Medicaid billing workshop for dental providers
Who is Provider Relations and what do we do?

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

- Medicaid is no longer managed by DSHS
- Medicaid is managed by the Health Care Authority
- “Apple Health” is the new name for Medicaid
Medicaid purchasing

How Medicaid purchases care

Fee for Service program | Managed Care

HCA’s goal is to have the majority of Medicaid clients on Managed Care. “Migration” to the plans started July 2012.
Eligibility programs

For a complete listing of BSP, visit the ProviderOne Billing and Resource Guide.
Accessing ProviderOne
Before logging into ProviderOne:

- Make sure you are using one of the following and your popup blockers are turned OFF:

<table>
<thead>
<tr>
<th>Computer operating systems</th>
<th>Internet browsers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Windows</td>
<td>Edge</td>
</tr>
<tr>
<td>• 10</td>
<td>• 101.0.1210.39</td>
</tr>
<tr>
<td>• 11</td>
<td></td>
</tr>
<tr>
<td>Macintosh</td>
<td>Google Chrome</td>
</tr>
<tr>
<td>• OS 11 Big Sur</td>
<td>• 101.0.4951.64</td>
</tr>
<tr>
<td>• OS 12 Monterey</td>
<td>• 55.0.2883</td>
</tr>
<tr>
<td></td>
<td>Firefox</td>
</tr>
<tr>
<td></td>
<td>• 100.0</td>
</tr>
<tr>
<td></td>
<td>Safari</td>
</tr>
<tr>
<td></td>
<td>• 15.4</td>
</tr>
<tr>
<td></td>
<td>• 12.0.1</td>
</tr>
</tbody>
</table>
ProviderOne address and login

➢ Use web address https://www.waproviderone.org

➢ Ensure that your system “Pop Up Blockers” are turned “OFF”.

➢ Login using assigned Domain, Username, and Password.

➢ Click the “Login” button.

If you are a system administrator for your domain and need assistance on setting up users, visit the how do I access ProviderOne webpage.
Eligibility & billing processes
How to obtain eligibility in ProviderOne

➢ Select the proper user profile.

➢ Select Benefit Inquiry under the Client area.
Eligibility search criteria

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

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

Basic client detail returned, including ID, gender, and DOB. The eligibility information can be printed out using the Printer Friendly Version link in blue.
Client eligibility spans

After scrolling down the page, the first entry is the **Client Eligibility Spans** which show:

- The eligibility program (CNP, ABP, etc.) and date span.

<table>
<thead>
<tr>
<th>Insurance Type Code</th>
<th>Recipient Aid Category (RAC)</th>
<th>Benefit Service Package</th>
<th>Eligibility Start Date</th>
<th>Eligibility End Date</th>
<th>Review End Date</th>
<th>ACES Coverage Group</th>
<th>ACES Case Number</th>
<th>Retro Eligibility</th>
<th>Delayed Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC: Medicaid</td>
<td>1201</td>
<td>ABP</td>
<td>03/01/2022</td>
<td>12/31/2999</td>
<td>04/30/2024</td>
<td>N05</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Some sections of the eligibility screens do not apply to dental providers such as Managed Care Information and Restricted Client Information.

Note: Occasionally the Medicare Information section will be utilized by a dental provider if the patient has a Medicare Part C plan listed. Providers will need to verify with this plan if it covers dental and if so, bill them as primary.
Coordination of benefits detail

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

If you don’t see a client’s commercial insurance information in ProviderOne, complete a Contact Us email. Choose “I am an Apple Health (Medicaid) biller or provider” and then choose the “Medical Provider” button. On the “Select Topic” dropdown, choose “Private Commercial Insurance.” Enter the client’s insurance information in the “Other Comments” section. The client’s file will be updated using this information. Check eligibility again in 3 to 5 business days to verify the update occurred. Only after verification of this information in ProviderOne should you bill the claim to the system.
Developmental disabilities

➢ Developmental Disabilities (DD) Client
  • Segment is labeled Developmental Disability Information.
  • It will show the start and end date.
  • If current, there will be an open-ended date with 2999 as the year.

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

➢ Foster Care Information
  • Client’s Medical Records History is available.
  • There is an extra button at the top of the eligibility screen.

➢ Click the **Medical Records** button to see:
  o Pharmacy services claims
  o Medical services claims (**includes dental**)
  o Hospital services claims

➢ See the [ProviderOne Billing and Resource Guide](#) for complete details. Web address is on the last slide.
Foster care medical records

- Foster Care Client’s Medical Records History shows claims paid by ProviderOne.

- Sort by using the “diamonds” under each column name.
- Search by using the “Filter by Period” boxes.
- If there are more pages of data use the Next or Previous buttons.
- If there is no data for the section, it will display “no records found.”
Gender and date of birth updates

Verified with ProviderOne system staff as of 01/27/14:

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

Coverage status can change at any time:

- Verify coverage for each visit.
- Print the Benefit Inquiry result.
- If eligibility changes after this verification, HCA will honor the printed screen shot.
  - Exception: Client with commercial insurance carrier that is loaded after you verify eligibility; commercial insurance must be billed first.
Direct data entry (DDE) claims

Fee for service claims and commercial insurance secondary claims
After this training, you can:

➢ Submit fee for service DDE claims

➢ Create and Submit TPL secondary claims DDE
  • With backup
  • Without backup
Using the portal to submit claims

➢ ProviderOne allows providers to enter claims directly into the payment system.

