

## DEPARTMENT OF HEALTH SERVICES

1744 P STREET  
SACRAMENTO, CA 95814

April 15, 1985

TO: All County Welfare Directors  
County Administrative Officers

Letter No. 85-28

JOHNSON V. RANK (USDC, N.D., NO. 84-5979 SC)

Reference: Title 22, California Administrative Code (CAC)  
Sections 50655-50659 and Title 42, Code of Federal  
Regulations (CFR) Section 435.832(c)(4)

On March 22, 1985, the United States District court in San Francisco issued a court order in Johnson v. Rank which mandated the Department of Health Services to develop procedures whereby long term care (LTC) individuals can deduct necessary noncovered medical expenses from their monthly Share of Cost (SOC). The court-ordered deadline for implementing this change is May 1, 1985.

Currently, individuals in LTC normally pay their total monthly SOC to the convalescent hospital. Under the Johnson v. Rank court order, LTC beneficiaries will be able to use necessary medical or remedial items and services which are not covered and/or paid for by the Medi-Cal program or any other third party payor, to help offset their share of cost. Any remaining SOC is paid to the LTC facility.

IMPLEMENTATION PROCEDURES

The Department of Health Services will send an information notice (form ID-104) describing the new SOC procedures to all individuals who are reported as LTC/SOC eligible for May 1985 month of eligibility on MEDS. Counties, therefore, need not send a beneficiary notice for ongoing (May 1985) eligibles. A copy of the beneficiary information notice is included with this letter as Attachment I.

Beginning in May 1985, counties will be required to issue the information notice to each new LTC/SOC beneficiary. Additionally, at the time of application, counties are required to fully explain this process to all new LTC beneficiaries, or the persons acting in their behalf. The information notice should also be forwarded to LTC beneficiaries as part of the annual redetermination process. The notice will refer LTC/SOC beneficiaries to their eligibility workers for questions, information and assistance.

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County Administrative Officers

An initial supply of the beneficiary notice has been included with this All County Letter. Additional copies may be ordered using current Department forms ordering procedures.

The (state issued) Medi-Cal card showing the total SOC will continue to be mailed monthly to all LTC Medi-Cal beneficiaries with a SOC, including Medically Indigent Adults (aid code 53). The LTC facility will bill the beneficiary on the first of the month for the total SOC indicated on the Medi-Cal card. From this total SOC collected, the LTC facility will pay for non-covered prescription drugs, noncovered therapeutic services and "other" necessary noncovered medical and remedial items and services which the beneficiary receives during the month.

The facility will be required to record these necessary non-covered services on form DHS 6114. This form identifies the beneficiary, the service received, the providers and the amounts paid for the specified services. The form will be maintained in the beneficiary's file at the LTC facility for subsequent post audit by the Department. The beneficiary, or someone acting on the beneficiary's behalf, will sign the form attesting to receipt the services listed.

Enclosed for your information is a copy of form DHS 6114 (Attachment II) and the provider bulletin which explains this new process (Attachment III).

The claim for payment which the LTC facility submits to the State at the end of each month, will be adjusted by the facility to reflect the difference between the SOC collected at the beginning of the month, and the amounts subsequently paid for noncovered services.

Following is an example of this process:

On May 1, the LTC beneficiary is issued a Medi-Cal card which indicates a \$200.00 SOC. In early May, the convalescent hospital collects the \$200.00 SOC from the beneficiary. During May, the beneficiary receives \$15.00 worth of noncovered prescription drugs, and \$20.00 worth of noncovered therapeutic services. The bills for these services are submitted to the convalescent hospital, which, in turn pays the providers and documents such payment. At the end of the month, the LTC facility bills the Medi-Cal program and indicates on the LTC claim form the SOC amount applied toward the facility charges. In this example, the LTC facility would indicate \$165.00 as the remainder of the SOC amount after payment of necessary non-program covered medical services. The above process would occur each month the beneficiary is eligible and receives necessary noncovered services.

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County Administrative Officers

Should you or your staff have questions regarding this policy,  
please contact Marie Harder at (916) 324-4956; for procedural  
questions, contact Karla Gurley of my staff at (916) 445-2759.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief  
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons  
Medi-Cal Program Consultants

Expiration date: August 1, 1985

Medi-Cal Identification Number (Taken from the Medi-Cal Card)													
<div style="text-align: center;">1</div>													
AID		7 DIGIT SERIAL NO.						FBU		PERS			

Month of Eligibility	Share of Cost (SOC)
<div style="text-align: center;">2</div>	<div style="text-align: center;">3</div>
MO. YR.	\$

PROVIDER NAME	PHYSICIAN NAME	DATE OF SERVICE	SERVICE DESCRIPTION	AMOUNT PAID FOR NON-COVERED SERVICES
4	5	6	7	8

TOTAL SOC	\$ 9
TOTAL NON-COVERED SERVICES	\$ 10
TOTAL SOC DEDUCTED FROM LTC CLAIM	\$ 11

- Item (1) Medi-Cal Identification Number..... This is the 14-digit number assigned by the county welfare department.
- Item (2) Month of Eligibility ..... This is the month the beneficiary is eligible for Medi-Cal coverage.
- Item (3) Share of Cost ..... This is the amount that must be paid or obligated by the beneficiary.
- Item (4) Provider Name ..... Enter provider name.
- Item (5) Physician Name ..... Enter patient's physician name.
- Item (6) Date of Service ..... Exact date services were received.
- Item (7) Service Description ..... Enter the specific service received.
- Item (8) Amount Paid for Non-Covered Services ..... Enter the amount paid for this specific noncovered service received.
- Item (9) Total Share-of-Cost ..... Enter the share-of-cost amount from "Share-of-Cost" box.
- Item (10) Total Non-Covered Services ..... Enter the total amount of non-covered services paid by the beneficiary.
- Item (11) Total Share-of-Cost Deducted from LTC Claim .. Enter the total share-of-cost amount that must be deducted from the LTC claim.

California - Health and Welfare Agency  
Medi-Cal Program

DEPARTMENT OF HEALTH SERVICES

OF NON-COVERED SERVICES

Identification Number (Taken from the Medi-Cal Card)										Month of Eligibility		Share of Cost (SOC)
												\$
7-DIGIT SERIAL NO.							FBU		PERS			
							MO		YR.			

BENEFICIARY NAME		LONG-TERM CARE (LTC) FACILITY NAME (You may use stamp)	
SECURITY NUMBER		ADDRESS	
DATE OF BIRTH		CITY	STATE ZIP

For non-covered services below. When completing this section, please indicate the provider of the service, the patient's physician name, date of service, service description and amount paid for the service(s) received. The amount paid for non-covered services must be totaled each month and entered in the "Total Non-Covered Services" box below. All services listed below must be consistent with the plan of care authorized by the attending physician and documented in the patient's medical record.

PROVIDER NAME	PHYSICIAN NAME	DATE OF SERVICE	SERVICE DESCRIPTION	AMOUNT PAID FOR NON-COVERED SERVICE

Form must be kept in the beneficiary's file and available to Department of Health Services staff for post-audit review.

I certify that the above listed non-covered services have been received.

I am the beneficiary/facility representative (indicate your relation to the beneficiary.)

If signature cannot be obtained, please indicate reason in this space.

Physician Use Only

I hereby declare under penalty of perjury that the above listed non-covered services have been paid.

TOTAL SOC

TOTAL NON-COVERED SERVICES

TOTAL SOC DEDUCTED FROM LTC CLAIM

\$	
\$	
\$	