

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

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

- 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.

II. Review the Payor Group Enrollment screen

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

Actions	Priority	Plan	Group	Subscriber/ Acct#	Subscriber/ Resp Party	Start Date	End Date
	1	ODS DMC- Non Peri	ODS-DMC Non-Peri	012345678A	Client, Test		

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

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.

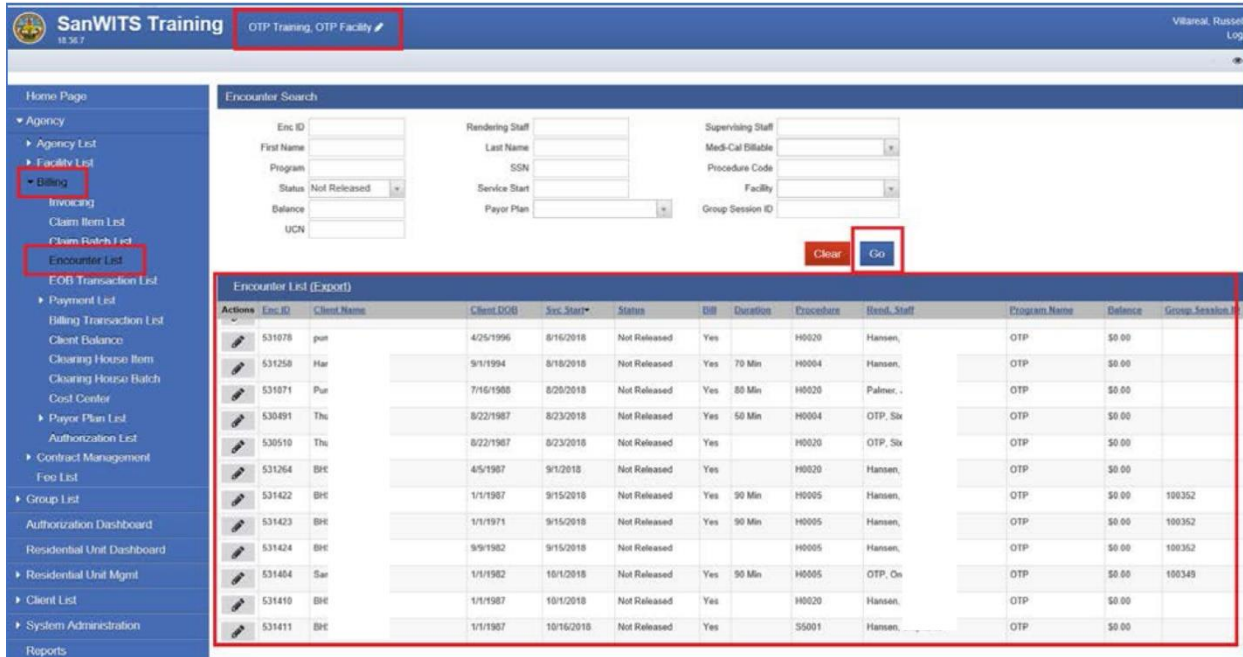
New update:

- 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 usps.com website to verify).

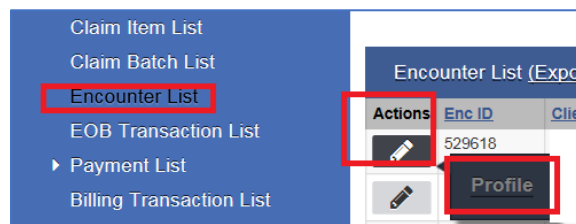
- After reviewing the Payor Group Enrollment screen and no changes is applied, click the Cancel button. Only click the Save button when updates or changes are made on this screen.

III. Review the Encounters screen

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



- 2) Open the **Encounter Profile** of the encounter you need to bill by clicking the Actions button (pencil).



3) Carefully review the Encounter fields

The screenshot displays the SanWITS Billing System interface. On the left is a navigation menu with 'Billing' and 'Encounter List' highlighted. The main form contains the following fields and values:

- Note Type: DMC Billable
- ENC ID: 531411
- Program Name: OTF Facility/OTF : 8/1/2018 -
- Service: Individual Counseling OTP
- Start Date: 10/16/2018
- End Date: 10/18/2018
- Service Location: Non-residential Substance Abuse TX Facility
- Travel Duration: 0 Min
- Documentation Duration: 10 Min
- Session Duration: 60 Min
- Total Duration: 70 Min
- Contact Type: Face To Face
- Emergency:
- Visit Type: AS-Assessment
- Medi-Cal Billable: Yes
- 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
- Diagnoses for this Service:
 - Primary: F11.11-Opioid abuse, in remission(ICD)
 - Secondary:
 - Tertiary:
- Rendering Staff: Hansen, Stephanie
- Supervising Staff:
- Administrative Actions: Release to Billing, Delete

Buttons at the bottom include Cancel, Save, Finish, and a right arrow.

