27. Share of Cost

A share of cost (SOC) is the amount of the family's net countable income which exceeds the maintenance need level for the size of the Medi-Cal Family Budget Unit (MFBU).

An individual's or family's SOC must be paid (or obligated to pay) toward the cost of health care services/prescriptions received before Medi-Cal will pay the provider for the remaining amount of the bill.

27.0.1 When SOC is Determined

CalWIN will determine the SOC:

- At application
- When there is a change in income or income deductions
- When there is a change in the size of the MFBU
- When there is a change in any other eligibility factors affecting the SOC.

27.1 Provider Responsibility

Providers are responsible for taking the following actions for SOC:

- Verify client's MC eligibility on-line
- Record on-line the amount paid or obligated to pay by the client for health services or prescription drugs.
- When a "Letter of Authorization" (SCD 2595) is requested and amount obligated to pay was not recorded on-line (MEDS is showing SOC has not been met even thought it has), complete the MC 1054 only when all of the following criteria are met:
  - The service has not already been paid by Medicare, other health coverage, or anyone else
  - The services were given within the month specified on the MC 1054

27.2 EW Responsibility

The EW is responsible for:

- Ensuring the client's record is active on MEDS
- Recording the client's SOC accurately
- Explaining the SOC to the client
- If the provider is unwilling or unable to input on-line (or for any other reason, the SOC was not updated on-line), the EW must complete the MEDS "Share of Cost Obligation" (SOCO) form (SCD 1296 SOCO) to request the "MEDS Terminal Operator" (MTO) to generate a SOCO transaction. [Refer to 33.8.2]

27.3 Change in the Share of Cost (SOC)

27.3.1 Changes Which Decrease the SOC

When a change in income, family composition, or other circumstances results in a decreased SOC, the client is entitled to an adjustment.

Table 27-1: Decrease in SOC

Change reported timely,	Timely reporting means that the client reports changes within 10 calendar days following the date the change occurred or is known, whichever occurs first. Example: The client is told on January 12 that his employment will be terminated on January 23. He must report the change no later than January 22 in order to meet timely reporting requirements. Determine what the correct SOC should have been during the months in which the decrease occurred. Example: A decrease in income occurred on April 29. The client reported this change on May 3. The EW must determine the correct SOC for April and May.

Table 27-1: Decrease in SOC

Change not reported timely,	Change the ongoing SOC by the first of the month following the month in which the change was reported. Example: Decrease in income occurred on January 10. Change reported on February 3. SOC change is effective March 1. No recomputation of SOC for January and February is done, unless good cause exists. **Note:** Make no adjustment for the excess cost the client may have paid or obligated before the ongoing SOC was changed, unless there was a good cause for failure to report in a timely manner.

27.3.2 Changes Which Increase the SOC

When a change in income or other circumstances is reported and results in an increased SOC, an adequate and timely NOA must be given.

Table 27-2: Increase in SOC

Reported timely,	Reevaluate the budget for the first of the month following the month in which the change is reported, if a 10-day notice can be given. Example: Change reported timely on January 8. SOC must be changed for February. Reevaluate for the first of the second month following the month in which the change is reported, if the SOC cannot be increased for the first of the following month because a 10-day notice cannot be given. Example: Change reported timely on January 25. Ten-day notice cannot be given for February. Reevaluate SOC for March. **Note:** When it is too late for a 10-day notice to increase the SOC and the change is made in the second month, there is no Medi-Cal overpayment. **Reminder:** Notices of Actions issued to decrease the SOC do not require a 10-day notification period.

Table 27-2: Increase in SOC

Not reported timely,	Revise the budget for the first of the month following the month in which the change is reported, if a 10-day notice can be given. Example: Change occurred on January 8 and reported on February 5. SOC must be reevaluated for March. Revise the budget for the first of the second month following the month in which the change is reported, if the SOC cannot be increased for the first of the following month because a 10-day notice cannot be given. Example: Change occurred on January 8 and reported on February 25. Ten-day notice cannot be given for March. SOC must be reevaluated for April. **Important:** Complete a potential overpayment referral if the client: • Received zero SOC MC but should have had a SOC, or • Met a SOC which was less than the correct SOC. [Refer to "Overpayments", Chapter 65 for referral criteria and procedure.] Excess income received or other changes that are reported AFTER the EW should have taken action is NOT a potential overpayment. Example: Change occurred on January 15 and is reported on January 30. Even if the client had reported the change within ten days (January 25), the EW cannot increase the SOC for February because a 10-day notice cannot be given for February. The change must be effective March 1. There is no potential overpayment for February.

