Substance Use Disorder Information System

ProviderConnect NX

PCNX TRAIN Guide: Primary User Billing Process

This guide is intended to orient providers to the forms used for submitting claims/billing within ProviderConnect NX (PCNX). This guide is intended only for direct service providers who submit claims directly into the Sage/PCNX application. As SAPC transitions from ProviderConnect (PCON) classic to PCNX, it is important to note that requirements and policies regarding what to bill and general billing practices have not changed. PCNX is simply a new user interface to submit claims.

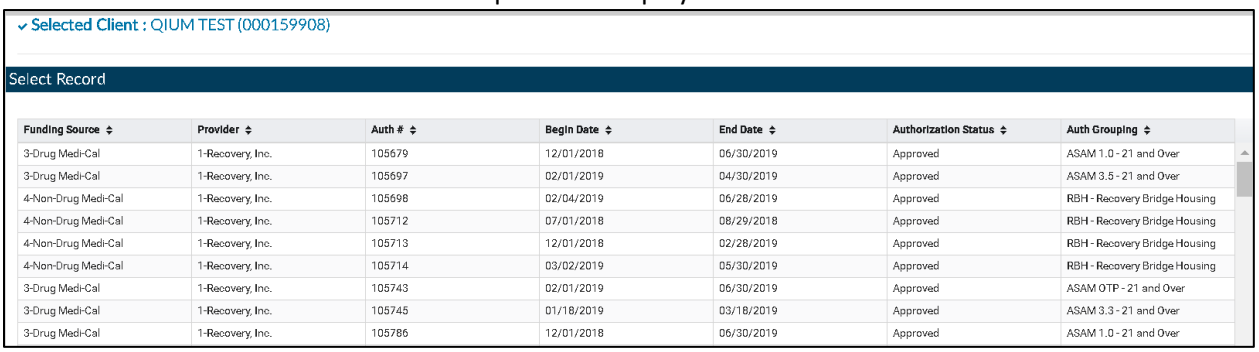
Please note that snips are taken from a test environment and no PHI is shared. Additionally, SAPC and Netsmart are continuing to update the PCNX environment therefore some items may look different in LIVE than in the TRAIN environment.

Contents

Required Forms Prior to Submitting Claims

As a reminder, the following forms are required to be complete to avoid billing denials prior to submitting claims. This is the same process as is currently utilized within ProviderConnect (PCON) classic. Details on each of these forms are included in the PCNX Admission/Intake Guide.

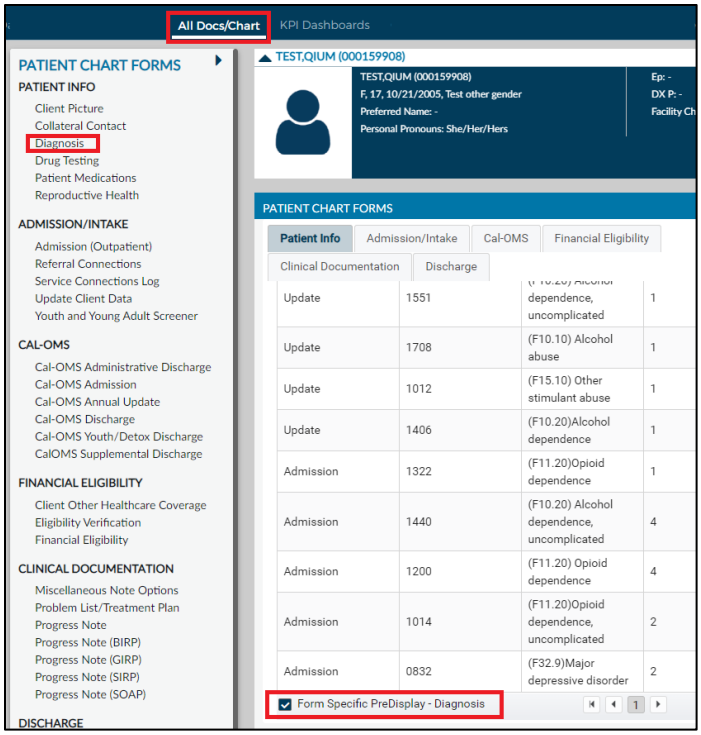
1. Approved Member or Provider Authorization (PAUTH)
    a. Providers must ensure that there is an approved member authorization or PAuth on file prior to billing.
    b. Billing on a pending or denied auth will create billing denials.
    c. Providers will be able to check authorization status using:
        i. Service Authorization Request Pre-display



Funding Source	Provider	Auth #	Begin Date	End Date	Authorization Status	Auth Grouping
3-Drug Medi-Cal	1-Recovery, Inc.	105679	12/01/2018	06/30/2019	Approved	ASAM 1.0 - 21 and Over
3-Drug Medi-Cal	1-Recovery, Inc.	105697	02/01/2019	04/30/2019	Approved	ASAM 3.5 - 21 and Over
4-Non-Drug Medi-Cal	1-Recovery, Inc.	105698	02/04/2019	06/28/2019	Approved	RBH - Recovery Bridge Housing
4-Non-Drug Medi-Cal	1-Recovery, Inc.	105712	07/01/2018	08/29/2018	Approved	RBH - Recovery Bridge Housing
4-Non-Drug Medi-Cal	1-Recovery, Inc.	105713	12/01/2018	02/28/2019	Approved	RBH - Recovery Bridge Housing
4-Non-Drug Medi-Cal	1-Recovery, Inc.	105714	03/02/2019	05/30/2019	Approved	RBH - Recovery Bridge Housing
3-Drug Medi-Cal	1-Recovery, Inc.	105743	02/01/2019	06/30/2019	Approved	ASAM OTP - 21 and Over
3-Drug Medi-Cal	1-Recovery, Inc.	105745	01/18/2019	03/18/2019	Approved	ASAM 3.3 - 21 and Over
3-Drug Medi-Cal	1-Recovery, Inc.	105786	12/01/2018	06/30/2019	Approved	ASAM 1.0 - 21 and Over

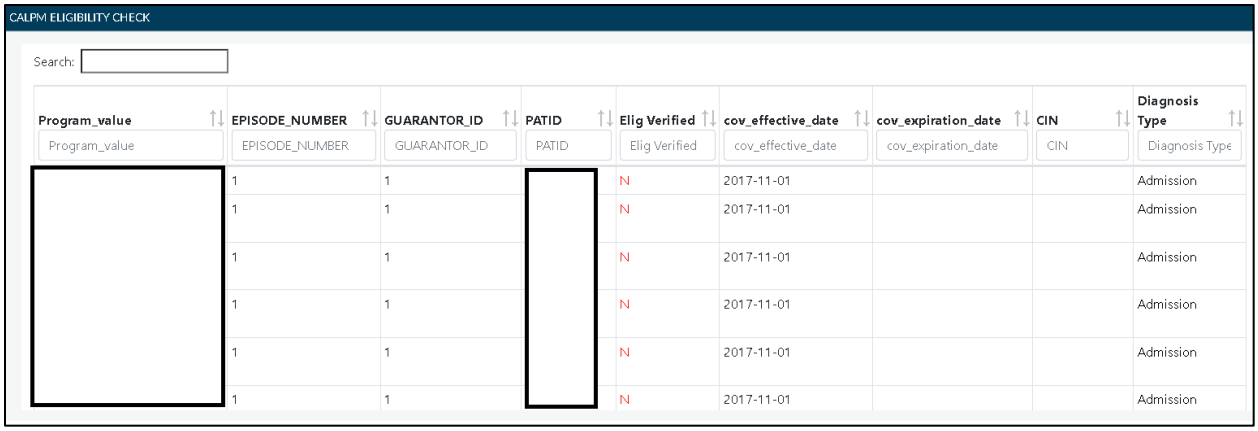
        ii. Authorization Status Request Report - This report was recreated in PCNX and will function similarly as it does in PCON classic.

