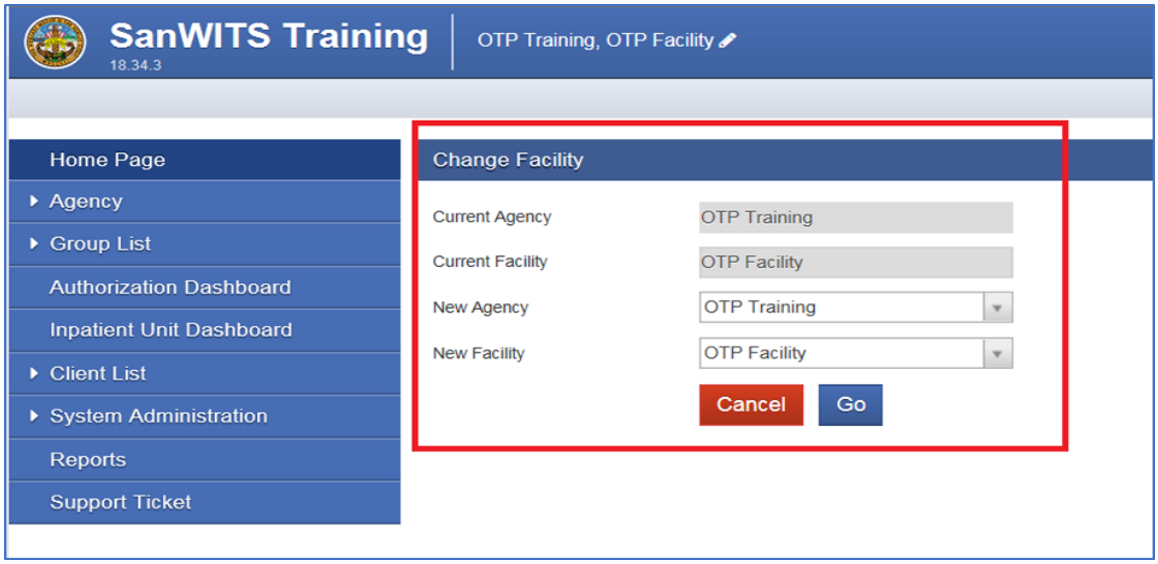
Log in to SanWITS – Enter your Agency and Facility- Click GO



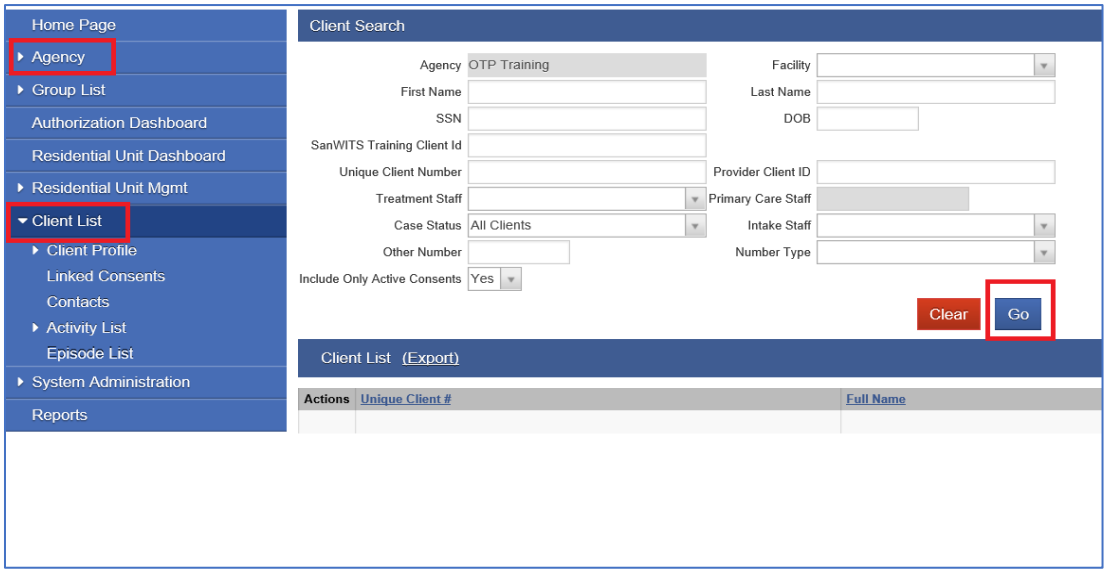
BHS Billing Unit requires all the providers to review the three important screens <u>prior</u> to releasing the encounters to billing.

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.

