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

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Contents

Rate Changes for Long Term Care Facilities

Effective for dates of service from August 1, 2004 through July 31, 2005, reimbursement rates for certain long term care facilities are increased to include the Quality Assurance Fee (QAF) mandated by AB 1629. This additional increase of either $3.16 or $3.66 pertains to the following providers and services: Free-Standing Nursing Facility Level B (NF-B) accommodation codes 01, 02, 03, 11 and 12, and Free-Standing subacute care accommodation codes 75, 76, 77, 78, 81 and 82. The QAF rate is determined by the total number of days on the NF-B or subacute care provider's annual cost report.

The updated information is reflected on manual replacement pages rate facil 2 (Part 2) and rate facil diem 3 (Part 2).

End Stage Renal Disease Pilot Project

Under a four-year pilot project, recipients with End Stage Renal Disease (ESRD) may enroll in "VillageHealth operated by SCAN Health Plan" (VillageHealth), a Medicare Health Maintenance Organization (HMO). Effective for dates of service on or after January 1, 2006, VillageHealth serves recipients in select ZIP codes in San Bernardino and Riverside counties. Ordinarily, recipients with ESRD would be excluded from enrollment in a Medicare HMO.

VillageHealth is partnering with DaVita and other providers in this endeavor, as follows:

- VillageHealth (an ESRD Specialty Health Plan/California Medical Services
  Demonstration Project) is the primary payer
- DaVita renders the dialysis services
- Other providers may render additional medical services

Provider Manual
Policy about this pilot project has been added to the *MCP: Special Projects* section of the Part 1 Medi-Cal provider manual.

Billing
Providers bill for services to VillageHealth members as follows:

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

Please see **VillageHealth**, *page 2*

VillageHealth *(continued)*

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. Therefore, billers should refer to the "Hard Copy Submission Requirements for Medicare Approved Services" in the Part 2 manual.

In their interpretation of the manual, billers should consider "VillageHealth" 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 "VillageHealth 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 VillageHealth and include a copy of the *Remittance Advice* (RA) received from VillageHealth. The RA must state "SCAN ESRD PILOT" in the *Remarks* section at the bottom left and include the address and telephone number for VillageHealth in the upper right corner.

Electronic billing may eventually be an option.

This information is reflected on manual replacement pages mcp spec 7 and 8 (Part 1) and medicare 3 (Part 1).

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	rate facil 1/2
Remove:	rate facil diem 1 thru 6
Insert:	rate facil diem 1 thru 8