LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH / *CENTRAL BUSINESS OFFICE*

CBO DISPATCH

The "B" means BUSINESS

CBO Dispatch No.: NGA 18-009 Issue Date: December 31, 2018

Updating Private Insurance Information in the Medi-Cal Eligibility Record

Other Health Coverage (OHC)

When a client who is a member of a private insurance healthcare plan (also known as Other Health Coverage [OHC]) receives services from a Los Angeles County Department of Mental Health (DMH) directly operated or contract provider, those services must be billed to the OHC and approved or denied prior to the claim being submitted to Medi-Cal. There are times, however, when providers will receive a denial from Medi-Cal even though the approval or valid denial from the prior payer is submitted on the claim. These denials occur when there is a mismatch between the information submitted on the claim about the prior payer and the information about the client's other insurance coverage in the State's eligibility record for the client. For example, a claim that includes a payment from Medicare when the State's record shows that the client is enrolled in a Medicare Advantage Plan would result in a denial coded CO 16/N479 (OHC=F, must be billed prior to the submission of this claim). In this example, the State's record is incorrect. Any claim submitted showing an approval or denial from any insurance other than a Medicare Advantage Plan will be denied.

Before these denied claims are replaced, providers should ensure that the client's eligibility record with the State is correct. Providers are able to see what is in the client's record with the State by verifying the client's Medi-Cal eligibility on the Medi-Cal website. When the response is received, review the client's eligibility closely and verify that it is correct. In instances where there is a conflict between the State's eligibility record and

what the client reported during financial screening, work with the client to confirm which is correct. If the client's financial profile has the wrong OHC or no OHC, update the profile to reflect the correct coverage; if the eligibility response shows incorrect OHC, then the client's Medi-Cal eligibility record with the State must be corrected. Providers should not wait for a denial. Begin correcting the record with the State as soon as the error is identified.

The California Department of Health Care Services (DHCS) recommends correcting erroneous OHC information on the client's eligibility using their OHC website (https://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx). There, providers are able to update the client's record by removing the incorrect OHC and/or adding the correct OHC when applicable. Providers must include information about the submitter/requester, the client, OHC carrier and policy, and about the request itself when adding or removing OHC on the OHC website and keep documentation supporting the change in the client's financial record. A chart with the information to be submitted is below. The manual for using the site is attached. Verify eligibility to confirm that the requested changes to the client's eligibility have been made before replacing claims for the client.

Please note that this procedure only works to correct information about private insurance plans. Providers should work with clients when contacting the Social Security Administration (SSA) or Centers for Medicare & Medicaid Services (CMS) to remove or add Medicare Part A, Part B or to permanently remove Medicare coverage.

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IBHIS providers, if you have any questions or need additional information, please use the following link create a HEAT Ticket using the HEAT app available on the LACDMH secure website: DMH SSLVPN.

Table 1	**Submitter Information**	**Client Information**
All Requests	Who is submitting the request (Medi-Cal member, County Worker, Provider, Insurance Carrier, DHCS Employee or Telephone Service Center)	Client Index Number (CIN)
	Name	Last Name
	E-mail address	First Name
	Phone number	Date of birth (MM/DD/YYYY)

	Removals	**Additions (one per form)**
Table 1 Information	Submitter Information	Submitter Information
	Client Information	Client Information
Request Information	Number of requests submitted for the client for the same OHC	Number of requests submitted for the client for the same OHC
	Has the request been submitted previously?	Has the request been submitted previously?
	Remove all active Other Health Coverage? Yes or No (If not removing all active carriers, select the carrier to be removed from the drop down list.) (Specify the names of the carries if removing more than three.)	
Carrier Information	Carrier Code (the alpha-numeric code of the OHC available on the Medi-Cal website)	Carrier Code (the alpha-numeric code of the OHC available on the Medi-Cal website)
	Carrier Name	Carrier Name
		Carrier Phone
		Plan Type (Select the plan type of the OHC being added from the drop-down list: PPO, HMO, Dental/Vision, Vision Only, Dental Only, Commercial Pharmacy, Medicare Advantage Plan [Part C])
		Carrier Billing Address
Policy Information	Policy End Date (Use 01/01/1900 if the client was never insured by the OHC)	Policy Holder Last Name (Last name of the subscriber)
	Reason for removal	Policy Holder First Name (First name of the subscriber)
	Other modifications	Health Insurance Policy Number
		Policy Start Date (MM/DD/YYYY)
		Employer Group Name
		Employer Group Number
Other Request Information	Submission Date	Submission Date

Other Health Coverage Reference Guide

Overview:

This guide is to be used as a reference to submit an OHC Addition or Removal request.

Individuals requesting updates to their Other Health Coverage (OHC) must either submit a request for an OHC Addition or Removal by completing the fillable form located on the DHCS website or by submitting their request via the Telephone Service Center toll free number (800 541-5555).

