Article 14 – MEDI-CAL CARD USE AND ISSUANCE

14A – COUNTY ISSUANCE OF MEDI-CAL IDENTIFICATION CARD, MC 301 AND MC 301 RED

1. Obtaining Blank Identification Cards (MC 301 and MC 301 RED)

2. Authorizing Issuance of MC 301 and MC 301 RED)

3. Preparation of Medi-Cal Card (MC 301 and MC 301 RED)

4. Recording and Reporting the Issuance of MC 301 and MC 301 RED

5. Voiding MC 301s and MC 301 REDs

6, 7. Summary Reporting

8. Reporting Coding

14B – HANDLING OF SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT MEDI-CAL CARD PROBLEMS

1. Routine Supplemental Security Income/State Supplementary Payment Medi-Cal Card Problems

2. Handling of Supplemental Security Income/State Supplementary Payment Medi-Cal Card Problems

3. CID Medi-Cal Card Mailing Address for Supplemental Security Income/State Supplementary Payment Eligibles

4. State Data Exchange Data Fields Used for Supplemental Security Income/State Supplementary Payment Medi-Cal Cards

5. State Conversion Logic, Federal County Code to State County Code

6. State Conversion of Master File Type Code to State Aid Code

7. State Data Exchange Medi-Cal Eligibility Determination.

8. Use of Form MC 5

9. Use of County Staff for New Procedures

10. Periodic Supplemental Security Income/State Supplementary Payment Medi-Cal Card Stuffer

14C – CHANGING COUNTY ID NAMES

14D – VERIFICATION OF MEDI-CAL ELIGIBILITY

A. Medi-Cal Providers

B. General Acute Care Hospitals and Licensed Primary Care Clinics (PCCs)

14E – LETTER OF AUTHORIZATION/MC 180 PROCESS

1. Letter of Authorization/MC 180 issuance for SSI/SSP recipients only

2. Definition of Administrative error

3. Administrative error procedures

4. Redesigned LOA (MC 180)

5. Form MC 180

14A — COUNTY ISSUANCE OF MEDI-CAL IDENTIFICATION CARD, MC 301 AND MC 301 RED

1. Obtaining Blank Identification Cards (MC 301 and MC 301 RED)

Blank temporary Medi-Cal cards, MC 301 and MC 301 RED, may be ordered by the counties as needed by submitting forms request MC 1 (or HCS 1) to:

Department of Health Services Warehouse
1723 20th Street
Sacramento, CA 95814

When ordering MC 301 RED temporary Medi-Cal cards, counties must underline the word "RED" on the order so Department of Health Services (DHS) will not confuse the order with the MC 301 blue Medi-Cal ID card stock.

2. Authorizing Issuance of MC 301 and MC 301 RED

a. Both MC 301 and MC 301 RED with MEDI and POE labels may be issued to beneficiaries in accordance with Section 50739. MC 301 REDs are issued to those persons with limited or expanded service status, i.e., persons enrolled in a pilot project or noncomprehensive PHP, eligible to receive minor consent services only, whose ability to obtain drug services has been restricted, or persons participating in the orthomolecular project (see Articles 19A and 19C for details).

b. Prior to authorizing issuance of an MC 301 or MC 301 RED, the PHP Status History File (the name will be changed to the Medi-Cal limited services status register in the near future) must be checked to determine whether the beneficiary is enrolled in a PHP or on restricted drug status. If the beneficiary is enrolled in a comprehensive PHP, a Medi-Cal card may not be issued.

c. If a resident of another county requests a Medi-Cal card, the card or labels should not be issued until the county of residence is contacted to ensure that the person is eligible and to determine whether the person should receive a limited or expanded service Medi-Cal card or no Medi-Cal card due to enrollment in a comprehensive PHP.

d. When an MC 301 or MC 301 RED is being issued to a resident of another county, use beneficiary identification number, including the county code, assigned by the county of residence.

e. Issuance of POE Labels to Providers.

(1) Upon written request, the county department may issue, or request that the Department issue, current or past month POE labels to the following providers if the provider has attempted but failed to obtain a label from a beneficiary:

(a) County hospitals.

(b) County mental health directors.

(c) University of California hospitals.

(d) Crippled Children Services.

(e) County-operated CHDP provider agencies.

(f) County-operated family planning services provider agencies.

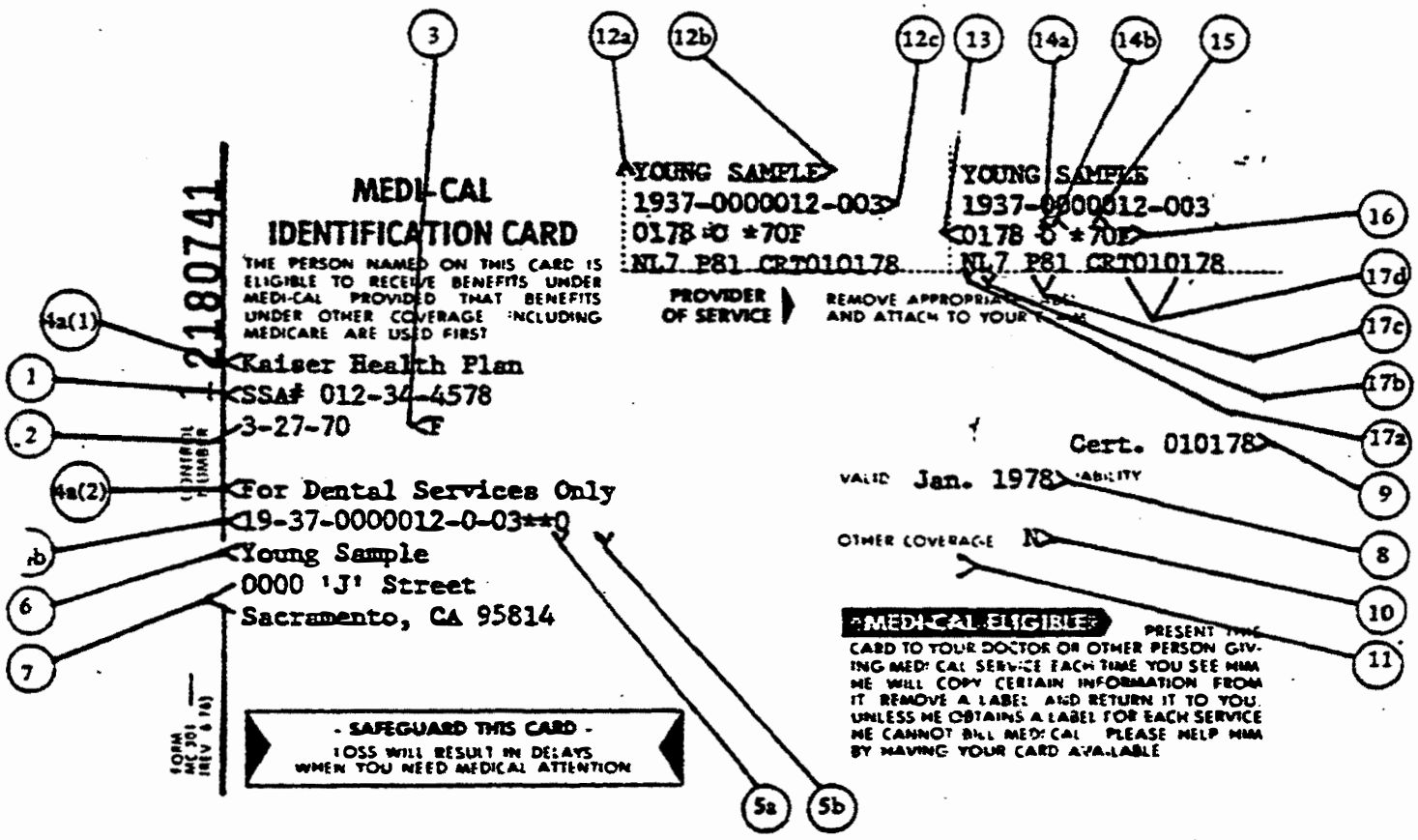
(g) County contract hospitals. The list of contract hospitals is provided in Procedure Section 14C.

(2) The county department may also issue, or request that the Department issue, current or past month POE labels to any provider who provided a service to a beneficiary who is now deceased.