2. Diagnosis
    a. A valid substance abuse disorder (SUD) diagnosis must be the primary diagnosis on file
    b. There must be an Admission Diagnosis Type in the patient record that is on or before the dates of service.
    c. To check diagnosis information, providers can use:
        i. All Docs/Chart View for the selected patient and click on Diagnosis under Patient Info
        ii. The checkbox for **Form Specific PreDisplay-Diagnosis** should be checked.



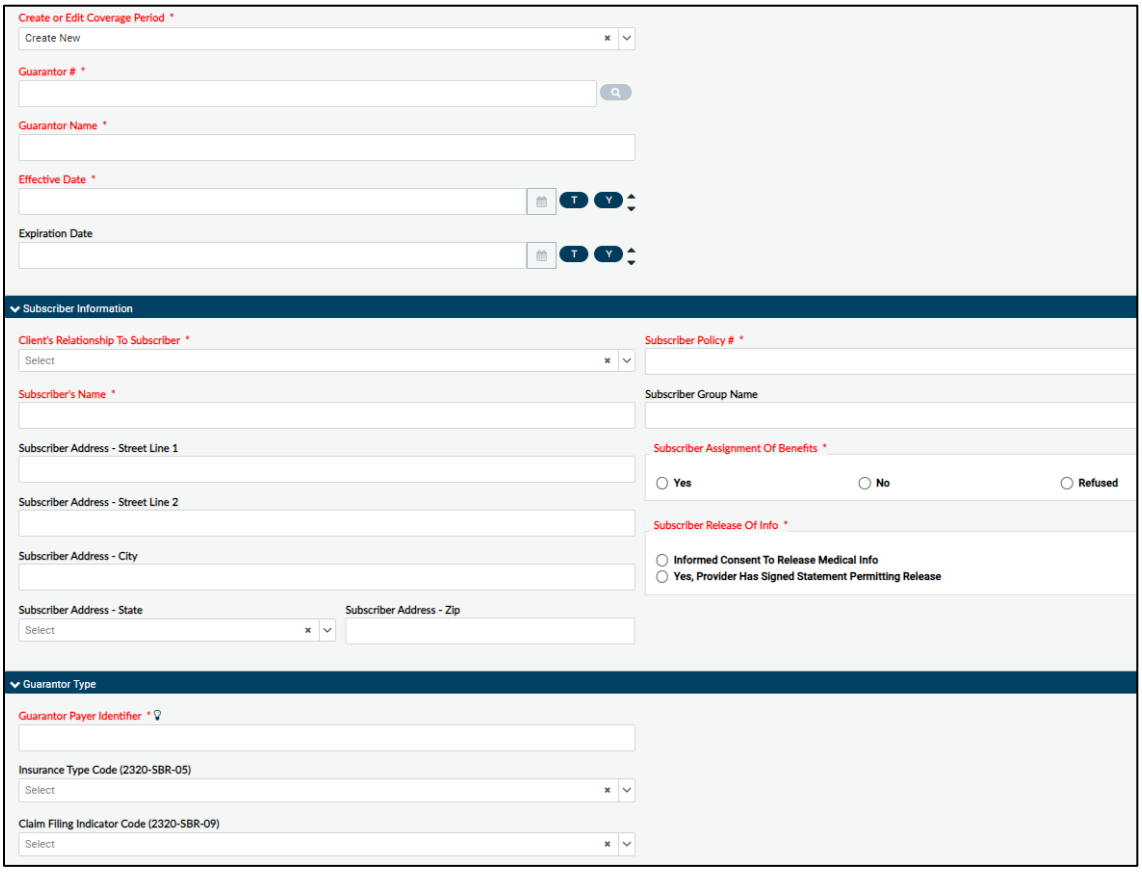
3. Financial Eligibility (FE)
    a. There are no changes to the requirements for Financial Eligibility or the Financial Eligibility form in Sage/PCNX.
    b. Providers must ensure that the forms are completed with the necessary information to avoid unnecessary denials.
    c. To assist providers in easily identifying denials for FE not found/verified in CalPM, SAPC has developed a widget that will be included for all financial user groups.
    d. The **CalPM Eligibility Check** widget will display any patient with missing or incorrect information that might cause a local eligibility denial.
        i. This denial is only triggered for the DMC guarantor when one or more of the following are met:
            1. Eligibility Verified is marked as “No”
            2. Coverage Effective Date is after the date of service
            3. Coverage Expiration Date is before the date of service
            4. The Client Index Number (CIN) is missing from the DMC guarantor
            5. An Admission Diagnosis Type is missing from the list of patient diagnoses
        ii. The widget logic is based on the below criteria. Patient rows will display when one or more of the following criteria are met:
            1. Eligibility Verified is “No”
            2. Coverage Expiration Date is present
            3. CIN is missing

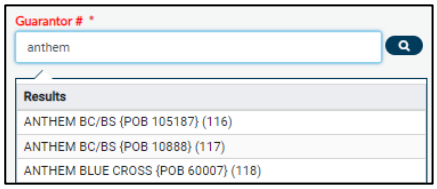
            Coverage Effective Date and Diagnosis Type are for visibility only and do not employ any logic within the widget.



4. Client Other HealthCare Coverage (if applicable)
    a. The **Client Other Healthcare Coverage** form is replacing the current Other Health Coverage form , which will no longer be used in PCNX.
    b. This form is required for all patients additional health coverage such as Medicare or private insurance. For specific policies and information on when to bill OHC, review the Other Health Coverage Provider Billing Manual.
        i. For information on how to complete this form, a video and job aid were posted under the clinical documentation PCNX training.

This form includes sections for Guarantor information, the subscriber's information, and the type of guarantor.



