County Medical Services Program Guide (CMSPG) Letter #09

February 7, 2012

Subject **UPDATES TO THE COUNTY MEDICAL SERVICES PROGRAM GUIDE (CMSPG) TO REFLECT CHANGED CMS PROCESSES**

Effective Date Upon receipt.

Reference County Policy

Purpose

The purpose of this letter is to inform staff of the:

- Clarification regarding case narratives.
- Revision to terms used to identify certain CMS workers.
- Revision to the CMS date of application exceptions,
- Update to the Automation section.
- Changes to Notice of Action (NOA) for excess income only denials.
- Clarification regarding use of investigation reports.

Background

Case Narrative

As part of the application, reapplication, and recertification process, workers are responsible for narrating all case actions in the case comments.

Clinic Outstation Services (COS)

The term "COS" is used to identify county eligibility workers who are stationed inside of clinics throughout San Diego County.

Date of application for HOS

Current CMSPG language indicates the date of application is dependent upon whether the HOS referral was received by the worker within 10 calendar days of the date of admission.

Exceptions to the CMS Date of Application

The date of a prior month uncertified visit may be used as the date of application if the applicant contacts the ASO, or is referred to HOS within 30 calendar days of the uncertified visit, and provides verification of the uncertified visit.

Updates to the Automation section

This section contains instructions for entering information into the two

systems used by workers to record CMS activity: CMS IT System and IDX.

Excess Income Only Denial NOA
Previously, when an applicant was denied for excess income only, the worker would create the Excess Income Only Denial NOA but would not automatically mail the notice. The worker would mail the Excess Income Only Denial NOA and CMS Hardship Application to the applicant the following day.

Use of Fraud Referrals
Current CMSPG language does not clarify the use of DHCS investigator reports in the CMS eligibility determination process.

Changes

Case Narrative Clarification
Workers must narrate all case actions in case comments. Narratives can support case documentation; however, case narratives are NOT required as a condition of eligibility.

Clinic Outstation Services (COS)
The term "COS" has been removed and replaced by "Non-HOS". These functions are performed throughout the county by Health Services Specialists in several locations.

Date of application for HOS
The 10 calendar day requirement has been revised to 10 business days.

Exceptions to the CMS Date of Application
The existing exceptions for establishing the CMS date of application has been expanded to include instances when an applicant has applied for Medi-Cal or LIHP benefits within 30 calendar days of the uncertified visit. The day after the uncertified visit is the date the 30 day time period starts.

Updates to the Automation section
This section has been updated to include information on the Provider Online Verification (POV) website.

Excess Income Only Denial NOA
Applicants/beneficiaries are evaluated for CMS and CMS Hardship concurrently, therefore the need to issue a CMS Hardship Application via the Excess Income Only denial NOA no longer exists. The excess income denial reason has been incorporated into the CMS denial NOA (CMS-39D). The Excess Income Only denial NOA is now obsolete.

Use of Fraud Referrals

DHCS and Public Assistance Fraud Division (PAFD) fraud investigation reports may be used to support a CMS fraud determination.

Required Actions

Workers are to familiarize themselves with the changes and updates.

Forms Impact

Forms	Title	Change
CMS-39D – Excess Income Only Denial Notice (Eng/Span)	Excess Income Only Denial NOA	Obsolete

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Automation Impact

None

Appeals Impact

None

ACCESS Impact

None

Quality Assurance Impact

Effective with the March 2012 review month, Quality Assurance will cite with the appropriate error any case that does not comply with the requirements outlined in this letter.

Summary of Changes

The table below shows the changes made to the CMSPG.

Article/Section	Changes
01.05	Removed references to COS.
02.01	• Added clarification regarding case narratives; • Replaced COS with new term; and • Revised exceptions for establishing date of application for CMS.
02.03, 02.05, 02.10,	Replaced COS with new term.

02.11	
09.01	Added POV information and removed excess income only denial NOA procedures.
11.02	Information added regarding the usage of DHCS investigation reports.

Manager Approval

for J. Bowman

Janya Bowman, Assistant Deputy Director
Health Care Policy Administration
Strategic Planning and Operational Support

SB

Article 1 Section 05 Acronyms and Terms Definitions

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01.05.01 Acronym Definitions

01.05.01
Definitions

The following table lists definition of acronyms used throughout the program guide.

