

Billing 201 Guide

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About this User Manual

This manual was developed to use in conjunction with the Billing 201 Training Course. It provides end users with basic knowledge regarding client financial screens, and the service completion and ready to bill processes.

Audience

This manual is intended for users with the Biller role.

Assumptions

- Ability to perform basic word processing such as typing and searching for documents in files.
- Understands data entry techniques into electronic forms and documents.
- Familiarity with running windows operating systems or other popular programs like Mac OS.
- Basic knowledge of how to use internet browsers like Microsoft Edge and Google Chrome.

For IT Support Requests:

Please call our Help Desk at (916) 214-8348 or submit a live chat question to <https://2023.calmhsa.org/>

Note: Before beginning to use SmartCare, make sure you have a compatible internet browser like Microsoft Edge and Google Chrome. CalMHSA recommends Google Chrome for the best user experience.

For: Live Chat

<https://2023.calmhsa.org/>

Coverage/Plan

In SmartCare, coverages (also called plans) are the insurance plans and payers who are billed to pay for the clients' services.

Adding a coverage to a client's record is a two-step process. The first step is to add the coverage to the client's record and the second is to add the coverage time span (effective and/or end dates). Both steps are accomplished via one screen, Coverages (Client).

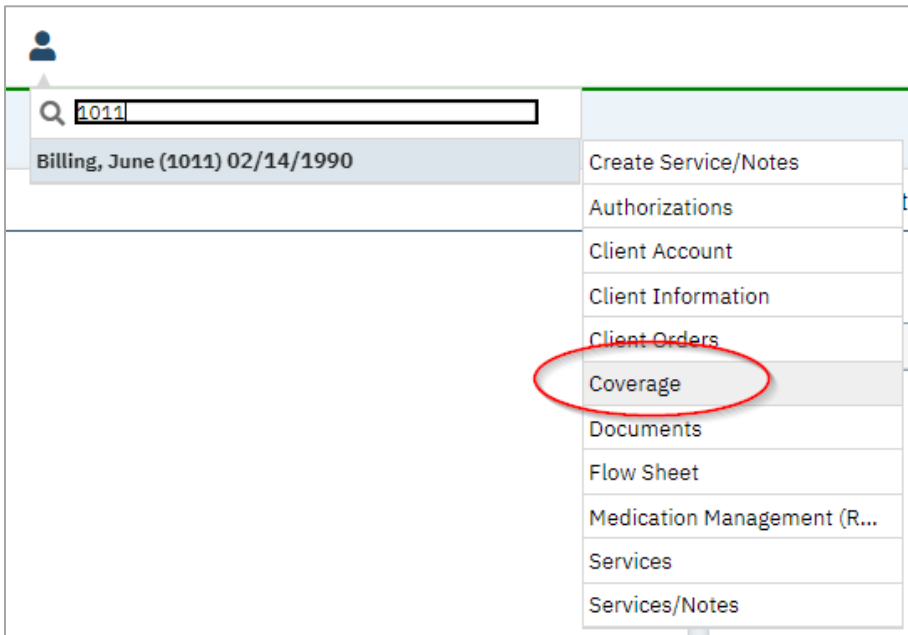
SmartCare has some unique features for coverages. The system can identify which order the coverages should be for Clients who have more than one coverage. All predefined Plans COB order is hardcoded, which sets the precedence for billing. Therefore, end users do not have to worry about selecting the coverage order because the system does it automatically.

Add a Coverage Plan

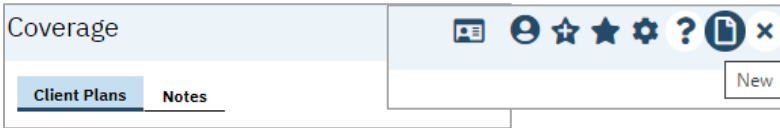
The first step to add a new coverage to a client's record is to add the coverage to the Client Plans section on the Coverage screen.

1. Search for client by clicking on the Person icon
2. Begin typing Last Name or record ID#
3. Click on the Client Name when it displays
4. Scroll to the right with mouse to select Coverage

The Coverage screen will open.



