TE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor
EPARTMENT OF HEALTH SERVICES
/744 P STREET
\MENTO, CA 95814

August 27, 1985

To: All County Welfare Directors
County Administrative Officers

Letter No. 85-59

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

Reference: All County Welfare Directors (ACWD) Letter No. 85-28

All County Welfare Directors Letter (ACWDL) No. 85-28 provided information and procedures to implement the Johnson v. Rank preliminary injunction which mandated that the Department of Health Services (DHS) develop procedures whereby long-term care (LTC) individuals are allowed to deduct the cost "of necessary but noncovered medical services" from their monthly Share of Cost (SOC). This letter describes revised procedures which LTC facilities will utilize to implement the court injunction.

The new facility procedures will not change county procedures nor the information notice (form I.D. - 104) which the counties are required to issue to each new LTC/SOC beneficiary. While counties should routinely refer questions regarding Johnson v. Rank to the long-term care facilities, this ACWD Letter will provide you with the same information and instructions issued to the long-term care providers and other Medi-Cal providers.

In response to the related Provider Bulletin (copy attached to ACWD Letter No. 85-28), numerous questions were raised by providers regarding the methodology used to implement the court decision. One area of concern was that many facilities prepare their CSC claims before the end of the month which means all bills for necessary but noncovered services may not have been submitted in time to be counted against the SOC, thus jeopardizing full reimbursement to beneficiaries or their families for noncovered services. Based upon this concern, a modified SOC adjustment process will be used whereby all necessary but noncovered services rendered in a month will be deducted by the facility from the following month's SOC. The new procedure, effective May 1985, is as follows:

1. The patient will continue to receive a Medi-Cal card with the share of cost amount printed on it by the first of each month.

2. The facility will continue to collect the entire share of cost from the patient at the beginning of each month.

3. The patient, family or provider will submit bills to the facility for necessary but noncovered services received during the first month. The facility will pay for the necessary noncovered services (up to the SOC amount) and record the amounts paid on the DHS 6114.

4. In the following month the facility will show on the claim to Computer Sciences Corporation (CSC) the amount it collected from the patient for the second month share of cost minus the amount the facility paid for noncovered services received in the prior month. The difference will be considered the amount the facility was actually able to retain from the share of cost. CSC will reimburse the facility up to the full month Medi-Cal rate based on that difference.

5. The DHS 6114 must be kept in the patient file for audit purposes.

6. The DHS 6114 form must be filled out by the facility for each month in which the patient receives necessary but noncovered services.

7. The patient or his/her representative must certify on the DHS 6114 that the services were received, and the facility must certify that the services were consistent with the physician's plan of care and were reimbursed.

8. If an LTC beneficiary dies or is discharged from the facility, received noncovered services prior to death or discharge, and the bill for the noncovered services is received after the claim for the last month of service is submitted, the LTC facility should pay the bill for the noncovered services and then use the CSC Claims Inquiry Form (CIF) adjustment process to obtain Medi-Cal payments.

9. This system, hereinafter referred to as "full month rollover," will continue for the duration of the patient's stay.

Enclosed for your information are several Johnson v. Rank questions and answers which were recently published in a California Association of Health Facilities (CAHF) bulletin.

Should you or your staff have questions regarding details of the Johnson v. Rank lawsuit, 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: October 1, 1985

ATTACHMENT

QUESTION AND ANSWERS

1. Q: What is considered "necessary noncovered care"?

   A: For the purpose of implementing the Johnson v. Rank preliminary injunction "necessary noncovered care" is any medical service which is consistent with the physician's plan of care, but is not paid for by Medi-Cal and is not included among the services which must be provided by the facility as part of the daily payment rate. In general, if the service is medical in nature and has been ordered by the physician, but would normally be billed to the patient or the patient's family, rather than to Medi-Cal, it can be considered "necessary noncovered care" and may be recorded on the DHS 6114.

2. Q: What services are included in the daily facility payment rate?

   A: Title 22, California Administrative Code, Section 51511, lists the equipment and supplies which a skilled nursing facility must furnish as part of the daily rate. These services cannot be used to reduced the share of cost. They must be provided to the patient by the facility on an "as needed" basis at no additional charge. Services which must be provided by the facility are:

   Canes, crutches, wheelchairs, walkers, autoclaves, sterilizers, beds, mattresses, bed rails, footboards, cradles, trapeze bars, patient lifts, patient examining equipment, infrared lamps, irrigating standards, scissors, forceps, nail files, weighing scales, ice bags, flashlights, all equipment (other than nasal catheters and positive pressure apparatus) necessary for the administration of oxygen, nonlegend analgesics and laxatives, lubricants, rubbing compounds, antiseptics, first aid supplies (such as alcohol, merthiolate, bandages, etc.), hypodermic syringes and needles, rubber goods such as rectal tubes, catheters, gavage tubing, soft restraints, incontinence pads and pants, urine bags, colostomy or ileostomy pouches and accessories, gauze dressing, thermometers, tongue depressors, applicators, besides utensils (such as bedpans, basins, irrigating cans and drinking tubes), charting supplies and other equipment and supplies commonly used in providing skilled nursing facility care.

3. Q: If the family insists that they want the patient to have his/her own personal wheelchair, or if they wish a custom chair which Medi-Cal will not approve, can the patient apply the cost of the chair toward the share of cost?