Acronym	Definition
ABD	Aged, Blind or Disabled
ASO	Administrative Services Organization
CFBU	Case Family Budget Unit
CI	Coverage Initiative
CMS	County Medical Services
DDSD	Disability Determination Service Division
DHCS	Department of Health Care Services
FPL	Federal Poverty Level
FRC	Family Resource Center
GR	General Relief
HCA	Health Coverage Access
HOS	Hospital Outstationed Services
IDX	Computer system used by the ASO
IEVS	Income and Eligibility Verification System
MEDS	Medi-Cal Eligibility Data System (State)
MFBU	Medi-Cal Family Budget Unit
MIA	Medically Indigent Adult
MNL	Maintenance Need Level
MPG	Medi-Cal Program Guide
NOA	Notice Of Action

OHC	Other Health Coverage
ORR	Office of Revenue & Recovery
PAFD	Public Assistance Fraud Division
PS	Program Specialist
QA	Quality Assurance
SAVE	Systematic Alien Verification for Entitlements
SDX	State Data Exchange
SSI/SSP	Social Security Supplemental Security Income/State Supplemental Program
SOC	Share of Cost
SPOS	Strategic Planning & Operational Support
TPL	Third Party Liability

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01.05.02 Term Definitions

01.05.02
Definitions

The following table lists definition of terms used throughout the program guide.

Term	Definition
Administrative Services Organization	A firm that performs administrative management functions and provides day-to-day administration of specific services related to CMS.
Adverse Action	An action taken which discontinues CMS eligibility or increases a CFBU's share of cost.
Applicant	An individual or family member making an application for aid.
Beneficiary	An adult certified as eligible for CMS.
Certification	A determination made by the County that an applicant meets CMS eligibility criteria.
CMS Adult	A person age 21 through 64. CMS adult status begins the month following the 21st birthday and ends the last day of the month before their 65th birthday.
CMS Provider	A medical or dental provider contracted by the County to provide medical services to CMS beneficiaries.
Combination MFBU	A combination MFBU includes a person who is eligible to Medi-Cal and a person who is eligible to CMS.

Competent	A person able to act on one's own behalf in business and personal matters.
Documentation	The act of recording in the case record, evidence submitted to enable the worker to determine eligibility. Documentation must include narrative entries in the case to show how the worker resolved inconsistent or unclear information reported by the applicant. Documentation may also include a narrative of how the worker evaluated submitted evidence, and how the worker arrived at the eligibility decision.
Family Member	A single person or a married couple and their children under age 21 living in the home.
Federal Poverty Level	An income level based on the official poverty line as defined by the Federal Office of Management and Budget and revised annually or at any shorter interval the Secretary of Health and Human Services deems feasible and desirable pursuant to Section 9902(2), Title 42, United States Code.
Hospital Outstationed Services	Staff located in hospitals contracted with the Hospital Association of San Diego & Imperial Counties responsible for processing CMS and Medi-Cal applications.
IDX	The computer corporation the County contracts with to provide software systems for the ASO to record CMS eligibility, and process claims and treatment authorizations
Inpatient	Refer to the HOS Policy and Procedures Manual
Linked	Meeting the SSI/SSP requirements of age, blindness or disability, or the Cal WORKS requirements of deprivation of parental support and care.
Maintenance Need Level	The amount of income an adult or family is allowed to keep for basic living expenses. The size of the CMS FBU and amount of monthly net non-exempt income determines the eligibility category and associated maintenance need level. The MNL for CMS is 165% FPL. The MNL for CMS Hardship is 350% FPL.
Medi-Cal	California's medical assistance program and the benefits available under that program.
Non- HOS Worker	Staff located in clinics, public health center and FRC's responsible for processing CMS applications.
Notice Of Action	A written statement of eligibility determination for CMS benefits.
Obligate	To incur a cost for health care services.
Outpatient	An adult who received medical services through an emergency room, a doctor's office, or a clinic.
Overpayment	The receipt of CMS benefits when there is no entitlement to all or a portion of the benefits received.

Reapplication	An application submitted after a one (1) month break in certification.
Recertification	A determination that a beneficiary continues to meet the CMS eligibility criteria without a one (1) month break in certification.
Revenue & Recovery	Per San Diego County Administrative Ordinance Article V, Section 92, Revenue & Recovery is the County department responsible for CMS Lien assertions.
Share of Cost	The monthly amount of discretionary income available to beneficiaries which must be paid or is obligated to be paid toward the cost of their CMS covered health care services each month.
Threshold Language	A threshold language is defined as the native language of a group who comprises five percent or more of the people served by the CMS Program. For CMS, the threshold language is Spanish.
Third Party Liability	The responsibility of insurers for payment of claims which are connected with injuries or trauma sustained by recipients as a result of fault or negligence of third parties (e.g., auto accident claims). The County is responsible for assuring the use of third party assets or for detection and collection of third party liability payments.
Uncertified Visit	Date of Service where medical care was provided to a patient without current CMS eligibility.
Unconditionally Available Income	Income to which it is unconditionally available if the applicant/beneficiary has only to claim or accept the income.
Verification	The process of obtaining acceptable evidence, which substantiates statements made by an applicant/beneficiary.

