STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
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June 7, 1993

MEDI-CAL ELIGIBILITY MANUAL LETTER NO: 116

TO: Holders of the Medi-Cal Eligibility Manual
All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Enclosed are revisions to the procedures portion of the Medi-Cal Eligibility Manual, Article 15A. The following descriptions identify the reason for each revision or addition. Listed are All County Welfare Directors (ACWD) Letters which may be discarded:
82-08, 83-77, 84-50, 86-35, 86-40, 86-49, 86-58, 87-04, 87-12, 87-20, 87-27, 87-28, 87-44, 87-57, 87-58, 88-07, 88-17, 88-53, 88-79, 88-92, 89-22, 89-25, 89-26, 89-30, 89-36, 89-37, 89-49, 89-64, 89-73, 89-89, 90-09, 90-10, 90-21, 90-28, 90-35, 90-36, 90-49, 90-70, 90-88, 91-12, 91-21, 91-35, 91-38, 91-59, 91-60, and 91-68.

Procedure Revision		Description
1.	Article 15A	Identifying, Reporting, and Coding Other Health Coverage - revised to remove outdated language and to provide current information of the process.

Filing Instructions

Remove Pages:	Insert Pages:
Article 15 Table of Contents First Page	Article 15 - Table of Contents First Page Second Page
15A-1 - 15A-10	15A-1 - 15A-14

If you have any questions concerning these revisions you may contact Steve Yien at (916) 323-9523.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Article 15 -- OTHER HEALTH COVERAGE AND MEDICARE BUY-IN COVERAGE

15A -- IDENTIFYING, REPORTING AND CODING OTHER HEALTH COVERAGE

1. Background and Overview
2. Definition of Other Health Coverage
3. Types of Other Health Coverage That Must Be Reported
4. Types of Coverage/Benefits and Situations When Other Health Coverage Should Not Be Reported
5. County Responsibilities for Identifying Other Health Coverage (OHC)
6. Reporting Other Health Coverage Information - County and Applicant/Beneficiary Responsibilities
7. Coding Other Health Coverage Information on the Medi-Cal Eligibility Data System
8. Scope of Coverage
9. Current and/or Prior Month Changes to Other Health Coverage Codes
10. Medi-Cal Eligibility Data System On-Line Other Health Coverage Code Override Process
11. Replacement Card Issuance with Corrected Scope of Coverage Codes
12. Beneficiary and County Welfare Department Inquires Regarding Other Health Coverage

15B -- MEDI-CAL CASUALTY CLAIMS

15C -- RECOVERY OF VETERAN'S AID AND ATTENDANCE BENEFITS

15D -- MEDICARE GENERAL INFORMATION

15E -- AGED ALIENS INELIGIBLE FOR MEDICARE

1. Background
2. County Procedures -- County-Determined Eligibles
3. State and County Procedures -- SSI/SSP Eligibles

15F -- BUY-IN AND MEDICARE

15G -- MEDICAL SUPPORT PROGRAM

15A IDENTIFYING, REPORTING AND CODING OTHER HEALTH COVERAGE (OHC)

This section provides information and procedures regarding identifying, reporting and coding of Other Health Coverage (OHC). Eligibility workers code OHC on the Medi-Cal Eligibility Data System (MEDS) and issue the Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) during each application and redetermination interview when applicant or beneficiary responds with a positive answer to the Other Health Coverage Question on the Aid to Families with Dependent Children (AFDC) Statement of Facts Supporting Eligibility for Assistance form (SAWS 2) or Statement of Facts form (MC 210). Form DHS 6155 is used by county Welfare Offices to report Other Health Coverage to the Department of Health Services (DHS) for inclusion on the Health Insurance System (HIS).

1. Background and Overview

The Department of Health Services is responsible for ensuring that Medi-Cal is the payor of last resort for medical care used by Medi-Cal eligibles in accordance with State Statute Welfare and Institutions Code Section 14124.90) and Federal Law (Section 1902(a) (25) of the Social Security Act). State laws (Welfare and Institutions Code, Sections 10020, 14000, 14003, 14005, 14016.3, and 14024) require Medi-Cal beneficiaries (OHC) to report and utilize these resources before using Medi-Cal. In instances where Medi-Cal has paid for a beneficiary's medical care first, these laws also require the program to seek reimbursement from the responsible third party.

