SAPC | Substance Abuse Prevention and Control

Other Health Coverage Billing Manual

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Introduction

This manual explains how Substance Abuse Prevention and Control (SAPC) contracted treatment provider agencies must handle Other Health Coverage (OHC) and Medicare before billing SAPC. It tells provider agencies how to identify when a client has OHC, when OHC or Medicare must be billed first, and how to send OHC denial information on claims to SAPC. SAPC's policies in this manual follow the Department of Health Care Services (DHCS) requirements.

Provider agencies should offer services as soon as possible to ensure clients do not face delays or barriers to treatment. Some clients may qualify for Medi-Cal or other County-funded programs, but their benefits may be inactive at intake or assessment. Provider agencies must help clients apply for or reactivate their Medi-Cal benefits and review eligibility promptly.

After provider agencies bill SAPC, the services are then billed by SAPC to Medi-Cal to utilize the client's Drug Medi-Cal benefits. SAPC does not pay for services when a client only has commercial private insurance and is not eligible for Medi-Cal or other County-funded programs. Substance Use Disorder (SUD) provider agencies may still serve these clients, but the client must pay the provider directly under the provider agency's own client fee determination scale. Sliding scale fees or flat fees are not allowed for Medi-Cal or for the County-funded program beneficiaries identified in this manual.

Section 1: OHC Overview

What is OHC?

Other Health Coverage (OHC) means any health insurance that pays for a client's services other than Medi-Cal. OHC includes Medicare and commercial private insurance plans. Federal and State rules require provider agencies to bill a client's OHC before billing Medi-Cal, unless an exception in this manual applies. [1]

Billing OHC Prior to SAPC

Enrolling with OHC Plans

Each OHC insurance plan, including Medicare Part C through a Managed Care Plan, has their own process for enrolling as a provider in order to submit claims for services. Provider agencies must contact the OHC to determine the process for enrollment and complete all required steps given by the insurance plan.

When to Bill OHC for Active Medi-Cal Beneficiaries

If a service is covered by both an OHC plan and Drug Medi-Cal (DMC), the client's OHC must be billed first. Medi-Cal requires that OHC is fully used before billing DMC. Provider agencies must not deny treatment to Medi-Cal beneficiaries because they have OHC.[2]

Services can be billed to SAPC once one or more of the following conditions are met: [3]

- All OHC benefits have been exhausted and there is a remaining balance on the claim
- The OHC does not cover SUD services and has denied the claims
- The OHC has not responded to the claim after 90 days from the submission date
- Specific situations when the client has Medicare and Medi-Cal (Medi-Medi), see sub-section Medicare as an OHC

Exceptions to Billing an OHC Prior to Billing SAPC

In certain scenarios, provider agencies can bill SAPC without billing the OHC first. These scenarios include:

1. If a client's OHC has expired, provider agencies must request the removal of the OHC from the client's record from DHCS, confirm the removal of the OHC, and then bill SAPC directly. OHC removal requests are made through the DHCS website. Please refer to the Removing Inactive OHC from a Client's Record section of this manual for more information.

Important! Provider agencies must ensure the OHC was removed from the DHCS system prior to billing SAPC or claims billed to Medi-Cal will be denied.

2. If the OHC covers only vision or dental services, provider agencies can bill SAPC for SUD services without billing the OHC first.
3. If the client qualifies for Minor Consent Program Services, which permits clients under 21 years of age access to confidential, limited Alcohol and Other Drug treatment services, provider agencies can bill SAPC prior to billing the OHC. Provider agencies must contact Medi-Cal directly to verify if a client qualifies for this program.
4. One of the following DMC-ODS services was delivered:[4]
    a. Peer Support Services (codes H0025 and H0038)
    b. Contingency Management services (code H0050 with modifier HF)
    c. Recovery Services (codes H2015 and H2017)
    d. Treatment Planning (codes H2014 and H2017)
    e. Care Coordination (code T1017)
    f. Prenatal care, at-risk assessment (code H1000)
5. If Non-DMC services are rendered, such as Recovery Bridge Housing, Room and Board, or incentives. Provider agencies do not need to report OHC information to SAPC for these services, and they should not be billed to the OHC.
6. For Medi-Medi beneficiaries:
    a. Service codes marked on the Billing Rules tab of the Rates Matrix with "No" in the column "Medicare COB Required."
    b. Services delivered by clinical trainees are not required to be billed to Medicare first. Claims submitted by clinical trainees with taxonomy codes beginning with 3902 and 1744 will bypass the Medicare COB requirement.

Non-Applicable Insurance Coverage

Clients may have insurance coverage that is not considered OHC and does not need to be billed prior to billing SAPC. These types of insurance include:

- Personal injury and/or medical payment coverage covered under automobile insurance
- Life insurance
- Workers' compensation
- Homeowners insurance
- Umbrella insurance

- Accident insurance
- Income replacement insurance (e.g., Aflac)

OHC Prior Authorization

Prior authorization means getting approval from an insurance company before a service is provided. If a client has OHC, the provider agency must find out if the OHC requires pre-approval and follow any instructions provided by the OHC. This is different than the Service Authorization request process initiated with SAPC.

Here are the rules for handling prior authorizations and billing:

- **Provider agencies must check requirements:** Always verify if the OHC requires prior authorization for the service. Without it, the insurance company may deny the claim. Medi-Cal does not consider OHC denials due to failure to request prior authorizations as an acceptable denial. The client's OHC is still considered active and must be used first.
- **What to do if the OHC denies the prior authorization request:** If prior authorization was properly requested and the OHC denies it for a valid reason, such as the OHC not covering the type of service, submit the claim to SAPC.

Clients with Multiple OHCs

A client may have multiple OHCs. Common reasons may include that the client:

- Is a minor or an adult who is 26 years of age or under with coverage through both of their parents
- Is married where both they and their spouse have dual coverage insurance through their respective employers
- Is 26 years of age or younger, married, and covered by their spouse's plan and their parent's plan
- Has both OHC and Medicare coverage

If a client has multiple OHCs, the amount paid by the OHCs cannot be more than 100% of the cost of the service.

Before billing SAPC:

1. Bill the primary insurance first.
2. If the primary insurance denied the claim or only partially paid the service, bill the secondary insurance.
3. Bill SAPC if there is still a remaining amount after billing the primary and secondary insurances.
    a. Medi-Cal will only pay up to its own maximum allowed rate, minus the amount paid by the primary and/or secondary insurances. [5]

Section 2: Eligibility

Verifying Active DMC and OHC

Provider agencies must verify client eligibility before admission and monthly thereafter to ensure clients are actively enrolled in Medi-Cal and/or OHC.[6] Federal and State regulations require provider agencies to take all reasonable measures to determine responsibility of a client's OHC to pay for services.[7]

To verify eligibility, provider agencies can use one or more of the following options:

- **DHCS Provider Portal Eligibility Transaction (Recommended)**
  - The Eligibility Transaction response in the DHCS Provider Portal provides key information regarding Medicare coverage, OHC insurance name, and the OHC code of the insurance. Key words to look for in the response are "Other Health Insurance." This indicates that there is OHC for the client and the name of the insurance will be listed.
  - Instructions for running an Eligibility Transaction in the DHCS Provider Portal can be found on the Medi-Cal website using the following link: Eligibility Transaction User Guide.
    - **Tip:** The DHCS eligibility transaction can be run using the CIN and Issue Date listed on the client's Medi-Cal Benefits Identification Card (BIC). If the BIC is not available, the eligibility transaction can be submitted using the client's Social Security Number and by entering the current date (the date the eligibility transaction is being conducted) in the Issue Date field.
  - Refer to Appendix A - DHCS Provider Portal Eligibility Transactions - in this manual for examples of DHCS Provider Portal transaction responses.
- **Sage Real Time Inquiry (270) Request form**
  - The Real Time Inquiry (270) Request form in Sage/ProviderConnect NX (PCNX) requests real-time Medi-Cal Eligibility directly from DHCS. Once the 270 Eligibility Request is submitted, the State will respond via the 271 Eligibility Response report that will include information about the client's OHC eligibility.
  - Although the report does not currently provide the specific details of the OHC, such as the insurance company's name, this process will show if a client has an active OHC. For step-by-step instructions on how to run the 270 Report, please refer to the 270/271 Process User Guide on the Sage website. If the 271 Response Report does not indicate that the client has OHC, no further action is needed to assess OHC enrollment.
  - Refer to Appendix A - Real Time 270 Inquiry Response Examples - in this manual for further details and examples.
- **DHCS Automated Eligibility Verification System (AEVS)**
  - AEVS can be accessed by calling (800) 456-2387 or (800) 541-5555.
  - Instructions for accessing and operating AEVS can be found on the Medi-Cal website using the following link: AEVS General Instructions. AEVS will return a message that includes OHC information in the form of OHC codes under the Eligibility Message section.
- **Availity**
  - Availity is a free online resource that can help verify client benefits, claim submissions, claim status, and authorizations. Visit the Availity website at https://www.availity.com/
- **Direct communication with the client's insurance carrier**
  - Contact the client's insurance carrier directly to confirm enrollment and coverage.

