



Molina Frequently Asked Questions (FAQs)

Skilled Nursing Facilities

Molina Healthcare of California

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Utilization Management

Prior Treatment Authorization Requests (TARs)

1. How will the Medi-Cal TARs be loaded into the health plan system?

- a) Molina anticipates receipt of Medi-Cal TAR information from the Department of Health Care Services (DHCS) and will honor TARs existing prior to the members' enrollment with Molina. Molina will use the Medi-Cal TAR to create an authorization in its system for the duration of the existing TAR (example: if the TAR for Mrs. Jones is approved through June 2015, Molina will enter an authorization in its system through June 2015). Molina will fax a copy of the authorization to the facility.
- b) If you have a Molina member in the facility and do not receive an authorization, the facility must notify Molina by faxing a copy of the Medi-Cal TAR effective prior to the member's enrollment with Molina to the Molina Prior Authorization Department at 800-811-4804. Molina will notify the facility within 5 working days after notice with the new authorization number.
- c) The facility may submit a renewal authorization request up to 60 days prior to the expiration of the current authorization.

2. If not automated, what is the health plan's procedure to assure that TARs are recognized?

- a) Molina will load TAR information received from DHCS into its system. However, to ensure accuracy, facilities must review the list from Molina and respond according to the instructions above.

3. How will claims be processed electronically under these circumstances? We suggest that the health plan recognize DHCS TAR numbers and process claims. They can retroactively verify if needed from the DHCS data submitted.

- a) As noted above, Molina will use the DHCS TAR information and issue new authorization numbers. Facilities must use the Molina authorization number on claims.
- b) A facility has up to six (6) months after the date of service to submit a claim to Molina. For a patient who was residing in the facility prior to enrollment in Molina, the facility has up to six (6) months to submit the TAR and the claim. Molina will authorize services (and payment) retroactive to the date that the patient became effective with Molina. Dates of service older than six (6) months from the claim will be denied. For authorization submission timeframes for new patients, please see instructions below.

Out of Network SNFs

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

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

2. What are the requirements for payment?

- a) Facility must have the following to receive payment:
 - Contract or Letter of Agreement
 - Authorization for the services for which facility is requesting payment

3. What are the requirements for payment?

Please refer to the *Provider Quick Reference Guide* (attached)

What are the health plan's prior authorization procedures?

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

- a) The Molina SNF Specialist RN will review the member's condition applying Title 22 criteria for medical necessity but will not be on-site. A SNF Specialist RN will contact the facility for clinical data to assist in making a determination. Custodial Members will be reviewed every 2 months. Please refer to the SNF SPECIALIST REFERENCE GUIDE for your county to contact your facilities assigned SNF Specialist RN. One of Molina's ambulatory Case Managers will be onsite to conduct the Cal MediConnect required face-to-face Health Risk Assessment. As part of this visit to the facility s/he will meet with the member, review the MDS and other information in the member's chart, and talk with facility staff about the member's condition. The Case Manager will share this information with the Molina SNF Specialist RN, particularly as it relates to Title 22 Nursing Facility Level of Care criteria. As needed, the Case Manager may make recommendations to the Molina SNF Specialist RN about the type/length of the authorization.

2. If so, how long will authorizations be effective?

- a) Molina will authorize custodial care for six (6) months or longer, with exceptions (shorter or longer authorizations) based on medical review.

3. If not onsite, will specific case managers be assigned to each facility?

- a) As Molina identifies how many members are residing in each facility and the geographic distribution of members and facilities, Molina will make assignments to specific case management staff.

4. Is there a different process for "skilled" level of care compared to "prolonged" level of care?

- a) Yes – see section on authorization for skilled level of care.

5. 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 custodial level of care	<ol style="list-style-type: none"> 1. <i>Molina Healthcare / Molina Medicare Prior Authorization Request Form</i> (see attached) 2. MDS 3. Physician's order 4. History / Physical 	Twenty-one (21) calendar days after admission to facility	Five (5) working days after receipt of complete request
Patient admitting from inpatient or ER for custodial level of care	If Molina authorized the ER or inpatient care, no prior auth request is required for level of care.	N/A	Two (2) working days after receipt of all documentation
	If Molina did not authorize the ER or inpatient care (example: authorized by Medicare FFS) submit: <ol style="list-style-type: none"> 1. Authorization Request Form 2. MDS 3. Physician's order 4. History / Physical 	Twenty-one (21) calendar days after admission to facility	Five (5) working days after receipt of complete request
Patient admitting for skilled level of care	No prior auth request required; Molina will obtain necessary documentation from the transferring facility	N/A	Two (2) working days after receipt of all documentation
Patient requiring change in level of care from skilled to custodial	If Molina authorized the skilled care, no request is required for custodial level of care.	N/A	Two (2) working days after receipt of all documentation
	If Molina did not authorize the skilled care (example: authorized by Medicare FFS), submit: <ol style="list-style-type: none"> 1. Authorization Request Form 2. MDS 3. Physician's order 4. History / Physical 5. Documentation of eligibility verification 	Twenty-one (21) calendar days after facility is aware that patient is enrolled in Molina	Five (5) working days after receipt of complete request
Bed Hold	<ol style="list-style-type: none"> 1. Physician's order must be for hospital admit and bed hold 2. Anticipated Length of Stay; of no greater than seven (7) days 3. Member must be in SNF, ICF, not Sub-acute at least twenty-four (24) hours prior to start of bed hold 	<ol style="list-style-type: none"> 1. Within twenty-four hours of departure and at least seven (7) days to prior to billing for service. 2. Date of departure counts as day one of bed hold 3. Member considered discharged if returned to facility on day eight (8) after an acute admission New authorization	Molina will provide authorization within 5 business days of receipt of complete request

