Share of Cost (SOC): UB-04 for Long Term Care

This section explains how to complete claims for services rendered to recipients who have a Share of Cost (SOC). Refer to the *Share of Cost (SOC)* section in the Part 1 manual for an explanation of SOC and how to determine the following:

- If a recipient must pay an SOC

- The SOC amount a recipient must pay

Instructions for performing SOC clearance transactions are given in the *AEVS: Transactions* section in the Part 1 manual or the *Medi-Cal Web Site Quick Start Guide*.

Share of Cost Clearance Transactions

Long Term Care (LTC) facilities may be required to perform SOC clearance transactions when a recipient with an unmet SOC is admitted, or when a recipient's SOC exceeds the total charges of the Medi-Cal rate for a given month's stay.

Determining How Much to Bill Recipient

LTC facilities must perform an eligibility verification transaction every month for each Medi-Cal recipient residing in the facility. The eligibility verification transaction shows how much SOC a recipient must pay for the month, if any. If a recipient has not spent any of the SOC in the month, the facility bills the recipient for the entire SOC.

SOC for Non-Covered Services

If a recipient has spent part of the SOC on "non-covered" medical or remedial services or items (see "Non-Covered Medical Services Defined: Requirements of <u>Johnson</u> v. <u>Rank</u>" on a following page in this section), the facility subtracts those amounts from the recipient's SOC and bills the recipient in an amount equal to the recipient's remaining SOC.

Medical expenses incurred during the month by new recipients while outside the facility may also reduce the amount which the facility bills to the recipient.

Note: LTC facilities must document a recipient's expenditures on non-covered medical services and items by completing the *Record of Non-Covered Services* (DHS 6114 form). Completion instructions appear on a following page in this section.

Refer to the *Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items* section in this manual for information on non-covered services.

Determining How Much to Bill Medi-Cal

To determine how much to bill Medi-Cal, subtract from a facility's monthly Medi-Cal rate the amount billed to the recipient and bill Medi-Cal for the remainder. (See the following "SOC Field on Claim." See the *UB-04 Completion: Long Term Care Services* section in this manual for detailed instructions on completing the UB-04 claim form.)

Non-Covered Medical Services Defined Requirements of Johnson v. Rank

As a result of the Johnson v. Rank lawsuit, Medi-Cal recipients, not their providers, can elect to use their Share of Cost (SOC) funds to pay for necessary, non-covered, medical or remedial-care services, supplies, equipment and drugs (medical services) that are prescribed by a physician and part of the "plan of care" authorized by the recipient's attending physician. (See the *Patient Plans of Care for Long Term Care* section in this manual for additional information.) Physicians' prescriptions for SOC expenditures must be maintained in the patient's medical record and available for audit by the Department of Health Care Services (DHCS).

A medical service is considered a non-covered benefit if either of the following statements is true:

- The medical service is rendered by a non-Medi-Cal provider; or

- The medical service falls into the category of services for which a *Treatment Authorization Request* (TAR) must be submitted and approved before Medi-Cal will pay and either (1) a TAR is not submitted or (2) a TAR is submitted but is denied by Medi-Cal because the service is not considered medically necessary.

SOC Field on Claim

SOC is entered in the *Value Codes and Amount* field (Box 39-41a thru d). If the SOC for a straight Medi-Cal claim is zero, enter 000 in this field. Do not leave blank.

In the following example, the SOC amount, $250.00, is entered as 25000. Do not enter decimal points or dollar signs. Enter the full dollar amount and cents amounts, even if the amount is even. Refer to the *UB-04 Completion: Long Term Care Services* section in this manual for additional information.

Sample: Share of Cost Amount in *Value Codes and Amount* Field (Box 39a)

Billing for LTC Resident Aid Code 13

Case scenario: A 65-year-old recipient resides in an LTC facility with a monthly SOC of $250. The recipient is Medi-Cal eligible with aid code 13.

