Molina Healthcare of California

Doula Provider Toolkit

July 2024

On January 1, 2023, the Department of Health Care Services (DHCS) added doula services as a covered benefit under the California State Medicaid program. Molina Healthcare of California (MHC) works with doula providers to provide emotional and physical support to prenatal, perinatal, and postpartum Medi-Cal members.

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Utilization Management

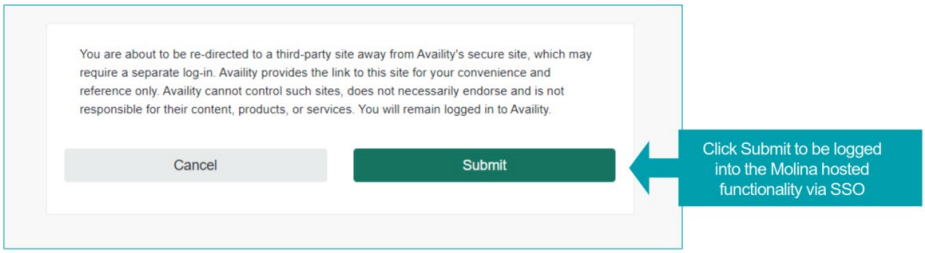
Prior Authorization

1. How do I submit for a new authorization once an initial authorization has expired?

The DHCS allows for a total of nine visits including one initial visit and eight follow-up visits, plus labor and delivery. The nine visits may be used throughout the perinatal period, as determined by the birthing person and doula. These first nine visits, plus the labor and delivery, are part of a standing order from DHCS and do not require a written recommendation from a licensed provider. More than nine visits may be provided with a renewed recommendation from a licensed provider. You must include the renewed recommendation from a licensed provider in the authorization request.

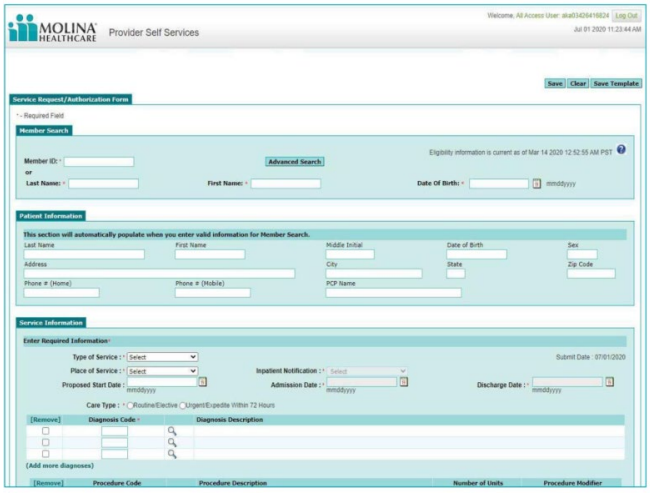
Authorization requests can be submitted utilizing the Molina portal at: provider.molinahealthcare.com/

Step 1:

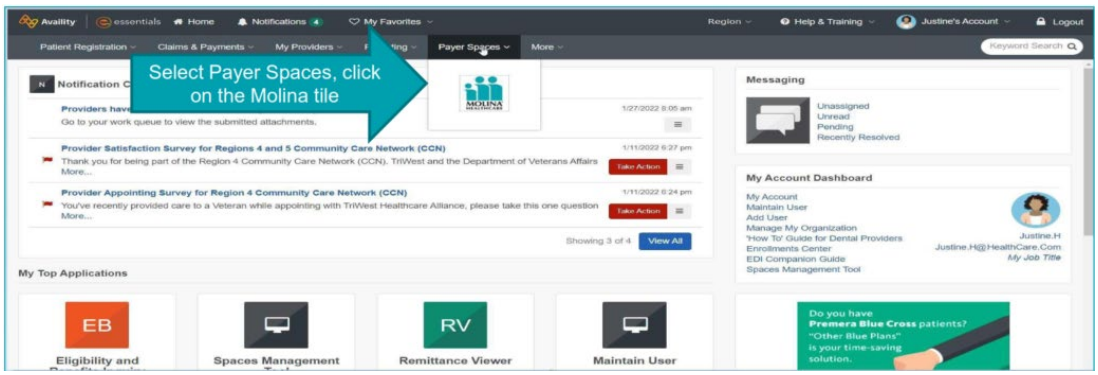


Step 2:

Complete form.

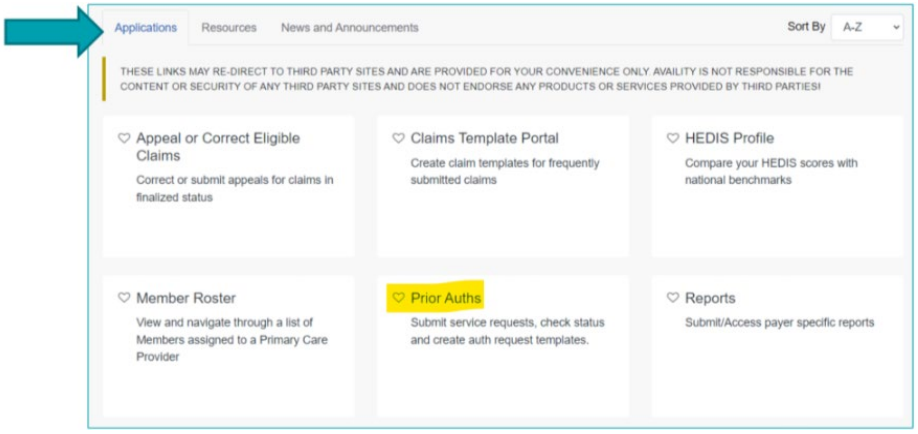


Step 3:



Step 4:

From Applications, select *Prior Auths*.



2. What is the turnaround timeline for Prior Authorizations?

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

Provider Contracts

Letter of Agreement (LOA)

1. Do I need to obtain a LOA?

When a member requests a doula in a service area where Molina has not completed contracting with a doula provider, Molina will allow the non-contracted doula to request a LOA. The LOA enables members to promptly access doula services while MHC establishes a long-term contract with the doula.

When a provider requests a Prior Authorization or Continuity of Care (CoC), the Utilization Management (UM) team will determine whether a LOA 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 LOAs executed for each member?

A one-time LOA with MHC is needed per member. This LOA will cover the individual member receiving services under the associated authorization. The Molina contracting team will continue with the contracting process and this process was put in place to allow members access to doula services quickly.

3. When should I receive payment once I return my LOA?

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

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
Maria Torres Manager Provider Contracts	562-679-4232	Maria.Torres6@molinahealthcare.com
Angelee Smith, Director Provider Contracts	562-542-1904	Angelee.Smith@molinahealthcare.com

Case Management

1. What does Molina's Case Management team do?

Our Case Management team assists Molina members with complex needs and/or who are having difficulty with coordinating their care including:

- Multiple comorbid diagnoses & medications
- Member needing help in accessing care or Continuity of Care
- Experiencing Health and/or Behavioral health crisis
- High Utilization (Admissions, ED visits)
- Barriers to accessing care
- Non-adherence
- At risk for Long Term Care/Institutionalization
- Long Term Services and Supports (LTSS)
- As needed collaboration with the Interdisciplinary Care team including the Primary Care Provider

2. What does a Transition of Care Coach assist with?

When a Molina member has been discharged from the hospital, a Transitions of Care Coach will reach out to the member to assist the member through their transition from the hospital back to their home. They will assist with:

- Following discharge instructions from the hospital such as medication orders and any equipment or referral needs.
- Education on signs and symptoms and when to report worsening conditions.
- Assist and ensure timely follow-up appointments after hospitalization.
- Referrals to resources to help reduce barriers related to SDOH (e.g., transitional meals, transportation, Enhanced Care Management/Community Supports).
- Assess and refer to complex case management for ongoing needs.

