SUD Treatment Claim Submissions 7/5/17

1. Prior to submitting invoice/claim, BHRS-AOD DMC providers are to run the AVATAR AOD Documentation at a Glance Report to ensure required fields are entered and correct any missing information. The following data is to be reviewed prior to finalizing claims by electronic submission and/or entered into AVATAR:

    a. Location Codes are entered for each billable DMC service
    b. Finalized Assignment of Benefits (AOB)
    c. Diagnosis (ICD-10)
    d. Current CALOMS Admission Bundle
    e. Treatment Plan date
    f. Consents
    g. ASI Status

2 Provider sends to Program analyst no later than the 10th of the month following the month of service:

    a. AOD Documentation at a glance Report
    b. Signed of BHRS/AOD Advanced Payment Invoice with original signature
    c. Signed DMC Claim Submission Form (form 100186) with ***original signature*** delivered to *BHRS MIS- 2000 Alameda De Las Pulgas, Suite 280 ~San Mateo, CA 94403 Attn: Nancy Ferreira*

3. Naming of DMC Submission Identifier for FORM 100186:
    - DMC Facility ID- Month-Year
    - DMC Facility ID- Month-Year- Retro

4. Provider sends to BHRS MIS:

    a. Electronic flat file, it can be sent or saved to FTP site
    or
    Provider Notifies BHRS MIS AOD-Corrections@smcgov.org and CC to Program Analyst by the 10th of the month that all services have been entered and finalized in AVATAR
    b. Provider will work promptly with BHRS MIS until all billing issues are resolved
    c. Provider must notify MIS at AOD-Corrections@smcgov.org with copy to BHRS Analyst and of all retroactive claims in file being submitted no later than the 10th of the month. The notification shall include:
        i. Client #
        ii. Episode #
        iii. Service dates
        iv. Proof of eligibility
        v. Reason the claim is late
        vi. Location Code changes
        vii. Original Retro DHCS FORM 100186, mailed to MIS

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

DRUG MEDI-CAL (DMC) CLAIM SUBMISSION CERTIFICATION - COUNTY CONTRACTED PROVIDER

County Name:_____

Provider Name (Legal Entity):_____

DMC Number(s): _____

Service Facility Location NPI(s):_____

DMC Submission Identifier:_____

FOR COUNTY USE ONLY:

Receipt Date:_____

EDI File Name:_____

EDI File Submission Date:_____

COUNTY CONTRACTED PROVIDER CERTIFICATION

As required by 42 CFR Part 455.18, this is to certify that the claim file information submitted by the provider in the DMC submission identified above is true, accurate and complete. I understand that payment of this claim file will be from Federal, State, and/or County Realignment funds, and that any falsification, or concealment of material facts, may be prosecuted under Federal and/or State laws.

I hereby agree to keep such records as are necessary to disclose fully the extent of the services provided to individuals under the State's Title XIX and Title XXI plan and to furnish information regarding any payments claimed for providing such services as the State Department of Health Care Services or the Department of Health and Human Services may require. I further agree to accept as payment in full the amount paid by the Medi-Cal program for those claim files submitted for payment under the program with the exception of authorized deductible, co-insurance, or similar cost sharing charge.

I certify that the services identified in the above identified DMC submission were medically indicated and necessary to the health of the patients and were personally furnished by me or an employee working for the provider.

Printed Name: AUTHORIZED SERVICE PROVIDER		
Signature: AUTHORIZED SERVICE PROVIDER	Phone Number	Date Signed

DHCS 100186 (Revised 6/2014)

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.