502-1

The Medi-Cal maintenance need for an MFBU of ____ persons is $___. (§50603; All-County Welfare Directors Letter No. 95-19, March 23, 1995)

502-2

The maintenance need for a member of the MFBU in Long-Term Care shall be $35 (except for individuals with therapeutic wages). (§50605(a))

502-3

A Long-Term Care (LTC) patient shall retain an amount of income for upkeep of a home in addition to the LTC maintenance need if the spouse or family of the LTC patient is not living in the home, the home is being maintained for the return of the LTC patient, and there is a verified medical determination that the LTC patient will return home within six months of the date that LTC patient status was established. The amount of the upkeep allowance is 133 and 1/3 percent of the income in kind value of housing for one person ($204) if the patient has been living alone in the home or 133 and 1/3 percent of the income in kind value of housing for 2 persons, divided by 2 ($137.00), if the home is shared with persons for whom the patient has no legal responsibility for support. (§50605(b)) See also Medi-Cal Procedure Manual 10 F-1 for in-kind values.

502-4

The Medi-Cal share of cost is computed by subtracting the appropriate maintenance need for the Medi-Cal Family Budget Unit from the net income (§50653(a))

502-4A MODIFIED

1/16

When the individual without therapeutic wages is in Long Term Care status for a full calendar month the share of cost is computed by subtracting the $35 maintenance need from net non-exempt income (§50653(a)(2))

502-5

As a result of the final settlement in the *Johnson* v. *Rank* lawsuit, Medi-Cal beneficiaries in Long-Term Care (LTC) facilities are allowed to deduct the cost of necessary medical or remedial drugs or services not covered by Medi-Cal from their Share of Cost (SOC). Effective October 1, 1989, these LTC beneficiaries must have a current physician's prescription or order for any drug or service which is to be used to meet the SOC. (All-County Welfare Director's Letter (ACWDL) No. 89-54, July 24, 1989)

502-6 ADDED 7/09

When the county encounters an application for a single person residing in a LTC facility, the county should determine whether or not LTC status has been achieved as defined in ACWDL 90-01, Section 50056. For a single person in a LTC facility, Title 22, California Code of Regulations, Section 50605(a)(1) is controlling. Section 50605(a)(1) requires that the maintenance needs allowance is reduced to $35 only when a single individual is in a LTC facility for an entire month. Where the single LTC individual is in a LTC facility for a partial month, the $35 maintenance need does not apply. (All County Welfare Director's Letter No. 97-32, July 28, 1997)."

504-1

When a change in income or circumstances results in a decrease in the SOC and is reported by a beneficiary in a timely manner, the county is to recompute the SOC for the month in which the change occurred and shall provide the beneficiary the option of having an adjustment made in the future amount of the SOC or processing a corrected Form MC 177S, or Medi-Cal card with a share of cost, for the month in question. The amount of any adjustment shall be based on those months in which income in excess of the correct SOC was paid or obligated toward medical bills. (§50653.3(a))

504-1A

In 1994, the Department of Health Services began converting from paper Medi-Cal Cards, issued monthly, to the plastic Benefits Identification Card (BIC). A new card is no longer issued to every Medi-Cal eligible person on a monthly basis. (All-County Welfare Directors Letter (ACWDL) No. 96-06, February 1, 1996)

As of July 1, 2003, there has been no change to §§50653.3 and 50657 which speak of the Form MC 177S and Medi-Cal cards, and there is no ACWDL nor MEPM revision which reflects the use of BICs. It should be noted, however, that effective June 1, 1997, paper Medi-Cal identification cards and the Medi-Cal share of cost MC-177 form were eliminated. Providers in all counties statewide use the plastic Benefits Identification cards (BICs) referenced in ACWDL No. 96-06.

(Denti-Cal Bulletin, Vol. 13, No. 13, June 1997)

505-1

In addition to the period of eligibility specified in §50193(c), an applicant shall be eligible for Medi-Cal in any of the three months immediately preceding the month of application or reapplication if all of the eligibility requirements are met in that month. (§50197(a))

505-1A

The beginning date of eligibility for persons applying only for Medi-Cal, whose eligibility has not yet been determined, shall be the first day of the month of application if all eligibility requirements of the appropriate Medi-Cal Program are met, or the first day of the month subsequent to the month of application during which the eligibility requirements of the appropriate Medi-Cal Program are met. (§50193(c), replacing §50701(c), effective September 19, 2000)

