

9999 Tip Sheet

This document provides an overview of '9999' and the steps on how to identify, review, and resolve the issues related to charges dropping to the '9999' pay source.

I. Why do charges fall to 9999?

Charges drop to the “9999” pay source for a variety of reasons but the main one is due to absence of a coverage plan in the system or expiration of existing coverage plan(s). The term “9999” or Default Plan or Default Payer or Client/Self-Pay is the “catch all” pay source and is the industry standard.”.

II. Purpose:

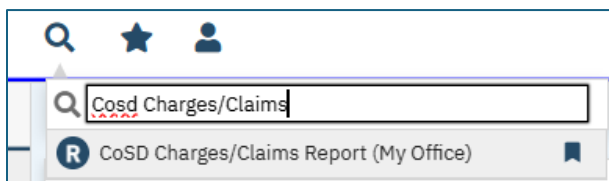
9999 acts as a placeholder for services to be reviewed for correct, alternative, or potential retroactive funding sources. In SmartCare, this is used for identifying service-specific activities and managing financial data for services. 9999 is a default plan/default pay source and is not part of the client’s coverage.

III. What report contains the 9999?

The 9999 plan or information is included in the CoSD Charges/Claims report.

IV. How to run the CoSD Charges/Claims

- a) Search for “CoSD Charges/Claims Report” in SmartCare.

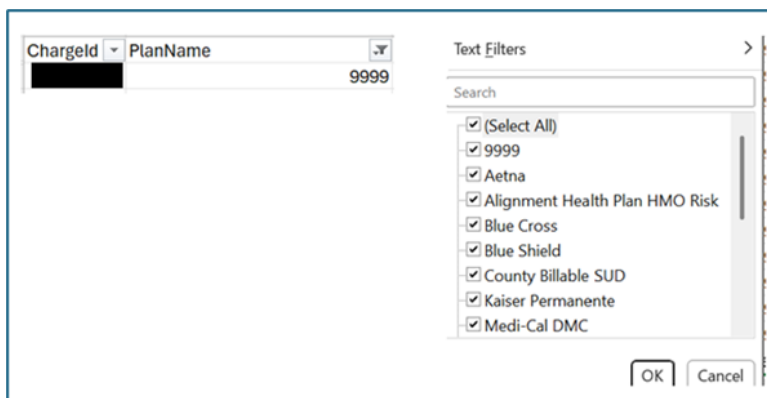


DOS From	<input type="text"/>	DOS To	<input type="text"/>	View Report
Program(s)	<input type="text"/>	Procedure Code(s)	<input type="text"/>	
Coverage Plan(s)	<input type="text"/>	Service Area Id	MH, DMC	
Client Id	<input type="text"/>	<input checked="" type="checkbox"/> NULL		

- b) **DOS ‘From and To’ fields:** enter the date range of Date of Service you want to view.
- c) **Program(s):** select your program.

- d) **Procedure Code(s):** “Select All” or the specific procedure code you need to view.
- e) **Coverage Plan(s):** “Select All” and filter the exported report per 9999 Plan Name select “9999” only.

Note: The report can be exported in CSV or Excel and the Plan Name “9999” can be filtered by the user.



- f) **Service Area Id:** select your assigned Service Area (MH or SUD).
- g) **Client ID:** Uncheck the “Null” box and enter the Client ID if you only need to review for a specific client. Leave the Null check mark if you are running a report for multiple clients.

V. Tracking frequency for 9999

It is recommended that programs run and review their 9999 on a bi-weekly basis (or as needed) to allow timely correction or billing of Medi-Cal billable services sitting under the ‘9999’ status. Focus should be on the oldest dates of service on the report in order for billing unit to meet the timely filing deadline with DHCS (12 months from DOS).

VI. How do we identify the 9999 scenarios or reasons and what are the actions required to resolve them?

The table below contains various scenarios and required steps to identify or resolve the issue.

Notes:

- a) BHS Programs should also run the CoSD Client Insurance and Time Span report to help with the 9999 analysis and determine if the client’s plan is up to date.
- b) Certain scenarios may apply specifically to Mental Health or Substance Use Disorder programs. Please look for this identifier.
- c) If the tip sheet does not provide an answer to your scenario or the scenario may be exempt from these rules, please reach out to your County COR directly.