Field	Description
Create or Edit Coverage Period*	Required. • If there are no previous entries, select Create New. • If editing a coverage period, select the available item from the drop down.
Guarantor #	Enabled after 1st question is answered then becomes conditionally required. Search the Guarantor from the search bar. If the desired guarantor is not available create a Sage Help Desk ticket so it may be added to the system.  *Quick Tip: Enter a portion of the name of the guarantor to get the most hits so you may find the correct guarantor.* *POB stands for P.O. Box*
Guarantor Name	This will prepopulate with the guarantor's name after the Guarantor # is selected. Do not edit this field.
Effective Date	Required. Enter the effective date of client's healthcare coverage with the selected guarantor
Expiration Date	Enter the date the guarantor coverage expired, if applicable.
Subscriber Information	Details about the subscriber's information which may be someone other than the patient.
Client's Relationship To Subscriber	Required. Select the most appropriate choice from the drop down.
Subscriber's Name	Required. Enter the subscriber's name which may be different that the patient.
Subscriber Address -Street Line 1	Enter the subscriber's address
Subscriber Address -Street Line 2	Enter the subscriber's address
Subscriber Address -City	Enter the subscriber's City
Subscriber Address -State	Select the subscriber's State
Subscriber Address -Zip	Enter the subscriber's zip code
Subscriber Policy #	Required. Enter the policy number
Subscriber Group Name	Enter the Group Name, if applicable.
Subscriber Assignment of Benefits	Select whether the subscriber has authorized payments to be sent directly to the provider
Subscriber Release of Info	Required. Select whether the subscriber releases client benefit information

Guarantor Payer Identifier	Enter the Guarantor's Payer Identifier
Insurance Type Code (2320-SBR-05)	Select the insurance type code.
Claim Filing Indicator Code (2320-SBR-09)	Select the claim filing indicator code.

Users must click **Submit** for the form to save.

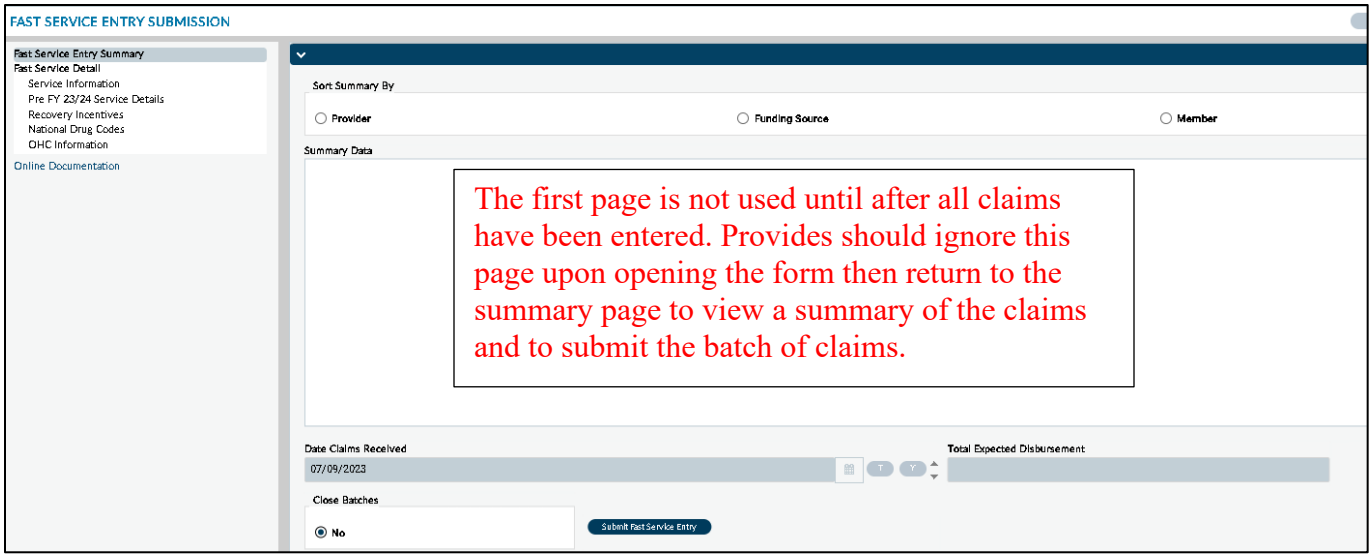
New Claiming Process in PCNX

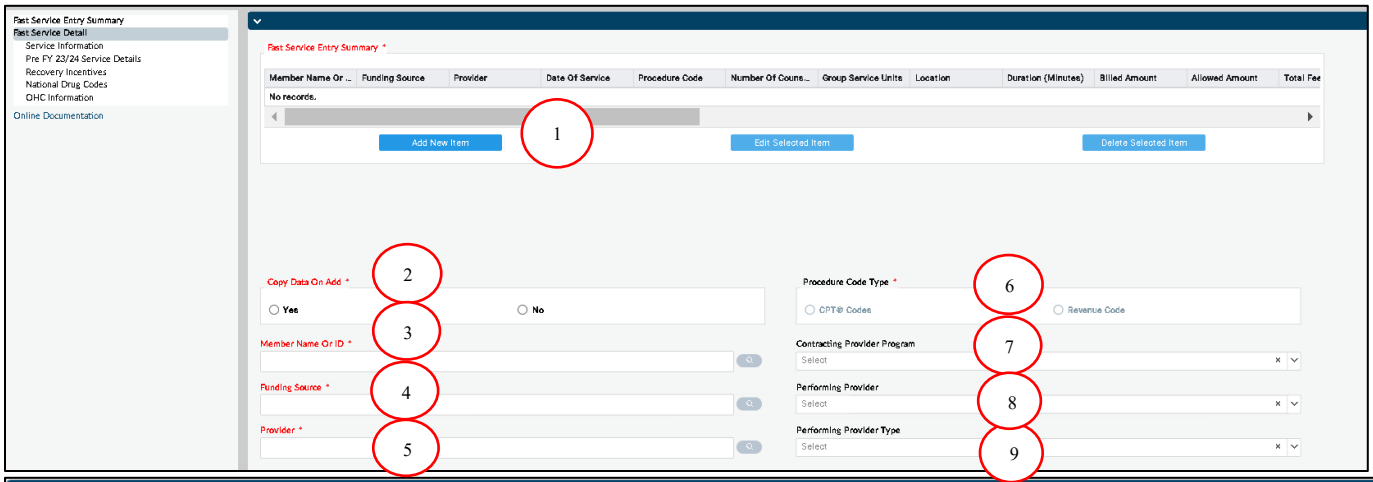
PCNX offers a completely new process for claiming as a Primary Sage User that simplifies the claiming process. The new service entry is not patient specific which allows providers to enter claims for multiple patients on the same form. Providers are able to submit up to 1000 services on the same claim submission for multiple patients and funding sources. Providers will receive instant pre-adjudication information for each service entered and can make real-time corrections. The SAPC adjudication process is not changing, only method of claims submission for Primary Sage Users is changing. Claims will be batched together and adjudicated in batches then compiled on EOBs as is the current process.