Billing for LTC Resident: Aid Code 13 Case Scenario

Dates	Gross Amount	SOC	Net Amount Billed
10/01/24 thru 10/30/24	$2000.00	$250.00	$1750.00

The facility collects SOC on the first day of the month, and the recipient pays her entire $250 SOC. The LTC facility bills Medi-Cal for 30 days of service and submits a claim showing that the patient liability of $250 has been met.

To bill, enter dates of service in the *Statement Covers Period From/Through* field (Box 6). Enter the total charges in the *Total Charges* field (Box 47). Enter the amount of recipient's SOC applied to this claim in the *Value Codes and Amount* field (Box 39-41a thru d). Enter the difference between Box 47 and Box 39-41a thru d in the *Estimated Amount Due* field (Box 55a thru c).

This is a sample only. Please adapt to your billing situation.

1			2				3a PAT. CNTL #			4 TYPE OF BILL
							b. MED. REC. #			
						5 FED. TAX NO.	6 STATEMENT COVERS PERIOD		7	
							FROM 100124	THROUGH 103024		

8 PATIENT NAME	a		9 PATIENT ADDRESS	a				
b			b		c	d		e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
100158																				

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37	
a							a
b							b

38				39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
			a	23 250:00		
			b			
			c			
			d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1					2000:00		1
2							2

Sample: Share of Cost Amount in *Value Codes and Amount* Field (Box 39a)

							TOTALS ➡	2190	60		
50 PAYER NAME		51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		
A **LTC MEDI-CAL**								1750 00	57		A
B									OTHER		B
C									PRV ID		C

Sample: Estimated amount due in *Estimated Amount Due* Field (Box 55a)

RAD Payment Summary

SOC claims are reviewed prior to payment. Because the recipient's SOC is met as indicated on the claim, services appear as "Denied" on *Remittance Advice Details* (RAD) code 022 or with a payment amount of $0. The $1750 appears in the "Approved" group as partially paid. The Medi-Cal allowed amount for this service is reduced by the SOC amount. RAD code 408 indicates payment was reduced because of patient liability.

Billing With Non-Covered Services on Claim

When a facility collects from recipients less than their full SOC (for example, part of SOC was expended on "non-covered" medical services or items), an explanation must be entered in the *Remarks* field (Box 80) of the *UB-04* claim form.

In the following example, the *Remarks* field identifies the SOC for the recipient as $300 minus the non-covered services of $27.70, leaving the patient's liability at $272.30 (Box 39a). The gross amount, $2769.30 (Box 47), minus the patient's liability, $272.30 (Box 39a), equals the net amount billed, $2497 (Box 55a).

```
80 REMARKS

SOC 300.00 - NCS 27.70 = PT LIAB
272.30
```

Sample: Non-covered services explained in *Remarks* Field (Box 80)

Over-the-Counter Drugs Included in Facility's Per Diem Rate

Non-legend (over-the-counter) drugs cannot be billed on a recipient's SOC since these drugs are included in the per-diem rate paid to a facility. Furthermore, under federal law insulin cannot be billed to a recipient's SOC by a Medi-Cal enrolled pharmacy because it is separately billable to the program. This applies to all separately billable services. If the recipient is in an LTC facility, over-the-counter drugs cannot be billed to Medi-Cal, to the patient or as a SOC transaction.

SOC Record Keeping: Record of Non-Covered Serviced (DHS 6114)

Expenditures from a recipient's SOC funds must be recorded on the *Record of Non-Covered Services* (DHS 6114 form). The following information must be entered:

- Name of company/provider rendering service

- Name of physician prescribing items or rendering service

- Date on which service is provided

- Description of service provided

- Amount patient paid for services

Refer to the sample completed DHS 6114 on a following page in this section.

For every month in which a recipient expends SOC on non-covered services, form DHS 6114 must be completed and retained for auditing purposes in the recipient's LTC facility case file for three years. It is not necessary to send this form to Medi-Cal.

