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

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Optional Benefits Excluded from Medi-Cal Coverage

Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009), the budget trailer bill for the recently signed budget bill, added Section 14131.10 of the *Welfare and Institutions Code* (W&I Code) to exclude several optional benefits categories from coverage under the Medi-Cal program to be implemented on July 1, 2009.

The following optional benefits are excluded from coverage under the Medi-Cal program:

- Acupuncture services
- Adult dental services
- Audiology services
- Chiropractic services
- Incontinence creams and washes products
- Optometric and optician services, including services provided by a fabricating optical laboratory
- Podiatric services
- Psychology services
- Speech therapy services

The following services are not impacted by AB X3 5 and continue to be covered under the Medi-Cal program:

- Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state
- Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy

In addition, the optional benefits exclusion policy does not apply to the following beneficiaries:

- Beneficiaries less than 21 years of age for services rendered pursuant to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program
- Beneficiaries less than 21 years of age and whose course of treatment is scheduled to continue after he/she turns 21 years of age (continuing care services for EPSDT recipients)
- Beneficiaries whose course of treatment began prior to July 1, 2009, and is scheduled to continue after July 1, 2009 (continuing care services)
- Beneficiaries residing in a skilled nursing facility (that is, Nursing Facilities Level A [NF-A] and Level B [NF-B]), as defined in subdivisions (c) and (d) of Section 1250 of the *Health and Safety Code* and licensed pursuant to subdivision (k) of Section 1250 of the *Health and Safety Code*.

  Note: An adult subacute facility is considered an NF-B facility
- Beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE)

Please see **Benefits**, *page 2*

Benefits *(continued)*

Additional General Criteria Information

- Both Medi-Cal fee-for-service and Managed Care Plans are impacted by this policy.
- The beneficiary is not required to physically receive the services in an NF-A or NF-B facility for the service to be reimbursable.
- Most claims for excluded optional benefit services billed by a physician or physician group remain reimbursable on or after July 1, 2009; however, these claims will be denied if the rendering provider is not a physician, but one of the optional benefit providers as listed below:
  - Acupuncturist
  - Dentist
  - Audiologist
  - Chiropractor
  - Optometrist
  - Dispensing optician
  - Podiatrist
  - Psychologist
  - Speech therapist

Note: Since services provided by fabricating optical laboratories are excluded in the Medi-Cal program, eye appliances (for example, eyeglasses) and related items will not be reimbursable by physicians and physician groups on or after July 1, 2009.

- Medicare/Medi-Cal crossover claims are not affected by this policy.
- Services authorized by the Genetically Handicapped Persons Program (GHPP), California Children's Services (CCS) are not affected by this policy.
- Child Health and Disability Prevention (CHDP) program services are not affected by this policy.

Additional Policy for Acupuncture, Audiology, Speech Therapy, Chiropractic, Podiatric and Psychology Services

In addition to those exemptions previously described in this article, this policy does not apply to the following:

Beneficiaries receiving the following services:

- Mental health services provided by the County Mental Health Plans (MHPs)
- Home health services provided by a Home Health Agency (HHA)

Beneficiaries receiving services in the following places of service:

- Medi-Cal-contracted acute inpatient hospitals when the service is included in the contracted rate. Reimbursement, however, is not permitted for ancillary services
- Out-of-state inpatient hospitals when the service is included in the all-inclusive rate
- Hospital outpatient departments

Federally required dental services and psychology services are not affected by this policy when provided at the following settings:

- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

Please see **Benefits**, *page 3*

Benefits *(continued)*

The following beneficiaries are affected by this policy effective July 1, 2009. Excluded optional benefits rendered to these beneficiaries are no longer reimbursable on or after July 1, 2009 unless they fall into one of the exemptions previously described in the article:

- Beneficiaries certified as developmentally disabled through the Regional Center who continue to reside in their home (non-institutionalized)
- Beneficiaries residing in Intermediate Care Facilities/Developmentally Disabled (ICF/DD) facilities, including ICF/DD-Nursing and ICF/DD-Habilitative facilities
- Beneficiaries currently enrolled in one of the Department of Health Care Services waivers
- Beneficiaries who receive services at Adult Day Health Care (ADHC) centers; however, ADHCs must continue to provide all services that are included in the bundled daily rate

New Billing/TAR Requirements

Effective for dates of service on or after July 1, 2009, for those excluded optional benefit services currently not requiring a *Treatment Authorization Request* (TAR), the procedure code must be billed with one of the following modifiers on the claim to identify the pregnancy-related and/or continuing care exemptions:

- **Modifier TH (obstetrical treatment/services, prenatal or postpartum):** Use to identify pregnancy-related exemptions. Medical justification for the service is not required for the claim, but must be included in the medical record.

