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## Share of Cost (SOC)

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«This manual section has been retained to provide reference to LTC-related billing instructions for dates of service prior to February 1, 2024. This manual section is not live and does not reflect current billing policy and should not be referenced when billing for dates of service on or after February 1, 2024. For current billing instructions as of February 1, 2024, refer to the appropriate manual section in the [Long Term Care Provider Manual](#).»

Some Medi-Cal subscribers (recipients) must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). A Medi-Cal subscriber's SOC is similar to a private insurance plan's out-of-pocket deductible.

### **County Welfare Department Generally Determines SOC Amount**

Generally, a subscriber's SOC is determined by the county welfare department and is based on the amount of income a subscriber receives in excess of "maintenance need" levels. Medi-Cal rules require that subscribers pay income in excess of their "maintenance need" level toward their own medical bills before Medi-Cal begins to pay.

### **How to Find Out If a Subscriber Must Pay an SOC**

Providers access the Medi-Cal eligibility verification system to determine if a subscriber must pay an SOC. The message returned by the eligibility verification system includes the SOC dollar amount the subscriber must pay. The eligibility verification system is accessed through the Automated Eligibility Verification System (AEVS), state-approved vendor software and the Medi-Cal Provider website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

In the following example of a Medi-Cal Provider website eligibility response, the subscriber has a \$38 SOC still to be paid.

**Share of Cost (SOC)/Spend Down Clearance Response**

**SOC (Spend Down) Amount transaction performed by provider:      on 1/13/2022 at 11:20 AM**

**Eligibility Message:** SUBSCRIBER LAST NAME: . SOC/SPEND DOWN AMT DEDUCTED: \$ 10.00. REMAINING SOC/SPEND DOWN \$ 38.00. SOC/SPEND DOWN CLEARANCE APPLIED. MEDI-CAL SUBSCRIBER HAS A \$00068 SOC/SPEND DOWN. ELIGIBILITY REPORTED RETROACTIVELY.

<b>Name:</b>	<b>Subscriber ID:</b>
<b>Service Date:</b> 01/05/2022	<b>Subscriber Birth Date:</b>
<b>Issue Date:</b> 03/01/2021	<b>Procedure Code:</b> 99211
<b>Total Claim Charge Amount:</b> 10.00	<b>Case Number:</b>
<b>SOC (Spend Down) Amount Applied:</b> 10.00	<b>Primary Aid Code:</b>
<b>First Special Aid Code:</b>	<b>Second Special Aid Code:</b>
<b>Third Special Aid Code:</b>	<b>Subscriber County:</b>
<b>HIC Number:</b>	
<b>SOC (Spend Down) Amount Obligation:</b> \$68.00	<b>Remaining SOC (Spend Down) Amount:</b> \$38.00
<b>Trace Number (Eligibility Verification Confirmation (EVC) Number):</b>	

**Figure 1: Basic Website Eligibility Response**

## **Obligating Payment**

Providers may collect SOC payments from a subscriber on the date that services are rendered or providers may allow a subscriber to “obligate” payment for rendered services. Obligating payment means the provider allows the subscriber to pay for the services at a later date or through an installment plan. Obligated payments must be used by the provider to clear Share of Cost. SOC obligation agreements are between the subscriber and the provider and should be in writing, signed by both parties for protection. Medi-Cal will not reimburse the provider for SOC payments obligated, but not paid by the subscriber.

## **Certifying SOC**

Subscribers are not eligible to receive Medi-Cal benefits until their monthly Share of Cost dollar amount has been certified online. Certifying SOC means that the Medi-Cal eligibility verification system shows the subscriber has paid or become obligated for the entire monthly dollar SOC amount owed.

Claims submitted for services rendered to a subscriber whose SOC is not certified through the Medi-Cal eligibility verification system will be denied.

**Exception:** Share of Cost is certified differently for Long Term Care (LTC) subscribers with specific aid codes.

To avoid duplicate billing, Hospice providers must indicate the SOC on the *UB-04* claim when billing for hospice room and board (revenue code 658) if the SOC was not already met on a *Payment Request for Long Term Care (25-1)* claim.

## Long Term Care SOC

Providers receiving an eligibility verification message (see following example) that indicates a subscriber has an LTC SOC should not clear the SOC online. Subscribers with aid codes 13, 23, 53 and 63 must have their LTC SOC cleared on the claim. The LTC facility includes the LTC SOC amount for Medi-Cal-covered services on the *Payment Request for Long Term Care (25-1)*. Refer to the *Share of Cost (SOC): 25-1 for Long Term Care* section in the Part 2 manual for additional information.

