

Billing 301 Guide

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About this User Manual

This manual was developed to use in conjunction with the Billing 301 Training Course. It provides end users with basic knowledge regarding billing claims and remittance processing.

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/>

Add-on Codes

Add-on codes are services performed in addition to a “primary” or “parent” procedure/service. When recording services, SmartCare handles add-on codes in two ways. The first requires the end user to select manually the add-on code, in addition to the primary procedure. The second is the system automatically applying the add-on code based on criteria configured in the Automatic Add On Codes screen. This requires no manual end user intervention. The additional charge for the add-on code is recorded at the time of Service Completion.

Manual Add-on Codes

In order for a procedure to be used as either a manual or automatic add-on code while recording services, it needs to be set up in the Procedure/Rates record via the Add-On Procedure Codes tab.

The screenshot shows the 'Procedure Code Details' window with the 'Add-On Procedure Codes' tab selected. Below the tab, there is a search bar and a checkbox labeled 'Show Only Selected Procedure Codes'. A dropdown menu is open, showing 'Ancillary Service' as the selected option.

Manually record an add-on procedure:

1. Navigate to the client’s Services (Client) screen and open an existing service or start a new one.
2. On the Service Detail screen fill out the required fields, including the primary procedure.
3. Once the primary procedure has been selected, the Add-On Codes tab will be displayed; select the tab.
4. Using the dropdown menu, choose the add-on code and then complete the Start Time and Duration fields
5. Save

The screenshot shows the 'Service Detail' window with the 'Add-On Codes' tab selected. The 'Add-On Codes' section contains a dropdown menu for 'Select Add-On Codes', 'Start Time' and 'Duration' input fields, and an 'Add' button. Below this, a table lists the added codes:

Add-On Codes	Start Time	Duration
X Ancillary Service	11:03 AM	30.00 Minutes

See **Billing Add-on Codes** section for additional information regarding the add-on charge and billing.

Automatic Add-on Codes

Configure Automatic Add-on Codes via the Automatic Add On Codes (Administration) screen. Once configured the procedures will be created automatically and no manual end user intervention is needed.

To configure Automatic Add-on Codes:

1. Navigate to the Automatic Add On Codes (Administration) screen and select the New icon.
2. Fill in the required and desired fields.
 - a. Services with Procedure Code – This is required and is that “primary” procedure selected on a service.
 - b. Under Program – This is not required, but can be selected to define further criteria.
 - c. At Location – This is not required, but can be selected to define further criteria.
 - d. When Client’s Primary Coverage is – This is not required, but can be selected to define further criteria.
 - e. Between DOS –
 - i. From – This is required and is the start date of the rule.
 - ii. To – This is not required and is the end date of the rule.
 - f. With Service Units Minimum and Maximum – These are not required. They can be used to specify if a minimum and/or maximum amount of service entry duration/units needs to be recorded for the automatic add-on code to be applied.
 - i. This setting relates to the Service Entry duration and NOT billing code units.
 - g. Should have Add On Code – This is required, and is the add-on procedure to be applied when the primary procedure is recorded and meets all specified criteria.
 - h. Add On Units Logic – These are not required. They can be used for additional add on units logic to further define the number of duration/units that should be calculated for the add-on code. In the example below the selection accounts for the minimum duration of the primary service, not including it into the calculation

Automatic Add On Code Details

General

Add On Code Details

Services with Procedure Code	<input type="text" value="Psychiatric Diagnostic Evaluation"/>	
Under Program	<input type="text"/>	
At Location	<input type="text"/>	
When Client's Primary Coverage is	<input type="text"/>	
Between DOS	From <input type="text" value="01/01/2023"/>	To <input type="text"/>
With Service Units	Minimum <input type="text" value="15.00"/>	Maximum <input type="text"/>
Should Have Add On Code	<input type="text" value="Prolonged Office or Other Outpatient EN"/>	
Add On Units Logic	Duration - <input type="text"/>	<input type="text" value="15"/>

Billing Add-on Codes

When an add-on code is added in addition to the primary procedure, at the time of Service Completion the additional service with the associated charge will be created. Both the primary and add-on procedure will have their own separate record in SmartCare.

In the example below, the “Office or Other Outpatient” service is the primary procedure. The “Ancillary Service” is the add-on procedure. The Services (Client and My Office) screens have a column that displays associated Add On Codes for quick reference.

DOS	Procedure	Group Name	Units	Status	Clinician/Provider	Program	Location	Charge	Payment	Client Bal	3rd Party Bal	Add On Codes
04/24/2023 11:03 AM	Office or Other Outpatient ...			Complete	Brydon, Jennie MD M...	Outpatient MH Ad...	Office	\$156.60			\$156.60	Ancillary S...
04/24/2023 11:03 AM	Ancillary Service 30 Minutes		2.00	Complete	Brydon, Jennie MD M...	Outpatient MH Ad...	Office	\$30.00			\$30.00	

There is a configuration via the Plan Details page that directs how add-on codes should be treated when being billed.

Plan Details

Primary Driven Record

General Billing Codes Rules Payments And Adjustments Eligi

General Information Common Psych, Medical, and SDOH Diagnoses

Active Information is Complete

Name Capitated Funding Source

Display As This is a Medi-Cal Plan

Payer This is a Medicare Plan

Type Electronic Eligibility Verification

Begin billing ICD10 Plan Does Not Allow Replacement Claims

COB Priority Workman's Comp

Send Allowed Amount on Claims Plan requires Delay Reason for Claims after days

Add-On Charges Do not bundle Auto bundle Bundle but Ignore Validations

Send Supplemental Information for each Claim Claim Lines

Add-On Charges

Select the applicable radio button to identify how to handle billing when add-on codes are added to the main procedure code selected on the service.

- Do not bundle - Primary services and Add-On charges can be billed on separate claims. Both charges must pass validation before they can be billed.
- Auto bundle - Primary services and Add-On charges are required to be submitted on the same claim.
- Bundle but Ignore Validations - Primary services and Add-On charges are required to be on the same claim, but if one charge fails the claims validation process, ignore the failure.

In the Charges/Claims screen, the services can be selected to bill.

	Charge Id	Plan	Client Name	DOS	Clinician	Procedure Name	Charge	Balance	Unbilled
<input type="checkbox"/>	784	Medi-Cal MH	Billing, June (1011)	04/24/2023 11:...	Brydon, Jennie	Ancillary Servi...	\$30.00	\$30.00	30.00
<input type="checkbox"/>	783	Medi-Cal MH	Billing, June (1011)	04/24/2023 11:...	Brydon, Jennie	Office or Othe...	\$156.60	\$156.60	156.60

If SmartCare is configured to Auto bundle, if one of the charges has an error, both will be stopped with a warning/error message. The message will identify the associated charge for reference.

Claims Processing
?

Claims Processing

You have selected 2 charges to be processed with a total amount of \$186.60

Electronic Process Later
 Paper Process Now

Select Batch:

Select: All, All on Page, None

Client Name	Procedure	DOS	Status	Staff Name	Charge	Warnings/Errors	Program
Billing, June	Office or Other Ou...	04/24/2023 11:03...	Selected	Brydon, Jennie	\$156.60	Please check plans billing cod...	Outpatient ..
Billing, June	Ancillary Service	04/24/2023 11:03...	Selected	Brydon, Jennie	\$30.00	Associated charge #784 has a...	Outpatient ..

Associated charge #784 has an error, Associated charge #784 has an error

Configuring the 837

Throughout SmartCare many fields and configurations come together to create all the data needed for 837p and 837i claim files. This section goes over some of the configurable areas in the system that contribute to the successful creation of claim files and billing.

Agency

The Agency table in SmartCare contains identifying information for the billing entity (the County).

