



Molina Healthcare of California

Intermediate Care Facilities for Individuals with Developmental Disabilities

Provider Toolkit – November 2025

MolinaHealthcare.com



Table of Contents

Utilization Management	3
Treatment Authorization Requests	3
Continuity of Care	3
Prior Authorization	5
Provider Contracts.....	10
Letter of Agreement.....	10
Full Contract	10
Claims	11
Claim Submissions.....	11
Availity Facility Claim Submissions.....	19
Non-Par Provider Claim Submissions	25
Case Management.....	26
ICF-DD and Subacute Carve-In	26
Molina Healthcare Case Management.....	26
Health Risk Assessment.....	27
Care Plan	27
Health Plans	29
Frequently Asked Questions	29
Provider Services	30
LTSS Liaisons.....	30
Frequently Asked Questions	30
MHC Contacts.....	34
Frequently Asked Questions	34
Molina Healthcare of California Contact List	34
Appendix.....	35
Prior Authorization/Pre-Service Review Guide	35
Molina ICF/DD Authorization Request Form	37
HS-231: Certification for Special Treatment Program Services	40
DHCS 6013A: Medical Review/Prolonged Care Assessment	42

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.

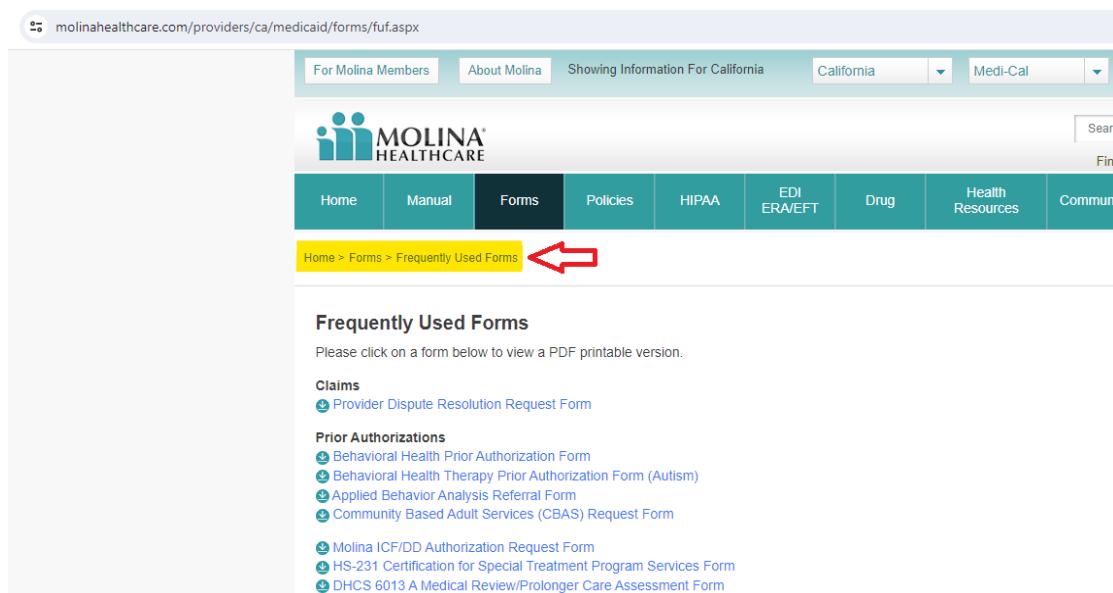
2. Will Molina accept our Medi-Cal TARs?

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:

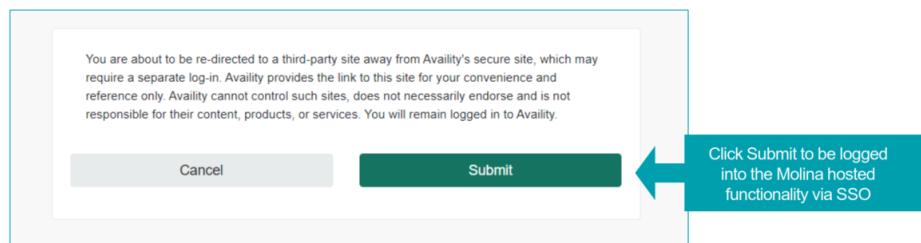
- HS 231
- DHCS 6013A
- MCP ICF/DD Authorization form
- ISP

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

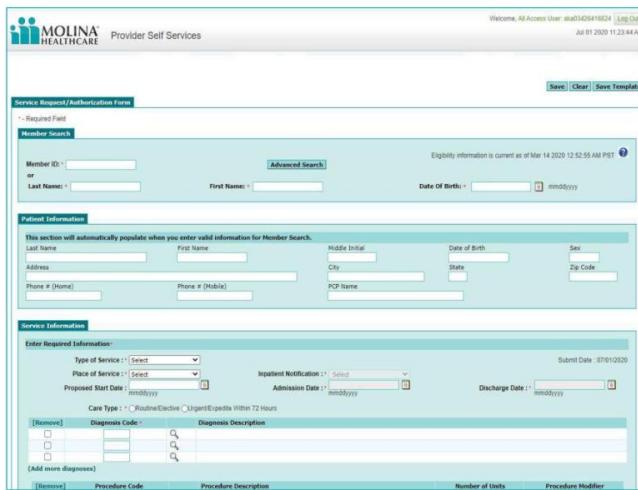
8. How do I submit for a new authorization once an initial authorization has expired, or a member was admitted after 1/1/2024?

