All Plan Letter 21-002 FAQs

1. **Can the originally released submission date of June 1, 2020 for the initial post-payment recovery report be extended?**
   Yes, the new submission deadline for the initial post-payment recovery report is extended to April 1, 2021. However, the Department of Health Care Services (DHCS) encourages Medi-Cal managed care health plans (MCPs) to submit reports prior to this date.

2. **Will each monthly report contain three years of historical data?**
   No, only the initial report will contain three years of historical data. The subsequent reports will contain 12 months of historical data.

3. **Are there additional values to report claims status besides "Paid," "Denied," and "Open?"**
   DHCS has added a fourth claim status, "Recouping." This code designates claims in established repayment agreements between the MCP and provider, where the full amount has not yet been recouped by the MCP within 12 months from the original date of payment. Disallowance claims pending a response from the provider should be identified as claim status "Recouping." The claim status should be changed to "Paid" once the full claim amount has been recouped from the provider. Should additional claim statuses become available, DHCS will notify all MCPs.

4. **Does the three-year look back period apply to all claims or just three years of post-payment recovery claims?**
   The three-year look back applies to claims where post-payment recovery was conducted. This includes claims that are "paid," "denied," "open," or "recouping." The look back period will start the month of submission and extend three years prior. For example, if the three-year look back report is due on April 1, 2021, the three-year lookback period would be from April 1, 2018, through March 31, 2021.

5. **Will the monthly post-payment recovery reports exclude claims where the money is recovered on time (within 12 months after the date of payment)?**
   No, the report will include claims where money is recovered on time (within 12 months from the date of payment of the claim).

6. **What should be populated in the check field if the check number is not available?**
   The check number can remain blank if unknown. However, in the event the payment was received via electronic fund transfer (EFT) or some sort of other financial transfer process, the EFT number or other identifier should be inputted into that field.

7. **If MCPs receive a check from the provider, would MCPs put the date they received the check?**
   Yes, the date the check was received will serve as the “claim date of remit.”

8. **Can DHCS elaborate on the “denied” indicator?**
   Denied indicates the third party payer processed the claim, but denied payment.

9. **Can DHCS elaborate on the “pending” status from page six of the webinar slides?**
   The status referred to as “pending” has been removed from Appendix B. MCPs should now defer to a status of “open.” “Open” includes any claim that the MCP has billed to Other Health Coverage (OHC) but has yet to receive payment.

10. **In the project type, it shows “other.” What “other” options are available?**
    There are no other project types at this time. To prevent error and confusion, DHCS has removed “other” as an option for the project type.

11. **If an MCP initiates a recoupment request within the required 12-month window but has yet to receive the monies at month 13, will the MCP be allowed to retain that monies, or will the MCP be required to transfer the monies to DHCS upon receipt?**
    The MCP will be allowed to retain the monies where an active repayment plan was agreed upon by the provider or carrier within 12 months.

12. **If MCPs have started a payment plan with a provider or have begun to recoup funds in month 12 or prior, do MCPs keep these recoveries, even if final payment is after month 12?**
    MCPs will be allowed to retain the monies. Once final payment is received, MCPs should change the claim status from “Recouping” to “Paid.”

13. **If MCPs receive recoveries but did not bill the OHC, what should the MCPs put for the "date claim was billed to Third Party Liability (TPL)" since the MCP did not bill the OHC?**
    If it is an unsolicited payment by the provider due to OHC, the billed date and received date would be the same. If the MCP billed the provider, the billed date is the date the MCP billed the provider, and date of payment is the date the MCP received payment from the provider.

14. **Some MCPs do not perform collections/billing direct from other health plans, but rather receive refunds from the provider. Are those included here as well?**
    Yes, include refunds from providers.

15. **Do the requirements only include retroactive OHC discovery, pay and chase, and TPL overpayments? Do the requirements also include other types of overpayments, such as the processor transposing a number of Coordination of Benefits (COB) claims causing an overpayment?**
    If the TPL overpayment is due to the existence of OHC, then yes, it is included.

16. **Does this include other overpayments not involving COB?**
    No.

17. **What happens in this scenario? A claim is processed and 364 days later, the provider submits a corrected claim. There is a reversal causing an overpayment. Does that go to the state?**
    No, it will not go to the state, because the reversal is not due to the existence of OHC.

18. **Do MCPs include unsolicited refunds? If a provider sends a payment to the MCP beginning month 13 or after, does the MCP send the refund to the state?**
    If the refund is due to the presence of OHC, payment should be returned to the state.

19. **If a provider audits their books and finds out after two years there is an overpayment and they submit it to the MCP, does the MCP need to turn that over to the state?**
    If the overpayment was due to the presence of OHC, then the payment should be returned to the state. If not, the payment should not be returned to the state as part of the post-payment recovery project.

20. **The first file submission is supposed to be a production file. Is a test file process possible?**
    Yes. MCPs will need to submit a file with test data by March 10, 2021, to their post-payment recovery folder on the Secure File Transfer Protocol (SFTP). This data should be ten line items and must be in the layout outlined in Appendix B of the All Plan Letter (APL). All MCPs will be notified of the status of their submitted test file.

