Other Health Coverage Provider Billing Manual

Version 1.0| February 2022

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Section 1: OHC Overview

Introduction

This manual provides guidance to SAPC network treatment providers detailing the process used to bill Other Health Coverage (OHC) prior to billing Medi-Cal for patients who have Medicare or commercial insurance and are Medi-Cal eligible. This manual also provides guidance on the billing and claiming process in instances where the patient's insurance carrier has denied the claim, where the patient's insurance carrier does not cover the services provided, or where you have not received a response from the OHC carrier on an appropriately submitted claim.

Services should be provided as soon as possible to those seeking care to avoid unnecessary barriers to treatment. It may be that individuals seeking care may be eligible for Medi-Cal, MyHealth LA, or other County funded programs but their benefits may not be active at the time of intake or assessment. Hence, it is important that providers use appropriate case management services to help individuals initiate the process to apply or reactivate their Medi-Cal benefits and ensure a timely benefits determination.

SAPC is not responsible for the reimbursement of claims for patients who have commercial private pay insurance and are ineligible for Medi-Cal, MyHealth LA, or other County funded programs. Substance Use Disorder (SUD) providers may serve these individuals through a sliding fee scale reimbursement directly from the patient using a client fee determination scale as defined by the SUD provider. Sliding scale fees or flat fees are not allowed for Medi-Cal, My Health LA eligible, or the select other County-funded program beneficiaries or participants.

What is OHC?

Other Health Coverage are benefits for health-related services or entitlements a Medi-Cal beneficiary has from payor sources other than Medi-Cal, including Medicare or commercial private pay insurance. Federal and State rules require the billing of a patient's OHC before billing Medi-Cal.[1] Exceptions to this requirement are noted in the following sections.

Billing OHC Prior to SAPC

When to Bill OHC for Active Medi-Cal Beneficiaries

For services covered by both an OHC and Drug Medi-Cal (DMC), the patient's OHC must be billed prior to billing DMC. Medi-Cal is a 'payor of last resort,' which means that Medi-Cal beneficiaries with an active OHC are required to exhaust their OHC benefits prior to using their DMC benefits. Beneficiaries are deemed responsible for the entire cost of services that are not covered by the OHC and DMC and DMC will not be held liable for non-covered services. In any case, providers are not allowed to deny Medi-Cal beneficiaries health services based on their potential third-party liability.[2] Additional information on allowable services can be found in the most current version of the Rates Matrix and Provider Manual.

Verifying Active DMC and OHC

Providers are required to confirm DMC eligibility before admission and monthly thereafter to ensure patients are actively enrolled in Medi-Cal.[3] During the monthly verification of DMC eligibility, providers must validate the patient's OHC to verify whether the patient is actively enrolled in an OHC. If at any point during the verification of an active OHC, if a patient's OHC is determined to be expired, providers should follow the steps outlined in the *Removing an Inactive OHC From a Patient's Record* in Section 1 of this manual and follow the steps to remove the OHC from the California Department of Health Care Services (DHCS) system.

For the verification process, providers can use Medi-Cal's Automated Eligibility Verification System (AEVS), to obtain a patient's OHC information. AEVS can be accessed by calling (800) 456-2387 or (800) 541-5555.

[1] California Code of Regulations (CCR), Title 22, Section 51005(a).
[2] Substance Use Disorder Treatment Service, Provider Manual, July 2020, Version 5.0, Page 21.
[3] Substance Use Disorder Treatment Service, Provider Manual, July 2020, Version 5.0, Page 149.

Instructions for accessing and operating AEVS can be found on the Medi-Cal website at: https://files.medi-cal.ca.gov/pubsdoco/AEVS_home.aspx. Once accessed, the AEVS will return a message that includes OHC information in the form of OHC codes under the Eligibility Message section. Please refer to Section 2: OHC Codes and Description in this document for OHC code definitions.

To determine whether the OHC carrier covers SUD services, AEVS or other eligibility determination methods will return a message stating the beneficiary's OHC code and Scope of Coverage (COV). The COV codes designate the specific service categories covered by a beneficiary's OHC and will determine whether the patient has active SUD benefits. In addition to using AEVS to verify a patient's OHC enrollment, providers can also use one or more of the following options:

- **Use of Availity:** Availity is a free online resource that can help verify patient benefits, claim submissions, claim status, and authorizations. https://www.availity.com/
- **Use of the Real Time 270 Eligibility Request Form:** The 270 Eligibility Request is the process in Sage that providers can use to request real-time Medi-Cal Eligibility directly from DHCS. Although it will not currently provide the details of an OHC, such as the carrier name, this process will show if a patient has an active OHC. For the step-by-step instructions on how to run the 270 report, please refer to the 270/271 Process User Guide on the Sage website. Once the provider submits the 270 request, the State will respond via the 271 Response Report that will include information about the patient's OHC eligibility. If the 271 Response Report does not indicate that the patient has OHC, no further action is needed to assess OHC enrollment.
- **Calling the Insurance Carrier:** Contact the patient's insurance carrier directly to confirm enrollment.

Prior Authorization

Once the provider has verified that the patient has active OHC and SUD benefits under the carrier, providers should determine if prior authorization is required from the OHC. If required, request this prior authorization from the OHC prior to billing DMC. Prior authorization is the process used to obtain approval or denial for a service with the specific OHC. When required, this approval is essential in determining reimbursement from an OHC for services provided to a patient. If the prior authorization results in a denial for the service, providers can then submit the claims to SAPC with consideration of the other requirements outlined in this manual.

Depending on the OHC carrier's policies, the claim may be denied by the OHC if this prior authorization is not requested. Furthermore, failure to receive prior authorization from the OHC is not a justification to bill DMC. The patient would still be considered to have active OHC whose benefits must be exhausted before DMC coverage begins.