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

Step 1:

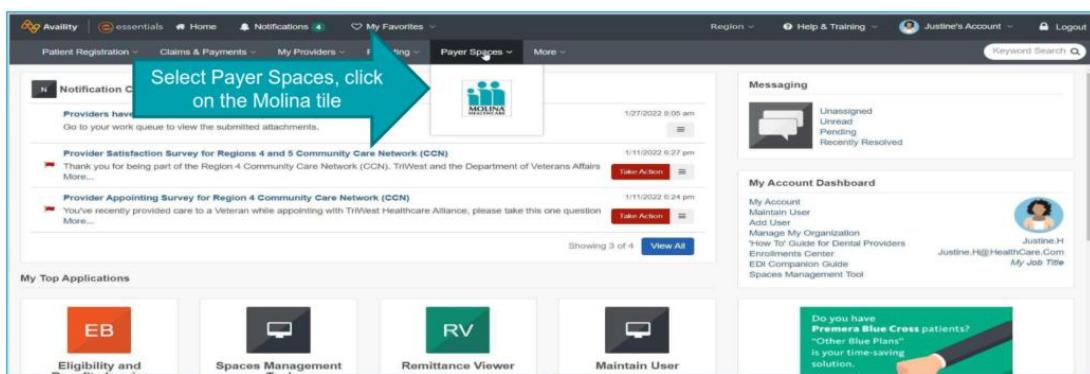


Step 2:
Complete form.



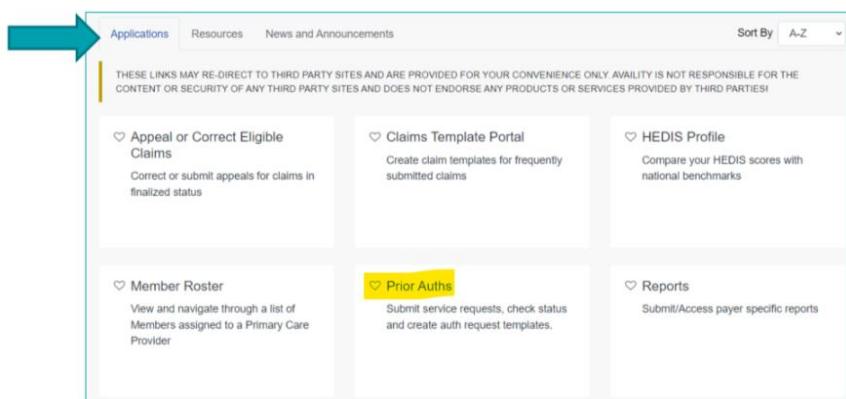
This screenshot shows the Molina Healthcare Provider Self Services Service Request/Authorization Form. The form is divided into several sections: Member Search, Patient Information, and Service Information. The Service Information section contains fields for Type of Service, Place of Service, Inpatient Notification, Proposed Start Date, Admission Date, Discharge Date, Care Type, Diagnosis Code, Diagnosis Description, and Procedure Code. A large teal arrow points to the Service Information section.

Step 3:



This screenshot shows the Molina Healthcare provider dashboard. The dashboard includes sections for Patient Registration, Claims & Payments, My Providers, and Player Spaces. The Player Spaces section displays a list of notifications and messages. A teal arrow points to the Player Spaces section. The My Account Dashboard section on the right shows various account management links.

Step 4:
From Applications, select *Prior Auths*.



This screenshot shows the Molina Healthcare Applications page. The page lists various applications: Appeal or Correct Eligible Claims, Claims Template Portal, HEDIS Profile, Member Roster, Prior Auths, and Reports. A teal arrow points to the 'Prior Auths' link, which is highlighted with a yellow box.

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	<p>Enter the Four-digit type of bill code as specified in the National Uniform Billing Committee (NUBC) UB-04 data manual.</p> <p>Bill Types:</p> <p>065X – Intermediate Care – Level 1 066X – Intermediate Care – Level 2</p> <p>4th digit is based on the following:</p> <p>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</p>
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	<p>Enter the beginning and ending date of service in MMDDYY format.</p> <p>*For services provided on a single day, enter the date of service as both the from and through date.</p>
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:

			<p>1 – Emergency 2 – Urgent 3 – Elective</p>
15	Admission Source	Not required	<p>Enter the source of referral for admission</p> <p>Admission code source:</p> <p>4 – Transfer from a Hospital 5 – Transfer from a Skilled Nursing Facility 6 – Transfer from another health care facility</p>
16	Discharge Hour	If Applicable	<p>Enter the hour of discharge</p> <p>*If patient has not been discharged, box can be left blank</p>
17	Patient Status	Required	<p>Enter the patient status/discharge code</p> <p>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</p>

			<p>65 – Discharged/transferred to a Psychiatric Hospital</p> <p>66 – Discharged/transferred to a Critical Access Hospital (CAH)</p> <p>70 – Discharged/transferred to another type of health care institution</p>				
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	<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> <thead> <tr> <th><u>Value code</u></th> <th><u>Value code Amount</u></th> </tr> </thead> <tbody> <tr> <td>24</td> <td>\$0.41</td> </tr> </tbody> </table> <p>Value codes:</p> <p>23 – Patient's Share of cost</p> <p>24 – Accommodation code</p> <p>66 – Non-Covered Cost (Required only if billing for non-covered cost)</p> <p>Accommodation codes applicable to:</p> <p>Revenue code 0101 (Effective for DOS on or after 2/1/24)</p> <p>Revenue code 0190 (DOS prior to 2/1/24)</p> <p>41 – ICF/DD 1 to 59 Beds</p> <p>42 – ICF/DD 60+ Beds</p> <p>61 – ICF/DD-H 4 to 6 Beds</p> <p>62 – ICF/DD -N 4 to 6 Beds</p> <p>65 – ICF/DD-H 7 to 15 Beds</p> <p>66 – ICF/DD-N 7 to 15 Beds</p>	<u>Value code</u>	<u>Value code Amount</u>	24	\$0.41
<u>Value code</u>	<u>Value code Amount</u>						
24	\$0.41						