		request is required for readmit to the SNF facility after day eight (8).	
		4. Discharge notification must be within three (3) days business days following discharge.	
Leave of Absence	Plan of care delineating Leave of Absence: 1. Dates and 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 Plan of care. 5. Appropriate for physical and mental well-being of member.	1. Request must be submitted two weeks prior to leave 2. Member voluntarily leaves facility without a leave request or member fails to return by midnight on the scheduled date of return member is considered AWOL 3. New authorization request is required for member returning after AWOL.	Molina will provide authorization within five business days of receipt of complete request

- a) The Authorization Request Form and supporting documentation must be faxed within the above timeframes to Molina at:
- 800-811-4804 for Medi-Cal covered services
 - 866-472-0596 for Medicare covered services
- b) For Medi-Cal ancillary services provided in the facility:
- Molina contracted providers must follow the ***Molina Healthcare / Molina Medicare of California Prior Authorization / Pre-Service Review Guide*** (attached) to determine which services require prior authorization
 - Providers that are not contracted with Molina must request prior authorization for all services by submitting the ***Molina Healthcare / Molina Medicare Prior Authorization Request Form*** (attached)

6. Is the authorization documented electronically and immediately available to the SNFs?

- a) Yes. Facilities have access to this information in the Molina Provider Portal.

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

- a) Yes. The facility must include the authorization number on the claim form. See section on claims submission.

8. Does the health plan need additional documents from the SNF in order to pay a claim? Can that documentation be submitted electronically? A hard copy of the authorization should not be required to pay the claims.

- a) The facility does not need to submit additional documentation with a claim for an authorized service. The facility must include the authorization number on the claim form. See section on claims submission.

9. Does the health plan delegate authorization to others, such as IPAs? If so, are the IPA authorizations tied to the health plan claims systems? No hard copy of authorization should be required to pay claims.

- a) Molina does not delegate authorization of facility services or payment of facility services to an IPA at this time.

10. If Medicare A SNF care is delegated to the IPA, when the patient reverts to Medi-Cal level of care, who is responsible for authorization and payment? Who resolves disputes between the IPA and the health plan for responsibility of payment? Is this in writing?

- a) Molina does not delegate authorization of facility services or payment of facility services to an IPA at this time.

11. Are the IPAs required to provide copies of the authorizations immediately to the SNF? We have heard that some IPAs will not provide copies until discharge. That is not acceptable for SNF services.

- a) Molina does not delegate authorization of facility services or payment of facility services to an IPA at this time.

12. What training is available on authorization procedures?

- a) Molina staff is available to provide orientations and trainings to all contracted facilities. Please refer to the **Provider Quick Reference Guide** (attached).

Sub-acute Services

1. Does the health plan recognize that SNFs may provide “skilled” (Medicare), “prolonged” (Medi-Cal) and sub-acute services all within the same facility?

- a) Yes.

2. All of the issues above are applicable to a SNF that provides Medi-Cal sub-acute services.

a) Please see the specific instructions for requesting authorization below:

Patient Type	Documentation Required	Submission Timeframe	Response Timeframe
Patient admitting from inpatient or ER for custodial level of care	If Molina authorized the ER or inpatient care, no request is required for custodial level of care.	N/A	Two (2) working days after receipt of all documentation
	If Molina did not authorize the ER or inpatient care (example: authorized by Medicare FFS), submit: 1. Molina Healthcare / Molina Medicare Prior Authorization Request Form (attached) 2. MDS 3. Physician's order 4. History / Physical	Seven (7) calendar days after admission to facility	Five (5) working days after receipt of complete request
Patient admitting for skilled level of care	No prior auth request required; Molina will obtain necessary documentation from the transferring facility	N/A	Two (2) working days after receipt of all documentation
Patient requiring change in level of care from Skilled to Custodial	If Molina authorized the skilled care, no prior auth request is required for custodial level of care.	N/A	Two (2) working days after receipt of all documentation
	If Molina did not authorize the skilled care (example: authorized by Medicare FFS), submit: 1. Authorization Request Form 2. MDS 3. Physician's order 4. History / Physical 5. Documentation of eligibility verification	Seven (7) calendar days after facility is aware that patient is enrolled in Molina	Five (5) working days after receipt of complete request
Bed Hold	1. Physician's order must be for hospital admit and be hold 2. Anticipated Length of Stay; not greater than seven (7) days 3. Member must be in SNF, ICF, not Sub-acute at least twenty-four (24) hours prior to start of bed hold	1. Within twenty-four hours of departure and at least seven (7) days to prior to billing for service. 2. Date of departure counts as day one of bed hold 3. Member considered discharged if returned to facility on day eight (8) after an acute admission 4. New authorization request is required for readmit to facility after day eight (8).	Molina will provide authorization within 5 business days of receipt of complete request

