

Provider Service
Corrections
SmartCare Training

Welcome to SmartCare Training



Course Content

- Part 1: Editing Services
- Part 2: Pre-Claiming
- Part 3: Understanding Post-Claiming
- Part 4: Making Post-Claiming Corrections

Part 1 - Editing Services

Requesting Edits to
Services

Erroring Services

Editing
Documentation

Service Status Descriptions

Show: A service status that indicates a service has not processed. (If a service is still in a show status after the Overnight Job, there is something preventing the service from switching from show to complete.)

Error: A service status that removes the service and any documentation (essentially deletes the service and progress note)

Complete: The service is ready to be claimed

Requesting Edits on Service Notes

- Edits can be made to a service if the information was entered in error
- Only pre-claimed services can be edited
- To request an edit on a service, please send an **ENCRYPTED** email to BHS-EHRsupport@saccounty.gov with the following:
 - Client Information (Name & Client ID)
 - Service Date & Time
 - Service Author
 - Procedure Code
 - The Edit That Is Being Requested

What Service Information can be Edited

- Location
- Mode of Delivery
- Start Date
- Start Time
- Service Time(Duration)
- Procedure
 - If the note type matches the new procedure
 - Not all procedures can be changed
 - Please Note:
 - We cannot change a billable service to non-billable
 - We cannot change a non-billable service to billable
 - If a code *cannot* be edited, then the service will need to be put in Error status by admin staff

- Once the EHR Support team has notified requester that the requested edits have been completed, please reach out to the Billing Team to regenerate the charge if the following have been updated:
 - Duration/Unit
 - Procedure Code

- The Billing Team can be reached via email BHS-EHRBilling@saccounty.gov

Regenerating Service Charges

➤ Run the “Program Staff Services Export (SAC) (My Office)” report

- The report will show service details for your program
- The status field on the report will show if a service has been claimed
- To view all service status definitions, refer to the cheat sheet posted on the Claiming page
 - <https://dhs.saccounty.gov/BHS/BHS-EHR/Pages/EHR-Claiming.aspx>

How do I Know a Service has been Claimed?

FTF	Travel	Doc	Status	Charge Code
8.00	0.00	5.00	C-Claim Sent	H2011
35.00	0.00	9.00	C-Claim Sent	H2011
50.00	60.00	10.00	C-Claim Sent	H2011
10.00	0.00	5.00	C-Paid	H2011
8.00	0.00	5.00	C-Paid	H2011
30.00	0.00	10.00	C-Claim Sent	H2011
90.00	0.00	30.00	C-Charge Created	H2011
120.00	0.00	30.00	C-Charge Created	H2011



What to do if the Service Cannot be Edited

- If a service cannot be edited it will need to be put in Error Status
- Reasons why a service may need to be put in Error
 - Duplicate service
 - Billed in error
 - If there are fields that cannot be edited
 - Clinician name
 - Some procedure codes
- Change the service status to Error
 - A service in Error will not bill out
 - **Putting a service in Error will also delete the attached progress note.**
 - If a progress note has been entered, make sure to work with the clinician before putting a service in Error. The clinician will need to save the content of their note prior to putting it in Error if applicable
- **Never put a claimed service in Error status**

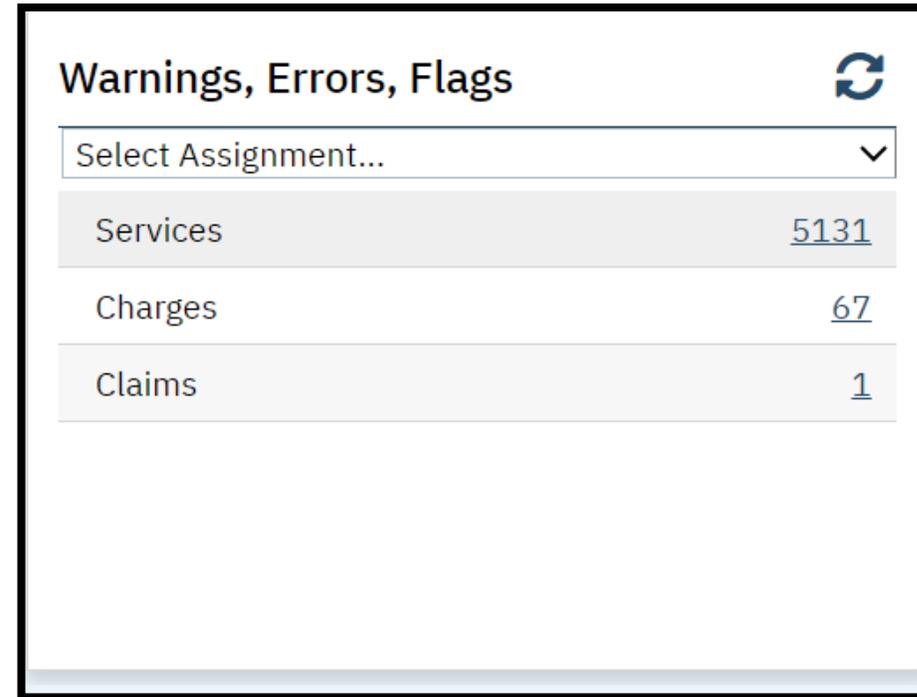
Demo - Changing a Service to Error

- Switch service status from Complete to Error



Widget: Warnings, Errors, Flags

- This widget will give the total number of services with errors. You will only have access to the first hyperlink for “Services”. The Charges and Claims links are specific to the EHR billing team.



