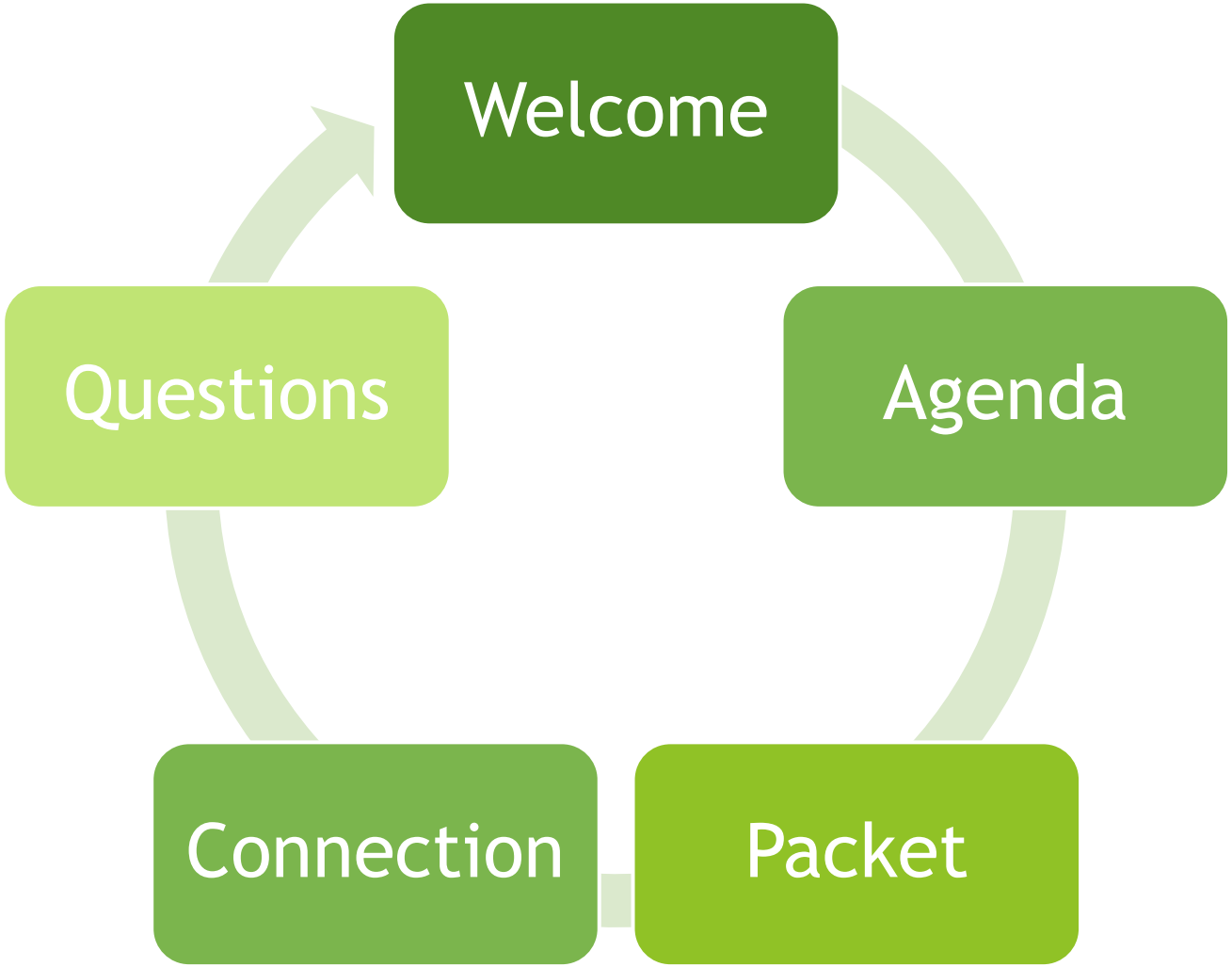
Provider Service Corrections SmartCare Training

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 attached 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

How do I Know a Service has been Claimed?

