SmartCare Provider Service Corrections Training

Course Content

- Editing Services & Progress Notes
- Pre-Claiming
- Transaction Types
- Post-Claiming Process
- Claim Adjustment Reasons Codes/Remittance Advice Remarks Codes (CARC's/RARC's)
- Claims Correction Spreadsheet (CCS)
- Modifiers
- Other SmartCare Corrections

Part 1 – Editing Services & Service Notes

- Editing Services
- Erroring Services
- Editing Documentation

Corrections Definitions

- Service: A Service is a billable or non-billable activity that is entered to be claimed by various Payors (Medi-Cal, private insurance, county funds)
- Procedure: A Procedure or Procedure Code is the specific code used for the service. The procedure is what is being billed
- Progress Note: Agencies who use SmartCare as their EHR, document services into SmartCare using a Progress Note. Progress Notes are entered by direct care staff only. The progress note documents the details of the service, while also generating a service
- Assessment: Documentation entered as a part of QM documentation standards. Assessments do not generate a service

Corrections Definitions Cont.

- Pre-Claiming: Services that have not been sent to the Payors yet
- Post-Claiming: After services have been sent to the Payors
- Show: A service status that indicates a service is not ready to be claimed. There is something wrong with the service that is preventing it from being claimed
- Complete: The service is ready to be claimed
- Error: A service status that removes the service and any documentation (essentially deletes the service and progress note

Editing Services

- If a service is in Show status or if it has not been claimed, then it can be edited
- Not everything on a service can be edited (See next slide)
- Any edit to a service will be done in the *Services (Client)* screen, even if the service was entered via a progress note
- If a service cannot be edited it can be put in error status
- 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
- Editing the service will not pull forward to the PDF of the service note (if a note was entered)
  - The Direct Care staff who entered the note can edit the note after the service has been edited and that will create a new PDF with the new service information

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
- Procedure (If the note type matches the new procedure)
- Service Time(Duration) (Billing team will need to regenerate the charge)

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

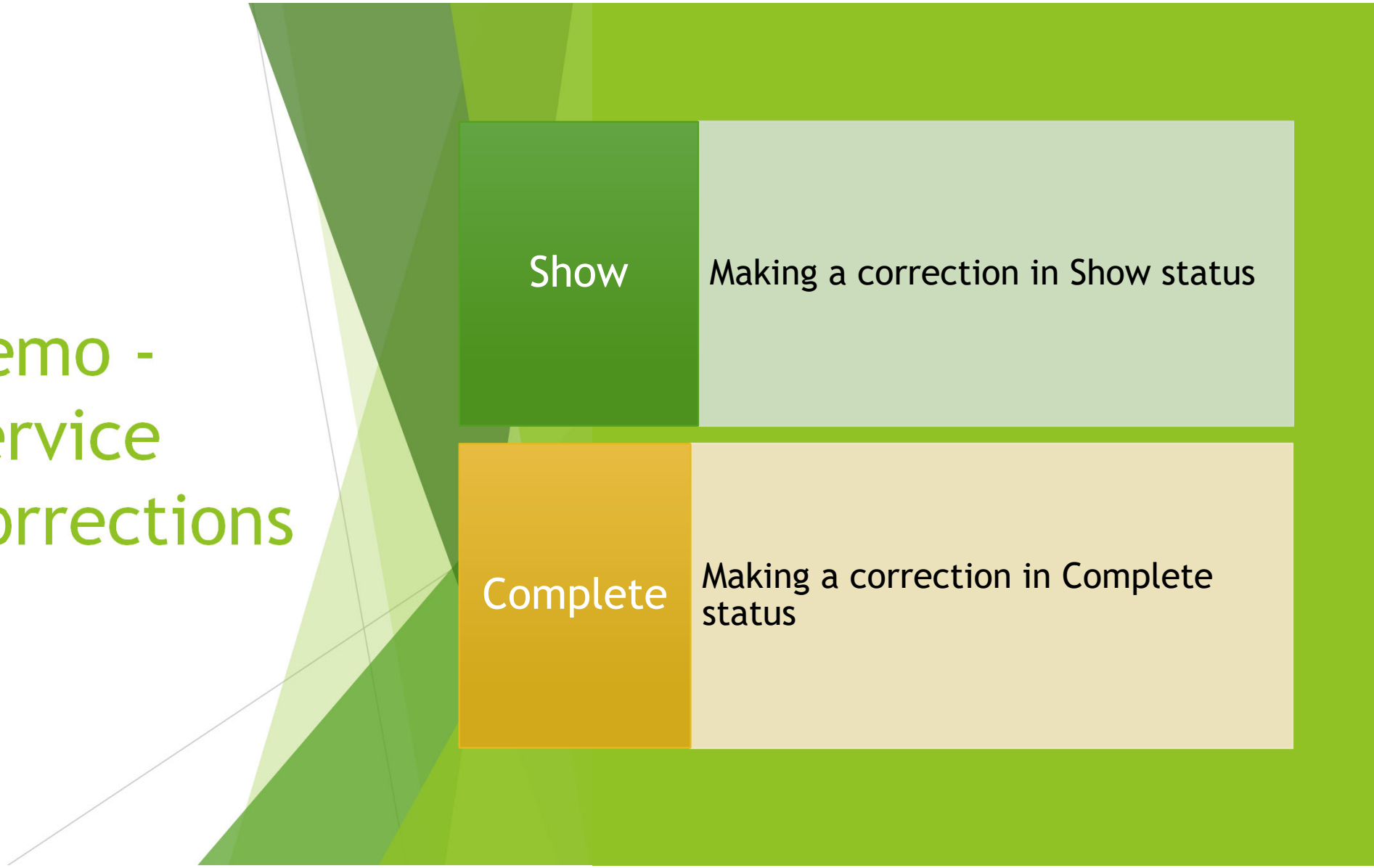
FTF	Travel	Doc	Status	Charge Code
8.00	0.00	5.00	C-Claim Sent	H2011
35.00	0.00	9.00	C-Claim Sent	H2011
50.00	60.00	10.00	C-Claim Sent	H2011
10.00	0.00	5.00	C-Paid	H2011
8.00	0.00	5.00	C-Paid	H2011
30.00	0.00	10.00	C-Claim Sent	H2011
90.00	0.00	30.00	C-Charge Created	H2011
120.00	0.00	30.00	C-Charge Created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

