Share of Cost (SOC)

Introduction

Purpose

The purpose of this module is to define recipient Share of Cost (SOC), to familiarize participants with the process, to discuss the *Share of Cost Case Summary* form and to explain SOC certification.

Module Objectives

- Define the SOC process (SOC is sometimes referred to as “spend down”)
- Explain how aid codes and/or specific services may relate to SOC
- Identify how Medi-Cal claims will reflect SOC clearance information
- Present the *Share of Cost Case Summary* form

Acronyms

A list of current acronyms is in the *Appendix* section of each complete workbook.

Share of Cost Description

Some Medi-Cal recipients must pay or agree to be obligated 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) also known as Spend Down.

Example: A Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible.

Share of Cost Spend Down Transactions

SOC Verification

If a recipient has paid or obligated a SOC, it must be cleared via the Point of Service (POS) network. Providers can do this by logging into Transaction Services.

B Share of Cost (SOC)

Page updated: November 2022

Providers have the option of applying or reversing an SOC by indicating which transaction they want to complete. The provider can only reverse an SOC if the total SOC has not been cleared.

Go to the Medi-Cal Provider website (www.medi-cal.ca.gov).

1. From the Providers drop-down menu, select **Transaction Services.**

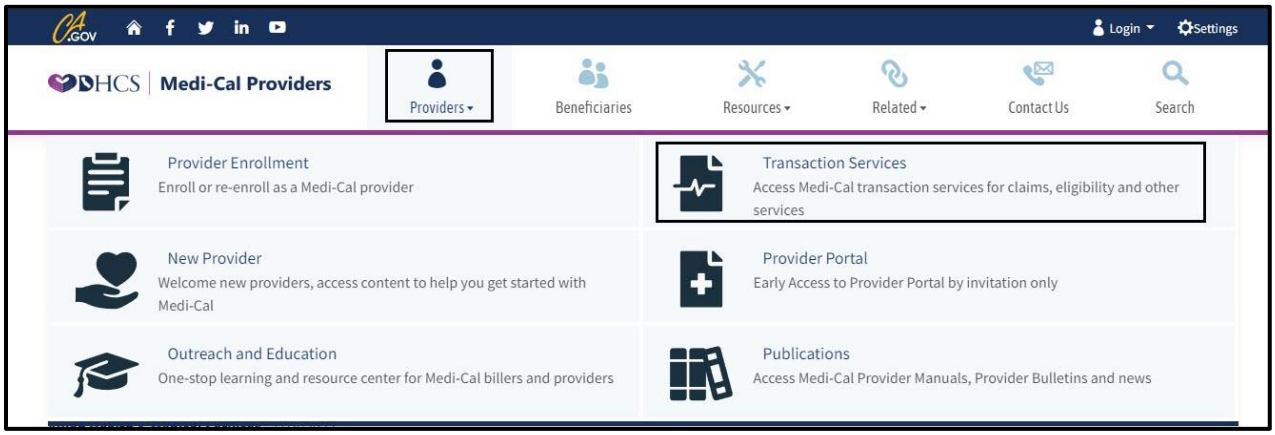


Figure 1.1: Transaction Services is located under the Providers drop-down menu.

2. To login to Transaction Services enter your User ID and Password then select **Login**.

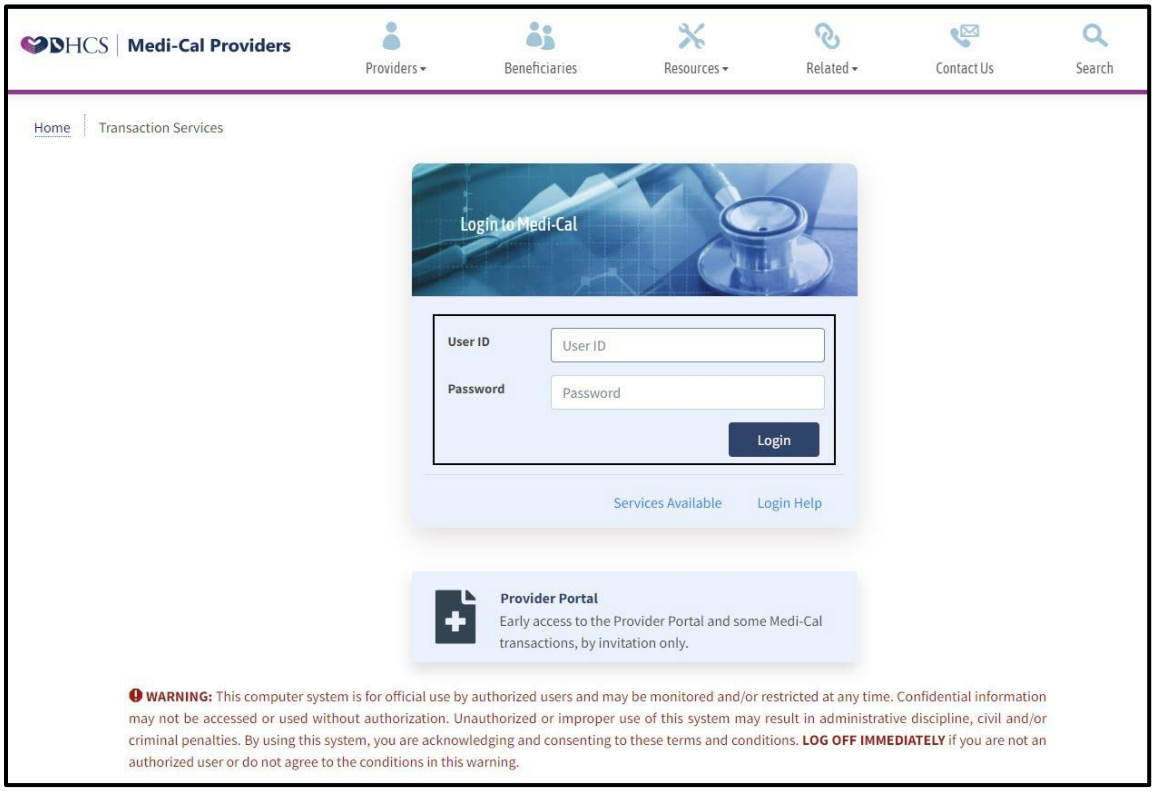


Figure 1.2: Transaction Services Login screen.

3. Under the Eligibility section, select **Share of Cost (SOC)/Spend Down Clearance**.

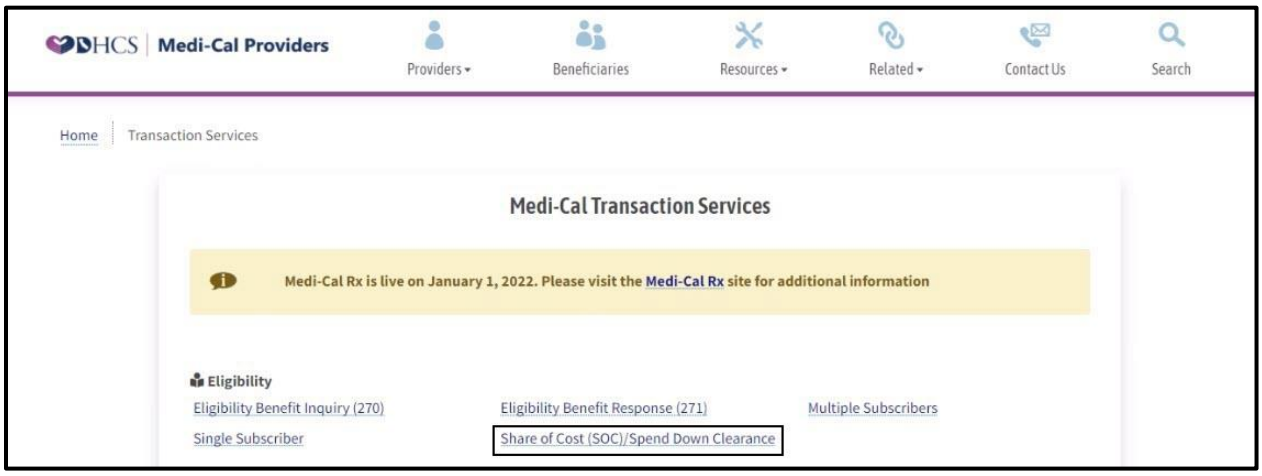


Figure 1.3: Share of Cost (SOC)/Spend Down Clearance selection.

