Washington State Health Care Authority

Contractor Guide for HCA Interpreter Services Program

For use by DES Sign Language Master Contractors

Washington State Health Care Authority

What has changed?

The table below outlines how this publication version differs from the previous one. This table is organized by subject matter. Each item in the Subject column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table. In addition to these updates, minor routine updates for clarity are made throughout the publication.

Subject	Change	Reason for Change
Claims Frequently Asked Questions	Updated to include guidance regarding finder's fee increases.	Important procedural updates.

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Section one: about this guide

The Interpreter Services team at Health Care Authority (HCA) created this guide to assist the Office of the Deaf and Hard of Hearing (ODHH) Department of Enterprise Services (DES) sign language master contractors with understanding the process and protocols for filling sign language requests made by Apple Health (Medicaid) providers for eligible clients. ProviderOne (P1) is a data management system designed to check for provider and client eligibility and to pay for Apple Health services. **Sign language master contractors** must use P1 to complete the tasks outlined in this manual, including:

- Obtaining approvals for Prior Authorization (PA) requests,
- How to complete billing for services,
- Use and account creation in P1.

Note: This guide is not intended to replace the DES Master contract.

Getting started

Note: This guide describes the process for Apple Health providers to make outpatient sign language requests only. Payment for inpatient sign language interpreter services is included in the Apple Health inpatient rates and therefore are not requested through the ODHH online form.

After you have registered as a provider with HCA, you will need access to P1. HCA has strict protocols for managing who has access to P1 due to confidential client information. Access is managed by ProviderOne Security.

Visit **ProviderOne Security** for details on how to get started and how to manage your P1 account. Email **ProviderOne Security** directly with any questions about this process.

Submitting a request with ODHH

ODHH has two online request forms, a general request form and an **Apple Health request form**. Any sign language request from an Apple Health provider should be submitted using the Apple Health request form.

Requestors who have not used the ODHH online request form will need to **create an account**. ODHH manages the account set up and can help answer provider questions.

After a sign language interpreter request is submitted, you will receive an automated email with the information you need to start processing. The automated email will include the following required information:

- ProviderOne client ID (nine-digit number ending in WA)
- Date of service
- Requesting Provider's NPI
- Appointment location

If you have any questions about the automated email or the ODHH online request form, please contact ODHH directly using the contact options on their **Sign Language Interpreter Contracts and Resources Program webpage**.

Once you have accepted the job, enter the request into P1 prior authorization (PA) to confirm eligibility. If the request is missing information, you must reach out to the requestor directly to obtain any further needed information prior to submitting the PA.

Once the PA is approved by HCA, you must add the PA number to the ODHH online request form.

If you are unable to fill the job for the requested time or date of service, and the requestor agrees to another time or date of service, a new request will need to be entered into the ODHH Service Request online system. You must coordinate with the provider to cancel the original request.

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Section two: requesting prior authorization

Note: All Apple Health sign language interpreter requests must be submitted through the ODHH online request form prior to your accepting and filling the job. If you receive a request via email or phone call, you may enter the request into the ODHH online request form on behalf of the requestor.

The purpose of a PA

A PA is an electronic eligibility request you must submit in the P1 system. The purpose of the PA is to:

- Determine the provider and client eligibility for interpreter services, and
- Approve the interpreter's time that will be paid on a claim.

The PA must be entered into the P1 system and be in an approved status prior to the appointment date to be considered payable. It is the responsibility of the contractor to ensure the PA includes the time the interpreter(s) will be booked for the appointment and any travel time.

Eligibility requirements for services

For HCA to cover the cost of sign language interpreting these eligibility criteria must be met:

- The provider requesting sign language interpreter services must be currently contracted with Apple Health.
- The client must be active on Apple Health, with a Benefit Service Package (BSP) and Recipient Aid Category (RAC) that covers interpreting services.

An approved PA ensures you have confirmation of Apple Health eligibility and allows for subsequent payment of services from HCA.

Sign language eligibility overview

You must submit PA requests for each appointment so HCA can determine eligibility. Eligibility can change at any time, and you should never assume a client who is eligible on one service date will remain eligible for any other service date, even if it is the next day.

If a PA is approved, HCA will cover the appointment even if the client's eligibility ends before the date of the appointment. This is only possible if you have an approved PA for every visit, which then ensures payment for all the jobs you fill.

HCA will send an email notification to you with a link to a **rejection letter** when a client is found to be ineligible and your PA has been rejected. You can send this letter to the requestor.

Apple Health programs with no sign language coverage

Apple Health clients are assigned a benefit service package (BSP) when they receive their coverage, though it can change throughout from month to month (often, but not always, on the first of the month). Each BSP has one or more recipient aid categories (RACs) which gives further definition to their type of Apple Health eligibility. HCA uses both to determine if a client is eligible to receive sign language interpreter services.

Clients with the following BSPs are **not** eligible for HCA Interpreter Services and PA requests will be rejected:

- GA = General Assistance
- TCFPO = Take Charge Family Planning Only
- QI -1 = Qualified Individual
- QMB = Qualified Medicare Beneficiary
- SLMB = Special Low Income Medicare Beneficiary

A client's RAC may make them ineligible even if they don't have one of the above BSPs. The following RACs do not provide coverage for sign language interpreter services:

- 1097
- 1098
- 1099
- 1100
- 1112
- 1113
- 1114
- 1115
- 1116
- 1117
- 1118
- 1214
- 1215
- 1216
- 1226
- 1227
- 1228
- 1229
- 1230
- 1231
- 1232
- 1233
- 1234
- 1235
- 1270
- 1272
- 1273
- 1282
- 1283
- 1284
- 1285

Clients are not eligible for sign language interpreter services if their eligibility indicates "Pending Spenddown, no coverage" or "Suspended – Inpatient Hospital Only". If they meet their assigned spenddown amount, their Apple Health coverage will begin on the date the client met their spenddown, and they will receive coverage under a new BSP and RAC beginning on the date they met their spenddown.

Contact **HCA customer service** with general questions about Apple Health client or provider eligibility**.**

PA request process overview

Use the following process to request a PA for sign language interpreter services:

1. A request for a sign language interpreter is submitted through the ODHH online Apple Health request form, which generates an ODHH Service Request Number (SR#).
2. You verify Apple Health will cover the job by submitting the request into the P1 PA system following the step-by-step instructions (see below). Once the request is successfully submitted, P1 generates a PA reference number. This is a reference number and not a guarantee of eligibility until it is in Approved status.
3. HCA Interpreter Services staff review the request within 2 business days to verify the client and provider are both eligible. If both the client and provider are eligible, HCA staff changes the PA status to Approved.
4. If the request is not an eligible request, HCA staff change the status to Rejected and will notify the contactor via email within two business days.
5. If the provider or client is not eligible, you may work out private pay arrangements with the provider, as they are still required by ADA and Title VI to provide an interpreter for the client. HCA has a **form letter** on the **sign language webpage** you can present to Apple Health providers reminding them of their responsibility.
6. If you enter the PA request after the date of service occurred, and the client or provider are determined not to be eligible, HCA will not pay for the service. See the **Retroactive sign language PA requests** section for more information.
7. If your request is last minute and less than two business days from the appointment, first enter a PA request, and then email **HCA Interpreter Services** with "Last minute request" and the PA number in the subject of the email. In the body of the email, include the information and details of the request. HCA Interpreter Services staff will prioritize these emails.
8. If a request has been validated as an eligible Apple Health request, it will show Approved and can be used to make your P1 claim payable, even if the client loses eligibility prior to the appointment date.
9. If the request includes lodging, airfare, or taxi/rideshare for interpreter(s), you must request preapproval for these expenses from HCA Interpreter Services prior to the appointment date. See the **Travel expenses and lodging** section below.

10. If a claim is denied because the client became ineligible after you obtained an approved PA, contact HCA Interpreter Services for reimbursement.

Important notes for submitting a PA

- HCA may ask you for additional information regarding the PA.
- A PA is only considered eligible when it is in "approved" status.
- If you submit a claim with a PA that has not been approved, P1 will automatically deny payment.
- Submit one PA for each client appointment. You do not need multiple PAs or multiple lines on the PA for an interpreter team.
- For consecutive (back-to-back) appointments, you must submit a separate PA for each individual client within the consecutive appointment series. Additionally, the same interpreter(s) must serve each appointment in the consecutive appointment series. See **Section three: submitting claims** for a consecutive appointment series example and billing guidance for such appointments.
- If you incorrectly enter any information on a PA request, you must email **HCA Interpreter Services** to cancel the PA, and then enter a new PA with the correct information.
- If you forget to add a valid SR# in the Comments field, HCA Interpreter Services will email you to request a valid SR# prior to approval of the PA.
- After submitting the PA, if the SR# is voided and needs to be replaced, you must email **HCA Interpreter Services** prior to the appointment with the PA # and the updated SR#.
- If you do not have interpreter(s) secured prior to submitting the PA, and need to update units on the PA, you must email the **HCA Interpreter Services** once you have secured an interpreter and calculated their travel time. In your email, include the PA number and the amount of units being added, as well as the reason for the additional units. This is only allowed when the request for additional units is made prior to the appointment. Be sure to check the status on the updated PA to make sure it is in Approved status before the interpreter(s) begin the appointment.

