Washington State Health Care Authority

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

Accessing ProviderOne

Topics

Eligibility & Billing Processes

Resources

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

Washington State Health Care Authority

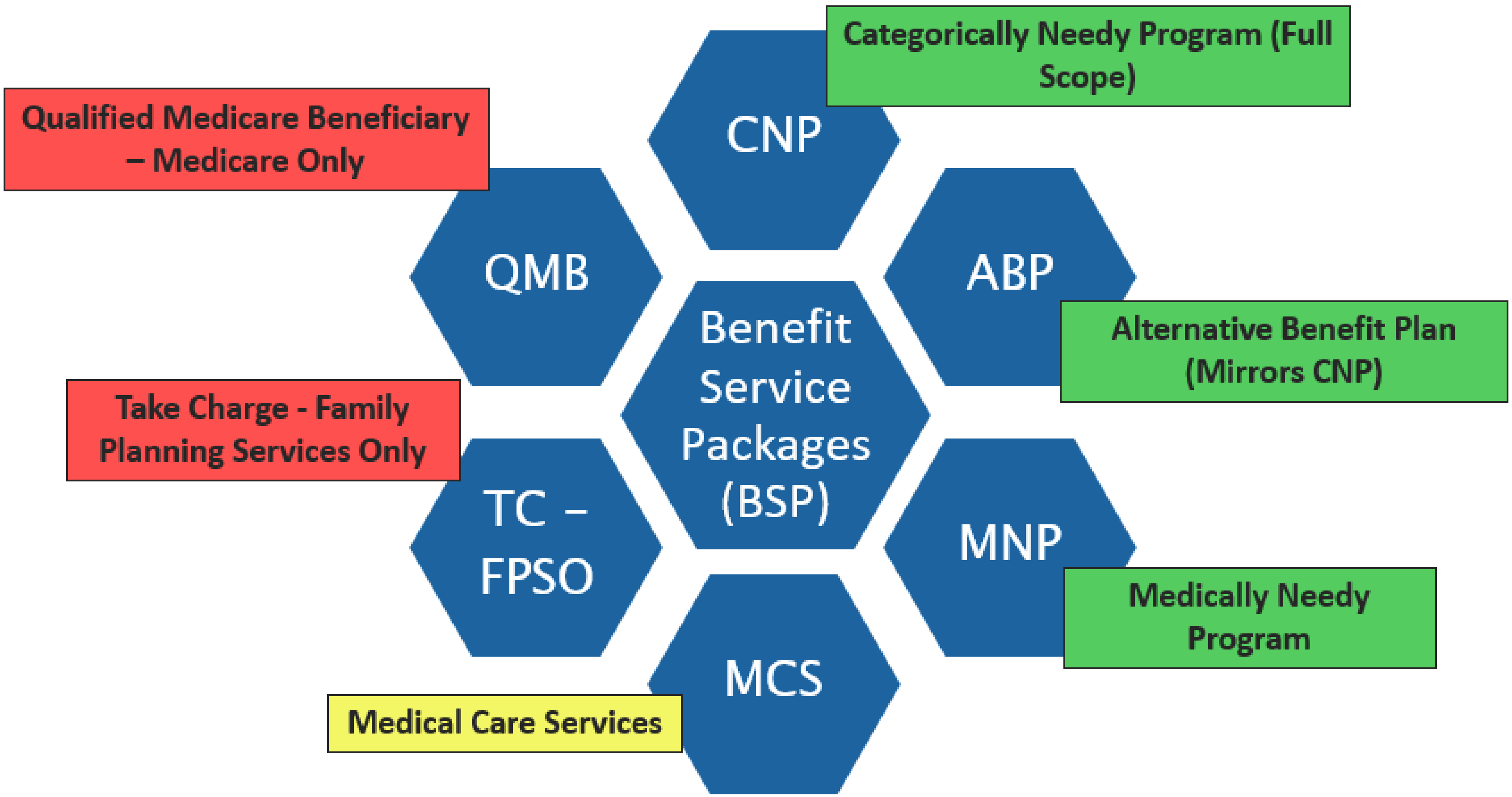
Medicaid purchasing

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

System requirements

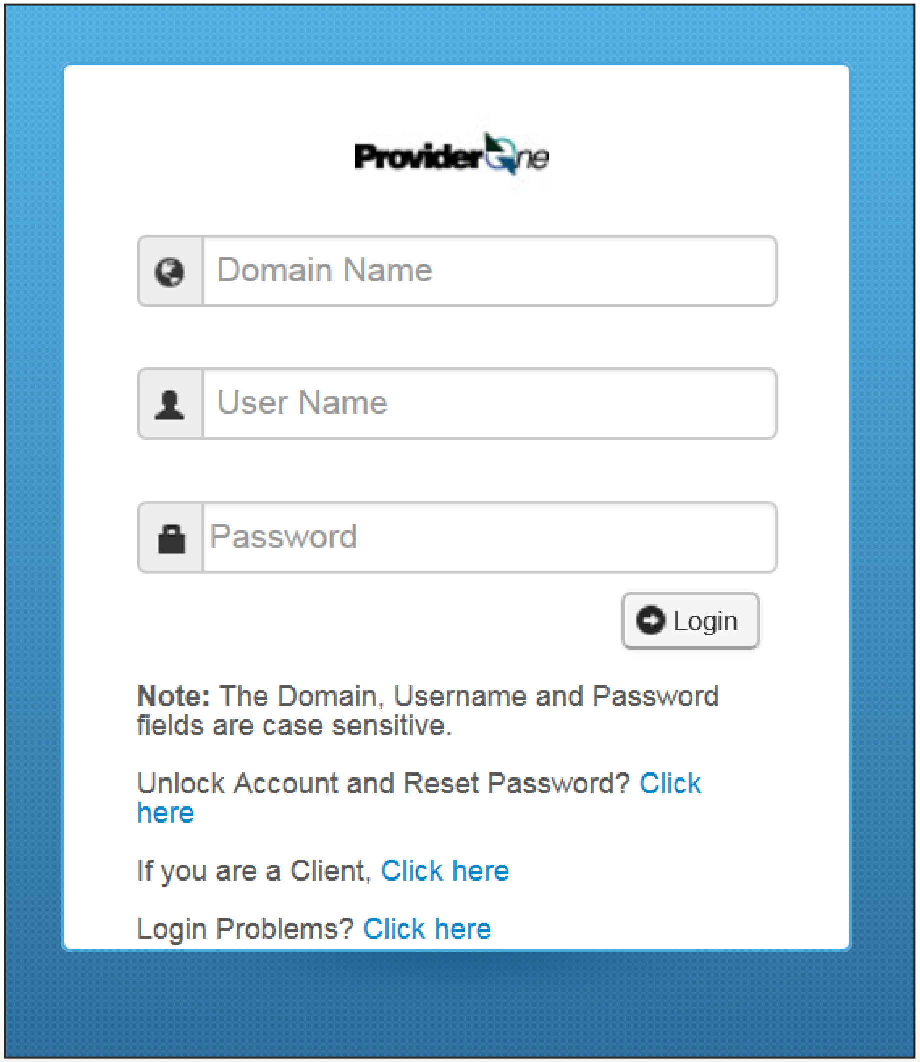
- Before logging into ProviderOne:
  - Make sure you are using one of the following and your popup blockers are turned **OFF**:

Computer operating systems	Internet browsers
Windows • 10 • 11	Edge • 101.0.1210.39
Macintosh • OS 11 Big Sur • OS 12 Monterey	Google Chrome • 101.0.4951.64 • 55.0.2883
	Firefox • 100.0
	Safari • 15.4 • 12.0.1

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.

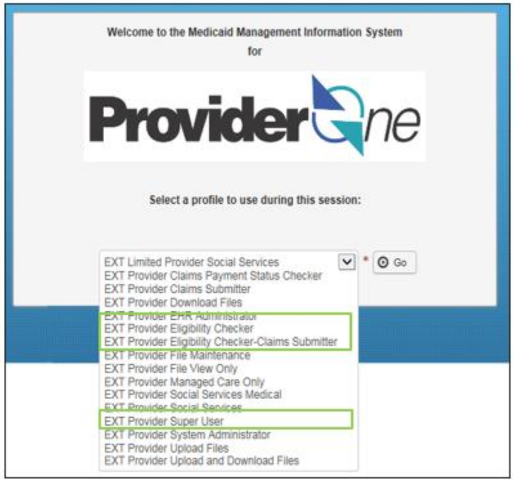
If you are a system administrator for your domain and need assistance on setting up users, visit the how do I access ProviderOne webpage.



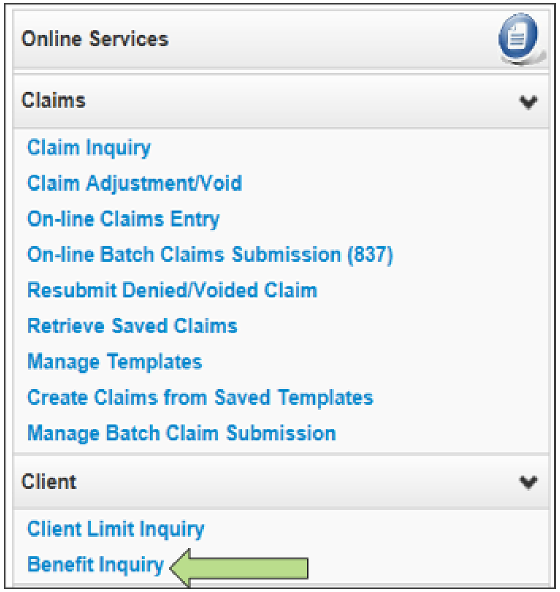
Eligibility & billing processes

How to obtain eligibility in ProviderOne

- Select the proper user profile.

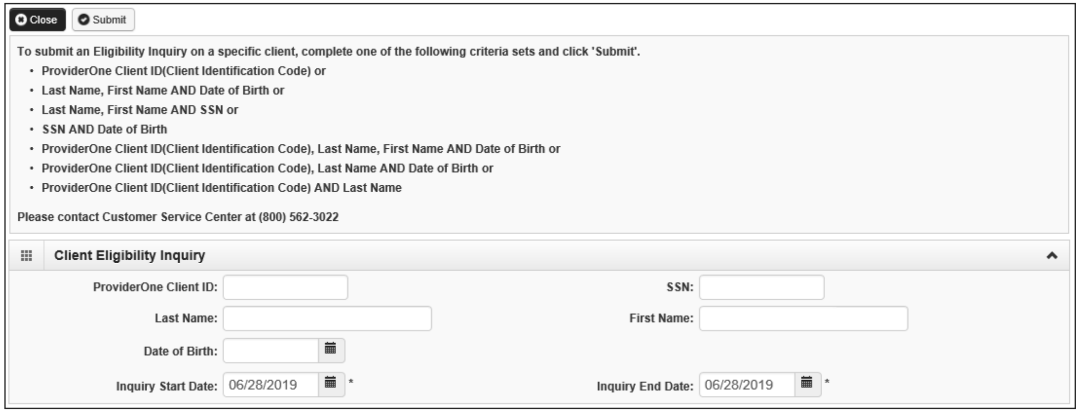


- Select Benefit Inquiry under the Client area.



Eligibility search criteria

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


Close | Submit

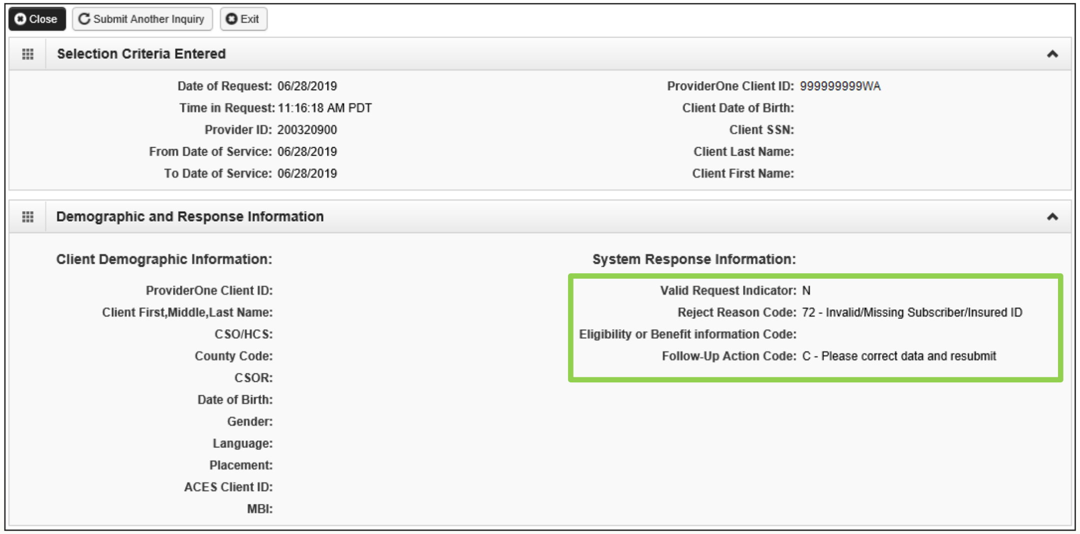
To submit an Eligibility Inquiry on a specific client, complete one of the following criteria sets and click 'Submit'.

