Molina Healthcare of California

My Care Program
Palliative Care Provider Toolkit

February 2025

MolinaHealthcare.com

MOLINA® HEALTHCARE

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Provider FAQ and Billing Guide

What is My Care?

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

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

What services are covered under My Care?

The services covered under the program are as follow:

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

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

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

How are members informed about My Care?

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

How are providers informed about My Care?

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

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

You will receive a **case rate** for **My Care** services, which is considered an all-inclusive payment for the services referenced above and rendered in accordance with your contract. The case rate applies per member, per month for the duration of the member's enrollment in the program. This includes four contacts with the member each month, with a minimum of one in-person visit. During exceptional times, the mandate for in-person visits may be conducted via telephonic or tele-video conferencing, in alignment with state guidance. Additionally, for the first month of a member's successful enrollment, you will be able to bill for an "initial patient assessment" for additional compensation. If you are unsuccessful in enrolling an approved member into the program, you may bill ONE month case rate for efforts made.

What codes do I bill to receive payment for members enrolled in My Care?

Claims must be billed with CPT Code **99497** with diagnosis code Z51.5 (encounter for palliative care) to trigger payment, in accordance with your contract. Additionally, on the FIRST month of a member's successful enrollment CPT Code **99344** may be billed **ONE TIME** for the Initial Patient Assessment with diagnosis code Z51.5. This CPT code/s and diagnosis code combination must be indicated on all authorization requests and claim submissions for successful case rate payment. Other codes billed on the case rate claim outside of your My Care Palliative Care contract will not be paid separately.

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

Case Rate includes professional fees, and all other CPT/service(s) rendered on the same day, which shall be included within the Case Rate Compensation. However, separate reimbursement is provided for additional visits that may be needed to manage the member's condition, in accordance with your contract. The only services which shall be separately payable are services provided by a Medical Doctor or Nurse Practitioner using CPT codes 99345 or 99350 and must be billed with diagnosis code Z51.5 in order to receive payment. All other services shall be denied as being included within the Case Rate Compensation.

What about Members that are not enrolled in My Care?

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

Completing the Claim Form and Billing Specifications

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

Initial Patient Assessment Reimbursement:

- ☐ Bill **99344** with dx code **Z51.5**, **ONLY** for the **FIRST** month of a successful member enrollment on a **HCFA 1500 professional claim form.** This can only be billed one time per member at the onset of enrollment.

Case Rate Reimbursement:

- ☐ Bill **99497** with dx code **Z51.5** on a **HCFA 1500 professional claim form** for the monthly case rate once per member per month.
- ☐ Do not include any other service codes **other than those already mentioned** as the case rate claim is considered an all-inclusive payment.
- ☐ Only **ONE** claim should be submitted per member, per month for members enrolled in **My Care.**

Physician and Nurse Practitioner Visit Reimbursement:

- ☐ Bill the applicable Medi-Cal service code **99345** or **99350** with dx code **Z51.5** on a **HCFA 1500 professional claim form**.
- ☐ Service codes **99345** and **99350** provider visits do not apply to the four (4) minimum visits as required in your contract and can only be reimbursed after the minimum visits for the month have been satisfied.
- ☐ Do not bill the case rate code 99497 or the initial patient assessment 99344 for these additional visits.

Each CPT code must be billed on a SEPARATE HCFA 1500 professional claim form in order to be paid out correctly.

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

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

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

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

Claims Quick Reference Guide

Claims Processing Standards

Molina is compliant with all state and federal processing standards.

