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ADP BULLETIN

Title		Issue Date: January 13, 2011 Expiration Date: N/A	Issue No. 11 - 01
Update - Processing Drug Medi-Cal Claims for Clients with Other Heath Coverage			
Deputy Director Approval dave neilsen Deputy Director Program Services Division	Function: [ ]Information Management [ ]Quality Assurance [ ]Service Delivery [X]Fiscal [ ]Administration [ ]Other	Supersedes Bulletin/ADP Letter No. 10-09 and July 28, 2010 letter regarding Drug Medi-Cal and Other Health Coverage	

PURPOSE

This bulletin consolidates the content of two previous communications that have been sent regarding the Drug Medi-Cal (DMC) claim process for clients who have Other Health Coverage (OHC). It combines and revises the information first provided in the Department of Alcohol and Drug Programs (ADP) Bulletin 10-09, and a related letter dated July 28, 2010, to County Administrators and DMC Providers.

This bulletin also provides additional information regarding an appropriate denial/response letter from the OHC, and DMC claim submission for Minor Consent services provided to Medi-Cal Full Scope eligible clients.

DISCUSSION

Federal Medicaid rules and the California Code of Regulations (CCR), Title 22, Section 51005(a) require billing a client's OHC before billing Medi-Cal. For clients whom the Medi-Cal Eligibility Determination System (MEDS) indicates have OHC, the Short-Doyle Medi-Cal (SDMC) billing system denies the DMC claim payment if the service provider does not bill the OHC carrier first and does not indicate the results of that billing in the submitted DMC claim. The results of billing the OHC may be received in electronic or written form. The sections below address several considerations that apply to billing for services provided to clients that are identified by MEDS as having OHC available.

Criteria for Billing DMC Without Billing OHC

1. A county or service provider may submit the DMC claim without having to bill the OHC first in the following two instances:

   a. Client's OHC is Vision, Dental, Hospital Inpatient or Prescription Only: The county or provider may submit the DMC claim without having to bill the OHC first

if a client's OHC is vision, dental, hospital inpatient or prescription only - which does not cover substance use disorder services on an outpatient basis.

b. Minor Consent Program Services: The county or provider may submit the DMC claim without having to bill the OHC first for minor consent services. The Minor Consent program permits youth under 21 years of age who are living with their parent(s) or guardian(s) access to confidential, limited alcohol and other drug treatment services without regard to the parental income and resources. This is in accordance with Family Code Section 6929; Welfare and Institutions Code Section 14010; and Title 22 of the CCR Section 51473.2. The Minor Consent program is funded by the State General Fund.

The SDMC system was modified to allow the above two exceptions as of July 2, 2010.

Delayed or No OHC Response

ADP implemented the following changes to the existing procedures to permit a more efficient process for submitting claims and issuing reimbursement:

1. Providers may presume that a claim for reimbursement submitted to an OHC carrier has been denied, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
    a. The provider has billed the service to the other carrier as required, and
    b. At least 90 calendar days have elapsed since the submission of the claim to the OHC carrier, and
    c. The provider has received none of the following:
        i. Payment for the claim,
        ii. A report (whether in hardcopy, electronic, or other form) of the results of the OHC carrier's adjudication of the claims,
        iii. Any communication, in any form, indicating that the claim submission was in an unacceptable form or otherwise in need of correction prior to adjudication by the OHC carrier.

2. When billing for DMC reimbursement based on a presumed denial as described in #1, above, providers shall report the presumed denial as follows for up to 12 months:
    a. Enter adjustment group code "OA" ("Other Adjustments"),
    b. Enter adjustment reason code "192".

3. Providers may consider a claim for reimbursement for particular services denied by the OHC carrier without submitting a billing claim to the OHC carrier, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
    a. The provider has billed the OHC carrier in the past 12 months, and
    b. In response to the previous attempt to bill the carrier, the provider has received a dated notification in written or electronic form that clearly indicates that the claim

for reimbursement is denied for an appropriate denial reason (see below, under "Appropriate OHC Denial or Adjustment Reasons") and that, for some specified span of time after the notification, claims for services provided under similar circumstances will not be accepted by that carrier, and

c. The services are within the scope of services for which the OHC carrier has indicated that they will not accept claims from the provider in the notification described in #3(b), and
d. The services were provided within the span of time identified in the notification described in #3(b) during which the OHC carrier would not accept the claims.

4. When billing for DMC reimbursement based on denial from a notification as described in #3, above, providers shall prepare their claims by mapping the justification for denial identified in the notification on which they are relying to the most appropriate combination of the following using the standard code sets in force at the time the claim is created or as submitted by the OHC carrier:
   a. Adjustment group code,
   b. Adjustment reason code, and,
   c. If necessary for the adjustment reason code given, health remarks code.