4. Fill out the **SOC/Spend Down Clearance** form then select **Submit**.

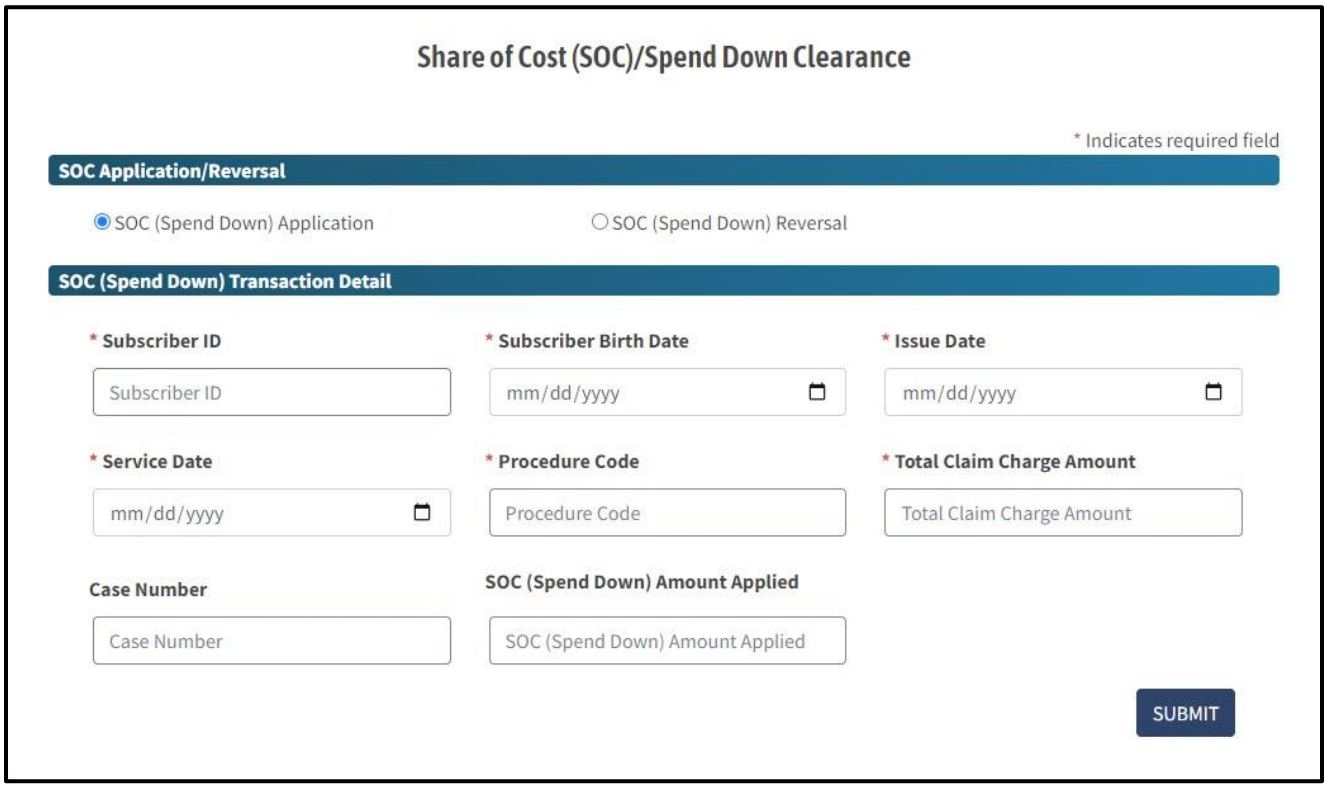
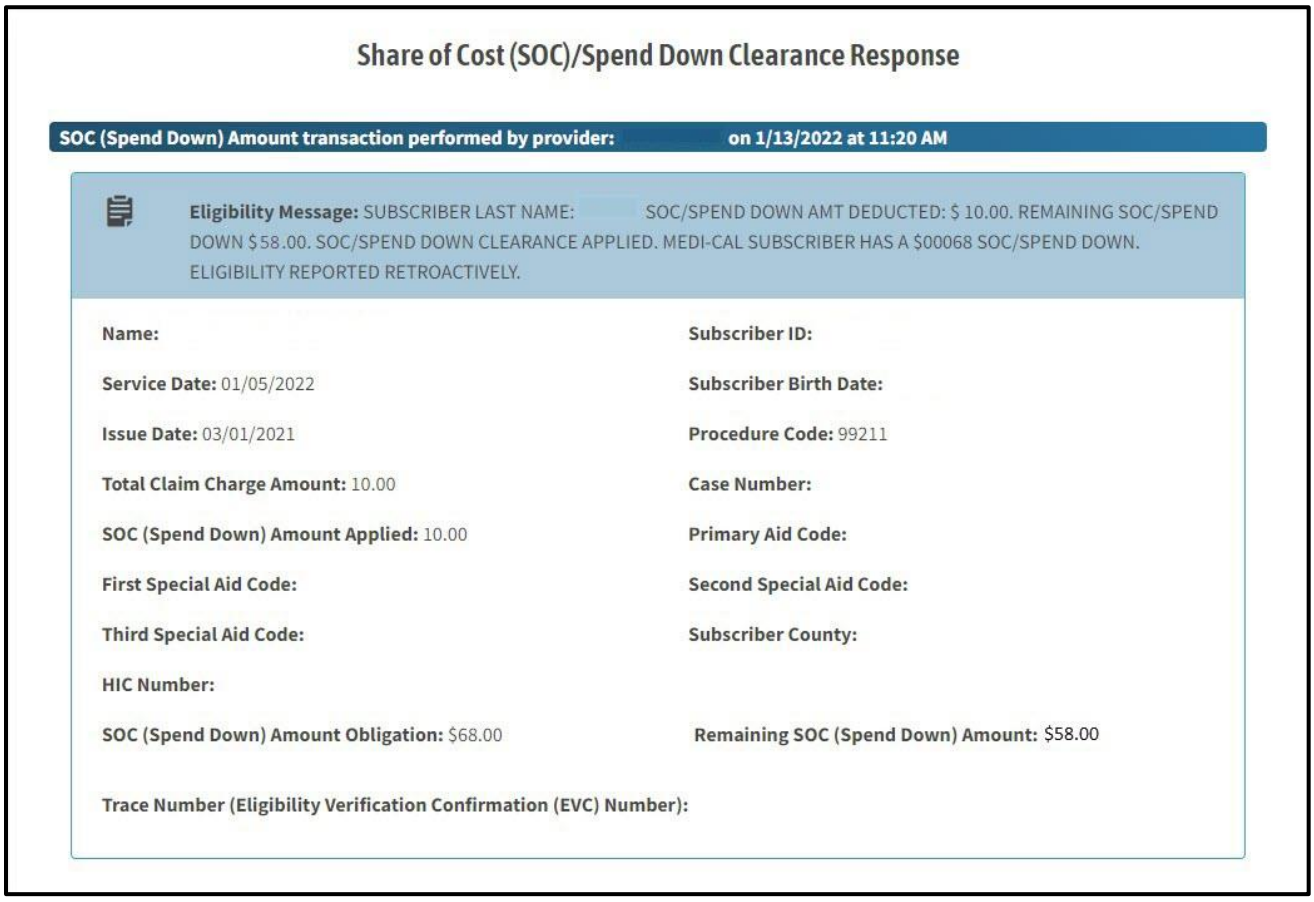


Figure 1.4: SOC/Spend Down Clearance Transaction Detail fields.

