

County Managed Care Advocate Meeting Q & A on the Health Insurance Unit of Benefit Recovery

Q: Does Benefit Recovery verify all policy information that is entered by county workers for accuracy and if the information is loaded incorrectly does the health insurance staff make the necessary corrections?

A: Benefit Recovery receives a daily report that includes all policies that are loaded in MMIS in a “non-reviewed” status for us to review and enter the appropriate carrier code. The carrier code clearly identifies the insurance company name and claims mailing address. Due to our extensive knowledge of the major insurance carriers and policy numbers that are identified with those major carriers, in most cases, health insurance staff will make changes to policies that appear to be loaded incorrectly. This would especially apply to policies loaded under a SSN. A majority of the major carriers have given Health Insurance staff access to their websites that allow us to view the policy #, group #, subscriber information and begin and end dates. We would access these sites in cases where inaccurate information is given in order to load them properly. In some cases, we will call the worker to see if they have a copy of the client’s card to obtain the correct information to load in MMIS. As a last resort we may enter the policy under the SSN to ensure we are cost avoiding on claims. We always correct when we receive calls from providers, recipients or workers and correct policy information is provided.

Q: Should pharmacy, dental and vision coverage be loaded separately from the medical policy?

A: In most cases this would be true. If the client presents 3-4 cards it can be clearly identified that there are 3-4 different insurance carriers. For example a client may have a Preferred One card (medical), Express Scripts (pharmacy), and a Delta Dental card. You would need to load three separate policies. There are some insurance companies that provide the medical and dental coverage together and many of the union plans provide coverage for medical, dental, pharmacy and vision. This would include the insurance carriers such as Wilson McShane and Zenith Administrators.

Q: When should a client be excluded from managed care using the HH exclusion?

A: Per policy, a client should be excluded from managed care when the policy has been determined cost effective.

Exclusion from Enrollment in a Managed Care Organization (MCO)

Exclude clients in the following categories from participation in managed care enrollment. These clients will receive health care through traditional [fee-for-service \(FFS\)](#).

- **MA eligible clients with private health care coverage that has been determined cost effective.**

Note: Exclude MA enrollees from managed care during the cost effective determination. If current MA enrollees gain access to health insurance that may be cost effective, continue managed care during the determination process. Disenroll them from managed care upon determining that the coverage is cost effective.

- MA eligible clients with non-cost effective private health care coverage through a Health Maintenance Organization (HMO) licensed under Minnesota Statutes §62D. These people may enroll on a voluntary basis if they select the same MCO as their private HMO.

Q: Are all policies reviewed for cost effective at the county level and if a policy is determined not cost effective, does a client have to stay enrolled in that insurance?

A: All policies that qualify for cost effective premium reimbursement are supposed to be reviewed at the county level. There are circumstances where county workers send cost effective referrals to BRU for review and determination. The Health Insurance staff generally provides same day or next day response to the referrals faxed in.

If the policy is determined not cost effective, the client may choose to drop the insurance coverage. Many clients choose to keep the insurance coverage and are responsible to pay for the monthly premium.

Q: How do workers determine a BCBS policy falls under Blue Plus to determine if it is state-certified HMO coverage?

A: Blue Plus policies are easy to distinguish because there is a **Z** in the group number suffix (example: EP852-ZA). These are always coded in MMIS with coverage type 06 (HMO). It has been this way for some time and it is my understanding that BCBS continues to contain the alpha character Z to identify the Blue Plus plans.

Q: How should county workers advise clients to access care when insurance coverage is through an absent parent and the coverage is out of state?

A: There are a couple scenarios in terms of out-of-state coverage.

- The absent parent who lives out of state (Indiana for example) may have insurance coverage that provides coverage here in MN or at least with a select number of providers. A phone call to the insurance company may be necessary by the custodial parent to determine the break-down of plan coverage and what providers are covered. If the insurance company will not provide the custodial parent with this information call BRS Health Insurance staff for review. We can try to work with the insurance company and determine if it is in the best interest of the client to load the policy information in MMIS. If the plan covers providers that are 30 or more miles away from the client and they have no way to access this coverage, we may determine it is not worth adding this insurance coverage. Or we may add it and use an exception code that bypasses the providers claims and pays them but allows us to bill to the insurance company.
- The insurance coverage does not cover any services in MN. In these cases there is no point in adding the insurance coverage. Make a case note that while the absent parent carries insurance coverage it is out of state coverage and services/providers are not covered in MN.

Q: How does it work when a client has drug with deductible coverage? How does the pharmacy find out how much the deductible is?

A: When we code a policy with a 04 coverage type (drug with deductible) it allows the pharmacy to bill claims to DHS without getting an edit for "other insurance coverage." DHS pays the claim and we turn around and bill the insurance company to determine if we are able to recover payment on any of the claims submitted. This coverage type is rarely used due to the labor involved in this process and possible misuse of state funds. The Health Insurance staff obtains information from the insurance company or client so the use of the 04 coverage type is justified. Many of the Union plans (Wilson McShane and Zenith) or individual plans carried by clients require the 04 coverage type. In these cases either the client is asked to pay up front for the full

cost of the prescription and then send in a claim for reimbursement to the insurance company or the plan has a large deductible (\$3000.00-\$5000.00) and prescriptions are not covered until this deductible is met.

In terms of the pharmacy finding out if the deductible has been met, unfortunately we are unsure if or when they find out. They do not call into BRS Health Insurance and provide us with this information. They may submit claims and indicate insurance payments and if this was noted by a BRS staff, we may change the coverage type from 04 to 05 (drug with co-pay) after verifying with the insurance company the deductible has been met. Because the providers are getting paid by DHS, most pharmacies continue to bill DHS without addressing the other insurance coverage. This is why it is rare for Health Insurance staff to enter policies using the 04 coverage type. There have been cases where the insurance company will call and notify us that prescriptions should be handled by the insurance company and we change the drug coverage type in those cases.

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