Warnings, Errors, Flags 	
Select Assignment...	▼
Services	5131
Charges	67
Claims	1

- To see a demonstration of how to add a widget to the dashboard, click on link below:
 - [How to Add a Widget to Your Dashboard - 2023 CalMHSA](#)



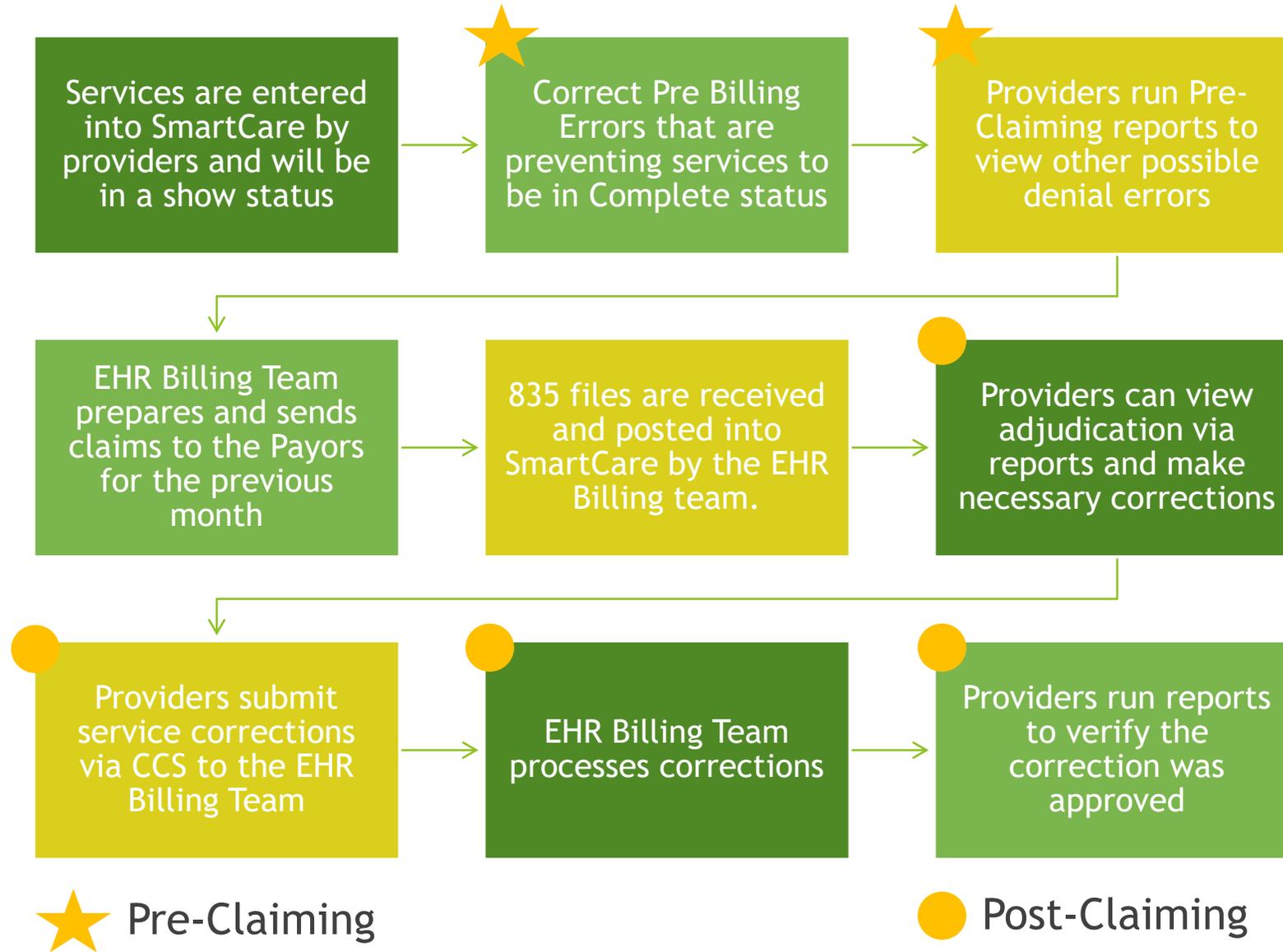
Part 2 - Pre-Claiming

Billing Process

Pre Claiming Errors

Pre Claiming
Reports

Billing Process



Corrections Definitions

Pre-Claiming:

- Services that have not been sent to the Payors yet

Post-Claiming:

- Services after they have been sent to the Payors

What is an Overnight Job?

