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

Diagram 1

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.

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**DISCLAIMER:** As we learn more about DMC ODS, the workflow/billing screens are subject to change.
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) From the Client Profile screen, click the Payor Group Enrollment (PGE) tab.

Residential providers must have 2 open or active PGE:
   1. ODS Residential: for government contract (i.e. Residential Bed Day)
   2. ODS-DMC Non-Peri (or Peri): for Medi-Cal billable service (i.e. Case Management).

Note: The Benefit Plan ODS DMC Non-Peri must not be set-up in SanWITS yet if providers are still waiting to be certified and do not have access to Medi-Cal Eligibility verification website. The ODS Residential must be set-up but use the code 99902 as the temporary Subscriber ID #. Please remember to update the Subscriber ID # field from 99902 to the required 9 digits and add the ODS DMC Non-Peri plan as soon as client’s Medi-Cal eligibility is verified, and provider is certified.
2) First, review the ODS Residential Plan by clicking the Actions button then select Edit to open the Plan information.
Notes:

- The Subscriber ID on the Gov’t. Contract Plan defaults to the Client’s Unique ID #. Keep it as it is per MIS.
- The Start Date field must cover the months being billed.
- If correction or update is made, click the Save button. If no changes on this screen, click Cancel.
- 3) Next, review the DMC Plan or ODS-DMC Non-Peri (for ODS-DMC clients from July 2018 onwards).
Notes:

1. The guides in completing the Payor Group Enrollment screen is included in the Organizational Provider Billing Manual.
2. Subscriber ID #: must be 8 numbers plus 1 upper case or capital letter (total of 9 digits).
3. Coverage Start Date: must match the Program Enrollment
4. Ensure the client’s name and DOB in Payor Group Enrollment matches the Medi-Cal eligibility verification report.
5. Coverage End Date: required if client is discharged from the program or aid code has changed from previous month to current month.

New update:

- 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.
- 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).

6. Aid Code field: 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. 06/2018), provider must end the existing Payor Group Enrollment using the last day of the previous month (ex. 06/30/2018) as the End Date. Then, open a new Payor Group Enrollment using the first day of the month (ex. 07/01/2018) that the new aid code is effective.

7. Address 1: must enter the physical address (no PO Box or do not type homeless). If
client is homeless, please use your Agency/Facility address.

8. Address 2 (white field) can be used for Apt. #, etc.

9. Zip Code: use the correct zip code (visit usps.com website to verify).

10. 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 – Activity List – Encounters to view the Encounter List.

![Diagram 7]

**Notes:**
- To view all the encounters, leave the Encounter Status field blank and click Go.
- If you want to view only the Released or Not Released, select the appropriate status from the dropdown then click Go.
- To run an Encounters report, click the **Export** hyperlink next to the Encounter List Title. Open the report using the Microsoft Excel.

2) In this example, I selected to view the “Not Released” encounters. Open the **Encounter Profile** by clicking the Actions/pencil icon.
3) Carefully review the Encounter fields (bright yellow fields and some white and gray fields).

Notes:

- **Note Type field:** select the appropriate type (DMC billable or County Billable). Use DMC Billable if client is Medi-Cal or County Billable if not. Enter the encounters as DMC Billable if client claims to have Medi-Cal/potential Medi-Cal eligible even if the facility is not yet DMC Certified.
- If client is identified with Share of Cost (SOC), the encounter type must be County Billable only for the SOC portion or services used to clear the SOC.
- **Billable field:** **Yes** (if you want to turn the encounter into a claim).
• Medi-Cal Billable: No (if billing for Residential Bed Day service).

*You will only answer Yes on this field if Service being billed is Case Management. Separate SanWITS screens/workflow for case management billing is available.

• Select the appropriate Service Location: Residential for Residential Bed Day and Non-Residential for Case Management.

• Service and Visit Type fields are set-up based on the Agency/Facility contract.

• Primary Diagnosis field must be present. The field is in gray/view only field because you added the diagnosis in the Diagnosis screen within the Admission record. Please do not create Diagnosis from the “Diagnosis List.” Also, use the ICD-10 Master Chart (version 10/2017) provided by BHS Billing Unit to ensure the diagnosis code is billable.

Diagram 10

• Rendering Staff field is defaulted to the SanWITS User/staff entering the encounters. Make sure to update the Rendering Staff field to the appropriate individual provider of service. Also, the Rendering Staff must have a valid NPI set-up by BHS-MIS Support Team on the Staff Members List page (SanWITS).
BILLING PROCESS:

I. Release to Billing

1) After carefully reviewing the client and encounters 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 and continue reviewing and releasing the rest of the encounters.

