Avatar Billing Reports

Updated 11/4/2011

These reports provide information about Clients and Services in the Avatar PM module. CBHS Providers generate these reports to confirm Client and Service information entered is accurate and complete; and, for information about billing to third party payers or patient accounts.

Report Name: Client Ledger

Menu Path:
AVATAR PM/ Client Management/ Account Management/ Client Ledger

Report Parameters : Client Name or PATID, Episode, Date Range

Description/ Purpose:
Generate this report to review a specific Client's service charges, guarantors and status, funding sources billed or to be billed.

The Client Ledger report provides a snapshot of a Program's Episode Services and its Status by Guarantor. Under the "Claim Number" column, there are three possible service status, these are: ***Open*** means service is not "closed" and can be edited or deleted; ***Unbilled*** means the service is in an Interim Claim Batch and will be billed to a third party payer soon; and, a ***Claim ID number*** which means the service charge is closed and submitted on a claim.

A guarantor number '99999' (CSM Default Payor) indicates the service charge is not posted because of a problem with the Client's Financial Eligibility record or due to another issue.

The report can used to determine whether services can be edited or deleted, or if a BH7019 must be completed; also, to review service history and to determine if there is a problem with service posting, claims, or guarantors. Use the report to help answer questions a Client may have about his/her patient statement, Clinic charges, or insurance payers billed.

A Summary of amounts assigned to each of the Client's guarantors or payer sources can be found at the end of the report.

How to resolve issues identified on the Report:

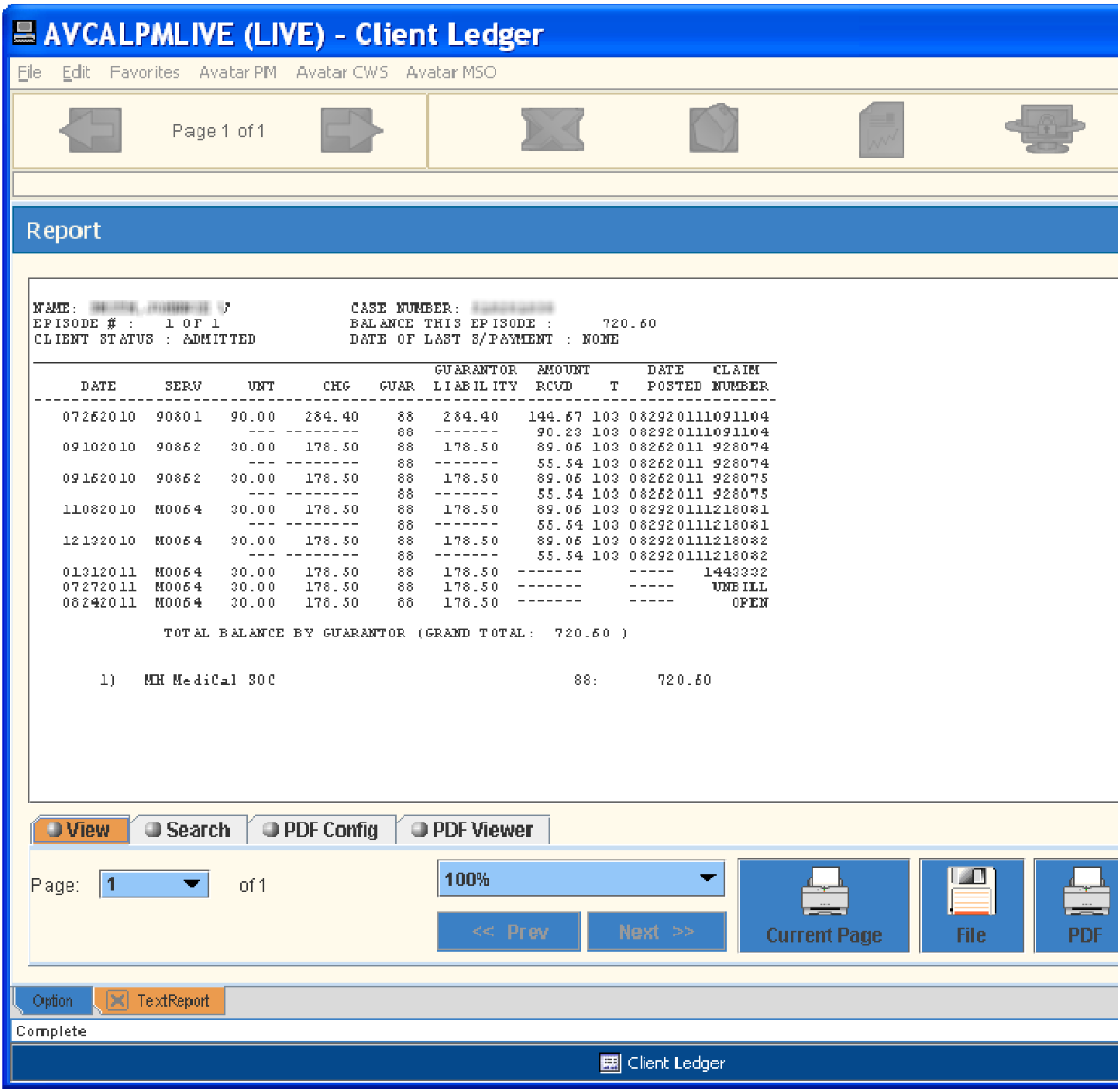
1. CSM Default Guarantor 99999 issues:
    - If the Client does not have a Financial Eligibility Record - verify eligibility and enter an FE record with Guarantor information for the Client

- Service(s) was entered with a default Practitioner ID or "Conversion Practitioner" – review Service detail information to confirm this is the problem and use Edit Service Information screen to update with the Practitioner ID of the rendering Clinician.