OHC Code Definitions

The presence of an OHC Code in an eligibility response signals that the client has OHC. Refer to the table below (Table 1) of OHC Codes, code description, and determination if the OHC is required to be billed before billing Medi-Cal via SAPC.[8] However, for Medi-Medi clients, the service code also needs to be reviewed using the

Billing Rules tab of the Rates Matrix to determine if the "Medicare COB Required" column indicates "Yes" (Refer to sub-section Medicare as an OHC in this manual). If the table below indicates "Required," the OHC must be consulted to determine if the plan covers SUD treatment. If the plan includes SUD treatment service coverage, the OHC must be billed.

Table 1. OHC Codes Chart

OHC Code	Code Description	Required to Bill OHC Prior to Medi-Cal
A	Pay and chase (applies to any carrier)	Optional
C	Military benefits comprehensive	Required
D	Medicare Part D Prescription Drug Coverage	Required
E	Vision plans	Not Required
F	Medicare Part C Health Plan	Required
H	Multiple plans comprehensive	Required
K	Kaiser	Required
L	Dental only policies	Not Required
N	No OHC	Not Required
P	PPO/PHP/HMO/EPO not otherwise specified	Required
Q	Commercial pharmacy plans	Required
W	Multiple plans non-comprehensive	Required

Scope of Coverage

Scope of Coverage indicates different types of services that a client is eligible to receive under their covered OHC (Figure 1). All SUD services fall under Hospital Inpatient (I), Hospital Outpatient (O), Medical and Allied Services (M), and/or Medicare Part D (R) service categories.

Figure 1. Scope of Coverage (COV) Codes Chart

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

Medicare as an OHC

Medicare Billing Criteria

When determining if a service needs to be billed to Medicare prior to billing SAPC, provider agencies must confirm that the three conditions below are met. If any of the three criteria are not met, the claims can be billed to SAPC without billing Medicare first.

1. The beneficiary is actively enrolled in both Medicare and Medi-Cal.

2. The rendering service provider is a Medicare-recognized provider type.
   a. Medicare-Recognized Provider Types: Physician, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist*, Licensed Professional Clinical Counselor*, Clinical Psychologist, and Occupational Therapist.[9]
      *If Medicare's education requirements have been met.
   b. Interns and clinical trainees of the licensed practitioners listed above are not Medicare-recognized provider types.
3. The service is a Medicare covered service. See the Medicare Coordination of Benefits (COB) sub-section for more information on this determination.

See Appendix B: Medi-Medi Billing Decision Tree for a visual summary of when to bill Medicare first versus billing SAPC directly.

For more information or support on billing Medicare for services delivered, please refer to the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network website.

Opioid Treatment Program (OTP) Services

Per SAPC Information Notice 20-01, OTP service providers must be enrolled as a Medicare provider and must bill Medicare first for covered services delivered by the OTP to Medicare recipients.

Medicare Part D covers most OTP medications. Always check with the Medicare plan to confirm which medications are covered. In general, Medicare does not cover Disulfiram, Buprenorphine combination, or Naltrexone: Long-Acting Injection, and can be billed to SAPC directly.

Medicare Coordination of Benefits (COB)

The Rates Matrix column "Medicare COB Required" on the Billing Rules tab indicates if the code is required to be billed to Medicare prior to billing SAPC. If the service is required to be billed to Medicare, this column will indicate "Yes." If the service is not required to be billed to Medicare, the column will indicate "No."

Overriding the Medicare COB Requirement

Medicare does not pay for services rendered by registrants/residents or by non-Medicare recognized provider types. The HL or GC modifier should be used for a service that is required to be billed to Medicare, delivered to a Medi-Medi client, and performed by a rendering provider not billable to Medicare.

The HL modifier should be used for the following rendering provider types:

- License-eligible LPHAs
- Licensed Marriage and Family Therapists (LMFT) and Licensed Professional Clinical Counselors (LPCC) that do not meet Medicare's education requirements

The GC modifier should be used for the following rendering provider types:

- Physician residents

Removing Inactive OHC From a Client's Record

When a client's OHC on file with DHCS has been verified as inactive, provider agencies must request its removal by DHCS prior to billing SAPC for DMC covered services. Once the provider agency has verified that the OHC is inactive, the provider should request the removal of inactive OHC by DHCS using the steps below.

1. Visit the website: https://www.dhcs.ca.gov/services/other-health-coverage/.
2. Select 'Submit Other Health Coverage Request.'
3. Complete all required fields and submit the form to DHCS.

Once the request to remove an inactive OHC has been processed, verify that the inactive OHC has been removed by conducting an eligibility verification. Inactive OHC records are typically removed within one (1) business day of the request if made within DHCS business hours. If the request is made outside of business hours, it can take up to two (2) business days for the inactive OHC to be removed from a client's record. Provider agencies must wait for the removal of the inactive OHC from the DHCS system prior to billing SAPC or the claims will be denied by Medi-Cal.

If unable to use the online form to request removal of an OHC record, agencies can call the DHCS Telephone Service Center at (800) 541-5555 to request removal of the inactive OHC from the client's record. When requesting to remove an inactive OHC via the telephone option, it is recommended to keep record of the case number given by DHCS. The provider agency can bill SAPC after verifying that the inactive OHC has been removed from the client's record in the DHCS system.

More information regarding adding or removing OHC from a client's record can be found on the DHCS Other Health Coverage Reference Guide. Refer to the Verifying Active DMC and OHC section of this manual for resources to verify OHC enrollment.

Section 3: SAPC Service Authorization Requests for Clients with OHC

SAPC requires provider agencies to submit a service authorization for all clients within 30 calendar days of admission, including those with both Medi-Cal and OHC benefits. Service authorization requests for clients with OHC must meet current standards and requirements, with limited exceptions for delays in establishing financial eligibility.[10] The provider agency must include a comment in the service authorization justification indicating the client has OHC. Provider agencies cannot send claims to SAPC for services until the OHC carrier has been billed and has either denied the claims or has not responded within 90 calendar days.

The purpose of submitting the service authorization before receiving an OHC denial is to allow agencies to secure authorization while the client is receiving SUD services. This allows the SAPC Utilization Management Care Manager to review the request, ask for clarification, and guide the agency in collecting any missing documentation.

Alternatively, provider agencies may wait to submit the member authorization request until the OHC denial is received. SAPC Utilization Management will accept authorization requests submitted more than 30 days from the date of service when the justification comments explain the delay was due to waiting for the OHC denial.[11]

Section 4: Required Supporting Documentation

DHCS Requirements

Medi-Cal requires that any service partially paid or denied by the client's OHC when being billed to Medi-Cal be accompanied by an Explanation of Benefits (EOB) or denial letter. An EOB or denial letter received from the OHC carrier is proof the OHC was billed for the service and the claim was denied or partially paid by the OHC.

DHCS requires that the information on the EOB or denial letter includes:

- Insurance name and address
- Beneficiary's name or Social Security Number (SSN)
- Date
- Statement of denial, termination, or amount paid
- Procedure or service rendered
- Coverage termination date or date of service

Provider agencies are required to use the Provider File Attach form in PCNX to upload EOBs and denial letters to the client's chart. When a service is not a covered benefit of the client's OHC, a copy of the original denial letter or EOB is acceptable for the service for a period of one year from the date of the original EOB or denial letter. It is the agency's responsibility to obtain a new EOB or denial letter at the end of the one-year period. Provider agencies can also submit a dated statement of non-covered benefits from the carrier if it matches the insurance name and address and the client's name and address.[12]

How to Provide Required Documentation

All OHC related documents are to be uploaded into PCNX via the Provider File Attach form. The naming convention for OHC documentation is as follows:

- **Standard Naming Convention Format:** [Type of Document]-[Dates of service covered by document (MM-DD-YY_MM-DD-YY)]-[Client's First & Last Initial]-ID[Client ID]
  - Type of Document for OHC: OHCSupport
- **OHC Documentation File Name Example:** OHCSupport-(12-12-20_12-31-20)-JD-ID99999

The list of required naming conventions for documents uploaded via the Provider File Attach form can be viewed at: http://publichealth.lacounty.gov/sapc/Sage/Documentation/FileNamingConvention.pdf.