➢ All claim types can be submitted through the DDE system:
  • Professional (CMS 1500)
  • Institutional (UB-04)
  • Dental (ADA Form)

➢ Providers can CORRECT and RESUBMIT denied or previously voided claims.

➢ Providers can ADJUST or VOID previously paid claims.
Determine what profile to use

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

➢ At initial login:

➢ And in the portal:

Note: Using “My Inbox” to change profiles, takes you back to the main profile screen.
Online claims entry

➢ From the Provider Portal select the Online Claims Entry option located under the Claims heading.
Choose claim type

Choose the type of claim that you would like to submit with the appropriate claim form:

• Professional – CMS 1500
• Institutional - UB04
• Dental - 2012 ADA
## Dental Claim

**Basic Claim Info**

**Other Claim Info**

### Billing Information

Go to "Other Claim Info" to enter information for providers other than the Referring provider.

#### Billing Provider

- **Provider NPI:**
- **Taxonomy Code:**

*Is the Billing Provider also the Rendering Provider?* [Yes] [No]

#### Subscriber/Client Information

**Subscriber/Client**

- **Client ID:**

**Additional Subscriber/Client Information**

**Other Insurance Information**

#### Claim Information

Go to "Other Claim Info" to enter additional claim information not displayed on this page.

**Claim Data**

- **Patient Account No.:**
- **Service Date:**
- **Place of Service:**

**Additional Claim Data**

**Diagnosis Codes**
DDE claim form – bottom half
Billing provider information

➢ Section 1: Billing Provider Information

Dental Claim

Note: asterisks (*) denote required fields.

Basic Claim Info | Other Claim Info
Billing Provider | Subscriber | Claim | Service

PROVIDER INFORMATION

Go to Other Claim Info to enter information for providers other than the Referring provider.

BILLING PROVIDER

* Provider NPI: ___________________________  * Taxonomy Code: ___________________________

* Is the Billing Provider also the Rendering Provider?  ○ Yes ○ No
Enter billing provider information

➢ Enter the Billing Provider NPI and Taxonomy code:
  • This will likely be the NPI and Taxonomy Code of the clinic/office where the service was performed and where you would like payment to be received.
Enter rendering provider information

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

* Is the Billing Provider also the Rendering Provider?  

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

* Is the Billing Provider also the Rendering Provider?  

**RENDERING (PERFORMING) PROVIDER**

* Provider NPI:  

* Taxonomy Code: 
Subscriber/client information

➢ Section 2: Subscriber/Client Information
Enter client ID

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

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

➢ Once the field is expanded enter the patient's Last Name, Date of Birth, and Gender.
  • Date of birth must be in the following format: MM/DD/CCYY.
Insurance other than Medicaid

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

➢ Then open up the “1 Other Payer Insurance Information” section by clicking on the red + expander.

Note: If the client has a Managed Medicare or Medicare Part C plan that includes dental coverage, bill the Part C payment in the Other Insurance Information area as shown on the following slides.
Other payer information

➢ Enter the Payer/Insurance Organization Name.

➢ Open up the “Additional Other Payer Information” section by clicking on the red + expander.
Insurance carrier code ID

➢ In the “Additional Other Payer Information” section fill in the following information:

➢ The next slide shows where to get the ID number.
Finding the carrier code

➢ Use the **Carrier Code** for the insurance found on the client eligibility screen under the Coordination of Benefits Information section as the **ID** number for the insurance company.
Enter primary payment

➢ Enter the total amount paid by the commercial private insurance.

Note: If you will be sending in the Insurance EOB via fax/mail, stop here.

➢ If the claim is for an insurance denial or insurance applied to the deductible, enter a 0 here.
Enter adjustment reason

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

Note: The agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the X12 organization’s [website](#).

➢ Enter the adjustment **Group Code**, **Reason Code** (number only), and **Amount**.
Claim information

➢ Section 3: Claim Information Section

CLAIM INFORMATION

Go to Other Claim Info to enter additional claim information not displayed on this page.

CLAIM DATA

Patient Account No: 123456

* Service Date: 03 10 2015

* Place of Service: 11-OFFICE

Additional Claim Data

Diagnosis Codes

PRIOR AUTHORIZATION

CLAIM NOTE

* Is this claim accident related? Yes No
Patient account number

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

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

➢ Enter the date of service here. This date will be placed on all lines of the claim.
  • The **Service Date** must be entered in the following format: MM/DD/CCYY.
With 5010 implementation, the **Place of Service** box has been added to the main claim section. Choose the appropriate **Place of Service** from the drop down.

**Place of Service:**

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

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

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

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

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

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

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

➢ Claim notes should be used only if noted in the program related billing guide.

