COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES DRUG MEDI-CAL ORGANIZATIONAL PROVIDERS BILLING MANUAL

Disclaimer: The SUD DMC Billing Manual is a live document and the information contained herein is subject to change as we learn more about DMC ODS.

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I. INTRODUCTION

The County of San Diego Health and Human Services Agency (HHSA) Behavioral Health Services Division oversees the administration of the Drug Medi-Cal (DMC) Substance Use Disorder (SUD) treatment services. The HHSA Financial Support Services Division Behavioral Health Services SUD Billing Unit (BHS-SUD BU) provides support to programs for the claiming and billing of services for Drug Medi-Cal Organized Delivery System providers, billing, reimbursement, and financial training for Perinatal and Non-Perinatal contractors.

The County of San Diego SUD and contract providers utilize the SanWITS system (a web- based application) for data collection, planning, administration, monitoring, billing, and reporting of Substance Use Disorder services and client treatment data.

The widespread use of electronic healthcare transactions and national identifiers are directed by the Health Insurance Portability and Accountability Act (HIPAA) standards. HIPPA regulations aim to improve health care efficiency and safeguard the patient medical records and other sensitive health data. HIPAA also requires that all business transactions conducted electronically through the DHCS Application Portal must use the standard health care transactions, code sets, and identifiers.

BHS BU performs the following electronic transactions through DHCS portal on a regular basis:

- 837P: Professional Healthcare Claims

- 835: Healthcare Remittance Advice

- SR Report: Error Report

- 999: Acknowledgment of submitted transaction

Code sets such as HCPCS (Healthcare Common Procedure Coding System), and ICD- 10 diagnoses codes are used in the electronic transactions.

BHS BU put together this manual to provide standardized DMC processes and SanWITS billing guidelines for the County of San Diego's Substance Use Disorder providers.

II. DMC-ODS SERVICES

All DMC-ODS services must be provided to eligible clients by DMC-ODS counties. The services include a continuum of care based on the American Society of Addiction Medicine (ASAM) criteria. Here are the reimbursable services under the DMC-ODS waiver:

- ASAM OTP Level 1 - Opioid (Narcotic) Treatment Program
- ASAM Level 1 - Outpatient Services
- ASAM Level 2.1 - Intensive Outpatient Treatment Services (IOS)
- ASAM Level 2.5 - Partial Hospitalization Services
- Residential Services
- Recovery Services
- Case Management
- Physician Consultation
- Withdrawal Management (WM)

Please visit the Optum website under **SUDPOH** tab for details on ASAM criteria, ASAM levels, and service descriptions.

III. BILLABLE TIME

What can be included with Service Time:

When attached to a direct service, documentation and travel time can be included.

Travel/Transportation Time – travel time to and from the provider facility and the appropriate community location can be included in the billing for outpatient treatment services. Travel time does not apply to OTP.

Please visit the OPTUM website under Toolbox for information on Transportation and Travel Time Guidelines.

Documentation Time –Documentation is the amount of time spent documenting per client. OTP does not bill for documentation time.

Group Counseling – limited to group size of 2-12 and until further notice one counselor per group.

Group Billing Formula – Total minutes for the group service includes the number of minutes for the group, plus number of minutes for travel/documentation. A progress note should be written for each beneficiary/client.

Formula: Session duration plus Travel duration divided by the total number of clients within a group then add the Documentation time per client. The system should divide by the 15 minute-increment.

IV. MEDICAID AND MEDI-CAL

Medicaid is a federal program established to provide medical benefits to recipients or eligible residents of the State. Medi-Cal is California's Medicaid program which offers a free or low-cost public health insurance to children and adults with limited income and resources. Drug Medi-Cal is a treatment funding source for Medi-Cal eligible recipients who have a SUD. Fees are waived for Medi-Cal eligible beneficiaries receiving DMC/SUD approved services considered medically necessary.

IV-1. MEDI-CAL ELIGIBILITY ACCESS

DMC programs must have access to Medi-Cal eligibility information to verify each client's Medi-Cal eligibility and benefits. Programs are required to verify Medi-Cal eligibility prior to rendering services and verify again prior to Batching claims to Billing each month. To obtain access, each contracted provider must complete and submit the Internet Agreement or Medi-Cal Point of Service (POS) Network to Department of Health Care Services. For detailed instructions on how to obtain the Medi-Cal eligibility verification access, visit the Medi-Cal website https://files.medi-cal.ca.gov/pubsdoco/signup.aspx or contact the Telephone Service Center (TSC) at 1-800-541-5555. You may be asked to provide your NPI or PIN to the operator. If your program is certified and has trouble getting the Medi-Cal eligibility access or PIN, please reach out to Lisa.Loopesko@dhcs.ca.gov or Joshua.Parkhurst@dhcs.ca.gov of DHCS Provider Enrollment Division. You can also call the PAVE Help Desk at (866) 252-1949 if contact persons have changed.

DMC contracted programs billing to Medi-Cal must also have the updated Medi-Cal Aid Code Master Chart to help identify the types of services for which Medi-Cal and Drug Medi-Cal recipients are eligible. The Aid code listing specifies what aid code is eligible to DMC Short/Doyle Medi-Cal services. The **SUD Aid Code Master Chart** can be found in the OPTUM website under

BILLING tab. To go to the Medi-Cal eligibility sample page, please click the **Medi-Cal eligibility examples** link. If the program has any questions regarding the aid codes and if they are billable to DMC, they should contact the Billing Unit.

IV-2. MEDI-CAL CARD

In commemoration of Medi-Cal's 50th anniversary, the Benefits Identification Card (BIC) has been redesigned. The new BIC design, featuring the California's State flower, will be provided to newly eligible recipients and recipients requesting replacement cards.

Providers shall be responsible for verifying the Medi-Cal eligibility of each client for each month of services prior to billing for DMC services for that client. Medi-Cal eligibility verification should be performed prior to rendering service once the program has been granted access to verify Medi-Cal eligibility, in accordance with and as described in the Department of Health Care Services (DHCS) DMC Provider Billing Manual. Additionally, providers shall verify that the person presenting a Medi-Cal card is the recipient to whom the card was issued. Both BIC designs should be accepted by providers.

NEW CA MEDI-CAL CARD

OLD CA MEDI-CAL CARD

IV-3. MEDI-CAL ELIGIBILITY VERIFICATION

Effective June 15, 2020, the Department of Health Care Services (DHCS) recommends that providers update all of their bookmarks and reset their browser cache to access the new Medi-Cal provider website https://www.medi-cal.ca.gov/systemstatus/Sysstat.aspx and to verify eligibility.

Programs must login to the **Transactions** page using their authorized/assigned User ID and password.

You can verify the Medi-Cal eligibility for Single Subscriber or Multiple Subscribers depending on your authorized access. Please have the following information (with asterisk) available:

- **Subscriber ID # :** 9 digits alphanumeric (8 numbers plus 1 capital letter). The Subscriber ID # is also called CIN (Client Index Number) or BIC # (Benefits Identification Card number).

  Note: The program may use the client SSN to substitute the Subscriber ID when verifying Medi-Cal eligibility in case the client is new to the Medi-Cal system and the Subscriber ID is not yet available.

- **Date of Birth :** 2-digit month, 2-digit day, and 4-digit year
- **Service Date :** enter the first day of the month/year of service being billed (e.g. 01/01/2020 for January 2020 services).

  Note: For clients with Hospital Presumptive Eligibility/HPE (e.g. aid code P3), the program may have to enter the actual service date on the Service Date field to verify, as HPE covers partial eligibility or is date specific. Please click or go to Section IV-10, Hospital Presumptive Eligibility/HPE to see the example.

▪ **Issue Date :** must be today's date not the issue date on the Medi- Cal or BIC card.

The eligibility must show full scope Medi-Cal coverage for beneficiaries to be eligible to the full array of DMC-ODS services. Please see eligibility sample on Section IV-10.– Full Scope Medi-Cal.

IV-4. MEDI-CAL TRAFFIC SIGNALS

The Medi-Cal eligibility verification uses signals similar to traffic lights to guide the authorized users on how to read the eligibility report.

Green light: Subscriber is full scope Medi-Cal with no Share-of-Cost or spend down; no Other Health Coverage or Medicare risk policy. Provider should consider the aid code in determining the correct coverage. Some aid codes are for emergency and pregnancy-related services only and are applicable for perinatal services only. In some cases, the light is green, but the coverage is California Children's Services (CCS) only and not Medi-Cal.

Yellow light: Subscriber is eligible for benefits under certain conditions. It serves as an alert if OHC, Medicare-risk coverage, or Share of Cost is present.

In some cases, yellow light appears on straight Medi-Cal client with PHP Health Plan with a note to call the Medi-Cal's 1-800 or 619 phone number indicated on the eligibility report. This means that client's OHC benefits are assigned to Medi-Cal and services should be billed straight to Medi-Cal. Yellow light also appears for clients with Medi- Cal and private insurance with dental or vision or Rx benefits only.

Red light: Client has no Medi-Cal eligibility or the staff verifying the eligibility entered an incomplete or invalid Medi-Cal information. Program should double-check if data entry error is causing the red light. Verify the eligibility one more time.

IV-5. MEDI-CAL SOC (SHARE OF COST)

Drug Medi-Cal clients cannot be charged any fees, except for share of cost. Clients shall not be refused any services based on race/ethnicity, disability, culture, religion, gender, sexual orientation, or the inability to pay. Some people who do not meet the low-income requirement will qualify for Medi-Cal with a Share of Cost (SOC). Please see sample SOC screenshot on Section IV-10. - Client with Share of Cost (SOC).

Medi-Cal offers health care coverage to individuals and families whose income exceeds the maximum allowable by requiring these beneficiaries to contribute to their health care by paying a share of the cost for the services they receive. Share of Cost is a term that refers to the amount of health care expenses a client must accumulate each month before Medi-Cal begins to offer assistance. Once a client's health care expenses reach a predetermined amount, Medi-Cal will pay for any additional covered expenses for that month.

Share of Cost is an amount that is owed to the provider of health care services, not to the State. "Share of Cost" requires beneficiaries to take full responsibility for health care expenses up to a predetermined amount. Share of Cost is not a premium; it is an amount that a client is financially responsible for each month in which Medi- Cal assistance for health care expenses is needed. The amount of the Medi-Cal Share of Cost is determined by the Department of Social Services. Programs must provide the Billing Unit with a list of each SOC client every month with the amount paid to the program. The Billing Unit will apply payments made by the client and or services reimbursed by BHS Admin in the DHCS Medi-Cal eligibility site up to the amount of SOC. Once the SOC has been met for the month, all subsequent services can be billed to Medi-Cal. At the time the client is determined to have SOC, the provider staff must offer payment plans to the client unless the client can pay the full SOC. Upon reaching the agreed amount, the client must sign the agreement form containing the total amount owed, installment amount, and the payment due date. Please note that a SOC should not be collected until the client received a service and there is a cost associated with the service. Notify the client of the SOC on the first visit of the month, check for SOC on all subsequent visits to determine the amount of SOC that needs to be collected. If the client cannot afford neither the SOC nor the installment amount, the provider staff shall work with the client to determine the best solution to meeting the SOC. Provider must not collect a SOC that exceeds the amount of service provided. If SOC is higher than the cost of service, then the provider must only collect the service amount. When the programs collect the SOC each month, the DMC Share of Cost Payment Sheet (a.k.a. SOC Tracking form) shall be completed by programs and mailed to ADSBillingUnit.HHSA@sdcounty.ca.gov accompanied by the latest Medi-Cal eligibility information from the Medi-Cal website that identifies the SOC for each month and year of service. These documents should be submitted to

the Billing Unit by the 10th of the following month to coincide with monthly claims or at the same time the program is batching their monthly billing.

Note: Before collecting any SOC or the SOC installment amount, the provider staff must login to https://www.medi-cal.ca.gov/Eligibility/Login.asp and check first the SOC status to ensure there is an amount due or if the amount has already been paid or cleared by other sources.

In case the client pays the full SOC prior to the end of the month, the program shall submit the documents to BHS-SUD Billing Unit as soon as possible for SOC clearance and to allow the client to receive Medi-Cal benefits without paying for other services outside of SUD within that month. Please do not send any money or check to the Billing Unit.