- ProviderOne Client ID(Client Identification Code) or
- Last Name, First Name AND Date of Birth or
- Last Name, First Name AND SSN or
- SSN AND Date of Birth
- ProviderOne Client ID(Client Identification Code), Last Name, First Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code), Last Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code) AND Last Name

Please contact Customer Service Center at (800) 562-3022

Client Eligibility Inquiry

ProviderOne Client ID: | SSN:
Last Name: | First Name:
Date of Birth:
Inquiry Start Date: 06/28/2019 * | Inquiry End Date: 06/28/2019 *


Close | Submit Another Inquiry | Exit

Selection Criteria Entered

Date of Request: 06/28/2019
Time in Request: 11:16:18 AM PDT
Provider ID: 200320900
From Date of Service: 06/28/2019
To Date of Service: 06/28/2019
ProviderOne Client ID: 999999999WA
Client Date of Birth:
Client SSN:
Client Last Name:
Client First Name:

Demographic and Response Information

Client Demographic Information:

ProviderOne Client ID:
Client First,Middle,Last Name:
CSO/HCS:
County Code:
CSOR:
Date of Birth:
Gender:
Language:
Placement:
ACES Client ID:
MBI:

System Response Information:

Valid Request Indicator: N
Reject Reason Code: 72 - Invalid/Missing Subscriber/Insured ID
Eligibility or Benefit information Code:
Follow-Up Action Code: C - Please correct data and resubmit

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

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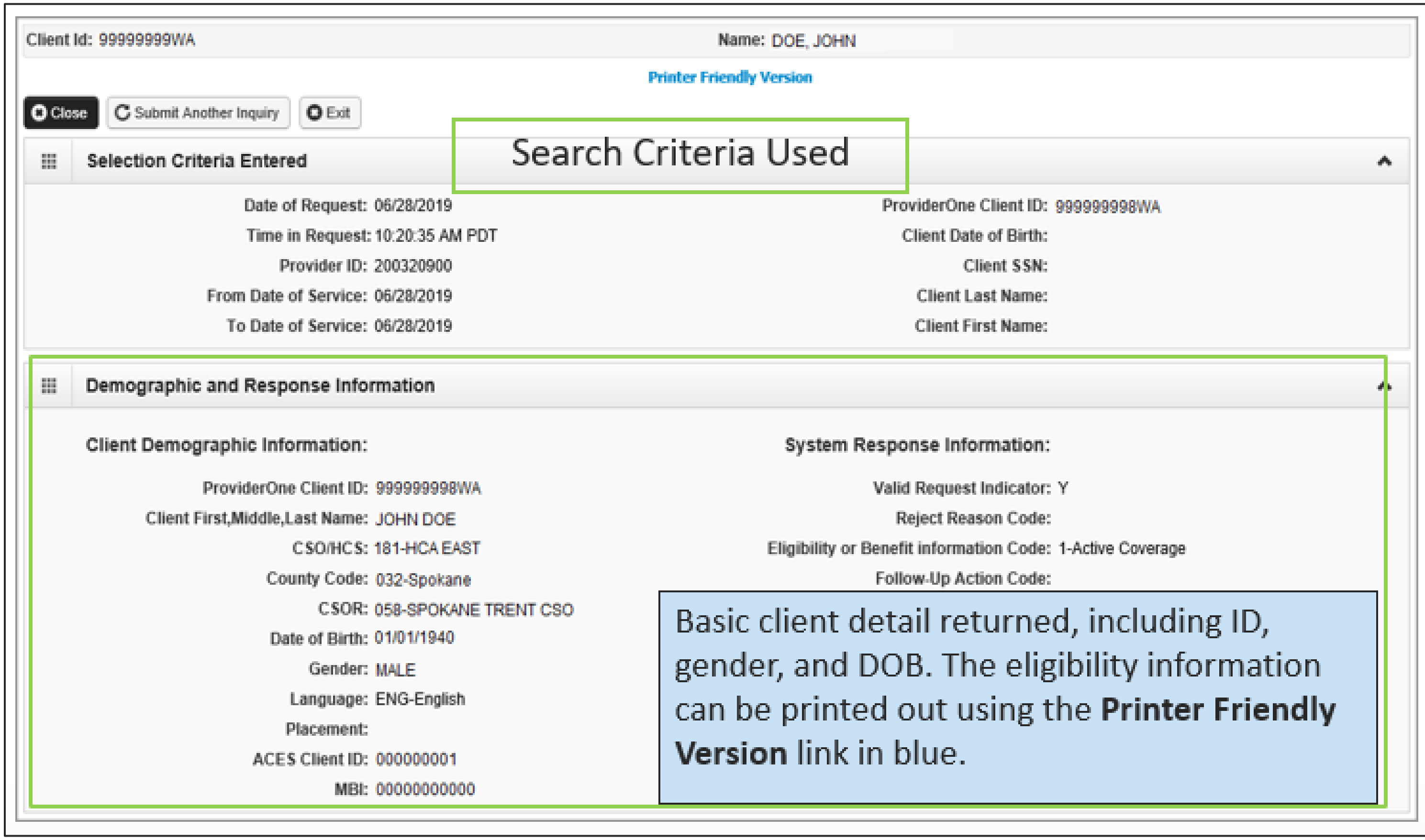
Successful eligibility check


Client Id: 99999999WA   Name: DOE, JOHN

Printer Friendly Version

Close | Submit Another Inquiry | Exit

Selection Criteria Entered

Search Criteria Used

Date of Request: 06/28/2019	ProviderOne Client ID: 999999998WA
Time in Request: 10:20:35 AM PDT	Client Date of Birth:
Provider ID: 200320900	Client SSN:
From Date of Service: 06/28/2019	Client Last Name:
To Date of Service: 06/28/2019	Client First Name:

Demographic and Response Information

Client Demographic Information:

ProviderOne Client ID: 999999998WA
Client First,Middle,Last Name: JOHN DOE
CSO/HCS: 181-HCA EAST
County Code: 032-Spokane
CSOR: 058-SPOKANE TRENT CSO
Date of Birth: 01/01/1940
Gender: MALE
Language: ENG-English
Placement:
ACES Client ID: 000000001
MBI: 00000000000

System Response Information:

Valid Request Indicator: Y
Reject Reason Code:
Eligibility or Benefit information Code: 1-Active Coverage
Follow-Up Action Code:

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.

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	Review End Date	ACES Coverage Group	ACES Case Number	Location	Estimated Release Date	Retro Eligibility	Delayed Certification
MC: Medicaid	1108	CNP	07/01/2023	12/31/2999	06/30/2026	S02					

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

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.

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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.

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	NORTHWEST ADMINISTRATORS (800) 458-3053	NW01	JANE DOE	555555555			08/01/2014	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	WASHINGTON DENTAL SERVICE (800) 537-3406	WD01	JANE DOE	555555555			08/01/2014	12/31/2999

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

- 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.

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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.

Developmental Disability Information

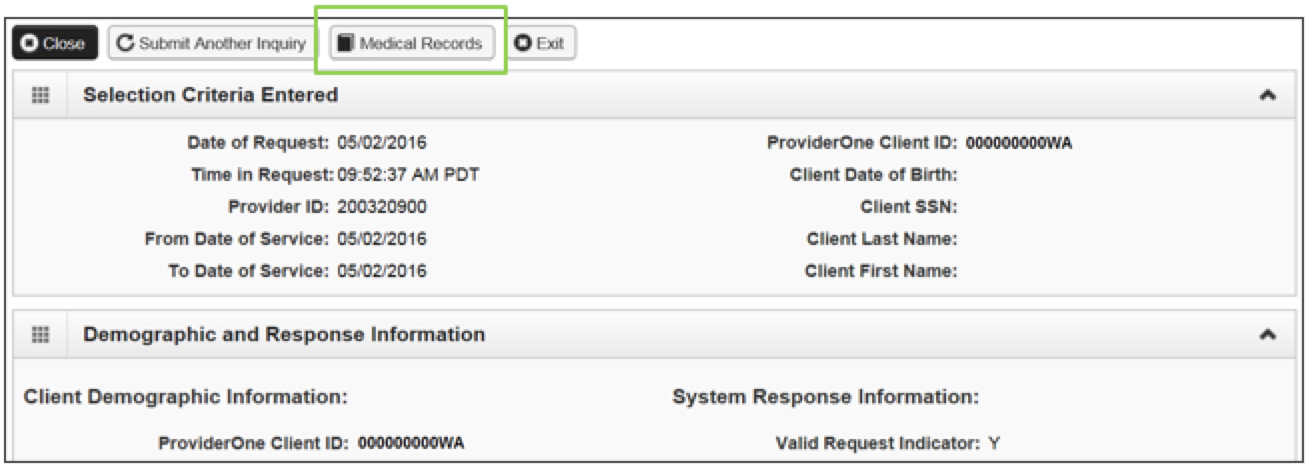
Start Date	End Date
02/04/2013	12/31/2999

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

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:
    - Pharmacy services claims
    - Medical services claims (**includes dental**)
    - 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.

Pharmacy

Filter By Period: All | Go

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
10/27/2015	GUANFACINE HCL	1 MG	60	30	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
10/23/2015	POLYETHYLENE GLYCOL 3350	0	527	30	07	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
04/13/2015	POLYETHYLENE GLYCOL 3350	0	527	30	03	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
04/02/2015	GUANFACINE HCL	1 MG	60	30	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
03/17/2015	DESONIDE	.05 %	15	7	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	

View Page: 2 | Go | Page Count | SaveToXLS — Viewing Page: 1 — First | Prev | Next | Last

Medical Services (primary and specialty care

Filter By Period: All | Go

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #
06/18/2014	06/18/2014			D0120,D1120,D1208			(206) 782-8223
06/12/2014	06/12/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049
05/29/2014	05/29/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049
05/22/2014	05/22/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049
05/21/2014	05/21/2014	3129 - Conduct disturbance NOS		90846		King County	(800) 790-8049

View Page: 11 | Go | Page Count | SaveToXLS — Viewing Page: 10 — First | Prev | Next | Last

Hospital Care

Filter By Period: All | Go

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	ER/Outpatient/Inpatient	DRG Description	Attending Provider Name	Billing Provider Name	Billing Provider Phone #
10/21/2015	10/21/2015	M6289 - OTHER SPECIFIED DISORDERS OF MUSCLE	Z4689	Outpatient		MOSCA, VINCENT	Molina Healthcare of Washington Inc	(800) 869-7165

- 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."

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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 <u>will honor</u> the printed screen shot.
    - <u>Exception</u>: 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

Washington State Health Care Authority

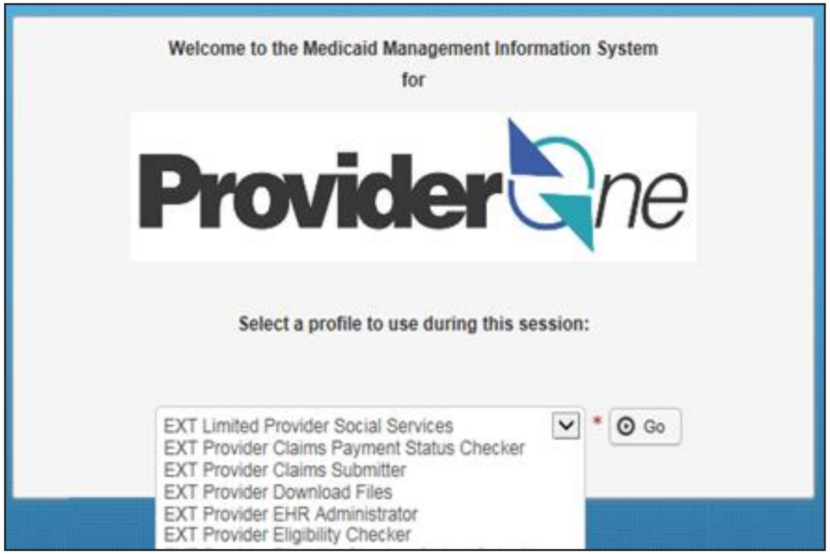
Using the portal to submit claims

- 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.

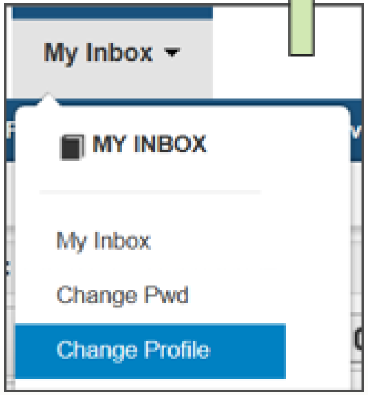
Washington State Health Care Authority

Determine what profile to use

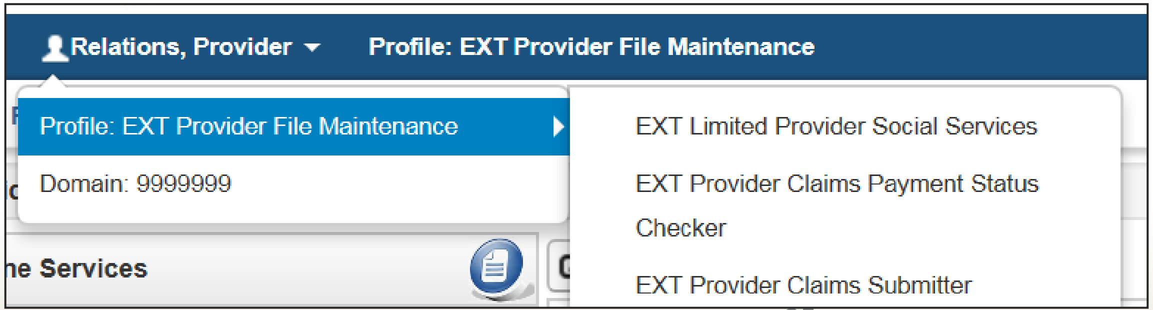
- With the upgrade to 3.0, ProviderOne allows you to change your profile in more than one place.
- At initial login:



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

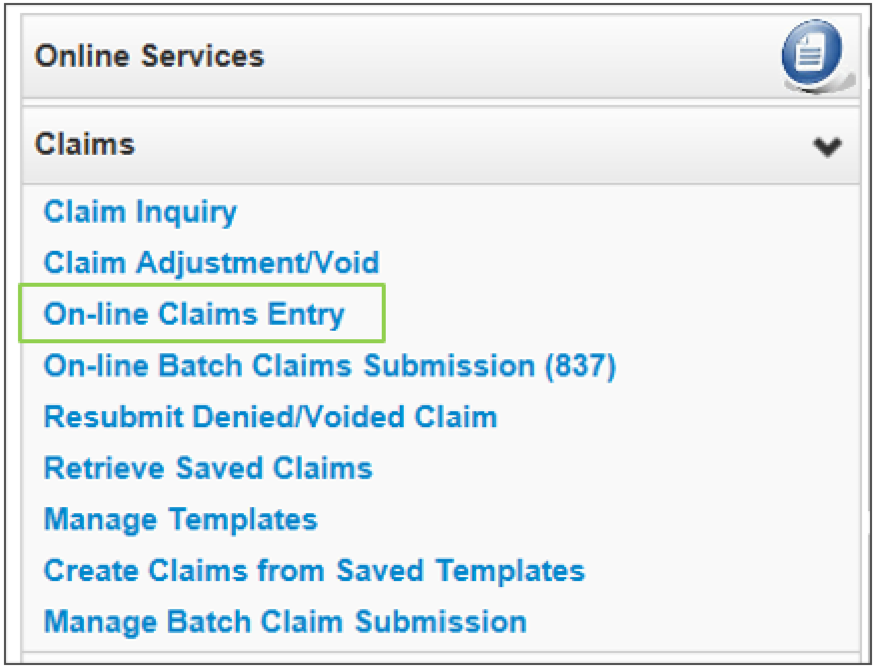


- And in the portal:



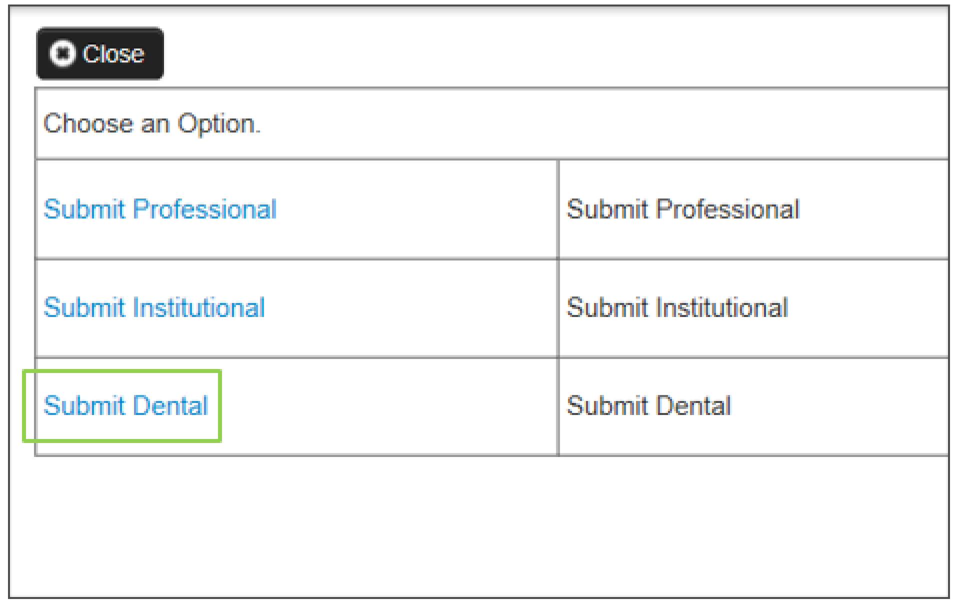
Online claims entry

- From the Provider Portal select the **Online Claims Entry** option located under the Claims heading.

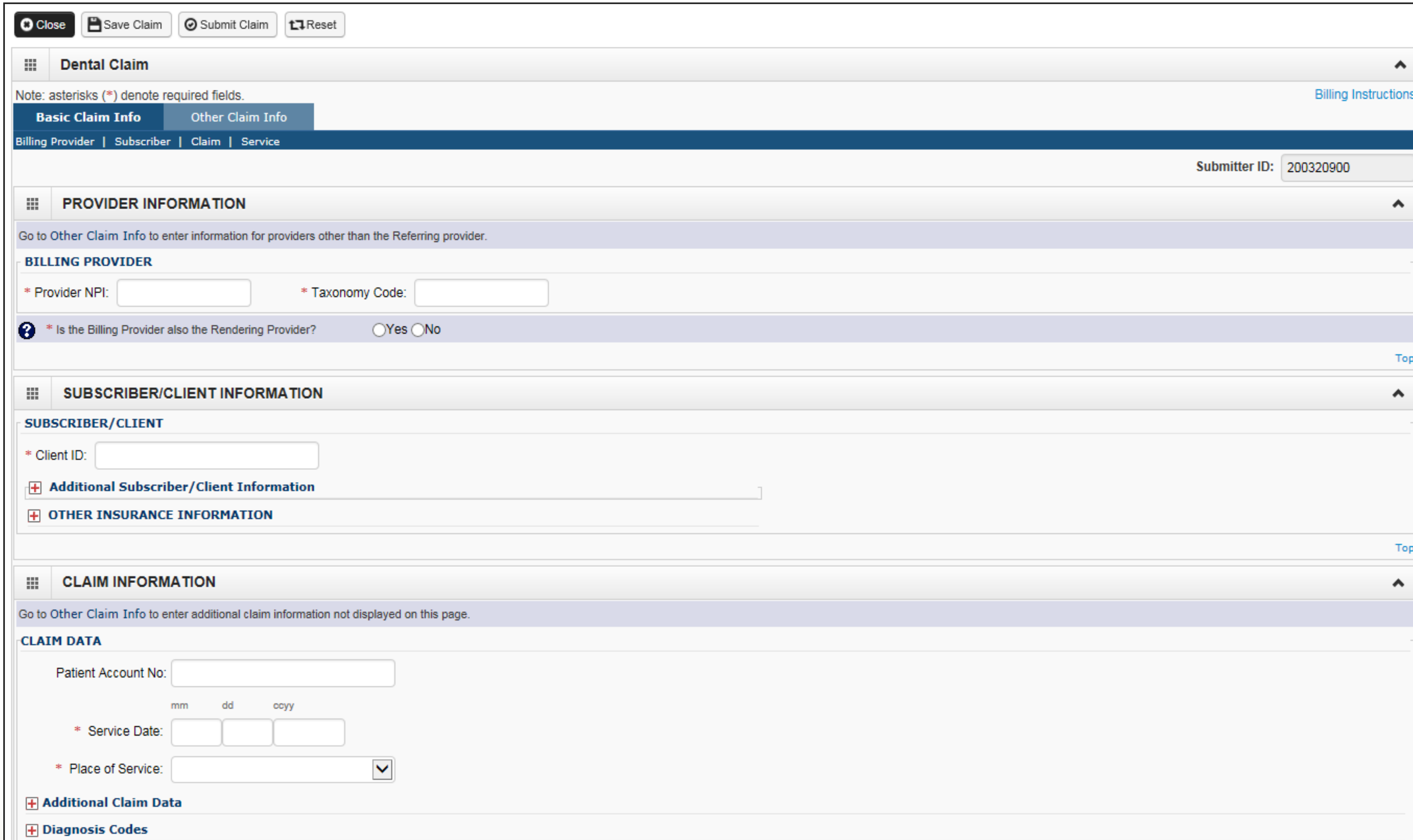


Choose claim type

- Choose the type of claim that you would like to submit with the appropriate claim form:
  - Professional – CMS 1500
  - Institutional - UB04
  - Dental - 2012 ADA



DDE claim form – top half


Close | Save Claim | Submit Claim | Reset

Dental Claim

Note: asterisks (*) denote required fields.

Billing Instructions

Basic Claim Info | Other Claim Info

Billing Provider | Subscriber | Claim | Service

Submitter ID: 200320900

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

Top

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

Additional Subscriber/Client Information

OTHER INSURANCE INFORMATION

Top

CLAIM INFORMATION

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

CLAIM DATA

Patient Account No:

mm dd ccyy

* Service Date:

* Place of Service:

Additional Claim Data

Diagnosis Codes

DDE claim form – bottom half

PRIOR AUTHORIZATION

CLAIM NOTE

* Is this claim accident related? Yes No

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.)

mm dd ccyy

Service Date: (If different from the claim service date)

mm dd ccyy

Appliance Placement Date:

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.

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

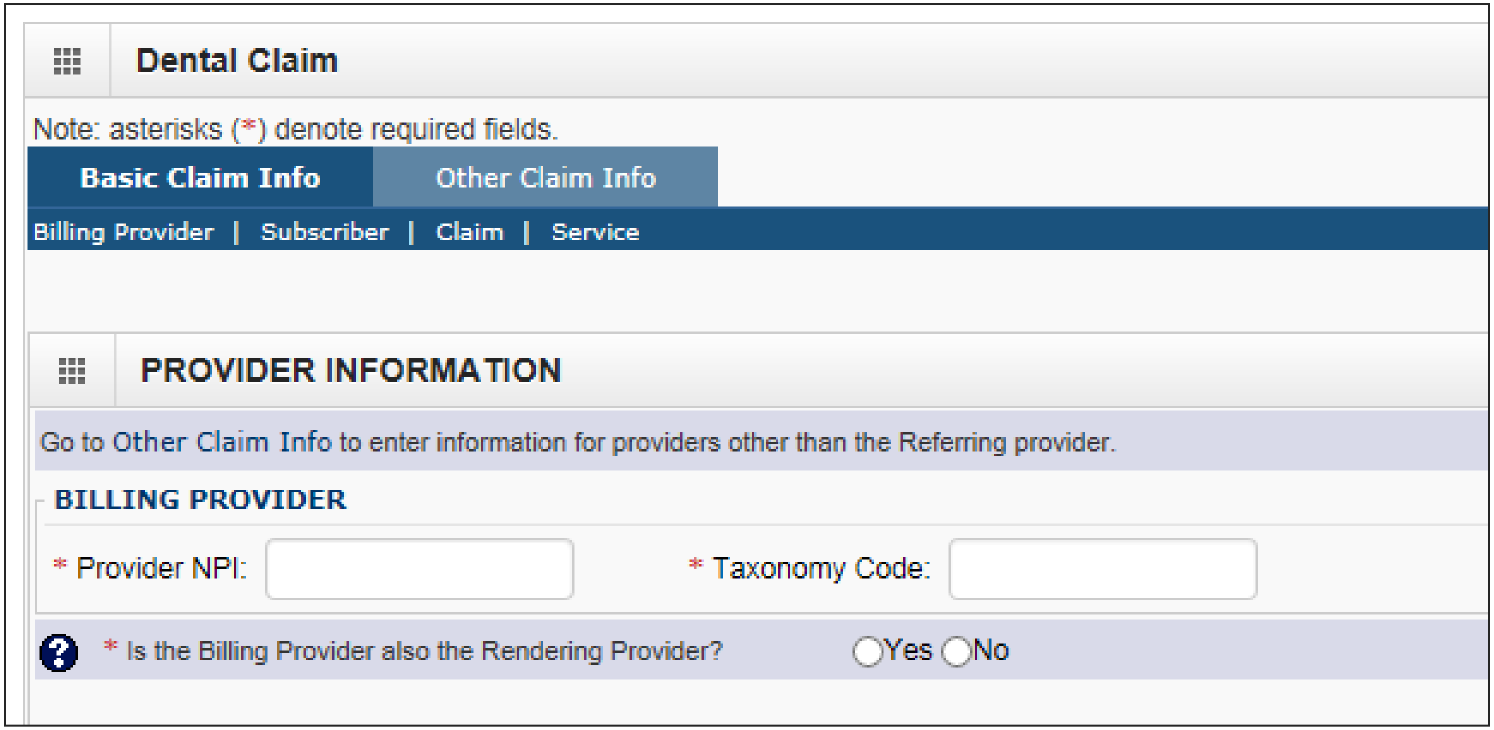
Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: $ 0.00

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number
			1	2	3	4	1	2	3	4	1	2	3	4	5					

Billing provider information

- Section 1: Billing Provider Information



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.

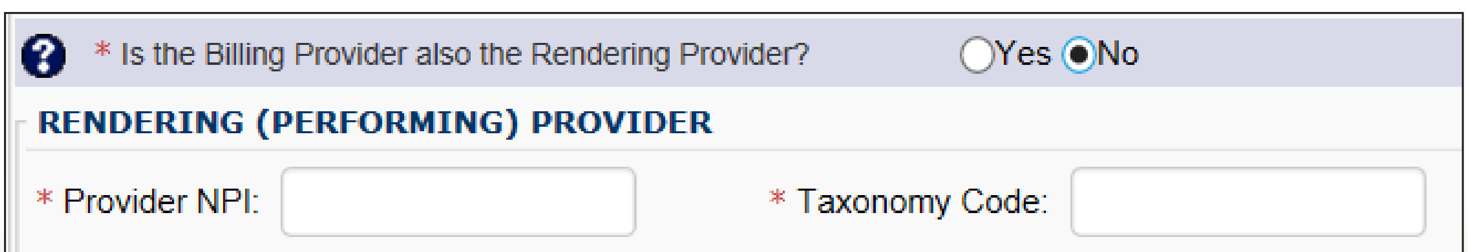
BILLING PROVIDER

* Provider NPI: ______ * Taxonomy Code: ______

Enter rendering provider information

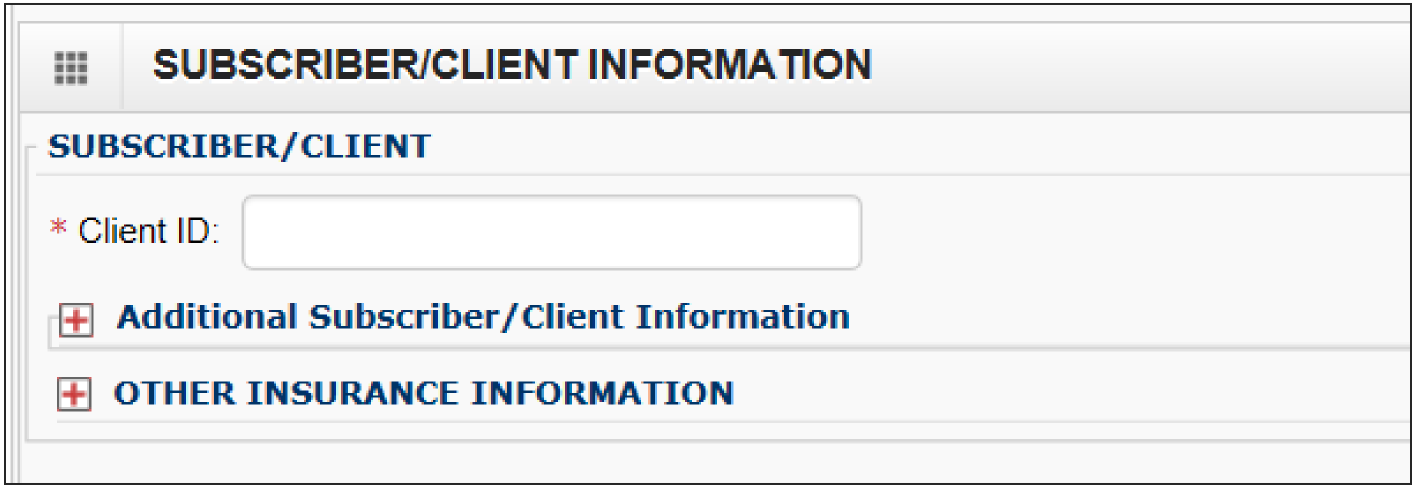
- If the Rendering Provider is the same as the Billing Provider answer the question **YES** and go on to the next section.