➢ For commercial insurance, as long as there is an attachment included or the insurance information is completed in the required fields, a **Claim Note** is not necessary.

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

➢ This question will always be answered **NO**. Washington Medicaid has a specific casualty office that handles claims where another casualty insurance may be primary.
  • The casualty office can be reached at 1-800-562-3022.
Basic service line items

➢ Section 4: Basic Line Item Information

### Basic Line Item Information

Click on the Other Svc. Info link associated with each added Service Line Item to enter line item information other than that displayed on this page.

#### Basic Service Line Items

- Procedure Code: 
- Submitted Charges: $
- Place of Service: 
- Modifiers: 1, 2, 3, 4

#### Diagnosis Pointers

#### Tooth Information

- Procedure Count/Units: (Billing for anesthesia? Please indicate minutes here.)
- Service Date: mm dd ccyy
- Appliance Placement Date: mm dd ccyy
- Oral Cavity Designation: 1, 2, 3, 4, 5

#### Prior Authorization

#### Additional Service Line Information

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

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $0.00

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Proc. Code</th>
<th>Submitted Charges</th>
<th>Modifiers</th>
<th>Diagnosis Petra</th>
<th>Oral Cavity</th>
<th>Units</th>
<th>Service Date</th>
<th>Appliance Placement</th>
<th>Tooth/Surface</th>
<th>PA Number</th>
</tr>
</thead>
</table>
Procedure code and charges

➢ Enter the **Procedure Code** using current codes listed in the coding manuals.

![Procedure Code field]

➢ Enter the **Submitted Charges**. If the dollar amount is a whole number, no decimal point is needed.

![Submitted Charges field]

**Note:** The agency requests that providers enter their usual and customary charges here. If providers have billed a commercial insurance, please enter the same charges here as billed to the primary. If a provider is billing a service that required prior authorization, please enter the same amount you requested on the authorization because these amounts **must** match.
Other service line info

➢ Optional - Place of Service Code (not required – already entered at the Claim Level).

➢ Modifiers and Diagnosis codes are not required on dental claims.
Tooth number information

➢ Tooth Number

• If the service requires tooth information, click on the + to expand this section.

• Enter the tooth number/letter.
• Use single digits (unless a supernumerary tooth).
• Enter tooth surface(s) if required.
• Only add one tooth per service line!
Service line units

➢ Enter procedure **Units**. At least one unit is required.
  • **DO NOT** enter minutes in this box.

➢ If billing two different dates of service on the same claim, enter the second date here (applied to this line only).
  • For orthodontic services, enter the banding date in the Appliance Placement Date field.

➢ If the second date entered at the line is before the date entered at the claim level, you will receive the following error:
Oral area designation

➢ If the service requires a HIPAA oral area designation:
  • Click on the appropriate **Arch designation**; or
  • Click on the appropriate **Quadrant designation**.

➢ Only indicate one oral area per service line.
Basic service line items

➢ If a **Prior Authorization** number needs to be added to a service line, click on the red + to expand the Prior Authorization area.

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

➢ The Additional Service Line Information is not needed for claims submission.
Add service line items

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

➢ Be sure all necessary claim information has been entered before clicking the Add Service Line Item button to add the service line to the claim.

➢ Once the procedure line item is added, ProviderOne will refresh and return to the top of the claim form.
Add additional service line items

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

➢ Follow the same procedure as outlined above for entering data for each line.
Update service line items

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

Note: Once the line number is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the Service hyperlink to quickly return to the service line item boxes and make corrections.
Once the service line is corrected, click on the **Update Service Line Item** button to add corrected information on the claim.

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

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

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

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

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

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

![Message from webpage](image)

Do you want to submit any Backup Documentation?

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

Note: If all insurance information has been entered on the claim, it is not necessary to send the insurance EOB with the claim.
Submit claim for processing – no backup

➢ ProviderOne now displays the **Submitted Dental Claim Details** screen.

➢ Click on the **Submit** button to finish submitting the claim!
Submit claim for processing – with electronic file attached

➢ The Claim’s Backup Documentation page is displayed.

- Enter the **Attachment Type**.
- Pick one of the following Transmission Codes:
  - EL- Electronic Only or Electronic file
  - Browse to find the file name
- Click the **OK** button.
Submit claim for processing – electronic file attached

➢ The Submitted Dental Claim Details page is then displayed.

➢ Click the Submit button to submit the claim!
Submit claim for processing – mailing or faxing backup

➢ The Claims Backup Documentation page is displayed.

• Enter the **Attachment Type**.
• Pick one of the following Transmission Codes:
  - **BM** - By Mail; or
  - **FX** – Fax.
• Click the **OK** button.
Submit claim for processing – cover page for mailing or faxing backup)

➢ If sending paper documents with the claim, at the Submitted Dental Claim Details page, click on the Print Cover Page button.
Submit claim for processing – with backup

➢ Fill in the TCN number received on your claim confirmation screen. Click outside this field or tab to expand the barcode.