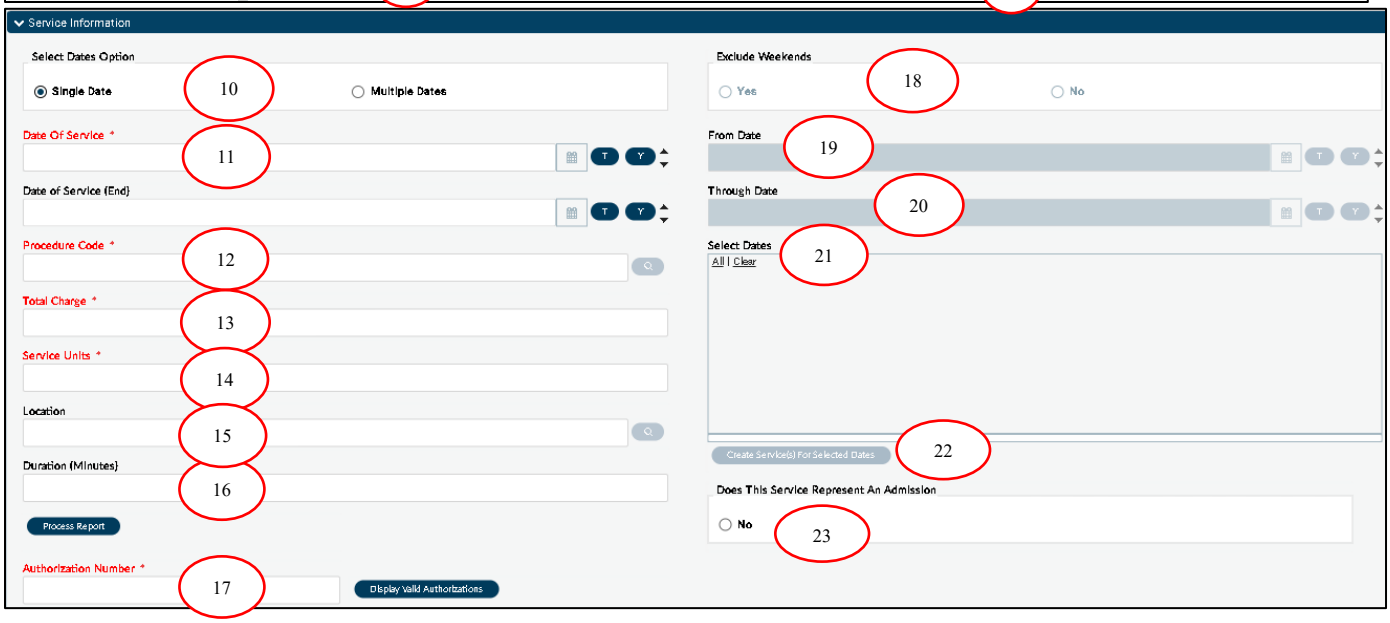
Fast Service Entry Submission

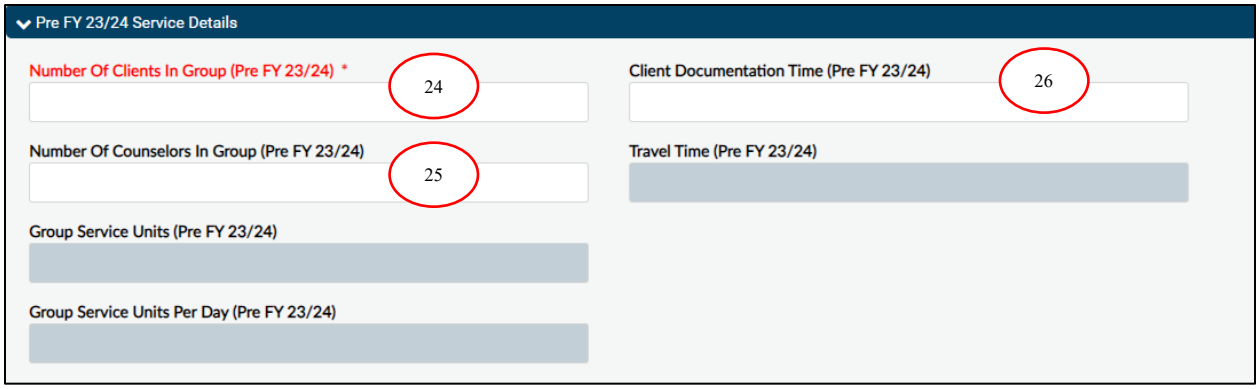
The **Fast Service Entry Submission** form is a new form that has replaced the Professional Treatment and Billing page previously used in PCON Classic. The Fast Service Entry Submission has combined many of the billing tasks into one comprehensive form, including multiple patient entry, instant pre-adjudication and submitting claims. All of the same billing fields are present on the form as those are standard billing requirements. There are no changes the information that must be submitted to bill nor associated billing policies that dictate information required for billing.

When opening the form, the user is taken to the **Fast Service Entry Summary** section, which only populates after claims are entered. Providers should immediately go to the **Fast Service Detail** section as the summary section is only required after claims are entered.


FAST SERVICE ENTRY SUBMISSION
Fast Service Entry Summary
Fast Service Detail
Service Information
Pre FY 23/24 Service Details
Recovery Incentives
National Drug Codes
OHC Information
Online Documentation
Sort Summary By
Provider
Funding Source
Member
Summary Data
The first page is not used until after all claims have been entered. Provides should ignore this page upon opening the form then return to the summary page to view a summary of the claims and to submit the batch of claims.
Date Claims Received
07/09/2023
Total Expected Disbursement
Close Batches
No
Submit Fast Service Entry


Fast Service Entry Summary
Fast Service Detail
Service Information
Pre FY 23/24 Service Details
Recovery Incentives
National Drug Codes
OHC Information
Online Documentation
Fast Service Entry Summary *
Member Name Or ...
Funding Source
Provider
Date Of Service
Procedure Code
Number Of Couns...
Group Service Units
Location
Duration (Minutes)
Billed Amount
Allowed Amount
Total Fee
No records.
Add New Item
1
Edit Selected Item
Delete Selected Item
Copy Data On Add *
2
Yes
No
Member Name Or ID *
3
Funding Source *
4
Provider *
5
Procedure Code Type *
6
CPT® Codes
Revenue Code
Contracting Provider Program
7
Performing Provider
8
Performing Provider Type
9


Service Information
Select Dates Option
Single Date
10
Multiple Dates
Date Of Service *
11
Date of Service (End)
Procedure Code *
12
Total Charge *
13
Service Units *
14
Location
15
Duration (Minutes)
16
Process Report
Authorization Number *
17
Display Valid Authorizations
Exclude Weekends
18
Yes
No
From Date
19
Through Date
20
Select Dates
All | Clear
21
Create Service(s) For Selected Dates
22
Does This Service Represent An Admission
No
23



Providers should immediately select the Fast Service Detail section to begin entering claims. Once on the above page, follow these steps to enter services:

Step #	*Field Name*	*Description*
1.	**Add New Item**	This must be selected prior before entering any data. This conveys to the system which row to input the data. To enter a new claim, users must always click Add New Item.
2.	**Copy Data on Add – automatically defaults to Yes**	This is used to copy the previous service information. Selecting **Yes** will copy all the relevant values to the next row of data if entering similar claims for a patient. Selecting **No** will leave all the fields blank to start a new patient's claim.
3.	**Member Name or ID**	Enter the PATID or Last Name, First for the patient.
4.	**Funding Source**	Enter the funding source name or corresponding number code as either Drug Medi-Cal (3) or Non-Drug Medi-Cal (4)
5.	**Provider**	Enter the PROVID or Legal Entity name
6.	**Procedure Code Type**	This is automatically defaults to CPT and cannot be changed as revenue codes are not available using this form.
7.	**Contracting Provider Program**	Enter the program name and address where the service was delivered. Can be entered in the search field or selected in the drop-down menu.
8.	**Performing Provider**	Enter the performing provider name of the person who delivered the service. Can be entered in the search field or selected in the drop-down menu.
9.	**Performing Provider Type**	This corresponds to the credential of the performing provider selected. This will no longer be limited to the 4 categories but will now match the specific credential/license of the provider.
Service Date(s)		