			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		0123456789 0653	
				6 FED. TAX NO. 951234567 6 PAYMENT COVERS PERIOD 6 FROM 02/01/2024 6 THROUGH 02/28/2024	
8 PATIENT NAME 8 PATIENT LAST NAME, FIRST NAME		8 PATIENT ADDRESS 8 PATIENT CITY		8 CA 8 12345	
10 BIRTHDATE 10 01/01/1901		11 SEX 11 M		12 AMOUNTS 12 30	
13 HR 13 01/10/2024		14 TYPE 14 30		15 CHR 15 18	
16 SRC 16 0000		17 STAT 17 18		18 19 19 20 20 21 21 22 22 23 23 24 24 25 25 26 26 27 27 28 28 29 29 30 30 31 31 32 32 33 33 34 34 35 35 36 36 37 37 38 38 39 39 40 40 41 41 42 42 43 43 44 44 45 45 46 46 47 47 48 48 49 49 50 50 51 51 52 52 53 53 54 54 55 55 56 56 57 57 58 58 59 59 60 60 61 61 62 62 63 63 64 64 65 65 66 66 67 67 68 68 69 69 70 70 71 71 72 72 73 73 74 74 75 75 76 76 77 77 78 78 79 79 80 80 81 81 82 82 83 83 84 84 85 85 86 86 87 87 88 88 89 89 90 90 91 91 92 92 93 93 94 94 95 95 96 96 97 97 98 98 99 99 100 100 101 101 102 102 103 103 104 104 105 105 106 106 107 107 108 108 109 109 110 110 111 111 112 112 113 113 114 114 115 115 116 116 117 117 118 118 119 119 120 120 121 121 122 122 123 123 124 124 125 125 126 126 127 127 128 128 129 129 130 130 131 131 132 132 133 133 134 134 135 135 136 136 137 137 138 138 139 139 140 140 141 141 142 142 143 143 144 144 145 145 146 146 147 147 148 148 149 149 150 150 151 151 152 152 153 153 154 154 155 155 156 156 157 157 158 158 159 159 160 160 161 161 162 162 163 163 164 164 165 165 166 166 167 167 168 168 169 169 170 170 171 171 172 172 173 173 174 174 175 175 176 176 177 177 178 178 179 179 180 180 181 181 182 182 183 183 184 184 185 185 186 186 187 187 188 188 189 189 190 190 191 191 192 192 193 193 194 194 195 195 196 196 197 197 198 198 199 199 200 200 201 201 202 202 203 203 204 204 205 205 206 206 207 207 208 208 209 209 210 210 211 211 212 212 213 213 214 214 215 215 216 216 217 217 218 218 219 219 220 220 221 221 222 222 223 223 224 224 225 225 226 226 227 227 228 228 229 229 230 230 231 231 232 232 233 233 234 234 235 235 236 236 237 237 238 238 239 239 240 240 241 241 242 242 243 243 244 244 245 245 246 246 247 247 248 248 249 249 250 250 251 251 252 252 253 253 254 254 255 255 256 256 257 257 258 258 259 259 260 260 261 261 262 262 263 263 264 264 265 265 266 266 267 267 268 268 269 269 270 270 271 271 272 272 273 273 274 274 275 275 276 276 277 277 278 278 279 279 280 280 281 281 282 282 283 283 284 284 285 285 286 286 287 287 288 288 289 289 290 290 291 291 292 292 293 293 294 294 295 295 296 296 297 297 298 298 299 299 300 300 301 301 302 302 303 303 304 304 305 305 306 306 307 307 308 308 309 309 310 310 311 311 312 312 313 313 314 314 315 315 316 316 317 317 318 318 319 319 320 320 321 321 322 322 323 323 324 324 325 325 326 326 327 327 328 328 329 329 330 330 331 331 332 332 333 333 334 334 335 335 336 336 337 337 338 338 339 339 340 340 341 341 342 342 343 343 344 344 345 345 346 346 347 347 348 348 349 349 350 350 351 351 352 352 353 353 354 354 355 355 356 356 357 357 358 358 359 359 360 360 361 361 362 362 363 363 364 364 365 365 366 366 367 367 368 368 369 369 370 370 371 371 372 372 373 373 374 374 375 375 376 376 377 377 378 378 379 379 380 380 381 381 382 382 383 383 384 384 385 385 386 386 387 387 388 388 389 389 390 390 391 391 392 392 393 393 394 394 395 395 396 396 397 397 398 398 399 399 400 400 401 401 402 402 403 403 404 404 405 405 406 406 407 407 408 408 409 409 410 410 411 411 412 412 413 413 414 414 415 415 416 416 417 417 418 418 419 419 420 420 421 421 422 422 423 423 424 424 425 425 426 426 427 427 428 428 429 429 430 430 431 431 432 432 433 433 434 434 435 435 436 436 437 437 438 438 439 439 440 440 441 441 442 442 443 443 444 444 445 445 446 446 447 447 448 448 449 449 450 450 451 451 452 452 453 453 454 454 455 455 456 456 457 457 458 458 459 459 460 460 461 461 462 462 463 463 464 464 465 465 466 466 467 467 468 468 469 469 470 470 471 471 472 472 473 473 474 474 475 475 476 476 477 477 478 478 479 479 480 480 481 481 482 482 483 483 484 484 485 485 486 486 487 487 488 488 489 489 490 490 491 491 492 492 493 493 494 494 495 495 496 496 497 497 498 498 499 499 500 500 501 501 502 502 503 503 504 504 505 505 506 506 507 507 508 508 509 509 510 510 511 511 512 512 513 513 514 514 515 515 516 516 517 517 518 518 519 519 520 520 521 521 522 522 523 523 524 524 525 525 526 526 527 527 528 528 529 529 530 530 531 531 532 532 533 533 534 534 535 535 536 536 537 537 538 538 539 539 540 540 541 541 542 542 543 543 544 544 545 545 546 546 547 547 548 548 549 549 550 550 551 551 552 552 553 553 554 554 555 555 556 556 557 557 558 558 559 559 560 560 561 561 562 562 563 563 564 564 565 565 566 566 567 567 568 568 569 569 570 570 571 571 572 572 573 573 574 574 575 575 576 576 577 577 578 578 579 579 580 580 581 581 582 582 583 583 584 584 585 585 586 586 587 587 588 588 589 589 590 590 591 591 592 592 593 593 594 594 595 595 596 596 597 597 598 598 599 599 600 600 601 601 602 602 603 603 604 604 605 605 606 606 607 607 608 608 609 609 610 610 611 611 612 612 613 613 614 614 615 615 616 616 617 617 618 618 619 619 620 620 621 621 622 622 623 623 624 624 625 625 626 626 627 627 628 628 629 629 630 630 631 631 632 632 633 633 634 634 635 635 636 636 637 637 638 638 639 639 640 640 641 641 642 642 643 643 644 644 645 645 646 646 647 647 648 648 649 649 650 650 651 651 652 652 653 653 654 654 655 655 656 656 657 657 658 658 659 659 660 660 661 661 662 662 663 663 664 664 665 665 666 666 667 667 668 668 669 669 670 670 671 671 672 672 673 673 674 674 675 675 676 676 677 677 678 678 679 679 680 680 681 681 682 682 683 683 684 684 685 685 686 686 687 687 688 688 689 689 690 690 691 691 692 692 693 693 694 694 695 695 696 696 697 697 698 698 699 699 700 700 701 701 702 702 703 703 704 704 705 705 706 706 707 707 708 708 709 709 710 710 711 711 712 712 713 713 714 714 715 715 716 716 717 717 718 718 719 719 720 720 721 721 722 722 723 723 724 724 725 725 726 726 727 727 728 728 729 729 730 730 731 731 732 732 733 733 734 734 735 735 736 736 737 737 738 738 739 739 740 740 741 741 742 742 743 743 744 744 745 745 746 746 747 747 748 748 749 749 750 750 751 751 752 752 753 753 754 754 755 755 756 756 757 757 758 758 759 759 760 760 761 761 762 762 763 763 764 764 765 765 766 766 767 767 768 768 769 769 770 770 771 771 772 772 773 773 774 774 775 775 776 776 777 777 778 778 779 779 780 780 781 781 782 782 783 783 784 784 785 785 786 786 787 787 788 788 789 789 790 790 791 791 792 792 793 793 794 794 795 795 796 796 797 797 798 798 799 799 800 800 801 801 802 802 803 803 804 804 805 805 806 806 807 807 808 808 809 809 810 810 811 811 812 812 813 813 814 814 815 815 816 816 817 817 818 818 819 819 820 820 821 821 822 822 823 823 824 824 825 825 826 826 827 827 828 828 829 829 830 830 831 831 832 832 833 833 834 834 835 835 836 836 837 837 838 838 839 839 840 840 841 841 842 842 843 843 844 844 845 845 846 846 847 847 848 848 849 849 850 850 851 851 852 852 853 853 854 854 855 855 856 856 857 857 858 858 859 859 860 860 861 861 862 862 863 863 864 864 865 865 866 866 867 867 868 868 869 869 870 870 871 871 872 872 873 873 874 874 875 875 876 876 877 877 878 878 879 879 880 880 881 881 882 882 883 883 884 884 885 885 886 886 887 887 888 888 889 889 890 890 891 891 892 892 893 893 894 894 895 895 896 896 897 897 898 898 899 899 900 900 901 901 902 902 903 903 904 904 905 905 906 906 907 907 908 908 909 909 910 910 911 911 912 912 913 913 914 914 915 915 916 916 917 917 918 918 919 919 920 920 921 921 922 922 923 923 924 924 925 925 926 926 927 927 928 928 929 929 930 930 931 931 932 932 933 933 934 934 935 935 936 936 937 937 938 938 939 939 940 940 941 941 942 942 943 943 944 944 945 945 946 946 947 947 948 948 949 949 950 950 951 951 952 952 953 953 954 954 955 955 956 956 957 957 958 958 959 959 960 960 961 961 962 962 963 963 964 964 965 965 966 966 967 967 968 968 969 969 970 970 971 971 972 972 973 973 974 974 975 975 976 976 977 977 978 978 979 979 980 980 981 981 982 982 983 983 984 984 985 985 986 986 987 987 988 988 989 989 990 990 991 991 992 992 993 993 994 994 995 995 996 996 997 997 998 998 999 999 1000	
PAGE 1 OF 1		CREATION DATE		TOTALS	\$5435.00
60 PATIENT NAME 60 MOLINA HEALTHCARE OF CA		61 HEALTH PLAN ID		62 AMOUNTS 62 0000	63 EST. AMOUNT DUE 63 123456789
64 INSURER'S NAME 64 PATIENT LAST NAME, FIRST NAME		65 INSURED'S UNIQUE ID 65 PATIENT MEDI-CAL ID		66 GROUP NAME	67 INSURANCE GROUP NO.
68 TREATMENT AUTHORIZATION CODES		69 DOCUMENT CONTROL NUMBER		70 EMPLOYER NAME	
71 ICD10 71 ICD10	72 ICD10 72 ICD10	73 OTHER PROCEDURE CODE 73 OTHER PROCEDURE CODE	74 OTHER PROCEDURE DATE 74 OTHER PROCEDURE DATE	75 OTHER PROCEDURE CODE 75 OTHER PROCEDURE CODE	76 OTHER PROCEDURE DATE 76 OTHER PROCEDURE DATE
77 ATTENDING 77 MR 77 123456789	78 LAST NAME 78 LAST 78 LAST	79 FIRST 79 FIRST 79 FIRST	80 QUAL 80 QUAL 80 QUAL	81 LAST NAME 81 LAST 81 LAST	82 FIRST 82 FIRST 82 FIRST
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.					

