CALIFORNIA CHILDREN'S SERVICES ADMINISTRATIVE CASE MANAGEMENT MANUAL

TABLE OF CONTENTS

INTRODUCTION

The California Children's Services (CCS) Program provides diagnostic and treatment services, case management, and physical and occupational therapy services to children and youth under age 21 with CCS eligible medical conditions. The CCS Program is administered as a partnership between County Public Health Departments and the California Department of Health Care Services (DHCS).

This CCS Administrative Case Management Manual serves as a policy reference for DHCS and County CCS Program staff. The purpose of this manual is to provide guidance on the implementation of the CCS Program case management and administrative procedures. This manual provides a roadmap for CCS administrative activities to bring uniformity to State and County CCS operations.

ABBREVIATIONS AND ACRONYMS

Acronym	Meaning
AAP	American Academy of Pediatrics
AB	Assembly Bill
ACIN	All County Information Notice
ACL	All County Letter
ACWDL	All County Welfare Directors Letter
AMR	Annual Medical Review
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
CIN	Client Identification Number
CMS	Case Management System
CMS	Centers for Medicare and Medicaid Services (Federal Program)
CMS Net	Children's Medical Services Network
COHS	County Organized Health System
CTO	Compensatory/Certified Time Off
CWS	Child Welfare Services
CYSHCN	Children and Youth with Special Health Care Needs
DHCS	Department of Health Care Services
DOR	Date of Referral
DOS	Date of Service
DSS	Department of Social Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EW	Eligibility Worker
FFP	Federal Financial Participation
FI	Fiscal Intermediary

Acronym	Meaning
FIG	Federal Income Guidelines
FPL	Federal Poverty Level
FTE	Full Time Equivalent
FY	Fiscal Year
GHPP	Genetically Handicapped Persons Program
HCC	Hearing Coordination Center
HCPCFC	Health Care Program for Children in Foster Care
HIPAA	Health Insurance Portability and Accountability Act
HRIF	High Risk Infant Follow-up
HRSA	Health Resources and Services Administration
IAA	Interagency Agreement
ICD-10	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
IEP	Individualized Education Plan
IFSP	Individualized Family Services Plan
IN	Information Notice
ISCD	Integrated Systems of Care Division
LEA	Local Education Agency
M&T	Maintenance and Transportation
MC 13	Medi-Cal
MC 13	Statement of Citizenship, Alienage, and Immigration Status
MC 219	Important Information for Persons Requesting Medi-Cal
MCOD	Medi-Cal Managed Care Operations Division
MCP	Medi-Cal Managed Care Health Plan
MCQMD	Medi-Cal Managed Care Quality and Monitoring Division
MEDIL	Medi-Cal Eligibility Division Information Letter
MEDS	Medi-Cal Eligibility Data System
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MTC	Medical Therapy Conference

Acronym	Meaning
MTP	Medical Therapy Program
MTU	Medical Therapy Unit
NBS	Newborn Screening
NHSP	Newborn Hearing Screening Program
NICU	Neonatal Intensive Care Unit
NL	CCS Numbered Letter
NPP	Notice of Privacy Practices
OPRC	Outpatient Rehabilitation Centers
OTLICP	Optional Targeted Low-Income Children's Program
PEDI	Provider Electronic Data Interchange
PHN	Public Health Nurse
PICU	Pediatric Intensive Care Unit
PIP	Provider Inquiry Process
POS	Point of Service Device
PSA	Program Services Agreement
RC	Regional Center
SB	Senate Bill
SCC	Special Care Center
SCHIP	State Child Health Insurance Program
SELPA	Special Education Local Planning Area
SOC	Share of Cost
SOW	Scope of Work
SPHN	Supervising Public Health Nurse
SPMP	Skilled Professional Medical Personnel
TCM	Targeted Case Management
TPL	Third Party Liability
WCM	Whole Child Model
WIC	Women, Infants, and Children Supplemental Nutrition Program

REFERENCES IN THE CCS ADMINISTRATIVE CASE MANAGEMENT MANUAL

- CCS Statutes: Health & Safety Code (H&SC), Citations for Robert W. Crown CCS Act, Sections 123800-123995
- CCS Regulations: California Code of Regulations (Cal. Code Regs.), Title 22, Subdivision 7, CCS, Sections 41401-42700
- WCM Statues: Welfare and Institution Code (WIC), Section 14094.5
- Policies: CCS Numbered Letters provide policy background, policy statements, and policy implementation direction.
- CCS Information Notices contain administrative information specific to the CCS Program.
- CCS Whole Child Model provides background, policy, policy implementation on the Whole Child Model along with contact information for various teams. Managed Care Providers should review the All Plan Letter (APL) 24-015 or any superseding APL
- CMS Net: CMS Net case management system for narratives, SAR processing, correspondence, and reports.

Additional Resources

- Standards for Providers and Vendors: DHCS Provider Standards
- Medical Eligibility for Medical Therapy Program (MTP): MTP DHCS Website
- Special Care Centers (SCC): SCC Center look-up
- SCC Standards listed with Provider Standards
- CCS Approved Hospital List: Refer to the current online CCS Provider list
- SAR Tools: SAR Tools

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 County CCS Program staff's responsibility to check for updates and current guidance on the DHCS CCS website. Report any errors or omissions to CCSProgram@dhcs.ca.gov. See Appendix C for additional resources.

CHAPTER ONE: REFERRAL TO DECISION ON CASE OPENING

Section I: A. Referrals

A. General Information[1]

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

    a. Is under 21 years of age;

    b. Is not currently enrolled in the CCS Program;

    c. Has, or is suspected of having, a CCS Program medically eligible condition; **AND**

    d. Resides in the state of California and the county to which they've applied.

2. The referral can originate from any source. Examples of who can initiate a referral include but are not limited to: Medi-Cal Managed Care Plans (MCP), health care providers, parents, legal guardians, school nurses, regional center counselors, or other interested parties.

3. The CCS Program case management actions are initiated when a complete referral is accepted by program staff based on the requirements in 1 above. See 5 below for requirements of a complete referral.

4. A referral to the CCS Program may be received in written or verbal form.[2] A referral may be submitted as any of the following:

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

    b. A medical report or miscellaneous correspondence on a potential applicant with the potential applicant's demographic information, potential CCS medically eligible condition noted, and states that it is a referral to the CCS Program;

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

[1] Appendix B: 3, 17, 24, 31, 60; Health & Safety Code Section 123805

[2] Examples of a verbal referral are a telephone call or in person request. A verbal referral may start the process, but still requires all written documentation as listed in 5 to complete the referral.

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

Reminder: When opening a case - only the first request for service for a given individual is a referral. If a beneficiary has not been previously deemed eligible for the CCS Program and multiple service requests are received, the initial complete request is considered the referral date for case opening.

5. A **referral is complete** when the following information is provided:

   a. First and last name of referred individual.

      1) Any "also known as" (AKA) names are helpful, additional information, but are not required.

   b. Date of birth

   c. Physical address of applicant along with the mailing address if applicable

   d. Telephone number

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

   f. SAR (optional)

   g. Name and address of agency or individual requesting services

   h. Current medical reports indicating the presence of a potential CCS medically eligible condition.[3] (See Section III.D. for requesting additional medical reports not included with the referral.)

6. A Social Security Number (SSN) or a pseudo-SSN is required to initiate the CCS Program application process. If the applicant does not yet have a SSN, a pseudo-SSN 123-45-678P will automatically populate after the Statewide Client Index Inquiry (SCI) is performed. If the applicant/beneficiary provides their SSN, update this field in CMS Net.

[3] Medical reports must be dated within the past 12 months of the referral date to be considered "current".

Section I: B. Referrals

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

1. **All counties must enter all referrals in CMS Net upon receipt**. Referrals can be received in any format (i.e. written, oral, email, CMS Net, provider electronic portals, Managed Care Plan Secure Portals, or Fax). Written referrals that do not have an electronic date must be date stamped on the date of receipt and documented in the CMS Net record.[4] The date a referral is received by the CCS Program is the referral date to be entered into CMS Net.

2. All County CCS Program staff will review the information provided and take one of the following actions within **five (5) calendar days** from the receipt of the referral:[5, 6, 7, 8]

    a. Complete referral: Accept the referral as complete as defined in Chapter 1. Section I. A. 5 of these procedures; or

    b. Incomplete referral, missing information: send a Referral Transmittal Notice (C-80) to the referral source following the instructions specified in 3. below.

    c. Incomplete referral, missing medical report(s): refer to Chapter 1. Section III.D.: Requesting Medical Records.

3. Responding to an incomplete referral.[9]

    a. A program referral that does not contain the required information identified in Chapter 1. Section I. A. 5 of these procedures is incomplete. The CCS Program eligibility and application processes **cannot** be initiated on an incomplete referral.

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

        1) Within **five (5) calendar days** from the date of receipt, send a Referral Transmittal Notice (C-80) to the referral sources stating:

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

[4] Appendix B: 29, 31; CCS N.L. 14-0582
[5] Appendix B: 31
[6] Appendix B: 29, 31, 32
[7] Inter-County Transfers – refer to Chapter 2. Section IV.
[8] CMS Net Registration Manual, Referral Tracking Procedures Section
[9] Appendix B: 29, 31, 32; CCS N.L. 14-0582

b) The referral source has **20 calendar days** from the date of the Referral Transmittal Notice (C-80) to provide the required information in order for the referral date to remain unchanged.

c) If the requested information is not received within the **20 calendar days** of the Referral Transmittal Notice (C-80), the referral will be considered incomplete and denied. Refer to Chapter 3. Section I.B.2. for instructions to send a NOA.

2) A case note needs to be added in CMS Net for any incomplete referral. If a Referral Transmittal Notice (C-80) cannot be completed due to incomplete information enter a case note regarding why a C-80 is unable to be sent.

4. Required steps in processing a new referral in all Counties:[10]

a. Search CMS Net using the applicant's name and date of birth or CIN # 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 beneficiary. (Refer to Chapter 2. Section III. 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 **b** through **d** below are to be followed.

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

c. If, at the time of referral to the CCS Program, an infant has not yet been added to the mother's Medi-Cal case by the county's Social Services Agency, the infant's CMS Net record should be established in CMS Net and a pseudo-SSN 123-45-678P will be assigned automatically.

d. If the referral information is received through a mechanism outside of CMS Net, click "Add New Referral" or "Register New Client" and enter the information in the Referral or Registration module. If the referral

[10] Appendix B: 29, 31, 32; CCS N.L. 14-0582

information already exists in CMS Net – click Referral – "My Awaiting Case Review", click on the referral listed and review the information entered. Review the CMS Net Registration Manual for additional details.

5. For Whole Child Model (WCM)/Classic Dependent County cases the following will apply:[11]

   a. If a SAR was submitted with the referral the Dependent County must notify DHCS with the DHCS SAR Cover Sheet via secure email or fax found on the CCS webpage.[12] See Chapter 3. Section II. Communication for DHCS email addresses.

      If applicable, Classic CCS Dependent County will enter the new referral, complete registration in the Registration Module, and pend the SAR in the Registration Module using the Add SAR button or select the SAR in the Awaiting Service Request module.

   b. Upon receipt of the notification a referral has been entered into CMS Net, the County will initiate residential and financial eligibility by following the procedures explained in Chapter 1. Section IV., prior to DHCS determination of medical eligibility following the procedures Chapter 1. Section III. Medical Eligibility Determination.

   c. Typically, residential and financial eligibility is determined prior to medical eligibility as outlined in Chapter 1. Section IV. Program Eligibility Determination; however, CCS Program eligibility and the medical eligibility determination processes can be done simultaneously.

   d. The County CCS Program staff will initiate the CCS Program application process identified in Chapter 1. Section II. Application Process.

[11] Appendix B: 31, 32
[12] DHCS SAR email inboxes address

Section I: C. Referrals

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 by the County or DHCS for an individual not known to the CCS Program and which *does not* state that it is a referral is ***NOT*** a CCS Program referral.[13]

2. Properly dispose of unsolicited medical report or miscellaneous correspondence in accordance with HIPAA guidelines.

[13] Appendix B: 31

Section II: A. Application Process

A. General Information

1. Application Timelines and Notices[14]

A potential applicant must 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 beneficiary. Timelines for notifying the potential applicant and the number of notices are established in the Cal. Code Regs., Title 22, Section 41514 and described in Section II.B. below.

2. Medical Eligibility Determination[15]

Determination of medical eligibility by the medical professional staff occurs with the receipt of a completed new referral of a potential CCS Program applicant. For beneficiaries with full scope no Share of Cost (SOC) Medi-Cal, the County or DHCS begins determining medical eligibility and case management services without delay. MTP medical eligibility must be established ***prior*** to an applicant or beneficiary being referred to an MTU for any service related to the MTP.[16]

3. Other Health Coverage (OHC)[17]

The Insurance Coverage screen includes the private insurance information specific to a beneficiary. Results can be obtained by user selection/entry or through a monthly automatic system update. If a user has manually entered insurance and the beneficiary becomes "Active," this information is sent to MEDS and posted on the Health Insurance System (HIS) to assist in post-payment recovery and cost avoidance. Refer to Chapter 1 Section IV. A. for additional information.

NOTE: Verify OHC in MEDS prior to performing the below steps.

If OHC in MEDS is incorrect: Visit DHCS OHC Webpage and follow the instructions to submit a request via the online form.

If OHC is correct in MEDS but incorrect in CMS Net: Use Service Now to submit a CMS Net service request for assistance in resolving any insurance adds/updates or insurance discrepancies for beneficiaries in our program.

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[14] Appendix B: 31
[15] Appendix B: 32, 39, 58, 61
[16] CCS N.L. 08-1024
[17] CCS N.L. 06-0394

4. CMS Net Entries

It is imperative that the responsible CCS Program staff enter information into CMS Net in a timely manner in order to facilitate compliance with administration procedural requirements. Typically, residential and financial eligibility is determined prior to medical eligibility determination, however CCS Program eligibility and the medical eligibility determination processes can be done simultaneously.

NOTE: If Medical determination is completed prior to financial determination make a note in the CMS Net medical eligibility case note entry as "pending program eligibility" or "pending financial eligibility".

Section II: B. Application Process

B. Application Procedures and County Responsibilities[18, 19]

1. A CCS Program application must 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 beneficiary.[20] A Release of Information Form (ROI) must accompany the application if the referral source is other than a CCS-paneled/approved provider(s). Instructions for requesting medical reports are in Chapter 2. Section II. Requesting Medical Reports.[21]

2. Application letters must 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.[22] The application must be accompanied by the CCS Program Notice of Privacy Practices (NPP), an ROI form (when applicable), and one of the following letters:

   a. Non-Medi-Cal: send letter entitled "CCS First Letter" (C-36)

   b. Medi-Cal beneficiaries with full scope no SOC: send letter entitled "Medi-Cal First Letter" (C-36M), Whole Child Model Counties send C-36WCM, which informs the referred individuals that the CCS Program case management authorizations will be limited to Medi-Cal benefits until the CCS Program application requirements are met by the required response date.

      NOTE: C-36WCM will not be available until a MEDS Inquiry in CMS Net has been completed after registering the applicant.

   c. Medical Therapy Program (MTP) Services only: send letter C-36MTU.

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, C-36M, or C-36WCM) to monitor for receipt of the application.

4. If a signed application is not received by the tickler date, send one of the following "SECOND NOTICE" letters to the referred individual within **five (5) calendar days** from the tickler date.[23] Counties will undertake a good faith

[18] CCS N.L. 11-0703
[19] See CMS Net Eligibility Program Manual for additional details.
[20] Appendix B: 31
[21] Appendix B: 31
[22] Appendix B: 31
[23] Appendix B: 31

effort to contact the referred individual using more than one modality, such as phone or email, to request the needed information.

a. Non-Medi-Cal: send letter entitled "CCS Second Letter" (C-36A)

b. Medi-Cal beneficiaries with full scope no SOC: send letter entitled "Medi-Cal Second Letter" (C-36MA), Whole Child Model Counties send C-36WCMA, which informs the referred individual that the CCS Program case management authorizations will be limited to Medi-Cal benefits only if the CCS Program application requirements are not met by the required response date.

c. Medical Therapy Program (MTP) Services only: send letter C-36MTU-A.

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, "THIRD NOTICE," must be sent to the referred individual within **five (5) calendar days** from the tickler date.[24]

   a. Non-Medi-Cal: send letter entitled "CCS NOA/Third Letter" (C-36B).

   b. Medi-Cal beneficiaries with full scope no SOC: send letter entitled "Medi-Cal NOA/Third Letter" (C-36MB), Whole Child Model Counties send C-36WCMB, which informs the referred individual that the CCS Program case management authorizations will be limited to Medi-Cal benefits only.

   c. Medical Therapy Program (MTP) Services only: send letter C-36MTU-B.

7. On the date the final letter is sent, the County must:[25]

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

   b. If the referred individual is a Medi-Cal beneficiary with full scope no SOC, enter into the CMS Net narrative that no application has been received.

8. Within **ten (10) business days** of notification that a referred individual, who is a non-Medi-Cal beneficiary will not be open to the CCS Program, the County must:[26]

[24] Appendix B: 31
[25] Appendix B: 11, 31
[26] Appendix B: 31

a. Deny any pending SARs and send the NOA(s). Follow the instructions in Chapter 3. Section I.B. for sending the NOA.

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

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

9. If a signed application is received after the date specified in the final letter, the County must:[27]

   a. Enter the date the application is received in the application receipt date field.

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

10. Upon timely receipt of the signed application, the County must check the CMS Net Narrative and/or Medical Eligibility/Ineligibility, and/or Display Events screen for the status of medical eligibility determination.[28]

    a. For non-Medi-Cal referred applicants, if the applicant has been determined **medically eligible** OR **medical eligibility determination is in process**, the County must initiate the program eligibility (residential and financial eligibility) determination process following the procedures identified in Chapter 1. Section IV. Program Eligibility Determination.

    b. If the applicant has been determined **medically ineligible**, then the County or DHCS medical consultant or designee is responsible for taking appropriate action as explained in Chapter 1. Section III. Medical Eligibility Determination. Follow notification instructions to the County found in Chapter 1. Section III.B.2.b.

[27] Appendix B: 31
[28] Appendix B: 31, 32

Section III: A. Medical Eligibility Determination

A. General Information

1. **Division of Responsibility by County Type**

   For additional services please review The Division of Responsibility table.

Administrative Activities	Classic CCS Independent County	Classic CCS Dependent County	Whole Child Model Independent County	Whole Child Model Dependent County
Determine medical program eligibility: initial determination and annual medical review	County	State	County	State
Determine Medical Therapy Program (MTP) eligibility: review and determine MTP eligibility	County	State	County	State
Authorizations: Coordinate and review authorizations for Neonatal Intensive Care Unit (NICU) services	County	State	Health Plan	Health Plan
Authorizations: Coordinate and review authorizations for High-Risk Infant Follow-Up (HRIF) services	County	State	Health Plan	Health Plan

2. **Medical eligibility determination**[29]

[29] Appendix B: 32; CCS N.L. 20-0997; CCS N.L. 08-1024

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) as described in Cal. Code Regs., Title 22 Section 41515.1 - 41518.9.

3. **Medical Reports**[30]

   Medical reports related to the CCS eligible condition(s) are required for the determination of the CCS Program medical eligibility. Medical reports should be the most current reports within the last 12 months of the referral date.

   NOTE: The requesting of medical reports for referrals required for the determination of medical eligibility is a collaborative effort between DHCS and the Dependent County and between the WCM MCP and the WCM County. The procedures and responsibilities for requesting the medical reports needed for determining medical eligibility are identified in Section III.D. below.

4. **CCS case management** is a beneficiary and family centered care approach to ensure needed clinical and non-clinical services for the CCS eligible condition, are made available to each CCS beneficiary through comprehensive, interdisciplinary, and person-centered care management and care coordination to provide case finding, authorizations for services and care coordination to ensure that CCS children and young adults have access to CCS paneled providers, equipment, and services necessary for treatment of the CCS eligible condition. Additional information on CCS case management is in the WCM N.L. 10-1224 and the Appendix D.

5. **CMS Net Entries**

   The CCS Program application and the medical eligibility determination can be initiated simultaneously. It is imperative that the responsible CCS Program staff member enter the information into CMS Net in a timely manner in order to facilitate compliance with administrative procedural requirements**.**

   NOTE: If medical eligibility determination is completed prior to financial eligibility determination note in the CMS Net medical eligibility case note entry as pending program eligibility or pending financial eligibility.

[30] Appendix B: 29

Section III: B. Medical Eligibility Determination

B. Process for Determination of Medical Eligibility

1. Determination of medical eligibility begins when:[31]

    a. The County or DHCS medical consultant or designee is notified that a referral has been entered into CMS Net; and

    b. Sufficient medical information has been received by the County or DHCS to make such a determination. Ensure all documentation needed to make a medical eligibility determination is uploaded into CMS Net. Refer to the determination timeline in N.L. 20-0997, or any superseding version of this NL.

    c. The County enters the referral into CMS Net and establishes the program eligibility start date in the Eligibility Module.

    d. Medical Eligibility is determined by:[32]

        1) **Dependent County:** DHCS performs the medical eligibility review.

            a) **WCM Dependent County:** the County must notify DHCS by secure email CCSdirectedreview@dhcs.ca.gov. A SAR is not needed since services are reviewed through the MCPs. MCPs will conduct reviews for NICU/HRIF eligibility.

            b) **Classic Dependent County:** If applicable, the County must pend the SAR within CMS Net for DHCS to be notified.

