

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

The screenshot shows the SanWITS Training interface. The top header includes the San Diego County logo and the text "SanWITS Training" and "San Diego County". A left sidebar contains navigation options: Home Page, Agency, Group List, Client List, System Administration, and Reports. The main content area is titled "Change Facility" and contains the following fields: "Current Agency" (San Diego County), "Current Facility" (empty), "New Agency" (Residential Train), and "New Facility" (RES Train 1). At the bottom of the form are "Cancel" and "Go" buttons. A red box highlights the "Change Facility" form area.

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

Note: All diagrams used in this guide are 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 SanWITS Training interface with the "Client Search" form. The left sidebar has "Client List" selected. The "Client Search" form contains the following fields: "Agency" (Residential Train), "Facility" (dropdown), "First Name", "Last Name", "SSN", "DOB", "SanWITS Training Client Id", "Unique Client Number", "Provider Client ID", "Treatment Staff" (dropdown), "Primary Care Staff", "Case Status" (dropdown), "Intake Staff", "Other Number", "Number Type", and "Include Only Active Consents" (Yes). At the bottom right are "Clear" and "Go" buttons. A red box highlights the "Go" button.

- 1) Review the client profile by entering the Client’s First and Last Name or the Unique Client ID #.
- 2) Click GO

Notes:

The guidelines in completing the Client Profile is part of the SanWITS Basic/Updates training and will be part of the SanWITS manual. If you only viewed the screen, click the Cancel or Finish button to exit. Only click Save when you make changes on the Client Profile.

Month, July | MJ01061575

Client Profile

Current First Name: July
Middle Name:
Current Last Name: Month
Birth First Name: July
Birth Last Name: Month
Mother's First Name: Mother
Gender: 1-Male
DOB: 6/15/1975
No Readmit Until:
Record Created By: Lansang, Cheryl-Resident
Last Updated By: Lansang, Cheryl-Resident

State Client ID: MJ01061575
State Client No:
Provider Client ID:
SSN: 99902
Driver's License: 99902
Medicaid #:
Date of Death:
Place of Birth: San Diego
Consent on File for Future Contact: No
Has Paper File: Yes
Created Date: 6/15/2018 2:02 PM
Last Updated Date: 6/15/2018 2:02 PM

Administrative Actions

Cancel Save Finish

II. Review the Payor Group Enrollment screen

Click the Actions button and Edit to open the Benefit Plan information

Payor List

Actions	Priority	Plan	Group	Subscriber_Acct#	Subscriber_Resp_Party	Start Date	End Date
	1	COS Residential	DMC-Billable	01234576A		6/1/2018	
	2	COS DMC- Non Pen	Medi-Cal - Non Perinatal	01234576A	Month, July	7/1/2018	
		DP-Non Perinatal	Medi-Cal - Non Perinatal	01234576A	Month, July	6/1/2018	6/30/2018

Payor Group Enrollment

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

Residential Unit Mgmt

Client List

Client Profile

Alternate Names

Additional Information

Contact Info

Collateral Contacts

Other Numbers

History

Payor Group Enrollment

Authorization

Allergies

Linked Consents

Contacts

Activity List

Episode List

System Administration

Reports

Benefit Plan/Private Pay Billing Information

Payor-Type Medicaid Plan-Group ODS DMC- Non Peri-Medi-Cal - Ni

Payor Priority Order 2 Policy #

Coverage Start 7/1/2018 End Payment Scale

Aid Code M1 Relationship to Subscriber/ Responsible Party Self

Subscriber/ Responsible Party:

First Name July Middle Last Name Month

Birthdate 8/15/1975 Gender 1-Male Subscriber # 01234578A

Address 1 555 Train Place

Address 2

City San Diego State California Zip 92108

Cancel Save

Notes:

- 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 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. 07/30/2018) 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 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

On the left-hand side of your screen (blue navigation pane), click Agency – Billing - Encounter List. Please Revised

The screenshot shows the 'Encounter Search' interface. The left navigation pane has 'Encounters' selected. The main area contains search filters for Start Date (10/22/2017), End Date (10/22/2018), and other criteria. Below the filters is an 'Encounter List (Export)' table with columns: Actions, Svc Date, Service, ENC ID, Rendering Start, Program Name, Group Session ID, and Status.