3. Preparation of Medi-Cal Card (MC 301 and MC 301 RED)

The MC 301 and MC 301 RED (full complement or POEs only) prepared by the county department must include all the information specified below. Required information must be typed without errors or corrections of any kind. Cards or labels with errors must be voided. Provider claims will be rejected by the Medi-Cal fiscal intermediary if they are accompanied by MC 301 or MC 301 RED cards or labels that have errors or corrections.

a. MC 301 and MC 301 RED Schematic


MEDI-CAL
IDENTIFICATION CARD
THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER MEDI-CAL PROVIDED THAT BENEFITS UNDER OTHER COVERAGE INCLUDING MEDICARE ARE USED FIRST
2180741
Kaiser Health Plan
SSA# 012-34-4578
3-27-70 F
For Dental Services Only
19-37-0000012-0-03**0
Young Sample
0000 'J' Street
Sacramento, CA 95814
- SAFEGUARD THIS CARD -
LOSS WILL RESULT IN DELAYS WHEN YOU NEED MEDICAL ATTENTION
YOUNG SAMPLE
1937-0000012-003
0178 0 *70F
NL7 P81 CRT010178
PROVIDER OF SERVICE
YOUNG SAMPLE
1937-0000012-003
0178 0 *70F
NL7 P81 CRT010178
Cert. 010178
VALID Jan. 1978
OTHER COVERAGE N
MEDI-CAL ELIGIBLE
PRESENT THIS CARD TO YOUR DOCTOR OR OTHER PERSON GIVING MEDICAL SERVICE EACH TIME YOU SEE HIM HE WILL COPY CERTAIN INFORMATION FROM IT REMOVE A LABEL AND RETURN IT TO YOU. UNLESS HE OBTAINS A LABEL FOR EACH SERVICE HE CANNOT BILL MEDICAL PLEASE HELP HIM BY HAVING YOUR CARD AVAILABLE
3
12a
12b
12c
13
14a
14b
15
16
17d
17c
17b
17a
9
8
10
11
4a(1)
1
2
4a(2)
4b
6
7
5a
5b

b. MC 300 and MC 301 Schematic Explanation

Basic Section

Item #	Description
1	"MEDICARE #" plus number itself (HIC#, SSA#, or RR#), if beneficiary is Medicare entitled. Otherwise, "HIC#", "RR#", or "SSA#", plus the federal ID number itself.
2	Beneficiary's date of birth.
3	Sex of recipient: "M" or "F".
4a (1)	Only for PHP and pilot project enrollees. Insert message as indicated in c (1).
4a (2)	Only for limited or expanded services beneficiaries. Insert message as indicated in c (1), (2), (3), and (4).
4b	Beneficiary's Medi-Cal ID #: County (2 digits), Aid (2 digits), Serial # (7 digits), FBU or MFBU (1 digit), Persons # (2 digits). SSI/SSP Recipients: County (2 digits), Aid (2 digits), Constant 9, Serial (9-digit Social Security Number)
5a	Pre/Post Indicator: "0", "1", or "2". 0 = Routine Medi-Cal Eligibility. 1 = Three-Month Retroactive Eligibility. 2 = AFDC Four-Month Continuing Eligibility.
5b	County use area; precede with asterisks.
6	Beneficiary name.
7	Beneficiary address area: include "C/O (addressee name)" if needed. In those instances where the county department has been instructed not to include a beneficiary home address (see Sections 16D 6. and 19B 2.a.), the county department address may be substituted here.

Item #	Description
8	Valid month of card. Type "RETRO" above if valid month is before current month. (see 14A.8 for definition of "Retro")
9	Dollar amount of share of cost for LTC patients only. Certification date for persons who met a share of cost.
10	Other coverage. (see Article 15A)
11	Copay status: Deleted. No entry required.

Label Section

Item #	Description
12a	Medicare Status: "2*" shows Medicare entitlement; "b*" sh lack of Medicare entitlement. (Note: b means blank space
12b	Beneficiary Name: normal sequence, or last name first or abbreviated (as needed) to still uniquely identify person as much as possible.
12c	Beneficiary ID.
13	Valid month of card. Precede with "R" or "1" if card is "retro" card. (see 14A.8 for definition of "Retro")
14a	Pre/Post Indicator: "0", "1", or "2". (see 5a)
14b	Copay status: Deleted. No entry required.
15	Year of beneficiary birth; last two digits only.

Item #	Description
16	Sex of beneficiary.
17a	Other Coverage Code. (see Article 15A)
17b	Only for limited or expanded services beneficiaries. See c (2), (3), and (4) below for proper codes.
17c	Only for Pilot Project/PHP codes. See c (1) below for codes.
17d	Dollar amount of share of cost for persons in LTC. Certification date for persons who have met a share of cost. This is a multi-use field. If applicable, this field should be coded as follows: (1) With the dollars amount of share of cost for persons in LTC. (2) With the certification date for persons who have met a share of cost. (3) With the word "Restricted" if the beneficiary's Medi-Cal coverage is restricted under the programs in Articles 19A and 19C.

c. Special Coding for MC 301 RED Medi-Cal Cards

(1) PHP/Pilot Projects

County	Plan/Project Name (Item 4a(1) on MC 301 Schematic)	Plan Number (Item 17c on MC 301 Schematic)	Restricted Message (Item 4a(2) on MC 301 Schematic)
Los Angeles	Kaiser Health Plan	P28	For dental services only
Orange	Kaiser Health Plan	P76	For dental services only
Riverside	Kaiser Health Plan	P77	For dental services only
San Bernardino	Kaiser Health Plan	P78	For dental services only
San Diego	Kaiser Health Plan	P79	For dental services only
Lake, Sonoma, Mendocino	Redwood Health Pilot Project	PP3	

(2) Minor Consent Services

Services Related to:	Special Coding (Item 17b on MC 301 Schematic)	Restriction Message (Item 4a(2) on MC 301 Schematic)
Sexual Assault	L6	LIMITED SERVICES ONLY
Drug or Alcohol Abuse (at least 12 years of age)	L7	LIMITED SERVICES ONLY
Pregnancy or Family Planning, other than for pregnant minors	L8	LIMITED SERVICES ONLY
Venereal Disease (at least 12 years of age)	L9	LIMITED SERVICES ONLY

If the minor is applying for services related to more than one of the areas listed, use the code for the service that is listed first.

(3) Restricted Services

Service	Special Coding (Item 17b on MC 301 Schematic)	Restriction Message (Item 4a(2) on MC 301 Schematic)
Individuals on restricted service status	R1 R5	RESTRICTED DRUGS RESTRICTED SCHED. DRUGS

(4) Orthomolecular Medicine Demonstration Project (OMDP)

Service	Special Coding (Item 17b on MC 301 Schematic)	Restriction Message (Item 4a(2) on MC 301 Schematic)
Individuals participating in the OMDP - eligible for OM in addition to other Medi-Cal benefits.	OM	Includes Orthomolecular Services

4. Recording and Reporting the Issuance of MC 301 and MC 301 RED

The county must maintain a record of all cards issued to beneficiaries or voided for any reason on form HAS 2007, "Control Log for MC 301". This record must be received at the Department of Health Services by the seventh working day of the following month. This can be accomplished by reporting on a flow basis throughout the month or on a monthly basis by the seventh working day of the following month. Counties reporting via EDP printout are urged to investigate the feasibility of reporting via magnetic tape.

Each time a temporary card is issued to a beneficiary, the county shall complete one line entry on the HAS 2007. Information should be the same as the data on the MC 301/301 RED and the control serial number on the card should be recorded.

Counties shall complete form HAS 2007 by following the detailed instructions contained in the "FORMS" section of the Medi-Cal Eligibility Manual.

5. Voiding MC 301s and MC 301 REDs

If it is found that an MC 301/301 RED should not have been prepared or was incorrectly prepared, the corresponding entry on the control log should be lined out and the MC 301/301 RED temporary card destroyed. Only if the log is no longer available for correction should the card be marked "VOID" and forwarded to DHS. Voiding should not obscure either the recipient ID number or the valid month shown on the card.

