

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET

P.O. BOX 942732

SACRAMENTO, CA 94234-7320

(916) 657-2941



September 8, 1995

TO: All County Welfare Directors
All County Medi-Cal Program Specialists/Liaisons

Letter No. 95-54

EXTENSION OF THE EARNED INCOME TAX CREDIT (EITC) TO AGED, BLIND, AND DISABLED (ABD) LINKED MEDI-CAL BENEFICIARIES

This All County Welfare Directors Letter is to inform counties that the EITC specified in Title 22, California Code of Regulations, Section 50543.5, is also applicable to individuals who are linked to Medi-Cal as ABD persons. Effective no later than November 1, 1995, extend the EITC exemption to ABD persons in new cases and apply this exemption to the EITC of ABD persons in continuing cases for months back through January 1, 1995 as the county becomes aware that EITC was received in any of these past months.

Direct questions or comments to Dave Rappolee of my staff at (916) 657-0163.

Sincerely,

ORIGINAL SIGNED BY
Frank S. Martucci, Chief
Medi-Cal Eligibility Section

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320



(916) 657-2941

October 17, 1995

**TO: All County Welfare Directors
All County Administrative Officers**

Letter No.: 95-54

**OTHER HEALTH COVERAGE CODING PROCEDURE CHANGE FOR HEALTH
MAINTENANCE ORGANIZATION/PREPAID HEALTH PLAN EMERGENCY
OUT-OF-AREA SERVICES**

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandates that health care service plans (including Health Maintenance Organizations [HMO] and Prepaid Health Plans [PHP]) must enroll children in the absent parent's health plan regardless of whether the children reside within the health plan's service area. There is no provision in OBRA 93, however, that requires the health plan to provide routine out-of-area coverage for medical services. Typically, HMO/PHP contracts cover only emergency care provided out of the service area by nonplan providers. Faced with the question of how to ensure maximum utilization of this out-of-area coverage without jeopardizing the children's access to care, the Department of Health Services (Department) will post-pay recover ("pay and-chase") claims for all recipients residing outside the service area of a private HMO/PHP, or who must travel more than 60 miles or 60 minutes to receive care.

Normally, a Medi-Cal eligibility record of a recipient with an HMO/PHP plan is assigned the Other Health Coverage (OHC) code "K"- Kaiser, "C"- Champus, or "P"- other HMO/PHP. In the past, if the recipient had to travel more than 60 miles or 60 minutes to receive care from a plan provider, the OHC code was replaced with an "N", denoting no other coverage.

As a result of the Department's decision to post-pay recover, effective December 1, 1995, the "K", "C", or "P" codes are to be replaced with the pay-and-chase code "A" when the client reports he/she resides outside the plan's service area or must travel more than 60 minutes or 60 miles to receive care from the HMO/PHP. A Health Insurance Questionnaire (DHS 6155) must be sent to the Department, with the statement "Outside Health Plan Area" noted in question number I, next to the insurance carrier's name.

The Department is currently developing the capability to bill the HMO/PHP for emergency out-of-area claims. Using the OHC code of "A" will facilitate the carrier billing. Providers will be advised that claims for recipients with such out-of-area coverage may be billed directly to Medi-Cal without proof of HMO/PHP denial.

All County Welfare Directors
All County Administrative Officers
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If you have any questions regarding this new procedure, please call Ms. Chari Hug of the Health Insurance Section at (916) 327-0492.

Sincerely,

ORIGINAL SIGEND BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance card, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions, information, contact, and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call 1-800-952-5294 (7:30 a.m. to 5:00 p.m.).

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS, HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDICAL ELIGIBILITY. HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDICAL ELIGIBILITY.

Case Name Case Address	FOR COUNTY USE ONLY		STATE USE ONLY	
	Worker Number		Verified By	
	Date		Date	Initials
	Worker Telephone Number		Date	Initials
Initial Intake <input type="checkbox"/> Re-determination <input type="checkbox"/> HIPP <input type="checkbox"/>		Optional Dist No	Scope	CC #

SECTION I: Beneficiary Information LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDICAL AND COVERED BY HEALTH INSURANCE POLICY					14-DIGIT MEDICAL NUMBER				
ONC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Co. Code	Aid Code	Case Number	SSU	Per No

SECTION II: Health Insurance Information

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
 Name: _____
 Address: _____
 City, State, ZIP: _____

Do you have to obtain medical services from a specific facility or a group of providers? (PHO/HMO/PPO) Yes No

2. Where do you send your claims?
 Name: _____
 Address: _____
 City, State, ZIP: _____

3. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued?
 Name: _____ Social Security Number: _____
 Address: _____ Telephone Number: (____) _____
 City, State, ZIP: _____ Absent Parent? Yes No

4. What is the policy number? _____

5. What are the dates of your policy? Beginning Date: _____ Ending Date (if applicable): _____

6. Medical coverage available through employer, but has not been applied for:
 Premium Amount: \$ _____ Monthly Quarterly Yearly
 How are premiums paid? By Insured to Insurance Carrier By Employer By Payroll Deduction

7. Give name of union, employer, group, organization, or school, address, and telephone number.
 Name: _____ Local or Group Number: _____
 Address: _____ Telephone Number: (____) _____
 City, State, ZIP: _____

8. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? Yes No
 If yes, please specify the illness: _____

9. Does your health insurance provide or pay for: (Check all that apply.)
 Hospital Outpatient (i.e., lab work/physical therapy) Prescription Drugs Long Term Care/Nursing Home
 Hospital Stays Dental Care Only specific illness (i.e., cancer)
 Doctor Visits Vision Care Type of illness: _____

10. Is the policy a Medicare Supplement? Yes No

Remarks: _____

"By signing this document, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Name of Applicant	Home Telephone	Work Telephone	Date
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RETURN COMPLETED FORM TO: RECOVERY BRANCH, P.O. BOX 1287, SACRAMENTO, CA 95812-1287
 Original—State Yellow—County File Pink (Taste Copy—District Attorney—Beneficiary)