21. **Per Appendix B, monthly recovery reporting requires *Explanation of Benefits (*EOB*)* information. Does an MCP retain recovery if it receives a check within 12 months from the date of payment of the service but receives the EOB after 12 months, or vice versa?**
    Yes, the recoveries would be retained by the MCP.

22. **Are fields with descriptions indicating recipient or client in Appendix B equivalent to member/beneficiary?**
    Yes, this is equivalent to member/beneficiary.

23. **If the three-year look back report is due on April 1, 2021, the report will contain paid dates from April 1, 2018, through March 31, 2021, which means there will be no recoveries for the third year in this report, as the paid dates have not passed the 12 month recovery period. Is this understanding correct?**
    No, the report should contain recovery activity that has occurred on all claims with a date of payment within the past three-year lookback period (Apr 2018 - Mar 2021).

24. **The following May 1, 2021, monthly report will contain information with payment dates from May 1, 2020, through April 30, 2021. There will only be recoveries in this report for May 2020, as that is the only month that has passed the 12-month period. Is this understanding correct?**
    No, the subsequent report should contain recovery activity that occurred from May 2020, through April 2021, for all claims within the past 12-month lookback period.

25. **Is there a dollar threshold that should be taken into account? Do MCPs need to identify all overpayments, regardless of the amount, or can MCPs exclude those under a certain dollar amount if MCPs do not pursue?**
    DHCS requires MCPs to maintain the same cost effectiveness standards as DHCS when pursuing recoveries. Please refer to California State Plan Attachment 4.22-B for more information:
    https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Attachment4.22-B.pdf.

26. **What about fraud identifications? Is the MCP able to collect regardless?**
    Fraud identification and collection is not within the scope of COB. MCPs should reference the Fraud and Abuse Reporting section of their contracts. MCPs can also visit DHCS' fraud reporting website at:
    https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

27. **Will implementation include OHC claims for services paid under Medi-Cal for non-Medicare benefits?**
    Yes, this is for any OHC claims paid by Medi-Cal.

28. **Per Appendix B, is the amount received from the TPL net recovery fee and any MCP administration fees tied to these incurred costs?**
    No, the amount reported should be the full recovered amount from the liable third party.

29. **Some MCPs are currently contracted with the same recovery contractor as DHCS to provide pay and chase recoveries, allowing the recovery contractor to bill the primary carrier on behalf of MCPs. The recovery contractor charges MCPs a percentage of the amount recovered. While this process is usually completed within 12 months of payment, there might be situations where the primary insurance reimburses MCPs beyond 12 months from the date of payment for claims billed within 12 months of the paid date. Per the APL, these recoveries will be redirected to DHCS. MCPs are seeking guidance on how the commission amount should be accounted for when the savings will no longer stay with the MCPs. Here is an example to help illustrate:**

    a) **Claim is paid by the MCP on 6/1/20 in the amount of $100.**

    b) **The recovery contractor bills the primary carrier on 4/1/2021, upon finding that the member was eligible on the date of service.**

    c) **The primary carrier reimburses $100 on 7/1/2021, (over 12 months from the original paid date).**

    d) **The recovery contractor charges the MCP $25 for the recovery.**

    Should MCPs redirect and report the total amount recovered ($100), or the net savings of $75?

    Report the full amount recovered, and remit the recovered amount, minus any contractor fee, to DHCS.

30. **Do the requirements include instances when a member is in a trauma, and the coverage is someone else's auto insurance?**
    No, this APL is outside the scope of third party tort liability. MCPs shall not make a claim for recovery on tort liability cases.

31. **If an MCP recoups claims and later finds the member's OHC coverage is terminated on a retroactive basis so that the OHC was not effective, does the MCP return the recovered amount to the MCP that was the primary carrier?**
    Yes, the MCP should return the funds to the carrier.

32. **The Automated Eligibility Verification System (AEVS) file includes various potential other coverage information for Medi-Cal members such as pharmacy, dental, and vision primary coverage information. What type of claims are MCPs supposed to recover on when the member is showing an OHC indicator "A" on the 834 file? Does OHC indicator "A" allow MCPs to recover on all types of claims for a member?**

An OHC indicator of “A” is for “pay and chase.” This gives providers the option of billing the OHC or Medi-Cal. MCPs should recover for these services directly from the carrier if the service provided is covered by the OHC.

33. Does the APL reflect the new effective recovery reporting date of April 1, 2021?
Yes.

34. Do the requirements listed in the APL change anything for OHC reporting requirements?
No, it does not change OHC reporting requirements. It provides an option for MCPs to report OHC information that is unknown to DHCS in batch updates.