27.4 Processing Cases When the SOC is Retroactively Reduced

Retroactive adjustments are needed when the EW determines that the client should have had a lower MC SOC than was originally computed. EWs are responsible for discussing the following options available to the clients who have their SOC retroactively reduced:

- Apply the SOC adjustment to the future SOC month(s), or
- Seek reimbursement from the provider.

  If the client chooses to seek reimbursement from the provider, the EW must instruct the client to give the provider a copy of "Share of Cost Medi-Cal Provider Letter" (MC 1054), so that the provider can bill MC and reimburse the client the appropriate SOC amount.

Note:

Clients whose future SOC is zero before an adjustment is applied, must be advised that the only recourse is to seek reimbursement from the provider.

27.4.1 Reimbursement From The Provider

When a client decides to seek reimbursement from a provider, it must first be determined whether the provider has billed or submitted a SOC clearance transaction for the month which reimbursement is requested. This can be determined by viewing the MEDS "SOC Case Make-Up Inquiry Request" [SOCR] screen for the appropriate month.

Table 27-3: SOCR Review for Reimbursement from Providers

If the SOC balance on the SOCR for the appropriate month is...	Then the provider...
The same as the county's original SOC,	Has NOT submitted a SOC clearance transaction for the month in which reimbursement is being requested. No reimbursement from the provider is necessary. The EW must update the appropriate Data Collection windows so that the SOC can be lowered for the affected month(s).

Table 27-3: SOCR Review for Reimbursement from Providers

<table>
<tr><th>If the SOC balance on the SOCR for the appropriate month is...</th><th colspan="2">Then the provider...</th></tr>
<tr><td rowspan="6">Less than the original SOC or zero,</td><td colspan="2">Has submitted one or more SOC clearance transactions.</td></tr>
<tr><td>If the recomputed SOC is...</td><td>Then...</td></tr>
<tr><td>Lower than the original SOC but higher than the SOC clearance transaction,</td><td>No SOC adjustment is necessary. The client cannot seek reimbursement from the provider or request a future SOC months adjustment.</td></tr>
<tr><td colspan="2">Example:
The original SOC is $100 and the provider has submitted a $25 SOC clearance transaction for medical services rendered. The recomputed SOC is $40. This recomputed SOC amount would be input to MEDS. NO SOC adjustment reimbursement from the provider or for future SOC month(s) is necessary because the $25 SOC clearance submitted by the provider is below the recomputed SOC which is $40. That means, the client has not yet met his/her correct SOC amount for the month.</td></tr>
<tr><td>Lower than the SOC clearance,</td><td>The client can seek reimbursement from the provider or request a future SOC months adjustment because the SOC for past months cannot be reduced on MEDS to an amount lower than the amount of clearance transactions posted.</td></tr>
<tr><td colspan="2">Example:
The original SOC is $100 and the provider has submitted a $25 SOC clearance transaction for medical services rendered. The recomputed SOC is $10. The SOC on MEDS may NOT be reduced to $10. MEDS does not accept an amount lower than what the client has already been certified for. The EW must complete the MC 1054. Advise the client to give the form to the provider so that the provider may bill Medi-Cal for the difference $15 ($25-$10) and reimburse the client.
Note:
CalWIN automatically generates a provider letter when the “MC 1054 Letter” option on the [Resolve Medi-Cal Overstated SOC] window is selected.</td></tr>
</table>

27.4.2 Adjustment of Future SOC Case Scenarios

Case Scenario 1

Client was eligible for July with a SOC and met the entire SOC (determined by viewing SOCR screen). It is later determined that the SOC should have been lower. The client requests an adjustment of future SOC amounts.

Table 27-4: Adjustment of Future SOC- Case Scenario 1

STEP	ACTION	
1	Update the appropriate CalWIN windows so that CalWIN can recompute the SOC for the overstated SOC month. Re-run EDBC and on the **Capture Discrepancy Information** window, set the July "Evaluate Benefit Discrepancy" switch to 'Y'.	
2	Change the "Medi-Cal Benefit Usage" option to 'Yes' and enter amount in the "SOC Amount Met" field. CalWIN will create an MC overstated SOC claim. The difference between the original and recomputed SOC is the amount of the adjustment.	
3	Select the option "Reduce SOC" on the **Resolve Medi-Cal Overstated SOC** window during authorization.	
	If...	Then...
	The amount of the adjustment is greater than the September SOC amount,	The client's SOC for September becomes zero after the adjustment. Any remaining balance of the adjustment (after September) must be carried over and applied to October and/or the following SOC months until the entire adjustment is made.

