MEDI-CAL UPDATE Part 2
Billing and Policy
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Long Term Care

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Contents

CDHS Quality Assurance Fee on Skilled Nursing Facilities for Rate Year 2006 – 2007

Effective August 1, 2006, for the rate year 2006 – 2007, the California Department of Health Services (CDHS) will begin collecting the 6 percent Quality Assurance Fee (QAF) authorized by the legislature on the total net revenue of all non-exempt Free-Standing Skilled Nursing Facilities and Free-Standing Skilled Adult Subacute Nursing Facilities Level-B (FS/NF-Bs), subject to the fee.

CDHS will collect the following QAF on a monthly basis:

- FS/NF-Bs with total annual resident days equal to or greater than 100,000 – $6.81 per resident day.
- FS/NF-Bs with total annual resident days less than 100,000 – $7.79 per resident day.

CDHS will send quarterly notices to each facility and three monthly payment forms. Payments are due on or before the last day of the month following the month for which the fee was imposed.

Questions about the QAF program may be submitted to:

FS/NF-B QAF Coordinator
California Department of Health Services
Long Term Care System Development Unit
1501 Capitol Avenue, Suite 71.4001
MS 4612
P.O. Box 997417
Sacramento, CA 95899-7417

Information about the Long Term Care System Development Unit (LTCSDU) and the QAF program is available on the CDHS Web site (**www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU**).

This *Medi-Cal Update* provides information concerning the QAF on each skilled nursing facility for the rate year August 1, 2006 to July 31, 2007. California *Health and Safety Code*, Sections 1324.20 through 1324.30, and *Welfare and Institutions Code*, Section 14105.06, authorize CDHS to collect a QAF from all non-exempt FS/NF-Bs. The purpose of this fee is to enhance federal financial participation in the Medi-Cal program, provide additional reimbursement to, and to support quality improvement efforts in licensed FS/NF-Bs providing services for the Medi-Cal program.

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Please see **2007 ICD-9**, *page 2*

2007 ICD-9 *(continued)*

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71	238.72	238.73	238.74
238.75	238.76	238.79	277.30	277.31	277.39	284.01
284.09	284.1	284.2	288.00	288.01	288.02	288.03
288.04	288.09	288.4	288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64	288.65	288.69	289.53
289.83	323.01	323.02	323.41	323.42	323.51	323.52
323.61	323.62	323.63	323.71	323.72	323.81	323.82
331.83	333.71	333.72	333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19	338.21	338.22	338.28
338.29	338.3	338.4	341.20	341.21	341.22	377.43
379.60	379.61	379.62	379.63	389.15	389.16	429.83
478.11	478.19	518.7	519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11	523.30	523.31	523.32
523.33	523.40	523.41	523.42	525.60	525.61	525.62
525.63	525.64	525.65	525.66	525.67	525.69	526.61
526.62	526.63	526.69	528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *	608.23 *	608.24 *	616.81 **
616.89 **	618.84 **	629.29 **	629.81 ** +	629.89 **	649.00 ** +	649.01 ** +
649.02 ** +	649.03 ** +	649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +	649.13 ** +
649.14 ** +	649.20 ** +	649.21 ** +	649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +	649.40 ** +	649.41 ** +	649.42 ** +
649.43 ** +	649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +	649.60 ** +	649.61 ** +
649.62 ** +	649.63 ** +	649.64 ** +	729.71	729.72	729.73	729.79
731.3	768.70 #	770.87 #	770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91	784.99	788.64	788.65
793.91	793.99	795.06 **	795.81	795.82	795.89	958.90
958.91	958.92	958.93	958.99	995.20	995.21	995.22
995.23	995.27	995.29	V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31	V58.32	V72.11	V72.19
V82.71	V82.79	V85.51	V85.52	V85.53	V85.54	V86.0 ** +
V86.1 ** +						

Restrictions
* Restricted to males only
** Restricted to females only
\# Restricted to ages 0 thru 1 year
\+ Restricted to ages 10 thru 99

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

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

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

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 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, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Manual replacement pages reflecting these ICD-9 code updates will be included in a future *Medi-Cal Update.*

Instructions for Manual Replacement Pages Part 2

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Remove and replace: mc sup lst3 13/14 *

* Pages updated due to ongoing provider manual revisions.