The California Children's Services (CCS) Program Administrative Case Management Manual	► Chapter One: Referral to Decision on Case Opening
	► Chapter Two: Ongoing Case Management
	► Chapter Three: General Information
	► Chapter Four: Appendices
	► Chapter Five: Glossary Abbreviations and Acronyms

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Background:

This manual was originally developed in 1996 for the purpose of defining the CCS Program case management principles and procedures for implementing the case management principles using the automated case management system known as CMS Net. At that time, CMS Net did not have a web-based authorization system (also known as E-47). The manual also integrates the information and instructions necessary to implement and standardize the CCS Program administrative procedures (known previously as "due process").

The 1996 CCS Program case management procedure manual was developed through the combined efforts of State and county staff who participated in the CCS Program Case Management Operating Procedures Task Force, which was convened in 1995 to identify the issues to be addressed in a case management procedure manual, and to work towards a consensus on regional office and county roles and responsibilities. At the time of the manual's release, CCS Numbered Letter 20-0997 informed all CCS county programs that they shall adopt the principles in the case management procedure manual.

The Task Force and the revisions done by the work group used an "80/20" rule in writing this manual. Every effort was made to include flexibility for individual office practices, while ensuring that procedures conform to the CCS Program laws, regulations, and policies. The procedures, as written, cover 80 percent of usual case management transactions, leaving room for the 20 percent of transactions that fall into the "exception" or "what if" area. Therefore, users of this manual are encouraged to use their best judgment with regard to specific case management issues that fall outside of specific written procedures, as long as the basic principles cited in this manual are applied.

2014 Update:

The core principles of the CCS Program services and case management activities for counties and/or regional offices have not changed. This 2014 update to the now titled CCS Program Administrative Case Management Manual, updates the procedural text to reflect the current CMS Net Legacy and web-based processes. This manual includes cross references to the applicable CCS Program statutes, regulations, policies referred to in the manual, appeals and fair hearings information, and other information that is needed to implement the CCS Program case management activities for the CCS Program and Medi-Cal beneficiaries.

> ***Note**: Effective January 1, 2013, the Healthy Families Program (HFP) no longer enrolled new applicants and all HF subscribers were transitioned in phases to the Medi-Cal program throughout 2013. A new Medi-Cal Program was created to provide coverage for children previously enrolled or eligible for the HFP [Link to HFP Transition letters/notices]. Access for Infants and Mothers (AIM) linked infants (with an income above 250 percent and up to 300 percent of the federal poverty level) were transitioned into the new Department of Health Care Services (DHCS) AIM-Linked Infants Program (ALIP) and will continue to receive case management and care coordination from the CCS Program.*

Manual Format:

This CCS Program Administrative Case Management Manual is formatted in chapters and sections. Within each section are general CCS Program case management principles on specific topics. The CCS Program case management principles in each section are followed by the procedures to be used for implementation using the CMS Net online system. The procedures integrate, for example, the steps required in sending a Notice of Action and a narrative on this procedure. This 2013 case procedures manual update to an electronic format accommodates "live" updates as changes in case management activities and the CMS Net system occur.

For additional information, please contact your State CCS Program office administrative or nurse consultant.

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The CCS Program References Noted in the CCS Program Case Procedures Manual:

CCS Statutes Health & Safety Code (H&SC), Citations for Robert W. Crown CCS Act, Sections 123800-123995

CCS Regulations California Code of Regulations (CCR), Title 22, Subdivision 7, CCS, Sections 41401-42700

Policies CCS Numbered Letters provide policy background, policy statements and policy implementation direction [hyperlink]

Procedures Due Process - Administrative Procedures Manual - July 2001; Revision of Due Process Manual issued 1992

CMS/CCS Manual of Procedures, Chapters 1-8. Note: some parts of this manual are available online.

- Chapter 1: General Administrative Procedures. Historical document replaced by policy letters [hyperlink]
- Chapter 2: Medically Eligible Conditions. No longer in effect. Replaced by CCR [hyperlink]
- Chapter 3: Standards for Vendors and Providers. Some sections available online [hyperlink]
- Chapter 4: Medical Eligibility for Medical Therapy Program [hyperlink]
- Chapter 5: Payment and Billing Guidelines. No longer in effect. Refer to the Medi-Cal Provider Manual [hyperlink]
- Chapter 6: Financial and Residential Criteria. Historical document; some sections replaced by new policy letters.
- Chapter 7: Special Care Centers. Refer to current online directory list. [hyperlink]
- Chapter 8: CCS Approved Hospital List. Refer to current online CCS Provider list [hyperlink]

Information Notices CMS Information Notices contain administrative information letters for all CMS programs [hyperlink]
CCS Information Notices contain administrative information letters specific to the CCS Program [hyperlink]

CMS Net Manual Legacy: CMS Net database for applicant/client registration and program eligibility procedures [hyperlink]
SAR/WEB: CMS Net case management system for narratives, SAR processing, correspondence, reports [hyperlink]

This Computes! Information bulletins distributed electronically provide CMS Net administrative and technical guidance [hyperlink]

Note: Due to ongoing changes in CCS policies, procedures, and guidelines, the cross references noted in this manual may not be current. It is the users' responsibility to check the validity and accuracy of the cross references. Users should report any errors or omissions to your State CCS office administrative or nurse consultant.

Special thanks to the CCS Program County and State staff who worked in the original development and updates to the CCS Program Case Management Procedure Manual:

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The CCS Program Case Procedures Manual Revision Record

	Date	Section	Subject	Brief Description of Change or Clarification	Name & Title of State Staff
1	4/29/14	All Sections	Healthy Families	Each reference to HFP or subscriber is noted with ~~strike-~~	Cyd Ramirez, NCIII
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Note: This CCS manual is maintained by the Systems of Care Division. Please contact the CCS nurse or administrative consultant regarding the content in this manual.

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Chapter One: Referral to Decision on Case Opening – Section I: A. Referrals

A. General Information

1. A referral to the CCS Program is defined as a request directed to the CCS Program to authorize medical services for a referred individual who:

   a. under 21 years of age **and**

   b. is not a client of the CCS Program **and**

   c. has, or is suspected of having, a CCS Program medically eligible condition.

2. A **referral is complete** when the following Information is provided:

   a. First and last name of referred individual.

   b. Helpful information, but not required, any “also known as” (AKA) names.

   c. Date of birth

   d. Address of applicant e. Telephone number

   e. First and last name of parent(s) or legal guardian (exception for 18+ over or emancipated minor)

   f. Statement of service requested

   g. Name and address of agency or individual requesting services

3. Provision of a Social Security Number (SSN) is not required to initiate the CCS Program application process.

4. The CCS Program case management actions are initiated on behalf of a referred individual or his/her parent or guardian when a complete referral is accepted by program staff based on the requirements in 1 & 2 above.

Section 1.A Cross References

[Link] to CMS Net Manuals

1-7 Appendix B: 3, 17, 24, 31, 60
1-7 Appendix C: 82

Continued: Chapter One: Referral to Decision on Case Opening - Section I: A. Referrals

5. The referral may originate from any source. Examples of who may initiate a referral include, but are not limited to: health care providers, parents, legal guardians, school nurses, regional center counselors, or other interested parties.

6. A referral to the CCS Program may be received in any written or oral format. A referral may be submitted as:

   a. A New Referral Service Authorization Request (SAR) DHCS 4488 form; **OR**

   b. A medical report or letter from an agency representative with a specific request for services from the CCS Program. A medical report or miscellaneous correspondence on a potential applicant that *does not* state that services are being requested from the CCS Program is not a referral; **OR**

   c. A written request by a parent/legal guardian; **OR**

   d. Information provided orally via a telephone call or in person at a CCS Program office.

   Reminder: When opening a case - only the first request for service for a given individual is a referral.

7. A referred individual or his or her parent/legal guardian who requests a CCS Program service which requires that she/he be seen in a CCS Program sponsored screening clinic (such as, but not limited to, a cardiology screening clinic) is a referral when the potential applicant has been given a specific date to be seen in the CCS Program screening clinic and when the required referral information identified in Section A.2 of these procedures has been provided.

8. For the purposes of utilizing this Manual, the following definitions should generally be followed:

   May: the term "may" is permissive for administrative decision.

   Should: the term "should" indicates a recommended procedure which may be subject to administrative variations as situations warrant but which, for the sake of program consistency, should generally be followed.

   Shall: the term "shall" indicates a mandatory requirement which requires adherence.

Section 1.A Cross References

[Link] to CMS Net User Manuals

See CMS Net Web Manual, Section 43, Referral Tracking Procedures Section

1-7 Appendix B: 3, 17, 24, 31, 60
1-7 Appendix C: 82

5 Appendix C: 82

Reminder: Appendix F: CCS Administrative Procedures, Due Process Manual – 2001

Chapter One: Referral to Decision on Case Opening - Section I: B. Referrals

B. Procedures and Responsibilities When Receiving Referrals to the CCS Program

1. Referrals received in any format (written, oral, email, web, or FAX) shall be recorded in the CMS Net record upon receipt. The electronic date a referral is received shall be the referral date. Written referrals which do not have an electronic date shall be date stamped on the date of receipt and must be documented in the CMS Net record.

2. Within **five (5) calendar days** from the receipt of the referral, the CCS Program staff shall review the information provided and take one of the followings actions:

   a. Accept the referral as complete as defined in Section A.2 of these procedures; or

   b. Reject the referral as incomplete and forward a transmittal notice to the referral source following the instructions specified in Section B.3. below.

   c. If medical reports are required, refer to Chapter One, Section III, Subsection D: Requesting Medical Records.

3. Responding to an incomplete referral.

   a. A program referral that *does not* contain the required information identified in A.2. of these procedures is incomplete. The CCS Program medical eligibility and application processes **cannot** be initiated on an incomplete referral.

   b. After review, the CCS Program staff who receives the referral and determines that it is incomplete shall:

      1) Within **five (5) working days** from the date of receipt, send a Referral Transmittal Notice to the referral sources stating:

         a) The required information needed for the referral to be complete.

         b) The referral source has **15 calendar days** from the date of transmittal notice to provide the required information in order for the referral date to remain unchanged.

Section 1.B Cross References

[Link] to CMS Net Manuals

See Web Manual, Section 34 for Letters and Notices

B Appendix G
1 Appendix B: 29, 31
1-4 Appendix C: 82

2-5 Appendix B: 31, 32

Inter-County Transfers – refer to Chapter Two-Section IV

2-3 CMS Net Web Manual, Section 43, Referral Tracking Procedures Section

3-5 Appendix B: 31, 32

c) If the requested information is not received within **15 calendar days** of the transmittal notice, the referral will not be honored.

d) If the requested information is not received, the CCS Program will take no further action on the referral.

2) Send a copy of the transmittal notice to the referred individual or parent/legal, guardian if a name and address have been provided.

4. Required steps in processing a new referral:

a. Check the Patient History File and/or CMS Net, Registration Option, to determine if the referred individual is known to the CCS Program.

1) If the referred individual is found to have a CCS number, and if confirmed the case is open/active, the referral for this individual is handled as a request for a CCS Program client. (Refer to Chapter Two, Section II, "Medical Case Management" for processing of a Request for Service.)

2) If unable to confirm the CCS case number is assigned to an open/active case, the procedures in **b** through **e** below are to be followed.

b. Determine if the referred individual is a M/C beneficiary by checking Medi-Cal Eligibility Data System (MEDS) file. If MEDS is not available, the CCS Program staff may use an alternative means available to determine M/C status. Examples of alternative methods include, but are not limited to contacting the local welfare department, asking the referring provider to utilize a M/C Point of Service (POS) device, etc.

c. If at the time of referral to the CCS Program the infant has not yet been added to the mother's M/C case by the county Social Services Agency, the infant's CMS Net record should be established in the CMS Net system and a pseudo SSN will be assigned.

d. Enter referral information into the CMS Net Registration and the request for service information into ENTER REQUEST options (following directions in CMS Net Manual).

Section 1.B Cross References

[Link] to CMS Net Manuals

See Web Manual, Section 34 for Letters and Notices

See CMS Net Web Manual, Section 43, Referral Tracking Procedures

B Appendix G
3-5 Appendix B: 31, 32
3 Appendix C: 82

4 Appendix B: 31, 32
4 Appendix C: 15, 82

4c Appendix C: 20

1) The date that the referral was noted as received (see referral date in B. 1 above) is entered in the “Ist REF DT” field and/or “REF/TFR DATE” field.

2) If the applicant’s primary diagnosis is unclear, enter ICD-9 “000.000” for Undiagnosed Condition in the Primary Diagnosis field.

5. For dependent county cases the following shall apply:

   a. The state office or the dependent county shall immediately notify the other CCS Program office via web message that the referral has been entered and is now a pending CCS Program case.

   b. Upon receipt of the notification referral has been entered into the CMS Net system, the state office staff shall initiate the determination of medical eligibility by following the procedures explained in Chapter One, Section III, Medical Eligibility Determination.

   c. The CCS county program staff shall initiate the CCS Program application process identified in Chapter One, Section II, Application Process.

Section 1.B Cross References

[Link] to CMS Net Manuals

5 Appendix B: 31, 32

C. Responding to Unsolicited Medical Reports or Miscellaneous Correspondence regarding Referred Individuals Not Known to the CCS Program or Identified as Potential CCS Program Applicants

1. An unsolicited medical report or miscellaneous correspondence received in the county office or state office for an individual not known to the CCS Program and which *does not* state that it is a referral ***or*** does not request a specific service from the CCS Program is ***NOT*** a CCS Program referral.

2. Return the unsolicited medical report or miscellaneous correspondence to the sender with a Correspondence Transmittal Notice. Enclose a CCS Program Referral form with the transmittal notice.

Section I.C Cross References

[Link] to CMS Net Manuals

See Web Manual, Section 34 for Letters and Notices

1 Appendix B: 31

Chapter One: Referral to Decision on Case Opening - Section II: A. Application Process

A. General Information

1. Application Timelines and Notices

A potential applicant shall be notified of the referral to the CCS Program and provided an opportunity to complete a program application, including the Medical Therapy Program (MTP) and MTP-only client. Timelines for notifying the potential applicant and the number of notices are established in the California Code of Regulations (CCR), Title 22, Section 41514.

2. Medical Eligibility Determination

Determination of medical eligibility by the medical professional staff occurs simultaneously with the receipt of a completed new referral of a potential CCS Program applicant. For M/C beneficiaries, with full scope (FS) with no share of cost (SOC), the county or state office immediately begins determination of medical eligibility and case management services.

Medical eligibility for the MTP shall be established ***prior*** to an applicant or client being referred to a MTU for any services or an authorization being issued for vendorized therapy services in lieu of services at an MTU.

3. The CCS Program Case Management Responsibilities for M/C full-scope no SOC (FS no SOC) beneficiaries.

Case management activities for M/C FS no SOC beneficiaries may be initiated prior to the receipt of the CCS Program application by the CCS Program when all of the following requirements are met:

a. CCS Program medically eligible condition.

b. M/C eligibility of the beneficiary has been confirmed as FS no SOC for the month of service.

c. Provider requesting services is a CCS-approved provider.

d. Service(s) requested is medically necessary to treat a CCS Program medically eligible medical condition or one that is associated with, or complicated by, the CCS Program medically eligible medical condition.

Section II.A Cross References

[Link] to CMS Net Manuals

See Web Manual, Section 34 for Letters and Notices

A Appendix G
1 Appendix B: 31

2 Appendix B: 32, 39, 58, 61
2 Appendix D

3 Appendix B: 11, 32,
3 Appendix C: 5, 49, 68, 83

3 Specific case management procedures for M/C FS no SOC beneficiaries are located in the appropriate sections of this manual.

3a Appendix D

3b Appendix B: 11, 31, 54
3b Appendix C: 59

3c Appendix B: 4, 66
3c Appendix E

3d Appendix B: 17, 32

4. Other Health Coverage

The Insurance Coverage screen includes the private insurance information specific to a client. Results can be obtained by user selection/entry or through MEDS Recon monthly update. If a user has manually entered insurance and the client becomes "Active," this information is sent to MEDS and posted on the Health Insurance Segment (HIS) to assist in post payment recovery and cost avoidance.

Reference the CMS Net Manual, Section 14, for insurance coverage information, including:

- Other Health Coverage
- Third Party Liability Information (Health and Safety Code, Section 123980)
- Insurance transactions and reports

Note: Contact the CCS Program Help Desk support staff at CMSHelp@dhcs.ca.gov for assistance to resolve any insurance adds/updates or insurance discrepancies for clients in our program.

5. The CMS Net Entries

The CCS Program application and the medical determination processes are done simultaneously. It is imperative that the responsible CCS Program staff member enter information into the CMS Net in a timely manner in order to facilitate compliance with administration procedural requirements

Note: Medical determination completed prior to financial determination may be noted in the CMS Net medical eligibility case note entry as pending program eligibility or pending financial.

Section II.A Cross References:

[Link] to CMS Net Manuals

See Legacy Manual, Section 14 for Insurance Coverage and Notices

4 Appendix A: 123980
4 Appendix C: 59

5 Appendix F: CCS Administrative Procedures, Due Process Manual – 2001

Chapter One: Referral to Decision on Case Opening - Section II: B. Application Process

B. Application Procedures and County Responsibilities

1. A CCS Program application shall be sent to a referred individual within **five (5) calendar days** from the date of a receipt of a completed referral, including the MTP and MTP-only client. A Release of Information Form shall accompany the application if the referral source is other than a CCS-paneled/approved provider(s). Instructions for requesting medical reports are located in Chapter Two, Section III Requesting Medical Reports.

2. The application shall be accompanied by the CCS Program Notice of Privacy Practices (NPP) and by one of the following letters and, when applicable, the Release of Information form. Application letters shall be sent using the CMS Net Application Status function to inform the potential applicant of the referral and the date by which the application is to be returned.

   a. Non-M/C, FS no SOC beneficiaries – send letter entitled "C-36"

   b. M/C beneficiaries with FS no SOC – send letter entitled "C-36M" which informs the referred individuals that the CCS Program case management authorizations shall be limited to M/C benefits until the CCS Program application requirements are met by the required response date.

   c. Medical Therapy Program (MTP) Services only – see Section C. below.

3. The CMS Net Application Status function will automatically set up a tickler date **20 calendar days** from the date of the **first** application letter (C-36 or C-36M) to monitor for receipt of the application.

4. If a signed application is not received by the tickler date, one of the following "SECOND NOTICE:" letters to the referred individual applicant shall be sent within **five (5) calendar days** from the tickler date of the first application letter:

   a. Non-M/C, FS no SOC beneficiaries – send letter entitled "C-36A"

   b. M/C beneficiaries with FS no SOC – send letter entitled "C-36MA" which informs the referred individual that the CCS Program case management authorizations shall be limited to M/C benefits only if the CCS Program application requirements are met by the required response date.

Section II.B Cross References:

[Link] to CMS Net Manuals

See Web Manual, Section 34 for Letters and Notices

[Link] to DHCS website regarding Notice of Privacy Practices (NPP) and the Health Insurance Portability and Accountability Act (HIPAA)

II.B Appendix G
1, 2, 4 Appendix B: 31
1-11 Appendix C: 5, 14, 27
1-11 Appendix G: 29-1105

.

4 Appendix B: 31

Continued: Chapter One: Referral to Decision on Case Opening - Section II: B. Application Process

5. The CMS Net Application Status function will automatically set up a tickler date of **20 calendar days** from the date of the second notice letter.

6. If a signed application is not received by the tickler date, a final letter shall be sent to the referred individual applicant within **five (5) calendar days** from the tickler date of the second notice.

   a. Non-M/C FS no SOC beneficiaries – send letter entitled "C-36B".

   b. M/C beneficiaries with FS no SOC – send letter entitled "C-36MB" which informs the referred individual applicant that the CCS Program case management authorizations shall be limited to M/C benefits only.

7. On the date the final letter is sent, the county shall:

   a. Update the CMS Net Application Status field to "No Action-No Response"; **OR**

   b. Dependent county to notify the state office via web message of this action: **OR**

   c. If applicant is a M/C beneficiary with FS no SOC, enter into the CMS Net narrative that no application has been received.

8. Within **ten (10) working days** of notification that a potential applicant, who is a non-M/C beneficiary will not be open to the CCS Program, the county shall:

   a. Issue a final Application Letter (C-36B) to each referral source.

   b. Change the CMS Net Registration status to "NOT OPEN."

   c. Enter into the CMS Net Application status field "No Action-No Response."

Section II.B Cross References

[Link] to CMS Net Manuals

See Web Manual, Section 34 for Letters and Notices

II.B Appendix G

5-8 Appendix C: 5, 14

6 Appendix B: 31
6 Appendix C: 5, 14

7 Appendix B: 11, 31, 52
7 Appendix C: 5, 14

8 Appendix B: 31
8 Appendix C: 5, 14

Continued: Chapter One: Referral to Decision on Case Opening - Section II: B. Application Process

9. If a signed application is received within the timeframe specified in the letter, the county shall:

   a. Enter into the CMS Net Application Status field “SIGNED APP.”

   b. Dependent county to notify the state office via web message of this action.

10. If a signed application is received after the date specified in the final letter, the county shall:

   a. Enter the date the application is received in the following CMS Net Registration fields: REF/TFR DT and 1ST REF DT.

   b. Update the CMS Net Application Status field to “SIGNED APP.”

   c. Dependent county to notify the state office via web message.

11. Upon receipt of the signed application, the county shall check the CMS Net Narrative and/or Medical Elig/Inelig, and/or Display Events screen for status of medical eligibility determination.

   a. If the applicant has been determined medically **eligible** OR medical eligibility determination is in process, the county staff shall initiate the program eligibility determination process following the procedures identified in Chapter One, Section IV, Program Eligibility Determination.

   b. If the applicant has been determined medically **ineligible**, then the county or state office medical consultant or designee is responsible for taking appropriate action as explained in Chapter One, Section III, Medical Eligibility Determination. Follow notification instructions to the county found in Chapter One, Section III, B.2.b.

Section II.B Cross References

[Link] to CMS Net User Manuals

9 Appendix B: 31
9 Appendix C: 5, 14

10 Appendix B: 31
10 Appendix C: 5, 14

11 Appendix B: 31, 32
11 Appendix C: 5,14

Chapter One: Referral to Decision on Case Opening - Section II: C. Application Process

C. Application procedures and responsibilities for an applicant for whom services will be limited to those available in the Medical Therapy Program (MTP) ONLY.

1. A CCS Program application shall be sent to the potential MTP Services Only applicant within **five (5) calendar** days of the receipt of a completed referral. A Release of Information Form (ROI) (C 17A) shall accompany the application if the source of the referral is not from a CCS-paneled/approved provider.

2. The application sent to the potential MTP only applicant shall be accompanied by the CMS Net letter (C-36MTU), informing the potential applicant of the referral and the date by which the application is to be returned.

3. The CMS Net Application Status function will automatically set up a tickler date of **20 calendar days** from the date of the initial application letter to monitor for receipt of application.

4. If a signed application is not received by the tickler date:

   a. A "SECOND NOTICE" letter C-36MTU-A shall be sent to the potential applicant within **five (5) calendar days**. CMS Net will automatically set up a tickler date of **20 calendar** days from the date of the letter.

   b. A final letter C-36MTU-B shall be sent to the potential applicant within **five (5) calendar days** of the second notice tickler date.

   c. On the date the final letter is sent, the CCS county shall update the Application Status field to "NO ACTION-NO RESPONSE". Dependent county to notify the state office via web message.

   d. The county shall generate and mail a copy of the final notice letter informing the referring provider that the potential applicant will not be opened to the CCS MTP.

5. If a signed application for the CCS MTP is received within the time frame specified in the letter:

   a. Update the CMS Net Application Status field to "SIGNED APP."

   b. Dependent county to notify the state office via web message.

Section II.C Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

[Link] to DHCS website regarding Notice of Privacy Practices and the Health Insurance Portability and Accountability Act (HIPAA)

C Appendix C: 61, 68
C Appendix D: MTP
C Appendix G

1-6 Appendix B: 16, 31, 31

1 Appendix E

1-7 Appendix C: 14, 61, 68

Continued: Chapter One: Referral to Decision on Case Opening - Section II: C. Application Process

6. If a signed application is received after the date specified in the final letter - refer to Section B.10 above, and:

   a. Update the CMS Net Application Status field to “SIGNED APP.”

   b. Dependent county to notify the state office via web message.

7. When a signed application is received, based on the decision by the medical consultant or designee that the applicant is:

   a. **Medically eligible**
   Follow the procedures identified in Chapter One, Section V: Opening and Reopening.

   b. **Not medically eligible**
   The county or state office medical consultant or designee is responsible for issuing a NOA following the procedures in Chapter One, Section III: Medical Eligibility Determination.

Section II.C Cross References

[Link] to CMS Net User Manuals

6 Appendix B: 16, 31

7 Appendix C: 14, 61, 68,

7a Appendix B: 39

7b Appendix B: 78, 79, 80

Chapter One: Referral to Decision on Case Opening - Section III: A. Medical Eligibility Determination

Section III.A Cross References

[Link] to CMS Net User Manuals

A. General Information

1. **Medical eligibility determination**

   Medical eligibility determination requires the review of medical reports that document and/or provide medical findings of a suspected CCS Program eligible medical condition(s). The determination of medical eligibility is expedited by the receipt of relevant medical reports. Refer to determination timeline in N.L. 20-0997.

1 Appendix B: 32
1 Appendix C: 49

2. **Medical Reports**

   Medical reports are essential for the determination of the CCS Program medical eligibility and on-going case management activities.

   Note: The requesting of medical reports for referrals required for the determination of medical eligibility is a joint state office and dependent county responsibility. The procedures and responsibilities for requesting the medical reports needed for determining medical eligibility are identified in subsection D in this chapter.

2 Appendix B: 29

3. **Medical case management functions for the CCS Program include the following activities**:

   a. Determination of medical eligibility.

   b. Determination of appropriate providers.

   c. Authorization of medically necessary services.

   d. Coordination of services in the community.

3a Appendix B: 32
3b Appendix B: 4, 64
3b Appendix E
3c Appendix D
3d Appendix B: 64, 67
3d Appendix D and E

4. **The CCS Program case management responsibilities for M/C full-scope beneficiaries with no SOC:**

   Case management activities for M/C beneficiaries, with full scope no SOC, may be initiated prior to the receipt of a CCS Program application by the CCS Program when all of the following requirements are met:

   a. M/C beneficiary has a CCS Program eligible medical condition.

4 Appendix B: 4, 11, 32, 61
4 Appendix C: 5

4a Appendix B: 32

b. M/C eligibility of the beneficiary has been confirmed full scope, no SOC for the month of service.

c. Provider requesting services is a CCS Program approved provider.

d. Services(s) requested are medically necessary to treat a CCS-eligible medical condition or one that is associated with, or complicated by, the CCS-eligible condition.

5. **CMS Net Entries** - the CCS Program application and the medical determination processes are initiated simultaneously. It is imperative that the responsible CCS Program staff member enter the information into the CMS Net in a timely manner in order to facilitate compliance with administrative procedural requirements.

   Note: Medical determination completed prior to financial determination may be noted in the CMS Net medical eligibility case note entry as pending program eligibility or pending financial.

Section III.A Cross References

[Link] to CMS Net User Manuals

4b Appendix B: 11

4c Appendix B: 4
4c Appendix E

4d Appendix B: 32
4d Appendix D

5 Appendix F: CCS Administrative Procedures, Due Process Manual – 2001

Chapter One: Referral to Decision on Case Opening - Section III: B. Medical Eligibility Determination

B. Process for Determination of Medical Eligibility

1. Determination of medical eligibility begins when:

   a. The county or state office medical consultant or designee is notified that a referral has been entered into the CMS Net; and

   b. Sufficient medical information has been received in the county or state office to make such a determination. Refer to determination timeline in NL 20-0997.

2. The medical consultant/designee shall enter the medical eligibility decision in the CMS Net case notes **within ten (10) working days** from the date that sufficient medical information was received to make that decision.

   a. **If medically eligible**, enter in the CMS Net narrative the medically eligible condition and the effective start date of coverage. (Refer to Chapter One, Section V. B. 1. d. for determining effective date.) The ICD code(s) shall be reviewed and updated on the CMS Net Registration, as appropriate.

      1) Enter if applicant (or potential applicant) is to be opened to the CCS Program as "diagnostic," which limits authorizations to those services required to confirm a CCS Program medically eligible condition.

      2) State office to notify the dependent county of medical eligible decision via web message.

   b. If **not** medically eligible, enter decision in the CMS Net narrative, and:

      1) If no application has been received, the county or state office staff shall determine the appropriate deny request letter to send to the referring provider. A copy of the letter shall be sent to the potential applicant or parent/legal guardian. Refer to NL 05-0608.

      2) If an application has been received, the county shall:

         a) Generate a NOA via CMS Net by inserting the selected explanation (citations from the NOA Explanation/Citation list). Enter in CMS Net case notes the NOA letter number.

Section III.B Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

B Appendix G
1 Appendix B: 32, 60, 61
1b Appendix C: 49

1-2 Appendix C: 10, 14, 45, 54, 57, 58, 62, 63

2a Glossary for "effective start date"
2a Appendix B: 17, 32, 63, 65

2a1 Appendix B: 65

2b Appendix B: 32

2b1 Appendix B: 78, 79, 80
2b1 Appendix C: 14

2b2 Appendix B: 78, 79, 80

Continued: Chapter One: Referral to Decision on Case Opening - Section III: B. Medical Eligibility Determination

b) Type in free text area the effective date the CCS Program will not be able to authorize services that have been requested. The date is usually the referral date.

c) Send a copy of the NOA to each provider who requested authorization for service(s) without the Appeal Process Information enclosure. Update the CMS Net "Deny Request" function. Refer to the CMS Net procedures for this function.

Reminder: Notification procedures differ for Provider Electronic Data Interchange (PEDI) providers. Refer to Chapter Two, Section II.D.

d) State office to notify the dependent county, on the same day the NOA was generated via the CMS Net web message.

Section III.B Cross References

[Link] to CMS Net User Manuals

[Link] to PEDI

Chapter One: Referral to Decision on Case Opening - Section III: C. Medical Eligibility Determination

C. Updating CMS Net Medical Eligibility Status

1. When program eligibility has been established (FIN/RES), update the CMS Net Establish Medical Eligibility/Ineligibility function to Treatment or Diagnostic Status. Enter the eligibility date, which is the date that the CCS Program coverage for requested service(s) is effective. The effective date of coverage is determined by the medical consultant or designee.

2. Follow procedures in Chapter One, Section V, Case Opening and Reopening.

Section III.C Cross References

[Link] to CMS Net User Manuals

1 Appendix B: 11, 51

Chapter One: Referral to Decision on Case Opening - Section III: D. Medical Eligibility Determination

D. Procedures for Requesting Medical Reports Required for Medical Eligibility

1. At the time the complete referral is registered in the CMS Net, the CCS Program office entering the referral shall determine if sufficient and relevant medical reports were submitted with the referral.

2. A Release of Information (ROI) signed by the applicant or parent/legal guardian is required **only** when a medical report is needed from a health care provider who is not the source of the referral to the CCS Program and/or CCS Program provider.

   Note: For applicant residing in a CCS Program dependent county, securing an appropriately signed Release of Information form is the responsibility of the county staff.

