OHC Technical Assistance Webinar for Secondary Sage Users

Los Angeles County Department of Public Health
Substance Abuse Prevention & Control

Wednesday November 3, 2021

1. General OHC Reminders
2. Required Segments and Companion Guide
3. Rejection Errors via 277CA and Critical Errors
4. OHC Related Denials
5. Examples
6. Resources

General OHC Reminders

What is an OHC?

OHC is:

- Other Health Coverage (OHC) refers to private health insurance. In most situations, OHC must be billed prior to billing Medi-Cal
- Providers are not allowed to deny Medi-Cal services based upon potential third party liability. To establish Medi-Cal's liability for a covered Medi-Cal service, the provider must obtain an acceptable denial letter from the OHC entity.
- Medicare Part C are Medicare Advantage plans or Medicare Risk, which ARE considered an OHC for all treatment providers.

OHC is not:

- Medical Managed Care Plans (i.e. LA Care, Healthnet, etc.) associated with CalMediconnect
- Medicare Part A & B (for non-OTP services)
  - Outpatient (non-OTP) and Residential programs can bill Medi-Medi patients directly to Medi-Cal, except when a patient has Medicare Part C

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- ~~Institutionalized (OHC Code "I") Deactivated code~~

https://filesaccepttest.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/otherguide.pdf

General OHC Rule for Billing

"Medi-Cal eligible" is the term Medi-Cal uses for a patient who currently is enrolled in Medi-Cal. This is not related to the SAPC definition of Applying for Medi-Cal

Medi-Cal–eligible clients must exhaust benefits available through any other OHC available to the client before they are eligible to have services reimbursed through Medi-Cal, including DMC.

In general, this means that DMC providers must [first] bill OHC carriers for services provided to DMC-eligible clients that have OHC to the OHC carrier BEFORE billing DMC for those services.

Providers may only bill DMC after the OHC has adjudicated the claim and either denied it for an acceptable reason (as described in Alcohol and Drug Programs (ADP) Bulletin #11-01) or issued partial payment.

The results of the OHC carrier's adjudication must be reported in the DMC claim as specified in the applicable Implementation Guides.

1.SDMC DMC Companion Guide V.1.8

NOTE All treatment services, regardless of whether the service is DMC reimbursable. I.e. Room and board must still be billed to OHC as some OHCs may reimburse for this service.

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

Generally, most OHC coverages will need to be billed to the OHC carrier before billing Medi-Cal.

https://filesacceptttest.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/otherguide.pdf

When is OHC not OHC for SUD?- ADP 11-01 & MHSUDS 16-064

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~~Q~~	~~Commercial pharmacy plans~~
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******If the patient has CalMediConnect listed in the Eligibility Message, DHCS should not code that as OHC, unless there are other carriers present******

https://www.dhcs.ca.gov/services/MH/MHSUD/Documents/ADP_Bulletins/ADP_11-01.pdf
https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_16-064.pdf

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

In addition to the OHC code, the Scope of Coverage will provide information on whether the claim needs to be submitted to OHC first or can be submitted directly to Medi-Cal.

For example, if the OHC code suggests an OHC is present, however the Scope of Coverage is P, V or D ONLY, this would not need to be billed to OHC first.

1.https://filesacceptttest.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/otherguide.pdf

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 K.

Sample: Medi-Cal Eligible Recipient with OHC (Other Health Coverage)

Name:		
Subscriber ID:		
Service Date:	Subscriber Birth Date:	Issue Date:
Primary Aid Code:	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County:	Medicare ID:	
Primary Care Physician Phone #:	Service Type:	
Spend Down Amount Obligation: $154.00	Remaining Spend Down Amount:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: SUBSCRIBER LAST NAME: EVC #: CNTY CODE: PRMY AID CODE: MEDI-CAL ELIGIBLE W/ LTC SOC/SPEND DOWN OF $00154. PART A, B MEDICARE COV W/MEDICARE ID #. BILL MEDICARE COVERED SVCS TO MEDICARE BEFORE MEDI-CAL. OTHER HEALTH INSURANCE COV UNDER CODE K - KAISER COMPREHENSIVE.		

https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/Workbook_bb.pdf

What is Required to Show Coverage

Per DHCS OHC Provider Manual 02 When billing Medi-Cal for any service partially paid for or denied by the recipient's OHC, the following is required to show proof of denial or coverage limitations with letters/EOBs included in the patient's medical record:

- ❑ OHC EOB or denial letter, the recipient's letter documenting that OHC is not available,
  - ❑ Documentation must include:
    - Carrier or carrier representative name and address
    - Recipient's name or Social Security Number (SSN)
    - Date of letter, including date of claim and denial date
    - Statement of denial, termination or amount paid
    - Procedure or service rendered
    - Termination date or date of service
- ❑ Users will be able to include the additional claim information as part of the configuration in Sage to be transmitted to the State.