2. Wrong or Missing Guarantors for the Client
    - Never Delete a guarantor from the Client's FE record
    - Please contact CBHS Billing

Recommended frequency to run this report:
As needed

Report Sample:


AVCALPMLIVE (LIVE) - Client Ledger
File Edit Favorites Avatar PM Avatar CWS Avatar MSO
Page 1 of 1
Report
NAME: [redacted] CASE NUMBER: [redacted]
EPISODE # : 1 OF 1 BALANCE THIS EPISODE : 720.60
CLIENT STATUS : ADMITTED DATE OF LAST S/PAYMENT : NONE
DATE SERV UNT CHG GUAR GUARANTOR LIABILITY AMOUNT RCVD T DATE POSTED CLAIM NUMBER
07252010 90801 90.00 284.40 88 284.40 144.67 103 08292011091104
--- 88 ------- 90.23 103 08292011091104
09102010 90862 30.00 178.50 88 178.50 89.06 103 08262011 928074
--- 88 ------- 55.54 103 08262011 928074
09162010 90862 30.00 178.50 88 178.50 89.06 103 08262011 928075
--- 88 ------- 55.54 103 08262011 928075
11082010 M0064 30.00 178.50 88 178.50 89.06 103 08292011218081
--- 88 ------- 55.54 103 08292011218081
12132010 M0064 30.00 178.50 88 178.50 89.06 103 08292011218082
--- 88 ------- 55.54 103 08292011218082
01312011 M0064 30.00 178.50 88 178.50 ------- ----- 1443332
07272011 M0064 30.00 178.50 88 178.50 ------- ----- UNBILL
08242011 M0064 30.00 178.50 88 178.50 ------- ----- OPEN
TOTAL BALANCE BY GUARANTOR (GRAND TOTAL: 720.60)
1) MH MediCal 30C 88: 720.60
View Search PDF Config PDF Viewer
Page: 1 of 1
100%
<< Prev Next >>
Current Page File PDF
Option TextReport
Complete
Client Ledger

Report Name: **Crystal Client Ledger**

Menu Path:
AVATAR PM/ Client Management/ Account Management / Crystal Client Ledger

Report Parameters : Client Name or PATID, Episode, Date Range

Description and Purpose:
This Crystal Reports version of the Client Ledger includes hyperlinks to Service Details, Practitioner, Financial Eligibility / guarantor information, Claims and Payments received for each service line.

Generate this report to review details of the Client's service, practitioner, guarantor, and claiming information.

Report Sample:

San Francisco DPH
1380 Howard St
San Francisco CA, 94103

Client Account Ledger

Client Name:
Client ID :
Selected Episode:

Diagnosis History
Graph of Charges & Payments By Month
Admit Date: 7/21/2010 Discharge Date:

Date of Service	Service Description	Full Charge	Practitioner	Guarantor Name	Guarantor Liability	Guarantor Payments	Claim Number
10/18/2010	NO SHOW	$ 0.00	00	General Fund	$ 0.00	$ 0.00	Open
04/04/2011	NO SHOW	$ 0.00	00	General Fund	$ 0.00	$ 0.00	Open
06/27/2011	NO SHOW	$ 0.00	00	General Fund	$ 0.00	$ 0.00	Open
09/26/2011	NO SHOW	$ 0.00	00	General Fund	$ 0.00	$ 0.00	Open
07/26/2010	PSYCHIATRIC DIAGNOSIS INTERVIEW EXAM	$ 284.40	00	DMH	$ 284.40	$ 234.90	1091104
09/10/2010	Medication Mgmt W/Brief Psychotherapy	$ 178.50	01	DMH	$ 178.50	$ 144.60	928074
09/16/2010	Medication Mgmt W/Brief Psychotherapy	$ 178.50	01	DMH	$ 178.50	$ 144.60	928075
11/08/2010	BRIEF MEDICATION VISIT	$ 178.50	00	DMH	$ 178.50	$ 144.60	1218081
12/13/2010	BRIEF MEDICATION VISIT	$ 178.50	00	DMH	$ 178.50	$ 144.60	1218082
01/31/2011	BRIEF MEDICATION VISIT	$ 178.50	00	DMH	$ 178.50	$ 0.00	1443332
07/27/2011	BRIEF MEDICATION VISIT	$ 178.50	00	DMH	$ 178.50	$ 0.00	Unbilled
08/24/2011	BRIEF MEDICATION VISIT	$ 178.50	00	DMH	$ 178.50	$ 0.00	Open
				Totals	$1,533.90	$813.30	

On the Crystal Client Ledger, click on the Blue hyperlink fields to view additional detail information.

Service Detail: (for this, Click on "Date of Service" hyperlink)

Report Name: **Missing Diagnosis Report**

Menu Path:

AVATAR PM / Billing / Billing Reports / Missing Diagnosis

Parameter: Program

Description and Purpose:

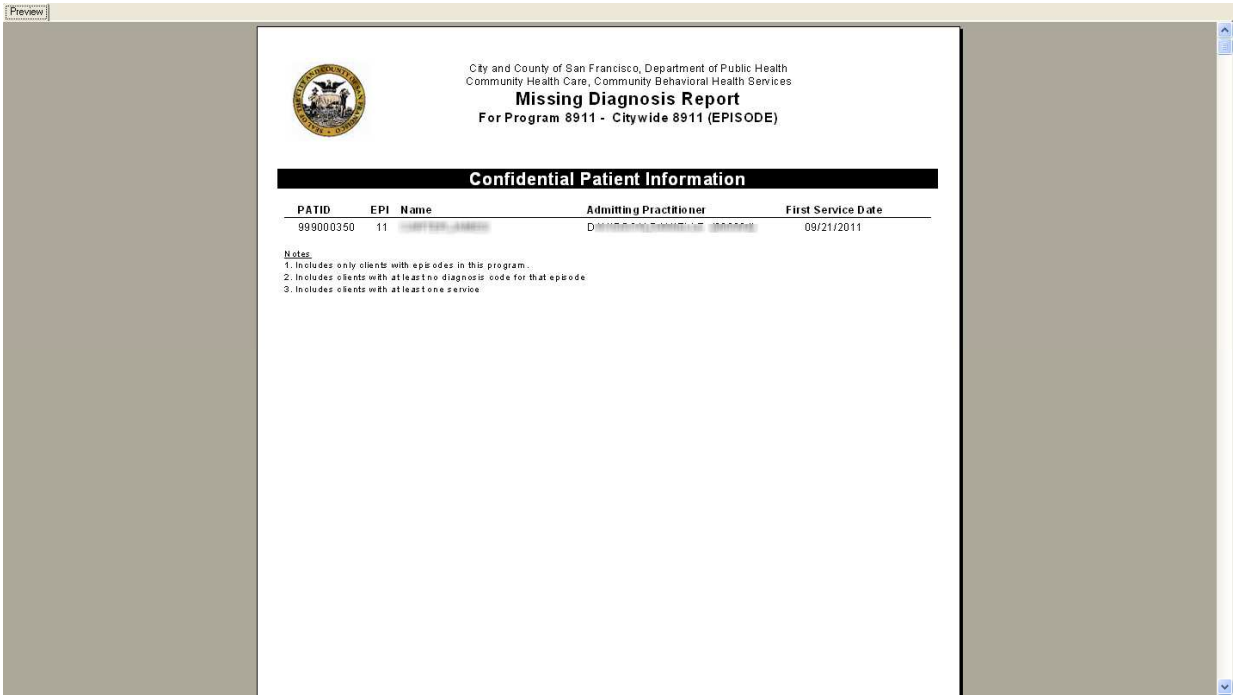
The report lists Clients without the required Diagnosis information in the program Episode. In Avatar, the Admission diagnosis entered for the Client must have an effective date that covers the "First Service date" listed on the report.

