

RELEASING OTP SERVICES TO MEDICARE RISK OHC AND PRINTING CMS-1500 FORM IN SANWITS

Please follow this p sheet if you are releasing encounters for a client with dual coverage (Medicare Part C as primary) and Medi-Cal as the secondary insurance.

- Medicare Part C (Medicare Risk or Medicare Advantage insurances). OTP providers are required to bill Medicare and Medicare Risk insurances.
- OTP providers should contact the County Billing Unit to inform us of any claims that was billed and denied or parally paid by Medicare Part C. Proof of billing or Explanaon of Benefits is required.

Steps in SanWITS:

1. Log into SanWITS.
2. Go to your Agency and Facility.
3. Go to Client List -> Enter First Name and Last Name -> Click Go -> click Client Profile.
4. Go to Payor Group Enrollment (PGE). Click Add Benefit Plan Enrollment.



5. Select Payor-Type and Plan-Group.

Payor-Type: Group Insurance

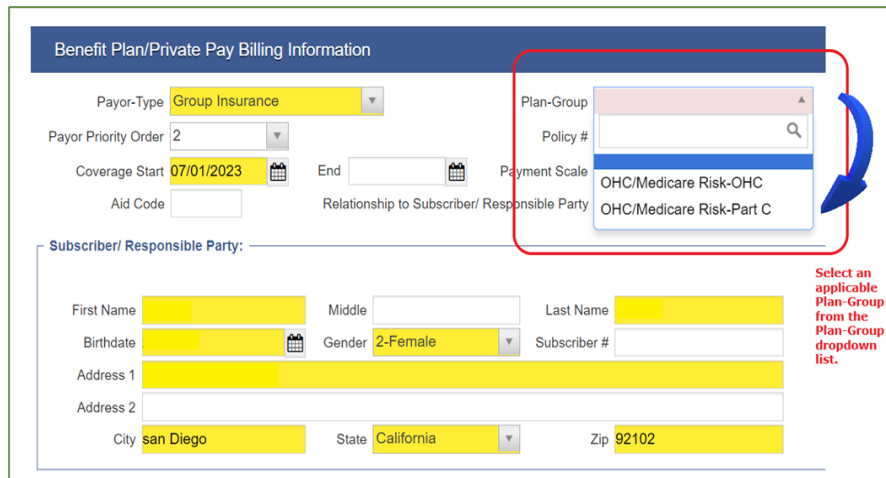
Plan-Group: Please select the appropriate Plan-Group:

OHC/Medicare Risk - Part C: select this option if the client has Medicare Risk/Medicare Part C coverage. If the provider can obtain a copy of the client's insurance card, please enter the insurance policy number in the Payor Group Enrollment's Policy # field.

Policy #: Enter the OHC or Medicare Risk/Part C policy # when available.

Subscriber #: Not a required field. Enter 000 if not available.

- Complete the rest of the required fields.
- Please add the Benefit Plan 'ODS-DMC Non-Peri' or 'ODS-DMC Peri' for DMC billable services.



Benefit Plan/Private Pay Billing Information

Payor-Type: Group Insurance

Payor Priority Order: 2

Coverage Start: 07/01/2023

Aid Code: []

Relationship to Subscriber/ Responsible Party: []

Subscriber/ Responsible Party:

First Name: [] Middle: [] Last Name: []

Birthdate: [] Gender: 2-Female

Address 1: []

Address 2: []

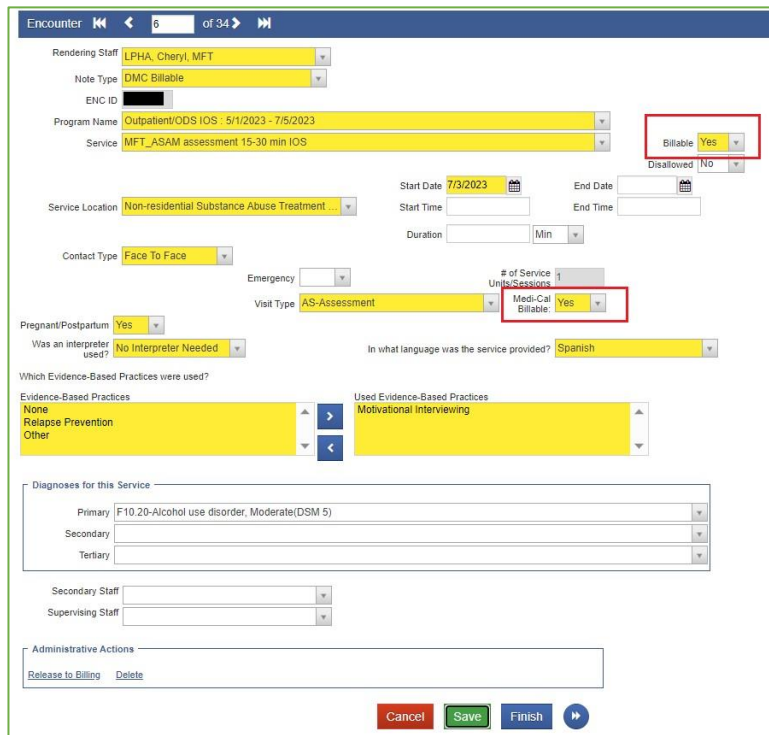
City: san Diego State: California Zip: 92102