Monitoring of OHC Documentation

SAPC will conduct periodic reviews of claims submitted with OHC information to validate that the EOB or denial letter was uploaded in PCNX. OHC claims lacking the required supporting documentation will be subject to disallowances of services and recoupment of funds. DHCS may also disallow services found during an audit that do not meet OHC denial documentation requirements, resulting in SAPC recoupments.

Section 5: OHC Payer Responses

Out-of-Network Denials

If a client's OHC denies services due to not being delivered by an in-network facility or practitioner, DHCS will accept this as an allowable denial reason if the client does not want to use an in-network provider. The denial letter or EOB must include a note stating, "Advisal given, recipient refused to utilize OHC."[13] This documentation

is critical to note that the client chose not to use their OHC benefits and allows for the services to be billed to Medi-Cal. The claims billed to SAPC must include the denial information from the OHC or the services will be denied by DHCS. Services do not need to continue to be billed to the out-of-network OHC to continue receiving denials; the prior out-of-network denial information can be used for one year from the date of the original denial.

In-Network Referrals and Warm Handoffs

If the OHC states that the client must use an in-network facility or practitioner and the client wants to use their OHC benefits, the provider agency must help the client with a warm handoff. This means actively assisting the client to smoothly transfer their care to a facility/practitioner that accepts their OHC.

Presumptive Denials

If the OHC does not provide a response to a claim within 90 calendar days from the billing date, DHCS allows for a service to be billed to Medi-Cal. This presumption of denial can only be made in the following situation:

- The provider agency has billed the service to the OHC carrier and at least 90 calendar days have elapsed since the submission to the OHC and there are none of the following:
    - Payment of the claim
    - A report (hardcopy, electronic, or other form) of the result of the OHC carrier's adjudication of the claim
    - Any communication regarding the submission of the claim or the need for corrections prior to adjudication by the OHC

If there is no adjudication from the OHC after 90 calendar days from the billing date, the provider must make a copy of the billing claim form that was sent to the OHC, write "90-day response delay" on the form, and upload the document to the Provider File Attach in PCNX.

DHCS requires that the claim to Medi-Cal includes the OHC information showing that $0 was paid by the carrier. For Presumed Denials, as defined by DHCS in ADP Bulletin 11-01, provider agencies should use OA 192 as the denial code on the service billed to SAPC.

Partial Payments

If a service is partially paid by the OHC, the service can be billed to SAPC. The claim must include the partial payment information and the charge amount must be the SAPC rate minus the amount paid by the OHC. The EOB from the OHC showing the partial payment must be submitted via the Provider File Attach form to the client's record in PCNX.

OHC Responses After 90 Days of Billing When SAPC Has Been Billed

In the event an OHC sends a delayed response to provider agencies (after more than 90 days) and a service has already been billed to SAPC, the service must be either voided or replaced.

VOID: If the OHC response pays the full amount charged to SAPC, the service must be voided.

REPLACE: If the OHC partially paid the service after billing SAPC, the provider agency must submit a replacement claim to add the OHC information onto the claim to note the partial payment information and

reduce the amount owed. Primary Sage Users should refer to the Replacement Claim Job Aid for more information about replacing services with OHC information.

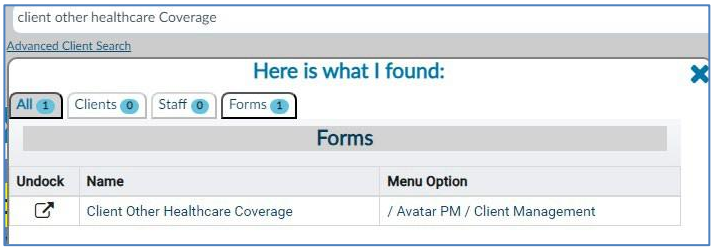
Section 6: Billing Claims with OHC Information in Sage (Primary Sage Users)

Primary Sage Users must enter OHC information on each applicable service through the Fast Service Entry Submission form in PCNX. OHC information must be added to each individual service that was denied, partially paid, or presumed denied by the OHC after 90 days of no response.

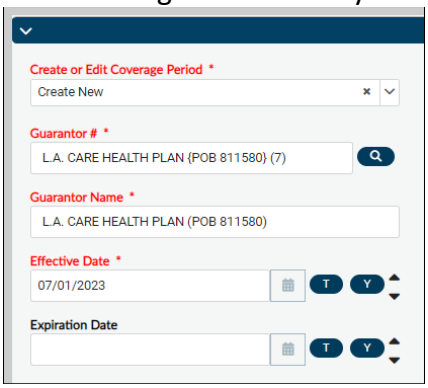
Completion of the Client Other Healthcare Coverage Form

For each client that has an active OHC, it is required that the Client Other Healthcare Coverage form be completed. This form collects the client's OHC information to be transmitted when billing Medi-Cal. Services billed for a client with OHC may be recouped if the form is not completed in Sage.

1. In the search field, type in 'Client Other Healthcare Coverage' and click on the form name in the search results.



2. Enter the name of the client in the **Select Client** field and select the appropriate client record.
3. Select the appropriate episode number in the episode table.
4. On the Client Other Healthcare Coverage record entry form, complete the required fields as noted in the following steps.
   i. Select 'Create New' in the **Create or Edit Coverage Period** dropdown list.
   ii. Enter the guarantor's name in the **Guarantor #** field. A list will populate based on the name entered. Select the appropriate guarantor. The **Guarantor Name** will prepopulate with the guarantor's name after the Guarantor # is selected in the previous step.
   iii. Enter the insurance effective date in the **Effective Date** field.
   iv. The **Expiration Date** field should only be completed if the client's OHC has officially expired and the client no longer is covered by the insurance plan.



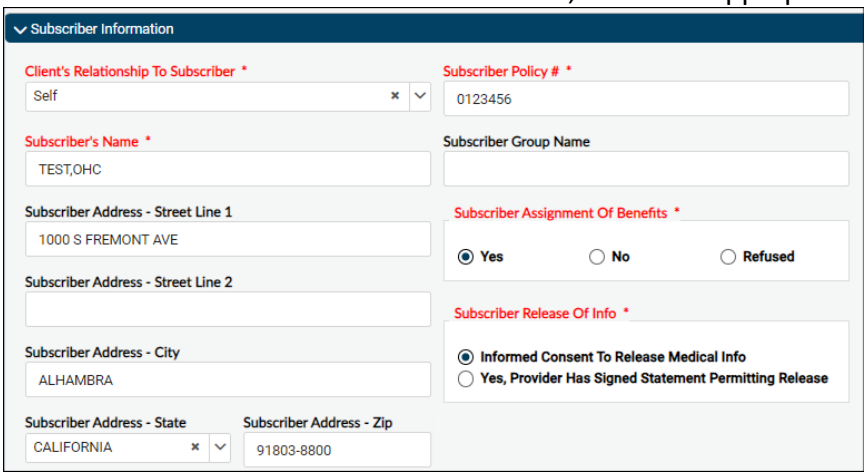
v. In the **Client's Relationship to Subscriber** field, select the appropriate response from the dropdown based on the client's relationship to the subscriber of the OHC insurance plan.
   a. If the client is the subscriber of the OHC insurance plan, select 'Self'.
   b. If the client is not the subscriber of the OHC insurance plan, select the response that best reflects their relationship to the OHC subscriber.

vi. In the **Subscriber Policy #** field, enter the policy number of the OHC insurance plan.

vii. In the **Subscriber Name** field, enter the name of the subscriber of the OHC insurance plan.
   a. If the client is the subscriber of the OHC insurance plan, type the client's name. This will auto populate if 'Self' is selected in the Client's Relationship to Subscriber field in a previous step.
   b. If the client is not the subscriber of the OHC insurance plan, type the name of the subscriber.

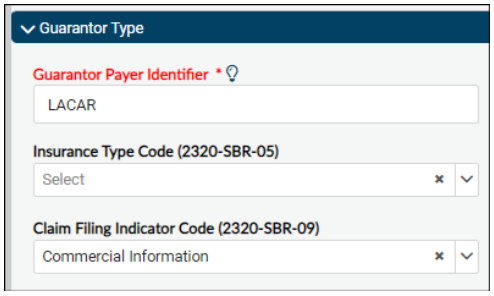
viii. In the **Subscriber Assignment of Benefits** field, select the appropriate response.

ix. In the **Subscriber Release of Information** field, select the appropriate response.



x. In the **Guarantor Payer Identifier** field, enter the OHC guarantor's payer ID.
   a. The payer ID can be found in two ways:
      1) Contacting the OHC
      2) Utilizing online resources such as - https://www.inovalon.com/payer-list/ or the insurance company's website.
   b. It is important that the correct payer ID is utilized or Medi-Cal may deny the service. Some large commercial insurance companies have multiple payer IDs for the different plans offered. Confirm the payment address for the insurance to help identify the appropriate payer ID to utilize.