10.	**Select Dates Option**	**Single Date:** Use to enter single service information when service is a distinct service and does not need to be duplicated for with additional dates (such as for day rate claims). **Multiple Dates:** Use to enter multiple dates in a date range where the same services were provided across a date range. This would be used to bill residential day rates or Recovery Bridget Housing (RBH) when the service is identical for the date range. When multiple dates are selected, the fields to the right are enabled and become required.
11.	**Date of Service**	Enter the date of service.
12.	**Procedure Code**	Enter the Procedure Code for the service. This can either be the name of the service code or the actual code, such as Group Counseling or H0005U7. *Quick Tip: the colon in the code is not required.*
13.	**Total Charge**	Enter the total charge for the service. ***IMPORTANT TIP:*** *Total Charge is a manual field in PCNX. If amounts entered in this field are different than the expected disbursement or Fee Table Amount, an adjustment will be added to the approved claim. The service will still be approved; however, it will have an approval notice of "Limited by Total Charge." If the Total Charge is lower than the Expected Disbursement/Fee Table Amount then the provider will be paid at the Total Charge rate. If the Total Charge is higher than the Expected Disbursement/Fee Table Amount then service will be paid at the Expected Disbursement/Fee Table Amount.* *Typically in medical billing the Total Charge is manually entered by the provider of the service and is required for OHC claims which may have different total charges and so that providers are able to adjust the total charge.* *To ensure accuracy of reports and claims, it is recommended to modify the Total Charge to match either field once they are populated with an approved amount before submitting the claim. Matching the Expected Disbursement fields will reconcile including OHC subtractions, where matching the fee table will reconcile with the total charge excluding OHC.* *Additionally, if the expected disbursement is lower than expected, it is likely due to the total charge being lower than the fee table amount and should be adjusted to match.*
14.	**Service Units**	Enter the number of units being claimed for the code.

		Tip: Service units must match the minimum and maximum units according to the Rates and Standards Matrix. *Note: Some CPT codes have a max of 1 unit but refer to longer durations or additional codes must be entered to account for the longer sessions.
15.	**Location**	Enter the name or the two-digit number code of the location type where the service was delivered. See appendix for full list of codes with corresponding numbers,
16.	**Duration**	Enter the duration of the service in minutes. This should match the CPT Code requirements. For example, if the CPT code has a maximum of 15 minutes, then the duration of the claim should be 15 minutes. The supplemental codes will add the remainder of the time for these codes.
17.	**Authorization Number**	Enter the authorization number for the service. *Tip: After all the service information is entered, clicking **Display Valid Authorizations** will list all the authorizations that match the service criteria.* Click the correct auth and it will populate to the Authorization Number field. This is the recommended method to avoid errors and ensure the correct authorization is chosen. Clicking **Process Report** will populate a report of all valid authorizations for the service criteria which can be entered manually. This report only lists the auth number and dates of the available authorization, but not the levels of care or program.

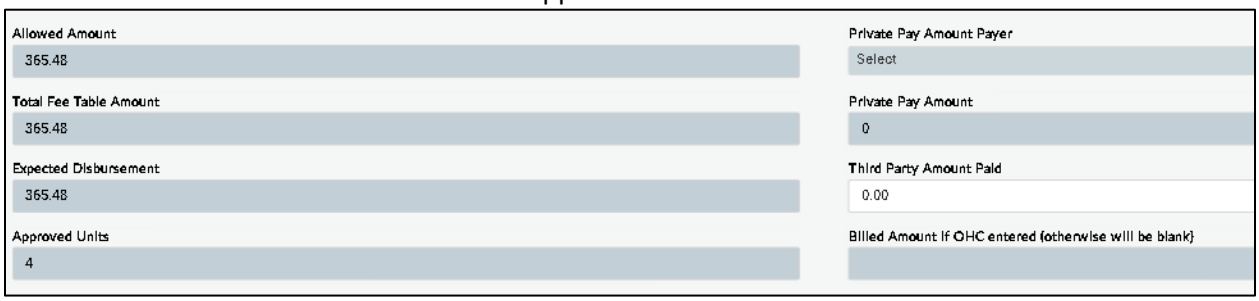
Multiple Dates/Date Range Entry:

If Multiple Dates are selected in step 10, these fields are required.		
18.	**Exclude Weekends**	Selecting **Yes** will exclude weekends from the list of dates to bill within the date range entered. Typically, weekends should be included in residential or RBH claims. Selecting **No** will include weekend dates.
19.	**From Date**	Enter the begin date of the date range for the services.
20.	**Through Date**	Enter the end date of the date range for the services then click tab or click inside the Select Dates box to populate dates to select.
21.	**Select Dates**	This will display all dates within the range entered. Users can choose which dates correspond to the services if they are not sequential or click **All** to select all dates listed. **Note: Ctrl A or Ctrl D do not work within the box to select or deselect the dates.*

22.	**Create Service(s) for Selected Dates**	This MUST be clicked to create the actual claims for the dates selected based on the service information entered. *Skipping this step will result in the services not being claimed.* When this button is clicked, it will automatically create new rows for each date in the summary table on the top of this page and add them to the summary information on page 1.
23.	**Does This Service Represent and Admission?**	This is a Sage specific function that SAPC does not utilize. Always select **No** even though the **Yes** option has been removed.

Fee and Rates per Service Display

The amount fields are all locked and will automatically populate if the service is approved. For denied services, the fields will remain as all 0s since this is associated with approved amounts. Use this section to validate the amounts and if the service is approved.



Field	*Description*
Allowed Amount	Total allowed amount (before adjudication) based on the contracted rate per unit. If providers enter an amount greater than the contracted amount in the Total Charge field, it will show as an approval with an adjustment to subtract the difference in charge from contracted rate.
Total Fee Table Amount	Contract rate per unit for the CPT code used in the Procedure Code field.
Expected Disbursement	The approved amount expected to be paid for the service.
Approved Units	If the service is approved then the approved units will display here.
Private Pay Amount Payer	For OHC claims only: automatically populated from the OHC information entered under **Enter Third Party Adjudication Data**.
Private Pay Amount	For OHC claims only: automatically populated from the OHC information entered under **Enter Third Party Adjudication Data**.
Third Party Amount Paid	For OHC claims only: automatically populated from the OHC information entered under **Enter Third Party Adjudication Data**.
Billed Amount if OHC entered (Otherwise will be blank)	For OHC claims only: automatically calculated to subtract any OHC payments from the total charge as shown on the **Enter Third Party Adjudication Data** section.