Actions	Svc Date	Service	ENC ID	Rendering Start	Program Name	Group Session ID	Status
	10/6/2018	Case Management 3.1 RES	531413		RES-3.1		Released
	10/5/2018	Residential Bed Day 3.1	531414		RES-3.1		Not Released
	9/11/2018	Residential Bed Day 3.1	531415		RES-3.1		Released
	9/10/2018	Case Management 3.1 RES	531416		RES-3.1		Released
	9/9/2018	Residential Bed Day 3.1	531417		RES-3.1		Released
	8/6/2018	Residential Bed Day 3.1	530540		RES-3.1		Not Released
	8/5/2018	Residential Bed Day 3.1	530210		RES-3.1		Released
	7/6/2018	Residential Bed Day 3.1	530209		RES-3.1		Not Released
	7/2/2018	Residential Bed Day 3.1	530208		RES-3.1		Released

Open the **Encounter Profile** by clicking the Actions button (pencil) Please revised

This close-up shows the 'Actions' column for the encounter dated 9/6/2018. A red box highlights the pencil icon, and a tooltip displays 'Review' and 'Clone' options. The table row shows: Svc Date: 9/6/2018, Service: Case Management 3.1 RES, ENC ID: 531414, Rendering Start: [blank], Program Name: RES-3.1, Group Session ID: [blank], Status: Not Released.

3) Carefully review the Encounter fields

NOTES:

- All the bright yellow fields are required by the system
- Some white fields (e.g. Duration) are also required
- Billable field: Yes
- Medi-Cal Billable: Yes

(note: if the service is used to clear the SOC, the service should be county billable).

Primary Diagnosis field must be present. Use the ICD-10 Master Chart (version 10/2017) from BHS Billing Unit.
 Rendering Staff: must have a valid NPI set-up in the Staff Members List page in SanWITS

BILLING PROCESS:

I. Release to Billing

After carefully reviewing the client and claims data, scroll all the way down to the Administrative Actions and click **Release to Billing**.

Save and Finish to return to the main screen of the Encounter List.

II. After Release to Billing

On the navigation pane, click Billing – Claim Item List

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.

Actions	Item #	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date	Charge	Group Session ID
	527774	Month, July	FFS	None	9/9/2018	H0006/U1	40 Min	Awaiting Review	10/22/2018	\$82.72	

4) Run your billing report (while claims are in Claim Item List and Awaiting Review status) by clicking the **Export** hyperlink.

Actions	Item #	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date	Charge	Group Session ID
	527718	Month, July	FFS	None	7/2/2018	H0019/U1	1 Days	Awaiting Review	8/5/2018	\$1.00	

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

Do you want to open or save **ClaimItemList_20180805.xls** (598 bytes) from **sandiego-training.witsweb.org**? Open Save Cancel X

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

The file format and extension of 'ClaimItemList_20180805.xls' don't match. The file could be corrupted or unsafe. Unless you trust its source, don't open it. Do you want to open it anyway? Yes No Help

7) The Excel file will appear like this:

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA		
Item #	ENC ID	Client Name	Payor	FFS Type	Add-On	Leve	Unique Client #	Rendering Staff Name	Payor Na	Group N:	Subscrib	Authoriz:	Service C	End Date	Service	Service L	Billing Un	Duration	Status	Release I	Charge	Group Se	DiC	Paym	primary d	seconda	tertiary d	Crete
527718	530208	Month, July	559999 - FFS	None		MJ01061575	Saline, Carmen	CDS Res	DMC Bill#	0123457:	100171	7/2/2018	7/2/2018	H0019U:	55	1	1Days	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.**