- 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.



Subscriber/client information

- Section 2: Subscriber/Client Information


SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

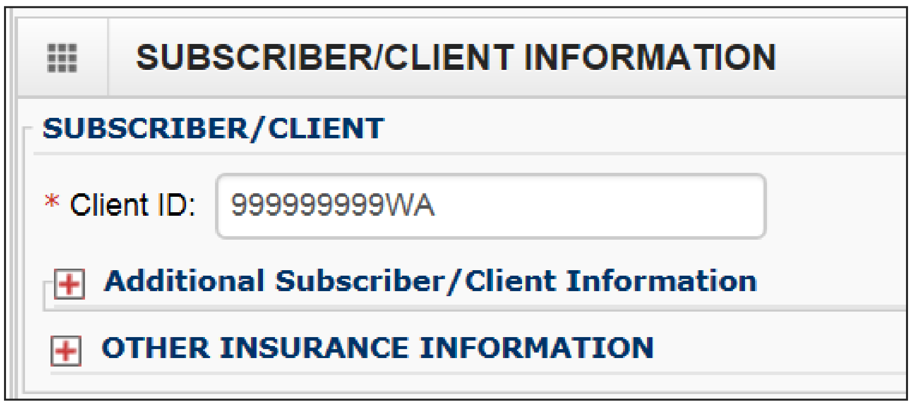
* Client ID:

Additional Subscriber/Client Information

OTHER INSURANCE INFORMATION

Enter client ID

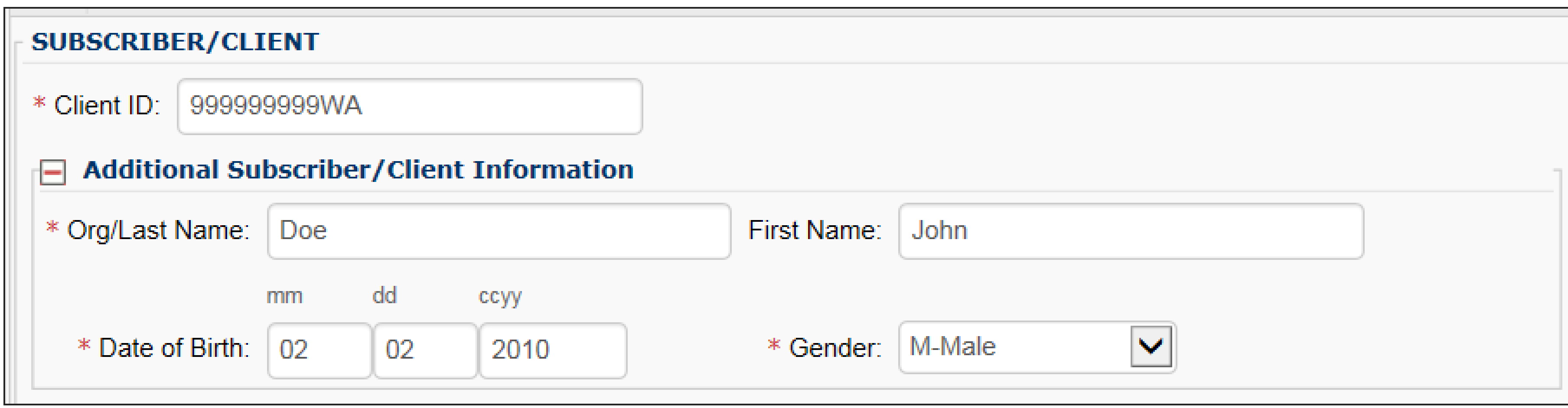
- Enter the Subscriber/Client ID found on the WA Medicaid services card. This ID is a 9-digit number followed by **WA**.
  - Example: **999999999WA**



- 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.


SUBSCRIBER/CLIENT

* Client ID: 999999999WA

Additional Subscriber/Client Information

* Org/Last Name: Doe First Name: John

mm dd ccyy

* Date of Birth: 02 02 2010 * Gender: M-Male

Insurance other than Medicaid

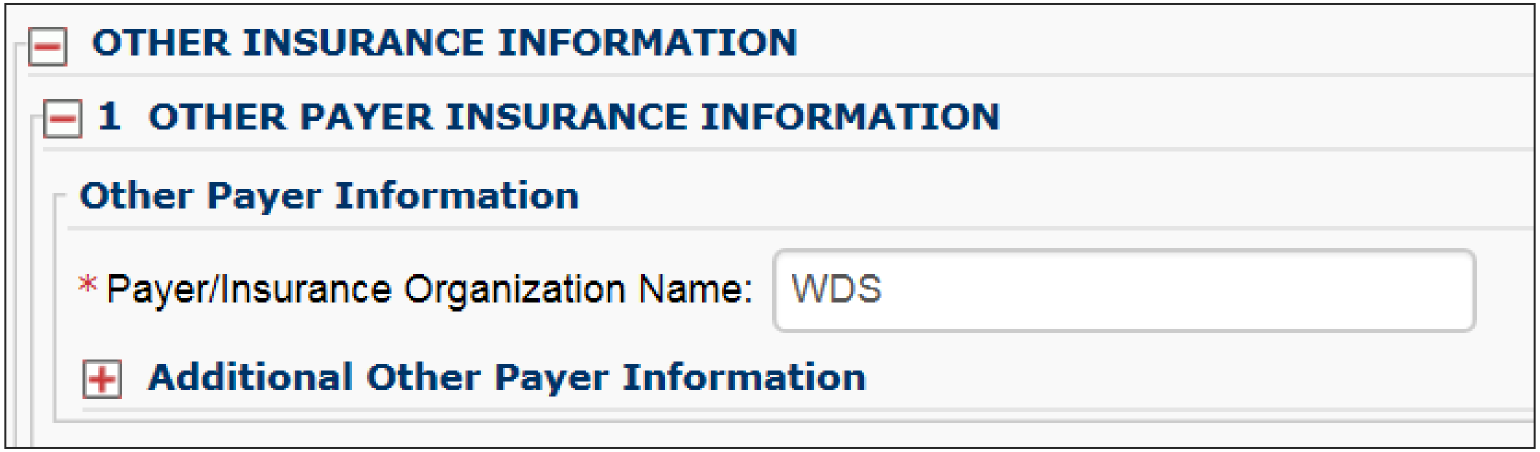
- If the client has other commercial insurance open the "Other Insurance Information" section by clicking on the red **+** expander. If there is no insurance skip over this.

- 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

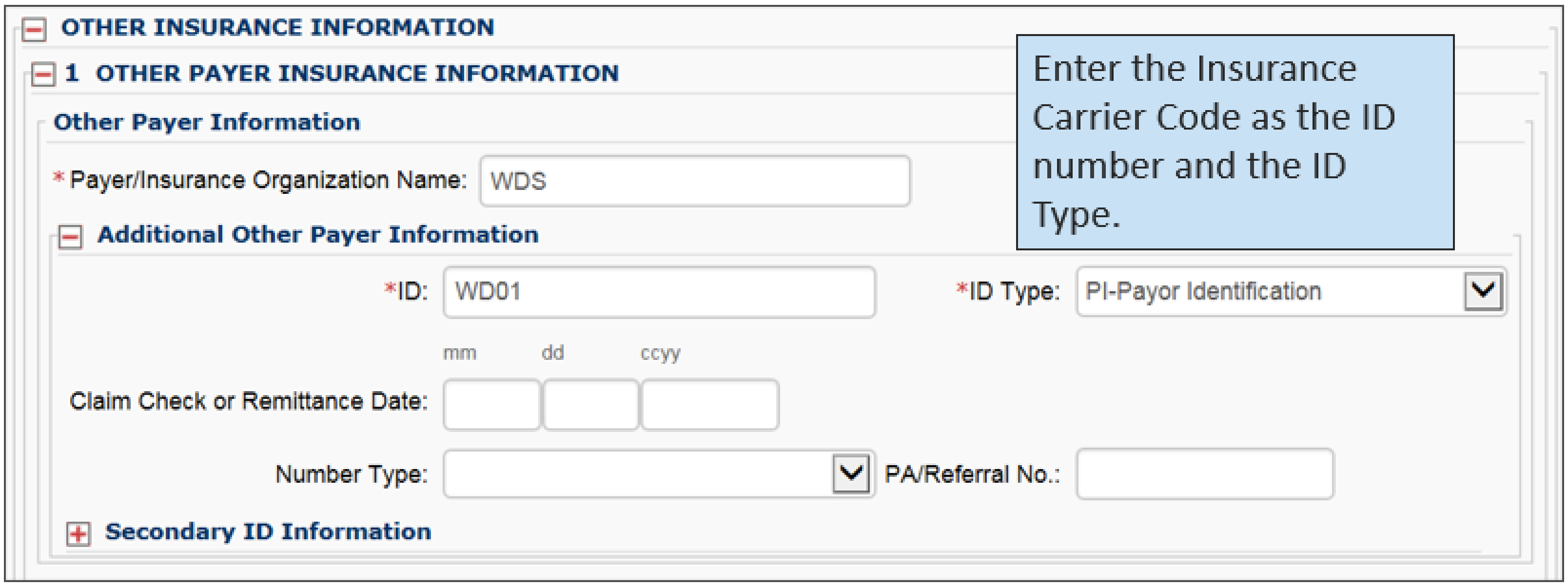
- Enter the Payer/Insurance Organization Name.



- 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.

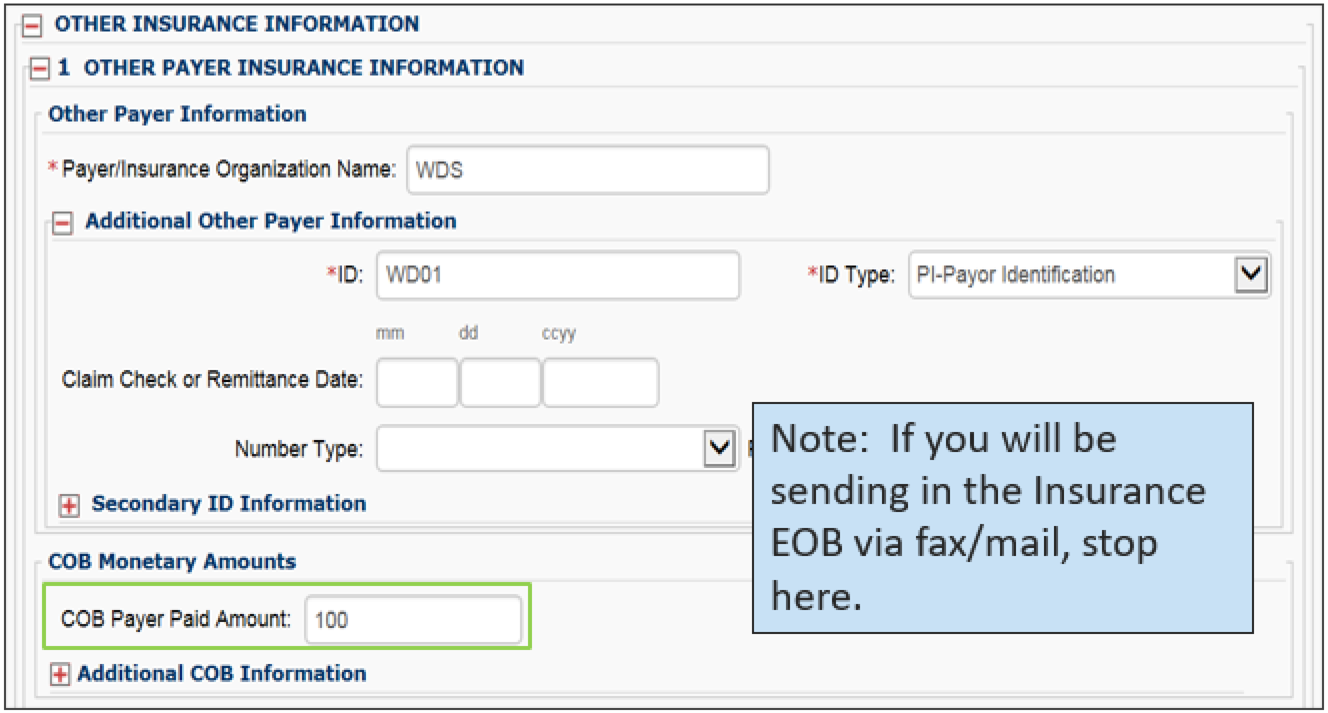
Coordination of Benefits Information

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	NORTHWEST ADMINISTRATORS (800) 458-3053	NW01	JANE DOE	555555555			08/01/2014	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	WASHINGTON DENTAL SERVICE (800) 537-3406	WD01	JANE DOE	555555555			08/01/2014	12/31/2999

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Enter primary payment

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



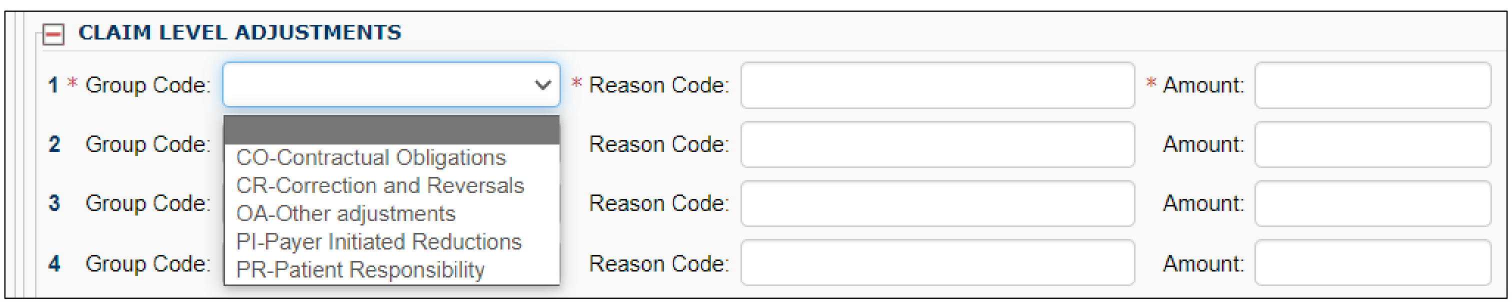
- If the claim is for an insurance denial or insurance applied to the deductible, enter a 0 here.