		5. Discharge notification must be within three (3) days business days following discharge.	
Leave of Absence	Plan of care delineating Leave of Absence: <ol style="list-style-type: none"> 1. Dates and 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 Plan of care. 5. Appropriate for physical and mental well-being of member. 	<ol style="list-style-type: none"> 1. Request must be submitted two weeks prior to leave 2. Member voluntarily leaves facility without a leave request or member fails to return by midnight on the scheduled date of return member is considered AWOL 3. New authorization request is required for member returning after AWOL. 	Molina will provide authorization within five business days of receipt of complete request

a) New Authorization required when:

- New admission to facility
- Member changes level of care (e.g. skilled to custodial or custodial to skilled)
- Readmission from acute greater than day # eight
- Member returns from approved LOA beyond approved time allowed.
- Member becomes Molina member while currently residing in facility (new beneficiary, change in county etc.

b) Discharge Notification required when:

- Member does not return from approved bed hold/LOA period
- The member returns to the facility during the bed hold period but has changed to a different payer (Molina to Health-Net)
- Member discharged from facility to another residence

Frequently Asked Questions

1. How often can a SNF submit claims? Providers are accustomed to weekly submission.

- a) A facility may submit claims as frequently as desired.

2. What is the health plan's check write schedule?

- a) Molina issues checks two (2) times per week, on Mondays and Wednesdays.

3. What is the average time necessary to process and pay a SNF "clean" claim?

- a) Molina will make every effort to pay a clean claim within fourteen (14) calendar days after receipt.

4. What type of form will SNFs need to use to submit claims?

- a) UB-04

5. What billing (revenue, accommodation, Medicare, sub-acute, bed hold, LOA, etc.) codes should be billed?

- a) Facilities should use standard Medicare revenue codes for Medicare-covered services, and Medi-Cal codes for Medi-Cal covered services.
 - Custodial claims should be billed using revenue code 0190
 - Skilled nursing and sub-acute should be billed using revenue codes 0191-0194.

6. Has the health plan tested payment for Medicare coinsurance/copayments, bed holds, leaves of absence?

- a) As a Medicare HMO, Molina already has systems in place for Medicare coinsurance/copayments. Molina will work closely with facilities to ensure timely and accurate processing of payments for authorized bed hold and leave of absence

7. Are the claims systems designed to process SNF claims with SOC deductions for non-covered services consistent with Johnson v. Rank? UB-04 for everything including SOC. We won't accept the Form 25-1.

- a) Yes, SNF facility claims must be billed on a UB-04 for everything including SOC. Molina will not accept the Form 25-1. The SOC (value code 23) should be entered in box 39 on the UB04 with the dollar value. Consistent with Johnson v. Rank, Medi-Cal recipients, not their providers can elect to use their SOC funds to pay for non-covered services. These non-covered services would need to be billed in box 80 using a NC qualifier and dollar amount.

8. What training is available?

- a) Molina staff is available to provide any training requested by providers. Training documents will be provided to the entire SNF network and additional training can be requested if needed. Please refer to the **Provider Quick Reference Guide** (attached).

9. Does the health plan have early boarding, i.e., the ability to send some test claims prior to going live?

- a) Yes. Molina has a very thorough claims testing process and providers have the ability to test claims. Facilities may contact James Loopeker at (562) 491-7069 for testing.

10. What are the Accommodation Codes for Long Term Care?

- a) Below lists the accommodation codes for Long Term Care.

<u>Description</u>	<u>Regular Services</u>	<u>Leave Days Non-DD Patient</u>	<u>Leave Days DD Patient</u>
NF-B Regular.....	01	02	03
NF-B Rural Swing Bed Program.....	04	05	N/A
NF-B Special Treatment Program-Mentally Disordered.....	11	12	N/A
NF-A Regular.....	21	22	23
Rehabilitation Program-Mentally Disordered.....	31	32	N/A
ICF Developmental Disability Program.....	41	N/A	43
ICF/DD-H 4-6 Beds.....	61	N/A	63
ICF/DD-H 7-15 Beds.....	65	N/A	68
ICF/DD-N 4-6 Beds.....	62	N/A	64
ICF/DD-N 7-15 Beds.....	66	N/A	69
	<u>Regular Services</u>	<u>Bed Hold</u>	<u>Leave of Absence</u>
NF-B Adult Subacute			
Hospital DP/NF-B – Ventilator Dependent.....	71	73	79
Hospital DP/NF-B – Non-ventilator Dependent.....	72	74	80
Free-standing NF-B – Ventilator Dependent.....	75	77	81
Free-standing NF-B – Non-ventilator Dependent.....	76	78	82
NF-B Pediatric Subacute			
Hospital DP/NF-B – Supplemental Rehabilitation Therapy Services.....	83	N/A	N/A
Hospital DP/NF-B – Ventilator Weaning Services.....	84	N/A	N/A
Hospital DP/NF-B – Ventilator Dependent.....	85	87	89
Hospital DP/NF-B – Non-ventilator Dependent.....	86	88	90
Free-standing NF-B – Ventilator Dependent.....	91	93	95
Free-standing NF-B – Non-ventilator Dependent.....	92	94	96
Free-standing DP/NF-B – Supplemental Rehabilitation Therapy Services.....	97	N/A	N/A
Free-standing DP/NF-B – Ventilator Weaning Services.....	98	N/A	N/A

a) Yes, accommodation codes are required codes/information that needs to be included on a UB. Applicable accommodation codes need to be included in Box 39 with value code 24.