The following SOC/Spend Down Response indicates the subscriber has a SOC/spend down amount obligation amount of $68 on service date March 1, 2021. The spend down amount applied was $10 leaving a remaining SOC balance amount $58.



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 $ 58.00. SOC/SPEND DOWN CLEARANCE APPLIED. MEDI-CAL SUBSCRIBER HAS A $00068 SOC/SPEND DOWN. ELIGIBILITY REPORTED RETROACTIVELY.

Name:
Subscriber ID:
Service Date: 01/05/2022
Subscriber Birth Date:
Issue Date: 03/01/2021
Procedure Code: 99211
Total Claim Charge Amount: 10.00
Case Number:
SOC (Spend Down) Amount Applied: 10.00
Primary Aid Code:
First Special Aid Code:
Second Special Aid Code:
Third Special Aid Code:
Subscriber County:
HIC Number:
SOC (Spend Down) Amount Obligation: $68.00
Remaining SOC (Spend Down) Amount: $58.00
Trace Number (Eligibility Verification Confirmation (EVC) Number):

Figure 1.5: SOC Response message example.

Knowledge Review 1

1. What is the recipient's SOC for the month of service?_____
2. What is the recipient's remaining SOC as of the date of service?_____

See the Appendix for the Answer Key.

Notes:

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SOC Certification

Recipients are not eligible to receive Medi-Cal benefits until their monthly SOC dollar amount has been certified.

SOC certification means that the Medi-Cal eligibility verification system shows the recipient has paid, or is obligated to pay, for the entire monthly dollar SOC amount.

Once SOC has been certified, an Eligibility Verification Confirmation (EVC) trace number is displayed in the message returned by the Medi-Cal eligibility verification system. Return of an EVC number does not guarantee that a recipient qualifies for full-scope Medi-Cal or County Medical Services Program (CMSP) benefits.

Note: Providers should carefully read the eligibility message to determine what Medi-Cal service limitations, if any, apply to the recipient.

Obligation Payments

An obligated payment means the provider allows the recipient to pay for the services at a later date or through an installment plan. Obligated payments may be used to clear a SOC.

SOC obligation agreements are between the recipient and the provider and should be in writing, signed by both parties for protection.

Clearance Transactions

Providers should perform a SOC clearance transaction immediately upon receiving payment or accepting obligation from the recipient for the service rendered. Delays in performing the SOC clearance transaction may prevent the recipient from receiving other medically needed services.

To reverse SOC transactions, providers must enter the same information 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 complete. Once the SOC has been cleared, providers can no longer conduct a reversal.

Notes:

Knowledge Review 2

1. Generally, a recipient's SOC is determined by the county Department of Social Services (or welfare) and is based on the amount of income a recipient receives each month in excess of "maintenance need" levels before Medi-Cal begins to pay.

   True ☐ False ☐

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

   True ☐ False ☐

3. When a recipient is unable to pay the SOC at the time of service, providers are required to allow the recipient to "obligate" the SOC amount for the future.

   True ☐ False ☐

4. Provider claims may be reimbursed by Medi-Cal, excluding the SOC amount that was obligated but not paid by the recipient, if the spend down has been cleared in the system.

   True ☐ False ☐

5. Once a recipient has been certified as having met the SOC, reversal transactions can no longer be performed.

   True ☐ False ☐

See the Appendix for the Answer Key.

Notes:

Scope of Coverage

Program-Specific Coverage

Long Term Care

Providers who receive an eligibility verification message that indicates a recipient has a Long Term Care (LTC) SOC should not clear the SOC online. LTC SOC is cleared solely by the facility in which the recipient resides. Recipients with aid codes 13, 23, 53 and 63 must have their LTC SOC cleared on the *Payment Request for Long Term Care* (25-1) claim form.

Providers who are submitting 837I (institutional) transactions in the 5010 format should use the HI value information segment in loop 2300 of the 005010X223A2 with a qualifier of BE and value code of FC to report SOC information. Many providers are reporting that the SOC is not being deducted from 837I claims, and this is due to the way the information is being submitted. Please refer to the CMC Billing and Technical Manual for more information regarding submitting electronic claims.

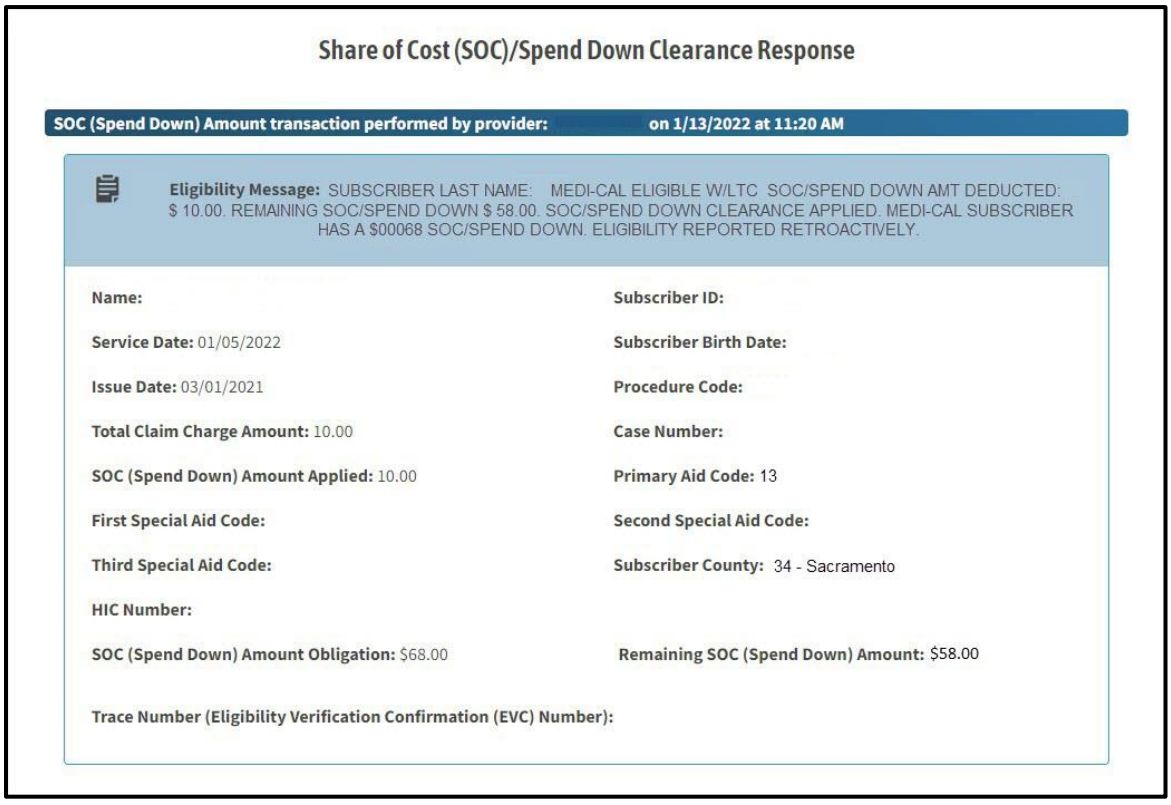

Figure 2.1: Share of Cost (SOC)/Spend Down Clearance Response page example with Eligibility Message.

