

SHD Paraphrased Regulations - Medi-Cal
540 Billing/Out of State Coverage etc.

540-1

Out-of-state medical care is limited to the following:

- (a)
 - (1) When an emergency arises from accident, injury or illness; or
 - (2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he/she return to California; or
 - (3) Where the health of the individual would be endangered if he/she undertook travel to return to California; or
 - (4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or
 - (5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided; and the proposed treatment is not available from resources and facilities within the State.
 - (6) Prior authorization is required for all out-of-state services, except:
 - (A) Emergency services as defined in §51056.
 - (B) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services.
- (b) No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

(§51006)

540-2

Under state law, CDHS may provide, by regulation and consistent with the regulations of the Federal Social Security Act, for the care and treatment of persons eligible for medical assistance, by providers in another state in those cases where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances. (Welfare and Institutions Code (W&IC) §14022)

541-1

State law provides that any provider of health services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of program-covered services from the eligible applicant or recipient. (Welfare and Institutions Code §14019.4, implemented in §51002(a))

541-2

Except for good cause, bills shall be received by the fiscal intermediary or to the group

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designated by the Director not later than the sixth month following the month of service. The Department, upon review of substantiating documentation received to justify late transmittal of the claim, may receive and process late claims if the reason for the delayed submission is failure, due to the deliberate concealment, to present identification as a Medi-Cal beneficiary. Delayed billing should be submitted no later than 60 days after the date certified by the provider as the date the patient was first identified as a Medi-Cal beneficiary. The date certified by the provider as the date the patient was first identified shall not be later than one year after the month in which the service is rendered. Bills may be submitted for processing beyond the time limits under special circumstances, provided such submittal is within two months after the date of the resolution of the circumstances causing the billing delay. These circumstances include court cases and state hearing decisions. (§§51008 and 51008.5)

541-3

In *Conlan v. Bontá*, the California Court of Appeals, First Appellate District, the plaintiffs asked the Court to order the CDHS to set aside fair hearing decisions which had denied requests to order reimbursement to the plaintiffs for medical costs incurred while Medi-Cal applications were pending. The applicants eventually had been granted Medi-Cal, after they had paid their medical bills.

The Court ordered CDHS to "ensure that Medi-Cal recipients entitled to reimbursement for covered services during the retroactivity period [i.e., before Medi-Cal was approved] are promptly reimbursed."

The court discussed the role of the ALJ and in the Disposition required "... ALJs to determine what amounts, if any, each petitioner is entitled to receive..." and order "direct reimbursement" or allow CDHS "a reasonable period of time in which to implement new procedures designed to effect such reimbursement."

(*Conlan v. Bontá* (2002) 102 Cal. App. 4th 745, 751, rehearing denied October 29, 2002)

542-1

The provider of services may grieve or complain concerning the payment or nonpayment of his/her services. This regulatory process is initiated by submitting the grievance to the fiscal intermediary. (§51015)

543-1

Providers shall inform beneficiaries of their right to a fair hearing related to denial, involuntarily discharge, or reduction in Drug Medi-Cal substance abuse services as it relates to their eligibility or benefits, per §50951.

Providers shall advise beneficiaries in writing at least 10 calendar days prior to the effective date of the intended action to terminate or reduce services. This notice shall state the action the provider intends to take; the reason for the intended action; a citation of the specific regulations supporting the intended action; an explanation of the right to request a state hearing, and how to request that hearing; and an explanation that the provider shall continue treatment services pending the fair hearing decision only if the beneficiary appeals in writing to the Alcohol and Drug Program (through the State Hearings Division of the California Department of Social Services) within 10 calendar days of the mailing or personal delivery of the notice of action. (§51341(p))

543-2

Each narcotic treatment program in California shall be licensed by the Department of Alcohol and Drug programs (ADP) in accordance with the provisions of Title 9 California Code of Regulations (CCR) §10000 et seq. (9 CCR §10010)

Each narcotic treatment program shall develop written rules and instructions which shall be provided to all patients receiving services and to applicants requesting services. (9 CCR §10170(a)) These rules and instructions shall include fair hearing procedures. (9 CCR §10170(b)(5))

The protocol for each program shall contain a detailed description of the pre-termination fair hearing procedures, and shall state that the patient has a right to a pretermination fair hearing in all cases of involuntary termination from the program for cause where continued participation in the program does not create a physically threatening situation for staff or other patients. (9 CCR §10420(a)) These hearings shall be conducted by a panel or a single hearing officer, and shall be scheduled within seven working days from the time the patient requests a hearing. (9 CCR §§10420(b) and (d)) Appeals from these decisions may be made through a writ of mandate, pursuant to Code of Civil Procedures §1094.5. (9 CCR §10420(g))

543-3

Federal regulations provide, in pertinent part, that:

- (b) A state plan must—
 - (1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and
 - (2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to—
 - (i) Administer or supervise the administration of the plan; and
 - (ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.
- (c) Determination of eligibility.
 - (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is—
 - (i) The Medicaid agency; or
 - (ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia).
 - (2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is—

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- (i) The Medicaid agency;
 - (ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia); or
 - (iii) The Federal agency administering the supplemental security income program under Title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the Title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.
- (e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency—
- (1) The agency must not delegate, to other than its own officials, authority to—
 - (i) Exercise administrative discretion in the administration or supervision of the plan, or
 - (ii) Issue policies, rules, and regulations on program matters.
 - (2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.
 - (3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

(42 Code of Federal Regulations §431.10)