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

Long Term Care

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Contents

Updated Facility-Specific Reimbursement Rates

For dates of service on or after August 1, 2005, the California Department of Health Services (CDHS) has updated provider reimbursement rates for Freestanding Nursing Facilities Level-B (FS/NF-B) and Freestanding 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, 2005.

The facility-specific rates are on the CDHS Web site (**www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm**). Providers should use the new rates to bill for services on or after August 1, 2005. Out-of-state or border providers will be reimbursed at the statewide weighted average of $142.11.

Note: Providers should retain all manual pages concerning reimbursement rates for dates of service prior to August 1, 2005 for the purpose of billing Medi-Cal for those dates of service.

Facility-specific reimbursement rates will be computed on an annual basis. Therefore, rates effective retroactive to August 1, 2005, were based upon the as submitted OSHPD Disclosure Reports with facility fiscal period end dates in 2003. Reimbursement rates effective August 1, 2006 will be based on the as submitted OSHPD Disclosure Reports with facility fiscal period end dates in 2004. Reimbursement rates effective August 1, 2007, will be based on the as submitted OSHPD Disclosure Reports with facility fiscal period end dates in 2005.

CDHS will use the six months of cost and/or supplemental data available during the annual rate-setting process to determine a facility-specific rate. Facilities that do not submit a supplemental schedule, submit an invalid supplemental schedule or indicate 0 (zero) on the supplemental schedule for pass-through costs will receive a 0 (zero) per diem for a direct pass-through cost component of the reimbursement rate.

The facility-specific rates impact the Hudman v. Kizer litigation policy, which authorizes reimbursement at the FS/NF-B rate under prescribed circumstances. Rates for the affected providers will be updated based on the Medi-Cal FS/NF-B weighted average rate for their respective peer group.

Please see **Facility-Specific Rates**, *page 2*

Facility-Specific Rates *(continued)*

The rate for a newly certified facility with no prior ownership will be the weighted average corresponding to its respective peer group. The facility-specific rate reimbursement methodology establishes seven peer groups. These groups, the counties included in each group, and the peer group's weighted average, are as follows:

Peer Group #	County Name	County Code #	Weighted Average Rate		Peer Group #	County Name	County Code #	Weighted Average Rate
1	Colusa	06	$135.06		4	Amador	03	$150.51
	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	$129.25
	Tulare	54						
	Yuba	58			6	Fresno	10	$142.77
						Orange	30	
2	Butte	04	$140.06			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	$163.19
	Tehama	52				Contra Costa	07	
	Yolo	57				Marin	21	
						Monterey	27	
3	Calaveras	05	$145.84			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 pages rates facil diem 1 and 2 (Part 2).

Providers Receiving RAD Messages for Over-One-Year Claims

Effective May 1, 2006, providers will no longer receive acknowledgement, approval or denial letters for claims submitted more than 12 months from the month of service and that meet established late submission requirements. Such claims will be noted on a *Remittance Advice Details* (RAD) with a message indicating the status of the claim.

The policy described above applies only to original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining recipient eligibility, reversal of decisions on appealed *Treatment Authorization Requests* (TARs), Medicare/Other Health Coverage delays or other circumstances beyond the provider's control, and were subsequently sent to EDS' Over-One-Year Unit.

This updated information is reflected on manual replacement page pay ltc sub 3 (Part 2).

Instructions for Manual Replacement Pages — Part 2

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Remove:	rate facil diem 1 thru 8
Insert:	rate facil diem 1 thru 7

Remove and replace:	pay ltc sub 3/4, 5/6*

* Pages updated due to ongoing provider manual revisions.