OHC Removal Forms

Section A:	**Section A: Submitter's Contact Information:**
1. Submitter's Information – Who is submitting the request? (i.e. Medi-Cal member, County Worker, Insurance Carrier, Health Provider, DHCS Employee, or Telephone Service Center . 2. Submitter's Name – Name of submitter. 3. Email Address – Submitter's **valid** email address. This information is used to contact the submitter if discrepancies arise and used to notify the submitter of request status. 4. Phone Number – Submitter's **valid** phone number at which submitter can be contacted directly. This information is used to contact submitter if discrepancies arise.	1. Submitter's Information - select one: [ ] 2. Submitter's Name [ ] 3. Email Address [ ] 4. Phone Number [ ]

Section B:

1. CIN/ID # – The Client Index Number (CIN) is found on the Medi-Cal member's Benefits Identification Card (BIC). **DO NOT** use the member's Social Security Number (SSN) or Medi-Cal Case number also knows as the Serial Number (7 character alpha-numeric number).
2. Last Name – Last name of Medi-Cal member having OHC removed/modified.
3. First Name – First name of Medi-Cal member having OHC removed/modified.
4. Date of Birth – Use the member's **complete** date of birth in the following format: MM/DD/YYYY. **DO NOT** use date of submission as the date of birth.

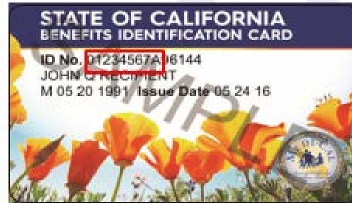
Section B: Member Information

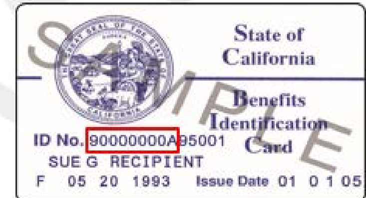
The Client Index Number **(CIN)** is found on the Medi-Cal member's Benefits Identification Card **(BIC)**. The CIN is comprised of the **first nine** characters of the 14-character ID number located on the front of the BIC (see sample BIC on OHC home web page). Please note that the CIN **is not** the member's Medi-Cal case number.

Example CIN/ID # **99999999X**

1. **CIN/ID #**
2. **Last Name**
3. **First Name**
4. **Date of Birth (MM/DD/YYYY)**

CIN/ID # Examples:





Section C:

1. Number of Requests Submitted – Select the number of times the OHC request has been submitted for the member for the specific OHC from the drop-down list. If the request has been submitted more than three times, provide details in the comment box.
2. Remove all Active OHC – Select "Yes" if you wish to remove **all active** OHC. If "No" is selected, please select the carrier name from the drop-down list and

Section C: Other Health Coverage

How many requests have you submitted for this member for the same OHC?

1. **Please select one of the following:**

If previously submitted, provide details (200 characters)

If you select **"Yes"** to the following question below, **ALL** active OHC (not Medi-Cal) will be terminated.
If you select **"No"** to the following question below, provide the carrier(s) that needs to be terminated by providing the carrier code(s) if known, carrier name(s) and policy stop date(s) below.

2. **Remove all active Other Health Coverage?**
○ Yes ○ No

If you need to remove more than **three** carriers, please specify additional carrier(s) in comments field.
Note: If the member never had OHC, please select **"None"** from the Carrier Name field and type **"01/01/1900"** in the Policy Stop Date field.

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provide the policy stop date for the OHC being requested to be removed. If carrier name is not on list, provide name in comment box.
3. Carrier Code – Input the carrier code needing to be removed. The carrier code is a 4 character alpha-numeric number starting with a letter followed by three numbers (i.e. A000). The carrier code specifies which OHC is to be removed. If the “Remove all Active OHC” option is selected “Yes”, <u>ALL</u> active carrier codes will be removed.
4. Carrier Name – Select the carrier name from the drop-down list for the OHC being requested to be removed. If carrier name is not on list, provide name in comment box. If the member never had OHC, please select “None” from the drop-down list.
5. Policy End Date – Provide the date the OHC policy terminated in the following format: MM/DD/YYYY. If the member never had OHC, please type “01/01/1900” in the Policy Stop Date field. <u>DO NOT</u> use 00/00/0000 or 12/31/9999.
6. Reason for OHC Removal – Provide the reason why the OHC is being removed. Select one of the options from the drop-down list. If neither of the options apply, provide details in the comment box.
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<td>
Carrier Code 2
3.
Carrier Name
4.
Other carrier, provide name below (200 characters):
Policy End Date (MM/DD/YYYY)
5.
Please select one of the following reasons for OHC Removal:
6.
Other modifications, provide details below (200 characters):
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7. Submission Date – Provide the date the request is being submitted in the following format: MM/DD/YYYY.	**Submission Date (MM/DD/YYYY)** 7. [ ] Note: The approximate time you submitted the request will appear at the bottom of your email response. On the bottom of the email response there will be two letters followed by the time of submission. For example, if you submit a request at 9:45am the item will appear at **EX/945**. This can be used as an identification for individuals submitting multiple requests.