The important columns for the claims generation process are:

The Agency Table		
Column Name	Description	837 Location
AgencyName		Loop 1000A (Submitter NM1*41) NM103 Submitter Last Name
BillingContact	The name of the contact for the organization	Loop 1000A (Submitter) PER02
BillingPhone	A phone number to contact the organization	Loop 1000A (Submitter) PER04
PaymentAddress		Loop 2010AA (Billing Provider Name) N301 and N302
PaymentCity		Loop 2010AA (Billing Provider Name) N401
PaymentState		Loop 2010AA (Billing Provider Name) N402
PaymentZip		Loop 2010AA (Billing Provider Name) N403
NationalProviderId	10 digit National Provider Id	Loop 2010AA (Billing Provider Name) NM109
TaxId	9 digit Tax Id	Loop 2010AA REF*EI Segment REF02

For the **PaymentAddress** field, if a second address line is required, the lines should be separated by Char(13) and Char(10) (carriage return and line feed) characters.

The **BillingPhone** field may be formatted as a normal phone number. It will be automatically converted to the unformatted number required by the 837 implementation guide.

Claim Format Configuration Details

There are base claim formats that are included in SmartCare. Claim formats are setup against each billable Plan in SmartCare. Plans such as Medi-Cal have specific logic built in, to support CA CalAIM requirements.

Claim Format Configuration Details

Claim Format
Rules

Format Details

System ReportId	<input type="text"/>		<input checked="" type="checkbox"/> Active
Format Name	<input type="text" value="MH HIPAA 837 Professional"/>	Format Type	<input type="text" value="HIPAA 837 Pr"/> Electronic <input checked="" type="radio"/> Yes <input type="radio"/> No
Format Description	<input type="text"/>	Receiver Code	<input type="text" value="DMH"/>
Stored Procedure	<input type="text" value="ssp_PMClaims837Professional"/> ⓘ	Receiver Primary Id	<input type="text" value="SDMCPHASETWODMH"/>
Billing Location Code	<input type="text" value="13"/>	Production/Test	<input type="radio"/> Production <input checked="" type="radio"/> Test
AuthorizationId Qualifier	<input type="text"/>	Version	<input type="text" value="005010X222A1"/>
AuthorizationId	<input type="text"/>	Application Receiver Code	<input type="text"/>
SecurityInfo Qualifier	<input type="text"/>	Element Delimiter	<input type="text"/>
SecurityId	<input type="text"/>	Component Element Separator	<input type="text"/>
Interchange Sender Qualifier	<input type="text"/>	Segment Terminator	<input type="text"/>
Interchange Receiver Qualifier	<input type="text"/>	Claim/Encounter Identifier	<input type="text"/>
Application Sender Code	<input type="text" value="C13000000000000"/>		

SmartCare allows for Billing Claims Overrides to the Claim Formats using the Billing Claims Overrides screen for special billing formatting needs. In the example below, there is a Billing Override to format the 837P claim to the specific requirements for the place of service "Home".

Billing Claims Overrides (4)

Claim Format	<input type="text"/>	Coverage Plan	<input type="text"/>	<input type="button" value="Apply Filter"/>
Payer	<input type="text"/>	Program	<input type="text"/>	
Location	<input type="text"/>	Procedure Code	<input type="text"/>	
Clinician Degree	<input type="text"/>	For Date Of Service	<input type="text"/>	<input type="button" value="📅"/>

ID	Claim Format	Payer	Coverage Plan	Clinician Degree	Procedure	Program	Location	From Date	To Date
1	MH HIPAA 837 Professional		Medi-Cal MH			Outpatient MH A...	Home	07/01/2022	

Billing Claims Override Details

Claims Provider Override Details

Provider Override Selection Criteria

The below override rules will apply for Charges that have the following values

Billing Coverage Plan	Medi-Cal MH	▼
Billing Payer		▼
With Claim Format	MH HIPAA 837 Professional	▼
Clinician Billing Degree		▼
Under Program	Outpatient MH Adult	▼
At Location	Home	▼
With Procedure Code		▼
Between DOS	From 07/01/2022	📅 ▼
	To	📅 ▼
Priority	100	

Provider Overrides

Billing Provider: Supported on Both Institutional (Loop 2010AA) and Professional (Loop 2010AA)	▼
Rendering Provider: Supported on Both Institutional (Loop 2310D) and Professional (Loop 2310B)	▼
Supervising Provider: Supported on Professional (Loop 2310D)	▼
Ordering Provider: Supported on Professional (Loop 2420E)	▼
Attending Provider: Supported on Institutional (Loop 2310A)	▼
Claim Service Facility: Supported on Institutional (Loop 2310E) and Professional (Loop 2310C)	▼
Claim Line Service Facility: Supported on Professional (Loop 2420C)	▼
ClientAddressNoNPI	▼

Plan Setup – 837i and 837p

Plans are the insurance plans and payers who are billed to pay for the clients' services in SmartCare. The plan contains information necessary for the 837 claim file creation.

Within each plan, the claim format for billing is defined. There are advance settings that allow for both 837p and 837i billing within the same plan. In addition, both paper CMS-1500 and UB04 claim formats can also be configured all under the same plan.

Plan Details

Primary Driven Record

- General
- Billing Codes
- Rules
- Payments And Adjustments
- Eligible Clients
- Care Management
- Reporting
- Copayment Defaults
- Custom

General Information

Active Information is Complete

Name Capitated Funding Source

Display As This is a Medicaid Plan

Payer This is a Medicare Plan

Type Electronic Eligibility Verification

Begin billing ICD10 Plan Does Not Allow Replacement Claims

COB Priority Workman's Comp

Send Allowed Amount on Claims Plan requires Delay Reason for Claims after days

Add-On Charges Do not bundle Auto bundle Bundle but Ignore Validations

Send Supplemental Information for each Claim Claim Lines

Claim Information

Claims Address [Details...](#)

Billing Diagnosis Type DSM ICD

Standard Electronic Claim Format [Advanced...](#)

Combine claims with other coverage plans for the same payer

Standard Paper Claim Format [Advanced...](#)

Provider Id [Advanced...](#)

Provider Id Type

Claim Filing Indicator Code

Electronic Claims Payer Id

Claim Office #

Claims Production

Charges and Claims is the process in SmartCare where charges are applied to services to create service lines on a client's account. Claims is the process where those service lines with charges applied are included on insurance claims or other paperwork to be billed to the payer. Claims can be generated as electronic claims or paper claims.

Charges/Claims Screen

The Charges/Claims screen in SmartCare is where all billing occurs (with the exception of self-play client billing).

To get to the Charges/Claims screen:

1. Using the Search icon type begin typing "Charges/Claims" and select the QuickLink when it appears.

The Charges/Claims screen will open.

Charges/Claims (28)

Select Action

3rd Party Plans All Payers Medi-Cal MH Financial Assignment... Apply Filter

Ready To Bill Only All Priorities All Programs All Procedure Codes

Show unbilled charges 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 01/01/2023 DOS To 01/31/2023 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

Select: All, All on Page, None

Charges Total \$0.00 Balance Total \$0.00

Charge Id	Plan	Client Name	DOS	Clinician	Procedure Name	Charge	Balance	Unbilled	Paid Amt	Bill Date	Flagged	Process	Batch	ClaimLine ItemId	Program Name
<input type="checkbox"/> 502	Medi-Cal MH	Billing, June (1011)	01/10/2023 10:...	Brydon, Jennie	PsychoTherapy	\$158.40	\$158.40	158.40							Outpatient MH A...
<input type="checkbox"/> 508	Medi-Cal MH	Billing, June (1011)	01/11/2023 10:...	Brydon, Jennie	Psychotherap...	\$473.36	\$473.36	473.36							Outpatient MH A...
<input type="checkbox"/> 509	Medi-Cal MH	Billing, June (1011)	01/11/2023 10:...	Brydon, Jennie	Psychotherap...	\$240.56	\$240.56	240.56							Outpatient MH A...
<input type="checkbox"/> 513	Medi-Cal MH	Billing, June (1011)	01/11/2023 10:...	Brydon, Jennie	EM Est Pt. Lvl...	\$25.00	\$25.00	25.00							Outpatient MH A...
<input type="checkbox"/> 519	Medi-Cal MH	Timmerly, Teresa (...)	01/09/2023 08:...	Stephan, Kristy	Psychotherap...	\$3.88	\$3.88	3.88							Outpatient MH A...
<input type="checkbox"/> 520	Medi-Cal MH	Timmerly, Teresa (...)	01/09/2023 08:...	Stephan, Kristy	Psychotherap...	\$15.52	\$15.52	15.52							Outpatient MH A...
<input type="checkbox"/> 523	Medi-Cal MH	Timmerly, Teresa (...)	01/17/2023 08:...	Stephan, Kristy	Psychotherap...	\$403.52	\$403.52	403.52							Outpatient MH A...