Pre-Claiming Edits

- If a service was entered prior to the current month, it is important that you run the "Program Staff Services Export (SAC) (My Office)" report before making any edits 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

SACRAMENTO COUNTY

Demo - Service Corrections



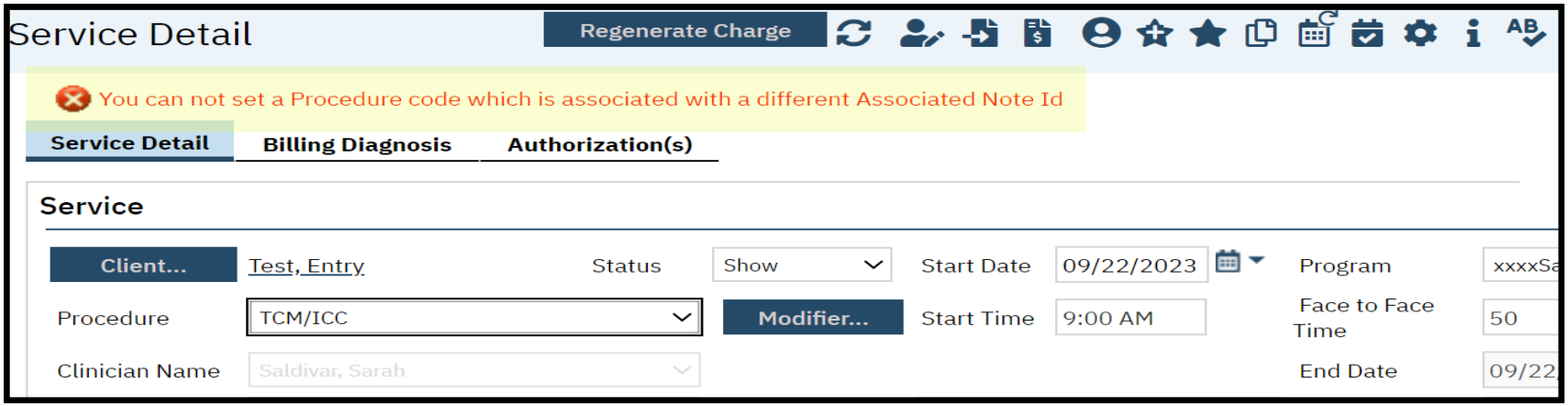
Regenerating Service Charges

- 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

Editing Progress Notes