What is Required to Show Denial Info

When SUD 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.

https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/othhlth.pdf

OTP Specific Claiming

DHCS MHSUDS IN 17-058

"In the case of DMC or the DMC Organized Delivery System Narcotic Treatment Program (NTP) providers, they have been given an exemption from submitting the claim to OHC due to the fact that they will always receive a denial for NTP claims."

This has been confirmed by the DHCS Third Party Payer Unit as still valid.

Required Segments: Values and Order

837 File Formatting

Sage (as well as most EHR/EDI systems) cannot interpret the data that is being processed. Systems can only validate that the format of each value matches a predefined syntax.

- For example, a provider submits CO*999 as the denial code from the insurance company in the CAS segment. The system does not know this isn't a valid CARC and will process because it matches the syntax for a CARC.
- However, this CARC is not approved by DHCS as a valid denial reason to submit OHC claims and will likely be denied by DHCS.
- Providers often use place holders in their EHR while awaiting actual values. SAPC has noticed that the place holders are left on claims rather than entering the final values once received. E.g. MSOXXXXXX for a PATID or NPI as XXXXXXXXX

Additionally, if loops and/or segments are in the wrong order as noted in the companion guide, the system may reject those files or claims with a critical error that might not match the actual issue. (Example on next slide)

Incorrect Order of Loop/Segment

Errors Found on 837 File

SBR*P*18**NONE*****HM
CAS*OA*192*79.4
AMT*D*0
AMT*EAF*79.4
OI***Y*P**Y

How This Error Is Found in Sage:

- The information here is all correct, however it is in the **wrong order** and does not follow the companion guide layout.
  - The CAS segment does not belong in loop 2000B, but should be in loop 2430 on 837 files.
  - This claim was rejected as a critical error for an Unbalanced Claim since the system could not reconcile the claim amount with the service line totals.
  - Critical Error: Line 509 Claim Balancing Error For Payer: NA. Loop 2320-AMT-02 Payer Payment (0.00) does not equal the sum of 2430-SVD-02 Payment Amounts (0) minus the sum of 2320-CAS Adjustment amounts (17.18).
  - NOTE: This was previously not rejected, but denied as Claim Level Payment/Adjustment Information Found and No Service Level Payment/Adjustment Found.

Loops, Segments and Elements… Oh MY

Subscriber Information: LOOP 2000B

Segment SBR, Element O1 (SBR01)- Payer Responsibility Sequence Number Code

- Required segment that indicates the order in which the payer is responsible for the claim
- **For OHC claims, Medi-Cal is ALWAYS coded as "S" for secondary, but MUST appear in this Loop, not the OHC loop**
- **All other segments and elements in this loop remain the same as any other claim.**

Name:	**Payer Responsibility Sequence Number Code**
Type:	**Data Element**
Definition:	Code identifying the insurance carrier's level of responsibility for a payment of a claim
Version:	005010
Data Element Reference Number:	1138
Permissible Values:	
Code / Value	**Meaning**
P	Primary
S	Secondary
Registration Authority:	Accredited Standards Committee X12
Source:	Accredited Standards Committee X12
Submitting Organization:	Washington Publishing Company

https://ushik.ahrq.gov/ViewItemDetails?system=sdo&itemKey=133189000

Other Subscriber Information, AKA OHC:

LOOP 2320B

This is identical required information as loop 2000B but is for the OHC carrier. If Loop 2000B indicates DMC is a secondary payer, then loop 2320 is required to process the claim.	Segment SBR, Element O1 (SBR01)- Payer Responsibility Sequence Number Code The OHC carrier is always entered as "P" for primary in this segment to indicate this is the primary payer of the service. SBR02- Individual Relationship Code- Typically 18 for self Skip SBR03 and SBR04 using asterisk **	SBR05- Insurance Type Code- Corresponds to the type of insurance company the OHC is identified as, I.e. Commercial, PPO, HMO Commercial = CI PPO = PR HMO = HM Complete list at https://ushik.ahrq.gov/ViewItemDetails?system=sdo&itemKey=133161000

