MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Long Term Care

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Contents

POS Network Exceptions to the Provider Identifier Dual-Use Period

The provider identifier "dual-use period" has been extended beyond November 26, 2007. The transactions listed below are exceptions to the dual-use period, because they are transactions where both sets of provider identifiers (Medi-Cal provider numbers and National Provider Identifiers [NPIs]) are not supported. Where both sets of provider identifiers are not supported, providers must continue to use the Medi-Cal provider number beyond the November 26, 2007 NPI implementation date. Providers defined by the HIPAA final rule and Medi-Cal policy as "atypical" will also continue to use only their nine-digit Medi-Cal provider numbers.

Modifications are being made to the following:

- POS device software
- Internet software
- Mainframe supportive software

Real-time processing transactions included are:

- Internet transactions
- Point of Service (POS)
- Automated Eligibility Verification System (AEVS)
- Supplemental Automated Eligibility Verification System (SAEVS)

POS Device Download
Beginning August 25, 2007, messages appeared on POS devices announcing an automatic software update download. This software update accommodates the 10-digit NPI in preparation for Medi-Cal's implementation. Providers must, until further notice, continue to enter the Medi-Cal provider number beyond the November 26, 2007 NPI implementation date.

Eligibility
For eligibility transactions, Medi-Services reservations and Share of Cost (SOC) spend down dial-up or leased-line transmissions, providers must, until further notice, continue to enter the Medi-Cal provider number beyond the November 26, 2007 NPI implementation date. Information about sending and receiving data via leased-line and dial-up submissions is available in the *ASC X12N 270/271Version 4010A1 Health Care Eligibility Benefit Inquiry and Response* companion guide located on the Medi-Cal Web site (**www.medi-cal.ca.gov**).

Please see **Exceptions**, *page 2*

Exceptions *(continued)*

Providers can access the guide by clicking the "References" tab, then the "HIPAA Update" link, and finally, "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link. On this page, click "ASC X12N 270/271 Version 4010A1 Health Care Eligibility Benefit Inquiry and Response (Real-Time and Batch)" to download the *270/271 Overview for Leased-Line, Dial-Up and Batch Submissions* section of the guide. Information about mandatory testing for the 270/271 v.4010A1 eligibility transaction using the NPI is in that section.

Note: Providers who tested 270/271 v.4010A1 eligibility transactions using their Medi-Cal provider numbers do not need to retest using NPI numbers.

Pharmacy
Providers must, until further notice, continue to enter the Medi-Cal provider number beyond the November 26, 2007 NPI implementation date for all National Council for Prescription Drug Programs (NCPDP) Version 5.1 dial-up and leased-line transmissions. NCPDP Version 5.1 technical publications are now available on the Web page referenced above. Test data for NCPDP transactions using the NPI are detailed in the NCPDP 5.1 specifications.

Supplemental Schedules Required for AB 1629 Rate Methodology

Assembly Bill 1629 requires the Department of Health Care Services (DHCS) to develop Medi-Cal cost-based, facility-specific reimbursement rates for Free-Standing Nursing Facilities Level B (FS/NF-B) and subacute care units of FS/NF-Bs. *Welfare and Institutions Code* (W&I Code), Section 14126.023(g), authorizes DHCS to collect supplemental information to implement this rate methodology.

To accurately distinguish costs, providers are required to submit the *Administration Costs Supplemental Schedule (Supplemental Schedule 1)* and Agency Costs for *Indirect Care Services Supplemental Schedule (Supplemental Schedule 2).* In addition, providers may voluntarily submit the *Capital Additions, Improvements and Replacements Supplemental Schedule*. The following chart indicates when the schedules are due to DHCS, in order for DHCS to calculate August 1, 2008 rates:

Schedule Name	**Due to DHCS by:**
Administration Costs Supplemental Schedule	January 15, 2008
Agency Costs for Indirect Care Services Supplemental Schedule	January 15, 2008
Capital Additions, Improvements and Replacements Supplemental Schedule	January 15, 2008

The W&I Code identifies the following five cost categories for setting facility-specific rates:

1. Labor
2. Indirect care non-labor
3. Administrative
4. Capital costs
5. Direct pass-through costs

W&I Code, Section 14126.027(c), authorizes DHCS to use *Medi-Cal Updates* for notifying providers about implementation of the cost-based, facility-specific rate methodology.

