Updates for Skilled Nursing Facility providers

October, 2022

Goal

Provide information to help you:

- Submit skilled nursing facility (SNF) and long-term care (LTC) authorization requests
- Submit claims that can be processed in a timely manner
- Understand APL 22-018 as part of Cal AIM initiatives

Agenda

1. Nursing facilities reference guide
2. Treatment authorization for short- and long-term care
3. APL 22-018 highlights
4. Claims & billing
5. Provider dispute resolution & corporate recoveries
6. Resources to support your work

Nursing facilities reference guide

Nursing facilities reference guide

Blue Shield of California
Promise Health Plan
Nursing Facilities
Reference Guide

A reference guide for nursing facility providers

January 2022

blue california | Promise Health Plan

blueshieldca.com
blueshieldca.com/promise

Table of Contents

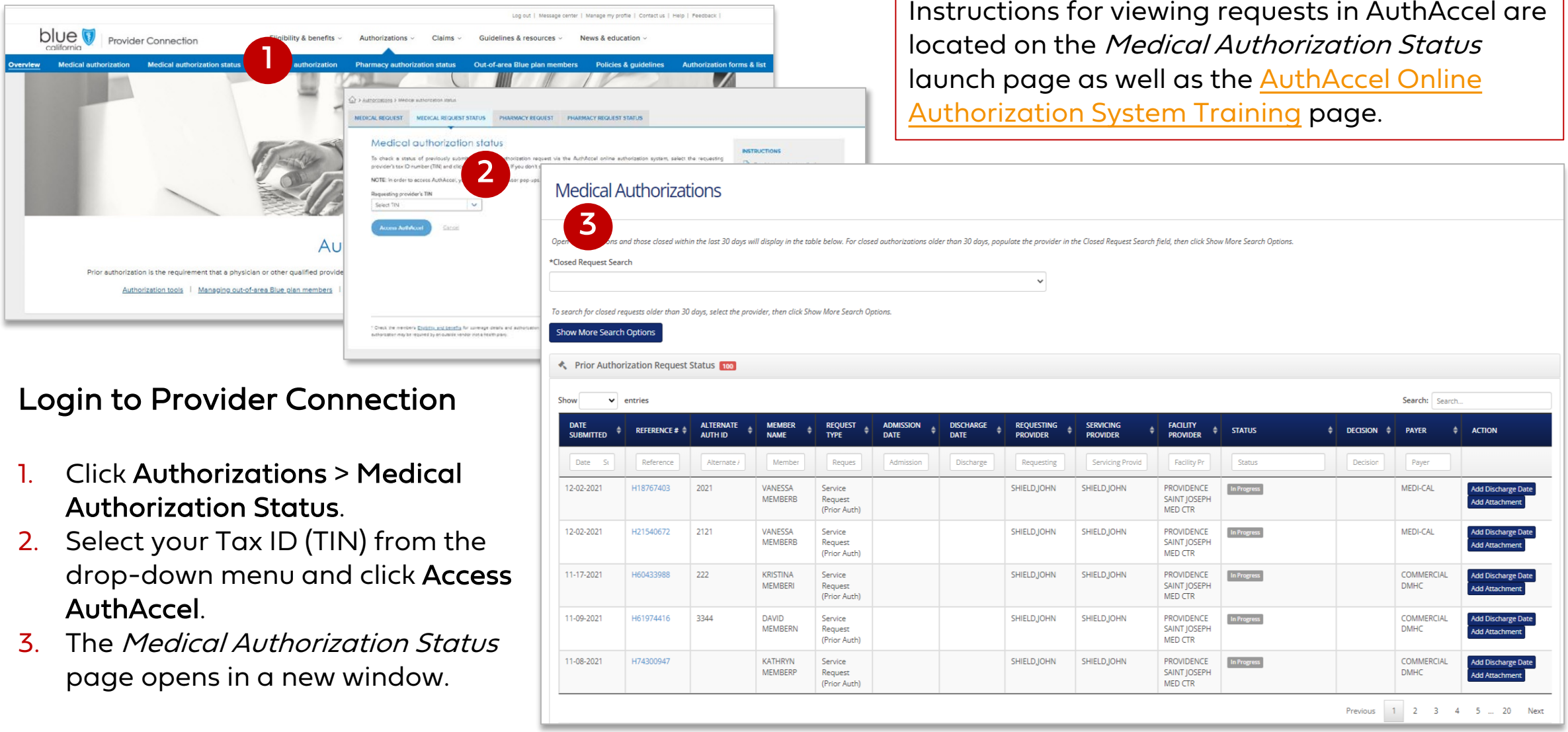
- One-stop resource
- Quicker than calling Blue Shield Promise Provider Customer Care.
- Located on Provider Connection:
  - Click **Guidelines & resources** at the top of the website,
  - Click **Provider Manuals** in the blue sub-menu bar.
  - Scroll to and click the blue box titled **Blue Shield Promise Nursing Facility reference guide**.
  - This opens a page with a PDF of the guide.
  - Direct link: Blue Shield Promise Nursing Facility reference guide