Providers must refer the patient back to their OHC if they do not obtain authorization for services and require that the patient obtain services within an in-network OHC facility. In this case, the provider should assist in a warm handoff transfer of the patient to an in-network facility that accepts the patient's OHC. As stated earlier, when a patient has an active OHC, the OHC will be held responsible for covering services provided to the patient until their OHC benefits are exhausted.

Clients with Multiple OHCs

There may be instances where a patient has multiple OHCs. Reasons for having multiple OHCs may include that the:

1. Patient is a minor or an adult who is 26 years of age or under with coverage through both of their parents.
2. Patient is married where both they and their spouse have dual coverage insurance through their respective employers.
3. Patient is 26 years of age or younger, married, and covered by their spouse's plan and their parent's plan.
4. Patient has OHC and Medicare coverage.

In any instance when multiple OHCs are involved, the total amount of coverage under multiple OHCs will never exceed 100% of the cost of the service. A patient's multiple coverages may include a primary and secondary insurance company. The primary insurance will be the insurance that covers the claim first. After the primary insurance has covered its appropriate share, the secondary insurance will cover the claim thereafter, where it may cover part or all of the remaining balance of a claim.

It is important that providers bill a patient's secondary insurance after their primary insurance when a patient has multiple OHCs. When all OHC benefits have been exhausted for a service, the remaining balance may be billed to Medi-Cal as the payor of last resort. Medi-Cal will only pay up to the maximum amount allowed under the Medi-Cal program, less the OHC payment amount, if any.[4]

When to Bill SAPC

Once all OHC benefits have been exhausted and there is a remaining balance on the claim, providers may bill the remaining claim balance to SAPC. Additionally, providers can bill SAPC if the OHC carrier does not cover and has denied the services provided to the patient. Services billed to SAPC for DMC coverage must be services the agency is DMC certified for and contracted to provide with SAPC.

What to Include When Billing SAPC

To utilize DMC coverage for a covered SUD service, providers are required to submit an Explanation of Benefits (EOB) or a denial letter received from the OHC carrier as a form of proof the OHC was billed for the service and the claim was denied by the OHC.[5] Medi-Cal requires that any service partially paid or denied by the patient's OHC when being billed to Medi-Cal must be accompanied by an EOB or denial letter. When billing to SAPC for DMC covered services, the information on the EOB or denial letter must include all of the following:

1. Carrier or carrier representative name and address
2. Beneficiary's name or Social Security Number (SSN)
3. Date
4. Statement of denial, termination, or amount paid
5. Procedure or service rendered
6. Termination date or date of service

Providers are required to use the 'Attachments' form in ProviderConnect to upload the EOB or denial letter to the patient's chart when billing DMC. Refer to the *Recordkeeping and Auditing* section of this manual for recordkeeping requirements including the required document naming convention for documentation supporting OHC.

Medi-Cal only permits the billing of OHC denied claims to DMC when: 1) The recipient's OHC coverage has been exhausted; or 2) The specific service is not a benefit of the OHC.[6]

Presumptive Denials

If a response to a claim from the OHC is not received within 90 calendar days from the billing date, the provider may presume that the claim is denied, and bill DMC covered services to SAPC for DMC coverage.[7] This presumption of denial can only be made in the following situation:

- The provider has billed the service to the OHC carrier and at least 90 calendar days have elapsed since the submission to the OHC and there are none of the following:
    1. Payment of the claim;

[4] DHCS, Other Health Coverage (OHC) Guidelines for Billing, Part 2, September 2020, Page 2.
[5] DHCS, Other Health Coverage (OHC) Guidelines for Billing, Part 2, September 2020, Page 3.
[6] ADP Bulletin 11 – 01, page 3.
[7] DHCS, Other Health Coverage (OHC) Guidelines for Billing, Part 2, September 2020, Page 4.

2. A report (hardcopy, electronic, or other form) of the result of the OHC carrier's adjudication of the claim; and
3. Any communication regarding the submission of the claim or the need for corrections prior to adjudication by the OHC.

If there is no adjudication from the OHC after 90 calendar days from the billing date, the provider must make a copy of the billing claim form that was sent to the OHC, write "90-day response delay" on the form, and upload the document to the Attachments form in ProviderConnect. For additional information on how to upload this document, refer to the *Recordkeeping and Auditing* section of this manual for recordkeeping requirements including the required document naming convention for documentation supporting OHC.

Exceptions to Billing an OHC Prior to Billing SAPC

There are certain situations where providers can bill SAPC for patients who have OHC without billing the OHC first. These situations include the following:

1. In the event the OHC of a patient has expired, providers must request the removal of the OHC from the patient's record from DHCS, confirm the removal of the OHC, and then bill SAPC directly. OHC removal requests are made through the DHCS website. Please refer to the *Removing Inactive OHC from a Patient's Record* section of this manual for more information.

Important! Providers must ensure the OHC was removed from the DHCS system prior to billing SAPC, or claims billed to DMC will be denied.

2. In the event the patient has active OHC but the OHC only covers vision, dental, hospital inpatient, or prescription services, providers can bill DMC for SUD services instead of the OHC carrier. In this situation, the State will allow DMC to cover the cost of the service(s).
3. In the event the patient qualifies for the Minor Consent Program Services, which permits patients under 21 years of age access to confidential, limited Alcohol and Other Drug treatment services, providers can bill SAPC prior to billing the OHC. This program is funded by the State General Fund and is in accordance with Family Code Section 6929, welfare and institutions code section 14010 and title 22 of the CCR section 51473.2. Providers must contact Medi-Cal directly to verify a patient qualifies for this program.

Removing an Inactive OHC From a Patient's Record

In situations where the OHC in a patient's record with DHCS is determined to be inactive, providers must request it to be removed by DHCS prior to billing SAPC for DMC covered services. Before a provider begins a request to remove an inactive OHC from a patient's record, it is strongly recommended that the provider verifies that the patient's OHC is inactive. Please refer to the *Verify Active DMC and OHC* section of this manual for resources to verify OHC enrollment.