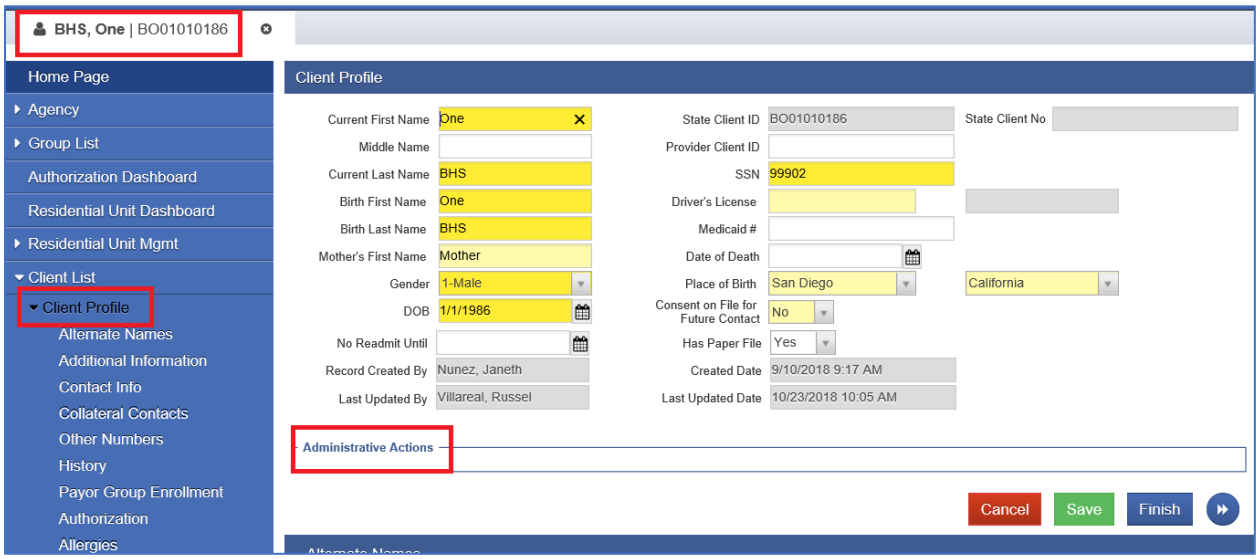
I. Review the <u>Client Profile</u> screen data



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

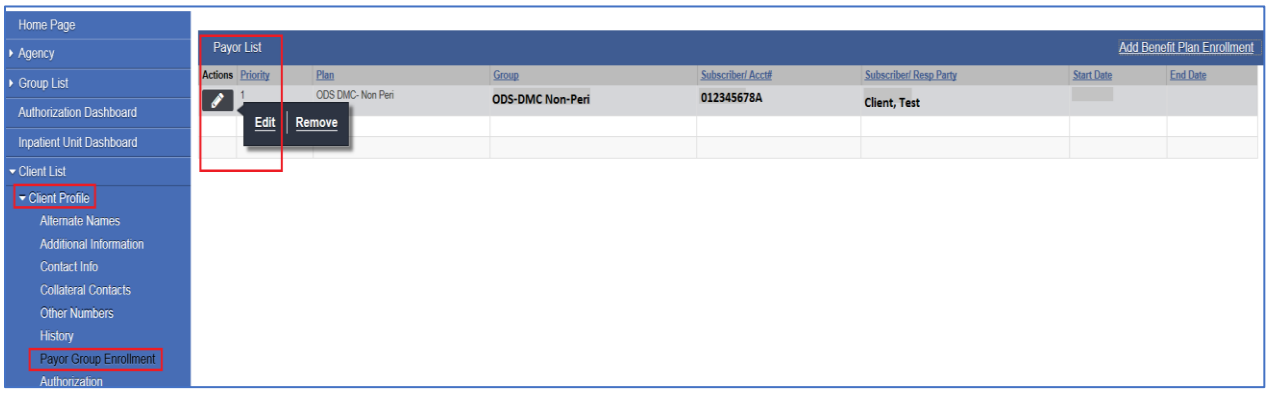
Notes:

- 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.