Once this information is received from the program, SUD Billing Unit will perform or complete the SOC clearing in the Medi-Cal website and in SanWITS. This will prevent the program from batching any claims that are used to clear the SOC. The Billing Unit will email the program once the SOC is cleared identifying what services were used to clear the SOC. Then, the Billing Unit will batch and submit the DMC billable claims to the Clearing House for further review and submit to DMC. The SOC collected from the client should be reported on the monthly invoice provided to the BHS invoicing staff or email your questions to BHS-Claims.HHSA@sdcounty.ca.gov.

For more information about the SOC workflow and forms, please visit the OPTUM website under **COMMUNICATIONS** tab to review the Information Notice -Share of Cost Process and to learn more about the Drug Medi-Cal Organized Delivery System Process for Share of Cost (SOC) and the SOC forms and requirements.

IV-6. MEDI-MEDI COVERAGE (CLIENTS WITH MEDI-CAL AND MEDICARE)

Outpatient and Residential programs can bill Medi-Medi directly to Medi-Cal. As of January 1, 2020, Medicare will be the primary payer for Medicare-enrolled Opioid Treatment Programs (OTP) providing Opioid Use Disorder treatment services to Medi-Medi beneficiaries (those enrolled in both Medicare and Medicaid). OTP programs should bill Medicare directly and or contract with the Medicare Advantage Plan. Once the Explanation of Benefits (EOB) is obtained, program should contact the Billing Unit to determine if any unpaid services or balance can be billed to Medi-Cal. If Medicare rate is higher, there is no need to cross to Medi-Cal. If an OTP program billed Medi-Cal and received payments while waiting on Medicare certification and billed Medicare once certified and received payments for the same dates of service, the program should submit the recoupment form (a.k.a. Payment Recovery Form) found in Optum website under **Billing** tab to BHS-SUD Billing Unit so that the services can be voided and payments returned to Medi-Cal. Please see Medi-Medi sample on Section IV-10.

> **Note:** The Medicare (Part B) is currently being reviewed by FEI and BHS. It will be setup in SanWITS, and tip sheets will be developed and posted on the Optum website as soon as it is approved.

IV-7. LTC (LONG TERM CARE)

LTC aid codes are restricted to NTP/OTP services only. Programs must clarify with the client if the Medi-Cal eligibility verification response showing LTC aid code is correct.

Sample LTC aid codes: 13, 23, 63

> **Note:** If client is no longer at the LTC facility, the program should refer the client to contact Medi-Cal to have the aid code updated to a regular DMC eligible aid code. LTC aid code billed to DMC will be denied.

IV-8. YOUNG ADULT EXPANSION ELIGIBILITY

In addition to SB75, children 19 and under, the state has added a new age category. According to the new California law effective January 1, 2020, full scope Medi-Cal will be given to young adult population between the ages of 19 through 25 regardless of their immigration status. To read more about the Young Adult Expansion Eligibility, please visit:

https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/YoungAdultExp.aspx

IV-9. COUNTY OF RESPONSIBILITY (OUT OF COUNTY)

All Counties are responsible in providing DMC services to all beneficiaries residing within that county. Each county has its assigned County Code (2 digits numeric or alphanumeric); San Diego's County code is 37. The Subscriber County is reported on the Medi-Cal eligibility transaction.

In July 2017 Information Notice 17-036 discussed the projected transitions on the County of Responsibility.

"This Information Notice clarifies that Counties are expected to establish contractual arrangements, when necessary, to ensure that the county of residence is financially responsible to pay for any DMC entitlement services being provided to its residents by another county given its BHS allocation for this purpose." This does not include EPSDT clients that are under 21 years of age."

Drug Medi-Cal claims adjudication has transitioned from county of service to the county of responsibility. Non-resident Medi-Cal recipients or clients will be required to change their residency to San Diego County to continue receiving DMC services. Clients who intend to reside in San Diego County can receive services in San Diego County with Out-of-County (OOC) DMC while they are waiting on their Medi-Cal to be updated with San Diego County DMC. The County of San Diego will reimburse SUD providers while waiting on the client to change their Medi-Cal to San Diego County for the month of admit and 60 days beginning with the first of the following month that the client started receiving services. If the client does not intend to reside or transfer their Medi-Cal to San Diego County, the program has the option to contract with the other county. Clients who have out-of-county Medi-Cal and do not intend to reside in San Diego County will be referred to their county of residence. DMC providers should be reviewing caseloads and assisting clients with the transition.

As exceptions to this rule, OTP can bill Methadone and Individual and Group counseling services for Out-of-County. OTP can provide courtesy dosing to clients who are temporary in San Diego. MAT and Case Management services are not billable for out of county clients and programs should be working with clients to transfer their Medi-Cal to San Diego County.

Additional exception is for clients under the age of 21, they are exempt from the county of resident requirements and are entitled to all benefits provided under EPSDT.

All SUD programs should visit the OPTUM website under **COMMUNICATIONS** tab to learn more about the Amended Process for Out-of-County clients. While you are on the **COMMUNICATIONS** tab, you can also read the OOC Medi-Cal Tip Sheets for Outpatient, OTP, and Residential programs.

Info Notice - Amended Process for Out-of-County Clients – Residential BD Out of County MCal Tip Sheet (pdf)

IV-10. SAMPLES OF MEDI-CAL ELIGIBILITY

A. MEDI-CAL ELIGIBILITIES THAT CAN BE BILLED STRAIGHT TO MEDI-CAL

FULL SCOPE MEDI-CAL

MEDI-CAL WITH OTHER HEALTH INSURANCE (OHC) UNDER CODE A

Code A allows the DMC services for this type of eligibility to be billed directly to Medi-Cal. Providers should check this code monthly as the code A may be updated and you will need to bill the insurance.

Health Plan Member CHG followed by call Medi-Cal with phone number

Name:	
Subscriber ID:	
Service Date: 03/01/2018	Subscriber Birth Date:	Issue Date: 04/10/2018
Primary Aid Code: T2	First Special Aid Code:
Second Special Aid Code:	Third Special Aid Code:
Subscriber County: 37 - San Diego	Medicare ID:
Trace Number (Eligibility Verification Confirmation (EVC) Number):	

Eligibility Message:
SUBSCRIBER LAST NAME: . EVC #: . CNTY CODE: 37. PRMY AID CODE: T2. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-COMMUNITY HLTH GRP: MEDICAL CALL (619)422-0422.

MEDI-CAL WITH OHC UNDER COVERAGE D (DENTAL)

Name:	
Subscriber ID:	
Service Date: 03/01/2018	Subscriber Birth Date:	Issue Date: 04/10/2018
Primary Aid Code:	First Special Aid Code: T1
Second Special Aid Code:	Third Special Aid Code:
Subscriber County: 37 - San Diego	Medicare ID:
Primary Care Physician Phone #:	Service Type: D
Trace Number (Eligibility Verification Confirmation (EVC) Number):	

Eligibility Message:
SUBSCRIBER LAST NAME: . EVC #: . CNTY CODE: 37. 1ST SPECIAL AID CODE: T1. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-MOLINA HEALTHCARE: MEDICAL CALL (888)665-4621. OTHER HEALTH INSURANCE COV UNDER CODE L - DENTAL COVERAGE ONLY. CARRIER NAME: UNITED HEALTH CARE DENTAL. ID: . CARRIER NAME: DENTAL BENEFIT PROVIDERS. ID: . COV: D.

MEDI-CAL WITH OHC UNDER CODE R (PRESCRIPTION)

Name:		
Subscriber ID:		
Service Date: 03/01/2018	Subscriber Birth Date:	Issue Date: 04/10/2018
Primary Aid Code: 60	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 37 - San Diego	Medicare ID:	
Primary Care Physician Phone #:	Service Type: R	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		

Eligibility Message:
SUBSCRIBER LAST NAME: . EVC #:   . CNTY CODE: 37. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-COMMUNITY HLTH GRP: MEDICAL CALL (619)422-0422. PART A, B AND D MEDICARE COV W/MEDICARE ID #   . MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. CARRIER NAME: MEDCO. COV: R.

MEDI-MEDI (MEDI-CAL WITH MEDICARE)

⚠ **Eligibility Message:** SUBSCRIBER LAST NAME: . EVC #:   . CNTY CODE: 37. PRMY AID CODE: 10. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-MOLINA HEALTHCARE: MEDICAL CALL (888)665-4621. PART A, B AND D MEDICARE COV W/MEDICARE ID #   . MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. CARRIER NAME: ENVISION RX PLUS. COV: R.

Subscriber Name:	Subscriber ID:
Subscriber Birth Date:	Issue Date: 04/21/2022
Primary Aid Code: 10	First Special Aid Code:
Second Special Aid Code:	Third Special Aid Code:
Responsible County: 37-San Diego	Medicare ID:
Primary Care Physician Phone:	Service Type: R
Service Date: 04/01/2022	Trace Number/Eligibility Verification Confirmation Number:

- Outpatient and Residential programs can bill Medi-Medi straight to Medi-Cal, *including services for clients with Medicare Part C (Medicare Risk/Medicare Advantage) with FFS-Equivalent Coverage Certification.*
- Medicare will pay for Opioid Treatment Programs services. OTP programs must be enrolled in Medicare (certified to bill) and bill out of their own system to get paid by Medicare.

CAL MEDICONNECT

⚠ **Eligibility Message:** SUBSCRIBER LAST NAME: _____ CNTY CODE: 37. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: COMMUNICARE ADVANTAGE CAL MEDICONNECT: MEDICAL CALL (888)244-4430. PART A, B AND D MEDICARE COV W/MEDICARE ID # _____ . MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL. NO MEDI-CAL PAYMENT FOR MEDICARE PART D COVERED DRUGS.

Name:	Subscriber ID:
Service Date: 04/01/2021	Subscriber Birth Date:
Issue Date: 04/01/2022	Primary Aid Code: 60
First Special Aid Code:	Second Special Aid Code:
Third Special Aid Code:	Subscriber County: 37-San Diego
HIC Number:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):	

Cal Medi Connect is a combination of Medicare and Medi-Cal benefits into one health plan, which includes additional care coordination benefits.

B. ELIGIBILITIES THAT CANNOT BE BILLED OR CANNOT BE BILLED DIRECTLY TO MEDI-CAL

CLIENT IS NOT MEDI-CAL ELIGIBLE

Subscriber ID:			
Service Date: 03/01/2018	Subscriber Birth Date:		Issue Date: 04/10/2018
Primary Aid Code:		First Special Aid Code:	
Second Special Aid Code:		Third Special Aid Code:	
Subscriber County: - unknown		Medicare ID:	
Primary Care Physician Phone #:		Service Type:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):			
Eligibility Message: NO RECORDED ELIGIBILITY FOR 03/18.			

Programs must ensure to enter the correct information in Medi-Cal Transaction site when verifying Medi-Cal eligibility. Wrong data could result to "no recorded eligibility" response.

AID CODE N7 (INPATIENT HOSPITAL FACILITY)

The program should advice the client to contact the county eligibility worker if no longer incarcerated to update to a regular aid code.

Note: If the client is recently released from jail, the program should work with the client to contact Medi-Cal to let them know they have been released from jail and request that their Medi-Cal status be updated.

CLIENT WITH SHARE OF COST (SOC)

Please read IV-5. MEDI-CAL SOC (SHARE OF COST) for more information on Share of Cost.

MEDI-CAL RECERTIFICATION IS NOT YET EFFECTIVE AT THE TIME OF SERVICE

Name:	
Subscriber ID:	
Service Date: 03/01/2018	Subscriber Birth Date: ▮▮▮	Issue Date: 04/10/2018
Primary Aid Code:	First Special Aid Code:
Second Special Aid Code:	Third Special Aid Code:
Subscriber County: 37 - San Diego	Medicare ID:
Primary Care Physician Phone #:	Service Type:
Trace Number (Eligibility Verification Confirmation (EVC) Number):	
Eligibility Message: SUBSCRIBER LAST NAME: ___ . EVC #: ___ CNTY CODE: 37. FAMILY PACT ELIGIBLE, RECERT DATE IS 05/21/2018.	