Appropriate OHC Denial or Adjustment Reasons

The Department of Health Care Services (DHCS) is the lead agency for administering California's Medicaid (Medi-Cal) Program. As the lead agency, DHCS provides Medi-Cal claim processing and payment guidance to other state departments. DHCS requires that Medi-Cal providers bill a client's OHC prior to billing Medi-Cal to receive either payment from the OHC, or a notice of denial from the OHC indicating that:

- The recipient's OHC coverage has been exhausted, or
- The specific service is not a benefit of the OHC.

There is another possible outcome of claims submitted to OHC providers. The OHC may cover the service, but only if the client obtains that service from the OHC's facility or through an OHC-approved provider. In such a case, a DMC provider submitting a claim to the OHC may receive a response indicating that the billing is denied because the services were not rendered by an in-network provider and/or because the services were not authorized according to the OHC's coverage requirements. Such a notice of denial may contain statements similar to the following:

- "HMO eligible, but services were not rendered by an HMO facility/provider; therefore, patient is not eligible for HMO benefits", or
- "The claim is denied. The procedure or services performed were not ordered or authorized by a Kaiser Permanente physician."

These are not acceptable denial reasons for submitting claims for DMC reimbursement as required by DHCS because they do not indicate that the OHC coverage has been exhausted, or that the service provided is not a benefit of the OHC. If a client has OHC,

and that OHC covers substance use disorder services, the client must exhaust the benefits available to them from the OHC before submitting the DMC claim for reimbursement.

Counties and providers that submitted DMC claims on or after January 1, 2010, and that were approved for such claims based on an OHC denial reason other than that the OHC coverage has been exhausted, or that the specific service is not a benefit of the OHC, must void those claims. If specific services within the approved claim (but not the entire claim) involved an OHC denial reason other than that the OHC coverage has been exhausted, or that the specific service is not a benefit of the OHC, then the claim should be resubmitted without those specific services. Failure to do so could result in an audit finding.

Clients with Multiple OHC Carriers

ADP has received inquires regarding whether DMC providers must bill all OHC carriers when a client has more than one OHC carrier identified in MEDS. As previously stated, DMC providers may bill DMC if they have a denial letter from the OHC stating that the recipient's OHC coverage has been exhausted. This means that each of the client's OHC carriers have been billed and the OHC coverage has been exhausted.

Claim to OHC Receiving Partial Payment

If a county or provider has submitted a claim to an OHC and received partial payment of the claim, they may submit the claim to ADP and are eligible to receive payment up to the maximum DMC rate for the service, less the amount of the payment made by the OHC.

Provider Responsibility to Identify and Bill OHC

It is the responsibility of DMC providers to assess whether the client's OHC includes substance use disorder services before providing a DMC reimbursable service to the client. This can be done by referring the client to the OHC or contacting the OHC on behalf of the client. If a DMC provider chooses to provide the service without assessing OHC first, then it does so at the risk of not being able to obtain DMC reimbursement.

DMC Claim Submission for Confidential Minor Consent Services Provided to Clients Without Minor-Consent-Only Aid Codes and Who Have Other Health Coverage

Minor Consent Medi-Cal aid codes are only assigned to clients that do not already have full scope, no-share-of-cost Medi-Cal eligibility. When a Minor Consent service is provided to a client without a Minor-Consent-Only aid code who has OHC and the OHC carrier is not billed first, the SDMC system will deny the DMC claim because the system treats only those claims submitted for clients with Minor Consent-Only aid codes as claims for confidential Minor Consent services (for which OHC need not be billed.)

ADP is investigating mechanisms to allow providers to specifically identify that DMC claims are for minor consent services. In the interim, for Minor Consent services provided to a client without a Minor-Consent-Only aid code, the DMC provider should submit the DMC claim without billing the OHC carrier first. These claims should be submitted to ADP as if denied by the OHC carrier, with the reason for denial reported as follows:

1. Enter adjustment group code “OA” (“Other Adjustments”),
2. Enter adjustment reason code “192”.

Counties and providers that submitted DMC claims for services provided as confidential Minor Consent services to clients without Minor-Consent-Only aid codes, which were denied because the OHC carrier was not billed, may submit replacement claims for those claims, following the procedure described above for reporting them as if denied by the OHC carrier.

Counties and providers that chose not to submit DMC claims for services provided as confidential Minor Consent services to clients without Minor-Consent-Only aid codes with OHC because they would have been denied, may now submit these claims following the procedure described above for reporting them as if denied by the OHC carrier. If the claim is submitted more than 30 days after the service date, the claim should use delay reason code “7”.

Records Retention

Trading partners shall retain all records relevant to the application of the rules communicated in this bulletin consistent with the records retention requirements identified in the State Administrative Manual and the trading partner’s DMC or Net Negotiated Amount/DMC contract with the State. This includes retaining documentation in the client files to support when confidential Minor Consent services are provided to clients without Minor-Consent-Only Aid Codes and who have other health coverage.

REFERENCES

California Code of Regulations, Title 22, Section 51005

QUESTIONS / MAINTENANCE

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