35. In the APL under policy, clarify if the notification can be sent via letter or Remittance Advice (RA).

- Beginning January 1, 2022, MCPs must include OHC information in their notification to the provider when a claim is denied due to the presence of OHC. OHC information includes, but is not limited to, the name of the OHC provider, the policy number, and contact or billing information. OHC information known to DHCS is provided to all MCPs on a monthly basis. Prior to January 1, 2022, MCPs may direct providers to access the necessary member OHC information utilizing the Automated Eligibility Verification System at (800) 427-1295, or the Medi-Cal Online Eligibility Portal.[1] Information pertaining to OHC carriers can be found in the Health and Human Services Open Data Portal.[2]

MCPs should incorporate OHC information on the RA. In instances where it cannot be incorporated on the RA, this information can accompany the denial on a standalone notice.

36. In the APL, under policy section, it states that MCPs should rely on the OHC information in the 834 file for cost avoidance and post-payment recovery purposes. An MCP currently has over 12,000 OHC indicators in the 834 file within the past 12 month period. When submitting the report to DHCS by April 1st would MCPs submit this OHC data for the applicable months?

POLICY:

1. Using the Medi-Cal Eligibility Record for Processing OHC Claims

    - MCPs should rely on the Medi-Cal Eligibility Record for cost avoidance and post-payment recovery purposes.

MCPs should submit the most recent verified OHC data if it is different from what is currently on the Medi-Cal Eligibility Record.

37. In the APL, it states MCPs must report the OHC to DHCS in ten calendar days if the OHC is not found or is different from what the Medi-Cal Eligibility Data System (MEDS) shows. Please confirm the start date for the ten calendar days in the following scenarios:

OHC Reporting Requirements and Delivery Options

- MCPs must report new OHC information not found on the Medi-Cal Eligibility Record or OHC information that is different from what is found on the Medi-Cal Eligibility Record to DHCS within 10 calendar days of discovery. This requirement ensures timely receipt of all new or updated OHC information so that the Third Party Liability and Recovery Division (TPLRD) can verify the information and update the member's Medi-Cal Eligibility Record, if valid. MCPs must report this OHC information to DHCS by either:

Case/Situation	Date 1	Date 2	Which date would be the start date to count 10 calendar days?
Returned Letter of Inquiry (LOI) by member reporting “no” OHC. MCP determines the member does have OHC later.	Stamp date* on the returned LOI letter envelope e.g. 05/13/2020	MCP discovers member has OHC. e.g. 05/15/2020	05/15/2020
Returned LOI by member with “yes” OHC but did not have all the required information. MCP has to reach out to the carrier to gather all the required OHC info.	Stamp date on the returned LOI letter envelope e.g. 05/13/2020	MCP gathers all the OHC detail. e.g. 05/15/2020	05/13/2020

Returned LOI by member with "yes" OHC, and the OHC is with Kaiser. MCP determines Kaiser coverage termed prior to member's enrollment date with MCP. Medi-Cal website shows different OHC than Kaiser.	Stamp date on the returned LOI letter envelope e.g. 05/13/2020	MCP gathers the other OHC detail. e.g. 05/15/2020	05/13/2020; if the Kaiser coverage is terminated and is reflected on the Medi-Cal website, there is no need to report OHC that already exists on the system.

*Stamp date is assumed to be the date the MCP received the letter.

38. **In the APL, it mentions "MCPs must not process claims for a member whose Medi-Cal Eligibility Record indicates OHC, other than a code of A or N, unless the provider presents proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly." Will MCPs need to deny all claims based on the OHC attribute?**

    - MCPs must not process claims for a member whose Medi-Cal Eligibility Record indicates OHC, other than a code of A or N, unless the provider presents proof that all sources of payment have been exhausted, or the provided service meets the requirement for billing Medi-Cal directly. For more information regarding direct bill services, please refer to the list of direct bill Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes.

    Yes, MCPs should reject all claims based on OHC unless the claim meets the criteria for direct Medi-Cal billing, comes with evidence the OHC is either exhausted, or if the OHC does not cover a service. A list of service codes which may be billed directly to Medi-Cal, regardless of OHC, may be found in the Provider Manual at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/Part2/othhlthcpt.pdf.

39. **Where can MCPs find the webinar presentation slides?**
    The webinar presentation slides will be provided by TPLRD to MCPs via email.

40. **Is the rule that MCPs must disclose newly identified OHC to DHCS within ten days new? Or has this rule always been in place, and this APL just reinforces a previous rule?**
    The rule is not new. Please refer to contract Exhibit E, Attachment 2. PROGRAM TERMS AND CONDITIONS, Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS), Reporting Requirements. The APL further highlights and explains the rule, which is also found in all MCP contracts.

41. **Is the requirement for MCPs to report OHC to DHCS within ten calendar days also extended to April 2021?**
    No, this is not a new requirement. MCPs should continue to report OHC via the online forms.

42. **Are OHC batch updates and OHC reporting also due in April 2021?**Reporting OHC in weekly batch updates is not required. It is offered to MCPs as an alternative to single submissions through the online form. MCPs may request access for OHC batch updates at any time.

43. **Which fields are required in the HI-36 form required by DHCS?**
    Please reference the “Instructions” tab on the HI-36 template spreadsheet for specifics.