Since the Medi-Cal Program is prohibited by federal law from paying for services which are covered by the beneficiary's health insurance or health plan, in most instances, providers must bill the appropriate carrier before billing Medi-Cal. This is called cost avoidance. If a beneficiary is enrolled in a private Prepaid Health Plan/Health Maintenance Organization (PHP/HMO), the beneficiary must be directed to his or her respective plan for treatment. Medi-Cal is not obligated to pay for services available through a PHP/HMO plan when the beneficiary chooses to seek treatment elsewhere.

In limited instances, a provider may bill the Medi-Cal program directly even though a beneficiary has OHC. The Department of Health Services then recovers the Medi-Cal payment from health insurance carriers using the State's automated billing system.

2. Definition of Other Health Coverage

Other Health Coverage (OHC) is defined as benefits for health related services or entitlements for which a Medi-Cal beneficiary is eligible under any private, group, or indemnification insurance program, under any other State or federal medical care program, or under other contractual or legal entitlement.

3. Types of Other Health Coverage That Must Be Reported

Insurance policies on the following list provide Other Health Coverage benefits. A Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) must be completed to identify the health coverage source and scope of coverage for these insurance types.

a. Cancer Only -- Policies that cover medical expenses related to cancer treatment only.

b. CHAMPUS -- The Civilian Health and Medical Program of the Uniformed Services pays for care delivered by health providers to retired members and dependents of active and retired members of the Armed Forces under 65.

c. Dental Only -- Policies that cover expenses related to dental work.

d. Employment-related Health Insurance -- Health insurance provided to employees and their dependents. This could include health insurance through union membership or membership in a national organization, fraternity or trust fund.

e. Employee Retirement Income Security Act (ERISA) Trusts -- Any health insurance that is offered through a trust fund operated by an employer under the authority of the U.S. Department of Labor (e.g., Carpenters, Pipefitters, Plumbers, Laborers, etc.).

f. Group Health -- Policies that provide health benefits to persons employed by or affiliated with an entity such as an employer, union, association or organization.

g. Health -- Policies that cover hospital expenses, surgical expenses, routine medical expenses, or major medical.

h. Hospital -- Policies that cover expenses incurred during hospitalization.

i. Indemnity -- Policies that pay benefits in the form of cash payments. These benefits are paid to the insured instead of the provider or services.

j. Long Term Care -- Policies that cover long term care expenses (e.g., custodial care, intermediate care, skilled nursing care).

k. Major Medical -- Policies that cover medical expenses over and above those expenses covered by a basic benefit plan.

l. Medical Support From Absent Parents -- An absent parent may be required to provide medical insurance premium payments or be responsible for a portion of medical bills, or, if employed, may be required to include dependent children in the medical insurance plan provided by the employer.

m. Medicare Supplemental -- Policies which pay that portion of medical services which Medicare does not pay.

n. Prepaid Health Plan/Health Maintenance Organization (PHP/HMO) -- Any health benefit plan which provides a wide range of comprehensive health care services for persons

insured by the policy or plan. Services are provided by plan designated providers at designated facilities.

o. Prescription -- Policies that cover prescribed drugs only.

p. Student Health -- Health insurance offered through an educational institution for enrolled students.

q. Surgical -- Policies that cover surgery-related expenses only.

r. Vision -- Policies that cover vision-related expenses only.

4. Types of Coverage/Benefits and Situations When Other Health Coverage Should Not Be Reported

The Department is specifically excluding the following coverage from the Other Health Coverage (OHC) coding requirements and/or reporting on a revision date 2/90 or later).

a. Accident Benefits.

b. Automobile, Burial, and Life Insurance benefits.

c. Casualty Workers Compensation benefits.

d. Disability benefits.

e. Medicare (Title XVIII benefits).

f. Veteran's Administration (VA) benefits.

g. Coverage under a PHP/HMO which has contracted with the Department to provide Medi-Cal services to enrolled beneficiaries. (Medi-Cal Capitated Health Plans)

h. Coverage which is considered unavailable in the following situations:

1. Coverage under any plan which is limited to a specific geographic service area and the beneficiary lives outside that area or the plan requires use of specified providers(s) and the beneficiary lives more than 60 minutes travel time from the specified provider(s). The beneficiary should be advised that many of these plans cover out of area care in emergency situations. In this situation, the beneficiary should provide OHC information to the emergency medical provider so that the provider may bill the plan before billing Medi-Cal.