Once the provider has verified that the OHC is inactive, the provider should request the removal of inactive OHC by DHCS using the steps below.

1. Visit the website: https://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx.
2. Select 'OHC Removal(s) Form'.
3. Complete all required fields and submit the form.

Once the request to remove an inactive OHC has been processed, the provider must verify that the inactive OHC has been removed by using the AEVS system, Availity, or the Real Time 270 Eligibility Request form. Inactive OHC records are typically removed within one (1) business day of the request if made within DHCS business hours. If the request is made outside of business hours, it can take up to two (2) business days for the inactive OHC to be removed from a patient's record. Providers must wait for the removal of the inactive OHC to be removed from the DHCS system prior to billing SAPC or the claims may be denied by DMC.

If unable to use the online form to request removal of an OHC record for a patient, providers can call the DHCS Telephone Service Center at (800) 541-5555 to request removal of the inactive OHC from the patient's record. When requesting to remove an inactive OHC via the telephone option, the caller will obtain a case number that should be kept for record keeping purposes. Once the request has been made, the provider must check the AEVS, Availity, or the Real Time 270 Eligibility Request form in ProviderConnect. The provider should bill SAPC, only after verifying that the inactive OHC has been removed from the patient's record in the DHCS system. Providers will not receive notification that the OHC has been removed from the patient's record. As such, providers should check the patients record to validate the OHC has been removed.

Medicare as an OHC

Patients who are enrolled in both Medicare and Medi-Cal concurrently (aka Medi-Medi) fall into two separate categories for claiming depending on the services provided.

A. **Non-OTP Providers:** General Medicare is not considered an OHC for Non-OTP providers in the SAPC network. DHCS has made an exemption for patients with Medicare Parts A and B and Medi-Cal. If the patient has coverage under Medicare Parts A and/or B only, those claims are exempt and should be billed directly to SAPC.
    a. If the patient has coverage under Medicare Part C or Medicare Advantage (MA) plans, then all services must be billed to the MA carrier first, before billing to SAPC. MA plans are not exempt from OHC.
    b. For any situation in which Medi-Cal has an associated OHC carrier, providers must follow standard OHC billing guidelines, regardless of Medicare status.
B. **OTP Providers:** Per SAPC Information Notice 20-01, OTPs must be enrolled as a Medicare provider and must bill Medicare first for all services delivered by the OTP to Medicare recipients.

When a beneficiary has both Medicare fee-for-service and Medi-Cal with an OHC, providers must bill in the following sequence[8]:

1. Medicare for all services delivered by OTP providers
2. Medi-Cal Other Health Coverage or the Medicare Advantage part C carrier for all providers and services
3. Drug Medi-Cal

When uploading supporting documentation for this scenario to the patient's chart in ProviderConnect, providers must attach:

- Medicare Explanation of Medicare Benefits/Medicare Remittance Notice or Medicare Common Working File documentation; AND
- The EOB with the denial from the OHC or the denial letter from the OHC.

Section 2: OHC Codes and Scope of Coverage Descriptions

Federal and State regulations require providers to take all reasonable measures to determine liability of a beneficiary's OHC to pay for services and requires beneficiary cooperation to identify an OHC.[9]

Medi-Cal beneficiaries who have OHC through a third-party insurance carrier or health plan are coded in AEVS with unique cost avoidance codes (OHC codes and COV codes). The combination of COV and OHC Codes helps a provider determine when to bill OHC before billing Medi-Cal.

Important! Patients with a COV of "O", "I", or "M" in combination with an OHC Code of "A", "C", "F", "H", "K", "P", or "W" must have SUD services billed to the OHC prior to billing

[8] DHCS, Other Health Coverage (OHC), November 2020, page 1
[9] MHSUDS 16-064

OHC Code Definitions

When an OHC Code appears in AEVS, this is an indication that the patient has other health insurance. Refer to table below of OHC Codes, code description, and determination if the OHC is required by Medi-Cal to be billed before billing Medi-Cal. If the OHC Code row indicates “Not Required,” in the "Required to Bill OHC Prior to Medi-Cal” column of the table below it means that the OHC does not need to be billed prior to billing Medi-Cal.

OHC Code	Code Description	Required to Bill OHC Prior to Medi-Cal
A	Pay and chase (applies to any carrier)	Not Required
C	Military benefits comprehensive	Required
D	Medicare Part D Prescription Drug Coverage	Not Required
E	Vision plans	Not Required
F	Medicare Part C Health Plan	Required
G	Medical parolee	Required
H	Multiple plans comprehensive	Required
K	Kaiser	Required
L	Dental only policies	Not Required
P	PPO/PHP/HMO/EPO not otherwise specified	Required
Q	Commercial pharmacy plans	Not Required
V	Any carrier other than the above (includes multiple coverage)	Required
W	Multiple plans non-comprehensive	Required

Scope of Coverage

Scope of Coverage indicates different types of services that a patient is eligible to receive under their covered OHC (chart 1). All SUD services fall under Hospital Inpatient (I), Hospital Outpatient (O), and/or Medical and Allied Services (M) service categories.