From this screen, filter the list to determine the charges that are displayed below.

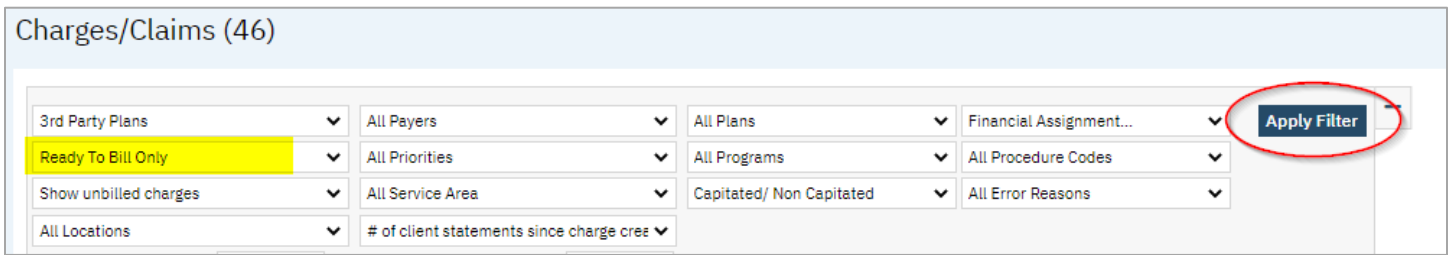
Ready to Bill

One of the steps in the nightly billing job is the Ready to Bill process. During this step, SmartCare confirms charges meet any Plan Rules configured in the system. If there is no warning or error, the charge will be marked as Ready to Bill.

Once a charge is marked as ready to bill, it can be added to a batch for claims processing.

To find Ready to Bill charges:

1. Navigate to the Charges/Claims screen.
2. Filter by Ready to Bill Only.
3. Set any additional filters as needed.
4. Select the Apply Filter button



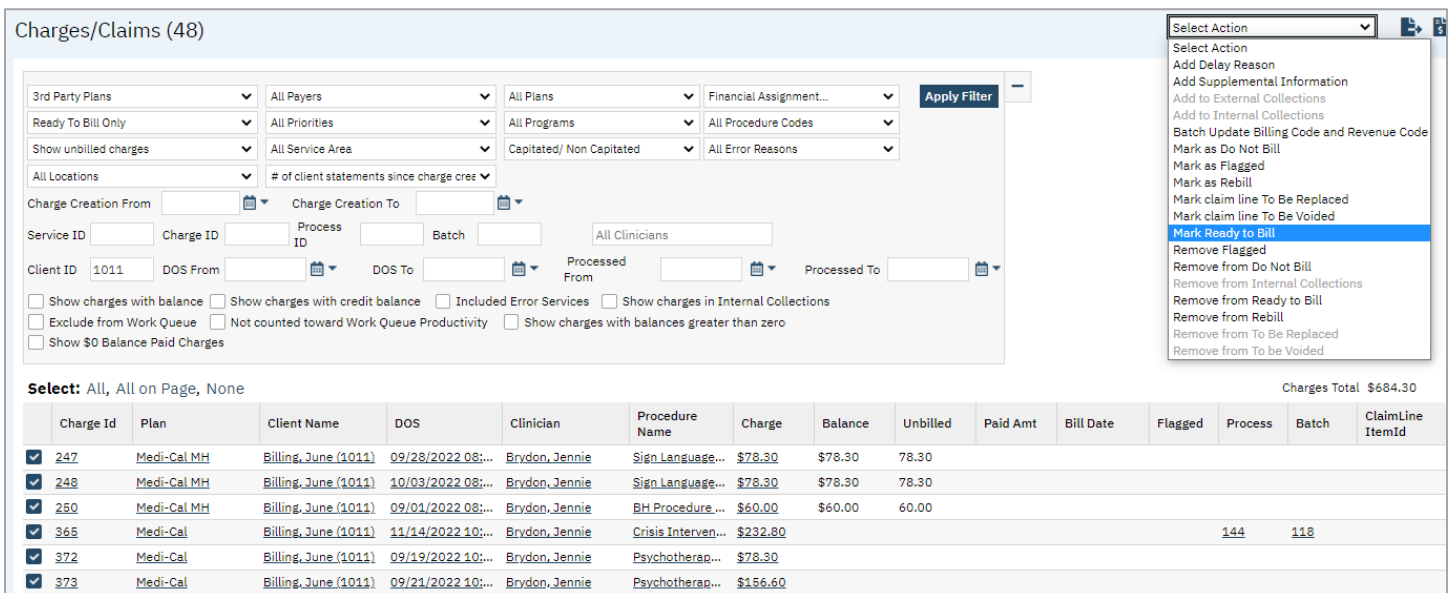
In order to run a claims batch, the filter must be set to “Ready to Bill Only.” This helps to make sure charges that are not ready to bill are not accidentally claimed.

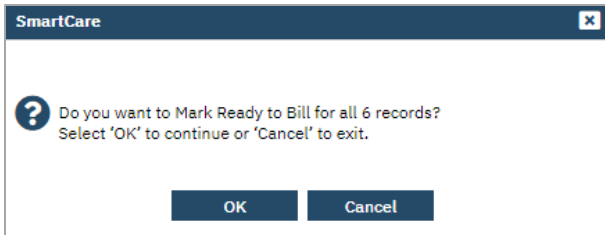
There are times a charge might need to be manually marked as ready to bill. Situations where this might happen include if a service was manually completed (rather than being completed via the overnight job), or a charge error needs to be overrode to bill.

There are two ways to mark charges as ready to bill.

Select Action Menu

1. Navigate to the Charges/Claims screen.
2. Apply filters as needed.
3. Select the checkbox next to each charge that needs to be marked as ready to bill.
4. Use the dropdown arrow in the Select Action menu and select “Mark Ready to Bill.”
5. At the popup select OK





Charge Details

1. Select the Charge ID hyperlink (this can be selected in multiple screens)

Charge Id	Plan
247	Medi-Cal MH
248	Medi-Cal MH

The Charge Details screen opens.

2. On the General tab, in the Status section, select the Ready to Bill checkbox
3. Save

Charge Details

General | Contact | Status History | Action History

General

Charge ID	247	Service ID	772		
Client	1011 - Billing, June	Payer	Medi-Cal MH	Priority	1

Status

<input checked="" type="checkbox"/> Ready To Bill	<input type="checkbox"/> Flagged	Internal Collections:	No	Delay Reason	<input type="text"/>
<input type="checkbox"/> Rebill	<input type="checkbox"/> Do Not Bill	External Collections:			

Note: The same actions can be taken to remove a charge from the Ready to Bill status.

Electronic and Paper Claims

All claims formats are billed via the Charges/Claims screen. This includes 837p, 837i, CMS-1500 and UB claim formats.

