

**California Department of Alcohol and Drug Programs
Questions & Answers Regarding Billing Drug Medi-Cal
for Patients Who Have Other Health Coverage
(Updated April 8, 2011)**

Federal Medicaid and California Medi-Cal laws and regulations

The basic federal law on billing Other Health Coverage (OHC) is the Social Security Act, Title 19, Section 1902(a)(25). The basic regulations on billing OHC are in Title 42 of the Code of Federal Regulations, Sections 433.138 and 433.139.

In addition to these, there are other federal laws and regulations related to billing OHC. Documents containing these federal laws and regulations can be found on the website for the Centers for Medicare & Medicaid Services (CMS), www.cms.gov. From the home page, follow these steps:

- Select “Medicaid” on the left side of the page
- Select “Third Party Liability”
- Select “Summary of Federal Statutory Requirements”
- Select “Summary of Federal Regulatory Requirements”
- Select “Summary of State Plan Requirements”

The last bullet above means the Medicaid State Plan. California administers its Medi-Cal Program through a Medicaid State Plan submitted to CMS.

The State regulation on billing OHC is the California Code of Regulations, Title 22, Section 51005. The basic State laws on billing OHC are found in the Welfare and Institutions Code, Sections 14005, 14023.7, 14024, and 14124.90. Other State laws on billing OHC are listed in the California Code of Regulations, Title 22, Section 51005 after item (e).

Questions from Counties/Service Providers and ADP Answers

1. **Q:** A letter from the OHC (Kaiser Foundation Health Plan) states that the patient did not have health coverage through the OHC on the date services were provided. Is this an acceptable denial reason? The patient has no other health care coverage.

A: *The letter provides the appropriate support for billing Drug Medi-Cal (DMC). The letter states that the client does not have other health coverage from Kaiser. If you have confirmed with the client that he/she does not have coverage through another OHC, then you can submit your claim to DMC. Please keep the OHC (Kaiser) letter on file to support the DMC billing.*

2. **Q:** In the past, we were required to bill ADP for DMC within 30 days from the date of service. Regarding clients who have OHC, do we still need to enter services within the 30-day window and somehow suppress them so we do not bill for DMC before we get OHC denial/payment? The alternative would be not to enter the client services until we get OHC denial/payment. Is this acceptable?

A: *A county or service provider (county/provider) must submit DMC claims to ADP within 30 days of the date of service. This is in accordance with the California Code of Regulations (CCR), Title 22, Section 51490.1. However, a county/provider may submit a DMC claim after 30 days if there is good cause for late submission, as defined in CCR, Title 22, Sections 51008 and 51008.5. Delays resulting from billings to OHC are circumstances that constitute good cause for late submission; but such billings must be submitted not later than one year after the month of service (see CCR, Title 22, Section 51008.5(a)(2)). Late billings with applicable good cause must use the appropriate delay reason code found on ADP's website (www.adp.ca.gov). Click on "Drug Medi-Cal Billing" and then select "Good Cause Certification - ADP 6065A (instructions) rev 3-4-10."*

3. **Q:** There are two reasons for denial acceptable to the Department of Health Care Services (DHCS) for DMC reimbursement for clients who have OHC. If the provider goes online to the private insurance carrier for a specific client, prints out documentation showing the client name, subscriber ID, effective and end dates, insurance carrier information AND policy information that indicates substance abuse in-network and out-of-network services are "not covered," is this acceptable to submit as proof of denial under "The specific service is not a benefit of the OHC" reason?

A: *We consulted with DHCS, the lead agency for administering California's Medicaid (Medi-Cal) Program, to answer this question. According to DHCS, this is not an acceptable proof of denial of coverage. If a beneficiary is coded as having OHC, then a notice or denial letter from the Medi-Cal beneficiary's OHC carrier must be obtained prior to billing DMC.*

4. **Q:** We are working on some denials where the claim was rejected because "Non-Medicare coverage not billed first." It is our understanding that Medicare is not required for ADP clients. However, one of our billers asked about Medicare HMO. For instance, clients receive services at Kaiser through a Medicare Risk HMO. Specifically, these clients have an "F" in the QM screen on State MEDS system. Why are these coming back as "Non-Medicare coverage" when they are a Medicare Risk HMO? Most of these are from a few months ago. Is this something that may have been changed? Should we resubmit as a replacement? ADP Bulletin #11-01 addresses HMO eligible and benefits, but not Medicare HMO Risk. Is there another letter that addresses Medicare HMO Risk?

A: *The problem appears to be that a Drug Medi-Cal (DMC) claim is being submitted without billing the OHC first. Therefore, the DMC claim is being denied. The solution is to bill the OHC before billing DMC.*

Medicare beneficiaries have the option to receive Medicare medical benefits through private health insurance plans, instead of directly from Medicare. These private plans are known as Medicare Advantage plans. Examples of such plans are Medicare HMO, Medicare Risk HMO, or Medicare Preferred Provider Organization (PPO) plans. The services for such a plan could be provided by an HMO such as Kaiser.