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
- 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:

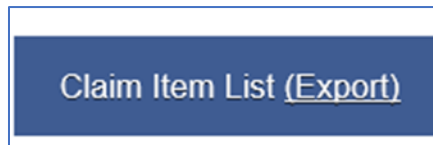
I. Release to Billing

- 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.



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).
- 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.

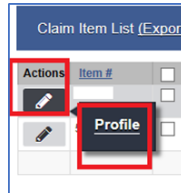
Notes:

- 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 the 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” first to be able to batch them.

Actions	Item #	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date	Charge
	527365	El Cajon, Niyaday	FFS	None	6/11/2018	H0015HG		Awaiting Review	6/11/2018	\$20.00
	527616	Six, Orange	FFS	None	6/19/2018	S5001UA/HG	60 Min	Awaiting Review	6/29/2018	\$15.00
	527625	Five, Green	FFS	None	6/22/2018	S5001UA/HG		Awaiting Review	6/29/2018	\$15.00
	527610	Mouse, Mini	FFS	None	6/26/2018	S5001UA/HG		Awaiting Review	6/26/2018	\$15.00
	527609	Haveagoodday, Deshonda	FFS	None	6/26/2018	S5001UA/HG	60 Min	Awaiting Review	6/26/2018	\$90.00
	527615	Five, Green	FFS	None	6/26/2018	S5001UA/HG	60 Min	Awaiting Review	6/29/2018	\$15.00
	527622	Four, Blue	FFS	None	6/29/2018	S5001UA/HG	60 Min	Awaiting Review	6/29/2018	\$15.00
	527627	One, Plek	FFS	None	6/29/2018	S5001UA/HG	50 Min	Awaiting Review	6/29/2018	\$15.00
	527743	OTP, Ein	FFS	None	6/1/2018	H0020UA/HG		Awaiting Review	6/1/2018	\$20.00
	527780	BHS, One	FFS	None	6/1/2018	H0020UA/HG		Awaiting Review	10/23/2018	\$135.40
	527779	BHS, One	FFS	None	6/1/2018	H0004UA/HG	70 Min	Awaiting Review	10/23/2018	\$156.68
	527775	OTP, BHS	FFS	None	10/1/2018	H0020UA/HG		Awaiting Review	10/23/2018	\$13.54

7) 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 check-mark 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.

The screenshot shows the 'Claim Item Search' interface. On the left is a navigation menu with 'Billing' and 'Claim Item List' highlighted. The main area contains search filters: Plan (Medi-Cal - ADP-Non Perin...), Group Enrollment, ENC ID, Client Name, Charge, Subscriber/Resp Party Name, SIR Party Last Name, Service, Subscriber/Resp Party Account #, Rendering Staff, Service Date, Authorization #, Item Status (All Awaiting Review), Facility (OTP Facility), FFS Type, Add-On Level, and Group Session ID. There are 'Clear' and 'Go' buttons. Below the search area is an 'Administrative Actions' section with a 'Create Agency Batches' link. At the bottom is a table titled 'Claim Item List (Export)' with columns: Actions, Item #, Client Name, FFS Type, Add-On Level, Service Date, Service, Duration, Status, Release Date, and In ID. Two rows are visible, both with status 'Awaiting Review'. A context menu is open over the second row with 'Hold' and 'Release' options.

