Molina Healthcare of California

Intermediate Care Facilities for Individuals with Developmental Disabilities Provider Toolkit

March 2024

MolinaHealthcare.com

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Utilization Management

Treatment Authorization Requests

Molina has loaded all Medi-Cal Treatment Authorization Request (TAR) data provided by the Department of Health Care Services (DHCS) to create an authorization in its internal system for the duration of the existing TAR.

1. Is MHC honoring current TARs until they expire?

Yes, MHC will honor existing TARs. Based on the TAR data received, TARs will extend to DHCS end date.

2. Do facilities need to add extra zeros to existing TAR numbers?

No, this is not needed. No additional zeros need to be added to existing TAR numbers.

3. Do facilities need a new TAR number from MHC before they can bill?

MHC is honoring existing DHCS-approved TARs through the Continuity of Care (CoC) process for members who enroll with Molina. Facilities must submit their existing TARs to Molina to request CoC for residents. Facilities must request a new authorization from MHC 30 to 60 days before the Molina issued Continuity of Care expiration date.

4. Thirty days have passed since submitting a TAR and CoC, and I have not received a Molina authorization number. How can I follow up to expedite my request?

Please reach out to the Long-Term Services & Supports (LTSS) liaison or provider services representative for inquiries regarding authorization status. For further instructions, please refer to page 35 of the 2024 Medi-Cal Managed Care Plan (MCP) Transition Policy Guide.

5. How is MHC completing Primary Care Provider (PCP) assignments?

ICFs are encouraged and have been advised to provide Molina with the attending physician so the Molina Contracting department can attempt to contract with them. Duals members are not assigned a PCP for their Medi-Cal coverage, and therefore, should continue seeing their Medicare provider.

Continuity of Care

Molina is responsible for all other approved authorization requests for services in an Intermediate Care Facility for Developmentally Disabled (ICF/DD) Home, exclusive of the ICF/DD Home per diem rate, for a period of 90 days after enrollment with Molina, or until Molina can reassess the member and authorize and connect the member to medically necessary services.

1. What is the difference between Prior Authorization (PA) and CoC?

CoC is a request to continue existing services that were previously approved by DHCS, with a provider who is not contracted with Molina. with a non-contracted provider. It does not necessarily require clinical review and must meet specific requirements in accordance with DHCS CoC Policy and the Health and Safety code.

PA is a new request to initiate services and treatment for members who were not previously living in an ICF. These requests are subject to medical necessity reviews and clinical determinations.

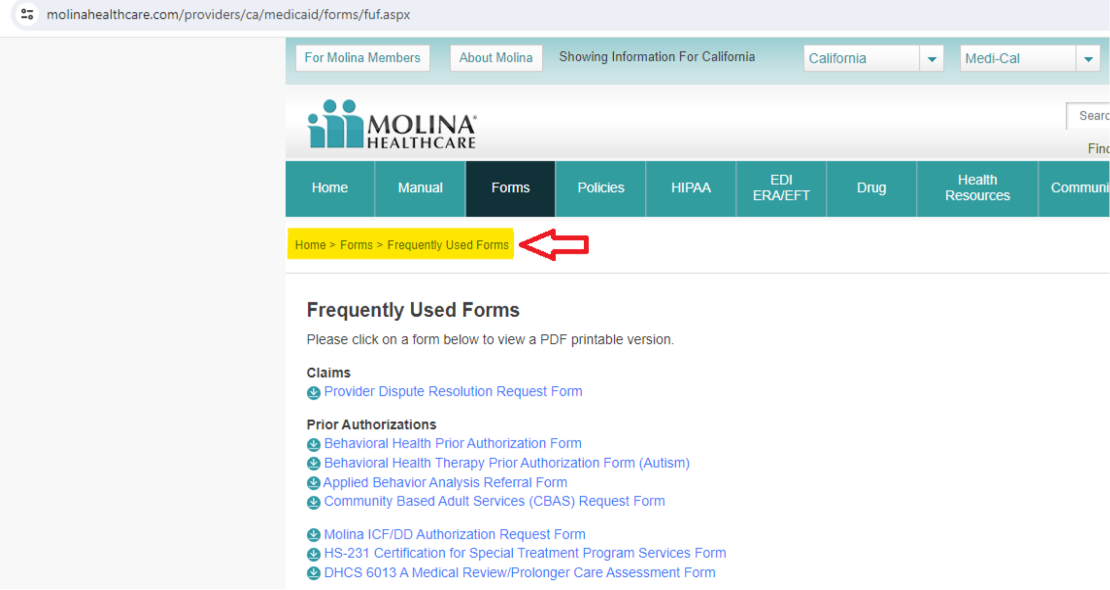
2. Will Molina accept our Medi-Cal TARs?

Where Molina has received TAR data from DHCS or the ICF, including rendering provider information, the TAR will be honored under CoC, which includes Durable Medical Equipment (DME) and medical supplies. However, not all TAR data was provided to the health plan. To ensure Molina has all of your member's TARs, please submit your TARs or other approval information found on the MHC CoC webpage via Excel spreadsheet to: mhccasemanagementcoc@molinahealthcare.com and CALTSS@MolinaHealthCare.Com.

3. Where can I access the CoC and the Pre-Service Request Form?

The CoC and the Pre-Service Request Form can be found on the MHC Medi-Cal Frequently Used Forms webpage or through the links below:

- CoC Request Form
- Molina ICF/DD Authorization Request Form



4. When is a physician signature required on a PA request?

A physician signature is required for new authorization requests for ICF/DD services and for authorization renewals after expiration of existing TAR and Molina-issued CoC authorizations. The ICF/DD Facility/Home's attending physician must sign the authorization request and certify to the MCP that the Member requires this level of care. ICF/DD Facility/Homes may submit the physician's signature through fax, scanning, or as an attachment to the authorization request.

5. **Can members continue seeing the same specialists or doctors if those providers are not contracted with MHC?**

If the member has received services from a non-contracted specialist within the past year, the specialist will need to complete the CoC Request Form and submit it to MHC in order to continue serving the member.

6. **How long does it take MHC to review CoC criteria?**

Per APL 21-011 and APL 23-022 timeframes are as follows:

	Calendar Days
Non-urgent/Routine	30
Immediate	15
Urgent (Risk of Harm)	3

7. **How is Molina ensuring CoC for ICF/DD Home Placement requests?**

While members should meet medical necessity criteria for ICF/DD services, continuity of care protection is automatic. Members currently residing in an ICF/DD Home do not have to request continuity of care to continue to reside in the ICF/DD Home.

For ICF/DD services, for new ICF-DD placements, medical necessity is determined by documentation reflecting current care needs and recipient's prognosis by the Regional Center. If documentation is lacking, Molina will request additional supporting documents to substantiate medical necessity.

8. **What happens if a facility is out of network with Molina?**

If a facility is not contracted with Molina, upon receipt of notice, Molina will engage the facility to execute a full contract or a global letter of agreement at the standard Medi-Cal rates as appropriate.

9. **Does a facility need a Contract or Letter of Agreement to receive payment for services?**

Yes, facilities must have a Contract or Letter of Agreement as well as authorization or DHCS TAR for the services for which the facility is requesting payment.

Prior Authorization

1. **Is a new authorization request required if a member is discharged from our care but returns to the facility after discharge?**

Yes. Per page 15 of APL 23-023, in instances where the member is being discharged from or transferred out of an ICF/DD Home, the new ICF/DD Home must submit an updated authorization request that includes the changed dates of service. Please refer to below timeframes as to when to expect a response from MHC.

PA Type	Timeline

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

2. What documents are needed for re-authorization?

Per page 15 of APL 23-023, ICF/DD Homes must submit the form HS 231 to MHC with any initial or reauthorization requests. MHC will accept the certification for HS 231 as evidence of the Regional Center's determination that the member meets the ICF/DD Home level of care. Whenever a reauthorization of ICF/DD-N Home services is requested, the ICF/DD-N Home must submit a copy of the member's Individual Service Plan (ISP). ISP submissions are required as part of the periodic review of ICF/DD-N Homes. In instances where the member is being discharged from or transferred out of an ICF/DD Home, the new ICF/DD Home must submit an updated authorization request that includes the changed dates of service.

3. Does MHC require the HS 231 on new authorizations?

Per APL 23-023, HS 231 is required as a prerequisite to providing coverage for ICF/DD services.

4. When can a facility submit a renewal authorization?

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

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

Facilities have 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 6 months to submit the TAR and the claim.

6. Will Molina retroactively authorize services and payment?

Yes. Molina will authorize services (and payment) retroactive to the date that the patient became effective with Molina. Dates of service older than 6 months from the claim will be denied. Please see the MHC Medi-Cal Provider Manual for timely filing requirements.