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 revenue codes and associated value codes for ICF/DD Homes?

The tables below include the 2024 accommodation codes established by DHCS. For further details, please refer to the [DHCS ICF Reimbursement Rates webpage](#).

Table 1 – All-inclusive Room and Board

Facility Type	Revenue Code	Value Code	Value Code Amount	Total Reimbursement Per Diem
ICF/DD 1-59 Beds	0101	24	41	100% of Medi-Cal
ICF/DD 60+ Beds	0101	24	42	100% of Medi-Cal
ICF/DD-H 4-6 Beds	0101	24	61	100% of Medi-Cal
ICF/DD-H 7-15 Beds	0101	24	65	100% of Medi-Cal
ICF/DD-N 4-6 Beds	0101	24	62	100% of Medi-Cal
ICF/DD-N 7-15 Beds	0101	24	66	100% of Medi-Cal

Table 2 – Bed Hold Accommodation

Facility Type	Revenue Code	Value Code	Value Code Amount	Total Bed Hold Reimbursement Per Diem
ICF/DD 1-59 Beds	0180	24	43	100% of Medi-Cal
ICF/DD 60+ Beds	0180	24	44	100% of Medi-Cal
ICF/DD-H 4-6 Beds	0180	24	63	100% of Medi-Cal
ICF/DD-H 7-15 Beds	0180	24	68	100% of Medi-Cal
ICF/DD-N 4-6 Beds	0180	24	64	100% of Medi-Cal
ICF/DD-N 7-15 Beds	0180	24	69	100% of Medi-Cal

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:** 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.