- 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

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

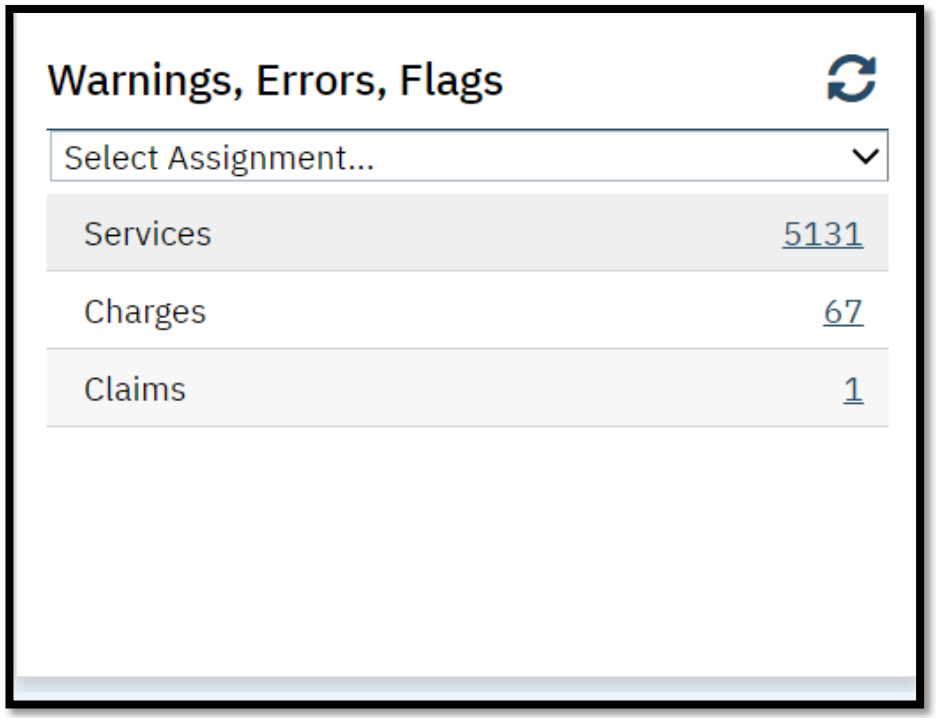
- If a service cannot be edited it will need to be put in Error Status
- Reasons why a service may need to be put in Error
  - Duplicate service
  - Billed in error
  - If there are fields that cannot be edited
    - Clinician name
    - Some procedure codes
- Change the service status to Error
  - A 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.



- 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

Corrections Definitions

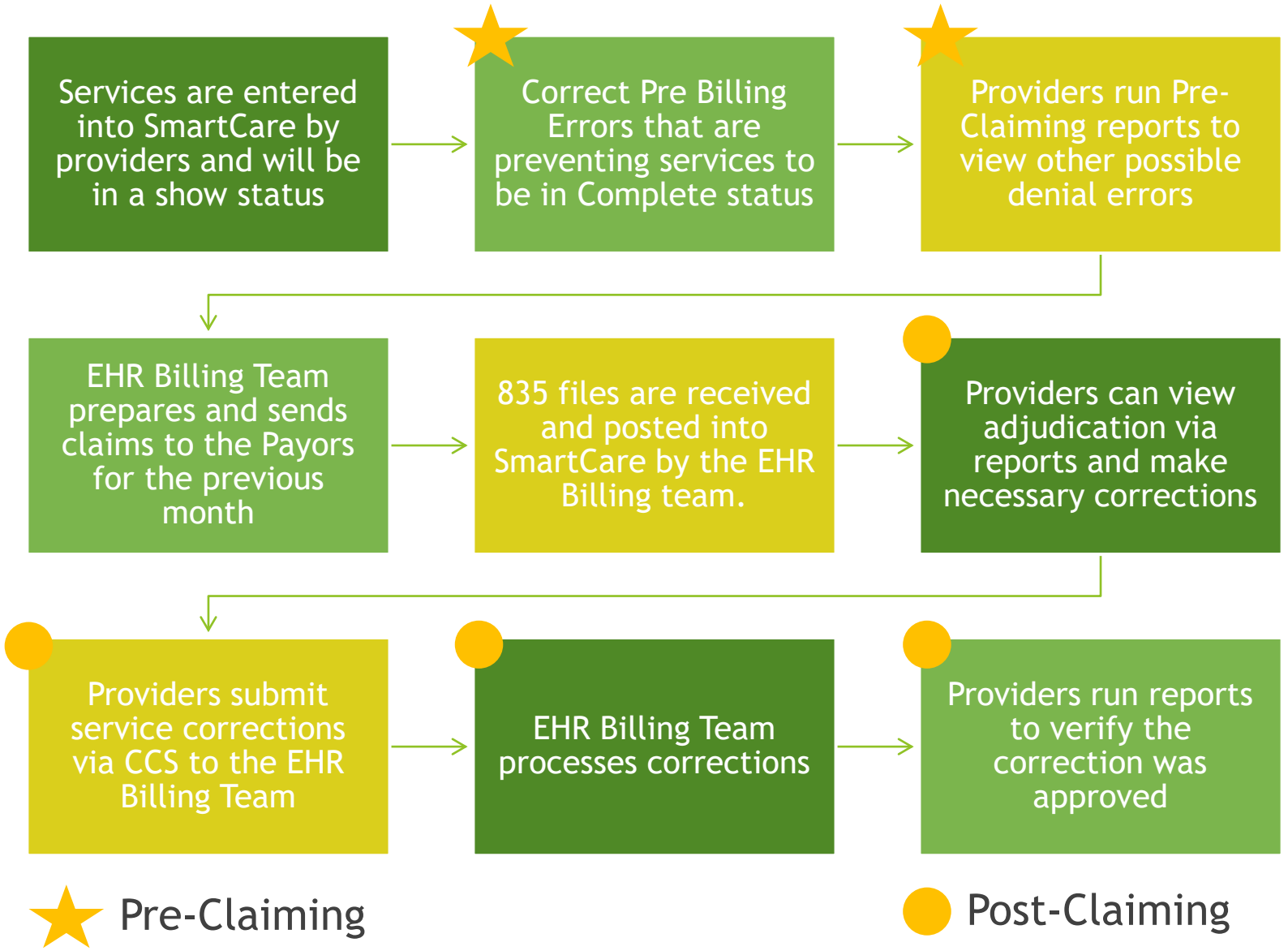
Pre-Claiming:

- Services that have not been sent to the Payors yet

Post-Claiming:

- Services after they have been sent to the Payors

Billing Process



Overnight Job

What is an Overnight Job?

