



State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

DATE: December 06, 2022

ALL PLAN LETTER 22-027
SUPERSEDES ALL PLAN LETTER 21-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH 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 managed care health plans (MCP) for cost avoidance and post-payment recovery requirements when an MCP Member has other health coverage (OHC). The APL also provides instructions on using the Department of Health Care Services' (DHCS) Medi-Cal Eligibility Record for processing claims, as well as reporting requirements. In addition, this APL provides a reference to APL 21-003 which outlines specific notice and submission requirements due to a significant change in the MCP's contracting arrangements with Network Providers and/or Subcontractors.

BACKGROUND:

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

¹ Welfare and Institutions Code (WIC) section 14124.90 is available at:
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14124.90.

² Title 22 of the California Code of Regulations (CCR), section 50763(a)(3). CCRs are searchable at:
[https://govt.westlaw.com/calregs/Document/1B1B147B0D4B811DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/1B1B147B0D4B811DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)).

third party is liable.³ This requirement is referred to as post-payment recovery and extends to MCPs. MCPs 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 services from the liable third party. Additional information detailing private health care coverage requirements are further defined in state law and the MCP contracts.^{4, 5}

POLICY:

1. Using the Medi-Cal Eligibility Record for Processing OHC Claims

- MCPs should rely on the Medi-Cal Eligibility Record for cost avoidance and post-payment recovery purposes.
- MCPs 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

- MCPs 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 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. MCPs 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 Batch updates regarding OHC information are processed by DHCS on a weekly basis. MCPs can contact their Managed Care Operations Division (MCO) Contract Manager for more information regarding this process.

³ Social Security Act section 1902(a)(25) is available at:
https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

⁴ WIC section 10022 is available at:
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=10022.&lawCode=WIC.

⁵ The MCP boilerplate contract is available at:
<https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

⁶ The OHC Removal and Addition forms are available at: <http://dhcs.ca.gov/OHC>.

⁷ Batch processing (multiple additions/removals at a time) is done via weekly submission of an HI-36 Excel spreadsheet. Contact your Managed Care Operations Division (MCO) contract manager for the HI-36 template and instructions on how to complete it.

- Beginning January 1, 2022, MCPs 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 MCPs on a monthly basis. Prior to January 1, 2022, MCPs 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, MCPs must ensure Providers review the Medi-Cal Eligibility Record for the presence of OHC. If the Member has active OHC, MCPs must ensure Providers compare the OHC code (Appendix A) to the requested service. If the requested service is covered by the OHC, MCPs must ensure Providers instruct the Member to seek the service from the OHC carrier.
- Regardless of the presence of OHC, MCPs must ensure Providers do not refuse a covered Medi-Cal service to a Medi-Cal Member.¹⁰
- Effective February 9, 2018, in accordance with federal law, prenatal care is subject to cost avoidance.¹¹ In cases where prenatal service billing is bundled with claims for other services, MCPs must ensure Providers cost-avoid the entire claim.
- MCPs must not process claims for a Member whose Medi-Cal Eligibility Record indicates OHC, other than a code of A or N, 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. For more information regarding direct bill services, please refer to the list of direct bill Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes.¹²
- 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

⁸ The Medi-Cal Online Eligibility Portal is available at: <https://www.medi-cal.ca.gov/Eligibility/Login.aspx>.

⁹ The Health and Human Services Open Data Portal is available at: <https://data.chhs.ca.gov/dataset/aevs-carrier-codes-for-other-health-coverage>.

¹⁰ Title 42 U.S. Code section 1396a(a)(25)(D) is available at: <https://www.law.cornell.edu/uscode/text/42/1396a>.

¹¹ Section 53102 of the Bipartisan Budget Act of 2018 is available at: <https://www.congress.gov/bill/115th-congress/house-bill/1892/text>.

¹² The full list of direct bill CPT and HCPCS codes is available at: <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/othhlthcpt.pdf>.

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.

- If disputes require MCPs to change contracting arrangements with Network Providers and/or Subcontractors that are deemed significant in accordance with APL 21-003, MCPs must meet notification and reporting requirements as specified.

4. Post-Payment Recovery

- MCPs must engage in post-payment recovery if OHC is discovered retroactively, or the Member had an OHC indicator code of A on their Medi-Cal Eligibility Record at the time of service.
- For the purpose of post-payment recovery, the reasonable value of the services is the average payment the MCP pays for similar services in the particular service area, but in no event less than the Medi-Cal fee-for-service payment rate for the services rendered.
- MCPs 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.
- MCPs 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 April 1, 2021, MCPs 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).
- At least one post-payment recovery test file needs to be submitted by March 10, 2021. This allows both parties to test the reporting process and resolve any issues prior to the April 1, 2021, deadline.
- The test file should contain ten line items and must be in the layout outlined in Appendix B.
- On a monthly basis, MCPs 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).

- Beginning March 1, 2023, MCPs must include the check or electronic fund transfer (EFT) control number under row “V”, field name “Filer” for all related Transaction Control Numbers on the monthly Appendix B report.
- MCPs are not required to produce retroactive Appendix B reports inclusive of the check or EFT control number for payments submitted prior to March 1, 2023.
- MCPs 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

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP’s contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its MCOD contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its contractually required P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP’s P&Ps 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.

MCPs 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.¹³ These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

¹³ For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.