Washington State Health Care Authority

Medicaid Billing Workshop for Medical Providers

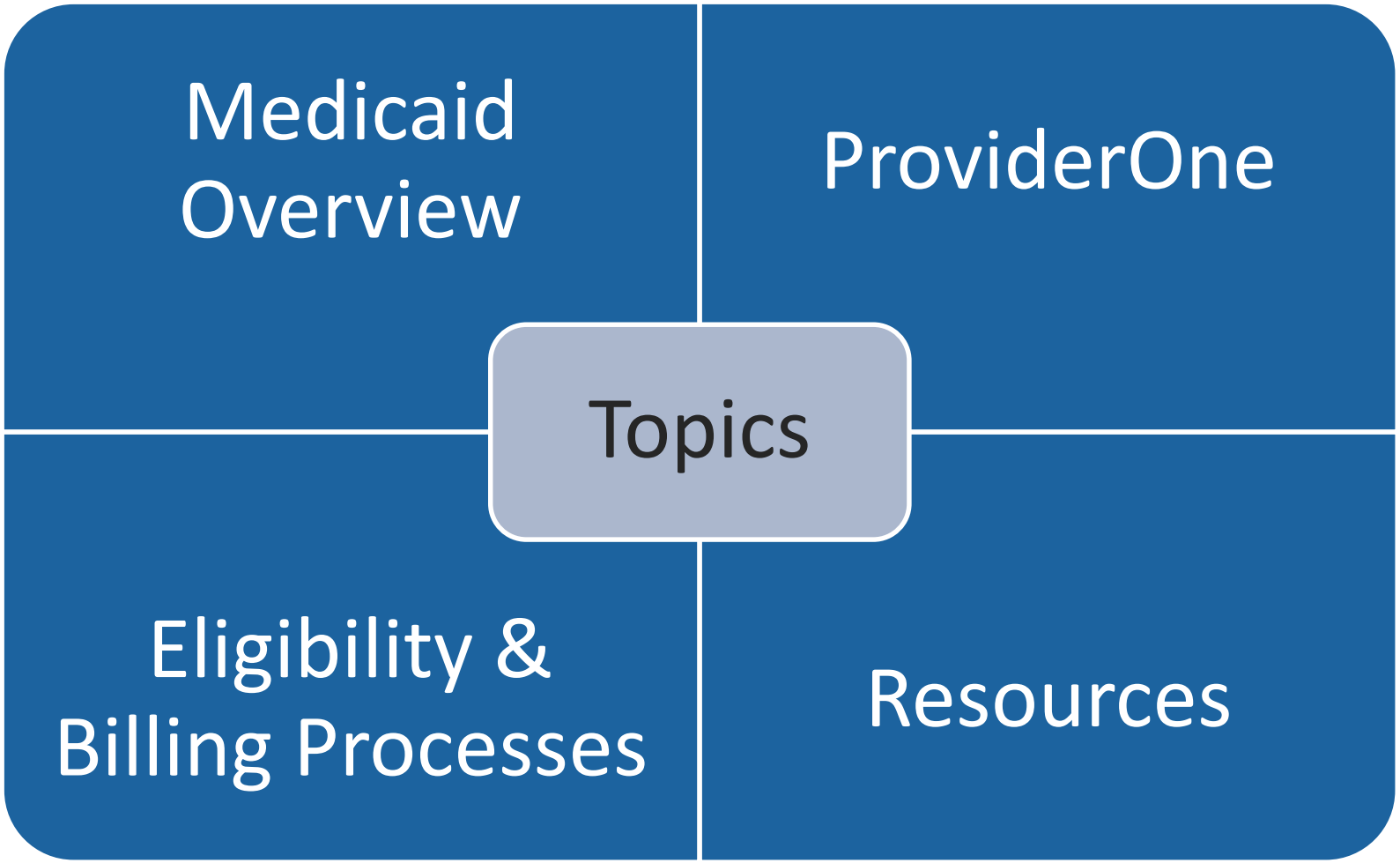
Provider Relations Unit
2017

Washington State Health Care Authority

Who is Provider Relations and what do we do?

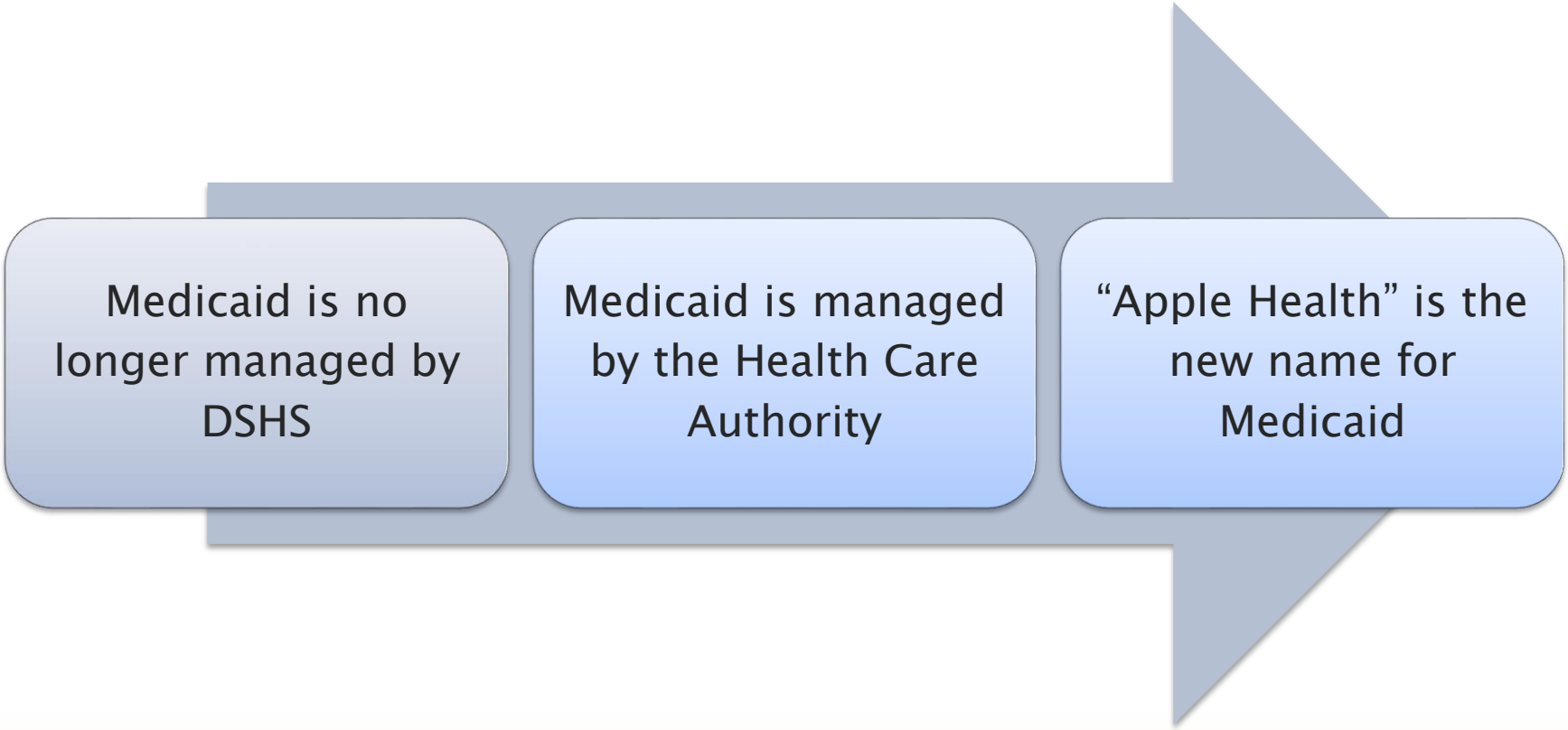
- Provide outreach and training for Washington Apple Health (Medicaid) providers
- Specialize in the use of the ProviderOne portal
- Assist with program and policy questions

Washington State Health Care Authority

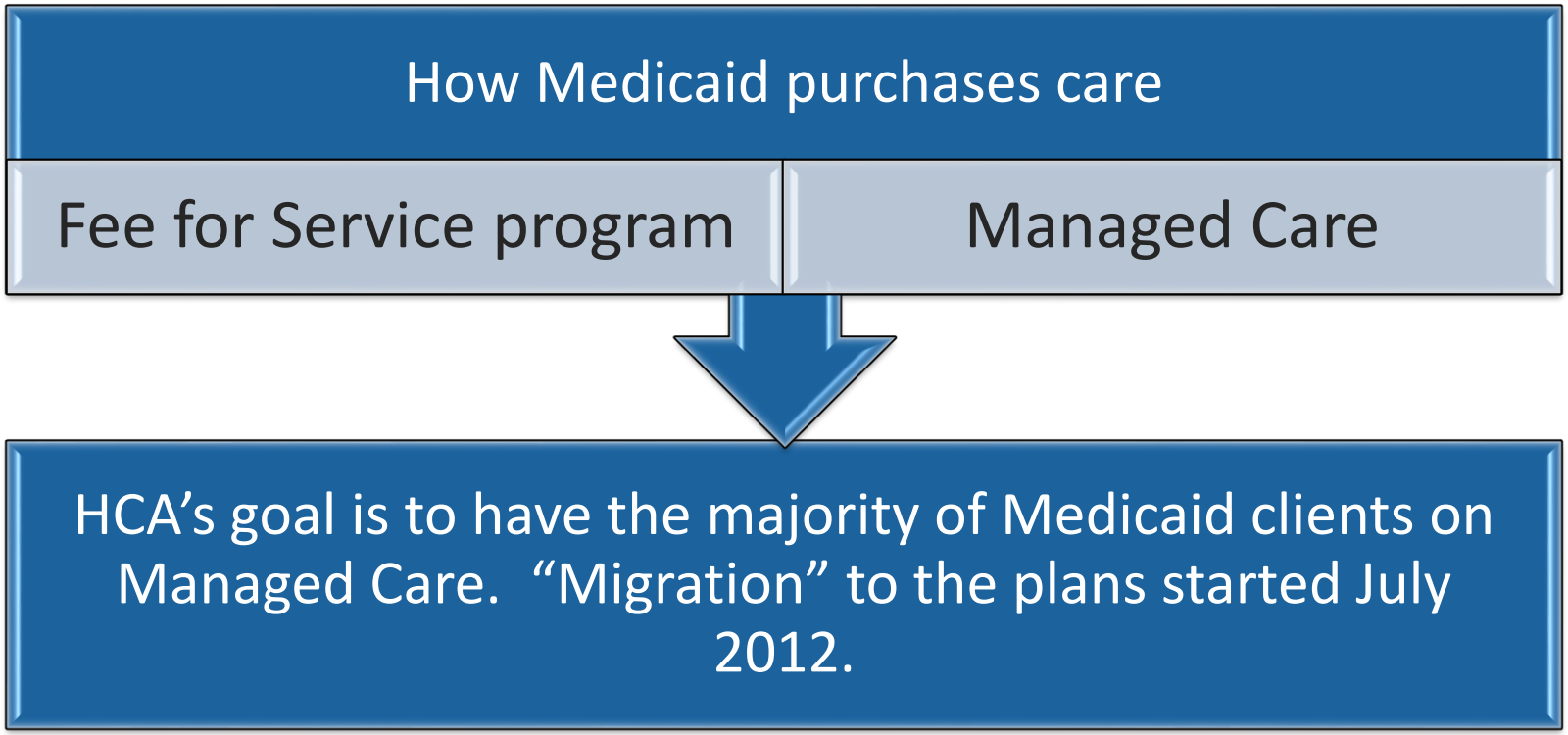


Medicaid Overview

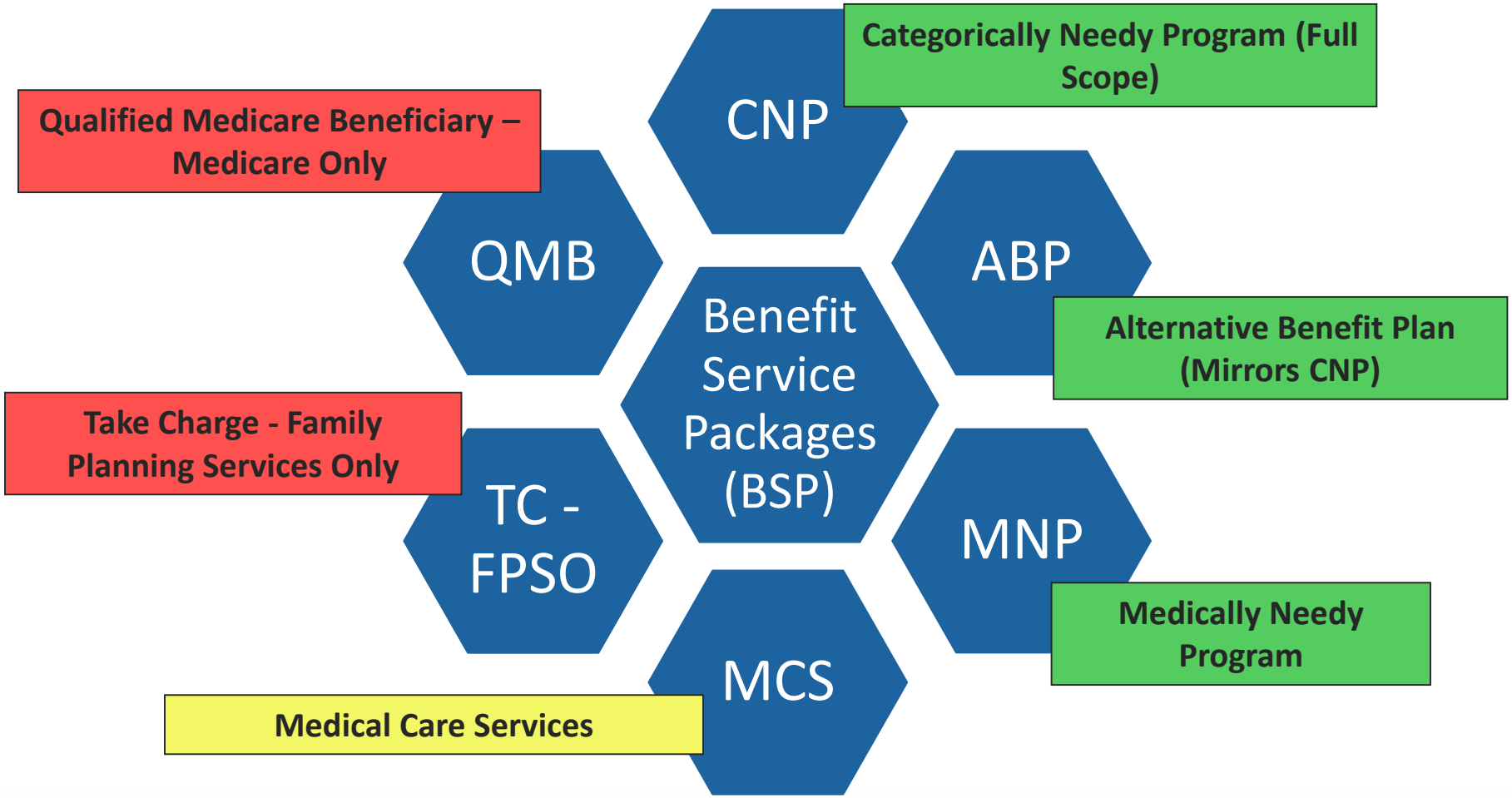
Medicaid Overview



Medicaid Overview



Eligibility Programs



For a complete listing of BSP, visit the ProviderOne Billing and Resource Guide.

Accessing ProviderOne

Accessing ProviderOne

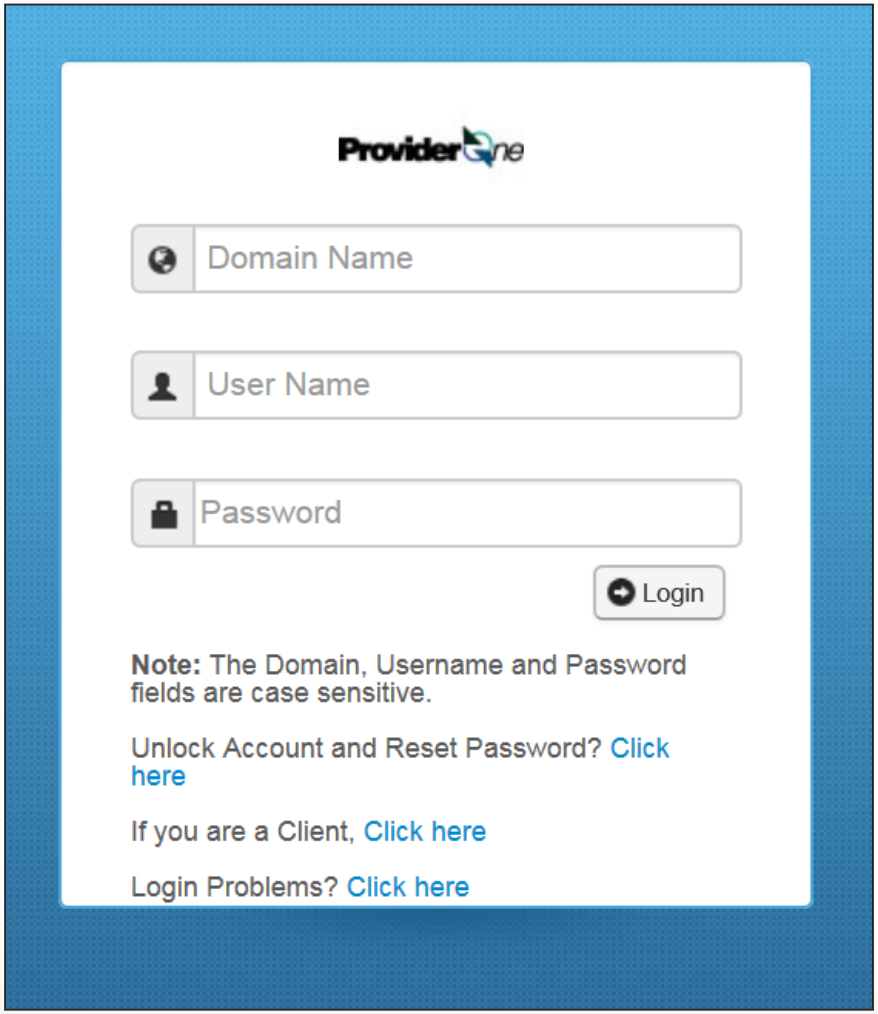
- Before logging into ProviderOne:
  - Make sure you are using one of the following and your popup blockers are turned **OFF**:

Computer operating systems	Internet browsers
Windows • 10 • 8.1 • 8 • 7	Internet Explorer • 11 • 10
Macintosh • OS 10.12 Sierra • OS X 10.11 El Capitan • OS X 10.10 Yosemite	Google Chrome • 55.0.2883 • 54.0.2840
	Firefox • 50.0.2 • 45.5.1 ESR
	Safari • 10.0.1

Washington State Health Care Authority

Accessing ProviderOne

- Use web address: https://www.waproviderone.org
- Ensure that your system **"Pop Up Blockers"** are turned **"OFF"**.
- Login using assigned Domain, Username, and Password.
- Click the **"Login"** button.



ProviderOne Users

HCA establishes System Administrators for your domain/NPI

- A System Administrator can assign profiles to other users as necessary.
- Staff can be assigned one or more security profiles to meet their job duties and provide them the level of access necessary in the system.

Visit the ProviderOne Security web page.

How to Get Access in ProviderOne

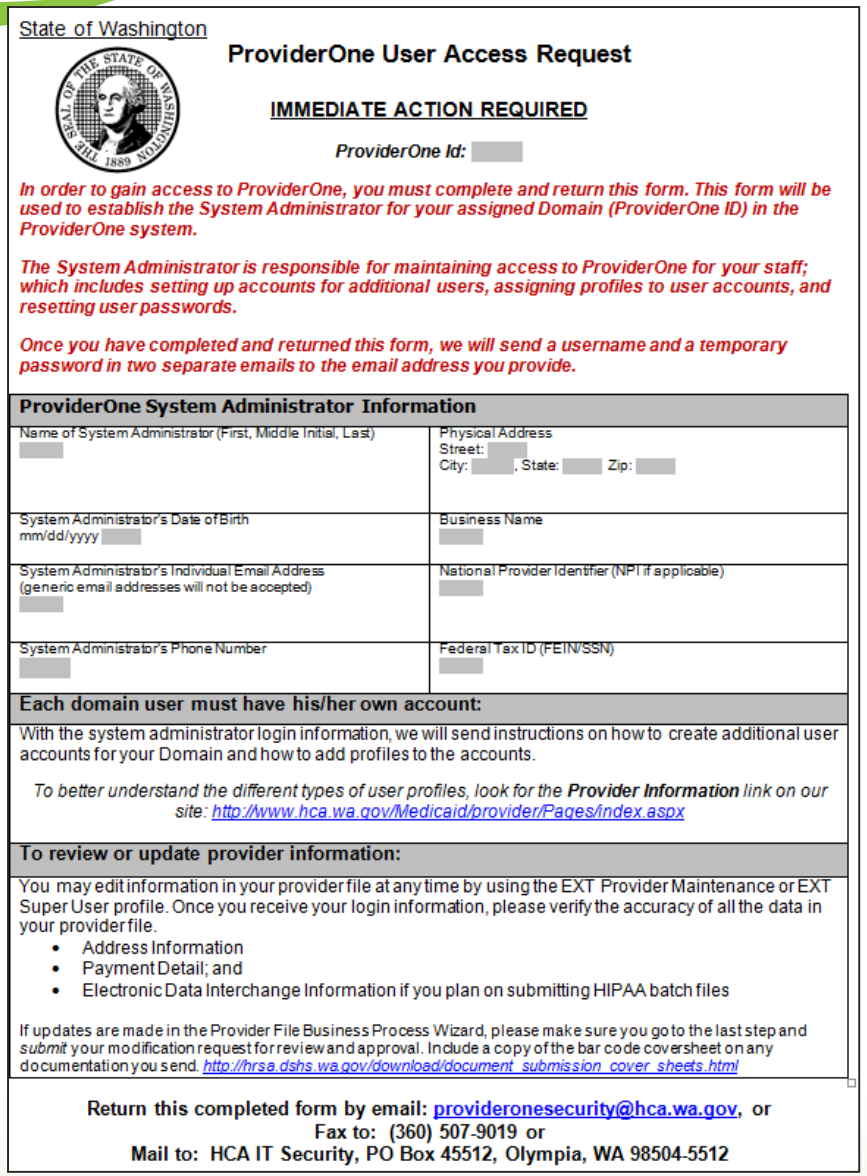
- Review the ProviderOne Security web page for detailed instructions on setting up users.

- New provider and don't have the form? Email ProviderOne Security at: provideronesecurity@hca.wa.gov (in the subject line enter "Request for ProviderOne User Access Request form").

Washington State Health Care Authority

How to Get Access in ProviderOne

- The ProviderOne User Access Request form is for a newly enrolled Facility, Clinic, Individual Provider, or a new Office Administrator.
- Complete the form and fax to: 360-507-9019.
- If changing System Administrators, a letter on office correspondence must also be completed and faxed with the form.



State of Washington

ProviderOne User Access Request

IMMEDIATE ACTION REQUIRED

ProviderOne Id:

In order to gain access to ProviderOne, you must complete and return this form. This form will be used to establish the System Administrator for your assigned Domain (ProviderOne ID) in the ProviderOne system.

The System Administrator is responsible for maintaining access to ProviderOne for your staff; which includes setting up accounts for additional users, assigning profiles to user accounts, and resetting user passwords.

Once you have completed and returned this form, we will send a username and a temporary password in two separate emails to the email address you provide.

ProviderOne System Administrator Information	
Name of System Administrator (First, Middle Initial, Last)	Physical Address Street: City: , State: Zip:
System Administrator's Date of Birth mm/dd/yyyy	Business Name
System Administrator's Individual Email Address (generic email addresses will not be accepted)	National Provider Identifier (NPI if applicable)
System Administrator's Phone Number	Federal Tax ID (FEIN/SSN)

Each domain user must have his/her own account:

With the system administrator login information, we will send instructions on how to create additional user accounts for your Domain and how to add profiles to the accounts.

*To better understand the different types of user profiles, look for the **Provider Information** link on our site: http://www.hca.wa.gov/Medicaid/provider/Pages/index.aspx*

To review or update provider information:

You may edit information in your provider file at any time by using the EXT Provider Maintenance or EXT Super User profile. Once you receive your login information, please verify the accuracy of all the data in your provider file.

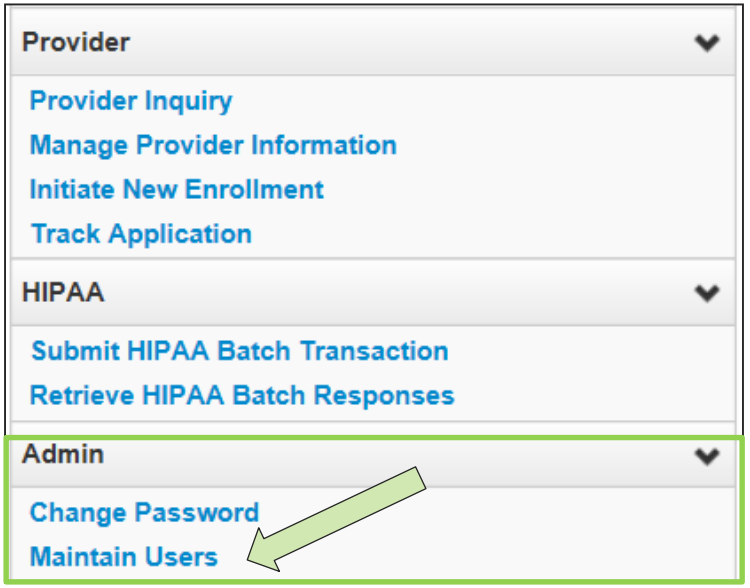
- Address Information
- Payment Detail; and
- Electronic Data Interchange Information if you plan on submitting HIPAA batch files

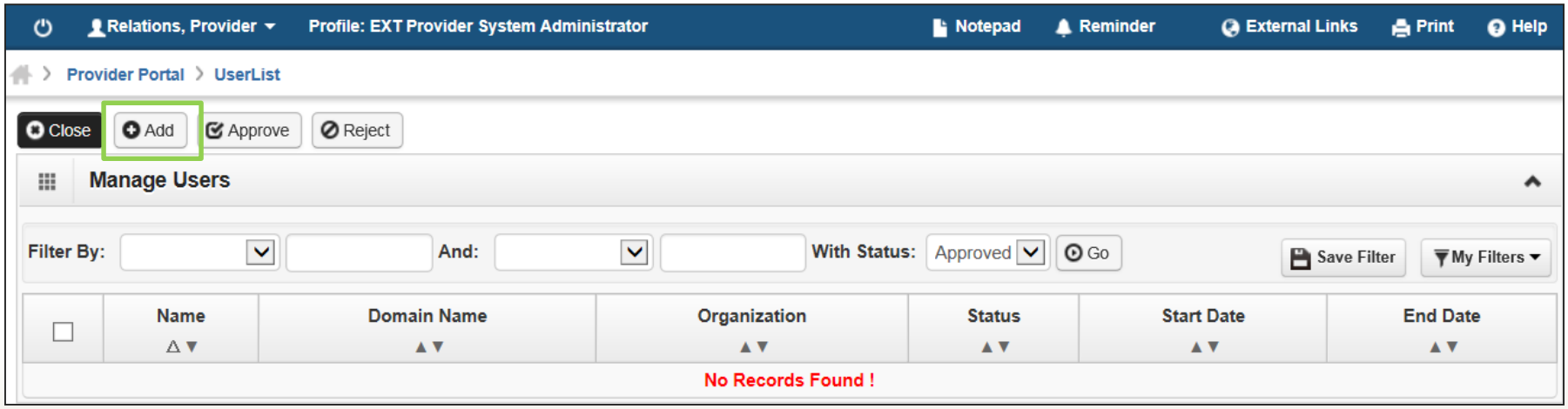
If updates are made in the Provider File Business Process Wizard, please make sure you go to the last step and *submit* your modification request for review and approval. Include a copy of the bar code coversheet on any documentation you send. *http://hrsa.dshs.wa.gov/download/document_submission_cover_sheets.html*

Return this completed form by email: provideronesecurity@hca.wa.gov, or
Fax to: (360) 507-9019 or
Mail to: HCA IT Security, PO Box 45512, Olympia, WA 98504-5512

How to Set Up a User

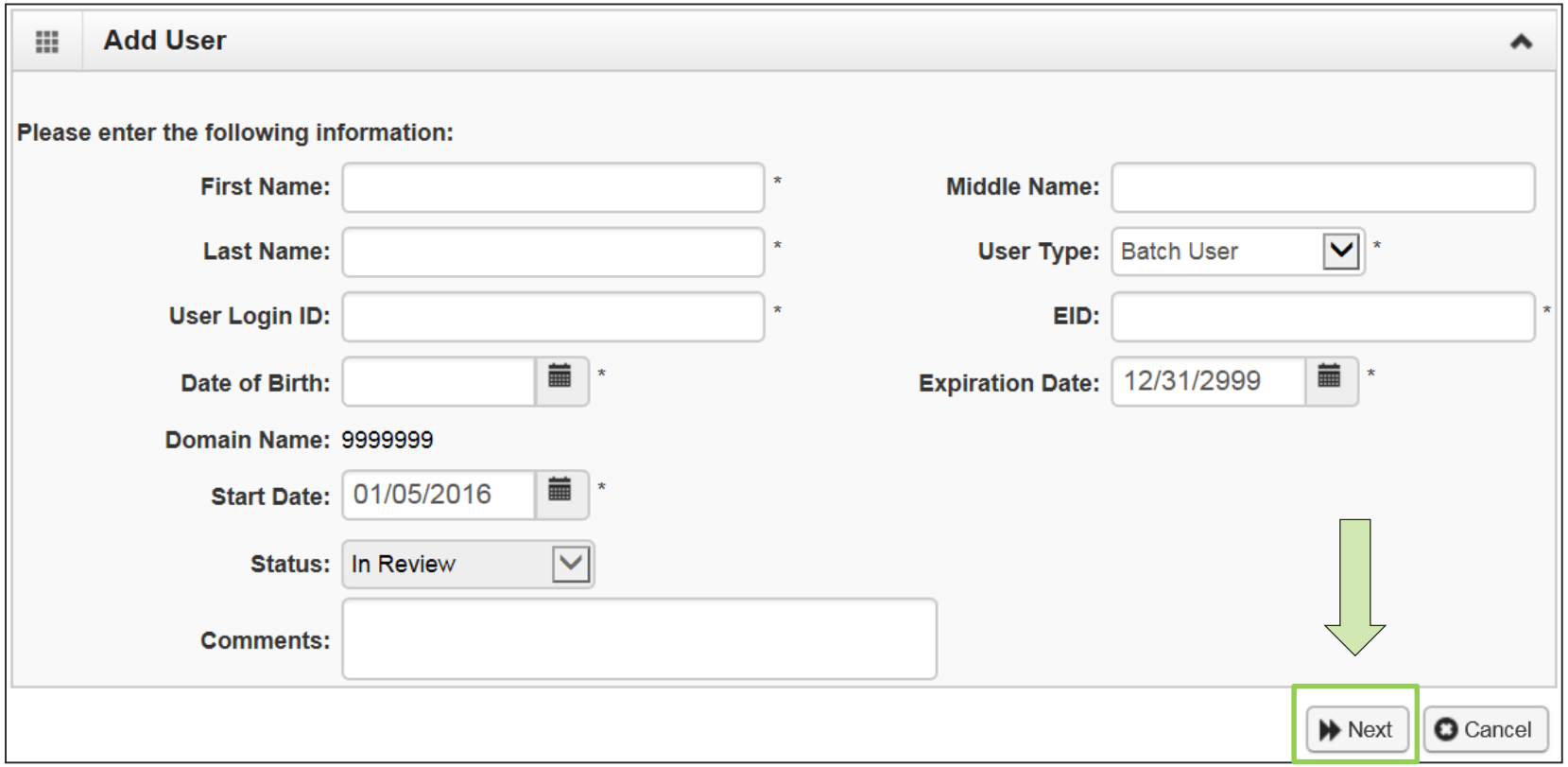
- Log in with the **System Administrator** Profile.
- Click on **Maintain Users.**
- The system now displays the User List screen.
- Click on the **Add** button.





How to Set Up a User

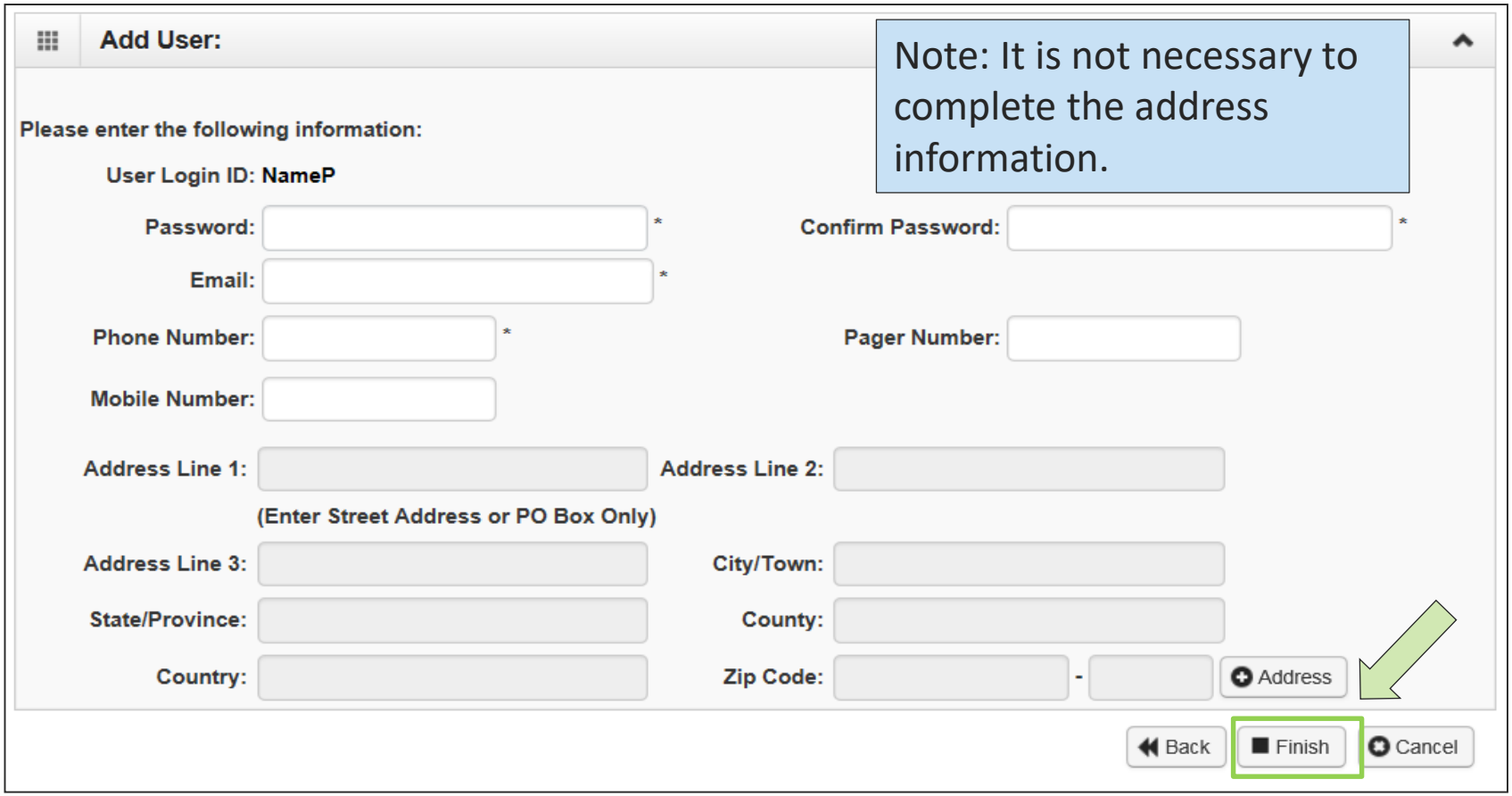
- Adding a user:



- Fill in all required boxes that have an asterisk *.
- Click the **Next** button.

How to Set Up a User

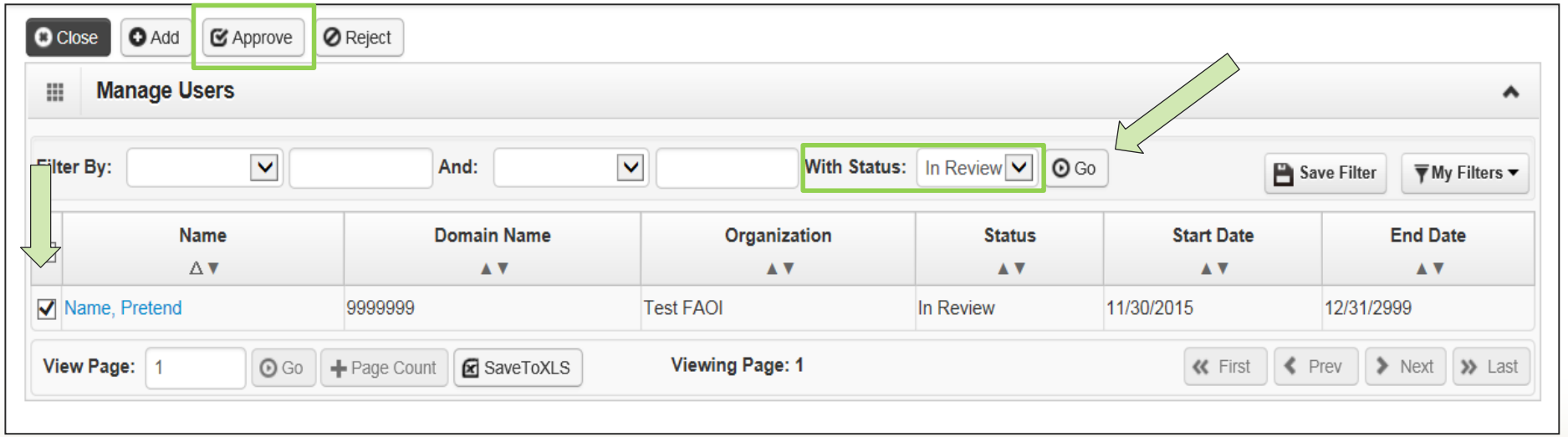
- Complete remaining required fields:



- Click the **Finish** button.

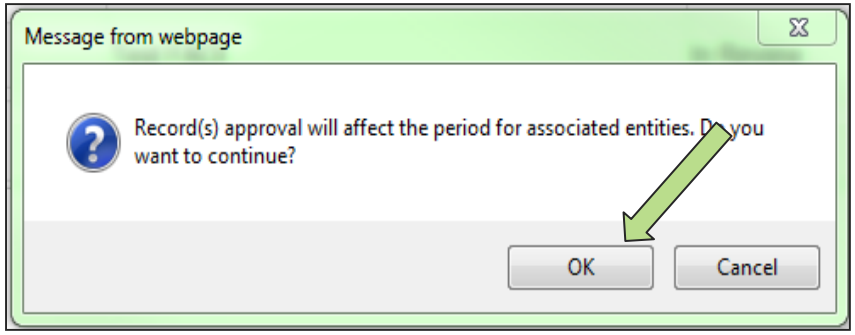
How to Set Up a User

- To display the new user:
  - In the **With Status** dropdown, select **In Review** and click **Go.**
  - The user's name is displayed with In Review status.
  - Click the box next to the user's name, then click the **Approve** button.

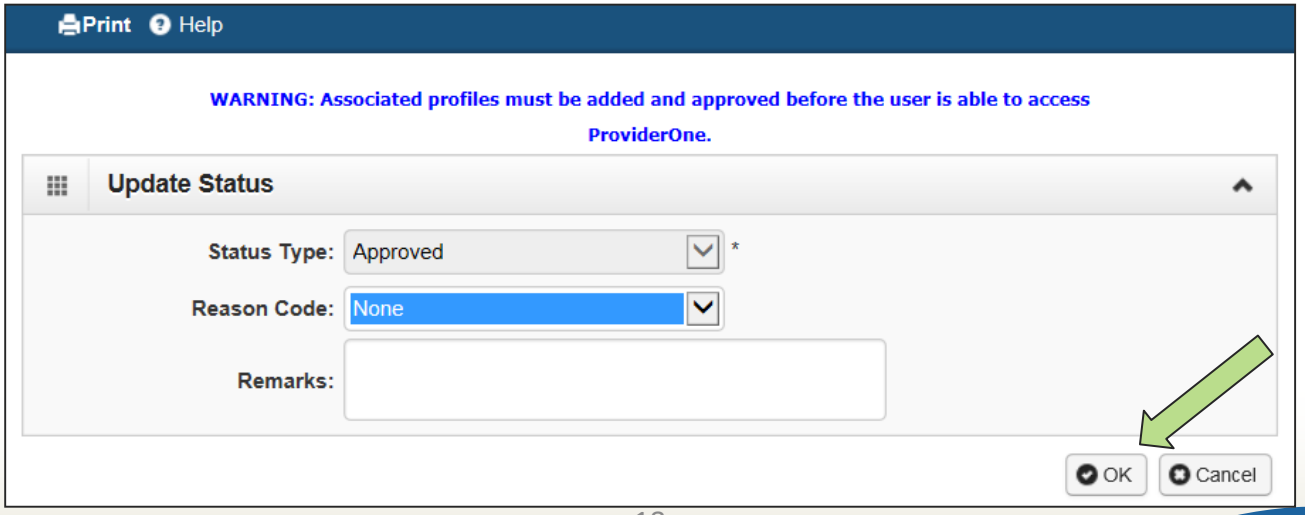


How to Set Up a User

- Once approved, a dialogue box will pop up, click **Ok.**

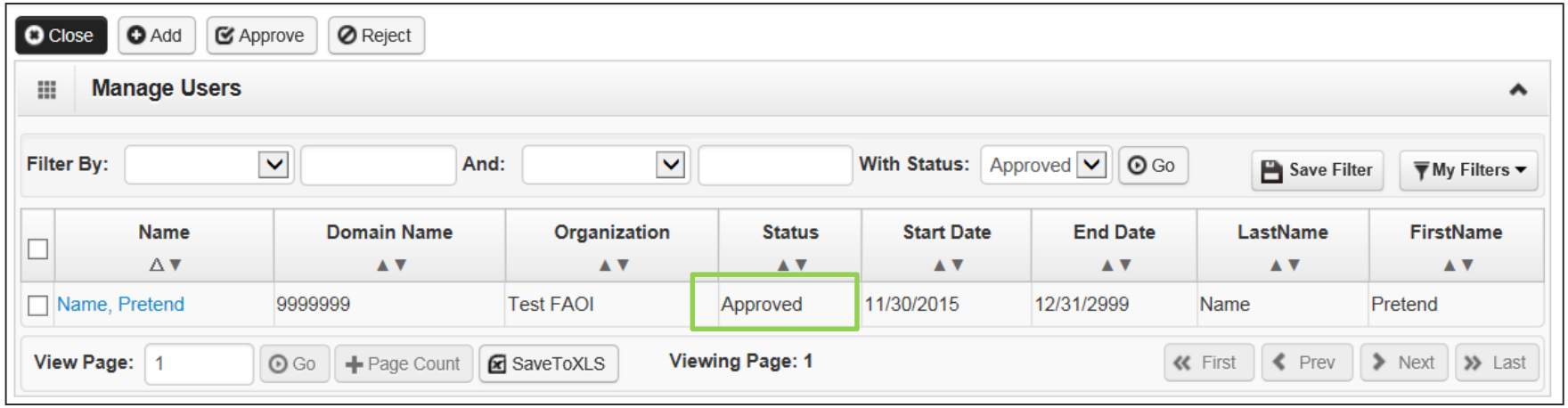


- Once clicked, another window will appear warning you that profiles must be added for this new user. Click **Ok** or **Cancel**.



How to Set Up a User

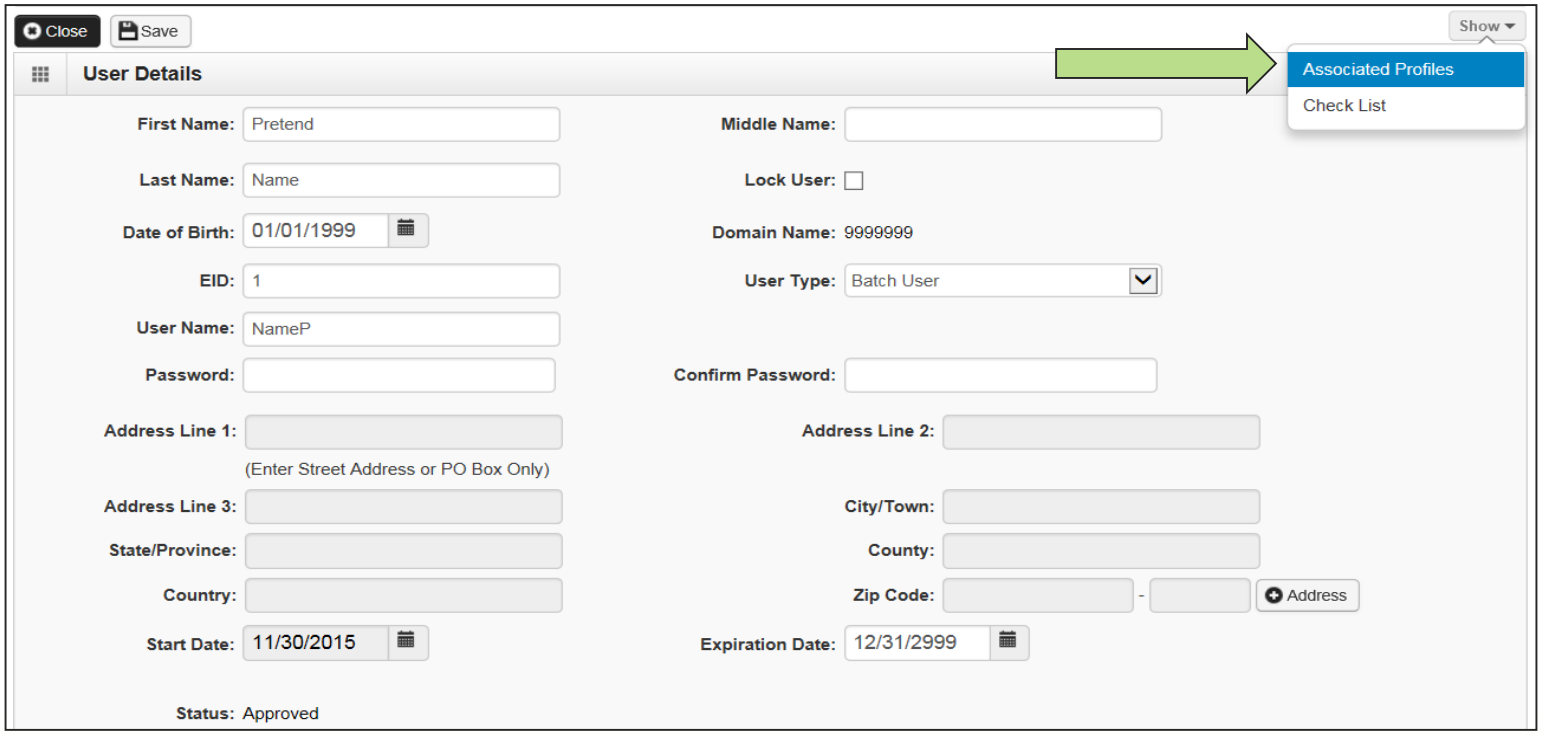
- The user is now in **Approved** status.



- Click on the **User Name** to access their user account and tell ProviderOne the functions they will perform in the system.

How to Set Up a User

- Adding Profiles:
  - Back on the User Details page, click on the **user's name** to access User Details.

