2012 PROVIDER MANUAL Supplement
State Coverage Insurance
(SCI)
and
The University of New Mexico State Coverage Insurance
(UNM SCI)

This is a supplement to the 2012 Provider Manual that addresses the Molina Healthcare of New Mexico, Inc. (Molina Healthcare) Salud managed care product. The Provider Manual Supplement is a reference tool that contains contact information as well as policies/procedures for services that Molina Healthcare specifically provides and administers on behalf of SCI and UNM SCI Members. All other Molina Healthcare contact information and policies/procedures not indicated in this supplement are located in the 2012 Provider Manual.

Please contact Molina Healthcare with questions you have regarding the SCI programs.

NOTE: UNM SCI Members must access all services through the UNM System.

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NOTE: Please refer to the Provider Manual for all other contact information and policies and procedures.

Overview

SCI: Effective July 1, 2005, Molina Healthcare of New Mexico, Inc. (Molina Healthcare) began offering State Coverage Insurance (SCI). SCI is a Medicaid program that offers insurance to low-income adults, ages nineteen (19) through sixty-four (64). SCI was developed in an effort to cover a portion of the uninsured working adults in the State of New Mexico.

UNM SCI: Molina Healthcare administers the University of New Mexico State Coverage Insurance (UNM SCI) Program. Molina Healthcare is responsible for utilization management, quality assurance, member services, anti-fraud oversight and Member/practitioner/provider complaints and appeals.

SCI and UNM SCI contracted practitioners/providers will follow the same policies and procedures outlined in the Provider Manual, **unless otherwise instructed in this supplemental manual**. This supplemental manual will refer back to the appropriate section in the Salud Provider Manual when applicable. Instructions are outlined for SCI and UNM SCI policies and procedures.

Please contact the Member Services Department in **Albuquerque at (505) 348-1578 or toll free at (866) 403-3018** with questions regarding this program.

Benefits

Practitioners/providers who participate in SCI (a Medicaid Program) agree to accept the amount paid as payment in full (see 42 CRF 447.15) with the exceptions of co-payment amounts. Co-payments are outlined in this section.

Other than co-payments, a practitioner/provider cannot bill a Molina Healthcare SCI or UNM SCI Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- **Failure to follow managed care policies:** A Member must be aware of the practitioners, pharmacies, hospitals, and other practitioners/providers who are contracted with SCI and UNM SCI;
- **Denied emergency room claims:** A Member is responsible for payment of a hospital outpatient emergency room visit if it is determined that an emergency did not exist at the time the service was provided. **The Member may only be billed for the emergency room charges if they have signed a waiver at the hospital stating they will be responsible for the charges if it is determined that an emergency did not exist.** A Member cannot be billed for the ancillary charges (i.e. laboratory & radiology services); or
- **Other Member responsibilities:** 1) The Member has been advised by the practitioner/provider that the service is not a covered benefit; 2) The Member has been advised by the practitioner/provider that they are not contracted with SCI or UNM SCI; and 3) The Member agrees in writing to have the service provided with full knowledge that he/she is financially responsible for payment.

The benefit grid on the following page is a summary of the Molina Healthcare benefits for SCI and UNM SCI Members. Please contact Member Services for questions regarding benefits and prior authorization requirements on benefits (refer to Section B of the 2012 Provider Manual for telephone numbers).

MOLINA HEALTHCARE

State Coverage Insurance (SCI) Summary of Benefits and Cost Sharing Limits

The SCI benefit package is limited to $100,000 in benefits payable per member per benefit year. Inpatient medical hospitalization coverage is limited to twenty-five (25) days per member per benefit year. This twenty-five (25) day limitation is combined with home health services and inpatient physical health rehabilitation. Inpatient behavioral health hospitalization coverage is limited to twenty-five (25) days per member per benefit year.

