STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
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August 11, 1993

MEDI-CAL ELIGIBILITY MANUAL LETTER NO.: 119

TO: Holders of the Medi-Cal Eligibility Manual
All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Enclosed are revisions to the procedures portion of the Medi-Cal Eligibility Manual, Article 15D,E,F. The following descriptions identify the reason for each revision or addition, and when appropriate, identify specific All County Welfare Directors (ACWD) Letters which may be discarded.

Procedure Revision		Description
1.	Article 15D	Medicare General Information--revised to provide current information on Medicare Part A and B premiums, deductibles and benefits.
2.	Article 15E	Aged Aliens Ineligible to provide current information on policy and procedures.
3.	Article 15F	Medicare and Medicare Premium Payment--revised to provide current information on Medicare and the Medicare Premium Payment Process. ACWD Letters 86-21, 86-48, 87-38, 89-108, and 90-26 may now be discarded.

Filing Instructions	Insert Pages
Remove Pages:	
Article 15 Table of Contents Pages 1-2	Article 15 Table of Contents Pages 1-2
15D-1	15D-1
15E-1 - 15E-2	15E-1 - 15E-2
15F-1 - 15F-13	15F-1 - 15F-32

If you have any questions concerning these revisions you may contact Steve Yien at (916) 323-9523.

Sincerely,

Original signed by
Frank S. Martucci, Chief

Medi-Cal Eligibility Branch

Original signed by
Frank S. Martucci, Chief

Article 15 -- OTHER HEALTH COVERAGE AND MEDICARE BUY-IN COVERAGE

15A -- IDENTIFYING, REPORTING AND CODING OTHER HEALTH COVERAGE

1. Background and Overview
2. Definition of Other Health Coverage
3. Types of Other Health Coverage That Must Be Reported
4. Types of Coverage/Benefits and Situations When Other Health Coverage Should Not be Reported
5. County Responsibilities for Identifying Other Health Coverage (OHC)
6. Reporting Other Health Coverage Information--County and Applicant/Beneficiary Responsibilities
7. Coding Other Health Coverage Information on the Medi-Cal Eligibility Data System
8. Scope of Coverage
9. Current and/or Prior Month Changes to Other Health Coverage Codes
10. Medi-Cal Eligibility Data System On-Line Other Health Coverage Code Override Process
11. Replacement Card Issuance with Corrected Scope of Coverage Codes
12. Beneficiary and County Welfare Department Inquiries Regarding Other Health Coverage

15B -- MEDI-CAL CASUALTY CLAIMS

15D -- MEDICARE GENERAL INFORMATION

1. Part A Medicare
2. Part B Medicare

15E -- AGED ALIENS INELIGIBLE FOR MEDICARE

1. Background
2. Supplemental Security Income (SSI) Aliens

15D MEDICARE GENERAL INFORMATION

PART A MEDICARE

1.	MONTHLY PREMIUMS	MEDI-CAL PAYMENT ON BEHALF OF THE ELIGIBLE BENEFICIARY
	• No monthly premium under Medicare Part A for most beneficiaries, but: - Those who buy Medicare Part A pay a monthly Part A premium, and - the premium may be higher for those who enroll late.	• $221.00 effective 1/93
2.	HOSPITAL CARE	
	• Deductible required on first admission to a hospital and subsequent admission if next admission is after 60 days from discharge.	• $676.00 effective 1/93
	• First 60 days	• None; fully covered by Medicare for rehabilitation or noncustodial care
	• 61st to 90th day	• $169.00 per day effective 1/93
	• Lifetime reserve - 60 days	• $338.00 per day effective 1/93
	• First 20 days	• None; fully covered by Medicare for rehabilitation or noncustodial care
	• 21st to 100th day	• $84.50 per day effective 1/93

PART B MEDICARE (Supplementary Medical Insurance)

1.	MONTHLY PREMIUM	• $36.60 effective 1/93
2.	DEDUCTIBLE FOR COVERED SERVICES	• $100.00 per year for 1993
3.	MEDICAL INSURANCE BENEFITS	• 80 percent of approved charges for covered services after deductible is met

15E AGED ALIENS INELIGIBLE FOR MEDICARE

BACKGROUND

Section 1836 (2) of the Social Security Act provides that any alien age 65 or older, who is not entitled to monthly Social Security Retirement/Disability (Title II) benefits or Railroad Retirement Benefits, must be a lawfully admitted resident of the United States with five (5) years continuous residence to be eligible for purchase of Medicare Part B coverage.

When confirmation of Medicare eligibility is received through Buy-In or the Beneficiary and Earnings Data Exchange (BENDEX), the Medi-Cal Eligibility Data System (MEDS) record is automatically coded to indicate Medicare eligibility (codes 1, 2, 3, 4, or 5 in the first and/or second digit of the Medicare status). In both situations, the beneficiary's Medi-Cal card is coded to indicate Medicare coverage, and providers are required to bill Medicare prior to billing Medi-Cal for services provided to these beneficiaries.

SUPPLEMENTAL SECURITY INCOME (SSI) ALIENS

Alien information from the State Data Exchange (SDX) file identifies aged aliens eligible for Supplemental Security Income (SSI). These eligibles are coded with a 99 alien indicator on the Medicare status line of MEDS to suppress printing of the Medicare indicator code on the Medi-Cal card. This process uses the Alien Code and the Immigration and Naturalization Service (INS) Entry Date from the SDX file. If there is no INS Entry Date, a date is established using the Medi-Cal date of eligibility from the SDX record.

SSI/SSP eligibles also include some aged aliens who are not entitled to Medicare. If such persons come to county offices because their Medi-Cal card erroneously shows Medicare coverage, counties are to report the situation using the State Buy-In Problem Report (Medicare Part A and B) DHS 6166 (4/90). This form is to be forwarded to the Premium Payment Unit.

Based upon county input, the Premium Payment Unit will update MEDS so Medi-Cal cards for these persons are not coded showing Medicare entitlement. The INS Entry Date is used to determine when the 5 year residency is met so action can be taken to attempt Medicare Buy-In. Semi-annually, an Alien Register (list of all aliens meeting the 5 year residency requirement) is provided to SSA district offices so beneficiaries can be instructed to apply for Medicare Part B benefits.

MEDICALLY NEEDY (MN) ALIENS

Under the previous system, counties reported the Alien Date of Residence (ADOR) into the United States for these aged aliens to the Premium Payment Unit on form DHS 6166 (formerly HAS 8). The Premium Payment Unit updated MEDS to identify the beneficiary as an aged alien (Medicare Status 99) and posted the ADOR. This in turn suppressed the Medicare indicator on the Medi-Cal card until the five year residency requirement was met. The ADOR was used to initiate Buy-In action.

In order for the Premium Payment Unit to determine which beneficiary is eligible for Medicare benefits, counties must now provide alien information when submitting approved case information to MEDS for all county determined cases.

COUNTY PROCEDURES

MEDS has three data elements (Refugee/Aged Alien Indicator, INS Entry Date and Eligibility Date) which are reported by counties when submitting case information for all county determined cases. These data elements are used by the State to determine Medicare card coding and whether to attempt Medicare Buy-In.

1. REFUGEE/AGED ALIEN INDICATOR

(MEDS Name = Aged Alien Indicator)

(DE 2009)

1 = Indochinese Refugee

7 = Other Refugee

8 = Cuban/Haitian Entrant

9 = Aged Alien

* = Delete Refugee/Alien Information

a) Codes 1, 7, and 8 are used to identify refugees (previously reported on the MC 255)

b) Code 9 is used to identify aged aliens who have not met the five (5) year residency requirement.

c) The asterisk (*) is used to delete codes incorrectly entered on MEDS.

NOTE: The Refugee/Alien Indicator will suppress Medicare coding on the Medi-Cal card until information is received from HCFA confirming Medicare eligibility.

2. INS ENTRY DATE

Counties may report the Alien Code and Date of Entry on MEDS transactions EW15, EW20, EW30, and EW55 online or via batch transactions to update Medicare status and Alien Entry Date on the MEDS file.

(MEDS Name = INS Entry--MMYY)
(DE 2005)

Refer to Medi-Cal Eligibility Manual Section 14D for instructions on preparing EW transactions.

3. ELIGIBILITY APPROVAL DATE

(MEDS Name = ELIG-APPRV--MMYY)
(DE 9252)

The Eligibility Approval Date is the month and year in which the eligibility worker completed determination and approved the case. (Refer to Medi-Cal Eligibility Manual Section 15F for additional information on determining Eligibility Approval Date).