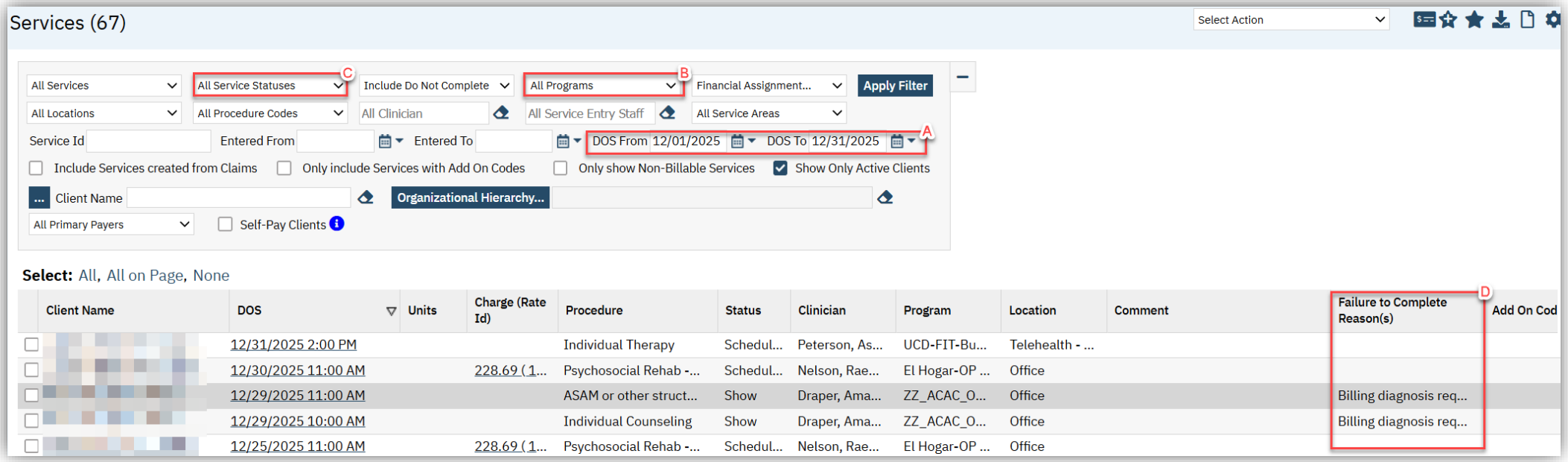
- A process that validates the services entered into SmartCare
- This will assign a status to each service that was entered:
  - **Complete:** The service is ready to be claimed
  - **Show:** Indicates a service has not processed
- If a service is still in a show status after the Overnight Job, there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

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:
  a) Chose Date Range - do not go higher than one month, otherwise the screen may lock you out
  b) Select your program
  c) Under Service Status, select Show
  d) Scroll to the far right to view “Failure to Complete Reasons”



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

Financial information has not been complete for the client

- Refer to the Client Account Screen, check the box for Financial Information is Complete

Billing diagnosis required before completing the services

- Run Services Diagnosis Error (Sac) (My Office) report

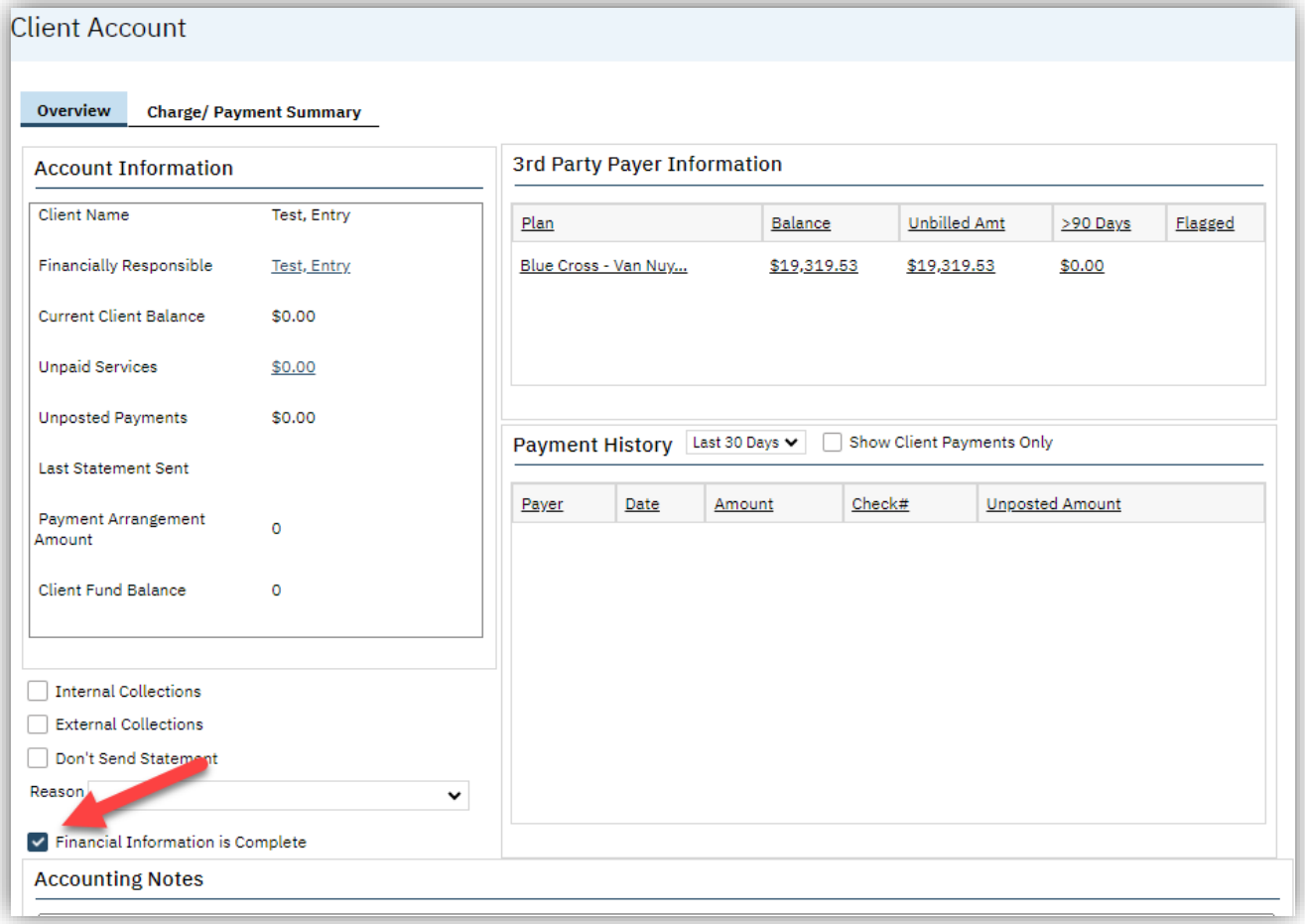
Unable to find matching rate for the selected procedure