Category of Eligibility	Category 062 I	Category 063 I	Category 064I
Income Guidelines	**0 - 100% FPL**	**101 - 150% FPL**	**151 – 200% FPL**
Service	**Co-payment***	**Co-payment***	**Co-payment***
Practitioner/Provider Visits (no co-pay for preventive services – see below)	$0	$5	$7
Pre/Post Natal Care	$0	$0	$0
Preventive Services	$0	$0	$0
Hospital Inpatient Medical/Surgical**	$0/per admission	$25/per admission	$30/per admission
Hospital Inpatient Maternity**	$0/per admission	$25/per admission	$30/per admission
Hospitalization/Inpatient** Behavioral Health	$0/per admission	$25/per admission	$30/per admission
Hospital Outpatient Surgery/Procedures	$0	$5	$7
Home Health**	$0	$5	$7
Physical Therapy, Occupational Therapy & Speech Therapy	$0	$5	$7
Diagnostic Services	$0 (included in office visit)	$0 (included in office visit)	$0 (included in office visit)
Durable Medical Equipment/Supplies	$0	$5	$7
Diabetes Treatment Equipment and Supplies Diabetes Management	$3 $0	$3 $5	$3 $7
Emergency Services	$0	$15 per visit, waived if admitted to a hospital within 24 hours	$20 per visit, waived if admitted to a hospital within 24 hours
Urgent Care	$0	$5	$7
Formulary Prescription Drugs: Generic and/or Name Brand	$3 per prescription	$3 per prescription	$3 per prescription
Behavioral Health and Substance Abuse: Outpatient office visit and outpatient substance abuse treatment Inpatient behavioral health and inpatient detoxification	$0 $0	$5 $25	$7 $30
Limits on Out-of-Pocket Expenses	The maximum amount that a member will pay out-of-pocket for the benefit year will be limited to 5 percent of countable household income.		

* Benefits are subject to plan exclusions, limitations, and prior authorization requirements. There is no co-payment requirement for services provided to Native Americans enrolled in the SCI program.

**Inpatient behavioral health hospitalization coverage is limited to twenty-five (wt) days per member per benefit year.

** Prescriptions filled by Native American members through Indian Health Services or tribal 638 facilities are not subject to the PDL.

Identification Cards

Member

John Doe
Identification #
1234567890

PCP Name: MOE LINA
PCP Phone: (555) 777-9999
PCP Location: 123 Elm St ALBUQUERQUE, NM 87105

Patient Responsibility:

Office Visits	No Copay
Inpatient Admission	No Copay
Prescriptions	$3.00
Emergency Room	No Copay

MEMBERS: For general information please call (505) 342-4681 (Albuquerque) or (800) 580-2811 (State-wide).

PROVIDERS: For general information please call (505) 341-7493 or (888) 825-9266.

BEHAVIORAL HEALTH: For information please call (505) 342-4660 or (800) 377-9594.

PRESCRIPTION DRUGS: For information please call (800) 261-3181.

TeleSalud NURSE ADVICE LINE: For English (888) 275-8750 or for Espanol (866) 648-3537.

Claims Submission: PO Box 22801, Long Beach, CA 90801

www.molinahealthcare.com

Identification Cards

Member
John Doe
Identification #
1234567890

UNM HOSPITAL
UNMSCI

PCP Name: Moe Lina
PCP Phone: (555) 777-9999
PCP Location: 123 Elm St ALBUQUERQUE, NM 87105

Patient Responsibility:

Clinic Visits	$0.00	MRI, CT, PET Scans	$0.00
Inpatient Admission	$0.00	Prescriptions	$3.00
PT, OT, ST Cardiac Rehab	$0.00	Outpatient Surgery	$0.00
Emergency Room	$0.00	DME, Prosthetics (Authorized Only)	$0.00

Administered | MOLINA HEALTHCARE

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BEHAVIORAL HEALTH

Access for Behavioral Health Services

Molina Healthcare is responsible for developing and maintaining a system that ensures access to behavioral health care services. Molina Healthcare is required to comply with access standards as defined by state and federal regulations. For additional information on access, please refer to Section F of the Provider Manual.