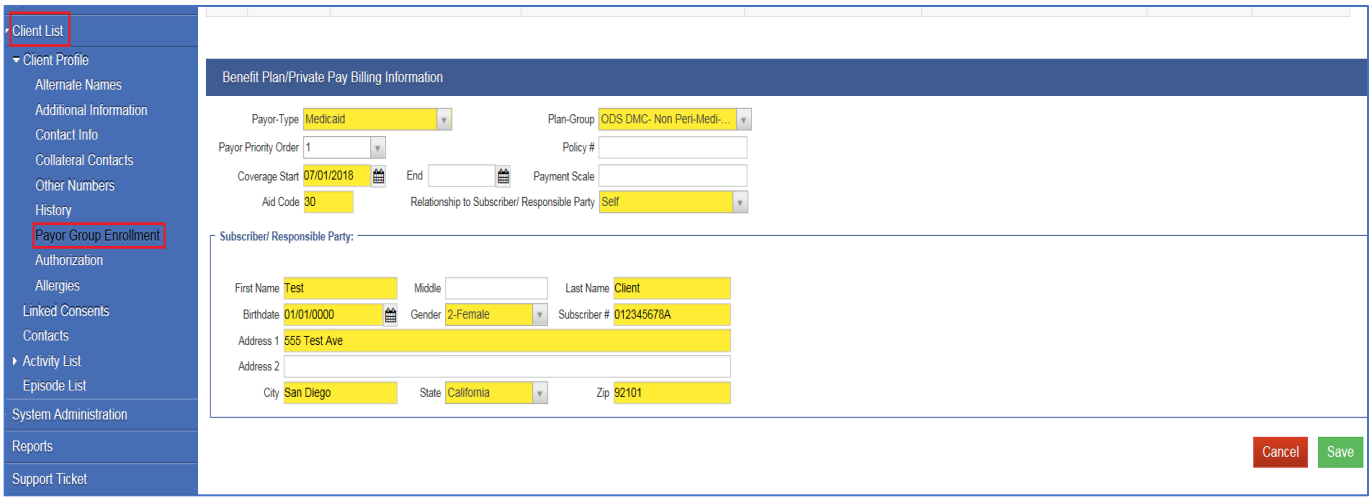


II. Review the Payor Group Enrollment screen

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



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:

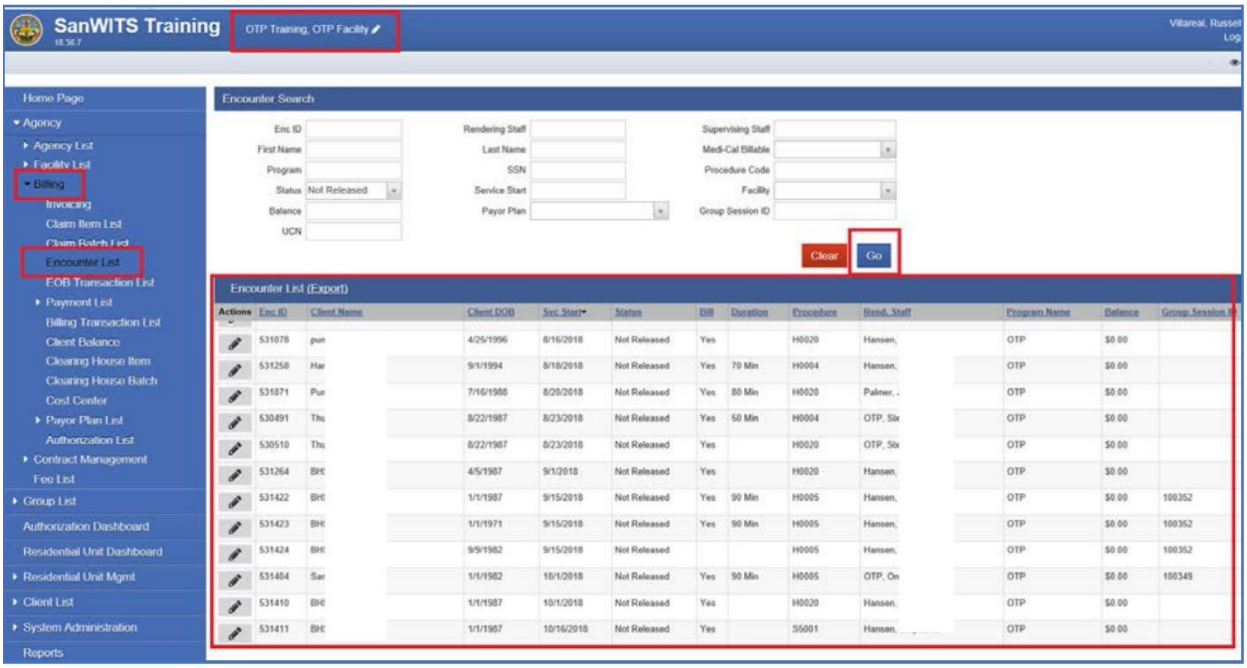
  a. If client falls out of Medi-Cal, please open the current ODS-DMC Non-Peri or Peri benefit plan and terminate it. Use the last day of the month the Medi-Cal policy is effective.

  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).

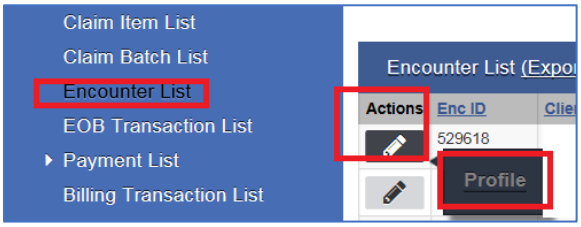
- After reviewing the Payor Group Enrollment screen and no changes is applied, click the Cancel button. Only click the Save button when updates or changes are made on this screen.

