Course Content

- Provider Admin Review
- Pre-Claiming Errors
- Transaction Types
- Post-Claiming Process
- Claim Adjustment Reasons Codes/Remittance Advice Remarks Codes (CARC's/RARC's)
- Claims Correction Spreadsheet (CCS)

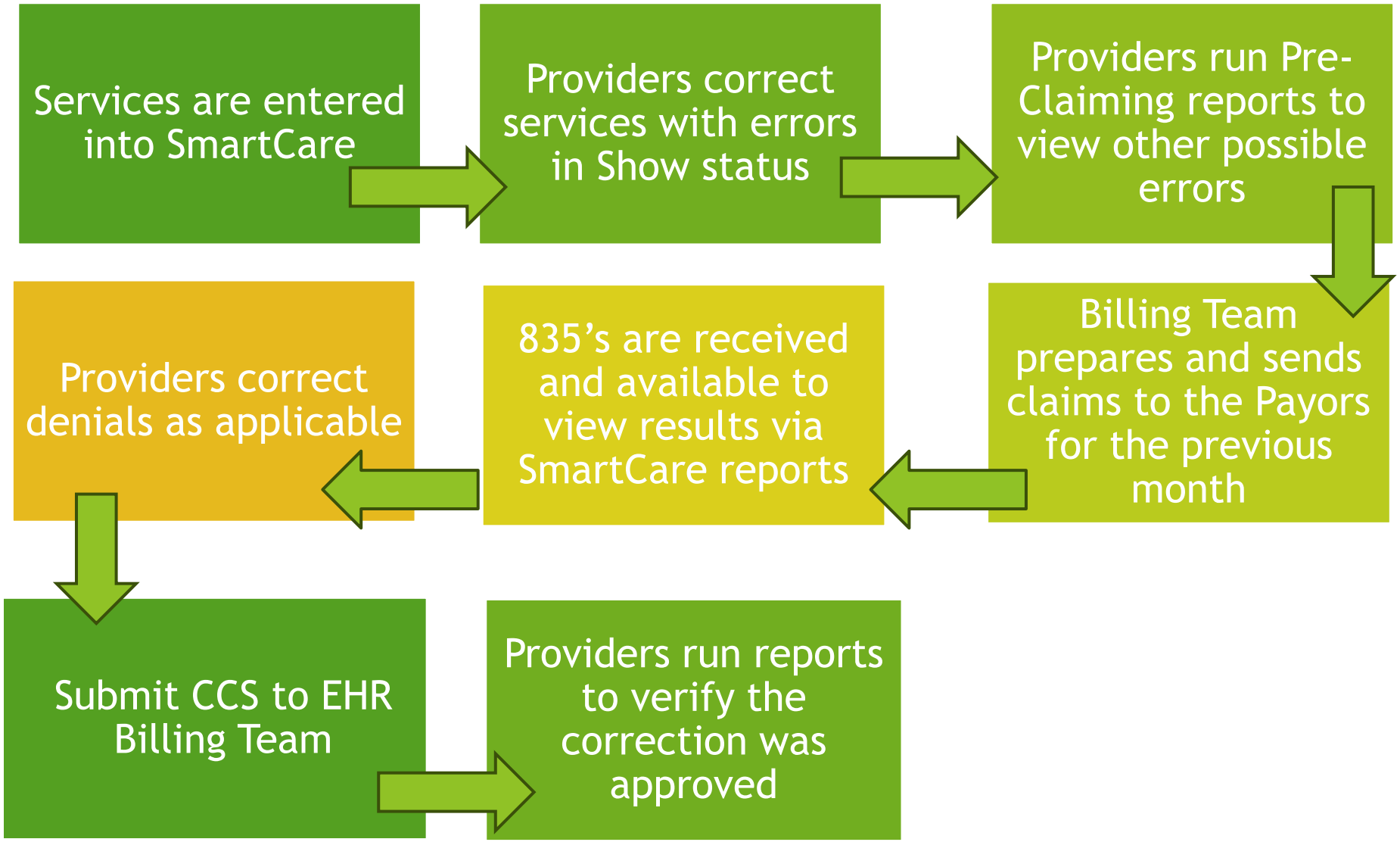
Provider Admin Review

- All services require a signed diagnosis that covers all dates of service
- “Coverage” screen must be completed for the client
- “Financial Information is Complete” box must be marked in the “Client Account” screen
- Services in Show status will not claim out
- The “Services (My Office)” screen and the “Services Needing Attention” widget will show services that are stuck in Show status