Enter adjustment reason

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

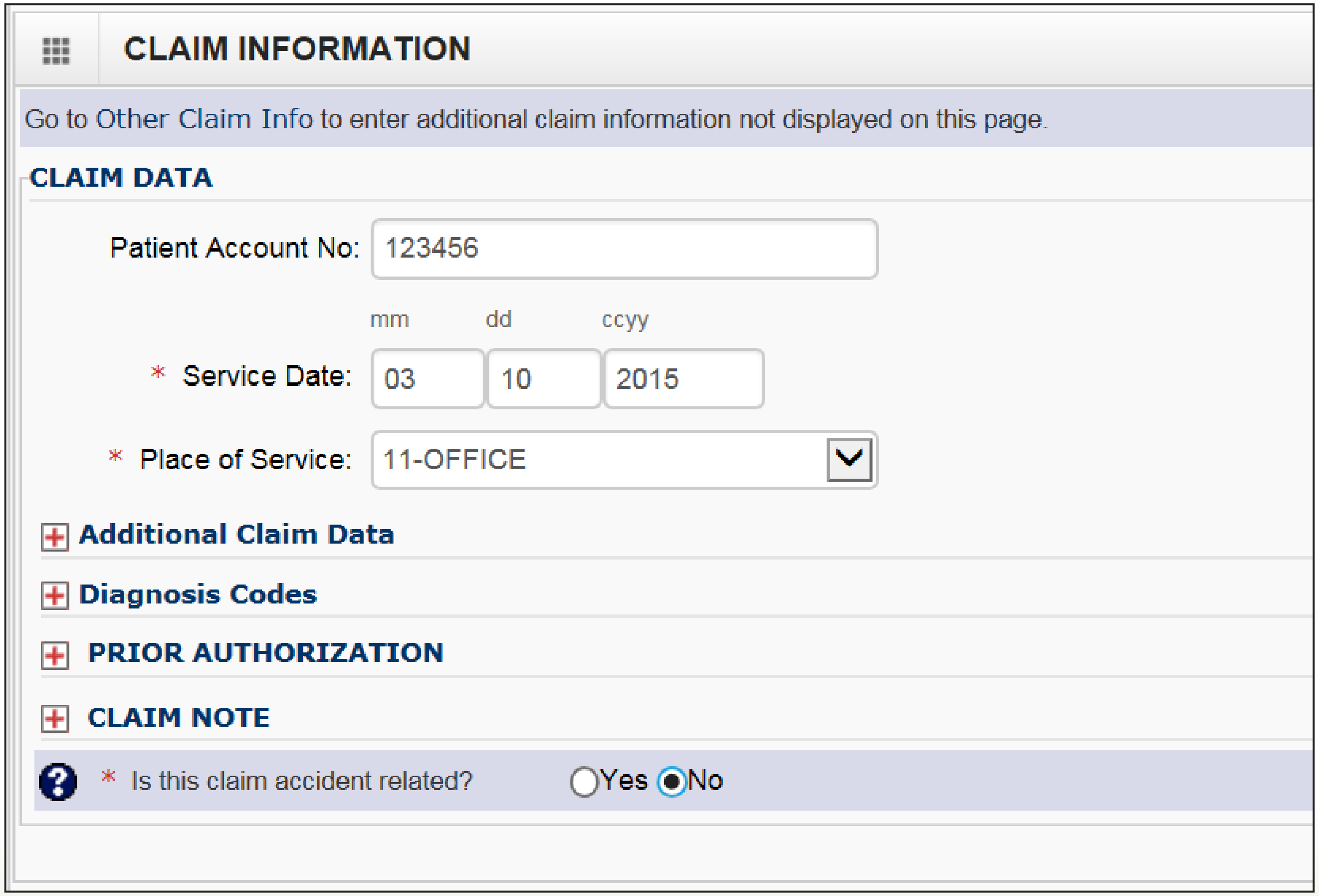
Note: The agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the X12 organization's website.

- 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

mm dd ccyy

* Service Date: 03 10 2015

* Place of Service: 11-OFFICE

Additional Claim Data

Diagnosis Codes

PRIOR AUTHORIZATION

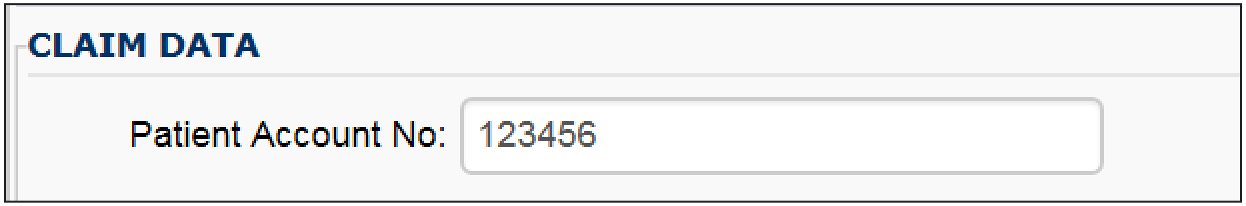
CLAIM NOTE

* Is this claim accident related? Yes No

Washington State Health Care Authority

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.

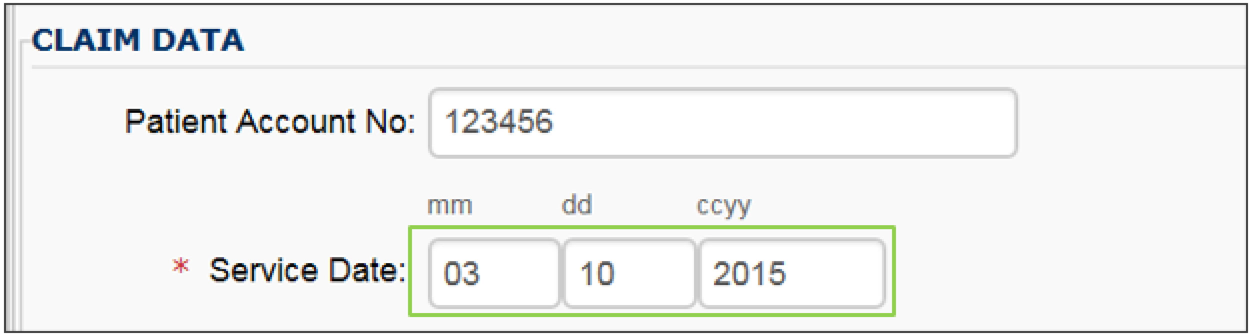

CLAIM DATA

Patient Account No: 123456

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.



Place of service

➢ 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.

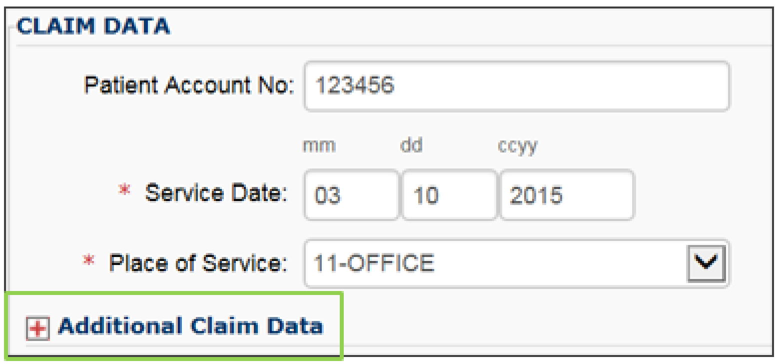
* Place of Service: 11-OFFICE

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

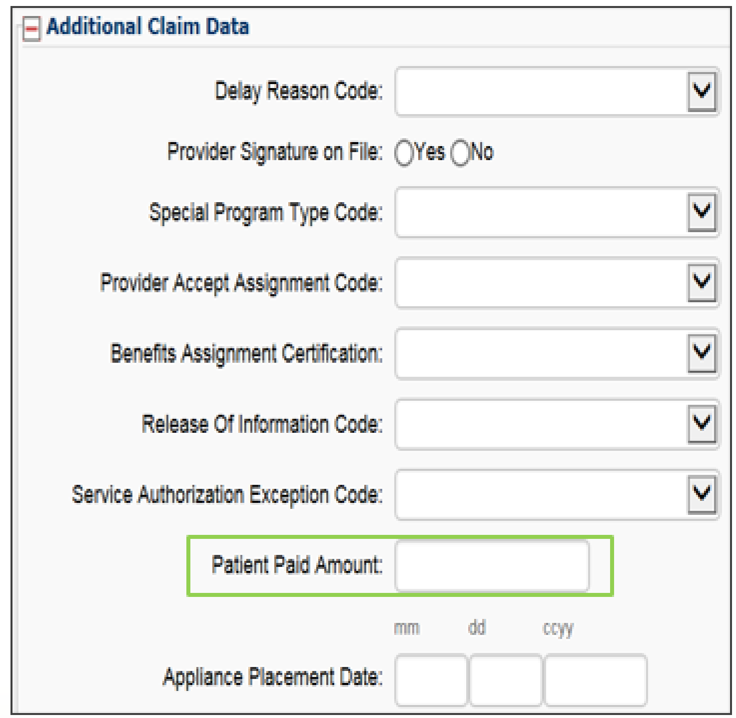
Note: The Place of Service is required in this section but can still be added to the line level of the claim. Line level is not required.

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.

PRIOR AUTHORIZATION

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

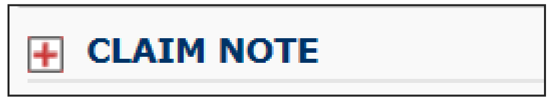
PRIOR AUTHORIZATION

1. * Prior Authorization Number:

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.

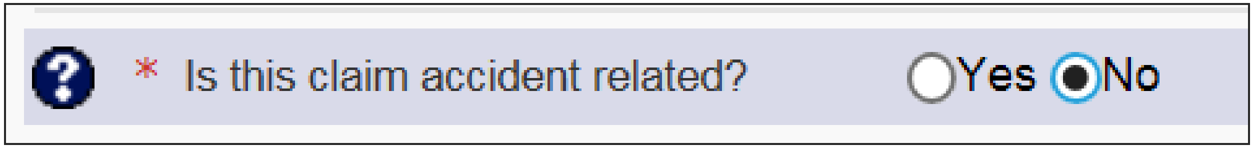


- For commercial insurance, as long as there is an attachment included or the insurance information is completed in the required fields, a **Claim Note** is not necessary.

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.)

mm dd ccyy

Service Date: (If different from the claim service date)

mm dd ccyy

Appliance Placement Date:

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.

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: $ 0.00

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number
			1	2	3	4	1	2	3	4	1	2	3	4	5					

Procedure code and charges

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

* Procedure Code:

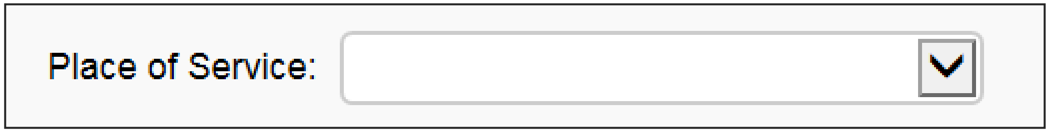
- Enter the **Submitted Charges**. If the dollar amount is a whole number, no decimal point is needed.

* Submitted Charges: $

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 <u>must</u> match.