SOC is certified differently for LTC recipients with specific aid codes. To avoid duplicate billing, hospice providers must indicate the SOC on the *UB-04* claim form when billing for hospice room and board (revenue code 0658), if the SOC was not already met on a *Payment Request for Long Term Care* (25-1) claim.

Obstetric Services

When the provider bills on a global basis for obstetric services, arrangements must also be made to collect or obligate the SOC for the initial antepartum visit (HCPCS code Z1032) and for non-global obstetric services (for example, sonogram or amniocentesis). When the intent to bill globally is prevented because the recipient moves or leaves care, providers bill on a fee-for-service basis and collect the SOC for each month of service.

Comprehensive Perinatal Services

Recipients who choose to participate in the Comprehensive Perinatal Services Program (CPSP) are required to pay or obligate their SOC each month even if the obstetrical services are billed globally.

Multiple Program Coverage

Multiple Plan Identification Factors (Aid Codes)

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

Once the SOC is certified for the month, the recipient is eligible for full-scope Medi-Cal benefits.

Note: The full-scope aid code will not be displayed until the SOC has been certified.

Example: Partial Eligibility message for recipient with multiple eligibility

SUBSCRIBER LAST NAME: DIAZ, CNTY CODE: 34, PRIMARY AID CODE: 48, MEDI-CAL ELIGIBLE FOR PREGNANCY/POSTPARTUM RELATED MEDICAL SVCS W/NO SOC.FOR ALL OTHER MEDI-CAL SVCS, RECIPT. HAS SOC OF $50.00. REMAINING SOC $ 50.00

County Medical Services

SOC is calculated independently for CMSP and Medi-Cal; however, the same recipient income is included in both calculations.

Providers may apply the same services used to clear a Medi-Cal SOC obligation to clear a CMSP SOC obligation, however two separate transactions are required.

Medicare/Medi-Cal Crossover Claims

Some recipients who are entitled to Medicare also have Medi-Cal with a SOC. In these cases, the recipient's liability is limited to the amount of the Medicare deductible and co-insurance.

The collection of Medi-Cal SOC after the Medicare payment will help prevent collecting amounts greater than the Medicare deductible and co-insurance.

Knowledge Review 3

1. When will a provider collect or obligate the SOC for each month in which services were provided? _____
2. The same medical expenses may be used to clear SOC for both CMSP and Medi-Cal.

   True ☐ False ☐
3. Clearing SOC for one program does not automatically clear SOC for the other program.

   True ☐ False ☐
4. When the recipient is eligible for both Medicare and Medi-Cal, providers should collect the Medi-Cal SOC at the time of service.

   True ☐ False ☐

See the Appendix for the Answer Key.

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Multiple Case Numbers

Eligibility messages may include multiple case numbers. When there are two or more case numbers in an eligibility verification message, they are listed in numerical order.

Share of Cost Case Summary Form

Recipients who have multiple case numbers will receive the *Share of Cost Case Summary* form on a monthly basis.

- Providers must refer to the *Share of Cost Case Summary* form to determine which case numbers correspond to which recipient.
- Recipients who are in more than one SOC case will receive a *Share of Cost Case Summary* form that lists all the cases for which the recipient may clear a SOC.

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

Notes:

Knowledge Review 4

1. The first case number listed on an eligibility response will correspond with the recipient for whom eligibility is being verified.

   True ☐ False ☐

2. In the *SOC Case Summary* form example found on the following page, can Sally apply her $100 Medical expenses to her child's SOC?

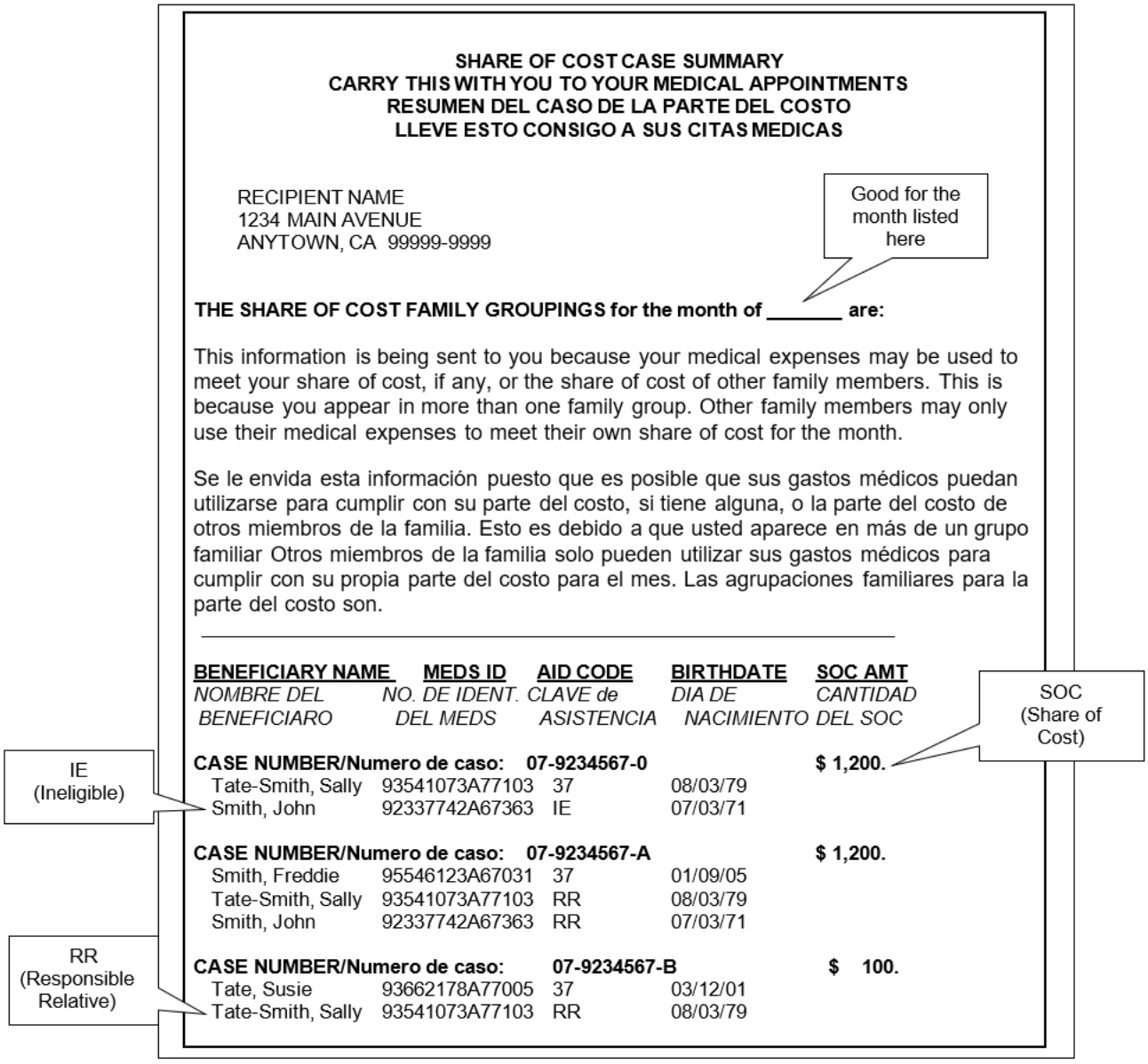
   Yes ☐ No ☐

3. In the family SOC example on the following page, can the mother apply a portion of the $100 to her own SOC and the balance to her child's SOC?