5. Click on New icon

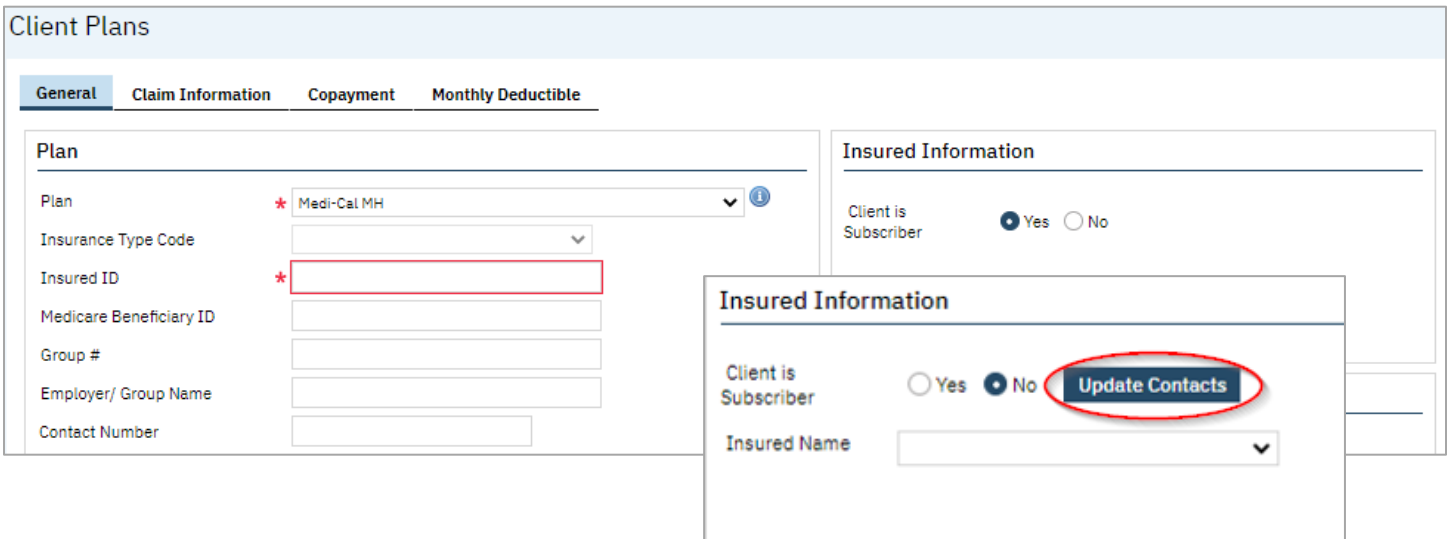


The Client Plans screen will open.

6. The fields are required when entering a new plan are:

- a. Plan – Select from the dropdown menu
- b. Insured ID – Enter Insured ID
- c. Client Is Subscriber
 - i. The Client is Subscriber radio button automatically defaults to Yes
 - ii. If the client is not the subscriber select the No radio button and select the subscriber from the dropdown list of the client’s contacts (second screenshot)
 - iii. If the subscriber has not been added to the client’s contacts, select the Update Contacts button and add the subscriber’s information to the client’s contacts
- d. Save and close

7. Repeat the above steps to add additional Coverages



Plan Time Spans

The second step to add a new coverage to a client's record is to add the plan time span (start/end dates). Client coverages added to the client's record are in the Client Plans section of the Coverage screen.

1. To add a plan time span:
 - a. Enter or select the Start Date
 - i. An End Date can also be entered if applicable but is not required
 - b. Click Add

Coverage

Client Plans **Notes**

Client Plans

Plan Name	△ Insured Id	Co-Pay	Start Date	End Date	COB	Service Area	
DMH - Molina	98578654A		<input type="text"/>	<input type="text"/>	<input type="text"/>	MH	Add
Medi-Cal DMC	98578654A		01/01/2023	<input type="text"/>	<input type="text"/>	DMC	Add

2. Once a Plan Time Span is added, it is viewable in the Plan Time Spans section of the screen
3. To view coverages for a client that have an end day, deselect the "Show Current Plans Only" checkbox

Show Current Plans Only DMC [Maximize Time Spans](#)

Plan Time Spans

01/01/2023 - No End Date [Change COB Order...](#)

✕	Medi-Cal DMC	98578654A-1500 Capitol Avenue MS 2704 Sacramento, CA 95899-...	<input type="text"/>	Set End Date
---	--------------	--	----------------------	------------------------------

4. Terminating a coverage in the Plan Time Spans section:
 - a. Enter the end date in the provided field
 - b. Select the Set End Date button

Show Current Plans Only DMC [Maximize Time Spans](#)

Plan Time Spans

01/01/2023 - No End Date [Change COB Order...](#)

✕	Medi-Cal DMC	98578654A-1500 Capitol Avenue MS 2704 Sacramento, CA 95899-...	<input type="text"/>	Set End Date
✕	SUD MHSA DDX	512586-1295 State Street El Centro, CA 92243	01/31/2023	Set End Date

- To view all current and historical coverage for a client, uncheck the “Show Current Plans Only” checkbox
- Use the dropdown to view Plans associated to the DMC and MH Service Areas

Plan Time Spans

Date Range	Plan Name	Address	Set End Date
02/01/2023 - No End Date	Medi-Cal DMC	98578654A-1500 Capitol Avenue MS 2704 Sacramento, CA 95899-...	Set End Date
01/01/2023 - 01/31/2023	Medi-Cal DMC	98578654A-1500 Capitol Avenue MS 2704 Sacramento, CA 95899-...	Set End Date
	SUD MHSA DDX	512586-1295 State Street El Centro, CA 92243	Set End Date

Coordination of Benefits (COB)

Managing COB in SmartCare is easy with the tools available. Assigned to each Plan is a coordination of benefits (COB) order in the setup, and this helps the system automatically add client coverages in the correct order. Below are steps to update manually the COB order.