Other service line info

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

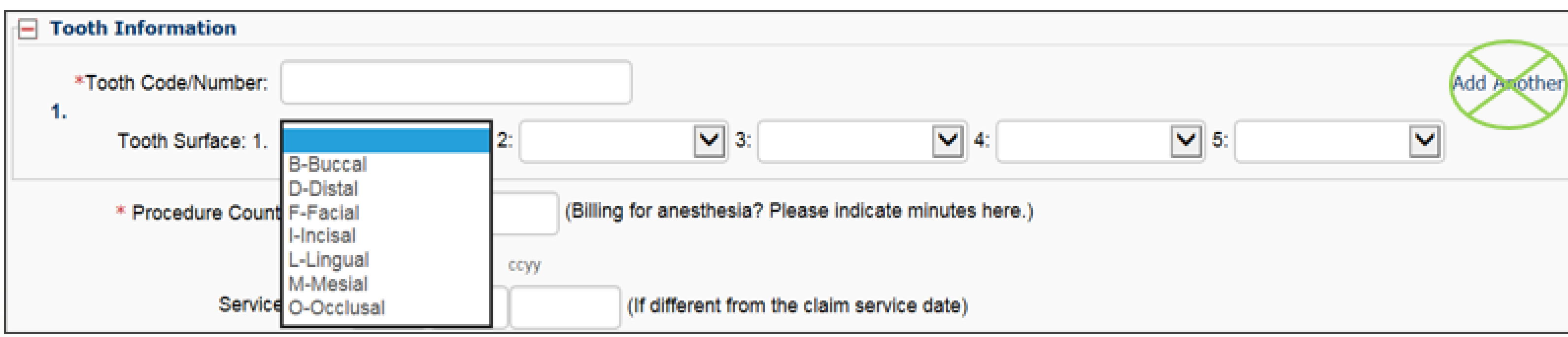


- Modifiers and Diagnosis codes are not required on dental claims.

Tooth number information

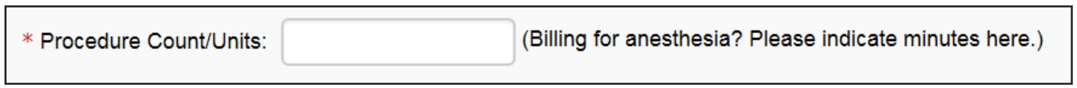
- **Tooth Number**
  - If the service requires tooth information, click on the + to expand this section.

  - 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!

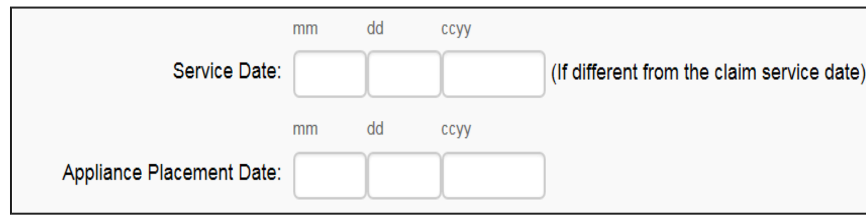


Service line units

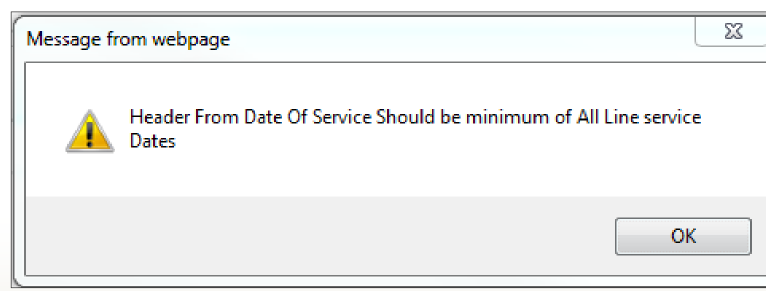
- Enter procedure **Units**. At least one unit is required.
  - <u>DO NOT</u> enter minutes in this box.



- 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.

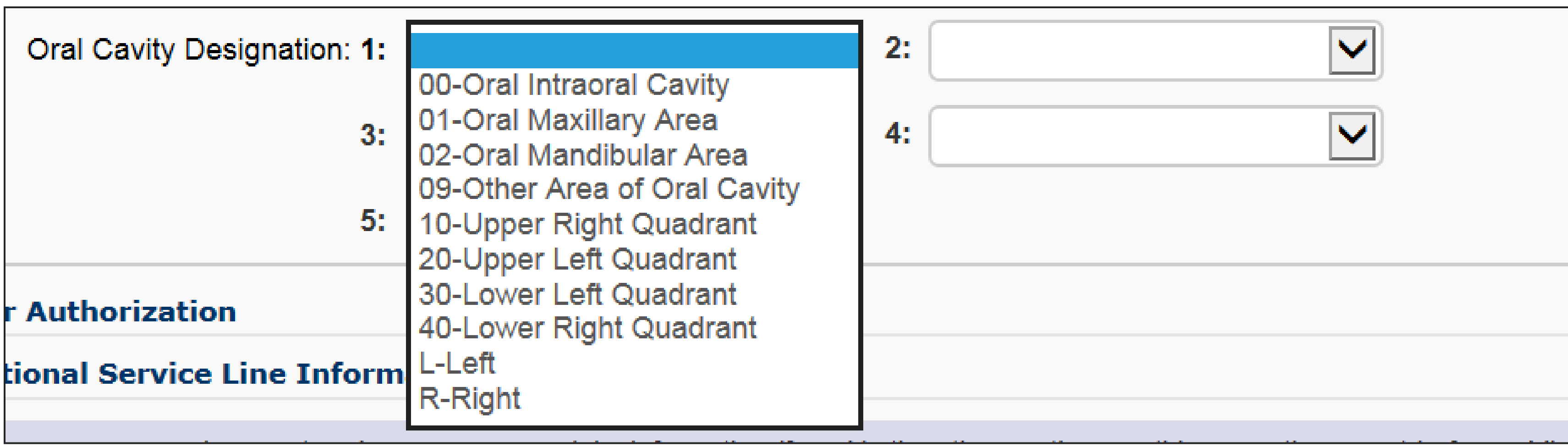


- If the second date entered at the line is before the date entered at the claim level, you will receive the following error:



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.

+ Prior Authorization

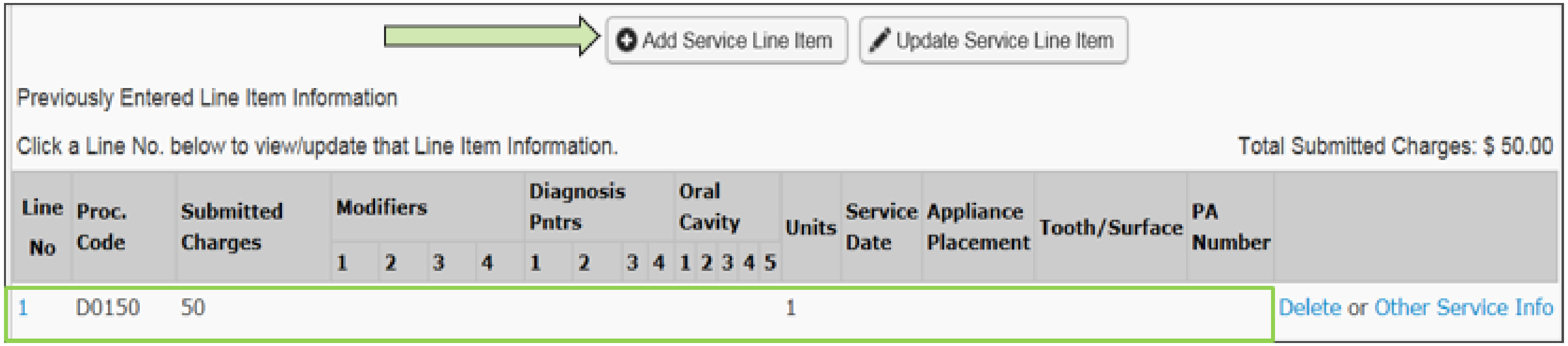
Note: If a Prior Authorization number was entered previously on the claim it is not necessary to enter it again here.

- The Additional Service Line Information is not needed for claims submission.

+ Additional Service Line Information

Add service line items

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



Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	1	2	3	4	5						
1	D0150	50														1					Delete or Other Service Info

- 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.

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

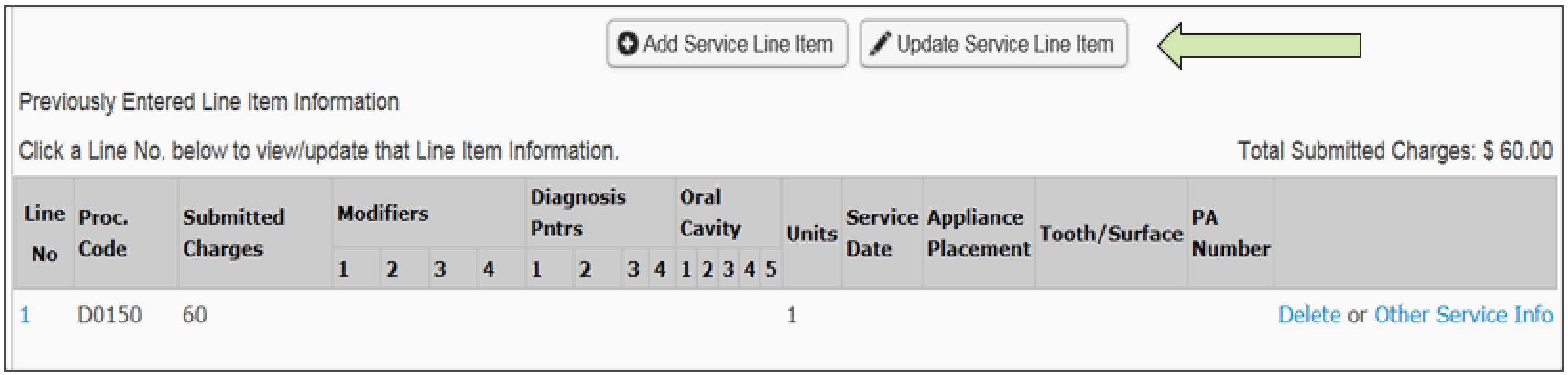
Total Submitted Charges: $ 50.00

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	1	2	3	4	5						
1	D0150	50														1					Delete or Other Service Info

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.

Update service line items (cont.)

- Once the service line is corrected, click on the **Update Service Line Item** button to add corrected information on the claim.



Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: $ 60.00

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	1	2	3	4	5						
1	D0150	60														1					Delete or Other Service Info

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.

Washington State Health Care Authority

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.

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

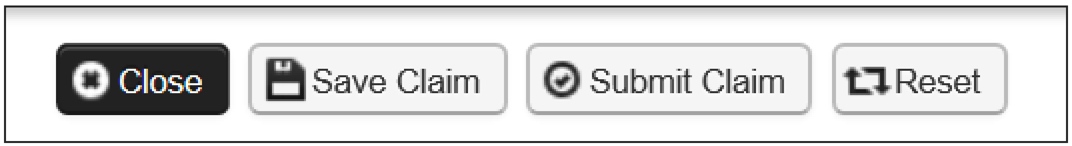
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 60.00

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth Surface	PA Number	
			1	2	3	4	1	2	3	4	1	2	3	4	5						
1	D0150	60														1					Delete or Other Service Info

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

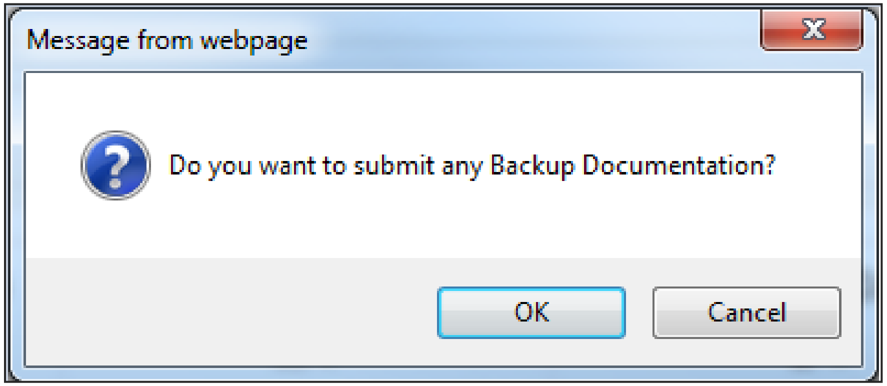
- When the claim is ready for processing, click the **Submit Claim** button at the top of the claim form.



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:

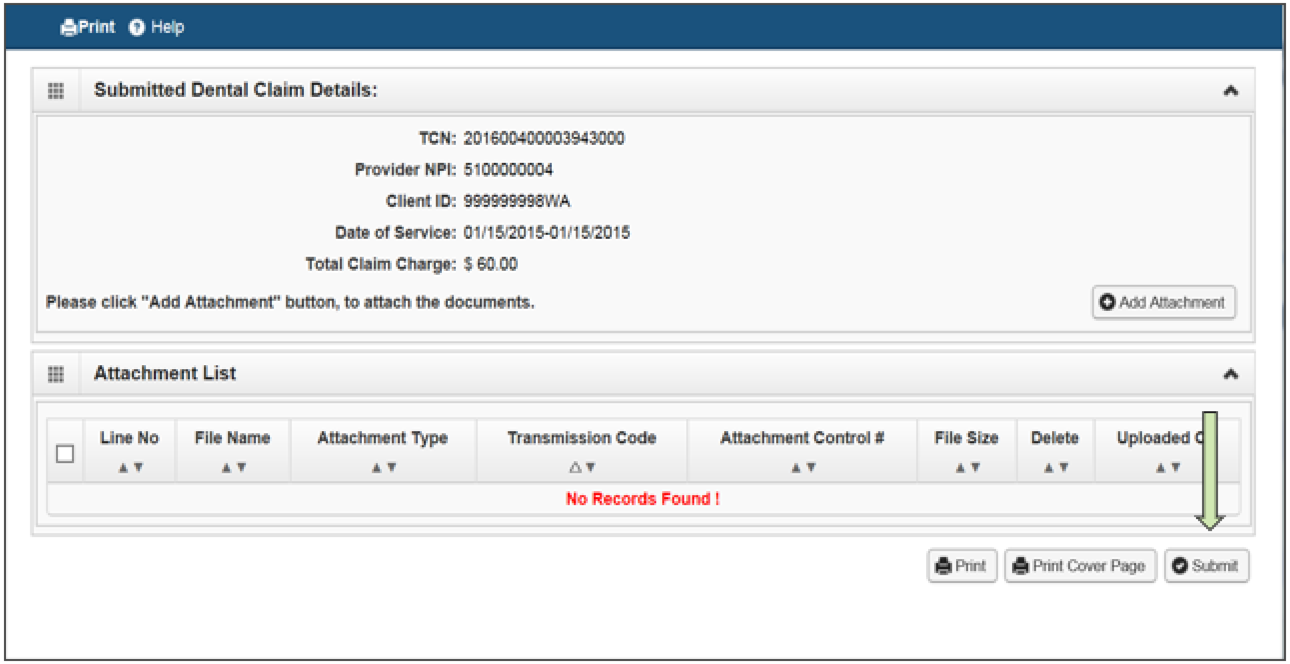


- Click on the **Cancel** button if no backup is to be sent.
- Click on the **OK** button if backup needs to be attached.