7. What forms need to be provided once an initial authorization has expired, or a member was admitted after 1/1/2024?

ICF/DD Homes will send the following as proof of Medical Necessity to the PA department at (800) 811-4804:

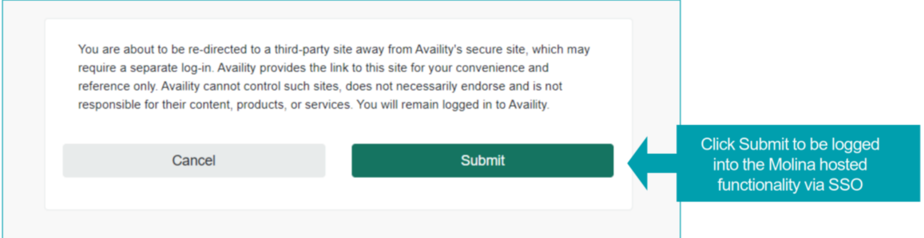
- HS 231
- DHCS 6013A
- MCP ICF/DD Authorization form
- ISP

Molina will notify the facility within 5 working days after notice of the new authorization number.

8. How do I submit for a new authorization once an initial authorization has expired, or a member was admitted after 1/1/2024?

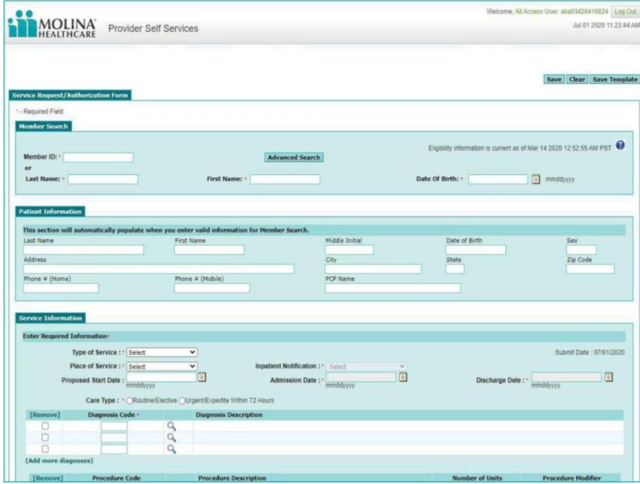
Authorization requests can be submitted utilizing the Molina portal at: https://provider.molinahealthcare.com/

Step 1:

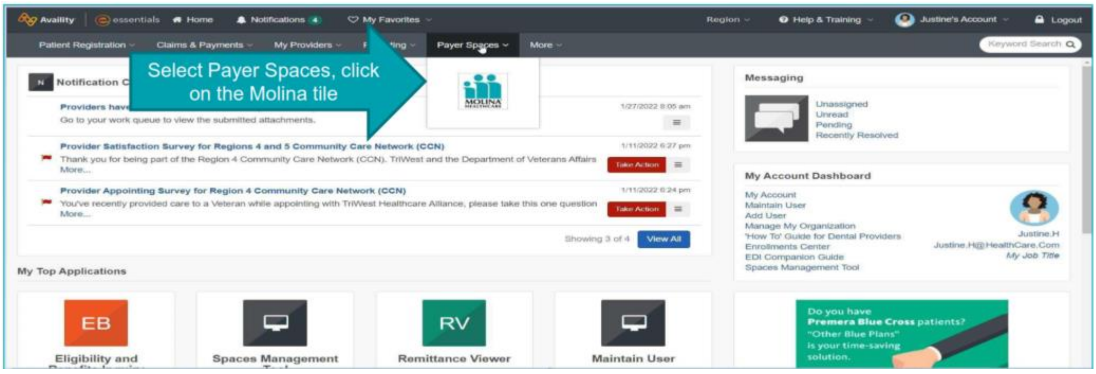


Step 2:

Complete form.

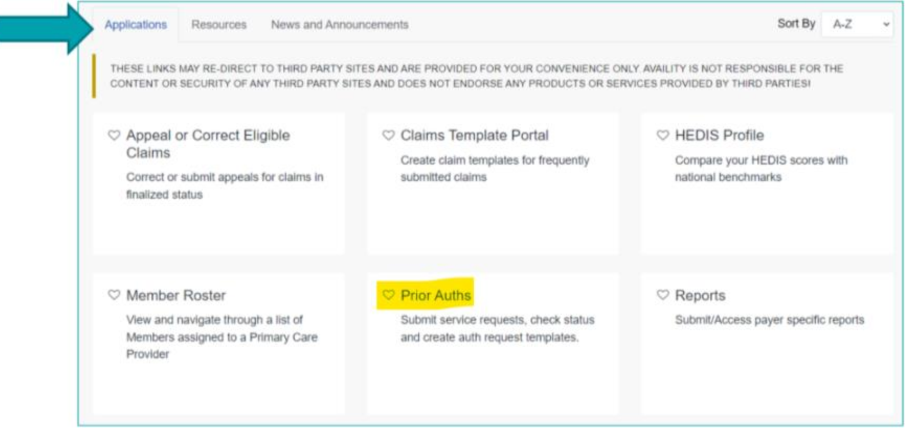


Step 3:



Step 4:

From Applications, select *Prior Auths*.



9. Are bed hold and leave of absence (LOA) authorizations requested separately?

Yes, a separate authorization is required for bed holds, due to the requirement to authorize up to a total of 7 calendar days per hospitalization and for coordination of care after a hospitalization, if needed. Please see below if an authorization is needed for a LOA.

10. Can members obtain LOA for family visits?

Per page 10 of APL 23-023 and the DHCS Medi-Cal Provider Manual, LOA may be granted for a visit with relatives or friends. Please refer to the DHCS Medi-Cal Provider Manual regarding the maximum period allowed. MHC does not require authorizations for LOAs. If members are leaving the facility on an LOA, please e-mail the MHC LTSS team at CALTSS@MolinaHealthCare.Com.

11. Is authorization required each time a member stays overnight with their family?

No authorization is needed for Leave of Absences for members residing in an ICF. If members are leaving the facility on an LOA, please e-mail the MHC LTSS team at CALTSS@MolinaHealthCare.Com. However, facilities must inform MHC when a member participates in a summer camp for the developmentally disabled due to the physician signature requirement. Furthermore, if a member is on an LOA and does not wish to return to the same ICF/DD Home following the LOA, MHC must be made aware in order to provide care coordination and transition support, including working with the assigned Regional Center, to assist the member in identifying another ICF/DD home within the MHC network that can serve the member. The Regional Center will arrange discharge and transition planning if the member wishes to transition to a non-Medi-Cal funded living situation with input from another stakeholder, such as the hospital, the original ICF/DD home, and MHC.

12. In 2023, we had 976 home visit days across 77 clients. Does MHC want an additional 900+ authorizations from us to bill $10 less each day?

MHC will not require authorization for a LOA. However, please see above for information regarding a member’s participation in a summer camp or if a member does not wish to return to the same ICF/DD Home.

13. Should I contact MHC first if my client needs to see a specialist?

If a specialist needs to be seen, refer to the Provider Online Directory. If additional assistance is needed in locating a provider after consulting the Provider Online Directory, please call (855) 322-4075. Please note, a request is only necessary if the specialist is non-contracted under the CoC.

14. According to APL 23-023, routine authorizations are subject to a turnaround time of five working days. Why does it take MHC 30 days to provide an authorization number?

If there are delays, please notify us of expedited needs by contacting the MHC LTSS team at CALTSS@MolinaHealthCare.Com.

15. What is the turnaround timeline for Prior Authorizations?

Per APL 21-011 and APL 23-022 timeframes are as follows:

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

16. What situations require immediate notification to Molina?

Please notify the Molina Care Review Clinician RN/LVN 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 relocates or passes away
- Bed holds

Provider Contracts

Letter of Agreement

1. How do I obtain a letter of agreement?

When a provider requests a PA or CoC, the Utilization Management (UM) team will determine whether a letter of agreement is necessary and initiate the request with the Molina Contracting team. The Contracting team will reach out to confirm rates and execute the agreement.

2. Are letters of agreement executed for each client?

A one-time letter of agreement with MHC is needed per entity. This letter of agreement will cover all MHC members receiving services at the associated ICF/DDs under the entity for 12 months.

3. When should I receive payment once I return my letter of agreement?

Providers may contact their Provider Relations Representative (PRR), and all questions and concerns will be triaged to the Claims and Contracting team.

4. If I have an established contract, will I receive an amended contract with the new revenue codes?

An amendment may be required. MHC Contract Manager will reach out to specific providers as necessary.