Plan-Group dropdown options: OHC/Medicare Risk-OHC, OHC/Medicare Risk-Part C

Select an applicable Plan-Group from the Plan-Group dropdown list.

6. Go to Encounters (OTP services). Click Release to Billing.

Note: To release billing, the Medi-Cal Billable box must have a 'Yes' response.



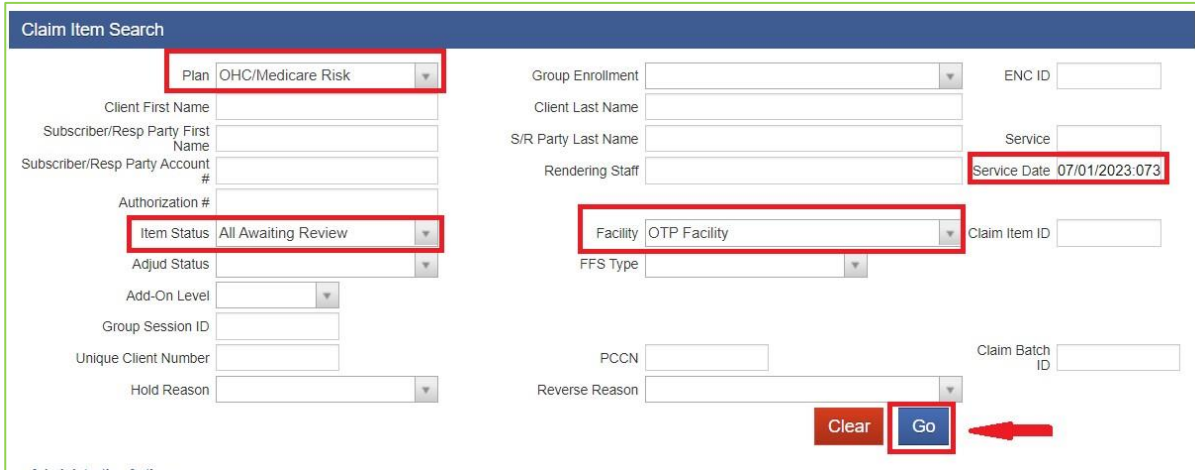
7. Select the appropriate group enrollment to bill on the Client Group Enrollment screen.

- You will select the Part C [OHC/Medicare Risk] if the client's primary plan is a Part C Medicare.



8. Click Finish.

9. Go to Claim Item List. Select the Plan “**OHC/Medicare Risk**” from the dropdown list. Set the Item Status to “**All Awaiting Review**”. Select your Facility. Enter the Service Date (e.g., 07012023:07312023). Click Go.



The screenshot shows the 'Claim Item Search' form. The following fields are highlighted with red boxes:

- Plan: OHC/Medicare Risk
- Item Status: All Awaiting Review
- Facility: OTP Facility
- Service Date: 07/01/2023:0731

At the bottom right, there are 'Clear' and 'Go' buttons. A red arrow points to the 'Go' button.

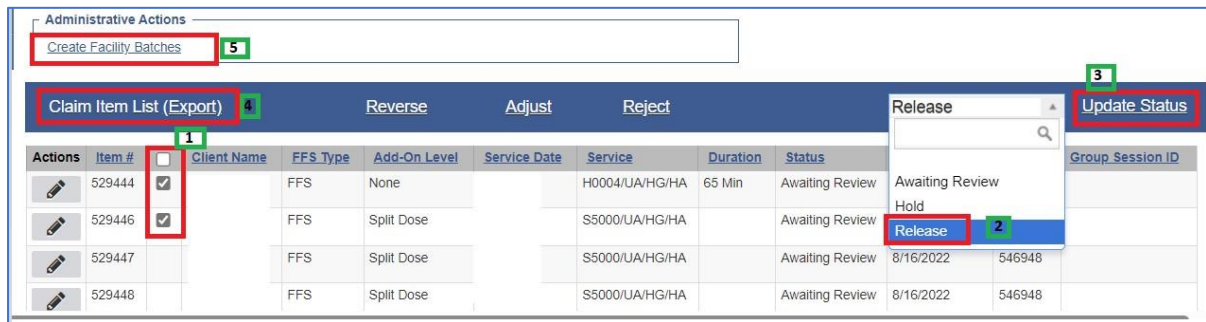
Notes:

- Remember not to leave any claim items in released status if you are not ready to batch. If you are not yet billing DMC and waiting for the primary insurance’s Explanation of Benefits (EOB), you can put the Medicare Risk claims in 'hold' status.
- It's important to check the OPTUM BHS Resources, Billing folder for guidelines on holding OHC claims for more than 90 days.