APPENDIX

THE COMMENTARIES ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

12. Should we be including share of cost and days/service unit information on UB? Where should we bill/include this information on the UB form?

- a) Yes, share of cost and days/service unit information needs to be included on a UB. Applicable share of cost codes need to be included in Box 39 with value code 23. Applicable days/service unit codes need to be included in Box 39 with value code 80.

1 FRIENDLY HOSPITAL 2255 RIVER STREET OUR TOWN, CA 99009										2 FRIENDLY HOSPITAL 2255 RIVER STREET OUR TOWN, CA 99009										3a PRI. CNTRL. # 000001 3b MED. REC. # 000021 3c FED. TAX NO. 25-5555555 3d STATEMENT COVERS PERIOD FROM 07/01/14 THROUGH 07/17/14										4 TYPE OF BILL 213									
5 PATIENT NAME: a JOHN DOE																				6 PATIENT ADDRESS: a THIS TOWN																			
b THIS TOWN																				c CA										d 98851									
10 BIRTHDATE: 11 SEX M 12 DATE 3/1/14 13 3 14 5 15 SEC 16 CHR 17 STAT 18 19 20 21										CONDITION CODES 22 23 24 25 26 27 28 29 30										31 OCCURRENCE DATE 32 OCCURRENCE DATE 33 OCCURRENCE DATE 34 OCCURRENCE DATE 35 OCCURRENCE DATE 36 OCCURRENCE DATE 37																			
38										39 VALUE CODES AMOUNT 23 000 24 001 40 VALUE CODES AMOUNT 41 VALUE CODES AMOUNT 80 1700										42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATE / HPPS CODE 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES 49																			
0190 CUSTODIAL ROOM AND BOARD																				17 \$8,000.00																			
PAGE 1 OF 1										CREATION DATE 7/18/14										TOTALS \$8,000.00																			
50 PAYER NAME MOLINA										51 HEALTH PLAN ID 9999										52 PRIOR PAYMENTS 53 EST. AMOUNT DUE 54 NPI 111112222																			
55 INSURECT'S NAME DOE, JOHN										56 PRIOR 18										57 OTHER PRIOR ID																			
58 INSURECT'S UNIQUE ID 99885522F										59 GROUP NAME MOLINA										60 INSURANCE GROUP NO.																			
61 TREATMENT AUTHORIZATION CODES 148888888										62 DOCUMENT CONTROL NUMBER										63 EMPLOYER NAME																			
64 780.79										65 250.00										66 404.00																			
67 ADMIT DATE 68 PATIENT REASON CODE 69 OTHER PROCEDURE DATE 70 OTHER PROCEDURE DATE 71 OTHER PROCEDURE DATE 72 OTHER PROCEDURE DATE 73 OTHER PROCEDURE DATE 74 OTHER PROCEDURE DATE 75 OTHER PROCEDURE DATE 76 OTHER PROCEDURE DATE 77 OTHER PROCEDURE DATE 78 OTHER PROCEDURE DATE 79 OTHER PROCEDURE DATE 80 OTHER PROCEDURE DATE 81 OTHER PROCEDURE DATE 82 OTHER PROCEDURE DATE 83 OTHER PROCEDURE DATE 84 OTHER PROCEDURE DATE 85 OTHER PROCEDURE DATE 86 OTHER PROCEDURE DATE 87 OTHER PROCEDURE DATE 88 OTHER PROCEDURE DATE 89 OTHER PROCEDURE DATE 90 OTHER PROCEDURE DATE 91 OTHER PROCEDURE DATE 92 OTHER PROCEDURE DATE 93 OTHER PROCEDURE DATE 94 OTHER PROCEDURE DATE 95 OTHER PROCEDURE DATE 96 OTHER PROCEDURE DATE 97 OTHER PROCEDURE DATE 98 OTHER PROCEDURE DATE 99 OTHER PROCEDURE DATE										75 ATTENDING NPI 111111333										76 LAST DOE FIRST ALAN																			
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SHARE OF COST

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Bibliography Consortium
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Case Management

Molina Healthcare Case Management

1. Who are Molina's Case Managers

- a) Molina employs primarily nurses (RN) and social workers (MSW or LCSW) as Case Managers. Staff is based in regional Molina offices in each of our service areas.

2. What is the purpose of Case Management for the long-term care membership?

- a) 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 to help facilitate that transition if needed.

3. How can a facility find out which Case Manager is assigned?

- a) To find out if a Molina 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:

Phone: 800-526-8196 Ext 127604

Fax: 562-499-6105

Email: MHCCaseManagement@MolinaHealthcare.com

Our staff will determine whether a Case Manager is already assigned, and if so, connect you with that person or provide her contact information to you. If not, the regional supervisor will be notified so that an assignment can be made.

