

# ICF/DD Process Review

Tuesday, February 20<sup>th</sup>, 2024

# Agenda

- 1 Introductions
- 2 TAR & Utilization Management Process
- 3 Letter of Agreement & Contracting Process
- 4 Claims Payment - Guide
- 5 Availability Facility Claims Submission
- 6 Non-Par Facility Claims Submission
- 7 Key Contacts



# TAR and Utilization Management Process Review

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*Presented by:*

*Veronica Mones, Vice President – Healthcare Services,*

*Blanca Martinez, Director – Healthcare Services, Care Management*

*Angelee Smith, Director - Contracting*


# Authorization Process - Existing Medi-Cal Treatment Authorization Requests (TARs)

- Molina has loaded all Medi-Cal TAR data provided by DHCS to create an authorization in its internal system for the duration of the existing TAR.
  - *The DHCS files did not always contain all necessary information to convert the DHCS TARs into authorizations. Information required to effectuate auth: Rendering provider name and NPI, unique procedure/service code information/description.*
  - *Minimal information provided by Health Net in Los Angeles: While Molina may be receiving the member information, Molina received TAR data from Health Net for only a few members.*
  - *Example of TAR Data received:*

BatchID	file_name	day_approved_numb	diagnosis_cod	diagnosis_description	rendering_provider_name	rendering_provider_n	service_cod	service_description
20240216	AE_TAR_Detail_HCP356_20231102.xlsx	7	L03.115	Cellulitis of right lower limb	Unknown	?	0	Acute Inpatient Hospital
20240216	AE_TAR_Detail_HCP356_20231102.xlsx	6	E11.10	Type 2 diabetes mellitus with ketoacidosis without coma	Unknown	?	0	Acute Inpatient Hospital
20240216	MCP_TAR_Detail_HCP131_20231106.xlsx	4	T18.4XXA	Foreign body in colon, initial encounter	Unknown	?	0	Acute Inpatient Hospital
20240216	MCP_TAR_Detail_HCP130_20231106.xlsx	0	K72.90	Hepatic failure, unspecified without coma	Unknown	?	47135	Liver Transplant
20240216	MCP_TAR_Detail_HCP130_20231106.xlsx	0	K72.90	Hepatic failure, unspecified without coma	Unknown	?	47135	Liver Transplant
20240216	MCP_TAR_Detail_HCP130_20231106.xlsx	0	K74.60	Unspecified cirrhosis of liver	SUTTER BAY HOSPITALS	1780742981	74183	MRI ABDOMEN W/O & W/DYE
20240216	MCP_TAR_Detail_HCP130_20231106.xlsx	0	K74.60	Unspecified cirrhosis of liver	Unknown	?	74183	MRI ABDOMEN W/O & W/DYE
20240216	MCP_TAR_Detail_HCP130_20231106.xlsx	1	K72.90	Hepatic failure, unspecified without coma	Unknown	?	0	Inpatient Days
20240216	MCP_TAR_Detail_HCP130_20231106.xlsx	1	K72.90	Hepatic failure, unspecified without coma	Unknown	?	0	Inpatient Days
20240216	AE_TAR_Detail_HCP356_20231102.xlsx	14	A41.9	Sepsis, unspecified organism	Unknown	?	0	Acute Inpatient Hospital
20240216	AE_TAR_Detail_HCP356_20231102.xlsx	6	A41.9	Sepsis, unspecified organism	Unknown	?	0	Acute Inpatient Hospital
20240216	LTC_TAR_Detail_HCP130_20231030.xlsx	365	I27.0	Primary pulmonary hypertension	Unknown	?	11	Subacute
20240216	LTC_TAR_Detail_HCP130_20231030.xlsx	365	I27.0	Primary pulmonary hypertension	Unknown	?	11	Subacute
20240216	LTC_TAR_Detail_HCP130_20231030.xlsx	366	J96.11	Chronic respiratory failure with hypoxia	Unknown	?	11	Subacute
20240216	LTC_TAR_Detail_HCP130_20231030.xlsx	84	J96.11	Chronic respiratory failure with hypoxia	Unknown	?	11	Pediatric Subacute Rehab Supp
20240216	LTC_TAR_Detail_HCP130_20231030.xlsx	84	J96.11	Chronic respiratory failure with hypoxia	Unknown	?	11	Pediatric Subacute Rehab Supp
20240216	MCP_TAR_Detail_HCP131_20231106.xlsx	5	F29.	Unsp psychosis not due to a substance or known physiol cond	Unknown	?	0	Acute Inpatient Hospital
20240216	MCP_TAR_Detail_HCP131_20231106.xlsx	7	F29.	Unsp psychosis not due to a substance or known physiol cond	Unknown	?	2	Admin Days Inpatient Hospital
20240216	AE_TAR_Detail_HCP356_20231102.xlsx	1	K35.80	Unspecified acute appendicitis	Unknown	?	0	Acute Inpatient Hospital
20240216	AE_TAR_Detail_HCP356_20231102.xlsx	2	K35.80	Unspecified acute appendicitis	Unknown	?	0	Acute Inpatient Hospital
20240216	MCP_TAR_Detail_HCP131_20231106.xlsx	0	Z78.9	Other specified health status	Unknown	?	X4100	Occupational therapy evaluation
20240216	MCP_TAR_Detail_HCP131_20231106.xlsx	0	Z78.9	Other specified health status	Unknown	?	X4102	Occupational therapy evaluation
20240216	MCP_TAR_Detail_HCP131_20231106.xlsx	0	Z78.9	Other specified health status	Unknown	?	X4110	Occupational therapy follow up trx
20240216	MCP_TAR_Detail_HCP131_20231106.xlsx	0	Z78.9	Other specified health status	Unknown	?	X4112	Occupational therapy follow up trx
20240216	LTC_TAR_Detail_HCP356_20231030.xlsx	183	J96.90	Respiratory failure, unsp, unsp w hypoxia or hypercapnia	Unknown	?	11	Subacute
20240216	LTC_TAR_Detail_HCP356_20231030.xlsx	0	?	Unknown	Unknown	?	A0420	AMBULANCE WAITING TIME 1/2 HR INCREMENTS
20240216	LTC_TAR_Detail_HCP356_20231030.xlsx	0	?	Unknown	Unknown	?	A0425	GROUND MILEAGE
20240216	LTC_TAR_Detail_HCP356_20231030.xlsx	0	?	Unknown	Unknown	?	A0426	ALS 1
20240216	LTC_TAR_Detail_HCP356_20231030.xlsx	365	J96.10	Chronic respiratory failure, unsp w hypoxia or hypercapnia	Unknown	?	11	Subacute
20240216	LTC_TAR_Detail_HCP356_20231030.xlsx	366	J96.10	Chronic respiratory failure, unsp w hypoxia or hypercapnia	Unknown	?	11	Subacute
20240216	LTC_TAR_Detail_HCP356_20231030.xlsx	90	J96.10	Chronic respiratory failure, unsp w hypoxia or hypercapnia	Unknown	?	11	Supplemental Rehab
20240216	LTC_TAR_Detail_HCP356_20231030.xlsx	91	J96.10	Chronic respiratory failure, unsp w hypoxia or hypercapnia	Unknown	?	11	Supplemental Therapy