Article 2 Section 01 Application Process

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02.01.01 Application Process

02.01.01A Overview

This section contains procedures for handling requests to apply for CMS. The adult requesting CMS or CMS Hardship may live alone, with a spouse, or with family members who are eligible to Medi-Cal.

When a CMS case is established using the CMS IT system, all documentation and verifications used to determine eligibility to and level of coverage within the CMS Program, including CMS forms completed by the patient, hospital and eligibility staff, must be imaged and saved into the CMS IT system. The Image Verification Checklist (CMS-107) may be used to eliminate the scanning of some forms for applicants/beneficiaries during the application process.

02.01.01B Good Cause

At each application, recertification or reapplication, the worker must:

- evaluate for good cause prior to taking a CMS eligibility adverse action when the applicant/beneficiary is unable to comply with eligibility requirements within the required timeframe;
- narrate in case comments that good cause was evaluated, whether good cause was found or not, and the reason why the good cause determination was made;

- establish a new due date, if needed, based on case situation. Inform the applicant/beneficiary and narrate in case comments of the new due date; and
- inform the applicant/beneficiary and narrate in case comments of any acceptable alternative verifications.

Good cause includes but is not limited to:

- Physical or mental illness or incapacity of the applicant/ beneficiary which prevents him/her from contacting the County and/or obtaining/submitting the required documents/verifications within the required timeframe;
- A level of literacy, in conjunction with other social and language barriers, of the applicant/beneficiary that would prevent him/her from meeting the established due date.
- A delay in the receipt of information and the delay is beyond the control of the applicant/beneficiary; and/or
- Obtaining the documents/verifications would cause harm to the individual.

02.01.01C Reporting Timely

Applicants are responsible for reporting changes in a timely manner. Any changes in income, assets or living situation which pertain to the determination of eligibility or SOC; are to be reported within 10 days.

02.01.01D Case Narrative

All case actions are to be narrated. Narratives can support case documentation; however, case narratives are NOT required as a condition of eligibility.

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02.01.02 Date of Application

02.01.02A HOS

The date of application is established as follows:

If the CMS IT referral is received by the HOS worker …	**Then the date of application is…**
within 10 business days of the date of admission,	the date the worker receives the CMS IT application referral or the date of admission to the hospital,

	whichever is earlier.
the CMS IT referral is received by the HOS worker more than 10 business days after the date of admission,	the date the worker receives the CMS IT System application referral.

Exceptions for establishing the date of application exceptions are listed in 02.01.02C.

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02.01.02B Non-HOS Worker

The date the applicant's information is entered into the CMS IT system establishes the date of application. The worker will print the signature page of the Statement of Facts (SOF) on the date of the intake interview and have the applicant sign and date the form, which is then scanned into the IT System to verify the application date. The CMS IT System gathers information to determine CMS eligibility. Refer to 02.02.01 for instructions on who may complete and sign the Statement of Facts and information regarding Authorized Representatives.

Exceptions for establishing the date of application exceptions are listed in 02.01.02C.

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02.01.02C Date of Application Exceptions

Applicants requesting coverage for an uncertified date of service prior to the date of the intake interview may establish the date of the uncertified visit as their application date. Eligibility will be effective the first on the month of the date of the uncertified visit if all of the following conditions are met:

If all of the conditions are not met, this exception does not apply.

The applicant…	
1	Was not in receipt of full scope Medi-Cal, LIHP, or CMS at the time they received medical treatment.
2	a) Contacts the Administrative Services Organization (ASO) within 30 calendar days of the date of the uncertified visit to schedule the intake interview, or b) Is referred to an HOS worker by an HOS hospital, receives an HOS referral within 30 calendar days of the date of the uncertified visit, or c) Has applied for Medi-Cal or LIHP within 30 calendar days of the date of the uncertified visit.

	Note: The 30 day time period starts the day after the date of the uncertified visit.
3	Provides verification of the date of the uncertified visit. The date of the uncertified visit, once verified, then becomes the date of application.
4	Provides all of the information and required verifications needed to determine eligibility for the month of the uncertified visit.
5	Meets all other eligibility requirements for the month of the uncertified visit.
6	May request coverage for a maximum of two uncertified visits per year.
7	Has 10 business days from the date of the missed appointment to call ASO to reschedule. Only one reschedule will be allowed for patients requesting coverage of a past month's ER visit. The application date for a patient with more than one reschedule shall be the date of the intake appointment and not earlier.