Case Scenario 2

Client was determined eligible for October with a SOC and met part of the SOC for that month. It is later determined that the SOC should have been lower. Client requests adjustment for the future SOC.

Table 27-5: Adjustment of Future SOC- Case Scenario 2

STEP	ACTION
1	View the SOCR screen for the month of October to determine amount of SOC that was met.

Table 27-5: Adjustment of Future SOC- Case Scenario 2

STEP	ACTION	
2	If...	Then...
	The amount cleared for the month of October is more than the recomputed SOC,	A SOC adjustment is needed. The difference between the amount cleared and the recomputed SOC will be the amount to be adjusted. Process adjustment according to Steps 1-3 in Case Situation 1. **Example:** Client's original SOC is $100, client paid $75; the recomputed SOC is $50, the amount to be adjusted for future month is $25.
	The amount cleared for the month of October is less than the recomputed SOC,	No adjustment is necessary. Ensure the change in the SOC is posted to MEDS.

27.4.3 Provider Reimbursement of SOC Case Scenarios

Case Scenario 3

Client was determined eligible for November with a SOC and met the SOC. A recomputation indicates the SOC should have been zero. Client wants a reimbursement of the SOC amount that was paid to the provider(s).

Table 27-6: Provider Reimbursement Case Scenario 3

STEP	WHO	ACTION
1	EW	Updates the appropriate CalWIN windows so that CalWIN can recompute the SOC for the overstated SOC month. Re-run EDBC and on the **Capture Discrepancy Information** window, set the November "Evaluate Benefit Discrepancy" switch to 'Y'.
2	EW	Changes the "Medi-Cal Benefit Usage" option to 'Yes' and enter amount in the "SOC Amount Met" field. CalWIN will create an MC overstated SOC claim. The difference between the original and recomputed SOC is the amount of the adjustment.
3	EW	Selects the option "MC 1054 Letter" on the **Resolve Medi-Cal Overstated SOC** window during authorization. CalWIN automatically generates a "SOC Medi-Cal Provider Letter."
4	Client	Submits the MC 1054 to the provider(s).
5	Provider(s)	Bills MC and reimburses the client after payment from MC is received. The provider needs to submit a copy of the MC 1054 with their MC billing. The provider must bill MC manually.

Case Scenario 4

Client had a SOC for the previous month of April, for $100, and according to the MEDS SOCR screen, met $50 of this SOC. It was later determined that the SOC should have been $75. Client wants reimbursement from the provider.

- In this situation, the client is not entitled to a provider reimbursement nor a future month SOC adjustment. Follow Step 1 in Case Situation 1 to lower the client's SOC.
- Ensure the SOC for April is changed to $75 on MEDS.

Case Scenario 5

Client had a SOC for the previous month of May in the amount of $200. The SOCR screen indicates that $150 of the SOC was met. It has been determined that the SOC should be $100. Client wants reimbursement from the provider.

Table 27-7: Provider Reimbursement Case Scenario 5

STEP	WHO	ACTION
1	EW	Follows Steps 1-3 in Case Situation 3.
2	EW	Requests an on-line MEDS entry to change the SOC on MEDS to $150 (MEDS will not accept a change below the amount of services that have already been certified towards the SOC).
3	EW	Completes an MC 1054 showing the original SOC as $150 and the revised amount as $100, and sends it to the client.
2	Client	Submits the MC 1054 to the provider(s).
3	Provider(s)	Bills MC and reimburses the client after payment from MC is received. The provider needs to submit a copy of the MC 1054 with their MC billing.

27.4.4 Share of Cost Adjustment Over a Year Ago

A "Letter of Authorization" (LOA) (SCD 2595) authorizes payment for medical services received 12 months or more prior to the current month. The "LOA Request" form (SCD 1594) must be sent to the MC Program Coordinator to request an LOA. [Refer to MC HB Chapter 39.22 for LOA process.]

A "Share of Cost Medi-Cal Provider Letter" (MC 1054) is completed by the EW for SOC changes for history months.

Case Situation 6

In July 2006, the EW determined that the client's correct SOC for June 2005 should have been $100. Client's original SOC previously recorded for June 2005 was in the amount of $200.

