Medi-Cal Update

Long Term Care | July 2013 | Bulletin 437

Print Medi-Cal Update

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1. Medi-Cal Checkwrite Schedule Updated

Effective July 1, 2013, the checkwrite schedule is updated for fiscal year 2013 – 2014. The schedule reflects warrant release dates and Electronic Fund Transfer (EFT) dates of deposit for all programs, including the following:

- Medi-Cal
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Abortion
- Family PACT (Planning, Access, Care and Treatment)
- Healthy Families (HF)
- Child Health and Disability Prevention (CHDP)

This information is reflected in the following provider manual(s):

Provider Manual(s)	Page(s) Updated
Part 1 – Medi-Cal Program and Eligibility	check (1)

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2. ICD-10: New FAQs Page

The HIPAA: ICD-10 page of the Medi-Cal website now includes new resources to help providers prepare for the upcoming ICD-10 code transition. One new resource is the ICD-10 frequently asked questions (FAQs) page. The FAQs page provides an overview of the transition to ICD-10 and answers some questions that providers may have about the upcoming ICD-10 code transition.

Providers may also submit ICD-10-related questions to the Medi-Cal ICD-10 mailbox at ICD-10Medi-Cal@xerox.com.

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3. Assisted Living Waiver Providers Exempt from Assembly Bill 97

Effective retroactively for dates of service on or after June 1, 2011, Assisted Living Waiver (ALW) Residential Care Facilities for the Elderly (RCFE) and Care Coordinator Agencies participating in the 1915(c) Home and Community-Based Services ALW are exempt from the 10 percent provider payment reduction authorized by Assembly Bill 97 (Chapter 3, Statutes of 2011).

No action is required of Medi-Cal providers. An Erroneous Payment Correction will be implemented to reprocess affected claims.

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4. Updated Reimbursement Rates for Distinct-Part Adult Subacute Nursing Facilities

Effective retroactively for dates of service on or after August 1, 2012, the Distinct-Part Adult Subacute Nursing Facility rates are updated. The rates are listed on the Distinct Part Subacute Care Facilities, 8/1/2012 Rates sheet on the Department of Health Care Services website.

No action is required of Medi-Cal providers. An Erroneous Payment Correction will be implemented to reprocess affected claims.

This information is reflected in the following provider manual(s):

Provider Manual(s)	Page(s) Updated
Long Term Care	rate facil diem (5)

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5. Updated Skilled Nursing Facility Level B Reimbursement Rates

Effective retroactively for dates of service on or after January 1, 2012, revised facility reimbursement rates for all non-exempt Free-Standing Skilled Nursing Facilities Level B (FS/NF-B) and Free-Standing Adult Subacute Nursing Facilities Level B (FSSA/NF-B) have been established. Assembly Bill (AB) X1 19 (Chapter 4, Statutes of 2011) mandates a Quality Assurance Fee (QAF) on Free-Standing Pediatric Subacute Nursing facilities. This mandate requires a revised rate for all non-exempt FS/NF-B and FSSA/NF-B.

Effective retroactively for dates of service on or after August 1, 2012, final facility reimbursement rates for FS/NF-B and FSSA/NF-B have been established. AB 1489 (Chapter 631, Statutes of 2012) provides that FS/NF-B and FSSA/NF-B will be reimbursed at the rates on file as of August 1, 2011, plus the cost of complying with new state or federal mandates.

Claims paid at the prior rates for services rendered above will be reprocessed for retroactive rate adjustments. The facility rates are posted on the Long-Term Care Reimbursement AB1629 page on the Department of Health Care Services (DHCS) website. Providers must use the new rates to bill for services.

The following provides information about how these changes will be implemented for the August 1, 2012, reimbursement rates.

Audit Data for 2010 Fiscal Period End Dates

The facility audit reports with 2010 fiscal period end dates will not be used to compute the August 1, 2012 facility rates.

Audit Appeals for 2008 Fiscal Period End Dates

An appeal that results in a revised audit with a 2008 fiscal period end date may result in a revised rate effective August 1, 2012. That revised August 1, 2010, rate will be applied for the appropriate rate year, and it will be the basis for the August 1, 2012 rate.

Change of Ownership or Licensed Operator

Changes of ownership or changes of licensed operator do not qualify for increases in reimbursement rates (May 2009 *Medi-Cal Update*).

If the previous operator participated in the Medi-Cal program, and on August 1, 2010, the rate was computed, that rate will be the basis for the August 1, 2012, rate. If the new FS/NF-B owner has submitted six months or more of audited cost data, a facility-specific rate will be computed. If the new FSSA/NF-B owner has submitted 12 months or more of audited cost data, a facility-specific rate will be computed.

If the prior owner did not participate in the Medi-Cal program, the peer group rate effective August 1, 2012, will be applied. If the

new FS/NF-B has submitted six months or more of audited cost data, a facility-specific rate will be computed. If the new FSSA/NF-B has submitted 12 months or more of audited cost data, a facility-specific rate will be computed.

