Molina Healthcare My Care Program

Palliative Care Provider Toolkit

MY CARE PALLIATIVE CARE PROGRAM

PROVIDER FAQ AND BILLING GUIDE

What is My Care?

My Care is Molina Healthcare's palliative care program for the Medi-Cal line of business and is designed to provide patient and family-centered palliative care services to eligible members meeting the criteria per Senate Bill 1004 (SB 1004). Additionally, Molina Healthcare of California (MHC) recognized the value of the program for all Medi-Cal members with chronic conditions who have a limited life expectancy (typically one year or less). Because of this benefit to our members, MHC expanded the eligible diagnoses beyond the initial four diagnoses of CHF, COPD, ESLD, and cancer included in SB1004 to include any diagnosis that limits life expectancy to one year or less.

The goal of the **My Care** program is to provide palliative care services to members to optimize quality of life by anticipating, preventing, and managing the acute symptoms of their disease process and side effects of their treatment. As part of this program, Molina Healthcare's Case Management team will facilitate care coordination by working collaboratively with the palliative care vendor, treating physicians, and any additional individuals who make up the member's care team.

What services are covered under My Care?

The services covered under the program are as follows:

1. Advance Care Planning
2. Palliative Care Assessment and Consultation
3. Plan of Care
4. Palliative Care Team
5. Care Coordination
6. Pain and Symptom Management
7. Mental Health and Medical Social Services (coordination and referral)

What is the process to identify members for referral into My Care?

The main referral sources include case identification through inpatient rounds, members identified by Case Management and Transitions of Care, provider referrals, and data mining from authorizations and claims/encounters.

How are members informed about My Care?

Members are informed of the palliative care benefit through our member handbook. Members already in Case Management and Transitions of Care who meet the criteria are contacted by the Case Management team and assessed for their willingness to participate in **My Care**. Members may also be informed of the program by their PCP or treating physician.

How are providers informed about My Care?

Molina Healthcare has issued fax communications to our providers regarding **My Care**. As a follow up to the initial fax notification, Molina conducted training for in-network providers, highlighting program eligibility and the referral process. **My Care** is discussed at Joint Operations Meetings with the contracted Medical Groups, Independent Provider Associations (IPAs), and other meetings with network providers. Molina has also worked with specific hospitals in Los Angeles, San Diego, and in the Inland Empire to promote the program and educate on the referral process.

How will I be reimbursed for services provided under My Care?

You will receive a **case rate** for **My Care** services, which is considered an all-inclusive payment for the services referenced above and rendered in accordance with your contract. The case rate applies per member, per month for the duration of the member's enrollment in the program. This includes four contacts with the member each month, with a minimum of one in-person visit. During exceptional times, the mandate for in-person visits may be conducted via telephonic or tele-video conferencing, in alignment with state guidance.

What codes do I bill to receive the case rate for members enrolled in My Care?

Claims must be billed with either CPT Codes 99497 or 99498 (use whichever code was submitted on the authorization request), with diagnosis code Z51.5 (encounter for palliative care) to trigger the case rate payment, in accordance with your contract. This CPT code and diagnosis code combination must be indicated on all authorization requests and claim submissions for successful case rate payment. Other codes billed on the case rate claim will not be paid separately.

What type of bill is used for palliative care services?

We do not prescribe a specific type of bill for palliative care reimbursement. Please use the type of bill that is most reflective and appropriate for your organization, as you would when billing for other, non-palliative care services. For example, My Care vendors who are hospice providers would use the hospice bill type (81X), while our other vendors who are home health providers would use the Home Health type of bill (32X). Please refer to the appropriate CMS billing guidelines for type of bill.

What if additional physician or nurse practitioner visits are needed outside of the case rate?

Separate reimbursement is provided for additional visits that may be needed to manage the member's condition, in accordance with your contract. However, you must bill valid Medi-Cal reimbursable codes with diagnosis code Z51.5 in order to receive payment.