Recommended Frequency for this report:
Weekly

How to resolve issues identified on the Report:

For the specified Episode, enter diagnosis information for the Client in AVATAR PM, Client Management/ Client Information/ Diagnosis screen.

Review the Admission Diagnosis' effective date entered for the Client covers his/her first Service date.


Preview

City and County of San Francisco, Department of Public Health
Community Health Care, Community Behavioral Health Services
Missing Diagnosis Report
For Program 8911 - Citywide 8911 (EPISODE)

Confidential Patient Information

PATID	EPI	Name	Admitting Practitioner	First Service Date
999000350	11	[redacted]	[redacted]	09/21/2011

Notes:
1. Includes only clients with episodes in this program..
2. Includes clients with at least no diagnosis code for that episode
3. Includes clients with at least one service

Report Name: **Invalid Diagnosis Report / DMC 799 Error Report**

Menu Path:
AVATAR PM / Billing/ Billing Reports/ Pre Claiming Reports / Invalid Diagnosis

Parameters: Program, Start and End Dates

Description and Purpose:
This report lists Clients with Program services within the date range parameter entered, and have an invalid diagnosis code. Diagnosis information in Avatar is validated against an ICD-9 diagnosis codes table. Diagnosis codes are updated annually nationally; some codes are deleted and new ones added. There are code edits in payer systems for electronic claims, such as in Medicare and in Medi-Cal. The report is used to prevent service claims from being denied due to an expired or invalid diagnosis code.

Services with an Invalid diagnosis on SDMC claims will cause the entire claim file to be rejected; therefore, these services are removed from the claim file submitted to DHCS. Services with non-covered or invalid diagnosis are transferred to the “General Fund” guarantor if not corrected timely.

Recommended Frequency for this report:
Weekly

How to resolve issues identified on the Report:
Invalid diagnosis may be in Axis 1, Axis 2, and/or Axis 3, in primary, secondary or tertiary diagnosis under each Axis. Verify and update the diagnosis code. There are free ICD-9 diagnosis look-up tools that are available on-line, to confirm diagnosis codes are valid.

Report Sample:

City and County of San Francisco, Department of Public Health
Community Health Care, Community Behavioral Health Services

Invalid Diagnosis Report
From 07/01/2010 to 07/31/2011

Confidential Patient Information

Citywide 8911 (EPISODE) (8911) * = Principal Diagnosis

Client ID	EP	Name	Diagnosis Date	Diagnosis Type	Diagnosis Practitioner	Axis 1	Axis 2	Axis 3
98	12		10/12/2010	A	(00 HEN	**309.81** *	799.91	
						303.91		
						304		
98	15		10/06/2010	A	(01 EPH	**296.67** *	799.91	
						304.8		

Notes
1. Includes only clients with services during user selected date range.
2. Includes clients who have an invalid diagnosis code in Axis I - 1, Axis I - 2, Axis I - 3, Axis II - 1, Axis II-2, or Axis II - 3
3. Includes client who have a diagnosis code of 799.9 or V71.09 in Axis III - 1, Axix III - 2, or Axis III - 3
4. Includes clients who have an episode for the selected Program

Report Name: **Uncleared Share-of-Cost by Program**

Menu Path:
Avatar PM / Billing / Billing Reports/ Pre Claiming Reports

Parameters: Program, Start and End Dates

Description and Purpose:
This report informs Providers about Medi-Cal Clients who have a monthly Share-of-cost based on information reported on the Monthly MEDS Extract File received from the State and applied in AVATAR. The cost of services received by the Client during the month is also reported.

CBHS Providers are required to obligate their Client to pay for the cost of services received during the month, up to their Share-of-Cost amount. If the Client is unable to pay this amount, an UMDAP sliding fee must be determined for their SOC services. Service amounts above the Client's SOC are billed to MediCal.

Clients are billed the full cost of services, or their Share-of-Cost amount, or their monthly UMDAP amount, whichever is less.

Note: CBHS Billing clears all Clients' monthly SOC amounts centrally prior to generating SDMC MH and SA claims.

How to resolve issues identified on the Report:

1. A Medi-Cal SOC Client is not listed on the report
    - New Clients with SOC must be linked to the MEDS file initially, when their Financial Eligibility record is entered in Avatar. If not linked, the report will not show Medi-Cal information. Share-of-Cost may not be cleared and, services will be denied by SDMC.
2. Client has a large monthly Share-of-Cost amount and informed Clinic staff he/she does not have any money or income.
    - Please refer the Client to their Medi-Cal Eligibility Worker at DHS Social Services department or County Welfare Office so they may reassess and update SOC based on the Client's current financial status.
3. According to the Client, he/she does not have a monthly MediCal SOC, but you see the Client listed on the report.
    - Please verify Medi-Cal eligibility through the Medi-Cal website or POS device or Real Time 270 Inquiry in Avatar. If Client's information (i.e., CIN, Medi-Cal eligibility, MEDS ID) is not the same, please contact CBHS Billing for further instructions.
4. It's the first of the month and the report does not show any data.
    - The report depends on the MMEF (Monthly MEDS Extract File) to be received from the State. If the file has not been applied in Avatar, the current month's data will not appear on the report. Also, the "Cost of

Services" field will be blank if services are not yet entered by any Provider. Wait two days and try generating the report again.