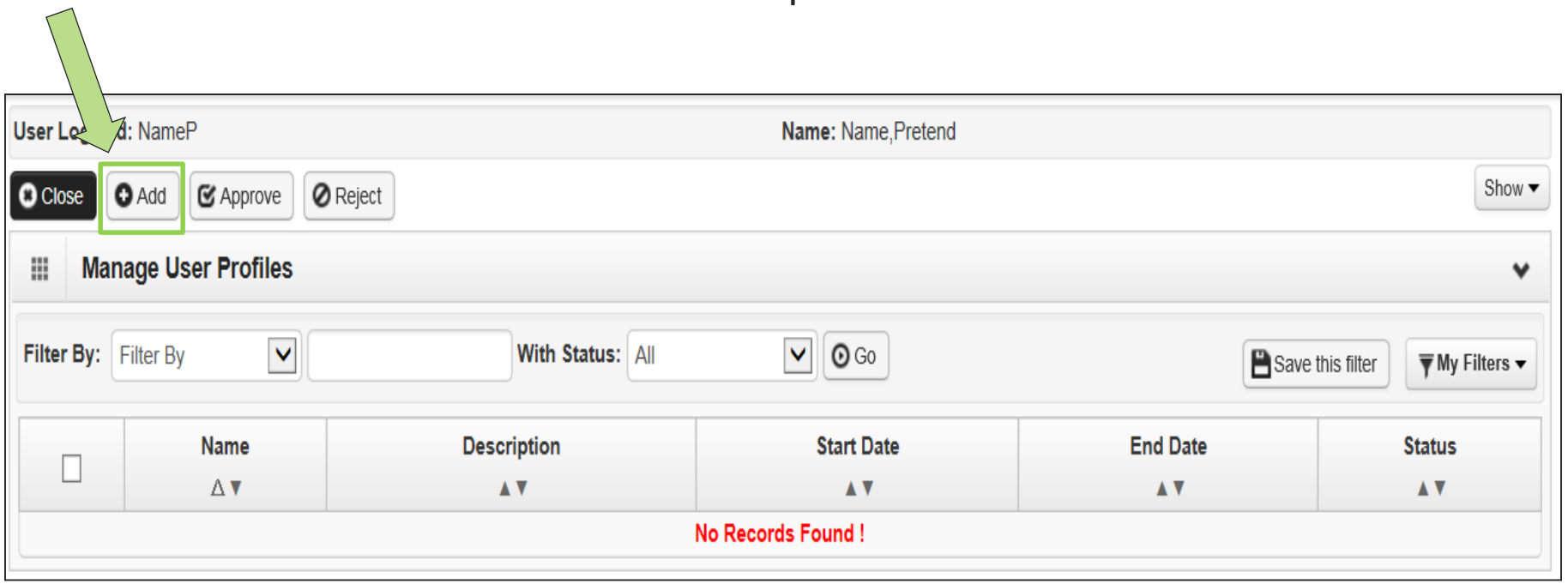


  - On the Show menu click on **Associated Profiles.**

How to Set Up a User

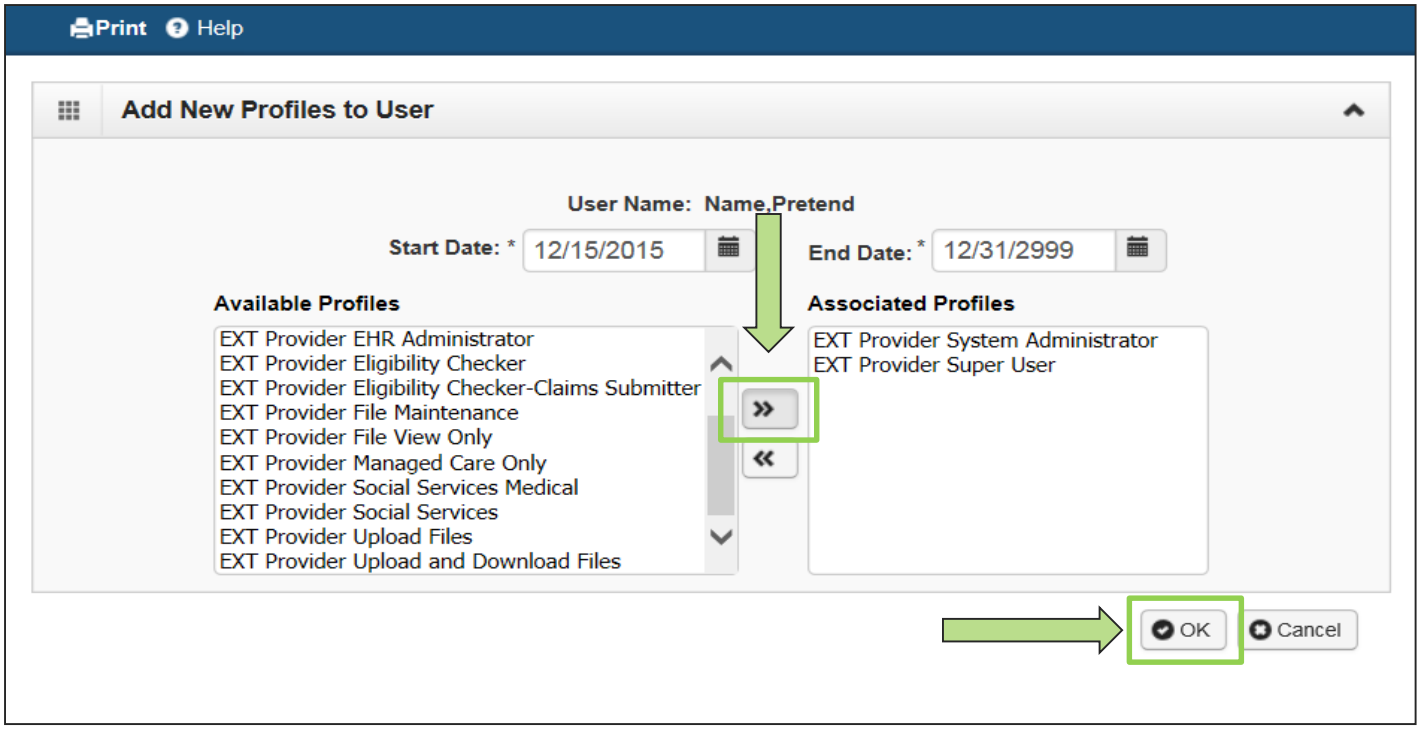
➢ Adding Profiles:

- Click on the **Add** button to select profiles.



How to Set Up a User

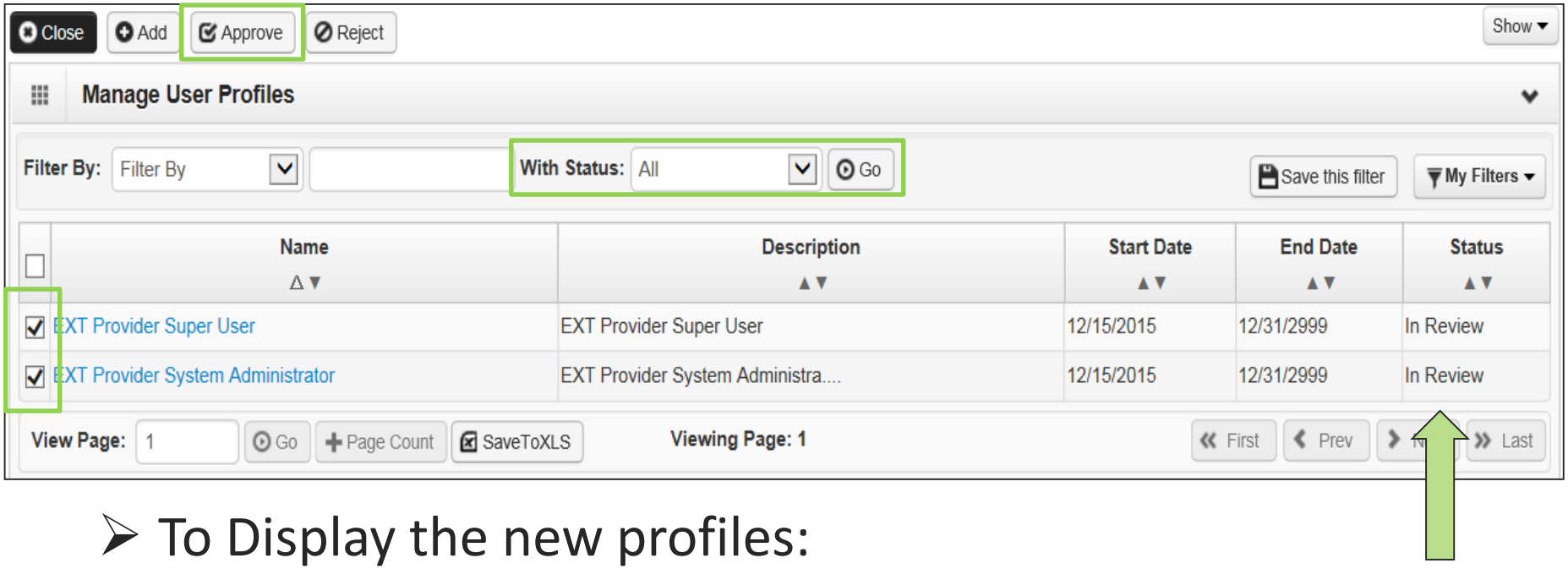
➢ Adding Profiles:



- Highlight Available Profiles desired.
- Click **double arrow button** and move to Associated Profiles box then click the **OK** button.

How to Set Up a User

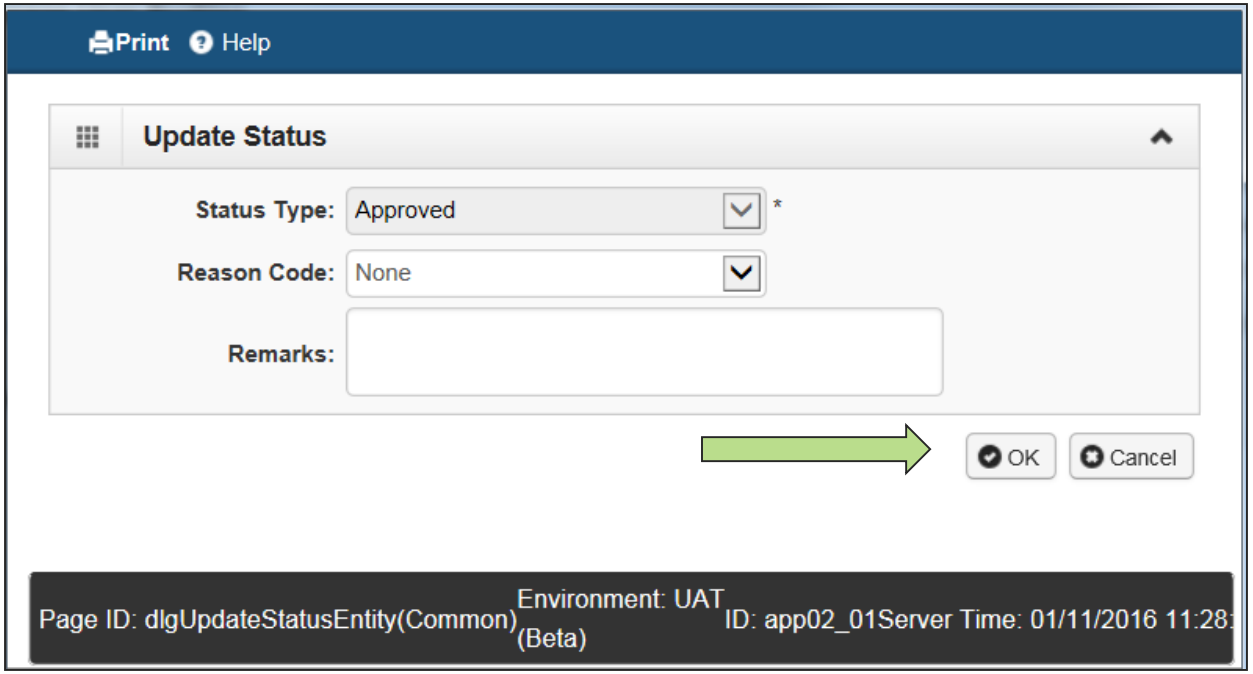
- Adding Profiles:



- To Display the new profiles:
  - The **With Status** dropdown box should state **All**. Click **Go**.
  - The profiles are displayed with **In Review** status.
  - Click the box next to the profile name, then click the **Approve** button.

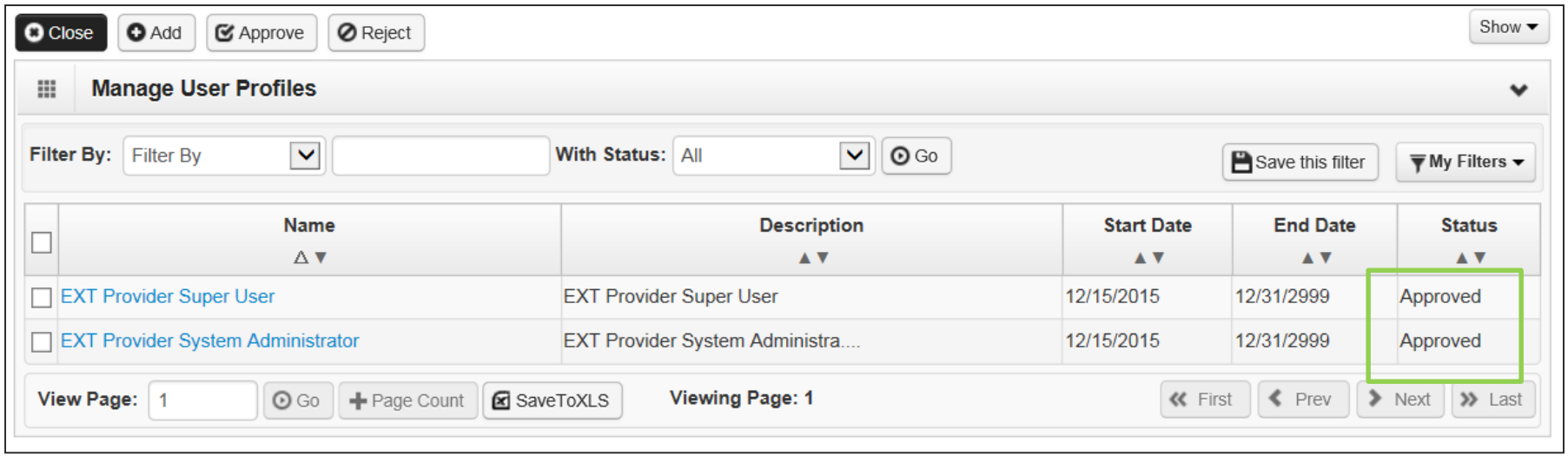
How to Set Up a User

- Once approved a dialogue box will pop up, click **Ok**.



How to Set Up a User

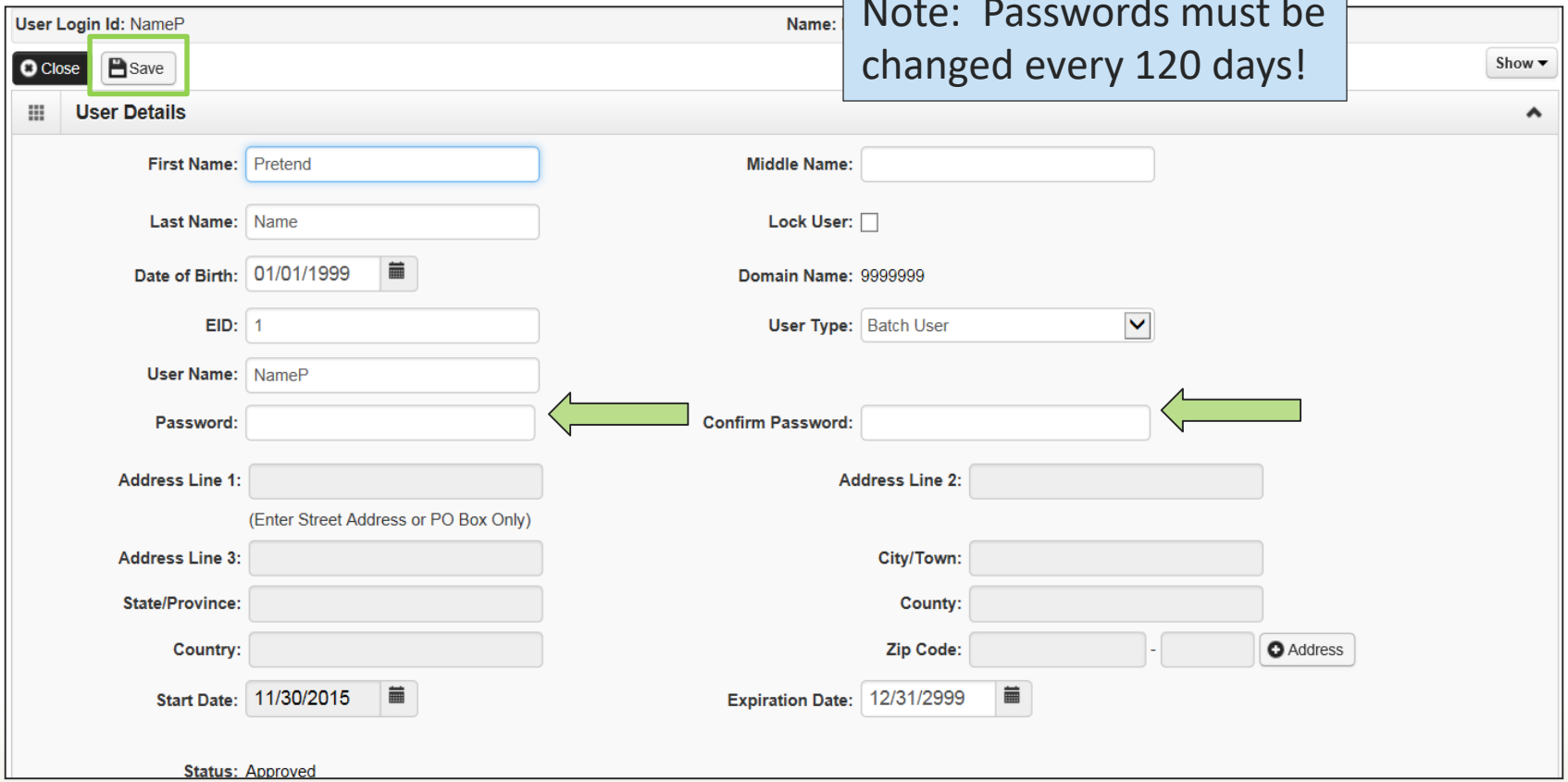
- The profile statuses are now **Approved**.



- Click **Close** to return to User Details.

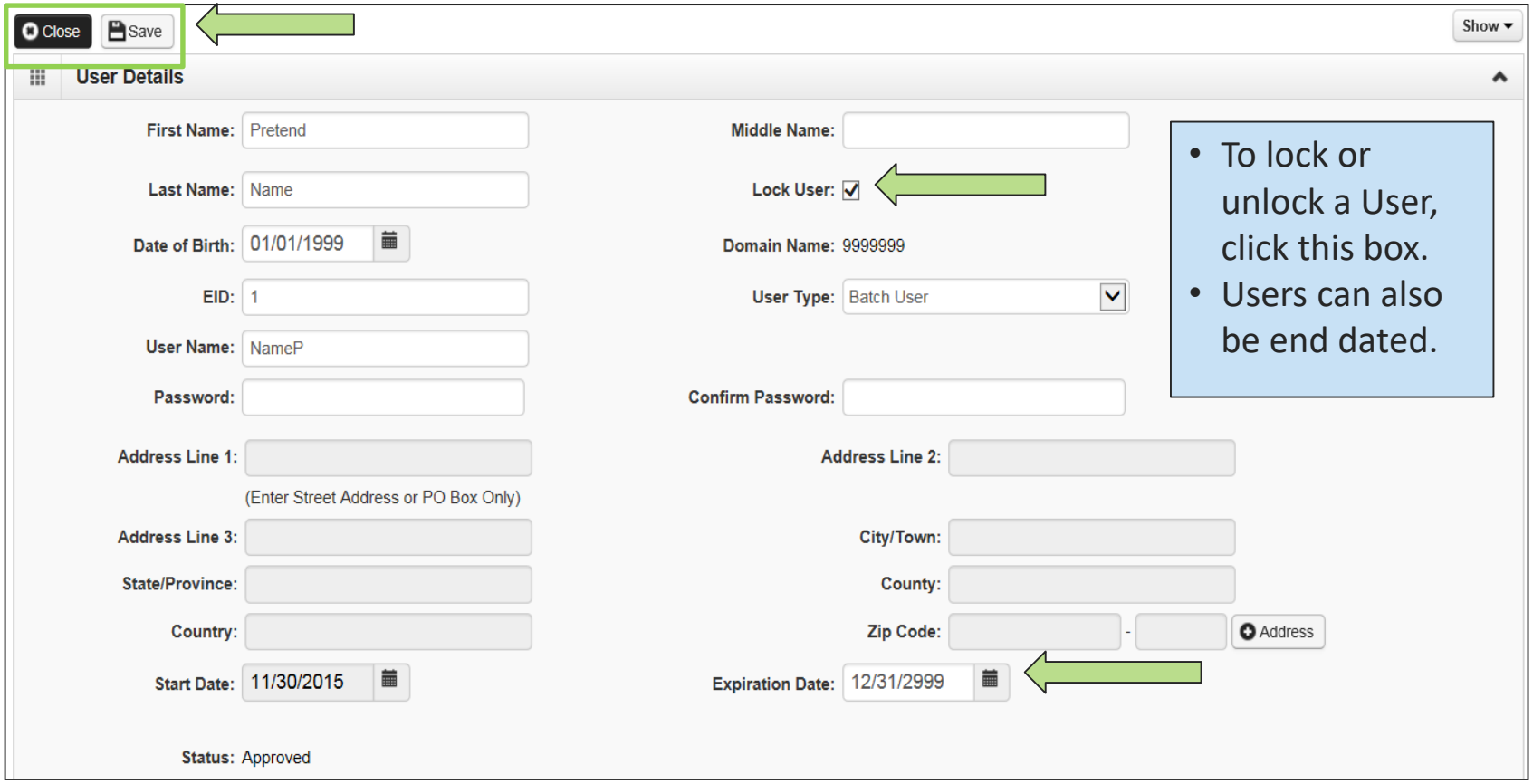
How to Set Up a User

- Setting up a user's password
  - Enter the new temporary password and click **Save** and then **Close**.



How to Manage a User

- How to lock or end date a user:

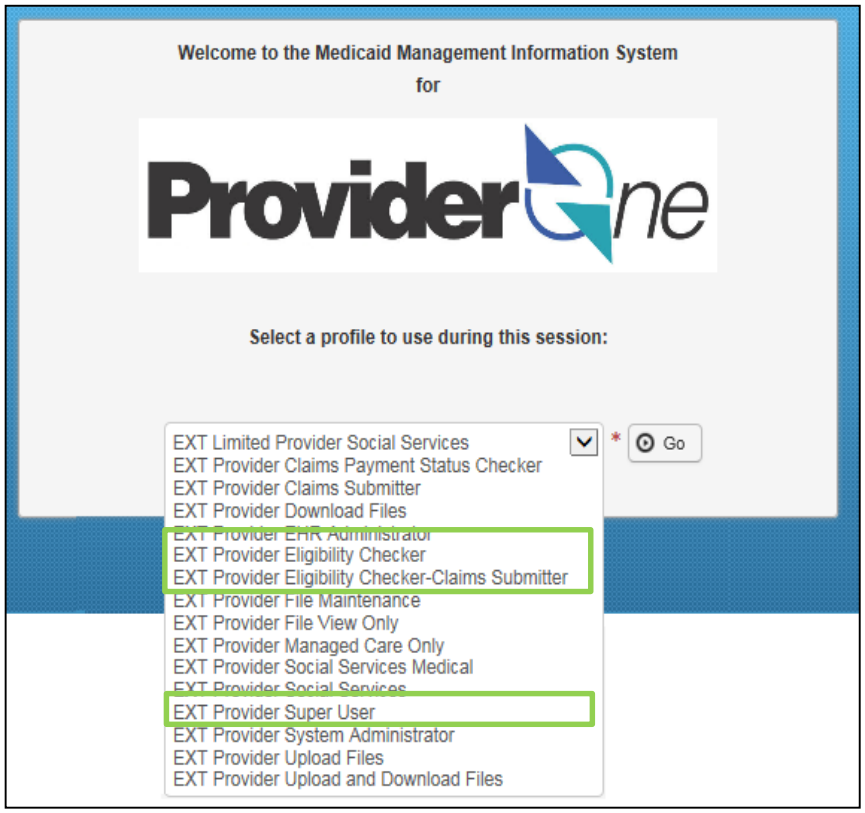


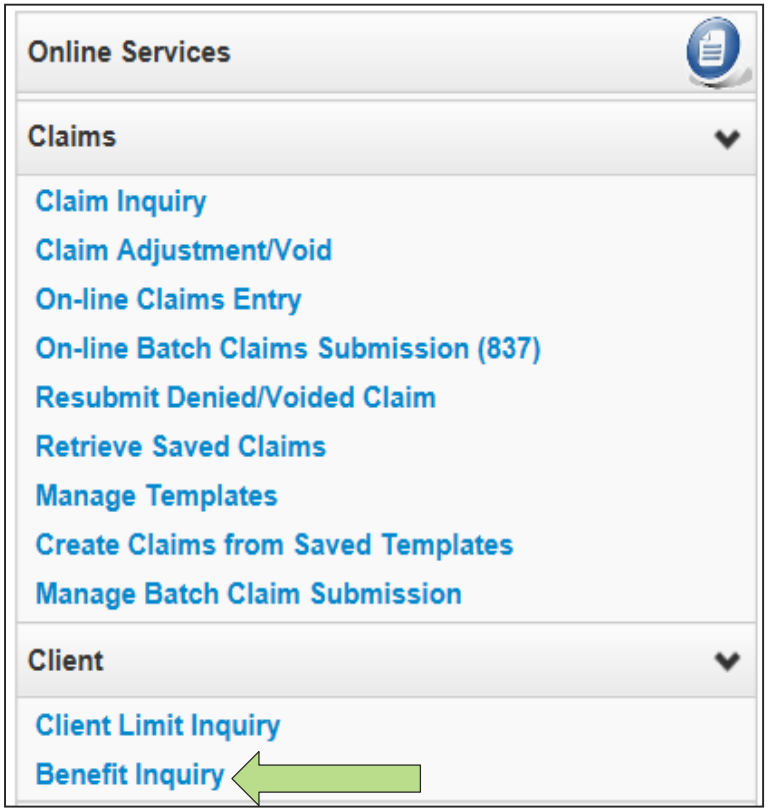
- Click **Save** and then **Close**.

Eligibility & Billing Processes

How Do I Obtain Eligibility in ProviderOne

- Select the proper user profile.

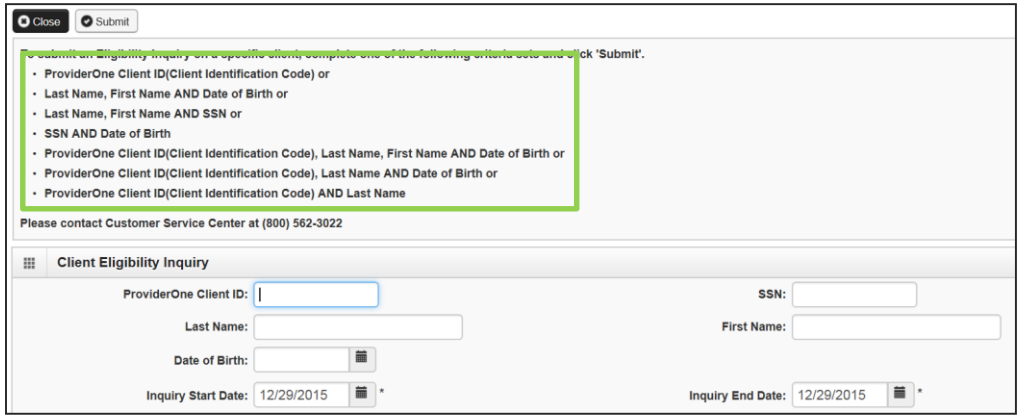




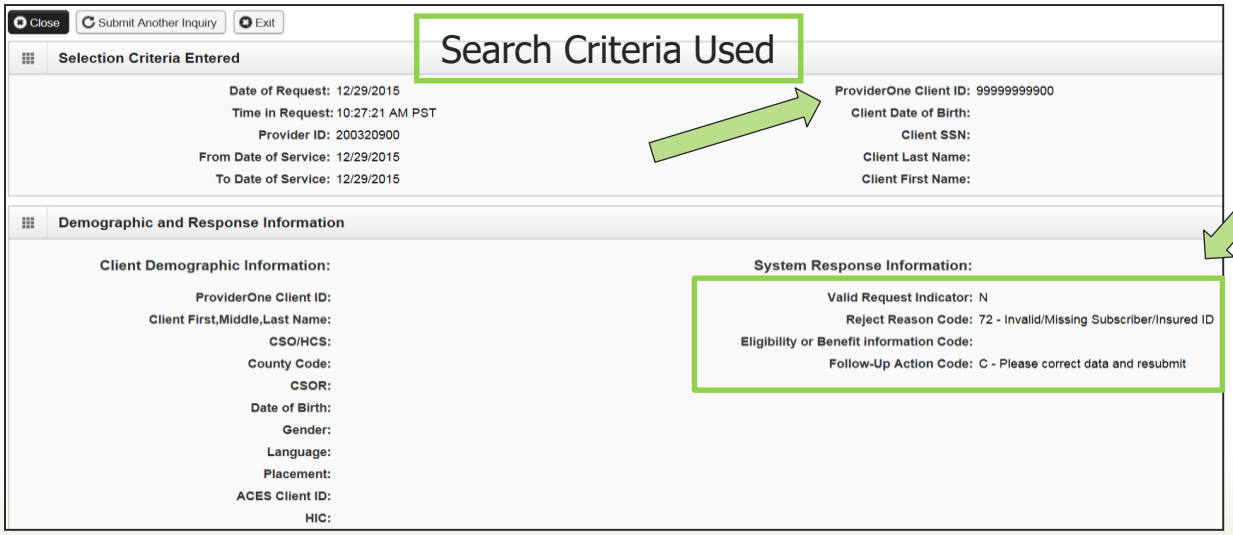
- Select Benefit Inquiry under the Client area.

How Do I Obtain Eligibility In ProviderOne

- Use one of the search criteria listed along with the dates of service to verify eligibility.



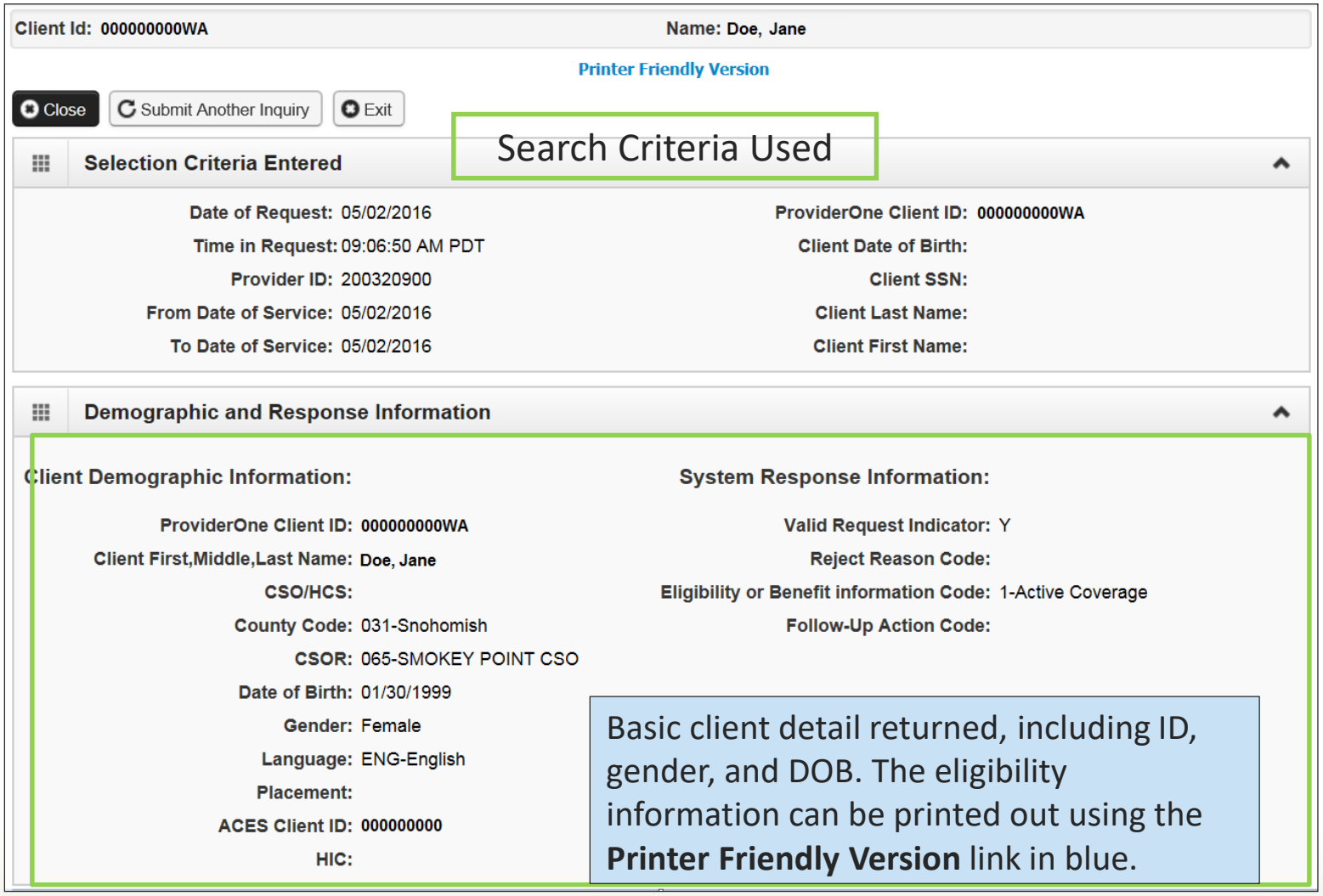
- An unsuccessful check would look like this:



- Unsuccessful eligibility checks will be returned with an error message
- Check your keying!

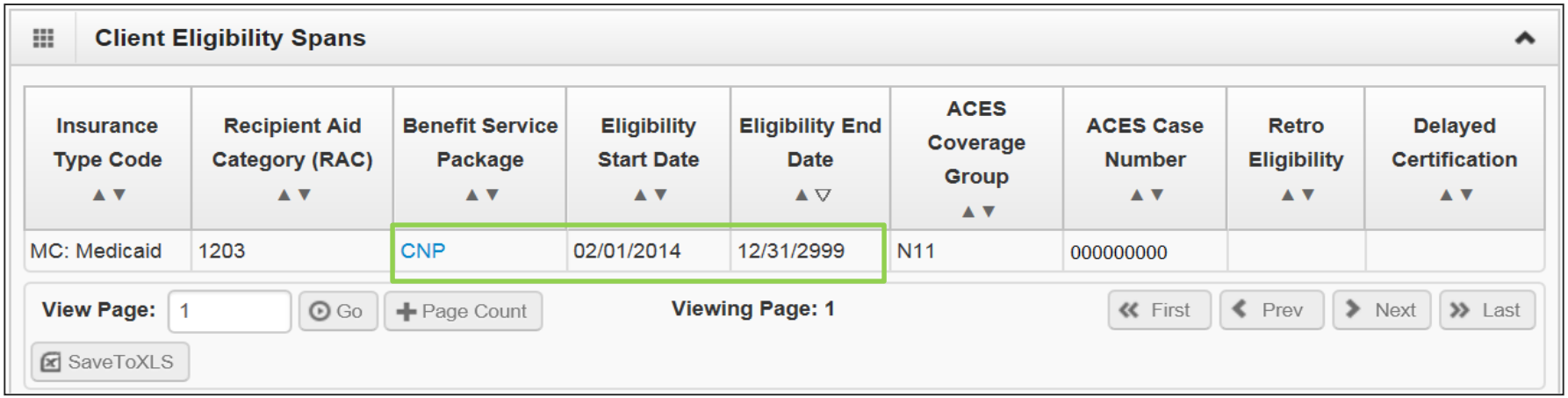
Washington State Health Care Authority

Successful Eligibility Check



Successful Eligibility Check

- After scrolling down the page the first entry is the **Client Eligibility Spans** which show:
  - The eligibility program (CNP, MNP, etc.).
  - The date span for coverage.



Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1203	CNP	02/01/2014	12/31/2999	N11	000000000		

View Page: 1 Go Page Count Viewing Page: 1 First Prev Next Last

SaveToXLS

Note: Use the benefit service package blue acronym to see the high level coverage for this program.

Successful Eligibility Check

➢ Managed Care Information

- Clients may have more than one of the following managed care programs listed on their eligibility screen. Refer to the ProviderOne Billing and Resource Guide for detailed information on each program.

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	MHC Healthy Options				03/01/2015	12/31/2999

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	CHPW Fully Integrated Managed Care				01/01/2016	12/31/2999

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	Coordinated Care Healthy Options Foster Care				12/01/2015	12/31/2999

Successful Eligibility Check

- **Managed Care Information** (continued)

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	OptumHealth Behavioral Health Organization				09/01/2015	12/31/2999

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	MHC Behavioral Health Services Only				03/01/2016	12/31/2999

Note: Effective for claims with dates of service on and after January 1, 2017, clients with other primary health insurance may be enrolled in an Apple Health Managed Care plan as their secondary insurance. Remember to always check for other primary payers when verifying eligibility in ProviderOne. See the Apple Health Medicaid provider alert and the ProviderOne Billing and Resource Guide for more detail.

Successful Eligibility Check

➢ Managed Care Information

- Primary Care Case Management (PCCM) and Health Homes provide care management for clients only and are not direct payers.

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	NATIVE HEALTH OF SPOKANE			NATIVE HEALTH OF SPOKANE	07/01/2012	12/31/2999

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	SE WA Aging and LTC - Health Home Only				07/01/2016	12/31/2999

Successful Eligibility Checks

- **Medicare Eligibility Information**
  - If client has Medicare Part A or Part B this information will be shown with the Medicare eligibility effective dates of service.

Medicare Eligibility Information

Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MA: Medicare Part A	02/01/1997	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	02/01/1997	12/31/2999

  - If the client has enrolled in a Medicare Advantage Plan (Part C), if reported it is listed in the **Coordination of Benefits Information** section.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part D			08/01/2009	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part C			08/01/2009	12/31/2999

Successful Eligibility Check

- **Coordination of Benefits Information**
  - Displays phone numbers and any Policy or Group numbers on file with WA Apple Health for the commercial plans listed.
  - For DDE claims the Carrier Code (Insurance ID) is found here.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA DENTAL	DN18					01/01/2012	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA HEALTHCARE	CH55					01/01/2012	12/31/2999

Please Note: If you know an Apple Health client has a commercial insurance and you do not see a Coordination of Benefits Information segment on their eligibility file in ProviderOne, you must complete a Contact Us email. Choose the option "I am an Apple Health (Medicaid) biller or provider" and then choose the "Medical Provider" button. On the "Select Topic" dropdown, choose "Private Commercial Insurance." Enter the client's insurance information in the "Other Comments" section. The agency's Coordination of Benefits unit will update the client's file using this information. Check eligibility again in ProviderOne in 3 – 5 business days to verify the update has been made. Only after verification of this information in ProviderOne should you bill the claim to the system.

Successful Eligibility Checks

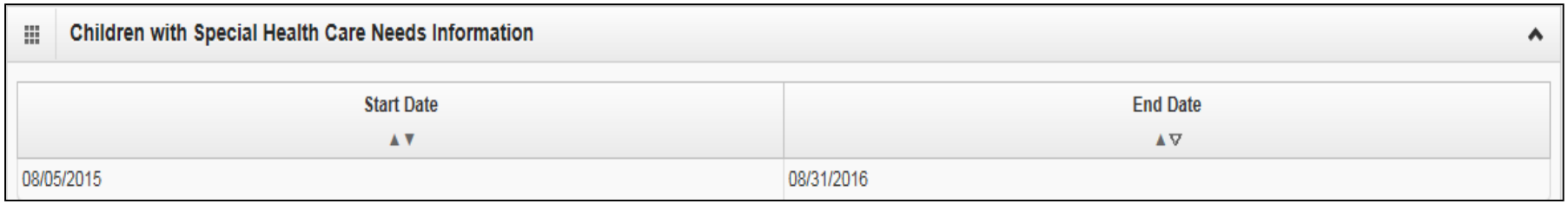
- **Restricted Client Information**
  - Clients may be restricted to specific Hospitals, PCP's, and Pharmacies for care. A referral is required from the PCP for specialized care.

Restricted Client Information

Assignment Type	Provider Name	Provider Phone Number	Period Start Date	Period End Date
Pharmacy	SAMUEL EASTERN INC		03/21/2011	12/31/2999
Pharmacy	REIDT PHARMACY CORPORATION		03/04/2011	12/31/2999
Primary Care Physician	MINOR AND JAMES MEDICAL PLLC		02/11/2009	12/31/2999
Primary Care Physician	COMM Health Assoc of Spokane		12/01/2009	12/31/2999
Hospital	PROVIDENCE HOLY FAMILY HOSPITA		08/08/2008	12/31/2999

Successful Eligibility Checks

- **Children with Special Health Care Needs (CSHCN) Information**
  - There may be an eligibility segment stating Children with Special Health Care Needs. These clients could also be enrolled into a managed care plan.



Children with Special Health Care Needs Information

Start Date	End Date
08/05/2015	08/31/2016

Successful Eligibility Checks

- **Hospice Information**
  - Client's may be enrolled in a Hospice agency for care:

Hospice Information

Hospice agency	Hospice Address	Hospice Phone	Hospice Contact	Start date	End date
	PROVIDENCE HOSPICE OF SEAT, 425 PONTIUS AVE N STE 300, SEATTLE, WA 98109-5312			01/04/2016	12/31/2999

Note: If a client is assigned to a Hospice agency, bill the Hospice agency for any care related to the client's terminal illness. WA Medicaid has paid a monthly payment to the agency to cover these services.

Note: If the service is not related to the client's terminal illness, bill these services to WA Medicaid with a note SCI=K.

- The last section of the eligibility check lists the source of the eligibility data.

Successful Eligibility Check

- **Developmental Disability Information**
  - It will show the start and end date.
  - If current, there will be an open-ended date with 2999 as the year.

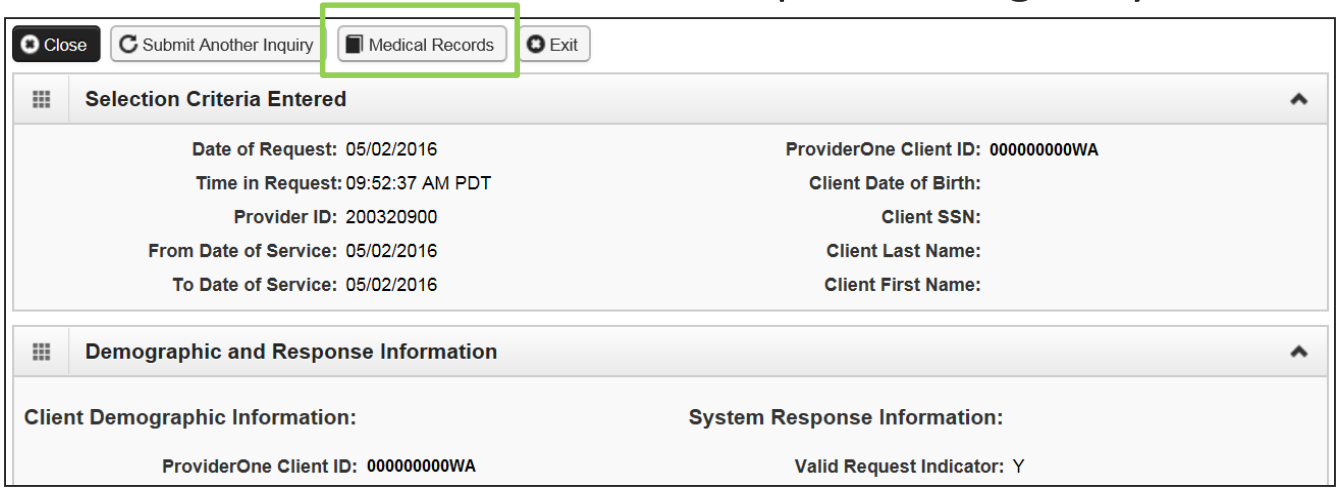
Developmental Disability Information

Start Date	End Date
10/06/1982	12/31/2999

Note: If a client has the DD indicator, they may be eligible for expanded benefits.

Successful Eligibility Check

- **Foster Care Information**
  - Client's Medical Records History is available.
  - There is an extra button at the top of the eligibility screen.

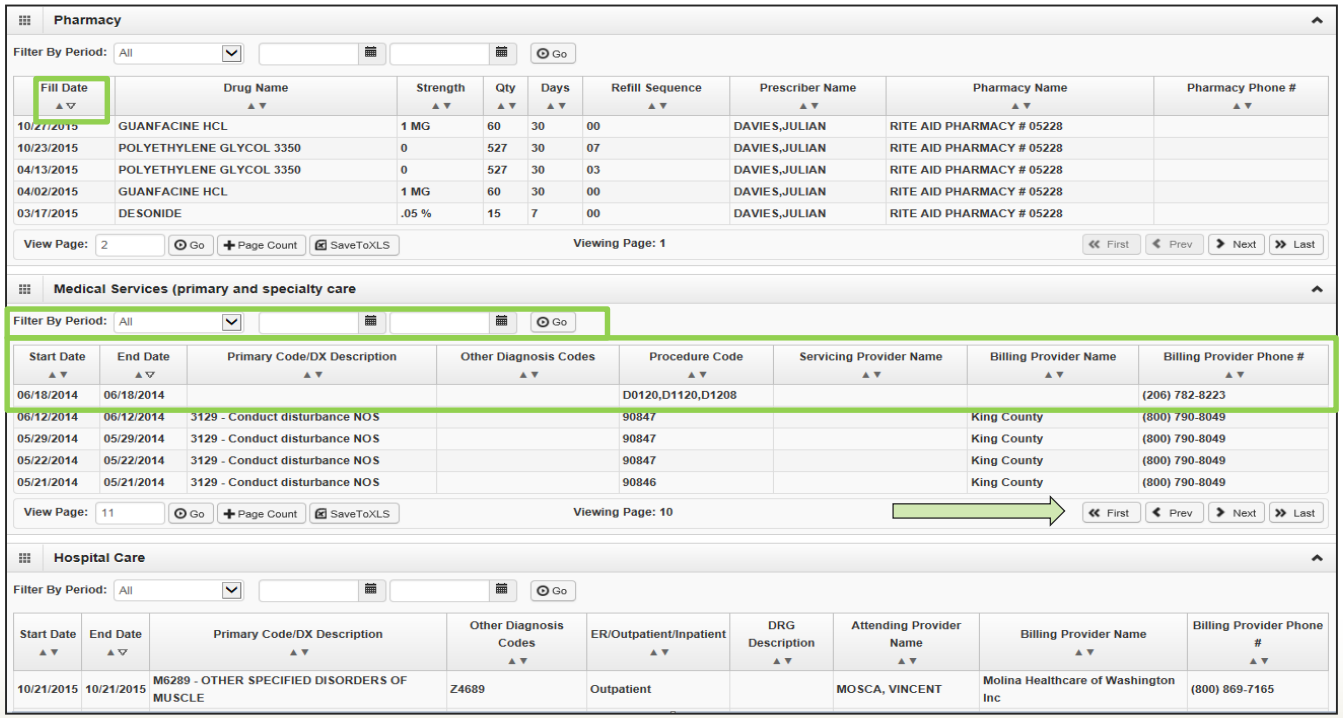


  - Click the **Medical Records** button to see:
    - Pharmacy services claims
    - Medical services claims (**includes dental**)
    - Hospital services claims
  - See the ProviderOne Billing and Resource Guide for complete details. Web address is on the last slide.

