Health Plan of San Joaquin

Mountain Valley Health Plan

Long Term Care

NF-B, DP-ASA,

&

ICF-DD

Time: 12pm - 1pm

April 25, 2025

Meeting Agenda

Topics	Facilitator
Introductions	Provider Services
Definitions	Christina Villar
Billing Terminology	Christina Villar
Billing Guidance	Christina Villar
Payment Requirements	J'neen Abramjian
Supplemental Payments	J'neen Abramjian
Closing / Open Forum	All

Health Plan of San Joaquin
Mountain Valley Health Plan

LONG TERM CARE (LTC) OVERVIEW

Christina Villar, Provider Services Representative II

Purpose

The purpose of the following presentation is to support the efforts to increase correct processing and payment with the first claim submission and guide you through the claim submission process for the various Long Term Care services.

Background

The Medi-Cal program provides benefits through both fee-for-service (FFS) and managed care plans (MCP). In efforts to standardize, help ensure consistency and reduce complexity across the state and reduce county-to-county differences, the Department of Health Care Services (DHCS) is implementing Benefit Standardization.

Effective January 1, 2023, HPSJ must authorized and cover medically necessary skilled nursing and custodial services provided in Skilled Nursing Facilities (SNF), meaning members who are admitted into a SNF will remain enrolled in HPSJ instead of being disenrolled.

Effective January 1, 2024, the remaining LTC members receiving the LTC benefit in a Subacute or Intermediate Care Facility (ICF) must be enrolled in an MCP.

Definitions: Type of Care

Long Term Care (LTC) involves a variety of services designed to meet a person's health or personal care needs during a short or long period of time.

Skilled Nursing Care is nursing and therapy care that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel. It is health care given when skilled nursing or therapy is needed to treat, manage, and observe a patient's condition, and evaluate their care.

Subacute Care is a level of care that is defined as comprehensive inpatient cared designed for someone who has an acute illness, injury or exacerbation of a disease process.

Intermediate Care provides 24-hour personal care, habilitation, developmental, and supportive health care services to developmentally disabled persons. There are three levels of care, ICF/DD, ICF/DD-H, and ICF/DD-N.

Definitions: Billing Terminology

Type of Bill Codes: Identifies the type of bill being submitted to a payer. Type of bill codes are four-digit alphanumeric codes that specify different pieces of information on claim form UB-04.

Frequency Codes: The third digit of the type of bill submitted on an institutional (UB04) claim to indicate the sequence of a claim in the patient's current episode of care.

Revenue Codes: Identifies specific accommodations, ancillary services, or unique billing calculations, or arrangements relevant to the claim.

Value Code: Identifies special circumstances that may affect processing of the claim

Accommodation Code: Identifies the type of accommodation utilized by the patient during the billing period.

Share of Cost: Some HPSJ members must pay, or agree to pay, a monthly dollar amount toward their medical expenses. This dollar amount is called Share of Cost (SOC). The Medi-Cal member's SOC is similar to a private insurance plan's out-of-pocket deductible.

Type of Bill and Frequency Codes

Long Term & Subacute Care:
021X: Skilled Nursing Facilities: Inpatient (Including Medicare Part A)
022X: Skilled Nursing Facilities: Inpatient (Including Medicare Part B)
Rural Hospital Swing Bed
028X: Skilled Nursing Facilities: Swing Beds
Intermediate Care Facilities
065X: Intermediate Care (DD)
066X: Intermediate Care (DD-H)
067X: Intermediate Care (DD-N)

Frequency Codes

1: Admit Through Discharge

2: Interim – First Claim

3: Interim – Continuing Claim

4: Interim – Last Claim

5: Late Charge(s) Only

7: Corrected Claim

Revenue and Accommodation Codes

Facilities must bill indicating the Revenue Code that is applicable to the specific accommodation services, in conjunction with the accommodation code as this drives the appropriate payment rate for a facility based on the California Medi-Cal rate for the facility.

- **0101** = All Inclusive Room and Board
- **0180** = Leave of Absence
- **0185** = Bed Hold
- **0190** = Subacute Care

Facilities must bill indicating the **Accommodation Code** that is applicable to the claim, as this drives the appropriate payment rate for a facility based on the California Medi-Cal rate for the facility.

Accommodation Codes should be billed with a **Value Code 24** and billed as a cent amount.