Treatment authorization for skilled nursing care (short term) and long-term care services

Short-term authorization requests

- Authorization request process
  - Work with facility case manager to determine if the member meets qualifications for skilled care
  - Complete a prior authorization form or request an authorization for admission by calling Blue Shield Promise provider services at **(800) 468-9935**
  - Fax supporting documentation to Blue Shield Promise at **(619) 219-3303**
  - Turn around time for prior authorization decisions: 72 hours
- Concurrent review process
  - Provide clinical updates to the Blue Shield Promise utilization manger on or before last day covered or when requested
    - Turn around time for concurrent review decisions: 72 hours
  - Establish a timely discharge plan
    - Identify barriers to discharge
    - Identify resources available to the member
    - Identify services needed to ensure a safe discharge and mitigate readmissions

View medical authorization status on Provider Connection using AuthAccel



Instructions for viewing requests in AuthAccel are located on the *Medical Authorization Status* launch page as well as the AuthAccel Online Authorization System Training page.

Login to Provider Connection

1. Click **Authorizations > Medical Authorization Status**.
2. Select your Tax ID (TIN) from the drop-down menu and click **Access AuthAccel**.
3. The *Medical Authorization Status* page opens in a new window.

Types of LTC covered services and turnaround times (TATs)

Initial admission assessment
=
3 calendar days
*2023= within 72 hours

Re-authorization of LTC stay
=
3 calendar days
*2023= within 72 hours

Urgent concurrent LTC review
=
72 hours
(DMHC criteria)

Discharge planning: home health, DME
=
5 business days

Ancillary skilled PT/OT/ST (default level 2)
=
5 business days

* CMC/DUAL = create a PAN authorization

* Medi-Cal = create a skilled auth (D/C LTC auth); PAN auth if NO evaluation and treatment notes

Document requirements

Highlighted documents do not need to be submitted for re-authorizations

1. Member's Face Sheet
2. DPOA (if any)
3. MDS (Minimum Data Set)
4. PASARR
5. List of Medications
6. MC 171
7. IDT Meeting Notes
8. List of all current Specialist providing care to the member
9. Date of last PCP visit and latest progress notes
10. Members History and Physical

- Treatment Authorization Request (TAR) MUST be present to create a case

  Long-Term Care (LTC) Authorization Request form

- Follow the NPSR/No Prior Auth List for LTC

  Medi-Cal/Cal MediConnect Prior Auth List Matrix

APL 22-018 highlights

All Plan Letter (APL) 22-018: Skilled nursing facilities - long term care benefit standardization and transition of members to managed care

- To further CalAIM's goals to standardize and reduce complexity across the state and reduce county-to-county differences, the Department of Health Care Services (DHCS) is implementing Benefit Standardization across Managed Care Health Plans (MCPs) statewide. Benefit Standardization will help ensure consistency in the benefits delivered by managed care and fee-for-service (FFS) statewide.
- Effective January 1, 2023, DHCS will require most non-dual and dual LTC Members (including those with a Share of Cost) to enroll in an MCP and receive their LTC benefits from their MCP. This APL focuses on the LTC benefit for SNF services (services included in the SNF rate).
- Effective July 1, 2023, the remaining LTC Members receiving the LTC benefit in a Subacute Facility or Intermediate Care Facility for the Developmentally Disabled must be enrolled in an MCP. APLs specific to the Subacute LTC benefit (both freestanding and hospital-based, as well as pediatric and adult subacute care facilities) and Intermediate Care Facility for the Developmentally Disabled LTC benefit will be released at a later date.

Leave of Absence 22 CCR 51535

Leave of Absence

a) Payment may be made to skilled nursing facilities, swing bed facilities, intermediate care facilities, intermediate care facilities for the developmentally disabled, intermediate care facilities for the developmentally disabled/habilitative and intermediate care facilities for the developmentally disabled-nursing, for patients who are on approved leave of absence. Payment for leave of absence shall not exceed the maximum number of days per calendar year indicated below:

(1) Developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing beneficiaries: **73 days.**

(2) Patients in a certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic and rehabilitative program approved and certified by a local mental health director: 30 days.

(3) All other patients:

(a) **18 days.** Up to 12 additional days of leave per year may be approved when the request for additional days of leave is in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient.