MEDI-CAL COVERAGE IS SUSPENDED

Name:	
Subscriber ID:	
Service Date: 03/01/2018	Subscriber Birth Date:	Issue Date: 04/10/2018
Primary Aid Code:	First Special Aid Code:
Second Special Aid Code:	Third Special Aid Code:
Subscriber County: - unknown	Medicare ID:
Primary Care Physician Phone #:	Service Type:
Trace Number (Eligibility Verification Confirmation (EVC) Number):	
Eligibility Message: SUBSCRIBER LAST NAME: ___ . SUBSCRIBER MEDI-CAL COVERAGE HAS BEEN SUSPENDED, CONTACT COUNTY WELFARE AGENCY FOR MORE INFORMATION.	

Note: Client should contact the county eligibility worker to find out the reason of suspension.

OUT-OF-COUNTY

Name:		
Subscriber ID:		
Service Date: 03/01/2018	Subscriber Birth Date:	Issue Date: 04/10/2018
Primary Aid Code:	First Special Aid Code: 40	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 13 - Imperial	Medicare ID:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: SUBSCRIBER LAST NAME: . EVC #: . CNTY CODE: 13. 1ST SPECIAL AID CODE: 40. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN.		

Please read section **IV-9 for Out-of-County** information.

MEDI-CAL WITH OHC

Name:		
Subscriber ID:		
Service Date: 02/01/2018	Subscriber Birth Date:	Issue Date: 03/05/2018
Primary Aid Code: 60	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 37 - San Diego	Medicare ID:	
Primary Care Physician Phone #:	Service Type: OIM P V	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: SUBSCRIBER LAST NAME: . EVC #: . CNTY CODE: 37. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. OTHER HEALTH INSURANCE COV UNDER CODE P - PPO/PHP/HMO/EPO ONLY COMPREHENSIVE. CARRIER NAME: ANTHEM BLUE CROSS. ID: . COV: OIM P V.		

Note: Please review Section V-3 of this manual to learn more about OHC.

MEDI-CAL WITH MEDICARE RISK OR PART C (OHC UNDER CODE F)

Name:	
Subscriber ID:	
Submitted ID:	

Service Date: 02/01/2020	Subscriber Birth Date:	Issue Date: 02/21/2020
Primary Aid Code: 1H	First Special Aid Code: 80	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 37 - San Diego	Medicare ID:	
Primary Care Physician Phone #:	Service Type: OIM R	

Trace Number (Eligibility Verification Confirmation (EVC) Number):

Eligibility Message:
SUBSCRIBER LAST NAME ___ . EVC #: ___ .CNTY CODE: 37. PRMY AID CODE: 1H. 1ST SPECIAL AID CODE: 80. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. PART A, B AND D MEDICARE COV W/MEDICARE ID # ___ . MEDICARE PART A AND B COVERED. OHCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. OTHER HEALTH INSURANCE COV UNDER CODE F - MEDICARE PART C HEALTH PLAN. CARRIER NAME: SCAN HEALTH PLAN. COV: OIM R.

Medicare coverage is provided through a Medicare Advantage plan, also known as a Medicare Risk HMO or Medicare Part C plan.

C. MEDI-CAL COVERAGE IS DATE SPECIFIC

o Medi-Cal with P3 (Hospital Presumptive Eligibility/HPE) Aid Code - The program cannot bill DMC for certain service dates within the same month.
o Program must contact the BHS-SUD Billing Unit for questions on P3 aid code.
o Program must work with the client to obtain full scope Medi-Cal with no restrictions.

This sample shows that client was not Medi-Cal eligible on 08/13/2019.

Subscriber ID:	

Service Date: 08/13/2019	Subscriber Birth Date:	Issue Date: 03/06/2020
Primary Aid Code:	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: - unknown	Medicare ID:	

Trace Number (Eligibility Verification Confirmation (EVC) Number):

Eligibility Message:
NO RECORDED ELIGIBILITY FOR REQUESTED DATE OF SERVICE 08/13/2019.

But the same client is Medi-Cal eligible on 08/31/2019.

Name:	
Subscriber ID:	
Service Date: 08/31/2019	Subscriber Birth Date:	Issue Date: 03/06/2020
Primary Aid Code:	First Special Aid Code: P3
Second Special Aid Code:	Third Special Aid Code:
Subscriber County: 37 - San Diego	Medicare ID:
Trace Number (Eligibility Verification Confirmation (EVC) Number):	
Eligibility Message: SUBSCRIBER LAST NAME: _ . EVC #: _ . CNTY CODE: 37. 1ST SPECIAL AID CODE: P3. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN.	

D. POST-PARTUM AID CODE

Post-partum means the 60-day period beginning on the last day of pregnancy (60 days after the pregnancy ends), regardless of whether other conditions of eligibility are met. In case the pregnancy is terminated, the services can still be billed as perinatal as long as the aid code specifies pregnancy and post-partum and the client is in a certified perinatal program.

The aid code M9 is a full scope Medi-Cal coverage for pregnant women. It provides family planning, pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, and emergency services to citizens/lawfully present pregnant women with income at 60 to 213 % of the Financial Poverty Level (FPL) with no age limitation.

Name:	
Subscriber ID:	
Service Date:	Subscriber Birth Date:	Issue Date: 07/08/2020
Primary Aid Code:	First Special Aid Code: M9
Second Special Aid Code:	Third Special Aid Code:
Subscriber County: 37-San Diego	HIC Number:
Trace Number (Eligibility Verification Confirmation (EVC) Number):	
Eligibility Message: SUBSCRIBER LAST NAME: _ . EVC #: _ . CNTY CODE: 37. 1ST SPECIAL AID CODE: M9. MEDI-CAL ELIGIBLE FOR PREGNANCY/POST PARTUM RELATED MEDICAL SVCS W/ NO SOC/SPEND DOWN. IF SUBSCRIBER IS PREGNANT OR POSTPARTUM, USE PREGNANCY DIAGNOSIS CODES ON CLAIMS FOR THE FULL RANGE OF MEDICALLY NECESSARY MEDI-CAL SERVICES INCLUDING MEDICAL AND DENTAL. FOR SPECIALTY MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, USE A PREGNANCY INDICATOR.	

Note: Per Provisional Postpartum Care Extension (PPCE), a 10-month extension is granted to qualifying pregnant and postpartum individuals to remain eligible to Medi-Cal or MCAP following the end of the postpartum period after the 60-day postpartum period. Please refer to DHCS Information Notice 20-14 for more information and for aid codes related to pregnancy or post-partum.

V. OTHER HEALTH COVERAGE (OHC)

Other Health Coverage (OHC) refers to private health insurance. Services may include medical, dental, vision, pharmacy, and Medicare-risk or supplemental plans. Please read the OHC Information Notice posted on DMS-ODS section- of Optum website under **COMMUNICATIONS** tab.

V-1. OHC CODES AND OTHER INFORMATION

The list below is the codes that identify OHC. As a matter of practice, programs should ask clients to check with their insurance carrier to find out if Substance Use Disorder services are a covered benefit under their plans. If residential treatment services are considered "a covered service" under the insurance plan, programs should refer the beneficiaries to seek treatment with their insurance carrier or get authorization/referral from the insurance to treat the client . Programs able to bill for third-party payer must bill the private insurance first prior to billing Medi-Cal.

V-2. OHC CODES DESCRIPTION

OHC Code	Carrier
A*	Pay and Chase (applies to any carrier)
C	Military Benefits Comprehensive
D	Medicare Part D Prescription Drug Coverage
E	Vision Plans
F	Medicare Part C Health Plan
G	Medical Parolee
H	Multiple Plans Comprehensive
I	Institutionalized
K	Kaiser
L	Dental only policies
P	PPO/PHP/HMO/EPO not otherwise specified
Q	Commercial Pharmacy Plans
V[2]	Any carrier other than the above (includes multiple coverage)
W	Multiple Plans Non-Comprehensive

*If the MEDS cost avoidance code for the beneficiary is "A," providers are allowed, but not required, to bill the OHC carrier prior to billing Medi-Cal.

Note: Codes D, E, G, I, L are not considered OHC for Billing purposes. You can also bill Medi-Cal for code A. Please make sure to carefully read the Medi-Cal eligibility response (bottom part of the eligibility report) regarding OHC.

Scope of Coverage/Service Type: OIM R

O	Outpatient
I	Inpatient
M	Medical and Allied Services
R	Medicare Part D

For OHC Code or Scope of Coverage information and other OHC details, please visit: https://www.dhcs.ca.gov/services/Pages/OHCResources.aspx

V-3. OHC AS PRIMARY COVERAGE

Medi-Cal beneficiaries may have dual-coverage or also have OHC through a third-party insurance carrier. If the eligibility response indicated the client has insurance other than Medi-Cal, claims cannot be billed directly to DMC. In this case, OHC benefits must be exhausted or billed first prior to billing DMC. Provider must obtain the required Explanation of Benefits (EOB) of "payment or denial" or Evidence of Coverage (EOC) a.k.a. Summary of Insurance Benefits describing the health care benefits covered by the health plan. The EOB shall be available after the private insurance is billed by the program, while the EOC can be obtained upon the client's request even without billing the insurance. **For all programs, the EOC must indicate that "SUD services are not covered" or must specify all coverage which may or may not include some SUD services. Not meeting Medical Necessity is also an acceptable denial for Residential.** Billing Unit needs to receive one of these documents to be able to bill DMC/Medi-Cal, which is the payer of last resort. Please provide the document(s) ASAP to meet the timely filing to DMC.

> **Note:** The EOC or EOB indicating "SUD services are not covered" is acceptable and can be used/valid for one year. After one year, the programs must submit a new EOC or EOB to the BHS-SUD Billing Unit.

When a provider receive verification from the insurance company of either a payment, denial or exhaustion of benefits, the BHS BU must be contacted immediately to determine the next steps.

A copy of the EOB or any supporting verification from the insurance company must be sent by the program to BHS BU via encrypted email to ADSBillingUnit.HHSA@sdcounty.ca.gov.

Medicare and Cal Medi-Connect do not cover SUD/DMC services with some exceptions on OTP. Per DMC guidelines, all SUD services must be billed to the insurance. If the insurance does not cover SUD or any types of SUD services covered under DMC, documentation is required.

V-4. OTHER HEALTH COVERAGE (EXCEPT MEDICARE) WHEN BILLING CERTAIN OTP SERVICES

OTP claims can be billed or submitted to the Short Doyle/Medi-Cal (SDMC) system or can be billed directly to Medi-Cal without proof of billing Other Health Coverage (OHC) carriers. This applies to Methadone, counseling, and group services. But OHC must be billed if providing MAT services.

BHS-SUD Billing Unit cannot provide further instructions on how to bill the private insurance because the County is not contracted with any private health plans. Also, the SUD billing system does not have a Clearing House to perform private insurance billing.

V-5. ASSIGNMENT OF INSURANCE BENEFITS (AOB)

When billing OHC, providers should have the client sign an AOB (Assignment of Insurance Benefits). The program must also have the release of information (42 CFR form) prior to billing or contacting the insurance provider. The AOB form version 05-2019 can also be found on the OPTUM website under **BILLING** tab.

V-6. OHC EOB NOT RECEIVED AFTER 90 DAYS

If a program billed the insurance company and have not received a response and followed up with the insurance company and still have not received a response and it has been over 90 days, the program should submit supporting evidence to the Billing Unit to confirm the services have been billed and document(s) that a follow-up contact was made so we can cross to Medi-Cal. Supporting evidence could be a confirmation that the claim was received, a copy of the 1500 or UB04 form submitted with a notation of the date the follow-up was made and the response. It is recommended that a follow-up be made within 45 days from the date the claim was submitted. If at a later date, the program receives any payment from an insurance company and the Billing Unit billed and got paid, the Billing Unit would need to be notified right away so that the billed service can be replaced if the amount is less than the billed amount or voided if the amount paid is equal or more than the billed amount.

V-7. OTHER HEALTH COVERAGE (OHC) PROCESS IN SANWITS FOR RESIDENTIAL PROGRAMS

Residential bed day billing, unlike outpatient utilizes the Contract Management functionality in SanWITS. Programs should release and hold the Residential Case Management services for clients with OHC while waiting for the EOC or EOB from the private insurance.