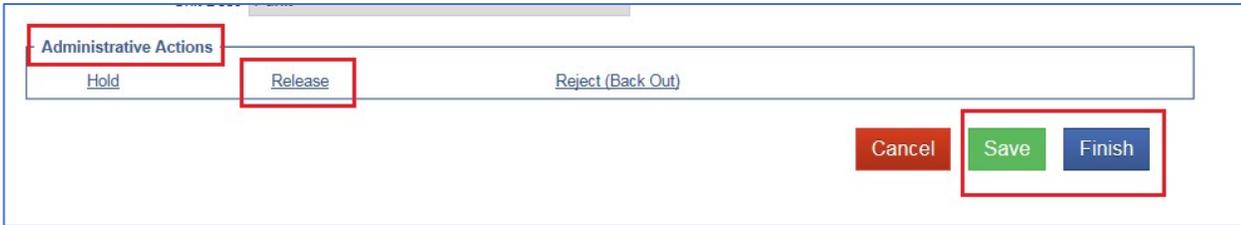
Notes: Providers have the option to either release the claims individually to review the claim information one more time or to release the claims in bulk/altogether.

4) Release claims to ready for batching. Providers can either release the claim individually to review the claim entry one more time or to release the claims altogether.

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



b. On the Administrative Actions, click Release.



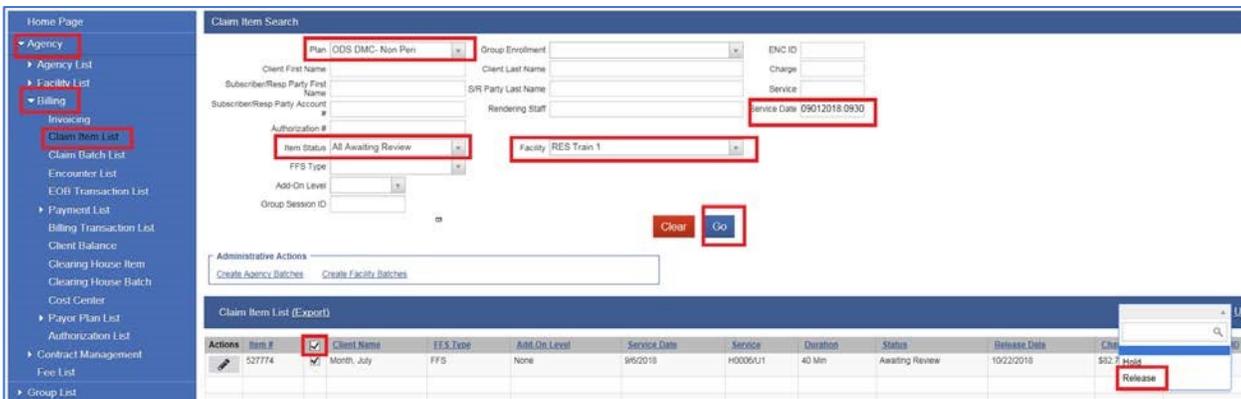
OR

a. 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

On the same screen (Claim Item List), change the Item Status field from All Awaiting Review to Released. Click GO. The released claims are ready to be batched.

3) To batch, click the hyperlink **Create Facility Batches**.

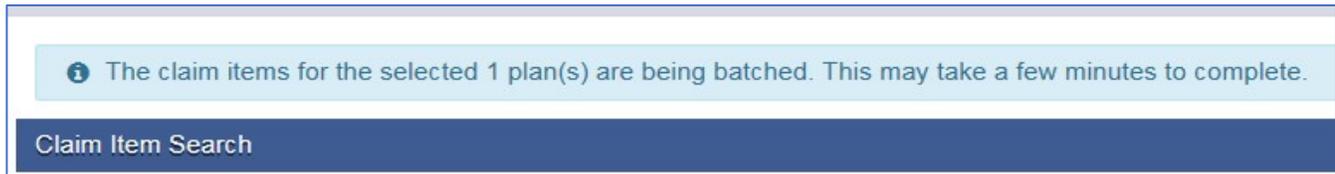
The screenshot shows the 'Claim Item Search' interface. On the left is a navigation menu with 'Agency' and 'Billing' expanded. The main area contains search filters: Plan (ODS DMC- Non Peri), Item Status (Released), Facility (RES Train 1), and Service Date (09012018.0930). At the bottom, the 'Administrative Actions' section includes a link for 'Create Facility Batches'.

