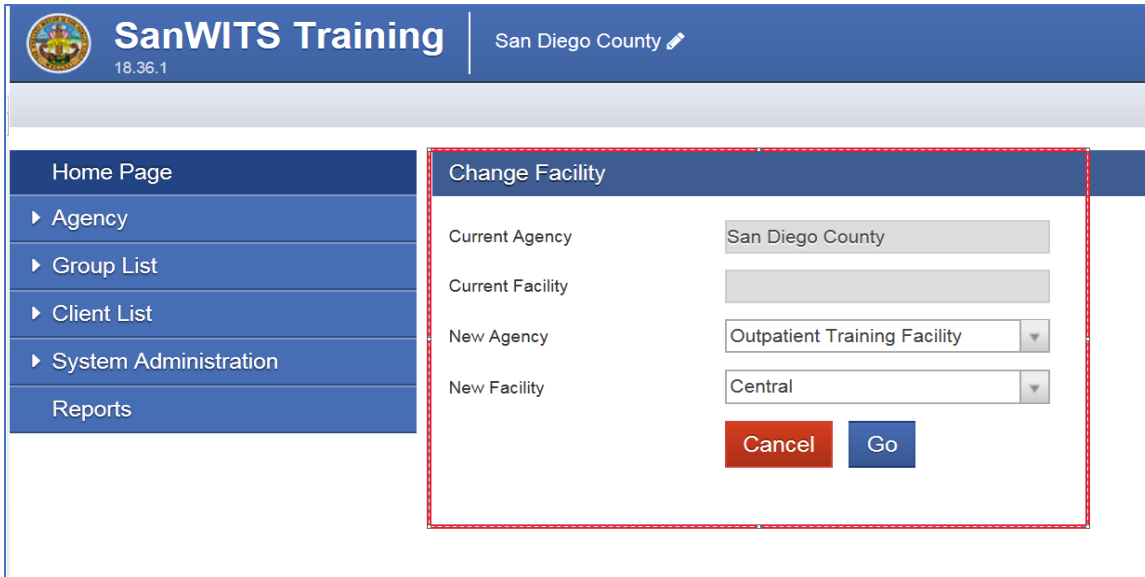


Log in to SanWITS – Enter your Agency and Facility- Click GO



The screenshot shows the SanWITS Training login interface. On the left is a navigation menu with options: Home Page, Agency, Group List, Client List, System Administration, and Reports. The main area is titled 'Change Facility' and contains the following fields:

- Current Agency: San Diego County
- Current Facility: (empty text box)
- New Agency: Outpatient Training Facility (dropdown menu)
- New Facility: Central (dropdown menu)
- Buttons: Cancel (red) and Go (blue)

BHS Billing Unit requires all the providers to review the three important screens prior to releasing the encounters to billing.

Note: All client information used in this guide are fictitious and solely for training purposes only.

REVIEW PROCESS:

Go to Agency - Client List – Enter the Client’s First and Last Name or the Unique Client ID # - click Go

I. Review the Client Profile screen data



The screenshot shows the 'Client Search' screen in SanWITS Training. On the left is a navigation menu with options: Home Page, Agency, Group List, Authorization Dashboard, Residential Unit Dashboard, Residential Unit Mgmt, Client List (highlighted with a red box), Client Profile, Linked Consents, Contacts, and Activity List. The main area contains the following search fields:

- Agency: Outpatient Training Facility
- Facility: (dropdown menu)
- First Name: (text box)
- Last Name: (text box)
- SSN: (text box)
- DOB: (text box)
- SanWITS Training Client Id: (text box)
- Unique Client Number: (text box)
- Provider Client ID: (text box)
- Treatment Staff: (dropdown menu)
- Primary Care Staff: (text box)
- Case Status: All Clients (dropdown menu)
- Intake Staff: (dropdown menu)
- Other Number: (text box)
- Number Type: (dropdown menu)
- Include Only Active Consents: Yes (checkbox)
- Buttons: Clear (red) and Go (blue)

- 1) Review the client profile data. Please refer to page 13 of your SanWITS User's Guide v. 2018 for details.

Notes:

- The steps in completing the Client Profile is part of the SanWITS User's Guide.
- If you only viewed the Client Profile screen, click the Cancel or Finish button to exit. Only click Save when you make changes on this screen.

II. Review the Payor Group Enrollment screen

- 1) Click the Actions button and Edit to open the Benefit Plan information

Home Page		Payor List						Add Benefit Plan Enrollment	
<ul style="list-style-type: none"> Agency Group List Residential Unit Dashboard Residential Unit Mgmt Client List <ul style="list-style-type: none"> Client Profile Alternate Names Additional Information Contact Info Collateral Contacts Other Numbers History Payor Group Enrollment Authorization Allergies 		<div> <div>Actions</div> <div> <div>Edit</div> <div>Remove</div> </div> </div>		Plan	Group	Subscriber Acct#	Subscriber Resp Party	Start Date	End Date
				ODS DMC- Non Peri	Medi-Cal - Non Perinatal	XXXXXXXXXXA	Billing, First	9/1/2018	

2) Make sure all the bright yellow fields have the correct information.

