STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
ACRAMENTO, CA 95814
16) 445-1912

April 29, 1982

To: All County Welfare Directors

Letter No. 82-23

COPAYMENT

This is to supplement and update the copayment information provided in County Welfare Director (CWD) Letter No. 82-7.

The copayment requirement for Medi-Cal recipients will become effective on May 10, 1982. Implementation was postponed pending receipt of necessary federal waivers which have now been obtained.

The beneficiary notification and a final draft of a letter sent to selected provider organizations regarding copayment are attached. A general provider bulletin will be released by CSC prior to the May 10 effective date. The attached letter supersedes Attachment III of CWD Letter 82-7. The beneficiary notification supersedes the notification included as Attachment IV of CWD Letter 82-7.

The beneficiary notification may be duplicated and provided to applicants and beneficiaries during face-to-face interviews. The provider notification and criteria chart should provide sufficient copayment information to enable the eligibility workers or Informational Referral workers to respond to beneficiary questions. Counties with Dual Choice programs will receive additional information under separate cover.

If you have further questions about copayment, please contact your Medi-Cal program consultant.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons

COPAYMENT FOR MEDICAL SERVICE

A new state law requires many Medi-Cal recipients to pay a small amount of money each time they get a medical service or prescribed drug. This is called a "copayment." No copayment is required for any person who is also eligible for Medicare, for any services rendered to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) children as a result of EPSDT diagnosis, treatment, or referral, or for children living in boarding homes or institutions for foster care. This new law will be effective May 10, 1982. The copayment will be collected by your provider at the time the service is rendered. Providers also have the option of not collecting copay.

You should read this card carefully to know when you might have to make copayment.

1. You must pay $5 for any nonemergency service received in a hospital emergency room, except for children aged 12 or under or women receiving perinatal care (services during pregnancy and the month following birth). To avoid this charge, you should go to the emergency room only when you believe it is necessary that you urgently require immediate medical attention. If the doctor decides that your visit was not really an emergency, you may have to pay $5. If you need prompt medical care but it is not truly an emergency, you should contact your physician or local outpatient clinic.
2. You must pay $1 for each drug prescription, except for persons aged 65 or over, 12 or under, persons who are inpatients in a health facility, such as a hospital or nursing home, and any person who has a chronic condition (for example, hypertension or diabetes) which requires more than one prescription. If you have a chronic condition which requires more than one prescription, your doctor should note this on your prescriptions so that the pharmacy will know not to charge you for copayment.
3. You must pay $1 per visit for the following outpatient services: physician, hospital or clinic outpatient, surgical center, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture, and dental. Children aged 12 or under, women receiving care during pregnancy or the first month after birth, and persons who are inpatients in a health facility do not have to pay the $1 charge.

If you have any questions about whether you have to make a copayment, please call your local county welfare department or the Department of Health Services, Medi-Cal Relations Unit, at (916) 445-0266.

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COOPERACION EN EL PAGO POR LOS SERVICIOS MEDICOS

Una nueva ley del estado exige que muchos de los que reciben Medi-Cal paguen una pequeña suma de dinero cada vez que reciben una atención médica o una medicina. Esto se llama una "cooperación en el pago." Esta contribución en el pago, no se le exige a una persona que también es elegible para Medicare, ni por cualquier servicio prestado a los niños por Temprana y Periódica Evaluación, Diagnosis y Tratamiento (Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)) como resultado del diagnóstico EPSDT, tratamiento o informe, ni a los niños que viven en pensionados o en hogares provisionales. Esta nueva ley será puesta en vigencia el 10 de mayo de 1982. Esta participación en el pago le será cobrada por su proveedor en el momento que recibe el servicio. Los proveedores tienen también la opción de no cobrarle esta contribución.

Usted debe leer cuidadosamente esta tarjeta para saber cuando puede tener que hacer este pago.