MEDICARE

1. EXPLANATION OF MEDICARE

Medicare, administered by the federal Social Security Administration (SSA), is a Health Insurance program that pays for certain medical services provided to individuals entitled to coverage. It covers the aged (65 and over), blind or disabled (persons eligible for Social Security Disability payments) and persons in need of renal dialysis or transplant. There are two parts to the Medicare program:

a. Part A Hospital Insurance is available to "insured" persons at no cost and helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care and hospice care. Those who do not qualify for "free" Part A can purchase such coverage through payment of a monthly premium.

b. Part B Supplemental Medical Insurance may be purchased from SSA through payment of a monthly premium and helps pay for doctor's services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

2. MEDICARE HEALTH INSURANCE CARD

Medicare Health Insurance cards are prepared and mailed by SSA and the Railroad Retirement Board (in instances where Railroad Retirement beneficiaries are involved) to beneficiaries who have established entitlement to Medicare benefits.

The red, white and blue card shows the Health Insurance Claim (HIC)number, entitlement to Part A and/or Part B and the effective date of each. The Medicare beneficiary receives a new card each time his/her Medicare eligibility status changes.

3. HEALTH INSURANCE CLAIM (HIC) NUMBER

The HIC number is an important piece of information used by the State and counties to identify an individual's Medicare record. A HIC number must be alpha/numeric and consist of ten to twelve positions. The HIC number must be in Social Security Number (SSN) or Railroad Retirement Board (RRB) number format.

a. SSN Format: If the first nine positions are numeric, the HIC number is assumed to be in SSN format. The following criteria must be met:

(1) The first nine positions must be numeric.

(2) Position 10 must be alphabetic; position 11 must be alphabetic, numeric, or blank; and position 12 must be blank (e.g., 123456789B, 123456789C2, 123456789BP).

b. RRB Format: If the first nine positions are not numeric, the HIC number is assumed to be in RRB format. The number consists of a one to three alphabetic character prefix in the first three positions, followed by a six or nine digit number. The following criteria must be met:

(1) The prefix must be A, H, CA, JA, MA, MH, PA, PD, PH, WA, WD, WH, WCA, WCD, or WCH, left justified (beginning in first position of field) with trailing blanks (if applicable). If the last nine positions are numeric, they must contain a valid SSN (e.g., A 123456789, WC 123456789, WCA123456789).

(2) If prefix is a single alpha character, it must be followed by two blanks (e.g., A 123456789). If prefix has two alpha characters, it must be followed by a single blank (e.g., WA 123456789).

MEDICARE PREMIUM PAYMENT

1. PART B PREMIUM PAYMENT (BUY-IN) PROGRAM

Buy-In refers to the arrangement through which the State uses Medi-Cal funds to pay the monthly Medicare Part B insurance premiums for qualifying Medi-Cal recipients who are also eligible for Medicare.

The Buy-In agreement was initiated to enable the State to obtain maximum Federal Financial Participation (FFP) for Medi-Cal recipients.

Under the Part B Buy-In agreement, the State may begin to pay Part B premiums for qualified Medi-Cal recipients at anytime and is not limited to SSA's defined open enrollment periods. The State may also Buy-In retroactively to the entitlement date of an individual at any time without paying a late enrollment penalty. All Medi-Cal recipients eligible for Medicare Part B coverage are required to participate in the Medicare Buy-In program in accordance with Section 50777 of Title 22 of the California Code of Regulations.

2. PART A PREMIUM PAYMENT

Medi-Cal pays Part A premiums only for QMBs who do not qualify for free Part A and for Qualified Disabled Working Individuals (QDWIs) (refer to Section 15F for a detailed explanation of these programs). Unlike Part B, the State does not have a Buy-In agreement for Part A. The State cannot, therefore, purchase retroactive Part A coverage as it does for Part B under the Buy-In agreement. In addition, enrollment of Medi-Cal recipients is limited to SSA's open enrollment periods.

In instances where the recipient did not apply for Medicare Part A eligibility within his/her seven (7) month Initial Enrollment Period (IEP), the State is assessed a ten percent (10%) penalty for late enrollment. The QDWI program offers a twelve (12) month grace period after the IEP to the State to begin payment of Part A premiums. If the individual enrolls after the twelve (12) months, the State will then be assessed the ten percent (10%) penalty for late enrollment. Once the IEP and any grace period has passed, an individual may enroll only during the General Enrollment Period (GEP) of January through March with eligibility beginning in July.

3. COVERAGE PERIODS

A. Medicare Part B Buy-In

(1) Part B Buy-In coverage begins:

(a) For SSI/SSP Recipients

The first month an individual is eligible for both Part B coverage and an SSI/SSP cash payment.

(b) For MN Recipients

The second month after the month in which an individual's eligibility for Medi-Cal is approved, providing the individual is eligible for Part B coverage. Approved, in this context, means the date on which the EW makes the determination that the beneficiary is eligible for Medi-Cal.

(2) Part B Buy-In coverage ends:

(a) The end of the last month for which an individual is eligible for the Medi-Cal program.

(b) The month in which an individual dies.

(c) The end of the last month for which an individual under sixty-five (65) is considered disabled or blind under Social Security.

NOTE: For MN beneficiaries, Buy-In coverage can end no earlier than the second month before the month in which SSA receives the deletion request from the State.

B. Medicare Part A

Part A coverage is paid by Medi-Cal for QMBs and QDWIs, not for the regular Medi-Cal population.

(1) QMB Part A coverage begins the month after the month in which an individual is approved for QMB eligibility and meets the following criteria:

(a) Is not entitled to premium free Part A.

(b) Has enrolled in Part A and has met his/her Part A entitlement date.

(2) QDWI Part A coverage begins the first month in which an individual is approved for QDWI eligibility and meets the following criteria:

(a) Is not entitled to premium free Part A.
(b) Has enrolled in Part A and has met his/her Part A entitlement date.

(3) Part A coverage ends:

(a) The end of the last month for which an individual is eligible for the QMB or QDWI program.

(b) The month in which an individual dies.

(c) The end of the last month for which an individual under sixty-five (65) is entitled to Part A.

AGENCY RESPONSIBILITIES

The Buy-In Agreement, Premium Payment programs and automated systems are administered jointly by the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), the State Department of Health Services' Premium Payment Unit, and the counties.

1. HEALTH CARE FINANCING ADMINISTRATION (HCFA)

HCFA central office has overall responsibility for administration of the Buy-In Agreement and the Premium Payment provisions of the Social Security Act.

2. SOCIAL SECURITY ADMINISTRATION (SSA)

SSA offices are responsible for determining SSI/SSP eligibility, processing applications for Medicare, providing information about SSA and Medicare benefits and replacing lost or stolen Medicare cards. SSA provides the State with information on SSI/SSP recipients by the way of the State Data Exchange (SDX) file. The State then utilizes this information to establish and maintain Medi-Cal eligibility.

3. PREMIUM PAYMENT UNIT

The Premium Payment Unit maintains the automated Medicare Premium Payment systems which interface with federal Social Security systems and the State Medi-Cal Eligibility Data System (MEDS). The Unit identifies and evaluates Medi-Cal recipients who may be entitled to Medicare benefits, requests additional information from counties if needed, and interacts with SSA to place all qualified Medi-Cal recipients onto the Buy-In, Qualified Medicare Beneficiaries (QMB) and Qualified Disabled Working Individuals (QDWI) programs. The actions of the Premium Payment Unit result in a shift of medical costs from the State/federal Medi-Cal Program to the federal Medicare program.

4. COUNTIES

A. Identifying and Reporting Potential Medicare Eligibles

Counties determine Medi-Cal and/or QMB eligibility and enter data on MEDS. The counties also determine QDWI eligibility and transmit information on potential QDWI eligibles using the Electronic Mail Communication Center/Totally Automated Office (EMC2/TAO) system. The State uses MEDS and QWDI information to identify potential Medicare eligibles. Information such as name, sex, date of birth, Medi-Cal eligibility effective date and the Health Insurance Claim (HIC) number is edited and matched with records at SSA and HCFA

Central Offices to determine whether Medi-Cal eligibles may also qualify for the Medicare program.

B. Verification of Data Reported

Procedures established by HCFA require a match of more than one characteristic of an individual's case in order to locate a corresponding record on HCFA's Health Insurance Master file. All of the information collected by the county EW must be complete and accurate to be of maximum benefit. It is important to verify that the HIC number is correct by checking the beneficiary's Medicare card. Additionally, when a disabled beneficiary receives his/her disability claim number (Title II), it should be reported to MEDS since it can also be used for Buy-In and/or QMB purposes.

C. Dealing with Incomplete Information

If the applicant is unable to provide the county EW with the necessary information (such as age, citizenship, or lawful alien status and residency), the county must assume the burden of establishing the applicant's medical insurance eligibility or refer the case to the Premium Payment Unit. If the applicant refuses to provide information needed to determine Medicare status, the county must deny Medi-Cal eligibility due to lack of cooperation.