When billing for room and board (revenue code 0658), the Hospice provider includes the LTC SOC amount for Medi-Cal-covered services on the *UB-04* claim form. Refer to the *Hospice Care: General Billing Instructions* section in the Part 2 manual for additional information.

**Share of Cost (SOC)/Spend Down Clearance Response**

**SOC (Spend Down) Amount transaction performed by provider: on 1/13/2022 at 11:20 AM**

**Eligibility Message:** SUBSCRIBER LAST NAME: MEDI-CAL ELIGIBLE W/LTC SOC/SPEND DOWN AMT DEDUCTED: \$ 10.00. REMAINING SOC/SPEND DOWN \$ 58.00. SOC/SPEND DOWN CLEARANCE APPLIED. MEDI-CAL SUBSCRIBER HAS A \$00068 SOC/SPEND DOWN. ELIGIBILITY REPORTED RETROACTIVELY.

<b>Name:</b>	<b>Subscriber ID:</b>
<b>Service Date:</b> 01/05/2022	<b>Subscriber Birth Date:</b>
<b>Issue Date:</b> 03/01/2021	<b>Procedure Code:</b>
<b>Total Claim Charge Amount:</b> 10.00	<b>Case Number:</b>
<b>SOC (Spend Down) Amount Applied:</b> 10.00	<b>Primary Aid Code:</b> 13
<b>First Special Aid Code:</b>	<b>Second Special Aid Code:</b>
<b>Third Special Aid Code:</b>	<b>Subscriber County:</b> 34 - Sacramento
<b>HIC Number:</b>	
<b>SOC (Spend Down) Amount Obligation:</b> \$68.00	<b>Remaining SOC (Spend Down) Amount:</b> \$58.00
<b>Trace Number (Eligibility Verification Confirmation (EVC) Number):</b>	

**Figure 2:** Website Eligibility Response Indicating Subscriber has an LTC SOC

## SOC Clearance Transaction

To clear a subscriber's SOC, the provider accesses the Medi-Cal eligibility verification system, enters a provider number, Provider Identification Number (PIN), subscriber identification number, Medi-Cal Benefits Identification Card (BIC) issue date, billing code and service charge. The SOC information is updated and a response is displayed on the screen or relayed over the telephone.

Several clearance transactions may be required to fully certify SOC. In other words, providers must continue to clear SOC until it is completely certified. (Clearing Share of Cost is also referred to as "spending down" the SOC.)

Providers must perform an SOC clearance transaction immediately upon receiving payment, or accepting obligation from the subscriber, for the service rendered. Delays in performing the SOC clearance transaction may prevent the subscriber from receiving other medically needed services.

Submit only one SOC clearance transaction for each rendered service used to clear the subscriber's Share of Cost, even if a payment plan is used to meet the obligation.

All medically necessary health services – including medical services, supplies, devices and prescription drugs, whether Medi-Cal covered or not – can be used to meet Share of Cost for Medi-Cal and County Medical Services Program (CMSP) purposes. (Refer to “CMSP: SOC Policy Applies” elsewhere in this section for additional information.)

## **Reversing SOC Transaction**

To reverse SOC transactions, providers enter the same information as for a clearance but specify that the entry is a reversal transaction. After the SOC file is updated, providers receive confirmation that the reversal is completed. Once a subscriber has been certified as having met the Share of Cost, reversal transactions can no longer be performed. Reversals may only be performed for partial clearance prior to the time the subscriber is certified as eligible.

## **Instructions for Performing SOC Transactions**

Instructions for performing SOC clearance transactions are available in the *AEVS: Transactions* section of this manual, vendor-supplied user guides and the Medi-Cal Web Site Quick Start Guide (available online only through the Transactions tab of the Medi-Cal Provider homepage.)