3. Upon determination that additional reports are required, the CCS Program office entering the referral shall:

   a. Request the required medical reports using the CMS Net Request Medical Report function to generate one of the following letters:

      1) Send letter entitled "C-13". If the medical report to be requested **is *not from the referral source*** and/or a CCS Program provider, a Release of Information form (C-17A) is required to obtain needed medical information.

      2) The county shall request the Release of Information form (C-17A) with enclosure letter "C 17".

   b. A CMS Net Narrative is automatically generated when a medical report has been requested. The state office or county shall notify the other office via the CMS Net web message.

4. Enter a tickler/due date in the CMS Net of **20 working days** from the date of the request to review for receipt of the medical report.

Section III.D Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

D Appendix B: 32
D Appendix G

1 Appendix B: 32
1-8 Appendix C: 13, 14

Continued: Chapter One: Referral to Decision on Case Opening - Section III: D. Medical Eligibility Determination

5. When medical reports are received, the county shall enter into the CMS Net the date the report was received using Receive Medical Report function. This entry removes the tickler date from the CMS Net Medical Report function.

6. If the medical report is not received by the tickler date, the county staff shall:

   a. Enter in the CMS Net Narrative that the medical report has not been received.

   b. Send a second (final) request letter entitled "C-14" to the medical provider.

   c. The state office or county shall notify the other office via web message.

   d. Send to the applicant a copy of the second request letter for medical reports to enlist the applicant/family's help in securing the required reports.

7. Enter a tickler/due date in the CMS Net of **20 working days** from the date of the second request to review for receipt of the medical report.

8. If the required medical report(s) has not been received by the tickler date of the second notice, the referral shall be reviewed by the medical consultant or designee for disposition of the case based on the following:

   a. If the decision by the medical consultant or designee is that medical eligibility cannot be determined because medical reports have not been received, then:

      1) The medical consultant or designee shall generate a NOA letter via the CMS Net Correspondence.

      2) Free text space is available on the NOA letter to add additional information or explanation, if necessary.

      3) A copy of the NOA without Appeal Information Process enclosure shall be sent to each provider who has requested an authorization for services.

         Reminder: notification procedures differ for PEDI providers. The PEDI providers will access the CCS Program denials via the PEDI system.

Section III.D Cross References:

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

III.D Appendix G
6 Appendix C: 13, 14

7 Appendix C: 13, 14

8 Appendix C: 13, 14

8a Appendix B: 32, 78, 79, 80
8a Appendix C: 14

[Link] to PEDI

Continued: Chapter One: Referral to Decision on Case Opening - Section III: D. Medical Eligibility Determination

4) State office or dependent county shall notify the other office on the same day the NOA was generated via the CMS Net web message.

5) If an application has not been received from the referred individual, the county shall issue a denial letter to each provider who requested authorization for service and shall:

   a) Send a copy of each letter to the referred individual.

   b) The state office or dependent county shall notify the other office on the same day the letter(s) is generated via the CMS Net web message.

Section III.D Cross References:

[Link] to CMS Net User Manuals

Chapter One: Referral to Decision on Case Opening-Section IV: A. Program Eligibility Determination

A. General Information re: Financial and Residential Eligibility Determination

1. For purposes of discussion in this manual, program eligibility refers to **financial** and **residential eligibility** for the CCS Program. The process of determining program eligibility is initiated upon receipt of a signed application and shall be performed simultaneously with the determination of medical eligibility. (Refer to Chapter One, Section II: Application Process, including the MTP and MTP-only client.)

2. Determination of program eligibility must be completed in compliance with the CCS Program regulations and numbered letters pertaining to residential and financial eligibility. Program Eligibility determination includes but is not limited to:

   a. Determination of financial and residential eligibility.

      1) Other Health Coverage

         a) The Insurance Coverage screen includes the private insurance information specific to a client. Results can be obtained by user selection/entry or through MEDS Recon monthly update. If a user has manually entered insurance and the client becomes "Active" this information is sent to MEDS and posted on the Health Insurance Segment (HIS) to assist in post payment recovery and cost avoidance.

            Reference the CMS Net Manual for insurance coverage information, including:

            - Other Health Coverage
            - Third Party Liability Information (Health and Safety Code, Section 123980)
            - Insurance transactions and reports

         Note: Contact the CCS Program Help Desk support staff at CMSHelp@dhcs.ca.gov for assistance to resolve any insurance adds/updates or insurance discrepancies for clients in our program.

   b. Referral for application to the M/C program.

   c. Completion of a signed PSA form which includes the effective date an applicant meets the CCS Program financial and/or residential eligibility.

Section IV.A Cross References:

[Link] to CMS Net User Manuals

See Legacy Manual, Section 14 for Insurance Information

1 Appendix B: 51
1-7 Appendix C: 6, 17, 21, 31, 32, 33, 35, 43, 59, 74, 75, 76, 80

2 Appendix B: 51, 54

2a Appendix B: 51

2a1 Appendix A: 123980
2a1 Appendix C: 59

2b Appendix B: 52

2c Appendix B: 51, 54

Note: Effective date an applicant meets the CCS Program financial and/or residential eligibility is based on receipt of referral or date application received if no response to first and second application letters. No PSA is to be signed by the applicant, parent or legal guardian until proof of M/C application has been received by the county program staff.

d. Explanation of the CCS Program and responding to questions from the applicant, parent or legal guardian.

3. Any applicant who may be eligible for the CCS Program is required to apply for the M/C Program (**Health & Safety Code 123995 Medi-Cal Application Requirements**). This requirement includes applicants who are POTENTIALLY eligible for M/C based on either income or a categorical program.

   a. **The applicant is not eligible for the CCS Program until the applicant, parent, or legal guardian has complied with all M/C program application requirements**.

   b. Determination by the welfare office of M/C program eligibility is **not** required prior to determining the CCS Program eligibility.

4. **Financial** eligibility determination is **not** required:

   a. for M/C FS no SOC beneficiaries when authorized by the CCS Program; **or**

   b. when services authorized by the CCS Program are limited to a diagnostic evaluation to establish a CCS Program medically eligible condition; **or**

   c. when services authorized by the CCS Program are limited to diagnostic services through the CCS High Risk Infant (HRI) Program; **or**

   d. when services are limited to the Medical Therapy Program, specifically for physical and occupational therapy and Medical Therapy Conference (MTC) services; **or**

   e. for services that are required to treat a CCS Program medically eligible condition which was present and diagnosed at the time of adoption.

Section IV.A Cross References:

[Link] to CMS Net User Manuals

1-7 Appendix C: 5, 6, 17, 21, 31, 32, 33, 35, 43, 59, 74, 75, 76, 80

2d Appendix B: 51

3 Appendix A: 123995

3a Appendix B: 51, 52

3b Appendix B: 11, 51. 54

4 Appendix B: 52

4a Appendix A: 123870

4b Appendix F: NL 12-1006

4c Appendix A : H&SC 123900
4d Appendix A : H&SC 123900

4d Health & Safety Code 123565

4e Appendix A: 123870

4f Appendix A: 123965

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: A. Program Eligibility Determination

5. **Residential** eligibility **is required** before any CCS Program funded service(s) may be authorized. As an agent of the M/C program, the CCS Program shall authorize services covered by the M/C program for FS no SOC beneficiaries when verification has been confirmed.

   a. Confirmation of M/C status and physical address may be done via MEDS.

   b. Procedures for opening a CCS Program case record for a M/C beneficiary without establishing residential eligibility are found in Chapter One, Sections I, II, III, and V of this manual.

6. Completion of a CCS PSA is required for all applicants who have been determined financially, residentially, and medically eligible for the CCS Program. The **exceptions** for the PSA requirement:

   a. M/C full scope no SOC beneficiaries.

7. To be eligible for the CCS Program, a CCS Program applicant may be required to pay an assessment fee and/or enrollment fee.

   a. The assessment fee is a sum of $20.00 (Reference: Health & Safety Code 123870(d)) that must be paid by the applicant, parent, or legal guardian **in addition** to any enrollment fee (defined in A.8 below) that is assigned.

   b. The assessment fee is:

      1) Based per family, not per applicant (or client if a sibling is already enrolled in the CCS Program). Therefore, if the family has two (2) or more children eligible for the CCS Program, a single assessment fee is collected.

      2) To be collected from the family of a CCS Program applicant:

         a) Whose income is over 100 percent of the federal poverty level, **OR**

         b) Who is eligible for M/C with a SOC or eligible for limited scope M/C, **AND**

Section IV.A Cross References

[Link] to CMS Net User Manuals

See Legacy Manual, Section 19 for Enrollment Fee and Assessment

5 Appendix B: 50
5 Appendix C: 5, 33, 43,

6 Appendix B: 17, 54
6 Appendix C: 5

7 Appendix A: 123870(d), 123900
7 Appendix B: 25, 51

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: A. Program Eligibility Determination

i. Who is receiving diagnostic services, **OR**

ii. Who is receiving treatment services, **OR**

iii. Who is receiving MTP services through a MTU or vendorized therapy services in lieu of the MTP and these services are not part of an individualized education plan (IEP).

c. An enrollment fee is required to be paid, on an annual basis, before authorizations for **treatment services** for an applicant may be issued.

1) An enrollment fee is **not** required if the:

a) Only services requested is for diagnostic services to determine medical eligibility; **OR**

b) Only service requested is for services through the MTP; **OR**

c) Client is a M/C beneficiary with FS no SOC; **OR**

d) Family of the client has gross annual income of less than 200 percent of the federal poverty level (FPL).

2) Payment of the enrollment fee is a condition of program participation for those applicants not identified in b.1. above and is independent of the assessment fee. It is the county's responsibility to determine who is required to pay the enrollment fee.

3) Appeal of the enrollment fee must be submitted in writing to the county.

4) Determination of the enrollment fee is based on:

a) "family size," based on the definition of family stated in the Health & Safety Code 123900. The following people are listed as family and shall be counted: the applicant, his or her natural or adoptive parents, sibling(s), and other family members who live together and whose expenses are dependent upon the family income.

b) the "family income," which is the family's gross income, or total income reported on the federal income tax form 1040 or 1040A. If income tax statements are not available, it is permissible to use other verification of income.

Section IV.A Cross References

[Link] to CMS Net User Manuals

See Legacy Manual, Section 19 for Enrollment Fee and Assessment

7c1c Appendix C: 5, 17, 21

7c1d Appendix C: 32

7c2 Appendix B: 55, 57

7c3 Appendix B: 55

7c4 Appendix B: 25, 51, 55

7c4a Appendix A: 123900

7c4b Appendix B: 25, 51, 55

Chapter One: Referral to Decision on Case Opening-Section IV: B. Program Eligibility Determination

B. Procedures for Program Eligibility Determination

1. The CCS county Program staff shall:

   a. Send the initial contact letter C-16 via the CMS Net Financial/Residential Eligibility function, and the CCS Program Health Insurance Form MC 2600, within **five (5) calendar days** from the receipt of the signed application.

   b. Enter "T + 15" in the CMS Net Financial/Residential Eligibility function, Pending Interview Status, Next Review Date field, to establish a tickler date of **15 calendar days** from the date the initial contact letter was mailed.

   c. Send a second letter entitled C-16A (Second Notice) within **five (5) calendar days** if no response is received by the tickler date of **15 calendar days** from the date the second notice was mailed. Enclose the CCS Program Health Insurance Form MC 2600.

   d. Enter "T + 15" in the CMS Net Financial/Residential Eligibility function, Pending Interview Status, Next Review Date field, to establish a tickler date of **15 calendar days** from the date the second notice was mailed.

   e. Send C-16B, the final notice, within **five (5) calendar days** of the tickler date. The C-16B is a Notice of Action (NOA) Letter with a second page, Appeal Process Information, providing a description of the CCS Program appeal process. Completion of the C-16B as a NOA letter requires the responsible staff member to:

      1) Insert the selected explanation/citation from the NOA Explanation/Citation List.

      2) Type in the free text space the effective date that the CCS Program will not be able to authorize services that have been requested. This date is usually the referral date.

      3) If the referral which started the CCS Program application process was submitted by a medical provider, a copy of the NOA, without the Appeal Process Information enclosure, is to be sent to that specific provider by the county staff member preparing the NOA. County or state office staff shall notify any other medical providers who may have submitted a request for the CCS Program services after receipt of the referral. (See notification instructions in 2.C below.)

Section IV.B Cross References:

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

B Appendix G

1-8 Appendix C: 14, 15, 49

1e Appendix B: 78, 79, 80

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: B. Program Eligibility Determination

4) The enclosure, Appeal Process Information, will automatically print with the applicant's name and other identifying information. The enclosure page must be mailed with the NOA to the applicant.

5) Update the CMS Net Financial/Residential Status field to "INELIGIBLE".

6) The state office or dependent county to notify the other office via web message at the time the NOA letter is mailed.

2. Within **ten (10) working days** of the date on the NOA letter (C-16B), the county shall:

   a. Update the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INELIG) status field to "INELIGIBLE".

   b. Update the CMS Net Registration status to "DENIED".

   c. Send copies of the NOA (C-16B) without the Appeal Process Information enclosure to all medical providers who have requested services except for the referring medical provider who received a copy of the NOA sent out by the CCS county program staff.

   Reminder: Notification procedures differ for PEDI providers.

3. For the applicant or parent/legal guardian who responds to the contact letter, the CCS county program staff shall schedule and conduct a program eligibility interview following the guidelines described in the CCS Program regulations.

   Note: The CCS Program regulations allow for completion of program eligibility by mail.

4. When determination is made that the applicant does not meet the CCS Program residential and/or financial eligibility requirements or fails to comply with submission of required documents (including the MTP and MTP-only client), he/she shall be informed via a NOA letter with the Appeal Process Information enclosure which provides a description of the CCS Program appeal process. Completion of a NOA letter requires the responsible CCS county program staff member to:

   a. Update the CMS Net Financial/Residential status field to "INELIGIBLE".

   b. Generate a NOA letter via CMS Net WEB Correspondence function:

Section IV.B Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

IV.B Appendix G

2 Appendix C 14, 15, 49

[Link] to PEDI

3 Appendix B: 31
3 Appendix C: 14, 15, 49

4 Appendix B: 78, 79, 80
4 Appendix C: 14, 15, 49

4b Appendix C: 14

1) Choose the appropriate NOA from the NOA Explanation and Citations List. Refer to the CMS Net, SAR/Web Manual, letter templates.

2) Type in the free text space the effective date that the CCS Program will not be able to authorize services that have been requested. This is usually the referral date.

3) Free text space is available on the NOA letter to add additional information or explanation, if necessary.

4) Send a copy of the NOA letter without the Appeals Process Information enclosure to the referral sources if the referral source is a medical provider to whom the CCS Program would authorize a medical service.

   a) The county shall send copies of the NOA letter to all other medical providers who requested service authorizations and who do not have PEDI access.

   b) If the referral to the CCS Program was from a school nurse, regional center counselor, etc., unless a release of information was included for the referral source, HIPAA privacy rules preclude a letter being sent to the referral source.

c. The Appeal Process Information enclosure will automatically print with the applicant's name and other identifying information. This enclosure must be mailed with the NOA to the applicant. The enclosure page is NOT to be sent to the medical provider who is being notified by the CCS county program staff that the CCS Program eligibility is being denied.

d. The state office or dependent county to notify the other office via web message at the time the NOA letter is generated.

5. Within **ten (10) working days** from the NOA date, the county shall:

   a. Update the Establish Medical Eligibility/Ineligibility status field to "INELIGIBLE".

   b. Update the CMS Net Registration status to "DENIED".

   c. Send copies of NOA, without the Appeal Process Information enclosure, following instructions in 2.c. above, to all medical providers who requested services **except** for the referring medical provider notified by the CCS county program staff. (Refer to B.1.e.3 above.)

Section IV.B Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

IV.B Appendix G

4 Appendix C: 14, 15, 49

5 Appendix C: 14, 15, 49

6. The following activities must be completed by the CCS county program upon determination of program eligibility:

   a. The applicant, parent, or legal guardian shall sign a PSA.

      Note: No PSA is to be signed by the applicant, parent, or legal guardian until proof of M/C application completion has been received by the county.

   b. Update the CMS Net Financial/Residential Eligibility Status field with the appropriate eligibility status.

   c. Dependent county to notify the state office of the completion of the program eligibility determination via web message.

7. When a M/C FS no SOC beneficiary has also met the CCS Program eligibility requirements and the applicant, parent, or legal guardian, has signed a CCS PSA, the CCS county program shall:

   a. Update the CMS Net Financial/Residential Eligibility status field with the appropriate eligibility status.

   b. Dependent county to notify the state office via web message that the PSA is signed.

8. Within **ten (10) working days** of notification of determination of program eligibility, the county or state office shall review to determine if:

   a. The applicant has been determined medically **eligible**. The case may then be opened following procedures in Chapter One, Section V, Case Opening and Reopening.

   b. The applicant has been determined to be medically **ineligible**. Follow the procedures in Chapter One, Section III, Medical Eligibility Determination for notification of applicant and provider of eligibility decision.

Section IV.B Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

IV.B Appendix G

6 Appendix B: 54
6 Appendix C: 14, 15, 49

7a Appendix C: 38

8a Appendix B: 32

8b Appendix B: 78, 79, 80
8b Appendix C: 14

Chapter One: Referral to Decision on Case Opening - Section IV: C. Program Eligibility Determination

C. Referral for application to the Medi-Cal Program as part of program eligibility interview

1. Upon determination that the applicant **must** apply for the M/C program, the CCS county program shall:

   a. Inform the applicant or parent/legal guardian that to be eligible for the CCS Program the applicant must complete an application to the M/C program. Application to the M/C program is defined as completing all necessary steps (i.e., submitting required forms, financial information, etc.) that are requested by the county responsible for M/C eligibility determination.

   b. Have the applicant or parent/legal guardian sign the CCS Program M/C Application Agreement Form. Inform the applicant or parent/legal guardian that the form is to be returned when M/C application requirements have been completed. The CCS Program M/C Application Agreement form:

      1) Acts as a written notice for the applicant to apply for the M/C program.

      2) Constitutes notification to the family that the CCS Program will not authorize medically necessary services until there is a confirmation that the applicant/family has complied with the M/C program application requirements, including submitting all required documents to the county department responsible for determination of M/C eligibility.

   c. Record in the CMS Net Case Notes if:

      1) The M/C Application Agreement form was signed by the applicant or parent /legal guardian and the date for expected completion of the application process, **OR**

      2) If an applicant or parent/legal guardian states that he/she refuses to comply with the M/C application requirements, request that he/she sign the M/C Application Agreement form indicating acknowledgement that refusal means the applicant **is not** eligible for the CCS Program.

      3) If the applicant or parent/legal guardian refuses to sign the form, record in the CMS Net case notes the statement made by the applicant or parent/legal guardian that he/she was verbally informed that refusal to apply for M/C means the applicant **is not** eligible for the CCS Program.

Section IV: C Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

1 Appendix B: 11, 52
1-3 Appendix C: 17, 20,21, 35
1 Appendix F: CMS I.N. 12-04: HF Transition to M/C
1a Appendix B: 51
1a Appendix C: 20, 21, 35, 46, 52, 53

1b Appendix B: 52

1b2 Appendix C: 35

1c Appendix B: 29

1c2 Appendix C: 35

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: C. Program Eligibility Determination

a) Establish a tickler date of **ten (10) working days** to check if applicant or parent/legal guardian changes his/her mind and proceeds with application to M/C.

b) If no information is received by the **ten-day tickler date**, send a NOA letter citing the appropriate reason from the NOA Explanation Citation List. Follow instructions in Chapter One, Section IV.B-4 for sending the NOA letter.

d. Upon obtaining a signature of intent to apply for M/C, update the status of FIN/RES Eligibility, Program Eligibility Status function to "Pending Medi-Cal."

e. Inform the applicant, parent or legal guardian that application to M/C must be completed within **60 calendar days** and:

1) Provide a copy of the CCS Program M/C Application Agreement to the applicant, parent/legal guardian to take to the appropriate county department responsible for M/C program determination.

2) Establish a tickler date **60 calendar days** from the date the applicant or parent/legal guardian has been referred to M/C to complete an application.

3) File the signed, original CCS Program M/C Application Agreement form in the applicant's case notes.

f. Monitor on a periodic basis the M/C application status of the applicant. The CMS Net narrative entries shall be made to document the progress (or lack thereof) of the follow-through with the M/C application process.

g. Upon receipt of evidence that the M/C application requirements have been met by the applicant:

1) Update the CMS Net Financial/Residential Eligibility status field to the appropriate status (Refer to the CMS Net Manual.).

2) Dependent county to notify the state office via the CMS Net web message.

Section IV.C Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

IV.C Appendix G

1-4 Appendix C: 17, 20,21, 35
1c3b Appendix B: 78, 79, 80

1c3e Appendix C: 35

1c3f Appendix C: 35

1c3g Appendix C: 35

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: C. Program Eligibility Determination

h. If the applicant or parent/legal guardian did not complete the M/C application requirements, generate a NOA via the Web Correspondence denying the CCS Program eligibility. Follow the instructions in Chapter One, Section IV, 5.B.4 for sending a NOA letter. Dependent county to notify the state office staff via the CMS Net web message.

2. Within **ten (10) working days** from the NOA notification date for failure to complete M/C application requirements, the CCS county program staff shall:

   a. Update the CMS Net function Establish Medical Eligibility/Ineligibility status field to "INELIGIBLE."

   b. Update the CMS Net Registration status to "DENIED."

   c. Follow instructions in Chapter One, Section IV, B.2 for notifying providers and denying requests for services that have been entered into the CMS Net.

      Reminder: notification procedures differ for PEDI providers.

3. The following activities must be completed by the CCS county program staff upon determination of program eligibility based on receipt of evidence that M/C application requirements have been met by the applicant.

   a. Update the CMS Net Financial/Residential Eligibility function to the appropriate eligible status.

   b. Dependent county to notify the state office via the CMS Net web message.

Section IV.C Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

IV.C Appendix G

1h Appendix B: 78, 79, 80

2 Appendix C:17, 20,21, 35

[Link] to PEDI

3 Appendix C:17, 20,21, 35

Chapter One: Referral to Decision on Case Opening - Section IV: D. Program Eligibility

D. Determination of the Enrollment Fee as Part of the Program Eligibility

1. The CCS county program shall determine the amount of the enrollment fee due for the period to be covered by the PSA as part of the program eligibility interview.

   a. Information provided by the applicant or parent/legal guardian on family size and income at the time of the program eligibility interview must be reviewed to determine if the applicant is required to pay the CCS Program Enrollment fee. If any of the following apply to the client, **NO** annual enrollment fee is required:

      1) The service being requested is limited to diagnostic services; **OR**

      2) The only service requested is for services through the MTP; **OR**

      3) The client is M/C FS no SOC beneficiary; **OR**

      4) The family of the client has a gross annual income of less than 200% of the federal poverty level (FPL).

   b. Upon determination that an enrollment fee is required, the applicant, parent, or legal guardian is informed that the:

      1) Amount of the fee due is based on the CCS Program Annual Enrollment Fee Schedule(Refer to CCR, T22, Sections 41479 and 41610).

      2) Enrollment Fee is due on the date the program eligibility is established. The applicant, parent or legal guardian is to be encouraged to pay the full enrollment fee in a single lump-sum payment. If periodic payments are agreed to by the CCS county program staff, the applicant, parent, or legal guardian is to be informed that:

         a) The due date for payment of the entire enrollment fee is due within **60 days** of this date.

         b) Failure to pay by the **60th day** will result in the applicant's case being closed to the CCS Program.

Section IV.D Cross References:

[Link] to CMS Net User Manuals

See Legacy Manual, Section 19 for Enrollment Fee and Assessment

D Appendix G
1-3 Appendix C: 6
1a Appendix B: 25, 51
1a Appendix C: 16, 17

1a4 Appendix C: 5, 16, 17

1a5 Appendix C: 5, 6, 32

1b Appendix B: 25, 55, 56, 57

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: D. Program Eligibility

c. Any documents that are signed by the applicant or parent/legal guardian relating to the payment agreement entered into with the CCS county program are to be filed in the applicant's chart maintained by the county.

d. Collect the enrollment fee and record the payment in the CMS Net Financial/Residential Eligibility function, Enrollment Fee and Comments field. If arrangements for payment of the Enrollment Fee are made, the amount to be paid, dates payable, and final due date are to be entered in the Enrollment Fee and Comment field.

e. A tracking system is to be set up for the applicant or parent/legal guardian who has arranged for periodic payments to provide for:

   1) Sending of a billing statement containing the total amount of the enrollment fee with the following information:

      a) Amount paid to date;

      b) Amount due and the due date;

      c) A statement that failure to pay the enrollment fee will be cause to be found financially ineligible and the CCS Program services will be terminated if the amount due is **not** paid within **60 calendar days** of the due date.

f. Send three billing statements starting with the first statement **30 calendar days** after the enrollment fee is due; second statement **45 days after** the enrollment is due. The third and final statement if the total enrollment fee has not been **paid by the 60th day** is a NOA. Generate a NOA letter via the CMS Net Web Correspondence. .

   1) Choose the appropriate NOA from the NOA Explanation and Citations List.

   2) Type in the free text space the effective date of the action. This date is the final date the enrollment fee was due.

   3) The Appeal Process Information enclosure will automatically print with the applicant's name and other identifying information. The enclosure page must be mailed with the NOA to the client.

      Reminder: Notification procedures differ for PEDI providers.

Section IV.D Cross References

[Link] to CMS Net User Manuals

See Legacy Manual, Section 19 for Enrollment Fee and Assessment

See Web Manual, Section 34 for Letters and Notices

IV.D Appendix G

1c Appendix B: 29
1d Appendix B: 56, 57
1e Appendix B: 57

1f Appendix B: 57, 78, 79, 80

[Link] to PEDI

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: D. Program Eligibility

4) Update the CMS Net Program Eligibility status field to "INELIGIBLE."

5) Dependent county to notify state office staff via the CMS Net web message at the time the NOA letter is mailed.

6) Reapplication to the CCS Program will require the applicant or parent/legal guardian to fully pay the outstanding enrollment fee debt which will result in a new effective date of coverage.

2. If the applicant or parent/legal guardian has failed to comply with the enrollment fee requirements, within **ten (10) working days** of the date on the NOA letter, the CCS county program shall:

   a. Update the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INELIG) Status field to "DENIED."

   b. Update the CMS Net Registration Status field to "DENIED."

   c. Send deny request letter, via "DENY REQUEST" function, to all providers who requested services.

   d. Dependent county to notify state office via web message when letter is sent.

3. A reconsideration of the enrollment fee based on a request to waive or reduce the amount by the applicant or parent/legal guardian shall be submitted to the county health department director or designee who is responsible to determine if the enrollment fee will result in undue hardship for the family.

   a. Any request for reconsideration of the enrollment fee must be submitted in writing by the applicant or parent/legal guardian to the CCS county program and must include:

      1) Name of the applicant;

      2) Name of the parent(s) or legal guardian;

      3) Explanation of any reduction in family income or unavoidable family expenditures which support reconsideration of waiving the enrollment fee.

Section IV.D Cross References

[Link] to CMS Net User Manuals

See Legacy Manual, Section 19 for Enrollment Fee and Assessment

See Web Manual, Section 34 for Letters and Notices

IV.D Appendix G

2 Appendix B: 78, 79, 80

3 Appendix B: 55, 57

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: D. Program Eligibility

b. The CCS county program shall enter in the CMS Net Financial/Residential Eligibility function, Enrollment Fee and/or Reason Not Collected field the decision made by the county health department director or designee the determination made to reduce, waive, or maintain the enrollment fee. The decision made by the county health department director may result in issuing of a NOA (see D.1.f. above).

1) Update the CMS Net Financial/Residential Eligibility function of the appropriate eligible status.Refer to the CMS Net Manual for complete instructions.

2) Dependent county to notify the state office via the CMS Net web message.

Section IV.D Cross References

[Link] to CMS Net User Manuals

See Legacy Manual, Section 19 for Enrollment Fee and Assessment

3b Appendix B: 78, 79, 80

Chapter One: Referral to Decision on Case Opening-Section IV: E. Program Eligibility Determination

E. Determination of the Assessment Fee

1. The CCS county program shall determine if the family is required to pay the $20.00 assessment due based on application to the CCS Program.

   a. Information provided by the applicant, parents/legal guardian at the time of program eligibility determination is reviewed to determine if the CCS Program assessment fee will be collected from the family of an applicant. The assessment must be collected if:

      1) The family income is over 100 percent of the federal poverty level; **OR**

      2) The applicant is eligible for M/C with a share of cost or eligible for limited scope M/C **AND** is receiving:

         a) diagnostic services; **OR**

         b) treatment services; **OR**

         c) Medical Therapy Program (MTP) services through a Medical Therapy Unit (MTU) or vendorized therapy services in lieu of the MTU that are NOT part of an individualized education plan (IEP).

   b. Upon determination that the assessment is due, the applicant or parent/legal guardian is informed:

      1) The assessment fee is due the date program eligibility is determined.

      2) That failure to pay the assessment fee will cause the applicant to be ineligible for the CCS Program and services will not be authorized.

   c. If the family fails to pay the assessment and thus is not eligible for the CCS Program, a NOA is generated via the CMS Net Web Correspondence.

      1) Choose the appropriate NOA from the NOA Explanation and Citations List.

Section IV.E Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

1 Appendix A: 123870
1-3 Appendix C: 6

1a1 Appendix B: 31

1a2 Appendix A: 123870
1a2 Appendix C: 17, 18

1a3 Appendix B: 123870

1b Appendix B: 57

1c Appendix B: 78, 79, 80

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: E. Program Eligibility Determination

2) Type in the free text space the effective date that the CCS Program will cancel open authorizations for services. This date is the final date that the assessment fee was due.

3) Reapplication to the program will require the applicant, parent, or /legal guardian to fully pay the outstanding assessment fee and will result in a new effective date of coverage.

4) The Appeal Process Information enclosure will automatically print with the applicant's name and other identifying information. The enclosure page must be mailed with the NOA to the client.

Reminder: Notification procedures differ for PEDI providers.

5) Update the CMS Net Program Eligibility status field to "INELIGIBLE."

6) Dependent county to notify state office via web message at the time the NOA is mailed.

2. If the applicant, parent, or legal guardian has failed to comply with the assessment fee requirements, within **ten (10) working days** of the date on the NOA letter, the county or state staff shall:

   a. Update the CMS Net Establish MED ELIG/INELIG Status field for "INELIGIBLE."

   b. Update the CMS Net Registration Status field to "DENIED."

   c. Send "DENY REQUEST" letter to all providers who requested services.

3. A reconsideration of the assessment fee based on a request to waive or reduce the amount by the applicant or parent/legal guardian shall be submitted to the county health department director or designee who is responsible to determine if the assessment fee will result in undue hardship to the family.

   a. Any request for reconsideration of the assessment fee must be submitted in writing by the applicant, parent, or legal guardian to the CCS county program and must include:

      1) Name of the applicant; and

      2) Name of the parent(s) or legal guardian; and

Section IV.E Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

IV.E Appendix G

1c3 Appendix B: 57

2 Appendix C: 6, 14

3 Appendix B: 55, 57
3 Appendix C: 6, 14

Continued: Chapter One: Referral to Decision on Case Opening - Section IV: E. Program Eligibility Determination

3) Explanation of any reduction in family income or unavoidable family expenditures which support reconsideration of waiving the assessment fee.

b. County shall enter in the CMS Net Financial/Residential Eligibility function, Enrollment Fee and/or Reason Not Collected field the decision made by the county health department director or designee the determination made to reduce, waive, or maintain the enrollment fee. The decision made by the county health department director may result in issuing a NOA (see E.1.c above).

