State/Territory: California

CONDITIONS UNDER WHICH DIRECT BENEFICIARY REIMBURSEMENT WILL BE MADE UNDER THE MEDI-CAL PROGRAM
(Post-Approval Period of Eligibility)

NOTE: Italicized print has been added for clarification only and is not meant to infer a change in meaning from the court-approved Plan of Implementation.

General

The Department of Health Care Services (DHCS) will adjudicate completed beneficiary claims for reimbursement of Medi-Cal covered physician and dentist service expenses incurred and paid for by the beneficiary during the post-approval period (the time period from issuance of the beneficiary's Medi-Cal card and beyond) for valid claims (1) by those Medi-Cal eligible beneficiaries to whom payment may be made in compliance with Section 1905(a) of the Social Security Act as interpreted by 42 CFR 447.25; and (2) for select instances in order to make corrective payments based on a successful appeal by a beneficiary who did not receive continued eligibility for covered services pending the appeal decision, and sought and paid for covered services (in compliance with 42 CFR 431.246 and 431.250(b)). Overpayments of share of cost will be included in the latter instance to the extent the overpayment is established through application of the notice and appeal process.

Adjudication will be within approximately 120 days from receipt of the completed claim(s). *Upon adjudication of approved claims, payment will be made immediately.*

The methods of beneficiary reimbursement during the post-approval period of eligibility will include (1) "cooperative" payments by providers; (2) "recoupment" actions against uncooperative Medi-Cal providers; and, (3) when necessary, direct reimbursement to the beneficiary up to the current Medi-Cal rate for the applicable Medi-Cal covered service(s), *at the time the service was rendered.*

The Medicaid claim for these expenditures will be made at the applicable Medi-Cal rate established for the respective service under the Medi-Cal program, at the time the service was rendered and at the current Federal Medical Assistance Percentage (FMAP) in effect.

Criteria for Processing Beneficiary Claims

Beneficiary claims must meet the following criteria in order to qualify for reimbursement. Claims that do not meet the criteria will be denied. The criteria for processing/adjudicating a beneficiary claim include all of the following:

- The beneficiary was eligible for Medi-Cal at the time the service(s) was (were) provided.
- The claimed service(s) was (were) provided on or after June 27, 1997 *(court-ordered start date for beneficiary reimbursement).*
- 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 *that would have been eligible for Federal Financial Participation (FFP) at the time the service(s) was (were) rendered.*
- The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or, 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.
- The beneficiary has submitted a completed STD 204 form.
- For those services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider(s) that show(s) 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 requirement(s).
- The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal/Denti-Cal, another Medi-Cal funded program, the healthcare provider or by a third party.
- The beneficiary did not have other health coverage at the time the service(s) was (were) rendered that would have been obligated to pay the claimed cost(s).

Claims for Medi-Cal covered service(s) provided during the evaluation period for date(s) of service on or after February 2, 2006 *(court-mandated date before which the State cannot require that the beneficiary seek services only from a Medi-Cal-enrolled provider)* must show that the service(s) was (were) rendered by a provider who at the time the service(s) was (were) rendered, was an active Medi-Cal authorized provider.

Submission Timelines for a Timely Claim

- The claim(s) for services that was (were) provided from June 27, 1997 through Novernber 16, 2006, must be received by DHCS by November 16, 2007 or within 90 days after issuance of the Medi-Cal card, whichever is the longest period of time.

- The claim(s) for services that was (were) provided after November 16, 2006, must be received by DHCS within one calendar year after the date the service(s) was (were) rendered or within 90 days after issuance of the Medi-Cal card or no more than 90 days after the issuance of a final appeals decision.