Providers billing for Social Service Medical services use a different method in which to submit claims.

Templates can be used when you have repetitive billing; where the claim is the same, or nearly the same, each time you bill.

With a template, you create a billing page that is reusable. Using templates is a great way to save time and make billing easier.

This “Create Template Social Service Medical” How-To provides instructions on:

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Create a Template Social Service Medical

Having templates with previously saved information will help cut down on errors by reducing the amount of data entry for each claim.

To create a social service medical template, first login to ProviderOne using the ‘EXT Social Services Medical’ profile.

From the ‘Provider Portal’ select ‘Manage Templates’ located under the ‘Claims’ area under ‘Online Services’ (located near the top left corner of the provider portal).

Providers performing social service medical services must bill through the medical portal.

For shared services, all other client coverages should be considered for payment before social services.

**Note:**

Creating a template is not the same as submitting a claim.

Managing templates is for adding or removing templates. No claims can be submitted from the Managing Templates area.
The ‘Create Claim Template’ page appears and is used to:

- **Add** a new template, or
- **Edit** a saved template, or
- **View** a saved template, or
- **Delete** a template, or
- **Change template name or Save as/Copy** template, or to
- **Create** a template batch

To create a new template, make sure to choose ‘Professional’ as the claim type in the dropdown menu and then click on ‘Add’.

**Note:**

*Social Service Medical ‘Type of Claim’ is Professional.*

Managing templates is for adding or removing templates. No claims can be submitted from the Managing Templates area.

Columns can be sorted from A-Z or Z-A order using the controls below the name of each column.
Create a Template Social Service Medical

The ‘Professional Claim’ screen appears. This page is a Professional Billing page with an added Template Name field.

- **Enter a Template name**
  
  This is determined by the user and is used internally to find your template.

**Note:**

Asterisks (*) denote required fields.

ProviderOne will check the following before allowing the template to be saved:

- Provider NPI
- Taxonomy
- Client ID
- Authorization Number
Next, enter:

- National Provider Identifier (NPI)
- Taxonomy Code associated to the service you are contracted to provide.*

Note:
Asterisks (*) denote required fields.
*Durable Medical Equipment (DME) providers do not have contracts with DSHS.

Work performed is done so in accordance with their Core Provider Agreement (CPA) with the Washington State Health Care Authority (HCA).

When entering taxonomy information, use the appropriate assigned taxonomy for the service provided either through your DSHS contract or CPA with HCA.
Create a Template Social Service Medical

Next:

- Select ‘Yes’ for the question, “Is the Billing Provider also the Rendering Provider?”
- Select ‘No’ for the question, “Is this service the result of a referral?”*

Note:
Asterisks (*) denote required fields.

*For some shared services, a referral may be required.

If required, select ‘Yes’ for the question, “Is this service the result of a referral?”

When answering yes, another field will appear asking for the referring providers NPI number. Enter the referring provider NPI and continue creating your Template.
Next under ‘**Subscriber/Client Information**’:

- Enter the **Client ID** (client ID ends in WA)
- Open the + next to ‘**Additional Subscriber/Client Information**’
- Enter the client
  - Last Name
  - Date of Birth
  - Gender

**Note:**

Asterisks (*) denote required fields.

*Client last name, DOB, and gender are the only required fields.*

*Patient is pregnant and Patient Weight fields do not apply.*
Next under ‘**Subscriber/Client Information**’:

Answer ‘**No**’ to the questions:

- Is this claim for a Baby on Mom’s Client ID?
- Is this a Medicare Crossover Claim?

**Note:**

Asterisks (*) denote required fields.
Next under ‘Claim Information’:

Open the + next to ‘Prior Authorization’.

- Enter the approved authorization number for the client.*

  *Certain claims may require a claim note. Please refer to your billing guide for more information.

  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.

- Answer ‘No’ to the question, “Is this claim accident related?”

**Note:**

Asterisks (*) denote required fields.
Next under 'Claim Data':

Use the dropdown menu and choose the appropriate 'Place of Service'.

Most social services performed will be in either an office or the client home.

If service is performed outside of those locations, choose the appropriate place of service from the list.

Note:
Asterisks (*) denote required fields.

Adult Family Homes, Assisted Living Facilities, and Enhanced Service Facilities are residential settings and thus considered the client home.
Next under ‘Claim Data’:

Enter the appropriate ICD-10 ‘Diagnosis Code’.

- At least 1 diagnosis code (DX) 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 any decimals to the DX code once the claim is submitted.

**Note:**
Asterisks (*) denote required fields.

ICD-10 diagnosis codes can be found from many online resources.

Client case managers and MACSC call center staff cannot supply ICD-10 diagnosis codes. Please use the online resources available to determine the appropriate code(s) based on the client diagnosis.
At this point you have entered the minimum required information needed to save a template.