Chart 1: Scope of Coverage (COV)

Scope of coverage (COV) Codes Chart

COV Code	Service Category
P	Prescription Drugs/Medical Supplies
L	Long Term Care
I	Hospital Inpatient
O	Hospital Outpatient
M	Medical and Allied Services
V	Vision Care Services
R	Medicare Part D
D	Dental Services

OHC Exceptions/Exemptions

Patients may have insurance coverage that is not considered OHC and does not need to be billed prior to billing SAPC. These types of insurance include:

- Personal injury and/or medical payment coverage covered under automobile insurance
- Life insurance
- Workers’ compensation
- Homeowners insurance
- Umbrella insurance
- Accident insurance
- Income replacement insurance (i.e., Aflac)

Section 3: SAPC Service Authorization Requests for Patients with OHC

SAPC strongly recommends providers submit a service authorization within 30 days of upon admission, including for patients with both Drug Medi-Cal and OHC benefits. Service authorization requests for patients with OHC must adhere to and meet current standards and requirements for service authorizations. If a patient has an OHC, the provider should include a comment in the service authorization justification indicating that the patient has an OHC. However, as previously indicated, providers should not send claims to SAPC for these services until the OHC carrier has already been billed and has denied the claims or a response has not been received for 90 calendar days.

The recommendation to submit the service authorization prior to claims being denied by the patient's OHC is to support providers in obtaining a member authorization at the time that the patient receives SUD services. This allows the SAPC Utilization Management Care Manager (Care Manager) to review the authorization submission and offer providers feedback to support the provider gathering any additional required documentation and to follow-up with the patient should the Care Manager require any clarification to approve the service authorization.

Non-DMC services such as Recovery Bridge Housing or incentive services authorized through Provider Authorizations (PAuths) will not be affected by a patient having OHC and will not require providers to submit any details to SAPC regarding OHC.

Providers will be able to hold submission of a member authorization request until a claim denial from the OHC has been received, and SAPC Utilization Management will consider authorization requests submitted more than 30 days following the date of service when providers include a comment in the service authorization justification indicating that the patient has an OHC and that the provider was delayed from submitting their service authorization due to waiting for receipt of an OHC denial. However, service authorization requests for patients with OHC must adhere to and meet current standards and requirements for service authorizations. Providers are at risk for denials of authorization when documentation does not adhere to these service standards, and correcting documentation deficiencies becomes more difficult to address when there are extended durations of time between the initial date of admission and the Care Manager's review of the authorization submission.

SAPC's standard policy requires authorization requests be submitted within 30 days from the initial date of service, with narrow exceptions associated with delays in establishing financial eligibility. Even with these exceptions, SAPC requires that all authorization requests be submitted no later than 120 days from the initial date of service.

Section 4: Recordkeeping and Auditing

Required Supporting Documentation for Claims

DMC billing requires that claims for any service partially paid or denied by a patient's OHC must be accompanied by an EOB or a denial letter from the OHC. As previously noted, the EOB or denial letter must include the following information:

1. Carrier or carrier representative name and address
2. Client name or Social Security Number
3. Date
4. Statement of denial, termination, or amount paid
5. Procedure or service rendered
6. Termination date or date of service

If the SUD service is not a covered benefit by the client's OHC it is acceptable to provide a copy of the original denial letter or EOB for the same client and service for a period of one year from the date of the original EOB or denial letter. Providers can also submit a dated statement of non-covered benefits from the carrier if it matches the insurance name and address and the client's name and address.

If the OHC has not responded to a claim within 90 (ninety) calendar days of submission, a copy of claim can be submitted as documentation in ProviderConnect. The document must have notation of "90-day response delay" and clearly show the date of submission and details of any follow-up efforts conducted with the OHC to receive an adjudication of the claim.

How to Provide Required Documentation

The required documentation to support claims when a patient has OHC must be uploaded to the patient's chart in ProviderConnect. It is recommended, but not required, that providers also keep a copy of the documentation in the patient's files for auditing purposes.

All OHC related documents are to be uploaded to ProviderConnect via the Attachments form. SAPC maintains a document with the required standardized naming conventions for documentation uploaded via the Attachments form. This document is located on the SAPC Sage website at: http://publichealth.lacounty.gov/sapc/Sage/Documentation/FileNamingConvention.pdf.

The naming convention for OHC documentation is to follow the standardized naming convention format as follows:

- **Standard Naming Convention Format:** [Type of Document]-[Dates of service covered by document (MM-DD-YY_M-DD-YY)]-[Patient's First & Last Initial]-[Patient ID]
  - **Type of Document for OHC:** OHCSupport
- **OHC Documentation File Name Example:** OHCSupport-(12-12-20_12-31-20)-JD-ID99999

Monitoring of OHC Documentation

SAPC will conduct periodic reviews of claims submitted with OHC information to validate that the appropriate documentation was attached in ProviderConnect and to ensure adherence to the OHC documentation requirements. OHC claims lacking the required supporting documentation may be subject to disallowances of services and recoupment of funds.

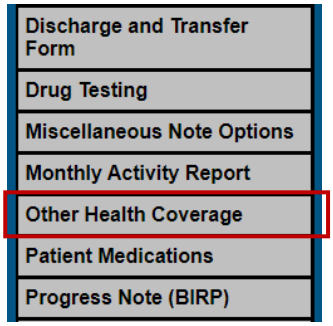
Section 5: Billing OHC via ProviderConnect (Primary Sage Users ONLY)

Primary Sage Users will enter OHC information on each appropriate claim and service through the Treatment page in Sage. OHC information must be added to each individual service that was denied, partially paid, or billed but did not receive a response by the OHC within 90 calendar days.

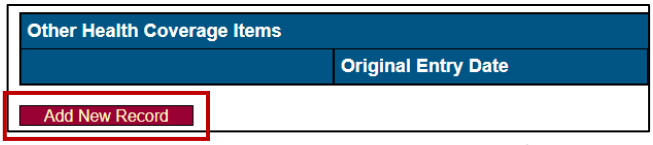
Completion of Other Health Coverage Form

For each active patient in Sage that has active OHC, it is required that the Other Health Coverage form be completed. This form collects the patient's OHC information to be transmitted when billing Medi-Cal.