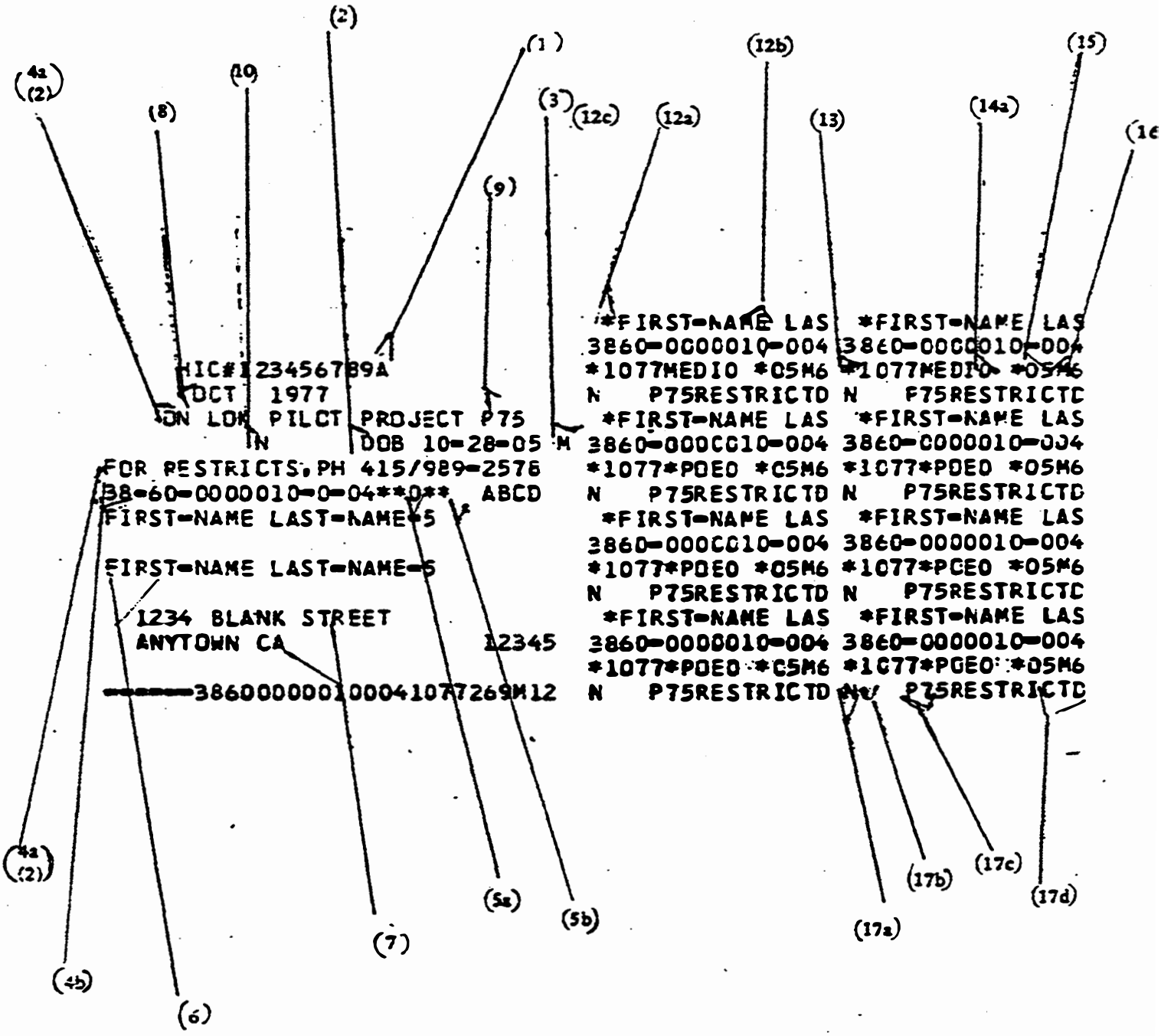
6. Summary Reporting

Each month counties shall submit an "MC 301 Issuance Report" (MC 401) to the Department by the seventh working day of the month following the month for which the county is reporting. The form should be sent to Department of Health Services, Data Processing Control Unit, 744 P Street, Sacramento, CA 95814. The MC 401 summary sheets will be used to monitor MC 301 card stock and to check for losses in mail delivery. The beginning and remaining stock counts verify receipt of new card stock. The monthly usage figure will be used to monitor the quantity of cards issued to insure that sufficient card stock is available to replenish county supplies. The counts of cards issued help to assure we have received all the logs.

7. The MC 300 and MC 300 RED are used by the Department of Health Services to computer print and mail Medi-Cal cards to those individuals reported eligible to receive cards by the county welfare departments and to persons eligible for Supplemental Security Income/State Supplementary Payment (SSI/SSP) as reported to the Department by the Social Security Administration. In addition some counties, upon Department approval, are using the MC 300 and MC 300 RED card stock to produce county issued replacement and POE only cards through the county's data processing system. The data printed on the Department issued MC 300 and MC 300 RED card stock is taken from the data supplied by the counties via the CID System, the Paper County Process (MC 208 input), and by the Social Security Administration via the State Data Exchange (SDX) process. Department issued cards for share-of-cost beneficiaries meeting their share of cost through the MC 177 (Record of Health Care Costs) process is based on the information provided by the county on the MC 177. Data regarding PHP, Pilot Project, Restricted Services, Expanded Services, or Medicare status are obtained from various other sources. For example, applicable PHP or Pilot Project information is extracted and printed on the cards from the enrollment reports received from the PHPs and Pilot Projects by the Department.

Below is a schematic drawing of the MC 300 and MC 300 RED. The coding instructions for these cards are identical to the coding instructions for the MC 301 and MC 301 RED cards. Please refer to Procedures Section 14A-3 for a definition of the data coded on the MC 300 and MC 300 RED.

MC 300 and MC 300 RED Schematic



8. Retroactive Coding

Cards issued by the county for past months of eligibility when an original card was issued during the month of eligibility shall not be coded "Retro". The "Retro" indicator shall be used only in the following situations:

a. When cards are being issued for retroactive months of eligibility as defined under CAC, Title 22, Section 50710.

b. When cards are being issued for prior months eligibility when the eligibility determination or the report of eligibility to the State for a card issuance was delayed beyond the month of eligibility.

c. When the share of cost certification of eligibility does not occur until after the month of eligibility.

d. When full complement or proof of eligibility (POE) Only replacement cards are being issued for cards originally issued under the circumstance noted in a-c above.

14B -- HANDLING OF SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT MEDI-CAL CARD PROBLEMS

1. Routine Supplemental Security Income/State Supplementary Payment Medi-Cal Card Processing

a. Source of Eligibility Data

The eligibility status and primary identifying information of all SSI/SSP recipients is sent to the State by SSA.

Most of the information is in the form of EDP magnetic tape records, sent via SSA's SDX system on an "as occurs" basis several times a week. The rest of the information, in the form of individual paper documents, is sent from SSA district offices to the Department, also on an "as occurs" basis. These are records for a relatively small number of SSI/SSP eligibles who cannot be reported by SSA via the SDX system because of restrictions built into SSA's EDP processing. These records, known as one-time payment (OTP) records, have been incorporated into the Department's SSI/SSP eligibility files since the January 1976 month of eligibility processing.

b. Editing and Reformatting of State Data Exchange Data

The Department edits records received from SSA to insure that they are usable for Medi-Cal card production and other Medi-Cal processes. The Department also converts SDX-supplied county codes and aid codes to the coding structure used for county-administered cases and realigns SDX address data so it fits on Medi-Cal cards. Both types of reformatting are done to make SSI/SSP Medi-Cal card formats compatible with cards produced from county-supplied data.

c. Medi-Cal Card Production

Initial Medi-Cal cards for new or reinstated SSI/SSP recipients are produced for the month in which the SDX eligibility records are received. These cards are produced on an "as notified" basis throughout the month.

In addition, the Department creates a "Main" CID Medi-Cal card file each month from the data base that has been built from SDX records received from SSA. "Main" cards are created from data in the most recent SDX records received prior to the monthly card process. Cards for all current recipients are produced from this file and mailed near the end of the month for use in the coming month. This card production process is equivalent to, and uses the same production steps as, monthly

Main CID card processing from county-supplied eligibility files. Main CID Medi-Cal cards for SSI/SSP recipients are suppressed on the basis of PHP enrollment and specially printed on the basis of pilot project enrollment and Medicare entitlement, just as county-originated CID cards are.

Page 14B-11 lists the SDX data fields which are used to print Medi-Cal card data for SSI/SSP recipients.

d. Time Lags in Processing of Supplemental Security Income/State Supplementary Payment Data

There is a certain amount of time needed to process data within SSA's system, transmit the data to the State, and process the data through the State's system. As a result, new information about a recipient which is reported to an SSA district office in one month often will not be reflected on CID Medi-Cal cards produced for the coming month. If a change is reported late enough in a month by a recipient, it may not affect the next two monthly Medi-Cal cards.

e. Medi-Cal Card Data Not Taken From State Data Exchange

Four data elements on Medi-Cal cards are not printed from information supplied directly from the SDX files: copay status, other health coverage data, Medicare entitlement code, and Medicare ID number.

(1) Copay Status: is a constant, "No Copay", for all SSI/SSP recipients.

(2) Other Health Coverage: is a constant. To date, this constant has been "OONO" ("No Other Health Coverage") for all SSI/SSP recipients. It will be changed in the near future so that the field is left blank, only on Medi-Cal cards themselves. (Note: In order for the State to recover SSI/SSP Medi-Cal costs from private health insurance carriers, other health coverage data is gathered on a special form. The form is handed out by Social Security district offices and completed and sent to the State by the recipients. Because this data is not updated on a monthly or quarterly basis, additional research is always needed as to what the other coverage of a particular SSI/SSP patient was during a given month. Therefore, private coverage for these patients is always paid in the form of reimbursements to the State after Medi-Cal has initially paid for the services in full. Other coverage coding on Medi-Cal cards is not needed under these circumstances.)

(3) Medicare Status/Medicare Identification Number

(a) For SSI/SSP recipients 65 years or older, positive Medicare status is always placed on the card by the State. The Medicare number on the card comes from data sent to the State from SSA's Medicare (Buy-In) system if that data is available; otherwise, the person's SSN is used. (Note: The State will shortly begin use of the SDX-reported Title II Claim Account Number (CAN) as the Medicare number for persons who are 65 or older, since SSA has confirmed that the two numbers are in fact identical. For those recipients who do not have a CAN reported, SSN will still be used as the Medicare number.)

(b) For SSI/SSP recipients under 65 years, Medicare status and Medicare numbers are obtained exclusively from data sent to the State by SSA's Medicare (Buy-In system). The State matches the Medicare data to the SSI/SSP eligibility data before CID Medi-Cal cards are produced.