Please do not batch them with the straight Medi-Cal clients. Once the EOC or EOB is available, please contact the ADSBillingUnit.HHSA@sdcounty.ca.gov so we can determine if the claims can be crossed or billed to the secondary coverage (Medi-Cal).

There are new billing enhancements in SanWITS that will help improve or simplify the billing processes for SUD providers and the Billing Unit. Please see section **XI. SanWITS Billing Enhancements** of this manual to learn more about them.

Based on the new billing enhancements, the residential bed day claims must be placed on hold in SanWITS Billing folder under Claim Item List if client has OHC, SOC, awaiting Medi-Cal eligibility, or for other reasons specified on the hold reason list. You will no longer batch and send these types of claims to the Government Contract.

Note: Providers must continue to monitor the claims placed on hold because some claims can be billed retroactively with valid delay reason code.

V-8. CHANGE OR UPDATE IN OHC STATUS

Providers can assist clients who no longer have OHC coverage where the client has not reported the change to Medi-Cal eligibility or the Medi-Cal access staff has not updated the Medi-Cal Eligibility by calling the access phone number 1-866-262-9881. If client no longer has the OHC but it still shows on the Medi-Cal eligibility report, the program can assist the client by going into http://dhcs.ca.gov/OHC then click the tab OHC Removals Forms:

OHC Removal(s) Form ▶

Providers who cannot access the online form can call the Telephone Service Center (TSC) at: 1-800-541-5555. On the site, click the OHC Removals Form tab, enter the security code to access the OHC Processing Center.

VI. MULTI-SERVICE BILLINGS, MAXIMUM SERVICE UNITS AND LOCKOUTS

According to DHCS for DMC clients, "in order to facilitate the correct placement, a client or beneficiary will be allowed to receive more than one service per day by various providers. Programs Should utilize the Billing Matrix (billing grid) shown below to avoid any incorrect billing or getting denied with duplicate billing. Completing the extra paperwork is no longer required for same day billing.

VII. DMC-ODS SAME DAY BILLING MATRIX

DMC ODS Same Day Billing Matrix

Same Day Billing Allowed
Same Day Billing Not Allowed

	Residential Withdrawal Management 3.2	Ambulatory Withdrawal Management 2	Ambulatory Withdrawal Management 1	Residential	Partial Hospital	Intensive Outpatient	Individual Counseling	Group Counseling	Individual Counseling NTP	Group Counseling NTP	Recovery Services - Individual	Recovery Services - Group	Recovery Services - Case Management	Recovery Services - Support	Methadone Dosing	MAT - Dosing NTP and Non-NTP	MAT - Non-NTP	Case Management	Physician Consultation
	H0012	H0014	H0014	H0019	S0201	H0015	H0004	H0005	H0004	H0005	H0004	H0005	H0006	H0006	H0020	S5000/S5001	H2010	H0006	G9008
Physician Consultation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y
Case Management	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	
MAT - Dosing NTP and Non-NTP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y		
MAT - NTP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y			
Methadone Dosing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N				
Recovery Services - Support	N	N	N	N	N	N	N	N	N	N	Y	Y	Y	Y					
Recovery Services - Case Management	N	N	N	N	N	N	N	N	N	N	Y	Y	Y						
Recovery Services - Group	N	N	N	N	N	N	N	N	N	N	Y	Y							
Recovery Services - Individual	N	N	N	N	N	N	N	N	N	N	Y								
Individual Counseling NTP	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y									
Group Counseling NTP	Y	Y	Y	Y	Y	Y	Y	Y	Y										
Individual Counseling	N	N	N	N	N	N	Y	Y											
Group Counseling	N	N	N	N	N	N	Y												
Intensive Outpatient	N	N	N	N	N	Y													
Partial Hospital	N	N	N	N	N														
Residential	N	N	N	N															
Ambulatory Withdrawal Management 1	N	N	N																
Ambulatory Withdrawal Management 2	N	N																	
Residential Withdrawal Management 3.2	N																		

To view the clear copy of the grid/billing matrix, please go to Optum website under **Billing** tab.

VIII. DMC BILLING IN SANWITS

All BHS clients must be set-up in SanWITS to allow billing for Drug Medi-Cal services. Programs should enter and release encounters based on the guidance provided by BHS. Please refer to the Encounters and Group Modules Training Manual on DMC-ODS page of the OPTUM website under **Training-SanWITS** tab. Also note that programs who are waiting on DMC Provider Certification and/or QM permission to bill should already have entered and released all services and be ready to bill once given the green light. Programs should also contact the BHS-SUD Billing Unit when they have been DMC certified so we are aware of the pending Delay Reason Code (DRC) request to DHCS. Once programs are caught up and are submitting claims on a regular basis, programs should submit their DMC billing to the Clearing House/Government Contract by the 10th of the following month (e.g. 07/2020 claim batches should be submitted to Billing Unit on or before 8/10/20).

DMC providers should be completing their internal process and reviews prior to submitting their Provider Batches to the Clearing House or Government Contract within the 10 days expected batch submission timeframe. Programs email the completed DHCS 100186 form or Submission Certification to the Billing Unit. The Billing Unit reviews all the received provider batches in the Clearing House and submits the 837P Transaction file to the State before the end of each month. Following the submission of the electronic file (837P), the Billing Unit submits the completed and signed Certified Public Expenditure (CPE) to DHCS. BHS BU staff will have all the DMC claiming and financial reports updated for internal use.

Note: DMC-ODS billing rate is the amount we bill to the State and the amount set-up in the SanWITS system, per service type. Billing rates are set-up annually in SanWITS by BHS MIS. The State approved County interim rate will be the maximum rate allowed per service subject to annual cost settlement.

VIII-1. COMMON CLAIM ERRORS AND HOW TO PREVENT THESE ERRORS:

Knowing and understanding the billing errors can help programs in minimizing or eliminating mistakes and extra processes. It also prevents the claim or batch from getting suspended or stuck in processing error. Most errors are easier to fix when claims are still in Awaiting Review at the Agency-Facility screen. Please refer to the table below for samples:

SAMPLE CLAIM ERRORS IN SANWITS	HOW TO PREVENT OR CORRECT ERROR
Wrong client DOB	Make sure to check the client's Medi-Cal ID card and enter the correct information in SanWITS PGE. **Note: If you make any changes or corrections on the SanWITS Profile screen, please notify the SUD MIS Support.**
Invalid Subscriber or Medi-Cal ID #	Check the Medi-Cal Eligibility and or Med-Cal ID for the correct Subscriber# or Medi-Cal# and enter the correct information in SanWITS PGE.
Wrong client gender	Make sure to check the client's Medi-Cal ID card or any available legal documentation proving the correct gender of the client. Then, enter the correct information in SanWITS PGE.
Client not Medi-Cal due to invalid DOB or Subscriber ID #	Check the Medi-Cal Eligibility and/or Medi-Cal ID for correct Subscriber# or Medi-Cal# and enter the correct information in SanWITS PGE.
Client Name in SanWITS does not match with the Medi-Cal eligibility report	Program must verify the correct client name and enter the correction information in SanWITS PGE.
Incorrect Total of Units or Total $ Amount	Run the export file in Claim Item List screen to review the total units and dollar amount. If calculation error is due to technical issues, please contact the SUD Billing Unit for further assistance. For OTP dosing's start and end date, review individual services and groups to make sure they were not billed in decimals.
Billing certification (DHCS-100186) is incomplete/not signed/not legible	Billing Unit will email the program to make the necessary corrections and send the properly completed document.

Invalid or not updated aid code in PGE	Program must verify Medi-Cal to obtain the aid code. Then, enter the correct aid code in SanWITS PGE. Contact the BHS-SUD Billing Unit if you need assistance in verifying the latest aid code.
Invalid Client address: P.O. Box, Homeless, or zip code	Program must enter a valid client physical address. If client is homeless, please use the Agency/Facility address. Please do not enter any P.O. Box in PGE.
With two open or active Payor Group Enrollments in SanWITS	The new **SanWITS Billing Enhancement under Client Intake Business Rules on section XI-9** of this manual shows how the system will alert the program if duplicate or overlapping Plan in PGE is created.
Payor Group Enrollment Does Not Cover the Service Dates Being Billed	Make sure there is an available benefit plan for the service dates being billed.
Client is not Medi-Cal eligible	Release to bill and hold if client's Medi-Cal approval is pending.
Client has Other Health Coverage other than Medi-Cal	Release to bill and hold. Program must bill the OHC and submit the EOC or EOB to Billing Unit.
Invalid Service Location	Please make sure to run and review the Export file in SanWITS Claim Item List. Service Location Code must be 55 for residential and code 57 for outpatient.
Aid code is not DMC billable	Program must verify the Medi-Cal eligibility and the Aid Code Master Chart.
Aid code is for emergency/post-partum services only but billing Non-Perinatal	This aid code applies to pregnant/post-partum clients. Check if your program is Perinatal certified. If not, make sure to mark the Encounter 's Pregnant/Post-Partum field YES.
Invalid ICD-10 diagnosis code	Refer to the ICD-10 Code Master Chart or contact the Billing Unit right away.
Aid code is not in Aid Code Master Chart	Contact the Billing Unit.
Out-of-County	Refer to Out-of-County **section IV-9** of this manual for details.

Client has SOC	Refer to **section IV-5** of this manual for details.
Wrong Rendering Staff	Check for data entry error or go to NPI Registry website to verify the correct Rendering Staff Name and NPI. You can also contact the MIS Support Team for further assistance.
With date of death entered in SanWITS even if client is not deceased	Review the Client Profile and make the correction. Please notify SUD MIS for any correction done in Client Profile screen. If claim was billed and denied by the State, contact the Billing Unit immediately.
Program submitted a late or retro billing with invalid delay reason	Program must refer to the Late Billing Master Chart and contact the Billing Unit immediately to request DHCS for pre-approval to late bill.

VIII-2. SANWITS BILLING PROCESS FOR OUTPATIENT, OTP PROGRAMS, AND RESIDENTIAL CASE MANAGEMENT

The providers are responsible in entering and completing the Encounters for all the clients and submitting the provider claim batches in a timely manner to SanWITS Clearing House. Please visit the ODS-DMC page of the OPTUM website under **BILLING** tab or click the Outpatient and OTP *SanWITS Billing Screens and Billing Workflow*.

Notes:
Outpatient/Intensive Outpatient Treatment
- Outpatient services are billed based on minutes of services. Staff should enter services for outpatient based on the actual time spent with the client, this includes Case management

OTP
- Individual and group counseling services are billed in 10 -minute increment (no fractions must be divisible by 10).
- Case Management is billed in 15-minute increment (fractional units accepted).
- MAT dosing is billed as one unit = daily dose (must be billed on single days)
- Methadone is billed as one unit = daily dose (can be billed in consecutive days within the same month).

- To see the **OTP Reimbursement Rates Clarification** tip sheet, go to Optum website and click the **SanWITS** tab.

Residential:
- Case Management is billed in 15-minute increment (fractional units accepted)

Prior to release of encounters to billing, programs must:

A. REVIEW CLIENT AND SERVICE DATA

BHS-SUD Billing Unit recommends that all programs review the information on these three important SanWITS screens before releasing the encounters to billing to avoid or lessen the billing errors: (1) Encounters, (2) Client Profile, and (3) PGE. It is also important to verify the clients' Medi-Cal eligibility, identify if client has a Share of Cost or Other Health Coverage. The OPTUM website, SanWITS tab also contains tip sheets on Encounters, PGE, Group Modules, and more.

1) ENCOUNTER SCREEN

Review the following data:
- Service Location
  - ➢ Code 57 is for Non-Residential Perinatal and Non- Perinatal programs.
  - ➢ Code 55 is for Residential program.
  - ➢ Code 02 is for Telehealth.

  Please make sure you select the correct service location.

- Rendering Staff: the person who provided the service and must have the appropriate credentials and NPI. The NPI must be entered in SanWITS to avoid any Batch Processing Error.

Please contact SUD_MIS_Support.HHSA@sdcounty.ca.gov if you need to submit or correct an NPI. Contact the QIMatters.HHSA@sdcounty.ca.gov if you have questions or clarifications on rendering staff credentialing.