How to submit a PA in ProviderOne

You must submit a PA in P1 to check for client/provider eligibility. Once you have submitted the PA, the PA will go through the error process. Errors are a routine part of PA process, meant to flag eligibility issues that P1 cannot resolve automatically, and do not signify the PA request was entered incorrectly.

If the client and provider are both found to be eligible, HCA will resolve the errors and put the PA in Approved status. Once the PA is in approved status, services may be rendered, and you can submit your claim for payment in P1.

1. Make sure to use one of the following internet browsers, and your popup blockers are turned off:

   a. Internet Explorer
   b. Microsoft Edge
   c. Google Chrome
   d. Firefox
   e. Safari

2. Navigate to https://www.waproviderone.org
3. Complete the **Domain**, **Username**, and **Password** fields and press the **Login** button.
4. On the next screen, use the User Profile drop-down menu to select **EXT Provider Super User** and select **GO**.
5. On the provider portal screen select **On-line Prior Authorization Submission**. This will advance you to the Organization Unit screen
6. On this screen select **530-PA-Sign Language** from the **Organization Unit** drop-down menu.
7. Select **In-Person** from the **Select Service Type Code** drop-down menu.
8. Complete all required client information fields, which are marked with an asterisk.
9. In the **Requesting Provider NPI**, enter the NPI of the requesting Apple Health provider.
   a. If the provider NPI is not on the ODHH form, you must reach out to the provider to get that information.
10. In the **Billing Provider NPI** field, enter your sign language contractor NPI.
11. On the service request information page, use the **Code Qualifier** drop-down menu to select **P – HCPCS Procedure Code**.
    a. This tells P1 you are using the Healthcare Common Procedure Coding System (HCPCS), a common type of medical coding used in the US to facilitate the processing of health insurance claims.
12. Enter **T1013** in the **National Code** field. This is a HCPCS code defined formally as "Sign language or oral interpretive services, per 15 minutes".
13. Input **U3** in the first modifier box. This indicates the PA is specifically for sign language interpreter services, as T1013 itself is not specific to sign language.
14. If the provider indicated on the ODHH form the visit is for mental health services or substance use disorder services, you will need to input **U9** (mental health) or **U8** (substance use disorder) in the second modifier box.

Modifier options for Sign language Interpreter Services

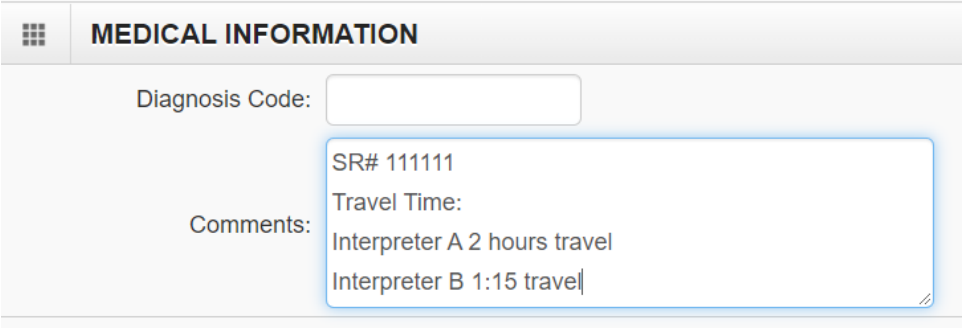
Modifier	Description	Note
U3	Sign Language	This must **always** be used with T1013 and T2024 in the **first** modifier position.
U8	Substance Use Disorder	**If** this code is used it will go in the **second** modifier position of the appointment code T1013
U9	Mental Health	**If** this code is used it will go in the **second** modifier position of the appointment code T1013.

15. In the **Appointment Date** section, enter the date of service (appointment date) in the **Proc From Date** and **Proc To Date** fields. You must indicate the same date in both fields.
16. Complete the **#Units/Days Requested** field, including both the appointment and, if available, travel time.
    a. To calculate how many appointment time units to enter (including the Base Rate, per your contract), use the formula in the next step. See the **Travel time** section for an example of how to calculate the travel time units.

17. Request **6 units** for the first hour of an appointment, plus an additional unit for every 15 minutes of an appointment after the first hour.
    a. If an appointment lasts less than 1 hour, you still request 6 units.
    b. If there are multiple interpreters, you will need to request the number of units needed for each member of the interpreting team.
18. Select the **Add Service Request Line-Item** button to add the service line information to the bottom of the screen, as shown below.
19. You do not need to enter a **Diagnosis Code** in the **Medical Information** section.
20. Select an option from the **Place of Service** drop-down menu. For example, **11 – Office appointment** or **12 – Appointment in the home**.

Line No	Service Request Dates From	To	Code Qualifier	National Code	Modifiers 1	2	# Units/Days Requested	$ Amount Requested	
1	02/16/2022	02/16/2022	P - HCPCS Procedure Code	T1013	U3		8		Delete

21. In the Comments field, add the following appointment information.
    - Add the valid SR#.
    - If the information is available, add any applicable interpreter travel time.
    - For interpreting teams, list each interpreter's travel time separately in the Comments field (see example below).



22. Scroll to the top left corner of the page and select **Submit PA Request Info**. This step is checking for errors and does not submit your PA to P1.
23. If there are any errors in what you submitted, P1 will display them in the top left corner of the page in **red**. You must correct these errors and select the submit PA request info tab before moving to the next step.
24. Your screen will advance and provide you with the **PA Request Number**, which you should write down (or print the page) for your records.

25. At the bottom of the screen select the **Submit** your PA request. If you skip this step, **your PA will not be submitted, and the PA number will be voided.**

Note: This is not a confirmation of eligibility, it is only a confirmation that you have submitted a PA request.

Travel time

Travel is covered under the DES statewide master contract if the appointment time is no longer than 7 hours in length.

If available at the time of PA submission, you must include the travel time units in the PA request. The PA must be in Approved status for the travel time to be payable. Reminder, all PAs must be submitted and in Approved status **prior** to the appointment taking place.

Reminder: If travel time is not available at the time of PA submission, email **HCA Interpreter Services** once you have secured an interpreter and calculated their travel time. Be sure to check the status on the updated PA to make sure it is in Approved status before the interpreter(s) begin the appointment.

You will need to report travel time in two places on your PA request:

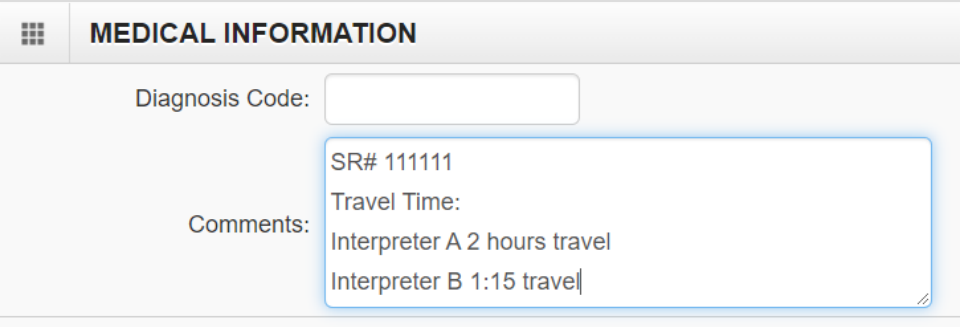
1. Enter the total units on the service line for the T1013 procedure code, by combining the appointment time and the interpreter travel time. Both are defined as 1 unit per 15 minutes.
    a. If there are multiple interpreters, include the travel units for all interpreters.
2. If available at the time of PA submission, you must also include the travel time details in hours and minutes in the Comments field of your PA request - where you also enter the valid SR#.
    a. If there are multiple interpreters, indicate the travel time for each interpreter in this field.

Example

1. A provider requested interpretation for a 2-hour appointment = 10 appointment time units, to include the base rate. You assign two interpreters to this job.
    b. **Interpreter A** has a total drive of 2-hours = 8 travel time units.
    c. **Interpreter B** has a total drive of 1 hour and 15 minutes = 5 travel time units.
2. On the PA, you request 33 units total: 20 appointment time units + 13 travel time units = 33 units.

Line No	Service Request Dates From	To	Code Qualifier	National Code	Modifiers 1	2	# Units/Days Requested	$ Amount Requested
1	01/01/2025	01/01/2025	P - HCPCS Procedure Code	T1013	U3		33	

3. In the comments, you indicate **Interpreter A** has 2 hours of travel time, and **Interpreter B** has 1 hour and 15 minutes of travel time.



Travel expenses and lodging

Prior to the appointment, you must always email and receive pre-approval from HCA Interpreter Services for **any** lodging, airfare, taxi and/or rideshare expenses.

