Revision Date:
April 9, 2020

Background:
This section provides staff with information about how beneficiaries use their Medi-Cal Beneficiary Identification Cards (BICs)/Managed Care Plans cards to obtain medical services.

Purpose:
This section is re-written in the new format and updated to current card usage.

Policy:
There are two benefit delivery systems available to Medi-Cal eligible persons in San Diego County: Managed Care and Fee-for Service (FFS).

Managed Care

Managed Care enrollment is mandatory for most Medi-Cal recipients in San Diego County. An explanation of the option and information on the individual Managed Care Plans are presented to applicants at Orientation and in the Health Plan Selection packet.

Enrollment in specific Managed Care Plans is determined by a recipient's ZIP code. Plans only serve specific geographic areas.

Managed Care Plan enrollees are issued identification cards by the plan. To obtain medical services, the enrollee will:

- Present the card to a provider in that plan
- In emergency circumstances, present the card to non-plan providers who will use the card to bill the Managed Care Plan.

Managed Care Plan enrollees may also be entitled to other Medi-Cal benefits. For example, in San Diego County, Managed Care Plans do not provide dental services, so all enrollees receive a Medi-Cal BIC to use for dental services.

FFS

A few Medi-Cal only beneficiaries may receive Medi-Cal benefits through FFS, as they cannot enroll in a Managed Care Plan, or they are in a voluntary aid code and choose not to enroll.

Medi-Cal BICs are issued by the state.

To obtain medical services, the recipient presents the BIC to medical providers of their choice who accept Medi-Cal. It is authorization for payment of claims for covered Medi-Cal services which are all the following:

- Incurred during the month in which the Medi-Cal card is valid
- Not paid for or obligated by the beneficiary to meet the share of cost requirement
- Not provided by any HCP of which the beneficiary is a member
- Not payable by a third party under a contractual or other legal entitlement
- Not prohibited due to the limited service status of the beneficiary.

Locations where the Medi-Cal BIC can be used include:
- Any California county
- Any state outside California for emergency services.

Each Medi-Cal beneficiary is required to sign and date his/her own Medi-Cal BIC in the space provided upon receipt of the card and before it is presented to a provider. Beneficiaries who can only make a mark (X) in place of a signature must make the mark on their card. This requirement does not apply to beneficiaries who are either:
- Under 18 years of age
- In Long Term Care
- Determined by the provider to be unable to sign the card because of disability.

A mother's Medi-Cal BIC can be used as authorization for services for her newborn child, during the month of birth and the month following the month of birth.

It is a misdemeanor for a beneficiary to sell, furnish, or give or lend the beneficiary's Medi-Cal BIC to any other person or persons for their use.

<u>Limited Service Delivery System</u>
Certain beneficiaries have limits placed on their use of Medi-Cal services. Their Medi-Cal record in MEDS has either restrictions based on their aid code or special coding which indicates any restrictions on their use of the cards.

The BIC may be used as authorization of payment of claims only for Medi-Cal services that are not restricted to the beneficiary.

Examples of limited service status:

Restriction	Description
Minor consent services	Can only be used for services connected to the minor consent situation.
Managed Care	Can only be used for services covered by the Managed Care plan.
Program abuse	Restriction code applied for beneficiaries identified as having a high drug usage pattern or a high Medi-Cal visit pattern. Limits are placed on the amount of services available.
Postpartum (Aid Code 76)	This aid code only covers postpartum and pregnancy-related services.
Special treatment programs	Dialysis and Total Parenteral Nutrition (TPN) aid codes only cover services in these programs.
Hospice services	Services are used to treat the symptoms of terminal illness in lieu of curative or life-extending care. Hospice care is oriented towards meeting the needs of patients and their families who are coping with the later stages of terminal illness. Medi-Cal can be used for all other non-terminal diagnosis related health care.

Restriction	Description
Restricted benefits	These aid codes for otherwise eligible OBRA aliens only cover emergency and pregnancy-related services.
Qualified Medicare Beneficiary (QMB)	QMB-only beneficiaries records will be coded to cover only Medicare deductibles and co-insurance. Dually eligible beneficiaries will have both the QMB and their regular aid code in MEDS.
Long-Term Care (Aid Code 53)	This aid code an only be used for services received while the beneficiary is residing in an LTC facility. The provider system shows the following message, “Services to acute hospital inpatients are not covered.”

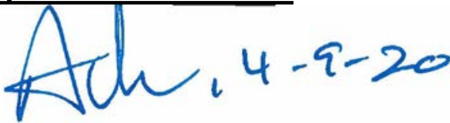
Procedure:
See above.

Program Impact/s:
None.

References:
Medi-Cal Eligibility Procedures Manual 19C
ACWDLs 88-42, 89-80, and 94-07

Sunset Date:
This policy will be reviewed for continuance by March 31, 2023

Approval for Release:



Rick Wanne, Director
Eligibility Operations