3. Where should pregnant Molina members be referred to?

If a pregnant Molina member is identified as needing any services mentioned here, please refer to:

- Email: MHIHighRiskOBTeam@MolinaHealthCare.Com
- Phone: (833) 234-1258

The Case Management Department will then contact the member. Case Management will screen the member for any complex needs and determine whether they could benefit from participating in case management.

Enhanced Care Management (ECM)

1. What is CalAIM?

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across the Medi-Cal program.

2. What are the goals of CalAIM?

The goals of CalAIM are to:

1. Identify and manage member risk and needs through whole-person care approaches and addressing Social Determinants of Health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

3. What is ECM?

ECM is a CalAIM program that provides a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. It addresses the clinical and non-clinical needs of members with the most complex medical and social needs through systematic coordination of services and comprehensive care management is community-based, interdisciplinary, high touch, and person-centered. DHCS' vision for ECM is to coordinate all care for members who receive it, including across the physical and behavioral health delivery systems. The ECM benefit builds on the current Health Homes (HH) Program and Whole Person Care (WPC) Pilots and replaced both initiatives, effective January 1, 2022.

4. What services does ECM offer?

ECM is intended for members with the highest need, providing intensive coordination of health and health-related services. The seven core services provided by ECM are:

- Outreach and engagement
- Comprehensive transitional care
- Comprehensive assessment and care plan
- Enhanced coordination of care
- Health promotion
- Individual and family/social supports
- Coordination and referral to community and social support services

5. Does ECM address birth equity?

The ECM Birth Equity Population of Focus (POF) aims to address known underlying risk factors for disparities in health and birth outcomes in specific populations with high maternal morbidity and mortality rates. In California, where Medi-Cal provides health insurance coverage for about 40% of all births annually, the Department of Health Care Services (DHCS) has implemented changes to improve prenatal and postpartum care and reduce pregnancy-related morbidity and mortality. The ECM Birth Equity POF launched on January 1, 2024. Members who qualify can receive these services along with doula services. We encourage you to talk to members about enrolling in ECM Birth Equity POF if they meet the eligibility criteria. Please see the Birth Equity POF FAQ that explains the eligibility criteria.

6. How do I refer a member for ECM services?

How to refer a member to ECM services:

1. Referral forms for ECM are available on our public website, located in the provider section, under Frequently Used Forms.
2. Submit the referral form to: MHC_ECM@Molinahealthcare.com

ECM Populations of Focus | Timeline

ECM Populations of Focus	Go-Live Date
Individuals Experiencing Homelessness:	
Adults and their Families Experiencing Homelessness	1/1/2022
Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	7/1/2023
Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	7/1/2023
Individuals At Risk for Avoidable Hospital or ED Utilization ("High Utilizers")	
Adults at Risk for Avoidable Hospital or ED Utilization	1/1/2022
Children/Youth at Risk for Avoidable Hospital or ED Utilization	7/1/2023
Individuals with Serious Mental Health and/or SUD Needs	
Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs	1/1/2022
Children/Youth with Serious Mental Health and/or Substance Use Disorder (SUD)	7/1/2023
Individuals Transitioning from Incarceration	
Adults Transitioning from Incarceration within the past 12 months	1/1/2024
Children/Youth Transitioning from Youth Correctional Facility within the past 12 months	1/1/2024
Adults Living in the Community who are at Risk for LTC Institutionalization	1/1/2023
Adult Nursing Facility Residents transitioning to the Community	1/1/2023
Children/Youth Enrolled in CCS or CCS WCM with Additional Needs beyond the CCS Condition	7/1/2023
Children/Youth Involved in Child Welfare	7/1/2023
Adults and Child/Youth Birth Equity	1/1/2024

Note: "**Adult**" is defined as an individual who is 21 years of age or older, and a "**Child or Youth**" is defined as an individual under 21.

Community Supports

1. What is Community Supports?

Molina offers Community Supports for members. Community Supports focuses on addressing combined medical and social determinants of health needs and avoiding higher levels of care or other future health care costs. The 14 Community Supports offered are:

1. Housing Transition Navigation Services
2. Housing Deposits (Move-in Assistance)
3. Housing Tenancy and Sustaining Services
4. Short-term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite (for caregivers)
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptions (Home Modifications)
12. Meals/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation

2. What are the eligibility criteria for Community Supports?

Eligibility Criteria for Community Supports:

- All referrals must be submitted to the Molina Community Supports Team for review and final approval.
- Referral forms for ECM are available on our public website, located in the provider section, under Frequently Used Forms.
- Submit referral form to: MHC_CS@molinahealthcare.com.
- Community Support services require prior authorization (except Sobering Centers).
- Each Community Support has specific qualifying criteria for members to be approved for the service. The request will be reviewed and decided by the HCS Community Supports team. The criteria are listed on the CS referral forms.
- Duplication of services is not permitted – the member cannot receive these services through another avenue, such as a state or county-funded program.

3. How can I learn more about ECM and CS?

Please review the links below to learn more:

- CalAIM Overview: CalAIM
- CalAIM ECM and CS: Enhanced Care Management and Community Supports (ILOS)
- CalAIM ECM Policy Guide: CalAIM Enhanced Care Management (ECM) Policy Guide

- ECM Provider Toolkit: Provider Toolkit (aurrerahealth.com)
- CalAIM CS Policy Guide: DHCS-Community-Supports-Policy-Guide.pdf (ca.gov)
- CalAIM CS Explainer: Medi-Cal Community Supports Explainer (aurrerahealth.com)
- Additional Resources: Publications - California Health Care Foundation (chcf.org)

4. Does MHC provide language assistance?

Molina contracts with a telephone language line for immediate language interpretation needs and a vendor that provides in-person interpretation with at least 5 days advance scheduling. This is at no cost to the member; Molina will cover any costs.

Interpretation Services		
Telephonic Interpreters	**Video Remote Interpreters**	**In-Person Interpreters**
• Available on demand, 24/7. • Telephonic interpretation is best for most routine appointments. • Call the Contact Center to be immediately connected to an interpreter. No appointment needed! • Over 125 languages • Providers can access interpreter services via Molina Member and Provider contact center.	• VRI is best for more complicated appointments or when the member needs access to a sign language interpreter. • VRI is HIPAA compliant. It can be accessed from any standard smartphone, tablet, or laptop equipped with a webcam and requires no special software. • Appointments should be scheduled at least 2 days in advance whenever possible. • On-demand VRI is also available as a backup.	• In-person interpretation is used for the most complex appointments, or when VRI is not possible. • Appointments should be scheduled at least 5 days in advance whenever possible. • Telephonic interpretation and VRI are both available as backups in case the in-person interpretation is not approved, or the interpreter does not show

5. How can I access Interpretation Services?

Please call Molina's Provider Contact Center at (855) 322-4075. For after-hours and weekends, please call Molina's Nurse Advice Line to connect to an interpreter (888) 275-8750.

Providers may use the California Relay Service to speak to members who are deaf, hard of hearing, or have speech difficulties. Dial 711 and give the Relay Operator (RO)/Communication Assistant (CA) the member's area code and telephone number.

6. What type of translation support does Molina offer?

Molina translates existing health education materials, care plans, and enrollment materials into the members' preferred language upon request. Please have the member contact Member Services at (888) 665-4621 to request translation of any documents.

Molina offers a variety of low-literacy health education materials in English and Spanish on the MHC Health Education Materials webpage.

7. How do I request documents in an alternative format?

Molina offers vital documents in large print, Braille, electronic files, and audio format. Please have the member contact Member Services at (888) 665-4621 to request this service.

8. How do I access cultural and linguistic training and resources?

Molina's Cultural Competency training videos and Provider Disability Education Series are available on the MHC Cultural and Linguistic Resources webpage.

Molina also offers tailored training on cultural competency and sensitivity to seniors and persons with disabilities. For cultural and linguistic consultations, questions regarding cultural beliefs and practices that may affect patient care, or to request training, contact Molina at HealthEducation.MHC@Molinahealthcare.com.

The MHC Ask the Cultural and Linguistics Specialist webpage is an interactive web-based question-and-answer forum to assist providers with delivering culturally appropriate care. All inquiries receive a response within 72 hours from Molina's Cultural Anthropologist.

