Medi-Cal Program Guide (MPG) Letter #720

Coverage Initiative Program Guide (CIPG) Letter #07

May 10, 2011

Subject **ARTICLE A - COUNTY MEDICAL SERVICES (CMS) AND COVERAGE INITIATIVE (CI)/MEDICAID COVERAGE EXPANSION (MCE) PROGRAM REQUIREMENT UPDATES**

Effective Date Upon receipt.

Reference County Policy

Purpose

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

- Update to the requirement to apply for unconditionally available income and disability-linked Medi-Cal.
- Collection and reimbursement requirement from third party settlements for CI/MCE.

Background

Unconditionally Available Income – CI/MCE and CMS

As a condition of CMS eligibility, applicants/beneficiaries who appear eligible for any unconditionally available income (e.g. Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI) benefits, etc.) are required to apply for and accept, the income to which they may be entitled.

Currently, the worker directs the applicant/beneficiary to apply for the unconditionally available income to which they may be entitled. Unlike the Hospital Outstation Services (HOS) program, the Clinic Outstation Services (COS) program approves CMS benefits for up to three (3) months when all other program requirements are met, upon directing the applicant/beneficiary to apply for unconditionally available income.

Unconditionally available income process is not in place for CI/MCE.

Disability-Linked Medi-Cal – CI/MCE and CMS

As a condition of eligibility, some applicants/beneficiaries are required to apply for disability linked Medi-Cal through the Disability Determination Services Division (DDSD).

Currently, unlike HOS, COS workers may certify for up to three (3)

months after directing the applicant/beneficiary to apply for disability-linked Medi-Cal. Documentation of the completed application is requested at recertification or reapplication. If the Medi-Cal application is denied for a non-disability reason such as no show, failure to provide, or for other reasons related to non-cooperation, the applicant/beneficiary is considered to be non-compliant and not entitled to future CI/MCE or CMS benefits until they comply.

Third Party Liability – CI/MCE
Third party liability process is not in place for CI/MCE.

Change

Unconditionally Available Income
As a condition of eligibility and in alignment with Medi-Cal policies, all CI/MCE/CMS applicants/beneficiaries, who appear eligible for any unconditionally available income, are required to provide verification of having applied for the unconditionally available income to which they may be entitled before benefits can be approved.

Disability-Linked Medi-Cal (DDSD)
As a condition of eligibility, all CI/MCE/CMS applicants/beneficiaries who are directed to apply for disability-linked Medi-Cal must apply for and complete the disability-linked Medi-Cal application process for full scope benefits, including retroactive months as needed, before benefits can be approved. **NOTE:** The DDSD decision is not required prior to approving CI//MCE/CMS benefits.

The CI-39A (Eng/Span) approval informing letter and CMS-39A (Eng/Span) eligibility approval notice of action have been revised to remove the statement directing the applicant/beneficiary to go to the Family Resource Center (FRC) to apply for disability linked Medi-Cal (Attachments A, B, C & D).

Third Party Liability
The CI/MCE program shall follow the CMS policies and procedures regarding reimbursement for CI/MCE health care services which may be covered through third party liability. Refer to Medi-Cal Program Guide, Article A, Section 6.

In an effort to streamline the use of forms when determining eligibility for the CI/MCE or CMS program, the third party liability report CMS-7Mares form has been revised to include CI/MCE (Attachments E & F).

Worker Required

Unconditionally Available Income

Action

CI/MCE/CMS benefits shall be approved upon receipt of verification of the application for unconditionally available income, as long as all other eligibility requirements are met.

Disability-Linked Medi-Cal (DDSD)

If all eligibility requirements are met, CI/MCE/CMS benefits shall be approved upon receipt of verification that the applicant/beneficiary:

- Has fully completed the Medi-Cal application process;
- Has met **all** Medi-Cal eligibility and verification requirements;
- The Medi-Cal application is pending in CalWIN; and
- The DDSD packet has been imaged into DoReS.

Third Party Liability

The worker must have the applicant/beneficiary complete and sign the Third Party Liability Report form (CMS-7Mares) acknowledging their responsibility to reimburse CI/MCE/CMS from potential responsible third parties. If they refuse to complete and sign the report, they are denied for refusal to comply with program requirements.

Forms Impact

The table below shows the revised NOA, informing letter and form affected by this letter.