Successful Eligibility Check

➢ Foster Care Medical Records History

- Shows claims paid by ProviderOne.
- Sort by using the “diamonds” under each column name.
- Search by using the “Filter by Period” boxes.
- If there are more pages of data use the **Next** or **Previous** buttons.
- If there is no data for the section it will display “no records found.”



Pharmacy

Filter By Period: All — Go

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
10/27/2015	GUANFACINE HCL	1 MG	60	30	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
10/23/2015	POLYETHYLENE GLYCOL 3350	0	527	30	07	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
04/13/2015	POLYETHYLENE GLYCOL 3350	0	527	30	03	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
04/02/2015	GUANFACINE HCL	1 MG	60	30	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
03/17/2015	DESONIDE	.05 %	15	7	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	

View Page: 2 — Go — Page Count — SaveToXLS — Viewing Page: 1 — First — Prev — Next — Last

Medical Services (primary and specialty care

Filter By Period: All — Go

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #
06/18/2014	06/18/2014			D0120,D1120,D1208			(206) 782-8223
06/12/2014	06/12/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049
05/29/2014	05/29/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049
05/22/2014	05/22/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049
05/21/2014	05/21/2014	3129 - Conduct disturbance NOS		90846		King County	(800) 790-8049

View Page: 11 — Go — Page Count — SaveToXLS — Viewing Page: 10 — First — Prev — Next — Last

Hospital Care

Filter By Period: All — Go

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	ER/Outpatient/Inpatient	DRG Description	Attending Provider Name	Billing Provider Name	Billing Provider Phone #
10/21/2015	10/21/2015	M6289 - OTHER SPECIFIED DISORDERS OF MUSCLE	Z4689	Outpatient		MOSCA, VINCENT	Molina Healthcare of Washington Inc	(800) 869-7165

Gender and Date of Birth Updates

- Verified with ProviderOne system staff as of 01/27/14:
  - A large number of claims are denied due to a mismatch between the patient's DOB in the provider's record and the ProviderOne's client eligibility file. Providers can send a secure email to mmishelp@hca.wa.gov with the client's ProviderOne ID, name, and correct DOB. The same is true if providers find a gender mismatch; send the ProviderOne client ID, name, and correct gender to the same email address.

Verifying Eligibility

- Coverage status can change at any time
  - Verify coverage for each visit.
  - Print the Benefit Inquiry result.
  - If eligibility changes after this verification, HCA will honor the printed screen shot
    - **Exception**: Client with commercial insurance carrier that is loaded after you verify eligibility; commercial insurance must be billed first.

Direct Data Entry (DDE) Claims

Fee For Service Claims and Commercial Insurance Secondary Claims

After this training, you can:

- Submit fee for service DDE claims
- Create and Submit TPL secondary claims DDE
  - With backup
  - Without backup

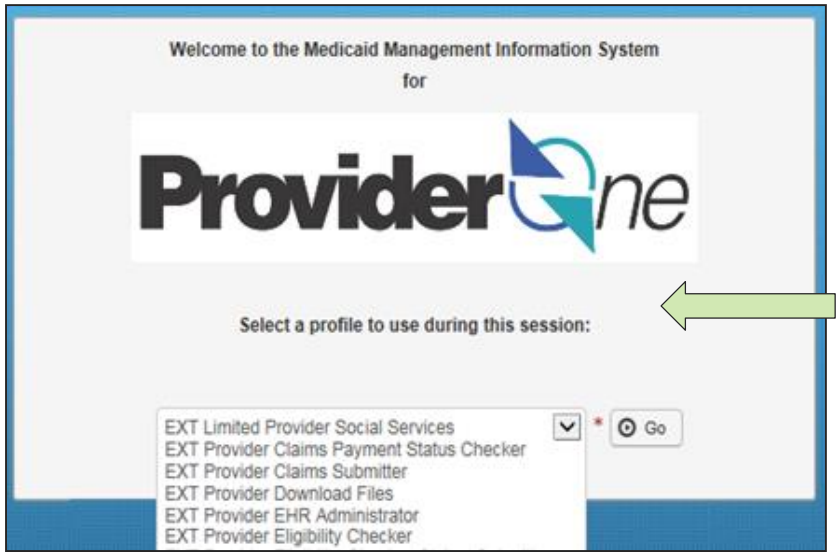
Direct Data Entry (DDE) Claims

- ProviderOne allows providers to enter claims directly into the payment system.
- All claim types can be submitted through the DDE system:
  - Professional (CMS 1500)
  - Institutional (UB-04)
  - Dental (ADA Form)
- Providers can CORRECT and RESUBMIT denied or previously voided claims.
- Providers can ADJUST or VOID previously paid claims.

Determine What Profile to Use

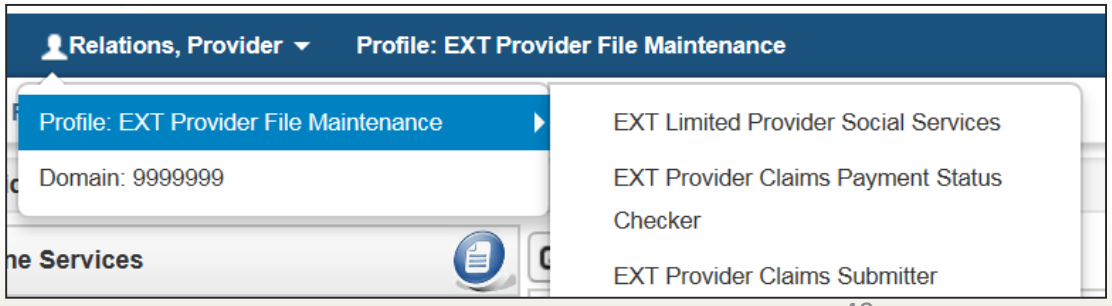
With the upgrade to 3.0, ProviderOne allows you to change your profile in more than one place.

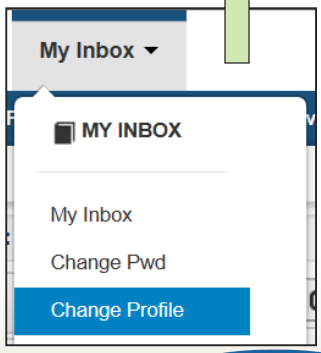
- At initial login:



Note: Using **My Inbox** to change profiles, takes you back to the main profile screen.

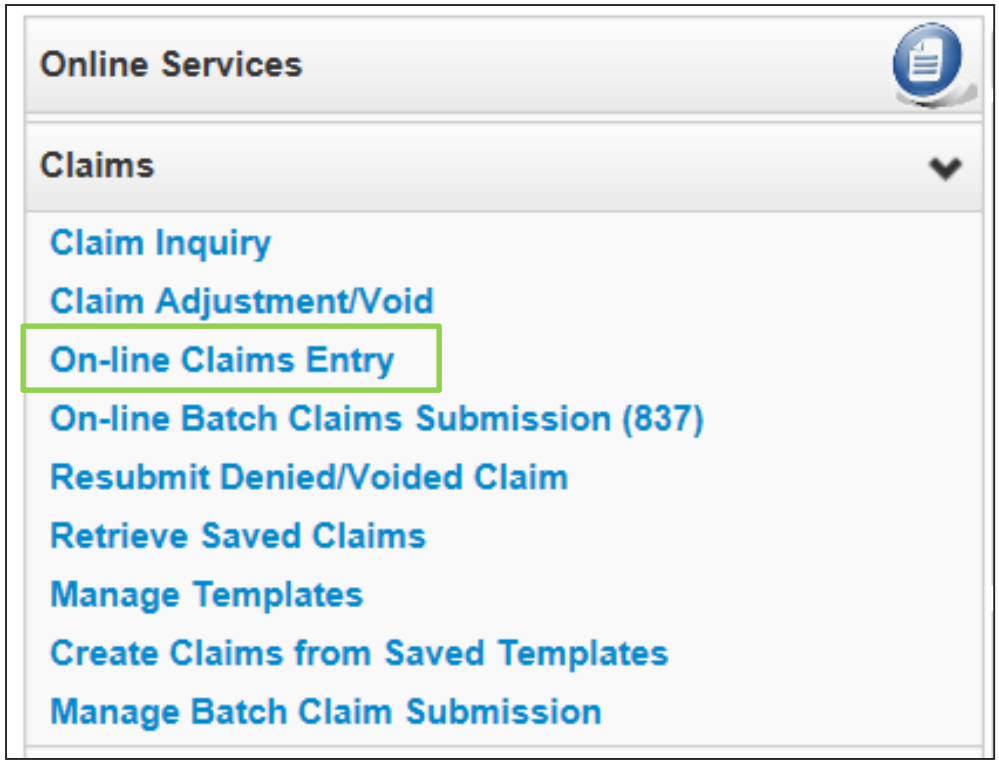
- And in the portal:





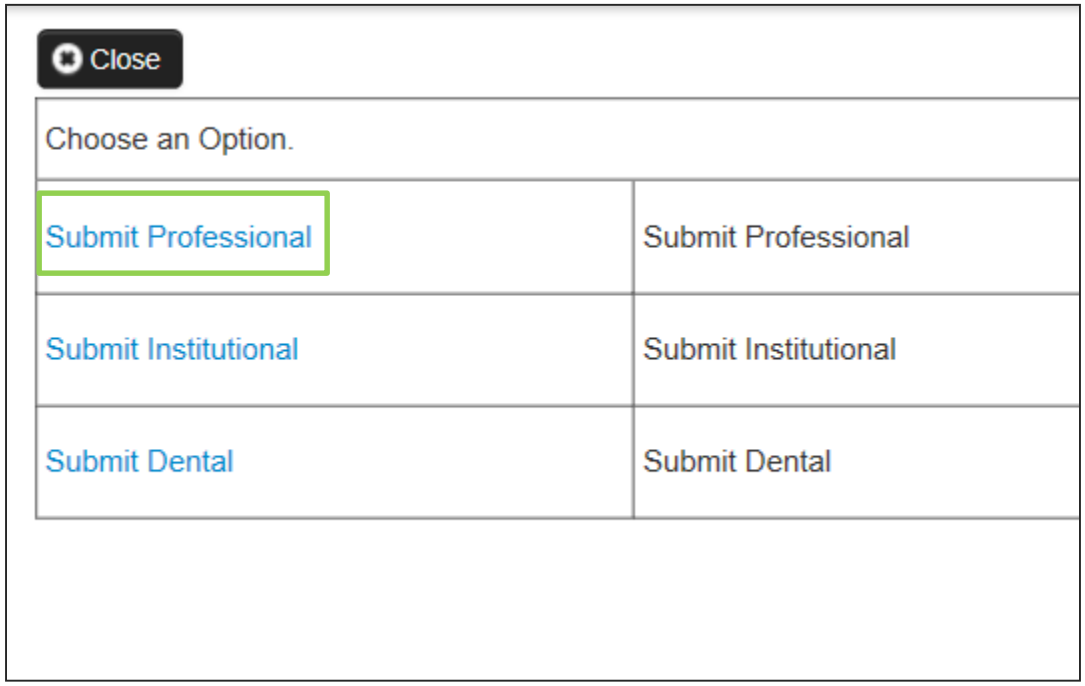
Direct Data Entry (DDE) Claims

- From the Provider Portal select the **Online Claims Entry** option located under the Claims heading.



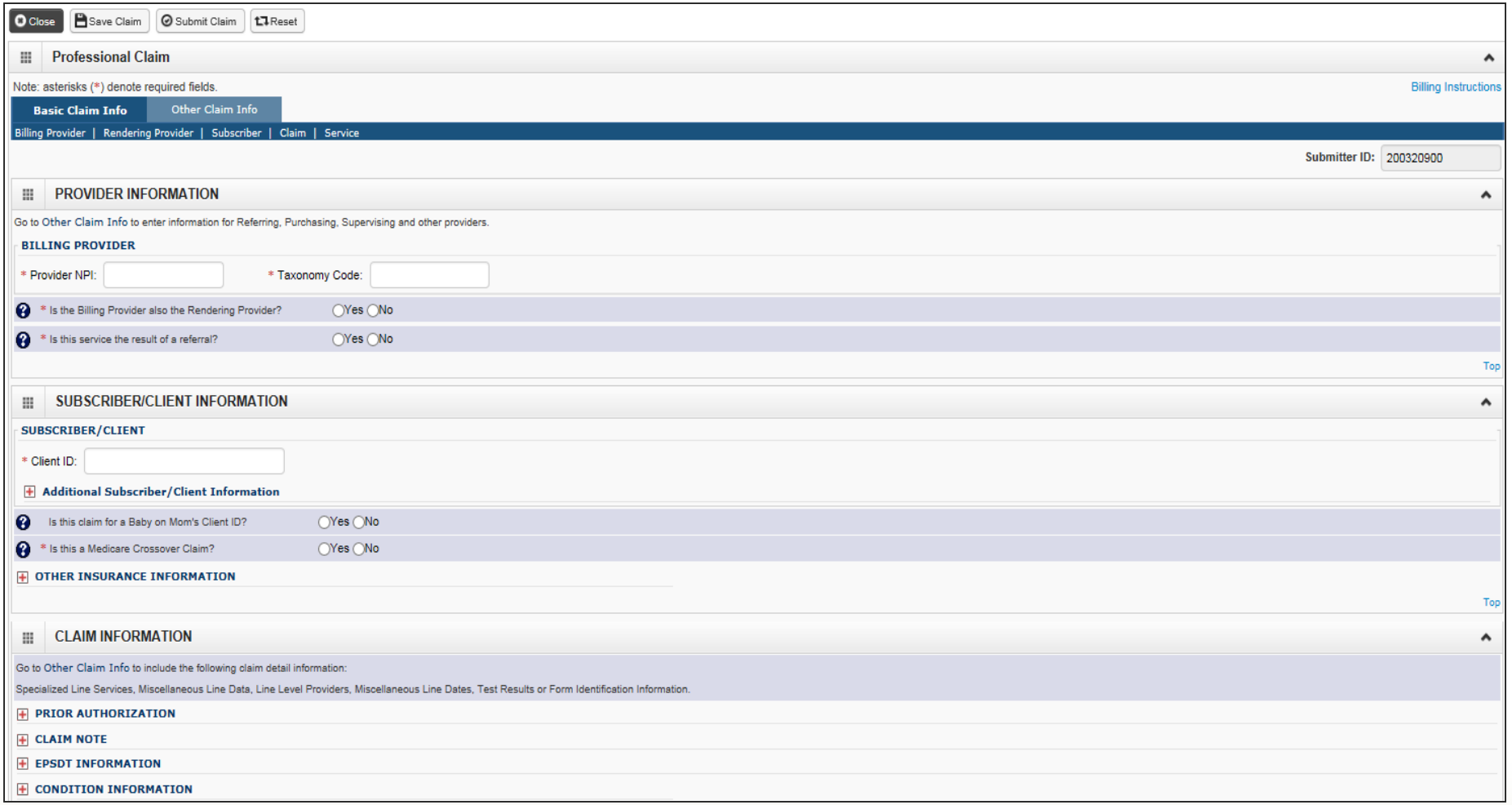
Direct Data Entry (DDE) Claims

- Choose the type of claim that you would like to submit with the appropriate claim form:
  - Professional – CMS 1500
  - Institutional - UB04
  - Dental - 2012 ADA



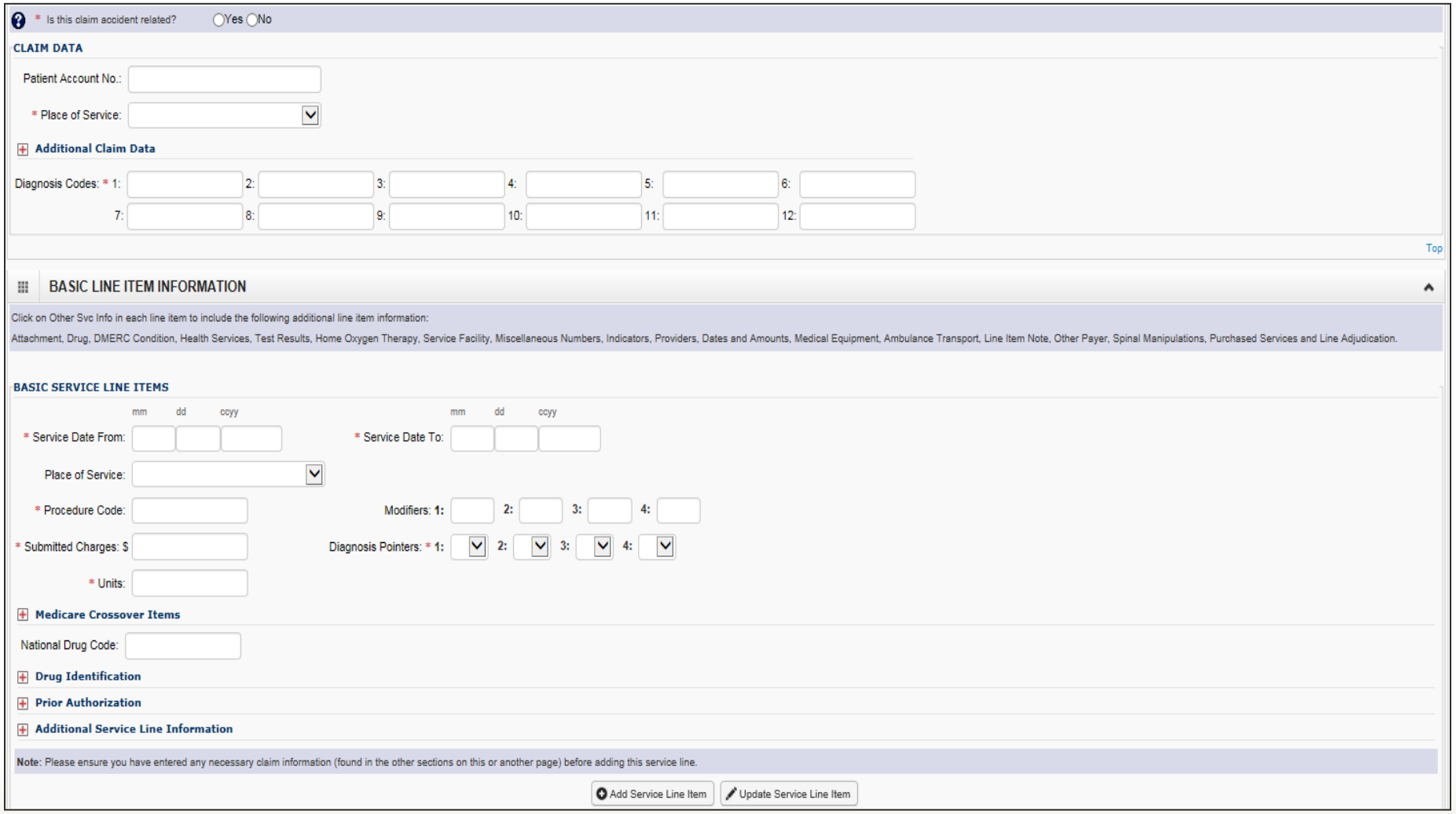
Washington State Health Care Authority

Direct Data Entry (DDE) Claims



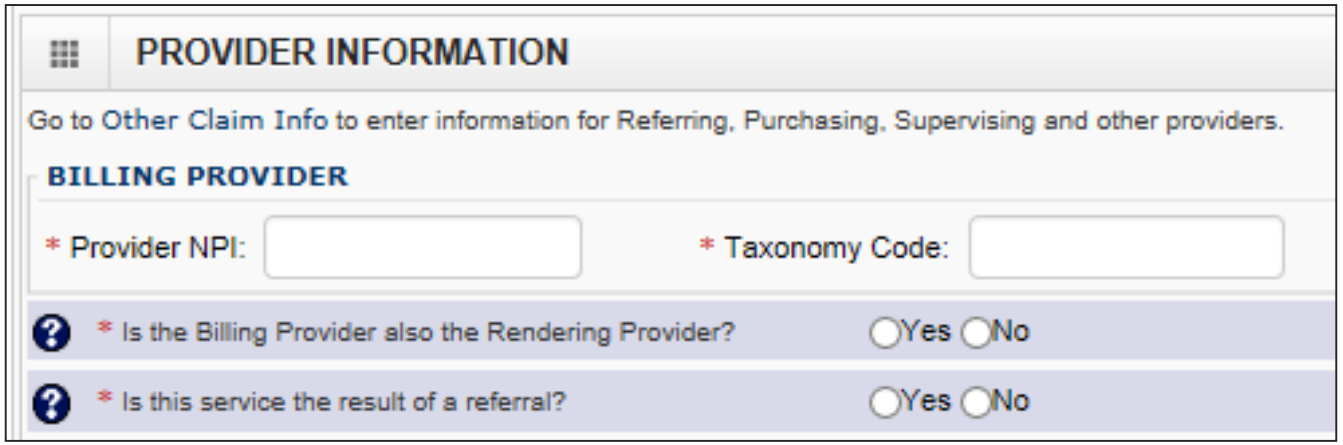
Washington State Health Care Authority

Direct Data Entry (DDE) Claims



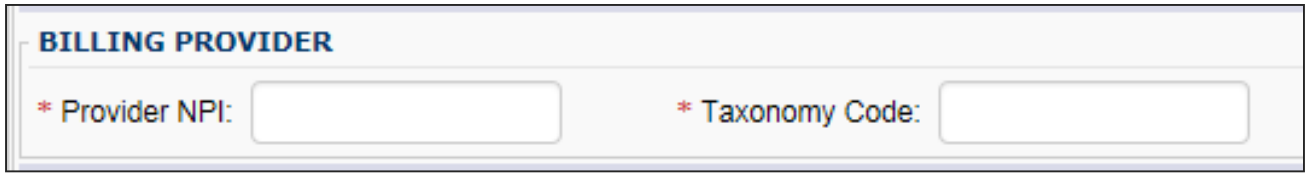
Billing Provider Information

- Section 1: Billing Provider Information



Billing Provider Information

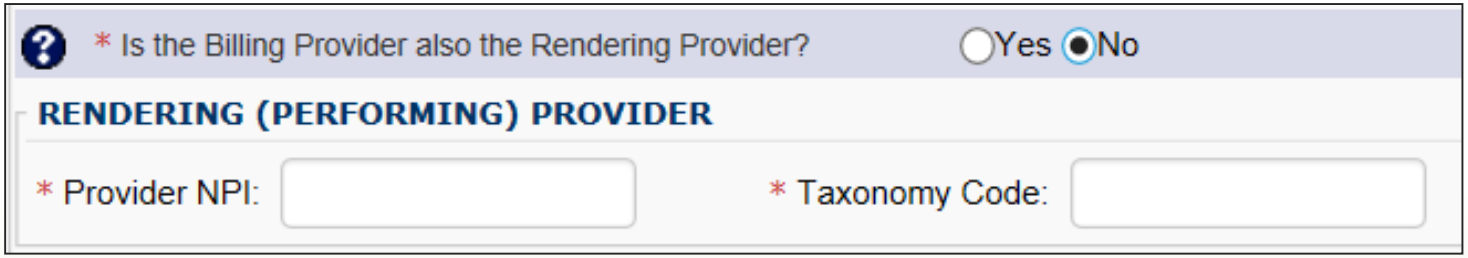
- Enter the Billing **Provider NPI** and **Taxonomy Code**.
  - This will likely be the NPI and Taxonomy Code of the clinic/office where the service was performed and where you would like payment to be received.



Rendering Provider Information

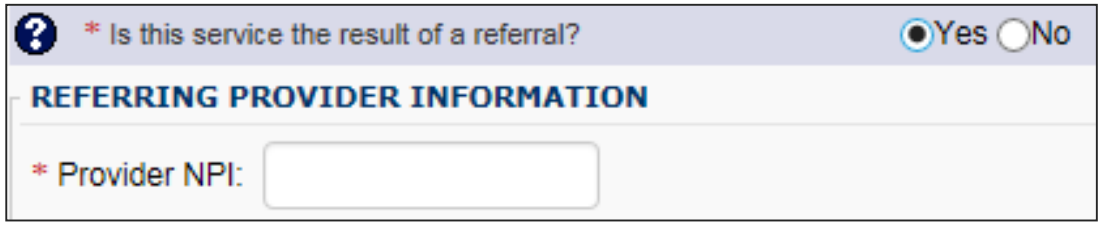
- If the Rendering Provider is the same as the Billing Provider answer this question **YES** and go on to the next section.

- If the Rendering Provider is different than the Billing Provider entered in the previous question, answer **NO** and enter the Rendering (Performing/Servicing) **Provider NPI** and **Taxonomy Code**.



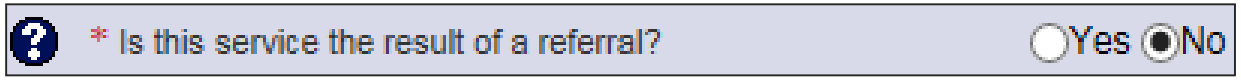
Referring Provider Information

- If the service **Is the result of a referral**, answer **Yes** to this question and add the referring **Provider NPI**.



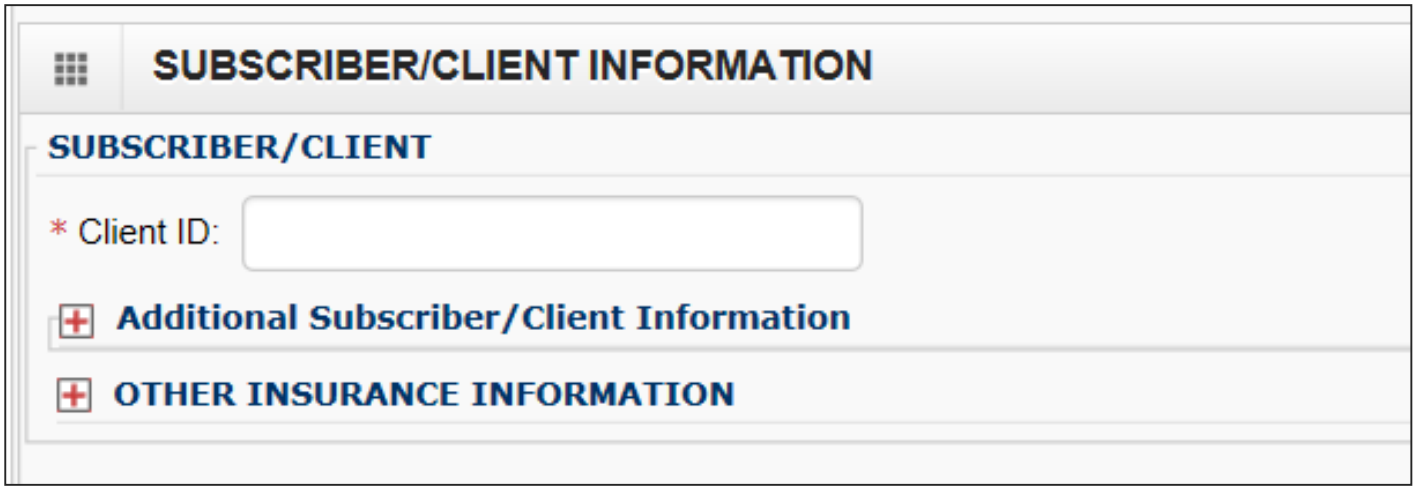
Note: Only the provider NPI number is required for referring providers.

- If the service **Is Not the result of a referral**, answer this question **No** and continue on to next section.



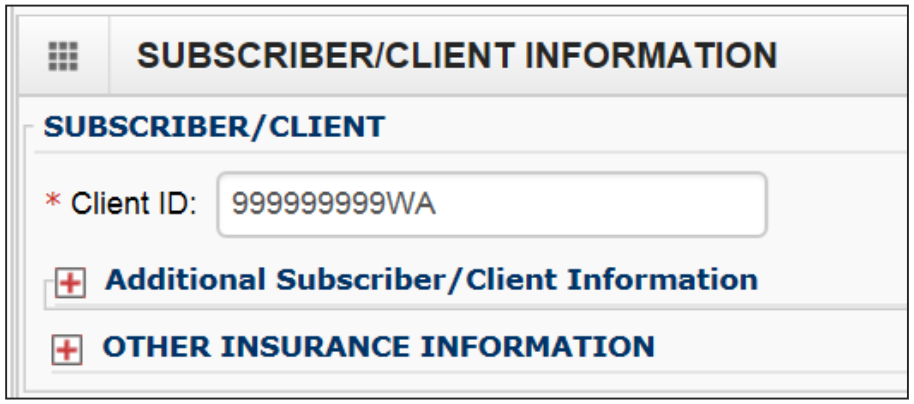
Subscriber/Client Information

- Section 2: Subscriber/Client Information



Subscriber/Client Information

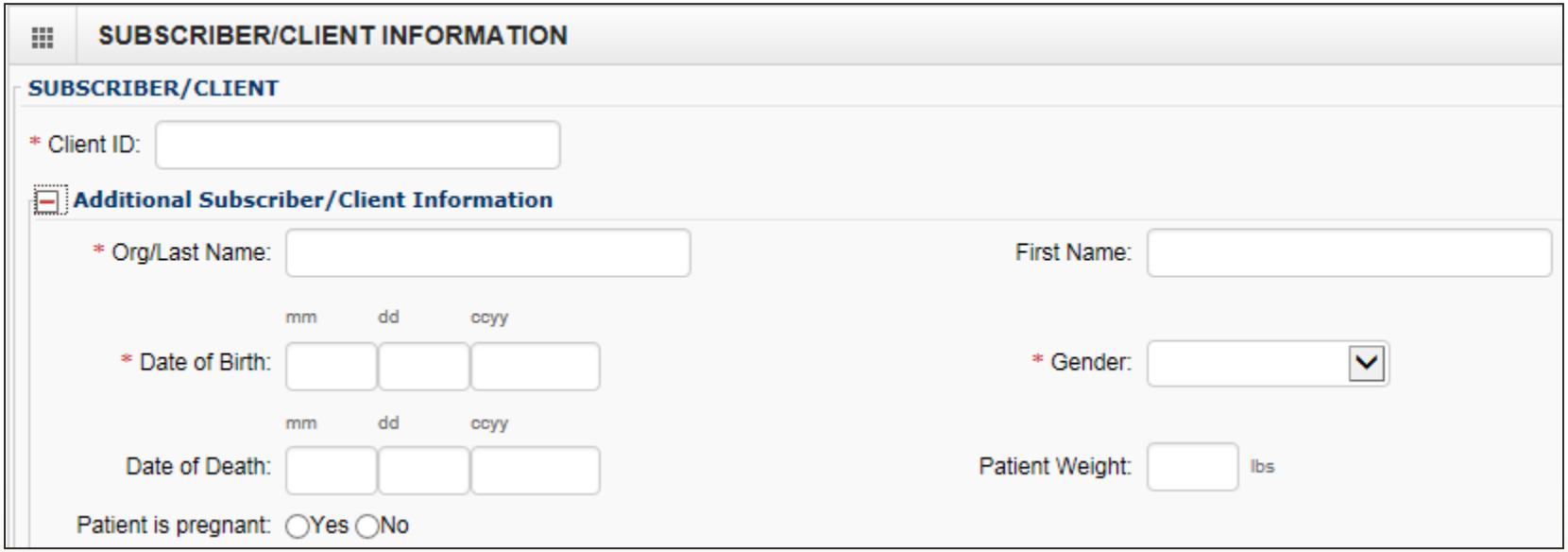
- Enter the **Subscriber/Client ID** found on the WA Medicaid services card. This ID is a 9-digit number followed by **WA**.
  - Example: **999999999WA**



- Click on the red **+** to expand the **Additional Subscriber/Client Information** to enter additional required information.

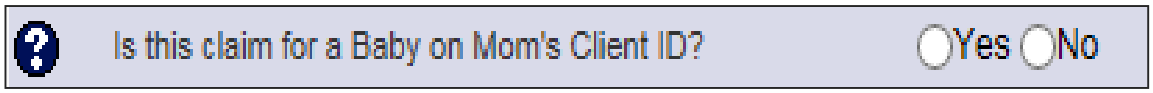
Subscriber/Client Information

- Once the field is expanded enter the **Patient's Last Name**, **Date of Birth**, and **Gender**.
  - Date of birth must be in the following format: **MM/DD/CCYY**.
  - The additional information fields are not needed.



Baby on Mom's Client ID

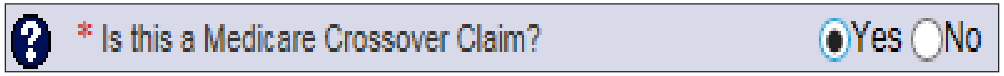
- If claim is **for a baby being billed under the Mom's ID** select **Yes** otherwise choose **No** and continue to next question.

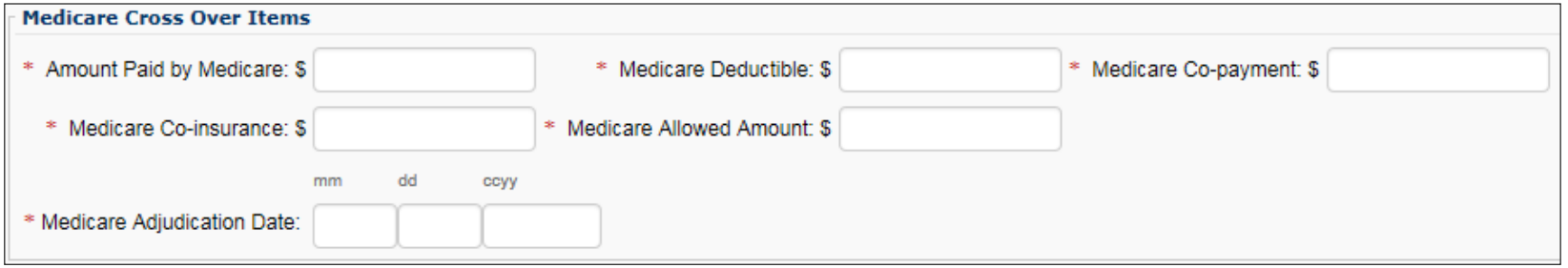


Note: If claim is for a baby using the mom's ID, use the baby's last name, the baby's date of birth, and gender when filling out the **Subscriber/Client Information** on the previous slide. Be sure to add the claim note **SCI=B** when billing for a baby using mom's ID.

Medicare Crossover Claim

- If the claim is considered a **Medicare Crossover** answer the question **YES.** This includes Managed Medicare Advantage Plans (Medicare Part C).





Note: WA Medicaid considers a claim as a crossover when Medicare allows the service. If Medicare makes a payment, a co-pay/coinsurance should be indicated or if the charges are applied to a deductible, Medicare may not make any payment.

- If Medicare did not make a payment answer the question **NO**.

Insurance Other than Medicaid

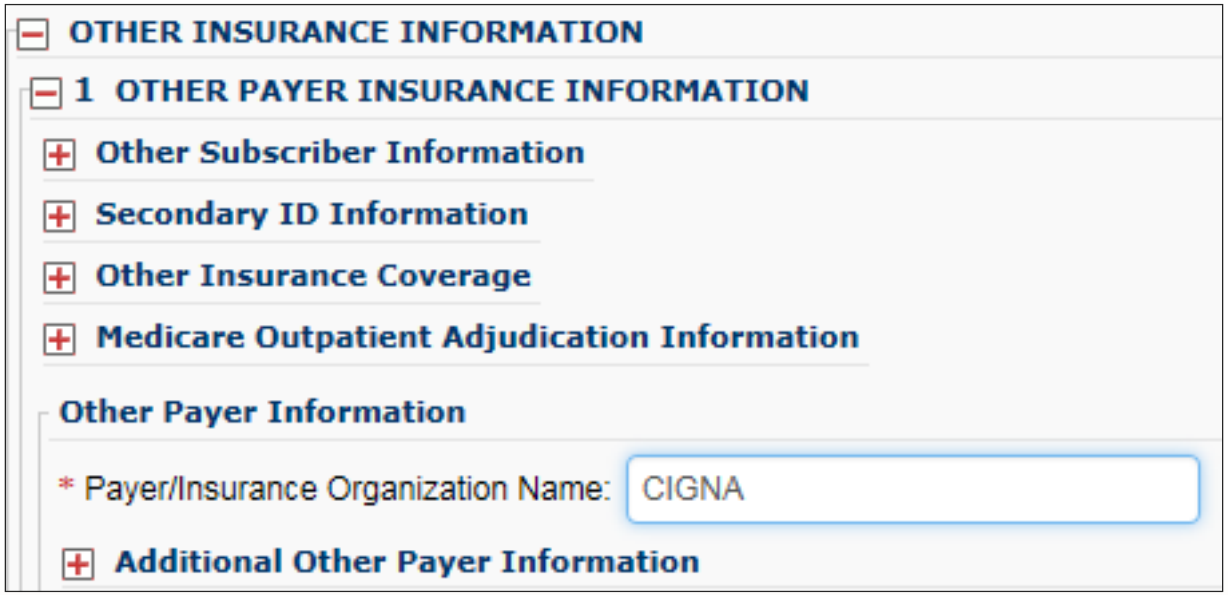
- If the client has other commercial insurance, open the **Other Insurance Information** section by clicking on the red **+** expander. If there is no insurance, skip over this.

- Then open up the **1 Other Payer Insurance Information** section by clicking on the red **+** expander.

Note: Bill paid and denied lines on the same claim. This will result in more efficient and quicker processing of your TPL claim.

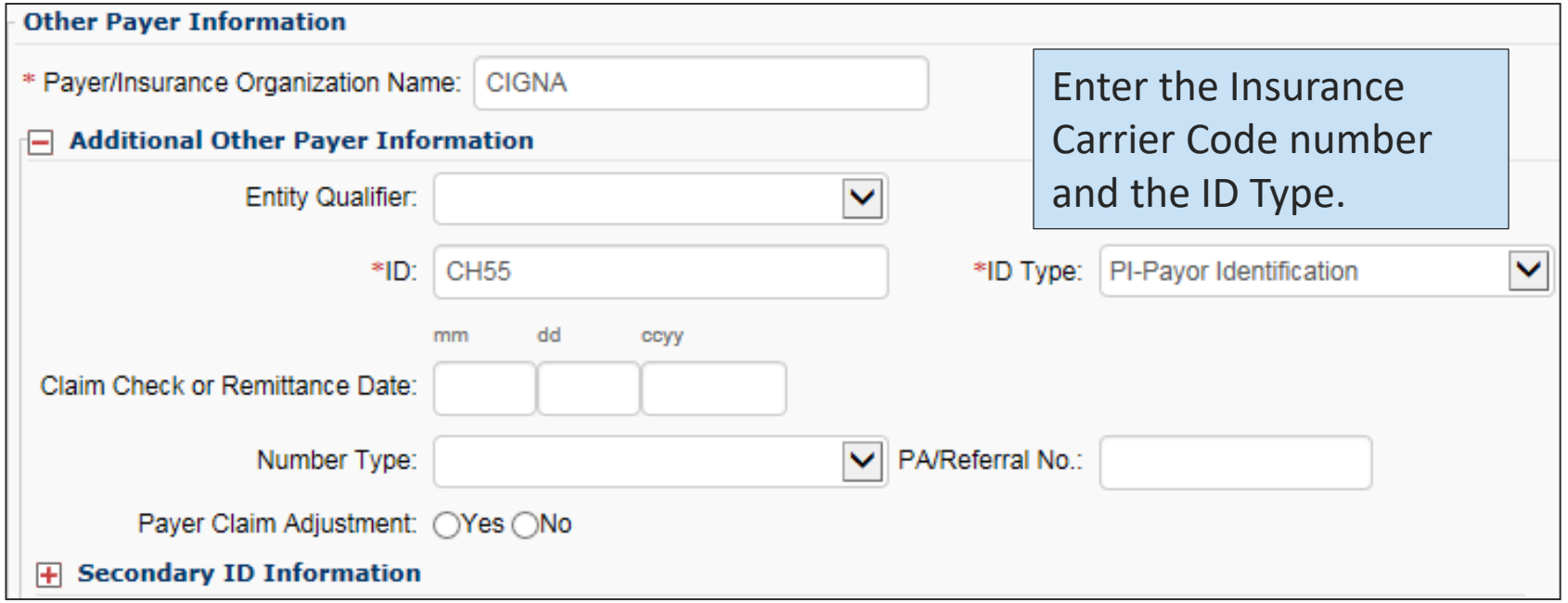
Insurance Other Than Medicaid

- Enter the **Payer/Insurance Organization Name**.
- Open up the **Additional Other Payer Information** section by clicking on the red **(+)** expander.



Insurance Other Than Medicaid

- In the **Additional Other Payer Information** section fill in the following:



Insurance Other Than Medicaid

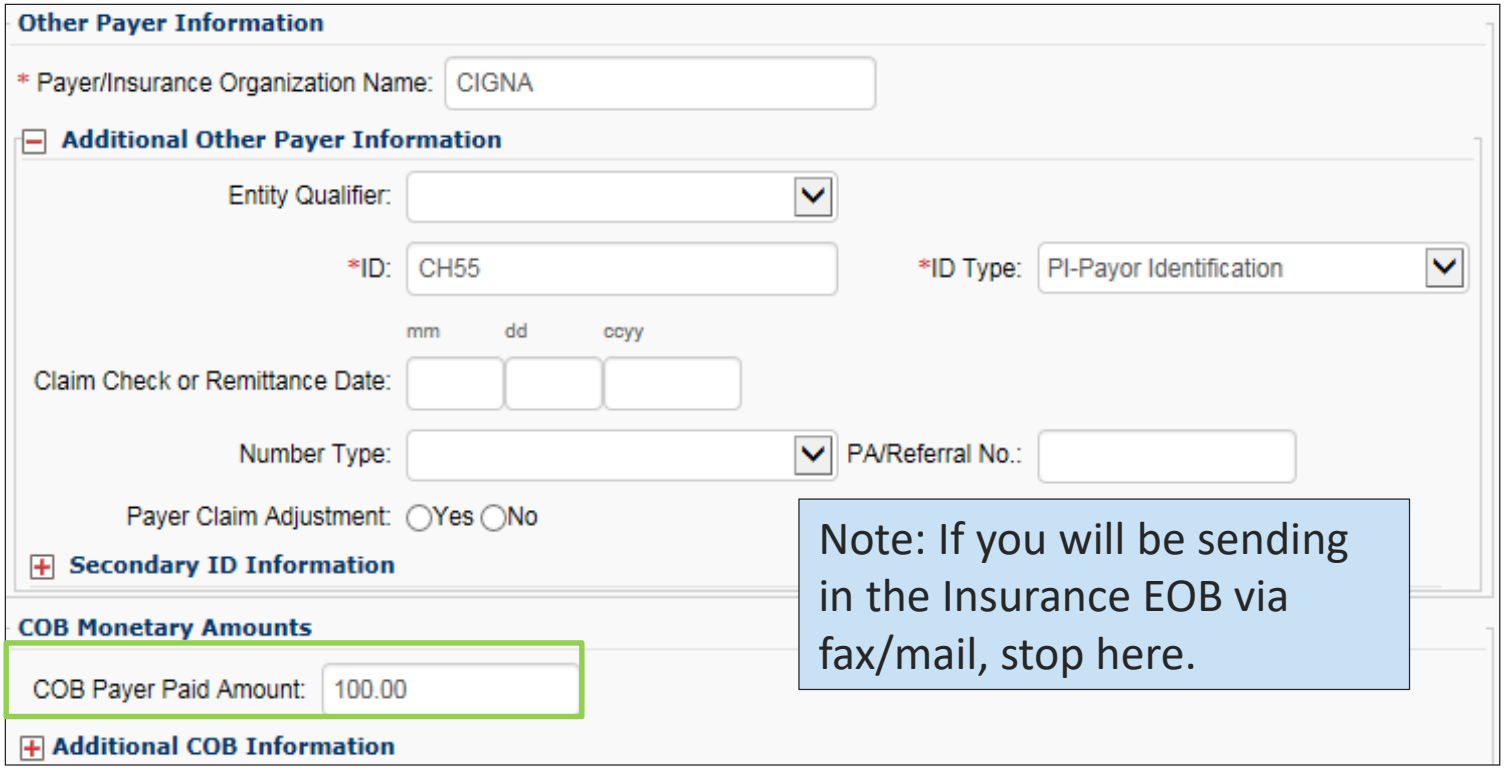
- Use the Insurance **Carrier Code** found on the client eligibility screen under the Coordination of Benefits section as the ID number for the insurance company.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA DENTAL	DN18					01/01/2012	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA HEALTHCARE	CH55					01/01/2012	12/31/2999

Insurance Other Than Medicaid

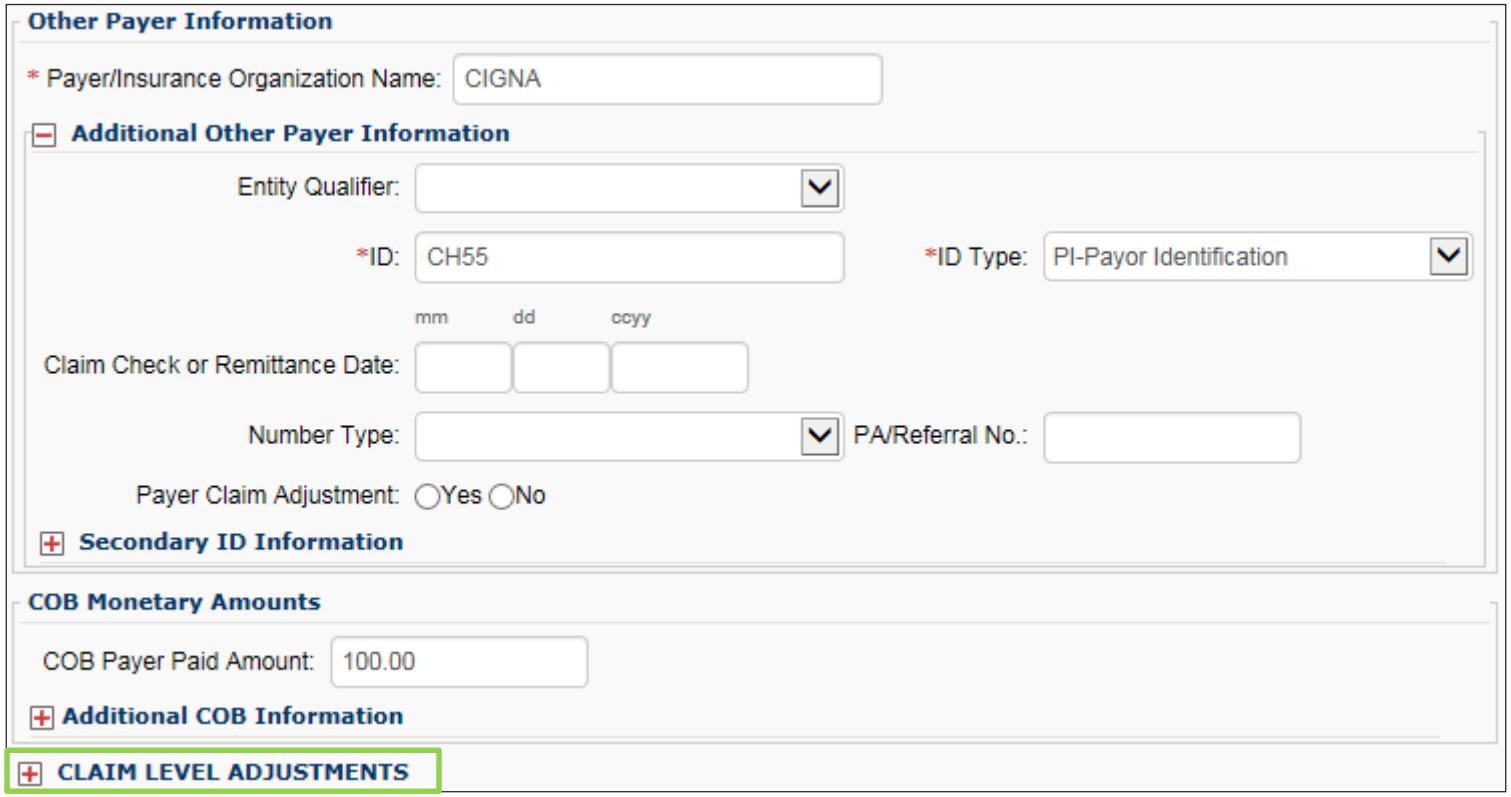
- Enter the total amount paid by the commercial private insurance in the **COB Payer Paid Amount** field.