A Member with the following conditions must be seen within the following timeframes:

- Life-threatening (Immediately);
- Emergent non-life threatening – no greater than six hours from request to appointment;
- Urgent – no greater than twenty-four (24) hours from request to appointment;
- Non-Urgent (Routine) – no greater than ten (10) business days from request to appointment;
- Specialty outpatient referral and/or consultation appointments - consistent with the clinical urgency, but no greater than twenty-one (21) calendar days, unless the Member requests a later time;
- Scheduled follow-up outpatient visit – consistent with the Member's clinical need;
- Ongoing scheduled appointments - consistent with the Member's clinical need; and
- Outpatient scheduled appointments – not more than thirty (30) minutes after the scheduled time, unless the Member is late or the practitioner was delayed due to an unforeseen emergency.

The role of the PCP is to refer the Member to the appropriate level of behavioral health care. A referral is not needed for a Molina Healthcare Member to access behavioral health care. The PCP should assist the Member in accessing needed behavioral health services.

The following is a list of risk factors and indicators for PCP referral for behavioral health services:

- Suicidal/homicidal ideation or attempts;
- Suspected or confirmed alcohol and/or drug abuse;
- Stressful life events such as divorce, bereavement, loss of job;
- Victims or perpetrators of neglect or abuse;
- Symptoms of depression, anxiety, posttraumatic stress, or other psychological disorder;
- Living with a chronic condition or terminal illness;
- Family history of mental illness;
- Lack of social support;
- Severe mental and/or functional impairment; and
- Previous major depressive episode.

BEHAVIORAL HEALTH (*continued*)

The PCP can assist Members by:

- Encouraging the Member to see a behavioral health care practitioner/provider when necessary;
- Providing the Member with Molina Healthcare's Member Services numbers in **Albuquerque at (505) 348-1578 or toll free at (866) 403-3018**; and/or
- Locating an appropriate behavioral health specialist in the Molina Healthcare Provider Directory.

Coordination of Care for Behavioral Health Services

When a Molina Healthcare SCI or UNM SCI Member is seen, the behavioral health practitioner/provider must provide appropriate follow-up information to the PCP. With the Member's documented permission, request appropriate medical records within seven (7) business days of the initial screening and evaluation.

If a behavioral health practitioner/provider meets with a Member who has not seen his/her PCP within the past year, the behavioral health practitioner/provider should refer the Member to his/her PCP for an appropriate consultation or checkup.

The following should be communicated between the Member's PCP and the behavioral health practitioner/provider:

- Drug therapy and medical consultation, including all medications, his/her doses, duration prescribed, why prescribed, and changes in the drug regimen;
- Laboratory and radiology results;
- Transition or changes in level of care, such as discharge from inpatient treatment;
- Sentinel events including, but not limited to hospitalization, emergencies, incarceration, suicide attempts;
- Treatment or care plans, including goals and treatment modalities; and
- Member compliance with follow-up appointments, medication and treatment plans.

Information should continue to be communicated between practitioners/providers throughout the duration of the patient's behavioral health care.

Molina Healthcare continuously evaluates the coordination of care our Members receive through medical record reviews, site audits, and by conducting Member and provider surveys.

BEHAVIORAL HEALTH (*continued*)

Utilization Management

Utilization Management (UM) Standards mandate that Molina Healthcare:

- Clearly define the structure and processes within its UM program and assign responsibility to appropriate individuals;
- Use written criteria based on sound clinical evidence and specify the procedures for appropriately applying the criteria for UM decisions;
- Provide access to staff for Members and practitioners seeking information about the UM process and authorization of care;
- Use qualified health professionals to assess the clinical information used to support UM decisions;
- Make utilization decisions in a timely manner to accommodate the clinical urgency of the situation;
- Obtain relevant clinical information and consult with the treating practitioner when making a determination of coverage based on medical necessity;
- Clearly document and communicate the reasons for each denial;
- Maintain written policies and procedures for thorough, appropriate and timely resolution of Member appeals;
- Adjudicate Member appeals in a thorough, appropriate and timely manner;
- Evaluate the inclusion of new technologies and the new application of existing technologies in the benefit package. This includes medical and behavioral health procedures, pharmaceuticals and devices;
- Evaluate Member and practitioner satisfaction with the UM process;
- Provide, arrange for or otherwise facilitate all needed emergency services including appropriate coverage of costs;
- Ensure that its procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals;
- Facilitate the delivery of appropriate care and monitor the impacts of the UM program to detect and correct potential under and over-utilization of services; and
- Provide oversight of UM delegates per Human Services Department/National Committee for Quality Assurance requirements. Protocols for UM provide guidelines for the provision of appropriate, cost-effective services that promote recovery or stabilization at the Member's highest level of functioning.

