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

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

November 14, 1988

TO: All County Welfare Directors
All County Administrative Officers

Letter: 88 - 90

SUBJECT: PROVIDER REFUNDS FOR RETROACTIVE MEDI-CAL COVERAGE

The Department of Health Services has received complaints from beneficiaries regarding providers who refuse to refund payments for covered services when retroactive coverage is granted. California Welfare and Institutions Code, Section 14019.3 mandates that providers must submit retroactive claims for covered services to the Medi-Cal program and return any and all payments made by the beneficiary, or any person on behalf of the beneficiary, upon receipt of reimbursement.

The purpose of this directive is to clarify that, in those applicable cases where eligibility is granted more than one year after the date of service, the county is to issue an appropriate letter addressed to the provider granting retroactive eligibility under authority of Title 22, California Code of Regulations Section 50703, 50710 and 50746. A sample letter is attached for your convenience. Claimants must be reminded to give a copy of this letter to their provider along with the appropriate Medi-Cal sticker. Since your offices receive the majority of calls on how to handle retroactive coverage and reimbursement, it is extremely important that all eligibility workers are reminded of the proper procedures.

For your information, we have also attached a draft copy of the Medi-Cal bulletin which will be sent to all providers in the near future reminding them of their responsibility to submit retroactive claims for covered services to the Medi-Cal program and reimburse any and all payments made by the beneficiary upon receipt of reimbursement.

If you have any questions regarding this information please contact John Richmond, Medi-Cal Eligibility Branch, (916) 323-6454.

Sincerely,

Original signed by

Angeline Mrva, for
Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal program Consultants

Expiration Date: September 15, 198

EXAMPLE

Dear_____:

Attached is a Medi-Cal card(s) _____ for the month(s) of _____. This card was issued in accordance with Title 22, California Code of Regulations, Sections 50703 and 50710 which entitles certain individuals to retroactive benefits. County welfare departments have been instructed to issue Medi-Cal cards more than one year after the date of service to these individuals.

To ensure that your claims will be processed, code the billing limit box on the claim form with an "8", mark the attachment box on the claim with an "X" and indicate the date proof of eligibility was received in the remarks section of the claim. Additionally, attach all the necessary documentation required to process the claim (e.g., Treatment Authorization Request (TAR) control number inserted in the appropriate box on the claim form; Sterilization Consent Form (PM 330); etc.) When requesting a retro-TAR from the Medi-Cal field office, it will facilitate processing if you attach a copy of this letter with the TAR request.

A copy of this letter, along with the patient's Medi-Cal label, must be attached to your completed claim form for the month of service. The completed claim form should then be submitted to:

Department of Health Services
Fiscal Intermediary Management Division
Provider Services Section
714 P Street, Room 950
P.O. Box 942732
Sacramento, CA 94234-7320

Should you have any question regarding this matter, please contact the welfare department at_____.

Sincerely,

_____
Medi-Cal Program Manager

SUGGESTED PROVIDER BULLETIN

MEDI-CAL RETROACTIVE PAYMENTS TO PROVIDERS

Reminder: Medi-Cal providers are obligated to accept Medi-Cal payment for covered services even if eligibility is established retroactively from the month of application.

It has come to our attention that providers have refused to bill the Medi-Cal program for services provided during a period in which the beneficiary was determined to be Medi-Cal eligible. In addition, providers have occasionally refused to return monies paid by or on behalf of a beneficiary for services provided prior to the receipt of his/her Medi-Cal card when such card authorizes retroactive eligibility and payment for services.

The California Welfare and Institutions Code (W&I), Section 14019 states that presentation of a Medi-Cal card is authorization for the provider to bill Medi-Cal for covered services rendered. If all eligibility conditions are met, eligibility may be established retroactively up to three months prior to the actual month of application (California Code of Regulations (CCR), Section 50701). The provider must bill Medi-Cal for covered services provided during that period of eligibility.

W&I Code, Section 14019.3 also states a beneficiary or any person on behalf of a beneficiary who has paid for and received health services otherwise covered by Medi-Cal shall be entitled to a return from the provider of any part of the payment under the following conditions:

(a) Payment was made during any period prior to the receipt of the beneficiary's Medi-Cal card for which the card authorizes payment;

(b) Payment was reimbursed to the provider by the Medi-Cal program following all audits and appeals to which the provider is entitled;

(c) Services are not payable by a third party under contractual or other legal obligation;

(d) That portion of the payment was not used to satisfy his or her paid or obligated liability (share of cost) for health care services or to establish eligibility.

When the beneficiary presents the Medi-Cal card or other proof of eligibility, the provider must submit a claim for reimbursement to Medi-Cal subject to program rules. The provider must then return any and all payments made by the beneficiary or on his or her behalf by other persons, other than third parties obligated to pay because of contractual or legal entitlements, upon provider receipt of Medi-Cal payment for the covered services.

Providers are reminded that when signing a Medi-Cal Provider Participation Agreement, they agree to comply with Chapter 7 (commencing with Section 14000) of the W&I Code and Division 3, Title 22 of the CCR. Failure to comply may result in suspension or termination of the Medi-Cal provider agreement and/or other legal sanctions, including civil penalties pursuant to the California Health and Safety Code.