Airfare

Airfare is covered under the DES statewide master contract. Airfare rates must be chosen by looking at what is most economical to the state. For acceptable rates and expectations, see **SAAM (wa.gov).**

You must request and receive approval for airfare from HCA prior to the appointment for the airfare expense to be considered payable.

Use the following process to request airfare:

- Email HCA Interpreter Services with "Airfare request" in the subject line. In the body of the email include the SR#, PA #, Date of Service of the appointment, airfare dates and destination, ticket type, and the reason for the request.
- HCA will review your request and notify you if it is approved. If needed, additional information may be requested.

- After the appointment, you must email **HCA Interpreter Services** with the PA # in the subject line and attach the paid airfare invoice. The invoice must include the total cost, airfare date, and destination.
- HCA Interpreter Services will review the invoice and notify you when you can submit your claim for this appointment and travel. See **Section three: submitting claims** for instructions on how to submit the claim. Remember, you must email **HCA Interpreter Services** with the Transaction Control Number (TCN) after submitting the claim.

Taxi/Rideshare

Taxi and/or rideshare is covered under the DES statewide master contract. Rideshare companies include Uber and Lyft. Rideshare rates must be chosen by looking at what is most economical to the state. For acceptable rates and expectations, see Chapter 10 of the **SAAM (wa.gov).**

You must request and receive approval for taxi/rideshare from HCA prior to the appointment for the taxi/rideshare expense to be considered payable.

Use the following process to request rideshare:

- Email **HCA Interpreter Services** with "Taxi/Rideshare request" in the subject line. In the body of the email include the SR#, PA #, Date of Service of the appointment, taxi/rideshare dates and destination, and the reason for the request.
- HCA will review your request and notify you if it is approved. If needed, additional information may be requested.
- After the appointment, you must email **HCA Interpreter Services** with the PA # in the subject line and attach the paid taxi/rideshare invoice. The invoice must include the total cost, taxi/rideshare date, and location of taxi/rideshare (with ZIP Code).
- HCA Interpreter Services staff will review the invoice and notify you when you can submit a claim for this appointment and travel. See **Section three: submitting claims** for instructions on how to submit the claim. Remember, you must email **HCA Interpreter Services** with the TCN after submitting the claim.

Lodging

Lodging is covered under the sign language contract using the **Office of Financial Management (OFM) per diem county rates map**.

You must request and receive approval for lodging from HCA prior to the appointment for the lodging expense to be considered payable.

Use the following process to request lodging:

- Email **HCA Interpreter Services** with "Lodging request" in the subject line. In the body of the email, include the SR#, PA #, date of service of the appointment, date and location of lodging, and the reason for the request.
- HCA will review your request and notify you if it is approved. If needed, additional information may be requested.
- After the appointment, you must email **HCA Interpreter Services** with the PA # in the subject line and attach the paid lodging invoice. The invoice must include the total cost, lodging date, and location of lodging (with ZIP Code).
- HCA Interpreter Services staff will review the invoice and notify you when you can submit a claim for this appointment and lodging. See **Section three: submitting claims** for instructions on how to submit the claim. Remember, you must email **HCA Interpreter Services** with the TCN after submitting the claim.

Retroactive sign language PA requests

Retroactive PA policy

Contractors must submit a PA for the interpreter's time and travel time **prior to** the appointment date to verify client and provider eligibility.

This process allows HCA sufficient time to manually approve the PA and guarantee that HCA will pay for the service.

HCA will not accept retroactive PAs without prior approval. HCA will grant an exception for the submission of a retroactive PA for the following reasons:

- The date of birth was entered incorrectly
- The client ID was entered incorrectly
- The requesting provider or billing provider NPI was entered incorrectly
- There was a change to the appointment date
- There were extenuating circumstances that the ODHH contract manager approved.

Contractors seeking exceptions based on the above criteria can contact **HCA Interpreter Services** for support.

Checking the status of a PA

Once you have successfully submitted a PA request, you can check the status or confirm the information you entered. This is particularly important for last-minute or urgent requests, so you can be sure your request was approved.

Keep in mind that HCA does not notify you each time a request has been approved. We will only notify you if the request is rejected.

1. From the Provider Portal select **Prior Authorization Inquiry**.
2. Enter one (not all) of the following search criteria combination:
    a. Prior Authorization number, or
    b. Provider NPI and P1 Client ID number, or
    c. Provider NPI, Client Last Name, Client First Name, and Client Date of Birth
3. Select the **Submit** button in the upper left corner of the search box. This will take you to the **PA Utilization** screen which displays the following:
    a. The PA number,
    b. Date of Service (in both the From Date and To Date),
    c. Units requested, and
    d. Status of request.
4. If you need to collect this PA information for your tracking purposes, you can press the **Save to XLS** button at the bottom to save the information as an Excel document.
5. See below list of potential statuses and what they mean.

Status	Description
Error	There is an error in the system that will be cleared by HCA staff. This only indicates the PA needs manual processing and does not necessarily indicate you have made any submission errors in your request.
Requested	HCA staff have cleared up any errors and will process your PA within 2 business days.
Approved	Request has been reviewed and approved. Once the appointment has been completed, you will be able to submit a claim associated to this PA.
Rejected	Request has not been approved. This can be due to lack of client or provider eligibility, or because you entered an incorrect procedure code, modifier, or made other clerical error(s). HCA Interpreter Services will email you an automated rejection

	letter. You can also email HCA Interpreter Services for more details, including what to do to fix any submission errors you've made. For instance, P1 may reject the PA for lack of eligibility, but HCA Interpreter Services may be able to tell this was not due to lack of eligibility, rather because you mis-keyed the P1 Client ID.
Approve/Hold	Request is eligible for provider reimbursement if an interpreter was not secured.
Cancelled	Request has been cancelled. Due to appointment cancelation or contractor needs to re-enter a new request correctly.

Pitfalls

- Using the incorrect NPI in the **Requesting Provider NPI** field – When you receive an Apple Health request through the ODHH form, the provider is required to enter their group NPI number. Do not enter your NPI in this field.
- Entering incorrect code or modifier – If you enter additional codes or codes different from the ones described in the steps above, your request will be rejected.
- Not including travel time prior to the appointment – Per the DES master contract travel time must be approved prior to the appointment taking place. You must include the time for the appointment and the time for interpreter travel on the PA. If interpreter travel time is not entered on PA prior to appointment, HCA will not update it after the appointment.
- Not selecting the final submit button.

How to upload documents into a PA

In some circumstances HCA may ask you to upload documentation to the prior authorization.

If you are required to upload documentation to the prior authorization you will follow the steps outlined in the ProviderOne How to Upload Documents in Prior Authorization Request presentation.

Frequently asked questions about PAs

Do I need a new PA if the appointment date changes?

Yes. If the date has changed you will need to create a new PA request and email HCA Interpreter Services to cancel the original one.

Do I need a new PA if the appointment time changes?

No. If the time has changed but the date remains the same, you do not need to create a new prior authorization.

When should I cancel a PA?

You should cancel a PA if the appointment has been cancelled, an interpreter has not been secured, and/or it is not a last-minute cancellation.

How do I cancel a PA?

Email HCA Interpreter Services with the PA number and the reason for cancelling.

How do I add additional time to a PA if I have already submitted it?

If you have secured an interpreter and learn travel time is necessary after you have submitted your PA request, email HCA Interpreter Services with the PA number and the amount of units being added, as well as the reason for the additional units. This is only allowed when the request for additional units is made prior to the appointment.

Can I add additional units after the interpreter has completed the appointment?

Email HCA Interpreter Services with the PA number and the amount of units being added, as well as the reason for the additional units. The ODHH contract manager must review and approve any measure of time added to a job after the appointment has taken place.

Do I need to put multiple interpreters on my PA service line?

No. Your PA request is only to verify client and provider eligibility. Enter the total appointment time and travel time units for all interpreters in your PA request's T1013 service line, with a breakdown of travel time details in the Comments field.

Do I need to add finder's fee code and mileage code to PA?

No. Billing for services, mileage, finder's fee and travel expenses will go on the claim, not the PA.

Am I required to upload documents with my PA request?

For most requests you do not need to upload documents to your PA request. If your request exceeds 60 units total, or if there are special circumstances that are unique, HCA may ask you for additional information.

Section three: submitting claims

Once an interpreting job has been completed and you need to bill for the interpreter's services, you must submit a claim in P1. This is the State of Washington's Medicaid Management Information system (MMIS), through which all Apple Health funds must be paid.

These procedures will walk you through each step to successfully submit a claim and walk you through the process of how the claim system works. View the **training PowerPoint** to access these steps online.

Note regarding consecutive appointments

When billing for consecutive appointments, you must submit a separate claim for each individual client in the consecutive appointment series. You may only bill for the finder fee, travel time, travel expenses, and mileage on one claim in the consecutive appointment series. See **Section two: requesting prior authorization** for information regarding how to submit PAs for consecutive appointments.