Doctors are not Rewarded for Denying Care

Molina Healthcare reminds our practitioners/providers that decisions about utilization management (effective use of services) are based only on whether care is appropriate and whether a Member has coverage. Molina Healthcare does not reward doctors or others for denying coverage or care. UM decisions are based only on appropriateness of care and service and existence of coverage. Molina Healthcare does not reward practitioners/providers or other individuals for issuing denials of coverage or service care; and UM decision-makers do not receive financial incentives.

BEHAVIORAL HEALTH (*continued*)

Who Makes our UM Decisions for Behavioral Health Services?

Physicians, appropriate behavioral health practitioner or a pharmacist, as appropriate, may perform pre-service, concurrent and post-service reviews. A board certified psychiatrist has substantial involvement in the development and implementation of the UM program. Case Managers cannot deny care. Only a physician, psychiatrist, doctoral level clinical psychologists or certified addiction medicine specialists can deny care for behavioral health services.

How are UM Decisions Made for Behavioral Health Services?

UM decisions are rendered in a fair, impartial and consistent manner that serves the best interest of the Member.

UM staff review and assess the clinical information submitted by the practitioner/provider to support the UM decision. Molina Healthcare has objective, measurable criteria that are used for making UM decisions. Molina Healthcare has a mechanism for assessing the consistency with which care coordinators and practitioners apply UM criteria.

How are Clinical Criteria Developed and applied for Behavioral Health Services?

For behavioral health, Molina Healthcare involves appropriate, actively practicing practitioners in the development or adoption of criteria, and in the development and review of procedures for applying the criteria. Molina Healthcare utilizes Interqual criteria, Medical Assistance Division regulations and directives, and Molina Healthcare Medical Guidance Criteria documents to determine behavioral health service request appropriateness. The criteria are reviewed at specified intervals and are updated as necessary, but at least annually. The clinical criteria for determining medical necessity are clearly documented and include procedures for applying the criteria based on the needs of the individual Member and characteristics of the local delivery system. Molina Healthcare considers at least the following factors when applying criteria to a given Member's care:

- Age;
- Co-morbidities;
- Complications;
- Progress of treatment;
- Psychosocial situation;
- Home environment, when applicable; and
- Characteristics of the local delivery system that are available for the Member.

BEHAVIORAL HEALTH (*continued*)

At least annually, Molina Healthcare evaluates the consistency with which the behavioral health care professionals involved in utilization review apply the criteria in decision-making. This is termed "interrater reliability." In the following manner, Molina Healthcare will make available to practitioners and Members upon request the clinical criteria we use to make utilization decisions.

- Clinical criteria used to make UM decisions is available for your review by calling Molina Healthcare Member Services in **Albuquerque at (505) 348-1578 or toll free at (866) 403-3018.**

Utilization Review Process for Behavioral Health Services

All utilization review forms necessary to request prior authorization for behavioral health services may be found at the end of the Behavioral Health Section of this manual. Prior authorization does not guarantee payment. Payment is subject to benefit coverage and eligibility at the time the service is rendered.

It is the provider/practitioner's responsibility to verify the Member's eligibility and benefits before rendering services. A claim will not be paid for a service rendered to an ineligible Member, to a Member who does not have the benefit, or to a Member who has reached his/her benefit limit.

Emergency Services for Behavioral Health Services

Facilities will be reimbursed for emergency services provided to Molina Healthcare Members. A medical emergency is defined as a condition in which a patient manifests acute symptoms and/or signs which represent a condition of severity such that the absence of immediate medical attention could reasonably be expected by a reasonably prudent lay person to result in death, serious impairment of bodily function or major organ, and/or serious jeopardy to the overall health of the patient.