10. Select the claims in awaiting review status that you need to bill by clicking the box next to the Item # column. From the dropdown menu on the right, select ‘Release’, then click the Update Status hyperlink.

Note: To guarantee billing accuracy, providers are required to review the claim item list before batching claims.

11. Once the claim items are in the 'released' status, click Create Facility Batches.



Administrative Actions

Create Facility Batches **5**

Claim Item List (Export) **4** Reverse Adjust Reject

Release **3** Update Status

Actions	Item #	<input type="checkbox"/>	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Group Session ID
	529444	<input checked="" type="checkbox"/>		FFS	None		H0004/UA/HG/HA	65 Min	Awaiting Review	
	529446	<input checked="" type="checkbox"/>		FFS	Split Dose		S5000/UA/HG/HA		Awaiting Review	
	529447	<input type="checkbox"/>		FFS	Split Dose		S5000/UA/HG/HA		Awaiting Review	8/16/2022 546948
	529448	<input type="checkbox"/>		FFS	Split Dose		S5000/UA/HG/HA		Awaiting Review	8/16/2022 546948

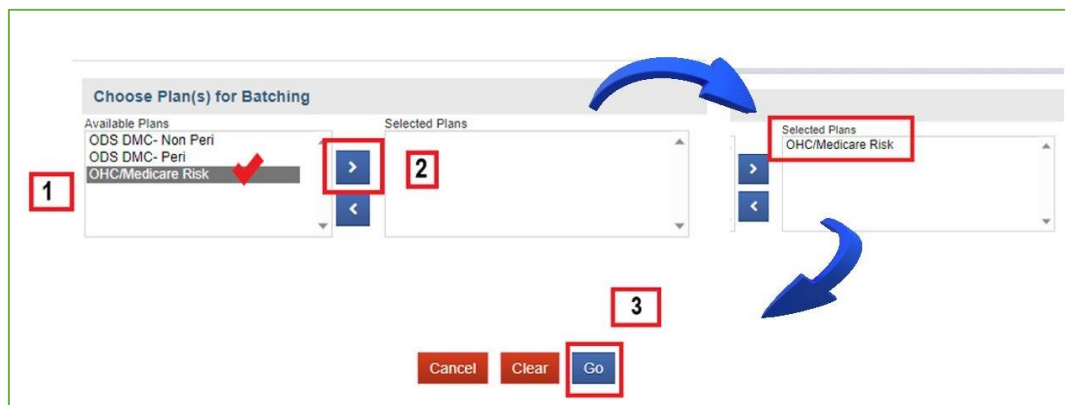
Release dropdown: Awaiting Review, Hold, Release **2**

[Drug Medi-Cal Organized Delivery System \(optumsandiego.com\)](http://optumsandiego.com)

SUD Billing Announcement: Other Health Coverage Rules for Outpatient Providers (msg)	Email announcement regarding OHC Rules	2022-07-14
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- Contact the County Billing Unit immediately if your program has proof of billing but have not received an acceptable response from the insurance company.

12. Choose the appropriate Plan for Batching. Click the right arrow to move it to the Selected Plans box. Click Go.



Choose Plan(s) for Batching

Available Plans

- ODS DMC- Non Peri
- ODS DMC- Peri
- OHC/Medicare Risk **1**

Selected Plans

- OHC/Medicare Risk **2**

Buttons: Cancel, Clear, Go **3**

13. Navigate to the Billing- Claim Batch List screen. Select the Plan Name OHC/Medicare Risk. Click Go. Click on the Acons pencil and from the Profile screen, Release the batch.

Provider Claim Batch List

Plan Name: OHC/Medicare Risk

Billing Form: [Dropdown]

Batch #: [Input]

FFS Type: [Dropdown]

Created Date: [Input]

Transmit Date: [Input]

Status: Awaiting Review

Clear Go

Claim Batch List (Export) Download 837

Actions	Batch #	Status	Batch For	FFS Type	Billing Form	837 Type	Order	Charges	Units	Service Mo/Yr	Created	Transmit	Agency Name	Facility Name
	105716	Released	OHC/Medicare Risk	FFS	CMS-1500	837P	P	\$140.44	1.00	Jul 2023	8/30/2023		MIS Testing Agency	Outpatient