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

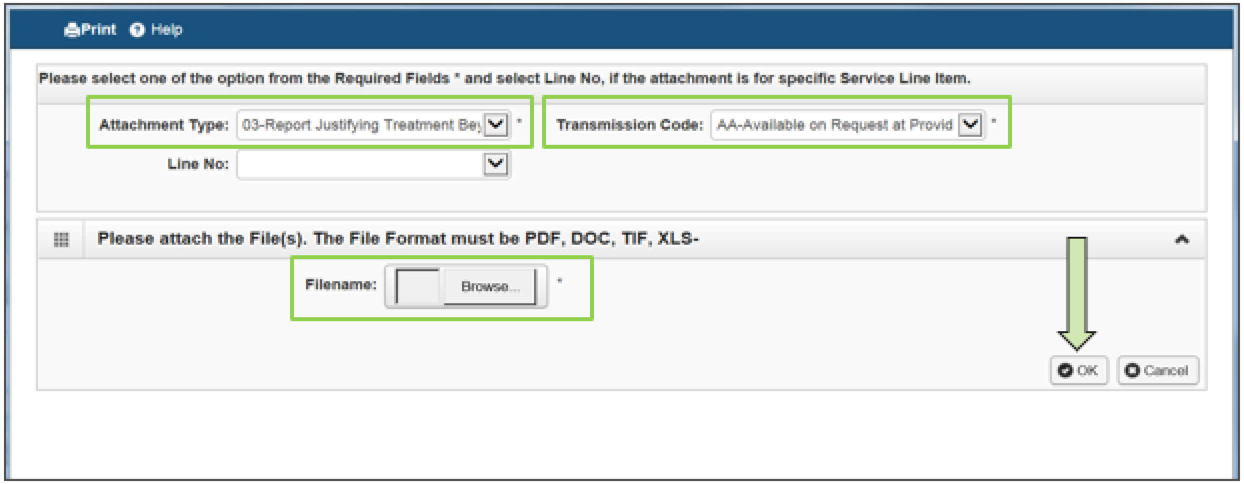
- ProviderOne now displays the **Submitted Dental Claim Details** screen.



- Click on the **Submit** button to finish submitting the claim!

Submit claim for processing – with electronic file attached

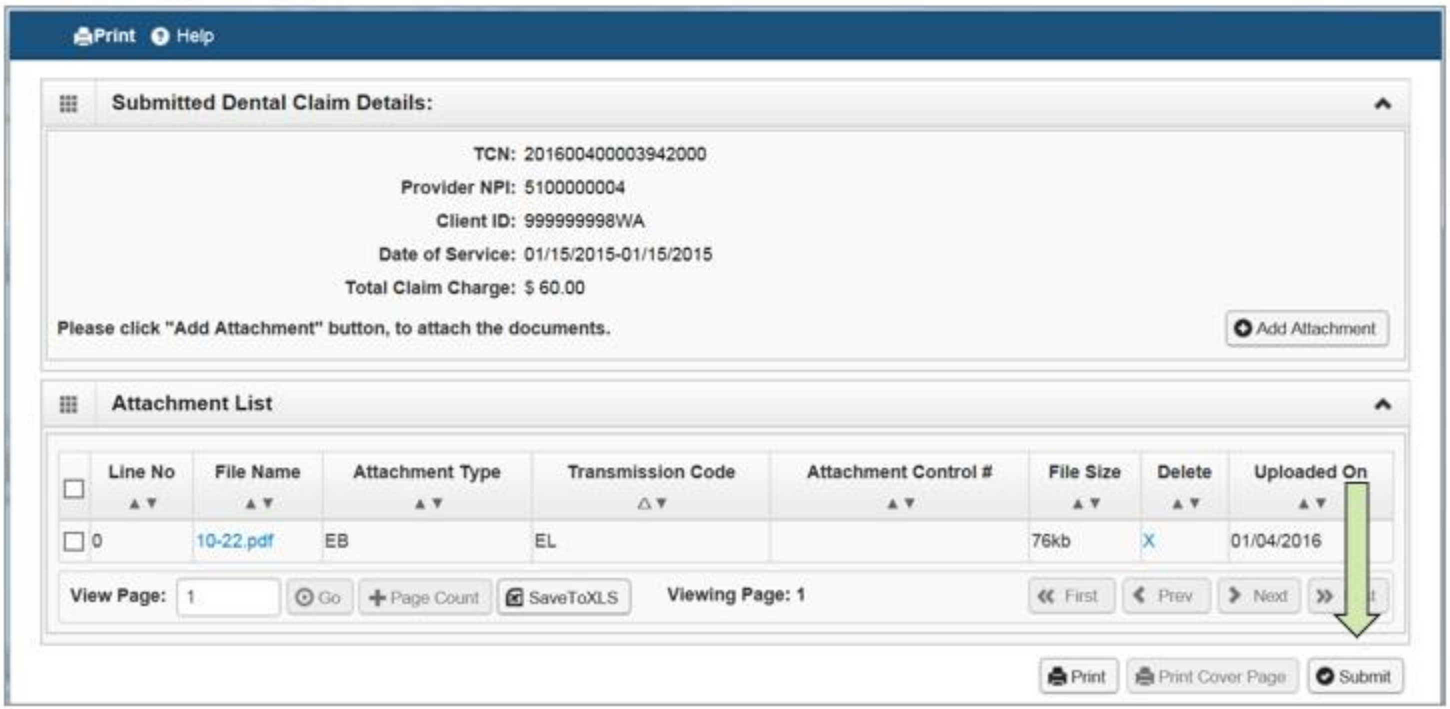
- The Claim's Backup Documentation page is displayed.



- 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

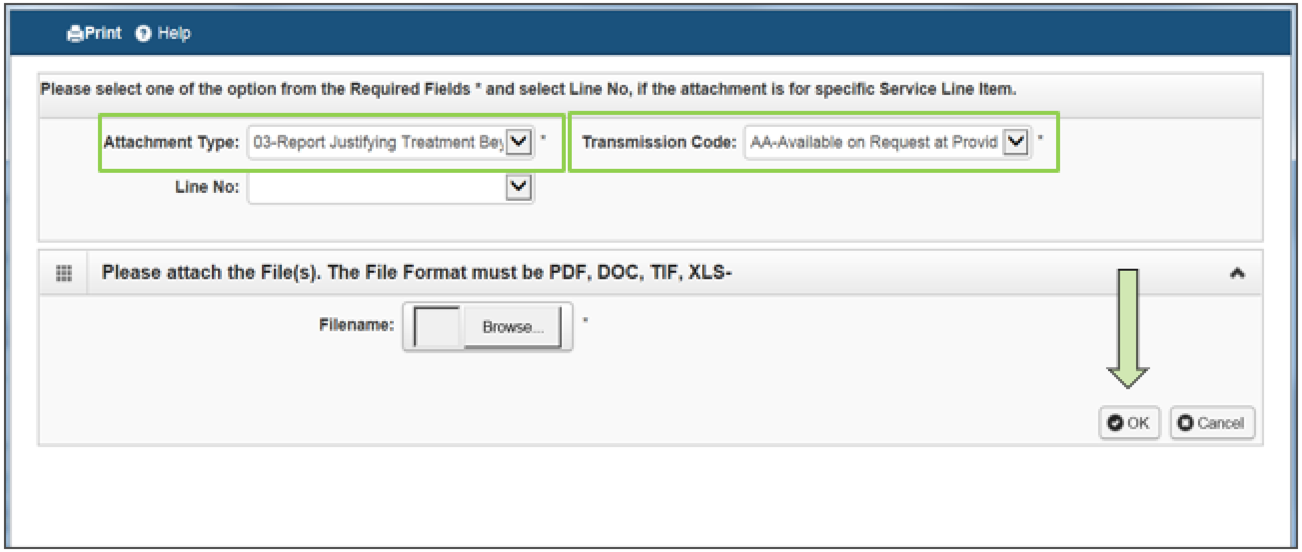
- The **Submitted Dental Claim Details** page is then displayed.



- Click the **Submit** button to submit the claim!

Submit claim for processing – mailing or faxing backup

➢ The Claims Backup Documentation page is displayed.

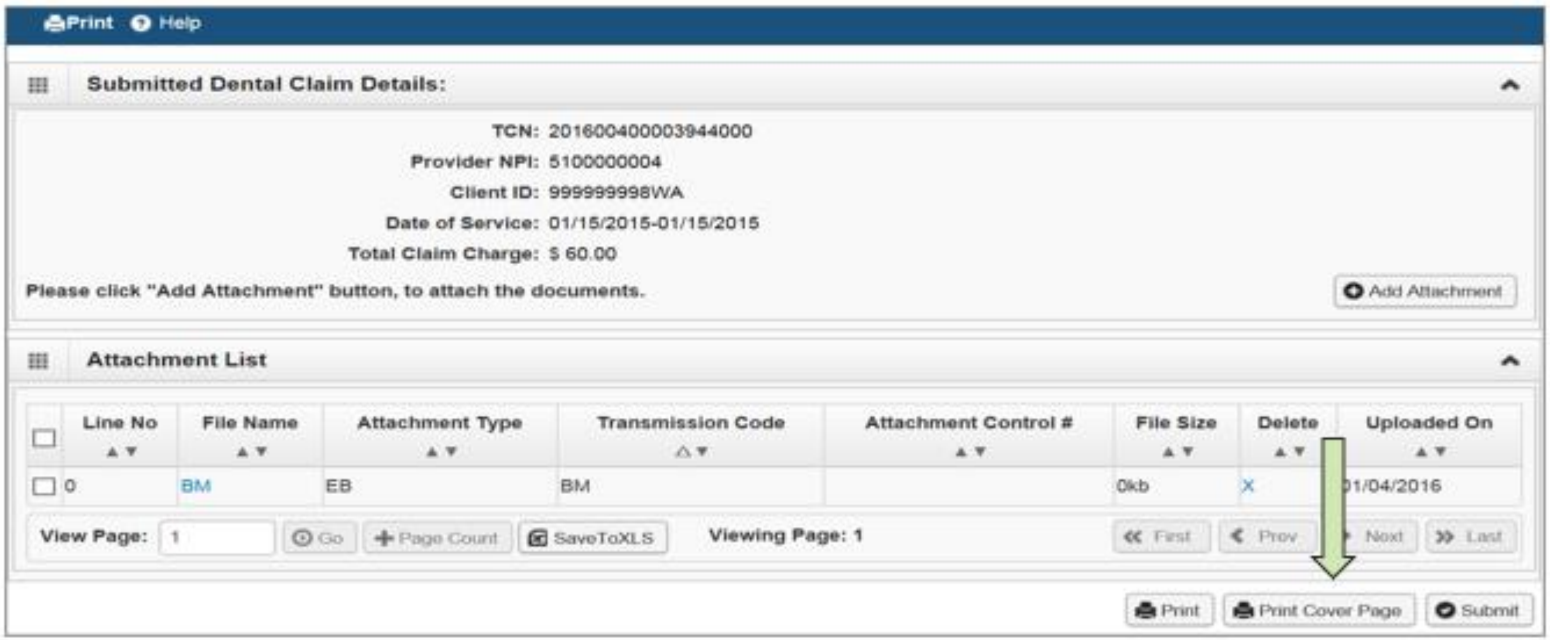


- Enter the **Attachment Type**.
- Pick one of the following Transmission Codes:
  - **BM** - By Mail; or
  - **FX** – Fax.
- Click the **OK** button.

Washington State Health Care Authority

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.



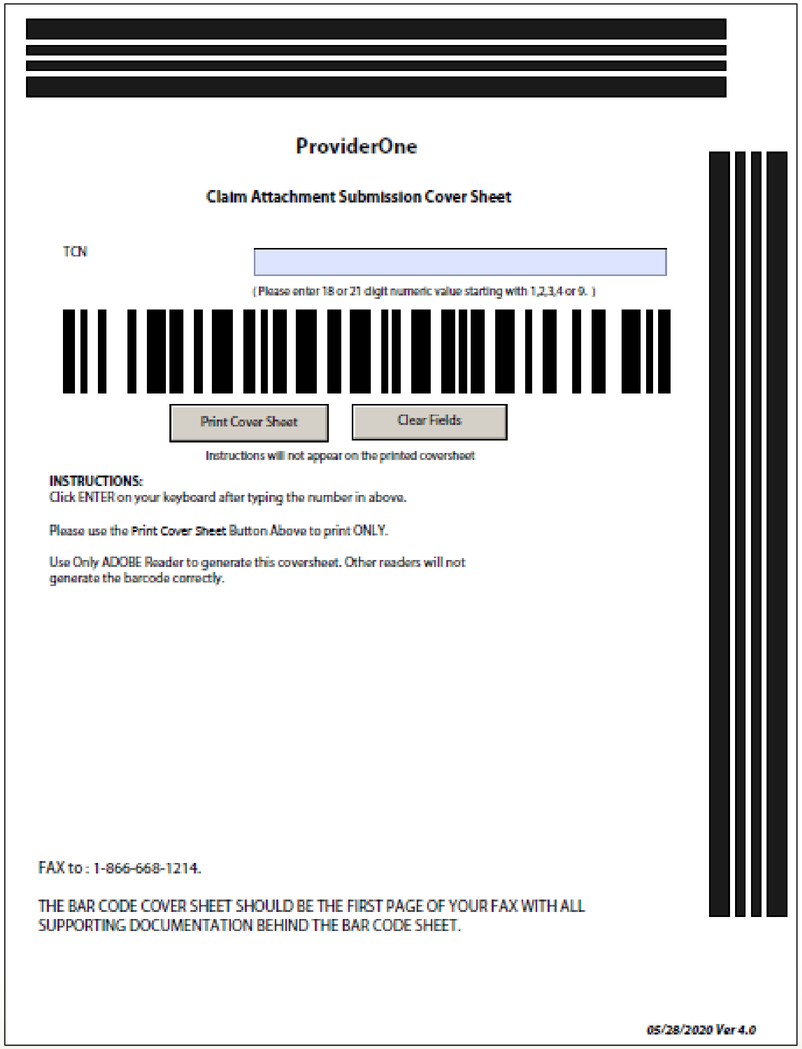
Submit claim for processing – with backup

- 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



ProviderOne

Claim Attachment Submission Cover Sheet

TCN

(Please enter 18 or 21 digit numeric value starting with 1,2,3,4 or 9.)