1) Update the CMS Net Financial/Residential Eligibility function of the appropriate eligible status.

2) Dependent county to notify the state office via the CMS Net web message.

Section IV.E Cross References

[Link] to CMS Net User Manuals

3b Appendix B: 78, 79, 80

Chapter One: Referral to Decision on Case Opening - Section V: A. Case Opening and Reopening

A. General Information regarding Case Opening and Reopening

1. A CCS Program case shall be opened when the eligibility criteria requirements have been met for the services to be authorized for the CCS Program or for the services of the MTP. The CCS Program case is opened and assigned a permanent CCS number when:

   a. A M/C FS no SOC beneficiary has been determined to be medically eligible.

   b. A CCS Program applicant has been determined residentially eligible and:

      1) has a suspected CCS Program eligible medical condition and a diagnostic evaluation is needed to establish medical eligibility; **OR**

      2) services to be authorized are limited to the CCS HRI Program benefits; **OR**

      3) medical eligibility for the MTP has been established and the CCS Program services will be limited to those usually available at a Medical Therapy Unit (MTU). These services are physical therapy, occupational therapy, and Medical Therapy Conference (MTC).

   c. A CCS Program applicant has been determined to be medically, residentially, and financially eligible and the applicant or parent/legal guardian has signed both a CCS Program application and a PSA.

2. Authorization for medical services cannot be issued until medical eligibility has been established and the case is opened.

3. A CCS Program case that has been closed may be “Reopened” when:

   a. A referral has been received on a former CCS Program client who had been assigned a CCS case number and whose case was subsequently closed.

   b. The former client is either:

      1) Assigned the CCS case number used prior to closure if the CCS number can still be found, either in the State Patient History file or in the CMS Net; or

Section V.A Cross References:

[Link] to CMS Net User Manuals

1 Appendix B: 32, 39, 50, 51

1a Appendix B: 31, 54
1a Appendix C: 59

1c Appendix B: 31, 54
1c Appendix G: NL 06-0394

2 Appendix B: 32
2 Appendix E

3 Appendix B: 32, 39, 50, 51

2) Assigned a new CCS case record number at the time of the case reopening if the prior case record cannot be found.

c. The former client meets one of the eligibility criteria in 1.a-c above. See Section V.C below.

Section V.B Cross References:

[Link] to CMS Net User Manuals

See Legacy Manual for Registration Procedures

Chapter One: Referral to Decision on Case Opening - Section V: B. Opening a Case

B. Opening a Case

1. Upon determination that a case may be opened to the CCS Program based on meeting one of the eligibility criteria in A.1.a-d, the CCS county program shall:

   a. Change the CMS Net Registration Status field, from “Pending” to “Active.”

   b. Change the CMS Net temporary case number to a permanent case number.

   c. Update the ICD code, if necessary. (Make sure ICD is not “Undiagnosed Condition.)

   d. Enter in the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INELIG) function the effective date of eligibility:

      1) Eligibility date will be initial date of referral to the CCS Program; **OR**

      2) If the client, parent, or legal guardian applied after the application deadline, then the eligibility date will be the date the signed application was received at the CCS Program office; **OR**

      3) In instances where prior authorization has not been requested.
      For example - emergency services: The CCS Program services may be authorized providing the request is submitted during the first day the CCS Program office was open following the time the service was provided**.** Refer to CCR, Title 41770 regarding Prior Authorization**.**

      Note: Exception to eligibility date (as noted in B.1. d.1-3 above) may be determined by the medical consultant or designee when appropriate.

   e. Enter in the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INELIG) function the appropriate case eligibility status as determined by the medical consultant/designee.

      1) “**Diagnostic**” – when the CCS Program authorization will be limited to services to confirm a suspected medically eligible condition treatment or authorization will be issued limited to the CCS HIR Program benefits and there is:

         a) Confirmation of a M/C full scope no SOC beneficiary; **OR**

         b) A signed CCS Program application on file.

Section V.B Cross References:

[Link] to CMS Net User Manuals

See Legacy Manual for Registration Procedures

1d3 Appendix B: 32, 63

1e1 Appendix B: 65

Continued: Chapter One: Referral to Decision on Case Opening - Section V: B. Opening a Case

2) **Treatment** – when an authorization will be issued for treatment of a CCS-medically eligible condition or a client is medically eligible to receive services through the MTP **AND** the client:

a) Is a M/C FS no SOC beneficiary; **OR**

b) Has a signed CCS Program application and PSA on file.

f. A M/C FS no SOC beneficiary may be assigned a permanent CCS case number upon confirmation of M/C coverage and determination of medical eligibility. The designation of "Diagnostic" or "Treatment" is determined by the medical consultant or designee.

Reminder: For M/C FS no SOC beneficiary, no signed application or PSA is required to open and authorize services. All such authorizations are issued with a statement that authorizations are subject to continued M/C eligibility and M/C benefits or Refer to the CMS Net Manual – Special Language section.

2. If the applicant has been determined to be medically eligible for MTP services but does not meet other program eligibility requirements, the case is opened under the case eligibility status "Treatment."

a. No authorizations are required for a client receiving clinic conferences or therapy services at a MTU.

b. When a MTP client requires therapy services not available at the MTU, an authorization for these services must be issued as "vendored therapy in lieu of MTP services."

c. Enter in the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INEL) the name of the MTU **OR** if no MTU in the county, "Eligible for MTP but MTU not Selected."

d. Enter the CMS Net Registration function the case status and type "Y" in MTU ONLY Field. This confirms the CCS Program eligibility is limited to services through the MTP.

Section V.B Cross References:

[Link] to CMS Net User Manual

See Legacy Manual for Registration Procedures

1e2 Appendix B: 66

2 CMS Manual of Procedures, Chapter 4, MTP Services
2 Appendix B: 39, 52
2 Appendix E: MTP

Chapter One: Referral to Decision on Case Opening - Section V: C. Reopening Cases

C. Reopening Case

1. Upon receipt of a referral requesting the CCS Program services on a previously closed case follow the instructions in Chapter One, Sections I, Referral: Section II, Application Process; and Section III, Medical Eligibility Determination.

   a. Search for previous CCS case number through the State Patient Transaction File or the CMS Net.

   b. A new application is required (including the MTP and MTP-only client), and program eligibility must be re-established.

   c. Request medical reports using the same procedures as for a new referral found in Chapter One, Section III: Medical Eligibility Determination.

   d. The CCS Program office receiving the referral shall update the CCS case status to “Reopen Pending” in the CMS Net Registration and update the REF/TRF date field.

2. When a case to be reopened meets the requirements in Chapter One, Sections I, II, III, and IV, the CCS county program shall:

   a. Enter in the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INELIG) field the new eligibility date and case status, “Diagnostic” or “Treatment”, as defined in B.1.d. above

   b. When updating the CMS Net, the eligibility date must be at least one day after the closure date.

   c. Update the Patient Registration function Status field to “ACTIVE” and change any other client fields, as appropriate.

Section V.C Cross References

[Link] to CMS Net User Manuals

See Legacy Manual for Registration Procedures

1c Appendix B: 32

End of Chapter One
Next page begins Chapter Two

Chapter Two: Ongoing Case Management - Section I: A. Annual Program Re-determination

A. General Information

1. For purpose of discussion in this manual, program eligibility refers to financial and residential eligibility for the California Children's Services (CCS) Program.

2. The process for determination of program eligibility must be done on an annual basis for the CCS Program enrolled clients. The annual redetermination should be completed by the date the previous PSA expires.

3. Annual redetermination of program eligibility must be completed in compliance with the CCS Program regulations and current policies, which includes but is not limited to:

   a. Redetermination of financial and residential eligibility

   b. Referral for application to the M/C program, if necessary (see #4 below)

   c. Completion of a signed PSA form which includes the effective dates for the next annual review period.

      Note: A Renewed PSA is **NOT** to be signed by the client, parent, or legal guardian until proof of completion of the M/C application has been received by the county program staff.

   d. Providing information on the CCS Program and responding to questions from the client, parent or legal guardian.

4. Any client who may be eligible for the CCS Program is required to apply for the M/C program to comply with the M/C application requirement. **(Reference: H&SC, 123995, M/C Application Requirements)**. This requirement includes clients who are POTENTIALLY eligible for the M/C program based on either income or a categorical program. The client may be determined to not have continuing eligibility for the CCS Program if the client, parent, or legal guardian has not complied with all M/C program application requirements.

5. If the client is a M/C beneficiary, FS no SOC, for whom no CCS Program application or PSA is on file,the annual redetermination shall consist of verification of current M/C status.

Section I.A Cross References:

[Link] to CMS Net User Manuals

Refer to Legacy Manual, Sections 12 and 13 for Financial and Residential Worksheets

1 Appendix B: 3, 50, 52
1-7 Appendix C: 6, 14,16,17, 22, 26, 30 31, 32, 33, 35, 38, 51, 52, 53, 54, 57, 58, 69, 70, 81

2 Appendix B: 51, 54

3 Appendix C: 6, 26, 30

3a Appendix B: 31, 50, 51, 52

3b Appendix B: 51, 52

3c Appendix B: 54

3d Appendix B: 31

4 Appendix A: 123995
4 Appendix B: 52

1-7 Appendix C: 6, 14,16,17, 22, 26, 30, 31, 32, 33, 35, 38, 51, 52, 53, 54, 57, 58, 69, 70, 81

5 Appendix A: 123900(f)

Continued: Chapter Two: Ongoing Case Management - Section I: A. Annual Program Re-determination

6. Clients receiving the following CCS Program services are **not** required to meet the CCS Program financial eligibility requirements:
   a. The CCS Program authorized services limited to the CCS High Risk Infant (HRI) program.
   b. The CCS Program authorized services limited to physical and occupational therapy and Medical Therapy Conference (MTC) services through the Medical Therapy Program (MTP).
   c. Services authorized by the CCS Program for a client who is adopted and when the services are to treat the medically eligible condition which was present and diagnosed at the time of adoption.

7. To be eligible for the CCS Program, a CCS Program client may be required to pay an assessment fee and/or an enrollment fee on an annual basis.
   a. The assessment fee is a sum of $20.00 (Reference: Health and Safety Code 123870(d) that must be paid by the client, parent, or legal guardian **in addition** to any enrollment fee (defined in A.8, below) that is assigned.
   b. The assessment fee is:
      1) Based per family, not per client. Therefore, if the family has two or more children eligible for the CCS Program, a single assessment fee is collected.
      2) To be collected from the family of the CCS Program clients:
         a) Whose income is over 100 percent of the federal poverty level, **OR**
         b) Who are eligible for M/C with a share of cost or eligible for limited scope M/C, **AND**
            i. Who are receiving diagnostic services, **OR**
            ii. Who are receiving treatment services, **OR**
            iii. Who are receiving MTP services through a Medical Therapy Unit (MTU) or vendorized therapy services in lieu of the MTU and these services are NOT part of an individualized education plan (IEP).

Section I.A Cross References

[Link] to CMS Net User Manuals

See Legacy Manual, Section 19 for Enrollment Fee and Assessment

6 Appendix A: 123870
6 Appendix C: 5, 16, 17
6-7 Appendix C: 6, 14, 16, 17, 22, 26, 30, 31, 32, 33, 35, 38, 51, 52, 53, 54, 57, 58, 69, 70, 81

7 Appendix A: 123900
7 Appendix B: 55, 56, 57
7a Appendix B: 32
7b Appendix A: 123870(d)
7c Appendix A: 123965
7c Appendix B: 25, 51, 55

8a Appendix A: 12870(d)

8b Appendix A: 25, 52, 55

8b1 Appendix A: 123900

8b2 Appendix B: 55, 56.57

c) An enrollment fee is required to be paid on an annual basis, before authorizations for treatment services for a client may be issued.

1) An enrollment fee is not required if the:

   a) Only service requested is for diagnostic services to determine medical eligibility, **OR**

   b) Only service requested is for services through the MTP, **OR**

   c) Client is a M/C beneficiary, FS no SOC, **OR**

   d) Family of the client has a gross annual income of less than 200 percent of the federal poverty level (FPL).

2) Payment of the enrollment fee is a condition of program participation for those clients not identified in b.1) above and is independent of the assessment fee. It is the county's responsibility to determine who is required to pay the enrollment fee.

3) Appeal of the enrollment fee must be submitted in writing to the county.

4) Determination of the enrollment fee is based on:

   a) "family size," based on the definition of family stated in the H&SC 123900. The following people are listed as family and shall be counted: the client, his or her natural or adoptive parents, sibling, and other family members who live together and whose expenses are dependent upon the family income.

   b) the "family income," which is the family's gross income, or total income reported income on the federal income tax form 1040 or 1040A. If income tax statements are not available, it is permissible to use other verification of income.

Section I.A Cross References

[Link] to CMS Net User Manuals

See Legacy Manual, Section 19 for Enrollment Fee and Assessment

8c1a Appendix B: 51

8c1b Appendix A: 123870

8c1c Appendix A: 123870
8c1c Appendix C: 5

8c1d Appendix A: 123900

8c2 Appendix A: 123900

8c3 Appendix B: 55, 57

8c4 Appendix A: 123870, 123900

8c4a Appendix A: 123900(c)

8c4b Appendix A: 123900(d)

Chapter Two: Ongoing Case Management - Section I: B. Annual Program Re-determination

B. Procedures for Annual Eligibility Redetermination

1. The county staff shall:

   a. Change the Program Eligibility date to the Annual Renewal Date. The dependent county shall notify the state office, via the CMS Net web message, that the annual review process is started.

   b. Update the Program Eligibility status to Pending Interview and send the program eligibility redetermination contact letter, C-38 and the CCS Program Health Insurance Form, MC 2600 within **60 calendar days** prior to the date the PSA is due to expire.

   c. Enter "T+15" in the CMS Net Financial/Residential/Eligibility function, Pending Interview Status, Next Review Date field to establish a tickler date of **fifteen (15) calendar days** from the date the initial contact letter was mailed.

   d. Send a second letter entitled C-38A, Second Notice, within **five (5) calendar days** if no response is received by the tickler date of **fifteen (15) calendar days**. Enclose the CCS Program Health Insurance Form, MC 2600.

   e. Enter "T+15" in the CMS Net Financial/Residential Eligibility function Pending Interview Status, Next Review Date field, to establish a tickler date of **fifteen (15) calendar days** from the date the second notice letter was mailed.

   f. Send the C-38B, Final Notice letter, within **five (5) calendar days** of the tickler date if no response is received. C-38B is a NOA letter with an Appeal Process Information enclosure, which provides a description of the CCS Program appeal process. Completion of the C-38B as a NOA letter requires the responsible staff member to:

      1) Type in the free text space the effective date that the CCS Program will cancel open authorization for services. This date is the date the current PSA expires.

      2) The Appeal Process Information enclosure will automatically print with the client's name and other identifying information. The enclosure page must be mailed with the NOA to the client.

Section I.B Cross References:

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

B Appendix G

1 Appendix B: 51

1f Appendix B: 78, 79, 80
1f Appendix C: 14

1f2 Appendix C: 51

Continued: Chapter Two: Ongoing Case Management - Section I: B. Annual Program Re-determination

3) Update the CMS Net Program Eligibility status field to “INELIGIBLE”.

4) Dependent county to notify the state office staff via the CMS Net web message at the time the NOA letter (C-38B) is mailed.

2. If a NOA is mailed, within **ten (10) working days** of the date on the NOA letter (C-38B), the CCS county program shall:

   a. Update the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INELG) Status field to “CLOSED.”

   b. Update the CMS Net Registration status to “CLOSED.”

   c. Send copies of the NOA (C-38B) without the Appeal Process Information enclosure to all medical providers who have open authorizations for services.

3. For the client, parent, or legal guardian who responds to the contact letter, the CCS county program shall schedule and conduct a program eligibility redetermination interview following the guidelines in the CCS Program regulations and current policies.

4. When the county staff determines that the client no longer meets the CCS Program residential and/or financial eligibility requirements or has failed to comply with timelines for submissions of required documents, the client shall be informed via a NOA letter with the Appeal Process Information enclosure, which provides a description of the CCS Program appeal process. Completion of a NOA letter requires the responsible CCS county program staff member to:

   a. Update the CMS Net Program Eligibility status field to “INELIGIBLE.”

   b. Generate a NOA letter via the CMS Net Web Correspondence function.

      1) Choose the appropriate NOA from the NOA Explanation and Citations List.

      2) Type in the free text space the effective date that the CCS Program will cancel open authorizations for services. This date is the date the current PSA expires.

      3) Free text space is available on the NOA letter to add additional information or explanation if necessary.

Section I.B Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

I.B Appendix G

3 Appendix B: 51;
3 Appendix C: 46, 52, 53

4 Appendix B: 78, 79, 80
4 Appendix C: 14

Continued: Chapter Two: Ongoing Case Management - Section I: B. Annual Program Re-determination

c. The Appeal Process Information enclosure will automatically print with the client's name and other identifying information. This enclosure **must** be mailed with the NOA to the client.

d. Dependent county to notify the state office staff via the CMS Net web message at the time the NOA letter is generated.

5. Within **ten (10) working days** from the NOA date, the CCS county program shall:

   a. Update the CMS Net Establish Medical Eligibility/Ineligibility Status field to "CLOSED."

      Note: the timeline for updating the CMS Net differs from NOA timeline.

   b. Update the CMS Net Registration Status field to "CLOSED"

   c. Send copies of the NOA without the Appeal Process Information enclosure, following the instructions in 2.c, to all medical providers who have open authorizations for services.

      Reminder: Notification procedures differ for PEDI providers.

6. The following activities must be completed by the CCS county program staff upon determination of continued program eligibility:

   a. The client, parent, or legal guardian shall sign a new PSA. See Reminder in Chapter One, Section V.B.2.f.

      Note: If a M/C application is required, no PSA is to be signed by the client, parent, or legal guardian until proof of the completed M/C application has been received by the CCS county program staff.

   b. Update the CMS Net Program Eligibility status field with the appropriate eligibility status. Refer to the CMS Net Manual for client registration procedures.

   c. Dependent county to notify the state office staff of the completion of the program eligibility redetermination via the CMS Net web message.

Section I.B Cross References:

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

I.B Appendix G

5c Appendix B: 78

6a Appendix B: 51, 52, 54

Continued: Chapter Two: Ongoing Case Management - Section I: B. Annual Program Re-determination

7. When a M/C FS no SOC beneficiary has also met the CCS Program eligibility and the client, parent, or legal guardian, has signed a CCS PSA, then the county staff shall:

   a. Update the CMS Net Program Eligibility Status field with the appropriate eligibility status.

   b. Dependent county to notify the state office of the date that the M/C beneficiary is eligible for the CCS Program services.

Section I.B Cross References:

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

7 Appendix C: 16, 17
7a Appendix C: 17, 38

C. Referral for Application to M/C as part of Annual Program Eligibility Redetermination

1. Upon determination that the client must apply for the M/C program, the county staff shall:

   a. Inform the client, parent, or legal guardian that continued eligibility for the CCS Program requires completion of an application for the M/C program. Application to the M/C program is defined as completing all the necessary steps (i.e., submitting required forms, financial information, etc.) that are requested by the county department responsible for M/C eligibility determination.

   b. Have the client, parent, or legal guardian sign the CCS M/C Application Agreement/Proof of Completion form (see the CMS Net, Web Manual, Correspondence). Inform the client, parent, or legal guardian that the form is to be returned when the M/C application requirements have been completed. The CCS M/C Application Agreement form:

      1) Acts as a written notice for the client to apply for the M/C program.

      2) Constitutes notification to the family that the CCS Program will not continue authorization of any medically necessary services if confirmation of completion of M/C application requirements is not received.

   c. Record in the CMS case notes if:

      1) The M/C Application Agreement form was signed by the client, parent, or legal guardian and the date for expected completion of the application process, **OR**

      2) If a client, parent, or legal guardian states that he/she refuses to comply with the M/C application requirements, request that he/she sign a M/C Application Agreement form indicating acknowledgement that refusal to apply for M/C means the client is not eligible for the CCS Program.

         Note: If the client, parent, or legal guardian refuses to sign the form, record in the CMS Net case notes the statement made by the client, parent, or legal guardian that he/she was verbally informed that refusal to apply for Medi-Cal means the client is not eligible for the CCS Program.

Section I.C Cross References:

[Link] to CMS Net User Manuals

See Legacy Manual for Application Procedures

1 Appendix B: 51, 52
1 Appendix C**:**, 32, 33, 35, 38, 52, 53, 81, 83,

Continued: Chapter Two: Ongoing Case Management - Section I: C. Annual Program Re-determination

a) Establish a tickler date for **ten (10) working days** to see if the client, parent, or legal guardian changes his/her mind and proceeds with an application to M/C.

b) If no information is received by the **ten (10) day tickler date**, send a NOA Letter citing the appropriate reason from the NOA Explanation Citation list. Follow the instructions in Chapter Two, Section I. 5 a-d above for sending the NOA letter.

2. Within **ten (10) working days** from the NOA date, the CCS county program shall:

   a. Update the CMS Net Function Establish Medical Eligibility/Ineligibility Status field to "CLOSED."

   b. Update the CMS Net Registration case status to "CLOSED."

   c. Send copies of the NOA without the Appeal Process Information enclosure, following the instructions in 2.c, to all medical providers who have open authorization for services.

   Reminder: Notification procedures differ for PEDI providers.

3. The CCS county program staff shall, upon obtaining a signature of intent to apply for M/C:

   a. Update the status in the CMS Net Financial/Residential Eligibility, Program Eligibility Status to "Pending Medi-Cal."

   b. Inform the client, parent, or legal guardian that an application to M/C must be completed **within 60 calendar** days and:

      1) Provide a copy of the CCS M/C Application Agreement/Proof of Completion form to the client, parent, or legal guardian to take to the appropriate county department responsible for M/C program determination.

      2) Establish a tickler date **60 calendar days** from the date the client, parent, or legal guardian has been referred to M/C to complete an application.

      3) File the signed original CCS M/C Application agreement form in the applicant's case record.

Section I.C Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

I.C Appendix G

1c2b Appendix B: 78, 79, 80

2-4 Appendix C: 16, 17, 32, 33, 35, 38, 52, 53, 81, 83,

3 Appendix B: 29, 52

Continued: Chapter Two: Ongoing Case Management - Section I: C. Annual Program Re-determination

c. Monitor on a periodic basis the M/C application status of the client. The CMS Net case notes entries shall be made to document the progress (or lack thereof) of the follow through with the M/C application process.

4. The following activities must be completed by the CCS county program staff upon determination of program eligibility based on receipt of evidence that the M/C application requirements have been met by the client and the PSA is signed:

   a. Update the CMS Net Financial/Residential Eligibility function to the appropriate eligible status.

   b. Dependent county to notify the state office via the CMS Net web message.

Section I.C Cross References

[Link] to CMS Net User Manuals

See Legacy Manual for Application Procedures

3-4 Appendix C**:** 32, 33, 35, 38 52, 53, 81, 83

4a Appendix C: 38

Chapter Two: Ongoing Case Management - Section I: D. Annual Program Re-determination

D. Re-determination of the Enrollment Fee as part of the Annual Program Eligibility Interview Process

1. The CCS county s program taff shall re-determine the amount of enrollment fee due for the next 12 months covered by the PSA during the annual program eligibility interview.

   a. Review the client's CCS Program case record to determine if the amount of the enrollment fee required is based on family size and income. If any of the following apply to the client, **NO** annual enrollment fee is required:

      1) The only service requested is for services through the MTP; **OR**

      2) The client is a M/C FS no SOC beneficiary; **OR**

      3) The family of the client has a gross annual income of less than 200 percent of the federal poverty level (FPL).

   b. Upon determination that an enrollment fee is required, the client, parent, or legal guardian is informed that the:

      1) Amount of fee due is based on the CCS Program Annual Enrollment Fee Schedule. Refer to CCR, Title 22, Section 41479.

      2) Enrollment Fee is due on the date that the previous PSA expires. The client, parent or legal guardian is to be encouraged to pay the full enrollment fee in a single, lump-sum payment. If periodic payments are agreed to by the CCS county program staff, the client, parent, or legal guardian is to be informed that:

         a) The due date for payment of the entire enrollment fee is **within 60 days** of this date.

         b) Failure to pay **by the 60th day** will result in the client's case being closed to the CCS program.

   c. Any documents that are signed by the client, parent, or legal guardian relating to the payment agreement entered into with the CCS county program are to be filed in the client's chart maintained by the county.

Section I.D Cross References

[Link] to CMS Net User Manuals

I.D Appendix G

1 Appendix B: 25, , 55
1 Appendix C: 5, 6, 16, 17, 32, 33, 35, 38, 52, 53, 69, 60,

1a Appendix A: 123900

1c Appendix B: 29, 57

Continued: Chapter Two: Ongoing Case Management **-** Section I: D. Annual Program Re-determination

d. Collect the enrollment fee and record the payment in the CMS Net Financial/Residential Eligibility function, Assessment and Enrollment Fee and Comments field. If arrangements for payment of the Enrollment fee are made, the amount to be paid, dates payable, and final due date are to be entered in the Enrollment Fee and Comment field.

e. A tracking system is to be set up for a client, parent or legal guardian who has arranged for periodic payments to provide for:

1) Sending of a billing statement containing the total amount of the enrollment fee with the following information:

2) Amount paid to date;

3) Amount due and the due date;

4) A statement that failure to pay the enrollment fee will be cause to be found financially ineligible and the CCS Program services will be terminated if the amount due is not paid **within 60 calendar days** of the due date.

f. Send three billing statements with the first statement **30 calendar days** after the enrollment fee is due; second statement **45 calendar days** after the enrollment is due. The third and final statement, if the total enrollment fee has not been paid by the **60th day** is a NOA. Generate a NOA letter via the CMS Net Web Correspondence.

1) Choose the appropriate NOA from the NOA Explanation and Citations List. Refer to the CMS Net SAR/Web Manual, Section 34, Web Correspondence.

2) Type in the free text space the effective date that the CCS Program will cancel open authorizations for services. This date is the final date that the enrollment fee was due.

3) Reapplication to the program will require the client, parent, or legal guardian to fully pay the outstanding fee debt which will result in a new effective date of coverage.

4) The Appeal Process Information enclosure will automatically print with the client's name and other identifying information. The enclosure page must be mailed with the NOA to the client.

Section 1.D Cross References

[Link] to CMS Net User Manuals

I.D Appendix G

1-3 Appendix A: 123900
1-3 Appendix C: 5, 6, 16, 17, 32, 33, 35 38, 52, 53, 69, 60,
1d Appendix B: 57

1e Appendix B: 57

1f Appendix B: 78, 79, 80

Continued: Chapter Two: Ongoing Case Management **-** Section I: D. Annual Program Re-determination

5) Update the CMS Net Program Eligibility status field to “INELIGIBLE.”

6) Dependent county to notify the state office staff via the CMS Net web message at the time the NOA letter is mailed.

2. Within **ten (10) working days** of the date on the NOA letter, the CCS county program shall:

   a. Update the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INELG) Status field to “CLOSED.”

   b. Update the CMS Net registration case status to “CLOSED.”

   c. Send copies of the NOA with the Appeal Process Information enclosure to all medical providers who have open authorizations for services.

      Reminder: Notification procedures differ for PEDI providers.

3. A reconsideration of the enrollment fee based on a request to waive or reduce the amount by the client, parent, or legal guardian shall be submitted to the county health department director or designee who is responsible to determine if the enrollment fee will result in undue hardship to the family.

   a. Any request for reconsideration of the enrollment fee must be submitted in writing by the client, parent, or legal guardian to the CCS county program and must include:

      1) Name of the client;

      2) Name of the parent(s) or legal guardian;

      3) Explanation of any reduction in family income or unavoidable family expenditures which support reconsideration of waiving the enrollment fee.

   b. The County staff shall enter in the CMS Net Financial/Residential Eligibility function, Assessment and Enrollment Fee and/or Reason Not Collected field the decision made by the county health department director or designee the determination made to reduce, waive or maintain the enrollment fee. The decision made by the county health department director may result in issuing of a NOA. Refer to D.1.f. above.

Section 1.D Cross References

[Link] to CMS Net User Manuals

I.D Appendix G

1-3 Appendix C: 6, 16, 17, 32, , 33, 35, 38, 52, 53, 69, 60,

2 Appendix B: 78, 79, 80

[Link] to PEDI

3 Appendix B: 55

Continued: Chapter Two: Ongoing Case Management **-** Section I: D. Annual Program Re-determination

1) Update the CMS Net Financial/Residential Eligibility function to the appropriate eligible status. Refer to the CMS Net Manual for complete instructions.

2) Dependent county to notify the state office via the CMS Net Web Message.

Section 1.D Cross References

[Link] to CMS Net User Manuals

3 Appendix B: 55
3 Appendix C: 5, 6, 16, 17, 32, 33, 35, 38, 52, 53, 69, 60,

Chapter Two: Ongoing Case Management - Section I: E. Annual Program Re-determination

E. Re-determination of the Assessment Fee as part of the Annual Program Eligibility Interview Process

1. The CCS county program staff shall determine if the family is required to pay the $20.00 assessment fee due for the next 12 months covered by the PSA during the annual program eligibility interview.

   a. The client's CCS Program case record is reviewed to determine if the CCS Program assessment fee will be collected from the family/client if:

      1) The family income is over 100 percent of the federal poverty level, **OR**

      2) The client is eligible for M/C with a share of cost or eligible for limited scope M/C, **AND** is receiving

         a) diagnostic services, **OR**

         b) treatment services, **OR**

         c) Medical Therapy Program (MTP) services through a Medical Therapy Unit (MTU) or vendorized therapy services in lieu of the MTU that are NOT part of an individualized education plan (IEP).

   b. Upon determination that an assessment fee is due, the client, parent, or legal guardian is informed:

      1) The assessment fee is due on or before the expiration date of the current PSA.

      2) That failure to pay the assessment fee will be cause for the client to be ineligible and The CCS Program services will be terminated.

   c. If the family fails to pay the assessment fee, and thus is not eligible for the CCS Program, a NOA is generated via the CMS Net Web Correspondence .

      1) Choose the appropriate NOA from the NOA Explanation and Citations List . Refer to the CMS Net SAR/WEB Manual, Section 34, Web Correspondence.

Section I.E Cross References

[Link] to CMS Net User Manuals

1 Appendix A: 123870(b)(d)
1 Appendix B: 51, 55
1-3 Appendix C: 6, 14, 22, 51, 54, 57, 58, 69, 70

1b Appendix B: 57

1c Appendix B: 78, 79, 80

[Link] to PEDI

Continued: Chapter Two: Ongoing Case Management - Section I: E. Annual Program Re-determination

2) Type in the free text space the effective date that the CCS Program will cancel open authorizations for services. This date is the final date that the assessment fee was due.