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Table 27-8: SOC Adjustment Over a Year Ago

STEP	WHO	ACTION		
1	EW	Views the SOCR screen on MEDS for the month of June 2005 to determine amount of SOC that was met.		
		If...		Then...
		None of the SOC was met,		No further action is needed.
		The client met any or all of the SOC,		Retroactive adjustment is needed.
2	EW	Explains to the client the option of whether to apply the SOC adjustment to the future month's SOC or seek reimbursement from the provider.		
		If the client chooses to....	And the previous SOC clearance is...	Then...
		Apply the SOC adjustment for future SOC months,	N/A	Follow the examples in Section 33.5.2.
		Seek reimbursement from the provider,	Equal to the revised SOC,	Complete an SC 1594. MC was not previously billed because the client did not meet the $200 original SOC.
			Lower than the revised SOC, Example: Client previously paid $75 (which is lower than the revised SOC of $100).	Complete an SC 1594 and an MC 1054. The client has to show the proof of the paid amount.
			Higher than the revised SOC, Example: Client previously paid $150.	Complete an SC 1594 and an MC 1054 which shows the original SOC and the revised SOC.
3	EW Supervisor	Reviews and forwards the SC 1594 and MC 1054, to the MC Program Coordinator.		
4	Program Coordinator	Completes the SCD 2595 and sends it back to the EW Supervisor.		
5	EW	Gives or sends the original and copy of the SCD 2595 and the MC 1054 to the client.		
6	Client	Submits the SCD 2595 and the MC 1054 to the provider(s).		
7	Provider(s)	Bills MC and reimburses the client after the payment from MC is received. The provider needs to submit the SCD 2595 and the MC 1054 with their MC billing.		

27.5 Repayment of SOC for Poverty Level Program Eligibles

Medi-Cal recipients may be eligible for a refund of their SOC from the provider when they are determined to be eligible for no SOC benefits under one of the special Federal Poverty Level (FPL) Programs.

They are entitled to a refund when:

- They have met all or part of their share of cost, AND
- They are later determined to be eligible for no SOC under the 100/133/200%, and Aged and Disabled (A&D) FPL Program.

Table 27-9: SOC Reimbursement for A&D FPL

If...	Then...
The family SOC was met, but the FPL Program eligible person had no medical expenses,	The FPL Program eligible person is not eligible for a reimbursement.
The FPL Program eligible person had medical expenses, but did not meet any of the SOC,	Activate the FPL Program eligible person on the appropriate FPL program.
The FPL Program eligible person had medical expenses and met any or all the SOC,	The FPL Program eligible person is entitled to a reimbursement.

In some cases, beneficiaries may choose to adjust a future SOC month(s) instead of seeking a reimbursement from the provider.

27.5.1 FPL Program Effective Dates

Use the appropriate amount corresponding to each year's level. The Poverty Level Programs began at different times. Do NOT apply FPL Programs for months prior to the effective dates listed below:

Table 27-10: FPL Program Effective Date

Program:	Effective Date:
100%	07/01/1991
133%	04/01/1990
200%	10/01/1998
A & D FPL	01/01/2001

27.5.2 SOC Partially or Fully Met

If the SOC has already been partially or fully certified, the reimbursement process is different, depending on whether the month of service was more or less than 12 months old.

Table 27-11: Process (Less Than 12 Months)

Step	Who	Action
1	EW	Updates the appropriate CalWIN Data Collection windows with the new data so that the system can determine the appropriate FPL program. Re-run EDBC and on the [Capture Discrepancy Information] window, set the overstated SOC month's "Evaluate Benefit Discrepancy" switch to 'Y'.
		Changes the 'Medi-Cal Benefit Usage" option to 'Yes' and enter amount in the "SOC Amount Met" field. CalWIN will create a Medi-Cal overstated SOC claim.
		Selects the option "MC 1054 Letter" on the [Resolve Medi-Cal Overstated SOC] window during authorization. CalWIN automatically generates a "SOC Medi-Cal Provider Letter".
		Sends the MC 1054(s) to the client, instructing the client to give it to the provider.
2	Client	Takes the MC 1054 to the provider.
3	Provider	Bills Medi-Cal and reimburses the client after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 1054 with their Medi-Cal billing.