14. In the Provider Claim Batch Profile, click Bill It.

Provider Claim Batch Profile

Batch #: 105716

Batch For: OHC/Medicare Risk

Created By: Saline, Carmen

Updated By: Rothenberger, Amy - WITS Admin Ac

Billing Form: CMS-1500

Order: Primary

Service Month/Year: 7/1/2023

Batch For: \$140.44

Status: Released

Created Date: 8/30/2023 1:31 PM

Updated Date: 8/31/2023 1:31 PM

Transmit Date: [Input]

Ignore Warnings: No

FFS Type: Fee for Service

Errors List (Export)

Batch #	Level	Message	Created

Administrative Actions: Awaiting Review Hold Void **Bill It**

Cancel Save Finish

15. You will be immediately taken to the CMS 1500 print screen. Press the **'No'** button and insert the red and white CMS 1500 form into your designated printer to print. Click Finish.

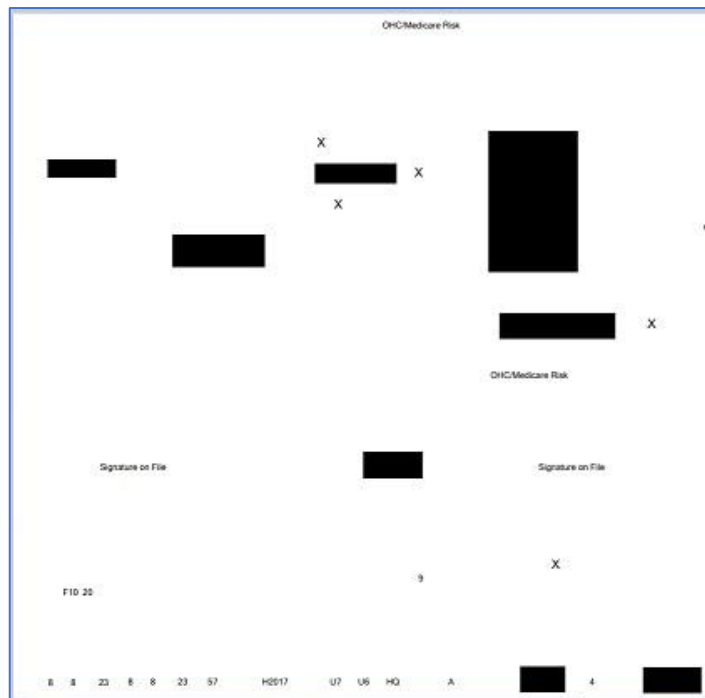
Would you like to print the background image of the CMS 1500 in addition to the data?

**Note: Selecting "No" allows a user to print directly onto a blank 1500 form. You may need to adjust your printer setting to ensure the data lines up with the form properly. This form was designed to print with no scaling and auto rotate and center box not checked.

**The CMS 1500 form is the Health Insurance Claim Form used to bill a private insurance for rendered services.*

Note: Clicking 'Yes' will result in the form printing with claims data. We have found that this printout is not acceptable but can be helpful to enter the data into an OHC billing system if they do accept the form. The CMS 1500 form's print view will be in black and white, with no lines and field titles.

CMS 1500 Print Preview



The screenshot shows a print preview of a CMS 1500 form. The form is mostly blacked out with redaction boxes. There are several 'X' marks scattered across the form, likely indicating where data is missing or where the form is not fully populated. The footer of the form contains the alphanumeric string: B 8 23 8 8 23 57 H817 U7 U6 HQ A [redacted] 4 [redacted].

Actual CMS 1500 Sample

HEALTH INSURANCE CLAIM FORM					
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12					
PICA <input type="checkbox"/>				PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)	
CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input checked="" type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)	
OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER		(For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		CITY	
STATE		8. RESERVED FOR NUCC USE		STATE	
ZIP CODE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
TELEPHONE (Include Area Code)		10. IS PATIENT'S CONDITION RELATED TO:		a. INSURED'S DATE OF BIRTH MM DD YY	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)	
b. RESERVED FOR NUCC USE		PLACE (State)		c. INSURANCE PLAN NAME OR PROGRAM NAME OHC/Medicare Risk	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		SIGNED		DATE	
SIGNED		DATE		SIGNED	

Note: The subscriber number prints in line 1A while the OHC policy number prints in line 11.



- Some insurance (OHC) payers may accept a CMS-1500 form with a black-and-white background, other payers may reject your claims if you do not use the CMS 1500 red/white form. It is not recommended to print the CMS-1500 form in grayscale.
- When using the CMS 1500 red/white ink, make sure your printer setting is correct so the claims data will print properly on the assigned fields.

For questions or comments about this p sheet or process, please contact the County Billing Unit at phone # (619)338-2584 or email us at: ADSBillingUnit.HHSA@sdcounty.ca.gov.

End of Tip Sheet