Please see **Schedules**, *page 3*

Schedules *(continued)*

Purpose of Supplemental Schedules
The August 1, 2008 facility-specific reimbursement rates will be based on audited data; if audited data is not available, then the as-submitted Office of Statewide Health Planning and Development (OSHPD) Disclosure Reports will be used. Certain costs are not currently identifiable on the OSHPD Report). Until the OSHPD Report is revised to specifically identify these costs, FS/NF-Bs are required to complete separate annual supplemental schedules detailing these expenditures. The *Administration Costs Supplemental Schedule* and *Agency Costs for Indirect Care Services Supplemental Schedule* and instructions for completing them are available at the DHCS Web site's Long Term Care System Development Unit page at **www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**.

Providers who meet expenditure thresholds can complete the voluntary supplemental schedule, which details major capital improvements, modifications or renovations. The *Capital Additions, Improvements and Replacements Supplemental Schedule* and related instructions define the expenditure and time period thresholds. This voluntary supplemental schedule is currently available at **www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**.

Supplemental Schedules Reporting Period
For the rate year beginning August 1, 2008, facility-specific reimbursement rates will be based on audited data or the as-submitted OSHPD Disclosure Reports with fiscal end dates in 2006.

Information submitted on the Supplemental Schedules 1 and 2, as well as the voluntary Capital Additions, Improvements and Replacements Supplemental Schedule, should be based on the identical time period as that of the facility's OSHPD Report with a fiscal period end date in 2006. If a FS/NF-B submitted more than one OSHPD Report with a fiscal period end date in 2006, refer to the posted instructions for details.

Electronic Submission Required
It is critical that providers submit supplemental schedules to DHCS in a standardized electronic format and in a timely manner, but no later than January 15, by following these instructions:

- Download the supplemental schedules in the prescribed Excel format from the DHCS Long Term Care System Development AB 1629 Web page (**www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**).
- Submit completed versions of the electronic supplemental schedules to DHCS via an e-mail address created specifically for these documents – **supp1629@dhcs.ca.gov**.
- Label the electronic files according to the posted instructions for the supplemental schedules on the Web site.
- If electronic download and submission is not available, please contact (916) 552-8613 for further instructions about transmitting this data.

Due Dates and Schedule Overview
Information on the supplemental schedules is required to calculate certain cost categories in each facility-specific Medi-Cal reimbursement rate for FS/NF-Bs subject to the new methodology. If an FS/NF-B does not comply by the required due date, DHCS will not have the necessary data to calculate several pass-through components of the reimbursement rate. The lack of supplemental schedule data will limit DHCS from fully identifying certain costs that AB 1629 legislation mandates to be reimbursed in cost groupings with higher reimbursement ceilings.

Facilities that do not submit the *Administration Costs Supplemental Schedule* by January 15, 2008 will remain at the costs shown on their fiscal period end 2006 OSHPD Report and will be subject to lower reimbursement ceilings for the administrative cost category.

Facilities that do not submit the Agency Costs for *Indirect Care Services Supplemental Schedule* by January 15, 2008 will be subject to a reduction for calculating this portion of the labor cost category.

Questions about supplemental schedules can be e-mailed to **supp1629@dhcs.ca.gov** or left as a voice mail message at (916) 552-8613.

Facility-Specific Reimbursement Rates Update

Effective for dates of service on or after August 1, 2007, the Department of Health Care Services (DHCS) has updated the provider reimbursement rates for Free-Standing Nursing Facilities Level B (FS/NF-B) and Free-Standing Subacute Nursing Facilities Level B (FSSA/NF-B). These rates are now facility-specific.

