



# MEDI-CAL UPDATE

## Part 2

Billing and Policy

[www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)

### Long Term Care

**June 2007 • Bulletin 364**

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*Medi-Cal Training Seminars*

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**Redirection of Treatment Authorization Request Services**

Effective July 1, 2007, several regionalized *Treatment Authorization Request* (TAR) services provided by the Fresno Medi-Cal Field Office (FMCFO) are being redirected to the Northern and Southern Pharmacy Sections (NPS and SPS), Sacramento Medi-Cal Field Office (SMCFO) and San Francisco Medi-Cal Field Office (SFMCFE).

TAR services currently handled by the FMCFO will be redirected as follows:

- Intravenous home infusion equipment services, including all medical supplies related to infusion therapy, and all Durable Medical Equipment (DME) and medical supplies related to enteral feeding, have been redirected to the NPS and SPS.
- Medical supplies related to incontinence, including urinary catheters and bags, have been redirected to the SMCFO.
- Breast pumps and supplies have been redirected to the SFMCFE.
- Physician-administered drugs and/or physician-performed services/procedures, radiology services, inpatient and outpatient surgeries and procedures that require a TAR and elective acute hospital admissions have been redirected to the SMCFO.

Providers located in Oregon border cities were required to submit their TARs, for core services only, to SMCFO effective May 1, 2004.

The California Department of Health Services (CDHS) does not anticipate any delays in adjudication of these TAR types.

*Manual replacement pages will be released in a future Medi-Cal Update.*

**Processing Changes for Treatment Authorization Requests**

Beginning May 1, 2007, the California Department of Health Services (CDHS) started phasing in several changes that impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service
- Courier services
- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

*Please see **Processing Changes**, page 2*

Processing Changes (continued)

**Processing Change Schedule**

Processing changes to paper TARs impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

<p><b>May 2007</b> Sacramento Medi-Cal Field Office</p>	<p><b>August 2007</b> Fresno Medi-Cal Field Office San Bernardino Medi-Cal Field Office San Diego Medi-Cal Field Office San Francisco Medi-Cal Field Office</p>
<p><b>June 2007</b> Northern Pharmacy Section (Stockton) Southern Pharmacy Section (L.A.)</p>	<p><b>September 2007</b> TAR Administrative Remedy Section In-Home Operations North</p>
<p><b>July 2007</b> L.A. Medi-Cal Field Office In-Home Operations South</p>	

**Incomplete TARs**

CDHS Medi-Cal field offices and pharmacy sections will be unable to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections.

Providers are to:

- Make the necessary corrections/changes on the paper TAR, and
- Resubmit with a copy of the *Incomplete TAR Form* on top of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

- The TAR form is illegible or damaged.
- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.
- The patient’s Medi-Cal ID number is missing, invalid or invalid in length, and the patient’s name/date of birth is missing.
- The patient is not Medi-Cal eligible.
- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.
- The requested service information is missing, invalid or invalid in length.
- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.
- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Providers may call 1-800-788-2949 for further information.
- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Providers may refer to the appropriate Part 2 manual for specific TAR preparation instructions.

Please see **Processing Changes**, page 3

**Processing Changes** (*continued*)**Adjudication Response**

CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

The ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

**Attachments**

On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

**SSN on TARs**

In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed.

Provider questions may be directed to the local Medi-Cal field office or pharmacy section.


**National Provider Identifier (NPI) Number**

Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the "Important NPI Time Frame Changes" article posted in the "HIPAA News" area of the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.

*Please see **Processing Changes**, page 4*

Processing Changes (continued)

State of California - Health and Human Services Agency Department of Health Services	<h2 style="margin: 0;">CONFIDENTIAL</h2> <p style="margin: 0;">Medi-Cal Operations Division</p> <h1 style="margin: 0;">ADJUDICATION RESPONSE</h1>	ARNOLD SCHWARZENEGGER, Governor  																																																																																																																					
Provider Number: HSCXXXXXX XXX CONTRACT HOSP #2 3215 PROSPECT PARK DR RNCHO CORDOVA, CA 95670-6017	DCN (Internal Use Only): 123456789101 Date of Action: 06/27/2006 Regarding: Jane Doe TAR Control Number: 9876543210																																																																																																																						
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Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.  If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.																																																																																																																							

**90-Day Window to Submit SOC-Related Claims**

Long Term Care (LTC) providers are advised to submit unbilled claims, electronic or paper, they did not submit because they believed the recipient's Share of Cost (SOC) would meet or exceed (zero out) the Medi-Cal payment. Claims may be submitted for dates of service on or after August 1, 2004. Providers should enter delay reason code "10" (circumstances beyond their control) in the *Billing Limit Exception* field (Box 11) of the claim.