Health Education

1. What Health Management Programs does Molina offer?

Molina offers Health Management Programs for our members. Programs and services include:

- Asthma (2+ y.o.)
- Diabetes (18+ y.o.)
- Hypertension (18+ y.o.)
- Heart Failure (18+ y.o.)
- Depression (18+ y.o.)
- COPD (35+ y.o.)
- Adult Weight Management and Obesity (18+ y.o.)
- Nutrition Consults (2+ y.o.)

Providers can reference the Health Education Resource Provider Flyer to learn more.

2. How do I refer a member for a Health Management Program?

Refer the member through one of the options below:

- Health Education Referral Form: bit.ly/3sSWQm1
- Call: (866) 891-2320, ext: 751137, option 2

3. Where do I refer members for smoking cessation?

Refer to KICK IT CA for quitting smoking, vaping, and smokeless tobacco. Counseling is available in multiple languages (English, Spanish, Korean, Vietnamese, Cantonese, and Mandarin). NRTs are covered by Molina, and 10 days of patches are available via KICK IT for qualifying members (for members 18+).

Speak with a Quit Coach:

- English: (800) 300-8086
- Spanish: (800) 600-8191

Chat with a Quit Coach:

- kickitca.org/chat

4. Where can members access maternal mental health services?

If you feel that a member requires additional screening for mental health, please refer them to our HROB email MHIHighRiskOBTeam@MolinaHealthCare.Com or call (833) 234-1258 to speak to someone in Case Management.

Claims

Claim Submissions

1. How do I submit a claim?

Providers should submit claims electronically. Claims can be sent to:

- 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.

2. Are paper claims acceptable?

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.

3. 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.

4. 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

3b	Medical Record Number	Optional	This is an (Optional Field)
4	Type of bill	Required	Enter the Four-digit type of bill code as specified in the National Uniform Billing Committee (NUBC) UB-04 data manual. **Bill Types:** **065X** – Intermediate Care – Level 1 **066X** – Intermediate Care – Level 2 <u>4th digit is based on the following:</u> 0 – Non-payment/zero claim 1 – Admit through discharge claim 2 – Interim first claim 3 – Interim continuing claim 4 – Interim last claim 7 – Replacement of prior claim 8 – Void/cancel of prior claim
5	Federal Tax Number	Required	Enter the number assigned to the provider by the federal government for tax reporting purposes.
6	Statement covers period "From" and "Through" dates of service	Required	Enter the beginning and ending date of service in MMDDYY format. *For services provided on a single day, enter the date of service as both the from and through date.
7	N/A	Not required	N/A
8a	Patient name – identifier		Enter the member's Medi-Cal ID number
8b	Patient Name	Required	Enter patient's last name, first name, and middle initial
9A thru E	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	Outpatient – Not Required Inpatient - Required	Enter the hour patient was admitted
14	Admission Type	Required	Enter the numeric code indicating the necessity for admission: **1** – Emergency **2** – Urgent **3** – Elective

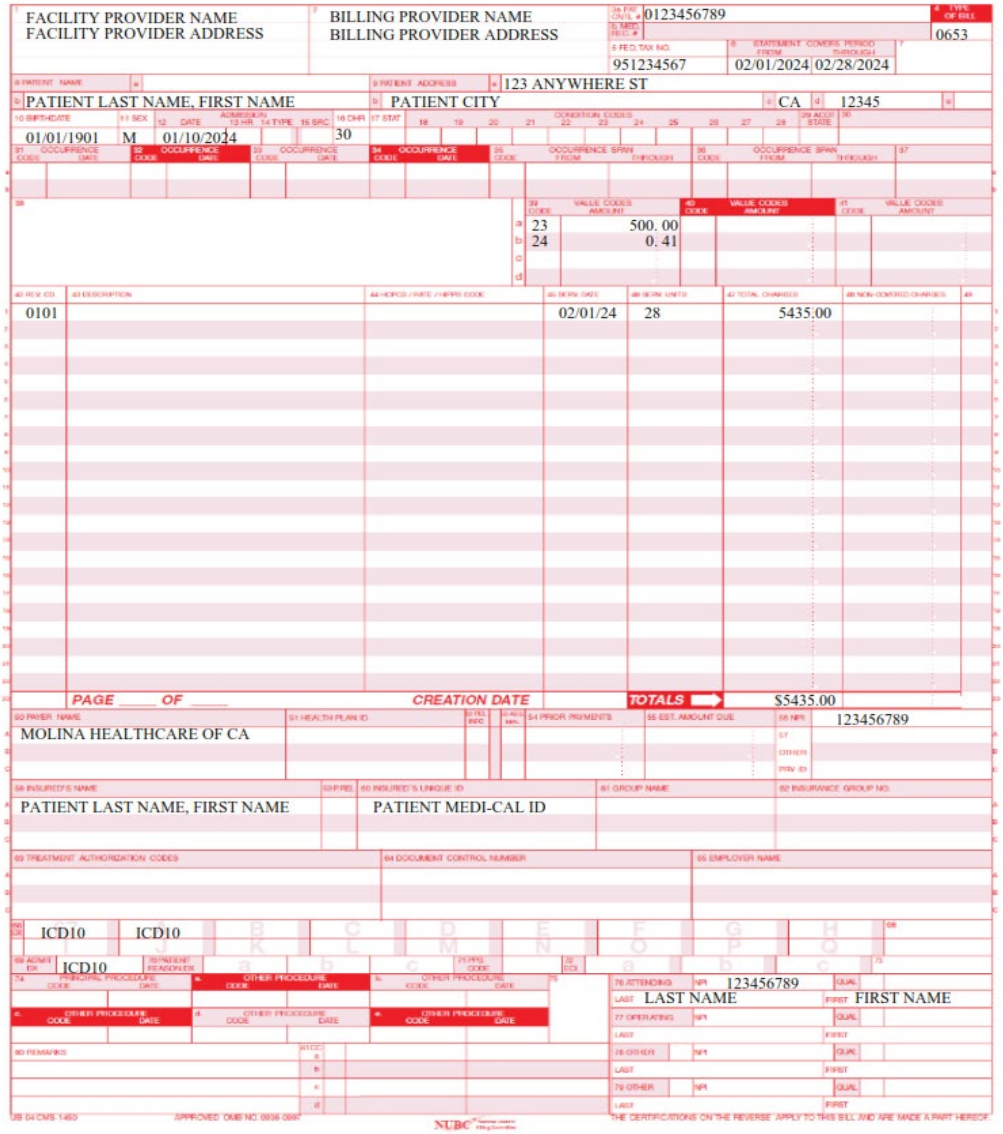
15	Admission Source	Outpatient – Not Required Inpatient - Required	Enter the source of referral for admission Admission code source: **4** – Transfer from a Hospital **5** – Transfer from a Skilled Nursing Facility **6** – Transfer from another health care facility
16	Discharge Hour	Outpatient – Not Required Inpatient - Required	Enter the hour of discharge *If patient has not been discharged, box can be left blank
17	Patient Status	Outpatient – Not Required Inpatient - Required	Enter the patient status/discharge code **01** – Discharged to Home or self-care **02** – Discharged/transferred to a short-term General Hospital for Inpatient Care **03** – Discharged/transferred to SNF **04** – Discharged/transferred to a Facility that provides Custodial care **05** – Discharged/transferred to a Designated cancer center or Childrens Hospital **20** – Expired **30** – Still Patient **40** – Expired at Home **41** – Expired in a Medical Facility **42** – Expired – Place unknown **43** – Discharged/transferred to a Federal Health Care Facility **50** – Hospice – Home **51** – Hospice – Medical Facility **61** – Discharged/transferred to an approved Swing Bed **62** – Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) **63** – Discharged/transferred to a Long-Term Care Hospital (LTCH) **64** – Discharged/transferred to a Nursing Facility certified under Medicaid **65** – Discharged/transferred to a Psychiatric Hospital **66** – Discharged/transferred to a Critical Access Hospital (CAH) **70** – Discharged/transferred to another type of health care institution
18-28	Condition Codes	If Applicable	Enter the codes that describe the corresponding code to identify the conditions or events that apply to the billing period.
29	Accident State	Not Required	
30	N/A	Not Required	