Full Contract

1. How do I obtain a Full Contract?

Providers may contact the MHC Contracting Department to discuss the necessary steps and documents to establish an Agreement. Contact information is listed below:

Provider Contracts	Contact Number	Email Address
Revelyn Soriano, Manager Provider Contracts (ICFDD)	562-491-4774	Revelyn.Soriano@molinahealthcare.com
Angelee Smith, Director Provider Contracts	562-542-1904	Angelee.Smith@molinahealthcare.com

Claims

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 1. 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:** **065X** – Intermediate Care – Level 1 **066X** – Intermediate Care – Level 2 <u>4th digit is based on the following:</u> 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 a Skilled Nursing Facility **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)

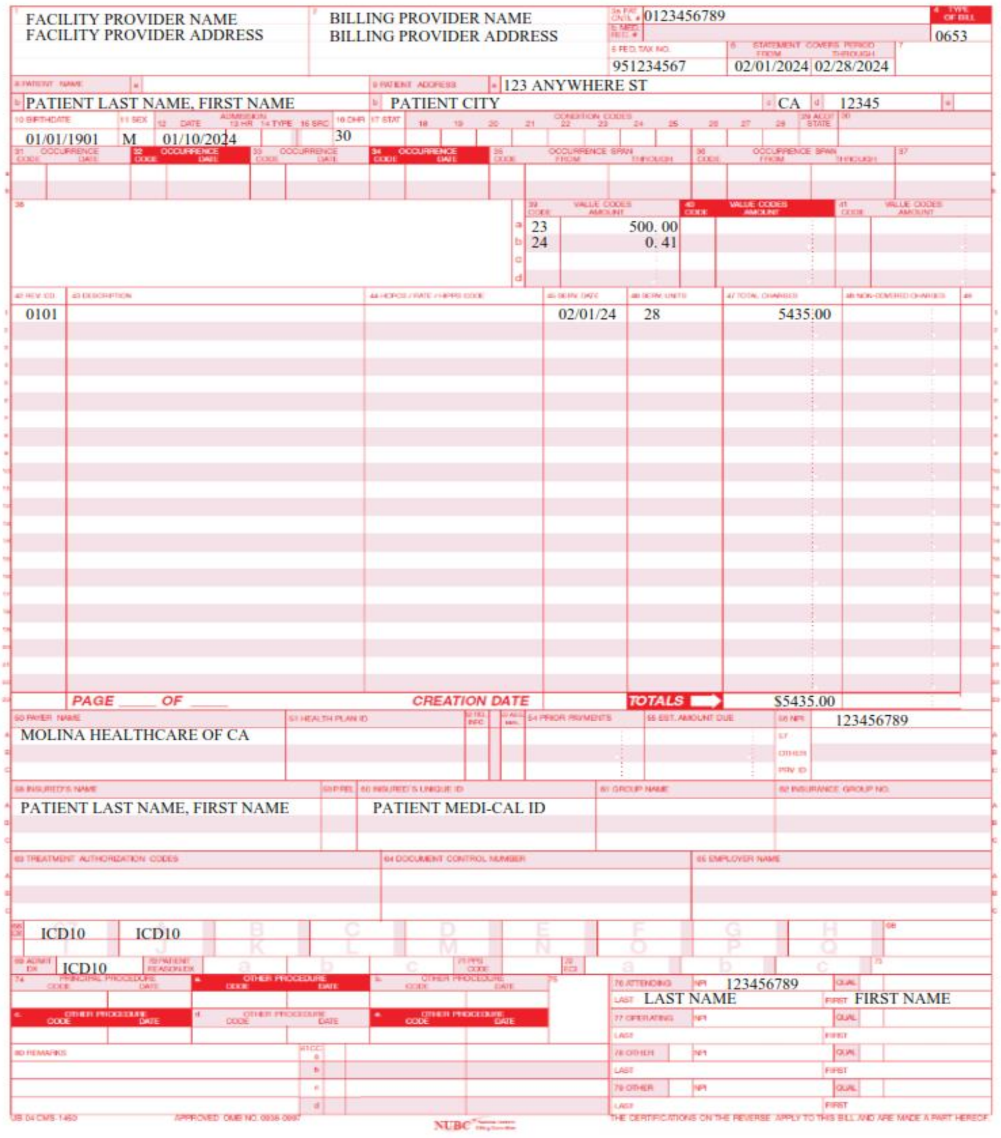
			63 – Discharged/transferred to a Long-Term Care Hospital (LTCH) **64** – Discharged/transferred to a Nursing Facility certified under Medicaid **65** – Discharged/transferred to a Psychiatric Hospital **66** – Discharged/transferred to a Critical Access Hospital (CAH) **70** – Discharged/transferred 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
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) Accommodation codes applicable to: **Revenue code 0101** (Effective for DOS on or after 2/1/24)

			Revenue code 0190 (DOS prior to 2/1/24) 41 – ICF/DD 1 to 59 Beds 42 – ICF/DD 60+ Beds 61 – ICF/DD-H 4 to 6 Beds 62 – ICF/DD -N 4 to 6 Beds 65 – ICF/DD-H 7 to 15 Beds 66 – ICF/DD-N 7 to 15 Beds **Revenue code 0180** 43 – ICF/DD 1 to 59 Beds 44 – ICF/DD 60+ Beds 63 – ICF/DD-H 4 to 6 Beds 64 – ICF/DD-N 4 to 6 Beds 68 – ICF/DD-H 7 to 15 Beds 69 – ICF/DD-N 7 to 15 Beds
42	Revenue code	Required	Enter the appropriate revenue code: **0101 – Room and Board** (Effective for DOS on or after 2/1/24) **0190 – Room and Board** (DOS prior to 2/1/24) **0180 – Leave of absence**
43	Revenue Description	Not Required	Enter the description of the revenue code used in box 42
44	HCPCS/Rate/HIPPS code	Not Required	
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?



FACILITY PROVIDER NAME
FACILITY PROVIDER ADDRESS

BILLING PROVIDER NAME
BILLING PROVIDER ADDRESS

3a PAT. CNTL # 0123456789

4 TYPE OF BILL 0653

5 FED. TAX NO. 951234567

6 STATEMENT COVERS PERIOD FROM 02/01/2024 THROUGH 02/28/2024

8 PATIENT NAME: PATIENT LAST NAME, FIRST NAME

9 PATIENT ADDRESS: 123 ANYWHERE ST, PATIENT CITY, CA 12345

10 BIRTHDATE 01/01/1901 | 11 SEX M | 12 ADMISSION DATE 01/10/2024 | 17 STAT 30

39 VALUE CODES: a 23 500.00; b 24 0.41

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0101			02/01/24	28	5435.00	
PAGE ___ OF ___		CREATION DATE	TOTALS		$5435.00	

50 PAYER NAME: MOLINA HEALTHCARE OF CA

56 NPI 123456789

58 INSURED'S NAME: PATIENT LAST NAME, FIRST NAME

60 INSURED'S UNIQUE ID: PATIENT MEDI-CAL ID

66 DX: ICD10 ICD10

69 ADMIT DX: ICD10

76 ATTENDING NPI 123456789 LAST NAME FIRST NAME

NUBC

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. What is the status of ICF/DD facilities' claims payment?

Claims are pending due to necessary provider and pricing updates. Claims were pending due to required provider updates needed in order to finalize claims. Providers have since been updated

and Molina has started processing payments and issuing checks. However, providers must be loaded in order to finalize claims.

6. As of today, have any ICF/DD facilities received payment for their claims?

While there were initial delays in claim payments due to provider load challenges, Molina has since started finalizing claims and issuing regular payments to submitting providers.

7. Why has MHC yet to respond to my claim?

We recognize that there have been delays in timely payment and authorization. The main issues are related to loading providers in our system and pricing claims appropriately. We are actively working on confirming and loading the providers in our systems to identify incoming claims while working through issues that arise from missing TIN and NPI data. Molina has started issuing regular payments.

8. Can I bill MHC with my approved Medi-Cal TAR number while I wait for my Molina authorization number?

Providers may bill MHC with a Medi-Cal TAR even if they do not yet have a Molina authorization number.

9. Which Patient Status Code is applicable for a home visit?

Code 30 would be appropriate for a home visit.

10. What are the accommodation codes for ICF/DD Homes?

The table below includes the 2024 accommodation codes. For further details, please refer to the DHCS ICF Reimbursement Rates webpage.

Facility Type	Regular Accommodation Code	Total Reimbursement Per Diem	Bed Hold Accommodation Code	Total Bed Hold Reimbursement Per Diem
ICF/DD 1-59 Beds	41	$369.73	43	$360.21
ICF/DD 60+ Beds	41	$421.42	43	$411.90
ICF/DD-H 4-6 Beds	61	$363.12	63	$353.60
ICF/DD-H 7-15 Beds	65	$378.14	68	$368.62
ICF/DD-N 4-6 Beds	62	$394.48	64	$384.96
ICF/DD-N 7-15 Beds	66	$445.65	69	$436.13

11. Are there any billing changes related to the Accommodation Code Sets from 1/1/24 to 1/31/24 and from 2/1/24 onwards?

For more information, please review page 19 of the ICF/DD Process Review PowerPoint.

12. Will an LOA impact claim submission?

Claims will be paid according to the currently published Medi-Cal rates for non-participating providers, regardless of the LOA.

13. Is it possible to define the bill types on this form as N or H?

Providers would need to determine the level of service that is being provided. DHCS provides billing guidance in the Medi-Cal Provider Manual.

14. Where can I find information regarding type of bill level I & II?

Providers would need to determine the level of service that is being provided. DHCS provides billing guidance in the Medi-Cal Provider Manual.

15. Do I need to respond to the Admission questions?

Admission fields are NOT required for ICF/DD Home providers.

16. How do I set up electronic billing?

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

17. Does Molina pay for EDI clearinghouses?

Change Healthcare is an outside vendor that is 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 get processed faster than paper claims.

