

Other Health Coverage (OHC) Guidelines for Billing

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A recipient eligible for Medi-Cal may also have Other Health Coverage (OHC). In most circumstances, OHC must be billed prior to billing Medi-Cal. For information about billing Medi-Cal after billing the OHC, refer to the Other Health Coverage (OHC) section in the Part 2 manual.

Cost-Avoided OHC and HMO Coverage Codes

If a recipient's OHC code is one of the following and the service rendered falls within the recipient's Scope of Coverage (COV) under the OHC, the provider must advise the recipient to contact the Health Maintenance Organization (HMO) or bill the OHC before billing Medi-Cal.

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

A recipient is required to utilize their OHC prior to Medi-Cal when the same service is **available under the recipient's private health coverage. Providers are not allowed to deny** Medi-Cal services based upon potential third party liability. If the recipient elects to seek services not covered by Medi-Cal, Medi-Cal is not liable for the cost of those services. To establish Medi-Cal's liability for a covered Medi-Cal service, the provider must obtain an acceptable denial letter from the OHC entity.

More information about the Medi-Cal program and benefits can be found at:

«<https://www.dhcs.ca.gov/Documents/myMediCal.pdf>»

Billing OHC Before Medi-Cal

In most situations, providers are required by law to exhaust the recipient's OHC before billing Medi-Cal. In those situations where OHC utilization is not required before billing Medi-Cal, providers are still encouraged to bill OHC first.

OHC Code A

Providers are allowed, but not required, to bill the OHC carrier prior to billing Medi-Cal if the response from the Medi-Cal eligibility verification system is the "A" OHC code.

OHC Code C

OHC Code "C" identifies Medi-Cal recipients who have OHC through a military benefits health care plan. Providers under military benefits health care plans (for example, Tricare) should treat the recipient. For other providers when the benefit is covered under such a plan, that provider should advise the recipient to utilize benefits under the military benefits health care plan. When submitting a bill to Medi-Cal, the provider must include satisfactory documentation that treatment is not available under the recipient's OHC coverage, a denial from the OHC for the billed claim or an explanation of benefits if the amount paid by the OHC is below the Medi-Cal contracted amount for the service.

OHC Code D

«OHC code "D" identifies Medi-Cal recipients who have Medicare Part D health insurance coverage (prescription drug plan). If the provider is not under the Part D plan and the benefit is available under the Part D plan, the provider should advise recipients to utilize their Part D benefits through a covered provider.

This code is not applicable to claims billed through the California MMIS Fiscal Intermediary.»

OHC Code E

OHC code "E" identifies Medi-Cal recipients who have health insurance coverage limited to vision care. This can be through either single or multiple vision plans. For an OHC-covered service, non-contracted vision providers of the insurance coverage should advise the recipient to utilize the OHC. When submitting a bill to Medi-Cal, the provider must include satisfactory documentation that treatment is not available under the recipient's OHC coverage, a denial from the OHC for the billed claim or an explanation of benefits if the amount paid by the OHC is below the Medi-Cal contracted amount for the service.

OHC Code F

OHC code “F” identifies Medi-Cal recipients who have health insurance coverage through a Medicare Part C Health Plan (also known as a Medicare HMO) in lieu of traditional Medicare fee-for-service. Recipients, who have both Medi-Cal and a Medicare Part C plan, should seek medical treatment through the Medicare Part C plan. If not a provider under the Medicare Part C plan and the benefit is covered under the Medicare Part C plan, the provider should advise recipients to utilize their Medicare Part C benefits with a provider in their Medicare Part C plan network. When submitting a bill to Medi-Cal, the provider must include satisfactory documentation that treatment is not available under the recipient’s OHC coverage, a denial from the OHC for the billed claim or an explanation of benefits if the amount paid by the OHC is below the Medi-Cal contracted amount for the service.

OHC Code G

California Correctional Health Care Services (CCHCS) contracted providers should contact CCHCS to verify recipient eligibility. If not a CCHCS contracted provider, the provider should advise recipients to utilize their benefits through CCHCS.