Example

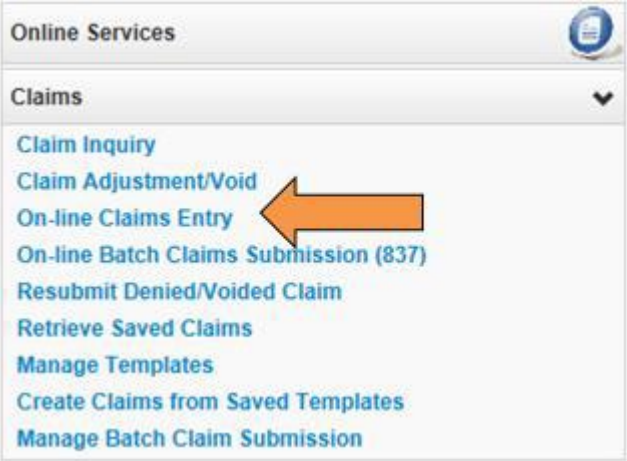
- 3 children have back-to-back appointments with the same medical provider.
  - Child 1 sees the provider from 10AM – 10:30AM
  - Child 2 sees the provider from 10:30AM – 11AM
  - Child 3 sees the provider from 11AM – 11:30AM
- The same interpreter provides interpretation for all 3 appointments.
- In total, the interpreter provides 1.5 hours of interpretation. The interpreter also has 2 hours of travel time.
- For these consecutive appointments, the referral agency contractor submits a separate claim for each child. Therefore, they submit 3 claims to HCA:
  - Claim 1 for child 1 includes 6 units for the base rate.
  - Claim 2 for child 2 includes 6 units for the base rate.
  - Claim 3 for child 3 includes 6 units for the base rate, 8 units for travel time, 1 finder's fee, and mileage.

Getting started

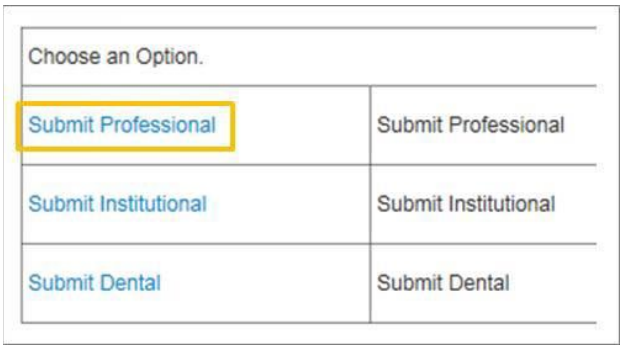
1. Make sure to use one of the following internet browsers, and your popup blockers are turned off:

a. Internet Explorer
b. Microsoft Edge
c. Google Chrome
d. Firefox
e. Safari

2. Navigate to waproviderone.org.
3. Complete the **Domain**, **Username**, and **Password** fields and press the **Login** button.
4. On the next screen, use the User Profile drop-down menu to select **EXT Provider Super User**, then select **Go**.
5. Select the **On-Line Claims Entry** link

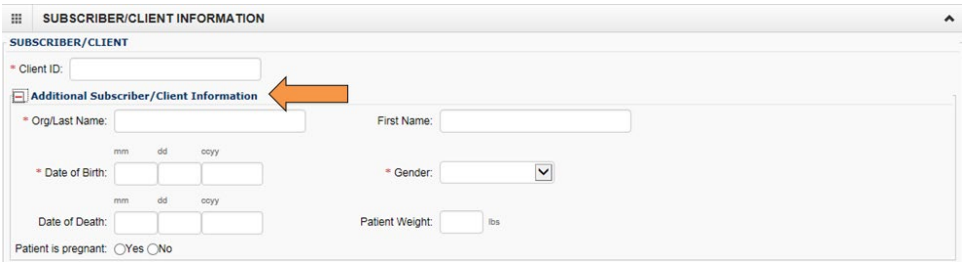


6. On the next screen select the **Submit Professional** hyperlink to navigate to the claim's submission form.



7. This will take you to the Provider Information section.

8. Enter your NPI in the **Provider NPI** field.
9. Enter 171R00000X in the **Taxonomy Code** field to indicate you are billing as a sign language interpretation provider.
10. Answer YES to **"Is the Billing Provider also the Rendering Provider?"**
11. Answer NO to **"Is the service the result of a referral?**"
12. Go to the Additional Subscriber/Client Information section.



Subscriber/client information

The subscriber is the Apple Health client. The information must be the same client name and P1 client ID as you submitted on your PA request.

1. Enter the patient's P1 client ID number in the **Client ID** field. This is the P1 client ID number the requesting provider should enter on the ODHH form. The number will be nine digits and end in WA and is a unique number for each individual client. If you do not receive this number from the ODHH system, you must contact the provider directly and they can provide this to you. If you do this via email, be sure to use encryption because you will be discussing Protected Health Information (PHI). For this reason, we recommend you communicate with the provider via phone or fax.
2. Select the red plus sign to expand the **Additional Subscriber/Client Information** section (indicated by the orange arrow in the screenshot above).
3. Enter the client's last name, first name, date of birth, and gender, which must all match what you submitted on your PA request.
4. Skip the **Date of Death, Patient Weight, and Patient is Pregnant (Yes/No)** fields.
5. Answer No to **"Is this claim for a Baby on Mom**'s **Client ID?"**
6. Answer No to **"Is this a Medicare Crossover Claim?"**
7. Select the red plus sign to expand the **Prior Authorization** section and enter the Prior Authorization number**.**

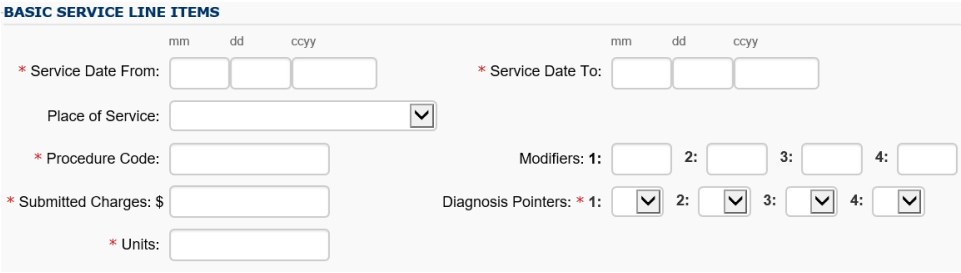
8. If your claim could be considered a duplicate due to you already having billed for a different appointment for the same client on the same day you are billing for, or if you are billing for an interpreting team, press the red plus sign to expand the Claim Note section.
    a. Select ADD Additional Information in the **Type Code** field.
    b. Enter SCI=RI in the **Note** field to indicate this is not a duplicate claim submission. Do not enter a space before or after the "=" as this will keep P1 from understanding what you entered.

        i. By entering this code, you are attesting that this is truly not a duplicate claim and that you are appropriately billing based on the provider agreement, billing guidelines, rules, and policies. For more information, review the **Using the claims bypass code (SCI=RI) for duplicate claims** section below**.**

9. Answer No to **"Is this claim accident related?"**
10. Optional: If you use a tracking system of your own and are using ID numbers other than P1 Client IDs, you can enter an alternative client account number in the **Patient Account No.** field. This will appear on your weekly Remittance Advice (RA) next to the P1 Client ID so you can more easily manage client information.
11. Select an option from the **Place of service** drop-down menu. This should be where the client received services.
12. Skip the **Additional Claim Data** section.
13. In the first **Diagnosis Code** field, enter Z710 and leave the rest of the fields blank.

Note: This is mandatory in claims submission but not in PA requests.

14. Go to the **Basic Service Line Items** section.



Finder's fee billing update

Per the DES Statewide Master contract, sign language contractor agencies are permitted to bill HCA for the administrative work they perform to secure a sign language interpreter for an appointment. Per the contract, when an appointment is cancelled before the 48 hours immediately preceding an appointment, the contractor is still eligible to bill HCA for the administrative costs to secure an interpreter if one was secured.

P1 was built with logic so the service line T2024 for the agency's finder fee will not pay a finder's fee when it is submitted on a claim without procedure code T1013 for interpreter time. This happens when the appointment is cancelled early enough that the interpreter isn't paid for the appointment time.

P1 has created a workaround to resolve this issue. To bill for just the finder's fee, the claim must include only a T2024 line with a U3 modifier in the first modifier box and the number 52 in the second modifier box. Remember, the contractor agency will only need to take this step when an appointment is cancelled, and the interpreter is not eligible to be paid for their time, but an interpreter was secured.

Example

Line	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units
No	From	To		1	2	3	4	1	2	3	4		
1	07/01/2024	07/01/2024	T2024	U3	52			1				42.32	1

Basic service line items

1. **Service Date From** and **Service Date To** fields, enter the date the service took place. This is the same date in both fields.
2. Skip the **Place of Service** field.
3. Enter your first **Procedure Code** for the services you are billing for, identified by the CPT codes below.

