DSHS
WASHINGTON STATE
Department of Social and Health Services

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FAQ: ProviderOne for Social Services Providers

ProviderOne account management

Account set-up

1. How long does it take to get approved in ProviderOne?

Your ProviderOne account should be activated shortly after all parties sign your DSHS/AAA contract. Once signed, your DSHS/AAA Contract Specialist sends the information to the Health Care Authority (HCA) to create your ProviderOne account. After approval and ProviderOne activation, you will receive a welcome letter from HCA with your 7-digit ProviderOne ID and steps on how to access your account. To check on the status of your contract and confirm HCA received your information, please contact your DSHS/AAA Contract Specialist.

If you are a Social Services Provider who plans to provide Medical Social Services, you must take additional steps after your ProviderOne account activation to get set up as a Social Services Medical Provider in ProviderOne. Contact your DSHS/AAA Contract Specialist for more information. Getting set up as a Social Services Medical Provider in ProviderOne can take anywhere from 6-8 months. See Question #24 for more information.

2. Is the ProviderOne system different than OneHealthPort?

OneHealthPort is a secure online portal where some providers access the ProviderOne system. OneHealthPort is not a separate billing system, it is just another way to access ProviderOne.

ProviderOne ID (Domain)

3. Why do I have more than one ProviderOne ID?

Social Services Providers are assigned a 7-digit ProviderOne ID (also known as your Domain) after the ProviderOne account is activated. As a Social Services Provider, you will also have 'Location Codes' to differentiate different service locations or contracts. When adding your 'Location Code(s)' to the end of your ProviderOne ID, this creates a 9-digit ID. For example, if your ProviderOne ID/Domain is 1234567 and you have three locations, you will have three location codes- 01, 02, 03. These location codes are added to the end of your ProviderOne ID for authorizations and claims. Your ProviderOne ID with the location codes would be 123456701, 123456702, 123456703. When contacting HCA or DSHS, you can provide either your 7-digit ID or your 9-digit ID. If you are a Social Services Medical Provider, you will also have a Location '00' listed under your Domain. You can see all of your location codes in ProviderOne by clicking on 'Manage Provider Information' and then clicking on the 'Location' step.

If you have two separate ProviderOne Domains with different IDs, this could be due to a previous change to your Federal Tax ID. If your Federal Tax ID changes, a new ProviderOne account must be created and the old account inactivated. If you have questions on why you have two separate domains/ProviderOne accounts, please contact your DSHS/AAA Contract Specialist or HCA Provider Enrollment.

4. Some case managers add a '01' after my ProviderOne ID. Will this create a problem with billing/payments once I start to bill for services? Which is the correct format of the ProviderOne ID on referral forms from the case manager?

Social Services Providers have a 2-digit 'Location Code' added to the end of their 7-digit ProviderOne ID/Domain which creates a 9-digit ID. If you have multiple locations, you will have multiple location codes listed under your Domain (see Question #3 for more information on Location Codes). The case manager should enter the 9-digit ProviderOne ID on the referral forms to indicate which location the services are authorized to. Before providing services and submitting claims, you must review your ProviderOne Authorization List to ensure services are authorized to the correct location (see the Authorizations section of this Q&A for directions on how to view your Authorization list).

Setting up system administrators and additional users

5. My ProviderOne account just got approved. How do I get set up as the System Administrator?

After your ProviderOne account is activated, you will receive a welcome letter from HCA. Follow the directions in the welcome letter to get set up as the System Administrator and to receive your ProviderOne login credentials. If you did not receive your HCA welcome letter, please visit HCA's ProviderOne Security webpage for more information on how to access your account and how to get set up as the System Administrator.

6. How do I remove a System Administrator who no longer works here and how do I get set up as the new System Administrator?

If there is another System Administrator on the ProviderOne account, they can add you as an additional System Administrator. If the previous System Administrator no longer works with the organization AND they were the only System Administrator on the account, your organization must submit the ProviderOne User Access Request Form and a letter on your organization's letterhead to HCA. The letter must state that the current system administrator (with their name) should no longer have access to ProviderOne. The office manager or person signing the letter must not be the same person requesting access. More information can be found here.

7. How do I set up an additional System Administrator?

If you are the current System Administrator, you can add additional System Administrators and Users by following the directions found in the Getting Started and Billing Essentials Guide. To replace a System Administrator who is no longer with your organization, see Question #6.

8. How do I add additional users to my ProviderOne account so they can assist with billing?

Your organization's ProviderOne System Administrator can add additional users to the ProviderOne account per the directions in the 'Adding Users and Assigning Profiles' section of the Getting Started and Billing Essentials Guide.

9. If I am the primary biller for my organization's ProviderOne account and I have a medical emergency, how can I set up someone else as a user on my ProviderOne account?

Your organization's ProviderOne System Administrator can add additional users to the account. If you are the only System Administrator for the ProviderOne account and you are out on medical leave and unable to add additional users, your organization must submit the ProviderOne User Access Request Form along with a letter on your organization's letterhead asking to remove you as the System Administrator and to add a new System Admin. The letter must be signed by someone other than the person requesting access. Once you return from medical leave, the new System Administrator can add you as an additional System Administrator or User. Best practice is to add a backup System Administrator and additional users as soon as the ProviderOne account is activated.

Logging in to ProviderOne

10. Can I use the Safari browser when using ProviderOne?

Yes, ProviderOne works on a variety of internet browsers including Safari, Google Chrome, Microsoft Edge and Firefox. For ProviderOne to work properly, you must ensure your browser is set to allow pop-ups. See How to turn off pop-up blockers for more information.

11. How are we supposed to login to ProviderOne? It switched to OneHealthPort a couple years ago. Is it switching back to directly logging in via ProviderOne?

Some providers access ProviderOne through OneHealthPort and some access ProviderOne directly through www.waproviderone.org. This is determined by HCA ProviderOne Security. If you have questions on your login options, contact HCA ProviderOne Security

12. When I login I use the 'EXT Provider Social Services' profile. How can I get the 'EXT Provider Social Services Medical' profile?

Providers contracted to provide non-medical Social Services will see the 'EXT Provider Social Services' profile when logging into ProviderOne. To get the 'EXT Provider Social Services Medical' profile, you must work with your

DSHS/AAA Contract Specialist and HCA Provider Enrollment to get set up as a Social Services Medical Provider in ProviderOne. Once you are approved by DSHS/AAA and HCA as a Social Services Medical Provider, you should see the 'EXT Provider Social Services Medical' profile when logging into ProviderOne. For more information, contact your DSHS/AAA Contract Specialist or HCA Provider Enrollment.

