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

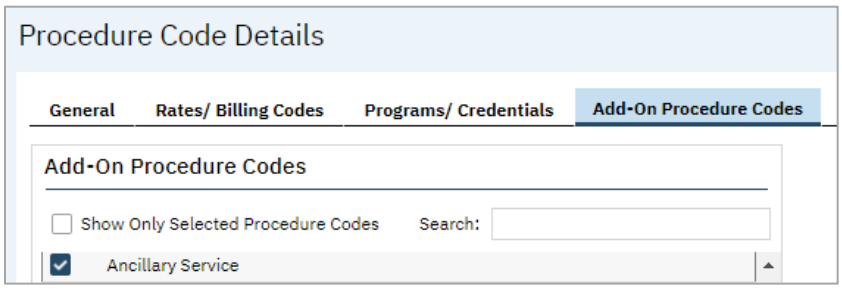
https://2023.calmhsa.org/

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.

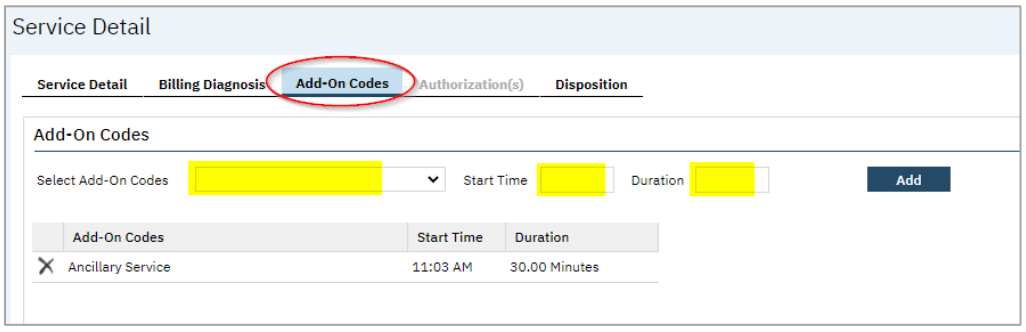
Manual Add-on Codes

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



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



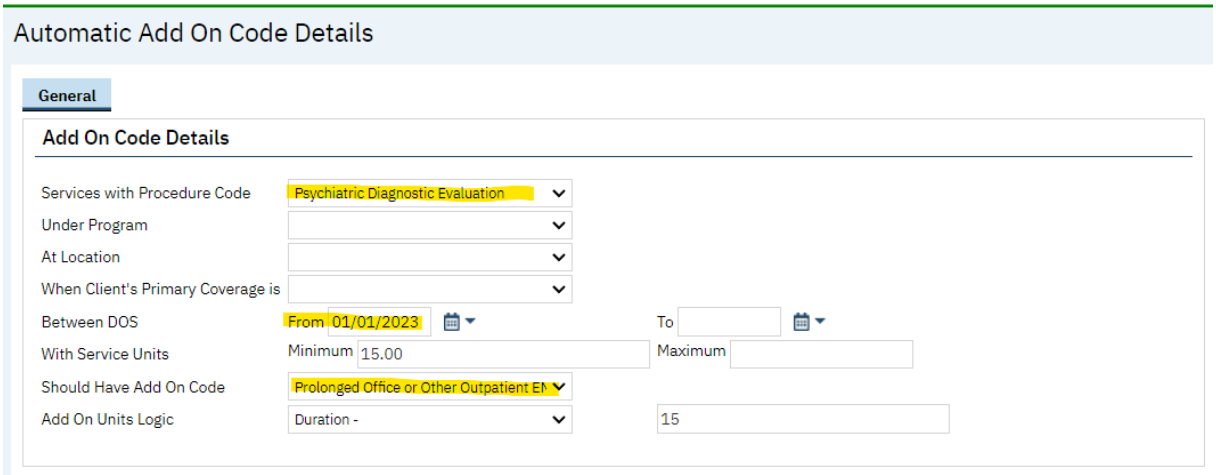
*See **Billing Add-on Codes** section for additional information regarding the add-on charge and billing.*

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



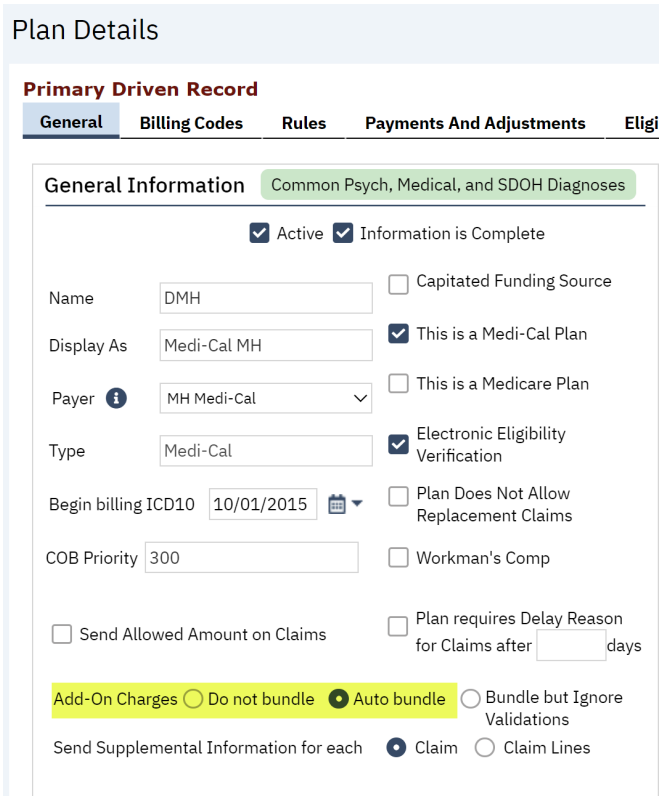
Billing Add-on Codes

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.

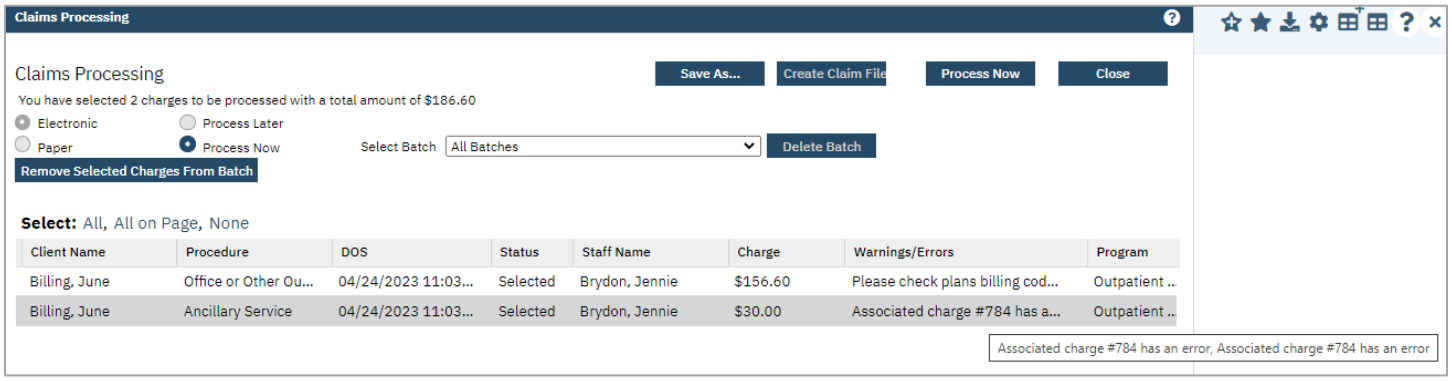


Add-On Charges	Select the applicable radio button to identify how to handle billing when add-on codes are added to the main procedure code selected on the service. • Do not bundle - Primary services and Add-On charges can be billed on separate claims. Both charges must pass validation before they can 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
☐	784	Medi-Cal MH	Billing, June (1011)	04/24/2023 11:...	Brydon, Jennie	Ancillary Servi...	$30.00	$30.00	30.00
☐	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.



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:

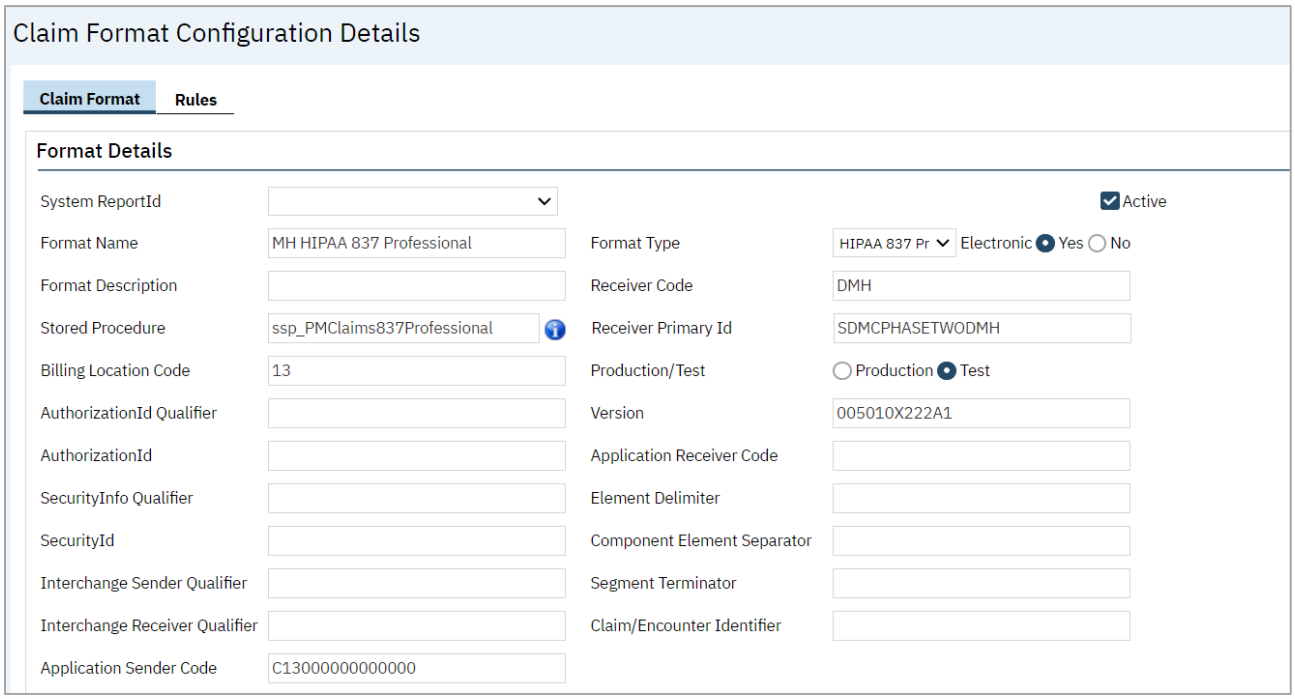
The Agency Table		
Column Name	Description	837 Location
AgencyName		Loop 1000A (Submitter NM1*41) NM103 Submitter Last Name
BillingContact	The name of the contact for the organization	Loop 1000A (Submitter) PER02
BillingPhone	A phone number to contact the organization	Loop 1000A (Submitter) PER04
PaymentAddress		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.

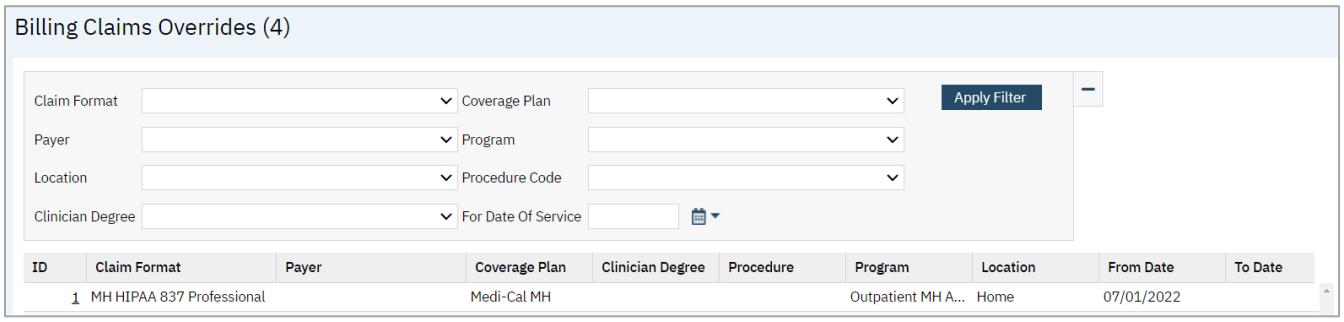
The **BillingPhone** field may be formatted as a normal phone number. It will be automatically converted to the unformatted number required by the 837 implementation guide.

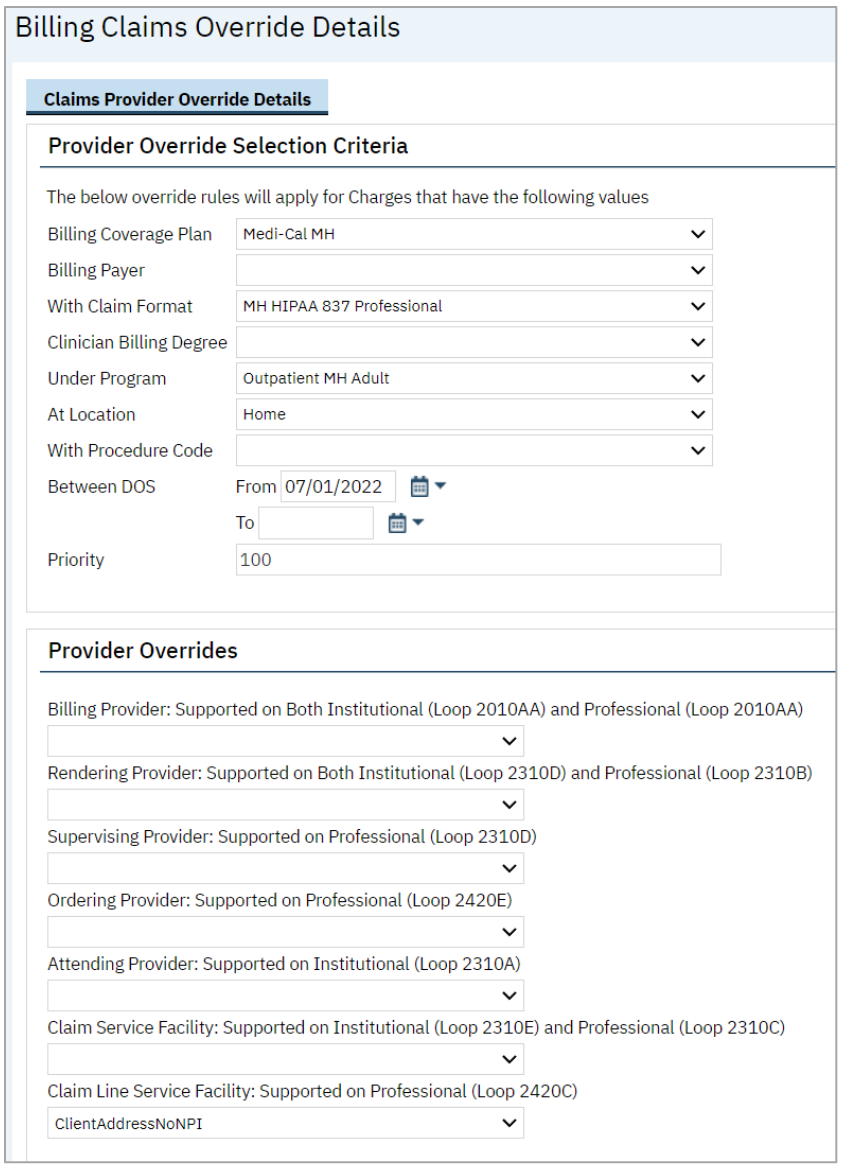
Claim Format Configuration Details

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.



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”.