Part 1 – Pre-Claiming

- Billing Process
- Program Staff Services Export (SAC) (My Office)
- Correcting Services in Show Status
- Correcting Services in Complete Status
- Correcting Procedures
- Putting a Service in Error Status
- Regenerating Service Charges

Billing Process



- Pre-claiming errors are errors that need to be fixed for a service to claim out
- Some possible pre-claiming errors that providers can work are:
  - There is no signed Diagnosis Document that covers all dates of service
  - Financial Information has not been completed for the client
- Post-claiming errors are errors that occur after a service has claimed out

Pre-Claiming Vs. Post-Claiming

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

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

Pre-Claiming Corrections

- If a service was entered prior to the current month, it is import that you run the “Program Staff Services Export (SAC) (My Office)” report before making any corrections to a service in Complete status
- If the service is within the current month, it has not been claimed and it is not necessary to run the report
- If the report shows the services have claimed out, do not make any edits and do not put the service in “Error” status

Service Corrections

- Corrections should be made prior to services being claimed
- Changes can be made if the service is in a Show or Complete status
  - Services (Client) & (My Office) screens will show the status of the service
- Only administrative staff can make corrections to a service
  - Clinical staff can make changes to their documentation
  - Admin staff can edit the service only, not the documentation

What Service Information can be Edited

Services in Show Status

- Location
- Mode of delivery
- Start date
- Start time
- Program
- Procedure
- Service Time (Duration)
- Clinician name (Only if the note is not signed)

Services in Complete Status

- Location
- Mode of delivery
- Start date
- Start time
- Program
- Procedure (If the note type matches the new procedure)
- Service Time(Duration) (Billing team will need to regenerate the charge)

Demo - Service Corrections

Show	Making a correction in Show status
Complete	Making a correction in Complete status

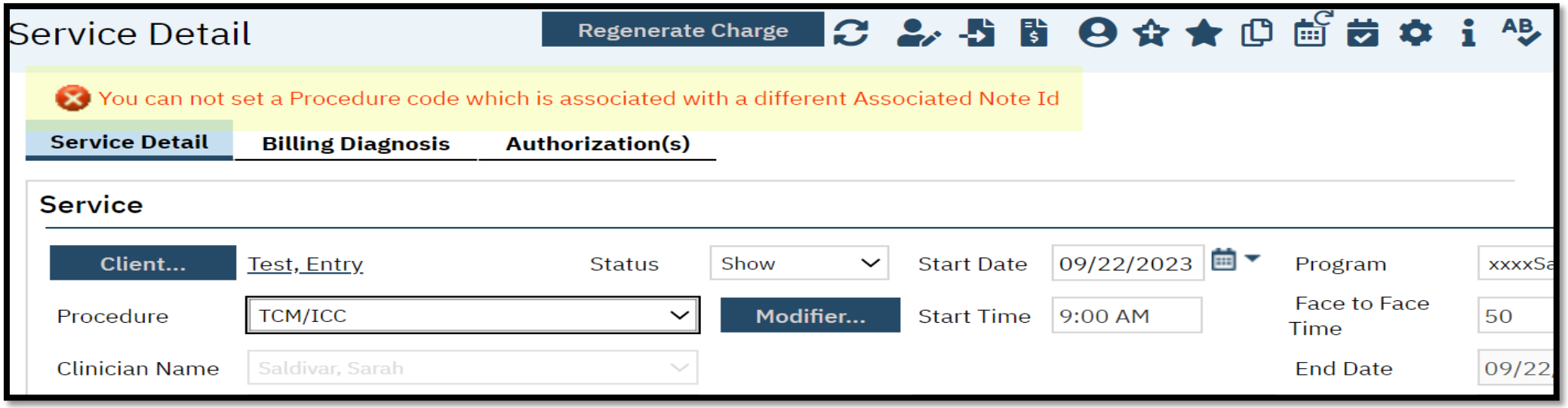
Regenerating Service Charges

- If your service is in Complete status and you change either of the following fields, reach out to the Billing Team to regenerate the charge
  - Duration/Unit
  - Procedure Code
- The Billing Team can be reached via email

BHS-EHRBilling@saccounty.gov

Correcting Procedures

- If you receive the error shown below, you will not be able to make the change in procedure
  - The service will need to be changed to Error status
- SmartCare allows you to change a procedure that is in Complete status as long as the note type is the same as the new procedure
  - If the service is in Show status the procedure can be changed



What to do if you Cannot Edit a Service

- 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

Pre-Claiming Reports

Active Client Eligibility (SAC) (My Office)

Program Coverage Report

Service Diagnosis Errors

Additional Pre-Claiming Errors

- 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

Additional Pre-Claiming Errors

- 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
  - 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				

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

Service Diagnosis Errors

SACRAMENTO COUNTY

T[redacted]

Program Name	Client Name	clientid	Error Type	First Problem Service	First DX
[redacted]			First DX Effective Date AFTER Date of Service	7/1/23	7/26/23
			NO DX in Program of Service	7/19/23	
			DX on file is not signed	7/21/23	7/21/23
			First DX Effective Date	8/3/23	8/5/23

Demo – Client Information (Client)

Update client's DOB & sex

Update client's address

Part 2 – Understanding Post-Claiming

- Post-Claiming Definitions
- Transaction Types
- Class Activity
  - Choosing the correct transaction

What is Post-Claiming?