# Authorization Process - Existing Medi-Cal Treatment Authorization Requests (TARs)

- Molina does not assign Duals to a Medi-Cal PCP unless requested by the member; therefore, all authorizations will be directed to Molina.
  - Members are being flagged in our core operating system (QNXT) and assigned to a default Primary Care Provider “REFER TO YOUR PRIMARY CARRIER”.



**Medi-Cal**

**Molina Healthcare of California**

**Member:** [REDACTED]  
**ID #:** [REDACTED]  
**DOB:** [REDACTED]  
**Provider:** REFER TO YOUR PRIMARY CARRIER  
**PCP Phone:** (562) 912-2041  
**Provider Group:** MOLINA DIRECT

**RxBIN:** 022659  
**RxPCN:** 6334225  
**RxGRP:** MediCalRx

**Member Service:** (888) 665-4621  
**Eligibility Info:** (800) 357-0172  
**24-Hour Nurse Help Line:** (888) 275-8750  
**Para Enfermera En Español:** (866) 648-3537  
**RX Questions:** Medi-Cal Rx (800) 977-2273  
**Hospital Admission Notification:** (866) 553-9263 (Fax)

[MyMolina.com](http://MyMolina.com)

# Authorization Process after Initial Authorization Expiration and Authorization for Members Admitted after 1/1/2024

- ICF/DD Homes will send the following as proof of Medical Necessity to the Prior Authorization department at 800-811-4804.
- HS231, DHCS 6013A, MCP ICF/DD Authorization form, Individual Service Plan (ISP)
- Molina will notify the facility within 5 working days after notice of the new authorization number.
- Authorization requests can be submitted utilizing the Molina portal at: <https://provider.molinahealthcare.com/>

1

You are about to be re-directed to a third-party site away from Availity's secure site, which may require a separate log-in. Availity provides the link to this site for your convenience and reference only. Availity cannot control such sites, does not necessarily endorse and is not responsible for their content, products, or services. You will remain logged in to Availity.

Cancel Submit

Click Submit to be logged into the Molina hosted functionality via SSO

2

MOLINA HEALTHCARE Provider Self Services

Service Request/Authorization Form

Member Search

Member ID: [ ] or Last Name: [ ] First Name: [ ] Date of Birth: [ ]

Advanced Search

Eligibility information is current as of Mar 14 2020 12:52:55 AM PST

Personal Information

Last Name: [ ] First Name: [ ] Middle Initial: [ ] Date of Birth: [ ] Sex: [ ]

Address: [ ] City: [ ] State: [ ] Zip Code: [ ]

Phone # (Home): [ ] Phone # (Mobile): [ ] PCP Name: [ ]

Service Information

Type of Service: [ ] Place of Service: [ ] Proposed Start Date: [ ] Inpatient Notification: [ ] Admission Date: [ ] Discharge Date: [ ]

Care Type: [ ] (Routine/Expedite/Expedite Within 72 Hours)

Diagnosis	Diagnosis Code	Diagnosis Description
<input type="checkbox"/>		
<input type="checkbox"/>		

Procedure Code: [ ] Procedure Description: [ ] Number of Units: [ ] Procedure Modifier: [ ]

3

Availity essentials Home Notifications My Favorites

Region Help & Training Justin's Account Logout

Notification Center

Providers have 1/27/2022 8:05 am

Provider Satisfaction Survey for Regions 4 and 5 Community Care Network (CCN) 1/11/2022 8:27 am

Provider Apportioning Survey for Region 4 Community Care Network (CCN) 1/11/2022 8:24 am

My Top Applications

EB Eligibility and Enrollment

Spaces Management

RV Remittance Viewer

Maintain User

Select Payer Spaces, click on the Molina tile

4

Applications Resources News and Announcements Sort By A-Z

THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!