Group Services: Prior to Fiscal Year 2023-2024 (Dates of Service through 6/30/2023)

With the implementation of CalAIM and Payment Reform requirements, from the Department of Health Care Services (DHCS), many procedures codes were reconfigured to comply with the new polices. Additionally, if the same code exists for services pre- and post-payment reform then the code cannot be configured multiple ways in Sage. This is primarily seen with group billing codes where the same code is being used in two different manners As such, billing for group services for dates of service through 6/30/2023 will depend on if the same code with modifiers is being used pre- and post-payment reform. Codes that have crossed fiscal years, will be billed differently than codes with modifiers that are no longer being used. There are two paths for billing these services.

Billing Method for "Alcohol and/or drug services; group counseling" by 15 minutes

1. Any group service with the CPT nomenclature of "Alcohol and/or drug services; group counseling" by 15 minutes must be billed as an individual service. The specific codes impacted for FY 22-23 are
    a. H0005:U7
    b. H0005:U7:SC

These codes will be billed as individual services; however, they will require a manual calculation of the group calculation before entering the service on the form. Providers will need to mimic the same calculation that is currently automated in ProviderConnect classic and manually enter the information into Fast Service Entry Submission fields.

The calculation that will be required is:

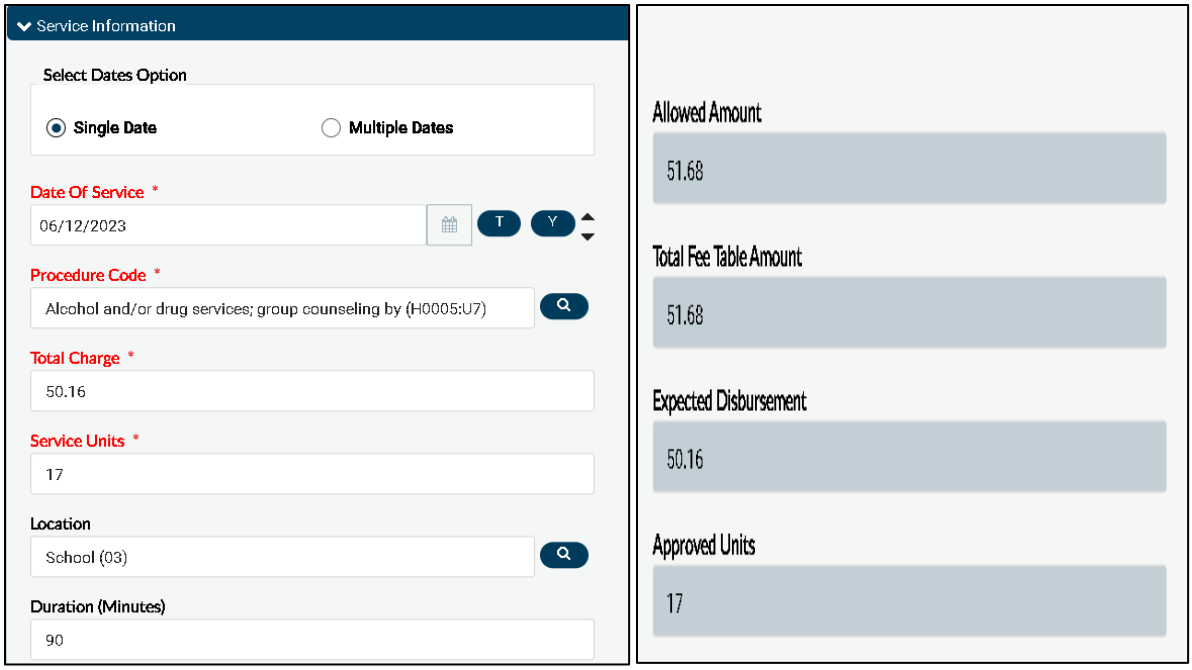
Total Charge:
(Group Duration (in minutes) **+** Documentation time (15, 30, or 45 minutes) **+** Travel Time (up to 30 minutes)**/** # of Group Participants) **x** per minute rate = Total Charge

Example: 90 minute group with 10 participants delivered at an approved field based site 30 minute of travel time and 45 minutes of documentation:

((90+45+30)/10)*3.04 for ASAM 1.0 = 17 service units and total charge of $50.16

Service Units:
(Group Duration (in minutes) **+** Documentation time (15, 30, or 45 minutes) **+** Travel Time (up to 30 minutes**)/** # of Group Participants) = Service Units (always round up for these codes two codes only). Service units must be rounded up for H0005:U7 and H0005:U7:SC as these codes do not allow fractional units per CalAIM.

The Allowed Amount will be higher than the charged amount because of the billing workaround and manual calculation. However, the system will pay out the amount entered in the Total Charge.



Pre FY23-24 Service Details- This section is only enabled for dates of service through 6/30/2023 and will not be available for services beyond that per Payment Reform billing rules. The following specific codes will enable and require this section to be completed:

Step #	*Field*	*Description*
24.	**Number of Client in Group (Pre FY 23-24)**	This field will be enabled for H0005:XX codes with the naming convention "Group Counseling." Enter the number clients in the group.
25.	**Number of Counselors In Group (Pre FY 23-24)**	This field will be enabled for H0005:XX codes with the naming convention "Group Counseling." Enter the number of counselors in the group.
26.	**Client Documentation Time (Pre FY 23-24)**	Enter the appropriate documentation time based on the Rate Matrix for the appropriate FY.

Group Services for FY 23-24 and Later:

All group counseling services H0005:XX and group codes where the HQ modifier is used for FY 23-24 will be billed the same as individual services with the full fees associated. The State has adjusted the published rates to reflect the group services calculation of each service divided by 4.5.

This group would have been reimbursed pre CalAIM/Payment Reform at a rate of $31.92 per participant for a total group reimbursement of $319.20. While the new method of calculating group reimbursement is slightly more complicated to reconcile, it results in greater disbursement per group.

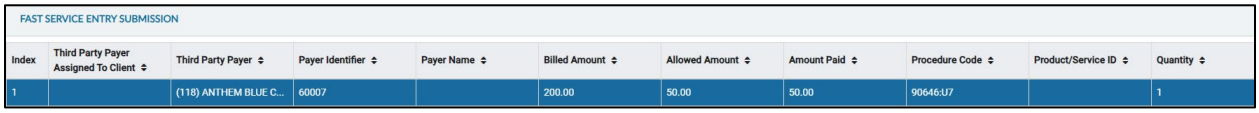
Recovery Incentives Diagnosis:

Recovery Incentives Section		
1.	**Diagnosis**	If billing for Recovery Incentives Program, enter the approved Stimulant Use Disorder diagnosis in this field.

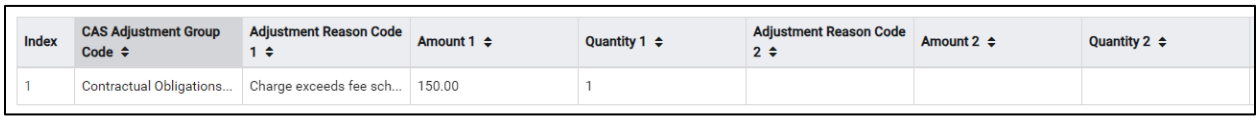
		This field must remain blank for all other services outside of Recovery Incentive Program.

