TIP SHEET: New TUOS Summary Report

MANAGEMENT INFORMATION SYSTEMS
SERVICE INTEGRITY CONNECTION

All programs currently run the TUOS (Total Units of Service), Residential Bed Day Claim Summary, and Non-Billable report each month for invoicing. The New TUOS Summary replaces the need for these reports and combines them into a single report that is a complete Total Units of Service. The top portion of the report is created based on claims and the sub report located at the end of the report is encounter based and has the finalized encounters that are disallowed. Users can only view their assigned facilities.

Report Section: This report is broken up into several sections that illustrate different parts of the billing process.

ADJUSTED UNITS							
DMC Billable	County Billable	Justice Override (County Billable)	Out of County (County Billable)	OHC	Medicare	No Valid Benefit Plan	Total Billing Unit Count

Adjusted Units- This is the number of billing units for each billable payor (SanWITS payor group enrollment).

DISALLOWED CLAIMS							
DMC Billable	County Billable	Justice Override (County Billable)	Out of County (County Billable)	OHC	Medicare	No Valid Benefit Plan	Total QM/Provider Disallowed Billed Units

Disallowed Claims- These are claims that were marked as disallowed after the encounter was released to billing

DMC BILLED STATUS							
Awaiting Review	Hold	Released	Batched	Awaiting Adjudication	Approved	Denied	Total DMC

DMC Billed Status- This is the current status of the claims when the report is run. These reports run in real time and there are steps that the providers and MIS billing department completes. This section helps identify what part of the billing process a claim is in. (For detailed descriptions, please review the TUOS Report profile pg 2-5)

DMC HOLD STATUS												
1	2	3	4	5	6	7	8	9	10	11	12	Total DMC Hold

DMC Hold Status- These are claims that were put on hold before batched. Each number represents a Hold Reason that was selected. (For detailed descriptions, please review the TUOS Report profile pg 2-5)

Report Profile for New Total Units of Service (TUOS) Claim Summary	
Report Description	
All programs run the TUOS (Total Units of Service), Residential Bed Day Claim Summary, and Non-Billable report each month for invoicing. This report replaces the need for these reports and will combine these reports into a single report that is a complete Total Units of Service. The top portion of the report is created based on claims. This report includes a sub report located at the end of the report that is encounter based and has the finalized encounters that are disallowed. Lastly, this report has security built in for providers to only see their facility to which they are assigned based on the staff that runs the report.	
Report Filters	
Agency	This filters by the name of the agency that user has access to
Contract #	This filters by the contract number that is entered in SanWITS on the Facility Profile as the Display Name
Facility Name	This filters by the name of the facility that the user has access to
Start Date From	This filters by the encounter start date.
Start Date To	This filters by the start date of the last encounter.
Modality	This filers by the modality defined on the program set-up. For an encounter to be created a client must be enrolled in a program
Service	This filters by the service type (Case Management OS, Group Counseling OTP, etc)
Payor	This filters by the name of the payor. (I.e. County Billable, DMC Billable, etc.)
Perinatal	This filter based on the perinatal indicator from the Client Program Enrollment
Column Name	**Column Description**
Contract #	This is the contract number that is entered in SanWITS on the Facility Profile as the Display Name
Agency	The name of the agency
Facility	The name of the facility
Program Enrollment	This is the program name from program set-up in SanWITS.
Perinatal	Perinatal indicator is entered on a Client Program Enrollment. When this = Yes, an HD modifier is added to the claim at RTB
Service	This is the Description of the Service selected on the Encounter. It is what the end user sees on the encounter screen.

Adjusted Units	
DMC Billable	This is the number of units for this payor group type
County Billable	This is the number of units for this payor group type
Justice Override (County Billable)	This is the number of units for this payor group type
Out of County (County Billable)	This is the number of units for this payor group type
OHC	This is the number of units for this payor group type
Medicare	This is the number of units for this payor group type
No Valid Benefit Plan	This is the number of units for a client that does not have any payor group assigned.
Total Billing Unit Count	The total number of billing units on a claim
Disallowed Claims	
DMC Billable	This is the number of units for this payor group type
County Billable	This is the number of units for this payor group type
Justice Override (County Billable)	This is the number of units for this payor group type
Out of County (County Billable)	This is the number of units for this payor group type
OHC	This is the number of units for this payor group type
Medicare	This is the number of units for this payor group type
No Valid Benefit Plan	This is the number of units for a client that does not have any payor group assigned.
Total QM/Provider Disallowed Billed Units	This is the total number of units marked as disallowed for each payor plan
DMC Billed Status	
Awaiting Review	This is the status of the claims. These claims are in Awaiting Review Status. They have not been released or batched.

Hold	This is the status of the claim. These claims do not have a CH batch and were placed on Hold.
Released	This is the status of the claim. These claims have been released. However, they have not been batched.
Batched	This is the status of the claim. These claims have been placed in a provider batch. However, they have not been sent to the Clearing House.
Awaiting Adjudication	This is the status of the claim. These claims have a CH Batch but have not received a payment.
Approved	This is the status of the claim. These claims have a payment and were approved.
Denied	This is the status of the claim. These claims were denied and have a $0 payment.
Total DMC	This is the total number of DMC units
DMC Hold Status	
1	Out of county clients with MAT and case management services
2	Out of county client
3	Not Medi-Cal eligible
4	Waiting for Medi-Cal eligibility
5	Client has SOC for clearance
6	OHC claims waiting for EOC/EOB/denial
7	Disallowed Res BD claim
8	Justice Override
9	County Billable
10	Waiting for DMC Certification/QM Approval
11	Medi-Medi - Awaiting Medicare EOB (OTP Client w/ Medi-Medi)
12	Other
13	Waiting on State System Update
Total DMC Hold	The total number of DMC units on Hold

Disallowed Sub-report (Finalized Encounters)	
Contract #	This is the contract number that is entered in SanWITS on the Facility Profile as the Display Name
Agency	The name of the agency
Facility	The name of the facility
Program Enrollment	This is the program name from program set-up in SanWITS.
Perinatal	Perinatal indicator is entered on a Client Program Enrollment. When this = Yes, an HD modifier is added to the claim
Service	This is the Description of the Service selected on the Encounter. It is what the end user sees on the encounter screen.
DMC Billable	This is the DMC Billable Units that have been disallowed
County Billable	This is the County Billable Units that have been disallowed
Justice Override (County Billable)	This uses the information from Encounter to predict what the County Billable Billing Unit count would have been for these Encounters if they had not been Disallowed.
Out of County (County Billable)	This uses the information from Encounter to predict what the County Billable Billing Unit count would have been for these Encounters if they had not been Disallowed.
OHC	This uses the information from Encounter to predict what the County Billable Billing Unit count would have been for these Encounters if they had not been Disallowed.
Medicare	This uses the information from Encounter to predict what the County Billable Billing Unit count would have been for these Encounters if they had not been Disallowed.
No Valid Benefit Plan	This uses the information from Encounter to predict what the County Billable Billing Unit count would have been for these Encounters if they had not been Disallowed.
QM/Provider Disallowed Projected Encounter Units	This uses the information from Encounter to predict what the Billing Unit count would have been for these Encounters if they had not been Disallowed.