Recommended Frequency for this report:
Monthly

Report Sample:

City and County of San Francisco, Department of Public Health
Community Health Care, Community Behavioral Health Services

Medi-Cal Share of Cost
From 09/01/2011 To 09/30/2011
Program Community [redacted]

Confidential Patient Information

PATID	EP #	Name	SOC Unmet	Cost of Services
98[redacted]	2	LA[redacted]	$621.00	**$3,360.60**
98[redacted]	32	LA[redacted]D	$974.00	**$2,306.40**
97[redacted]	1	MY[redacted]	$685.00	**$2,403.96**
22[redacted]	1	OL[redacted]E	$581.00	**$2,124.38**
98[redacted]	2	PE[redacted]NO	$564.00	$156.51
97[redacted]	2	SE[redacted]	$603.00	**$1,856.60**
81[redacted]	2	TA[redacted]E	$886.00	**$920.65**

Notes
1. Includes only clients with unmet shared of cost values greater than zero for user selected date range and program

Report Name: **Subscriber Address Validation by Program**

Menu Path: Avatar PM/ Billing/ Billing Reports/

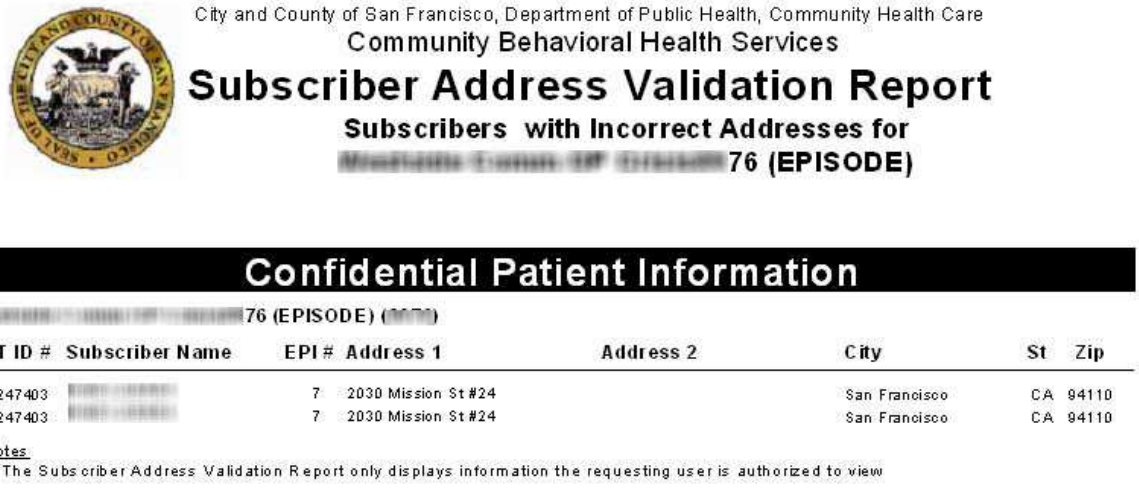
Description and Purpose:
This report was created because the entire SDMC mental health and substance abuse service claim files were being rejected when files contain invalid information and fails the State's initial HIPAA file format edits. One of these edits pertain to Clients' Address information.

The report lists Clients with invalid address information or containing values not accepted in HIPAA electronic files, such as punctuation marks or symbols, such as: #, periods or commas. For HIPAA 5010, the report will list Client address Zip Codes that are missing the required 4-digit extension. The HIPAA 5010 format will be enforced in CBHS programs, beginning 12/1/2011.

How to resolve issues identified on the Report:
Remove invalid values entered in Avatar PM, Client Address records. (Menu path: Avatar PM/ Client Management/ Client Information/ Update Client Data) Changes to Client address are automatically pushed to all Guarantor records in the Client's Financial Eligibility record(s).

Recommended Frequency for this report:
Monthly

Report Sample:



City and County of San Francisco, Department of Public Health, Community Health Care
Community Behavioral Health Services

Subscriber Address Validation Report

Subscribers with Incorrect Addresses for
[redacted]76 (EPISODE)

Confidential Patient Information

[redacted]76 (EPISODE) ([redacted])

PAT ID #	Subscriber Name	EPI #	Address 1	Address 2	City	St	Zip
981247403	[redacted]	7	2030 Mission St #24		San Francisco	CA	94110
981247403	[redacted]	7	2030 Mission St #24		San Francisco	CA	94110

Notes
1. The Subscriber Address Validation Report only displays information the requesting user is authorized to view

Report Name: **Possible Duplicate Services by Program**

Menu Path: Avatar PM/ Billing/ Billing Reports/ Ad Hoc Reports

Parameters: Program, Start and End Dates

Description and Purpose:
Within the date range parameters used, this report lists multiple services that were entered for a Client, with the same service date under the Program's episode. This includes entries made using ADM codes (for No Show or for Administrative Note). A Duplicate Override Code must be entered for these services to indicate they are in fact, valid. Any duplicate services billed in error must be deleted or adjusted/ backed out.

How to resolve issues identified on the Report:
For Valid multiple services, Program staff enter Modifiers in each Client's Avatar PM service record thru the "Edit Service Information" screen. All services must include the duplicate override code required, including on the first service entered. A "lightbulb" on the screen next to the Modifier field, provides a guide for each code and format required.

SDMC requires Void transactions for MH and SA services billed in error to the Medi-Cal program. CBHS Providers use the BH7019 Claim & Cost Report Adjustment form and process, to submit claimed service corrections to CBHS Billing.

Recommended Frequency for this report:
Generate the report weekly to find Service records that require a duplicate override code, or to submit a Service Deletion request to CBHS Billing, while Service charges are still in "OPEN" status (see Client Ledger).