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

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

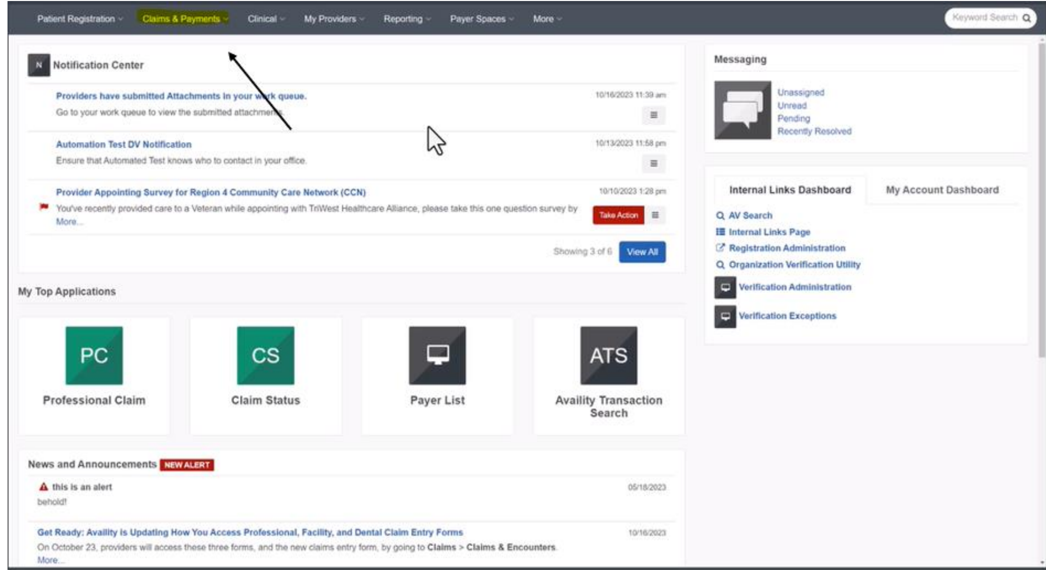
18. How do I contact the MHC Claims department?

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

Availity Facility Claim Submissions

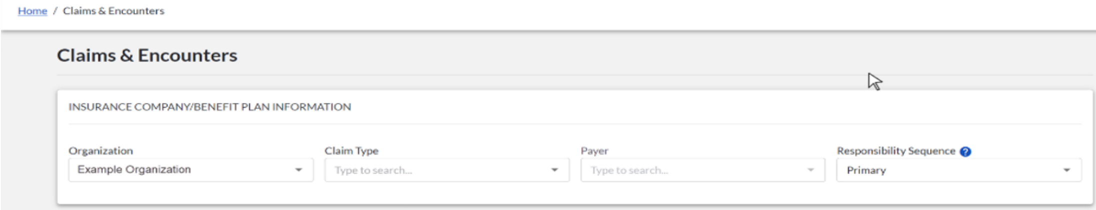
Below is a step-by-step walkthrough of the claim submission process through the Availity Provider Portal.

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

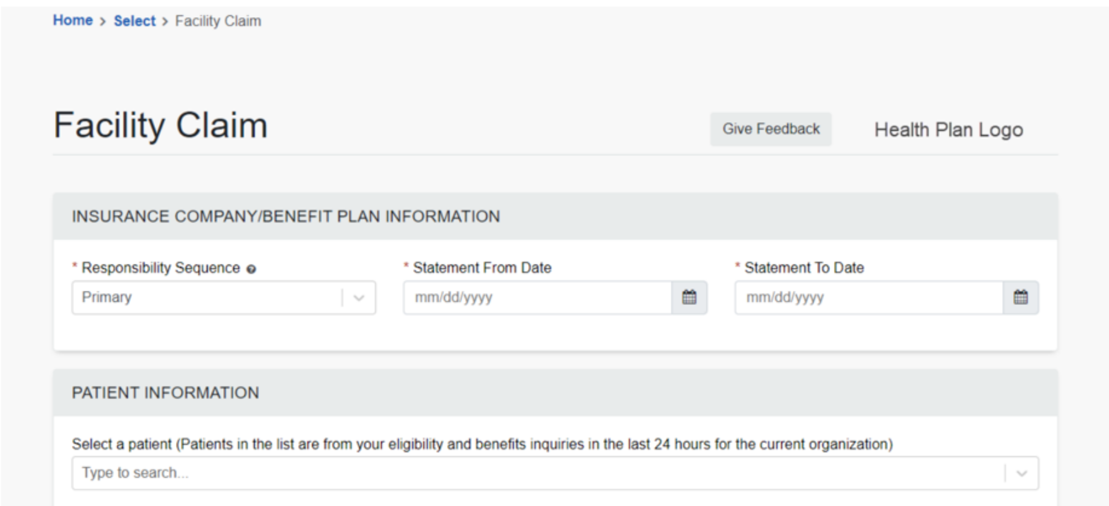


2. Select Claims & Encounters

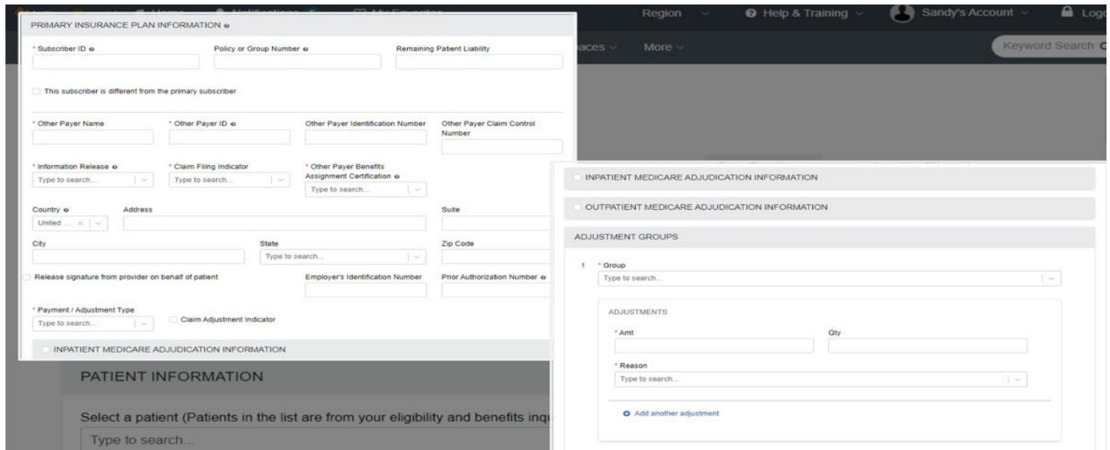
3. To begin the claim submission, you will need to select the organization to which you will be submitting the claim. You will also need to select the Claim type and Payer.



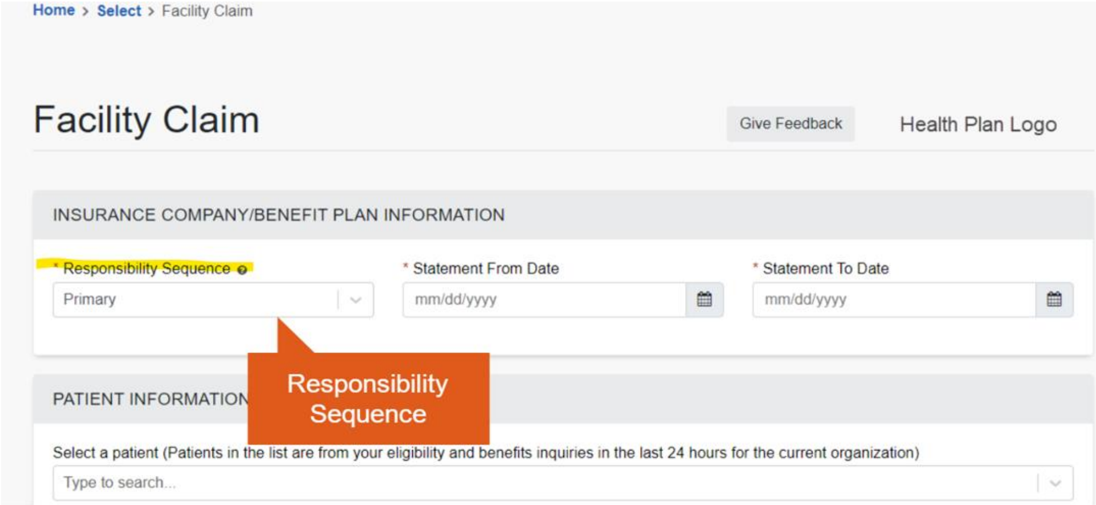
4. In the first section, select the responsibility sequence: primary, secondary, or tertiary.