44. **Where can MCPs review the OHC codes to make sure they have a full understanding of the definition for each and the expectation for processing the claims?**
    A list of OHC codes and their descriptions can be found in the OHC Provider Manual: https://medi-cal.ca.gov/file/manual?fn=otherguide.pdf

45. **MCPs are seeing many of the OHC codes move to A (Pay & Chase) over time for members within the 834 file. MCPs would like to understand why this is the case.**
    When coverage is added or updated that affects the OHC code categorization for historical months, the OHC is updated to reflect the insurance in the system. System limitations only allow historical OHC codes (dating back 12 months) to update to OHC codes “A” or “N” (pay and chase, or no coverage). This is to prevent interference with provider billing for previously approved dates of service.

46. **Information from AEVS and Health Insurance System Database (HISDB) are inconsistent. For example, AEVS reflects OHC, but HISDB reflects the termed service date entered in AEVS. Which one is more accurate?**

The HISDB is the official record. A change made on the HISDB takes 24 hours to update, and may take an additional 24 hours to update on other systems, such as AEVS.

47. **Another example of inconsistent information from AEVS and HISDB: AEVS reflects OHC under Blue Shield under ID 1234567890000. Per Blue Shield's website, the member's ID is XEH123456789.**
When looking at the Policy Numbers provided **123456789**0000 and XEH**123456789**, MCPs can identify that the bold portion is the same, which is the policy number. Anthem Blue Cross submitted the policy number that is reflected in HISDB, the "0000" are fillers within our data exchange layout. The "XEH" is an identifier that Anthem Blue Cross adds within their own system. Claims will be properly routed with either policy number format.

48. **What is DHCS' expectation of MCPs' submission of policy removal requests for policies that were never active?**
In DHCS' online removal request, there is an opportunity for submitters to select that the OHC never belonged to the member. On the OHC batch reporting spreadsheet, submit the policy start and stop dates as one day apart (e.g. coverage starts 1/1/2020, coverage ends 1/2/2020).

49. **How can MCPs identify OHC information in files like the 834 file? MCPs would like assistance in identifying policy information such as the other primary carrier, policy number, and contact information for the other carrier to set members up in their system with other primary coverage. How can MCPs determine when and if the member's other coverage terms? What indicators are in the data that would help MCPs update their member to move them back to primary status?**
The 834 file only has an indicator of whether or not a member has OHC. OHC information is available in the HISDB. MCPs will need access to AEVS, or the HISDB extract to view the OHC details. To gain access to the HISDB, MCPs should contact their *Managed Care Operations Division (MCOD)* contract manager.

50. **Please confirm that the Veterans Affairs (VA) and Tricare are OHC and have the OHC code of "C."**
Yes, that is correct.

51. **Do MCPs still request disenrollment to DHCS when they find that enrollees have an OHC code?**
DHCS does not receive requests from MCPs to disenroll members when they find that beneficiaries have an OHC code. Members may still have an MCP if they have OHC; however, Medi-Cal is the payer of last resort. Federal and state laws require

Medi-Cal members to report OHC to ensure Medi-Cal is the payer of last resort. When Medi-Cal learns that a member has OHC, the Medi-Cal record is then updated to reflect the OHC. Medi-Cal members can submit a request to modify their OHC at the following DHCS website: http://dhcs.ca.gov/OHC.

52. **When will MCPs be able to validate if they have access to the SFTP site?**
Usernames and passwords were sent the week of June 1, 2020. If MCPs have not received their credentials, they should contact their MCOD contract manager.

53. **Is there a specific folder or file path for the SFTP submission?**
The specific folder and file path will be the MCP's designated folder on DHCS' SFTP. MCPs can identify their MCP's specific folder in the reporting procedures provided by DHCS.

54. **Do MCPs need to send any notification to DHCS after the monthly file is uploaded, or will they get a confirmation from DHCS?**
MCPs do not need to send a notification to DHCS, and will only receive a notification if there is an error or the file is not received.

55. **Is the SFTP being referenced the Department's E-Transfer site?**
Yes.

56. **Can DHCS confirm that all parties have the appropriate data use and Business Associate Agreements (BAAs) in place?**
DHCS has confirmed the appropriate data use agreements and BAAs are in place.

57. **Is Medicare considered OHC? Do the new rules apply to our Medicare refunds and overpayments?**
Yes, Medicare is considered OHC. The new rules apply to Medicare.

58. **Is California Children's Services defined as an OHC, and would these claims be a part of the requirements?**
No.

59. **If MCPs that become aware of OHC can also use that information, does that mean that they can process the claim with the EOB attached regardless of the OHC indicator on the 834 reflecting that the member does not have OHC?**
If the 834 has an OHC indicator of "N" and the discovered OHC is already in the HISDB, do not use the OHC. If the OHC indicator is "N" and the discovered OHC is not in the HISDB, please report the unknown OHC to DHCS. MCPs may process the claim using the newly discovered OHC.