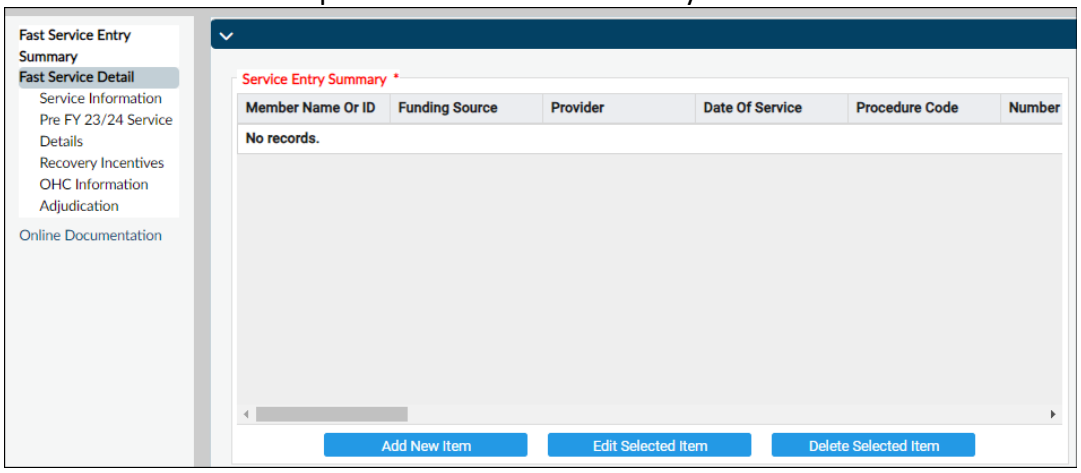
xi. For the **Claim Filing Indicator Code** field, select the appropriate insurance type from the dropdown. Examples of insurance plans and the appropriate selection:
   a. For private health insurance, select 'Commercial Information.'
   b. For Medicare Advantage Plans (Part C), select 'Health Maintenance Organization (HMO) Medicare Risk.'
   c. For Medicare Part A or B, select either 'Medicare Part A' or 'Medicare Part B.'



xii. Click the **Submit** button to save the form.

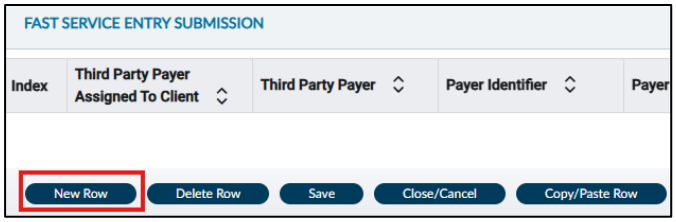
Creating a Fast Service Entry Submission with OHC Information

1. Navigate to the Fast Service Entry Submission form.
2. Navigate to the Fast Service Detail area in the left menu.
3. Select **Add New Item** to open the fields for service entry.

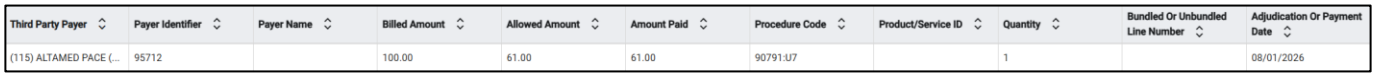


4. Enter the details of the service as required for standard service entry.
5. In the OHC Information section of the form, click the **Enter Third Party Adjudication Data** button to open the fields for OHC adjudication information.

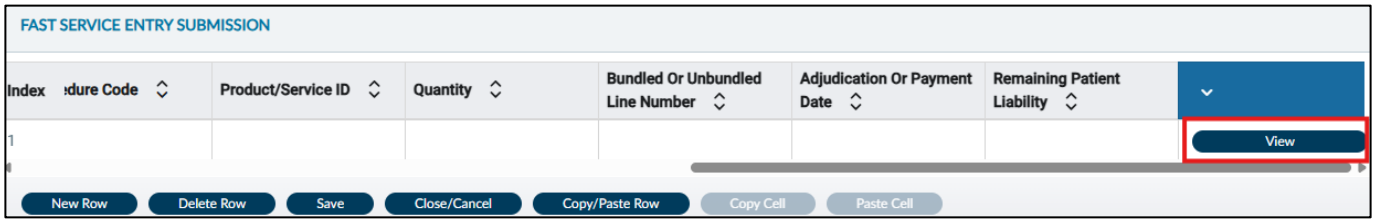
6. Click the **New Row** button to add a record for OHC adjudication information.



7. In the **Third Party Payer** field, select the name of the third-party payer and click **Select**.
8. In the **Payer Identifier** field, enter the payer ID for the client's OHC carrier and click **OK**. This should match what was entered on the Client Other Healthcare Coverage form.
9. In the **Billed Amount** field, enter the amount billed to the OHC.
10. In the **Allowed Amount** field, enter the amount the insurance allows for the service.
11. In the **Amount Paid** field, enter the amount paid by the OHC.
12. In the **Procedure Code** field, enter the Procedure Code and click **OK**.
13. In the **Quantity** field, enter "1" and click **OK**. <u>This must always be 1</u>.
14. In the **Adjudication Or Payment Date** field, enter or select the date of the OHC adjudication.

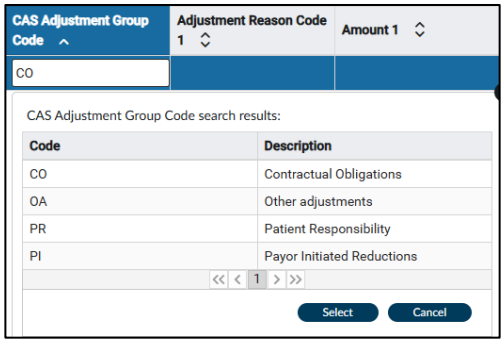


15. Click the **View** button on the far right of the line to open the adjudication entry form.

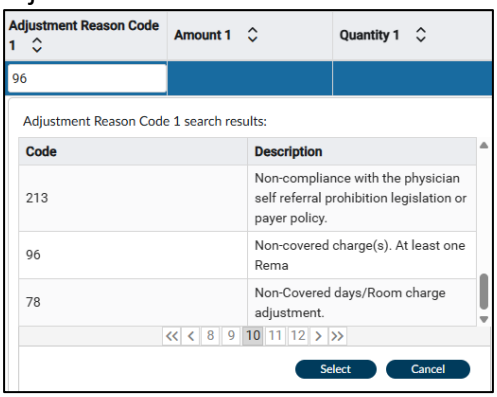


i. Click **New Row** to open the form for entry.

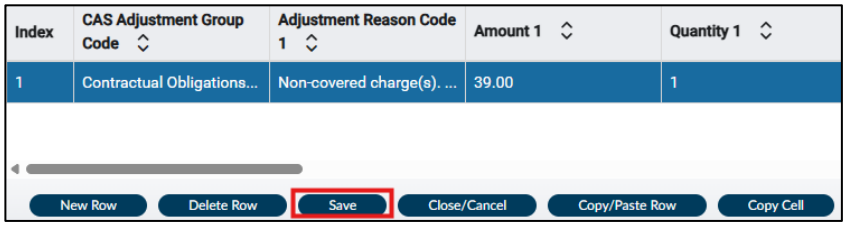
16. In the **CAS Adjustment Group Code** field, select the appropriate code from the drop-down menu and click **Select**.



17. In the **Adjustment Reason Code** field, enter the Adjustment Reason code associated with the Adjustment Code and click **Select**.

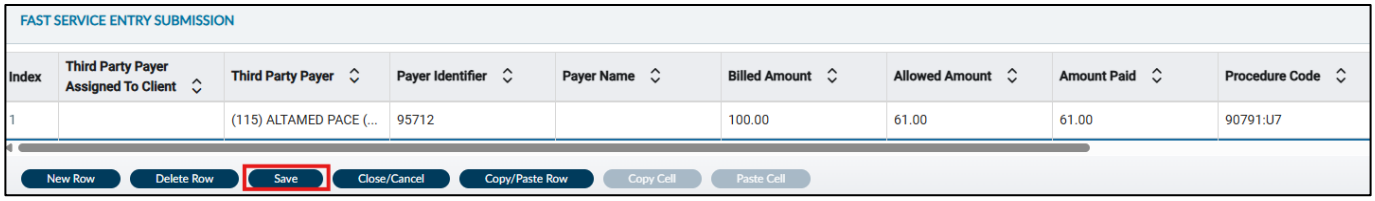


18. In the **Amount field**, enter the denied amount by OHC.
19. In the **Quantity** field, enter "1" for quantity. <u>This must always be 1</u>.
20. Click **Save**.



i. Click **Yes** to exit the grid.