        2) **Independent County:** the County performs the medical eligibility review.

            a) **WCM Independent County**: MCPs will conduct reviews for NICU/HRIF eligibility.

2. The medical eligibility decision must be entered into the CMS Net Medical Eligibility section of the Eligibility-Program module including a case note within **five (5) business days** from the date that sufficient medical information was received by the County or DHCS to make that decision.[33]

    a. **If medically eligible**, enter a case note narrative in the CMS Net Medical Eligibility section of the Eligibility-Program module of the

[31] Appendix B: 32, 60, 61
[32] The Division of Responsibility table
[33] CCS N.L. 20-0997

medically eligible condition and the effective start date of coverage. (Refer to Section III.C. below for determining the effective date.) The ICD code(s) must be entered in the CMS Net Registration module.[34]

1) Enter if the 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 or treatment.[35] See Section III.C. below for additional information.

2) DHCS to notify the Dependent County of medical eligibility decision via web message.[36]

b. **If not medically eligible**, the decision must be entered into the CMS Net Medical Eligibility section of the Eligibility-Program module with a narrative explaining the decision, and:

1) If an application **has not** been received, the County must determine the appropriate denial letter to send to the applicant or parent/legal guardian with a Notice of Action (NOA). A copy of the letter must be sent to the referring provider. If a SAR was submitted send a Service Authorization Request Notice of Action (SAR NOA).

2) If an application **has** been received, the County must:[37, 38]

a) Update eligibility in CMS Net by selecting "INELIGIBLE" in the Eligibility-Client module. Enter in the effective date of the denial (usually the referral date). Refer to CMS Net procedures for this function.

b) **Classic/WCM Independent Counties** will generate a NOA in the Eligibility-Client module by selecting the appropriate citation(s) from the drop-down list. If a SAR was submitted generate a SAR NOA.

c) For **Classic/WCM Dependent Counties**, DHCS will generate the NOA and notify the County via CMS Net web message. The County will then mail the NOA.

d) Providers will receive notification of the NOA through PEDI.

[34] Appendix B: 17, 32, 63, 65; CCS N.L. 08-1024
[35] Appendix B: 65
[36] Appendix B: 32
[37] Appendix B: 78, 79, 80
[38] CCS N.L. 04-0423

Section III: C. Medical Eligibility Determination

C. Updating CMS Net Medical Eligibility Status

1. When medical eligibility has been determined, update the CMS Net Medical Status screen. 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, which may differ from the referral date.[39]

    a. Enter in the CMS Net Medical Status field the appropriate case eligibility status as determined by the medical consultant/designee. In the Dx Only field, choose either "Yes" for Diagnostic or "No" for Treatment:

        1) **Diagnostic** – Authorization will be limited to services to confirm a suspected CCS Program medically eligible condition. Counties must have:[40]

            a) Confirm the applicant is a Medi-Cal full scope no SOC or OTLICP beneficiary; **OR**

            b) A signed CCS Program application on file; **AND**

            c) Proof of county residency and Other Health Coverage (OHC), if applicable. See Chapter 1 Section IV A.2. for additional information on OHC; **AND**

            d) Received or invoiced the family the $20 assessment fee (exception is: HRIF, Newborn Screening, Newborn Hearing Screening, Orthodontia for the HLD exam phase only, or receiving MTP services and these services are part of an individualized education plan (IEP)).[41]

        2) **Treatment** – Authorization is issued for treatment when a beneficiary has a:

            a) Confirmed CCS-medically eligible condition; [42]

            b) Signed CCS Program application; and

            c) Signed PSA on file (for CCS State-Only).

[39] Appendix B: 11, 51
[40] Appendix B: 65
[41] Health & Safety Code 123870
[42] Appendix B: 66

NOTE: A PSA is **not** required for applicants who are a Medi-Cal full scope no SOC beneficiary, MTP-Only, or Diagnostic-Only. However, DHCS recommends all applicants sign a PSA.

2. Follow procedures in Chapter 1. Section V., Case Opening and Reopening.

Section III: D. Medical Eligibility Determination

D. Procedures for Requesting Medical Reports Required for Medical Eligibility[43, 44]

1. If the referral does not include complete medical documentation:

    a. **Classic/WCM Independent County:** The county must reach out to the provider (for Classic Counties) or the WCM MCP (for WCM Counties) to request additional relevant medical documentation to determine CCS Medical Eligibility. Counties must reach out to providers in accordance with HIPAA guidelines.

    NOTE: If the MCP sends the referral to the County CCS Program, the MCP is responsible for providing medical records.

    b. **Classic/WCM Dependent County**: DHCS will notify the County of incomplete documentation. The county must reach out to the provider (for Classic Counties) or the WCM MCP (for WCM Counties) to request additional relevant medical documentation. Upon receipt, the County will forward the information to DHCS. DHCS will determine CCS Medical Eligibility and notify the County of its decision. Counties must reach out to providers in accordance with HIPAA guidelines.

2. A Release of Information (ROI) signed by the applicant or parent/legal guardian is required when a medical report is not included with the referral, or the referral is from a provider that is not a CCS paneled provider. It is the County's responsibility to obtain the signed ROI.

3. Upon determination that additional medical reports are required, the County must:

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

        1) Send letter C-13. If the medical report is needed, a Release of Information form (C-17A) is required to obtain needed medical information.

        2) The County must request the Release of Information form (C-17A) with enclosure letter C-17.

[43] Appendix B: 32; CCS N.L. 04-0424

[44] See CMS Net Eligibility Program manual for additional information and procedures.

b. A CMS Net case note is automatically generated when a medical report has been requested.

4. The CMS Net Request Medical Report function will automatically set up a tickler date of **20 calendar days** from the date of the request to review for receipt of the medical report.

5. When medical reports are received, the County must enter the date the report was received into CMS Net using the 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 must:

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

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

   c. Notify the referral source.

   d. Send 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. While determining medical eligibility CMS Net will automatically set a due date of **20 calendar 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 must 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:[45]

      1) The medical consultant or designee must generate a NOA via CMS Net Correspondence. Generate a Service Authorization Request Notice of Action (SAR NOA) if a SAR was submitted.

[45] Appendix B: 32, 78, 79, 80; CCS N.L. 04-0424

2) Use free text space available on the NOA to add additional information or explanation, if necessary. Ensure language is clear and specific with citations.[46]

3) Providers will receive notification of the NOA through PEDI.

4) DHCS will notify the Dependent County on the same day the NOA was generated via a CMS Net web message. The Dependent County will then send out the letter(s) as directed.

   If an application has not been received from the referred individual, the County must determine the appropriate denial letter to send to the applicant or parent/legal guardian with a Notice of Action (NOA). A copy of the letter must be sent to the referring provider.

[46] CCS N.L. 04-0424

Section IV: A. Program Eligibility Determination

A. General Information

1. For purposes of the discussion in this section, program eligibility refers to **residential** and **financial eligibility** for the CCS Program. The process of determining program eligibility can be performed prior to the determination of medical eligibility (Refer to Chapter 1. Section III).

2. Determination of program eligibility must be completed in compliance with the CCS Program statutes, regulations, and numbered letters pertaining to residential and financial eligibility.[47, 48] In addition to residential eligibility (see Section IV. B.) and financial eligibility (see Section IV. C.), program eligibility determination includes but is not limited to:

   a. Refer the applicant to Medi-Cal if the applicant is eligible and is not enrolled in Medi-Cal, or has not already applied.[49] Any applicant who may be eligible for the CCS Program is required to apply for Medi-Cal if they may be eligible for Medi-Cal benefits (Health & Safety Code 123995 Medi-Cal Application Requirements). This requirement includes applicants who are potentially eligible for Medi-Cal based on either income or a categorical program.

   b. The applicant is not eligible for the CCS Program until the applicant, parent/legal guardian, or legal representative has complied with all Medi-Cal application requirements. Determination by the welfare office of Medi-Cal eligibility is not required prior to determining the CCS Program eligibility.

   c. For beneficiaries not enrolled in Medi-Cal Full Scope no SOC, complete a signed PSA form which includes the effective date an applicant meets the CCS Program financial and/or residential eligibility.

      NOTE: The effective date an applicant meets the CCS Program financial and/or residential eligibility is based on the receipt of the referral or the date the application was received if no response to the first and second application letters. Do not have the applicant, parent/legal guardian, or legal representative sign the Program Services Agreement (PSA) until MEDS shows the Medi-Cal application is pending.

[47] Review the CCS Numbered Letters webpage for the most up to date guidance.
[48] Appendix B: 51
[49] CCS N.L. 26-0905; CCS N.L. 11-0601

NOTE: A PSA is not required for applicants who are a Medi-Cal full scope no SOC beneficiary, MTP-Only, or Diagnostic-Only. However, DHCS recommends all applicants sign a PSA.

d. Disclosure of Other Health Coverage (OHC)[50]

CCS is the payor of last resort and as such, the program requires applicants/beneficiaries to disclose their private health insurance coverage information, referred to as "Other Health Coverage" (OHC). While OHC must be disclosed, CCS eligibility should not be denied because an applicant has OHC, regardless of the type of OHC.

The Insurance Coverage screen includes the private insurance information specific to a beneficiary. OHC information is also available in MEDS. If a user has manually entered insurance and the beneficiary becomes "Active" this information is sent to MEDS and posted on the Health Insurance System (HIS) to assist in post-payment recovery and cost avoidance. The CCS Program requires all applicants/beneficiaries to utilize their OHC, including indemnity coverage, a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), Medicare or TRICARE, before using CCS and Medi-Cal funds.[51, 52]

1) During the enrollment period, the applicant must inform the CCS Program of the existence of OHC and provide a current copy of an evidence of coverage. The applicant must report OHC at the time of initial application, annual renewal, and at any time that OHC begins, ends, or changes.[53]

2) Upon enrollment into the CCS Program a beneficiary must provide current OHC information to providers at the time services are delivered. This information must include the name of the OHC, policy, group numbers, and termination date, if available.

   NOTE: If the beneficiary is showing OHC exists, but states they do not have OHC, the beneficiary needs to contact the local Medi-Cal field office to request the OHC be removed or visit the OHC webpage for more information.

3) CCS is the payor of last resort and requires OHC to be billed prior to CCS. The provider must submit the SAR along with the denial letter

[50] Appendix B: 51; CCS N.L. 06-0394
[51] Appendix B: 54
[52] The following is not considered OHC: Medical Managed Care Plans, Medicare Part A & B, Institutionalized (OHC Code "I"), Medi-Cal
[53] Appendix B: 51, 54; CCS N.L. 06-0394

from the OHC. In cases where the OHC did not deny a service or benefit, CCS requires a copy of the OHC explanation of benefits or other documentation that details the beneficiary's responsibility under their OHC. CCS beneficiaries with OHC must meet their OHC co-pays/deductibles before CCS covers treatment, services and/or DME. After the co-pays/deductibles are met, CCS may cover the remaining cost, up to the Medi-Cal rate.

4) Children who are covered under an HMO plan are not eligible for the Medical Therapy Conference (MTC).[54] The HMO may hold its clinics for MTU-eligible children at the MTU as this preserves the comprehensive team approach. The HMO is solely responsible for processing all documentation generated at the clinics. Physician findings will require documentation from these clinics, just as they would be for any privately prescribing physician.

NOTE: Use Service Now to contact the CCS Program Help Desk support staff for assistance in resolving any insurance adds/updates or insurance discrepancies for beneficiaries in the CCS Program.

3. **Residential** eligibility **is required** before any CCS funded service(s) can be authorized. As an agent of Medi-Cal, the CCS Program must authorize services covered by Medi-Cal for full scope no SOC and OTLICP beneficiaries when residential verification has been confirmed.[55] See Section IV.B. for additional information on residential eligibility verification.

   a. Confirmation of Medi-Cal or OTLICP status and physical address can be done via MEDS.[56]

      1) All applicants who have been determined financially, residentially, and medically eligible for the CCS Program must complete a PSA.

         NOTE: A PSA is not required for applicants who are a Medi-Cal full scope no SOC beneficiary, MTP-Only, or Diagnostic-Only. However, DHCS recommends all applicants sign a PSA.

[54] Under special circumstances an exception may be made, at DHCS discretion, to provide MTC services to the beneficiary. Provide the beneficiary's information and HMO coverage information to MTPCentral@dhcs.ca.gov with an explanation of the situation and why an exception should be made.
[55] Appendix B: 50; CCS N.L. 19-0901; CCS N.L. 11-1500
[56] CCS N.L. 11-1500

4. To be eligible for the CCS Program, a CCS Program applicant may be required to pay an assessment fee and/or enrollment fee.[57]

    a. An enrollment fee is determined by CMS Net and is required to be paid, on an annual basis, before authorizations for **treatment services** for an applicant can be issued. See Section IV.F. for enrollment fee information.

    b. The assessment fee is a sum of $20.00 (Reference: Health & Safety Code 123870(d)) that must be paid by the applicant, parent/legal guardian, or legal representative **in addition** to any enrollment fee that is assigned. See Section IV.G. for assessment fee information.

[57] Health & Safety Code 123870, Health & Safety Code 123900, Health & Safety Code 123965; Appendix B: 25, 51

Section IV: B. Program Eligibility Determination

B. Determination of Residential Eligibility[58]

1. The applicant must be a resident of the County in which they have been referred or are applying and must establish proof of residency. The applicant must provide at least one item listed below, up to two items may be required at the discretion of the County. The address on the items must be identical. P.O. boxes will not be accepted.

    a. A California rent or mortgage receipt or utility bill within the past 60 days in the name of the parent, legal guardian, or emancipated minor.

    b. A current California motor vehicle driver's license, California Identification Card, or a motor vehicle registration issued by the California Department of Motor Vehicles in the name of the parents, legal guardians, or emancipated minor.

    c. A copy of the parent, legal guardian, or emancipated minor's most recent California State Resident Income Tax Form.

    d. An employment document showing that the parent, legal guardian, or emancipated minor is employed in California.

    e. A document showing that the parent, legal guardian, or emancipated minor has registered with a private or public employment agency in the State such as the Employment Development Department (EDD).

    f. Evidence that the parent, legal guardian, or an emancipated minor is receiving public assistance in the form of cash grants from the State of California, including, but not limited to, Special Supplemental Nutrition Program for Women, Infants, & Children (WIC), Supplemental Nutrition Assistance Program (SNAP), or CalWORKS.

    g. Evidence of registration to vote in California.

    h. Other credible evidence specified by DHCS when the parent, legal guardian, or an emancipated minor declares, under penalty of perjury, that the applicant does not possess any of the evidence specified in the above clauses.

    NOTE: A specific time period of residence is not required to establish residential eligibility.

[58] Appendix B 50, 51; CCS N.L. 11-1500; CCS N.L. 19-0901

2. If an applicant is between 18 – 20 years old and is not claimed by their parent/legal guardian/legal representative as a dependent on state income tax forms, they will be considered an adult in determining their residence for CCS eligibility. However, if the applicant is claimed as a dependent on state income tax forms the applicant's residence is that of the parent/legal guardian/legal representative.

3. Use the following table to establish the residence location of a beneficiary that is under age 18 and not emancipated or up to age 21 if in school and claimed on the parent's/legal guardian's/legal representative's state income tax:

   NOTE: In the table "parent" refers to the parent or legal guardian unless otherwise specified. Court-issued documents are required for proof of divorce, custody agreements, and/or appointment of legal guardian or legal representation.

Residency Status	Residence to Use
Minor lives with parents living together	Use the parent's address.
Minor lives with a parent that are not living together (unmarried, separated, legally separated, or divorced)	Use the custodial parent's address with whom the minor maintains their abode.
There is a court order that stipulates joint physical custody	Use the address of where Medi-Cal app is completed; or where client lives more than 50% of the time; or residence during school term.
Minor has a court-appointed legal guardian who is not a parent	Use legal guardian's address.
Minor is residing with relatives; no legal guardianship is awarded[59]	Use the parent's address based on the most applicable situation in this table.
Minor is living in a medical facility in a different county than the parent(s)	See Intercounty Transfer N.L. 10-1123 or any superseding version of this N.L.
Minor is adopted	Use the adopting parent(s) address. Adopting parents must be California residents.
Minor is a dependent child of the court	Eligible for Medi-Cal, refer to court documents for county residence.
Minor lived with a parent(s) who is incarcerated	Use the county where the parent previously resided if the minor is voluntarily placed with friends or family and the child is not receiving CalWORKs.
Minor is incarcerated[60]	Use the county of the court that sentenced them.
Minor is in Foster Care	Use the residence of the county where the child was physically placed by the court (if the minor is eligible for CalWORKs residential eligibility determination is not required since the minor is/will be enrolled in Medi-Cal).
Minor lives with parents who are Armed Forces personnel	Use residency that is indicated on enlistment papers as the State of Designation. Home of Record is not used.
Minor lives with a parent who is a military nonresident and a nonmilitary parent claiming California residency (must demonstrate the intent to reside in California).	Use the documented legal residence of the nonmilitary parent.

Section IV: C. Program Eligibility Determination

C. Determination of Financial Eligibility:[61]

1. Financial eligibility for treatment services under this program is limited to persons in families with an adjusted gross income (AGI) of forty thousand dollars ($40,000) or less in the most recent tax year.

   Counties can process applications for families that do not meet Medi-Cal's financial eligibility, for example AGI income over $40,000, if the estimate cost of care is expected to be more than 20 percent of the family's AGI and the child has a CCS medical eligible condition. These CCS beneficiaries are known as CCS state-only.

   The cost of care consists of those services to the eligible client for treatment of their CCS eligible condition and can include insurance premiums when insurance coverage offsets health care expenses. The estimation of the cost of care is based on a review of the treatment plan recommended by the CCS paneled provider by the CCS Program medical consultant or designated skilled medical professional.

   Contact the provider to obtain evidence of coverage from the most recent fiscal year. Additionally, inquire about scheduled tests and anticipated charges to estimate what the anticipated medical expenses will be. Review documentation of the applicant's current health insurance plan to estimate what the out-of-pocket medical expenses are expected to be.

   If the child previously was enrolled in Medi-Cal, a cost analysis request can be submitted to DHCS to provide an expenditure report of Medi-Cal claims. The request should include the:

   - Child's full name
   - Date of birth
   - CCS case number and/or Medi-Cal CIN
   - Dates of service for expenditures

[59] Legal guardianship is only awarded by the courts. A letter signed by the parent, awarding custody to another individual or relative who is not the parent, whether notarized or not, cannot be accepted as documentation of legal guardianship.
[60] Minors who are **incarcerated** at an institution or camp operated by the California Youth Authority, a county jail, a state, or a federal prison are not eligible for the CCS Program. A minor who is **detained** may still be eligible for the CCS Program.
[61] Appendix B: 51, 52, 53, 54

Submit request via secure email to the CCSProgram@dhcs.ca.gov inbox.

2. Financial eligibility determination is not required for:[62]

   a. Medi-Cal full scope no SOC beneficiaries or OTLICP beneficiaries; **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 Follow-Up (HRIF) program;[63] **or**

   d. When services are limited to the Medical Therapy Program (MTP)-only, specifically for physical and occupational therapy and Medical Therapy Conference (MTC) services;[64] **or**

   e. For services that are required to treat a CCS Program medically eligible condition that was present and diagnosed at the time of adoption.[65]

3. Use the most current year California state income tax return (540) and federal income tax return (1040) with the most current W2 as documentation of AGI.[66] If income tax return or W2 documentation is unavailable the applicant/family must submit 3 months of pay stubs, or as many months are available, from their current employer to estimate yearly income. If the applicant is not receiving income, submit documentation from the Employment Development Department. See table for the source of income to be used when determining financial eligibility:

   NOTE: Court-issued documents are required for proof of divorce, custody agreements, and/or appointment of legal guardian or legal representation.

[62] Appendix B: 52; CCS N.L. 12-1202; Health & Safety Code 123870
[63] Health & Safety Code 123900
[64] CCS N.L. 17-0589
[65] Health & Safety Code 123965
[66] Appendix B: 52

Status of Parents/Guardians	Income Source to Use
Unmarried, living together	Use both parents' incomes
Unmarried, not living together	Use only the single parent's income
Single parent	Use only the single parent's income
Married	Use both parents' income
Separated	Use both parents' income as married[67]
Legally separated	Use only custodial parent's income unless there is a joint custody order for the child
Divorced	Use only custodial parent's income unless there is a joint custody order for the child
Joint custody	Use both parents' income
Foster parent	All beneficiaries in foster care are awarded full scope Medi-Cal no SOC. Financial eligibility determination is not needed.
Legal guardian	Use income from birth parent(s) following entries above **unless** the legal guardian is required by the court to provide financial support. If the legal guardian is not required to provide financial support **and** the parent(s) income is not obtainable the child will have zero income.
Stepparent	Use income from birth parent(s) following entries above. Do **not** use income from stepparents.

a. If the income source is receiving spousal support, the sum total of the support payments should be added to the income source's AGI.

b. If the family notifies the County CCS Program regarding a change in family income (e.g., temporary layoff or unemployment, permanent reduction in earnings, increase in family income, or a change in family size), the County may perform a new financial eligibility determination.

c. Financial eligibility redeterminations must be done annually for all clients. If the client has been and continues to be eligible for full scope no SOC Medi-Cal or an OTLICP beneficiary, the annual redetermination will consist of verification of current Medi-Cal status.