What about members that are not enrolled in My Care?

Follow your normal process for members that are not enrolled in **My Care**, however, please **do not bill diagnosis code Z51.5** for these members to avoid payment discrepancies.

COMPLETING THE CLAIM FORM AND BILLING SPECIFICATIONS:

All claims for members enrolled in My Care must be submitted with dx code Z51.5 to receive the appropriate payment.

Case Rate Reimbursement:

- Bill either **99497** or **99498** with dx code **Z51.5** on a **UB facility claim form**. Use the code that was submitted on the authorization request.
- Please bill the appropriate revenue codes for palliative care: 651, 690-694, 697 & 699.
- Do not include any other service codes as the case rate claim is considered an all-inclusive payment. Any other codes submitted on the same claim are not separately reimbursable.
- Only **ONE** claim should be submitted per member, per month for members enrolled in **My Care**.

Physician and Nurse Practitioner Visit Reimbursement:

- Bill the applicable Medi-Cal service code with dx code **Z51.5.** Do not bill the case rate codes 99497 or 99498.
- Additional physician or nurse practitioner visits outside of the case rate should be billed on **a separate claim form by using a HCFA 1500 for professional services**.

Please ensure that all past and present chronic conditions are assessed and evaluated during the visit with the member, and **all associated diagnoses are indicated on the claim form.**

Please submit all claims **electronically**, using Molina Healthcare **Payor ID 38333**.

Please complete all the required fields in accordance with CMS guidelines, including, but not limited to:

- Member information, including full name, date of birth, gender, address, and member insurance information
- The *Billing Provider Address* and *Service Facility Locations* must be a full address. P.O. Boxes and lock box addresses should not be submitted
- The full nine-digit zip code is required for *Billing Provider Address* and *Service Facility Locations.* Adding "0000" to end of the zip code will not be accepted

CLAIMS QUICK REFERENCE GUIDE

Claims Processing Standards

Molina is compliant with all state and federal processing standards.

Claims Submission Options

1. Submit claims directly to Molina Healthcare of California
2. Clearinghouse (Change Healthcare)
   - Change Healthcare is an outside vendor that is used by Molina Healthcare of California
   - When submitting 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

Provider Portal Claims Submission:

- Register to access our online services. A video will guide you through the easy online registration process
- Submit claims
- Print claims reports
- If you experience any problems with the Provider Portal, please contact Molina Healthcare's Help Desk at (866) 449-6848 for technical assistance or call your Provider Services Representative directly

EDI Claims Submission Issues

- Please call the EDI customer service line at (866) 409-2935 and/or submit an email to: EDI.Claims@MolinaHealthCare.Com
- Contact your respective county provider services representative

Claims Customer Service

- For assistance with any claims related processes or individual claims issues, please contact Claims Customer Service at: (877) 665-4626

Provider Disputes (Medi-Cal, Marketplace, Cal MediConnect)

Definition of a Provider Dispute

A Provider Dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted, or contested.
- Challenges a request for reimbursement for an overpayment of a claim
- Seeks resolution of a billing determination or other contractual dispute

Provider Dispute Time Frame

Molina Healthcare of California accepts disputes from providers if they are submitted within 365 days of receipt of Molina Healthcare's decision indicating claim was denied or adjusted.

For paper submission, MHC will acknowledge receipt of the dispute within fifteen (15) working days. If additional information is needed from the Provider/Practitioner, MHC has forty-five (45) working days to request necessary additional information. Once notified in writing, the Provider/Practitioner has thirty (30) working days to submit additional information or claim dispute will be closed by MHC.

Submission of Provider Disputes

All provider disputes require the submission of a Provider Disputes Resolution Form.