Follow these steps to save the template.

Once all the required information has been entered:

- To save the template, click on ‘Save Template’ (at the top of the screen).
- After choosing to save the template, you will be asked, “Do you want to save the Template?”

Select ‘OK’ to confirm the save of the template. Select ‘Cancel’ if you are not ready to save the template or need to make changes.

Note:
In ProviderOne, ‘OK’ signifies a YES response and ‘Cancel’ a NO response.
You will now be returned to the ‘Create a Claim Template’ page.

Here, you will see the template you have created. You can see the template name, template type, the user who made the last update and the last updated date.

To edit any information on the template, check the box next to the template name and select edit. Make the needed edits and save the template.

To view or delete the template, check the box next to the template name and choose the appropriate action button.

Note:
Columns can be sorted from A-Z or Z-A order using the controls below the name of each column.
As a way to save time, you can use the template you have just created to make similar templates for other clients.

To do this, you can make a copy of an existing template, change the client information, rename the template, and save.

**To Copy Template:**

- Check the box next to the desired template name.
  - You can click the box at the top of the column header if the changes you are making apply to all the templates in the list.
- Select ‘SaveAs/Copy’.

**Note:**

Creating new templates from a previously saved template can save you time. However, be mindful of the information being entered.

Incorrect authorization numbers, billing provider ID or client IDs will prevent the template from being saved.
After choosing ‘SaveAs/Copy’, the original saved template appears.

**To Update Template:**

- Change the **Template Name**.
- Change the **Client ID**.
- Open the + next to “**Additional Subscriber/Client Information**”, and
  - Change the client information
    - Last Name
    - Date of Birth
    - Gender
- Open the + next to “**Prior Authorization**”, change the authorization number.
- Change the **Diagnosis Code**, and then
- To save the new template, click on ‘Save Template’.

**Note:**

*Provider NPI* will remain the same when using copy of template.

Incorrect required information will prevent the template from being saved.
After choosing to save the template, you will be asked, “Do you want to save the Template?”

Select ‘Ok’ to confirm the save of the template. Select ‘Cancel’ if you are not ready to save the template or need to make changes.

Note:
In ProviderOne, ‘OK’ signifies a YES response and ‘Cancel’ a NO response.
You will now be returned to the ‘Create a Claim Template’ page.

The new saved template will be shown along with the original template.

Repeat the process as many times as needed.

To edit any information on the template, check the box next to the template name and select edit. Make the needed edits and save the template.

To view or delete the template, check the box next to the template name and choose the appropriate action button.

Note:
Columns can be sorted from A-Z or Z-A order using the controls below the name of each column.
As previously mentioned, claims cannot be submitted from the ‘Manage Template’ field.

To submit claims using the templates that have been saved, first login to ProviderOne using the ‘EXT Social Services Medical’ profile.

From the ‘Provider Portal’ select ‘Create Claims from Saved Templates’ located under the ‘Claims’ area under ‘Online Services’ (located near the top left corner of the provider portal.)

Providers performing social service medical services must bill through the medical portal.

For shared services, all other client coverages should be considered for payment before social services.
Next, you will be taken to the **Create Claim from Saved Templates List**.

To submit a claim using a saved template, select the blue ‘hyperlinked template name’.
The saved template will load with all the previously entered information.

This includes:
- Provider NPI
- Taxonomy Code
- Client ID
- Client Last Name, DOB and Gender
- Authorization Number
- Place of Service
- Diagnosis Code
- Answers to all required questions denoted by an asterisk (*)

Note:
If at this point you discover any incorrect information that has been entered, close out of the current screen and return to the ‘Manage Templates’ area to make the needed corrections.
Next under ‘**Basic Line Item Information**’:

- Enter ‘**Service Date From**’ and ‘**Service Date To**’. Claims are for a single day per line. Service From and To dates are the same.

- Enter ‘**Procedure Code**’ and ‘**Modifier**’ *(if applicable)*.
Next under ‘Basic Service Line Items’:

- Enter ‘Submitted Charges’ *(The provider is responsible for the calculation of submitted charges. Unit x Rate = Submitted Charge.)*
- Enter the number of ‘Units’.
- Select the corresponding ‘Diagnosis Pointer’ number from the diagnosis pointers dropdown.

*(Entered data into #1 diagnosis code box = #1 diagnosis pointer.)*
Once the service line information has been entered, click ‘Add Service Line Item’. The ‘Basic Service Line Information’ clears. This allows entry of any subsequent service lines before submitting your claim, i.e., billing for multiple days in a month.

Additional service lines must be for the same authorization. Different service codes are allowed if they are from the same authorization.