Loops, Segments and Elements Cont…

County of Los Angeles Public Health

Other Subscriber Information, AKA OHC:

LOOP 2320B

Segment AMT- Coordination of Benefits (COB) Total Non-Covered Amount

AMT01 is always coded as D for "Payor Amount Paid"

Followed by AMT02 for the actual amount that was paid by the OHC, which could be $0 or partial payment

Segment AMT- Remaining Patient Liability

AMT01 is always coded as EAF for "Patient Liability"

Followed by AMT02 which represents the amount left from the initial claim charge that is the patient's responsibility

Partial amount or full amount depending on how much was paid by the OHC

Segment OI- Other Insurance Coverage Information

OI01, OI02, OI03 and OI05 are all skipped and marked with an asterisk *

OI04- Patient Signature Source Code and Oi06- Release of Information Code should match the same values as CLM09 and CLM10

Loops, Segments and Elements Cont…

County of Los Angeles Public Health

Other Subscriber Name:

LOOP 2330BA

Segment NM1- Other Subscriber Name

All elements in this segment should match what the OHC carrier has on file for the patient name, which should match to Loop 2010BA, which is what DMC and SAPC have on file.

NM101- Entity Identifier Code should always be coded as IL for "Insured or Subscriber"

NM109 is the member ID from the OHC

Segment N3- Other Subscriber Address

Should match Loop 2010BA, segment N3

Segment N4- Other Subscriber City/State/Zip Code

Should match Loop 2010BA, segment N4

Loops, Segments and Elements Cont…

LOOP 2330B- Other Payer

Segment- NM1 Other Payer Name

NM101- Entity Identifier Code = PR for “Payer”

NM102- Entity Type Qualifier = 2 for “Non Person Entity”

Skip NM104-107 using ****	NM108- Identification Code Qualifier = Generally (not always) will be “PI” for Payer Identifier	NM109- Other Payer Primary Identifier = OHC Payer ID For example Aetna HMO is 60054

LOOP 2430- Line Adjudication Information for Claims to OHC

SVD- Line Adjudication Information

- SVD01- Other Payer Primary Identifier- This must match the number used in LOOP 2330B, Segment NM1, Element NM109 (I.e. the OHC Payer ID)
- SVD02- Service Line Paid Amount- How much did the OHC pay toward the cost of service- $0 to partial payment
- SVD03- Procedure Code and Modifier(s) corresponds to the same service information from SV101 in LOOP 2400
- Skip SVD04 with *
- SVD05- Paid Service Unit Count- How many units were paid by the OHC

CAS- Line Adjustment (AKA Denial Info)

- CAS01- Claim Adjustment Group Code- Must be either PR/CO/OA as indicated by the OHC denial letter, EOB or 835.
- CAS02- Adjustment Reason Code (CARC)- Enter the CARC supplied by the OHC carrier on the denial
  - If no CARC was supplied or the OHC did not respond after 3 months, utilize OA 192 per ADP 11-01

LOOP 2430- Line Adjudication Information for Claims to OHC

Segment DTP- Line Check or Remittance Date

- DTP01- Date Time Qualifier must be entered as 573 for “Date Claim Paid” or date of adjudication
- DTP02- Date Time Period Format Qualifier must be D8.
  - Cannot be a date range with DR8 qualifier
- DTP03- Adjudication or Payment Date, which must be expressed in the CCYYMMDD format-

Claims Rejected for Critical Errors

County of Los Angeles Public Health

Unbalanced Claim

- The sum of the services within the claim do not equal the total claim amount. Providers need to ensure all services are listed for the claim and that the corresponding charge amounts equal the total charge amount on the claim level.
- This error can also occur if the system cannot determine the services being claimed due to Loops or segments being out of order per the 837 Companion Guide.

