Molina Healthcare of California

Skilled Nursing Facilities Provider Toolkit

September 2024

Table of Contents

Utilization Management

Skilled/Subacute Skilled (Medicaid/Marketplace)

1. Does Molina have on-site case managers to conduct the medical review of "Skilled" residents?

No, the Molina Care Review Clinician (CRC) nurse will review the member's condition by applying Milliman Care Guidelines (MCG) for medical necessity. The CRC nurse will not be on-site.

2. How do I contact my assigned CRC?

CRCs will contact their assigned facilities with their contact information. Facilities can utilize MHC's Inpatient Discharge Planning Line at (866) 814-2221, available Monday through Friday from 8:30 a.m. to 5:30 p.m. Staff will connect providers to their assigned CRC.

3. How long will Skilled services be authorized?

Molina will authorize skilled level of care on a weekly basis (7 days) based on MCG criteria and clinical documentation received from the provider unless otherwise stated.

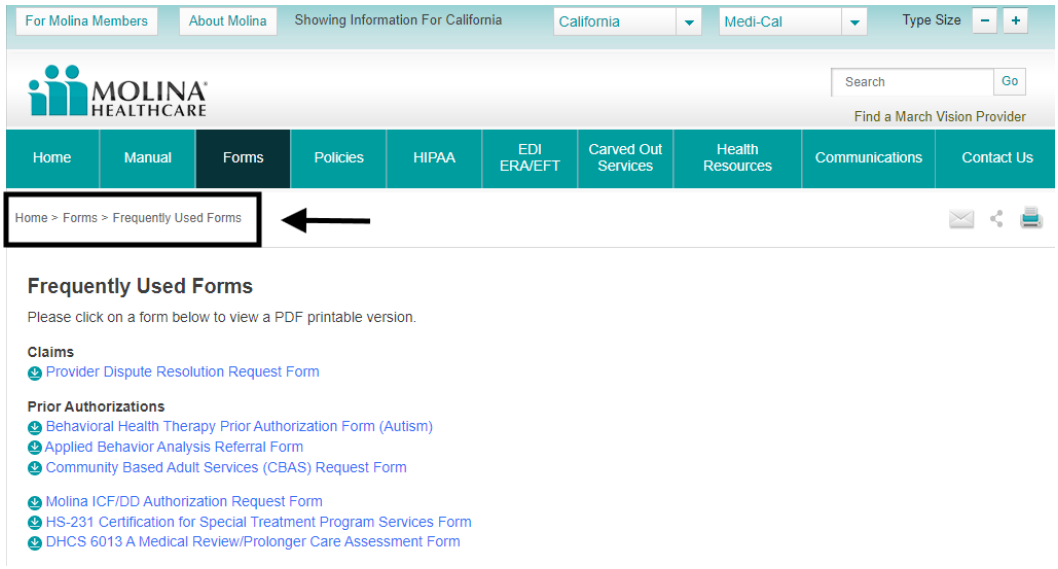
4. Does Molina require Prior Authorization (PA) for Skilled/Skilled Subacute admissions?

Yes, Molina requires authorization prior to admission to a skilled nursing facility (SNF). All requests for PA should be faxed to (866) 553-9263 or submitted through the Availity Provider Portal with the following documentation:

- Service Request Form (SRF)
- Admitting Orders
- Supporting clinicals of skilled services
- H&P
- Pre-Admission Screening and Residential Review (PASRR)

5. Where can I access the Pre-Service Request Form?

The Pre-Service Request Form is located on the MHC Medi-Cal Provider Frequently Used Forms page.



6. What is the process for notifying Molina of a Skilled Admission?

Molina requires notification of all Skilled/Skilled Subacute admissions within 24 hours of admission. Notification of admission should include the following materials:

- Fact sheet
- Admitting orders for Skilled/Skilled Subacute level of care
- H&P
- Supporting documentation of skilled services (PT/OT, Wounds, IV ABX, etc.)
- Pre-Admission Screening and Residential Review (PASRR)

All documentation should be faxed to Inpatient Services at (866) 553-9263 or submitted via the Availity Provider Portal.

7. Is there a different process for "Custodial/Long Term Care (LTC)" level of care?

Yes, please see the Custodial/Subacute Custodial section below to learn about Custodial/LTC Authorizations.

8. How often does Molina require Concurrent Reviews?

SNFs must provide substantiating medical necessity supporting clinical documentation every 7 days (unless otherwise stated) including current orders to continue skilled nursing level of care.

9. Does Molina have a different process for Molina Medicare members?

Yes, Molina's Corporate team manages Molina Medicare members. Please see below for Molina's Medicare process.

10. Our facility uses electronic medical records. Can we grant Molina access to view them?

Yes, please call our Inpatient Line at (866) 814-2221. Molina staff will connect you with the appropriate team member for EMR access.

11. What training is available on authorization procedures?

Molina staff and CRC assigned to the facility can provide education on the authorization process. Facilities may also reach out to their Provider Relations Representative (PRR) to coordinate additional in-service.

12. What situations require immediate notification to Molina?

Please notify the Molina CRC of the following situations as soon as possible:

- A change in the member's physical or mental health and/or a change in the level of care needed.
- Member signed out against medical advice (AMA)
- Member discharged or expired.
- Members transferred to the ER or admitted to the hospital.
- Member discharging and has discharge needs (DME/HH)

13. What if Molina denies a facility's request for PA?

Molina offers providers the option to request a peer-to-peer (P2P) upon receipt of an adverse determination within five (5) business days from the notification. Please call (866) 814-2221 to arrange a P2P with a facility physician and Molina's Medical Director. P2Ps are not held with facility case managers; they must be with a physician.

14. What is a Pre-Admission Screening and Residential Review (PASRR)?

The PASRR is a federal requirement (Code of Federal Regulations (CFR), Title 42, Sections 483.100-138) for all members initially entering an SNF to determine if they have a possible SMI (Serious Mental Illness) or have an ID/DD/RC (Intellectual Disability/Developmental Disability/Related Conditions). If a member is found to have a possible SMI or ID/DD/RC, the Level II evaluation helps determine whether SNF care is the most appropriate or whether the member needs specialized services beyond services typically provided in an SNF.

Federal regulation indicates that a PASRR is **required** for all members who apply for admission into a Medicaid-certified SNF, regardless of the individual's insurance type or payment source. This requirement also applies to members who already reside in a Medicaid-certified SNF.

15. Does Molina require the PASRR prior to admitting a member to an SNF?

Yes, the PASRR information is required prior to admission to an SNF. If Level I is negative, Molina only requires notification, either verbally or faxed, of the Level I results, the date the review was

performed, and the CIN. If Level I is positive, the provider must fax Molina the Level II determination prior to Molina issuing an authorization for services.

16. Is the authorization documented electronically and is it immediately available to SNFs?

Yes. Facilities have access to this information in the Availity Provider Portal.

17. Is the authorization electronically tied to the claims processing system?

Yes. The facility must include the authorization number on the claim form. Please see the Claims Submissions section below.

18. What is the turnaround timeline for PAs?

PA Type	Timeline
Routine	5 business days but no more than 14 calendar days
Urgent	72 hours

19. What are the required documents to submit for authorization and when and how must they be submitted?

Patient Type	Documentation Required	Submission Timeframe	Response Timeframe
Patient admitting from the community for Skilled/Skilled Subacute	*1. Molina Healthcare Prior Authorization Request Form* (see attached) 2. Physician's order 4. History / Physical 4. PASRR 5. Supporting clinicals for skilled level of care	Prior to Admission	Five (5) working days after receipt of complete request
Patient admitting from inpatient or ER for Skilled/Skilled Subacute	*1. Molina Healthcare Prior Authorization Request Form* (see attached) 2. Physician's order 3. History / Physical 4. PASRR 5. Supporting clinicals for skilled level of care **Acute Hospital Requesting SNF Services can outreach to:** ***Member Inpatient at Hospital:*** Call Inpatient Discharge Planning Line (866) 814-2221 **Member in the Emergency Department** Emergency Department Support Unit	Prior to Admission to SNF	Within 24 hours

	(844) 966-5462		
Patient requiring change in level of care from skilled to custodial	*1. Molina Healthcare Prior Authorization Request Form* (see attached) 2. Physician's order 3. History / Physical 5. Supporting clinicals for skilled level of care	Within 24 hours	Up to five (5) working days after receipt of complete request

For Medi-Cal Skilled covered services, the Authorization Request Form and supporting documentation must be faxed to (866) 553-9263.

For Medi-Cal ancillary services provided in the facility:

- Molina contracted providers must follow the Molina Healthcare Pre-Service Review Guide to determine which services require PA.
- Providers that are not contracted with Molina must request PA for all services by submitting the Molina Healthcare Pre-Service Request Form.