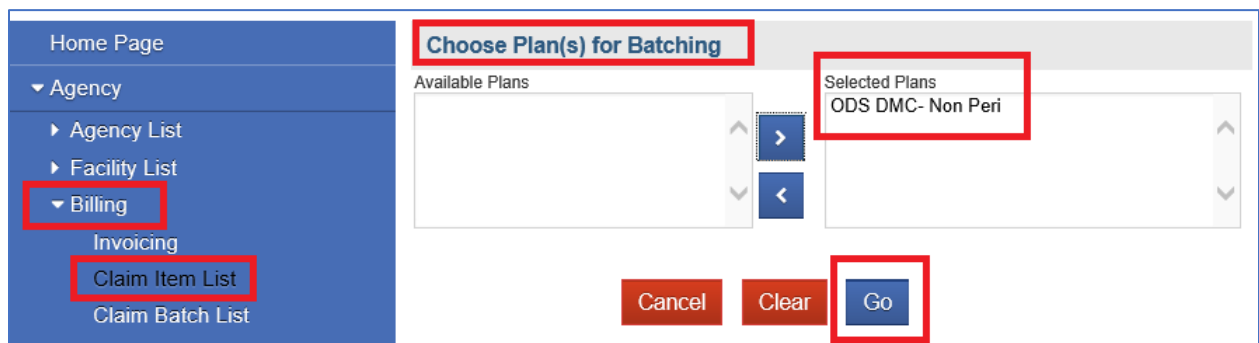
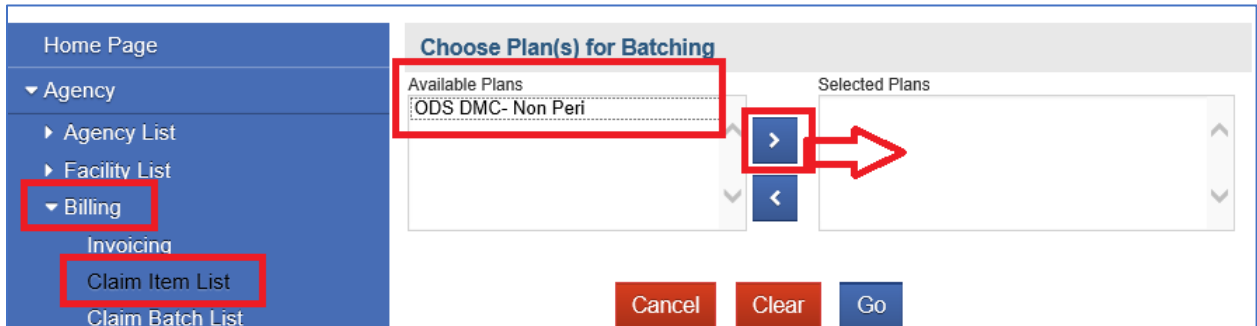
III. Claim Item List - Released Status

- 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 **Claim Batch List**.

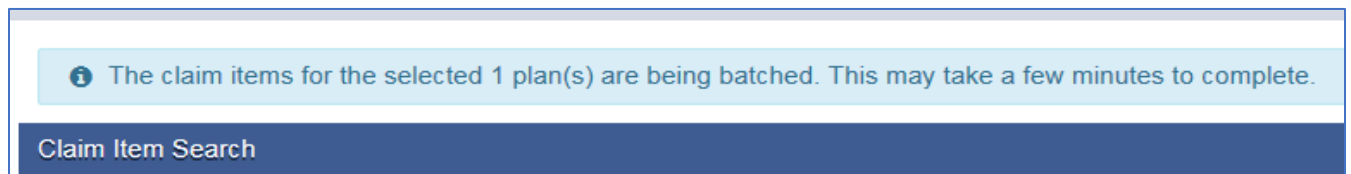
This screenshot shows the 'Claim Item Search' interface after the status change. The search criteria are: Plan (ODS DMC- Non Peri), Group Enrollment, ENC ID, Client Name, Charge, Subscriber/Resp Party Name, SIR Party Last Name, Service, Subscriber/Resp Party Account #, Rendering Staff, Service Date, Authorization #, Item Status (Released), Facility (OTP Facility), FFS Type, Add-On Level, and Group Session ID. There are 'Clear' and 'Go' buttons. Below the search area is an 'Administrative Actions' section with 'Create Agency Batches' and 'Create Facility Batches' links. The table at the bottom shows one row with status 'Released'.