- A process that validates the services entered into SmartCare
- This will assign a status to each service that was entered:
 - **Complete**: The service is ready to be claimed
 - **Show**: Indicates a service has not processed
- If a service is still in a show status after the Overnight Job, there is something preventing the service from switching from show to complete - See Failure to Complete Reasons.

Overnight Job

Pre-Claiming Errors

- What is a pre claiming error?
 - These types of errors will prevent a service from claiming out.
- How to find pre claimed errors?
 - Run the Services (My Office) list page to view the Failure to Complete Reason(s):

Services(My Office)

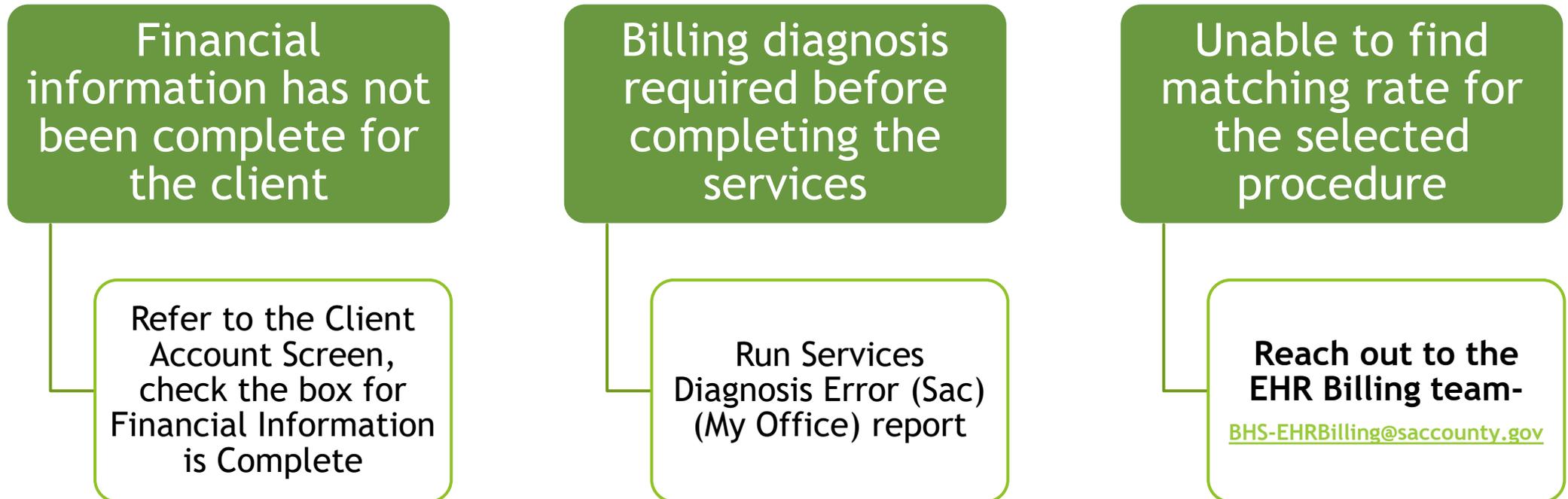
- Run the Services (My Office) list page to view the Failure to Complete Reason(s):
- Filter the information below:
 - Chose Date Range - do not go higher than one month, otherwise the screen may lock you out
 - Select your program
 - Under Service Status, select Show
 - Scroll to the far right to view “Failure to Complete Reasons”

The screenshot shows the 'Services (67)' interface. At the top right, there is a 'Select Action' dropdown and utility icons. The main filter area includes dropdowns for 'All Services', 'All Service Statuses' (annotated with 'C'), 'All Programs' (annotated with 'B'), and 'Financial Assignment...'. Below these are 'All Locations', 'All Procedure Codes', 'All Clinician', 'All Service Entry Staff', and 'All Service Areas'. A date range filter is set to 'DOS From 12/01/2025' to 'DOS To 12/31/2025' (annotated with 'A'). There are also checkboxes for 'Include Services created from Claims', 'Only include Services with Add On Codes', 'Only show Non-Billable Services', and 'Show Only Active Clients'. A 'Client Name' field and 'Organizational Hierarchy...' dropdown are also present. Below the filters, a table lists services with columns: Client Name, DOS, Units, Charge (Rate Id), Procedure, Status, Clinician, Program, Location, Comment, Failure to Complete Reason(s) (annotated with 'D'), and Add On Cod. The table contains five rows of service data.