1. Usted debe pagar $5 por cualquier servicio que no es de emergencia pero que lo recibe en la sala de emergencia de un hospital, excepto para los niños de 12 años o menos o para las mujeres que reciben cuidado prenatal (servicios durante el embarazo y el mes siguiente al parto). Para evitar este pago, Ud. debe ir a emergencia sólo cuando cree que necesita urgentemente atención médica inmediata. Si el doctor determina que su visita no era realmente una emergencia, Ud. puede tener que pagar $5. Si Ud. necesita atención médica inmediata, pero que no es verdaderamente una emergencia, Ud. debe ponerse en contacto con su médico o con la clínica local para pacientes externos.
2. Usted debe pagar $1 por cada medicina prescrita, con excepción de las personas de 65 años de edad o más, de 12 años o menos, pacientes en un centro de salud, ya sea en un hospital o en casa para ancianos, y cualquier persona que tenga una dolencia crónica (por ejemplo, presión alta o diabetes) que requieren más de una prescripción. Si Ud. tiene una dolencia crónica que requiere más de una receta, su doctor debe anotar esto en sus prescripciones, a fin de que la farmacia lo sepa y no le cobre participación en el pago.
3. Usted debe pagar $1 por visita a los siguientes servicios para pacientes externos, médico, hospital o clínica para pacientes externos, centros quirúrgicos, optometría, quiropráctica, psicología, podiatría, terapia ocupacional, terapia física, terapia del lenguaje, del oído, acupuntura y servicio dental. Los niños de 12 años o menos, las mujeres que reciben atención durante el embarazo o el primer mes después del parto y las personas que son pacientes externos en un centro de salud no tienen que pagar el cargo de $1.

Si Ud. tiene preguntas acerca de sí tiene que hacer un pago o no, por favor llame a su departamento local de bienestar del condado o al Departamento de Servicios de Salud, Centro de Relaciones de Medi-Cal (Department of Health Services, Medi-Cal Relations Unit) al (916) 445-0266.

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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
16) 445-1995

Dear

This is to provide you with advance information about changes in state law which require copayment from Medi-Cal recipients on a selected basis.

Effective May 10, 1982, Medi-Cal recipients will be required to pay a minimal copayment for each outpatient visit, some emergency room services, and some prescribed drugs. This is the result of state legislation passed in 1981 which requires that a Medi-Cal beneficiary pay providers a specified amount of money (termed "copayment") for selected services. Implementation of the law was postponed pending the receipt of necessary federal waivers which have now been obtained.

The copayment is to be collected directly from the beneficiary and will have no impact on providers billing for services, or payment for services from Medi-Cal. Beneficiaries will be notified of the requirement by a notice to be sent with their May Medi-Cal card. Since beneficiaries by law must receive a ten day notice of any reduction in benefits, providers cannot collect copayment before the May 10 effective date.

Listed below are the general guidelines for collection of copayment. These guidelines will be published in a provider bulletin which will be released before the May 10 effective date.

General Exemptions from Copayment

Copayment is never required for the following:

1. Persons who are also eligible for Medicare benefits (cross-over beneficiaries). These are persons 65 years of age or older, or who have a "Medicare" indicator on their Medi-Cal card. (The Medicare indicator is explained in the CSC provider manual.)

2. Children in boarding homes or institutions for foster care. These persons can be identified by certain aid codes. The aid codes will be identified in the provider bulletin.

3. All Child Health Disability Prevention (CHDP) services rendered to children. CHDP is the name for California'a program which meets federal requirements for an Early Periodic Screening, Diagnosis, and Treatment program. Persons receiving a CHDP health assessment or any diagnostic and treatment services, including dental care as a result of the assessment are exempt.

   If the provider has any doubt whether the service being provided is a CHDP service, the provider may wish to ask the beneficiary for the CHDP referral form or evidence of a CHDP assessment.

