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Long Term Care

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Contents

Multi-Level Retirement Community Quality Assurance Fee Exemption List and Policy for Freestanding Skilled Nursing Facility Level-Bs

Introduction

Health and Safety Code, Sections 1324.20 through 1324.30 require the California Department of Health Services (DHS) to implement a Quality Assurance Fee (QAF) program for Freestanding Skilled Nursing Facility Level-Bs (FS/NF-B) and Freestanding Skilled Adult Subacute Nursing Facility Level-Bs (FSSA/NF-B). The purpose of the program is to provide additional reimbursement for, and to support quality improvement efforts in, licensed skilled nursing facilities. The Centers for Medicare & Medicaid Services approved the DHS request to implement the QAF program. State law authorizes DHS to use the funds from the fee to support the costs of rate increases in the Medi-Cal program.

This *Medi-Cal Update* includes information about the Multi-Level Retirement Community (MLRC) facilities that are exempt from the QAF program, which is effective retroactively to August 1, 2004. It also describes the DHS process for requesting exemption in future rate years.

Welfare and Institutions Code, Section 14126.027(c), allows DHS to use articles published in *Medi-Cal Updates* as alternatives to regulations until July 31, 2007, in order to implement the provisions of the statute.

This *Medi-Cal Update* uses the same definition of an MLRC as described in the September 2005 *Medi-Cal Update* in section 100:

> "§ 100(f) "Multi-Level Retirement Community" (MLRC) means a provider of a continuum of services, including independent living services, assisted living services and skilled nursing care on a single campus which has not received a certificate of authority or a letter of exemption from the Department of Social Services, *Health and Safety Code*, Section 1771.3."

DHS is adding sections 140 and 141 to the instructions implementing *Health and Safety Code*, Section 1324.20(b) to clarify the facilities exempt from the QAF. These two sections follow September 2005 *Medi-Cal Update* section 131, and include the final update to the exempt facilities list and a description of the process for facilities to request exemption in future rate years.

§ 140 MLRC FS/NF-Bs Exemption List – Final Update for Rate Years 2004-06

(a) The MLRC FS/NF-Bs listed below are exempt from the QAF program effective August 1, 2004 through July 31, 2006.

(b) This list will remain in effect each rate year unless a facility reports a change in corporate structure or business practice to DHS by May 1 of each year.

(c) The following MLRC FS/NF-Bs are exempt from the QAF program:

Skilled Nursing Facilities	Office of Statewide Health Planning and Development (OSHPD) Number
Ararat Nursing Facility	206194558
Artesia Christian Home	206190618
Auburn Ravine Terrace	206312230

Please see **Quality Assurance Fee**, *page 2*

Quality Assurance Fee *(continued)*

Skilled Nursing Facilities	Office of Statewide Health Planning and Development (OSHPD) Number
Bethany Home Society of San Joaquin County	206390796
Bethel Lutheran Home	206100684
Bethesda Home	206010760
Bixby Knolls Towers Health Care & Rehab	206190101
California Christian Home	206190122
California Home for the Aged	206100689
Canyon Villas	206374177
Casa De Modesto	206500821
Christian Heritage	206364097
Claremont Manor Care Center	206196220
Dorothy & Joseph Goldberg Healthcare	206374064
Fillmore Convalescent	206560547
Fredericka Manor Care Center	206370708
Friends House	206492287
Glenwood Gardens	206154109
Gold Country Health Center	206092347
Grancell Village-Jewish Homes for Aging	206190124
Grossmont Gardens	206374041
Health Center at Sierra Sunrise Village	206044028
Home for Jewish Parents	206074085
Hope Manor	206101843
Inland Christian Home	206360042
Jeanne Jugan Residence	206190947
Jones Convalescent	206010855
Kingsley Manor Care Center	206190444
Knott Avenue Care Center	206301280
Las Villas De Carlsbad	206374186
Las Villas Del Norte	206371735
Life Care Center of Corona	206330206
Lincoln Glen Skilled Nursing	206431530
Lutheran Health Facility at Alhambra	206190493
Lytton Gardens, Inc.	206431865
Meadowood Health & Rehab Center	206394041
Meadows of Napa Valley, The	206284010
Mercy Retirement and Care Center	206013696
Mesa Verde	206301259
Mission Lodge Sanitarium	206190539
Monte Vista Grove Homes	206190544
Nazareth House of Fresno	206100767
Nazareth House of Los Angeles	206190957
Nazareth House of San Rafael	206211023