3) The Appeal Process Information enclosure will automatically print with the client's name and other identifying information. The enclosure page must be mailed with the NOA to the client/family.

4) Update the CMS Net Program Eligibility status field to "INELIGIBLE".

5) Dependent county to notify the state office staff via the CMS Net web message at the time the NOA letter is mailed.

6) Reapplication to the CCS Program will require the client, parent, or legal guardian to fully pay the outstanding assessment fee and will result in a new effective date of coverage.

2. Within **ten (10) working days** of the date on the NOA letter, the CCS county program shall:

   a. Updates the CMS Net Establish Medical Eligibility/Ineligibility (MED ELIG/INELIG) Status field to "CLOSED."

   b. Update the CMS Net registration case status to "CLOSED".

   c. Send copies of the NOA **without** the Appeal Process Information enclosure, to all medical providers who have open authorizations for services.

      Reminder: Notification procedures differ for PEDI providers.

3. A reconsideration of the assessment fee based on a request to waive or reduce the amount by the client, parent, or legal guardian shall be submitted to the county health department director or designee who is responsible to determine if the assessment fee will result in undue hardship to the family.

   a. Any request for reconsideration of the assessment fee must be submitted in writing by the client, parent, or legal guardian to the CCS county program and must include:

Section I.E Cross References

[Link] to CMS Net User Manuals

I.E Appendix G

1-3 Appendix C: 5, 6, 14, 22, 51, 54, 57, 58, 69, 70

3 Appendix B: 55
3 Appendix C: 5, 6, 14, 22, 51, 54, 57, 58, 69, 70

3a Appendix B: 55

Continued: Chapter Two: Ongoing Case Management - Section I: E. Annual Program Re-determination

1) Name of the client.

2) Name of the parent(s) or legal guardian.

3) Explanation of any reduction in family income or unavoidable family expenditures which support reconsideration of waiving the assessment fee.

b. The CCS county program staff shall enter in the CMS Net Financial/Residential Eligibility function, Assessment and Enrollment Fee and/or Reason Not Collected field the decision made by the county health department director or designee the determination made to reduce, waive, or maintain the assessment fee. The decision made by the county health department director may result in issuing of a NOA (see E.1.c. above).

1) Update the CMS Net Financial/Residential Eligibility function the appropriate eligible status. Refer to the CMS Net Manual for complete instructions.

2) Dependent county to notify the state office via the CMS Net web message.

Section I.E Cross References

[Link] to CMS Net User Manuals

3 Appendix C: 5, 6, 14, 22, 51, 54, 57, 58, 69, 70

Chapter Two: Ongoing Case Management – Section II: A. Medical Case Management and Service Authorizations

A. General Information

1. Definitions:

   a. A **referral** to the CCS Program is defined as a request directed to the CCS Program to authorize medical services for a potential CCS Program applicant who:

      1) Is under 21 years of age **and**

      2) Is not a client of the CCS Program **and**

      3) Has, or is suspected of having a CCS-medically eligible condition.

         Note: The referral may originate from any source. Examples of who may initiate a referral include, but are not limited to, health care providers, health plans, parents, legal guardians, school nurses, regional center counselors, or other interested parties.

   b. A **request for service** is defined as a request directed to the CCS Program from a health care provider or plan requesting authorization for specifically identified health care service(s) or equipment on behalf of a client/applicant.

      Note: When opening a case - only the first request for service for a given individual is a referral.

2. Authorization

   a. Authorization for diagnostic or treatment services of a CCS-medically eligible condition or for services which complicate or are associated with the eligible condition, may be issued after a CCS case number has been assigned and case record is opened and active. A case may be opened to the CCS Program when medical eligibility has been established and the client:

      1) Has established program eligibility **OR**

      2) Is a M/C FS no SOC beneficiary.

Section II.A Cross References

[Link] to CMS Net User Manuals

1-2 Appendix C: 5, 9,16, 17, 26, 30, 52, 53

1a Appendix B: 3, 17, 31,32

2 Appendix B: 32, 63

2a Appendix B: 31, 32, 58, 60, 61, 65

2a Appendix: E

b. Types of Authorizations

Diagnostic evaluations to establish or rule out a CCS-medically eligible condition may be authorized when**:**

1) There is a signed application on file and medical and residential eligibility have been established **OR**

2) The client is confirmed as a M/C FS no SOC beneficiary.

Treatment services may be authorized when medical, residential and financial eligibility have been established and:

1) There is a signed application and the CCS Program Services Agreement on file **OR**

2) The client is confirmed as a M/C FS no SOC beneficiary.

c. **All authorizations issued by the CCS Program shall have effective and expiration dates.**

Authorization expiration may not be beyond the annual redetermination date. Expiration dates are required for any authorized service including one time purchased items such as purchase or rental of durable medical equipment. Authorizations may vary based on the following:

1) **Clients who are M/C FS no SOC beneficiaries** who have **not** signed a CCS Program application or the CCS PSA.

REMINDER: The CCS Program eligible services may be authorized for M/C beneficiaries with FS no SOC. All such authorizations are issued with a statement that authorizations are subject to continued M/C eligibility and M/C benefits. This statement **must** be added to any authorization issued for a M/C beneficiary to ensure providers are aware that the CCS Program is not responsible for payment for those medical services not covered by the M/C program. Refer to the CMS Net Manual – Special Language section.

Section II.A Cross References

[Link] to CMS Net User Manuals

2 Appendix C: 5, 9,16, 17, 26, 30, 52, 53
2b Appendix B: 60, 65, 66
2b Appendix C: 5, 17
2b Appendix F: NL 01-0108

2) Clients who are M/C beneficiaries **with** SOC or Limited Scope M/C or Private Insurance or the CCS Program Coverage only:

a) Before diagnostic services may be authorized, there must be a signed CCS Program Application.

b) Before treatment services may be authorized a completed CCS Program application and a signed PSA must be received.

d. Authorizations and the Medical Therapy Program (MTP)

Authorizations are not issued for MTP services provided exclusively at a CCS Program Medical Therapy Unit (MTU). When there are no occupational or physical therapy staff available at an MTU, therapy services may be vendored to a CCS-paneled physical therapy provider or paneled occupational therapy provider.

Note: Financial eligibility is NOT required for vendored therapy in lieu of MTU services.

Medical services for the MTP client identified by the MTP that are to be provided outside of a MTU including, but not limited to orthopedic surgery, prosthetic devices, wheelchairs, and other such durable medical equipment require the following:

1) Financial eligibility determination and a signed CCS Program PSA.

2) Authorization for services to be covered.

Section II.A Cross References

[Link] to CMS Net User Manuals

2c2 Appendix B: 31, 54
2c2 Appendix: G

2c2a Appendix C: 59

2d CMS Manual of Procedures, Chapter 4: MTP
2d Appendix A: 123900(f)**.**
2d Appendix B: 16, 34, 39, 52, 54
2d Appendix E: MTP
2d Appendix F

Chapter Two: Ongoing Case Management Section II: B. Medical Case Management and Service Authorizations

B. Issuing and Denying Authorizations

1. Authorizations

a. The services being requested from the CCS Program shall be entered by the CCS Program county staff upon receipt of the request. In the CMS Net, enter request function by following the directions in the CMS Net User Manual. **Note:** only enter specific requests from provider or parent that identifies the service requested and the provider.

b. Requests for service shall be reviewed by the county or state office medical consultant or designee to determine if/when services and providers are to be authorized.

c. Upon approval of a request for service, the county medical consultant or designee shall:

1) Verify provider panel status for those specialties required to be the CCS Program providers.

2) Enter in the CMS Net case note, the service to be authorized, provider and the dates to be placed on the authorization; **OR**

3) Revise a previously entered request for service. The medical consultant or designee must determine if the modification/change requires generation of a NOA.

Note: A NOA may be required if the modification or change of the requested service is necessary. Refer to CCR, Title 22, Section 42132.

d. The county shall issue the authorization via the CMS Net. Refer to the CMS Net Manual.

e. Enter the provider to be authorized, effective dates of authorization and any other required service specific information including special language on the authorization.
Refer to the CMS Net Manual – Special Language section.

Section II.B Cross References

[Link] to CMS Net User Manuals

1 Appendix B: 78, 79, 80

1b Appendix B: 32

1c1 Appendix B: 4, 30

1c2 Appendix B: 32

1c3 Appendix B: 79
1c3 Appendix C: 14
1c3 Appendix F: CCS Administrative Procedures, Due Process Manual - 2001

Continued: Chapter Two: Ongoing Case Management: Section II: B. Medical Case Management & Service Authorizations

2. **Denials**

a. Any applicant or CCS Program client has the right to appeal the medical denial decision except when the service has been terminated by a CCS Program physician with responsibility for the medical supervision of the client.

1) Per the CCS Program regulations, NOAs are not issued when the medical service is terminated by the client's CCS Program physician.

2) Requests for a medical service denied by the CCS Program medical consultant or designee require a NOA including the Appeal Process enclosure.

b. A NOA to deny a medical services request is generated by the CMS Net Correspondence function and accompanied by a SAR denial.

1) A NOA is to be sent to the client with the Appeal Process Information enclosure. Refer to the CMS Net, Section 34, Citations Mapping and Closure Reasons.

2) Free text space is available on the NOA letter to add additional information or explanation, if necessary.

3) For procedures related to denying SARs, refer to the CMS Net Manual, Section 22.

4) A copy of the NOA is to be sent to the non-PEDI provider. Do not send with the Appeal Process enclosure.

Reminder: notification procedures differ for PEDI providers.

c. For the M/C beneficiary with FS no SOC whose requested service will not be authorized by The CCS Program as it does not treat the CCS-eligible condition or an associated/complicating condition, a NOA is to be sent which includes a notation to: "Please request services through the Medi-Cal program." (Specify M/C field office or managed care plan).

d. Requests denied for an EPSDT-Supplemental Service shall be discussed with the CCS county program's medical consultant.

Section II.B Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

2 Appendix F: CCS Administrative Procedures, Due Process Manual - 2001
2 Appendix B: 78, 79, 80, 81
2 Appendix C**:** 5, 14, 16, 17, 22, 26, 30,
2a1 Appendix B: 80

[Link] to PEDI

2d Appendix C: 22

1) Following N.L. 03-0205, the county medical consultant shall seek consultation with the state office medical consultant before issuing denials for EPSDT-Supplemental Service.

2) Language for the EPSDT-Supplemental Service NOA was developed jointly by the CCS Program and the Medi-Cal program staff. The NOA provides notice to the M/C beneficiary of the denial of the service and the first level appeal decision. For this notice the next level of appeal is to request a CCS Program fair hearing. This notice also informs of the right to request a fair hearing. Refer to the CMS Net Manual, Section 34, Citations Mapping and Closure Reasons.

3) A NOA is sent informing the client that the service is denied as a CCS Program and a M/C service.

e. A CMS Net case note must be entered that the NOA was sent and a copy maintained in the client's CCS Program record.

Section II.B Cross References

[Link] to CMS Net User Manuals

2e Appendix B: 29

Chapter Two: Ongoing Case Management – Section II: C. Medical Case Management and Service Authorizations

C. Annual Medical Review

The purpose of the Annual Medical Review (AMR) is to assure all aspects of the client's case are up-to-date without gaps in services and review (case find) for any new medically eligible conditions. The AMR documented in the CMS Net case notes provides a rapid review of the client's medical and social status and summary of the current plan for case management. Completion of the AMR should include an annual update of the client's CMS Net Registration Face Sheet to ensure all appropriate ICD diagnoses are listed and ineligible diagnoses are removed.

1. The medical consultant or designee shall conduct, at a minimum, an AMR on any case that has had no activity or authorization for the previous 12 months. This AMR review should begin approximately **60 days before** the annual financial review day. Based on this review, the case may:
   a. Remain active requiring a new financial eligibility determination; **OR**
   b. Remain active but request additional medical reports; **OR**
   c. Be closed. Refer to Chapter Two, Section V.
2. The AMR is the same date as the financial redetermination due date.
3. Therapy consultants must review MTU reports and any other reports related to the MTU eligible condition.
4. Additional medical record review is to be done by medical consultant or designee on the following:
   a. The CCS Program client who is hospitalized over two weeks.
   b. Transition planning at ages 14, 16, 18, and before 21st birthday. Refer to the CCS Information Notice 10-03 Health Care Transition Planning for Children with Special Health Care Needs.
   c. Other as required; such as clients requiring possible transplantation (heart, lung, bone marrow or liver); failure of client to follow through with center care, etc.
   d. Deaths.

Section II.C Cross References

[Link] to CMS Net User Manuals

C Appendix A: 123870, 123925
C Appendix B: 26, 51, 52
C Appendix E: N.L. 01-0108
C Appendix G

2 Appendix B: 51

3 Appendix B: 39
3 CCS Manual of Procedures, Chapter 4, MTP
3 Appendix E: MTP/MTU

4b Appendix B: 3
4b Appendix C: 8

4c Appendix F: N.L. 01-0108

4d Medical Quality Assurance Review: *CA Health & Safety Code, Section 123830 and 123835; and CCR, Title 22, 41515.1*

Chapter Two: Ongoing Case Management - Section III: A. Requesting Medical Reports

A. General Information

1. Medical reports are essential for the determination of the CCS Program medical eligibility and on-going case management activities. The requesting of medical reports for referrals required for the determination of medical eligibility is a state office and/or county responsibility. The procedures and responsibility for requesting the medical reports needed for determination of medical eligibility are listed in Section III.B

2. Obtaining medical reports required for requests related to the occupational and physical therapy to be provided through the Medical Therapy Program (MTP), is the responsibility of the CCS county staff.

3. A Release of Information (ROI) signed by the applicant, parent or legal guardian is needed when a medical report is being requested from a health care provider who is not the source of the requested service to the CCS Program or is not a CCS-paneled provider.

Section III.A Cross References

[Link] to CMS Net User Manuals

1 Appendix B: 17, 26, 29, 30

2 Appendix B: 17, 26, 29, 30

3 Appendix B: 28
3 Appendix C: 23, 27, 29

[Link] to DHCS website regarding Notice of Privacy Practices and the Health Insurance Portability and Accountability Act (HIPAA)

Chapter Two: Ongoing Case Management - Section III: B. Requesting Medical Reports

B. Procedures for Requesting Medical Reports for Medical Case Management

1. Upon determination that a medical report is required, the CCS county programs shall:
   a. Request the required medical reports using the CMS Net Request Medical Reports function to generate the letters to request medical reports:
      1) If the initial referral is received without a medical report, the CCS county program shall send the medical report request form letter C-13. If the medical report requested is ***not from the referral source,*** the county shall obtain a Release of Information (ROI) form (C-17A) and enclose it with the request for medical reports using the cover letter C-17.
      2) If the medical report to be requested is ***not from the referral source*** – send a ROI form (C-17A) to obtain needed medical information.

      Note:
      - Form C-13 is the medical report request letter.
      - Form C-17 is the medical report request letter and ROI form.

   b. Enter into the CMS Net case note that medical reports have been requested. The dependent county to notify the state office via the CMS Net web message.
2. Enter a tickler due date in the CMS Net of **20 working days** from the date of the request to establish a review date for receipt of the medical report.
3. When medical reports are received, the CCS county program shall enter into the CMS Net the date the report was received using Receive Medical Report function. This entry removes the Medical Report Request from the tickler. Notify the CCS Program staff person who requested the report.
4. If the medical report is not received by the tickler date, the CCS county program shall:
   a. Enter in the CMS Net Note that the medical report has not been received.
   b. Send a second medical report request letter C-14 to the medical provider.
   c. Delete the first request from the tickler using the Request Medical Report function.

Section III.B Cross References

[Link] to CMS Net User Manuals

B Appendix G

1 Appendix B: 17, 26, 32

4 Appendix B: 3, 32

Continued: Chapter Two: Ongoing Case Management - Section III: B. Requesting Medical Reports

d. Enter a tickler/due date in the CMS Net of **20 working days** from the date of the second request to establish a review date for receipt of the medical report.

e. State office or dependent county to notify other county via the CMS Net web message.

5. If the required medical report(s) are not received by the tickler date of the second notice, the case record shall be referred to the county or state office medical consultant or designee for disposition.

Section III.B Cross References

[Link] to CMS Net User Manuals

B Appendix G

Chapter Two: Ongoing Case Management - Section III: C. Requesting Medical Reports

C. Requesting medical reports or a prescription for therapy services to be provided in a Medical Therapy Unit (MTU).

1. Upon review of an MTU record, if the need is identified for a medical report, the therapy consultant shall note the need for the report and the physician or healthcare provider who is being requested to send it.
2. The CCS county program shall:
   a. Send MTU letter #1 to the physician responsible for the medical management of the client's physical disability with a copy to the parent or legal guardian. Tickle the system for **20 working days** to review for receipt of the report.
   b. If report is not received by the tickler date, **within five (5) working days,** send a letter requesting the required information following the steps for requesting medical reports in B. above.
   c. If the requested medical report/prescription is not received **within 20 working days**, the county shall:
      1) contact the family and request their assistance in encouraging the physician to send the necessary information and to let them know the consequences of not receiving the reports
      2) notify the state office therapy consultant via the CMS Net web message.
   d. If no medical report or prescription is received **within 20 working days** from the date that the county staff contacted the family, the county or state office medical consultant or designee shall review the case for appropriate action.
3. Upon receipt of the requested medical report(s) and/or prescriptions, forward to the county or state office therapy consultant for action and update the CMS Net Receive Medical Report function to remove request from the tickler.

Section III. C Cross References

[Link] to CMS Net User Manuals

C Appendix G

1 Appendix B: 32, 39
1 Appendix D

2d Appendix B: 78, 79, 80

Chapter Two: Ongoing Case Management - Section IV: A. Transfer of the CCS Program Case to Another County

A. General information re: transfer of a CCS Program case to another county.

1. A client receiving services is not to be denied or suffer an interruption of services because of relocation to another county in California. Refer to CCS N.L. 15-1207 regarding Inter-County Transfer Policy and policy implementation.

2. In this section of the Case Procedures Manual, "**original county**" refers to the county which has an opened the CCS Program record and is notified that the client may have established residency in another county. The term "**new county**" refers to the county where the new address is located and in which residence in that county has been established before the original county can cancel authorized services, close the CCS Program record and transfer the case record to the new county.

   The CCS county programs shall collaborate on transfer issues to reach mutual agreement on the date of case closure and transfer. This will ensure that when a child's care is transferred from one CCS county program to another there is no lapse in services for the child.

   Note: The dependent county shall discuss the inter-county case transfer with the responsible state office staff, including the nurse case manager responsible for the client's medical case management. The state office will provide transfer procedures guidance to dependent county staff, including effective date of closure.

3. To ensure that authorized services and/or Medical Therapy Program (MTP) services are not denied or interrupted when a client has moved to a new county of residence, the following apply:

   a. All cases should be reviewed by the original county for current financial eligibility and medical eligibility and services prior to case transfer and should be transferred only when there is current documentation which indicates a client's case remains active and medically eligible. Refer to CCS N.L. 15-1207 regarding inter-county case transfers.

Section IV.A Cross References

[Link] to CMS Net User Manuals

1 Appendix B: 50, 51
1 Appendix C: 15

2 Appendix B: 50, 51
2 Appendix C: 15

3 Appendix B: 50, 51

3a Appendix C: 15

3b Appendix B: 50, 51

Continued: Chapter Two: Ongoing Case Management – Section IV. A: Transfer of the CCS Program Case to Another County

b. The original county is responsible for sending out the contact letters when notified by client or his/her parent or legal guardian or it determines there is evidence indicating that a client or his/her parent or legal guardian may no longer reside in the county. The only exception to sending out the contact letters is if the new county contacts the original county that the family has notified them and the new county is requesting a closure date. The client or his/her parent or legal guardian is responsible for providing the information requested by the new county to establish residency in the county.

c. The CCS Program signed application (if applicable) and PSA (if applicable) from the original county shall be accepted by the new county once county residence is established. The PSA must be renewed by the client, parent, or legal guardian based on the annual renewal date established by the original county.

d. Transfer of a CCS Program client who is either M/C FS no SOC beneficiary should not be delayed as long as the address change shows in MEDS or has been confirmed through contact with MRMIB.

e. The two counties involved with the transfer shall coordinate and mutually agree on the date which authorizations are to be cancelled and the CCS Program case record closed in the original county and reopened in the new county. The case in the original county shall be closed on one day and opened in the new county on the following day.

f. The original county shall ensure the client's CCS Program case records are transferred **within ten (10) working days** from the date that the original county and new county agree on a closing and opening date.

Section IV.A Cross References

[Link] to CMS Net User Manuals

IV.A Appendix G

3 Appendix B: 50, 51
3 Appendix C: 15
3c Appendix B: 54

3d Appendix C: 17

Chapter Two: Ongoing Case Management - Section IV: B. Transfer of the CCS Program Case to Another County

B. Procedures for confirming address when there is evidence that a client, parent, or legal guardian may no longer reside in the original county

1. When the original county determines there is evidence a client or his/her parent/legal guardian may no longer reside in the county, contact letters must be sent to the client or his/her parent/ legal guardian.

   a. Send first transfer correspondence letter to the client, parent, or legal guardian that confirmation must be received **within 15 days** from the date stated in the contact letter that the client continues to reside in the original county or has relocated to a residence in a new county in the state.

   b. If new county does not notify original county that the client, parent, or legal guardian has contacted the new county, the original county shall send a second transfer letter to the original address within **five (5) working days** after due date of first letter. The client, parent or legal guardian is given **15 calendar days** to notify new county.

   c. All open authorizations for services will be cancelled and the client's CCS Program record closed on the effective date stated in the contact letter.

   d. If the new county is contacted by the client, parent or legal guardian after receiving a closure NOA letter, then the new county and original county should coordinate a mutually agreed upon date of transfer. Follow instructions in Chapters I, II, and III of this manual.

2. Within **five (5) working days** of being notified that the client, parent, or legal guardian **may** have moved to another county in the State, the CCS county program noting the information shall record the possible "new" address, the source of the information (medical report, regional center staff, mail returned, etc.) in the CMS Net case notes. Dependent county to notify the state office via the CMS Net web message.

3. Upon obtaining a possible address outside of the county, the original county shall:

   a. Change the CMS Net Registration Primary Addressee to the new address and the Residence County field to the new county. The Legal County and Client Address fields shall remain the same until residence at the "new" address is confirmed.

Section IV.B. Cross References

[Link] to CMS Net User Manuals

Refer to CMS Net Manual:
Section 42, Transfer Letter Series
Section 44, Registration

B Appendix G

1 Appendix B: 51, 51, 52
1 Appendix C: 15

b. Enter the CMS Net, Web Correspondence to send contact letter for case transfer. The CMS Net will generate the letter about the change of county residence identified in Section C, below, to the client at the Client Address (original county) with a copy generated to the Primary Address (new county) and the new CCS county program.

4. Within **ten (10) days** of the date of the NOA letter (C-20B or C-21B), the CCS county program shall:

   a. Update the CMS Net Establish Medical Eligibility/Ineligibility Status field to "CLOSED".

   b. Update the CMS Net Registration Status field to "CLOSED".

   c. Send copies of the NOA Letter (C-20B or C-21B) without the Appeal Process Information enclosure, to all medical providers who have open authorizations from the CCS Program.

      Reminder: Notification procedures differ for PEDI providers.

5. Refer to CCS N.L. 15-1207 regarding inter-county case transfer policy in conjunction with the CMS Net Manual procedures on pending transfers. A summary of transfer procedures follows:

TRANSFER OF A CCS PROGRAM CASE TO ANOTHER COUNTY, TRANSFER LETTER, PROCEDURES & TIMELINES

Procedure	Source = Family	Source =
Original county receives notification of client/family change of county		
Original county sends first transfer letter to original address. Client or parent/legal guardian is given **15 calendar days** to notify new county	C-20	C-21
If new county does not notify original county that client or parent/legal guardian has contacted new county, original county shall send a second transfer letter to original address within **five (5) working days** after due date of first letter. Client or parent/legal guardian is given **15 calendar days** to notify new county.	C-20A	C-21A
If the original county is not notified that client or parent/legal guardian has contacted the new county, the original county sends the final NOA transfer letter to the original address within **five (5) working days** after due date of second letter. The effective closure date is the date stated in the second letter by which the client or parent/legal guardian had to confirm the address in the new county. The NOA must include the Appeal Procedures in the information enclosure.	C-20B	C-21B

Section IV.B Cross References

[Link] to CMS Net User Manuals

IV.B Appendix G

4c Appendix B: 50, 78, 79, 80
4c Appendix C: 14

5 Appendix B: 78, 79, 80

Chapter Two, Section IV: C. Transfer of the CCS Program Case to Another County

C. Responding to a CCS Program State File Number (case number) registered in another county

1. If a family moves to a “new county” without informing the “original county” that they have moved, the new county staff shall attempt to confirm the validity of the CCS number via the CMS Net Patient History File or MEDS/HAP to determine whether the child is already known to the CCS Program.

   a. If the child is determined not to have an open case in another county or has a closed case, the “new county” will proceed as usual with determining the CCS Program eligibility.

2. If the child is determined to already have an open case in another county, the new county shall:

   a. Notify the original county that a referral was received but it appears to be a request for service with a need to confirm the client’s address.

   b. Request the original county initiate the confirmation of transfer letters following the procedures in Section B. above

      Note: The state office or dependent county to enter a the CMS Net case note and notify the other office via the CMS Net web message if a change in client’s address is identified. Dependent county to follow transfer procedures in Section IV: B above.

Section IV.E Cross References

[Link] to CMS Net User Manuals

1 Appendix B: 50, 51
1 Appendix C: 15

Chapter Two: Ongoing Case Management - Section V: A. Case Closure

A. General information

1. Cases are to be closed for a variety of reasons including, but not limited to, the following:

   a. Client has reached 21 years of age.

   b. Client has left the state (residence criteria is no longer met).

   c. Family is no longer financially eligible/has not completed program eligibility criteria.

   d. Client's condition no longer meets the CCS Program medical eligibility criteria.

   e. Client, parent or legal guardian do not wish to participate in the CCS Program (statutes, regulations, policies and procedures).

   f. Treatment completed. Refer to the CMS Net Web Manual, Section 34, for closure reasons.

   g. Death of patient.

2. County or state office medical consultant or designee must approve closure of cases when reason for closure pertains to medical eligibility.

3. Cases are closed only when the case status has been "active", that is, the case has been assigned a CCS Program case number and "opened" based on meeting specific eligibility criteria.

4. If a case was assigned a pending number but was "not opened" and the case will not have any CCS Program activity, then the appropriate status is "Not Open."

5. The reason for closure of a CCS Program case record must always be documented in the narrative.

6. Closure of a case may require a NOA. Reference CCRs and CCS NOA policy NL 05-0608.

   EXCEPTIONS: There are circumstances under which the CCS Program will initiate either the closure of an open or pending case and/or the cancellation of an existing authorization that are not the result of a CCS Program eligibility decision.

Section V.A Cross References:

[Link] to CMS Net User Manuals

1 Appendix B: 3, 32, 50, 51, 52
1 Appendix C: 14, 46, 49, 78

1a Appendix B: 3

1b Appendix B: 50

1c Appendix B: 51, 52

1d Appendix B: 32

1f Appendix C: 14

2 Appendix B: 32
2 Appendix E

5 Appendix B: 30

6 Appendix F: CCS Administrative Procedures, Due Process Manual – 2001
6 Appendix G

Continued: Chapter Two: Ongoing Case Management - Section V: A. Case Closure

a. A Denial or Deferral letter may be issued to the provider and/or family when:

1) No services are prescribed or recommended.

2) An authorized provider has terminated services because the treatment is complete.

3) An authorized provider has ended services or declined the referral.

4) The CCS Program client or client's family request a change of provider.

5) Denti-Cal has denied orthodontia services for severity.

6) The client or client's family decline the CCS Program services.

7) Death of the client.

8) The client is over 21 years of age.

9) The client is no longer a resident of the county.

10) There is no response at the client's last known address.

11) A negotiated case transfer to another county.

Section V.A Cross References:

[Link] to CMS Net User Manuals

6 Appendix F: CCS Administrative Procedures, Due Process Manual – 2001
6 Appendix G
6a Appendix C: 14

Chapter Two: Ongoing Case Management - Section V: B. Case Closure

B. The CMS Net Procedures for Case Closure

1. Request for closure of the CCS Program case record may be made by county or state office staff.

   Note: If the dependent county identifies the need for the case closure, they must notify the state office via the CMS Net web message that closure is recommended.

   REMINDER: County or state office medical consultant or designee is responsible for case closure determination related to a medical eligibility denial.

2. The CCS county program responsible for closure of a case shall:

   a. Document in the CMS Net case notes reason for closure and any follow-up attempts to contact the family and any other relevant issues.

   b. Update the CMS Net County Close Request Date field in Registration.

   c. Check possible referrals to other programs, including the Genetically Handicapped Persons Program (GHPP) and enter in the CMS Net case notes.

   d. The CMS Net system automatically cancels all authorized medical SARs and deletes pending SARS. Refer to the CMS Net SAR module procedures.

   e. Update the CMS Net Registration and Medical Eligibility/Ineligibility status fields. In Establish Medical Eligibility/Ineligibility function, select reasons for closure at the prompt.

   f. Check possible referrals to other programs and notify county regarding any required action. Enter information in the CMS Net case notes.

   g. Authorizations must be cancelled for a CCS Program case record closed due to reasons stated in **e**. above. The provider shall be notified via a Cancel Authorization stating reason as follows:

      1) Client has died.

      2) Client no longer has a CCS-eligible medical condition.

      3) Client has established residential eligibility in _county.

Section V.B Cross References:

[Link] to CMS Net User Manuals

1-4 Appendix C: 14, 22, 46, 49, 51 54, 57, 58, 78

2a Appendix B: 32

2c Appendix G: 8

2e Appendix B: 50, 78, 79, 80

2e Appendix F: CCS Administrative Procedures, Due Process Manual - 2001

2g Appendix C: 14

2g Refer to CMS Net SAR Cancellation procedures

2g3 Appendix B: 3

4) Client has established residency in another state.

3. Case closure procedures for M/C FS no SOC beneficiary:

   a. Conditions under which these cases are closed include:

      1) Treatment for the CCS-eligible condition is completed or the CCS-eligible condition is no longer present as documented by the authorized treating the CCS Program specialist or special care center.

      2) Client is no longer a M/C beneficiary with FS no SOC; or client is an infant previously covered under mother's M/C eligibility and now not covered under his/her own M/C eligibility and there is no signed CCS Program application or PSA on file.

      3) When the family chooses non-CCS-paneled specialist or special care center provider to treat the CCS-eligible condition.

      4) Moved to another county/state.

      5) Death of client.

   b. When a case is closed, the CMS Net system cancels all authorized medical SARs and deletes pending SARs. See the CMS Net Manual for SAR and PEDI correspondence procedures.

Section V.B Cross References

[Link] to CMS Net User Manuals

3a2 Appendix B: 11, 54
3a2 Appendix C: 21

3a3 Appendix B: 66
3a3 Appendix F

3a4 Appendix B: 50

[Link] to PEDI

End of Chapter Two
Next page begins Chapter Three

Chapter Three: General Information - Section I: A. NOAs and First Level Appeals

A. General Information

2. A NOA is required when the CCS Program eligibility or services are denied or discontinued. Follow CCS N.L. 05-0608 Right to Appeal Decisions of the CCS Program.

   a. Excluded from the CCS Program administrative due process procedures are provider disagreements regarding a denial related to medical eligibility or program policy. (This is not to be considered a formal appeal and is separate from a client's due process.)