OHC Addition Forms

Section A: 1. Submitter's Information – Who is submitting the request? (i.e. Medi-Cal member, County Worker, Insurance Carrier, Health Provider, DHCS Employee, or Telephone Service Center . 2. Submitter's Name – Name of submitter. 3. Email Address – Submitter's **valid** email address. This information is used to contact the submitter if discrepancies arise and used to notify the submitter of request status. 4. Phone Number – Submitter's **valid** phone number at which submitter can be contacted directly. This information is used to contact submitter if discrepancies arise.	**Section A: Submitter's Contact Information:** **Submitter's Information - select one:** 1. [ ] **Submitter's Name** 2. [ ] **Email Address** 3. [ ] **Phone Number** 4. [ ]

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Section B:

1. CIN/ID # – The Client Index Number (CIN) is found on the Medi-Cal member's Benefits Identification Card (BIC). **DO NOT** use the member's Social Security Number (SSN) or Medi-Cal Case number also knows as the Serial Number (7 character alpha-numeric number).
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3. First Name – First name of Medi-Cal member having OHC removed/modified.
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Section B: Member Information

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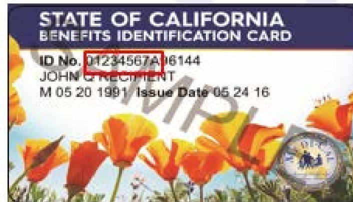
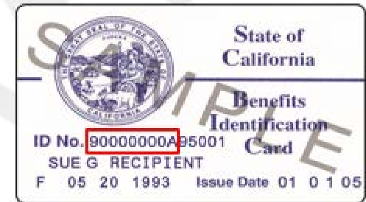
Example CIN/ID # **99999999X**

1. **CIN/ID #**
2. **Last Name**
3. **First Name**
4. **Date of Birth (MM/DD/YYYY)**

CIN/ID # Examples:





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Section C:

1. Number of Requests Submitted – Select the number of times the OHC request has been submitted for the member for the specific OHC from the drop-down list. If the request has been submitted more than three times, provide details in the comment box.
2. Carrier Code – Input the carrier code needing to be added. The carrier code is a 4 character alpha-numeric number starting with a letter followed by three numbers

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Section C: Other Health Coverage

How many requests have you submitted for this member for the same OHC?

1. **Please select one of the following:**

If previously submitted, please provide details.

If you need to add more than **one** commercial insurance policy, please use an additional form. If you do not know the carrier code, you **must provide both** the name and billing address to allow appropriate identification of the private health insurance plan.

2. **Carrier Code (if known)**

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Instructions	Form
(i.e. A000). The carrier code specifies which OHC is to be added. If more than more than **one** commercial insurance policy needs to be added, please use an additional form. 3. Carrier Name – Select the carrier name from the drop-down list for the OHC being requested to be added. If carrier name is not on list, provide name in comment box. 4. Carrier Phone Number – Provide a phone number at which the carrier can be contacted. 5. Plan Type – Select the plan type of the OHC being added from the drop-down list. 6. Carrier Billing Address – Provide the address to which claims are submitted to the carrier for payment. 7. Policy Holder Last Name – Last name of the primary policy holder for the health insurance plan. 8. Policy Holder First Name – First name of the primary policy holder for the health insurance plan. 9. Health Insurance Policy Number – Policy number for the health insurance plan. 10. Policy Start Date – Date the policy number was first effective in the following format: MM/DD/YYYY. 11. Employer Group Name – Name of the employer group.	3. Carrier Name Other carrier, provide name below (200 characters): 4. Carrier Phone Number 5. Plan Type 6. Carrier Billing Address Street City State Zip Code 8. Who is the primary account holder for this commercial health insurance plan? Policy Holder Last Name Policy Holder First Name 9. Health Insurance Policy Number 10. Policy Start Date (MM/DD/YYYY) 11. Employer Group Name

12. Employer Group Number – Number of the employer group. 13. Submission Date – Provide the date the request is being submitted in the following format: MM/DD/YYYY.	**12. Employer Group Number** **Comments (200 character limit)** **Submission Date (MM/DD/YYYY)** **13.** Note: The approximate time you submitted the request will appear at the bottom of your email response. On the bottom of the email response there will be two letters followed by the time of submission. For example, if you submit a request at 9:45am the item will appear at **EX/945**. This can be used as a confirmation for individuals submitting multiple requests.