60. **Should members with month-to-month policies be included in the batch update process?**
    Yes, please submit as discovered.

61. **There are major barriers to obtaining OHC information to report to DHCS. Examples include no streamlined channel for obtaining OHC information, conflicting information from provider and member, and challenging coverage verifications. What is the state's understanding in working through these barriers?**
    When MCPs are made aware of previously unknown OHC, they should attempt to verify the information prior to providing it to the state. Tools that can be used to verify OHC information include, but are not limited to, calling insurance carriers, using automated systems, or using online provider portals with the available partial OHC information to complete the OHC record.

62. **What tools will DHCS make available for efficient and timely OHC discovery?**
    MCPs are required to provide DHCS with previously unknown OHC information that has been provided to the MCP by other sources. The unknown OHC reported by MCPs, providers, and members supplement existing information. Some tools DHCS uses include, but are not limited to, calling insurance carriers, using automated systems, or using online provider portals. DHCS relies on verified data to ensure successful COB for Medi-Cal members.

63. **What should MCPs do if they do not have all the required information for the OHC when discovered?**
    MCPs should obtain all of the required information prior to submitting the OHC to DHCS. Tools that can be used to obtain complete OHC information include, but are not limited to, calling insurance carriers, using automated systems, or using online provider portals with the available partial OHC information to complete the OHC record. Partial OHC records should not be submitted to DHCS.

64. **Once a member has been identified as having OHC, and it is reported to DHCS, is the OHC confirmed at a later point? If so, how often?**
    DHCS receives OHC information on a monthly basis from most major insurance carriers.

65. **Does DHCS verify OHC that it submits to the Health Insurance System?**
    The majority of DHCS OHC information is received directly from health plans. For all other OHC information submitted to DHCS, DHCS uses its available resources to verify the OHC. However, DHCS relies on submitters providing sufficient and valid policy information.

66. **Health Management Systems, Inc. (HMS) regularly reconfirms OHC for MCPs in contract with HMS. Verification includes new coverage, continued coverage, and terminated coverage updates for each member. Does this information need to be provided to DHCS?**
Yes. If the information is unknown to DHCS, it should be provided to DHCS.

67. **How quickly will the state update the eligibility files with the newly identified OHC information from MCPs?**
Eligibility files will be updated on MEDS within 24 hours from the time they are processed. It may take up to another 24 hours for other systems to update.

68. **What are current expectations for MCPs to submit OHC upon discovery?**
OHC information should be submitted to DHCS within ten calendar days of discovery.

69. **How can MCPs get more information on the OHC batch update process?**
MCPs will receive SFTP instructions from DHCS. If additional information is needed after reviewing these instructions, MCPs should contact their MCOD contract manager.

70. **Are OHC reporting requirements separate from the monthly TPL reporting submitted to DHCS?**
Yes, OHC reporting is separate.

71. **Can MCPs use OHC information from sources other than DHCS?**
Yes; however, if the OHC indicator is "N" and the discovered OHC is not in the HISDB, please report the unknown OHC to DHCS. MCPs may process the claim using the newly discovered OHC.

72. **Is OHC information (primary carrier, primary policy number, and address) available in the 834 file?**
The 834 file only contains the OHC indicator. Known OHC information is available on AEVS or the HISDB files.

73. **If not all information is known for OHC, do MCPs send whatever OHC they know with the RA?**
MCPs must provide the name and contact information of the OHC. Contact information for OHC known to DHCS is in the Carrier Code Master file, which is available at CHHS' Open Data Portal: https://data.chhs.ca.gov/dataset/aevs-carrier-codes-for-other-health-coverage.

74. **Does HMS validate OHC for the state before the MCPs see it in their 834 file?**
No, HMS does not validate OHC for the state.

75. **Will DHCS add HMS' cost avoidance product in the near future?**
DHCS does not intend to contract with HMS for cost avoidance at this time.

76. **During the webinar, DHCS mentioned that when the MCP submits the OHC update to DHCS, it will take 24 hours for DHCS to update the information and it will take another 24 hours for DHCS to send the information back to the MCP. What information is sent back to MCPs and in what format and through what mechanism, e.g., SFTP folder, how frequently? In a batch? What data elements will be included?**
DHCS does not return any files to MCPs as a direct response to the OHC batch processing; however, MCPs can request access to the HISDB file which contains member OHC information from their MCOD contract manager. Batch files submitted by MCPs remain in the subfolder until the Thursday after they are processed in case they need to be referenced and will be deleted thereafter.

77. **Can MCPs deliver OHC information to providers through their secured provider portal and refer providers to the portal to look up OHC information?**
MCPs should incorporate OHC information on the RA. In instances where it can not be incorporated on the RA, this information can accompany the denial on a standalone notice. Medi-Cal providers may access OHC information from DHCS' eligibility system.

78. **The current process is for a dedicated resource/account to log into the DHCS portal and upload a file to a specific folder. Is there any way to get DHCS the monthly recovery report without human intervention?**
It may be possible for MCPs to create scripts to place this information automatically on the SFTP.