Code	Description	Note
T1013	Interpreters Time	This is the appointment time and travel time, per the DES/ODHH contract.
T2024	Agencies Finder's Fee	Enter only a U3 modifier, with no additional modifiers. This is only to be used by agencies, not individual interpreter contractors.
S0215	Mileage	Enter only a U3 modifier, with no additional modifiers.
A0170	Parking Fees/Tolls/Ferry/Airfare/Taxi/Rideshare	Enter only a U3 modifier, with no additional modifiers.
S9976	Lodging	Enter only a U3 modifier, with no additional modifiers.

4. Modifiers give additional information about the Procedure Code and give more details about each line being billed. Modifiers may be used in combination, up to four per service line. Below is a table of possible modifiers that could be used on sign language interpreter claims.

Modifier	Description	Note
U3	Sign Language	This must always be used in the first modifier position, with T1013, A0170, S9976 and T2024.
U8	Substance Use Disorder	**If** this code is used, it will go in the second modifier position.
U9	Mental Health	**If** this code is used, it will go in the second modifier position.
52	Last minute Cancellation/No Show	**If** this code is used, it will always go in the last modifier position.

5. Enter the charges for each line item in the **Submitted Charges** field. This should be the charges for only this service line, not the total amount of the claim. If the dollar amount is a whole number, no decimal point is needed.
6. You will only need to select one **Diagnosis Pointer** and it will always be the number one, which tells P1 this service is related to the Z710 diagnosis code you entered above.
7. Enter the appropriate number of units for this Service Line in the **Units** field, based on the table below. As a reminder, you must request pre-approval for appointment and travel time as well as any airfare, taxi, rideshare, and lodging expenses (see **Section two: requesting prior authorization**).

Procedure code	Unit description	Note
T1013 – Interpreter time	15 minutes = 1 unit	Appointment and pre-approved travel time.
T2024 Finder's Fee	1 unit = 1 interpreter	If there is more than one interpreter do not put multiple units. Add multiple lines of T2024/U3 with 1 unit.
S0215 – Mileage	1 unit = 1 mile	Total mileage.
A0170 – Parking Fee/Tolls/Ferry/Airfare/Taxi/Rideshare	1 unit = 1 fee	For units it will be one. In the submitted charges field, you will enter the fee invoiced amount. Add multiple lines of A0170/U3 with 1 unit for multiple expenses.
S9976 - Lodging	1 unit = 1 fee	For units it will be one. In the submitted charges field, you will enter the exact approved lodging amount.

8. Skip the following fields:
    a) Medicare Crossover Items,
    b) Drug Identification,
    c) Prior Authorization (this is used by providers who use a different PA for each service line, rather than one for the entire claim, as you entered above), and
    d) Additional Service Line Information.
9. To add this Service Line to the claim, press the **Add Service Line-Item** button. This will move the information entered in the data fields to a line at the bottom, then clear the fields so you can enter your next Service Line.

10. Repeat the steps above until you have entered all the Service Lines for your claim.

Example of how a claim might look for a sign language interpreter with parking, taxi, and airfare expenses

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
1	07/01/2024	07/01/2024	T1013	U3				1				110	6
2	07/01/2024	07/01/2024	A0170	U3				1				10.00	1
3	07/01/2024	07/01/2024	A0170	U3				1				30.25	1
4	07/01/2024	07/01/2024	A0170	U3				1				250.10	1

Interpreter
Parking Fee
Taxi
Airfare

11. Each sign language interpreter must be billed on their own Service Line.
12. Each agency finder's fee will have its own line with 1 unit. If there are multiple interpreters, then multiple lines of T2024 must be billed on the claim.

Example of how a claim might look for a sign language interpreting team serving a mental health services visit

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
1	09/01/2021	09/01/2021	T013	U3	U9			1				210	6
2	09/01/2021	09/01/2021	T1013	U3	U9			1				220	6
3	09/01/2021	09/01/2021	T2024	U3				1				35	1
4	09/01/2021	09/01/2021	T2024	U3				1				35	1

Interpreter #1 Service line
Interpreter # 2 Service line
Interpreter #1 Finders Fee
Interpreter #2 Finders Fee

13. After completing all the necessary Service Lines, select the **SUBMIT CLAIM** button at the top left of the screen.
14. If there are errors, you will see a description in **red** at the top of the screen. This indicates you have left a mandatory field blank or filled it with information P1 does not recognize (for example, a P1 Client ID without the "WA" at the end).
15. If there are no errors, you will see a pop-up window asking if you want to submit back-up documentation, which is not necessary for sign language interpreter claims. Press the **Cancel** button.

16. Next you will see the **Submitted Professional Claim Details screen**. This is **NOT** a final submit and your claim has not fully been submitted into P1. This screen will display a summary of the basic claim information, as well as the TCN, often referred to as a claim number. You may want to keep this number for your records.
    a. If you have submitted documentation P1 will display your attachment on this page. (This is not a required step unless HCA requests you upload specific documents).
17. Once you are ready to submit your claim to P1, select the **Submit** button at the bottom right of the screen. This will successfully submit your claim for payment.
18. If claiming for any parking fees/tolls/ferry expenses in the amount of $50 or more, or if you are claiming for lodging, airfare, taxi, and/or rideshare expenses:
    a. You must email **HCA Interpreter Services** with the TCN after submitting the claim.
    b. HCA Interpreter Services will provide you with an update after reviewing the claim. See the **Travel expenses and lodging** section for more information.

Pitfalls

- If you have a denied claim or partially paid claim you must research your Remittance Advice (RA) in P1 to find the error. See the **Reviewing Claim Status** section below.
- Your RA claim can show a claim as suspended or denied as being duplicate, even when a claim is not a true duplicate. View the **Using the claims bypass code (SCI=RI) for duplicate claims** section below to resolve a duplicate claim.
- Sign Language contractor referral agencies have the option of billing for a finder's fee. When submitting a claim in P1 with a finder's fee (T2024) you will never add a U8/U9 modifier to this code.
- Denial code on claim is date of birth mismatch. This means client's date of birth entered on the PA does not match the client's date of birth on the claim. If you receive a denial code with date of birth mismatch you will compare:
    - the original Service Request you received from ODHH,
    - the PA you entered in P1, and
    - the claim.
- When you find the discrepancy correct the date of this information in the claim.

How to set up a claim template

You will find that there are many things that are the same on your P1 claims each time you submit. The things that will change are the specifics about the client, the appointment, and the interpreter(s). You can create a template to streamline your claims submission process, so you do not have to key the same information repeatedly.

1. Log into P1 the same way you would when entering claim.
2. Select **Manage Templates** hyperlink from the Claims menu.
3. At the top of the screen select Professional from the **Type of Claim** drop-down menu.
4. Press the **Add** button.
5. You will now see a template form with a **Template Name** field at the top. You can label this however you wish.
6. Minimum required information to save to a claim template.
    a. Is the Billing Provider also the Rendering Provider? – **Yes**
    b. Is this service the result of a referral? – **No**
    c. Is the claim for a Baby on Mom's Client ID? **– No**
    d. Is this a Medicare Crossover claim? – **No**
    e. Is this claim accident related? **– No**
7. Enter your NPI in the **Provider NPI** field so it will be on every claim you submit using this template.
8. Enter 171R00000X in the **Taxonomy Code** field so it will be on every claim you submit using this template.
9. Enter Z170 in the **Diagnosis Code** field so it will be on every claim you submit using this template.
10. Once the template is complete and ready to save, select **Save Template**.
11. Press **OK** on the pop-up asking, "Do you want to save the Template?"
12. After the template is saved, it is listed on the Claim Template List. From here you will be able to edit, view or delete, or copy your templates.
13. To bill from a claim template, you will go out to the Provider Portal.
14. From the Claims menu select **Create Claims from Saved Templates**.
15. This will take you to a screen where you can select from a list of your templates.

Once you have entered all required information (such as client information and Service Lines) press the **Submit Claim** button at top left.

Payment process

P1 makes weekly payments every Friday, which will include payments for every clean claim you submitted since the previous Tuesday.

- Clean claims are claims that have all the required data elements and do not conflict with Apple Health program policies.
- Claim submission cutoff is Tuesday at 5 p.m. Pacific Time. All clean claims submitted by cutoff are paid the following Friday.
    - On occasion, claims submitted before cutoff (5 PM on Tuesday) may not actually process until after the cutoff time. These claims be processed and paid on the following Friday.
- Clean claims submitted after cutoff will be paid the following payment cycle on the following Friday.

P1 issues an RA every week, following Friday's payment cycle.

Retrieving the Remittance Advice (RA)

The Remittance Advice (RA) is a weekly summary and breakdown of the status of your claims in P1.

The RA is broken down into key elements:

- RA newsletter
- RA summary
- Paid Claims
- Denied Claims
- In-process claims
- Adjusted claims

There are two ways to access your RA, which is a weekly summary of your claim's activities in P1:

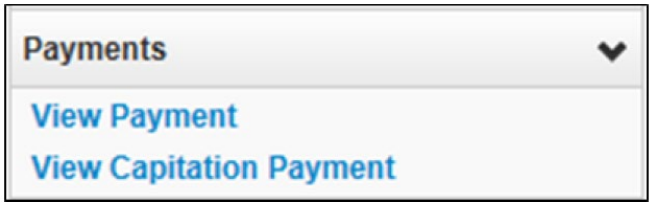
- ProviderOne portal (PDF file)
- HIPAA EDI transactions (Electronic 835)

This guide covers the process related to using the ProviderOne portal. EDI transactions are processed with professional medical billing software which will have its own instructions.