- If the documentation of a service note needs to be edited that can only be completed by the original author of the note
  - If the author edits their note, they should enter a blurb at the top of the note stating it was edited.
  - A note cannot be edited after 45 days from the date of service
- Please see QM's policy and procedure around editing documentation
  - https://dhs.saccounty.gov/BHS/Documents/BHS-Policies-and-Procedures/PP-BHS-QM-10-30-Progress-Notes-%28Mental-Health%29.pdf

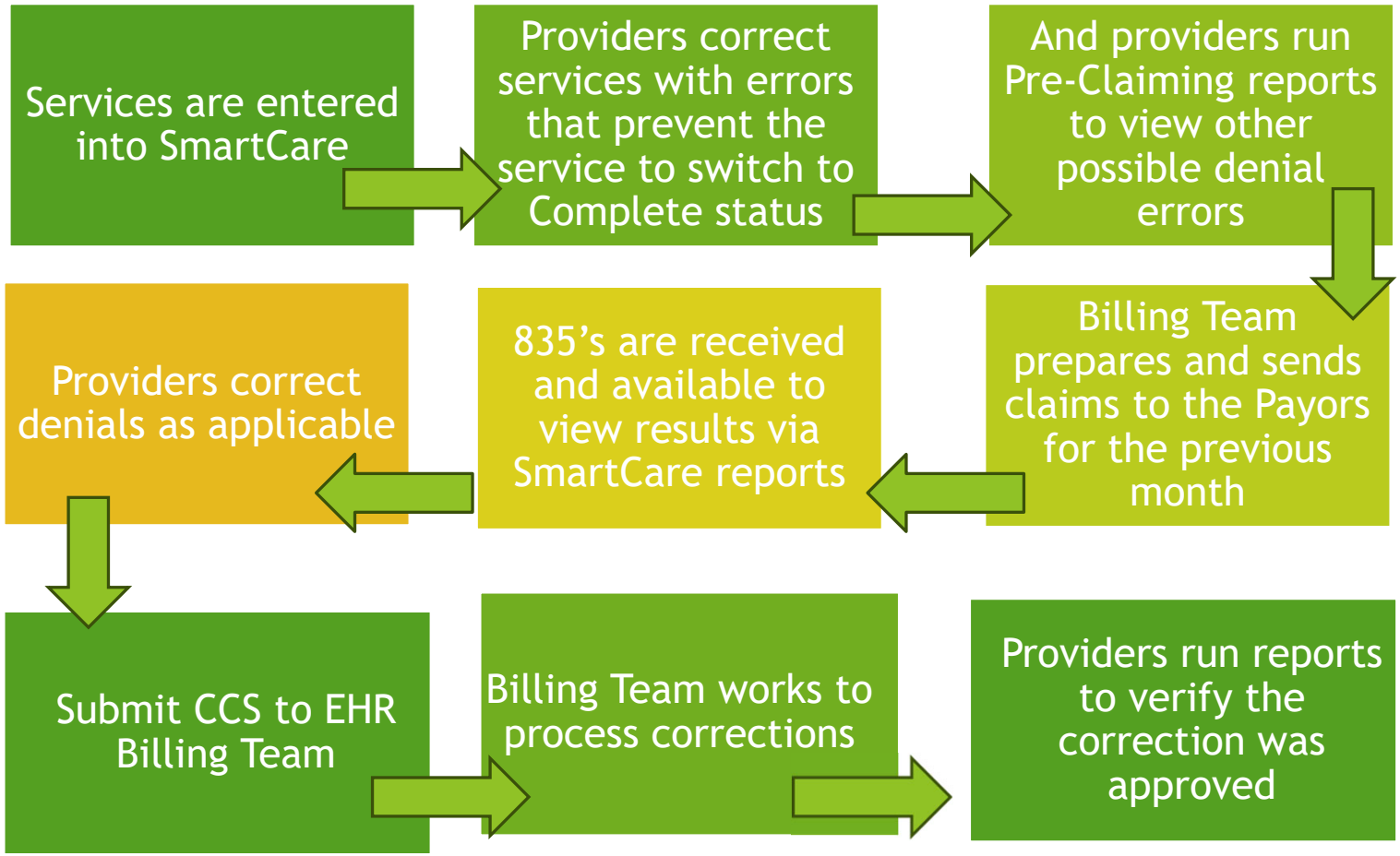
Editing Progress Notes Cont.

