DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: **April 26, 2023**

ALL PLAN LETTER 23-002

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: COST AVOIDANCE AND POST-PAYMENT RECOVERY FOR OTHER HEALTH COVERAGE

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification and guidance to Medi-Cal Dental Managed Care (DMC) for cost avoidance and post-payment recovery requirements when a DMC Plan member has other health coverage (OHC). In addition, the APL provides instructions on using the Department of Health Care Services' (DHCS) Medi-Cal Eligibility Record for processing claims, as well as reporting requirements.

BACKGROUND:
Federal and state law requires Medi-Cal to be the payer of last resort for services in which there is a responsible third party.[1] Medi-Cal members with OHC must utilize their OHC for covered services prior to utilizing their Medi-Cal benefits.[2] Cost avoidance is the practice of requiring providers to bill liable third parties prior to seeking payment from the Medi-Cal program.

Pursuant to federal law, states must take all reasonable measures to determine the legal liability of third parties, and seek reimbursement for covered services for which the third party is liable.[3] This requirement is referred to as post-payment recovery and extends to DMC Plans. DMC Plans that have paid a provider claim for which OHC was/is available on the member's Medi-Cal Eligibility Record at the time of service must engage in post-payment recovery for the reasonable value of the dental services from the liable third party. Additional information detailing private health coverage requirements are further defined in state law[4] and the DMC contracts.[5]

[1] Welfare and Institutions Code (WIC) 14124.90

[2] 22 CCR § 50763
[3] Social Security Sec. 1902. [42 U.S.C. 1396a]
[4] WIC 10022
[5] https://www.dhcs.ca.gov/services/Documents/DMC_Boilerplate.pdf

POLICY:

1. Using the Medi-Cal Eligibility Record for Processing OHC Claims
   - DMC Plans should rely on the Medi-Cal Eligibility Record for cost avoidance and post-payment recovery purposes.
   - DMC Plans that become aware of OHC from sources other than the Medi-Cal Eligibility Record may use this OHC information but must report the OHC to DHCS and the OHC.

2. OHC Reporting Requirements and Delivery Options
   - DMC Plans must report new OHC information not found on the Medi-Cal Eligibility Record or OHC information that is different from what is found on the Medi-Cal Eligibility Record to DHCS within ten (10) calendar days of discovery. This requirement ensures timely receipt of all new or updated OHC information so that the Third Party Liability and Recovery Division (TPLRD) can verify the information and update the member's Medi-Cal Eligibility Record, if valid. DMC Plans must report this OHC information to DHCS by either:
     - Completing and submitting an OHC Removal or Addition form;[6] or
     - Reporting OHC information to DHCS in batch updates:[7]
   - By January 1, 2024, DMC Plans must include OHC information in their notification to the provider when a claim is denied due to the presence of OHC. OHC information includes, but is not limited to, the name of the OHC provider and contact or billing information. OHC information known to DHCS is provided to all DMC Plans on a monthly basis. Prior to January 1, 2024, DMC Plans may direct providers to access the necessary member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295, or the Medi-Cal Online Eligibility Portal.[8] Information pertaining to OHC carriers can be found in the Health and Human Services Open Data Portal.[9]

3. Cost Avoidance
   - Prior to delivering services to members, DMC Plans must ensure providers review the Medi-Cal Eligibility Record for the presence of OHC (OHC code L or Scope of Coverage “D” indicator (not OHC code D)). If the member has active

[6] http://dhcs.ca.gov/OHC
[7] Batch Processing (multiple additions/removals at a time) is done via weekly submission. DMC Plans can contact the Medi-Cal Dental Services Division (MDSD) at DMCDeliverables@dhcs.ca.gov for more information regarding this process.
[8] https://www.medi-cal.ca.gov/MCWebPub/Login.aspx
[9] https://data.chhs.ca.gov/dataset/aevs-carrier-codes-for-other-health-coverage.

