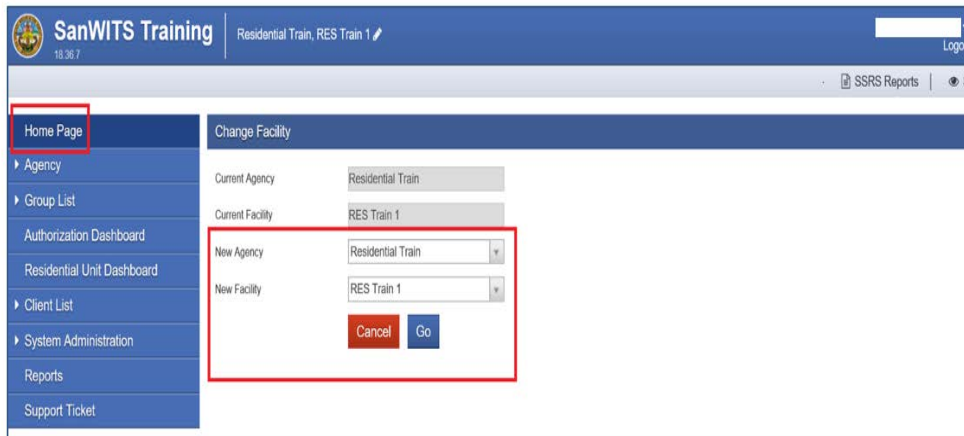
BHS Billing Unit requires all the providers to review the three important screens in SanWITS prior to releasing the encounters to billing.

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

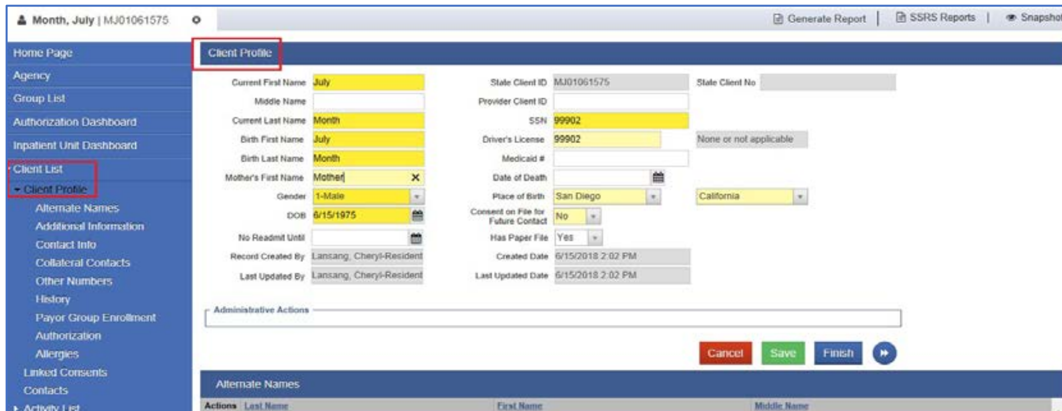
A. REVIEW PROCESS

- To start the review, log in to SanWITS – Enter your Agency and Facility- Click Go.



- 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



Notes:

- Please refer to the SanWITS User's Guide about guidelines in completing the Client Profile.
- If you only viewed the Profile screen, click the Cancel or Finish button to exit. Only click the Save button when you make changes on the Client Profile.

II. Review the Payor Group Enrollment screen

1) From the Client Profile screen, click the Payor Group Enrollment (PGE) tab.

Residential providers must have 2 open or active PGE in SanWITS:

a) ODS Residential: for government contract (i.e. Residential Bed Day)
b) ODS-DMC Non-Peri (or Peri): for Medi-Cal billable service (i.e. Case Management).

Note: The Benefit Plan **ODS DMC Non-Peri** should not be set-up in SanWITS until providers are certified and can verify the client's Medi-Cal eligibility.

2) Review the ODS Residential Plan by clicking the Actions button then select Edit to open the Plan information.