- If a note is unsigned and the author is no longer at the agency, the service must be put into Error status
  - To save the content of the note, another provider can enter the documentation with a non-billable procedure code
- Edits to the service do not affect the PDF of signed document
  - The author of the document will have to create a new version by editing the note and signing it again

Part 2 – Pre-Claiming

- Billing Process
- Pre Claiming Errors
- Pre Claiming Reports

Billing Process



Overnight Job

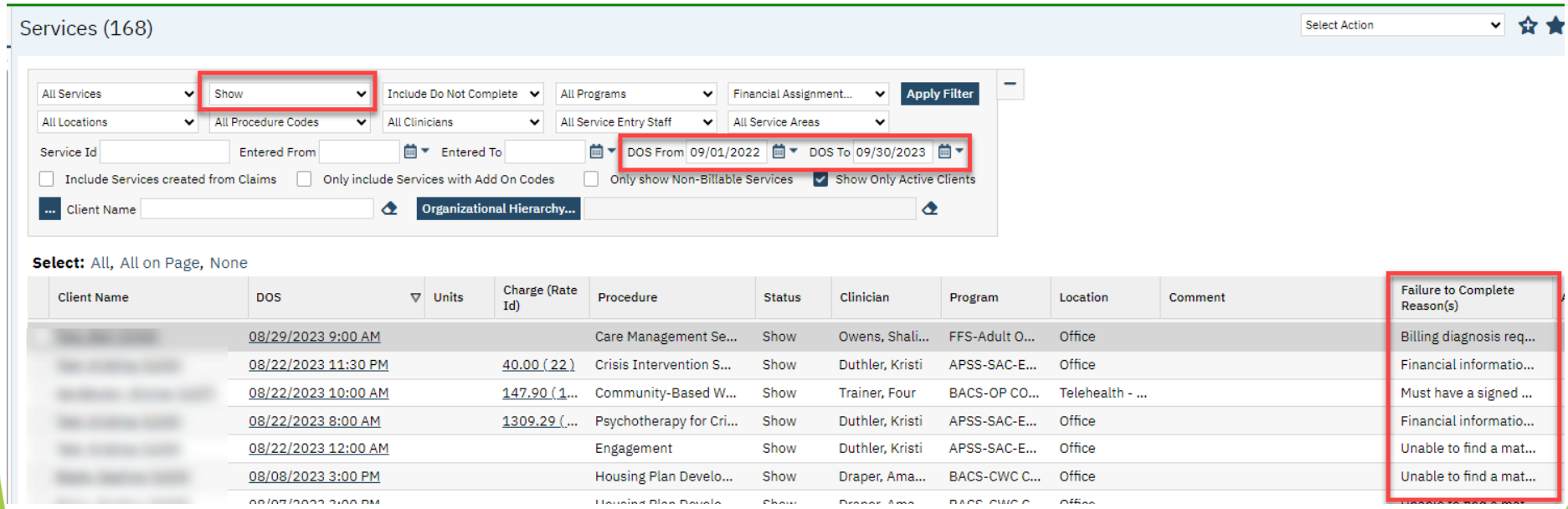
- What is an Overnight Job?
  - Overnight Job validates the services entered into SmartCare
  - It will assign a status to each service that was entered: Show or Complete
    - **Complete:** service is ready to be claimed
    - **Show:** there may be some issues with the service that need to be addressed

Errors That will Prevent a Service from Billing Out

- The errors listed below will prevent a service from billing out
- Below each error, is the resolution to fix the error
  - 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

Services(My Office)

- Run the Services (My Office) list page to view the Failure to Complete Reason(s):



Additional Pre-Claiming Reports

- 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)
- Service Diagnosis Errors (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				