   A: Yes. However, in any case where the noncovered item is normally included in the facility rate, documentation that the service is medically necessary and "noncovered" is critical. The medical record must clearly show that the physician ordered the item or service for the patient and that the item or service available in the facility is insufficient to meet the patient's needs. Further, it is strongly recommended that a TAR be submitted to the Medi-Cal Field Office for such items or services. If the TAR is denied, the combination of the physician's order and the Medi-Cal denial will serve as sufficient documentation that the item or service was considered medically necessary by the physician, that the need cannot be met by the facility, and that Medi-Cal will not pay.

4. Q: Can the cost of personal care items be used to meet the share of cost?

   A: No. Personal care items are not medical in nature and cannot be used to meet the share of cost even if ordered by the physician. Personal care items include such items as:

   Toothbrushes, toothpaste, denture cleaners, shaving soap, lotions, cosmetics, hair combs, brushes, tissue wipes for individual use, tobacco products and accessories, beauty shop services (hair trims, shaves or shampoos are performed by the facility staff as part of routine patient care) and television rental.

5. Q: What if a service is covered by Medi-Cal but is not covered if rendered in the facility? Can it be applied toward the share of cost?

   A: Yes. A "necessary noncovered service" means a service Medi-Cal does not pay for which is consistent with the physician's plan of care. Therefore, if Medi-Cal denies coverage for any reason, including the fact that the setting makes it a non-payable service, it is noncovered and may be applied toward the share of cost.

6. Q: Can the facility apply the private daily rate toward the share of cost?

   A: No. For long term care facilities, only the Medi-Cal rate may be applied toward the share of cost, unless the patient's monthly share of cost is greater than the maximum which Medi-Cal would pay for a full month of care.

7. Q: Can the facility apply bedhold day costs beyond the seven days permitted by Medi-Cal to the share of cost? If so, at what rates (private or Medi-Cal) may these costs be applied?

   A: Yes. The cost of bedhold days beyond the seven days allowed by Medi-Cal may be applied toward the share of cost. However, these days may only be charged at the Medi-Cal reimbursement rate.

8. Q: If the bills submitted to the facility for "necessary noncovered services" exceed the share of cost amount, does the facility have to pay all of them?

   A: No. The facility is responsible only for "necessary noncovered services" up to the total monthly share of cost, and CSC will not adjust facility reimbursement for more than the share of cost amount. If bills submitted to the facility do exceed the share of cost, they should be reimbursed in order based on date of service. Thus, the last services rendered are not to be paid. However, the patient is not limited in the amount he or she wishes to spend, but can only be reimbursed up to the share of cost amount.

9. Q: Should the facility attach bills or receipts for "necessary noncovered services" to the DHS 6114?

   A: It is not essential, but advisable to keep documentation presented to the facility for "necessary noncovered services" with the DHS 6114. However, it is mandatory that documentation showing payment was made by the facility for the amount listed on the DHS 6114 is retained by the facility.

10. Q: If the bill or receipt does not specify the drug or item of service, does the facility need to request additional documentation?

A: Yes. The facility should request that the individual submitting the documentation indicate on the bill or receipt what the drug or item of service is. The facility is not expected to verify the accuracy of the information submitted by the patient or his representative.

11. Q: If the patient uses "necessary noncovered" drugs to meet the share of cost, must the facility list each drug on the DHS 6114 under description of service?

A: Yes. The name of the drug or the item received must be specified. However, as noted above, the submitter's statement as to what the item is will be sufficient.

12. Q: Can the facility establish facility-specific administrative procedures to enable the facility to implement the court order and DHS requirements?

A: Yes. Reasonable administrative procedures may be established as long as those procedures do not adversely impact patients.

13. Q: What if the family represents the patient but will not sign the DHS 6114?

A: No payments should be made under any circumstances unless and until someone signs the DHS 6114 indicating that the patient received the listed services. If neither the patient, family nor the conservator is able or available to sign the form, DHS will accept the signature of a facility representative, the patient's physician, or other person acting on the patient's behalf. The facility should be certain that patient receipt of the service is documented in the patient's record.

14. Q: The facility often bills Medicare for podiatry services (or other services) and bills Medi-Cal for the 20 percent coinsurance. May the facility now apply the coinsurance to the share of cost?

A: No. Medi-Cal will still pay the 20 percent coinsurance. Therefore, it (and the Medicare deductible) is a covered service and not applicable to the share of cost.

15. Q: Can a patient who has no share of cost also obtain "necessary noncovered services" at Medi-Cal's expense?

A: No. This process applies only to share of cost patients, and only up to the share of cost amount.

16. Q: Suppose a patient who receives and pays for "necessary noncovered services" in July is discharged or dies in July. If the facility has already reimbursed the patient, how will the facility be repaid by CSC for that expense?

A: The Claims Inquiry Form (CIF) process should be used to accomplish a retroactive payment adjustment for July.

17. Q: If the facility makes an error in the process of learning this new system, may the facility submit billing corrections to CSC?

A: Yes. Again, the CIF process is used to accomplish the correction.

18. Q: Should the facility send copies of the DHS 6114 and/or receipts to CSC with the claim for payment?

A: No. It is neither necessary nor desirable to provide CSC with such documentation, and in fact could result in slower payments. All documentation should be kept in the patient's record at the facility.