Providers do not need to rebill. EDS will process any retroactive rate adjustments for claims paid at the prior rate for services provided on or after August 1, 2007. The facility-specific rates are on the DHCS Web site (**www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**). Providers must use the new rates to bill for services on or after August 1, 2007.

Facility-specific reimbursement rates are computed on an annual basis. Therefore, rates effective on or after August 1, 2007, are based upon audited data with fiscal end dates in 2005. If audited data is not available, then the as-submitted Office of Statewide Health Planning and Development (OSHPD) Disclosure Reports with fiscal end dates in 2005 will be used.

Facility Pay Base
The following are the reimbursement specifications for each type of facility:

- Facilities with a change of ownership will be reimbursed based on the prior owner's rates.
- Newly certified facilities with no prior ownership will be reimbursed based on the weighted average corresponding to its respective peer group. The facility-specific rate reimbursement methodology establishes seven peer groups.
- Out-of-state or border providers will be paid based on the statewide weighted average of $152.48. Three out-of-state providers (XLTC00031 Lenox Healthcare of Yuma, XLTC00078 Accessible Space of Las Vegas and LTC20225F Yuma Nursing Center) will be reimbursed at the statewide weighted average, effective August 1, 2007.
- Reimbursement for hospice revenue code 658 (room and board) continues to be 95 percent of the FS/NF-B facility-specific rate.

Peer Group No.	County Name	County Code #	Weighted Average Rate		Peer Group No.	County Name	County Code #	Weighted Average Rate
1	Colusa	06	**$140.02**		4	Amador	03	**$155.41**
	Del Norte	08				El Dorado	09	
	Imperial	13				Nevada	29	
	Kern	15				Placer	31	
	Kings	16				Tuolumne	55	
	Lake	17						
	Lassen	18			5	Los Angeles	19	**137.82**
	Tulare	54						
	Yuba	58			6	Fresno	10	**153.72**
						Orange	30	
2	Butte	04	**152.06**			Riverside	33	
	Humboldt	12				San Bernardino	36	
	Inyo	14				San Diego	37	
	Madera	20				Santa Cruz	44	
	Mendocino	23				Solano	48	
	Merced	24						
	San Luis Obispo	40			7	Alameda	01	**175.78**

Please see **Reimbursement Rates**, *page 5*

Reimbursement Rates *(continued)*

Peer Group No.	County Name	County Code #	Weighted Average Rate		Peer Group No.	County Name	County Code #	Weighted Average Rate
	Tehama	52				Contra Costa	07	
	Yolo	57				Marin	21	
						Monterey	27	
3	Calaveras	05	**156.10**			Napa	28	
	Glenn	11				Sacramento	34	
	Plumas	32				San Francisco	38	
	San Joaquin	39				San Mateo	41	
	Shasta	45				Santa Barbara	42	
	Siskiyou	47				Santa Clara	43	
	Stanislaus	50				Sonoma	49	
	Sutter	51						
	Ventura	56						

This updated information is reflected on manual replacement page rate facil diem 2 (Part 2).

TAR Submissions Redirected

Effective for dates of service on or after November 1, 2007, *Treatment Authorization Requests* (TARs) for regionalized oxygen and respiratory equipment, respiratory care services and medical supplies not otherwise designated will be redirected from the Fresno Medi-Cal Field Office (FMCFO) to the Sacramento Medi-Cal Field Office (SMCFO).

The Department of Health Care Services (DHCS) Utilization Management Division does not anticipate any delays as a result of this change. The SMCFO has already begun its in-service training and TAR adjudication processes.

This information is reflected on manual replacement pages and tar field 3 and 6 (Part 2).

Changes in TAR Submissions for Core Services

Effective December 1, 2007, in order to effectively deal with the closure of the Fresno Medi-Cal Field Office (FMCFO), providers in Monterey, San Benito, San Luis Obispo, Santa Barbara and Santa Cruz counties will be required to submit their *Treatment Authorization Requests* (TARs) for core services to the San Francisco Medi-Cal Field Office (SFMCFO).