- If the claim is for an insurance denial or insurance applied to the deductible, enter a 0 here.

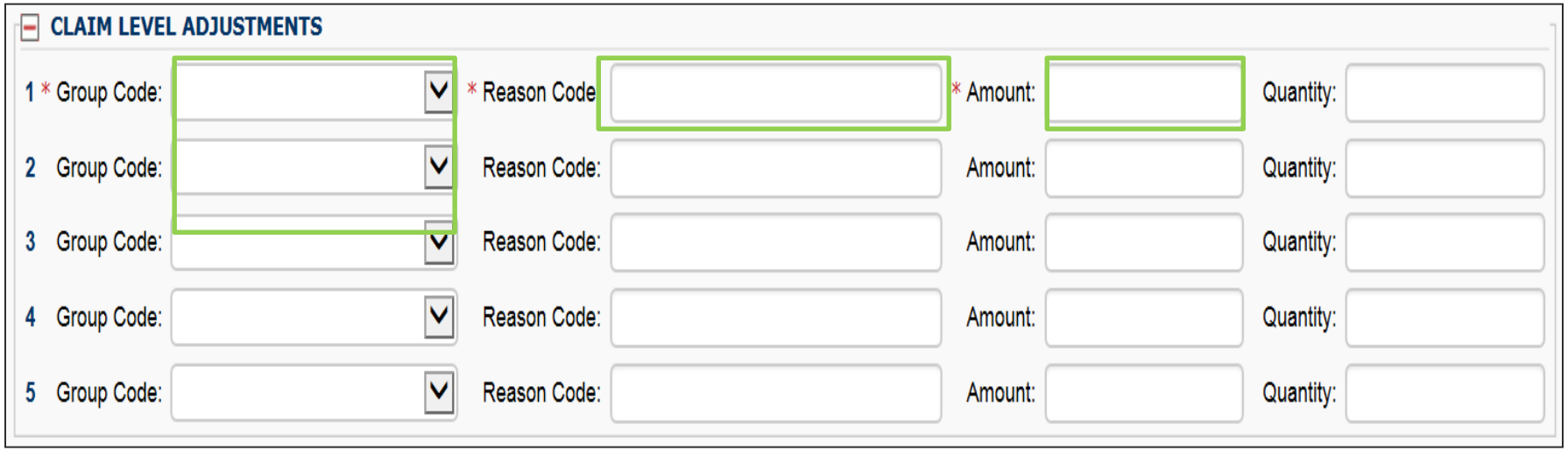
Insurance Other Than Medicaid

- Click on the red **+** to expand the **Claim Level Adjustments** section.



Insurance Other Than Medicaid

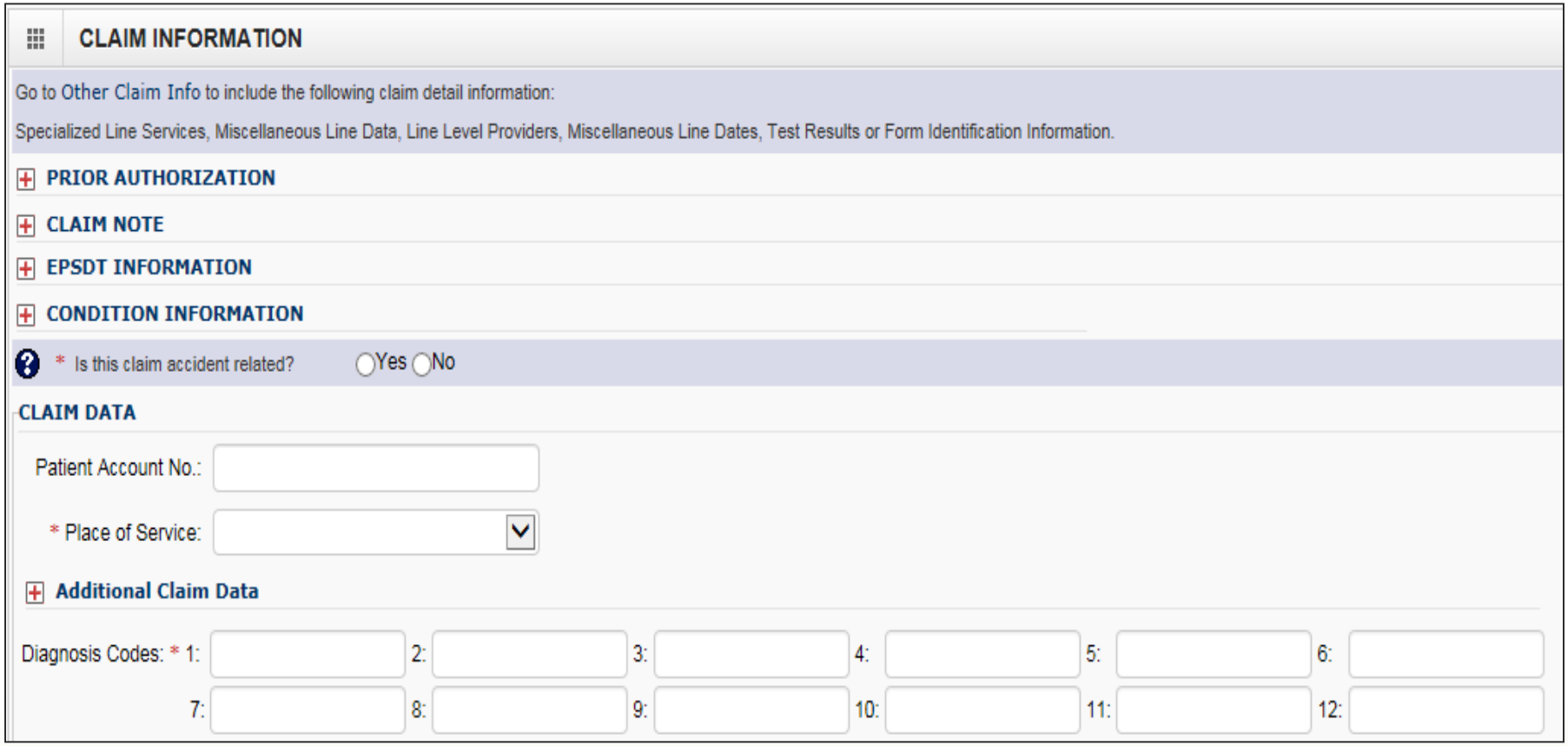
- Enter the adjustment **Group Code**, **Reason Code** (Number Only), and **Amount**.



Note: The agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the Washington Publishing Company's (WPC) website.

Claim Information

- Section 3: Claim Information Section



Prior Authorization

- If a Prior Authorization number needs to be added to the claim, click on the red **+** to expand the **Prior Authorization** fields.

- EPA numbers are considered authorization numbers and should be entered here.

Note: We recommend that providers enter any authorization number in these boxes. Entering the number here will cover the entire claim.

Claim Note

- A note may need to be added to the claim to assist in the processing.

- Click on the red **+** to expand the **Claim Note** section.

Note: Recent system changes to ProviderOne have changed how claim notes are read. If a specific program or service requires you to enter a claim note as instructed in a program billing guide, they will still be read by the system. If no claim note is needed, skip this option.

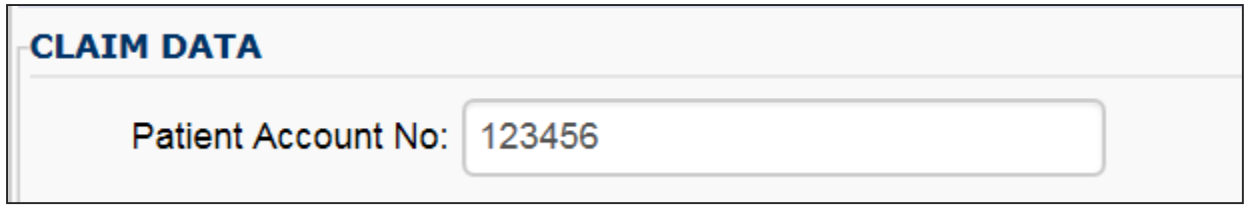
- For commercial insurance, as long as there is an attachment included or the insurance information is completed in the required fields, a claim note is not necessary.

Is the Claim Accident Related?

- This question will always be answered **NO**. Washington Medicaid has a specific Casualty Office that handles claims where another casualty insurance may be primary.
  - The Casualty office can be reached at 800-562-3022 ext. 15462.

Patient Account Number

- The **Patient Account No**. field allows the provider to enter their internal patient account numbers assigned to the patient by their practice management system.



Note: Entering internal patient account numbers may make it easier to reconcile the weekly remittance and status report (RA) as these numbers will be posted on the RA.

Place of Service

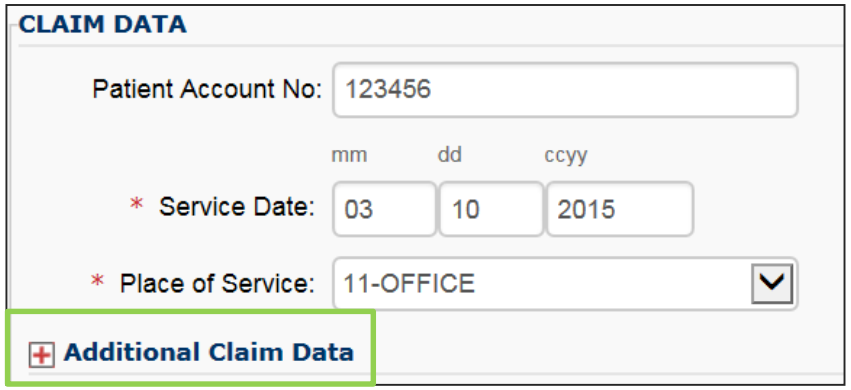
- With 5010 implementation, the Place of Service box has been added to the main claim section. Choose the appropriate **Place of Service** from the drop down.

01-PHARMACY
03-SCHOOL
04-HOMELESS SHELTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY
08-TRIBAL 638 PROVIDER-BASED FACILITY
09-PRISON/CORRECTIONAL FACILITY
11-OFFICE
12-Home
13-ASSISTED LIVING FACILITY
14-Group Home
15-MOBILE UNIT
16-TEMPORARY LODGING
17-WALK-IN RETAIL HEALTH CLINIC
20-URGENT CARE FACILITY
21-INPATIENT HOSPITAL
22-OUTPATIENT HOSPITAL
23-EMERGENCY ROOM - HOSPITAL
24-AMBULATORY SURGICAL CENTER
25-BIRTHING CENTER
26-MILITARY TREATMENT FACILITY
31-SKILLED NURSING FACILITY (SNF)
32-NURSING FACILITY
33-CUSTODIAL CARE FACILITY
34-Hospice
41-AMBULANCE - LAND
42-AMBULANCE - AIR OR WATER
49-INDEPENDENT CLINIC
50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
51-INPATIENT PSYCHIATRIC FACILITY
52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
53-COMMUNITY MENTAL HEALTH CENTER
54-INTERMEDIATE CARE FACILITY (ICF/MR)
55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
60-MASS IMMUNIZATION CENTER
61-COMPREHENSIVE INPATIENT REHAB FACILITY
62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
65-END-STAGE RENAL DISEASE TREATMENT FACILITY
71-PUBLIC HEALTH CLINIC
72-RURAL HEALTH CLINIC (RHC)
81-INDEPENDENT LABORATORY
99-OTHER PLACE OF SERVICE

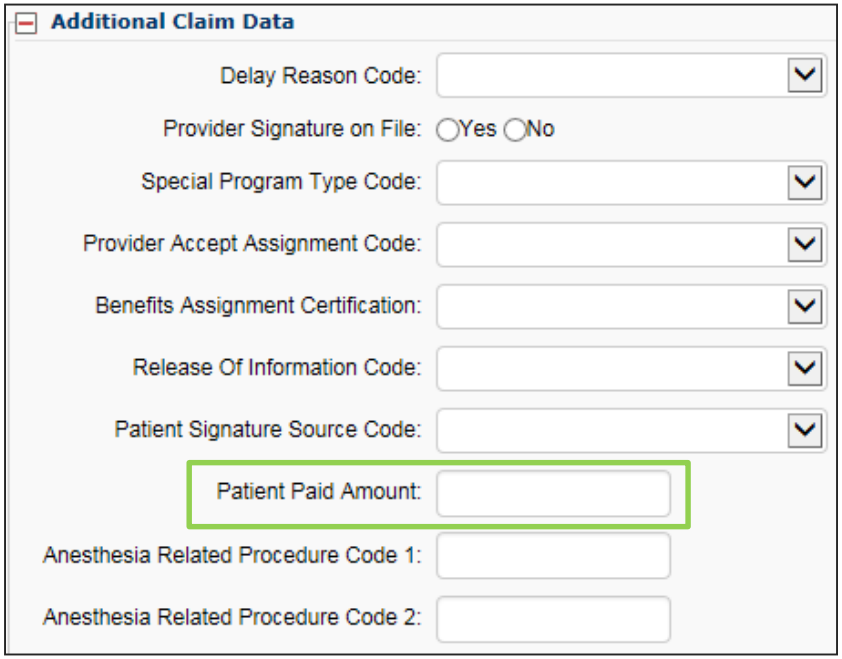
Note: The Place of Service is required in this section but can still be added to the line level of the claim. Line level is **NOT** required.

Additional Claim Data

- The **Additional Claim Data** red **+** expander will allow the provider to enter the patient's spenddown amount.



- If patient has a spenddown click on the red **+** expander to display the below image. Enter the spenddown amount in the **Patient Paid Amount** box.



Diagnosis Codes

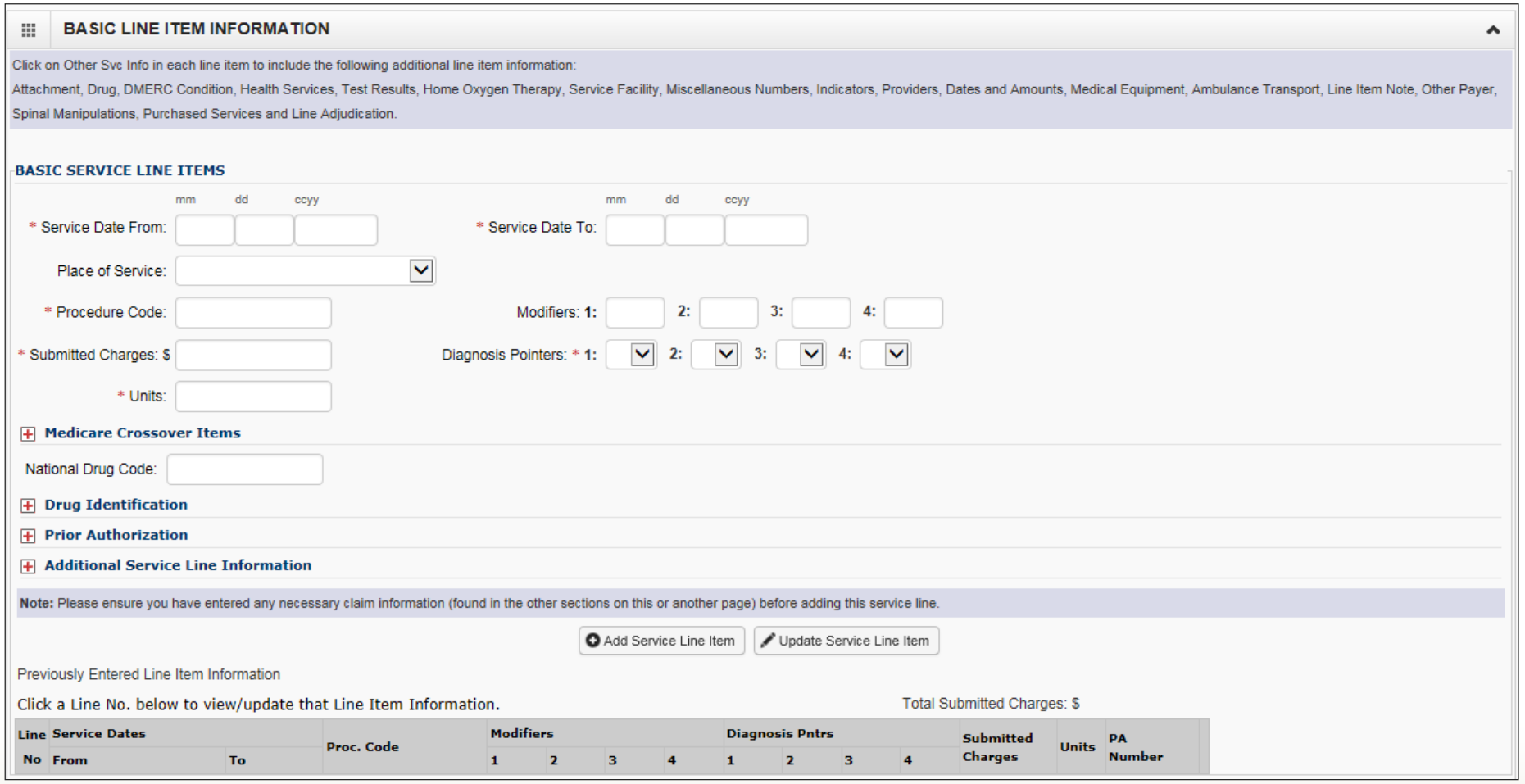
- Enter the appropriate ICD-10 **Diagnosis Code** or codes.

Note:

- At least 1 diagnosis code is required for all claims.
- ProviderOne will allow up to 12 ICD-10 diagnosis codes.
- Do not enter decimal points in DX codes. ProviderOne will add these in once the claim is submitted.

Basic Service Line Items

- Section 4: Basic Line Item Information



BASIC LINE ITEM INFORMATION

Click on Other Svc Info in each line item to include the following additional line item information:
Attachment, Drug, DMERC Condition, Health Services, Test Results, Home Oxygen Therapy, Service Facility, Miscellaneous Numbers, Indicators, Providers, Dates and Amounts, Medical Equipment, Ambulance Transport, Line Item Note, Other Payer, Spinal Manipulations, Purchased Services and Line Adjudication.

BASIC SERVICE LINE ITEMS

* Service Date From: mm dd ccyy
* Service Date To: mm dd ccyy
Place of Service:
* Procedure Code:
Modifiers: 1: 2: 3: 4:
* Submitted Charges: $
Diagnosis Pointers: * 1: 2: 3: 4:
* Units:

Medicare Crossover Items

National Drug Code:

Drug Identification

Prior Authorization

Additional Service Line Information

Note: Please ensure you have entered any necessary claim information (found in the other sections on this or another page) before adding this service line.

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: $

Line No	Service Dates From	Service Dates To	Proc. Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Diagnosis Pntrs 1	Diagnosis Pntrs 2	Diagnosis Pntrs 3	Diagnosis Pntrs 4	Submitted Charges	Units	PA Number

Basic Service Line Items

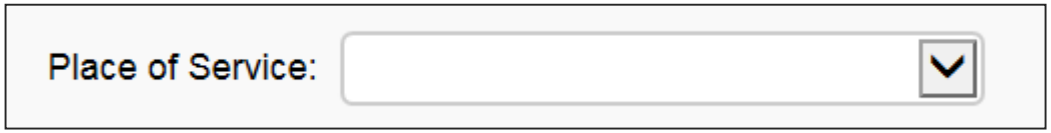
- Enter the **Service Date From**:

- Enter the **Service Date To**:

Note: The dates of service must be in the format of a 2 digit month, 2 digit day, and 4 digit year (e.g. 10/03/2016).

Basic Service Line Items

- The **Place of Service Code** is not required here as it is already entered at the Claim Level.



01-PHARMACY
03-SCHOOL
04-HOMELESS SHELTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY
08-TRIBAL 638 PROVIDER-BASED FACILITY
09-PRISON/CORRECTIONAL FACILITY
11-OFFICE
12-Home
13-ASSISTED LIVING FACILITY
14-Group Home
15-MOBILE UNIT
16-TEMPORARY LODGING
17-WALK-IN RETAIL HEALTH CLINIC
20-URGENT CARE FACILITY
21-INPATIENT HOSPITAL
22-OUTPATIENT HOSPITAL
23-EMERGENCY ROOM - HOSPITAL
24-AMBULATORY SURGICAL CENTER
25-BIRTHING CENTER
26-MILITARY TREATMENT FACILITY
31-SKILLED NURSING FACILITY (SNF)
32-NURSING FACILITY
33-CUSTODIAL CARE FACILITY
34-Hospice
41-AMBULANCE - LAND
42-AMBULANCE - AIR OR WATER
49-INDEPENDENT CLINIC
50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
51-INPATIENT PSYCHIATRIC FACILITY
52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
53-COMMUNITY MENTAL HEALTH CENTER
54-INTERMEDIATE CARE FACILITY (ICF/MR)
55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
60-MASS IMMUNIZATION CENTER
61-COMPREHENSIVE INPATIENT REHAB FACILITY
62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
65-END-STAGE RENAL DISEASE TREATMENT FACILITY
71-PUBLIC HEALTH CLINIC
72-RURAL HEALTH CLINIC (RHC)
81-INDEPENDENT LABORATORY
99-OTHER PLACE OF SERVICE

Basic Service Line Items

- Enter the **Procedure Code**:

Note: Use current codes listed in the coding manuals.

- Enter the appropriate procedure **Modifier(s)** if needed.

Note: ProviderOne allows up to 4 Modifiers to be added to a single procedure code.

Basic Service Line Items

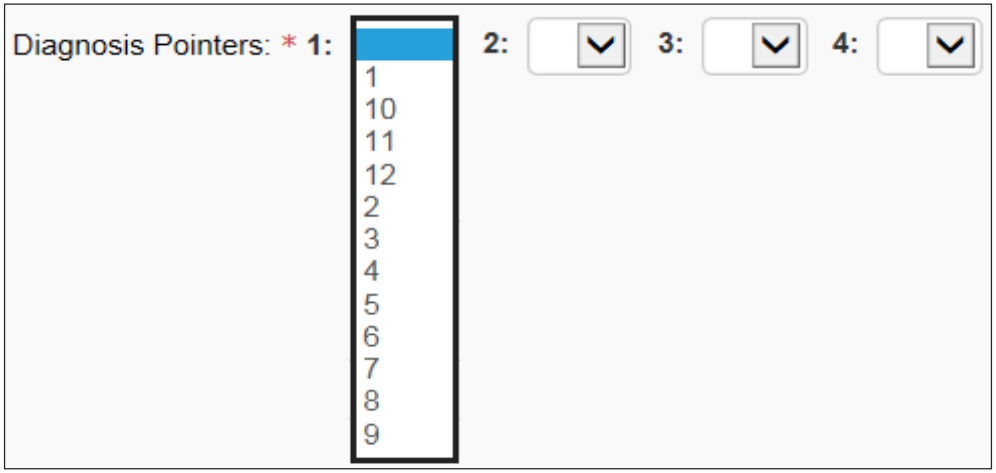
- Enter **Submitted Charges**:

Note: If the dollar amount is a whole number, no decimal point is needed.

Note: The agency requests that providers enter their usual and customary charges here. If providers have billed a Commercial Insurance or Medicare as primary, please enter the same charges here as billed to the primary. If a provider is billing for DME supplies that required prior authorization, please enter the same amount here as was on the authorization request because they must match.

Basic Service Line Items

- Enter appropriate **Diagnosis Pointer**:

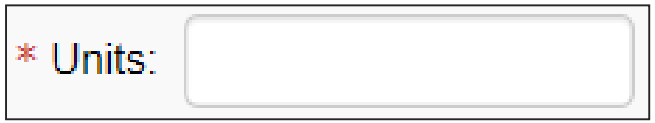


Note:

- At least one DX pointer is required.
- Up to 4 DX codes can be added per service line.
- Diagnosis Pointer 1 is the primary DX code.
- Diagnosis Pointer drop down corresponds with DX codes entered previously.

Basic Service Line Items

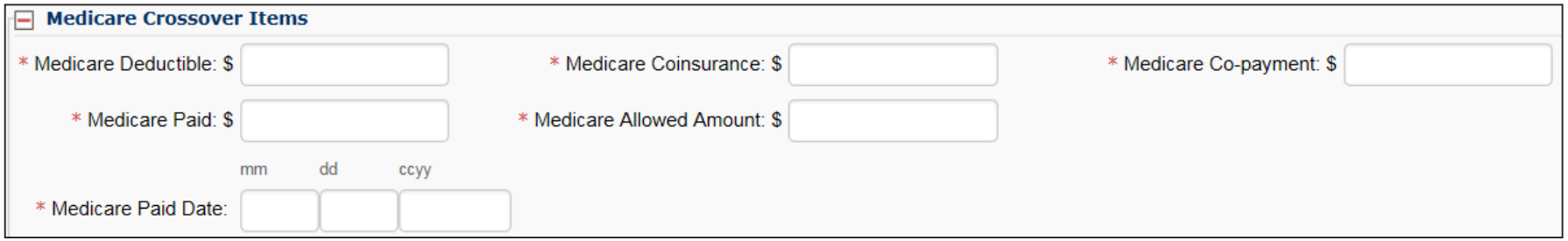
- Enter procedure **Units**:



Note: At least 1 unit is required.

Basic Service Line Items

- If the claim is a Medicare Crossover, complete the following **Medicare Crossover Items**:



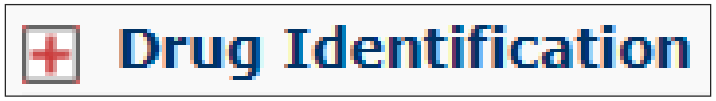
Note: Entering the line level Medicare information is required here if the previous question concerning Medicare Crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.

Note: For complete instructions on how to submit a Medicare Crossover claim please view the online fact sheet titled 5010 DDE Medicare Crossover Claims.

Basic Service Line Items

- Enter **National Drug Code** (NDC) if billing an injectable procedure code.

- The **Drug Identification** red **(+)** expander is not needed when billing for injectable procedure codes**.**



Basic Service Line Items

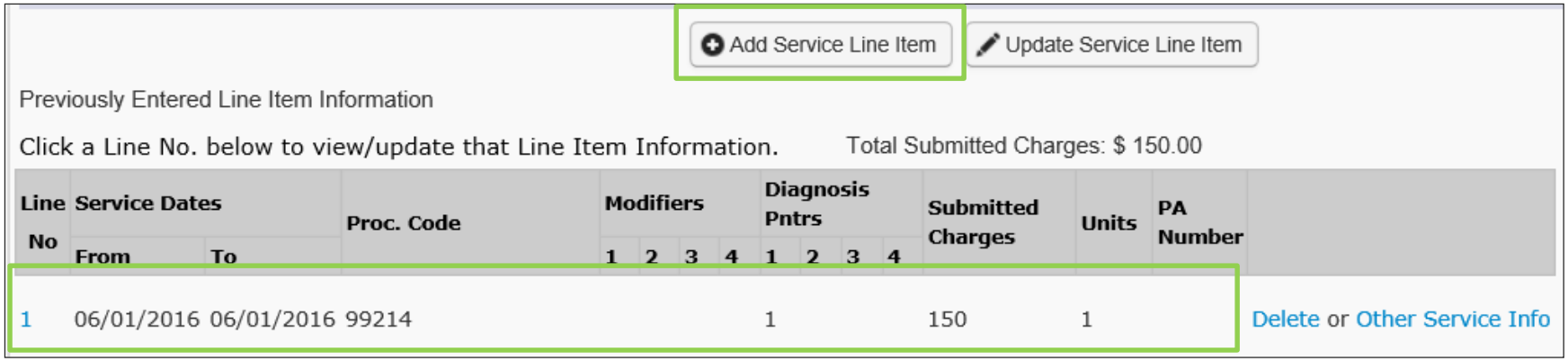
- If a Prior Authorization number needs to be added to a line level procedure code, click on the red **+** to expand the **Prior Authorization** option.

Note: If a Prior Authorization number was entered previously on the claim it is not necessary to enter it again here.

- The **Additional Service Line Information** is not needed for claims submission.

Add Service Line Items

- Click on the **Add Service Line Item** button to list the procedure line on the claim.

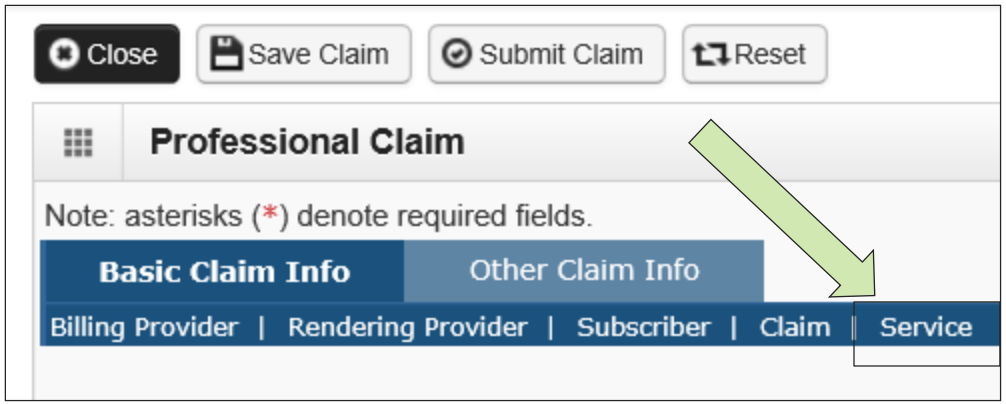


Note: Please ensure all necessary claim information has been entered before clicking the **Add Service Line Item** button to add the service line to the claim.

Note: Once the procedure line item is added, ProviderOne will refresh and return to the top of the claim form.

Add Additional Service Line Items

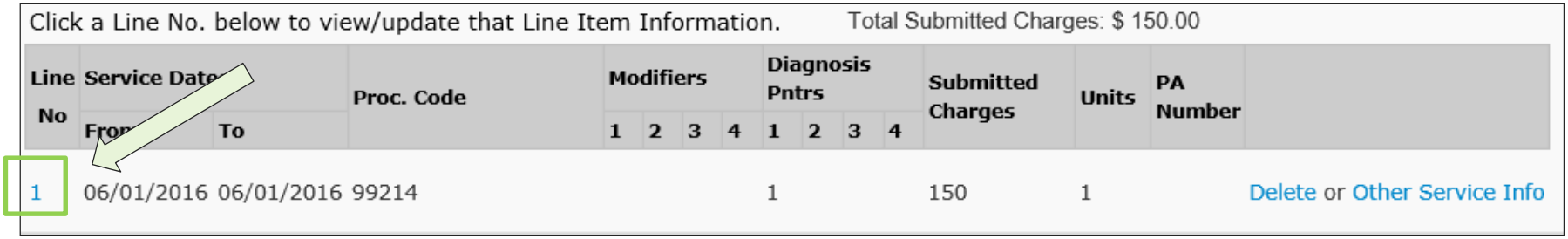
- If additional service lines need to be added, click on the **Service** hyperlink to get quickly back to the **Basic Service Line Items** section.



- Then follow the same procedure as outlined above for entering data for each line.

Update Service Line Items

- Update a previously added service line item by clicking on the **Line No.** of the line that needs to be updated. This will repopulate the service line item boxes for changes to be made.

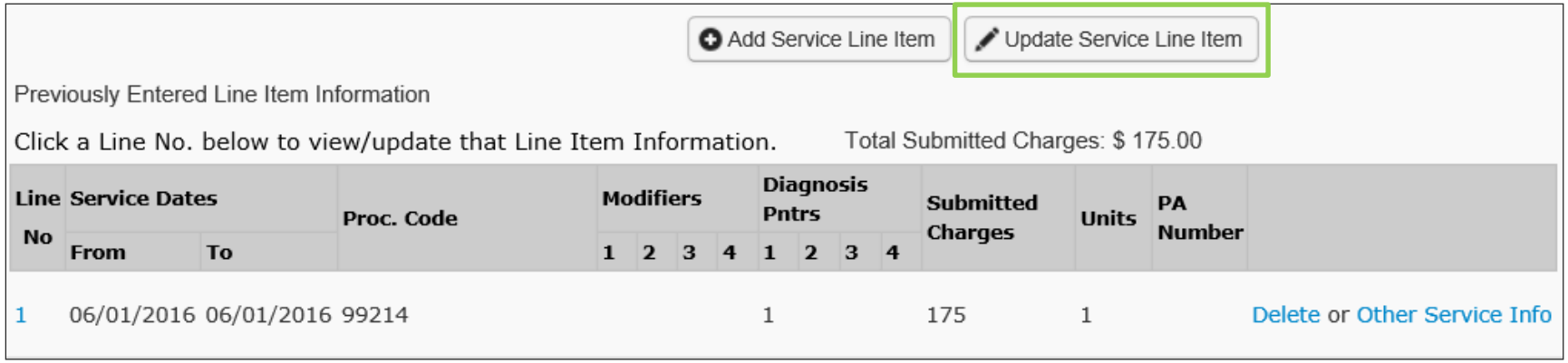

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 150.00

Line No	Service Date From	Service Date To	Proc. Code	Modifiers 1	2	3	4	Diagnosis Pntrs 1	2	3	4	Submitted Charges	Units	PA Number	
1	06/01/2016	06/01/2016	99214					1				150	1		Delete or Other Service Info

Note: Once the line number is chosen, ProviderOne will refresh the screen and return to the top of the claim form. Use the **Service** hyperlink to quickly return to the service line item boxes and make corrections.

Update Service Line Items

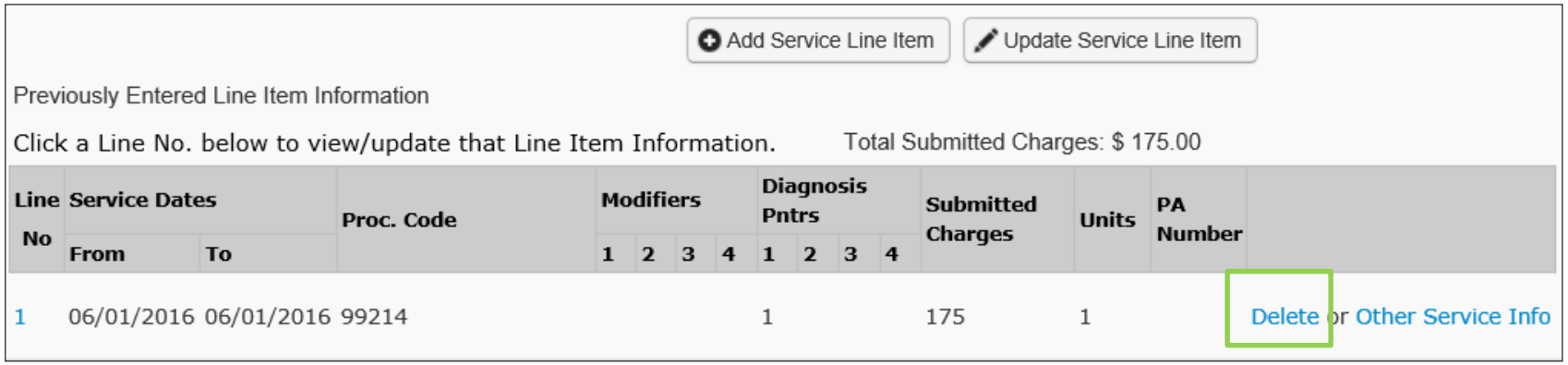
- Once the service line is corrected, click on the **Update Service Line Item** button to add corrected information on claim.



Note: Once the **Update Service Line Item** button is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the **Service** hyperlink to quickly return to the service line item section to view and verify that changes were completed.

Delete Service Line Items

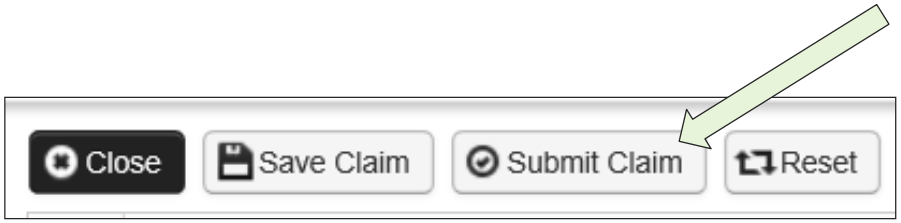
- A service line can easily be deleted from a claim before submission by clicking on the **Delete** option at the end of the added service line.



Note: Once the service line item is deleted it will be permanently removed from claim. If the service line was accidently deleted, the provider will need to re-enter the information following previous instructions.

Submit Claim for Processing

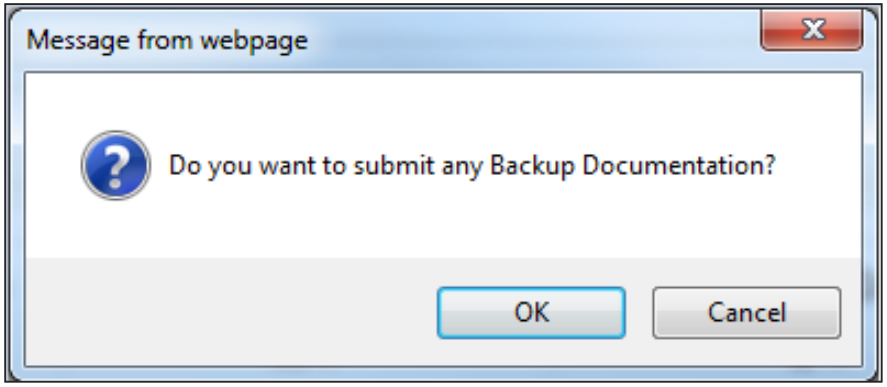
- When the claim is ready for processing, click the **Submit Claim** button at the top of the claim form.



Note: Make sure the browser **Pop Up Blocker** is off or your system will not allow the claim to be submitted.

Submit Claim for Processing

- Click on the Submit Claim button to submit the claim. ProviderOne should then display this prompt:

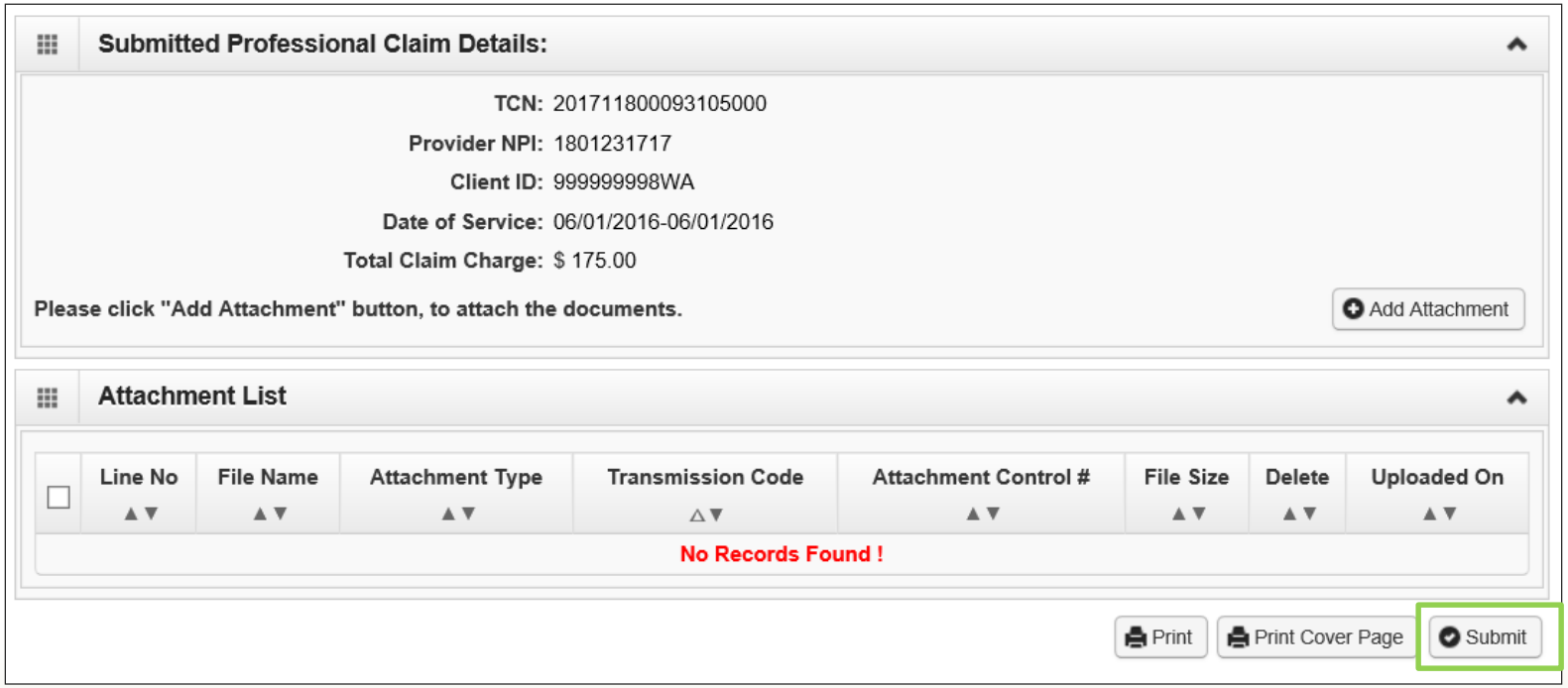


- Click on the **Cancel** button if no backup is to be sent.
- Click on the **OK** button if backup needs to be attached.

Note: If all insurance information has been entered on the claim, it is not necessary to send the insurance EOB with the claim.

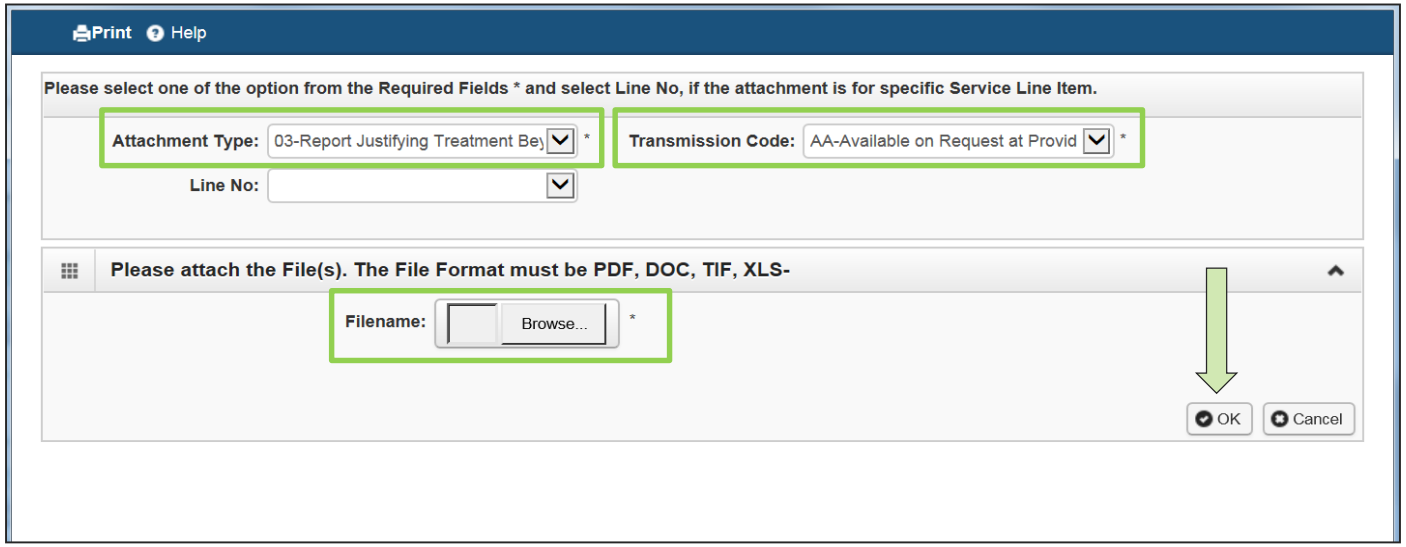
Submit Claim for Processing – No Backup

- ProviderOne now displays the **Submitted Professional Claim Details** screen.
- Click on the **Submit** button to finish submitting the claim.



Submit Claim for Processing – With Backup (Electronic File Attached)

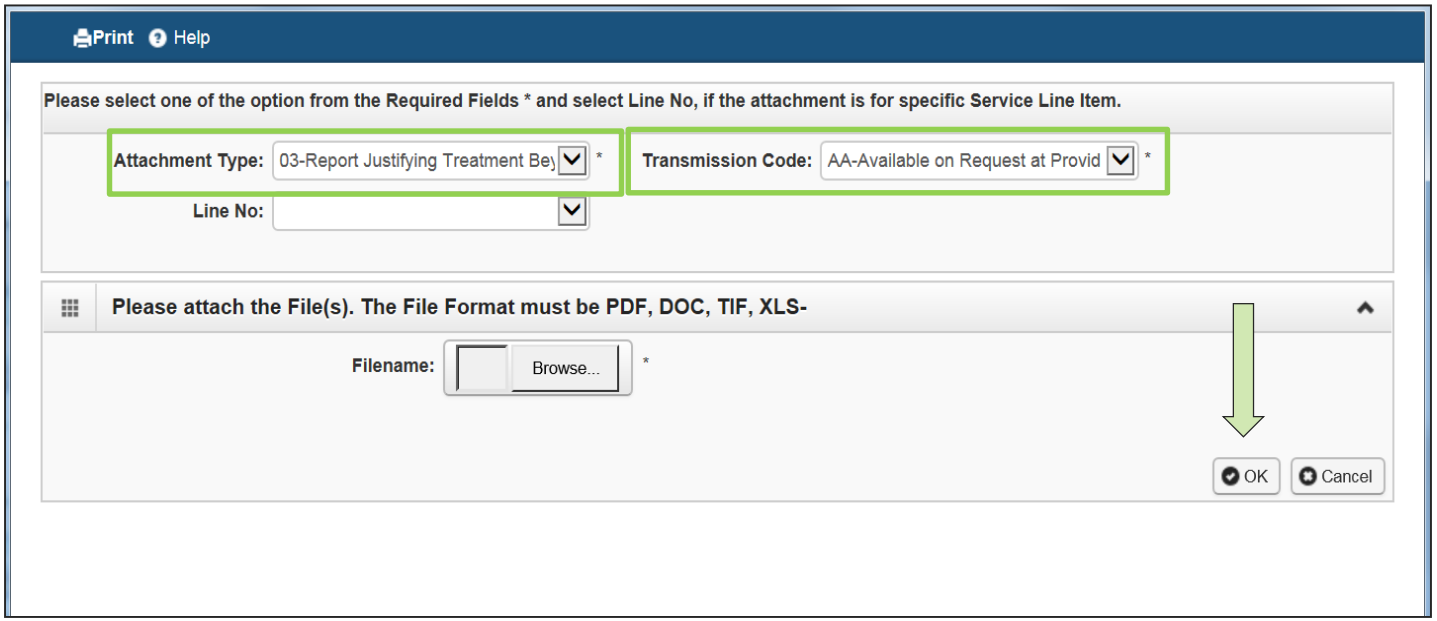
- The Claim's Backup Documentation page is displayed.



- Enter the **Attachment Type.**
- Pick one of the following Transmission Codes:
  - **EL**- Electronic Only or Electronic file
  - Browse to find the file name
- Click the **OK** button.