III. Review the Encounters screen

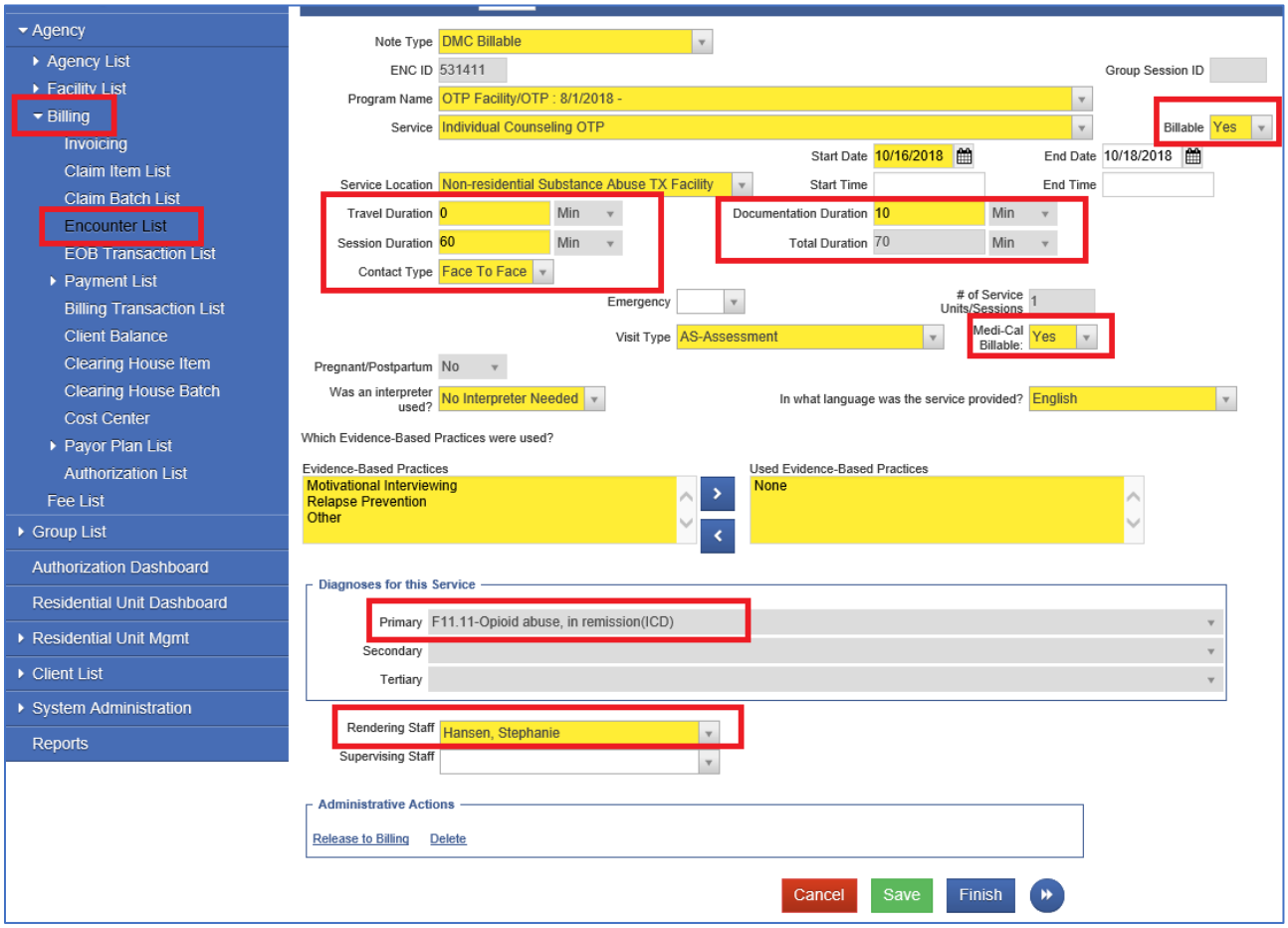
1) On the left-hand side of your screen (blue navigation pane), click **Agency – Billing - Encounter** List.



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



3) Carefully review the Encounter fields



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

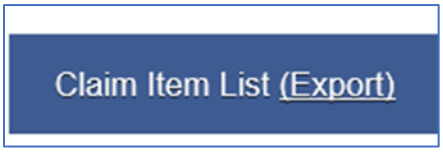
BILLING PROCESS:

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.