1. From the Client Record page, click **Other Health Coverage** from the left-hand menu bar.



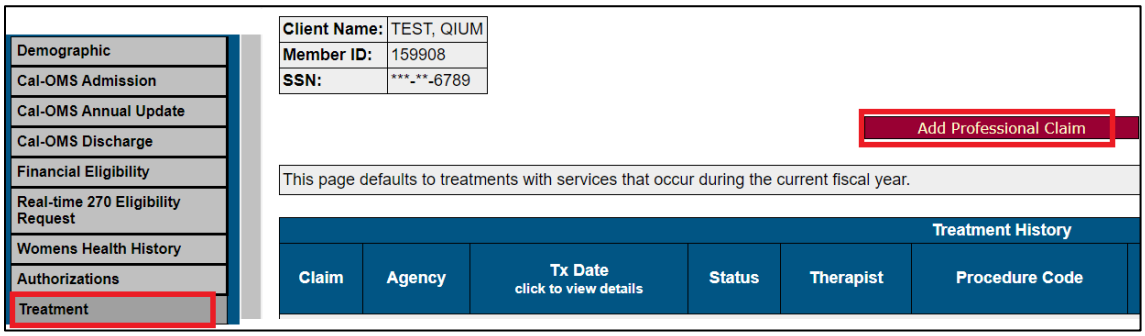
2. If the patient has more than one episode, select the appropriate episode number for the Program to enter the OHC information under.
3. Select **Add New Record** on the Other Health Coverage Items screen.



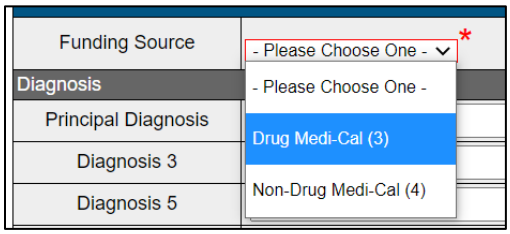
4. On the Other Health Coverage record entry form, complete the required fields as noted in following steps.
5. Enter today's date in the **Original Data Entry Date** field.
6. Enter the date the patient's OHC insurance effective date in the **Effective Date** field.
    a. The **Expiration Date** field should only be completed if the patient's OHC has officially expired and the patient no longer is covered by the insurance plan.
7. For the **Payer Responsibility** field, select 'Primary' from the dropdown.
8. For the **Client's Relationship to Subscriber** field, select the appropriate response from the dropdown based on the patient's relationship to the subscriber of the OHC insurance plan.
    a. If the patient is the subscriber of the OHC insurance plan, select 'Self'.
    b. If the patient is not the subscriber of the OHC insurance plan, select the response that best reflects their relationship to the OHC subscriber.
9. In the **Subscriber Name** field, enter the name of the subscriber of the OHC insurance plan.
    a. If the patient is the subscriber of the OHC insurance plan, type the patient's name.
    b. If the patient is not the subscriber of the OHC insurance plan, type the name of the subscriber.
10. In the **Subscriber Policy Number** field, enter the policy number of the OHC insurance plan.
11. For the **Subscriber Assignment of Benefits** field, select the appropriate response.
12. For the **Subscriber Release of Information** field, select the appropriate response.
13. In the **Third Party Payer Name** field, enter the name of the patient's OHC carrier.
14. In the **Third Party Payer Identifier** field, enter the OHC carrier's Payer Identification code.
15. For the **Claim Filing Indicator Code** field, select 'Commercial Insurance Co.'
16. Click the **Save Changes** button to save the OHC record.

Creating a Treatment with OHC Information

1. Click on the **Treatment** option on the left-hand menu of the patient's chart.
    a. Click **Add Professional Claim**.

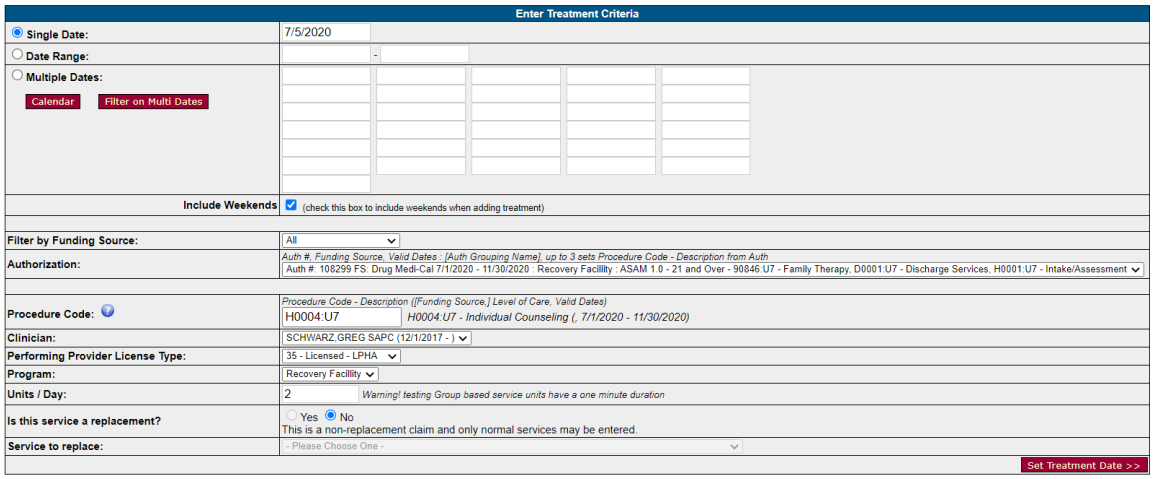


    b. Under **Funding Source**, select Drug Medi-Cal (3) and click the Add Claim button. <u>OHC entry is not required for Non-DMC claims</u>.



    c. Click **Add Professional Service.**

    d. Enter the details of the service in the **Enter Treatment Criteria** page as usual.