Post Claiming occurs after services have been sent to the payor

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

Approved services can also be corrected if necessary

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

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
  - Timelines for each program can be found on the Claiming tab of the BHS EHR webpage

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.

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
    - Example CIN correction
    - ECM providers will only be using Rebill when processing their corrections
- Correction timelines and requirements are different for MH, SUPT, & ECM programs
  - transactionTypes_04222015.xlsx (saccounty.gov)
  - ECM Transaction Types_02072024.xlsx (saccounty.gov)

- BHS EHR Webpage

  BHS EHR Claiming (saccounty.gov)
  - SmartCare Claiming section
  - Medi-Cal Transaction Document
  - ECM Transaction Document

Demo

What 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

Part 3 – Making Post-Claiming Corrections

- Post-Claiming Process
- Viewing Approved and Denied Services
- CARCS/RARCS
- CCS
- Modifiers

Post-Claiming Corrections Process

Run the Program Denials Report to view denials and denial codes

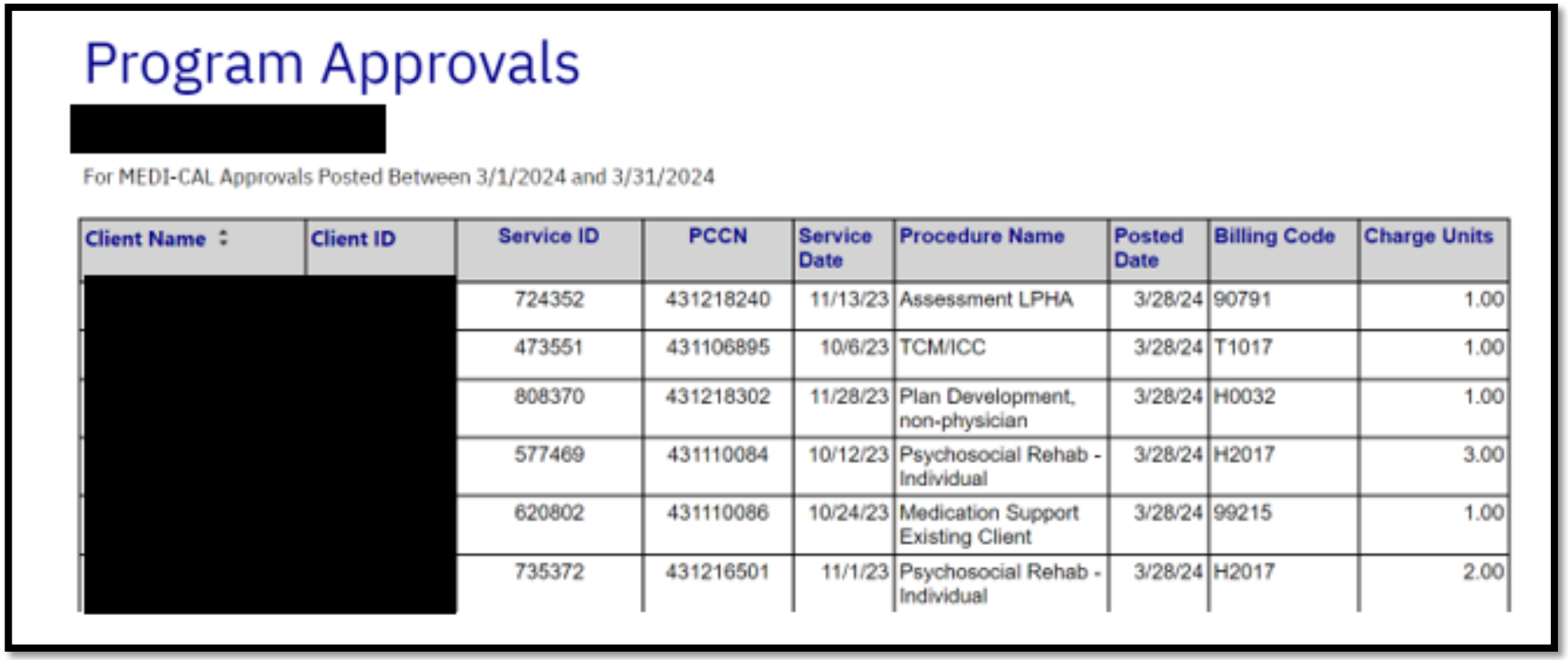
Go onto the Claims webpage and click on the link to the state's webpage CARC/RARC

