Medi-Cal Aid Codes and the CCT Project

Aid Code

The Department of Health Care Services (DHCS) has assigned specific codes, termed "aid codes" to identify the various types of recipient under the Medi-Cal Program.

The aid codes in this chart are meant to assist providers in identifying the types of services for which Medi-Cal and Public Health Program recipients are eligible. The chart includes only aid codes used to bill for services through the Medi-Cal claims processing systems and for other non Medi-Cal programs that need to verify eligibility through the Eligibility Verification System (EVS).

Note**:** Unless stated otherwise, these aid codes in the master chart cover United States citizens, United States Nationals, and immigrants in a satisfactory immigration status. Satisfactory immigration status includes lawful permanent residents, Permanently Residing in the U.S. Under Color of Law (PRUCOL) aliens and certain amnesty aliens.

Question: May individuals with PRUCOL status enroll in the CCT Project?

Answer: Yes. PRUCOL, or **Permanent Residence Under Color of Law** is not recognized as an immigration status by the U.S. Citizenship and Immigration Services (USCIS). This category was created by the courts and is a public benefits eligibility category. If an individual claims PRUCOL status **and** meets resident eligibility and other Medi-Cal requirements, s/he may be deemed eligible to receive Medi-Cal benefits.

Someone designated as PRUCOL is an illegal alien and may have been able to give birth to a US citizen or be so debilitated that they collect SSI, or for other health reasons, have benefits coming to them, or they are in the process of filing to obtain such benefits. It means that they are illegal but may still stay in the USA. Because the illegal alien can stay they have the same rights as if they were legal. Someone with PRUCOL status may not apply for U.S. citizenship. (www.usborderpatrol.com).

Question: Do aid codes stay the same for each person all the time?

Answer: Aid codes change depending on an individual's situation. Once an individual residing in an inpatient nursing facility goes home, their aid code will change from the one they had in the nursing facility to a community code. Because of this change, the Lead Organization (LO) will assist the CCT enrollee with finding out what their aid code most likely will be prior to transition, to insure the enrollee doesn't lose his/her Medi-Cal eligibility for services after transition.

Question: Does the LO need special permission to find this information out about a CCT enrollee?

Answer: Yes. The enrollee must complete/sign the Medi-Cal Appointment of Representative Form, to allow the LO/transition coordinator (TC) to work with the county Medi-Cal eligibility office on behalf of the enrollee. See the URL below for the form: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc306.pdf

Question: My local county Medi-Cal eligibility office will not work with the LO/TC, even though the form was signed by the enrollee.
Answer: The LO needs to contact the County Medi-Cal Policy/Program Coordinator about the issue, and request a contact person to work with on the CCT enrollee's Medi-Cal eligibility. Check with DHCS CCT Nurses for a list of these county contacts.

Aid Code Master Chart

The Aid Codes Master Chart was developed for use in conjunction with the Medi-Cal Eligibility Verification System (EVS). Providers must submit an inquiry to the EVS to verify a recipient's eligibility for services. The eligibility response returns a message indicating whether the recipient is eligible, and for what services. The message includes an aid code if the recipient is eligible. If a recipient has an unmet Share of Cost (SOC), an aid code is not returned, since the recipient is not considered eligible until the Share of Cost is met. A recipient may have more than one aid code, and may be eligible for multiple programs and services.

The Aid Code Master Chart lists the following information for each code:

1. **Benefits** - The types of services for which the individual is eligible under that service code are listed as one of the following:

- Full benefits;
- Restricted to a specific type of service listed: Restricted to emergency services;
- Valid for ambulatory prenatal care services;

2. **Share of Cost** (SOC) or Spend down: Yes; No; or Y/N;

3. **Programs/Descriptions**:

- Disabled – SSI/SSP – Cash
- Medically Indigent – Long Term Care (LTC) services.
- Aid to the Aged – Long Term Care (LTC).

Information on Medi-Cal aid codes may be found in the **Medi-Cal Aid Code Master Chart** located on the Medi-Cal website. Use the following URL or type "aid code master chart" in the search box located in the upper right-hand corner. **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes_z01c00.doc**

Aid Codes that show the individual currently is not eligible for CCT Services

Aid Code	Explanation
53	This code is used for individuals who are aged 21 or older but under 65 who are residing in an ICF or SNF. Benefits are restricted to LTC and related services. Individuals, who may have a qualifying disability, can have aid code 53 during the period of verification of their disability status. The aid code could change, if verification is ascertained, and the individual may be eligible to participate in CCT. ---- **Recheck each individual's aid code each month for several months to determine eligibility for CCT before determining s/he is not eligible.**
D6	This code is used for someone who is an undocumented immigrant who is receiving care in a LTC facility. If verification of citizenship occurs, the aide code will change. ---- **Recheck each individual's aid code each month for several months to determine eligibility for CCT before determining s/he is not eligible.**

Two aid codes that show the county individual's Medi-Cal eligibility is under re-determination.

Aid Code	Information
1E	Covers former Supplemental Security Income/State Supplementary Payment recipients who are aged, until the county re-determines their Medi-Cal eligibility.
6E	Covers former Supplemental Security Income/State Supplementary Payment recipients who are disabled, until the county re-determines their Medi-Cal eligibility.

Beneficiary needs to check with his/her Medi-Cal Eligibility Worker to determine if documents are needed for the redetermination. This code may result from an unopened Medi-Cal packet sent back return to sender due to an address change or an incorrect address. If needed information is not returned to the county Medi-Cal office in time, beneficiary may loss his/her Medi-Cal eligibility. If eligibility is lost, beneficiary may re-apply for services again.