D. Informing the Beneficiary

The county EW should advise the applicant of the following:

(1) By filing an application for Medicare benefits, the individual may establish entitlement to Medicare Part B. If an individual wishes to enroll in the QMB or QDWI programs, he/she must first establish Part A eligibility.

(2) Refusal to apply for Medicare benefits may result in a denial of Medi-Cal benefits.

E. Establishing Medicare Entitlement

If an applicant has yet to establish Medicare entitlement, the county EW must refer the applicant to the nearest local SSA district office to apply for Medicare benefits. It is very important that the applicant establishes Medicare entitlement so that the State may defer costs of medical services to Medicare.

F. Handling Premium Payment Problems

The Premium Payment Unit is available to assist in resolving county Buy-In, QMB and QDWI problems. Counties are encouraged to use the services of this unit.

To resolve a Buy-In and/or QMB problem that has been detected by a county, complete and forward form DHS 6166 to:

Department of Health Services
Premium Payment Unit
P.O. Box 1287
Sacramento, CA 95812-1287

To resolve a QDWI problem that has been detected, send all pertinent information to the Premium Payment Unit via the Totally Automated Office (TAO), "E Mail for QDWI" screen, found in the forms section of TAO.

MEDICARE PREMIUM PAYMENT PROCESSES AND SYSTEMS

Medi-Cal recipients who are eligible for Medicare Part A and/or Part B benefits are identified via the State Medi-Cal Eligibility Data System (MEDS) which is maintained through State, county and federal Social Security Administration (SSA) data input. The State issues a Medi-Cal card each month. From that action, the State Medi- Cal and Medicare Premium Payment systems are alerted and, when appropriate, Premium Payment activity is initiated for eligible beneficiaries by the State or HCFA.

1. MEDICARE PREMIUM PAYMENT SYSTEM

The month-to-month operations of the Medicare Part B Buy-In and Part A QMB programs are accomplished through an automated exchange of data between the State and SSA. The State computer file, containing accretion and deletion records for potential Medicare eligibles who are on a county- administered Medi-Cal Program, is sent to SSA in Baltimore, Maryland, no later than the 25th of each month in order to be included in the next month's Premium Payment update operations.

The Premium Payment Unit maintains the State's Medicare Part B Buy-In and Part A Premium Payment systems which interface with federal Social Security systems and MEDS. These automated systems are designed to pay the Medicare Part B and/or Part A premiums for the Medi-Cal Program. The Qualified Disabled Working individual (QDWI) program is the only program not fully incorporated into MEDS and the automated Buy-In and Premium Payment systems. It is maintained on a manual system within the Premium Payment Unit. Premium Payment Unit staff are able to resolve problem cases by accessing these systems.

2. MEDI-CAL CARD AND MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) MEDICARE CODING

The two digit Medicare status codes on MEDS (refer to next page) identify Medicare Part A and/or Part B coverage for eligible Medi-Cal recipients. These codes are translated to a one-digit code on the Medi-Cal card which alerts providers to the type of Medicare coverage available to a beneficiary and is used to determine if Medicare must be billed prior to billing Medi-Cal.

3. COUNTY ALERTS/MESSAGES

County Alerts/Messages are generated to the counties as part of the monthly processing of the Buy- In Response File received from HCFA for Medicare Part A and Part B. These Alerts/Messages provide county staff with a quick reference to the updated status of each eligible beneficiary under

his/her control without having to access MEDS. Alerts/Messages are sorted in the sequence each county has requested. Messages are generated only for current active county-controlled recipients or for QMBs.

The following is a Summary Table of the Buy-In County Alerts/Messages each county receives:

COUNTY ALERTS/MESSAGES

Alert Number	Alert	Response
8003	HIC-NO CHANGED BY PREMIUM PAYMENT UNIT OR SSA	SEE APPENDIX 2
8004	CLOSED PERIOD ACCRETION	NO RESPONSE NECESSARY
8005	DISABLED BUT NOT YET ELIGIBLE FOR MEDICARE	NO RESPONSE NECESSARY
8006	ACCRETION FAILED HCFA MATCH CRITERIA	SEE APPENDIX 2
8007	STATE INITIATED ACCRETION	NO RESPONSE NECESSARY
8008	FED INITIATED, STATE CONTROLLED ACCRETION	NO RESPONSE NECESSARY
8009	FED DELETION; INELIGIBLE FOR MEDICARE	SEE APPENDIX 2
8010	STATE INITIATED DELETION	NO RESPONSE NECESSARY
8011	FED INITIATED DELETION	NO RESPONSE NECESSARY

Message Number	Message	Response
9004	ACTIVE MEDI-CAL RECIPIENT - DECEASED PER HCFA BUY-IN	SEE APPENDIX 2
9005	ACTIVE MEDI-CAL RECIPIENT - OUT-OF-STATE PER HCFA BUY-IN	SEE APPENDIX 2
9006	QMB ELIGIBLE - BUY-IN REJECTED - NO PART A ENTITLEMENT	SEE APPENDIX 2

County Alerts/Messages

8003 HIC-NO CHANGED BY PREMIUM PAYMENT UNIT OR SSA
This alert informs county staff that either SSA or the Premium Payment Unit has changed the beneficiary's HIC number on MEDS. Data elements associated with this alert display the new HIC number from the transaction, the old HIC number from MEDS, and the HIC-SOURCE.

RESPONSE: County records should be updated to reflect the new HIC number so that if eligibility is terminated and later re-established, the latest HIC number will be reported to MEDS.

8004 CLOSED PERIOD ACCRETION (Part B only)

This is an informational alert to inform county staff that a Buy-In accretion transaction covering a history period has been received from SSA. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: No response necessary.

8005 DISABLED BUT NOT YET ELIGIBLE FOR MEDICARE

This is an informational alert to inform county staff that an accretion transaction was rejected by Baltimore with a status code indicating that the recipient is not yet eligible for Medicare but will be as soon as the waiting period is completed as indicated by the Date of Medicare Entitlement. Data elements associated with this alert display the HIC number and the Date of Medicare Entitlement.

RESPONSE: No response necessary

8006 ACCRETION FAILED HCFA MATCH CRITERIA

This alert indicates that an attempt to purchase Medicare coverage was rejected by HCFA because the recipient identification information did not match any record on HCFA's Health Insurance Master File. Data elements associated with this alert display the HIC number and the Buy-In Effective Date. MEDS will initiate a Buy-In accretion for anyone in a potential Medicare covered aid code who is not identified as a Medicare ineligible alien and either:

A. has a HIC number on MEDS;
B. is age sixty-five (65) or over; or,
C. is eligible in a blind or disabled aid category.

If the accretion attempt did not match a record on HCFA's Health Insurance Master File, the system is unable to confirm whether or not the Medi-Cal recipient is entitled to Medicare.

RESPONSE: The response will vary depending on the following circumstances:

A. If the recipient is sixty-five (65) years of age or over, and:

   1. recipient is an aged alien who is ineligible for Medicare, enter the Immigration and Naturalization Service (INS) entry date and the alien indicator code of 9 directly onto MEDS. This process will suppress Medicare indicator coding on the Medi-Cal card;

   2. recipient has not yet applied for Medicare coverage, notify the recipient of the requirement to apply for Medicare coverage as a condition of Medi-Cal eligibility; or

   3. neither 1. nor 2. apply, check for problems as noted under item 2 below.

B. If the recipient is a dialysis eligible or if you have information confirming that the recipient is either receiving Social Security disability benefits (Title II) or is entitled to Medicare coverage; and

1. the HIC number and/or sex on MEDS is incorrect, submit a correction to update MEDS using the appropriate EW transaction;

2. the name and/or birthdate on MEDS does not match information on the recipient's Medicare Card or his/her disability (Title II) award letter from SSA, report the name and birthdate information from the Medicare Card or award letter to the Premium Payment Unit on Form DHS 6166 to update the alternate name/birthdate information on MEDS; and,

3. neither 1. nor 2. apply, report that information to the Premium Payment Unit on Form DHS 6166. The Premium Payment Unit will contact SSA to resolve the problem that is preventing the Premium Payment accretion from matching HCFA's file.

C. When the recipient is under 65, is not receiving Social Security disability benefits (Title II), is not entitled to Medicare coverage; and

1. the HIC number displayed with this message is blank, no action is required;

2. the HIC number displayed with this message is not blank, submit the appropriate EW transaction to remove the HIC number from MEDS.

8007 STATE INITIATED ACCRETION

This alert informs county staff that a State initiated Buy-In accretion transaction was accepted by HCFA. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: No response necessary.

8008 FED INITIATED, STATE CONTROLLED ACCRETION

This is an informational alert to inform county staff that an accretion transaction was initiated by HCFA. A HCFA initiated accretion action normally results either from a complaint or from a Medicare applicant reporting Medi-Cal eligibility. The data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: No response necessary.