- **Reach out to the EHR Billing team-**
  BHS-EHRBilling@saccounty.gov

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

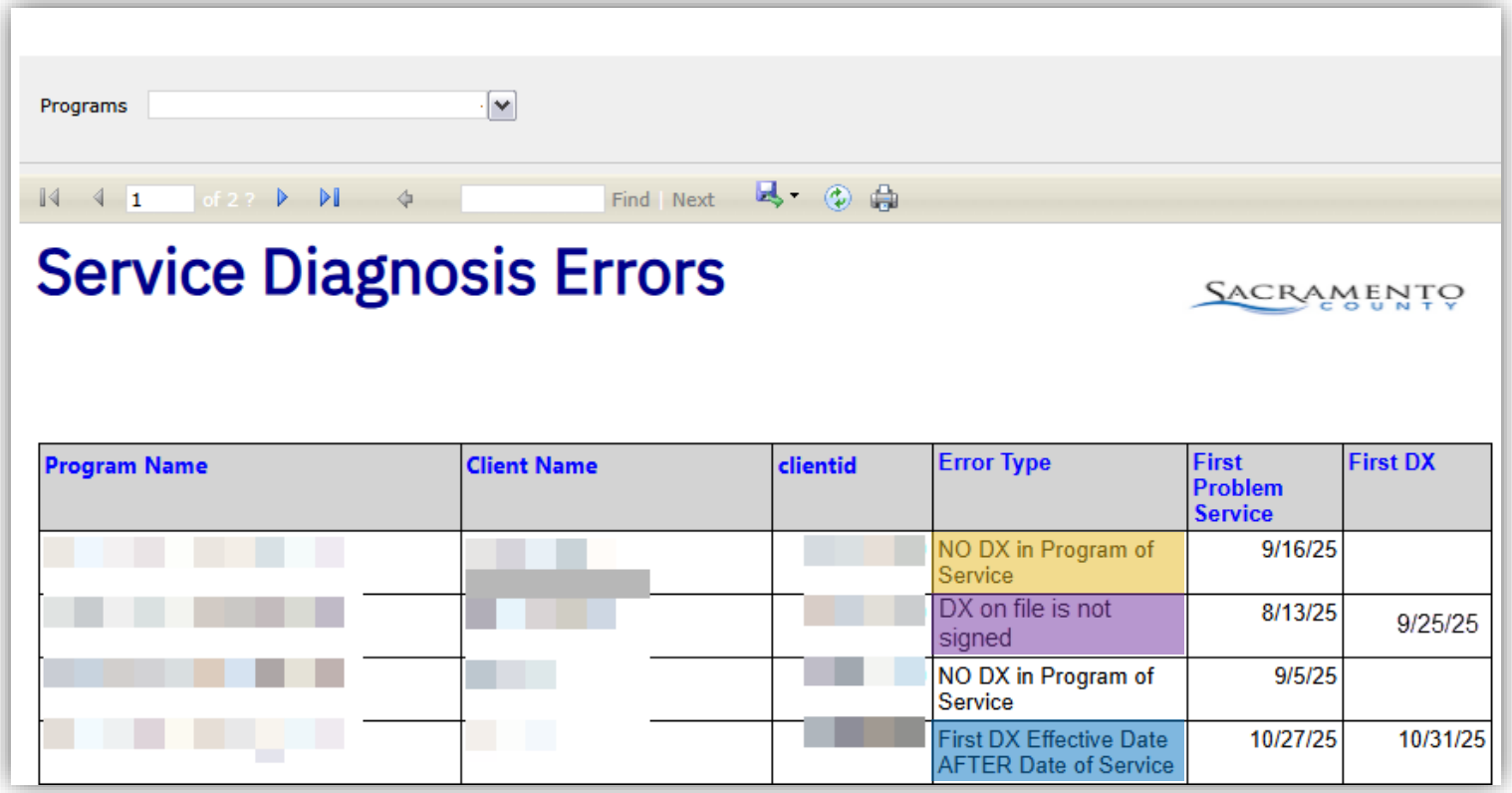
Error: Financial Information has not been Completed for the Client

