



Long Term Care

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Facility-Specific Rate Methodology Policy Clarification and Updates

Effective for dates of service on or after the August 1, 2008, the Department of Health Care Services (DHCS) has amended the Professional Liability Insurance (PLI) policy for Free-Standing Nursing Facilities Level B (FS/NF-Bs) that was published in the April 2007 *Medi-Cal Update*.

Professional Liability Insurance (PLI) Pass Through

Effective August 1, 2008, for the rate year 2008-09 and future rate years, the PLI pass-through per diem will be based on audited data; if audited data is not available, then the PLI pass-through per diem will be calculated based on the amount reported on Supplemental Schedule 1. PLI costs will be removed from the administration cost grouping, in order to be paid as a pass-through. If audited data is not available, the following methodology applies to the PLI reported on the Supplemental Schedule 1 as follows:

- The PLI amount reported on Supplemental Schedule 1 will be used to calculate the PLI per diem when the facility’s Office of Statewide Health Planning and Development (OSHPD) ID and fiscal period end date match the facility’s “as submitted” OSHPD report that is used in rate-setting. This amount will be validated by DHCS.
- If the submitted Supplemental Schedule 1 is based on a different fiscal period end date than the “as submitted” OSHPD report used in rate-setting, and there is no audit for the rate-setting period, then the prior year’s audited PLI amount, inflated by the California Consumer Price Index, will be used to determine the PLI pass-through per diem.
- If the submitted Supplemental Schedule 1 is based on a different fiscal period end date than the “as submitted” OSHPD report used in rate-setting, and there is no audit for a prior rate period, a “proxy” pass-through per diem will be calculated to determine the PLI pass-through per diem. The “proxy” pass-through per diem will be based on the peer group weighted average PLI per diem, based on all facilities that submitted a valid Supplemental Schedule 1 with PLI costs.
- If no Supplemental Schedule 1 is submitted, and if audited data is not available, the facility PLI pass-through per diem will be zero.

PLI pass-through costs are not capped, but are limited by the overall maximum annual increases, permitted by legislation.

Determination of Reasonable Administrator Compensation for Long Term Care Facilities

Assembly Bill 1629 (Stats. 2004, c. 875), effective September 29, 2004, enacted the Medi-Cal Long Term Care Reimbursement Act (“Act”) (see amended *Welfare and Institutions Code* [W&I Code] Section 14105.06 and new W&I Code Sections 14126 – 14126.035). The Act directed DHCS to implement a facility-specific rate-setting system for nursing facilities, effective August 1, 2005. The Act also directed DHCS to seek approval by the Centers for Medicare and Medicaid Services (CMS) of an amendment to the Medicaid state plan outlining the reimbursement methodology developed in response to the Act. (See W&I Code Section 14126.025.)

Please see Rate Updates, page 2

Rate Updates (*continued*)

An amendment to the state plan describing the overall reimbursement rate methodology for FS/NF-Bs, both publicly and privately operated, and subacute care units of FS/NF-Bs, was approved by CMS on September 9, 2005 (SPA 05-005, Supplement 4 to Attachment 4.19-D). The amendment provides that for purposes of calculating reasonable compensation of facility administrators, DHCS will follow the standards established under Chapter 9 of CMS's Provider Reimbursement Manual (HIM 15). The amendment also provides that DHCS will conduct its own compensation survey for calculating reasonable compensation for facility administrators. Based on the data collected from such surveys, DHCS will develop compensation range tables to evaluate facility administrator compensation during audits of FS/NF-B facilities and adjust the costs accordingly.

DHCS is also required to determine reasonable allowable costs based on Medicare reimbursement principles as specified in Code of Federal Regulations (CFR), Title 42, Part 413. (See SPA No.00-010, Attachment 4.19-D, II.B, and W&I Code Section 14126.023[h][3].)

In accordance with the applicable federal and state laws, DHCS conducted a Long Term Care (LTC) administrator compensation survey for the purpose of determining reasonable compensation of facility administrators in California. Based on the data collected from the survey, DHCS developed compensation range tables for the purpose of evaluating facility administrator compensation during audits of those facilities.

The latest administrator compensation survey was conducted for calendar year 1999. Until another base year administrator compensation survey is conducted, the compensation rate tables are updated by an annual inflation factor issued by CMS.

Under the Act, DHCS may implement the provisions of the Act by means of a provider bulletin or other similar instruction, without taking regulatory action. (See W&I Code Section 14126.027[c].) Pursuant to this authority, the compensation range tables developed by DHCS are hereby adopted with this provider bulletin. The current Administrator Compensation range tables for LTC facilities can be viewed at www.dhcs.ca.gov/ProvGovPart/Pages/FinancialAuditsBranch.aspx, by scrolling to the bottom of the page and then clicking the link directly under "Administrator Compensation Ranges." This information can also be obtained by contacting the DHCS Audits and Investigations, Audit Review and Analysis Section at (916) 650-6696, or by sending an e-mail request to Gary.Wong@dhcs.ca.gov.

Processing Changes for TARs

Beginning May 1, 2007, the Department of Health Care Services (DHCS) phased in several changes which impacted how paper *Treatment Authorization Requests* (TARs) are processed.

These changes were 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

Incomplete TARs

DHCS 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.

Please see Processing Changes, page 3

Processing Changes (*continued*)

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 should 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 should refer to the appropriate Part 2 manual for specific TAR preparation instructions.

Adjudication Response

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 DHCS’ Payment Systems Division, Provider Enrollment Division (PED). Providers should ensure PED 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). From the home page, click the “Provider Enrollment” link and then the “Provider Reminders” link.

Please see Processing Changes, page 4

Processing Changes (continued)

Attachments

On November 15, 2006, DHCS 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.

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								
This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:									
Svc #	Service Code	Modifier(s)	Service Description	From Date of Service	Thru Date of Service	Units	Quantity	Status	P.I.
1	123ABC	1	Service Description 1	01-01-2006	01-31-2006	12345	1000000.123	1 Approve	1
2	ABC123	2	Service Description 2	01-01-2006	01-31-2006	12345	1000000.123	2 Modify	0
Reason(s):		GEN: Modified, refer to comments							
Comment(s):		Comments from Field Office Consultant 2							
3	ABC123	3	Service Description 3	01-01-2006	01-31-2006	12345	1000000.123	3 Deny	3
Reason(s):		GEN: Denied, refer to comments							
Comment(s):		Comments from Field Office Consultant 3							
4	ABC123	4	Service Description 4	01-01-2006	01-31-2006	12345	1000000.123	4 Defer	5
Reason(s):		GEN: Deferred, refer to comments							
Comment(s):		Comments from Field Office Consultant 4							
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.									

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Remove and replace: appeal form 3 thru 9 *
cif co 9 thru 11 *
cif sp ltc 1/2 *, 7/8 *
cif sub 3/4 *
forms reo ltc 1/2 *
leave 7/8 *
medi cr ltc ex 3 thru 6 *, 9 *

Remove: pay ltc comp 3 thru 19
Insert: pay ltc comp 3 thru 14 *

Remove and replace: remit ex ltc 1 thru 8 *
resub comp 1/2 *, 5/6 *
share ltc 5/6 *
tar comp ltc 15/16 *
tar crit dp 7/8 *

* Pages updated due to ongoing provider manual revisions.