➢ When completed click on the **Print Cover Sheet** button and mail to:

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

   **OR**

   Fax: 1-866-668-1214
Submit claim for processing – with backup (mailing or faxing backup)

➢ Now push the Submit button to submit the claim!
Saving and retrieving a direct data entry claim
Saving a DDE claim

- ProviderOne now allows a provider to save a claim if the provider is interrupted during the process of entering.
- Provider retrieves the saved claim to finish it and submit the claim.
- The following data elements are the minimum required to be completed before a claim can be saved:

<table>
<thead>
<tr>
<th>Section 1: Billing Provider Information</th>
<th>Section 2: Subscriber/Client Information</th>
<th>Section 3: Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider NPI</td>
<td>Client ID number</td>
<td>Is this claim accident related?</td>
</tr>
<tr>
<td>Billing Provider Taxonomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[?] Is the Billing Provider also the Rendering Provider?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Saving a DDE claim (cont.)

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

![Provider Portal Claim Submission](image)

➢ ProviderOne now displays the following confirmation box:

![Message from webpage](image)

➢ Click the **OK** button to proceed or **Cancel** to return to the claim form.

➢ Once the **OK** button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.

➢ If all data fields are completed, ProviderOne saves the claim and closes the claim form.
Retrieving a saved DDE claim

➢ At the Provider Portal, click on the **Retrieve Saved Claims** hyperlink.
Saved claims list

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

- The system loads the saved claim in the correct DDE claim form screen.
  - Continue to enter data, then submit the claim.

- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claim List.
Claim inquiry
Claim inquiry search data

➢ How do I find claims in ProviderOne?
  • Choose **Claim Inquiry**

➢ Enter search data then click **Submit**.
Claim inquiry list

➢ Claim TCN’s are returned:
  • Click on a TCN number to view the claim data.
    o Denied claims will show the denial codes.
    o Easiest way to find a timely TCN number for rebilling.
Why can’t I pull up my claim?

➢ There are many reasons why you might not be able to retrieve a claim (for any system functions):

- If the claim was adjusted - you can’t retrieve a claim that has already been adjusted.
- It has been replaced by another claim.
- It hasn’t finished processing.
- It was billed under a different domain.
- You could be using the wrong profile.
- Trying to do a resubmit on a paid claim or an adjustment on a denied claim.
- Claims you billed with an NPI not reported in ProviderOne.
- Claims you billed with an ID only rendering provider NPI number as the pay-to provider.
Timely billing
Timely billing guidelines

➢ What are the agency’s timeliness guidelines?

• The initial billing must occur within **365** days from the date of service on the claim.

• Providers are allowed **2** years in total to get a claim paid or adjusted.

• For Delayed Certification client eligibility, the agency allows **12** months from the Delayed Cert date to bill.

• Recoupments from other payer’s timeliness starts from the date of the recoupment, not the date of service.

• The agency uses the Julian calendar for dates.
What is a TCN?

**18 digit number that ProviderOne assigns to each claim received for processing. TCN numbers are never repeated.**
How do I read a TCN?

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

2nd digit-Type of Claim
- 0-Medical/Dental
- 2-Crossover or Medical

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

Example TCN: 301610465325134000

- 3 Electronic submission via batch
- 0 Medical claim
- 16 Year claim was received-2016
- 104 Day claim was received-April 13
How do I prove timeliness?

➢ Direct Data Entry (DDE) Claims
  • Resubmit Original Denied/Voided Claim.
  • ProviderOne will automatically detect the timely claim number as the timely TCN is now attached to the new transaction.

➢ HIPAA EDI claims
  • Submit a HIPAA batch transaction using a frequency 7 to adjust/replace the original claim or a frequency 8 to void the original claim.
Adjust or void a Claim
Adjust/void a paid claim

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

➢ Enter the **TCN** number if known; or

➢ Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.

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

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

➢ Check the box of the TCN to adjust/void.

➢ ProviderOne loads the DDE screen with the claim data.
  • Update the claim information to adjust, then submit.
  • Claim data cannot be changed when doing a void, just submit the void.
  • To resubmit a voided claim, use the credit claim TCN represented by a negative payment amount found on your remittance advice.
Resubmit denied claims
Resubmit a denied claim

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

➢ Enter **TCN**, if known; or

➢ Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.
Resubmit a denied claim (cont.)

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

➢ Check the box of the TCN to resubmit and click **Retrieve**.

➢ ProviderOne loads the DDE screen with the claim data.
  • Update the claim information that caused the claim to deny, then submit.
Templates
Creating a claim template

ProviderOne allows creating and saving templates:

• Log into ProviderOne.
• Click on the **Manage Templates** hyperlink.
• At the Create a Claim Template screen, use the dropdown to choose the **Type of Claim**.
• Click the **Add** button.
Saving a claim template

➢ Once a template type is chosen the system opens the DDE screen.

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

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

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

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

- Additional templates can be created by:
  - Copying a template on the list; or
  - Creating another from scratch.