OHC Code H

OHC code “H” identifies Medi-Cal recipients who have multiple health insurance coverages which are comprehensive. If not a contracted provider of the insurance coverage and the service is covered by the OHC, the provider should advise recipients to utilize their OHC. When submitting a bill to Medi-Cal, the provider must include satisfactory documentation that treatment is not available under the recipient’s OHC coverage, a denial from the OHC for the billed claim or an explanation of benefits if the amount paid by the OHC is below the Medi-Cal contracted amount for the service.

OHC Code K

OHC code “K” identifies Medi-Cal recipients who have health insurance coverage through Kaiser. If not a Kaiser contracted provider and the service is covered by Kaiser, the provider should advise recipients to utilize their Kaiser benefits. When submitting a bill to Medi-Cal, the provider must include satisfactory documentation that treatment is not available under the recipient’s OHC coverage, a denial from the OHC for the billed claim or an explanation of benefits if the amount paid by the OHC is below the Medi-Cal contracted amount for the service.

OHC Code L

OHC code “L” identifies Medi-Cal recipients whose third party coverage is limited to dental services. This code is not applicable to claims billed through the California MMIS Fiscal Intermediary.

OHC Code P

OHC code “P” identifies Medi-Cal recipients who have health insurance coverage through a PPO/PHP/HMO/EPO not otherwise specified. If not a PPO/PHP/HMO/EPO contracted provider and the service is covered by the PPO/PHP/HMO/EPO, the provider should advise recipients to use their benefits under the PPO/PHP/HMO/EPO. When submitting a bill to Medi-Cal, the provider must include satisfactory documentation that treatment is not available under the recipient’s OHC coverage, a denial from the OHC for the billed claim or an explanation of benefits if the amount paid by the OHC is below the Medi-Cal contracted amount for the service.

OHC Code Q

«OHC code “Q” identifies Medi-Cal recipients who have health insurance limited to commercial pharmacy coverage. This can be through either single or multiple commercial pharmacy plans. If not a contracted commercial pharmacy provider of the insurance coverage and the service is covered by the OHC, the provider should advise recipients to utilize their OHC.

This code is not applicable to claims billed through the California MMIS Fiscal Intermediary.»

OHC Code V

OHC code “V” identifies Medi-Cal recipients who have multiple coverages. If not a contracted provider of the insurance coverage and the service is covered by the insurance coverage, the provider should advise recipients to utilize their insurance coverage. When submitting a bill to Medi-Cal, the provider must include satisfactory documentation that treatment is not available under the recipient’s OHC coverage, a denial from the OHC for the billed claim or an explanation of benefits if the amount paid by the OHC is below the Medi-Cal contracted amount for the service.

OHC Code W

OHC code “W” identifies Medi-Cal recipients who have multiple health insurance coverages which are non-comprehensive. If not a contracted provider of the insurance coverage and the service is covered by the OHC, the provider should advise recipients to utilize their OHC. When submitting a bill to Medi-Cal, the provider must include satisfactory documentation that treatment is not available under the recipient’s OHC coverage, a denial from the OHC for the billed claim or an explanation of benefits if the amount paid by the OHC is below the Medi-Cal contracted amount for the service.

Not Considered to be OHC

The following is a partial list of insurance that is not considered to be OHC.

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

Note: Medi-Cal providers should advise recipients enrolled in Medi-Cal managed care plans to contact the plan for treatment unless the provider is authorized to treat under the plan. Refer to the MCP: An Overview of Managed Care Plans section in this manual for more information.

Reporting OHC

State law requires Medi-Cal providers to notify the Department of Health Care Services (DHCS) if they believe a recipient is entitled to OHC. To update or modify OHC information, providers may use the secure OHC Processing Center Forms accessible on the OHC page of the DHCS website: <http://dhcs.ca.gov/OHC>.

Providers who are unable to use the online forms should call the Telephone Service Center (TSC) at 1-800-541-5555.

Locating Recipient's OHC Information

The Medi-Cal eligibility verification system returns a message that includes OHC information, when known. The eligibility verification system is accessed through the *Automated Eligibility Verification System (AEVS)*, state-approved vendor software and the Medi-Cal website at www.medi-cal.ca.gov.

