STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

June 22, 1984

To: All County Welfare Directors Letter No. 84-24

BRU PHASEOUT; MC 177s RETURNED FOR CORRECTIONS

BRU Phaseout:

This is to inform you that certain functions currently performed by the Benefits Review Unit (BRU) are being automated. The share-of-cost claims clearance functions will be automated and transferred to the fiscal intermediary by July 1985, while the share of cost certification function was transferred to Data Systems Branch/System Support Section (DSB/SSS) effective May 1, 1984. During 1984, the number of staff at BRU is being drastically reduced due to this transfer. In 1985 the remaining function, clearance of SOC claims, will be automated and transferred to the Medi-Cal fiscal intermediary (Computer Science Corporation). During and after this phaseout period, various procedural changes will be taking place and counties will be notified by "all county letters" as the changes occur.

One such change relates to BRU's decreasing ability to respond to telephone inquiries due to staff reductions. We are asking that county personnel exhaust all alternative information sources before attempting to contact BRU. With full statewide implementation of MEDS, all counties now have the capability of obtaining the most current information available via their MEDS terminal. In the future, BRU will have no additional information, such as date of card issuance or cert day, other than that which appears on MEDS.

Therefore, counties should utilize their own records and MEDS inquiries to answer client or provider questions. Problems with MEDS should be referred to your Eligibility Branch MEDS liaison (see ACL 84-16) and Medi-Cal Eligibility questions should be directed to the appropriate contact in the Eligibility Branch Policy Section (see ACL 83-72).

Returned MC 177s

In an effort to facilitate more timely processing of MC 177s and due to the staffing decrease, the following procedure is being implemented regarding the return of MC 177s for corrections.

Effective immediately, Form MC 2002 will, in most cases, no longer be used to transmit MC 177s to counties for corrections. In cases where the State is attempting to certify a share-of-cost (SOC) case on MEDS and the transaction

fails batch edits, the MC 177 will be returned to the county along with a copy of the MEDS 5.1.1.1 report (see attached example). The report lists the information entered on the transaction, the conflicting data field contents and the error message for each transaction. DSB/SSS will review the error reports to ensure that the reject is not due to key entry error prior to returning the reports to the county. Only rejected transactions will appear on these reports. The records of family members which were accepted for card issuance will be lined out on the MC 177. Report entries requiring no county action will be crossed out. (Please note that the title of the report is currently "State Worker Alert". However, a future programming change may alter the title as well as sequencing of the records. The records are currently listed in alphabetical order.)

The MC 2002 will continue to be used where no MEDS report is available; for example, for transactions rejected by on-line edits or when erroneous entries or omissions are identified prior to key entry.

If either an MC 2002 or a MEDS error report is received with an MC 177, counties should take prompt action to correct the MC 177s and/or MEDS, as appropriate, and return the MC 177 to the State as soon as possible. In addition, if the county is aware that for any reason a SOC case cannot be certified on MEDS, a notation should be made on the MC 177 so that certification will not be attempted on MEDS. For example, MEDS does not allow a change from a non-share-of-cost aid code to a share-of-cost aid code in the same month. Therefore, the following or similar notation should be made on the MC 177: "Do not attempt to certify this case through MEDS." In this example, the county has the choice of hand typing the card or requesting issuance through CID. This should also be noted on the MC 177.

We feel these procedures, with your assistance, will facilitate processing of MC 177s as we continue to phase down BRU staff. If you or your staff have any questions regarding this letter, please contact Russ Hart of my staff at (916) 322-3463.

Sincerely,

Original signed by

Odette Nicoll for
Caroline Cabias, Chief
Medi-Cal Eligibility BranchS

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

STATE OF CALIFORNIA — DEPARTMENT OF HEALTH

REPORT NO	REPORT DATE	.....TITLE.....
5.1.1.1	04/06/84	STATE WORKER ALERT

CASE NAME		PERSON NAME		BIRTHDATE
HU[redacted]ON	,DANI	HU[redacted]ON	DANIEL	09/21/946

SOURCE	TRANS	DATE	DATA FIELD.....	DATA FIELD CONTENTS.....
2U0H	BR30	04/04/84	0412 AID-CODE FEB	30
			0432 ELIG-STAT FEB	001

CASE NAME		PERSON NAME		BIRTHDATE
JE[redacted]NS	,JE[redacted]	JE[redacted]NS	JE[redacted]IE	03/31/918

SOURCE	TRANS	DATE	DATA FIELD.....	DATA FIELD CONTENTS.....
2U0H	BR30	04/04/84	0433 ELIG-STAT MAR	999

.....COUNTY.....
FRESNO

COUNTY ID 10-37-04[redacted]07-0-01
MEDS ID 568-60-[redacted]1

. MESSAGE..... STATUS..

4206 SOC CERT INVALID FOR RECIPIENT WITH NO SOC ON FILE REJECT

COUNTY ID 10-17-04[redacted]69-0-02
MEDS ID 548-28-[redacted]1

. MESSAGE..... STATUS..