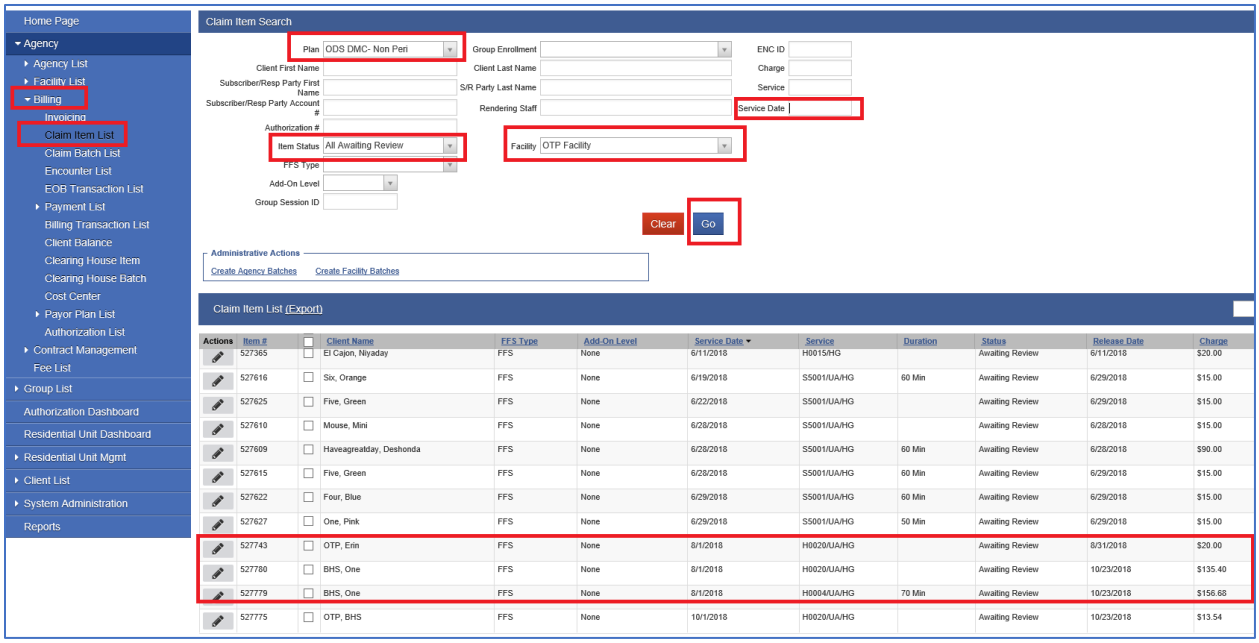


5) Once you click Export, the pop-up box will ask if you want to save or open the file.

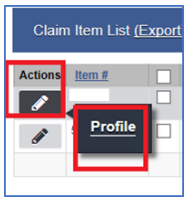
Notes:

- 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.

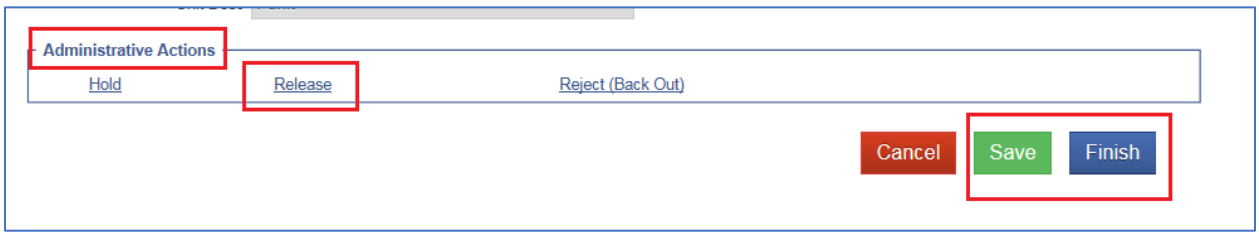
6) After double checking your claims and there's no error found, the claims in Awaiting Review status must be "released" first to be able to batch them.



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.

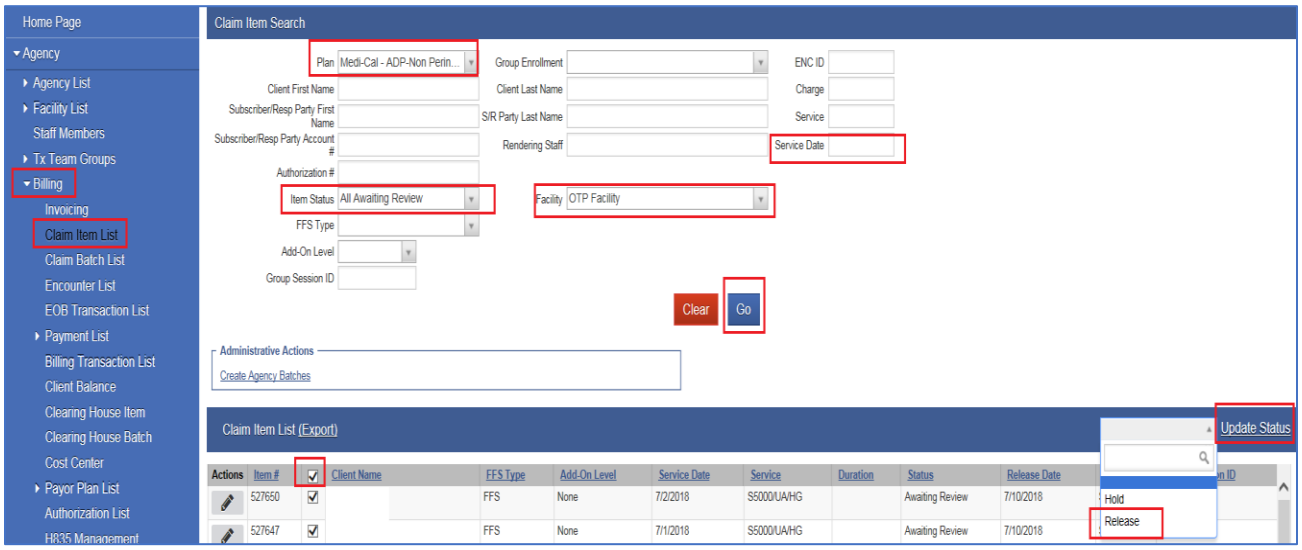


   b. On the Administrative Actions, click <u>Release</u>.