- On the Plan Time Spans section of the Coverage screen select the Change COB Order button
- Enter the correct order for each Plan
- Click Save and then Close

COB Order

COB Order Details

Plan Name	Insured ID	COB
SUD MHSA DDX	512586	2
Medi-Cal DMC	98578654A	1

270/271 Eligibility Transactions

SmartCare has the capability to submit and receive 270/271 real-time eligibility transactions for Medi-Cal from the Coverage screen. In addition, with the click of a button, the system will update the client's Medi-Cal coverage.

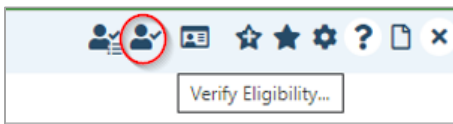
Run real-time eligibility transactions on demand in three areas of the system:

- Coverage (Client) screen
- Inquiry (Client) screen
- Registration (Client) screen

Note: This guide only covers information for the 270/271 transactions in the Coverage (Client) screen.

Real-Time 270/271 Eligibility Transactions

1. Navigate to the Client Coverage Screen
2. Click the icon for Verify Eligibility



3. The Insurance Eligibility Verification window will open to the Request tab
 - a. Electronic Payer defaults to Medi-Cal
 - b. The Insured and Client Information values can be updated if needed before running the transaction
 - c. Both Start and End Date defaults to the current date
 - i. The Start Date is the Card Issue Date (leave as current date if issue date is unknown)
 - ii. The End Date is the date of eligibility being searched for
4. Select Submit Request
 - a. The Response tab should display within seconds

A screenshot of the "Insurance Eligibility Verification" window. The window has a title bar and a "Print Response" button. The main area is divided into several sections: "Coverage Plan" with a dropdown for "Electronic Payer" set to "Medi-Cal" and "Payer Id" set to "MCOA"; "Insured Information" with fields for "First Name" (Peter), "Last Name" (Pan), "SSN", "Insured Id", "Date Of Birth" (02/14/1965), and "Sex" (Male); "Client Information" with fields for "Relationship to the insured" (Self), "First Name" (Peter), "Last Name" (Pan), and "Date Of Birth" (02/14/1965); and "Date Range" with "Start Date" (08/24/2022) and "End Date" (08/24/2022). The "Request" tab is selected and circled in red. A "Submit Request" button is circled in red in the bottom right corner.

5. On the Response tab, scroll down to view additional benefits and client information

Insurance Eligibility Verification

Request **Response**

Info	Coverage Level	Service Type	Insurance Type	Benefit Entity Name	Plan Coverage Description	Group Policy Num	Start Service Date	End Service Date	Commercial Insurance Name	Network	Co-insurance	Co-Pay amount	Deductible	Out of Pocket	Message 1	Message 2	Message 3
Co-Payment	Individual	Urgent Care								In		\$ 65				Copy \$0.65 between \$2.00-\$10.00, Copy \$1.30 between	
Deductible	Individual	Health Benefit Plan Coverage								In			\$0			\$10.01-\$25.00, Copy \$2.55 between \$25.01-\$50.00, Copy \$3.80 above \$50.00.	

Additional Subscriber Information
 Gender: Male
 DOB: 19650214
 Patient ID: 123456789
 Information Contact:
 Sub Supplemental ID: Group Policy #

Information Source
 Payer Name: Medi-Cal
 Payer ID: 96321
 Information Receiver
 Provider ID: 9976543211
 Provider Secondary ID:

Scroll to view all benefit and eligibility information

6. Click the Update Coverage button to automatically update the client's Medi-Cal coverage

Insurance Eligibility Verification

Request **Response**

Update Coverage Plans

Medi-Cal
 Subscriber
 Patient
 Dependent

Print Response Close

Info	Coverage Level	Service Type	Insurance Type	Benefit Entity Name	Plan Coverage Description	Group Policy Num	Start Service Date	End Service Date	Commercial Insurance Name	Network	Co-insurance	Co-Pay amount	Deductible	Out of Pocket	Message 1	Message 2	Message 3
------	----------------	--------------	----------------	---------------------	---------------------------	------------------	--------------------	------------------	---------------------------	---------	--------------	---------------	------------	---------------	-----------	-----------	-----------

7. Submitted requests that error will display an error message

Insurance Eligibility Verification

Request **Response**

Medi-Cal
 Subscriber
 Patient
 Dependent

Eligibility check failed: Subscriber or Insured Not Found
 Action to take: Please Correct and Resubmit.