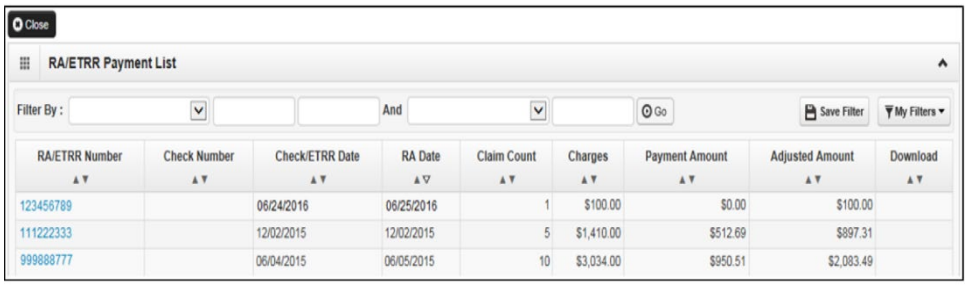
To retrieve your RA via the ProviderOne Portal:

1. Log in to P1.
2. Choose your **EXT Provider Super User** profile. Select **View Payment.**

3. P1 will display the RA/ETRR Payment List.



4. By default, P1 will sort this list by RA number, so if you wish to easily find the most recent RA, sort by RA Date using the arrows in that column. You can also use the filters to specify which dates or RA numbers you are looking for.



RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
123456789		06/24/2016	06/25/2016	1	$100.00	$0.00	$100.00	
111222333		12/02/2015	12/02/2015	5	$1,410.00	$512.69	$897.31	
999888777		06/04/2015	06/05/2015	10	$3,034.00	$950.51	$2,083.49	

5. Select **RA/ETRR Number** in the first column to review your RA. This will download as a PDF file which you can save to your computer for future reference.

Reviewing updates and key messages

P1 uses the RA newsletter to communicate changes and new information relevant to P1 users. Taking the time to review this section will ensure you see the most current and important changes, messages, and announcements. These will apply to all Apple Health providers, not just sign language interpreter contractors.

Example of a typical RA

Health Care Authority Remittance Advice

HEALTH CARE AUTHORITY A

PO BOX 45505

OLYMPIA, WA 98504-5505
Phone: (800) 562-3022

Prepared Date: 06/25/2016
RA Date: 06/25/2016 D

Page 1

RA Number: 123456789 B

Billing Provider: 5100000004 C

If you have questions about the Remittance Advice (RA), go to http://www.hca.wa.gov/medicaid/provider/Pages/providerone_billing_and_resource_guide.aspx and then click on "Current Guide".

For DSHS Social Service Providers: If you have questions about this document, call 1-800-562-3022, select Provider Services, then select Social Services.

You may dispute overpayments by sending a written request for review to:

- Department of Corrections (DOC): Department of Corrections, Medical Disbursement Unit (MDU) at PO BOX 41107, Olympia, WA 98504-1107 within 30 days of the payment date. The Medical Disbursement Unit will review your request and adjust payment, or send a written denial of charges
- For Health Care Authority (HCA) Medical Providers: Office of Legal Affairs at P.O. Box 45504, Olympia, Washington 98504-5504 within 28 days of the RA date in accordance with RCW 41.05A.170. A formal hearing will be scheduled after HCA receives the request. Hearings are conducted under the Administrative Procedure Act. You may be offered a Pre-Hearing in an attempt to resolve your dispute prior to the Formal Hearing

Your request for review must be in writing:

- Be sent by Certified Mail (return receipt) or other manner that proves that MDU or HCA have received your request. You may be required to prove that your request was received by MDU or HCA.
- Include a statement as to why you think the overpayments are not correctly adjudicated,
- Include a copy of this Remittance Advice (RA) and
- Any other supporting documentation.

2. Important changes affecting ALL providers April 1, 2016.

E

Please go to http://www.hca.wa.gov/medicaid/provider/Pages/index.aspx for details

The above image displays:

A. Sign Language Biller demographic,
B. The number assigned to the RA,
C. The billing NPI used in P1,
D. The date the RA was prepared, and the RA Date (payment date), and
E. The main body of the RA page is the newsletter with important provider updated information (sometimes specific to certain provider groups).

Review the summary page

The summary page lists the totals of all the claim payments and adjustments amounts.

Prepared Date: 08/01/2014
RA Date: 08/01/2014

RA Number: 1591591
Warrant/EFT # 123456! (A) Warrant/EFT Date: 07/31/2014
Warrant/EFT Amount: $367808.08 (B) 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
(C) 8882	Paid	$3565979.70	$642398.02	$850.69	$0.00	$337.65	$396293.96
9991118882	Denied	$5692237.80	$0.00	$0.00	$0.00	$0.00	$0.00
(D) 8882	Adjustments	-$187481.35	-$79841.70	$0.00	$0.00	$0.00	-$34060.85
9991118882	In Process	$2415404.48	$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
9991118882	2223334445556/ 30143650001112 2000	System Initiated	NOC Invoice	$0.00	$0.00	$5336.57
9991118882	2223334445556/ 30143650001112 2000	System Initiated	NOC Referred to CARS	$5336.57	(E) $336.57	$0.00
9991118882	3335559996667/ 30143780002229 9000	System Initiated	NOC Invoice	$0.00	$0.00	$158.87
9991118882	3335559996667/ 30143780002229 9000	System Initiated	NOC Referred to CARS	$158.87	$158.87	$0.00
9991118882	99966885/ 30149850005553 0000	Provider Initiated	P1OFF Recoupment	$72.77	(F) [illegible]	$51.78
9991118882	99966885/ 30149850005553 0000	Provider Initiated	P1OFF Recoupment	$14.95	$14.95	$0.00

The above image displays:

A. Check number (also called Warrant or EFT) and date,
B. Total payment received on the check,
C. Total of the paid claims on this RA,
D. Deduction due to a claim adjustment form the total paid amount,
E. Deduction due to an overpayment, and
F. Deduction due to a provider adjustment.

To see more information about adjustments visit the complete **ProviderOne Billing and Resource Guide**.

Washington State Health Care Authority

Reviewing paid claims

Locate the **Paid** section on the RA.

Each claim will have several rows of information, some of which apply to claims for other provider types (such as Rx claim #). The headings that apply to sign language interpreter claims include:

- Client Name/Client ID – this will be what you entered on your claim.
- TCN/Claim Type – This displays the TCN and the claim type (yours will always be Professional Claims).
- Line # - each service line on your claim will be identified with a line number.
- Service Date(s) – these will be the "from" and "to" dates on your claim, which should always be the same date.
- Svc Code – this is the HCPCS code you entered on each line.
- Total Units – this is the number of units you entered on your claim for each HCPCS code.
- Billed amount – the dollar amount that you entered on your service line after you entered the HCPCS code and number of units
- Allowed Amount – the amount HCA allows for each line.
- Paid Amount – the amount HCA is paying for each line. This will be equal to the Allowed Amount.
- Some paid claims may also contain denied service lines, which will display on the line that denied. These will also be displayed in the paid claims section within the specific claim that was paid but will have the same remark codes as denials in the denied section.

RA Number: 111222333 Warrant/EFT #: 000001! Warrant/EFT Date: 06/25/2016 Prepared Date: 06/25/2016 RA Date: 06/25/2016
Category: Paid Billing Provider: 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
DOE, JOHN 999999997WA	20160990003711500 Professional Claim	1		02/17/2016-02/17/2016	92507	1.0000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.41		
		Document Total:		02/17/2016-02/17/2016		1.0000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.41		
DOE, JANE 999999998WA	20160990003712400 Professional Claim	1		02/24/2016-02/24/2016	92507	1.0000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.41		
		Document Total:		02/24/2016-02/24/2016		1.0000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.41		

Pitfalls

- Overlooking a paid claim page or section. This may result in a claim rebill or time spent trying to track down where payment is.

Reviewing denied claims

Locate the Denied section on the RA.

RA Number: 111222333 Warrant/EFT #: 000001! Warrant/EFT Date: 06/25/2016 Prepared Date: 06/25/2016 RA Date: 06/25/2016
Category: Denied Billing Provider: 5100000004 Page 10

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
DOE, JANE 999999998WA	20161250004297800 Professional Claim	1		03/16/2016-03/16/2016	92507	1.0000	$47.41	$0.00	$0.00	$0.00	$0.00	$0.00	N288	16 = $47.41
Document Total:				03/16/2016-03/16/2016		1.0000	$47.41	$0.00	$0.00	$0.00	$0.00	$0.00	N288	16
DOE, JOHN 999999997WA	20161250004300500 Professional Claim	1		03/23/2016-03/23/2016	92507	1.0000	$47.41	$0.00	$0.00	$0.00	$0.00	$0.00	N288	16 = $47.41

Every denied claim (or denied line item on a Paid claim) will have an Adjustment Reason Code, which are HIPAA-compliant rejection codes used to indicate why a claim was denied. Some will also have an RA Remark Code for further information. This is because some claim adjustment reason codes can be very general in nature and require the extra remark to provide specificity.