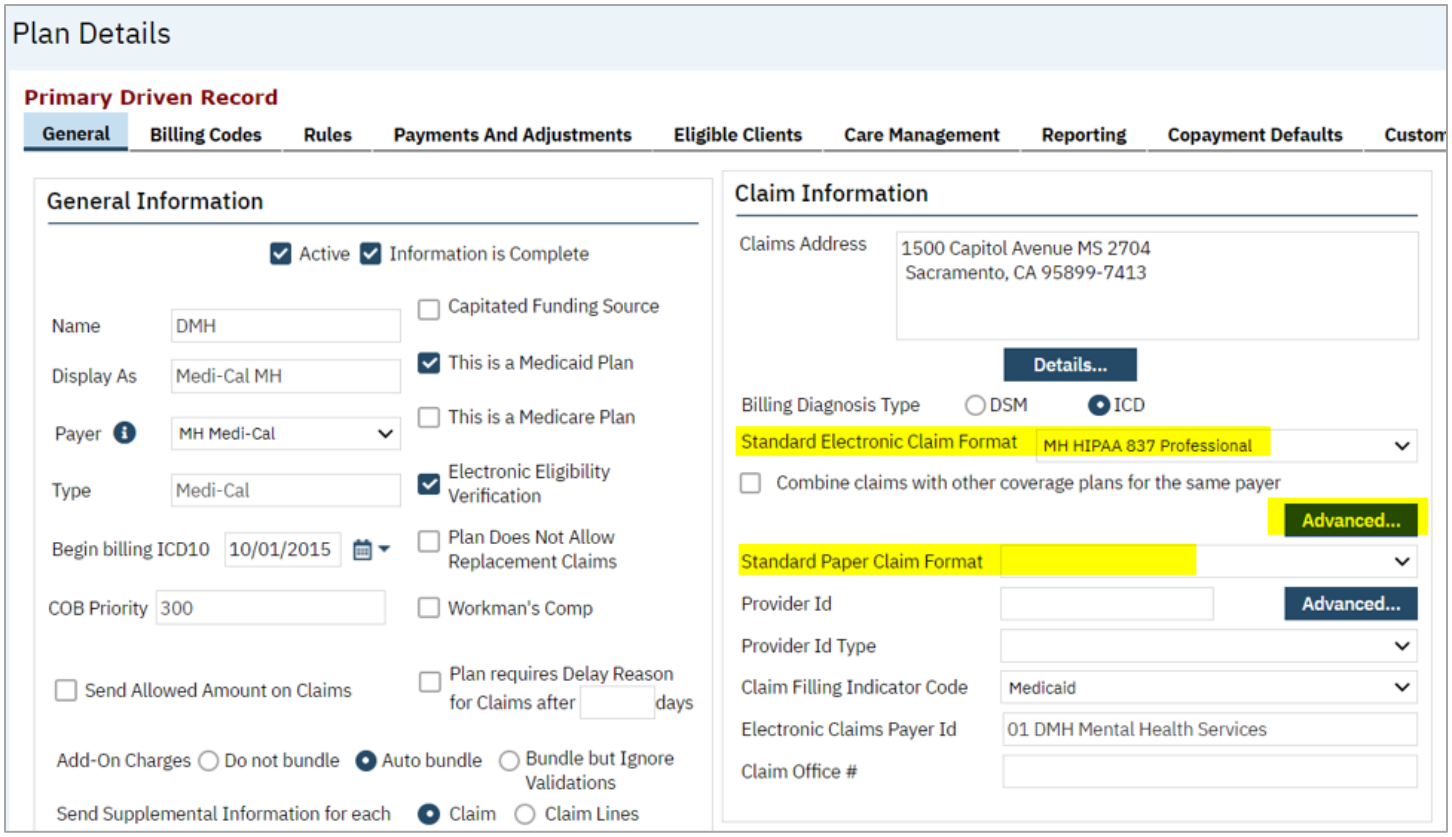




Plan Setup – 837i and 837p

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
General Information
Active
Information is Complete
Name
DMH
Display As
Medi-Cal MH
Payer
MH Medi-Cal
Type
Medi-Cal
Begin billing ICD10
10/01/2015
COB Priority
300
Capitated Funding Source
This is a Medicaid Plan
This is a Medicare Plan
Electronic Eligibility Verification
Plan Does Not Allow Replacement Claims
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
1500 Capitol Avenue MS 2704
Sacramento, CA 95899-7413
Details...
Billing Diagnosis Type
DSM
ICD
Standard Electronic Claim Format
MH HIPAA 837 Professional
Combine claims with other coverage plans for the same payer
Advanced...
Standard Paper Claim Format
Provider Id
Advanced...
Provider Id Type
Claim Filling Indicator Code
Medicaid
Electronic Claims Payer Id
01 DMH Mental Health Services
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.

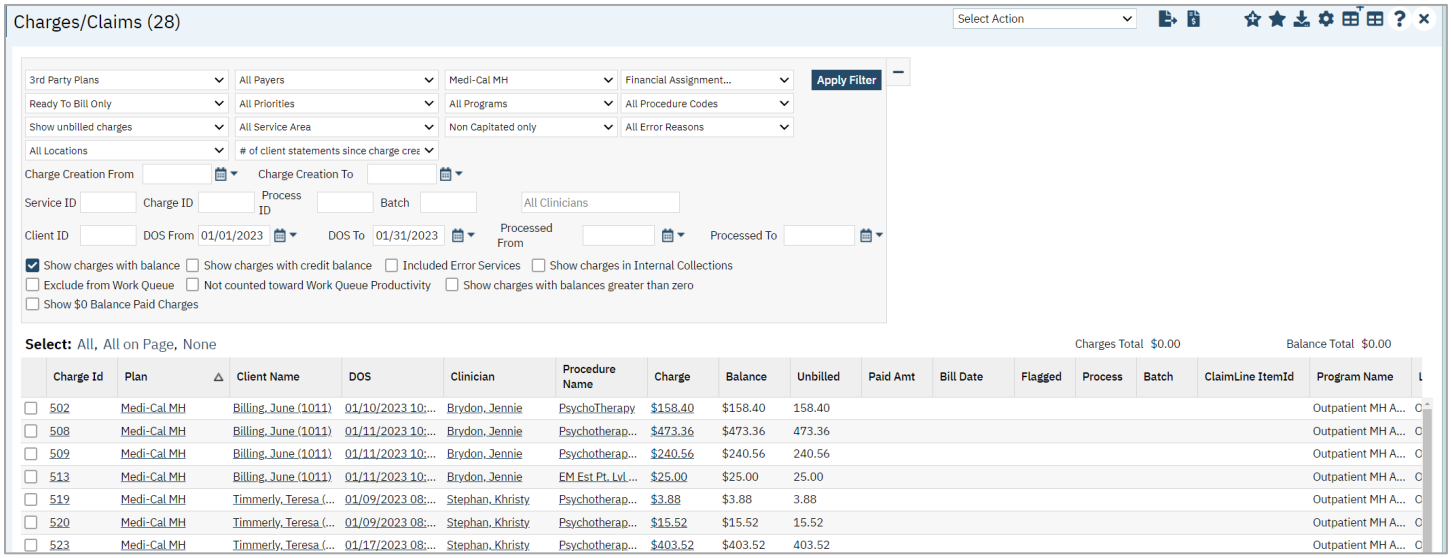
Charges/Claims Screen

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.



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

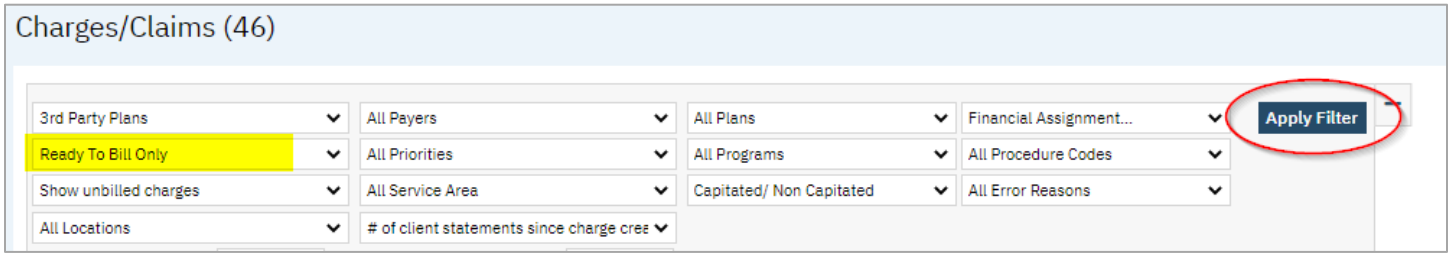
Ready to Bill

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



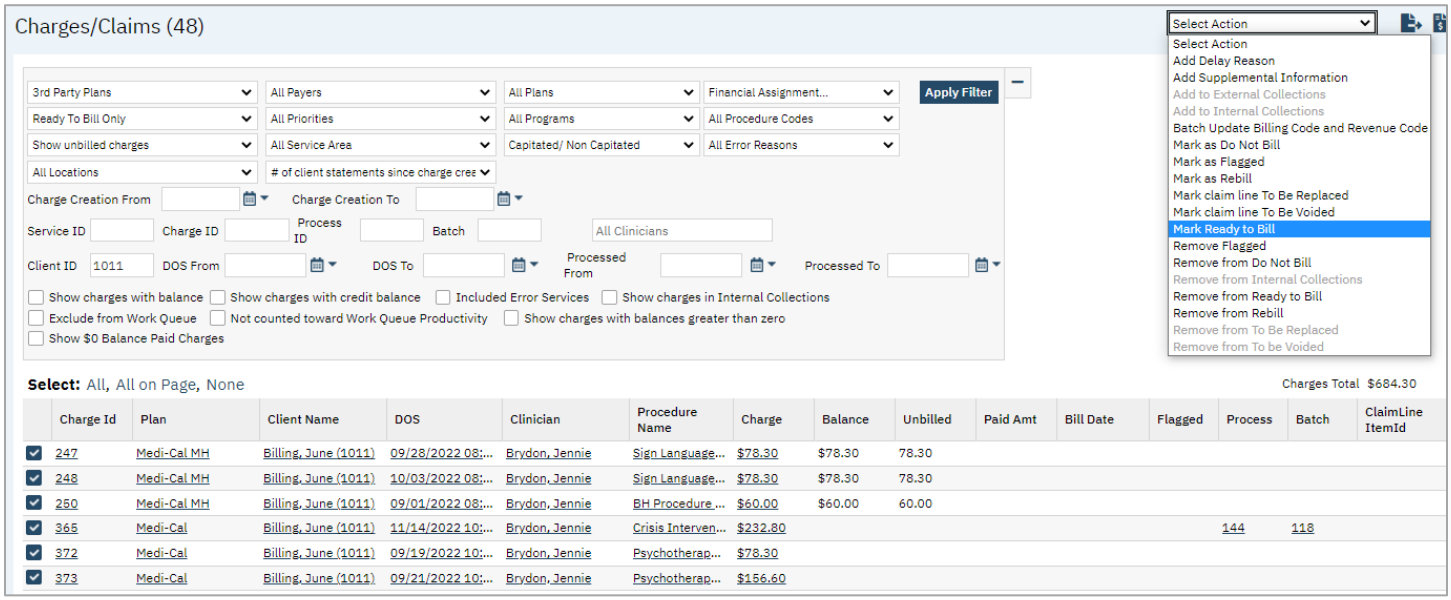
In order to run a claims batch, the filter must be set to "Ready to Bill Only." This helps to make sure charges that are not ready to bill are not accidentally claimed.

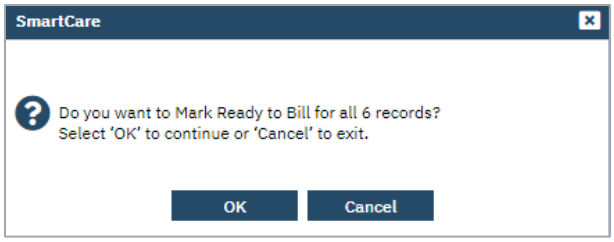
There are times a charge might need to be manually marked as ready to bill. Situations where this might happen include if a service was manually completed (rather than being completed via the overnight job), or a charge error needs to be overrode to bill.