(c) **Medicare Notes**

1) An aged SSI/SSP recipient who is also receiving regular (Title II) Social Security benefits will be automatically bought in by SSA. If he/she is not receiving regular Title II benefits, his/her SSA district office must still complete an application for Medicare. Accordingly, an SSI/SSP recipient complaint based on nonapplication for Medicare is <u>not</u> a valid complaint.

2) Unlike Medicare information for county-administered recipients, new Medicare status/data for SSI/SSP recipients is automatically sent monthly to the State via SSA's Medicare Buy-In system.

2. <u>Handling of Supplemental Security Income/State Supplementary Payment Medi-Cal Card Problems</u>

a. <u>Form MC 5 (Supplemental Security Income/State Supplementary Payment Medi-Cal Card Problem Notice)</u>

(1) General

Form MC 5 is divided into sections according to the type of problem being reported. In all cases the recipient data portion of the form should be completed.

Completed MC 5 forms and Medicare-related forms go to:

Department of Health Services
Medicare Operations Unit
MS 4719
P.O. Box 997422
Sacramento, CA 95899-7422

Forms of both types should be batched and mailed weekly.

(2) Repeat Submission of Form MC 5 for the Same Case/Problem

Card problems which need to be reported may be correctable through a single systems change, or they may have to be corrected on a case-by-case basis. Under either circumstance, reporting of a given problem for a particular client needs to be done only once. If special action needs to be taken to correct a particular type of problem, e.g., referring all clients with that problem to a Social Security district office, then the Department will advise counties of that need. The Department will also keep counties advised of systems corrections as they are identified and made.

b. Correction of Medi-Cal Card Data Not Taken From the State Data Exchange

(1) Correction of Copay/Other Coverage Data

If codes appearing on SSI/SSP Medi-Cal cards are different from the fixed codes described above, this indicates a state computer systems error. No reporting via MC 5, or case-by-case correction, is called for. Errors in either type of code should be reported to the Department of Health Medi-Cal field representative for your county, along with Medi-Cal ID number, recipient name, and valid month of a representative erroneous card. A photocopy of the erroneous card is also requested.

(2) Correction of Medicare Data

If a recipient reports a Medicare data error, the appropriate data in the Medicare portion of the MC 5 should be filled in. These forms should be sent to the Department's Buy-In Unit.

The Buy-In Unit will work with both the SSI/SSP and the Medicare organizations within SSA to resolve the problems and correct the Department's data.

If a recipient has both a Medicare and a non-Medicare card problem, a separate form should be filled out for each.

c. Correction of Medi-Cal Card Data Taken From the State Data Exchange

When a recipient reports that data on his/her Medi-Cal card is either erroneous or outdated, the following steps should be taken in the sequence shown.

(1) Check the county's SDX listing to see if the data in question on the card is equivalent to or the same as the data for that client on the SDX listing. Pages 14B-11 through 14B-13 explain where in an SDX record the data on the card is found and explains the simple conversion logic that is used to convert a recipient's county code and aid code from the federal coding scheme on the SDX to the state coding scheme on Medi-Cal cards.

If the data on the SDX is not the same as is on the card, this indicates a problem in the Department's processing which should be reported on an MC 5.

(2) If the data on the SDX is the same as is on the Medi-Cal card, find out if the client has reported correcting or updating information to an SSA district office.

(a) If the new or corrected data has not been reported, it should be, preferrably by sending a Social Security notification form, (forms SSA 8150 or equivalent) signed by the recipient, to the proper district office. The recipient should also be advised at this time that the new data may not appear on his/her next two monthly Medi-Cal cards.

(b) If the recipient reported either correcting or updating information to a district office, either

this month or the month before, then the new or corrected information is probably still making its way through the federal or state computer systems; no further action needs to be taken at this time.

(c) If correcting or updating information was reported to a district office but three Medi-Cal cards with the same error or outdated data have been received since then, an MC 5 should be filled out and sent to the Department.

(d) If the client received his/her Medi-Cal card but the client wants a CID mailing address different from that shown on the card, see the section on CID mailing addresses.

d. Handling Erroneous Receipts of Medi-Cal Cards

(1) If a client reports receipt of two or more SSI/SSP Medi-Cal cards for the same valid month, either with the same ID number or with different ID numbers, that situation should be reported on an MC 5. If two different SSNs are involved, the MC 5 has a place to show the correct SSN. In either case the erroneously issued card should be returned to the Department with the MC 5; if the cards are identical, either one may be returned.

If two cards with different SSNs are received and the client also received two gold SSI/SSP checks, the local SSA district office should be advised. In other instances of duplicate SSI/SSP card receipt, the Department will work with SSA as needed to eliminate the problem.

(2) If a client states that he/she has received an SSI/SSP discontinuance notice from SSA and has received an SSI/SSP Medi-Cal card afterward, the following steps should be taken:

(a) Check the county's SDX listing. If the client is not shown as eligible, a processing problem is indicated, and an MC 5 should be made out.

(b) If the client is eligible according to the SDX listing and the discontinuance notice was received either this month or last month, the discontinuance information is probably still making its way through the federal or state computer systems, and no further

action needs to be taken. However, the client should be told that if he/she subsequently receives a second month's Medi-Cal card after receiving the discontinuance notice of action, that a problem exists and it should be reported to the county. See the next item for details.

Note: Suspension notices of action are a likely source of confusion. If the client has been suspended because he/she is changing representative payees, he/she should be advised that the State continues to produce Medi-Cal cards for him/her because that type of suspension does not mean loss of Medi-Cal eligibility under SSI/SSP.

(c) If the client is eligible according to the SDX listing but has received Medi-Cal cards for two months _____ ng the ineligibility notice of action, this should be reported on an MC 5.

(3) If a client reports receipt of both an SSI/SSP Medi-Cal card and a Medi-Cal card for a county-administered program, the following steps should be taken:

(a) Check the county's SDX listing. If the client is not shown as eligible, a processing problem is indicated, and an MC 5 should be made out. The SSI/SSP Medi-Cal card should be retrieved from the client if possible.

(b) If the client is shown as eligible on the county's SDX listing, the county-caused Medi-Cal card should be returned to the Department and the case discontinued by the county.

e. Handling Erroneous Nonreceipt of Medi-Cal Cards

(1) Types of Nonreceipt Problems

Client nonreceipt of an SSI/SSP Medi-Cal card will fall into one of six categories:

(a) The client is not entitled to the card so no monthly card was produced.

(b) The client is entitled to the card, but the computer processing for the client, either by the Department or by SSA, erroneously kept that entitlement from resulting in a card.

(c) The client is one of the special group of OTP recipients who must be processed outside of SSA's normal computer system and the special OTP process of SSA reporting and departmental card production has not worked for that client.

(d) The monthly card was produced with an incorrect address and the card either was not or could not be forwarded.

(e) The monthly card was misdirected somewhere between its production and its receipt by the client. This category includes postal service mishandling, departmental mishandling, and theft.

(f) The monthly card was not produced because the client is a PHP enrollee.

(2) Steps to Identify Problem

To help identify the problem source the following steps should be taken when a client reports card nonreceipt. Steps should be taken in the sequence shown. Check the county's SDX listing for the month.

(a) If the client is shown as eligible:

1) Check the county's PHP enrollee listing to see if the client is an enrollee for the month.

(Note: The State is modifying its SSI/SSP processing to include PHP enrollment status in SDX records sent to counties. A description of the coding to be used and its location in SDX records will be supplied before the change is installed.) If the client <u>is</u> shown as enrolled for the month in a PHP which has comprehensive Medi-Cal coverage, the client should be so advised and referred to the PHP for specifics of how to receive services.

2) If PHP enrollment is not involved, check the address(es) shown on the SDX listing. The sequence of steps to follow is described later in the CID Mailing Address section (Section 3).

3) If the client indicates that he/she has given an SSA district office all the information needed to produce a correct Medi-Cal card address and that the necessary time frame has passed without a card being received, the case should be reported as a problem on an MC 5.

4) If there appears to be no card address error based on SDX data and on client information, the case should be reported on an MC 5.

(b) If the client is not shown as eligible on the county's SDX listing:

1) Determine what basis the client has for believing he/she is eligible in the current month. If no check has been received or a discontinuance notice of action has been received previously from SSA, the indication is that the person is not currently eligible for SSI/SSP; accordingly, an application for Medi-Cal under a county-administered program should be taken and developed.

2) If the income, resources, living arrangement, and other circumstances as given in the application indicate current SSI/SSP eligibility, the person should be referred to the local SSA district office for resolution of his/her SSI/SSP status. The Department will be notified of the results of the SSA determination via the SDX or via the OTP notification process.

3. CID Medi-Cal Card Mailing Address for Supplemental Security Income/State Supplementary Payment Eligibles

a. Background

The mailing address put on SSI/SSP CID Medi-Cal cards must be taken from one of the two addresses found in SDX records: "Mailing Address" or "Residence Address".