Refer to CCR 51535 for more details on Leave of Absence approval

Bed Hold 22 CCR 51535.1

Bed Hold

(a) Payment shall be made to skilled nursing facilities, swing bed facilities, intermediate care facilities, intermediate care facilities for the developmentally disabled, intermediate care facilities for the developmentally disabled habilitative, and intermediate care facilities for the developmentally disabled-nursing for bed hold days for any beneficiary who exercises the bed hold option provided by Title 22, California Code of Regulations, Sections 72520, 73504, 76506 and 76909.1.

(b) Payment for bed hold days shall be limited to a maximum of seven days for each period of acute hospitalization.

"Blue Shield Promise strongly encourages and asks the collaboration of its nursing facility partners to notify the member or the member's authorized representative in writing of the right to exercise the bed hold provision."

Refer to CCR 515351 for more details on this requirement

Continuity of care

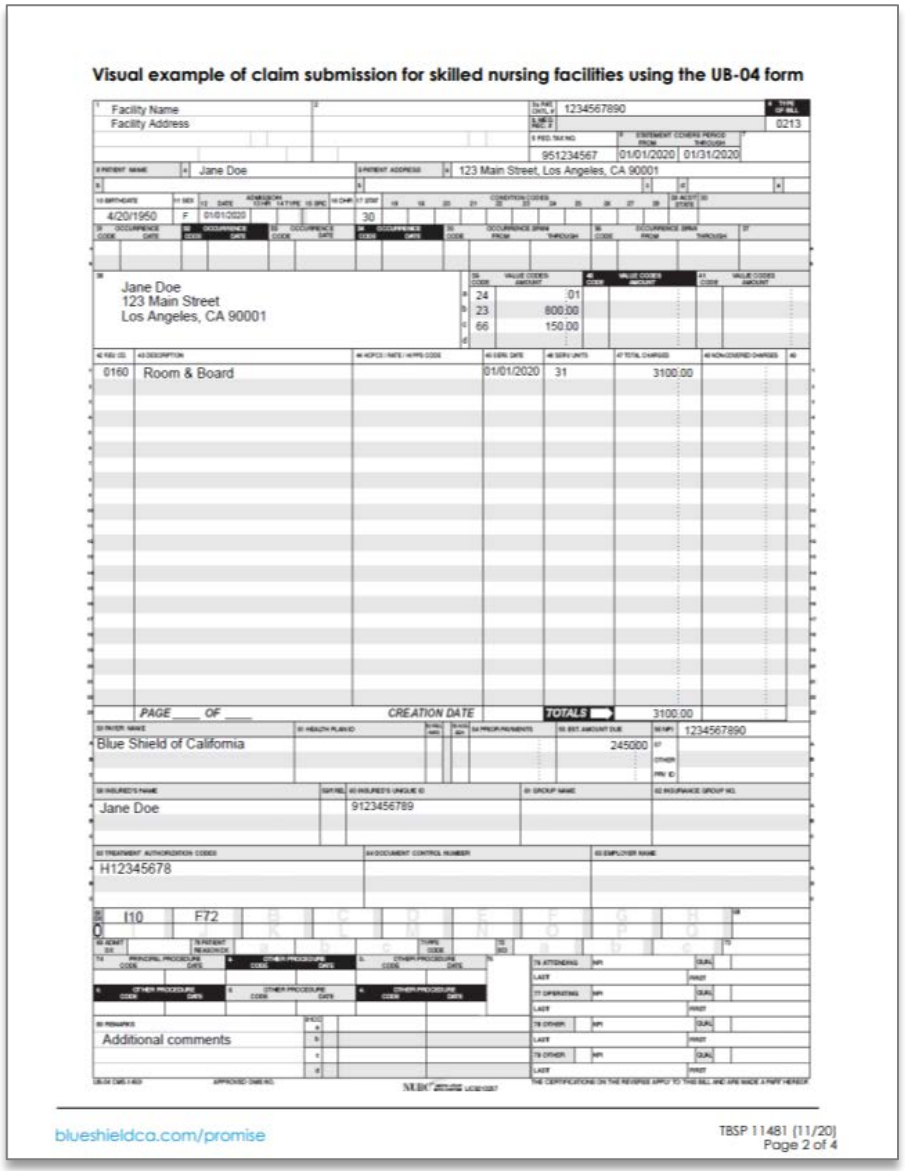
- From January 1 for July 1, 2023, for SNF residents transitioning from Medi-Cal FFS to Medi-Cal managed care, Blue Shield Promise will automatically provide 12 months of continuity of care for SNF placement.
    - Automatic continuity of care means if the member is currently residing in a SNF, they do not need to request continuity of care to continue to remain there. Members must still meet medical necessity criteria for SNF services.
- Following the initial 12-month automatic continuity of care period, members may request an additional 12 months of continuity of care, following the process established by APL 18-008, Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care or any superseding APL.
- A member newly enrolling in a Blue Shield Promise Medi-Cal plan and residing in a SNF after June 30, 2023 does not receive automatic continuity of care and must request it following the process established by APL 18-008, or any superseding APL.
    - MCPs must notify the member or their authorized representative, as well as the SNF in which the member resides, of the Member's right to request continuity of care consistent with APL 18-008 or any superseding APL.