Custodial/Subacute Custodial

1. Will Molina have on site case managers who conduct the medical review of Custodial residents?

No, the CRC nurse will review the member's condition by applying Title 22 criteria (Custodial/LTC) for medical necessity. The CRC nurse will not be on-site.

2. How long will Custodial/LTC authorizations be effective?

Molina will authorize custodial care for six months based on Title 22 Nursing Facility Level of Care criteria.

3. When can a facility submit for renewal of custodial authorization?

Facilities may submit a renewal authorization request up to 60 days prior to the expiration of the current custodial authorization.

4. What is the turnaround timeline for PA?

PA Type	Timeline
Routine	5 business days but no more than 14 calendar days
Urgent	72 hours

5. What happens if a facility is out of network with Molina and requires a Custodial re-authorization?

If a facility is not contracted with Molina, upon receipt of the notice, Molina will execute a Letter of Agreement at the standard Medi-Cal rates as appropriate.

6. How long do I have to submit a Custodial claim to Molina?

Facilities can submit a claim to Molina up to six (6) months after the date of service.

7. What fax number do we utilize to fax Custodial re-authorizations?

Please fax custodial re-authorizations to (866) 553-9263.

8. When a member transitions from Skilled to Custodial, who is responsible for authorization or payment services?

If a member transitions from Skilled to Custodial, Molina is responsible for authorization and payment of Custodial Care.

9. If the patient is authorized for SNF care and goes to hospice, who should request the hospice authorization?

If a member transitions to hospice, the hospice provider is responsible for submitting and obtaining authorization.

Patient Type	Documentation Required	Submission Timeframe	Response Timeframe
Patient admitting from the community for Custodial/Custodial Subacute	*1. Molina Healthcare Prior Authorization Request Form* (see attached) 2. Physician's order 3. History / Physical 4. PASRR 5. Supporting clinicals for custodial level of care 6. MDS must be submitted by SNF when member admits	N/A	Five (5) working days after receipt of complete request
Patient admitting from inpatient or ER for Custodial/Custodial Subacute	*1. Molina Healthcare Prior Authorization Request Form* (see attached) 2. Physician's order 3. History / Physical 4. PASRR 5. Supporting clinicals for custodial level of care 6. MDS must be submitted by SNF when member admits **Acute Hospital Requesting Custodial Services can outreach to:**	N/A	Within 24 hours

	Member Inpatient at Hospital: Call Inpatient Discharge Planning Line (866) 814-2221 **Member in the Emergency Department** Emergency Department Support Unit (844) 966-5462		
Patient requiring re-authorization	*1. Molina Healthcare Prior Authorization Request Form* (see attached) 2. Physician's order 3. History / Physical 4. PASRR 5. Supporting clinicals for custodial level of care 6. MDS	N/A	Five (5) working days after receipt of complete request

Discharge Notification is required when:

- Member does not return from approved bed hold/leave of absence period.
- The member returns to the facility during the bed hold period but has changed to a different payer.
- Member is discharged from a facility to another residence.

Bed Hold/Leave of Absence

1. Is a separate authorization required for a bed hold?

Yes, a separate authorization is required for bed holds.

2. If a member returns to Custodial level of care within the seven (7) day bed hold, is a new custodial authorization required?

If a member goes out of the facility on a bed hold and **returns** within seven (7) days, no new custodial authorization is required. If a member returns to an SNF **after** seven (7) days, a new custodial authorization is required.

3. Where do we fax bed holds and leave of absence to?

Please fax bed holds and leave of absence requests to fax (800) 811-4804.

4. What are the required documents to submit for authorization and when must they be submitted?

Patient Type	Documentation Required	Submission Timeframe	Response Timeframe
Bed Hold	1. The physician's order must be for a hospital admission and bed hold 2. Anticipated Length of Stay; of no greater than seven (7) days	1. Within twenty-four hours of departure and at least seven (7) days prior to billing for service. 2. Date of departure counts as day one of bed hold 3. Members are considered discharged if returned to a facility on day eight (8) after an acute Admission. A New authorization request is required for readmit to the SNF facility after day seven (7). 4. Discharge notification must be within three (3) days business days following the discharge.	Five (5) working days after receipt of complete request
Leave of Absence	Plan of care delineating Leave of Absence: 1. Dates and the intended destination of leave. 2. Visit with family/friends 3. Outpatient diagnostic or treatment services at an acute facility 4. Summer camp for members with developmental disabilities addressed in the Plan of care. 5. Appropriate for the physical and mental well-being of members.	1. ASAP 2. Members are considered discharged if returned to a facility on day eight (8) after an acute Admission. A New authorization request is required for readmit to the SNF facility after day seven (7).	Molina will provide the tracking number within five business days of receipt of the complete request

Out of Network SNFs

1. How will the health plan process claims for members who resided in the SNF prior to enrollment?

If a facility is not contracted with Molina, upon receipt of the notice, Molina will engage the facility to execute a contract or a member-specific letter of agreement at the standard Medi-Cal rates, Medicare rate, and/or Exchange rates as appropriate.

2. What are the requirements for payment?

Facilities must have the following to receive payment:

- Contract or Executed Letter of Agreement (LOA)
- Authorization for the services for which the facility is requesting payment.

3. How often can an SNF submit claims?

A facility may submit claims as frequently as desired.

Physician Contract

1. Does the provider making the rounds at the SNF need to be contracted/credentialed by Molina?

In the initial months, some of the providers making rounds at the SNFs may not be contracted and/or credentialed by Molina. Molina's goal is to work closely with the facilities to get such providers contracted and credentialed. In the interim, we encourage providers to continue to do so to maintain continuity of care for the members under their care. Even without a contract, Molina will pay the physicians that round and care for the members at mutually agreed upon rates.

At this time, for Riverside, San Bernardino, Los Angeles, San Diego, and Sacramento counties, Molina will work with each facility to get contracts in place with the physicians that round at your facilities. Please contact Molina's contracting department to provide information on any and all providers that your facility utilizes to provide professional services, including rounding and specialty care services to residents.

Frequently Asked Questions

Question	Answer	Phone Number
Appeals & Grievances		
How do I dispute a claim?	**Method 1:** Molina Availity Essentials Portal (most preferred method): provider.molinahealthcare.com/ You can search and identify adjudicated claims and submit a dispute/appeal. Upload the required documents or proof to support the dispute. **Method 2:** Fax to (562) 499-0633 **Method 3:** Mail to: Molina Healthcare of California Attn: Provider Dispute Resolution Unit P.O. Box 22722 Long Beach, CA 90801	
How do I check for status?	Method 1: Availity Essentials Portal is Molina's preferred method. (Please refer to Availity section of FAQ below) Method 2: You can call claims customer service.	(855) 322-4075
Authorizations		
How do I submit an authorization?	Participating providers are encouraged to use the Molina Availity Essentials Portal for prior authorization submissions whenever possible. For TARs/Continuity of Care please refer to the FAQ UM section.	

How do I check for status?	**Method 1**: Availity Essentials Portal is Molina's preferred method. (Please refer to Availity section of FAQ below). **Method 2:** You may contact the prior authorization department.	(844) 557-8434
What is the phone number? to UM?	Please refer to the Molina Healthcare of California contact list.	
Balance Billing		
	The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.	
Availity		
What is Availity?	Availity Essentials is Molina Healthcare's official secure provider portal for traditional (non-atypical) providers. Some of the core features available in Essentials for Molina Healthcare include eligibility & and benefits, attachments, claim status, Smart claims, and Payer Space (submit and check prior authorizations as well as appeal status and appeal/dispute).	
How do I register?	Availity Essentials Portal When you register for Availity, please be sure that your organization name and NPI matches with the NPPES NPI Registry.	(800) AVAILITY (800) 282-4548
Claims		
How do I submit my claims to Molina? *What type of form do I use? *How do I know what bill type and revenue codes to use?	*Refer to the Claims FAQ section*	
Who is your clearinghouse/EDI vendor?	EDI Vendor: Emdeon Payer ID: 38333 Clearinghouse: SSI Claimsnet, LLC (SSI Group) Registration Form: SSI.ProviderRegistration.Web (ssigroup.com) Payer ID: 38333	(855) 322-4075
How do I check for claim status?	**Method 1:** Availity Essentials Portal is Molina's preferred method. (Please refer to Availity section of FAQ below) **Method 2:** You can call claims customer service. **Method 3:** If you are registered with Molina's clearing house SSI Claimsnet you can view claim status.	(855) 322-4075
How often can I submit claims?	As frequently as desired.	
How many days do I have from DOS to	Claims must be submitted to Molina within ninety calendar days for PAR, 180 calendar days for non-PAR providers after the discharge for	