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

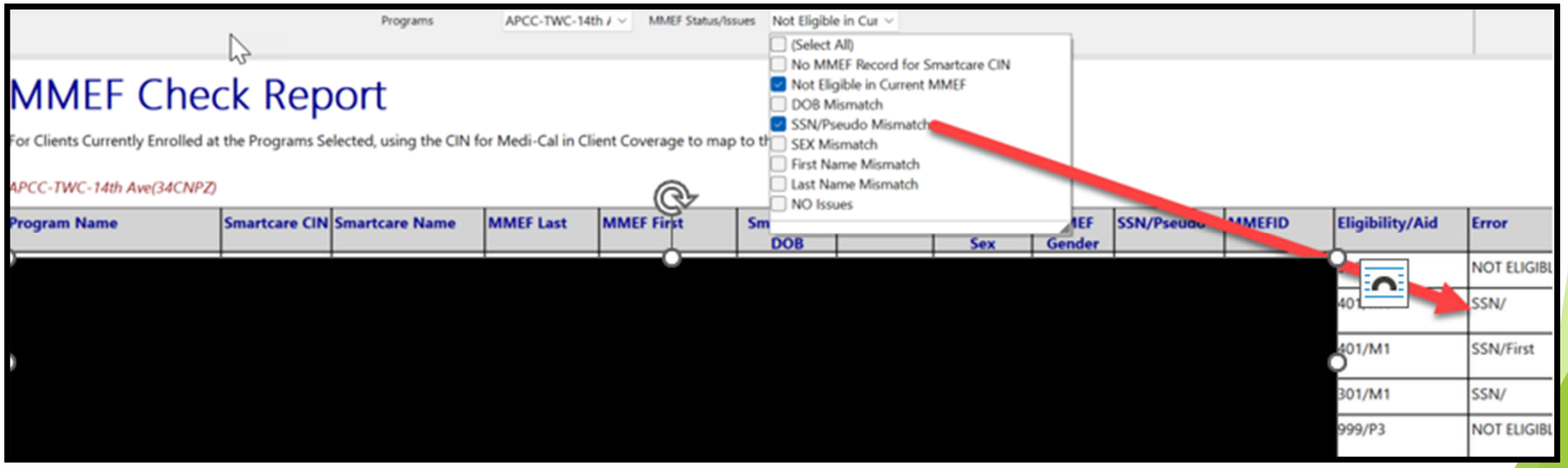
SACRAMENTO COUNTY

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

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
- Class Activity
  - Choosing the correct transaction

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

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

Part 4 – Making Post-Claiming Corrections

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

Post-Claiming Corrections Process

Correcting Approvals

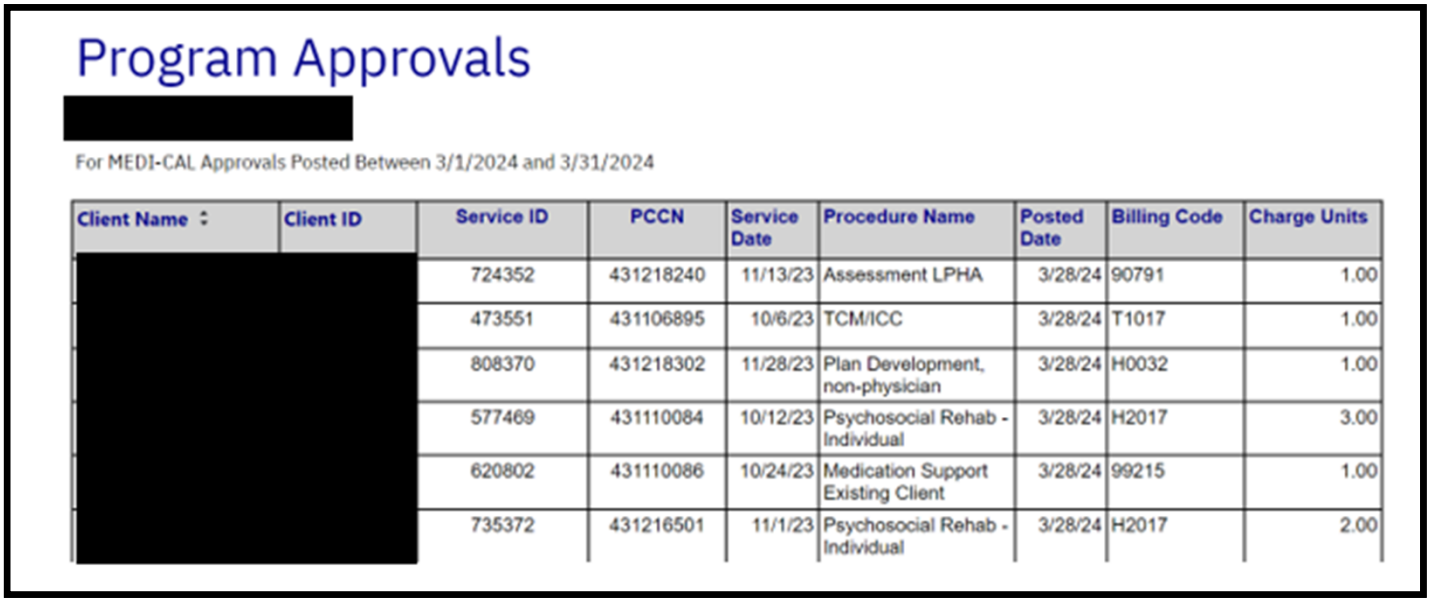
- Determine whether the service has been approved and/or adjudicated by running the Program Approvals Report view all approved services
- Complete a CCS and email encrypted to BHS-EHRBilling@Saccounty.gov
- Use the Medi-Cal Correction Tracking report to view when the Billing Team has submitted the corrections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