2. Coverage to which a child may be entitled when:

a. The parent or guardian refuses to provide the necessary information due to "good cause". Good cause shall be determined by the county. Good cause exists when cooperation in securing medical support and payments, establishing paternity, and obtaining or providing information concerning liable or potentially liable third parties from the absent parent can be reasonably anticipated to result in serious physical or emotional harm to

reasonably anticipated to result in serious physical or emotional harm to the child for whom support is to be sought or to the parent or caretaker which whom the child is living, or;

b. The absent parent cannot be located; and

c. The custodial parent or guardian would be in a separate Medi-Cal Family Budget Unit (MFBU) from the child if he/she were also applying for Medi-Cal.

3. Any coverage to which a child may be entitled in those instances where the child is applying for minor consent services in accordance with California Administrative Code, Title 22, Section 50147.1. The obligation to report and utilize OHC before using Medi-Cal coverage is not enforced in this situation, since utilization of OHC would violate the minor's right to confidentiality regarding his/her medical services.

5. County Responsibilities for Identifying Other Health Coverage (OHC)

a. **Review Statement of Facts:**

Review the applicant's/beneficiary's MC 210 or CA 2 to determine if there is a positive response to the question about having private health or hospitalization insurance. If there is a positive response, go to procedure b. If there is no positive response to having private health insurance, but the applicant/beneficiary was recently employed, retired, serves in the military, or there is an absent parent or current spouse, proceed to procedure b.

b. **Ask Questions to Identify OHC:**

Based on a review of the Statement of Facts, ask key questions for identifying the availability of OHC, such as:

- **If the applicant is over age 65:**

  Do you have Medicare coverage?

  Do you have health insurance in addition to Medicare?

  What type of supplemental health insurance do you have, in addition to Medicare?

- **To explore other insurance possibilities related to education:**

  Are you enrolled in any educational program?

  (If so --) Do you have health insurance through a student health plan?

  Is the spouse or absent parent enrolled in any educational program?

  (If so --) Does he/she have health insurance through a student health plan?

  (If so --) Are the children also covered?

- **To explore work-related health insurance**:

  Does (did) your employer provide a health insurance plan?

  (If a former employer provided health insurance --) Did you continue the health insurance plan on your own after leaving your last employer?

  Does (did) your union provide a health insurance plan?

  Does (did) your spouse's or absent parent's employer provide health insurance coverage for you and/or your children?

  Do you belong to any national organization?

  (If so --) Does that organization provide health insurance for you and/or your children?

- **To explore military**:

  Were you ever in the military? (Do not assume that only men have serviced in the military!)

  Was your spouse or absent parent ever in the military?

c. **Inform Applicant/Beneficiary**:

1. **Reporting OHC Does Not Affect Medi-Cal Eligibility**:

   Inform applicants/beneficiaries that having and reporting OHC does not in any way interfere with their eligibility for or use of Medi-Cal benefits. Under federal law Medi-Cal providers cannot deny care because a beneficiary has OHC.

2. **Do Not Advise Applicants/Beneficiaries To Drop OHC**:

3. **Responsibility To Report And Apply For/Retain Employer Related Health Coverage Benefits**:

   Advise applicants/beneficiaries that federal law requires an individual, as a condition of Medi-Cal eligibility (in order to become or remain Medi-Cal eligible), to report employer related health insurance benefits available to him/her. The Medi-Cal program may pay the health coverage premiums if it is determined cost-effective. Forward any information obtained from applicants/beneficiaries with available employer related health benefits to the Department's Health Insurance Premium Payment program for review of cost-effectiveness (refer to Procedure Manual, Article 15, Section 15H - Health Insurance Premium Payment Program).