Number	Title	Change	Attachments
CI-39A (Eng/Span)	CI Approval Informing Letter	Revised	A & B
CMS-39A (Eng/Span)	CMS Eligibility Approval Notice of Action	Revised	C & D
CMS-7Mares (Eng/Span)	Third Party Liability Report	Revised	E & F

The revised CMS NOA and form have been uploaded into Xerox Print Services and are available to be ordered.

CMS IT System Impact

The revised CI-39A, CMS-39A, and CMS-7Mares will be uploaded into the CMS IT system.

ACCESS Impact

No impact.

Quality Assurance

CMS

Effective with the June 2011 sample month, Quality Assurance will cite

Impact

with the appropriate error any case that does not follow the requirements of this letter.

CI/MCE
Effective with the June 2011 sample month, HCPA staff will cite with the appropriate error any CI/MCE case that does not follow the requirements of this letter.

Summary of Changes

The table below shows the changes to Article A of the MPG.

Section	Change
A.2.2, A.2.3 & A.2.5	Updated the disability-linked Medi-Cal DDSS requirement.
A.5.1	Updated the unconditionally available income requirement.
A.7.2, A.7.3 & A.7.5	Removed example and reference to the short certification for applicants/beneficiaries required to comply with program regulations.
A.8.2	• Update to mandatory referrals IDX comment entries. • Removed reference to the A-R status code for referring to Medi-Cal DDSD.

The table below shows the changes to the CIPG.

Section	Change
02.02.01	Added Third Party Liability other coverage requirement.
07.01.01	Added unconditionally available income requirement.

Manager Approval

Janya Bowman, Assistant Deputy Director
Health Care Policy Administration
Office of Health Systems Innovation

Sylvia Melena, Assistant Deputy Director
Self-Sufficiency Programs
Strategic Planning and Operational Support Division

JP

HEALTH CARE COVERAGE INITIATIVE
APPROVAL INFORMING LETTER

Date: _____ Member ID#: _____

CI Representative: _____

To _____ Phone: _____

_____ Location: _____

_____ Address: _____

_____

_____

Your application for the Coverage Initiative (CI) Program has been approved from ___/___/___ through ___/___/___.

Comments: _____

The CI program provides medical services including disease management, enhanced specialty and dental services. Please remember to go to the clinic/medical home listed on the front of your CI card. Your clinic/ medical home manages your medical care. Except for emergencies, always contact your primary care provider for your care.

CI provides medical services for serious health problems. This approval does not imply that all services are covered by CI. Refer to the CI patient handbook for additional information on coverage.

To continue your CI coverage past the dates listed above, you must call the Eligibility Appointment Line 1-800-587-8118 in the month prior to the expiration month on your current CI card.

To report any changes in your address, income, or any other circumstance, please call 1-888-553-5552.

If you disagree with this action you have the right to request an Administrative Review. You must do this within ten (10) calendar days of the date of this letter by calling (858) 492-2462 or by faxing a written request to (858) 492-2276.

Requests submitted after 10 calendar days shall only be considered if you present good cause for missing the deadline.

The Consumer Center for Health Education and Advocacy may be able to offer you free advice on how to handle your request for a review. For more information, call 1-877-734-3258 (toll free).

HEALTH CARE COVERAGE INITIATIVE
CARTA INFORMATIVA DE APROBACION

Fecha:_____ No. de Miembro:_____

Representante de CI:_____

Para:_____ Teléfono:_____

_____ Ubicación:_____

_____ Domicilio:_____

_____

_____

Su solicitud para el programa Coverage Initiative (CI, por sus siglas en inglés) ha sido aprobada a partir del ___/___/___ hasta el ___/___/___.

Comentario: _____

El programa CI proporciona servicios médicos para ayudar con el cuidado y manejo de su condición médica, así como servicios especializados avanzados y dentales. Por favor recuerde ir al centro médico/clínica de cuidado primario que está anotado en su tarjeta de CI. Su centro médico/clínica de cuidado primario coordinará su cuidado médico. Siempre llame a su proveedor de cuidado primario para su cuidado, excepto en caso de emergencia.

El programa CI le proporciona servicios médicos para problemas de salud graves. Esta aprobación no implica que todos los servicios médicos serán cubiertos por CI. Consulte su manual de paciente de CI (CI Patient Handbook) para más información de los servicios que cubre el programa CI.