## **EVC Number**

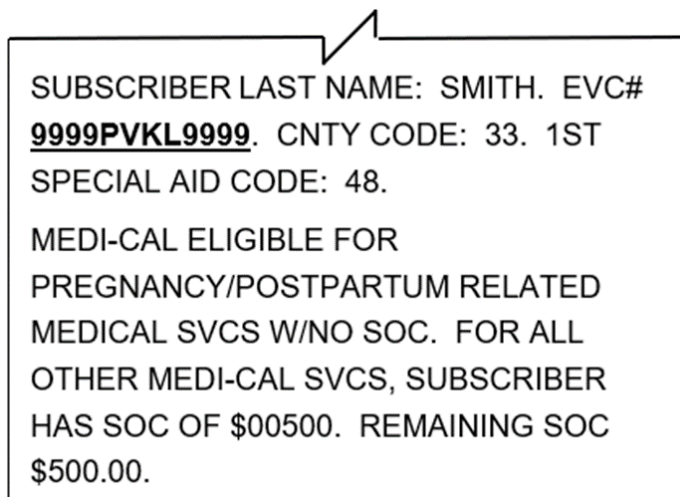
Once SOC has been certified, an Eligibility Verification Confirmation (EVC) number is displayed in the message returned by the Medi-Cal eligibility verification system. Return of an EVC number does not guarantee that a subscriber qualifies for full-scope Medi-Cal or CMSP benefits. It does, however, indicate that the subscriber qualifies for at least partial services. Providers should carefully read the eligibility message to determine what Medi-Cal service limitations, if any, apply to the subscriber.

Providers are not required to include the EVC number on the claim, but may choose to do so for their own record keeping purposes. When included, the EVC number should be entered in the remarks area of the claim.

## **Multiple Aid Codes and SOC**

Some subscribers may qualify for assistance for limited scope Medi-Cal eligibility or from programs other than Medi-Cal at the same time they qualify for full-scope Medi-Cal with a Share of Cost. Aid codes displayed by the eligibility verification system identify additional programs or services for which Medi-Cal subscribers are eligible. In such instances, the subscriber may be required to pay a Share of Cost for one set of services, but not for another.

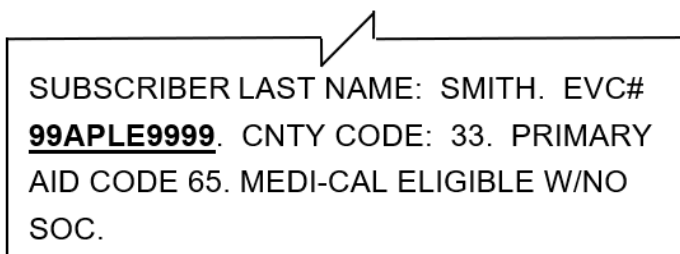
In the following example, aid code 48 indicates the subscriber is eligible for pregnancy/postpartum-related services with “NO SOC.” (For full descriptions of aid codes, refer to the *Aid Codes Master Chart* section in this manual). For services related to pregnancy/postpartum, no SOC is necessary. The subscriber also is eligible for full-scope Medi-Cal benefits with a SOC of \$500. For all services not related to pregnancy or postpartum services, the provider must collect the SOC amount from the subscriber and clear it through the eligibility verification system.



SUBSCRIBER LAST NAME: SMITH. EVC#  
**9999PVKL9999**. CNTY CODE: 33. 1ST  
SPECIAL AID CODE: 48.  
  
MEDI-CAL ELIGIBLE FOR  
PREGNANCY/POSTPARTUM RELATED  
MEDICAL SVCS W/NO SOC. FOR ALL  
OTHER MEDI-CAL SVCS, SUBSCRIBER  
HAS SOC OF \$00500. REMAINING SOC  
\$500.00.

**Figure 3:** Partial POS Message for Subscriber with Multiple Eligibility.

Once the SOC obligation is met for the month, the subscriber is eligible for full-scope Medi-Cal benefits. The full-scope aid code will not be displayed until the SOC obligation is met.

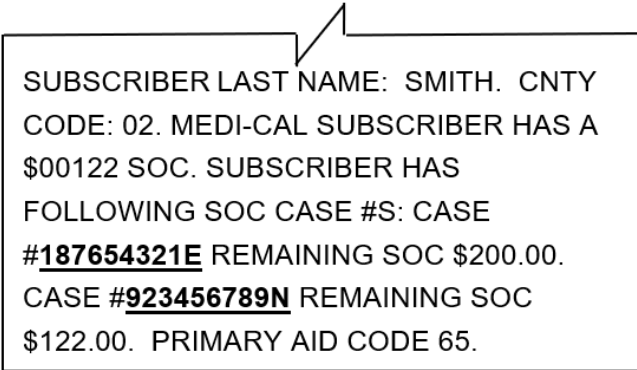


SUBSCRIBER LAST NAME: SMITH. EVC#  
**99APPLE9999**. CNTY CODE: 33. PRIMARY  
AID CODE 65. MEDI-CAL ELIGIBLE W/NO  
SOC.

