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

Long Term Care

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Professional Liability Insurance Pass-Through Reimbursement

AB 1629 Facility-Specific Rate Methodology Rate Reimbursement Clarification

Welfare and Institutions Code (W&I Code), Sections 14126 through 14126.035 (Medi-Cal Long Term Care Reimbursement Act, added by California Assembly Bill 1629 [Statutes of 2004]), mandate facility-specific, rate-setting methodology for Free-Standing Skilled Nursing Facilities Level B (FS/NF-Bs) and subacute care units of Free-Standing Skilled Nursing Facilities Level B (FSSA/NF-Bs).

W&I Code, Section 14126.027(c) authorizes the Department of Health Care Services (DHCS) to use provider bulletins as an alternative to regulations in order to implement the provisions of AB 1629. The DHCS is issuing this provider bulletin pursuant to this authority.

This provider bulletin clarifies Section 14126.023(a)(5) of the W&I Code, the direct pass-through Professional Liability Insurance (PLI) cost reimbursement as applicable to non-commercial insurance. These clarifications follow Medicare reasonable cost principles of reimbursement as outlined in the Provider Reimbursement Manual (CMS Publication 15-1).

Non-Commercial PLI Pass-Through Reimbursement

Subject to any changes in state or federal law, this article is effective retroactively to rate year beginning August 1, 2008, and will be applicable to 2006 audited cost reports.

For rate-setting purposes, liability insurance is a direct pass-through cost limited by the overall maximum annual increases permitted by legislation. In order to determine reasonable allowable pass-through costs, Section 14126.023(h)(3) of the W&I Code requires Audits and Investigation (A&I) Division of DHCS to follow Medicare reasonable cost principles consistent with Title 42, Part 413 of the *Code of Federal Regulations*.

Non-commercial PLI pass-through costs are defined as premium costs charged by commercially purchased insurance carriers. These costs follow Medicare reasonable cost principles and are subject to the methodology outlined below.

The DHCS used the following methodology to determine the reasonable allowable non-commercial PLI pass-through premium costs:

- Commercially available PLI premium costs were removed from audited 2006 cost reports and organized according to their peer groups;
- Costs were further organized by descending PLI value;
- To exclude "outlier" costs, a benchmark of 90th percentile was determined as reasonable cost for each peer group.

The 90th percentile benchmark will be applied by the A&I Division to all facilities that are above it.

Optional Benefits Exclusion Policy Update

Effective July 1, 2009, several optional benefits have been excluded from coverage under the Medi-Cal program. For details, providers should refer to the "Optional Benefits Excluded from Medi-Cal Coverage" article that was published in the June *Medi-Cal Update* bulletin. Additional information regarding the optional benefits exclusion policy is described below:

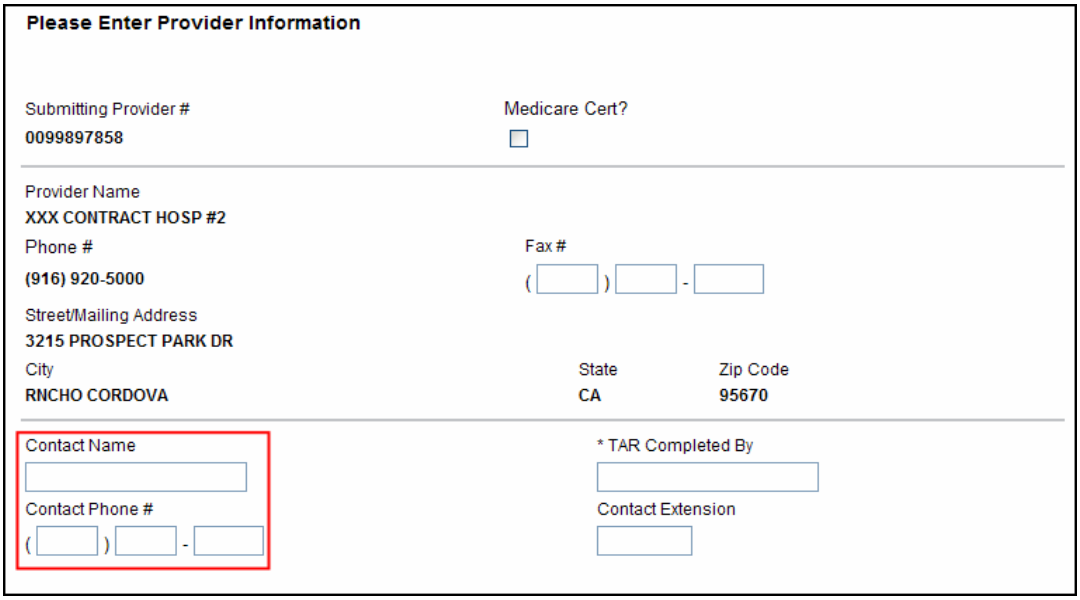
- Excluded dental services will remain available to beneficiaries that are residents of Intermediate Care Facilities/Developmentally Disabled (ICF/DD) facilities, including ICF/DD-Nursing and ICF/DD-Habilitative.
- EPSDT exemption clarification: EPSDT-eligible beneficiary means persons younger than 21 years of age with full-scope Medi-Cal. EPSDT-eligible beneficiaries will continue to receive the optional benefits.
- Continuing care exemption clarification: continuing care exemption only applies to medical/surgical care required for the treatment and the resolution of the acute episode.

This information is reflected on manual replacement pages opt ben exc 1, 2, 4 thru 7, 9 and 10 (Part 2).

Include Contact Name and Phone Number for eTARs

Providers using electronic Treatment Authorization Requests (eTARs) are strongly encouraged to fill out the *Contact Name* and *Contact Phone Number* fields, even though these are not required. Providers should provide their direct contact information in case the eTAR reviewer needs to speak to the submitter directly. This will expedite the TAR adjudication process.

The *Contact Name* and *Contact Phone Number* fields for medical providers can be found in the **Please Enter Provider Information** section of the medical eTAR.



Providers should refer to the eTAR Medical Services Tutorial on the Medi-Cal Web site (**www.medi-cal.ca.gov**) for more information.

Health Insurance Portability and Accountability Act (HIPAA) National Administrative Codes

As part of the continuing effort to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), new national administrative codes will be implemented effective September 1, 2009. Updates to the valid list of Place of Service codes from the Centers for Medicare & Medicaid Services (CMS) and updates to the valid type of bill codes by the National Uniform Billing Committee (NUBC) are necessary for HIPAA compliance.

Place of Service Codes
Following are the new Place of Service codes being added to the currently acceptable administrative code values for billing Medi-Cal:

01, 03 – 08, 13 – 16, 20, 26, 33, 34, 49 – 52, 56, 57, 60 and 61

Resources
The Medi-Cal provider manual will be updated to include the new Place of Service and type of bill codes recently developed by the National Uniform Claim Committee (NUCC) and NUBC. Providers should continue to watch the monthly *Medi-Cal Updates* for further information or call the Telephone Service Center (TSC) at 1-800-541-5555.

Instructions for Manual Replacement Pages — Part 2

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Remove:	opt ben exc 1 thru 8
Insert:	opt ben exc 1 thru 10