4. **Responsibility To Report and Repay Medi-Cal For Insurance Payments Received**:

   a. Forward reimbursement payments to:

      Department of Health Services
      Third Party Liability Branch
      P.O. Box 671
      Sacramento, CA 95812-0671

   b. Beneficiaries should endorse checks from insurance carriers as follows:

      - Name of Payee -- Party to whom the check is made payable. Signed either by the payee or their agent.
      - Medi-Cal Identification Number of Beneficiary -- This may be a different person than the one who received the check.
      - "For Deposit Only to Health Care Deposit Fund" -- This will ensure that the check will be properly applied to the State fund only.

   c. Beneficiaries must enclose with the check the date(s) of service, the provider's name, and a daytime phone number where they can be reached.

5. **Confidentiality for Minor Consent Services**:

   Inform applicants/beneficiaries for minor consent services that Medi-Cal will not report coverage nor bill private insurance carriers for such services provided to beneficiaries under 21 years of age who are receiving minor consent services. When a restricted Minor Consent service card is issued to a minor, the card should not be coded with an OHC code and OHC should not be reported on MEDS nor on a Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later).

6. Reporting Other Health Coverage Information - County And Applicant/Beneficiary Responsibilities

   County Responsibilities

   a. **Issuance of Health Insurance Questionnaire** (DHS 6155):

      If the applicant/beneficiary indicates, either on the statement of facts or verbally, that he/she has Other Health Coverage (OHC) , issue the Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later). The applicant/beneficiary completes the DHS 6155 for the types of coverage outlined in Section 15A (3. Types of Other Health Coverage That Must be Reported) for all members of the family unit with OHC. Help the applicant/beneficiary complete the form by asking if he/she has an insurance identification card or other materials that may contain the necessary information.

b. **Completion And Accuracy of The DHS 6155:**

Review the DHS 6155 for complete and accurate information.

- Check the accuracy of information, particularly numbers. Be sure to check the Social Security Numbers, birth dates, policy/group numbers and phone numbers. If possible, attach a copy of the policy or copy of the insurance card.
- Be sure the applicant's/beneficiary's name is listed, if covered, and are spelled correctly.
- Be sure the applicant's/beneficiary's complete address is provided.
- Be sure the insurance policy holder's name is provided and spelled correctly. This name may be different from the applicant's/beneficiary's name.
- Be sure the insurance policy holder's Social Security Number is provided.
- Provide complete and accurate eligibility worker information. This includes worker number and telephone number, including area code.
- Be sure the form is signed by the applicant/beneficiary and dated.

c. **Information On Scope of Coverage:**

When reviewing a completed DHS 6155, check the scope of coverage field, item 10, to insure this information is reported. If the applicant/beneficiary does not know the scope of coverage, request that he/she either review the policy or contact the insurance carrier to obtain this information. Scope of coverage information is essential in completing the DHS 6155 and must be provided. See Section 15A (8. Scope of Coverage) for more information about scope of coverage.

d. **Applicants/Beneficiaries With More Than One Insurance Policy:**

If the applicant/beneficiary has more than one insurance policy, provide him/her with a DHS 6155 to be completed for each carrier. This includes policies covering single services, such as dental only coverage and vision services.

e. **Code MEDS with the Appropriate OHC Code:**

Please refer to Section 15A (7. Coding Other Health Coverage Information on The Medi-Cal Eligibility Data System) for procedures.

f. **Batching and Mailing DHS 6155:**

Weekly, batch and mail the white copy of the DHS 6155 and any copies of health insurance identification cards or health insurance policies to:

Department of Health Services
Health Insurance Section
P.O. Box 1287
Sacramento, CA 95812-1287

g. **Retain the Yellow Copy of the DHS 6155**:

Retain a copy of the DHS 6155 form in applicant's/beneficiary's case file.

h. **Send the Pink Copy to DA or Beneficiary**:

Send the pink copy of the DHS 6155 to the DA's office in absent parent cases. Give it to the beneficiary when it is not an absent parent situation (refer to Procedure Manual, Article 15, Section 15G - Medical Support Program).

i. **Notify the Department of OHC Changes, Lapses in Coverage, or Changes in Scope of Coverage**:

When there has been a change to the scope of coverage, policy number, insurance billing information, or if the beneficiary's OHC has lapsed, will lapse or change, update MEDS with the corrected OHC code as needed. County Eligibility Workers (EWs) must send in corrected OHC information on a completed DHS 6155 or by calling the Department of Health Services Health Insurance Section at 1-800-952-5294 when:

1) OHC has changed or is obtained;

2) If reporting was not timely, but the county learns OHC has terminated or changed within 12 months prior to redetermination, ask beneficiary to complete a DHS 6155. Include the policy's termination date.