20. Click **Save** again.



Once the OHC information has been entered for the applicable services, proceed with billing as usual. All entered OHC information will populate in the claim that SAPC will send to Medi-Cal.

Replacing Claims with OHC

If a service with OHC needs to be replaced to add, edit, or remove OHC information, void the service (only if approved locally and not State denied) and resubmit as a new original service using the Fast Service Entry Submission form. If the service was already denied by the State and recouped or if the service was denied locally, there is no need to void the service before resubmitting as a new original service.

Section 7: Billing Claims with OHC Information via 837 (Secondary Sage Users)

Secondary Sage Users need to ensure proper formatting and information is included on the 837 files submitted to SAPC as indicated in SAPC's 837 Companion Guides. Services delivered in levels of care 3.7-Withdrawal Management and 4.0-Withdrawal Management (WM) should follow the 837I Companion Guide, while all other services should follow the 837P Companion Guide.

Important! If the client has a Medicare Advantage Plan with an OHC Code of "F," loop 2320 with segment SBR must indicate "16" or Medi-Cal will deny the service.

Provider agencies must enter the denial or partial payment information from an OHC into their EHR. Denial letters and EOBs are required to be uploaded to the client's record in PCNX when billing services with OHC. Agencies must also ensure that the OHC claim information populate in the correct loops (Loop 2320, Loop 2330A, and 2330B) when creating 837s to transmit to SAPC. Refer to the 837P companion guide regarding guidance for OTP providers and Medi-Medi claiming. Each claim must include the service line adjudication information in Loop 2430 for each service. See Appendix C: Example 837s with OHC Info (Secondary Sage Users) for details and examples.

As each Secondary Sage User utilizes a unique system as their primary electronic health record and has unique workflows, it is the responsibility of the provider agency to ensure their system and workflows are configured appropriately.

OHC claim information must indicate or include the following information:

1. Medi-Cal as a secondary payer (Loop 2000B – SBR segment)
2. The OHC/Primary payer information, including Payer ID, Subscriber Assignment of Benefits, and Subscriber Release of Info (Loop 2320 – SBR segment and OI segment and Loop 2330B – NM1 segment)
3. Amount paid by OHC, which should be 0 if the payment was denied (Loop 2320 – AMT segment and Loop 2430 – SVD segment)

4. Amount denied by OHC (Loop 2430 – CAS segment)
   i. In some instances, there may be more than one CAS segment. All CAS segments must be included.
5. Claim Adjustment Reason Code (CARC) sent by OHC (Loop 2430 – CAS segment)
   ii. For Presumed Denials, as defined by DHCS in ADP Bulletin 11-01, in which the OHC did not respond to the provider inquiries within 90 calendar days of request, provider agencies should use OA 192 as the CARC in the CAS segment.[14]
6. Date of remittance from OHC (Loop 2430 – DTP segment)

837 Rejections or Denials Due to OHC Information

Errors in formatting will result in the file being rejected or claims being denied. Claims that have incomplete or invalid OHC information when OHC is required will be rejected on the 277CA. The errors noted on the Critical Error Report need to be corrected for the claim to be adjudicated. For instance, if the payer ID is missing on the claim, it will be rejected with the following message:

- A7:479 Other Payer Primary ID is missing or invalid or the value sent in the 2330 loop does not match the value sent in the 2430 loop

The claim dollar amount and service dollar amounts must be balanced, where adding all the individual service amounts equals the total claim amount. If the dollar amounts are unbalanced, this can result in claim rejections on the 277CA and critical errors. Rejected claims do not move through the adjudication process and will not show on EOBs or 835s. Provider agencies must review all 277CA files and Critical Error Reports for rejected claim information. Common rejection codes on the 277CA for out of balance claims are:

- A7:178 Total claim charge amount not equal sum of line-item charge amount
- A7:400 Claim is out of balance - service line paid amount + all service line adjustment amounts do not equal the line-item charge amount

For 837 files transmitted with incomplete or missing OHC information, claims will be accepted and approved at the local level, as Sage does not validate they have been completed or if the information is valid. In these cases, the claims are reviewed after adjudication and recouped by SAPC with denial code CO 16 N480. Please verify all claims contain all required segments/loops in the specific order referenced in Appendix C.

Section 8: OHC and Billing Support

General Support

For questions regarding OHC billing, provider agencies should reach out to the appropriate party to receive support and technical assistance.

- For technical assistance to resolve or understand OHC denials from the State or to understand SAPC billing requirements, open a Sage Help Desk ticket using the Request Billing Assistance form.
- For technical assistance with understanding requirements within SAPC's 837 Companion Guides, contact SAPC IT at SAPC_support@ph.lacounty.gov.

- For assistance with AEVS or a client's record with DHCS, contact DHCS directly. For assistance with AEVS, provider agencies can contact the AEVS help desk at (800) 427-1295. For questions on Medi-Cal policy, provider agencies can contact the Medi-Cal Telephone Support Center (800) 541-5555.
- For additional resources from DHCS on OHC, guidelines for billing OHC and additional information can be found on DHCS's OHC webpage.
- For information and support billing Medicare, visit the CMS Medicare Learning Network website.

Denial Resolution Resources

The following resources on the Sage Finance Training page - Denial Troubleshooting section, provide additional guidance on identifying and resolving claim denials:

- The **Sage Guide to Claims Denial Resolution** explains types of denials, general investigation steps, and how to use the Denial Crosswalk.
- The **Sage Claim Denial Reason and Resolution Crosswalk** lists local and State denial codes and provides resolution steps to correct claims.

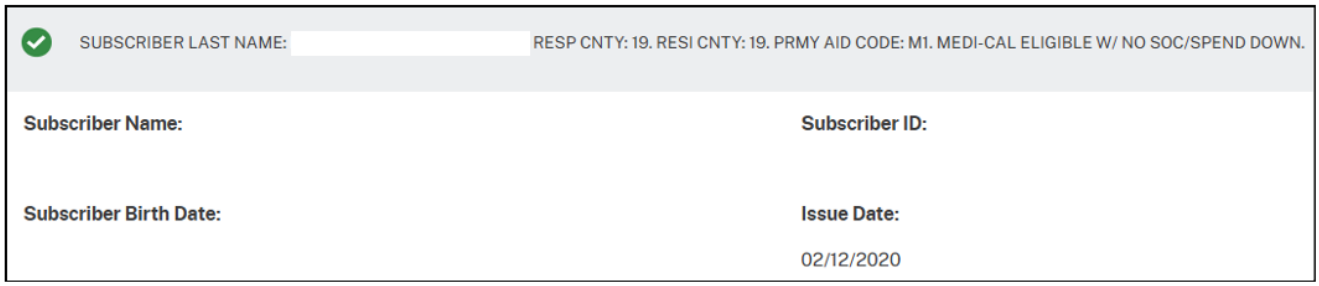
Appendix A: Eligibility Response Examples

DHCS Provider Portal Eligibility Transactions

Medi-Cal Only (No OHC or Medicare)

Example Response with Regular Medi-Cal

Regular Medi-Cal will show a green check mark before the response details and will not include any additional plan descriptions such as "Health Plan Member" or "PHP," which indicate a Medi-Cal Managed Care Plan. In the example below, the response contains the green check mark and Medi-Cal is indicated as, **"MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN,"** with no other details.