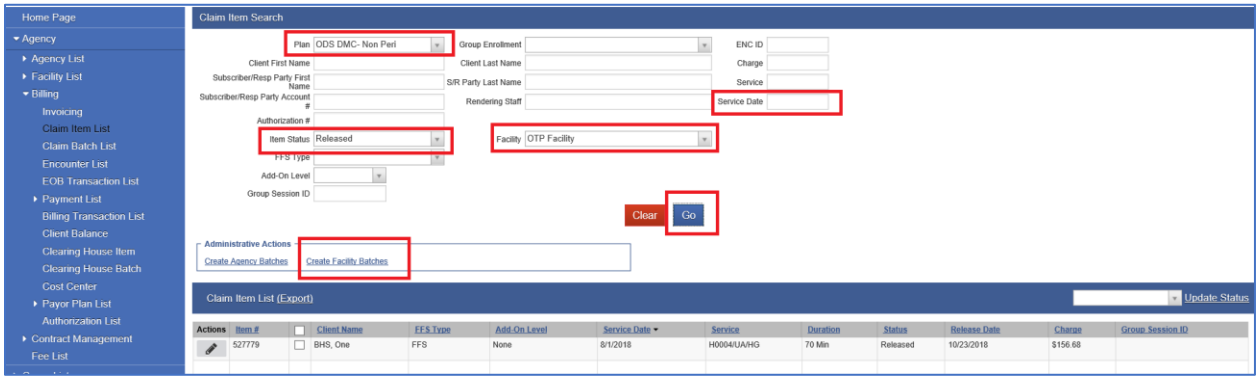
OR

   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 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.

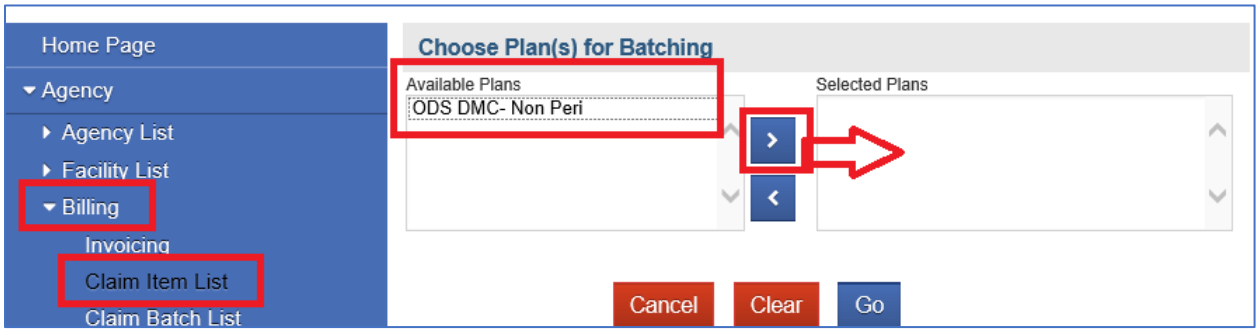


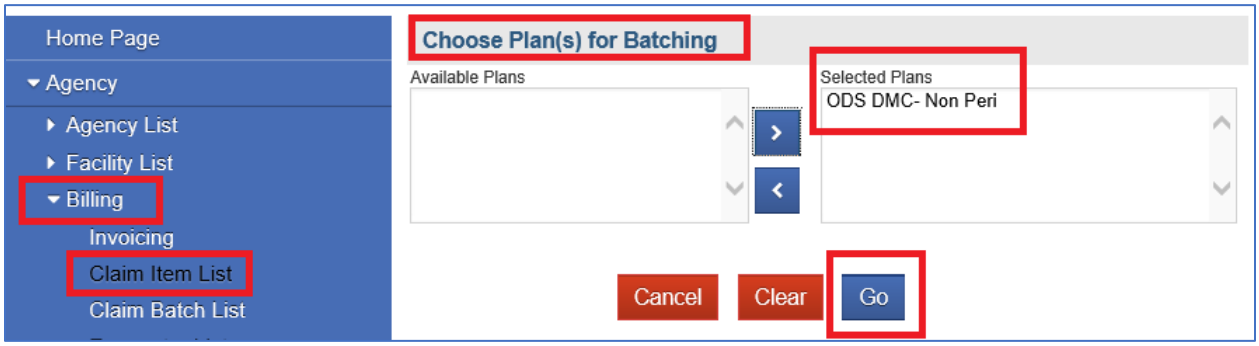
III. Claim Item List - Released Status

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**.