Month, July | MJ01061575

Home Page
Agency
Group List
Authorization Dashboard
Residential Unit Dashboard
Client List
Client Profile
Alternate Names
Additional Information
Contact Info
Collateral Contacts
Other Numbers
History
Payor Group Enrollment
Authorization

Payor List

Actions	Priority	Plan	Group
	1	ODS Residential	DMC Billable
	2	ODS DMC- Non Peri	Medi-Cal - Non Perinatal
		Medi-Cal - ADP-Non Perinatal	Medi-Cal - Non Perinatal

Government Contract Billing Information

Plan Type: Government Contract
Contract: 559999,559999
Plan-Group: ODS Residential-DMC Billable
Subscriber #: MJ01061575
Payor Priority Order: 1
Start Date: 6/1/2018
End Date:

Administrative Actions:

Notes:

- The Subscriber ID on the Gov't. Contract Plan defaults to the Client's Unique ID #. Keep it as it is.
- The Start Date field must cover the months being billed.
- If correction or update is made, click the Save button. If no changes is made on this screen, click Cancel.

3) Next, review the DMC Plan or ODS-DMC Non-Peri (for ODS-DMC clients from July 2018 onwards).

Notes:

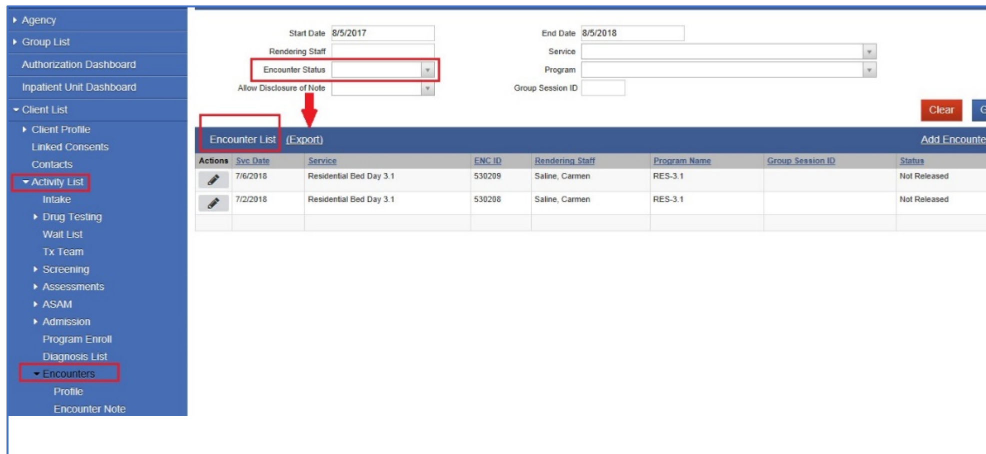
a) The guides in completing the Payor Group Enrollment screen is included in the Organizational Provider Billing Manual.
b) Subscriber ID #: must be 8 numbers plus 1 upper case or capital letter (total of 9 digits).
c) Coverage Start Date: must match the Program Enrollment
d) Ensure the client's name and DOB in Payor Group Enrollment matches the Medi-Cal eligibility verification report.
e) Coverage End Date: required if client is discharged from the program or aid code has changed from previous month to current month.

- 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.
- 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).

f) Aid Code field: 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. 06/2018), provider must end the existing Payor Group Enrollment using the last day of the previous month (ex. 06/30/2018) as the End Date. Then, open a new Payor Group Enrollment using the first day of the month (ex. 07/01/2018) that the new aid code is effective.
g) Address 1: must enter the physical address (no PO Box or do not type homeless). If client is homeless, please use your Agency/Facility address.
h) Address 2 (white field) can be used for Apt. #, etc.
i) Zip Code: use the correct zip code (visit usps.com website to verify).
j) 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 Agency – Activity List – Encounters to view the Encounter List.

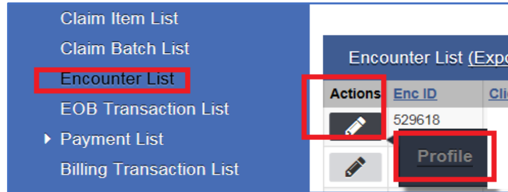


a) To view all the encounters, leave the Encounter Status field blank and click Go.
b) If you want to view only the Released or Not Released, select the appropriate