      1) All such differences in **A. 1.a**. are to be resolved through an informal process, which includes provider provision of information or clarification of documented medical necessity.

      2) Review of a request for reconsideration of the denial must be reviewed by the county medical consultant or designee.

3. The appropriate CCS Program independent county staff responsible for medical or administrative case management decision-making shall determine the NOA letter type and effective date.

4. State office staff for dependent county applicant/client shall determine denial or discontinuation of medical eligibility or medical services, or certain program eligibility issues requiring medical consultant review.

5. Dependent county staff shall determine financial or residential program ineligibility. Dependent county's over-income/out-of-pocket financial analysis must be reviewed and approved by state office medical consultant prior to NOA being generated and sent.

Section I.A Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

A Appendix B: 78, 79, 80
A Appendix F: CCS Administrative Procedures, Due Process Manual – 2001

1 Appendix C: 14

1a Welfare & Institutions Code 14133.05

Chapter Three: General Information - Section I: B. NOAs and First Level Appeals

B. Denials and NOA Procedures

1. Denials

   a. Any applicant or the CCS Program client has the right to appeal the medical denial decision except when the service has been terminated by a CCS physician with responsibility for the medical supervision of the client.

      1) Per the CCS Program regulations, NOAs are not issued when the medical service is terminated by the client's CCS physician.

      2) Requests received for a medical service which is denied by the CCS Program medical consultant or designee require a NOA including the Appeal Process enclosure.

   b. A NOA to deny a medical services request is generated by the CMS Net Correspondence function and accompanied by a SAR denial.

      1) A NOA is to be sent to the client with the Appeal Process Information enclosure. Refer to the CMS Net, Section 34, Citations Mapping and Closure Reasons.

      2) Free text space is available on the NOA letter to add additional information or explanation, if necessary.

      3) For procedures related to denying SARs, refer to CMS Net Manual.

      4) PEDI providers will access the CCS Program denials via the PEDI system.

      5) A copy of the NOA is to be sent to the non-PEDI provider.

         Reminder: Do not send NOA with the Appeal Process enclosure.

   c. For the M/C beneficiary with FS no SOC whose requested service will not be authorized by the CCS as it does not treat the CCS-eligible condition or an associated/complicating condition, a NOA is to be sent with a notation to: "Please request services through the Medi-Cal program." (Specify M/C field office or managed care plan).

Section I.B Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

1 Appendix B: 78, 79
1 Appendix C: 14
1 Appendix F: CCS Administrative Procedures, Due Process Manual – 2001

[Link] to PEDI

Chapter Three: General Information - Section I: B. NOAs and First Level Appeals

2. NOA Procedures

   a. A NOA letter is generated through the CMS Net by the appropriate CCS Program staff. To prepare the letter the appropriate county or state office staff member shall:

      1) Select the appropriate explanation/citation from NOA Explanation/Citation list.

      2) Type in the free text space applicable information to individualize the NOA reason. The following are guidelines of what should be entered in the free text space:

         a) Effective date of the NOA (required by regulation)

         b) Service(s) requested (if appropriate)

         c) Medical condition (if appropriate).

         d) Additional information, as needed (Letter Text allows up to 9 lines of Free Text.).

   b. NOAs shall be sent to the applicant/client or parent/legal guardian with the enclosure, Appeal Process Information, which provides an explanation of the appeals procedure and is required per CCR, Section 42131.

   c. Instructions for when a copy of the NOA is to be sent to the provider who requested authorization for a medical service are found in Chapters One and Two.

      Reminder: Notification procedures differ for PEDI providers.

3. Refer to the **CCS Program Administrative Procedures Manual, Due Process July 2001 Revision**:

   a. NOA citations list and examples.

   b. Appeal Process enclosure to NOA letters

   c. Numbered Letters relating to Appeals and Fair Hearings

   d. Flowcharts from the original “Due Process” manual.

   e. Provider request for reconsideration of denial. Refer to informal process. See **A.1.a-c** above.

Section I.B Cross References

[Link] to CMS Net User Manuals

See Web Manual, Section 34 for Letters and Notices

2 Appendix B: 78, 79, 80
2 Appendix C: 14
2 Appendix F: CCS Administrative Procedures, Due Process Manual – 2001
2 Appendix G

[Link] to PEDI

3 Appendix B: 82-97
3c Appendix C: 14
3 Appendix F: CCS Administrative Procedures, Due Process Manual – 2001

3d Appendix G
3e Welfare & Institutions Code 14133.05

Chapter Three: General Information - Section I: C. NOAs & First Level Appeals

C. Receipt of First Level Appeals

1. The claimant has 30 days from the NOA date to file an appeal; however, if the appeal is late:
   a. The CCS county program office **may** establish a "grace period" (informal); and
   b. The county office should apply reasonableness in establishing "good cause" for the late appeal.
2. Once the appeal is received, the county office has **21 calendar days** to respond. If additional information is required to make a decision, the county office response to the appeal must be made within 21 days of receipt of the information. Refer to established CCS Program Due Process procedures.
3. The county is to provide assistance to the family in the appeal process. This includes, but is not limited to, supplying copies of documentation and regulations, numbered letters, information on how decisions are reached and referrals to public advocates. (The county may charge a fee for any copies made for the claimant.)
4. The state office must have a tracking system for all appeals.
5. Dependent county receipt of first level appeals:
   a. **All first level appeals for dependent counties are decided by a state office.**
      1) If an appeal is received by the dependent county, the county must indicate the date of receipt on the appeal request. The appeal, including a copy of the NOA and related documentation (for financial/residential issues), must be faxed to the appropriate state office medical consultant within **one (1) working day** from the date of receipt. The county must document the actions taken in the CMS Net case notes.
      2) The state office medical consultant or designee reviews and responds to all appeals.

Section I.B Cross References

[Link] to CMS Net User Manuals

C Appendix F: CCS Administrative Procedures, Due Process Manual – 2001
C Appendix G

1-4 Appendix B: 82-97

4 Appendix B: 80
4 Appendix C: 54

Chapter Three: General Information - Section II: A. Communication: Case Management Issues

A. General information regarding County Communication with State Office

1. Case management questions are to be directed to the appropriate state office staff.

   a. **Independent** county staff may contact the state office administrative, nurse, or medical consultant(s).

   b. **Dependent** county staff may contact the appropriate state office clerical and/or nurse case manager assigned to the client's case. See additional case management information for dependent counties in the next section Chapter Three, Section II.B.

      Note: Dependent counties that participate in the *Case Management Improvement Project* (CMIP) Level III, receive comprehensive case management guidance and oversight directly from state office nurse consultants. CMIP Level III communication to the state is usually through the county's assigned state office nurse consultant.

2. Always provide the client's name, the CCS case number, and county - and note if the case issue is urgent.

3. If no response is received within **three (3) working days**, the state office supervisor and/or manager should be contacted.

4. If no response is received from the supervisor within **two (2) working days**, the Dependent County Operations Section Chief should be contacted.

Section II.A Cross References

[Link] to CMS Net User Manuals

1 Appendix F: NL 30-0985

Chapter Three: General Information - Section II: B. Communication Case Management Issues

B. Situations Requiring Notification From Dependent County to State Office

1. The situations described below are examples of dependent county case management activities that require documentation in the CMS Net case notes.

   a. The CCS county program staff are to notify the state office via web message upon the occurrence of any of these situation below:

      1) New referral
      2) Third application letter sent
      3) Financial completed (including over-income cost analysis)/ financial not completed
      4) Request for services received at county and not state office
      5) Parent requesting services such as a piece of durable medical equipment
      6) Hospitalization with unmet Share of Cost
      7) Change in providers requested by family
      8) Change in center care requested by family
      9) Change of address
      10) All Medi-Cal information
      11) Inter-County Transfers
      12) Request for closure
      13) Request for denial
      14) MTC finding and request(s) for services and equipment outside the MTU

   b. Dependent county questions regarding cases are to be directed to the appropriate state office staff (i.e., nurse case manager or other designated office staff). CMIP level III communication is usually through the county's assigned state office nurse consultant.

Section II.B Cross References

[Link] to CMS Net User Manuals

B Appendix F: NL 30-0985

Chapter Three: General Information - Section II: C. Communication: Case Management Issues

C. Situations requiring notification from State Office to Dependent County

The situations described below are examples of state office case management activities that are documented in the CMS Net case notes. State offices are to notify the CCS county program staff via web message upon the occurrence of any of these situations:

1. New referral/request for service not received at the county.
2. Authorizations issued or direction for county to generate authorizations for the client/provider.
3. Case notes entered affecting or requiring action by the county.
4. Medical eligibility determinations including Medical Therapy Program.
5. High cost cases – such as extended hospital stays, acute rehabilitation stays, unmet SOC, etc.
6. Transplants.

Section II.C Cross References

[Link] to CMS Net User Manuals

Chapter Three: General Information - Section II: D. Communication: Case Management Issues

D. Communication through the Provider Electronic Data Interchange (PEDI)

1. The CMS Net Provider Electronic Data Interchange (PEDI) is a web-based tool that enables approved CCS Program providers and health plans to electronically access the status of the CCS Program Requests for services/authorizations. In addition to viewing authorizations, each approved provider/facility has the ability to print service authorizations requests (SARs), denial letters, NOAs, and generate standard reports.

2. The CCS Program Responsibilities

   a. The CCS county program and state offices and the CMS Network shall work together to support the CMS Net PEDI functionality.

      1) The CCS Program state offices shall be responsible for the following:

         a) Work cooperatively with the CCS county program offices in authorizing, denying, and/or canceling requests for services/authorizations, ensuring that authorizations, denials, and cancellations are completed in a timely manner.

      2) The CCS county program offices shall be responsible for the following:

         a) Work cooperatively with the designated state office with respect to entering requests for services.

         b) Enter requests for services into the CMS Net system in a timely manner ensuring that authorizations, denials and cancellations are completed in a timely manner.

      3) The CMS Network Section shall be responsible for the following:

         a) Reviewing and processing applications from providers/plans/facilities for access to the CMS Net PEDI.

         b) Daily maintenance of the CMS Net PEDI application.

         c) The PEDI user ID assignment and maintenance, including user passwords.

Section II.D Cross References

[Link] to CMS Net User Manuals

[link] to PEDI Provider Responsibilities

Chapter Three: General Information - Section III: A. The CMS Net Report Generation

A. Requesting Reports from the CMS Net:

1. There are standard reports available in the CMS Net as well as the CMS Net Business Objects which contains data related to patient demographics, registration, authorizations, case notes, medical and financial/residential eligibility, M/C status, correspondence, application status, vendors, etc. Refer to the CMS Net Tools, Business Objects for more information.

2. Counties may work through their County Program Administrator or County System Administrator-Plus to request ad hoc report assistance by submitting a Change Request to the CMS Net Help Desk at CMSHelp@dhcs.ca.gov

   a. Do not send the CMS Net-generated documents or data to the state office or county via the U.S. Mail system.

   b. Any emails containing Protected Health Information (PHI) data or documents are required to be sent using encryption software.

      1) Refer to the Health Insurance Privacy and Portability Act (HIPPA) for rules and guidelines regarding the transmission of PHI.

      2) For questions regarding PHI, contact your HIPPA or Privacy Officer.

Section III.A Cross References

[Link] to CMS Net User Manual

[Link] to CMS Net Tools

[Link] to CMS Net Change Request

[Link] to DHCS website regarding Notice of Privacy Practices and the Health Insurance Portability and Accountability Act (HIPAA)

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End of Chapter Three

Chapter Four: Appendices begins on the next page

CHAPTER FOUR:

APPENDICES

A. CCS Program Statutes……..……..……..……..... 96

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E. CCS Provider Panel Requirements and Standards……..... 114

F. MS/CCS Program Administration Policies……..…..…..… 116

G. CCS Due Process Timelines ……..……..…. 121

Appendix A

The California Children's Services (CCS) Program Statutes

To view text of program statutes - search Health and Safety Code, Section 123800 et seq. Enter code number.

Code	The CCS Program Statutes, Health and Safety Code Sections 123800-123995
123800	Title of Act
123805	Services for physically defective or handicapped minors; powers and duties of department
123810	Transfer of duties, purposes, responsibilities and jurisdiction
123815	Possession and control of records, equipment and supplies
123820	Transfers of officers and employees
123822	Claims for services; submission to fiscal intermediary; centralized billing system
123825	Intent
123830	Handicapped child
123835	Keeping program abreast of advances in medical science; pilot studies
123840	Services
123845	The CCS Program
123850	Designation of agency to administer the CCS Program; standards of local administration
123855	Case finding; consent of parent or guardian
123860	Diagnosis for handicapped children
123865	Application for Services
123870	Standards of financial eligibility; exception for services under the medical therapy program in public schools; fee. Also reference: Government Code, Sections 243, 244
123872	Repayment agreement for treatment services
123875	Determination that handicapped child is eligible for therapy by the CCS Medical Therapy Program unit conference team; disagreement; further justification Also reference: Government Code, Section 7575(b)
123880	Continued eligibility; receipt of treatment services under teaching program
123885	Panel members; qualifications
123980	Burn victims; treatment in hospital without separate facilities for children
123895	Determination of eligibility; certification for care
123900	Annual enrollment; exceptions; one time start-up fee; accounting
123905	Certification of eligibility; authorization and payment for services; reimbursement
123910	Payment for services with certification; furnishing services; gifts and legacies
123915	Direct arrangement for services; agreements with parents for payment of enrollment fees
123920	Payment of services for non-resident children; special grants or allotments for costs
123925	Supervision over services; records
123930	Consent of parent or guardian; exception
123935	Effect of mental retardation
123940	County appropriations and expenditures; State matching
123945	State emergency aid
123950	Administration of medical therapy program; cost; standards; regulations
123955	The CCS Program; sharing costs; standards
123960	Program data; purposes
123965	Placement of handicapped children for adoption; entitlement to services
123970	Notification of prospective adopting parents; termination of program funds
123975	Screening newborn infants for deafness; follow up and assessment
123980	Actions against third persons liable for injury; notice
123982	Treatment provided under children's services program; claim against judgment, award or settlement received against third party; liens
123985	Bone marrow transplant; reimbursement; conditions
123990	Adoption of regulations; authority of department
123995	Medi-Cal application requirements

Appendix B

Cross References to the CCS Program Case Management Procedure Manual's Regulations and Statutes:

- The California Code of Regulations (CCR) and
- The Health & Safety Code (H&SC) Reference Sections.

To view CCR text and H&SC Authority Citations – click on California Code of Regulations
Note: CCR text also located in CMS Information Notice 09-02 [hyperlink]
The CCS Program statute text also located in the CMS Information Notice 09-03 [hyperlink]

Subdivision 7. The California Children's Services (CCS) Program *Source: Barclay's California Code of Regulations, Register 2009, No. 5; 1-3-2009*		
#	**Chapter 1. Definitions**	**H&SC Reference Sections Cited**
1	41401 Abnormal	123830, 123835
2	41407 Benign Neoplasm	123830, 123835
3	41410 CCS Program, The	123830, 123835, 123845. 123865, 123870
4	41412 CCS Program Physician, The	123830, 123910, 123925
5	41414 Client	123830
6	41421 Department	123805, 123850
7	41422 Director	123850
8	41423 Disability	123830, 123835
9	41424 Disfiguring	123830, 123835
10	41427.5 Expert Physician	123850
11	41431 Full Medi-Cal Benefits	123805, 123990, 123915, 123990
12	41432 Function	123830, 123835
13	41437 Hearing Officer	123850
14	41445 Life Threatening	123830, 123835
15	41448 Malignant Neoplasm	123830, 123835
16	41450 Medical Therapy Program	123830, 123835, 123950
17	41452 Medically Necessary Benefits	123840, 123845, 123925
18	41453 Mental Disorder	123830, 123835
19	41454 Mental Retardation	123830, 123835
20	41455 Monitoring	123830, 123835
21	41461 Normal	123830, 123835
22	41471 Physical	123830, 123835
23	41472 Primitive Reflexes	123830, 123835
24	41478 Rehabilitation Services	123830, 123835
25	41479 Sliding Fee Scale	123870, 123900, 123915, 123990
	Chapter 2. Administration, Article 1. General Provisions	
26	41510.2 Case Finding and Reporting	123855
27	41510.3 After-Care Services	1507.5, 123865
	Article 5. Records and Reports	
28	41510.4 Confidential Nature	123925, 124980, 124995
29	41511 Maintenance of Records and Reports	123925
30	41512 Patient Records	123925

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Continued Appendix B: The CCR Cross References to the CCS Program Case Management Procedures

#	Chapter 3. Client Application & Eligibility Requirements Article 1. General Provision	H&SC Reference Sections Cited
31	41514 Application for CCS Services	123870, 123900, 123990
	Article 2. Medical Eligibility	
32	41515.1 Determination of Medical Eligibility	123830, 123835
33	41515.2 Infectious Diseases	123830, 123835
34	41516. Neoplasms	123830, 123835
35	41516.1 Endocrine, Nutritional and Metabolic and Immune Disorders	123830, 123835
36	41516.3 Diseases of Blood and Blood-Forming Organs	123830, 123835
37	41517 Mental Disorders and Mental Retardation	123830, 123835
38	41517.3 Diseases of the Nervous System	123830, 123835
39	41517.5 Medical Therapy Program	123830, 123835
40	41517.7 Disease of the Eye	123830, 123835
41	41518 Diseases of the Ear and Mastoid	123830, 123835, 123975
42	41518.2 Diseases of the Circulatory System	123830, 123835
43	41518.3 Diseases of the Respiratory System	123830, 123835
44	41518.4 Diseases of the Digestive System	123830, 123835
45	41518.5 Diseases of the Genitourinary System	123830, 123835
46	41518.6 Diseases of the Skin & Subcutaneous Tissues	123830, 123835
47	41518.7 Diseases of the Musculoskeletal System and Connective Tissue	123830, 123835
48	41518.8 Congenital Anomalies	123830, 123835
49	41518.9 Accidents, Poisonings, Violence, and Immunization Reactions	123830, 123835
	Article 3. Residential Eligibility	
50	41519. Residential Eligibility Determination	123895; 123990; and Government Code Sections 243 and 244;
51	41610 The CCS Program Residential & Financial Eligibility and Enrollment Fee Determination	123865, 123870, 123895, 123900, 123930, 123965, 123990
	Article 4. Financial Eligibility	
52	41670 Financial Eligibility Determination	123870, 123900, 123990, 123995
53	41671 Eligibility Treatment Plans	123870, 123900, 123925
54	41672 The CCS Program Legal Agreement Outline	123900, 123915, 123990
	Article 5. Annual Enrollment Fee	
55	41674 Annual Enrollment Fee Determination	123900, 123990
56	41676 Annual Enrollment Fee Reporting	123870, 123900, 123915, 123990
57	41684 Annual Enrollment Fee Collection	123870, 123900, 123915, 123990
	Chapter 4. Program Benefits **Article 3. Diagnostic Services**	
58	41700 Availability	123860, 123925
59	41701 Facilities	123855
60	41702 Eligibility	123860
	Article 4. Treatment Services	
61	41740 Eligibility for Treatment Services	123840, 123870, 123880, 123885, 123925
62	41760 Bone Marrow Transplantation for Cancer	123985
63	41770 Prior Authorization	123865

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Continued Appendix B: The CCR Cross References to the CCS Program Case Management Procedures

#	Chapter 9. Professional Medical Care Providers Article 1. General Provisions	H&SC Reference Sections Cited
64	42000 General Supervision	123880, 123925, 123955
	Article 3. Physicians	
65	42020 Diagnostic Services	123840, 123860, 123925
66	42030 Treatment Services	123880, 123885, 123925
67	42050 Family Physician	123880, 123885
	Article 4. Other Health Care Professionals	
68	42075 Podiatrists	123880, 123885
	Chapter 10: Hospital Providers **Article 1. General Provisions**	
69	42110 Facilities	1254; 123840, 123925
70	42115 Separate Facilities for Children	123850, 123925
71	42120 Isolation	123840, 123925
72	42125 Nursing Requirements	123840, 123925
73	42126 Clinical Laboratories	123850, 123925
74	42127 Dietary Services	123840, 123925
75	42128 Physical and Occupational Therapy	123840, 123925
76	42129 Social Worker Services	123840, 123925
	Article 4. Special Hospital	
77	42130 Special Hospital	123840, 123925
	Chapter 13. Resolution of Complaints and Appeals by the CCS Program **Clients or Applicants Article 1. Notice of Action**	
78	42131 Written Notice of Action	123805, 123850
79	42132 Reasons for Notice of Action	123805, 123835, 123850, 123865, 123870, 123905, 123925
	Article 2. Designated CCS Program **Agency**	
80	42140 Right to Appeal	123850, 123925
81	42160 First Level Appeal	123850, 123925
	Article 4. The CCS Program **Fair Hearing**	
82	42180 Request for the CCS Program Fair Hearing	123850, 123925
83	42305 Notice of the CCS Program Fair Hearing	123805, 123850
84	42320 Time and Place of Formal Fair Hearing	123805, 123850
85	42321 Continuation	123805, 123850
86	42326 Hearing Officer's Authority	123805, 123850
87	42330 Discovery	123805, 123850; and Government Code Section 11507.6;
88	42400 Subpoenas	123805, 123850
89	42401 Preparation for the CCS Program Fair Hearing	123805, 123850
90	42402 Conduct of the CCS Program Fair Hearing	123805, 123850
91	42403 Official Notice	123805, 123850; and Evidence Code, Sections 451 and 453
92	42404 Continued Hearings	123805, 123850
93	42405 Evidence	123805, 123850
94	42406 Representation at a CCS Program Fair Hearing	123805, 123850
95	42407 Oral Argument and Briefs	123805, 123850
96	42420 Disqualification of Hearing Officer	123805, 123850
97	42700 Decision	123805, 123850, 123925

Appendix C

Cross Reference to Numbered Letters & Information Notices in the CCS Program Administrative Case Management Manual

To view online policy letters and information notice list – click on hyperlink:

- CCS Numbered Letters (NL)
- CCS Information Notices (IN)
- CMS Information Notices (CMS IN)
- Medi-Cal Managed Care Division Letters (MCMC)

** Document is not available online*			
#	Type	Number	Title/Subject
			BLANK
			BLANK
			BLANK
			BLANK
			BLANK
			BLANK
			BLANK
			BLANK
			BLANK
			BLANK
5	Medi-Cal		Healthy Families Program (HFP) Transition to Medi-Cal Letter No.: 12-30 [hyperlink]
6	CMS IN	**11-05**	Update of Table 1 (Family Size and Annual Income Level Chart) –Medi-Cal Year 2011 Federal Poverty Level Chart (FPL); Effective April 1, 2011.
7	NL	**03-0810**	Maintenance and Transportation to Assist Clients in Accessing CCS Authorized Medical Services Note: 03-0810 supersedes 01-0104, 16-0801 and 05-0492
8	CCS IN	**10-03**	Statewide Guidelines for **Health Care Transition Planning** for Children with Special Health Care Needs Note: 10-03 supersedes CCS IN 09-01
9	CMS IN	**09-03**	CCS, CHDP, NHSP and GHPP Laws (update to set of laws previously provided). For historical references to CCS laws – see: • NL 50-1294* CCS Program Benefit Regulations • NL 01-0194* CCS Laws • NL 43-1091* CCS Laws, 1991 Legislative Session • NL 27-0791* CCS Laws • NL 23-0791* New State Laws • NL 24-0889* CCS Laws • NL 49-1184* Legislation • NL 33-0883* CCS Laws
10	CMS IN	**09-02**	**Updated CCS Program Regulations** (Supplements NL 05-0500) Note: the changes in this notice reflect renumbering of the regulations and non-substantive changes in language. This IN does not replace 05-0500 regarding CCS Medical Eligibility Regulations. Also see **Appendix E** for Medical Eligibility & Medical Necessity policies
11	NL	**08-1109**	Unique CCS Aid Codes for Children Participating in the Pediatric Palliative Care Waiver. See also **07-0401** Criteria for Assignment of CCS Unique Aid Codes to CCS Eligible Children
12	CCS IN	**08-05**	Family Handbook – What Parents/Guardians Should Know About CCS
13	NL	**03-0409**	Interim Appeal & Fair Hearing Process for Dental and Orthodontic Denials Made By Denti-Cal for CCS
14	NL	**05-0608**	Right to Appeal Decisions of the CCS Program
15	NL	**15-1207**	CCS Inter-County Case Transfer Note: 15-1207 supersedes 06-0285; 06-0288

Appendix C - continues on the next page

Continued Appendix C: Cross Reference to Numbered Letters & Information Notices

* *Document is not available online*			
#	**Type**	**Number**	**Title/Subject**
16	NL	**15-1206**	Supplement to CCS NL 12-1006 and HF Statement of Annual Income
17	NL	**12-1006**	Updated CCS Policies Relating to Children who are HF Subscribers. Note: 12-1006 supersedes 19-0605; 01-0299, 07-0598
18	NL	**05-0406**	Directions for Completion of the Quarterly Time Study (QTS) for MTP for 100 % State-Funding to Comply with Interagency Agreements (AB 3632)
19	CMS IN	**03-07**	**CMS Online Archive for Policy Letters and Information Notices**
20	NL	**26-0905**	Newborn Referral to the Medi-Cal Program and Newborn Referral Form
21	NL	**24-0905**	CCS Services for Infants Born to Mothers Participating in the AIM Program who subsequent to birth are enrolled in the HF Program
22	NL	**03-0205**	Delegation of Authority to Authorize EPSDT-SS to County CCS Programs and CMS Regional Offices, EPSDT-SS Worksheet & Instructions, and NOA and First Level Appeal Decision Letter
23	NL	**01-0105**	Dependent and Independent County CCS MTP Guidelines for Development of Policies & Procedures for Implementation of the Health Insurance Portability and Accountability Act (HIPPA). See also: 04-0403
24	CMS IN	**03-07**	CMS Online Archive for Policy Letters and Information Notices
25	CCS IN	**03-04**	Health Insurance Information Form (MC 2600) Now available in Spanish
26	NL	**12-0803**	Implementation of Assembly Bill (AB) 495; Expansion of Children's Health Insurance Coverage
27	NL	**11-0703**	Notice of Privacy Practices for CCS Clients; Compliance with Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule
28	NL	**10-0703**	Child Health and Disability Prevention (CHDP) Program Gateway
29	NL	**04-0403**	Notice of Privacy Practices (NPP) for CCS MTP; Compliance with Health Insurance Portability & Accountability Act (HIPPA) Privacy Rule
30	NL	**02-0203**	CCS Policies Relating to Healthy Families (HF) Eligible Children
31	NL	**12-0202**	CCS Financial Eligibility Policy re: Native American Indians
32	NL	**20-1101**	CCS Financial Policy re: Clients whose Annual Adjusted Gross Income is Below 200 Percent of the Federal Income Guidelines but the Current Enrollment Fee Scale Indicates a Fee is to be Charged
33	NL	**19-0901**	CCS Residential Policy re: Persons Here on a VISA or Temporary Permit
34	NL	**17-0901**	Policies and Guidelines for Identifying, Documenting, Claiming, and Reporting HF Subscriber Cases when the Family's Annual Adjusted Gross Income is Greater than $40,000
35	NL	**11-0601**	CCS Policy re: the Requirement that all CCS Applicants Shall Make Application to the Medi-Cal Program; H&SC Section 123995 Note: this letter supersedes 03-0300; 19-1299
36	NL	**09-0501**	Electronic Billing
37	NL	**04-0301**	Electronic Claiming
38	NL	**07-0401**	Criteria for Assignment of CCS Unique Aid Codes to CCS Eligible Children Note: this letter has had 2 updates; most recent correction February 2013
39	*	**2001**	**CMS/CCS Administrative Procedures - Due Process Manual – Revision June 2001** See also: **41-1091** Due Process System
40	**NL**	**02-0301**	Implementation of Section 14133.05 of the Welfare & Institutions Code Regarding Treatment Authorizations
41	NL	**01-0301**	Instructions for Completion of the "State-Approved 100 Percent State-Funded Staff Allocation for County Medical Therapy Programs" Form
42	NL	**10-1400**	CCS Rate Increases for Medical Services
43	NL	**11-1500**	Verifying Residential Eligibility for Children who are M/C Full Scope or HF
44	NL	**06-0600**	Duplication of Physician or Therapy Services Being Provided Thru MTP
45	NL	**05-0500**	**CCS Medical Eligibility Regulations** **Note: 05-0500 has outdated regulation numbers.** See CMS IN 09-02 for renumbering of the regulations. Refer to CCRs, Title 22 for current CCS regulation numbers. Note: 05-0500 letter supersedes 06-0599, 11-0999, 50-1294*

Appendix C - continues on the next page

Continued Appendix C: Cross Reference to Numbered Letters & Information Notices

* *Document is not available online*			
#	**Type**	**Number**	**Title/Subject**
46	NL	**04-0400**	Case Management of Medi-Cal Eligible Beneficiaries with a CCS Eligible Condition Enrolled in a Medi-Cal Managed Care Plan
47	NL	**22-1299**	CCS Medical Therapy Unit (MTU) List
48	NL	**27-1298**	**CCS Hospital Standards**. See also Appendix F for Policies and Standards for Providers
49	NL	**20-0997**	Case Management Timelines
50	NL	**06-0397**	Medical Therapy Program (MTP): Dispute Resolution Through "Expert" Physician. See also: 42-1194 Implementation of Expert Opinion on Level of Service in MTP
51	NL*****	**03-0197**	Appeals. See also: 18-0594, 11-0494 and June 2001 Due Process Manual
52	MMCD	**96-10**	Medi-Cal Managed Care Division (MMCD) letter re: Managed Care Plan (MCP) whose contracts exclude CCS Services
53	MMCD	**96-02**	Medi-Cal Managed Care Division (MMCD) letter re: Managed Care Plan (MCP) whose contracts include CCS Services
54	NL	**03-0195**	Tracking First Level Appeals. See also: June 2001 Due Process Manual
55	NL*	**51-1294**	Draft Medi-Cal Referral Screening Tool
56	NL	**34-0994**	Designation of a New Identifier to Capture Costs Related to the MTP
57	NL	**18-0594**	Appeal Guidelines. See also: June 2001 Due Process Manual
58	NL	**11-0494**	First Level Appeals. See also: June 2001 Due Process Manual
59	NL	**06-0394**	Required Use of Health Insurance
60	NL*	**20-0593**	Medi-Cal Case Management: Restricted Alien Codes
61	NL*	**36-1292**	Determining Medical Eligibility for the MTU See also: Appendix E for medical eligibility topics listed by subject
62	NL*	**22-0992**	MTUs and Due Process
63	NL*	**20-0992**	Fair Hearing Communications. See also: June 2001 Due Process Manual
64	NL*	**19-0992**	Annual Assessment Fee
65	NL*	**16-0992**	ICD-9 CM Codes
66	NL*	**12-0792**	Application to CCS and Enrollment Fee Requirements
67	NL*	**10-0692**	Supplemental Security Income (SSI)
68	NL*	**02-0392**	Determination of Medical Eligibility for MTP Services.
69	NL*	**49-1291**	Enrollment Fee Information Request
70	NL*	**40-1091**	Enrollment Fees
71	NL*	**17-0591**	Medi-Cal Eligibility Aid Codes
72	NL*	**04-0191**	Health Maintenance Organizations (HMOs)
73	NL*	**36-1190**	Length of Stay Guidelines (Hospital)
74	NL*	**17-0589**	Adoptions and Financial Eligibility
75	NL*	**33-1185**	Health Insurance. See also: 06-0587
76	NL*	**32-1185**	Residence Eligibility
77	NL*	**34-0784**	Attorneys Required to Notify CCS
78	NL*	33-0888	CCS Case Management and Authorization for Medi-Cal Children
79	NL*	20-0788	Insurance Disclaimers
80	NL*	**30-0784**	Medi-Cal Referral and Eligibility Criteria
81	NL*	**32-0883**	Medi-Cal Application
82	NL*	**14-0582**	Referral of Medi-Cal Eligible Children to CCS
83	NL*	**05-0182**	Medi-Cal Applications