79. **"Paid Date" is not included in the post-pay recovery report. Is this an oversight by DHCS? Do MCP's need to provide "Paid Date?"**
MCPs do not need to provide paid date on the post-payment recovery report as it is on the paid claims file.

80. Does DHCS agree with the example report date ranges defined below for each report?

Report Number	Report Month	Report Start Date (PAID DATE)	Report End Date (PAID DATE)
Report#1 (Initial Report)	April - 2021	April 1, 2018	March 31, 2021
Report#2 (Monthly Report)	May - 2021	May 1, 2020	April 30, 2021
Report#3 (Monthly Report)	June – 2021	June 1, 2020	May 30, 2021
Report#4 (Monthly Report)	July - 2021	July 1, 2020	June 31, 2021

Yes.

81. Can the same recovery be reported to DHCS across multiple monthly reports as long as the claim is within the defined paid dates?
Yes.

82. Will a recovery automatically drop off from a report when the claim paid date does not fall within the defined paid date for that report?
Yes.

83. For the monthly report, should MCPs include claims that were previously reported to DHCS if the claim status has changed? For example, a previously open recovery that is now in paid or recouping status? Or a previously recouping recovery that is now in paid status?
Yes. MCPs should include claims that were previously reported to DHCS if the claims status has changed.

84. Can monthly reports contain newly billed recoveries that fall outside the current report period? For example, the MCP initiated a new recovery in April 2021 for a claim with paid date that is January 1, 2020.
The MCP should not attempt recovery for this claim as it is not within 12 months from date of payment.

85. Do monthly reports only include recoveries for claims paid after April 1, 2018?
Yes.

86. **Will DHCS pursue recovery on claims with "open" claim status that have dropped off the monthly reports?**
Yes.

87. **If claims with "open" claim status drop off from the monthly report, does that mean the MCP should stop pursuing those recoveries actively?**
Yes.

88. **Can MCP retain monies if "Bill Date" is within 12 months from the "Claim Paid Date" irrespective of when the actual refund was received?**
An MCP may only retain the monies if the recovery had an active repayment agreement from the provider or carrier in place within the past 12 months.

89. **MCPs must remit the recovered amount to DHCS if "Bill Date" is after 12 months from the "Claim Paid Date" and a refund was received for this recovery?**
Yes.

90. **The "Remit Amount" will show the full amount recovered, but the actual amount remitted to DHCS will be less. Would it be helpful to include another field like "Net Remit Amount?"**
DHCS does not plan to add "net remit amount."

91. **Is the monthly report requesting for MCPs to report claims where the MCP is paid as the primary but later confirmed that the MCP should have been the secondary payer?**
DHCS is asking MCPs to report claims where the MCP paid as the primary and has successfully performed a recovery of the payment or has entered into an active repayment plan to recover the payment.

92. **If the member has comprehensive OHC, should MCPs treat them like Medicare primary?**
If the service rendered falls within the member's Scope of Coverage under OHC, the provider must bill the OHC before billing Medi-Cal.

93. **Based on the OHC Provider Manual 2, when a recipient has both Medicare fee-for-service (FFS) and OHC, the provider must bill payers in the following order: 1) Medicare for Medicare-covered services, 2) OHC carrier, 3) Medi-Cal. *The Centers for Medicare and Medicaid Services (CMS)* often requires third party coverage to pay before Medicare is billed, then only Medi-Cal if applicable. Can DHCS please clarify this contradiction?**

Medi-Cal shall remain the payer of last resort. When a recipient has both Medicare FFS and OHC, the provider must bill the appropriate third part(ies) prior to billing Medi-Cal. DHCS will update the provider manual to clarify this.

94. **Data elements on Appendix B do not include the paid date of the claim by the MCP. How will DHCS know what claims to recover if this data element is not provided on the monthly report?**
This information is found in the paid claims and encounter files.

95. **Does DHCS expect MCPs to bill the primary carriers as opposed to recouping the overpayments from the providers that the MCP has paid?**
MCPs may bill the primary carrier, or recoup the overpayment from the provider.

96. **Appendix B requests for "CCO Bill Amount, amount billed to TPL." How does DHCS define Coordinated Care Organization (CCO) in Appendix B, and is CCO the provider rendering the services or the MCP?**
CCO is the same as an MCP. DHCS updated the terminology in Appendix B of the APL to reflect MCP.

97. **Appendix B Requests for "CCO Paid Amount, amount MCP paid to the provider." With this data request, is the CCO the provider that the MCP paid for rendered services or does this represent what the MCP paid to the provider for rendered services that DHCS expects the MCP to bill the TPL/OHC for reimbursement?**
CCO is the same as an MCP. DHCS updated the terminology in Appendix B of the APL to reflect MCP. This represents what the MCP paid to the provider for rendered services.

98. **If a member termed with an MCP, would they remain on the MCP's OHC file provided by DHCS?**
Members will remain on the OHC file provided by DHCS until the MCP no longer requests that information via Fiscal Intermediary Access to MEDS Eligibility (FAME). The monthly OHC file records are only for beneficiaries matched from a given request file received from the MCP. It contains complete HIS data for that specific set of beneficiaries.