- Templates can be edited, viewed, and deleted.
Submitting a template claim

Claims can be submitted from a Template:

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

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

➢ Enter or update the data for claim submission then submit as normal.
HIPAA transactions
HIPAA batch transactions

➢ Who can submit batch transactions to ProviderOne?
  • Anyone can as long as you or your clearinghouse have gone through testing to confirm your software is HIPAA compliant.
  • Link to HIPAA Electronic Data Interchange (EDI) web page.
HIPAA transaction resources

➢ What kinds of transactions are available?
  • All the available HIPAA transactions and their descriptions can be found at the HIPAA Electronic Data Interchange (EDI) webpage.
HIPAA transaction assistance

➢ Where do I get information:
  • [HIPAA Electronic Data Interchange (EDI) webpage](#)

➢ Contact information:
  • [hipaa-help@hca.wa.gov](mailto:hipaa-help@hca.wa.gov)
Reading the Remittance Advice (RA)
Retrieving the RA

How do I retrieve the PDF file for the RA?

• Log into ProviderOne with a **Claims/Payment Status Checker, Claims Submitter, or Super User** profile.

• At the Portal click on the hyperlink **View Payment**.

• The system will open your list of RAs.

• Click on the **RA number** in the first column to open the whole RA.
The Summary Page of the RA shows:

- Billed and paid amount for Paid claims
- Billed amount of denied claims
- Total amount of adjusted claims
- Provider adjustment activity
RA details

➢ Adjustments:

• P1Off (offset) adjustments: These adjustment amounts can carry over on each week’s RA until the amount is paid off or reduced by the amount paid out for claims adjudicated that week.
  o Claims that caused these carry over adjustment amounts can be on previous RAs.
  o Updates to the RA format now provide the parent TCN under the FIN Invoice Number for reference.

• NOC (non-offset) Referred to CARS: System-generated recoveries or adjustments that are referred to OFR for collection.
  o Updates to the RA format now provide the parent TCN under the FIN Invoice Number for reference.

➢ Retention Policy:

• Providers must keep RA’s on file for 7 years per Washington Administrative Code (WAC).
RA categories

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

➢ EOB Codes

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

<table>
<thead>
<tr>
<th>Adjustment Reason Codes / NCPDP Rejection Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>119: Benefit maximum for this time period or occurrence has been reached.</td>
</tr>
<tr>
<td>15: The authorization number is missing, invalid, or does not apply to the billed services or provider.</td>
</tr>
<tr>
<td>16: Claim service lacks information or has submission/filing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
</tr>
<tr>
<td>18: Exact duplicate claim/service (Use only with Group Code OA, except where state workers’ compensation regulations require CO)</td>
</tr>
<tr>
<td>13: Lifetime benefit maximum has been reached.</td>
</tr>
<tr>
<td>56: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Remark Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N30: Service not payable with other service rendered on the same date.</td>
</tr>
<tr>
<td>N329: Missing/incomplete/invalid patient birth date.</td>
</tr>
<tr>
<td>N37: Missing/incomplete/invalid tooth number/letter.</td>
</tr>
<tr>
<td>N39: Procedure code is not compatible with tooth number/letter.</td>
</tr>
</tbody>
</table>

➢ The complete list of standardized codes can be located on the X12 organization’s website.
Authorization
Authorization process

➢ A new feature in ProviderOne has been implemented allowing you to enter your authorization request directly into the ProviderOne portal.

➢ Step-by-step training resources have been created:
  • DDE authorization submission for dental providers

➢ Using the 13-835 General Information for Authorization form is still allowed and is covered step-by-step in the following slides.
Authorization form

1. Complete Authorization Form 13-835
2. Submit Authorization Request to the Agency with Required Back-up
3. Check the Status of a Request
4. Send in Additional Documentation if Requested by the Agency
1. Example of a completed Authorization Form 13-835:
   a) Fill (type) in all required fields as indicated on the directions page.
   b) Use the codes listed in the directions for the required fields.
   c) Add as much other detail as necessary that may help in approval.
   d) The data on this form is scanned directly into ProviderOne.
   e) Processing begins as soon as a correctly filled out form is received.

For step by step instructions visit the following resources:
- Prior authorization webpage
- ProviderOne Billing and Resource Guide
Authorization form instructions part 1

Instructions to fill out the General Information for Authorization form, HCA 13-836