Note: When evaluating for a prior month's uncertified ER or clinic visit, the worker must indicate the date of application being used and confirm in the case comments that appropriate verification for the uncertified ER or clinic visit was received and reviewed.

Article 2 Section 03 Face-to-Face Interviews

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02.03.01 Face-to-Face Interviews

02.03.01A Initial Application Requirement

A face-to-face interview is required unless noted below. Exceptions to this requirement for HOS are listed in the HOS Policy and Procedures Manual.

02.03.01B Waiving the Face-to-Face Interview

1) HOS

   May waive the face-to-face interview when the applicant has been discharged before the intake interview can be scheduled, or as otherwise stated in the HOS Policy and Procedures Manual.

2) Non-HOS

   a) Workers must waive the face-to-face interview when applicants/beneficiaries are living in a skilled nursing facility, intermediate are facility, or board and care.
   b) Workers must also waive the face-to-face interview when applicants/beneficiaries are housebound because of illness or injury. However, these applicants/beneficiaries may request a face-to-face interview.
   c) Face-to-face interviews are also waived for hostile or uncooperative applicants/ beneficiaries.
   d) Workers may request to waive the face-to-face interview for other reasons based on the individual needs of the applicant/ beneficiary. This will be done on a case-by-case basis and with supervisor approval.

3) The reason for waiving the interview must be documented in the case comment in the CMS IT System.

4) When a face-to-face interview has been waived, the application is processed by mail.

Article 2 Section 05 Linkage to Medi-Cal

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02.05.01 Potential Linkage to Medi-Cal

02.05.01A General

CMS requires some applicants/beneficiaries to apply for Medi-Cal as a condition for eligibility for CMS.

Parents of minor children, who are disabled, incapacitated, or unemployed, must be referred to CalWORKS or Medi-Cal. Workers evaluate linkage based upon the definition in MPG Article 5, Section 2.

- HOS workers shall process the Medi-Cal and CMS applications concurrently.
- Non-HOS workers shall refer the parent to apply for Medi-Cal using form HHSA: CMS-5 and deny CMS. Refer to CMSPG 08.05 for case processing if the parent is denied CalWORKS or Medi-Cal.

CMS applicants and beneficiaries with a disabling condition that may potentially link them to Medi-Cal must apply for and if eligible, accept full scope Medi-Cal coverage. They must apply for disability linked Medi-Cal through Disability Determination Services Division (DDSD). If they refuse to apply for or accept full scope Medi-Cal, they are not eligible to CMS

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02.05.01B Pending SSI/SSA Disability

A CMS applicant/beneficiary with a pending SSI or SSA Disability application or a pending appeal decision should have applied for Medi-Cal at the time they applied for SSI/SSA. If they did not apply for Medi-Cal, in order to protect the Medi-Cal filing date, the worker must refer or process the Medi-Cal application as instructed in 02.10. Medi-Cal applicants appealing an SSI/SSA denial issued within the last 12 months for not having a disabling condition may be denied Medi-Cal on the basis of no disability in CalWIN. This denial action protects the Medi-Cal filing date so that if the final appeal decision is favorable to the CMS beneficiary, CMS Recovery staff will initiate a corrective action memo to rescind the Medi-Cal denial and receive reimbursement from Medi-Cal.

02.05.01C Previous Medi-Cal Application Denied

1. Returning CMS Applicant/Beneficiary

If the CMS applicant/beneficiary is denied disability linked Medi-Cal (DDSD) because he or she is not linked and returns to apply for CMS within ninety (90) days of the Medi-Cal denial, the worker must:

1	Review the denial reason.		
2	**If the …**	**Then…**	
	denial reason is correct and is not due to no show, failure to provide or failure to cooperate,	1	Certify for up to the allowable period, if otherwise eligible.
		2	Document the Medi-Cal denial reason in the case record comments.
	denial reason is questionable, (e.g. SSI denied for reasons other than no disability; 250% Working Disabled Program not evaluated for working individual, etc.),	1	Refer the applicant/ beneficiary to appeal.
		2	If otherwise eligible, CMS may be approved for the allowable period once the individual has complied with the Medi-Cal DDSD appeals process. **Note:** CMS cannot be recertified until the individual has fully completed the Medi-Cal DDSD appeals process.
	ninety (90) day appeal timeframe has expired,	1	Re-refer the applicant/ beneficiary to apply for

			Medi-Cal DDSD using form CMS-5. Specify on the CMS-5 the beginning month for the Medi-Cal application and retroactive months as needed..
		2	If otherwise eligible, CMS may be approved for the allowable period **after** it is verified in CalWIN that the individual has fully complied in completing the Medi-Cal application process, has met **all** Medi-Cal eligibility and verification requirements, and the DDSD packet has been imaged into DoReS. **Note:** The DDSD decision is not required prior to approving CI/CMS benefits.