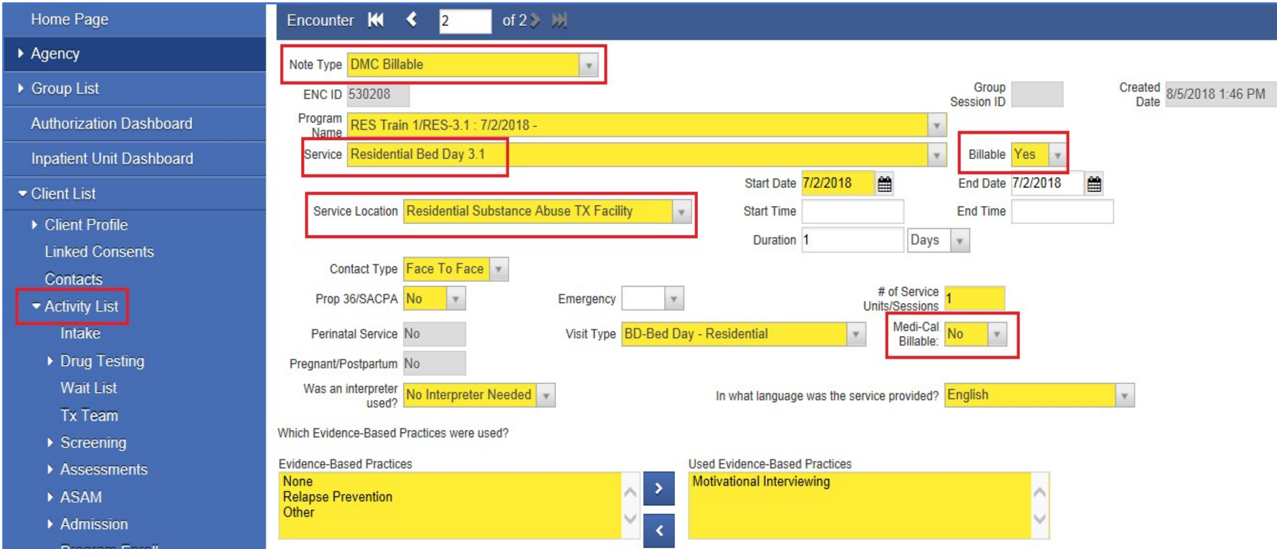
status from the dropdown then click Go.

c) To run an Encounters report, click the **Export** hyperlink next to the Encounter List Title. Open the report using the Microsoft Excel.

2) In this example, I selected to view the “Not Released” encounters. Open the **Encounter Profile** by clicking the Actions/pencil icon.



3) Carefully review the Encounter fields (bright yellow fields and some white and gray fields).



Notes:

a) Note Type field: select the appropriate type (DMC billable or County Billable). Use DMC Billable if client is Medi-Cal or County Billable if not. If client is identified with Share of Cost (SOC), the encounter type must be County Billable only for the SOC portion or services used to clear the SOC.

b) Billable field: **Yes** (if you want to turn the encounter into a claim).

c) Medi-Cal Billable: **No** (if billing for Residential Bed Day service). **You will only answer Yes on this field if Service being billed is Case Management. Separate SanWITS screens/workflow for case management billing is available.*

d) Select the appropriate Service Location: Residential for Residential Bed Day and

Non- Residential for Case Management.

e) Service and Visit Type fields are set-up based on the Agency/Facility contract.

f) Primary Diagnosis field must be present. The field is in gray/view only field because you added the diagnosis in the Diagnosis screen within the Admission record. Please do not create Diagnosis from the "Diagnosis List." Also, use the ICD-10 Master Chart (version 10/2017) provided by BHS Billing Unit to ensure the diagnosis code is billable.

g) Rendering Staff field is defaulted to the SanWITS User/staff entering the encounters. **Note:** Make sure to update the Rendering Staff field to the actual individual provider of service. Also, the Rendering Staff must have a valid NPI set-up by BHS-MIS Support Team in SanWITS. Please contact the MIS team for assistance.

B. BILLING PROCESS:

I. Release to Billing

1) After carefully reviewing the client and encounters 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 and continue reviewing and releasing the rest of the encounters.

Note: You can release all the encounters if the client is already discharged.