City and County of San Francisco, Department of Public Health, Community Health Care
Community Behavioral Health Services

Possible Duplicate Services by Program

Clients with Possible Duplicate Services For [redacted] (38[redacted])
From 9/1/2011 To 9/30/2011

Confidential Patient Information

Client#	EP	Client Name	Service Code / Modifier		Duration	DOS	Program Code	Name	Practitioner Name (ID)	Guarantor ID(s)
461060010	3	A[redacted]N	H2015IT	HE,76	50	09/07/2011	38[redacted]	[redacted]	M[redacted]07)	88
461060010	3	A[redacted]N	H2015IT	HE,76	15	09/07/2011	38[redacted]	[redacted]	M[redacted]07)	88
461060010	3	A[redacted]N	H2015IT		30	09/21/2011	38[redacted]	[redacted]	M[redacted]07)	88
461060010	3	A[redacted]N	H2015IT		20	09/21/2011	38[redacted]	[redacted]	M[redacted]07)	88
461060010	3	A[redacted]N	H2015IT		15	09/21/2011	38[redacted]	[redacted]	M[redacted]07)	88
698303100	3	A[redacted]ARLEN	H2010MT		135	09/09/2011	38[redacted]	[redacted]	B[redacted]2)	88
698303100	3	A[redacted]ARLEN	H2010MT		75	09/09/2011	38[redacted]	[redacted]	B[redacted]2)	88
698303100	3	A[redacted]ARLEN	T1017	HE,76	60	09/09/2011	38[redacted]	[redacted]	D[redacted]	88
698303100	3	A[redacted]ARLEN	T1017	HE,76	30	09/09/2011	38[redacted]	[redacted]	D[redacted]	88
981300367	2	B[redacted]	90804		20	09/29/2011	38[redacted]	[redacted]	Y[redacted]	88
981300367	2	B[redacted]	90804		48	09/29/2011	38[redacted]	[redacted]	V[redacted]3711)	88
981300367	2	B[redacted]	H2015IT		20	09/19/2011	38[redacted]	[redacted]	K[redacted])	88
981300367	2	B[redacted]	H2015IT		20	09/19/2011	38[redacted]	[redacted]	N[redacted]	88
981251230	20	B[redacted]S	H2010MT	HE,76	15	09/06/2011	38[redacted]	[redacted]	B[redacted]2)	88
981251230	20	B[redacted]S	H2010MT	HE,76	60	09/06/2011	38[redacted]	[redacted]	B[redacted]2)	88
981251230	20	B[redacted]S	H2015IT	HE,77	50	09/02/2011	38[redacted]	[redacted]	M[redacted]07)	88
981251230	20	B[redacted]S	H2015IT	HE,77	20	09/02/2011	38[redacted]	[redacted]	C[redacted]094)	88

Report Name: **NTST Guarantor Clean Up Report by Program**
Aka "99999 Cleanup Report"

Menu Path: Avatar PM/ Billing/ Billing Reports
Parameters: Program, Start & End Dates

Description and Purpose:
This report lists Clients with missing or erroneous data in their Program Episode, which prevent their services from posting.

In Avatar, each episode requires a corresponding Financial Eligibility record. The FE record for the Program's Episode for the Client may be missing.

The report may include Client services that are under an incorrect episode. The Clinician may have picked the incorrect episode when entering the Client's progress note in CWS, or when charges were entered in PM. This resulted in the service record in Avatar PM to be under the wrong program episode.

How to resolve issues identified on the Report:
If a Financial Eligibility record was not entered during Client's admission into your Program, obtain and verify the Client's healthcare coverage information as soon as possible, and enter the correct guarantor(s) for the Client in Avatar PM.

If Service(s) is in the wrong episode because of the incorrect CWS entry, contact the Avatar Help Desk. Provide the Client number, Service information (date, procedure code, Clinician), the incorrect episode used and what the correct Episode for the service should be, and any other information that will assist Help Desk Staff to resolve this issue. If the service record was created from a CWS Progress Note, the deleted service will turn the Progress Note into an "Independent Note" which, under specific circumstances, can be re-linked to the new (correct) service record in PM.

If the Service records are under the wrong Client and wrong episode, they will need to be deleted in Avatar PM, and the progress note expunged from the wrong Client record in CWS.

Inform the Clinician about corrective actions taken and request appropriate measures to be taken, in order to prevent future errors.

If the Service was entered via Client Charge Entry, contact the Avatar Help Desk and request the service to be deleted. Enter the service under the correct episode **AFTER** confirming that the Service record was successfully deleted from Avatar PM.

Recommended Frequency for this report:
Weekly, correct errors as soon as possible.

Report Sample:

San Francisco DPH
1380 Howard St
San Francisco CA, 94103

Guarantor 99999
Cleanup Report

Client ID	*Episode #*	*Client Name*	*Date of Service*	*Service Code*	*Duration*	*Guarantor Liability*	*Status*	*Data Entered By*
Program								
981401370	3	B IG	9/20/2011	H2015GT	140	73.73	Open	Cir
999001774	1	Tl	9/13/2011	H2015IT	67	211.72	Open	Jor
999001774	1	Tl	9/20/2011	H2015IT	46	145.36	Open	Jor
999001774	1	Tl	9/27/2011	H2015IT	37	116.92	Open	Jor
999014395	1	G	9/28/2011	H2015AS	40	133.20	Open	Lir
			Guarantor Liability Total			**680.93**		

Report Name: **Financial Eligibility by Program**

Menu Path: Avatar PM/ Billing/ Billing Reports/ Pre Claiming Reports

Parameters: Program, Start and End Dates

Description and Purpose:
This report provides a listing of the Program's active Clients and the Financial Eligibility information entered under the Episode. The report lists: entered Guarantors, Medi-Cal CIN and/or health insurance Policy ID number, and selections made for the Client's: assignment of benefits, authorization to release information for billing purposes, and agreement to coordinate healthcare benefits.

Provider Staff reviews this report to confirm their Clients' Financial Eligibility and guarantor information are accurate and complete. Look for inconsistencies with the guarantor information entered for Clients; for example, if a Client has Full Scope Medi-Cal benefits with no monthly Share-of-Cost requirement, the Client should not have a Self-Pay UMDAP guarantor. If the Client has a Medi-Cal guarantor, their record must include a CIN or beneficiary ID number. If the Client has Medicare benefits or Insurance coverage, their record must have a HIC number or Policy number in the Avatar FE, Subscriber ID field.

Recommended Frequency for this report:
Weekly for large programs (Active Caseload of 200 Clients or more) or **Monthly** for smaller programs, to ensure Services are correctly billed.