Appendix C - continues on the next page

Continued Appendix C: Cross Reference to Archived Letters & Notices

Note: To locate NL's and IN's not included in this cross reference list - search the following:

- CMS 03-07 CMS Online Archive for Policy Letters and Information Notices
- NL* 24-0594 Numbered Letter Log and Index
- NL* 30-1193 Numbered Letter Log and Index
- NL* 09-0393 Numbered Letter Log
- NL* 32-1192 Numbered Letter Index
- NL* 20-0591 Numbered Letter Index and Log

Appendix D – begins on the next page

Appendix D

CCS Medical Eligibility and Medical Necessity
List of Numbered Letters (NL) and Information Notices (IN)
Topics Grouped by Subject

To view online letters and notice list and text – click on hyperlink:

- CCS Numbered Letters (NL)
- CCS Information Notices (CCS IN)
- CMS Information Notices (CMS IN)

Note: Each subject in this appendix includes all known medical policy letters. As other historical medical policy documents are identified - they will be added to these lists. An * in the table means the letter is not available online

Table	Subject	Page
1	Audiology; Hearing Services; hearing aids, maintenance and parts	
2	Dental & Orthodontia	
3	Durable Medical Equipment & Medical Supplies	
4	Early Periodic Screening, Diagnosis & Treatment - Supplemental Services	
5	Home Health Services & Pediatric Palliative Care Services & Options	
6	Medical Eligibility & Medical Necessity for Diagnostic Evaluations, Treatments and Therapies	
7	Medical Therapy Program and Medical Therapy Unit	
8	Nutrition – Enteral Products and Medical Foods	
9	Pharmacy	
10	Screenings – Newborn; Diagnostic Services for Infants	

Appendix D – continued

Table 1. Audiology – Hearing Services

NUMBER	TYPE	TITLE
		Blank
01-0513	NL	Bone Anchored Hearing Aids (BAHA) Note: 01-0513 supersedes 03-0207
11-1211	NL	Diagnostic Audiology and Treatment Services for Children with Hearing Loss. Note: 11-1211 supersedes 21-1299.
10-1211	NL	Cochlear Implant Updated Candidacy Criteria and Authorization Procedure Note: 10-1211 supplements 03-0411; and supersedes 09-1028
09-1011	NL	Cochlear Implant Post-Surgical Services Note: 09-1011 supplements 09-1028)
08-1011	NL	Genetics Evaluation for Children with Hearing Loss
07-1011	NL	Hearing Aids
03-0411	NL	Cochlear Implants (Supplements 09-1208) Note: 03-0411 supersedes 02-0796
02-0411	NL	Cochlear Implant Batteries & Parts (Supplements 13-1106) Note: 02-0411 supersedes 12-1007 & 09-0900
10-1208	NL	Update and Clarification of Policy related to the Authorization of Frequency Modulation (FM) Systems or Assistive Learning Devices (Supplements 13-0605)
09-1208	NL	Cochlear Implants Note: 09-1208 supersedes 09-0900 & 02-0796
12-1007	NL	Cochlear Implant Batteries and Parts (includes Cochlear Implant Replacement Parts & Batteries Request Form) (Supplements 09-0900)
11-0807	NL	Hearing Aid Supplies and Maintenance Note: 11-0807 supersedes 30-1205.
03-0207	NL	Bone Anchored Hearing Aids (BAHA) and BAHA Request Form
13-1106	NL	Cochlear Implant Speech Processor Upgrades
02-0106	NL	Update to Medi-Cal Approved Centers of Excellence for Cochlear Implants Providing Services for CCS Eligible Beneficiaries. Note: see also 14-1003. Note: 02-0106 superseded by 03-0411
30-1205	NL	Benefits for Hearing Aid Maintenance: Batteries, Accessories, Ear molds and Repair/Modifications Note: 30-1205 superseded by 07-1011
13-0605	NL	Delegation of Authority for Authorization of Assistive Listening Devices to County CCS Programs and CMS Regional Offices and Request for Hearing Aids and Assistive Listening Devices (Supplements 10-1208). Note: 13-0605 supersedes 12-0999.
12-0605	NL	Delegation of Authority for Authorization of Hearing Aids Previously Reviewed as "Non-Conventional Hearing Aids" to County CCS Programs & CMS Regional Offices and Request for Hearing Aids and Assistive Learning Devices Note: this letter is supplemented by 07-1011. Note: 12-0605 supersedes 12-0999.
11-0605	NL	Delegation of Authority for Authorization for Aural Rehabilitation Services to CCS Programs & Medi-Cal Certified Outpatient Rehabilitation Centers
02-0104	NL	Purchase & Utilization of Loss & Damage (L&D) Insurance for Hearing Aids, Cochlear Implants Processors, or Alternative Listening Devices for CCS Case-Managed Beneficiaries
10-1300	NL	Authorization of Audiology Services
10-1200	NL	Non-Conventional Hearing Aids Note: 10-1200 superseded by 07-1011, 12-0605.
21-1299	NL	Authorization of Services for Children with Hearing Loss
12-0999	NL	Request for Audiology Services Note: 12-0999 superseded by 12-0605 and 13-0605.
10-0899	NL	Communication Disorder Center (CDC) Standards
20-0594	NL	CCS Audiology Program Consultant
08-0291	NL	Communication Devices Note: this letter revised 14-0590 and 40-1290

Appendix D - continues on the next page

Appendix D - continued

Table 2. Dental and Orthodontia

NUMBER	TYPE	TITLE
		Blank
04-0613	NL	Dental Implant Requests Note: 04-0613 supersedes 16-0898
28-6804	NL*	Malocclusion
07-0700	NL	By-Report Dental Procedures Reimbursement Fees Note: 07-0700 supersedes N.L. 11-0291
16-1099	NL	Dental Benefits for CCS Clients Note: the enclosures are not available online
03-0299	NL	Denti-Cal Bulletin & Processing of Denti-Cal Claims for CCS/Full Scope No Share of Cost Medi-Cal Beneficiaries Case Managed and Services Authorized by CCS
22-0998	NL	EPSDT-SS for Dental Services for CCS Medi-Cal Clients
10-0494	NL*	Case Management & Payment for Orthodontic Care of Cleft Palate Patients who Lose Medi-Cal Eligibility
02-0294	NL*	CCS Orthodontic Program
34-1192	NL*	Increase in Dental Rates
44-1091	NL*	CCS Advisory Orthodontic Committee
24-0791	NL*	Orthodontia
12-0288	NL*	Extended Treatment Visits for Orthodontic Care
31-1085	NL*	Orthodontic Services and additional information
17-0483	NL*	Dental Services SMA

Table 3. Durable Medical Equipment; Accessories and Medical Supplies

NUMBER	TYPE	TITLE
		Blank
		Blank
01-0111	NL	Authorization of Insulin Infusion Pumps
02-0107	NL	Authorization of Rental of Portable Home Ventilators
18-0605	NL	Nationwide Recall of VAIL Enclosed Bed Systems and FDA Notice to Public
13-0605	NL	Delegation of Authority for Authorization of Assistive Listening Devices to County CCS Program and CMS Regional Offices and Request for Hearing Aids and Assistive Listening Devices (Supplements 10-1208).
03-12	CCS IN	Incontinence Medical Supplies Note: 03-12 IN supplements NL 08-0703
09-0703	NL	Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Medical Equipment-Rehabilitation DME-R) Note: 09-0703 supersedes 08-0291 and 23-0793
08-0703	NL	Authorization for Purchase of Incontinent Medical Supplies (IMS) Note: 08-0703 supersedes 06-0492
02-0102	NL	Pulse Oximeters Note: 02-0102 supersedes 01-0191
14-0801	NL	Synthesized Speech Augmentative Communication (SSAC) Devices (aka: ACCs) Note: 14-0801 supersedes 05-0397
17-1199	NL	Automobile Orthopedic Positioning Devices (AOPDS)
02-0197	NL	Authorization of Flutter Valves and ThAIRapy Vests
06-0492	NL*	Medical Supplies
07-0291	NL*	Guidelines for Durable Medical Equipment Recommendations for Purchase
24-0788	NL*	Durable Medical Equipment (DME)
13-0788	NL*	Payment for Repairs to DME Not Originally Purchased by CCS Also see: 13-0388
13-0486	NL*	Continuous Passive Motion
40-1285	NL*	Durable Medical Equipment
47-1183	NL*	Rental vs. Purchase of Durable Medical Equipment
13-0483	NL*	Apnea Monitors and Pneumograms; Home Patient Monitoring Kit
06-0283	NL*	Update/Clarification of 39-1182: M/C Coverage of Cotton, Tape, Bandages

Appendix D – continues on the next page

Appendix D - continued

Table 4. EPSDT – Supplemental Services

NUMBER	TYPE	TITLE
		Blank
		Blank
01-0114	NL	EPSDT- Private Duty Nursing and Pediatric Day Health Care, Treatment Authorization Requests (TAR) and Services Authorization Requests (SAR)
07-1011	NL	Hearing Aids Note: this letter supplements NL 12-0605
03-0411	NL	Cochlear Implants Note: this letters supplements NL 09-1208
02-0411	NL	Cochlear Implants Batteries and Parts Note: This letter supplements NL 13-1106 Note: 02-0411 supersedes NL 12-1007
10-1208	NL	Update and Clarification of Policy Related to the Authorization of Frequency Modulation (FM) Systems or Assistive Learning Devices. Note: this letter supplements 13-0605
17-0605	NL	Authorization of Radiology Services as EPSDT-SS
16-0605	NL	Delegation of Authority to Authorize Medical Nutrition Services to County CCS Programs and CMS Regional Offices
15-0605	NL	Delegation of Authority to Authorize Speech Pathology Services and Medi-Cal Certified Outpatient Rehabilitation Centers
14-0605	NL	Authorization of Occupational Therapy (OT) Services and Medi-Cal Certified Outpatient Rehabilitation Centers
13-0605	NL	Devices to County CCS Programs and CMS Regional Offices and Request for Hearing Aids and Assistive Listening Devices
12-0605	NL	Delegation of Authority for Authorization of Hearing Aids Previously Reviewed as Non-Conventional Hearing Aids" to County CCS Programs and CMS Regional Offices and Request for Hearing Aids and Assistive Listening Devices Note: This letter supplemented by 07-1011
11-0605	NL	Delegation of Authority for Authorization of Aural Rehabilitation Services to County CCS Programs and CMS Regional Offices and Medi-Cal Certified Outpatient Rehabilitation Centers
03-0205	NL	Delegation of Authority to Authorize EPSDT-SS to County CCS Programs and CMS Regional Offices, EPSDT-SS Worksheet, EPSDT-SS Worksheet Instructions, and Notice of Action (NOA) and First Level Appeal Decision Letter
02-0104	NL	Purchase and Utilization of Loss and Damage (L&D) Insurance for Hearing Aids, Cochlear Implant Processors, or Alternative Listening Devices for CCS Case- Managed Beneficiaries
08-0703	NL	Authorization for Purchase of Incontinence Medical Supplies (IMS) Note: this letter supersedes NL 06-0492
11-1002	NL	Outpatient Mental Health Services as CCS Benefits
26-1298	NL	CCS Responsibilities for Case Management of Shared Medi-Cal Eligible Beneficiaries Who Are Receiving EPSDT-SS Long Term Nursing Services Through Medi-Cal In Home Operations (IHO)
22-0998	NL	EPSDT-SS for Dental Services for CCS Medi-Cal Clients

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Appendix D - continued

Table 5. Home Health Services; Palliative Care Waiver Options

NUMBER	TYPE	TITLE
		Blank
		Blank
01-0114	NL	EPSDT- Private Duty Nursing and Pediatric Day Health Care, Treatment Authorization Requests (TAR) and Services Authorization Requests (SAR)
06-1011	NL	Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care
07-1109	NL	CCS Nurse Liaison Position in Partners for Children (Pediatric Palliative Care Waiver Program)
05-0207	NL	Short-Term Shift Nursing Services and HCPCS Codes for Short-Term Shift Nursing Services
04-0207	NL	Palliative Care Options for CCS Eligible Children and Codes Available for Authorization of Pediatric Palliative Care Services
07-0506	NL	Intermittent Home Health Services Provided by a Home Health Agency (HHA) and Services Allowances (Time) per Visit List
11-0489	NL*	Supplemental Nursing Services. See also: 02-0189
02-0189	NL*	Nursing Services in the Home. See also: 11-0489
26-0788	NL*	Home Health Agency Services
29-0985	NL*	Home Care and Case Management Guidelines
26-0985	NL*	Respite Care and the Level of Care Providers Who May Be Authorized by CCS
25-0985	NL*	Medi-Cal In-Home Medical Care (IHMC) Program; CCS In-Home Nursing Program

Table 6. Medical Eligibility and Medical Necessity

NUMBER	TYPE	TITLE
		Blank
		Blank
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		Blank
04-0314	NL	Guidelines for Critical Congenital Heart Disease Screening Services
14-1213	NL	Telehealth Services for CCS and GHPP Programs
10-1113	NL	High Risk Infant Follow-up Program Note: 10-1113 supersedes 09-0606
14-1213	NL	Telehealth Services for CCS and GHPP Programs
02-0413	NL	Neonatal Intensive Care Unit (NICU) Authorizations Note: 02-0413 supersedes 04-0511
05-0612	NL	Intrathecal Baclofen (ITB) Pumps for the Management of Spasticity and Dystonia
04-0511	NL	NICU Authorizations Note: 02-0413 supersedes 04-0511
02-0510	NL	Service Code Grouping (SCG) 51 Implementation
09-03	CMS IN	CCS, CHDP, NHSP and GHPP **Laws** Note: update to set of laws previously provided in CMS I.N. 05-08, 01-07, 96-7
09-02	CMS IN	**Updated CCS Program Regulations** Note: this CMS IN supplements NL 05-0500 CCS Medical Eligibility Regulations. Changes in this IN reflect renumbering of the regulations and non-substantive changes in language.
10-0707	NL	Revised Guidelines for Authorization of Oxygen, Oxygen Delivery Equipment, and Related Supplies Note: 10-0707 supersedes 01-0107 and 47-1191
08-0507	NL	Vagal Nerve Stimulator (VNS) Implantation

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Appendix D - continued

Table 6 continued: Medical Eligibility and Medical Necessity

NUMBER	TYPE	TITLE
10-0806	NL	Authorization of Emergency Services Related to Trauma Note: this letter details policy re: authorizations to non-paneled physicians
15-0605	NL	Speech Pathology Services & Medi-Cal Certified Outpatient Rehab Centers
09-0606	NL	High Risk Infant Follow-Up (HRIF) Program Services Note: 09-0606 supersedes 06-0403
03-0206	NL	Neonatal Intensive Care Unit (NICU) Authorizations
14-0605	NL	Authorization of Occupational Therapy (OT) Services and Medi-Cal Certified Outpatient Rehab Centers
11-0605	NL	Delegation of Authority for Authorization of Aural Rehabilitation Services to County CCS Programs and CMS Regional Offices and Medi-Cal Certified Outpatient Rehabilitation Center
13-0903	NL	Medical Eligibility Nephrotic Syndrome
08-0703	NL	Authorization for Purchase of Incontinent Medical Supplies (IMS) Note: this letter is the corrected version. Note: 08-0703 supersedes 06-0492
07-0503	NL	Injuries to Joints and Tendons Policy Clarification Note: 07-0503 supersedes 08-0501
11-1002	NL	Outpatient Mental Health Services as CCS Benefits
05-0502	NL	Medical Eligibility for Care in a CCS-Approved Neonatal Intensive Care Unit (NICU) Note: this letter is the corrected version. Note: 05-0502 supersedes 11-0999
02-0102	NL	Pulse Oximeters Note: 02-0102 supersedes 01-0191
14-0801	NL	Synthesized Speech Augmentative Communication (SSAC) Device Note: 14-0801 supersedes 05-0397
12-0701	NL	Children at Risk for Human Immunodeficiency Virus (HIV) Infection Note: 12-0701 supersedes 01-0105 and 12-0701
10-0501	NL	Kawasaki Disease
11-1600	NL	Duplication of Physician or Therapy Services being provided through the CCS MTP Also see: 06-0600
05-0500	NL	**CCS Medical Eligibility Regulations** Note: 05-0500 supersedes 06-0599 Note: 05-0500 supplemented by CMS IN 09-02
01-0200	NL	Indicators for Social Work & Psychologists **Services** for CCS/GHPP Clients Note: 01-0200 supersedes 14-1099 and 02-0299
09-0899	NL	New Medical Treatment Modalities/Interventions which are **not** Established CCS Program Benefits
33-0994	NL*	Medical Eligibility for the Children with Proven HIV Infection
23-0594	NL*	Organ Transplants – Heart, Liver, Bone Marrow, Lung and Heart-Lung Note: 23-0594 supersedes 08-0394
22-0594	NL*	Lung and Heart-Lung Transplants
15-0494	NL*	Bone Marrow Transplants for Cancer, Section 273, H&SC
11-0393	NL*	Guidelines for Diagnosis and Treatment of Lead Poisoning Note: 11-0393 supersedes 09-0592
37-1292	NL*	Coverage of Experimental and/or Investigational Services
17-0992	NL*	Chronic Lung Disease of Infancy
33-0891	NL*	Luconex BAC Wheelchair/Mobile Stander
10-0291	NL*	DNA Probes for Hemophilia, Cystic Fibrosis, Sickle Cell, and Phenylketonuria. Note: this letter is re: Genetic Testing (Carrier & Prenatal Testing); See: 32-0990
31-0990	NL*	Heart Transplants
23-0790	NL*	CCS Program Coverage of Women for AFP Testing
10-0390	NL*	Emergency Regulations for HIV Screening
27-0890	NL*	Organ Transplants – Heart, Liver, Bone Marrow
06-0290	NL*	Liposuction
04-0290	NL*	Selective Posterior Rhizotomy (SPR)

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Appendix D - continued

Table 6 continued: Medical Eligibility and Medical Necessity

NUMBER	TYPE	TITLE
19-0789	NL*	Occupational Therapy for Swallowing and/or Feeding Problems in Patients with CCS Eligible Conditions Note: 19-0789 supersedes 03-0189
04-0289	NL*	Liver Transplant: Global Physician Service Reimbursement
37-1288	NL*	Extracorporeal Membrane Oxygenation (ECMO)
01-0189	NL*	Magnetic Resonance Imaging (MRI)
29-0788	NL*	Epikeratophakia
07-0788	NL*	Magnetic Resonance Imaging (MRI) Update
07-0188	NL*	Magnetic Resonance Imaging (MRI)
05-0788	NL*	Clarification of CCS Eligibility for GE Reflux
05-0288	NL*	Clarification of CCS Eligibility for GE Reflux
02-0188	NL*	Eye Prostheses (eye appliances)
17-1087	NL*	CCS Services to Children Who Live In Intermediate Care Facilities for the Developmentally Disabled. Note: see also 32-0784
05-0587	NL*	AIDS
32-1286	NL*	Scoliosis: Lateral Electrical Surface Stimulation (LESS). Also see: 17-0785, 37-0983, 11-0383
20-0786	NL*	Diseases of the Newborn
19-0786	NL*	Angioplasty or Therapeutic Cardiac Catheterizations (TCC)
18-0786	NL*	Epilepsy
17-0786	NL*	Diabetes Mellitus
16-0786	NL*	Medical AIR Ambulance Transportation
05-0286	NL*	Eye
37-1285	NL*	Neural Tube Defects Compared with Other Birth Defects
10-0585	NL*	Heart Transplants
01-0185	NL*	Bone Marrow Transplantation for Cancer
52-1284	NL*	Liver Transplants
41-1083	NL*	Artificial Eyes: CCS Coverage and Maximum Allowances
26-0683	NL*	New Hemophilia Treatment Products
22-0583	NL*	CCS/GHPP Cystic Fibrosis Treatment Benefits
21-0583	NL*	Prenatal Diagnosis of Sickle Cell Disease
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Appendix D - continued

Table 7. Medical Therapy Program (MTP) and Medical Therapy Unit (MTU)

NUMBER	TYPE	TITLE
		Blank
		Blank
		Blank
02-0214	NL	Implementation of Updated Tools for Classification of Function and Measurement of Functional Outcomes in the Medical Therapy Program
07-0612	NL	Implementation of the Episodic Treatment Method (ETM) as an Alternative Therapy Provision Method (ATPM) in the Medical Therapy Program (MTP)
05-0811	NL	Participation in the CCS Medical Therapy Program (MTP) Medical Therapy Conference (MTC) by CCS Program Medical Directors and Medical Consultants
06-07	IN	Revised Implementation Plan for the Quarterly Time Study (QTS) for MTP for 100 Percent State-Funding to Comply with IA Regulations (AB 3632)
02-0205	NL	Functional Outcome Measurement for the MTP
18-0901	NL	Reimbursement of LEA or SELPA for Provision of Medically Necessary Therapy Services to Children Medically Eligible for CCS/Medical Therapy Program (MTP)
14-0801	NL	Synthesized Speech Augmentative Communication (SSAC) Devices (Formerly known as Augmentative/Alternative Communication (AAC) Devices) Note: 14-0801 supersedes 05-0397
13-0701	NL	Revised Interagency Agreement (IAA) Between the CMS Branch and the California Department of Education (CDE), Special Education Division (SED)
11-1600	NL	Duplication of Physician or Therapy Services provided through CCS MTP. Also see: 06-0600
21-1299	NL	CCS MTP List. (The enclosure is not available online.)
06-0397	NL	The MTP: Dispute Resolution through "Expert " Physician
34-0994	NL*	Designation of a New Identifier to **Capture Costs** Related to the MTP
21-0594	NL*	Vendored Therapy Sites
26-0793	NL*	Designation of Code 50 on Form MC 255B to Represent Vendored Therapy in Lieu of MTU Services
36-1292	NL*	Determination of Medical Eligibility for the Medical Therapy Unit (MTU)
30-1092	NL*	Vendored Physical Therapy and Occupational Therapy Rates
22-0992	NL*	MTUs and Due Process. Also see 06-0397
02-0392	NL*	Determination of Medical Eligibility for MTP Services. See also: • 39-1290 Medical Eligibility for the Medical Therapy Program • 03-0788 Medical Eligibility for MTP • 03-0288 Medical Eligibility for MTP
38-0991	NL*	Program Advisory from Dept. of Ed on Occupational Therapy & Physical Therapy
34-0891	NL*	Oregon Orthotic System
29-0891	NL*	Vendored Therapy Rates for Services in Lieu of MTU Services
28-0891	NL*	Notification of Due Process Hearings for Special Education
06-0391	NL*	Responsibility for Local MTU Services for Out-of-County Residents Enrolled in Public Schools
43-1290	NL*	County Responsibility for MTU Services for Children Enrolled in Public Schools
34-1290	NL*	Payment for Occupational & Physical Therapy Services in Lieu of MTU Services
09-0389	NL*	Provision of Medical Therapy Unit (MTU) Services Including Physical Therapy/Occupational Therapy Consultation Outside the MTU Note: 09-0389 supersedes 11-0288
08-0389	NL*	Revised Procedure for Coding Cerebral Palsy on CCS Forms
09-0288	NL*	Revised Procedure for Coding Cerebral Palsy on CCS Form
04-0288	NL*	CCS Physical & Occupational Therapy Services to Home-Bound Children
24-0986	NL*	CCS-MTU (Therapy) Services to Children Residing in ICF-DDs
55-1284	NL*	Prosthetic and Orthotic SMA Effective 9/26/84
53-1284	NL*	Changes in Recording of PT and OT Services and Related Information
48-1184	NL*	ICF-DD and ICF-DD-H (MTU letter)
32-0784	NL*	CCS Services and Children who are covered by Medi-Cal and Live in ICF-DD
24-0984	NL*	CCS-MTU Services to Children Residing in ICF-DDs
49-1283	NL*	Payment for Contract Therapists at a Medical Therapy Unit (MTU)
23-0682	NL*	Additions to the Prosthetic and Orthotic Appliances SMA

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Appendix D - continued

Table 8. NUTRITION - Enteral Products and Medical Foods

NUMBER	TYPE	TITLE
		BLANK
		BLANK
22-0805	NL	Enteral Nutrition Products as a CCS Benefits and Request for Enteral Nutrition Product(s) Form Note: 22-0805 supersedes 04-0399, 04-0293, 38-1292, 29-0893, 10-0188 Note: 29-0893 provides guidelines for parenteral feeding equipment
20-0605	NL	Non-Benefit Status of Regular Infant Formulas
16-0605	NL	Delegation of Authority to Authorize Medical Nutrition Therapy Services to County CCS Programs and CMS Regional Offices
03-08	CMS IN	California WIC Supplemental Nutrition Program Infant Formula Changes
15-0801	NL	Medical Nutrition Assessment and Medical Nutrition Therapy for Children with CCS Medical Eligible Conditions Note: 15-0801 supersedes 11-1100, 02-0200, 02-0299
05-0399	NL	Medical Foods as a CCS/GHPP Benefit
35-0888	NL*	Nutritional Supplements Note: 35-0888 is revision of 10-0788

Table 9: PHARMACY

NUMBER	TYPE	TITLE
		BLANK
		BLANK
14-01	CCS IN	Prescriptions Containing Acetaminophen Limited to 325mg per Dosage Unit
13-08	CCS IN	Diagnosis Related Group Inpatient Reimbursement and Hemophilia Factor Drugs
13-05	CMS IN	Synagis Update 2013-2014 RSV Season
01-0113	NL	**SYNAGIS** (Palivizumab) Note: 01-0113 supersedes 04-0509
05-0612	NL	Intrathecal Baclofen (ITB) Pumps for the Management of Spasticity and Dystonia
03-0512	NL	Ivacaftor (Kalydeco)
11/18/10	CCS IN	Notice from CCS About Prescription Drug Coverage and Medicare
01-0510	NL	**BOTOX** (Botulinum Toxin) Note: 01-0510 supersedes 07-0407
09-05	CMS IN	Contracting for **FACTOR** Products Begins July 1, 2009
04-0509	NL	**SYNAGIS** (Palivizumab) Note: this letter supersedes 11-1006; 27-1005; 05-0904; 01-0203; 13-0999
01-0109	NL	**KUVAN** (Sapropterin Dihydrocholoride)
5/3/07	CMS IN	GHPP and CCS Become Title XIX Federal Medicaid Waiver Programs
06-0506	NL	**GROWTH HORMONE** Note: 06-0506 supersedes 25-0791, 20-0789, 43-1285
23-0905	NL	Epoetin Alfa and Carnitine Removed from "Table of Drugs Requiring Separate Authorization" Note: 23-0905 supersedes 20-0895; 12-0393; 15-0892; 01-0192; 27-0989
21-1101	NL	**PULMOZYME** (Dornase Fulfate) Note: 21-1101 supersedes N.L. 06-0195, 27-0694, 07-0394
05-18	CCS IN	Medicare Part D Coverage – Important Notice from CCS
17-0494	NL*	Gonadotropin Releasing Hormone (**GnRH**) agonist Analogues. See also: 32-0891
16-0494	NL*	**NUTROPIN** (Growth Hormone)
12-0393	NL*	**EPOGEN** (Erythropoietin) Note: this letter supersedes 01-0192, 27-0989
05-0191	NL*	**IVIG** Intravenous Immunoglobulin Note: supersedes 25-0793 & 41-1290
01-0190	NL*	Oral Zidovudine (**AZT)**
16-0889	NL*	Antihemophilic **FACTOR** Criteria Also see: 19-0885

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Appendix D – continued

Table 10. Screenings - Diagnostic Services for Newborns and Infants

NUMBER	TYPE	TITLE
		BLANK
04-0314	NL	Guidelines for Critical Congenital Heart Disease Screening Services
10-1113	NL	High Risk Infant Follow-up Program Note: 10-1113 supersedes 09-0606
02-0612	NL	Providing Contact Information to the Newborn Hearing Screening Program
07-08	CCS IN	Reporting to the New Hearing Coordination Center Contractor for the NHSP in the Northeastern and Central California Region
06-1008	NL	Authorization of Diagnostic Services for Infants Referred Through the NHSP Note: 06-1008 supersedes 21-0705. Also see 20-1299.
09-0607	NL	Authorization of Diagnostic Services for Infants Referred Through the California Newborn Screening (NBS) Program for Cystic Fibrosis (CF) and Biotinidase Deficiency (BD)
21-0705	NL	Authorization of Diagnostic Services for Infants Referred Through the California NHSP and Newborn Hearing Screening Program (NHSP) Referral Form See also: 20-1299
08-0505	NL	Authorization of Diagnostic & Treatment Services for Infants Referred by the California Newborn Screening (NBS) Program Including for Additional Metabolic Disorders & Congenital Adrenal Hyperplasia
05-0405	NL	Authorization of Diagnostic and Treatment Services for Infants Referred by the California Newborn Screening Program and Overview of the Genetic Disease Branch Newborn Screening Program
08-0802	NL	Two Additional CCS Approved Metabolic Centers Providing Diagnostic Services for Infants Referred from the Newborn Screening Program Mass Spectrometry (MS/MS) Research Project (Supplements 01-0102)
01-0102	NL	Authorization of Diagnostic Services for Infants Referred by Newborn Screening Program (Genetic Disease Branch) for Unusual Tests Results from the Supplemental Screening for Multiple Metabolic Disorders Tandem Mass Spectrometry (MS/MS) Research Project (Supplements 08-0802)
20-1299	NL	Authorization of Diagnostic Services for Infants Referred Through the California Newborn Hearing Screening Program (NHSP). Also see 06-1008
07-2099	NL	Infant Hearing Screen Program (NHSP) – Infant Hearing Screening Provider Standards

End of Appendix D

Appendix E

The CCS Program Provider Panel Requirements and Standards for Physicians, Special Care Centers, and Hospitals

Note**:** this list includes non-CCS Program providers who provide services to the CCS Program children.