    1) For OTLICP beneficiaries send the applicant an Income Statement form and use the applicant's self-reported income to determine the appropriate aid code. Refer to Chapter 1 Section V.B. for aid codes.

[67] Exception: If the absent parent cannot be located or refuses to provide the needed information use one parent's income

Section IV: D. Program Eligibility Determination

D. Procedures for Program Eligibility Determination[68]

1. The County CCS Program staff must:

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

    NOTE: If residential eligibility can be confirmed by Medi-Cal, then the applicant is not required to provide proof of residency.[69]

    b. Establish first tickler date: CMS Net automatically establishes a tickler date of **15 calendar days** from the date when "Pending Determination" is selected in the Residential Status Field to when the first notice is mailed. Review the "Ready to Send" feature when the tickler is due.

    c. If no response is received by the tickler date: send the letter entitled CCS Second Letter (C-16A) within **five (5) business days** if no response is received by the tickler date of **15 calendar days** from the date the first notice was mailed. Enclose the CCS Program Health Insurance Form MC 2600 with the letter.

    d. Establish second tickler date: CMS Net automatically establishes a tickler date of **15 calendar days** from the date the second notice was mailed. Review the "Ready to Send" feature when the tickler is due.

        1) If no response is received by the second tickler date: send the final notice, and a Notice of Action (NOA). If a SAR was submitted, send the Service Authorization Request NOA (SAR NOA), within **five (5) business days** of the tickler date. Follow the instructions in 4 below.

        2) For the applicant or parent/legal guardian who responds to the contact letter, the County CCS Program staff must schedule and conduct a program eligibility intake following the guidelines described in the CCS Program regulations.[70]

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

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[68] Refer to CMS Net Eligibility Program manual.
[69] CCS N.L. 11-1500
[70] Appendix B: 31

2. When the determination is made that the applicant does not meet the CCS Program residential and/or financial eligibility requirements or fails to comply with the submission of required documents (including the MTP and MTP-only beneficiary), he/she must be informed via a NOA with the Appeal Process Information enclosure which provides a description of the CCS Program appeal process. If a SAR was submitted, a SAR NOA must be sent. Completion of a NOA requires the responsible County CCS Program staff member to:[71]

    a. Update the CMS Net Financial and Residential status fields to "INELIGIBLE".

    b. Generate a NOA in the Eligibility-Client Module:

        1) In the Denial Information Section, enter the denial date and select the denial reason from the drop-down list. Refer to the CMS Net, SAR/Web Manual, and letter templates.

        2) The denial date is the effective date that the CCS Program will not authorize services that have been requested. This is usually the referral date.

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

        4) Send a courtesy copy of the NOA to the referral sources.

            a) Providers will receive notification through PEDI.

            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 from being sent to the referral source.

    c. The Appeal Process Information enclosure must be mailed with the NOA to the applicant.

    d. DHCS will notify the Dependent County via web message with instructions to mail the NOA.

    e. All County offices must enter a case note documenting the date the NOA was mailed to the beneficiary.

3. Within **ten (10) business days** from the NOA date, the County must:[72]

[71] Appendix B: 78, 79, 80; CCS N.L. 04-0424

[72] CCS N.L. 04-0424

a. Deny any pending SARs and send the NOA(s). Follow the instructions in Chapter 3. Section I.B. for sending the NOA.

b. Update the Eligibility – Client section in CMS Net to "DENIED".

c. Send copies of NOA, following instructions in 2.b. above

4. The following activities must be completed by the County CCS Program staff upon determination of program eligibility for CCS state-only applicants:[73]

   a. The applicant, parent/legal guardian, or legal representative must sign a PSA.

      NOTE: For CCS state-only applicants, no PSA is to be signed by the applicant, parent/legal guardian, or legal representative until MEDS shows the Medi-Cal application is pending.[74] See Chapter 1. Section IV.E. for additional details. A PSA is not required for applicants who are a Medi-Cal full scope no SOC beneficiary, MTP-Only, or Diagnostic-Only. However, DHCS recommends all applicants sign a PSA.

   b. Update the CMS Net Financial and Residential Eligibility Status fields with the appropriate eligibility status.

5. When a Medi-Cal full scope no SOC or OTLICP beneficiary has also met the CCS Program eligibility requirements the County CCS Program staff will update the CMS Net Financial and Residential Eligibility status fields with the appropriate eligibility status.

6. Within **ten (10) business days** of financial and residential eligibility determination, the Independent County or DHCS (on behalf of the Dependent County) must review to determine if:

   a. The applicant is **medically eligible**. The case can then be opened following procedures in Chapter 1. Section V. Case Opening and Reopening.[75]

   b. The applicant is **medically ineligible**. Follow the procedures in Chapter 1. Section III. Medical Eligibility Determination for

[73] Appendix B: 54; CCS N.L. 04-0424
[74] CCS N.L. 11-0601
[75] Appendix B: 32

notification of the applicant and the provider of the eligibility decision.[76]

[76] Appendix B: 78, 79, 80; CCS N.L. 04-0424

Section IV: E. Program Eligibility Determination

E. Referral for Application to Medi-Cal as Part of Program Eligibility Interview

1. Upon determination that the applicant **must** apply for Medi-Cal (the beneficiary potentially meets eligibility requirements and is not already enrolled in Medi-Cal) the County CCS Program staff must:[77]

    a. Inform the applicant or parent/legal guardian that to be eligible for the CCS Program the applicant must complete an application to Medi-Cal. Application to Medi-Cal is defined as completing all necessary steps (i.e., submitting required forms, financial information, etc.) that are requested by the County responsible for Medi-Cal eligibility determination.[78]

    b. Upon obtaining intent to apply for Medi-Cal, update the Program Eligibility Type field to "Medi-Cal Pending" and enter in the Medi-Cal Agreement Signed Date.

    c. Inform the applicant, parent/legal guardian, or legal representative that the application to Medi-Cal must be completed within **60 calendar days**.[79]

        1) CMS Net will automatically establish a tickler date **60 calendar days** from the date the applicant, parent/legal guardian, or legal representative has been referred to Medi-Cal to complete an application.

    d. Monitor on a periodic basis the Medi-Cal application status of the applicant. The CMS Net narrative entries will be made to document the progress (or lack thereof) of the follow-through with the Medi-Cal application process.

    e. If the applicant, parent/legal guardian, or legal representative has recently applied to Medi-Cal and their application is still pending, enter the date they submitted the application in the "Self-Declared Date" field in the Pending Medi-Cal sub-section.

        1) Based on the family's self-declaration and all necessary program documents have been signed, the CCS case will be activated, and appropriate medically necessary services authorized. If the applicant/client/family has been determined to be medically, residentially, and financially eligible for the CCS Program, CCS will continue to authorize all medically necessary services while Medi-Cal

[77] Appendix B: 11, 52
[78] Appendix B: 51; CCS N.L. 26-0905; CCS N.L. 11-0601; CCS N.L. 04-0400
[79] CCS N.L. 11-0601

eligibility is pending, whether or not those services are considered to be emergencies.

f. Verify Medi-Cal application completion in MEDS or with the local social services agency that the Medi-Cal application was completed and enter the date verified in the Medi-Cal Application Completed Date. Once confirmed the applicant has met the application requirements:

1) Note the date the Medi-Cal application was completed in the Medi-Cal Application Date field. Update the CMS Net Program Eligibility status fields to the appropriate status.

2. If the applicant, parent/legal guardian, or legal representative did not complete the Medi-Cal application requirements:

a. Enter the date the County discovered the client was not compliant in going through with the Medi-Cal application process with the local social services agency in the "Deter. M/C Not Compliant Date" field.

b. Ensure that a NOA was generated denying the CCS Program eligibility. If a SAR was submitted, send a SAR NOA. Follow the instructions in Chapter 3 Section I.B. for sending a NOA.[80]

c. Enter a case note documenting the date the NOA was mailed.

3. Within **ten (10) business days** from the NOA notification date for failure to complete Medi-Cal application requirements, the County CCS Program staff must:

a. Update the Eligibility – Client section in CMS Net to "DENIED".

b. Providers will receive notification of the NOA through PEDI.

4. Upon determination of program eligibility based on receipt of evidence that Medi-Cal application requirements have been met by the applicant, the County CCS Program staff must update the CMS Net Financial and Residential Eligibility fields to the appropriate eligibility status.

5. If an applicant, parent/legal guardian, or legal representative states that they refuse to comply with the Medi-Cal application requirements: [81]

a. Enter in the Medi-Cal Application Refused Date the date they refused to apply for Medi-Cal.

[80] Appendix B: 78, 79, 80
[81] Health & Safety Code 123995; CCS N.L. 11-0601

b. Record a case note with the statement made by the applicant or parent/legal guardian and that he/she was verbally informed that refusal to apply for Medi-Cal means the applicant is not eligible for the CCS Program in the CMS Net case notes.

c. Send a NOA citing the appropriate reason from the NOA Explanation Citation List. If a SAR was submitted, send a SAR NOA. Follow the instructions in Chapter 3 Section I.B. for sending the NOA.[82]

[82] CCS N.L. 04-0424

Section IV: F. Program Eligibility Determination

F. Determination of the Enrollment Fee as Part of the Program Eligibility[83]

1. The County CCS Program will 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 beneficiary, **NO** annual enrollment fee is required:[84]

        1) The beneficiary is a Medi-Cal full scope no SOC beneficiary or OTLICP beneficiary;

        2) The family of the beneficiary has a gross annual income of less than 200% of the federal poverty level (FPL);

        3) The only service being requested is limited to diagnostic services;

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

        5) The beneficiary was adopted with a known eligible condition.

    b. Upon determination that an enrollment fee is required, the applicant, parent/legal guardian, or legal representative is informed that the:[85]

        1) The amount of the fee due is automatically calculated by CMS Net and is based on the CCS Program Annual Enrollment Fee Schedule (Refer to Cal. Code Regs., Title 22, Sections 41479 and 41610).

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

[83] Appendix B: 55, 56, 57; Health & Safety Code 123900
[84] Appendix B: 25, 51
[85] Appendix B: 25, 55, 56, 57

a) The due date for payment of the entire enrollment fee is due on the final date of the agreed payment plan of this date.

b) Failure to pay by the final day of the agreed payment plan will result in the applicant's case being denied to the CCS Program.

c. In the Fees Section click "Add a Payment Plan" and enter in the payment plan information the applicant or parent/legal guardian who has arranged for periodic payments to provide for:[86]

1) The total amount of the enrollment fee is automatically calculated. Enter the amount due and the due date.

2) Once a payment plan is added, enter in any payments made by clicking "Add Payment" and entering in the received date and the amount.

d. Any documents that are signed by the applicant or parent/legal guardian relating to the payment agreement entered into with the County CCS Program must be entered into the applicant's case notes.

e. Collect the enrollment fee and record the payment in the CMS Net Payment Plan section, Received Amount ($) field. It will also show the Balance Due ($). Enter a case note of the payment amount and the date it was received. If an additional payment plan exists, a new Fee Letter noting the balance due, due date and invoice stub will be auto generated in CMS Net Correspondence.[87]

2. The applicant/family can submit a reconsideration of the enrollment fee to waive or reduce the amount to the County Health Department Director or designee to determine if the enrollment fee will result in undue hardship for the applicant/family.[88]

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

1) Name of the applicant;

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

[86] CMS Net Eligibility Program Manual
[87] CMS Net Eligibility Program Manual
[88] Appendix B: 55, 57; Health & Safety Code 123900

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

b. The County CCS Program will enter the entire enrollment fee in the CMS Net Enrollment Fee--Reduced Amount ($) field. In the Reduced Fee Reason, the County will choose the appropriate reason from the dropdown list: Appeal, Hardship, or Other. If "Other" is chosen, the County should enter a case note with the County Health Department Director or designee's decision to reduce, waive, or maintain the enrollment fee and the reason(s). The County Health Department Director's or designee's decision may result in issuing a NOA (see 3. below).[89]

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

3. If there is an outstanding balance due past a payment plan date send three enrollment fee letters via CMS Web correspondence starting with the "Fee Letter" (C-40) after the enrollment fee is due. CMS Net will auto-generate "Fee Letter #2" (C-40A) **30 days after** the first letter is sent. The third letter, Fee Letter #3" (C-40B), is auto-generated by CMS Net **30 days after the second letter was sent**. If the fee has still not been paid, send a NOA. If a SAR has been submitted for the beneficiary, send a SAR NOA.

a. In CMS Net Correspondence, select "Notice of Action" and "Create Letter".

b. Enter the effective date of the action in the Effective Date field. This date is the final date the enrollment fee was due.

c. From the dropdown list in the Denial/Closure Description field, choose "FIN4 -- Failure to Pay Fee(s)". The Appeal Process Information enclosure will automatically print and must be mailed with the NOA to the beneficiary. Providers will receive notification of the NOA through PEDI.[90]

d. In the Eligibility-Program, Financial Status field, choose "INELIGIBLE". In the dropdown list of the Reason Ineligible field, choose "Failure to Pay Fees".

[89] CMS Net Eligibility Program Manual
[90] PEDI provider portal

e. Add a case note in CMS Net at the time the NOA is printed and mailed by the County.

4. If the applicant or parent/legal guardian has failed to comply with the enrollment fee requirements, within **ten (10) business days** of the date on the NOA, the County CCS Program must:[91]

   a. Update the Eligibility – Client section in CMS Net to "DENIED."

   b. If a SAR was submitted, select the SAR in the Authorization Section, and in the Service Request Action field update the status to "DENIED."

      1) Enter the Reason for Denial and choose "Failure to Pay Fee(s)" from the dropdown list.

   c. In the Effective Date, enter the initial date of service or the date the referral/SAR was submitted.

   d. Ensure that a NOA was generated. If a NOA was not generated, in Web Correspondence, choose Notice of Action and Search for Letters, then select the appropriate NOA-SAR.

      1) Select Create First Level Appeal Denial Letter.

      2) In the Effective Date field, enter the SAR beginning date or the date the referral/SAR was submitted. Add the medical provider/facility to Courtesy Copy History. The county will print out and send the letter to the beneficiary with the Appeal Information.

   e. Enter a case note when the NOA is mailed.

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

[91] Appendix B: 78, 79, 80; CCS N.L. 04-0424

Section IV: G. Program Eligibility Determination

G. Determination of the Assessment Fee

1. The County CCS Program must determine if the family is required to pay the $20.00 assessment due based on application to the CCS Program.[92]

    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. Applicants are exempt from the assessment fee if:

        1) The family has two (2) or more children eligible for the CCS Program, a single assessment fee is collected. In Reason Not Required dropdown select "Sibling on Program" if the family has already paid the assessment fee for another beneficiary.

        2) The family income is less than 100 percent of the federal poverty level;

        3) The applicant is a beneficiary of full scope Medi-Cal no SOC;

        4) The beneficiary was adopted with a known eligible condition;

        5) The applicant is in waiver-induced programs: HRIF, Newborn Screening, Newborn Hearing Screening, and Orthodontia for the HLD exam phase only; **OR**

        6) The applicant is receiving Medical Therapy Program (MTP) services through a Medical Therapy Unit (MTU) or vendorized therapy services in lieu of the MTU that is 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 must be received before eligibility can be activated.

        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.

            a) If a family is unable to pay the assessment fee the CCS Program can waive the fee on a case-by-case basis.

2. The applicant/family can submit a reconsideration of the assessment fee to waive or reduce the amount to the County Health Department Director or

[92] Health & Safety Code 123870

designee to determine if the enrollment fee will result in undue hardship for the applicant/family.[93]

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

    1) Name of the applicant; and

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

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

b. County must enter the entire assessment fee in the CMS Net Assessment Fee--Reduced Amount ($). In the Reduced Fee Reason, the County will choose the appropriate reason from the dropdown list: Appeal, Hardship, or Other. If Other is chosen, the County should enter a case note as to the reason(s) for 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 or designee may result in issuing a NOA (see 3. below).

    1) Update the CMS Net Financial and Residential Eligibility fields with the appropriate eligible status.

3. If the family fails to pay the assessment and thus is not eligible for the CCS Program, a NOA must be sent. Ensure a NOA is generated via CMS Net Web Correspondence. If a SAR was submitted, send a SAR NOA.[94]

    a. If a NOA is not automatically generated, in CMS Net Correspondence, select "Notice of Action" and "Create Letter".

    b. Enter the effective date of the action in the Effective Date field. This date is the final date the assessment fee was due.

    c. From the dropdown list in the Denial/Closure Description field, choose "FIN4 -- Failure to Pay Fee(s)". The Appeal Process Information enclosure will automatically print and must be mailed with the NOA to the beneficiary. Providers will receive notification of the NOA through PEDI.[95]

[93] Health & Safety Code 123870

[94] Appendix B: 78, 79, 80; CCS N.L. 04-0424

[95] PEDI provider portal

d. In the Eligibility-Program, Financial Status field, choose “INELIGIBLE”. In the dropdown list of the Reason Ineligible field, choose “Failure to Pay Fees.

e. Dependent County to notify DHCS staff via CMS Net web message at the time the NOA is mailed.

4. If the applicant, parent/legal guardian, or legal representative has failed to comply with the assessment fee requirements, within **ten (10) business days** of the date on the NOA, the County must:[96]

   a. Update the Eligibility – Client section in CMS Net to “DENIED.”

   b. If a SAR was submitted, select the SAR in the Authorization Section and in the Service Request Action field update the status to "Denied."

      1) Enter the Reason for Denial and choose "Failure to Pay Fee(s)" from the dropdown list.

   c. In the Effective Date, enter the initial date of service or the date the referral/SAR was submitted.

   d. In Web Correspondence, choose Notice of Action and Search for Letters, then select the appropriate NOA. If a SAR was submitted send a SAR NOA.

      1) Select Create First Level Appeal Denial Letter.

      2) In the Effective Date field, enter the SAR beginning date or the date the referral/SAR was submitted. Add the medical provider/facility to Courtesy Copy History. The County will print out and send the letter to the beneficiary with the Appeal Information. The provider will be notified via PEDI.

   e. Add a case note when the NOA is mailed out.

[96] CCS N.L. 04-0424

Section V: A. Case Opening and Reopening

A. General Information Regarding Case Activating and Reopening

1. A CCS Program case will be set to Active status in CMS Net when the eligibility criteria requirements have been met for the services to be authorized for the CCS Program or for the MTP. The CCS Program case is opened and assigned a permanent CCS number based on one of the following:[97]

    a. A Medi-Cal full scope no SOC or OTLICP beneficiary has been determined to be CCS medically and residentially eligible.

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

        1) Is medically eligible for diagnostic services based on the suspicion of a medically eligible condition (Diagnostic-only beneficiaries);

        2) Services to be authorized are limited to the CCS HRIF program benefits;

        3) The WCM MCP has determined HRIF program eligibility criteria are met; **OR**

        4) 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).[98] (MTP-only beneficiaries).

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

        NOTE: A PSA is not required for applicants who are a Medi-Cal full scope no SOC beneficiary, MTP-Only, or Diagnostic-Only. However, DHCS recommends all applicants sign a PSA.

2. Authorization for medical services cannot be issued until medical, residential, and financial eligibility have been established.[99]

    NOTE: Diagnostic services do not require financial eligibility determination.

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[97] Appendix B: 32, 39, 50, 51, 54

[98] CCS N.L. 08-1024

[99] Appendix B: 32, 39, 50, 51, 54

3. A CCS Program case that has been closed can be "Reopened" when:

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

   b. The former beneficiary is either:

      1) Assigned the CCS case number used prior to closure if the CCS number can still be found in CMS Net; or

      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 beneficiary meets one of the eligibility criteria in A.1.a-b above. See Section V.C. below for additional information on case reopening.

4. When a CCS beneficiary gets adopted **all County CCS Program (Classic CCS and WCM)** staff must:

   a. Close out the old CCS case the day before the effective date of adoption and add a case note that the beneficiary was adopted.

      1) In the old CCS case, County or DHCS must cancel all active SARs. Any pended SARs should remain pended or be denied, if appropriate. In the new CCS case, manually enter the pended and new SARs (that was previously authorized from the old CCS case) for adjudication.

         NOTE: Denied SARs from the old CCS case must provide a clear explanation for denial and also include the new CCS case number in the NOA, as a reference. Follow the instructions in Chapter 3. Section I.B. for sending the NOA.