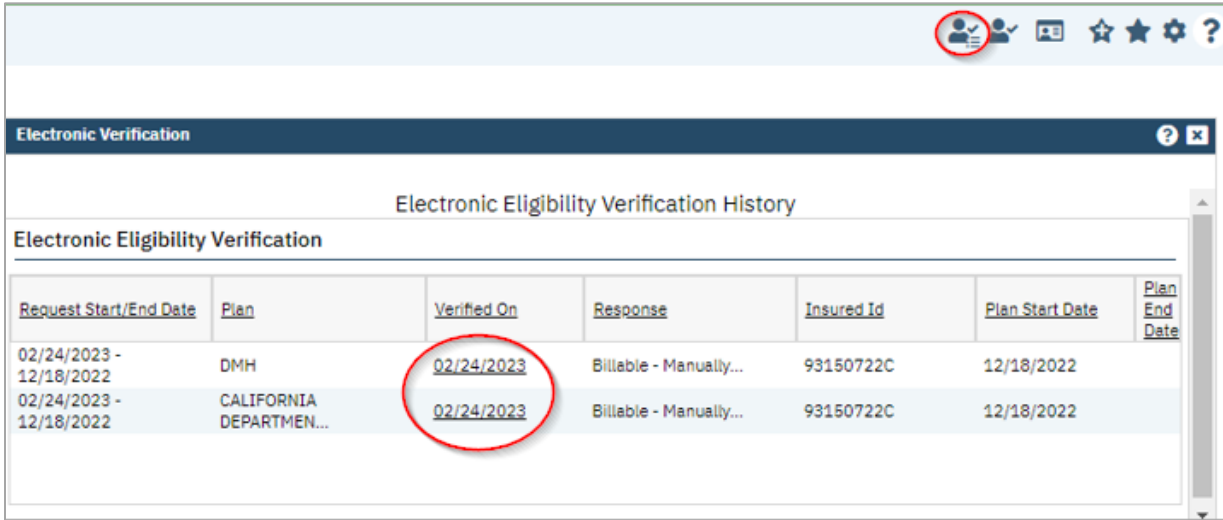
Print Response Close

Info	Coverage Level	Service Type	Insurance Type	Benefit Entity Name	Plan Coverage Description	Group Policy Num	Start Service Date	End Service Date	Commercial Insurance Name	Network	Co-insurance	Co-Pay amount	Deductible	Out of Pocket	Message 1	Message 2	Message 3
------	----------------	--------------	----------------	---------------------	---------------------------	------------------	--------------------	------------------	---------------------------	---------	--------------	---------------	------------	---------------	-----------	-----------	-----------

Real-Time 270/271 Transaction History

Find a client's history of 270/271 transactions via the Client Coverage screen.

1. Click the icon for Verification History
2. Click the Verified On hyperlink to review the specific transaction information



<u>Request Start/End Date</u>	<u>Plan</u>	<u>Verified On</u>	<u>Response</u>	<u>Insured Id</u>	<u>Plan Start Date</u>	<u>Plan End Date</u>
02/24/2023 - 12/18/2022	DMH	02/24/2023	Billable - Manually...	93150722C	12/18/2022	
02/24/2023 - 12/18/2022	CALIFORNIA DEPARTMEN...	02/24/2023	Billable - Manually...	93150722C	12/18/2022	

Entering Services

Entering a service in SmartCare launches the billing process. A procedure code associated with the service determines whether the service is billable or not and whether it requires a service note. If it does require a service note, the clinician creates one and signs it after the service has been provided.

A service can be entered via a Progress Note, the Service Detail screen and through the Batch Service Entry screen.

Progress Note

For the clinicians' workflows for completing the Progress Note, please refer to the Clinical Documentation at our training website:

<https://2023.calmhsa.org/clinical-documentation/>




Service Detail

Billing and Financial end users typically use the Service Detail (Client) screen to enter services.

1. Navigate to the Services (Client) screen
2. Select the New icon

The Service Detail screen opens.

3. Complete the Service Detail tab with the required information:
 - a. Set the Status
 - b. Update the Start Date if needed (defaults to today's date)
 - c. Clinician Name
 - d. Program
 - e. Procedure
 - f. Location
 - g. Face to Face Time
 - h. Travel Time
 - i. Documentation Time
 - j. Save

Service Detail Regenerate Charge   

Service Detail | Billing Diagnosis | Authorization(s)

Service

Client... Billing, June | Status Scheduled | Start Date 04/16/2023 | Program [Yellow]

Procedure [Yellow] | Modifier... [Blue] | Start Time [Blue] | Face to Face Time 0.00

Clinician Name [Yellow] | End Date [Grey]

Location [Yellow] | Attending [Grey] | Referring [Grey]

Client was present | Other Person(s) Present [Grey] | Cancel Reason [Grey]

Group... | Charge | Balance | Rate ID

Billable | Do Not Complete

Mode Of Delivery [Grey]

Travel Time [Blue] | Note [Grey]

----- [Grey]

Documentation Time [Blue]

Evidence Based Practices [Grey]

Transportation Service No


Override Charge Amount | Overridden By [Grey]

Override Errors | Overridden By [Grey]

Interpreter Services Needed

4. Select the Billing Diagnosis tab
5. Add the diagnosis to the service (see below) if needed
 - a. Note: If the client has a current Diagnosis Document on file relate to the CDAT, the diagnosis will auto-populate
6. To add the diagnosis select the ICD 10 blue button
7. In the pop-up window search by either entering the ICD 10 code, or a description; select the Search button
8. In the list select the radio button for the diagnosis
9. Select Ok

Diagnosis ICD Ten PopUp

F43.2 | [Yellow] |  **Search**

ICD10 | SNOMED | Billable and Non Billable [Grey]