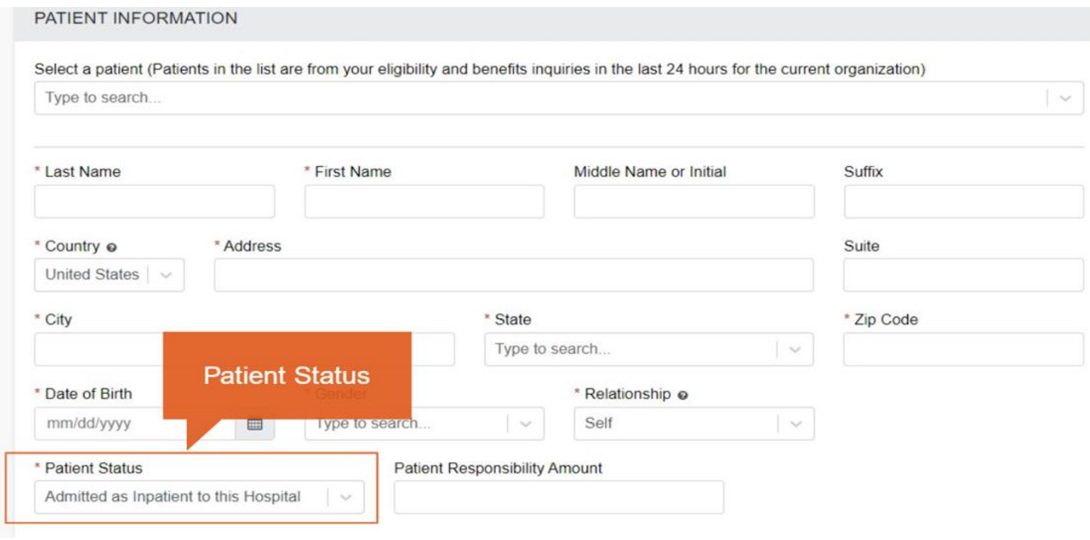
5. If you select secondary or tertiary, additional fields will be displayed on the form for you to enter the COB information.



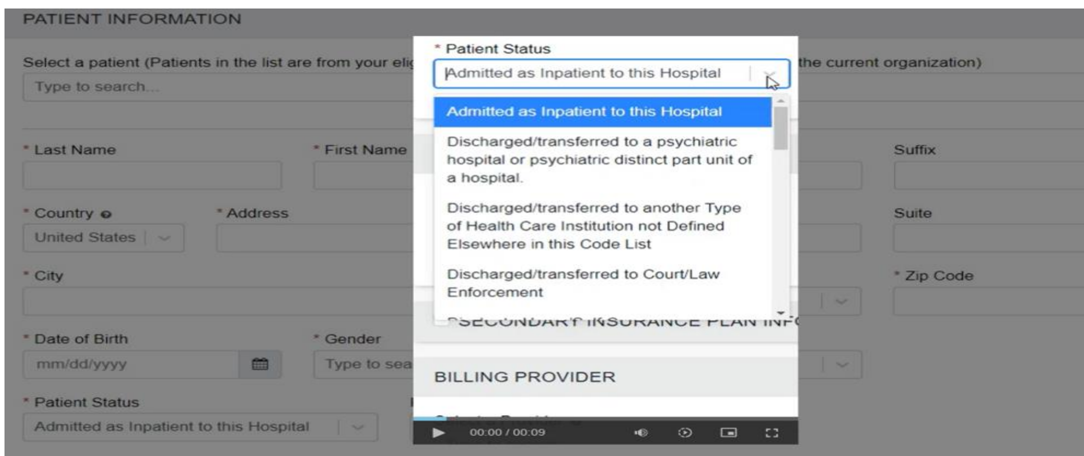
6. In the patient information section, you can manually enter the patient's information. If you have checked eligibility for the member in the last 24 hours, you can select it from the drop-down menu.



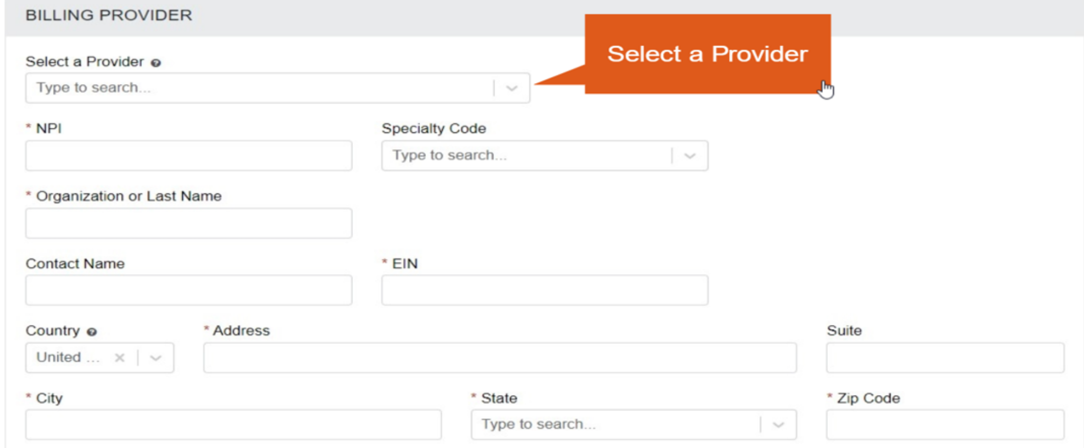
7. For most payors, the patient status field defaults to Admitted as an Inpatient to this Hospital.



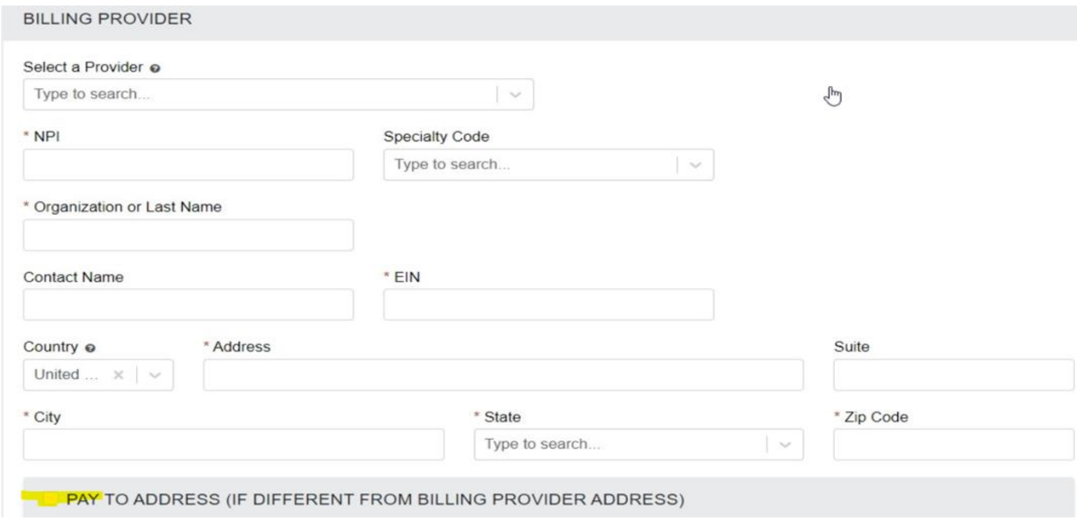
8. You can select another option in the field if applicable.



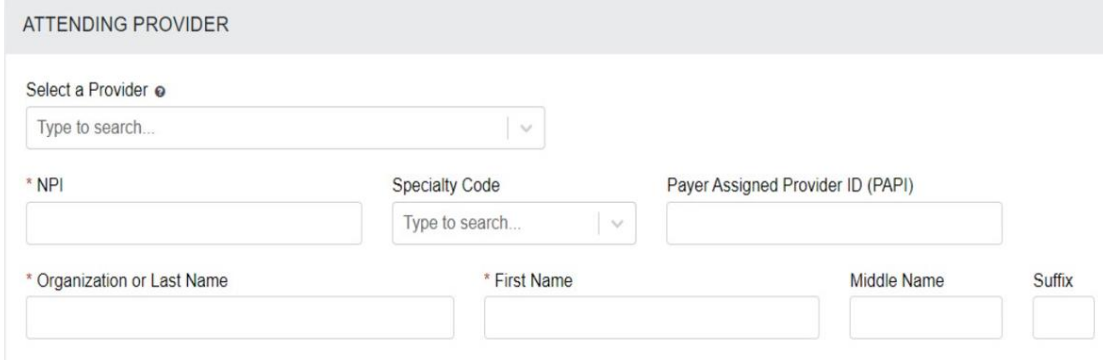
9. In the BILLING PROVIDER section, you can manually enter the required field or select a provider from your organization's provider express entry setup.



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

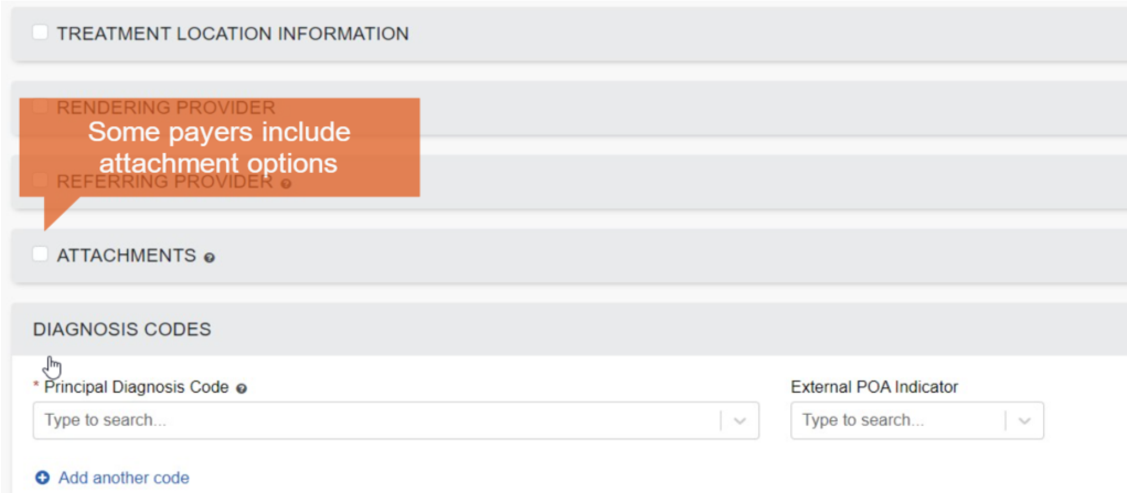


11. Next, enter the attending provider information or select the provider from your organization's provider express setup.