31-34	Occurrence Codes	Outpatient – Not Applicable Inpatient - Required	Enter the occurrence code "42" and the date of hospital discharge (in six-digit format) when the date of dis
35-36	Occurrence Span	If Applicable	
37	N/A	Not required	
38	N/A	Not required	
39-41	Value Codes and Amounts	Required	Enter the value codes and amounts. *Amounts should be entered in dollar format. Example: Value code 24 with accommodation code 41 will be submitted as follows: Value code Value code Amount 24 $0.41 **Value codes:** **23 – Patient's Share of cost** **24 – Accommodation code** **66 – Non-Covered Cost** (Required only if billing for non-covered cost) Accommodation codes applicable to: **Revenue code 0101** (Effective for DOS on or after 2/1/24) **Revenue code 0190** (DOS prior to 2/1/24) 41 – ICF/DD 1 to 59 Beds 42 – ICF/DD 60+ Beds 61 – ICF/DD-H 4 to 6 Beds 62 – ICF/DD -N 4 to 6 Beds 65 – ICF/DD-H 7 to 15 Beds 66 – ICF/DD-N 7 to 15 Beds **Revenue code 0180** 43 – ICF/DD 1 to 59 Beds 44 – ICF/DD 60+ Beds 63 – ICF/DD-H 4 to 6 Beds 64 – ICF/DD-N 4 to 6 Beds 68 – ICF/DD-H 7 to 15 Beds 69 – ICF/DD-N 7 to 15 Beds
42	Revenue code	Required	Enter the appropriate revenue code: **0101 – Room and Board** (Effective for DOS on or after 2/1/24) **0190 – Room and Board** (DOS prior to 2/1/24) **0180 – Leave of absence**
43	Revenue Description	Not Required	Enter the description of the revenue code used in box 42
44	HCPCS/Rate/HIPPS code	Outpatient Claims – Required	Enter the applicable procedure code and modifier.

		Inpatient Claims -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	Enter the appropriate 10-digit National Provider Identifier (NPI) number
57	Other provider ID	Not Required	
58A thru C	Insured's Name	Required	Enter the name of the member If billing for an infant using the mother's ID, enter the Medi-Cal recipient's name and the patient's relationship to the Medi-Cal recipient in the Patient's Relationship to Insured field (Box 59)
59A thru C	Patient's relationship to insured	If applicable	
60A thru C	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	Inpatient Claims: Enter the appropriate ICD-10-PCS code identifying the primary medical or surgical procedure.
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
78	Other	Not Required	Inpatient Claims: Enter the admitting physician's NPI in the first box
79	Remarks	If Applicable	Use this area for procedures that require additional information, justification, or an Emergency Certification Statement.

5. Can I have a claim submission example?



6. How can I monitor the status of my claims?

Once claims are processed into MHC's system, providers may view them online through the Availity Provider Portal. To learn more about Availity or receive assistance, please contact your PRR.

7. What are the billing codes for Doula services?

Claims for doula services do not require a diagnosis code. The following codes may be used for all services listed above when submitting claims:

Prenatal and Postpartum Visits

- Z1032 – Extended initial visit 90 minutes
- Z1034 – Prenatal visit
- Z1038 – Postpartum visit
- T1032 – Extended postpartum doula support, per 15 minutes

Labor and Delivery Support

- CPT® 59409 – Doula support during vaginal delivery only
- CPT 59612 – Doula support during vaginal delivery after previous cesarean section
- CPT 59620 – Doula support during cesarean section

Abortion or Miscarriage Support

- HCPCS T1033 – Doula support during or after miscarriage
- CPT 59840 – Doula support during or after abortion

Billing codes HCPCS code T1033 for miscarriage support and CPT code 59840 for abortion support are each limited to once per pregnancy.

All claims must be submitted with the modifier XP (separate practitioner: a service that is distinct because it was performed by a different practitioner), appended to the billing code. This is to distinguish the claim from the services by the medical provider.

8. How do I set up electronic billing?

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

9. Does Molina pay for EDI clearinghouses?

Change Healthcare is an outside vendor 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 are 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

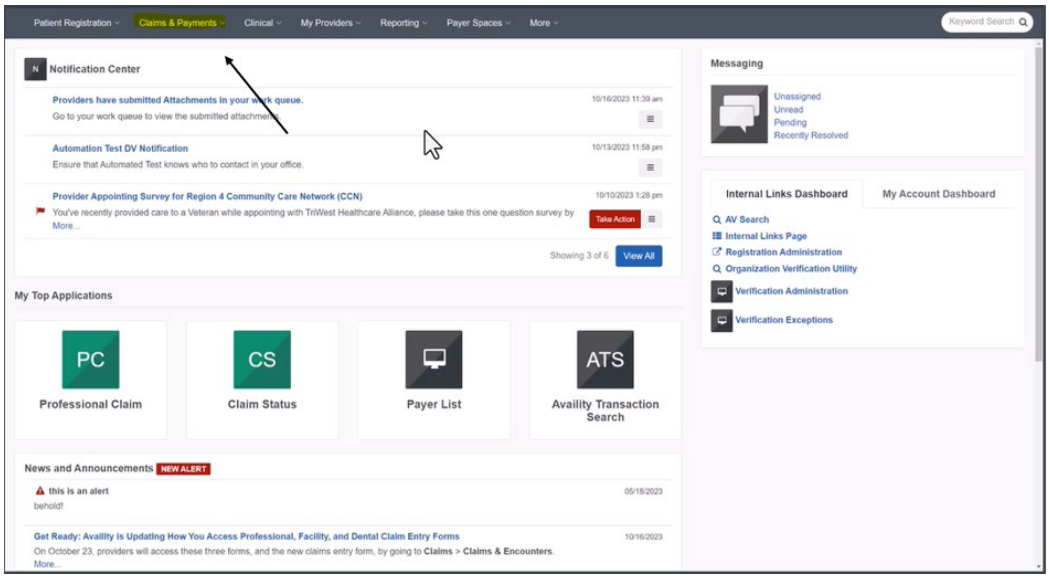
10. How do I contact the MHC Claims department?

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

Availity Facility Claim Submissions

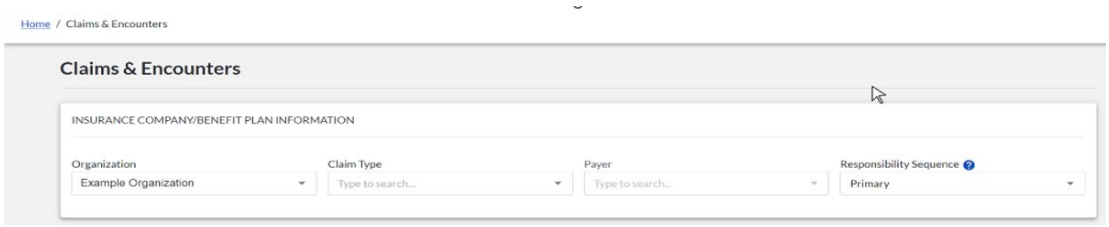
Below is a step-by-step walkthrough of the claim submission process through the Availity Provider Portal.

