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

March 7, 1988

All County Welfare Directors
All County Administrative Officers

Letter 88-17

Subject: Other Health Coverage

Reference: ACWDL 87-44

The State has two methods for utilizing third party liability information on Medi-Cal beneficiaries. These are the Cost Avoidance and the Post Recovery methods. Under the Cost Avoidance method, the provider must bill the other health coverage prior to billing Medi-Cal. Currently, providers are required to bill Kaiser (K), CHAMPUS (C), Ross Loos (R), Prepaid Health Plans (P), American General (G), Blue Cross (B), and Blue Shield (S), prior to billing Medi-Cal. The fiscal intermediary (FI) will deny claims for beneficiaries with a Medi-Cal card coded with one of these coverages unless an Explanation of Benefits (EOB) from the other coverage carrier is attached to the claim indicating a denial of payment or a partial payment. The only exception to the requirement to bill these carriers first is when the claim is for long term care services or for drugs for patients in long term care facilities.

Under the Post Recovery method, providers are encouraged but not required to bill health insurance carriers other than those listed above. The FI processes claims for beneficiaries coded for such coverage (reflected by an A, M, X, Y or Z on the Medi-Cal card) without an EOB from the other coverage carrier. The FI forwards information about claims paid for beneficiaries with one of these other coverage codes to the Department of Health Services. The Department's Recovery Branch bills and pursues payment from the other insurance carrier, using information provided by the County on the Health Insurance Questionnaire (DHS 6155).

At this time, the State is utilizing both methods; the Cost Avoidance and Post Recovery. The emphasis is, however, on converting from a post recovery to a cost avoidance system as required by Federal and State law.

Initially, the responsibility for determining whether a beneficiary has coverage with one of the "cost avoidance" carriers has been only with DHS. DHS places cost avoidance codes on MEDs as a result of tape matches with insurance companies if the policy offers full coverage. However, since the tape matches currently do not match dependent data, the counties were directed in ACWDL 87-44 to place cost avoidance codes for all dependents covered under a parent's or spouse's policy.

Effective immediately, another step is to be implemented in the cost avoidance system. In addition to the tape matches and dependent coding for cost avoidance, the counties are to begin placing cost avoidance codes on MEDs. Placing cost avoidance codes on MEDs is to be done at intake and redetermination for companies with which DHS has already done tape matches. These companies are currently Blue Shield, Blue Cross, American General (Cal West) and Aetna (scheduled). The codes are to be used only when it can be determined that a beneficiary's policy offers full coverage. In order to determine this, the following questions should be asked at application and redetermination once it has been determined the beneficiary has available other health coverage. These questions are to be asked only if the beneficiary indicates that he/she has either Blue Cross, Blue Shield, American General, or Aetna coverage. When coverage is identified with Kaiser, CHAMPUS, Ross Loos and Prepaid Health Plans, the questions do not apply because these plans are already identified as full coverage. The questions are:

1. Does your health insurance provide or pay for hospital stays?

2. Does your health insurance pay for hospital outpatient (eg. lab work, physical therapy)?

3. Does your health insurance pay for doctor's visits?

4. Does your health insurance pay for prescriptions?

If the beneficiary answers yes to at least three of the above four questions, the appropriate cost avoidance code should be entered. These are:

B = Blue Cross
S = Blue Shield
G = American General
E = Aetna

For beneficiaries whose eligibility is being redetermined, the cost avoidance code must be entered for the future month. For new applicants only, the cost avoidance code may be entered effective the first month of eligibility. If at a future date, the beneficiary informs the county that he/she no longer has the cost avoidance coverage, the override procedures described in ACWDL 87-44 should be used to remove the cost avoidance code.

If the policy covers only two of the four services listed above, or if the beneficiary does not know the scope of coverage, enter as before, the following post recovery codes:

X = Blue Shield
Y = Blue Cross North
Z = Blue Cross South
A = American General or Aetna ("A" is used for all carriers for which a unique code has not been assigned)

Beneficiaries will not receive notification by the state of the county added cost avoidance code. Therefore, the county worker must explain the meaning of the cost avoidance code to the beneficiary. Please see enclosed recommended explanation.

The Health Insurance Questionnaire must be completed by the county worker for cost avoidance OHC codes only if health coverage was available prior to the effective date of the cost avoidance code and the other health coverage has not been previously reported. Counties must enter "CA/Retro" in the upper right hand corner of the Health Insurance Questionnaire. Health Insurance Questionnaires are no longer required for dependents who are covered under a parent's policy that has been cost avoided.

If you have any questions, please call Paula Marty at (916) 739-3276.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

Expiration Date: March 31, 1989

EXPLANATION FOR COST AVOIDANCE CODES

Medi-Cal is expanding its program for using private health insurance. This program is called Cost Avoidance and it means that if you have private health insurance, Medi-Cal will not pay for medical services covered by your 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.

Your Medi-Cal card will have a " " code in the other health coverage field on your card to indicate this coverage. Your provider of service will have to bill your private health insurance first. If your insurance company denies payment, your provider may then bill Medi-Cal.