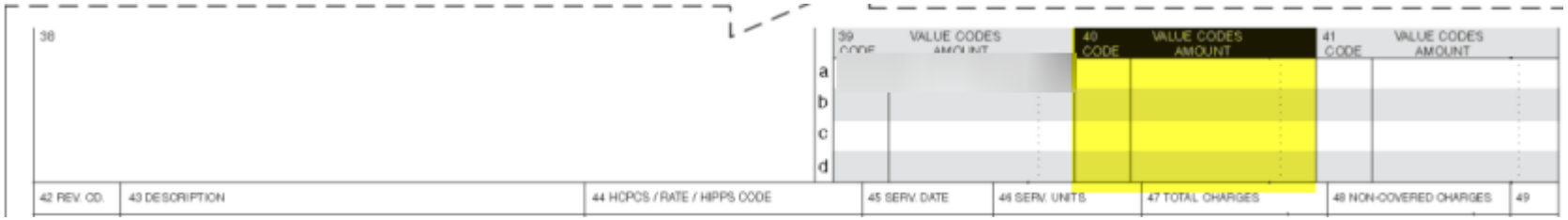
Revenue and Accommodation Code Crosswalk

Crosswalk Legend
The following abbreviations are used:
• Accom. – Accommodation
• Amt. – Amount
• DD – Developmentally Disabled
• Non-DD – Non-Developmentally Disabled
• DP/NF-B – Distinct Part Nursing Facility Level B
• ICF – Intermediate Care Facility
• ICF/DD – Intermediate Care Facility Developmental
Disability Program
• ICF/DD-H – Intermediate Care Facility Developmental
Disability Program, Habilitative
• ICF/DD-N – Intermediate Care Facility Developmental Disability Program, Nursing
• NF-B – Nursing Facility Level B
• Value Code 24 – Medicaid Rate Code (MRC)
• Value Code 24 Amount – Designated State Level
Medicaid Rate Code (DSLMRC)

Link: LTC Code and Claim Form Conversion: LTC Accommodation Code to Revenue Code, Value Code and Value Code Amount Crosswalk

Billing Value and Accommodation Codes

Value Code = 24 billed in box 40 on the UB04 with associated accommodation code billed as the value code amount in a cent format (example,.01).



Billing the SOC on a UB04 or 837i

837i (electronic) Claim Submission

When submitting 837i(institutional) transactions in the 5010 format should use the **HI** value information segment in loop 2300 of the 005010X223A2 with a qualifier of **BE** and value code of **FC** .

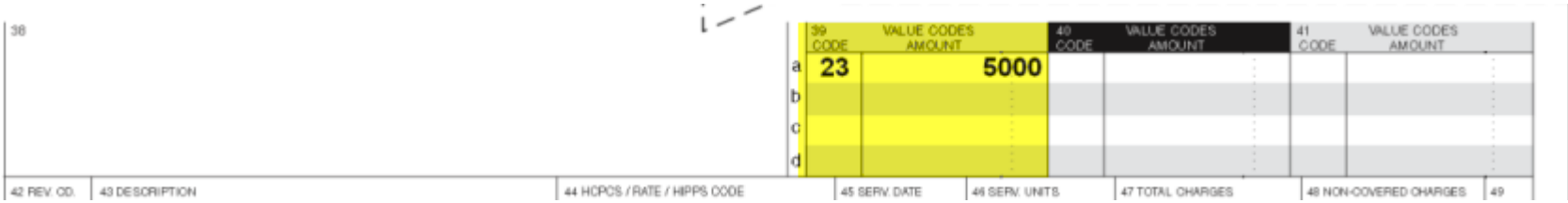
** Please reach out to your clearinghouse on additional field requirements*

UB04 (paper claim) Submission

SOC amounts are entered in these fields:

- Value Codes Amount (Boxes 39-41)

Note: *Value code "23" in the Code column filed designates that the corresponding "amount" column contains the SOC.*