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

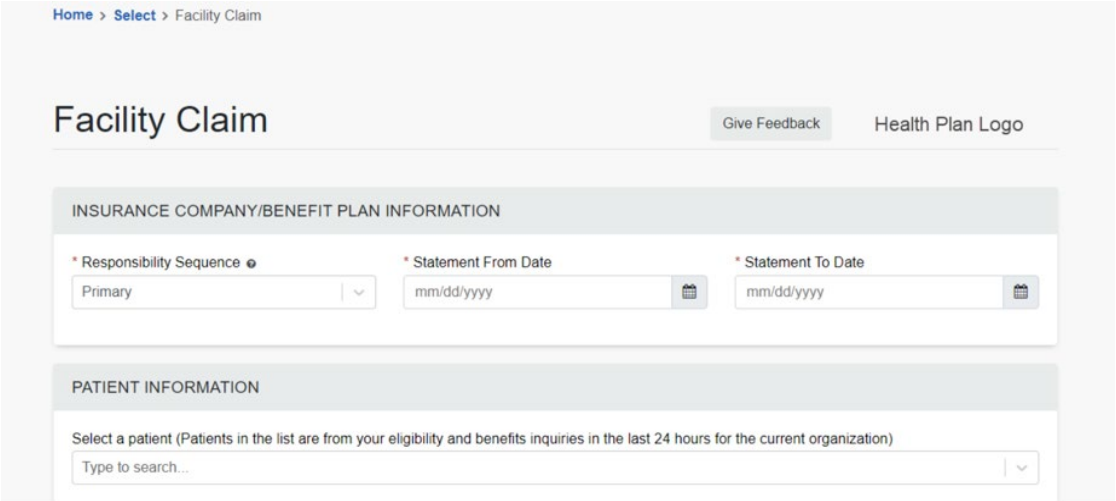


2. Select Claims & Encounters

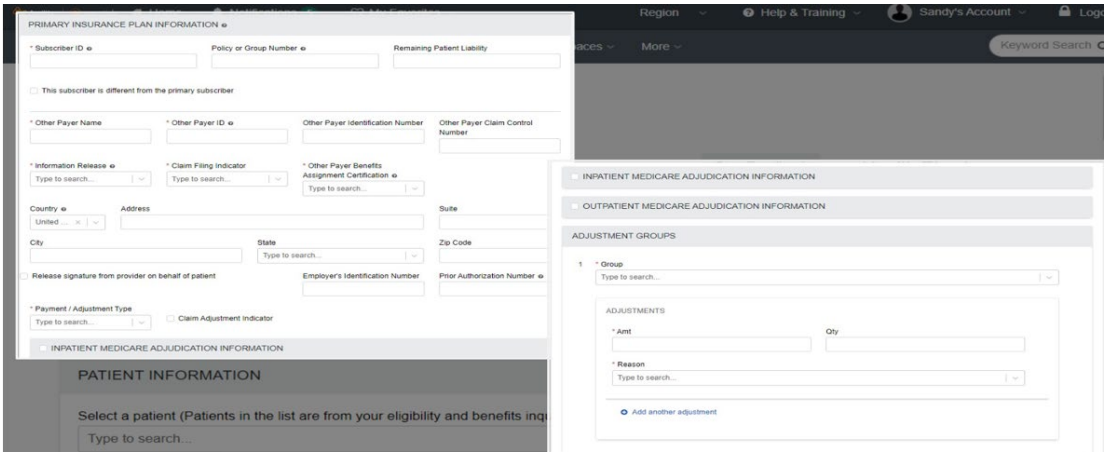
3. To begin the claim submission, you will need to select the organization to which you will be submitting the claim. You will also need to select the Claim type and Payer.



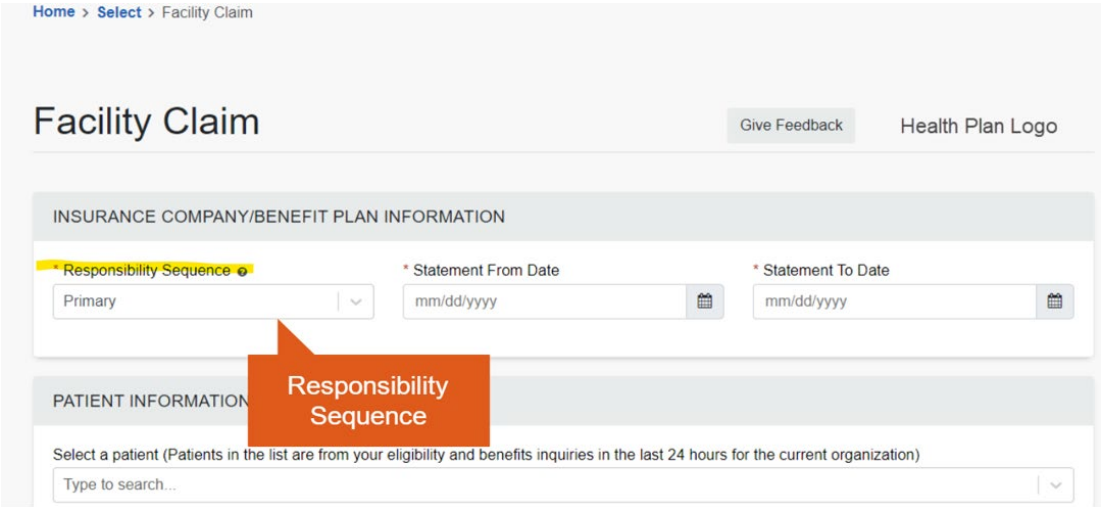
4. In the first section, select the responsibility sequence: primary, secondary, or tertiary.



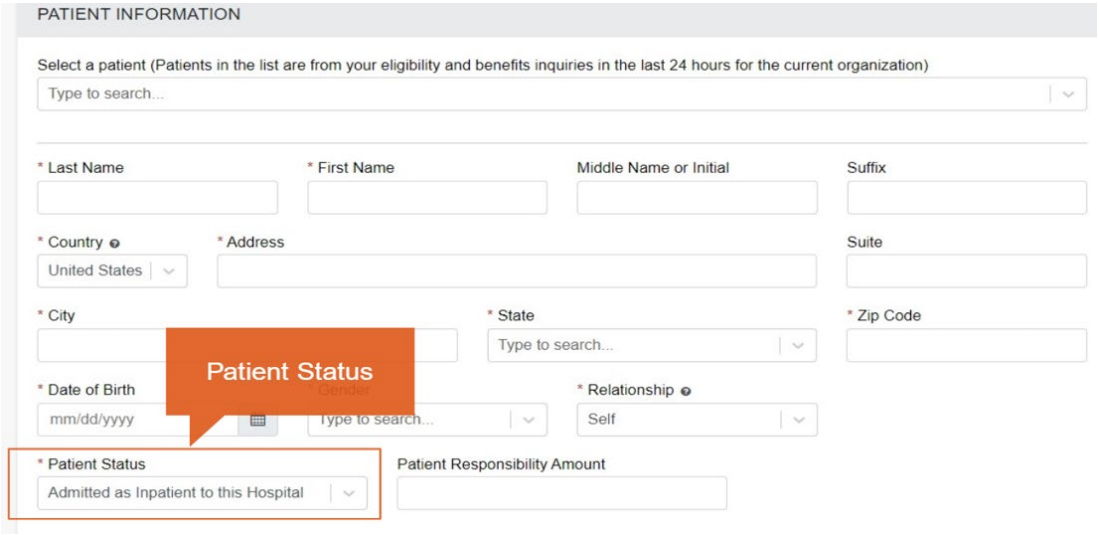
5. If you select secondary or tertiary, additional fields will be displayed on the form for you to enter the COB information.