Client Name	DOS	Units	Charge (Rate Id)	Procedure	Status	Clinician	Program	Location	Comment	Failure to Complete Reason(s)	Add On Cod
[blurred]	12/31/2025 2:00 PM			Individual Therapy	Schedul...	Peterson, As...	UCD-FIT-Bu...	Telehealth - ...			
[blurred]	12/30/2025 11:00 AM		228.69 (1...	Psychosocial Rehab - ...	Schedul...	Nelson, Rae...	El Hogar-OP ...	Office			
[blurred]	12/29/2025 11:00 AM			ASAM or other struct...	Show	Draper, Ama...	ZZ_ACAC_O...	Office		Billing diagnosis req...	
[blurred]	12/29/2025 10:00 AM			Individual Counseling	Show	Draper, Ama...	ZZ_ACAC_O...	Office		Billing diagnosis req...	
[blurred]	12/25/2025 11:00 AM		228.69 (1...	Psychosocial Rehab - ...	Schedul...	Nelson, Rae...	El Hogar-OP ...	Office			

If there is no rate on the Completed service (and it is NOT a non-billable), make sure Coverage has been entered

Failure to Complete Reasons: Errors That will Prevent a Service from Billing Out



These errors can all be found on the Services (My Office) screen

Error: Financial Information has not been Completed for the Client

- Check the Client Account (client) screen to make sure the box for *Financial Information is complete* is checked

Client Account

Overview Charge/ Payment Summary

Account Information

Client Name	Test, Entry
Financially Responsible	Test, Entry
Current Client Balance	\$0.00
Unpaid Services	\$0.00
Unposted Payments	\$0.00
Last Statement Sent	
Payment Arrangement Amount	0
Client Fund Balance	0

Internal Collections
 External Collections
 Don't Send Statement

Reason

Financial Information is Complete

3rd Party Payer Information

Plan	Balance	Unbilled Amt	>90 Days	Flagged
Blue Cross - Van Nuy...	\$19,319.53	\$19,319.53	\$0.00	

Payment History Last 30 Days Show Client Payments Only

Payer	Date	Amount	Check#	Unposted Amount
-------	------	--------	--------	-----------------

Accounting Notes

Error: Services Diagnosis Error (Sac) Report

- If you see a failure reason that says **Billing Diagnosis Required** run the Services Diagnosis Error (sac) report to find the diagnosis error and make the necessary corrections in the Diagnosis Document (Client) screen

Program Name	Client Name	clientid	Error Type	First Problem Service	First DX
			NO DX in Program of Service	9/16/25	
			DX on file is not signed	8/13/25	9/25/25
			NO DX in Program of Service	9/5/25	
			First DX Effective Date AFTER Date of Service	10/27/25	10/31/25

Error: Unable to Find Matching Rate For The Selected Procedure

- If you see a failure reason that says **Unable to find matching rate for the selected procedure** on the Services (My Office) list page Reach out to the EHR Billing team for further review -
 - BHS-EHRBilling@saccounty.gov

Services (33)

All Services All Service Statuses Include Do Not Complete APCC-TWC-14th Ave Financial Assignment... Apply Filter

All Locations All Procedure Codes All Clinician All Service Entry Staff All Service Areas

Service Id Entered From Entered To DOS From 12/01/2025 DOS To 12/31/2025

Include Services created from Claims Only include Services with Add On Codes Only show Non-Billable Services Show Only Active Clients

Client Name Organizational Hierarchy...

All Primary Payers Self-Pay Clients

Select: All, All on Page, None

Client Name	DOS	Units	Charge (Rate Id)	Procedure	Status	Clinician	Program	Location	Comment	Failure to Complete Reason(s)
<input type="checkbox"/> Test, Andrew (80044015...	12/18/2025 8:00 AM			Adult Residential Day	Show	Miller, Justin	APCC-TWC-...	Inpatient Ho...		Billing diagnosis req...
<input type="checkbox"/> Test, Andrew (80044015...	12/18/2025 8:00 AM			Crisis Residential Day	Show	Callahan, Sta...	APCC-TWC-...	Inpatient Ho...		Billing diagnosis req...
<input type="checkbox"/> Test, Bailey (800440186)	12/18/2025 8:00 AM			Crisis Residential Day	Show	Callahan, Sta...	APCC-TWC-...	Inpatient Ho...		Billing diagnosis req...
<input type="checkbox"/> Test, Jordan (800440248)	12/18/2025 8:00 AM			Crisis Residential Day	Show	Miller, Justin	APCC-TWC-...	Office		Unable to find a mat...
<input type="checkbox"/> Test, Mari (800440275)	12/17/2025 7:00 PM			Adult Residential Day	Show	Draper, Ama...	APCC-TWC-...	Office		Unable to find a mat...
<input type="checkbox"/> Test, Andrew (80044015...	12/17/2025 9:00 AM			Adult Residential Day	Show	Draper, Ama...	APCC-TWC-...	Office		Billing diagnosis req...