      2) Mark the old CCS case as duplicate to release the CIN for the new CCS case. The same CIN number must be used.[100, 101]

   b. Open a new CCS case on the effective date of adoption and add a case note that the beneficiary was adopted.

   c. Add a case alert on both the old and the new case to allow nurses to review past medical history.[102] Example:

[100] ACWDL 18-23

[101] Refer to the CMS Net Mark Client Duplicate manual for additional instructions.

[102] Refer to CMS Net Case Alerts Manual for additional instructions.

- On case # 5551234 – an alert is created – Adopted. See new CCS# 1234567
- On case # 1234567 – an alert is created – Adopted. See old CCS# 5551234

d. For older cases where beneficiary information was already changed with new adoption information without closing and opening a new case, leave the case as is.

e. If any Release of Information Request (ROI) comes in the County user should review and go through all information and redact information that can lead to the beneficiary's old identity or the identity of the previous parent/legal guardian/legal representative before the adoption. Examples include, but are not limited to, birth surname, birth address/county, birth parent's name, birth parents address, etc.

5. When a CCS beneficiary is placed in Foster Care:

a. For **all County CCS Program (Classic CCS and WCM)**: County staff must reach out to Foster Care Programs within the County and find out where correspondence and reports should be sent to and update the Primary Addressee field in the Registration Client Information module. The current active case will remain open. For opening a new case, follow the instructions outlined below to open a case and use the Primary Addressee provided by the county foster care program.

b. Contact the County Foster Care Program to find out who can receive and discuss information regarding the beneficiary and place Case Alerts as necessary.[103]

[103] Refer to CMS Net Case Alerts Manual for additional instructions.

Section V: B. Case Opening and Reopening

B. Opening a Case

1. Upon determination that a case can be opened to the CCS Program based on meeting one of the eligibility criteria in Section V: A.1. above, the County CCS Program must:

    a. Confirm the Eligibility Start Date is correct. This is the start date of the aid code.

    b. Choose the appropriate aid code from the drop-down menu:[104, 105]

        9K CCS: CCS state-only. Eligible for all CCS benefits (such as diagnosis, treatment, therapy, and case management).

        9K CCS: Diagnostic only; HRIF.

        9M MTP Only: Eligible for CCS Medical Therapy Program (MTP)-only.

        9N Medi-Cal: Eligible for CCS if concurrently eligible for full scope no SOC Medi-Cal. Eligible for all CCS benefits (such as diagnostics, treatment, therapy, and case management).

        9R: **CCS-eligible OTLICP child**. A child in this program is enrolled in OTLICP and is eligible for all CCS benefits (such as diagnosis, treatment, therapy, and case management). The child's county of residence has no cost sharing for the child's CCS services. Family's adjusted gross income is **over** $40,000 per year.

        9U: **CCS-eligible OTLICP child**. A child in this program is enrolled in OTLICP and is eligible for all CCS benefits (such as diagnosis, treatment, therapy, and case management). The child's county of residence has county cost sharing for the child's CCS services. Funding is between Federal, State, and County. Family's adjusted gross income is **under**$40,000 per year or family income is unknown.

        a) To determine 9R/9U aid code use the family's self-reported income from the Income Statement form.

    NOTE: The CMS Net temporary case number will automatically update to a permanent case number and become an "active" case.

[104] Aid Codes Master Chart
[105] CMS Net Eligibility Administration Manual

c. Update the ICD code, if necessary, in the Registration Module. (Make sure ICD is not "Undiagnosed Condition".)

d. Enter in the CMS Net Eligibility Module:

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

2) In instances where prior authorization has not been requested (for example - emergency services) The CCS Program services can be authorized provided the request is submitted during the first day the CCS Program office was open following the time the service was provided**.** Refer to Cal. Code Regs., Title 22, Section 41770 regarding Prior Authorization**.**[106]

NOTE: Exception to eligibility date can be determined by DHCS or the County medical consultant or designee when appropriate.

e. A Medi-Cal full scope no SOC beneficiary can be assigned a permanent CCS case number upon confirmation of Medi-Cal coverage and determination of CCS medical eligibility. The designation of "Diagnostic" or "Treatment" is determined by the medical consultant or designee.

Reminder: For Medi-Cal full scope 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 Medi-Cal eligibility and Medi-Cal benefits. Refer to the CMS Net Authorization Manual for information on SAR Special Instructions.

2. If the applicant has been determined to be eligible for MTP services but does not meet CCS Program financial eligibility requirements, the case is opened under the case eligibility status "Treatment" as a MTP-only case.[107]

a. No authorizations are required for a beneficiary receiving Medical Therapy Conference , occupational therapy, or physical therapy services at a MTU.

[106] Appendix B: 63
[107] Appendix B: 39, 52; CCS N.L. 08-1024

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

   1) Enter in the CMS Net Eligibility Program “Not Required” in the PSA Status field. Choose "MTP-only" in the Reason Not Required field.

   2) Choose "Not Required" in the Financial Determination field. Choose "MTU Services Only" in the Reason Not Required field.

   3) In the Registration module, choose "9M MTP Only" in the Aid Code field.

   NOTE: If the County of the beneficiary's residence does not have an MTU or cannot adequately serve the beneficiary’s rehab needs within their own county MTP, the County can approach neighboring counties about providing services to the beneficiaries in the arrangement of a courtesy case. A courtesy case is when a neighboring county provides MTP therapy services to the beneficiary in their county's MTU. Often, they are registered at the treating MTU in order to allow for OPRC billing of services. However, the case remains with the County of residence for any SARs and other services outside of MTP therapy.

3. **WCM Counties:** Send the applicant the WCM-eligibility letter from the correspondence module of CMS Net upon opening the case. Send the referring provider the WCM-SAR letter**.** If the letter is not available from the drop-down list, go into the MEDS inquiry module and run a search. This should make the letter available in the correspondence module.

Section V: C. Case Opening and Reopening

C. Reopening Case

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

    a. Search for the previous CCS case number in CMS Net, Client-Search Client module.

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

    c. Request medical reports using the same procedures as for a new referral found in Chapter 1. Section III: Medical Eligibility Determination.[108]

    d. The CCS Program office receiving the referral must update the CCS case status to "Reopen Pending" in the CMS Net Registration Referral Type field and update the Referral Received On date field.

2. When a case to be reopened meets the requirements in Chapter 1. Sections I, II, III, and IV, the County CCS Program must:

    a. Enter in the CMS Net Medical Status field the appropriate case eligibility status as determined by the medical consultant/designee. In the Dx Only field, choose either "Yes" for Diagnostic or "No" for treatment as defined in Chapter 1. Section III.C. above.

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

    c. Update the client's case status in the Registration module:

        1) Enter the Eligibility Start Date, which is usually the date of referral.

        2) Choose the appropriate aid code from the dropdown list. Refer to Chapter 1. Section V.B. for a list of aid codes and their uses.

        3) Once saved, the case is re-activated, and the Registration Status in the Registration module is automatically updated to "Active".

[108] Appendix B: 32

CHAPTER TWO: ONGOING CASE MANAGEMENT

Section I: A. Annual Eligibility Redetermination

A. General Information

1. The CCS Program conducts annual eligibility redetermination to verify beneficiaries are still eligible for the CCS Program. In this section, program eligibility refers to financial and residential eligibility for the CCS Program. See Chapter 2 Section I.C. for annual medical eligibility redetermination, also known as Annual Medical Review (AMR).

2. The process for determination of program eligibility must be done on an annual basis for CCS Program enrolled beneficiaries. The annual redetermination should be completed prior to the date the previous Program Services Agreement (PSA) expires or the Program End Date if the PSA is not applicable.

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

    a. Providing information on the CCS Program and responding to questions from the beneficiary, parent/legal guardian, or legal representative.

    b. Redetermination of financial eligibility (see 6. below for exceptions) and residential eligibility;

    c. Redetermination of medical eligibility;

    d. Referral for application to the Medi-Cal, if necessary (see 4. below);[109] **and**

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

    NOTE: A PSA is **not** required for applicants who are a Medi-Cal full scope no SOC beneficiary, MTP-Only, or Diagnostic-Only. However, DHCS recommends all applicants sign a PSA.

4. Any beneficiary who may be eligible for the CCS Program is required to apply for Medi-Cal to comply with the Medi-Cal application requirement. This requirement includes beneficiaries who are POTENTIALLY eligible for

[109] Health & Safety Code 123995; CCS N.L. 11-0601

Medi-Cal based on either income or a categorical program. The beneficiary may be determined to not have continuing eligibility for the CCS Program if the beneficiary, parent/legal guardian, or legal representative has not complied with all Medi-Cal application requirements.[110]

5. If the beneficiary is a Medi-Cal full scope no SOC beneficiary or OTLICP beneficiary, for whom no CCS Program application or PSA is on file, the annual redetermination will consist of verification of current Medi-Cal status.[111]

6. Beneficiaries receiving the following CCS Program services are **not** required to meet the CCS Program financial eligibility requirements:[112]

    a. The CCS Program authorized services limited to the CCS High Risk Infant Follow-Up (HRIF) program and Newborn Screening 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 beneficiary who is adopted and when the services are to treat the medically eligible condition that was present and diagnosed at the time of adoption.[113]

7. To be eligible for the CCS Program, a CCS Program beneficiary may be required to pay an enrollment fee and/or an assessment fee on an annual basis.[114] See Chapter 2 Section I.D. and E. for additional information on the enrollment fee and assessment fee respectively

[110] Health & Safety Code 123995; CCS N.L. 11-0601
[111] Health & Safety Code 123870; CCS N.L. 11-1500
[112] Health & Safety Code 123870; CCS N.L. 05-1016
[113] Health & Safety Code 123965
[114] Health & Safety Code 123900; Appendix B: 55, 56, 57

Section I: B. Annual Eligibility Redetermination

B. Procedures for Annual Program (financial and residential) Eligibility Redetermination[115]

1. For beneficiaries with full scope Medi-Cal no SOC or OTLICP

    a. The annual program redetermination will consist of verification of current Medi-Cal status.[116]

    b. The County staff must add a new program period. The new begin date will automatically populate with the next calendar date after the current Program Eligibility End Date.

2. For beneficiaries **without** full scope no SOC Medi-Cal or OTLICP the County staff must:[117]

    a. Create a new Program Eligibility Start Date that is the date after the current Program Eligibility End Date.

    b. Update the Eligibility Type to Interview Pending and Coverage Type to "Neither Medi-Cal (full scope no SOC) or OTLICP". Select "Annual" in the Interview Type field and "CCS" in the Letter Type field. Send the program eligibility redetermination contact letter, CCS First Letter (C-38), the CCS Program Health Insurance Form (MC 2600), and the Income Statement (optional) within **60 business days** prior to the date the program eligibility date is due to expire.

    c. CMS Net will automatically establish a tickler date of **fifteen (15) calendar days** from the date the initial contact letter was mailed.

    d. If no response by the tickler date, send the letter entitled CCS Second Letter (C-38A), within **five (5) business days** of the tickler date. Enclose the CCS Program Health Insurance Form (MC 2600) and the Income Statement (optional) with the C-38A.

    e. CMS Net will automatically establish a second tickler date of **fifteen (15) calendar days** from the date the C-38A notice letter was mailed.

    f. If no response by the tickler date, send the CCS NOA/Third Letter (C-38B), which is a NOA with an Appeal Process Information enclosure that provides a description of the CCS Program appeal process, within **five (5)**

[115] Refer to CMS Net Eligibility Program manual

[116] Health & Safety Code 123870; CCS N.L. 11-1500

[117] Appendix B: 51

business days of the tickler date. Completion of the NOA requires the responsible staff member to:[118]

1) The effective date of the NOA is automatically entered into the Effective Date field along with the Denial Reason from a dropdown list. This date is the date of the current program eligibility date.

2) The Appeal Process Information enclosure will automatically print and must be mailed with the NOA to the beneficiary.

3) The CMS Net Client Eligibility status field will automatically update to "INELIGIBLE".

g. If no response within ten **(10) business days** of the date on the NOA (C-38B), the County CCS Program must:

1) Deny any pending SARs and send the NOA(s). Follow the instructions in Chapter 3. Section I.B. for sending the NOA.

2) Update the CMS Net Eligibility-Client Closure Date Field with the date of closure, which is the date the current program eligibility period expires. Select the reason from the dropdown box in the Reason Closed field.

3) The CMS Net Registration status will automatically update to "CLOSED."

4) Medical providers will receive notification of the NOA through PEDI.

h. For the beneficiary, parent/legal guardian, or legal representative who responds to the contact letter, the County CCS Program must schedule and conduct a program eligibility redetermination interview following the guidelines in the CCS Program regulations and current policies.[119]

i. The following activities must be completed by the County CCS Program staff upon determination of continued program eligibility:

1) The beneficiary, parent/legal guardian, or legal representative must sign a new PSA.

NOTE: A PSA is **not** required for applicants who are a Medi-Cal full scope no SOC beneficiary, MTP-Only, or Diagnostic-Only. However, DHCS recommends all applicants sign a PSA.

[118] Appendix B: 78, 79, 80; CCS N.L. 04-0424
[119] Appendix B: 51

2) Update the CMS Net Eligibility Program module with the appropriate eligibility status.

j. If the County staff determines that the beneficiary 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 beneficiary must be informed via the appropriate NOA depending on the ineligibility reason. Completion of a NOA requires the responsible County CCS Program staff member to:[120]

1) Update the CMS Net Eligibility-Client Closure Date Field with the date of closure, which is the date the current program eligibility period expires. Select the reason from the dropdown box in the Reason Closed field.

2) A NOA will automatically generate with the effective date and reason that was selected in the Closure Date and Reason Closed fields.

3) The Appeal Process Information enclosure will automatically print and must be mailed with the NOA to the beneficiary.

4) The CMS Net Registration status will automatically update to "CLOSED."

5) Providers will receive notification of the NOA through PEDI.

[120] Appendix B: 78, 79, 80; CCS N.L. 04-0424

Section I: C. Annual Eligibility Redetermination

C. Annual Medical Review[121]

The purpose of the Annual Medical Review (AMR) is to verify a beneficiary is still medically eligible for the CCS Program. An AMR includes a review of the beneficiary's residential, financial, and medical eligibility. The AMR process should begin 60 days prior to the program eligibility end date.

Completion of the AMR should include an annual update of the beneficiary's program eligibility modules to ensure all appropriate fields are up to date, including, but not limited to, ICD 10 codes related to the CCS eligible condition, medical home, diagnostic and treatment status, and beneficiary contact information.

1. The Medical consultant or designee must conduct an AMR on all active cases at least every 12 months. This AMR review must begin no later than **60 calendar days before** the program eligibility end date. Based on this review, the case may:

    a. Remain active after verification of eligibility status, which may result in a change;

    b. Remain active but may require additional information that can result in action to the case; **OR**

    c. Close. Refer to Chapter 2. Section V.

2. The AMR and financial redetermination can occur simultaneously.[122]

3. Classic and Whole Child Model (WCM) Independent Counties will conduct AMRs.

4. Classic and Whole Child Model (WCM) Dependent County must notify DHCS, via secure email at CCSDirectedReview@dhcs.ca.gov, that an annual medical review (AMR) is needed for a beneficiary's annual program redetermination. Include the coversheet on the DHCS website and check the "Annual Medical Reviews (AMRs)" box. See Chapter 2. Section II. for additional information on requesting medical reports. If DHCS requests additional medical reports, the County must notify DHCS once relevant medical reports are received and available for review.

[121] Health & Safety Code 123925
[122] Appendix B: 51

5. The CCS medical consultant or their designee must review any reports related to the CCS eligible condition.

6. Additional medical record review is to be done by a medical consultant or designee on the following:

    a. Transition planning at ages 17 and 20 as outlined in Numbered Letter (N.L.) 09-1123 Attachment A or any superseding N.L. Refer to the CCS Information Notice 10-02 Statewide Guidelines for Health Care Transition Planning for Children with Special Health Care Needs or any superseding policy guidance.[123]

    b. Other as required, such as beneficiaries requiring possible transplantation (heart, lung, bone marrow, or liver), failure of the beneficiary to follow through with center care, etc.[124]

    c. Deaths.

7. For WCM Counties:[125]

    a. **Independent Counties**: The CCS Program maintains responsibility for AMR based on the most current medical records provided by the MCP. The County CCS Programs must request medical records **90 calendar days** in advance of the WCM member's Program Eligibility End Date.

    b. **Dependent Counties**: DHCS is responsible for conducting CCS medical eligibility annual medical redeterminations, using the most current medical records related to the CCS medically eligible condition(s) provided to the County CCS Program by the MCP. If additional medical documentation or reports are needed the County CCS Program Staff must submit a request to the MCP. See Chapter 2. Section II. for additional information on requesting medical reports.

[123] CCS IN 10-02
[124] CCS N.L. 01-0108
[125] Refer to the Division of Responsibility Table and the WCM MOU for additional information on AMR requirements and procedures.

Section I: D. Annual Eligibility Redetermination

D. Referral for Application to Medi-Cal as part of Annual Program Eligibility Redetermination

1. Upon determination that the beneficiary must apply for Medi-Cal (the beneficiary meets eligibility requirements and is not already enrolled in Medi-Cal), the County staff must:[126]

    a. Inform the beneficiary, parent/legal guardian, or legal representative that continued eligibility for the CCS Program requires completion of an application for Medi-Cal. Application to Medi-Cal 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 Medi-Cal eligibility determination.[127]

    b. Record in the CMS Net case notes if a beneficiary, parent/legal guardian, or legal representative states that he/she refuses to comply with the Medi-Cal application requirements.

        1) Enter in the Medi-Cal Application Refused Date the date they refused to apply for Medi-Cal.

        2) Record in the CMS Net case notes the statement made by the beneficiary, parent/legal guardian, or legal representative and that they were verbally informed that refusal to apply for Medi-Cal means the beneficiary is not eligible for the CCS Program.

        3) Send a NOA citing the appropriate reason from the NOA Explanation Citation list. If a SAR was submitted, send a SAR NOA. Follow the instructions in Chapter 3. Section I.B. for sending the NOA.

2. The County CCS Program staff must, upon obtaining intent to apply for Medi-Cal:[128]

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

    b. Inform the beneficiary, parent/legal guardian, or legal representative that an application to Medi-Cal must be completed **within 60 calendar** days.

[126] Appendix B: 11, 52
[127] CCS N.L. 11-0601
[128] Appendix B: 51; CCS N.L. 26-0905; CCS N.L. 11-0601; CCS N.L. 04-0400

1) CMS Net will automatically establish a tickler date **60 calendar days** from the date the beneficiary, parent/legal guardian, or legal representative has been referred to Medi-Cal to complete an application.

c. Monitor on a periodic basis the Medi-Cal application status of the beneficiary. CMS Net case notes entries will document the progress (or lack thereof) of the follow-through with the Medi-Cal application process.

d. Verify completed Medi-Cal application status in MEDS.[129]

3. Upon determination of program eligibility based on receipt of evidence that Medi-Cal application requirements have been met by the applicant the County CCS Program staff must update the CMS Net Financial and Residential Eligibility fields to the appropriate eligibility status.[130]

4. If the applicant, parent/legal guardian, or legal representative did not complete the Medi-Cal application requirements:

   a. Enter the date the County discovered the client was not compliant in going through the Medi-Cal application process with the local social services agency in the "Deter. M/C Not Compliant Date" field.

   b. Ensure that a NOA was generated denying the CCS Program eligibility. If a SAR was submitted, send a SAR NOA. Follow the instructions in Chapter 3. Section I.B. for sending a NOA.[131]

5. Within **ten (10) business days** from the NOA date, the County CCS Program must:[132]

   a. Update the Eligibility – Client section in CMS Net to "DENIED."

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

   c. Providers will receive notification of the NOA through PEDI.

[129] County CCS Program staff can request MEDS access through CA-MMIS
[130] Refer to CMS Net Eligibility Program manual.
[131] Appendix B: 78, 79, 80
[132] CCS N.L. 04-0424

Section I: E. Annual Eligibility Redetermination

E. Redetermination of the Enrollment Fee as part of the Annual Program Eligibility Interview Process

1. The enrollment fee is required to be paid on an annual basis before authorizations for treatment services for a beneficiary can be issued.

2. The County CCS Program staff must re-determine the amount of enrollment fee due for the next 12-month period covered by the PSA during the annual program eligibility interview.[133]

    a. Review the beneficiary's CCS Program case record to determine if the enrollment fee is required. **NO** annual enrollment fee is required if:[134]

        1) The beneficiary is a Medi-Cal full scope no SOC beneficiary or OTLICP beneficiary;

        2) The family of the beneficiary has a gross annual income of less than 200% of the federal poverty level (FPL);

        3) The only service being requested is limited to diagnostic services;

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

        5) The beneficiary was adopted with a known eligible condition.

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

        1) The amount of fee due is automatically calculated by CMS Net and is based on the CCS Program Annual Enrollment Fee Schedule. Refer to Cal. Code Regs., Title 22, Section 41479.