99. **In connection with FAQ #98, are MCPs still expected to provide OHC details in the claim denial notice in this situation?**
If the claim is for a service date in which the member was eligible for the MCP, then yes, MCPs are expected to provide OHC details in the claim denial notice. However, if the claim is for a period in which the member was ineligible, then the additional OHC details to accompany the denial are not necessary.

100. Can DHCS confirm whether the field "Medicaid Number" refers to the Client Index Number (CIN) or the MCP-assigned Member ID number?
CIN.

101. The Medicaid Number, Tax ID Number (TIN), and Transaction Control Number (TCN) fields are formatted to be "text," not numeric. Can DHCS confirm whether the file will accept traditional numeric characters for these fields?
The listed fields will accept traditional numeric characters.

102. The first file is asking for a three-year look back. Is the MCP expected to remit dollars for any recovery that meets the remit criteria during that span?
MCPs are not expected to retroactively review recoveries received past the 12 month mark and remit those dollars. MCPs are expected to remit dollars beginning the first month of implementation and forward. For example, if the MCP received a recovery in March 2020 for a claim with a date of payment of July 2017, it is able to retain those dollars. If an MCP has a recovery in April 2021 for a claim with a date of payment of July 2019, it is expected to remit that payment to DHCS.

103. Can DHCS clarify how TPL is defined within the Field Description in Appendix B? Is DHCS defining TPL as cases as a result of subrogation or as other insurance coverage?
For post-payment recoveries, DHCS defines TPL as other insurance coverage.

104. Can MCPs submit more than one monthly post-payment recovery report file?
Yes, receiving more than one monthly Post-Payment Recovery file from an MCP is acceptable, if the MCP is unable to combine the reports.

105. Can DHCS advise on how to proceed or clarify the difference in the scenarios from FAQ #11 and #29?
FAQ #11, MCPs must have initiated the recoupment request within 12-months to be eligible to retain the money.
FAQ #29 applies to MCPs that are contracted with a recovery contractor. It mentions that the recovery process is usually completed within 12 months, but recoveries that occur beyond 12 months must be redirected to DHCS.

106. Can 'Provider Name' be blank if the MCP provides the "Provider TIN" on the report?
MCPs should attempt to supply both fields for accuracy and validation purposes. If the Provider Name is unknown, it may be left blank.

107. Can DHCS please confirm if reports will be accepted if submitted by the 15th each month?

MCPs should make every attempt to submit their report as close to the 1st day of each month as possible; however, the report will be accepted if submitted by the 15th day of each month.

108. **Is it possible to request historical data from the past 12 months in HISDB?**
The HISDB extracts are snapshots in time. Including prior months of data that have now been superseded may not be valuable. If MCPs seek historical data, they should contact their MCOD data coordinator as there are certain data releases and associated timeframes that must be completed.

109. **FAQ #57 confirms that Medicare is OHC. However, this conflicts with an excerpt from the DHCS website about OHC (http://dhcs.ca.gov/OHC), which indicates Medicare is not OHC. Can DHCS clarify which is correct?**
Medicare coverage is considered a liable third party in regards to coordination of benefits and claims payments. It is referenced as so on the webpage in question because Medicare Part A and B is not loaded as OHC in our HISDB, and we do not have the ability to terminate the Part A or B coverages. The listing on the webpage in question is intended to mitigate the number of erroneous submissions asking for disenrollment in Medicare, when the members should be making the request through the Social Security Administration.

    For the purposes of OHC batch reporting, Medicare plans do not have to be reported via the HI-36 as discovered OHC. However, MCPs should consider Medicare as a liable third party and conduct post-payment recovery activities where appropriate.

110. **On the HI-36, there is no column to include the Medicare Part A/B/D effective dates and termination dates. How should this information be transmitted on HI-36, if at all?**
Most Medicare plans are being sent by CMS and do not need to be resubmitted by the MCP. In the instance that there is a Part C or D plan that did not successfully match on our side, those can be submitted on the HI-36. Start dates and termination dates can be entered in columns Q and R like any other plan-effective dates for Part C and D plans only. Medicare Part A and B eligibility is not updated by the DHCS and is sent to us via data exchanges with CMS.

111. **What is the schedule and frequency of the HISDB files drops to eTransfer?**
Daily and monthly files are sent out to eTransfer. The monthly file is sent out at the end of the month, following MEDS Renewal.

112. **How does "MEDS_ID" in HISDB link to correlating field(s) in the 834? What is the key to match to CIN?**

The MEDS ID is in position 3-11 in the 834 file, and the CIN is in positions 27-35. MEDS-ID is a member's social security number (SSN), or if the member does not have a SSN, it will be their pseudo-SSN. Like a CIN, a pseudo-SSN will start with a 9, but the ending letter will be a P or Q.

