STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
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SACRAMENTO, CA 95814
(916) 324-4950

MAY 9, 1989

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS

LETTER NO: 89-37

SUBJECT: OTHER HEALTH COVERAGE

REFERENCE: ALL COUNTY WELFARE DIRECTORS LETTERS 87-44 AND 88-92

I. Prepaid Health Plan/Health Maintenance Organizations (PHP/HMO)

Many insurance carriers are now offering coverage through PHP/HMO plans as well as fee-for-service policies. Under the PHP/HMO plans, the insured must obtain medical care from a specific facility(ies) or network of providers; minor exceptions to this rule are made for emergency services. Care rendered by other providers without prior authorization is not covered by the insurance policy.

Under federal and state laws, Medi-Cal cannot pay for services which are covered by other health insurance. This law includes PHP/HMO covered services and PHP/HMO services rendered by non-plan providers. If a Medi-Cal beneficiary with PHP/HMO coverage chooses to receive unauthorized non-plan provider services, neither the PHP/HMO nor Medi-Cal is obligated to pay. Therefore it is important that the Medi-Cal card be coded accurately to reflect the beneficiary's PHP/HMO coverage. Proper coding alerts the provider of the need to refer the beneficiary to the PHP/HMO for treatment.

After determining that the beneficiary has a full coverage policy, the eligibility worker should ask the beneficiary: Do you have to obtain medical services from a specific facility or a group of providers? If the beneficiary answers yes, the Medi-Cal card should be coded with a PHP/HMO code. If the beneficiary has Kaiser, CHAMPUS or Ross Loos/CIGNA coverage, the "K", "C", "R" code should be assigned. Any other PHP/HMO coverage should be coded "P", even though a unique cost avoidance code exists for that carrier's fee for service coverage. For example, should a beneficiary have full coverage through Travelers Insurance, but coverage is limited to services provided by a specific group of professionals and hospitals, the PHP/HMO code "P" should be used instead of the cost avoidance code "T".

To aid the eligibility worker in determining if a beneficiary has PHP/HMO coverage, the DHS 6155 will be revised to include the question: "Do you have to obtain medical services from a specific facility or a group of providers?" The revised form is expected to be available within three to six months.

II. Completed Data Match

DHS has recently completed a data match with CHAMPUS to identify Medi-Cal beneficiaries eligible for coverage under the CHAMPUS program. Following a complete verification of CHAMPUS coverage, the Department will be coding cards of Medi-Cal beneficiaries with CHAMPUS coverage with a "C".

As verification is completed, counties will receive the OHC Indicator Change Report (RCV 139-BR002) listing the beneficiaries coded as a result of the match. Counties are not required to update their records to match MEDS. However, because other health coverage information is printed on share of cost forms (MC 177), counties should at least update their MC 177 share of cost records to alert providers to a beneficiary's cost avoidance coverage prior to their rendering services.

If the beneficiary informs the county that he/she no longer has the cost avoidance coverage, the override procedures described in ACWDL 87-44 must be used to remove the cost avoidance code from MEDS.

If the beneficiary's coverage is now with an insurance carrier other than CHAMPUS, refer to the procedures in ACWDL 88-92 for the appropriate coding of his/her Medi-Cal card.

III. Proposed Data Match

The Department of Health Services (DHS) will be conducting a data match with the California Public Employees Retirement System (PERS) to identify Medi-Cal beneficiaries currently insured with this program. PERS contracts with several insurance carriers, all meeting the definition of full coverage; therefore, matched beneficiaries' cards will be coded for cost avoidance. As a result of the data match, DHS will update the MEDS with the Other Health Coverage (OHC) cost avoidance codes of K, P, R, or V. These codes will be reflected on the beneficiaries' Medi-Cal cards.

Affected beneficiaries will be sent a letter (enclosed) explaining cost avoidance, the data match and coding. The letter will also inform the beneficiary of one of the following requirements:

- If your Medi-Cal card is coded with "V", your providers will have to bill your private health insurance before billing Medi-Cal. If your insurance denies payment, your provider may then bill Medi-Cal; or,

- If your Medi-Cal card is coded with a "K", "P", or "R", you have been identified as having health coverage provided through a prepaid health plan or health maintenance organization. Beneficiaries with this coverage are required to go to their specific plan to receive health care services. If your prepaid health plan/health maintenance organization does not provide the needed service, you must request from the plan a "Denial Letter" or "Explanation of Benefits" clearly stating that the service requested is not covered under the terms of your plan. Present the Denial Letter or Explanation of Benefits to a Medi-Cal provider and he/she will attach the letter to a Medi-Cal claim for service and submit it to Medi-Cal for reimbursement.