Additional Pre-Claiming Reports - Used to Prevent Denials

- The information shown on the following reports will not prevent services from claiming out
- These types of errors are errors that will later cause a **denial**
- These types of errors can still be corrected during post-claiming
 - The corrections process is easier if caught during pre-claiming
- It is best practice to run these reports at least once a month prior to services claiming out

Additional Pre-Claiming Reports



Active Client Eligibility (SAC) (My Office)



Program Coverage Report (SAC) (My Office)



MMEF Check Report (SAC) (My Office)

Active Client Eligibility (SAC) (My Office)

- Run the Active Client Eligibility (SAC) (My Office) report to catch the following errors
 - Client sex, SSN, or DOB is missing
 - CIN is entered in the correct format and matches Medi-Cal
 - Corrections to the DOB, sex, and SSN can be made in the “Client Information (Client)” screen
 - Corrections to the CIN can be made on the “Coverage (Client)” screen

Active Client Eligibility

Currently enrolled clients at xxxxSacCo-APSS-Broadway(34CZKA) and their Medi-Cal CIN

Client ID ↕	First Name	Last Name ↕	DOB	Sex	SSN	Medi-Cal CIN ↕
758277000	Entry	Test	07/04/82		899999998	91236547a
758277000	Entry	Test	07/04/82		899999998	92344151G
758277000	Entry	Test	07/04/82		899999998	95468742A
788367041	Client	Test	01/01/78	M		91234567F
788367041	Client	Test	01/01/78	M		98765432E

Report Version 8/25/2023

2/29/2024 4:31:14 PM

Program Coverage Report (SAC) (My Office)

- Run the “Program Coverage Report (SAC) (My Office)” to catch the following errors
 - Client’s address is missing or incorrect
 - Can be corrected using the “Client Information (Client)” screen
 - Make sure to click the “Details” button to verify the address has been broken out line by line
 - Financial Information has been completed for the client
 - Can be corrected using the “Client Account (Client)” screen
 - Verify coverage has been entered for the client
 - Coverage can be entered in the “Coverage (Client)” screen

Program Coverage Report

xxxxSacCo-APSS-Broadway(34CZKA)

Open enrollments Between 2/1/2024 and 2/29/2024 with First 4 Current Payers

Client ID	Client Name ↕	Enrolled/DC ↕	Cov1 ↕	Cov2 ↕	Cov3 ↕	Cov4 ↕
788367041	Test, Client	02/01/24	Kaiser Foundation Health (300) 9876543221			
758277000	Test, Entry	07/01/23	Medi-Cal MH 92344151G	Managed Care-Aetna (601) 94567812A	MH County Funds 12345	
800000538 Bad Address	Test, Reina Financial Info Incomplete	11/17/23				



Part 3 -
Understanding
Post-Claiming

Post-Claiming
Definitions

Transaction
Types

Post-Claiming Definitions

- 837- Transaction that includes claim information for the purpose of reimbursement for a rendered service
- 835- Transaction that is sent in response to an 837 and contains remittance information about claims submitted for rendered services
 - You can view the 835 information using reports in SmartCare
- Adjudication- The process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements
- Payor Claim Control Number (PCCN)- The unique ID number for the claim in the State's Medi-Cal adjudication system.

What is Post-Claiming?

Post Claiming occurs after services have been sent to the payor



Post-claiming corrections must be completed after the payor adjudicates the service



If a payor denies a service, a denial will be created



Approved services can also be corrected if necessary

Program Types

- There are different timelines and requirements for the three different program types
 - MH
 - SUPT
 - ECM
- When making post claiming corrections, make sure to use the correct timelines and guidelines for your program type
 - Timelines for each program type can be found on the Claiming tab of the BHS EHR webpage

Transaction Types

- The transaction types, definitions, and special circumstances can be found on our webpage under the SmartCare Claiming tab
- The transaction types are listed below:
 - **Initial:** The initial claim for services
 - **Void:** Used to remove a service
 - **Replacement:** Used to replace a service claimed with incorrect information
 - **Rebill:** Used when the correction doesn't meet additional billing requirements on the “Transaction Types” document
 - ECM providers will only be using Rebill when processing their corrections. (Sacramento County is no longer providing ECM services as of 12/31/25 however providers are still able to make corrections to services within 6 months from the service date)
- Correction timelines and requirements are different for MH, SUPT, & ECM programs
 - [Medi-Cal Transaction Types](#)
 - [ECM Transaction Types](#)

➤ BHS EHR Webpage

[BHS EHR Claiming \(saccounty.gov\)](http://saccounty.gov)

- SmartCare Claiming section
 - Claim Status
- Medi-Cal Transaction Document
- ECM Transaction Document