Prior Authorization for Behavioral Health Services

All Behavioral Health services require prior authorization with the exception of an initial evaluation and the first seven (7) outpatient Behavioral Health services, requiring only claims submission. Practitioners/providers may submit prior authorization requests for services by completing an SCI Prior Authorization Request Form or the UNM SCI Prior Authorization Request Form and faxing it **toll free at (888) 802-5711**. Inpatient behavior health reviews will be performed through concurrent review. Sufficient clinical information to support the level of care and amount of care being requested must be submitted. If Molina Healthcare does not receive sufficient information to support a decision, Molina Healthcare reserves the right to request additional information such as medical records, progress reports or other pertinent data necessary to make a utilization management decision.

BEHAVIORAL HEALTH (*continued*)

Practitioners/providers can fax the form toll free to:

Molina Healthcare of New Mexico, Inc.
Utilization Management Department
FAX: (888)802-5711

Concurrent Reviews for Behavioral Health Services

Ongoing Outpatient Treatment

Practitioners/providers requesting concurrent review authorizations for ongoing care can do so by submitting updated clinical information for review. The submission must contain sufficient clinical information to support the level and amount of care requested. Practitioners/providers can fax the document toll free to **(888) 802-5711.**
Molina Healthcare of New Mexico, Inc.
Utilization Management Department
FAX: (888)802-5711

Inpatient Concurrent Review

Elective, non-urgent Hospitalizations

Inpatient Substance Abuse Detoxification is a covered benefit in the SCI program. Molina Healthcare contracts require prior authorization **before** a hospital admission for all elective procedures. The request and the relevant clinical information submitted is evaluated and reviewed against established criteria to determine the medical necessity and appropriateness of an inpatient stay and proposed treatment plan. The purpose of this review is to assure:

- Only patients with a medical need for hospitalization are approved for admission;
- The proposed treatment is customary for the diagnosis; and
- Treatment will take place in the most cost effective and appropriate setting.

Urgent/Emergency Hospitalizations:
Refer to Section J.

Retrospective (Post Service) Reviews for Behavioral Health Services

Retrospective reviews are conducted by UM staff based on established decision-making guidelines. The process includes reviewing medical and behavioral health treatments after the service has been rendered and a claim has been submitted. The most common opportunities for conducting post service reviews include:

BEHAVIORAL HEALTH (*continued*)

- Medical Review;
- Claims Review;
- Focused Review;
- Pattern Review; and
- Peer Review.

All BH reviews can be performed to:

- Establish medical necessity of care when a pre service authorization was not obtained due to an emergency or failure of the practitioner/provider to obtain a pre-service authorization
- Establish that charges are appropriate and necessary and reflect the actual care delivered to the Member;
- Provide information to a practitioner and/or doctoral level clinical psychologist that may clarify issues in an appeal of a denial;
- Provide information regarding treatment patterns and trends, and over or under utilization;
- Provide information regarding quality issues;
- Review complaints, appeals and grievances (CAGs); and
- Review utilization statistics for the purposes of education and quality.

Emergency room (ER) claims will only be reviewed for purposes of identifying over and under-utilization patterns by practitioners/providers and Members.

Denial Procedures

For behavioral health, Molina Healthcare employs appropriately licensed behavioral health professionals to supervise all review decisions. Physicians, board certified licensed psychiatrists or doctoral level clinical psychologists render all denials of care based on medical necessity.

When a denial is rendered, Molina Healthcare provides written notification of the denial to the member and practitioner/provider. The written notification contains the following:

- The specific reason for the denial in easily understandable language;
- A reference to the benefits provision, guideline, protocol or other similar criterion on which the denial decision was based;
- Notification that the Member and practitioner/provider can obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial decision was based, upon request; and
- Includes information about appeal and fair hearing rights and processes;
- Information on how to contact the Medical Director
- The circumstances under which expedited resolution of an appeal is available and how to request it; and
- The Member's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.

BEHAVIORAL HEALTH (*continued*)

Coordination of Medical and Behavioral Health Services

Purpose: To assist practitioners/providers in the sharing of appropriate and timely information, in order to improve patient satisfaction and treatment outcomes, and to promote and support an integrated health care delivery system for all Molina Healthcare Members.