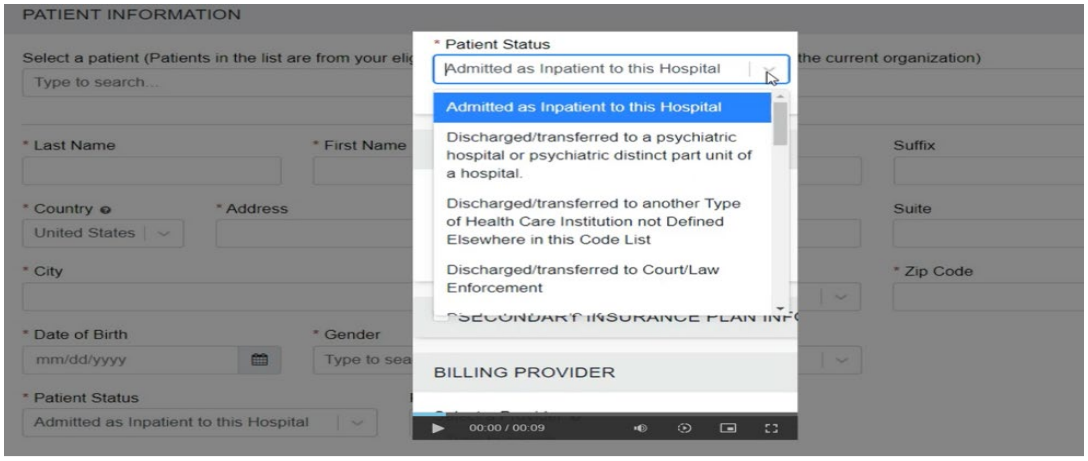
6. In the patient information section, you can manually enter the patient's information. If you have checked eligibility for the member in the last 24 hours, you can select it from the drop-down menu.



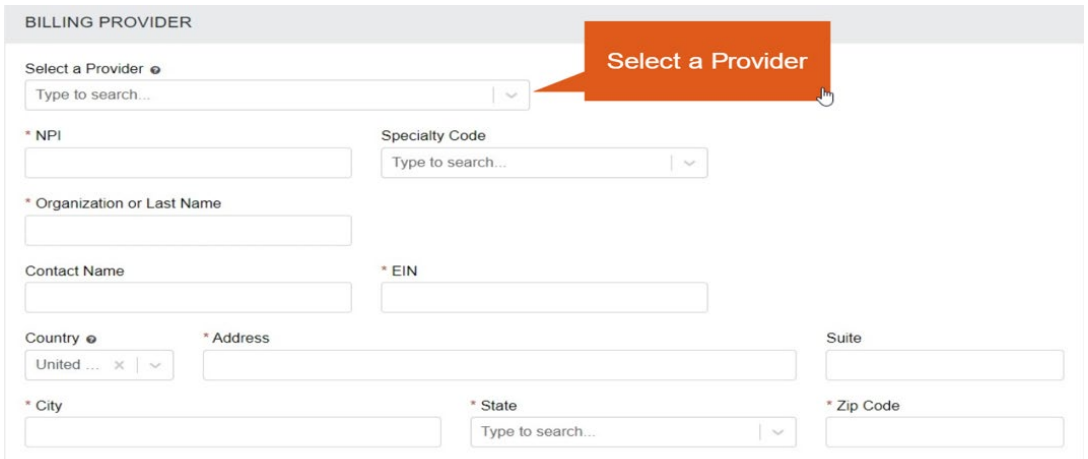
7. For most payors, the patient status field defaults to Admitted as an Inpatient to this Hospital.



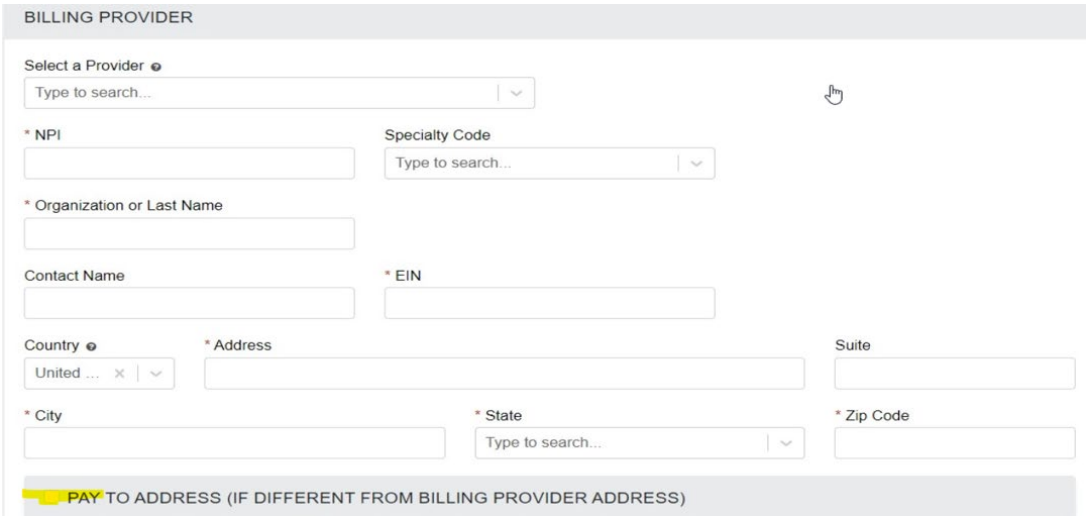
8. You can select another option in the field if applicable.



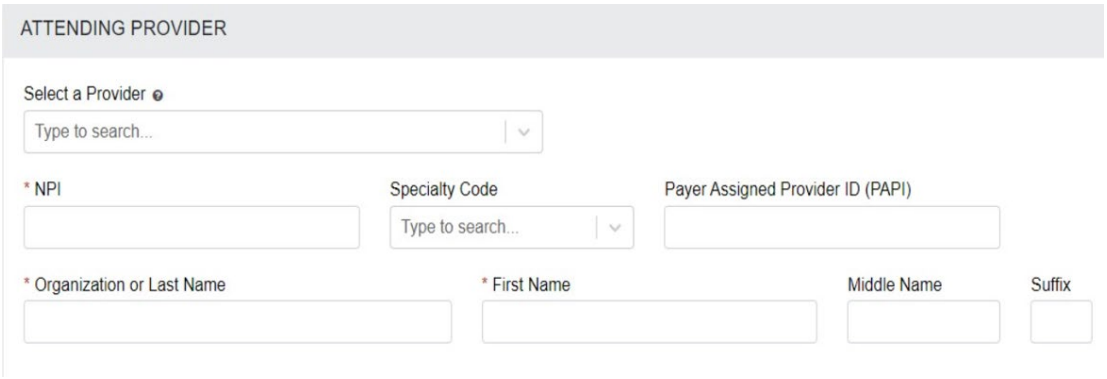
9. In the BILLING PROVIDER section, you can manually enter the required field or select a provider from your organization's provider express entry setup.



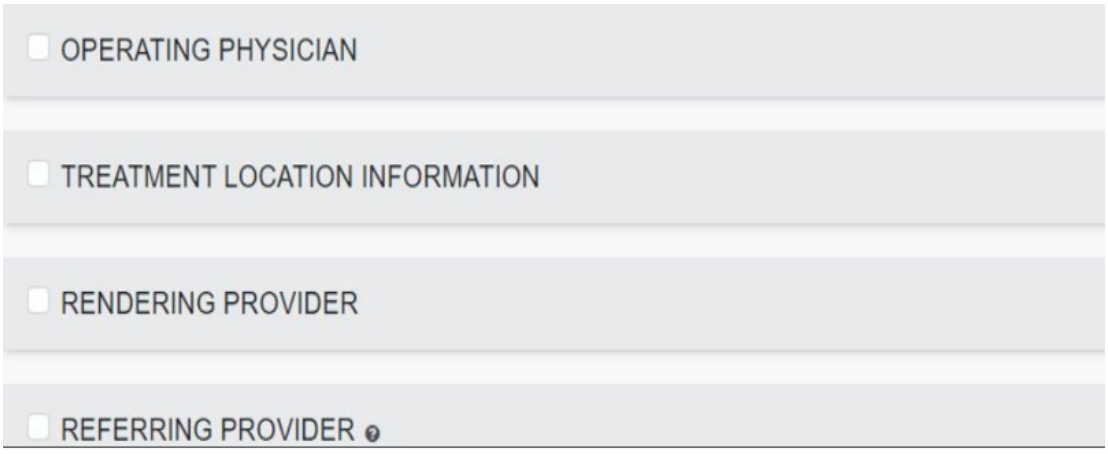
10. If the pay-to-address is different, select the checkbox to display fields to enter the pay-to-address information.