Demo



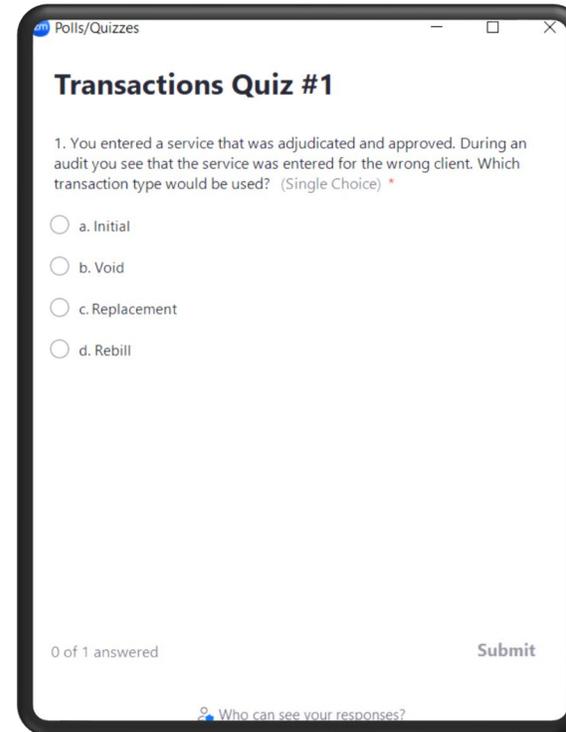
Transaction Types Review



The following questions are to test your knowledge of transaction types



A question will come on your screen, select the answer you think best fits

A screenshot of a web browser window titled "Polls/Quizzes". The main heading is "Transactions Quiz #1". The question text reads: "1. You entered a service that was adjudicated and approved. During an audit you see that the service was entered for the wrong client. Which transaction type would be used? (Single Choice) *". Below the question are four radio button options: "a. Initial", "b. Void", "c. Replacement", and "d. Rebill". At the bottom left of the quiz area, it says "0 of 1 answered". At the bottom right, there is a "Submit" button. Below the quiz area, there is a link that says "Who can see your responses?".

Polls/Quizzes

Transactions Quiz #1

1. You entered a service that was adjudicated and approved. During an audit you see that the service was entered for the wrong client. Which transaction type would be used? (Single Choice) *

- a. Initial
- b. Void
- c. Replacement
- d. Rebill

0 of 1 answered Submit

[Who can see your responses?](#)

Which Transaction do we use?

- You entered a service that was adjudicated and approved. During an audit you see that the service was entered for the wrong client. Which transaction type would be used?
 - a. Initial
 - b. Void
 - c. Replacement
 - d. Rebill

The answer is Void, the service was previously approved and was done in error. There is no service to replace for this client, we are just voiding the incorrect service.

Which Transaction do we use?

- You entered a service and notice the duration of the service was entered incorrectly. The service has been claimed. You complete a CCS so billing team can make the edit. Which transaction would be used?
 - a. Initial
 - b. Void
 - c. Replacement
 - d. Rebill

The answer is Replacement, it's a legitimate service we still want to bill for, there was just a mistake made on the service that we didn't notice till after it was claimed.



Part 4 - Making Post- Claiming Corrections

Post-Claiming Process

Viewing Approved and Denied
Services

CARCS/RARCS

CCS

Modifiers

Post-Claiming Corrections Process

Correcting Approvals

- Determine whether the service has been approved and/or adjudicated by running the Program Approvals Report view all approved services
- Complete a CCS and email encrypted to BHS-EHRBilling@Sacounty.gov
- Use the Medi-Cal Correction Tracking report to view when the Billing Team has submitted the corrections to the state
- Run the Approvals report to confirm the service has been approved

Correcting Denials

- Run the Program Denials Report to view denials and denial codes
- Go onto the EHR Claims webpage and click on the link to the state's webpage CARC/RARC
- Make corrections based on the denial
- Complete a CCS and email encrypted to BHS-EHRBilling@Sacounty.gov
- Use the Medi-Cal Correction Tracking report to view when the Billing Team has submitted the corrections to the state
- Run the Approvals report to confirm the service has been approved

Viewing Approved Services

- Program Approvals Report- This is run by the dates that an approval was posted. All programs can run this report monthly to view their approvals.
 - The report pulls based off the posted date, not approval date. The report should only be run once per date range.
 - Corrections can be made to approved claims as needed.

Program Approvals

For MEDI-CAL Approvals Posted Between 3/1/2024 and 3/31/2024

Client Name :	Client ID	Service ID	PCCN	Service Date	Procedure Name	Posted Date	Billing Code	Charge Units
		724352	431218240	11/13/23	Assessment LPHA	3/28/24	90791	1.00
		473551	431106895	10/6/23	TCM/ICC	3/28/24	T1017	1.00
		808370	431218302	11/28/23	Plan Development, non-physician	3/28/24	H0032	1.00
		577469	431110084	10/12/23	Psychosocial Rehab - Individual	3/28/24	H2017	3.00
		620802	431110086	10/24/23	Medication Support Existing Client	3/28/24	99215	1.00
		735372	431216501	11/1/23	Psychosocial Rehab - Individual	3/28/24	H2017	2.00

Viewing Denied Services

- Program Denials Report- This is run by the dates that a denial was posted. All programs must run this report monthly to view their denials.
 - The report pulls based off the posted date, not denial date. The report should only be run once per date range.
 - Denials will continue to show on this report once they've been corrected.