To verify the provider's NPI, go to: https://npiregistry.cms.hhs.gov/

- Diagnosis Code: The Primary, Secondary, and Tertiary diagnoses must be different from each other (No duplicate or same exact diagnosis for the same date of

service). Keep your ICD-10 Diagnosis Master Chart accessible; this chart can be found in Optum website under **Billing** Tab.

2) **CLIENT PROFILE**

Please review all the fields.

3) **PAYOR GROUP ENROLLMENT SCREEN**

If client has dual coverage (OHC and Medi-Cal), please make sure you create a PGE for OHC and another PGE for Medi-Cal. You can check the section IX. PGE in SanWITS for Client with Dual Coverage of this Billing Manual for more information.

Review the following:

- Subscriber ID #: must be 8 numbers plus 1 upper case/capital letter (total of 9 digits).
- Client Name and Date of Birth must match the Medi-Cal eligibility verification report.
- Gender: Select or enter the correct client gender code (1- male or 2-female) when completing this field. The gender "Other" is an acceptable value in SanWITS but claim gets denied with CO/16/MA39 (gender not matched with MEDS) when billed to the State. Please do not select Other. In billing, use the gender shown on the client's Medi-Cal ID card.
- Coverage Start Date: must match the Program Enrollment
- Coverage End Date: required if client is discharged from the program or aid code has changed.

NOTES:

FOR CLIENTS WHO LOST MEDI-CAL ELIGIBILITY

Currently, BU does not recommend terminating or putting an end date on the PGE- DMC Plan if a client loses Medi-Cal eligibility to avoid rejecting or backing out the claims and release again to billing once the client becomes retroactive Medi-Cal.

There is a new billing enhancement that prevents the overlapping or duplication of the same Benefit Plan in PGE. Please read section XI SanWITS Billing Enhancements of this manual for more information.

FOR CLIENTS WAITING FOR MEDI-CAL ELIGIBILITY AND CLAIMS ARE ON HOLD

Provider must continue checking the client's Medi-Cal eligibility status every month to be able to bill for retroactive services. Please contact the BHS-SUD Billing Unit if you have retroactive billing or click Late or Retro Billing link to learn more about Late Billing.

FOR CLIENTS WITH REINSTATED MEDI-CAL ELIGIBILITY

In case the PGE DMC Plan is inactive, and the client's Medi-Cal eligibility resumes or starts again, the program needs to 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 January 2020, enter 01/01/2020) and enter the appropriate aid code.

- Valid aid code for the month and year of service must be entered in the Aid Code field. If the aid code changes from last month (ex. 12/2019), provider must end the existing Payor Group Enrollment using the last day of the previous month (e.g. 12/31/2019) as the End Date. Then, open a new Payor Group Enrollment using the first day of the month (ex. 01/01/2020) that the new aid code is effective.
- Address 1: use the physical address. Do not use P.O. Box or enter the word "homeless". Do not enter code 99902 or 00 on the address field. If client is homeless or address is not available, please use your facility address instead.
- Address 2 (white field): can be used for Apt. #, etc.
- Zip Code: use the correct U.S. zip code. Visit https://www.usps.com/ to verify the correct zip code by city.

Note: After reviewing the Payor Group Enrollment screen and no changes has been made, click the Cancel button. Only click the Save button when updates or changes are made on this screen.

B. <u>RELEASE TO BILLING</u>

Providers must release all DMC Billable encounters to billing.
1) Click the Actions button (pencil icon) next to the Encounter ID to open the Encounter Profile of the encounter you need to release to billing.
2) Review the Encounter Profile information one more time then click the Administrative Actions hyperlink: Release to Billing.
3) Click Save and Finish.

> The encounter will automatically release to billing if the client only has ODS-DMC PGE. But if client has other coverage than Medi-Cal (e.g. OHC and Medi-Cal), program must create two PGEs: 1 for OHC and another for ODS-DMC Peri or Non-Peri.

4) For client with two PGEs (e.g. OHC and ODS-DMC), you will need to select the appropriate Client Group Enrollment (CGE) to successfully release the encounter to billing.

> **Note:** Please refer to the MIS Informational Notice on **Service Claims and Payor Group Enrollment New Procedure** posted on the [OPTUM website under SANWITS](#) tab for detailed information on releasing DMC and county billable encounters to billing. The county billable claims need to be released to billing and placed on hold for TUOS reporting purposes.

C. RUN THE CLAIM ITEM LIST REPORT

SUD programs and BHS BU staff can perform billing transactions, review claims information, and run the basic billing report and remittance advice (835 EOB Transaction List) review in this screen.

1) After releasing the DMC billable encounters to billing, go to-> Billing folder -> Claim Item List.
2) Complete the four (4) fields: Plan, Item Status (Item Status default: All Awaiting Review), Facility, and Service Date fields.

3) Click GO. The services you released to billing will appear with status: Awaiting Review.

4) Run your Claim Item List report by clicking the Export hyperlink. See below steps on how to run the Claim Item List Report.

The Claim Item List report provides detailed information on number of billed units and dollar amount per month and year of service, and per procedure code. This report is also useful when you are reviewing the accuracy of your claims <u>prior to creating a provider batch</u>.

C-1. HOW TO RUN THE CLAIM ITEM LIST REPORT

1) Login to Agency/Facility –> Billing -> Claim Item List page

2) Complete these fields to export the file:

   a) Plan: select ODS-DMC Peri for Perinatal programs or Non-Perinatal for non-pregnant.

   b) Item Status: all newly released Encounters defaults to All Awaiting Review status

   c) Service Date: enter the service range using the Begin and End dates of the service month being billed.

   Note: Due to large volume of claims, programs may need to run the export report in portions (by splitting the service dates) as SanWITS only allows to view 5000 claims. You will get this red message or alert to narrow down your search parameters.

   ⊗ For performance reasons, you are only allowed to see up to 5000 records.

   d) Facility: select the appropriate facility. Some Agencies have more than one Facility and by selecting the specific Facility when billing prevents the system from automatically pulling services from other facilities.

3) Click the Go button to display the requested claim items.

4) Click the hyperlink Export.

5) A pop-up box will ask to Save, Save As or Open File.
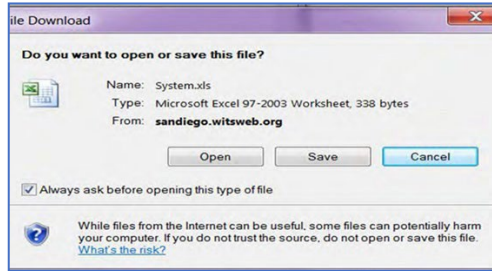
6) Open the file and filter the report content based on the billing requirements. The exported file will appear like this:

7) Retain the following columns for your report:

D. **CREATE PROVIDER BATCH**

1) When billing review is done, release all the services in Claim Item List page
   To successfully create a batch, the claim items must be in status: Released. Claim Items can be released individually or in bulk.

   To update the claim items status from awaiting review to release:
   A. Check the top box between the Item # and Client Name columns to select all claims you want to batch.
   B. From the dropdown menu, select Release
   C. Click the hyperlink "Update Status". All claims selected must be in Release status.

2) Create a provider batch by clicking the <u>Create Facility Batch</u> hyperlink.

3) Choose Plan(s) for Batching. Click the ODS-DMC Medi-Cal-Non- Perinatal or Perinatal depending on your program from the Available Plans table and add or move it to the Selected Plans box. Click Go.

4) Message (in blue) will appear on top of the screen indicating the batch is in process and may take a few minutes to complete.

ⓘ The claim items for the selected 1 plan(s) are being batched. This may take a few minutes to complete.

5) Proceed to Claim Batch List folder and locate your batch in Awaiting Review status. Click Go. The system automatically creates a 6-digit (all numeric) batch #. Write it down as you will need it in completing your billing certification (DHCS 100186) or other reports.

6) If batching is successful, select your batch by clicking the pencil icon in Actions column. You will be given a choice to click the Claim Items or the Profile.
   a) Click the Claim Items to view, run a report or fix an error in the batch or,
   b) Click the Profile if you are ready to proceed to the next steps. Do not forget to write down your Batch #.

If a batch does not come up in Claim Batch page after at least 15 minutes or longer, change the Status field from Awaiting Review to Batch Processing Error then click Go. The batch may have encountered an error and fixing is required.

The Batch Processing Error commonly occurs when the Rendering Staff entered is not the correct provider of service or it is missing the valid 10-digit NPI in SanWITS. The Rendering Staff field defaults to the current SanWITS user and when this staff is not licensed, the batch will not process or create successfully.

If Batch Processing Error occurs, check the Troubleshooting SanWITS Error *section of this manual for instructions on how to fix or resolve the issue.*

7) Once you open the Provider Batch Profile, scroll down to the Administrative Actions. Click Release.

8) The final billing step in SanWITS for Non-residential providers and providers billing for Case Management/Recovery Services is to click the link "**Send to the Clearing House**". Then, on the next screen click the Finish button. BHS BU will not receive your submitted batch when this step is omitted or skipped.

Note: Please visit the DMC-ODS section of the OPTUM website, go to **BILLING** tab to view the *Provider Billing SanWITS Screens for Outpatient, OTP, and Residential Case Management.*

9) Provider must submit the completed and signed Submission Certification (DHCS 100186) to ADSBillingUnit.HHSA@sdcounty.ca.gov as soon as the Provider Claim Batch is submitted to Clearing House.

E. COMPLETE AND SUBMIT THE SUBMISSION CERTIFICATION (DHCS 100186)

The Drug Medi-Cal Claim Submission Certification form was distributed by BHS-SUD Billing Unit to SUD programs and must be completed every billing period, soon after the claim batch is submitted to the Clearing House or the Government Contract. This form certifies that programs carefully reviewed their billing and claims data and the submitted batches are true and correct.

DHCS 100186 Form

DHCS 100186 Form Completion Instructions

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY   DEPARTMENT OF HEALTH CARE SERVICES

COMPLETION INSTRUCTIONS FOR DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY CONTRACTED PROVIDER
(DHCS 100186)

GENERAL
The DMC Claim Submission Certification form for County Contracted Providers (DHCS 100186) is used by a Drug Medi-Cal provider to certify the submission of Drug Medi-Cal claim files to a County. The county must have certification of all claim files prior to submission for processing to the State. The County must retain and make available the DMC Claim Submission Certification form to DHCS on demand.

HEADING INSTRUCTIONS
a. COUNTY NAME: enter the name of county of where services are being provided.
b. PROVIDER NAME (LEGAL ENTITY): enter the name of provider performing the service.
c. DMC NUMBER(S): enter the DMC number(s) of the provider performing the service.
d. SERVICE FACILITY LOCATION NPI(S): enter the service facility NPI(s) of the provider performing the service.
e. DMC SUBMISSION IDENTIFIER: enter the filename, tracking number, or other identifier agreed to between the county and provider which uniquely
     identifies the claim file or group of claim files being certified on this form.

SIGNATURE BLOCK INSTRUCTIONS
One original signature is required on the DHCS 100186, that of the authorized claim submitter.
a. PRINTED NAME: AUTHORIZED SERVICE PROVIDER: print the name of the authorized service provider.
b. SIGNATURE: AUTHORIZED SERVICE PROVIDER: signature line for the authorized service provider.
c. PHONE NUMBER: enter the area code and phone number of the authorized service provider.
d. DATE SIGNED: enter the date the form was signed by the authorized service provider.

COUNTY USE ONLY HEADING INSTRUCTIONS
a. RECEIPT DATE: enter the date the form was received by the county from the provider.
b. EDI File Name: Enter the name of the EDI file in which the claims certified on this form were submitted to DHCS by the county.
c. EDI File Submission Date: Enter the date in which the EDI file was submitted for processing.

DHCS 100186 (Revised 6/2014)

Note: The DHCS 100186 and instructions on how to complete this form are posted on the Optum website under **Billing** tab.

VIII-3. SANWITS BILLING PROCESSES FOR RESIDENTIAL BED DAY PROGRAMS

For residential treatment to be reimbursed on a daily basis, the service provided must include a required service activity on the date of billing. At least 1 hour of those services must be provided in order to bill for the residential services day.

Note: Residential Bed Day and Withdrawal Management 3.2 services are billed per day.