8009 FED DELETION INELIGIBLE FOR MEDICARE

This alert informs county staff that a deletion transaction was initiated by HCFA because, according to HCFA, it appears that the Medi-Cal recipient does not meet eligibility requirements for Medicare. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: If the Medi-Cal recipient believes that he/she is entitled to Medicare, refer recipient to an SSA district office.

8011 FED INITIATED DELETION

This is an informational alert to inform county staff that a deletion transaction was initiated by HCFA based on either a complaint, a problem memorandum or other written request to terminate Medicare Part A and/or B. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: No response necessary.

9004 ACTIVE MEDI-CAL RECIPIENT - DECEASED PER HCFA

This alert informs county staff that either a State initiated accretion transaction was rejected by HCFA or HCFA initiated a deletion transaction because, according to HCFA, this beneficiary is deceased. MEDS shows this beneficiary as a currently active Medi-Cal recipient. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: County staff should verify whether the recipient is in fact deceased and, if so, terminate Medi-Cal eligibility. If the recipient is not deceased, refer recipient to an SSA district office to correct the problem.

9005 ACTIVE MEDI-CAL RECIPIENT - OUT-OF-STATE PER HCFA

This alert informs county staff that, according to HCFA, this recipient has changed the state of residence to a state other than California. MEDS shows this recipient as a currently active Medi-Cal recipient. The data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: County staff should verify if the recipient has moved out of state and, if so, terminate Medi-Cal eligibility. If the recipient has not moved out of state, refer recipient to an SSA district office to correct the problem.

9006 QMB ELIGIBLE - BUY-IN REJECTED - NO PART A ENTITLEMENT

This alert informs county staff that the State's accretion attempt for Part B Buy-In for a QMB eligible has been rejected by HCFA because, according to HCFA, this recipient is not entitled to Medicare Part A. Non-entitlement to Medicare Part A would make a recipient ineligible as a QMB. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: County staff should verify if the recipient has confirmation of Part A entitlement and, if not, terminate QMB eligibility. If the recipient believes that he/she is currently entitled to Medicare Part A Benefits, refer recipient to an SSA district office to correct the problem. If the recipient does have confirmation of Part A entitlement, send proof of Part A entitlement along with a DHS 6166 complaint form to the Premium Payment Unit.

* NOTE: MEDS alerts that read "Potential Medicare Buy-In age 64 years 9 months or over" are generated for county information and use. County EWs should either assist the Medi-Cal recipient to enroll into the Medicare Part B Buy-In Program or enter the INS entry date and alien code 9 on MEDS.

- o has been entitled to disability insurance benefits under Title II;
- o continues to have a disabling physical or mental condition;
- o has lost Title II benefits due to earnings exceeding the SGA limits;
- o is not otherwise entitled to Medicare;
- o whose income does not exceed the income level established at an amount of 200% of the federal income poverty line;
- o whose resources do not exceed twice the SSI standard; and
- o who is not otherwise eligible for medical assistance under Title XIX (except see discussion under 4. Dual Eligibility).

A QDWI is considered a Medi-Cal recipient and must meet all other conditions of eligibility such as filing an application, residency, citizenship, status reporting, etc.; therefore, an OBRA alien is not eligible for QDWI benefits.

1. REPORTING ELIGIBILITY

Due to the small number of QDWI eligibles, MEDS will not carry QDWI records, nor issue the QDWIs Medi-Cal cards. Instead QDWI records will be established by county reporting eligibility using the MEDS Electronic Mail System and maintained manually by the Premium Payment Unit. QDWI beneficiaries will use a Medicare card issued by the Social Security Administration to obtain covered medical care.

County workers should report QDWI eligibility to the Premium Payment Unit via the EMC2/TAO form screen no later than the 17th of the month. The Premium Payment Unit will then notify Health Care Financing Administration (HCFA) of QDWI accretions and deletions by the 25th of the month. The Premium Payment Unit will then notify the county EW, through E-Mail, when HCFA confirms an accretion/deletion. Counties may contact the Premium Payment Unit regarding status on QDWIs or to correct or revise a QDWI record. Use the E-Mail address "Buy-In".

2. RETROACTIVITY

Counties will be able to grant three-month retroactive benefits to eligible individuals. QDWI eligibility effective dates cannot, however, be prior to July 1990, when the program went into effect.

3. E-MAIL SCREEN

Following is a copy of the "E Mail for QDWI" screen and its instructions. To access the EMC2/TAO screen for QDWIs, sign on through MEDS. At the EMC2/TAO User Menu, select option "B" or bulletin board. The QDWI form is located under option "Forms". The first screen to appear will be the "E-Mail for QDWI" screen. Complete all applicable fields. A second screen provides instructions for adding or deleting eligibles within the required fields.

6. DATA EXCHANGE WITH SSA

The State processes Medicare Part B Buy-In, QMB and QDWI tapes for transmission to Baltimore Data Processing (BDP). Accretions/deletions are processed in BDP around the 25th calendar day of each month. HCFA initiates actions for Part B SSI beneficiaries; the State is responsible for non-SSI beneficiaries, QMBs and QDWIs. A separate file, Third Party Master (TPM), is maintained by BDP to control premium billing to states and other third-party payors. These tapes contain accretions, deletions or changes for Buy-In, QMB and QDWI beneficiaries.

BUY-IN EFFECTIVE DATE FOR MEDICALLY NEEDY (MN) PERSONS

In order to comply with Federal requirements for determining the Buy-In effective date, counties must report Medi-Cal approval date to MEDS for potential Buy-In of MN recipients. This approval date is required for each new period of MN eligibility that is not contiguous with prior eligibility. (Prior eligibility can include Supplemental Security Income/State Supplemental Program or Aid to Families with Dependent Children cash eligibility which automatically conferred Medi-Cal eligibility).

Buy-In coverage for a qualified Aged, Blind or Disabled MN eligible beneficiary begins the second month after the month in which Medi-Cal eligibility is approved for medical assistance, unless the individual was a Public Assistance (PA) or other PA eligible in the month immediately preceding the month in which MN eligibility began. The two month lag time for an MN Eligible Beneficiary is automatically calculated by the State from the date of eligibility approval by the county. When a beneficiary receiving Medicare changes from PA to MN status, there should be continuous Buy-In and the two month lag time does not apply.

Approval date means the month and year in which the Eligibility Worker (EW) makes the determination that the beneficiary is eligible for Medi-Cal. For example, an applicant applies for Medi-Cal on May 5, 1992, requesting retroactive coverage to February 1992. On June 20, 1992, the EW determines the applicant is eligible retroactive to February 1992. The approval date in this case is June 1992.

The approval date should be reported on EW05, EW20 or EW30 transactions which establish new MN eligibility on MEDS: (1) when the recipient is a potential Medicare eligible (aged, blind, or disabled, including chronic renal disease); or, (2) the recipient is AFDC-MN and either has a valid HIC number with an "A", or "H" prefix; or an A, J1-J4, M, M1 or T suffix, or is over age 65.

Any overstated shares of cost resulting from the "third month" Buy-In assumption (i.e., assumption that Buy-In will occur in the second month after the month in which eligibility is approved) can be adjusted in later months as provided in Title 22, Section 50653.3. Adjustments should however, be minimal.

QUALIFIED DISABLED WORKING INDIVIDUALS (QWDI) PROGRAM

Section 6408(d) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) requires that the State pay Part A Medicare premiums for individuals who lost Title II and Medicare benefits due to earned income above the required Substantial Gainful Activity (SGA) limit beginning July 1, 1990. Unlike the Qualified Medicare Beneficiary Program (QMB), States are not required to pay coinsurance and deductibles or the Part B premium. A QDWI is eligible to enroll in premium Medicare Part A Hospital Insurance, under a special program and:

o has not attained age 65;

4. DUAL ELIGIBILITY

The Department of Health Services (DHS) will pay Medicare Part A premiums from State funds for Dually Eligible QDWIs (individuals receiving Medi-Cal after meeting their share of cost or without a share of cost), thus allowing coverage of this group.

5. MEDICARE PART A ENROLLMENT PERIODS

The Medicare Part A Initial Enrollment Period (IEP) for a QDWI begins with the month in which the individual receives notice that his/her Part A benefits under the regular Medicare program will end due to excess earnings and ends 7 months later.

For those enrolling during the IEP, benefits begin either the first day of the second month after the month of enrollment, or the first day of the third month, depending on when the individual enrolls. If the individual fails to enroll for Medicare Part A benefits during the IEP, he/she must wait until the General Enrollment Period (GEP) of January through March. Those who enroll in the GEP will not receive benefits until July.

6. WHEN ENTITLEMENT ENDS

Medicare entitlement under these provisions ends when an individual is either no longer disabled, requests voluntary termination of the coverage, becomes eligible for Medicare under some other provision (i.e., premium free Medicare), fails to pay the required premiums, or no longer meets eligibility factors.

QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

Section 301 of the Medicare Catastrophic Coverage Act (MCCA) of 1988 requires the State to pay the Medicare Part A and B cost sharing expenses for certain low income Medicare beneficiaries. Cost sharing expenses are:

- Premiums ($221.00 for Part A, if not available free, and $36.60 for Part B in 1993);
- Deductible ($676.00 for Part A and $100.00 for Part B in 1993); and
- Coinsurance fees in Part A and B.

Due to the need for State legislation, California was granted a waiver to delay implementation of the QMB program until January 1, 1990.

1. QMB ELIGIBILITY CRITERIA

A) Meet the QMB property requirements under the regular Medi-Cal program or have net nonexempt property, as determined for a QMB, at or below twice California's regular Medi-Cal property limits;

B) Meet the QMB income standard. That is, a QMB must have net nonexempt income at or below 100% of the federal poverty level;

C) Be eligible for Part A Medicare hospital insurance with or without a premium; and,

D) Be otherwise eligible for Medi-Cal, i.e., meet all other Medi-Cal requirements such as California residency and linkage (e.g., being aged, blind, disabled).

2. QUALIFIED MEDICARE BENEFICIARIES

There are two groups of QMBs:

A. QMB Dual;

Those receiving regular, full scope Medi-Cal either as cash grant recipients (e.g., Supplemental Security Income/State Supplemental Program (SSI/SSP)) or Medically Needy (MN) beneficiaries. These eligibles already meet the Medi-Cal property limits (QMB property limits are two times the Medi-Cal property limits) and must be determined to meet the QMB income requirement. This group is dually eligible (i.e., eligible for regular Medi-Cal and QMB benefits),

B. QMB Only;

Those eligible as QMB Only do not want regular Medi-Cal or are not eligible for regular Medi-Cal due to property above the regular Medi-Cal property limits but not in excess of the QMB property limits.

3. AID CODE

Aid code 80 was established as the aid code to identify QMB eligibility. Dual eligibles will have both a regular Medi-Cal aid code and the QMB aid code. QMB Only eligibles will have just the QMB aid code. The indicator "QMB" in the Special Program 1 segment of MEDS is used to show QMB eligibility.

4. MEDICARE PART A AND B ENROLLMENT PERIODS

A. Part A Enrollment

1) If an individual is not already receiving Medicare Part A, application for Part A can be made only:

a. During the Initial Enrollment Period (IEP):

- o No earlier than three months before age 65 but no later than three months after the individual's 65th birthday.
- o After 24 months of receiving Title II disability benefits, to be effective in the 25th month.
- o When receiving dialysis related health care services (including renal transplants) at any age.

b. During the Special Enrollment Period (SEP), which is the month after an individual stops working if he/she is over 65.

c. During the General Enrollment Period (GEP) of January - March to be effective the following July, for a Medicare beneficiary who did not enroll in an IEP or SEP. Such eligibles must apply at the Social Security Administration (SSA) office during the GEP. If they fail to do so, they would have to wait until the next year's GEP and would not be eligible for Part A Medicare and therefore QMB until July of that year.

2) Penalties

An individual who does not apply for Part A at the first opportunity is charged a 10% penalty by SSA. Under the QMB program, the State will pay the penalty for a Medicare beneficiary's late enrollment in Part A.

B) Part B Enrollment

1) Part B enrollment criteria for an individual not on Buy-In are the same as for Part A enrollment; however, for those individuals who are Medi-Cal and/or QMB eligible, the GEP, SEP or IEP is waived. The State may begin paying the Part B premium after conditions of eligibility are met (i.e., benefits for a QMB Only begin no earlier than the month after the date of county approval).

2) There are Part B penalties for late enrollment similar to those of late enrollment for Part A; however, under the Buy-In agreement, the State is not charged a penalty for Medicare beneficiaries who would otherwise be assessed a penalty for late enrollment in Part B.

5. QMB BENEFITS EFFECTIVE DATE

QMB benefits may be effective the first of the month following the date of approval (i.e., first of the month following the date the county makes the determination of eligibility) if:

A) Beneficiary is already enrolled in Part A; or

B) Beneficiary enrolls in Part A during his/her IEP or SEP. If a beneficiary enrolls in Part A during the GEP, QMB benefits may be effective the following July. There are no retroactive QMB benefits.

6. PART A AND B COVERAGE ENDS

A) The end of the last month during which an individual is eligible for the QMB program; or,

B) The end of the month in which an individual dies.

7. FEDERAL FINANCIAL PARTICIPATION

Although Medi-Cal pays Medicare Part B premiums, or "Buys-In", for Medically Needy (MN) beneficiaries because it is cost effective, the Medi-Cal Program currently does not receive Federal Financial Participation (FFP) in Part B premiums for MNs. With the implementation of the QMB program, FFP is available for MNs who are also eligible for the QMB program. Thus, it is to the

State's advantage to enroll MN individuals with free Part A as QMBs, if eligible. The State receives FFP for payment of all Part A premiums.

MEDICARE CODING, MEDI-CAL CARDS AND MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

Medicare coding on MEDS is determined from information on the MEDS Medicare Buy-In information screen, MEDS BENDEX Title II information screen and MEDS Miscellaneous screen. Counties are not able to directly input or change the Medicare Coding on the MEDS Medicare Status Line. However, if a coding error is detected, Eligibility Workers (EW) should detail the problem on the State Buy-In Problem Report Form (DHS 6166) and send it to the Premium Payment Unit (see Section 15F "Reporting Problems to the State's Premium Payment Unit").

1. MEDICARE CODING ON MEDS

The MEDS Medicare Status Line shows Medicare Part A and Part B entitlement information as well as whether a premium is required and who pays the premium.

The MEDS Medicare Status codes are shown below. The left digit indicates the Medicare Part A status, while the right digit indicates the Medicare Part B status.

PART A	PART B
Blank/O - No Medicare Part A	Blank/O - No Medicare Part B
1 - Paid by Beneficiary	1 - Paid by Beneficiary
2 - Paid by State	2 - Paid by State
3 - Free	3 - Not Applicable
4 - Not applicable	4 - Paid by Other Entity
5 - BI Reject, BENDEX Eligible 1/	5 - BI Reject, BENDEX Eligible 1/
6 - BI Reject, Presumed Eligible 1/	6 - BI Reject, Presumed Eligible 1/
7 - Presumed Eligible	7 - Presumed Eligible
8 - BI Reject, Not Presumed Eligible 1/	8 - BI Reject, Not Presumed Eligible 1/
9 - Alien	9 - Alien

1/ BI Reject means a rejection by Social Security Administration (SSA) of the State's attempt to Buy-In.

2. MEDICARE CODING ON MEDI-CAL ID CARDS

The Medicare Indicator codes which appear on the Medi-Cal ID cards are shown below. The Automated Eligibility Verification System which answers provider inquiries regarding Medi-Cal eligibility also uses the following codes:

Blank	-	No Medicare Coverage
1	-	Medicare Part A Coverage Only
2	-	Medicare Part B Coverage Only
3	-	Medicare Part A and B Coverage

This coding alerts providers to the type of Medicare coverage for which the recipient is eligible so they can determine if Medicare should be billed prior to billing Medi-Cal. For example, if the recipient's Medi-Cal card shows an indicator of "1" (Part A only) a hospital will know it must bill Medicare for inpatient services.

3. HAND TYPED CARDS:

In those rare instances where counties are required to hand type an MC 301 Medi-Cal card, the following procedures should be followed:

- o If the beneficiary is over 65 years old and has not met the 5 year residency requirement, leave the Medicare Indicator blank to indicate no Medicare entitlement. If he or she is not identified as an alien, Medicare Part B eligibility is presumed, so use an indicator of "2";
- o Use a Medicare Indicator of "1" if the beneficiary has proof of entitlement from Medicare for Medicare Part A only; and,
- o Use a Medicare indicator of "3" if the beneficiary has proof of eligibility from Medicare for both Part A and Part B.

REPORTING PROBLEMS TO THE STATE'S PREMIUM PAYMENT UNIT

The Department of Health Service's Premium Payment Unit is available to assist in resolving county Buy-In problems. Each county is encouraged to use the services of this unit when regular Buy-In procedures do not accomplish the desired result. Prior to reporting problems to the State's Premium Payment Unit, the MEDS INQB "Buy-In and BENDEX Information" screen should be reviewed for the current Buy-In status.