How to resolve issues identified on the Report:
Review the report for the following:

1. Clients have appropriate and complete Guarantor information, including the billing order or sequence for all Guarantors within the Financial Eligibility record. (i.e., "General Fund" is listed as the last guarantor.)
2. If the Medi-Cal CIN or health insurance policy number is missing, please obtain and enter this information in the guarantor record.
3. "Y" must be in the last 3 columns of the report Assignment of Benefits, Release of Information, Coordination of Benefits. The Client's services will not be billed if any other value (besides a "Y") is entered. Update the Client's guarantor information: if Client should not be billed, enter your name, effective date, and reason for non-billing in the guarantor record's "Coverage Comments" field, or contact CBHS Billing (see #8).
4. Refer **HMO insured Clients** to their HMO for non-crisis or planned services. Otherwise, obtain a Prior-authorization or Documentation of insurance denial of coverage for them, and determine their Patient Fee payable (see #6)
5. Clients are billed the cost of services up to their monthly **Medi-Cal Share-of-Cost** amount. These services are not payable by Medi-Cal and are the responsibility of the Client.

- Enter a “Full Pay, no UMDAP” guarantor for Clients who wish to pay their MC Share-of-Cost.
- If the Client is unable to pay their monthly Medi-Cal Share-of-Cost amount, the Client can be obligated to pay an UMDAP annual liaibility amount. Enter a “Self-Pay UMDAP” guarantor in these Clients’ Financial Eligibility record, complete the Avatar PM Family Registration screen to create a Patient Account, and have the Client sign the PFI consent form.

6. A “Self-Pay UMDAP” or “Full Pay – No UMDAP” guarantor is required for Clients who have **Restricted Medi-Cal benefits**. Only Pregnancy and/or Emergency services will be payable by Medi-Cal. Complete a Family Registration record to create a Patient Account for these Clients, to determine their Patient fee amount payable, and have the Client sign the PFI consent form. An emergency or pregnancy indicator is required on all services submitted to SDMC.
7. A “Self-Pay UMDAP” or “Full Pay – NO UMDAP” guarantor is required for Clients who do not have Medi-Cal benefits. . Complete a Family Registration record to create a Patient Account for these Clients and have the Client sign the PFI and agreement to pay the Patient fee determined.
8. Contact the CBHS Billing Inquiry Line, (415) 255-3557 and leave a message with your contact information if you have further questions.

Report Sample:

City and County of San Francisco, Department of Public Health
Community Health Care, Community Behavioral Health Services

Financial Eligibility For Program
From 09/01/2011 To 09/30/2011

Confidential Patient Information

Client ID	EPI	Name	#	Guarantor	CIN	Policy #	Assign of Benefits	Release of Info	Coord Benefits
98	1	AA	1	Self Pay UMDAP			Y	Y	Y
			2	General Fund			Y	Y	Y
98	1	AA	1	Medicare Part B - Outpatient		430136118A	Y	Y	Y
			2	MH MediCal Full Scope	95727242E	95727242E	Y	Y	Y
			3	Self Pay UMDAP			Y	Y	Y
			4	General Fund			Y	Y	Y
99	1	AB	1	DMH Medi-Cal with Share of Cost	98048200C	98048200C	Y	Y	Y
			2	General Fund			Y	Y	Y
99	1	AB M	1	Self Pay UMDAP			Y	Y	Y
			2	Healthy San Francisco		33801159123092	Y	Y	Y
			3	General Fund			Y	Y	Y
98	3	AB	1	Medicare Part B - Outpatient		564932806A	Y	Y	Y
			2	MH MediCal Full Scope	96872127D	96872127D	Y	Y	Y
			3	Self Pay UMDAP			Y	Y	Y
			4	General Fund			Y	Y	Y
99	1	AB URAD	1	Self Pay UMDAP			Y	Y	Y
			2	General Fund			Y	Y	Y
98	1	AB	1	Medicare Part B - Outpatient		571190794A	Y	Y	Y
			2	MH MediCal Full Scope	94475945C	94475945C	Y	Y	Y
			3	General Fund			Y	Y	Y
98	3	AB A	1	Kaiser Permanente		13319078	Y	Y	Y
			2	MH Restricted MediCal	93669884E	93669884E	Y	Y	Y
			3	General Fund	93669884E		Y	Y	Y

Avatar Data as of 10/18/2011 Financial Eligility by Program v2 Page 1 of 81

Report Name: **Assignment of Benefits Validation Medi-Cal Report**

Menu Path: Avatar PM/ Billing/ Billing Reports/ Pre-claiming Reports

Parameter: Program

Description and Purpose:
This report provides a listing of the Program's active Clients who have a Medi-Cal guarantor within an episode's Financial Eligibility record. The report lists: Client, Medi-Cal CIN (Client Index Number, the beneficiary's MediCal number), and what was entered for Assignment of benefits, Authorization to release information for billing purposes, and agreement to Coordinate healthcare benefits.

Provider Staff review this report to confirm their Clients' Financial Eligibility and Medi-Cal guarantor information is accurate and complete in order to ensure Medi-Cal is billed for program services

Recommended Frequency for this report:
Monthly

How to resolve issues identified on the Report:

- If the Medi-Cal CIN or health insurance policy number is missing, please obtain and enter this information in their guarantor record.
- A "Y" must be in the report columns for Assignment of Benefits, Release of Information, and Coordination of Benefits in order for the Client's services to be billed to Medi-Cal. The Client's services will not be billed if any other value (besides a "Y") is entered. In these cases, Program Staff include their Name, entry date, and a brief explanation of the reason(s) SDMC should not be billed, in "Coverage Comments" field in the Client's Financial Eligibility record. If a data entry error was made, please correct the Medi-Cal guarantor record.