Peer Groups

These seven geographic rates apply only to facilities that are newly certified or facilities that previously were decertified from Medi-Cal for six months or longer and are returning to the program.

Benchmarks

This refers to limits or caps placed on individual cost components (labor costs limited to the 90th percentile constitute the computed benchmark) that comprise the final facility rate. There are no updates to individual cost components. No change to the benchmarks will be made.

Fair Rental Value System

No change to the Fair Rental Value System rate will be made. However, each facility's age will be adjusted based on the current age of the facility, which includes any adjustment from approved Fiscal Year End 2010 capital costs.

Mandates

For the 2012 – 2013 rate year, the state-mandated QAF will be $15.61 for facilities with less than 100,000 resident days and $14.88 for facilities with 100,000 resident days or more.

For the 2012 – 2013 rate year, 51 cents will be included in each facility's rate to cover costs associated with the Minimum Data Set 3.0 and 25 cents will be included to cover costs associated with aerosol transmissible diseases.

For the 2012 – 2013 rate year, a combined add-on of 47 cents will be included in each facilities rate to cover the following costs: Federal Unemployment Tax Act (FUTA), Informed Consent, Standard Admission Agreement, Centers for Medicare & Medicaid Service (CMS) Revalidation, Elder Justice Act, and 5010 Implementation.

Statewide Weighted Average

Out-of-state border providers will be reimbursed at the statewide weighted average of $162.51.

Bed Hold Reduction

The Leave of Absence/Bed Hold reduction is $6.28.

This information is reflected in the following provider manual(s):

Provider Manual(s)	Page(s) Updated
Long Term Care	rate facil (2, 7); rate facil diem (1–3)

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6. Rural Hospital Swing Bed Reimbursement Rates Update

Effective retroactively for dates of service on or after June 1, 2011 through July 31, 2011, and August 1, 2011, the rural hospital swing bed reimbursement rates are updated.

Assembly Bill 97 (Statutes 2011) added sections 14105.07 and 14105.192 and amended section 14126.033 of the *Welfare and Institutions Code* (W&I Code) authorizing the Department of Health Care Services (DHCS) to implement payment reductions for various Medi-Cal covered services. AB 97 specifies that rates are not to exceed the rates established for the 2008 – 2009 rate year reduced by 10 percent, subject to DHCS determining that such rates comply with federal Medicaid law and obtaining federal approval of such rates.

In accordance with approved State Plan Amendment 08-009D, page 15.4c of attachment 4.19-D, DHCS has updated the Rural Swing Bed rates to the rates established in 2008 – 2009, as shown in the table below. Providers will **not** receive a 10 percent payment reduction to these rates.

Rural Hospital Swing Bed Rates Effective 6/1/11 – 7/31/11	
Accommodation Code	**Rate**
04	$305.15
05	$299.11

Rural Hospital Swing Bed Rates Effective 8/1/11 Includes $2.10 Add-ons for MDS, Aerosol & Transmittable Disease (Immunization)	
Accommodation Code	**Rate**
04	$307.25
05	$300.97

No action is required. Affected claims will be automatically adjusted through the Erroneous Payment Correction process.

This information is reflected in the following provider manual(s):

Provider Manual(s)	Page(s) Updated
Long Term Care	rate facil diem (4, 5)

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7. Additional Contact Information for TAR Appeals

The Utilization Management Division (UMD), Appeals and Litigation Section has added a voice mail box, email address and fax line for *Treatment Authorization Request* (TAR) appeal inquiries. The voice mail line is not answered by a live attendant, but voice mail messages are checked often during each business day. The UMD mailing address and phone number for TAR appeals remain the same. TAR appeals are not to be submitted by fax.

Main Line	(916) 552-9110
Voicemail	(916) 552-9376
Email	appeals@dhcs.ca.gov
Fax	(916) 440-5332

This information is reflected in the following provider manual(s):

Provider Manual(s)	Page(s) Updated
Adult Day Health Care Centers Audiology and Hearing Aids Chronic Dialysis Clinics Clinics and Hospitals Durable Medical Equipment General Medicine Heroin Detoxification Home Health Agencies/Home and Community-Based Services Hospice Care Program Inpatient Services Long Term Care Medical Transportation Obstetrics Orthotics and Prosthetics Pharmacy Psychological Services Rehabilitation Clinics Therapies	tar submit (2)

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8. HIPAA 5010 Companion Guide Updated

An updated version of the HIPAA 5010 Companion Guide is now available on the HIPAA 5010 page of the Medi-Cal website under the “Technical Specifications” heading. The updates to the guide are as follows.

- The “Other Diagnosis Information” and “Other Procedure Information” rows in the Health Care Claim: Institutional section now contain comments relating to the diagnosis related groups (DRG) reimbursement methodology.
- The “Sender Depository Financial Institution (DFI) Identification” and “Sender Bank Account Number” rows in the Health Care Claim Payment/Advice section now contain the information for the new Originating Depository Financial Institution (ODFI).

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Note: If you cannot view the MS Word or PDF (Portable Document Format) documents correctly, please visit the Web Tool Box to link to a download site for the appropriate reader.