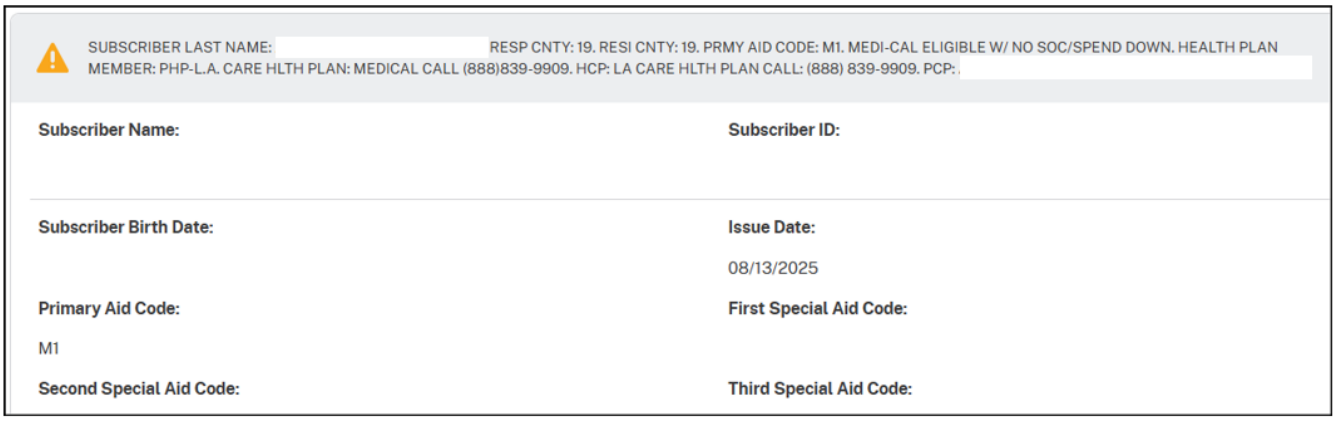

SUBSCRIBER LAST NAME: RESP CNTY: 19. RESI CNTY: 19. PRMY AID CODE: M1. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN.

Subscriber Name: **Subscriber ID:**

Subscriber Birth Date: **Issue Date:** 02/12/2020

Example Response with Medi-Cal Managed Care Plan

Medi-Cal Managed Care Plans are identified by the words, "**HEALTH PLAN MEMBER,**" followed by **"PHP"** (Prepaid Health Plan), and the name of the Managed Care Plan, such as, **"L.A. CARE HLTH PLAN."** The Medi-Cal Managed Care Plan is not considered OHC and does not need to be billed prior to billing SAPC.


SUBSCRIBER LAST NAME: RESP CNTY: 19. RESI CNTY: 19. PRMY AID CODE: M1. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (888)839-9909. HCP: LA CARE HLTH PLAN CALL: (888) 839-9909. PCP:

Subscriber Name: **Subscriber ID:**

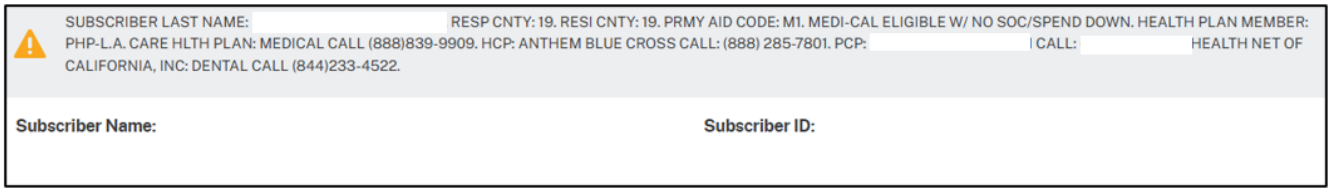
Subscriber Birth Date: **Issue Date:** 08/13/2025

Primary Aid Code: M1 **First Special Aid Code:**

Second Special Aid Code: **Third Special Aid Code:**

Example Response with Multiple Medi-Cal Managed Care Plans

Clients with multiple Medi-Cal Managed Care Plans are identified by the words, **"HEALTH PLAN MEMBER,"** followed by **"PHP,"** and then **"HCP."**

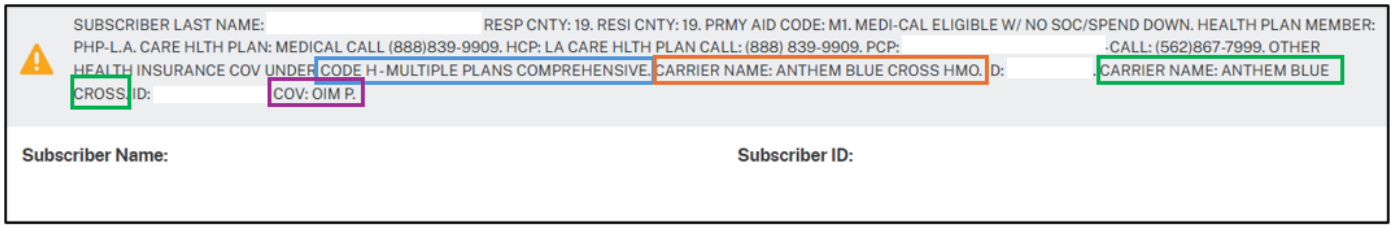


Medi-Cal and OHC

Private insurance is identified by the words, **"OTHER HEALTH INSURANCE,"** paired with the OHC Code immediately after. The insurance plan names will appear after, **"CARRIER NAME."** The end of the response will also include the OHC Scope of Coverage indicated by **"COV"** with the Scope of Coverage Codes immediately after.

In the example below, the client has multiple OHCs, each broken down into separate details:

- Blue Box: The OHC Code is indicated as, **"CODE H-MULTIPLE PLANS COMPREHENSIVE."**
- Orange Box: The first OHC plan is indicated as, **"CARRIER NAME: ANTHEM BLUE CROSS HMO."**
- Green Box: The second OHC plan is indicated as, **"CARRIER NAME: ANTHEM BLUE CROSS."**
- Purple Box: The Scope of Coverage codes are indicated as, **"COV: OIM P,"** which designates the coverage as Hospital Outpatient (O), Hospital Inpatient (I), Medical and Allied Services (M), and Prescription Drugs (P).



Medi-Cal and Medicare

Medicare plans are indicated in the response with the Medicare Part (aka plan) listed. Medicare Advantage Plans (Medicare Part C) will be listed after the words, **"OTHER HEALTH INSURANCE,"** and will provide the Medicare Part C insurance plan.

In the example below, the client has multiple Medicare Parts which are broken down into multiple details.

- Red Box: The Medicare Parts are listed as, **"PART A, B, AND D MEDICARE COV W/MEDICARE."**
- Blue Box: The OHC Code is indicated as, **"CODE F – MEDICARE PART C HEALTH PLAN."**
- Orange Box: The Medicare Part C (Medicare Advantage) plan is indicated as, **"CARRIER NAME: LA CARE MEDICARE PLU HMO DSNP."**
- Purple Box: The Scope of Coverage codes are indicated as, **"COV: OIM VR,"** which designates the coverage as Hospital Outpatient (O), Hospital Inpatient (I), Medical and Allied Services (M), Vision Care Services (V), and Medicare Part D (R).

SUBSCRIBER LAST NAME: RESP CNTY: 19. RESI CNTY: 19. PRMY AID CODE: 1H. 1ST SPECIAL AID CODE: 80. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-L.A. CARE HLTH PLAN: MEDICAL CALL (888)839-9909. HCP: LA CARE HLTH PLAN CALL: (888) 839-9909. PCP: CALL THE HCP FOR PCP INFO. PART A, B AND D MEDICARE COV W/MEDICARE MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. OTHER HEALTH INSURANCE COV UNDER CODE F - MEDICARE PART C HEALTH PLAN. CARRIER NAME: LA CARE MEDICARE PLU HMO DSNP COV: OIM VR.

Real Time 270 Inquiry Response Examples

Medi-Cal Only (No OHC or Medicare)

If a client has only Medi-Cal coverage, the 271 Response will be brief and only include information regarding Medicaid. In the example below, no other eligibility information is listed for the client, only the Medi-Cal/Medicaid information. This indicates that no other eligibility information was found for Medicare or OHC.

1.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(W) Other Source of Data
2.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(1) Active Coverage
	Service Type Code	:	(30) Health Benefit Plan Coverage
	Insurance Type Code	:	(MC) Medicaid

Medi-Cal and OHC

If a client has Medi-Cal and OHC coverage, the 271 Response will include the Medi-Cal/Medicaid information as well as an indication that the client has OHC by displaying, **"(R) Other or Additional Payor**" and **"(CB) Coverage Basis."** The 271 Response has limited information on the client's OHC and if the response indicates the client has OHC, SAPC strongly recommends that the DHCS Provider Portal Eligibility Transaction is run to identify the OHC plan and details.

In the example below, the client has multiple types of coverage which are broken down into multiple details.

- Orange Box: The Medi-Cal information is shown by the **"Insurance Type Code: (MC) Medicaid"**.
- Blue Box: The OHC is indicated when an "Eligibility Or Benefit Information" line shows "(R) Other or Additional Payor" and the following section includes the "Plan Coverage Description" with the associated Scope of Coverage codes. In this example, the Scope of Coverage is OIM P, which designates the coverage as Hospital Outpatient (O), Hospital Inpatient (I), Medical and Allied Services (M), and Prescription Drugs (P).