Facility Claim

Give Feedback

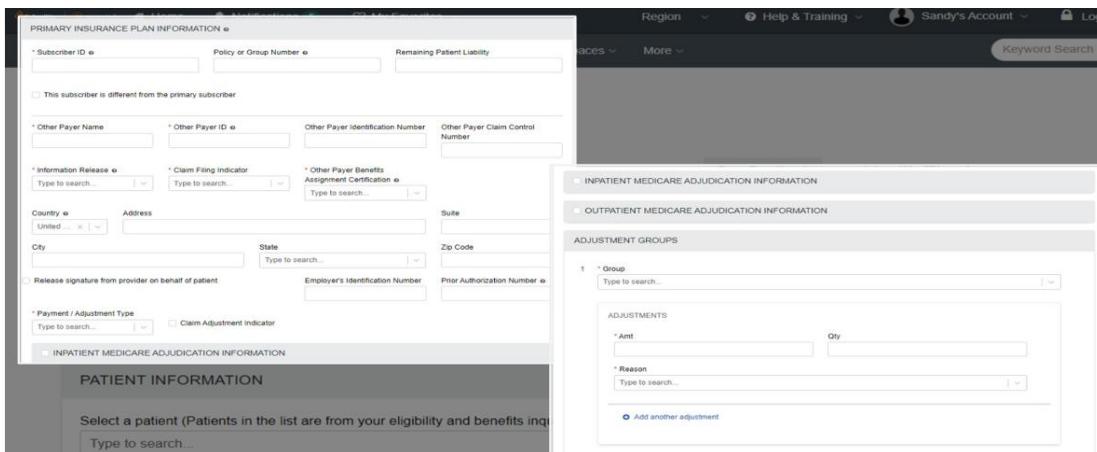
INSURANCE COMPANY/BENEFIT PLAN INFORMATION

* Responsibility Sequence	* Statement From Date	* Statement To Date
Primary	mm/dd/yyyy <input type="button" value="Calendar"/>	mm/dd/yyyy <input type="button" value="Calendar"/>

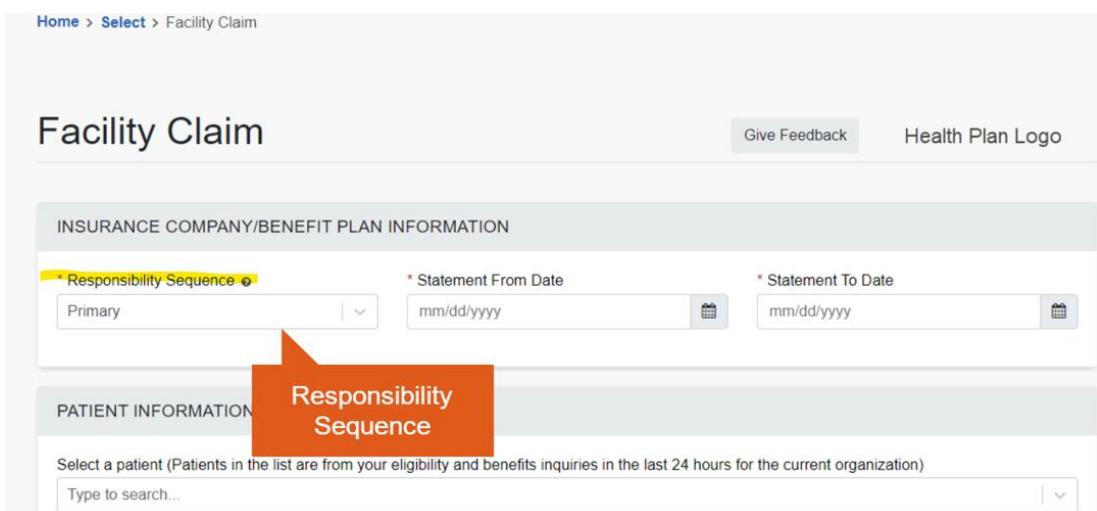
PATIENT INFORMATION

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

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.

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...

* Last Name	* First Name	Middle Name or Initial	Suffix
* Country <input type="radio"/> United States		* Address	
* City	* State		* Zip Code
* Date of Birth mm/dd/yyyy	Gender Type to search...		* Relationship <input type="radio"/> Self
* Patient Status Admitted as Inpatient to this Hospital		Patient Responsibility Amount	

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

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...

* Last Name	* First Name	
* Country <input type="radio"/> United States		
* City	* Address	
* Date of Birth mm/dd/yyyy	Gender Type to search...	
* Patient Status Admitted as Inpatient to this Hospital		

* Patient Status
Admitted as Inpatient to this Hospital

Admitted as Inpatient to this Hospital

Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

Discharged/transferred to Court/Law Enforcement

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.

BILLING PROVIDER

Select a Provider Type to search...

Select a Provider

* NPI	Specialty Code Type to search...
* Organization or Last Name	
Contact Name	* EIN
Country <input type="radio"/> United ...	
* City	* State Type to search...
* Address	
* Zip Code	
Suite	

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

BILLING PROVIDER

Select a Provider ⓘ

Type to search...

* NPI Specialty Code

* Organization or Last Name

Contact Name * EIN

Country ⓘ * Address

United ...

* City * State Type to search...

* Zip Code

PAY TO ADDRESS (IF DIFFERENT FROM BILLING PROVIDER ADDRESS)

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

ATTENDING PROVIDER

Select a Provider ⓘ

Type to search...

* NPI Specialty Code Payer Assigned Provider ID (PAPI)

Type to search...

* Organization or Last Name * First Name Middle Name Suffix

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.