i. Fill out the date(s) of service:
   1. **Single Date**: Type the date in MM/DD/YYYY format.
   2. **Date Range**: Type both dates in MM/DD/YYYY format.
   3. **Multiple Dates**: Either type all dates in MM/DD/YYYY format or click on **Calendar** to select each date individually.
      a. If using the **Calendar**, click on each date the service was provided on. Once finished, click **Select Dates**.

ii. Select the appropriate **Authorization** and **Procedure Code.**

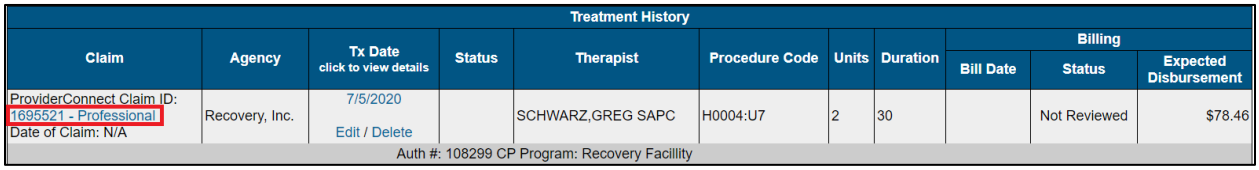
iii. Select the **Clinician**, **Performing Provider License Type**, and **Program**.

iv. Enter the number of **Units/Day.**

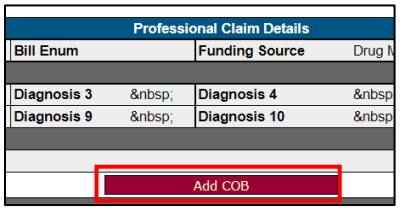
e. Click **Set Treatment Date** when complete.
   i. Fill out the **Duration**, **Location**, and **Private Pay Amount Add/Edit** fields.

f. Click **Add Treatment(s).**

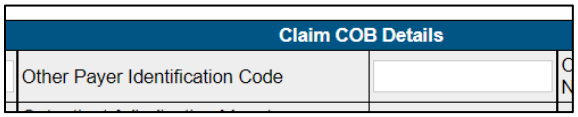
2. Once the Treatment(s) is added, return to the Treatment page to find the services that need the OHC information added. You may need to filter by Fiscal Year and Month of Services Entered.
3. Under the Claim column click on the blue hyperlinked Claim ID number for the Service which needs OHC information added. This will direct to the Professional Claim Details page.



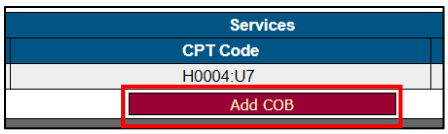
4. Click **Add COB** under the Professional Claim Details section.



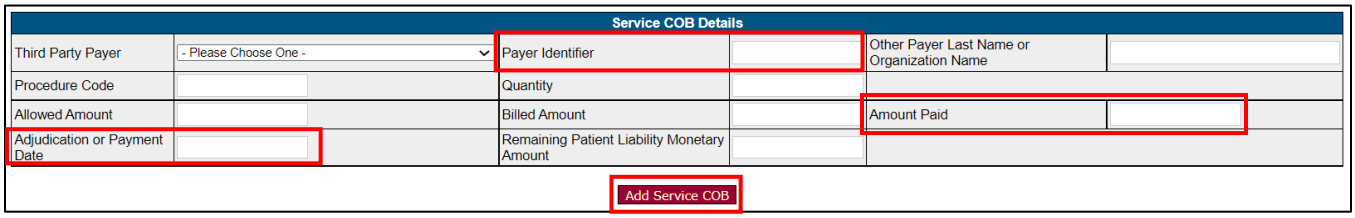
5. In the **Other Payer Identification Code** field, enter the Payer Identification code for the patient's OHC carrier. <u>No other fields should be completed on this form.</u>



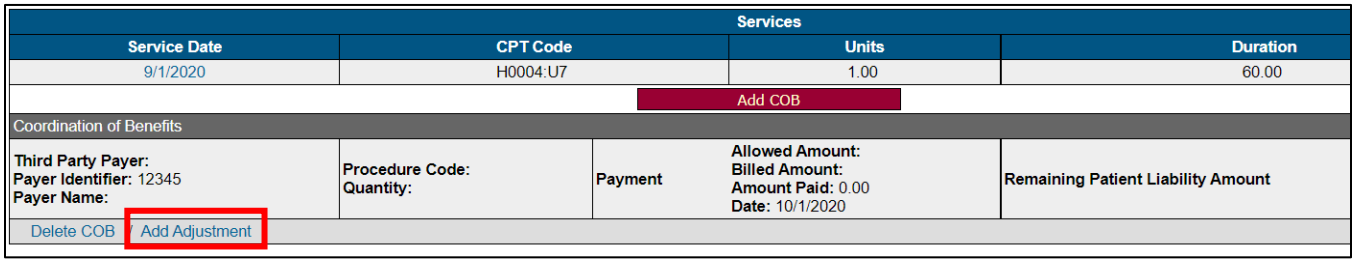
6. Click the **Add Claim COB** button to save the information and to go back to the Professional Claim Details screen.
7. Click **Add COB** under the Services section.



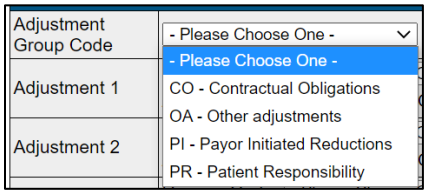
8. Enter the information from the OHC EOB into the noted fields.
    a. In the **Payer Identifier** field, enter the Payer Identifier code for the patient's OHC carrier.
    b. In the **Amount Paid** field, enter the amount paid for the service by the OHC.
        i. If the claim was denied by the OHC, enter a zero in this field.
        ii. If the claim was not adjudicated by the OHC and is being billed under the 90-day delay allowance, a zero should be entered in this field.
    c. In the **Adjudication or Payment Date** field, enter the adjudication or payment date for the service billed to the OHC.
        i. If OHC information is being entered for a claim not adjudicated by the OHC for 90 calendar days, enter a date at least 91 days from the date of service.
    d. Click the **Add Service COB** button to save the information and to go back to the Professional Claim Details screen.



