Medi-Cal Program Guide Letter #669

February 23, 2009

Subject **ARTICLE A – COUNTY MEDICAL SERVICES (CMS) CERTIFICATION PERIOD, PATIENT HANDBOOK, POTENTIAL LINKAGE TO DISABILTY DETERMINATION SERVICES DIVISION (DDSD) MEDI-CAL AND COVERAGE INITIATIVE (CI) PROGRAM OPEN ENROLLMENT**

Effective Date February 1, 2009

Reference County Policy

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

- CMS standard certification period for non-chronics correction;
- PCC site noted inside cover of the CMS Patient Handbook;
- Disability linked Medi-Cal (DDSD) denied for no linkage;
- Open enrollment for CI ends January 31, 2009; and
- Discontinue screening and evaluating for the CI program.

Background Effective June 1, 2008, a new certification period was added and existing certification periods were redefined for non-chronic and chronic CMS beneficiaries (refer to MPG SN 08-07).

When a beneficiary is approved CMS benefits, the worker will ask the beneficiary to pick a primary care clinic (PCC) that contracts with CMS as their medical home. This information is entered into the CMS IT System which will be transferred to the CMS card.

CMS requires some applicants/beneficiaries with a disabling condition to apply for disability linked Medi-Cal through DDSD and if eligible, accept Medi-Cal coverage.

CI is a federally funded program for individuals with chronic conditions such as hypertension, and diabetes. Effective July 1, 2008, CMS eligibility workers screened individuals for the CI program before screening for CMS program. If the applicant was potentially eligible for CI, the worker would explain the benefits of the CI program and ask

the applicant if he or she wanted to be evaluated for CI. If so, the worker would process the CI and CMS applications concurrently, but would enroll the applicant in only the CI program if the applicant qualified for CI.

CMS Certification Period

Any reference to the standard certification period for non-chronic CMS beneficiaries in Article A, Section 7 has been corrected to six months.

Patient Handbook

The wording that the PCC site will also be transferred to the inside cover of the CMS Patient Handbook has been removed from Article A, Section A.2.2.G.

Potential Linkage to Medi-Cal

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 review the denial reason. If the denial is correct and is not due to no show, failure to provide or failure to cooperate, the worker may certify for the standard period, if otherwise eligible, and must document the Medi-Cal denial reason in the case record comments. If the denial reason is questionable, (e.g. SSI denied for reasons other than no disability; 250% Working Disabled Program not evaluated for working individual, etc.), the worker must refer the applicant/beneficiary to appeal and may certify for up to three (3) months. If the ninety (90) day appeal timeframe has expired, the worker must re-refer the applicant/beneficiary to apply for Medi-Cal and may certify for up to three (3) months. The worker must select the appropriate status code from the Medi-Cal status box in AuthMed and state the reason for the short certification in the case record comments and on the NOA that approves CMS.

If 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 evaluate if the denial is within the Medi-Cal ninety (90) day appeal timeframe. If it is within the appeal timeframe, the worker must refer the applicant to appeal and may certify for up to three (3) months. If the appeal timeframe has expired, the worker must re-refer the applicant to apply for Medi-Cal and may certify for up to three (3) months. The worker must select the appropriate status code from the Medi-Cal status box in AuthMed and state the reason for the short certification in the case record comments and on the NOA that approves CMS.

CI Program

Effective February 1, 2009, workers will no longer screen for the CI program. Open enrollment for the CI program ended January 31, 2009 (refer to CI SN 09-01). The CI program is dependent on funding and enrollment limits. Enrollment will occur only during open enrollment periods. Workers will be notified of future open enrollment periods via CI Special Notices. CMS eligibility workers will screen, evaluate and enroll individuals into the CI program only during the open enrollment period. Workers will be notified in the future of any changes to the enrollment period via a CI SN.

Automation Impact

None.

Quality Assurance Impact

Effective with the April 2009 review month, Quality Assurance will cite the appropriate error on 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 Program Guide.

Article	Change
Article A, Section 2	Removed wording that the PCC site will be transferred to the inside cover of the patient handbook. Added instructions to follow when Medi-Cal is denied for no linkage. Added CI enrollment period information.
Article A, Section 7	Corrected the standard certification period for non-chronics.