Appeal or Correct Eligible Claims

Correct or submit appeals for claims in finalized status

Claims Template Portal

Create claim templates for frequently submitted claims

HEDIS Profile

Compare your HEDIS scores with national benchmarks

Member Roster

View and navigate through a list of Members assigned to a Primary Care Provider

Prior Auths

Submit service requests, check status and create auth request templates.

Reports

Submit/Access payer specific reports



## Authorization Process after Initial Authorization Expiration and Authorization for Members Admitted after 1/1/2024

- Facilities may submit a renewal authorization request up to 60 days prior to the expiration of the current authorization.
- *Facilities should use the Molina authorization number on claims.*
- Facilities have up to 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.
- 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 Molina's [Provider Manual](#) for timely filing requirements. Provider Manual (Provider Handbook) (molinahealthcare.com)

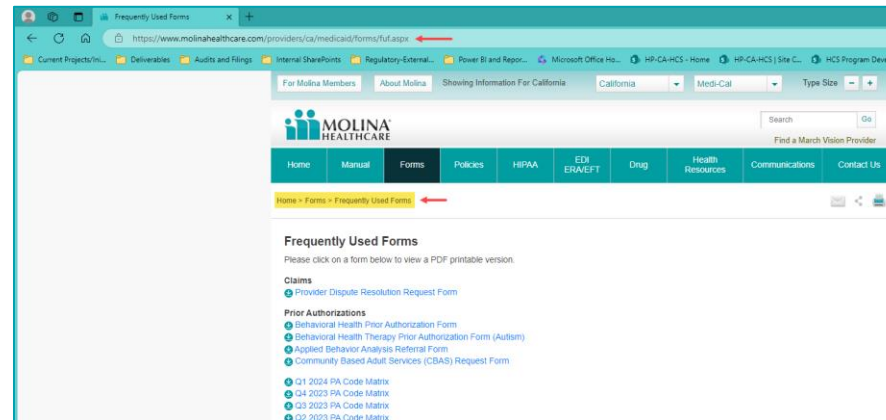
## Continuity of Care- ICF/DD Home Residents with Existing TARs

- Molina is responsible for all other approved authorization requests for services in an 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.
  - *Routine CoC request will be processed within 30 days of the notification.*
  - *Where Molina has received complete TAR data from DHCS, including the rendering provider information, the TAR will be honored under CoC, which may include DME and medical supplies – a new authorization request is **NOT** required.*
  - *In cases where we have received limited/incomplete TAR data, we have collaborated with the ICF/DD providers to obtain information for these types of services to ensure that transitioning members can continue to receive DME and other services.*
  - *Prior authorization requirements for DME have been **waived for the next six months** to facilitate access to these services/supplies.*



# Continuity of Care- ICF/DD Home Residents with Existing TARs

- Molina utilizes the Medi-Cal TAR data provided by DHCS to create an authorization in its internal system for the duration of the existing TAR.
  - If a facility does not receive an authorization, the facility must notify Molina by faxing a copy of the Medi-Cal TAR effective prior to the member's enrollment with Molina to the Prior Authorization/CoC department at 800-811-4804.
- Applicable forms will be accessible on Molina's public-facing provider website, under [Frequently Used Forms](#):



## Continuity of Care- ICF/DD Home Placement

- Molina ensures continuity of care to services for members in an ICF/DD Home by honoring the ICF/DD authorization request or treatment authorization requests (TAR) approved by DHCS for the member enrolled into Molina.
- 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.

## Continuity of Care- Out of Network Facilities

- If a facility is not contracted with Molina, upon receipt of notice, Molina will engage the facility to execute a contract or a member specific letter of agreement at the standard Medi-Cal rates and/or Medicare RUG rates as appropriate
- Facility must have the following to receive payment:
  - *Contract or Letter of Agreement*
  - *Authorization for the services for which facility is requesting payment.*
- ***During initial 180 days post 1/1/24: Molina is sweeping its claims system to identify claims submitted without adequate documentation and manually overturning denials and pricing claims to effectuate payments.***



# Authorization Process - Bed Holds and Leave of Absences (LOAs)

- **Bed Holds:** A separate authorization is required for bed holds, to provide care coordination and transitions between level of care.
- **Leave of Absence:** Molina does not require authorization for a LOA, however, notification must occur for the following circumstances:
  - *Facilities must inform MHC when a member participates in a summer camp for the developmentally disabled due to the physician signature requirement.*
  - *If a member is on a LOA and does not wish to return to the same ICF/DD Home following a LOA, Molina must be notified 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.*

# Letter of Agreement (LOA) and Contracting Process

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*Presented by:  
Angelee Smith, Director - Contracting*

# Letter of Agreement (LOA) and Contracting Process

- Requested ICF-DD providers to contact Molina to effectuate a Letter of Agreement or contract.
- Proactive outreach has been ongoing since the State announced the benefit.
- Per DHCS policy and legal requirements, a LOA is required for non-par providers; however, retroactive application to 1/1/24 is acceptable.
- Global Letter of Agreement required per TIN on behalf of all listed NPIs.
- Authorization and LOA apply for 12 months

**MOLINA HEALTHCARE OF CALIFORNIA  
GLOBAL LETTER OF AGREEMENT**

**SIGNATURE PAGE**

In consideration of the promises, covenants, and warranties stated, the Parties agree as set forth in this Global Letter of Agreement ("Agreement"). The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

