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

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

April 22, 1991
Letter No: 91-38

TO: All County Welfare Directors
All County Administrative Officers

SUBJECT: COST AVOIDANCE PHASE III

The purpose of this letter is to inform the counties of the changes that will occur once the State's Cost Avoidance Phase III is implemented, and to let counties know how it will affect existing Other Health Coverage (OHC) procedures.

Background

Federal legislation enacted in 1985 required all State Medicaid programs to convert to a cost avoidance method of paying claims for beneficiaries having private health insurance coverage. Phase III is the final stage of California's implementation of the federal mandate.

From the outset of Phase III development, two constraints were placed upon the project goals: one, claims for recipients with limited insurance coverage would not be cost avoided unless a method was developed to identify the scope of coverage; and two, county processes and systems be impacted as little as possible. In review of the project goals, it became apparent that the existing level of data processing support to the health insurance function was inadequate. Phase III therefore contains significantly upgraded data processing capabilities. The following is a description of Phase III and its impact on county and Medi-Cal Eligibility Data Systems (MEDS) activities.

OHC Codes on MEDS and on the Medi-Cal Card

The Department developed the Health Insurance System (HIS) to store the scope of coverage information, to report insurance information to the fiscal intermediary, Electronic Data Systems (EDS), and to provide more system support to the Other Coverage Section (OCS). OHC code updates to MEDS will be relayed to the HIS, and changes to OHC information on the HIS will create OHC code update transactions to MEDS. Updates to both files will be applied nightly.

HIS stores the health insurance billing information and scope of coverage codes so the information can be printed on the newly redesigned Medi-Cal card and provided to EDS for claims processing. The codes will advise providers which service categories are covered by the recipient's insurance.

Claims Processing

In order to cost avoid claims for recipients with limited insurance coverage, EDS has modified the OHC cost avoidance edits to focus only on those services actually covered by the recipient's insurance, using scope of coverage codes to identify the covered health care services. These modifications to the system will be installed in April.

Recipients previously identified on MEDS and Medi-Cal Cards as having either cost avoidance or pay and chase health coverage will continue to be identified with only their OHC code when scope of coverage information is not available to the State. Until the scope of coverage can be identified, providers must continue to bill the health insurance carrier for all services when the OHC code is a cost avoidance code. When a recipient is identified with a pay and chase OHC code, providers are encouraged, but not required, to bill the other health insurance carrier prior to billing Medi-Cal.

Once Phase III begins, recipients who are known to have either cost avoidance or pay and chase codes but whose scope of coverage is not available in State files will be sent a form asking them to list the type of services their insurance policy covers. When the form is completed and returned to the Department, OCS staff will enter scope of coverage codes onto the new MEDS-linked HIS. For all beneficiaries whose scope of coverage has been coded, providers will then be required to bill the other insurance carrier before billing Medi-Cal for those services included in the scope of coverage. Claims for services not within the scope of coverage may be billed to Medi-Cal as though the recipient had no insurance available. Federal exemptions to cost avoidance (pre-natal and preventive pediatric services and cases involving IV-D (child support) enforcement) will still be in effect.

Enclosed is the text of the Provider Bulletin which will be released by EDS announcing these changes to Medi-Cal providers.

County Responsibilities

There are no significant changes to county responsibilities or procedures. Counties will continue to obtain OHC information from recipients during the initial intake and redetermination process. Counties will continue to code MEDS with the appropriate one digit OHC code using instructions in All County Welfare Directors Letter 88-92 and send the completed Health Insurance Questionnaire (DHS 6155) to the Department at least weekly, so that scope of coverage can be defined as quickly as possible. It is very important that counties use the revised DHS 6155 (revision date 5/89 or later) because these forms have a question asking for the scope of insurance coverage. Since scope of coverage information is vital to Phase III implementation, county staff must make sure that recipients complete question 10 on the form.

With Phase III implementation, scope of coverage coding will apply to all OHC recipients. Counties will continue to assign a pay and chase code ("A", "M", "X", or "Z") to individuals with fewer than three of the four major service categories. The pay and chase code will be changed on MEDS to a cost avoidance code once the Department receives the DHS 6155 and OCS staff enter scope of coverage codes to the HIS record. Replacement of the pay and chase code with a cost avoidance code when scope of coverage has been entered is a correct procedure under Phase III implementation even for partial coverage policies. Counties are not to change the cost avoidance code back to the original pay and chase code.

Counties will continue to update the MEDS OHC code and to issue replacement cards when recipients, including Supplemental Security Income/State Supplemental Payment (SSI/SSP) recipients, report changes to their insurance coverage. County MEDS updates which delete the OHC code will also deactivate the insurance information on HIS and discontinue OHC related claims processing activities. Counties should request corrections to recipient's scope of coverage, policy number, or insurance billing information by either submitting a corrected DHS 6155 or by calling the Department of Health Services' OCS directly at 1-800-952-5294.