<table>
<thead>
<tr>
<th>FIELD</th>
<th>NAME</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Org (Required)</td>
<td>Enter the Number that Matches the Program/Unit for the Request</td>
</tr>
<tr>
<td></td>
<td></td>
<td>501 - Dental</td>
</tr>
<tr>
<td></td>
<td></td>
<td>502 - Durable Medical Equipment (DME)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>504 - Home Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>505 - Hospice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>506 - Home Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>507 - Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>508 - Medical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>509 - Medical Nutrition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>611 - Outpatient Program (OPD)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>613 - Physical Medicine &amp; Rehabilitation (PM &amp; R)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>614 - Aging and Long-Term Care Administration (ALTSC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>616 - LTAC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>619 - Respiratory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>521 - Maternity Supportive Case Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>524 - Conventional Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>525 - ABA Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>526 - Total Rehabilitation Technology (TRT)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>527 - Chemical/Drug Abuse Program (CDAP)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>FIELD</th>
<th>NAME</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Service Type (Required)</td>
<td>Enter the letter(s) in all CAPS that represent the service type you are requesting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If you selected &quot;501 - Dental&quot; for field #1, please select one of the following codes for this field:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ASC for ASC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DEN for Dentures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DP for Dentures/Partial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EXT for Extractions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OA for General Anesthesia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GA for General Anesthesia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If you selected &quot;502 - Durable Medical Equipment (DME)&quot; for field #1, please select one of the following codes for this field:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AA for Ambulatory Acts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BB for Bath Bench</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BEV for Bath Equipment (tub/s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BGS for Bone Growth Stimulator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BRP for Blood Pressure Monitor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C for Convolal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CG for Compression Garments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CSC for Convolal/Shower Chair</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POC Billing)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER/SD for ER/SD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FF for Floor Sitter/Feeder Seat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GL for Glasses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HB for Hospital Beds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HC for Hospital Cribs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HS for Inpatient Supplies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MMN for Manual Wheelchair - Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MWF for Manual Wheelchair - NF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MVR for Manual Wheelchair Repair</td>
</tr>
</tbody>
</table>

HCA 13-836 (Rev)

HCA 13-835 (Rev)
Authorization form instructions part 2

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

<table>
<thead>
<tr>
<th>FIELD</th>
<th>NAME</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL FIELDS MUST BE TYPED.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Service Type (Required)

- If you selected '514 – Aging and Long-Term Support Administration (LTSA)' for field #1, please select one of the following codes for this field:
  - PDN for Private Duty Nursing
  - MISC for Miscellaneous

- If you selected '516 – LTAC' for field #1, please select one of the following codes for this field:
  - ERSC for ERSC-PA
  - LTAC for LTAC
  - Q for Other

- If you selected '510 – Respiratory' for field #1, please select one of the following codes for this field:
  - CPAP for CPAP/IBP/Noninvasive for Oxygen
  - ERGO for ERGO-PA
  - NEB for Nebulizer
  - OXY for Oxygen

- If you selected '521 – Maternity Support/Infant Case Management (MSI)' for field #1, please select one of the following codes for this field:
  - ICM for Infant Case Management
  - PO for Post Pregnancy Only
  - PPP for Prenatal/Post Pregnancy
  - Q for Other

- If you selected '524 – Concurrent Care' (for children on Hospice) for field #1, please select one of the following codes for this field:
  - CC for Concurrent Care Services

- Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected '525 – ABA Services' for field #1, please select one of the following codes for this field:
  - L for In/Out/Community/Office
  - USA for Day Program

- If you selected '528 – Complex Rehabilitation Technology' (CRT) for field #1, please select one of the following codes for this field:
  - FR for ERSC-PA
  - PW for Power Wheelchair - Home
  - PWNP for Power Wheelchair - NF

#### Descriptions of Service being requested

- A short description of the service you are requesting (examples: manual wheelchair, eyeglasses, hearing aid)

#### Code Qualifier (Required)

- Enter the letter corresponding to the code from below:
  - T - GTD Proc Code
  - O - OPT Proc Code
  - D - DRG
  - P - HPCPS Proc Code
  - I - ICD-9-MC Proc Code
  - R - Rev Code
  - N - NDC-National Drug Code
  - S - ICD-10 Diagnosis Code

#### National Code (Required)

- Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.

#### Modifier

- When appropriate enter a modifier.

#### Units/Days Requested

- Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Medicaid Provider Guide for the appropriate unit designation for the service code entered).

#### Amount Requested

- Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Medicaid Provider Guide and fee schedules for assistance. Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00))

#### Part # (DME only) (Required)

- Enter the manufacturer part # of the item requested.
Authorization form instructions part 3

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

<table>
<thead>
<tr>
<th>FIELD</th>
<th>NAME</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Tooth or Quad# (Required for dental requests)</td>
<td>Enter the tooth or quad number as listed below: Q100 = full mouth 01 = upper arch 02 = lower arch 10 = upper right quadrant 20 = upper left quadrant 30 = lower right quadrant 40 = lower left quadrant Tooth # 1-32, A-T, A5-T5, and S1-S2</td>
</tr>
<tr>
<td>28</td>
<td>Diagnosis Code</td>
<td>Enter appropriate diagnosis code for condition.</td>
</tr>
<tr>
<td>29</td>
<td>Place of Service</td>
<td>Enter the appropriate two digit place of service code.</td>
</tr>
</tbody>
</table>

