CRISS Guide to CCS Aid Codes

Aid Codes	9K	9M	9N	9R	9U
CCS Program Tx Eligibility	▪ For CCS-only clients with Med/Res/Fin eligibility ▪ Current, signed PSA required ▪ For MC and OTLICP clients if signed PSA on file and current* ▪ Only use for OTLICP if income <40k, and signed app and PSA	▪ PSA not required ▪ Signed Tx consent ▪ No Fin required ▪ Med/Res elig	▪ Unsigned PSA ▪ Full Scope MC with no SOC ▪ Med elig	▪ OTLICP with income over $40k ▪ No PSA because client is only elig with OTLICP coverage ▪ Med elig	▪ OTLICP coverage—program elig process incomplete—income unknown ▪ No PSA ▪ Med elig
*For full-scope Medi-Cal with no Share of Cost, no signed application or PSA is required to open and authorize services. All such authorizations are issued with a statement that authorizations is valid only as long as client's Medi-Cal eligibility is active. If client does not have Medi-Cal eligibility on the date services are rendered, the claim will not be paid (from CCS Program Administrative Case Management Manual, page 43)					
CCS Program Dx Eligibility (NL 07-0401)	▪ Signed application only ▪ Fin elig not required ▪ CCS-only clients with Res eligibility	N/A	▪ Unsigned PSA ▪ Full Scope MC with no SOC ▪ Med elig for dx	▪ OTLICP with income over $40k ▪ No PSA because client is only elig with OTLICP coverage ▪ Med elig for dx	▪ OTLICP coverage—program elig process incomplete—income unknown ▪ No PSA ▪ Med elig for dx
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	If MC/OTLICP coverage is lost services will continue to be authorized and paid if current PSA is on file. Requires fin/res redetermination before renewing program eligibility period.	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 OTLICP coverage. Case should be closed if OTLICP coverage is dropped. (NL 12- 1006)	Claims will not be paid if client drops OTLICP coverage. If case is closed client is entitled to due process including the right to appeal the decision to close the case.
Who pays?	CCS only clients: State 50%, County 50% MC clients: State 100% OTLICP clients: Federal 65% State 17.5%, County 17.5%	State 50% and County 50% except for CCS therapist's participation with the LEA in the development of a client's IEP which is State 100%	MC clients: Federal 50% State 50%	OTLICP clients: Federal 65% State 35%	OTLICP clients: Federal 65%, State 17.5%, County 17.5%
Common SAR Special Instructions	HF/MC/OHC #3 re: OHC If applicable: HF/MC/OHC #2 re: infant covered under mother's MC	Therapy in lieu of MTU	HF/MC/OHC #1 Same as 9K	HF/MC/OHC #1 Same as 9K	HF/MC/OHC #1 Same as 9K

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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-MC clients, dental is covered by Denti-Cal, no SAR required	N/A	For MC clients, dental is covered by Denti- Cal, no SAR required	Same as 9N	Same as 9N
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 MC clients covered by Denti-Cal, no SAR required	N/A	Ortho for MC clients covered by Denti-Cal, no SAR required	Same as 9N	Same as 9N

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Newborn Hearing Screening Program (NHSP)	Send copy of SAR to the Hearing Coordination Center fax, 800-866-1074 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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<table>
<tr><th>Aid Codes</th><th>9K</th><th>9M</th><th>9N</th><th>9R</th><th>9U</th></tr>
<tr><td>Retro authorizations</td><td colspan="5">Retro SAR is okay for client with MC. Retro auth should be denied for CCS-only clients.

<u>Emergency-only Medi-Cal:</u>
Section 14133.05 of the Welfare and Institutions Code specifically states “a request for treatment authorization received by the department shall be reviewed for medical necessity only.” If the child had Emergency-Only Medi-Cal on the date of service and went to the ED with a bona fide Emergency, then 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-only clients should be requested that day or the next business day.</td></tr>
<tr><td rowspan="2">Referral Date / Eligibility Start Date

ESD =
Elig Start Date</td><td>CCS MC: ESD can go back six months from referral date

CCS-only: ESD can go back two business days from referral date</td><td>Referral date</td><td>ESD can go back six months from referral date</td><td colspan="2">Same as 9N</td></tr>
<tr><td colspan="5">In the event of an accident, if the referral is received within timeframe for referrals established by CCS regulations, the date of the accident should be considered the referral date. Counties should be reasonable in the evaluation of any extenuating circumstances that may have resulted in the referral being untimely.</td></tr>
</table>