Updating information in ProviderOne

13. The 'Specializations' Step on my ProviderOne account is showing as 'Incomplete'. What do I do?

Specializations or 'taxonomies' indicate which services you are contracted to provide. The taxonomy/taxonomies listed under the 'Specializations' Step on the Business Process Wizard in ProviderOne feed over from your DSHS/AAA Contract. Social Services Providers cannot update their taxonomies/specializations in ProviderOne. If this step is showing as 'Incomplete', please contact your DSHS/AAA Contract Specialist and they will work with HCA to fix the issue.

14. The taxonomy (specialization) listed on my ProviderOne account is incorrect. How do I update this in ProviderOne?

You must contact your DSHS/AAA Contract Specialist to update the taxonomy/taxonomies listed on the Specializations Step of your ProviderOne account. Since the taxonomy codes listed on your ProviderOne account are tied to your DSHS/AAA Contract, you cannot update this information yourself in ProviderOne.

15. If I have two adult family homes (AFHs) that have the same name, do I have to create two billing addresses?

Your AFH business will have a single ProviderOne domain. If you have multiple homes, each physical location requires its own Location Code (see Question #3 for a description of Location Codes). While the 'Pay-To' and 'Mailing' addresses may be the same for each home, each location must have a different 'Physical' address. Contact your DSHS/AAA Contract Specialist for more information and to ensure you are set up correctly in ProviderOne.

16. Who do I contact to review my information that is pre-loaded in ProviderOne? Is there someone that can go over what I currently have and suggest or point out some suggestions?

Directions on how to review and update your ProviderOne account information can be found in the Getting Started and Billing Essentials Guide. Contact HCA Provider Enrollment if you need additional assistance. Note, you must contact your DSHS/AAA Contract Specialist to update your Contract or Specialization details in ProviderOne as you cannot update this information yourself in ProviderOne. If you make any changes to your Physical Location(s) in ProviderOne, you must also inform your contract specialist so they can update your contract as needed.

17. How can I update the National Provider Identifier (NPI) on my ProviderOne account?

If you are a Social Services Medical Provider and you need to update the NPI listed on your ProviderOne account, please contact HCA Provider Enrollment. If you are a Social Services (non-medical) Provider, this question does not apply to you.

18. I am having issues when attempting to upload my Department of Health (DOH) license to ProviderOne. Who do I contact?

For assistance with uploading DOH licensure in ProviderOne, contact HCA Provider Enrollment. If you are a Social Services (non-medical) Provider, this question does not apply to you.

Signing up for electronic funds transfer (direct deposit)

19. How do I set up direct deposit?

Providers can find directions on how to sign up for electronic funds transfer (EFT) a.k.a. direct deposit in the 'Payments Details' section of the Getting Started and Billing Essentials Guide.

20. I set up direct deposit and it was approved. Why am I still receiving a paper check?

It may take up to 30 days for the ProviderOne system to validate your banking information once you successfully enroll for direct deposit (EFT). If you are still receiving a paper check 30 days after approval, please contact HCA Provider Enrollment.

21. One of my locations in ProviderOne is signed up for direct deposit, but my other one is not. How do I sign up for direct deposit for my other location?

If you have multiple locations, you must enroll for direct deposit for each location in ProviderOne. See the 'Payment Details' section in the Getting Started and Billing Essentials Guide for directions on how to sign up for EFT for each location.

22. Will the first ProviderOne payment always be a mailed check? Or can you start out with direct deposit?

When your ProviderOne account is activated, paper check is the default payment method. However, if you sign up for electronic funds transfer (EFT)/direct deposit prior to submitting your first claim, your first payment should be processed electronically. After signing up for EFT in ProviderOne, you should ensure the status is showing as 'Approved' before submitting your first claim to ensure payment will be processed via EFT. Directions on how to sign up for electronic funds transfer/direct deposit can be found in the 'Payment Details' section of the Getting Started and Billing Essentials Guide.

23. Sometimes providers find the process of setting up direct deposit confusing as they need to complete other steps. What is the best process for setting up direct deposit?

You'll find directions on how to sign up for direct deposit in the 'Payment Details' section of the Getting Started and Billing Essentials Guide. When updating information in ProviderOne, if other steps on the Business Process Wizard screen show as 'Required' and 'Incomplete', providers must complete these steps first. Providers also must click on 'Final Steps' after making any changes to their ProviderOne domain. If providers do not click on 'Final Steps', the changes will not be sent to HCA and the changes will not be processed. For assistance with setting up direct deposit, providers can contact HCA Provider Enrollment.

Adding medical social services and MCO contracting

24. I would like to set up a new ProviderOne account so I can bill for Medical Social Services. How do I do this?

As a contracted DSHS/AAA 'non-medical' Social Services Provider, once your ProviderOne account activates, this remains your only ProviderOne account. If you would like to provide 'Medical' Social Services such as private duty nursing, nurse delegation, CBHS, IBSS, ECS, etc., you must complete additional steps to get set up as a medical provider* in ProviderOne such as:

- Obtain a National Provider Identifier (NPI) from the federal government at NPPES. Your NPI is *not* issued by HCA or DSHS. For questions regarding how to register for an NPI and how long this process takes, contact NPPES.
- Fill out a ProviderOne Billing Provider Application and Core Provider Agreement with HCA. Contact your DSHS/AAA Contract Specialist or HCA Provider Enrollment to obtain the application packet and for assistance with completing the application.
- Some Medical Social Services may be covered by the client's Medicaid Managed Care Organization (MCO). If services are covered by the client's MCO, you will bill the MCO directly (claims are not submitted through ProviderOne). Contact the MCOs for assistance with this process and any MCO billing questions.

Throughout this process, you should work closely with your DSHS/AAA Contract Specialist and HCA Provider Enrollment to ensure you complete the correct paperwork and are fully set up before accepting new clients.

***Note:** The process of getting set up as a Social Services Medical Provider can take up to 8 months. Providers should not accept new Medicaid clients or provide medical services until they are fully set up to bill.

25. I have registered to bill through the Medicaid Managed Care Organizations (MCO), but I haven't heard back. How long does it take to get my NPI number?

See Question #24 for more information on how to get set up as a Social Services Medical provider. If you need help completing your ProviderOne Billing Provider Application or to check on the status of your application, contact HCA Provider Enrollment. If you have questions about signing up for an NPI, contact NPPES. If you have questions on contracting with the MCOs and MCO billing questions, contact the MCOs. Your DSHS/AAA Contract Specialist can also assist you with this process.

26. Can I change my ProviderOne application from individual to facility?

If you are a Social Services Provider trying to get set up as a Social Services Medical Provider in ProviderOne and you need help with your ProviderOne application, you must work with your DSHS/AAA Contract Specialist. If you have already submitted your application and you need to change the application type or other application information, contact HCA Provider Enrollment.