**Figure 4:** Partial POS Message After SOC is Certified.

## **Multiple Case Numbers**

Eligibility messages may include multiple case numbers. This occurs for two major reasons: 1) Individuals within a family have varying SOC's (Sneede v. Kizer) or 2) part of the family is eligible only for Medi-Cal while the other part is eligible only for CMSP services. (For additional information refer to "Sneede v. Kizer" in this section.)



SUBSCRIBER LAST NAME: SMITH. CNTY  
CODE: 02. MEDI-CAL SUBSCRIBER HAS A  
\$00122 SOC. SUBSCRIBER HAS  
FOLLOWING SOC CASE #S: CASE  
**#187654321E** REMAINING SOC \$200.00.  
CASE #**923456789N** REMAINING SOC  
\$122.00. PRIMARY AID CODE 65.

**Figure 5:** Subscriber with Multiple Case Numbers and SOC.

### **Case Numbers are Listed in Numeric Order**

When there are two or more case numbers in an eligibility verification message they are listed in numeric order. The first case number listed does not necessarily correspond with the subscriber for whom eligibility is being verified. Subscribers who have multiple case numbers receive a *Share of Cost Case Summary* form. Providers must refer to the *Share of Cost Case Summary* form to determine which case numbers correspond to which subscriber. (For information about the *Share of Cost Case Summary* form, refer to "Share of Cost Case Summary Form: Multiple Case Numbers" in this section.)

**Note:** In the preceding example the subscriber's case number is reported first (case #187654321E) and indicates the remaining SOC for this subscriber is \$200.

## Share of Cost Case Summary Form: Multiple Case Numbers

Subscribers who are in more than one Share of Cost case will receive a *Share of Cost Case Summary* form that lists all of the cases for which the subscriber may clear Share of Cost.

**SHARE OF COST CASE SUMMARY**  
**CARRY THIS WITH YOU TO YOUR MEDICAL APPOINTMENTS**  
**RESUMEN DEL CASO DE LA PARTE DEL COSTO**  
**LLEVE ESTO CONSIGO A SUS CITAS MEDICAS**

SUBSCRIBER NAME  
 1234 MAIN AVENUE  
 ANYTOWN, CA 99999-9999

**THE SHARE OF COST FAMILY GROUPINGS for the month of \_\_\_\_\_ are:**

This information is being sent to you because your medical expenses may be used to meet your share of cost, if any, or the share of cost of other family members. This is because you appear in more than one family group. Other family members may only use their medical expenses to meet their own share of cost for the month.

Se le envia esta informacion puesto que es posible que sus gastos medicos puedan utilizarse para cumplir con su parte del costo, si tiene alguna, o la parte del costo de otros miembros de la familia. Esto es debido a que usted aparece en mas de un grupo familiar. Otros miembros de la familia solo pueden utilizar sus gastos medicos para cumplir con su propia parte del costo para el mes. Las agrupaciones familiares para la parte del cost son.

<u>BENEFICIARY NAME</u>	<u>MEDS ID</u>	<u>AID CODE</u>	<u>BIRTHDATE</u>	<u>SOC AMT</u>
<i>NOMBRE DEL BENEFICIARIO</i>	<i>NO. DE IDENT. DEL MEDS</i>	<i>CLAVE de ASISTENCIA</i>	<i>DIA DE NACIMIENTO</i>	<i>CANTIDAD DEL SOC</i>
<b>CASE NUMBER/Numero de caso:</b>		<b>01-1234567-0</b>		<b>\$ 1,200.</b>
Tate-Smith, Sally	<u>99999999A99999</u>	37	08/03/53	
Smith, John	<u>99999999B99999</u>	IE	07/03/55	
<b>CASE NUMBER/Numero de caso:</b>		<b>01-1234567-A</b>		<b>\$ 1,200.</b>
Smith, Freddie	<u>99999999C99999</u>	37	01/09/81	
Tate-Smith, Sally	<u>99999999A99999</u>	RR	08/03/53	
Smith, John	<u>99999999B99999</u>	RR	07/03/55	
<b>CASE NUMBER/Numero de caso:</b>		<b>01-1234567-B</b>		<b>\$ 100.</b>
Tate, Susie	<u>99999999D99999</u>	37	03/12/78	
Tate-Smith, Sally	<u>99999999A99999</u>	RR	08/03/53	