Local and State Related OHC Denials

County of Los Angeles Public Health

Local/Sage Denials

CO 16
N379

- CARC: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)
- RARC: Claim level information does not match line level information.(379)
- Sage/KPI: Claim Level Payment/Adjustment Information Found and No Service Level Payment/Adjustment Found.
- Service level is missing or does not contain required segments, including adjustment information.
- This denial is for FY 18/19 only. Claims with this issue are being rejected as a critical error and will show on the Critical Error report.

State Denial Codes for OHC

Historically, OHC denials were denied for patient being ineligible under the umbrella of CO 177 codes.

- Sometimes including a RARC code of N30.
- When troubleshooting a denial for CO177, if the aid and county codes appear valid, AND the CIN is correct, the issue may be related to OHC coverage.

More recently, the State has been sending a CARC/RARC combination specific to OHC:

- **CO 22 N479**
  - This care may be covered by another payer per coordination of benefits. (22)
  - Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). (N479)
  - SAPC has begun recouping these denials for all providers.
    - Primary Sage Users can work these claims and prepare them, however, cannot resubmit until Sage has been configured.
    - Secondary Sage Users can resubmit OHC denials and new OHC denials without issue.

Examples of OHC Claims

837P Companion Guide, Page 36

```
PER*IC*BILLING MANAGER*TE*2135551234~
HL*2*1*22*0~
SBR*S*18**LASAPC*****MC~
NM1*IL*1*Tartest*OHCMEDI****MI*MSO15~
N3*118336 STREET TO NOWHERE~
N4*LOS ANGELES*CA*900051744~
DMG*D8*20001122*M~
NM1*PR*2*LASAPC*****PI*CA DEPT OF ALCOHOL AND DRUG PROGRAMS~
N3*1901 16TH STREET~
N4*SACRAMENTO*CA*958149998~
CLM*13032*59***11:B:1*Y*A*Y*Y~
HI*ABK:O99320~
NM1*82*1*COUNSLER*JIM****XX*1245319599~
PRV*PE*PXC*2084P0800X~
SBR*P*18**Aetna Insurance - RISK HMO*****CI~
AMT*D*39~
AMT*EAF*20~
OI***Y***Y~
NM1*IL*1*Tartest*OHCMEDI****MI*MSO15~
N3*118336 STREET TO NOWHERE~
N4*LOS ANGELES*CA*900051744~
NM1*PR*2*Aetna Insurance - RISK HMO*****PI*60054~
LX*1~
SV1*HC:H0049:U8*59*UN*2***1~
DTP*472*D8*20170707~
REF*G1*P1136~
NTE*DCP*99~
SVD*60054*39*HC:H0049:U8**2~
CAS*CO*45*20~
DTP*573*D8*20170901~
SE*41*000000001~
GE*1*261616027~
IEA*1*261616027~
```

Drug Medi-Cal is identified as the secondary insurance in SBR01

The OHC payer is identified as the Primary. The coordination benefits (COB) amount paid

NM109 shows the Other Payer Primary Identifier

Service Line Adjudication Information: Identifies the payer, amount paid by the payer for the service, the claim adjustment reason code (CARC), and the Remittance Date

OHC Claim- Full Denial

```
SBR*S*18*******MC
NM1*IL*1*      *      .****MI*MSOXXXXXX
N3*
N4*      *     *
DMG*D8*20050112*M
NM1*PR*2*SAPC*****PI*SAPC001
N3*1000 S. FREEMONT AVE
N4*ALHAMBRA*CA*918039998
CLM*                *34.74***11:B:1*Y*A*Y*Y
DTP*435*D8*20200724
HI*ABK:F1210
NM1*82*1*      *     * ***XX*
NM1*77*2*          *****XX*
N3*
N4*      *    *
SBR*P*18*       ******CI
AMT*D*0
AMT*EAF*34.74
OI***Y***Y
NM1*IL*1*      *      .****MI*555555
N3*
N4*     *    *
NM1*PR*2*KAISER PERMENANTE OF SOUTHERN CALIFORNIA*****PI*KSXXX
LX*1
SV1*HC:H0006:U7*34.74*UN*1***1
DTP*472*D8*20210831
REF*6R*
CN1*09***
REF*G1*
SVD*KSXXX*0*HC:H0006:U7**1
CAS*PR*4*34.74
DTP*573*D8*20211011
HL*3*1*22*0
```

Total claim is $34.74 in the CLM segment

Blanks are related to PHI, which has been removed, however the relevant OHC data remains intact

Amount paid by OHC is $0

Patient responsibility section is required however, the patient is NOT actually responsible for the remaining balance since DMC will be reimbursing the charges.