submit an initial & corrected claim?	inpatient services or the Date of Service for outpatient services, unless otherwise stated in your contract. If Molina is not the primary payer under the coordination of benefits or third-party liability, the Provider must submit claims to Molina within ninety calendar days after the final determination by the primary payer. Corrected claims must be sent within 180 calendar days of the date of service of the claim.	
Case Management		
	Refer to the Case Management FAQ section	
Continuity of Care		
	Refer to the UM FAQ section	
Customer Service		
What is the Molina costumer service number?	Provider Contact Center	(855) 322-4075
Electronic Payments		
How do I register for electronic payments?	Change Healthcare/ECHO: To register for EFT and remittance advise, please go to ECHO Health (echohealthinc.com) Important Note: To opt out of the Virtual Card Services, please visit ECHO Health: Payments Simplified and select the appropriate option. Once you choose your option, you can enter the draft # payment received and elect to receive it via check. Please visit our website for additional step-by-step ECHO registration.	
Eligibility		
How do I verify member eligibility?	Method 1: Through the Availity Essentials Portal. Method 2: You may call the Molina eligibility department.	Medi-Cal: (888) 665-4621
Fraud Waste & Abuse		
How do I report Fraud Waste & Abuse?	Through the Molina tip line.	(866) 606-3889
Molina website		
How do I access the Molina website?	Molina Healthcare California Website	
Pharmacy		
What pharmacy is Molina contracted with?	Prescription drugs are covered by Molina Healthcare through the Medi-Cal Pharmacy Benefit carve-out to Medi-Cal Rx (MRx).	(800) 977-2273
Provider Contracts		
Who do I contact if I have questions regarding my contract.	Refer to the Molina Healthcare of California contact list.	
Provider Demographic Changes		
How do I submit demographic changes to Molina?	Los Angeles: MHC_LAProviderServices@MolinaHealthcare.com Sacramento: MHCSacramentoProviderServices@MolinaHealthcare.com	

	San Bernardino: MHCIEProviderServices@MolinaHealthcare.com Riverside: MHCIEProviderServices@MolinaHealthcare.com San Diego: MHCSAnDiegoProviderServices@MolinaHealthcare.com Imperial: MHCImperialProviderServices@MolinaHealthcare.com	
Provider Manual		
How do I access Molina's provider manual?	Medi-Cal Provider Manual	
Training		
How do I request an overview of Molina?	Contact your assigned Provider Relations Representative	Reference the contacts below under "Who is my point of contact"
How do I request an onboarding Training?	Contact your assigned Provider Relations Representative	Reference the contacts below under "Who is my point of contact"
Translation Services /Cultural and Linguistic Services		
Does Molina offer translation service?	The Cultural & Linguistic Services Department provides interpreter services and makes available cultural and linguistic consultation and training to assist providers in delivering culturally competent care.	(888) 665-4621
Transportation Services		
Does Molina offer transportation services?	American Logistics Transportation – Medi-Cal LOB Only	(844) 292-2688
For more details on each topic above, please refer to the New Provider Orientation presentation (NPO), Molina Medi-Cal Provider Manual, or contact your assigned PRR.		

Case Management

1. Who are Molina's Case Managers and Transition of Care Coaches?

Molina employs primarily nurses (RN or LVN) and social workers (MSW or LCSW), as well as other healthcare workers as Case Managers and Transition of Care Coaches. Transition of Care Coaches collaborate with members transferring from one setting or level of care to another, including but not limited to discharging from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home or community-based settings, post-acute facilities, or LTC settings, including ICFs.

2. What is the purpose of case management for long-term care membership?

Case managers work to ensure Molina members are at the appropriate level of care and have timely access to needed covered benefits, carved-out services, and community resources. The state also requires that we assess for willingness and ability to return to community living and help facilitate that transition if needed.

3. How can a facility find out which case manager is assigned to a Medicare or Medi-Cal member?

To find out if a Molina Medicare or Medi-Cal member has an assigned case manager, please contact us with the member's full name and date of birth via one of the methods below:

Line of Business	Referral Information
Medi-Cal	**Phone:** (833) 234-1258 **Fax:** (562) 499-6105 **Email:** MHCCaseManagement@MolinaHealthcare.com
Molina Medicare (EAE)	Phone Number: 562-549-4804 **Fax:** 833-741-3193 **Email:** Medicare_CM_Team@MolinaHealthcare.com
Marketplace	Phone: 855-322-4075 **Email:** CM_MPWest@molinahealthcare.com

Our staff will determine whether a Case Manager or Transition of Care Coach is already assigned, and if so, connect you with that person or provide their contact information to you. If no Case Manager is identified and the member has Case Management needs, a Case Manager will be assigned.

4. Who is the Molina point person in Case Management?

The assigned Case Manager or Transition of Care Coach will be your contact and can assist you in coordinating care for the member. Please note that the Case Manager or Transition of Care Coach may not be able to immediately answer your questions related to authorizations, claims, billing, contracting, etc. However, they can assist in getting someone from the appropriate department involved.

5. When should a facility contact the Case Manager?

Please contact the Case Manager/Transition of Care Coach for questions related to the Health Risk Assessment, care plans, or any needs identified that you need assistance with.

Health Risk Assessment

The Health Risk Assessment (HRA) is an assessment to identify the medical, functional, cognitive, psychosocial, and mental health needs of the member. The Case Manager/Transition of Care Coach will interview the member and/or the member's representative, as well as seek information from the member's health records (H&P, consults, and nursing notes) to gather information about the member's clinical history, behavioral health status, sensory and I/ADL deficits, cultural/linguistic needs, etc. The members who have a change in condition will have Case Management outreach that may include the HRA. The survey tool Molina uses has been approved by the state and the Centers for Medicare & Medicaid Services (CMS).

1. Why is the HRA important?

a. Member engagement
b. Establishing rapport, which enhances member satisfaction.
c. Timely outreach to address member needs.
d. Meeting the member's requests for benefits and change in health status.

2. Once the HRA is complete, how often will the Case Manager/Transitions of Care Coach be in contact with the facility?

The HRA results will indicate the frequency and intensity of Case Management services.

Members who are not stable may require more frequent contact. This would include members who recently transitioned from a skilled level of care to custodial care or members with recent or frequent admissions to an acute setting. Members determined to be willing and able to return to a community setting will require more intense management.

Care Plan

1. What will the Molina Care Plan look like?

The care plan is individualized and member centric and serves as an action plan that includes concerns and/or care gaps identified during the HRA and member contacts. The care plan is developed by the Case Manager/Transitions of Care Coach in collaboration with the member.

The individualized care plan will document a plan of action to address any unmet needs. It will also document non-Molina services the member may be eligible for (e.g., IHSS, MSSP, California Community Transitions Project).
Molina will send the facility a copy of the care plan. Please review it and let the Case Manager know of any recommendations or concerns and place a copy of the Molina care plan in the member's medical record.

2. What is the Interdisciplinary Care Team (ICT)?

An Interdisciplinary Care Team (ICT) is a group of individuals who work together in a coordinated manner toward common goals for the member.

The ICT is actively interdependent with an established means of on-going communication among the team members to ensure all aspects of the member's health care needs are integrated, addressed, and met.

All ICT members, including the member, have responsibility for shared, complementary tasks that include, but are not limited to:

a. Identifying and addressing the member's problems, needs, and gaps/barriers to quality. care
b. Integrating the member's care/needs while focusing on the member's goals
c. On-going, effective communication to facilitate coordinated care.
d. Collaborating to coordinate all care and services for the member

3. Who participates in the ICT?

Molina Case Managers will schedule the ICT, if indicated, and will invite the members of the care team. Anyone who is involved in providing care to the members is encouraged to participate with member approval. Invitations for the ICT for members in an LTC setting will be extended to the SNF where the member resides.

Claim Submissions

Providers should submit claims electronically. If electronic claim submission is not possible, please submit paper claims to the following address:

Molina Healthcare of California
PO Box 22702
Long Beach, CA 90801

Paper claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box. Claims received outside of the designated PO Box will be returned for appropriate submission. Please ensure claim submissions are billed with the Molina Member ID.

1. What are the paper claim guidelines?

Paper claims are required to be submitted on original red and white CMS-1500 and CMS1450 (UB-04) Claim forms. Paper claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include claims with handwriting. Claims must be typed with either 10-point or 12-point Times New Roman font, using black ink.

