My Choice Wisconsin® Partnership Medicaid
Pre-Service Review Guide
Effective: 01/01/2025

Refer to Molina's Provider Website or Prior Authorization Look-Up Tool for specific codes that require Prior Authorization

Only covered services are eligible for reimbursement

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS DO NOT REQUIRE PRIOR AUTHORIZATION.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

The following services may require Prior Authorization:

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment, Intensive Outpatient above 16 units require notification and subsequent concurrent review.
  - Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - 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**
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST):** PA required after initial eval plus six (6) visits per year per discipline
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (per State benefit).** All LTSS services require PA regardless of code(s).
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale should be submitted with the prior authorization request.
- **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 or 24, 51, 52
  - Other State mandated services
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy:** PA required after initial eval +12 visits per calendar year for office and outpatient settings
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Sleep Studies:** PA required if done in facility setting
- **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 MOLINA 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 and servicing provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials may also be 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.
- My Choice Wisconsin has a full-time Medical Director available to discuss medical necessity decisions for Inpatient Hospitalizations with the requesting physician. Please contact our Customer Service center at (800) 963-0035 to set up a time to discuss the case. Peer to Peer reviews must be requested within 5 business days from the date of discharge or date of denial whichever is later.

A retroactive authorization will be accepted if it meets the following requirements:

- **Request is received by My Choice Wisconsin within 14 calendar days of the start of the provision of services**
- **Request precedes a bill for services**
- **Request includes justification for beginning the service prior to receiving authorization:**
  - **The member was not able to tell the provider about their insurance coverage prior to rendering services, or**
  - **The provider verified different insurance coverage prior to rendering services**

IMPORTANT My Choice Wisconsin HEALTHCARE MEDICAID CONTACT INFORMATION

(Service hours 8am-4:30pm local M-F, unless otherwise specified)

Outpatient Prior Authorizations including Behavioral Health Authorizations: Phone: (800) 963-0035 Fax: (608) 210-3050	**Inpatient Authorizations:** Phone: (800) 963-0035 Fax: (608) 210-4050 Peer to Peer: (800) 963-0035
Retail Pharmacy Authorizations: Phone: (800) 665-3086 Fax: (866) 290-1309	**Dental: Skygen** Phone: (800) 508-4890 Website: https://pwp.skygenusasystems.com/PWP/Landing
Physician Administered Meds: Phone: (800) 963-0035 Fax: (608) 210-4050	**Vision: VSP** Phone: (855) 492-9028 Website: https://www.vspproviderhub.com/cintact.html
Provider Contact Center: Phone: (855) 326-5059 Fax: (877) 556-5863 Email: MHWIProviderNetworkManagement@MolinaHealthcare.com	**Member Customer Service, Benefits/Eligibility:** Phone: (800) 963-0035/ TTY/TDD 711

Claims: Cognizant
Phone: (855) 878-6699
Claims: WPS
Phone: (800) 233-6016
Fax: (608) 327-6332

Transplant Authorizations:
Phone: (800) 963-0035
Fax: (608) 210-4050

Radiology Authorizations:
Phone: (800) 963-0035
Fax: (608) 210-4050

24 Hour Nurse Advice Line (7 days/week)
Phone: (800) 963-0035/TTY: 711

My Choice Wisconsin– Pre-Service Request Form: Fax to 608-210-4050

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Medicare**		**Date of Request:**
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – **Clinical Reason for Urgency Required**:_____ ☐ EPSDT/Special Services			

REFERRAL/SERVICE TYPE REQUESTED

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

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

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

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

PROVIDER INFORMATION

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:**

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

My Choice Wisconsin – Behavioral Health Request Form: Fax to 608-210-4050

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐	☐	**Date of Request:**
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – **Clinical Reason for Urgency Required**:_____ ☐ Emergent Inpatient Admission			

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

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: **Description:**

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

PROVIDER INFORMATION

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:**

For Molina Use Only:

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.