   Yes ☐ No ☐

See the Appendix for the Answer Key.

Notes:



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

RECIPIENT NAME
1234 MAIN AVENUE
ANYTOWN, CA 99999-9999

Good for the month listed here

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 envida esta información puesto que es posible que sus gastos médicos 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 más de un grupo familiar Otros miembros de la familia solo pueden utilizar sus gastos médicos para cumplir con su propia parte del costo para el mes. Las agrupaciones familiares para la parte del costo son.

BENEFICIARY NAME *NOMBRE DEL BENEFICIARO*	**MEDS ID** *NO. DE IDENT. DEL MEDS*	**AID CODE** *CLAVE de ASISTENCIA*	**BIRTHDATE** *DIA DE NACIMIENTO*	**SOC AMT** *CANTIDAD DEL SOC*
CASE NUMBER/Numero de caso: 07-9234567-0				**$ 1,200.**
Tate-Smith, Sally	93541073A77103	37	08/03/79	
Smith, John	92337742A67363	IE	07/03/71	
CASE NUMBER/Numero de caso: 07-9234567-A				**$ 1,200.**
Smith, Freddie	95546123A67031	37	01/09/05	
Tate-Smith, Sally	93541073A77103	RR	08/03/79	
Smith, John	92337742A67363	RR	07/03/71	
CASE NUMBER/Numero de caso: 07-9234567-B				**$ 100.**
Tate, Susie	93662178A77005	37	03/12/01	
Tate-Smith, Sally	93541073A77103	RR	08/03/79	

SOC (Share of Cost)

IE (Ineligible)

RR (Responsible Relative)

The reverse side of the *Share of Cost Case Summary* form contains additional information regarding family SOC.

Example:

The Smith family consists of a stepfather (husband John Smith), a mother (wife Sally Tate-Smith), a son (Freddie Smith) from the husband and wife, and the mother's separate child (Susie Tate) from a previous marriage. The husband is listed on the first case as "IE" (Ineligible Recipient) with the wife having an SOC of $1200.00. The mother and father are listed as "RR" (Responsible Relative) with their child Freddie Smith in the second case with a $1200.00 SOC. The mother is also on her daughter's case listed as an RR.

Billing Information

Unpaid Medical Expenses

General Policy

According to Hunt v. Kizer, the Department of Health Care Services (DHCS) no longer imposes time limits on unpaid medical expenses that Medi-Cal recipients may use to meet their SOC.

Note: Although the County Medical Services Program (CMSP) was not a party to this lawsuit, the CMSP also has adopted the court-ordered SOC changes to simplify the administration of unpaid expenses.

Long Term Care Policy

According to Johnson v. Rank, current unpaid medical bills are still applied against current SOC at the nursing home for LTC recipients. Therefore, nursing homes should continue their current procedure of deducting from SOC the bills and receipts submitted within the last two months of the current month.

Claim Form Completion

This section of the workbook module explains how to complete claims for services rendered to recipients who paid a Share of Cost (SOC). The following forms will be discussed:

- *CMS-1500* claim form
- *Payment Request for Long Term Care* (25-1) claim form
- *UB-04* claim form

Refer to the correct section to locate specific information regarding form completion.

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CMS-1500 Claim Form

The following information provides guidelines for entering SOC quantities on the *CMS-1500* claim form.

Form Fields

SOC amounts are entered in these fields:

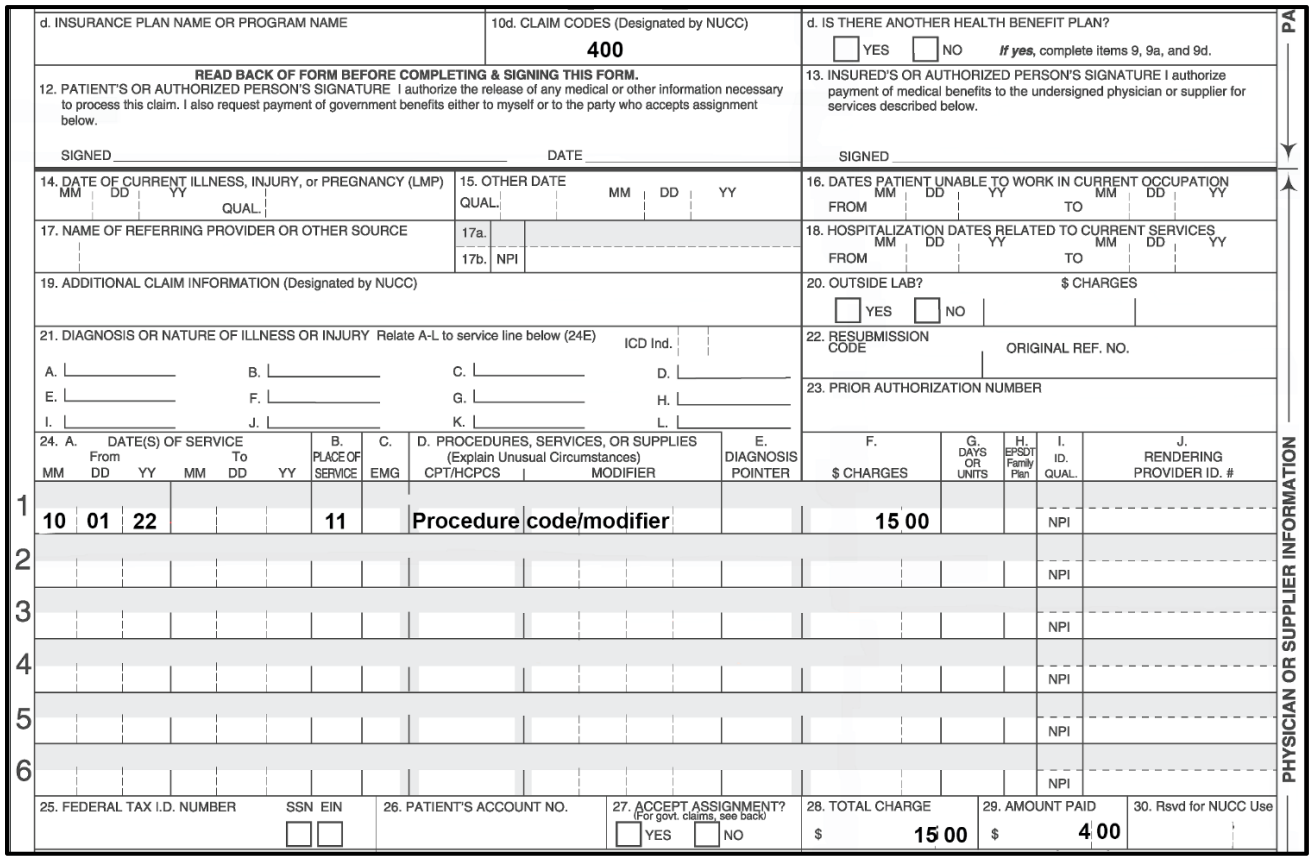
- *Claim Codes* (Box 10d)
- *Amount Paid* (Box 29)

Instructions

Enter full dollar and cents amount, even if the amount is even. Do not enter decimal points (.) or dollar signs ($).

In the example below, $4.00 is entered as 400.

Partial Example: SOC amount in *Claim Codes* field (Box 10d) and *Amount Paid* field (Box 29).



