STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
ACRAMENTO, CA 95814

October 20, 1989

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS

Letter No.: 89-89

Subject: Health Insurance Questionnaire (DHS 6155) Revision

Recently, important changes have been made to the Health Insurance Questionnaire (HIQ), DHS 6155 (rev. 5/89), used to report other health coverage. A copy of the revised form is enclosed. The purpose of this letter is to:

1. advise counties of the changes to the DHS 6155 form;

2. alert counties that the form must now be used for all Medi-Cal recipients with health insurance regardless of the type of coverage;

3. provide instructions on how to review forms for accuracy and completeness.

BACKGROUND

Currently, applicants and persons whose eligibility is being redetermined (Title 22, Section 50765) are required to complete a HIQ only when it is determined that they have less than comprehensive health insurance coverage. The information reported via the HIQ has been used by Department of Health Services (DHS) for post-payment insurance billings. Medi-Cal claims for persons enrolled in PHP/HMOs or having comprehensive coverage are cost avoided and thus specific insurance information has not been required. The revised DHS 6155 has been designed to elicit more detailed information in light of recent changes to federal and state laws mandating the following other health coverage (OHC) processes: Health Insurance Premium Payment (HIPP), Focused Cost Avoidance (based on scope of benefits) and pre-natal and pediatric exceptions to cost avoidance.

HIPP

With the passage of Assembly Bill 3328 in 1986, the DHS is permitted to pay private health insurance premiums for Medi-Cal beneficiaries when it is cost effective to do so. DHS has developed HIPP procedures to identify beneficiaries with chronic or severe illnesses where private health insurance policy has or is about to lapse.

Questions #5, #6 and #9 on the HIQ are geared to elicit responses from beneficiaries regarding the status of their policy and type of illness. Please refer to All County Welfare Directors Letter No. 89-31 for more information on the HIPP program.

FOCUSED COST AVOIDANCE (BASED ON SCOPE OF BENEFITS)

Federal COBRA legislation (1985) mandates that states convert their fiscal intermediary operations from a post payment OHC recovery process to a cost avoidance process. The DHS is developing a cost avoidance process that is focused to screen claims only for services covered by the recipient's insurance. Question #10 on the HIQ asks the beneficiary to list specific services covered under his or her insurance plan.

The OHC coding on the Medi-Cal card will in the future be expanded to include a new two digit scope of benefits code. This code will inform providers which services must be billed to the insurance carrier before billing Medi-Cal. Counties will not be required to modify their systems to accommodate the new codes as DHS staff will input the scope of benefit data to MEDS upon receipt of the HIQ. While focused cost avoidance will not be fully implemented until January 1991, we will begin MEDS input shortly so that scope of benefits information will be available for all recipients upon implementation. Counties will continue to assign and input the one digit OHC code to MEDS in accordance with current procedures.

When focused cost avoidance is implemented, counties will receive instructions on how to issue immediate need cards with scope of benefit codes.

PREPAID HEALTH PLAN/HEALTH MAINTENANCE ORGANIZATION (PHP/HMO)

Under the PHP/HMO plans, the insured must obtain medical care from a specific facility(ies) or network of providers. Medical care rendered by other providers without prior authorization is not covered by the insurance policy. State and federal laws prohibit Medi-Cal from paying for services that are covered by other health insurance. This includes PHP/HMO covered services and PHP/HMO services rendered by non-plan providers.

Therefore, it is important that the Medi-Cal card be coded accurately to reflect the beneficiary's PHP/HMO coverage. Question #2 asks the beneficiary whether available health coverage stipulates that medical services must be obtained from a specific facility or group of providers. If the answer to this question is yes, the beneficiary must be assigned a PHP/HMO other coverage codes. If the beneficiary has Kaiser, CHAMPUS or Ross Loos/CIGNA, the "K", "C", or "R" code as appropriate should be used. Any other PHP/HMO coverage should be coded "P", even though a unique cost avoidance code exists for that carrier's fee for service coverage.

PRE-NATAL AND PEDIATRIC EXCEPTIONS

Federal law mandates exceptions to cost avoidance when claims are for pre-natal or preventive pediatric services. In these instances, the State is required to pursue post-payment insurance recoveries. Given the potential number of cost avoided beneficiaries affected by these exceptions, OHC information must be reported via the HIQ for all OHC covered individuals, including those with PHP/HMO coverage, at intake and redetermination.

FORM INFORMATION/APPROVAL/AVAILABILITY

The DHS has incorporated CWDA's suggestions into the attached revised DHS 6155 form. The form contains instructions for completion on the reverse side and is now available. Counties should place their initial order for the revised DHS 6155 immediately. In the interim, county staff should continue to use the old stock of forms. However, once the revised form is received, existing stock should be destroyed.

COUNTY RESPONSIBILITIES

Starting October 1, 1989, county staff must ensure that all applicants and eligibles who have other health coverage complete a DHS 6155. Previously, eligibles who were covered by a PHP/HMO, CHAMPUS or cost avoided insurance were not required to complete this form. Failure to complete the DHS 6155 will not impact the applicant's eligibility to receive AFDC.