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

- a) The assigned Case Manager will be your contact and can assist you in coordinating care for the member. Please note that they 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?

- a) Please contact the Case Manager for questions related to the HRA, care plan, or issues related to the member making a transition back to the community. Please notify the SNF Specialist RN as soon as possible for the following situations:
 - There is a change in the member's physical or mental health and/or has a change in the level of care needed
 - Member goes to the ER or is admitted to the hospital
 - The member moves or dies
 - Bed holds

The SNF Specialist RN will ensure that the authorizations are updated or new authorizations created to address the member's current level of care. The SNF Specialist RN will notify the Case Manager and collaborate with her as needed.

Please note that the Case Manager 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.

Health Risk Assessment

1. When/how will the HRA be conducted?

- a) The regulations state that members residing in a long-term care facility be assessed face-to-face within 90 days of enrollment into Cal MediConnect.

2. What does the HRA entail?

- a) The HRA is a bio/medical/psycho/social/functional assessment. The Case Manager will interview the member and/or the member's representative as well as seek information from the member's facility records (MDS, H&P, and nursing notes) in order to gather information about the member's clinical history, behavioral health status, sensory and I/ADL deficits, cultural/linguistic needs, etc. The survey tool Molina uses has been approved by the state and CMS.

3. Once the HRA is complete, how often will the Case Manager be onsite or be in contact the facility?

- a) The HRA results will indicate the frequency and intensity of case management services. Members who are stable will receive at least quarterly follow up by phone. We anticipate that this will be the case for the majority of the long-term care members.

Members who are not stable may require more frequent contact, by phone and/or in person. This would include members who recently transitioned from a skilled level of care to custodial or a member with recent or frequent admission to an acute setting.

For 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?

- a) 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. Regional Center, California Community Transitions Project).

Care plans are required to be member-centric, so whenever possible, it will be discussed with and agreed-upon by the member and/or his/her designated representative.

We anticipate that for stable custodial members, the Molina care plan will primarily reflect the same elements that the facility has in their care plan.

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. Place a copy of the Molina care plan in the member's medical record.

2. *What if the Molina Care Plan contradicts with the facility care plan?*

- a) Please contact the Case Manager to discuss. If needed, contact the Case Management supervisor or request an Interdisciplinary Care Team meeting.

3. *What is the Interdisciplinary Care Team (ICT)?*

- a) The ICT is a group of key people involved in the care of the member, including but not limited to the member and his/her representative, the primary physician and the Case Manager. As needed, or by member request, additional members might include caregiver(s), family, specialty providers, social worker, nurse, dietitian, physical therapist, etc.

ICT meetings can be formal or informal. Facility staff may be contacted by the Molina Case Manager or Medical Director to participate in an ICT meeting on either an ad hoc basis (consultative) or invited to a planned meeting. If appropriate, please invite the Molina Case Manager to any case conferences or other meetings held at the facility to discuss our mutual members.

Delegation of SNF & Custodial Care

1. Do IPA Members automatically remain with IPA during CCI Transition?

- a) Molina, upon receipt of State files will use established processes to appropriately assign members to Medical Groups/IPAs. Medical Groups/IPAs receive monthly e-lists (enrollment files) for the MMP program from Molina and also ad-hoc communication if there are enrollment changes throughout the month.

2. Which Medical Groups/Independent Physician Associations (IPAs) has Molina delegated for Custodial and Skilled Nursing Facility Services? Do these applicable delegated groups have risk for both professional or facility services?

- a) Heritage Provider Network is the only contracted Molina provider that has both professional and facility risk for “skilled” services. Heritage does not have risk for “custodial” care, this is Molina’s responsibility. For all other Molina network Medical Groups/IPAs, the risk for both skilled and custodial care remain Molina’s responsibility.

For Molina members in your facilities that are assigned to Heritage Provider Network only, you will need to contact Heritage Provider Network and follow their prior authorization guidelines for skilled services only. For members in your facilities that are receiving custodial care, please follow Molina’s prior authorization guidelines. Please note, once a Heritage Provider Network assigned members goes to custodial care, Molina will be disenrolling this member from Heritage Provider Network and assigning them to a Molina specific provider to ensure appropriate follow-up, coordination and continuity of medical care. Custodial care is not delegated to Heritage or any other Molina contracted Medical Group and/or IPA; it is strictly Molina’s responsibility.

For all other Molina members (non-Heritage Provider Network members), please follow Molina’s prior authorization guidelines for skilled and custodial care services (please refer to initial SNF FAQ. It can be accessed at www.molinahealthcare.com/providers/ca/duals/manual/Pages/provd.aspx).

Again, Molina does not delegate custodial care or payment of custodial services to any Medical Group/IPA, including Heritage Provider Network. Please follow Molina’s prior authorization guidelines - face sheet, H&P and authorization are needed. Molina requires submission of Medi-Cal Long-Term Care Facility Admission and Discharge Notification MC171 but not PASAR.

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

- a) Please note, Molina does not delegate custodial care or payment of custodial services to any Medical Group/IPA, including Heritage Provider Network. Please follow Molina’s prior authorization guidelines (refer to initial SNF FAQ and public website for prior authorization documents and form).