2. What fields are required on the UB-04 form?

Field	Field Description	Field Type	Instructions
1	Rendering Provider Name, Address, and zip code	Required	The name and service location of the provider submitting the bill. Enter information in this format: Line 1: Provider Name Line 2: Street Address Line 3: City, State, ZIP code
2	Billing Provider Name, address, and zip code	Required	Enter the address that the provider submitting the bill intends the payment to be sent if different than field one. Line 1: Billing provider Name Line 2: Street Address or post office box Line 3: City, state, and zip code

3a	Patient control number	Required	Enter patient's unique number assigned by provider
4	Type of bill	Required	Enter the Four-digit type of bill code as specified in the National Uniform Billing Committee (NUBC) UB-04 data manual. **Bill Types:** **021X** – SNF Part A **022X** – SNF Part B Fourth digit is based on the following: **0** – Non-payment/zero claim **1** – Admit through discharge claim **2** – Interim first claim **3** – Interim continuing claim **4** – Interim last claim **7** – Replacement of prior claim **8** – Void/cancel of prior claim
5	Federal Tax Number	Required	Enter the number assigned to the provider by the federal government for tax reporting purposes.
6	Statement covers period "From" and "Through" dates of service	Required	Enter the beginning and ending date of service in MMDDYY format. *For services provided on a single day, enter the date of service as both the from and through date.
7	N/A	Not required	N/A
8a	Patient name – identifier		Enter the member's Medi-Cal ID number
8b	Patient Name	Required	Enter patient's last name, first name, and middle initial
9	Patient Address	Required	Enter patient's mailing address
10	Patient Birthdate	Required	Enter patient's date of birth in MMDDYYYY format
11	Patient's Sex	Required	Enter a "M" (male) or a "F" (female)
12	Admission Date	Required	Enter the date the patient was admitted MMDDYY format
13	Admission Hour	Not required	Enter the hour patient was admitted

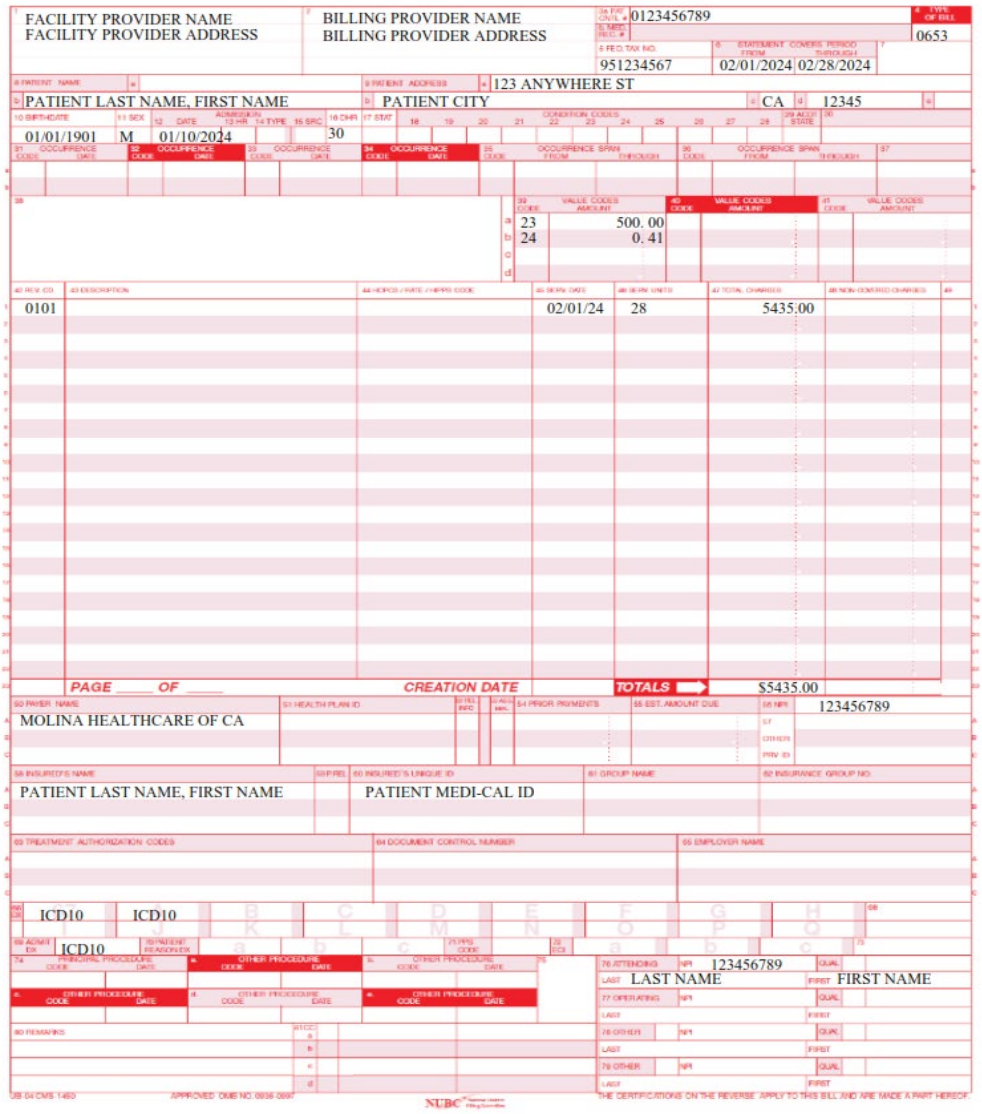
14	Admission Type	Not required	Enter the numeric code indicating the necessity for admission: **1** – Emergency **2** – Urgent **3** – Elective
15	Admission Source	Not required	Enter the source of referral for admission. Admission code source: **4** – Transfer from a Hospital **5** – Transfer from an SNF **6** – Transfer from another health care facility
16	Discharge Hour	If Applicable	Enter the hour of discharge. *If patient has not been discharged, box can be left blank
17	Patient Status	Required	Enter the patient status/discharge code. **01** – Discharged to Home or self-care **02** – Discharged/transferred to a short-term General Hospital for Inpatient Care **03** – Discharged/transferred to SNF **04** – Discharged/transferred to a Facility that provides Custodial care **05** – Discharged/transferred to a Designated cancer center or Childrens Hospital **20** – Expired **30** – Still Patient **40** – Expired at Home **41** – Expired in a Medical Facility **42** – Expired – Place unknown **43** – Discharged/transferred to a Federal Health Care Facility **50** – Hospice – Home **51** – Hospice – Medical Facility **61** – Discharged/transferred to an approved Swing Bed **62** – Discharged/transferred to an Inpatient Rehabilitation Facility (IRF)

			63 – Discharged/transferred to a Long-Term Care Hospital (LTCH) **64** – Discharged/transferred to a Nursing Facility certified under Medicaid **65** – Discharged/transferred to a Psychiatric Hospital **66** – Discharged/transferred to a Critical Access Hospital (CAH) **70** – Discharged/transferred to another type of health care institution
18-28	Condition Codes	If Applicable	Enter the codes that describe the corresponding code to identify the conditions or events that apply to the billing period.
29	Accident State	Not Required	
30	N/A	Not Required	
31-34	Occurrence Codes	If Applicable	Enter the occurrence code and associated date that identifies events relating to the billing period.
35-36	Occurrence Span	If Applicable	
37	N/A	Not required	
38	N/A	Not required	
39-41	Value Codes and Amounts	Required	Enter the value codes and amounts. *Amounts should be entered in dollar format. Example: Value code 24 with accommodation code 41 will be submitted as follows: Value code Value code amount 24 $0.41 **Value codes:** **23** – Patient's Share of cost **24** – Accommodation code **66** – Non-Covered Cost (Required only if billing for non-covered cost) **80** – Covered Days Accommodation codes applicable to Nursing Facility stays reference:

			LTC Code and Claim Form Conversion: LTC Accommodation code
42	Revenue code	Required	Enter the appropriate revenue code. **Nursing facility revenue codes:** **0101** – All-inclusive Room and Board **0190** – Subacute care (General) **0199** – Subacute care (Pediatric) **0180** – Leave of absence (General) **0185** – Leave of absence (Hospitalization) **Skilled Nursing Facility revenue codes:** **0022** – Skilled Nursing Facility PPS **0191- 0192** – Skilled Nursing Care **0193** – Rehab Skilled Nursing Care **0194** – Subacute Skilled Nursing Care
43	Revenue Description	Not Required	Enter the description of the revenue code used in box forty-two
44	HCPCS/Rate/HIPPS code	If applicable	Enter appropriate HIPPS code when billing SNF Part A
45	Service Date	Required	Enter the date of service
46	Service Units	Required	Enter the total number of accommodation days
47	Total Charges	Required	Enter the total charge related to the revenue code
48	Non-covered Charges	Not required	
49	N/A	Not Required	
50	Payer Name		Enter payer from whom payment will be received for this claim
51	Health Plan ID	Not Required	
52	Release of Information Certification Indicator	Not Required	
53	Assignment of Benefits Certification Indicator	Not Required	

