County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-03-10**
	Effective Date	**01-01-2008**
	Revision Date	**01-01-2021**
Title: **Conlan vs. Bonta Claims**	Functional Area: **Beneficiary Protection**	
Approved By: (Signature on File) **Signed version available upon request** **Alexandra Rechs, MFT** Program Manager, Quality Management		

BACKGROUND/CONTEXT:

The California Department of Health Care Services (DHCS) was ordered by the Superior Court to implement a process, effective November 16, 2006, 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. Valid beneficiary reimbursement claims for paid out-of-pocket expenses for Medi-Cal covered services for dates of services 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. Beneficiaries or their representatives are required to submit a completed beneficiary reimbursement claim packet to the Beneficiary Service Center established by State Department of Mental Health when requesting reimbursement for paid out-of-pocket medical expenses pursuant to the Court's orders.

PURPOSE:

The Sacramento County Mental Health Plan (MHP) and Substance Use Prevention and Treatment (SUPT), in an effort to comply with this court order, has implemented the following policy and procedure to address claims relating to Conlan vs. Bonta. All communication will be channeled through Quality Management Problem Resolution staff.

DETAILS:

Beneficiary Reimbursement

Medi-Cal beneficiaries may obtain prompt reimbursement for out-of-pocket expenses for Medi-Cal covered services received during periods of Medi-Cal eligibility. These periods include:

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

Medications covered under Medicare Part D is not a covered benefit under the Medi-Cal Program and is not eligible for reimbursement. Beneficiaries must call 1-800-Medicare for questions regarding Medicare Part D.

Deadline For Filing Reimbursement Claims

Beneficiaries must submit a claim within ***one year of receipt of services or within 90 days after issuance*** of the Medi-Cal card, which ever is longer.

How To File A Reimbursement Claim

To file a reimbursement claim, beneficiaries must call or write to Medi-Cal at:

California Department of Health Services Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008
(916) 403-2007

A complete 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.

Beneficiaries or their representatives are required to submit a completed beneficiary reimbursement claim packet to the Beneficiary Service Center (BSC) when requesting reimbursement for out-of-pocket medical expenses pursuant to the Court's orders. The Beneficiary Service Center is responsible for responding to questions and ensuring the completeness of claims. Incomplete claims will be returned to the submitter for completion. Incomplete claims that are not resubmitted within thirty (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. A letter will be sent to the beneficiary with an explanation for the denial and notifying the beneficiary of the right to request a State Fair Hearing.

State Fair Hearings

If Medi-Cal denies a claim for reimbursement, the BSC will notify the beneficiary of his/her right to appeal the decision through the State Fair Hearing process, and will provide the beneficiary with a Beneficiary Reimbursement Hearing Request Form in case s/he chooses to file a State Fair Hearing. The beneficiary will have (90) days from the date of notice to file a State Fair Hearing. A request for a State Fair Hearing may be made in writing to the State Hearing Division, California Department of Social Services, P.O. Box 944243, Mail Station 19-99, Sacramento, CA 94244-2430, or by telephone to 1-800-952-5253. 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 County's letterhead.

MHP and SUPT Responsibilities

The MHP and SUPT must process specialty mental health and acohol and drug services reimbursement claims with dates of service of July 1, 2006, and later. The MHP and SUPT are required to:
1. Receive and log the reimbursement claim. The log must include, but is not limited to: The date that the claim was received, the claim issue number referenced on the bottom of the claim form, the name of the beneficiary, the date the 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 or SUPT date of payment.
2. Validate that the beneficiary reimbursement claim belongs to the MHP or SUPT, and that the claim is for a covered specialty mental health or alcohol and drug service. If the MHP or SUPT identifies that the claim belongs to a different MHP or drug Medi-Cal (DMC-ODS) Plan, the Plan will return the claim to DHCS in writing within 10 days of receipt of the claim.

3. The MHP or SUPT must determine if there is a previous payment through the Short Doyle/Medi-Cal (SD/MC) system. The MHP or SUPT can contact PEDCorr@dhcs.ca.gov for technical assistance.
4. If a previous payment through the SD/MC system exists, the MHP or SUPT notifies the provider of a duplicate payment and instructs the provider to refund the beneficiary within 30 days. The provider is to notify the MHP or SUPT in writing of the refund. The MHP or SUPT then sends a letter to the beneficiary informing that the provider has sent payment, and submits a copy to DHCS to verify the refund.

Criteria For Establishing Validated Beneficiary Claims

Claims that meet all of the following criteria are considered valid

1. The beneficiary was eligible for Medi-Cal at the time the service(s) was(were) provided;
2. 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;
3. 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;
4. For those Medi-Cal services that would have required Medi-Cal authorization, the beneficiary has documentation from the MHP or SUPT that shows medical necessity for the services(s);
5. The claimed cost(s) was(were) not required to meet co-payments, share of cost or other cost-sharing requirements;
6. The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal other Medi-Cal funded program, the healthcare provider or by the third party; or
7. 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).
8. For claims for Medi-Cal covered service(s) provided during the evaluation period, 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.

Invalid Beneficiary Reimbursement Claim

If the claim is determined to be invalid, the MHP or SUPT will send a Notice of Adverse Benefit Determination with the Notice of Appeal Resolution Your Rights enclosure to the beneficiary denying the claim, and provide a copy to DHCS to verify the denial.

Reimbursement Of Beneficiary Reimbursement Claims

The provider is required to reimburse the beneficiary within thirty (30) days of receipt of the beneficiary's claim. If the provider fails to reimburse the beneficiary, the MHP or SUPT is responsible for reimbursing the beneficiary within thirty (30) days of the provider's refusal to do so. If both the provider and the MHP or SUPT fail to reimburse the beneficiary, DHCS will do so within twenty (20) days of the MHP's or SUPT's refusal to do so and will withhold the amount of that reimbursement from future payments to the MHP or SUPT.

Provider Problem Resolution

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

Record Retention

The MHP and SUPT shall keep all beneficiary reimbursement claims, denied or approved, on file for three (3) years from the date of receipt.

REFERENCE(S)/ATTACHMENTS:

- W&I Code, Section 14019.3
- W&I Code, Section 10951(b)(2)
- DMH Notice No. 06-09
- DMH Letter No. 07-01

RELATED POLICIES:

- No. 03-01 Problem Resolution

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	**X**	DHHS Human Resources
	Mental Health Treatment Center		
X	Adult Contract Providers		
X	Children's Contract Providers		
X	Substance Use, Prevention, and Treatment Services		

CONTACT INFORMATION:

- Quality Management Infomration
  QMInformation@SacCounty.net