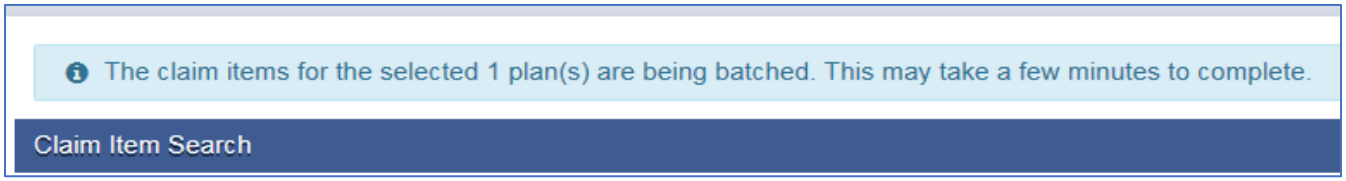


4) Click the Available Plan and the arrow right to move to the Selected Plan.

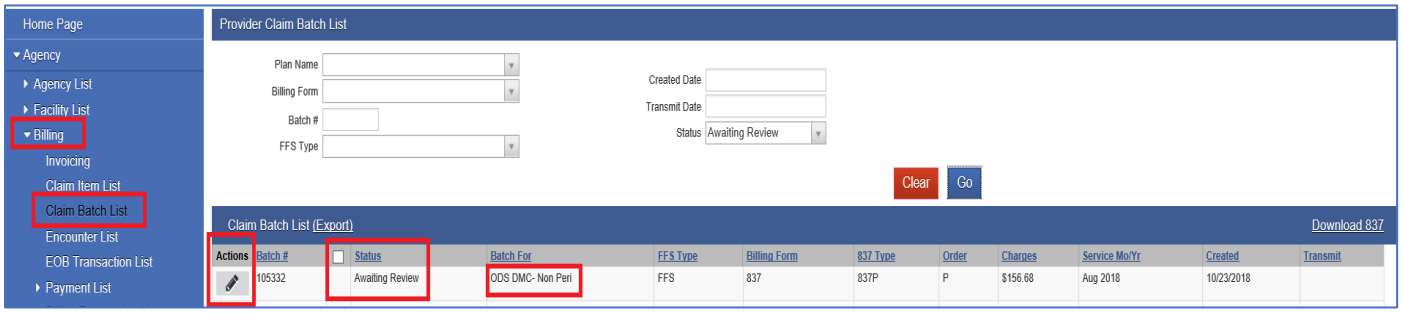




5) Click GO. The blue message will appear on top of your screen -claims are being batched.



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

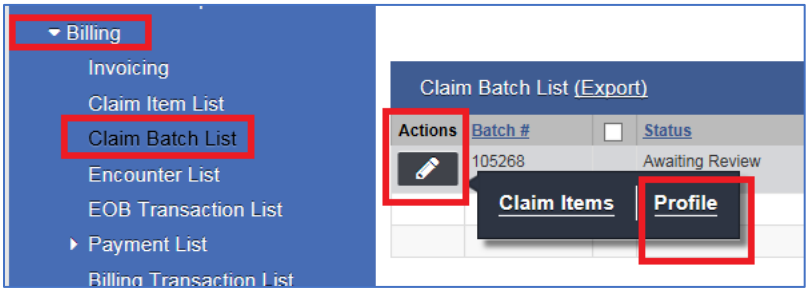


Notes:

- 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.