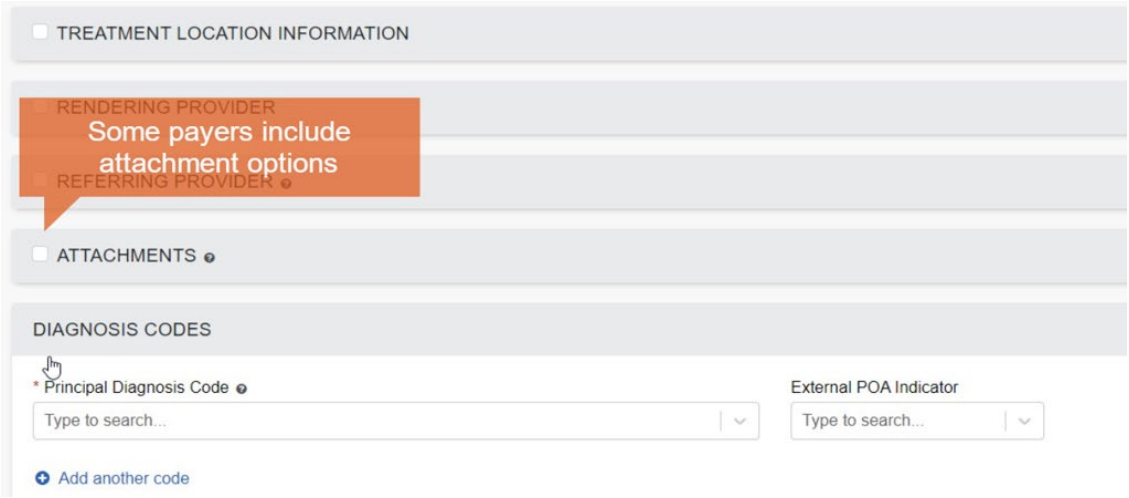
11. Next, enter the attending provider information or select the provider from your organization's provider express setup.



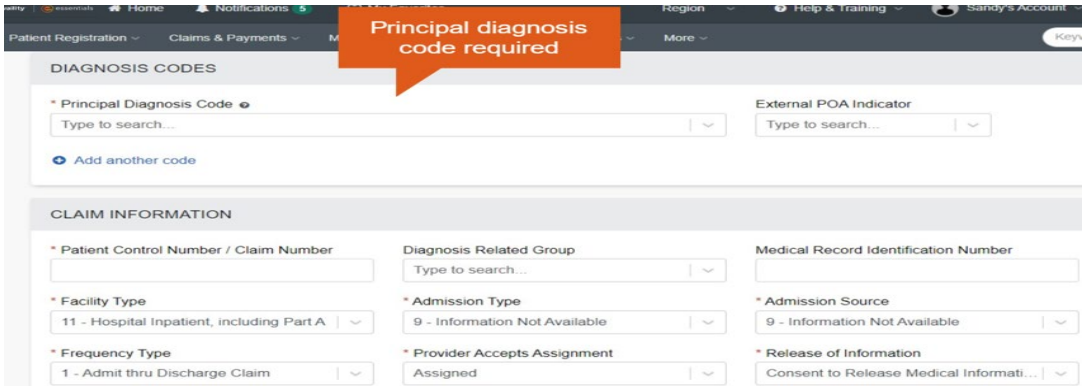
12. If the claim has additional information like operating physician, treatment location, rendering provider, and referring provider, select the check box to display that section.



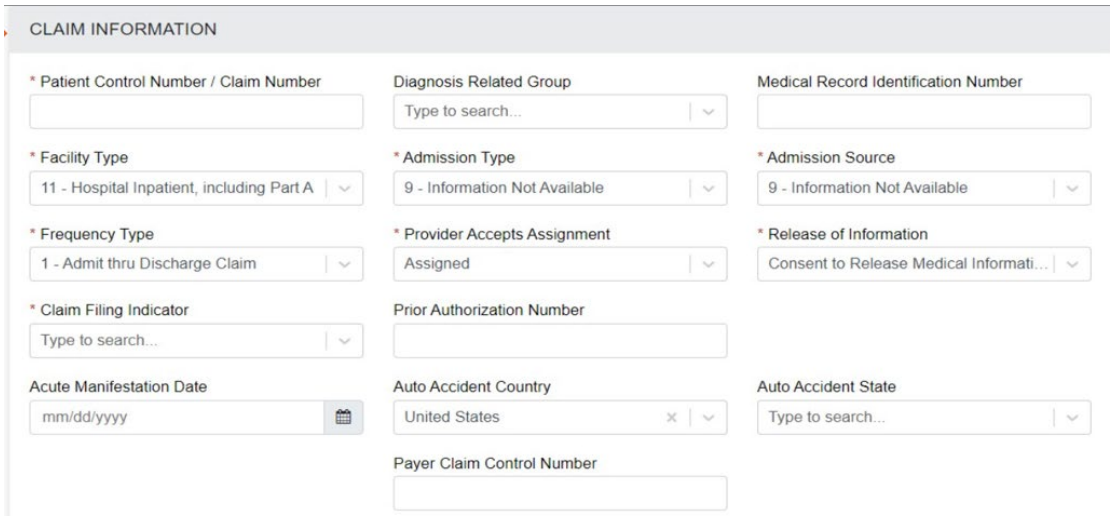
13. Molina gives the option to include attachment information. Select the check box to display the section.



14. The principal diagnosis code is required. Should more codes need to be added, select the "Add another code" link to enter up to eleven additional codes.



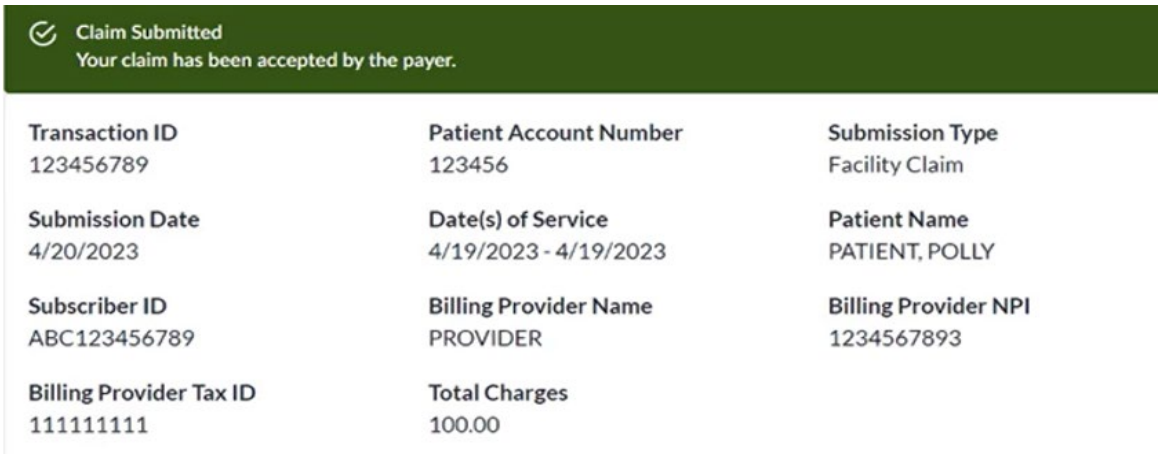
15. In the "Claim Information" section, enter the required fields and optional information for the claims. As you make selections in fields, additional fields related to the claim information might be displayed.



16. Once you have entered all the information on the claim, click submit. You click the start over only if you want to clear the form.

17. Availity conducts front-end validation to ensure your claim is as clean as possible before it's submitted to Molina Healthcare. If your claim has front-end validation errors, Availity will display a message to help you correct the errors. Simply correct the errors and submit the claim.

