

UNDERPAYMENTS

Underpayments (30-768)

Underpayments occur when a recipient receives fewer services than she/he is entitled to, or when the share-of-cost paid by the recipient is greater than the correct share-of-cost. Underpayments can be corrected by increasing the service hours, or by a retroactive payment issued in an amount equal to that of the calculated underpayment. All underpayment corrections must be reviewed and approved by the Social Work Supervisor.

Underpayment means the recipient was entitled to more service than was authorized, or that the share of cost paid by the recipient was greater than the correct amount.

- An underpayment has occurred when IHSS staff fails to determine the correct share of cost or authorize the correct amount of service when all essential information was available to the County.
- An underpayment has not occurred when there is a disagreement in the IHSS staff's exercise of discretion or opinion, where discretion or opinion is allowed in the determination of the need for service.

How To Calculate Underpayments

Incorrect Service Authorization

Subtract the number of hours actually authorized from the number of hours to which the recipient was entitled.

Multiply this amount by the County's Individual Provider hourly wage rate during the time period.

Restaurant Meals

When the amount paid was less than the amount to which there was entitlement, subtract the amount paid from the correct amount.

Correcting Underpayments

There are two methods for correcting underpayments.

Underpayments will be adjusted by an increase in the service authorization when:

- The unauthorized service was yard hazard abatement or heavy cleaning.
- The service was not previously provided through another source, at no cost to the recipient.

All other underpayments will be corrected by a retroactive payment issued to the recipient in an amount equal to that of the calculated underpayment.

Notifying Recipient Of The Underpayment

If IHSS staff determines that an underpayment has occurred as defined above, the Social Worker will prepare a Notice of Action to notify the recipient of the following:

- The time period during which the underpayment occurred;
- The reason for the underpayment;

- The amount of the underpayment, and description of how the amount was calculated; and
- The method by which the County proposes to adjust the underpayment.

Share-of-Cost Underpayments

When the correct share-of-cost was less than the recipient paid, the resulting underpayment is determined by subtracting the correct amount from the amount paid.

Conlan II Reimbursement Process

The *Conlan v. Bonta* and *Conlan v. Shewry* lawsuits resulted in the issuance of two separate decisions by the First District Court of Appeal. The first decision is referred to as *Conlan I* and was issued on September 30, 2002. The second decision, referred to as *Conlan II*, was issued on August 15, 2005. These court decisions directed California Department of Health Services (CDHCS) to adopt and implement procedures to ensure reimbursement to Medi-Cal beneficiaries for covered medical services received and paid for by a beneficiary during the following periods.

- The Retroactive Period - The three-month period prior to applying for Medi-Cal.
- The Evaluation Period - The period when the Medi-Cal application is pending.
- The Post Approval Period - The denial period between a beneficiary's application for Medi-Cal eligibility and reversal of the denial.

Reimbursement to Medi-Cal beneficiaries also includes excess co-payment and excess Share-of-Cost (SOC) expenses. The Medi-Cal application date, *not the IHSS application date*, is used to determine eligibility to reimbursement for IHSS expenses.

The CDHCS implementation plan allows eligible Medi-Cal recipients (including IHSS recipients) to request reimbursement for covered services, and be informed of the procedures for requesting and submitting a claims packet to the California Department of Health Care Services (CDHCS).

Social Worker Responsibility

IHSS staff will (if requested by the recipient) assist with the following:

- Providing a copy of the granting Notice of Action NA 690.
 - The notice must be provided to the recipient within 10 business days.
 - If the Notice of Action is not available, form SOC 828 “Conlan II County Verification” verifying the recipient's medical necessity must be provided instead. Form SOC 828 is only used to verify medical necessity and not to provide case information.
- If requested, the Social Worker will assist the recipient with completion of the claims packet.
- If the recipient's Conlan II claim is denied, the Social Worker will assist with the appeal procedure.

The recipient has 90 days from the receipt of the denial notice to request an appeal.

Claim Processing

Claims are submitted to CDHCS, Benefits Service Center (BSC). BSC will forward the claim to the California Department of Social Services-Adult Programs Division (CDSSAPD) within 15 days. DSS-APD has 120 days (four months) to deny/approve or partially deny/approve a claim. Recipients may receive more information on claims reimbursement by calling toll free at:

1-(877) 508-1327.

For out-of-pocket expenses from June 27, 1997 - November 16, 2006:

- A completed Conlan II claim form must be received no later than November 16, 2007, or 90 days from the receipt of the Medi-Cal card (whichever period is longer).

For out-of-pocket expenses after November 16, 2006:

- The applicant has one year from receipt of services to file a Conlan II claim, or 90 days from receipt of Medi-Cal card (whichever period is longer).

All recipients who believe they have paid an excess SOC must submit their claims through the Department of Health Care Services (CDHCS) Beneficiary Services Center (BSC), unless it is a Buy-Out claim for reimbursement for:

- The current eligibility month.
- One month prior to the current eligibility month.

Reimbursements for the *current month or one month prior* may be made by using the Special Pre-Authorized Transaction (SPEC) created for this purpose.

The BSC will then forward the claims to CDSS, APD. CDSS will review and process claims as required. The complexity of these claims requires that State staff analyze and sort through the facts associated with each claim. An additional ACL is in development that will provide the necessary instructions for the county “Buy-Out” determination process described above. It will also include examples and details on how to determine if the recipient missed the Buy-Out through **no fault of their own**.

Social workers should refer recipients who wish to file a claim to the BSC at:

(916) 403-2007

TDD (916) 635-6491