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

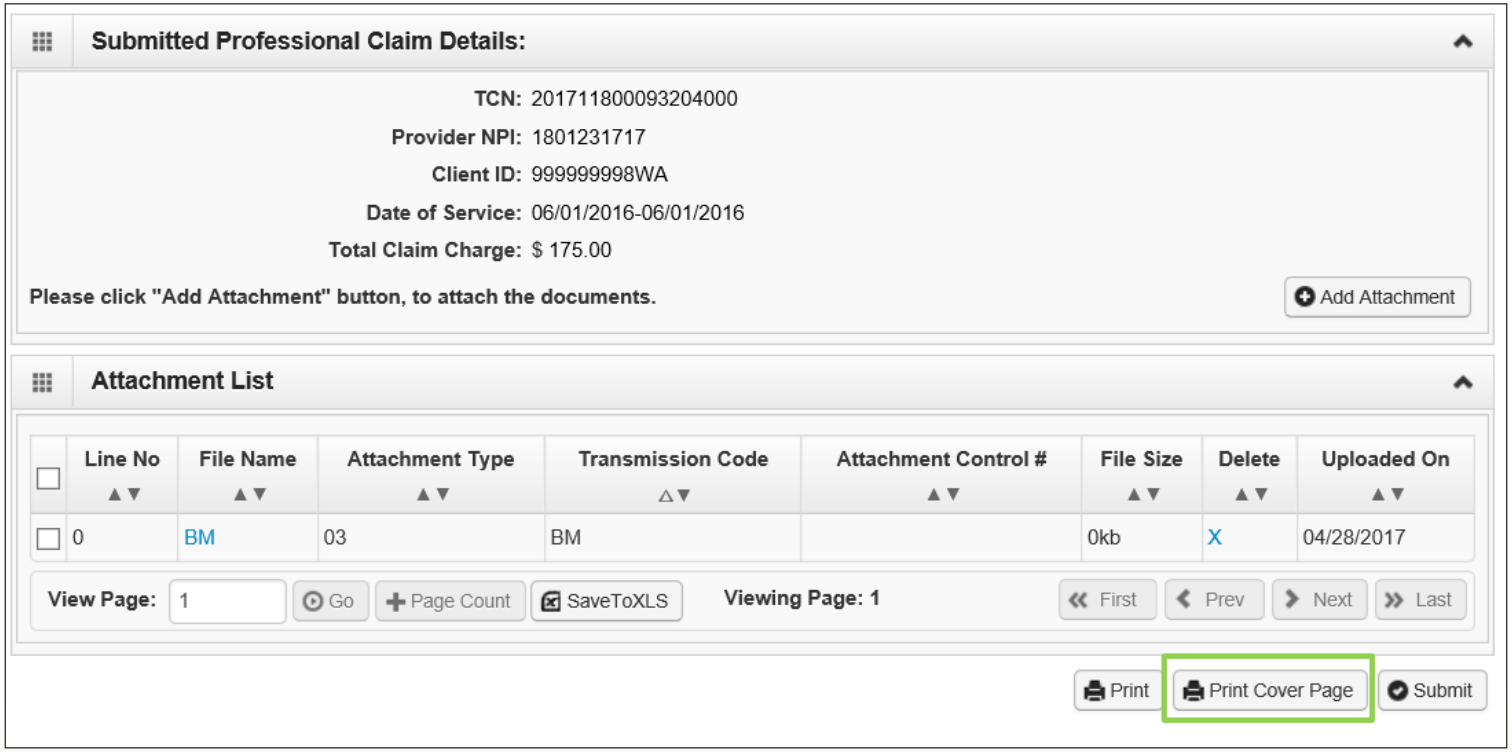
- The Claims Backup Documentation page is displayed.



- Enter the **Attachment Type.**
- Pick one of the following Transmission Codes:
  - **BM** - By Mail; or
  - **FX** - Fax
- Click the **OK** button.

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- If sending paper documents with the claim, at the Submitted Professional Claim Details page click on the **Print cover Page** button.



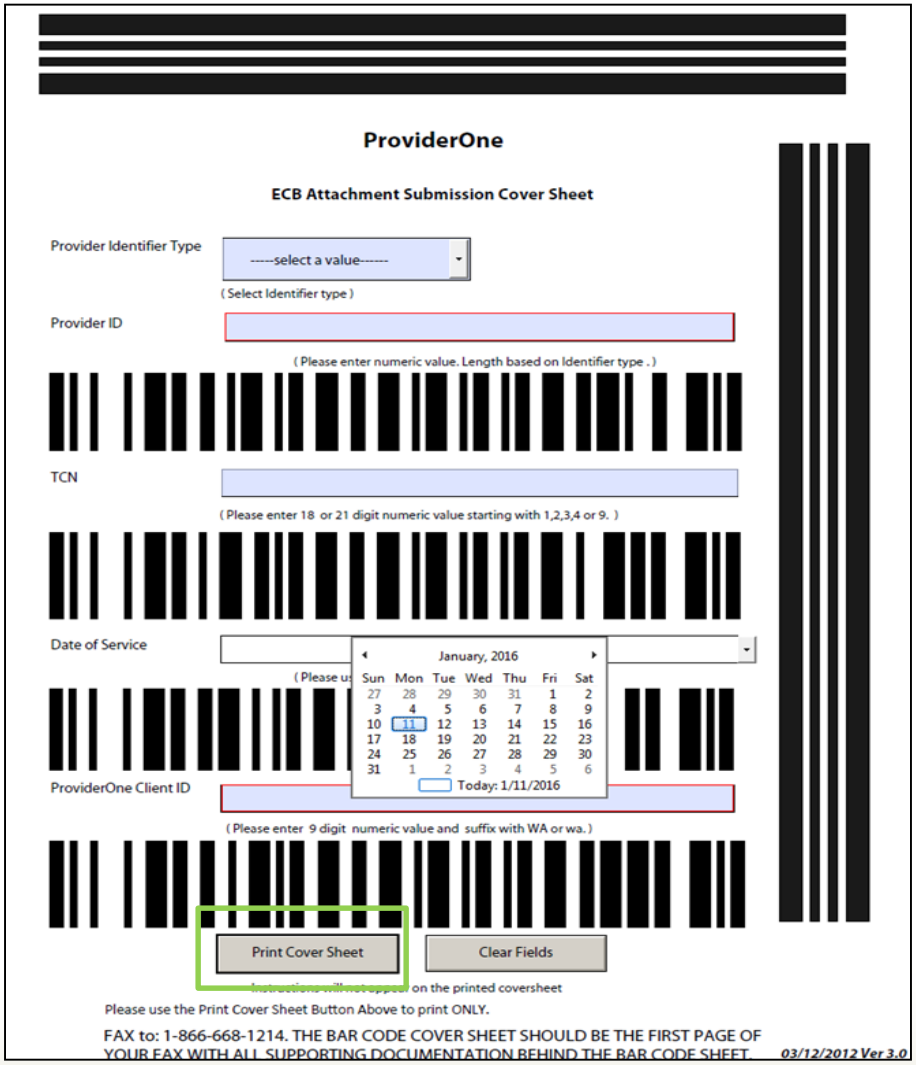
Submit Claim for Processing – With Backup

- Fill in the boxes with the appropriate information:
  - Tab between fields
  - Expands the bar code
- When completed click on the **Print Cover Sheet** button and mail to:

Electronic Claim Back-up Documentation
PO BOX 45535
Olympia, WA 98504-5535

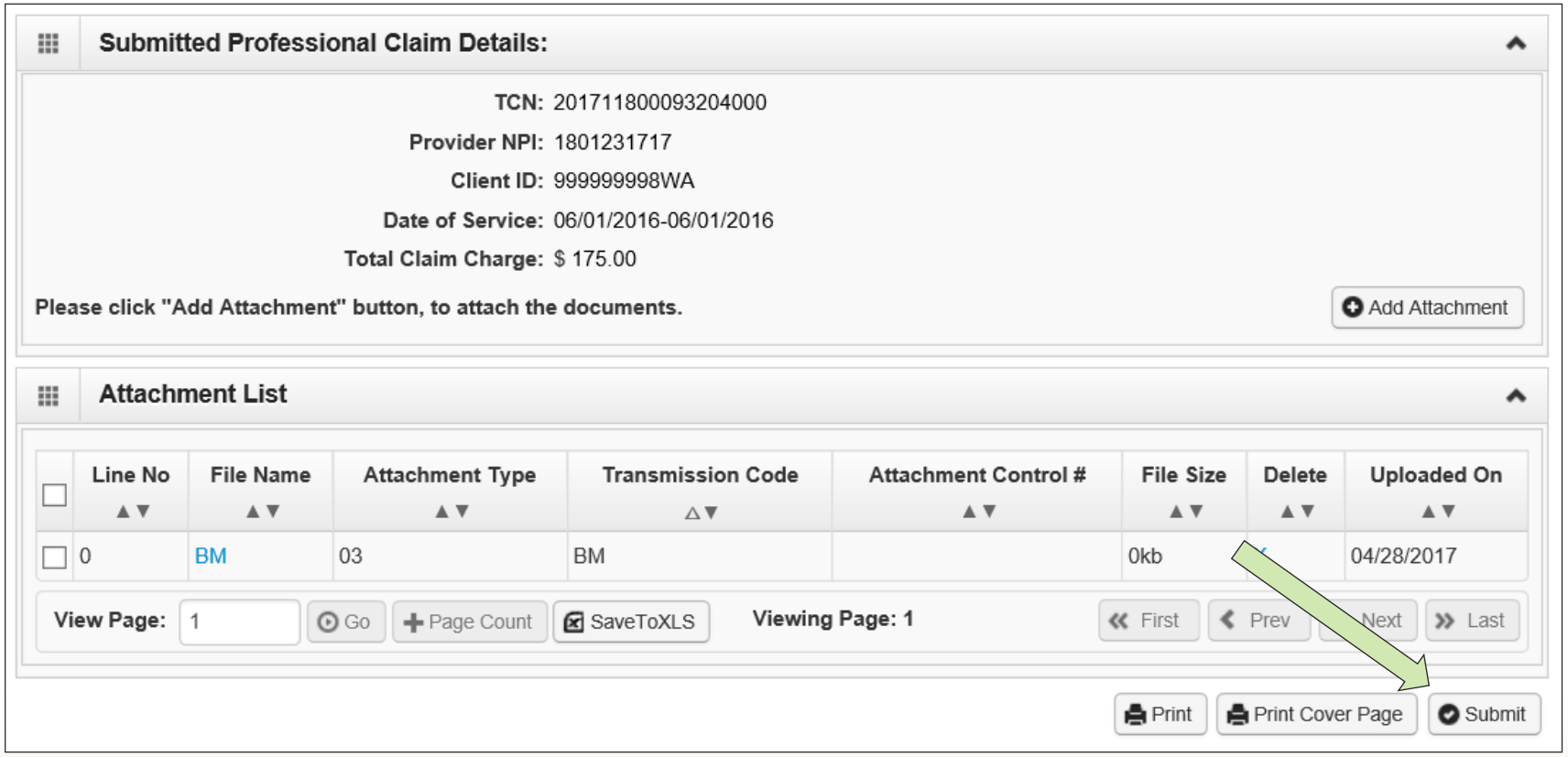
OR

Fax: 1-866-668-1214



Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- Push the **Submit** button to submit the claim.



Saving and Retrieving a Direct Data Entry Claim

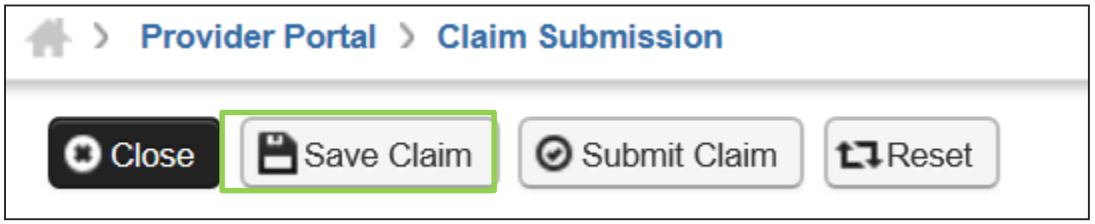
Saving a Direct Data Entry Claim

- ProviderOne allows a provider to save a claim if you are interrupted during the process of entering.
- You can retrieve the saved claim to finish entering the needed information and submit the claim.
- The following data elements are the minimum required to be completed before a claim can be saved:

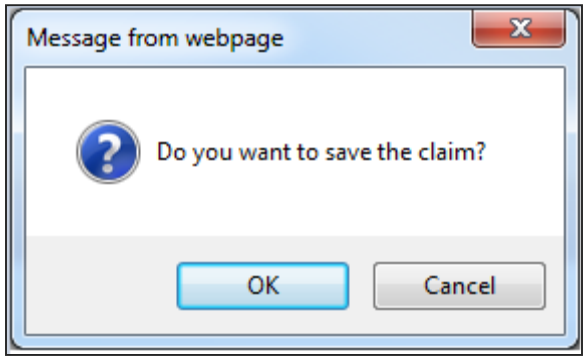
Section 1: Billing Provider Information	Section 2: Subscriber/Client Information	Section 3: Claim Information
Billing Provider NPI	Client ID number	Is this claim accident related? 
Billing Provider Taxonomy		
Is the Billing Provider also the Rendering Provider? 		

Saving a Direct Data Entry Claim

- Save the claim by clicking on the **Save Claim** button**.**



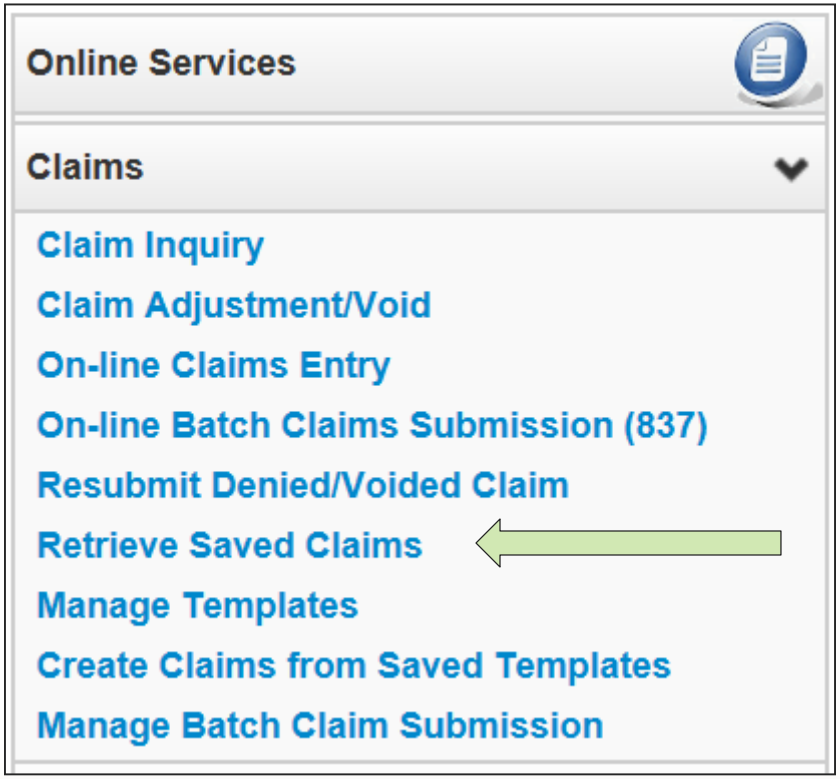
- ProviderOne now displays the following confirmation box:



- Click the **OK** button to proceed or **Cancel** to return to the claim form.
- Once the **OK** button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.
- If all data fields are completed, ProviderOne saves the claim and closes the claim form.

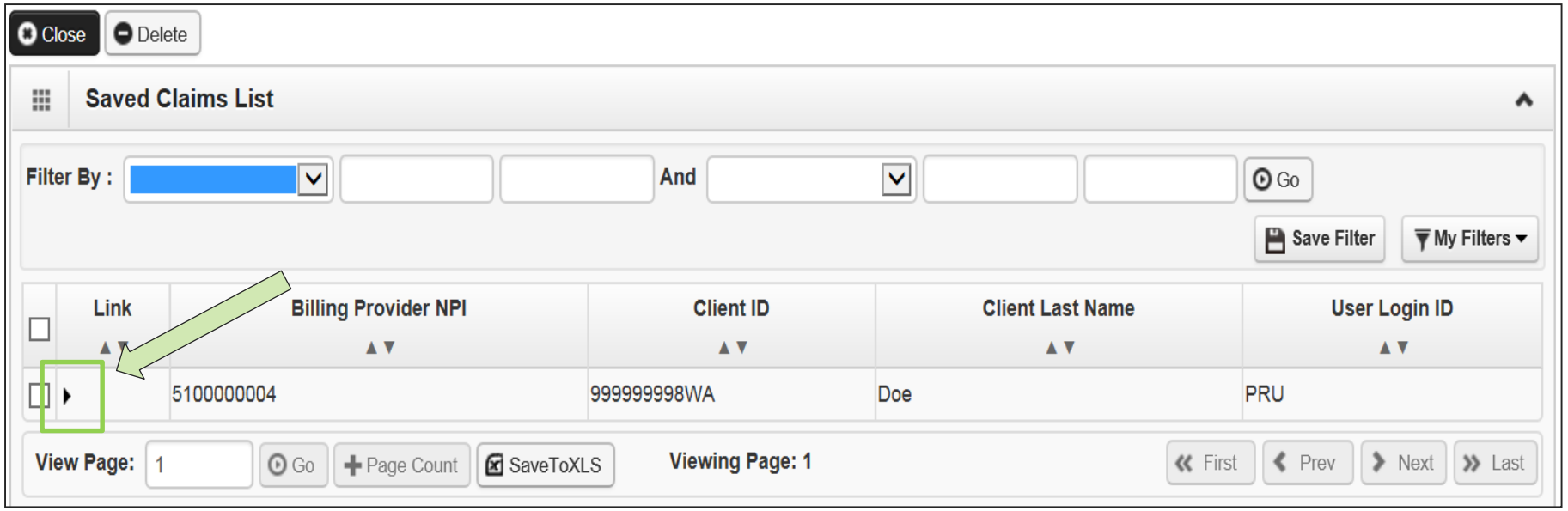
Retrieving a Saved Direct Data Entry Claim

- At the Provider Portal, click on the **Retrieve Saved Claims** hyperlink.



Retrieving a Saved Direct Data Entry Claim

- ProviderOne displays the **Saved Claims List**:
  - Click on the Link Icon to retrieve a claim.



- The system loads the saved claim in the correct DDE claim form screen.
- Continue to enter data, then submit the claim as normal.
- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claims List.

Medicare Crossover

Common Terminology

- Coinsurance
  - An amount a Medicare client may be required to pay as their share of the cost for services.
- Deductible
  - The amount for which a beneficiary is responsible before Medicare starts paying.
- Capitated Copayment
  - A predetermined set dollar amount a Medicare client may be required to pay as their share of the cost for services.
- Non-Capitated Copayment
  - An amount a Medicare client may be required to pay as their share of the cost for services.

Overview – Medicare Crossover

- There are 4 types of Medicare coverage:
  - Medicare Part A covers Inpatient hospital services
  - Medicare Part B covers professional and vendor services
  - Medicare Part C is a managed care version of Medicare, a Medicare Advantage Plan
  - Medicare Part D covers prescription drugs

- When is a claim a Medicare crossover claim?
  - If Medicare pays or applies to the deductible, the claim billed to HCA is a crossover.
  - The general rule is to bill the Agency after Medicare on the same claim form billed to Medicare.
  - The Agency is not paying Part D co-pays (Part D is not covered in this presentation).

Overview - Medicare Crossovers

- When is a claim **NOT** a crossover claim?
  - Claims (services) denied by Medicare when billed to us are not crossover claims.
  - We still require the Medicare EOB to demonstrate non-payment.

- Sometimes Medicare does **NOT** forward claims automatically to the Agency
  - Can submit Direct Data Entry (DDE) or Electronically without the EOMB (if Medicare denies the service, the EOMB IS required for electronic billing).
  - The Medicare Advantage Plans do not cross claims over directly so they must be billed separately through DDE or Electronically as crossover claims.

Overview - Medicare Crossovers

- If Medicare denies an Apple Health-covered service that requires Prior Authorization, the service still requires authorization:
  - You may request it after the service is provided.
  - The agency waives the “prior” requirement in this circumstance.

Medicare Eligibility

- Eligibility checks may show Medicare as:
  - QMB – Medicare Only (Qualified Medicare Beneficiary)
    - This program pays for Medicare premiums and may pay deductibles, coinsurance, and copayments according to Medicaid rules.
  - CNP-QMB (Categorically Needy Program – Qualified Medicare Beneficiary)
    - Client has full Medicaid as well as QMB benefits.

Medicare Eligibility

- Programs that HCA would not consider for secondary payment after Medicare:
  - SLMB (Special Low Income Medicare Beneficiary)
    - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.
  - QI-1 (Qualified Individual 1)
    - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.
  - QDWI (Qualified Disabled Working Individual) –
    - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.

Medicare Eligibility

- Determine Medicare eligibility using ProviderOne. Scroll down to the **Medicare Eligibility Information** area.

Medicare Eligibility Information

Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MA: Medicare Part A	02/01/1997	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	02/01/1997	12/31/2999

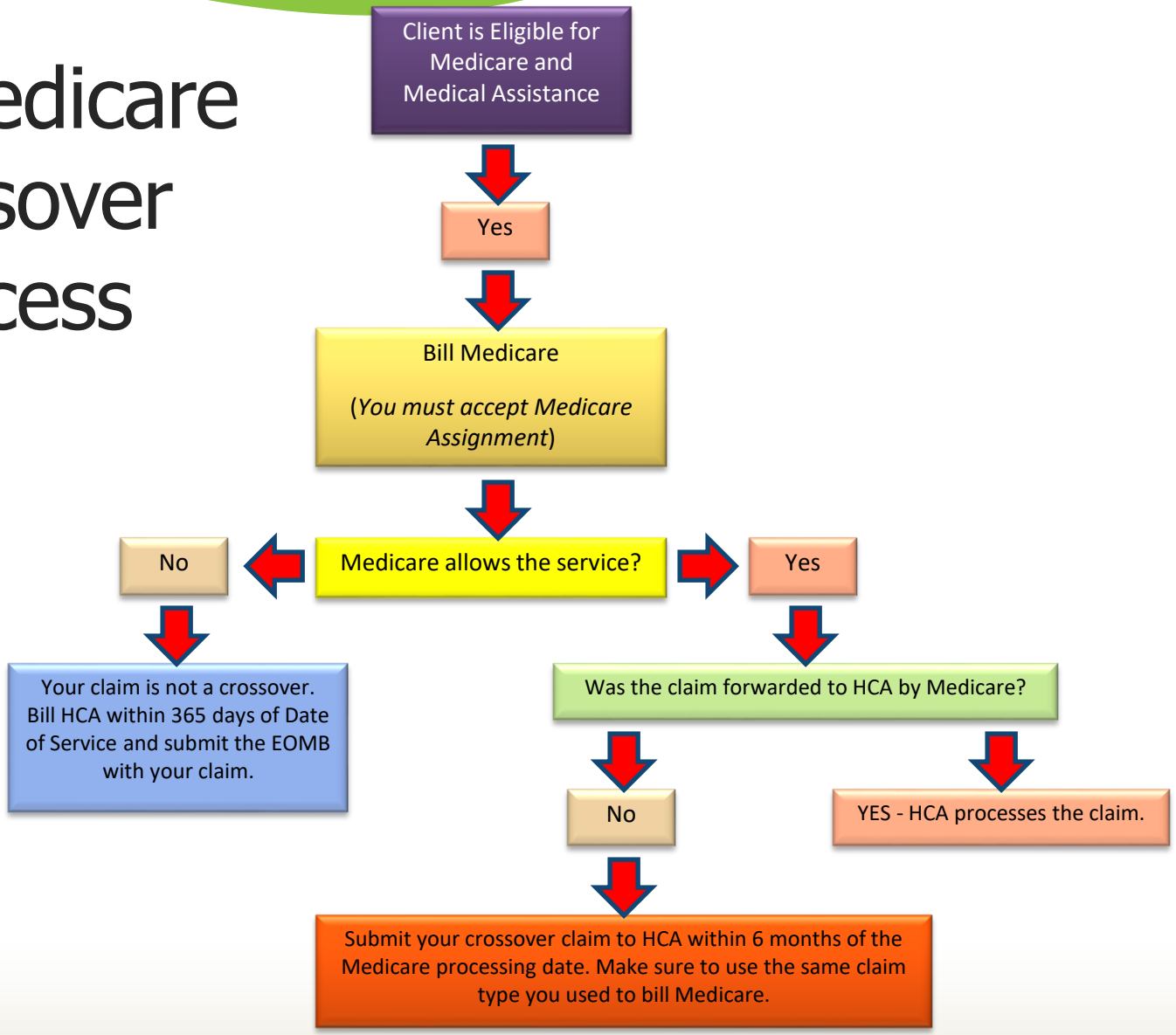
  - The Medicare HIC number is listed under the Client Demographic area.

- Medicare Part C information (if loaded) is located under the **Coordination of Benefits Information** area.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part D			08/01/2009	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part C			08/01/2009	12/31/2999

The Medicare Crossover Process



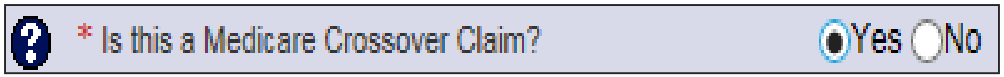
Medicare Billing Part B

Medicare Billing – Part B

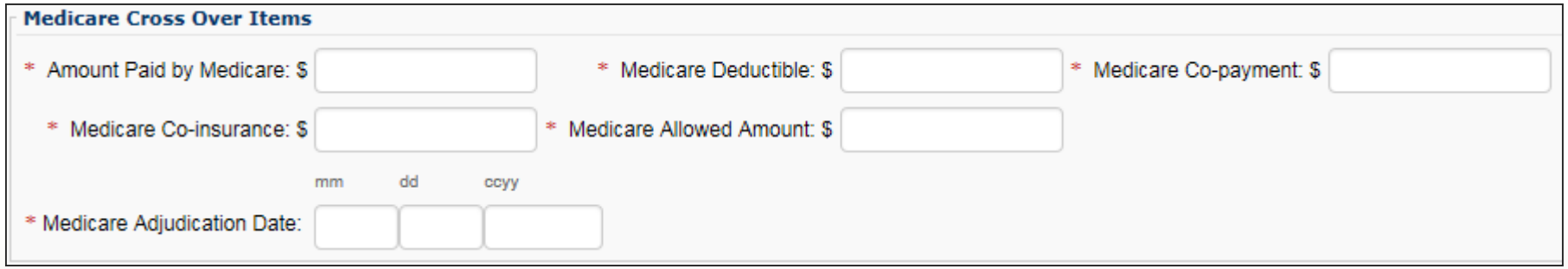
- DDE Professional, 837P
  - If Medicare has paid all lines on your claim and did not forward the claim to Apple Health, submit the crossover claim to the Agency.
  - If Medicare has allowed and denied service lines on your claim:
    - You will need to submit **TWO** claims to the Agency;
      - One crossover claim for services Medicare paid; and
      - One professional claim for services Medicare denied.

Medicare Billing – Part B

- Bill the Agency using the same service codes and billed amounts sent to Medicare.
- Medicare and Medicare Advantage Plans are Medicare:
  - HCA does not consider Medicare as insurance.
- When submitting via Direct Data Entry (DDE)
  - Click the Radio button **YES** to indicate this claim is a crossover.

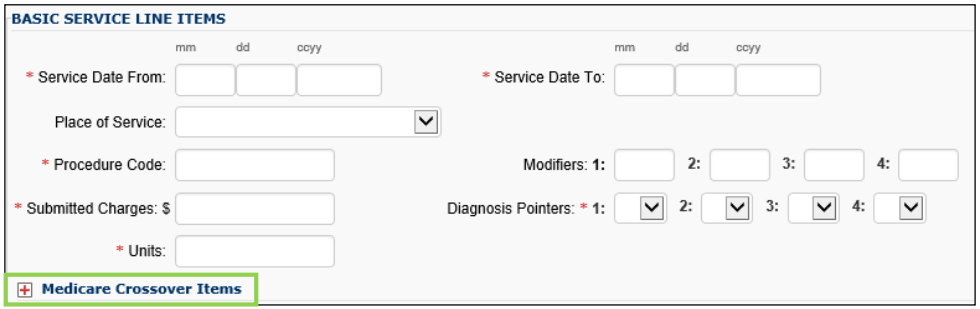


  - Additional data boxes open to be filled in as required at claim level.

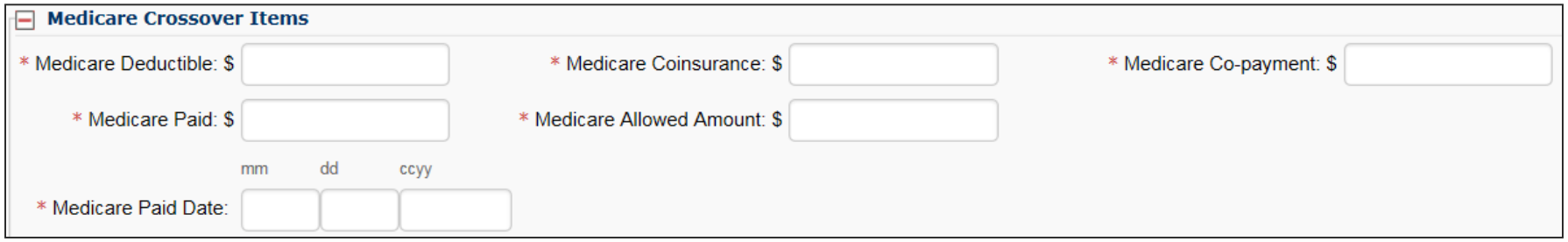


Medicare Billing – Part B

- The rest of the claim information is filled out as normal down to the service line information. Expand the **Medicare Crossover Items** by clicking the red **+**.



- Entering the line level Medicare information is required. The line level Medicare payment amounts must match the claim level Medicare payment total entered.



- No EOB is required with the DDE crossover claim.

Washington State Health Care Authority

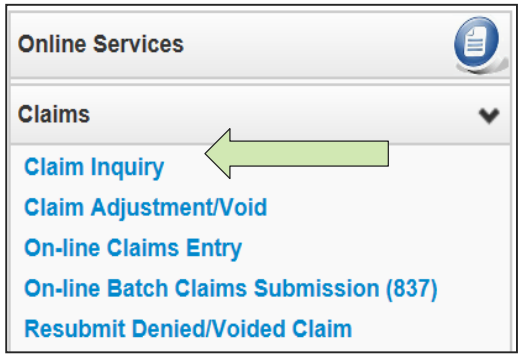
Tips on Billing Crossovers

- Bill your taxonomy code(s) to Medicare the same as you bill your taxonomy code(s) to Medicaid.
- If you bill Medicare with an NPI that has not been loaded in ProviderOne, the agency will not be able to identify the provider when these claims are forwarded by Medicare.
- The claim format billed to Medicare must match the claim format billed to ProviderOne.
- The coding and dollar amount billed must match.
- Complete all required fields on the DDE crossover screen.

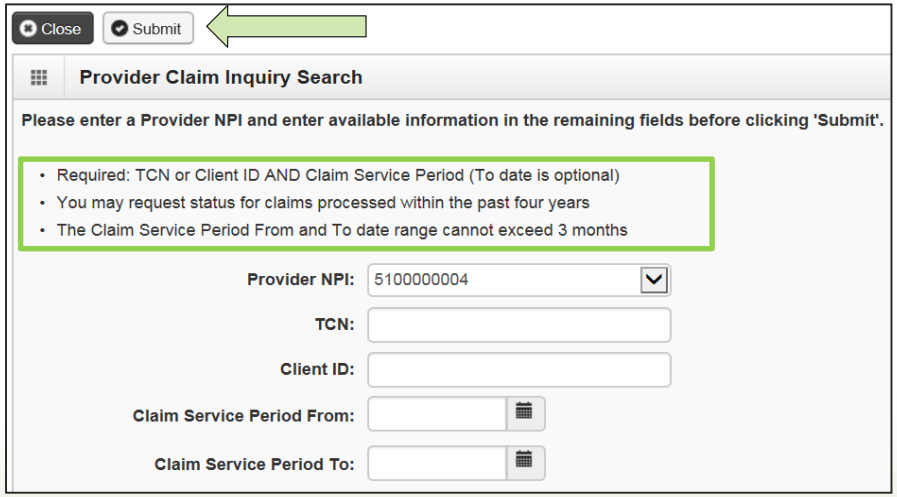
Claim Inquiry

Claim Inquiry

- How do I find claims in ProviderOne?
  - **Claim Inquiry**

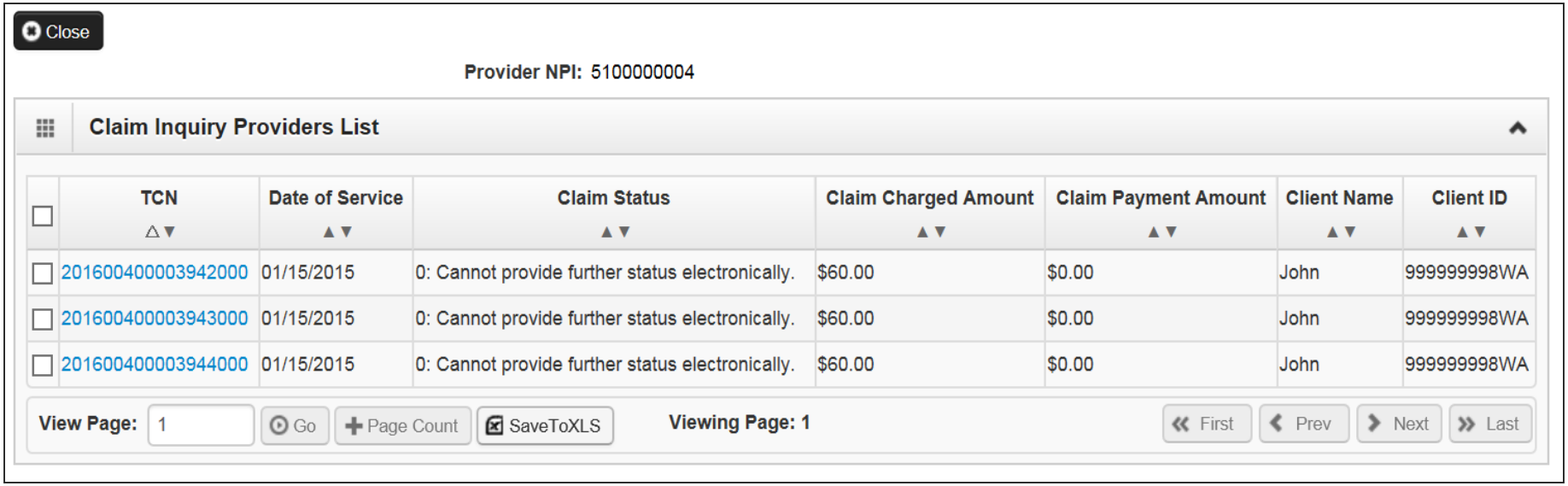


- Enter search data then submit



Claim Inquiry

- Claim TCN's returned
  - Click on TCN number to view the claim data.
    - Denied claims will show the denial codes.
    - Easiest way to find a timely TCN number for re-billing.



Why can't I pull up my claim?

- There are many reasons why you might not be able to retrieve a claim (for any system functions):
  - It has been adjusted, you can't retrieve a claim that has already been adjusted.
  - It has been replaced by another claim.
  - It hasn't finished processing.
  - It was billed under a different domain.
  - You could be using the wrong profile.
  - Trying to do a resubmit on a paid claim or an adjustment on a denied claim.
  - Claims you billed with an NPI not reported in ProviderOne.
  - Claims you billed with an ID only rendering provider NPI number as the pay-to provider.

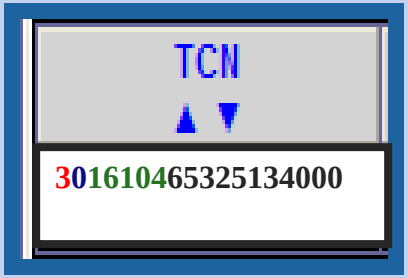
Timely Billing

Timely Billing

- What are the agency's timeliness guidelines?
  - The initial billing must occur within **365** days from the date of service on the claim.
  - Providers are allowed **2** years total to get a claim paid or adjusted.
  - For Delayed Certification client eligibility the agency allows **12** months from the Delayed Cert date to bill.
  - Recoupments from other payer's timeliness starts from the date of the recoupment, not the date of service.
  - The agency uses the Julian calendar on claim numbers for tracking.

What is a TCN?

TCN=Transaction Control Number



18 digit number that ProviderOne assigns to each claim received for processing. TCN numbers are never repeated.

Washington State Health Care Authority

How do I read a TCN?

1st digit-Claim Medium Indicator

- 1-paper
- 2-Direct Data Entry
- 3-electronic, batch submission
- 4-system generated (Credits/Adjustment)

2nd digit-Type of Claim

- 0-Medical/Dental
- 2-Crossover or Medical

3rd thru 7th digits-Date Claim was Received

- 3rd and 4th digits are the year
- 5th, 6th and 7th digits are the day it was received

Example TCN:

30161046532513400 0

3 Electronic submission via batch
0 Medical claim
16 Year claim was received-2016
104 Day claim was received-April 14

How do I prove timeliness?

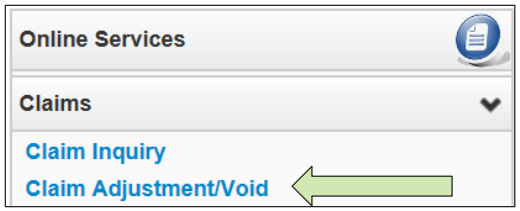
- HIPAA EDI claims
  - Submit a HIPAA batch transaction using a frequency 7 to adjust/replace the original claim or a frequency 8 to void the original claim.

- Direct Data Entry (DDE) Claims
  - Resubmit Original Denied/Voided Claim; or
  - Enter timely TCN in the Claim Note.

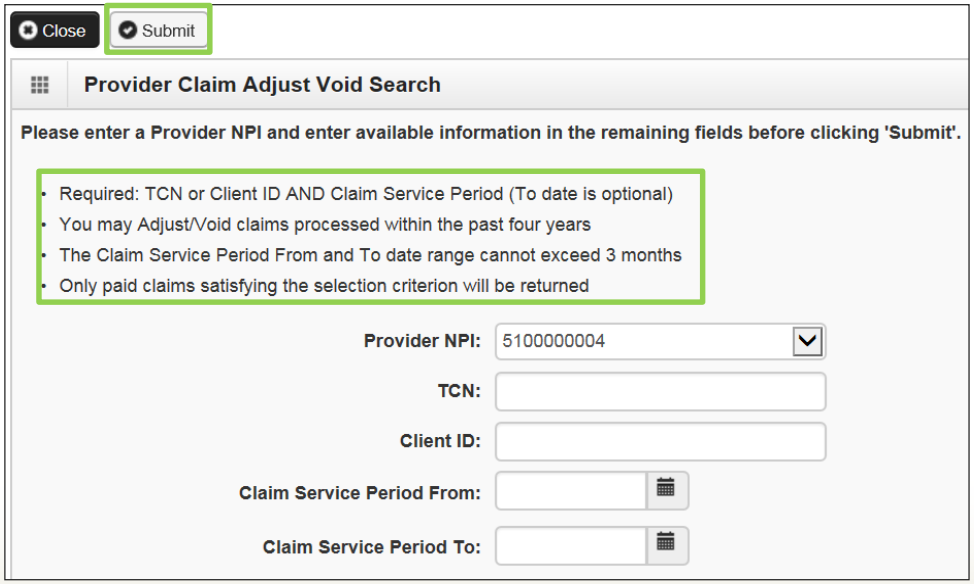
Adjust / Void a Claim

Adjust/Void a Paid Claim

- Select **Claim Adjustment/Void** from the Provider Portal.



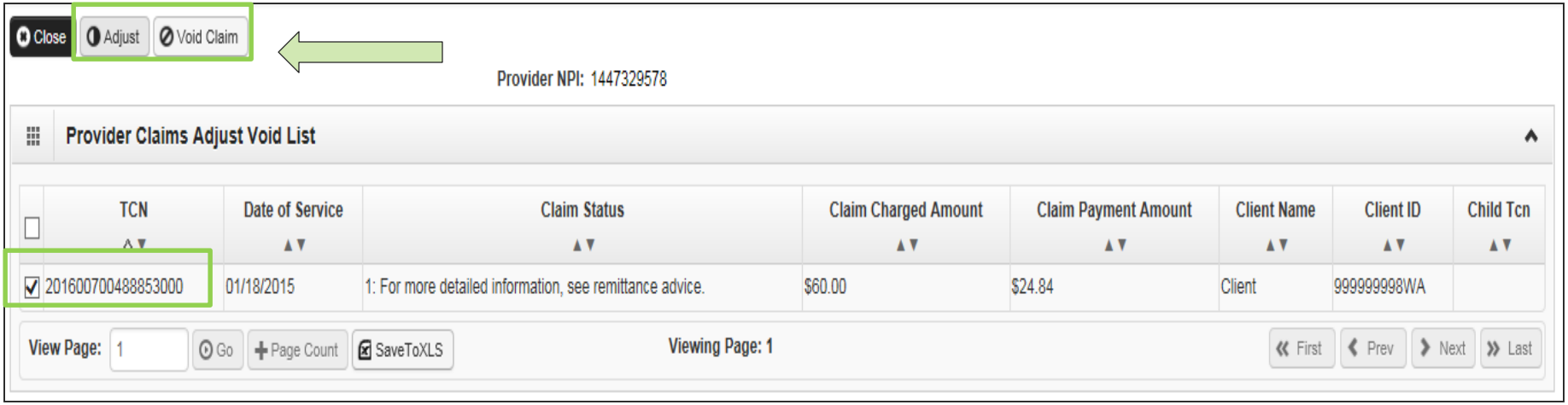
- Enter the **TCN** number if known; or
- Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.



Note: Per WAC 182-502-0150 claims can only be adjusted/voided in ProviderOne 24 months from the date of service. Prescription drug claims have only 15 months.

Adjust/Void a Paid Claim

- The system will display the paid claim(s) based on the search criteria.

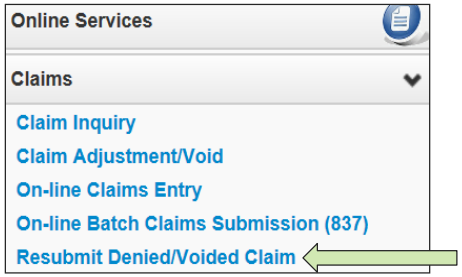


- Check the box of the TCN to adjust/void.
- ProviderOne loads the DDE screen with the claim data.
  - Update the claim information to adjust, then submit.
  - Claim data cannot be changed when doing a void, just submit the void.

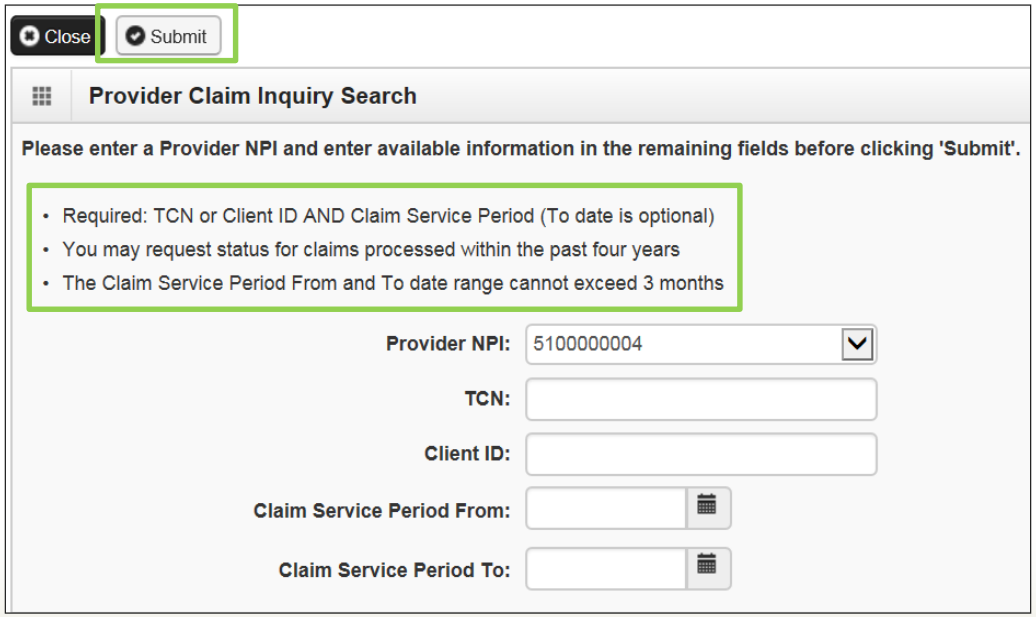
Resubmit Denied Claims

Resubmit a Denied Claim

- Select **Resubmit Denied/Voided** Claim from the Provider Portal.

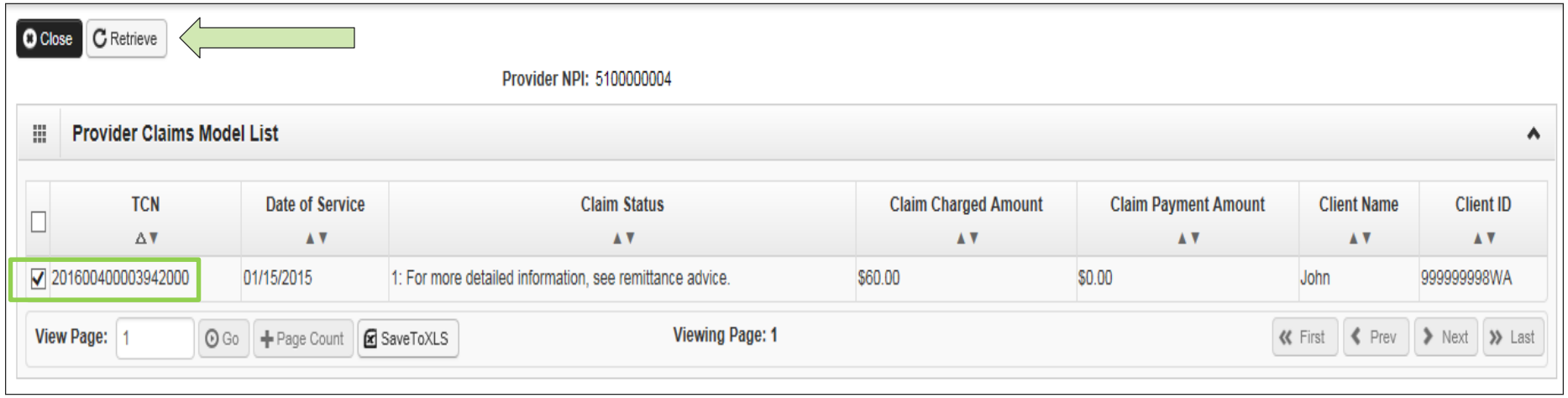


- Enter **TCN**, if known; or
- Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.



Resubmit a Denied Claim

- The system will display the claim(s) based on the search criteria.

