

BHS Billing Unit - Billing Office Hours FAQs



Functionality	Question	Response
CoSD Charges and Claims Report – 9999-Client Plan	<i>How should we be clearing the 9999s on the Charges and Claims Report</i>	Please refer to the “9999 Tip Sheet” posted on the Optum website.
	<i>Why are some claims for a client denied and all the others are approved?</i>	Medi-Cal have billing rules set up in their system when processing claims received from BHS BU. If the claim(s) passed all billing rules, then they will be marked for payment. There are various reasons why claims are denied by DHCS. It is not always about the client’s Medi-Cal eligibility record. It could have something to do with the procedure code used on the service or the rendering provider. BHS BU is currently working with our system vendor on modifying the Claims Denial Report so programs can run the report and be able to see the reason why the claims were denied.
	<i>We have clients that have been closed to our program, but their Medi-Cal expired after, and the report is still showing as denied claims when they had Medi-Cal at time of service.</i>	CoSD Client Insurance & Date Span Report may display that client is still active at time of service however, Medi-Cal denied the claim because according to their records, client was not eligible. Client’s 3 rd party coverage in CCBH were migrated to SmartCare so the information might not be current at time of service. We strongly advise that programs verify client’s Medi-Cal eligibility on DHCS Provider Portal to get more current information.
	<i>I’m still confused on what to do with the people in the “9999” report. We have some people staging to 9999 that have active Medi-Cal per the CoSD Insurance & Date Span report at the time of service and some people who don’t have insurance at all.</i>	CoSD Client Insurance & Date Span Report may display that client is still active at time of service however, Medi-Cal denied the claim because according to their records, client was not eligible. Client’s 3 rd party coverage in CCBH were migrated to SmartCare so the information might not be current at time of service. We strongly advise

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		that programs verify client's Medi-Cal eligibility on DHCS Provider Portal to get more current information.
CoSD Charges and Claims Report	<i>Where can we find the reason why a claim was "denied"? What does "closed" status mean?</i>	Denied is a claim status and only seen on charges sitting under the Medi-Cal plan. There are different reasons why Medi-Cal denies the claim. BHS BU is currently working with the SC vendor in modifying an existing claims denial report to be CDAG compliant or be available for programs to run. Closed status mean there is no longer a balance for the service because it was paid by the client's coverage plan(s).
	<i>How often should I check the CoSD Charges and Claims Report?</i>	It is recommended that programs run and review the 9999 report on a bi-weekly basis (or as needed) to allow timely correction or billing of Medi-Cal billable services sitting under the 9999 plan. 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).
Payment Recovery Form (PRF)	<i>When a PRF form is received with QA responses what are we to do? Once we error the services indicated by QA, what is the process after?</i>	Once QA sent the PRF to MHBUS, you no longer need to follow up with QA unless the disallowances submitted are related to your QAPR.
General	<i>Is there a report available that is equivalent to the Suspense Report?</i>	There is currently no report in SmartCare that is similar to the Suspense Report in CCBH. Services that have errors (i.e., invalid diagnosis, authorization missing, etc.) will remain in SHOW status until the error(s) has/have been resolved by the programs.
	<i>How are we supposed to interpret and utilize the insurance date span report?</i>	The CoSD Client Insurance and Date Span report displays the coverage plans for one client or all clients enrolled in your program based on the insured from/to date

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		<p>used to run the report. If the client's coverage plan is still active, there will be an effective date with no expiration date. If plan has expiration date, it is marked Inactive. BHS BU recommends that this report be used as a reference when working the "9999" report to verify what coverage the client has in SmartCare and if client has coverage at time of service. Even if the plans show as active or inactive, providers should still verify clients' Medi-Cal eligibility on DHCS Provider Portal.</p>
<p>General</p>	<p><i>Will the charges and claims report be incorporated into the reconciliation template process? I have been having a hard time managing all the reports that we have to use and trying to make sure everything is corrected and am hoping to streamline the process.</i></p>	<p>At this time, there are no plans to incorporate the charges and claims report to the reconciliation template process due to the complexity in working with different billing tables where majority of the information is stored.</p>
	<p><i>Will services be recalculated when insurances get updated in member profiles?</i></p>	<p>There is a nightly billing job called "Reallocation" that looks at changes in client's coverage plan and when found, will reallocate "unbilled" charges from one plan to another. For example, if charges for a client are sitting under the 9999 pay source because client didn't have any coverage or existing coverage then Medi-Cal plan was inserted or new date span entered that covers the DOS, the reallocation job will move those charges from 9999 to Medi-Cal. Recalculate is the term we used in CCBH and Reallocation is the term used in SmartCare.</p>
	<p><i>How soon does the client insurance plan need to be submitted to billing? Once enrolled?</i></p>	<p>If client is new to our system of care or does not currently exist in SmartCare, please submit the Client Plan Request form to the billing unit as soon as you're able. If client</p>

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		<p>already exists in SmartCare but is new to your program, run CoSD Client Insurance and Date Span Report first to determine if client already has coverage in the system. Client's coverage plan in SmartCare is applicable to any program the client is enrolled in.</p>
<p>General</p>	<p><i>Do we have to bill all services to their OHC? Therapy, BHAs, Psych Evals, PEER services, nurse visits and follow-up Med appointment?</i></p>	<p>If the charges for the services are currently sitting on the client's OHC, yes, you will need to bill all those services. There are specific services that Medi-Cal states we can bill directly to them without billing OHC first and one example is TCM/ICC. There is a billing rule setup in the system that will automatically distribute the charge for TCM/ICC to Medi-Cal even if client has OHC as their primary plan.</p>
	<p><i>What about what used to be the Suspense Code "V" no signed AOB on file. How do we solve this when a client is physically unable to sign or refuses to sign? CCBH had a notes section we were able to write that information in and SmartCare does not. My program deals with seniors so we come across this a lot especially with Cognitive decline.</i></p>	<p>On the Client Insurance Plan Request, there is field labeled "Assignment/Release of Information obtained?" with a Yes or No box that you can check and add short comment. When billing unit inserts or updates the coverage plan, we will add the information on the comments section of their account in SmartCare. You will need to keep a copy of that request in your records in case you have issues dealing with their OHC.</p>

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