**Figure 6:** *Share of Cost Case Summary* letter.



## SOC Case Summary Form: Additional Information

The following information appears on the reverse side of the *Share of Cost Case Summary* form and provides helpful SOC information:

*Your Medi-Cal case has been affected by a lawsuit called Sneede v. Kizer. This lawsuit limits which family members may use medical expenses that are not billed to Medi-Cal to meet their family's Share of Cost.*

*If you are a spouse or a parent, you have the choice of listing your medical expenses in any case number on the reverse side of this form in which your name appears. You may list all your medical expenses in a single case number, or you may divide up the expense and list it in two or more case numbers in which your name appears. However, the total being reported for the single service cannot be more than the original bill.*

*If you are a caretaker relative such as a grandparent, aunt, uncle, etc., your medical expenses may only be listed in the case number in which your name appears.*

*If you are a minor mother, a mother age 21 or younger who*

*lives in the home with her parent(s), you may list your medical expenses in both the case number with your parent(s) and again in the case number where you are in an aid code "IE" with your child. The same medical expense for minor mothers should be listed TWICE IN FULL. The medical expense is never divided up.*

*IMPORTANT: A person listed as "IE" or "RR" in the aid code section on the reverse side of this form will not receive Medi-Cal benefits when the Share of Cost for that case number has been met. In order to receive Medi-Cal benefits, this person must meet the Share of Cost for a case number where the person is not listed as an "IE" or "RR."*

*This summary does not guarantee Medi-Cal eligibility. This summary only shows which members of the family have a Share of Cost for Medi-Cal.*

**Note:** "IE" means ineligible and "RR" means Responsible Relative.

### **Sneede v. Kizer**

According to the Sneede v. Kizer lawsuit, a subscriber's eligibility and SOC must be determined using his/her own property. Children and spouses within the same family may have varying SOC's and, therefore, multiple case numbers listed on the *Share of Cost Case Summary* form.

Sneede v. Kizer cases may result in the following scenarios:

Scenario 1: A mother has medical expenses totaling \$75 that have not been billed to Medi-Cal. The mother has a *Share of Cost Case Summary* form that lists her in two separate cases. She is listed with an “RR” code with her child and she is listed by herself with aid code 37. She may do one of the following:

- Apply the entire \$75 to her own \$100 SOC.
- Apply the entire \$75 to her child’s \$125 SOC.
- Apply any amount less than \$75 to her SOC and the balance of the \$75 to her child’s SOC. The total amount reported cannot exceed the original \$75.

Scenario 2: The Smith family consists of a stepfather (husband), a mother (wife) and the mother’s separate child. The wife and her husband are listed together on the *Share of Cost Case Summary* form as eligible subscribers with a \$100 SOC. The mother is listed as an “RR” with her child in the second case with a \$125 SOC.

The mother has medical expenses totaling \$100 that have not been billed to Medi-Cal. She may do one of the following:

- Apply the entire \$100 to her own \$100 SOC.
- Apply the entire \$100 to her child’s \$125 SOC.
- Apply any amount less than \$100 to her SOC and the balance of the \$100 to her child’s SOC. The total amount reported cannot exceed the original \$100.

In all other cases that do not involve a natural or adoptive parent, Share of Cost can be cleared only for a person’s own medical expenses. Examples:

- Caretaker relatives (such as a grandparent, aunt or uncle) can use their medical expenses to clear only their own Share of Cost.
- Children can use their medical expenses to clear only their own Share of Cost.

Scenario 3: A minor mother is listed on the *Share of Cost Case Summary* form with an “IE” (ineligible) or “RR” aid code in the same case with her child. In addition, the minor mother also may be in a second case, either listed with her parent(s) or in her own case. In this situation only, full medical expenses may be used to clear SOC in both cases. Two separate transactions are required.

A minor mother is defined as a mother age 21 or younger who resides in the home of her parent(s).

## **Recipient Share of Cost in EVC Spend Down Fields**

There are several instances when a Medi-Cal recipient shows a Share of Cost (SOC), also referred to as "spend down," in one or more spend down fields on eligibility messages.