Manager Approval

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A.2.2

Hospital Outstationed Services (HOS)

General

The procedures in this section apply to HOS workers only.

A. Application Form/ Application Date

Aside from the exceptions listed below, CMS eligibility is established the date the worker receives the CMS IT System application referral or the date of admission to the hospital whichever is earlier.

Exception #1: If the CMS IT System application referral is received by the HOS worker more than 10 calendar days after the date of admission, eligibility is established the date the HOS worker received the application referral.

Exception #2: If the HOS worker receives a request for CMS to cover an Emergency Room (ER) visit occurring prior to the hospital admission, AND ONLY if the HOS referral was received within 30 days of the ER visit, the application date shall be the date of the ER visit. However, if the referral was not received within 30 days of the ER visit, or if the patient is determined ineligible for any reason for the ER visit month, then this exception does not apply and there is no CMS coverage for the ER visit. HOS workers shall refer to MPG A-2-3A for additional eligibility criteria regarding requests for coverage of an ER visit (uncertified visit) for a prior month.

B. Statement of Facts/Grant of Lien Form

HOS workers use the Statement of Facts located on the CMS IT System plus appropriate supplemental forms to determine CMS eligibility. Refer to MPG 4-2-4 for instructions on who may complete and sign the Statement of Facts and information regarding Authorized Representatives. A copy of the signed Statement of Facts signature page shall be maintained in the case record.

When an Individual applies for CMS, the worker will screen for the CI Program first (See A-2-6 below and the CI Program Guide). If the applicant is potentially eligible for CI, the worker will explain the benefits of the CI program and ask the applicant if he/she would like to be evaluated for CI. If yes, the worker will process the CI and CMS applications concurrently, but will enroll the applicant in only the CI program if the applicant qualifies for CI.

Effective 12/01/07, as a condition of eligibility, all applicants are required to sign the CMS Lien Information form (CMS-

123) and CMS Grant of Lien form (CMS-122) naming the County of San Diego as grantee to secure any and all real property of the applicant as security for repayment of all claims totaling $5,000 or more paid by the CMS Program on their behalf. The CMS Lien Information form (CMS-123) and the CMS Lien Acknowledge Statement (CMS-123A) may be included on the Image Verification Checklist (CMS-107). The CMS-122 may not be included on the CMS-107. The lien will be filed against any real property that is currently owned or real property that may be purchased in the future. Refer to MPG Article A, Section 5-5 for additional information regarding liens.

C. Face to Face Interviews

1. Waiving the Face-to-Face Interview

The HOS worker may waive the face-to-face interview when the applicant has been discharged before the intake interview can be scheduled. The HOS worker sends a standard appointment letter giving the applicant the option of returning to the hospital or completing the application by mail.

2. Processing Mail-in Applications

When the applicant chooses to mail in forms and verifications, the HOS worker will:

a) Review the forms for completeness and accuracy.
b) Clarify discrepancies and missing information by phone.
c) Document the phone conversation and clearly narrate the clarification in the case narrative.
d) Note the information in the County Use Section of the Statement of Facts, including an entry to "see narrative dated _____."
e) Return Statement of Facts pages when the signature is missing, or when the majority of the form is not completed, or in the event that a fraud referral has been made. Workers must have the applicant/beneficiary complete the missing items on the Statement of Facts. The worker shall:
   (1) Send a copy of the page with the missing information to the applicant/beneficiary to complete.
   (2) Send a notice of action requesting the applicant/ beneficiary provide the completed form(s) along with any necessary verification within 10 days from the date of the notice.
   (3) Continue processing the case with the information

received over the phone, however, the worker must receive all completed forms, including signature and required verifications prior to the approval of CMS benefits.

D. Rights and Responsibilities/ Lien Information /Grant of Lien/ Credit Check Authorization

Applicants must help the worker determine CMS eligibility by:

1) Completing all required forms.
2) Providing all necessary verification.
3) Reporting all pertinent facts within 10 days of their intake appointment.
4) Reading and signing the Rights and Responsibilities form (HHSA: CMS-15). Applicants who do not attend a face-to-face interview must return the signed originals to the worker for the case record.
5) Reading and signing the CMS Lien Information form (CMS-123) and the CMS Grant of Lien form (CMS-122). Applicants who refuse to provide the signed form and agreement are not eligible to CMS and their application will be denied.
6) Effective with applications taken on or after July 1, 2008, As a condition of eligibility applicants/beneficiaries must sign a Credit Check Authorization Form (CMS-99). The credit checks will be used as a verification tool for financial, property and eligibility information only, which the applicant/beneficiary provided.