The SDX system does not allow a recipient to give a separate address specifically for Medi-Cal card mailing; nor does it allow a recipient to choose which of the two addresses the Medi-Cal card is to go to if the addresses are different.

In the majority of cases, there is no residence address shown in an SDX record because the mailing address and the residence address are the same.

Even if there are two addresses in an SDX record, the mailing address is used as the CID mailing address with three exceptions:

(1) When the payee address has been annotated by SSA as being a bank address. (Note: This use of payee address by SSA has been discontinued.)

(2) When the SDX record is coded to show that a state hospital is the representative payee of the client and the record is also coded to show that the client is not physically in the custody of the state hospital.

(3) When the SDX record is coded to show that the client is in a suspended status because a new representative payee must be designated for the client but has not been selected yet.

Note: The State is modifying its SSI/SSP processing to include an "address indicator" in SDX records sent to counties to show which of the two addresses was used as a recipient's CID mailing address and why. A description of the coding to be used will be supplied before the change is installed. The steps given below do not depend on that indicator; they will be modified when the indicator becomes available.

b. Handling Address Problems

(1) If a monthly SSI/SSP Medi-Cal card is not being received and an address problem may be the cause:

(a) Determine if the address(es) in the SDX listing is/are current and correct according to the client. If so, the case should be reported on an MC 5.

Note: If the SDX shows two addresses and both are correct, the client should be advised to make sure that the card is not going to the opposite address from the one he/she expects.

(b) If the address(es) in the record is/are not correct or current, find out if the client has given correcting or updating information to a local SSA district office and if so, when. If a correction/update was reported but a correctly addressed card is still not being received as of the third monthly card since reporting, the case should be submitted on an MC 5.

(2) If the client has two correct addresses on the SDX and wants the card to go to the opposite address from the one it is going to:

(a) Find out if the client's circumstances match the type of address that is being used for the Medi-Cal card. (Example: If the recipient is in the process of changing his/her representative payee, is the residence address being put on his/her Medi-Cal card?)

1) If the recipient's circumstances fit the type of address being used, this must be explained to the client.

Note: There may be additional categories of recipients that should have Medi-Cal cards delivered to their residence addresses. If counties identify any such groups, the Department should be advised so it can jointly determine with SSA if SDX coding permits identification of these additional groups.

2) If the recipient's circumstances do not fit the type of address being used, find out whether the change in circumstances has been reported to an SSA district office. If it has been reported and the proper time has passed since then, submit the case on an MC 5.

3) If the payee address and residence address are correct as shown on the SDX but the recipient needs cards delivered to a third address, the limitations of the SDX should be explained to the client.

4. State Data Exchange Data Fields Used for Supplemental Security Income/State Supplementary Payment Medi-Cal Cards

Medi-Cal Identification Number:

County Code:

SDX Field 42, "Residence State and County Code" (positions 415-419), or

SDX Field 15, "Payee State and County Code" (positions 208-212), if Field 41 is blank

See below for state conversion logic for federal coding.

Aid Code:

SDX Field 6, "Master File Type Code"
(positions 29-30)

See below for state conversion logic for federal coding.

Social Security Account Number:

SDX Field 4, "Social Security Number"
(positions 8-16)

Name of Recipient:

SDX Field 7, "Individual's Name"
(positions 31-60)

Recipient Address:

SDX Fields 13/14, "Payee Name and Mailing Address"
(address portion only)/"Payee ZIP Code"
(positions 71-202/203-207), or

SDX Fields 40/41, "Residence Address"/"Residence ZIP Code"
(positions 300-409/410-414)

If available, Residence Address/ZIP Code is used only in designated circumstances as indicated by coding in other SDX fields.

Medicare Identification Number (pending use):

SDX Field 5, "Title II Claim Account Number"
(positions 17-28)

This field will be used for recipients 65 years or older if it is not blank. The number in this field should also be identical to the Medicare ID number used for disabled SSI/SSP recipients as reported separately by SSA at the time "Buy-In" of the recipient on behalf of the State is confirmed.

Sex:

SDX Field 8, "Sex Code"
(position 61)

Date of Birth:

SDX Field 10, "Date of Birth"
(positions 63-68)

5. State Conversion Logic, Federal County Code to State County Code

Federal codes are five digits. For California, code range is 05000 through 05680. County code is defined by third and fourth digits, as follows:

Federal Code	Conversion Logic
00 through 17	add one to produce state code for county
20	equals 19 (Los Angeles County)
30 through 68	subtract 10 to produce state code for county

6. State Conversion of Master File Type Code to State Aid Code

Type Code	Aid Code
AI	10
AS	10
BI	20
BS	20
DI	60
DS	60

7. State Data Exchange Medi-Cal Eligibility Determination

There are three critical fields in the SDX tape record which are necessary in order to determine Medi-Cal eligibility. They are:

	Field Name	Tape	Key Field Contents
a.	Transaction Code	445-446	05, 07, OW
b.	Payment Status	262-264	S06, S08, C01, M01
c.	Medicaid Eligibility Indicator	416	Y

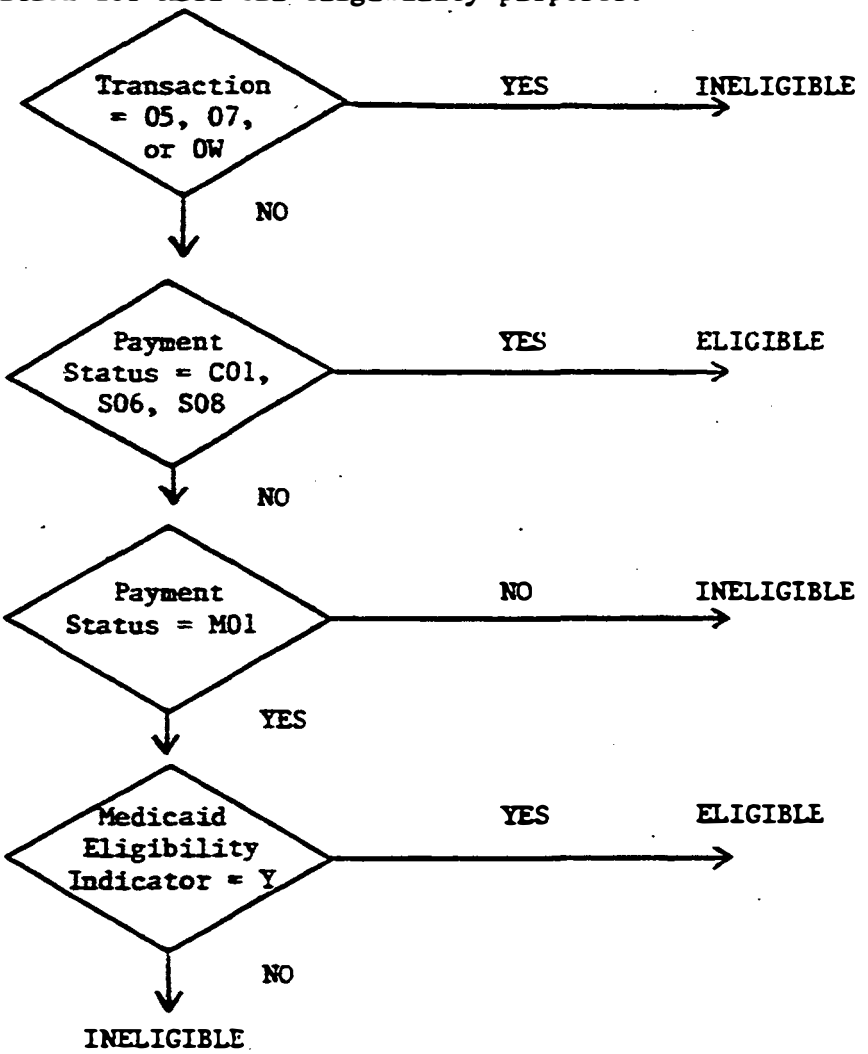
The method to be employed for determination of Medicaid eligibility is as follows:

a. The transaction code must be other than 05, 07, or OW. (Code 05 is an out-of-state move; codes 07 and OW are terminations. Presence of either an 05, 07, or OW code means automatic ineligibility regardless of other data element contents.)

b. Assuming transaction code is acceptable, definite eligibles are those whose Payment Status Code is C01, S06, or S08. (Cards are not sent to S06s as this code is an indication of an address problem.) Persons with Payment Status M01 may or may not be eligible; Medicaid Eligibility Indicator becomes the final key.

c. Persons with an M01 Payment Status (and an acceptable transaction code) are eligible if their Medicaid Eligibility Indicator is Y.

The following flow chart shows the SDX data elements and their interpretation for Medi-Cal eligibility purposes.



8. Use of Form MC 5

Form MC 5 is to be used for reporting specific problem cases to the State. The completed forms will be used in four ways:

a. For Medicare-related problems they will be the basis for a case-by-case research and correction of those problems by the Department's Buy-In Clerical Unit, with federal help as needed.

b. For other problems they will be used as a tool for state and federal analysts to decide how the current systems can be changed to prevent future instances of those problems.

c. In some cases changing the systems to prevent future problems may not correct existing cases with those problems. The forms will be used to identify such problem types, and they will be used as needed on a case-by-case basis to correct the existing cases.

d. As much as is possible with the resources available, the Department will use those forms which report address problems as the basis for address correction of individual cards, on a trial basis.