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

Select Action Menu

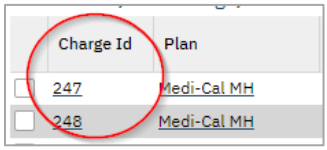
1. Navigate to the Charges/Claims screen.
2. Apply filters as needed.
3. Select the checkbox next to each charge that needs to be marked as ready to bill.
4. Use the dropdown arrow in the Select Action menu and select "Mark Ready to Bill."
5. At the popup select OK





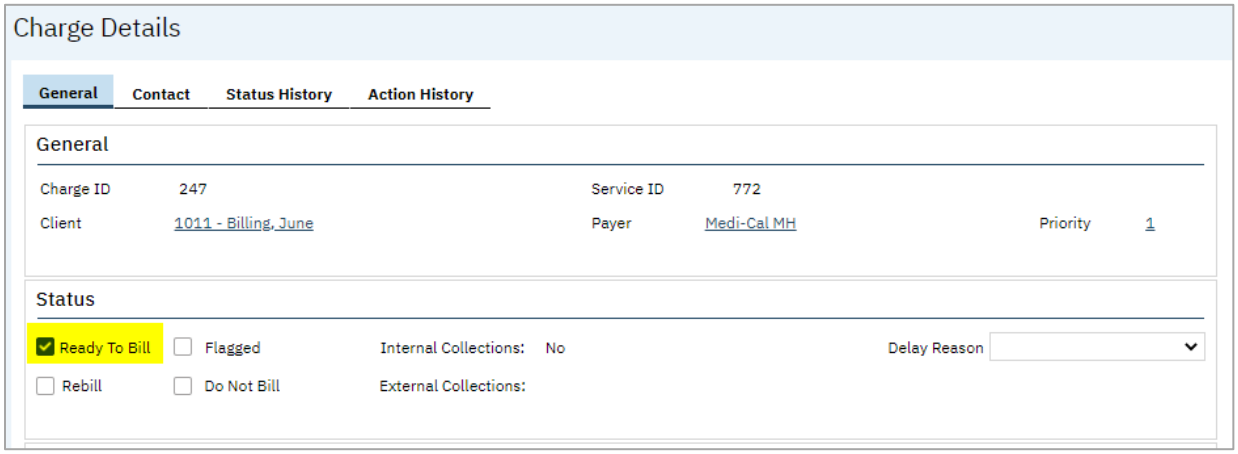
Charge Details

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



The Charge Details screen opens.

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



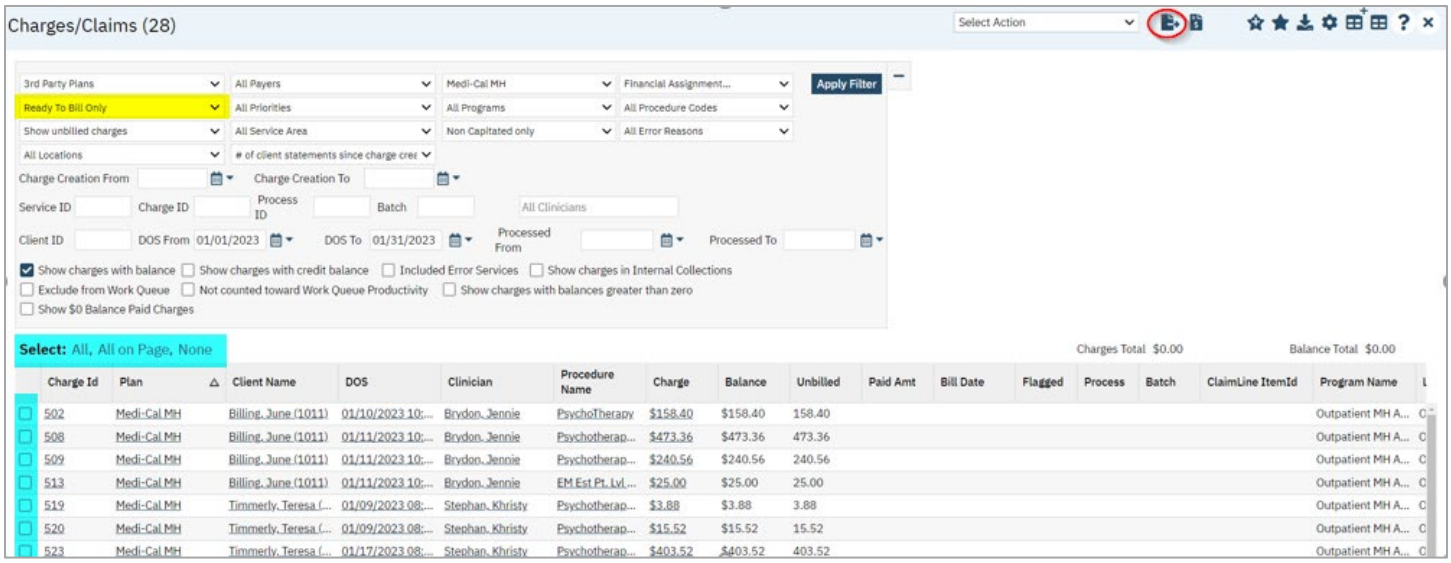
Note: The same actions can be taken to remove a charge from the Ready to Bill status.

Electronic and Paper Claims

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

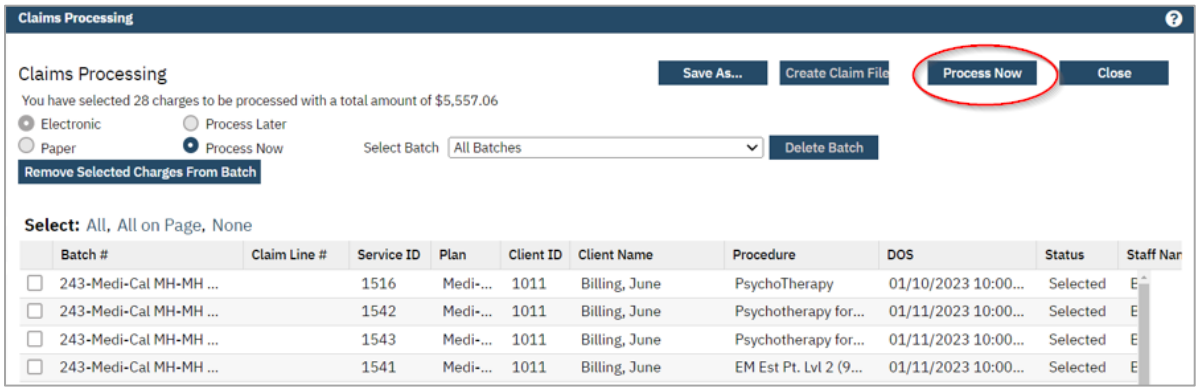
To create electronic claims:

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



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

The Claims Processing window will open.

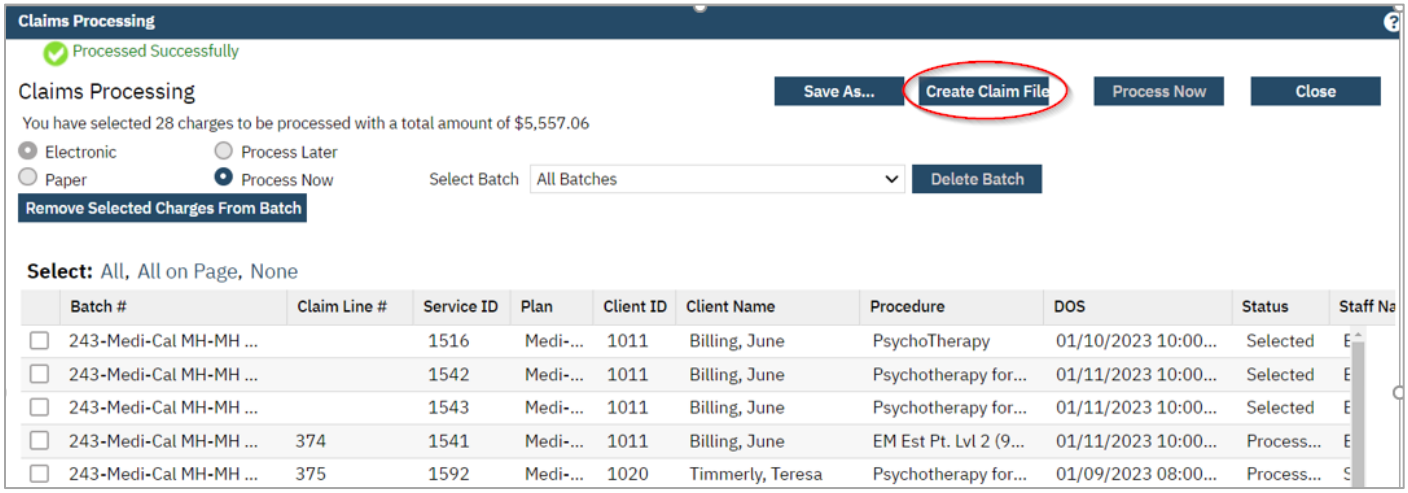


The service lines that are ready to be included in a claim file to the plan are listed.

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.