To create electronic claims:

1. Filter the list to determine the charges displayed below to bill
 - a. Set the "All Charges" dropdown filter to "Ready to Bill Only"
 - b. Select the dates of service to create claims for those services
 - c. Select the Apply Filter button
2. When the charges are filtered to the desired selection, determine the charges to include in your claim batch by doing any of the following:
 - a. Select the All hyperlink (this will automatically check all charges filtered)
 - b. Select the All on Page hyperlink (this will automatically check all charges displayed on the page)
 - c. Select specific charges by checking the checkbox on the charge record line

The screenshot shows the 'Charges/Claims (28)' window. At the top, there are several dropdown filters: '3rd Party Plans' (Medi-Cal MH), 'All Payers' (All Payers), 'All Procedures' (All Procedures), and 'Financial Assignment...' (Financial Assignment...). The 'Ready to Bill Only' filter is selected. Below the filters are date pickers for 'Charge Creation From' and 'Charge Creation To', and 'Client ID', 'DOS From' (01/01/2023), and 'DOS To' (01/31/2023). There are also checkboxes for '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', and 'Show charges with balances greater than zero'. A 'Select: All, All on Page, None' dropdown is visible. Below the filters is a table with columns: Charge Id, Plan, Client Name, DOS, Clinician, Procedure Name, Charge, Balance, Unbilled, Paid Amt, Bill Date, Flagged, Process, Batch, ClaimLine ItemId, and Program Name. The table contains 7 rows of data, with the first row highlighted in blue.

Charge Id	Plan	Client Name	DOS	Clinician	Procedure Name	Charge	Balance	Unbilled	Paid Amt	Bill Date	Flagged	Process	Batch	ClaimLine ItemId	Program Name
502	Medi-Cal MH	Billing, June (1011)	01/10/2023 10:...	Brydon, Jennie	PsychoTherapy	\$158.40	\$158.40	158.40							Outpatient MH A...
508	Medi-Cal MH	Billing, June (1011)	01/11/2023 10:...	Brydon, Jennie	Psychotherap...	\$473.36	\$473.36	473.36							Outpatient MH A...
509	Medi-Cal MH	Billing, June (1011)	01/11/2023 10:...	Brydon, Jennie	Psychotherap...	\$240.56	\$240.56	240.56							Outpatient MH A...
513	Medi-Cal MH	Billing, June (1011)	01/11/2023 10:...	Brydon, Jennie	EM Est Pt. Lvl...	\$25.00	\$25.00	25.00							Outpatient MH A...
519	Medi-Cal MH	Timmerly, Teresa (...)	01/09/2023 08:...	Stephan, Kristy	Psychotherap...	\$3.88	\$3.88	3.88							Outpatient MH A...
520	Medi-Cal MH	Timmerly, Teresa (...)	01/09/2023 08:...	Stephan, Kristy	Psychotherap...	\$15.52	\$15.52	15.52							Outpatient MH A...
523	Medi-Cal MH	Timmerly, Teresa (...)	01/17/2023 08:...	Stephan, Kristy	Psychotherap...	\$403.52	\$403.52	403.52							Outpatient MH A...

3. To create an electronic 837 claim file, select the E-Claim icon to create the claim file.

The Claims Processing window will open.

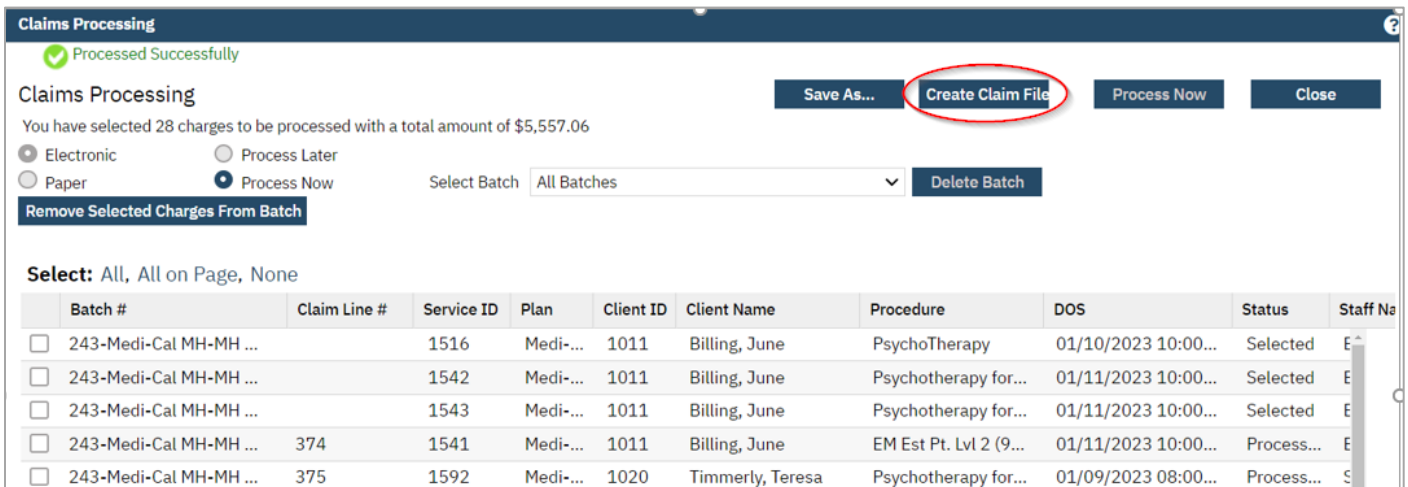
The screenshot shows the 'Claims Processing' window. At the top, there are buttons for 'Save As...', 'Create Claim File', 'Process Now' (circled in red), and 'Close'. Below the buttons, there is a message: 'You have selected 28 charges to be processed with a total amount of \$5,557.06'. There are radio buttons for 'Electronic' (selected) and 'Paper', and a 'Process Later' option. A 'Select Batch' dropdown is set to 'All Batches', and there is a 'Delete Batch' button. Below the filters is a 'Select: All, All on Page, None' dropdown. At the bottom is a table with columns: Batch #, Claim Line #, Service ID, Plan, Client ID, Client Name, Procedure, DOS, Status, and Staff Nar. The table contains 4 rows of data, with the first row highlighted in blue.

Batch #	Claim Line #	Service ID	Plan	Client ID	Client Name	Procedure	DOS	Status	Staff Nar
243-Medi-Cal MH-MH ...	1516	Medi-...	1011	Billing, June	PsychoTherapy	01/10/2023 10:00...	Selected	E	
243-Medi-Cal MH-MH ...	1542	Medi-...	1011	Billing, June	Psychotherapy for...	01/11/2023 10:00...	Selected	E	
243-Medi-Cal MH-MH ...	1543	Medi-...	1011	Billing, June	Psychotherapy for...	01/11/2023 10:00...	Selected	E	
243-Medi-Cal MH-MH ...	1541	Medi-...	1011	Billing, June	EM Est Pt. Lvl 2 (9...	01/11/2023 10:00...	Selected	E	

The service lines that are ready to be included in a claim file to the plan are listed.

All charges listed on the page will be included in the claims you create. You do not need to select the radio buttons to include a service line in a claim.

- To remove charges from the list, click the radio button to the left of each service line you want to delete from a batch and click the “Remove Selected Charges From Batch” blue button.
 - To move forward with charges within your batch, click the “Process Now” button.
 - All claims listed on the page are processed into claims, unless there is a problem with the service line, in which case the service line is excluded from the claim.
 - When the process is complete, a status message appears in the top left corner of the window. In this example you will see a green message stating “**Processed Successfully**”
1. Verify that the **Create Claim File** button is activated and not grayed out. If the button is grayed out, scroll to the right on the lower panel in the window to find the **Warnings/Errors** column. Any text in this column indicates that there was a problem processing the charge into a claim.
 2. Click the **Create Claim File** button to create the 837 file out of SmartCare. SmartCare will send the file to the PC’s download folder. (File generation will be changed in a future enhancement to send files to the server for retrieval)
 3. If there is a warning or error message, troubleshoot the problem and fix it so you can reprocess the charge to create a claim. If you do not fix the warning or error problem, the charge will not be included on a claim to the payer and will remain with the warning/error associated with the claim.