2. <u>New CMS Applicant</u>

When a new CMS applicant was denied disability linked Medi-Cal (DDSD) because he or she is not linked and continues to declare a disabling condition, the CMS worker will:

1	Evaluate if the denial is within the Medi-Cal ninety (90) day appeal timeframe.		
	If…	Then…	
	it is within the appeal timeframe	1	Refer the applicant to appeal the denial.
		2	If otherwise eligible, CMS may be approved for the allowable period once the individual has complied with the Medi-Cal DDSD appeals process.

			Note: CMS cannot be recertified until the individual has fully completed the Medi-Cal DDSD appeals process.
	the appeal timeframe has expired,	1	Re-refer the applicant to apply for Medi-Cal DDSS using form CMS-5**..**
		2	If otherwise eligible, CMS may be approved for the allowable period **after** it is verified in CalWIN that the individual has fully complied in completing the Medi-Cal application process, has met **all** Medi-Cal eligibility and verification requirements, and the DDSD packet has been imaged into DoReS. **Note:** The DDSD decision is not required prior to approving CI/CMS benefits.

3. Unrelated to Disability

If the Medi-Cal application is denied for a reason unrelated to disability, such as no show, failure to provide, or failure to cooperate, they are not eligible for CMS until they comply.

02.05.01D SSI Advocate Referred

SSI Advocacy Services

A CMS applicant who has been identified as potentially eligible to Medi-Cal or SSI may be referred to the Legal Aid SSI Advocate for assistance in applying for or reapplying for SSI benefits or assisting with the process of filing an SSDI/SSI appeal. Worker will :

- either mail or fax form HHSA:CMS-2 to the SSI Advocate; and
- notes in the case comment section of the CMS IT system, “SSI Advocacy Services referred.” Refer to 08.06 for more information.

02.05.01E Deceased Person

Because CMS is the program of last resort, it will not consider applications made on the behalf of a deceased person. CMS denies all provider claims for services given to a CMS applicant/beneficiary who dies while in the hospital. Deceased applicants/beneficiaries are linked to Medi-Cal because Medi-Cal defines disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death."

02.05.01F Cash Assistance Program for Immigrants (CAPI) Applicants

CAPI is a cash program for certain immigrants who are ineligible to SSI/SSP solely due to their immigration status. A CMS applicant who has a pending CAPI application must also apply for Medi-Cal DDSD and may be granted CMS while the DDSD decision is pending. The DDSD process for CAPI is the same as Medi-Cal; however a separate Medi-Cal application has to be requested by the applicant. A CMS applicant who has an active CAPI case is linked to Medi-Cal and is not eligible to CMS.

02.05.02 Medi-Cal Disability Linkage is Established

02.05.02A Linkage Established

CMS beneficiaries determined to be disabled by State or Federal DDSD are not eligible for CMS. Upon receipt of the DDSD decision, CMS Recovery enters the disability information into IDX and CMS Recovery staff sends an informing letter advising beneficiaries to complete the Medi-Cal application process. CMS eligibility continues until the certification period expires or until eligibility to full scope Medi-Cal begins, whichever occurs first. CMS beneficiaries who have applied for Medi-Cal have the responsibility to complete the entire full scope Medi-Cal application process. If they have been determined disabled but fail to finish the full scope Medi-Cal eligibility determination process, they cannot remain on, or return to CMS.

Article 2 Section 10 Approvals

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02.10.01 Approvals

02.10.01A CMS Only

Workers enter the applicant/beneficiary information directly into the CMS IT system to certify CMS applications. When the applicant/ beneficiary is determined to be eligible to CMS benefits, the Notice of Action CMS-39A is used to inform the applicant of the approval and the eligibility category to which they have been approved.

02.10.01B CMS Approved Medi-Cal DDSD Needed (HOS)

The worker opens an automated Medi-Cal case on CalWIN and places it in a pending status. The worker must also evaluate for retroactive Medi-Cal when the applicant/beneficiary has had CMS coverage in the retroactive period. The HOS worker shall assist applicants, as needed; with the Medi-Cal application process including helping them complete the State of Facts and DDSD packet (refer to Medi-Cal Linkage in 02.05 for more instructions). **The HOS worker CANNOT approve CMS until the Medi-Cal application and DDSD packet are received fully completed and all eligibility and verification requirements for both Medi-Cal and CMS have been met.** In addition, CMS should not be certified if there is a pending fraud investigation on the Medi-Cal application. The date the DDSD packet was sent must be recorded on the CalWIN Disability screen within 30 days from the date of application.