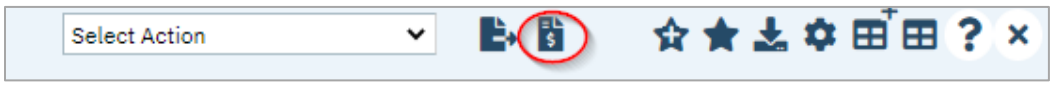
- To remove charges from the list, click the radio button to the left of each service line you want to delete from a batch and click the "Remove Selected Charges From Batch" blue button.
- To move forward with charges within your batch, click the "Process Now" button.
- All claims listed on the page 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.



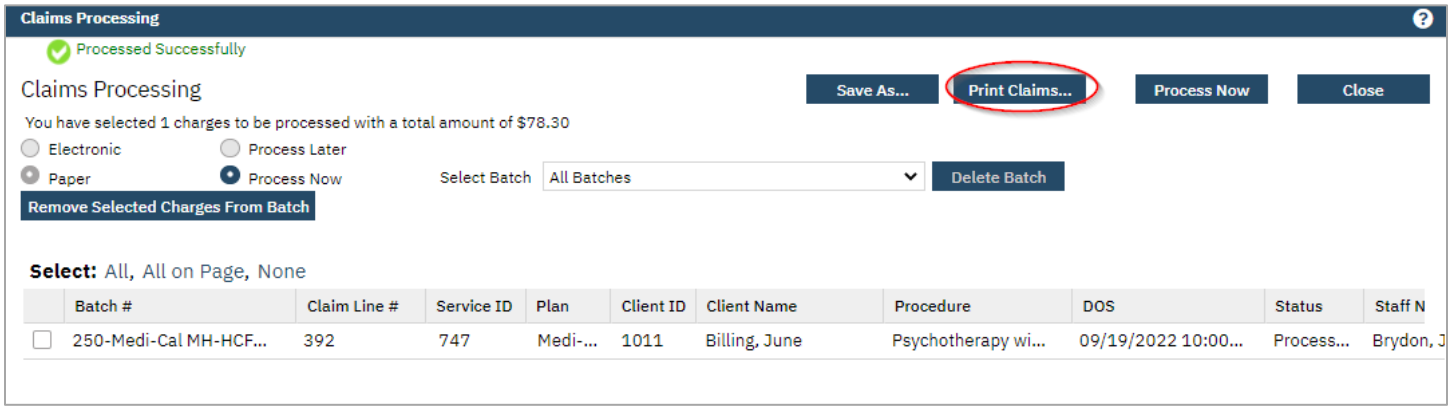
To create paper claims:

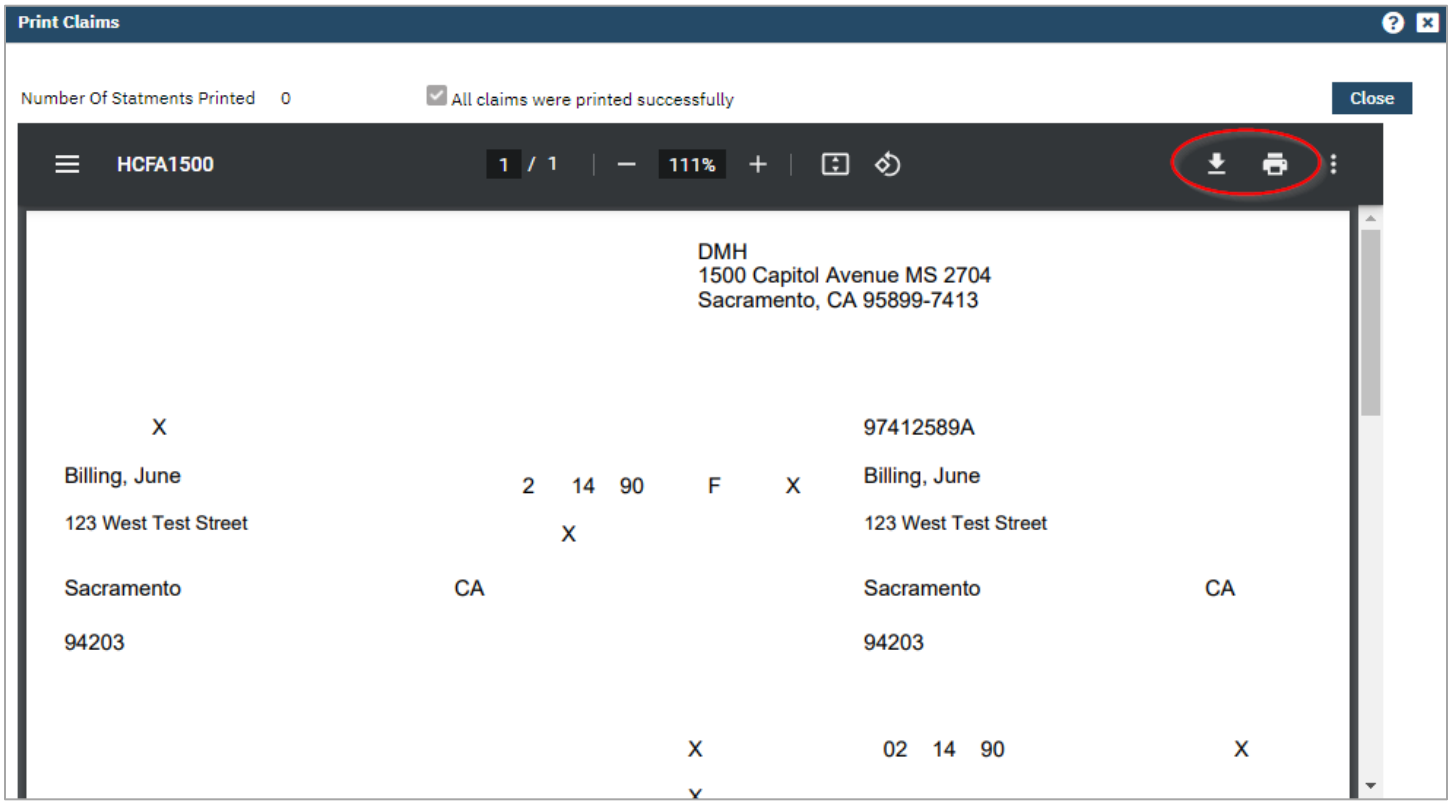
1. Follow the same steps 1-5 above to filter the charges for paper claims creation.
2. Select the Paper Claims icon.



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.

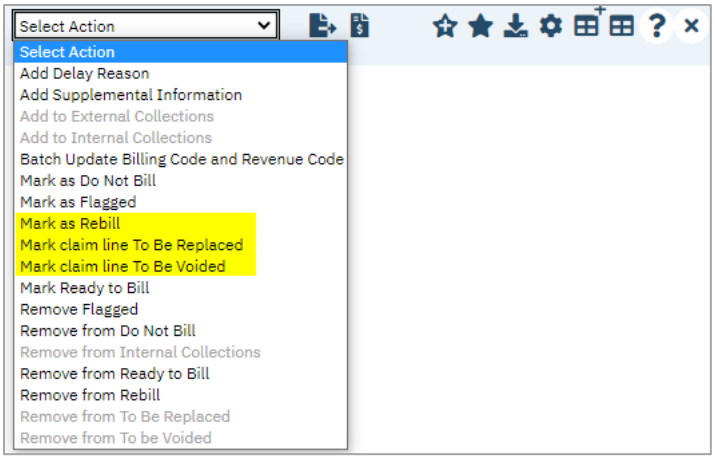
- When the process is complete, a status message appears in the top left corner of the window. In this example you will see a green message stating "Processed Successfully
- Click the **Print Claims** button and the claims are rendered on the screen where the user can save them as a PDF to print.