Program Denials											
For Denials Posted Between 1/1/2024 and 1/31/2024											
Client Name	Client ID	Service ID	PCCN	Service Date	Procedure Name	Denial Reason	Remark Code Description	Posted Date	Billing Code	Charge Units	
		99887	426885630	7/25/23	Psychosocial Rehab - Individual	CO 96 16	N288 - Missing/incomplete/invalid rendering provider taxonomy., N290 - Missing/incomplete/invalid rendering provider primary identifier., N54 - Claim information is inconsistent with pre-certified/authorized services., N95 - This provider type/provider specialty may not bill this service.	1/20/24	H2017	3.00	
		523205	431107054	10/13/23	TCM/ICC	CO 97	M86 - Service denied because payment already made for same/similar procedure within set time frame.	1/21/24	T1017	1.00	
		39739	426885679	7/7/23	Plan Development, non-physician	CO 96 16	N288 - Missing/incomplete/invalid rendering provider taxonomy., N290 - Missing/incomplete/invalid rendering provider primary identifier., N54 - Claim information is inconsistent with pre-certified/authorized services., N95 - This provider type/provider specialty may not bill this service.	1/20/24	H0032:SC	1.00	
		39663	426885681	7/7/23	Individual Therapy	CO 96 16	N288 - Missing/incomplete/invalid rendering provider taxonomy., N290 - Missing/incomplete/invalid rendering provider primary identifier., N54 - Claim information is inconsistent with pre-certified/authorized services., N95 - This provider type/provider specialty may not bill this service.	1/20/24	90834:93	1.00	

Multiple Denial Reasons

- A single client can have multiple denial reasons for a service
- Make sure to address each of the reasons, if all denial reasons are not addressed that can lead to a delay in the corrections process and can possibly even lead to a correction not meeting timeliness guidelines

Start Date	End Date	Programs	View Report										
3/22/2024	12/18/2024	[REDACTED]	46 of 47 ?	1552547	Find	Next	[Icons]						
[REDACTED]	[REDACTED]	1552547	441381354	3/22/24	Assessment LPHA	CO 22 96 16	N288 - Missing/incomplete/invalid rendering provider taxonomy., N290 - Missing/incomplete/invalid rendering provider primary identifier., N54 - Claim information is inconsistent with pre-certified/authorized services., N95 - This provider type/provider specialty may not bill this service.	5/16/24	90791:HL				
[REDACTED]	[REDACTED]	1552932	441381354	3/22/24	Prolonged Office or Other Outpatient EM Service(s) beyond the Maximum Time	CO 22 16 96	N288 - Missing/incomplete/invalid rendering provider taxonomy., N290 - Missing/incomplete/invalid rendering provider primary identifier., N54 - Claim information is inconsistent with pre-certified/authorized services., N95 - This provider type/provider specialty may not bill this service.	5/16/24	G2212:HL				
[REDACTED]	[REDACTED]	1552547	463222208	3/22/24	Assessment LPHA	CO 22		12/18/24	90791:HL:XP				

Claim Adjustment Reason Code/Remittance Advice Remark Code (CARCs/RARCs)

- The denial remarks can be found on the Program Denials report, if additional details are needed you can view the CARC/RARC
- Use the denial code you found on the Program Denials Report and look up that denial code description on the CARCs/RARCs
- There is a separate CARC/RARC for SUPT & MH providers

Demo - CARCs/RARCs

- MH CARCs/RARCs
- SUPT CARCs/RARCs



Claims Correction Spreadsheet (CCS)

- After identifying and correcting any errors if possible that caused the denial in SmartCare, complete a CCS and send to BHS-EHRBilling@Saccounty.gov
 - All CCS's must be emailed encrypted to protect client PHI
 - Multiple services and multiple clients can be listed on the same CCS
- Not all denial errors can be corrected by the provider, the next slide shows examples of things that can/cannot be corrected by the provider
- The CCS is posted on the EHR Claiming webpage
- The first tab of the CCS has detailed instructions on how to fill out the document
 - Refer to these instructions if you are unsure of which transaction to use in column A
 - At the bottom of the instructions, it goes over the purpose and restrictions for each transaction type
- The CCS can take several weeks for billing team to process

What Information can be Edited After Adjudication?