27. How do I set up my ProviderOne account so I can bill for Nurse Delegation (ND) or Private Duty Nursing (PDN)?

You must first be contracted with DSHS/AAA to provide these services. You will then need to work with your DSHS/AAA Contract Specialist and HCA Provider Enrollment to get set up as a Social Services Medical Provider in ProviderOne (see Question #24) . You can also visit the DSHS Nurse Delegation webpage and Private Duty Nursing webpage for more information.

28. How do I add other Social Service Contracts to my ProviderOne account (i.e., Expanded Community Services-ECS)?

Residential providers interested in becoming contracted for ECS can reference the DSHS/HCLA Residential Long-Term Care Facilities Specialty Contracts webpage for specialty contract and contact information. A Regional Specialty Contracts Coordinator will follow-up with provider inquiries to ensure the contracting process, training, and contract information is completed to include ProviderOne database submissions once a contract is awarded. For additional questions about this process or to become contracted for additional Social Services, please contact your DSHS/AAA Contract Specialist.

29. How do I sign up and bill for the Intensive Behavioral Supportive Supervision (IBSS) program and the Community Behavioral Health Support (CBHS) services program?

More information about the CBHS program and how to sign up/bill can be found on HCA's CBHS website. More information about the IBSS program and how to sign up/bill can be found on the HCA IBSS Fact Sheet. If interested in either of these programs, contact your DSHS/AAA Contract Specialist for more information.

Authorizations

30. How will I know if an authorization is in 'Error' status?

If an authorization is in 'Error' status, you will see this on your ProviderOne Authorization List under the 'Error Status' column. View the error details by clicking on a specific authorization line and then clicking 'View Error List'. For directions on how to view your ProviderOne Authorization List and view errors, see the Getting Started and Billing Essentials Guide.

31. What should I do if my client's authorization is in 'Error' status?

Contact the client's authorizing case manager to resolve any authorization errors. Claims will deny if you attempt to adjust or resubmit claims without clearing the error status of the authorization.

32. How do I know if an authorization changed and how do I view what changed?

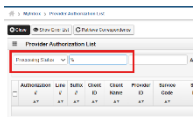
When an authorization changes, ProviderOne generates a new authorization letter. Providers are notified of an updated letter either electronically or by mail. The client or their representative also receives a copy of the authorization letter via mail. Providers may also view the letter in ProviderOne under the ProviderOne Authorization

List. To update how you are notified of authorization changes, see the 'Managing Provider Information' section of the Getting Started and Billing Essentials Guide.

To view what has changed on the authorization, search for the authorization # on your ProviderOne Authorization List. In the 'Filter By' field, filter by 'Processing Status' and enter the % sign (see Question #33). This will show you past and inactive authorization lines. You can save the Authorization List to an Excel spreadsheet to compare what has changed from the previous authorization and the new authorization. See the Getting Started and Billing Essentials Guide for more information.

33. On my Authorization List, how can I view past or inactive authorizations?

In the ProviderOne Authorization List, filter by 'Processing Status' and enter the % sign. This will show you past and inactive authorization lines:



34. How do I add a new client to ProviderOne?

Providers do not add clients to ProviderOne. Clients are assigned to providers after the client completes an annual assessment with their authorizing case manager (CM). Before authorizing services to a provider, the CM contacts the provider to confirm they are able to provide services to the client. The CM will then authorize the services, at which point the client shows up on the provider's Authorization List in ProviderOne.

35. Why does it take 10-14 days for a new rate to show up in ProviderOne?

Once a rate is updated on an authorization, you should be able to see the current rate on your ProviderOne Authorization List the same day. If you have questions about the rate assigned to a service, or if the new rate is not updated correctly on your Authorization List, contact the client's authorizing case manager.

36. Why is my client's authorization still in 'Reviewing' status after services were provided?

Some services require providers to submit an invoice to the client's authorizing case manager (CM) before payment is issued. If you have submitted the invoice to the CM and the authorization is still in 'Reviewing' status, contact the CM and ask them to change the authorization from 'Reviewing' to 'Approved'. Once the CM has verified that the good/service was delivered/complete and they have received the final invoice cost, they will update the authorization status to 'Approved' and will change the end date on the authorization. Once the status is changed to 'Approved' and the end date has been reached, you should receive payment within a week or two. If you have not received payment two weeks after the status was changed to 'Approved' and the end date reached, contact the CM.

37. Who do I contact if the wrong dates, rate, service code, or units are authorized?

If you think the dates, rate, service code, or units authorized are incorrect, contact the client's authorizing case manager. Case manager contact information can be found on your ProviderOne Authorization List and on your the authorization letters. See the Getting Started and Billing Essentials Guide for directions on how to view your Authorization List and authorization letters.

38. When Billing Type shows as 'Monthly Recurring', does that mean the authorization will automatically reactivate next month?

Most services are authorized for a year. 'Monthly Recurring' refers to set amounts without variance repeated monthly. For example, if your client is authorized for 112 units 'Monthly Recurring', this means you can submit multiple claims up to 112 units each month for the active authorization. If the authorization shows as 'Monthly Recurring' but the client is only authorized for one month and you believe the authorization should be longer than one month, contact the client's authorizing case manager.

Client responsibility/participation

39. What is client responsibility and how do I know if my client has client responsibility?

Client Responsibility (CR) is the amount that a client must pay towards the cost of their long-term care services before DSHS will pay. If your client has other resources, those resources must be accessed first before DSHS can pay. CR is comprised of three elements:

- Third Party Resources-TPR (private insurance, Medicare, long-term care insurance, Veteran Affair Benefits, L&I income, WA Cares Fund)
- Room & Board (only applicable in residential settings such as Adult Family Homes, Enhanced Adult Residential Care, Assisted Living, and Adult Residential Care)
- Participation (the amount a client pays towards their cost of care)

If your client has CR, the amount the client must pay you (the provider) will be listed on your ProviderOne Authorization List and on the authorization letter. If there are any questions about whether CR should be applied to your authorization, please contact the client's authorizing case manager. If you or the client have questions about the amount of CR assessed for the client, contact the client's public benefits specialist (PBS).

40. Who can I contact if I have questions about client responsibility (CR)/client participation?

Contact the client's authorizing case manager with questions about the amount of CR applied to the authorization or claims. If there is a question about the client's financial eligibility or the maximum amount they may have to pay in CR, contact the client's public benefits specialist.

41. How do I bill for the participation fee after the client's admission?

If a client has client responsibility (CR), this amount will be automatically deducted from claims in ProviderOne. You (the provider) will then need to collect the CR amount directly from the client. See the authorization letter or your ProviderOne Authorization List for the amount you must collect from the client. Contact the client's authorizing case manager if you have additional questions on how to collect CR from the client.