Payment Request for LTC (25-1) Claim Form

The following information provides guidelines for entering SOC quantities on the *Payment Request for LTC* (25-1) form.

Form Fields

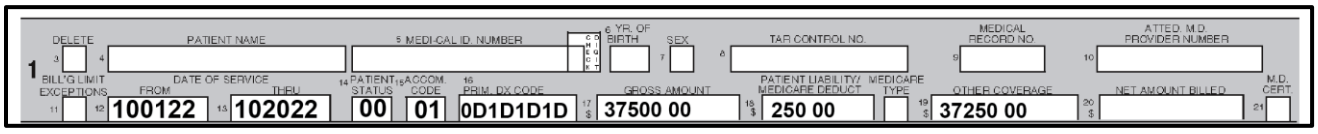
SOC amounts are entered in these fields: Boxes 18, 37, 56, 75, 94 or 113 (*Patient Liability/Medicare Deduct* field)

Instructions

If the SOC for a straight Medi-Cal claim is zero, enter 000 in this field. Do not leave it blank.

SOC is entered in Patient Liability/Medicare Deduct field (Box 18). Do not enter decimals for charges.

Partial Example: SOC amount in *Patient Liability/Medicare Deduct* field (Box 18).



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UB-04 Claim Form

The following information provides guidelines for entering SOC quantities on the *UB-04* claim form.

Form Fields

SOC amounts are entered in these fields:

- *Value Codes Amount* (Boxes 39-41)

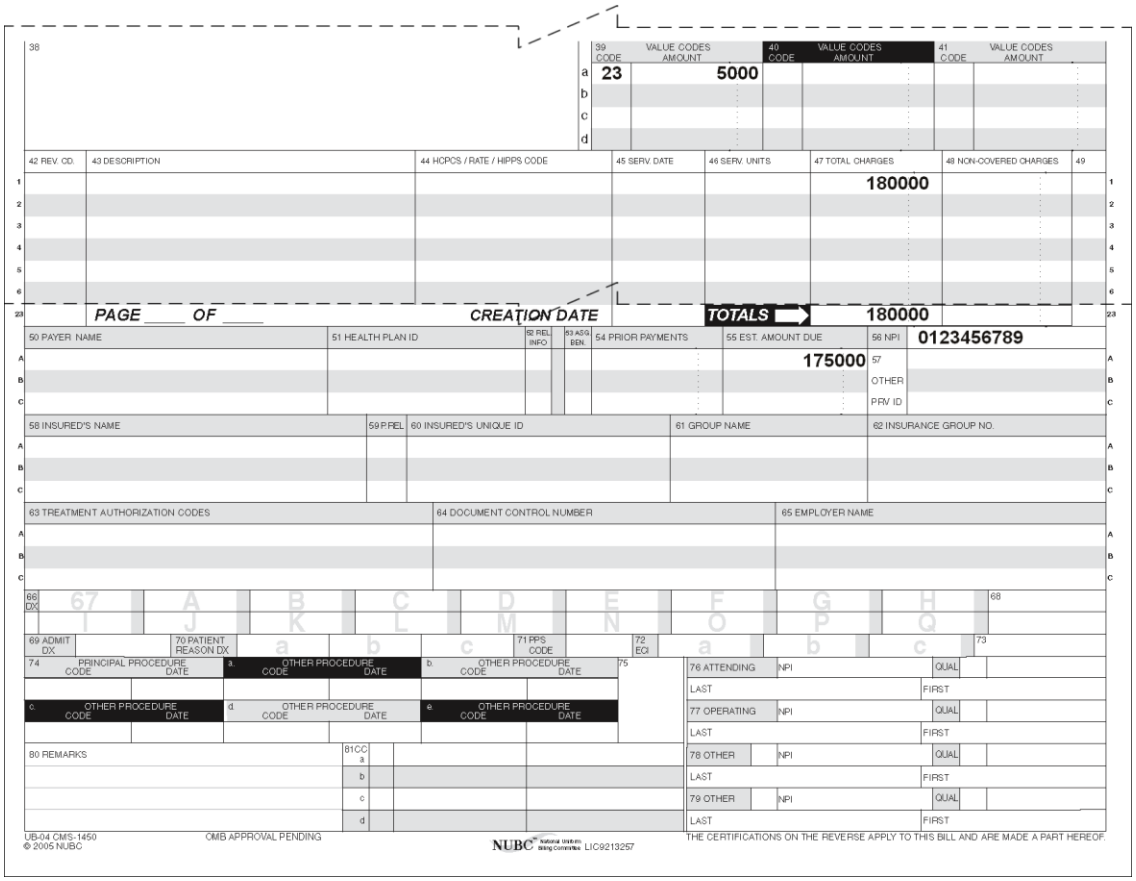
  Note: Value code “23” in the *Code* column field designates that the corresponding “amount” column contains the SOC.

Instructions

- Enter the full dollar and cents amounts, including zeros. Do not enter decimal points (.) or dollar signs ($).
- Use only one claim line for each service billed.

  Note: *Est. Amount Due* (Box 55) is the difference of *Total Charges* ($1800.00) less SOC ($50.00), which equals $1750.00.

  Partial Example: The $50.00 SOC amount is entered as 5000.



Learning Activities

Activity 1: Multiple Services on Different Dates

Case Scenario

A recipient with an abscess on her finger goes to the doctor's office. The doctor examines the finger and sends the recipient home with some initial treatment instructions. The abscess does not clear up and she returns to the doctor, who makes an appointment to drain the abscess the following day. The recipient has a $40.00 SOC.

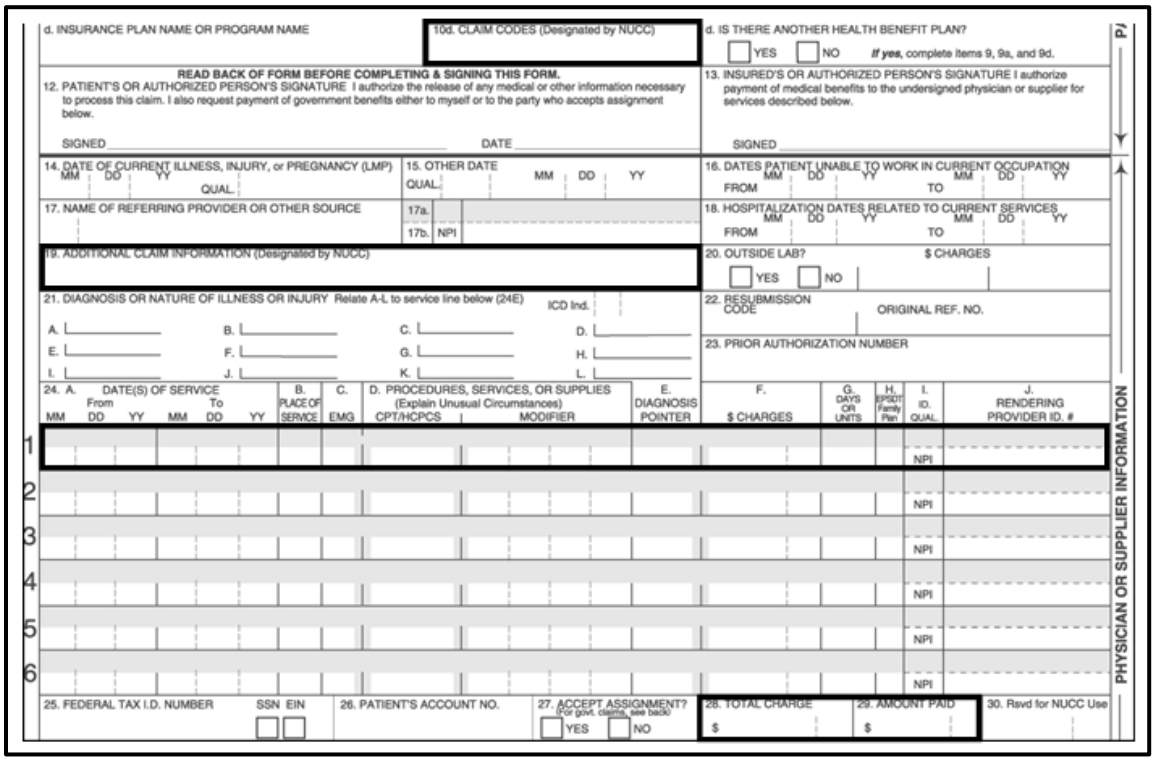
Dates	Service	Amount	SOC Cleared
06/01/22	Office Visit	$20.00	$20.00
06/14/22	Office Visit	$15.00	$15.00
06/15/22	Drainage	$20.00	$5.00
None	Total of Services	$55.00	$40.00