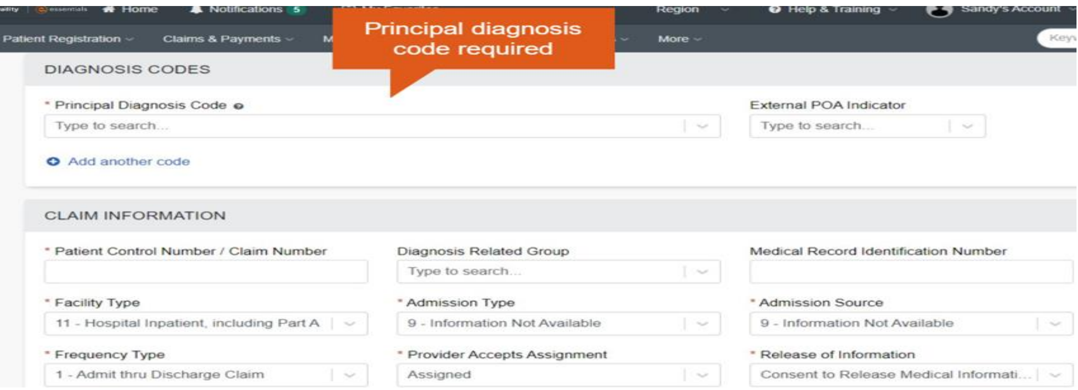


12. If the claim has additional information like operating physician, treatment location, rendering provider, and referring provider, select the check box to display that section.

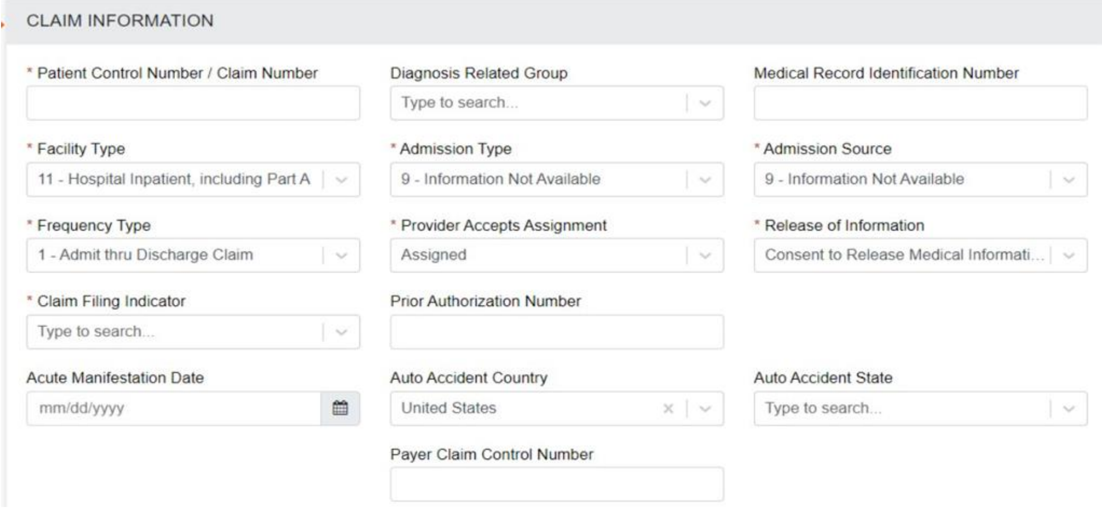
13. Molina gives the option to include attachment information. Select the check box to display the section.



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.



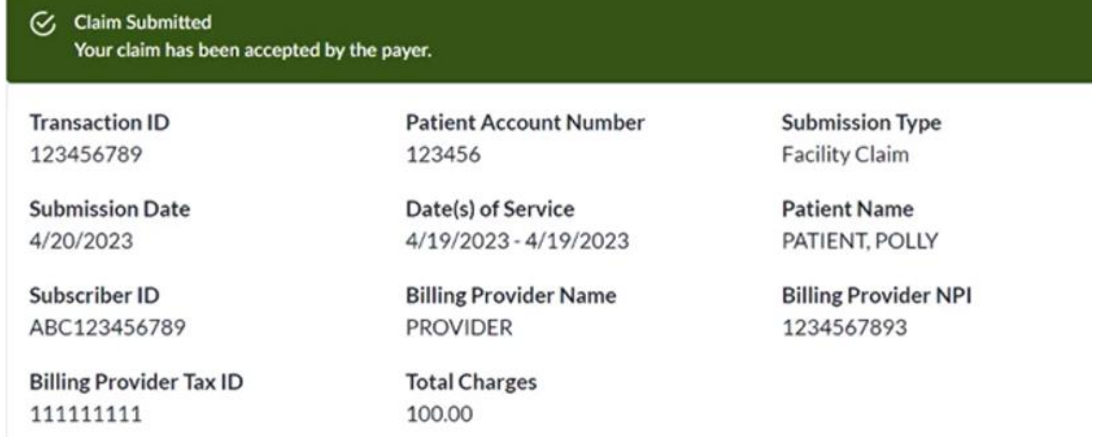
15. In the "Claim Information" section, enter the required fields and optional information for the claims. As you make selections in fields, additional fields related to the claim information might be displayed.



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's 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: https://products3.ssigroup.com/ProviderRegistration/register.
    - When submitting fee-for-service EDI claims, please utilize the payer ID: 38333.

Case Management

ICF-DD and Subacute Carve-In

Effective January 1, 2024, all managed care plans (MCPs), including Molina Healthcare, will become responsible for the full long-term care (LTC) benefit for the following Intermediate Care Facility (Home) Types:

- Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H)
- Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N)

All qualifying Medi-Cal beneficiaries residing in ICF/DD, ICF/DD-H, and ICF/DD-N Homes are mandatorily enrolled into a Medi-Cal MCP for their Medi-Cal covered services. Molina will continue the Member's authorization and begin payment to the ICF/DD Home. Molina will now be at risk for authorizing for the individual's other Medi-Cal covered benefits.

Molina Healthcare 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 Case Managers and Transition of Care Coaches. Transition of Care Coaches work 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 the 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. Molina Case Managers will collaborate with the Regional Centers and the ICFs to ensure the member is receiving all services identified in their ISP.

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

To find out if a Molina member has an assigned Case Manager or Transition of Care Coach, please contact us with the member's full name and date of birth via one of the methods below:

Phone: (833) 234-1258
Fax: (562) 499-6105
Email: MHCCaseManagement@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 (HS 231, DHCS 6301a, ISP, H&P, 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.

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/Transition 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 or a member with recent or frequent admission to an acute setting.

Care Plan

1. What will the Molina Care Plan look like?

The individualized care plan will document a plan of action to address any unmet needs. It will also identify non-Molina services the member may be eligible for and will provide contact information or initiate referrals, if indicated.

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. Whenever possible, it will be discussed, and any changes agreed upon by the member and/or his/her designated

representative. The care plan is developed by the Case Manager/Transitions of Care Coach in collaboration with the member.

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 is the Interdisciplinary Care Team?

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. Why is the ICT important?

a. Promotes comprehensive and cost-effective member care
b. Improves care by increasing coordination of services
c. Integrates health care for a wide range of problems and needs
d. Serves members of diverse cultural backgrounds
e. Uses time more efficiently
f. Increases professional satisfaction
g. Facilitates shift in emphasis from acute, episodic care to long-term preventative care
h. Encourages innovation
i. Allows providers to focus on individual needs

4. 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 member is encouraged to participate with member approval. Invitations for the ICT for members in an LTC setting will be extended to the ICF where the member resides.

Health Plans

Frequently Asked Questions

1. Can newly enrolled Los Angeles County MHC members switch back to Health Net?

Yes. MHC will honor TARs. Los Angeles County MHC members can contact Health Net's Member Services to make an affirmative request to change health plans. Upon receipt of the request, Health Net will notify MHC of the member's disenrollment.

2. How are case management responsibilities shared between MHC and Regional Centers?

DHCS APL 23-023 outlines the health plan's role in relation to Case Management on page 18. MHC has also met with Regional Centers to review the Memorandum of Understanding and clearly define our shared roles and responsibilities to reduce duplication of efforts. MHC will collaborate with the Regional Center Service Coordinator to ensure all the services for which the member qualifies are being provided. A Molina Transition of Care Coach will also reach out to the Regional Centers and the ICFs when a member is admitted to the hospital. The Molina Transition of Care Coach will ensure the member's needs are met during the transition from one level of care to another.

