CRISS Guide to CCS Aid Codes

Aid Codes	9K	9M	9N	9R	9U
CCS Program Tx Eligibility	• Signed PSA required (see note below) • For MC, HF, and CCS-only clients with Med / Res / Fin elig	• PSA not required • Signed Tx consent • No Fin required • Med / Res elig	• Unsigned PSA • Full Scope MC with no SOC • Med / Res elig	• PSA not required because client is only elig with HF coverage • HF with income over $40,000 • Med / Res elig	• Unsigned PSA • HF coverage • Med elig • Can be assigned before Res elig is actually demonstrated
Per Harvey Fry: The CCS Legal Agreement provided for in Section 42110 of Title 22 CCR (generically referred to as the CCS PSA) is a procedural requirement intended to protect the CCS family from arbitrary actions by the CCS program. Neither Section 42110 nor any other provision of law provides authority to deny CCS services to and otherwise eligible child absent a Legal Agreement executed by the CCS family.					
CCS Program Dx Eligibility (NL 07-0401)	• Signed application only • Fin / Med elig not required • CCS-only clients with Res eligibility	N/A	Per Harvey Fry: Diagnostic services are a benefit of the CCS program for all children, including those assigned aid codes 9N, 9R, and 9U, pursuant to Section 123840 of the Health and Safety Code and Section 42130 of Title 22 CCR. Certain exceptions for children enrolled in Medi-Cal managed care plans are provided for in Medi-Cal Managed Care (MMCD) Letter 96-10.		
SOC	Client may have SOC MC	N/A	No SOC	Client may have SOC MC too, in some cases.	Client may have SOC MC too, in some cases.
Program Description	• CCS benefits: DX, TX, and/or vendored therapy • MTP services if medically eligible for MTP • Dental / Ortho (see page 2 - 3)	Medical Therapy Program (MTP) only	Same as 9K	Same as 9K	Same as 9K
MEDS Message	CCS Prior Auth required for CCS services	N/A	CCS Prior Auth required for CCS services	CCS Prior Auth required for CCS services (“Prior” auth not required if client has a MEDS OC code)	CCS Prior Auth required for CCS services (“Prior” auth not required if client has a MEDS OC code)

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Related Policies / Procedures		MTP clients with full scope MC can be opened as 9N. This helps with DME SARs.	Claims will not be paid if client drops MC coverage. If case is closed client is entitled to due process including the right to appeal the decision to close the case.	Claims will not be paid if client drops HF coverage. Case should be closed if HF coverage is dropped. (NL 12-1006)	Claims will not be paid if client drops HF coverage. If case is closed client is entitled to due process including the right to appeal the decision to close the case.
Who pays? F = Federal S = State C = County	CCS only clients: S 50%, C 50% MC clients: S 100% HF clients: F 65%, S, 17.5%, C 17.5%	S 50% and C 50% except for CCS therapist's participation with the LEA in the development of a client's IEP which is S 100%	MC clients: S 100%	HF clients: F 65%, S 35%	HF clients: F 65%, S, 17.5%, C 17.5%
Common SAR Special Instructions	COHS #1 re: Partnership & EDS HF/MC/OHC #4 re: OHC If applicable: HF/MC/OHC #3 re: infant covered under mother's MC	Therapy in lieu of MTU	HF/MC/OHC #2 Same as 9K too	HF/MC/OHC #1 Same as 9K	HF/MC/OHC #1 Same as 9K too

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Dental Only for dental services that are medically necessary to treat the client's CCS condition	For CCS only clients, dental is covered by Denti-Cal with a SAR For CCS-HF clients, dental is covered by Denti-Cal with a SAR For CCS-MC clients, dental is covered by Denti-Cal, no SAR required	N/A	For CCS-MC clients, dental is covered by Denti-Cal, no SAR required	Dental services that are medically necessary to treat the client's CCS condition are covered by Denti-Cal	Dental services that are medically necessary to treat the client's CCS condition are covered by Denti-Cal
Orthodontics After F&R: open case to Tx. (N.L. 06-1004) Med elig determined by Denti-Cal	Ortho for CCS only clients covered by Denti-Cal with a SAR Ortho for HF clients covered by Denti-Cal with a SAR Ortho for MC clients covered by Denti-Cal, no SAR required	N/A	Ortho for MC clients covered by Denti-Cal, no SAR required	Ortho for HF clients covered by Denti-Cal with a SAR	Ortho for HF clients covered by Denti-Cal,with a SAR

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Newborn Hearing Screening Program (NHSP)	Send copy of SAR to the Hearing Coordination Center Attn: Beth Lannon, Ed.D 925-947-4318 fax Per N.L.: 06-1008 CCS shall issue an authorization to a CCS-approved Type C CDC to perform a diagnostic evaluation on ALL infants referred through the NHSP who meet the referral criteria. Auths shall be issued: Within five working days of receipt of referral. Without regard to the patient's insurance coverage or the family's income. Without waiting for a denial of coverage from patient's Health Maintenance Organization (HMO) or other third-party payer. Without regard to other CCS-eligible conditions. Issuance of this authorization for diagnostic services requires only the receipt of a Request for Services Form or SAR, a signed application or proof of Medi-Cal or Healthy Families coverage, and a copy of the screening results. There is no need to complete a financial and residential eligibility determination. Authorization for a diagnostic hearing evaluation for NHSP infants with other CCS-eligible conditions shall not be delayed while completing determination of program and medical eligibility associated with other CCS-eligible condition. Authorization for a diagnostic hearing evaluation for NHSP infants shall not be denied on the basis of previously verified HMO or private insurance coverage for other CCS-eligible conditions. The $20 assessment fee is waived for these services. An authorization for a diagnostic hearing evaluation shall be issued to a CCS-approved Type C CDC and shall be for 90 days. The authorization shall cover all diagnostic testing and evaluation procedures contained in the Service Code Group (SCG) 04.				

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Retro authorizations	Retro SAR is okay for client with MC. Retro auth should be denied for CCS-only and CCS- HF clients. Per Harvey: Authority for retroactive authorization of services is provided for Access for Infants and Mothers (AIM) linked CCS/Healthy Family Children (Aid Code 0C) pursuant to Section 123929 of the Health and Safety Code. <u>Emergency MC:</u> (Per D. Jimenez) Section 14133.05 of the Welfare and Institutions Code specifically states "a request for treatment authorization", which I interpret to mean for any eligible Medi-Cal beneficiary, "received by the department shall be reviewed for medical necessity only. The law makes no distinction between emergency/limited scope MC and full MCal eligibility. (Per Sharon Lambton) If the child had Emergency Only Medi-Cal on the date of service and went to the ED with a bonafide Emergency, then yes, those services could be considered "as if the child had fs MC, no SOC" for that service on that date. Emergency related SARs for CCS-HF and CCS-only clients should be requested that day or the next business day.				
Referral Date / Eligibility Start Date ESD = Elig Start Date	CCS MC: ESD can go back six months from referral date CCS HF: (same as 9R and 9U) CCS-only: ESD can go back two business days from referral date	Referral date	ESD can go back six months from referral date	Per HF/CCS MOU- providers are to refer a subscriber to the CCS program within two days of a suspicion of the presence of a /CCS eligible condition. (see note below)	
	Per Harvey Fry: The ESD for a HF subscriber is the referral date. The HF plan is responsible for the HF subscribers care prior to the referral to CCS. In the event of an accident, if the referral is received within time frame for referrals established by CCS regulations, the date of the accident should be considered the referral date. Of course you should be reasonable in the evaluation of any extenuating circumstances that may have resulted in the referral being untimely.				