

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

share ltc
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Share of Cost (SOC): 25-1 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 *POS: Eligibility Transaction Procedures* section of the *POS Device User Guide*, the user guide that accompanies state-approved vendor software, 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 Johnson v. Rank" 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 *Payment Request for Long Term Care [25-1] Completion* section in this manual for detailed instructions on completing the 25-1 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 *Patient Liability/Medicare Deduct* field (Box 18, 37, 56, 75, 94 or 113). 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 *Payment Request for Long Term Care (25-1) Completion* section in this manual for additional information.

3	4	PATIENT NAME		5	6	7	8	9	10	
DELETE				5	6	7	TAR CONTROL NO.	MEDICAL RECORD NO.	ATTED. M.D. PROVIDER NUMBER	
1	2	3	4	5	6	7	8	9	10	
BILL/G LIMIT EXCEPTIONS	DATE OF SERVICE FROM	DATE OF SERVICE THRU	14	15	16	17	PATIENT LIABILITY/ MEDICARE DEDUCT TYPE	OTHER COVERAGE	NET AMOUNT BILLED	M.D. CERT
11	12	13	14	15	16	17	18	19	20	21
	111107	113007	00	01	93419	37500 00	250 00		37250 00	
25 YR. OF										

Sample. Share of Cost Amount in *Patient Liability/Medicare Deduct* Field (Box 18).

**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 *Explanations* area of the *Payment Request for Long Term Care*. See *Figure 1* on a following page in this section.

Line 1 Explanation

The *Explanations* area 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 18). The gross amount, \$2769.30 (Box 17), minus the patient’s liability, \$272.30 (Box 18), equals the net amount billed, \$2497 (Box 20).

Line 2 Explanation

The *Explanations* area identifies the SOC for the recipient as \$200 minus the non-covered services of \$47, leaving the patient’s liability at \$153.00 (Box 37). The gross amount, \$2769.30 (Box 36), minus the patient’s liability, \$153 (Box 37), equals the net amount billed, \$2616.30 (Box 39).

DO NOT STAPLE IN BAR AREA

1 CLAIM CONTROL NUMBER . FOR F.I. USE ONLY

6
FASTEN
HERE

PROVIDER'S NAME, ADDRESS, ZIP CODE

ANYHOME FOR THE AGED
1234 MAIN STREET
ANYTOWN CA

2 Provider Number

0123456789

128 Zip Code

958235555

PAYMENT REQUEST FOR LONG TERM CARE

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE
REGARDING THE COMPLETION OF THIS FORM