To view online letters and notice list and text – click on hyperlink:

- CCS Numbered Letters (NL)
- CCS Information Notices (IN)
- CMS Information Notices (CMS IN)
- HRIF Program Letters (PL)

NUMBER	TYPE	TITLE
		BLANK
		BLANK
		BLANK
05-0314	NL	The CCS Program Pediatric Intensive Care Unit Standards Update: Annual PICU Report
03-0314	NL	Standards for Neonatal Intensive Care Unit (NICU)
01-1113	PL	High Risk Infant Follow-up Program (this is a CCS Program Letter for Providers) Note: PL 01-1113 supersedes PL 01-0606.
14-1213	NL	Telehealth Services for CCS and GHPP Programs
05-0612	NL	Intrathecal Baclofen (ITB) Pumps for the Management of Spasticity and Dystonia
11-02	IN	Quality Assurance Monitoring of SCG 51 Note: IN 11-02 supersedes IN 11-01
02-0510	NL	Service Code Grouping (SCG) 51 Implementation
07-1109	NL	Policy Relating to CCS Nurse Liaison Position in Partners for Children (Pediatric Palliative Care Waiver)
10-01	IN	Requirements for the Participation in the CCS Program by Family Practice Physicians
08-07	CMS IN	California Newborn Hearing Screening Program (NHSP) Legislation and Policy Update for Participating Hospitals
07-08	CMS IN	Reporting to the New Hearing Coordination Center Contractor for the NHSP in the Northeastern and Central California Region
01-0108	NL	CCS Outpatient Special Care Center Services Note: 01-0108 supersedes 08-0900
10-0806	NL	Authorization of Emergency Services Related to Trauma Note: this letter is re: authorizations to non-approved hospitals and physicians
09-0606	NL	High Risk Infant Follow-Up (HRIF) Program Note: 09-0606 supersedes 06-0403
02-0106	NL	Update to Medi-Cal Approved Centers of Excellence for Cochlear Implants Providing Services for CCS Eligible Beneficiaries Note: see also 14-1003
15-0605	NL	Speech Pathology Services and Medi-Cal Certified Outpatient Rehab Centers
14-0605	NL	Authorization of Occupational Therapy (OT) Services and Medi-Cal Certified Outpatient Rehabilitation Centers
05-12	IN	Deactivation of "CGP" Prefix Inpatient Provider Numbers
06-0505	NL	Intermediate Care Facility / Developmental Disabled – Nursing (ICF/DD-N) Statewide Facility Listing
03-20	IN	Letter to CCS Paneled Providers Regarding Updating Paneling Listing
03-19	IN	New CCS Hypertonicity Special Care Centers

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Appendix E continued: The CCS Program Provider Requirements and Standards

NUMBER	TYPE	TITLE
14-1003	NL	Additional Medi-Cal Approved Center of Excellence for Cochlear Implants Note: 14-1003 supplements 09-0900
06-0403	NL	High Risk Infant Follow-Up (HRIF) Services Note: 06-0403 supersedes 09-0902; 06-0403 superseded by 09-0606
08-0802	NL	Two Additional CCS Approved Metabolic Centers Providing Diagnostic Services for Infants Referred from the Newborn Screening Program Tandem Mass Spectrometry (MS/MS) Research Project Note: 08-0802 supplements 01-0102
06-0301	NL	Revision of CCS/GHPP Program Panel Applications
10-1000	NL	Registered Dieticians: Ketogenic Diet for Refractory Surgeries as a CCS Benefit Provided by Registered Dieticians
01-0200	NL	Indicators for Social Work and Psychologists Services for CCS and GHPP clients Also see: 14-1099
18-1199	NL	Presumptive Approval for Board Certified Physician Providers in Medi-Cal Managed Care (MCMC) or Healthy Families (HF) Plans
15-1099	NL	Funding Social Work an Psychologist Services for CCS and GHPP clients Also see: 01-0200
14-1099	NL	Indicators for Social Work and Psychologists Services for CCS and GHPP clients
10-0899	NL	Communication Disorder Center (**CDC**) Standards Note: view online enclosure
07-2099	NL	Infant Hearing Screening Program (**NHSP**) – Provider Standards
29-1298	NL	CCS Pediatric Intensive Care Unit (**PICU**) Standards
28-1298	NL	CCS Neonatal Intensive Care Unit (**NICU**) Standards
27-1298	NL	CCS Hospital Standards
43-1194	NL	Utilization Review for Outpatient Rehabilitation Center Certification
37-1094	NL	Implementation of Paneling Dieticians
28-0694	NL	Revised Panel Procedures
29-1092	NL	Rehabilitation Facilities Admission Criteria
09-0191	NL	Pediatric Cardiac Transplants Note: 09-0191 replaced 42-1290
36-1190	NL	Hospital - Length of Stay Guidelines
22-0805	NL	Paneling CCS/GHPP Special Care Center Nurse Specialists
08-0900	NL	CCS Special Care Center (SCC) Services
33-0888	NL*	Medi-Cal In-Home Medical Care (IHMC) Program. See also: 14-0483
23-0688	NL*	Approved Transplant Centers (including those with provisional approval) Note: this letter references 25-1186, 01-0185, 10-0585, 52-1284
02-0185	NL*	Services by Family Practice Physicians and by Podiatrists
36-0884	NL*	Inpatient Transfer Policies for Medi-Cal Contract Hospitals. See also: clarification of 13-0484
14-0284	NL*	Respite Care and the Level of Care Providers Who May Be Authorized by CCS. Note: does this letter supersede 09-0284
13-0484	NL*	Inpatient Transfer Policies for Medi-Cal Contract Hospitals. See also: 36-0884 for clarification.
14-0483	NL*	In-Home Medical Care (IHMC). See also: 33-0888
42-1282	NL*	Hospitals Contracting with Medi-Cal

End of Appendix E

Appendix F

The CMS/CCS Program Administration Policies

Note: This appendix lists many general CCS Program administration policies and procedures not cross referenced in the Case Management Procedure Manual.

To view online letters and notice list and text – click on hyperlink:

- CCS Numbered Letters (NL)
- CCS Information Notices (CCS IN)
- CMS Information Notices (CMS IN)

NUMBER	TYPE	TITLE
Healthy Families Program (HFP) Transition to Medi-Cal Letter No.: 12-30 [hyperlink]		
Memorandum of Understanding (MOU) between the CCS Program and Healthy Families Program (HFP). Note: MOU is located in Section 5 of the CMS Plan and Fiscal Guidelines Manual [hyperlink]		
Delineation of Responsibilities for the CMS, Regional Offices, Independent & Dependent Counties as they Relate to the Healthy Families Program (HFP) MOU. Note: MOU is located in Section 5 of the CMS Plan and Fiscal Guidelines Manual [hyperlink]		
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03-0314	NL	Standards for Neonatal Intensive Care Unit (NICU)
14-1213	NL	Telehealth Services for CCS and GHPP Programs
12-1113	NL	Optional Targeted Low Income Children's Program Aid Codes T1, T2, T3, T4, and T5 and Separate Children's Health Insurance Program Section 2101 (f) Aid Codes E2 and E5; Assignment of CCS Unique Aid Codes
13-01	CCS IN	Update of Table 1 (Family Size and Annual Income Level Chart) - MEDI-CAL Year 2012 Federal Poverty Level Chart; Effective Beginning January 26, 2012
13-01	CMS IN	Plan and Fiscal Guidelines Update
12-04	CMS IN	Transition of Children and Adolescents Who are Healthy Families Program Subscribers to Medi-Cal
12-02	CMS IN	Web Source for Preliminary Draft of Narrative for Federal Fiscal Year (FFY) 2012- 13 Title V Block Grant Application and Progress Report
12-01	CCS IN	Fiscal Year (FY) 2012-13 County Allocations for CCS County Administration and the CCS Medical Therapy Program (MTP)
11-05	CMS IN	Update of Table 1 (Family Size and Annual Income Level Chart) – Medi-Cal Year 2011 Federal Poverty Level Chart; Effective April 1, 2011. To reference prior Table 1 Updates, see Annual CCS Information Notices.
11-02	CMS IN	**CMS Branch Plan and Fiscal Guidelines (PFG)**
10-04	CMS IN	**CMS Branch Plan and Fiscal Guidelines (PFG)** Note: the PFG is no longer posted by individual FY. The PFG will be updated or revised for each upcoming FY as programmatic and budget changes occur.

Appendix F – continues on the next page

Appendix F continued: The CCS Program Administration Policies

NUMBER	TYPE	TITLE
10-03	CMS IN	California Children's Services (CCS) Fiscal Year (FY) 2010-2011 Diagnostic, Treatment, Vendored Therapy, and Dental Funding Certifications
08-08	CCS IN	GHPP Forms
05-0608	NL	Right to Appeal Decisions of the CCS Program
5/3/07	CMS IN	GHPP and CCS Become Title XIX Federal Medicaid Waiver Programs
13-1007	NL	Implementation of Assembly Bill (AB) 1642
15-1206	NL	Supplement to NL 12-1006 and Healthy Families Statement of Annual Income
21-1006	NL	Updated CCS Policies Relating to Children who are Healthy Families Subscribers
05-0406	NL	Directions for Completion of the Quarterly Time Study (QTS) for MTP for 100 Percent State-Funding to Comply with IAA (AB 3632)
01-0106	NL	CCS Expenditure Reporting to the California's Department of Finance (DOF) for the Purpose of Calculation of Realignment Caseload Growth
29-1105	NL	Changes to CCS Notices of Privacy Practices, Spanish and English Version
28-1105	NL	Instructions for Certification of Funding Under H&SC Section 123945
26-0905	NL	Newborn Referral to the Medi-Cal Program and Newborn Referral Form
25-0905	NL	Hurricane Katrina
24-0905	NL	CCS Services for Infants Born to Mothers Participating in the Access to Infants and Mothers (AIM) Program Subsequent to Birth are Enrolled in the HF Program
19-0605	NL	CCS/HF Subscribers Deemed Financially Eligible for CCS and Correction of Errors in Monthly County Expenditure Reports
10-0605	NL	MTU Medi-Cal Reimbursement State County Cost Sharing and Reconciliation
06-0505	NL	ICF/DD-Nursing Statewide Facility Listing
01-0105	NL	Dependent and Independent County CCS MTP Guidelines for Development for Policies and Procedures for Implementation of the HIPPA
-/17/04 (date)	CCS IN	Direct Electronic Submission of Patient Therapy Record Data (PTR) Batches via CMS Net for MTU Services
07-1004	NL	Health Care Financing Administration Common Procedural Coding System (HCPCS) Code Changes Effective 11/1/04 for DME and Diabetic Supplies
03-1004	NL	RESCINDED MTP billing, reimbursement, reconciliation
04-14	CCS IN	CMS Net System Availability
04-13	CCS IN	Implementation of the CMS Network Enhancement 47 (E 47) Project
04-03	CMS IN	Five Percent Rate Reduction from Non-Medical CCS & GHPP Services & Exemptions from the Reduction
04-01	CMS IN	New CMS Branch Mailing Address Note: includes list of Mail Stop Codes
03-18	CCS IN	Elimination of All CGP Provider Numbers
03-17	CCS IN	Revision and Translation of CCS Materials
03-07	CMS IN	CMS Online Archive for Policy Letters and Information Notice
15-1103	NL	Request for Pilot Project Application; Medical Therapy Program
12-0803	IN	Implementation of Assembly Bill (AB) 495; Expansion of Children's Health Insurance Coverage
11-0703	NL	Notice of Privacy Practices for CCS Clients; Compliance with Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule Note: 11-0703 supersedes 05-0403
10-0703	NL	Child Health and Disability Prevention (CHDP) Program Gateway
04-0403	NL	Notice of Privacy Practices for CCS Medical Therapy Program; Compliance with Health Insurance Portability and Accountability Act Privacy Rule
12-1202	NL	CCS Financial Eligibility Policy Regarding Native American Indians
10-1002	NL	Designation of CCS Staff for Obtaining Healthy Families Eligibility Information from the Managed Risk Medical Insurance Board (MRMIB)
04-0402	NL	CCS Policy Related to the Implementation of SB 344; Posting of the CCS Application on the DHS Website
20-1101	NL	CCS Financial Policy Regarding Clients whose Annual Adjusted Gross Income is Below 200 Percent of the Federal Income Guidelines but the Current Enrollment Fee Scale Indicates a Fee is to be Charged
19-0901	NL	CCS Residential Policy re: Persons Here on Visa or Temporary Entry Permit
18-0901	NL	Reimbursement of LEA or SELPA for Provision of Medically Necessary Therapy Services to Children Medically Eligible for CCS/Medical Therapy Program (MTP)

Appendix F – continues on the next page

Appendix F continued: The CCS Program Administration Policies

** Document is not available online.*

NUMBER	TYPE	TITLE
17-0901	NL	Policy for Identifying, Documenting, Claiming, and Reporting HF Subscribers Cases when Family's Annual Adjusted Gross Income is Greater than $40,000
13-0701	NL	Revised Interagency Agreement (IAA) Between the CMS Branch and the California Department of Education (CDE), Special Education Division (SED)
11-0601	NL	CCS Policy re: the Requirement that all CCS Applicants Shall Make Application to the Medi-Cal Program; H&SC Section 123995 Note: 11-0601 supersedes 03-0300; 19-1299
09-0501	NL	Electronic Billing
07-0401	NL	(Corrected 2 – Released 2/19/13) Criteria for Assignment of CCS Unique Aid Codes to CCS Eligible Children
04-0301	NL	Electronic Claiming
02-0301	NL	Implementation of Section 14133.05 of the Welfare & Institutions Code re: Treatment Authorizations
01-0301	NL	Instructions for Completion of the "State-Approved 100 Percent State-Funded Staff Allocation for County Medical Therapy Programs" Form Note: 01-0301 supersedes 20-0898
11-1500	NL	Verifying Residential Eligibility for Children who are Medi-Cal Full Scope or Healthy Families Eligible
10-1400	NL	CCS Rate Increases for Medical Services
04-0400	NL	Case Management of Medi-Cal Eligible Beneficiaries with a CCS Eligible Condition Enrolled in a Medi-Cal Managed Care Plan
15-1099	NL	Funding for Social Work and Psychologists Services for CCS and GHPP clients
01-0299	NL	Healthy Families (HF) Program Referrals to the CCS Program Note: 01-0299 supersedes 07-0598
20-0997	NL	Case Management Timelines
16-0597	NL	Medical Therapy Program (MTP) Clerical Support Staffing
19-0795	NL	New Law Allowing Caregivers to Authorize Health Care including Medical and Dental Treatment for a Minor
03-0195	NL	Tracking First Level Appeals
45-1194	NL*	Definition of "Family"
39-1094	NL*	Billing Procedure: CCS County Administrators, Medical Consultants, Chief/Supervising Therapists and State Regional Office Staff
35-0994	NL	Revised Diagnostic, Treatment & Therapy Expenditure Claim Forms for Counties Using the DHCS Fiscal Intermediary. Note: see CCS IN 05-14 for current forms
34-0994	NL	Designation of a New Identifier to Capture Costs Related to the MTP
19-0594	NL*	Instructions for Certification of Funding Under H&SC Section 266
18-0594	NL	Appeal Guidelines
06-0394	NL	Required Use of Health Insurance
32-1293	NL	Revised Diagnostic, Treatment, and Therapy Expenditure Claim Forms for Independent Counties. Note: see CMS IN 05-14 for current forms
26-0793	NL*	Designation of Code 50 on Form MC 255B to Represent Vendored Therapy in Lieu of MTU Services
22-0992	NL*	MTUs and Due Process. Also see 06-0397
19-0591	NL*	Assignment of Analysts for Hospital Reimbursement Rates
18-0591	NL*	Out of State Reimbursement Rates and Corresponding Regulations
17-0591	NL*	Medi-Cal Eligibility Aid Codes
13-0591	NL*	Major Risk Medical Insurance Program (MRMIP)
20-0590	NL*	Capitated Health System Plans
07-0290	NL*	200 % Medi-Cal Coverage for Pregnant Women & Infants Up to One Year Old
18-0689	NL*	Revision of California's Disease Reporting Regulations
07-0289	NL*	Presumptive Disability Under Medi-Cal
33-0888	NL*	CCS Case Management and Authorization for Medi-Cal Children
20-0788	NL*	Insurance Disclaimers
19-0488	NL*	Public Access to California Children's Services (Telephone Coverage)

Appendix F – continues on the next page

Appendix F continued: The CCS Program Administration Policies

** Document is not available online.*

NUMBER	TYPE	TITLE
17-0388	NL*	Confidentiality of CCS Patients
16-0388	NL*	CCS Application for Treatment Services – Form for Adult Clients
15-0388	NL*	Form 2 – Release of Information (MC 2701)
01-0388	NL*	Out of State Hospital Rates
17-1087	NL*	CCS Services to Children Who Live in Intermediate Care Facilities for the Developmentally Disabled. See also **32-0784*** CCS Services and Children Who Are Covered by Medi-Cal and Live in ICF-DD
06-0587	NL*	Use of Health Insurance. See also: 06-0394; 33-1185
04-0587	NL*	Proof of California Residence
07-0386	NL*	Out of State Provider Services
38-1285	NL*	State Staff – New Personnel
33-1185	NL*	Health Insurance
32-1185	NL*	Residence Eligibility
16-0785	NL*	Referral of Undocumented Applicants to Medi-Cal. See also: 05-0385
05-0385	NL*	Referral of Undocumented Applicants to Medi-Cal, effective immediately See also: 16-0785
50-1184	NL*	Diagnostic and Treatment Funds
37-0884	NL*	Case Coordinator Procedure Manual Revisions
19-0484	NL*	Medi-Cal Provider Relations
42-1083	NL*	(1) Medi-Cal Application (2) Guardians
16-0483	NL*	Caseload Records (Case Load Policy)
32-0883	NL*	Medi-Cal Application
09-0883	NL*	Seventh Day Adventist Health Care Assistance Plan (HCAP)
3/14/83	*	Policies/Procedures – Questions and Answers
01-0183	NL*	Medi-Call Application as a Requirement for CCS Treatment Services
24-0682	NL*	Adult CCS Clients
14-0582	NL*	Referral of Medi-Cal Children to CCS. Note: This letter includes Memorandum regarding client with long term care.

Note: To locate NL's and IN's not included in this cross reference list - search the following:

- CMS 03-07 CMS Online Archive for Policy Letters and Information Notices
- NL* 24-0594 Numbered Letter Log and Index
- NL* 30-1193 Numbered Letter Log and Index
- NL* 09-0393 Numbered Letter Log
- NL* 32-1192 Numbered Letter Index
- NL* 20-0591 Numbered Letter Index and Log

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Appendix G

The CCS Program Due Process Timelines **Page**

Figure 1 Relationship of Administrative Procedures to the Total CCS Program System ……122

Figure 2 Overview of Administrative Procedures……123

Figure 3 Application Timelines……124

Figure 4 When to Send Notice of Action (NOA) ……..125

Figure 5 First Level Appeal ……126

Figure 6 The CCS Program Fair Hearing……....127

Figure 7 Continuation of Services During an Appeal……..128

Note: Figures are from the CMS/CCS Program Administrative Procedures Manual – 2001. Refer to CMS Information Notice 09-02 for renumbering of the regulations.

Figure 1 RELATIONSHIP OF ADMINISTRATIVE PROCEDURES TO TOTAL CCS SYSTEM

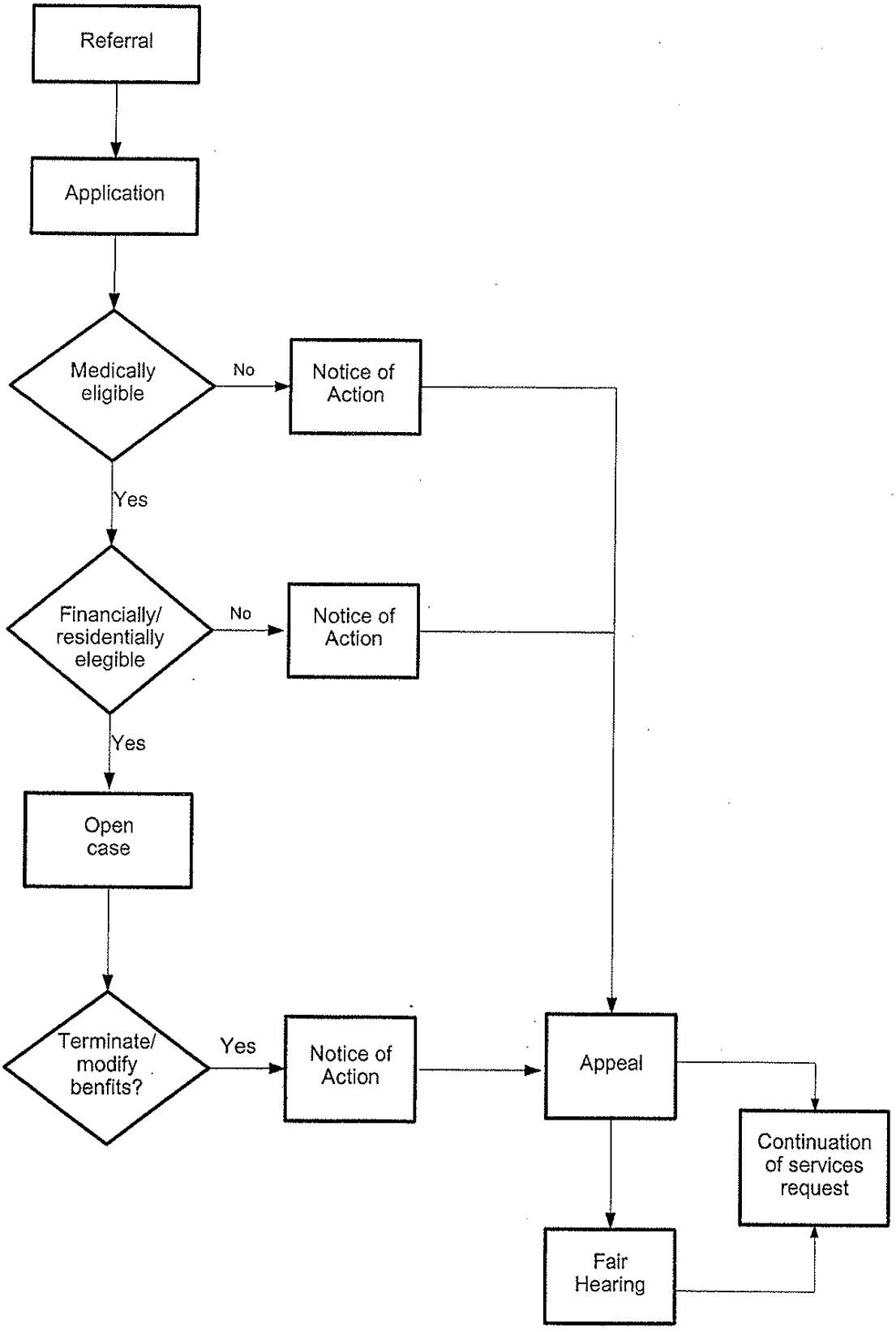


Figure 2

OVERVIEW OF THE ADMINISTRATIVE PROCEDURES

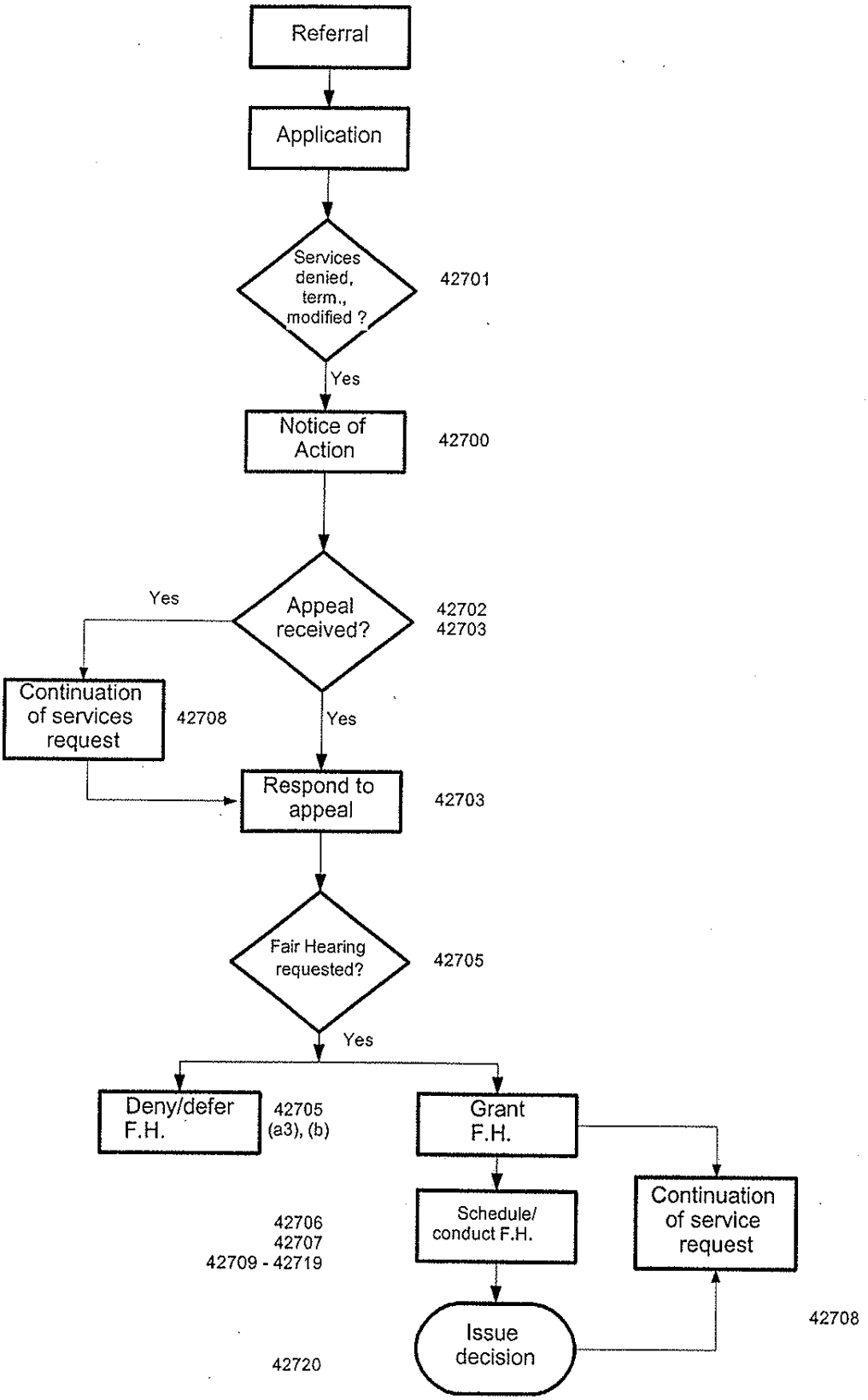


Figure 3

APPLICATION TIMELINES

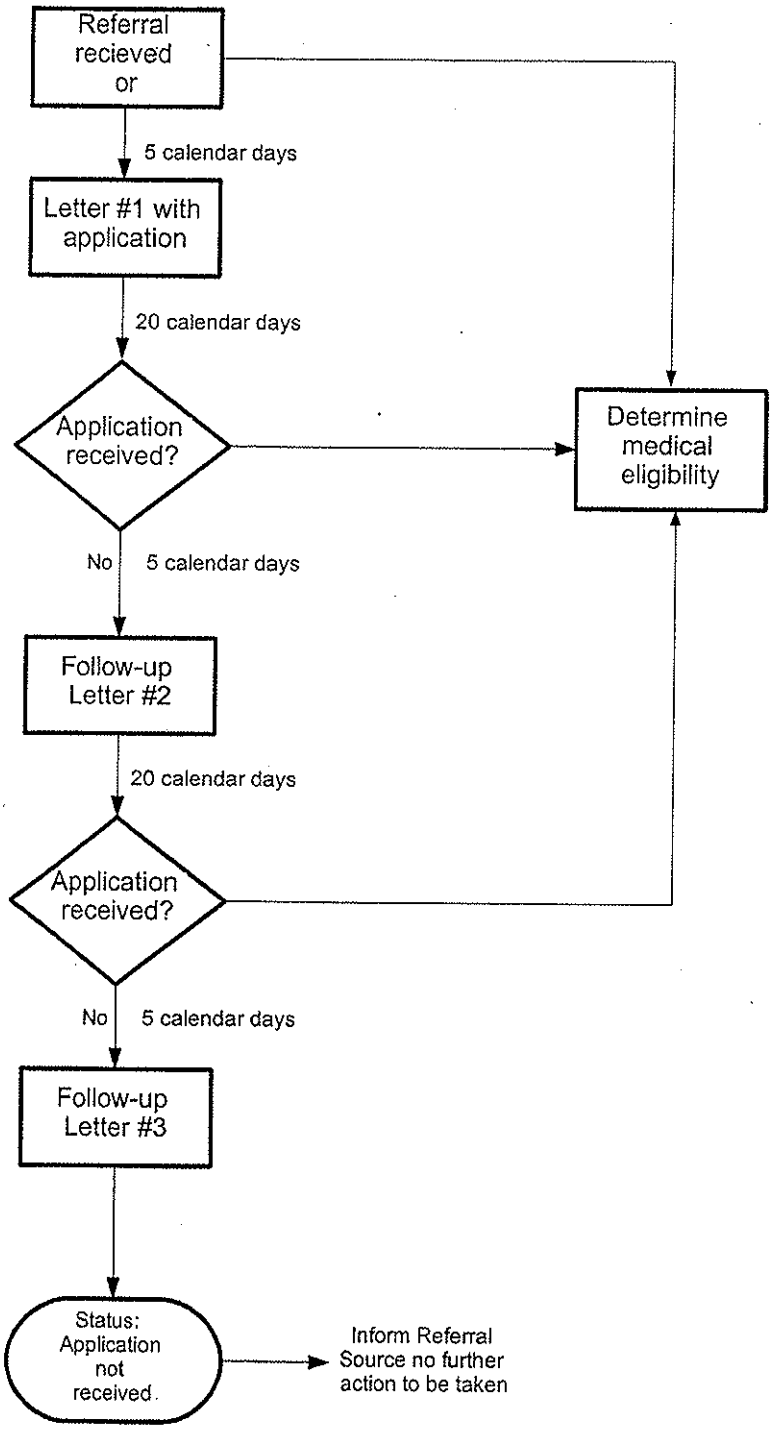
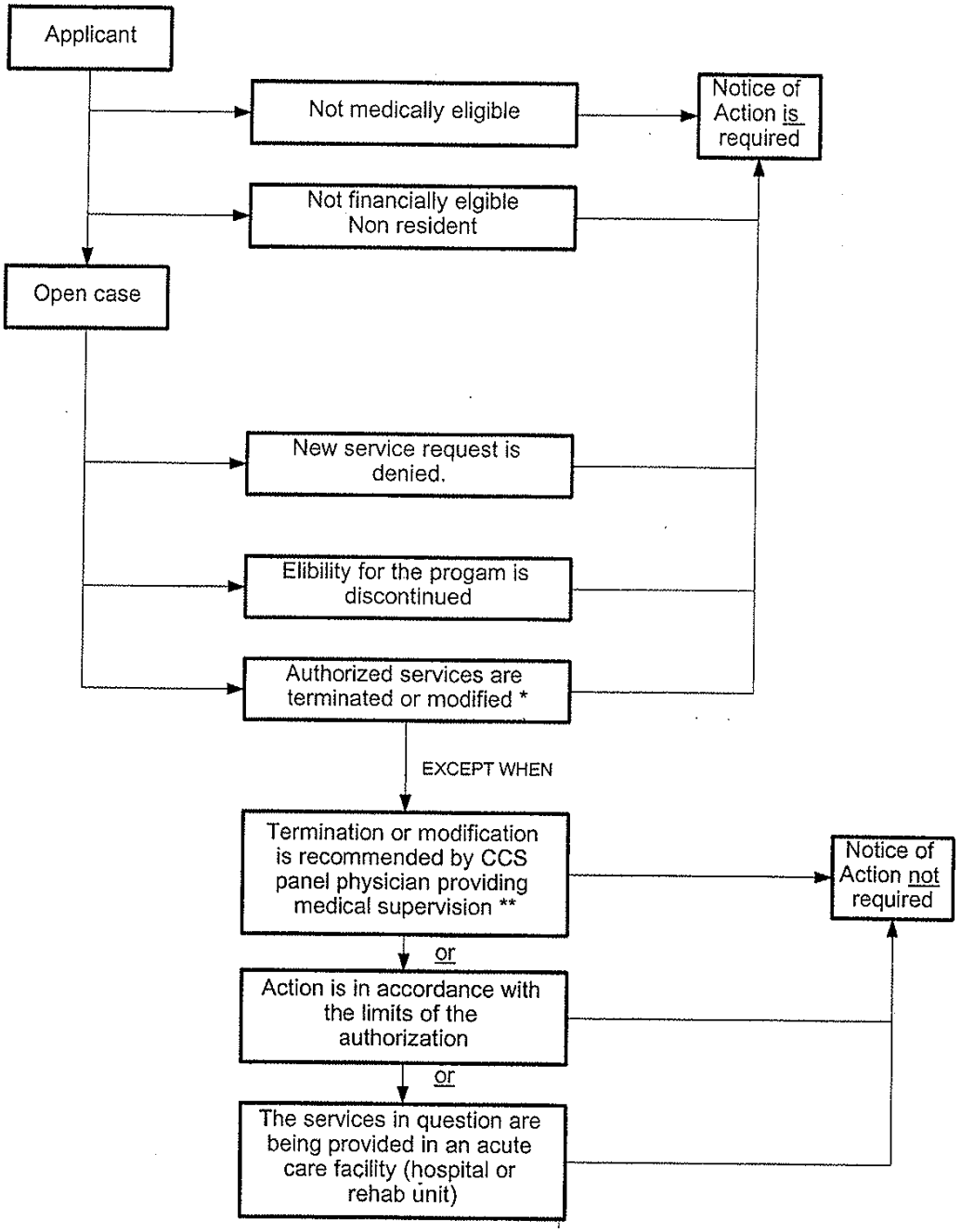


Figure 4

WHEN TO SEND NOTICE OF ACTION (NOA)



* Modified: Frequency or duration is reduced, place or provider of service is changed, or nature of service benefit is altered.