At the bottom of your RA, each Adjustment Reason Codes and Remark Codes will be listed, with an explanation of what each one means.

If you are unable to understand the reasons a claim or line denied, you can email **HCA Interpreter Services** for assistance. After reviewing the adjustment reason code and RA remarks codes, determine the denial reason and if the claim can be corrected. Resubmit the claim when the entire claim is denied.

> **Tip:** Use the **Denied Claims Desk Aid for Sign Language Contractors** to troubleshoot denials.

Pitfalls

- Overlooking a denied claim page or section on your RA.
- Overlooking a claim or line that needs to be rebilled or resubmitted and delay payment.
- Overlooking rebilling or resubmitting a claim or line until it is past the timely billing period.

Reviewing adjusted claims

Locate the **Adjustments** section on the RA.

This section of the RA lists claims that have been adjusted or modified after the original payment (denied claims must be resubmitted as new claims, rather than adjusted).

You may have submitted an adjustment request to correct a paid claim. In other cases, P1 initiates an adjustment due to an overpayment or some other kind of error. Adjusted claims may or may not affect the amount of the payment for services, depending on the changes made. For instance, it may be necessary to change a modifier on a claim, so you would see a paid claim adjusted to a new TCN with no change in the paid amount.

Page through the RA until the section category labeled "Adjustments", as shown below.

RA Number: 111222333 Warrant/EFT #: 000001! Warrant/EFT Date: 06/25/2016 Prepared Date: 06/25/2016 RA Date: 06/25/2016
Category: Adjustments Billing Provider: 5100000004 Page 6

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
DOE, JANE 999999998WA 301615300164976000	40161631001323500 Professional Claim	1		06/01/2016-06/01/2016	96150 25	1.0000	-$150.00	-$150.00	$0.00	$0.00	$0.00	-$150.00		119 = $0.00
	40161631001323500 Professional Claim	2		06/01/2016-06/01/2016	96101 U7	1.0000	-$10.00	-$10.00	$0.00	$0.00	$0.00	-$10.00		119 = $0.00
			Document Total:	06/01/2016-06/01/2016		2.0000	-$160.00	-$160.00	$0.00	$0.00	$0.00	-$160.00		
DOE, JANE 999999998WA 301615300164976000	40161622001827500 Professional Claim	1		06/01/2016-06/01/2016	96150 25	1.0000	$150.00	$150.00	$0.00	$0.00	$0.00	$150.00		
	40161622001827500 Professional Claim	2		06/01/2016-06/01/2016	96101 U7	1.0000	$10.00	$10.00	$0.00	$0.00	$0.00	$10.00		
			Document Total:	06/01/2016-06/01/2016		2.0000	$160.00	$160.00	$0.00	$0.00	$0.00	$160.00		
				Category Total:		4.0000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		
				Billing Provider Total:		31.0000	$1980.00	$1820.00	$0.00	$0.00	$0.00	$1820.00		

Credit

Debit

Adjustments to modify or correct claim billing errors utilizes these basic accounting principles and will have two transactions displayed on the RA:

- The **Credit** transaction is a copy of the original claim with dollar amounts listed as a negative.
- The **Debit** transaction is a repayment that displays the modification or corrections made to the original claim with the associated repayment dollar amounts.

Through this process, P1 recoups the original payment amount from the adjusted claim, then includes this amount in the current payment amount.

Washington State Health Care Authority

Reviewing in process or suspended claims

This section of the RA displays claims that are currently in process. These claims are in the payment system but may be pending review by HCA claims processing staff. These will appear in the In-Process section on each RA until they are paid or denied.

Review the section under the "In Process" claims category.

RA Number: 111222333 Warrant/EFT #: 000001! Warrant/EFT Date: 06/25/2016 Prepared Date: 06/25/2016 RA Date: 06/25/2016

Category: In Process Billing Provider: 5100000004 Page 25

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
DOE, JANE 999999998WA	20161100022020600	1		03/02/2016-03/02/2016	92507	1.0000	$47.41	$0.00	$0.00	$0.00	$0.00	$0.00		
Document Total:				03/02/2016-03/02/2016		1.0000	$47.41	$0.00	0.00	$0.00	$0.00	$0.00		

When a claim is suspended, it must be reviewed by staff before it will become payable.

Examples include:

- Meeting the mileage cap.
- Being recognized as a possible duplicate claim, in situations where the SCI=RI indicator does not apply (for example, you accidentally submitted the same claim twice).

Note: Reach out to HCA Interpreter services if your TCN has been suspended for longer than 10 days.

Pitfalls

- Rebilling a claim because you do not see them in the other sections of the RA; make sure to review the claim "in process" section.
- Mistaking a suspended claim for a denied claim.

Reviewing the EOB codes to determine denial reason

There could be multiple reasons a claim may deny. You can find definitions of relevant HIPAA-compliant Adjustment Reason Codes and RA Remark Codes on the last page of your RA. These are called Explanation of Benefits (EOB) codes.

The complete list of the Federal adjustment reason codes and remark codes are located on the **Washington Publishing Company's website**. All HIPAA-compliant billing systems are restricted to using these codes and are unable to create codes of their own to be more specific to a given program. Therefore, it can be difficult for P1 to post a denial that that relays clear information to claim submitters.

Pitfalls

- It is easy to mistype a DOB, which P1 requires in the claim submission process. Check the original request form to ensure you have the correct DOB. If the form and your claim match, check the **client's eligibility** page to determine if the date of birth matches what is entered into P1.
- PA information could be missing or incorrect. Make sure the codes and modifiers are correct, and the prior authorization number itself was not keyed incorrectly.

Adjustments and resubmissions

P1 does not process claim appeals. If a claim has any paid amount (i.e., is not in denied status) you must submit an adjustment to make any changes to it. If a claim was denied, verify the denial reason(s) and correct the error(s), then resubmit the claim. Denied claims cannot be adjusted, instead they must be resubmitted (with your corrections) as new claims.

Adjust a **paid** claim when you have made a billing error to claim elements such as:

- Client ID
- Billed amount
- Service date
- Number of units

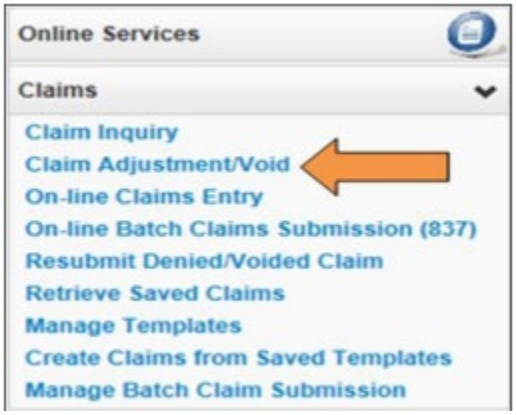
These can result in overpayment or underpayment, which can both be resolved by adjusting your claim. Sometimes there are multiple errors, in which case it may be easier to void the claim and resubmit it as a new claim, which has the same effect as an adjustment, but will not be displayed in the Adjustments section of your RA.

Denied claims can be resubmitted using the P1 resubmit feature and correcting the error that caused your claim to deny. P1 does not deny claims as duplicates of previously denied claims, nor will it allow adjusting or voiding on denied claims.

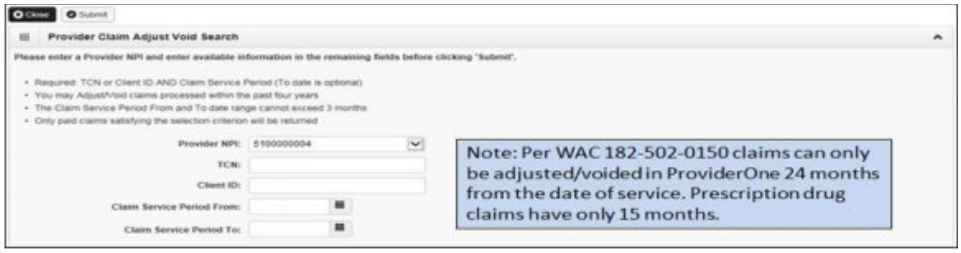
Adjusting or voiding a claim

If the claim was paid (or partially paid) then you must submit an adjustment to make any corrections or modifications using the following steps:

- Log into P1
- Select Claim Adjustment/Void from the Provider Portal



- At the search screen enter required information to find the claim to adjust or void and select submit.



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

  At this stage, you have the option to correct your claim by adjusting it, or to void the claim and start all over with a new claim submission.