For the Department to make effective use of the reporting forms, it is extremely important that only system-caused problems are reported. Examples of problems that should not be reported are: card non-receipt because the client is enrolled in a PHP; card nonreceipt because the client has not reported a new address to SSA; or card problems where correcting data has not had time to make its way through the reporting "pipeline".

9. Use of County Staff for New Procedures

To the extent that they can, counties should use available Medi-Cal staff for the problem reporting steps. The more complete the problem reporting is, the better the State and SSA will be able to pinpoint and correct systems defects, and the more effective the case-by-case correction activity will be.

For all cases that report SSI/SSP card problems, counties should decide which cases to refer to SSA district offices, which cases to report to the State, which cases to take Medi-Cal applications on, and which cases to issue temporary Medi-Cal cards for.

10. Periodic Supplemental Security Income/State Supplementary Payment Medi-Cal Card Stuffer

A "stuffer" notice will be sent out periodically with monthly SSI/SSP Medi-Cal cards to help recipients understand what their

role is in preventing or correcting Medi-Cal card errors, what the respective roles of SSA district offices and counties are, and what the time frames involved are. The notice will also be sent out with initial Medi-Cal cards for newly reported SSI/SSP eligibles. The wording of the stuffer is as follows:

IMPORTANT MEDI-CAL CARD INFORMATION FOR SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT RECIPIENTS

- If you change your name or address, please report that change to your Social Security district office. You must also report the change to the Post Office on a Change of Address form to be sure your card continues to arrive each month.

- If you live in an apartment, the Post Office cannot deliver your card unless your name is on your mail box.

- It takes many steps to change information on a Medi-Cal card; so it may be one or two months after you report new or correcting information, before your card is changed. In the meantime, if you need a corrected card, contact your county welfare department.

- If you need medical care and you have received a gold SSI/SSP check for a month but no Medi-Cal card, or you have lost your Medi-Cal card, contact your county welfare department.

- Your Medi-Cal card is valid anywhere in the State of California, regardless of what the address is on the card.

PLEASE KEEP THIS CARD AS A REMINDER

(A Spanish version of this message will be printed on the reverse of the "stuffer".)

14C -- CHANGING COUNTY ID NUMBERS

The following are guidelines which counties must follow when changing the 14-digit county identification (ID) numbers associated with county computer system changes.

County Procedures

A. The county must submit written notification requesting a change to the 14-digit Medi-Cal ID number to the State Department of Health Services, Medi-Cal Eligibility Branch, Att: MEDS Liaison, 714 P Street, Room 1692, Sacramento, CA 95814.

   - The notification letter must be received four months prior to the implementation date. This time frame is based upon the processing due dates indicated in these guidelines.

B. The county must submit a cross-reference file tape for testing purposes to the State Department of Health Services, Data Systems Branch, 744 P Street, Room 1100, Sacramento, CA 95814. The tape must contain an external tape label and/or transmittal which clearly identifies it as a test file and indicates the contents of the tape, the number of records, and the address to which the tape is to be returned. The name and telephone number of the technical contact person should also be included in the event that a problem with the tape should arise.

   1. The cross-reference file test tape must be received by Data Systems Branch (DSB) two months prior to the implementation date in order to evaluate the test tape and prepare a test file tape for California Dental Services (CDS) and Computer Sciences Corporation (CSC). However, it is recommended that receipt of the test tape be as early as possible.

   2. The cross-reference file test tape submitted to DSB must be in the format specified in Attachment I and must contain the following characteristics in order for it to be processed.

      a. IBM compatible.

      b. Nine-track tape with 6250 or 1600 BPI.

      c. Standard label (no other internal labels necessary).

      d. EBCDIC coding.

      e. Blocking factor of 100 is recommended.

3. The cross-reference file tape submitted to DSB for testing must only contain information on active recipients. (Active recipients consist of continuing eligible recipients, recipients in HOLD status, and recipients eligible with a share of cost (SOC) whether or not the SOC has been met.)

4. If the cross-reference file test tape submitted to DSB is not acceptable, the county welfare department (CWD) will be contacted via a telephone call by DSB describing the invalid data.

5. The county will submit a corrected cross-reference file test tape to DSB until the tape is accepted and approved by the Department.

C. If the cross-reference file test tape submitted to DSB is acceptable, the CWD will be contacted via telephone by their MEDS liaison approving the change to the 14-digit identifier and indicating the exact date the production cross-reference file is needed.

- o A production cross-reference file tape will be submitted to DSB using the address indicated above, one month prior to the implementation date.

D. The county must submit a Batch EW30 tape for testing purposes to the State Department of Health Services, Data Guidance, 744 P Street, Room 1050, Sacramento, CA 95814. The tape must be submitted two months prior to the implementation date in order to evaluate the contents and format.

1. The Batch EW30 transactions must contain the following data elements in order for them to be processed by MEDS Support:

   a. New County ID

      (1) Aid code.

      (2) Serial number.

      (3) FBU.

      (4) Person number.

   b. Eligibility information effective date (ELIG-INFO-EFF-DATE) (must be upcoming month).

c. Eligibility Status Action Code (ESAC)

(1) If recipient will be in HOLD status for upcoming month, the ESAC must be B.

(2) If the recipient is a normal eligible for the upcoming month, ESAC must be a one.

(3) If the recipient is a Four Month or Nine Month Continuing eligible for the upcoming month, the ESAC must be one or six and additional data elements are required depending on the following:

(a) Four Month Continuing (Aid Code 39 or 54)

ESAC Six.

TERM DATE and TERM REASON.

(b) Nine Month Continuing (Aid Code 55 or 59)

ESAC One.

No TERM DATE or TERM REASON.

Note: Any existing TERM DATE and TERM REASON on MEDS will be erased.

or,

ESAC Six.

TERM DATE and TERM REASON.

d. LTC indicator (LTC-IND) (if upcoming month is LTC/SOC).

e. SOC-AMOUNT (if upcoming month has SOC).

f. District and EW code (if used by county) for distribution of eligibility worker alert reports.

2. The Batch EW30 test tape submitted to MEDS Support must only contain information on active recipients. (Active recipients consist of continuing eligible recipients, recipients in HOLD status, and recipients eligible with an SOC whether or not the SOC has been met.)

3. If the Batch EW30 test tape submitted to DSB is acceptable and eligibility information is valid, the CWD will be contacted via telephone by their MEDS liaison approving the change to the 14-digit Medi-Cal ID number.

4. If the Batch EW30 test tape is not acceptable and eligibility information is invalid, the CWD will be contacted via telephone by the DSB staff describing the invalid data.

5. The county must submit a corrected Batch EW30 test tape until the file is accepted and approved by the Department.

E. A Production Batch EW30 must be submitted to the Department of Health Services, Data Guidance, 744 P Street, Room 1050, Sacramento, CA 95814. Please coordinate with your MEDS liaison for the exact date to submit the Production Batch EW30.

DATE: 5-25-85
REVISION:
SYSTEM/PROJECT:

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
RECORD LAYOUT
FILE NAME: BENEFICIARY ID CROSS-REFERENCE RECORD

ORIGINATOR: KELLEY KLEMIN
REVIEWER:
SOURCE PROGRAM:

OLD BENEFICIARY ID					NEW BENEFICIARY ID					REDS' ID	BENEFICIARY	
COUNTY	AID CODE	CASE NUMBER	SEQ	SUFFIX	COUNTY	AID CODE	CASE NUMBER	SEQ	SUFFIX		SURNAME	FIRST INITIAL

NAME			SOURCE CODE	DATE OF BIRTH			FILLER
FIRST NAME (CONT.)		M.I.		MM	DD	YY	

SOURCE CODE (BYTE 061): MUST CONTAIN AN "X" TO INDICATE AN XREF RECORD.

(THIS RECORD FORMAT IS VALID ONLY FOR CROSS-REFERENCE FILES RECEIVED FROM THE COUNTIES AND SENT TO CALIFORNIA DENTAL SERVICE. IT IS NOT COMPATIBLE WITH THE XREF RECORD SENT TO COMPUTER SCIENCES CORPORATION.)

MODE: BINARY - B [ ]
PACKED - P [ ]
LABELS: STANDARD [X]
NON-STANDARD [ ]
RECORD FORMAT: FIXED - F [X]
VARIABLE -V [ ]
RECORD LENGTH: 86
RECORDS PER BLOCK:
BLOCK SIZE:
PROGRAM: N/A
USE: INPUT [ ]
OUTPUT [ ]
(SOURCE: HOKKLEM:CDSXREF RECORD)

14D -- VERIFICATION OF MEDI-CAL ELIGIBILITY

Counties are required to provide either proof of, or verification of, Medi-Cal eligibility to Medi-Cal providers under certain circumstances. The following procedure defines the circumstances under which verification/documentation of eligibility must be provided and the county's responsibilities in providing such information.