        2) The Enrollment Fee is due on the program eligibility date. The beneficiary, parent/legal guardian, or legal representative is to be encouraged to pay the full enrollment fee in a single, lump-sum payment. If periodic payments plan(s) are agreed to by the County CCS Program staff, the beneficiary, parent/legal guardian, or legal representative is to be informed that:[135]

[133] Appendix B: 25, 55; CCS N.L. 11-0601

[134] Health & Safety Code 123900

[135] Refer to CMS Net Eligibility Program Manual for how to add a payment plan.

a) The due date for payment of the entire enrollment fee is due on the final date of the agreed payment plan of the program eligibility date.

b) Failure to pay by the final date of the agreed payment plan will result in the beneficiary's case being closed to the CCS Program.

c. Any documents that are signed by the beneficiary, parent/legal guardian, or legal representative relating to the payment agreement entered into with the County CCS Program are to be filed in the beneficiary's CMS Net case.[136]

d. Collect the enrollment fee and record the payment in the CMS Net Payment Plan section, Received Amount ($) field. It will also show the Balance Due ($). Enter a case note of the payment amount and the date it was received. If an additional payment plan exists, a new Fee Letter noting the balance due, due date and invoice stub will be auto generated in CMS Net Correspondence.[137]

e. CMS Net automatically generates miscellaneous tickler(s), the appropriate Fee Letter, and a billing invoice that outlines the following:[138]

1) 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 **by the final date of the agreed payment plan**.

3. If a family is unable to pay the enrollment fee, they can submit a reconsideration of the enrollment fee to waive or reduce the amount to the County Health Department Director or designee to determine if the enrollment fee will result in undue hardship for the applicant/family.[139]

[136] Appendix B: 29, 57
[137] Appendix B: 57
[138] Appendix B: 57
[139] Appendix B: 55, 57; Health & Safety Code 123900

a. Any request for reconsideration of the enrollment fee must be submitted in writing by the beneficiary, parent/legal guardian, or legal representative to the County CCS Program and must include:

    1) Name of the beneficiary;

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

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

b. The County staff must enter in the CMS Net Enrollment Fee section Reason Not Required or Reduced fields the decision made by the County Health Department Director or designee to reduce, waive, or maintain the enrollment fee. If the enrollment fee is refused, not collected, or the beneficiary was not compliant, enter the date and reason in the appropriate fields in the Fees Section. The decision made by the County Health Department Director or designee may result in the issuing of a NOA.[140]

    1) If the case is to be closed for fees not collected, enter the date to close the case in the Closure Date field. Refer to the CMS Net Manual for complete instructions.

c. If there is an outstanding balance due past a payment plan date send a fee letter First Letter (C-40). Once the fees screen is saved the first fee letter is created and ready to be completed in the Correspondence module. If any changes are made to the fees screen a new letter must be generated. The Second Letter (C-40A) is created **30 calendar days** after the First Letter is sent if there is an outstanding balance. The Third Letter (C-40B) is created **30 calendar days** after the Second Letter is sent. The final statement, if the total enrollment fee has not been paid, is a NOA. Ensure a NOA was generated. If a NOA was not automatically created, generate a NOA via CMS Net Web Correspondence.[141]

    1) In CMS Net Correspondence, select "Notice of Action" and "Create Letter".

    2) Enter the effective date of the action in the Effective Date field. This date is the final date the enrollment fee was due.

[140] CMS Net Eligibility Program Manual
[141] Appendix B: 78, 79, 80

3) From the dropdown list in the Denial/Closure Description field, choose "FIN4 -- Failure to Pay Fee(s)". The Appeal Process Information enclosure will automatically print and must be mailed with the NOA to the beneficiary. Providers will receive notification of the NOA through PEDI.[142]

4) In the Eligibility-Program, Financial Status field, choose "INELIGIBLE". In the dropdown list of the Reason Ineligible field, choose "Failure to Pay Fees.

5) Dependent County to add a case note in CMS Net at the time the NOA is printed and mailed by the County.

4. If the applicant or parent/legal guardian has failed to comply with the enrollment fee requirements, within **ten (10) business days** of the date on the NOA, the County CCS Program must:[143]

   a. Update the Eligibility – Client section in CMS Net to "DENIED."

   b. If a SAR was submitted, select the SAR in the Authorization Section, and in the Service Request Action field update the status to "DENIED."

   c. Enter the Reason for Denial and choose "Failure to Pay Fee(s)" from the dropdown list.

   d. In the Effective Date, enter the Type in the effective date for the NOA. This is the final date that the enrollment fee was due.

   e. Generate and mail the NOA. See Chapter 3. Section I.B. for additional instructions generating and mailing a NOA.

[142] PEDI provider portal

[143] Appendix B: 78, 79, 80; CCS N.L. 04-0424

Section I: F. Annual Program Redetermination

F. Redetermination of the Assessment Fee as part of the Annual Program Eligibility Interview Process

1. The County CCS Program staff must determine if the family is required to pay the $20.00 assessment fee due for the next 12 months during the annual program eligibility interview.[144]

    a. The beneficiary's CCS Program case record is reviewed to determine if the CCS Program assessment fee will be collected. The assessment fee is **NOT** required from the family/beneficiary if:

        1) The family already has another beneficiary enrolled in the CCS Program and has already paid the assessment fee. The assessment fee is based per family, not per beneficiary, therefore, if the family has two or more children eligible for the CCS Program, a single assessment fee is collected;

        2) The family income is under 200 percent of the federal poverty level;

        3) The beneficiary has full scope no SOC Medi-Cal or OTLICP;

        4) The beneficiary was adopted with a known eligible condition;

        5) The applicant is in waiver-induced programs: HRIF, Newborn Screening, Newborn Hearing Screening, and Orthodontia for the HLD exam phase only; **OR**

        6) Medical Therapy Program (MTP) services through a Medical Therapy Unit (MTU), or vendorized therapy services in lieu of the MTU, that are part of an individualized education plan (IEP).

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

        1) The assessment fee is due on or before the program eligibility date.

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

2. A reconsideration of the assessment fee based on a request to waive or reduce the amount by the beneficiary, parent/legal guardian, or legal representative must be submitted to the County Health Department Director

[144] Health & Safety Code 123870

or designee who is responsible for determining if the assessment fee will result in undue hardship to the family.[145]

a. Any request for reconsideration of the assessment fee must be submitted in writing by the beneficiary, parent/legal guardian, or legal representative to the County CCS Program and must include:

    1) Name of the beneficiary.

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

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

b. The County staff will enter in the CMS Net Assessment Fee section Reason Not Required or Reduced fields the decision made by the County Health Department Director or designee to reduce, waive, or maintain the assessment fee. If the assessment fee is refused, not collected, or the beneficiary was not compliant, enter the date and reason in the appropriate fields in the Fees Section. The decision made by the County Health Department Director or designee may result in the issuing of a NOA (see c. below).

    1) If the case is to be closed for fees not collected, enter the date to close the case in the Closure Date field. Refer to the CMS Net Program Eligibility Manual for complete instructions.

c. If the family fails to pay the required assessment fee, and thus is not eligible for the CCS Program, ensure a NOA is generated. If a NOA is not generated when the case is closed generate a NOA via CMS Net Web Correspondence.[146]

    1) Type in the effective date for the NOA. This is the final date that the assessment fee was due.

    2) Choose the Denial Reason from the dropdown list in the Denial/Closure Field.

    3) The Appeal Process Information enclosure will automatically print and must be mailed with the NOA to the

[145] Health & Safety Code 123870
[146] Appendix B: 78, 79, 80; CCS N.L. 04-0424

beneficiary/family. Providers will receive notification of the NOA through PEDI.

4) Enter the date to close the CCS Case in the Closure Date field of the Eligibility-Client module. The closure date should be the date the current Program Period ends for the CCS state-only beneficiary. CMS Net will automatically set the Eligibility Status field to "CLOSED".

5) Reapplying to the CCS Program will require the beneficiary, parent/legal guardian, or legal representative to fully pay the outstanding assessment fee and will result in a new effective date of coverage.

d. If the applicant, parent/legal guardian, or legal representative has failed to comply with the assessment fee requirements, within ten (10) business days of the date on the NOA, the County must:[147]

1) Update the Eligibility – Client section in CMS Net Registration Status field to “DENIED.”

2) If a SAR was submitted, select the SAR in the Authorization Section and in the Service Request Action field update the status to "Denied."

3) Enter the Reason for Denial and choose "Failure to Pay Fee(s)" from the dropdown list.

4) In the Effective Date, enter the initial date of service or the date the referral/SAR was submitted.

[147] CCS N.L. 04-0424

Section II: A. Requesting Medical Reports

A. General Information

1. Medical reports are essential for the determination of the CCS Program medical eligibility and ongoing case management activities. In WCM Counties the MCP must provide medical reports necessary for annual medical reviews. If a County CCS Program in a WCM county believes the medical report(s) provided by the MCP is insufficient to make the medical eligibility determination, the County must work with the MCP to get the documentation necessary to reach a decision.[148] The procedures and responsibility for requesting the medical reports needed for the determination of medical eligibility are listed in Chapter 2 Section II.B.[149] Review the Division of Responsibility Table for additional information on County, DHCS, and MCP responsibility by county type.

2. In Dependent Classic Counties and in Dependent WCM Counties it is DHCS responsibility to coordination with the MCP to obtain medical reports required for the Medical Therapy Program (MTP) Occupational Therapy (OT) and Physical Therapy (PT) if additional records are needed. Obtaining medical records for the MTP OT and PT in Independent Classic Counties is the responsibility of the County, and for Independent WCM Counties it is the responsibility of the County to coordinate with the MCP.[150]

3. A Release of Information (ROI) signed by the applicant, parent/legal guardian, or legal representative is needed when a medical report is requested from a provider with whom CCS does not have an established provider relationship for the beneficiary.[151]

[148] See CCS N.L. 10-1224, or any superseding NL and CCS APL 24-015, or any superseding NL
[149] Appendix B: 29, 30
[150] Appendix B: 29, 30; Division of Responsibility Table
[151] CCS N.L. 01-0105; CCS N.L. 11-0703

Section II: B. Requesting Medical Reports

B. Procedures for Requesting Medical Reports for Case Management

1. Upon determination that a medical report is required, the Classic County CCS Programs must:[152]

    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 with insufficient medical documentation or without a medical report, the County CCS Program must send the medical report request form letter C-13.

        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. Check the "Ready to Send" folder in CMS Net to access and send the form.[153]

            NOTE:

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

            NOTE: The MCP is responsible for providing medical records in WCM Counties.

    b. CMS Net automatically generates a case note and link to the C-13 or C-17 letter in the beneficiary's CCS Program record.

2. CMS Net will automatically generate a tickler date from the date of the request to establish a review date for receipt of the medical report.

3. When medical reports are received, the County CCS Program must enter the date the report was received into CMS Net using the Receive Medical Report function. This entry removes the Medical Report Request from the tickler. When medical records are received, the County CCS Program must enter in the correspondence section of CMS Net:

    a. Use the drop-down "report received" and note the date in the notes section then follow the local county procedure for notification.

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[152] Appendix B: 17, 26, 32

[153] CCS N.L. 29-1105; CCS N.L. 01-0105; CCS N.L. 11-0703

4. If the medical report is not received by the tickler date, the County CCS Program must:

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

    b. Send a second medical report request letter C-14 to the medical provider, using the Request Medical Report function. This will delete the first request from the tickler. Check the "Ready to Send" folder in CMS Net to send the form.

    c. The CMS Net Application Status function will automatically set up a tickler date of **20 calendar days** from the date of the second request to establish a review date for receipt of the medical report.

5. If the required medical report(s) are not received by the **20 calendar days,** the case may be denied. See Chapter 3. Section I.

Section II: 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 medical consultant or designee must note the need for the report and the physician or healthcare provider who is being requested to send it.[154]

2. The County CCS Program for Independent Counties/DHCS for Dependent Counties must:

    a. Send MTU letter #1 to the physician responsible for the medical management of the beneficiary's physical disability with a copy to the parent/legal guardian, or legal representative. CMS Net will automatically set up a tickler date of **20 calendar days** from the date of the request to review for receipt of the report.

    b. If the report is not received by the tickler date, within **five (5) calendar days**, send a letter requesting the required information following the steps for requesting medical reports in Chapter 2 Section II. B. above.

    c. If the requested medical report/prescription is not received within **20 calendar days**, the County must:

        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) Dependent Counties notify the DHCS therapy consultant via MTPCentral@dhcs.ca.gov.

    d. If no medical report or prescription is received within **20 calendar days** from the date that the County staff contacted the family, the County or DHCS medical consultant or designee must review the case for appropriate action.[155]

3. Upon receipt of the requested medical report(s) and/or prescriptions, forward to report(s) the DHCS therapy consultant for action and update the CMS Net Receive Medical Report function to remove the request from the tickler.

[154] Appendix B: 32, 39
[155] Appendix B: 78, 79, 80

Section III: A. 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:[156]

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

      2) Is not a current beneficiary of the CCS Program; **and**

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

         NOTE: The referral can originate from any source. Examples of who can initiate a referral include but are not limited to: Medi-Cal Managed Care Plans (MCPs), health care providers, health plans, parents, legal guardians, school nurses, regional center counselors, or other interested parties. See Chapter 1. Section I.A. 5. for definition of a complete referral.

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

2. Authorization

   a. Authorization for diagnostic or treatment services of a CCS eligible condition or for conditions that complicate or are associated with the eligible condition can be issued after a CCS case number has been assigned and the case record is opened and active. A case can become "active" when medical, residential, and financial eligibility has been confirmed.[157]

   b. Types of Authorizations

      Diagnostic evaluations to establish or rule out a CCS eligible condition can be authorized when:[158]

[156] Appendix B: 31
[157] Appendix B: 32, 50, 52,
[158] Appendix B: 58, 59, 60

1) There is a signed application on file, there is indication of a CCS eligible condition, **and** residential eligibility has been established; **OR**

2) The beneficiary is confirmed as a Medi-Cal full scope no SOC or OTLICP beneficiary.

Treatment services can be authorized when medical, residential, **and** financial eligibility have been established and:[159]

1) There is a signed application on file.

2) There is a CCS Program Services Agreement (PSA) on file**.**

   NOTE: A PSA is **not** required for applicants who are a Medi-Cal full scope no SOC beneficiary, MTP-Only, or Diagnostic-Only. However, DHCS recommends all applicants sign a PSA.

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

Authorization expiration must not be beyond the Program End Date. Expiration dates are required for any authorized service including one-time purchased items such as purchase or rental of durable medical equipment. Authorizations can vary based on the following:

1) Beneficiaries who are Medi-Cal full scope no SOC or OTLICP beneficiaries who have **not** signed a CCS Program application.

   REMINDER: The CCS Program eligible services can be authorized for Medi-Cal beneficiaries with full scope no SOC or OTLICP. All such authorizations are issued with a statement that authorizations are subject to continued Medi-Cal eligibility and Medi-Cal benefits. This statement **must** be added to any authorization issued for a Medi-Cal beneficiary to ensure providers are aware that the CCS Program is not responsible for payment for those medical services not covered by Medi-Cal. Refer to the CMS Net Authorization Manual for information on Special Instructions.

2) Beneficiaries who are Medi-Cal beneficiaries **with** SOC or Limited Scope Medi-Cal or Private Insurance or CCS state-only coverage:[160]

[159] Appendix B: 61, 63
[160] Appendix B: 54

a) Before diagnostic services can be authorized, there **must** be a signed CCS Program application.

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

c) Providers must bill the beneficiary's Other Health Coverage (OHC) before billing CCS. The CCS Program is the "payor of last resort".[161, 162, 163] CCS payment to a provider is considered payment in full and must not be billed to the beneficiary.[164]

d. Authorizations and the Medical Therapy Program (MTP)[165]

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 can be vendored to a CCS-paneled physical therapy provider or paneled occupational therapy provider. In addition, County MTPs may arrange for their County's eligible residents to be served at neighboring County's MTUs per a courtesy case arrangement.

Medical services for the MTP beneficiary identified/referred 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) There is a signed application on file.

2) Authorization for services to be covered.

NOTE: Financial eligibility is **NOT** required for MTP, including vendored therapy in lieu of MTU services.

[161] For question regarding Pharmacy billing please contact the Medi-Cal Rx Customer Service Center for assistance.
[162] Health & Safety Code 125155
[163] For questions regarding Faith Based OHC billing please contact DHCS at CCSProgram@dhcs.ca.gov.
[164] Welfare and Institutions Code 14019.3
[165] Health & Safety Code 123875; Appendix B: 16, 39

Section III: B. Case Management and Service Authorizations

B. Issuing and Denying Authorizations

1. **Authorizations for Service Authorization Requests (SARs)**[166]

   a. **All SARs received must be entered into CMS Net.** A provider must enter a SAR using the PEDI system. When there is a disruption to the PEDI system that delays the provider from submitting an eSAR for more than 72 consecutive hours, a SAR can be submitted through secured email, fax, or postal carrier. SARs received outside the PEDI system must be entered into CMS Net by the County staff. The SAR must contain the following:

      1) The provider's National Provider Identifier (NPI) number;

      2) The provider's contact name;

      3) The provider's contact telephone number;

      4) The provider's email address and, if applicable, fax number;

      5) The client's first and last name, and date of birth;

      6) The client's case number or client index number (CIN);

      7) The code for the client's diagnosis or disease as specified in the International Classification of Diseases (ICD), as maintained and distributed by the U.S. Department of Health and Human Services;

      8) The code for the client's requested medical procedure or service as specified in the Current Procedural Terminology (CPT), as maintained and distributed by the American Medical Association, or the Healthcare Common Procedure Coding System (HCPCS), as maintained and distributed by the U.S. Department of Health and Human Services;

      9) The description of the requested medical procedure or service;

      10) The units or quantity of the requested medical procedure or service;

      11) The beginning and ending dates of the requested medical procedure or service;

[166] Appendix B: 63; Health & Safety Code 123929

12) The medical documentation to support the requested medical procedure or service; **AND**

13) The printed name and signature of the physician or other provider who prescribes the requested medical procedure or service and the date signed.

b. For WCM counties, the Independent County or DHCS on behalf of the Dependent County must:

1) **Enter all SARs received into CMS Net.** If the beneficiary is covered by the MCP the SAR must be denied.

2) Deny the SAR and select "Request is referred to WCM Plan" from the drop-down denial reason.

a) The County must send the denial letter with the enclosed appeals process information to the beneficiary.

3) Send a separate deferral letter to the requesting provider with information on submitting the SAR to the WCM MCP for authorization.

c. For Classic CCS:

1) All SARs received must be entered into CMS Net by the County CCS Program staff upon receipt of the request. The CMS Net Authorization manual outlines the process for entering SARs into CMS Net.

NOTE: Requests must be specific, outlining the beneficiary's name, diagnosis, and the service requested.

2) Service Authorization Requests (SARs) must be reviewed by the County in Independent Counties or reviewed by DHCS in Dependent Counties to determine if/when services and providers are to be authorized.[167]

3) Enter the provider to be authorized, effective dates of authorization, and any other required service-specific information including Special Instructions on the authorization if not already in CMS Net. Refer to the CMS Net Authorization Manual for additional information.

[167] Appendix B: 63; CMS Net Authorization Manual

REMINDER: Submission of SARs differs for PEDI Providers. These show up as Awaiting Service Requests (ASRs) for the CCS Program beneficiary.

4) Prior to approving a request for service, the County must:

   a) Verify the provider is CCS paneled;

   b) Revise a previously entered request for service. The County/DHCS must determine if the modification/denial requires the generation of a NOA.[168]

      NOTE: A NOA may be required if the modification of the requested service is necessary. Refer to Cal. Code Regs., Title 22, Section 42132 and the CCS NOA policy CCS N.L. 04-0424, or any superseding N.L.

5) The County must issue the authorization via CMS Net.

2. **SAR Decision Options within CMS Net**

   a. **Pending**: SAR is accepted and awaiting review.

   b. **Request-Approval:** an EPSDT SAR from a Dependent County requires DHCS approval. Independent Counties will review their own EPSDT SARs and update the SAR status to the appropriate decision drop-down. Client coverage should be Full Scope Medi-Cal with no SOC.[169] For Dependent Counties DHCS will update the status to Approved-Y (authorized) or Approved-N (not authorized) on behalf of the Dependent County.

   c. **Authorized**: The Authorization Details section must be completed. An authorized SAR can be extended up to 999 days.

   d. **Denied**: Once saved the SAR can no longer be modified.

      1) Independent Counties may consult with DHCS prior to denial of EPSDT SARs. See 3.d in this section below for additional details.

      2) If a SAR or eSAR is denied or must be modified a NOA is required. See Chapter 3 Section I. B. for NOA procedures.

   e. **Cancelled**: Cancelling SARs are completed in the event an already authorized SAR needs to be discontinued. Cancelling a SAR allows the provider to use the SAR up to and including the cancellation Effective

[168] Appendix B: 79; CCS N.L. 04-0424

[169] CCS state-only beneficiaries can receive EPSDT services, however the funds will come from both county and state funding. If the beneficiary has OHC, CCS is always the payor of last resort.