PLEASE TYPE ALL REQUIRED INFORMATION

← Typewriter Alignment →

DELETE	1 PATIENT NAME DOE JOHN	5 MEDICAL ID NUMBER 90000000A95001	6 YR OF BIRTH 26	7 SEX F	8 TAR CONTROL NO 01234567890	9 MEDICAL RECORD NO 12345	10 ATTED. M.D. PROVIDER NUMBER 1234567890				
BILL'G LIMIT EXCEPTIONS	11 FROM 110107	12 THRU 113007	13 PATIENT STATUS 00	14 ACCOM CODE 01	15 PRIM DX CODE 436	16 GROSS AMOUNT 2769 30	17 PATIENT LIABILITY/ MEDICARE DEDUCT 272 30	18 MEDICARE TYPE	19 OTHER COVERAGE	20 NET AMOUNT BILLED 2497 00	21 M.D. CERT
DELETE	22 PATIENT NAME DOE JOHN	24 MEDICAL ID NUMBER 90000000A95001	26 YR OF BIRTH 27	27 SEX F	28 TAR CONTROL NO 01234567891	29 MEDICAL RECORD NO 23451	30 ATTED. M.D. PROVIDER NUMBER 2345678901				
BILL'G LIMIT EXCEPTIONS	31 FROM 110107	32 THRU 113007	33 PATIENT STATUS 00	34 ACCOM CODE 01	35 PRIM DX CODE 436	36 GROSS AMOUNT 2769 30	37 PATIENT LIABILITY/ MEDICARE DEDUCT 153 00	38 MEDICARE TYPE	39 OTHER COVERAGE	40 NET AMOUNT BILLED 2616 30	41 M.D. CERT
DELETE	42 PATIENT NAME	43 MEDICAL ID NUMBER	44 YR OF BIRTH	45 SEX	46 TAR CONTROL NO	47 MEDICAL RECORD NO	48 ATTED. M.D. PROVIDER NUMBER				
BILL'G LIMIT EXCEPTIONS	49 FROM	50 THRU	51 PATIENT STATUS	52 ACCOM CODE	53 PRIM DX CODE	54 GROSS AMOUNT	55 PATIENT LIABILITY/ MEDICARE DEDUCT	56 MEDICARE TYPE	57 OTHER COVERAGE	58 NET AMOUNT BILLED	59 M.D. CERT
DELETE	60 PATIENT NAME	62 MEDICAL ID NUMBER	64 YR OF BIRTH	65 SEX	66 TAR CONTROL NO	67 MEDICAL RECORD NO	68 ATTED. M.D. PROVIDER NUMBER				
BILL'G LIMIT EXCEPTIONS	69 FROM	70 THRU	71 PATIENT STATUS	72 ACCOM CODE	73 PRIM DX CODE	74 GROSS AMOUNT	75 PATIENT LIABILITY/ MEDICARE DEDUCT	76 MEDICARE TYPE	77 OTHER COVERAGE	78 NET AMOUNT BILLED	79 M.D. CERT
DELETE	80 PATIENT NAME	81 MEDICAL ID NUMBER	83 YR OF BIRTH	84 SEX	85 TAR CONTROL NO	86 MEDICAL RECORD NO	87 ATTED. M.D. PROVIDER NUMBER				
BILL'G LIMIT EXCEPTIONS	88 FROM	89 THRU	90 PATIENT STATUS	91 ACCOM CODE	92 PRIM DX CODE	93 GROSS AMOUNT	94 PATIENT LIABILITY/ MEDICARE DEDUCT	95 MEDICARE TYPE	96 OTHER COVERAGE	97 NET AMOUNT BILLED	98 M.D. CERT
DELETE	99 PATIENT NAME	100 MEDICAL ID NUMBER	101 YR OF BIRTH	102 SEX	103 TAR CONTROL NO	104 MEDICAL RECORD NO	105 ATTED. M.D. PROVIDER NUMBER				
BILL'G LIMIT EXCEPTIONS	106 FROM	107 THRU	108 PATIENT STATUS	109 ACCOM CODE	110 PRIM DX CODE	111 GROSS AMOUNT	112 PATIENT LIABILITY/ MEDICARE DEDUCT	113 MEDICARE TYPE	114 OTHER COVERAGE	115 NET AMOUNT BILLED	116 M.D. CERT
ATTACH- MENTS	117 PROV. REF. NO	118 DATE BILLED 120607	120 121 122 123 124 125 126								

PLEASE DO NOT MARK IN SHADED AREAS

F.I. USE ONLY

EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

LINE 1: SHARE OF COST 300.00 - NCS 27.70 = PT LIAB 272.30

LINE 2: SHARE OF COST 200.00 - NCS 47.00 = PT LIAB 153.00

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

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x *M. Jones*

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM

25-10Z 09/07

Figure 1. Non-Covered Services in Explanations Area of Claim.

**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
Services (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)		Month of Eligibility	Share of Cost (SOC)							
①	②	③								
AID	7 DIGIT SERIAL NO	MO.	YR.							
FBU	PERS									
BENEFICIARY NAME ④		LONG TERM CARE (LTC) FACILITY NAME (You may use stamp.)								
SOCIAL SECURITY NUMBER ⑤		ADDRESS ⑦								
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	⑨	⑩	⑪	⑫						
PROVIDER NAME	PHYSICIAN NAME	DATE OF SERVICE	SERVICE DESCRIPTION	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		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100px;">TOTAL SOC</td> <td style="text-align: right;">\$ ⑬</td> </tr> <tr> <td>TOTAL NON-COVERED SERVICES</td> <td style="text-align: right;">\$ - ⑭</td> </tr> <tr> <td>TOTAL SOC DEDUCTED FROM LTC CLAIM</td> <td style="text-align: right;">\$ ⑮</td> </tr> </table>			TOTAL SOC	\$ ⑬	TOTAL NON-COVERED SERVICES	\$ - ⑭	TOTAL SOC DEDUCTED FROM LTC CLAIM	\$ ⑮
TOTAL SOC	\$ ⑬									
TOTAL NON-COVERED SERVICES	\$ - ⑭									
TOTAL SOC DEDUCTED FROM LTC CLAIM	\$ ⑮									
X Signature of beneficiary / family member / other (Indicate your relation to the beneficiary)										
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.

<u>Item</u>	<u>Description</u>
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.

<u>Item</u>	<u>Description</u>
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 <i>Share of Cost</i> 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.