Claims and billing

Use the UB-04 claim form for submitting LTC and ICF/DD* claims

Blue Shield Promise requires **LTC facility claims** and **ICF/DD claims** be submitted on a UB-04 claim form.

- This *SNF Claims Billing Guide* provides step-by-step instructions for how to complete claim forms.
- Get the guide on Provider Connection:
  - Click **Guidelines & resources**.
  - Click **Forms** link under the section title.
  - Click the blue box titled **Forms for Blue Shield Promise providers**.
  - Click **Claims and payment forms and templates**.
  - Direct link: SNF Claims Billing Guide.

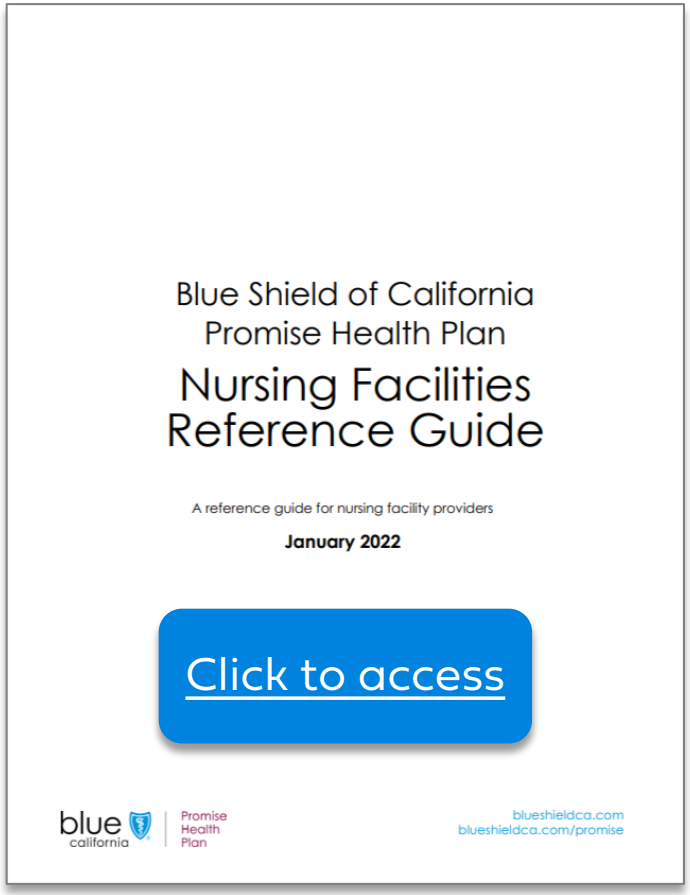

Visual example of claim submission for skilled nursing facilities using the UB-04 form

Facility Name
Facility Address
1234567890
0213
951234567
01/01/2020
01/31/2020
Jane Doe
123 Main Street, Los Angeles, CA 90001
4/20/1950
F
01/01/2020
30
Jane Doe
123 Main Street
Los Angeles, CA 90001
24 01
23 800.00
66 150.00
0160 Room & Board
01/01/2020
31
3100.00
PAGE ___ OF ___
CREATION DATE
TOTALS
3100.00
Blue Shield of California
245000
1234567890
Jane Doe
9123456789
H12345678
I10
F72
Additional comments
blueshieldca.com/promise
TBSP 11481 (11/20)
Page 2 of 4

*Intermediate Care Facilities/Developmentally Disabled

Key points when submitting LTC and SNF claims

- **Timeliness:** Claims must be submitted within 180 days from the date of service, or they will be denied for timely filing.
- **Share of cost (SOC):** When a Medi-Cal beneficiary has a long-term care aid code and a SOC, the nursing facility must separate the covered services SOC from the non-covered services.
  - SOC amount for covered services should be billed with value code 23.
  - SOC amount for non-covered services should be billed with value code 66.
- **Revenue/accommodation codes:** Facilities must bill with the correct revenue/accommodation code combination.
  - Accommodation codes should be billed with value code 24, and as a cent amount.
  - Incorrect revenue/accommodation code combinations will result in a denial.



