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Department of Health Care Services



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GOVERNOR

DATE: July 18, 2016

ALL PLAN LETTER 16-007
SUPERSEDES ALL PLAN LETTER 15-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: DESIGNATED PUBLIC HOSPITALS: BILLING FOR BENEFICIARIES
WITH CALIFORNIA CHILDREN'S SERVICES ELIGIBLE CONDITIONS
AND/OR MEDI-CAL MANAGED CARE

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide information to Medi-Cal managed care health plans (MCPs) regarding the billing of inpatient services at Designated Public Hospitals (DPHs) for beneficiaries with California Children's Services (CCS)-eligible conditions who are also enrolled in an MCP. This APL applies the CCS Service Authorization Request (SAR) policies contained in APL 16-008¹.

BACKGROUND:

CCS reimburses providers for services provided to Medi-Cal eligible children with specified conditions through Medi-Cal fee-for-service (FFS), with some exceptions. Payments to hospitals for these services align with the payment methodology utilized for all other Medi-Cal FFS providers.

Many Medi-Cal beneficiaries with CCS-eligible conditions are also enrolled in MCPs. CCS services are generally carved-out of the MCP contracts; however, there are some MCPs in certain counties that carve-in CCS services. For those MCPs in which CCS services are carved-out, the MCPs are responsible for providing medically necessary services that are not related to the CCS condition. For those MCPs in which CCS services are covered, the MCPs are responsible for covering CCS services in addition to all medically necessary services not related to the CCS condition.

Prior to the issuance of APL 15-011, inpatient services provided at DPHs to beneficiaries with CCS-eligible conditions that were enrolled in MCPs where CCS services were carved-out were paid through Medi-Cal FFS. Payments were based on the number of days authorized on a CCS SAR. If an MCP beneficiary was hospitalized

¹ APL 16-008 is available at: <http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx>

for a CCS-eligible condition, as well as a condition covered by the MCP, a provider was required to bill Medi-Cal FFS for the days covered by the CCS SAR and bill the MCP for the days covered by the MCP. This was called billing by payer source.

REQUIREMENTS:

The following billing policy will apply for services provided to a Medi-Cal beneficiary with a CCS-eligible condition that is enrolled in an MCP in which CCS services are carved-out:

- If a beneficiary is admitted to a hospital for a CCS-eligible condition, the entire stay must be billed to Medi-Cal FFS, regardless of whether any services provided during that stay are covered by the MCP. The hospital will receive payment for the entire stay based on the applicable DPH Medi-Cal inpatient interim per diem rate. No billing will be allowed to the MCP;
- If a beneficiary is admitted to a hospital for a non-CCS-eligible condition, and subsequently receives services during the stay for a CCS-eligible condition, the full stay must be billed to Medi-Cal FFS. A SAR will be authorized back to the day of admission². The hospital will receive payment for the entire stay based on the applicable DPH Medi-Cal inpatient interim per diem rate. No billing will be allowed to the MCP; and
- When a beneficiary stay includes delivery and well-baby coverage under an MCP, the entire claim must be billed to the MCP. If, during the stay, the baby develops a CCS-eligible condition, the entire stay for the baby will require a SAR from the date of admission and must be billed to Medi-Cal FFS. MCPs must not be billed for the baby's stay. In this case, the hospital will receive two payments. One for the delivery and well-baby stay from the MCP and one for the baby under the applicable DPH Medi-Cal inpatient interim per diem rate.

² Section 123929 of the Health and Safety Code provides for prior authorization of CCS services. Section 123929(a) provides:

Prior authorization is contingent on determination by the department or its designee of all of the following:

1. The child receiving the services is confirmed to be medically eligible for the CCS program.
2. The provider of the services is approved in accordance with the standards of the CCS program.
3. The services authorized are medically necessary to treat the CCS-eligible medical condition.

The general criteria for determining CCS medical eligibility and the CCS Medically eligible conditions are specified in Section 41515.1 - 41518.9, Title 22, California Code of Regulations. However, by policy letter the CCS program has long provided for acuity based medical eligibility determination for inpatient neonatal intensive care unit (NICU) services including physician services. The operative CCS policy letters that provide for this are CCS Numbered Letter 02-0413 and 05-0502 which are available at the following links:

<http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl020413.pdf>

<http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl050502.pdf>

For days of service and for DPH stays, the following billing policy will apply for services provided to a Medi-Cal beneficiary with a CCS-eligible condition who is enrolled in an MCP in which CCS services are covered:

- If a beneficiary is admitted to a hospital for either a CCS-eligible condition or a non-CCS-eligible condition, the entire claim must be billed to the MCP. The hospital will receive one payment for the entire stay from the MCP.

If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services