4208 RECIPIENT NOT ELIGIBLE ON MEDS FOR CERTIFICATION MONTH REJECT

I-CAL PROGRAM
ORD OF HEALTH CARE COSTS - SHARE OF COST

MC 177-SA-M (4)

Attachment

READ INSTRUCTIONS ON BACK BEFO COMPLETING.

Only Medical expenses in the following month may be listed below.	Share of Cost: The amount that you must pay or obligate is:	Page Of	Retro. Elig?
02-84 (Mo. Yr.)	$ 125.00		NO (Yes/No)

COUNTY OF FRESNO

CASE NAME - HUXXXXON, DANIEL

DANIEL HUXXXXON
501 SOCK AVENUE
FRESNO, CA 93700

WELFARE DEPARTMENT
COUNTY OF FRESNO
4455 EAST KINGS CANYON ROAD
FRESNO, CA 93750

COUNTY CODE
10

Medical expenses of family members listed below may be used to meet Share of Cost

State Number: Aid	State Number: 7 Digit Serial No.	State Number: FBU	State Number: Pers	Name - Last, First	B	A	Birthdate Mo. Day Yr.	Sex	Other Cov. Code	Social Security No.	HIC or RR No.
37	04XXX87	0	01	HUXXXXON, DANIEL			09-21-46	M	N	568-60-XXX1	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I received payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will neither claim nor accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient"

I understand that the amount to be reimbursed by insurance or any other third party for the service rendered cannot be listed on this form.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME / PROVIDER NO.	DATE OF SERVICE MO. DAY YR.	SERVICE	PROC. CODE/ PRESC. NO	TOTAL BILL	BILLED PATIENT	BILLED MEDI-CAL
Fresno Provider Inc. / GR00000	2 13 84	A-Scan	76510	$ 75	$ 75	$ 0
PATIENT NAME: Daniel Hu[redacted]on	2 14 84	Cat + IOL	66980	2150	100	2050.00
PROVIDER SIGNATURE (SEE DECLARATION ABOVE): Melvin Williams						
PROVIDER NAME / PROVIDER NO.						
PATIENT NAME						
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)						
PROVIDER NAME / PROVIDER NO.						
PATIENT NAME						
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)						
PROVIDER NAME / PROVIDER NO.						
PATIENT NAME						
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)						

D. DAY YR.	REVIEWED BY:	TRANS	REFUSE
TIFICATION			

I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed above in the "Billed Patient" column.

X Daniel Huxxxxon
SIGNATURE OF APPLICANT

2/14/84
DATE

177-SA-M (4) (5-82)

READ INSTRUCTIONS ON BACK OF THIS FORM BEFORE COMPLETING.

RD OF HEALTH CARE COSTS - SHARE OF COST

MC 177-SA-M (4)

Attachment

READ INSTRUCTIONS ON BACK BEF[illegible] COMPLETING.

Only Medical Expenses in the following month may be listed below.	Share of Cost: The amount that you must pay or obligate is:	Page / Of	Retro. Elig?
03-84 (Mo. Yr.)	$ 34.00	1 / 1	NO (Yes/No)

COUNTY OF FRESNO

CASE NAME - Je[illegible]ns, Je[illegible]ie

JE[illegible]IE JE[illegible]NS
123 C St
FRESNO
CALIFORNIA 937[illegible]

WELFARE DEPARTMENT
COUNTY OF FRESNO
4455 EAST KINGS CANYON ROAD
FRESNO, CALIFORNIA 937[illegible]

COUNTY CODE: 10

Medical expenses of family members listed below may be used to meet Share of Cost

State Number: Aid	7 Digit Serial No.	PBU	Pers	Name - Last, First	B	A	Birthdate: Mo. Day Yr.	Sex	Other Ins. Code	Social Security No.	HIC or RR No.
17	04XXX69	0	02	JE[illegible]NS JE[illegible]IE			03-31-18	F	N	548-28-XXX1	

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I received payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will neither claim nor accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that the amount to be reimbursed by insurance or any other third party for the service rendered cannot be listed on this form.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

VIDER NAME	PROVIDER NO.	DATE OF SERVICE: MO.	DAY	YR.	SERVICE	PROC. CODE/ PRESC NO.	TOTAL BILL	BILLED PATIENT	BILLED MEDI-CAL
oseph M. Provider, M.D.	A-00000	3	15	84	Internal Med Visit	90050	$ 31.00	$ 31.00	$ 0
PATIENT NAME: Je[illegible]ie Je[illegible]ns		3	15	84	EKG With Interp	93000	48.00	3.00	45.00
PROVIDER SIGNATURE (SEE DECLARATION ABOVE): Joseph M Provider MD									
VIDER NAME	PROVIDER NO.								
PATIENT NAME									
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)									
VIDER NAME	PROVIDER NO.								
PATIENT NAME									
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)									
VIDER NAME	PROVIDER NO.								
PATIENT NAME									
ER SIGNATURE (SEE DECLARATION ABOVE)									

DAY	YR.	REVIEWED BY:	TRANS	REPLACE

I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed above in the "Billed Patient" column.

X Je[illegible]ie Je[illegible]ns — 3/15/84

SIGNATURE OF APPLICANT — DATE

READ INSTRUCTIONS ON BACK OF THIS FORM BEFORE COMPLETING