Specific Copayment Provision and Exceptions

Welfare and Institutions Code, Section 14134 has been amended by AB 251 (Statutes of 1981, Chapter 102) to require copayment as follows:

1. Nonemergency Services in an Emergency Room

   A copayment of $5 is required for nonemergency services received in an emergency room. "Nonemergency services" are defined as "any services not required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which if not immediately diagnosed and treated would lead to disability or death".

   Exceptions: Children age 12 or under or any woman receiving services during pregnancy and the month following birth are not required to make copayments for any emergency room services.

2. Drug Prescriptions

   A copayment of $1 is required for each drug prescription.

   Exceptions: The following categories of persons are not required to make copayments for drug prescriptions:

   a. Age group 65 or over; 12 or under;

   b. Inpatient in a health facility (hospital, skilled nursing facility, intermediate care facility);

   c. Persons having a chronic condition requiring multiple prescriptions as determined by that person's attending physician. In this case the physician should write on the prescription form "chronic condition" or "no copayment". Otherwise the pharmacist may be expected to collect the copayment.

3. Outpatient Services

A copayment of $1 is required for the following outpatient services:

Physician	Optometric
Hospital or Clinic Outpatient	Chiropractic
Surgical Center	Psychology
Podiatric	Audiology
Occupational Therapy	Acupuncture
Physical Therapy	Dental
Speech Therapy	

Exceptions: The following categories of persons are not required to make a copayment for any of the above outpatient services.

a. Persons age 12 or under;

b. Women receiving services during pregnancy and the month following birth;

c. Persons who are inpatients in a health facility (hospital, nursing facility, intermediate care facility, etc.).

Collection of Copayment

The copayment amount is to be collected by, or obligated to the provider at the time the service is rendered. These amounts are in addition to the usual provider reimbursement and no deduction will be made from the amounts otherwise paid to the provider by Computer Science Corporation. It is up to the provider to determine whether or not the collection of copayment is indicated, in accordance with the foregoing criteria. The collection of the copayment by the provider is optional. It may be waived entirely at her or his discretion.

Enclosed with this letter is a chart for easy reference to the above classifications and exclusions.

If you have any questions, please feel free to contact Jim Cicconetti of my staff at (916) 445-1995.

Sincerely,

Stephen R. Wilford, Chief
Benefits Branch

Enclosure

MEDI-CAL COPAYMENT CRITERIA

RVICES SUBJECT TO COPAYMENT	COPAYMENT FEE	EXCEPTIONS TO FEE **
NEMERGENCY SERVICES PROVIDED IN AN EMERGENCY ROOM nemergency services are defined as "any service not guired for the alleviation of severe pain or the mediate diagnosis and treatment of severe medical nditions which, if not immediately diagnosed and eated would lead to disability or death." ch services provided in an emergency room would subject to copayment.	$5.00	1. Children age 12 or under 2. Any woman receiving services during pregnancy and the month following birt
PPATIENT SERVICES ysician, optometric, chiropractic, psychology, eech therapy, audiology, acupuncture, dental, cupational therapy, podiatric, surgical center, spital or clinic outpatient, physical therapy	$1.00	1. Children age 12 or under 2. Women receiving services during pregnancy and the month following birth 3. Persons who are inpatients in a health facility (hospital, skilled nursing facility (SNF), or intermediat care facility (ICF)
JG PRESCRIPTIONS h drug prescription	$1.00	1. Children age 12 or under 2. Persons age 65 or older 3. Inpatients in a health facility (hospital, SNF, ICF) 4. Persons having a chronic condition requiring multiple prescriptions as determined by that person's attending physician. (Physician should state "chronic condition" or "no copayment" on prescription)

ADDITIONAL EXCEPTIONS TO COPAYMENT:

addition to the specific exceptions listed above, copayment will be required of anyone in the following categories:

1. Persons eligible for Medicare benefits
2. Children in boarding homes or institutions for foster care
3. All Child Health and Disability