II. After Release to Billing

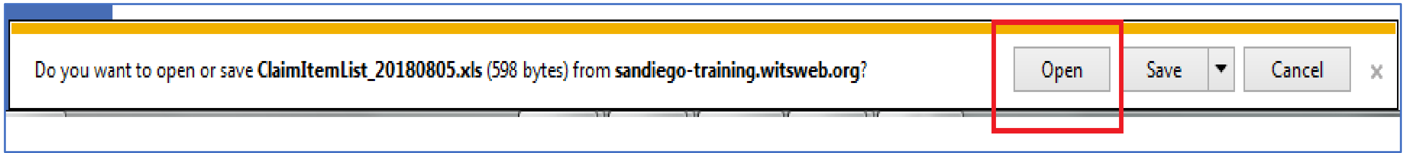
1) On the navigation pane, click **Agency - Billing – Claim Item List** folder.
2) Complete the four (4) fields: Plan, Item Status (Item Status default: All Awaiting Review), Facility, and Service Date fields.

Note: to enter a service date range, use this format: 07012018:07312018 (for July 2018 services).

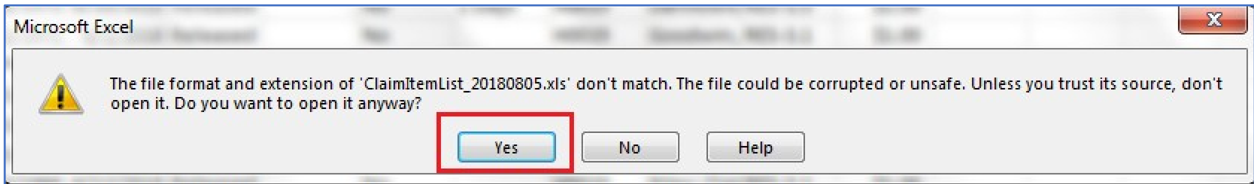
3) Click Go. The services you released to billing will appear at the bottom of your screen.

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.



6) You can open the file but read the Warning sign before clicking Yes.



7) The Excel file will appear like this:

A	B	C	D	E	F	G	H	I	J	K	L	M	N
Item #	ENC ID	Client Name	Payor	FFS Typ	Add-On Leve	Unique Client #	Rendering Staff Name	Payor Na	Group Na	Subscrib	Authoriza	Service D	End Date
527718	530208	Month, July	559999 -	FFS	None	MJ01061575	Saline, Carmen	ODS Res	DMC Bill	0123457	100171	7/2/2018	7/2/2018

O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
Service	Service L	Billing Un	Duration	Status	Release I	Charge	Group Se	OIC Paym	primary d	seconda	tertiary di	Create
H0019/U	55	1	1 Days	Awaiting	8/5/2018	$1.00		$0.00	F10.151			8/5/20

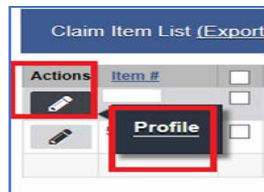
Notes:

- 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 the error before batching the claims.
- Save this report to your preferred folder.

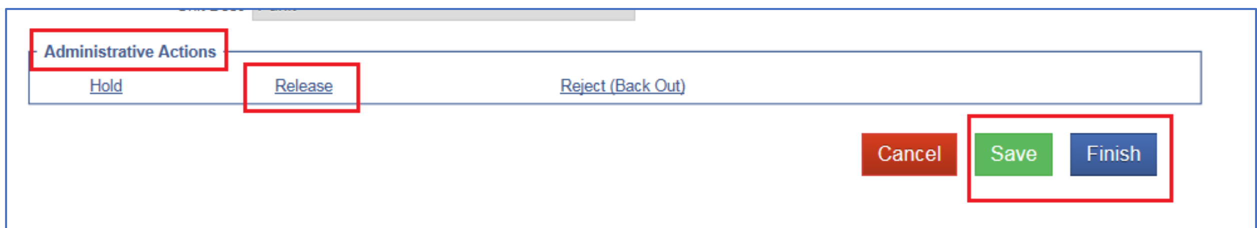
8) After double checking your claims and there's no error found, the claims in Awaiting Review status must be "released" first to be able to batch them. **Only release (Second release) the claims that you are ready to batch. If you are not ready to batch the claims please leave the status as awaiting review.**

Note: Providers have the option to either release the claims individually to review the claim information one more time or to release the claims in bulk/altogether.

a) To release encounter individually, click the pencil icon and click Profile.



b) On the Administrative Actions, click <u>Release</u>.