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@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
- 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 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

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

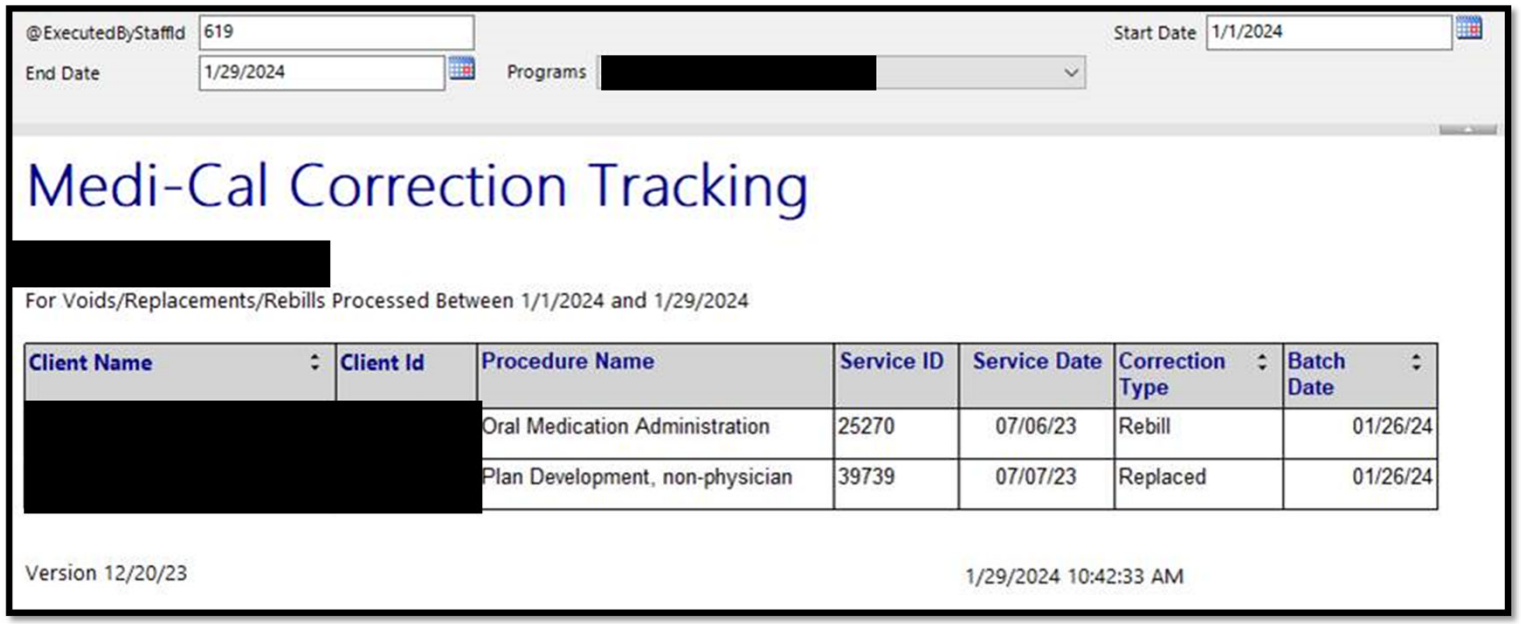
- Correcting a denial reason
- CCS

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	

OHC Timeliness Example

- Below is an example of an OHC denial and how long each correction step can take.
  - **Service Date:** 8/4/23
  - **CCS Received:** 3/22/2024- received within the allowable timeline
  - **Moved to OHC:** 4/20/2024- corrected in a timely manner
  - **Claimed to OHC:** 5/19/2024- the corrected claim cannot be sent out until midway through the next month
  - **No response from OHC (required 90-day wait) DHCS RULE-** for these types of denials, DHCS requires a 90-day waiting period
  - **Moved to Medi-Cal:** 8/26/2024- billing team made the correction in a timely manner
  - **Claimed to Medi-Cal:** 9/20/2024- claim sent the next month
- In the example above, even though the CCS was sent within the approved timeline, the service was later denied again, because the process did not complete within the approved timeline

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

Part 5- Other SmartCare Corrections

- Procedure Codes
- Deleting or Editing Other Types of Documents
- Correcting Common Error Messages
- Getting Locked out of SmartCare

Procedure Code Corrections

- Access to procedure codes are based on the practitioner's classification and the program itself
- If a procedure code is missing for a staff member it could mean:
  - The staff's license is expired or missing in SmartCare
  - The procedure code is unavailable to their classification or their program
    - If a procedure code needs to be added to the program, reach out to your contract monitor
- Not all procedure codes can be edited once a service is in Complete status
  - If a code cannot be edited, then the service will need to be put in Error status by admin staff
- If a staff member is missing procedure codes on their procedure drop-down, this means their license needs to be updated in SmartCare
  - License updates and questions can be sent directly to QM at DHSQMStaffReg@Saccounty.gov

Deleting or Editing Other Documents

- Assessments and Diagnosis Documents can only be edited by the author of the document