54	Prior Payments	Not required	
55	Estimated Amount Due	Not Required	
56	National Provider ID	Not Required	
57	Other provider ID	Not Required	
58	Insured's Name	Required	Enter the name of the member
59	Patient's relationship to insured	If applicable	
60	Insured's Unique ID	Required	Enter the member's Medi-Cal ID number
61	Group Name	Not Required	
62	Insurance Group Number	Not Required	
63	Treatment Authorization Codes	If Applicable	Enter the required authorization or referral number assigned by the payer for the services that require preauthorization or referral
64	Document Control Number (DCN)	If Applicable	Enter the number of the original claim when submitting a corrected claim.
65	Employer Name	Not Required	
66	Diagnosis codes	Required	Enter the DX codes related to claim. ICD -10 Codes
67	Principal Diagnosis Code	If applicable	Enter the principal DX code
68	N/A	Not Required	
69	Admit Diagnosis	Required	Enter the Admit DX code
70	Patient Reason Diagnosis	If Applicable	
71	PPS Code	Not Required	
72	External Cause of Injury Code	Not Required	
73	N/A	Not Required	
74	Principal Procedure Code and Date	Not Required	
75	N/A	Not Required	
76	Attending Provider	If Applicable	Enter the Attending provider NPI and Name
77	Operating Provider	If Applicable	Enter the Operating Provider NPI and Name

3. Can I have a claim submission example?



4. How can I monitor the status of my claims?

Once claims are processed into MHC's system, providers may view them online through the Availity Provider Portal. To learn more about Availity or receive assistance, please contact your PRR.

5. How do I set up electronic billing?

Providers can work with their designated PRR for assistance with electronic billing setup.

6. Does Molina pay for EDI clearinghouses?

Change Healthcare is an outside vendor used by Molina Healthcare of California. When submitting fee-for-service EDI Claims (via a clearinghouse) or to Molina Healthcare of California, please utilize the following payer ID: 38333. EDI or electronic claims are processed faster than paper claims.

Providers can use any clearinghouse of their choosing. Note that fees may apply. Details on Molina's clearinghouse is below:

- **EDI Clearinghouse**: SSI Claimsnet, LLC (SSI Group)
- **Registration Form:** products3.ssigroup.com/ProviderRegistration/register.
- **Payer ID**: 38333

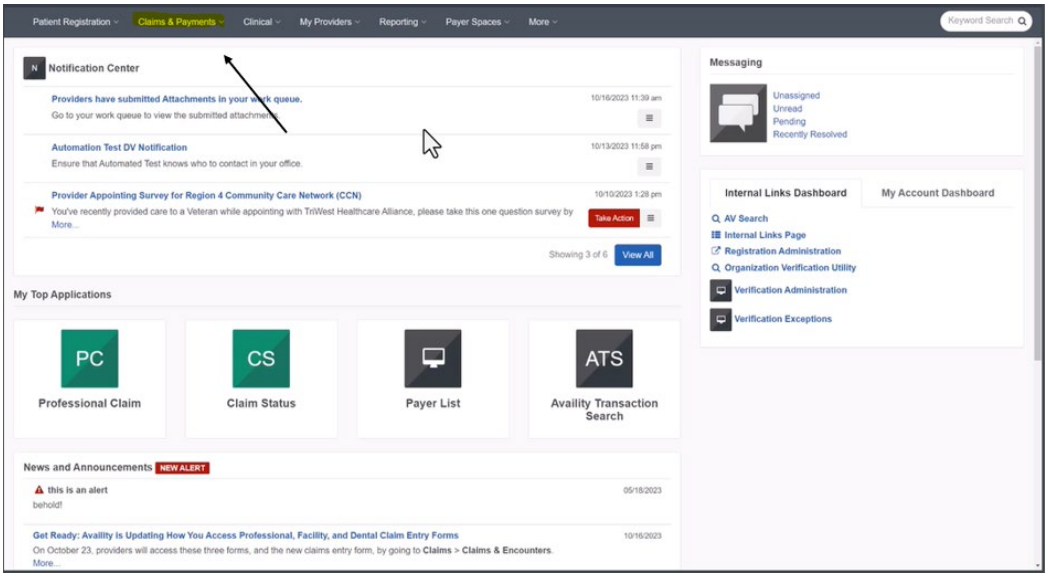
7. How do I contact the MHC Claims department?

Providers may contact their PRR. The PRR will triage all questions and concerns to the Claims team.

Availity Facility Claim Submissions

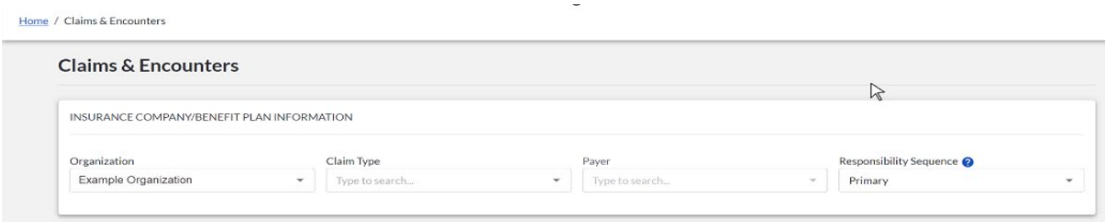
Below is a step-by-step walkthrough of the claim submission process through the Availity Provider Portal.

1. To navigate to the claims application, you will select the Claims & Payments navigation bar.

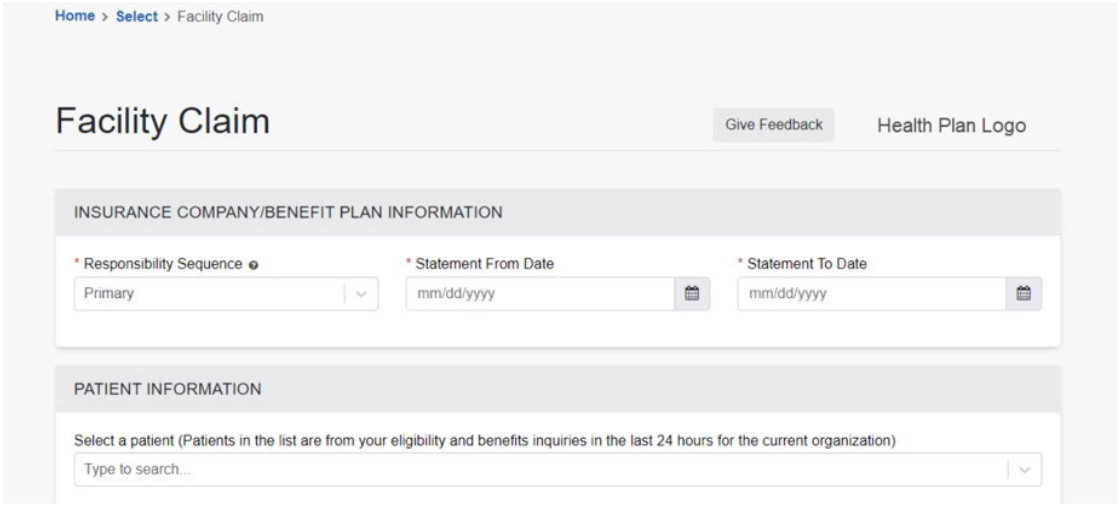


2. Select Claims & Encounters

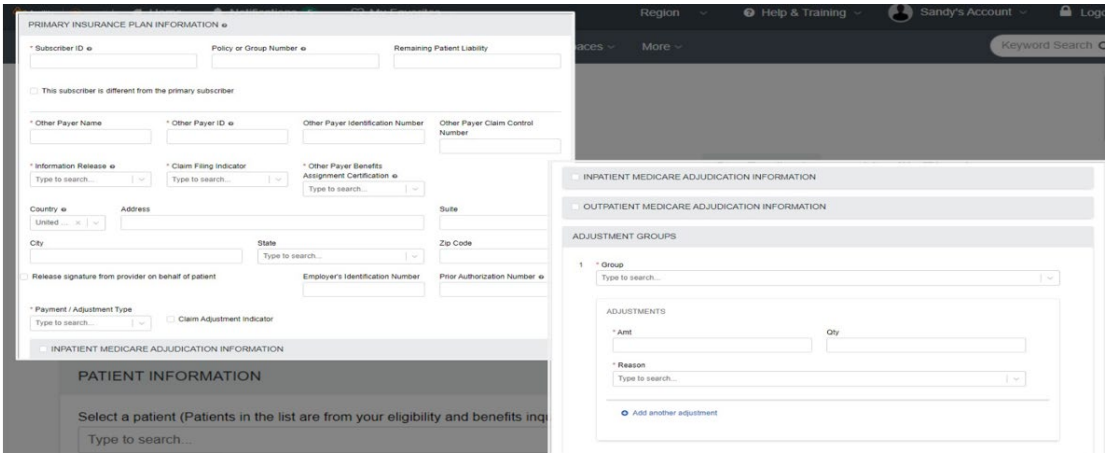
3. To begin the claim submission, you will need to select the organization to which you will be submitting the claim. You will also need to select the Claim type and Payer.