These circumstances are:

- Sneede v. Kizer (different cases)
- Family SOC (same case)
- 250 Percent Working Disabled Program

Providers should read eligibility messages carefully. If a recipient has no SOC for Medi-Cal but still has SOC amounts in the "Remaining Spend Down Amount," "Spend Down Amount Case Balance" and/or "Spend Down Obligation Amount" fields, several elements may appear in the eligibility message. An Eligibility Verification Confirmation (EVC) number will appear in the message along with a message regarding the no SOC coverage.

### **Sneede v. Kizer Spend Down (Different Cases)**

Based on the settlement in the Sneede v. Kizer lawsuit, if the SOC amount is due to the possibility that a recipient's medical expenses can be applied to another Medi-Cal case, there will be a sentence at the end of the EVC message stating the Medi-Cal case number(s) and the SOC amount remaining in the cases for which the recipient can choose to apply their medical expenses.

Spend Down Amount Obligation:	Remaining Spend Down Amount: \$2,173.00
Spend Down amount Case# - 1: 19	Spend Down Amount Case Balance: \$2,173.00
Spend down Amount Case# - 2: 19	Spend Down Amount Case Balance: \$2,173.00
Trace Number (Eligibility Verification Confirmation (EVC) Number): 4 B	
Eligibility Message: SUBSCRIBER LAST NAME: EVC #: 4 B. CNTY CODE: 19. PRMY AID CODE: M5. MEDI-CAL ELIGIBLE W/ NO SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (888)839-9909. HCP: LA CARE HLTH PLAN CALL: (888) 839-9909. PCP: JANE SMITH CALL: (916)555-5555. SUBSCRIBER CAN ALSO CHOOSE TO APPLY MEDICAL EXPENSES TOWARDS FAMILY SOC/SPEND DOWN. SUBSCRIBER HAS FOLLOWING SOC/SPEND DOWN CASE #S: CASE # 19B 1 REMAINING SOC/SPEND DOWN \$2173.00. CASE # 19B 3 REMAINING SOC/SPEND DOWN \$2173.00.	

## Family SOC Spend Down (Same Case)

If a recipient can choose to apply their medical expenses toward a family SOC in the same case, there will be no Medi-Cal case numbers. The message will state that the recipient can choose to apply their medical expenses to meet the family SOC. In this case, providers should inform the recipient that they may choose to apply their medical expenses to either the family SOC or to the SOC of another case. However, providers should not charge the recipient for the SOC amount if the recipient does not choose to apply their medical expenses to the family's SOC or the SOC of another case.

Spend Down Amount Obligation	Remaining Spend Down Amount: \$2,173.00
Trace Number (Eligibility Verification Confirmation (EVC) Number): 9 2	
Eligibility Message: SUBSCRIBER LAST NAME: EVC #: 9 2. CNTY CODE: 19. PRMY AID CODE: T2. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (888)839-9909. HCP: LA CARE HLTH PLAN CALL: (888) 839-9909. PCP: JANE DOE CALL: (916)555-5555. SUBSCRIBER CAN ALSO CHOOSE TO APPLY MEDICAL EXPENSES TOWARDS FAMILY SOC/SPEND DOWN. REMAINING SOC/SPEND DOWN \$2173.00.	

## 250 Percent Working Disabled Program Recipients

When the SOC amount in the "Spend Down Obligation Amount" field is due to the 250 percent Working Disabled Program, the message will state that the recipient is eligible for full-scope Medi-Cal under aid code 6G with no SOC. An EVC number will also appear. In this case, the SOC amount is a premium that the recipient pays directly to the Department of Health Care Services (DHCS). Providers are not to collect SOC amounts from 250 percent Working Disabled Program recipients.

Spend Down Amount Obligation: \$20.00	Remaining Spend Down Amount:
Trace Number (Eligibility Verification Confirmation (EVC) Number): 7 2	
Eligibility Message: SUBSCRIBER LAST NAME: EVC #: 7 2. CNTY CODE: 19. PRMY AID CODE: 6G. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN.	

## **CMSP: SOC Policy Applies**

SOC policy also applies to County Medical Services Program (CMSP) providers and subscribers.