Other Healthcare Coverage:

OHC guarantor information



Denial information



OHC Information (Only required if needing to report OHC claim and service data)		
1.	**Co-Pay Counts Towards Deductible**	If patient has a Co-Pay, then select Yes. If there is no Co-Pay, then select **No**. Most services should be No.
2.	**Enter Third Party Adjudication Data button** Enter Third Party Adjudication Data	This is required to report OHC information for the claim. When this button is clicked, it opens a new table to enter all the relevant OHC information and matches the same fields within PCON classic that providers use to enter OHC.
		Other Health Coverage Provider Billing Manual. Only enter information in the following fields, all other fields can remain blank. These are the same fields that were required in PCON classic. There is no changed to required information in PCNX: ***NOTE: New Row**: Always select new row before entering any new data.* After entering data in each box, users should press the Tab or Enter Key on the keyboard to record the entry.

Third Party Payer (search bar selection)	Type the name of the carrier and select from the results. If the carrier name does not populate, submit a helpdesk ticket to enter a new guarantor for OHC.
Payer Identifier	This is the alphanumeric code assigned to each payer. Free text field.
Billed Amount	Enter the amount billed to the OHC.
Allowed Amount	Enter the rate per unit from the OHC.
Amount Paid	Enter the amount the OHC reimbursed. Could be a

		partial amount or for denials, this would be 0.
		Procedure Code: Enter the procedure code billed.
		Quantity #: This should always be 1.

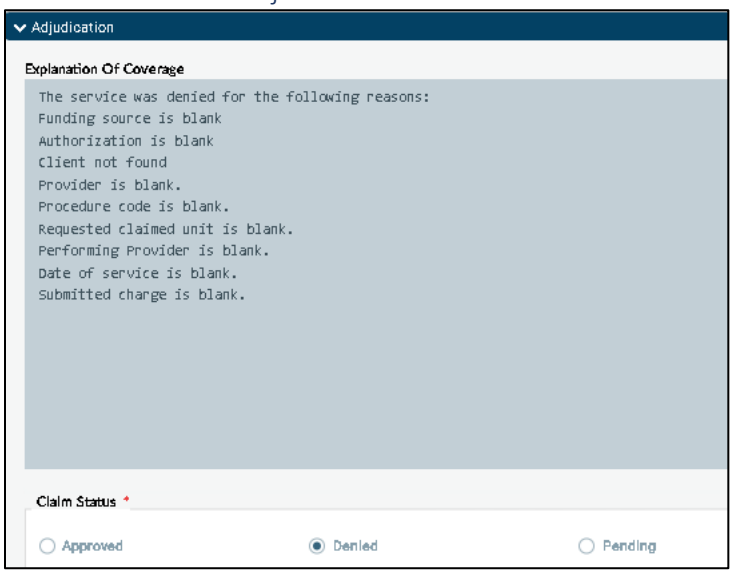
View

Once page 1 has been completed, scroll to the right to click the View button to enter the CAS information.
Note: Always select New Row before entering new information.

CAS Adjustment Group Code	Enter either OA, PR, PI or CO and click tab or enter.
Adjustment Reason Code	Enter the denial reason code from the OHC.
Amount	Enter the amount denied by the OHC.
Quantity	This should always be 1.

After all the information is entered, make sure to click Save for each section. There are two save buttons that providers must click to officially submit the OHC information.
The first screen of the Third-Party Adjudication saves claim level information and the second screen from the View button saves s the service level information. Both must be saved.

Real-Time Service Adjudication:



At the bottom of the Fast Service Details page, there is a real-time service adjudication display that is updated with each addition or change in the service details. When no data is entered, it shows all the

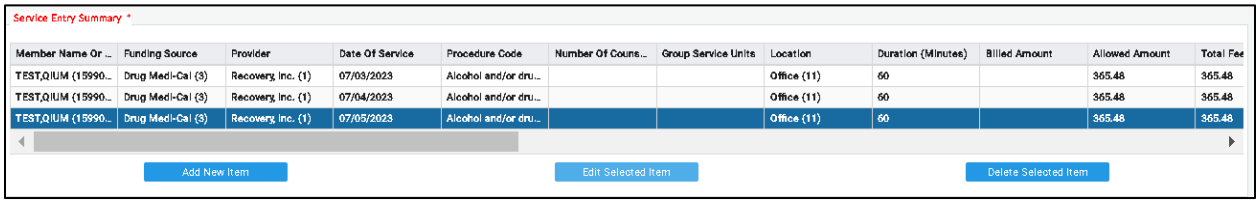
potential denials as seen above. As data is entered, the applicable denials will be removed until the service is approved.

The Explanation of Coverage shows all the potential denial reasons, while the Claim Status shows the claim status if the service was submitted without any corrections. Denied services will show on the Service Entry Summary table at the top of the screen. SAPC recommends removing any services from the claim batch that are showing denied if those denials cannot be corrected. Providers should submit a helpdesk ticket if unable to identify the reason for the denial.

Service Entry Summary:

When all services have been entered, providers should check the Service Entry Summary table to validate the services have all been approved and there are no missing fields or blank rows.

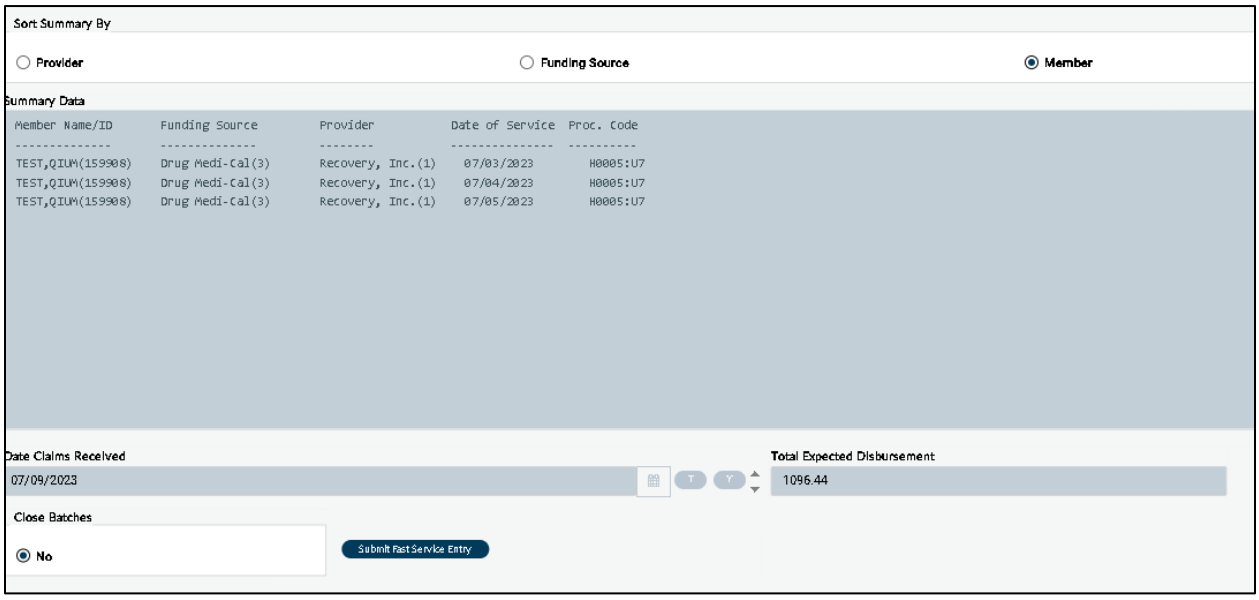
Providers can scroll through the table to verify that each service has the correct information entered and there is an expected disbursement amount. If the service was approved and has a fee associated to it, the Allowed Amount, Total Fee Table Amount and Expected Disbursement columns should all have numbers listed.