When incorrect information is discovered in any of the screen's fields, attach a printout of the INQB screen to a State Buy-In Problem Report (DHS 6166), enter the nature of the error and the correct information in the "Remarks" section of the form and mail to:

State of California
Department of Health Services
Premium Payment Unit
P. O. Box 1287
Sacramento, CA 95812-1287

COUNTY PROCEDURES FOR COUNTY ADMINISTERED PERSON

In order to resolve a Buy-In problem, provide the following information on the DHS 6166. All data is needed to fully describe the case in question and enable the State to determine the appropriate periods of Buy-In eligibility.

1. Health Insurance Claim (HIC) number, Social Security, or RR HIC number.
2. Name.
3. Sex.
4. Date of birth.
5. County code, aid code, case number, family budget unit and person's number (use the appropriate 14-digit case identification for each period of eligibility identified for this individual).
6. Beginning effective date (for each closed period of Medi-Cal eligibility in which there is a discrepancy).
7. Ending effective date (for each closed period of Medi-Cal eligibility in which there is a discrepancy).
8. For Medically Needy recipients, we need the eligibility approval date as described in Section 15F "Buy-In Effective Date for Medically Needy (MN) persons".

RESOLUTION TIME

Considerable time is needed to correct Buy-In Medicare coding problems. The time required for a problem resolution results from a long sequence of activities involving the processing of an individual problem through county, State and Social Security Administration (SSA) channels and numerous data processing files.

For example, a beneficiary complaining about a premium should expect a minimum wait of four months from the time of the complaint until the billing is corrected by SSA. Once a problem is resolved, a beneficiary must allow SSA 90 to 120 days to refund erroneously deducted or paid premiums.

SSI BUY-IN PROBLEMS

Refer to Sections 14B and 14E of the Medi-Cal Eligibility Manual for handling of Supplemental Security Income/State Supplementary Payment Medi-Cal card coding problems.

INQB SCREEN FORMAT AND DEFINITIONS

The following are the field definitions for the Buy-In and BENDEX segments of the INQB screen:

MEDS BUY-IN AND BENEFICIARY AND EARNINGS DATA EXCHANGE (BENDEX) INQUIRY (INQB) SCREEN

This MEDS screen (example shown below) provides various data to assist county staff in determining the Buy-In status of Medi-Cal eligibles. Refer to Appendix 1 for INQB Screen Definitions.

```
    INQB        ** BUY-IN AND BENDEX INFORMATION **

MEDS-ID                     NAME                        MEDS-CUR-MMYY

= = = = = = = = = = = = = = MEDICARE PART  "B" BUY IN INFORMATION= = = = = = = = = = = = = = =

A. HIC-NO                   D. HIC-SOURCE               F. BUY-IN-ELIG-CD
B. CUR-BUY-IN-STATUS        E. BUY-IN-EFF-DT            G. LAST-PART-B-CHG
C. DOME-DT
= = = = = = = = = = = = = MEDICARE PART "A" BUY-IN INFORMATION= = = = = = = = = = = = = = = = =
H. CUR-BUY-IN-STATUS        J. BUY-IN-EFF-DT            K. LAST-PART-A-CHG
I. DOME-DT
= = = = = = = = = = = = = = = = = =BENDEX TITLE II  INFORMATION= = = = = = = = = = = = = = = = = = = =
L. CLAIM-NO                                             U. LAST-BENDEX-CHG
M. INITIAL-ENTL-DATE        Q. BENDEX-PAY-STATUS        V. COMMUNICATION-CODE
N. OLD-BENEFIT-AMT $        R. HI-ENTL-DATE             W. SMI-ENTL-DATE
0. CUR-BENEFIT-AMT $        S. HI-TERM-DATE             X. SMI-TERM-DATE
P. DUAL-ENTL-IND            T. HI-OPTION-CD             Y. SMI-CODE
                                                        Z. PREMIUM-PAYOR
IN___ENTER QA,QF,QH,QM,QO,QP,QX,Q1,Q2,XC,XE,XM,XN * ENTER KEY RETURNS TO LIST
```

BUY-IN AND BENDEX INQUIRY (INQB) SCREEN DEFINITIONS

1. MEDICARE PART B INFORMATION SEGMENT DEFINITIONS

   A. HIC-NO (Health Insurance Claim Number)

   This field will show the current HIC number if it was reported by either the county or federal government (for HIC-SOURCE, see letter D); otherwise a blank will show. The HIC number shown may not be the correct HIC number.

   B. CUR-BUY-IN-STATUS (Current Buy-In Status)

   The following is a list of valid Buy-In Status Codes with explanations:

Valid Buy-In Status Codes	Code(s) Explanation
1. State Initiated Accretions	Used by the State to accrete an individual to the State's Buy-In Program. Expect response from

	61, 62, 63, 64	HCFA within one month from the current date.
2.	State Controlled Accretions 1161, 1164, 1165, 1167	An accretion submitted by the State has been added to the Buy-In Program.
3.	State Initiated Deletions 50, 51, 53, 81	Used by the State to delete an individual from the State's Buy-In Program. Expect response from HCFA within one month from current date.
4.	State Controlled Deletions 1750, 1751, 1753, 1781	A deletion submitted by the State has been dropped from the Buy-In Program.
5.	Federal Controlled Accretions 1180	Informs the State that HCFA has established a Buy-In record on the Third Party Master (TPM) File for an SSI recipient. The accretion was added to the Buy-In Program.
6.	Federal Controlled Deletions 1500, 1600, 1728, 1759, 1787	HCFA informs the State that an SSI recipient was deleted from the QMB Part A program.
7.	Interim/Special 1800, 1900, 3200, 3300, 3662	Informs the State that although there is no evidence of Medicare entitlement, a claim for Medicare is being developed by Social Security Administration.
8.	Rejection (Accretion/Deletion) 2100, 2400, 2550, 2560, 2081	Informs the State that the submitted Buy-In Accretion/Deletion was rejected because of error(s): HIC number, effective date, etc.
9.	Under investigation 3150, 3160	Buy-In Accretion/Deletion is under investigation. Expect a response from HCFA within one month from current date.
10.	DOME 2200	Indicates Prospective Medicare Entitlement (For Date of Medicare Entitlement, see letter C below).
11.	Alien DOME 2290	Indicates prospective Medicare entitlement for Aged Aliens (For Date Of Medicare Entitlement, see letter C below).
12.	Blank	Indicates no Current Buy-In Activity.

C. DOME-DT (Date of Medicare Entitlement) (MM/YY)

This field indicates the prospective Medicare Entitlement Date unless there is termination of Disability Benefits.

D. HIC-SOURCE

For State Use Only. This field contains an internal code that identifies the county, federal or State system through which the HIC number was last reported.

E. BUY-IN-EFF-DT (Effective Date) (MM/YY)

This field indicates Effective month and year, of current Buy-In Status.

F. BUY-IN-ELIG-CD (Eligibility Code)

For State Use Only. This field indicates availability of Federal Financial Participation in the payment of premiums.

G. LAST-PART-B-CHG (Medicare Change Date) (MM/DD/YY)

This field indicates the month and year in which Buy-In activity most recently updated the MEDS record. Buy-In updates occur between the 19th and 25th of the month.

2. MEDICARE PART A INFORMATION SEGMENT DEFINITIONS

H. CUR-BUY-IN-STATUS (Current Buy-In Status)

I. DOME-DT (Date of Medicare Entitlement) (MM/YY)

This field indicates the prospective Medicare Entitlement Data.

J. BUY-IN-EFF-DT (Effective Date) (MM/YY)

This field indicates Effective month and year of current Part A Buy-In Status.

K. LAST-PART-A-CHG (Medicare Change Date) (MM/DD/YY)

This field indicates the month and year in which Part A Buy-In activity most recently updated the MEDS record. Buy-In updates occur between the 19th and 25th of the month.

3. BENDEX TITLE II INFORMATION SEGMENT DEFINITIONS

L. CLAIM-NO

Claim Number or Social Security Number under which SSA benefit is filed.

M. INITIAL-ENTL-DATE (MM/YY)

Initial date of entitlement to Title II benefits.

N. OLD-BENEFIT-AMT ($$$.cc)

Net amount previously certified by SSA for payment.

0. CUR-BENEFIT-AMT ($$$.cc)

The net amount due the beneficiary under Title II on the 3rd of the next month after the BENDEX record is produced. EXAMPLE: The BENDEX file produced on 4/11/90 contained payment information for the 5/3/90 SSA check.

Money amounts are displayed even if the beneficiary was only previously entitled or is in a nonpayment status (see letter Q for current BENDEX-PAY- STATUS). Zeros normally appear if the beneficiary was denied benefits.

P. DUAL-ENTL-IND

Indicates whether the beneficiary is or was entitled to SSA Title II benefits under more than one claim number.