42. The wrong amount of client responsibility was applied to the claim. What do I do?

Look at your Authorization List in ProviderOne and the authorization letters to confirm the client responsibility (CR) amount for the specific month in question. If the amount of CR on your Authorization List and letter is different than the amount applied to the claim, you can try reprocessing the claims yourself in ProviderOne. See the ProviderOne for Social Services Billing Guides for directions on how to reprocess the claim (a.k.a. adjusting a paid claim). If adjusting the claim yourself does not fix the problem, contact HCA MACSC or the client's authorizing case manager for assistance. If you think the amount of CR on your Authorization List or authorization letter is incorrect, contact the client's authorizing case manager.

Claiming

Submitting claims

43. How do I submit claims for payment?

Before you submit claims for payment, you must ensure you can view your clients' authorizations in ProviderOne. Directions on how to view authorizations can be found in the Getting Started and Billing Essentials Guide. If no authorizations are loaded in ProviderOne, or if your authorizations are in 'Error' or 'Canceled' status, you must contact the client's authorizing case manager prior to providing services or submitting claims. If your authorizations are in 'Approved' and 'No Error' status, you are ready to provide services and submit claims for payment. You should only submit claims for services you have provided to the client. Directions on how to submit claims, as well as how to void or adjust claims, can be found in the ProviderOne for Social Services Billing Guides. If you need additional assistance with submitting claims, contact HCA MACSC.

44. I have always had another person do my billing but would like to start doing it myself. Is there someone that can help me learn the billing process?

Directions on how to submit claims, as well as how to void and adjust claims, can be found in the ProviderOne for Social Services Billing Guides. The 'Billing Guides and ProviderOne Basics Webinar' also provides a good overview of ProviderOne and the claiming process: View the webinar | Presentation slides. If you need assistance with submitting claims for the first time, please contact HCA MACSC. As a professional contracted provider, you are expected to be able to understand the Medicaid billing processes and procedures. DSHS and HCA have created resources to ensure your success. Although HCA MACSC and DSHS Payment Staff can assist with specific billing situations on a case-by-case basis, providers are expected to use the available resources when claiming.

45. What is the latest time one can submit a claim on Tuesday to be paid the following Friday?

Claims submitted in the ProviderOne system by 5 p.m. (Pacific Time) on Tuesday should pay the same week on Friday or the following week on Monday. Holidays and ProviderOne outages may impact the claim cutoff day/time. Providers will see a message when logging into ProviderOne of any payment changes or delays.

46. What is the timeline for submitting claims?

Providers must submit initial claims and have a TCN assigned no later than 12 months (365 days) from the date of service. Providers have 24 months from the date of service to adjust, resubmit, or void an initial claim. ProviderOne makes weekly payments. Claims submitted in ProviderOne by 5 p.m. (Pacific Time) on Tuesdays should pay the same week on that Friday or the following week on Monday. Providers are encouraged to set up a billing schedule that works for them. Best practice is to submit claims on a monthly basis (rather than weekly submissions), especially if the client has Client Responsibility.

47. What should I do if I receive an error on my claim stating the dates are no longer authorized or there is a client eligibility issue?

First, review your Authorization List in ProviderOne to see if the authorization is in 'Error' or 'Canceled' Status. If the authorization is in 'Error' or 'Canceled' status, contact the client's case manager so they can fix the issue. Once the authorization is fixed, you can try resubmitting your claim.

If the authorization is in 'No Error' and 'Approved' status, check the dates you entered on your claim to confirm they match the authorized dates. If you have verified the dates claimed match the authorization, contact HCA MACSC to confirm client eligibility and also to confirm you are submitting everything correctly on the claim.

48. I am getting a message for one of my clients that states: "Warning Service Code and/or Modifier do not match those on the Social Service Authorization for the Claim DOS". Who do I talk to fix this?

First, confirm the client's authorization is not in 'Error' or 'Canceled' status. If the authorization is in 'Error' or 'Canceled' status, contact the client's case manager.

If the authorization is in 'Approved' and 'No Error' status, compare the information you entered on the claim matches what is on the authorization list (client ID, dates of service, service code, and modifier). If the information you entered on the claim matches the client's authorization and you are still receiving this error, contact HCA MACSC.

49. I received Error code 150061. What do I do?

If the error is posting when trying to submit a direct data entry claim or template batch claim, contact HCA MACSC. If you received the error when trying to update information on your ProviderOne account, contact HCA Provider Enrollment. If the error is posting when trying to upload a .dat batch file or HIPAA batch file, contact the HCA HIPAA Help Desk.

50. I'm having a challenge to claim for bed hold. I reached out to the client's case manager, and they said the authorization had been issued, however, the issue still persists. Who can I contact?

When billing for a bed hold (SA685 or SA686), there are a few things to keep in mind:

- Verify that you do not have residential service claims in paid status while the resident was on medical leave. If there are claims in paid status, you will need to void these before submitting the bed hold claim. Directions on how to void a claim can be found in the ProviderOne for Social Services Billing Guides.
- Verify the authorized dates for the bed hold are not in error status and consistent with what you expect to be authorized for based on when your resident was on medical leave.
- If a bed hold spans multiple months, you must submit separate claim lines for each month. For example, your client is authorized for 12 units of SA686 (Bed Hold 8-20 days) for 5/31/24-6/11/24. You must submit one claim line for 5/31/24 with 1 unit and one claim line with 11 units for 6/1/24-6/11/24.
- If you are a Social Services Medical Provider, you will use the 'Social Services Authorization and Billing' section within ProviderOne to submit a bed hold claim. Bed hold codes are 'non-medical' and cannot be submitted under the 'Claims' section in ProviderOne. Directions on how to submit a non-medical social services claim can be found in the Submitting and Adjusting Social Services Claims Guide.

If you still need assistance with submitting or adjusting claims after reviewing the ProviderOne for Social Services Billing Guides, contact HCA MACSC. If the bed hold authorization is in error status, contact the client's authorizing case manager.

51. Where can I find a list of all social service codes and modifiers with descriptions and rates?

A list of all billable Social Services Codes, a description of the code, and their associated rates can be found on the Office of Financial Management website. Modifiers are added to some codes to ensure accurate payment. For additional questions about service codes and modifiers, providers can contact the client's authorizing case manager, their DSHS/AAA Contract Specialist, or the Program Manager. If you are a Social Services Medical Provider billing for a shared HCA service, see the HCA Billing Guides & Fee Schedule webpage for more information on billable Social Services Medical codes.

52. How do I know how many units to charge for a task? Is there a unit to conversion chart?

Each code has an assigned 'Unit Type'. The Unit Type informs how the code should be claimed. The Unit Type is listed next to the service code on the ProviderOne Authorization List. The unit types used for Social Service codes are: Each, Monthly, Daily, Hourly, ½ Hour, ¼ Hour, Miles, and Visit.