Provider Services

LTSS Liaisons

LTSS liaisons serve as a single point of contact for service providers in both a provider representative role and to support care transitions, as needed. LTSS liaisons assist service providers in addressing claims and payment inquiries in a responsive manner and assist with care transitions among the LTSS provider community to best support a Member's needs.

Frequently Asked Questions

Question	Answer	Phone Number
Appeals & Grievances		
How do I dispute a claim?	**Method 1:** Molina Availity Essentials Portal (most preferred method): https://provider.molinahealthcare.com/ You can search and identify adjudicated claim and submit a dispute/appeal. Upload 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 Change Health Care 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 submit an initial & corrected claim?	Claims must be submitted to Molina within 90 calendar days for PAR, 180 calendar days for non-PAR providers after the discharge for inpatient services or the Date of Service for outpatient services, unless otherwise stated in your contract. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit claims to Molina within 90 calendar days after 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 service?	American Logistics Transportation	(844) 292-2688
Molina Provider Relations Contacts		
Who is my Molina point of contact?		

Service County Area	Provider Relations Representative	Contact Number	Email
California Hospital Systems (SNFs, LTSS, ICF/DD)	Teresa Suarez	562.549-3782	teresa.suarez2@molinahealthcare.com
	Laura Gonzalez	562.549.4887	laura.gonzalez3@molinahealthcare.com

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.

MHC Contacts

Frequently Asked Questions

1. Who should members contact with any questions?

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

2. Who should providers contact with questions?

Care Management, UM, and Provider Relations contacts have been provided in the Provider Toolkit and Training slide deck. PRRs will work with their assigned ICF/DD Homes to assist with issues and relay concerns to the appropriate MHC department.

Molina Healthcare of California Contact List

Provider Relations	Contact Number	Email Address
Teresa Suarez, Sr. Provider Relations	562-549-3782	Teresa.Suarez2@molinahealthcare.com
Laura Gonzalez, Provider Relations	562-549-4887	Laura.Gonzalez3@molinahealthcare.com
Kristin Rosemond, AVP Network Strategy & Services	323-303-2573	Kristin.Rosemond@molinahealthcare.com

Provider Contracts	Contact Number	Email Address
Maria Torres, Manager Provider Contracts (LOAs)	562-549-4232	Maria.Torres6@molinahealthcare.com
Revelyn Soriano, Manager Provider Contracts (ICFDD)	562-491-4774	Revelyn.Soriano@molinahealthcare.com
Angelee Smith, Director Provider Contracts	562-542-1904	Angelee.Smith@molinahealthcare.com

Case Management	Contact Number	Email Address
Case Management referrals and inquiries	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

Utilization Management	Contact Number	Email Address
After hours, weekends and holidays (EDSU 24/7/365)	844-966-5462	N/A
Prior Authorization	Ph: 844-557-8434 Fax: 800-811-4804	N/A
Veronica Mones, Vice President of Healthcare Services	562-528-5599	Veronica.Mones@molinahealthcare.com
Sonia Hernandez, Director	562-517-1477	Sonia.Hernandez2@molinahealthcare.com

Appendix

Prior Authorization/Pre-Service Review Guide

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

Molina ICF/DD Authorization Request Form

State of California — Health and Human Services Agency

Department of Health Care Services

Prior Authorization Phone: (844) 557-8434
Prior Authorization Fax: (800) 811-4804

Medi-Cal Managed Care Plan Intermediate Care Facility/Home for the Developmentally Disabled Authorization Request

1. Member Name
2. Medi-Cal Identification Number
3. Medi-Cal Eligibility
4. Facility/Home Name
5. Facility/Home Address (Street Name, City, State, Zip Code)
6. Facility/Home Contact Information
7. International Classification of Diseases (ICD) Diagnoses Codes

8. Initial, Transfer, Re-admission, or Reauthorization

9. Prescribing Physician Name

10. Prescribing Physician License Number

11. Level of Care Requested (ICF/DD, ICF/DD-H, or ICF/DD-N)

12. The "Admit" Date

13. The "From" Date

14. The "Through" Date

Explanation of Form Items

1. **Member Name.** Enter the Member's full name from the Benefits Identification Card (BIC).
2. **Medi-Cal Identification Number and Eligibility.** When entering the recipient identification number from the BIC, begin in the farthest left position of the field. Do not enter any characters (dashes, hyphens, special characters, etc.) in the remaining blank positions of the Medi-Cal ID field. The county code and aid code must be entered just above the recipient Medi-Cal Identification Number box.
3. **Facility/Home Address and Contact Information.** Enter the facility/home's physical address and the name, email, and telephone contact information for the individual submitting the re- quest.
4. **ICD Diagnosis Codes**. List the ICD diagnosis codes for the Member, up to three.
5. **New, Transfer, or Readmission Authorization**. Note if the authorization is for a new Member, a transfer to another ICF/DD Facility/Home, or for a readmission.
6. **Prescribing Physician Name and License Number**. Enter the full name and license number for the physician authorizing the service from the Facility/Home. The state license number is the Medi-Cal rendering provider number.

7. Enter **Level of Care** — ICF-DD, ICF/DD-H, or ICF/DD-N, as defined below:
Intermediate Care Facility/Home for the Developmentally Disabled (ICF/DD, ICF/DD-H, and ICF/DD-N). These three models are offered, as appropriate, to individuals with intellectual and developmental disabilities (IDD) who are eligible for Regional Center services as administered by the Department of Developmental Services. The models offer specialized living arrangements and are briefly defined as follows:

- **ICF/DD (Developmentally Disabled):** "Intermediate care facility/home/developmentally disabled" is a facility/home (up to over 60 beds) that offers 24-hour personal care, habilitation, developmental, and supportive health services for individuals with IDD whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
- **ICF/DD-H (Habilitative):** "Intermediate care facility/home/developmentally disabled habilitative" is a home with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services for 15 or fewer individuals with IDD who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
- **ICF/DD-N** (Nursing): "Intermediate care facility/home/developmentally disabled-nursing" is a home with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for individuals with IDD who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.

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State of California — Health and Human Services Agency Department of Health Care Services

8. **Admit Date This Service**. Enter the recipient's admission date to the facility/home in six-digit format (for example, November 1, 2006 = 110106).
9. **Period Of Care Requested.** Enter the "From Date" and the "Through Date" requested for authorization in six-digit format (for example, November 1, 2006 = 110106). This applies to numbers 9-10.
10. **Physician Signature**. The authorization request must be initiated by the ICF/DD Facility/Home. Per 22 CCR section 51343(a), the ICF/DD Facility/Home's attending physician must sign the authorization request and certify to the MCP that the Member requires this level of care. ICF/DD Facility/Homes may submit the physician's signature through fax, scanning, or uploading as an attachment.

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HS-231: Certification for Special Treatment Program Services

State of California–Health and Human Services Agency | Department of Health Care Services

CERTIFICATION FOR SPECIAL TREATMENT PROGRAM SERVICES

(Read Instructions on Reverse Before Completing Form)

PART I—Completed by facility	Date	FOR OFFICIAL USE
Beneficiary name and address	Medi-Cal Identification number	
	Birth date / Age / Sex: M F	
Facility name and address	Guardian/Representative name and address	Program Category: ❐ Developmentally Disabled ❐ ICF/DD ❐ ICF/DDH ❐ ICF/DDN ❐ Mentally Disordered

Part II—Completed by designee of regional center director/local mental health director

❐ Grant
❐ Deny

List below supportive information for this recommendation

Part III–Certification by:

❐ Regional Center Director
❐ Local Mental Health Director

❐ You are authorized to claim payment for treatment as recommended

From ___________________________

To ___________________________

which is a total of

_____________ days

❐ Request denied
Comments:

Signature	Date	Signature	Date
Title	Affiliation	Title	

FORM DISTRIBUTION:

Developmentally Disabled: Original–facility; Copies–regional center director/designee
Mentally Disordered: Original–facility; Copies–local mental health director/designee

HS 231 (9/09)

PROCEDURES FOR CERTIFICATION OF CLIENT
ELIGIBILITY FOR SPECIAL TREATMENT PROGRAM SERVICES

1. Upon completion of the client assessments, the designee of the Regional Center Director or the Local Mental Health Director shall forward the original of the client assessment form to the Regional Center Director or the Local Mental Health Director along with a certification form with his recommendation to certify or deny certification of each client assessed. The designee shall also retain one copy of the client assessment form for his files.

2. The facility shall retain one copy of the client assessment form in the client's chart, and forward one copy to the Department with the completed application package.

3. The designee shall recommend program certification based on the following criteria:

   3.1 **Developmentally Disabled**

   3.1.1 The client shall have a primary or secondary diagnosis of a developmental disability.

   3.1.2 The client shall be physically able to participate in and benefit from the program.

   3.1.3 The client assessment shall indicate significant areas in need of remediation.

   3.1.4 Clients whose assessment indicates that an optimal level of functioning has been reached, but whose medical condition requires that he receive the level of basic care provided by the facility, may be recommended for certification in order to maintain current functioning level.

   3.1.5 A client whose assessment indicates that an optimum level of functioning has been reached and whose physical condition is such that he can function at a lower level of care shall not be recommended for certification.