Also effective December 1, 2007, providers in Fresno, Kern, Kings, Madera, Mariposa, Merced, Stanislaus, Tuolumne and Tulare counties will be required to submit their TARs for core services to the Sacramento Medi-Cal Field Office (SMCFO).

This information is reflected on manual replacement pages tar field 6 and 9 (Part 2).

Fresenius Joins End Stage Renal Disease Pilot Project

Under an existing pilot project, recipients with End Stage Renal Disease (ESRD) may enroll in Fresenius Medical Care Health Plan (FMCHP), a Medicare Advantage Private Fee-for-Service Plan (PFFS). Effective for dates of service on or after January 1, 2007, FMCHP serves recipients in San Diego and Imperial counties. Ordinarily, recipients with ESRD would be excluded from enrollment in a Medicare Advantage plan.

Please see **Pilot Project**, *page 6*

Pilot Project *(continued)*

FMCHP joins "VillageHealth operated by SCAN Health Plan" (VillageHealth) in the pilot project. VillageHealth began serving recipients with ESRD in January 2006.

FMCHP is partnering with Balboa Nephrology, Heritage Health Systems, Fresenius Medical Services and other providers in this endeavor, as follows:

- FMCHP (an ESRD Specialty Health Plan/California Medical Services Demonstration Project) is the primary payer
- Balboa Nephrology renders the nephrology services
- Fresenius Medical Services renders the dialysis services
- Heritage Health Systems is the fiscal intermediary, acting like a Medicare fee-for-service contractor
- Other providers render additional medical services

Provider Manual
Policy about the pilot project is included in the *MCP: Special Projects* section of the Part 1 Medi-Cal provider manual.

Billing
Providers bill for services to FMCHP members as follows:

- Plan-covered services to FMCHP
- Copayments, coinsurance or deductibles for plan-covered services to Medi-Cal (similar to crossover claims)
- Services denied or not covered by FMCHP, to Medi-Cal as standard fee-for-service claims

Copayments, Coinsurance and Deductibles
Claims for copayments, coinsurance or deductibles must be submitted as paper claims. Instructions for submitting paper claims closely parallel instructions for billing Medicare/Medi-Cal hard copy crossover claims, except for the few additional requirements noted below.

In their interpretation of policy in the Part 2 manual, billers should consider "FMCHP" the same as "Medicare." For example, in the *Medicare/Medi-Cal Crossover Claims: Long Term Care* section, under the "Where to Submit Hard Copy Crossover Claims" heading, the reference to "Medicare approved service" would be interpreted as "FMCHP approved service."

In addition, claims for copayments, insurance or deductibles treated like crossovers must be billed to Medi-Cal with the same national procedure codes and modifiers billed to FMCHP and include the following:

- A copy of the *Remittance Advice* (RA) received from FMCHP. The RA must state "FMCHP is an ESRD 1 demonstration project" in the *Remarks* section at the bottom left and include the address and telephone number for FMCHP in the upper right corner.

Electronic billing is precluded at this time but may eventually be an option.

This information is reflected on manual replacement pages mcp spec 7 thru 9 (Part 1) and medicare 3 (Part 1).

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Remove and replace: prov bil 1/2 *

Remove and replace after the *Provider Billing After Beneficiary Reimbursement (Conlan v. Shewry)* section: *Request for Beneficiary Reimbursement Letter (Letter 08)* 1/2 *

Remove and replace:
rate facil 1/2, 5 thru 7 *
rate facil diem 1/2
remit pay 1/2 *
rural hosp 1/2 *
share ltc 9/10 *
tar comp ltc 11/12 *
tar field 3 thru 6, 7/8 *, 9/10, 11 *
util review 1/2 *

* Pages updated due to ongoing provider manual revisions.