

SHD Paraphrased Regulations - Medi-Cal

520 Beneficiaries and Cards

520-1

The Medi-Cal card shall be authorization for the person named on the card to receive those Medi-Cal services for which the person is eligible. (§50733(a))

521-1

The county department may issue current or past Medi-Cal cards, as limited by §50746, to all Medi-Cal eligibles who do not have a share of cost, who are not enrolled in a comprehensive Pre-paid Health Plan for which a card is requested, and who did not receive a Medi-Cal card. (§50743)

522-1

The county department shall not provide a Medi-Cal card or request that a Medi-Cal card be issued by the Department to any Medi-Cal beneficiary more than one year subsequent to the month of service, unless one of the following conditions is met:

- (1) A court action requires that a Medi-Cal card be issued.
- (2) An adopted state hearing decision or other administrative hearing decision requires a redetermination of eligibility which results in the beneficiary's entitlement to a Medi-Cal card.
- (3) An adopted state hearing decision states that, due to county department or Department administrative error, a Medi-Cal card for a month was not received by the beneficiary.
- (4) The Department requests that the Medi-Cal card be issued.
- (5) The county department determines that an administrative error has occurred.

(§50746(a))

522-2

For purposes of issuing a Medi-Cal card more than one year subsequent to the month of service, a county administrative error shall include, but is not limited to:

1. The County Welfare Department failed to approve a Medi-Cal application by a potentially eligible individual due to legitimate errors made in the course of determining eligibility (e.g., an applicant was incorrectly denied and did not file an appeal, or an applicant's file was misplaced so eligibility was never determined).
2. The county or MEDS system showed an incorrect beneficiary address for the month of request.
3. The county never sent the original MC 177 to the State, or the original MC 177 is still in the case file after being returned by the State for the county to correct.
4. The county issued a card within one year but it was coded incorrectly and could not be used to bill for the services rendered.

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(Medical Eligibility Manual, Procedures Section 14E-1, as set forth in All-County Welfare Directors Letter No. 94-77, October 11, 1994, interpreting §50746)

522-3

When an applicant has excess resources, counties must still complete eligibility determinations within the time limits set forth in §50177. If the applicant provides verification at a later date that excess property was spent on qualified medical expenses (up to three years from the date of the Notice of Action denying benefits), the county must rescind the denial if the applicant is otherwise eligible.

When billing may occur more than one year beyond the date of the service, the county shall complete and send a letter of authorization (MC 180) following the procedures in Medi-Cal Eligibility Procedures Manual §14E and §50746, and shall indicate that eligibility is granted as a result of court order (*Principe v. Belshé*).

(All-County Welfare Directors Letter No. 97-41, October 24, 1997)

522-4

Prior to 1994, all Medi-Cal beneficiaries received a paper Medi-Cal card for each month in which the beneficiary was eligible. In 1994, the Department of Health Services (DHS) began converting from paper Medi-Cal cards to the plastic Benefits Identification Card (BIC). Using the BIC, a provider can verify the beneficiary's Medi-Cal eligibility through the Point of Service (POS) Network. A new card is no longer issued to every Medi-Cal eligible person on a monthly basis. (All-County Welfare Directors Letter No. 96-06, February 1, 1996)

As of June 1, 1997, both Medi-Cal cards, and the Form MC-177, had been eliminated and had been replaced by the BIC system. (Denti-Cal Bulletin, Vol. 13, No. 13, June 1997)

For purposes of determining whether to issue a Medi-Cal card [which card no longer exists] more than one year subsequent to the month of service, and no administrative error exists, but extenuating circumstances exist beyond the beneficiary's or the county's control, the county may contact the Medi-Cal Eligibility Branch for assistance. Billing problems are not by themselves considered an extenuating circumstance. Furthermore, beneficiaries who are sent to collections after providing a Medi-Cal card should be told that W&IC §14019.4 precludes a provider from billing the beneficiaries in these situations.

An example of extenuating circumstances beyond a beneficiary's control would be a medical condition that severely impaired his/her functioning. Additionally, the beneficiary would need to describe how this reduced function prevented him/her from giving the provider(s) the necessary documentation of his/her Medi-Cal eligibility.

The Medi-Cal Eligibility Branch will evaluate whether a Letter of Authorization (LOA)/MC 180 can be issued pursuant to §50746(a)(4), which provides for an LOA/MC 180 to be issued by DHS request. The procedure to seek DHS authorization for issuance in these cases is as follows:

> The request must be in writing on county letterhead.

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- > It must list chronologically the sequence of events in the processing of the case and the circumstances surrounding the error.
- > It must carry the original signature of a County Welfare Department Director or his/her DHS-approved designee (photocopied signatures will not be accepted).
- > The request must be accompanied by an original LOA/MC 180 for each provider. However, in the event that one provider is billing for services for more than one month, one original LOA/MC 180 is sufficient.
- > To insure proper use of this form, please cross out any months/years that are not being requested or not being used on the LOA for Medi-Cal billings.