Based on the Unit Type of the code (which can be found on your ProviderOne Authorization List), providers can convert units. Examples:

- Unit Type '1/4 hour' = 15 minutes. Divide the # of units by 4 to get the # of hours. Example: 200 units/4 = 50 hours.
- Unit Type '1/2 hour' = 30 minutes. Divide the # of units by 2 to get the # of hours. Example: 100 units/2=50 hours.
- Unit Type 'Hour' = 60 minutes. Example: 1 unit = 1 hour
- Unit Type 'Daily' or 'Visit', claim one unit per day regardless of the actual time spent providing the services
- Unit Type 'Miles', claim one unit for one mile driven

For questions on how to convert your service hours to billable units or how to bill for specific services, contact your DSHS/AAA Contract Specialist or Program Manager.

53. Is there a way to see the number of units used on an authorization? Or how many remaining units there are?

While you can't see the remaining units on your ProviderOne Authorization List, you can see the total units authorized per month. You can track how many units have been provided/billed by reviewing each of your remittance advices (RAs) when they become available in ProviderOne. It is your responsibility to keep track of how many units you have provided and billed.

54. Is there an approved billing software by HCA?

Some providers choose to contract with an outside billing vendor or clearinghouse to assist with claim submissions/processing. For questions regarding which clearinghouses or billing software are compatible with ProviderOne, please contact HCA's HIPAA Help Desk at hipaa-help@hca.wa.gov.

55. When submitting a claim, do I submit the date of the referral or the date the service was provided?

You should enter the date the service was provided. If you have specific questions on how to bill for a service, please contact your DSHS/AAA Contract Specialist or Program Manager.

56. If l send several caregivers out for the same client in a single day, how do l claim for services provided by each caregiver?

If billing for nurse delegator services, services are billed per quarter hour not by task. Therefore, if the Nurse Delegator is delegating to multiple caregivers at the same time, they would simply bill for the time it took. Regardless of the number of caregivers, if it took them one hour to delegate then they would bill for one hour. For additional information or questions on how to bill for nurse delegation, contact the DSHS Nurse Delegation Program Manager.

If you are a Home Care Agency billing for personal care services or respite care services, you would bill for services provided by each caregiver. To differentiate between the different caregivers, be sure to enter the Social Service Servicing Only Provider (SSSOP) IDs on the claim along with other required EVV claim elements. For additional information or questions on how to bill for personal care services or respite care services, contact your DSHS/AAA Contract Specialist or Program Manager.

57. If I am authorized to take 3 clients out at a time, but only 2 or 1 go, how do I bill for that? Is there a rate difference? Also, how do I split up mileage?

For specific billing scenarios like this, contact your DSHS/AAA Contracts Specialist or Program Manager.

58. When submitting claims, can you enter multiple days in one entry? For example, can I enter the date range of 5/1-5/3 and 3 units? Or do I need to enter each day individually as 1 unit?

This depends on the type of code you are billing. See the ProviderOne for Social Services Billing Guides for more information. If your client has client responsibility, best practice is to submit separate claims for separate months. This ensures client responsibility is applied correctly.

Service codes that are 'Daily' or 'Monthly' Unit Types should be able to be entered as a 'date range' in ProviderOne. ProviderOne will split the date range into individual days/services lines. One exception to this is billing for a bed hold (see Question #50).

Codes with Unit Types '1/4 Hour' or 'Mile' need to be billed for specific dates of service for the specific number of units served on that day and each day must be entered individually. You can submit one claim for the services, but you would need to enter individual service lines for each date of service. Using claim templates might save you time submitting claims with individual lines. See the ProviderOne for Social Services Billing Guides for more information on using claim templates.

59. When claiming, can we combine and claim all of the authorized service codes for one client on one claim? For example, if the client is authorized for T1020 U1 and T2033 U1 can I submit one claim for all codes?

Yes, if the codes are authorized under the same authorization number, you should be able to submit one claim (with multiple claim lines) for all authorized service codes. See the ProviderOne for Social Services Billing Guides for directions on how to submit claims. Contact HCA MACSC if you need further assistance.

60. When I submit a claim, I receive the message 'no record found'. What does this mean?

The 'no record found' message refers to claim attachments. Most Social Services Providers do not need to attach back-up documentation to claims. If you are a Social Services only (non-medical) Provider and you receive this

message, you can disregard. If you are a Social Services Medical Provider, refer to the Submitting and Adjusting Social Service Medical Claims Guide for more information on attaching back-up documentation to a claim.

61. Can you explain the 7-minute rule?

Generally, service codes are either 'timed' or 'untimed'. Timed codes are billed based on the duration of the time spent providing the service to the client. Most timed codes are billed per 15-minute increments. Untimed codes are billed once per session regardless of the time spent with the client. Federal Centers for Medicare & Medicaid Services (CMS) rules require that for a provider to bill one unit of a 15-minute code, the provider must provide at least eight (8) minutes of service. If you have questions on how to bill for a certain code, please contact your DSHS/AAA Contract Specialist or Program Manager.

62. How do I claim for mileage?

If you are authorized for mileage, you will see this on your ProviderOne Authorization List. To claim for mileage, you will claim for each specific date of service for actual miles driven. For example, if you are authorized 100 miles for the month of August 2025 but you only drove a total of 23 miles on 8/15/25, you would submit one claim for date of service 8/15/25 for 23 miles. Even though you are authorized for 100 miles, you are not allowed to claim for miles not driven. Only submit claims for actual miles driven. Contact your DSHS/AAA Contract Specialist if you have additional questions on how to bill for mileage.

63. I have two locations. Do I bill the same for each location?

If you have multiple locations, you will see authorizations for each location on your ProviderOne Authorization List. Before providing services or submitting claims, review your Authorization List to ensure services are authorized to the correct location. You can also save the Authorization List to an Excel spreadsheet to assist you with claiming. This ensures claims are submitted correctly for each location. If you have any questions on your authorizations, contact the client's authorizing case manager. If you have specific billing questions, contact your DSHS/AAA Contract Specialist or Program Manager.

64. What code do I use to bill for skin observations?

See the DSHS Nursing Services webpage for information on billing for nursing services. Contact DSHS's Nursing Program Managers if you have questions on which codes to bill or for more information on how to bill for nursing services.