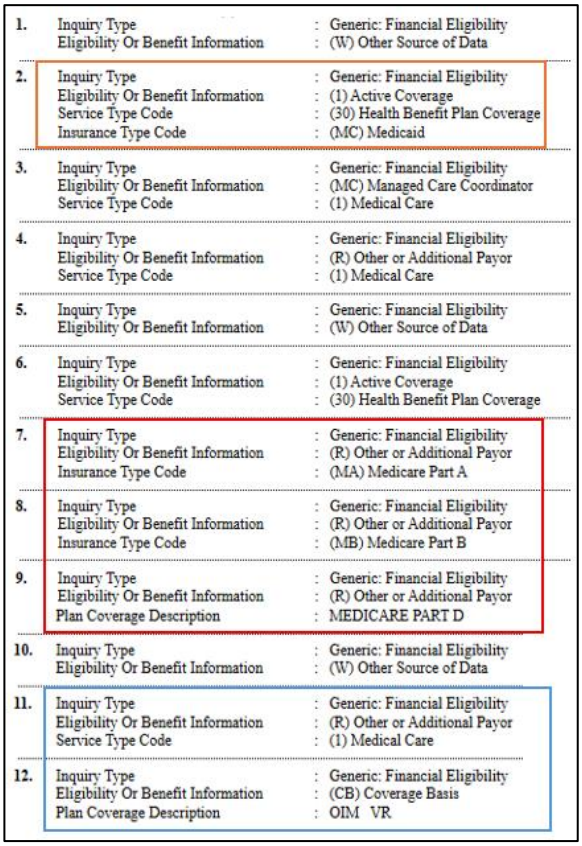
1.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(W) Other Source of Data
2.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(1) Active Coverage
	Service Type Code	:	(30) Health Benefit Plan Coverage
	Insurance Type Code	:	(MC) Medicaid
3.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(MC) Managed Care Coordinator
	Service Type Code	:	(1) Medical Care
4.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(R) Other or Additional Payor
	Service Type Code	:	(1) Medical Care
5.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(L) Primary Care Provider
6.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(R) Other or Additional Payor
	Service Type Code	:	(1) Medical Care
7.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(CB) Coverage Basis
	Plan Coverage Description	:	OIM P

Medi-Cal and Medicare

If a client has Medi-Cal and Medicare coverage, the 271 Response will include the Medicaid/Medi-Cal information as well as the Medicare details. The Medicare Part A, B, and/or D information will appear with the indications of, **"(MA) Medicare Part A," "(MB) Medicare Part B,"** and/or **"MEDICARE PART D."** The Medicare Part C information appears as other OHC plans appear with general OHC information indicated with, **"(R) Other or Additional Payor**" and **"(CB) Coverage Basis."** It is important to run the DHCS Provider Portal Eligibility Transaction to determine if the OHC indication is a Medicare Part C plan. The 271 Response treats this as OHC and will not clearly indicate if it is Medicare Part C.

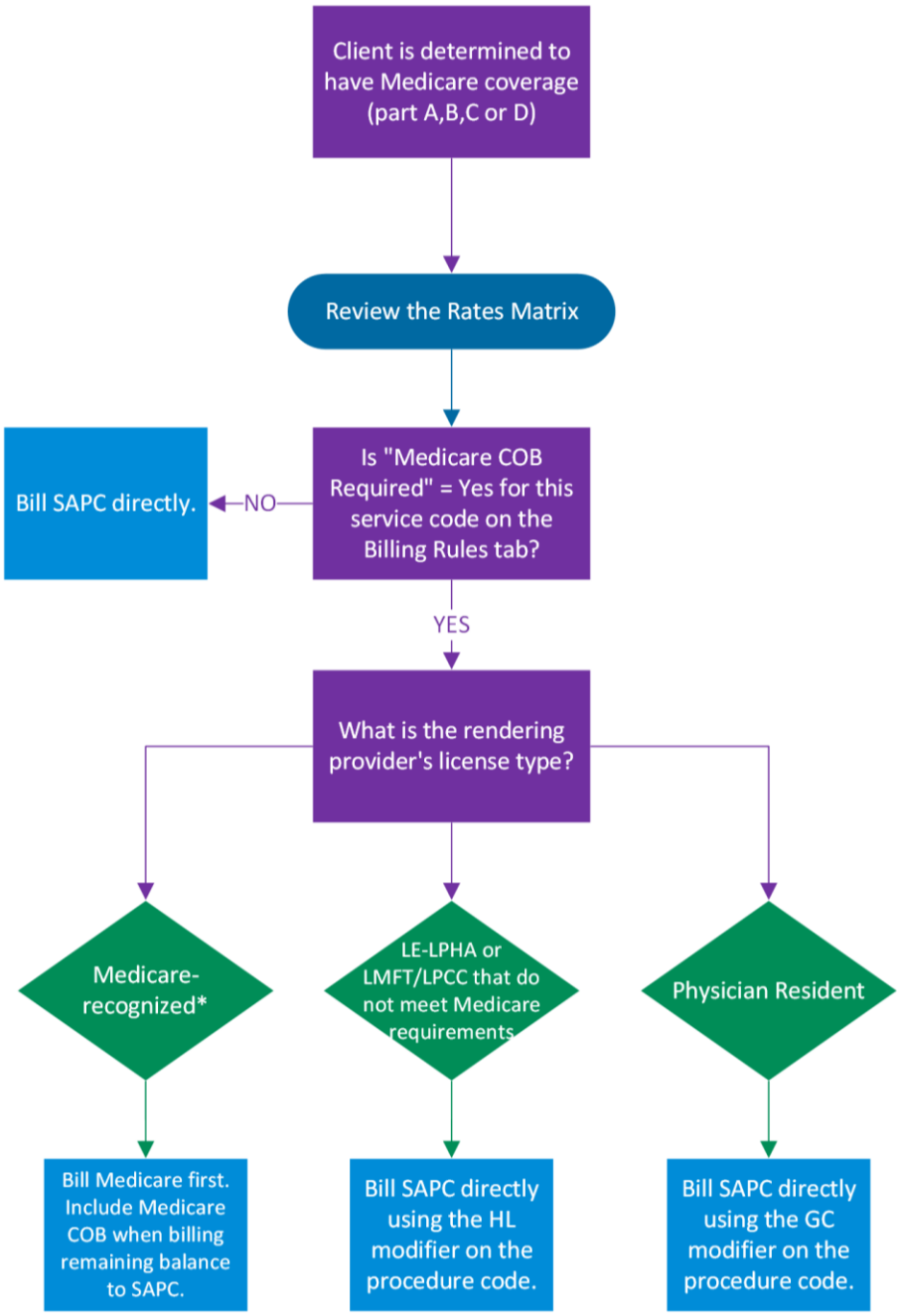
In the example below, the client has multiple types of coverage which are broken down into multiple details.

- Orange Box: The Medi-Cal information is shown by the **"Insurance Type Code: (MC) Medicaid"** text.
- Red Box: The Medicare Part A, Part B, and/or Part D is shown as, **"(MA) Medicare Part A," "(MB) Medicare Part B,"** and **"MEDICARE PART D."**
- Blue Box: The Medicare Part C information is indicated like other OHC plans, when an "Eligibility Or Benefit Information" line shows "(R) Other or Additional Payor" and the subsequent section includes the "Plan Coverage Description" with the associated Scope of Coverage codes. The Scope of Coverage codes are indicated as, **"COV: OIM VR,"** designating the coverage as Hospital Outpatient (O), Hospital Inpatient (I), Medical and Allied Services (M), Vision Care Services (V), and Medicare Part D (R).



1.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (W) Other Source of Data
2.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (1) Active Coverage
	Service Type Code	: (30) Health Benefit Plan Coverage
	Insurance Type Code	: (MC) Medicaid
3.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (MC) Managed Care Coordinator
	Service Type Code	: (1) Medical Care
4.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (R) Other or Additional Payor
	Service Type Code	: (1) Medical Care
5.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (W) Other Source of Data
6.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (1) Active Coverage
	Service Type Code	: (30) Health Benefit Plan Coverage
7.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (R) Other or Additional Payor
	Insurance Type Code	: (MA) Medicare Part A
8.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (R) Other or Additional Payor
	Insurance Type Code	: (MB) Medicare Part B
9.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (R) Other or Additional Payor
	Plan Coverage Description	: MEDICARE PART D
10.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (W) Other Source of Data
11.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (R) Other or Additional Payor
	Service Type Code	: (1) Medical Care
12.	Inquiry Type	: Generic: Financial Eligibility
	Eligibility Or Benefit Information	: (CB) Coverage Basis
	Plan Coverage Description	: OIM VR

Appendix B: Medi-Medi Billing Decision Tree



*Medicare-recognized provider types: Physician, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist**, Licensed Professional Clinical Counselor**, Clinical Psychologist, and Occupational Therapist.