Table 27-12: Process (MORE THAN 12 MONTHS)

Step	Who	Action
1	EW	Approves FPL program following Step 1 above.
		Reviews MEDS for the month in question to determine what portion of the SOC was met by the FPL program eligible person.
		Submits a retroactive Medi-Cal request via online MEDS as follows: • Complete a "Request for Online Transaction" (SC 1296), requesting the MTO to generate an EW 50 transaction. • Use the ORIGINAL share of cost 14 - Digit County I.D. number with the original SOC Aid Code, AND • The original share of cost. **Note:** When the provider's bill is more than a year old, the state's fiscal intermediary can only identify the recipient as eligible by using the original SOC Aid Code that was reported to MEDS. • Complete a separate MC 1054 for each provider to whom the client paid a SOC, using the ORIGINAL 14 - Digit County I.D. number as both the old and new number. (Attach to SC 1296.)
		Sends the MC 1054(s) to the client, instructing the client to give it to the provider.
2	Client	Gives the MC 1054 to the provider.
3	Provider	Submits a new claim to the State.
		Reimburses the client, once the provider has been repaid by Medi-Cal.

27.6 Applying Unpaid Medical Bills to the SOC (Hunt v. Kizer)

Any MC applicant or recipient having medical expenses incurred and unpaid must be allowed to use those medical expenses to reduce any current or future SOC, provided the medical bills remain unpaid and acceptable documentation of the unpaid expense is received.

Old medical bills are not acceptable if they are fully paid prior to the month of submission. Only any unpaid portion may be applied toward a SOC adjustment.

An old medical bill may not be accepted if it was paid by the recipient in a previous month and then refunded by the provider in the month it is submitted to the EW.

Exception:

Individuals receiving MC under state only programs (aid codes 53 and 81) are not able to apply old medical bills to their SOC.

A medical bill is considered *current* when it is incurred in the same month for which it will be applied to the recipient's SOC.

A medical bill is considered *old* when it is incurred in a month previous to the month for which it will be applied to the SOC.

Note: If a portion of the old medical bill has been paid, only the unpaid portion may be applied toward the beneficiary's SOC.

27.6.1 Acceptable Medical Bills

Acceptable medical bills and medical expenses are those which are rendered by a state-licensed health-care provider.

In addition, when a client wishes to adjust expenses for medically-related equipment, supplies or drugs which have been prescribed but which are available without a prescription, the EW may require a statement from the health-care provider if the expense is questionable. The provider's statement must include:

- A short description of the condition being treated.
- The name of the drug, supply or equipment which was prescribed.
- A statement that it is customarily considered by the medical profession to be an item primarily for health care and medical treatment and that it will be used solely by the recipient for that purpose.

27.6.2 Qualifying Criteria

Liability for Debt

A person must be legally liable for the debt. A person is considered to be legally liable for the debt if it is less than four years old on the date of submission to the EW. If the debt is more than four years old, then the client must show evidence of current liability, such as:

- There has been a judgment; or
- There is a contract between the provider and the recipient which extends the statute of limitations beyond four years and the bill falls within the contract period, or
- A payment has been made on the debt within the last four years, or

- There is other reasonable verification showing the person is still liable for the debt.

One Time Only Rule

A medical bill (or portion of a medical bill) can only be used once. For example, if a $30 office visit charge is used towards the client's September 2005 SOC and an MC card is issued for September, then the same bill cannot be applied to the October 2005 SOC, even though the bill remains unpaid.

Other Health Coverage

Only medical bills (or a portion of the medical bill) which will not be paid by a third party can be used to meet a SOC. If a client has any other health coverage, only medical expenses which are not covered by his/her insurance can be used to reduce the SOC.

Medical expenses which have been paid (or will be paid) by Medicare, MC or other private or group coverage cannot be used to meet or reduce a share of cost.

If the bill does not show the amount owed solely by the client, then the client must obtain a statement from the provider or the insurer showing the total amount of the service and the amount for which solely the client is liable.

MFBU

Medical expenses for anyone who would have been a member of the MFBU on the date the medical expenses were incurred may be used to reduce the SOC.

Provider Expenses (IHSS, Licensed, Certified etc.)

IHSS expenses cannot be used to reduce the SOC; however out of pocket personal care services paid to a qualified provider can be used to **meet** the SOC when the required services are included in the IHSS needs assessment or prescribed by a physician. The services must be intended solely for the health care and medical treatment of the individual. The MC recipient is required to verify the out of pocket expenses for the services each month in order to meet their SOC.

Interest Charges

Interest or other finance charges accumulated on unpaid medical bills cannot be used to offset the SOC.

No Payment Required

There is no requirement that the client be making payments on a bill in order for the remaining balance to be used to reduce a SOC.