Again, beneficiaries will be instructed to contact their county welfare department in the event that they no longer have the coverage identified on their Medi-Cal card.

The list below will assist workers in using the correct cost avoidance PHP/HMO codes when a Medi-Cal applicant is identified as having OHC administered through PERS:

Health Plan Administered by PERS	Cost Avoidance Code
Kaiser South	K
Kaiser North	K
Bay Pacific Health Plan	P
Childrens Hospital Health Plan	P
Equicor Health Plan	P
Foundation Health Plan	P
French Health Plan	P
Greater San Diego Health Plan	P
HEALS Health Plan	P
Healthcare	P
Health Net	P
Health Plan of America	P
Health Plan of the Redwoods	P
IPM Health	P
Lifeguard	P
Maxicare	P
PARTNERS Health Plan	P
Peak Health Plan	P
Take Care Health Plan	P
Travelers Health Network	P
ValuCare	P

California Association of Highway Patrolmen (CAHP) Health Benefits Trust	V
California Correctional Peace	V
California Professional Firefighters Association	V
PERS-CARE	V
Peace Officers Research Association of California	V

If a beneficiary's coverage is with Equicor or Travelers and the plan is not administered through PERS, the cost avoidance codes would remain "Q" and "T" as stated in ACWDL 88-92.

If a beneficiary informs the county eligibility worker that he/she no longer has the cost avoidance coverage, the override procedures described in ACWDL 87-44 must be used to remove the cost avoidance code from MEDS.

If you have any questions regarding MEDS input, contact your MEDS liaison. All other questions should be directed to Michael Jimenez of the Health Insurance Unit at (916) 739-3262.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: May 9, 1990

STATE OF CALIFORNIA- HEALTH AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES
MEDICAL ASSISTANCE

IMPORTANT MEDI-CAL INFORMATION

MEDI-CAL IS EXPANDING ITS PROGRAM FOR USING PRIVATE HEALTH INSURANCE. MEDI-CAL WILL NOT PAY FOR MEDICAL SERVICES COVERED BY YOUR PRIVATE HEALTH INSURANCE. HOWEVER, YOU WILL STILL BE ABLE TO USE YOUR MEDI-CAL CARD FOR MEDI-CAL COVERED SERVICES THAT YOUR PRIVATE HEALTH INSURANCE DOES NOT COVER.

OUR RECORDS INDICATE THAT YOU HAVE PRIVATE HEALTH INSURANCE ADMINISTERED THROUGH THE PUBLIC EMPLOYEES RETIREMENT SYSTEM (PERS). BEGINNING WITH YOUR [MONTH] 1989 MEDI-CAL CARD, EITHER A "K," "P," "R," OR "V" CODE WILL BE PLACED IN THE OTHER COVERAGE FIELD OF YOUR MEDI-CAL CARD TO INDICATE COVERAGE WITH ONE OF THE SPECIFIC PLANS WHICH CONTRACTS WITH PERS.

EFFECTIVE [MONTH] 1, 1989, IF YOUR MEDI-CAL CARD IS CODED WITH A "V," YOUR PROVIDERS WILL HAVE TO BILL YOUR PRIVATE HEALTH INSURANCE BEFORE BILLING MEDI-CAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT, YOUR PROVIDER MAY THEN BILL MEDI-CAL.

IF YOUR MEDI-CAL CARD IS CODED WITH A "K," "P," OR "R," YOU HAVE BEEN IDENTIFIED AS HAVING HEALTH COVERAGE PROVIDED THROUGH A PREPAID HEALTH PLAN OR HEALTH MAINTENANCE ORGANIZATION. BENEFICIARIES WITH THIS COVERAGE ARE REQUIRED TO GO TO THEIR SPECIFIC PLAN TO RECEIVE HEALTH CARE SERVICES. IF YOUR PREPAID HEALTH PLAN/HEALTH MAINTENANCE ORGANIZATION DOES NOT PROVIDE THE NEEDED SERVICE, YOU MUST REQUEST FROM THE PLAN A "DENIAL LETTER" OR "EXPLANATION OF BENEFITS" CLEARLY STATING THAT THE SERVICE REQUESTED IS NOT COVERED UNDER THE TERMS OF YOUR HEALTH PLAN. PRESENT THE DENIAL LETTER OR EXPLANATION OF BENEFITS TO A MEDI-CAL PROVIDER AND HE/SHE WILL ATTACH THE LETTER TO YOUR MEDI-CAL CLAIM FOR SERVICE AND SUBMIT IT TO MEDI-CAL FOR REIMBURSEMENT.