* DSM-5-TR

	DSM 5/ICD 10	Billable	SNOMED	ICD/ DSM Description	SNOMED Description
<input type="radio"/>	F43.20*	Yes	162218007	Adjustment disorder, Unspecified	Stress-related problem (disorder)
<input checked="" type="radio"/>	F43.20*	Yes	17226007	Adjustment disorder, Unspecified	Adjustment disorder (disorder)
<input type="radio"/>	F43.20*	Yes	192041001	Adjustment disorder, Unspecified	Acute situational disturbance (disorder)
<input type="radio"/>	F43.20*	Yes	192054008	Adjustment disorder, Unspecified	Culture shock (disorder)
<input type="radio"/>	F43.20*	Yes	192064004	Adjustment disorder, Unspecified	Elective mutism due to an adjustment reaction (disorder)
<input type="radio"/>	F43.20*	Yes	192065003	Adjustment disorder, Unspecified	Hospitalism (disorder)
<input type="radio"/>	F43.20*	Yes	225021007	Adjustment disorder, Unspecified	Abnormal grief reaction to life event (finding)
<input type="radio"/>	F43.20*	Yes	271952001	Adjustment disorder, Unspecified	Stress and adjustment reaction (disorder)
<input type="radio"/>	F43.20*	Yes	365241005	Adjustment disorder, Unspecified	Finding of grieving process stage
<input type="radio"/>	F43.20*	Yes	386821008	Adjustment disorder, Unspecified	Adjustment reaction in infancy (disorder)
<input type="radio"/>	F43.20*	Yes	386822001	Adjustment disorder, Unspecified	Adjustment reaction of adolescence (disorder)

10. Set the Diagnosis pointer by clicking the dropdown menu

Service Detail Regenerate Charge

Service Detail **Billing Diagnosis** Authorization(s)

Billing Diagnosis ICD 10...

F43.20 - Adjustment disorder, Unspecified

1 [Diagnosis](#) [Refresh Diagnosis](#)

2

3

4

5

6

7

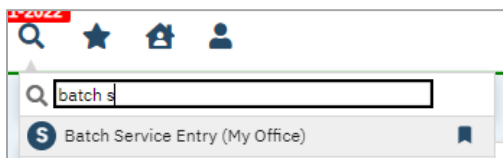
8

11. Save

Batch Service Entry

Batch Service Entry lets end users enter services that have already occurred for multiple clients at the same time. Once the services are entered, they are checked during the overnight billing job to ensure they pass all service validations.

1. Navigate to Batch Service Entry (My Office) screen



2. Select Date and enter any other criteria needed and Apply Filter
3. Complete the Default Values fields to apply to the multiple clients
4. Select the checkbox to the right of each client's name who should have the service
5. If needed, select the plus sign button to the left of the client's name to add another row to the client for additional services on the same date of service
6. Save

Batch Service Entry

Client Preference: M TU W TH F
 Also Include Complete/Show Services for the day
 Only Show Clients Seen In Last 90 Days

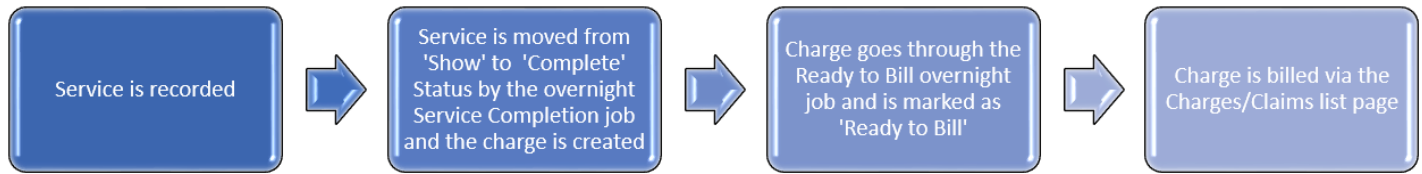
Last Name Begins With:

Default Values

	Client Name	Staff	Procedure Code	Date	Time In	Time Out	Dur.	Location	Comments
<input checked="" type="checkbox"/>	CalMHSA Testing (1176)	<input checked="" type="checkbox"/> Stephan, Khristy	BH - Unspecified Procedi	01/03/202	10:00 AM	11:00 AM	60	Location	
<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/> Stephan, Khristy	Psychoanalysis	01/03/202	10:00 AM			Location	
<input checked="" type="checkbox"/>	Caloms Six (1203)	<input checked="" type="checkbox"/> Stephan, Khristy	BH - Unspecified Procedi	01/03/202	10:00 AM	11:00 AM	60	Location	
<input checked="" type="checkbox"/>	Cinnamon-Crunch Toast (1103)	<input checked="" type="checkbox"/> Stephan, Khristy	BH - Unspecified Procedi	01/03/202	10:00 AM	11:00 AM	60	Location	
<input checked="" type="checkbox"/>	Clayton Cliff (1312)	<input type="checkbox"/>		01/03/202					

Service Completion and Charge Creation

Overview of the Service Completion, Charge Creation and Ready to Bill Processes in SmartCare:



Rate Calculations and Billing Units

When a service is entered with all required fields completed, the rate for the service will be automatically calculated based on the Procedure/Rates set up in the system.

The rates are set up in the background to calculate automatically based on the clinician's license/degree and other criteria set.

