

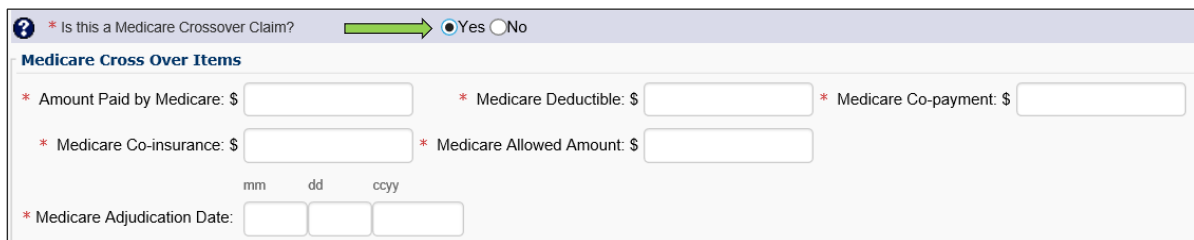
Submitting professional crossover claims with secondary insurance electronically to ProviderOne

The Health Care Authority (HCA) offers a process for providers to submit crossover and secondary insurance claims electronically. The ProviderOne system has a Direct Data Entry (DDE) feature for submitting crossover claims with secondary insurance. The agency also accepts and processes HIPAA-compliant electronic batch claims that contain all the required information along with Adjustment Reason Code(s) without sending the EOB. The Medicare Advantage Plans claims need to be submitted to ProviderOne as crossover claims, as these plans are NOT processed as commercial insurance.

DDE claim – not sending the EOB:

A provider would log into their ProviderOne domain and use the **Claims Submitter** or **Super User profile**. Go to the Claims area and click the **Online Claims Entry** option, then choose **Submit Professional**. Fill in the claim information boxes, including all fields marked with a red asterisk (*) and answer all the questions required to submit a claim.

Answer the **Is this a Medicare Crossover Claim?** question as **Yes**. This will expand the Medicare Crossover area.



Yes No

Medicare Cross Over Items

* Amount Paid by Medicare: \$ * Medicare Deductible: \$ * Medicare Co-payment: \$

* Medicare Co-insurance: \$ * Medicare Allowed Amount: \$

mm dd ccyy

* Medicare Adjudication Date:

Complete all the fields marked with a red asterisk (*) using the Medicare EOB.

For secondary insurance click on the red + expander titled **Other Insurance Information**.

 **OTHER INSURANCE INFORMATION**

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

 **OTHER INSURANCE INFORMATION**

 **1 OTHER PAYER INSURANCE INFORMATION**

Enter the **Payer/Insurance Organization Name**.

Expand the **Additional Other Payer Information** section and fill in the insurance company **ID number** and use the dropdown to complete the **ID Type**.

When billing the claim, always use the insurance carrier code as the ID number. The ID Type will always be **PI-Payor Identification**. The insurance carrier code can be found under the **Coordination of Benefits Information** section when doing a client eligibility check using the ProviderOne portal.

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

Next enter the amount paid by the insurance in the **COB Payer Paid** field. If the insurance applied to deductible, enter a zero here. If the insurance denied the claim, enter a zero in this field.

Note: If you will be faxing or mailing the Insurance EOB, stop after entering the insurance payment in COB Payer Paid Amount.

Next expand the **Claim Level Adjustments** area by clicking the red +. Use the dropdown to enter the **Group Code**, the **Reason Code** (HIPAA reason code only), and the dollar **Amount** associated.

CLAIM LEVEL ADJUSTMENTS

1	* Group Code:	<input type="text"/>	* Reason Code:	<input type="text"/>	* Amount:	<input type="text"/>	Quantity:	<input type="text"/>
2	Group Code:	<input type="text"/>	Reason Code:	<input type="text"/>	Amount:	<input type="text"/>	Quantity:	<input type="text"/>
3	Group Code:	<input type="text"/>	Reason Code:	<input type="text"/>	Amount:	<input type="text"/>	Quantity:	<input type="text"/>
4	Group Code:	<input type="text"/>	Reason Code:	<input type="text"/>	Amount:	<input type="text"/>	Quantity:	<input type="text"/>
5	Group Code:	<input type="text"/>	Reason Code:	<input type="text"/>	Amount:	<input type="text"/>	Quantity:	<input type="text"/>

Finish entering all other claim data and complete the **Basic Service Line Item** information fields. With HIPAA 5010 implementation, the Medicare data for each service line is also required. Click the red + expander and open the **Medicare Crossover Items** section.