The components of residential treatment are established in the DMC-ODS Waiver special terms and conditions (SC), Section 134 including:

- o   Intake
- o   Individual
- o   Group Counseling
- o   Patient Education
- o   Family Therapy
- o   Collateral Services
- o   Crisis Intervention Services

- o Treatment Planning
- o Transportation Services provision of or arrangement for transportation to and from medically necessary treatment
- o Discharge Services

Please refer to SUDPOH for detailed requirements.   Visit the Optum website and click the **SUDPOH** tab.

A. REVIEW CLIENT AND SERVICE DATA

Provider must have the DMC encounters ready. Please refer to the DMC-ODS portion of the OPTUM website under **SANWITS** and **Training-SanWITS** tabs for more information on Residential Bed Management, Encounters, Group Modules, and tip sheets on Residential Service Claims and Payor Group Enrollment. The RESIDENTIAL BED MANAGEMENT,ENCOUNTERS AND GROUP MODULES includes PGE information for Residential programs.

If client has dual coverage (OHC and Medi-Cal), please make sure you create a PGE for OHC and another PGE for Medi-Cal. You can check the **section IX. of this manual PGE in SanWITS for Client with Dual Coverage** of this Billing Manual for more information.

Sample Residential PGE for client with dual coverage: OHC and Medi-Cal:

Payor List						Add Benefit Plan Enrollment	Add Government Contract Enrollment	
Actions	Priority	Plan	Group	Subscriber/ Acct#	Subscriber/ Resp Party	Start Date	End Date	
✎	1	ODS Residential	Residential Bed Day			7/20/2019		
✎	2	Other Health Care Coverage (OHC)	General			7/1/2020		
✎	3	ODS DMC- Non Peri	Medi-Cal - Non Perinatal			7/1/2018		

BHS-SUD Billing Unit recommends reviewing the three important screens in SanWITS before releasing the encounters to billing to avoid or lessen the billing errors: (1) Encounters, (2) Client Profile, 3) Payor Group Enrollment.

Some SanWITS claims review processes for Residential bed days are similar to outpatient, OTP, and Residential Case Management. Click this link to view the tips on how to review the claims prior to batching them: Review Client and Service Data (pages 32 to 35).

Note: For residential bed day, the rendering staff must also be present at the facility the day of the encounter.

You can also visit the **BILLING** tab posted on Optum website to learn more about **Residential Bed Day, Case Management and Recovery Services Billing Screens**. These tip sheets provide the step-by-step instructions on how to review and batch your claims.

B. RELEASE TO BILLING (BED DAY)

1) If the service meets the "billable" criteria, the encounter Billable field must answer "Yes", and the Medi-Cal Billable field is "No".

2) In Administrative Action, click Release to Billing and Save.
3) The encounter will automatically release to billing if the client only has ODS-DMC PGE. But if client has other coverage than Medi-Cal (e.g. OHC and Medi-Cal), program must create two PGEs: 1 for OHC and another for ODS-DMC Peri or Non-Peri.
4) For client with two PGEs (e.g. OHC and ODS-DMC), you will need to select the appropriate Client Group Enrollment (CGE) to successfully release the encounter to billing.
5) Click Finish.

C. RUN THE CLAIM ITEM LIST REPORT

After releasing all the DMC Billable claims to billing, go to Billing folder -> Claim Item List -> Claim status: All Awaiting Review. You can run or export the Claim Item List to double-check your claims prior to creating the provider batch.

Click here or go to C-1 section of this manual to view the steps on how to run the Claim Item List export/report.

Note: A non-adjudicated bed day claim will display a charge amount of $1.00. To view the actual dollar amount per bed day service, the provider should run the Claim Item List Report soon after the Billing Unit is done adjudicating the provider batches submitted to the Government Contract.

D. CREATE PROVIDER BATCH

1) When billing review is done, release all the services in Claim Item List page
   Note: To successfully create a batch, the claim items must be in status: Released.

   To update the claim items status from awaiting review to release:
   A. Check the top box between the Item # and Client Name columns to select all claims you want to batch.
   B. From the dropdown menu, select Release
   C. Click the hyperlink "Update Status". All claims selected must be in Release status.

2) Create a provider batch by clicking the Create Facility Batch hyperlink.

3) Choose Plan(s) for Batching. Click the ODS-DMC Medi-Cal-Non- Perinatal or Perinatal depending on your program from the Available Plans table and add or move it to the Selected Plans box. Click Go.

4) Message (in blue) will appear on top of the screen indicating the batch is in process and may take a few minutes to complete.

ⓘ The claim items for the selected 1 plan(s) are being batched. This may take a few minutes to complete.

6) Proceed to Claim Batch List folder and locate your batch in Awaiting Review status. Click Go. The system automatically creates a 6-digit (all numeric) batch #. Write it down as you will need it in completing your billing certification (DHCS 100186) or other reports.

7) If batching is successful, select your batch by hovering the mouse on the pencil icon in Actions column. You will be given a choice to click the Claim Items or the Profile.
   o Click the Claim Items to view, run a report or fix an error in the batch, or
   o Click the Profile if your batch is ready for the next steps. Do not forget to write down your Batch #.

Note: If a batch does not come up in Claim Batch page after 15 minutes or longer, change the Status field from Awaiting Review to Batch Processing Error then click Go. The Batch Processing Error commonly occurs when the Rendering Staff entered is not the correct provider of service or missing a valid 10-digit NPI in SanWITS. The Rendering Staff field defaults to the current user and when the user is not licensed, the batch will not create successfully.

Refer to [Troubleshooting SanWITS Error](#) section of this manual for details and instructions.

8) Once you open the Provider Batch Profile, scroll down to the Administrative Actions. Click Release.

9) The final billing step in SanWITS for Residential Bed Day billing is to click the link "Bill It". On the next screen, click the Finish button.

BHS-SUD Billing Unit will review and adjudicate the Residential Bed Day provider batches that you submitted to Government Contract. The adjudicated DMC claims will be batched automatically by the system and will be sent to the Clearing House for State submission.

10) Provider must submit the completed and signed Submission Certification (DHCS 100186) to ADSBillingUnit.HHSA@sdcounty.ca.gov as soon as the Provider Claim Batch is sent to the Government Contract. Click here to view the **COMPLETE THE SUBMISSION CERTIFICATION (DHCS 100186)** page.

IX. PGE IN SANWITS FOR CLIENTS WITH DUAL COVERAGE (OHC & DMC)

For clients with dual coverage (OHC and Medi-Cal), Perinatal or Non-Perinatal programs must create two Plans in Payor Group Enrollment screen (PGE) in SanWITS for clients with dual coverage (OHC and Medi-Cal) prior to releasing encounters to billing.

Note: If client is DMC Billable, please create a DMC PGE as well.

Payor List						Add Benefit Plan Enrollment	
Actions	Priority	Plan	Group	Subscriber/ Acct#	Subscriber/ Resp Party	Start Date	End Date
✎	1	Other Health Care Coverage (OHC)	General	000	Billing, Pregnant	8/1/2019	
✎	2	ODS DMC- Peri	Medi-Cal - Perinatal	12345678A	Billing, Pregnant	8/1/2019	

Here are the steps in setting up the PGEs in SanWITS for clients with dual coverage:

PGE BENEFIT PLANS:

Plan-Group 1. Other Health Coverage (OHC)

- Since the Subscriber ID # is a required field, you have the option to enter the three (3) zeroes for the OHC Plan-Group. Once completed, click Save.
- The Policy # field is not a required field, but programs are recommended to enter the insured's Policy # when it is available.
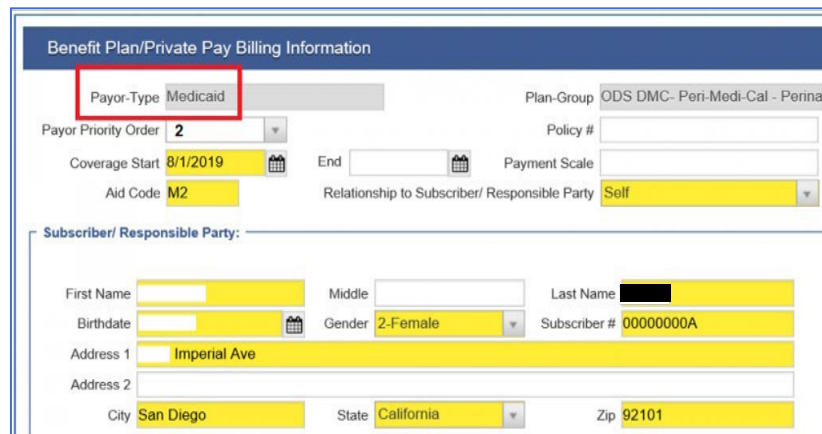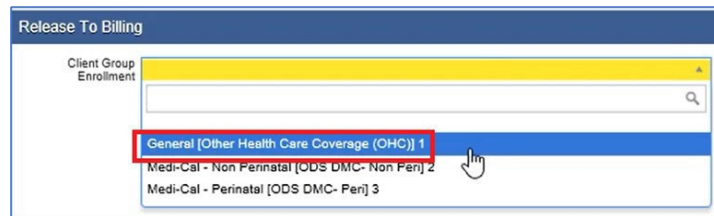
Plan-Group 2. ODS DMC-Peri or Non-Peri

ENCOUNTER SCREEN

- On the encounter screen, after clicking the administrative action "release to billing", the program should select the Client Group Enrollment (CGE) "General - Other Health Coverage Plan" to complete releasing the encounters.

Notes:

1) After release to billing, programs should place the claims on hold in Billing folder (Claim Item List screen) for clients with OHC or those claims that cannot be billed yet to DMC to prevent the claims from getting billed erroneously to the State. Programs must obtain the EOC or bill the private insurance for EOB. Please contact the BHS-SUD Billing Unit as soon as you receive the EOC or EOB so we can determine if the claims can be billed to Medi-Cal.

2) Remember to visit the Optum website- Billing tab to view the tip sheets on

a. How to Release Residential Case Management to OHC and How to Print the OHC CMS-1500 Form using SanWITS.

b. How to Release the Outpatient Services to OHC and How to Print the OHC CMS-1500 Form Using SanWITS.

3) Medicare PGE for OTP clients with Medi-Medi (Medicare and Medi-Cal) coverage is still being reviewed by BHS and FEI. PGE will be setup in SanWITS, and tip sheets will be posted on the Optum website as soon as the Medicare PGE is approved.

X. PRINTING THE CMS-1500 FORM

SUD programs are required to bill OHC for clients with dual coverage (with OHC as primary). For programs without an internal Clearing House to handle private insurance billing or without OHC electronic billing system, the option is to manually submit a professional claim form known as the CMS-1500 (red/white form) or Health Insurance Claim Form.

SanWITS pulls the claims data and allows the programs to print using the professional CMS-1500's red/white form. Please visit the DMC-ODS section on Optum website under BILLING tab to view the instructions on:

- Outpatient Release to OHC and Printing CMS-1500 Form
- Residential Case Management Release to OHC and Printing CMS-1500 Form

XI. SANWITS BILLING ENHANCEMENTS

Some billing screens and functionalities have been enhanced to ease the daily processes and reporting needs of BHS-SUD Billing Unit and SUD Programs.

XI-1. CLAIM ITEM LIST SEARCH CRITERIA

Additional search criteria on the Claim Item List screen has been added to find the claim information easily. Users can search by:

A. Unique Client Number (UCN)

B. Claim Item ID

C. Claim Batch ID

D. Hold Reason

E. Reverse Reason

F. Adjudication Status

G. PCCN (for Billing Unit use only)

H. Export- This will now include the Claim Batch ID, Hold Reason, Reverse Reason, Adjudication Status, NDC, and PCCN.

XI-2. UPDATE STATUS IN CLAIM ITEM LIST IN BULK

There will be new headers to the Claim Item List that will allow *status update to be made in bulk* instead of doing it individually :

A. **Replace/Adjust**
- This functionality is for **BHS-SUD Billing Unit's use only**/for service replacement and void processes.

B. **Reject**

- Programs and SUD BU have access to reject the claim items in bulk on condition that the claims have not been billed to the State yet.