OPERATING PHYSICIAN

TREATMENT LOCATION INFORMATION

RENDERING PROVIDER

REFERRING PROVIDER ⓘ

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

TREATMENT LOCATION INFORMATION

RENDERING PROVIDER
Some payers include attachment options
REFERRING PROVIDER

ATTACHMENTS

DIAGNOSIS CODES

* Principal Diagnosis Code

Type to search...

External POA Indicator

Type to search...

Add another code

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.

Principal diagnosis code required

Patient Registration Home Notifications More Help & Training Sandy's Account Keys

DIAGNOSIS CODES

* Principal Diagnosis Code

Type to search...

External POA Indicator

Type to search...

Add another code

CLAIM INFORMATION

* Patient Control Number / Claim Number

Diagnosis Related Group

Type to search...

Medical Record Identification Number

* Facility Type

11 - Hospital Inpatient, including Part A

* Admission Type

9 - Information Not Available

* Frequency Type

1 - Admit thru Discharge Claim

* Provider Accepts Assignment

Assigned

* Admission Source

9 - Information Not Available

* Release of Information

Consent to Release Medical Informati...

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

Diagnosis Related Group

Type to search...

Medical Record Identification Number

* Facility Type

11 - Hospital Inpatient, including Part A

* Admission Type

9 - Information Not Available

* Frequency Type

1 - Admit thru Discharge Claim

* Provider Accepts Assignment

Assigned

* Admission Source

9 - Information Not Available

* Release of Information

Consent to Release Medical Informati...

* Claim Filing Indicator

Type to search...

Prior Authorization Number

Acute Manifestation Date

mm/dd/yyyy

Auto Accident Country

United States

Auto Accident State

Type to search...

Payer Claim Control Number

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.

**Start Over to
clear the form**

e form.

Start Over

Submit

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.

Procedure Code	Procedure Description	* Revenue Code <input type="text" value="Type to search..."/>	
* Charge Amount <input type="text" value="100.00"/>	* Qty <input type="text" value="1"/>	* Quantity Type <input type="text" value="Unit"/>	Non Covered Charge Amount <input type="text"/>
Modifier 1 <input type="text"/>	Modifier 2 <input type="text"/>	Modifier 3 <input type="text"/>	Modifier 4 <input type="text"/>
<input type="checkbox"/> NATIONAL DRUG CODE (NDC) INFORMATION			
<input type="checkbox"/> RENDERING PROVIDER			

18. Claims submission confirmation screen.

Claim Submitted
Your claim has been accepted by the payer.

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

Non-Par Provider Claim Submissions

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

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

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

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 members' 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?	<p>Method 1: Molina Availability Essentials Portal (most preferred method): https://provider.molinahealthcare.com/</p> <p>You can search and identify adjudicated claim and submit a dispute/appeal. Upload required documents or proof to support the dispute.</p> <p>Method 2: Fax to (562) 499-0633</p> <p>Method 3: Mail to:</p> <p>Molina Healthcare of California Attn: Provider Dispute Resolution Unit P.O. Box 22722 Long Beach, CA 90801</p>	
How do I check for status?	Method 1: Availability Essentials Portal is Molina's preferred method. (Please refer to Availability 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 Availability 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?	<p>Method 1: Availability Essentials Portal is Molina's preferred method. (Please refer to Availability section of FAQ below).</p> <p>Method 2: You may contact the prior authorization department.</p>	(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.	
Availability		

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?	<p>Availity Essentials Portal</p> <p>When you register for Availity, please be sure that your organization name and NPI matches with the NPPES NPI Registry.</p>	(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?	<i>Refer to the Claims FAQ section</i>	
Who is your clearinghouse/EDI vendor?	<p>EDI Vendor: Emdeon Payer ID: 38333</p> <p>Clearinghouse: SSI Claimsnet, LLC (SSI Group) Registration Form: SSI.ProviderRegistration.Web (ssigroup.com) Payer ID: 38333</p>	(855) 322-4075
How do I check for claim status?	<p>Method 1: Availity Essentials Portal is Molina's preferred method. (Please refer to Availity section of FAQ below)</p> <p>Method 2: You can call claims customer service.</p> <p>Method 3: If you are registered with Molina's clearing house Change Health Care you can view claim status.</p>	(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?	<p>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.</p> <p>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.</p> <p>Corrected claims must be sent within 180 calendar days of the date of service of the claim.</p>	
Case Management		
	<i>Refer to the Case Management FAQ section</i>	
Continuity of Care		
	<i>Refer to the UM FAQ section</i>	
Customer Service		
What is the Molina costumer service number?	Provider Contact Center	(855) 322-4075

Electronic Payments		
How do I register for electronic payments?	<p>Change Healthcare/ECHO: To register for EFT and remittance advise, please go to ECHO Health (echohealthinc.com)</p> <p>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.</p> <p>Please visit our website for additional step-by-step ECHO registration.</p>	
Eligibility		
How do I verify member eligibility?	<p>Method 1: Through the Availity Essentials Portal.</p> <p>Method 2: You may call the Molina eligibility department.</p>	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?	<p>Los Angeles: MHC_LAProviderServices@MolinaHealthcare.com</p> <p>Sacramento: MHCSacramentoProviderServices@MolinaHealthcare.com</p> <p>San Bernardino: MHCIEProviderServices@MolinaHealthcare.com</p> <p>Riverside: MHCIEProviderServices@MolinaHealthcare.com</p> <p>San Diego: MHCSanDiegoProviderServices@MolinaHealthcare.com</p> <p>Imperial: MHCImperialProviderServices@MolinaHealthcare.com</p>	
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	
How do I request an onboarding Training?	Contact your assigned Provider Relations Representative	
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?	Find your assigned Provider Relations representative: MHC Provider Relations Contact List	
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

Find your assigned Provider Relations representative: [MHC Provider Relations Contact List](#)

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

Pharmacy Authorizations:

Phone: (800) 977-2273

Fax: (800) 869-4325

Radiology Authorizations:

Phone: (855) 714-2415

Fax: (877) 731-7218

Provider Customer Service:

Phone: (855) 322-4075

Fax: (562) 499-0619

Transportation:

Phone: (855) 253-6863

Fax: (877) 601-0535

24 Hour Behavioral Health Crisis (7 days/week):

Phone: (888) 275-8750

Dental:

Phone: (800) -322-6384

Website: www.dental.dhcs.ca.gov

Vision:

Phone: (844) 336-2724

Fax: (855) 640-6737

Member Customer Service, Benefits/Eligibility:

Phone: (888) 665-4621/ TTY/TDD 711

Fax: (866) 507-6186

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

- Member Name.** Enter the Member's full name from the Benefits Identification Card (BIC).
- 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.
- 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 request.
- ICD Diagnosis Codes.** List the ICD diagnosis codes for the Member, up to three.
- 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.
- 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.