(Medi-Cal Eligibility Procedures Manual §14E-2, 3)

523-1

A beneficiary who has been determined by the Department to be misusing or abusing Medi-Cal benefits by obtaining drugs or other services at a frequency or amount not medically necessary may be subjected to utilization restrictions in any of the following forms:

- (1) Prior authorization for all Medi-Cal services.
- (2) Prior authorization for specific Medi-Cal services.
- (3) Restriction to utilization of a specific, beneficiary-or Department-selected pharmacy.
- (4) Restriction to a specific beneficiary- or Department-selected primary provider of medical services.

(§50793(a))

The restriction described in (a) shall be for a period of two years from the effective date on the Notice of Action. (§50793(d))

523-2

If the beneficiary who has been determined to have abused or misused Medi-Cal benefits requests a hearing and the request is received prior to the effective date of the action, the action will not be taken until the hearing has been held and a final decision rendered. (§50793(f))

When the request is received on or after the effective date of the action, the action will remain in full force and effect pending a decision. (§50793(g))

523-3

Prescribed drugs shall be limited to no more than six per month unless: Prior authorization is obtained; the beneficiary is receiving care in a nursing facility; or the drugs are prescribed for family planning. (Welfare and Institutions Code (W&IC) §14133.22)

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526-2

To meet the SOC, the provider of services will certify that payment for services will be sought from the patient and not from the Medi-Cal Program or a third-party insurer. (§50657(a)(6))

526-3

Retroactive adjustment of the SOC would be appropriate in situations where eligibility for a deduction is determined at a later date. (Medi-Cal Eligibility Procedures Manual §12 C)

526-3A ADDED 3/07

California Code of Regulations, Title 22, Section 50653.3(c), discuss the need to make adjustments when a person has been determined to have a lower Medi-Cal SOC for a given month(s) than was originally computed. Welfare and Institutions Code Paragraph 14019.3 speaks to provider return of payments for services covered by Medi-Cal. Persons determined to be entitled to a lower share of cost (SOC) have the option of:

1. Having future SOC amounts adjusted by the county; or
2. Adjusting with providers, the amounts obligated or paid to those providers to meet the overstated portion of the original SOC.

Medi-Cal Eligibility Procedures Manual §12C, p. C1)

526-4

When a person retroactively establishes property eligibility, under *Principe v. Belshé*, none of the medical expenses paid with otherwise excess property in order to establish eligibility shall be used to meet the applicant's SOC, nor applied to the SOC under *Hunt v. Kizer*. (All-County Welfare Directors Letter No. 97-41, October 24, 1997)

527-1 ADDED 11/05

In *Conlan v. Bontá*, the California Court of Appeals, First Appellate District, the plaintiffs asked the Court to order the CDHS to set aside fair hearing decisions which had denied requests to order reimbursement to the plaintiffs for medical costs incurred while Medi-Cal applications were pending. The applicants eventually had been granted Medi-Cal, after they had paid their medical bills.

The Court ordered CDHS to "ensure that Medi-Cal recipients entitled to reimbursement for covered services during the retroactivity period [i.e., before Medi-Cal was approved] are promptly reimbursed."

The court discussed the role of the ALJ and in the Disposition required "... ALJs to determine what amounts, if any, each petitioner is entitled to receive..." and order "direct reimbursement" or allow CDHS "a reasonable period of time in which to implement new procedures designed to effect such reimbursement."

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(*Conlan v. Bontá* (2002) 102 Cal. App. 4th 745, 751, rehearing denied October 29, 2002)

527-2 ADDED 3/07

The CDHS has been ordered by the superior court in *Conlan v Bonta* and *Conlan v Shewry* to implement a Beneficiary Reimbursement process enabling Medi-Cal beneficiaries to obtain reimbursement of paid out-of-pocket expenses for Medi-Cal covered services received during specific periods of beneficiary's Medi-Cal eligibility. These periods include 1) the retroactive period (up to three months prior to the Medi-Cal application month; 2) the evaluation period (from the time of the Medi-Cal application until eligibility is established), and 3) the post-approval period (the time period after eligibility is established)

A notice was sent out to current and former beneficiaries indicating they may seek reimbursement for out-of-pocket medical or dental expenses if they were eligible for Medi-Cal anytime since June 27, 1997 or are currently eligible for Medi-Cal.

The address and phone number for Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims is:

California Department of Health Care Services
Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008
(916) 403-2007 TDD: (916) 635-6491

(ACWDL 07-01, January 12, 2007)

527-3 ADDED 9/09

The Court of Appeal held the Department is required to:

- (1) Send notice of the new monetary reimbursement process available to all current and former Medi-Cal beneficiaries who may have claims arising on or after June 27, 1997;
- (2) Provide monetary reimbursement to any individual who has a valid claim for reimbursement arising on or after June 27, 1997;
- (3) Provide reimbursement for valid claims arising from the date an application for Medi-Cal eligibility is submitted to the date that the application is granted (the "evaluation period");
- (4) Provide reimbursement for services rendered by non-Medi-Cal providers if the services were provided during the retroactivity period; and
- (5) For valid claims, reimburse the beneficiary the amount paid, not to exceed the rate established for that service under the Medi-Cal program.

