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

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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 <u>Johnson</u> v. <u>Rank</u> 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 <u>either</u> 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.

9	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT	
a	23	25000						
b								
С					÷			
d								

**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.

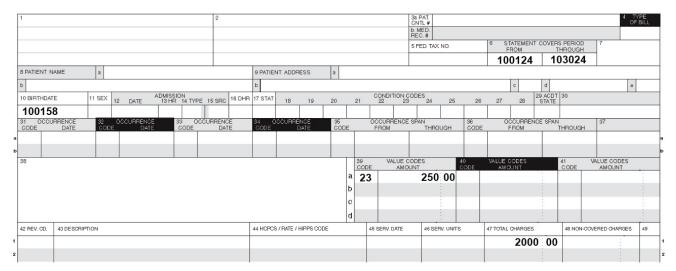
Billing for LTC Resident: Aid Code 13 Case Scenario

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

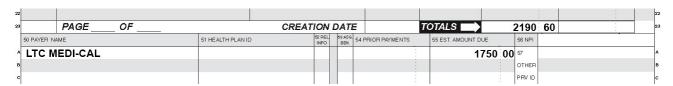
The facility collects SOC on the first day of the month, and the recipient pays her entire \$250 SOC. The LTC facility bills Medi-Cal for 30 days of service and submits a claim showing that the patient liability of \$250 has been met.

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.



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



**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).



**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				
ECORD OF NON-COVERED	SERVICES							
edi-Cal Identification Number	(Taken from the Medi-Cal Card)				Month of Eligit			
					_(2)	(soc) (3)		
AID 7 DIGIT SE	ERIAL NO FBU	PERS			MO.	YR.		
BENEFICIARY NAME 4		LONG T	ERM CARE (	LTC) FACILIT	Y NAME (You may use	stamp.)		
(	<u> </u>					7		
SOCIAL SECURITY NUMBER	(5)	ADDRE	SS					
DATE OF BIRTH 6		CITY			STATE	ZIP		
amount paid for the service(s) recei	When completing this section, please in ived. The amount paid for non-covered istent with the plan of care authorized l	services must be t	otaled each mo	onth and entered	d in the "Total Non-Covere	d Services" box below. All		
8 PROVIDER NAME	9 PHYSICIAN NAME (1	DATE OF S	ervice (1	1) SERVICE	EDESCRIPTION (12)	AMOUNT PAID FOR NON-COVERED SERVICES		
Sacramento Acute	Du Vilan							
Care Clinic Sacramento Acute	Dr. Xylar							
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 H	alth Service	a staff for po	st-audit review.			
I hereby certify that the above listed non-o	overed services have been received							
Χ					. 🙃			
Bignature of beneficiary / family member /	other (Indicate your relation to the beneficiary)		TOTAL 800		(13)			
			SERVICES	4-COVERED	s - (14)			
				DEDUCTED	1(1)			
If beneficiary signature cannot be o	btained, please indicate reason in this	space	FROM LTC	CLAIN	s (15)			
LTC Facility Use Only								
	that the above listed non-covered							
services have been paid.								
Signature of Nursing Home Repres	emendiwe							
	<del>-</del>							

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	<b>Provider Name</b> . Enter the name of company or provider billing for the				
	service.				
9	<b>Physician Name</b> . Enter the physician name prescribing items or providing				
10	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	<b>Total Share of Cost</b> . 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.				

## **Legend**

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

Symbol	Description
<b>((</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.