A Public Entity
Inland Empire Health Plan

Other Health Coverage (OHC) FAQs
(APL 20-010)

Pre-Service	
How do I determine if a Member has OHC?	Details of our Member's other health coverage can be obtained the following ways: • Log on to IEHP's Provider portal at www.iehp.org • Call IEHP's Provider Relations Team at (909) 890-2054 • Log on to DHCS's Automated Eligibility Verification System (AEVS) at https://www.medi-cal.ca.gov/MCWeb/Login.aspx
How will this OHC change affect me as a Provider?	State law requires Medi-Cal to be the payer of last resort for services in which there is a responsible third party. Providers are advised to verify and utilize the Members Other Health Coverage for covered services prior to accessing their Medi-Cal benefits. Provider is responsible to review the OHC information to identify the responsible payer.
The Member does not want to use their OHC, because their preferred Provider is not in the OHC network. What should I advise the Member?	Members must utilize their primary OHC for covered services. Providers are expected to verify eligibility and confirm if the Member has OHC prior to seeing any Member. If the primary OHC does not cover the service, the Provider should submit a copy of the source denial document to IEHP during the authorization request and claim submission.
What if a Provider is not contracted with the Member's OHC?	Provider should contact the Member's OHC prior to rendering services to verify if the OHC will issue an authorization for services.
If a Provider becomes aware of OHC that is not listed on IEHP's portal or DHCS's Automated Eligibility Verification System (AEVS), how do I report this to IEHP?	You can report newly discovered OHC or a change to the OHC information to IEHP's Provider Relations Team at (909) 890-2054. Please have any source documents available.
A walk-in Member has requested an appointment (no authorization required) however the Member has OHC. What do I do?	Provider should contact the OHC and coordinate approval for the service. Advise the Member that there is another carrier on file but do not refuse service or decline care to the Member.

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Pre-Service *(continued)*	
I have received an authorization from the Member's OHC, however, the Member has a $250 copay. How do I get reimbursed for the copay?	Do not collect a copayment or deductible amount from the Member at the time of service. Submit a claim to IEHP along with the OHC explanation of benefits or denial letter. IEHP will coordinate benefits and calculate secondary payer liability.
If a Member has OHC, why are some referrals being cancelled while others are approved?	IEHP has noted a system configuration issue and is actively working on the resolution. Providers are expected to verify eligibility and confirm if the Members has OHC prior to seeing the Member. As noted on the authorization form: Authorization does not guarantee payment.
What will happen to Prescription Authorizations if Member is found to have OHC?	All drug prior authorization requests will need to be made to the primary insurance Provider rather than IEHP.
How will OHC impact retail pharmacy transactions?	All prior authorization requests will need to be made to primary insurance provider rather than IEHP.

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Post-Service	
Who does a Provider bill as primary, secondary or tertiary if an IEHP Member has both Fee for Service Medicare and OHC?	The Provider must bill payers in the following order: 1. Medicare for Medicare-covered services 2. OHC CarrierIEHP: Attach the Medicare EOMB and the OHC carrier EOB to the claim
How does IEHP calculate secondary payer liability for Members with primary Fee for Service Medicare coverage?	Welfare and Institutions Code, Section 14109.5, limits Medi-Cal's payment of the deductible and coinsurance to an amount which, when combined with the Medicare payment, should not exceed the amount paid by Medi-Cal for similar services. This limit is applied to the sum total of the claim. Therefore, the combined Medicare/Medi-Cal payment for all services of a claim may not exceed the amount allowed by Medi-Cal for all services of the claim.
How does IEHP calculate secondary payer liability for members with Other Health Coverage?	Medi-Cal's payment of the deductible and coinsurance and copayment is limited to an amount which, when combined with the OHC payment should not exceed the amount paid by the OHC for similar services. This limit is applied to the sum total of the claim. Therefore, the combined OHC/Medi-Cal payment for all services of a claim may not exceed the amount allowed by Medi-Cal for all services of the claim. The below principles must be followed when billing IEHP 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. 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. (Continued on the next page)

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Post-Service (continued)	
	5. Medi-Cal approved HCPCS codes, CPT codes, and modifiers should be billed. Do not bill with HCPCS codes, CPT codes, or modifiers where OHC paid, but which Medi-Cal does not recognize or allow.
Why are my claims being denied when IEHP has approved the authorization request?	During Claims processing, IEHP utilizes OHC information provided by DHCS and OHC payment information submitted by the Provider. As noted on the authorization form: Authorization does not guarantee payment. Providers are expected to verify eligibility and confirm if the Members has OHC prior to seeing any Member. It is possible that a request for authorization might hit an auto-authorization rule and that is currently under review to look at opportunities to modify existing auto-authorization processes.
Why did my Claim get denied when UM approved the request and I had provided the source document indicating the requested service is not covered by the OHC?	In addition to providing the source denial document to the UM Department during the pre-service process, Providers must also ensure that the source document is submitted with the claim.
I have submitted a request to the Members assigned IPA for authorization. I received an authorization from the IPA, however, when I sent my claim to IEHP, claim was denied because the Member has OHC.	Authorization is not a guarantee for payment. Providers are expected to verify eligibility and confirm if the Member has OHC prior to seeing any Member. The Provider should first submit a claim to the OHC. Once the OHC has made a payment determination, the Provider should then submit a secondary claim to IEHP along with: 1. A copy of IEHP's original denial and 2. The OHC explanation of benefits Upon receipt, IEHP will reconsider the claim as the secondary payer.

Contact Us	
Help! My question wasn't listed above.	You can contact IEHP's Provider Relations Team at: • Email address: ProviderServices@iehp.org • Telephone: (909) 890-2054