51005 Other Health Care Coverage

(a)

Wherever beneficiaries eligible for benefits under this program are also eligible for the same benefits, either full or partial, under any other State or Federal medical care program or under other contractual or legal entitlement, including but not limited to a private group or indemnification insurance program or the Federal Medicare program, the Department shall require the full utilization of benefits available through the other programs, before utilizing Medi-Cal covered benefits. This requirement shall not apply to beneficiaries covered under Medi-Cal capitated contracting arrangements except to the extent permitted under the capitated contract. (1) The maximum reimbursement by Medi-Cal for services rendered to beneficiaries with other State, Federal, or private health care coverage shall be the reimbursement calculated on a claim for similar services established under chapter 7 (sections 14000 through 14199) of the Welfare and Institutions Code, less the amount of the payment made by the other State, Federal, or private health care program. (2) Where a claim for medical services involves coverage under both the Medicare and Medi-Cal programs, the maximum reimbursement by Medi-Cal shall be the amount established for similar services under chapter 7 (sections 14000 through 14199) of the Welfare and Institutions Code, less the amount paid by Medicare. In the event the Department cannot for any reason establish the amount it would have paid for similar services, the maximum reimbursement shall be the

amount of the Medicare deductible and coinsurance claimed.

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The maximum reimbursement by Medi-Cal for services rendered to beneficiaries with other State, Federal, or private health care coverage shall be the reimbursement calculated on a claim for similar services established under chapter 7 (sections 14000 through 14199) of the Welfare and Institutions Code, less the amount of the payment made by the other State, Federal, or private health care program.

(2)

Where a claim for medical services involves coverage under both the Medicare and Medi-Cal programs, the maximum reimbursement by Medi-Cal shall be the amount established for similar services under chapter 7 (sections 14000 through 14199) of the Welfare and Institutions Code, less the amount paid by Medicare. In the event the Department cannot for any reason establish the amount it would have paid for similar services, the maximum reimbursement shall be the amount of the Medicare deductible and coinsurance claimed.

(b)

If the billing information is different from what appears on the Medi-Cal card, or is not on the Medi-Cal card a provider of services shall notify the Department of any other health care coverage of a Medi-Cal beneficiary within 60 days of learning such entitlement exists. The information shall include the name and Medi-Cal identification number of the beneficiary, the insured and the name of the health insurance carrier providing the beneficiary's other health care coverage; the policy and group number, and termination date, if available. This information shall be provided to the Department's Health Insurance Unit referral desk via the toll free telephone number 1-800-952-5294 as published in the Medi-Cal Provider Manuals and Provider Bulletins.

(c)

If the Department has established probable existence of third party liability before a claim is filed, the Department's fiscal intermediary shall, as directed by the Department, deny provider claims submitted for a beneficiary who has other health care coverage in effect unless the claim is accompanied by a notice of denial of liability, proof of termination of coverage, or partial payment notice. The provider shall first seek payment from the beneficiary's other health care coverage prior to submitting a claim to the Department.

(d)

When the Department has paid for services and other health care coverage benefits are available as enumerated in subsection (a), the Department may recover payment for those services from the liable party.

(e)

Whenever the Department receives payment for a health care service provided to a beneficiary which is in excess of both the amount which the Department has expended on behalf of the beneficiary for said service, and the administrative costs incurred in the collection of such payment, the excess shall be returned to the payor who made the payment.