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



Error: Services Diagnosis Error (Sac) Report

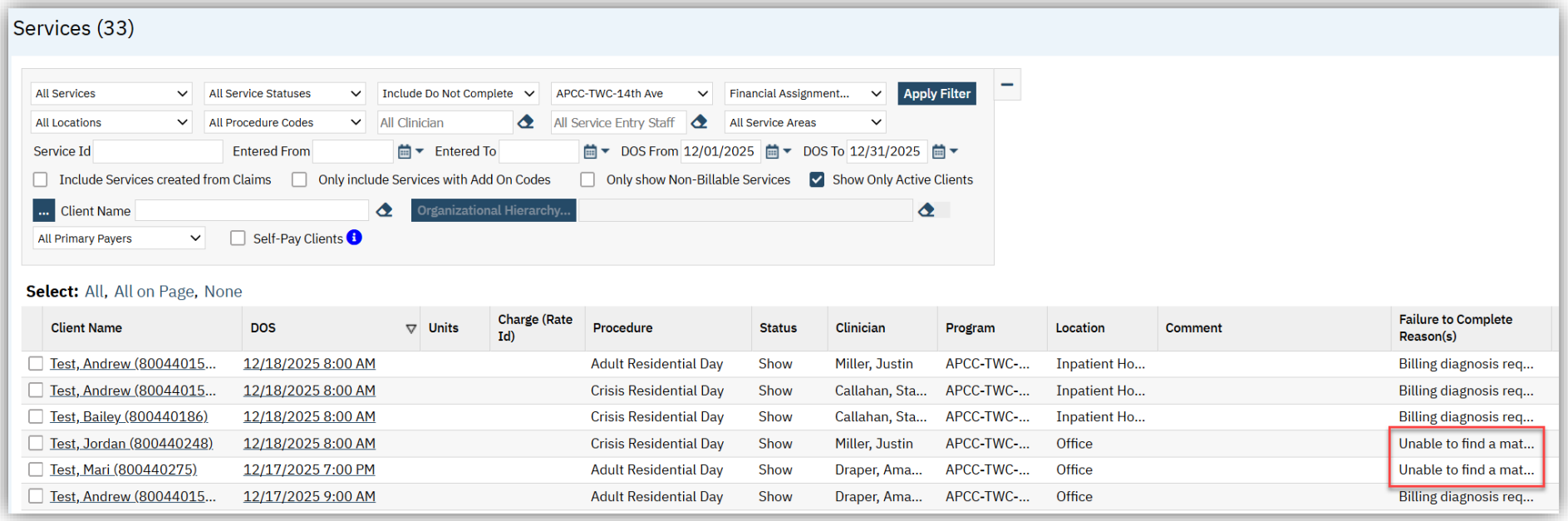
- If you see a failure reason that says ***Billing Diagnosis Required*** run the Services Diagnosis Error (sac) report to find the diagnosis error and make the necessary corrections in the Diagnosis Document (Client) screen



Program Name	Client Name	clientid	Error Type	First Problem Service	First DX
[redacted]	[redacted]	[redacted]	NO DX in Program of Service	9/16/25	
[redacted]	[redacted]	[redacted]	DX on file is not signed	8/13/25	9/25/25
[redacted]	[redacted]	[redacted]	NO DX in Program of Service	9/5/25	
[redacted]	[redacted]	[redacted]	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



