MolinaHealthcare Of New Mexico Marketplace
Prior Authorization/Pre-Service Review Guide
Effective: 07/01/2024

Refer to Molina's Provider website or Prior Authorization Look up Tool/Matrix for specific codes that require authorization
Only covered services are eligible for reimbursement

Prior authorization is not required for New Mexico Gold Card Providers. ONLY for the specific codes determined to be exempt for each individual provider.

Office Visits to Contracted/Participating (PAR) providers & Referrals to Network Specialists Do Not Require Prior Authorization. Emergency Services Do Not Require Prior Authorization.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Transitional Residential Treatment for Substance Use, Partial Hospitalization, Day Treatment
  - Intensive Outpatient above 16 units
  - Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD).
- **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 or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Inpatient Hospitalization and NICU Admissions:** (Except emergency services)
- **Long Term Services and Supports (LTSS):** Not a covered benefit.
- **Miscellaneous & Unlisted 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.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** **Except for 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 stay, 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 services based on State requirements.
- **Occupational, Physical & Speech Therapy:** After the first 12 visits for PT/OT or first 6 visits for ST
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** All non-emergent transportation.
- **Vision:** Pediatric Low Vision Optical Devices and Services: Please contact VSP (Vision Service Plan) at 1 (800) 877-7195 or visit their website at www.vsp.com/advantage

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MARKETPLACE 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 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 (855) 322-4078.

Important Molina Healthcare Marketplace Contact Information

New Mexico: A registered professional nurse or physician is available by telephone seven days a week, 24 hours a day, to render utilization management determinations for providers or to respond to inquiries concerning emergency or urgent care.

Prior Authorizations including Behavioral Health Authorizations:
Phone: (855) 322-4078
Fax: (833) 322-1061

Pharmacy Authorizations:
Phone: (855) 322-4078
Fax: (866) 472-4578

Radiology Authorizations:
Phone: (855) 714-2415
Fax: (877) 731-7218

Transplant Authorizations:
Phone: (855) 714-2415
Fax: (877) 813-1206

Vision:
Phone: (800) 877-7195
Website: www.vsp.com/advantage

Member Customer Service, Benefits/Eligibility:
Phone: (888) 295-7651/ TTY/TDD 711

Provider Customer Service:
Phone: (855) 322-4078
Available 24 hours, 7 days/week for emergent PA requests

24 Hour Nurse Advice Line (7 days/week)
Phone: (888) 275-8750/TTY: 711
Members who speak Spanish can press 1 at the IVR (Interactive Voice Response) prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members.
No referral or prior authorization is needed.

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

- Authorization submission and status
- Member Eligibility
- Provider Directory
- ♦ Claims submission and status
- ♦ Download Frequently used forms
- ♦ Nurse Advice Line Report

Molina® Healthcare of New Mexico, Inc.
Prior Authorization Request Form
Medical/Behavioral Health/Pharmacy

To file electronically, send to:	To file via facsimile, send to:	To contact the coverage review team for Pharmacy and Healthcare Services, please call:
Healthcare Services: https://provider.molinahealthcare.com/provider/login **Pharmacy:** https://www.covermymeds.com/ https://surescripts.com/	**For Medicaid:** Healthcare Services: 1-833-558-6769 Pharmacy: 1-866-472-4578 **For Marketplace:** Pharmacy 1-866-472-4578 Healthcare Services: 1-833-322-1061	1-855-322-4078 Monday through Friday between the hours of 8am and 5pm MST. **For after-hours review, please contact:** 1-855-322-4078

MEMBER INFORMATION

Date of Request:		
Health Plan:		
Enrollee Information:		**DOB** (MM/DD/YYYY):
Member ID#:		**Member Phone**:
Street Address:		
City, State, Zip Code		
Priority and Frequency:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____ ☐ Emergent Inpatient Admission	

PROVIDER INFORMATION

Please note: processing delays may occur if rendering provider does not have appropriate documentation of medical necessity. Ordering provider may need to initiate prior authorization.

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:**

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

MEDICAL REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital ☐ Inpatient Transplant ☐ Inpatient Hospice ☐ Long Term Acute Care (LTAC) ☐ Acute Inpatient Rehabilitation (AIR) ☐ Skilled Nursing Facility (SNF) ☐ Other Inpatient:_____	☐ Chiropractic ☐ Dialysis ☐ DME ☐ Genetic Testing ☐ Home Health ☐ Hospice ☐ Hyperbaric Therapy ☐ Imaging/Special Tests	☐ Office Procedures ☐ Infusion Therapy ☐ Laboratory Services ☐ LTSS Services ☐ Occupational Therapy ☐ Outpatient Surgical/Procedures ☐ Pain Management ☐ Palliative Care	☐ Pharmacy ☐ Physical Therapy ☐ Radiation Therapy ☐ Speech Therapy ☐ Transplant/Gene Therapy ☐ Transportation ☐ Wound Care ☐ Other: _____.

HCPCS/CPT/CDT/Primary ICD-10/Code: **Description:**

DATES OF SERVICE		**PROCEDURE/ SERVICE**	**DIAGNOSIS CODE**	**REQUESTED**	**REQUESTED**
START	**STOP**	**CODES**		**SERVICE**	**UNITS/VISITS**

Molina® Healthcare of New Mexico, Inc.
Prior Authorization Request Form
Medical/Behavioral Health/Pharmacy

BEHAVIORAL HEALTH 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 Case Management	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____

HCPCS/CPT/CDT/Primary ICD-10/Code: **Description:**

Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PRESCRIPTION DRUG

Diagnosis name and Primary ICD-10 code:

Patient Height (if required):	Patient Weight (if required):

Route of administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other: Explain:

Administered: ☐ Doctor's Office ☐ Dialysis Center ☐ Home Health/Hospice ☐ By Patient

Medication Requested	Strength (include both loading and maintenance dosage)	Dosing Schedule (including length of therapy)	Quantity per month or Quantity Limits

Is the patient currently treated with the requested medication(s)?: ☐ Yes* ☐ No
*If "Yes", when was the treatment with the requested medication started? Date:

Anticipated medication start date (MM/DD/YY):

General prior authorization request. Explain the clinical reason(s) for the requested medications, including an explanation for selecting these medications over alternatives:

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Prior Authorization Request Form
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Rationale for drug formulary or step-therapy exception request:

[ ] Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure, specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s).

[ ] Patient is stable on current drug(s), high risk of significant adverse clinical outcome with medication change. Specify anticipated significant adverse clinical outcome below.

[ ] Medical need for different dosage and/or higher dosage, specify below: (1) Dosage(s) tired; (2) explain medical reason**.**

[ ] Request for formulary exception, specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome.
[ ] Other (explain below)

Required explanation(s):

List any other medications patient will use in combination with requested medication:

List any known drug allergies

Previous services/therapy (including drug, dose, duration, and reason for discontinuing each previous service/therapy)

	Date Discontinued:
	Date Discontinued:
	Date Discontinued:

Attestation

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Requester Signature: **Date:**

DO NOT WRITE BELOW THIS LINE, FIELDS TO BE COMPLETED BY PLAN

Authorization # **Contact Name**

Contact's credentials/designation