Provider Edit

- DOB
- Gender
- Coverage updates
 - CIN
 - Policy number

Billing Team Edit

- Service Time (Duration)
- Location
- Start date
- Program
- Procedure

Demo

- Correcting a denial reason
- Claiming Webpage
 - [Claims Correction Spreadsheet](#) (MH and SUPT)
- Filling out a CCS

- As of July 1, 2025, upon submitting a CCS the billing team will assign you a CCS tracking number
 - This number should be used when communicating with Billing Team regarding your CCS
 - The tracking number(s) will be added to the CCS as well as the email's subject line when they respond back
 - Each CCS will have their own tracking number
 - The Billing Team will respond back to you with the tracking number within 2 weeks
 - The CCS may not be processed within 2 weeks, but you will receive a tracking number that confirms receipt of your CCS
 - If you do not receive a tracking number within 2 weeks, follow up with the Billing Team

CCS Tracking

Reports for Tracking Corrections

- Medi-Cal Correction Tracking Report- This is used as a tool to track post-claiming corrections. When a submitted CCS has been processed the corrected service will appear on this report, once it's been claimed to the state. Staff can cross-check this report with the Program Denials Report to view corrections that have been submitted.
- The adjudication of the corrected service will not appear on this report. Adjudication will appear on the "Client Account" screen.

@ExecutedByStaffId 619 Start Date 1/1/2024

End Date 1/29/2024 Programs [Redacted]

Medi-Cal Correction Tracking

[Redacted]

For Voids/Replacements/Rebills Processed Between 1/1/2024 and 1/29/2024

Client Name	Client Id	Procedure Name	Service ID	Service Date	Correction Type	Batch Date
[Redacted]	[Redacted]	Oral Medication Administration	25270	07/06/23	Rebill	01/26/24
[Redacted]	[Redacted]	Plan Development, non-physician	39739	07/07/23	Replaced	01/26/24

Version 12/20/23 1/29/2024 10:42:33 AM



A CCS should be submitted for post claiming corrections as soon as possible

No later than 6 months from the date of service for denial reasons other than missing OHC or Medicare. Missing OHC or Medicare should be submitted sooner, as those processing times may take longer



Billing Team prioritizes CCS's based on claiming timelines

Corrections Timeliness



Modifiers

- A modifier is used to give additional information about a service
- Modifiers are primarily used when the client or the procedure codes are in a lockout situation
- Some procedure codes require a modifier to be entered when paired with other procedure codes
 - These types of modifiers may not always be caught during pre-claiming, if this was missed it can be fixed using the post-claiming corrections process

Entering Modifiers

- Sacramento County Billing Team will enter the modifiers, at the request of the providers
- To request a modifier be entered onto a service, complete a Claims Correction Spreadsheet (CCS)
 - If caught at pre-claiming: use Initial for the transaction type
 - If caught at post-claiming: use Replacement for the transaction type
 - Do not combine both pre-claiming and post-claiming services on the same CCS

Demo - Claiming Webpage

- Modifiers
- Billing Manual



BHS EHR Webpage

- SmartCare Claiming
 - Claiming resources, such as links to the state's webpage, Claims Correction Spreadsheet, and transaction types
 - [BHS EHR Claiming \(saccounty.gov\)](https://saccounty.gov)
- SmartCare Training Resources
 - Tip sheets, training guides, and training slides
 - [BHS EHR Training & Schedule \(saccounty.gov\)](https://saccounty.gov)
- SmartCare CalMHSA
 - Navigational guides and videos, link to the LMS portal
 - [Home - 2023 CalMHSA](https://saccounty.gov)

Additional
Service
Corrections
Resources

How can I get Additional EHR Support?

- **BHS EHR Team** can be contacted for pre-claiming or progress note questions
 - E-mail: BHS-EHRSupport@SacCounty.gov
 - Phone: 916-876-5806
 - Office Hours: Monday-Friday 8am-5pm, except for county holidays
- **BHS EHR Billing Team** can be contacted for post-claiming questions or “Unable to find matching rate” errors
 - E-mail: BHS-EHRBilling@SacCounty.gov
 - Office Hours: Monday-Friday 8am-5pm, except for county holidays
- **BHS EHR Training-** Contact once you’ve completed your post-training quiz
 - E-mail: bhs-ehrtrainingreg@saccounty.gov
 - Office Hours: Monday-Friday 8am-5pm, except for county holidays

Additional Documentation Support

- **Quality Management-Contact for documentation questions**
 - QMInformation@saccounty.gov
- **Quality Management Staff Registration-Contact for staff license updates**
 - DHSQMStaffReg@saccounty.gov

Next Steps...

- You will receive an email with a quiz link and training survey link shortly. Please complete the survey and the quiz as soon as possible
- Once you complete and submit the quiz with a score of 80% or above, please reply to the e-mail from bhs-ehrtrainingreg@saccounty.gov so we can verify you've passed the quiz successfully
- Upon successful completion, permissions will be added to your profile and you will be emailed your username and login instructions
- After passing your quiz, if you would like hands on access to the SmartCare TRAIN environment, email bhs-ehrtrainingreg@saccounty.gov. (***You will not get access to the live Production environment until you are finished using TRAIN***)
- If you need assistance logging into SmartCare, please refer to the SmartCare login tip sheet located at <https://dhs.saccounty.gov/BHS/BHS-EHR/Pages/EHR-Training.aspx>, or call the Sacramento County BHS EHR Team at 916-876-5806

End of Training