Recommendations: Coordination of medical and behavioral health care is necessary, and it is the responsibility of the PCP and behavioral health specialist to ensure that effective coordination of care takes place. Information exchange must be documented in the Member's medical record. Coordination is required for those patients who have recently initiated behavioral health care and those who are receiving behavioral health services on an ongoing basis.

Confidentiality and the Right to Refusal for Behavioral Health Services

It is the practitioner/provider's responsibility to help the Member understand the importance of coordinating care and to ensure that a consent form authorizing the release of medical information is signed by the patient prior to the sharing of information between practitioners/providers. In addition, all practitioners/providers must adhere to state and federal regulations regarding confidentiality of medical records. Members have the right to refuse coordination of medical records, although Molina Healthcare anticipates that the majority of patients will allow coordination to take place. Should a Member refuse to consent to the release of medical information, this must be documented in the Member's medical record.

Continuity and Coordination of Care for Behavioral Health Services

Molina Healthcare ensures the continuity and coordination of care that Members receive. Please reference Section J of the 2012 Provider Manual for details regarding Molina Healthcare's continuity and coordination of care efforts. Molina Healthcare monitors a behavioral health practitioner/provider's compliance with continuity and coordination of care standards through medical record audits. Well documented care facilitates coordination and continuity of care and promotes the efficiency and effectiveness of care.

Molina Healthcare has established standards for the organization and documentation of medical records. On an annual basis, Molina Healthcare assesses practitioners against these standards. The results of these reviews are used as a Molina Healthcare statewide quality of care indicator, and is considered a factor in the re-credentialing of individual practitioners. Behavioral health practitioners' medical records are audited for compliance with medical record documentation standards as outlined in Medical Assistance Division (MAD) regulation 8.306.8.9 and 8.305.8.17. In addition to the requirements established in Section G of the 2012 Provider Manual, behavioral health practitioners/providers are responsible for coordination of services between physical and behavioral health practitioners/providers, and between waiver programs, and the Children, Youth & Families Department when appropriate as outlined in MAD regulation 8.305.9.10.

NURSE ADVICE LINE

SCI

Available twenty-four (24) hours a day, seven (7) days a week by calling the Molina Healthcare Nurse Advice Line **toll free at (888) 275-8750 (TTY: (866) 735-2929), Spanish (866) 648-3537 (TTY: (866) 833-4703).**

UNM SCI

Available twenty-four (24) hours a day, seven (7) days a week by calling the Statewide Nurse Advice Line **toll free at (877) 725-2552.**

PHARMACY SERVICES

SCI

Refer to the Benefits Grid for co-payment information and to Section J of the Provider Manual for other information regarding this service. SCI Members have access to all pharmacies contracted with Molina Healthcare.

UNM SCI

UNM SCI Members must have all of the prescriptions filled at UNM Hospital (UNMH) Pharmacy.

Monday – Friday: 7:00 a.m. – 5:00 p.m. and Saturday: 9:00 a.m. – 5:00 p.m.
UNMH Hospital
1209 University Blvd. NE
Albuquerque, NM 87106
In Albuquerque: (505) 272-2308

HTTP://HOSPITALS.UNM.EDU/OUTPT/PHARMACY/MAIN_PHARMACY.SHTML

Molina Healthcare of New Mexico, Inc. (Molina Healthcare)

Salud/SCI and SCI/UNM SCI Prior Authorization Matrix _____

This Prior Authorization (PA) Guide applies to all Molina Healthcare Salud, SCI and SCI/UNMCI Members. The guide lists ALL Services that require PA.