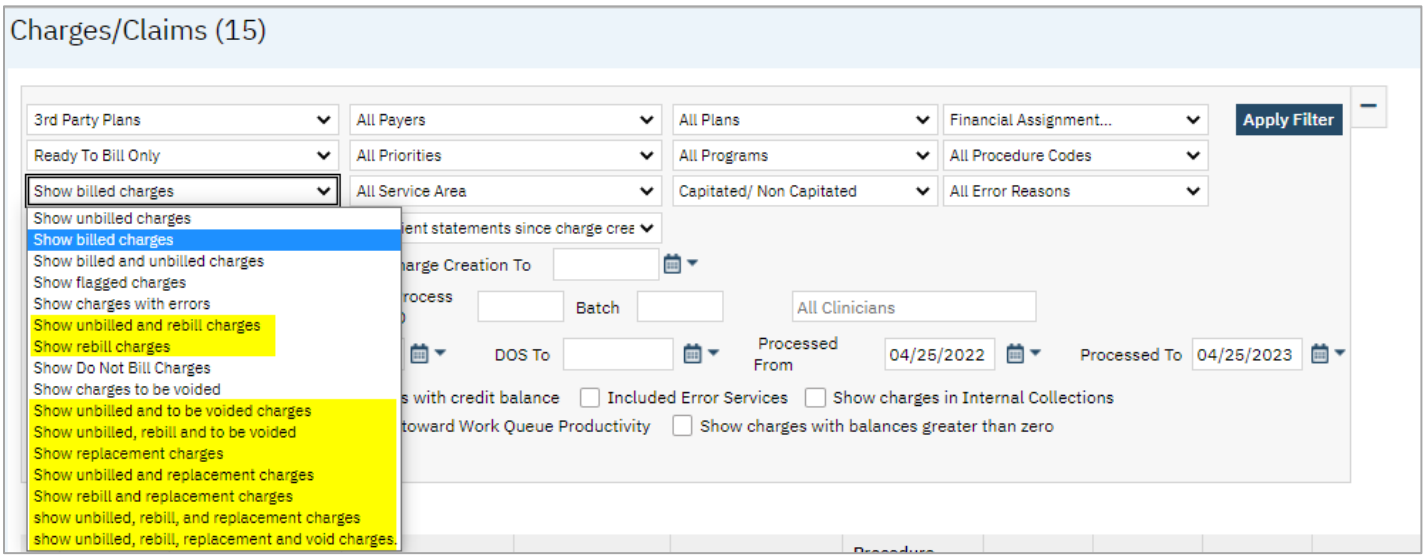




Processing Denials and Rebills

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

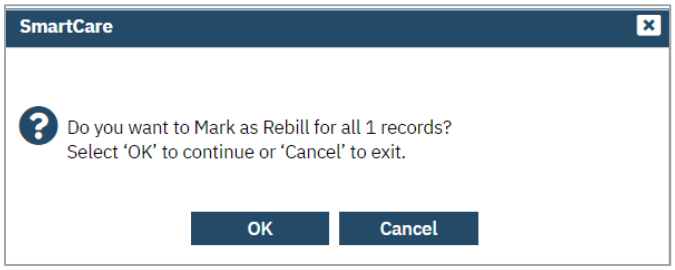
In SmartCare terminology, “rebill” refers to the charge being billed again as an original claim. This selection will not require the PCCN number returned on the 835 file and typically used when rebilling Medicare and Commercial Insurance for electronic or paper claims.

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?*

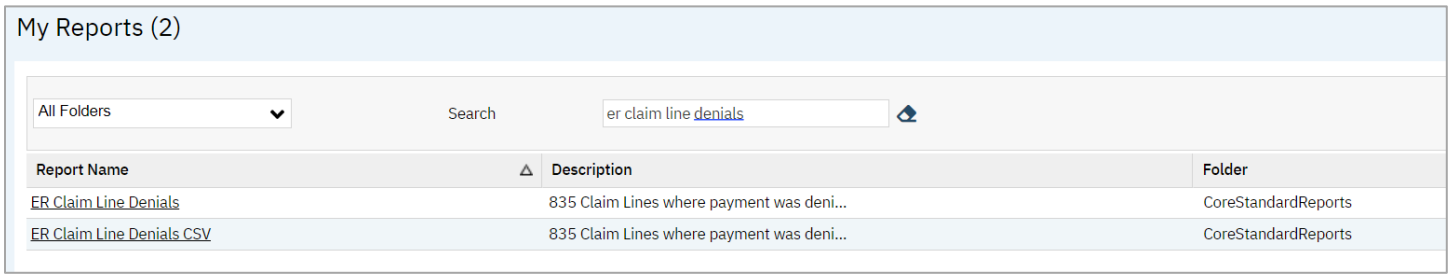


1. Click the OK button.
2. Your corrected claim is now marked for rebill

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.



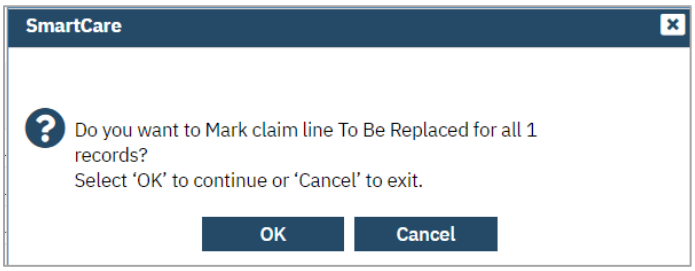
Replacement claims are often called "corrected claims." When this option is selected claims will be billed as a replacement claim. Replacement claims require the PCCN number returned via the 835 file. SmartCare will automatically insert the PCCN number in the replacement claim file if the payment was 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.

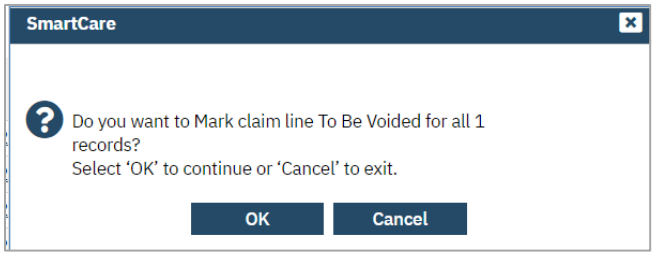
Voided Claims

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:
    - Thru Service Note: clicking Edit will make billing strip editable as well as the note.
    - Thru Service Detail: Use golden key to edit. Does not allow note edit.
- Completed Note:
    - 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.
    - 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.

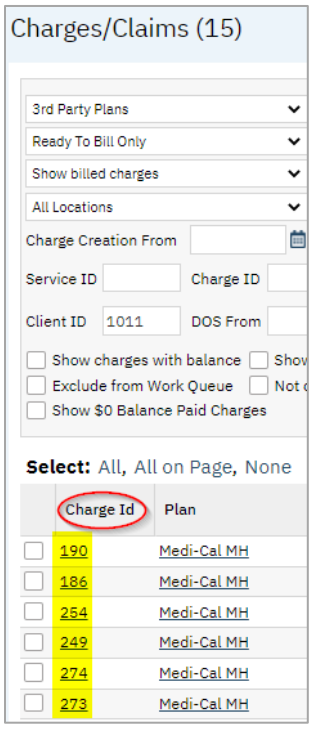
Special Circumstances

Charge Override

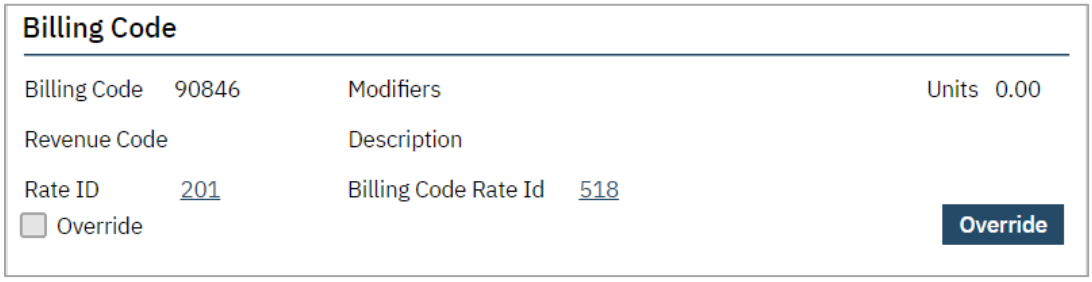
There may be a need to change a billing code cross reference to change the scope of a service on a claim. For example, a lockout override, where the service would need to be evaluated first, and then a billing code updated, or a modifier added/changed.

To override a charge:

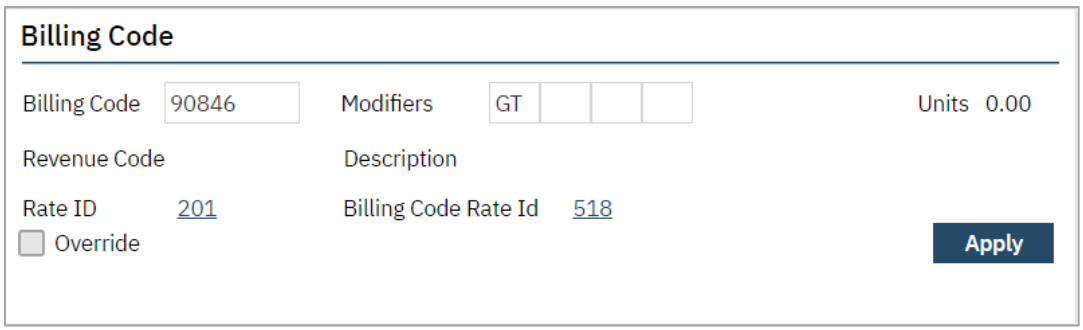
1. From the Charges/Claims list page, click on the Charge ID hyperlink to access the charge details page.



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



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

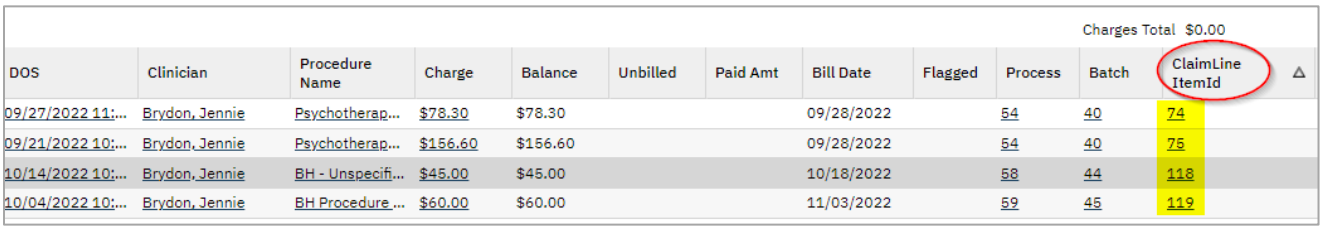


4. Make the necessary changes to the Billing Code or Modifiers, then click Apply
5. Click the **Save** button in the tool bar
6. The change is only made for this charge.