65. Is there a way to check that the submitted billing has been received with the TCN numbers before payment goes out?

Yes. After you submit your claim in ProviderOne, you will receive a pop-up window with the claim information, including the claim # (TCN). Be sure to record this information as you can use it later to look up the claim in ProviderOne and/or track it on your remittance advices (RA). To look up a claim in ProviderOne, use the 'Claim Inquiry' function. You can search for the claim using the TCN or by entering the client or authorization information and the claim service dates. If the claim was submitted successfully but the claim hasn't paid yet, the claim will show as 'In Process/Pending'. If the claim has been submitted successfully and has been fully processed and reflected on a RA, ProviderOne will show the final status of the claim (paid, denied, adjusted, etc.). Additional directions on how to view claims in ProviderOne can be found in the Viewing Claim Status and Payments Guide.

Adjusting and voiding claims

66. What is the difference between voiding a claim and adjusting a claim?

Adjusting is the reprocessing of a paid claim with the expectation that the outcome will still be a header TCN in paid status. You typically adjust a paid claim to change the billed dates or units. Paid claims are also sometimes adjusted to correct client responsibility application (in this situation, you are not changing any elements of the claim but instead are just resubmitting the paid claim so that it is reprocesses and pays correctly). Voiding a paid claim changes the entire claim so that it is no longer in paid status and the expected outcome is an overpayment for the full amount. You should only void a claim when you never should have received payment (i.e., you received

payment for a service you didn't provide). See the ProviderOne for Social Services Billing Guides for more information.

67. Can I correct an error I know I made on a claim after submitting but before the payment deadline? Or do I have to wait for denial?

You must wait until the claim has gone through the adjudication process and is in 'RA Generated' status before correcting the error. Once the claim is in the final (RA Generated) status you can then adjust the claim (if it is in 'Paid' status) or resubmit (if in 'Denied' status) to make any needed changes. Do not submit a new duplicate claim.

68. How do I fix claims that were billed at the wrong rate?

If your claim automatically filled in the authorized rate and the authorized rate was incorrect, the client's authorizing case manager will need to update the authorization to fix the rate. Once the authorized rate is fixed, you can adjust ('reprocess') your paid claims so that they pay at the correct rate. If you entered a billed amount incorrectly on the claim, you should be able to adjust the claim and change the billed amount on the specific claim line. For assistance, contact HCA MACSC.

69. Can we "void" and then "resubmit" the claim for the same client on the same cycle? Will ProviderOne process it correctly?

No. You can only void a paid claim. You will need to wait for the claim to pay and then you can void it. If you need to make changes to a claim but still want it to pay out, you should adjust the claim rather than void it. Just like voiding a claim, you must wait until the claim pays before you can adjust it.

70. When adjusting a claim, I received an error message stating the 'authorization does not match the claim submission'. What is the preferred method for escalation to support?

First, confirm the client's authorization is not in 'Error' or 'Canceled' status. If the authorization is in 'Error' or 'Canceled' status, contact the client's authorizing case manager. If the authorization is in 'Active' and 'No Error' status and the claim details match the authorization details, contact HCA MACSC.

71. Why did DSHS or HCA adjust my claim?

DSHS and HCA are federally required by the Centers for Medicare and Medicaid Services (CMS) to perform program integrity activities to identify improper payments, fraud, waste, and abuse. When an improper payment is identified, DSHS and HCA are required to provide written notice to the provider and are required to recoup any identified overpayments. To correct the claim and process the overpayment, DSHS and HCA must first adjust the claim in ProviderOne.

72. Why do I owe money after my claims were adjusted?

If you receive a vendor overpayment notice from the Office of Financial Recovery (OFR) after a claim was adjusted, it means that the new paid amount is less than the original paid amount, thus creating an overpayment. Overpayments can result from any of the changes below:

- The authorized rate on your paid claims was incorrect
- You are no longer an eligible provider. If you have questions about your contract and provider status, contact your DSHS/AAA Contract Specialist.
- Client responsibility (CR) was applied differently from the original claim. If the amount of CR deducted from your claim changes, be sure to review the CR application on your Authorization List and CR deduction from any other claims for that specific client and month of service. If you have questions about the CR amount reach out to the client's authorizing case manager.
- Your client's authorization was cancelled prior to the adjustment of the paid claim
- The start or end service dates were changed on the authorization
- You received a duplicate payment

The reason code and description on your overpayment notice will provide some explanation as to why the claim was adjusted. If you have additional questions on why the claim was adjusted, there should be a name and email

address of the person who adjusted the claim on the overpayment notice. If there is no contact listed on the notice, you can contact the client's authorizing case manager or HCA MACSC.

Understanding and resubmitting denied claims

73. I submitted a claim, and it was denied due to errors on the authorization. The errors have since been corrected. Do I submit a new claim?

If the authorization is no longer in error status, rather than submitting a new claim, you should resubmit the denied claim for reprocessing. For directions on how to resubmit a denied claim see the ProviderOne for Social Services Billing Guides.

74. How long do I have to correct a denial?

Initial claims must be submitted to ProviderOne and assigned a transaction control number (TCN) within 12 months (365 days) from the date of service. Initial claims may be resubmitted, modified, or adjusted within 24 months from the date of service. If you are unsure on why the claim denied or if you need assistance with correcting and resubmitting a denied claim, contact HCA MACSC.

75. Who can I contact if I don't understand the reason for a claim denial?

If a claim denies, you will see an Adjustment Reason Code or Remark Code on your remittance advice (RA) next to the denied claim. On the last page of your RA, you will find a description of the code which explains why the code denied. A list of the most common Adjustment Reason Codes/Remark Codes and what to do if you receive the code can be found in the Viewing Claim Status and Payments Guide. If you still need help understanding why a claim denied, contact HCA MACSC.

76. If a claim denies for reason code N54, what are the next steps before resubmitting the claim?

Review the Viewing Claim Status and Payments Guide for a list of specific adjustment and denial codes and how to resolve them. N54 usually posts when the authorization is in 'Error' status. If the authorization is in 'Error' status, you will need to reach out to the client's authorizing case manager to have them clear the error before resubmitting the claim. It is best practice to review your Authorization List regularly and verify that authorizations are not in error before providing services and before submitting claims.

Claim templates & batch billing

77. Can you explain what the batch claiming process is?

There are a few different 'batch' claiming processes available to Social Services Providers:

- **Template batch claiming**. Optional billing method for both Social Services-only (non-medical) and Social Services Medical Providers. A template batch is a group of claims that share the same date of service. Template batch claiming allows providers to create and submit a group (batch) of claims for multiple clients that share the same date of service. More information can be found in the Submitting and Adjusting Social Services Claims Guide, Submitting and Adjusting Social Services Medical Claims Guide, or by contacting HCA MACSC.
- **.dat batch file upload**. Optional billing method for Social Services-only (non-medical) Providers. Allows providers to extract billing data elements from their current timekeeping and/or billing software, convert it to a .dat file, and upload the .dat file claim data into the ProviderOne system. More information can be found in the Submitting and Adjusting Social Services Claims Guide or by contacting HCA's HIPAA Help Desk.
- **HIPAA file batch upload.** Optional billing method for Social Services Medical Providers. Allows providers to extract billing data elements from billing software and upload the claim(s) data into the ProviderOne system. More information can be found in the Submitting and Adjusting Social Services Medical Claims Guide or by contacting HCA's HIPAA Help Desk.

