Department may be sent by telephone, fax, mail, or on the web via Molina's ePortal. Phone numbers and address are:

(800) 642-4168 (option 1, option 1) ePortal: www.MolinaHealthcare.com Telephone: (866) 449-6843 Molina Healthcare of Ohio, Inc. Mail: Member Transportation Information: (800) 642-4168 (option 2)

Attention: Service Requests

PO Box 349020

Columbus, Ohio 43234-9020

Providers are encouraged to use the Molina Healthcare of Ohio Service Request Form. All requests should include the following information, as applicable, for the requested service:

Required Information for Prior Authorization Requests

- Member demographic information (name, DOB, social security # etc.)
- Provider information (Referring Physician and Referred to Specialist)
- Requested service/procedure (including specific CPT/HCPCS codes)
- Member diagnosis (ICD-9 Code and description)
- Location where the service will be performed
- Requested length of stay (for inpatient requests)

- Clinical indications for the service or referral, including:
 - Adequate patient history related to the requested services
 - Physical examination that addresses the area of the request
 - Supporting lab and/or X-ray results to support the request
 - Relevant PCP and /or Specialist progress notes or consultations
 - Any other relevant information or data specific to the request

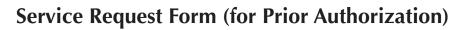
Molina Healthcare of Ohio will process any "non-urgent" requests as quickly as possible and no later than within 14 working days of receipt of a request. "Urgent" requests will be processed as soon as possible within 72 hours of receipt of the request.

Upon approval the requestor will receive an authorization number. The number may be provided by phone or fax. If a request must be denied, the requestor 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 if at all possible or by fax with confirmation of receipt if telephonic communication fails. Verbal and fax denials are given the same business day of making the denial decision. The written letter is mailed at the time the denial is issued.

Extension of Authorization

Once a service has been previously authorized, the provider may call Molina Healthcare of Ohio directly to request an extension of services.

Details regarding the appeals process can be found in the Molina Provider Manual. Members or Providers may call Member Services at 1-800-642-4168 with their appeal or submit the appeal in writing to:





Service Request Identification #:_____ Date:____

Medical Management		nber: 800-642-41 r: 866-449-6843	68 (option 1,	option 1)		
		Information				
Member Name (Last, First, MI)	Wiember	Date of Birth		Member I.D.		
Address: (No., Street, City, State, Zip)	//		Phone Number:			
Service Is: ☐ Medically Emergent (N☐ Elective/Routine	Is there another Insurance Carrier for this service? Y N If yes, Name of Company:					
Please re	Referral/Servi	ce Type Requ	ested	e authorization		
☐ Inpatient Admission ☐ Hospital ☐ Skilled Nursing Facility ☐ Rehabilitation Facility Facility Name: Requested Length of Stay: Date/Time of Service: * Requests for hysterectomies, sterilizations and abortions must be accompanied by the appropriate ODJFS form.	☐ Ambulatory Surgical Service ☐ Bariatric procedures and tree ☐ Cosmetic/Plastic procedure ☐ Durable Medical Equipment ☐ Experimental/Investigationa ☐ Home Health Care, Home Ir ☐ Injectible Medications and Ir ☐ Pain Management ☐ Radiology (MRI, MRA, PET ☐ Referral to non-participating second opinions: ☐ Transplant evaluation, proce	atment I procedures Infusion I procedures I procedures	# Visits requested: DME/Supplies: Injectibles: Place of Service Provider Office			
appropriate oz) ro romi	Referring Pro	vider Inform	l ation			
Requesting Provider Name: (Last, First) Specialty:				Phone Number:		
Address: (No., Street, City, State, Zip)			Fax Number:			
Tax I.D. #:						
	Referred to Pro	ovider Inform	ation			
Referred to Provider Name: (Physicia	Specialty:		Phone Number			
Address: (No., Street, City, State, Zip)			Fax Number	Fax Number		
Tax I.D. #:						
		Information es required)				
ICD-9 Code & Description:	· · · · · · · · · · · · · · · · · · ·	··		C & Description:		
Clinical Indications for Request: (ma	y attach clinical or progress notes.	Please include per	tinent previous	testing results):		
Requesting Provider Signature: Date of Scheduled Service (Please include future dates, if applicable):				PCP Name:		
	For Mol	ina Use Only				
Service Request status: ☐ Approved ☐ Pending ☐ Deni	Comments:					
Utilization Management Staff Signature:				Date:		
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