Note: If you need to make corrections but the claims have been batched and the provider batch is submitted to the Clearing House or Government Contract, please contact BHS-SUD Billing Unit immediately for assistance or instructions.

C. **Awaiting Review**

- The Awaiting Review option is added to the bulk dropdown list to allow the providers or SanWITS users to return the claims status from Released or Hold to Awaiting Review "in bulk", instead of performing this administrative action individually or per claim item.

- Check mark the box in between the Item # and Client Name columns to select all the claim items to be updated. On the right-hand side, click the dropdown box -> select Awaiting Review -> click the Update Status button.

Claim Item List (Export)			Reverse		Adjust		Reject					▲		
													🔍	
Actions	Item #	☑	Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date			roup Session ID
✏	531524	☑		FFS	None	7/6/2020	H0004/U8/HD	70 Min	Released	7/27/2020	Awaiting Review		
✏	531618	☑		FFS	None	8/3/2020	H0004/U8/HD	78 Min	Released	8/19/2020	Hold		
✏	531710	☑		FFS	None	9/5/2020	H0005/U7/HA	60 Min	Released	9/10/2020	Release	$27.49 532013 100264	

XI-3. AVAILABILITY OF HOLD STATUS REASONS

Claims are usually placed on hold by programs in Claim Item List screen because the services cannot be billed to DMC or client is not yet Medi-Cal eligible. Please visit the Optum website under SanWITS to view the SanWITS Flow Chart for Encounters Released to Bill and Placed on Hold.

SanWITS will now require a reason when putting a claim item on hold. Programs must select the appropriate reason from the Hold Reason dropdown list, then click Confirm. The hold reasons will help the programs track the status of their hold claims and to do the necessary review and billing if client becomes retroactive Medi-Cal.

You have the option to put the claim on hold individually (one by one) or in bulk. The bulk hold requires a uniform hold reason to hold multiple claims successfully.

Sample of a bulk claim hold:

Visit the DMC-ODS section of the Optum website under **Billing** tab to view the list of **Claim Item Hold Reasons**.

XI-4. CLAIM ITEM PROFILE

1. The Claim Item Profile has been updated with additional fields to provide additional information to Billing Unit and SUD programs. The added fields are the following:

    A. The PCCN Field *(BHS-SUD Billing Unit use only)*
    B. The Pregnant/postpartum indicator from the delivered service.
    C. The Perinatal indicator from the program enrollment on the delivered service.
    D. The Claim Batch ID.

Additionally, the Profile header was updated to include the UCN, DOB, and age on delivered service start date.

2. Paid Claim items may be reversed (voided) by clicking the Reverse button.

   Note: Administrative Actions Reverse and Adjust are for SUD Billing Unit's use only. Providers should not click them. If service replacement is required or a claim item needs to be voided, please contact the BHS-SUD Billing Unit for assistance.

3. The claim item with status "Awaiting Review" may be put on hold by clicking the Hold button in Claim Item Profile.

Upon clicking Hold, the Hold Reason dropdown will appear, select the appropriate reason, and click the Confirm button to move forward.

4. The Delay Reason Code, Report Transmission Type, and Attachment Control Number are required on original and replacement claims 180 days after the encounter start date.

Note: DMC does not require the DRC on replacement claims until 180 days from the original claim finalization date. BHS-SUD Billing Unit is in-charge of service replacement in SanWITS. Adding a hold reason to old claims (over 6 months from the date of service) on hold should not require the delay reason fields.

SanWITS will require the following late billing fields 180 days after the finalization* of the original claim instead of the delivered service start date:

    A. Delay Reason Code
    B. Report Transmission Type
    C. Attachment Control Number

For more information on late billing or retroactive billing processes, please click here to go to section XV. of this manual.

XI-5. CLAIM BATCH LISTS AND EXPORTS

1. The Claim Batch List has been updated with additional columns to provide useful information.

    A. The Units column was added to display the total batch units
    B. The Claim Batch List export was updated to include a Units column, Agency Name Column, and Facility Name Column
    C. The Service Date column was added to display the start date from the delivered service
    D. The Service column has been updated to display all 4 modifiers in the format [Procedure]/[mod1]/[mod2]/[mod3]/[mod4]. Example: S5000/UA/HG
    E. A Group Session ID column was added to display the group session ID

F. An Enc ID column was added to display the encounter ID
G. The Claim Item List for Batch Export will include the Billing Units, Rendering staff name, Adjudication status, Group session ID, and Enc ID

Note: Make sure to click the Export hyperlink to view the full data.

XI-6. EOB TRANSACTION LIST

The Medi-Cal payment and denial transactions can be viewed in SanWITS Billing folder -> EOB Transaction List. Make sure you logged in to your Agency and Facility location to access this feature.

1. The EOB Transaction List has been updated with additional fields to provide additional information. The following fields were added:

A. Subscriber #

B. Facility

C. Unique Client Number

D. Aid Code

E. Service Date

F. Procedure Code

G. Payment Date

H. Claim Item #

I. PCCN
J. Claim Item # column
K. Procedure column
L. Remarks" column

Note: The remarks column tells you the denial code or denial reason from the State. Please contact the SUD MIS Support if you need a simplified or user-friendly EOB Transaction Report in SSRS.

XI-7. CLAIM HISTORY SCREEN

The Claim History Screen has been updated with a Remarks column on the EOB Transaction List. To view the billing history, click the Billing Transaction List under Billing. The Remarks column will display any remarks for the claim from the 835 file (a.k.a. Remittance Advice). Also, there may not be remarks when the claim is paid in full.

XI-8. ENCOUNTER END DATE

This enhancement is for OTP Methadone service:

1. Methadone encounters may span the entire month. Since the end date is not required on consecutive services, OTP providers may sometimes forget to enter it. The resulting 837P has a mismatch between the dates spanned and the total billing units. This enhancement will require an encounter end date when the service is consecutive.
   A. There is an "End Date Required at RTB" indicator added on the service profile.
   B. When the "Date Span Allowed" indicator = "Yes" the "End Date Required at RTB" will be a dark yellow required field. Otherwise, the field is hidden and null.
   C. The encounter end date will be optional for save when the "End Date Required" indicator = yes for the selected service.
   D. There is an existing business rule which throws an error when the units do not equal the [end date] – [start date].

XI-9. CLIENT INTAKE BUSINESS RULES

1. When a client is created with the Contact Benefit Type = Medi-Cal, there should be a corresponding Medi-Cal PGE. The user should create the intake from the contact profile and then enter a Medi-Cal PGE. In addition, users should not be able to enter multiple PGEs for the same plan. These client intake business rules will help limit the mistakes made on the screens below.

Throw an information message during edit when the Benefit Type "Medi-Cal" is selected: "A Med-Cal Payor Group Enrollment should be entered after entering the Intake."

2. There is a client intake business rule. When the client contact benefit type = Medi-Cal and there is no active payor group enrollment (PGE/CGE) with Payor Type = Medicaid: Throw warning message at save:
    A.   "The contact benefit type is Medi-Cal, but the Medi-Cal Payor Group Enrollment has not been entered." The same message should appear on the activity list when user clicks Finish.

B. "Enter Medi-Cal Payor Group Enrollment". The action is visible when the client contact benefit type = Medi-Cal and there is no active payor group enrollment (PGE/CGE) with Payor Type = Medicaid. Otherwise the action is invisible.

Upon selecting the "Enter Medi-Cal Payor Group Enrollment" action, navigate to the Payor Group Enrollment (PGE/CGE) and insert a Benefit Plan Enrollment record.

3. There is a Benefit Plan PGE business rule. An error *message "There is an existing payor group enrollment for this period"* on benefit plan enrollment has been inserted when the coverage dates overlap an existing record for the same Payor-Type. This will help the programs in preventing any duplicate or overlapping PGEs.

XI-10. AGENCY/BILLING/ENCOUNTER LIST

The Encounter List has been updated with additional search criteria and columns to provide more information:

    A. There is a "Billable" search criterion added

    B. The Medi-Cal Billable column will have a checkbox visible for records "Not Released" AND Billable = Yes

    C. The Bill column was changed to Medi-Cal Billable

    D. The Export has been updated to show the changes in column names

XI-11. DISALLOWANCE FIELD ON ENCOUNTER PROFILE

The Encounter Profile has been updated to allow for disallowance and prevent the encounter from being billed.

The new disallowed indicator will be visible and optional, regardless of the claim status and will default to No. When the disallowed indicator is Yes, there will be a Disallowance reason that appears under the service field. Click the dropdown arrow to view the selections. The Disallowance Reason field will be a dark yellow required field. Otherwise, this field is hidden and not required.

Please click here to review the STEPS FOR DISALLOWED SERVICES IN SANWITS or go to the Optum website under **SanWITS** tab.

XII. CLAIM DENIALS

This section provides information on DMC claim denials from the State.

XII-1. 835 FILE WITH DENIED CLAIMS

The State issues the 835 file or Remittance Advice, known as the Health Care Claim Payment or Remittance Advice (RA) for every 837 file (Health Care Claim Transactions/claims) submitted to the State. The 835 file may contain claims approval, denial, or void adjustment. But it usually contains claim denials when the 835 file is received a few hours or days after the claim submission to the State.

The Billing Unit will upload the 835 file in SanWITS. Once the denials are posted and the report is generated, Billing Unit will run the denial report and will email the encrypted list to all programs with denied claims. The programs must review the denial list and contact the Billing Unit soon after they determine if the denial is valid or needs to be replaced and rebilled to the State.

Note: Programs must keep the copy of the denial reports (spreadsheet) received from the Billing Unit.

The claim denials are categorized into two:

1. **True or valid denial:** claims denied with valid reason and can no longer be replaced and rebilled to the State.
2. **Invalid denial:** claims denied due to program's data entry error/billing data does not match State's record/claims erroneously denied. Invalid denials must be further reviewed for appeal and proper adjudication.

On February 13, 2020, the Billing Unit sent the email or announcement to SUD programs about the discontinuation of the Claim Adjustment Form. This form was originally used by programs to report the valid (cannot be replaced and rebilled) claim denials to BHS-SUD Billing Unit. We decided to discontinue the use of this form to lessen the manual processes done by the programs and the Billing team. However, the SUD programs must continue to track the DMC billed units, denied units (including valid denials and service replacement), and the voided or disallowed units for cost report or claims reconciliation purposes. Also, Billing Unit emails the denial report to programs with denied claims per month and year of service, please save your copy for monitoring or claims reconciliation purposes.

XII-2. SAMPLES OF CLAIM DENIALS FROM THE STATE

1. **VALID OR TRUE DENIALS (CANNOT BE REPLACED/REBILLED)**

DENIAL CODES	DENIAL DESCRIPTIONS	ADDITIONAL NOTES
CO/96/M80	Service line is a duplicate service. Service is not payable with other service rendered on the same date.	Please refer to the multiple billing algorithm or the Billing Matrix.
CO/16/M76	ICD-10 diagnosis or condition is not valid for DMC.	Please refer to the SUD ICD-10 Code Master Chart on OPTUM website-Billing tab.
CAS/CO 177	Beneficiary is not eligible	- Client is not Medi-Cal eligible - With SOC that has not been cleared - Not SUD aid codes - Medi-Cal eligibility is for California Children's Services (CCS) only - Client's Medi-Cal benefits are on hold or pending (no County Code or Aid Code on the eligibility response.) - Medi-Cal coverage is outside the State of California (exceptions: OTP courtesy dosing and EPSDT clients) - Inmate aid code (N7) - Client has OHC.
N424	Out of County (OOC)	Please see the Out of County page for details.

2. INVALID DENIALS (CAN BE CORRECTED, REPLACED AND REBILLED TO THE STATE)

DENIAL CODES	DENIAL DESCRIPTIONS	ADDITIONAL NOTES
CO/16/N327	Date of Birth submitted on the 837 is not equal to Date of Birth indicated on MEDS at time of adjudication.	• Verify client information and data entered in SanWITS • Provider entered and billed the wrong DOB (data entry error). • Provider billed the correct DOB, but State database has different information.
CO/16/MA39	Gender submitted on the 837 is not equal to Gender indicated on MEDS at time of adjudication.	• Provider entered the billed the wrong gender (data entry error). • Provider billed the correct gender, but State database has different information. • If client gender in State database is wrong, provider must have the client or County Medi-Cal worker contact the State to correct the information.
N30	Invalid or wrong diagnosis code used	• If it is a result of data entry error, please contact the Billing Unit for further instructions.
CO16 479	Client has the Medicare Advantage Risk Part C	• If the claims are billed and denied by the State, the program can still contact or bill the Medicare Risk insurance to get the EOC or EOB. Then, submit the document to Billing Unit.

