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

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Rate Methodology and Rate Review Process Update

The following is additional information to Section 203: Basis for Facility-Specific Rate Setting System Rate Reimbursement Methodology, which was previously released in the October 2005 *Medi-Cal Update* 343.

The Medi-Cal Cost Report Office of Statewide Health Planning and Development (OSHPD Disclosure Report) data used to set rates will be the as-submitted cost report. Supplemental schedules will be based upon the as-submitted cost report.

Reimbursement rates will be computed on an annual basis. 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.

The California Department of Health Services 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.

Exceptions to Submitting CIFs

Providers are reminded not to submit *Claims Inquiry Forms* (CIFs) for the following Remittance Advice Details (RAD) code messages, unless information on the CIF specifically addresses the denial reason. For example, if the denial was 002, but an error is found in the recipient ID on the original claim, this would be an appropriate CIF, with a changed recipient ID. However, if providers wish to challenge the determination, a CIF will result in the same denial. A review by a person in the appeals unit is the only way of resolving denials if the claim has a unique circumstance needing human intervention.

Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.

Please see **Exceptions***, page 2*

Exceptions *(continued)*

Code	Message
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.

The updated information is reflected on manual replacement page cif co 2 (Part 2).

CHDP 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine eligibility for the Child Health and Disability Prevention (CHDP) program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following chart.

For additional CHDP information, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
1	$ 1,634	$ 19,600
2	$ 2,200	$ 26,400
3	$ 2,767	$ 33,200
4	$ 3,334	$ 40,000
5	$ 3,900	$ 46,800
6	$ 4,467	$ 53,600
7	$ 5,034	$ 60,400
8	$ 5,600	$ 67,200
9	$ 6,167	$ 74,000
10	$ 6,734	$ 80,800
For each additional person, add	$ 567	$ 6,800

Medicare Part D Impact on Ancillary Costs

Effective immediately, Long Term Care (LTC) providers are not to bill the Medi-Cal program for the Medicare prescription drug costs of Medi-Cal recipients who are also enrolled in Medicare (referred to as "dual-eligibles" or "Medi-Medis"). LTC providers must exclude Medicare prescription drug costs from their ancillary charges and bill Medicare directly retroactive to January 1, 2006.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 was signed into law on December 8, 2003, and the prescription drug benefit under Medicare, designated as "Part D," was effective January 1, 2006. The Medicare program assumes responsibility for providing prescription drugs in most drug categories for dual-eligibles. In the past, dual-eligibles received their prescription drug coverage through the Medi-Cal program. Retroactive to January 1, 2006, dual-eligibles obtain their prescription drugs from a Medicare drug plan. Each Medicare drug plan has its own drug formulary and pharmacy network. Drugs offered by the plan may or may not be identical to the drugs the recipient currently obtains from Medi-Cal. In addition, under Part D, dual-eligibles are required to pay $1 or $3 copays for their drugs.

The federal government has established all policies and procedural requirements with regard to program implementation and the transition of the dual-eligibles from Medi-Cal to the federal Medicare program. The primary role of the State in this implementation process has been to assist the federal government in education and outreach to inform recipients and health care providers about the transition.

Instructions for Manual Replacement Pages — Part 2

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Remove:	cif co 1 thru 10
Insert:	cif co 1 thru 11