Para continuar su cobertura de CI después de las fechas mencionadas arriba, necesita llamar a la Línea para Cita de Elegibilidad al 1-800-587-8118 para renovar CI en el mes antes de que la cobertura de su tarjeta actual termine.

Para reportar cambios de domicilio, ingresos o cualquier otra circunstancia, llame al 1-888-553-5552.

Si usted no está de acuerdo con esta acción, tiene el derecho de pedir una Revisión Administrativa (Administrative Review). Usted debe pedir dicha revisión dentro de diez (10) días consecutivos de la fecha de esta carta llamando al (858) 492-2462, o enviando un fax con su petición por escrito al (858) 492-2276.

Las peticiones que se reciban después de 10 días consecutivos se considerarán solamente si usted presenta una buena causa que le impidió hacerlo a tiempo.

Si necesita ayuda durante el proceso de cómo dirigirse con su petición de una revisión, el Centro del Consumidor para Educación sobre la Salud y Defensa de sus Derechos le puede dar asistencia gratuita. El número de teléfono sin costo es 1-877-734-3258.

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

Date: _____ Member ID#: _____

CMS Representative: _____

To _____ Phone: _____

_____ Location: _____

_____ Address: _____

_____

_____

The following action has been taken on your application for County Medical Services (CMS):

❒ Your application has been approved from _____through_____ with no Monthly Share of Cost.

❒ Your application for CMS Hardship has been approved. You are eligible to CMS with the Monthly Share of Cost listed below from _____through_____.

Your Monthly Share of Cost is: $_____.

Comments: _____

Your Medical Home/Primary Care Clinic (PCC) is listed on your CMS card. Your primary care provider coordinates your medical care, as appropriate. Except for emergencies, always contact your primary care provider for your care.

Share of Cost is the amount you must pay or be obligated to pay toward the cost of your CMS covered health care services each month. In any month you receive CMS services, you will be billed by the County for your share of cost or the amount of CMS services, whichever is less. You will not be billed for any months in which you did not receive CMS services.

If you are eligible for CMS with a monthly Share of Cost and your spouse is eligible for Medi-Cal with a Share of Cost, the money spent to meet the Medi-Cal spouse's SOC may be applied to reduce the CMS SOC amount using CMS rates, as long as the services are within CMS scope of services. To be eligible for a CMS SOC deduction, you must send the itemized statement for services received by the Medi-Cal spouse, proof of the amount paid towards the Medi-Cal SOC amount and billing statement when sending your CMS SOC payment to the County.

CMS provides medical services for serious health problems. This approval does not imply that all services are covered by CMS. A medical determination for each health care service you receive will be made each time you visit the CMS health care provider.

To continue your CMS coverage past your certification period you must call the CMS Eligibility Appointment Line (800) 587-8118 **before your CMS expiration month to request a recertification appointment.**

To report changes in your address, income, or any other circumstance, call 1-888-553-5552.

If you disagree with this action, you have the right to request a First Level Supervisory Review. You must do this within fourteen (14) calendar days of the date of this notice in writing or by phone:

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

You may write to:

CMS Program (O557E)
FIRST LEVEL SUPERVISORY REVIEW
P.O. BOX 85222
SAN DIEGO, CA 92186-5222

OR

You may call:

CMS CALENDAR CLERK
(858) 492-2200

Requests submitted after 14 calendar days shall only be considered if you present good cause for missing the deadline.

The Consumer Center for Health Education and Advocacy may be able to offer you free advice on how to handle your appeal. For more information call 1-877-734-3258.

CMS Regulations:

COUNTY MEDICAL SERVICES
AVISO DE ACCION

Fecha:_____ No. de Miembro:_____

Representante de CMS:_____

Para:_____ Teléfono:_____

_____ Ubicación:_____

_____ Domicilio:_____

_____

La siguiente acción se ha tomado sobre su solicitud para elegibilidad al programa County Medical Services (CMS):

❒ Su solicitud ha sido aprobada a partir del _____hasta el _____ sin Parte de Costo Mensual.

❒ Su solicitud para la Circunstancia Extrema del Programa CMS ha sido aprobada. Usted es elegible a CMS con Parte de Costo Mensual anotado abajo a partir del_____hasta el _____.

Su Parte de Costo Mensual es: $ _____.