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

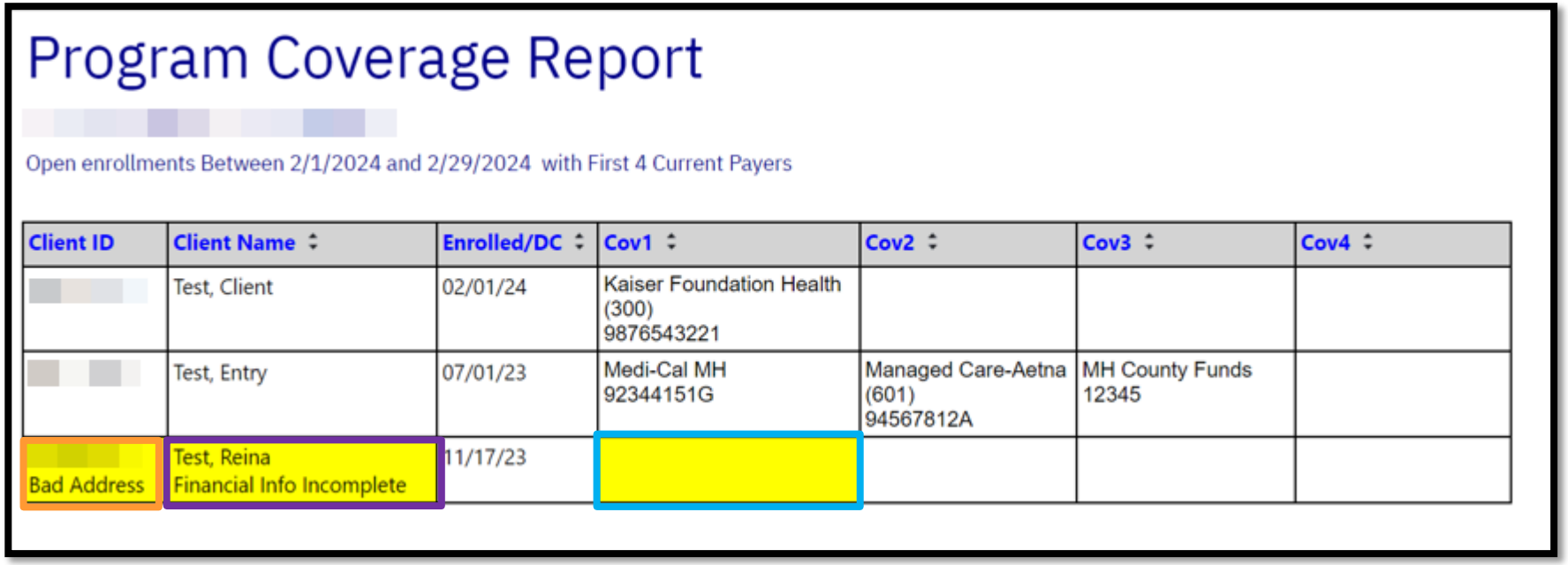
Currently enrolled clients at xxxxSacCo-APSS-Broadway(34CZKA) and their Medi-Cal CIN

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 is incomplete for the client:
    - Can be corrected using the “Client Account (Client)” screen
  - Coverage is incomplete for the client:
    - Payors can be entered in the “Coverage (Client)” screen



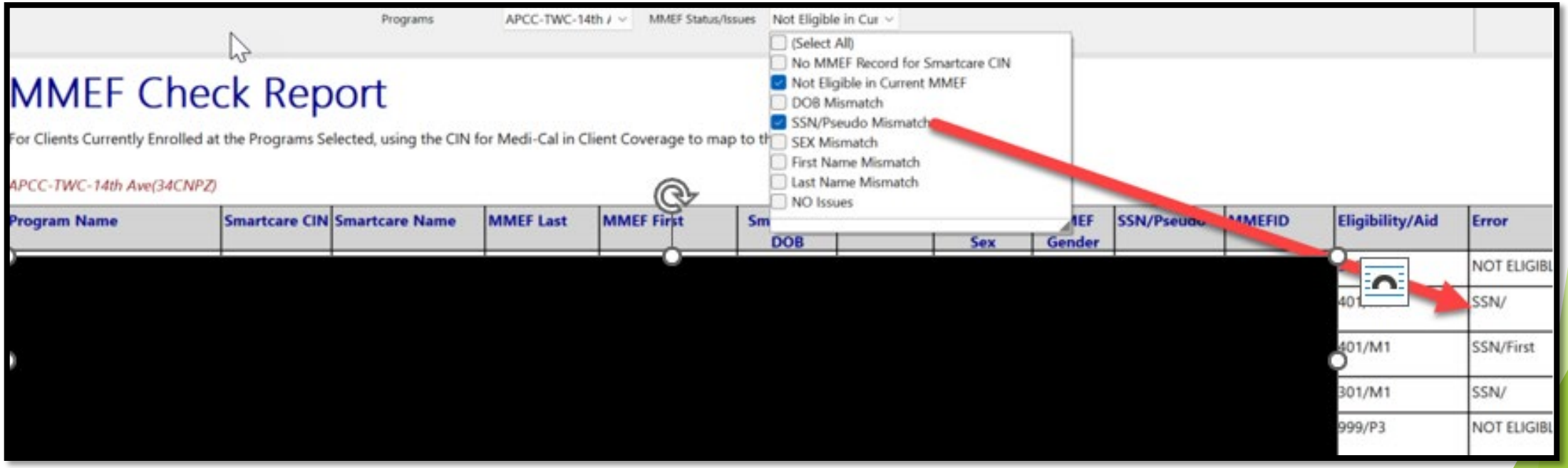
Program Coverage Report

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
	Test, Client	02/01/24	Kaiser Foundation Health (300) 9876543221			
	Test, Entry	07/01/23	Medi-Cal MH 92344151G	Managed Care-Aetna (601) 94567812A	MH County Funds 12345	
Bad Address	Test, Reina Financial Info Incomplete	11/17/23				

MMEF Check Report (SAC)

- This report displays clients whose Medi-Cal Insured ID number in the Coverage screen matches Medi-Cal CIN in the MMEF file that is uploaded by the EHR Billing Team. This displays discrepancies in the client's first and last names, DOB, sex, SSN/pseudo-SSN, or if there is no match at all



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 an adjudicated and approved claim
  - **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

Demo – Transaction Types

- BHS EHR Webpage
  - SmartCare Claiming section
    - Claim Status
    - Medi-Cal Transaction Document
    - ECM Transaction Document

Knowledge Check

Correct Answer:

B

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.