***If Medicare's education requirements have been met.*

Appendix C: Example 837s with OHC Info (Secondary Sage Users)

Below are details and example 837s based on guidance from SAPC's 837 companion guides. This section is for Secondary Sage Users to use when verifying OHC details in 837P and 837I files prior to billing SAPC. Services delivered in levels of care 3.7-WM and 4.0-WM should follow the 837I Companion Guide, while all other services should follow the 837P Companion Guide. *Note: the examples shown below are for demonstration purposes and do not include PHI.*

EDI Details

The following table indicates the specific information that must be included for OHC claims. See Section 7: Billing Claims with OHC Information via 837 (Secondary Sage Users) for more information regarding general OHC billing requirements.

Table 2. Key Loops and Segments

Information	EDI/837 Details
Medi-Cal as a secondary payer	Loop 2000B – SBR segment
The OHC/Primary payer information and Payer ID	Loop 2320 – SBR segment and Loop 2330B – NM1 segment
Amount paid by OHC (0 if denied)	Loop 2320 – AMT*D segment and Loop 2430 – SVD segment
Amount denied by OHC	Loop 2430 – CAS segment and Loop 2320 – AMT*EAF segment
Subscriber Coordination of Benefits and Subscriber Release of Info	Loop 2320 – OI segment
CARC sent by OHC*	Loop 2430 – CAS segment
Date of remittance from OHC	Loop 2430 – DTP segment

* For Presumed Denials, as defined by DHCS in ADP Bulletin 11-01, in which the OHC did not respond to the provider inquiries within 90 calendar days of request, provider agencies should use OA 192 as the CARC in the CAS segment.

837P Example

The following is a sample 837P file format that Secondary Sage Users would submit to SAPC.[15] The EDI Segment column displays an example 837 segment and the Note column highlights key data to verify before submitting the 837P file to SAPC. While only certain segment data elements are highlighted, all are required. The highlighted data elements are for emphasis and to indicate where errors often occur that will lead to denials from DHCS.

Table 3. Example 837P with OHC Information

EDI Segment	Note
SBR*S*18**LACSAPC*****MC	Start of Loop 2000B. DMC is identified as the secondary payer in SBR01. SBR01 must indicate "S" for "Secondary", meaning that

	Medi-Cal is the secondary insurance plan (the OHC is the first).
SBR*P*18**AETNA INSURANCE - RISK HMO*****CI	Start of Loop 2320. The OHC payer is identified as the primary payer in SBR01. SBR01 must indicate "P" for "Primary", meaning that the OHC is the first/primary insurance plan.
AMT*D*39	The coordination of benefits (COB) amount paid by the OHC is displayed in AMT02. This is the amount that the OHC paid.
AMT*EAF*20	The remaining liability is displayed in AMT02.
OI***Y***Y	The subscriber assignment of benefits indicator is listed in OI03 and the subscriber release of information code is listed in OI06.
NM1*IL*1*CLIENT*TREATMENT****MI* MSO1234	Start of Loop 2330A – OHC subscriber information
NM1*PR*2*AETNA INSURANCE - RISK HMO*****PI*60054	Start of Loop 2330B (OHC payer information). NM103 contains the OHC payer name and NM109 contains the OHC payer ID.
SVD*60054*39*HC:H0049:U8**2	Start of Loop 2430 (line adjudication information). The service line paid amount is displayed in SVD02.
CAS*CO*45*20	This segment displays the CARC(s) and adjustment amount(s). In this example the CARC is CO 45 and the adjustment amount is $20.
DTP*573*D8*20170901	DTP03 displays the OHC remittance date.

837I Example

The following is a sample 837I file format that Secondary provider agencies would submit to SAPC.[16] The EDI segment column displays an example data line, and the Note column highlights key areas to review before transmitting the 837I file to SAPC. While only certain segment data elements are highlighted, all are required. The highlighted data elements are for emphasis and to indicate where errors often occur that will lead to denials from DHCS.

Table 4. Example 837I with OHC Information

EDI Segment	Note
SBR*S*18*******MC	Start of Loop 2000B. DMC is identified as the secondary payer in SBR01. SBR01 must

	indicate "P" for "Primary", meaning that the OHC is the first/primary insurance plan.
SBR*P*18**ALTAMED*****CI	Start of Loop 2320. The OHC payer is identified as the primary payer in SBR01. SBR01 must indicate "P" for "Primary", meaning that the OHC is the first/primary insurance plan.
AMT*D*31.85	The coordination of benefits (COB) amount paid by the OHC is displayed in AMT02. This is the amount that the OHC paid.
AMT*EAF*800.00	The remaining liability is displayed in AMT02.
OI***Y***Y	The subscriber assignment of benefits indicator is listed in OI03 and the subscriber release of information code is listed in OI06.
NM1*IL*1*OHC*TEST****MI*MSO112345	Start of Loop 2330A – OHC subscriber information
NM1*PR*2*ALTAMED*****PI*95712	Start of Loop 2330B (OHC payer information). NM103 contains the OHC payer name and NM109 contains the OHC payer ID.
SVD*95712*31.85*HC:0953:37*0953*1	Start of Loop 2430 (line adjudication information). The service line paid amount is displayed in SVD02.
CAS*OA*192*800.00	This segment displays the CARC(s) and adjustment amount(s). In this example the CARC is OA 192 and the adjustment amount is $800.
DTP*573*RD8*20220511	DTP03 displays the OHC remittance date.

Appendix D: Acronyms

Acronym	Term
AEVS	Automated Eligibility Verification System
BIC	Benefits Identification Card
CalAIM	California Advancing and Innovating Medi-Cal
CARC	Claim Adjustment Reason Code
CCR	California Code of Regulations
CMHC	Community Mental Health Centers
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COV	Scope of Coverage
DMC	Drug Medi-Cal
DHCS	Department of Health Care Services
EOB	Explanation of Benefits
FQHC	Federally Qualified Health Center
HMO	Health Maintenance Organization
IOP	Intensive Outpatient Program
LPHA	Licensed Practitioner of the Healing Arts
MA	Medicare Advantage
Medi-Medi	Clients eligible for both Medicare and Medi-Cal
OHC	Other Health Coverage
OTP	Opioid Treatment Program
PCNX	ProviderConnect NX (Also known as “Sage”)
PPO	Preferred Provider Organization
RHC	Rural Health Clinics
SAPC	Substance Abuse Prevention and Control Bureau
SUD	Substance Use Disorder

Version History

Date	Version	Updates
3/23/2022	1.1	Page 5 – Updated link for the ADP 11-01 bulletin with the correct DHCS link Page 7 – Updated "Important" box COV codes
9/1/2023	2.1	Document updated to reflect changes with the implementation of PCNX, which include new PCNX snippets and additional guidance for billing Medi-Medi clients at OTPs.
8/6/2026	3.0	• Service list not required to bill to OHC first updated • Expanded section on Medicare as an OHC • Updated OHC Code definitions table • Updated steps to include Select **Adjudication Or Payment Date** field requirement • Removed references to MyHealthLA • Updated guidance on verifying eligibility • Modified text/language and reorganized sections for clarity and brevity throughout the manual • Appendices added

[1] California Code of Regulations (CCR), Title 22, Section 51005(a).
[2] SAPC, SAPC Substance Use Disorder Treatment Services Provider Manual 11.0, June 2026, Pages 21-24.
[3] DHCS, ADP Bulletin 11-01, January 2011, page 3.
[4] DHCS, DMC-ODS Billing Manual, July 2026, Page 65.
[5] DHCS, Other Health Coverage (OHC), December 2021, Page 2.
[6] SAPC, SAPC Substance Use Disorder Treatment Services Provider Manual 11.0, June 2026, Page 16.
[7] DHCS, Other Health Coverage (OHC), February 2023, page 1.
[8] DHCS, MHSUDS 16-064, December 2016, page 3.
[9] Noridian, Eligible Specialties, July 2025.
[10] SAPC, SAPC Substance Use Disorder Treatment Services Provider Manual 11.0, June 2026, Pages 174-178.
[11] SAPC, SAPC Substance Use Disorder Treatment Services Provider Manual 11.0, June 2026, Page 178.
[12] DHCS, Other Health Coverage (OHC), August 2020, Page 3.
[13] DHCS, Other Health Coverage (OHC), August 2020, Page 4.
[14] DHCS, ADP Bulletin 11-01, January 2011, page 2.
[15] SAPC, Companion Guide HIPAA 837P, June 2024, Page 36.
[16] SAPC, Companion Guide HIPAA 837I, March 2023, Page 38.