Medicare subsidizes these Medicare Advantage plans to reduce a beneficiary's out-of-pocket medical expenses. Medicare pays the private health plan a set amount every month for each member. The beneficiary usually pays a monthly premium for the plan, and pays a co-payment and/or coinsurance for covered services. These private plans are required to offer a benefit package that is at least as good as Medicare's. They are required to cover everything that Medicare covers, and may cover services that Medicare does not cover. The federal Centers for Medicare and Medicaid Services (CMS) determined that the services provided within DMC are categorically not covered by Medicare. As a result, when the service provider provides DMC services to a Medicare-eligible client, that service provider may bill DMC directly and is not required to bill Medicare before billing DMC. However, the CMS determination does not apply to the various private Medicare Advantage plans that are available. As Medicare Advantage plans may cover services that Medicare does not cover, the State is not free to allow service providers to bill DMC directly without billing the Medicare Advantage plans first.

When the beneficiary notifies the county that he/she has a Medicare Advantage plan, the beneficiary is coded in the Medi-Cal Eligibility Determination System (MEDS) with an Other Health Coverage (OHC) code of "F". MEDS recognizes the beneficiary as having OHC as a substitute for traditional Medicare coverage. If a service provider submitted a DMC claim for such a beneficiary, the Short-Doyle/Medi-Cal claim processing system would assess whether the OHC (i.e., Medicare Advantage plan) was billed first before paying the DMC claim. If the system does not detect the OHC billing, the DMC claim would be denied. The solution is for the service provider to consider the Medicare Advantage plan an OHC (e.g., Medicare HMO, Medicare Risk HMO, Medicare PPO) and bill DMC similar to how it bills DMC for any other beneficiary having OHC. ADP Bulletin #11-01 provides instructions for billing DMC for beneficiaries having OHC.

Normally, when a service provider provides a substance use disorder service to a Medicare beneficiary, that service provider does not need to bill Medicare first before billing DMC. However, the "F" code in the beneficiary's MEDS record recognizes the Medicare beneficiary as having OHC, and requires the service provider to bill the OHC before billing DMC.

ADP Bulletin #11-01 does not address these Medicare Advantage Plans; however, we will provide updates on the subject in our next bulletin.

5. ADP Bulletin #11-01 states that there are only two denial reason codes:

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

Service providers have received a number of different denial reasons from various OHC insurance companies. Following are questions and answers about whether each of these can be interpreted as a legitimate denial and how to submit the claim to DMC.

Note: If the OHC carrier's denial notice is unclear, the county/provider should seek clarification of the denial notice by contacting the OHC carrier. After contacting the OHC carrier, if the county/provider confirms that the denial notice means the beneficiary did not have OHC on the date of service; the beneficiary's OHC has been exhausted, or the specific service is not a benefit of the OHC, then the county/provider may bill DMC and include the information regarding the OHC denial.

Q: "Client unidentified," "Client cannot be found in database," "Client not known to provider" – after exhausting every effort to identify the client, can the county assume the client is not eligible for OHC and bill Medi-Cal?

A: *The county/provider must clarify the identification problem with the OHC carrier and, if necessary, seek the client's help. After contacting the OHC carrier, if the county/provider determines that the beneficiary does not have OHC, then the county/provider may submit the DMC claim and include the information regarding the OHC denial.*

Q: "Member Termed" before service date – can this be interpreted as coverage has been exhausted?

A: *After contacting the OHC carrier, if the county/provider confirms that "Member Termed" means that the client no longer has OHC, then the service provider may submit the DMC claim and include the information regarding the OHC denial.*

Q: Timeliness -- if the OHC company refuses to pay because the bill was received too late, can the county still bill Medi-Cal?

A: *Under this circumstance, the county should not bill Drug Medi-Cal. An untimely claim to the OHC carrier does not allow the OHC carrier the opportunity to deny the claim under its normal claim processing timeline. The county/provider should adjust its claim processing procedures to conform to the OHC carrier's timeline.*

Q: Billed code is mutually exclusive or incidental to primary procedure billed – the insurance company will only pay for one service per day. If the client received two services (i.e., an individual treatment and methadone dosage on the same day), can the county bill Medi-Cal for the service that was not paid?

A: *After contacting the OHC carrier, if the county/provider confirms that the OHC carrier will only pay for one service per day, then the service provider may bill the other service to DMC. It is only by contacting the OHC carrier that the question can be answered and a solution determined. The problem could relate to a billing code rather than an interpretation that the OHC carrier will only pay for one service per day.*

Q: Patient did not have health coverage through health plan on dates provided – can this be interpreted as a denial and bill Medi-Cal?

A: *After contacting the OHC carrier, if the county/provider confirms that the client does not have OHC, then the service provider may submit the DMC claim and include the information regarding the OHC denial. It is the county's responsibility to assure that correct, current information about the OHC is on file with the State for Medi-Cal beneficiaries in accordance with the California Code of Regulations, Title 22, Section 50765.*