Eligibility: Service Restrictions

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When a provider accesses the Medi-Cal eligibility verification system, a message is returned indicating the type of services covered and any limitations or special instructions.

Service Restriction Messages and Codes

When Medi-Cal recipients are limited to specific medical services, and/or dental services, a service restriction message will be returned from the Medi-Cal eligibility verification system when verifying eligibility.

Documenting Service Restrictions

Providers should maintain documentation indicating that their services relate to the applicable restriction. Document the date of service and the name of the provider who prescribed limited services. Documentation should be readily retrievable.

Documenting on the Claim

To help ensure prompt claims processing, the following statement must be included in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim: “This service is applicable to [related service restriction].”

Prescription Drugs

The Department of Health Care Services (DHCS) restricts access to prescription drugs for some recipients. These recipients receive a regular Benefits Identification Card (BIC); but when verifying eligibility, the Medi-Cal eligibility verification system will return a message stating TAR REQUIRED FOR DRUGS. This restriction requires an approved *Treatment Authorization Request* (TAR) for all non-emergency prescription drugs. Retroactive paper ID cards for recipients with this restriction will have the code “P/A ALLRX.”

Scheduled Drugs

DHCS also restricts some recipients’ access to scheduled drugs. These recipients receive a regular BIC; but when verifying eligibility, the Medi-Cal eligibility verification system will return a message stating AUTHORIZATION REQUIRED FOR SCHEDULED DRUGS. This restriction requires an approved TAR for all non-emergency prescription drugs. Retroactive paper ID cards for recipients with this restriction will have the code “P/A SCHRX.”

Note: Authorization is not required for non-scheduled drugs contained in the *Contract Drugs List* sections of the appropriate Part 2 manual.

Outpatient Physician Visits

DHCS also restricts some recipients' number of outpatient physician and/or dental visits. These recipients receive a regular BIC; but when verifying eligibility, the Medi-Cal eligibility verification system will return a message stating AUTHORIZATION REQUIRED FOR PHYSICIAN VISITS or AUTHORIZATION REQUIRED FOR PHYSICIAN VISITS AND DENTAL VISITS. An approved TAR is required for all non-emergency outpatient physician and/or dental visits. Retroactive paper ID cards for recipients with this restriction will have the code "P/A OV."

Outpatient Physician and/or Dental Visits and Scheduled Drugs

DHCS also restricts some recipients' outpatient physician and/or dental visits and scheduled drugs. These recipients receive a regular BIC; but when verifying eligibility, the Medi-Cal eligibility verification system will return a message stating AUTHORIZATION REQUIRED FOR PHYSICIAN VISITS AND SCHEDULED DRUGS or AUTHORIZATION REQUIRED FOR PHYSICIAN VISITS, DENTALVISITS AND SCHEDULED DRUGS. An approved TAR is required for non-emergency patient physician and/or dental visits and non-emergency prescription drugs. Retroactive paper ID cards for recipients with this restriction will have the code "P/A RX/OV."

Primary Care Provider Program (PCPP)

When a recipient is restricted to an assigned primary care provider, an approved TAR is required for all non-emergency services and scheduled drugs. The Medi-Cal eligibility verification system will return a message stating RESTRICTED TO PRIMARY PHYSICIAN WITH AUTHORIZATION FOR SCHEDULED DRUGS.

Authorization/Restrictions: Requesting Additional Instructions

Providers can receive instructions on requesting authorization from the Telephone Service Center. Instructions regarding drug, office visit and PCPP restrictions can be obtained by contacting DHCS, Beneficiary Utilization Review Unit, at (916) 322-1071.

Institutions for Mental Disease (IMD)

Medi-Cal should not be billed for medical ancillary services (such as laboratory, X-ray or other medical services) performed off-site for persons residing in IMDs as inpatients, when they receive services in an acute care hospital for a medical condition. Health care providers who perform medical ancillary services must directly bill the county of responsibility as identified on the Medi-Cal Eligibility Data System (MEDS).

Other Health Coverage Coding

Other Health Coverage (OHC) includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide all or most of the recipient's health care needs.

The Medi-Cal program is prohibited by federal law from paying for services for recipients enrolled in other insurance or health plans when services are covered by those plans. For example, services for a recipient with Medicare coverage must be billed to Medicare prior to billing Medi-Cal.

If the Medi-Cal eligibility verification system indicates that a recipient has OHC but the recipient claims there is no OHC, advise the recipient to contact the county welfare eligibility worker. If it is determined that the recipient is not covered by health insurance, the eligibility file will be updated.

If the Medi-Cal eligibility verification system responds with one of these OHC codes, bill the listed carrier before billing Medi-Cal.

Refer to the *Other Health Coverage* (OHC) section in the Part 2 manual for specific information about billing claims for recipients with Other Health Coverage.

Medicare Coverage

If the Medi-Cal eligibility verification system indicates a recipient has Medicare coverage, Medicare must be billed first (refer to the *Medicare/Medi-Cal Crossover Claims Overview* section in this manual). The only exceptions are services that can be billed directly to Medi-Cal, which are found in the *Medicare Non-Covered Services: CPT® Codes* and *Medicare Non-Covered Services: HCPCS Codes* sections in the appropriate Part 2 manual.

Share of Cost

If the Medi-Cal eligibility verification system indicates a recipient has a Share of Cost (SOC), the SOC must be met before a recipient is eligible for Medi-Cal benefits. Refer to the *Share of Cost* (SOC) section in this manual and the Share of Cost section of the appropriate Part 2 manual for additional information.

‹‹Responsible County and Residence County Definitions

Providers may refer to the *Eligibility: Recipient Identification* section of this manual for the definitions of responsible county and residence county.››

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.