Date. The Cancellation Details section must be completed and included with the SAR.

f. **Deleted**: CMS Net will automatically detect and delete any duplicate SARs. SARs should not be deleted by any County CCS Program staff without DHCS approval. County CCS staff must send any SAR deletion requests to CCSDirectedReview@dhcs.ca.gov.

3. **Denials of Service Authorization Requests (SARs)**[170]

a. Any CCS Program applicant, CCS Program beneficiary, and/or their authorized representative (i.e. parent, legal guardian, or legal representative) has the right to appeal the medical denial decision except when the service has been terminated by a CCS paneled provider with responsibility for the medical supervision of the beneficiary. See also Chapter 3. Section I. for additional details on NOAs and First Level Appeals.

1) Per the CCS Program regulations, NOAs are not issued when the medical service is terminated by the beneficiary's CCS paneled physician. When this is the case, choose the "Treatment Complete" closure reason in CMS Net to issue the correct correspondence.[171]

NOTE: The County will add a case note stating that the CCS-paneled physician has determined that the CCS eligible condition is no longer present or that treatment for the eligible condition is complete.

2) Denied SARs by County/DHCS require a SAR NOA that includes the Appeal Process enclosure.

A provider has **90 calendar days** to submit a request for reconsideration to the County/DHCS if the provider has new information to submit that has not previously been reviewed. The provider must resubmit a SAR and include the additional information, and a copy of the denial that can justify the authorization.[172]

b. A SAR NOA to deny a service request is generated by the CMS Net Correspondence function.

[170] Appendix B: 78, 79, 80, 81; CCS N.L. 04-0424
[171] Appendix B: 79, 80
[172] Welfare & Institutions Code 14133.05

1) The County will send a SAR NOA to the beneficiary with the Appeal Process Information enclosure. Refer CCS N.L. 04-0424, or any superseding N.L. and Chapter 3. Section I.B.

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

3) For procedures related to denying SARs, refer to the CMS Net Authorization Guide Manual.

4) Providers will receive notification of the NOA through PEDI.

c. For an OTLICP beneficiary or a Medi-Cal beneficiary with full scope 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, the SAR **must be denied,** and a SAR NOA must be sent. In addition, an optional deferral letter may be sent which includes additional information to: "Please request services through Medi-Cal via a Treatment Authorization Request or to the MCP." (Specify Medi-Cal or the MCP).

d. Before denying a request for EPSDT services, County staff must consult with the County CCS Program's Medical Consultant.

1) The County Medical Consultant can seek consultation with the DHCS medical consultant before issuing denials for EPSDT services by sending a secure email to the ISCD-MedicalPolicy@dhcs.ca.gov inbox.

2) A provider has the option to submit a request for reconsideration to the County/DHCS within **90 calendar days** if the provider has additional information to submit along with the SAR that would justify authorization.

3) The EPSDT NOA provides notice to the Medi-Cal beneficiary of the denial of the service and the right to a first level appeal. If the family or beneficiary disagree with the EPSDT NOA they can submit a first level appeal. Refer to CCS N.L. 04-0424, or any superseding N.L. and Chapter 3. Section I.B.

4. A CMS Net case note must be entered that the SAR NOA or EPSDT NOA was sent.

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.[173]

1. A beneficiary 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. 10-1123, or any superseding N.L., regarding the Inter-County Transfer Policy and policy implementation.

2. In this section of the CCS Administrative Case Management Manual, "**Sending County**" refers to the county that has an opened CCS Program record. The term **"Receiving County**" refers to the new county to which a beneficiary is moving and in which they establish residency.

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

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

   a. All cases should be reviewed by the Sending County for current residential eligibility and medical eligibility and services prior to case transfer and should be transferred only when there is current documentation that indicates a beneficiary's case remains active, medically eligible, and residentially eligible in Receiving County.

   b. The Sending County is responsible for sending out a transfer letter when the County determines there is evidence indicating that a beneficiary or their parent/legal guardian, may no longer reside in the county. The only exception to sending out the transfer letter is if the Receiving County contacts the Sending County that the family has notified them, and the Receiving County is requesting a Transfer Date. The beneficiary, their parent/legal guardian, or legal representative is responsible for providing the information requested by the Receiving County to establish residency in the county. See Chapter 2 Section IV.B. for additional details.

   c. The CCS Program signed application (if applicable) and PSA (if applicable) from the Sending County must be accepted by the Receiving County once

[173] CCS N.L. 10-1123, or any superseding N.L.

county residence is established. The PSA must be renewed by the beneficiary, parent/legal guardian, or legal representative based on the annual renewal date established by the Sending County.

d. Transfer of a CCS Program beneficiary who is Medi-Cal full scope no SOC beneficiary should not be delayed as long as the address change shows in MEDS.

    1) If the address change does not display in MEDS after the beneficiary has transferred to the Receiving County, the Receiving County must work with the beneficiary/family to contact the county Medi-Cal eligibility office to ensure this change is made in MEDS. Refer to CCS N.L. 10-1123, or any superseding N.L. for additional information.

    2) For Medi-Cal beneficiaries receiving CCS Program services, the Receiving County must not delay the approval of the transfer because the beneficiary's address has not been updated in MEDS.

e. The two Counties involved with the transfer must coordinate and mutually agree on the date on which authorizations are to be canceled and the CCS Program case record closed in the Sending County and reopened in the Receiving County. The case in the Sending County will be closed on one day and opened in the Receiving County on the following day.

f. The Sending County must ensure the beneficiary's CCS Program case records, outlined in Chapter 2. Section IV.B. and in CCS N.L. 10-1123 Intercounty Transfer Policy (or any superseding N.L.), are sent to the Receiving County within **seven (7) business days** from the date that the Sending County and the Receiving County agree on a transfer date:[174]

NOTE: For beneficiaries who moved out of the County or out of state due to educational purposes, please refer to CCS N.L. 10-1123 Intercounty Transfer Frequently Asked Questions, or any superseding N.L.

[174] WIC § 10003(a)

Section IV: B. Transfer of the CCS Program Case to Another County

B. Sending County Procedures

1. When the Sending County determines there is evidence a beneficiary or their parent/legal guardian may no longer reside in the County, transfer letters must be sent to the beneficiary or their parent/legal guardian.[175]

    a. Send C-21, first transfer correspondence letter, to the beneficiary, parent/legal guardian, or legal representative that confirmation must be received **within 15 business days** from the date stated in the transfer letter that the beneficiary continues to reside in the Sending County or has relocated to a residence in a Receiving County in the state.

    b. If the Receiving County does not notify the Sending County that the beneficiary, parent/legal guardian, or legal representative has contacted the Receiving County, the Sending County must send a second transfer letter (C-21A) to the original address within **five (5) business days** after the due date of the first letter. The beneficiary, parent/legal guardian, or legal representative is given **15 business days** to notify the Receiving County.

    c. If no response to the second transfer correspondence, then all open authorizations for services will be canceled and the beneficiary's CCS Program record closed on the effective date stated in the transfer letter. Case status must be updated to Closed using closure reason "No response to the last known address".

    d. If the Receiving County is contacted by the beneficiary, parent/legal guardian, or legal representative after receiving a closure NOA (C-21B), then the Receiving County and the Sending County should coordinate a mutually agreed upon date of transfer and follow intercounty transfer procedures outlined in this section and CCS N.L. 10-1123, or any superseding N.L.

2. Within **five (5) business days** of being notified that the beneficiary, parent/legal guardian, or legal representative **may** have moved to another County in the State, the County CCS Program noting the information will record the possible "new" address, the source of the information (medical report, regional center staff, mail returned, etc.) in CMS Net case notes.

[175] CCS N.L. 10-1123, or any superseding NL

3. Upon obtaining confirmation from the beneficiary's family, Receiving County, or MEDS of an address outside of the county, **AND** the beneficiary is CCS Program eligible the Sending County must:

    a. Change the CMS Net Registration Primary Addressee to the new address.

    b. Coordinate a Transfer Date with the Receiving County to avoid any gap or overlap in services. The Sending County and Receiving County must mutually agree on a Transfer Date.

    c. The Sending County must ensure all of the following documentation are sent to the Receiving County within **seven (7) business days** from the date that the Sending County and Receiving County agree on a Transfer Date:

        1) A completed copy of CCS N.L. 10-1123, or any superseding version of this NL Attachment 3, "California Children's Services Intercounty Transfer Check List";

        2) Most recent residential and financial eligibility forms (Income Statement Form, Parent's California State Income Tax Form, Federal Income Tax Form, Beneficiary's Medi-Cal application, Health Insurance form, and Enrollment Fee Agreement, W-2, or paystubs, Assessment Fee Agreement, if applicable);

        3) Documents establishing the beneficiary's residence and financial eligibility (e.g., utility bills, divorce agreements, guardianship, and/or adoption documents, if applicable);

        4) Other Health Coverage (OHC) information, if applicable, including copies of all Health Maintenance Organization (HMO) denials within the last 12 months;

        5) Copies of all medical reports for the previous 12 months, if applicable; and

            a) When the beneficiary in the Sending County is enrolled in a WCM Managed Care Plan (MCP), the Sending County must request the medical reports from the WCM MCP and provide the WCM MCP a 10-business day deadline using Attachment 4, or an equivalent process agreed upon between the Sending County and the WCM MCP. The Sending County should also request case management notes and utilization information from the WCM MCP as this information will not be available in CMS Net. The Sending County

should obtain the beneficiary's medical information even if the transfer is to the same WCM MCP in a Receiving County.

b) If there are no copies of the reports within the last 12 months because the Sending County does not save reports, the transfer case note should include the following:

   i. A written statement indicating that there are no physical copies of medical reports for the last 12-month period.

   ii. A case notes entry documenting review of medical records containing:

      1. Medically eligible condition(s).

      2. Services currently received by the beneficiary.

      3. Care coordination activities (actions taken by CCS to help children and families who have barriers to accessing care) and/or other significant issues (social services, foster care, etc.). If the Sending County is a WCM County, the Sending County must send any information provided by the WCM MCP in subsection i. above, including a completed copy of Attachment 4, to the Receiving County.

   iii. If the Receiving County requires access or copies of the beneficiary's electronic medical records, the Receiving County should request this from the beneficiary's providers. The Receiving County may request assistance from the Sending County to obtain these records.

   iv. If there are medical reports attached to Service Authorization Requests (SARs) that are effective at the time of transfer, the Sending County can mention these medical reports on Attachment 3 without sending those reports to the Receiving County.

   v. Beneficiary record transfers must be completed in accordance with state and federal health privacy laws and regulations.

   vi. The transfer of medical records should not delay or prevent a beneficiary's transfer to the Receiving County. ICT cases can be open to the MTU, but MTU treatment services are unable to begin until a current prescription or treatment plan is available.

vii. For beneficiaries who have received Medical Therapy Program (MTP) services, the Sending County must send the beneficiary's full Medical Therapy Unit (MTU) chart up to 21 years. Full MTU charts up to 21 years must be retained by Receiving Counties, even if the Receiving County does not have an MTU.

4. For beneficiaries found not to be CCS Program eligible, the Sending County must:

   a. Notify the Receiving County of the beneficiary's CCS ineligibility.

   b. Close the case without initiating any further steps in the ICT process.

   c. Inform the beneficiary/family of their appeal rights and that the family can initiate an appeal in any county (the appeal will be defended by the County that denied the eligibility determination). Aid paid pending or continuation of service can be requested by the beneficiary and/or family while awaiting a decision from a state hearing.[176]

   d. Inform the family that they can reapply to the CCS Program in the Receiving County and reapplication can be done simultaneous to appealing the ineligibility determination.

5. Refer to CCS N.L. 10-1123, or any superseding N.L. regarding inter-county case transfer policy in conjunction with the CMS Net Manual procedures on pending transfers. A summary of transfer procedures follows:

[176] Appendix B: 78, 79, 80

Transfer of a CCS Program Case to Another County, Transfer Letter, Procedures, and Timelines

Procedure	Source = Family	Source = Other
Original county receives notification of beneficiary/family change of county		
Original county sends the first transfer letter to the original address. Beneficiary or parent/legal guardian is given **15 business days** to notify the Receiving County	C-20	C-21
If the beneficiary/parent/legal guardian has not contacted the Receiving County, the Sending County must send a second transfer letter to the original address within **five (5) business days** after the due date of the first letter. Beneficiary or parent/legal guardian is given **15 business days** to notify the Receiving County.	C-20A	C-21A
If the beneficiary or parent/legal guardian has contacted the Receiving County, the Sending County sends the final NOA transfer letter to the original address within **five (5) business days** after the due date of the second letter. The effective closure date is the date stated in the second letter by which the beneficiary or parent/legal guardian had to confirm the address in the Receiving County. The NOA must include the Appeal Procedures in the information enclosure.	C-20B	C-21B

Section IV: C. Transfer of the CCS Program Case to Another County

C. Receiving County Procedures

1. If a family moves to a "Receiving County" without informing the "Sending County" that they have moved, the Receiving County staff will attempt to confirm whether the child is already known to the CCS Program via a search in CMS Net.

    a. If the beneficiary is determined not to have an open case in another county or has a closed case, the "Receiving County" will proceed as usual with determining the CCS Program eligibility.

2. If the beneficiary is determined to already have an open case in another County, the Receiving County must:[177]

    a. For Medi-Cal beneficiaries verify the address in the MEDS.

        1) If the address change does not display in MEDS after the beneficiary has transferred to the Receiving County, the Receiving County must work with the beneficiary/family to contact the county Medi-Cal eligibility office to ensure this change is made in MEDS.

        NOTE: For Medi-Cal beneficiaries receiving CCS Program services, the Receiving County must not delay the approval of the transfer because the beneficiary's address has not been updated in MEDS.

    b. For non-Medi-Cal beneficiaries, the Receiving County must verify the beneficiary's residential eligibility with proof of residence.[178] See Chapter 1 Section IV.B. for information on proof of residence.

    c. Notify the Sending County that a referral was received but it appears to be a request for service with a need to confirm the beneficiary's address.

    d. Request the Sending County initiate the confirmation of transfer letters following the procedures in Chapter 2 Section IV.B. above.

    e. Accept the Sending County's CCS medical and MTP eligibility determination(s) and begin the adjudication of new SARs based on the eligibility determination of the Sending County immediately upon

[177] CCS N.L. 10-1123, or any superseding NL
[178] Appendix B: 50, 51

transfer. The Receiving County must activate appropriate SARs and establish the beneficiary's case record on the Transfer Date to ensure that previously authorized services continue without interruption.

NOTE: DHCS will notify the Dependent County about a change in the beneficiary's address via case note and Web Message. Using the SAR Fax Cover Sheet, the Dependent County will notify DHCS of a change in the beneficiary's address only when the address is confirmed and upon receipt of current medical reports so that a continued medical eligibility review can be conducted.

Section IV: D. Transfer of the CCS Program Case to Another County

D. Responsibilities of transfer to another county, by county type

1. Sending County responsibilities by county type

   a. For **Classic and WCM CCS Program Independent** Counties, County CCS Program staff will review and complete ICT requests following Chapter 2. Section IV.A. and Section IV.B. and the Intercounty Transfer N.L. 10-1123 or any superseding N.L.

   b. For **Classic and WCM CCS Program Dependent** Counties, County CCS Program staff must submit ICT requests to DHCS CCS Program staff at CCSDirectedReview@dhcs.ca.gov, or secure RightFax number, (916) 440-5768. DHCS CCS Program staff are responsible for ICT case review and completion.

   c. For beneficiaries enrolled in the **Whole Child Model (WCM) MCP**:

      1) The Sending County must request the WCM MCP to complete the WCM Intercounty Transfer Form and packet (or the equivalent agreed upon between a county and its health plan) and forward these materials back to the Sending County within **seven (7) business days** of request so that the Sending County can review and complete the ICT request. For WCM Dependent Counties, the Sending County will forward the MCP's materials to DHCS as outlined in 1. b. above. Once reviewed and approved, by the County for Independent Counties and by DHCS for Dependent Counties, the Sending County will forward the MCP's materials to the Receiving County as part of the intercounty transfer packet. This process should not result in any gaps in coverage for a beneficiary.

      2) The Sending County must collaborate with the MCP on the Transfer Date negotiations with the Receiving County so the MCP can review any out-of-network requests during the ICT process and close any outstanding SARs/TARs in accordance with the Transfer Date.

         a. If the beneficiary moves to another County and is still enrolled in a MCP in the County which they moved from and needs non-emergency care that same month in the new county, the beneficiary or either county can request an expedited

disenrollment from their MCP to the Medi-Cal Managed Care Ombudsman at 888-452-8609.

NOTE: A request to the Medi-Cal Managed Care Ombudsman for immediate disenrollment from a MCP is only a temporary solution. If the beneficiary's new address change is not entered into MEDS by the County, the beneficiary's address will revert to their original address, and they will remain enrolled in the WCM MCP. As such, the Receiving County still needs to assist the beneficiary in changing their MEDS address through their Medi-Cal County office.

2. Receiving County Responsibilities by County Type

    a. **All CCS Counties**: After transfer the Receiving County should notify the family to contact the county Medi-Cal office to update the beneficiary's address in MEDS if the address has not been changed to reflect the current residence. If the child has Supplemental Security Income (SSI), the family needs to contact the SSI office in the child's Receiving County to update the address in MEDS.

    b. **Classic/WCM Independent Counties**: The Receiving and Sending County CCS Program staff will discuss and agree upon a Transfer date. The Receiving County will accept the Sending County's medical eligibility determination. All current SARs will be automatically canceled once the Sending County closes the case. The Receiving County will open the case and issue new SARs the following day after the case closure date to ensure that previously authorized services continue without interruption.

    c. **Classic/WCM Dependent Counties**: Receiving Dependent Counties will discuss and agree upon a Transfer date with the Sending County, regardless of whether the Sending County is an Independent or Dependent County, or a WCM or Classic CCS County. The Receiving County will accept the Sending County's medical eligibility determination. All current SARs will be automatically canceled once the Sending County closes the case. Receiving Dependent Counties are responsible for opening the case. The following day after the case closure date, the Receiving County will open the case, pend the new SARs, and notify DHCS of the SARs.

    d. **WCM County**: For WCM Counties, responsibilities differ depending on whether the child is enrolled in the MCP or Fee-for-Service (FFS CCS state-only):

1) For beneficiaries enrolled in the WCM MCP, the Receiving County will notify the MCP of the Transfer Date during their negotiations of a Transfer Date with the Sending County. This allows the MCP to review any necessary SARs on the Transfer Date, so the beneficiary does not experience any gaps in care.

2) For beneficiaries that are eligible for Medi-Cal benefits but not yet enrolled in the WCM MCP, the Receiving County will issue authorizations until the child is enrolled in the MCP or for up to **ninety (90) calendar days**, whichever occurs first. The following Special Instructions should be printed on the SAR:

   *If patient's eligibility shows enrollment in the **[Receiving County health plan name]** on date of service, submit claim with this SAR to the **[Receiving County health plan name]**.*

3. In circumstances where the Sending County, Receiving County, or the WCM MCP cannot agree on the transfer process, the counties or health plan should contact DHCS for assistance at CCSProgram@dhcs.ca.gov.

4. For additional information refer to CCS numbered letter (N.L.) 10-1123 or any superseding N.L.

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:[179]

    a. Beneficiary has reached 21 years of age.[180]

    b. Beneficiary has left the state (residence criteria are no longer met).[181]

    NOTE: For beneficiaries who moved out of the County or out of state due to educational purposes, please refer to CCS N.L. 10-1123, or any superseding N.L.

    c. Family is no longer financially eligible/has not completed program eligibility criteria.[182]

    d. Beneficiary's condition no longer meets the CCS Program medical eligibility criteria.[183]

    e. Beneficiary, parent/legal guardian, or legal representative does not wish to participate in the CCS Program (statutes, regulations, policies, and procedures)(also known as disenrollment).

    f. Treatment completed.

    g. Death of patient.

    NOTE: For a full list of closure reasons please refer to CMS Net Eligibility Client manual.

2. County medical consultant or designee, or DHCS medical consultant or designee (for Dependent Counties) must approve closure of cases when the reason for closure pertains to medical eligibility.

3. Cases are closed only when the case status has been "active" (the case has been assigned a CCS Program case number) and "opened" based on meeting specific eligibility criteria.

[179] Refer to CMS Net Eligibility Client Manual for a full list of closure reasons.
[180] Appendix B: 3
[181] Appendix B: 50, 51
[182] Appendix B: 52, 53, 54
[183] Appendix B: 32

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 the closure of a CCS Program case record must always be documented in CMS Net as a case note.[184]

6. Do not delete any medical records from a closed case.

7. Closure of a case requires a NOA to be sent to the beneficiary. Refer to Chapter 3. Section I. and CCS N.L. 04-0424, or any superseding N.L.

[184] Appendix B: 30

Section V: B. Case Closure

B. CMS Net Procedures for Case Closure[185]

1. Request for closure of the CCS Program case record can be made by County or DHCS staff.

   NOTE: If the Dependent County identifies the need for the case closure, they must notify DHCS via secure email to CCSDirectedReview@dhcs.ca.gov that closure is recommended.