E. Case Handling

1) Case Folder

HOS is unique in that workers may be dealing with both an electronic CMS IT system case, as well as a Medi-Cal case, automated through CalWIN. Case handling is different depending on the status of the patient's Medi-Cal eligibility.

a) CMS only FBU

When the FBU contains only adults, the HOS worker creates an electronic case in the CMS IT system. The manual non-automated CMS case folder will be requested from Record Library (RL) for review only and then returned to RL for storage.

b) When the applicant is an ineligible member of a Medi-Cal case, the HOS worker creates a separate CMS case electronically in the CMS IT system, as stated in item (e) below. This CMS case lists the CMS adult(s) only. However, CMS eligibility is based upon the income and

property of the total MFBU, except when Sneede and Gamma rules apply. Refer to MPG Article 5, Section 13 for Sneede and Gamma rules.

c) If there is an existing non-automated case file at another eligibility site, the worker may request the case folder to retrieve previously received verifications. There should not be a new case folder created.

d) Prior to March 2007, CMS only cases were tracked using the case name only. As of March 2007, in order to prepare for the eventual storage of all CMS cases at the County Record Library, case folders shall be manually created and a case number shall be assigned. Workers shall manually create or convert new and existing case folders to a 6-digit case number.

e) As of July 1, 2008, CMS eligibility determinations are automated. Workers will enter applicant information directly into the CMS IT System, AuthMED, there is no paper case file created. The CMS IT System will assign case numbers to each applicant. The applicant will retain this case number throughout the lifetime of the CMS case.

2) Denial/Failure to Provide Requirements

CMS follows Medi-Cal rules as outlined in Article 4, Section 13 of the MPG. If required verifications have not been provided after the initial 10 days have passed as outlined in MPG 4-13-3B (1), the worker prints the automated #936 from the CMS IT System, to inform CMS applicants that they have an additional 10 days to provide the verifications that were not provided during the initial 10-day period.

3) Denial – 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 patient may be certified for. When the patient is not eligible to CMS due to excess income (more than 165% FPL up to and including 350% FPL) and is otherwise eligible, the patient may apply for a CMS Hardship Evaluation. Refer to Article A, Section 13 for additional information. The

worker shall not deny the case, but will continue to evaluate whether the patient is eligible for a CMS Hardship evaluation. The worker shall advise the patient 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. NOA HHSA: CMS-39D is provided to the CMS applicant, indicating reason for denial and the budget used in the determination.

4) CMS Approved – No Medi-Cal Disability Evaluation (DDSD Pending

Workers enter the applicant information directly into the CMS IT System to certify CMS applications. 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.

5) CMS Approved – Medi-Cal Disability Evaluation (DDSD) Pending

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 Statement of Facts and DDSD packet (see Medi-Cal Linkage in Article A, Section 2, Item 5 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: Per MPG 5-4.2, DDSD's must be submitted within 10 days of receipt of the Statement of Facts.

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 sent in the case comments of the CMS and Medi-Cal case. Example: CMS 5/05-10/05, MC P (xx/xx application date) DDSD sent 6/12/05. This entry alerts the DDSD Recovery Specialist that there is potential reimbursement from Medi-Cal to CMS. The HOS worker then sends the Medi-Cal case to the DDSD workers 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 Article 4, Section 2.7(C). Upon approval or denial of Medi-Cal, the DDSD FRC worker sends form 14-10 HHSA to the ASO at O-557B. The CMS case is sent to HQ for filing in the Record Library.

F. Notification

Workers must verify through the CMS IT System that the appropriate Notices of Action were sent to applicants, including the Notice of Privacy Practices and the CMS Medical/Dental Form (HHSA-CMS-127) when certifying or recertifying CMS eligibility.

The CMS IT System will upload to the ASO at the end of the business day notifying the IDX System when CMS eligibility is approved or denied. Hospitals are able to view the status of an applicant's eligibility using the CMS IT Systems Provider Online Verification (POV) site.

G. Clinic Assignment

1) Upon approval, the worker asks the beneficiary to pick one of the primary care clinics (PCC) that contract with CMS as a medical home. Worker enters the PCC site in the CMS IT System which will be transferred to the CMS card and mailed to the beneficiary. If the patient is not able or available to select a PCC site, the worker will designate the PCC site based on the following factors:
   - PCC site closest to beneficiary's address;
   - PCC site previously designated in IDX, or
   - Select the site based on information known to the worker as to where follow-up care would be given.

2) Native Americans

   When the worker is aware that a CMS beneficiary is a Native American, the worker enters the information into the CMS IT System the appropriate form the HHSA:CMS-120, "Health Services Information for Native Americans" will populate which informs Native Americans that they may

choose to receive their primary health care through the CMS Primary Care Clinic they selected as part of the CMS enrollment process and/or a participating Indian Health Clinic. The worker must narrate that the form was given.

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H.
CMS Card

Upon approval, the CMS IT System will mail the CMS card along with the Approval Notice of Action (NOA) within 3 business days. The CMS card will not be automatically mailed to the homeless applicants. Once an approval action is taken an electronic version of the NOA and CMS card will be available on the CMS IT System. The worker will be able to print the NOA and CMS card for the applicant upon request. The CMS identification card is attached to the bottom of the NOA with a perforated seam. Certification Period will no longer be printed on the card, but will be stated on the NOA. Printed on the CMS identification card is the member number and the PCC site chosen.

I.
Patient Handbook

Upon approval of CMS, the worker informs the beneficiary that the CMS Patient Handbook will be mailed within 3 business days along with the Approval NOA and CMS card. The CMS Patient Handbook will not be automatically mailed to the homeless beneficiary. The worker gives a CMS Patient Handbook to the homeless beneficiary. The handbook provides information on how to access care through the CMS Program. It lists the CMS scope of services, contracted clinics, hospital and pharmacies as well as the information regarding required Share of Cost. Information is also provided regarding how to resolve problems, file complaints and file appeals.

J.
Share of Cost

Workers shall give the applicant the CMS-39A NOA and review the Share of Cost (SOC) with patient explaining the payment process.

K.
Coverage Information

Beneficiaries shall sign the form acknowledging that they have reviewed the information and they understand the limitations of CMS coverage and their responsibilities for Share of Cost (SOC) payments when certified for CMS with a SOC. A copy of the signed form shall be maintained in the case record.

L. Lien Information

Applicants/beneficiaries shall complete the CMS-122 and sign the CMS-123 acknowledging that they have reviewed the information, and that they understand and agree to the requirements for repayment of any and all claims totaling $5,000 or more which are paid for on their behalf by the CMS Program (refer to Article A-5-5 for more information). A copy of the signed forms shall be maintained in the case record. The Grant of Lien form (CMS-122) must be signed and witnessed at every application and reapplication. Staff may waive the lien requirement for recertification after they verify the Grant of Lien form (CMS-122) obtained during the application/reapplication process was signed and witnessed by either a Deputy County Clerk or a Notary Public. If the lien form on file was not witnessed by either a Deputy County Clerk or a Notary Public, the worker shall obtain new lien forms.

A.2.5

Potential Linkage to Medi-Cal

A. Potential Linkage to Medi-Cal Disability

CMS applicants and beneficiaries with a disabling condition that may potentially link them to Medi-Cal must apply for and if eligible, accept Medi-Cal coverage. If they refuse to apply for or accept full scope Medi-Cal, they are not eligible to CMS.

1) CMS requires some patients to apply for disability linked Medi-Cal through Disability Determination Services Division (DDSD) as a condition for eligibility for CMS and generally follows Medi-Cal regulations regarding applying for unconditionally available income. Medi-Cal does not consider SSI unconditionally available income because it is viewed as Public Assistance. 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: CMS2 to the Legal Aid SSI Advocate and notes in the case comment section of the CMS IT system, “SSI Advocacy Services referred.” (See Article A, Section 7, Item 3C for more information.)

2) A CMS applicant/beneficiary with a pending SSI or SSA Disability application or appeal decision should have applied for Medi-Cal at the time they applied for SSI/SSA. If they did

not apply, in order to protect the Medi-Cal filing date, the CMS worker must refer or process the Medi-Cal application as instructed in MPG Article A, Section 2, Item 3.D.4. 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.

3) 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 review the denial reason. If the denial is correct and is not due to no show, failure to provide or failure to cooperate, the worker may certify for the standard period, if otherwise eligible, and must document the Medi-Cal denial reason in the case record comments. If the denial reason is questionable, (e.g. SSI denied for reasons other than no disability; 250% Working Disabled Program not evaluated for working individual, etc.), the worker must refer the applicant/beneficiary to appeal and may certify for up to three (3) months. If the ninety (90) day appeal timeframe has expired, the worker must re-refer the applicant/beneficiary to apply for Medi-Cal and may certify for up to three (3) months. This allows the applicant enough time to appeal the denial while getting the necessary medical treatment. The worker must select the appropriate status code from the Medi-Cal status box in AuthMed and state the reason for the short certification in the case record comments and on the NOA that approves CMS.

4) If 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 evaluate if the denial is within the Medi-Cal ninety (90) day appeal timeframe. If it is within the appeal timeframe, the worker must refer the applicant to appeal and may certify for up to three (3) months. If the appeal timeframe has expired, the worker must re-refer the applicant to apply for Medi-Cal and may certify for up to three (3) months. The worker must select the appropriate status code from the Medi-Cal status box in AuthMed and state the reason for the short certification in the case record comments and on the NOA

that approves CMS.

5) 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.

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B. Medi-Cal Disability Linkage is Established

CMS beneficiaries determined to be disabled by State or Federal DDSD are ineligible to CMS. Upon receipt of the DDSD decision, CMS enters the disability information into IDX and HCPA CMS Recovery staff sends informing letter (HHSA: CMS 34) telling 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 Medi-Cal application process. If they have been determined disabled, but fail to finish the Medi-Cal eligibility determination process, they cannot remain on, or return to CMS.

C. 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 beneficiary who dies while in the hospital. In this situation, the beneficiary is 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.”

D. 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. All CAPI applications and re-determinations are processed in the Mission Valley Family Resource Center. A CMS applicant who has a pending CAPI application must also apply for Medi-Cal and may be granted CMS pending the DDSD decision. 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.

A.2.6

Linkage to Coverage Initiative (CI)

A. Linkage

CI is a federally funded program for individuals with chronic conditions such as hypertension, and diabetes (refer to the CI Program Guide for a complete listing of eligible conditions). When an applicant applies for CMS, the worker will screen for the CI Program first (See CI Program Guide). If an applicant is potentially eligible for CI, the worker shall explain the benefits of the CI program and ask the applicant if he/she would like to be evaluated for CI. If yes, the worker will process the CI and the CMS applications concurrently, but will enroll the applicant in only CI program if the applicant qualifies for CI. If there are pending verifications for CI, the worker is to send/give the pending verifications checklist to the applicant informing them of the 10 day requirement to provide verifications needed for both CI and CMS. The worker will refer the applicant to the Certified Applicant Assistor (CAA) for assistance in getting verifications needed for CI.

The 10/10 process will apply for all pending verifications. If after the first 10 days the applicant has provided needed CMS verifications but not CI verifications, send a second 10-day notice asking for the remaining CI verifications. After the second 10-day period:

- Grant CI if the applicant provided the CI verifications , or
- Grant CMS if the applicant did not provide CI verifications but did provide the needed CMS verifications, or
- Deny both CI and CMS if the applicant did not provide the needed verifications for either program and does not have good cause.

B. Coverage Initiative (CI) Open Enrollment

The CI program is dependent on funding and enrollment limits. Enrollment will occur only during open enrollment periods. Open enrollment periods are defined via CI Special Notices. CMS eligibility workers will screen, evaluate and enroll individuals into the CI program only during the open enrollment period.

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A.7.1

Certification

A. Beginning Month

The applicant must meet all eligibility criteria before certification. The first month of the certification period depends upon when the applicant has met all eligibility criteria. If all criteria are met for the application month, then the certification period begins that month. If all criteria are not met until the following month, the certification begins the month following the application month.

(Note: In the case of erroneous certification, refer to Item C below.)

EXAMPLE 1: The applicant is admitted to the hospital on July 28 and discharged on August 5. His net non-exempt income for July exceeds the CMS income limit, and his estimated net non-exempt income for August is below the CMS income limit. The beginning month of the certification period is August.

EXAMPLE 2: The applicant is admitted to the hospital on June 15 and discharged on June 20. In June, her net non-exempt property exceeds the CMS property limit. She has thirty days from the denial notice of action to spend the excess property down to within the limit. On July 10, she provides proof that she spent the property appropriately. The beginning month of the certification period is June.

EXAMPLE 3: The applicant received treatment at a Primary Care Clinic or Hospital Emergency Room on June 15. They had no current CMS eligibility at the time the treatment was provided but are now requesting CMS coverage for that uncertified visit. If within 30 days from the date of the uncertified visit, the patient contacts the ASO to schedule the CMS intake interview, and if all other eligibility factors are met, the beginning month of the certification period is June. If the phone call was made more than 30 days from the date of the uncertified visit, or if patient does not meet all other eligibility factors for the month of the uncertified visit, the beginning month of eligibility is the month of July. Refer to Article A, Sections 2-2.A and 2-3.A for additional information.

B. Ending Month

The standard certification period for applicants is six months. When a foreseeable change in circumstances that affects eligibility is expected during the certification period, the certification period may be less than six months. The last month of the certification period is the last month when all eligibility criteria are met. When the certification period is less

than six months, the worker must state the reason in the case record comments and on the NOA that certifies CMS.

EXAMPLE 1: The applicant's net non-exempt income is below the income limit in the month of application, but is expected to exceed the income limit the following month. The certification period is one month.

EXAMPLE 2: The applicant lives in San Diego County in the month of application, but says he is moving out of county the next month. The certification period is one month.

EXAMPLE 3: The applicant's INS document expires in three months. The certification period is three months.

EXAMPLE 4: The applicant needs to see a doctor or fill a prescription within 72 hours and is unable to get a bank statement. The worker can call the bank to verify the account balance and certify one month. Upon receipt of the bank statement, the worker may extend the certification period.

EXAMPLE 5: The applicant applies in the month of May and is receiving bi-weekly gross earned income of $595. Based on the paydays, the applicant will receive two paychecks per month for the period of May through August and will get a third paycheck in September. The gross income totals $1,289.36 when converted to a monthly amount using the 2.167 factor. The net non-exempt income is $1,199.36 after deducting the $90 standard work expense, which puts the applicant over the CMS MNL. The worker will re-compute eligibility using the actual income of $595 x 2 paydays in the month. This equals a net countable income of $1,100 after deducting the $90. The worker will certify for the months of May through August.

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C. Erroneous Certification Required Actions

Upon the discovery of an error resulting in erroneous certification of CMS, the worker must immediately contact their Supervisor. Depending on when the error is discovered, the worker will immediately take action as instructed under 1 or 2 below. The erroneous certification details must be recorded in the case narrative.

Note: This process will remain the same until CMS IT system is upgraded.

1. If the error was discovered within 30 calendar days of the erroneous action, and based on worker clearance of IDX, no claims have been received, the worker shall rescind the certification back

to the original application date by taking the following actions:

a) Issue Notice of Action CMS CMS-34R to the applicant, informing them of the error and the rescission.
b) Send a CMS-4 to the CMS Program Administrative Services Organization (ASO) at O557-B noting the change in eligibility status and the reason for the error.

2. If the error is discovered more than 30 calendar days after the erroneous action or within 30 calendar days but worker clearance of IDX reflects claims submitted for dates of service within the erroneous certification period, the worker shall discontinue CMS eligibility by taking the following actions:

a) Issue Notice of Action CMS CMS-34R to the applicant, informing them of the error and date of discontinuance.
b) Discontinue CMS benefits effective immediately.
c) Send a CMS-4 to the CMS Program ASO at O557-B noting the change in eligibility status and the reason for the error.
d) Send the case to the CMS Third Party Liability (TPL) Program Specialist (PS) at 0557-A for additional action including overpayment assessment and collections, as applicable.

NOTE: The TPL PS shall determine if additional actions are required, on a case by case basis, and as directed by the CMS Sr. Program Manager. In some cases, the provider may be liable for repayment of claims paid erroneously.

A.7.2

Recertification

General

Recertification is a determination that a beneficiary continues to meet the CMS eligibility criteria and has not had a break in aid of more than one (1) month. CMS has two standards for recertification: standard and chronic. Recertification information shall be recorded in the case narrative.

A. Recertification Eligibility

All CMS beneficiaries who wish to recertify must submit a completed CMS Medical/Dental Need Form (HHSA:CMS-127) to the ASO prior to requesting an eligibility appointment. The beneficiary will not be

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given an eligibility appointment if the completed form has not been received by the ASO.

EXCEPTION:

A CMS-127 is **not** needed when:

1) AmeriChoice has an approved Treatment Authorization Request (TAR) waiting to be used. An approved TAR is verification of a medical need.
2) A CMS inpatient (as identified in the Hospital Outstationed Services (HOS) Policy and Procedures manual) has been hospitalized and referred to HOS. The hospital admission is verification of a medical need.
3) Beneficiaries identified by AmeriChoice as having a chronic medical condition by the "CHRONIC" indicator on IDX Eligibility Enrollment Summary Screen.
4) Share of Cost has been met in the last month of certification.
5) A CMS beneficiary has been treated in the emergency room and calls the CMS Eligibility Appointment Line (ASO) within 30 days of the emergency room visit to schedule an intake interview. The emergency room visit is verification of a medical need.

A CMS-127 **is** needed when:

1. Requesting a recertification appointment.
2. Requesting a reapplication appointment within 6 months of their previous CMS certification expiring.

B. Non-Chronics

Non-chronics may be recertified for up to six months.

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C. Chronics

Chronics may be recertified up to twelve months. Chronics are those beneficiaries who have been identified by the ASO as having a chronic medical condition by entering a "**CHRONIC**" indicator on the IDX Eligibility Enrollment Summary Screen. Before recertifying, the worker **must** look for the "**CHRONIC**" indicator. CMS beneficiaries with the "**CHRONIC**" indicator, who fail to recertify timely, may still be certified for a 12-month period if they apply no later than two months from the last month of CMS eligibility and meet all eligibility requirements.

D. Exceptions

CMS beneficiaries, both chronic and non-chronic, are to be recertified for the standard period with the following exceptions:

When a beneficiary must comply with program requirements or has a foreseeable change in circumstances that affects eligibility during the recertification period, the recertification period may be less than the standard. When the recertification period is less than the standard, the worker must state the reason in the comment section of the CMS IT automated NOA that certifies CMS and in the case narrative.

EXAMPLE 1: A CMS beneficiary with the "CHRONIC" indicator on IDX claims or is identified as having a disabling condition that may potentially link him/her to Medi-Cal. The worker refers the beneficiary to apply for Medi-Cal noting "Referred to MC DED" in the case narrative. This example also applies to a non-chronic CMS beneficiary.

EXAMPLE 2: A CMS beneficiary with the "CHRONIC" indicator on IDX will turn 65 years old in nine months. The worker will recertify for eight months and note "Turns 65 month/year" in the comment section of the enrollment form. In this example, if the beneficiary is a non-chronic, the worker will recertify for six months and note "Turns 65 month/year" in the case narrative.

EXAMPLE 3: A CMS beneficiary with a "CHRONIC" indicator on IDX has a certification period that ends on January 31, 2001 and fails to recertify in February. He/she reapplies in March 2001 and meets all eligibility requirements and has no foreseeable changes that may affect eligibility. CMS is to be certified for 12 months. This information must be recorded in the case narrative.

A.7.5

Parents Potentially Linked To CalWORKs or Medi-Cal

General

Parents of minor children, who are disabled, incapacitated, or unemployed, must be referred to CalWORKS or Medi-Cal. Clinic workers evaluate linkage based upon the definitions in MPG Article 5, Section 2, refer the parent using form HHSA: CMS-5 and deny CMS. If the parent is denied CalWORKS or Medi-Cal because he or she is not linked and returns to re-apply for CMS, the worker must review the denial reason. If the denial appears correct, the worker will certify for six months. The worker may, upon request of the parent, rescind the CMS denial to the original application date by processing the application through the CMS IT System. If the denial reason is questionable, the worker must advise the parent to appeal and may certify for up to three months. This allows the parent enough time to appeal the denial while getting necessary medical treatment.