State of California-Health and Human Services Agency
Department of Health Services

California Department of Health Services
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Director

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Index: Eligibility

TO: ALL COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS) ADMINISTRATORS, MEDICAL CONSULTANTS, AND STATE CHILDREN'S MEDICAL SERVICES (CMS) BRANCH STAFF

SUBJECT: CCS/HEALTHY FAMILIES (HF) SUBSCRIBERS DEEMED FINANCIALLY ELIGIBLE FOR CCS

Background

With the implementation of the CMS Web based authorization system, county CCS programs were advised to continue issuing legacy authorizations for services delivered to CCS clients who are HF subscribers and who are deemed eligible for CCS because their family's income is over $40,000, or who do not have a signed application and/or Program Services Agreement (PSA). Counties were directed to continue to submit claims for services provided pursuant to these authorizations to the CMS Branch in Sacramento for verification of eligibility and approval. This advice was conveyed in several of the Enhancement 47 telephone conference calls with county programs and in the CMS Net Frequently Asked Questions posted on the CCS web site. Even so, some counties have been issuing web based Service Authorization Requests (SARs) for services for 9R clients. Providers forward claims submitted pursuant to these SARs directly to the fiscal intermediary for adjudication and these counties subsequently adjusted the county share of cost for these claims using the long standing procedures for correcting monthly expenditure reports (i.e., MR-0-940 paid claims reports).

Recently several additional counties suddenly became aware that claims for services provided to their 9R children billed pursuant to SARs would not automatically pay with 100 percent State funded State match for the HF Title XXI State Children's Health Insurance (SCHIP).

The following policy is being instituted to assure appropriate payment of providers for authorized services, with the appropriate county/state share of the match for Title XXI funding.

Policy and Policy Implementation

1. Authorization of medically necessary services for CCS clients who are HF subscribers and who are deemed financially eligible for CCS because their families have incomes above $40,000 (as verified by the Major Risk Medical Insurance Board [MRMIB]), should continue to be issued in the legacy system, except for dental and orthodontic services which should be authorized with a web based SAR.

    a. Claims for services for these clients billed pursuant to a legacy authorization must continue to forwarded to the CMS Branch for authorization of payment at 100 percent State funded match for the Title XXI funds until further notice.

    b. Detail on this process is provided in Numbered Letter (NL) 02-0203 dated July 11, 2003.

2. Authorization of medically necessary services for CCS clients who are HF subscribers and who have not signed a CCS program application or Program Services Agreement should be issued in the CMS Net web based SAR system.

    a. There is no statutory authority for the state to continue to pay 100 percent of the state match for the Title XXI funds for these clients.

    b. These claims will be paid at the 50 percent State/50 percent county sharing rate for the state match for the Title XXI funds.

3. The CMS Branch will assist county CCS programs in obtaining adjustment of the county share of charges for adjudicated claims for services provided to CCS clients who have been assigned aid code 9R as follows:

    a. A list of CCS/HF clients who are “deemed financially eligible” (i. e., are over income) for CCS in accordance with Section 123870 H&SC and for whom there should have been no county share of cost pursuant to 123940(c)(2) H&SC is maintained by the State Program. Updated

copies of this list are distributed to the CMS Branch Regional Offices (RO) each time the State Program records new income verifications.

b. The county will identify all claim lines for the clients on the confirmed list on their county MR-O-940 paid claims report that have been billed pursuant to a SAR and submit that listing to their CMS RO in accordance with the procedures in the attached instruction, "Correction of Errors In Monthly Expenditure Reports." (Note: These error correction guidelines are generic. While they do not refer specifically to the situation addressed in this NL, they are applicable.)

c. The CMS Branch RO will compare the county's request for adjustment with the list maintained by the State Program (3.a., above) and will notify the county in writing of the amount that has been approved for adjustment.

d. The county will enter approved adjustments on the county's quarterly "CCS Claim For Reimbursement Diagnostic And Treatment." Part 1, 1c, Diagnostic Expenditures, Adjustments and 2c, Treatment Expenditures, Adjustments as appropriate. The county will attach the CMS Branch RO approval letter as documentation.

4. Adjustment of services authorizations for CCS/HF clients deemed financially eligible for CCS (as verified by MRMIB):

a. The county shall issue a legacy authorization and cancel SAR simultaneously. The effective date of the legacy authorization shall be the date following the date of the cancellation of the SAR. **Do not cancel the SAR retroactively.**

b. The county must coordinate this replacement activity with providers to assure that there are no lapses in access to care for the clients and to avoid claims adjudication problems for the providers.