  Modifier TH is not required if the place of service is an FQHC, RHC, Indian Health Services (IHS) or inpatient hospital; however, medical justification for the service must be included with an attachment on the claim. Modifier TH can be used for up to 60 days after termination of pregnancy.
- **Modifier GY (item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit):** Use to identify continuing care exemptions (for recipients who reach the age of 21 during course of treatment for services received on or after July 1, 2009; and for recipients ages 21 and older who began a course of treatment prior to service date July 1, 2009, and will require additional time to complete treatment after this date). Medical justification for the service is not required for the claim but must be included in the medical record.

  Modifier GY is not required if the place of service is an FQHC, RHC, IHS or inpatient hospital; however, medical justification for the service must be included with an attachment on the claim.

For those excluded optional benefit services currently requiring TAR, on or after July 1, 2009, a TAR is still required and authorization will be given only if one of the following conditions is met:

- For pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy. In this instance, the service(s) billed on the claim and requested on the TAR must include modifier TH, unless the place of service is at a FQHC, RHC, IHS or inpatient hospital. For those claims, modifier TH is not required; however, medical justification for the service must be included with an attachment on the claim. Modifier TH can be used for up to 60 days after termination of pregnancy.
- For Medi-Cal eligible recipients who reach the age of 21 during a course of treatment for services received on or after July 1, 2009. In this instance, the service(s) billed on the claim and requested on the TAR must include modifier GY, unless the place of service is at a FQHC, RHC, IHS or inpatient hospital. For those claims, modifier GY is not required; however, medical justification for the service must be included with an attachment on the claim.
- For Medi-Cal eligible recipients ages 21 and older who began a course of treatment prior to service date July 1, 2009. In this instance, the service(s) billed on the claim and requested on the TAR must include modifier GY, unless the place of service is at a FQHC, RHC, IHS or inpatient hospital. For those claims, modifier GY is not required; however, medical justification for the service must be included with an attachment on the claim.

Please see **Benefits***, page 4*

Benefits *(continued)*

Nursing Facility Claims

When billing excluded optional benefit services for Medi-Cal beneficiaries residing in an NF-A or NF-B, the nursing facility's name must be included in Box 17 (name of referring provider or other source) and the National Provider Identifier (NPI) of the nursing facility in Box 17b (NPI) on the *CMS-1500* form.

Additional Policy for Incontinence Creams and Washes Products

Effective for dates of service on or after July 1, 2009, incontinence creams and washes are no longer Medi-Cal benefits. This policy applies to HCPCS codes A4335 (incontinence supply; miscellaneous) and A6250 (skin sealants, protectants, moisturizers, ointments, any type, any size). Exemptions to this policy are described previously in this article.

Billing Requirements

A TAR is required for reimbursement for the following exemption cases.

- Beneficiaries 21 years of age or older who are receiving pregnancy-related services
  - Documentation must be included that substantiates the pregnancy and that the service is pregnancy-related or will treat a condition that may complicate the pregnancy. Providers must bill with modifier TH for these claims. If place of service is an FQHC, RHC, IHS or inpatient hospital, no modifier is used, but justification for the service must be included on an attachment to the claim. Modifier TH can be used for up to 60 days after termination of pregnancy.

  Note: Incontinence creams and washes supplied to recipients residing in an NF-A or NF-B are included as part of the facility's daily rate and are not separately reimbursable.

- EPSDT claims for incontinence creams and washes for recipients younger than 5 years of age will continue to require an approved TAR.
- EPSDT beneficiaries who begin a physician-ordered course of treatment before turning 21 years of age. In addition to the TAR, providers must bill with modifier GY to identify these recipients. If place of service is an FQHC, RHC, IHS or inpatient hospital, no modifier is used, but justification for the service must be included on an attachment to the claim.
  - The TAR must specify the exact date of initiation of the course of treatment and the expected duration of therapy (example: "Prescription written on 7/20/09 for treatment of acute skin inflammation and/or tissue breakdown. The beneficiary is turning 21 years old on July 24, 2009. The prescription must include the duration of treatment, such as 'apply for 10 days'").

  Note: Use for ongoing prophylaxis does not qualify for the exemption.

- Medi-Cal beneficiaries 21 years of age or older who began a course of treatment prior to July 1, 2009, and will require additional time to complete the course of treatment after July 1, 2009. Providers must bill with modifier GY to identify these recipients. If place of service is an FQHC, RHC, IHS or inpatient hospital, no modifier is used, but justification for the service must be included on an attachment to the claim.
  - The TAR must specify the exact date of initiation of the course of treatment and expected duration of therapy (example: "Prescription written on 6/28/09 for treatment of acute skin inflammation and/or tissue breakdown. The prescription must include the duration of treatment, such as 'apply for 10 days'").