** Please Note: Although NOA is not required, when clinic or legal guardian learns of the terminator or modification (e.g. in office of provider, clinic or other means) and disagrees with the action, resolution in such cases is by "expert" opinion (42702a).

Figure 5

FIRST LEVEL APPEAL

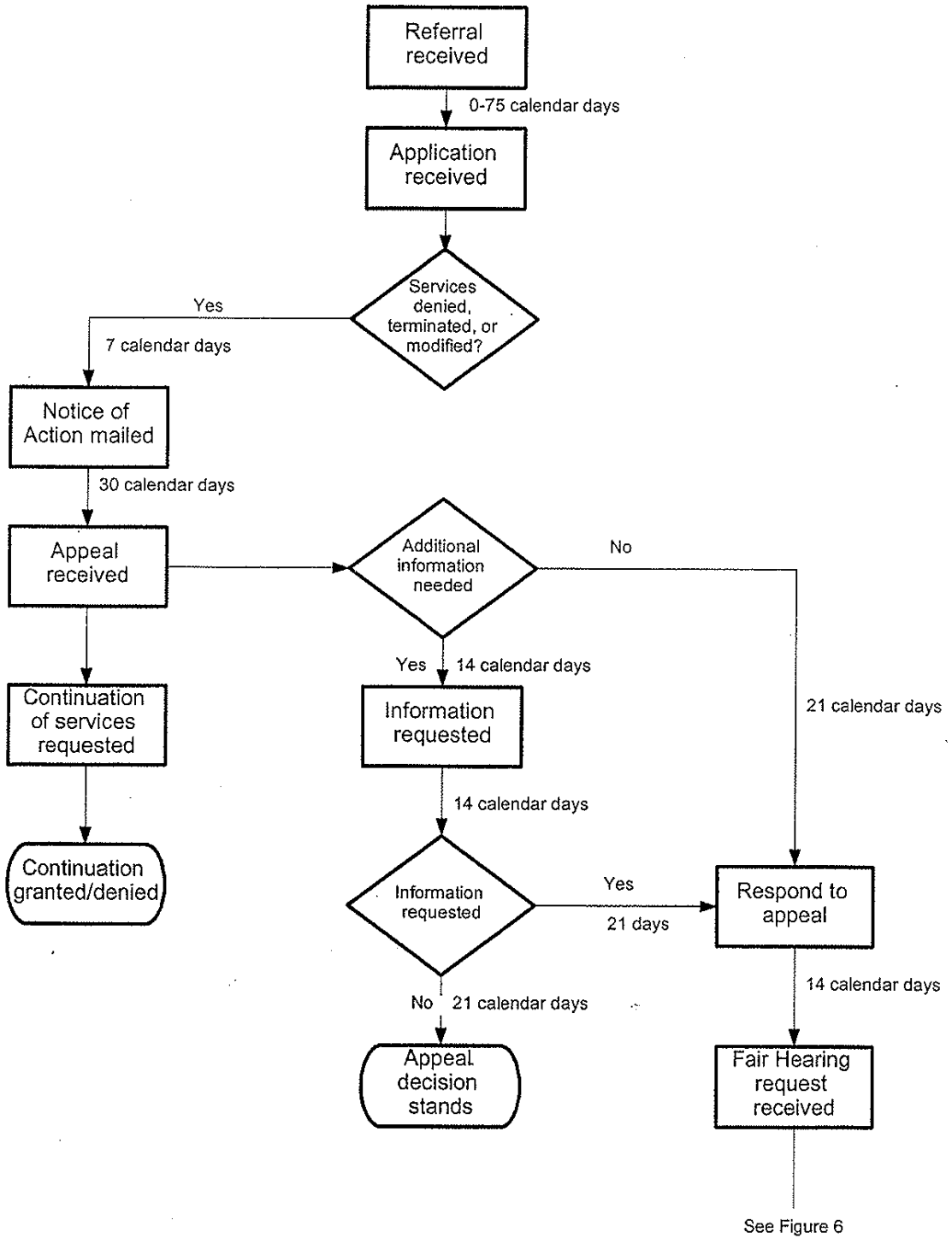


Figure 6 CCS FAIR HEARING

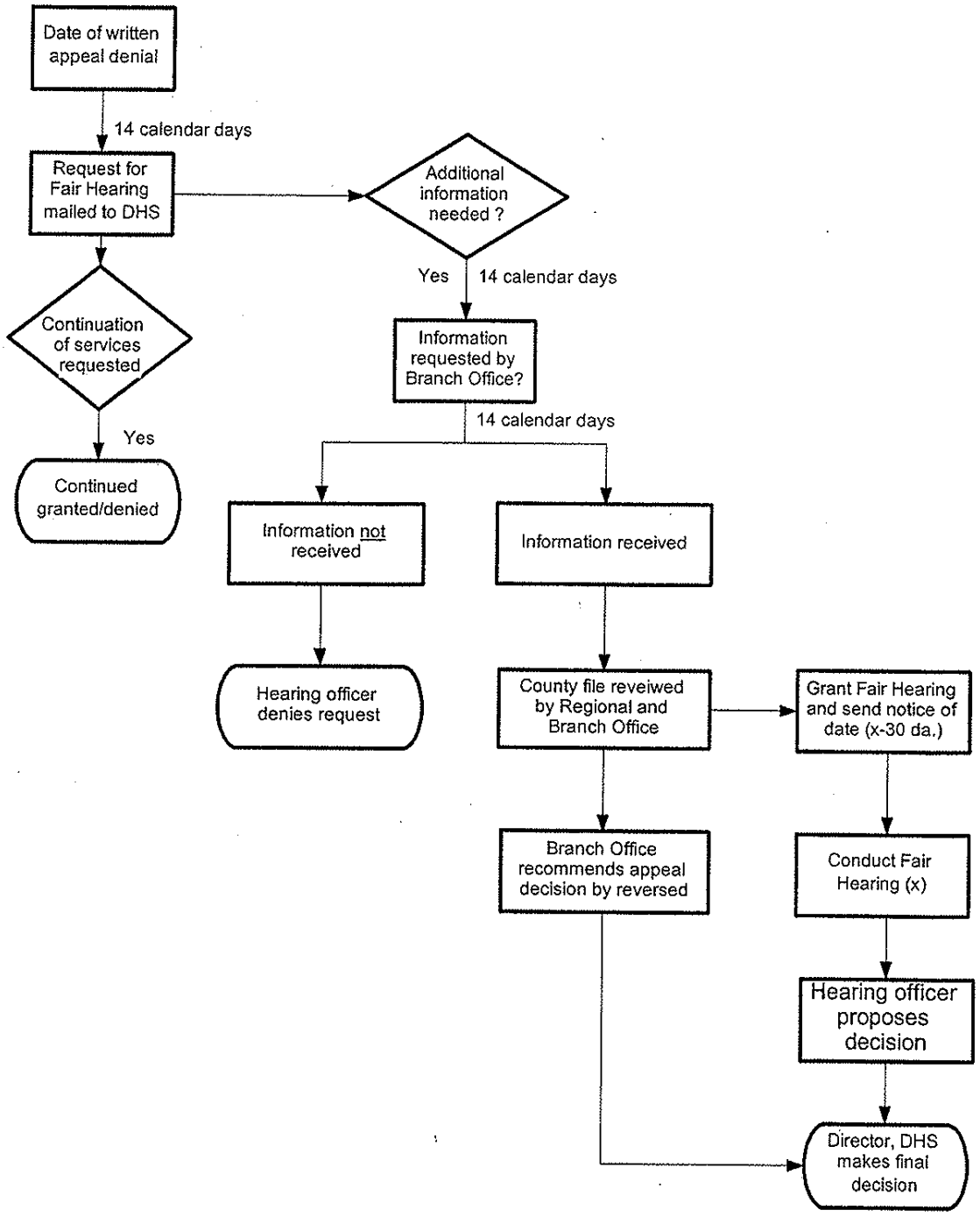
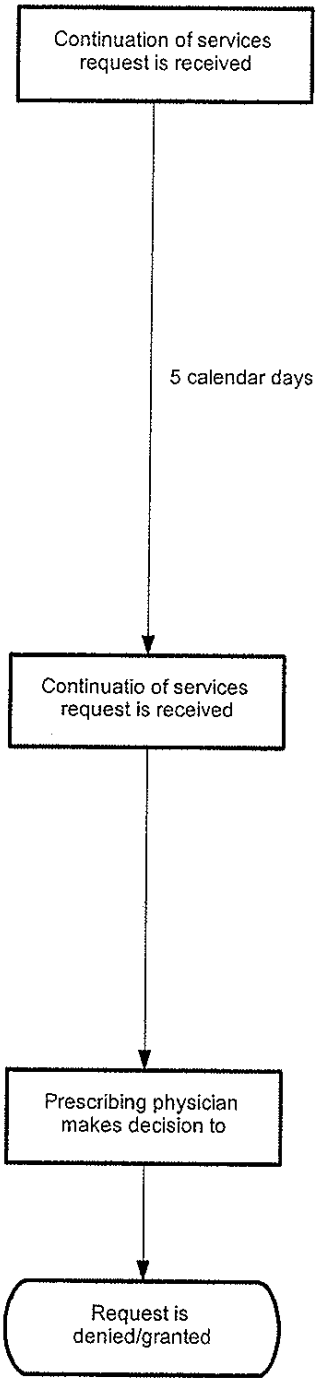


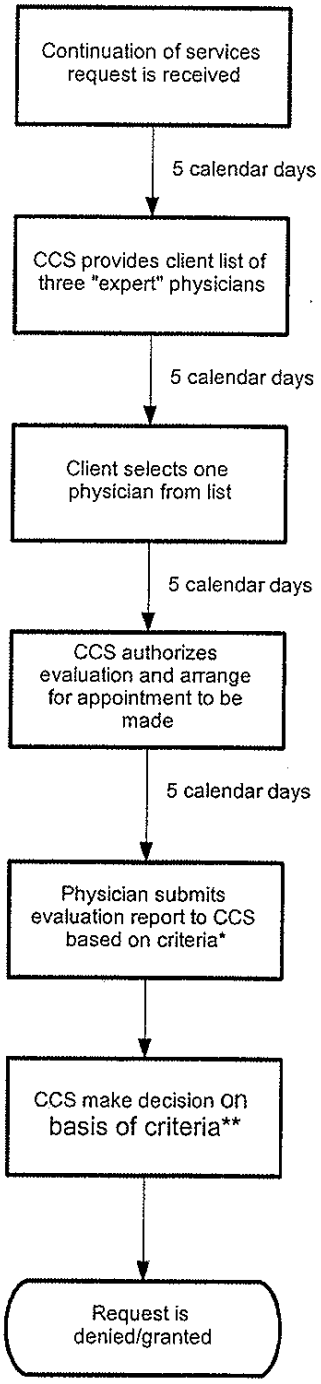
Figure 7

CONTINUATION OF SERVICES DURING AN APPEAL OR FAIR HEARING

When an appeal or Fair Hearing issue is the termination or modification of previously authorized services <u>because of financial eleigibility or residence</u>:



When an appeal or Fair Hearing issue is the termination or modification of previously authorized services <u>because of medical eleigibility or need for the medical services</u>:



* For criteria to be used by prescribing physician or the "expert" physician, see VII/B.4.

** For criteria to be used by the program, see VII/B.5.

CHAPTER FIVE: APPENDICES

Glossary…….. Page 130

Abbreviations and Acronyms ……. Page 139

Glossary

Active Case

An active case is when a client is opened to the CCS Program and is receiving case management diagnostic and/or treatment services

Administrative Case Management

The CCS Program staff are responsible for program-wide activities, such as: program administration; fiscal/budget management; Medical Therapy Program therapy and administration services; and administrative case management, which includes the proactive function of concurrent review of documents and reports to provide authorization of services anticipated. See Plan and Fiscal Guidelines for the CCS Program Services

Aid Code

Aid Codes assist providers and programs in identifying the types of services for which Medi-Cal and Public Health Program recipients are eligible. The Aid Code is verified through the Medi-Cal Eligibility Data System (MEDS), the Point of Service System (POS), the Automated Eligibility Verification System (AEVS), and at the Medi-Cal Internet Site.

Annual Medical Review

The purpose of the Annual Medical Review (AMR) is to assure all aspects of the client's case are up to date without gaps in services and review for any new medically eligible conditions. The AMR documented in the CMS Net case notes provides a rapid review of the client's medical and social status and summary of the current plan for case management. Completion of the AMR should include an annual update of the client's CMS Net Registration Face Sheet to ensure all appropriate ICD diagnoses are listed and ineligible diagnoses are closed and removed.

Applicant

The individual for whom the CCS Program services may be authorized. A potential CCS Program applicant is not a client of the CCS Program.

Application

When a potential CCS Program applicant or his/her parents or legal guardian applies (submits a written application) to the CCS Program in the county of residence to request services for a physically handicapping condition (H&S Code 123865).

Authorization

An approval for the CCS Program medically eligible and medically necessary diagnostic or treatment services.

The CCS Program Case Number

The CCS **Program** case number is a seven digit number assigned to a case when a CCS **Program** record is opened as the client is eligible for CCS **Program** case management services. The CCS **Program** case number is also known as the State File Number.

The CCS-Only Client

The CCS Program clients who are not eligible for full-scope Medi-Cal are referred to as “CCS-only” clients.

Caregiver

Sections 6550 and 6552 of the Family Code state that a non-parent adult caregiver relative with whom a minor is living may authorize medical and dental care for the minor by signing a “Care Giver Authorization Affidavit.”

The parent or legal guardian must still sign the CCS Program Application and Program Services Agreement (see Numbered Letter 19-0795).

Case Activity

Client who continues to receive treatment services within the last 12 months, California Code of Regulation, Title 22, Section 41610(a).

Children’s Health and Disability Prevention (CHDP) Program

The CHDP Program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The CHDP Program provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. [hyperlink]

Children’s Medical Services Network (CMS Net)

The CMS Net is a web-based case management system used by the CCS programs Statewide and the GHPP. The CMS Net is used to implement case management activities, such as program referrals, eligibility determinations, authorization issuance, narratives, and Notices of Actions. [hyperlink]

Client

A person who has an active CCS Program case number.

Client Index Number (CIN)

The CIN is a number assigned by the Statewide Client Index (SCI) Search and is shared across all programs participating in the use of SCI, including Medi-Cal, Healthy Families, the CCS Program and the GHPP. Using the CIN, you can accurately identify a single patient/client record in MEDS.

Effective Date

The date determined by appropriate procedure or staff to begin or terminate services.

Electronic Health Record (EHR)

Refer to definition for Electronic Health Record.

Electronic Medical Record (EMR)

A digital version of the paper charts in a health care provider's office. An EMRcontains the client's medical and treatment history.

Federal Poverty Level (FPL)

The Federal poverty level is a specified amount of income that families need to provide for basic needs. The Department of Health and Human Services (DHHS) establishes this amount annually based upon family size and this is often referred to as Federal poverty guidelines. Many Federal programs (Head Start, Medi-Cal, Food Stamps) use these guidelines as a base for eligibility. The Federal poverty level is updated every year. Refer to CCS Information Notices regarding annual federal poverty levels.

The Genetically Handicapped Persons Program (GHPP)

Programs for persons over age 21 with specific handicapping conditions [hyperlink].

Healthy Families Program (HFP)

The HFP is a State and federally funded health, dental and vision insurance program for children up to 19 years of age who reside in households with an annual income below 250 percent of the federal poverty level, and who are not otherwise eligible for full-scope, no Share of Cost Medi-Cal. In California, the State Children's Health Insurance Program (SCHIP) is known as HF [hyperlink].

International Classification of Diseases (ICD)

The ICD is the standard diagnostic tool used to classify diseases and other health problems. Records saved using these codes provide the basis for the compilation of national mortality and mortality by the World Health Organization (WHO) Member States. It is used for reimbursement and resource allocation decision-making as well.

Legacy System

The CMS Net system was utilized for all the CCS Program case management procedures and processes prior to the implementation of the E47 system July 1, 2004 (CCS Numbered Letter 04-0604). The current Legacy System continues to operate during ongoing transitions of legacy functionality to the SAR/WEB System. The Legacy System is currently utilized for all Registration and Client Eligibility procedures [Legacy Manual]. Updates to CMS Net system are announced in periodic *This Computes! Change Cycle* bulletins.

Legal Guardian

A person who has been appointed or empowered by the court to act on behalf of an individual when that individual is unable to act on his/her own behalf.

May

For the purpose of utilizing this Manual, the term "may" is permissive for administrative decision. See definitions for "shall" and "should".

Medi-Cal Eligibility Data Systems (MEDS)

An automated system available to all Children's Medical Services programs. The system is used to verify the current and historical eligibility status of a Medi-Cal beneficiary for up to 15 months history.

Medi-Cal Full Scope no Share of Cost

A Medi-Cal beneficiary who is eligible for all Medi-Cal services and who has no share of cost (SOC) for medical expenditures.

Medi-Cal with a Share of Cost

A Medi-Cal beneficiary who has a share of cost (SOC) for medical expenditures. If the Medi-Cal eligibility verification system indicates a recipient has a share of cost, the share of cost must be met before a recipient is eligible for Medi-Cal benefits.

Medically Necessary

Medically necessary benefits are those services, equipment, tests, and drugs which are required to meet the medical needs of the client's CCS-eligible medical condition as prescribed, ordered, or requested by a CCS Program physician and which are approved within the scope of benefits provided by the CCS Program. Refer to California Code of Regulation, Title 22, Section 41452.

Medical Therapy Program (MTP)

The MTP means the specific component of the CCS Program located in public schools that provides physical therapy, occupational therapy, and physician consultations to children with specifically defined eligible conditions. Refer to California Code of Regulation, Title 22, Section 41450.

MTU Only

"MTU Only" refers to children who are eligible for services through the CCS Medical Therapy Program but are not eligible for the CCS general program based on one or more of the following: financial ineligible (over $40,000, adjusted gross income); coverage is through a Health Maintenance Organization (HMO).

These children may receive physical and occupational therapy and Medical Therapy Conference (MTC) physician services at a Medical Therapy Unit (MTU) located at a public school or they may receive physical and occupational therapy services vendored to a therapist in private practice or at an outpatient medical facility.

New County

Refers to the county where the client's new address is located and where residence is established before the original county can transfer the case to the new county.

Notice of Action (NOA)

A NOA is a written notice of the action taken by a CCS Program agency to deny, reduce, or alter the medical service or benefit requested. This is the first step in the applicant/client appeal process. [CMS Net Denial and Closure Reason Listing]

Obligated

A Medi-Cal term used in reference to Share of Cost. A Medi-Cal beneficiary may be required to obligate, that is, sign a statement of agreement to pay a designated amount each month towards his/her medical expenses before Medi-Cal program will pay for services in excess of this amount of money.

Original County

Refers to the county which has an open CCS Program case and is notified that the client may have established residency in another county.

Paneled Provider

A primary care provider, specialist and/or subspecialist provider, hospital, or special care center who submits a CCS Program application and is subsequently paneled (approved) as a CCS Program provider. Only paneled physicians of the appropriate specialty can be authorized to medically manage/treat the client's CCS-eligible medical condition(s). [Becoming a CCS Provider]

Pending Case

A case which has been referred for the first time or is re-referred to the CCS Program and program eligibility is yet to be determined.

Pending Service Authorization Request (SAR)

A request for service which has been entered into the SAR/WEB system and is pending adjudication. Changes may be made to the pended SAR before authorization or denial.

Provider Electronic Data Interchange (PEDI)

A web-based tool that enables approved CCS Program providers and health plans to electronically access the status of requests for services/authorizations, including to print authorizations, denials and NOAs.

Potential Applicant

The individual for whom the CCS Program services may be authorized once a signed application is received by the CCS Program.

Referral

A referral is defined as a request directed to the CCS Program to authorize medical services for a potential CCS Program applicant. A referral may be received in any written or oral format.

Re-referral

A referral has been received on a former CCS Program client who had been assigned a CCS Program case number and whose case was subsequently closed.

Referred Individual

An individual who has been referred to the CCS Program by a hospital, physician, or other party, but has not yet made application to the CCS Program. A referred individual is not referred to as a CCS Program applicant.

Request for Services

A request for service is defined as a request directed to the CCS Program from a health care provider requesting authorization for specifically identified health care services(s) on behalf of an applicant/client. The healthcare provider must submit a completed Service Authorization Request (SAR).

Service Authorization Request (SAR)

The term and acronym SAR has multiple meanings and various states. Providers may request health care services related to a client's CCS-eligible medical condition by completing one of the CCS Program SAR forms found online [SAR Forms]. SARs can also refer to the authorization issued for services or when a SAR is pended, cancelled, deleted, modified, or denied.

SAR/WEB System

The SAR/WEB system, also known as E47, is the CMS Net case management system implemented July 1, 2004 (CCS N.L. 04-0604). While the Legacy System continues to operate, procedural functionalities are gradually transitioned to the SAR/WEB System. Updates are announced in periodic *This Computes!*

Shall

For the purpose of utilizing this Manual, the term "shall" indicates a mandatory requirement which requires adherence. See definitions for "may" and "should".

Share of Cost (SOC)

A monthly expenditure that must be obligated before the Medi-Cal program will pay for medical services that are benefits of the Medi-Cal program. Share of cost may change each month. Medi-Cal will not pay for services until the share of cost is obligated (for the month in which services occurred). [This Computes #206]

State File Number

The State File Number, also known as the CCS Number, is a unique CCS Program client identification number assigned to a CCS Program case record when the record is opened to the CCS Program as an active base on meeting specific program eligibility requirements.

Should

For the purpose of utilizing this Manual, the term "should" indicates a recommended procedures which may be subject to administrative variation as situations warrant but which, for the sake of program consistency, should generally be followed. See definitions for "may" and "should".

Third Party Liability (TPL)

TPL is an agency within the Department of Health Care Services which oversees the post payment recovery and the cost avoidance process. The agency is responsibility for ensuring the client's insurance records are posted accurately to the MEDS and claims are paid or denied appropriately based on the posted insurance.

This Computes!

Informational bulletins distributed electronically which provide technical and administrative case management guidance. Updates to CMS Net system are announced in periodic This Computes! Change Cycle bulletins [hyperlink].

Xerox

DHCS Fiscal Intermediary for the Medi-Cal Program since August 2012.

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expansion of glossary

Abbreviations and Acronyms

Source: The CMS Plan & Fiscal Guidelines (PFG) Manual.

To access PFG Manual – click on hyperlink and select Chapter 10: Appendix

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ACS …….. Affiliated Computer Systems, past DHCS Fiscal Intermediary
AAP ……..……. American Academy of Pediatrics
AB ……..… Assembly Bill
ACIN ……..……..…….. All County Information Notice
ACL ……..…… All County Letter
ACWDL ……..…….. All County Welfare Directors Letter
AER ……..…….…….. Annual Eligibility Review
AFLP ……..…….…… Adolescent Family Life Program
AMR ……..……..…….…… Annual Medical Review
BIC …… Benefits Identification Card
BO ……. Business Objects
BY ……..…… Budget Year
CalWIN …… CalWorks Information Network
CalWORKS ..…… California Work Opportunity and Responsibility Network
CCR ……..……..... California Code of Regulations
CCS ……..……California Children's Services
CDC ……..……. Centers for Disease Control and Prevention
CDPH ……..…… California Department of Public Health
CFR ……..……..... Code of Federal Regulations
CHDP ……..…… Child Health and Disability Prevention Program
CIN ……..……. County Identification Number
CMS Net ……..……..……Children's Medical Services Network
CMS ……..…..Centers for Medicare and Medicaid Services (federal program)
CMS ……..……..….. Children's Medical Services (state program)
CMSP ……..……..……County Medical Services Program
COHS ……..……..….. County Organized Health System
CSHCN ……..…. Children with Special Health Care Needs
CTO ……..……..…… Compensatory/Certified Time Off
CWS ……..……..……. Child Welfare Services
CWS/CMS ……..…… Child Welfare System/Case Management System
CY ……..…. Calendar Year
DHCS ……..……..…. Department of Health Care Services
DOR ……. Date of Referral
DSS …… Department of Social Services
E47 ……..……. Enhancement 47
EDS …… Electronic Data Systems (former DHCS Fiscal Intermediary)

EPSDT …….…….. Early and Periodic Screening, Diagnosis, and Treatment
EPSDT-SS ……..…. Early and Periodic Screening, Diagnosis, and Treatment – Supplemental Services
EW …….. Eligibility Worker
FFP ……..….. Federal Financial Participation
FI ……. Fiscal Intermediary
FIG ……..…. Federal Income Guidelines
FPL …… Federal Poverty Level
FTE ……..…… Full Time Equivalent
FY …….…… Fiscal Year
GHPP ……..…...….. Genetically Handicapped Persons Program
GMC ……. Geographic Managed Care
HCC ……..…… Hearing Coordination Center
HCFA ……..…… Health Care Financing Administration (now known as CMS)
HCPCFC ……..……. Health Care Program for Children in Foster Care
HF …….….. Healthy Families
HFP ……..…… Healthy Families Program
HIPPA ……..… Health Insurance Portability and Accountability Act
HRIF ……..……. High Risk Infant Follow-up Program
HRSA ……... Health Resources and Services Administration
IAA …….…. Interagency Agreement
ICD-10 ……..... International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
ICD-9 ……..…… International Statistical Classification of Diseases, Ninth Revision
ICOS ……. Independent County Operations Section
IEP …… Individualized Education Plan
IFSP …….. Individualized Family Services Plan
IHO ……... In-Home Operations
IN ……..…… Information Notice
ITS ……... Information Technology Section
LEA …… Local Education Agency
M&T ……...….Maintenance and Transportation
MC 13 ……..….... Statement of Citizenship, Alienage, and Immigration Status
MC 201 ……..……..…. Statement of Facts (Medi-Cal Only Mail-In Application)
MC 219 …….. Important Information for Persons Requesting Medi-Cal
MC 321 HF ……..… Medi-Cal/Healthy Families Mail-In Application
M/C……... Medi-Cal
MCMC ……..……..…. Medi-Cal Managed Care
MEBIL ……..…… Medi-Cal Eligibility Branch Information Letter
MEDS ……..……...…… Medi-Cal Eligibility Data System
MMCD ……..…… Medi-Cal Managed Care Division
MOE ……..…… Maintenance of Effort
MOU ……. Memorandum of Understanding

MPP …….…… Manual of Policies and Procedures
MRMIB……..…… Managed Risk Medical Insurance Board
MTC ……..…… Medical Therapy Conference
MTP ……..……. Medical Therapy Program
MTU ……..……. Medical Therapy Unit
NHSP ……..……... Newborn Hearing Screening Program
NICU ……..…….. Neonatal Intensive Care Unit
NL ……..……..……. CCS Numbered Letter
NPP ……..……... Notice of Privacy Practices
OTLIC/MC ……..…… Optional Targeted Low Income Children/Medi-Cal
OPRC ……..…… Outpatient Rehabilitation Centers
PEDI ……..…… Provider Electronic Data Interchange
PFC …… Partners for Children Palliative Care Waiver Program
PFG ……...…….. Plan and Fiscal Guidelines
PHD ……..……. Public Health Department
PHN ……..…… Public Health Nurse
PICU ……..……. Pediatric Intensive Care Unit
PIP ……..…….…. Provider Inquiry Process
POS ……..…….. Point of Service Device
PSA ……..…… Program Services Agreement
PSS ……..……..…… Program Support Section
PSU ……..…… Provider Services Unit
RC ……..……..……..…… Regional Center
RO ……..……...…... Regional Office
SB ……...…… Senate Bill
SCC ……...……...…. Special Care Center
SCD ……...…….. Systems of Care Division
SCHIP ……..……...… State Child Health Insurance Program
SCRO ……..... Southern California Regional Office
SELPA ……..……. Special Education Local Planning Area
SFRO …..… San Francisco Regional Office (now known as Bay Area/Oakland Office)
SOC ……..……..…… Share of Cost
SOW ……..……..……. Scope of Work
SPHN …….. Supervising Public Health Nurse
SPMP ……..… Skilled Professional Medical Personnel
SPS ……... Statewide Programs Section
SRO …… Sacramento Regional Office
SY ……..……..……. School Year
TCM ……..……. Targeted Case Management
TLIC/MC ……..……. Targeted Low Income Children/Medi-Cal
TPL ……..……..……..… Third Party Liability
WIC ……...……..…Women, Infants and Children Supplemental Nutrition Program