BASIC SERVICE LINE ITEMS

* Service Date From:	<input type="text"/>	<input type="text"/>	<input type="text"/>	* Service Date To:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Place of Service:	<input type="text"/>						
* Procedure Code:	<input type="text"/>						
* Submitted Charges: \$	<input type="text"/>						
* Units:	<input type="text"/>						
Modifiers: 1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>
Diagnosis Pointers: * 1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>

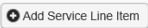
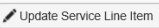
Medicare Crossover Items

Fill in the totals of the Medicare data specific to the service line that is being entered. The amounts you enter on the service line for Medicare payments must equal the total Medicare payment you entered above.

Medicare Crossover Items

* Medicare Deductible: \$	<input type="text"/>	* Medicare Co-insurance: \$	<input type="text"/>	* Medicare Co-payment: \$	<input type="text"/>
* Medicare Paid: \$	<input type="text"/>				
* Medicare Allowed Amount: \$	<input type="text"/>				
* Medicare Paid Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>		

After completing all the service line information, add the service line item(s) to the claim so they are displayed by clicking the **Add Service Line Item** button.

Previously Entered Line Item Information

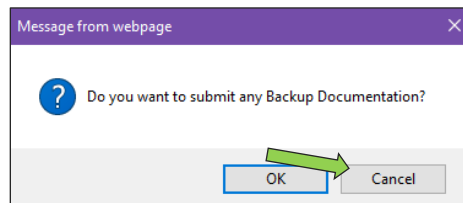
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 150.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/02/2017	01/02/2017	99214					1				150	1		Delete or Other Service Info

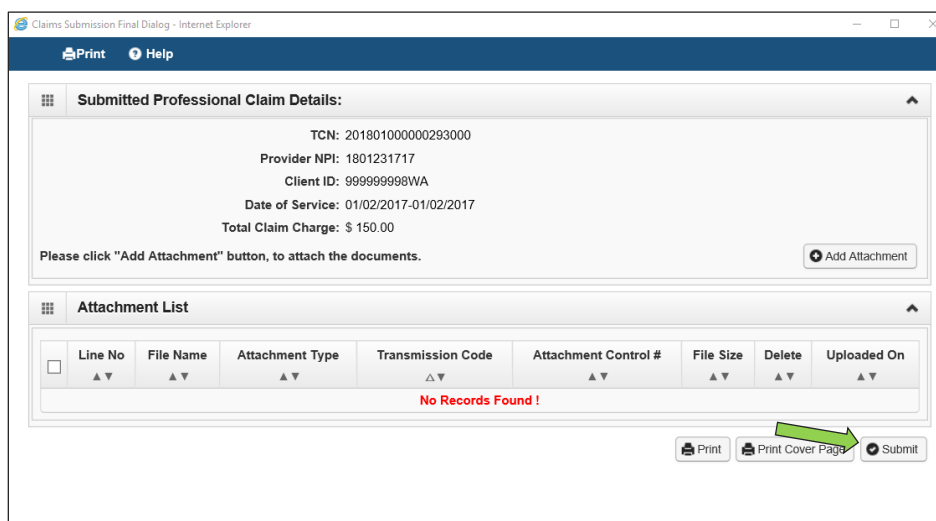
All Medicare, commercial insurance, and claim data is now added to your claim. Click on the **Submit Claim** button at the top of the claim screen to submit the claim.




Since all Medicare and commercial insurance information has been entered, you can click **Cancel** when the backup documentation dialogue box appears.



On the Submitted Professional Claim Details page, you must click the final **Submit** button to finalize the claim.



You do not have to send the insurance or Medicare EOB with claims entered using this method!



Note: Split out lines Medicare paid on into a crossover claim and the denied lines into a non-crossover claim, depending on how Medicare processed the claim. Also use this method to submit a claim when all services were paid by Medicare but denied by the insurance company.

HIPAA Batch Claims

Providers can send batch E-claims to the agency if they are HIPAA compliant claims with all the required data elements. Contact hipaa-help@hca.wa.gov for detailed information.

- Visit our [HIPAA web page](#)
- Visit our [ProviderOne resources](#) web page for more training tools
- Complete step by step instructions for submitting DDE claims can be found in the [ProviderOne Billing and Resource Guide](#)