The guides in completing the Payor Group Enrollment screen is included in the Organizational Provider Billing Manual.

- Subscriber ID #: must be 8 numbers plus 1 upper case letter (total of 9 digits).
- Coverage Start Date: must match the Program Enrollment
- Ensure the client's name and DOB in Payor Group Enrollment matches the Medi-Cal eligibility verification report.
- Coverage End Date: required if client is discharged from the program or aid code has changed.
 - a. If client falls out of Medi-Cal, please open the current ODS-DMC Non-Peri or Peri benefit plan and terminate it. Use the last day of the month the Medi-Cal policy is effective.
 - b. If client's Medi-Cal eligibility resumes or starts again, add a new ODS-DMC Non-Peri or Peri Benefit Plan. On the service date field, use the 1st of the month the Medi-Cal eligibility is effective (e.g. if effective September 2018, enter 09/01/2018).
- A valid aid code for the month and year of service must be entered in the Aid Code field. If aid code changes from last month (ex. 07/2018), provider must end the existing Payor Group Enrollment using the last day of the previous month (ex. 07/31/2018) as the End Date. Then, open a new Payor Group Enrollment using the first day of the month (ex. 08/01/2018) that the new aid code is effective.

- Address 1: must enter the physical address (no PO Box or do not type homeless). If client is homeless, please use your facility address instead.
- Address 2 (white field) can be used for Apt. #, etc.
- Zip Code: use the correct zip code (visit the usps.com website to verify).
- After reviewing the Payor Group Enrollment screen and no changes is applied, click the Cancel button. Only click the Save button when updates or changes are made on this screen.

III. Review the Encounters screen

- 1) On the left-hand side of your screen (blue navigation pane), click Activity list → Encounters

Actions	Svc Date	Service	ENC ID	Rendering Staff	Program Name	Group Session ID	Status
	9/24/2018	Individual Counseling OS	531421	Hansen, Stephanie, LMFT, LMFT	OS		Released
	9/20/2018	Individual Counseling OS	531081	Hansen, Stephanie, LMFT, LMFT	OS		Released

- 2) Open the **Encounter Profile** by clicking the Actions button (pencil)

3) Carefully review the Encounters fields

The screenshot displays the 'Encounters' form in the SanWITS Billing System. The form is divided into several sections with various input fields. Key fields highlighted in bright yellow include 'Note Type' (DMC Billable), 'Program Name' (DMC Billing Test Facility/OS - 9/20/2018 -), 'Service' (Individual Counseling OS), 'Service Location' (Non-residential Substance Abuse TX Facility), 'Start Date' (9/27/2018), 'Start Time', 'End Date', 'End Time', 'Travel Duration' (0 Min), 'Documentation Duration' (5 Min), 'Session Duration' (60 Min), 'Total Duration' (65 Min), 'Contact Type' (Face To Face), 'Emergency' (No), 'Visit Type' (SC-Screening), 'Pregnant/Postpartum' (No), 'Was an interpreter used?' (No Interpreter Needed), 'In what language was the service provided?' (English), 'Evidence-Based Practices' (Motivational Interviewing, Relapse Prevention, Other), 'Used Evidence-Based Practices' (None), 'Primary' diagnosis (F10.10-Alcohol abuse, uncomplicated(ICD)), and 'Rendering Staff' (Hansen, Stephanie, LMFT, LMFT). Red boxes highlight the 'Billable' (Yes), 'Medi-Cal Billable' (Yes), 'Primary' diagnosis, and 'Rendering Staff' fields. The left sidebar shows the navigation menu with 'Encounters' selected under 'Diagnosis List'.

All the bright yellow fields are required by the system; some white fields may also be required

- Billable field: Yes
- Medi-Cal Billable: Yes
- Primary Diagnosis field must be present. Use the ICD-10 Master Chart (version 10/2017) provided by the BHS Billing Unit.
- Rendering Staff: select the name of the actual provider of service from the dropdown. The individual provider must have a valid NPI set-up in SanWITS. Please contact the MIS team if you need the NPI added or corrected in SanWITS.

BILLING STEPS:

I. Release to Billing

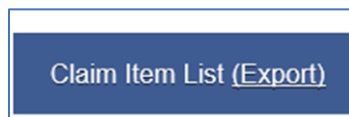
- 1) After carefully reviewing the client and claims data, scroll all the way down to the Administrative Actions and click **Release to Billing**.
- 2) Save and Finish to return to the main screen of the Encounter List.