Knowledge Check

Correct Answer:

C

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

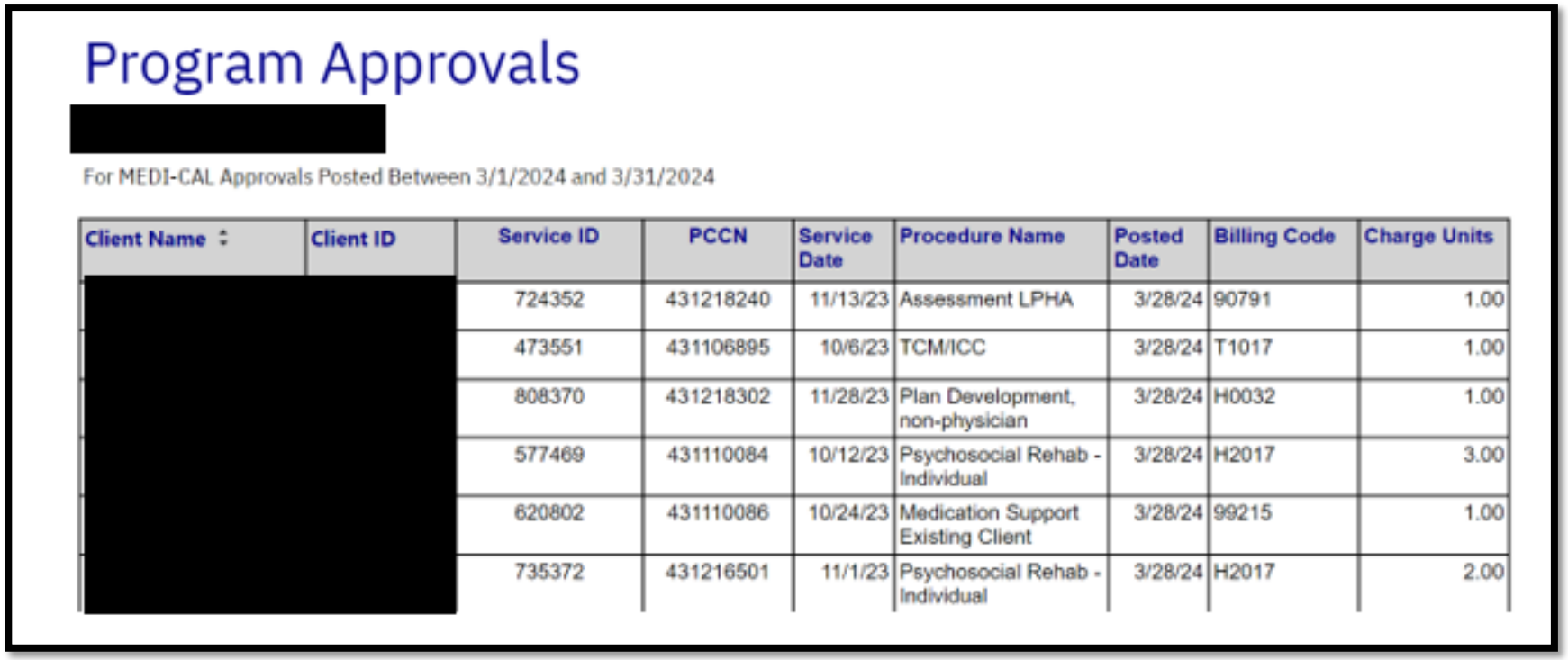
- Determine whether the service has been adjudicated and approved by running the Program Approvals Report.
- Complete a CCS and email encrypted to BHS-EHRBilling@Saccounty.gov
- Use the Medi-Cal Correction Tracking report to view when the Billing Team has submitted the corrections to the state
- Run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

[redacted]

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
[redacted]		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

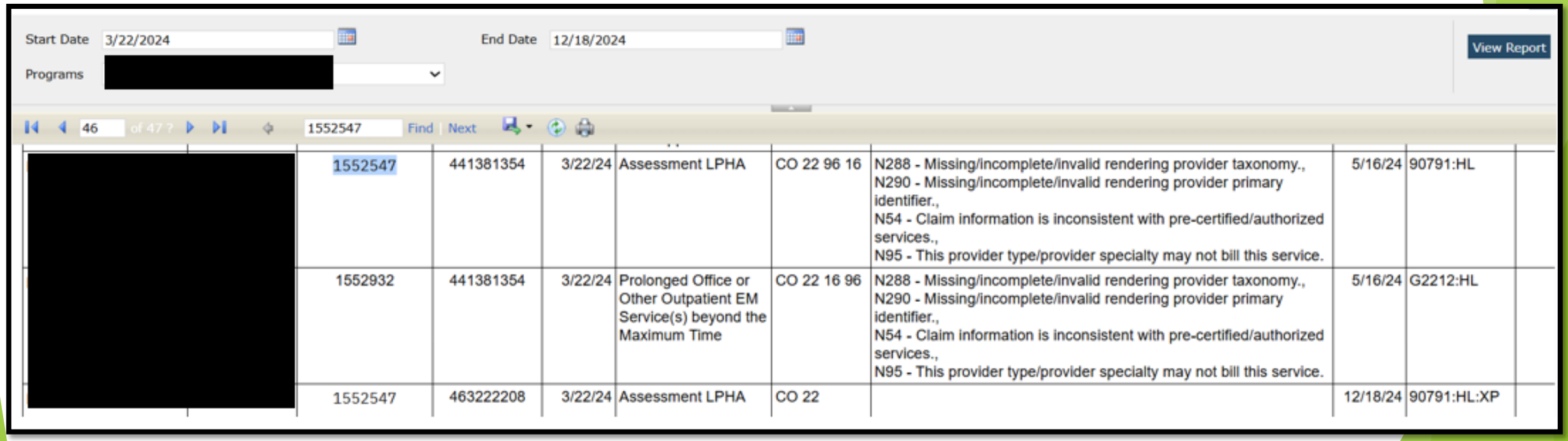
[redacted]