Claims Submission Options

1. **Molina strongly encourages participating Providers to submit Claims electronically (via clearinghouse or the Availity portal) whenever possible.**
   - Change Healthcare is an outside vendor that is used by Molina Healthcare of California.
   - When submitting EDI Claims (via a clearinghouse) or to Molina Healthcare of California, please utilize the following payer ID 38333.
   - EDI or Electronic Claims get processed faster than paper claims.
   - Providers can use any clearinghouse of their choosing. Note that fees may apply.
   - To verify the status of your claims, please use the Availity portal. Claims questions can be submitted through the chat feature on the Availity portal or contact Provider Relations.
   - Telephone (855) 322-4075
2. **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

Provider Portal Claims Submission:

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

EDI Claims Submission Issues

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

Claims Customer Service

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

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

1. Definition of a Provider Dispute

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

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

2. Provider Dispute Time Frame

Molina Healthcare of California accepts disputes from providers if they are submitted within 365 days of receipt of Molina Healthcare's decision indicating claim was denied or adjusted. For paper submission, MHC will acknowledge receipt of the dispute within fifteen (15) working days. If additional information is needed from the Provider/Practitioner, MHC has forty-five (45) working days to request necessary additional information. Once notified in writing, the Provider/Practitioner has thirty (30) working days to submit additional information or claim dispute will be closed by MHC.

3. Submission of Provider Disputes

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

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

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

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

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

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

OR

Fax to (562) 499-0633

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

Medicare Contracted Inquiries

- Medicare Contracted: MedicareSpecialProjects@MolinaHealthcare.com
- Please include the following components in your submission:

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

Appendix

Pre-Service Review Guide & Request Form

Molina® Healthcare Medicaid
Pre-Service Review Guide
Effective: 01/01/2025

Refer to Molina's Provider Website or Prior Authorization Look-Up Tool for specific codes that require Prior Authorization

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**
- **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.
- **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**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** Non-emergent air transportation.

STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with the claim.

IMPORTANT INFORMATION FOR MOLINA MEDICAID PROVIDERS

Information generally required to support authorization decision making includes:

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

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

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.

  Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (866) 814-2221.

IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

(Service hours 8:30am-5:30pm local M-F, unless otherwise specified)

Prior Authorizations including Behavioral Health Authorizations: Phone: (844) 557-8434 Fax: (800) 811-4804	**24 Hour Behavioral Health Crisis (7 days/week):** Phone: (888) 275-8750
Pharmacy Authorizations: Phone: (800) 977-2273 Fax: (800) 869-4325	**Dental:** Phone: (800) 336-8478 Website: www.dental.dhcs.ca.gov
Radiology Authorizations: Phone: (855) 714-2415 Fax: (562) 499-0619	**Vision:** Phone: (844) 336-2724 Fax: (855) 640-6737
Provider Customer Service: Phone: (855) 322-4075 Fax: (562) 499-0619	**Member Customer Service, Benefits/Eligibility:** Phone: (888) 665-4621/ TTY/TDD 711 Fax: (866) 507-6186
Transportation: Phone: (855) 253-6863 Fax: (877) 601-0535	**Transplant Authorizations:** Phone: (855) 714-2415 Fax: (877) 813-1206
	24 Hour Nurse Advice Line (7 days/week) Phone: (888) 275-8750/TTY: 711 Members who speak Spanish can press 1 at the IVR prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members. *No referral or prior authorization is needed.*

Providers may utilize Molina Healthcare's Website at: provider.molinahealthcare.com/Provider/Login

Available features include:

- Authorization submission and status
- Member eligibility
- Provider directory

- ☐ Claim submission and status
- ☐ Download frequently used forms
- ☐ Nurse advice Report

Molina® Healthcare, Inc. – Pre-Service Request Form

MEMBER INFORMATION

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

REFERRAL/SERVICE TYPE REQUESTED

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

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

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

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

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

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

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

SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):

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

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

MOLINA HEALTHCARE

CLINICAL INFORMATION ONLY:

My Care Palliative Care

For Molina External Use Only

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

PRODUCT: ☐MEDI-CAL		
Total Pages included in fax including cover sheet:		Date: / /
Member Name (Last, First, Middle Initial)	Date of Birth / /	Member I.D.
Materials to be reviewed when Prior Authorization (PA) request is received from provider		
Assessment ☐	Clinical progress notes ☐	Care Plan ☐
Other ☐	Other description:	
Sender name, phone number and fax number:		

Confidentiality Notice: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon the fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately and destroy the original documents. Thank you.

6.14.2018