Inform beneficiaries that such information must be reported to the county within ten (10) days following the event.

Applicant/Beneficiary Responsibilities

a. **Report Current OHC Information to Counties**:

Applicants/Beneficiaries who have contractual or legal entitlement(s) to any health care coverage must disclose this information to the EW and must also provide specific health information to the health care provider so that the provider may bill the liable third party.

b. **Report Available OHC to Counties**:

Applicants/Beneficiaries are required to report the availability of employer related health benefits.

c. **Report OHC Changes to Counties**:

Applicants/Beneficiaries who change, terminate, or obtain OHC must report such information to the county within ten (10) days following the event.

d. **Report OHC Information to Providers**:

Applicants/Beneficiaries are required to provide current OHC billing information to the provider at the time medical/dental services is received. This information shall include group number and billing office address. Willful failure to provide such information may allow a provider to bill the beneficiary as a private pay patient.

7. Coding Other Health Coverage Information on the Medi-Cal Eligibility Data System

Eligibility Workers (EWs) must code Other Health Coverage (OHC) on the Medi-Cal Eligibility Data System (MEDS) at the time eligibility is determined or redetermined or at any time a beneficiary reports a change in coverage.

a. **Coding for No OHC**:

When an applicant/beneficiary states that he/she does not have OHC, enter the letter code "N" (No Other Health Coverage) on MEDS in the OHC field.

b. **Coding OHC**:

The following is a list of OHC codes and instructions on how to determine the appropriate OHC code to place on MEDS. In order to determine the appropriate code, the following questions should be asked at the application and redetermination interview once the applicant/beneficiary has reported OHC:

- Does your health insurance provide or pay for hospital in patient care?
- Does your health insurance pay for hospital outpatient care (e.g., emergency room visits, lab work, physical therapy)?
- Does your health insurance pay for doctor's visits?
- Does your health insurance pay for prescriptions?

1) **Cost Avoidance OHC Codes**:

If the applicant/beneficiary answers "yes" to at least three of the four questions listed above, enter the appropriate cost avoidance code on MEDS. Cost avoidance codes to use are:

B	Blue Cross
C	CHAMPUS
D	Prudential
E	Aetna
G	American General
H	Mutual of Omaha
I	Metropolitan Life
J	John Hancock
K	Kaiser
L	Dental Only Policies

P	PHP/HMO, not otherwise specified
Q	Equicor
S	Blue Shield
T	Travelers
U	Connecticut General (CIGNA)
V	Variable, any carrier not uniquely identified
W	Great West Life Insurance
2	Provident Life and Accident
3	Principal Financial Group
4	Pacific Mutual Life Insurance
5	Alta Health Strategies, Inc.
6	American Association of Retired Persons (AARP)
8	New York Life Insurance
9	Crown Life Insurance

(2) **Prepaid Health Plan/Health Maintenance Organization (PHP/HMO) Other Health Coverage Codes**:

If you determine from the questions above that an applicant/beneficiary requires a cost avoidance code, ask the beneficiary: "Do you have to obtain medical services from a specific facility or a group of providers?" If the applicant/beneficiary answer "yes", enter a PHP/HMO code on MEDS. If the applicant/beneficiary has Kaiser or CHAMPUS, assign a "K" or "C" code. Code any other PHP/HMO coverage with a "P", even though a unique cost avoidance code may exist for that carrier's fee-for-service coverage. For example, should an applicant/beneficiary have full coverage through Travelers Insurance, but coverage is limited to services provided by a specific group of professionals and hospitals, use the PHP/HMO code "P" instead of the cost avoidance code "T".