Report Sample:

City and County of San Francisco, Department of Public Health
Community Health Care, Community Behavioral Health Services

Assignment of Benefits Validation Medi-Cal Report
For Program [redacted]

Confidential Patient Information

Dore St Clinic Mode 10 (EPISODE) (38GMD)

PATID	EPI	Name	Guarantor	CIN	Assign of Benefits	Release of Info	Coord Benefits
981[redacted]	24	I[redacted]	DMH	9003[redacted]	Y	I	Y

Notes
1. Includes only clients with episodes in this program.
2. Includes clients who have a financial eligibility record with the Assignment of Benefits not equal to "Y", or Subscriber Release of Information not equal to "Y" or "I", or the Coordination of Benefits not equal to "Y"

Report Name: **Face-to-Face Error Report by Program**

Menu Path: Avatar PM/ Billing/ Billing Reports/ Pre Claiming Reports

Parameters: Program, Start and End Dates

Description and Purpose:
This report lists Program Clients with service records in Avatar PM that are missing CBHS required durations for Face-to-Face time (FTF) and/or Documentation/Travel time. The Service record may have been created from Clinician entered CWS Progress Notes, or from Client Charge entries that are missing this required information.

Medicare is billed only the FTF portion of services. If information is missing, the resulting Medicare claim will be incorrect. For Medi-Medi services, the SDMC billed amount and service units will also be incorrect.

Note: ADM or an Administrative note records are listed on this report because FTF time is not normally entered; instead, Clinicians enter Total Durations for the ADM note. Providers review ADM durations to confirm appropriate amounts of time were entered for documenting the No Show (ADM00) or for entering the Administrative Note (ADM99) in Clients' CWS record. If additional time was spent on other activities, a separate progress note with the appropriate procedure code may be entered. Consult the CBHS Documentation Manual for guidelines related to administrative notes and Client services.

How to resolve issues identified on the Report:
If Services in error are in "Open" status, enter the missing FTF and/or Doc/Travel Time by updating the Client's Service record in Avatar PM in the "Edit Service Information" screen.

If Services in error were already submitted on a third-party payer Claim and/or reported on FY Cost Reports with incorrect Units of Service, complete the BH7019 and submit to CBHS Billing. Enter an "addendum" in the Client's CWS Progress Note to notate the error and its correction.

Contact the Avatar Help Desk if you need further assistance.

Recommended Frequency for this report:
Weekly. Missing Information and any updates needed must be entered as soon as possible, and prior to service closing dates.

Report Sample:

City and County of San Francisco, Department of Public Health, Community Health Care
Community Behavioral Health Services

Face to Face Error Duration by Program

Services From 09/01/2011 To 09/30/2011

Confidential Patient Information

Client ID - EP #	Name	Staff ID	Service Code	Date of Service	Total Duration	Cost of Service	FTF Time	Doc Time
228311930 - 1			4 ADM00	09/12/2011	50	$ 0.00	0	0
228311930 - 1			0 H2015AS	09/06/2011	20	$ 66.60	0	0
698301680 - 1			7 T1017	09/23/2011	20	$ 50.60	0	0
698301680 - 1			0 T1017	09/14/2011	30	$ 75.90	0	0
698301680 - 1			0 H2010MT	09/28/2011	30	$ 170.10	0	0
981470407 - 4			9 ADM00	09/16/2011	30	$ 0.00	0	0
981292668 - 7			3 ADM00	09/23/2011	30	$ 0.00	0	0
981292668 - 7			9 ADM00	09/29/2011	30	$ 0.00	0	0
999006142 - 4			0 M0064	09/16/2011	15	$ 89.25	0	0
128409360 - 1			0 T1017	09/12/2011	10	$ 25.30	0	0
128409360 - 1			0 ADM99	09/22/2011	30	$ 0.00	0	0
981381031 - 1		AGN	2 ADM00	09/08/2011	30	$ 0.00	0	0
981260963 - 3			3 ADM00	09/16/2011	30	$ 0.00	0	5
981459120 - 3			9 ADM00	09/29/2011	30	$ 0.00	0	0
718700730 - 1			2 ADM00	09/06/2011	30	$ 0.00	0	0
718700730 - 1			8 T1017	09/15/2011	10	$ 25.30	0	0
718700730 - 1			8 T1017	09/16/2011	45	$ 113.85	0	0
999008342 - 2			7 ADM00	09/22/2011	30	$ 0.00	0	0
461120070 - 1			0 T1017	09/06/2011	20	$ 50.60	0	3
461120070 - 1			0 T1017	09/26/2011	25	$ 63.25	0	5
981431617 - 2			4 ADM00	09/13/2011	30	$ 0.00	0	0
999012192 - 1			4 ADM00	09/20/2011	50	$ 0.00	0	0
981300674 - 6			2 ADM00	09/26/2011	30	$ 0.00	0	0
981373424 - 2			9 H2010MT	09/01/2011	15	$ 85.05	0	0
981348731 - 1			0 ADM99	09/29/2011	45	$ 0.00	0	0
981454947 - 8			9 ADM00	09/09/2011	30	$ 0.00	0	0
981357320 - 1			2 ADM00	09/22/2011	30	$ 0.00	0	0
981466711 - 12			3 ADM00	09/22/2011	30	$ 0.00	0	5
69001840 - 1			3 ADM00	09/02/2011	30	$ 0.00	0	0
999007502 - 2		B	3 T1017	09/08/2011	60	$ 151.80	0	0
129102630 - 1		JA M	7 T1017	09/08/2011	10	$ 25.30	0	0
129102630 - 1		JA M	7 T1017	09/29/2011	10	$ 25.30	0	0
129102630 - 1		JA M	7 ADM99	09/30/2011	10	$ 0.00	0	0
129102630 - 1		JA M	9 T1017	09/14/2011	15	$ 37.95	0	0

Report Name: **Duration Exception Report by Program**

Menu Path:
Avatar PM/ Billing/ Billing Reports/ Pre Claiming Reports/

Parameters: Program, Start and End Dates

Description and Purpose:
This report lists Outpatient MH Service records with the following criteria:

- Medication services with durations that are over 4 hours or less than 5 minutes
- Case Management services with durations over 5 hours and less than 5 minutes
- Individual, Group, Assessment, and Collateral services with durations over 5 hours and less than 5 minutes

The report was developed to assist Providers and program staff in identifying their billing errors, including duration data entry and coding mistakes.

Recommended Frequency for this report:
Weekly - missing Information and updates needed must be entered as soon as possible, and prior to the monthly closing date.

How to resolve issues identified on the Report:
Update the Client's Service record in Avatar PM, by using the "Edit Service Information" screen to enter missing Face-to-Face (FTF) and/or Doc/Travel time.