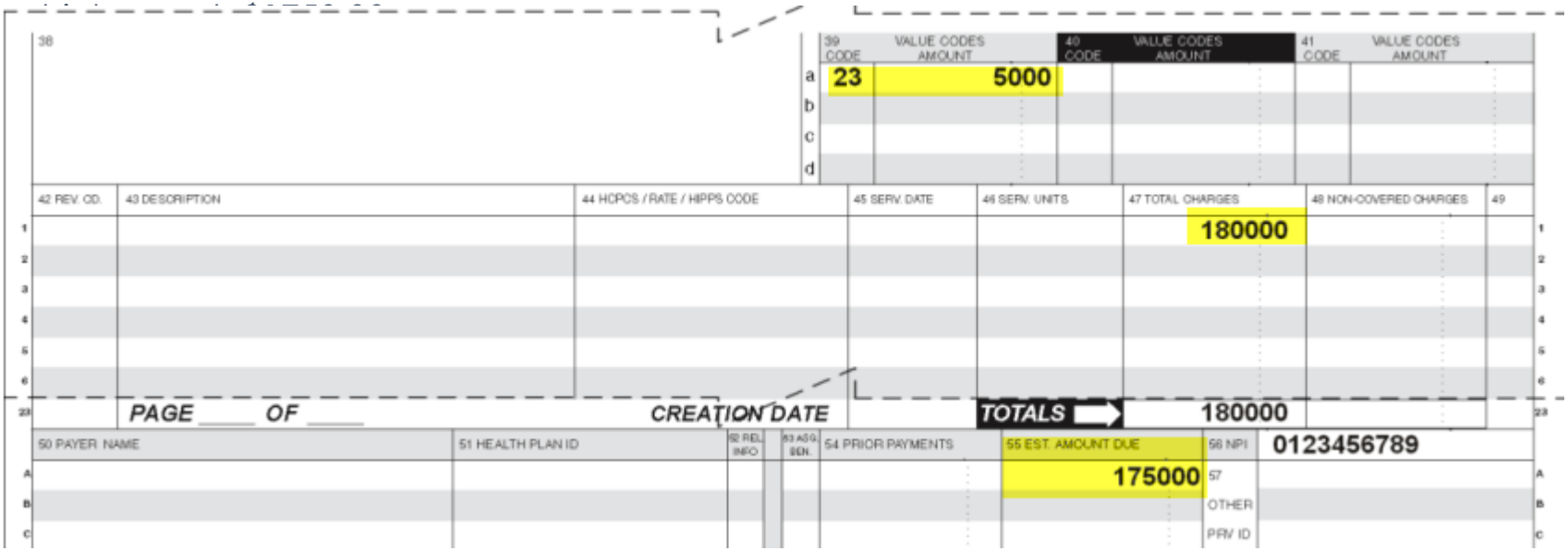


Billing the SOC on a UB04 continued…

Enter the full dollar and cents amounts, including zeros. Do not enter decimal points (.) or dollar signs ($).

Use only one claim line for each service billed.

Note: *Est. Amount Due (Box 55) is the difference of Total Charges ($1800.00) less SOC ($50.00),*



* Please go to https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/modules/bb/workbook_soc_bb.pdf for additional billing guidance

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LONG TERM CARE (LTC) FACILITY REQUIREMENTS AND SUPPLEMENTAL PAYMENTS

J'neen Abramjian, Manager, Provider Relations

Facility Payment Requirements

HPSJ shall reimburse claims from a network provider furnishing institutional Long-term Care Services to a member in accordance with the Medi-Cal fee-for-service (FFS) rate as defined by DHCS.

The reimbursement requirement only applies to the room & board, leave of absence, or bed hold days starting on the first day of a member' stay.

HSPJ shall coordinate benefits with other health coverage (OHC) programs or entitlements in accordance with APL 21-002, Cost Avoidance and Post-Payment Recovery for Other Health Coverage, including recognizing OHC as primary, and the Medi-Cal program as the payer of last resort.

HPSJ shall pay the full deductible and coinsurance in accordance with APL 13-003, Coordination of Benefits; Medicare and Medi-Cal for members who are dually eligible for Medi-Cal and Medicare.

Links:

OHC APL -APL 21-002

COB APL - APL 13-003

ICF APL - APL 23-023

SNF APL - APL 23-004

Supplemental Payment

Billing within 45 days (Lifetime Benefit)

Health Plan will continue paying a supplemental payment for the first 45 days of admission at a rate that reflects in your contract. This is a lifetime benefit.

Effective ***June 1, 2023***, to receive this supplemental payment, facilities will need to submit ***Rev Code 0420 and HCPCS G0128***, with applicable units, to be reimbursed withing the first 45 days.

Billing after 45 days

After the 45 days, if the member requires additional Physical Therapy (PT), Occupational Therapy (OT) or Speech Therapy (ST) these services need to go through the prior authorization process. Billing will need to be billed on a separate claim form(outpatient claim) from the room and board (inpatient claim)billing process.

Therapy Services / Prior Authorization

Paper Prior Authorization Form

- Comments – Nursing Facility Therapy Services

JIVA Provider Portal (DRE) – Provider Auth Portal

- Prior Authorizations – Outpatient
- Service Type – Nursing Facility Therapy Services

LTC/ICF Contacts and Resources

Provider Services Mailbox

- providerservices@hpsj.com

LTC Mailbox

- ltc@hpsj.com

LTC / ICF – Program Details

- Long Term Care Services - HPSJ/MVHP
- Intermediate Care Facilities (ICF) - HPSJ/MVHP

Christina Villar (Liaison)

- Email - cvillar@hpsj.com

Contracting Department

- Email - ContractingDepartment@hpsj.com

Questions?

THANK YOU!

Health Plan of San Joaquin

Mountain Valley Health Plan

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