Blank No dual entitlement

1. Beneficiary is entitled on more than one claim number and all records are active

2. Indicates the beneficiary has been entitled on more than one claim number and one of the records is now inactive

Q. BENDEX-PAY-STATUS

The BENDEX payment status code indicates whether the benefit amount in the CUR-BENEFIT-AMT is payable or the reason it is not payable; a CP in this field indicates that the benefit is payable. Other codes have the following meanings:

A one or two-position code reflecting the SSA payment status for this beneficiary.

BENDEX Information Definitions

Adjustment:

AA	Withdrawal to split payments
AC	Correction in benefit rate
AD	Adjusted for dual-entitlement
AE	Withdrawn for recomputation
AJ	Worker's compensation offset
AM	Withdrawal from HI-only status; monthly benefits being awarded
AR	Withdrawal from S or T status to place in CP status

AW	Worker's compensation offset
A&	Withdrawn from nonpayment status to place in CP status
A-	Withdrawn from CP status to be placed in nonpayment status
AO,Al,A2,	Rate reduction is being figured
A3,A4,A5	
A6,A7,A8	
A9	Miscellaneous adjustment not separately defined
Abatement:	
B	Claimant died prior to entitlement
Current Payment:	
CP	Current Payment Status
Deferred:	
DP	Receipt of public assistance
DW	Receipt of worker's compensation
DI	Engaging in foreign work
D2	Beneficiary overpaid because of work
D3	Auxiliary's benefits withheld because of D2 status for primary beneficiary
D4	Failure to have child in care.
D5	Auxiliary's benefits withheld because of a DI status for primary beneficiary
D6	Deferred to recover overpayment for reason not attributable to earnings
D9	Miscellaneous deferment
Denied:	
N	Disallowed claim
ND	Disability claim denied for non-medical reason
Delayed:	
K	Advanced filing for deferred payment
L	Advanced filing
P	Adjudication pending
PB	Benefits due but not paid
PT	Claim terminated from delayed status
PF,PH,PJ,	The beneficiary is to be placed in S payment status upon final adjudication.
PK,PL,PM	The low order position has the same meaning as the corresponding low
PP,PW,PO	order of payment status S. Upon final adjudication
P1,P2,P3	
P4,P5,P6,	
P7,P8,P9	
Suspended:	
SO	Determination of continuing disability is pending
S1	Beneficiary engaged in work outside the U.S.
S2	Beneficiary is working in the U.S. and expects to earn in excess of annual allowable limit
S3	Auxiliary's benefits withheld because of S2 status of primary beneficiary
S4	Failure to have child in care
S5	Auxiliary's benefits withheld due to S1 status for primary beneficiary

S6	Check was returned - correct address being developed
S7	Disabled beneficiary suspended due to refusal of vocational rehabilitation; imprisoned; extended trial work period
S8	Suspended while payee is being determined
S9	Suspended for reason not separately defined
SD	Technical entitlement only. Beneficiary is entitled on another claim
SF	Special age 72 beneficiary fails to meet residency requirement
SH	Special age 72 beneficiary is receiving a government pension
SJ	Alien suspension
SK	Beneficiary has been deported
SL	Beneficiary resides in a country to which checks cannot be sent
SM	Beneficiary refused cash benefits (entitled to HI-SMI only)
SP	Special age 72 beneficiary suspended due to receiving public assistance
SS	Post secondary student summer suspension
SW	Suspended because of worker's compensation

Terminated:

TA	Terminated prior to entitlement
TB	Mother, father terminated because beneficiary is entitled to disabled widow(er)'s benefits
TC	Disabled widow attained age 62 and is not entitled as an aged widow
TJ	Advanced filed claim terminated after maturity
TL	Termination of post secondary student
TP	Terminated because of change in type of benefit or post entitlement action
T&	The claim was withdrawn
T-	Converted from disability benefits to retirement benefits upon reaching age 65
TO	Benefits are payable by some other agency
T1	Terminated due to death of the beneficiary
T2	Auxiliary terminated due to death of the primary
T3	Terminated due to divorce marriage or remarriage of the beneficiary
T4	Child attained age 18 or 22 and is not disabled; mother/father terminated because last child attained age 18
T5	Beneficiary entitled to other benefit
T6	Child is no longer a student or disabled; or the last entitled child died or married
T7	Child beneficiary was adopted; mother/father terminated as last child adopted
T8	Primary beneficiary no longer disabled; or the last disabled child no longer disabled
T9	Terminated for reason not separately defined

Uninsured:

U Beneficiary is entitled only to HI or SMI

Withdrawal:
W Withdrawal before entitlement

Other Adjustment or termination status:

XO Claim transferred to RRB

X1 Beneficiary died

X5 Entitled to other benefits

X7 HIB/SMIB terminated

X8 Payee is being developed

X9 Terminated for reason not separately defined

XD Withdrawn for adjustment

XF Entitlement transferred to another PSC

XK Beneficiary deported

XR Withdrawn from SMIB

R. HI-ENTL-DATE (MM/YY)

This field will show the current date of entitlement to Hospital Insurance (HI) Part A benefits

S. HI-TERM-DATE (MM/YY)

This field will show the most recent termination date from HI benefits

T. HI-OPTION-CD

This field will show the current HI status code

C No (cessation of disability)

D No (denied)

E Yes (automatic entitlement, no premium necessary)

F No (terminated for invalid enrollment or enrollment voided)

G Yes (good cause)

H No (not eligible for free health insurance benefits (Part A))

P Railroad jurisdiction

R No (refused free Part A)

S No (no longer under renal disease provision)

T No (terminated for non payment of premiums)

W No (withdrawal from premium Part A)

X No (Part A terminated because or Title II termination (Section 2268))

Supplemental insurance medical benefits (Part B) unchanged

Y Yes (premium is payable)

U. LAST-BENDEX-CHG (MM/DD/YY)

The last date, month, day and year, BENDEX updated MEDS.

V. COMMUNICATION-CODE MATCHED

This information is supplied by SSA to help the State analyze records returned in response to State direct input, records being accreted through the Buy-In System, and records previously established as BENDEX which are undergoing change.

Alpha Numeric Codes derived by the BENDEX system to help the State interpret the data received.

Codes for fully processed records

WASbXXXb BENDEX exchange is transferred to your agency: Agency XXX will no longer receive BENDEX exchange. See CFbXXXbb below.

MATCHEDb Current data was extracted from the Master Beneficiary Record (MBR).

REPbPAYE This is a fully processed record with current data extracted from the MBR. The check is payable to someone other than the beneficiary.

FINbMMYY The benefits for this beneficiary terminated for the month indicated. If earnings data was requested, it will be sent.

XREFbNUM Beneficiary is terminated on this record; there is no cross reference MBR or other entitlement.

UTLbXREF Pertinent data was extracted on this claim number. No MBR has been located however, for a cross-reference number.

CFbXXXbb Record is in conflict with another agency, XXX. This record represents the last automated data for the receiving agency. Since BENDEX receives input from most States, as well as other SSA systems, a priority of processing has been established to follow in the event multiple actions are received in a month for an individual.

W. SMI-ENTL DATE (MM/YY)

This field will show the current date of entitlement to Supplemental Medical Insurance (SMI) Part B benefits.

X. SMI-TERM-DATE (MM/YY)

This field will show the most recent termination date from SMI benefits.

Y. SMI-CODE

This field will show the current SMI status code:

C No (disability ceased)
D No (denied)
F No (terminated for invalid enrollment)
G Yes (good cause, enrolled in SMI)
N No (dual technically entitled beneficiary not entitled to SMI)
P Railroad has jurisdiction and collects the premium
R No (refused)
S No (no longer under renal disease provision)
T No (terminated for nonpayment of premiums)
W No (withdrawal)
Y Yes (enrolled in SMI)

Z. PREMIUM-PAYOR

Indicates the Entity making the Supplemental Medical Insurance (Part B) Premium Payment. The following is an explanation of legends/codes:

1. CIVIL - Civil Service is billed for SMI premium payments
2. PRITP - Private Third Party is billed for SMI premiums
3. RRB - Railroad Board has Jurisdiction
4. SELF - The beneficiary is responsible for the SMI premium
5. 010 to 650 - Indicates the State is paying the Part B premium. California's State Code for Part B beneficiaries is 050.

