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

Long Term Care

May 2009 • Bulletin 387

Contents

AB 1629 Facility-Specific Rate Methodology Clarifications

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]) mandates 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). This provider bulletin clarifies the rate-setting methodology for facilities that have been de-certified and later re-certified to participate in the Medi-Cal program. It further clarifies the rate-setting methodology for facilities that have undergone a change of ownership. Unless otherwise specified, all the clarifications apply to both FS/NF-Bs and 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. DHCS is issuing this provider bulletin pursuant to this authority.

Rate-Setting for De-certified FS/NF-Bs and FSSA/NF-Bs

FS/NF-Bs and FSSA/NF-Bs newly certified to participate in the Medi-Cal program, and that have been de-certified from Medi-Cal for at least six months prior to re-certification, will receive an interim reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate.

DHCS will calculate the FS/NF-B facility-specific rate when six months of audited Medi-Cal cost and supplemental data becomes available for the timeframe that will be used for rate-setting purposes. The facility-specific rate based on the audited six months of Medi-Cal cost and supplemental data will be calculated prospectively and will be effective on August 1 of each rate year, pursuant to W&I Code, Section 14126.021.

The facility-specific rate for FSSA/NF-Bs will be based on 12 months of audited Medi-Cal cost and supplemental data, and will be calculated in accordance to the methodology specified above.

Rate-Setting for FS/NF-Bs and FSSA/NF-Bs and Changes of Ownership

Changes of ownership or changes of the licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. If the previous operator participated in the Medi-Cal program, DHCS will continue to reimburse the facility the per diem payment rate of the previous provider.

DHCS will calculate the FS/NF-B facility-specific rate when six months of audited Medi-Cal cost and supplemental data becomes available for the timeframe that will be used for rate-setting purposes. The facility-specific rate based on the audited six months of Medi-Cal cost and supplemental data will be calculated prospectively and will be effective on August 1 of each rate year, pursuant to W&I Code, Section 14126.021.

The facility-specific rate for FSSA/NF-Bs will be based on 12 months of audited or reviewed Medi-Cal cost and supplemental data, and will be calculated in accordance to the methodology specified above.

Sign Language: Benefits Expanded and Provider Manual Section Title Changed

Effective for dates of service on or after June 1, 2009, sign language interpreter services benefits are expanded to allow for reimbursement of communications outlined in the first two bulleted entries below. The service specified in the third bulleted item is the current Medi-Cal benefit.

- Communication between a deaf or hearing-impaired adult representative of the Medi-Cal recipient and a Medi-Cal-enrolled provider when necessary to facilitate medically necessary health services for the recipient
- Communication between a deaf or hearing-impaired adult who receives services or training on behalf of the recipient and the Medi-Cal-enrolled provider who renders the medically necessary health care services to the recipient
- Communication between a deaf or hearing-impaired Medi-Cal recipient and a Medi-Cal-enrolled provider during the course of a medically necessary health care examination or other procedure

Sign language interpreter services are now reimbursable for all Medi-Cal providers employing fewer than 15 people. Previously, these services were reimbursable only to physicians or physician groups employing fewer than 15 employees (dates of service prior to June 1, 2009).

Providers must document that they employ fewer than 15 employees in the *Explanations* area of the claim, or on a claim attachment. These services may not be billed using the "from-through" format.

The codes for billing sign language interpreter services (HCPCS codes Z0324, Z0326, Z0328 and Z0329) have not changed. Descriptors are located in the *Sign Language Interpretation* section, which was previously titled *Translation Services*.

Updates are included on manual replacement pages sign 1 thru 3 (Part 2).

Medical Supplies Code Conversion: Billing Clarification

In response to comments from providers, some Part 2 manual sections have been updated to clarify billing instruction details for the recent medical supplies code conversion policy changes, including the use of Universal Product Numbers (UPNs) and UPN qualifiers.

This information is reflected on manual replacement pages incont 8 and 9 (Part 2).

Instructions for Manual Replacement Pages — Part 2

May 2009

Long Term Care Bulletin 387

Remove and replace:	*Contents for Long Term Care Billing and Policy* iii/iv * incont 7 thru 10
Insert new section after the *Share of Cost (SOC): 25-1 for Long Term Care* section:	sign 1 thru 3 *(new)*

* Pages updated due to ongoing provider manual revisions.