Reminder: Refer to MPG 5.4.1 regarding when to submit the DDSD packet

Note: If CalWIN Disability Screen input is not completed within 30

days from the date of application, all CalWIN entries will fail. The worker records the CMS certification period and the date the DDSD packet was imaged into DoReS in case comments of the CMS and Medi-Cal case. This entry alerts the CMS Recovery Specialist that there is potential reimbursement from Medi-Cal to CMS. The HOS worker then sends the Medi-Cal case to the DDSD worker at the Family Resource Centers (FRC). IDX screen prints reflecting CMS eligibility and IDX comments must be in the case file as referenced in MPG 4.2.10D. Upon approval or denial of Medi-Cal, the DDSD FRC worker sends form 14-10 HHSA to the ASO at 0557B. The CMS case is sent to HQ for filing in the Record Library.

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02.10.01C
CMS Approved Medi-Cal DDSD Needed (Non-HOS)

As a condition of eligibility, applicants/beneficiaries with a disabling condition that may potentially link them to disability linked Medi-Cal (DDSD) must apply for and complete the Medi-Cal application process for full scope benefits. If otherwise eligible, CMS/CMS benefits shall be approved upon receipt of verification that the individual has fully completed the Medi-Cal application process, has met **all** Medi-Cal eligibility and verification requirements, the application is pending in CalWIN, and the DDSD packet (MC220, MC223) has been imaged into DoReS (refer to Medi-Cal Linkage in 02.05 for more instructions). CMS should not be certified if there is a pending fraud investigation on the Medi-Cal application.

The worker will:	
1	Refer the individual to apply for Medi-Cal DDSD using form CMS-5.
2	Specify on the CMS-5 the beginning month for the Medi-Cal application and retroactive months as needed. Retroactive Medi-Cal is needed when the individual has had CMS coverage in the 3 months prior to the CMS date of application.
3	The CMS application is to be left in a pending status until it is determined whether the individual complied with the Medi-Cal application requirement. The Medi-Cal application requirement is listed as a pending verification. The standard ten-ten (10/10) timeline will apply. **Note:** Good cause shall be determined for extending the CMS due date for verifications if the Medi-Cal application due date to provide verifications is **after** the 10/10 CMS timeline.

4	If otherwise eligible, CMS may be approved for the allowable period **after** it is verified in CalWIN that the individual has fully complied in completing the Medi-Cal application process, has met **all** Medi-Cal eligibility and verification requirements, and the DDSD packet has been imaged into DoReS. **Note:** The DDSD decision is not required prior to approving CI/CMS benefits.

Article 2 Section 11 Denials

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02.11.01 Denials

02.11.01A Overview

Workers enter the applicant/beneficiary information directly into the CMS IT system to determine the applicant's/beneficiary's CMS eligibility. When the applicant/beneficiary is determined not to be eligible to CMS benefits, the Notice of Action CMS-39D is use to inform the applicant of the denial.

02.11.01B Failure to Provide

Refer to Appendix 02.11A for a complete listing of denial reasons/codes.

Prior to denying an applicant for failure to provide essential information, the worker:

Step	Action
1	provides the applicant with a list of outstanding verification and allowed the applicant at least 10 calendar days to provide.
	extends the 10-day deadline if the applicant indicates that

	he/she may have difficulty in providing the verifications by the given deadline. If an extended deadline is agreed to, the worker will document in case comments
2	will provide the applicant with a 2nd request for verifications, and allows the applicant another 10 calendar days to provide, when the deadline has passed and the verifications are still missing.
3	denies the applicant's application for failure to provide, if the required verifications still have not been provided within the standard ten-ten (10/10) timeline and good cause is not determined.

02.11.01C Excess Income

Income is a CMS eligibility factor. The worker inputs the applicant information directly into the CMS IT System, and the system will determine whether or not the CFBU is within the CMS income limits and to which CMS eligibility category (CMS or CMS Hardship) the applicant may be certified for. When the applicant is not eligible to CMS due to excess income (more than 165% FPL up to and including 350% FPL) and is otherwise eligible, the applicant may apply for a CMS Hardship Evaluation. Refer to Article 13 for additional information. The worker shall advise the applicant of the repayment agreement and the 10 day deadline in which to provide any pending verifications.