Note: A worksheet for recording eligibility information conveyed via telephone, the *Automated Eligibility Verification System (AEVS) Response Log*, is in the *AEVS: Transactions* section of the Part 1 manual.

Website Eligibility Response

In the following example of a Medi-Cal website eligibility response, the OHC information is found in the Eligibility Message section: Other Health Insurance Coverage Under Code B; Scope of Coverage-IOMP.

Name: Doe, Jane		
Subscriber ID: 1234567890		
Service Date: 01/15/2019	Subscriber Birth Date: 12-22-1976	Issue Date: 07-02-2017
Primary Aid Code: 48	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 34 - Sacramento	HIC Number:	
Primary Care Physician Phone #:	Service Type:	
Spend Down Amount Obligation: \$50.00	Remaining Spend Down Amount: \$50.00	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: SUBSCRIBER LAST NAME: DOE, CNTY CODE: 34, PRIMARY AID CODE: 48, MEDI-CAL ELIBIGLE FOR PREGNANCY/POSTPARTUM SVCS W/NO SOC, ALL OTHER MEDI-CAL SVCS, RECIPT, HAS SOC OF \$50.00, REMAINING SOC \$50. OTHER HEALTH INSURANCE COVERAGE UNDER CODE B, SCOPE OF COVERAGE: IOMP.		

Figure 1: Sample Website Eligibility Response

POS/AEVS: Multiple Insurer Messages

If a recipient has reported multiple insurance policies, the Point of Service (POS) network returns a message identifying the OHC codes of the other insurance carriers. If eligibility is checked via the AEVS, a carrier code that identifies the insurer is stated. A list of carrier codes is in the *AEVS: Carrier Codes for Other Health Coverage* section of the Part 1 manual available on the Medi-Cal website at www.medi-cal.ca.gov.

Eligibility Verification

When requesting eligibility verification for a recipient with OHC, the Medi-Cal eligibility verification system returns a message stating a recipient's Scope of Coverage (COV). COV codes designate the specific service categories covered by a recipient's health coverage.

OHC Code Explanation

When an OHC code appears, this indicates the existence of other health insurance. This code indicates the name of the recipient's health care plan. Other insurance companies or HMOs have different codes. In the website eligibility response sample on a previous page, "Other Health Insurance Coverage Under Code "B" is located in the "Eligibility Message".

Scope of Coverage (COV) Code Explanation

Each COV code indicates a different set of services. Refer to the COV code chart below.

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

Function of OHC and COV Codes

The combination of the OHC and COV codes helps providers determine when to bill OHC before billing Medi-Cal.

Emergency Care

Most HMO and PPO plans cover emergency care until the recipient's condition permits the transfer to the exclusive networks facilities. Providers should contact the OHC network for emergency treatment authorization and billing instructions. A recipient should never be denied emergency care services.

Foster Care Children

Medi-Cal providers should request the removal of the OHC indicator from the Medi-Cal Eligibility Data System (MEDS) for foster care children by calling the Telephone Service Center at 1-800-541-5555 or by using the secure OHC Processing Center Forms accessible on the OHC page of the DHCS website: <http://dhcs.ca.gov/OHC>. This policy applies to all children in foster care regardless of the aid code assigned to the child. The request for removal will be valid for 12 months. At that time, a new request must be submitted. After the OHC indicator has been removed, claims for Medi-Cal benefits may be billed directly to Medi-Cal.

The provider must treat all children in foster care regardless of the OHC indicator.

The provider is not required to submit the above documentation to DHCS. All documentation of non-coverage should be retained in the foster care child's medical file, as it may be subject to future review by DHCS.

Nondiscrimination

Under state law, when a provider obtains proof of eligibility, the provider must accept the Medi-Cal recipient and is bound by the rules and regulations of the Medi-Cal program. Obtaining proof of eligibility is done through the Medi-Cal eligibility verification system (see "Locating Recipient's OHC Information" on a previous page).

If a provider obtains proof of eligibility that indicates a recipient is eligible to receive services, the provider is not permitted to treat the recipient as private pay because of the recipient's OHC status for a Medi-Cal covered service. However, if the provider does not participate in the recipient's OHC plan, the provider should advise the recipient to use their OHC.

<<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.
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