DHCS 3762 (New 1/2024)

Page 3 of 4

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.

DHCS 3762 (New 1/2024)

Page 4 of 4

HS-231: Certification for Special Treatment Program 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	
<p>Part II—Completed by designee of regional center director/local mental health director</p> <p><input type="checkbox"/> Grant <input type="checkbox"/> Deny</p> <p>List below supportive information for this recommendation</p>			
<p>Program Category:</p> <p><input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> ICF/DD <input type="checkbox"/> ICF/DDH <input type="checkbox"/> ICF/DDN <input type="checkbox"/> Mentally Disordered</p> <p>Part III—Certification by:</p> <p><input type="checkbox"/> Regional Center Director <input type="checkbox"/> Local Mental Health Director</p> <p><input type="checkbox"/> You are authorized to claim payment for treatment as recommended</p> <p>From _____</p> <p>To _____</p> <p>which is a total of _____ days</p> <p><input type="checkbox"/> Request denied</p> <p>Comments: _____</p>			
Signature		Date	Signature
Title		Affiliation	Title

FORM DISTRIBUTION:

Developmentally Disabled: Original-facility: Copies—regional center director/designee

Mentally Disordered: Original-facility, Copies-local mental health director/designee

**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	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Annual
Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Case number	Birth date
Admission date	Attending physician	Present status <input type="checkbox"/> NH <input type="checkbox"/> IC <input type="checkbox"/> RC <input type="checkbox"/> Other		
Facility				
Address (number, street)		City	ZIP code	
Diagnoses		Medications		
1.	2.	3.	4.	5.
6.	7.	8.	9.	
Diet				

Remarks

- 1) Is the patient involved in school and is treatment plan coordinated with the school?
- 2) Is the patient involved in daily planned activities or any type of learning experience?
- 3) Is patient and staff interaction ongoing?
- 4) Is there any potential?
- 5) Is Plan of Care current?
- 6) Are individual goals reviewed and/or met/updated?
- 7) Are quarterly notes written timely?
- 8) Are psychological evaluations done?
- 9) Is there QMRP input in the chart and/or whole interdisciplinary team?

Before admission

After admission

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Every 90 days?

	Dates of visits	Recommendation	
		<input type="checkbox"/> Chart review	<input type="checkbox"/> Skilled nursing
	Interviewer	<input type="checkbox"/> ICF	<input type="checkbox"/> RCF
		<input type="checkbox"/> ICF/DD	<input type="checkbox"/> ICF/DD/H