When denying the application for excess income (more than 350% FPL), it is imperative that the correct CFBU size as well as both the total gross and the net countable income used in the determination are reflected.

02.11.01D Excess Property

When an applicant/beneficiary has been determined to have excess property, the worker denies the application and sends an automated Notice of Action (CMS-39D) telling the applicant that CMS has been denied because of excess property and giving the applicant the opportunity to spend the excess. The applicant has 30 days from the date of the notice to pay allowable expenses and to submit receipt(s) to the worker. If the applicant submits receipt(s) within the 30 days, the worker verifies that the property excess has been spent correctly, and is now within the property limit, and rescinds the denial. The certification period begins the month of application as long as all other eligibility factors are met. The worker notes in the comments section of the CMS IT System "spend down medical receipts in the amount of $_____ ." The worker completes a CMS-4 and attaches the receipts to the CMS-4 sent via interoffice mail to ASO Spenddown Data Entry Eligibility Supervisor. The receipts enable the ASO to identify the provider(s) that

the applicant has paid. If the receipts are not received within 30 days, the denial stands.

02.11.01E Failure to Attend Appointment

Referrals decentralized from HOS which do not meet the HOS Policy and Procedures Manual (PPM) criteria are scheduled an eligibility appointment with a Non-HOS worker. If the applicant fails to show to their scheduled Intake appointment, the worker will deny the application for failure to attend appointment, if good cause is not determined.

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02.11.01F Loss of Contact

An application for CMS is to be denied if, after reasonable attempts to contact the applicant/beneficiary, the worker determines that there is loss of contact.

Reasonable Attempts

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1.</td><td>Attempt to contact the client by phone. If client does not have a telephone, proceed to Step 2

<table>
<tr><th>If…</th><th>Then the worker will…</th></tr>
<tr><td>Contact is made</td><td>• Confirm that client has not moved; AND
• Document contact in case comment;
• No further action is needed</td></tr>
<tr><td>There is no answer</td><td rowspan="3">• Deny/discontinue the case; AND
• Document contact attempt in case comment.</td></tr>
<tr><td>Number has been disconnected</td></tr>
<tr><td>Person answering the telephone confirms that client has moved and left no forwarding address</td></tr>
</table>
</td></tr>
<tr><td>2.</td><td>Send a letter to the client requesting that the client contact the worker within 10 days to confirm his/her whereabouts.</td></tr>
</table>

If…	Then…
Client responds and confirms his/her whereabouts	• Document contact in case comment; • No further action is to be taken.
Does not respond to letter within 10 days	• Deny/discontinue case. • Document in case comment the attempt to contact by mail & client's failure to respond.

02.11.02 Application Withdrawn

02.11.02A General

The following procedures will apply whenever an applicant or person authorized to act on behalf of the applicant requests withdrawal of an application for CMS benefits.

An applicant/beneficiary may withdraw his/her application for CMS benefits by:

- submitting a signed statement indicating the request for withdrawal or;
- Making an oral request for withdrawal.

02.11.02B Processing Request for Withdrawal

When the request is...	Then the worker will ...
Written	• deny the case; • send the appropriate NOA to the client; and • save the written request, along with the NOA, in the CMS case record.
Oral	• ask that the request be made in writing; • document that an oral request has been received and written confirmation has been requested; • deny the case; and • send appropriate NOA. It is not necessary to wait for the written request before the case is denied. When the written request is received, it is to be saved in the CMS case record.

02.11.02C Disputed Requests for Withdrawal

If the applicant fails to return a written request for withdrawal and later disputes the oral request, and there is no other basis for the denial, the worker will immediately rescind the action. Otherwise, the action will be considered valid.

02.11 Appendix A Eligibility Denial Codes

Eligibility Denial Codes

Denial Codes	Denial Code Names
01	You have excess property
02	You have excess income
03	Not a county resident
04	Not a citizen/eligible alien
05	Failure to provide/cooperate
06	Medi-Cal linkage
08	Lien forms not completed
27	Application withdrawn
48	Failed to attend appointment
49	Whereabouts unknown
51	Failure to complete Medi-Cal process
52	Recertification mail-in packet not received timely
53	Failure to complete credit report
58	LIHP Linkage
59	You were offered the opportunity to change clinics and declined

Article 9 Section 01 CMS Information Technology (IT) System

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09.01.00 Automation

09.01.00A General

This section contains instructions for entering information into the two systems used by workers to record CMS activity: the CMS IT System and IDX. Workers must clear all CMS applications including GR recipients on the CMS IT System, CalWIN, MEDS, and IDX systems before approving CMS benefits.