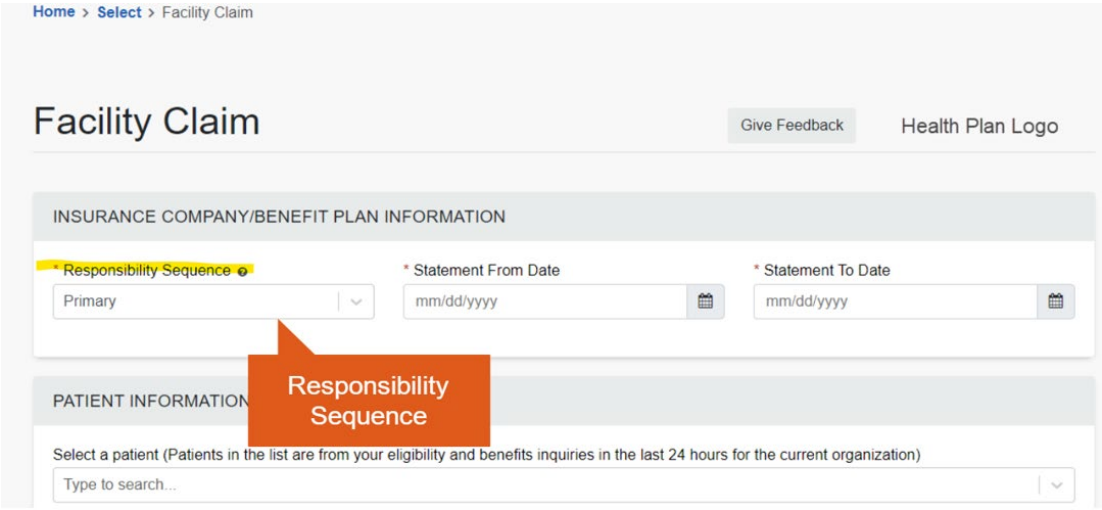
4. In the first section, select the responsibility sequence: primary, secondary, or tertiary.



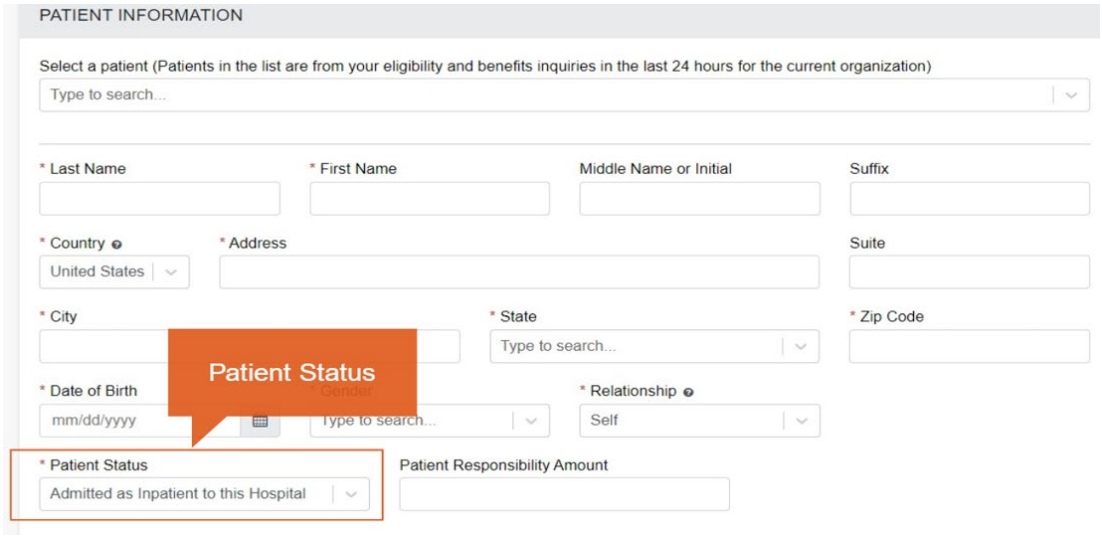
5. If you select secondary or tertiary, additional fields will be displayed on the form for you to enter the COB information.



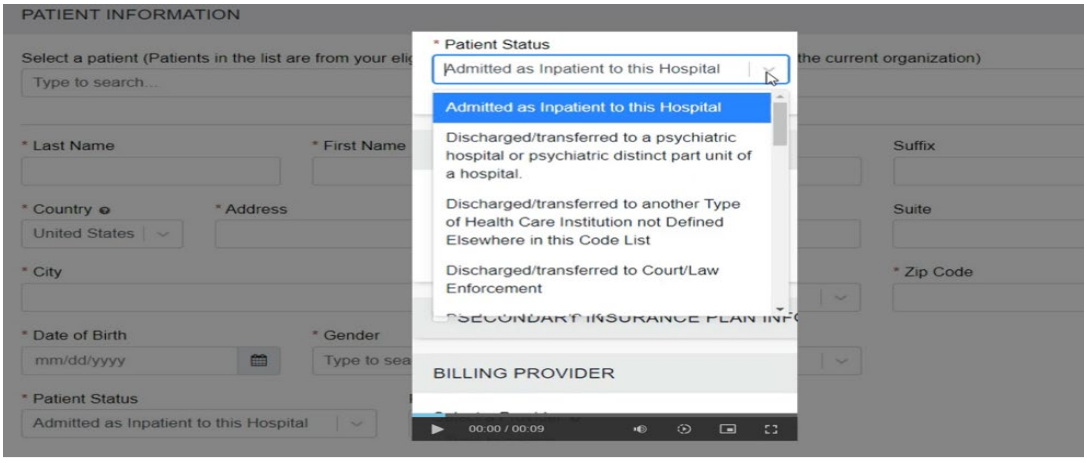
6. In the patient information section, you can manually enter the patient's information. If you have checked eligibility for the member in the last 24 hours, you can select it from the drop-down menu.



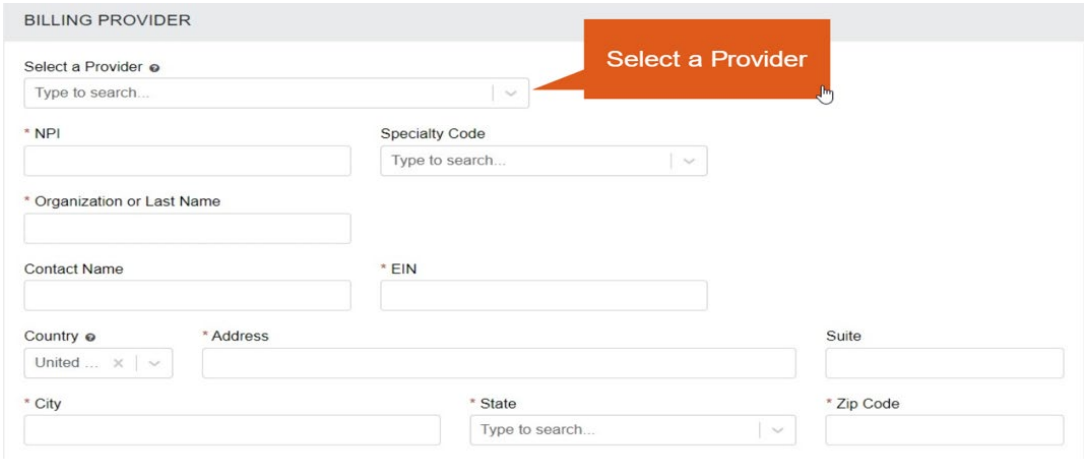
7. For most payors, the patient status field defaults to Admitted as an Inpatient to this Hospital.