9999 Reasons	Action Items	Additional Actions Items
<p>1. The client was not eligible at Medi-Cal at the time of service.</p>	<p>Program should manually verify the client’s Medi-Cal using the unique access to the DHCS Provider Portal.</p>	<ul style="list-style-type: none"> • If client is Medi-Cal eligible and the CoSD Client Insurance Time Span report does not contain the Medi-Cal information at the time of service, the program should complete the Client Insurance Plan Request form and submit it to the BHS Billing Unit. <p>MH: mhbillingunit.hhsa@sdcounty.ca.gov</p> <p>SUD: adsbillingunit.hhsa@sdcounty.ca.gov</p> <ul style="list-style-type: none"> • If client is ‘Medi-Cal eligible and the CoSD Client Insurance Time Span report contains the correct Medi-Cal information and payer order, program should contact the BHS Billing Unit to further review and troubleshoot the issue.
<p>2. Medi-Cal coverage has lapsed, with restrictions, or the client lost coverage.</p>	<p>Program should verify the client’s Medi-Cal and identify the lapse.</p>	<ul style="list-style-type: none"> • If the client falls out of Medi-Cal or has a gap in coverage, the program should assist the client in applying for Medi-Cal coverage. Please suggest applying for retroactive Medi-Cal coverage so that the gap can be covered and billed to Medi-Cal. • Submit the completed Client Insurance Plan Request form to the BHS Billing Unit as soon as the Medi-Cal coverage is reinstated.

9999 Reasons	Action Items	Additional Actions Items
<p>3. Out-of-County (OOC) Medi-Cal eligibility.</p> <ul style="list-style-type: none"> The MMEF is processed monthly by CoSD to automatically add new and update existing client eligibility and time plans for Medi-Cal. However, SmartCare does not verify whether the client's CIN# belongs to San Diego or other counties or whether the client's residence is "in county" or not. In this case, the charges will drop to 9999 if the Medi-Cal plan or no plan is added to the client's coverage. 	<p>SUD: The OOC rules remain that if the program confirms that the client has the intent to reside or transfer to Medi-Cal San Diego, the County will cover the cost of medically necessary and clinically appropriate services from the initial date of service, and a maximum of 60 days from the first of the month following the initial month of service across BHS system of care. During this period, Programs are to assist Out-of-County Medi-Cal clients with changing their Medi-Cal enrollment.</p> <p>MH: There are some scenarios with Presumptive Transfer requirements, and providers are recommended to contact the COR or BHS Fiscal team.</p>	<p>SmartCare is designed to automatically cascade the charge to Medi-Cal from 9999 when the Medi-Cal Plan is added to the client's coverage in SmartCare.</p> <p>SUD: If the CoSD Client Insurance and Time Span report does not show any Medi-Cal eligibility because the client is OOC, program should submit the Client Insurance Request form to the ADS Billing Unit so we can manually add the Medi-Cal DMC plan. During the transfer to San Diego, the SUD Billing Unit will make an effort to bill Medi-Cal. If a denial is received, we will replace and rebill the denied claim "if" the eligibility's effective date covers the denied claims.</p>
<p>4. Incorrect client information</p> <ul style="list-style-type: none"> If Medi-Cal eligibility cannot be determined due to missing or wrong information, the charges will drop to 9999. 	<p>Program should verify client's information, if Medi-Cal eligibility is not recorded. Error or conflicting information on the client's DOB, SSN, Name, gender or DOD may have caused the issue. The program or the appropriate Billing team (MH or SUD) should submit a correction request through Health Management Information (HIM) using the BHS-025 Form.</p>	<p>The BH-025 Form and instructions are available on the Optum BHS Resources website.</p>
<p>5. Client is incarcerated</p> <ul style="list-style-type: none"> If a client is incarcerated or has partial incarceration within the month of service, the charge will be staged to the holding area '9999'. 	<p>The program should verify Medi-Cal eligibility.</p>	<p>The charges will remain in 9999.</p> <p>Programs should contact the corresponding COR or BHS Fiscal if you have further questions.</p>
<p>6. Medi-Cal eligibility has a special aid code only and no primary aid code, and the client has no other insurance coverage</p>	<ul style="list-style-type: none"> The program must manually verify Medi-Cal eligibility using the DHCS Medi-Cal Provider Portal. If the primary aid code is blank and only has a special aid code, there are no other plans available, please complete and submit the Client Insurance Plan Request form, making note of the special aid code only. 	<ul style="list-style-type: none"> Upon receipt of the completed client insurance plan form, the BHS BU will add the Medi-Cal plan to the client's coverage. The BHS Billing Unit will mark the custom field 'special aid code' on the coverage screen, and we will handle the regeneration of charges from 9999 to Medi-Cal. Please contact the BHS Billing Unit (MH or SUD) if you have any questions.

Disclaimer: The 9999 Tip Sheet is intended solely for general information and education purposes. The information provided in this document may change as we receive new data or updates.



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Links to Resources:

[CoSD Charges/Claims Report Profile](#)

[SmartCare EHR](#)

[Client Insurance Request Form](#)

[BH-025](#)