<b>PROVIDER NAME ("Provider")</b>		<b>Molina Healthcare of California ("Health Plan")</b>	
Provider Signature:		Health Plan Signature:	
Signatory Name (Printed):		Signatory Name (Printed):	<b>Jennifer Eisberg</b>
Signatory Title (Printed):		Signatory Title (Printed):	<b>VP of Provider Network &amp; Ops</b>
Signature Date:		Signature Date:	
Provider Payment Name & Address (attach W-9)	<b>SEE LOCATIONS BELOW</b>		Molina Healthcare of California Provider Contracting Dept. 200 Oceanate #100 Long Beach, CA. 90802 Attn: Jennifer Eisberg
Telephone #		Telephone #	<b>562-549-4184</b>
Fax #		Fax #	<b>833-679-4353</b>
E-mail Address		E-mail Address:	Jennifer.Eisberg@molinahealthcare.com
Tax ID #	XX-XXXXXXX		
NPI #	SEE ATTACHED LIST OF NPI		

<b>Member Line of Business</b>	<b>Medi-Cal</b>
<b>Dates Of Service</b>	<b>January 1, 2024 - December 31, 2024</b>

**GLOBAL LETTER OF AGREEMENT**

Health Plan and Provider enter into this Agreement as set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a "Party" and collectively as the "Parties".

- 1.1 **Definitions.** Capitalized words or phrases in this Agreement have the meaning set forth below.
  - a. Covered Service means medically necessary services by Health Plan and described in this Agreement.
  - b. Member means the person identified by Health Plan in this Agreement who is eligible to receive Covered Services
  - c. Clean Claim means a Claim for Covered Services submitted on an industry standard form, which has no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.
- 1.2 **Provision of Covered Services.** Provider agrees to provide Covered Services to Member within the scope of Provider's business, practice, and/or license.

**Description of Covered Service:**

Type of Service/s	Intermediate Care Facility For Developmentally Disabled Long-Term Care
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- 1.3 **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services provided. Provider agrees to accept such payments and, when applicable, co-payments, co-insurances, deductibles, and coordination of benefits collections as payment in full for Covered Services. Except as provided in this section, Provider will not bill Member for services rendered under Title XXII and the Knox-Keene Act.

<b>Compensation Schedule. 100% of Medi-Cal Fee For Service in effect on date of service</b>
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# Claims Payment – ICF/DD Guide

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*Presented by:  
Tanya Contreras, AVP - Claims*



# Claims Reference

## Claims Submission

- 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.
- Claim's Billing Reminder: Please ensure claim submissions are billed with the Molina Member ID

## Paper Claims 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.

# UB-04 Form

Providers billing for Long Term Care institutional services must bill on an UB-04 form.  
The claim form must be completed with the following fields:

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.  <b>Bill Types:</b> <b>065X</b> – Intermediate Care – Level 1 <b>066X</b> – Intermediate Care – Level 2  <u>4<sup>th</sup> 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

# Fields 16-38

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  <b>01</b> – Discharged to Home or self-care <b>02</b> – Discharged/transferred to a short-term General Hospital for Inpatient Care <b>03</b> – Discharged/transferred to SNF <b>04</b> – Discharged/transferred to a Facility that provides Custodial care <b>05</b> – Discharged/transferred to a Designated cancer center or Childrens Hospital <b>20</b> – Expired <b>30</b> – Still Patient <b>40</b> – Expired at Home <b>41</b> – Expired in a Medical Facility <b>42</b> – Expired – Place unknown <b>43</b> – Discharged/transferred to a Federal Health Care Facility <b>50</b> – Hospice – Home <b>51</b> – Hospice – Medical Facility <b>61</b> – Discharged/transferred to an approved Swing Bed <b>62</b> – Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) <b>63</b> – Discharged/transferred to a Long Term Care Hospital (LTCH) <b>64</b> – Discharged/transferred to a Nursing Facility certified under Medicaid <b>65</b> – Discharged/transferred to a Psychiatric Hospital <b>66</b> – Discharged/transferred to a Critical Access Hospital (CAH) <b>70</b> – 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	

# Fields 39-42

39-41	Value Codes and Amounts	Required	<p>Enter the value codes and amounts. *Amounts should be entered in dollar format.</p> <p>Example: Value code 24 with accommodation code 41 will be submitted as follows:</p> <table border="0"> <thead> <tr> <th><u>Value code</u></th> <th><u>Value code</u></th> <th><u>Amount</u></th> </tr> </thead> <tbody> <tr> <td>24</td> <td></td> <td>\$0.41</td> </tr> </tbody> </table> <p><b>Value codes:</b>  <b>23 – Patient’s Share of cost</b>  <b>24 – Accommodation code</b>  <b>66 – Non-Covered Cost</b> (Required only if billing for non-covered cost)</p> <p>Accommodation codes applicable to:</p> <p><b>Revenue code 0101</b> (Effective for DOS on or after 2/1/24)  <b>Revenue code 0190</b> (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</p> <p><b>Revenue code 0180</b>  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</p>	<u>Value code</u>	<u>Value code</u>	<u>Amount</u>	24		\$0.41
<u>Value code</u>	<u>Value code</u>	<u>Amount</u>							
24		\$0.41							
42	Revenue code	Required	<p>Enter the appropriate revenue code:</p> <p><b>0101 – Room and Board</b> (Effective for DOS on or after 2/1/24)  <b>0190 – Room and Board</b> (DOS prior to 2/1/24)  <b>0180 – Leave of absence</b></p>						

# Fields 43-77

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



# Availity Facility Claims Submission

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*Presented by:*

*Clemente Arias, Provider Services Representative - Network*



# Step 1

The screenshot shows a web application dashboard with a dark navigation bar at the top. The navigation bar includes the following items: Patient Registration, **Claims & Payments** (highlighted in yellow), Clinical, My Providers, Reporting, Payer Spaces, and More. A search bar labeled 'Keyword Search' is located on the right side of the navigation bar. Below the navigation bar, the dashboard is divided into several sections:

- Notification Center:** Contains three notification cards. The first card, 'Providers have submitted Attachments in your work queue', has a red arrow pointing to the 'Claims & Payments' navigation bar. The second card is 'Automation Test DV Notification'. The third card is 'Provider Appointing Survey for Region 4 Community Care Network (CCN)'. A mouse cursor is hovering over the second card. At the bottom right of this section, it says 'Showing 3 of 6' and a 'View All' button.
- My Top Applications:** A row of four application tiles: 'PC Professional Claim', 'CS Claim Status', 'Payer List', and 'ATS Availability Transaction Search'.
- News and Announcements:** A section with a 'NEW ALERT' badge. It contains two announcement cards. The first is a warning: 'this is an alert behold!'. The second is 'Get Ready: Availity is Updating How You Access Professional, Facility, and Dental Claim Entry Forms'.
- Messaging:** A sidebar on the right with a 'Messaging' header and a list of message categories: Unassigned, Unread, Pending, and Recently Resolved.
- Internal Links Dashboard:** A sidebar on the right with a 'My Account Dashboard' header and a list of links: AV Search, Internal Links Page, Registration Administration, Organization Verification Utility, Verification Administration, and Verification Exceptions.

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

# Step 2

The screenshot displays a dashboard with the following sections:

- Claim Status & Payments:** Includes links for Claim Status (CS), Remittance Viewer (RV), Appeals (A), Appeals - Payer (A), and Overpayments (OP).
- EDI Clearinghouse:** Includes links for Send and Receive EDI Files (EDI), File Restore (FR), EDI Reporting Preferences (EDI), FTP and EDI Connection Services (FTP), View EDI Plans (EDI), Transaction Enrollment (TE), and Payer List.
- Patient Payments:** Includes links for RevSpring - Administration (RSA) and Patient Payments Dashboard.
- Fee Schedule Listing:** Includes a link for Fee Schedule Listing (FSL).
- Claims:** Includes links for Professional Claim (PC), Facility Claim (FC), Dental Claim (DC), **Claims & Encounters (CE)** (highlighted), Quick Claims (QC), and Dental Attachments (DA). Each link includes a note: "Use the 'Claims & Encounters' link to submit professional, facility, and dental claims."

You will then select Claims & Encounters.

# Step 3

[Home](#) / [Claims & Encounters](#)

## Claims & Encounters

INSURANCE COMPANY/BENEFIT PLAN INFORMATION

Organization: Example Organization ▼

Claim Type: Type to search... ▼

Payer: Type to search... ▼

Responsibility Sequence <sup>?</sup>: Primary ▼

- 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.


# Step 4


Home > Select > Facility Claim


## Facility Claim

[Give Feedback](#) [Health Plan Logo](#)

**INSURANCE COMPANY/BENEFIT PLAN INFORMATION**

\* Responsibility Sequence   | v

\* Statement From Date  

\* Statement To Date  

**PATIENT INFORMATION**

Select a patient (Patients in the list are from your eligibility and benefits inquiries in the last 24 hours for the current organization)

| v

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

# Step 5

The screenshot shows a web application interface for Medicare adjudication. The top navigation bar includes 'Region', 'Help & Training', 'Sandy's Account', and 'Log Out'. A search bar is visible on the right. The main content area is divided into several sections:

- PRIMARY INSURANCE PLAN INFORMATION**: Contains fields for Subscriber ID, Policy or Group Number, Remaining Patient Liability, and checkboxes for 'This subscriber is different from the primary subscriber' and 'Release signature from provider on behalf of patient'. It also includes fields for Other Payer Name, ID, Identification Number, and Claim Control Number, along with dropdown menus for Information Release, Claim Filing Indicator, and Other Payer Benefits Assignment Certification.
- INPATIENT MEDICARE ADJUDICATION INFORMATION**: A section header for the current step.
- OUTPATIENT MEDICARE ADJUDICATION INFORMATION**: A section header for the next step.
- ADJUSTMENT GROUPS**: A section with a dropdown for 'Group' and a search field. Below it is an 'ADJUSTMENTS' table with columns for '\* Amt' and 'Qty', and a 'Reason' dropdown. An 'Add another adjustment' link is at the bottom.

At the bottom of the form, there is a 'PATIENT INFORMATION' section with a search field and the text 'Select a patient (Patients in the list are from your eligibility and benefits inquiry)'.

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

# Step 6

Home > Select > Facility Claim

## Facility Claim

Give Feedback Health Plan Logo

### INSURANCE COMPANY/BENEFIT PLAN INFORMATION

\* Responsibility Sequence  | v

\* Statement From Date  |

\* Statement To Date  |

### PATIENT INFORMATION

Select a patient (Patients in the list are from your eligibility and benefits inquiries in the last 24 hours for the current organization)

| v

**Responsibility Sequence**

- 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.