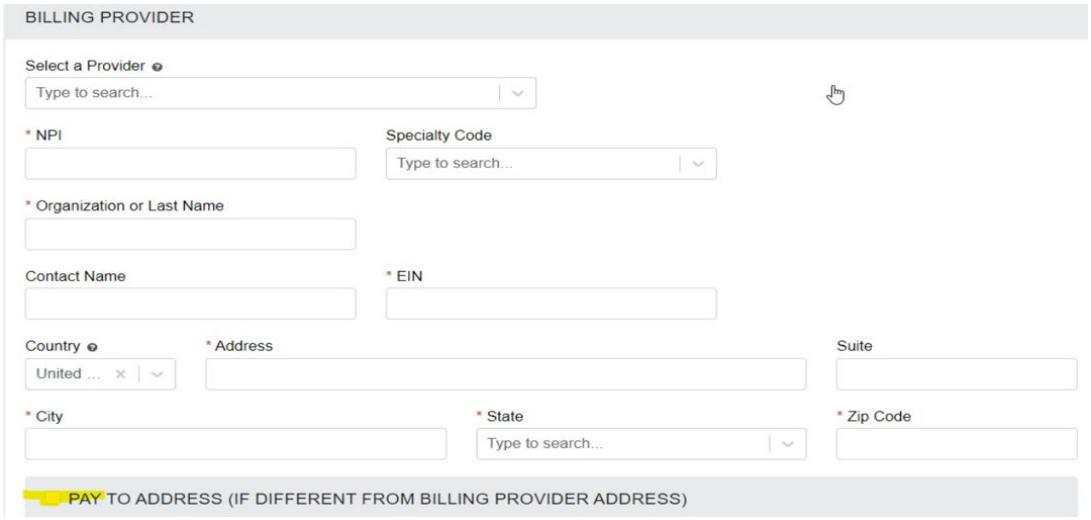
8. You can select another option in the field if applicable.



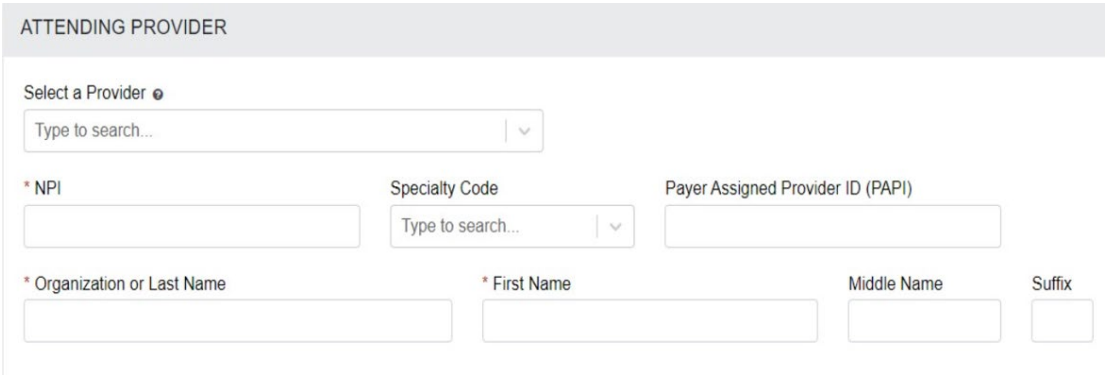
9. In the BILLING PROVIDER section, you can manually enter the required field or select a provider from your organization's provider express entry setup.



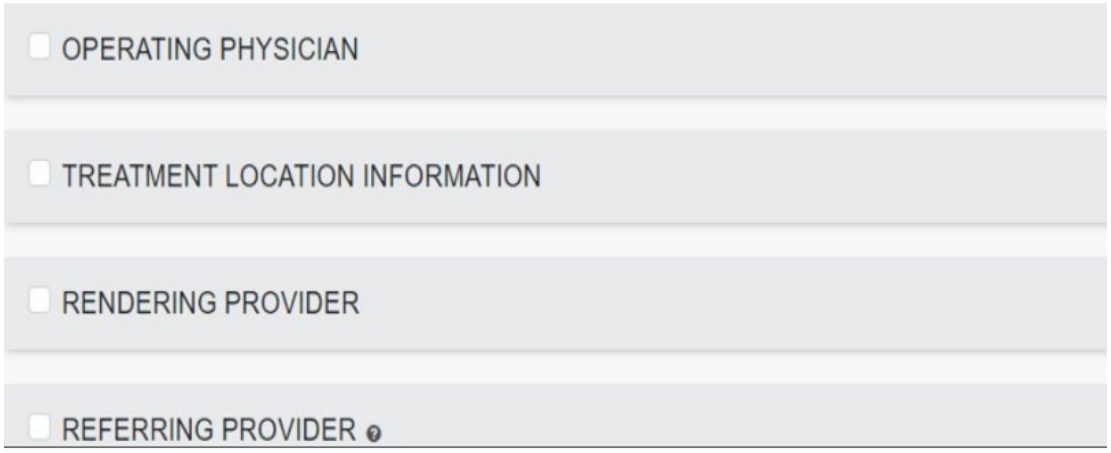
10. If the pay-to-address is different, select the checkbox to display fields to enter the pay-to-address information.



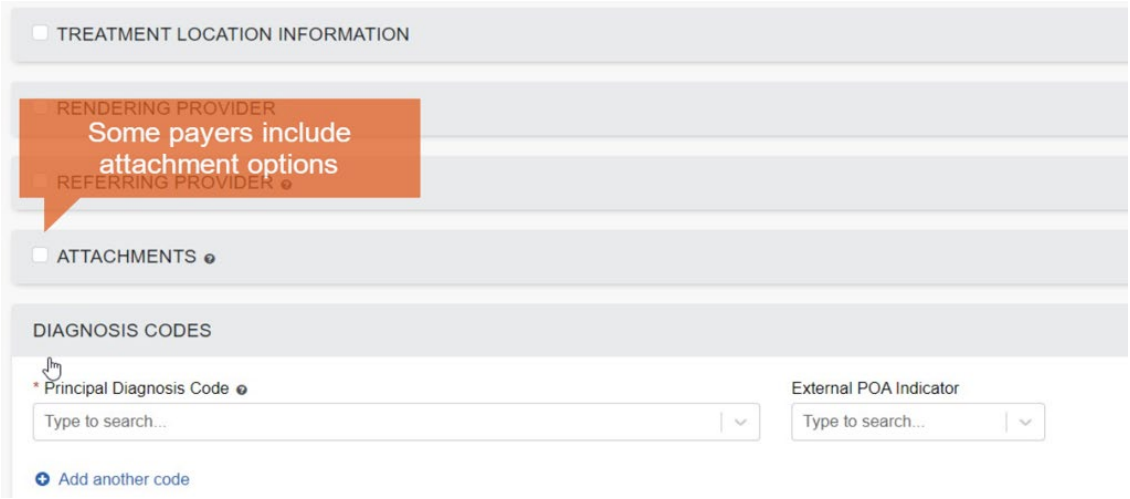
11. Next, enter the attending provider information or select the provider from your organization's provider express setup.



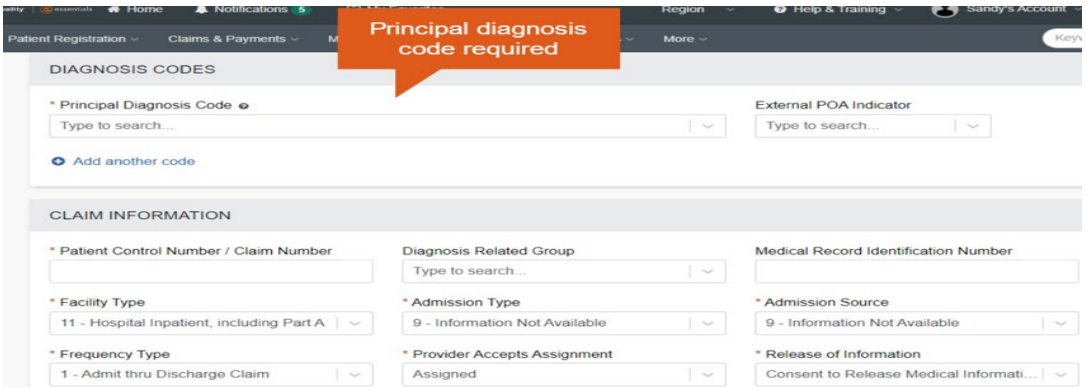
12. If the claim has additional information like operating physician, treatment location, rendering provider, and referring provider, select the check box to display that section.