The screenshot shows a web interface with a section titled "Administrative Actions". Below this title, there are two buttons: "Release to Billing" and "Delete". At the bottom right of the interface, there are three buttons: "Cancel" (red), "Save" (green), and "Finish" (blue). Red boxes highlight the "Administrative Actions" section, the "Release to Billing" button, and the "Save" and "Finish" buttons.

II. After Release to Billing

- 1) On the navigation pane, click Billing – Claim Item List
- 2) Complete the four (4) fields: Plan, Item Status (Item Status default: All Awaiting Review), Facility, and Service Date fields.
Note: to enter a service date range, use this format: 07012018:07312018 (for July 2018 services). If you have more than 1000 claims for the whole month, you can split the service date range into two (e.g. 07012018:07152018 and 07162018:07312018) to be able to view them or export the file.
- 3) Click GO. The services you released to billing will appear at the bottom of your screen.
- 4) Run your billing report (while claims are in Claim Item List and Awaiting Review status) by clicking the **Export** hyperlink.



- 5) Once you click Export, the pop-up box will ask if you want to save or open the file.

Notes:

- You can filter the file based on the data you need.
- You can also use this report to double-check some billing data (i.e. Client Name, Subscriber ID # Rendering Staff,

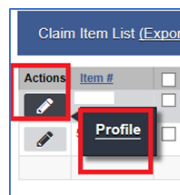
Service Date, Service Location, Primary Diagnosis, etc.) and correct any error before batching the claims.

- Save this report to your preferred folder.

- 6) After double checking your claims and there's no error found, the claims in Awaiting Review status must be "released" so you can batch them.

Actions	Item #	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date	Charge	Group Session ID
	527781	Billing, First	FFS	None	9/27/2018	H0004U7	65 Min	Awaiting Review	10/24/2018	\$145.27	
	527782	Billing, First	FFS	None	9/28/2018	H0006U7	42 Min	Awaiting Review	10/24/2018	\$86.74	

- 7) Release the claims for batching. Providers can either release the claim individually to review the claim data one more time or to release the claims in bulk.
- To release the encounter individually, click the pencil icon and click Profile.



- On the Administrative Actions, click Release.

OR

b. Release all claims together.

- To do this, put a checkmark on the tiny box in between the Item # and Client Name titles. By doing so, all the Item # boxes will be selected by the system.
- On the right side of the screen, click the dropdown menu and select Release.
- Click Update Status. All awaiting review claims will be staged to status: Release.

III. Claim Item List - Released Status

- 1) On the same screen (Claim Item List), change the Item Status field from All Awaiting Review to Released.
- 2) Click GO. The released claims are ready to be batched.
- 3) To batch, click the hyperlink **Create Facility Batches**.

- 4) Select the appropriate Available Plan and the arrow right to move it to the Selected Plan.

- 5) Click GO. The blue message will appear on top of your screen -claims are being batched.

- 6) Click the **Claim Batch List** folder. Batch status is defaulted to status: Awaiting Review.

Actions	Batch #	Status	Batch For	FFS Type	Billing Form	837 Type	Order	Charges	Service Mo/Yr	Created	Transmit
	100333	Awaiting Review	ODS DMC- Non Peri	FFS	837	837P	P	\$232.01	Sep 2016	10/24/2016	

Notes:

- The system creates the batch and the batch # automatically.
- If Batch does not appear in more than 10 minutes, change the Status field from Awaiting Review to Batch Processing Error to check if your batch has error. Commonly, batch error is caused by invalid rendering staff NPI.

IV. Claim Batch List and Send to Clearing House

- 1) The Batch will appear if batching is successful.
- 2) Hover the mouse on the Actions button next to the Batch # then click Profile.

Facility List
Billing
 Invoicing
 Claim Item List
Claim Batch List
 Encounter List
 EOB Transaction List
 Payment List
 Billing Transaction List
 Client Balance
 Clearing House Item

Batch #
 FFS Type

Claim Batch List (Export)

Actions	Batch #	Status	Batch For
	105333	Awaiting Review	ODS DMC- Non Peri

Claim Items **Profile**

- 3) On the Claim Batch List Profile, click the Administrative Actions: Release
- 4) Click Save.