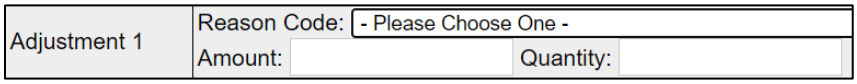
9. If a claim was fully or partially denied by an OHC the Denial Codes provided by the OHC on the EOB are required by the State for processing.
10. Once the Add Service COB is clicked the screen will return to the Add Professional Service screen. In the services section the added COB information is now visible. To add the denial code click **Add Adjustment.**



11. On the Adjustment Details form, enter the information from the OHC EOB into the noted fields.
    a. Enter the Denial Code(s) as provided by the OHC. If a response was not received within 90 days of the request, the State indicates to use OA 192.
    b. Select the **Adjustment Group Code** from the drop-down menu.



    c. Select the **Reason Code** from the drop-down menu.
        i. You may enter the number associated with the Claim Adjustment Reason Code and the drop-down will go to directly to that code.
            1. If the denial code provided by the OHC is not available in the drop-down, please open a Sage Help Desk ticket.

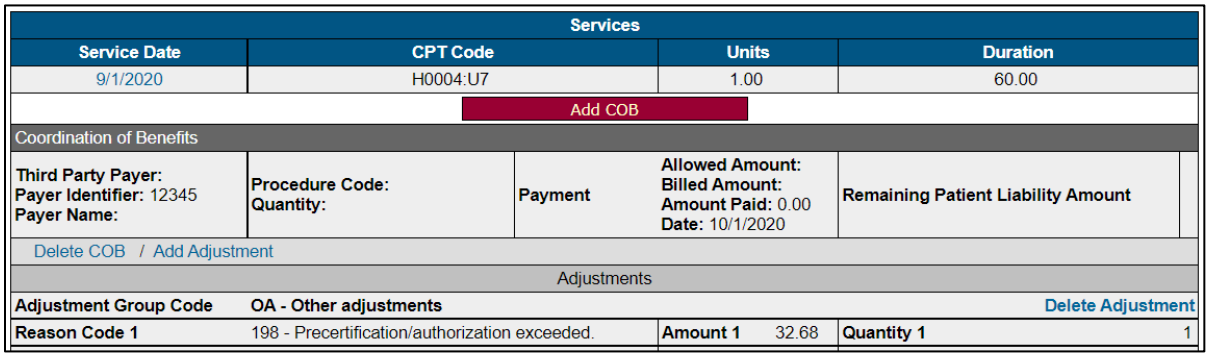


    d. Enter the dollar amount associated with the denial code in the **Amount** field.

e. Enter '1' in the **Quantity** field.
f. Click **Add Adjustment** when all adjustments have been entered.

Add Adjustment

12. The added adjustments are now attached to the service.



Services			
Service Date	**CPT Code**	**Units**	**Duration**
9/1/2020	H0004:U7	1.00	60.00
	Add COB		
Coordination of Benefits			
Third Party Payer: **Payer Identifier:** 12345 **Payer Name:**	**Procedure Code:** **Quantity:**	**Payment**	**Allowed Amount:** **Billed Amount:** **Amount Paid:** 0.00 **Date:** 10/1/2020	**Remaining Patient Liability Amount**
Delete COB / Add Adjustment			
Adjustments			
Adjustment Group Code	**OA - Other adjustments**		Delete Adjustment
Reason Code 1	198 - Precertification/authorization exceeded.	**Amount 1** 32.68	**Quantity 1** 1

13. If an error was made in the Add Adjustment screen, delete the entry by clicking **Delete Adjustment** and enter the correct information.

Once the OHC information has been entered for the desired claims and services, proceed with billing by generating a new bill. All entered OHC information will populate in the bill that SAPC will send to the State. When the State adjudicates the claim and notes the OHC information, this action will prevent State denials that are caused by OHC reasons.

OHC Responses After 90 Days of Billing When SAPC Has Been Billed

In the event an OHC is delayed in responding to providers and a claim has already been billed to SAPC, the provider may need to either void or replace the claim(s).

VOID: If the OHC response pays the full amount charged to SAPC, the provider should void the claim as payment has been rendered by the OHC.

REPLACE: If the OHC pays less than the full amount charged to SAPC, the provider should replace the claim. The replaced claim should include the new OHC information and only charge SAPC the uncovered portion of the claim.

Section 6: Billing OHC via 837 (Secondary Sage Users ONLY)

Providers using the 837 HIPAA transaction process, i.e. Secondary Sage Users, need to ensure the proper formatting and information is included on the 837 files submitted to SAPC as indicated in the current 837 companion guides. Providers delivering Withdrawal Management 3.7 and 4.0 should reference the 837I Companion Guide, all other service providers should use the 837P Companion Guide.