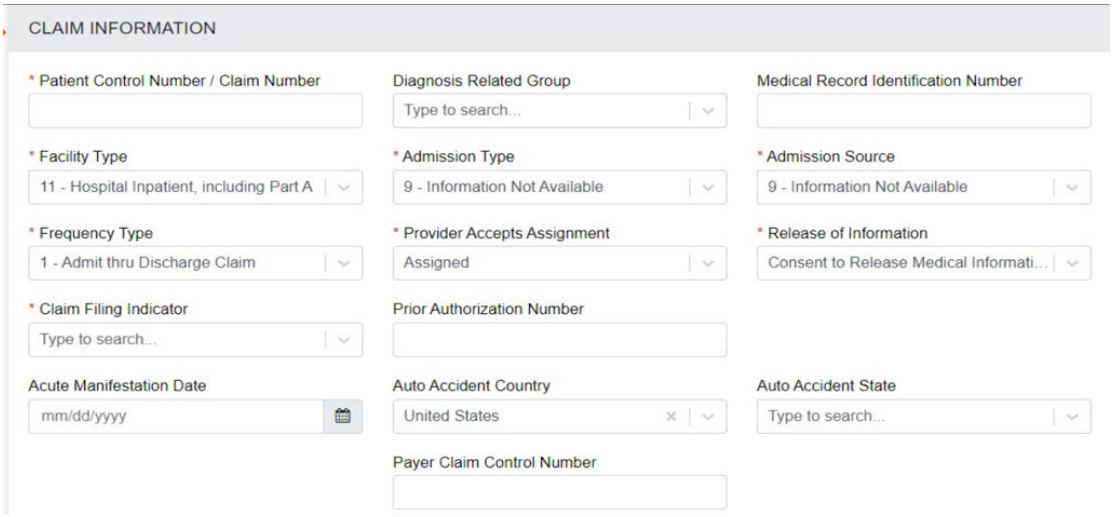
13. Molina gives the option to include attachment information. Select the check box to display the section.



14. The principal diagnosis code is required. Should more codes need to be added, select the "Add another code" link to enter up to eleven additional codes.



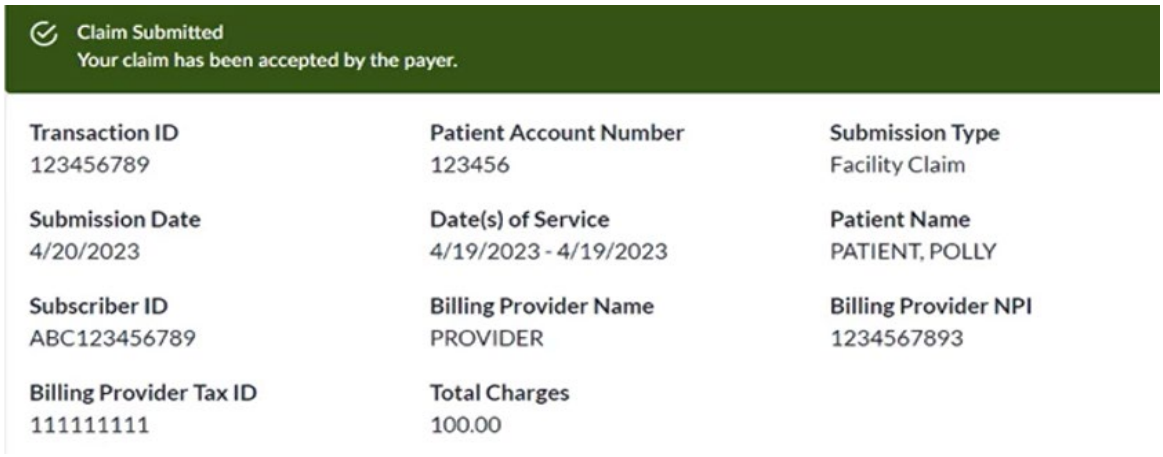
15. In the "Claim Information" section, enter the required fields and optional information for the claims. As you make selections in fields, additional fields related to the claim information might be displayed.



16. Once you have entered all the information on the claim, click submit. You click the start over only if you want to clear the form.

17. Availity conducts front-end validation to ensure your claim is as clean as possible before it is submitted to Molina Healthcare. If your claim has front-end validation errors, Availity will display a message to help you correct the errors. Simply correct the errors and submit the claim.

18. Claims submission confirmation screen.



Non-Par Provider Claim Submissions

1. What are the claims submission options for non-participating providers?

Non-PAR providers can submit claims using the below options:

- Submit paper claims directly to Molina Healthcare of California at the following address: PO Box 22702 Long Beach, CA 90801
- Clearinghouse: SSI Claimsnet, LLC (SSI Group)
- Registration Form: products3.ssigroup.com/ProviderRegistration/register
    - When submitting fee-for-service EDI claims, please utilize the payer ID: 38333

MHC Contacts

Frequently Asked Questions

1. Who should members contact with questions?

Molina Member Services is available 24/7 for questions at (888) 665-4621.

2. Who should providers contact with questions?

Please review the contact lists below for Care Management, Utilization Management, and Provider Relations. If additional support is needed in other areas, PRRs will work with their assigned SNFs to assist with issues and relay concerns to the appropriate MHC department.

Provider Relations Contact List

Provider Relations	Contact Number	Email Address
Laura Gonzalez, Provider Relations	562-549-4887	Laura.Gonzalez3@molinahealthcare.com
MiMi Howard, Provider Relations	562-549-3532	SMiMi.Howard@molinahealthcare.com
Kristin Rosemond, AVP Network Strategy & Services	323-303-2573	Kristin.Rosemond@molinahealthcare.com

Provider Contracts Contact List

Provider Contracts	Contact Number	Email Address
Maria Torres, Manager Provider Contracts (LOAs)	562-549-4232	Maria.Torres6@molinahealthcare.com
Revelyn Soriano, Manager Provider Contracts	562-491-4774	Revelyn.Soriano@molinahealthcare.com

Case Management Contact List

Case Management	Contact Number	Email Address
Case Management referrals and inquiries (Medicaid)	Ph: 833-234-1258 Fax: 562-499-6105	MHCCaseManagement@molinahealthcare.com
Blanca Martinez, Director & LTSS Liaison	562-485-4966	Blanca.Martinez@molinahealthcare.com
Trista Friemoth, Manager & LTSS Liaison	414-293-0133	Trista.Friemoth@molinahealthcare.com

Pamela Jimenez, Manager Transitions of Care	562-912-6828	Pamela.Jimenez@molinahealthcare.com
Ruby Silva, Marketplace Director of Case Management	430-271-4633	Ruby.Silva@molinahealthcare.com

Utilization Management Contact List

Utilization Management	Contact Number	Email Address
After hours, weekends, and holidays (EDSU 24/7/365)	Ph: 844-966-5462 Fax: 877-665-4625	N/A
Prior Authorization	Ph: 844-557-8434 Fax: 800-811-4804	N/A
Inpatient Authorization	Ph: 866-814-2221 Fax: 866-553-9263	N/A
Lisa Kelly, Supervisor	Ph: 562-456-4694	Lisa.Kelly@molinahealthcare.com
Nicole Ruffalo, Manager	Ph: 562-517-1511	Nicole.Ruffalo@molinahealthcare.com
Sonia Hernandez, Director	562-517-1477	Sonia.Hernandez2@molinahealthcare.com

Appendix

Pre-Service Review Guide

MOLINA HEALTHCARE
Your Extended Family

Molina® Healthcare Medicaid
Prior Authorization/Pre-Service Review Guide
Effective: 01/01/2024

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.

- **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** (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**
- **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.
- **Neuropsychological and Psychological Testing** after initial 4 hours of testing
- **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**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Sleep Studies**
- **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 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 (866) 814-2221.

IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

(Service hours 8:30am-5:30pm local M-F, unless otherwise specified)

Prior Authorizations including Behavioral Health Authorizations: Phone: (844) 557-8434 Fax: (800) 811-4804	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (888) 275-8750
Pharmacy Authorizations: Phone: (800) 977-2273 Fax: (800) 869-4325	**Dental:** Phone: (800) -322-6384 Website: www.dental.dhcs.ca.gov
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Vision:** Phone: (844) 336-2724 Fax: (855) 640-6737
Provider Customer Service: Phone: (855) 322-4075 Fax: (562) 499-0619	**Member Customer Service, Benefits/Eligibility:** Phone: (888) 665-4621/ TTY/TDD 711 Fax: (866) 507-6186
Transportation: Phone: (855) 253-6863 Fax: (877) 601-0535	**Transplant Authorizations:** Phone: (855) 714-2415 Fax: (877) 813-1206
	24 Hour Nurse Advice Line (7 days/week) Phone: (888) 275-8750/TTY: 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.*

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

Pre-Service Request Form

MOLINA HEALTHCARE
Your Extended Family

Molina® Healthcare, Inc. – Pre-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:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Other Inpatient:_____	☐ 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:				

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.