OR

a. Release all claims together.
   - To do this, put a check-mark on the tiny box in between the Item # and Client Name titles. By doing so, all the Item # boxes/claims will be selected by the system. It is important to enter the Service Date(s) when creating a batch.
   - On the right side of the screen, click the dropdown menu and select Release.
   - Click the hyperlink **<u>Update Status</u>**. All claims in awaiting review 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.

3) Once all your claim items are in 'released' status, you can now proceed to batching them. To batch, click the Administrative Actions: **Create Facility Batches**.

4) Select the Available Plan (ODS Residential if you are billing for Residential Bed Day) and click the arrow right to move it to the Selected Plan box.

Note: Residential providers billing for Case Management will have another Available Plan which is, ODS-DMC Non-Peri. You will only select this plan if you are billing for Case Management. A separate billing instruction is available for Case Management billing.

Choose Plan(s) for Batching

Available Plans

Selected Plans

ODS Residential

Cancel Clear Go

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

The claim items for the selected 1 plan(s) are being batched. This may take a few minutes to complete.

Claim Item Search

6) From the navigation pane, click the **Claim Batch List** folder. Batch status is defaulted to status: Awaiting Review.

Notes:

- The system creates the batch and the 6-digit batch # automatically. Please list down your batch #.
- If Batch does not appear in more than 10 minutes, change the Status field from Awaiting Review to Batch Processing Error. Click Go.
  Note: Commonly, batch error is caused by invalid rendering staff name or incorrect individual 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.

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

5) It will take you to the next screen.
6) Scroll down to the Administrative Actions and click **Bill It.**

Note: If you are billing for Case Management, you will not see the Bill It hyperlink. Instead, you will see Send to Clearing House.

7) Once your provider batch is submitted to the County Government Contract folder, email the 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.

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY CONTRACTED PROVIDER

County Name: ______________________

Provider Name (Legal Entity): ______________________

DMC Number(s): ______________________

Service Facility Location NPI(s): ______________________

DMC Submission Identifier: ______________________

FOR COUNTY USE ONLY:

Receipt Date: ______________________

EDI File Name: ______________________

EDI File Submission Date: ______________________

COUNTY CONTRACTED PROVIDER CERTIFICATION

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.

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.

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.

Printed Name: AUTHORIZED SERVICE PROVIDER		
Signature: AUTHORIZED SERVICE PROVIDER	Phone Number ( )	Date Signed

ADP 100186 (Effective 12-31-2009)

8) Click Save and Finish.
9) Your batch will be received by the County under Government Contract (Payor Adjudicator) module for processing.
10) County BHS Billing Unit will review the received provider batch and we will determine which claims are County billable and which ones are DMC billable (can be billed to the State/Medi-Cal).
    a. If claims are County billable/payable, no further action is required from the provider.
    b. If claims are DMC billable, BHS Billing Unit will return the DMC claims to providers for batching process (for Medi-Cal billing). Please see instructions below on how to bill Medi-Cal claims below.

Provider's Steps on How to Bill for DMC claims:

1) Residential bed day claims payable by DMC will be rejected from the Government Contract (BHS BU) to return the claims to the provider's SanWITS Agency -Facility location. **The system's auto batch processor will create a DMC provider batch; this batch will be submitted straight to the Clearing House. Billing Unit will notify the provider about the Clearing House batch/batch # (to be billed to Medi-Cal) and will require the provider to submit the billing certification for this new batch. Provider can run the claim items or claim batch report to identify the claims we billed to DMC.** Please contact the Billing Unit if you have further questions on these steps.

2) Billing Unit will process the DMC provider batch received at the Clearing House.

3) Provider must submit a new ADP100186 or Claim Submission Certification for the Medi-Cal billable batch sent to the Clearing House to ADSBillingUnit.HHSA@sdcounty.ca.gov.

   Note: Every batch submitted to the Government Contract and Clearing House must be accompanied by a completed ADP 100186 form.

4) The BU staff will contact the provider in case errors are detected on the Provider Batch (Medi-Cal).

POST Billing Processes:

1) Any claims denied by the State or Medi-Cal will be emailed (encrypted) to providers for further review.
2) Billing Unit will work with you in replacing and rebilling the claims denied in error (i.e. data entry error).
3) If claims are denied by the State correctly (e.g. claims denied because aid code is not
4) DMC billable), please contact the BHS Billing Unit for further instructions.

******DISCLAIMER:** *As we learn more about DMC ODS, the workflow/billing screens are subject to change.*