A claim service line appears under ‘Previously Entered Line Information’. The claim service line will show service dates, service code and modifier, units and submitted charges.
Once all service line information is entered and checked for accuracy, click ‘Submit Claim’ at the top of the screen.

Your pop-up blockers must be turned off to allow the Claim Detail screen to appear.

If the pop-up blockers are not turned off, the screen will flash and no pop-up will appear which allows you to complete billing.

Note:
If submitting a claim with the pop-up blockers on, the claim information will remain on the screen. Providers should turn off popup blockers before logging into ProviderOne.

Attempting to click ‘Submit Claim’ again will return an error message that the information you are trying to submit, has been queried by another user.

To remedy this, log out of ProviderOne, turn off your browsers pop-up blockers, then login to ProviderOne again and return to the billing screen to submit a new claim.
A message will appear asking, “Do you want to submit any Backup documentation?”

Certain shared services require backup documentation such as a denial from another payer. If required, select ‘OK’ and upload the needed documentation before continuing to submit the claim.

If no backup documentation is needed, select ‘Cancel’ and continue submitting the claim.

Note:
If submitting a claim with the pop-up blockers on, the claim information will remain on the screen. Providers should turn off popup blockers before logging into ProviderOne.

Attempting to click ‘Submit Claim’ again will return an error message that the information you are trying to submit, has been queried by another user.

To remedy this, log out of ProviderOne, turn off your browsers pop-up blockers, then login to ProviderOne again and return to the billing screen to submit a new claim.
With the pop-up blockers turned off, select submit claim. The ‘Submitted Social Service Claim Details’ screen appears.

Here you will see the ‘Transaction Control Number’ (TCN). The TCN is the 18 digit unique identifier for each submitted claim. The TCN is used to identify and track claims.

You will also see the ‘Provider NPI’, ‘Client ID’, ‘Date of Service’, and ‘Total Claim Charge’.

Note:
No records found refers to attachments such as backup documentation. Social service providers will not add attachments. Social Service Medical providers may need to add attachments. Refer to your service billing guides for more information.
When you see the **Submitted Social Service Details** or **TCN Pop-Up** screen you will want to record the information. You may print, print to a file on your machine or record this information in another manner.

***However, your claim has not yet been submitted.***

To submit the claim, you must click on the ‘Submit’ button *(located in the bottom right corner of the page)* to complete the claims submission and send the claim to ProviderOne for processing.

**Note:**

*No records found* refers to attachments such as backup documentation. Social service providers will not add attachments. Social Service Medical providers may need to add attachments. Refer to your service billing guides for more information.
## Common Adjustment & Denial Codes

Below is a short list of common Adjustment Reason and Remarks Codes you may find on your Remittance Advice (RA):

<table>
<thead>
<tr>
<th>RA adjustment reason/remark code/description</th>
<th>Possible causes</th>
<th>Provider action</th>
</tr>
</thead>
<tbody>
<tr>
<td>142 - Monthly Medicaid patient liability amount.</td>
<td>Client responsibility (participation) applied to the claim</td>
<td>You must collect this amount from the client</td>
</tr>
<tr>
<td>198 - Precertification/authorization exceeded</td>
<td>Social Service Authorization Approved Units have already been claimed</td>
<td>Contact your case worker if you question the number of units authorized</td>
</tr>
</tbody>
</table>
| 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication | 1. Claimed dates of service are not within the authorization period  
2. The authorization line is in error | 1. Contact your case worker if you have questions about the authorization dates  
2. Contact your case worker if you have questions about authorization errors |
| 18 - Exact duplicate claim/service | 1. Claimed the same units on two different lines for the same day, or  
2. Claim is an exact duplicate of one already submitted | 1. Adjust the claim and report the number of units on a single claim line  
2. No action is needed if duplication was unintended. |
| 177 - Patient has not met the required eligibility requirements | The client is not financially eligible | Contact your case worker if you have questions |
| A1 - Claim/Service denied | The authorization is in cancelled status | Contact your case worker if you have questions |
| B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service | Your contract may be expired. | Contact your contract manager or case worker if you have questions |
| N54 - Claim information is inconsistent with pre-certified/authorized services | Authorization line is in error | Contact your case worker if you have questions |
| N63 - Rebill services on separate claim lines | A separate claim line is required for each date of service for the service/procedure code entered | If you are billing quarter hour units or for each unit types, do not use a date span (example: 1/1/2015 to 1/31/2015) to bill. Adjust the claim to reflect separate claim lines for the date of service for each service provided and resubmit claim |
| N362 - The number of Days or Units of Service exceeds our acceptable maximum | Too many units claimed. Example: Provider billed two units on monthly units or provider billed two units on daily units with one day date span | Change the number of units to the correct amount and resubmit your claim |