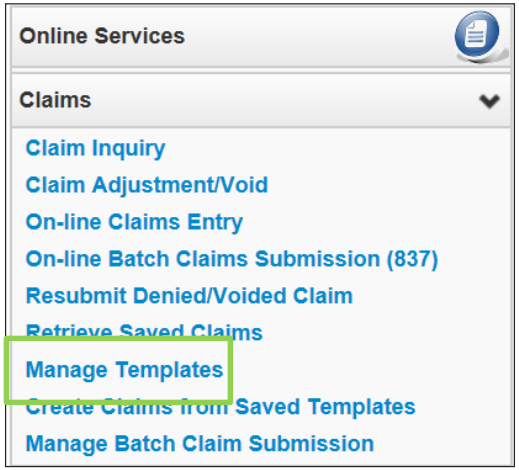


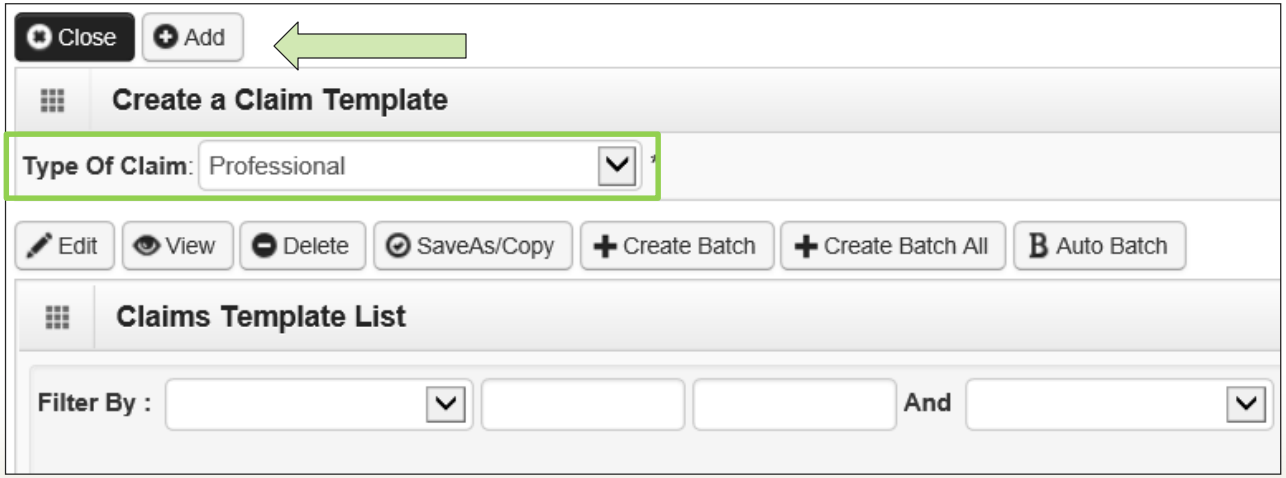
- Check the box of the TCN to resubmit and click **Retrieve**.
- ProviderOne loads the DDE screen with the claim data.
  - Update the claim information that caused the claim to deny, then submit.

Claim Templates

Creating a Claim Template

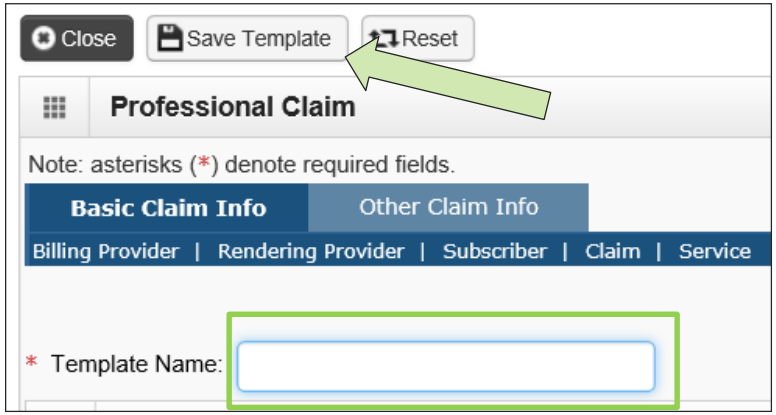
- ProviderOne allows creating and saving templates:
  - Log into ProviderOne.
  - Click on the **Manage Templates** hyperlink
  - At the Create a Claim Template screen, use the dropdown to choose the **Type of Claim**.
  - Click the **Add** button.





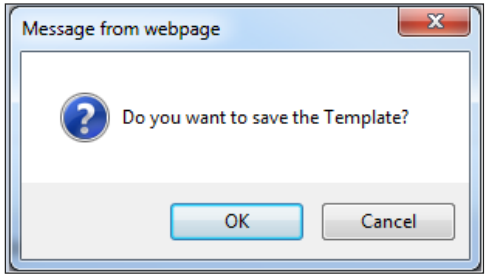
Creating a Claim Template

- Once a template type is picked the system opens the DDE screen:



- Name the template then fill in as much data as wanted on the template.

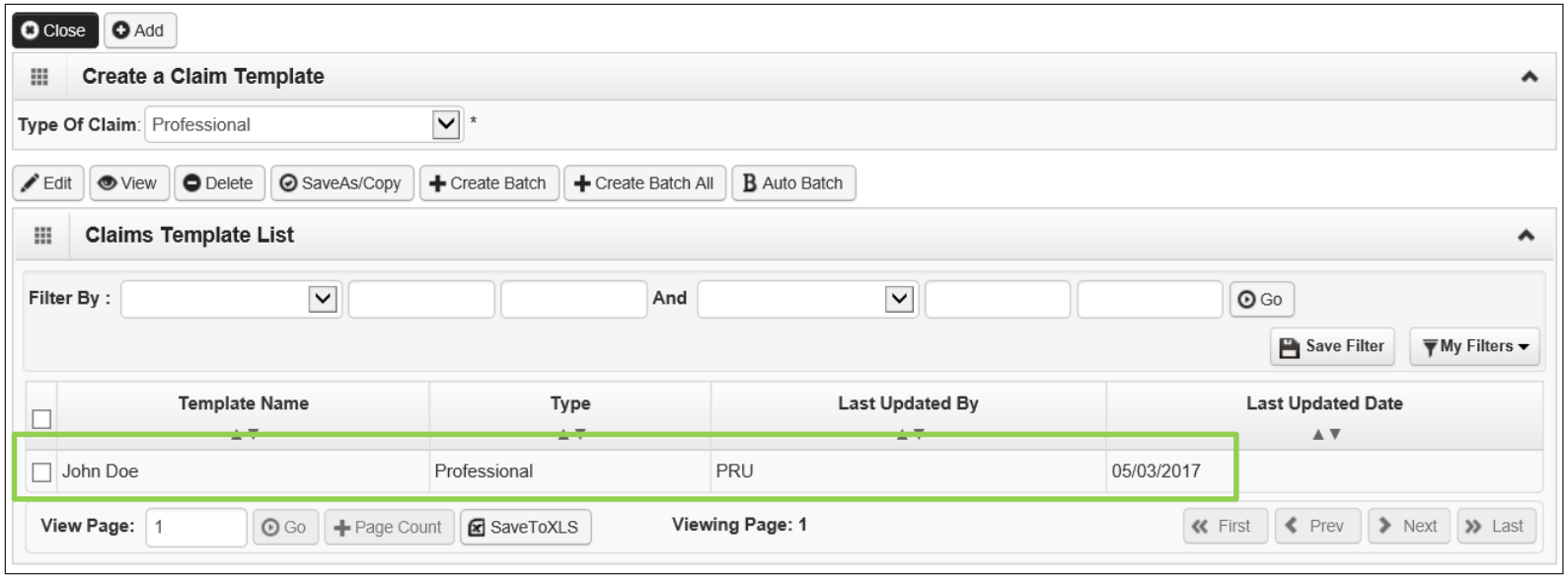
- Click on the **Save Template** button and the system verifies you are saving the template.



Note: The minimum information required to save a template is the **Template Name and answer required questions**.

Creating a Claim Template

- After the template is saved it is listed on the **Claims Template List**.

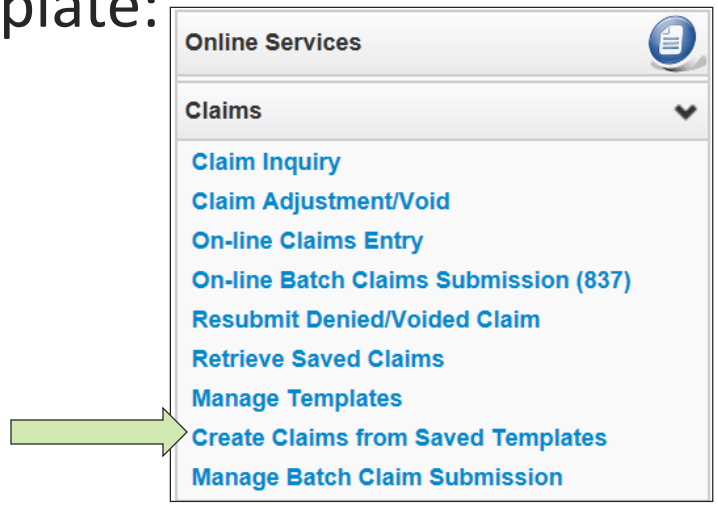


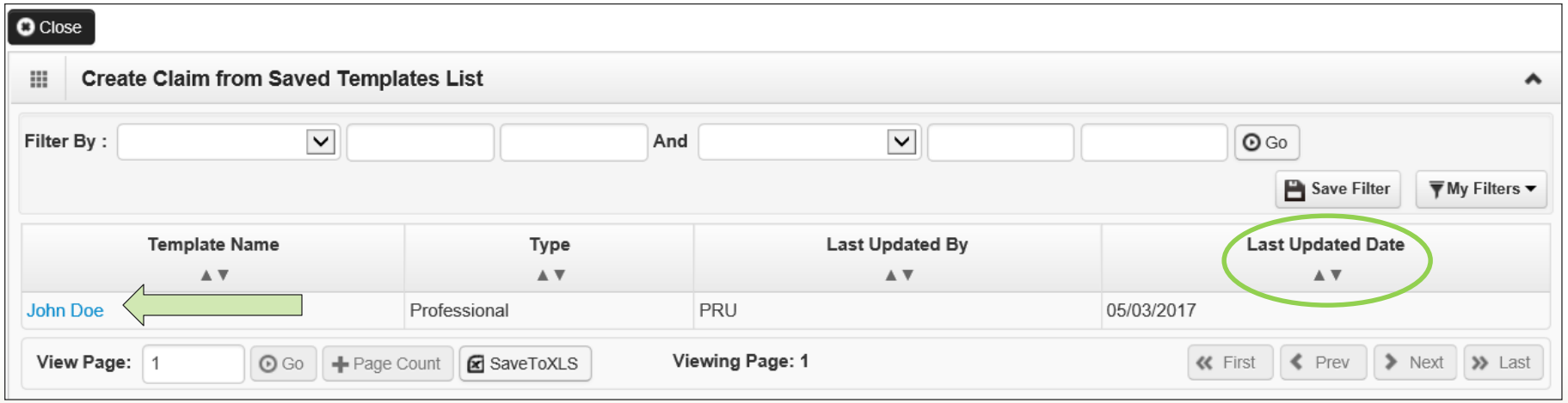
- Additional templates can be created by:
  - Copying a template on the list; or
  - Creating another from scratch.
- Templates can be edited, viewed, and deleted.

Submitting a Template Claim

- Claims can be submitted from a template:

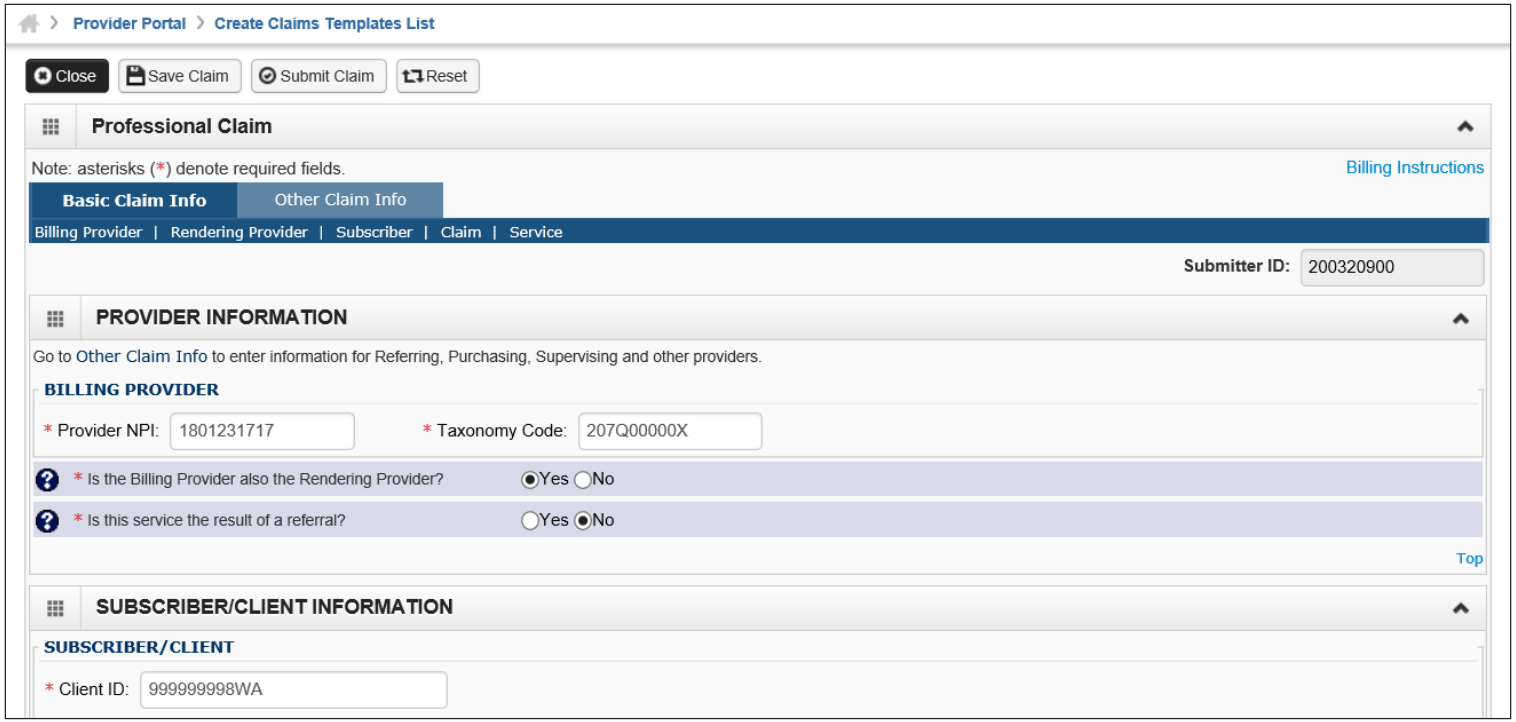
  - Log into ProviderOne.
  - Click on the **Create Claims from Saved Templates.**
  - At the **Saved Templates List** find the template to use (sort using the sort tools outlined).





Submitting a Template Claim

- Click on the template name.
- The DDE screen is loaded with the template.

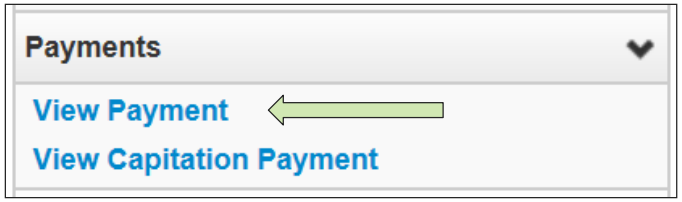


- Enter or update the data for claim submission then submit as normal.

Reading the Remittance Advice (RA)

Reading the Remittance Advice (RA)

- How do I retrieve the PDF file for the RA?
  - Log into ProviderOne with a **Claims/Payment Status Checker, Claims Submitter, or Super User** profile.



  - At the Portal click on the hyperlink **View Payment**.
  - The system will open your list of RAs.

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
500649639			08/06/2015	2	$300.00	$0.00	$300.00	
500955089			12/16/2015	1	$100.00	$0.00	$100.00	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

  - Click on the **RA number** in the first column to open the whole RA.

Reading the Remittance Advice (RA)

- The Summary Page of the RA shows:
  - Billed and paid amount for Paid claims
  - Billed amount of denied claims
  - Total amount of adjusted claims
  - Provider adjustment activity

Prepared Date: 05/30/2014
RA Date: 05/30/2014

RA Number: 8765432
Warrant/EFT # 852741!
Warrant/EFT Date: 05/29/2014

Warrant/EFT Amount: $9325.93
Payment Method: EFT

Page 2

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Sales Tax	Total Client Resp Amount	Total Paid
1122334455	Paid	$28930.00	$16114.57	$0.00	$0.00	$0.00	$9325.93
1122334455	Denied	$6525.50	$0.00	$0.00	$0.00	$0.00	$0.00
1122334455	Adjustments	-$2981.00	-$3371.87	$0.00	$0.00	$0.00	-$3266.00
1122334455	In Process	$5946.50	$0.00	$0.00	$0.00	$0.00	$0.00

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
1122334455	214148190028/ 40140123456789 0000	System Initiated	NOC Invoice	$0.00	$0.00	$3266.00
1122334455	214148190028/ 40149870123456 0000	System Initiated	NOC Referred to CARS	$3266.00	$3266.00	$0.00

Total Adjustment Amount $3266.00

Reading the Remittance Advice (RA)

- Adjustments:
  - P1Off (offset) adjustments: These adjustment amounts can carry over on each week's RA until the amount is paid off or reduced by the amount paid out for claims adjudicated that week.
    - Claims that caused these carry over adjustment amounts can be on previous RAs.
    - Updates to the RA format now provide the parent TCN under the FIN Invoice Number for reference.
  - NOC (non-offset) Referred to CARS: System-generated recoveries or adjustments that are referred to OFR for collection.
    - Updates to the RA format now provide the parent TCN under the FIN Invoice Number for reference.
- Retention Policy:
  - Providers must keep RA's on file for 7 years per Washington Administrative Code (WAC).

Reading the Remittance Advice (RA)

- The RA is sorted into different Categories as follows (screen shown is sample of Denials):
  - Paid
  - Denied
  - Adjustments
  - In Process

RA Number: 500955089 Warrant/EFT #: Warrant/EFT Date: Prepared Date: 12/16/2015 RA Date: 12/16/2015

Category: Denied [illegible]der: 5100000004 Page 3

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
Client, Pseudo 999999998WA	201534801403737000 Professional Claim	1		12/01/2015-12/01/2015	96152	3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	N255 N290 N95	170 = $100.00
			Document Total:	12/01/2015-12/01/2015		3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	N255,N290	16,B7
					Category Total:	3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00		
					Billing Provider Total:	3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00		

Reading the Remittance Advice (RA)

- EOB Codes
  - Adjustment Reason Codes and Remark Codes for denied claims & payment adjustments are located on the last page of the RA

Adjustment Reason Codes / NCPDP Rejection Codes
119 : Benefit maximum for this time period or occurrence has been reached. 15 : The authorization number is missing, invalid, or does not apply to the billed services or provider. 16 : Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. 18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) 35 : Lifetime benefit maximum has been reached. 96 : Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remark Codes
N20 : Service not payable with other service rendered on the same date. N329 : Missing/incomplete/invalid patient birth date. N37 : Missing/incomplete/invalid tooth number/letter. N39 : Procedure code is not compatible with tooth number/letter.

- The complete list of Federal codes can be located at the Washington Publishing Company's (WPC) website.

Authorization

Washington State Health Care Authority

Authorization

1. Complete Authorization Form 13-835
2. Submit Authorization Request to the Agency with Required Backup
3. Check the Status of a Request
4. Send in Additional Documentation if Requested by the Agency

Authorization

1. Example of a completed Authorization Form **13-835**:
   a) Fill (type) in all required fields as indicated on the directions page.
   b) Use the codes listed in the directions for the required fields.
   c) Add as much other detail as necessary that may help in approval.
   d) The data on this form is scanned directly into ProviderOne.
   e) Processing begins as soon as a correctly filled out form is received.

Step by step instructions:

ProviderOne Billing and Resource Guide

Washington State Health Care Authority

General Information for Authorization

Org	1. 502	Service Type	2. HB
Client Information			
Name	3. Doe, John	Client ID	4. 999999998WA
Living Arrangements	5. Home	Reference Auth #	6.
Provider Information			
Requesting NPI #	7. 1234567890	Requesting Fax #	8. 111-222-3333
Billing NPI #	9. 1234567890	Name	10. The Hospital
Referring NPI #	11. 1234567890	Referring Fax #	12.
Service Start Date:	13.		
Service Request Information			
Description of service being requested: 15. Safety Enclosure for hospital bed		16.	17.
18. Serial/NEA or MEA #			

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. Req...	25. Part # (DME Only)	26. Tooth or Quad #
P	E0316		1		6145-001	

Medical Information			
Diagnosis Code	27. R54	Diagnosis name	28. AGE-RELATED PHYSICAL DEBILITY
Place of Service Code	29. 21		
30. Comments:	Client is extremely fragile.		

Sample form only

Please fax this form and any supporting documents to 1-866-668-1214.

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. HIPAA Compliance: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment, or to perform other specific health care operations.

Washington State Health Care Authority

Directions for Authorization form 13-835

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	Org **(Required)**	Enter the Number that Matches the Program/Unit for the Request 501 – Dental 502 – Durable Medical Equipment (DME) 504 – Home Health 505 – Hospice 506 – Inpatient Hospital 508 – Medical 509 – Medical Nutrition 511 – Outpt Proc/Diag 513 – Physical Medicine & Rehabilitation (PM & R) 514 – Aging and Long-Term Support Administration (ALTSA) 518 – LTAC 519 – Respiratory 521 – Maternity Support/Infant Case Management 524 – Concurrent Care 525 – ABA Services 526 – Complex Rehabilitation Technology (CRT) 527 – Chemical-Using Pregnant (CUP) Women Program
2	Service Type **(Required)**	Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "501 – **Dental**" for field #1, please select one of the following codes for this field: ASC for ASC; CWN for Crowns; DEN for Dentures; DP for Denture/Partial; EXT for Extractions; EXTD for Extractions w/Dentures; GA for General Anesthesia; GAE for General Anesthesia w/ extractions; IP for In-Patient; ODC for Orthodontic; OUTP for Out-Patient; PSM for Perio-Scaling/Maintenance; PTL for Partial; RBS for Rebases; RLNS for Relines; TC for Transfer Case; MISC for Miscellaneous If you selected "502 – **Durable Medical Equipment (DME)**" for field #1, please select one of the following codes for this field: AA for Ambulatory Aids; BB for Bath Bench; BEM for Bath Equipment (misc.); BGS for Bone Growth Stimulator; BP for Breast Pump; C for Commode; CG for Compression Garments; CSC for Commode/Shower Chair; DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing); ERSO for ERSO-PA; FSFS for Floor Sitter/Feeder Seat; GL for Gloves; HB for Hospital Beds; HC for Hospital Cribs; IS for Incontinent Supplies; MWH for Manual Wheelchair - Home; MWNF for Manual Wheelchair – NF; MWR for Manual Wheelchair Repair; OS for Orthopedic Shoes; OTC for Orthotics; OP for Ostomy Products; ODME for Other DME; OTRR for Other Repairs; PL for Patient Lifts; PWH for Power Wheelchair - Home; PWNF for Power Wheelchair – NF; PWR for Power Wheelchair Repair; PRS for Prone Standers; PROS for Prosthetics; RE for Room Equipment; SC for Shower Chairs; SBS for Specialty "Beds/Surfaces; SGD for Speech Generating Devices; SF for Standing Frames; STND for Standers; TU for TENS Units; US for Urinary Supplies; WDCS for VAC/Wound - decubiti supplies; MISC for Miscellaneous

HCA 13-835 (5/15)

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
2	Service Type **(Required)** (Continued)	If you selected "504 – **Home Health**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA; HH for Home Health; MISC for Miscellaneous; T for Therapies (PT / OT / ST) If you selected "505 – **Hospice**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA; HSPC for Hospice; MISC for Miscellaneous If you selected "506 – **Inpatient Hospital**" for field #1, please select one of the following codes for this field: BS for Bariatric Surgery; ERSO for ERSO-PA; OOS for Out of State; O for Other; PAS for PAS; RM for Readmission; S for Surgery; TNP for Transplants; VNSS for Vagus Nerve Stimulator; MISC for Miscellaneous If you selected "508 – **Medical**" for field #1, please select one of the following codes for this field: BSS2 for Bariatric Surgery Stage 2; BTX for Botox; CIERP for Cochlear Implant Exterior Replacement Parts; CR for Cardiac Rehab; ERSO for ERSO-PA; HEA for Hearing Aids; I for Infusion / Parental Therapy; MC for Medications; NP for Neuro-Psych; OOS for Out of State; PSY for Psychotherapy; SYN for Synagis; T for Therapies (PT/OT/ST); TX for Transportation; V for Vision; VST for Vest; VT for Vision Therapy; MISC for Miscellaneous If you selected "509 – **Medical Nutrition**" for field #1, please select one of the following codes for this field: EN for Enteral Nutrition; MN for Medical Nutrition; MISC for Miscellaneous If you selected "511 – **Output Proc/Diag**" for field #1, please select one of the following codes for this field: CCTA for Coronary CT Angiogram; CI for Cochlear Implants; ERSO for ERSO-PA; GCK for Gamma/Cyber Knife; GT for Genetic Testing; HO for Hyperbaric Oxygen; HY for Hysterectomy; MRI for MRI; OOS for Out of State; OTRS for Other Surgery; PSCN for PET Scan; O for Other; S for Surgery; SCAN for Radiology; MISC for Miscellaneous If you selected "513 – **Physical Medicine & Rehabilitation (PM & R)**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA; PMR for PM and R; MISC for Miscellaneous

HCA 13-835 (5/15)

Washington State Health Care Authority

Directions for Authorization form 13-835

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
2	Service Type **(Required)** (Continued)	If you selected "514 – **Aging and Long-Term Support Administration (ALTSA)** for field #1, please select one of the following codes for this field: PDN for Private Duty Nursing MISC for Miscellaneous
		If you selected "518 – **LTAC**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA LTAC for LTAC O for Other
		If you selected "519 – **Respiratory**" for field #1, please select one of the following codes for this field: CPAP for CPAP/BiPAP ERSO for ERSO-PA NEB for Nebulizer OXM for Oximeter OXY for Oxygen SUP for Supplies VENT for Vent O for Other
		If you selected "521 – **Maternity Support/Infant Case Management (MSS)**" for field #1, please select one of the following codes for this field: ICM for Infant Case Management PO for Post Pregnancy Only PPP for Prenatal/Post Pregnancy O for Other
		If you selected "524 – **Concurrent Care**" (for children on Hospice) for field #1, please select one of the following codes for this field: CC for Concurrent Care Services
		Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "525 – **ABA Services**" for field #1, please select one of the following codes for this field: IH for In Home/Community/Office DAYP for Day Program
		If you selected "526 – **Complex Rehabilitation Technology**" (CRT) for field #1, please select one of the following codes for this field: ERSO for ERSO-PA MWH for Manual Wheelchair - Home MWNF for Manual Wheelchair - NF MWR for Manual Wheelchair Repairs MWS for Manual Wheelchair Supplies PWH for Power Wheelchair - Home PWNF for Power Wheelchair – NF PWR for Power Wheelchair Repairs PWS for Power Wheelchair Supplies
		If you selected "527 – **Chemical-Using Pregnant (CUP) Women Program**" for field #1, please select one of the following codes for this field: DX for Detox DM for Detox/Medical Stabilization MS for Medical Stabilization

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
3	Name: **(Required)**	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: **(Required)**	Enter the client ID - 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): ▪ You will need to contact HCA at 1-800-562-3022 and the appropriate extension of the Authorization Unit. ▪ A reference PA will be built with a placeholder client ID. ▪ If the PA is approved – once the client ID is known – you will need to contact HCA either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: **(Required)**	The 10 digit number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI #: **(Required)**	The 10 digit number that has been assigned to the billing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: **(Required).**	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA or MEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA/MEA# to access the x-rays/pictures for this request.
20	Code Qualifier: **(Required).**	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S – ICD-9/10 Diagnosis Code
21	National Code: **(Required).**	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: **(Units or $ required).**	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Medicaid Provider Guide for the appropriate unit/day designation for the service code entered).
24	$ Amount Requested: **(Units or $ required).**	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Medicaid Provider Guide and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00).
25	Part # (DME only): **(Required for all requested codes).**	Enter the manufacturer part # of the item requested.

Directions for Authorization form 13-835

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION	
		ALL FIELDS MUST BE TYPED.	
26	Tooth or Quad#: **(Required for dental requests).**	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-32, A-T, AS-TS, and 51-82	
27	Diagnosis Code	Enter appropriate diagnosis code for condition.	
28	Diagnosis name	Short description of the diagnosis.	
29	Place of Service	Enter the appropriate two digit place of service code.	
		Place of Service Code(s)	**Place of Service Name**
		1	Pharmacy
		3	School
		4	Homeless Shelter
		5	Indian Health Service Free-standing Facility
		6	Indian Health Service Provider-based Facility
		7	Tribal 638 Free-standing Facility
		8	Tribal 638 Provider-based Facility
		9	Prison-Correctional Facility
		11	Office
		12	Home
		13	Assisted Living Facility
		14	Group Home
		15	Mobile Unit
		16	Temporary Lodging
		17	Walk in Retail Health Clinic
		20	Urgent Care Facility
		21	Inpatient Hospital
		22	Outpatient Hospital
		23	Emergency Room – Hospital
		24	Ambulatory Surgical Center
		25	Birthing Center
		26	Military Treatment Facility
		31	Skilled Nursing Facility
		32	Nursing Facility
		33	Custodial Care Facility
		34	Hospice
		41	Ambulance - Land
		42	Ambulance – Air or Water
		49	Independent Clinic
		50	Federally Qualified Health Center
		51	Inpatient Psychiatric Facility

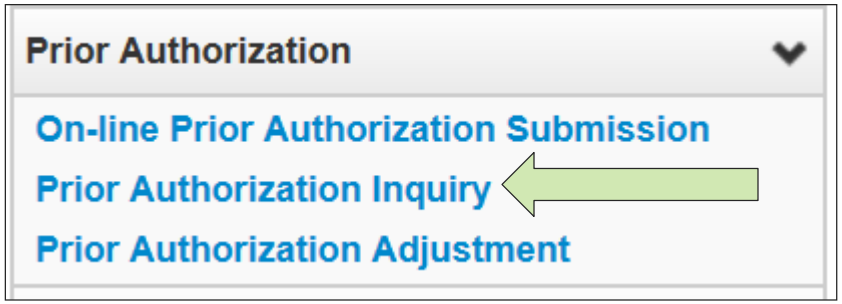
HCA 13-835 (5/15)

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION	
		ALL FIELDS MUST BE TYPED.	
29	Place of Service	52	Psychiatric Facility-Partial Hospitalization
		53	Community Mental Health Center
		55	Residential Substance Abuse Treatment Facility
		56	Psychiatric Residential Treatment Center
		57	Non-residential Substance Abuse Treatment Facility
		60	Mass Immunization Center
		61	Comprehensive Inpatient Rehabilitation Facility
		62	Comprehensive Outpatient Rehabilitation Facility
		65	End-Stage Renal Disease Treatment Facility
		71	Public Health Clinic
		72	Rural Health Clinic
		81	Independent Laboratory
		99	Other Place of Service
30	Comments	Enter any free form information you deem necessary.	

Check the Status of an Authorization Request

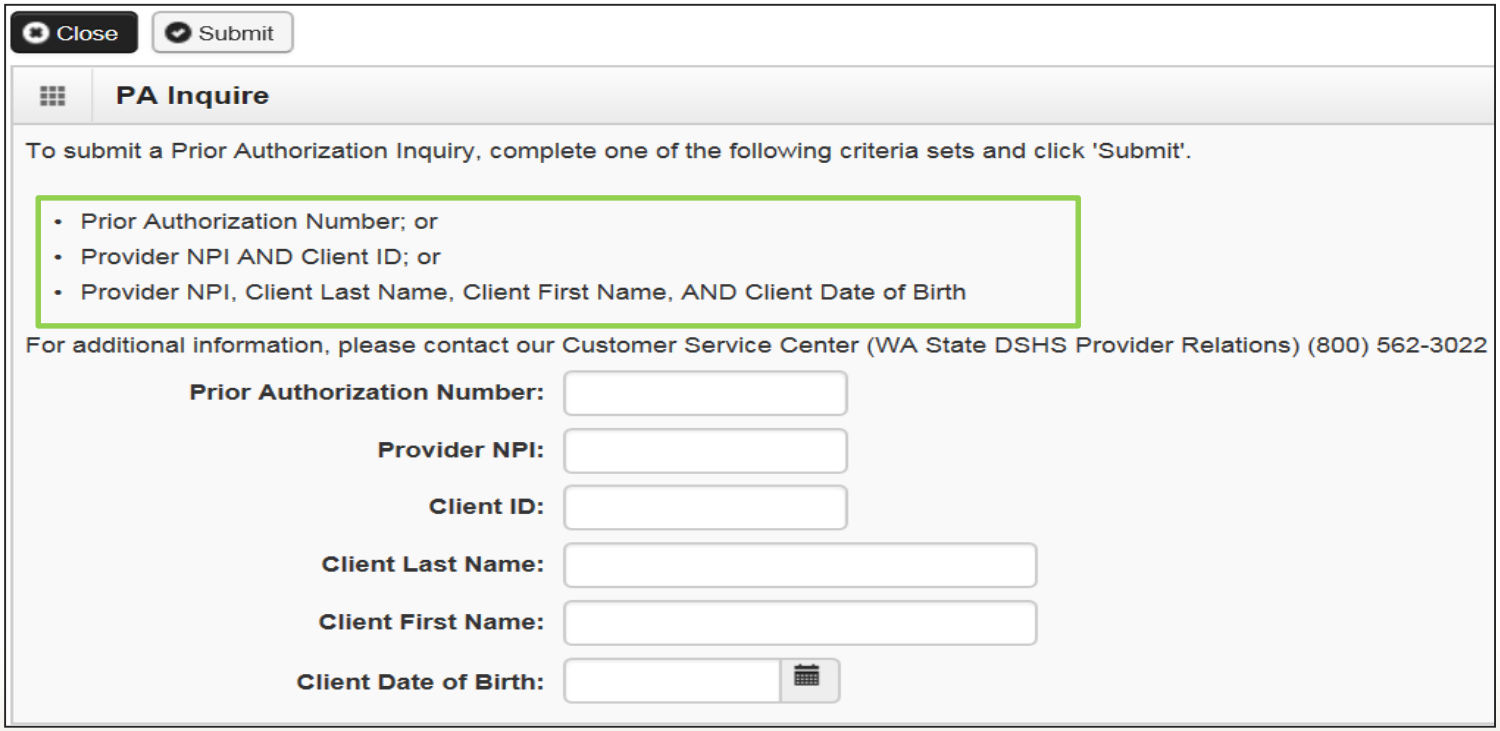
- Necessary Profiles for checking Authorization Status:
  - EXT Provider Claims Submitter
  - EXT Provider Eligibility Checker
  - EXT Provider Eligibility Checker-Claims Submitter
  - EXT Provider Super User



- Select the **Provider Authorization Inquiry**

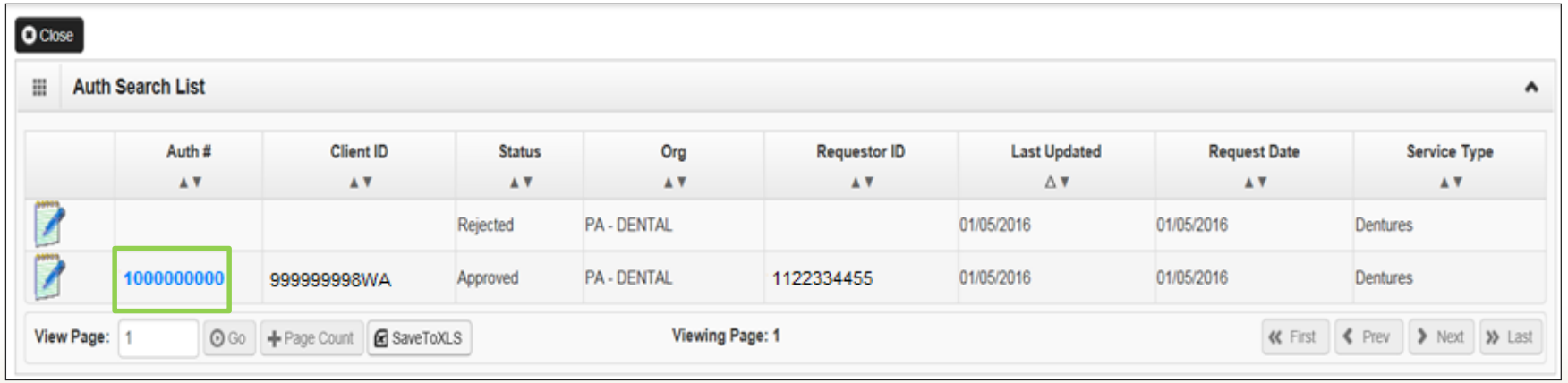
Check the Status of an Authorization Request

- Search using one of the following options:
  - Prior Authorization number; or
  - Provider NPI and Client ID; or
  - Provider NPI, Client Last & First Name, and the client birth date.



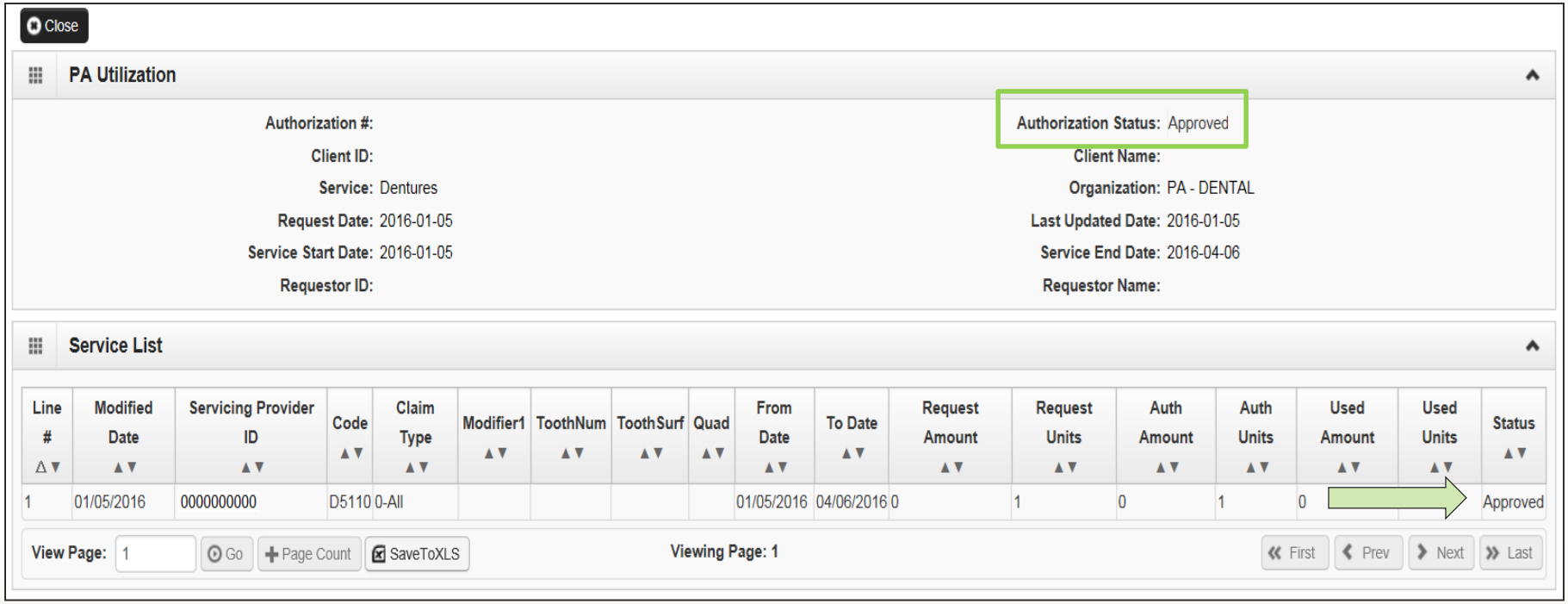
Check the Status of an Authorization Request

- The **Auth Search List** screen returns the information requested from the search criteria used:
  - Click on the **Auth #** hyperlink to access the PA Utilization screen.
  - Do not submit multiple requests for the same client/service.
  - Check online after 48 hours to verify the authorization request was received before resubmitting.
  - The status of these requests are explained in more detail on the following slides.



Check the Status of an Authorization Request

- The system returns the following information, with the status of the request noted in the upper right side of the **PA Utilization** screen:



Authorization Status

- The following list shows the different statuses you may see on the PA Utilization screen with definitions:

Requested	This means the authorization has been requested and received.
In Review	This means your authorization is currently being reviewed.
Cancelled	This means the authorization request has been cancelled.
Pended	This means we have requested additional information in order to make a decision on the request.
Referred	This means the request has been forwarded to a second level reviewer.
Approved/Hold	This means the request has been approved, but additional information is necessary before the authorization will be released for billing.
Approved/Denied	This means the request has been partially approved and some services have been denied.
Rejected	This means the request was returned to you as incomplete.
Approved	This means the Department has approved your request.
Denied	This means the Department has denied your request.

Submit the Prior Authorization Request

ProviderOne

PA Pend Forms Submission Cover Sheet

Authorization Reference # 123456789

(Please enter 9 digit numeric value.)

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet

INSTRUCTIONS:
Click ENTER on your keyboard after typing the number in above.

Please use the **Print Cover Sheet** Button Above to print ONLY.

Use Only ADOBE Reader to generate this coversheet. Other readers will not generate the barcode correctly.

DO NOT USE FOR PHARMACY RELATED AUTHORIZATION REQUESTS!

Privacy Statement:
This material in this facsimile is intended only for the use of the individual who it is addressed and may contain information that is confidential, privileged and exempt from disclosure under applicable law.

HIPAA Compliance:
Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment to see insurance payment or to perform other specific health care operations.

FAX to : 1-866-668-1214.

THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.

For more information, visit the [document submission cover sheets] web page.

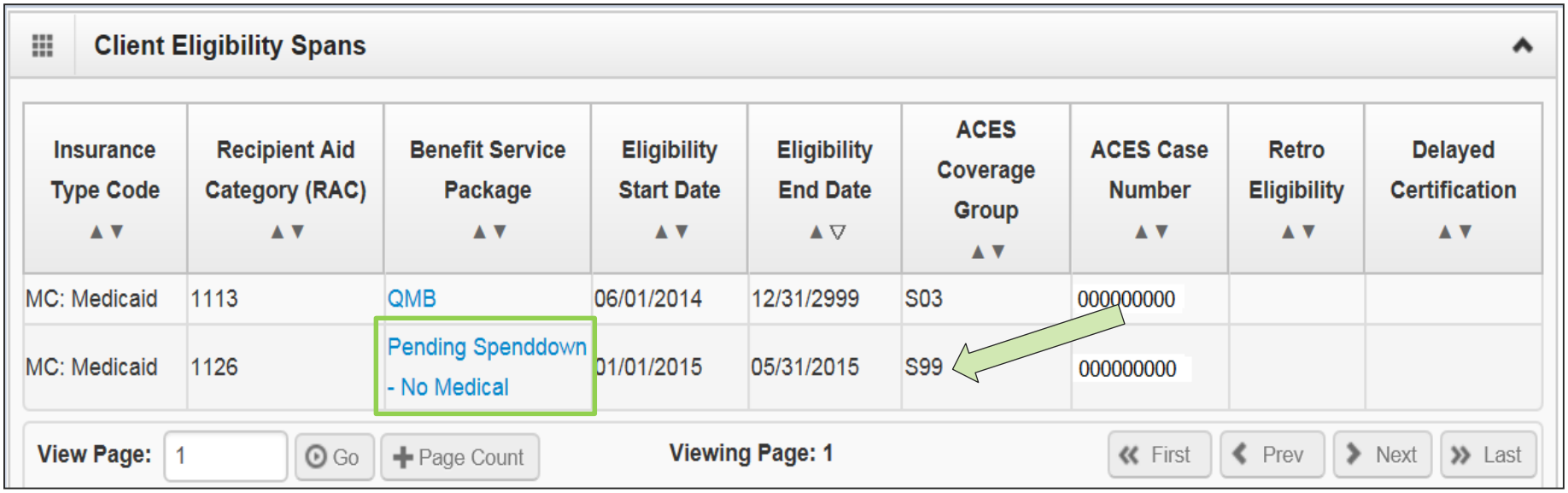
Spenddown

What is a Spenddown?

- An expense or portion of an expense which has been determined by the agency to be a client liability.
- Expenses which have been assigned to meet a client liability are not reimbursed by the agency.
- Spenddown liability is deducted from any payment due the provider.
- Call the customer service line at 1-877-501-2233.

How does a Provider know if a client has a Spenddown Liability?

- The client benefit inquiry indicating **Pending Spenddown – No Medical** looks like this:



Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1113	QMB	06/01/2014	12/31/2999	S03	000000000		
MC: Medicaid	1126	Pending Spenddown - No Medical	01/01/2015	05/31/2015	S99	000000000		

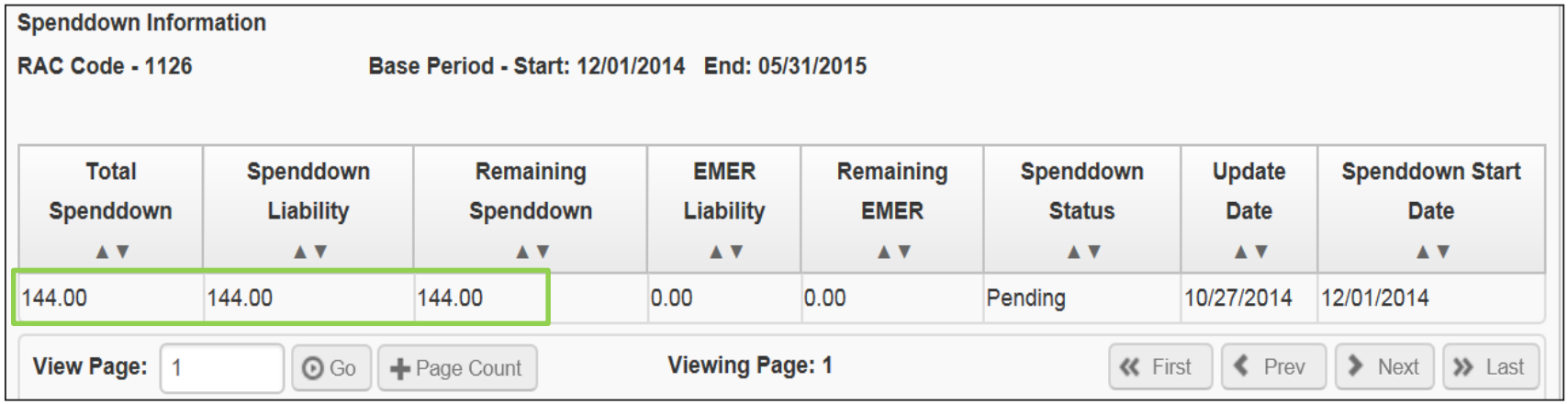
View Page: 1 Go Page Count Viewing Page: 1 First Prev Next Last

- No longer pending – has MNP coverage:

MC: Medicaid	1124	LCP-MNP		11/01/2014	01/31/2015	S99

What is the Spenddown amount?

- The same eligibility check indicates the spenddown amount:



Spenddown Information

RAC Code - 1126 **Base Period - Start: 12/01/2014 End: 05/31/2015**

Total Spenddown	Spenddown Liability	Remaining Spenddown	EMER Liability	Remaining EMER	Spenddown Status	Update Date	Spenddown Start Date
144.00	144.00	144.00	0.00	0.00	Pending	10/27/2014	12/01/2014

View Page: 1 Go Page Count Viewing Page: 1 First Prev Next Last

- The clients "award" letter indicates who the client pays.
- Call the spenddown call center at Call 1-800-394-4571.
- See the Provider Spenddown Step-by-Step fact sheet for more detail and information about where to bill the spenddown amount on claims.

Billing a Client

Background

Washington Administrative Code (WAC) 182-502-0160, Billing a Client, allows providers, in limited circumstances, to bill fee-for-service or managed care clients for covered healthcare services. It also allows fee-for-service or managed care clients the option to self-pay for covered healthcare services.

Note: The full text of WAC 182-502-0160 can be found on the Apple Health (Medicaid) manual WAC index page.