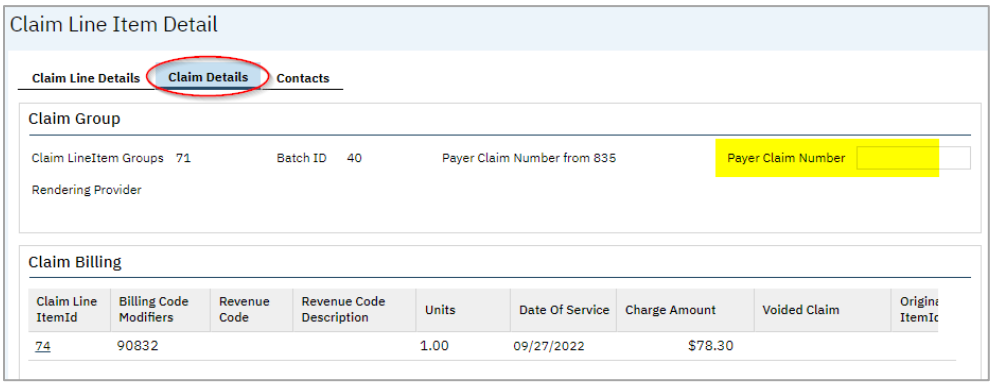
PCCN Number

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



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



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

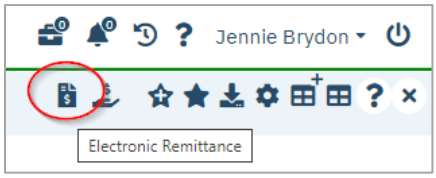
Remittance Processing

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.

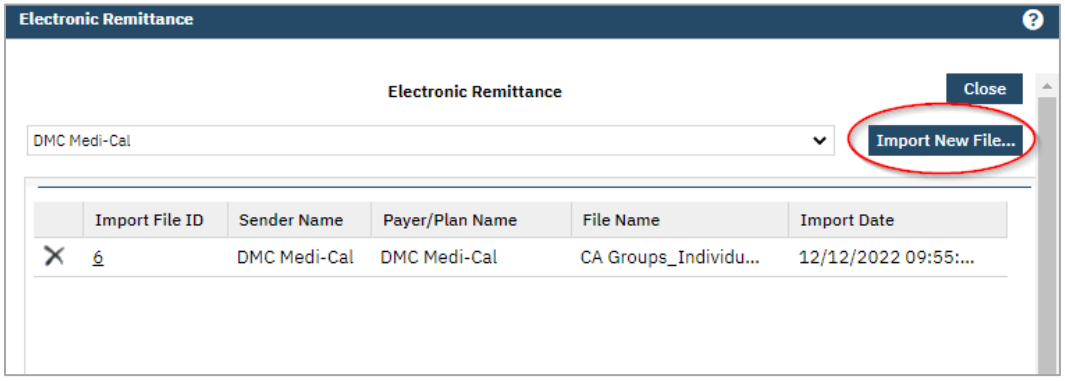
Importing 835 Files

To Import an 835 file for processing:

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

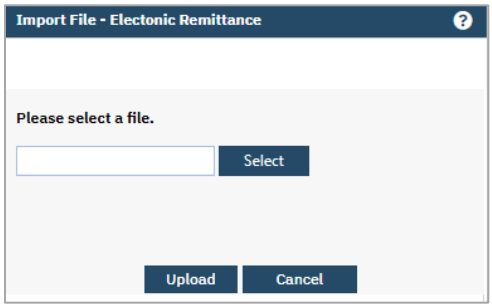


The Electronic Remittance window opens.

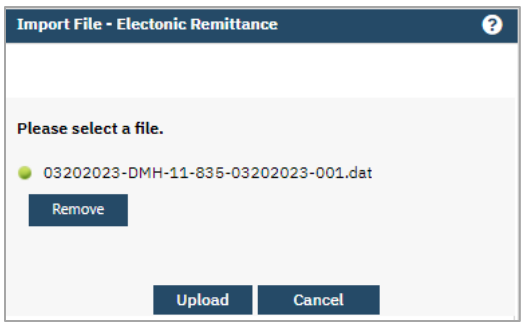


3. Select the Import New File button

The Import File – Electronic Remittance window opens.

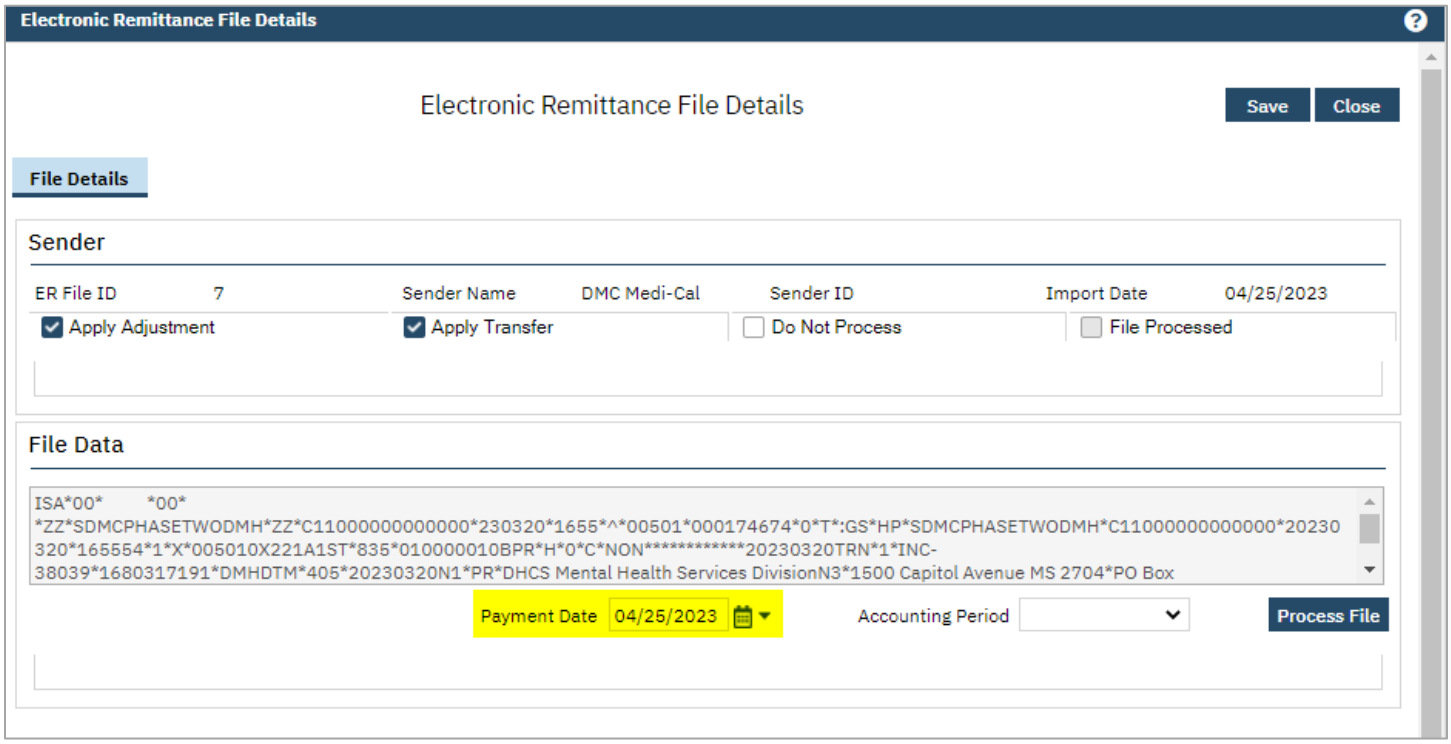


4. Use the Select button to locate the 835 file and select it.
5. If a file was selected in error, use the Remove button



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

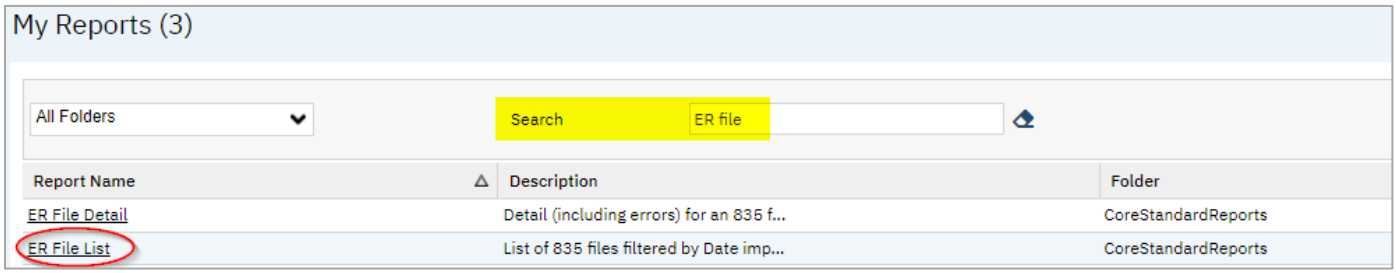
Note: The system will automatically select the Account Period. Do not select the Process File button. The overnight billing job will automatically process the file during off hours.