Department of Health Care Services (DHCS) rates

Long-Term Care Reimbursement AB 1629

The Long-Term Care (LTC) System Development Unit establishes the Medi-Cal reimbursement rates for Freestanding Skilled Nursing Facilities Level-B (FS/NF-B), Adult Freestanding Subacute Facilities Level-B (FSSA/NF-B), NF-Bs designated as Institutions for Mental Diseases (IMD), Distinct Part Pediatric Subacute (DP/PSA) and Freestanding Pediatric Subacute Facilities Level B (FS/PSA).

- For Blue Shield Promise to price LTC per diem rates, we utilize the DHCS website, which posts rate information based on facility and/or general rates per facility type.

- To price appropriately, Blue Shield Promise requires a copy of the DHCS rate letter for NPIs not included in this website.

Intermediate Care Facilities - Developmentally Disabled, Habilitative, Nursing rates

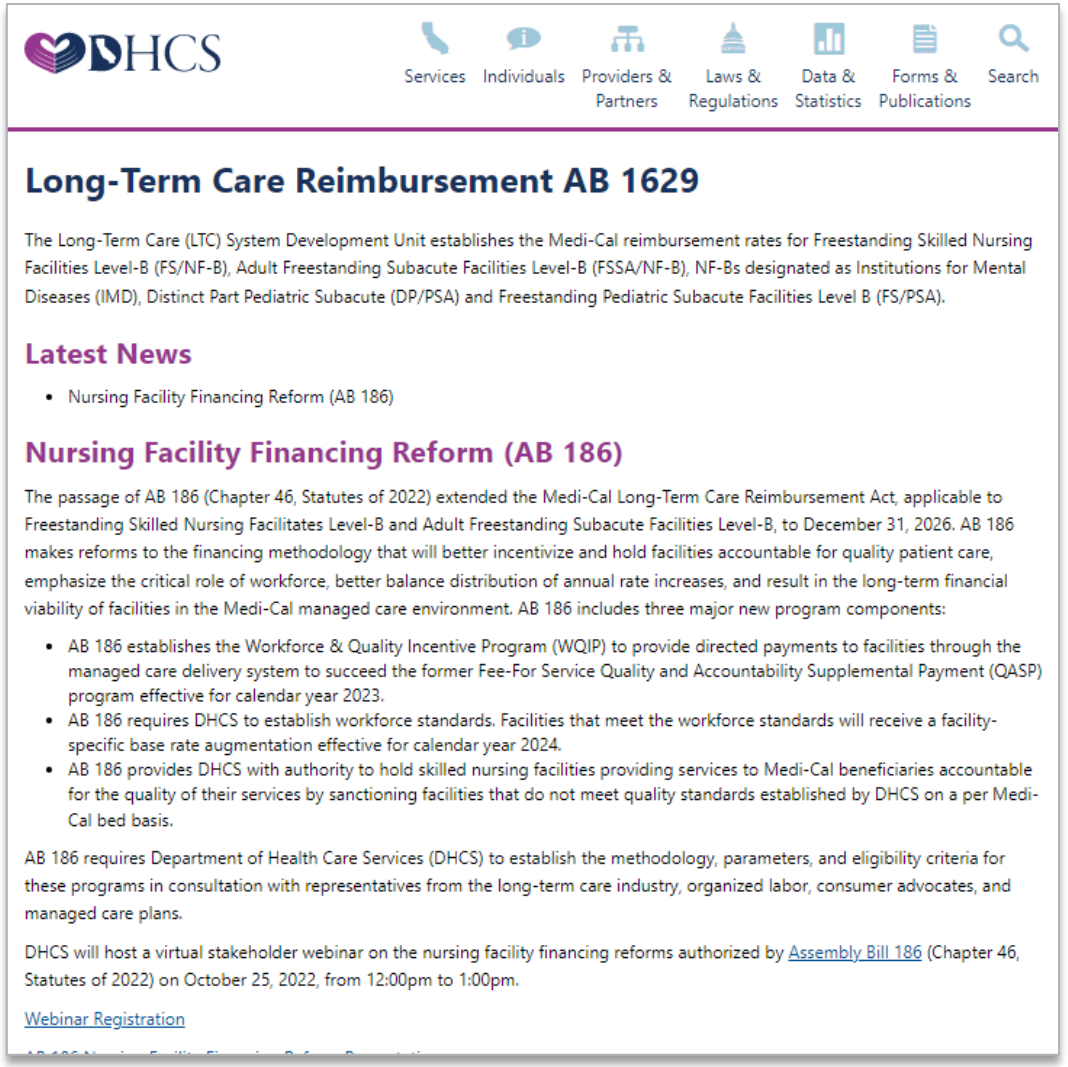
Intermediate Care Facilities - Developmentally Disabled, Habilitative, Nursing

Reimbursement rates for Intermediate Care Facilities, Developmentally Disabled (ICF/DD), Habilitative (ICF/DD-H), and Nursing (ICF/DD-N) are updated annually using an unfrozen, peer-grouped, cost-based rate methodology in accordance with Attachment 4.19-D of the California Medicaid State Plan. Facilities are classified into peer groups by level of care and bed size. The reimbursement rates for each peer group are established at the 65th percentile of the group's projected costs based on the most recent reported and audited cost data adjusted for inflation, plus the projected cost of complying with new state or federal mandates (such as state minimum wage increases) and the Quality Assurance Fee (QAF).