Hospice Services

A Medi-Cal beneficiary receiving hospice services is eligible to be a CCT participant if s/he meets the CCT residency and eligibility requirements (refer to "Residency and Eligibility Requirement – Update" below). As a CCT enrollee/participant, s/he may be enrolled in the NF/AH waiver and also receive hospice care; however there can be **no** duplication of services. For example, if the participant is receiving Waiver Personal Care Services (WPCS) under the NF/AH waiver for personal hygiene care, personal care **may not** be provided by hospice during that same time period. However, s/he **may** receive WPCS through the NF/AH waiver and nursing care from a hospice provider for control of pain and other symptoms during the same time period. If the enrollee/participant does not meet eligibility to receive skilled care, the family members or other support persons, such as IHSS workers, must provide needed "hands on" care, along with the hospice staff.

Occasionally a CCT participant has a 900 restriction code on their Medi-Cal eligibility history file indicating s/he is eligible for hospice services only. In this case, in order for the individual to receive CCT services, s/he must be removed from Hospice and placed back on Medi-Cal. The facility must fill out paperwork and the individual or their authorized representative must sign the document. The signed document will be sent to the county in which the individual resides, and they will remove the restriction. Then the LTSS provider may pick up the individual and the provider will get paid for any service provided. NOTE: the effective date of the change in status must predate any date of service billed for the CCT Project.

Locating the Aid Code Master Chart

The aid code master chart and other information on aid codes may be found in the **Medi-Cal Aid Code Master Chart** located on the Medi-Cal website. Use the following URL or type "aid code master chart" in the search box located in the upper right-hand corner of the home page

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http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes_z01c00.doc

Example of CCT acceptable Aid Code

Code	Benefits	SOC	Program/Description
13	Full	Y/N	Aid to the Aged – Long Term Care (LTC). Covers persons 65 years of age or older who are medically needy and in LTC status.

Tutorial “Recipient Eligibility Tutorial

Using the Medi-Cal Eligibility Response Form found on Web

Information needed to access the Medi-Cal Eligibility Site:

- Beneficiary’s full Medi-Cal Number (15 digits)
- Beneficiary’s Medi-Cal Card Issue Date
- Dates service(s) are being/were provided.

Determining Medi-Cal Card Issue Date using the full Medi-Cal ID Number

<u>The Medi-Cal card issue date is needed to access the M/C website which will allow Lead Organization staff to verify whether a participant is Medi-Cal eligible.</u>

Use the following the steps to determine the correct date:

1. Refer to the two Julian Day Table pages which are attached to this issue (one for non-leap years and one for leap years) to assist in calculating the issue date. The next leap year is 2012.

2. Take the last four digits of the full 14 digit Medi-Cal number, and use the formula <u>in the example</u> below.

3. If the last 4 digits are: 5053

4. Then the first digit which is 5 = the year 2005

5. The remaining three digits which are 053, which on the Julian calendar = 02/22

6. Therefore, the issue date is 02/22/2005.

Signing in on the Medi-Cal Website

Enter your User ID and Password.

Sign in as a: Single subscriber.

When checking Medi-Cal eligibility, do not rely on the colored green and/or yellow lights. The red light is definite, the person is not eligible, but the other two colors are not absolute, or without problems.

Each month all LOs are responsible for checking aid code and eligibility status, including share of cost and managed care status, to insure the individual is eligible and that the LO will get paid for services rendered.

Reading a Medi-Cal Eligibility Response Form

Below is a blank Medi-Cal Eligibility Response Form. Please review it to learn the important areas to check when reviewing eligibility of Demonstration Participants for Medi-Cal services.

Name

____

Subscriber ID

____

Service Date ____________ Subscriber Birth Date ____________ Issue Date ____________

Primary Aid Code ____________ First Special Aid Code ____________

Second Special Aid Code ____________ Third Special Aid Code ____________

Subscriber County ____________ HIC Number ____________

Primary Care Physician Phone # ____________ Service Type ____________

Spend Down Amount Obligation (aka Share of Cost) ____________ Remaining Spend Down Amount ____________

Trace Number (Eligibility Verification Confirmation (EVC) Number)

____

Eligibility Message:

Subscriber Las Name_______________ ; EVC number_______________ ; County (Cnty) Code _______________ ; Primary (Prmy) Aid Code _______________ ; Medi-Cal Eligible w/ LTC SOC/Spend Down of _______________ ; Parts A, B, and D Medicare Coverage w/HIC number _______________ ; Medicare Part A and B covered services must be billed to Medicare before billing Medi-Cal. No Medi-Cal payment for Medicare Part D Covered Drugs. Other Health Insurance Coverage (Cov) Under Code V. Carrier Name _______________ ; ID: Carrier Name: _______________ ; Coverage _______________ ; Subscriber last name _______________ ; EVC number _______________ ; County Code _______________ ; Primary Aid Code _______________ ; Medi-Cal Eligible w/ LTC SOC/Spend Down of _______________ ; Part A, B, and D Medicare coverage w/ HIC_______________ ; Medicare Part A and B covered services must be billed to Medicare before billing Medi-Cal. No Medi-Cal payment for M.

Please be aware that in cases where participant has **Other Health Insurance Coverage**, the other coverage must be billed first. If not paid, the denial must be submitted with the Medi-Cal service claim.

****Remember:** Medi-Cal is payer of last resort.