

OBRA and IRCA

Restricted or full-scope Medi-Cal benefits are extended to previously ineligible aliens, effective on or after October 1, 1988. This program was mandated by the *Federal Omnibus Budget Reconciliation Act of 1986* (OBRA) and the *Immigration Reform and Control Act of 1986* (IRCA). IRCA created a legalization program under which the status of certain aliens unlawfully residing in the United States may be adjusted over time to permanent resident status. In granting these aliens amnesty, the law specifies that their participation in certain assistance programs be restricted to five years. OBRA applies to other aliens such as undocumented aliens and temporary visitors.

Aid Codes: The Department of Health Care Services (DHCS) has assigned seven aid codes to identify various types of OBRA, IRCA and Non-Permanently Residing Under Color of Law (Non-PRUCOL) recipients. These codes are 5F, 51, 52, 55, 56, 57 and 58. They are defined as follows:

<u>Aid Code</u>	<u>Recipient Type</u>	<u>Definition</u>
5F	OBRA Aliens: Limited Services	Pregnant women who are undocumented aliens and certain temporary visitor aliens, regardless of age. These individuals are eligible for emergency and/or pregnancy-related medical benefits only.
51	IRCA Aliens	Aliens qualifying for Medi-Cal as temporary or permanent lawful residents who are aged, blind, disabled, or children under 18 years of age. These individuals are eligible for the full scope of Medi-Cal benefits.
52	IRCA Aliens: Restricted Services	Aliens qualifying for Medi-Cal as temporary or permanent lawful residents who are not aged, blind, disabled, or children under 18 years of age. These individuals are eligible for emergency and/or pregnancy-related medical benefits only.
55	Non-PRUCOL Aliens: Restricted and Non-Emergency LTC Services	Undocumented aliens qualifying for Medi-Cal who currently reside in Long Term Care (LTC) facilities who are not determined to have PRUCOL status by the Immigration and Naturalization Service. Non-PRUCOL aliens are eligible for non-emergency LTC services; all emergency benefits (including labor and delivery, and Renal Dialysis (RD) services); and all non-emergency pregnancy-related medical benefits.
56	IRCA Special Agricultural Workers (SAWs)	SAWs aliens qualifying for Medi-Cal as temporary or permanent lawful residents who are either aged, blind or disabled, or children under 18 years of age. These individuals are eligible for the full scope of Medi-Cal benefits.

Emergency or Pregnancy-Related Medical Services: Covered Benefits

For recipients whose coverage is limited to emergency and/or pregnancy-related medical benefits, the following services are covered when ordered by the primary provider: pharmacy, radiology, laboratory, dialysis and dialysis-related services. The *Omnibus Budget Reconciliation Act of 1993* removed kidney transplant services from the list of benefits for these recipients.

Emergency Medical Conditions Definition

“Emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction to any bodily organ or part

Eligible individuals are entitled to all inpatient and outpatient services that are necessary for the treatment of an emergency medical condition as certified by the attending physician or other appropriate provider and in the same manner as administered under Section 51056 of Title 22 of the *California Code of Regulations*. Continuation of medically necessary inpatient hospital services and follow up care after the emergency has resolved shall not be authorized or reimbursed for aliens eligible for restricted benefits only.

All acute level inpatient days (except an emergency admission for labor and delivery) continue to require authorization via a *Treatment Authorization Request* (TAR) from the appropriate Medi-Cal field office. Admissions for labor and delivery require authorization after the first two days (for a vaginal delivery) or the first three days (for a cesarean section delivery) of the patient’s stay. For additional information, refer to the contract services section in the appropriate Part 2 manual for more information.

Documentation Required for Emergency Services

When billing for emergency services, providers must indicate emergency treatment on the claim and submit a statement that describes the nature of the emergency, including relevant clinical information about the patient's condition and why the emergency services rendered were considered to be immediately necessary. It must be comprehensive enough to support a finding that an emergency existed. The statement must be signed by the provider. A mere statement that an emergency existed is not sufficient. Refer to the claim completion section of the appropriate Part 2 manual for specific claim form instructions.

**Non-Emergency and
PHP Services**

The following information describes non-emergency and Prepaid Health Plan (PHP) covered services for the specified aid codes.

Aid Code 5F, 52, 57 or 58

Claims for all non-emergency services for recipients with aid code 5F, 52, 57 or 58 are denied with RAD code 093.

Aid Code 55

Claims for non-emergency (except LTC services) and vision care services for Non-PRUCOL aliens with aid code 55 are denied with RAD code 284 or 626.

PHP Services

OBRA, IRCA and aid code 55 recipients are not covered under Medi-Cal County Health Systems or other PHP contracts. All claims for services for these recipients must be submitted to the DHCS Fiscal Intermediary (FI). Authorization of services, when required, must be obtained from the appropriate Medi-Cal field office.

Pregnancy-Related Services

Recipients with aid codes 5F, 52, 55, 57 and 58 are limited to:

- Emergency care services, including emergency labor and delivery, and
- Pregnancy-related services

“Pregnancy-related services” are required to assure the health of the pregnant woman and the fetus. These services include prenatal care, services for complications of pregnancy, labor, delivery, postpartum care and family planning services. Pregnancy-related services may be provided prenatally from the day that pregnancy is medically established and postnatally to the end of the month in which the 60th day following delivery occurs. Family planning services may be provided beyond the 60-day postpartum period if the recipient presents the provider with a Medi-Cal card valid for the month of service. Claims for family planning services must be billed with a primary or secondary diagnosis code within the range of V25 – V25.5. (This code restriction is not applicable to pharmacy providers.)

Drug coverage, prescribed for pregnancy-related services and dispensed within this eligibility time period, includes the full scope of Medi-Cal pharmaceutical benefits.

Baby Services Billed With Mother’s ID Number

Baby services billed under the mother’s ID number are payable only for services rendered during the month of birth and the following month.

Medicare/Medi-Cal Crossovers

Medicare crossover benefits are payable for full-scope IRCA program recipients (aid code 51 or 56).

Medicare crossover benefits for limited-scope OBRA/IRCA program recipients are restricted to emergency or pregnancy-related services (aid code 5F, 52, 57 or 58). In addition to these services, crossover benefits for Non-PRUCOL program recipients cover LTC services (aid code 55).