To create paper claims:

1. Follow the same steps 1-5 above to filter the charges for paper claims creation.
2. Select the Paper Claims icon.



3. When you click the **Paper Claims** button, the Claims Processing window is displayed.
 - Click the **Process Now** button. When you are ready to create the claims.
 - To remove charges from the list, click the radio button to the left of each service line you want to delete from a batch and click the “Remove Selected Charges From Batch” blue button.
 - To move forward with charges within your batch, click the “Process Now” button.
 - All claims listed on the page are processed into claims, unless there is a problem with the service line, in which case the service line is excluded from the claim.

- When the process is complete, a status message appears in the top left corner of the window. In this example you will see a green message stating **“Processed Successfully”**
- Click the **Print Claims** button and the claims are rendered on the screen where the user can save them as a PDF to print.

Claims Processing ?

✔ **Processed Successfully**

Claims Processing Save As... **Print Claims...** Process Now Close

You have selected 1 charges to be processed with a total amount of \$78.30

Electronic Process Later
 Paper Process Now

Select Batch: All Batches Delete Batch

Remove Selected Charges From Batch

Select: All, All on Page, None

Batch #	Claim Line #	Service ID	Plan	Client ID	Client Name	Procedure	DOS	Status	Staff N
<input type="checkbox"/> 250-Medi-Cal MH-HCF...	392	747	Medi-...	1011	Billing, June	Psychotherapy wi...	09/19/2022 10:00...	Process...	Brydon, J

Print Claims ? X

Number Of Statments Printed 0 ✔ All claims were printed successfully Close

HCFA1500 1 / 1 | - 111% + | [Zoom] [Refresh] [Download] [Print] [More]

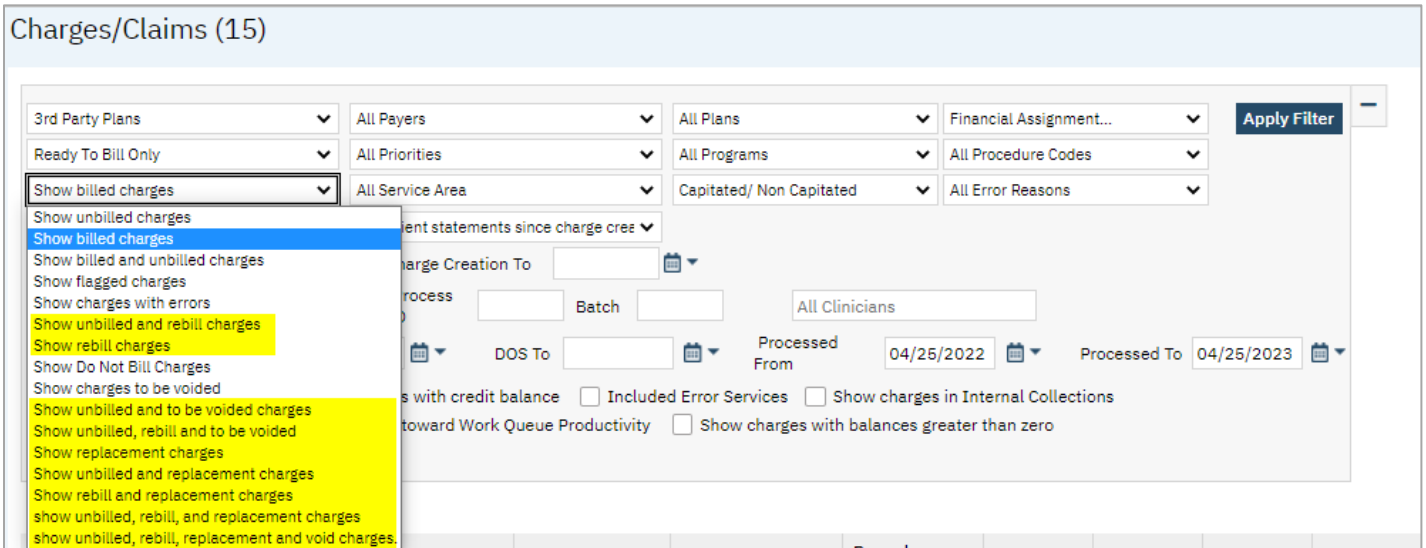
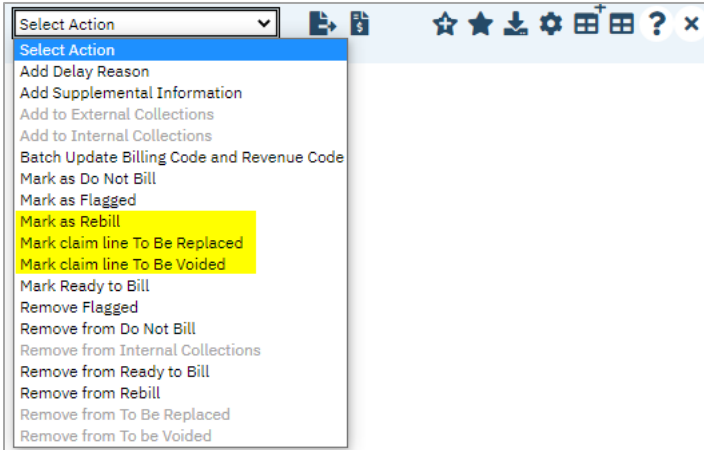
DMH
1500 Capitol Avenue MS 2704
Sacramento, CA 95899-7413

<p>X</p> <p>Billing, June</p> <p>123 West Test Street</p> <p>Sacramento CA</p> <p>94203</p>	<p>97412589A</p> <p>Billing, June</p> <p>123 West Test Street</p> <p>Sacramento CA</p> <p>94203</p>
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X 02 14 90 X

Processing Denials and Rebills

SmartCare is able to handle easily and efficiently the management of denials, including replacement and void claims, and with rebills. Charges can be marked for all three of these by using the Select Action menu in the Charges/Claims screen. In addition, to identify these charges, there are filters available.



Rebills

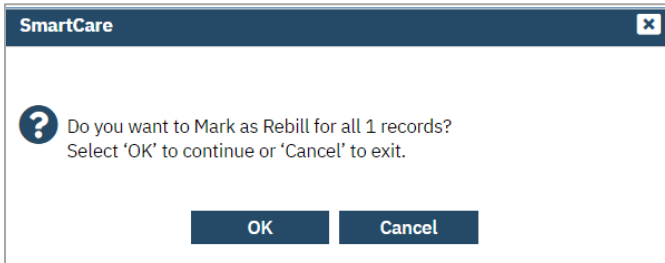
In SmartCare terminology, “rebill” refers to the charge being billed again as an original claim. This selection will not require the PCCN number returned on the 835 file and typically used when rebilling Medicare and Commercial Insurance for electronic or paper claims.

