I. CLAIM ITEM LIST AND ITEM STATUS CHANGE

1. Additional search criteria on the Claim Item List screen has been added to find the claim information easily. Users can search by:

    A. Unique Client Number (UCN)   F. Reverse Reason
    B. Claim Item ID   G. Adjudication Status
    C. Claim Batch ID   H. PCCN (for Billing Unit use only)
    D. Hold Reason
    E. Export- This will now include the Claim Batch ID, Hold Reason, Reverse Reason, Adjudication Status, NDC, and PCCN.

2. There will be new headers to the Claim Item List that will allow changes to be made in bulk:

    A. Replace/Adjust - this is for SUD Billing Unit's use only/for service replacement and void processes.
    B. Reject – programs and SUD Billing Unit will have access to reject the claim items in bulk on condition that the claims have not been billed to the State yet.
    C. Awaiting Review - this allows the programs or SanWITS users to return the claims status from Released or Hold to Awaiting Review "in bulk", instead of doing it individually or per claim item.

II. HOLD STATUS REASONS

Claims are usually placed on hold by providers in Claim Item List screen because the services cannot be billed to DMC or client is not yet Medi-Cal eligible. SanWITS will now require a reason when putting a claim item on hold. Programs must select the appropriate reason from the Hold Reason dropdown list, then click Confirm.

*The hold reasons will help the programs track the status of their hold claims and to do the necessary review and billing if client becomes retroactive Medi-Cal.

Programs have the option to put the claim on hold individually (one by one) or in bulk. The bulk hold requires a uniform hold reason to hold multiple claims successfully.

Note: There is a current bug when changing the claim item status from "Hold to Awaiting Review" in bulk. The system vendor (FEI) is working on it and this function is anticipated to be available soon.

* Please check the [Optum website under Billing](#) tab to view the full list of Claim Item Hold Reasons.

III. CLAIM ITEM PROFILE

1. The Claim Item Profile has been updated with additional fields to provide additional information to Billing Unit and SUD programs. The added fields are the following:
   A. The PCCN Field (SUD Billing Unit use only)
   B. The Pregnant/postpartum indicator from the delivered service.
   C. The Perinatal indicator from the program enrollment on the delivered service.
   D. The Claim Batch ID

The Profile header was also updated to include the UCN, DOB, and age on delivered service start date.

2. The claim with status "Awaiting Review" may be put on hold individually by going to the Claim Profile and clicking the Hold button in Claim Item Profile. Upon clicking Hold, the Hold Reason dropdown will appear, select the appropriate reason, and click the Confirm button to move forward.
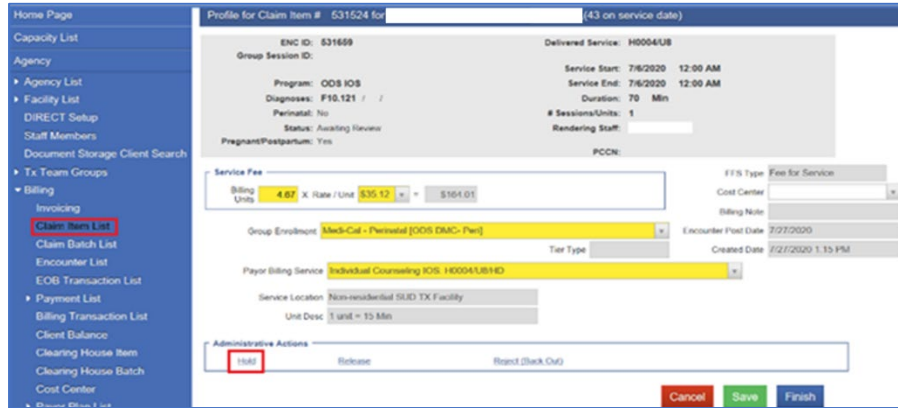
3. The delay reason fields: Delay Reason Code, Report Transmission Type, and Attachment Control Number are required on original and replacement claims 180 days after the encounter start date.
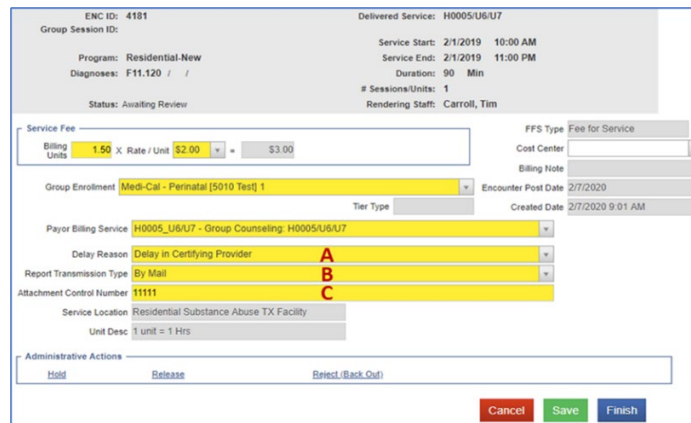
Note: Adding a hold reason to old claims (over 6 months from the date of service) in hold status should not require the delay reason fields.