# Step 7

**PATIENT INFORMATION**

Select a patient (Patients in the list are from your eligibility and benefits inquiries in the last 24 hours for the current organization)

Type to search... | v

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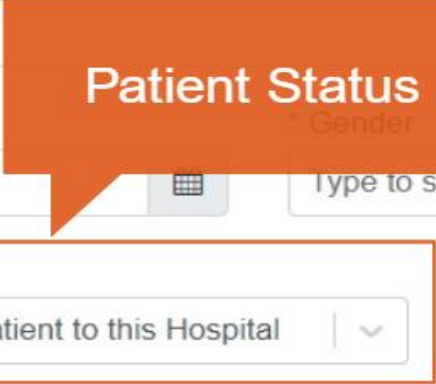
\* Last Name  \* First Name  Middle Name or Initial  Suffix

\* Country  \* Address  Suite

\* City  \* State  \* Zip Code

\* Date of Birth  \* Gender  \* Relationship

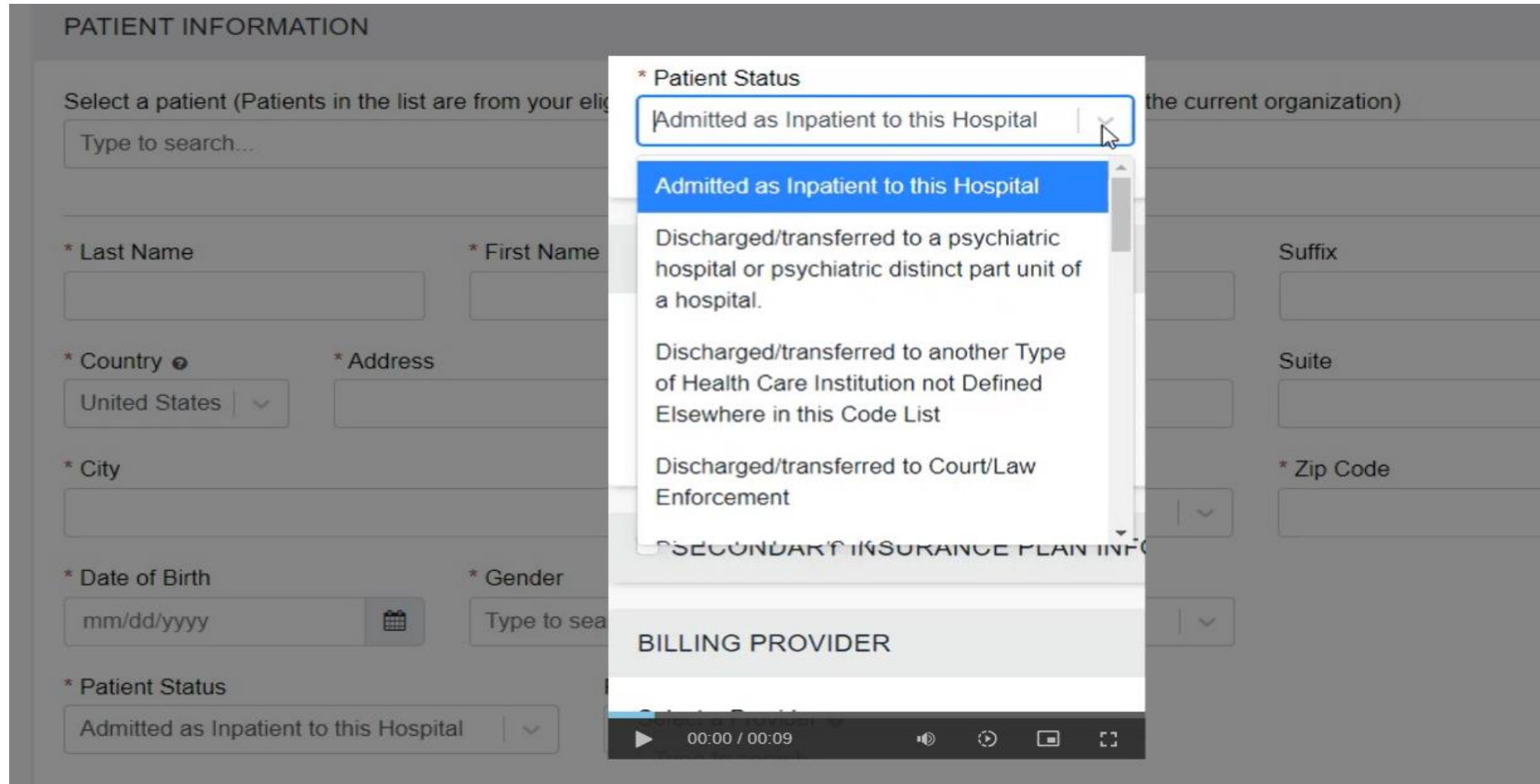
\* Patient Status  Patient Responsibility Amount



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




# Step 8



You can select another option in the field if applicable.

# Step 9

**BILLING PROVIDER**

Select a Provider 

Type to search... | v


\* NPI

Specialty Code  
Type to search... | v

\* Organization or Last Name

Contact Name

\* EIN

Country  United ... x | v

\* Address

Suite

\* City

\* State  
Type to search... | v


\* Zip Code

**Select a Provider**

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

# Step 10

**BILLING PROVIDER**

Select a Provider 

Type to search... | v


\* NPI

Specialty Code  | v

\* Organization or Last Name

Contact Name

\* EIN

Country   x | v

\* Address

Suite

\* City

\* State  | v


\* Zip Code


PAY TO ADDRESS (IF DIFFERENT FROM BILLING PROVIDER ADDRESS)

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


# Step 11

### ATTENDING PROVIDER

Select a Provider 

\* NPI

Specialty Code  

Payer Assigned Provider ID (PAPI)

\* Organization or Last Name

\* First Name

Middle Name

Suffix

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

# Step 12

OPERATING PHYSICIAN

TREATMENT LOCATION INFORMATION

RENDERING PROVIDER

REFERRING PROVIDER 

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

# Step 13

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

The screenshot shows a web form with several sections. At the top, there is a checkbox labeled "TREATMENT LOCATION INFORMATION". Below it are two more checkboxes: "RENDERING PROVIDER" and "REFERRING PROVIDER". An orange callout box with white text is positioned over these two checkboxes, stating "Some payers include attachment options". Below the callout box is a checkbox labeled "ATTACHMENTS". The bottom section is titled "DIAGNOSIS CODES" and contains a dropdown menu for "\* Principal Diagnosis Code" with a search field "Type to search..." and a dropdown arrow. To the right of this is another dropdown menu for "External POA Indicator" with a search field "Type to search..." and a dropdown arrow. At the bottom left of the "DIAGNOSIS CODES" section is a blue plus icon followed by the text "Add another code".