Home Page
 Agency
 Agency List
 Facility List
Billing
 Invoicing
 Claim Item List
Claim Batch List
 Encounter List
 EOB Transaction List
 Payment List
 Billing Transaction List
 Client Balance
 Clearing House Item
 Clearing House Batch
 Cost Center
 Payor Plan List
 Contract Management
 Payor Adjudication
 Fee List
 Group List
 Residential Unit Dashboard
 Residential Unit Mgmt
 Client List
 System Administration

Provider Claim Batch Profile

Batch # 105333
 Batch For ODS DMC- Non Peri
 Created By User, System
 Updated By User, System
 837 Type 837P
 Order Primary
 Service Month/Year 9/1/2018

Charge Amount \$232.01
 Status Awaiting Review
 Created Date 10/24/2018 9:09 AM
 Updated Date 10/24/2018 9:09 AM
 Transmit Date
 Ignore Warnings No
 FFS Type Fee for Service
 HIPAA Processing Set
 837 File Status
 Transmission Message

Errors List (Export)

Batch #	Level	Message	Created

Administrative Actions
 Release Hold Void

Cancel **Save** Finish

- 5) It will take you to the next screen.
- 6) Scroll down to the Administrative Actions and click **Send to the Clearing House.**

Provider Claim Batch Profile

Batch # **105333**

Batch For ODS DMC- Non Peri

Created By User, System

Updated By Lucas, Mayuri

Charge Amount \$232.01

Status Released

Created Date 10/24/2018 9:09 AM

Updated Date 10/24/2018 9:14 AM

Transmit Date

837 Type 837P

Order Primary

Service Month/Year 9/1/2018

Ignore Warnings No

FFS Type Fee for Service

HIPAA Processing Set

837 File Status

Transmission Message

Errors List (Export)

Batch #	Level	Message	Created

Administrative Actions

[Awaiting Review](#) [Hold](#) [Void](#) **[Send To Clearing House](#)**

[Cancel](#) [Save](#) [Finish](#)

- 7) Click Save and Finish.
- 8) The Clearing House will receive the batch and will be processed.
- 9) Email the Billing Submission Certification (ADP 100186 form) to the billing unit at: ADSBillingUnit.HHSA@sdcounty.ca.gov.

How to complete the ADP 100186 form (billing submission certification)

- County Name will be San Diego
- Provider Name: enter your facility name
- DMC Number: 4-digit Provider number
- Service Facility Location NPI: your location NPI
- DMC Submission Identifier: Provider Batch Number.

- 10) The ADP 100186 form must be signed and dated by the authorized provider signatory. Enter a valid contact phone # on the field provided.

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY		DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS				
DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY CONTRACTED PROVIDER						
<div style="border: 2px solid red; padding: 5px;"> <p>County Name: _____</p> <p>Provider Name (Legal Entity): _____</p> <p>DMC Number(s): _____</p> <p>Service Facility Location NPI(s): _____</p> <p>DMC Submission Identifier: _____</p> </div>		<div style="border: 1px solid black; padding: 5px;"> <p style="font-size: x-small;">FOR COUNTY USE ONLY:</p> <p>Receipt Date: _____</p> <p>EDI File Name: _____</p> <p>EDI File Submission Date: _____</p> </div>				
<p>COUNTY CONTRACTED PROVIDER CERTIFICATION</p> <p>As required by 42 CFR Part 455.18, this is to certify that the claim file information submitted by the provider in the DMC submission identified above is true, accurate and complete. I understand that payment of this claim file will be from Federal and/or State funds, and that any falsification, or concealment of material facts, may be prosecuted under Federal and/or State laws.</p> <p>I hereby agree to keep such records as are necessary to disclose fully the extent of the services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Department of Alcohol and Drug Programs or the Department of Health and Human Services may require. I further agree to accept as payment in full the amount paid by the Medi-Cal program for those claim files submitted for payment under the program with the exception of authorized deductible, co-insurance, or similar cost sharing charge.</p> <p>I certify that the services identified in the above identified DMC submission were medically indicated and necessary to the health of the patients and were personally furnished by me or an employee working for the provider.</p>						
<p>Printed Name: AUTHORIZED SERVICE PROVIDER _____</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%;">Signature: AUTHORIZED SERVICE PROVIDER _____</td> <td style="width: 25%;">Phone Number () _____</td> <td style="width: 30%;">Date Signed _____/_____/_____</td> </tr> </table> <p style="font-size: x-small;">ADP 100186 (Effective 12-31-2009)</p>				Signature: AUTHORIZED SERVICE PROVIDER _____	Phone Number () _____	Date Signed _____/_____/_____
Signature: AUTHORIZED SERVICE PROVIDER _____	Phone Number () _____	Date Signed _____/_____/_____				

Notes:

- The Billing Unit staff will contact you if errors are detected on the batch.
- Batch will be submitted to the State. Any claim denials will be emailed (encrypted) to the providers for further review.

Summary of Changes:

Title/Comment	Page	Date Changed
Coverage End Date	3	11/2018
Updated #3 to hyperlink, Create Facility Batches	8	05/22/2019
Updated #9: added the word Billing before the name Submission Certification (ADP 100186 form)	11	06/14/2019

DISCLAIMER:

The workflow/billing screens are subject to change as we learn more about DMC ODS.