27.6.3 Verification Requirements

The client must provide the EW with an original billing statement which includes ALL of the following:

- The date the bill was issued. The bill must be unpaid at some time during the month that it is submitted to the EW. Generally, this condition is satisfied if the bill's date of issuance is within the last 90 days at the time it is given to the EW, unless there is evidence that it has already been paid.

  Reminder: A statement over 90 days old can be used if supplemental documentation is provided.

- The name and address of the provider who rendered the service.
- The name of the person who received the medical service.
- A short description of the service.
- The date(s) of the medical service.
- A “Procedure Code” (medical reference number) unless the bill was incurred prior to 1/1/92.
- The provider's MC provider identification number, federal tax identification number, provider's license number, or the provider's MC identification number. (It is not necessary that the provider accept MC in order for the expense to be allowed.)
- The amount still owed by the client which is not subject to any third party or other health coverage.

Important:

An original or any substitute billing statement which has been altered is not acceptable unless the bill has been updated by the provider and the provider has signed or initialed the notation.

Original Bills versus Photocopies

Generally, old, unpaid medical bills which are submitted to be applied towards a SOC must be original, conventional health-care provider billing statements or invoices. An original bill does not have to be the first bill.

If the medical bill is a photocopy:

- It must be signed, initialed or signature-stamped by the provider; or,
- There must be other original documentation submitted that verifies the validity and accuracy of the bill.

Missing Information

If an original bill lacks any required information, supplemental information can be provided by a supplemental bill or written statement from the provider, or the provider's representative, e.g., a collection agency, attorney.

The client has an obligation to make an effort to obtain any missing verification information. If the client has made an effort but has not been able to get the missing information, the EW must assist in obtaining it. The EW must contact the provider to request the needed information.

- The EW is not required to obtain a medical bill for a client who claims to have a medical expense but has no medical bill.
- When the missing verification is provided by phone, document the information and initial and date on the old medical bill.

Affidavit

When the client and the EW are unable to obtain the missing information, an SCD 101 can be signed by the client, provided he/she can attest to the accuracy of the information, including:

- Date of service and person who received it.
- Provider's name and address.
- Type of service.
- Provider's federal tax ID number, Medi-Cal provider ID number, or the provider's license number.
- Procedure code (if the client has contacted the provider to get it).

Important:

An affidavit signed by the client cannot be used to confirm the amount of the bill which is owed solely by the client or the date the bill was issued. Only the provider (or the provider's representative) can supply this information.

27.6.4 Credit Card Statements

Unpaid medical expenses which have been charged to a credit card may be allowed if the client provides a credit card statement for every month beginning with the month in which the medical expense was incurred and ending with the month previous to the one in which the statement is submitted to the EW.

The statements must show that no payments have been made on the account since the medical expense was incurred.

- If payments have been made, the medical expense applied to the SOC must be reduced by the amount paid on the account.
- If the client is unable to provide all credit card statements necessary to show his/her payment record since the charged medical expense was incurred, then the credit card statement cannot be used to verify the medical expense.

Reminder: Do not allow any finance charges.

In a situation where the client had to use someone else's credit card to charge the medical bill and subsequently been paid by the owner of the credit card, the amount of the medical bill may still be allowed as long as there is clear documentation and verified that client's obligation to pay continuous to exist.

Example:

The granddaughter used her personal credit card to pay her grandmother's medical expenses. When the monthly statement is received, the granddaughter paid the entire credit card bill to avoid finance charges; however, she expects her grandmother to pay the medical expenses originally charged to her credit card.

27.6.5 Incomplete Information

If the medical bill does not meet all of the qualifying criteria and verification requirements, the EW must contact the client by mail or by phone to request the missing information within ten days from the date that the medical bill is submitted to the EW.

- Return the original bill to the client and scan a copy of the bill into the IDM system.
- Allow 10 days for the client to provide the information.

Note: The EW may contact the provider directly to get additional information. Also, additional time may be allowed to obtain the missing information, as long as the client is cooperating.

- The client is responsible to keep the returned medical bills if he/she wishes to resubmit them at a later date.

