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ADP BULLETIN

Title:
Clarification of Drug Medi-Cal Share of Cost, Co-Payment, and the Right to a Fair Hearing

Deputy Director Approval

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Program Operations Division

Function:
[X]Information Management
[ ]Quality Assurance
[ ]Service Delivery
[ ]Fiscal
[X]Administration

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PURPOSE

This bulletin is to provide information regarding the Drug Medi-Cal (DMC) share-of-cost
(SOC), co-payment, and notification of the right to a fair hearing.

HISTORY

S**OC:** Some Medi-Cal beneficiaries must meet a specified SOC for medical expenses before Medi-Cal will pay claims for services provided in that month. The SOC is determined by the county welfare department and is based on the beneficiary's or family's income and living arrangement. Members of the family may have the same or different share of cost amounts. The monthly SOC may change at any time if the individual's or family's income increases or decreases, or the family's living arrangement changes.

Co-Payment: Welfare and Institutions Code (WIC), Section 14134 requires patients who are recipients of Medi-Cal benefits to pay a small co-payment to the provider at the time services are received. This co-payment is retained by the provider and is not to be confused with the SOC.

A co-payment of one dollar ($1) is imposed for doctor's visits, drug prescriptions or refills, and other outpatient services. A co-payment of five dollars ($5) is imposed for non-emergency services received in an emergency room. Although co-payments are required by law, the collection of the co-payment by the provider is optional. The co-payment can be waived, collected at the time of service, or obligated. However, WIC Section 14134(h) specifies that a provider is prohibited from denying care or services to an individual because that person is unable to pay the co-payment.

DISCUSSION

SOC: The SOC is determined by the county welfare office on a monthly basis and may change from month to month. It is important that providers verify Medi-Cal eligibility every calendar month prior to rendering services. Beneficiary eligibility and SOC can be determined from the Medi-Cal Host computer using one of three methods:

1. Slide the Beneficiary Identification Card through the Point of Service (POS) device. All providers are eligible to receive their first POS device free. Call the POS Help Desk at 1-800-427-1295,

2. Use the Claims and Eligibility Real-Time System (Certs) Software which requires a modem, or

3. Use the Automated Eligibility Verification System (AEVS) by calling 1-800-456-2387. This method is recommended for low volume providers.

Providers receiving a message from the eligibility inquiry that the beneficiary has an unmet SOC must clear that "deductible" on-line before any eligibility information will be provided. The patient may meet the monthly SOC by either paying or obligating it to the provider for medical services. Providers may collect the SOC on the date that services are rendered, or may allow the patient to obligate the payment. To "obligate the payment" means the provider is willing to allow the beneficiary to pay the SOC to the provider at a later date or through an installment arrangement. SOC obligations are between the patient and the provider and, for the protection of each, should be in writing and signed by both parties. It is up to the provider whether the patient is allowed to obligate the SOC payment. All health services, including medical services, supplies, devices, and prescription drugs, whether Medi-Cal covered or not, can be used to meet the SOC for Medi-Cal purposes.

Once the beneficiary pays or obligates the SOC, the provider must submit a SOC clearance transaction immediately upon receiving payment at the time the service is rendered, or, in the case of a SOC obligation, at the time the beneficiary and provider agree to the obligation, so that the beneficiary can obtain any needed services from the substance abuse provider and other providers in that month.

Instructions for performing SOC clearance transactions are given in Section 500-10, Transaction Procedures, of the POS Device User Guide; Section 500-110, Software Transaction Procedures, of the CERTS User Guide (the guide which came with your vendor-supplied software); or in the section entitled Eligibility Verification Transactions,

AEVS, of the Allied Health Provider Manual (beginning on page 100-93-1). The provider manuals are on the Internet at www.medi-cal.ca.gov. Click on "Publications" and then
"Provider Manuals."

Fair Hearing: Title 22, California Code of Regulations, Section 51341.1(p) requires providers to inform all beneficiaries of their right to a fair hearing related to denial, involuntary discharge, or reduction in DMC substance abuse services as it relates to their eligibility or benefits. Notification of termination or reduction of services must be in writing at least ten calendar days prior to the effective date. Providers are not required to notify beneficiaries of their right to a fair hearing solely because the beneficiary did not meet the SOC, unless it becomes necessary for the beneficiary to be involuntarily discharged from the program or for services to be reduced. However, beneficiaries may not be terminated from the program for failure to pay the co-pay of $1.00 since law prohibits the provider from denying care or services if that person is unable to pay the co-pay.

QUESTIONS/MAINTENANCE

Please contact Marie Leonard, Program and Fiscal Policy Branch, Program Operations Division, at (916) 322-0495 if you have any questions.

EXHIBITS

None

DISTRIBUTION

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