CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

January 31, 2007

DMH LETTER NO.: 07-01

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: IMPLEMENTATION OF THE CONLAN v. BONTA (2002) 102 CAL.APP. 4TH 745, AND CONLAN v. SHEWRY (2005) 131 CAL.APP. 4TH 1354 APPELLATE COURT DECISIONS AND RELATED SUPERIOR COURT ORDERS

REFERENCE DMH INFORMATION NOTICE NO.: 06-09 BENEFICIARY REIMBURSEMENT IMPLEMENTATION EFFECTIVE NOVEMBER 16, 2006

This letter provides guidance to Mental Health Plans (MHPs) regarding MHPs' responsibilities pursuant to the order(s) issued by the Superior Court, County of San Francisco in the above-referenced matters.

The California Department of Health Services (CDHS) has been ordered by the Superior Court to implement a process enabling Medi-Cal beneficiaries to obtain prompt reimbursement for paid out-of-pocket expenses for Medi-Cal covered services received during periods of beneficiary Medi-Cal eligibility. These periods include:

1. The retroactive eligibility period (up to 3 months prior to the month of application to the Medi-Cal Program);
2. The evaluation period (from the time of application to the Medi-Cal Program until eligibility is established); and
3. The post-approval period (the time period after eligibility is established).

BENEFICIARY REIMBURSEMENT GENERAL IMPLEMENTATION PROCESS

On December 26, 2006, the CDHS began mailing Beneficiary Notices (Enclosure 1) to the address of record of all current Medi-Cal beneficiaries (approximately 4 million heads of household), as well as those individuals (approximately 8 million) who were eligible for Medi-Cal at any time since June 27, 1997. The beneficiary notices will inform the individuals of their right to file a claim for reimbursement of out-of-pocket expenses paid for by the beneficiary or their representative and the process available for filing such claims.

Beneficiaries or their representatives are required to submit a completed beneficiary reimbursement claim packet to Electronic Data Systems (EDS) when requesting reimbursement for paid out-of-pocket medical expenses pursuant to the *C*ourt's orders. The beneficiary reimbursement claim packets are received by the EDS Beneficiary Service Center (BSC) and screened for completeness and for beneficiary Medi-Cal eligibility during the claim period. The BSC is responsible for responding to questions or requests for claim materials and ensuring the beneficiary reimbursement claims are complete by following up with beneficiaries and providers as necessary. Claims that are determined to be incomplete will be returned to the submitter for correction and/or additional information. Incomplete claims that are not resubmitted within 30 days or that have been returned to the submitter for a third time, as well as claims that are determined to be invalid will be denied by process by the BSC. A letter will be sent to the beneficiary on behalf of CDHS by the BSC explaining why their reimbursement claim was denied and notifying the beneficiary of the right to request a State Hearing (also referred to as a State Fair Hearing).

DEADLINES FOR FILING BENEFICIARY REIMBURSEMENT CLAIMS

Valid beneficiary reimbursement claims for paid out-of-pocket expenses for Medi-Cal covered services for dates of service between June 27, 1997, and the Court ordered implementation date of November 16, 2006, must be submitted within one year from the implementation date, November 16, 2007.

Beneficiary reimbursement claims for dates of service on or before November 16, 2006, that are submitted after November 16, 2007, will be denied by the BSC (unless the beneficiary received their eligibility approval within 90 days of November 16, 2007, and was eligible for the service on the date of service).

A complete beneficiary reimbursement claim consists of:

1. A completed claim form;

2. A completed State of California Standard 204 (Payee Data Record) form;

3. A copy of the Medi-Cal Benefits Identification Card;

4. Dated proof of payment(s) by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.), with an itemized list of services covered by the payment, and to whom the payment was made; and

5. Medical necessity documentation and declarations, when required.

MHP INSTRUCTIONS FOR PROCESSING BENEFICIARY REIMBURSEMENT CLAIMS

The BSC will continue to respond to questions or requests for claim materials and ensure the beneficiary reimbursement claims are complete. Nevertheless, MHPs are required to process specialty mental health services beneficiary reimbursement claims with dates of service of July 1, 2006, and later. EDS will send complete beneficiary reimbursement claims with a service date of July 1, 2006, or later, to the responsible MHP, with a copy sent to the Department of Mental Health (DMH) for tracking purposes, within 15 days after receipt of the beneficiary reimbursement claim. The MHP is required to:

- Receive and log the beneficiary reimbursement claim. The log must include, but is not limited to: the date that the beneficiary reimbursement claim was received, the claim issue number referenced on the bottom of the claim form, the name of the beneficiary, the date the beneficiary reimbursement claim was referred to the provider for payment, the date of provider payment or denial of payment, and if the provider refuses to pay, the MHP date of payment (Enclosure 2).

