Dear Provider,

Molina Healthcare of Nevada will begin its collaboration with New Century Health (NCH), a cardiology quality management company, to administer prior authorizations. NCH will simplify the administrative process for providers to support the effective delivery of quality patient care.

Effective April 1, 2022, cardiology services will require a prior authorization from NCH before services are provided in either a provider office, outpatient setting, inpatient setting or ambulatory surgical center. This prior authorization requirement applies to Medicaid members ages 18 and older for the following services:

- Non-Invasive Cardiology,
- Non-Invasive Vascular,
- Cardiac Cath and Interventional Cardiology,
- Vascular Radiology and Intervention
- Vascular Surgery,
- Thoracic Surgery,
- Cardiac Surgery,
- Electrophysiology

The benefits of Molina Healthcare of Nevada partnering with NCH for cardiology services include:

- The use of clinical criteria, based on nationally recognized guidelines, to promote quality care
- Increased collaboration with physician offices to foster a team approach
- Physician discussions with true peers, cardiologists who can understand and better discuss treatment plans
- A provider web portal to:
  - Obtain real-time approvals when selecting evidence-based NCH treatment care pathways
  - Determine which clinical documentation is necessary for medical review
  - View all submitted requests for authorization in one location
  - Check member eligibility

Prior Authorization Process:

The requesting physician must complete an authorization request using one of the following methods:

- Logging into the NCH Provider Web Portal: my.newcenturyhealth.com/
- Calling (888) 999-7713, Cardiology, option 3

NCH may approve cardiac treatment for a period up to 90 days.

Should you have any questions or need access/training on the NCH provider portal, please call NCH Network Operations department at (888) 999-7713, option 6. You may also contact Molina Healthcare of Nevada at (833) 685-2103.

We look forward to offering you this program and hope that it will enhance your experience with cardiology service authorizations.

Sincerely,

Molina Healthcare of Nevada

Frequently Asked Questions

Q: What membership is in-scope for New Century Health (NCH)?
 A: Medicaid members ages 18 and older.

Q: What services are in-scope for NCH?
A: NCH will review prior authorizations requested **by all specialties** for the following services:

- Non-Invasive Cardiology
- Non-Invasive Vascular
- Cardiac Cath and Interventional Cardiology
- Vascular Radiology and Intervention
- Vascular Surgery
- Thoracic Surgery
- Cardiac Surgery
- Electrophysiology

Q: What CPT codes are in-scope for NCH?
 A: Refer to the Prior Auth Lookup Tool located on the Molina Nevada website under the Health Care Professionals
   dropdown or you may visit: Molinahealthcare.com/providers/nv/medicaid/

Q: What is the NCH authorization process?
A: NCH provider will follow one of the following methods:
   ➢ Log in the NCH portal at my.newcenturyhealth.com/
   ➢ Telephonic Intake: (888) 999-7713, option 3

Q: How long is the NCH authorization valid?
A: NCH may approve authorizations for a period up to 60 days.

Q: Is there a retrospective review process?
A: Retrospective authorization requests are handled through the claims appeal process. Appeals should be directed
    to Molina Healthcare for review.

Q: When will I receive my username and password for NCH Portal?
A: NCH will send the username and password to the email address provided a few days prior to go-live date of 4/1.

Q: How can a physician's office request training for this process?
A: To request training you may contact NCH Network Operations at (888) 999-7713, option 6 or send an email to
providertraining@newcenturyhealth.com.

Q: What if a member is not appearing eligible or is not found when searching within the NCH web portal?
A: If a member is not appearing eligible or is not found, please call Molina Healthcare at the number listed on
    the member's identification card or call NCH at (888) 999-7713, option 3.

Q: What are the NCH hours of operation?
A: NCH normal business hours are Monday through Friday 5 a.m. – 6 p.m. PT

MOLINA® HEALTHCARE MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2022

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

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 Special Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial Hospitalization, Day Treatment
  - Intensive Outpatient beyond 16 units
  - 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** (Except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations)
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST required after evaluation and initial 6 visits)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services & Support (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 must be submitted with the prior authorization request.

- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** PA is required for office visits, procedures, labs, diagnostic studies, and inpatient stays except for:
  - Emergency and Urgently Needed Services;
  - Professional fees for Medicaid enrolled providers associated with ER visits and approved Ambulatory Surgery Center (ASC) or inpatient stays;
  - Local Health Department (LHD) services;
  - Radiologists, anesthesiologists, and pathologists professional services when billed in POS 19, 21, 22, 23 or 24;
  - PA is waived for professional component services or services billed from Medicaid enrolled providers with Modifier 26 in ANY place of service setting;
  - Other State mandated services.
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Kidney, Liver and Bone Marrow:** (Cornea transplant does not require authorization)
- **Transportation Services:** Non-emergent air transportation requires authorization (see below for contact information for non-emergency 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 HEALTHCARE 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 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 (833) 685-2103.

Important Molina Healthcare Medicaid Contact Information
(Service hours 8am-5pm local M-F, unless otherwise specified)

Prior Authorizations including Behavioral Health Authorizations:
Phone: (833) 685-2103
Fax: (775) 460-4900

24 Hour Behavioral Health Crisis (7 days/week):
Phone: (833) 685-2102 / TTY/TDD: 711

Pharmacy Authorizations:
Phone: (833) 685-2103
Fax: (844) 259-1689

New Century Health (Cardiac authorizations beginning 4/1/22)
Fax: (877) 622-6879

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

Vision: (VSP)
Phone: (833) 685-2102
Website: VSP.com

Provider Customer Service:
Phone: (833) 685-2103

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

Non-Emergency Transportation:
Phone: (844) 879-7341 or
(833) 685-2102 / TTY/TDD: 711

24 Hour Nurse Advice Line (7 days/week)
Phone: (833) 685-2104 / TTY/TDD: 711
Members who speak Spanish can press 1 at the IVR prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members.
No referral or prior authorization is needed.

Member Customer Service, Benefits/Eligibility:
Phone: (833) 685-2102/ TTY/TDD 711

Member Customer Service, Benefits/Eligibility:
Phone: (833) 685-2102/ TTY/TDD 711

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 form
- Nurse Advice Line Report

Molina® Healthcare, Inc. – Prior Authorization Service Request Form

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:

State/Health Plan (i.e. CA):	

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
☐ EPSDT/Special Services

REFERRAL/SERVICE TYPE REQUESTED

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

Inpatient Services:

☐ Inpatient Hospital
☐ Inpatient Transplant
☐ Inpatient Hospice
☐ Long Term Acute Care (LTAC)
☐ Acute Inpatient Rehabilitation (AIR)
☐ Skilled Nursing Facility (SNF)
☐ Other Inpatient:_____

Outpatient Services:

☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Genetic/Genomic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Hyperbaric Therapy	☐ Pain Management	☐ Wound Care
☐ Imaging/Special Tests	☐ Palliative Care	☐ 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:

For Molina Use Only:

Molina® Healthcare, Inc. – BH Prior Authorization Service Request Form

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:	

State/Health Plan (i.e. CA):

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:

☐ Inpatient Psychiatric
    ☐ Involuntary   ☐ Voluntary

☐ Inpatient Detoxification
    ☐ Involuntary   ☐ Voluntary

If Involuntary, Court Date:_____

Outpatient Services:

☐ 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: _____

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:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review