Please see **Quality Assurance Fee**, *page 3*

Quality Assurance Fee *(continued)*

Skilled Nursing Facilities	Office of Statewide Health Planning and Development (OSHPD) Number
New Bethany	206244031
Our Lady of Fatima Villa	206430840
Pilgrim Place Health Services Center	206190617
Pioneer House	206340980
Plymouth Square	206390987
Plymouth Tower	206331300
Rancho Vista	206371677
Redwoods, The	206210916
Sierra View Homes	206100799
Simi Valley Care Center	206560536
St. Anne's Home	206380958
St. Claire's Nursing Center	206342225
St. John of God Retirement & Care Center	206190755
St. Paul's Senior Homes & Services	206371598
Stollwood Convalescent Hospital	206571047
Twilight Haven	206100817
Venturan Convalescent Center, The	206560539
Villa Scalabrini Special Care Unit	206194113
Villa Siena	206431833
Wine Country Care	206390894
Wish-I-Ah Care Center	206100833

(d) Any FS/NF-B not included on the above list for the 2004-05 and the 2005-06 rate years which did not notify DHS of its exemption must comply with the rate review process, which can be viewed on the DHS Web site at **http://www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm** and was also published in the October 2005 *Medi-Cal Update*. This list was final and effective on August 31, 2005.

MLRC FS/NF-Bs Requests for Exemption from the QAF Program in Future Rate Years

§ 141 DHS Policy and Requirements

(a) DHS requires any FS/NF-B requesting exemption from the QAF program as an MLRC facility for the 2006-07 and future rate years to comply with the following:

(b) Each facility must submit to DHS by May 1 of each year the following documentation:

1. A copy of a current Residential Care For The Elderly (RCFE) license and Skilled Nursing Facility (SNF) license.
2. Information that proves that both the SNF and RCFE are owned by the same entity (common ownership). The facility owner's name, federal tax identification number and Medi-Cal provider number must be correct and consistent with each other.
3. Any FS/NF-B that has changes to its facility's corporate structure or general business practices must provide DHS with six or more months of cost reports as operating under the new ownership or business practice.
4. A description of the campus that indicates that the campus provides a continuum of services, including independent living services, assisted living services and skilled nursing care on a single campus.

Please see **Quality Assurance Fee**, *page 4*

Quality Assurance Fee *(continued)*

5. If the addresses of the SNF building and the RCFE building are different, the provider must send in proof that they are on the same campus and the ownership is the same.
6. Each facility must provide its Medi-Cal provider number, federal tax identification number and the Office of Statewide Health Planning and Development number of the current owner.

(c) From the date of the application for exemption, DHS will have 30 days to request any additional information.

(d) DHS will approve or deny the request within 60 days but no later than August 1 of the rate year.

(e) For any FS/NF-B that DHS approves as an exempt MLRC, DHS will adjust its rates effective August 1 of each rate year.

(f) The information must be sent to:

Department of Health Services
Medi-Cal Policy Division/Long Term Care
System Development Unit
MLRC Reporting Policy
MS 4612
1501 Capitol Avenue, Suite, 71.4001
P.O. Box 997417
Sacramento, CA 95899-7417

Long-Term Care Reimbursement Act Update

Effective for dates of service on or after August 1, 2005 and as mandated by California *Health and Safety Code*, Sections 1324.20 – 1324.30, the California Department of Health Services (DHS) will implement additional policy guidelines for facility-specific reimbursement for Freestanding Nursing Facilities, Level-Bs (FS/NF-Bs) and Freestanding Subacute Nursing Facilities, Level-Bs (FSSA/NF-Bs). Unless otherwise stated, policies discussed in this article apply to both FS/NF-Bs and FSSA/NF-Bs.