# Step 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.

The screenshot shows a web interface with a dark navigation bar at the top containing links for 'essentials', 'Home', 'Notifications 5', 'Region', 'Help & Training', and 'Sandy's Account'. Below the navigation bar, there are tabs for 'Patient Registration', 'Claims & Payments', and 'More'. The main content area is divided into two sections: 'DIAGNOSIS CODES' and 'CLAIM INFORMATION'. In the 'DIAGNOSIS CODES' section, there is a required field for 'Principal Diagnosis Code' with a search prompt 'Type to search...' and a dropdown arrow. To its right is an 'External POA Indicator' field with a similar search prompt. Below these fields is a blue link that says '+ Add another code'. The 'CLAIM INFORMATION' section contains several required fields: 'Patient Control Number / Claim Number' (text input), 'Diagnosis Related Group' (dropdown with search prompt), 'Medical Record Identification Number' (text input), 'Facility Type' (dropdown with '11 - Hospital Inpatient, including Part A'), 'Admission Type' (dropdown with '9 - Information Not Available'), 'Admission Source' (dropdown with '9 - Information Not Available'), 'Frequency Type' (dropdown with '1 - Admit thru Discharge Claim'), 'Provider Accepts Assignment' (dropdown with 'Assigned'), 'Release of Information' (dropdown with 'Consent to Release Medical Informati...'), 'Claim Filing Indicator' (text input), and 'Prior Authorization Number' (text input).



# Step 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.

CLAIM INFORMATION

* Patient Control Number / Claim Number <input type="text"/>	Diagnosis Related Group Type to search...   v	Medical Record Identification Number <input type="text"/>
* Facility Type 11 - Hospital Inpatient, including Part A   v	* Admission Type 9 - Information Not Available   v	* Admission Source 9 - Information Not Available   v
* Frequency Type 1 - Admit thru Discharge Claim   v	* Provider Accepts Assignment Assigned   v	* Release of Information Consent to Release Medical Informati...   v
* Claim Filing Indicator Type to search...   v	Prior Authorization Number <input type="text"/>	
Acute Manifestation Date mm/dd/yyyy	Auto Accident Country United States x   v	Auto Accident State Type to search...   v
	Payer Claim Control Number <input type="text"/>	