Share of Cost is calculated independently for CMSP and Medi-Cal, however, the same subscriber income is included in both calculations. Therefore, the same medical expenses may be used to clear SOC for both programs. Providers may apply the same services used to clear a Medi-Cal SOC obligation to clear a CMSP SOC obligation. Two separate transactions are required. Clearing Share of Cost for one program does not automatically clear SOC for the other program.

## **Families With Both CMSP and Medi-Cal Coverage**

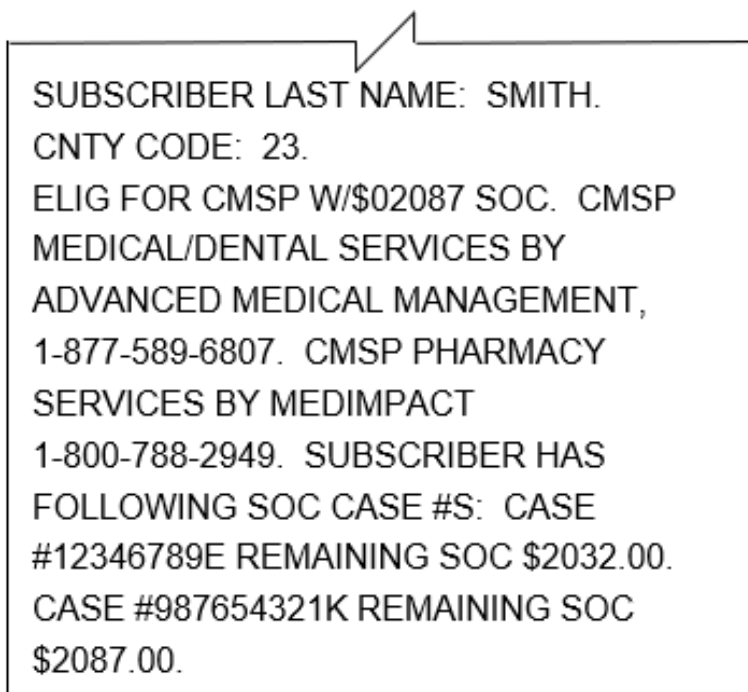
To identify a case involving a family with both CMSP and Medi-Cal coverage, both of the following must be true:

- The Medi-Cal eligibility verification message lists the subscriber in multiple SOC cases.
- On the subscriber's *Share of Cost Case Summary* form, the subscriber receiving services is named in two or more SOC cases.

In addition, one of the following also must be true:

- The CMSP subscriber's aid code is 50, 85 or 89. The Medi-Cal SOC lists this subscriber with an "IE" aid code and the other family member(s) with an aid code of 50, 85 or 89.
- The Medi-Cal subscriber's aid code is 17, 27, 37, 67 or 83. The CMSP SOC lists this subscriber with an "IE" aid code and the other family member(s) with an aid code of 50, 85 or 89.

## CMSP Printout



SUBSCRIBER LAST NAME: SMITH.  
CNTY CODE: 23.  
ELIG FOR CMSP W/\$02087 SOC. CMSP  
MEDICAL/DENTAL SERVICES BY  
ADVANCED MEDICAL MANAGEMENT,  
1-877-589-6807. CMSP PHARMACY  
SERVICES BY MEDIMPACT  
1-800-788-2949. SUBSCRIBER HAS  
FOLLOWING SOC CASE #S: CASE  
#12346789E REMAINING SOC \$2032.00.  
CASE #987654321K REMAINING SOC  
\$2087.00.

**Figure 7:** CMSP with SOC.

## **Billing SOC**

Refer to the appropriate Medi-Cal Part 2 provider manual for SOC billing instructions.

## **Claims Processing: Share of Cost Review**

Claims with dates of service on or before the date the subscriber's SOC was certified are reviewed in the claims processing system. The system determines the amount of the claim, if any, to be applied against the subscriber's Share of Cost.

## **Medicare/Medi-Cal Crossover Claims: Subscriber Liability**

Some subscribers who are entitled to Medicare also have Medi-Cal with a Share of Cost. In these cases, the patient's liability is limited to the amount of the Medicare deductible and coinsurance. Providers are strongly advised to wait until they receive a Medicare payment before collecting SOC. This avoids collecting amounts greater than the Medicare deductible and/or coinsurance.