Since eligibles will be asked to provide detailed health insurance information, county staff should review the health insurance questionnaire and:

- be certain that complete information is provided. County staff should assist applicants to furnish information (e.g., asking for an insurance card or other materials that may contain the necessary information). In addition, county staff should check the form for abbreviations and request that these be spelled out.

- be certain that applicant's complete name is spelled out and spelled correctly. If the applicant has an AKA, also include that name.

- be certain the insurance policyholder's social security number is provided.

- be certain form is signed by the applicant and dated. This form is also an authorization for the release of information and the signature block and date are very important.

- if the applicant checks three of the first four coverage categories (hospital stays, hospital outpatient, doctor visits and prescription drugs) in question #10, code the case on MEDS for cost avoidance in accordance with current procedures.

- if the applicant indicates PHP/HMO coverage or answers yes to question #2, code the case on MEDS for PHP coverage in accordance with current procedures. Please refer to ACWD Letter No. 89-37.

- if the applicant indicates multiple OHC, obtain a DHS 6155 for each policy and staple forms together.

STATE RESPONSIBILITIES

- The DHS, Other Coverage Section (OCS), will review the DHS 6155 for accuracy and completeness.

- Health Insurance Unit (HIU) will make changes directly to the OHC code on MEDS, if necessary. The counties will be informed of changes through the normal worker alert process.

- HIU will determine the scope of benefit coding (2 digit code) and input to MEDS, when this process is implemented.

If you have any questions regarding the revised DHS 6155 form, please call Cathy Corgiat of the Health Insurance Unit at (916) 739-3276.

Sincerely,

Original signed by

Robert Horel, Deputy Director
Welfare Programs Division
Department of Social Services

Sincerely,

Original signed by

Frank Martucci, Chief
Medi-Cal Eligibility Branch
Department of Health Services

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants
County Welfare Directors Association (CWDA)

Expiration Date: October 20, 1990

State of California—Health and Welfare Agency

Department of Health Services

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions and information collection and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call toll-free 1-800-952-5294 (7:30 a.m. to 5:00 p.m.).

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY; HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case Name / Case Address	FOR COUNTY USE ONLY	STATE USE ONLY	
	Worker Number	Verified By	
	Date	Date	Initials
	Worker Telephone Number ( )	Date	Initials
Initial Intake ☐ Yes ☐ No Redetermination ☐ Yes ☐ No			

SECTION I: Beneficiary Information

LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY					14-DIGIT MEDI-CAL NUMBER				
OHC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Co. Code	Aid Code	Medi-Cal ID Number Case Number	F BU	Pers. No.

SECTION II: Health Insurance Information

State Use Only
CC No.:

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
   Name: _____
   Address: _____
   City, State, ZIP: _____
2. Do you have to obtain medical services from a specific facility or a group of providers? ☐ Yes ☐ No
3. Where do you send your claims?
   Name: _____
   Address: _____
   City, State, ZIP: _____
4. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued? Include street number, city, state, and ZIP.
   Name: _____ Social Security Number: _____
   Address: _____ Telephone Number: _____
   City, State, ZIP: _____ Absent Parent? ☐ Yes ☐ No
5. What is the policy number? Policy Number: _____
6. What are the dates of insurance coverage? Beginning Date: _____ Ending Date: _____
   Check any that apply: ☐ Policy will lapse on _____ ☐ Policy lapsed on _____
   ☐ Medical coverage available through employer, but has not been applied for.
7. Premium Amount: $ _____ ☐ Month ☐ Year
   How are premiums paid? ☐ By Insured to Insurance Carrier ☐ By Employer ☐ By Payroll Deduction
8. Policy Type: Give name of union, employer, group, organization, or school, address, and phone number. Include group or local number.
   Name: _____ Local or Group Number: _____
   Address: _____ Telephone Number: _____
   City, State, ZIP: _____
9. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? ☐ Yes ☐ No
   If yes, please specify the illness: _____
10. Type of Coverage: Does your health insurance provide or pay for: (Check all that apply.)

    State Use Only
    Scope: ___ ___

    ☐ Hospital stays ☐ Prescription drugs ☐ Medicare Supplement
    ☐ Hospital outpatient (i.e., lab work/physical therapy) ☐ Dental care ☐ Only specific illness (i.e., cancer)
    ☐ Doctor visits ☐ Vision care ☐ Type of illness: _____
11. Has your health insurance policy been terminated due to work-related disability or accident? ☐ Yes ☐ No
    Injury Date: _____ Policy Termination Date: _____

"By signing this document, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Signature of Applicant	Home Telephone	Work Telephone	Date
	( )	( )	

RETURN COMPLETED FORM TO: RECOVERY BRANCH, P.O. BOX 1287, SACRAMENTO, CA 95812-1287