### Field Breakdown:
- **Place of Service Codes**
  - 1: Pharmacy
  - 3: School
  - 4: Homeless Shelter
  - 5: Indian Health Service Free-standing Facility
  - 6: Indian Health Service Provider-based Facility
  - 7: Tribal 638 Free-standing Facility
  - 8: Tribal 638 Provider-based Facility
  - 9: Prison-Correctional Facility
  - 10: Office
  - 12: Home
  - 13: Assisted Living Facility
  - 14: Group Home
  - 15: Mobile Unit
  - 16: Temporary Lodging
  - 17: Walk in Retail Health Clinic
  - 19: Urgent Care Facility
  - 21: Inpatient Hospital
  - 22: Outpatient Hospital
  - 23: Emergency Room – Hospital
  - 24: Ambulatory Surgical Center
  - 25: Imaging Center
  - 26: Medical Treatment Facility
  - 31: Skilled Nursing Facility
  - 32: Nursing Facility
  - 33: Custodial Care Facility
  - 34: Hospice
  - 41: Ambulance – Land
  - 42: Ambulance – Air or Water
  - 49: Independent Clinic
  - 50: Federally Qualified Health Center
  - 51: Inpatient Psychiatric Facility

### Comments
Enter any free form information you deem necessary.
Authorizations – supporting information

2. Submit Authorization Request to the agency with Required Back-up
   a) By Fax
      – 1-866-668-1214
      – Form 13-835 must be first
   b) By Mail
      Authorization Services Office
      PO Box 45535
      Olympia, WA 98504-5535

➢ If mailing x-rays, photos, CDs, or other non-scannable items, do the following:
   • Place the items in a large envelope;
   • Attach the PA request form to the outside of the envelope;
   • Write on the outside of the envelope:
     o Client name
     o Client ProviderOne ID
     o Your NPI
     o Your name
     o Sections the request is for:
       ❖ Dental or Orthodontic

Another option for submitting photos or x-rays:

Providers can submit dental photos or x-rays for Prior Authorization by using the FastLook and FastAttach services provided by National Electronic Attachment, Inc. (NEA). Providers may register with NEA by visiting www.neafast.com and entering “FASTWDRZ1M” in the promotion code box for a 0$ registration fee and 1 month of free service. Contact NEA at 800-782-5150 ext. 2 with any questions. When this option is chosen, fax requests to the agency and indicate the NEA# in the NEA field on the PA Request Form. There is an associated cost, which will be explained by the NEA services.
Check status of an authorization request

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

➢ Select the Provider Authorization Inquiry.

For step-by-step instructions visit the following resources:
  • Prior authorization webpage
  • ProviderOne Billing and Resource Guide
Authorization status search options

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

➢ This authorization list was returned using the NPI and the Client ID.

• Do not submit multiple requests for the same client/service.
• Check on-line after 48 hours to verify the authorization request was received before resubmitting.
• The status of these requests are explained in more detail on the following slides.
Authorization request status returned

➢ The system may return the following status information:

This authorization example is in approved status. Other possible statuses of authorization requests are listed on the slide below.
The agency receives up to 4,000 requests a month (orthodontia requests up to 2,000). Currently the turnaround time is approximately 30 to 35 days.

List of statuses for authorization requests

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

For more information, visit the document submission cover sheets web page.
Spenddown
What is a spenddown?

➢ An expense or portion of an expense which has been determined by the agency to be a client liability.

➢ Expenses which have been assigned to meet a client liability are not reimbursed by the agency.

➢ Spenddown liability is deducted from any payment due the provider.

➢ Call the customer service line at 1-877-501-2233 and leave a message to request a call back from the specialized Spenddown Unit.
How does a provider know if a client has a spenddown liability?

➢ The client benefit inquiry indicating “Pending Spenddown – No Medical” looks like this:

➢ No longer pending – has MNP coverage:
What is the spenddown amount?

➢ The same eligibility check indicates the spenddown amount:

➢ The clients “award” letter indicates who the client pays.

➢ Call the customer service line at 1-877-501-2233 and leave a message to request a call back from the specialized Spenddown Unit.
How does a provider report the spenddown amount on a claim?

➢ Dental paper claim enter the spenddown:
  • In field 35, comments
  • Enter Spenddown
  • Then enter the $\$\$ amount

➢ 837D – HIPAA/EDI dental claim:
  • Enter amount in Loop 2300, data element AMT02
    o In AMT01 use the F5 qualifier
Billing a client
Background

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

The full text of WAC 182-502-0160 can be found on the Apple Health (Medicaid) manual WAC index page.
Billing a client definitions

<table>
<thead>
<tr>
<th>Healthcare Service Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>The groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's <strong>Benefit Service Package (BSP)</strong>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excluded Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>A set of services that we do not include in the client’s BSP. There is no Exception To Rule (ETR) process available for these services (e.g. Family Planning Only).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered service</th>
</tr>
</thead>
<tbody>
<tr>
<td>A healthcare service contained within a &quot;service category&quot; that is included in a medical assistance BSP as described in WAC 182-501-0060.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-covered service</th>
</tr>
</thead>
<tbody>
<tr>
<td>A specific healthcare service (e.g., crowns for 21 and older) contained within a service category that is included in a medical assistance BSP, for which the agency does not pay without an approved exception to rule (ETR) (see WAC 182-501-0160). <strong>A non-covered service is not an excluded service</strong> (see WAC 182-501-0060). Non-covered services are identified in WAC 182-501-0070 and in specific health-care program rules.</td>
</tr>
</tbody>
</table>
Agreement to Pay for Healthcare Services
WAC 182-502-0160 ("Billing a Client")

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

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

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

<table>
<thead>
<tr>
<th>CLIENT'S PRINTED NAME</th>
<th>CLIENT'S ID NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER'S PRINTED NAME</td>
<td>PROVIDER NUMBER</td>
</tr>
</tbody>
</table>

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

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

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

AGREEMENT TO PAY FOR HEALTHCARE SERVICES
HCA 13-879 (8/12)
## Sample form (cont.)