4. How is Molina addressing SNF concerns and preparing delegated entities with CCI?

- a) Heritage Provider Network is a limited Knox-Keene licensed organization. This is the only provider to whom risk is being delegated and the risk that Molina has delegated to Heritage Provider Network is for skilled services only. Molina did not delegate custodial care to Heritage Provider Network.

Molina has been working closely with Heritage Provider Network in preparation for CCI and will continue to do so over the coming months to ensure the concerns raised by SNF facilities are being addressed and that all applicable entities are providing members the right care, in the right time, at the right setting.

For all of our other Medical Groups/IPAs, Molina did not delegate skilled services or custodial care. The risk remains with Molina and Molina is responsible for the authorization, case management and claims payment processes. Molina, however, has also been working closely with these partners to educate them on CCI, applicable Policies and Procedures (including continuity of care) and Health Plan expectations.

5. Will GeriNet be expanding to cover all SNFs in the IE?

- a) At this time for Riverside, San Bernardino, Los Angeles and San Diego counties, Molina will work with each facility to negotiate/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.

6. Is separate authorization required for a bed hold and another one for when the patient returns from bed hold?

- a) Separate authorization is needed for a bed hold but when patient returns to the facility, they return to the previous authorization number that was given to facility.

7. If the patient is authorized for SNF care and goes on hospice, who requests the hospice authorization? Hospice provider or SNF?

- a) Hospice provider is responsible for submitting and obtaining authorization.

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

- a) 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 the providers that are currently rounding at the facilities 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 and San Diego 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. Please refer to the attached *Provider Quick Reference Guide* to identify regional contracting team member information.

9. What training is available on authorization procedures?

- a) Molina staff is available to provide orientations and trainings to all contracted facilities. Please refer to the attached *Provider Quick Reference Guide* and reach out to applicable county provider services representatives to coordinate additional on-site in servicing.

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

- a) Yes. Please call our Director of UM Concurrent Review, Leslie Fonseca at 888-562-5442, Ext. 121586 and she can help to coordinate.

11. What is Heritage Provider Network's contact information?

- a) Please see attached Heritage Provider Network quick reference guide by group and department.

Molina Healthcare/Molina Medicare of California
Prior Authorization/Pre-Service Review Guide
Effective: 01/01/2014

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare/Molina Medicare Members.

Referrals to Network Specialists do not require Prior Authorization
 Office visits to contracted (par) providers do not require Prior Authorization

Authorization required for services listed below.
Pre-Service Review is required for elective services.
Only covered services are eligible for reimbursement

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| <ul style="list-style-type: none"> • Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services: Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), Electroconvulsive Therapy (ECT). <ul style="list-style-type: none"> ○ Non MD/APRN BH Outpatient Visits & Community Based Outpatient programming: After initial evaluation for outpatient and home settings. ○ Medicare does not require authorization for outpatient behavioral health services. • Chiropractic Services • Cosmetic, Plastic and Reconstructive Procedures (in any setting): which <u>are not usually covered</u> benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation, dermabrasion, Botox injections, etc. • Dental General Anesthesia: >7 years old or per state benefit (Not a Medicare covered benefit). • Dialysis: Notification only. • Durable Medical Equipment: Refer to Molina's website for specific codes that require authorization. <ul style="list-style-type: none"> ○ Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462. • 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. • Home Healthcare: After 3 skilled nursing visits. • Home Infusion • Hospice & Palliative Care: Notification only. • Imaging: CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, Intimal Media Thickness Testing, Three Dimensional (3D) Imaging. • Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice (Hospice requires notification only). • Long Term Services and Supports: (per state benefit) e.g., Personal Attendant Services (PAS), Personal Care Services, Day Adult Health Services (DAHS). Not a Medicare covered benefit. • Neuropsychological and Psychological Testing and Therapy • Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stays except for: <ul style="list-style-type: none"> ○ Emergency Department services ○ Professional fees associated with ER visit, approved Ambulatory Surgery Center (ASC) or inpatient stay ○ Women's Health, Family Planning and Obstetrical Services ○ Child and Adolescent Health Center Services ○ Local Health Department (LHD) services ○ Other services based on state requirements | <ul style="list-style-type: none"> • Nutritional Supplements & Enteral Formulas. • Occupational Therapy: After initial evaluation for outpatient and home settings • Office-Based Surgical Procedures do not require authorization except for Podiatry Surgical Procedures (excluding routine foot care) • Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures: Refer to Molina's website for specific codes that are EXCLUDED from authorization requirements. • Pain Management Procedures: including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (Acupuncture is not a Medicare covered benefit). • Physical Therapy: After initial evaluation for outpatient and home settings. • Pregnancy and Delivery: Notification only. • Prosthetics/Orthotics: Refer to Molina's website for specific codes that require authorization. Includes but not limited to: <ul style="list-style-type: none"> ○ Orthopedic footwear/orthotics/foot inserts ○ Customized orthotics, prosthetics, braces • Rehabilitation Services: Including Cardiac, Pulmonary, and Comprehensive Outpatient Rehab Facility (CORF). CORF Services for Medicare only. • Sleep Studies. • Specialty Pharmacy drugs (oral and injectable) used to treat the following disease states, but not limited to: Anemia, Crohn's/Ulcerative Colitis, Cystic Fibrosis, Growth Hormone Deficiency, Hemophilia, Hepatitis C, Immune Deficiencies, Multiple Sclerosis, Oncology, Psoriasis, Pulmonary Hypertension, Rheumatoid Arthritis, and RSV prophylaxis: Refer to Molina's website for specific codes that require authorization. • Speech Therapy: After initial evaluation for outpatient and home settings. • Transplant Evaluation and Services including Solid Organ and Bone Marrow (Cornea transplant does not require authorization). • Transportation: non-emergent ambulance (ground and air). • Unlisted and Miscellaneous 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. • Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy. |
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***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 claim. (Medicaid benefit only)**