XIII. SERVICE REPLACEMENT PROCESS

Service Replacement is a process done or handled by BHS-SUD Billing Unit after the programs have corrected the error on certain denied claims. Billing Unit will submit the corrected claims to the State so they can null and void the original claim, then adjudicate a corrected claim in place of the prior claim. A service replacement can also be used to correct a billing error, such as a claim billed with the wrong group apportioned, or total units billed are in error.

> "A Replacement claim must be submitted to the State no later than six months after the date the replaced claim was finalized (approved and paid, approved and payment deferred, or denied, as reported on an 835). Extensions will not be granted". The program must communicate with the SUD Billing team once they found out the claim denial was due to data entry error and claims need to be replaced and rebilled to the State.

The program must send an encrypted email to ADSBillingUnit.HHSA@sdcounty.ca.gov, detailing the result of the claim denial review. Service replacement or adjustment will be done by BHS BU staff in SanWITS and will rebill to the State if the rebill reason is justifiable.

Any data entry error missed during the claims review process may impact the proper adjudication of claims or may result to denial of claims. Please review the section VIII-1 Common Billing or Claim Errors and SanWITS Billing Processes before billing to prevent the common claim errors or denials.

Soon after the 835 Claim File is generated in SanWITS, BHS-SUD Billing Unit will download the denial report, pre-filter and review it, then will email the encrypted denial report to programs. The programs must review the list and identify the real reason why claims are denied, then contact the Billing Unit within 1 or 2 business days, especially if corrections are required on the denied claims. Once the error is corrected, the Billing will proceed with the service replacement and will bill the corrected claims to the State.

Every now and then, the State may deny claims because the client's name/DOB/gender does not match with their database. If a program could not find any error in SanWITS and on the billed claims after reviewing the denial, please contact the BHS-SUD Billing Unit right away so we can conduct a further research on the issue or we can check the eligibility status on DHCS Medslite website. If the State database is the one with error, SUD BU will email the program to request the client or case worker to contact the State and make the corrections on file.

XIV. VOID OR DISALLOWANCE PROCESS

Void claims mean to treat a previously finalized claims as invalid or null. In SanWITS, a void is an administrative action performed by BHS-SUD Billing Unit to address or disallow services that <u>have been billed and approved by the State</u> but later identified by BHS QM or program's quality review team that services have not met the DMC standards or not Medi-Cal eligible and should have not been billed to DMC. Soon after determining the disallowed services, the program must complete the required Payment Recovery Form and send via secure email to ADSBillingUnit.HHSA@sdcounty.ca.gov. The Payment Recovery Form with Instructions (tab 2) is posted on the Optum website, **Billing** tab.

Note: The Adjustment Reason (AR) "11-Other" has been added to the Payment Recovery Form's AR list. Providers will only select "Other" as an option if the disallowed claims do not fall into AR categories 1 through 10. Please make sure to enter a short note/description why you picked "Other" on the line provided.

**Adjustment Reason is:
1. Beneficiary not D/MC eligible.
2. Service not provided.
3. Service not D/MC eligible.
4. Location of service not D/MC certified.
5. Medical necessity not established.
6. DSM code not identified or incorrect.
7. Incorrect use of "Good Cause" code.
8. Admission criteria time frames not met.
9. Treatment plan time frames not met.
10. Continuing services/treatment time frames not met.

11. Other (Explain or provide a brief description): _____

PAYMENT RECOVERY FORM (Rev. 10/15/2020)

Form | Instructions | ⊕

The Billing Unit will manually void or reverse the disallowed claims in SanWITS and will report them to DHCS by submitting the 837P Claim File. Any voided claims cannot be voided again nor can be replaced. We strictly encourage programs to carefully check the client and claim details in SanWITS (Claim Item List screen) when completing the Payment Recovery form to prevent voiding the valid claims.

There is no time limit or deadline to void a claim, provided that the claim has been billed and paid.

Also, please check the **Disallowance After Release to Billing** processes on the OPTUM website under **BILLING** tab and read the document that applies to your program.

Disallowance After Release to Billing OTP (pdf)

Disallowance After Release to Billing Outpatient (pdf)

Disallowance After Release to Billing Residential BD (pdf)

Disallowance After Release to Billing Residential Case Mgt (pdf)

XV. LATE OR RETRO BILLING

Drug Medi-Cal claims are considered late when submitted to billing after six months from the end of the month of service. Anything submitted beyond the 6-month period must have a good cause or a suitable delay reason code (DRC) provided by the program. SUD programs must contact the BHS-SUD Billing Unit when billing beyond 6 months for further assistance. SanWITS also requires the programs to complete the three (3) late billing fields per claim to create a provider batch.

Note: We have up to a year to bill for retro-active Medi-Cal, it depends on when the client was granted Medi-Cal. Please work with BHS-SUD Billing Unit for the good cause certification if you have claims to bill over 6 months.

XV-1. DELAY REASON CODES TABLE

HIPAA Delay Reason Code	HIPAA Descriptions	Description	Good Cause Certification (Paperwork) Required?
1	Proof of Eligibility Unknown or Unavailable	Patient or legal representative's failure to present Medi-Cal identification	No

7	Third Party Processing Delay	Billing involving other coverage including, but not limited to Medicare, Roos-Loos or CHAPMUS	No
8	Delay in Eligibility Determination	Circumstances beyond the control of the local program/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the State or county.	Yes
4,11	4-Delay in Certifying Provider 11-Other	Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster, willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency, when applicable.	Yes
10	Administrative Delay in Prior Approval Process	Special circumstances that cause a billing delay such as a court decision or fair hearing decision.	No
2	Litigation	Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code (WIC). Do not override late billing.	No

XV-2. LATE BILLING PROCESSES IN SANWITS

1) Provider must Login to their assigned Agency
2) Go to Billing -> Claim Item List
3) Select your Plan (Perinatal or Non-Perinatal)
4) Enter Item Status: Awaiting Review
5) Enter the service date or service date range
6) Click Go
7) The searched service(s) will display on your screen
8) Click the Profile per item/service
9) These three (3) fields must be completed by the provider/biller:

> 1. **DELAY REASON:** select the appropriate delay reason (click here to view the Valid Delay Reason List)
> 2. **REPORT TRANSMISSION TYPE:** by fax
> 3. **ATTACHMENT CONTROL NUMBER:** (use the format: 4-digit Provider Number, month and year of late service and the word "late"). Example: 37XX012020late, if you are billing for 01/2020 services.

10) After completing the required fields, click Release.

11) Create Batch and Send to the Clearing House or Government Contract.

12) Submit your provider's completed monthly billing report, submission certification (DHCS 100186 form) and if applicable, the Good Cause Certification.

   Note: Some delay reasons require extra paperwork (i.e. DHCS 6065A or DHCS 6065B) from county and provider to be submitted to the State. Make sure to refer to the Delay Reason Code Table when completing the late billing.

13) BHS BU staff will process the submitted provider batch and submit the 837P claim file to the State.

XVI. TROUBLESHOOTING SANWITS CLAIM PROCESSING ERRORS

Medi-Cal billing through SanWITS is direct and easy to follow. But some details and steps when overlooked may cause claim or batch processing errors. Each scenario presented below has its corresponding solution:

➢ **PROGRAM UNABLE TO CREATE A PROVIDER BATCH**

Issue: The system will not create a provider batch if claim items are in Awaiting Review status.

Solution: To successfully create a provider batch, programs must put the claim items in Released status.

Then, click the hyperlink Create Facility Batches.

Administrative Actions											
Create Agency Batches	Create Facility Batches										

Claim Item List (Export)			Reverse		Adjust		Reject					Update Status

Actions	Item #		Client Name	FFS Type	Add-On Level	Service Date	Service	Duration	Status	Release Date	Charge	ENC ID	Group Session ID
✏️	531674	☐		FFS	None	7/27/2020	H0005/U7	75 Min	Released	8/26/2020	$85.90	531920	100252

➢ **BATCH PROCESSING ERROR**

Issue: Claim Batch List is in error

Solution: Go to Billing- Claim Batch List page and select status: Batch Processing Error. Click Go. Open the Batch Profile and read the error description. A lot of times, the processing error is caused by invalid rendering staff or NPI.

To avoid batch processing error, make sure your program submitted the correct rendering staff information to BHS-MIS prior to billing. Also, the encounter screen's Rendering Staff field defaults to the current user. Select the correct rendering staff and click save before releasing to billing. Contact the Billing Unit if the batch processing error is different from the NPI error.

➢ **RENDERING STAFF OR NPI ERROR**

Issue: Rendering staff or NPI error is found after release to billing but claims are not yet batched.

Solution:

- Go to Claim Item List page - status: Awaiting Review or Released status, open the claim profile and in Administrative Actions, click Reject (Back out). The rejected claim item goes back to the Encounter List page. From there, enter the correct rendering staff and release the corrected claim to billing. Repeat these steps if you have multiple claims with rendering staff error.

- If wrong NPI instigated the batch error, the program should contact the SUD_MIS_Support.HHSA@sdcounty.ca.gov for assistance. Once the error is corrected, program should go back to SanWITS, Claim Batch folder. Open the Batch Processing Error profile and click the Administrative Action Reprocess Batch.

➢ **DATA ENTRY ERROR IS FOUND AFTER SUBMITTING THE CLAIM BATCH TO THE CLEARING HOUSE OR GOVERNMENT CONTRACT.**

Issue: Program needs to do data correction, but claims are already batched and submitted to the Clearing House or Government Contract.

Solution: Program should contact the BHS-SUD Billing Unit for assistance in rejecting the provider batch.

- A batch submitted to the Clearing House can still be rejected by the billing team as long as it is not yet submitted to the State.

- A residential Bed Day batch submitted to the Government Contract but not yet adjudicated by the Billing Unit can still be rejected and fixed. However, Billing Unit cannot reject any batch that is already adjudicated. Please contact ADSBillingUnit.HHSA@sdcounty.ca.gov for further assistance.

➢ **DATA ENTRY ERROR IN PGE**

Issue: Wrong Client Name/DOB/Subscriber ID # was entered in Payor Group Enrollment (PGE) screen

Solution: There is no need for the claim item or provider batch to be rejected. The program should go to the PGE screen, fix the error, and click the Save button.

Note: Any changes made to the Client Profile screen must be communicated or reported by program to SUD Help Desk.

XVIII. SUD ACRONYM LOOKUP

ACRONYM	DEFINITION/DESCRIPTION/MEANING
BHS	Behavioral Health Services
SUD	Substance Use Disorder
DMC-ODS	Drug Medi-Cal Organized Delivery System
OTP	Opioid Treatment Programs (former NTP)
ODF	Outpatient Drug Free
ADS	Alcohol and Drug Services
MIS	Management Information System (SUD Help Desk)
WITS	Web Infrastructure for Treatment Services
SanWITS	San Diego version of WITS
HIPAA	Health Insurance Portability and Accountability Act
COR	Contracting Officer Representative
QAR	Quality Assurance Review
DHCS	Department of Health Care Services
CIN	Client Identification Number or Medi-Cal Subscriber ID #
BIC	Benefits Identification Card
SOC	Share of Cost
OHC	Other Health Coverage or private insurance
COSD	County of San Diego
OOC	Out-of-County
BHS-SUD BU	Behavioral Health Services- Substance Use Disorder Billing Unit
MEDS	Medi-Cal Eligibility Data System
Programs	DMC certified providers
Encounter	Service
EOC	Evidence of Coverage
EOB	Explanation of Benefits
PCCN	Payer Claim Control Number
Medi-Medi	Medicare and Medi-Cal
BU/ SUD BU/BHS-SUD BU	County Billing Unit
837P File	Professional Health Care Claims submitted to the State
835 File	Remittance Advice or denial received from the State
AR	Adjustment Reason