18. Claims submission confirmation screen.



Non-Par Provider Claim Submissions

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

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

- Submit paper claims directly to Molina Healthcare of California at the following address: PO Box 22702 Long Beach, CA 90801
- Clearinghouse: SSI Claimsnet, LLC (SSI Group)

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

Provider Disputes

A provider grievance or complaint is described in Title 22, California Code of Regulations (CCR), as a written entry into the appeals process. Molina maintains two (2) types of appeals:

- Appeals regarding non-payment or processing of claims known as Provider Disputes
- Appeals regarding modifications or denial of a pre-service request are considered member appeals

1. Who can submit an appeal?

A provider of medical services may submit to Molina an appeal concerning the modification or denial of a requested service or the payment processing or non-payment of a claim. Molina will comply with the requirements specified in Section 56262, of Title 22 of the CCR, and Title 28, CCR, Section 1300.71.38.

2. What is a provider dispute?

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

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

3. What is the timeline for MHC to process the dispute?

All provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first-level appeal by the provider. For paper submission, MHC will acknowledge the receipt of the dispute within fifteen (15) working days and within two (2) working days for electronic submissions. If additional information is needed from the provider, MHC has forty-five (45) working days to request necessary additional information. Once notified in writing, the provider has thirty (30) working days to submit additional information or the claim dispute will be closed by MHC.

4. How long do I have to submit a dispute to MHC?

Providers may dispute by submitting and completing a Provider Dispute Resolution Request Form within three hundred sixty-five (365) days from the last date of action on the issue. A written dispute form must include the provider's name, identification number, contact information, date of service, claim number, explanation for the dispute, and all required documentation or proof to support the dispute.

Disputes with incomplete information and missing required documentation will not be processed. Molina will provide a written response to the provider within 45 working days from the date of the dispute and allows two levels of dispute.

5. How do I submit a provider dispute?

Method 1: Molina Provider Portal (most preferred method)

- Log onto Molina's Provider Portal at: provider.molinahealthcare.com/
- Search and identify adjudicated claims and submit a dispute/appeal
- Complete the required information on the portal and upload the required documents or proof to support the dispute

Method 2: Fax

- Fax to (562) 499-0633

Method 3: Mail

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

Frequently Asked Questions

Question	Answer	Phone Number
Appeals & Grievances		
How do I dispute a claim?	**Method 1:** Molina Availity Essentials Portal (most preferred method): provider.molinahealthcare.com/ You can search and identify adjudicated claim and submit a dispute/appeal. Upload required documents or proof to support the dispute. **Method 2:** Fax to (562) 499-0633 **Method 3:** Mail to: Molina Healthcare of California Attn: Provider Dispute Resolution Unit P.O. Box 22722 Long Beach, CA 90801	
How do I check for status?	Method 1: Availity Essentials Portal is Molina's preferred method. (Please refer to Availity section of FAQ below) Method 2: You can call claims customer service.	(855) 322-4075
Authorizations		
How do I submit an authorization?	Participating providers are encouraged to use the Molina Availity Essentials Portal for prior authorization submissions whenever possible. For TARs/Continuity of Care please refer to the FAQ UM section.	
How do I check for status?	**Method 1**: Availity Essentials Portal is Molina's preferred method. (Please refer to Availity section of FAQ below).	(844) 557-8434

	Method 2: You may contact the prior authorization department.	
What is the phone number to UM?	Please refer to the Molina Healthcare of California contact list.	
Balance Billing		
	The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a member be liable to the provider for any sums that are the legal obligation of Molina to the provider. Balance billing a member for Covered Services is prohibited, except for the member's applicable copayment, coinsurance, and deductible amounts.	
Availity		
What is Availity?	Availity Essentials is Molina Healthcare's official secure provider portal for traditional (non-atypical) providers. Some of the core features available in Essentials for Molina Healthcare include eligibility & and benefits, attachments, claim status, Smart claims, and Payer Space (submit and check prior authorizations as well as appeal status and appeal/dispute).	
How do I register?	Availity Essentials Portal When you register for Availity, please be sure that your organization name and NPI matches with the NPPES NPI Registry.	(800) AVAILITY (800) 282-4548
Claims		
How do I submit my claims to Molina? *What type of form do I use? *How do I know what bill type and revenue codes to use?	*Refer to the Claims FAQ section*	
Who is your clearinghouse/EDI vendor?	EDI Vendor: Emdeon Payer ID: 38333 Clearinghouse: SSI Claimsnet, LLC (SSI Group) Registration Form: SSI.ProviderRegistration.Web (ssigroup.com) Payer ID: 38333	(855) 322-4075
How do I check for claim status?	**Method 1:** Availity Essentials Portal is Molina's preferred method. (Please refer to Availity section of FAQ below) **Method 2:** You can call claims customer service. **Method 3:** If you are registered with Molina's clearing house Change Health Care you can view claim status.	(855) 322-4075
How often can I submit claims?	As frequently as desired.	
How many days do I have from DOS to submit an	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.	

initial & corrected claim?	If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit claims to Molina within 90 calendar days after final determination by the primary payer. Corrected claims must be sent within 180 calendar days of the date of service of the claim.	
Case Management		
	Refer to the Case Management FAQ section	
Continuity of Care		
	Refer to the UM FAQ section	
Customer Service		
What is the Molina costumer service number?	Provider Contact Center	(855) 322-4075
Electronic Payments		
How do I register for electronic payments?	Change Healthcare/ECHO: To register for EFT and remittance advise, please go to ECHO Health (echohealthinc.com) Important Note: To opt out of the Virtual Card Services, please visit ECHO Health: Payments Simplified and select the appropriate option. Once you choose your option, you can enter the draft # payment received and elect to receive it via check. Please visit our website for additional step-by-step ECHO registration.	
Eligibility		
How do I verify member eligibility?	Method 1: Through the Availity Essentials Portal. Method 2: You may call the Molina eligibility department.	Medi-Cal: (888) 665-4621
Fraud Waste & Abuse		
How do I report Fraud Waste & Abuse?	Through the Molina tip line.	(866) 606-3889
Molina Doula Webpage		
How do I learn more about the doula process?	Molina Doula Step-By-Step Process	
Pharmacy		
What pharmacy is Molina contracted with?	Prescription drugs are covered by Molina Healthcare through the Medi-Cal Pharmacy Benefit carve-out to Medi-Cal Rx (MRx).	(800) 977-2273
Provider Contracts		
Who do I contact if I have questions regarding my contract.	Refer to the Molina Healthcare of California contact list.	
Provider Demographic Changes		
How do I submit demographic changes to Molina?	Los Angeles: MHC_LAProviderServices@MolinaHealthcare.com Sacramento: MHCSacramentoProviderServices@MolinaHealthcare.com San Bernardino: MHCIEProviderServices@MolinaHealthcare.com Riverside: MHCIEProviderServices@MolinaHealthcare.com San Diego: MHCSAnDiegoProviderServices@MolinaHealthcare.com	

	Imperial: MHCImperialProviderServices@MolinaHealthcare.com	
Provider Manual		
How do I access Molina's provider manual?	Medi-Cal Provider Manual	
Training		
How do I request an overview of Molina?	Contact your assigned Provider Relations Representative	Reference the contacts under "MHC Contacts"
How do I request an onboarding Training?	Contact your assigned Provider Relations Representative	Reference the contacts under "MHC Contacts"
Translation Services /Cultural and Linguistic Services		
Does Molina offer a 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 services?	American Logistics Transportation – Medi-Cal LOB Only	(844) 292-2688
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. How do I become a doula?

Please review the MHC Doula Provider Training to learn more about doula requirements, training, and enrollment.

2. What steps do I need to follow as a doula?

Please follow the MHC Doula Step-by-Step Process for a high-level overview of doula responsibilities. Additional DHCS documentation and billing resources can also be found on this page.

3. Who should members contact with any questions?

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

4. Who should providers contact with questions?

Providers may reach out to their appropriate PRR with any questions. The PRR will assist with issues and relay concerns to the appropriate MHC department.

Molina Healthcare of California Contact List

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

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

Case Management	Contact Number	Email Address
Case Management referrals and inquiries	Ph: 833-234-1258 Fax: 562-499-6105	MHCCaseManagement@molinahealthcare.com
Covered CA Case Management referrals and inquiries	888-858-2150 M-F, 8 am-6 pm PST	N/A
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