  Note: Use for ongoing prophylaxis does not qualify for the exemption.

This information is reflected on manual replacement pages opt ben exc 1 thru 8 (Part 2).

Quality Assurance Fee for Designated Intermediate Care Facilities

Health and Safety Code Sections 1324 through 1324.14 authorize the Department of Health Care Services (DHCS) to implement a Quality Assurance Fee (QAF) program for certain Designated Intermediate Care Facilities (DICFs) as defined in subdivision (c) of Section 1324. This provider bulletin informs DICFs about the QAF program, including the payment procedures and reporting requirements.

Health and Safety Code Section 1324.6(c) authorizes DHCS to use provider bulletins as an alternative to regulations in order to implement this QAF program. DHCS is issuing this provider bulletin pursuant to this authority.

Code Section	**Description**
§100: Facilities Subject to QAF	Each DICF, as defined in *Health and Safety Code* Section 1324(c), shall pay a QAF to DHCS pursuant to *Health and Safety Code* Section 1324.2.
§101: Calculation of QAF	Each DICF shall determine the QAF by multiplying the gross receipts, as defined in *Health and Safety Code* Section 1324(a), for the preceding quarter by the rate in accordance with Title 42, *United States Code* Section 1396b(w)(4)(C)(ii).
§102: Payment and Reporting Requirements	(a) Each DICF shall remit payment quarterly on or before the last day of each quarter of the state fiscal year (September, December, March, June) to DHCS with a completed *Quality Assurance Fee (QAF) – Quarterly Payment Designated Intermediate Care Facility (DICF) form DHCS 9085* (Rev. 4-09), herein incorporated by reference in its entirety as *DHCS 9085* (Rev. 4-09). (b) If a DICF fails to submit the *DHCS 9085* (Rev. 4-09) and QAF payment by the due date specified in subsection (a), DHCS shall send a letter to the DICF demanding payment of any QAF amount owed and completion of the *DHCS 9085* (Rev. 4-09). (c) Each DICF shall submit a completed *Quality Assurance Fee (QAF) – Annual Report Designated Intermediate Care Facility (DICF) form DHCS 9102* (Rev. 4-09), herein incorporated by reference in its entirety as DHCS 9102 (Rev. 4-09), to DHCS on or before August 31 of every year for the preceding state fiscal year ending on June 30. (d) If a DICF fails to submit a completed *DHCS 9102* (Rev. 4-09) by the due date specified in subsection (c), DHCS shall determine if additional QAFs are owed. (e) If a DICF owes additional QAFs, the unpaid QAF shall be due upon demand by DHCS. DHCS shall send a letter demanding payment that specifies the period of time the unpaid QAF covers and the amount due for that period. (f) If payment is not received within 30 days from the date of the demand letter specified in subsection (e), the unpaid QAF shall be recovered by any of the methods specified in Section 103. (g) Each DICF shall pay interest at the rate of seven percent per annum on any unpaid QAF from the date the payment was due, as specified in subsections (a) and (e), until the QAF and interest is paid in full. (h) If a DICF overpays the QAF, the overpaid amount shall be credited against each DICF's QAF liability for future quarters.

Please see **QAF**, *page 6*

QAF *(continued)*

Code Section	**Description**
§103: Failure to Pay QAF – Recovery	If a DICF fails to pay all or part of the QAF within 60 days of the date of the demand letter specified in Section 102(b), the outstanding QAF amount shall be recovered by any of the following methods until the unpaid QAF and interest, as specified in Section 102(g), is recovered: (1) Lump sum payment by the provider; (2) Offset against current payments due to the provider; or (3) A repayment agreement executed between the provider and DHCS.
§104: Change of Ownership and Payment Requirements	The QAF shall be assessed on each DICF irrespective of any change in ownership, change in ownership interest or control, or the transfer of any portion of the assets of a DICF to another owner. A new owner shall be responsible for payment of QAFs owed by the prior owner.

Note: The *DHCS 9085* and *9102* forms can be found on the Medi-Cal Forms page (click "Forms" on the Medi-Cal home page [**www.medi-cal.ca.gov**] and then scroll to the desired form).

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Remove and replace:	*Getting Started: Where to Find the Answers* C-1 thru C-4 * *Contents for Long Term Care Billing and Policy* i/ii *
Insert new section after the O-P tab:	opt ben exc 1 thru 8 (*new*)

* Pages updated due to ongoing provider manual revisions.