5. Adjustment of service authorizations for CCS/HF clients whose family's income has not been verified by MRMIB to be above $40,000

a. SARs for these clients should not be end-dated or retroactively cancelled.

b. Claims submitted for services provided pursuant to these SARs will appropriately have been paid at the 50 percent State/50 percent county sharing rate for the state match for the Title XXI funds.

A unique aid code is being developed for assignment to these clients. You will be informed when the payment system is modified to accept this new aid code and will be provided with instructions for its assignment to CCS clients at that time.

6. Dental and orthodontic services for 9R clients should be authorized with web based SARs. This is necessary because Denti-Cal bases the subsequent Treatment Authorization Request (TAR) that is issued for orthodontics in part on the CCS SAR. Funding adjustments can then be made in accordance with the procedures in three above for clients who are deemed financially eligible for CCS because their families income is over $40,000.

Prospective changes in the Electronic Data System (EDS) claims payment system and reports that should be implemented at the time the new aid code cited above becomes available will enable authorization of all services for 9R children using web based SARs and provide for submission of provider claims directly to EDS.

If you have any questions, please contact Harvey Fry, at (916) 327-2435 or hfry@dhs.ca.gov.

Original signed by Harvey Fry for

Marian Dalsey, M.D., M.P.H., Acting Chief
Children's Medical Services Branch

Enclosures

CORRECTION OF ERRORS IN MONTHLY COUNTY EXPENDITURE REPORTS

PROCEDURES

Expenditures for ccs clients are reported monthly: by county, client name, provider and date of service. The following errors occasionally occur:

1. The county is billed for a child who either is not CCS-eligible or whose ccs case was closed on the date(s) of service.

2. The wrong county is billed for a CCS-eligible child.

3. The correct county is billed for a CCS-eligible child but for a provider not authorized for the child.

4. The correct county is billed for a CCS-eligible child, for an authorized provider, but for a date of service not authorized.

5. The child has Medi-Cal, but the service is paid from 100 percent CCS funds.

6. The child has insurance, but the service is from 100 percent CCS funds.

Each county reviews its monthly expenditure reports (MR-O-940) for errors; e.g., children not residing in the county, date(s) of service (DOS) prior to referral date, DOS after closure of case, Medi-Cal coverage.

When errors are found, a copy of the pertinent page of the report, with the error highlighted, is sent to the appropriate regional office, to the attention of the Regional Administrative Consultant (RAC), for review and correction.

The RAC reviews the report pages and determines if the highlighted error references a regional office child.

Where necessary, when the case belongs to the Regional Office, the RAC can pull the chart for the case in question and determine if the DOS and/or the provider are correct.

When the highlighted errors have been reviewed by the RAC and it is determined that they are in error, the RAC sends a memo to the county with the following information, based on the type of circumstance:

1. The RAC notifies the county, in writing, to decrease their expenditures on the quarterly invoice by the amount of the erroneous charge. The RAC notifies the provider that they billed, and were paid, for services provided to a non-CCS-eligible person or to a CCS-eligible child whose case was closed. The RAC cites patient's name, the date(s) of service, the procedure code(s), the date(s) of payment and the amount(s) paid. (To get all of this information, the RAC will have to order a Claim Detail Report (CDR) for the CCS ID number and date(s) of service.)

2. The RAC notifies the county, in writing, to decrease their expenditures on the quarterly invoice by the amount of the erroneous charge. The RAC also notifies the county which should have been charged to increase their quarterly invoice expenditures by the same amount.

3.The RAC notifies the county, in writing, to decrease their quarterly invoice expenditures by the amount paid on the erroneous charge. (A method of getting the State reimbursed by the non-authorized provider has either not yet been developed or is not known to this author. It is suggested that a letter be written to the

provider, explaining the situation and providing the patient's name, the date(s) of service, the procedure code(s), the date(s) of payment and the amount(s) paid. This data can be retrieved by ordering a CDR, as stated above.)

4. Same as #3.

5. The RAC verifies that the child had Medi-Cal for the month of service and that the service was a Medi-Cal benefit on that date. If this is valid, tr.e RAC notifies the county, in writing, to work with the provider to have the provider bill Medi-Cal for the covered service. Once the provider is paid by Medi-Cal, EDS will make the adjustments to the MR-O-940 which the county will showon future quarterly invoices.

6. The RAC verifies that the child had insurance for the month of service and that the service was a covered benefit on that date. If this is valid, the RAC notifies the county, in writing, to work with the provider to have the provider bill the insurance for the covered service and reimburse the county by that amount; and then the county either reimburses the state for its portion or it reduces its quarterly invoice by that amount, with written justification attached.

The RAC must maintain a tickle file of the processed report pages so that the corrections may be tracked to ensure that the errors are corrected in a timely manner.