Actions	Item #	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date	Charge	Group Session ID
	527779	BHS, One	FFS	None	8/1/2018	H0004/UA/HG	70 Min	Released	10/23/2018	\$156.68	

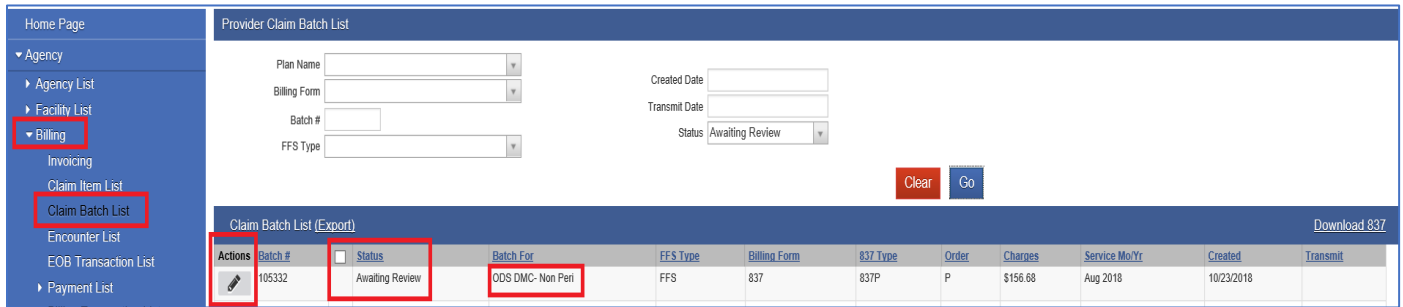
4) Click the Available Plan and the arrow right to move to the Selected Plan.



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.

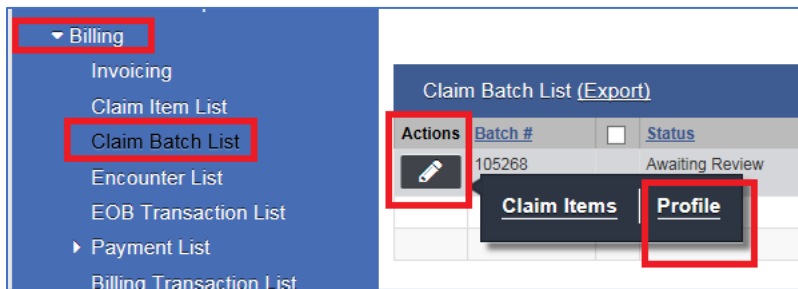


Notes:

- 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

- 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.

The screenshot shows the 'Provider Claim Batch Profile' interface. On the left, a navigation menu includes 'Billing' and 'Claim Batch List', both highlighted with red boxes. The main content area displays the following information:

- Batch #**: 105332 (highlighted in red)
- Batch For**: ODS DMC- Non Peri
- Created By**: User, System
- Updated By**: User, System
- Charge Amount**: \$156.68
- Status**: Awaiting Review
- Created Date**: 10/23/2018 4:11 PM
- Updated Date**: 10/23/2018 4:11 PM
- Transmit Date**: (empty)
- 837 Type**: 837P
- Order**: Primary
- Service Month/Year**: 8/1/2018
- Ignore Warnings**: No
- FFS Type**: Fee for Service
- HIPAA Processing Set**: (empty)
- 837 File Status**: (empty)
- Transmission Message**: (empty)

Below the profile information is an 'Errors List (Export)' table with columns for Batch #, Level, Message, and Created. The table is currently empty.

At the bottom, the 'Administrative Actions' section is highlighted with a red box and contains three links: 'Release' (highlighted in red), 'Hold', and 'Void'. To the right of this section are three buttons: 'Cancel', 'Save' (highlighted in red), and 'Finish'.

5) It will take you to the next screen.

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

- 7) Click Save and Finish.
- 8) Your batch will be received by the Clearing House for processing.
- 9) Email Submission Certification to the billing unit at: ADSBillingUnit.HHSA@sdcounty.ca.gov
- 10) 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.
- 11) 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							
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							
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. As							
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.							
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="padding: 2px;">Printed Name: AUTHORIZED SERVICE PROVIDER</td> </tr> <tr> <td style="width: 50%; padding: 2px;">Signature: AUTHORIZED SERVICE PROVIDER</td> <td style="width: 20%; padding: 2px;">Phone Number ()</td> <td style="width: 30%; padding: 2px;">Date Signed</td> </tr> </table>		Printed Name: AUTHORIZED SERVICE PROVIDER			Signature: AUTHORIZED SERVICE PROVIDER	Phone Number ()	Date Signed
Printed Name: AUTHORIZED SERVICE PROVIDER							
Signature: AUTHORIZED SERVICE PROVIDER	Phone Number ()	Date Signed					
ADP 100186 (Effective 12-31-2009)							

Notes:

- The Billing Unit Administrator 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 providers for further review.

DISCLAIMER:

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