09.01.01 CMS IT System

09.01.01A General

The CMS IT System is a web-based eligibility system (sdcmsapps.com). All CMS applications will be processed and maintained on the CMS IT System. All case documentation and verifications will be stored on the CMS IT System. The CMS IT System also affords CMS contracted providers the ability to access the Provider Online Verification (POV) website (www.sdcmspov.com) to view CMS case status.

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09.01.01B Notices of Action (NOAs)

1. NOAs Requiring Manual Mailing

   Homeless

   The CMS it System will create various NOAs and Informing Notices for homeless applicants/beneficiaries but will not automatically mail the notices. The notices will be stored in the applicant's/beneficiary's record in the CMS IT system.

   If the applicant/beneficiary requests a copy of their NOA or Informing Notice, the worker will be able to access the notice and print it on site for the applicant/beneficiary. The worker shall make a narrative entry indicating the date the notice was provided and shall specify which notice was provided.

2. NOAs Which Will Be Automatically Mailed

   a) Approval NOAs
      The certification period will be automatically filled-in prior to the NOA being mailed.

   b) Denial NOAs
      Workers shall enter all case specific information applicable to the denial into the CMS IT system at the time the denial action is taken (i.e. what specific items the applicant/beneficiary failed to provide, the amount the applicant/beneficiary needs to spend down). The case specific information will be automatically filled-in prior to the NOA being mailed.

09.01.01C Approval/ Denial Actions

1. Approval Action
   Based on the applicant's/beneficiary's information entered, the CMS IT System will recommend if the individual is approved for CMS benefits. The worker makes the final determination of eligibility.

   All approval actions taken by the worker will remain in a "pending approval" status for a minimum of one (1) night. Each night the CMS IT System randomly selects from the pending approvals, which approvals are to be review by a supervisor, which pending approvals can be approved without a supervisor review.

2. Denial Actions
   Based on the applicant's/beneficiaries information entered,

the worker will determine the appropriate denial action, and the CMS IT System will generate a denial NOA and automatically mail it to applicant, as appropriate. Some denial actions require manual NOA mailing.

09.01.01D Credit Report

1. Ordering a Credit Report
   Worker **MUST** order a credit report at initial application, recertification or reapplication when:
   - Information is received from applicant or beneficiary or circumstances are noted which could indicate the possibility of fraud; or
   - An applicant/beneficiary states that they are unable to obtain legal documentation of their divorce, legal separation, deceased spouse, or represent that they are no long residing with their spouse and are unable to obtain the spouse's signature. (Refer to 06.06).

   Reasonable care must be taken to input the applicant's/ beneficiary's identification information accurately when requesting a credit profile report.

   When a case consists of a married couple meeting the Responsible Relative criteria (Refer to 02.23), both spouses must sign the Credit Authorization Report (CMS-99).

2. Credit Report Usage
   CMS will use the credit report as a verification tool for financial, property and eligibility information, which the applicant/beneficiary has provided on their application for CMS.

3. Processing a Credit Report
   At the end of each business day, the CMS IT System will batch and submit all credit report requests to Experian. The credit profile report is received from Experian on the following business day. The worker must follow-up with applicant/beneficiary on discrepancies found on report. The worker must verify that all verifications/documents are provided to clear up discrepancy on report to evaluate for CMS eligibility as described in 02.06.

NOTE: The credit check authorization is good for only one (1) credit report profile request.

Credit reports obtained through the CMS IT System may not be

given to the applicant/beneficiary. If the applicant/beneficiary requests a copy of their credit report, refer them to the sources listed on the Credit Check Authorization form CMS-99. If the applicant/beneficiary have questions regarding the information found on the credit report, refer them to the source listed on the CMS-99 or to their financial advisor.

Article 11 Section 02 Fraud Policy

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11.02.01 Fraud Policy

11.02.01A General

CMS is a County program, which is not within the State Investigator's jurisdiction. However, DHCS and Public Assistance Fraud Division (PAFD) fraud investigation reports may be used to support a CMS eligibility determination.

A designated HCA worker has the responsibility of receiving CMS fraud referrals and investigating the situation to determine the facts.

Workers first use investigative interviewing techniques to resolve unclear, conflicting or inconsistent information.

If the worker is …	**Then…**
able to resolve issues,	eligibility is determined and no referral is necessary.
unable to resolve issues and determine eligibility,	a referral to the CMS fraud worker is necessary.

On applications, the Fraud worker recommends what action the worker should take. On certifications, the Fraud worker determines if an overpayment has occurred and sets up a repayment plan as necessary.

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