27.6.6 Denial of Medical Bill(s)

If the missing information is not provided within 10 days and the client has not requested an extension, or if the missing information is provided but the expenses cannot be adjusted, the EW must:

1. Record the denial in CalWIN on the **Collect Hunt v. Kizer Benefits Denial Detail** window. To access this window, follow the steps below:

   - Open the **Display Medical Expense Summary** window and click [Add],
   - Complete all the relevant fields when the **Collect Medical Expense Detail** window appears,
   - Click on the **Billing and Payment** button,
   - Complete the **Collect Billing and Payment Detail** window including the billing amount,
   - Click on the **Bill Discrepancies** button,
   - Check the appropriate reason for the denial on the **Collect Hunt v. Kizer Benefits Denial Detail** window.

2. CalWIN automatically generates a Hunt v. Kizer denial NOA (MC 353 HK). Review to ensure it is correct before issuing to the client.

3. Scan a copy of the rejected bill into the IDM system and return the original to the client.

Note:

If the missing information is eventually provided, a SOC adjustment can later be allowed.

27.6.7 Limitations of Hunt v. Kizer SOC Adjustment

When applying Hunt v. Kizer, consider the following limitations:

- The old medical expense must completely meet the SOC in the month it is being applied. If it does not fully meet the SOC, the client will not benefit. Return the bill to the client for future use.

- The client may request that the SOC adjustment begin in the future month, but he/she does not have the right to request that the SOC adjustment start several months in the future. Advise the client to resubmit the bill one month before he/she wishes to use it.

- If the bill(s) submitted exceed the client's monthly SOC, the SOC adjustment must be continued in consecutive months until the bill(s) are fully used. The client does not have the right to start and stop the adjustments. The adjustments will stop only if the case changes to no share of cost or Medi-Cal is discontinued. Any remaining SOC adjustment will be applied when the case is later reopened.

- Clients can request that an old medical bill be applied to a past month if all of the following conditions are met:

- The medical bill was incurred prior to the past month to which it is being applied.
- The client has not already met the SOC and/or received a MC card for the past month(s).
- The month(s) for which the adjustment is requested is not more than 12 months prior to the current month (unless a Letter of Authorization is being issued due to county error or another valid reason).

27.7 Recurring Medical Expenses

Recurring medical expenses not covered by insurance can be applied towards the SOC in the month the payment was made. The client must provide proof of the payment each month in order to apply the amount paid.

Important:

A medical expense is not the same as an income deduction. A medical expense adjusts the share of cost (SOC) one month at a time (must be verified each month). An income deduction (e.g. health insurance premium) reduces the client's countable income (must be verified at renewal).

27.7.1 Qualifying a Medical Expense

To determine if an expense qualifies as a bona fide medical expense, it must meet the following criteria:

1. Prescribed by a physician as necessary to treat a medical condition and;
2. Customarily considered by the medical profession as primarily for health care and medical treatment and;
3. Intended, and will be used, solely for the health care and medical treatment of the individual.

All three criteria must be met. A letter from the healthcare provider attesting to each of the three criteria for the specific expense is acceptable proof.

There is no exhaustive list of what expenses may qualify, but a few of the most common are: prescription drugs, over-the-counter (OTC) items (e.g. incontinence supplies, vitamins/minerals, first aid items, etc.), medical equipment (e.g. oxygen tank, wheelchair, walker, etc.).

Note:

SOC will be adjusted through MEDS only for medical expenses unrelated to Hunt v. Kizer

27.8 Processes for Adjusting the SOC

27.8.1 CalWIN Adjustment

When an old, unpaid medical bill meets all of the qualifying criteria and verification requirements and is accepted for adjustment of a SOC, the EW must:

- Open the **Display Medical Expense Summary** window and click [Add] to open the **Collect Medical Expense Detail** window.
- Complete all the relevant fields including: Expense Type, Frequency, Provider Name, and Date of Service.
- Click on the [Billing and Payment] button to open the **Collect Billing and Payment Detail** window.
- Complete the **Collect Billing and Payment Detail** window including the billing amount.

Note: CalWIN will apply the SOC adjustment until the total unpaid medical bill has been adjusted. Adjustment details are displayed in Wrap-up on the **Display Medi-Cal SOC/Financial Eligibility Determination** window.

- CalWIN automatically generates a Hunt v. Kizer approval NOA (MC 352 HK). EW must review to ensure the adjustment amount is correct.
- Document details of the bill (provider, date of service, amount of unpaid bill, and month first applied to SOC) on the Maintain Case Comments window.
- Scan the bill into the IDM system. Make a copy of the bill for the client and include it with the approval NOA. Original bills are not to be returned to the client.

Reminder:

To insure the same bill is not used again, the EW must view Case Comments and the adjustment history on the **Collect Medical Expense Detail** window prior to approving any SOC adjustment.