Introduction
It is the intent of the California State Legislature to devise a Medi-Cal Long Term Care (LTC) reimbursement methodology that more effectively ensures individual access to appropriate LTC services, promotes quality resident care, advances decent wages and benefits for nursing home workers, supports provider compliance with all applicable state and federal requirements and encourages administrative efficiency.

The Medi-Cal Long-Term Care Reimbursement Act, California *Welfare and Institutions Code* Sections 14126 – 14126.035 (added by California Assembly Bill [AB] 1629, Statutes of 2004, Chapter 875) authorizes DHS to implement a facility-specific rate setting system that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities, as defined in California *Health and Safety Code*, subdivision (c) of Section 1250. The facility-specific rate setting system will be effective August 1, 2005 and will be implemented on October 1, 2005.

California *Welfare and Institutions Code* Section 14126.027(c) authorizes DHS to use Medi-Cal Provider bulletins as an alternative to regulations in order to implement the provisions of the statute. This Provider bulletin article is being issued by DHS pursuant to the authority granted by this statute.

Policies for Facility-Specific Rate Methodology
§218 Out-of-State and Border Providers
Reimbursement for out-of-state and border providers will be the statewide facility-specific weighted average rate applicable to the period during which services are provided.

§219 Bed Hold
Reimbursement for bed hold under the facility-specific rate methodology will be in accordance with *California Code of Regulations* (CCR), Title 22, Section 51535.1.

Please see **Reimbursement Act**, *page 5*

Reimbursement Act *(continued)*

§220 Leave of Absence
Reimbursement for leave of absence under the facility-specific rate methodology will be in accordance with *California Code of Regulations* (CCR), Title 22, Section 51535.

§221 Special Treatment Program for the Mentally Disordered
Reimbursement for special treatment program for the mentally disordered under the facility-specific rate methodology will be in accordance with *California Code of Regulations* (CCR), Title 22, 51511.1.

§222 Hospice
Reimbursement for hospice room and board services under the facility-specific rate methodology will be 95 percent of the rate applicable to the Nursing Facility Level-B in which the patient resides.

CMC Claim Submission for Medicare/Medi-Cal Crossover Billers

Medi-Cal can now receive electronic crossover claims directly from approved submitters via the ASC X12N 837 v.4010A1 transaction. Submitters using the 837 format must include Medicare payment information at the detail/claim line level. Additionally, Medi-Cal can receive electronic crossover claims automatically from Mutual of Omaha and United Government Services Medicare intermediaries for most Part B services billed to Part A intermediaries. This new provision primarily affects outpatient and dialysis providers who were previously required to bill these claims on paper. Providers of Part B services billed to Part A intermediaries other than Mutual of Omaha and United Government Services must continue to bill their claims directly to Medi-Cal either on paper or in the new HIPAA standard 837 electronic transaction until a new automatic crossover process is established with the Medicare Consolidated Coordination of Benefits Contractor sometime in 2006.

In order to comply with HIPAA electronic standards, providers billing crossover claims on paper for Part B services billed to Part A intermediaries will be required to attach the detail/claim line level *National Standard Intermediary Remittance Advice* (Medicare RA) to a *UB-92 Claim Form* and comply with revised billing instructions. Any claims received after October 24, 2005 that do not comply with the new billing and attachment requirements will be returned to providers for correction before processing.