To accommodate the new CalAIM billing guidelines, the units for services that require rounding have been configured in SmartCare. Clinicians will continue to enter the Face to Face time for services with clients, and SmartCare will automatically calculate the correct units for billing based on the rounding that has been set up.

Example:

A Procedure that is set to round as "Per 15(7/7)," rounds off to the next multiple of 15. If the service provided is 7 minutes or less, the billing unit = 0. If the service is between 8 and 22 minutes, the unit = 1.

- 8-14 minutes is rounded up to 15 minutes
- 16-22 minutes is rounded down to 15 minutes

Once the number of minutes for any 15 minute increment reaches the 8th minute the unit will be rounded up to the next whole unit.

Workflow for Rate Calculations

1. Service is recorded by a clinician or other staff member
 - a. Service is in a 'Show' status
 - b. System will match to a Rate ID and calculate the Charge amount, but **the charge has not been created yet**

Service Detail

Service Detail	Billing Diagnosis	Authorization(s)	Disposition				
Service							
Client...	Test, George	Status	Show				
Start Date	04/14/2023	Program	Inpatient PHF				
Procedure	Bed Day	Modifier...	Start Time	12:00 AM	Total Duration	1	Days
Clinician Name	Admin, System	End Date					
Location	Inpatient Psychiatric Facility	Attending	Chopra, Ravi	Referring			
<input checked="" type="checkbox"/> Client was present	Other Person(s) Present	Cancel Reason					
Group...	Charge	\$700.00	Balance	Rate ID	995		
<input checked="" type="checkbox"/> Billable	<input type="checkbox"/> Do Not Complete						
Mode Of Delivery							

2. Overnight Service Completion job runs and looks for all services in a 'Show' status
 - a. If the service has no warnings or errors the service will be completed
 - i. Service is now in a 'Complete' status
 - ii. The charge has been created and a ledger entry now exists for the charge

Service Detail	Billing Diagnosis	Authorization(s)	Disposition				
Service							
Client...	Test, George	Status	Complete				
Start Date	04/14/2023	Program	Inpatient PHF				
Procedure	Bed Day	Modifier...	Start Time	12:00 AM	Total Duration	1	Days
Clinician Name	Admin, System	End Date	04/14/2023				
Location	Inpatient Psychiatric Facility	Attending	Chopra, Ravi	Referring			
<input checked="" type="checkbox"/> Client was present	Other Person(s) Present	Cancel Reason					
Group...	Charge	\$700.00	Balance	\$ 700.00	Rate ID	995	
<input checked="" type="checkbox"/> Billable	<input type="checkbox"/> Do Not Complete						
Mode Of Delivery							

Overnight Billing Jobs

The Nightly Billing Job has 15 steps it goes through to complete automatically specific functions in SmartCare. The Billing Job and each step runs every night in the following order.

1. 835 Process Uploaded Files – Processes any imported 835 files
2. Create Bed Services – Creates bed services when using the automatic census in the Inpatient/Residential module
3. Generate Bundled Services – Creates bundled services when using the bundled services functionality
4. Attach Diagnosis to Show Services – Refreshes Billing Diagnosis tab
5. Service Completion – Completes services that are in a Show status with no service validation errors
6. Set Charge Ready to Bill – Sets charge to Ready to Bill if there are no charge errors
7. Reallocation – Based on changes in the system, charges are reallocated if needed
8. Ready to Bill 2 – If any charges have been reallocated they are run through the Ready to Bill job again
9. Allowed Amount Adjustments – Processes adjustments based on setup in the Plan
10. Client Fee Adjustments – Processes adjustments based on active Client Fee records
11. Auto Post Client Payments – Client payments are applied to oldest balance first
12. Fix Open Charges, Unposted Payments and Client Balance
13. Custom Timely Filing Warnings – Generates charge errors for Delay Reason Codes
14. Custom EPSDT Indicator – Adds the EPSDT indicator to claim files


Service Errors

As part of the Service Completion (job step #5), the system will look for Service Validation errors. If a service has one or more errors, the service will stay in the Show status, and the error(s) will display.

To locate service validation errors in the system for correction, navigate to the Dashboard and locate the Warnings, Errors, Flags Widget, or navigate to the Services (My Office) screen and set the filters.

Dashboard Widget

1. Navigate to the Dashboard
2. Locate the Warnings, Errors, Flags Widget
3. Select the Services hyperlink
4. The Services (My Office) screen will open and the filters will automatically be set to Services with Warnings or Errors



Warnings, Errors, Flags	
Select Assignment...	▼
Services	672
Charges	220
Claims	17

Services (My Office)

1. Navigate to Services (My Office)
2. Set filter to Services with Warnings or Errors
3. Apply Filter

Services (673)

Services with Warnings or Errors | All Service Statuses | Include Do Not Complete | All Programs | Financial Assignment... | Apply Filter

All Locations | All Procedure Codes | All Clinicians | All Service Entry Staff | All Service Areas

Service Id | Entered From | Entered To | DOS From | DOS To

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

Client Name | Organizational Hierarchy...