Make corrections based on the denial

Complete a CCS and email encrypted to BHS-EHRBilling@Saccounty.gov

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

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 code on the CARCs/RARCs
- There is a separate CARC/RARC for SUPT & MH providers

Demo

MH CARCs/RARCs

SUPT CARCs/RARCs

- After fixing the problem that caused the denial in SmartCare, complete a CCS and send to BHS-EHRBilling@Saccounty.gov
  - All CCS's must be emailed encrypted
  - Multiple services and multiple clients can be listed on the same CCS
- 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

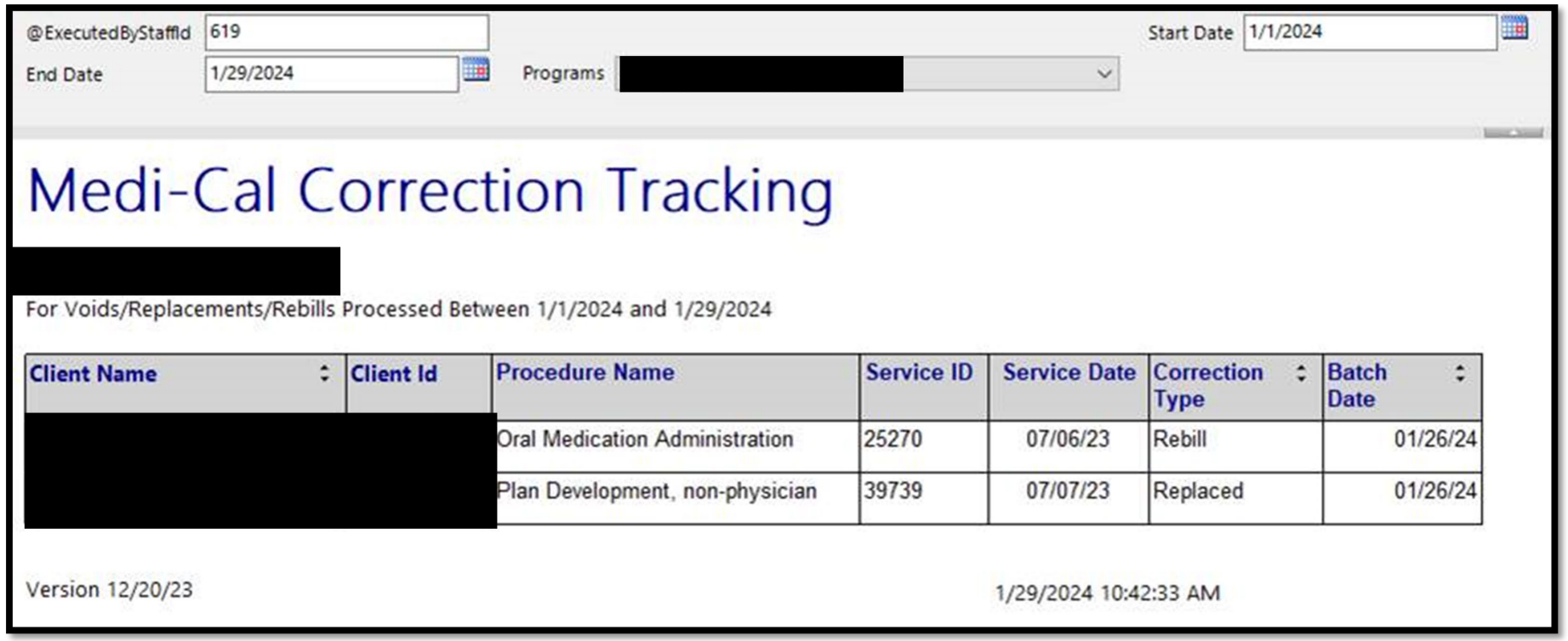
Claims Correction Spreadsheet (CCS)

Demo

- Correct denial reason
- CCS

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

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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- BHS EHR SmartCare Claiming Webpage

https://dhs.saccounty.gov/BHS/BHS-EHR/Pages/EHR-Claiming.aspx

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 license updates
  - DHSQMStaffReg@saccounty.gov