- If the author of the document is no longer with the agency the document cannot be edited
  - Staff are able to create a new document if necessary
  - If a pending document needs to be deleted, send the details of that request to BHS-EHRSupport@Saccounty.gov in an encrypted email
- Scanned documents can be deleted in the Scanning (My Office) screen
  - Only the person who scanned in the document can edit or delete the scanned document
  - You will not be able to delete a scanned document in the Documents (Client) screen
  - If the person who scanned in the document is no longer at your program, send the details of that request to BHS-EHRSupport@Saccounty.gov in an encrypted email
- Refer to the tip sheet on the BHS Training Page for instructions on how to delete or edit a scanned document
  - BHS EHR Training & Schedule

Error Messages

- If you are unable to access certain fields or receive a red error message, follow these basic troubleshooting steps:
  - Ensure you are launching SmartCare in Microsoft Edge or Google Chrome
  - Clear your browser cache
    - Log out of SmartCare
    - Go to the web browser's privacy settings and clear your cached images and files
    - See the Clear Browser Cache tip sheet for instructions
      - https://dhs.saccounty.gov/BHS/BHS-EHR/Pages/Support.aspx
  - Switch web browser
  - Contact EHR Support

Error Message: You Are Not an Authorized User

- SmartCare will lock your account for one of these 3 reasons:
  - Password is entered incorrectly at least 3 times
  - Security questions are answered incorrectly (Capitalization Matters!)
  - Password is autosaved with the wrong information
- SmartCare allows 3 attempts to enter a password before your account is locked
  - Use the “Forgot Your Password” link after the second attempt to reset your password
  - To unlock your account, you must call the EHR Support Line at 916-876-5806
    - Office hours are Monday-Friday 8am-5pm, except for county holidays
- Tip: Click on the “eyeball” on the password line to check for any typos

Error: Saved Password no Longer Working

- Browsers' password manager may have been updated with the wrong information
  - Easiest way to avoid this to not use password autosave feature in Chrome or Microsoft Edge
- Go to your browser's password settings to remove incorrect entries
  - See the Remove Autofill tip sheet for instructions for Google Chrome and Microsoft Edge
    - SmartCare Technical Support

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