After receiving the benefits information from the OHC, including EOBs, denial letters, or partial payments, providers must enter that information into their primary electronic health record system to populate the 837 files sent to SAPC. Providers must also ensure that when creating 837s to transmit to SAPC, the OHC claim information is populated on the correct loops (Loop 2320, Loop 2330BA, and 2330B). SAPC and DHCS require OHC information to be entered at the service level for each claim. As such, each claim must include the service line adjudication information in Loop 2430 for each service rendered. Errors in formatting will result in the file being rejected or claims being denied. Claims that indicate OHC is required for billing but have incomplete or invalid OHC information, will be rejected on the 277CA and the Critical Error Report and need to be corrected before being adjudicated. For instance, if the payer ID is missing on the claim, it will be rejected using:

- *A7:479 Other Payer Primary ID is missing or invalid or the value sent in the 2330 loop does not match the value sent in the 2430 loop*

It is important that the claim dollar amount and service dollar amounts are balanced, where adding all the individual services equals the total claim. If the dollar amounts are unbalanced, this can result in various claim rejections on the 277CA and critical errors, especially for claims that contain multiple services. Claims/Services that are rejected do not move through the adjudication process and will not show on corresponding EOBs or 835s. If there are formatting errors, the entire file can be rejected outright where no claim is processed. When entire files are rejected, SAPC IT will reach out to the provider contact with the rejection information. For files that are accepted, but contain rejected claims, providers also need to review all corresponding 277CA files for rejected claim information. Common rejection codes on the 277CA for out of balance claims are as follows:

1. *A7:178 Total claim charge amount not equal sum of line-item charge amount*
2. *A7:400 Claim is out of balance - service line paid amount + all service line adjustment amounts do not equal the line-item charge amount*

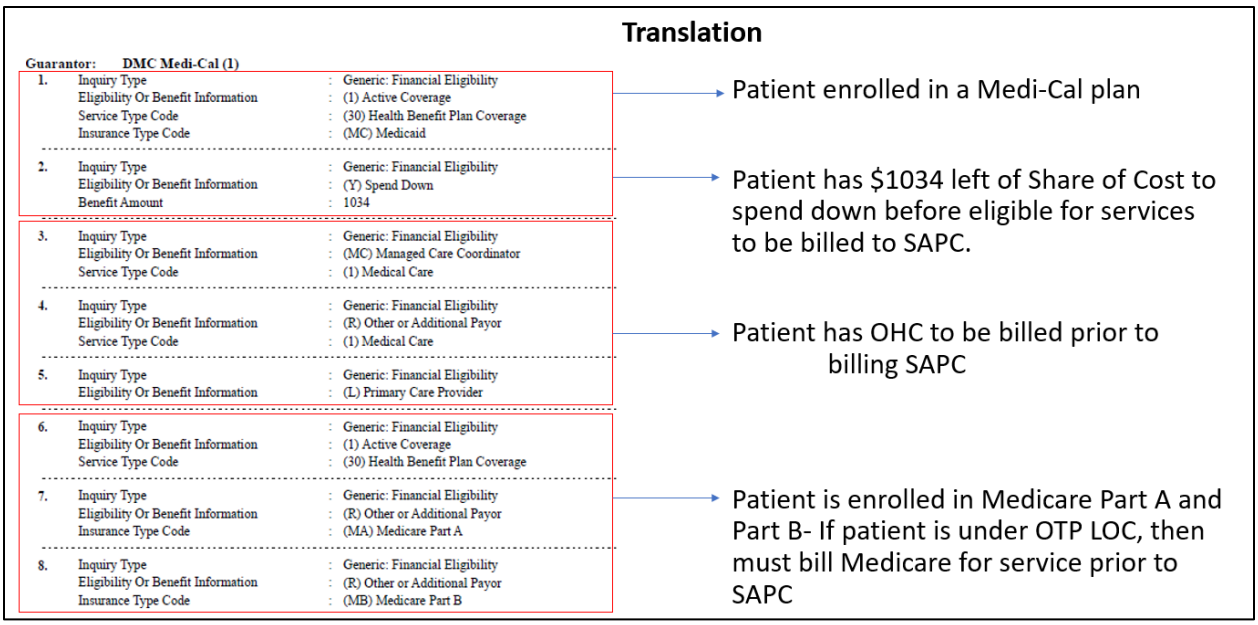
As each Secondary Sage User utilizes a unique system as their primary electronic health record and has unique workflows, it is the responsibility of the provider to ensure their system and workflows are configured to provide the correct information on the corresponding 837 files. OHC claim information must indicate or include the following information:

1. Medi-Cal as a secondary payer
2. The OHC/Primary payor information, including Payer ID
3. Amount paid by OHC, which should be 0 if the payment was denied
4. Amount denied by OHC
5. CARC code sent by OHC
    a. For Presumed Denials, as defined by DHCS in ADP Bulletin 11-01, in which the OHC did not respond to the provider inquiries within 90 days of request, providers should use OA 192 as the CARC code in the CAS segment.
6. Date of remittance from OHC

Section 7: State Denials for OHC

Preventing OHC Denials

As Medi-Cal is the payor of last resort, the State will deny claims for patients who had OHC and there is no indication on the claim that OHC was billed prior to billing DMC. State denials for OHC related reasons are preventable. As indicated in the Provider Manual, providers are required to run eligibility checks prior to admission and monthly while the patient is in treatment. Running the Real Time 270 Eligibility Request will check if the patient has OHC. Below is a sample 271 Eligibility Response with OHC.



Providers should check with the patient to obtain more specific information about what other health plan they have to determine if the OHC covers DMC services and providers should follow the recommendations and requirements as noted in this manual.

Section 8: OHC Support

For questions regarding OHC billing, providers should reach out to the appropriate party to receive support and technical assistance. Suggested contacts are listed below.

- For technical assistance to resolve or understand OHC denials from the State or to understand SAPC billing requirements, submit a ticket to the Sage Help Desk via phone at (855) 346-2392 or via the online portal at https://netsmart.service-now.com/plexussupport.
- For technical assistance with understanding requirements within SAPC's 837 Companion Guides, contact SAPC IT at SAPC_support@ph.lacounty.gov.
- For assistance with AEVS or a patient's record with DHCS, contact DHCS directly. For assistance with AEVS, providers can contact the AEVS help desk at (800) 427-1295. For questions on Medi-Cal policy, providers can contact the Medi-Cal Telephone Support Center (800) 541-5555.
- For additional resources from DHCS on OHC, guidelines for billing OHC and additional information can be found on DHCS's OHC webpage at https://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx.