Communication Release
3/25/2022

OHC Updates & Reminders

OHC FAQ

SAPC has completed it's OHC FAQ based on the questions proposed by providers during the 2/15/2022 training on Entering Other Health Coverage Information for Primary Providers. The FAQ will be posted to the Sage website on the [Sage Trainings – Finance](#) page under the Billing section, within one week.

Updated OHC Billing Provider Manual

SAPC has re-published the Other Health Coverage Provider Billing Manual on the Sage website on the Sage Trainings – Finance page under the Billing section. If providers have saved the manual, SAPC requests that it be updated with the updated version to ensure accurate information and links are maintained.

The following updates were made to the manual:
- Page 5 – Updated the link to ADP Bulletin 11-01 in footnote 6 to the correct link
- Page 7 – Updated the "Important" notification box regarding OHC and Scope of Coverage codes

How to Locate OHC Payer IDs

SAPC has monitored the ProviderConnect Other Health Coverage forms that have been submitted and noted that inaccurate information is being entered in the Third Party Payer Identifier field. The OHC's 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. For example, Aetna Better Health California's payer ID is 128CA. The carrier's payer ID can be found through a variety of different ways:
- Internet search for the carrier and their payer ID
  - A helpful website to search for carrier payer IDs is: http://www.healthdataservices.com/payerid/payerlist.htm. SAPC cannot confirm the accuracy or maintenance of this list as it is not a SAPC or governmental website but is an extensive list of carrier information including payer IDs.
- Contacting the carrier directly
- Reviewing the patient's insurance carrier benefits card

Submit Billing Questions via the Sage Help Desk

SAPC requests that providers with questions regarding billing submit a Sage Help Desk ticket via phone - (855) 346-2392 - or the Help Desk portal - https://netsmart.service-now.com/plexussupport. This will ensure that all questions are answered in a timely and appropriate manner. This process will ensure that the question is directed to the appropriate person and also provides a history of the communication and resolution to providers, Netsmart, and SAPC. Questions directed to an individual staff member will be redirected to the Sage Help Desk in order to have their question addressed.

Progress Note Final to Draft Justifications

When submitting a Sage Help Desk ticket requesting a finalized note to be set to draft, it is required that providers include a specific justification that includes what information needs to be changed on the note. The justification is used by SAPC Contracts to determine whether the request will be approved or denied. Information in the note is used to verify services rendered and any changes made to the note may result in negative impact on invoicing. Once providers have made the updates to the note as indicated in the justification,

SAPC will verify that only the identified edits were made. Additional edits made by the provider other than what was noted in the justification may be rejected by SAPC.

Justifications without sufficient and specific detail such as "wrong information in note, linguistic error, need to update note, edits needed," etc. will not be approved. The justification must include the specific field and information that is being requested to change.

Examples of specific and detailed justifications are below:
- Incorrect group size. Need to update to 6 instead of 7.
- Need to update service start time. Correct start time should be 3:00 with 4:30 as the end time.
- Need to update number of counselors. Total counselors should be 2 instead of 22.
- Misclassified the note as GIRP. Note should have been saved as a BIRP note.
- Incorrect program selected from dropdown menu. Will update to 1335 Recovery Way.
- Note finalized by accident before LPHA reviewed.

Help Desk Validation of MEDS Information

In an effort to decrease state denials related to eligibility, SAPC and the Sage Help Desk collaborated on a workflow to allow the Help Desk to provide the patient's date of birth and gender as noted in the MEDS information, as those are the two primary demographic fields that are used in verifying a beneficiary's identity when adjudicating a claim. When the beneficiary's date of birth, gender, and Client Index Number (CIN) all match, then the beneficiary is verified on the claim.

As these are critical fields, and are available on the Beneficiary Identification Card, SAPC is allowing providers to contact the Help Desk for that information only. The Sage Help Desk cannot provide any other information from the MEDS file, such as addresses, aid codes, OHC information etc. If providers contact the Help Desk asking for information other than DOB and gender, the case will be immediately resolved as that information is not accessible by the Help Desk or SAPC. These cases will not be escalated as SAPC cannot provide that information.

Updating the Financial Eligibility When Patient's Obtain DMC Benefits

SAPC has become aware of an issue where claims are being denied or failing pre-adjudication due to Eligibility not found/Verified in CalPM when the Financial Eligibility has both Applying for Medi-Cal and DMC guarantors, where the DMC guarantor has a Coverage Effective Date or Coverage Expiration Date that does not cover all the services on the claim. SAPC and Netsmart are working on a resolution to this issue and will update the Financial Eligiblity job aids with the official workflow as soon as a resolution is available.

SAPC is recommending the following workaround to ensure claims are properly approved in situations when a patient begins treatment under Applying for Medi-Cal and successfully obtains benefits in LA County during the treatment episode. When providers become aware that the Medi-Cal benefits were approved with an official effective date, providers should:
1. Bill all remaining services covered under Applying for Medi-Cal as soon as possible, before adding the DMC guarantor.
2. Wait for all claims to be appropriately adjudicated under Applying for Medi-Cal
    - Verify claims were appropriately denied or approved using Provider Connect, EOBs, KPI or 835s.
3. When the provider has received all expected approvals, the DMC guarantor can be entered with the correct Coverage Effective Date
    - Additionally the Coverage Expiration Date for the Applying for Medi-Cal can be entered, which should be no more than 30 days from admission based on currently policy.
4. Billing will only be approved for dates of service that fall within the DMC coverage dates once the DMC guarantor is entered.
    - If providers need to bill for any previous Applying for Medi-Cal claims, the DMC guarantor would have to be deleted and re-entered once that billing has been adjudicated.