Medi-Cal beneficiaries covered by Kaiser, CHAMPUS, or other PHP/HMOs must use the designated facilities. Medi-Cal will reject bills for services provided to beneficiaries with cards coded "K", "C", or "P". Medi-Cal will pay for services only when the service is not a covered benefit under the designated plan. The service provider, however, must attach payment denial information from the plan indicating the service is not a covered plan benefit. This will generate an override in the claims payment system and allow payment to the provider.

Since the Department cannot obtain reimbursement from Kaiser, CHAMPUS, or other PHP/HMOs, the importance of the "K", "C", or "P" coding on the Medi-Cal card cannot be overemphasized.

Medi-Cal beneficiaries entitled to CHAMPUS benefits who live outside the CHAMPUS geographic service area can obtain health services from private providers and bill CHAMPUS for those services if they obtain a statement of non-availability from CHAMPUS.

(3) **Post Payment Recovery OHC Codes**:

If the applicant/beneficiary responds "yes" to fewer than three of the four questions

listed above, or if the applicant/beneficiary does not know the scope of coverage, enter the following post payment recovery codes:

A Other Coverage code for any insurance company;

M Multiple coverage; beneficiary has more than one insurance company (use only when companies are identified as post payment recovery codes).

(4) **Multiple Cost Avoidance or PHP/HMO Other Health Coverage:**

If an applicant/beneficiary has multiple (two or more) full coverage policies, one of which is a PHP/HMO, use the appropriate PHP/HMO code (K, C, or P). Otherwise, assign the appropriate cost avoidance code for the carrier that provides the most comprehensive coverage.

(5) **Dental OHC Code:**

If the applicant/beneficiary respond "no" to all four questions listed above, ask if he/she has an insurance policy for dental only coverage. If the applicant/beneficiary responds "yes" to having dental only coverage and he/she does not have any other health insurance policy, enter the cost avoidance code "L" (Dental Only Policies) on MEDS.

8. Scope of Coverage

Upon receipt of a Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later), the Department enters insurance billing information and scope of coverage codes onto the Health Insurance System (HIS). This information is printed on Medi-Cal cards. The scope of coverage information assists providers in determining which services must be billed to the beneficiary's insurance. The scope of coverage codes are as follows:

I	-	Hospital Inpatient Care
O	-	Hospital Outpatient Care
M	-	Medical/Doctor's Visits
P	-	Prescription Drugs
L	-	Long Term Care
V	-	Vision Care
D	-	Dental Care

When an EW initially assigns a post payment recovery code on the MEDS, the Department will changes it to a cost avoidance code upon receiving the DHS 6155 and entering the scope of coverage codes on HIS. Replacement of the post payment recovery code with a cost avoidance code when scope of coverage has been entered is a correct procedure. Counties are not to change the cost avoidance code back to the original post payment recovery code.

If Medi-Cal beneficiaries have health insurance, but the Medi-Cal program has not yet received information about the insurance coverage, the word "COMPREHENSIVE" will appear on Medi-Cal cards instead of scope of coverage codes. This designation "COMPREHENSIVE" alerts providers

to bill the other health insurance for all services provided.

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

9. Current and/or Prior Month Changes to Other Health Coverage Codes

1. **Current and/or Prior Month Changes for New Eligibles:**

If beneficiaries are initially eligible for Medi-Cal and are reported with a cost avoided insurance policy, counties may enter a cost avoidance code for current and/or prior months.

2. **Current and/or Prior Month Changes for Ongoing Cases:**

No cost avoidance Other Health Coverage (OHC) codes may be assigned to current and/or prior months for ongoing cases. The message M373 "ONLY PAY AND CHASE (POST PAYMENT RECOVERY) OTHER-COV ALLOWED WHEN ELIGIBLE ON MEDS" will appear when EWs attempt to enter a cost avoidance OHC code to current and/or prior months for a beneficiary who is already MEDS eligible.

If an ongoing eligible has been identified with unreported OHC which is currently available or was available at any time during MEDS' history months, assign the post payment recovery code "A" for the current and prior months and use the appropriate OHC code for pending month. Send a completed Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) to the Department. It is very important for EWs to make sure the insurance policy start date is included on the DHS 6155 because the retroactive post payment recovery process enables the Department to bill the insurance carrier for services already received.