Washington State Health Care Authority

Billing a Client

Healthcare Service Categories

The groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's **Benefit Service Package (BSP)**.

Excluded Services

A set of services that we do not include in the client's BSP. There is no Exception To Rule (ETR) process available for these services (e.g. Family Planning Only).

Covered service

A healthcare service contained within a "service category" that is included in a medical assistance BSP as described in WAC 182-501-0060.

Non-covered service

A specific healthcare service (e.g., crowns for 21 and older) contained within a service category that is included in a medical assistance BSP, for which the Agency does not pay without an approved exception to rule (ETR) (see WAC 182-501-0160). **A non-covered service is not an excluded service** (see WAC 182-501-0060). Non-covered services are identified in WAC 182-501-0070 and in specific health-care program rules.

Washington State Health Care Authority

Agreement to Pay for Healthcare Services

WAC 182-502-0160 ("Billing a Client")

Form 13-879

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

Client - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.
Provider - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

Directions:

- Both the provider and the client must fully complete this form **before** an HCA client receives any service for which this Agreement is required.
- You must complete this form no more than 90 calendar days before the date of the service. If the service is not provided within 90 calendar days, the provider and client must complete and sign a new form.
- The provider and the client must complete this form only **after** they exhaust all applicable HCA or HCA-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 182-501-0160 or the administrative hearing process, if the client chooses to pursue these processes.
- Limited English proficient (LEP) clients must be able to understand this form in their primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. Both the client and the provider must sign a translated form.

Fully complete the table on back of this form. If needed, attach another sheet for additional services. The client, provider, and interpreter (if applicable) must sign and date each additional page.

Important Note from HCA:

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 182-502-0160 or does not satisfy HCA conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 182-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client's medical record for 6 years from the date this agreement is signed. Give a copy of this completed, signed agreement to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at http://hrsa.dshs.wa.gov/mpforms.shtml.

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR/NFJ REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE	
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)

- I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.
- I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; 2) submit a Non-Formulary Justification (NFJ) with the help of my prescriber fro a non-formulary medication; or 3) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.
- I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above.
- I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC.
- *I agree to pay the provider directly for the specific service(s) listed above.*
- I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form.
- I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care.

I AFFIRM: I understand and agree with this form's content, including the bullet points above.	CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE	DATE
I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.	PROVIDER OF SERVICE(S) SIGNATURE	DATE
I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.	INTERPRETER'S PRINTED NAME AND SIGNATURE	DATE

The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the agency.)

Printed or copied records requested by the client. Department of Health has established a policy noted at WAC 246-08-400.

WHEN CAN A PROVIDER BILL A CLIENT WITHOUT FORM 13-879

The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a Washington Apple Health.

The client refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill a third party insurance carrier for a service.

The client chose to receive services from a provider who is not contracted with Washington Apple Health.

The service is covered by the agency with prior authorization, all the requirements for obtaining authorization are completed and was denied, the client completes the administrative hearings process or chooses to forego it or any part of it, and the service remains denied by the agency as not medically necessary.

The service is covered by the agency and does not require authorization, but the service is a specific type of treatment, supply, or equipment based on the client's personal preference that the agency does not pay for. The client completes the administrative hearings process or chooses to forego it or any part of it.

WHEN CAN A PROVIDER BILL A CLIENT WITH FORM 13-879?

If the service is not covered, the provider must inform the client of his or her right to have the provider request an ETR, and the client chooses not to have the provider request an ETR .

The service is not covered by the agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.

Washington State Health Care Authority

WHEN CAN A PROVIDER NOT BILL A CLIENT?

Services for which the provider did not correctly bill the agency.

If the agency returns or denies a claim for correction and resubmission, the client cannot be billed.

Services for which the agency denied the authorization because the process was placed on hold pending receipt of requested information but the requested information was not received by the agency. (WAC 182-501-0165(7)(c)(i)). This includes rejected authorizations, when the authorization request is returned due to missing required information.

The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (e.g., precious metal crown vs. stainless steel).

Washington State Health Care Authority

Providers are not allowed to:

- “Balance bill” a client
- Bill a client for missed, cancelled, or late appointments
- Bill a client for a “rescheduling fee”

"Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care.

WHEN CAN A PROVIDER NOT BILL A CLIENT?

Services for which the provider has not received payment from the agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment (example: billing using a diagnosis code which is not a primary diagnosis code per ICD10).

Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to:

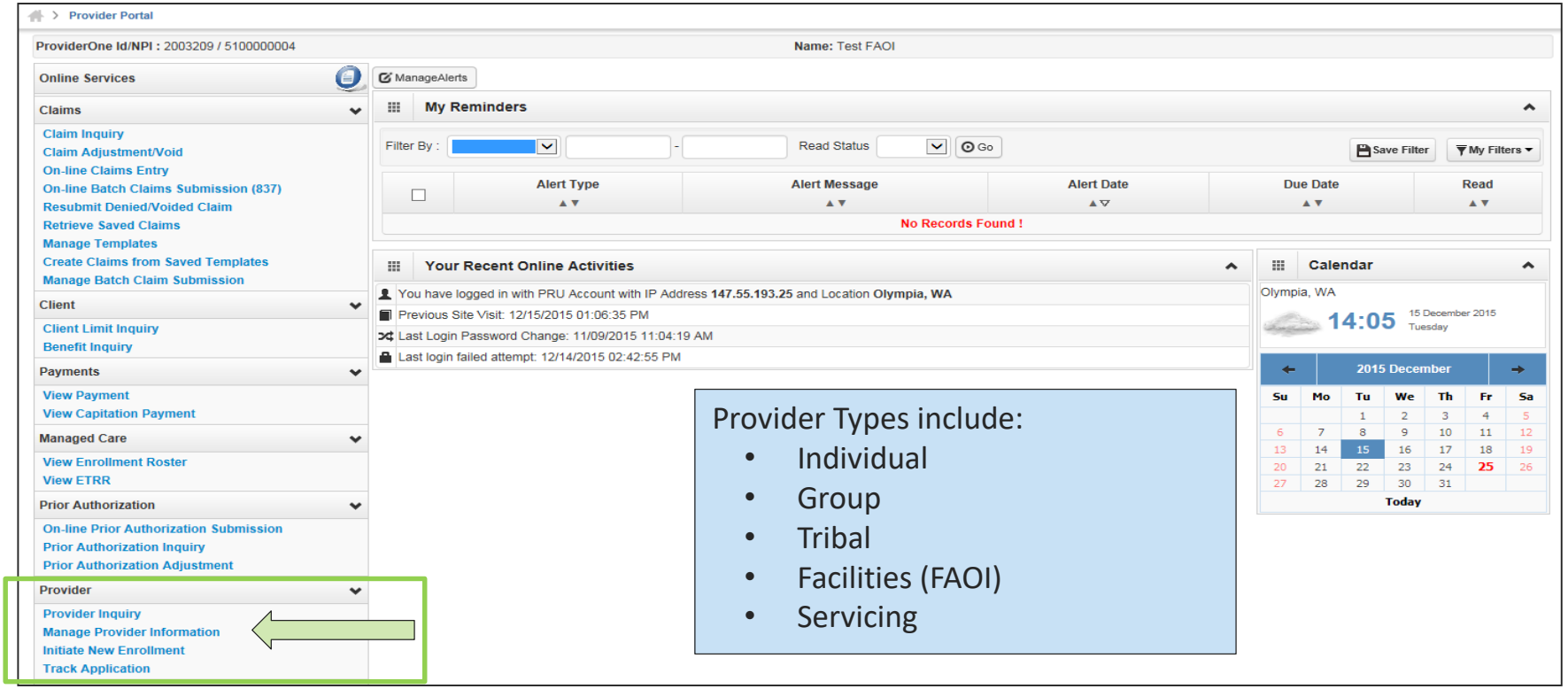
- Medical/dental charts,
- Radiological or imaging films
- Laboratory or other diagnostic test results
- Postage or shipping charges related to the transfer

Provider File Maintenance

Provider File Maintenance

➢ Modifying Provider File Information

- Log into ProviderOne with the **Provider File Maintenance** or **Super User** profile.
- Click on the **Manage Provider Information** hyperlink

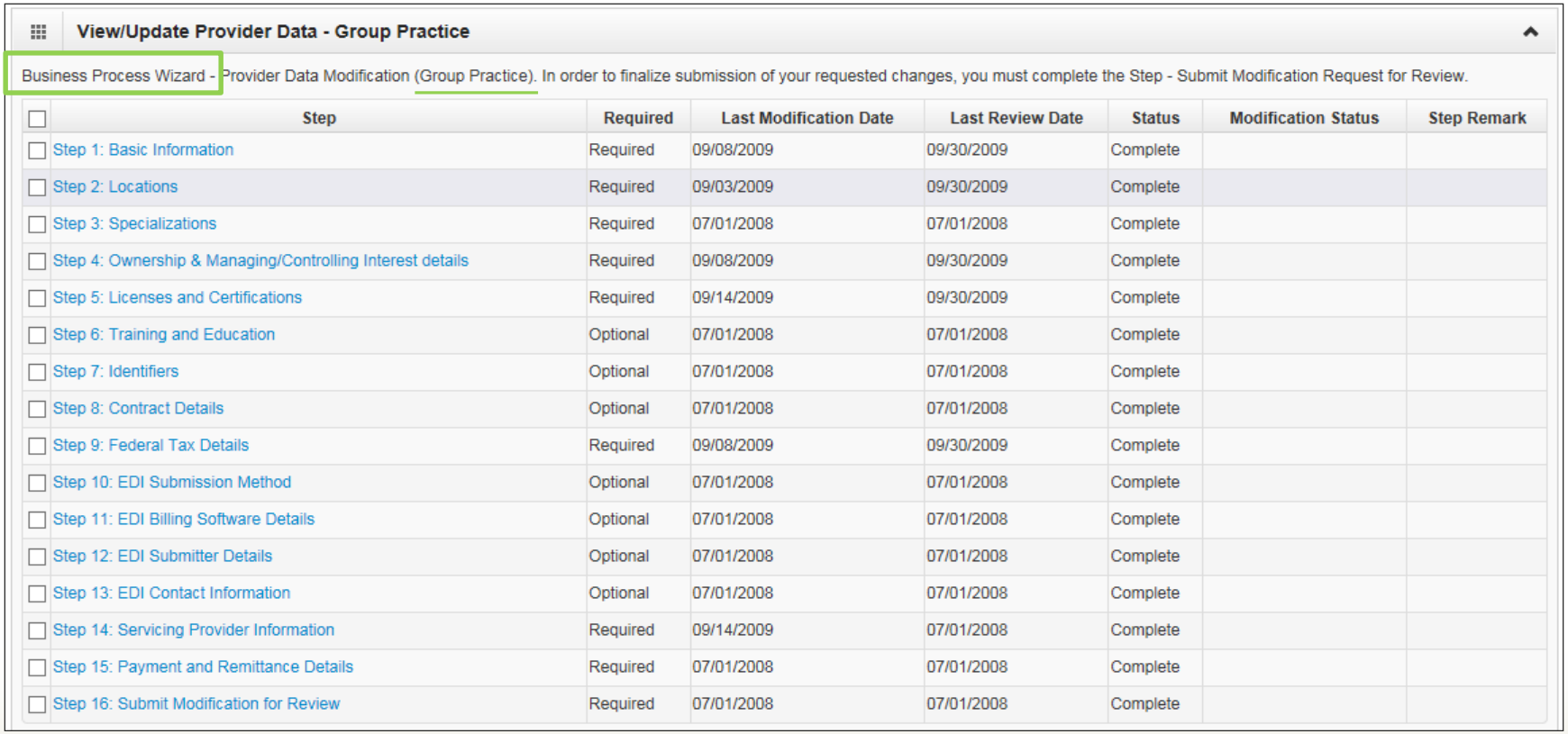


Go to the [ProviderOne user manuals web page] for more information on provider file updates for the different provider types.

Provider File Maintenance

➢ Modifying Provider File Information

- The **Business Process Wizard** contains the steps for modification. Click on the step title to modify.



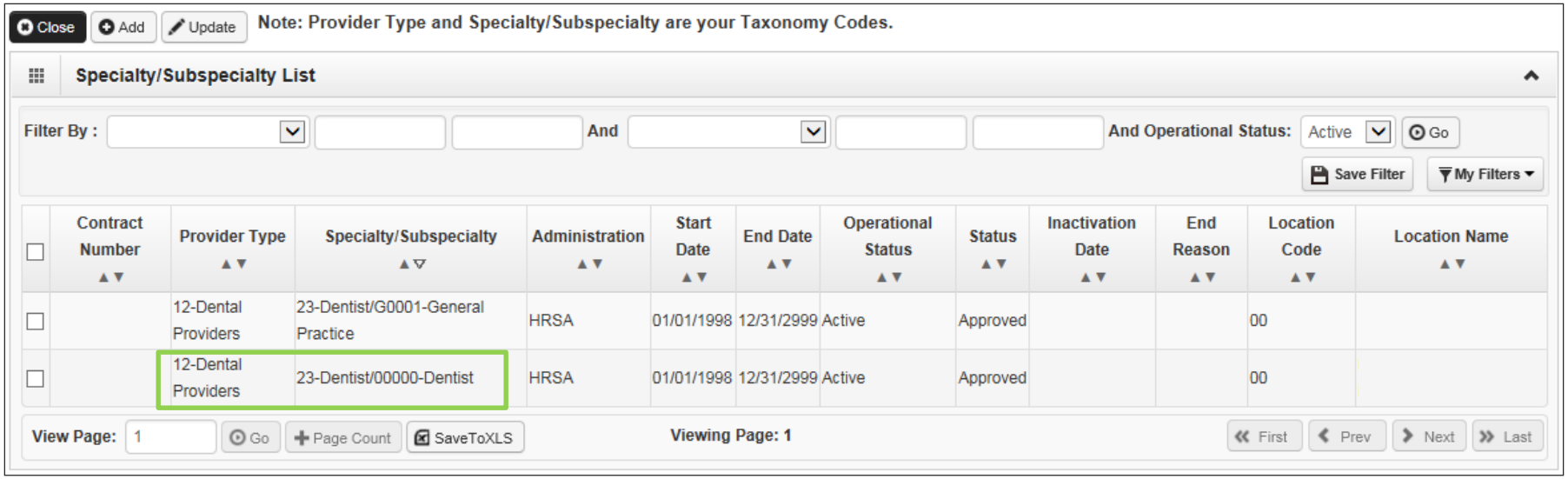
View/Update Provider Data - Group Practice

Business Process Wizard - Provider Data Modification (Group Practice). In order to finalize submission of your requested changes, you must complete the Step - Submit Modification Request for Review.

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Basic Information	Required	09/08/2009	09/30/2009	Complete		
Step 2: Locations	Required	09/03/2009	09/30/2009	Complete		
Step 3: Specializations	Required	07/01/2008	07/01/2008	Complete		
Step 4: Ownership & Managing/Controlling Interest details	Required	09/08/2009	09/30/2009	Complete		
Step 5: Licenses and Certifications	Required	09/14/2009	09/30/2009	Complete		
Step 6: Training and Education	Optional	07/01/2008	07/01/2008	Complete		
Step 7: Identifiers	Optional	07/01/2008	07/01/2008	Complete		
Step 8: Contract Details	Optional	07/01/2008	07/01/2008	Complete		
Step 9: Federal Tax Details	Required	09/08/2009	09/30/2009	Complete		
Step 10: EDI Submission Method	Optional	07/01/2008	07/01/2008	Complete		
Step 11: EDI Billing Software Details	Optional	07/01/2008	07/01/2008	Complete		
Step 12: EDI Submitter Details	Optional	07/01/2008	07/01/2008	Complete		
Step 13: EDI Contact Information	Optional	07/01/2008	07/01/2008	Complete		
Step 14: Servicing Provider Information	Required	09/14/2009	07/01/2008	Complete		
Step 15: Payment and Remittance Details	Required	07/01/2008	07/01/2008	Complete		
Step 16: Submit Modification for Review	Required	07/01/2008	07/01/2008	Complete		

Provider File Maintenance

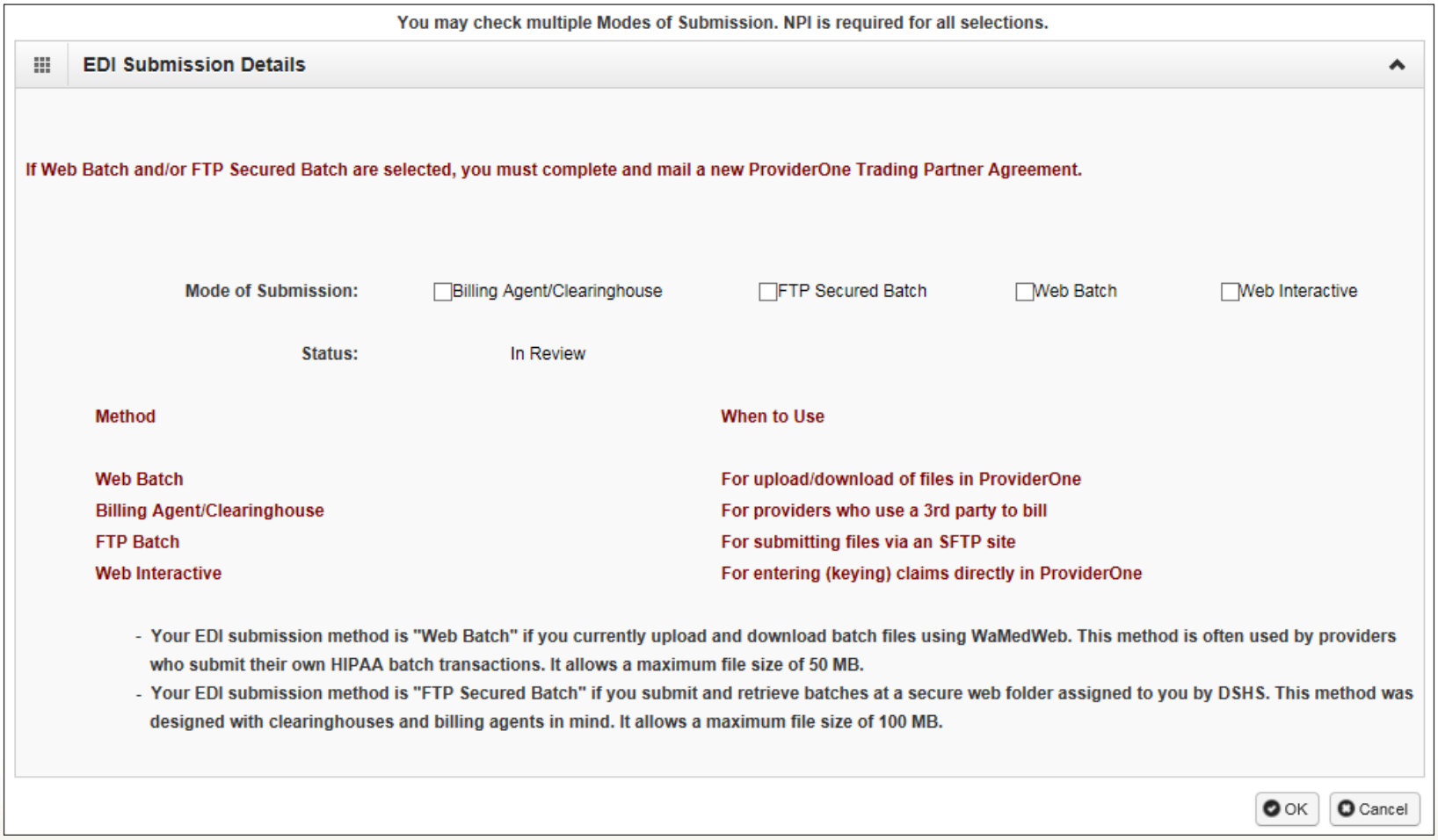
- Step 3: Specializations (Taxonomy Codes)



- The taxonomy code shown here is separated by type and subspecialty. Add an "**X**" to the end of each taxonomy code you bill with (e.g. 122300000X).
- Be aware of the taxonomy code start date (should be the same as provider start date).
- Additional taxonomy codes may be added (based on the provider credentialing).

Provider File Maintenance

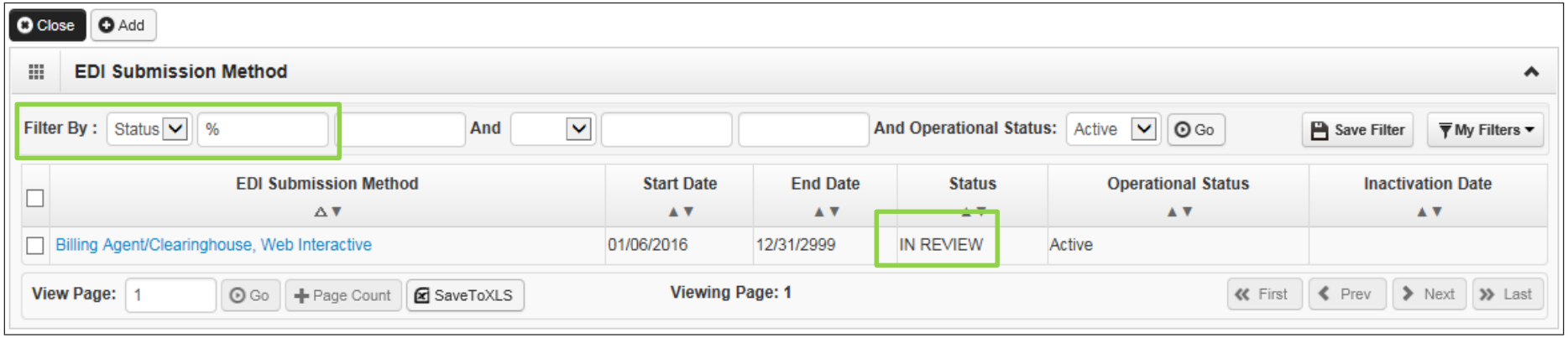
- Step 10: EDI Submission Method - How are you going to bill?



Provider File Maintenance

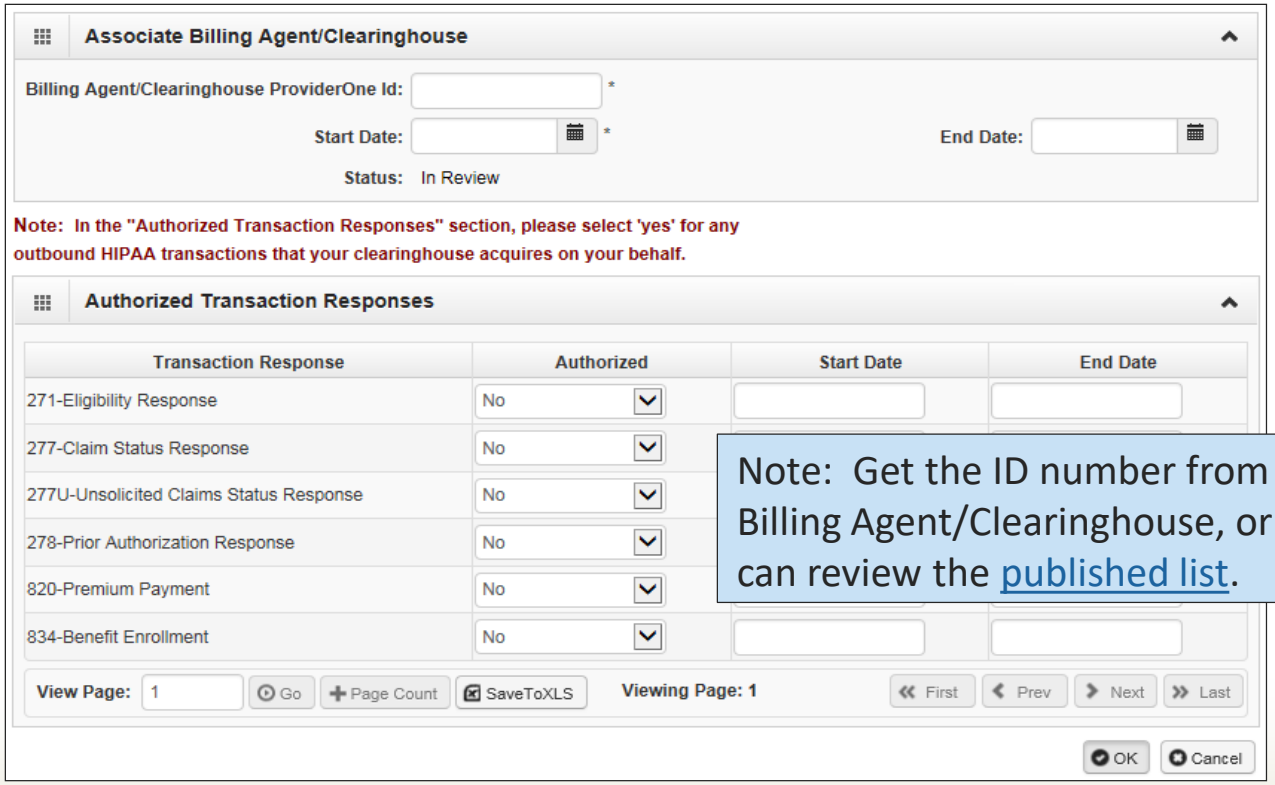
➢ Step 10: EDI Submission Method - Updates

- For adding or changing submission method, such as Billing Agent/Clearinghouse.
- To see your addition, filter by **Status**.
- Enter % and click **Go**.
- Your request appears with **In Review** status.



Provider File Maintenance

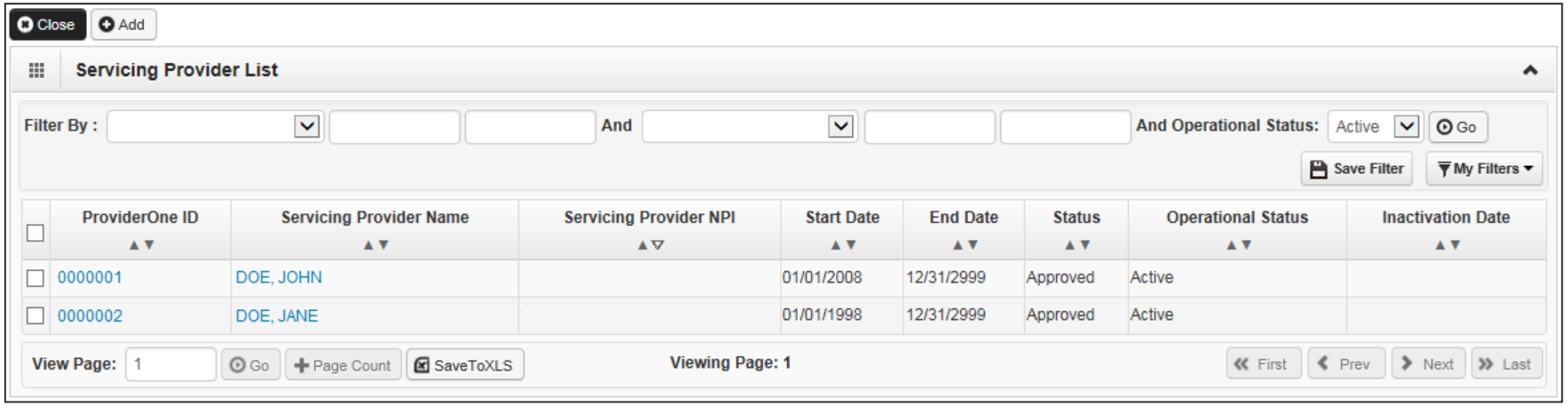
- Step 12: EDI Submitter Details – Billing Agent/Clearinghouse
  - Add the Billing Agent/Clearinghouse ProviderOne ID;
  - Add the start date with your organization;
  - Select authorized HIPAA transactions and click **Ok**.



Note: Get the ID number from the Billing Agent/Clearinghouse, or you can review the published list.

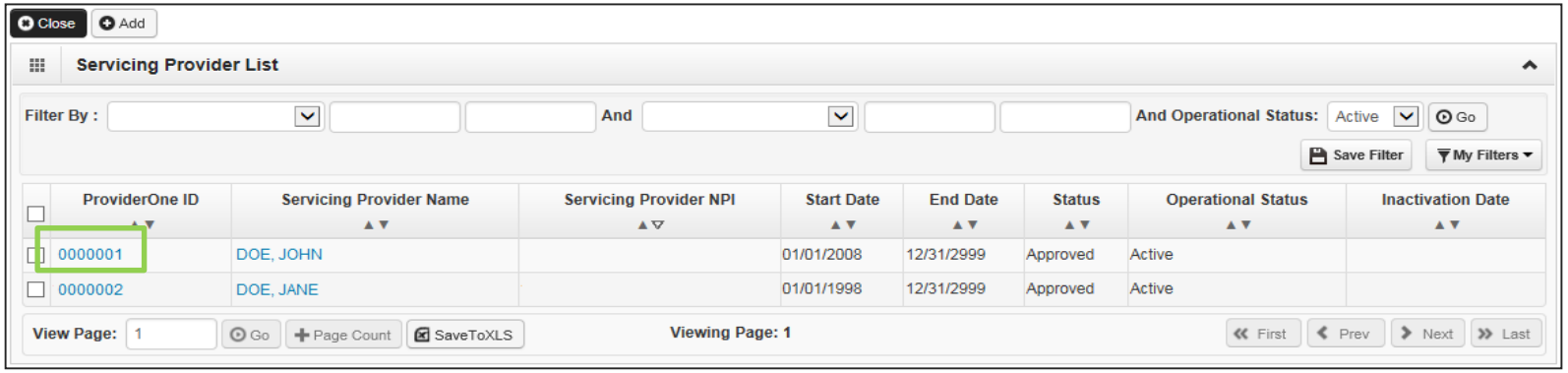
Provider File Maintenance

- Step 14: Servicing Provider Information
  - View the list of providers that work at the clinic.

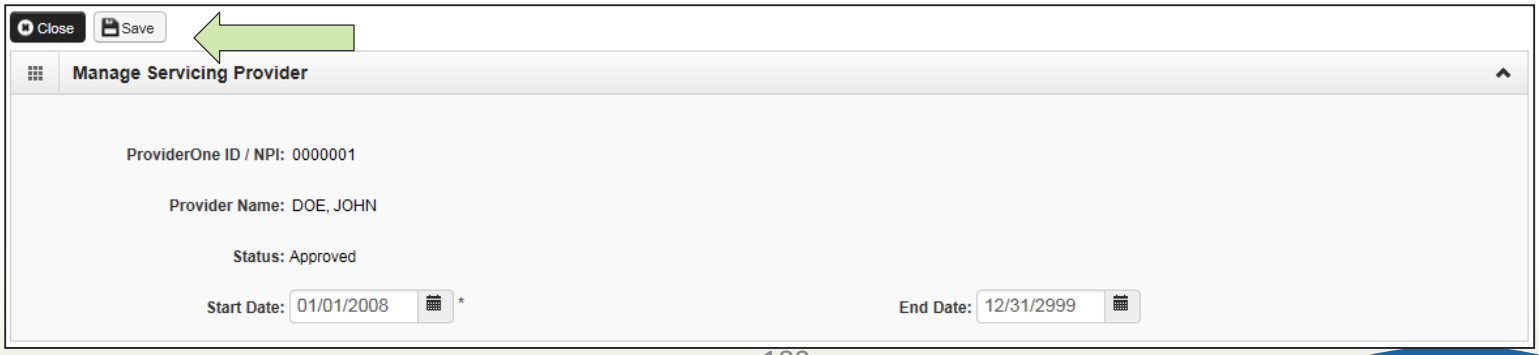


Provider File Maintenance

- Step 14: Servicing Provider Information – Ending a provider association:
  - Click on the **ProviderOne ID** on the provider list.



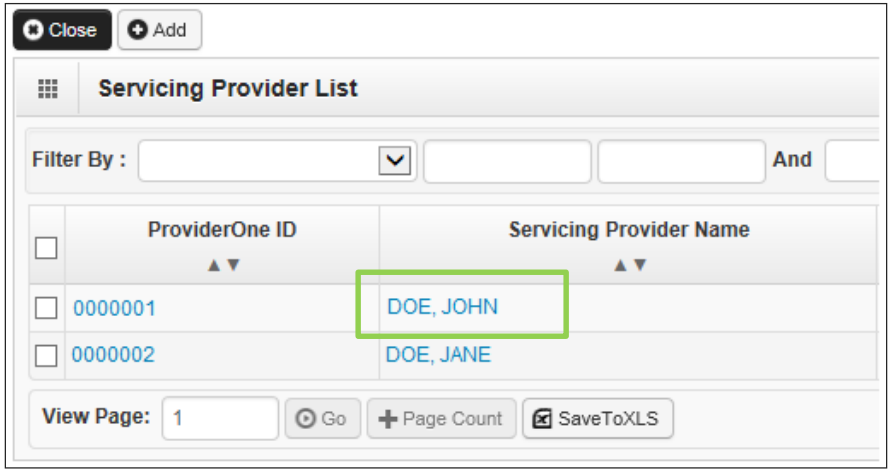
  - Enter an end date and click the **Save** button.



Provider File Maintenance

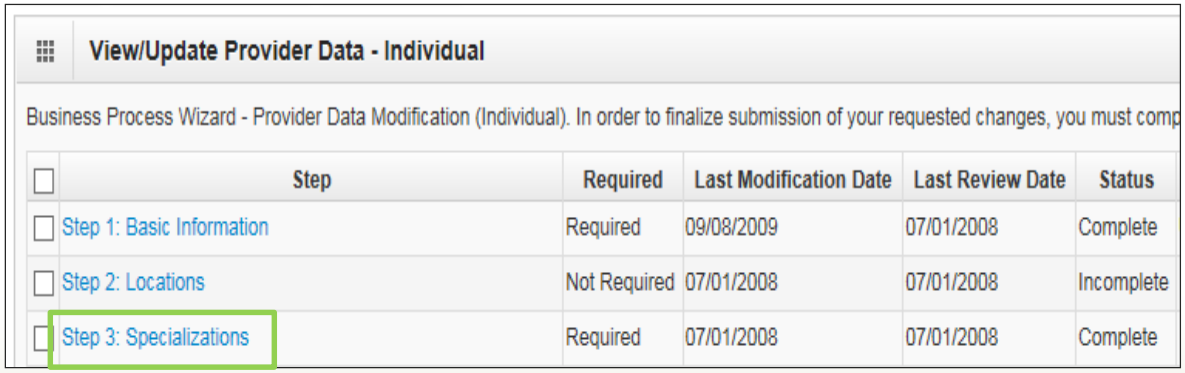
➢ Step 14: Servicing Provider Information

- Viewing a Servicing Provider's taxonomy codes:



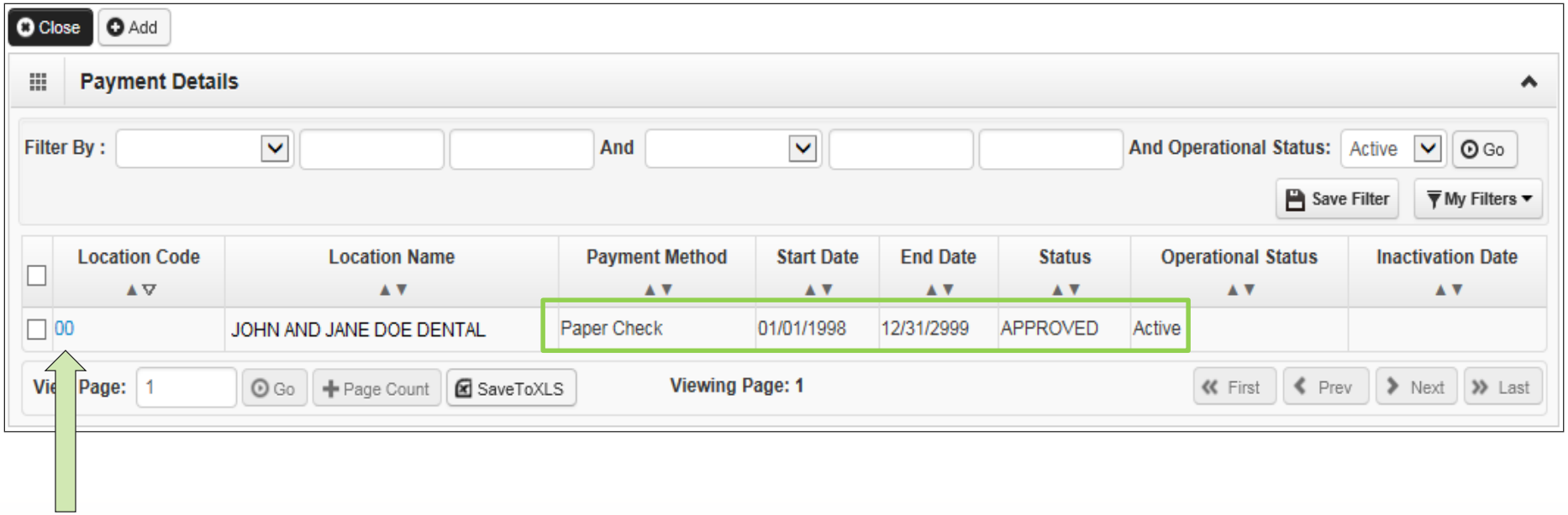
- At the provider list page, click on the **provider's name.**
- ProviderOne opens the individual provider's **Business Process Wizard** (BPW).

- Click on **Step 3: Specializations** to see the taxonomy code list for your provider.



Provider File Maintenance

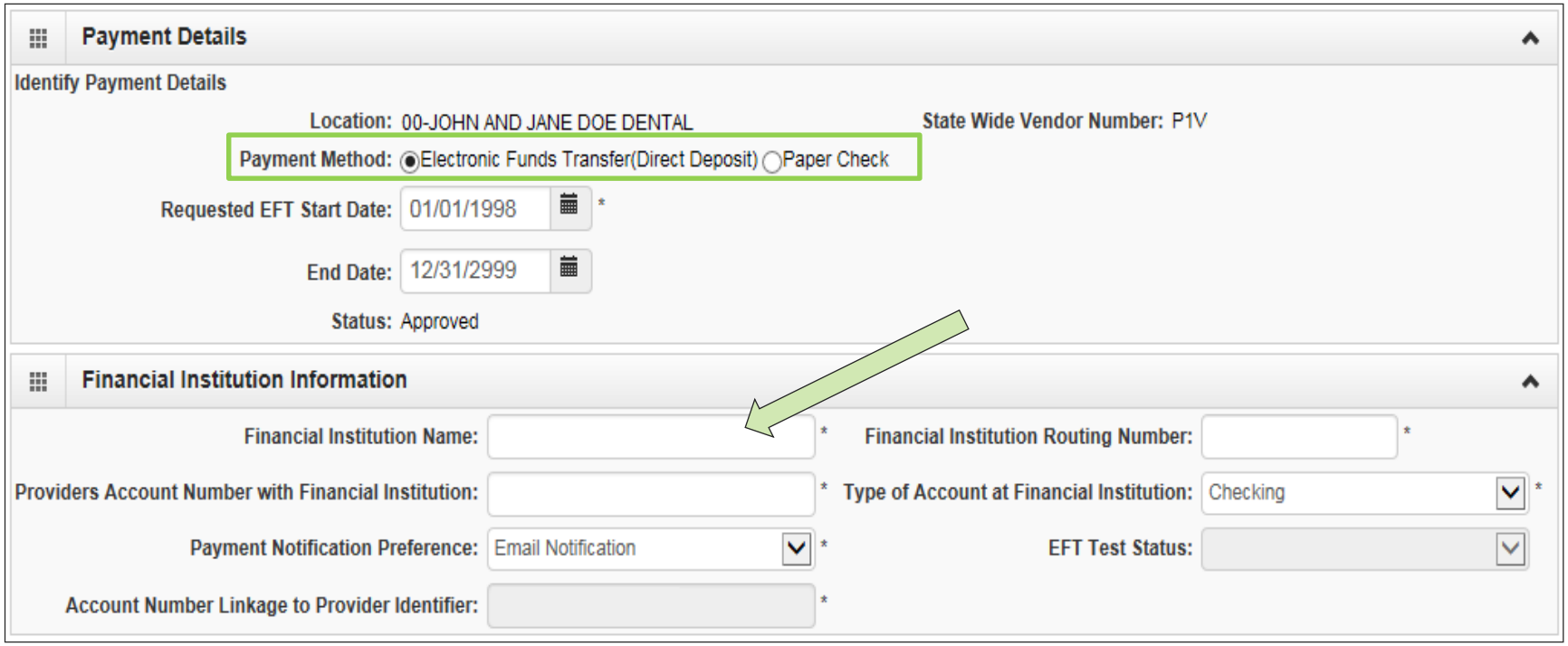
- Step 15:Payment Details
  - Current payment information is displayed.
  - To modify click on the **00** hyperlink.



Provider File Maintenance

➢ Step 15: Payment Details

- Switching to Electronic Funds Transfer (preferred):



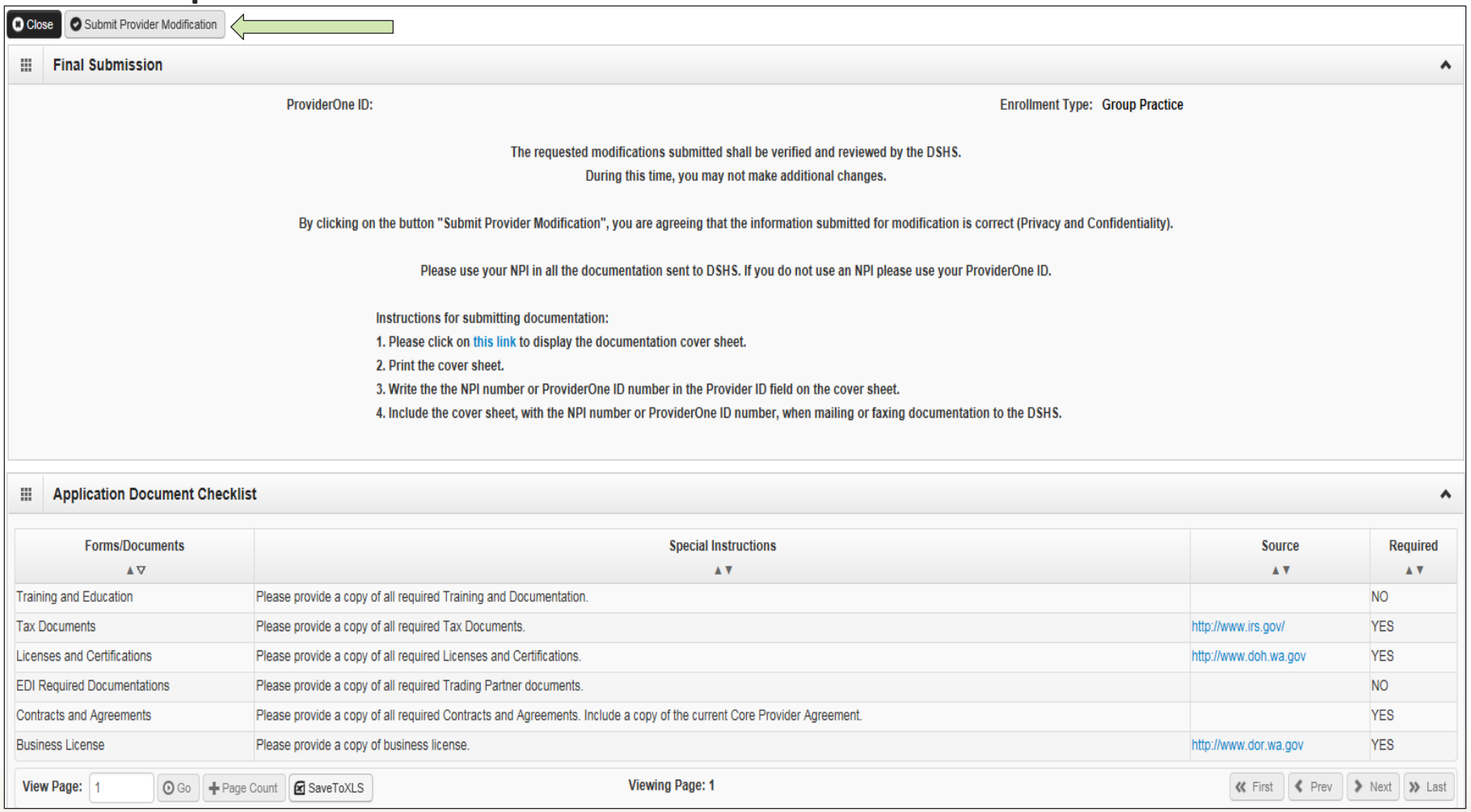
- Enter your banking information under the Financial Institution Information fields and click **OK**.

Provider File Maintenance

- Step 15: Payment Details
  - Complete the Authorization Agreement for Electronic Funds Transfer form:
    - Use Form 12-002 for new EFT set up.
    - Check the box for change of EFT account number.
  - Have the form signed.
  - Fax in to 360-725-2144; or
  - Mail to address on the form.
  - Find the form at the Forms web page.

Provider File Maintenance

➢ Step 16: Submit Modification for Review



Provider File Maintenance

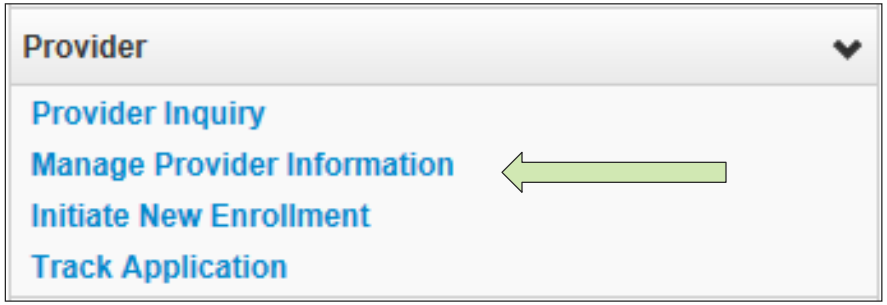
- More information on provider file maintenance, visit the ProviderOne user manuals web page.

- Find your manual to review.

Enroll an Existing Rendering Provider

Enroll an Existing Rendering Provider

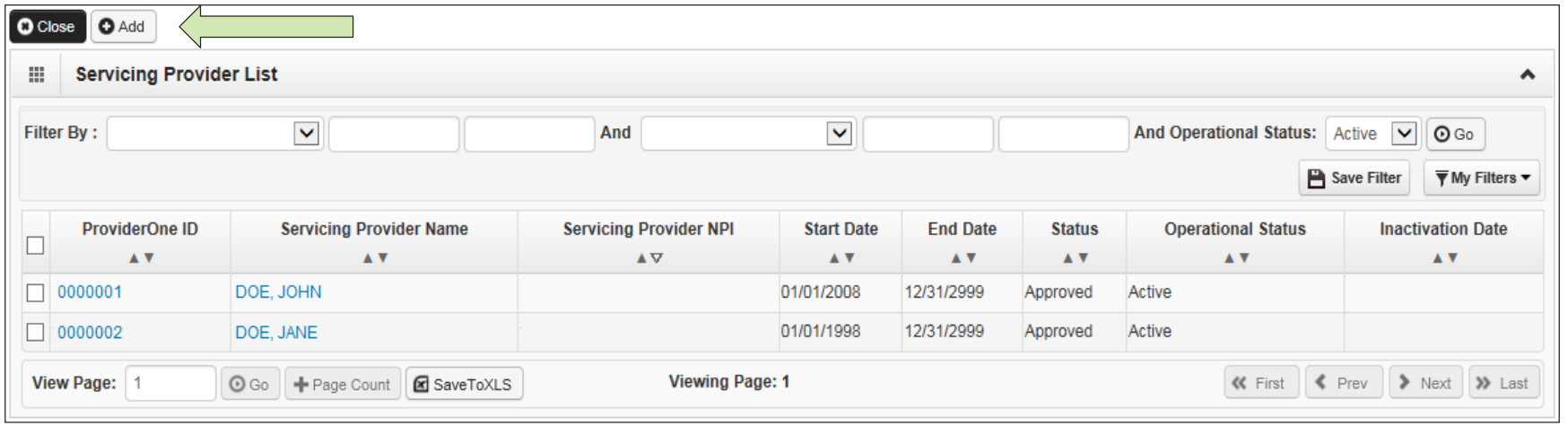
- Log into ProviderOne using the **File Maintenance or Super User profile**:



- Under Provider click on the hyperlink **Manage Provider Information**.
- At the Business Process Wizard click on **Step 14: Servicing Provider Information**.