TCN	Date of Service	Claim Status	Claim Charged Amount	Claim Payment Amount	Client Name	Client ID	Child Tcn
201429200006545000	06/01/2016	1: For more detailed information, see remittance advice.	$160.00	$87.92	JANE DOE	999999998WA	

To adjust a paid claim, select the box next to the TCN and press the **Adjust** button in the upper left-hand corner. P1 will display the claim as you submitted it originally, then you can make the necessary changes and submit the adjustment for processing.

Remember to select **Submit** on the **Submitted claim Details** screen to finish sending the adjusted claim. P1 will create two new TCNs based on this submission:

- One TCN to represent a recoupment (credit) of the entire paid amount of the original claim
- A second TCN to represent a new claim with the new paid amount (debit), based on the corrections/changes you made when adjusting the original TCN.

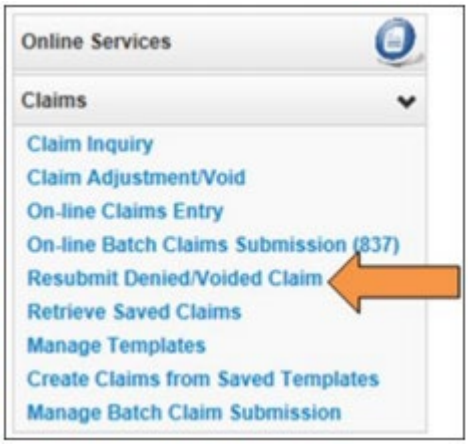
See the section above on Adjustments on your Remittance Advice for a visual depiction of how the credit and debit appear on your RA.

In situations where you need to do additional adjustment(s), you must adjust the newest version of your claim (the debit). Because the original TCN has been recouped, it can no longer be adjusted.

If you have a TCN that has been adjusted and you wish to learn what the new TCN is, you can refer to the RA for the week you adjusted the claim. You may also use the claim search function in P1 to search by Client ID and claim date, to view both the original and the newer, adjusted claim.

Resubmitting a denied or voided DDE claim

- Select **Resubmit Denied/voided Claim** from the provider portal.



Search for the claim by entering information required in one of the bulleted criteria (you do not need to meet all four of them) then select **Submit.**

P1 will display the claim list screen. Select the box next to the TCN of the claim to be resubmitted then select **Retrieve** in the upper left-hand corner to display the claim.

Make any necessary changes and submit the claim for processing. The system will go through the same final steps of the claim submission asking if you want to send back up documentation.

Pitfalls

- Adjusting the wrong claim or claim line.
- Failing to select **Submit** on the **Submitted Claim Details** Screen.

Washington State Health Care Authority

Using the claims bypass code (SCI=RI) for duplicate claims

Background

P1 is designed to deny duplicate claims to protect against both human error and fraud. Unlike most medical providers, sign language interpreters often have multiple appointments with the same client in one day or require an interpreter team at appointments. P1 is programmed to consider these as duplicate submissions. A claim may deny or suspend when submitted under one of these scenarios.

Use of SCI=RI

P1 has bypass codes called Special Claims Indicators (SCI). SCI=RI is one specific code that can be used to prevent your claim from being denied or suspended as a duplicate. If you are billing and it is not a duplicate, you must add **SCI=RI** in the claim notes section. This will indicate to the P1 system to bypass the duplicate denial logic and pay the claim. Using this bypass code on a claim you enter in P1 means you agree that the claim is not being submitted fraudulently. This means you have verified the claim is not a duplicate, and there was more than one service rendered or multiple interpreters required for the specific date of service.

When not to use SCI=RI

Note: By using SCI=RI, you acknowledge the claim is not a duplicate submission and represents the separate appointments. It is considered fraudulent to use SCI=RI to make duplicate claims payable when the claims in question are duplicate submissions for the same appointment.

Sometimes a claim denies as duplicate against another claim (referred to as a TCN in P1) that was partially paid (some codes paid but others denied). You **must not** use SCI=RI to bypass the duplicate denial. This would be considered an inappropriate use of the bypass code and may be considered fraud. Instead, you need to adjust the partially paid TCN (claim) to make any necessary corrections to that specific TCN.

HCA Interpreter Services conducts claims auditing with SCI=RI overrides to ensure appropriate use.

Resources

- **Denied claims:** ProviderOne Billing and Resource Guide
- **Email:** HCA Interpreter services

Washington State Health Care Authority

Troubleshooting denied claims in ProviderOne

Note: This list is intended to help troubleshoot the most common sign language billing errors. This is not a complete list of all possible errors or denials. Email HCA Interpreter services with questions.

Date of birth error

Error/remark code on RA	Error description	Resources to correct error

• **Adjustment reason 02125**
• **Remark code N329**
	• Recipient date of birth (DOB) mismatch
	• Missing, incomplete, or invalid patient birth date
		• Confirm you entered the correct Client ID
		• Check the original provider request to verify DOB
		• If the DOB matches provider request correct DOB by:
		  ○ Checking eligibility in ProviderOne
		  ○ Emailing HCA Interpreter Services.
		  ○ Calling HCA customer service at 1-800-562-3022

Procedure requires prior authorization

Error/remark code on RA	Error description	Resources to correct error
• **Adjustment reason 11120**	• Procedure requires prior authorization (PA) • Precertification/authorization • Notification/pre-treatment absent	• Check the PA number is present and entered correctly • Confirm the date of service on the claim and PA match • Verify modifier on PA matches modifier on claim entry (if service line coding is different)

Procedure codes are not covered

Error/remark code on RA	Error description	Resources to correct error
• **Adjustment reason 03837** • **Remark code N674**	• Procedure code(s) are not covered unless T1013 is paid on same claim	• This code will be attached to the S0215, T2024, and A0170 when the 11120-denial code is on the claim • Once you fix the error posting on the T1013, the 03837 will no longer appear

Services not covered under patient's plan

Error/remark code on RA	Error description	Resources to correct error
• **Adjustment reasons 02190 and 02200** • **Remark code N192**	• This service/equipment drug is not covered under patient's benefit plan • Patient receives Medicaid/Qualified Medicare Beneficiary (QMB) coverage only	• The client's benefit service package does not cover interpreter services • Contractor can work out payment arrangements with requestor if they choose

Client does not match

Error/remark code on RA	Error description	Resources to correct error
• **Adjustment reason 11010** • **Remark code N54**	• PA recipient ID mismatch • Claim information is inconsistent with pre-certified/authorized service	• Ensure the client you entered on the ODHH request form and P1 PA request matches the client that was entered on the P1 claim

Claim is suspended

Error/remark code on RA	Error description	Resources to correct error

• **Error Allocated**
• **Suspended**
	• PA recipient ID mismatch
	• Claim information is inconsistent with pre-certified/authorized service
		• The claim has been put in a suspend folder for HCA Interpreter services staff to review
		  ○ This is not a denied claim
		  ○ These will be released within 10 days

Claim is denied

Error/remark code on RA	Error description	Resources to correct error
• **03390**	• Modifier invalid with procedure code	• Modifier used on this service line does not belong • Example: T2024 should only have a U3 modifier, no secondary modifiers

Suspended for mileage cap

Error/remark code on RA	Error description	Resources to correct error
• **12028**	• Units exceed maximum daily limits for S0215	• P1 has a mileage cap. If the mileage on the claims goes above the cap of 200 miles, you must email HCA Interpreter Services to review the job. HCA Interpreter Services may request further documentation before releasing payment.

Frequently asked questions about claims

Why can't I find my TCN?

You may not be able to find your TCN if the final submit button was not selected when entering the claim or you entered the wrong TCN. P1 generates a TCN before your claim is submitted, so it is possible to have a TCN that is never submitted.

How do I find out why my claim was denied?

You can find denial codes and reasons on your remittance advice (RA). Learn more about **how to read a remittance advice**. You can also check the status of the claim in P1.

What does it mean if my claim was not fully paid?

If your claim did not fully pay it will have denial coding and reason on your RA explaining the partial payment and which line(s) denied. To adjust a claim, see the Adjusting or Voiding a Claim section.

Why is only one finder's fee paid when I had multiple interpreters?

When you have an interpreting team each finder's fee code (T2024/U3) needs its own line on the claim with one unit.

Who is responsible for updating the finder's fee in ProviderOne?

You must email **HCA Interpreter Services** prior to any DES amendments taking effect which increase your finder's fee. HCA Interpreter Services will notify you once the finder's fee has been updated in ProviderOne.

Why did the claim not pay the increased finder's fee amount?

If you notify HCA Interpreter Services of a finder's fee increase after the effective date for the DES amendment which stipulates the increase, you are responsible for adjusting any claims which underpaid the finder's fee. HCA Interpreter Services will notify you once the finder's fee has been updated in ProviderOne, and when you can submit adjustments for underpaid claims.

Section four: resources

- **Email:** **HCA Interpreter services**
- **Online:**
  - **Sign language webpage**
  - **ODHH webpage**
  - **Provider enrollment webpage**
- **Request forms:**
  - **Apple Health sign language interpreter request form**