(*Conlan v Shewry* (2005) 131 Cal. Application. 4th 1354)

527-4 ADDED 9/09

On February 17, 2006, the San Francisco Superior Court approved the Department's "Revised Plan for Beneficiary Reimbursement." Under this court-approved plan, the Department is required to mail a Beneficiary Notice to all current Medi-Cal beneficiaries and to those individuals who were eligible for Medi-Cal at any time since June 27, 1997. That notice informs

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current and past Medi-Cal beneficiaries that they may be entitled to reimbursement from Medi-Cal for medical or dental bills they paid.

Under the superior court's order, the Revised Plan for Beneficiary Reimbursement sets forth the process and criteria governing the reimbursement of Medi-Cal beneficiaries who have paid out-of-pocket for covered services. In relevant part, the court-approved plan provides as follows:

F. Criteria for Processing Beneficiary Claims

Claims must meet the following criteria in order to qualify for reimbursement. In some cases to satisfy the criteria a declaration might supplement other documentary evidence. A declaration shall not substitute for documentation of medical necessity. Claims that do not meet the following criteria will be denied:

- The beneficiary was eligible for Medi-Cal at the time the service(s) was(were) provided;
- The claimed service(s) was (were) provided on or after June 27, 1997;
- The service(s) provided was (were) a Medi-Cal covered service-i.e., a Medi-Cal benefit at the time the service(s) was (were) rendered;
- The beneficiary was eligible to receive the service(s) at the time the service(s) was (were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits;
- The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.), with an itemized list of services covered by the payment, and to whom the payment was made;
- The beneficiary has submitted a completed STD 204 form;
- For those Medi-Cal services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider that shows medical necessity for the service(s);
- The claimed cost(s) was (were) not required to meet co-payments, share of cost or other cost-sharing requirement(s);
- The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal/Denti-Cal, other Medi-Cal funded program, the healthcare provider or by a third party;
- The beneficiary did not have other health coverage at the time the service(s) was (were) rendered that would have been obligated to pay the claimed cost(s);

Claims for Medi-Cal covered service(s) provided during the evaluation period for date(s) of service on or after February 2, 2006, and claims for Medi-Cal covered service(s) provided during the post approval period for date(s) of service on or after June 27, 1997, the service(s)

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must have been rendered by a provider who at the time the service(s) was (were) rendered was an active Medi-Cal authorized provider.

(Conlan v. Shewry, Superior Court No. 987697)

527-5 ADDED 9/09

In those situations where the claimant has a valid claim for reimbursement, the Revised Plan for Beneficiary Reimbursement provides as follows:

- If reimbursement for the full amount has been made to the beneficiary by the healthcare provider(s) voluntarily, the Department will close the claim and send a letter to the beneficiary indicating that the claim was closed due to payment from the health care provider.

- If the Medi-Cal provider has not made full reimbursement, the Department will initiate recoupment from the Medi-Cal provider if appropriate.
 - If recoupment is appropriate, then the Department will notify the Medi-Cal provider that the Department will initiate recoupment proceedings against the Medi-Cal provider. The Department will permanently divert funds from the Medi-Cal provider sufficient to reimburse the claim in full, reimburse the beneficiary, and close the claim. The recoupment action will delay the reimbursement process timeline.

 - If recoupment is not appropriate, the Department will directly reimburse the beneficiary for those services approved on the beneficiary's claim. Reimbursement may be up to the allowable Medi-Cal rate(s) for the specific Medi-Cal covered service(s), and shall be considered payment in full of the claim. The Department will also send a letter to the beneficiary indicating that the claim was paid along with pertinent claim payment information and information on requesting a State Hearing.

(Conlan v. Shewry, Superior Court No. 987697)

527-6 ADDED 3/10

The California Department of Social Services (CDSS), Adult Programs Division, Conlan II Unit has the primary responsibility for adjudicating Conlan II claims for IHSS. In order to be considered for reimbursement, the recipient must have experienced an actual out-of-pocket expense for the excess SOC amount. IHSS recipients who paid their provider an excess share of cost can file a Conlan II claim to request reimbursement.

The recipient will be requested to submit proof of payment with the claim, such as receipts or cancelled checks. Only IHSS recipients are entitled to reimbursement under the Conlan II court order. IHSS providers should not be instructed to contact the BSC to request reimbursement for providing IHSS.

In order to be reimbursed, the recipient must:

1. Contact the DHCS Beneficiary Services Center (BSC), at (916) 403-2007 to request a Conlan II claim packet for IHSS.

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2. Complete the claim packet and return it directly to the BSC at the address provided on the claim packet.

(ACIN I-03-10) (*Conlan v. Shewry*, Superior Court No. 987697)