   REMINDER: The County or DHCS is responsible for case closure determination related to a medical eligibility denial.

2. The County CCS Program staff responsible for closure of a case must:

   a. Document the reason for the closure and any follow-up attempts to contact the family and any other relevant issues in CMS Net case notes.[186]

   b. Check possible referrals to other programs, including the Genetically Handicapped Persons Program (GHPP), enter in CMS Net case notes, and notify the County and any other relevant stakeholders regarding any required action.

   c. In Eligibility - Client, enter the Closure Date and select the Reason Closed from the dropdown list.

   d. CMS Net automatically cancels all authorized medical SARs and deletes pending SARS. Refer to the CMS Net SAR module procedures.

   e. Authorizations must be canceled for a closed CCS Program case. The provider must be notified via a Cancel Authorization stating the reason as follows:[187]

      1) Beneficiary has died.

      2) Beneficiary no longer has a CCS eligible medical condition.

      3) Beneficiary has established residential eligibility in another County.[188]

      4) Beneficiary has established residency in another state.

[185] Refer to CMS Net Eligibility Client Manual; CCS N.L. 04-0424; CCS N.L. 04-0400; CCS N.L. 18-0594
[186] Appendix B: 32
[187] CCS N.L. 04-0424; Refer to CMS Net SAR Cancellation Procedures
[188] Appendix B: 3; CCS N.L. 10-1123, or any superseding NL

3. Additional case closure procedures for Medi-Cal full scope no SOC or OTLICP 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 CCS Program specialist or special care center.

        2) Beneficiary is no longer a Medi-Cal beneficiary with full scope no SOC or OTLICP beneficiary; or beneficiary is an infant previously covered under mother's Medi-Cal eligibility and now not covered under their own Medi-Cal eligibility and there is no signed CCS Program application or PSA on file.[189]

        3) Family requests case closure (also known as disenrollment). Clearly notate in CMS Net case notes who requested the closure and the reason for the case closure.

        4) Moved to another County/state.[190]

        5) Death of beneficiary.

    b. When a case is closed, CMS Net cancels all authorized medical SARs and deletes pending SARs. See the CMS Net Authorization Manual for SAR and PEDI correspondence procedures.

[189] Appendix B: 11, 54; CCS N.L. 26-0905
[190] Appendix B: 50

CHAPTER THREE: GENERAL INFORMATION

Section I: A. NOAS and First Level Appeals

A. General Information[191]

1. A NOA is required when the CCS Program eligibility or services are modified, terminated, reduced or denied. Follow CCS N.L. 04-0424, or any superseding N.L.[192]

    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 beneficiary's due process.)[193]

        1) All such differences are to be resolved through an informal process, which includes provider provision of additional information or clarification of documented medical necessity.

        2) Review of a request for reconsideration of the denial must be reviewed by either the County or DHCS medical consultant or designee.

2. For **Classic/Whole Child Model (WCM) Independent Counties**: the appropriate CCS Program Independent County staff responsible for medical or administrative case management decision-making must determine the NOA type and effective date.

3. For **Classic/WCM Dependent Counties**: DHCS staff will determine denial or discontinuation of medical eligibility or certain program eligibility issues requiring medical consultant review. In Classic Dependent Counties DHCS staff will determine denial or discontinuation of medical services. DHCS will determine the type of NOA and the effective date and send a web message via CMS Net to the Dependent County.

    a. Dependent County staff must determine financial or residential program ineligibility. Dependent County's over-income/out-of-pocket financial analysis must be reviewed and approved by the DHCS medical consultant prior to NOA being generated and sent.

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[191] Appendix B: 78, 79, 80, 81; CCS N.L. 04-0424
[192] CCS N.L. 04-0424
[193] Welfare & Institutions Code 14133.05

4. Overview of the CCS Program Appeals and State Hearing Process[194]

    a. Notice of Action: All NOAs for denial of services or eligibility are automatically generated in CMS Net when an adjudicator determines that the requested services are not a covered CCS benefit or does not qualify for eligibility. First Level Appeal decision NOAs are sent by the County CCS Program that determined the eligibility or service denial.

    b. **First Level Appeal**: The Claimant (a CCS applicant, beneficiary, parent/legal guardian, or authorized representative) has the right to appeal decisions in response to a NOA.[195] The requirements and timelines associated with a First Level Appeal for CCS state-only claimants and claimants with Medi-Cal in CCS Classic Counties are detailed in Chapter 3. Section I. C.

    c. **State Hearing**: If a Claimant submitted a First Level Appeal and does not agree with the decision or their request has been denied, they can request a State Hearing.[196] A Claimant is not required to request and exhaust the First Level Appeal process before requesting a State Hearing. State Hearings are venues to resolve disputes between Claimants and the County CCS Program regarding services and eligibility in an impartial, independent, fair, and timely manner, in accordance with federal and state law. See Chapter 3. Section I. C. for details.

    d. For claimants in WCM Counties, the Managed Care Plan (MCP) will follow the guidance outlined in All Plan Letter (APL) 21-011, or any superseding version.

[194] CCS N.L. 04-0424
[195] Appendix B: 80, 81
[196] Appendix B: 82, 83, 84

Section I: B. NOAS and First Level Appeals

B. Denials and NOA Procedures

1. Denials[197]

   a. Any applicant or CCS Program beneficiary has the right to appeal the medical denial decision except when the service has been terminated by a CCS authorized physician with responsibility for the medical supervision of the beneficiary's CCS medically eligible condition.

      1) Per the CCS Program regulations, a Notice of Action (NOA) is not issued when the medical service has been terminated by the beneficiary's CCS authorized physician. When this is the case, choose the "Treatment Complete" closure reason in CMS Net to issue the correct correspondence.

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

   b. A SAR NOA (Service Authorization Request Notice of Action) is a notice of a denial of services and/or eligibility and is generated by the CMS Net Correspondence function and includes the rights to a First Level Appeal and/or a State Hearing.

      1) Free text space is available on the NOA to write a thorough explanation which should be written in non-clinical language. Refer to CCS N.L. 04-0424 or any superseding N.L.

      2) For procedures related to denying SARs, refer to Chapter 2. III.B. and CMS Net Authorization Manual.

      3) The right to appeal information is automatically included when a SAR NOA is generated and must be mailed with the NOA to the applicant/beneficiary.

      4) PEDI providers will access the CCS Program denials via the PEDI system.

   c. For the Medi-Cal beneficiary with full scope no SOC whose requested service will not be authorized by CCS as it does not treat the CCS eligible condition or an associated/complicating condition, a NOA is to be sent

[197] Appendix B: 78, 79; CCS N.L. 04-0424

with a notation to: "Please request services through Medi-Cal or [the name of the Managed Care Health Plan]."

d. **Whole Child Model Counties:** WCM Medi-Cal Managed Care Plan (MCP) is responsible for reviewing and authorizing services. Service requests sent to the County instead of the MCP must be denied and routed to the MCP. The NOA must include appeal rights even when services are sent to alternative payors. Counties must:

   1) Enter the SAR into CMS Net

   2) Deny the SAR and select "Please request services through the [name of the Managed Care Health Plan]" from the drop-down. Refer to Chapter 2. III.B. for procedures related to denying SARs.

   3) Send the NOA to the applicant/beneficiary.

   4) PEDI providers will access the CCS Program denials via the PEDI system.

   5) Enter in a case note that the SAR was denied, the provider was instructed to send the request to the MCP and the NOA was mailed.

2. Notice of Action (NOA) Procedures[198]

   a. A NOA must be issued when:

      1) There is a denial, modification, or reduction of a service requested and/or a previously approved SAR.

         NOTE: A NOA related to a service request is not required if the reduction, termination, or modification is ordered by the CCS paneled physician providing medical supervision of the claimant.[199]

      2) Eligibility for the CCS Program is denied or discontinued.

      3) The amount the family must pay the program for treatment services is increased. However, if the family agrees with the new amount and signs a dated statement, which can be prepared by either the family or the agency, agreeing to the new amount, the family's copy of the statement constitutes written Notice of Action. No form is required.

[198] Appendix B: 78, 79, 80; CCS N.L. 04-0424
[199] See CCS N.L. 04-0424 for additional exceptions.

b. A NOA is generated through CMS Net by the appropriate County CCS Program staff. To prepare the letter the appropriate County or DHCS staff member must:

    1) Select the appropriate explanation/citation from the 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 written in non-technical language, at a sixth-grade level.

        a) Effective date of the NOA (required by regulation)

        b) Specific regulation or statute citation

        c) Service(s) requested (if appropriate)

        d) Additional information, as needed (Letter Text allows up to 9 lines of Free Text.).

c. For **NOAs related to a SAR** (SAR NOA): If a SAR is denied a SAR NOA must be sent.

    1) In the CMS Net Authorization Module of the CCS beneficiary update the Service Request Action drop-down field to DENIED.

    2) Complete the Denied By, Effective Date, and Reason for Denial fields.

    3) Search for the special instructions for a matching description and add additional information and explanation, if necessary, in the free text box. Ensure language is clear and specific with citations.

    4) Once saved, the information entered will appear in the SAR NOA in the Correspondence module. Print out and mail the NOA.

d. NOAs must be sent to the applicant/beneficiary or parent/legal guardian with the enclosure, Appeal Process Information, which provides an explanation of the appeals procedure and is required per Cal. Code Regs., Title 22, Section 42131.

e. Providers will receive notification of the NOA through PEDI.

3. Refer to the CCS Right to Appeal Decisions of the CCS Program CCS N.L. 04-0424, or any superseding N.L., for additional guidance.

Section I: C. NOAS and First Level Appeals

C. Receipt of First Level Appeals and State Hearing[200]

1. The claimant has **30 calendar days** from the NOA date to file an appeal. The first level appeal must be postmarked within 30 calendar days from the date of the NOA;[201] however, if the appeal is late the County should apply reasonableness in approving "good cause" for the late appeal.

2. The appeal must describe the denial, deferral, or modification reason, include supporting regulations and/or citations, and request relief or outcome, including any request for continuation of CCS services during the appeals process (known as Aid Paid Pending). The County CCS Program or DHCS must assist the Claimant when they request assistance with appealing the decision.

    a. **Aid Paid Pending (APP)**: A Claimant has the right to continue receiving previously approved service(s) while awaiting a final determination from a First Level Appeal and/or State Hearing.[202] Claimants must request APP for it to be provided**.** See CCS Program Appeals and State Hearings Process CCS N.L. 04-0424 or any superseding N.L. for additional information.

3. **First Level Appeal Response**:

    a. Classic/WCM Independent Counties: Once the appeal is received, the County has **21 calendar days** to respond with a First Level Appeal Response NOA. If additional information is required to make a decision, the County must provide a written response within **21 calendar days** of receipt of the additional information. If the Claimant does not agree with the County CCS Program's resolution of their appeal, they have the right to request a State Hearing.[203] That said, the Claimant can request a State hearing at any time after receiving the Notice of Action, including but not limited to, during the time the appeal process is going forward.

    b. Classic/WCM Dependent Counties: All first level appeals for Dependent Counties are decided by DHCS within **21 calendar days** of receiving the Claimant's appeal. If DHCS needs additional information to make a decision, DHCS must provide a written response within **21 calendar days** of receipt of the additional information. If the Claimant does not agree with DHCS' resolution of their appeal, they have the right to request a State Hearing.[204] That said, the Claimant can request a state hearing at any time

[200] Appendix B: 82-97
[201] Cal. Code Regs., Title 22, Section 42160
[202] Cal. Code Regs., Title 22, Section 42160
[203] Cal. Code Regs., Title 22, Section 42160 and Cal. Code Regs., Title 22, Section 42180
[204] Cal. Code Regs., Title 22, Section 42160 and Cal. Code Regs., Title 22, Section 42180

after receiving the Notice of Action, including but not limited to, during the time the appeal process is going forward.

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 emailed to the appropriate DHCS medical consultant within **one (1) business day** from the date of receipt at ISCDHAU@dhcs.ca.gov. The County must document the actions taken in CMS Net case notes.

2) DHCS designee reviews and responds to all appeals.

4. **State Hearing:** If a Claimant submitted a First Level Appeal and does not agree with the decision or their request has been denied, they can request a State Hearing.[205] State Hearings are venues to resolve disputes between Claimants and the CCS Program regarding services and eligibility in an impartial, independent, fair, and timely manner, in accordance with federal and state law. Per the 1135 Waiver, the claimant can request a State Hearing within **120 calendar days** of receiving the NOA. After June 30, 2025, the claimant must file their request within **90 calendar days** of receiving the NOA.

   a. Independent Counties: Develop, jointly with DHCS, a plan of action and strategize for the hearing as well as respond to any DHCS coordination on cases. Represent their County CCS Program at the State Hearing. Finally, they will create and send a statement of position to the claimant outlining the position of the County CCS Program and why the action/decision was made.

   b. Dependent Counties: DHCS will provide representation for the County CCS Program at the state hearing.

5. The County CCS Program 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.)

6. DHCS and Independent County CCS Programs must have a tracking system for all first level appeals and state hearings that includes data elements: CCS/State Hearing number, Method of Appeal, Demographic Data (DOB, gender, Ethnicity, Primary language spoken, resident county, zip code), reason for

[205] Cal. Code Regs., Title 22, Section 42180

appeal/state hearing, appeal or State Hearing result, date appeal/State Hearing filed, and date appeal/State Hearing closed.[206]

[206] Appendix B: 80

Section II: A. Communication: Case Management Issues

A. County Communication with DHCS

Purpose	Inbox	Response Time
» Dependent County SAR submission and questions that require Expedited RN review: » Bleeding Disorders: Blood Factor and Hemlibra » Cystic Fibrosis: Kalydeco, Orkambi, Symdeko » Duchenne Muscular Dystrophy: Eteplirsen, Golodirsen, Deflazacort » Growth Disorders: Lupron, Histrelin, Triptorelin » High-Risk Infants: Synagis » Hospital Discharge Needs » Metabolic Diseases: Kuvan, Palynziq, medical foods, enteral nutrition products » Retinal Disease: Luxturna » Seizure Management: Epidiolex » Spasticity Management: Botulinum Toxin » Spinal Muscular Atrophy: Spinraza, Zolgensma » Upcoming Surgery, including Selective Dorsal Rhizotomy » Anything labeled "Urgent" or "Expedite"	CCSExpeditedReview@dhcs.ca.gov RightFax: (916) 440-5306 Include the SAR Cover Sheet	1 business day

Purpose	Inbox	Response Time
» Dependent County SAR submission and questions that require immediate MD review: » Transplants, including CAR-T: Yescarta, Kymriah » Cochlear implant surgery » Out of State	CCSPhysicianReview@dhcs.ca.gov RightFax: (916) 440-5308 Include the SAR Cover Sheet	2-3 business days
» SAR related questions that require Expedited MD review: » Genetic Testing: Whole Exome / Whole Genome » Off-label or Investigational Service » Previous Decision Reconsideration » Request for ISCD Physician Review » Selective Dorsal Rhizotomy » CCS Program eligibility requirements » Independent County questions about SAR processing » Audiology » Specialty Drugs » Brineura » Deflazacort » Eteplirsen » Golodirsen » Luxturna » Trikafta » Zolgensma	ISCD-MedicalPolicy@dhcs.ca.gov	2-3 business days

Purpose	Inbox	Response Time
» Dependent County SAR types and tasks that require ISCD action » Annual Medical Review (AMR) » Additional diagnosis needs to be added to a case » Request for case closure or denial » Diabetes supplies, pumps, and monitoring devices » Durable medical equipment (DME) » Genetic Testing: Routine, Whole Exome, Whole Genome » Inter-County Transfer » Medical Eligibility Determination » Whole Child Model Counties » Medical Therapy Program (MTP) » Neonatal intensive care unit (NICU) » Off-label or Investigational Service » Previous Decision Reconsideration » Request for ISCD Physician Review » SARs submitted more than 45 days ago	CCSDirectedReview@dhcs.ca.gov RightFax: (916) 440-5768 Include the SAR Cover Sheet	2-3 business days
» CCS Administrative Questions » CCS Policy inquiries (e.g., CCS Numbered letter, etc.)	CCSProgram@dhcs.ca.gov	2-3 business days

Purpose	Inbox	Response Time
CCS Appeals and Grievances Questions	CCSGrievances@dhcs.ca.gov	2-3 business days
CCS Hearing and Appeals Questions	ISCDHAU@dhcs.ca.gov	2-3 business days
Provider Enrollment Questions	ProviderPaneling@dhcs.ca.gov	2-3 business days
WCM MCP Questions	DHCSMCQMDWCM@dhcs.ca.gov	2-3 business days
Potential Data Breach or Unauthorized Access of Health Information	CCSProgram@dhcs.ca.gov	1-2 business days

NOTE: When sending case information **always send a secure email** with the beneficiary's name, the CCS case number, and a brief summary of the issue in the body of the email.

Section II: B. Communication: Case Management Issues

B. Situations requiring notification from DHCS to Dependent County

The situations described below are examples of DHCS case management activities that are documented in CMS Net case notes. DHCS is to notify the County CCS Program staff via web message upon the occurrence of any of these situations:

1. New referral/request for service received by DHCS that was not received at the County.
2. Authorizations issued or directions for the County to generate authorizations for the beneficiary/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. Communication: Case Management Issues

C. Communication through the Provider Electronic Data Interchange (PEDI)

1. The CMS Net application PEDI is a web-based tool that enables approved CCS Program providers and MCPs 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 authorization requests (SARs), denial letters, NOAs, and generate standard reports.

2. The CCS Program responsibilities

    a. The County CCS Program, DHCS, and the CMS Net team must work together to support CMS Net PEDI functionality.

        1) The DHCS CCS Program will be responsible for the following:

            a) Work cooperatively with the County CCS 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 County CCS Program offices will be responsible for the following:

            a) Work cooperatively with DHCS with respect to entering requests for services.

            b) Reviewing and pending eSARs in a timely matter.

            c) Enter requests for services into CMS Net ensuring that authorizations, denials, and cancellations are completed in a timely manner.

        3) The CMS Network Section will be responsible for the following:

            a) Reviewing and processing applications from providers/plans/facilities for access to PEDI.

            b) Daily maintenance of the CMS Net PEDI application.

Section III: A. CMS Net Report Generation

A. Requesting Reports from CMS Net

1. There are standard reports available in CMS Net as well as the Microsoft Business Intelligence (MSBI) which contains data related to patient demographics, registration, authorizations, case notes, medical and financial/residential eligibility, Medi-Cal status, correspondence, application status, vendors, etc.

2. County staff with MSBI access are able to run reports. County staff can request MSBI access through CA-MMIS Service Now.

3. Counties may request ad hoc report assistance by submitting an "All Report Request" in Service Now. Requests are submitted to the CMS Net Help Desk team through CMS Net ServiceNow.

    a. Do not send CMS Net-generated documents or data to DHCS 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 Portability and Accountability Act (HIPAA) for rules and guidelines regarding the transmission of PHI.

        2) For questions regarding PHI, contact your county's HIPAA or Privacy Officer.

    4. If a CCS beneficiary or family requests their medical records provide them with DHCS HIPAA form 6236.

        a. Upon receipt of the completed DHCS 6236, the CCS health care information may only be shared with the beneficiary, authorized representatives, or other agencies providing services as outlined by Civil Code, Section 1798.

    5. Immediately report any potential data breaches or unauthorized access to health information to CCSProgram@dhcs.ca.gov.

CHAPTER FOUR: APPENDICES

Appendix A

The California Children's Services (CCS) Program Statutes

To view the text of program statutes - search Health and Safety Code, Section and Welfare and Institutions Code

Enter the code number.