   3.2 **Mentally Disordered**

   3.2.1 Clients shall have a primary or secondary diagnosis of a mental disorder.

   3.2.2 Clients shall have a chronic psychiatric impairment whose adaptive functioning is at least of moderate impairment.

   3.2.3 Each recommendation for certification of eligibility shall describe the basis upon which such recommendation is based.

   3.2.4 Each recommendation for certification of eligibility shall include and describe the impairment level of adaptive functioning.

   3.2.5 Clients shall be physically capable to participate in the program.

   In addition to the above, clients may meet one or more of the following:

   3.2.6 The client is in the terminal stages of an acute psychiatric episode and requires intensive services in preparation for placement at a lower level of care.

   3.2.7 The client requires a significant number of individual interventions to modify antisocial or uncooperative behavior which prevents optimal participation in the treatment program.

   3.2.8 A client may be recommended for certification on a maintenance basis only if he exhibits bizarre or unusual behavior presenting management problems which cannot be solved in a general nursing care setting.

4. Whenever the designee recommends not to certify a client for special treatment program services, he shall specify the reason, or reasons, in writing to the Local Regional Center Director or the Local Mental Health Director.

5. Upon receipt of the client assessment forms and the certification forms with the recommendations of his designee, the Regional Center Director or the Local Mental Health Director shall make a determination of each client's eligibility.

6. Upon determination of whether or not to certify a client as eligible for special treatment program services, the Regional Center Director or Local Mental Health Director shall complete the certification form and transmit four (4) copies of the form to the facility.

7. Whenever certification is denied by the Regional Center Director or Local Mental Health Director, he shall give his reasons in the space provided on the certification form.

8. The Regional Center Director or Local Mental Health Director shall retain one copy of the certification form and transmit one copy to his designee.

9. Clients shall be re-certified as eligible for special treatment program services at specified intervals using the procedures outlined above.

DHCS 6013A: Medical Review/Prolonged Care Assessment

State of California—Health and Human Services Agency

Department of Health Care Services

MEDICAL REVIEW/PROLONGED CARE ASSESSMENT

IC-ICF/DD—ICF/DD-H ☐ Semi-Annual ☐ Annual

Name	Sex	Case number	Birth date
	☐ Male ☐ Female		

Admission date	Attending physician	Present status
		☐ NH ☐ IC ☐ RC ☐ Other

Facility

Address (number, street)	City	ZIP code

Diagnoses	Medications
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
Lab Work	6.
	7.
	8.
	9.
Diet	

Remarks

1) Is the patient involved in school and is treatment plan coordinated with the school? ☐ Yes ☐ No
2) Is the patient involved in daily planned activities or any type of learning experience? ☐ Yes ☐ No
3) Is patient and staff interaction ongoing? ☐ Yes ☐ No
4) Is there *any* potential? ☐ Yes ☐ No
5) Is Plan of Care current? ☐ Before admission ☐ After admission ☐ Yes ☐ No
6) Are individual goals reviewed and/or met/updated? ☐ Yes ☐ No
7) Are quarterly notes written timely? ☐ Yes ☐ No
8) Are psychological evaluations done? ☐ Yes ☐ No
9) Is there QMRP input in the chart and/or whole interdisciplinary team? ☐ Yes ☐ No
   Every 90 days? ☐ Yes ☐ No

Dates of visits	Recommendation
	☐ Chart review ☐ Skilled nursing ☐ ICF
Interviewer	☐ RCF ☐ ICF/DD ☐ ICF/DD/H

DHCS 6013 A (4/09)

Utilization Management Division

INSTRUCTIONS: For ICF/DD/H—Complete all appropriate boxes; others—exclude ICF/DD/H only.

Patient name	Birth date	Sex

Medi-Cal ID number	Admission date	Room number

Facility name	Phone number
	( )

Facility address (number, street)	City	ZIP code

Signature of person completing form	Title	Current diagnosis

Patient's Condition Now
- ☐ Stable
- ☐ Unstable
- ☐ Terminal

Rehabilitation Potential
- ☐ Good
- ☐ Fair
- ☐ Poor

Complete this section for ICF/DD/H only

Program Provided

Frequency: 1—Once a day; 2—BID; 3—TID; 4—2; or more per week; 5—weekly

- ☐ Range of motion
- ☐ Preventive/corrective positioning
- ☐ Ambulation skills
- ☐ Transfer skills
- ☐ Grooming/dressing skills
- ☐ Mental stimulation
- ☐ Communication skills
- ☐ Bladder retraining
- ☐ Bowel retraining
- ☐ Feeding skills
- ☐ Social behavior
- ☐ Aggression
- ☐ Self-injurious
- ☐ Smearing
- ☐ Destruction of property
- ☐ Running or wandering away
- ☐ Temper tantrums or emotional outbursts

Plan of Care

Individual goals are met and updated?
☐ Yes ☐ No

Is the plan of care complete and updated?
☐ Yes ☐ No

Degree of Retardation
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Profound

Activities of Daily Living

Mark either—Independent (1), Assist. with mechanical device (A1) Assist. with a person (A) Assist. by person and device (A3) or Total Dependent (D)

- ☐ Walking
- ☐ Transferring
- ☐ Wheeling
- ☐ Bathing
- ☐ Dressing
- ☐ Grooming
- ☐ Toileting

Visual
- ☐ No apparent handicap
- ☐ Correctable vision w/glasses
- ☐ Severe visual impairment
- ☐ Legally or totally blind

Auditory
- ☐ No apparent hearing problem
- ☐ Mild hearing problem
- ☐ Wears hearing aid
- ☐ Deafness, corrected by aid
- ☐ Deafness, not corrected

Mental and Behavioral Status
- ☐ Receiving psychiatric care x3
- ☐ Alert and oriented x3
- ☐ Disoriented
- ☐ Confused
- ☐ Wanderer
- ☐ Noisy, yells/agitated
- ☐ Aggressive
- ☐ Combative
- ☐ Other antisocial behavior
- ☐ Withdrawn
- ☐ Comatose
- ☐ Follows simple instructions

Communication
- ☐ Able to make needs known
- ☐ Speaks no English
- ☐ Can write, not speak
- ☐ Cannot speak or write, but seems to comprehend
- ☐ Aphasic, partial
- ☐ Aphasic, complete

Wound Care—Dressings
- ☐ Dry sterile dressing
- ☐ Open, draining
- ☐ Sterile/medicated dressing

Diabetic Care
- ☐ Inability to manage diabetic condition
- ☐ Well-regulated by diet only
- ☐ Well-regulated with medication
- ☐ Uncontrolled
- ☐ Urine testing

Rehabilitation and M.D. Orders
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy

☐ **Rehabilitative Nursing Program**

Other Special Needs/Problems
- ☐ Amputee—location
- ☐ Braces/cast
- ☐ Seizures
- ☐ Paralysis/area
- ☐ Joint motion/pain/swelling
- ☐ Inhalation/oxygen therapy
- ☐ Tracheostomy care
- ☐ Suctioning
- ☐ Multiple injections or IVs
- ☐ Fluid retention
- ☐ Isolation techniques
- ☐ Contractures

Bowel Control
- ☐ Occasionally involuntary
- ☐ Involuntary
- ☐ Colostomy/Ileostomy
- ☐ Self-care

Bladder Control
- ☐ Occasionally incontinent
- ☐ Incontinent
- ☐ Catheter
- ☐ Bowel-Bladder Training—Date

Feeding
- ☐ Feeding program date
- ☐ Feeds self with assistive device
- ☐ Needs partial help in feeding
- ☐ Needs to be fed
- ☐ N-G tube
- ☐ Gastrostomy
- ☐ Parenteral
- ☐ Supplemental feedings

Current Medications
- ☐ Antibiotics
- ☐ Cardiac drugs
- ☐ Diuretics
- ☐ Anticoagulants
- ☐ Chemotherapy
- ☐ Insulin
- ☐ Tranquilizers
- ☐ Hypnotics
- ☐ Narcotics
- ☐ Oral hypoglycemic

Decubitus Ulcer
- ☐ None or healed
- ☐ Stage I—red/inflamed area
- ☐ Stage II—superficial skin break w/red surrounding
- ☐ Stage III
- ☐ Stage IV

DO NOT COMPLETE BELOW THIS LINE—STATE USE ONLY

General Appearance of Patient

		Yes	No
1.	Clean	☐	☐
2.	Hair clean and neat	☐	☐
3.	Shaved	☐	☐
4.	Fingernails clean/trimmed	☐	☐
5.	Toenails clean/trimmed	☐	☐
6.	Dressed appropriately	☐	☐
7.	Out of bed	☐	☐
8.	Restrained	☐	☐
9.	Transportation	☐	☐
10	Equipment	☐	☐

	Yes	No
Physician's progress notes timely?	☐	☐
Medications reviewed and signed timely?	☐	☐

Date of tuberculin testing or chest X-ray:________________

Date of last physical

Significant laboratory results

Notes:

(For additional comments, use the back.)

Chart review	Yes ☐	No ☐	Patient interview	Yes ☐	No ☐	Prolonged care	Yes ☐	No ☐	Reviewer's signature	Date

DHCS 6013 A (4/09) Utilization Management Division