The written dispute form must include the Provider/Practitioner name, identification number, contact information, date of service, claim number, and explanation for the dispute. In addition, the following documentation is required to review and process a claim dispute:

- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include a clear identification of the disputed item, the date of service, and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect
- If the dispute is not about a claim, a clear explanation of the issue and the basis of the provider's position

If the provider dispute does not include the required information as outlined above, the dispute is returned to the provider with a written statement requesting the missing information necessary to resolve the dispute. The provider must resubmit an amended dispute along with the missing information within the time frame for dispute submissions, and the amended dispute must include the information requested and required to make the dispute complete.

Provider Disputes and supporting documentation (via paper) should be submitted to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn: Provider Dispute Resolution Unit

If you need further information regarding the changes required under Title 28, CCR, Sections 1300.71 and 1300.71.38 related to claims processing and provider disputes please contact MHC at (888) 665-4621.

Medicare Contracted inquiries:

- Medicare Contracted: MedicareSpecialProjects@MolinaHealthCare.com

Please include the following components in your submission:

Claim #	Member ID	Date of Birth	Member Name	Date of Service	Provider Name or Group Name	Billed Amount	Paid / Denied Date	Paid Amount	Issues Description/ Comments	Expected Outcome

MOLINA® HEALTHCARE MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2023

REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK-UP TOOL/MATRIX FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

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

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment, Intensive Outpatient above 16 units, 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**
- **Inpatient Hospitalization** (Except Emergency and Urgently Needed Services)
- **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**
- **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 HEALTHCARE MEDICAID PROVIDERS

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT, Lab or X-ray report/results).
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (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) 336-8478
Radiology Authorizations: Phone: (855) 714-2415 Fax: (877) 731-7218	**Vision:** Phone: (844) 336-2724
Provider Customer Service: Phone: (855) 322-4075 Fax: (562) 499-0619	**Member Customer Service, Benefits/Eligibility:** Phone: (888) 665-4621 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® Healthcare, Inc. – Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**			**Date of Request:**
State/Health Plan (i.e. CA):				
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____ ☐ Emergent Inpatient Admission ☐ EPSDT/Special Services			

REFERRAL/SERVICE TYPE REQUESTED

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

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

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

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

DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

Provider Name:		**NPI#:**	**TIN#:**
Phone:	**FAX**:	**Email**:	
Address:	**City:**	**State:**	**Zip:**
PCP Name:		**PCP Phone**:	
Office Contact Name:		**Office Contact Phone**:	

SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):			
NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par** ☐**COC**
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**

For Molina Use Only:

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

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

Member Information

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

Referral/Service Type Requested

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

Inpatient Services:	**Outpatient Services:**	
☐ Inpatient Psychiatric ☐Involuntary ☐Voluntary ☐ Inpatient Detoxification ☐Involuntary ☐Voluntary If Involuntary, Court Date:_____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____

Please send clinical notes and any supporting documentation

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

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

Provider Information

Requesting Provider / Facility:

Provider Name:	**NPI#:**	**TIN#:**	
Phone:	**FAX**:	**Email**:	
Address:	**City:**	**State:**	**Zip:**
PCP Name:	**PCP Phone**:		
Office Contact Name:	**Office Contact Phone**:		

Servicing Provider / Facility:

Provider/Facility Name (Required):				
NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par**	☐**COC**
Phone:	**FAX:**	**Email:**		
Address:	**City:**	**State:**	**Zip:**	

For Molina Use Only:

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

MOLINA HEALTHCARE

CLINICAL INFORMATION ONLY:

My Care Palliative Care

For Molina External Use Only

Instructions: Please fax clinical documents to 1-800-811-4804.

PRODUCT: ☐MEDI-CAL		
Total Pages included in fax including cover sheet:	Date: / /	
Member Name (Last, First, Middle Initial)	Date of Birth / /	Member I.D.

Materials to be reviewed when Prior Authorization (PA) request is received from provider

Assessment ☐	Clinical progress notes ☐	Care Plan ☐
Other ☐	Other description:	
Sender name, phone number and fax number:		

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