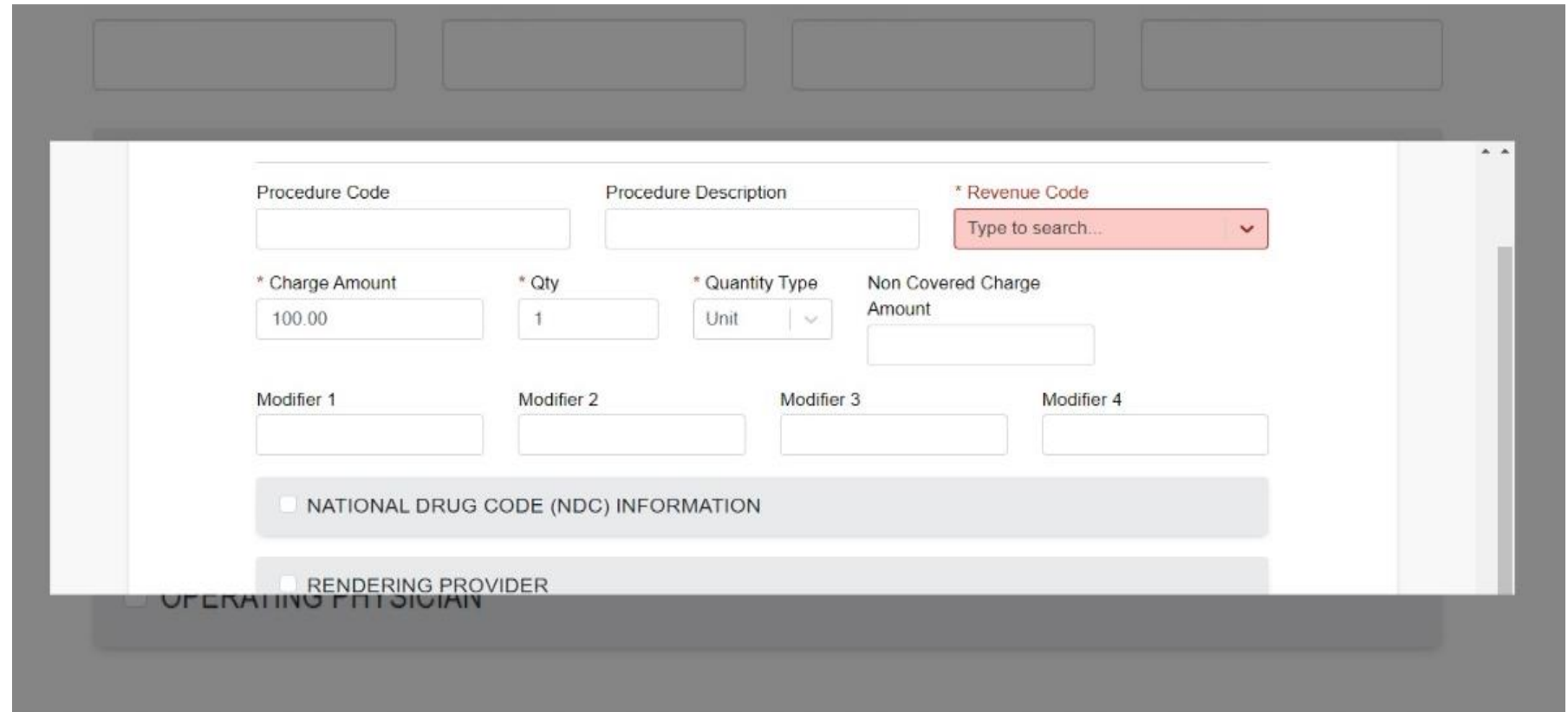
## Step 16



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.

# Step 17

- Avality 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, Avality will display a message to help you correct the errors.
  - Simply correct the errors and submit the claim.



The screenshot shows a web-based form for entering claim data. The form includes the following fields and sections:

- Procedure Code**: A text input field.
- Procedure Description**: A text input field.
- \* Revenue Code**: A dropdown menu with the placeholder text "Type to search...".
- \* Charge Amount**: A text input field containing "100.00".
- \* Qty**: A text input field containing "1".
- \* Quantity Type**: A dropdown menu with "Unit" selected.
- Non Covered Charge Amount**: A text input field.
- Modifier 1, 2, 3, 4**: Four text input fields for additional modifiers.
- NATIONAL DRUG CODE (NDC) INFORMATION**: A checkbox that is currently unchecked.
- RENDERING PROVIDER**: A checkbox that is currently unchecked.
- OPERATING PHYSICIAN**: A checkbox that is currently unchecked.

Red error messages are visible above the Revenue Code dropdown and the Charge Amount field, indicating validation failures.

# Step 18

 **Claim Submitted**  
Your claim has been accepted by the payer.

<b>Transaction ID</b> 123456789	<b>Patient Account Number</b> 123456	<b>Submission Type</b> Facility Claim
<b>Submission Date</b> 4/20/2023	<b>Date(s) of Service</b> 4/19/2023 - 4/19/2023	<b>Patient Name</b> PATIENT, POLLY
<b>Subscriber ID</b> ABC123456789	<b>Billing Provider Name</b> PROVIDER	<b>Billing Provider NPI</b> 1234567893
<b>Billing Provider Tax ID</b> 111111111	<b>Total Charges</b> 100.00	

Claims submission confirmation screen

# Availity Enrollment

## Streamlining Access for Non-Contracted Providers

- Molina's Availity portal access is available to both par and non-par providers
  - Status available after initial claims are submitted
- While awaiting integration:
  - Contact Molina Contact Center for claim or referral status
- Support for billing and claims tracking:
  - Consistent for contracted and non-contracted providers
  - Options include the Molina Contact Center, Provider Reps, messaging feature through Availity

# Non-Par Facility Claims Submission

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*Presented by:*

*Kristin Rosemond, AVP - Network*

# Non-Par Provider Claims Submission

Claims submission options:

1. Submit paper claims directly to Molina Healthcare of California at the following address:
  - PO Box 22702 Long Beach, CA 90801
2. Clearinghouse (Change Healthcare)
  - Change Healthcare is an outside vendor that is used by Molina Healthcare of California.
    - Change Healthcare has relationships with hundreds of other clearing houses. Typically, Providers can continue to submit claims to their usual clearinghouse
  - Molina accepts EDI transactions through our gateway clearinghouse (Change Healthcare) via the 837P for Professional and 837I for institutional.
  - When submitting fee-for-service EDI claims please utilize payer ID 38333
  - When your claims are filed via a Clearinghouse:
    - You should receive a 999 acknowledgement from your clearinghouse.
    - You should also receive 277CA response file with initial status of the claims from your clearinghouse



# Key Contacts

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# Key Contacts

Provider Relations	Contact Number	Email Address
Teresa Suarez, Sr. Provider Relations	562-549-3782	<a href="mailto:Teresa.Suarez2@molinahealthcare.com">Teresa.Suarez2@molinahealthcare.com</a>
Laura Gonzalez, Provider Relations	562-549-4887	<a href="mailto:Laura.Gonzalez3@molinahealthcare.com">Laura.Gonzalez3@molinahealthcare.com</a>
Kristin Rosemond, AVP Network Strategy & Svcs.	323-303-2573	<a href="mailto:Kristin.Rosemond@molinahealthcare.com">Kristin.Rosemond@molinahealthcare.com</a>

Provider Contracting	Contact Number	Email Address
Maria Torres, Manager Provider Contracts (LOAs)	1-562-549-4232	<a href="mailto:Maria.Torres6@MolinaHealthCare.Com">Maria.Torres6@MolinaHealthCare.Com</a>
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Angelee Smith, Director Provider Contracts	1-562-542-1904	<a href="mailto:Angelee.Smith@molinahealthcare.com">Angelee.Smith@molinahealthcare.com</a>

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**Utilization Management:**

Phone: 844-966-5462

*After hours, weekends and holidays (EDSU 24/7/365)*

Prior Authorization Phone: 844-557-8434

Prior Authorization Fax: 800-811-4804

Veronica Mones, *Vice President of Healthcare Services*

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# Thank You