78. Is there a way to enter a billing date that stays the same for every client entered on that date?

Yes. Template batch claiming allows you to submit a batch of claims that share the same date of service. Template batch claiming allows providers to create a group (batch) of claim templates, change the date of service on all the templates at one time, and submit the batch all at once. For more information see the ProviderOne for Social Services Billing Guides.

79. How do I set up a claim template after I receive a new client?

Directions on how to set up a claim template can be found in the Submitting and Adjusting Social Service Claims Guide (non-medical social services) or the Submitting and Adjusting Social Service Medical Claims Guide (medical social services). For additional assistance with setting up claim templates, providers can contact HCA MACSC.

Looking up claims in ProviderOne

80. How do I search for paid claims in ProviderOne?

You can search for paid claims in ProviderOne by using the 'Claim Inquiry' search. You can also view paid, denied, adjusted, and in process claims on your remittance advices (RA). Directions on how to search for claims using the 'Claim Inquiry' search and how to view and download your RAs can be found in the Viewing Claim Status and Payments Guide.

81. How can I look up a claim in ProviderOne if I don't remember the claim number (TCN) or don't have the TCN?

You can search by the client's ProviderOne ID along with the claim service dates or by the authorization # and the claim service dates. If searching by claim service dates, make a note that if your submitted claim is outside of the date range you are searching for, it won't show up in your results and you will get an error message. For example, if you submitted a claim for 8/30/2025-9/30/2025 but you enter '9/1/2025-9/30/2025' as your search criteria, this claim will not show in your results. Directions on how to search for a claim in ProviderOne can be found in the Viewing Claim Status and Payments Guide.

82. When I try looking up a claim, I receive the message 'no record found'. Why am I receiving this message?

If you receive this message, it could be that the search criteria you entered is incorrect or it could mean the claim was not submitted successfully in the system. Please review the Viewing Claim Status and Payments Guide for directions on how to look up claims in ProviderOne. If you continue to have trouble finding a claim, please contact HCA MACSC.

Managed care organization (MCO) claiming

83. How do I know if a resident is eligible for MCO services?

To help you understand programs, client eligibility, and whether the services are covered by a managed care organization (MCO), contact the client's authorizing case manager, your DSHS/AAA Contract Specialist, or the Program Manager.

84. How do I bill for Community Behavioral Health Services (CBHS)? Do I use ProviderOne to bill for CBHS and if so, do I use the same billing screens in ProviderOne?

If the client has Medicaid coverage through a Managed Care Organization (MCO) and if CBHS is authorized through the client's MCO, you will bill the MCO directly (not through ProviderOne). Contact the client's authorizing case manager & the client's MCO for more information. If the client does not have Medicaid coverage through an MCO, you will submit the CBHS claim through ProviderOne. See HCA's CBHS website for more information.

85. If a service is covered by the client's Managed Care Organization (MCO), do we still submit claims in ProviderOne?

No. If the service is covered by the client's MCO, you will bill the MCO directly. Contact the client's MCO for more information. If the client is authorized for other services that are not covered by the MCO, you will continue to claim those services directly through ProviderOne.

Payments and overpayments

86. How often does ProviderOne make payments?

ProviderOne makes weekly payments. Claims submitted in ProviderOne by 5 p.m. (Pacific Time) on Tuesday should pay the same week on Friday or the following week on Monday. Holidays and ProviderOne outages may impact the claim cutoff day/time. Providers will see a message when logging into ProviderOne of any payment changes or delays. Even though ProviderOne makes weekly payments, best practice is to submit claims monthly. This ensures you only bill for services that were actually provided and ensures client responsibility (if any) is distributed properly.

87. Do holidays affect the payment schedule for ProviderOne? If so, will we get notified?

Yes, holidays may impact ProviderOne pay dates and claim submission deadlines. When a payment date or claim submission deadline changes, HCA and DSHS notify providers via an alert in ProviderOne as well as via GovDelivery email notifications. Providers should ensure they are signed up for GovDelivery email notifications:

- DSHS ProviderOne Social Services Newsletter/alerts
- HCA provider alerts

88. Why are we not able to track PACE payments in ProviderOne?

PACE services are billed and paid differently than other Social Services payments. For more information about the PACE program and how services are paid, see Chapter 22c of the Long-Term Care Manual or contact your DSHS/AAA Contract Specialist or the PACE Program Manager.

89. Is there a way to search for non-client payments like reimbursements for start-up costs that were approved by the case manager?

If the payment was processed through ProviderOne, you should be able to view the payment on the corresponding remittance advice (RA), or by searching for the claim in ProviderOne using the claim number (TCN). See Question #80 for directions on how to view your RAs and how to look up claims in ProviderOne. If you are unable to find the claim or payment in ProviderOne or on your RAs, contact your authorizing case manager.

90. Why was my check returned to DSHS? How can I request a new check be issued?

Checks are mailed to the 'Pay-To' address in ProviderOne. If your check was returned to DSHS, this more than likely means your 'Pay-To' address is not correct. Directions on how to view and update your 'Pay-To' address can be found in the 'Managing Provider Information' section of the Getting Started and Billing Essentials Guide. If you have multiple locations, you must review the 'Pay-To' address for each of your locations to ensure each address for each location is correct.

If your check is returned, DSHS will contact you to confirm the correct mailing address and will then issue a new check to that address. If DSHS cannot reach you to confirm your address, the check will be cancelled. If the check is cancelled and/or if it is reissued but you have still not received it, you can request a new check be issued by filling out and mailing the DSHS Affidavit of Lost, Stolen, or Destroyed Warrant form (Form #09-013) to DSHS. See the form for specific instructions.

91. Is there someone we can contact to write an emergency check if ProviderOne is denying a payment?

DSHS rarely issues emergency payments, however, if you are experiencing billing or claims issues, please contact HCA MACSC. They will assist you with submitting your claims and can troubleshoot any ProviderOne technical issues that may be causing a delay in payment. MACSC will triage your request for an emergency payment and will escalate to the DSHS Payment Teams for review. If the claim is denying due to an authorization error, you must contact the client's authorizing case manager so that they can clear the error.

92. Is there a way to request uniform formatting of each remittance advice (RA) or find a better solution for consistency?

When you download the RA, it saves as a PDF. Some providers have reported they are able to convert the PDF to an Excel file. Contact your Office Manager to see if this is an option.