Submit Fast Service Entry:

After all services have been validated and are ready to submit, providers must return to the first section of the form by clicking the Fast Service Entry Summary tab on the top left menu of the form. Providers will be able to view the full summary of all the services entered in Fast Service Detail, both approved and denied.

Sort Summary/Summary Data:



The summary can be sorted by:

1. **Provider**, which will not change as this form is limited to one provider only,
2. **Funding Source** (DMC or NonDMC)
    a. Providers can enter both DMC and NonDMC claims on the same batch. The form will automatically sort them and submit them as separate batches.
3. **Member**
    a. If billing for multiple patients, then this will sort the claims by patient.

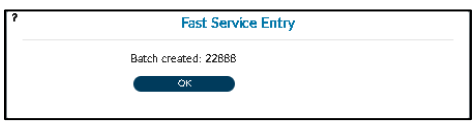
This will provide additional validation of the services being billed. Providers can verify the correct number of services will be submitted by clicking the notepad icon on the right side of the Summary Data table  , copying all the rows and pasting into Excel to verify the count of services. Additionally, providers should check the Total Expected Disbursement field to ensure the value populated matches the what the provider is expecting to receive from internal records.

The Close Batches field has been modified to only allow providers to select “No” so that Finance can process the claims as normal.

When ready to submit the batch to SAPC, providers should click the “Submit Fast Service Entry” button at the bottom of the form.

***Note:** The **Process** button at the top of the form that normally submits forms in PCNX is permanently disabled for this particular form.*

When the batch has been successfully submitted, the user will receive a message with the batch number that was created. This number can be helpful for looking up claims later in KPI or other reports.



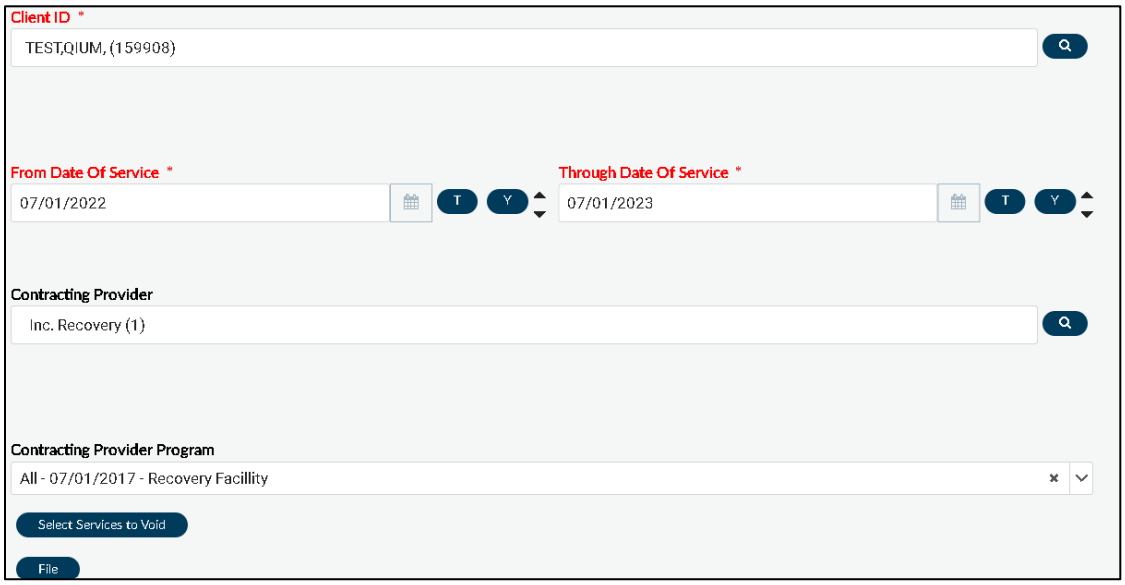
Voiding Services:

PCNX offers a new method to void submitted services that allows providers to void multiple services for a given patient at the same time, without having to switch screens per voided service.
When voiding services in PCNX, providers can enter the information per patient for a given date range, not to exceed 365 days using the Void Claim Assignment form.

Claims can only be voided once they are processed and closed by Finance. Finance closes all batches daily.

Void Claim Assignment

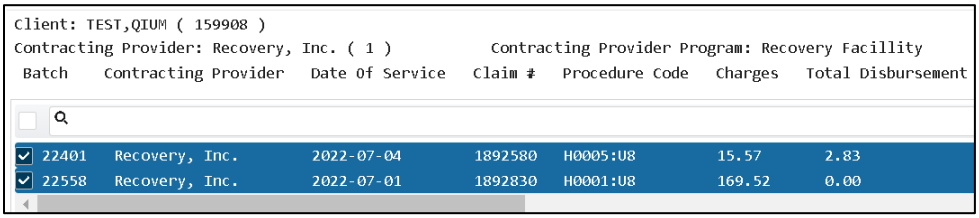
The **Void Claim Assignment form** replaces the void process from PCON classic, and allows for multiple claims to be voided per patient.



Enter all the required fields indicated by red text

1. Client ID
2. From Date of Service
3. Through Date of Service
4. Contracting Provider: prepopulated and cannot be changed
5. Contracting Provider Program: optional to narrow down the results further

   Click “Select Services to Void” button for a list of services meeting the entered criteria
   a. Select the check box next to the row to flag the claim for voiding.
   b. Clicking the check box on top next to the search bar will select/deselect all rows.



6. Click File when done selecting voids for that patient.
7. Once filed, providers can enter a new patient to continue voiding other claims if needed.

Finance Related Reports:

Report Name	Description
Provider Services Summary Report	Mimics the current Provider Billing Summary report. Provides a summary of services billed by desired date range (date of service or submission date), grouped by program.
Provider Services Detail Report	Mimics the current Provider Billing Details report. Provides a detail of services billed by desired date range (date of service or submission date), grouped by program.
Check/EFT Number Report	Same as the current Check/EFT report. Lists each selected EFT/Check number and all EOBs with services associated to that check/eft.
Provider EOB Remittance Advice	Gives providers direct access to all EOBs in Sage exactly in the same format that are sent on the SFTP.
Provider Activity Report	Replicated in PCNX to give providers a spreadsheet of all finalized BIRP/SIRP/GIRP/SOAP and Misc. Notes with necessary billing information for billers to input on the Fast Service Entry Submission form.
Progress Note Status Report	New report based off the new “Progress Note” form that will be available in PCNX. This report will replace the Provider Activity Report.

Additional reports are in the process of being configured to ensure HIPAA compliance. Once ready they will be made available to the network.