IF YOU DO NOT HAVE PRIVATE HEALTH INSURANCE WITH THE PLAN THAT WE HAVE CODED ON YOUR CARD, CONTACT YOUR COUNTY WELFARE DEPARTMENT.

IMPORTANTE INFORMACION DE MEDI-CAL

MEDI-CAL ESTA AMPLIANDO SU PROGRAMA PARA USAR EL SEGURO PRIVADO DE SALUD. MEDI-CAL NO PAGARA POR SERVICIOS MEDICOS CUBIERTOS POR SU SEGURO PRIVADO DE SALUD. SIN EMBARGO, UD. TODAVIA PODRA USAR SU TARJETA DE MEDI-CAL POR SERVICIOS CUBIERTOS POR MEDI-CAL QUE SU SEGURO PRIVADO DE SALUD NO CUBRE.

NUESTROS REGISTROS MUESTRAN QUE UD. TIENE SEGURO PRIVADO DE SALUD ADMINISTRADO A TRAVES DEL SISTEMA DE RETIRO PARA LOS EMPLEADOS PUBLICOS (PUBLIC EMPLOYEES RETIREMENT SYSTEM (PERS)). COMENZANDO CON SU TARJETA DE MEDI-CAL DE (MES) 1989, UNA CLAVE QUE PUEDE SER UNA "K," "P," "R," O "V" SERA PUESTA EN LA PARTE DE LA OTRA COBERTURA DE SALUD EN SU TARJETA DE MEDI-CAL PARA INDICAR LA COBERTURA CON UNO DE LOS PLANES ESPECIFICOS QUE TIENEN CONTRATO CON PERS.

A PARTIR DEL 1º DE (MES) DE 1989, SI SU TARJETA DE MEDI-CAL ESTA CODIFICADA CON UNA "V" SUS PROVEEDORES TENDRAN QUE COBRARLE A SU SEGURO PRIVADO DE SALUD ANTES DE COBRARLE A MEDI-CAL. SI SU COMPAÑIA DE SEGUROS NO QUIERE PAGAR, ENTONCES SU PROVEEDOR PUEDE COBRARLE A MEDI-CAL.

SI SU TARJETA DE MEDI-CAL ESTA CODIFICADA CON UNA "K," "P," O "R," SIGNIFICA QUE UD. TIENE COBERTURA DE SALUD PROPORCIONADA A TRAVES DE UN PLAN DE SALUD PREPAGADO O DE UNA ORGANIZACION DE MANTENIMIENTO DE LA SALUD. LOS BENEFICIARIOS CON ESTA COBERTURA SON REQUERIDOS DE IR A SU PLAN ESPECIFICO PARA RECIBIR LOS SERVICIOS DE CUIDADO PARA LA SALUD. SI SU PLAN DE SALUD PREPAGADO/ORGANIZACION DE MANTENIMIENTO DE LA SALUD NO LE PROPORCIONA EL SERVICIO NECESITADO, UD. DEBE REQUERIR DEL PLAN UNA "CARTA NEGATIVA" O "EXPLICACION DE LOS BENEFICIOS" EN QUE MANIFIESTE CLARAMENTE QUE EL SERVICIO REQUERIDO NO ESTA CUBIERTO BAJO LOS TERMINOS DE SU PLAN DE SALUD. PRESENTE LA CARTA NEGATIVA O EXPLICACION DE LOS BENEFICIOS A SU PROVEEDOR DE MEDI-CAL Y EL/ELLA ADJUNTARA DICHO DOCUMENTO A SU RECLAMO A MEDI-CAL POR EL SERVICIO NEGADO Y LO PRESENTARA A MEDI-CAL PARA SU PAGO.

SI UD. NO TIENE SEGURO PRIVADO DE SALUD CON EL PLAN QUE HEMOS CODIFICADO EN SU TARJETA, PONGASE EN CONTACTO CON SU DEPARTAMENTO DE BIENESTAR DEL CONDADO.