State of California – Health and Welfare Agency
Medi-Cal Program

DEPARTMENT OF HEALTH SERVICES

RECORD OF NON-COVERED SERVICES

Medi-Cal Identification Number (Taken from the Medi-Cal Card)

① | Month of Eligibility ② | Share of Cost (SOC) $ ③

AID | 7 DIGIT SERIAL NO | FBU | PERS | MO. | YR.

BENEFICIARY NAME ④	LONG TERM CARE (LTC) FACILITY NAME (You may use stamp.) ⑦
SOCIAL SECURITY NUMBER ⑤	ADDRESS
DATE OF BIRTH ⑥	CITY	STATE	ZIP

List non-covered services below. When completing this section, please indicate the provider of the service, the patient's physician name, date of service, service description and amount paid for the service(s) received. The amount paid for non-covered services must be totaled each month and entered in the "Total Non-Covered Services" box below. All services listed below must be consistent with the plan of care authorized by the attending physician and documented in the patient's medical record.

⑧ PROVIDER NAME	⑨ PHYSICIAN NAME	⑩ DATE OF SERVICE	⑪ SERVICE DESCRIPTION	⑫ AMOUNT PAID FOR NON-COVERED SERVICES
Sacramento Acute Care Clinic	Dr. Xylar			
Sacramento Acute Care Clinic	Dr. Yamoto			
Health Aide Drugs	Dr. Zorn			
Dr. Averbach	Dr. Averbach			

This form must be kept in the beneficiary's file and available to Department of Health Services staff for post-audit review.

I hereby certify that the above listed non-covered services have been received

X
Signature of beneficiary / family member / other (indicate your relation to the beneficiary)

TOTAL SOC $ ⑬

TOTAL NON-COVERED SERVICES $ − ⑭

TOTAL SOC DEDUCTED FROM LTC CLAIM $ ⑮

If beneficiary signature cannot be obtained, please indicate reason in this space

LTC Facility Use Only

I certify under penalty of perjury that the above listed non-covered services have been paid.

Signature of Nursing Home Representative

DHS6114(5/85)

Sample: *Record of Non-Covered Services* (DHS 6114 Form)

Explanation of Form Items

The following item numbers and descriptions correspond to the sample DHS 6114 form on the previous page. All items must be completed unless otherwise noted in these instructions.

Explanation of Form Items

Item	Description
1	**Medi-Cal Identification Number (Taken From The Medi-Cal Card)**. The 14-character number on the recipient's Benefits Identification Card (BIC).
2	**Month Of Eligibility**. Identifies the month and year the recipient is eligible for Medi-Cal coverage.
3	**Share Of Cost (SOC)**. Identifies the amount that must be paid or obligated by the recipient.
4	**Beneficiary Name**. Enter the recipient's name.
5	**Social Security Number**. Not required by Medi-Cal.
6	**Date Of Birth**. Enter the date of birth in a six-digit format.
7	**Long Term Care (LTC) Facility Name (You May Use Stamp.), Address, City, State, Zip**. Enter the facility name, address, city, state and nine-digit ZIP code.
8	**Provider Name**. Enter the name of company or provider billing for the service.
9	**Physician Name**. Enter the physician name prescribing items or providing services.
10	**Date Of Service.** Enter the exact date services were rendered.
11	**Service Description**. Enter the specific service rendered.
12	**Amount Paid For Non-Covered Services**. Enter the amount paid for this specific non-covered service received.
13	**Total Share of Cost**. Enter the SOC amount from the *Share of Cost* box (Item 3).
14	**Total Non-Covered Services**. Enter the total amount for non-covered services paid by the recipient.
15	**Total Share of Cost Deducted From LTC Claim**. Enter the total SOC amount that must be deducted from the LTC claim to Medi-Cal.

<u>Legend</u>

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

Symbol	Description
‹‹	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.