



MEDI-CAL UPDATE

Part 2

Billing and Policy

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Long Term Care

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Contents

Medi-Cal Training Seminars

Rate Review Methodology and Process Correction	1
Skilled Nursing Facilities QAF Retro Payment Form Correction.....	2
2006 CPT-4/HCPSC Code Update Reminder.....	2
Orange County Welfare Department Address Change	3
Provider Restrictions for O & P Reimbursement.....	3

Rate Review Methodology and Process Correction

This bulletin supersedes sections 204(a) and 214 of the *Rate Methodology and Rate Review Process* article published in the October 2005 *Medi-Cal Update* bulletin. The corrected text is shown in bold and underlined type. Please replace your current version of these sections with this corrected text. The following sections have been amended to read as follows:

§204 The Labor Cost Category:

- (a) Direct resident care labor costs of permanent full or part time facility employees include salaries, wages, and benefits related to routine nursing services personnel employed directly by the facility. Routine services include nursing, social services, and activities. Direct resident care labor costs include labor expenditures associated with permanent direct care employees. **These services include expenditures associated with contract, registry or temporary agency staffing.** These costs are limited to the 90th percentile of each respective peer-group. DHS will calculate the direct resident care labor daily payment from the FS/NF-Bs and FSSA/NF-Bs actual allowable Medi-Cal cost reported on the most recent published cost report, as adjusted for audit findings. The ceiling for each daily payment will be the 90th percentile of each peer-group allowable Medi-Cal direct resident care labor cost. DHS will reimburse each facility either at actual cost or the ceiling for its peer group, whichever is lower. DHS will also establish an inflation index, based on DHS labor study using the most recent industry-specific historical wage data as reported to OSHPD. DHS will apply this index to allowable direct resident care labor daily costs. Each facility's direct resident care labor costs will be increased from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

§214 Change in Facility Fiscal Period:

Facilities that change their cost report period may file two OSHPD reports. For example, if the fiscal period end date changes from March 31, 2004 **to** December 31, 2004, disclosure reports may be filed for the period April 1, 2003 through March 31, 2004 and a second report for the period of April 1, 2004 through December 31, 2004. DHS will use the most recent period available if it contains more than six months of data. If the newest report contains less than six months of data, the earlier period will be used.

Skilled Nursing Facilities Quality Assurance Fee - Retro Payment Form Correction Notice

This article corrects the rate year date range for the 2004-05 *Skilled Nursing Facilities Quality Assurance Fee (QAF) - Retroactive Payment* form and letter mailed to providers on September 29 or October 21, 2005. Corrections are indicated by “strike-out” and italicized text. Future QAF payment notification forms and letters will reflect the corrected dates.

Clarification

In accordance with *Welfare and Institutions Code*, Section 14105, and in order to implement expeditiously the budgeting decisions of the legislature, the Department of Health Services will, to the extent permitted by federal law, adopt regulations setting rates that reflect these budgeting decisions within one month after the enactment of the annual state budget and of any other appropriation that changes the level of funding for Medi-Cal services. Therefore, for purposes of implementing the QAF program, the rate year begins August 1. This is one month after the state fiscal year that begins July 1.

Form Correction

All reported resident days of service are in the 2004 – 2005 Medi-Cal rate year. Please strike out the text on the *Skilled Nursing Facilities Quality Assurance Fee -Retroactive Payment* form and replace it with the corrected italicized text as follows:

CALCULATION OF THE QUALITY ASSURANCE FEE FOR *THE RATE YEAR SFY 2004 – 2005*
(~~JULY 1, 2004 TO JUNE 30, 2005~~)(*AUGUST 1, 2004 TO JULY 31, 2005*).

Form Clarification:

All other days such as Medicare, HMO, Private Pay, Insurance, Hospice and Charity should be reported on the form under Line 3, “Non Medi-Cal (Private Pay).” Additionally, bed hold days are reportable and must be included in the proper line.

Payment Clarification

Each facility that provides service for a County Organized Health Systems (COHS), such as Partnership, Cal Optima, Solano or Santa Barbara, should report their resident days as required on Line 2. If the facility has not received the QAF rate adjustment from the COHS, the facility is not required to pay the amount of the fee for “Medi-Cal Managed Care.” Please include the name(s) of the COHS below the dollar amount extension of the fee on Line 2 in the “QAF Extension” column. This will help explain the difference in amounts when the total fees paid may be less than the total fees due. Providers will be notified of the due date for the payment of the fee that is based on COHS Medi-Cal Managed Care days.

For providers who paid the QAF reimbursement for the month of July 1 – 31, 2004, a credit will be applied to a future QAF collection period.

2006 CPT-4/HCPCS Code Update Reminder

The 2006 updates to the *Current Procedural Terminology*, Fourth Edition, (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) Level II codes become effective for Medicare on January 1, 2006. The Medi-Cal program has not yet adopted the 2006 updates. Do not use 2006 codes to bill for Medi-Cal services until notified to do so in a future *Medi-Cal Update*.

Orange County Welfare Department Address Change

Effective immediately, the new address for the Orange County Welfare Department is as follows:

Orange County Social Services Agency-MSRC
LTC Coordinators/SSSI
1200 North Main Street
Santa Ana, CA 92701
(714) 480-6300
Fax: (714) 480-6402

This change to the attachment of the *Medi-Cal Long Term Care Facility Admission and Discharge Notification* (MC 171) form will be reflected in a future *Medi-Cal Update*.

Provider Restrictions for O & P Reimbursement

Providers are reminded that effective for dates of services on or after October 1, 2003, only physicians, podiatrists, certified orthotists and prosthetists may be reimbursed for orthotic and prosthetic appliances. Codes with double asterisks (**) in the *Orthotic and Prosthetic Appliances: Billing Codes and Reimbursement Rates — Orthotics* section of the provider manual are also reimbursable to pharmacists.

Long Term Care Bulletin 345

This Part 2 *Medi-Cal Update* does not contain provider manual pages.