Member ID from OHC

OHC Payer ID

OHC service adjudication line information, including amount paid by OHC

Denial reason and amount denied by OHC

Date of adjudication/payment

OHC Claim- OHC Partial Payment

```
SBR*S*18*******MC
NM1*IL*1*      *      .****MI*MSOXXXXXX
N3*
N4*     *     *
DMG*D8*20050112*M
NM1*PR*2*SAPC*****PI*SAPC
N3*1000 S. FREEMONT AVE
N4*ALHAMBRA*CA*918039998
CLM*                *69.48***11:B:1*Y*A*Y*Y
DTP*435*D8*20200724
HI*ABK:F1210
NM1*82*1*       *     * ***XX*
NM1*77*2*          *****XX*
N3*
N4*     *    *
SBR*P*18*       ******CI
AMT*D*34.74
AMT*EAF*34.74
OI***Y***Y
NM1*IL*1*       *      .****MI*555555
N3*
N4*     *    *
NM1*PR*2*KAISER PERMENANTE OF SOUTHERN CALIFORNIA*****PI*KSXXX
LX*1
SV1*HC:H0006:U7*69.48*UN*2***1
DTP*472*D8*20210831
REF*6R*
CN1*09***
REF*G1*
SVD*KSXXX*34.74*HC:H0006:U7**1
CAS*PR*4*34.74
DTP*573*D8*20211011
HL*3*1*22*0
```

Total claim is $69.48 in the CLM segment

Blanks are related to PHI, which has been removed, however the relevant OHC data remains intact

Amount paid by OHC is $34.74

Patient responsibility section is required however, the patient is NOT actually responsible for the remaining balance since DMC will be reimbursing the charges.

Service line indicates the original service and rate of $69.48, which should match for both payers SV1 segments

OHC service adjudication line information, including amount paid by OHC of $34.74

Denial reason and amount denied by OHC of $34.74

OHC Claim- Rejected for a Critical Error

```
SBR*S*18*******MC
NM1*IL*1* ****MI*MSO
N3*
N4*
DMG*D8*19991031*M
NM1*PR*2*SAPC*****PI*SAPC001
N3*1700 K ST
N4*SACRAMENTO*CA*95814
CLM*    *79.4***11:B:1*Y*A*Y*I*P
DTP*435*D8*20201001
REF*EA*
HI*ABK:F1120
NM1*82*1*    ****XX*
NM1*77*2*                 *****XX
N3*
N4*
SBR*P*18**NONE*****HM
CAS*OA*192*79.4
AMT*D*0
AMT*EAF*79.4
OI***Y*P**Y
NM1*IL*1*           ***MI*
NM1*PR*2*NONE*****PI*NA
DTP*573*D8*2021-11-01
LX*1
SV1*HC:H0004:UA:HG*79.4*UN*5***1
DTP*472*RD8*20190507-20190507
```

Medi-Cal/SAPC as secondary "S" payer listed first and an OHC payer is indicated

OHC is listed as "NONE", which may cause a State denial

CAS segment is in the wrong order, which caused the system to misread the claim information.

Payer indicator is listed as NA, which may cause a State denial

Missing SVD segment

Resources

Sage Help Desk

- **Sage Help Desk Phone Number: (855) 346-2392**
  Sage Help Desk ServiceNow Portal: https://netsmart.service-now.com/plexussupport

SAPC IT Direct Email

- **sapc_support@ph.lacounty.gov**
- **For questions related to the companion guide**

SAPC Sage Website

- **http://publichealth.lacounty.gov/sapc/providers/sage/**

Companion Guides

Companion Guide HIPAA 837P
Companion Guide HIPAA 837I

X12

- **https://x12.org/codes**
- **Manages and maintains all EDI standards, including current and valid CARC and RARC codes**

Agency for Healthcare Research and Quality

- **https://ushik.ahrq.gov/lists/DataElements?system=sdo&organization=X12**
- **Website provides details on approved data elements available for each loop and segment of the 837 file.**

Medi-Cal Billing Basics Powerpoint

- https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/Workbook_bb.pdf