27.8.2 Adjustments through MEDS

Once the SOC adjustment has been completed in CalWIN the information will automatically be sent to MEDS. If there is a system issue or the required months cannot be established in CalWIN the EW may

request that the MEDS Terminal Operator (MTO) enter the medical bill information on the [SOCR] screen.

Note:

For recurring medical expenses (unrelated to Hunt v. Kizer), there are no CalWIN entries needed and adjustment will be completed through MEDS only.

- The MC 176 M must be completed for every month that an adjustment is made.
  - Enter adjustment amount in the Underpayment Adjustment Box (Column III, Line 15).
- Manually generate Hunt v. Kizer approval NOA MC 352 HK (for Hunt v. Kizer cases only).
- Request an on-line SOCO transaction via SCD 1296 SOCO.

Reminder:

A 10-day NOA is always required to increase a SOC.

27.9 Discontinued Cases

A case may be discontinued before all medical bills have been used to adjust the SOC.

- At reapplication or restoration, the remaining balance which has not been used as a SOC adjustment must be continued.
- The adjustment for medical bills must be continued and the client does not need to provide new verification of the amount still owed, as the required verification was provided prior to the initial adjustment period.

A SOC adjustment must continue whenever there is an intercounty transfer. (Copies of pertinent documents must be sent with all transfers.)

27.10 Examples

27.10.1 Intake

SOC Applicant, No Retroactive Coverage

Joseph applies on September 6, 2017, and is determined eligible with a $300 SOC. He has $1500 in unpaid medical expenses with dates of service between June 2015 and August 31, 2017. When the required documentation has been received, these unpaid bills are to be divided and used to meet his SOC for September, October, November, December 2017 and January 2018.

Reminder:

In January, a 10-day NOA must be issued in order to increase the SOC to $300 for February.

SOC Applicant, Retroactive Coverage Requested

Alexis applies for MC on September 23, 2017 and is determined eligible with $70 SOC. She asks for retroactive coverage for June, July and August 2017. She has unpaid medical bills in the amount of $35 for services provided in April 2017, one for $18 in May 2017 and a $350 bill for June 2017. The bills for April and May total $53, thus reducing the June SOC to $17. For June 2017, the $350 is used to meet her remaining June SOC ($17). The provider can then bill MC for the unpaid portion ($350 minus $17) of Alexis' June bill.

In this case, there would be no remaining bills to reduce the SOC for current and continuing months. There is no requirement to use certain bills for certain months, only that the same medical expense or portion of a medical bill not be used twice.

27.10.2 Continuing

Saving Old and Current Bills to Apply in a Future Month

Adam has a SOC of $100 each month. Every month he pays approximately $20 for a prescription that is not covered by MC. Since this amount is less than his SOC ($100), he is never able to meet his SOC. Under the *Hunt v. Kizer* provisions, as long as he still owes the bills after five months ($20 times 5 months = $100 SOC), he can submit all of the $20 bills to meet his SOC for one month.

Ineligible Member of MFBU

Mrs. Brown and her children have had a SOC of $300 every month for the last two years. Her husband, Mr. Brown lives with her but he is not eligible for MC. He has a $3,000 hospital bill from three years ago which Mr. and Mrs. Brown still owe but which is not covered by insurance or any medical program. Mrs. Brown and the children may use his bill to meet their SOC for 10 months ($3,000 divided by $300 a month = 10 months).

27.10.3 Intake and/or Continuing

Client Fails to Provide Timely Documentation

Kyle is determined eligible for Medi-Cal on October 1, 2017, with a $100 SOC. He informs the eligibility worker that he has unpaid medical expenses for May and June 2017, but doesn't have a current bill with all of the required documentation.

In December 2017, he brings in the required documentation. His SOC is reduced beginning January 2018 until all of his unpaid medical expenses are applied to his SOC.

Old Medical Expenses for Persons No Longer in the MFBU

Morgan is applying for MC today. She has unpaid bills for her husband who died in May 2017. Her husband would have been a member of the MFBU had they applied prior to his death. Since medical expenses may be used for anyone who would have been a member of the MFBU on the date the medical expenses were incurred, Morgan’s husband’s unpaid bills may be used to reduce her future month(s) SOC.

Unpaid bills for individuals not in the home on the date the medical expenses were incurred may not be used to adjust a SOC. Further verification may be necessary to determine if the expenses are allowable.