EDS will accept the claims for processing from June 15, 2007 through September 12, 2007. Claims submitted for this special processing exception after September 12, 2007 will be denied. Claims indicating no SOC will be considered invalid submissions and will be excluded from this special processing.

An Erroneous Payment Correction (EPC) is being scheduled to reprocess all LTC claims denied with Remittance Advice Details (RAD) code **0022: This service is the patient's liability (Share of Cost)** if they were billed to meet the patient's liability (SOC) and exceeded the amount due.

### HCBS Waiver Program Service Updates

Effective for dates of service on or after July 1, 2007, two waiver program codes are added to the Home and Community-Based Services (HCBS) program and a third code is redefined with updated rates and an additional provider type eligibility.

Also effective for dates of service on or after July 1, 2007, HCPCS code T2025 (waiver services, not otherwise specified) is no longer a benefit.

Added to the program are codes G9012 (Transitional Case Management [TCM], per hour) and T2017 (habilitation, residential, waiver; 15 minutes). For a complete description of the code, see the updated *Home and Community-Based Services (HCBS) Billing Codes and Reimbursement Rates* section in appropriate Part 2 Medi-Cal provider manual.

Also, code T2038 is redefined as “Community transition – waiver; per service. Non-recurring set-up expenses for individuals transitioning from a licensed medical facility to the community where the person is directly responsible for his/her own living expenses.” It is now additionally a benefit for non-profit proprietary agencies, and has a new rate limit not to exceed a lifetime benefit of \$5,000.

### Nursing Facilities Level B – Audit Appeals Policy Clarification

Pursuant to State Plan Amendment 05-005, when a Free-Standing Nursing Facility Level B (FS/NF-B) obtains an audit appeal decision resulting in the revision of the facility’s allowable costs, those costs will be used to recalculate the facility’s reimbursement rate for the respective rate year. For revised audited costs, the final revised rate will be reduced by the same percentage reduction applied during the initial rate-setting to comply with the legislatively mandated program limits defined in *Welfare & Institutions Code* (W&I Code), Section 14126.033(a)(2)(A).

For example, an audit appeal by a facility results in a recomputation by Audits & Investigations (A&I) for a December 31, 2004 fiscal period end date. The revised allowable costs are then used by the California Department of Health Services (CDHS) to compute a new facility-specific rate effective August 1, 2006. If a facility’s initial August 1, 2006 rates were reduced by 94.08 percent, then the facility will receive a recalculated rate due to revised audit findings that will also be reduced by 94.08 percent.

Once audit appeal documents from A&I are accepted by CDHS, the revised rate is installed for claim payment purposes. Previously paid claims are then reprocessed using the revised rate. Additionally, a retroactive adjustment in the facility-specific reimbursement rate will be made.

### Medi-Cal Share of Cost and Medicare Part D Reminder

Medicare-eligible recipients with a Medi-Cal Share of Cost (SOC) are not eligible for Medi-Cal benefits until their SOC is met. Under the Medicare Part D prescription drug program, Medicare beneficiaries with a Medi-Cal SOC may have higher prescription drug payment obligations than beneficiaries without an SOC. These payment obligations may include deductibles and copayments.

All medically necessary health services, whether covered by Medi-Cal or not, can be used to meet SOC for Medi-Cal purposes. All prescription drug payments required under Medicare Part D are considered medically necessary health services. For more information, refer to the Part 1 provider manual.

Prescription drug payments required under the Medicare Part D prescription drug program should be applied to the recipient’s SOC upon receiving payment or accepting obligation for payment from the recipient. Delays in performing the SOC clearance transaction may prevent the recipient from receiving other medically needed services.

**Long Term Care Bulletin 364**

Remove and replace  
at the end of *Manual*

Ordering section: *Subscriber Order Form 1/2 \**

Remove and replace: admis 11 \*  
child 1 thru 4 \*  
forms reo ltc 1/2 \*  
leave 5 thru 8 \*  
medi cr ltc ex 3 thru 9 \*

Remove and replace  
at the end of the *Other*  
*Health Coverage*

(OHC) section: *Long Term Care Insurance Denial of Coverage Referral form \**

Remove and replace: pay ltc comp 1/2 \*, 13/14 \*  
pay ltc tips 1/2 \*

Remove: share ltc 3 thru 12  
Insert: share ltc 3 thru 10 \*

Remove and replace: tar comp ltc 3/4 \*, 7 thru 10 \*, 13 thru 16 \*  
tar crit dp 7 thru 10 \*  
tar dis 7/8 \*

Remove entire  
section: tar sub clk 1 thru 3

Remove and replace: tar submis 3 \*

Remove: tar submit 1/2  
Insert: tar submit 1 \*

\* Pages updated due to ongoing provider manual revisions.