

DEPARTMENT OF HEALTH SERVICES

714-744 P STREET
P O BOX 942732
SACRAMENTO, CA 94234-7320



January 25, 1991

Letter No.:91-06

TO: All County Welfare Directors
All Administrative Officers

SUBJECT: REPAYMENT OF SHARE OF COST FOR THE 185/200/133 PERCENT
BENEFICIARIES - ALL COUNTY WELFARE DIRECTORS LETTER (ACWDL)
90-106 - REVISED MC 1054

REFERENCE: ACWDL 90-106 and EMC2 DHS #91003

The ACWDL 90-106 (dated December 14, 1990), contained a camera ready copy of the revised Share-of-Cost Medi-Cal Provider Letter (MC 1054) dated December 1990. As stated in EMC2 DHS #91003 (dated January 14, 1991), the revised MC 1054 is missing three words. This ACWDL is a follow-up to EMC2 DHS #91003. Enclosed is a corrected camera ready copy of the revised Share-of-Cost Medi-Cal Provider Letter (MC 1054).

This copy contains the missing three words omitted from the revised MC 1054 attached to ACWDL 90-106. The second paragraph, last sentence should read, "The Welfare and Institutions Code Section 14019.3 and the regulation further requires that the provider accept an underpayment adjustment from the Medi-Cal program for such beneficiaries and reimburse such beneficiaries the full amount of that adjustment, up to the amount actually received in payment from the beneficiary for the medical services in question."

Effective immediately, the MC 1054 must be used to reduce the beneficiary's share-of-cost to zero or a lesser amount. A supply of this revised MC 1054 should be available in the Department of Health Services Warehouse by March 1, 1991. Until such time, please use the enclosed camera ready copy.

If you have any questions, please contact Tina Velasquez, MEDS Liaison, at (916) 323-9510.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

SHARE-OF-COST MEDI-CAL PROVIDER LETTER

(County Address)

(Provider Address)

RE: _____
 (1) _____ (2) _____
 Old Share of Cost County I.D. New Non-Share of Cost County I.D.

The individual(s) shown above was determined eligible for Medi-Cal for the month(s)/year of _____

with a monthly share-of-cost of \$ _____. Upon review, it has been determined by the county welfare department that the share-of-cost for each month indicated should have been only \$ _____.

The California Code of Regulations, Title 22, Section 51471.1, requires providers to cooperate with the Department of Health Services in making reimbursements to beneficiaries for Medi-Cal program underpayments. The Welfare and Institutions Code Section 14019.3 and the regulation further requires that the provider accept an underpayment adjustment from the Medi-Cal program for such beneficiaries and reimburse such beneficiaries the full amount of that adjustment, up to the amount actually received in payment from the beneficiary for the medical services in question.

The following information will assist you in making the reimbursement required by this regulation.

Beneficiary Share-of-Cost Reduced to Zero

1. If the beneficiary paid or obligated to pay an original share-of-cost amount to you, and you billed Medi-Cal for the balance of the charges, you must submit a Claims Inquiry Form (CIF) with this MC1054 form attached. DO NOT submit a new claim, as it will be considered a duplicate claim and payment will be denied. Once the CIF is approved and payment is received, you are required to reimburse the beneficiary any share-of-cost previously paid or to eliminate the outstanding share-of-cost obligated for the service billed.
2. If the beneficiary paid or obligated to pay an original share-of-cost amount to you, and you did not bill Medi-Cal because the charges equaled the share-of-cost amount you collected or which is still an outstanding charge, you may now bill the program for the services you rendered. You must submit a claim with a zero (0) in the "Patient's Share-of-Cost" field, and attach this MC1054 form. Once the claim is approved and payment is received, you are required to reimburse the beneficiary any share-of-cost previously paid or to eliminate the outstanding share-of-cost obligated for the service billed.

Beneficiary Share-of-Cost Reduced to a Lesser Amount

In those situations where a beneficiary's share-of-cost amount has been reduced (but not to zero), the county welfare department will be required to issue the beneficiary a "revised" MG177, Record of Health Care Costs. Any provider who rendered services for which a share-of-cost amount was paid or obligated should complete the "revised" MC177. Upon completion of this process, the beneficiary will return the MC177 form to the county welfare department, to be processed and mailed to the State. Subsequently, the fiscal intermediary share-of-cost records will be updated. Providers should allow approximately 30 days for this process before submitting a CIF or claim.

Follow the same procedures previously described in steps 1 and 2 when submitting a CIF or claim, except the reduced share-of-cost amount must be entered in the "Patient's Share-of-Cost" field on the claim instead of zero (0).

Eligibility Worker's Signature

Phone Number