- For Blue Shield Promise to price LTC per diem rates, we utilize the DHCS website, which posts DHCS ICF-DD rates based on level of care and bed size.

Annual retro rate process

- Annually, DHCS posts retro rates on their website for new rates.
- Blue Shield Promise reviews this website regularly. Once DHCS posts new rates, we run a report and adjust claims as appropriate.
- For LTC rates that have been reduced by DHCS, Blue Shield Promise sends a recovery letter for previously processed claims.
- You DO NOT need to rebill.



DHCS

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Latest News

- Nursing Facility Financing Reform (AB 186)

Nursing Facility Financing Reform (AB 186)

The passage of AB 186 (Chapter 46, Statutes of 2022) extended the Medi-Cal Long-Term Care Reimbursement Act, applicable to Freestanding Skilled Nursing Facilitates Level-B and Adult Freestanding Subacute Facilities Level-B, to December 31, 2026. AB 186 makes reforms to the financing methodology that will better incentivize and hold facilities accountable for quality patient care, emphasize the critical role of workforce, better balance distribution of annual rate increases, and result in the long-term financial viability of facilities in the Medi-Cal managed care environment. AB 186 includes three major new program components:

- AB 186 establishes the Workforce & Quality Incentive Program (WQIP) to provide directed payments to facilities through the managed care delivery system to succeed the former Fee-For Service Quality and Accountability Supplemental Payment (QASP) program effective for calendar year 2023.
- AB 186 requires DHCS to establish workforce standards. Facilities that meet the workforce standards will receive a facility-specific base rate augmentation effective for calendar year 2024.
- AB 186 provides DHCS with authority to hold skilled nursing facilities providing services to Medi-Cal beneficiaries accountable for the quality of their services by sanctioning facilities that do not meet quality standards established by DHCS on a per Medi-Cal bed basis.

AB 186 requires Department of Health Care Services (DHCS) to establish the methodology, parameters, and eligibility criteria for these programs in consultation with representatives from the long-term care industry, organized labor, consumer advocates, and managed care plans.

DHCS will host a virtual stakeholder webinar on the nursing facility financing reforms authorized by Assembly Bill 186 (Chapter 46, Statutes of 2022) on October 25, 2022, from 12:00pm to 1:00pm.

Webinar Registration

No balance billing

What is balance billing?

- Balance billing occurs when doctors, ancillary providers or hospitals charge beneficiaries for Medi-Cal and/or Medicare covered services

- Providers must not balance bill members for any covered/authorized services.

Title 22, Section 51002 of the California Code of Regulations:

"A provider of service under the Medi-Cal program shall not submit to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service."

How to submit claims

Claims can be submitted to Blue Shield Promise electronically via electronic data interchange (EDI) or by mail.

Submit claims electronically

Provider Connection provides detailed information on how to enroll in EDI and how to submit claims and receive payments electronically. Steps Include:

- Complete the ePayments Provider auth form
- Enroll with one of these approved clearinghouses:
  - Change Health Plan (Payer ID: 57115)
    (866) 371-9066 www.changehealthcare.com
  - Office Ally (Payer ID: C1SCA)
    (360) 975-7000
    www.officeally.com
- For help contact the EDI help desk at