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE/MOLINA MEDICARE

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 the enrollee's 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 and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition.
- Providers 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 800 526-8196

Important Molina Healthcare/Molina Medicare Contact Information

Medical Prior Authorizations: 8:00 a.m. – 5:00 p.m.

Phone: 888-665-4621 Fax: 800-811-4804

Radiology Authorizations:

Phone: 855-714-2415 Fax: 877-731-7218

NICU Authorizations:

Phone: 855-714-2415 Fax: 877-731-7218

Medical Pharmacy Authorizations:

Phone: 888-665-4621 Fax: 866-508-6445

Medicare Pharmacy Authorizations:

Phone: 888-665-1328 Fax: 866-290-1309

Transplant Authorizations:

Phone: 855-714-2415 Fax: 877-731-7218

Medical Member Customer Service

Benefits/Eligibility:

Phone: 888-665-4621 Fax: 310-507-6168

TTY/TDD: 711

Medicare Member Customer Service

Phone: 800-665-0898 TTY/TDD: 711

Molina Dual Options Cal MediConnect Member Customer Service

Phone: 855-665-4627 TTY/TDD: 711

Provider Customer Service: 8:00 a.m. – 5:00 p.m.

Phone: 888 665-4621 Fax: 562 901-9632

24 Hour Nurse Advice Line

English: 888-275-8750 TTY: 866-735-2929

Spanish: 866-648-3537 TTY: 866-833-4703

Medical Vision:

Phone: 888-493-4070

Medicare Vision:

Phone: 800-327-4462

Medical Dental:

Phone: 800-423-0507

Medicare Dental:

Phone: 855-214-6779

Medicare Non-emergent Transportation:

Phone: 866-475-5423

Fax: 888 589-6164

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com

Available features include:

- Authorization submission and status
- Claims submission and status (EDI only)
- Download Frequently used forms
- Member Eligibility
- Provider Directory
- Nurse Advice Line Report

Molina Healthcare of California – Medicaid/Medicare Prior Authorization Request Form

Medical Fax Number: 800-811-4804

Medicare Fax Number: 866-472-0596

Radiology Fax Number: 877-731-7218

MEMBER INFORMATION			
Plan:	<input type="checkbox"/> Molina Medicaid	<input type="checkbox"/> Molina Medicare	<input type="checkbox"/> Other:
Member Name:		DOB:	/ /
Member ID#:		Phone:	() -
Service Type:	<input type="checkbox"/> Elective/Routine	<input type="checkbox"/> Expedited/Urgent*	

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Referral/Service Type Requested			
Inpatient <input type="checkbox"/> Surgical procedures <input type="checkbox"/> ER Admits <input type="checkbox"/> SNF <input type="checkbox"/> Rehab <input type="checkbox"/> LTAC	Outpatient <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Diagnostic Procedure <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: </div> <div> <input type="checkbox"/> Rehab (PT, OT, & ST) <input type="checkbox"/> Chiropractic <input type="checkbox"/> Infusion Therapy </div> </div>		<input type="checkbox"/> Home Health <input type="checkbox"/> DME <input type="checkbox"/> In Office
Diagnosis Code & Description:			
CPT/HCPC Code & Description:			
Number of visits requested:		Date(s) of Service:	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:			
Facility Providing Service:			
Contact at Requesting Provider's office:			
Phone Number:	() -	Fax Number:	() -

For Molina Use Only:



Molina Healthcare of California

UM Contact List



Main Phone: (888) 562-5442

FAX RESOURCES		
Admission Face Sheets	877-708-2110	
Medi-Cal Clinical Reviews	866-553-9263	
Medicare Clinical Reviews	866-472-0596	
SNF SPECIALIST RN MEDI-CAL RESOURCES	REPRESENTATIVE	EXTENSION
LOS ANGELES	Jon Mark Ventura, RN <i>Molina SNF RN</i>	EXT. 117660
	Jody McLeish, RN <i>Supervisor</i>	EXT. 121231
INLAND EMPIRE	Jon Mark Ventura, RN <i>Molina SNF RN</i>	EXT. 117660
	Michele Ruffalo, RN <i>Supervisor</i>	EXT. 127575
SAN DIEGO	Nancy Spillane, RN <i>Molina SNF RN</i>	562-822-5202
	Michelle Norman, RN <i>Supervisor</i>	EXT. 121747
SNF SPECIALIST RN MEDICARE RESOURCES	REPRESENTATIVE	EXTENSION
LA AND IE	Tonya Zwirz, RN <i>Molina SNF CRC</i>	EXT. 127727
	Kelly Frost, RN <i>Supervisor</i>	EXT. 117816
SAN DIEGO	Lisa White, RN <i>Molina SNF CRC</i>	EXT. 127550
	Kelly Frost, RN <i>Supervisor</i>	EXT. 117816
Molina UM Manager	Leslie Fonseca, RN	EXT. 121586
After hours, weekends and holidays call: 855-322-4075		