A. Medi-Cal Providers

Counties are to verify eligibility and provide limited beneficiary eligibility information to all providers of Medi-Cal services upon request. However, only county welfare departments and their outstationed staff may have access to Medi-Cal Eligibility Data System (MEDS) terminals for inquiry and update of eligibility information. In addition, counties cannot provide MEDS printouts to any provider, nor proof of eligibility (POE) labels to any provider except for deceased beneficiaries and as described in B below.

When a provider requests beneficiary information, the county should obtain the provider's name, telephone number, and enough information to identify the beneficiary. This information must be sufficient to assure the county that there is no question as to the identity of the beneficiary before it releases any information.

Typically, providers will request the beneficiary's county ID number and/or verification of eligibility for a specific month to enable them to bill the Medi-Cal program for services rendered.

If the provider is unable to furnish the beneficiary's birth date or Social Security number, but is able to provide sufficient information to identify the beneficiary (i.e., beneficiary's name and home address), the county may release the following beneficiary information:

1. County ID number (14 digits).
2. Date of birth.
3. Eligibility status for requested month(s) (e.g., eligible, ineligible, share-of-cost amount, long-term care status).
4. Other health coverage.
5. Restricted status (if applicable).
6. Medicare coverage (if applicable).

The county is not to release information concerning an ineligible individual other than the fact that he/she is not eligible for Medi-Cal for a specific month.

Counties may issue current or past month POE labels for a beneficiary who is now deceased to any Medi-Cal provider who provided a service.

B. General Acute Care Hospitals and Licensed Primary Care Clinics (PCCs)

In addition to the eligibility information which must be provided to any provider of Medi-Cal services, county welfare departments are required by Section 14018.4, Welfare and Institutions (W&I) Code, to issue a POE label to a general acute care hospital or licensed PCC which meets specified conditions.

1. Definitions

a. General acute care hospital means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. A general acute care hospital may include more than one physical plant maintained and operated on separate premises as provided in Section 1250.8. A general acute care hospital which exclusively provides acute medical rehabilitation center services, including at least physical therapy, occupational therapy, and speech therapy, may provide for the required surgical and anesthesia services through a contract with another acute care hospital. In addition, a general acute care hospital which, on July 1, 1983, provided required surgical and anesthesia services through a contract or agreement with another acute care hospital may continue to provide these surgical and anesthesia services through a contract or agreement with an acute care hospital. (Health and Safety Code, Section 1250 (a))

b. Licensed PCC includes a community clinic, which means a clinic operated by a taxexempt, nonprofit corporation which is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions. In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale; and

A free clinic, which means a clinic operated by a taxexempt, nonprofit corporation supported in whole by voluntary donations, bequests, gifts, grants, government funds or contributions. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. (Health and Safety Code, Section 1204)

County and other governmentally operated clinics do not meet the definition of a licensed PCC.

2. Conditions for Issuance

POE labels are to be provided to general acute care hospitals and licensed PCCs upon request when all the following conditions are met:

a. The hospital, PCC, or authorized billing agent submits each request or listing with a cover letter on hospital or PCC letterhead, signed by an official authorized to act on behalf of the hospital or PCC, which certifies that the following provisions of W&I Code, Section 14018.4, have been met:

(1) The hospital or PCC unsuccessfully attempted to obtain a label from the beneficiary at the time the services were provided.

(2) The hospital or PCC made a subsequent attempt to obtain a label or other appropriate documentation from the beneficiary.

If the hospital or PCC utilizes a billing agent, the letter must certify that the billing agent is empowered to act on behalf of the provider.

b. The beneficiary was eligible for Medi-Cal in the county in the month for which the POE is requested.

c. The request is for a POE within one year of the month of service, except when:

(1) Eligibility was delayed and later granted due to corrective action on state or county administrative error, fair hearing decision, or court order; and

(2) The hospital or PCC requests the POE label within two months after eligibility was granted.

3. Request Format

Hospitals and PCCs have been informed that each request should contain:

a. Beneficiary name.

b. Beneficiary ID number (for month(s) of service).

c. Social Security number.

d. Sex.

e. Date of birth.

f. Address (current and at time of service, if known to be different).

g. Month(s) of service.

If the hospital or PCC is unable to provide all the specified information, the county must ensure that the information provided is sufficient to positively identify the beneficiary before it provides a POE label.

14E—LETTER OF AUTHORIZATION (LOA)/MC 180 PROCESS

The county welfare department shall not issue a Letter of Authorization (LOA) original numbered MC 180 except as provided by Section 50746. Section 50746 limits issuance of LOA/MC 180 to: 1) those Medi-Cal beneficiaries whose Supplemental Security Income/State Supplementary Payment (SSI/SSP) eligibility was approved but the California Department of Health Services (CDHS) did not or could not update the Medi-Cal Eligibility Data Systems (MEDS), 2) court ordered, 3) state or other administrative hearing decisions, 4) county administrative errors, 5) and State CDHS request.

According to Section 50746 of Title 22 of the California Code of Regulations, a county shall not provide a LOA to any Medi-Cal beneficiary more than one year subsequent to the month of eligibility, unless one of the five conditions are met. The purpose of the LOA is not to provide documentation for late provider billing, but rather late eligibility determinations. Hence, the issuance of the LOA must be directly related to the time of late eligibility determination.

The issuance of an LOA is an exception in federal law for a provider to submit a claim one year after the date of service. Therefore, an inappropriate issuance of an LOA causes an inappropriate claim for payment to be submitted to the federal government. Under the federal False Claims Act (31 U.S.C.A. § 3729), the federal government can bring civil action against persons who knowingly present a false or fraudulent claim for payment. Penalties include treble the amount of damages caused plus a penalty of $5000 to $10,000 for each false claim. The government does not have to prove specific intent to defraud. A person may be liable if he or she has actual knowledge of the false claim, or acts in deliberate ignorance or in reckless disregard of the truth or falsity of the relevant information.

1. LETTER OF AUTHORIZATION/MC 180 ISSUANCE FOR SSI/SSP RECIPIENTS ONLY

The period of SSI/SSP-based Medi-Cal eligibility begins with the month SSI/SSP cash assistance payment should have been paid. This is usually the month following the month of application if the person was found eligible in that month. In case of a disabled individual under the age of 21, who applies for SSI/SSP in or after February 2007, Medi-Cal eligibility begins with the month of SSI/SSP application if the child was found eligible in that month even though no cash payment was issued for that month. However, the Medi-Cal Eligibility Data System (MEDS) may not automatically update due to CDHS interface problems with Social Security Administration or when SSI/SSP retroactive benefits exceed 13 months. Since the person was entitled to Medi-Cal eligibility, but CDHS did not add, or could not add, eligibility to MEDS, this is considered a state administrative error.

Before issuing an original numbered LOA/MC 180 to an SSI/SSP recipient who requests a LOA more than one year after the date of service, the county must ensure that the claimant was eligible for SSI/SSP in the month for which a request is being made. The claimant must obtain from Social Security proof of his/her SSI/SSP eligibility for the month in question. (See Section 50167 (a)(1)(B) for examples of acceptable proof of SSI/SSP eligibility). The documents most often provided pursuant to this section would be an “award letter” or a letter from the Social Security Administration containing the information from the award letter.

Please note, a request for MC 180(s) must be timely as described under 3, paragraph 6.

2. DEFINITION OF ADMINISTRATIVE ERROR

As mentioned above, one of the reasons listed in Section 50746 for issuance of an LOA/MC 180 for billing beyond the one-year limit is if an administrative error occurred. An administrative error is defined as an erroneous action, or a required action not taken, which resulted in the failure of the county or the state to provide a Benefits Identification Card (BIC) along with adding eligibility to MEDS within one year of the date of service when the eligibility determination has been conducted in accordance with state regulations, policy and procedures.

Some examples of acceptable administrative errors include the following:

- Failure of the county welfare department to approve a Medi-Cal application by a potentially eligible individual due to legitimate errors made in the course of determining eligibility (e.g., an applicant was denied, but should have been approved, and did not file an appeal, or an applicant's file was misplaced and eligibility was never determined.)

- Failure to mail the BIC to the correct address because the MEDS address was not updated in a timely manner after the beneficiary had reported a change in address.

- The county updates Medi-Cal eligibility on MEDS within one year, but eligibility is incorrectly established on a restricted aid code instead of full scope benefits. Consequently, providers could not bill for non-restricted services for which a beneficiary was entitled (e.g., MEDS shows a Medically Indigent/Long-Term Care (53) aid code and the applicant was eligible for acute care services in that month under another aid code).

It is not possible to list all examples of an administrative error. If the county is unsure whether a particular situation meets the definition of an administrative error, the Medi-Cal Eligibility Branch should be contacted for clarification.

3. ADMINISTRATIVE ERROR PROCEDURES

Whenever an administrative error occurs, it must be documented and described fully in the case file or county automated system journal as soon as possible after the error has occurred or has been identified.