505-2

The applicant is not entitled to three-month retroactive coverage if the applicant was previously denied Medi-Cal for the month in question, unless the application was denied because of county error or a failure to cooperate when that failure, or the applicant's subsequent failure to reapply, was due to circumstances beyond the control of the applicant. (§50197(a)(3), replacing §50710(a)(3), effective September 19, 2000)

505-3

A person or family applying for retroactive Medi-Cal must submit a completed application to the county if the application is for retroactive coverage only. Such request made in conjunction with, or after an application for public assistance or Medi-Cal, must be made on the application form, on the Statement of Facts or by submitting a written request. The application must be submitted within one year of the month for which retroactive coverage is requested. (§50148)

505-4

Actual income is used in computing the SOC in retroactive Medi-Cal months. Income verification used to determine current month eligibility on the MC 210 can be used to determine income as long as "no change" is reported by the beneficiary on the MC 210A. (All-County Welfare Directors Letter No. 02-43, August 27, 2002)

506-4

Pursuant to the *Hunt* v. *Kizer* court order, as implemented by the DHCS, individuals are allowed to apply medical bills from previous months (old medical bills) toward their current month's SOC provided these old medical bills were unpaid at the time they were submitted to the county. Individuals are also permitted to save old or current medical bills and apply them as old medical bills toward their SOC in a future (later) month, provided these old medical bills remain unpaid. Individuals are allowed to use credit card or collection agency statements as evidence of medical expenses.

(Medi-Cal Eligibility Procedures Manual (MEPM) §10R-1)

506-5

The DHCS has defined the following terms for purposes of the *Hunt* v. *Kizer* procedures.

Current Month: This refers to the current calendar month.

Future Month: A future month is any month which is future to the current month.

Previous Month: A previous or past month is any month prior to the current month.

Current Medical Bills: The term "current medical bill" refers to a medical bill which is/was incurred in the same month (month of eligibility) for which it will be applied toward the individual's Share of Cost (SOC). As used in these procedures, the term "current medical bill" does not refer to the bill's chronological age.

Old Medical Bills: The term "old medical bill," refers to a medical bill which was incurred in a month previous to the month for which it will be applied toward the individual's SOC.

Old and current medical bills are sometimes treated differently and subject to different requirements for purposes of determining whether they can be applied toward the SOC. The most notable difference is that current medical bills may be applied toward the SOC whether unpaid or paid, while old medical bills must be unpaid before they can be applied toward the SOC.

Month In Which A Medical Bill Is Incurred: A medical bill is incurred on the date the medical service or drug is provided. The month in which a medical bill is incurred is the month in which this date of service falls.

Medical Bills Spanning Two Or More Months: In some instances, a medical bill will show a single medical expense for a medical service, such as a hospital stay, which was rendered over multiple days and therefore shows multiple dates of service. A medical bill showing such a multiple-day medical expense spanning more than one month is incurred in each month containing one or more dates of service for that expense.

When a medical bill spans two months, a portion of that bill is incurred in each month. If an individual submits such a medical bill to the county, the county must determine how much of the bill was incurred in each month. To calculate the portion of the medical expense that was incurred in the first month the county should first calculate the daily charge for the medical service by dividing the medical expense for that service by the number of dates of service for that expense, and then multiply the daily charge by the number of dates of service falling within the first month. Similarly the amount of the bill incurred in the second month is the daily charge multiplied by the number of days of service in the second month.

Unpaid Old Medical Bills: Unpaid old medical bills are old medical bills which are unpaid at some time in the month in which they are submitted to the county. If a portion of the old medical bill has been paid, the unpaid portion may still be applied toward the individual's SOC.

Medical Bills and Medical Expenses: Medi-Cal can accept for application toward a individual's SOC only medical bills for bona fide medical expenses. Expenses for medically-related services qualify as bona fide medical expenses if the service was rendered by a State-licensed health-care provider.

Expenses for medically-related equipment, supplies or drugs qualify as bona fide medical expenses if the equipment, supply-item or drug was:

1. Prescribed by a physician as necessary to treat a medical condition and;

2. Is customarily considered by the medical profession as primarily for health care and medical treatment and;

3. Is intended, and will be used, solely for the health care and medical treatment of the individual.

Medi-Cal presumes that medical expenses for drugs and supplies which are available only through a prescription are necessary to treat a medical condition and that expenses for these items are therefore bona fide medical expenses.

This presumption does not apply to medically-related equipment, drugs and supplies which a physician has prescribed but which are available without a prescription. For drugs, supplies, and medical equipment which have been prescribed, but which are available without a prescription, counties may require that the individual obtain a statement from the prescribing health-care provider attesting that each of the three above- numbered requirements are satisfied. The statement must include a short description of the condition being treated and must name the drug, supply, or medical equipment which the physician has prescribed.