Common Service Validation Errors

1. Financial information has not been completed for this client
 - a. To correct, navigate to the Client Account (Client) screen and select the Financial Information Complete checkbox
2. Billing diagnosis required for completing the service
 - a. To correct, review Diagnosis Document for errors, and check the Billing Diagnosis tab via the Service Detail
3. Required authorization missing
 - a. To correct, navigate to the Authorizations (Client) screen and create or update the authorization
4. Must have a signed note before completing the service
 - a. To correct, follow-up to make sure the service receives a signed note
5. Unable to find a matching rate for the selected procedure
 - a. To correct, review the Procedure/Rate setup for the selected Procedure

Once a service is corrected, the overnight billing job will run the Service Completion step again, and complete the service.

Billing Rules and Charge Errors

As part of the Ready to Bill (job steps #6 and #8), the system will look for charge errors. If a charge has one or more errors, the charge will not be marked as Ready to Bill, and the error(s) will display.

Billing Rules are configured via the Plan setup, and these rules are what will trigger charge errors.

To locate charge errors in the system for correction, navigate to the Dashboard and locate the Warnings, Errors, Flags Widget, or navigate to the Charges/Claims (My Office) screen and set the filters.

Dashboard Widget

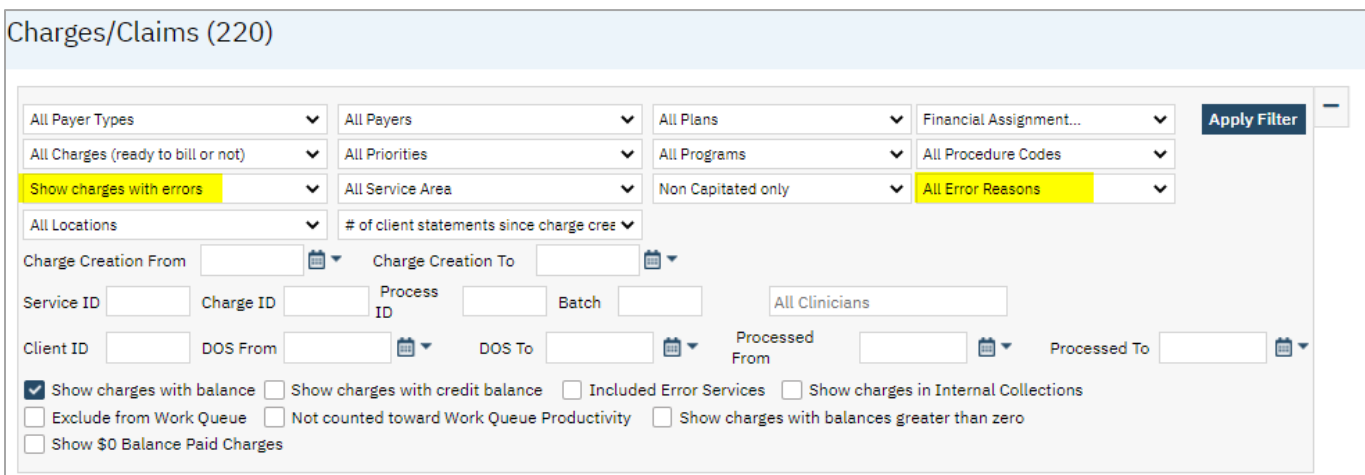
1. Navigate to the Dashboard
2. Locate the Warnings, Errors, Flags Widget
3. Select the Charges hyperlink
4. The Charges/Claims (My Office) screen will open and the filters will automatically be set to Charges with Warnings or Errors



Warnings, Errors, Flags	
Select Assignment...	
Services	672
Charges	220
Claims	17

Charges/Claims (My Office)

1. Navigate to Charges/Claims (My Office)
2. Set filter to Charges with Warnings or Errors
3. Apply Filter



Charges/Claims (220)

All Payer Types	All Payers	All Plans	Financial Assignment...	Apply Filter
All Charges (ready to bill or not)	All Priorities	All Programs	All Procedure Codes	
Show charges with errors	All Service Area	Non Capitated only	All Error Reasons	
All Locations	# of client statements since charge cre			

Charge Creation From [] Charge Creation To []

Service ID [] Charge ID [] Process ID [] Batch [] All Clinicians []

Client ID [] DOS From [] DOS To [] Processed From [] Processed To []

Show charges with balance Show charges with credit balance Included Error Services Show charges in Internal Collections

Exclude from Work Queue Not counted toward Work Queue Productivity Show charges with balances greater than zero

Show \$0 Balance Paid Charges

Common Charge Errors

1. Timely Filing Limit – Delay Reason Code Required

- a. To correct, obtain Delay Reason Code, and add it via the Select Action menu, or in the Charge Details screen

Charges/Claims (220)

Select Action

Select Action

Add Delay Reason

Add Supplemental Information

Add to External Collections

Add to Internal Collections

Batch Update Billing Code and Revenue Code

Mark as Do Not Bill

Mark as Flagged

Mark as Rebill

Mark claim line To Be Replaced

Mark claim line To Be Voided

Mark Ready to Bill

Remove Flagged

Remove from Do Not Bill

Remove from Internal Collections

Remove from Ready to Bill

Remove from Rebill

Remove from To Be Replaced

Remove from To Be Voided

All Payer Types All Payers All Plans Financial Assignment... Apply Filter

All Charges (ready to bill or not) All Priorities All Programs All Procedure Codes