Click the Available Plan and the arrow right to move to the Selected Plan.

This screenshot shows the 'Choose Plan(s) for Batching' screen. The 'Available Plans' list contains 'ODS DMC- Non Peri'. A red box highlights this plan, and another red box highlights the right-pointing arrow button. The 'Selected Plans' list is currently empty.

This screenshot shows the same 'Choose Plan(s) for Batching' screen after the plan has been moved. The 'Available Plans' list is now empty, and the 'Selected Plans' list contains 'ODS DMC- Non Peri'. A red box highlights the 'Go' button at the bottom right.

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



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



Notes:

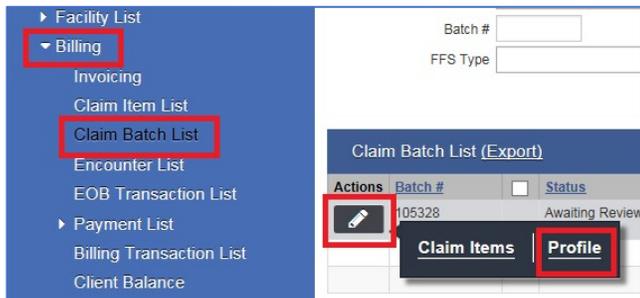
The system creates the batch and the batch # automatically.

If Batch does not appear in more than 10 minutes, change the Status field from Awaiting Review to Batch Processing Error. Commonly batch error is caused by error or missing rendering staff NPI.

IV. Claim Batch List and Send to Clearing House

The Batch will appear if batching is successful.

Hover the mouse on the Actions button next to the Batch # then click Profile.



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

The screenshot shows the 'Provider Claim Batch Profile' interface. On the left is a navigation menu with 'Billing' and 'Claim Batch List' highlighted. The main area displays details for Batch # 105328, including Charge Amount (\$82.72), Status (Awaiting Review), and various dates. Below this is an 'Errors List (Export)' table which is currently empty. At the bottom, the 'Administrative Actions' section shows 'Release', 'Hold', and 'Void' options. A red box highlights the 'Release' button, and another red box highlights the 'Save' button in the bottom right corner, next to 'Cancel' and 'Finish' buttons.

It will take you to the next screen.

Scroll down to the Administrative Actions and click **Send to the Clearing House**.

This screenshot shows the same 'Provider Claim Batch Profile' interface, but the 'Status' is now 'Released' and the 'Updated By' is 'Lucas, Mayuri'. In the 'Administrative Actions' section at the bottom, the 'Send To Clearing House' option is highlighted with a red box. The 'Save' button in the bottom right corner is also highlighted with a red box, along with the 'Cancel' and 'Finish' buttons.

Click Save and Finish. Your batch will be received by the Clearing House for processing. Once your provider batch is submitted to the Clearing House 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: _____						
<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 style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black;">Signature: AUTHORIZED SERVICE PROVIDER</td> <td style="width: 20%; border-bottom: 1px solid black;">Phone Number</td> <td style="width: 40%; border-bottom: 1px solid black;">Date Signed</td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;">()</td> <td style="border-bottom: 1px solid black;"> </td> </tr> </table> <p>ADP 100186 (Effective 12-31-2009)</p>		Signature: AUTHORIZED SERVICE PROVIDER	Phone Number	Date Signed		()	
Signature: AUTHORIZED SERVICE PROVIDER	Phone Number	Date Signed					
	()						

The Billing Unit Administrator will contact you if errors are detected on the batch. Batch will be submitted to the State.

POST Billing Processes:

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

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
Run your billing report Claim Item List (export hyperlink)	6	5/22/2019
Updated #3 to hyperlink, Create Facility Batches	8	5/22/2019

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