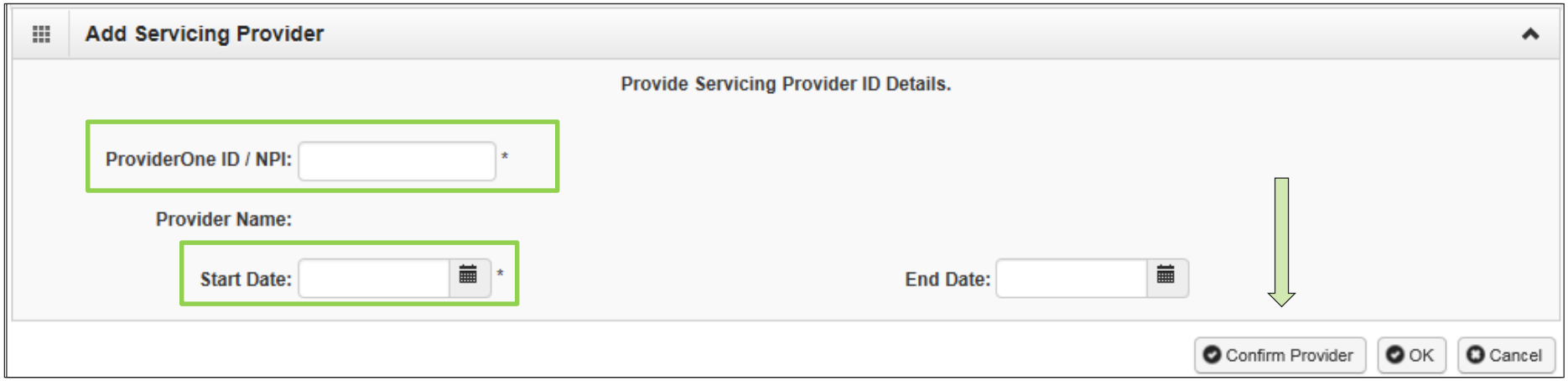
Enroll an Existing Rendering Provider

- When the Servicing Provider List opens, click on the **Add** button.



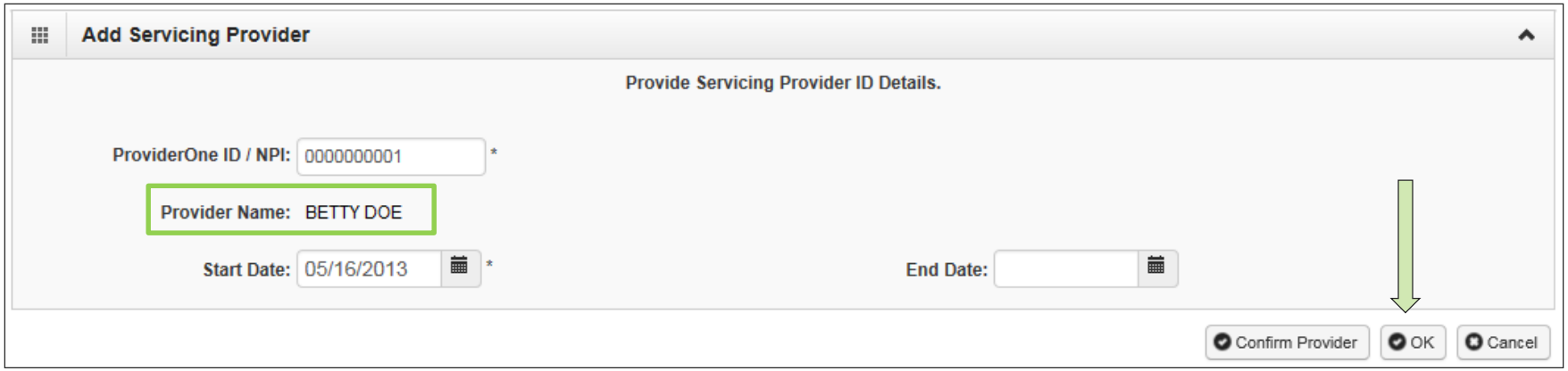
Enroll an Existing Rendering Provider

- At the **Add Servicing Provider** screen:
  - Enter the provider's NPI;
  - Enter their start date at your clinic;
  - Click on the **Confirm Provider** button.



Enroll an Existing Rendering Provider

- If the provider is already entered in ProviderOne - their name will be confirmed.

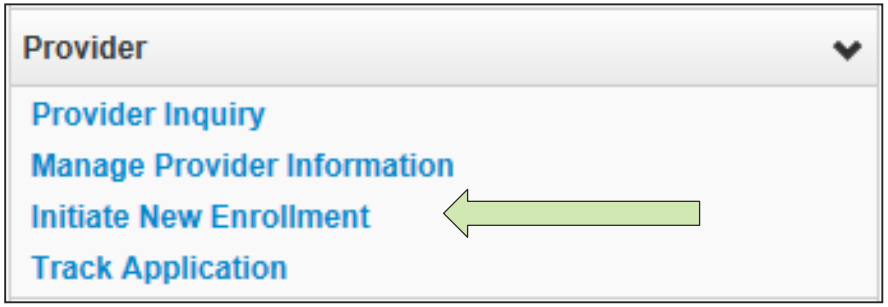


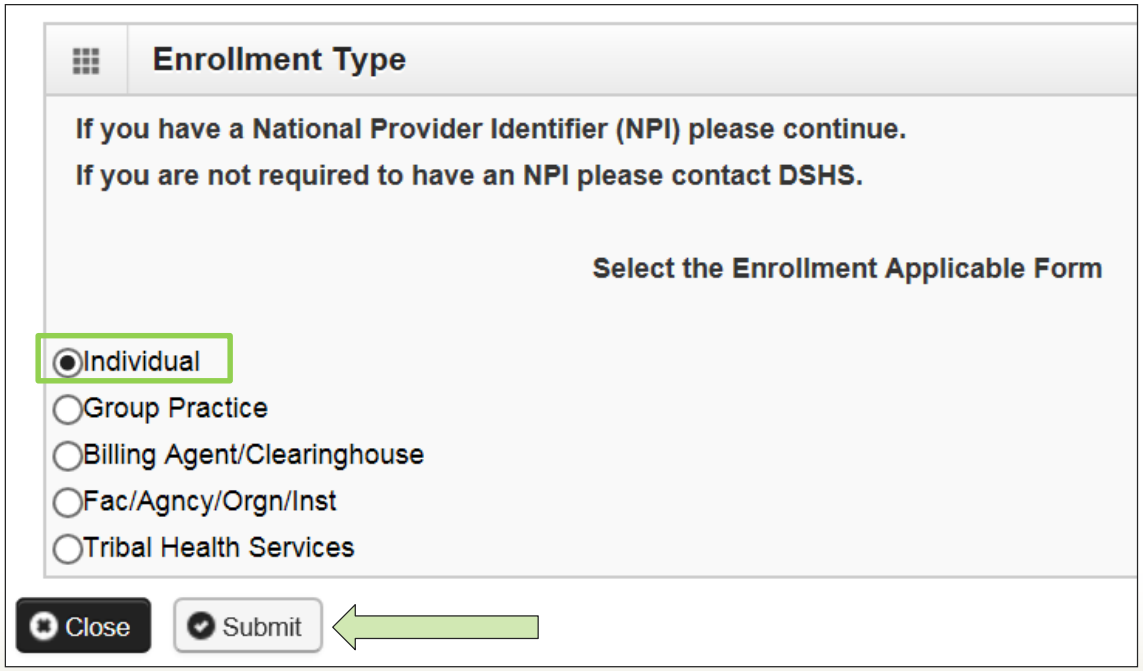
- Click the **OK** button to add the provider to your list.
- Remember to click **Step 16: Submit Modification for Review**.
- Your modification request will be reviewed and worked in chronological order.

Enroll a New Rendering Provider

Enrolling a New Rendering Provider

- On the Provider Portal, select the **Initiate New Enrollment** hyperlink.

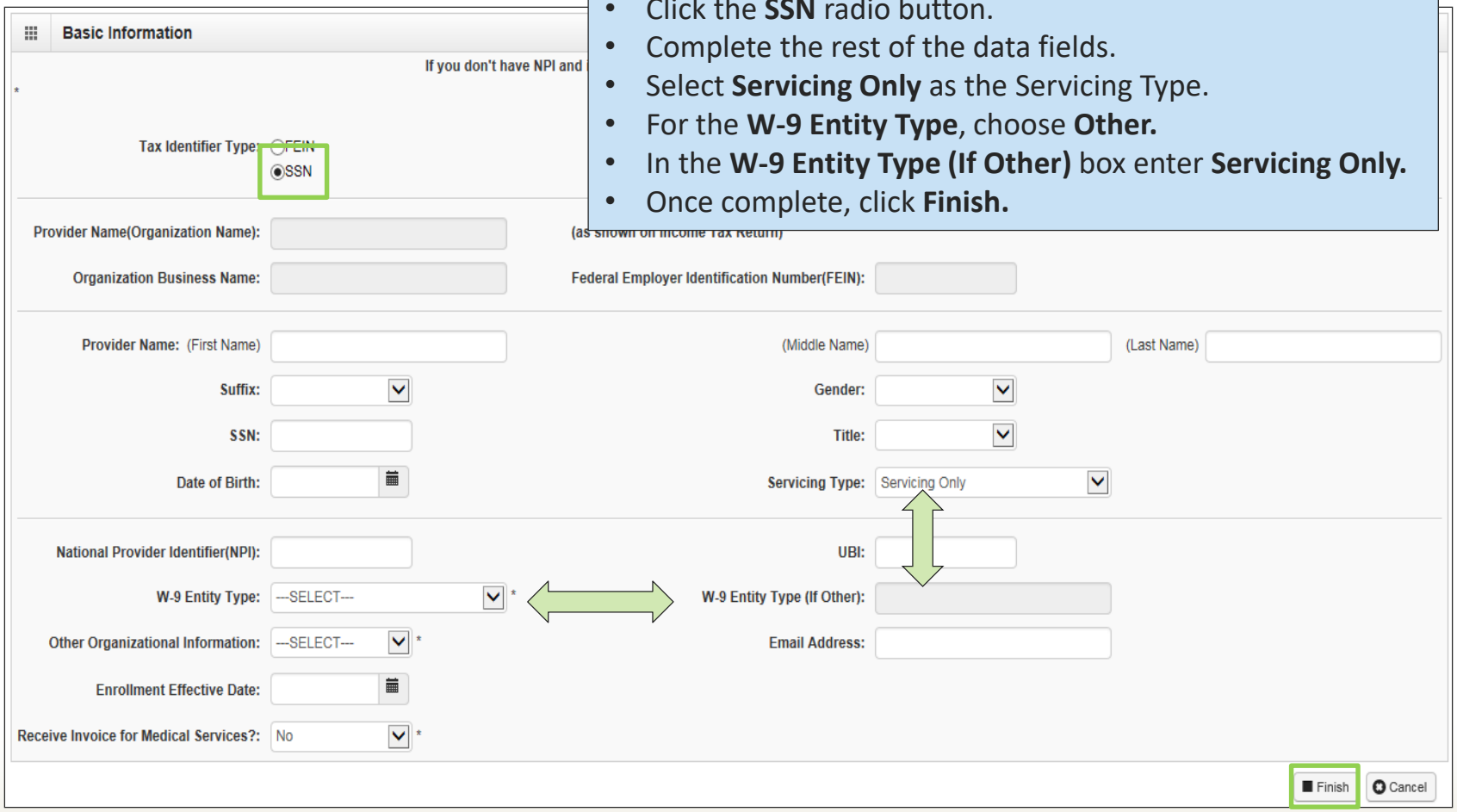




- Click on **Individual** to start a new enrollment for the rendering or servicing provider and click **Submit**.

Enrolling a New Rendering Provider

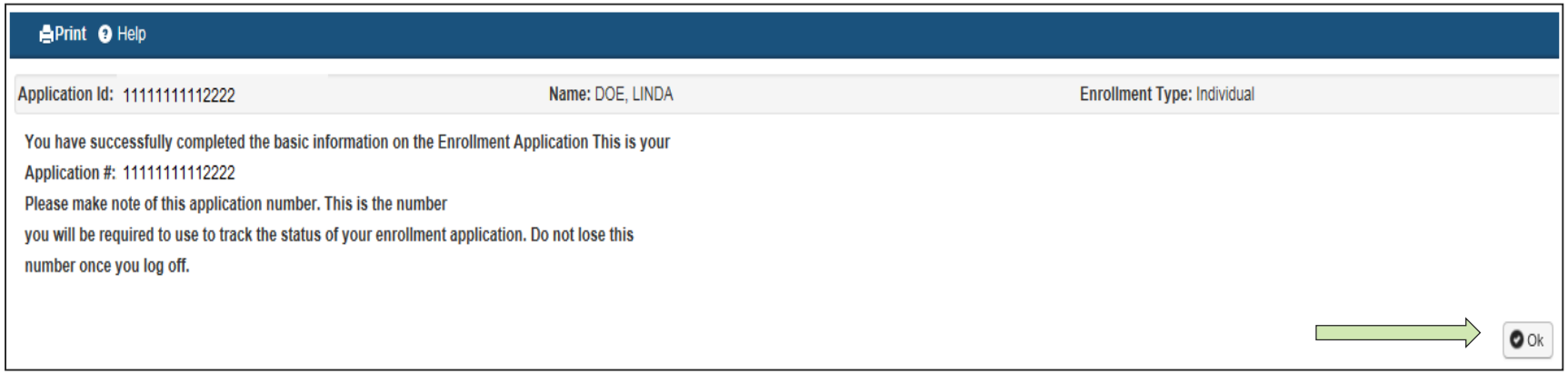
- At the **Basic Information** page for the rendering provider enrollment:



- Click the **SSN** radio button.
- Complete the rest of the data fields.
- Select **Servicing Only** as the Servicing Type.
- For the **W-9 Entity Type**, choose **Other.**
- In the **W-9 Entity Type (If Other)** box enter **Servicing Only.**
- Once complete, click **Finish.**

Enrolling a New Rendering Provider

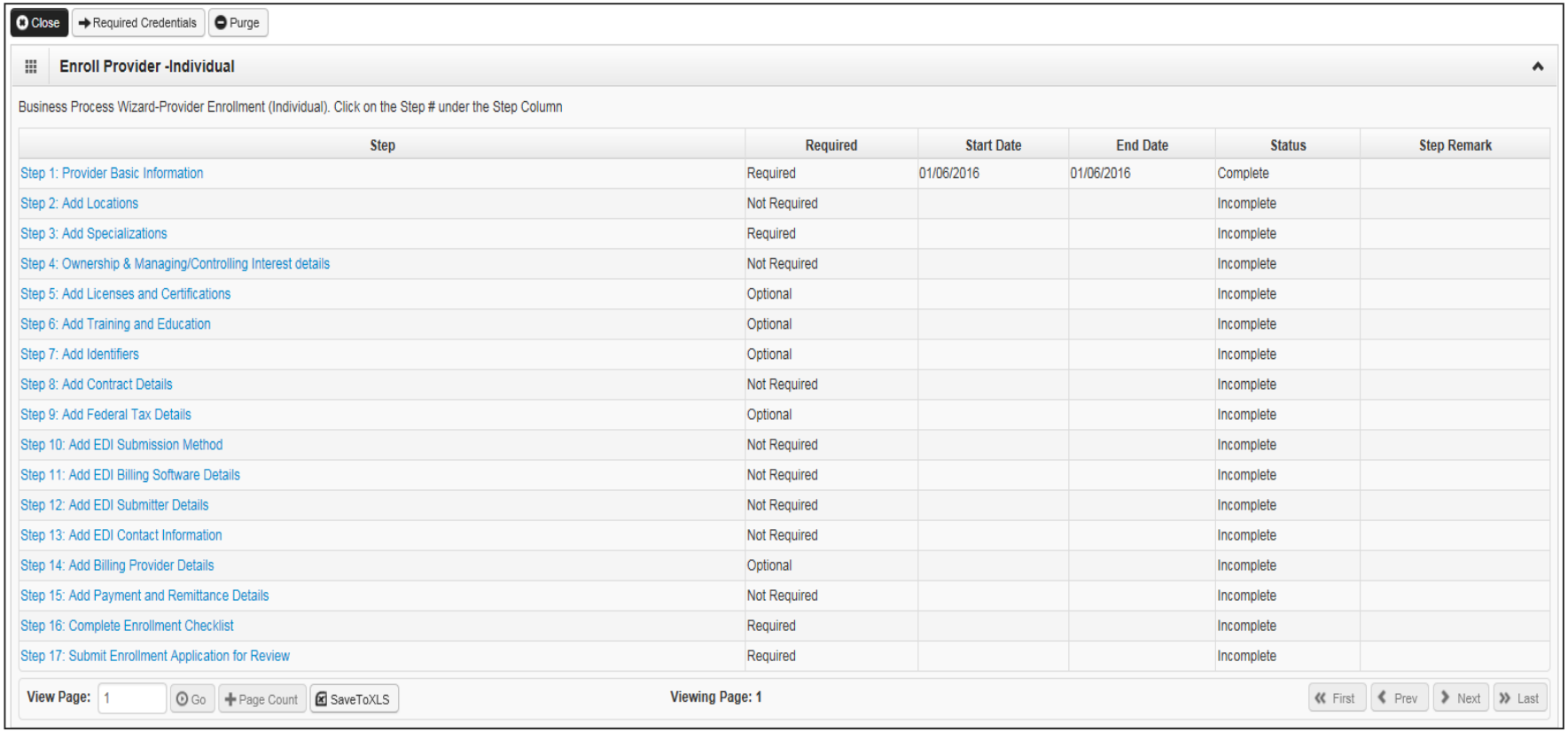
- Once the fields are completed on the Basic Information screen, the enrollment application is submitted into ProviderOne which generates an application number.



- Be sure to record this application number for use in tracking the status of the enrollment application.
- Click **OK.**

Enrolling a New Rendering Provider

- The Business Process Wizard - Step 1 shows complete:



Close | Required Credentials | Purge

Enroll Provider -Individual

Business Process Wizard-Provider Enrollment (Individual). Click on the Step # under the Step Column

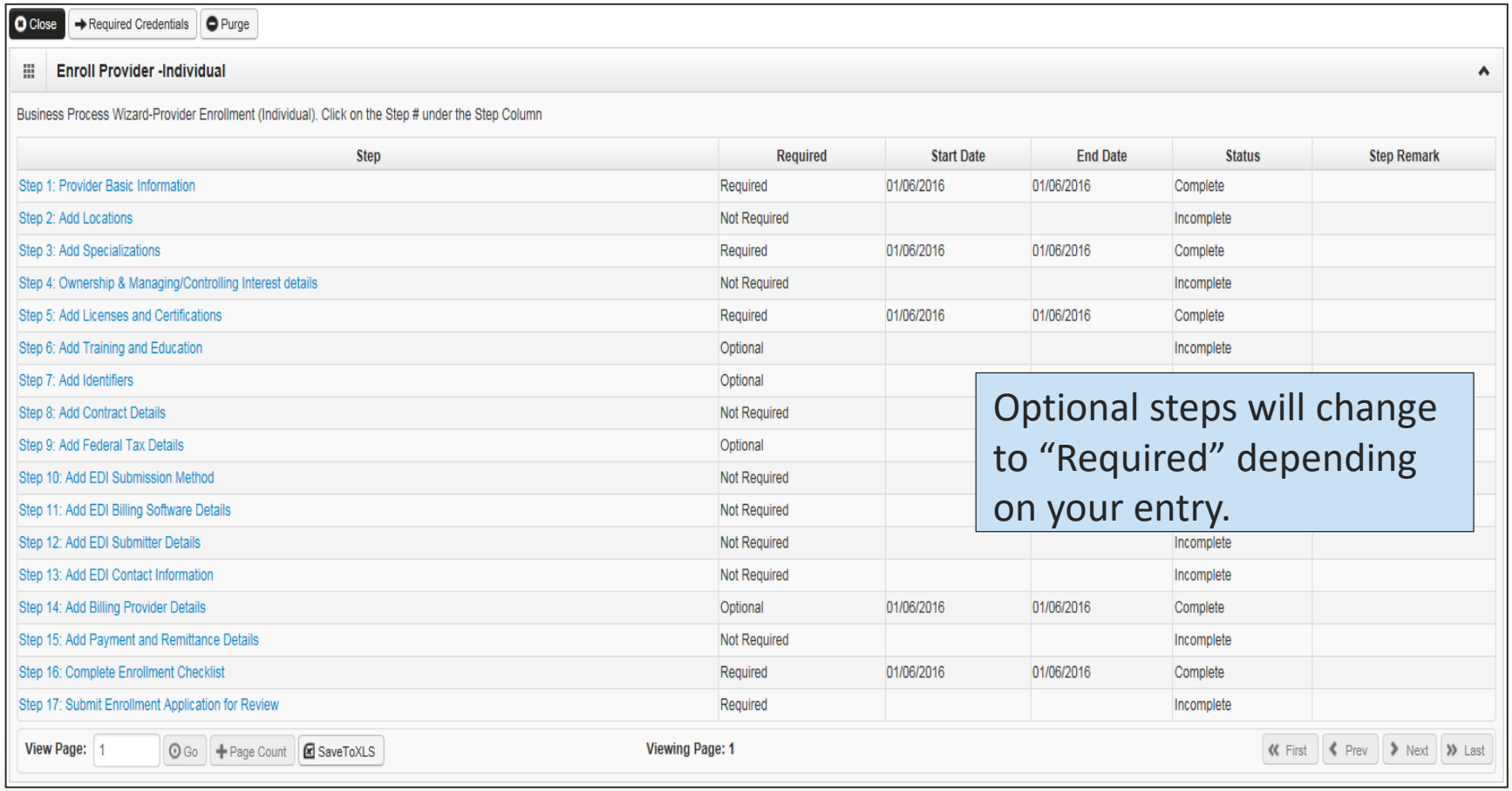
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	01/06/2016	01/06/2016	Complete	
Step 2: Add Locations	Not Required			Incomplete	
Step 3: Add Specializations	Required			Incomplete	
Step 4: Ownership & Managing/Controlling Interest details	Not Required			Incomplete	
Step 5: Add Licenses and Certifications	Optional			Incomplete	
Step 6: Add Training and Education	Optional			Incomplete	
Step 7: Add Identifiers	Optional			Incomplete	
Step 8: Add Contract Details	Not Required			Incomplete	
Step 9: Add Federal Tax Details	Optional			Incomplete	
Step 10: Add EDI Submission Method	Not Required			Incomplete	
Step 11: Add EDI Billing Software Details	Not Required			Incomplete	
Step 12: Add EDI Submitter Details	Not Required			Incomplete	
Step 13: Add EDI Contact Information	Not Required			Incomplete	
Step 14: Add Billing Provider Details	Optional			Incomplete	
Step 15: Add Payment and Remittance Details	Not Required			Incomplete	
Step 16: Complete Enrollment Checklist	Required			Incomplete	
Step 17: Submit Enrollment Application for Review	Required			Incomplete	

View Page: 1 | Go | Page Count | SaveToXLS | Viewing Page: 1 | First | Prev | Next | Last

- The steps indicated as **Required** are a reflection of the W-9 Entity Type selected on the Basic Information screen.

Enrolling a New Rendering Provider

- The required steps for Servicing Only are shown here. See next slide for description:

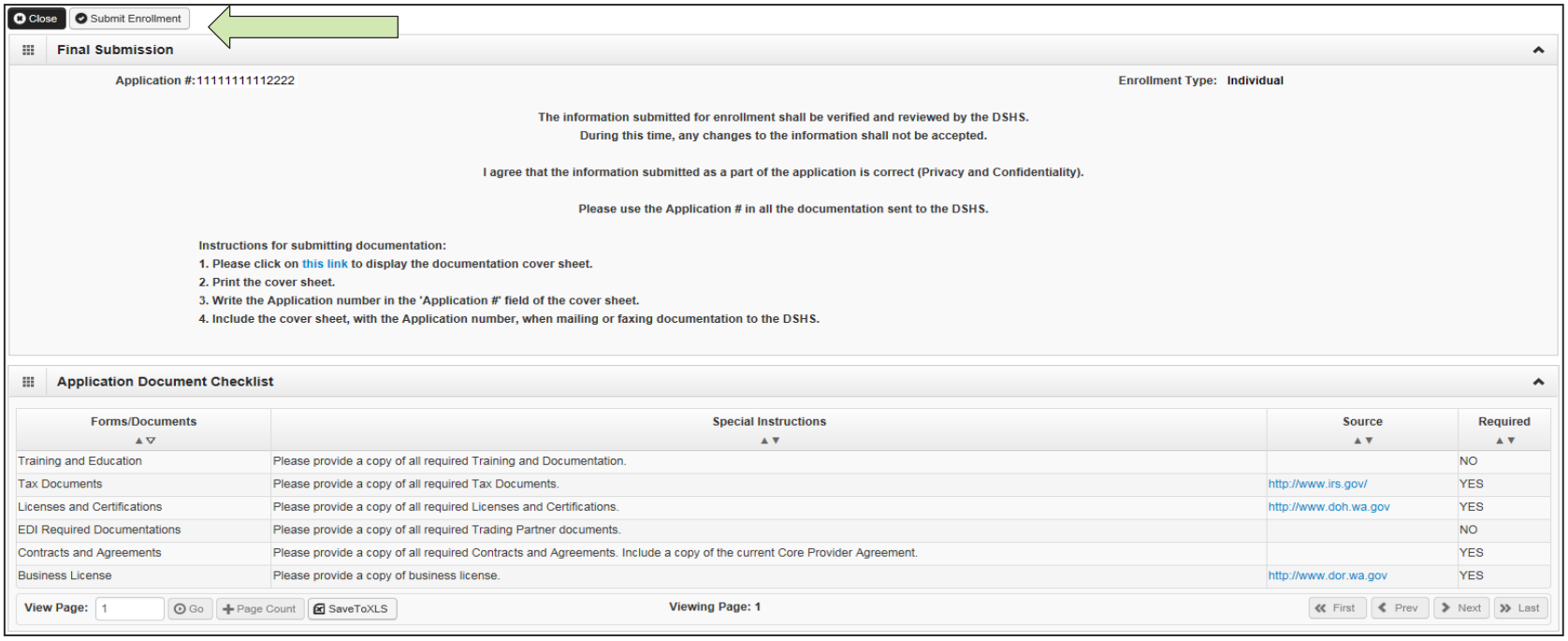


Enrolling a New Rendering Provider

- Step 3: Specializations
  - Add Taxonomy here.
- Step 5: Licenses and Certifications
  - Enter license/certification issued by the Department of Health.
- Step 7: Identifiers
  - Add DEA number (if applicable).
- Step 14: Billing Provider Details
  - Add the NPI and Name of clinic that will bill for this rendering provider's services.
- Step 16: Complete Enrollment Checklist
  - Answer questions displayed; and
  - Click **Save** and then **Close**.

Enrolling a New Rendering Provider

- Step 17: Submit Modification for Review
  - Click this step to initiate sending the enrollment; and
  - Click the **Submit Enrollment** button.



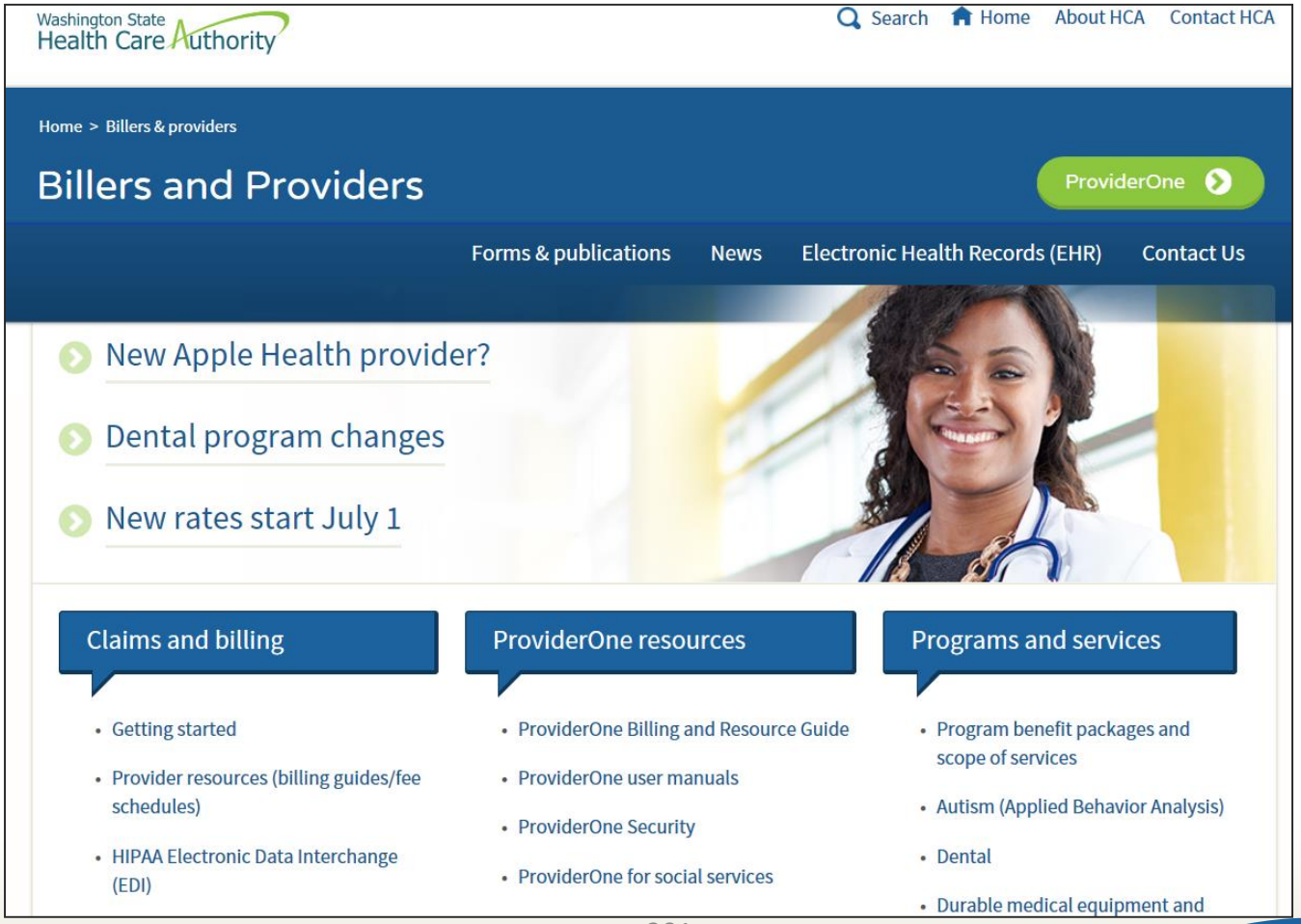
- Send in all required supporting documentation (CPA, Certifications, etc.).

Washington State Health Care Authority

Online Resources

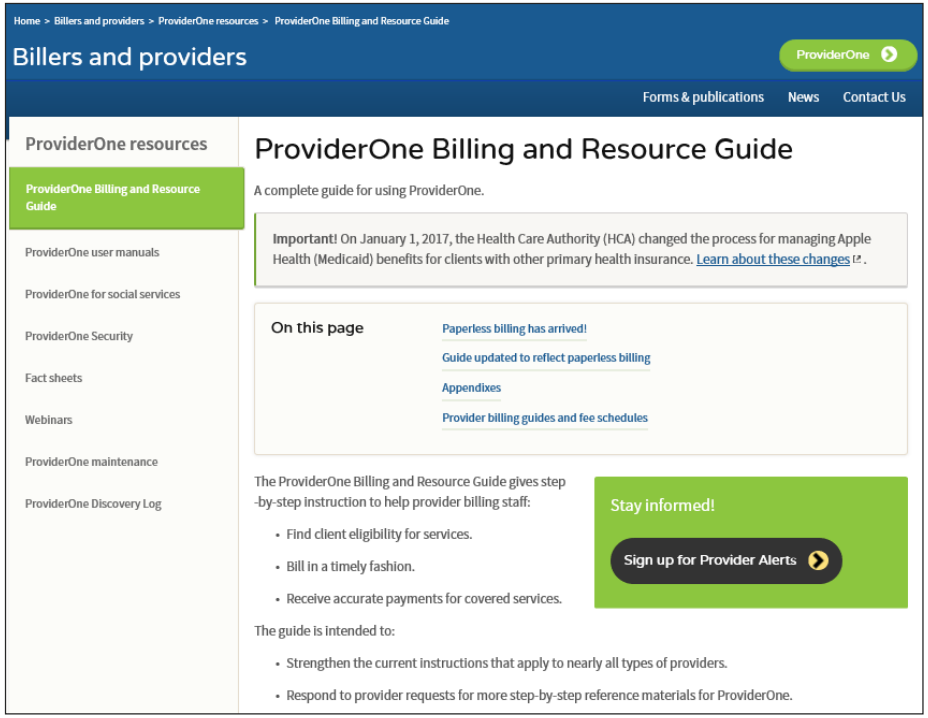
Online Resources

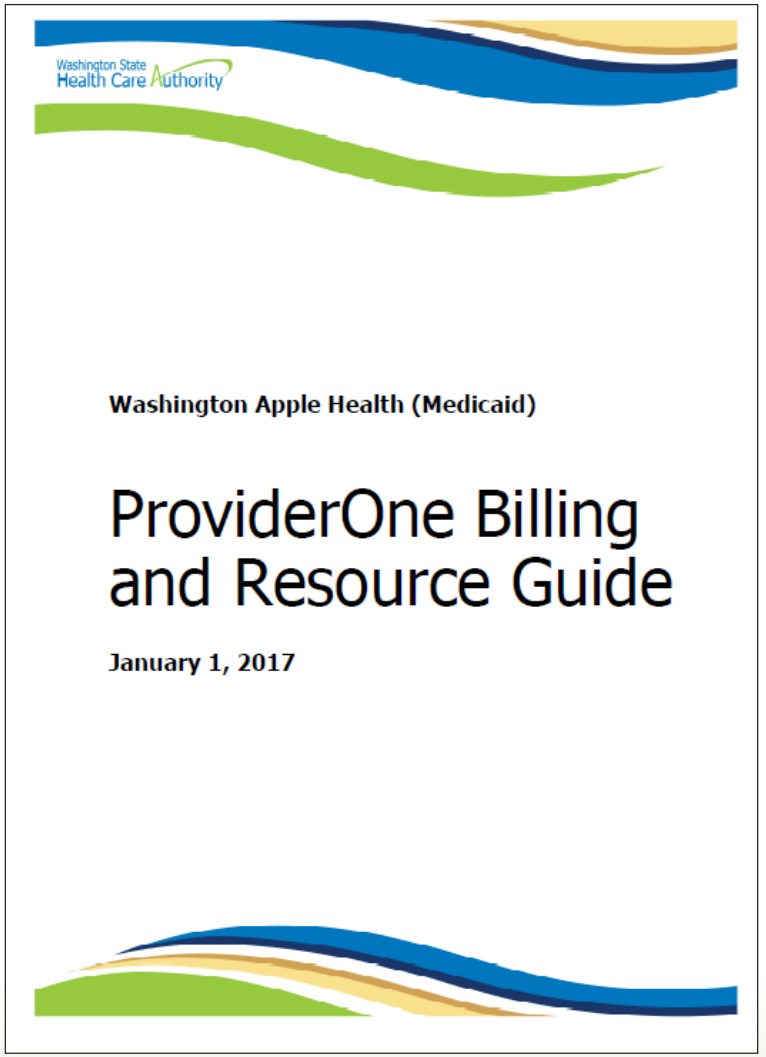
- Medicaid Providers' Home (www.hca.wa.gov/billers-providers).



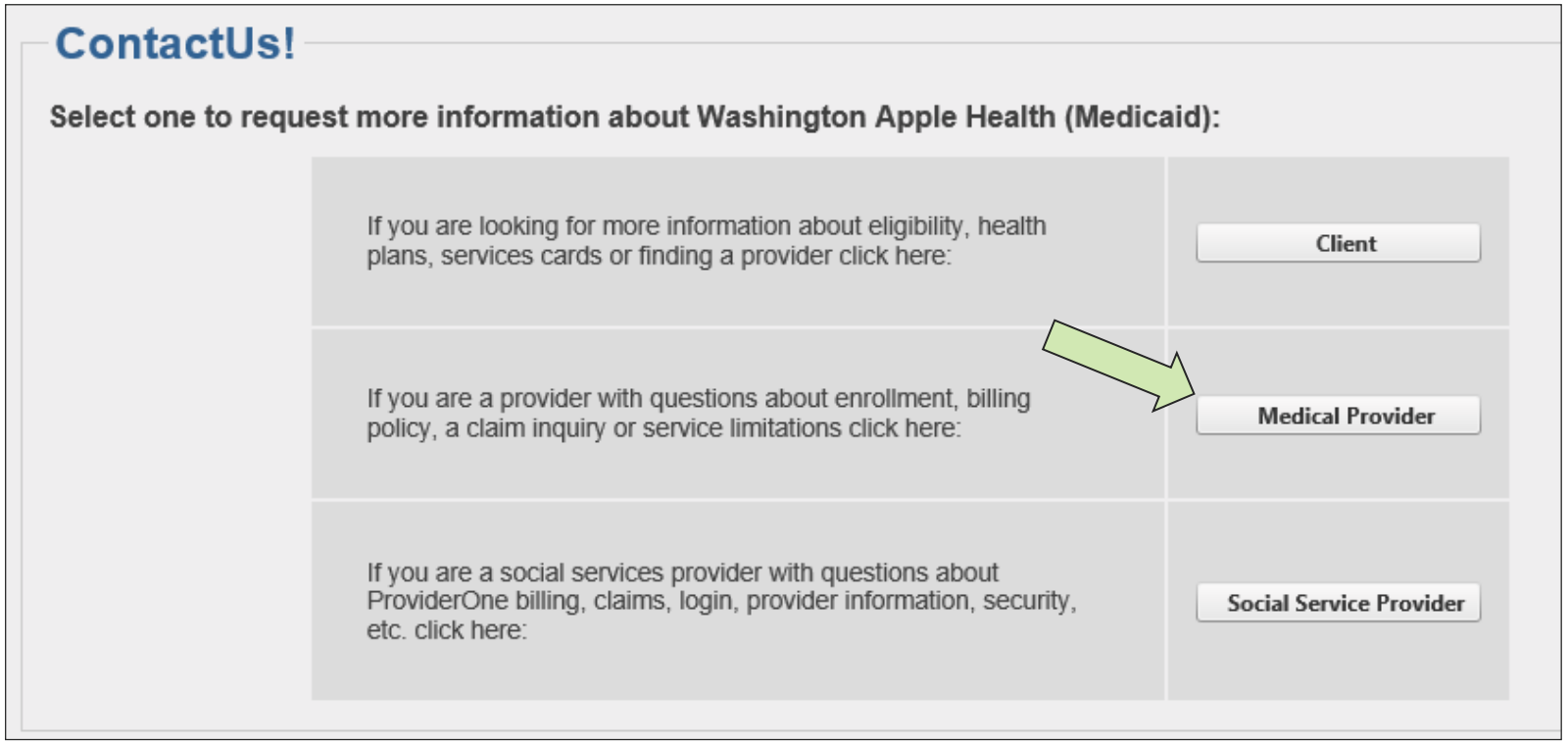
Online Resources

- ProviderOne Billing and Resource Guide webpage





Contact Us

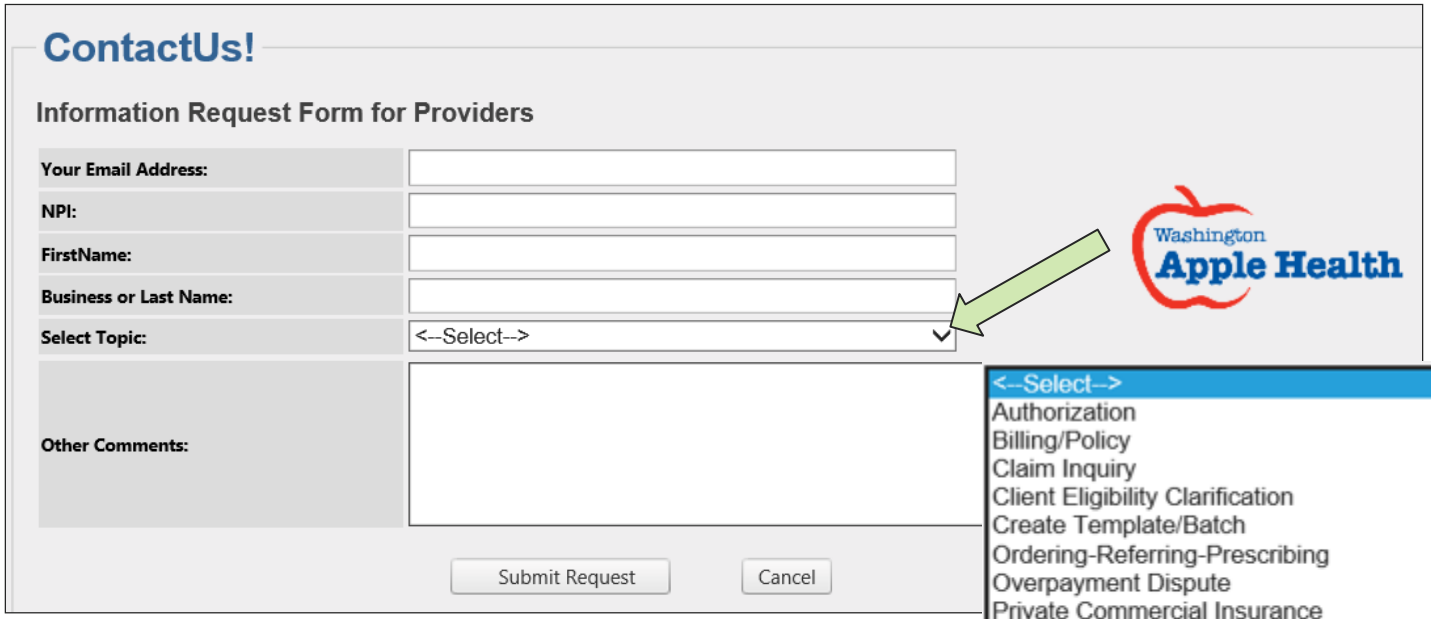


Use the Apple Health web form!

https://fortress.wa.gov/dshs/p1contactus/

Contact Us

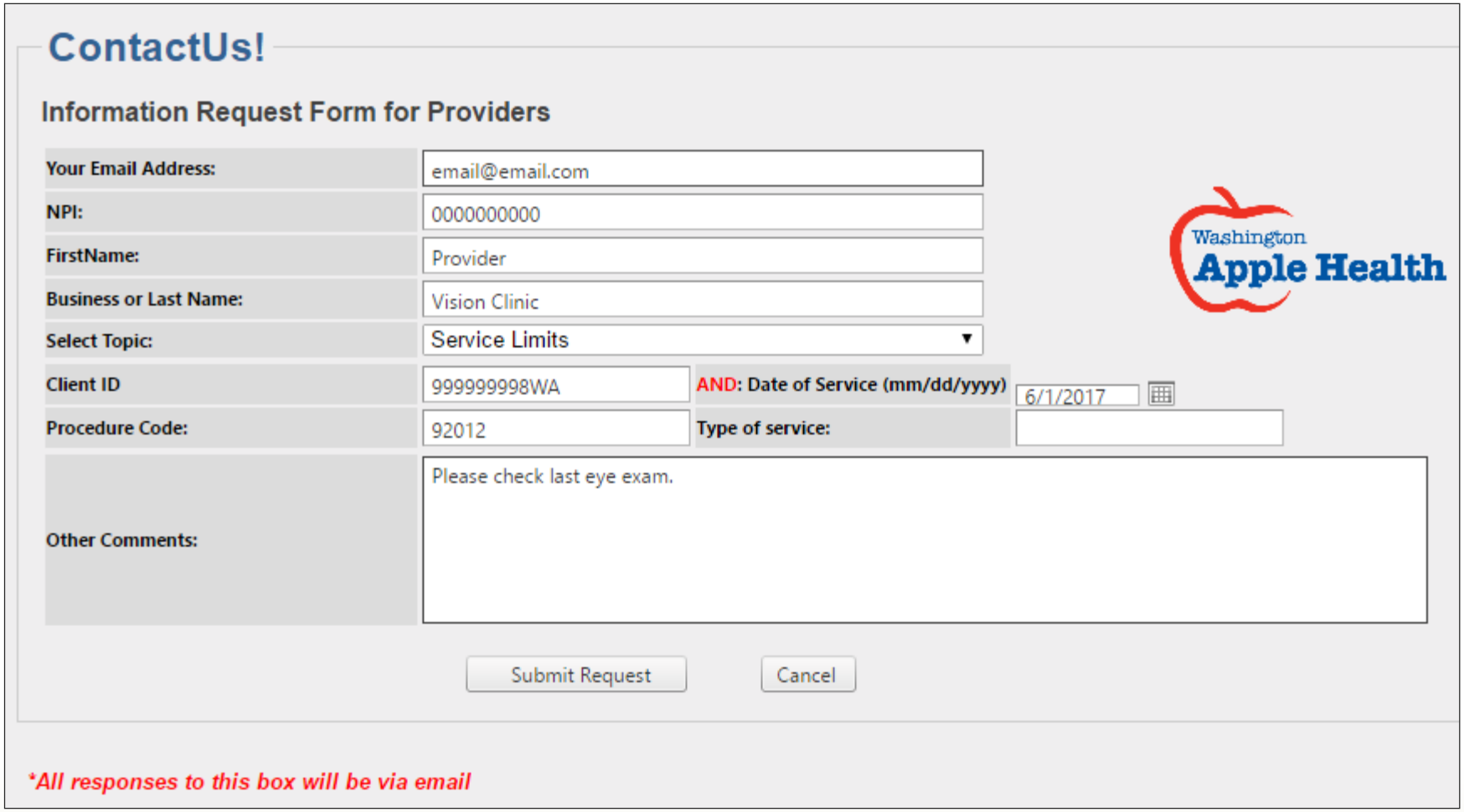
- Using the drop down Select Topic, gives the following options to choose from:



- 48 hour turnaround for **Service Limit** checks:
  - Be sure to include the Date of Service (DOS)
  - Procedure Code and the date range for search
  - ProviderOne Domain number

Washington State Health Care Authority

Contact Us



ContactUs!

Information Request Form for Providers

Your Email Address:	email@email.com
NPI:	0000000000
FirstName:	Provider
Business or Last Name:	Vision Clinic
Select Topic:	Service Limits
Client ID	999999998WA
AND: Date of Service (mm/dd/yyyy)	6/1/2017
Procedure Code:	92012
Type of service:	
Other Comments:	Please check last eye exam.

Submit Request Cancel

Washington Apple Health

*All responses to this box will be via email

Washington State Health Care Authority

Online Resources

- Programs and Services information:
  - Program billing guides and fee schedules: https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides
  - Hospital Rates: https://www.hca.wa.gov/billers-providers/claims-and-billing/hospital-rates-and-billing-guides
- Provider Enrollment webpage and email:
  - providerenrollment@hca.wa.gov
  - Webpage: https://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider
- Provider Relations webpage and email:
  - providerrelations@hca.wa.gov
  - https://www.hca.wa.gov/billers-providers/providerone-resources
- HCA Forms webpage: http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx
- Washington Administrative Code webpage – Administration of Medical Programs: https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/apple-health-medicaid-manual-wac-index


Q
A