## **Share of Cost Medi-Cal Provider Letter (MC 1054)**

Some subscribers may have had their SOC incorrectly determined. In these cases the subscriber will receive a Notice of Action or a *Share of Cost Medi-Cal Provider Letter* (MC 1054) from the county showing the change in SOC obligation for the affected month(s) or year(s). The MC 1054 contains the subscriber's unique 14-digit County Identification number that authorizes the adjustment. For subscribers seeking reimbursement, providers may submit a Medi-Cal claim for repayment of the SOC amounts. The MC 1054 must be attached to any document submitted for reimbursement.

## **Hunt v. Kizer**

On December 15, 1989, the United States District Court issued a revised Preliminary Injunction in the case of Hunt v. Kizer. This injunction requires that the Department of Health Care Services (DHCS) no longer impose time limits on unpaid medical expenses that Medi-Cal subscribers may use to meet their Share of Cost (SOC).

## **Subscriber May Use Unpaid Medical Expenses to Clear SOC**

This means that Medi-Cal subscribers having unpaid medical expenses for which they are still legally liable, regardless of when the expenses were incurred, are allowed to use these bills toward meeting their SOC in current and, if necessary, future months. Although the County Medical Services Program (CMSP) was not a party to this lawsuit, for ease of administration, CMSP also has adopted the court ordered SOC changes.

## **Supplying Billing Statements**

To comply with the terms of this injunction, DHCS has notified subscribers that their current monthly Medi-Cal SOC may be adjusted to reflect the cost of any unpaid medical bills from previous months for which they are still legally responsible and which have not yet been credited as SOC in other months. Because they can now use them to meet or reduce their current monthly SOC, subscribers may be requesting these bills from their medical providers. They may ask for a copy of the initial billing statement. In these cases, providers should supply a copy of the statement showing the amount currently owed and the current date.

## **County Welfare Office Processes Old Medical Bills**

Old medical bills (incurred previous to the month of eligibility) applied toward SOC under Hunt must be brought by the subscriber to his/her county welfare office. The county welfare office, not the provider, is responsible for processing old medical bills for application toward the subscriber's SOC.

## Old Medical Bills Apply Toward SOC

To satisfy the Hunt requirements for qualifying an old medical bill for application toward SOC, subscribers may occasionally request providers to: (1) re-issue a medical bill, (2) add missing information to a pre-existing medical bill, or (3) clarify certain items on a medical bill.

## Appending Bills

When a provider appends a medical bill to give information, the notation must be signed, signature-stamped or initialed to verify that the provider, and not the subscriber, has added the information.

## Reissuing Bills

When a provider reissues a bill, Medi-Cal assumes that the bill is unpaid in the month in which the bill was reissued. The validity of this assumption is requisite to several of the Hunt v. Kizer remedies. If the provider is reissuing a bill for a medical service that has been paid by the subscriber (for example, the bill is reissued in response to the subscriber's request that the provider furnish information missing from the previous bill and needed by one of the Hunt remedies) the provider should write "PAID" and include their initials next to the dollar amount billed. This will inform Medi-Cal that the bill's reissuance does not signify the bill is still unpaid as of the reissuance date.

**Note:** Photocopies of medical bills, statements of verification, handwritten statements, billing summaries and other statements other than the original bill issued for the medical service must contain the provider's signature, initials or stamped-signature.



## Issuing Medical Bills

When the provider issues a medical bill to a Medi-Cal subscriber, the bill must contain information the county welfare office will need in the event the subscriber should later submit the medical bill to the county for processing.

The information includes:

- Provider's name and address.
- Name of the person receiving the service.
- Short description of the medical service rendered.
- Date of service.
- Procedure code.
- Provider federal Tax Identification Number (TIN), provider license number, National Provider Identification (NPI) or Medi-Cal provider identification number.
- Date the bill was issued.
- Amount owed solely by the subscriber at the time of the bill's issuance or reissuance, net of any third party coverage. Indicate the amount billed to the other health insurer.
- Notification that any prior medical bill amount has been credited as SOC.

## **Long Term Care (LTC) Facilities: Johnson v. Rank**

For Long Term Care patients, current unpaid medical bills are still applied against current SOC at the nursing home as established under Johnson v. Rank. Therefore, nursing homes should continue their current procedure for deducting from SOC the bills and receipts submitted within the last two months of the current month.

Old unpaid medical bills, or those bills submitted more than two months after the month of service, may not be accepted by the nursing home under Johnson v. Rank.

## **Legend**

Symbols used in the document above are explained in the following table.

<b>Symbol</b>	<b>Description</b>
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.