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
[redacted]		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
- It is essential to address each denial reason thoroughly, as failing to do so may result in delays in processing and/or another denial from Medi-Cal.



Start Date 3/22/2024 End Date 12/18/2024 View Report

Programs [redacted]

46 of 47 ? 1552547 Find | Next

[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	
	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	
	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

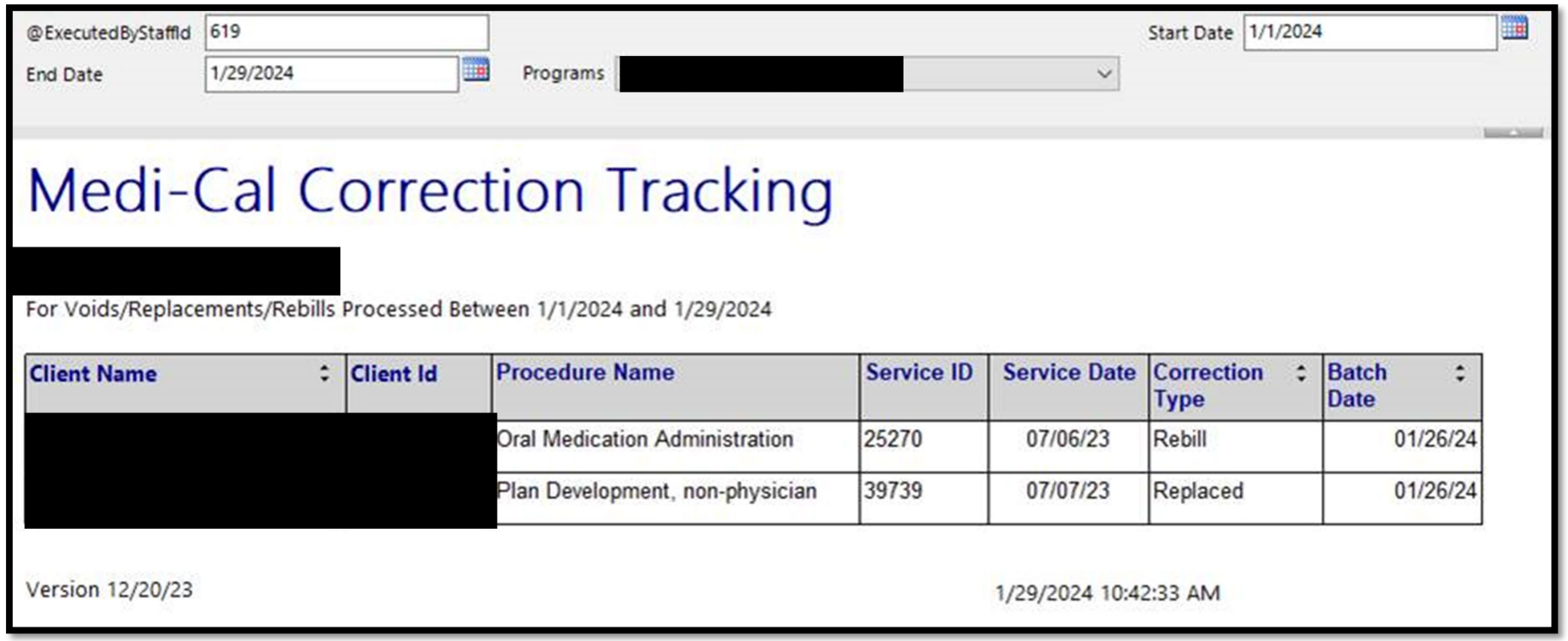
- Correcting a denial reason
- Filling out a CCS

CCS Tracking

- 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

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]		Oral Medication Administration	25270	07/06/23	Rebill	01/26/24
		Plan Development, non-physician	39739	07/07/23	Replaced	01/26/24

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

Corrections Timeliness

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	

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 or removed from 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

Additional Service Corrections Resources

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)
- SmartCare Training Resources
  - Tip sheets, training guides, and training slides
  - BHS EHR Training & Schedule (saccounty.gov)
- SmartCare CalMHSA
  - Navigational guides and videos, link to the LMS portal
  - Home - 2023 CalMHSA

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