Electronic Remit Report (ER Reports)

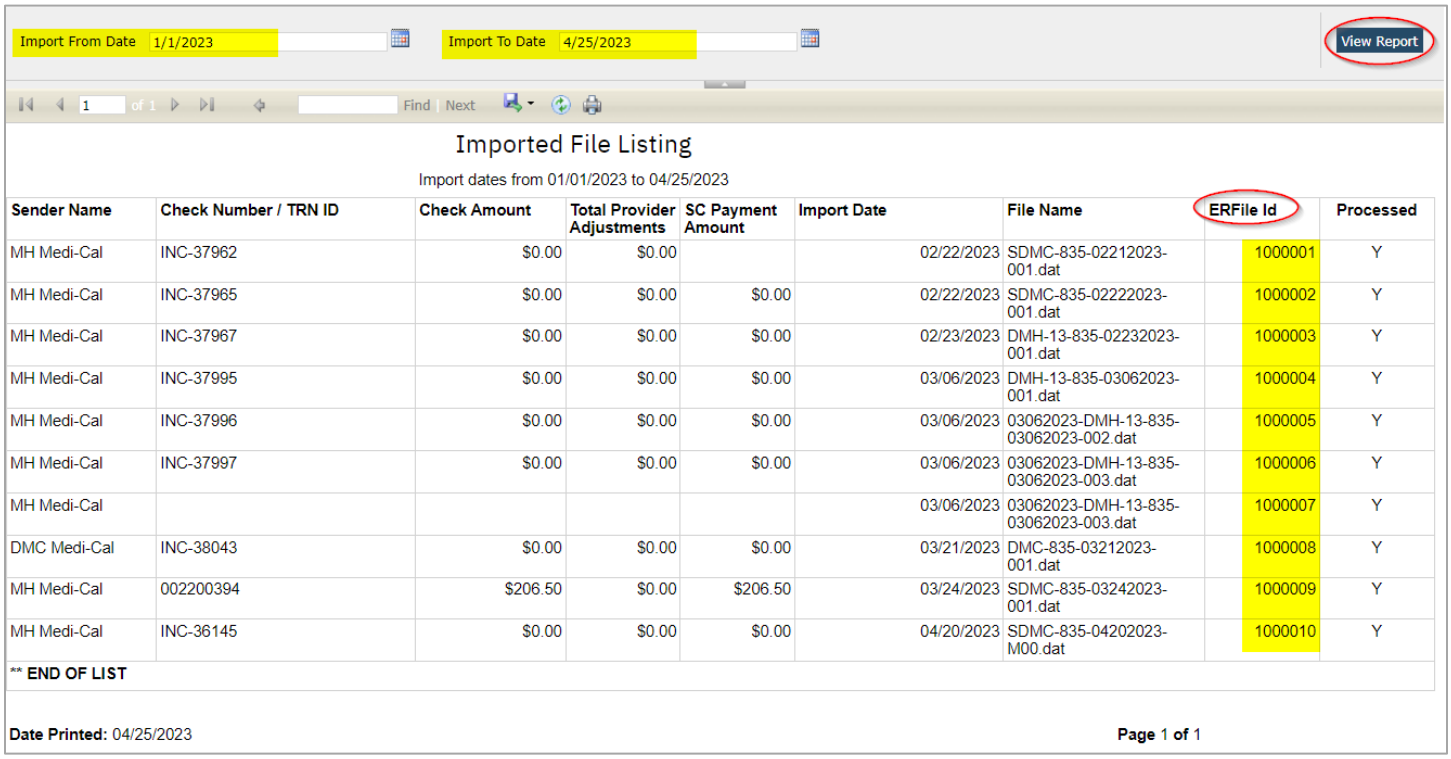
Once 835 files have been processed by the overnight job, data regarding the files can be found via the Electronic Remit Reports.

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



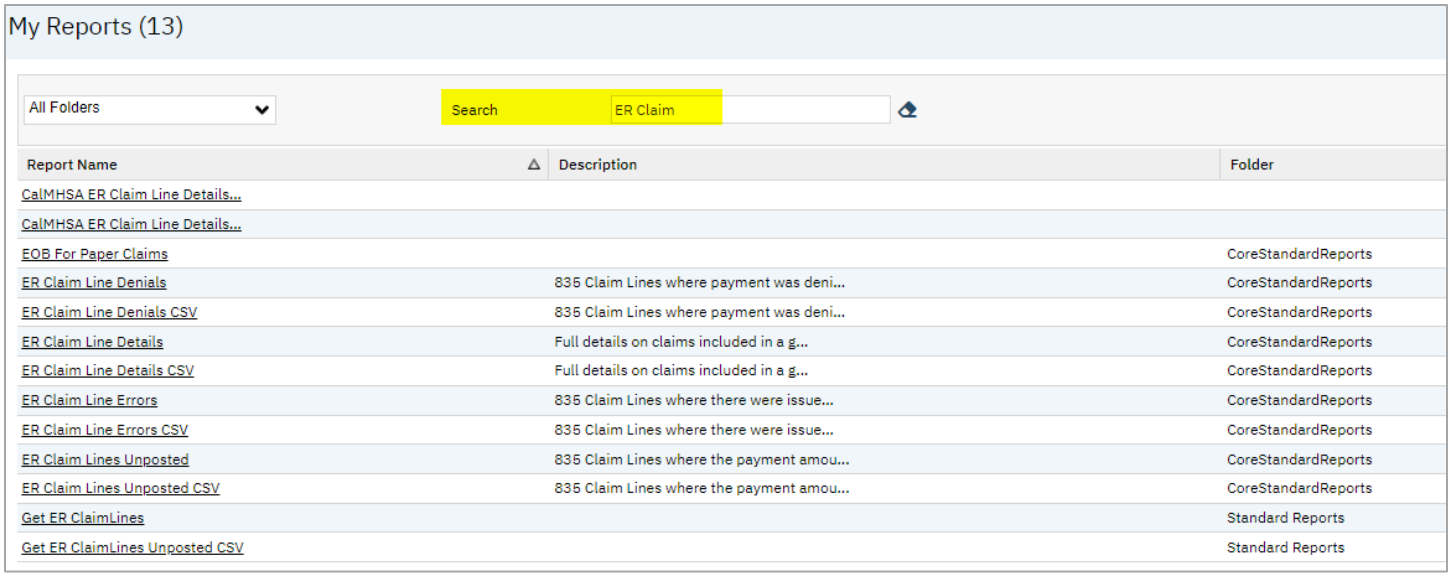
    c. In the report viewer, enter the Import From and To dates.
    d. Select View Report



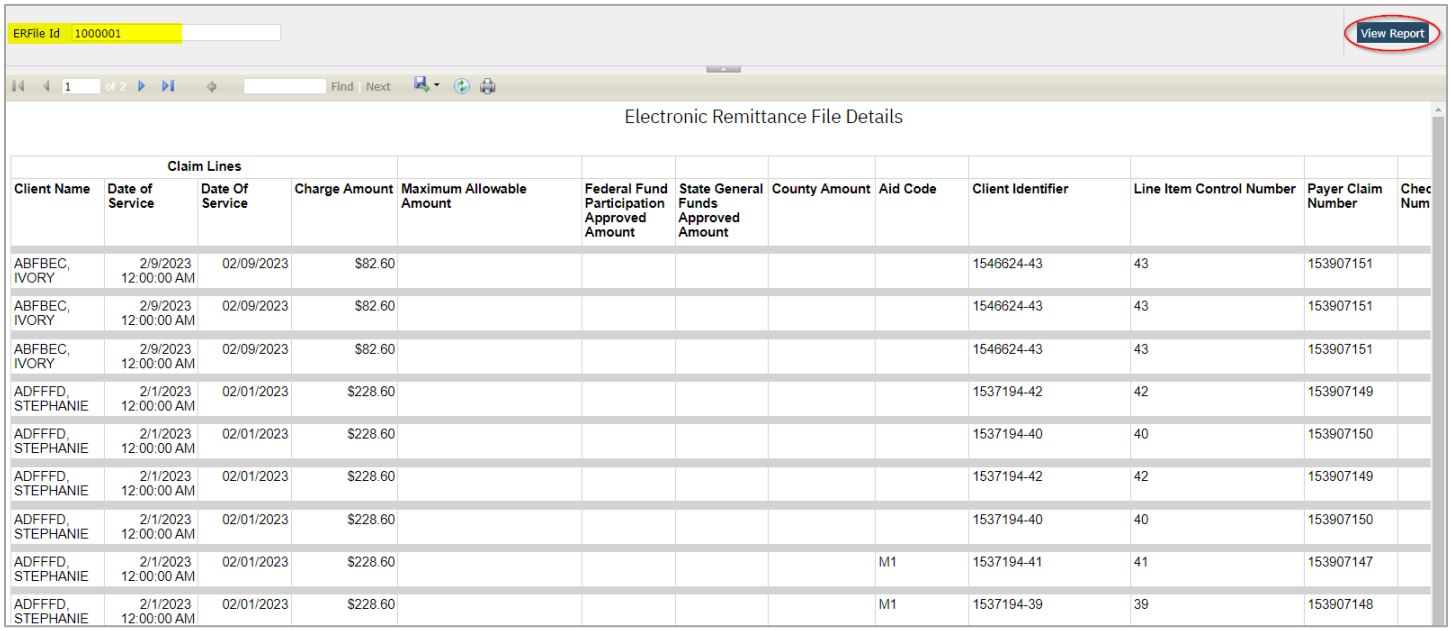
Sender Name	Check Number / TRN ID	Check Amount	Total Provider Adjustments	SC Payment Amount	Import Date	File Name	ERFile Id	Processed
MH Medi-Cal	INC-37962	$0.00	$0.00		02/22/2023	SDMC-835-02212023-001.dat	1000001	Y
MH Medi-Cal	INC-37965	$0.00	$0.00	$0.00	02/22/2023	SDMC-835-02222023-001.dat	1000002	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.



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



7. 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.