IV. CLAIM BATCH LISTS AND EXPORTS

The Claim Batch List has been updated with additional columns to provide useful information:

A. The Units column was added to display the total batch units
B. The Claim Batch List export was updated to include a Units column, Agency Name Column, and Facility Name Column.
C. The Service Date column was added to display the start date from the delivered service
D. The Service column has been updated to display all 4 modifiers in the format [Procedure]/[mod1]/[mod2]/[mod3]/[mod4]. Example: S5000/UA/HG
E. A Group Session ID column was added to display the group session ID
F. An Enc ID column was added to display the encounter ID
G. The Claim Item List for Batch Export will include the Billing Units, Rendering staff name, Adjudication status, Group session ID, and Enc ID

Note: Make sure to click the Export hyperlink to view the full data.

V. EOB TRANSACTION LIST

The Medi-Cal payment and denial transactions can be viewed in SanWITS Billing folder -> EOB Transaction List. Make sure you logged in to your Agency and Facility location to access this feature.

The EOB Transaction List has been updated with additional fields to provide additional information. The following fields were added:

A.   Subscriber #
B.   Facility
C.   Unique Client Number
D.   Aid Code
E.   Service Date
F.   Procedure Code

G. Payment Date
H. Claim Item #
I. PCCN
J. Claim Item # column
K. Procedure column
L. Remarks column

Note: The remarks column tells you the claim denial code or denial reason from the State.

VI. CLAIM HISTORY SCREEN

The Claim History Screen has been updated with a Remarks column on the EOB Transaction List. To view the billing history, click the Billing Transaction List under Billing. The Remarks column will display any remarks for the claim from the 835 file (a.k.a. Remittance Advice). Also, there may not be remarks when the claim is paid in full.

VII. ENCOUNTER END DATE

This enhancement is for OTP Methadone service. Methadone encounters may span the entire month. Since the end date is not required on consecutive days services, OTP providers may sometimes forget to enter it. The resulting 837P (claim file) has a mismatch between the dates spanned and the total billing units. This enhancement will require an encounter end date when the service is consecutive.

A. There is an "End Date Required at RTB" indicator added on the service profile. RTB means Release to Billing.
B. When the "Date Span Allowed" indicator = "Yes" the "End Date Required at RTB" will be a dark yellow required field. Otherwise, the field is hidden and null.
C. The encounter end date will be optional for save when the "End Date Required" indicator = yes for the selected service.
D. There is an existing business rule which throws an error when the units do not equal the [end date] – [start date].

VIII. CLIENT INTAKE BUSINESS RULES (RELATED TO PGE)

1. When a client is created with the Contact Benefit Type = Medi-Cal, there should be a corresponding Medi-Cal PGE. The user should create the intake from the contact profile and then enter a Medi-Cal PGE. In addition, users should not be able to enter multiple PGEs for the same plan. These client intake business rules will help limit the mistakes made on the screen below. When Benefit Type "Medi-Cal" is selected, a message will show, *"A Med-Cal Payor Group Enrollment should be entered after entering the Intake."*

2. There is a client intake business rule. When the client contact benefit type = Medi-Cal and there is no active payor group enrollment (PGE/CGE) with Payor Type = Medicaid: Throw warning message at save:

   A. "The contact benefit type is Medi-Cal, but the Medi-Cal Payor Group Enrollment has not been entered." The same message should appear on the activity list when user clicks Finish.

   B. "Enter Medi-Cal Payor Group Enrollment". The action is visible when the client   contact benefit type = Medi-Cal and there is no active payor group enrollment (PGE/CGE) with Payor Type = Medicaid. Otherwise the action is invisible.

   Upon selecting the "Enter Medi-Cal Payor Group Enrollment" action, navigate to the Payor Group Enrollment (PGE/CGE) and insert a Benefit Plan Enrollment record.

3. There is a Benefit Plan PGE business rule. An error message "There is an existing payor group enrollment for this period" on benefit plan enrollment has been inserted when the coverage dates overlap an existing record for the same Payor-Type. This will help the programs in preventing any duplicate or overlapping PGEs.

IX. AGENCY/BILLING/ENCOUNTER LIST

The Encounter List has been updated with additional search criteria and columns to provide more information:

A. There is a "Billable" search criterion added
B. The Medi-Cal Billable column will have a checkbox visible for records "Not Released" and Billable = Yes
C. The Bill column was changed to Medi-Cal Billable
D. The Export has been updated to show the changes in column names

X. DISALLOWANCE FIELD ON ENCOUNTER PROFILE

The Encounter Profile has been updated to allow for disallowance and prevent the encounter from being billed. The new disallowed indicator will be visible and optional, regardless of the claim status and will default to No. When the disallowed indicator is Yes, there will be a Disallowance reason that appears under the service field. Click the dropdown arrow to view the selections. The Disallowance Reason field will be a dark yellow required field. Otherwise, this field is hidden and not required.

These changes or enhancements will be included in the revised DMC-ODS Providers Billing Manual. Please contact us at ADSBillingUnit.HHSA@sdcounty.ca.gov if you have any comments or questions.