Molina Healthcare of California

Case Management Contact List



Main Phone: (888) 562-5442

REGION	REPRESENTATIVE	EXTENSION
IMPERIAL	Larynda Jones <i>Supervisor</i>	EXT. 121596
LOS ANGELES	Blanca Martinez <i>Supervisor</i>	EXT. 127353
	Linda Blades <i>Supervisor</i>	EXT. 127302
RIVERSIDE	Betsy Roberts <i>Supervisor</i>	EXT. 127080
SACRAMENTO	Larynda Jones <i>Supervisor - Interim</i>	EXT. 121596
SAN BERNARDINO	Betsy Roberts <i>Supervisor</i>	EXT. 127080
SAN DIEGO	Larynda Jones <i>Supervisor</i>	EXT. 121596
	Elizabeth Whitteker <i>Supervisor</i>	EXT. 121725
	Colleen Schuster <i>Supervisor</i>	EXT. 121353
TRANSITIONS OF CARE <i>(All Counties)</i>	Blanca Martinez <i>Supervisor - Interim</i>	EXT. 127353
ALL	Jennifer Rasmussen <i>Director</i>	EXT. 127884



Molina Healthcare of California

Your Provider Services Team



Provider Quick Reference Guide | IMPORTANT NUMBERS

REGION	REPRESENTATIVE	EXTENSION
LOS ANGELES 200 Oceangate, Suite 100 Long Beach, CA 90802 (562) 499-6191 Fax: (562) 951-1529	Sandra Rascon <i>Manager</i>	EXT. 127685
	Elizabeth Bishop <i>Representative</i>	EXT. 122233
	Mylene Tabing <i>Representative</i>	EXT. 121934
	Lorena Guerra <i>Representative</i>	EXT. 120104
	Louise Salter <i>Representative</i>	EXT. 127690
RIVERSIDE/SAN BERNARDINO 887 E. 2 nd St., Suite B Pomona, CA 91766 (800) 232-9998 Fax: (909) 868-1761	Sue Roth <i>Supervisor</i>	EXT. 128010
	Lori Cadle <i>Representative</i>	EXT. 128007
	Janina Hidalgo <i>Representative</i>	EXT. 127709
	Candice Reed <i>Representative</i>	EXT. 126556
SAN DIEGO 9275 Sky Park Court, Suite 400 San Diego, CA 92123 (858) 614-1580 Fax: (858) 503-1210	Cindy Meacock <i>Supervisor</i>	EXT. 121587
	Vidiana Cervantes <i>Representative</i>	EXT. 120098
	Sonya Martinez <i>Representative</i>	EXT. 121588
	Jaclynn Thompson <i>Representative</i>	EXT. 126236
	Taide Villa <i>Representative</i>	EXT. 126225



Molina Healthcare of California

Your Provider Contracting Team



Provider Quick Reference Guide | IMPORTANT NUMBERS

REGION	REPRESENTATIVE	EXTENSION
LOS ANGELES 200 Oceangate, Suite 100 Long Beach, CA 90802 (562) 499-6191 Fax: (562) 951-1529	Nicole Vanderploeg <i>Supervisor, Provider Contracting</i>	EXT. 127573
	Jessica Frausto <i>Supervisor, Provider Contracting</i>	EXT. 119865
	Henry Cuevas <i>Provider Contract Specialist</i>	EXT. 111525
	Jamee Donaldson <i>Provider Contract Specialist</i>	EXT. 127676
	Patrice Washington <i>Provider Contract Specialist</i>	EXT. 127534
RIVERSIDE / SAN BERNARDINO 887 E. 2 nd St., Suite B Pomona, CA 91766 (800) 232-9998 Fax: (909) 868-1761	Roberta De La Fuente <i>Provider Contract Specialist</i>	EXT. 128027
	Regina Stanton <i>Provider Contract Specialist</i>	EXT. 124606
	Shree Browne <i>Provider Contract Specialist</i>	EXT. 126529
	Christina Rojas <i>Provider Contract Specialist</i>	EXT. 127266
SAN DIEGO 9275 Sky Park Court, Suite 400 San Diego, CA 92123 (858) 614-1580 Fax: (858) 503-1210	Adriana Cuellar <i>Provider Contract Specialist</i>	EXT. 121589



Molina Healthcare of California

Pharmacy Contact Information



Phone Number	Fax	Direct Extension
(800) 526-8196 <ul style="list-style-type: none">✓ <i>Option 3 - Providers</i>✓ <i>Option 2 - Pharmacy</i>✓ <i>Option 2 - Pharmacy Prior Authorization</i>	(866) 508-6445	x751130