Show charges with errors All Service Area Non Capitated only All Error Reasons

All Locations # of client statements since charge crea

Charge Creation From Charge Creation To

Service ID Charge ID Process ID Batch All Clinicians

Client ID DOS From DOS To Processed From Processed To

Show charges with balance Show charges with credit balance Included Error Services Show charges in Internal Collections

Exclude from Work Queue Not counted toward Work Queue Productivity Show charges with balances greater than zero

Show \$0 Balance Paid Charges

Charge Details

General Contact Status History Action History

General

Charge ID 41 Service ID 146

Client Payer Medi-Cal DMC Priority 1

Status

Ready To Bill Flagged Internal Collections: No

Rebill Do Not Bill External Collections:

Revenue Work Queue Management

Charge Status Charge Created Status Date 09/01/2022 Exclude Charge from Queue Do Not

Status Comments

Delay Reason

01 Proof of eligibility unknown or unavailable

02 Litigation

03 Authorization Delays

04 Delay in Certifying Provider

05 Delay in Supplying Billing Forms

06 Delay in Supplying Custom-made Appliances

07 Third Party Processing Delay

08 Delay in Eligibility Determination

09 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

10 Administration Delay in the Prior Approval Process

11 Other

15 Natural Disaster

- b. Add the Delay Reason Code Control Identifier Number via the Charges/Claims screen and the Select Action menu or the Charge Details screen

Charges/Claims (1)

Select Action

Select Action

Add Delay Reason

Add Supplemental Information

Add to External Collections

Add to Internal Collections

Batch Update Billing Code and Revenue Code

Mark as Do Not Bill

Mark as Flagged

Mark as Rebill

Mark claim line To Be Replaced

3rd Party Plans All Payers All Plans Financial Assignment

Ready To Bill Only All Priorities All Programs All Procedure Codes

Show billed charges All Service Area Capitated/ Non Capitated All Error Reasons

All Locations # of client statements since charge crea

Charge Creation From Charge Creation To Claim Line Item ID Payer

Supplemental Information

ID 123456 Type Transmission Code

2. Authorization is required
 - a. To correct, navigate to the Authorizations (Client) screen and create or update the authorization
3. Plan will not pay for this procedure
 - a. To correct, follow defined internal workflows (write-off charge, correct service, transfer charge to the next payer, etc.)
4. Non Billable Location
 - a. To correct, follow defined internal workflows (write-off charge, correct service, etc.)

Overriding a Charge Error

There are times when a charge error will need to be overrode, rather than resolved. This should only be done per internal workflow instruction.

1. In the Charges/Claims screen select the charge to be overrode by checking the checkbox next to the charge ID
2. Manually mark the charge as Ready to Bill via either the Select Action dropdown or in the Charge Details screen
3. A Confirmation Message will pop-up, select Yes

Charges/Claims (1)

3rd Party Plans All Payers All Plans Financial Assignment

Ready To Bill Only All Priorities All Programs All Procedure Codes

Show billed charges All Service Area Capitated/ Non Capitated All Error Reasons

All Locations # of client statements since charge crez

Charge Creation From Charge Creation To Claim Line Item ID Payer

Service ID Charge ID 240 Process ID Batch All Clinicians

Client ID DOS From DOS To Processed From 04/13/2023 Pro

Show charges with balance
 Show charges with credit balance
 Included Error Services
 Show charges in Internal Collection
 Exclude from Work Queue
 Not counted toward Work Queue Productivity
 Show charges with balances greater than zero
 Show \$0 Balance Paid Charges

Select Action

- Select Action
- Add Delay Reason
- Add Supplemental Information
- Add to External Collections
- Add to Internal Collections
- Batch Update Billing Code and Revenue Code
- Mark as Do Not Bill
- Mark as Flagged
- Mark as Rebill
- Mark claim line To Be Replaced
- Mark claim line To Be Voided
- Mark Ready to Bill
- Remove Flagged
- Remove from Do Not Bill
- Remove from Internal Collections
- Remove from Ready to Bill
- Remove from Rebill
- Remove from To Be Replaced
- Remove from To Be Voided

Select: All, All on Page, None Charges Total \$41

Charge ID	Plan	Client Name	DOS	Clinician	Procedure Name	Charge	Balance	Unbilled	Paid Amt	Bill Da
<input checked="" type="checkbox"/> 240	Blue Sheild of CA...	Blue Shield / 159...	02/02/2023 09:...	SOLS, BRENDA	Medication Tr...	\$419.10	\$419.10			04/13/...

Charge Details

General Contact Status History Action History

General

Charge ID	240	Service ID	11913
Client	SSMHS - Dist. Services	Payer	Blue Sheild of CA-FEP Priority <u>1</u>

Status

Ready To Bill Flagged Internal Collections: No Delay Reason

Rebill Do Not Bill External Collections:

Confirmation Message



This charge has errors associated with it. Do you wish to override these errors and bill the charge?

Yes

No