<table>
<thead>
<tr>
<th>SPECIFIC SERVICES(S) OR ITEMS(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE</th>
<th>OPTION/CPT/HCPCS CODE (BILLING CODES)</th>
<th>AMOUNT TO BE PAID BY CLIENT</th>
<th>REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)</th>
<th>COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT</th>
<th>DATE(S) ETR/PA REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncovered service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noncovered service, ETR waived</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-formulary drug, NFJ waived</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered but denied as not medically necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered, but specific type not paid for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order, prescribed, or referred by non-enrolled licensed health care professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

I AFFIRM: I understand and agree with this form’s content, including the bullet points above. CLIENTS OR CLIENT’S LEGAL REPRESENTATIVE’S SIGNATURE DATE

I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-602-0160. PROVIDER OF SERVICE(S) SIGNATURE DATE

I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above. INTERPRETER’S PRINTED NAME AND SIGNATURE DATE
When can a provider bill a client **without** form 13-879?

- The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the agency).
- Printed or copied records requested by the client. Department of Health has established a policy noted at WAC 246-08-400.
- The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a Washington Apple Health.
- The client refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill a third-party insurance carrier for a service.
- The client chose to receive services from a provider who is not contracted with Washington Apple Health.
When can a provider bill a client with form 13-879?

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

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

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

➢ The service is not covered by the agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.
When can a provider **not** bill a client?

- Services for which the provider did not correctly bill the agency.
- If the agency returns or denies a claim for correction and resubmission, the client cannot be billed.
- Services for which the Agency denied the authorization because the process was placed on hold pending receipt of requested information, but the requested information was not received by the agency. (WAC 182-501-0165(7)(c)(i)). This includes rejected authorizations, when the authorization request is returned due to missing required information.
- The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (e.g., precious metal crown vs. stainless steel).
- Services for which the provider has not received payment from the agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment; (example: billing using a diagnosis code which is not a primary diagnosis code per ICD-9).
When can a provider **not** bill a client (cont.)?

- Providers are not allowed to:
  - Balance bill a client
  - Bill a client for missed, cancelled, or late appointments
  - Bill a client for a rescheduling fee

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

- Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to:
  - Medical/dental charts,
  - Radiological or imaging films
  - Laboratory or other diagnostic test results
  - Postage or shipping charges related to the transfer
Online resources
Webpage menus

- Apple Health provider homepage
- Hover over a topic to highlight and click to expand the mega menu.
ProviderOne billing and resource guide

ProviderOne Billing and Resource Guide and webpage

ProviderOne Billing and Resource Guide

- View the complete guide
- Appendices
- Paperless billing at HCA
- Provider billing guides and fee schedules

The ProviderOne Billing and Resource Guide gives step-by-step instruction to help provider billing staff:
- Find client eligibility for services.
- Bill in a timely fashion.
- Receive accurate payments for covered services.

View the complete guide

The guide is intended to:
- Strengthen the current instructions that apply to nearly all types of providers.
- Respond to provider requests for more step-by-step reference materials for ProviderOne.

ProviderOne Billing and Resource Guide

Stay informed! Learn about changes to rates and updates to our billing guides.

Sign up / view provider alerts
Online resources for authorization

➢ Prior authorization webpage

• Contains step by step instructions

• Links to the most commonly used billing guides for services requiring authorization

• Links to prior authorization forms

• An Expedited Prior Authorization (EPA) Inventory guide
Contact us

Use the Apple Health [web form]!
Using the drop down **Select Topic**, choose **Service Limits**:

- **48 hour turnaround for Service Limit checks:**
  - Be sure to include the Date of Service (DOS)
  - Procedure Code and the date range for search
  - NPI number
Contact us – service limit

➢ Sample request for Service Limit check:

➢ Check the box at the bottom of the web form to confirm you are authorized to submit the request.
➢ Once that box is checked the Submit Request button becomes available.
Contact us submitted request

➢ Sample confirmation screen:

The confirmation screen provides your Service Request (SR) number.

➢ You can print this page for your records, as needed.
Additional resources

➢ **Dental provider webpage**
  • [Email](#) for authorization questions
  • [Email](#) for policy and rates questions

➢ **Programs and Services information**
  • [Program billing guides and fee schedules](#)
  • [Hospital rates](#)

➢ **Provider Enrollment webpage** and [email](#)

➢ **Learn ProviderOne**

➢ **HCA Forms webpage**

143