Providers may obtain detailed Medicare RAs by printing the "Single Claim" report, which can be accessed through the latest version of PC Print software, available free of charge. PC Print software and instructions are available on the United Government Services Web site (**www.ugsmedicare.com**) by clicking "Providers," then "EDI" and then the "PC Print Software" link. Providers should obtain the PC Print software from Medicare as soon as possible to ensure they can print the appropriate Medicare RAs.

2006 ICD-9-CM Diagnosis Code Updates

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after January 1, 2006. Providers may refer to the *2006 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptions.

Additions

259.50	276.50	276.51	276.52	278.02	287.30	287.31	287.32
287.33	287.39	291.82	292.85	327.00	327.01	327.02	327.09
327.10	327.11	327.12	327.13	327.14	327.15	327.19	327.20
327.21	327.22	327.23	327.24	327.25	327.26	327.27	327.29
327.30	327.31	327.32	327.33	327.34	327.35	327.36	327.37
327.39	327.40	327.41	327.42	327.43	327.44	327.49	327.51
327.52	327.53	327.59	327.8	362.03	362.04	362.05	362.06
362.07	426.82	443.82	525.40	525.41	525.42	525.43	525.44
525.50	525.51	525.52	525.53	525.54	567.21	567.22	567.23
567.29	567.31	567.38	567.39	567.81	567.82	567.89	585.1
585.2	585.3	585.4	585.5	585.6	585.9	599.60	599.69
651.70	651.71	651.73	760.77	760.78	763.84*	770.10*	770.11*
770.12*	770.13*	770.14*	770.15*	770.16*	770.17*	770.18*	770.85*
770.86*	779.84*	780.95	799.01	799.02	996.40	996.41	996.42
996.43	996.44	996.45	996.46	996.47	996.49	V12.42	V12.60
V12.61	V12.69	V13.02	V13.03	V15.88	V17.81	V17.89	V18.9
V26.31	V26.32	V26.33	V46.13	V46.14	V49.84	V58.11	V58.12
V59.70§	V59.71§**	V59.72§**	V59.73†§	V59.74†§	V62.84	V64.00	V64.01
V64.02	V64.03	V64.04	V64.05	V64.06	V64.07	V64.08	V64.09
V69.5	V72.42§	V72.86	V85.0††	V85.1††	V85.21††	V85.22††	V85.23††
V85.24††	V85.25††	V85.30††	V85.31††	V85.32††	V85.33††	V85.34††	V85.35††
V85.36††	V85.37††	V85.38††	V85.39††	V85.4††			

Restrictions

*	Restricted to ages 0 thru 1 year
**	Restricted to ages 10 thru 35 years
†	Restricted to ages 35 thru 55 years
††	Restricted to ages 18 thru 99 years
§	Restricted to females only

Inactive Codes

Effective for dates of service on or after January 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

276.5, 287.3, 567.2, 567.8, 585, 599.6, 770.1, 799.0, 996.4, V12.6, V17.8, V26.3, V58.1, V64.0

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

285.21, 307.45, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 728.87, 780.51, 780.52, 780.53, 780.54, 780.55, 780.57, 780.58

All manual replacement pages reflecting these ICD-9 code updates will be included in future *Medi-Cal Updates.*

Inpatient Provider Cutoff Date for Proprietary and Non-HIPAA Standard Electronic Claim Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal is planning to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claim transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Self-Service HIPAA Transaction Utility Tool
A self-service environment, HIPAA Transaction Utility Tool, will soon be available for submitters. Initially, the utility tool will be available only for inpatient submitters to validate ASC X12N 837 v.4010A1 transactions in preparation for proprietary format discontinuance. However, the utility tool will become available to other submitter communities as their timeline for proprietary format discontinuance is determined.

The utility tool will offer transaction validation (inclusive of Companion Guide-level editing), troubleshooting and reporting features that enhance, but do not replace, Medi-Cal's current testing and media activation requirements. Inpatient submitters have been notified of the utility tool's availability via e-mail or letter depending on information availability.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cutoff dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

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This Part 2 *Medi-Cal Update* does not contain provider manual pages.