Counties must take precautions to ensure that case-processing delays, which are the result of routine errors in filing, photocopying, etc, do not contribute excessively to the incidence of administrative errors.

It is usually a request from a beneficiary for an LOA/MC 180 to pay for bills more than one year after the date of service that starts the process to determine if an administrative error occurred. However, there are situations, as limited by Procedures Section 14D, in which a request from an acute care hospital or primary care clinic can generate an administrative error determination. Participating providers can easily obtain eligibility information on any Medi-Cal patient up to 13 months (current month and previous 12 months) through the Automated Eligibility Verification System. This should help providers obtain eligibility information timely and thereby avoid having to request an LOA because of an administrative error determination at a later date.

Should the county find that an administrative error has occurred, an original numbered LOA/MC 180 must be completed with the "administrative error" line checked, and a description of the administrative error given, with the appropriate provider and case information provided (Client Identification Number (CIN), application date, eligibility worker's name, phone, and etc.). The LOA/MC 180 that is given to the beneficiary (for the provider) must bear the original signature of the county authorized staff person. Photocopies will not be accepted.
A category exists to accommodate Social Security Administration decisions that approve SSI/SSP benefits for periods beyond a year when SSI/SSP based Medi-Cal benefits are to be issued beyond the one-year limit.

The beneficiary should request a Medi-Cal LOA/MC 180 within six months of the decision or four months from date of State Data Exchange update. This requirement is explained on the form MC 19 mailed to all new SSI/SSP recipients. Exceptions due to unusual circumstances should be referred to Medi-Cal Eligibility Branch.

If the county finds that an administrative error does not exist in a particular situation, but extenuating circumstances exist beyond the beneficiary's or the county's control, the county may contact the Medi-Cal Eligibility Branch for assistance. Please be advised that billing problems are not by themselves considered an extenuating circumstance. Furthermore, beneficiaries who are sent to collections after presenting their BIC to the provider should be told that Welfare and Institutions Code, Section 14019.4 precludes a provider from billing the beneficiaries in these situations.

An example of extenuating circumstances beyond a beneficiary's control would be a medical condition that severely impaired his/her functioning. Additionally, the beneficiary would need to describe how this reduced function prevented him/her from giving the provider(s) the necessary documentation of his/her Medi-Cal eligibility.

The Medi-Cal Eligibility Branch will evaluate whether an LOA/MC 180 can be issued pursuant to Title 22, CCR, Section 50746 (a)(4), which provides for an LOA/MC 180 to be issued by CDHS request. The procedure to seek CDHS authorization for issuance in these cases is as follows:

- The request must be written on county letterhead;
- It must list chronologically the sequence of events in the processing of the case and the circumstances surrounding the error;
- It must carry the original signature of a County Welfare Department Director or his/her CDHS-approved designee (photocopied signatures will not be accepted); and;
- The request must be accompanied by an original LOA/MC 180 for each provider. However, in the event that one provider is billing for services for more than one month, one original LOA/MC 180 is sufficient.
- To insure proper use of this form, please cross out any months/years that are not being requested or not being used on the LOA for Medi-Cal billings.

In the event that CDHS, upon consideration of the request, authorizes issuance of an LOA/MC 180, the LOA(s) will be signed by an authorized CDHS staff person and returned to the county.

4. LOA/MC 180 RETENTION

Standard retention policies provided in Procedure Section 2G apply. A case copy and supporting eligibility documentation must be retained at the County Welfare Department (CWD). When the LOA/MC 180 is for a beneficiary in an active public assistance case, the county must file a copy of the LOA/MC 180 with supporting documentation in the county case record. When the LOA/MC 180 is for a beneficiary whose public assistance case has been closed prior to the month of the LOA/MC 180, the LOA/MC 180 and supporting documents must be retained in a central file that is accessible for audit purposes. This action prevents the forms and documents from being purged too early based on the case closure date.

In those situations in which an LOA/MC 180 is issued for a beneficiary (such as an SSI/SSP recipient) who does not have a county public assistance case, a central file must be retained for future review that includes a copy of the LOA/MC 180 and documentation that supports the issuance of the LOA/MC 180.

5. LOA/MC 180 LOG

If LOAs are being distributed by more than one office in the county, it is mandatory that a central log be maintained that identifies all issued LOAs. Counties can create their own LOA LOG, but must contain the minimum following information.

- LOA Document Number
- Issuance Date of LOA/MC 180
- First and last name and middle initial if appropriate of LOA beneficiary
- CIN of LOA beneficiary
- Month/Year of Requested Medi-Cal Billing
- Filing location of LOA/MC 180 and supporting documentation, that is in CWD case file (include CWD Case Number) or in Central LOA/MC 180 file.

The LOA/MC 180 document stock should be maintained in a secured area until the forms are issued to beneficiaries

*MC 180 LOG

County Name: _____ District Name: _____

MC 180 Number	Beneficiary Name	Case # or CIN #	Date of Issuance	Comments
1).				EX: SSI approved retroactively per verification received from SSA. Issuing LOA at Client's request for months with medical bills outstanding.
2).				
3).				
4).				
5).				
6).				
7).				
8).				
9).				
10).				
11)				

*This is an example form only and is not maintained by DHS. Counties may use this format or create their own form as needed.

6. LOA/MC 180 FORM COMPLETION

Individual LOA/MC 180 forms are to be completed for each provider from whom the Medi-Cal beneficiary has received services that are to be billed under the LOA/MC 180 process. The form has been designed so that more than one month can be listed on the form. Line through any MO/YR spaces that are not needed and do not leave any blank spaces. The copy with the original CWD signature is to be given to the beneficiary. The bottom case copy is to be retained in the county case file or in the central file when a county case is not available.

- Issuance Date of LOA/MC 180- this is the date the form is being completed and signed
- Provider name – this information is listed in the left top corner of the form (optional)
- Provider Number (optional)
- Beneficiary name and address
- Issuing County – this information is listed in the right top corner of the form
- CIN/Pseudo No. - this is the client identification number or MEDS Pseudo
- COUNTY I.D.- this is the county ID that should have been assigned based on MEDS requirements.
- Date of Approval – SSI only
- Worker Name – when there is no current worker, this should be the name of the person signing the form
- Worker File Number – when there is no current worker, leave blank
- Worker Telephone Number – when there is no current worker, this should be the number of the person signing the form.
- Other Health Coverage Code – enter the appropriate code based on MEDS requirements.
- Check appropriate Reason Box for LOA issuance. If CDHS requests issuance, an original signature of authorized CDHS staff person is needed. If an Administrative Error has occurred, a description must be listed
- Signature – authorized CWD official

The bottom of the form contains the address of the Electronic Data System Federal Corporation. All LOA/MC 180 forms are to be sent to this corporation by the provider.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

ELIGIBILITY LETTER OF AUTHORIZATION

Document Number

Issuance Date of MC-180: _____ Date

Provider Name _____

Provider No _____

Beneficiary's Name, Address, City, State and Zip

BENEFICIARY NAME

ADDRESS

CITY STATE ZIP

Issuing County:
SSN / Pseudo No /CIN No.:
County I.D.:
Date of Approval (SSI only):
* Worker's Name:
* Worker's Number:
* Worker's Telephone #:
Other Health Coverage (Code):

MEDI-CAL BILLING FOR:

Mo. / Yr.	Mo. / Yr.	Mo. / Yr.	Mo. / Yr.
Mo. / Yr.	Mo. / Yr.	Mo. / Yr.	Mo. / Yr.
Mo. / Yr.	Mo. / Yr.	Mo. / Yr.	Mo. / Yr.

This original numbered MC-180 is approval for Medi-Cal providers to bill services provided to you during the above referenced months. An MC-180 is being issued in accordance with Title 22, California Code of Regulations (CCR) Section 50746. This regulation permits county welfare departments to issue documentation of eligibility which can be used by beneficiaries for periods more than one year after the month of service as a result of one of the following reasons:

1. ☐ SSI/SSP eligibility was approved for a retroactive period but cards were not issued by the California Department of Health Services.
2. ☐ A court order requires that Medi-Cal be issued.
3. ☐ A State Hearing or other administrative hearing decision requires that Medi-Cal be provided.
4. ☐ The California Department of Health Services requests that Medi-Cal be issued. (Original signature of an authorized CDHS staff person: _____).
5. ☐ An Administrative Error has occurred.
(Description) _____

Please immediately give your doctor or other medical provider this form for the applicable month(s)/year(s) of service.

If you were provided services by more than one doctor or provider, please contact your local welfare office immediately to obtain additional original form(s).

INSTRUCTIONS TO PROVIDER
Submit this form, along with the claim(s), to:

EDS Federal Corporation
Attention: Over-One-Year-Unit
P.O. Box 13029
Sacramento, CA 95813-4029

If this service you are billing for requires a Treatment Authorization Request (TAR) you must still send your TAR request along with this form to the Medi-Cal Field Office. After approval you must send them both to the address above. This form does not override the TAR process.

_____
(Original Signature of Authorized County Administrative Staff)

* This information is not needed when eligibility is established by the Social Security Administration.

MC180 (2/06)

County Copy