Department of Health Services' Functions

Department implementation of HIS and related functions is scheduled to begin in April. The Department's OCS staff have been coding scope of coverage from the DHS 6155s received since July 1990. This information may begin to appear on the Medi-Cal cards as early as June. Recipients whose scope of coverage has not been identified will be contacted by mail over the next few months.

Enclosed is a summary of county and State procedures under Phase III.

If you have any questions regarding Phase III of cost avoidance, please contact Shar Schroepfer of the Health Insurance Unit at (916) 739-3275, ATSS 497-3275.

Sincerely,

ORIGINAL SIGNED BY

FRANK S. MARTUCCI, CHIEF
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Summary of Cost Avoidance, Phase III Procedures

- Counties will continue to identify Other Health Coverage (OHC) during initial intake and redetermination process.

- When OHC is identified, the beneficiary must fill out a Health Insurance Questionnaire (DHS 6155, Revision Date 5/89, or later). Scope of coverage must be identified for all private health insurances. (Question number 10 on the Health Insurance Questionnaire addresses scope of coverage).

- Counties will continue to code the Medi-Cal Eligibility System (MEDS) with the appropriate one-digit OHC code.

- Counties will continue to send DHS 6155s to the Department of Health Services (DHS) on at least a weekly basis.

- When the Department receives the completed DHS 6155, DHS staff will enter insurance information and scope of coverage codes to the Health Insurance System (HIS).

- Once the scope of coverage codes are entered into HIS by the Department, the MEDS OHC pay and chase code will be converted to a cost avoidance code. This OHC code change is correct. Counties are not to change the code back to a pay and chase code.

- When a change to the scope of coverage, policy number, or insurance billing information is necessary, counties should request corrections by either submitting a corrected DHS 6155 or by calling the Department of Health Services' Other Coverage Section directly at 1-800-952-5294.

Text of Provider Bulletin

Other Health Coverage Identification and Billing Procedures Revised

Medi-Cal Other Health Coverage (OHC) identification and billing procedures will be revised in the next few months to better define a recipient's health insurance coverage, refine claims processing when health insurance is involved, and make more insurance information available to providers.

Current Requirements

Under current other coverage billing requirements, providers must bill the recipient's other health insurance carrier for all services before billing Medi-Cal (cost avoidance). Proof of insurance billing is required even when the service is not a benefit of the recipient's policy.

Recipient Scope of Coverage--Revision Effective April 1, 1991

Beginning April 1, 1991, the claims processing system will be changed to include scope of coverage information provided by the recipient at the time of enrollment for Medi-Cal. Beginning in April 1991, the eligibility system will be changed to provide scope of coverage information to the claims processing system. The other coverage requirements (i.e., the requirement that a denial or proof of partial payment from the insurance carrier be included with the Medi-Cal claim) will then apply only to the service categories reported by the recipient as being covered by the insurance policy. When a recipient's scope of coverage information is not available to the Department of Health Services (DHS), the other coverage billing requirements will apply to all services.

Medi-Cal ID Cards--Revision Effective in May 1991

Shortly after the implementation of the redesigned Medi-Cal card, a new OHC scope of coverage code (when available) will be printed on the Medi-Cal ID card. This code, designated as "COV" on the address portion of the card, is a series of alpha indicators that describe the scope of the recipient's private health insurance. The scope of coverage service categories are based on the Medi-Cal claim types.

The scope of coverage codes (COV) and service categories are:

COV Code	Service Category	Claim Type
P	Prescription Drugs/Medical Supplies	01
L	Long Term Care	02
I	Hospital Inpatient	03
O	Hospital Outpatient	04
M	Medical and Allied Services	05
V	Vision Care Services	07
D	Dental Services	Not Applicable to EDS Claims

When the scope of coverage information is not available, the message "COMPREHENSIVE" will be printed on the Medi-Cal card. Therefore, providers should bill the other carrier prior to billing Medi-Cal for all services.

Billing Procedures

Providers should refer to both the other health coverage "O/C" code and scope of coverage codes "COV" indicated on the card to determine when other coverage billing is required prior to billing Medi-Cal. If the recipient's Medi-Cal card contains an other coverage code and the services being requested fall within the recipient's scope of coverage, the provider must first bill the other coverage before billing Medi-Cal. If the recipient's Medi-Cal card contains a PHP/HMO

code and the service being requested falls within the scope of coverage, the provider must refer the recipient to the health plan for treatment.

If the service is not within the scope of coverage, the provider may bill Medi-Cal as though the recipient had no insurance at all. However, when the recipient's card is coded with a non-restricted O/C code (A, M, X, Y or Z), providers are encouraged, but not required, to bill the other coverage prior to billing Medi-Cal.

Recipients whose ID cards have errors in either COV or O/C code should be referred to the County Welfare Department for corrective action.

Explanation of Benefits (EOB)

Beginning in April 1991, when a claim is denied because the other coverage was not billed before Medi-Cal, information regarding the recipient's other coverage will be included on the EOB. If available, the information will include the insurer's name and billing address as well as the social security number of the policy holder. This information will assist providers in billing the other carrier.