How to mark a claim for Rebill

1. Make the correction for the charge that created the denied claim.

2. On the Charges/Claims screen, filter your data to show billed charges and find your charges. Use of the filters is very helpful.
3. Click the checkbox next to the charge. You can select multiple charges at once.
4. When all the charges are selected that you want, click the **Select Action** drop down list in the tool bar. (screenshot above)
5. Select **Mark as Rebill** from the drop down list

A message box is displayed, *Do you want to Mark as Rebill for all ## records?*

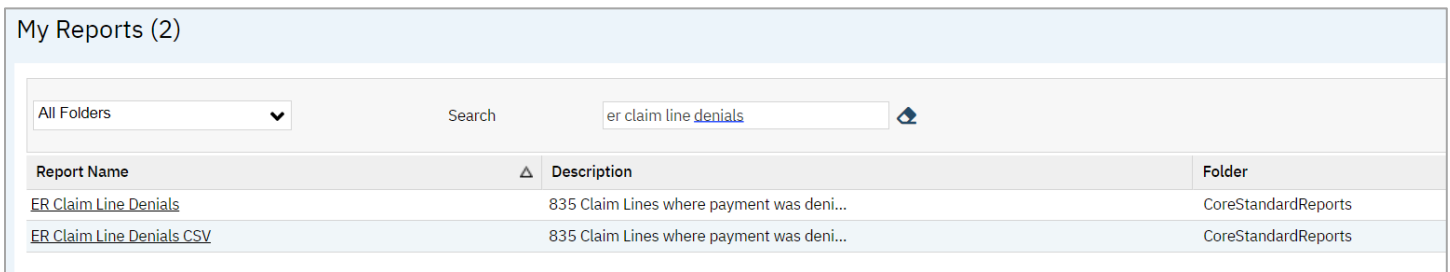


1. Click the OK button.
2. Your corrected claim is now marked for rebill

The user is now able to change the filters on the Charges/Claims screen to show unbilled and rebill charges to make it simple to create a batch for rebill charges.

Replacement Claims

When a claim is denied, there may be an opportunity to correct the charge and rebill. SmartCare includes a denial report and an exportable spreadsheet formatted denial report under the users My Reports menu.



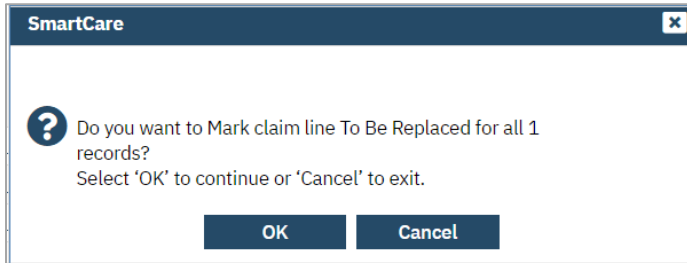
Replacement claims are often called “corrected claims.” When this option is selected claims will be billed as a replacement claim. Replacement claims require the PCCN number returned via the 835 file. SmartCare will automatically insert the PCCN number in the replacement claim file if the payment was received via 835. In addition, SmartCare will automatically insert the correct frequency code in the claim file to signify a replacement claim.

How to mark a claim for Replacement

1. Make the correction for the charge that created the denied claim.

2. On the Charges/Claims screen, filter your data to show billed charges and find your charges. Use of the filters is very helpful.
3. Click the checkbox next to the charge. You can select multiple charges at once.
4. When all the charges are selected that you want, click the **Select Action** drop down list in the tool bar. (screenshot above)
5. Select **Mark claim line to be Replaced** from the drop down list

A message box is displayed, *Do you want to Mark claim line to be Replaced for all ## records?*



6. Click the OK button.
7. Your corrected claim is now marked for replacement

The user is now able to change the filters on the Charges/Claims screen to show unbilled and replacement charges to make it simple to create a batch for replacement charges.

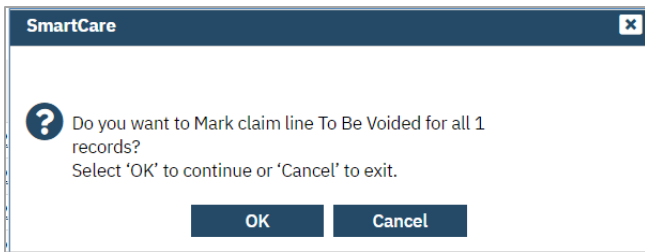
Voided Claims

Void claims are submitted when a claim needs to be removed from a payer's system completely. Void claims will require the PCCN number returned via the 835 file. SmartCare will automatically insert the PCCN number in the void claim file if the payment was received via 835. In addition, SmartCare will automatically insert the correct frequency code in the claim file to signify a voided claim.

How to mark a claim for Void

1. On the Charges/Claims screen, filter your data to show billed charges and find your charges that you need to void. Use of the filters is very helpful.
2. Click the checkbox next to the charge. You can select multiple charges at once.
3. When all the charges are selected that you want, click the **Select Action** drop down list in the tool bar. (screenshot above)
4. Select **Mark claim line to be voided** from the drop down list

A message box is displayed, *Do you want to Mark claim line to be Voided for all ## records?*



1. Click the OK button.
2. Your claim is now marked for void

The user is now able to change the filters on the Charges/Claims screen to show unbilled and voided charges to make it simple to create a batch for voided charges.

Error Corrections

Depending on where a charge is at in its lifecycle, and what needs to be corrected, error corrections can be made in various areas of the system. The further along in the lifecycle a charge is the more complex it is to fix the error.

Provided below is a list of common scenarios and how to correct them in SmartCare.

Is the service signed by clinician, and completed? No

- Because no charges were created the clinician can correct the service and billing does not have to be involved.

Is the service signed? Yes

- Service Override Detail (Golden Key) – only use if change to Service Detail does not affect billing
- Progress Note Document Edit (if allowed) – only edit note if it is content related, and does not affect what was recorded, and subsequently billing.

Is this Service Completed? Yes. A completed note has generated a charge based on the service details, therefore changes to the details would not recalculate for billing.

Is the service billed? No

- Because no claims were created the clinician can correct the service following “error” process and billing does not have to be involved. “Error” process involves setting service status as Error (retract service), or to create a new service using Copy Service icon and move document function.

Did the client pay? Yes

- Move the payment off the service to be applied to another service or to be refunded to client.

The service was billed

- Need to send a void claim
- If service was marked as error before the void claim, the claim will be marked as voided. The work process to run claims will need to include periodic checks for “error” services marked for void claiming.

Did we get paid by insurance?

- Wait for payer to do takeback, or recoupment in future payment file after void claim submission

* SmartCare will not stop staff from attempting to edit a service that is already completed, billed, etc. Counties can restrict access to Service Detail thru Role Definition, which will permit clinical staff to continue doing session notes but will prevent them from accessing the Service Detail screen.

Edit Options:

- Signed Session Note but not yet in Completed status:
 - o Thru Service Note: clicking Edit will make billing strip editable as well as the note.
 - o Thru Service Detail: Use golden key to edit. Does not allow note edit.
- Completed Note:
 - o Thru Service Note: edit feature will allow for note edit but many of the billing strip fields on the Service tab are grayed out including Program, Procedure, Location, Start Date, time fields and Specific Location.
 - o Thru Service Detail: Same as signed note. Use golden key to edit. Does not allow note edit. Need to be aware of Service billing status and potential implications.

Service Detail “Copy Service” and Move Documents feature:

- Copy Service toolbar icon will create a copy of the original service with date set to today’s date and a status of Scheduled. Staff may need to modify the date/time on the copied service. This ONLY copies forward the service details info (i.e. no progress note). Use the Move Documents button to copy forward the note.
- The original service remains as is.
- Click the Move Documents button on the copied service to copy forward a note. This button is only visible from the Service Detail screen. Note: the status of the service that the note is being copied from (i.e. the original service) will automatically be set to “Error”.

Service Detail “Error” feature:

- This should be used to error out a service that should not have been recorded. Otherwise, use the Copy Service/Move Documents process, which will error out the original service when finished.
- Simply change the service Status to Error.
- Golden Key can be used to modify fields but the status of Error cannot be changed.
- Service will no longer appear on Services/Notes list page.

Special Circumstances

Charge Override

There may be a need to change a billing code cross reference to change the scope of a service on a claim. For example, a lockout override, where the service would need to be evaluated first, and then a billing code updated, or a modifier added/changed.