The following illustrates the propriety of various OHC code changes for current and/or prior months:

PERMISSIBLE CHANGES

Cost Avoidance Code	TO	Post Payment Recovery Code
Cost Avoidance OR Post Payment Recovery Code	TO	No Other Health Coverage Code (N)
No Other Health Coverage (N)	TO	Post Payment Recovery Code

PROHIBITED CHANGES

No Other Health Coverage (N)	TO	Cost Avoidance Code
Post Payment Recovery Code	TO	Cost Avoidance Code
Cost Avoidance Code	TO	A Different Cost Avoidance Code

10. Medi-Cal Eligibility Data System On-Line Other Health Coverage Code Override Process

a. **County-Controlled Cases**:

To change the Other Health Coverage (OHC) code to cost avoidance for the future month on county-controlled cases, report the proper cost avoidance code by using an EW20 or EW30.

If a corrected Medi-Cal card is required for a current and/or prior months, use an EW15 to change the OHC code to a post payment recovery code "A" and issue the corrected Medi-Cal card(s).

When making on-line changes to OHC codes, always send in a Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) containing the old insurance policy information to the Department (include termination date of the policy). Submit another DHS 6155 containing the new insurance policy information (include the start date and scope of coverage of the policy).

b. **Supplemental Security Income/State Supplemental Payment Cases**:

To change the OHC code to cost avoidance for the future month on Supplemental Security Income/State Supplemental Payment (SSI/SSP) cases, report the proper cost avoidance code for the future month by submitting a completed DHS 6155 to the Department. The Department will assign the proper cost avoidance code and scope of coverage. Submit another DHS 6155 containing the old insurance information (include termination date of the policy).

If a corrected Medi-Cal card is required for a current and/or prior months, use and EW55 to change the OHC code to a post payment recovery code "A" and issue the corrected Medi-Cal card(s).

When making on-line changes to OHC codes, always send in two DHS 6155s, one containing the old insurance policy information and the other containing the new insurance policy information.

Be aware that changing the OHC code will delete scope of coverage and health insurance information on the Medi-Cal card. This safety measure is intended to prevent the possibility of the insurance information failing to match the new OHC value.

11. Replacement Card Issuance With Corrected Scope of Coverage Codes

EWs must issue replacement Medi-Cal cards for both county-controlled and SSI/SSP eligible cases when the OHC code is in error. If a beneficiary needs an IMMEDIATE NEED CARD only because of the OHC code is incorrect, follow the on-line instructions described in Section 15A (10. MEDS On-Line Other Health Coverage Code Override Process). If the beneficiary needs an IMMEDIATE NEED CARD because the scope of coverage coding is incorrect, proceed as follows:

- If the beneficiary can wait a few days for a card, call the Health Insurance Section at 1-800-952-5294 and request a change to the scope of coverage coding on the Health

Insurance System (HIS). Allowing one day for the HIS update, request a Medi-Cal card the next day using the EW45.

- If the beneficiary needs a card the same day, use the EW15 or EW 55 transaction to change the OHC code to an "A" and to issue a Medi-Cal card. This action will suspend HIS so that NO scope of coverage or health insurance is displayed on the IMMEDIATE NEED CARD. In order to report the proper cost avoidance code for the future month on county-controlled cases, initiate an OHC code change using the EW20 or EW30 and send a completed Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) containing the corrected scope of coverage to the Department. For SSI/SSP cases, send a completed DHS 6155 to the Department. The Department will assign the proper cost avoidance code and update HIS with the corrected scope of coverage.

12. Beneficiary and County Welfare Department Inquiries Regarding Other Health Coverage

Other Health Coverage questions can be answered between 8:00 a.m. and 5:00 p.m., Monday through Friday, by calling the Health Insurance Section's toll-free number, 1-800-952-5294. Spanish speaking operators are also available from 8:00 a.m. to 5:00 p.m., Monday through Friday. Eligibility Workers may give this toll-free number to beneficiaries with the understanding that only health insurance related questions can be answered.