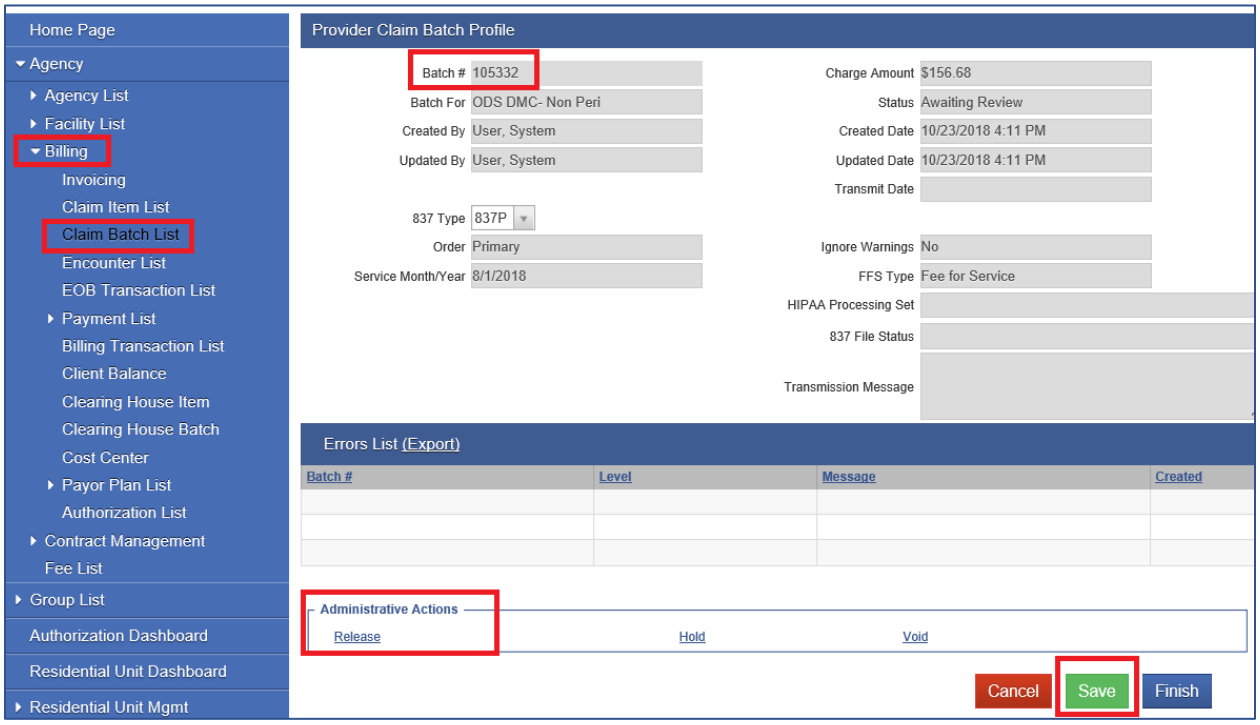
IV. Claim Batch List and Send to Clearing House

1) The Batch will appear if batching is successful.
2) Hover the mouse on the Actions button next to the Batch # then click Profile.

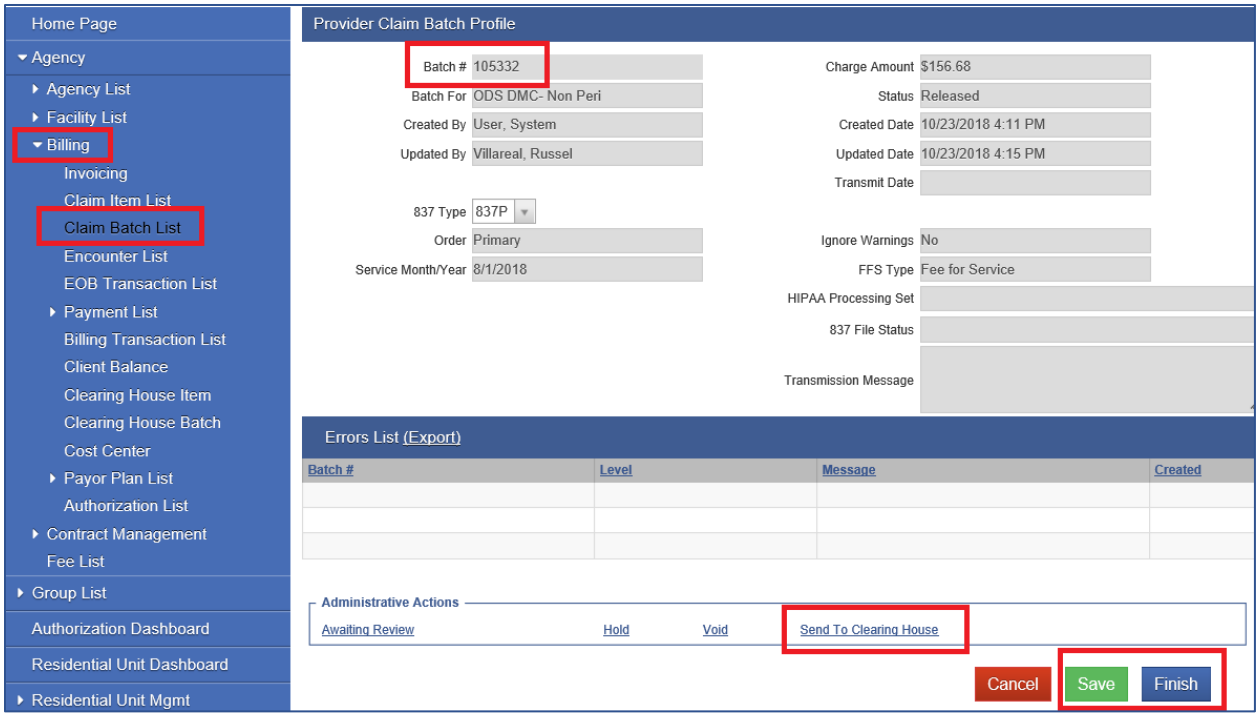


3) On the Claim Batch List Profile, click the Administrative Actions: Release

4) Click Save.



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

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)

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.*