TABLE OF BENEFICIARY IDENTIFICATION CODES (BICs)

SSA BIC	TYPE OF BENEFIT
A	Primary Claimant
B	Aged Wife, age 62 or over (1st claimant)
B1	Aged husband, age 62 or over (1st claimant)
B2	Young wife, with a child in her care (1st claimant)
B3	Ages wife (2nd claimant)
B4	Aged husband (2nd claimant)
B5	Young wife (2nd claimant)
B6	Divorced wife, age 62 or over (1st claimant)
B7	Young wife (3rd claimant)
B8	Aged wife (3rd claimant)
B9	Divorced wife (2nd claimant)
BA	Aged wife (4th claimant)
BD	Aged wife (5th claimant)
BG	Aged husband (3rd claimant)
BH	Aged husband (4th claimant)
BJ	Aged husband (5th claimant)
BK	Young wife (4th claimant)
BL	Young wife (5th claimant)
BN	Divorced wife (3rd claimant)
BP	Divorced wife (4th claimant)
BQ	Divorced wife (5th claimant)
BR	Divorced husband (1st claimant)
BT	Divorced husband (2nd claimant)
BW	Young husband (2nd claimant)
BY	Young husband (1st claimant)
Range C1 Thru C9	Child (includes minor, student, or disabled child)
Range CA Thru CK	Child (includes minor, student, or disabled child)
D	Aged widow, age 60 or over (1st claimant)
D1	Aged widower, age 60 or over (1st claimant)
D2	Aged widow (2nd claimant)
D3	Aged widower (2nd claimant)
D4	Widow (remarried after attainment of age 60) (1st claimant)
D5	Widower (remarried after attainment of age 60) (1st claimant)
D6	Surviving divorced wife, age 60 or over (1st claimant)
D7	Surviving divorced wife (2nd claimant)
D8	Aged widow (3rd claimant)
D9	Remarried widow (2nd claimant)
DA	Remarried widow (3rd claimant)
DC	Surviving divorced husband (1st claimant)
DD	Aged widow (4th claimant)
DG	Aged widow (5th claimant)
DH	Aged widower (3rd claimant)
DJ	Aged widower (4th claimant)

SSA BIC	TYPE OF BENEFIT
DK	Aged widower (5th claimant)
DL	Remarried widow (4th claimant)
DM	Surviving divorced husband (2nd claimant)
DN	Remarried widow (5th claimant)
DP	Remarried widower (2nd claimant)
DQ	Remarried widower (3rd claimant)
DR	Remarried widower (4th claimant)
DS	Surviving divorced husband (3rd claimant)
DT	Remarried widower (5th claimant)
DV	Surviving divorced wife (3rd claimant)
DW	Surviving divorced wife (4th claimant)
DX	Surviving divorced husband (4th claimant)
DY	Surviving divorced wife (5th claimant)
DZ	Surviving divorced husband (5th claimant)
E	Mother (widow) (1st claimant)
E1	Surviving divorced mother (1st claimant)
E2	Mother (widow) (2nd claimant)
E3	Surviving divorced mother (2nd claimant)
E4	Father (widower) (1st claimant)
E5	Surviving divorced father (widower) (1st claimant)
E6	Father (widower) (2nd claimant)
E7	Mother (widow) (3rd claimant)
E8	Mother (widow) (4th claimant)
E9	Surviving divorced father (widower) (2nd claimant)
EA	Mother (widow) (5th claimant)
EB	Surviving divorced mother (3rd claimant)
EC	Surviving divorced mother (4th claimant)
ED	Surviving divorced mother (5th claimant)
EF	Father (widower) (3rd claimant)
EG	Father (widower) (4th claimant)
EH	Father (widower) (5th claimant)
EJ	Surviving divorced father (3rd claimant)
EK	Surviving divorced father (4th claimant)
EM	Surviving divorced father (5th claimant)
F1	Father
F2	Mother
F3	Stepfather
F4	Stepmother
F5	Adopting father
F6	Adopting mother
F7	Second alleged father
F8	Second alleged mother
J1	Primary Prouty entitled to health insurance benefits (HIB) (less than 3 quarters of coverage (Q.C.)) (General Fund)

SSA BIC	TYPE OF BENEFIT
J2	Primary Prouty entitled to HIB (over 2 Q.C.) (Retirement and Survivors Insurance (RSI) Trust Fund)
J3	Primary Prouty not entitled to HIB (less than 3 Q.C.) (General Fund)
J4	Primary Prouty not entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
K1	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (1st claimant)
K2	Prouty wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (1st claimant)
K3	Prouty wife not entitled to HIB (less than 3 Q.C.) (General Fund) (1st claimant)
K4	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (1st claimant)
K5	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (2nd claimant)
K6	Prouty wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (2nd claimant)
K7	Prouty wife not entitled to HIB (less than 3 Q.C.) (General Fund) (2nd claimant)
K8	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (2nd claimant)
K9	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (3rd claimant)
KA	Prouty wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (3rd claimant)
KB	Prouty wife not entitled to HIB (less than 3 Q.C.) (General Fund) (3rd claimant)
KC	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (3rd claimant)
KD	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (4th claimant)
KE	Prouty wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (4th claimant)
KF	Prouty wife not entitled to HIB (less than 3 Q.C.) (General fund) (4th claimant)
KG	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (4th claimant)
KH	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (4th claimant)
KJ	Prouty wife entitled to HIB (over 2 Q.C., (RSI Trust Fund) (5th claimant)
KL	Prouty wife not entitled to HIB (less than 3 Q.C.,) (General Fund) (5th claimant)
KM	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (5th claimant)
M	Uninsured beneficiary (not qualified for automatic HIB)
M1	Uninsured beneficiary (qualified for automatic HIB but requests only SMIB)
T	• Fully insured beneficiaries who have elected entitlement only to HIB (usually but not always along with SMIB) • Uninsured beneficiary or renal disease beneficiary only • Deemed insured (hospital insurance only)
TA	Medicare Qualified Government Employment (MQGE) primary beneficiary
TB	MQGE aged spouse (1st claimant)
TC	MQGE childhood disability benefits (CDB) (1st claimant)
TD	MQGE aged widow(er) (1st claimant)
TE	MQGE yound widow(er) (1st claimant)
TF	MQGE parent (male)
TG	MQGE aged spouse (2nd claimant)
TH	MQGE aged spouse (3rd claimant)

TJ	MQGE aged spouse (4th claimant)
TK	MQGE aged spouse (5th claimant)
TL	MQGE aged widow(er) (2nd claimant)
TM	MQGE aged widow(er) (3rd claimant)
TN	MQGE aged widow(er) (4th claimant)
TP	MQGE aged widow(er) (5th claimant)
TQ	MQGE parent (female)
TR	MQGE young widow(er) (2nd claimant)
TS	MQGE young widow(er) (3rd claimant)
TT	MQGE young widow(er) (4th claimant)
TU	MQGE young widow(er) (5th claimant)
TV	MQGE disabled widow(er) (5th claimant)
TW	MQGE disabled widow(er) (1st claimant)
TX	MQGE disabled widow(er) (2nd claimant)
TY	MQGE disabled widow(er) (3rd claimant)
TZ	MQGE disabled widow(er) (4th claimant)
Range T2 Thru T9	MQGE (CDB) (2nd to 9th claimant)
W	Disabled widow, age 50 or over (1st claimant)
W1	Disabled widower, age 50 or over (1st claimant)
W2	Disabled widow (2nd claimant)
W3	Disabled widow(er) (2nd claimant)
W4	Disabled widow (3rd claimant)
W5	Disabled widower (3rd claimant)
W6	Disabled surviving divorced wife (1st claimant)
W7	Disabled surviving divorced wife (2nd claimant)
W8	Disabled surviving divorced wife (3rd claimant)
W9	Disabled widow (4th claimant)
WB	Disabled widower (4th claimant)
WC	Disabled surviving divorced wife (4th claimant)
WF	Disabled widow (5th claimant)
WG	Disabled widower (5th claimant)
WJ	Disabled surviving divorced (5th claimant)
WR	Disabled surviving divorced husband (1st claimant)
WT	Disabled surviving divorced husband (2nd claimant)

TABLE OF RAILROAD RETIREMENT BOARD PREFIXES AND EQUIVALENT SSA BENEFICIARY IDENTIFICATION CODES (BICs)

RRB Claim Prefix	SSA Bic	Type RRB Beneficiary
A	10	Retirement--employee or annuitant
H	80	RR pensioner (age or disability)
MA	14	Spouse or RR employee or annuitant (husband or wife)
MH	84	Spouse of RR pensioner
WCD*	43	Child or RR employee
WCA*	13	Child or RR annuitant
CA	17	Disabled adult child or RR annuitant
WD	46	Widow or widower of an RR employee
WA	16	Widow or widower of an RR annuitant
WH	86	Widow or widower of an RR pensioner
WCD*	43	Widow of employee with a child in her care
WCA*	13	Widow of annuitant with a child in her care
WCH	83	Widow of pensioner with a child in her care
PD	45	Parent of RR employee
PA	15	Parent of RR annuitant
PH	85	Parent of RR pensioner
JA	11	Survivor joint annuitant (an annuitant who has taken a reduced amount to guarantee payment to a surviving spouse)

*WCD and WCA have two designations each.

Railroad Retirement Board numbers are either six or nine digit letters. For reporting purposes, the second and third position of the RR number must contain a letter or be left blank, i.e.:

A	706306
MA	706306
WCA	706306