Health and Safety Code Sections 123800-123995

Code	The CCS Program Statutes Title
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 the fiscal intermediary; centralized billing system
123825	Intent
123830	Handicapped child
123835	Keeping the 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
123853	Contracts with manufacturers
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 the teaching program

Health and Safety Code Sections 123800-123995 continued

Code	The CCS Program Statutes Title
123885	Panel members; qualifications
123890	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
123929	Prior authorization
123930	Consent of parent or guardian; exception
123935	Effect of intellectual disability
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	Newborn screening for hearing loss; 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 the department
123995	Medi-Cal application requirements

Welfare and Institutions Code 14094-14094.20

Code	The CCS Program Statutes Title
14094	The CCS Program
14094.1	Paneled provider standards; reporting; rates
14094.2	Oversight
14094.3	Implementation timeline; pilot project stipulations
14094.4	Whole Child Model program definitions
14094.5	County implementation
14094.6	Goals of Whole Child Model program
14094.65	Neonatology
14094.7	Department requirements
14094.9	Memorandum of understanding template; written notice of allocation
14094.10	Medi-Cal managed care plan assessment process

Welfare and Institutions Code 14094-14094.20 continued

Code	The CCS Program Statutes Title
14094.11	Medi-Cal managed care plan requirements
14094.12	Medi-Cal managed care plan responsibilities
14094.13	Continuity of care
14094.14	Requesting primary care provider
14094.15	Medi-Cal managed care plan requirements
14094.16	Pay rates
14094.17	Advisory groups
14094.18	Evaluation of the Whole Child Model program
14094.19	CCS Program
14094.20	Implementation and interpretation of the article; contracts

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 (HSC) Reference Sections

Chapter 1. Definitions

#	California Code of Regulations Section	Health and Safety Code
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 (Beneficiary)	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,
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

#	California Code of Regulations Section	Health and Safety Code
	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

Chapter 3. Client Application & Eligibility Requirements

#	California Code of Regulations Section	Health and Safety Code
	Article 1. General Provision	
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	123850, 123875, 123950, GOV 757
40	41517.7 Disease of the Eye	123830, 123835
41	41518 Diseases of the Ear and Mastoid	123830, 123835
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

#	California Code of Regulations Section	Health and Safety Code
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

#	California Code of Regulations Section	Health and Safety Code
	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

Chapter 9. Professional Medical Care Providers

#	California Code of Regulations Section	Health and Safety Code
	Article 1. General Provisions	
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

#	California Code of Regulations Section	Health and Safety Code
	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
	Article 1. General Provisions continued	
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 Beneficiaries or Applicants

#	California Code of Regulations Section	Health and Safety Code
	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

#	California Code of Regulations Section	Health and Safety Code
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

Additional Resources

CCS Approved Hospitals and CCS Paneled Providers	
"**CCS Approved Hospitals**" have been determined by the CCS Program to meet the requirements in order to render services to a CCS applicant or beneficiary. "**CCS Paneled Providers**" have been determined by DHCS to meet the advanced education, training, and/or experience requirements for their provider type in order to render services to a CCS applicant or beneficiary.	CCS Provider and Hospital Lists
CCS Children's Medical Services (CMS) Web Portal	
CMS Net is a DHCS secure case management system that serves primarily CCS and GHPP. CMS Net provides online access to health care professionals, case managers, and administrators to manage a variety of information for case management.	CMS Net Portal
CCS Forms List	
Various CCS forms for beneficiaries, providers, and county users	DHCS CCS Forms Web Page
CCS Policy Documents	
Information Notices: Notices regarding policy guidance for the administration of the CCS Program.	CCS Information Notices
Numbered Letters: Policy guidance for the administration of the CCS Program.	CCS Numbered Letters
Provider Standards: General requirements and standards of care for hospitals, Special Care Centers (SCC), and CCS paneled providers.	Provider Standards
CCS Statutes	
Health & Safety (H&S) Code legislative statutes related to the administration of the CCS Program.	Sections 123800-123995

Cal. Code Regs., Title 22, Subdivision 7, CCS, Sections 41401-42700	California Code of Regulations (CCR)
CCS Training Website	
The CCS Program training website is designed to provide guidance and training to County CCS Programs and the Integrated Systems of Care Division (ISCD) DHCS staff. This is the primary source for current and future trainings offered by DHCS.	CCS Training
Covered California	
Covered California was created to assist citizens and legal residents with applying for marketplace coverage, in order to comply with the Affordable Care Act ("ACA"), by offering subsidized Obamacare plans for California.	Covered California Information
EPSDT (also known as Medi-Cal for Kids & Teens)	
Resources for members and providers. Medi-Cal for Kids & Teens provides free services, including check-ups, shots, and health screenings, to keep kids healthy from birth to age 21.	Medi-Cal for Kids & Teens Information
Resources for DHCS Stakeholders. Early and Periodic Screening, Diagnostic, & Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs.	DHCS EPSDT Information
Genetically Handicapped Persons Program (GHPP)	
The Genetically Handicapped Persons Program (GHPP) is a healthcare program for adults with specific genetic diseases. Webpage has the application, submission, and contact information	DHCS GHPP Page

Medi-Cal	
Instructions on how to apply for Med-Cal by mail, in person, or online and a frequently asked questions resource.	Ways to Apply for Medi-Cal
The Medi-Cal Providers website provides access to Medi-Cal billing support services and to perform secure Medi-Cal Fee-for-Service and other associated health care program claims and transactions.	Medi-Cal Providers Website
Medi-Cal Rx	
The Medi-Cal Rx provider portal offers publicly available content with Medi-Cal Rx resources and information for providers to be able to successfully conduct pharmacy business.	Medi-Cal Rx Provider Portal
For question regarding Pharmacy billing please contact the Medi-Cal Rx Customer Service Center for assistance.	RxCarveOut@dhcs.ca.gov.
MTP Information	
The CCS MTP provides medically necessary physical and occupational therapy services as well as medical therapy conference services to children and young adults under age 21 with CCS MTP-eligible conditions.	MTP DHCS Web Page
Plan and Fiscal Guidelines	
For a copy of the Plan and Fiscal Guidelines send a request to the CCS Program inbox.	CCSProgram@dhcs.ca.gov
Provider Enrollment Webpage	
Resources and contact information on how to become a CCS paneled provider.	DHCS Becoming a CCS Provider
Question Regarding CMS Net	
For issues or requests for CMS Net use the Service Now platform.	Service now

SAR Tools Page	
Lists of various service codes, restricted drugs, and medical supply tools.	DHCS Service Authorization Request Tools
Special Care Centers (SCC)	
Special Care Centers (SCC) provide comprehensive, coordinated health care to beneficiaries with specific medical conditions.	SCC Look-Up
SCC Standards are listed with Provider Standards.	SCC Standards
Whole Child Model (WCM)	
Legislative statutes related to the transition and administration of the WCM.	Welfare and Institution Code (WIC), Section 14094.5 - 14094.20
DHCS homepage listing current CCS WCM policy and transition documents and resources.	Whole Child Model DHCS Home Page
All Plan Letters (APLs) are how DHCS conveys information to the Medi-Cal Managed Care Plans.	Managed Care All Plan Letters

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 County CCS Program's responsibility to check for updates and current guidance on the DHCS CCS website. Report any errors or omissions to CCSProgram@dhcs.ca.gov.

Appendix D

CCS Case Management Core Activities

Case Finding

- In the event the beneficiary/member does not qualify, or a specific service is not medically necessary or related to the CCS eligible condition, consult with the family and the Medi-Cal Managed Care Plan (MCP) about other resources available to them to meet their needs.

Support for Family Navigation

- Support beneficiary/member participation in the community by providing information on community-based activities, such as resources for exercise and socialization for children with physical disabilities;
- Educate, explain, and link families to resources to help them obtain services their children need including but not limited to CCS, Medi-Cal, County mental health, Regional Centers, public health nursing and/or schools, Enhanced Care Management (ECM), Community Supports, CalFresh and Women, Infants & Children (WIC) Program;
- When the CCS Provider elects to contract with an MCP as an ECM Provider, provide a broader set of ECM services to Medi-Cal beneficiaries/members that qualify for ECM as described in their contract with the MCP and DHCS' ECM Policy Guide;
- Educate families about the CCS regional system of care, including special care centers and community resources (i.e., peer and family support organizations);
- Reach out to families who are having difficulty maintaining their Medi-Cal enrollment and troubleshoot challenges in maintaining Medi-Cal;
- Provide consultation and support to the beneficiary's/member's educational team in the school setting when requested by patients and/or their families eligibility, and
- Educate families on available transportation resources and provide maintenance and transportation services when they are needed.

Assessments, Interventions, and Coordination of Care

- Link beneficiaries/members to appropriate CCS-paneled physicians, CCS Special Care Centers (SCC), and CCS-approved hospitals, according to program guidelines and standards;[207, 208]
- Review the care plan established by CCS-authorized specialists and SCC; assist the beneficiary/member and family in identifying and utilizing the most appropriate resources to accomplish the recommended care plan while assessing the understanding of and responsiveness to overall care plan. Ensure coordination of the beneficiary's/member's care plan between SCC, community physicians, and the Medical Therapy Program (MTP);
- Maintain list of utilization of services across the healthcare system to limit duplication and ensure access to the most appropriate services;
- Assess eligibility for and coordinate referrals to additional MCP-administered services and benefits, including but not limited to Complex Care Management, ECM, and Community Supports.
- Determine and coordinate referrals to appropriate social support services to meet the needs of beneficiaries/members including services that address social determinants of health needs such as CalFresh and Women, Infants & Children (WIC) Program;
- Link and/or refer beneficiaries/members to appropriate pharmacies and/or providers for their medication needs; appropriate medical home; and programs that coordinate appropriate dental care as determined by the patient's needs and preferences;
- Coordinate appointments with Durable Medical Equipment (DME) vendors and collaborate to identify DME that is appropriate;
- Provide professional support to ensure that families remain engaged;
- Arrange Private Duty Nursing (PDN) services for the CCS eligible condition, as medically necessary, and engage in agency nursing resource finding as needed per N.L. 04-0520 or any superseded guidance;

[207] California Children's Services Provider List
[208] California Children's Services Provider Standards

- Conduct multidisciplinary case management team conferences, including CCS professional staff, community providers and families as needed to address complex needs and challenges to care coordination, and
- Facilitate referrals for behavioral health services and pediatric palliative care (PPC) services, in accordance with State guidance.

Management of Transitions

- Assist beneficiaries/members families, hospital discharge planners, MCP Transitional Care Services care managers, and community partners to ensure safe and successful transitions from the hospital to the home and/or community, when applicable;
- Partner with families to accomplish a smooth transition from the pediatric to the adult healthcare system, and
- Provide transition assessment and intervention at appropriate age for beneficiary/member and, for selected beneficiaries/members, conduct internal analyses of patients' transition needs and develop a transition plan.

CHAPTER FIVE: GLOSSARY

Active Case

An active case is when a beneficiary is opened to the CCS Program and is receiving case management, diagnostic, and/or treatment 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 verify a beneficiary is still medically eligible for the CCS Program. An AMR includes a review of the beneficiary's residential, financial, and medical eligibility. The AMR process should begin 60 days prior to the program eligibility end date. See Chapter 2. Section I.C.

Authorization

A pre-approval for the CCS Program medically eligible and medically necessary diagnostic or treatment services. See Chapter 2. Section III.

Beneficiary

A person who has an active CCS Program case. Interchangeable with client or member.

Business Day(s)

Monday through Friday within standard business hours. Business days exclude weekends and state holidays. List of California state holidays.

CCS Program Case Number

The CCS Program case number is a unique identification number assigned to a CCS/MTP-only beneficiary when the record is opened to the CCS Program as active, based on meeting specific program eligibility requirements.

CCS State-Only Beneficiary

The CCS Program beneficiary who is not financially eligible for Medi-Cal but is financially, medically, and residentially eligible for the CCS Program is referred to as a "CCS state-only" beneficiary.

Caregiver

A family member or paid helper who provides direct care for a child or a sick, elderly, or disabled person. Family Code Sections 6550 and 6552 state that a non-parent adult caregiver relative with whom a minor is living can authorize medical and dental care for the minor by signing a "Care Giver Authorization Affidavit." The parent/legal guardian, or legal representative must sign the CCS Program Application and Program Services Agreement.

Case Management

The California Children's Services (CCS) case management is a beneficiary- and family-centered care approach to ensure needed clinical and non-clinical services for the CCS eligible condition, are made available to each CCS beneficiary through comprehensive, interdisciplinary, and person-centered care management and care coordination to provide case finding, authorizations for services and care coordination to ensure that CCS children and young adults have access to CCS paneled providers, equipment, and services necessary for treatment of the CCS eligible condition.

CCS Paneled Provider

A provider who has been approved to meet the advanced education, training, and/or experience requirements for their provider type in order to render services to a CCS applicant or client. For more information see the provider paneling page.

Children's Medical Services Network (CMS Net)

CMS Net is a web-based case management system used by the CCS Programs and the GHPP statewide. CMS Net has replaced the previous version known as CMS Legacy. CMS Net is used to implement case management activities, such as program referrals, eligibility determinations, authorization issuance, narratives, and Notices of Actions.

Claimant

Applicant, beneficiary, authorized representative, or legal guardian that is in the CCS appeals process.

Classic California Children's Services (CCS)

- Independent Counties: In Classic CCS Independent Counties, the authorization for CCS state-only, Fee-for-Services, and non-Whole Child Model Managed Care treatment for the CCS eligible condition, including case management, is provided directly through the County CCS Program office.

- Dependent Counties: In Classic CCS Dependent Counties, the authorization for CCS state-only, Fee-for-Services, and non-Whole Child Model Managed Care treatment for the CCS eligible condition, including case management, is provided in partnership with DHCS and the County CCS Program office.

Client

A person who has an active CCS Program case. Interchangeable with member and beneficiary, as used throughout this manual.

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, Optional Targeted Low Income Children's Program (OTLICP), the CCS Program, and the GHPP. Using the CIN, you can accurately identify a single patient/client record in MEDS.

Copayments

Copayments are per visit charges that the provider is required to collect from the insured patient as part of the private insurance reimbursement. The CCS family is required to pay these charges.

Dependent County

Any reference to a Dependent County with no specification includes both Classic CCS Dependent Counties and Whole Child Model Dependent Counties. Counties with a total population under 200,000 persons may administer the County CCS Program independently or jointly with the department.

Early Periodic Screening and Diagnostic and Treatment (EPSDT)

EPSDT, also known as Medi-Cal for Kids & Teens, is a Medi-Cal benefit that provides a comprehensive array of preventive, diagnostic, and treatment services for individuals under 21 years of age who have full scope Medi-Cal eligibility. See the Medi-Cal for Kids & Teens site for additional information.

Effective Date

The date determined by appropriate procedure or staff to begin, terminate, or deny services.

Electronic Service Authorization Request (eSAR)

An Electronic Service Authorization Request or "eSAR" is a SAR submitted electronically through the Provider Electronic Data Interchange system (PEDI). eSARs are a request for prior authorization from CCS to provide a procedure or service to a client.

Federal Poverty Level (FPL)

The FPL is a specified amount of income that families need to provide for basic needs. The Department of Health Care Services (DHCS) establishes this amount annually based on 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.

Fiscal Year

The state Fiscal Year is July 1 through June 30; the federal Fiscal Year is October 1 through September 30.

Genetically Handicapped Persons Program (GHPP)

Program for persons over age 21 with specific eligible genetic medical conditions, such as, but not limited to: hemophilia, cystic fibrosis, or other eligible conditions. See the GHPP webpage for additional information.

Good Faith Effort

A determination that a county has taken all reasonable action necessary to meet compliance standards and exhausted all methods to complete an action.

Independent County

Any reference to an Independent County with no specification includes both Classic CCS Independent Counties and Whole Child Model Independent Counties. Counties with a total population in excess of 200,000 persons will administer the County CCS Program independently.

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.

Legal Guardian/Legal Representative

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 their own behalf. This may be a guardian, conservator, or other legally designated individual.

May

For the purpose of utilizing this Manual, the term “may” is permissive for administrative decisions. See definitions for “should”.

Medi-Cal Eligibility Data System (MEDS)

The Medi-Cal Eligibility Data System (MEDS) is a data system maintained by DHCS that contains information on Medi-Cal eligibility. MEDS maintains eligibility history for Medi-Cal and other health and human services programs. It has data exchanges and interfaces with the Statewide Automated Welfare System (SAWS), the federal Social Security Administration, Medicare intermediaries, and the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). The system is used for a variety of eligibility, enrollment, and reporting functions specific to Californians receiving Medi-Cal benefits.

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 Managed Care Plans

Medi-Cal Managed Care Plans contracts with the Department of Health Care Services (DHCS) to provide high-quality, accessible, and cost-effective health care through managed care delivery systems, which emphasize primary and preventive care.

Medi-Cal with a Share of Cost

A Medi-Cal beneficiary who has a share of cost (SOC) for medical expenditures. SOC is the dollar amount a Medi-Cal beneficiary must pay toward their medical expenses before they qualify for Medi-Cal benefits. A Medi-Cal beneficiary's SOC is similar to a private insurance plan’s out-of-pocket deductible. The SOC may change each month. If the Medi-Cal eligibility verification system indicates a recipient has a SOC, the SOC must be met before a recipient is eligible for Medi-Cal benefits.

Medically Necessary

Medically necessary are benefits services, equipment, tests, and drugs that are required to meet the medical needs of the beneficiary'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 Cal. Code Regs., Title 22, Section 41452.

Medical Therapy Program (MTP)

The MTP is a special component of the CCS Treatment program with separate criteria for eligibility. The CCS MTP is a partnership between the California Department of Education (CDE) and DHCS. MTP operates in Medical Therapy Units (MTUs) to provide physical and occupational therapy services to individuals who meet eligibility criteria. Medical Therapy Conference (MTC) services are also provided to beneficiaries with specifically defined conditions. Refer to Cal. Code Regs., Title 22, Section 41517.5 and the DHCS MTP webpage site.

Medical Therapy Program (MTP) Services Only

"MTP-only" refers to children who are eligible for services through the CCS Medical Therapy Program (MTP) but are not eligible for the CCS general program. MTP eligibility has a unique set of criteria, separate from the CCS general treatment program and does not require financial eligibility determination.

Beneficiaries eligible for the MTP may receive services at a MTU located at a public school or an alternate site approved for service provision. The MTP offers Physical and Occupational Therapy and, if eligible, Medical Therapy Conference (MTC) physician services

Notice of Action (NOA)

A formal letter from a CCS Program agency to inform a client about events identified in accordance with Cal. Code Regs., Title 22, Section 42132, including the 1) denial of financial, residential, or medical eligibility or discontinuation of CCS Program eligibility; 2) the denial, reduction, or modification of a medical service or authorization, or denial of noncovered or new benefit; or 3) increases in amount to be repaid to the CCS Program for treatment services when a client in disagreement.

Optional Targeted Low-Income Children's Program (OTLICP)

The OTLICP is a state and federally funded health, dental, and vision insurance program, formerly known as Medi-Cal for Families program, for children up to 19 years of age who reside in households with an annual income between 160% and 266% of the

federal poverty level, and who are not otherwise eligible for full scope no Share of Cost (SOC) Medi-Cal. OTLICP is part of the Medicaid Expansion and operates alongside other programs like the Medi-Cal Access program and the County Children's Health Initiative.

Pending Case

A case that has been referred for the first time or is re-referred to the CCS Program and program eligibility is yet to be determined. Pending cases referred for the first time are assigned a Temporary case number, starting with the letter T.

Pending Service Authorization Request (SAR)

A request for service that has been entered into CMS Net/PEDI system and is pending adjudication. Changes may be made to the pended SAR before authorization or denial.

Program Services Agreement (PSA)

The PSA lists the CCS Program requirements and must be signed by the applicant, parent, or legal guardian and CCS representative except for beneficiaries that are enrolled in full scope Medi-Cal with a Share of Cost, are only receiving Medical Therapy Program (MTP) services only or are only receiving diagnostic services from the CCS Program. However, DHCS recommends all applicants sign a PSA. The PSA is effective from the eligibility date indicated and will be reviewed every 12 months.

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. See the PEDI webpage site for additional information.

Receiving County

The county to which a beneficiary is moving and in which they will claim residence.

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. A referral can be made by anyone, including, but not limited to, a medical provider, family, community provider, or Medi-Cal Managed Care Plan (MCP). See Chapter 1. Section I.A. 5. for the contents of a complete referral. The Whole Child Model (WCM) MCP will refer to their most current WCM MOU on how to submit referrals to the WCM County.

Re-referral

A subsequent referral that has been received by the CCS Program.

Referred Individual

An individual who has been referred to the CCS Program but has not yet submitted an application to the CCS Program.

Request for Services

A request directed to the CCS Program and/or the Medi-Cal Managed Care Plan (MCP) in Whole Child Model (WCM) Counties from a health care provider requesting authorization for specifically identified health care services(s) on behalf of an applicant/beneficiary.

Sending County

The county from which a beneficiary is moving.

Service Authorization Request (SAR)

Refers to the prior authorization and/or authorization request from a CCS-approved provider for health care services and medical equipment related to a client's CCS-eligible condition. See the CCS Program SAR submission instructions for additional information.

Share of Cost (SOC)

A Share of Cost (SOC) is the amount of money an individual is responsible for paying towards their medical related services, supplies, or equipment before Medi-Cal will begin to pay. The SOC amount applies to all immediate household members who do not qualify for free Medi-Cal.

Special Care Centers (SCC)

Special Care Centers (SCC) provide comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) beneficiaries with specific medical conditions. SCCs are organized around a specific condition or system. SCCs are comprised of multi-disciplinary, multi-specialty providers who evaluate the beneficiary's medical condition and develop family-centered healthcare plans to facilitate the provision of timely, coordinated treatment. See the DHCS SCC webpage site for additional information.

Should

For the purpose of utilizing this Manual, the term “should” indicates recommended procedures that 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”.

Whole Child Model (WCM) Counties

The WCM provides medically necessary services and equipment for California Children’s Services (CCS) and non-CCS medical conditions. WCM provides case management and care coordination for primary specialty and behavioral health services for CCS and non-CCS conditions. WCM operates in certain counties. Medi-Cal Managed Care plans are responsible for providing CCS services except for CCS state-only beneficiaries, which are the responsibility of the County CCS Program or the state. See the DHCS WCM webpage site for additional information.