Depending on the number of claims submitted, the RA could be a few pages long up to hundreds of pages long. Regardless of the number of pages, each RA is formatted the same and each RA contains four specific sections that are consistent each week:

- Section 1: Mailing information
- Section 2: Current RA messages
- Section 3: Payment summary (shows amount you were paid and a summary of payments/adjustments/denials)
- Section 4: Payment information (detailed list of all claims submitted during the RA cycle)

Providers are encouraged to review the How to view your remittance advice (RA) resource. This resource explains each section of the RA and what to look for in each section.

93. Is there a way to get a copy of the billing we enter at the end of the month?

The remittance advice (RA) provides a list of paid, denied, adjusted, and in-process claims. A new RA is available in ProviderOne each Friday for claims submitted during the previous week by the Tuesday, 5 p.m. deadline. More information about how to download and view the RA can be found in the Viewing Claim Status and Payments Guide.

94. Why did I receive a Vendor Overpayment Notice from the Office of Financial Recovery (OFR)?

If you receive a vendor overpayment notice from OFR, this means that you voided one or more paid claims and/or an adjustment was made to one or more paid claims and the void/adjustment created an overpayment. Voiding a claim always results in an overpayment. Adjusting a claim results in an overpayment if the new paid amount is less than the original paid amount. If you have questions on why your claims were adjusted, contact the client's authorizing case manager. If you voided a claim but didn't mean to, you can resubmit the claim by following the 'Resubmit Denied or Voided Claims sections' in the ProviderOne for Social Services Billing Guides.

95. A change on my authorization created an overpayment for me. What do I do?

Contact the client's authorizing case manager. The case manager will explain why the authorization changed to create the overpayment and can assist you with adjusting/reprocessing any claims if needed.

96. What if I disagree with an overpayment?

You will find details on requesting an administrative hearing on your Vendor Overpayment Notice. If you would like to request an administrative hearing, you must do so within 28 days of receipt of the notice.

97. I was told the claims were fixed and I don't think I have an overpayment. Who do I contact?

Even if the claim was "fixed" or corrected, if the adjustment caused a decrease in the original paid amount, a debt or overpayment was incurred. You may contact the client's authorizing case manager with any questions.

98. How do I pay my overpayment? Can I make payment arrangements?

Mail payment to the address listed on your Vendor Overpayment Notice within 20 days after receipt of the notice. To discuss payment arrangements, please contact OFR. Contact information can be found on the overpayment notice.

99. I've been making payments towards my overpayment. How much do I still owe?

Office of Financial Recovery (OFR) sends monthly statements showing account payments and balances for your records. Contact OFR with any questions about your statement and current balance.

100. What happens if I don't pay my overpayment?

Once you receive a Vendor Overpayment Notice, payment is due 20 days after the receipt of the notice. If the overpayment is not paid, involuntary collection may be taken against you. OFR has the ability to collect an overpayment debt by:

- Reducing your future ProviderOne payments
- Liens or foreclosures
- Distraint or seizure and sales against your personal property

- Order to withhold and deliver
- Any other collection action available to OFR to satisfy the overpayment debt (RCW 43.20B.675).

OFR may also charge interest, and any costs associated with the collection of an overpayment (RCW 43.20B.695).

101. My overpayment was set up to go against my future claims, why am I still getting a statement?

OFR sends monthly statements showing account payments and balances for your records. Contact OFR with any questions about your statement.

102. What do the terms 'NOC Invoice' and 'NOC Referred to CARS' on my Remittance Advice (RA) mean?

If you see 'NOC Invoice' and 'NOC Referred to CARS' on your RA, this means you have an overpayment, and the overpayment was referred to the Office of Financial Recovery (OFR) for collection.

- NOC - Non-Offset to CARS
- CARS - Collections and Accounts Receivable System. This is the system OFR uses to track overpayments.
- NOC Invoice – will post together with a 'NOC Referred to CARS' line when the overpayment was referred to OFR and an invoice created.
- NOC Referred to CARS - occurs when a voided claim or an adjusted claim results in a non-offset overpayment referred to OFR's Collection and Accounts Receivable System (CARS) for recovery.

The adjusted TCN that caused the overpayment will be listed next to the 'NOC Invoice' and NOC Referred to CARS' messages. You can search for that TCN on the RA and/or in ProviderOne to view the adjustment reason code. You will receive a Vendor Overpayment Notice from OFR within a few days of seeing this message on your RA. If you have questions on why your claims were adjusted, review the overpayment notice or contact the client's authorizing case manager. See the Viewing Claim Status and Payments Guide for more information.

103. Is there a way to pay my overpayments via electronic funds transfer or have payments taken out of future claims?

While payments cannot be paid via electronic funds transfer, overpayment recoveries may be taken from future claims through a process called 'Offset'. Call or e-mail OFR to request your overpayment be turned to 'Offset'. ProviderOne will then deduct the debt from future claims until satisfied over a six month period. The Adjustment Summary on your Remittance Advice (RA) reflects the deductions each month. If the debt is not satisfied within six months, the debt will be referred back to OFR and you will then need to work with OFR on making continued payments to pay off the debt.

Tax information

104. How do I get my tax information from the prior year?

DSHS mails out tax forms via U.S. Mail. Forms are mailed by January 31 each year. If you are a Social Services Provider who receives payment through ProviderOne and have not received your 1099 tax form by mid-February, please email the appropriate contact:

- DSHS Social Services Adult Family Homes (AFHs), contact 1099reporting@hca.wa.gov
- DSHS Social Services Providers (other than AFHs), contact taxinfo@dshs.wa.gov
- Individual providers/caregivers working for Consumer Direct Care Network Washington (CDWA) or a home care agency should contact CDWA or the home care agency for a copy of their tax documents.

105. I am an AFH owner, and I live in the same household as my client. Where can I find more information about IRS Notice 2014-7: Difficulty of Care Payments Excludable from Income for Washington State?

Please see the IRS FAQ related to this issue. Providers may reach out to the IRS for more information.

Additional resources

- Contact information
- Contact us online form
- ProviderOne for Social Services webpage
- Getting Started and Billing Essentials Guide
- Submitting and Adjusting Social Services Claims Guide
- Submitting and Adjusting Social Services Medical Claims Guide
- Viewing Claim Status and Payments Guide
- FAQ: ProviderOne setup and payment information for new providers

Acronyms

AAA - Area Agency on Aging
CR - Client responsibility
DSHS - Department of Social & Health Services
EFT - Electronic funds transfer
HCA - Health Care Authority
MCO - Managed Care Organization
OFR - Office of Financial Recovery
RA - Remittance Advice
TCN - Transaction Control Number (also known as the claim number)