RMD Bulletin

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CHEAT SHEET:

Understanding Billing Medi-Cal and OHC

In general, when a client who is a member of a private insurance healthcare plan (also known as Other Health Coverage [OHC]) requests services from a Los Angeles County Department of Mental Health (DMH) directly operated or contract provider, the client should be referred back to the OHC. The client has paid for the OHC for services and those plans are responsible for managing that client's care. (See DMH Policy 401.8 attached.) However, this client may be seen with prior authorization from the OHC if one of the following conditions exists:

- ✓ Mental health services are not a covered benefit of the health plan.
- ✓ The client has exhausted the allowable mental health benefits under their specific insurance plan for the coverage year.
- ✓ The client requires emergency care. (Providers should contact the OHC for emergency treatment authorization and billing instructions within 24-48 hours of the emergency service being rendered.)
- ✓ None of the above conditions exists and the OHC authorizes the clinic to provide services.

If none of the above conditions exist, and the client insists on receiving treatment from a DMH directly operated or contract provider clinic, the client may be seen only if the client agrees to pay for the full cost of care, **unless the client has unrestricted Medi-Cal.**

The attached table reflects the client's responsibility to pay for services rendered if the client has the following different coverage types:

- ✓ OHC & Medi-Cal with no share of cost (SOC)
- ✓ OHC & Medi-Cal with SOC
- ✓ OHC Only (No Medi-Cal)

We're here to help you…

If you have any questions or require further information, please do not hesitate to contact RMD at (213) 480-3444 or RevenueManagement@dmh.lacounty.gov.

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CHEAT SHEET: OHC AUTHORIZATION FOR SERVICES AND CLIENT'S RESPONSIBILITY TO PAY

****Insurance Authorization and Assignment of Benefits Form must be signed by the client****

Coverage Type	OHC Authorized Services?	Bill OHC?	Bill Unpaid Balance to Medi-Cal?	Bill Client?	Comment
OHC & Medi-Cal with no Share of Cost	Yes	Yes	Yes	No	Bill Medi-Cal after receiving an approval or denial from the OHC or after 90 days if the OHC did not respond. Medi-Cal is responsible for the balance not paid by OHC.
	No	Yes	Yes	No	Bill Medi-Cal after receiving an approval or denial from the OHC or after 90 days if the OHC did not respond. Medi-Cal is responsible for the balance not paid by OHC.
OHC & Medi-Cal with Share of Cost	Yes	Yes	Yes, once MEDI-CAL eligible	**No**, if the client is Medi-Cal eligible **Yes**, if the client has an outstanding SOC balance	Bill Medi-Cal the balance after Share of Cost is cleared **AND** the OHC approved/denied the claim (or after 90 days with no response from the OHC). Bill the client the annual liability, the cost of service, or Share of Cost, *whichever is less*.
	No	Yes	Yes, once MEDI-CAL eligible	**No**, if the client is Medi-Cal eligible **Yes**, if the client has an outstanding SOC balance	Bill Medi-Cal the balance after Share of Cost is cleared **AND** the OHC approved/denied the claim (or after 90 days with no response from the OHC). Bill the client the annual liability, the cost of service, or Share of Cost, *whichever is less*.
OHC Only (No Medi-Cal)	Yes	Yes	N/A	Yes	Bill the client the annual liability or the cost of service, *whichever is less*.
	No	No	N/A	Yes	Bill client the Full Cost of Care.

*To claim these services in the Integrated System (IS), enter all the service information and as much claim information as you have and **SAVE** the claim without submitting. Once you receive the approval or denial from the OHC, **SUBMIT** the claim. Please note that claims may be submitted if OHC has been billed but has not approved or denied the claim within 90 days. Enter $0.00 as the payment amount, OA as the Adjustment Group Code, and A7 as the Adjustment Code.*

DOES NOT APPLY TO FEE-FOR-SERVICE PROVIDERS