To override a charge:

1. From the Charges/Claims list page, click on the Charge ID hyperlink to access the charge details page.

Charges/Claims (15)

3rd Party Plans
Ready To Bill Only
Show billed charges
All Locations
Charge Creation From
Service ID Charge ID
Client ID DOS From
 Show charges with balance Show
 Exclude from Work Queue Not c
 Show \$0 Balance Paid Charges

Select: All, All on Page, None

Charge Id	Plan
<input type="checkbox"/> 190	Medi-Cal MH
<input type="checkbox"/> 186	Medi-Cal MH
<input type="checkbox"/> 254	Medi-Cal MH
<input type="checkbox"/> 249	Medi-Cal MH
<input type="checkbox"/> 274	Medi-Cal MH
<input type="checkbox"/> 273	Medi-Cal MH

2. In the Charge Details screen, on the General tab, locate the **Billing Code** override section.

Billing Code

Billing Code 90846 Modifiers Units 0.00

Revenue Code Description

Rate ID [201](#) Billing Code Rate Id [518](#)

Override

3. Click the **Override** button, which will open up the Billing Code and Modifiers boxes.

Billing Code

Billing Code Modifiers Units 0.00

Revenue Code Description

Rate ID [201](#) Billing Code Rate Id [518](#)

Override **Apply**

4. Make the necessary changes to the Billing Code or Modifiers, then click Apply
5. Click the **Save** button in the tool bar
6. The change is only made for this charge.

PCCN Number

There may be a special circumstance where the user will need to manually add the PCCN number to a charge. If this happens, follow the steps below to add the PCCN number before flagging your claim for a replacement or void claim. A Claim Line ID needs to be assigned to the charge in order to access the field.

1. From the Charges/Claims list page, select the **ClaimLineItemId** hyperlink

Charges Total \$0.00												
DOS	Clinician	Procedure Name	Charge	Balance	Unbilled	Paid Amt	Bill Date	Flagged	Process	Batch	ClaimLine ItemId	Δ
09/27/2022 11:...	Brydon, Jennie	Psychotherap...	\$78.30	\$78.30			09/28/2022		54	40	74	
09/21/2022 10:...	Brydon, Jennie	Psychotherap...	\$156.60	\$156.60			09/28/2022		54	40	76	
10/14/2022 10:...	Brydon, Jennie	BH - Unspecifi...	\$45.00	\$45.00			10/18/2022		58	44	118	
10/04/2022 10:...	Brydon, Jennie	BH Procedure ...	\$60.00	\$60.00			11/03/2022		59	45	119	

2. Navigate to the Claim Details tab
3. Enter the PCCN number in the Payer Claim Number field.

Claim Line Item Detail

Claim Line Details **Claim Details** Contacts

Claim Group

Claim LineItem Groups 71 Batch ID 40 Payer Claim Number from 835 **Payer Claim Number**

Rendering Provider

Claim Billing

Claim Line ItemId	Billing Code Modifiers	Revenue Code	Revenue Code Description	Units	Date Of Service	Charge Amount	Voided Claim	Original ItemId
74	90832			1.00	09/27/2022	\$78.30		

4. Click **Save** in the tool bar.

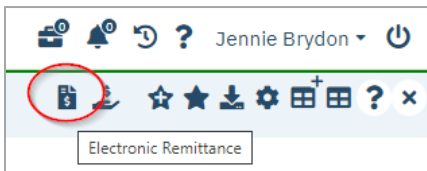
Remittance Processing

SmartCare has the ability to post automatically 835 files once the files have been uploaded into the system for processing. Based on various configurations and settings in the system, SmartCare will automatically apply payments, adjustments and transfers to charges.

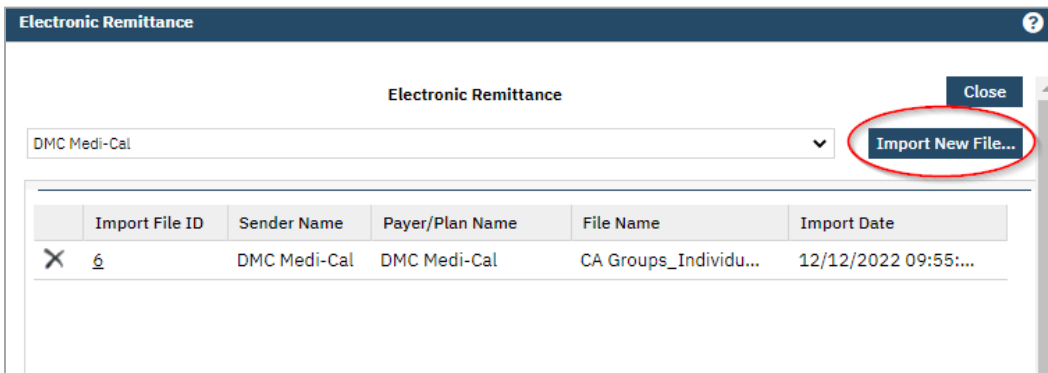
Importing 835 Files

To Import an 835 file for processing:

1. Navigate to the Payments/Adjustments screen.
2. Select the Electronic Remittance icon.

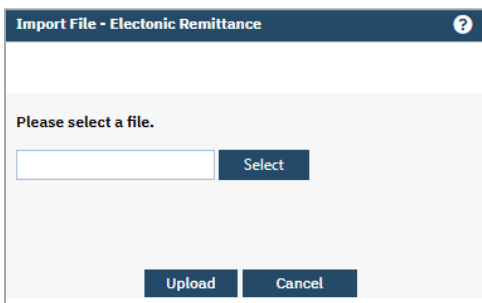


The Electronic Remittance window opens.

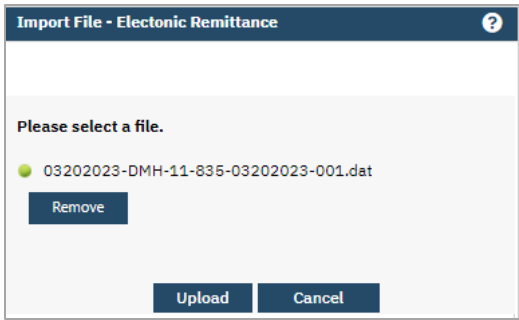


3. Select the Import New File button

The Import File – Electronic Remittance window opens.