Knowledge Review 5

What information will be submitted in this claim form? How will the collected SOC be entered on the claim form?

See the Appendix for the Answer Key.

Partial *CMS-1500* claim form



Activity 2: Multiple Services on Same Date

Case Scenario

A recipient requires speech therapy services and receives two speech therapy services on the same day. Recipient has an $85.00 SOC.

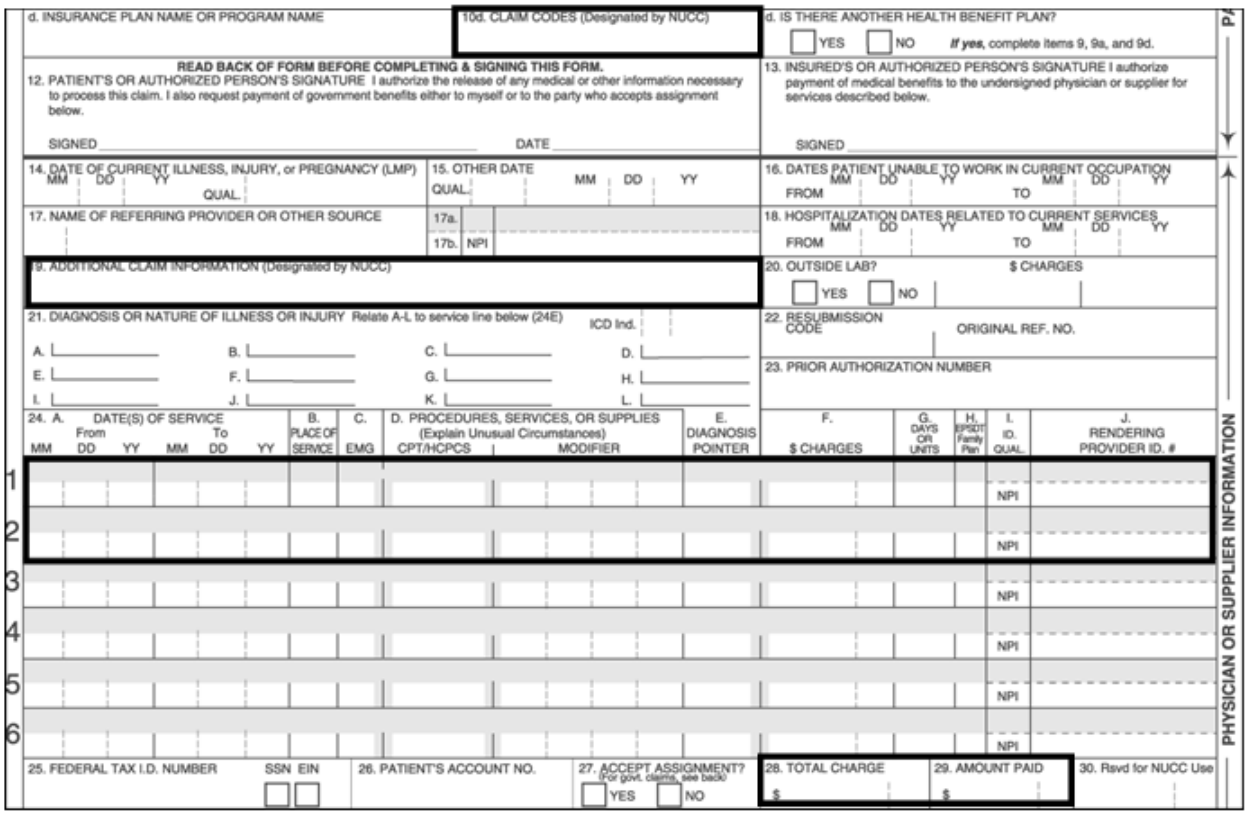
Dates	Service	Amount	SOC Cleared
06/02/22	Speech Evaluation (X4301)	$75.00	$75.00
06/02/22	Speech Therapy (X4303)	$50.00	$10.00
None	Total of Services	$125.00	$85.00

Knowledge Review 6

What information will be submitted on this claim form? How will the collected SOC be entered on the claim form?

See the Appendix for the Answer Key.

Partial *CMS-1500* claim form



Activity 3: Inpatient Claim with SOC

Case Scenario

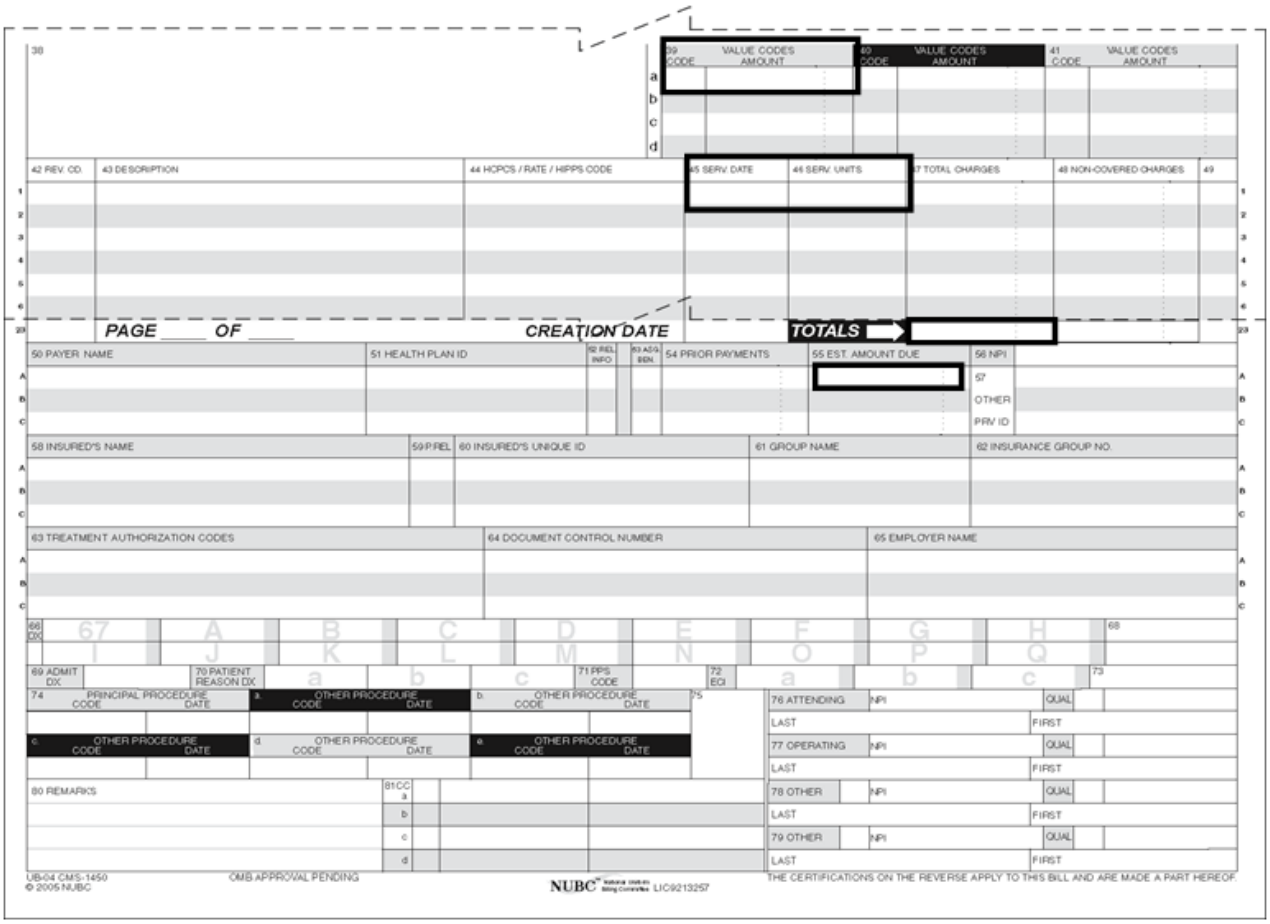
A recipient has a $100.00 SOC. She paid $50.00 to provider “A”, who performed a SOC spend down transaction for $50.00. The remaining $50.00 is paid or obligated to the hospital staff (provider “B”), which performs a second SOC clearance transaction. The recipient’s SOC is now fully certified. The total cost of services rendered for the inpatient claim is $3,430.50.