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 <input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Terminal		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) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Walking</td></tr> <tr><td><input type="checkbox"/> Transferring</td></tr> <tr><td><input type="checkbox"/> Wheeling</td></tr> <tr><td><input type="checkbox"/> Bathing</td></tr> <tr><td><input type="checkbox"/> Dressing</td></tr> <tr><td><input type="checkbox"/> Grooming</td></tr> <tr><td><input type="checkbox"/> Toileting</td></tr> </table>		<input type="checkbox"/> Walking	<input type="checkbox"/> Transferring	<input type="checkbox"/> Wheeling	<input type="checkbox"/> Bathing	<input type="checkbox"/> Dressing	<input type="checkbox"/> Grooming	<input type="checkbox"/> Toileting										
<input type="checkbox"/> Walking																				
<input type="checkbox"/> Transferring																				
<input type="checkbox"/> Wheeling																				
<input type="checkbox"/> Bathing																				
<input type="checkbox"/> Dressing																				
<input type="checkbox"/> Grooming																				
<input type="checkbox"/> Toileting																				
Rehabilitation Potential <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		Communication <input type="checkbox"/> Able to make needs known <input type="checkbox"/> Speaks no English <input type="checkbox"/> Can write, not speak <input type="checkbox"/> Cannot speak or write, but seems to comprehend <input type="checkbox"/> Aphasic, partial <input type="checkbox"/> Aphasic, complete																		
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 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Range of motion</td></tr> <tr><td><input type="checkbox"/> Preventive/corrective positioning</td></tr> <tr><td><input type="checkbox"/> Ambulation skills</td></tr> <tr><td><input type="checkbox"/> Transfer skills</td></tr> <tr><td><input type="checkbox"/> Grooming/dressing skills</td></tr> <tr><td><input type="checkbox"/> Mental stimulation</td></tr> <tr><td><input type="checkbox"/> Communication skills</td></tr> <tr><td><input type="checkbox"/> Bladder retraining</td></tr> <tr><td><input type="checkbox"/> Bowel retraining</td></tr> <tr><td><input type="checkbox"/> Feeding skills</td></tr> <tr><td><input type="checkbox"/> Social behavior</td></tr> <tr><td><input type="checkbox"/> Aggression</td></tr> <tr><td><input type="checkbox"/> Self-injurious</td></tr> <tr><td><input type="checkbox"/> Smearing</td></tr> <tr><td><input type="checkbox"/> Destruction of property</td></tr> <tr><td><input type="checkbox"/> Running or wandering away</td></tr> <tr><td><input type="checkbox"/> Temper tantrums or emotional outbursts</td></tr> </table>		<input type="checkbox"/> Range of motion	<input type="checkbox"/> Preventive/corrective positioning	<input type="checkbox"/> Ambulation skills	<input type="checkbox"/> Transfer skills	<input type="checkbox"/> Grooming/dressing skills	<input type="checkbox"/> Mental stimulation	<input type="checkbox"/> Communication skills	<input type="checkbox"/> Bladder retraining	<input type="checkbox"/> Bowel retraining	<input type="checkbox"/> Feeding skills	<input type="checkbox"/> Social behavior	<input type="checkbox"/> Aggression	<input type="checkbox"/> Self-injurious	<input type="checkbox"/> Smearing	<input type="checkbox"/> Destruction of property	<input type="checkbox"/> Running or wandering away	<input type="checkbox"/> Temper tantrums or emotional outbursts	Wound Care—Dressings <input type="checkbox"/> Dry sterile dressing <input type="checkbox"/> Open, draining <input type="checkbox"/> Sterile/medicated dressing	
<input type="checkbox"/> Range of motion																				
<input type="checkbox"/> Preventive/corrective positioning																				
<input type="checkbox"/> Ambulation skills																				
<input type="checkbox"/> Transfer skills																				
<input type="checkbox"/> Grooming/dressing skills																				
<input type="checkbox"/> Mental stimulation																				
<input type="checkbox"/> Communication skills																				
<input type="checkbox"/> Bladder retraining																				
<input type="checkbox"/> Bowel retraining																				
<input type="checkbox"/> Feeding skills																				
<input type="checkbox"/> Social behavior																				
<input type="checkbox"/> Aggression																				
<input type="checkbox"/> Self-injurious																				
<input type="checkbox"/> Smearing																				
<input type="checkbox"/> Destruction of property																				
<input type="checkbox"/> Running or wandering away																				
<input type="checkbox"/> Temper tantrums or emotional outbursts																				
Plan of Care Individual goals are met and updated? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the plan of care complete and updated? <input type="checkbox"/> Yes <input type="checkbox"/> No Degree of Retardation <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound		Bowel Control <input type="checkbox"/> Occasionally involuntary <input type="checkbox"/> Involuntary <input type="checkbox"/> Colostomy/Ileostomy <input type="checkbox"/> Self-care Bladder Control <input type="checkbox"/> Occasionally incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter <input type="checkbox"/> Bowel-Bladder Training—Date Feeding <input type="checkbox"/> Feeding program date <input type="checkbox"/> Feeds self with assistive device <input type="checkbox"/> Needs partial help in feeding <input type="checkbox"/> Needs to be fed <input type="checkbox"/> N-G tube <input type="checkbox"/> Gastrostomy <input type="checkbox"/> Parenteral <input type="checkbox"/> Supplemental feedings Current Medications <input type="checkbox"/> Antibiotics <input type="checkbox"/> Cardiac drugs <input type="checkbox"/> Diuretics <input type="checkbox"/> Anticoagulants <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Insulin <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Hypnotics <input type="checkbox"/> Narcotics <input type="checkbox"/> Oral hypoglycemic Decubitus Ulcer <input type="checkbox"/> None or healed <input type="checkbox"/> Stage I—red/inflamed area <input type="checkbox"/> Stage II—superficial skin break w/ired surrounding <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV																		
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) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Walking</td></tr> <tr><td><input type="checkbox"/> Transferring</td></tr> <tr><td><input type="checkbox"/> Wheeling</td></tr> <tr><td><input type="checkbox"/> Bathing</td></tr> <tr><td><input type="checkbox"/> Dressing</td></tr> <tr><td><input type="checkbox"/> Grooming</td></tr> <tr><td><input type="checkbox"/> Toileting</td></tr> </table>		<input type="checkbox"/> Walking	<input type="checkbox"/> Transferring	<input type="checkbox"/> Wheeling	<input type="checkbox"/> Bathing	<input type="checkbox"/> Dressing	<input type="checkbox"/> Grooming	<input type="checkbox"/> Toileting	Communication <input type="checkbox"/> Able to make needs known <input type="checkbox"/> Speaks no English <input type="checkbox"/> Can write, not speak <input type="checkbox"/> Cannot speak or write, but seems to comprehend <input type="checkbox"/> Aphasic, partial <input type="checkbox"/> Aphasic, complete											
<input type="checkbox"/> Walking																				
<input type="checkbox"/> Transferring																				
<input type="checkbox"/> Wheeling																				
<input type="checkbox"/> Bathing																				
<input type="checkbox"/> Dressing																				
<input type="checkbox"/> Grooming																				
<input type="checkbox"/> Toileting																				
Wound Care—Dressings <input type="checkbox"/> Dry sterile dressing <input type="checkbox"/> Open, draining <input type="checkbox"/> Sterile/medicated dressing		Diabetic Care <input type="checkbox"/> Inability to manage diabetic condition <input type="checkbox"/> Well-regulated by diet only <input type="checkbox"/> Well-regulated with medication <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Urine testing																		
Visual <input type="checkbox"/> No apparent handicap <input type="checkbox"/> Correctable vision w/glasses <input type="checkbox"/> Severe visual impairment <input type="checkbox"/> Legally or totally blind		Auditory <input type="checkbox"/> No apparent hearing problem <input type="checkbox"/> Mild hearing problem <input type="checkbox"/> Wears hearing aid <input type="checkbox"/> Deafness, corrected by aid <input type="checkbox"/> Deafness, not corrected																		
Rehabilitation and M.D. Orders <input type="checkbox"/> Physical therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Speech therapy		Rehabilitative Nursing Program Mental and Behavioral Status <input type="checkbox"/> Receiving psychiatric care x3 <input type="checkbox"/> Alert and oriented x3 <input type="checkbox"/> Disoriented <input type="checkbox"/> Confused <input type="checkbox"/> Wanderer <input type="checkbox"/> Noisy, yells/agitated <input type="checkbox"/> Aggressive <input type="checkbox"/> Combative <input type="checkbox"/> Other antisocial behavior <input type="checkbox"/> Withdrawn <input type="checkbox"/> Comatose <input type="checkbox"/> Follows simple instructions																		
Other Special Needs/Problems <input type="checkbox"/> Amputee—location <input type="checkbox"/> Braces/cast <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis/area <input type="checkbox"/> Joint motion/pain/swelling <input type="checkbox"/> Inhalation/oxygen therapy <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Suctioning <input type="checkbox"/> Multiple injections or IVs <input type="checkbox"/> Fluid retention <input type="checkbox"/> Isolation techniques <input type="checkbox"/> Contractures																				

DO NOT COMPLETE BELOW THIS LINE—STATE USE ONLY