NOTE:

- **Chemotherapy DOES NOT require a PA.**
- **Chemotherapy Drugs listed on the back of this grid DO NOT require a PA. All other drugs ≥ $200 (*_contracted rates_) DO require a PA.**
- **Outpatient (OP) Surgeries that are listed on the back of this grid DO require a PA. All other OP Surgeries DO NOT require PA, BUT _must_ meet Interqual (IQ) criteria for appropriate setting (Inpatient vs. Outpatient). PA requirements for all procedures will continue to follow American Medical Association and/or Centers for Medicare and Medicaid Services industry standards for recommended place of service.**

SERVICE	Salud	SCI	UNM SCI
Behavioral Health Visits	Optum Health	>7 visits - X	>7 visits - X
Cardiac Rehab	X	X	X
Cochlear Implants	X	X	X
Contact Lenses/Glasses following Cataract Surgery	X	X	X
CT Scans	X	X	N/A
Medical Dental Procedures	X	X	X
Dialysis-	X	X	N/A
DME > $500 paid charges (**ALL** Rentals/Repairs/Diapers/Chux/Enterals)	X	N/A	N/A
DME listed below require PA	N/A	X	X
Genetic Testing	X	X	X
Home Health Care (including PT/OT/ST/Respitory Therapy in home setting)	X	X	X
Hospice-PA issued for 6 months	X	X	X
In Home IV Therapies	X	X	X
Inpatient ▪ Urgent/Emergent/Direct Admissions- require notification *next* business day ▪ Elective Procedures – require *prior* authorization	X	X	X
Infused/Injectible Medications ≥ $200 ***contracted rates*** (including Chemo Drugs, refer to Service Group Code List for medications that do not require PA)	X	X	X
Maternity In Patient (for Non-Delivery/Complicated Delivery only)	X	X	X
Medical Supplies ≥$500 ****contracted rates***	X	X	X
MRI/MRA	X	X	N/A
OB Prenatal Care-notification required at first prenatal visit.	X	X	X
Oral Surgery	X	X	X

Organ Transplants and all associated care	X	X	X
Orthotics ≥ $500 ***contracted rates***	X	X	X
Out of Plan Services-**ALL**	X	X	X
Outpatient Surgery (only those services listed on the OP Surgery Exception List (OP Setting per IQ Criteria)	X	X	X
Pain Management Services-PA **NOT** required for Evaluation and 1st injection	X	X	X
PET Scan	X	X	X
Pharmacy (non-Formulary and infused/ injections ≥ $200 ***contracted rate***	X	X	X
Prosthetics ≥ $500 ***contracted rate***	X	X	X
Reconstructive or Plastic Surgeries	X	X	X
Skilled Nursing	X	X	X
Sleep Disorder Studies	X	X	X
Substance Abuse IP or OP	X	X	X
****Therapies-PT/OT/ST** (except first 6 visits for Salud Members ≤ 21 yrs of age)	*X	X	X
Transportation	X-Call ITM	Emer. Only	Emer. Only
Unlisted Procedures/DME (ALL)	X	X	X

Contracted Rates are determined by contract.

****PT/OT/ST Therapies / Salud Members ≤ 21 years of age – Notification is still required. Prior Authorization form must be completed with dates of therapy and faxed to Molina at 888-802-5711.***

OUTPATIENT SURGERY EXCEPTION LIST- *PA Required*

The following procedures, when performed in any contracted provider outpatient setting, including practitioner offices, *require Prior Authorization from Molina Healthcare:*

- Arthroereisis subtalar - 28899, S2117
- Blepharoplasty - 15820-15823, 67950-67966
- Breast repair and reconstruction - 19357-19369, 19316, 19318, 19324-19325, 19328-19330, 19340-19342, 19396
- Category III codes - 0016T-0170T
- Cosmetic procedures - ALL
- Decompression intervertebral disc, any method - 63001-63017, 63045-63103, 63005
- Echosclerotherapy - S2202 (Per Wellmark and BlXBlSH policies. this procedure is considered investigational)
- Genioplasty - 21120-21123
- Gynecomastia - 19300
- Hyperbaric oxygen therapy - 99183
- Kyphoplasty - 22523-22525
- Medical procedures in a Dental Office and TMJ procedures;
- ALL Meniscal Transplant – 29868
- Orthotripsy, ECSWT - 28890, 28899, 0020T-0019T
- Pain Procedures (facet, epidurals) - 62350-62351, 62360-62362, 99601-99602, 62273-62282, 64000-64640, 64680-64681
- Panniculectomy - 15830-15839, 15876-15879
- Ptosis repair - 67901-67909
- Rhinophyma excision - 30120
- Rhinoplasty - 30460-30462, 30400-30420, 30430-30450
- Sclerotherapy - 36468-36471
- Transplants – ALL
- Unlisted procedures - ALL ***(except for Dental Carries code – CPT-4: 41899***)
- Uvulopharyngoplasty (UPPP) - 42145, S2080(Laser Assisted) (Per BLXBSH policy this procedure is considered investigational)
- Vein Ablation - 36475-36479
- Vein Ligation and Stripping - 37700-37785, 37650
- Virtual Colonoscopy - and 0066T, 0067T
- Wireless Capsule Endoscopy. 91110-91111

