Other Health Coverage (OHC)

This section describes the required steps for billing Medi-Cal when a recipient also has Other Health Coverage (OHC) or Medicare. Refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in the Part 1 manual for information about how to determine OHC beneficiary eligibility.

To update or modify OHC information, providers may use the secure OHC Processing Center Forms accessible on the OHC page of the Department of Health Care Services (DHCS) website at*: 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.

Medicare and OHC

When a recipient has both Medicare fee-for-service and OHC, the provider must bill payers in the following order:

1. Medicare for Medicare-covered services

2. OHC carrier

3. Medi-Cal. Attach the Medicare Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN) or Medicare Common Working File documentation and the OHC Explanation of Benefits (EOB) to the Medi-Cal claim.

VillageHealth Claims Medicare Part C Recipient

Claims for coinsurance and/or deductible claims only for dual-eligible VillageHealth Medicare Part C recipients with dates of service from January 1, 2006, through December 31, ‹‹2022››, must meet the following billing requirements:

- The *Remittance Advice* (RA) submitted with these claims must show "VillageHealth Medicare Part C" in the *Remarks* section in the bottom left corner and show the VillageHealth address and telephone number in the upper right corner.

- The claims must show the VillageHealth Plan Automated Eligibility Verification System (AEVS) carrier code for other health coverage: S323" in Box 51 of the *UB-04* claim form for institutional claims, Box 11c of the *CMS-1500* claim form for professional claims or Box 126A for Long Term Care (LTC) claims on the *Payment Request for Long Term Care* (25-1) claim form.

Claims for services not covered by Medicare Part C may be billed as regular Medi-Cal claims without other special billing requirements.

Medical Supply Claims: OHC Documentation

OHC documentation requirements for providers billing for medical supplies are simplified. Refer to the *Medical Supplies* section of the appropriate Part 2 manual for information.

Billing Medi-Cal After OHC

These principles must be followed when billing Medi-Cal after billing OHC:

1. Medi-Cal may be billed for the balance, including OHC copayments, OHC coinsurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any.

2. Medi-Cal will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as payment in full.

3. An EOB or denial letter from the OHC must accompany the Medi-Cal claim, except for pharmacy providers. Refer to "Pharmacy: Self-Certification for OHC" in this section.

4. The amount, if any, paid by the OHC carrier for all items listed on the Medi-Cal claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any OHC payment. Refer to claim form completion instructions in this manual for more information.

5. Medi-Cal approved HCPCS codes, CPT® codes and modifiers should be billed.

6. Do not bill with HCPCS codes, CPT codes or modifiers where OHC paid, but which Medi-Cal does not recognize or allow.

7. If services normally require a Treatment Authorization Request (TAR), the related procedures must be followed. Refer to the TAR Overview section of the Part 1 provider manual for additional information.

<u>OHC EOB or Denial Letter: Documentation Required by Medi-Cal</u>

When billing Medi-Cal for any service partially paid for or denied by the recipient's OHC, the OHC EOB or denial letter, or the recipient's letter documenting that OHC is not available, must accompany the claim and state the following:

1. Carrier or carrier representative name and address

2. Recipient'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

When a service or procedure is not a covered benefit of the recipient's OHC, a copy of the original denial letter or EOB is acceptable for the same recipient and service for a period of one year from the date of the original EOB or denial letter.

A dated statement of non-covered benefits from the carrier is also acceptable if it matches the insurance name and address and the recipient's name and address.

It is the provider's responsibility to obtain a new EOB or denial letter at the end of the one-year period. Claims not accompanied by proper documentation will be denied.

If a recipient changes to a different OHC, a new EOB, denial letter or dated statement of non-covered benefits is required from the new carrier.

Medical Supply Providers

After submitting an initial claim that establishes proof that OHC does not cover that supply, medical supply providers may submit claims for that supply for the same recipient and OHC without proof of OHC denial for a period of one year from the date of the EOB or OHC denial letter.

Providers billing for medical supplies may refer to the *Medical Supplies* section of the appropriate Part 2 manual for important OHC billing information.

OHC Cost-Sharing

Providers may not bill a Medi-Cal recipient more than the nominal Medi-Cal copayment amount. For further details, providers may refer to the *Provider Regulations* section of the Part 1 provider manual.

Delayed Insurance

If a response from the OHC carrier is not received within 90 days of the provider's billing date, providers may bill Medi-Cal. A copy of the completed and dated insurance claim form must accompany the Medi-Cal claim. State "90-day response delay" on the billing claim form.

Medi-Cal Remittance Advice Details (RAD)

OHC billing information is included on the Medi-Cal *Remittance Advice Details* (RAD) when a claim is denied because the provider did not include proof of insurance billing with the Medi-Cal claim.

If available, the OHC information provided will include the insurer's name and billing address and the policyholder's Social Security Number (SSN). This information helps providers billing OHC. For more information, refer to the RAD examples and *Remittance Advice Detail (RAD): Payments and Claim Status* section in this manual. For general RAD information, refer to the *Remittance Advice Details (RAD) and Medi-Cal Financial Summary* section in the Part 1 manual.

OHC Closed Network Denial Letters (FI)

The California MMIS Fiscal Intermediary often receives OHC denial letters containing the statement: "OHC eligible, but services were not rendered by an in-network facility/provider; therefore, recipient is not eligible for OHC benefits." This is an acceptable denial letter if the recipient denied the advisal to use OHC coverage. State "Advisal given, recipient refused to utilize OHC" on the billing claim form.

In order to establish Medi-Cal liability to pay claims for a recipient with coverage, the provider must obtain a denial letter or EOB from the OHC closed network and clearly state on the billing claim form "Advisal given, recipient refused to utilize OHC."

Prescription Drugs For Long-Term Care Recipients: COV Code "P"

Pharmacy providers are required to bill OHC prior to billing Medi-Cal for prescription drugs dispensed to recipients in LTC facilities. The provider may request that Scope of Coverage (COV) code "P" be removed from the recipient's eligibility record if:

1. The recipient has no insurance;

2. The recipient's OHC has lapsed;

3. The OHC does not cover pharmacy services dispensed in an LTC facility; or

4. The OHC is limited to specific pharmacy providers who cannot meet facility licensing standards.

Pharmacy: Self-Certification For OHC

Pharmacy providers may complete self-certification for OHC electronically or by using the *Pharmacy Claim Form* (30-1). Pharmacy providers do not need to submit an OHC attachment. However, providers must be able to readily retrieve proof of claim submission and payment if collected from other payer(s).

Note: The ability to self-certify for OHC on pharmacy claims does not apply to medical supplies with the exception of diabetic supplies.

Electronic Self-Certification

OHC will be self-certified for providers submitting electronic claims if a valid OHC code is entered. If an invalid code is entered for a recipient with OHC, the claim will be denied.

Questions regarding the placement of OHC codes in claims produced by pharmacy software programs should be directed to the software vendor.

Claim Form Self-Certification

OHC will be self-certified for providers submitting paper claims if the *Other Coverage Paid* field (Box 26) and the *Other Coverage Code* field (Box 27) are completed as instructed in the *Pharmacy Claim Form* (30-1) *Completion* section of the Part 2 manual.

‹‹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.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.