Comentario: _____

Su Centro Médico/Clínica de Cuidado Primario (PCC) está anotado en su tarjeta de CMS. Su proveedor de cuidado primario coordinará su cuidado médico, como sea apropiado. Siempre llame a su proveedor de cuidado primario para su cuidado, excepto en caso de emergencia.

Parte de Costo es la cantidad que usted debe pagar u obligarse a pagar cada mes hacia el costo de sus servicios médicos que cubre CMS. Cualquier mes que usted reciba servicios médicos del programa CMS, el Condado le cobrará la cantidad de su parte de costo o la cantidad de sus servicios médicos, la cantidad que sea menor. Usted no recibirá un cobro por ningún mes en el cual usted no recibió servicios médicos de CMS.

Si es elegible para CMS con parte de costo y su cónyuge es elegible para Medi-Cal con parte de costo, puede ser que la cantidad que se gastó para satisfacer la Parte de Costo del cónyuge elegible a Medi-Cal se aplique para reducir la Parte de Costo de CMS usando la cantidad del precio que usa CMS, siempre y cuando los servicios médicos recibidos son parte del criterio de cobertura del programa CMS. Para ser elegible a la deducción de Parte de Costo de CMS, debe de enviar el estado detallado de los servicios recibidos por su cónyuge elegible a Medi-Cal, prueba de la cantidad pagada hacia la Parte de Costo de Medi-Cal y el estado de cuenta cuando envíe su pago al Condado.

CMS provee servicios médicos para problemas serios de salud. Esta aprobación no implica que todos los servicios serán cubiertos por CMS. Se hará una determinación médica por cada servicio de cuidado médico que usted reciba cada vez que usted visite al proveedor de salud de CMS.

Para continuar su cobertura del programa CMS usted debe de llamar a la Línea para Citas de Elegibilidad al (800) 587-8118 antes de que su elegibilidad este programada a terminar para solicitar una cita para renovar el programa CMS.

Para reportar cambios de domicilio, ingresos o cualquier otra circunstancia, llame al 1-888-553-5552.

COUNTY MEDICAL SERVICES
AVISO DE ACCION

Si usted no esta de acuerdo con esta acción, usted tiene el derecho de pedir una Revisión de Primer Nivel por un Supervisor. Debe solicitar la revisión dentro de catorce (14) días consecutivos de la fecha de este aviso escribiendo o llamando a:

Puede escribir a:

CMS Program (0557E)
FIRST LEVEL SUPERVISORY REVIEW
P.O. BOX 85222
SAN DIEGO, CA 92186-5222

O

Puede llamar a:

CMS CALENDAR CLERK
(858) 492-2200

Peticiones recibidas después de 14 días consecutivos serán consideradas solamente si usted presenta una buena causa que le impidió hacerlo a tiempo.

El Centro del Consumidor Para Educación Sobre La Salud y Defensa de Sus Derechos puede darle información gratuita de cómo llevar acabo su apelación. Para mas información llame al 1-877-734-3258.

CMS Regulations:

THIRD PARTY LIABILITY REPORT

Case Name	COS Site/Hospital

Complete the following information for all applicants who have medical bills for which another party may be responsible (e.g., auto accident, job injuries, injuries because of another's negligence). Include area codes for all telephone numbers.

A: Injured Applicant Information			
Name:		Birth Date:	Social Security Number:
Address (Street, Apt., Space):	City:	Zip:	Phone:
Applicant's Representative/Attorney/Insurance Company:			Phone:
Address (Street or P.O. Box):	City:	Zip:	

B: Accident Report			
Date accident/injury occurred:		at (location):	
Initial treatment was given at (name of hospital/clinic):			
Type of accident		Type of injury	
Police report filed? [ ] Yes [ ] No		Did injury occur on the job? [ ] Yes [ ] No	

C: Party who may be responsible for payment for accident/injury			
Name of Insured/Responsible Party:			
Address of Insured/Responsible Party:	City:	Zip:	Phone:
Name of Insurance Company:	Policy Number:		Claim Number:
Address of Insurance Company:	City:	Zip:	Phone:
Name of Attorney:			Phone:
Address of Attorney:	City:	Zip:	
Additional Information:			

I understand I am responsible for immediately reporting to a Coverage Initiative (CI)/Medicaid Coverage Expansion (MCE)/County Medical Services (CMS) Representative when there is the possibility of payment of CI/MCE/CMS services from 1) my own insurance company or 2) from a third party when a lawsuit is filed and the action results in a judgment awarded to me. I agree to repay CI/MCE/CMS for services related to this incident from any proceeds I receive from my own insurance or judgment up to the amount paid by CI/MCE/CMS to providers of my medical care. I authorize CI/MCE/CMS to release information necessary to resolve this third party claim.

Applicant's Signature _____ Date _____ Worker's Signature _____

REPORTE DE RESPONSABILIDAD DE TERCEROS

Case Name	COS Site/Hospital

Complete la siguiente información para todo solicitante que tenga cuentas médicas de las cuales otra persona pudiera ser responsable (ej., accidente automovilístico, daño de trabajo, daños por negligencia de otros). Incluya código de área de todos los números de teléfono.

A: Información del Solicitante Herido.		
Nombre:	Fecha de Nacimiento:	Número de Seguro Social:
Domicilio (Calle. Apt., Espacio): Ciudad: Código Postal:		Teléfono:
Representante del Solicitante/Abogado/Compañía de Seguros:		Teléfono:
Domicilio (Calle o Apartado Postal): Ciudad: Código Postal:		

B: Reporte del Accidente	
Fecha de cuándo ocurrió el accidente/la herida : Lugar:	
Los primeros tratamientos se recibieron en (nombre del hospital/clínica):	
Tipo de accidente	Tipo de herida/daño
¿Se presentó un reporte policíaco? [ ] Si [ ] No	¿La herida ocurrió en el trabajo? [ ] Si [ ] No

C: Persona/Entidad que pudiera ser responsable del pago para el accidente/herida			
Nombre de la persona asegurada/responsable:			
Dirección de la persona asegurada/responsable: Ciudad:		Código Postal:	Teléfono:
Nombre de la Compañía de Seguros:	Número de Póliza:		Número de Reclamo:
Dirección de la Compañía de Seguros: Ciudad:		Código Postal:	Teléfono:
Nombre del Abogado:			Teléfono:
Dirección del Abogado: Ciudad:		Código Postal:	
Información adicional:			

Entiendo que soy responsable de reportar inmediatamente al Representante de Coverage Initiative (CI, por sus siglas en inglés)/Medicaid Coverage Expansion (MCE)/County Medical Services (CMS) cuando exista la posibilidad de pago a CI/MCE/CMS de parte de: 1) mi propia compañía de seguros o 2) de una tercera persona responsable cuando se lleve a cabo una demanda judicial y resulte en una orden judicial a mi favor. Estoy de acuerdo con reembolsar a CI/MCE/CMS por servicios relacionados con este incidente de cualquier recurso que reciba de mi propio seguro o de la demanda judicial, todo dinero pagado por CI/MCE/CMS a instituciones que me proporcionaron atención médica. Por este medio autorizo a CI/MCE/CMS que revele información necesaria con el fin de resolver este reclamo a un tercer responsable.

Firma del Solicitante _____ Fecha _____ Firma del Trabajador(a) _____

A.2.2 Hospital Outstation Services (HOS)

E. Case Processing

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

The worker opens an automated Medi-Cal case in 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.2.5 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.** CMS should not be certified if there is a pending fraud investigation on the Medi-Cal 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 04.02.10D. 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.

F. Notification

The CMS IT System will generate and mail to the applicant the appropriate Notice of Action when certifying or recertifying CMS eligibility. Exceptions to the automatic mailing are listed in A.8.1.

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.

Workers must also send form HHSA: CMS-4 to the ASO at 0557B to record in IDX COMMENTS any information that needs an explanation/clarification or changes that impact the applicant's/beneficiary's eligibility.

MPG Letter #720 (05/11)

A.2.3 Primary Care Clinics and Public Health Centers

D. Case Processing

6) Approved – Medi-Cal Disability Evaluation (DDSD) Pending

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, CI/MCE/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. (See Medi-Cal Linkage in A.2.5 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.

A.2.5 Potential Linkage to Medi-Cal

D. Previous Medi-Cal Application Denied

1) Returning CMS Applicant/Beneficiary

When the 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. DDSD application denied because SSI was denied for reason other than no disability; 250% Working Disabled Program not evaluated for working individual, etc.),	1 Refer the individual to appeal the Medi-Cal DDSD 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.

	ninety (90) day appeal timeframe has expired,	1 Re-refer the individual 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 the 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 worker must:

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 individual to appeal the Medi-

		Cal DDSD 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.

MPG LTR #720 05/11)

A.5.1 Income

I. Unconditionally Available Income

The definition and treatment of unconditionally available income is the same a Medi-Cal (MPG Article 4, Section 12) with the following differences:

1) CMS Only

At initial application, recertification or reapplication, as a condition of eligibility and in alignment with Medi-Cal policies, all applicants/beneficiaries, who appear eligible for any unconditionally available income (e.g. Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI) benefits, etc.), are required to apply for the unconditionally available income to which they may be entitled. CMS benefits shall be approved upon receipt of verification of the application for unconditionally available income as long as all other eligibility requirements are met.

NOTE: Applicants or beneficiaries who do not have a potential claim present on the IEVS EDD on-line real time match should not be referred to EDD to apply for UIB or DIB (State Disability) unless it is an out of state claim. **A copy of the screen is required in the case record for documentation**.

MPG LTR# 720 (05/11)

A.7.2 Recertification

C. Exceptions

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

When a beneficiary has a foreseeable change in circumstances that affects eligibility during the recertification period, the recertification period may be less than the allowable period. When the recertification period is less than the allowable, 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 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.

MPG LTR #720 (05/11)

A.7.3 Left Blank Intentionally

A.7.5 Parents Potentially Linked To CalWORKs or Medi-Cal

A. Denied for No Linkage

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 reason is...	Then the worker...
correct,	will certify CMS for up to the allowable period. 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.
questionable,	must refer the parent to appeal the CalWORKS/Medi-Cal denial and may certify for up to the allowable period once the parent has complied with the appeals process. **Note:** CMS cannot be recertified until the parent has fully completed the appeals process.

MPG LTR #720 (05/11)

A.8.2 IDX System

A. Recording Case Activity

Disposition

The disposition of every CMS application and recertification is automatically communicated from the CMS IT System to IDX each night.

IDX Comment Entries

Workers must send form HHSA: CMS-4 to the ASO at 0557B to record in IDX COMMENTS any information that needs an explanation/clarification or changes that affect eligibility.

MPG LTR 720 (05/11)

D. Medi-Cal Status

CMS uses status codes to track the progress of Medi-Cal applications. When beneficiaries are approved Medi-Cal retroactively, CMS bills Medi-Cal for reimbursement and notifies the hospitals and clinics that they need to bill Medi-Cal for services rendered.

1) Medi-Cal Pending (Status Code A-P)

This status code identifies beneficiaries who have applied for Medi-Cal and have a case pending on CalWIN. The worker writes the Medi-Cal application date in the case narrative. This code is also used when beneficiaries have a SSI application or SSI appeal pending. The worker writes the date of the SSI application or the filing date and level of the SSI appeal on the case narrative. When the beneficiary has a record on MEDS, the SSI appeal information is on the MEDS QP screen. Workers must document that they asked the beneficiary for an updated status of their Medi-Cal, Social Security application or appeal at every interview. If there is a change, the entry must be made in the case narrative.

If the beneficiary is approved for Medi-Cal, Social Security disability benefits or SSI, the worker must immediately forward this information to the Recovery Program Specialist at 0557A, by e-mail or fax. If the award letter is available, it is attached to the information; if not, the worker must ask the beneficiary to provide a copy of the award letter and forward it when received. **NOTE: Workers must not approve CMS benefits for a beneficiary that has been determined disabled who has a pending Medi-Cal case, pending SSI/Social Security Disability application or has an appeal pending at SSA Hearing level.**

2) Medi-Cal Approved (Status Code N-A)

This status code identifies beneficiaries whose Medi-Cal eligibility has been **verified** on MEDS.

Coverage Initiative Program Guide (CIPG)

02.02.01 Eligibility Criteria

02.02.01G Other Coverage

B. Third Party Liability

CI/MCE shall follow the CMS policies and procedures regarding reimbursement for CI/MCE health care services which may be covered by third party liability. Refer to Medi-Cal Program Guide, Article A, Section 6.

CIPG LTR #07 (05/11)

07.01.01 Income

07.01.01F Unconditionally Available Income

The treatment and requirement to apply for unconditionally available income is the same as CMS. Refer to Medi-Cal Program Guide, Article A, Section 5.

CIPG LTR #07 (05/11)