DRUG/MEDICATION SERVICE GROUP CODE LISTINGL: J9000 – J9999 - No PA required regardless of dollar amount

Non Covered as of May 14, 2010

- Morbid obesity procedures - 43644-43645, 43770-43774, 43842-43848, 43886-43888

PA Required for SCI/UNM SCI Effective May 15, 2011

- Blood Glucose Monitors and Supplies
- External Defibrillator
- Fracture Frames
- Feeding and Nutritional Supplies
- Helmets
- Infusion Pumps
- Intermittent Positive Pressure Breathing Treatments and Supplies
- Lancets and Related Devices
- Lymphedema Pumps
- Manual Wheelchairs and Related Equipment
- Motorized Wheelchairs and Accessories
- Orthotics/Prosthetics
- Ostomy and Urinary Pouch Supplies
- Qxygen and Related Equipment and Supplies
- Parenteral Nutrition
- Suction Machine and Related Supplies
- Syringes
- Tracheostomy Supplies
- Uterine Monitor
- Wound care

MOLINA HEALTHCARE

SCI PRIOR AUTHORIZATION REQUEST

Urgent Requests:
§ *(877) 262-0187 toll free*
§ *(505) 798-7371 in Albuquerque*

Routine Requests (MUST be faxed)
Fax: (888) 802-5711 toll free

Member Name_____ DOB_____

Member ID#_____ PCP Name_____

Ordering Physician_____ Phone#_____Fax#_____

Submittal Date_____ Contact Person_____

MEDICAL SERVICES REQUESTED

Provider/Facility_____ Phone#_____ Fax#_____

Clinical Indications (including prior test and treatment; attach notes if applicable)_____

_____

Diagnosis_____ICD-9 Code(s)_____

Procedure_____CPT Code(s)_____

o DME/P&O_____ HCPC Code(s)_____
(include copy of physician order for DME, P&O, PT, OT, ST, Home Health Services)

o Consult/Evaluation	o Home Health	o Procedure/Surgery	o Physical Therapy
o Prenatal Care	o Skilled Nursing	o Inpatient	o Occupational Therapy
EDD _____	o Home Health Aide	o Outpatient	o Speech Therapy
o Behavioral Health Services			

Beginning Date_____ End Date_____Planned DOS_____ # of Visits_____

Utilization Management Department Use

Reviewer_____ Date_____

o Need Additional Information_____

o Approved Authorization_____

If applicable Initial # of visits _____+ Addl visits _____ =Total # of Approved visits _____

o Denied_____

Prior Authorization numbers do not guarantee payment. Payment is subject to benefit coverage and eligibility at the time the service is rendered.

MOLINA HEALTHCARE

UNM SCI PRIOR AUTHORIZATION REQUEST

Urgent Requests:
- *(877) 262-0187 toll free*
- *(505) 798-7371 in Albuquerque*

Routine Requests (MUST be faxed)
Fax: (888) 802-5711 toll free

Member Name_____ DOB_____

Member ID#_____ PCP Name_____

Ordering Physician_____ Phone#_____ Fax#_____

Submittal Date_____ Contact Person_____

MEDICAL SERVICES REQUESTED

Provider/Facility_____ Phone #_____ Fax#_____

Clinical Indications (including prior test and treatment; attach notes if applicable)_____

_____

Diagnosis_____ICD-9 Code(s)_____

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