If the county is uncertain whether the drug or other item is available without a prescription, the county may require that the individual obtain a statement from the provider stating either that the item or drug is available only through a prescription, or attesting that each of the three above-numbered requirements is satisfied.

The county may disallow the application toward meeting the SOC of a medical expense for a drug or other item which is available without a prescription despite a provider's statement attesting to the three above-numbered items if the provider's statement is contrary to common sense.

Remedy: The word "remedy" is used in these procedures to denote certain benefits belonging to the Medi-Cal individual which have arisen as a result of the *Hunt* v *Kizer* lawsuit.

(MEPM §10R-1 through 4)

Under *Hunt* v. *Kizer* procedures, an individual may apply an "old medical bill" toward his/her SOC when all of the conditions below are satisfied.

1. The old medical bill, or the portion of the old medical bill, which will be applied toward the SOC was unpaid at some time in the month of its submission to the county.

2. The bill is not more than four years old as of the date of its submission, unless it falls under one of the exceptions to the Statute of Limitations set forth in §V.

3. The old medical bill satisfies the qualifying criteria (§III.A of these procedures), verification requirements (§III.B of these procedures) and other applicable conditions discussed in these procedures.

4. An old medical bill submitted for application toward the SOC must not have previously been applied toward the SOC and must not have been for a medical expense which is subject to payment by the Medi-Cal program.

Individuals may also save and accumulate unpaid medical bills from a current month and then submit these bills as old medical bills toward their SOC in a later month. An old medical bill may also be applied toward a past month IF the bill was incurred previous to that past month and IF the individual had not already met his/her SOC in that past month. These bills cannot be applied to months more than 12 months previous to the month of their submission (months for which a Letter of Authorization would be necessary) unless the individual could qualify for a Letter of Authorization on grounds of administrative error.

(MEPM §10R-4, 5)

506-7

All the criteria which a medical bill must satisfy (under *Hunt* v. *Kizer*) before the county can apply the bill toward the SOC, set forth below, apply to UNPAID OLD medical bills. Criteria 3-6 apply to CURRENT medical bills.

1. The old medical bill must be unpaid at some time in the month of the bill's submission to the county (i.e., the bill must not have been paid previous to the month in which it is submitted).

2. The old medical bill is less than four years old as of the date of the bill's submission, with certain exceptions.

3. That portion of the old or current medical bill for which a third party is liable must first be subtracted from the amount billed to the individual.

4. The portion of a current or old medical bill previously used to meet a Medi-Cal SOC may not be re-applied toward the SOC.

5. The current or old medical bill must be an original bill, an authenticated copy, or an acceptable substitute.

6. The current or old medical bill must satisfy the list of verification requirements.

If completely paid previous to the month of their submission, unpaid old medical bills cannot be applied toward the SOC. If partly paid previous to the month of their submission, only the portion of the old medical bill which remains unpaid in the month of submission can be applied toward the SOC.

Current medical bills can be applied toward the SOC whether paid or unpaid (provided they meet other applicable requirements.)

(MEPM §10R-5, 6)

506-8

Current and old medical bills applied towards an individual's SOC (under *Hunt* v. *Kizer*) must contain certain items of information. These verification requirements apply both to current medical bills and to old medical bills, except where noted. The verification requirements which must be satisfied are:

1. Current and old medical bills must show the name and address of the provider who provided the service.

2. Current and old medical bills must show the name of the person who received the medical service.

3. Current and old medical bills must contain a short description of the medical service received.

4. Current and old medical bills must show a "Procedure Code" (a medical reference number).

5. Current and old medical bills must show either the provider's Medi-Cal provider identification number, taxpayer identification number, or provider license number.

6. Current and old medical bills must show the date(s) the medical service was provided.

7. Current and old medical bills must show the date on which the bill was issued. If the bill is an unpaid old medical bill, its billing date must be within 90 days of the date the bill is received by the county.

8. Current and old medical bills must show the amount owed solely by the individual and not subject to third party coverage. If the individual has other health care coverage, the amount billed solely to the individual may be demonstrated by a bill which shows the total amount of the bill and a separate amount billed to the individual.

Some of the numbered verification requirements listed above may be supplied by the individual in a sworn statement (Section VII of these procedures) if they are missing from the medical bill.

(MEPM §10R-6, 7)

506-12

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)

506-13 ADDED 9/09

Eligible and Ineligible MFBU members are eligible to have the cost of their health services used to meet the share of cost for the MFBU (§50657(a)(1)(A) and (B))