  (800) 480-1221 or

  edi_bsc@blueshieldca.com

Submit claims by mail

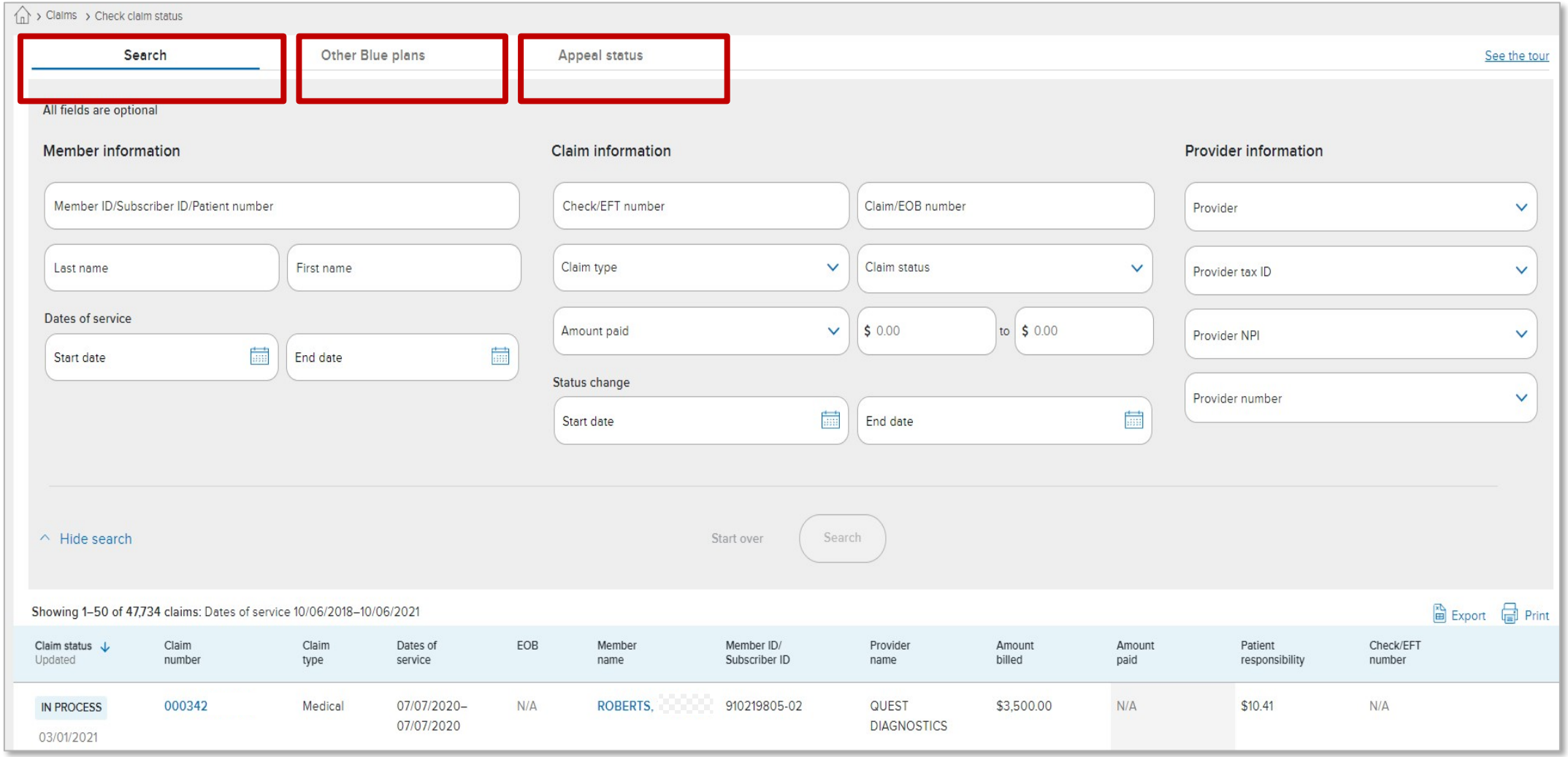
Mail completed claims to:

Blue Shield of California Promise Health Plan
P.O. Box 272660
Chico, CA 95927-2640

- This address is listed on the back of the member ID card.
- You can also find it by using the Claims routing tool or by viewing the Claims mailing addresses list on Provider Connection.

How to check claims status

The *Check claims status* tool is available from the Provider Connection home page and from the Claims section after log in. **Search** - Locate Blue Shield Promise claims and related EOBs.



Instructions also in the Blue Shield Promise Provider Connection Reference Guide

Provider dispute resolution & corporate recoveries

Provider dispute resolution: Medi-Cal SNF

To submit a written dispute

1. Complete and print the Provider Dispute Resolution Request Form.
2. Include the original claim and appropriate supporting documentation.
3. Mail to: Blue Shield Promise Provider Dispute and Resolution Dept, PO Box 3829, Montebello, CA 90640.