- Validate that the beneficiary reimbursement claim belongs to the MHP, and that the beneficiary reimbursement claim is for a covered specialty mental health service.

    - If the MHP identifies that the beneficiary reimbursement claim belongs to a different MHP, the MHP will return the claim to DMH at 1600 9th Street, Sacramento, CA 95814, Room 100, and fax the claim to (916) 651-0493, Attention: Beneficiary Reimbursement Claim, with a brief explanation in writing within 10 days of receipt of the beneficiary reimbursement claim.

- The MHP must determine if there is a previous payment through the Short Doyle/Medi-Cal (SD/MC) system. The MHP can contact DMH to assist in making this determination by calling (916) 654-5722 and requesting to speak with the beneficiary reimbursement claims staff in the Medi-Cal Mental Health Operations Unit.

- Once the MHP has determined that there was a previous payment through the SD/MC system, the MHP notifies the provider of duplicate payment and instructs the provider to refund the beneficiary within 30 days (Enclosure 3, Letter #8).
    - The provider refunds to the beneficiary and notifies the MHP in writing of the refund.
    - In return, the MHP will send a letter to the beneficiary to let them know that the provider has sent payment (Enclosure 4, Letter #10), and submits a copy to DMH to verify the refund.

Invalid Beneficiary Reimbursement Claim

- If the claim is determined to be invalid, the MHP will send a letter to the beneficiary denying the claim (Enclosure 5, Letter #7), and provide a copy to DMH to verify the denial.

State Hearings

- The MHP is responsible for preparation of a position paper for the State Hearing process. All letters and correspondence are to be printed on the MHP's letterhead. Technical assistance will be available to each MHP through County Operations contract managers listed at:

http://www.dmh.ca.gov/CountyOps/contact.asp

CRITERIA FOR ESTABLISHING VALIDATED BENEFICIARY CLAIMS

Beneficiary reimbursement claims must meet the following criteria in order to qualify for reimbursement. In some cases to satisfy the criteria, a declaration by an individual might supplement other documentary evidence. Nevertheless, declarations shall not be an acceptable substitute for documentation of medical necessity. Claims that meet all of the following criteria will be considered valid:

- The beneficiary was eligible for Medi-Cal at the time the service(s) was(were) provided;
- The service(s) provided was(were) a Medi-Cal covered service – i.e., a Medi-Cal benefit at the time the service(s) was(were) rendered;

- The beneficiary was eligible to receive the service(s) at the time the service(s) was(were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits;

- For those Medi-Cal services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider that shows medical necessity for the service(s);

- The claimed cost(s) was(were) not required to meet co-payments, share of cost or other cost-sharing requirements;

- The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal/Denti-Cal, other Medi-Cal funded program, the healthcare provider or by a third party; or

- The beneficiary did not have other health coverage at the time the service(s) was(were) rendered that would have been obligated to pay any portion of the Medi-Cal covered rate of the claimed cost(s).

- For claims for Medi-Cal covered service(s) provided during the evaluation period, (the date an application for Medi-Cal eligibility is submitted to the date that the application is granted) for date(s) of service on or after February 2, 2006, the service(s) must have been rendered by a provider who was an active Medi-Cal authorized provider.

PROVIDER PROBLEM RESOLUTION

In the event that there is a disagreement between the MHP and the provider, the MHP will assure the Provider Problem Resolution Processes as described in California Code of Regulations (CCR), Title 9, Section 1850.305 and Section 1850.310 is followed.

REIMBURSEMENT OF BENEFICIARY REIMBURSEMENT CLAIMS

The provider is required to reimburse the beneficiary within 30 days of receipt of the beneficiary's claim. In the event that the provider fails to reimburse the beneficiary, the MHP is responsible for reimbursing the beneficiary within 30 days of the provider's refusal to do so. If both the provider and the MHP do not reimburse the beneficiary, DMH will do so within 20 days of the MHP's refusal to do so and will withhold the amount of that reimbursement from future payments to the MHP.

RECORDS RETENTION

The MHP shall keep all beneficiary reimbursement claims, denied or approved, on file for three years from the date of receipt.
If you have any questions, please contact the County Operations Contract Manager at the site listed on Page 4 of this letter. Thank you for your cooperation and assistance in this matter.

Sincerely,

Original signed by:

STEPHEN W. MAYBERG, Ph.D.
Director

Enclosures