Knowledge Review 7

What information will be submitted on this claim form? How will the collected SOC be entered on the claim form?

See the Appendix for the Answer Key.

Partial *UB-04* claim form



Note: For record keeping purposes only and to help reconcile payment on the *Remittance Advice Details* (RAD) form, providers may show in the *Remarks* field (Box 80) the SOC amount that the recipient paid or is obligated to pay.

Activity 4: Multiple Services Rendered on Same Date of Service Outpatient Claim with SOC

Case Scenario

Two services are rendered to a recipient on the same date. In this case, the recipient visits the emergency room twice to see a doctor about recurring chest pains. The outpatient clinic bills for the room use, as well as the blood tests and handling. The recipient has a $60.00 SOC.

Dates	Service	Amount	SOC Cleared
06/18/22	E.R. room use (Z7502)	$50.00	$60.00
06/18/22	Panel Tests (80061)	$30.00	$0.00
06/18/22	Amino Acid Nitrogen (82127)	$15.00	$0.00
06/18/22	Collection and Handling (99000)	$5.00	$0.00
06/18/22	E.R. room use (Z7502)	$24.50	$0.00
None	Total of Services	$124.50	$60.00

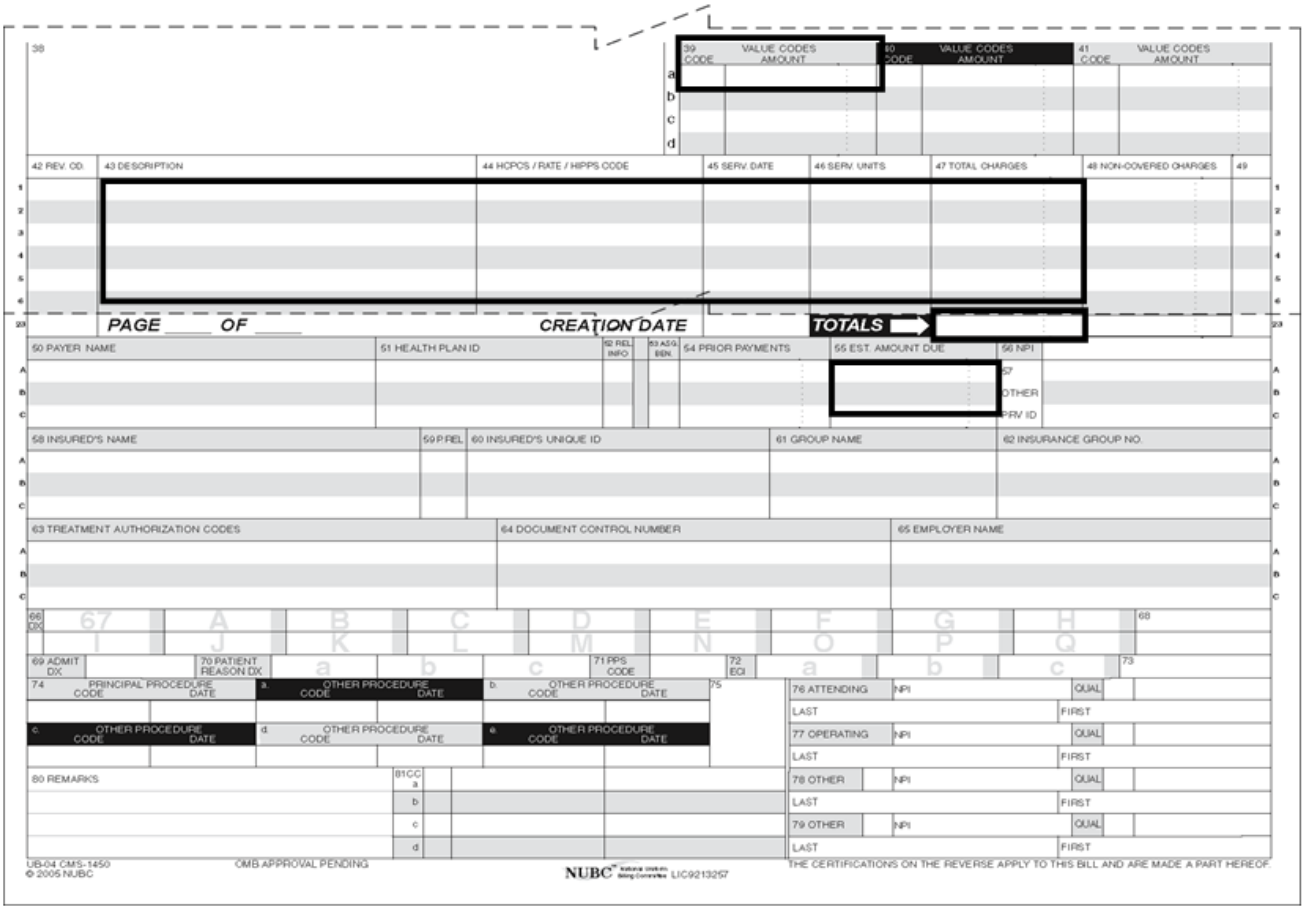
Notes:

Knowledge Review 8

What information will be submitted on this claim form based on the case scenario from the previous page? How will the collected SOC be entered on the claim form?

See the Appendix for the Answer Key.

Partial *UB-04* claim form



Resource Information

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

County Medical Services Program (CMSP) (county med)
Share of Cost (SOC) (share)

Part 2

Share of Cost (SOC): 25-1 Long Term Care (share ltc)
Share of Cost (SOC): CMS-1500 (share cms)
Share of Cost (SOC): UB-04 for Inpatient Services (share ip)
Share of Cost (SOC): UB-04 for Outpatient Services (share op)