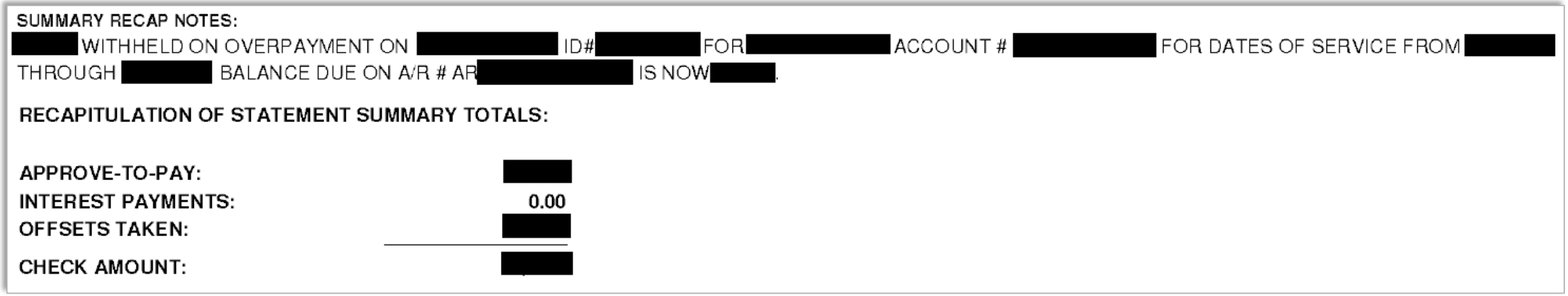
Timelines

- For Medi-Cal providers to file an initial formal written dispute with Blue Shield Promise: **365 days from date of action**.
- For BlueShield Promise to process a written dispute once its received and logged into our database:
  - Blue Shield Promise will send acknowledgement letter **within 15 working days of receipt.**
  - Blue Shield Promise will send written closure letter with the resolution to the provider **within 45 working days.**

Provider dispute resolution help: (800) 468-9935

Corporate recoveries process

- Blue Shield Promise has 365 days from paid date to notify a provider overpayment has occurred.
- If overpayment is identified, Blue Shield Promise will send a letter to the provider including the reason for the overpayment, claim and member details, and dispute instructions.
- Providers have 30 days to repay or dispute the overpayment.
- If repayment or dispute is not received within 30 days, Blue Shield Promise will offset future claims for providers who have offset language in their contract.
- Payment reductions – offsets – are reflected on the claim EOB and look like this:



SUMMARY RECAP NOTES:
[redacted] WITHHELD ON OVERPAYMENT ON [redacted] ID# [redacted] FOR [redacted] ACCOUNT # [redacted] FOR DATES OF SERVICE FROM [redacted]
THROUGH [redacted] BALANCE DUE ON A/R # AR [redacted] IS NOW [redacted].

RECAPITULATION OF STATEMENT SUMMARY TOTALS:

APPROVE-TO-PAY:	[redacted]
INTEREST PAYMENTS:	0.00
OFFSETS TAKEN:	[redacted]
CHECK AMOUNT:	[redacted]

Resources to support your work

Resource	Description
APL 22-018 (DHCS)	Skilled nursing facilities -- long term care benefit Standardization and transition of members to managed Care
Blue Shield Promise Nursing Facilities Reference Guide	One-stop resource designed to answer questions related to providing care and submitting claims for Blue Shield Promise members.
SNF Claims Billing Guide	Step-by-step instructions for how to complete LTC SNF and ICF/DD UB-04 claim forms as well as examples of each.
Special guidelines for claim forms (UB-04)	Guidelines to help you submit forms correctly so claims process efficiently. Scroll down the page for UB-04 information.
Enroll in EDI	Overview – no login required – of how to enroll in EDI to submit claims and receive payments electronically.
Blue Shield Promise provider support for LTC services	Phone: **(855) 622-2755** / Fax: **(844) 200-0121** Urgent UM ancillary requests: **(323) 889-5403;** Urgent PCS/transportation requests: **(323) 889-6506**
Blue Shield Promise provider support for short-term care services	Contact Blue Shield Promise Provider Services – **(800) 468-9935** – to request an authorization and/or fax authorizations to **(619) 219-3303**
Blue Shield Provider Dispute Resolution & Corporate Recovery	Phone: **(800) 468-9935** Address: PO Box 3829, Montebello, CA 90640
Blue Shield Promise Provider Services	Phone: **(800) 541-6652**
Blue Shield Promise Health Plan Provider Information and Enrollment	Contact for questions about address, phone, fax, and practice changes, group additions/deletions, provider directory updates, contractual obligations, etc. Phone: **(800) 258-3091** / Fax: **(916) 350-8860**
Blue Shield Promise Provider Connection Reference Guide	Step-by-step instructions to help you locate information and perform common online tasks.
Authorization request forms	Online access – no login required – to authorization forms related to short-term care, LTC, and SNF-related services.
Blue Shield Promise SNF Provider Inquiry mailbox	For submission of letters listed below. Letters must be forwarded within 30 days of receipt from regulators. • Change of Ownership (CHOW) approval letter from the Department of Public Health • Suspended and Ineligible Provider List (DOPNA/SOPNA) – CMS clearance letter • Department of Health Care Services rate appeal- DHCS has approved a rate not reflected on the DHCS website. (No annual rate adjustments letters)