Other Health Coverage (OHC) FAQ

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The questions referenced in this FAQ were submitted by SAPC contracted providers during the SAPC training webinar on Entering Other Health Coverage Information for Primary Providers, held on February 15, 2022. The training recording and slides can be reviewed at the following link: http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm.

General OHC Billing Questions

#	Question	Response
AEVS & Verifying OHC Information		
1	How can we get the AEVS and what is it? We are having a problem getting enrolled in AEVS. Who do we contact?	The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers the ability to access beneficiary eligibility. Information on AEVS can be found on the DHCS website; SAPC recommends reviewing DHCS's AEVS General Instructions guide to learn more about AEVS, how to access it, and who to contact for questions about the system.
2	What if the patient doesn't know who their OHC is or doesn't know that they have OHC? Would an OHC be visible as well on the DHCS AEVS system?	Refer to the "Verifying Active DMC and OHC" section of the SAPC OHC Billing Manual for resources available to verify OHC coverage. Per DHCS's AEVS Transactions guide on page 5, the AEVS system provides information on the patient's OHC including the OHC code, OHC name, carrier code, and scope of coverage code. For more information on the AEVS system, providers can refer to DHCS's AEVS General Instructions guide.
3	If the stoplight system does not say OHC, do we have any other way to know if the client has OHC and not a managed Medi-Cal plan like Health Net or LA Care?	DHCS's Point of Service (POS) network, allows providers to access information related to OHC, refer to DHCS's Provider Training guide, beginning on page 25 for more information on what information is presented via the POS network which allows providers to access information related to a recipient eligibility, OHC, Medicare, Medi-Cal Managed Care Plans, and Medi-Services. If AEVS and the 271 Response Report do not indicate the patient has an OHC, as DHCS does not have record of an OHC, and the patient indicates they do not have additional insurance coverage, providers should feel confident that the patient only has Medi-Cal coverage and will not need to provide any OHC information to SAPC when billing for DMC services.
4	Where do we obtain the Payer ID?	The OHC payer identifier is an identifying number assigned to the insurance carrier. Generally, the carrier's payer ID is five digits and can be fully numeric or alphanumeric. The

		payer ID can be found through an Internet search or by contacting the OHC carrier directly.
5	Will we be able to see if a patient has OHC via the Real Time 270 Eligibility Request?	Yes, the 271 Response Report received when submitting the 270 Eligibility Request form, will include information about the patient's OHC eligibility. The 271 Response Report will only indicate general OHC information and does not provide the name of the OHC or the OHC codes/Scope of Coverage codes. Providers can refer to the 270/271 Process User Guide on the Sage website for more information on how to read the 271 Response Report.
6	Where can the OHC provider manual be found?	The SAPC OHC Provider Billing Manual is posted to the Sage website under the Sage Trainings – Finance page.
7	What is COB? Where do we obtain the COB code?	COB stands for Coordination of Benefits. This term refers to the information that allows a plan to determine their payment responsibilities. There is no "COB code." The information for COB is made up of a variety of details of the OHC and the OHC denial/payment information. Information on what COB information is required by Primary Sage Users to submit can be found in the SAPC OHC Provider Billing Manual, Section 5 on Billing OHC via ProviderConnect, beginning on page 10.
8	If OHC has been removed, does the OHC form in ProviderConnect still need to be completed?	If the OHC has been removed, then the OHC does not need to be claimed for any services after the termination of OHC. If the form was valid and completed previously, the expiration date should be entered when the OHC has been confirmed as removed. Providers should refer to the process "Verifying Active DMC and OHC" in the SAPC OHC Provider Billing Manual to ensure an OHC is not active. If the OHC was active at the time the service was conducted, the OHC form must be completed. If the OHC was removed at a certain date, the expiration date should be added on the form so the system will only apply the OHC information for the services delivered when the OHC was active.
9	If a client's eligibility states Medi-Medi Part A & B NO OHC but also states "OIMV-R," to my understanding OIMV-R is not considered private insurance, correct?	Per DHCS's Provider Training guide, the codes that appear on the eligibility transaction results, such as "OIMV-R" are in reference to the OHC's scope of coverage (COV) codes. Page 40 on the referenced guide from DHCS provides additional information on what the COV codes are and what the service category is for that COV code. For patients with Medi-Medi, providers can review the "Medicare as an OHC" section of the SAPC OHC Provider Billing Manual on page 7 for information on when Medicare is considered an OHC and when it is not.

10	In the future with CalAIM, what is the percentage of participants that will have OHC with Medi-Cal?	It is unknown at this time how CalAIM may affect the percentage of participants with OHC and Medi-Cal.
Availity		
11	What is Availity?	Availity is a free online resource that can help verify patient benefits, claim submissions, claim status, and authorizations.
Billing an OHC		
12	How do you set things up to bill an OHC?	Each OHC may have different billing requirements. Providers should reach out to the OHC to learn about their contract and billing processes.
13	Are we going to be sending our claims through Sage or our own system?	Sage does not have functionality to bill OHCs directly. Providers will need to use an alternate system to bill a patient's OHC carrier.
14	If a client has OHC and the insurance carrier does not want to cover residential treatment but would cover another level of care, would that denial be an acceptable denial?	Per DHCS ADP Bulletin 11-01, DHCS accepts denials from the OHC for the reasons of: • The recipient's OHC coverage has been exhausted, or • The specific service is not a benefit of the OHC If an alternate denial was received from the OHC, the State may deny the claim as it was not denied for either of the two acceptable denial reasons indicated.
15	Do we still have to contact the OHC agency for authorization? Is there a special authorization necessary for an agency to bill a OHC?	Each OHC may have different requirements. Providers should reach out to the OHC to learn about their contract and billing processes.
16	For OHC code A – HMO – can we bill Medi-Cal without billing OHC – per the chart guidelines?	Per page 8 of the SAPC OHC Provider Billing Manual, an "A" OHC code does not require the OHC to be billed prior to billing Medi-Cal.
17	Is there a manual that listed all the private insurances, so we can refer to them?	DHCS has published a list of OHC Carrier Codes which can be located on the DHCS website.
18	Do we need to be a network provider for the identified OHC to provide services? If we are not contracted by the OHC, should we refer to another provider who does?	Each OHC may have different requirements. Providers should reach out to the OHC to learn about their contract and billing processes.
19	Can SAPC provide training or technical assistance for providers to bill an OHC?	SAPC is working with CIBHS to conduct a series of technical assistance trainings/webinars for providers on billing OHCs directly. More information will be sent to the provider treatment network when it is available.
20	If a client has both OHC and Medi-Cal but the OHC will only cover for example 5 days but Medi-Cal covers 60 days, will Medi-Cal cover it as an approved denial?	Per DHCS ADP Bulletin 11-01, DHCS accepts denials from the OHC for the reasons of: • The recipient's OHC coverage has been exhausted, or • The specific service is not a benefit of the OHC In the scenario presented in the question, if the OHC only covers 5 days but Medi-Cal will cover 60 days, once the

		benefits of 5 days have been exhausted, and the provider has either obtained a denial for the 6th day or has a letter/document indicating that only 5 days of benefits are covered, the claims can be billed to SAPC with the reason provided by the OHC.
Billing SAPC for Services Not Billed to the OHC		
21	If we have denied claims for FY 18/19, do we need to bill the OHC although it's been way over a year?	Per DHCS ADP Bulletin 11-01, Federal Medicaid rules and CA Code of Regulations, Title 22, Section 51005(a) require billing a client's OHC before billing Medi-Cal. SAPC recommends working with the patient's OHC directly if there are concerns or questions regarding billing them over one year from the date of service. SAPC is unable to provide specifics on what each individual OHC carrier will permit.
22	All FY 18-19 denial claims can still be entered and reimbursed?	SAPC has not established a last date to bill for FY 18-19 services. Until providers are given that date, they can continue to bill SAPC. Any FY 18-19 claims received as of 3/1/2022 will be settled during the conclusion of SAPC's cost settlement process with the State.
23	What if we didn't receive authorization for primary insurance and OHC denies as no auth received?	Per DHCS ADP Bulletin 11-01, Federal Medicaid rules and CA Code of Regulations, Title 22, Section 51005(a) require billing a client's OHC before billing Medi-Cal. DHCS accepts denials from the OHC for the reasons of: • The recipient's OHC coverage has been exhausted, or • The specific service is not a benefit of the OHC If an alternate denial was received from the OHC, the State may deny the claim as it was not denied for their two acceptable denial reasons. Failure to receive prior authorization from the OHC is not a denial accepted by DHCS.
24	Is there a blanket denial code that providers can utilize at this point in time to get paid on FY 18-19 OHC denied claims?	Per DHCS ADP Bulletin 11-01, Federal Medicaid rules and CA Code of Regulations, Title 22, Section 51005(a) require billing a client's OHC before billing Medi-Cal. DHCS accepts denials from the OHC for the reasons of: • The recipient's OHC coverage has been exhausted, or • The specific service is not a benefit of the OHC If an alternate denial was received from the OHC, the State may deny the claim as it was not denied for their two acceptable denial reasons. Failure to receive prior authorization from the OHC or to bill the OHC timely is not a denial accepted by DHCS.
Managed Care Plans		

25	How does it work if an individual has Medi-Cal with say Kaiser or another insurance as their provider? Do we have to bill Kaiser or that insurance first? Or can it be considered straight DMC?	Medi-Cal Managed Care Plans received through L.A. Care or Health Net do not need to be billed as OHC. • The L.A. Care Managed Care Plan is delegated through Kaiser Foundation Health Plan, Anthem Blue Cross, and Care 1st Health Plan. • The Health Net Managed Care plan is delegated through Molina Health Care. It is important for providers to validate each OHC to confirm if the carrier should be billed prior to billing SAPC. While Kaiser does operate a Medi-Cal Managed Care Plan and would not need to be billed prior to SAPC, not all Kaiser plans are Medi-Cal Managed Care Plans. It is important to validate the OHC code and Scope of Coverage code to confirm if the OHC should be billed first. Section 2 of the SAPC OHC Provider Billing Manual provides assistance with understand the OHC and Scope of Coverage codes.
26	Is there any kind of written assurance stating that if the patient has a Medi-Cal Managed Care Plan and no denial is obtained from that plan before billing DMC, that the state won't recoup it? Some plans such as Molina has encouraged me to submit a pre-authorization for residential services as some are actually covered. Thus, a denial letter would be better proof that Molina is not liable to pay those services.	Per DHCS, as noted on the Other Health Coverage (OHC) webpage, Medical Managed Care Plans such as L.A. Care are not considered OHC. To validate that an OHC does not need to be billed prior to billing Medi-Cal, providers should check the OHC code and COV code, as this is the most accurate way to determine the need to bill the OHC prior to Medi-Cal. Section 2 of the SAPC OHC Provider Billing Manual provides assistance with understand the OHC and Scope of Coverage codes.
Medicare and OHC		
27	Does this apply to receiving payment for state denials with clients denied OHC Medicare Part C? Our understanding back in 2018 we did exactly what was indicated in the Provider Manual to accept Medicare Medi-Cal clients. It has since been updated.	The SAPC OHC Provider Billing Manual has a subsection titled "Medicare as an OHC" which provides guidance for patients with both Medicare and Medi-Cal. SAPC recommends providers review this section of the manual for more information on when to bill Medicare prior to billing Medi-Cal and when it is not required.
SAPC Service Authorizations for Patients with OHC		
28	For OHC are we to not admit the patient before the preauthorization has been denied or approved to make sure they don't need to be referred out because we are not part of their network?	SAPC has provided guidance regarding Service Authorizations for patients with OHC in Section 3 of the SAPC OHC Provider Billing Manual.
Miscellaneous Questions		
29	Is Room and Board considered non-Drug Medi-Cal?	Room and board are still billed under DMC. Room and board is not a DMC reimbursable service, however, it is to be billed under the DMC auth for that level of care if that patient has Medi-Cal. If the patient has Drug Medi-Cal, then the services will be under a DMC funding source

		authorization. The only exception being RBH and Screening-No Admission.
30	Do we need to enter Other Health Coverage Form in Sage if we are secondary users?	No, the Other Health Coverage Form in ProviderConnect is for Primary Sage Users only.
31	This is done in lieu of the financial eligibility?	No, determining Financial Eligibility and completion of the Financial Eligibility form is still a requirement.
32	For presumptive denials, is the amount of days 91?	Per DHCS ADP Bulletin 11-01, "providers may presume that a claim submitted to an OHC carrier has been denied, and may submit a claim for DMC reimbursement on that basis, when all of the following are true: a) The provider has billed the service to the other carrier as required, and b) At least 90 calendar days have elapsed since the submission of the claim to the OHC carrier, and c) The providers has not received payment for the claim, a report of the results of the OHC carrier's adjudication of the claims, any communication, in any form, indicating that the claim submission was in an unacceptable form or otherwise in need of correction prior to adjudication by the OHC carrier."
33	Is SASH aware of OHC limitations and coverage?	The Substance Abuse Service Helpline (SASH) conducts a basic eligibility and income verification to determine Medi-Cal or My Health LA eligibility and enrollment, or participation in the AB 109, Drug Court, JJCPA, or PSSF-TLFR, if ineligible for Medi-Cal, or My Health LA. It is the provider's responsibility to verify a patient's eligibility immediately upon admission and at a minimum monthly thereafter.

Technical OHC Billing Questions

#	Question	Response
34	When will the Other Health Coverage tab appear in Sage?	The Other Health Coverage form was made available in ProviderConnect/Sage on 2/16/2022.
35	I notice it's [the Other Health Coverage form] under the second section normally finance only do not have access will this be available to billing staff?	The Other Health Coverage form was made available to all ProviderConnect access groups with the exception of the Audit User and Clinical Visible Only groups.
36	The address for OHC does not get entered here?	The OHC address is not required to be entered on the Other Health Coverage form.
37	If not OHC we are doing the old method and this process is only if we claim left to be paid after the OHC has paid or denied?	The process that was reviewed during the 2/15/2022 training webinar was targeted for entry of services for patients who had an active OHC where billing the OHC was required prior to billing Medi-Cal. If a patient did not have active OHC or an OHC that was not required to be billed prior to Medi-Cal, the process outlined is not required to be followed.

38	What if 2 complete months of services were denied?	If an OHC denied services for two months, the denial adjudication information should be entered on to the COB forms for the services that were denied and the Other Health Coverage form should be completed for the patient. Refer to Section 5 of the SAPC OHC Provider Billing Manual on how to complete the Other Health Coverage form and submit the denial adjudication information via the COB forms.
39	If the patient has only private insurance, then we can still use our clearing house correct?	Yes, if the patient does not have Medi-Cal, they do not need to be billed to SAPC and the process outlined in the training does not apply.
40	As an IOP provider we only bill with 906 revenue code? That will not be the same if we bill Sage.	The codes used to bill the OHC and Medi-Cal may not be the same codes. Providers will still bill SAPC using the appropriate code as indicated on SAPC's Rates and Standards Matrix.