113. **Is there additional clarity around "TRANSACTION TYPE" in HISDB and how they are used to enter/impact records? How do MCPs identify the most relevant record segment?**
Transaction type refers to what action was most recently completed for the segment, with "C" for "change" being the most common for an updated record. Segment policy start and stop dates should be the primary focus for identifying current OHC.

114. **Daily OHC additions/removals submissions are not appearing on HISDB. Are there negative impacts if MCPs proceed with only providing the monthly HI-36 file to DHCS?**
Some of the daily changes are likely not showing up on the monthly file HISDB due to manual removals during daily processing, or the timing of data exchanges. If a segment has a term date the day after the start date, those segments are automatically removed from the HISDB once a month. MCPs should be fine proceeding with the monthly HI-36 file primarily. The daily files may include additional records for cost avoidance on a more current basis; however, the monthly reconciliation is meant to refresh eligibility.

115. **There are differences in the records from the daily files and the monthly file. Are there any major impacts if MCPs proceed with only loading the monthly HISDB file?**
Some of the daily changes are likely not showing up in the monthly HISDB extract file due to manual updates occurring during daily processing, or the timing of data exchanges. If a segment has a term date the day after the start date, those segments are automatically removed from the HISDB during MEDS renewal. The daily files provide a more frequent update of any changes made from the previous day; however, the monthly file is sent after the monthly reconciliation and refreshes overall eligibility. The monthly HISDB file is sufficient for capturing most OHC; however, it may not include any OHC removals that occur throughout the month.

116. ***For* MCPs with no active repayment plan*, what is the required timeframe for the MCP* to remit warrants, payable to DHCS, for recovered monies that are 13 months or older from the date of payment of a service?**
MCPs *must remit warrants to DHCS within* 30 days from the start of the 13th month after the date of payment of a service.

117. Do MCPs need to supply any information along with warrant remittance to DHCS?

Yes, MCPs must include an invoice cover letter titled "MCP TPL Recovery Remittance" to accompany warrants. MCPs must also include the date of the check, check number, check amount, MCP contract ID/name, MCP contact name, MCP contact number.

118. When are revised policies and procedures due?

Revised policies and procedures will be due within 90 days of the release of the revised APL 21-002.

119. Are remittances only owed to DHCS for post-payment recoveries received on or after April 1, 2021?

Yes, MCPs must remit warrants to DHCS for all recovered monies received on or after April 1, 2021 that are 13 months or older from the date of payment of a service, unless the payment is for an active repayment plan.

120. Can MCPs process a claim with the EOB attached regardless of the OHC indicator on the 834 reflecting that the member does not have OHC?

MCPs may utilize newly identified OHC after reporting it to DHCS. MCPs do not need to wait for the OHC indicator to be updated on the 834 file.

121. How will DHCS update future 834 and HISDB based on discovery and submission of new OHC? What OHC code will be assigned to these OHC?

In most cases, member records are updated within 72 hours of submission. The following month's 834 file or following daily/monthly HISDB file will contain the updated OHC information.

The OHC code will be assigned in alignment with the OHC on file. If there is a historical policy start date, the OHC code will be updated to "A" for the months starting at the policy start date through the previous month. The current month and following month will reflect the correct OHC code that aligns with the member's OHC.

OHC Codes can be found within the provider manual here: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part1/otherguide.pdf.

122. Can MCPs use OHC information from sources other than DHCS?

Yes. MCPs may utilize OHC information from other sources. However, any OHC that differs from DHCS' Eligibility Record, must be reported to the department prior to utilizing.

123. Please confirm implementation dates for: a) Using HISDB Data file b) Recovery reporting based on HISDB data c) Pay state for fund collected after 12 months d) Sending out OHC Info to Providers who's claims are denied for OHC as primary.

a) MCPs are not required to utilize the HISDB file; AEVS may be utilized. DHCS provides the daily and monthly HISDB file for assistance only. To obtain the HISDB file, please contact your MCOD contract manager.
b) April 1, 2021
c) April 1, 2021
d) January 1, 2022

124. What does the Medicare Retro Billing data in the HISDB file represent?
Medicare retro billing data represents the availability of Medicare as a potential source of recoupment for the set time period.
• M990 – Medicare Part A
• M991 – Medicare Part B

125. For those with indicator Outpatient, Inpatient, Medical, and Pharmacy on Medicare Retro Billing, why are there discrepancies with coverage dates compared to 834 data?
Discrepancies between the HISDB file and the 834 file generally come down to a matter of timing. The HISDB file may currently reflect something that is different than the last received 834 file as the 834 file is a snapshot of the HISDB at a specific time, and will not reflect changes until the next 834 file is received.

126. Can the MCP obtain a supplemental TPL file or a separate 834 file that includes all OHC information?
Yes, please contact your MCOD contract manager and request the HISDB daily and monthly files.

127. System limitations only allow historical OHC codes (dating back 12 months) to update to OHC codes "A" or "N" (pay and chase, or no coverage). Where is code "N" in the Provider Manual?
DHCS is working to update the provider manuals to include OHC Code "N" for No OHC.