![Diagram 11](image)

II. After Release to Billing

1) On the navigation pane, click **Agency - Billing – Claim Item List** folder.
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.
6) You can open the file but read the Warning sign before clicking Yes.

![Diagram 14](image)

7) The Excel file will appear like this:

![Diagram 15](image)

**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.

8) 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.

**Note:** Providers have the option to either release the claims individually to review the claim information one more time or to release the claims in bulk/altogether.

a. To release encounter individually, click the pencil icon and click Profile.
• On the Administrative Actions, click **Release**.

**Diagram 17**

OR

b. 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/claims will be selected by the system. It is important to enter the Service Date(s) when creating a batch.

• On the right side of the screen, click the dropdown menu and select Release.

• Click the hyperlink **Update Status**. All claims in awaiting review will be staged to status: **Release**.

**Diagram 18**
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.

Diagram 19
3) Once all your claim items are in ‘released’ status, you can now proceed to batching them. To batch, click the Administrative Actions: Create Facility Batches.

Diagram 20

4) Select the Available Plan (ODS Residential if you are billing for Residential Bed Day) and click the arrow right to move it to the Selected Plan box.

Diagram 21
**Note:** Residential providers billing for Case Management will have another Available Plan which is, ODS-DMC Non-Peri. You will only select this plan if you are billing for Case Management. A separate billing instruction is available for Case Management billing.

**Diagram 22**

![Choose Plan(s) for Batching](image)

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

**Diagram 23**

![The claim items for the selected plan(s) are being batched. This may take a few minutes to complete.](image)
6) From the navigation pane, click the **Claim Batch List** folder. Batch status is defaulted to status: Awaiting Review.

![Diagram 24](image-url)

**Notes:**

- The system creates the batch and the 6-digit batch # automatically. Please list down your batch #.
- If Batch does not appear in more than 10 minutes, change the Status field from Awaiting Review to Batch Processing Error. Click Go.
  **Note:** Commonly, batch error is caused by invalid rendering staff name or incorrect individual 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.

![Diagram 25](image-url)
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 **Bill It**.

**Note:** If you are billing for Case Management, you will not see the Bill It hyperlink. Instead, you will see Send to Clearing House.

7) Once your provider batch is submitted to the County Government Contract folder, email the Submission Certification (ADP 100186 form) to the Billing Unit at: 
   [ADSBillingUnit.HHSA@sdcounty.ca.gov](mailto:ADSBillingUnit.HHSA@sdcounty.ca.gov).
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.

Diagram 27
8) Click Save and Finish.
9) Your batch will be received by the County under Government Contract (Payor Adjudicator) module for processing.
10) County BHS Billing Unit will review the received provider batch and we will determine which claims are County billable and which ones are DMC billable (can be billed to the State/Medi-Cal).
   a. If claims are County billable/payable, no further action is required from the provider.
   b. If claims are DMC billable, BHS Billing Unit will return the DMC claims to providers for reprocessing and batching (for Medi-Cal billing). Please see instructions below on how to batch and bill Medi-Cal claims below.

Provider’s Steps on How to Bill for DMC claims:

1) Residential bed day claims not payable by the County will be rejected by Government Contract (BHS BU) to return the claims to the provider’s SanWITS Agency-Facility location under Claim Item List under status: Released.
2) On the same screen, click the Export hyperlink to run the claim items report. Save the report on your preferred folder to monitor the number of units to be billed to Medi-Cal.

3) Then click the Administrative Actions “Create Agency Batches” to create the DMC provider batch.
4) You will receive a blue message telling you that batch is being created. From the navigation pane, go to **Claim Batch List** folder.

5) The successfully created provider batch will be in Awaiting Review Status.

6) Open the batch profile. Click the Administrative Action: **Send to Clearing House**.

**Diagram 32**

Note: The DMC batching and billing processes are currently being reviewed by WITS vendor (SanWITS developer) for possible enhancement. Changes in DMC billing may occur. BHS Billing Unit will communicate any changes or enhancement in the billing workflow.

7) Submit the ADP100186 or Claim Submission Certification for Provider Batch sent to Clearing House to **ADSBillingUnit.HHSA@sdcounty.ca.gov**.

   **Note:** Every batch submitted to the Government Contract and Clearing House must be accompanied by a completed ADP 100186 form.

8) The BHS Billing Unit Administrator will contact you if errors are detected on the Provider Batch (Medi-Cal).

**POST Billing Processes:**

1) Any claims denied by the State or Medi-Cal will be emailed (encrypted) to providers for further review.

2) Billing Unit will work with you in replacing and rebilling the claims denied in error (i.e. data entry error).

3) If claims are denied by the State correctly (e.g. claims denied because aid code is not DMC billable), please contact the BHS Billing Unit for further instructions.