CBHS Medi-Cal Claims Correction Process - Void & Replace Flowchart
For Mental Health & Drug MC Services processed in the AVATAR system

- CBHS Provider enters Client, Episode, Services info AVATAR within 30-60 days of service month
  - Services billed based on Clients’ Guarantor records. MH services processed and Claims generated to Client’s 3rd Party Payers: Medicare, Insurance, Short-Doyle MH or Drug Medi-Cal

- CBHS Billing process and posts SDMC 835 files for Approved and Denied claims, and transfers liability in AVATAR. Scans BH-7019 with Control Number, files retained for Fiscal audits
  - DHCS process 837 files and sends 835 with adjudication info Payment or Refund amounts by Provider
  - SDMC 837 with Void & Replace transactions are generated and sent to DHCS by CBHS Billing before DHCS due dates
  - CBHS Billing Unit submits 837 claim files to SDMC.

- DPH Fiscal Cost Report Unit reconciles SDMC Claims and EOBs, reports on service units and dollar amounts by Provider for Approved, Denied, and Pending claims, Voids and Replacement services, and Payments received or Refunds made. Prepares FY Cost Reports to DMH and ADP, Provider UOS reconciliation and cost settlement

- Client / Service errors corrected and Replace transaction created
  - Valid services but not SDMC are Voided & charges transferred to GF

- CBHS Billing logs forms received from Providers and from Compliance, research and evaluates SDMC claim error corrections, enters Void & Replace transactions in AVATAR, process Medicare and/or Insurance claim corrections, issues payment refunds, transfers liability to Client guarantors

- CBHS Billing process 837 files. SDMC Approved and Denied Services Report sent to Providers. Provider instructed to review claimed services and submit corrections to Billing: to Replace denied or approved services, or to Void denied or approved services entered in error

- Providers have 45 days from 835 date to submit corrections to denied or approved SDMC services billed with error(s)

- OR: CBHS Program Review/Compliance audit determines services are in error and Void required: for complete back-out or, if Valid but not MediCal (County GF)

- Provider enters corrections on BH-7019 form, assigns Control Number, submits electronic file and signed form to CBHS Billing before specified due date

- OR: Compliance provides spreadsheet of Provider service adjustments w/assigned Control Number to CBHS Billing

- Providers reconciles UOS adjustments, invoices, payments, retains records, reports and/or data files for audits, Program Compliance reviews per CBHS Policy

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* CWS & CalPM record exists but shows “deleted” Option to report available