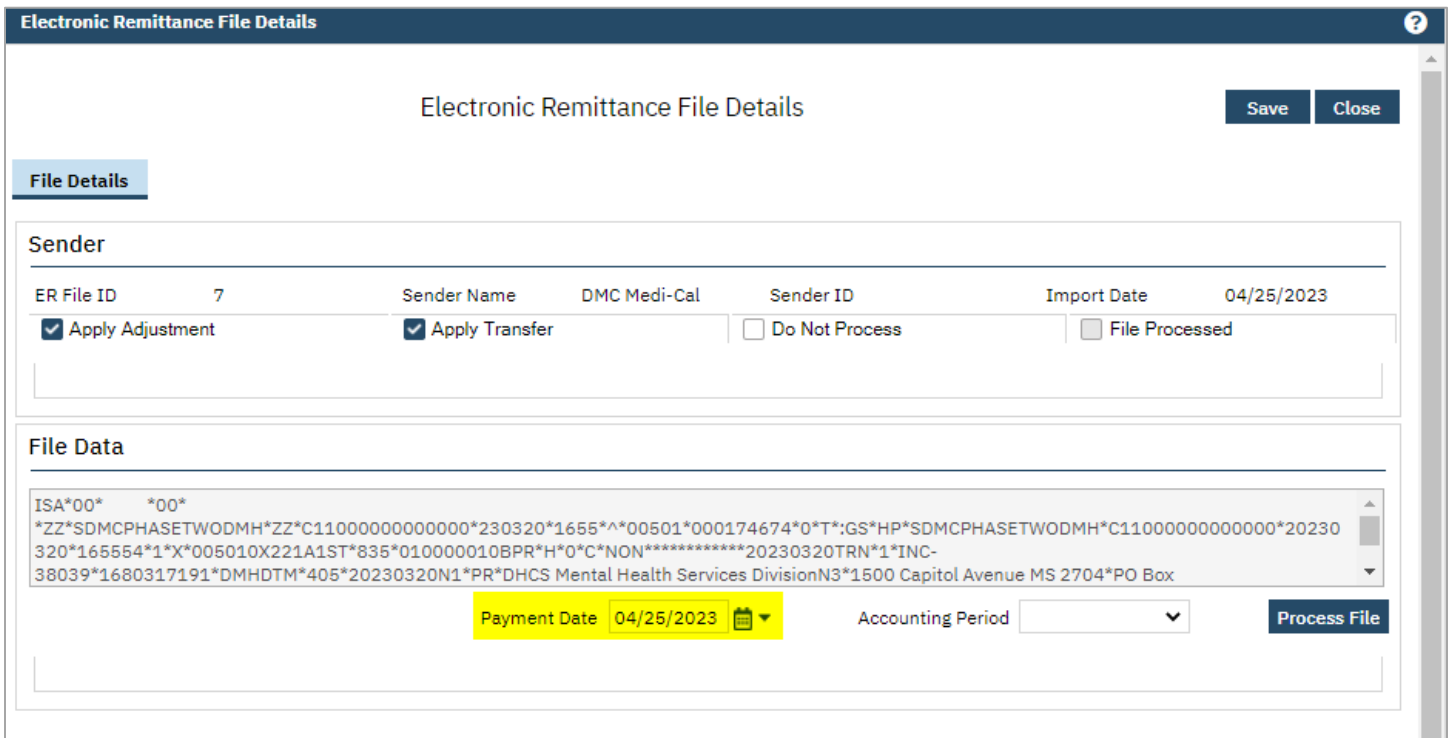


4. Use the Select button to locate the 835 file and select it.
5. If a file was selected in error, use the Remove button



6. Select the Upload button when the correct file has been selected.

The Electronic Remittance File Details window will open.



7. Enter the Payment Date.

8. Select Save

Note: The system will automatically select the Account Period. Do not select the Process File button. The overnight billing job will automatically process the file during off hours.

Electronic Remit Report (ER Reports)

Once 835 files have been processed by the overnight job, data regarding the files can be found via the Electronic Remit Reports.

To access the reports:

1. Navigate to the My Reports screen.
2. Each ER report requires the ER File ID to pull the data into the report.
 - a. To find the ER File ID(s) search by "ER file."
 - b. Select the hyperlink for the ER File List

My Reports (3)		
All Folders	Search	ER file
Report Name	Description	Folder
ER File Detail	Detail (including errors) for an 835 f...	CoreStandardReports
ER File List	List of 835 files filtered by Date imp...	CoreStandardReports

- c. In the report viewer, enter the Import From and To dates.
- d. Select View Report

Sender Name	Check Number / TRN ID	Check Amount	Total Provider Adjustments	SC Payment Amount	Import Date	File Name	ERFile Id	Processed
MH Medi-Cal	INC-37962	\$0.00	\$0.00		02/22/2023	SDMC-835-02212023-001.dat	1000001	Y
MH Medi-Cal	INC-37965	\$0.00	\$0.00	\$0.00	02/22/2023	SDMC-835-02222023-001.dat	1000002	Y
MH Medi-Cal	INC-37967	\$0.00	\$0.00	\$0.00	02/23/2023	DMH-13-835-02232023-001.dat	1000003	Y
MH Medi-Cal	INC-37995	\$0.00	\$0.00	\$0.00	03/06/2023	DMH-13-835-03062023-001.dat	1000004	Y
MH Medi-Cal	INC-37996	\$0.00	\$0.00	\$0.00	03/06/2023	03062023-DMH-13-835-03062023-002.dat	1000005	Y
MH Medi-Cal	INC-37997	\$0.00	\$0.00	\$0.00	03/06/2023	03062023-DMH-13-835-03062023-003.dat	1000006	Y
MH Medi-Cal					03/06/2023	03062023-DMH-13-835-03062023-003.dat	1000007	Y
DMC Medi-Cal	INC-38043	\$0.00	\$0.00	\$0.00	03/21/2023	DMC-835-03212023-001.dat	1000008	Y
MH Medi-Cal	002200394	\$206.50	\$0.00	\$206.50	03/24/2023	SDMC-835-03242023-001.dat	1000009	Y
MH Medi-Cal	INC-36145	\$0.00	\$0.00	\$0.00	04/20/2023	SDMC-835-04202023-M00.dat	1000010	Y
** END OF LIST								

e. Note the ERFile Id(s) needed

3. To narrow down the search for the ER reports, use "ER Claim" in the Search filter and select Apply Filter.

My Reports (13)

Report Name	Description	Folder
CalMHSA ER Claim Line Details...		
CalMHSA ER Claim Line Details...		
EOB For Paper Claims		CoreStandardReports
ER Claim Line Denials	835 Claim Lines where payment was deni...	CoreStandardReports
ER Claim Line Denials CSV	835 Claim Lines where payment was deni...	CoreStandardReports
ER Claim Line Details	Full details on claims included in a g...	CoreStandardReports
ER Claim Line Details CSV	Full details on claims included in a g...	CoreStandardReports
ER Claim Line Errors	835 Claim Lines where there were issue...	CoreStandardReports
ER Claim Line Errors CSV	835 Claim Lines where there were issue...	CoreStandardReports
ER Claim Lines Unposted	835 Claim Lines where the payment amou...	CoreStandardReports
ER Claim Lines Unposted CSV	835 Claim Lines where the payment amou...	CoreStandardReports
Get ER ClaimLines		Standard Reports
Get ER ClaimLines Unposted CSV		Standard Reports

- Each ER report comes with an option of a CSV file.
- Select the hyperlink for the ER report to run it.
- Enter the ERFile Id and select View Report.

Electronic Remittance File Details												
Client Name	Date of Service	Date Of Service	Charge Amount	Maximum Allowable Amount	Federal Fund Participation Approved Amount	State General Funds Approved Amount	County Amount	Aid Code	Client Identifier	Line Item Control Number	Payer Claim Number	Chec Num
ABFBEC, IVORY	2/9/2023 12:00:00 AM	02/09/2023	\$82.60						1546624-43	43	153907151	
ABFBEC, IVORY	2/9/2023 12:00:00 AM	02/09/2023	\$82.60						1546624-43	43	153907151	
ABFBEC, IVORY	2/9/2023 12:00:00 AM	02/09/2023	\$82.60						1546624-43	43	153907151	
ADFFFD, STEPHANIE	2/1/2023 12:00:00 AM	02/01/2023	\$228.60						1537194-42	42	153907149	
ADFFFD, STEPHANIE	2/1/2023 12:00:00 AM	02/01/2023	\$228.60						1537194-40	40	153907150	
ADFFFD, STEPHANIE	2/1/2023 12:00:00 AM	02/01/2023	\$228.60						1537194-42	42	153907149	
ADFFFD, STEPHANIE	2/1/2023 12:00:00 AM	02/01/2023	\$228.60						1537194-40	40	153907150	
ADFFFD, STEPHANIE	2/1/2023 12:00:00 AM	02/01/2023	\$228.60					M1	1537194-41	41	153907147	
ADFFFD, STEPHANIE	2/1/2023 12:00:00 AM	02/01/2023	\$228.60					M1	1537194-39	39	153907148	

- The details of the report will display.

The “CalMHSA ER Claim Details” report has been developed specifically for 835s for Medi-Cal. It includes additional columns specific to Medi-Cal claims. See the report itself in the system for information on all available data columns.