Service procedure code corrections are also made using the "Edit Service Information" screen.

If Services in error were already submitted on a third-party payer Claim and/or reported on FY Cost Reports with incorrect Units of Service, complete the BH7019 and submit to CBHS Billing. Enter an "addendum" in the Client's CWS Progress Note to notate the error and its correction.

Contact the Avatar Help Desk if you need further assistance.

Report Sample:

City and County of San Francisco, Department of Public Health, Community Health Care
Community Behavioral Health Services

Duration Exception List by Program

Services From 09/01/2010 To 09/30/2010

Confidential Patient Information

Program [redacted] (38G[redacted])

Outpatient MH Services

PATID	EPI	Name	Date	Service	Provider	Total Time	Cost
981[redacted]	2	C[redacted] M	03/21/2011	H2015AS	COI[redacted]	308	$1,025.64
999[redacted]	3	H[redacted]	08/16/2011	H2015AS	OVE[redacted]	310	$1,032.30
999[redacted]	2	M[redacted]	08/29/2011	H2015AS	OVE[redacted]	305	$1,015.65

Program [redacted] (38G[redacted])

Outpatient MH Services

PATID	EPI	Name	Date	Service	Provider	Total Time	Cost
9813[redacted]	##	BC[redacted]	07/22/2010	H2015AS	DAS[redacted]	326	$1,085.58
9813[redacted]	##	BC[redacted]	08/07/2010	H2015CI	DAS[redacted]	342	$1,138.86
9813[redacted]	##	BC[redacted]	09/17/2010	H2015AS	DAS[redacted]	343	$1,142.19
9814[redacted]	1	JO[redacted] LL	09/08/2010	90847	DOI[redacted]	302	$954.32

Program [redacted] (38G[redacted])

Outpatient MH Services

PATID	EPI	Name	Date	Service	Provider	Total Time	Cost
981[redacted]	##	WI[redacted]	08/20/2011	H2015IT	COL[redacted]	488	$1,542.08
981[redacted]	2	GC[redacted]	10/20/2010	H2015AS	OVE[redacted]	312	$1,038.96
981[redacted]	2	GC[redacted]	08/15/2011	H2015CI	OVE[redacted]	4	$13.32
981[redacted]	5	GF[redacted]	12/14/2010	H2015IT	COF[redacted]	340	$1,074.40
981[redacted]	5	GF[redacted]	12/28/2010	H2015IT	COF[redacted]	311	$982.76
981[redacted]	5	GF[redacted]	02/03/2011	H2015IT	COF[redacted]	312	$985.92
981[redacted]	5	GF[redacted]	04/14/2011	H2015IT	COF[redacted]	319	$1,008.04
981[redacted]	5	GF[redacted]	04/21/2011	H2015IT	COF[redacted]	312	$985.92
981[redacted]	5	GF[redacted]	04/28/2011	H2015IT	COF[redacted]	313	$989.08
981[redacted]	5	GF[redacted]	06/09/2011	H2015IT	COF[redacted]	302	$954.32
981[redacted]	3	ST[redacted]	06/03/2011	H2015IT	LOF[redacted]	310	$979.60
981[redacted]	5	BR[redacted]	09/23/2011	H2015IT	LOF[redacted]	308	$973.28
981[redacted]	6	GA[redacted]	12/02/2010	H2015AS	DAS[redacted]	305	$1,015.65
981[redacted]	9	DE[redacted]	02/24/2011	H2015IT	RUD[redacted]	315	$995.40

Program [redacted]

Medication Services

PATID	EPI	Name	Date	Service	Provider	Total Time	
9813[redacted]	4	KR[redacted]	08/03/2010	H2010MT	H[redacted]	1	
9814[redacted]	1	MU[redacted]	01/13/2011	H2010MT	AL[redacted]	3	
9814[redacted]	1	MU[redacted]	03/23/2011	M0064	KC[redacted] DR	0	
9814[redacted]	1	NA[redacted]	07/28/2011	H2010MT	BR[redacted]	0	
9814[redacted]	##	LY[redacted]	03/28/2011	M0064	H[redacted]	255	9
9814[redacted]	1	MC[redacted]	04/06/2011	H2010MT	BR[redacted]	0	
9814[redacted]	6	GR[redacted]	02/07/2011	M0064	AL[redacted]	3	
9814[redacted]	##	TO[redacted]	08/09/2011	H2010MT	BR[redacted]	2	
9814[redacted]	2	HA[redacted]	08/04/2010	H2010MT	H[redacted]	1	
9814[redacted]	1	MC[redacted] B	03/04/2011	M0064	AL[redacted]	0	
9990[redacted]	1	AB[redacted]	12/27/2010	M0064	H[redacted]	270	9
9990[redacted]	3	RC[redacted] TA	05/02/2011	M0064	H[redacted]	260	9
9990[redacted]	1	RI[redacted]	04/18/2011	M0064	H[redacted]	290	9

Outpatient MH Services

PATID	EPI	Name	Date	Service	Provider	Total Time	
18[redacted]	7	MR[redacted]	06/09/2011	H2015AS	BR[redacted]	0	
98[redacted]	8	WE[redacted]	04/06/2011	H2015AS	ZA[redacted]	4,040	$1
10[redacted]	2	SU[redacted]	10/13/2010	H2015CI	RO[redacted]	4	
12[redacted]	1	VL[redacted]	06/06/2011	H2015IT	ZA[redacted]	3,535	$1
13[redacted]	3	CI[redacted]	10/20/2010	H2015IT	VA[redacted]	860	9
22[redacted]	7	GA[redacted]	12/10/2010	H2015IT	LE[redacted]	0	
42[redacted]	3	HA[redacted]	11/17/2010	H2015IT	VA[redacted]	960	9
69[redacted]	2	RD[redacted] R	01/13/2010	H2015CI	ALT[redacted]	0	
98[redacted]	2	VL[redacted]	07/21/2010	H2015IT	CA[redacted]	0	
98[redacted]	2	BO[redacted]	05/31/2011	H2015GT	WI[redacted]	60,600	###
98[redacted]	2	GR[redacted]	01/31/2011	H2015CI	ZA[redacted]	2,525	9