OHC, DMC Plans must ensure providers compare the OHC code (Appendix A) to the requested service. If the requested dental service is covered by the OHC, DMC Plans must ensure providers instruct the member to seek the service from the OHC carrier.

- Regardless of the presence of OHC, DMC Plans must ensure providers do not refuse a covered Medi-Cal service to a Medi-Cal member.[10]
- DMC Plans must not process claims for a member whose Medi-Cal Eligibility Record indicates dental third party coverage, designated with a OHC code L or Scope of Coverage "D" indicator (not OHC code D), unless the provider presents proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly.
- Acceptable forms of proof that all sources of payment have been exhausted include a denial letter from the OHC for the service, an explanation of benefits (EOB) indicating that the service is not covered by the OHC, or documentation that the provider has billed the OHC and received no response for 90 days.

4. Post-Payment Recovery
   - DMC Plans must engage in post-payment recovery if OHC is discovered retroactively, or the member had an OHC Code of L or Scope of Coverage indicator code of "D", on their Medi-Cal Eligibility Record at the time of service.
   - DMC Plans that initiate and complete post-payment recovery within 12 months from the date of payment of a service are entitled to retain all monies recovered.
   - DMC Plans that initiate an active repayment plan with providers or carriers that is agreed upon prior to, and extends beyond 12 months from the date of payment of a service, will be allowed to retain the recovered monies.
   - An active repayment plan is considered active if the provider or carrier has agreed to repay the liability but has not yet paid the full amount.
   - DHCS' TPLRD will conduct post-payment recoveries and/or leverage its recovery contractor to initiate post-payment recovery beginning the 13th month following the date of payment of a service. TPLRD's recovery contractor assists with the identification and recovery of paid Medi-Cal claims for which there is liable third party. Monies recovered by TPLRD or its recovery contractor starting the 13th month after the date of payment of a service will be retained by DHCS.
   - Beginning January 1, 2024, DMC Plans are required to submit detailed information regarding their recoveries to DHCS on a monthly report utilizing DHCS' Secure File Transfer Protocol no later than the 15th of each month (See Appendix B for the specifics regarding the file format, required data elements, and other submission requirements).

[10] https://www.law.cornell.edu/uscode/text/42/1396a

- At least one post-payment recovery test file needs to be submitted by August 1, 2023. This allows both parties to test the reporting process and resolve any issues prior to the January 1, 2024 deadline.
- The test file should contain ten line items and must be in the layout outlined in Appendix B.
- On a monthly basis, DMC Plans must report all recovered OHC monies that are 13 months or older from the date of payment of a service to DHCS utilizing the monthly report (Appendix B).
- DMC Plans must include the check or electronic fund transfer (EFT) control number under row "V", field name "Filer" for all related Transaction Control Numbers (TCN) on the monthly Appendix B report.
- DMC Plans must remit warrants, payable to DHCS, for all recovered monies that are 13 months or older from the date of payment of a service, unless the payment meets the criteria of an active repayment plan, to the following address:

  Bank of America
  P.O. Box 742635
  Los Angeles, CA 90074-2635

REQUIREMENTS:

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in a DMC Plan's Policies and Procedures (P&P's), the DMC Plan must submit its updated P&P's with and without Track Changes to DMCDeliverables@dhcs.ca.gov within 90 days of the release of this APL. If the DMC Plan determines that no changes to its P&P's are necessary, the DMC Plan must submit an email attestation to DMCDeliverables@dhcs.ca.gov within 10 days of the release of this APL, stating that the DMC Plans P&P's have been reviewed and no changes are necessary. The email confirmation must include the title of this APL, as well as the applicable APL release date in the subject line.

DMC Plans are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each DMC Plan to all Subcontractors and Network Providers.

If you have any questions, please contact DMCDeliverables@dhcs.ca.gov.

Sincerely,

Original signed by:

Adrianna Alcala-Beshara, JD, MBA
Division Chief
Medi-Cal Dental Services Division
Department of Health Care Services