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet

INSTRUCTIONS:
Click ENTER on your keyboard after typing the number in above.

Please use the **Print Cover Sheet** Button Above to print ONLY.

Use Only ADOBE Reader to generate this coversheet. Other readers will not generate the barcode correctly.

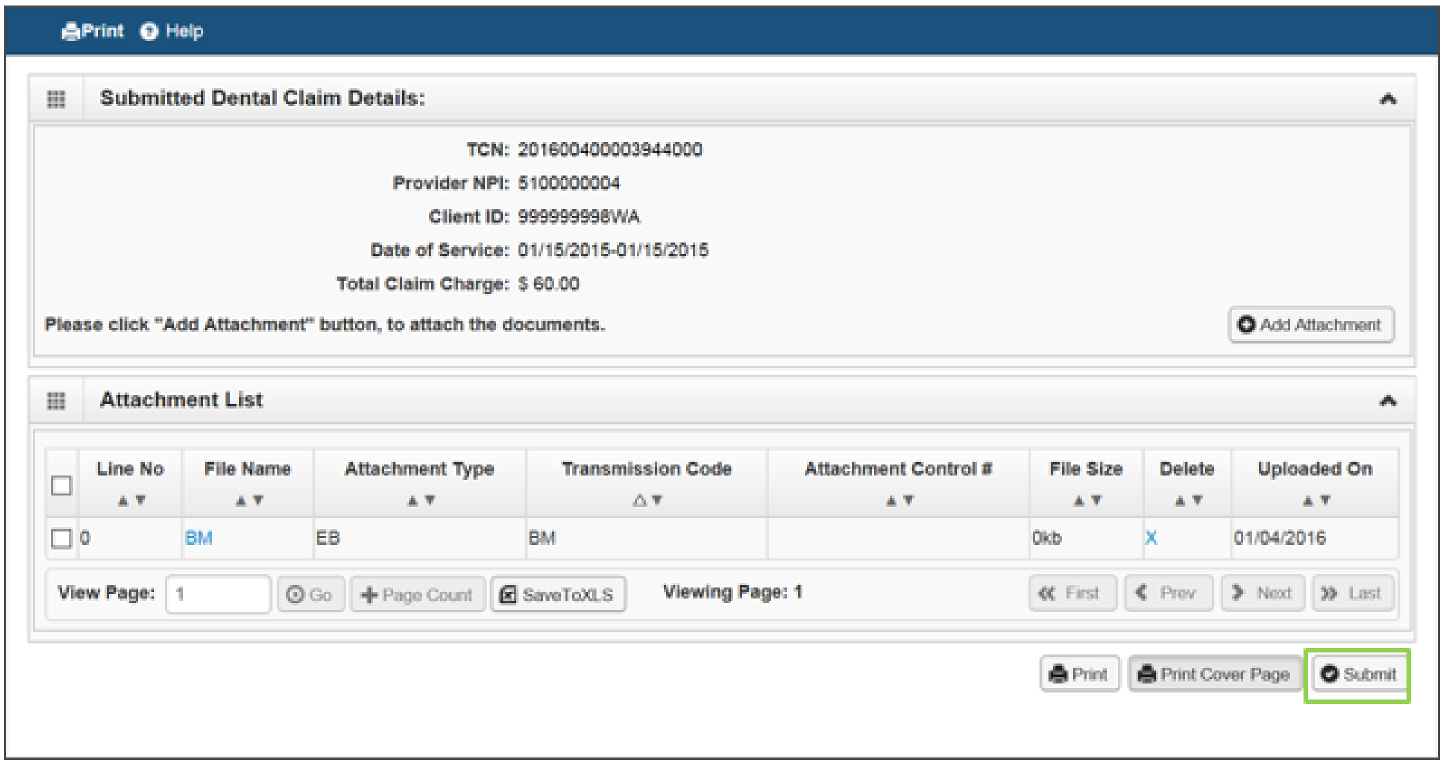
FAX to : 1-866-668-1214.

THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.

05/28/2020 Ver 4.0

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

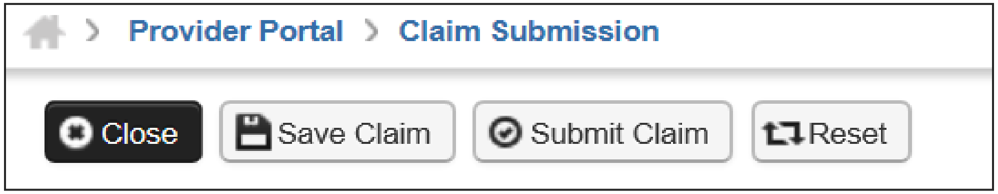
Saving a DDE claim

- 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:

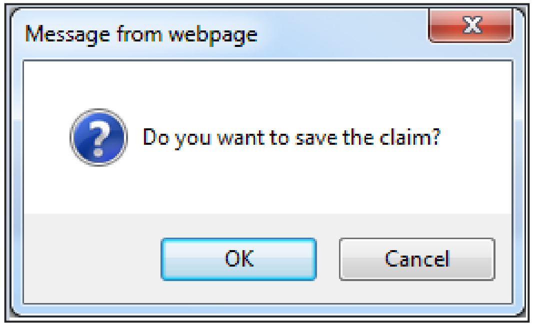
Section 1: Billing Provider Information	Section 2: Subscriber/Client Information	Section 3: Claim Information
Billing Provider NPI	Client ID number	Is this claim accident related?
Billing Provider Taxonomy		
Is the Billing Provider also the Rendering Provider?		

Saving a DDE claim (cont.)

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



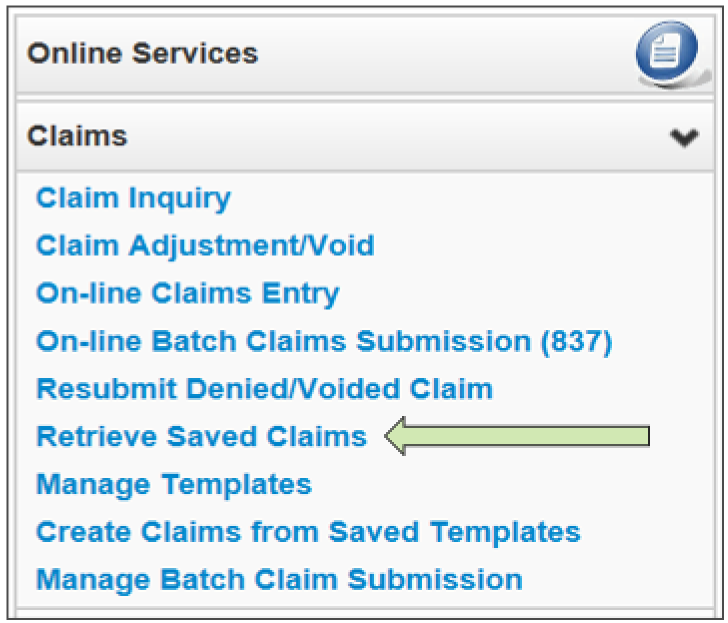
- ProviderOne now displays the following confirmation box:



- 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.

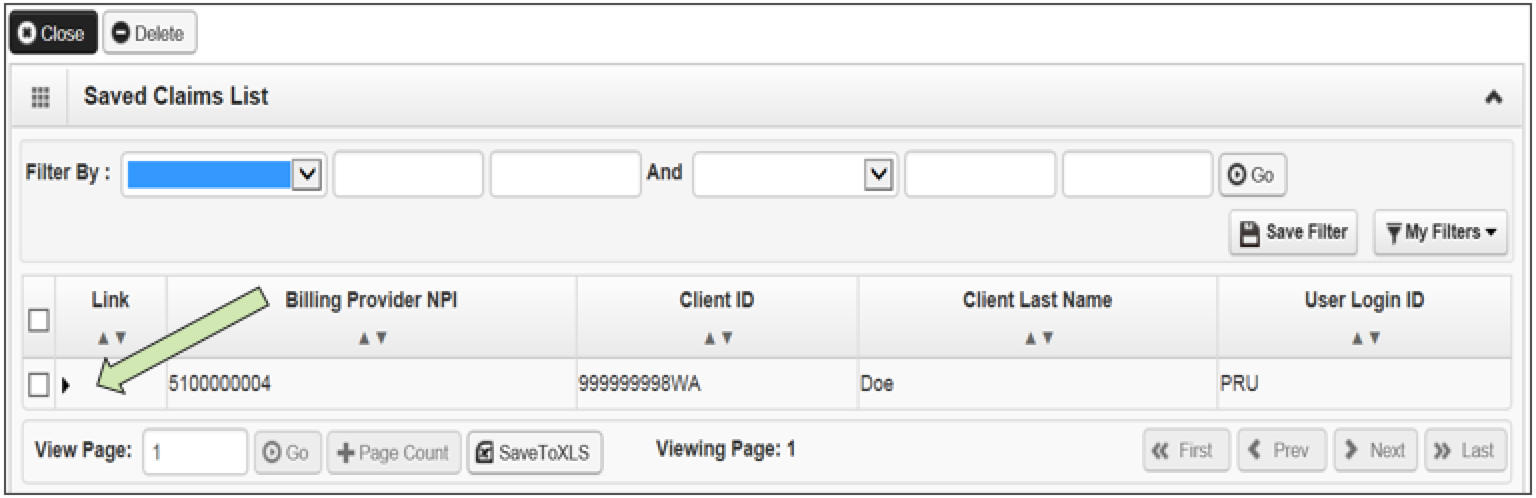
Retrieving a saved DDE claim

- 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.



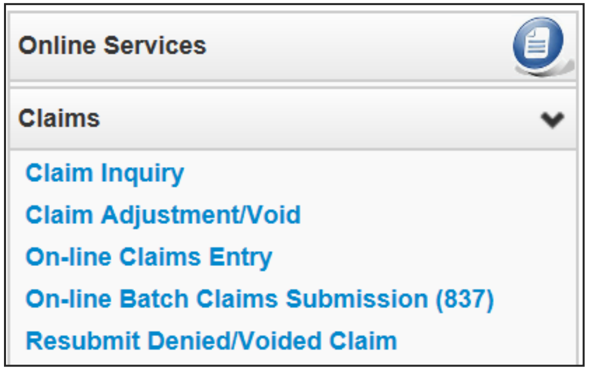
- The system loads the saved claim in the correct DDE claim form screen. Continue to enter data, then submit the claim.
- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claim List.

Claim inquiry

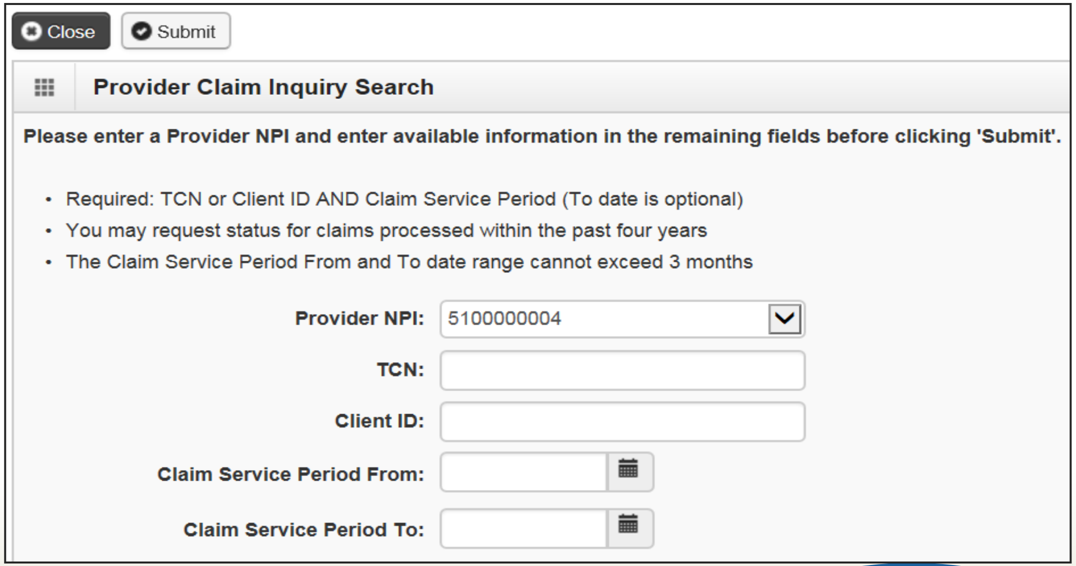
Washington State Health Care Authority

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.
    - Denied claims will show the denial codes.
    - Easiest way to find a timely TCN number for rebilling.

Close

Provider NPI: 5100000004

Claim Inquiry Providers List

	TCN	Date of Service	Claim Status	Claim Charged Amount	Claim Payment Amount	Client Name	Client ID
☐	201600400003942000	01/15/2015	0: Cannot provide further status electronically.	$60.00	$0.00	John	999999998WA
☐	201600400003943000	01/15/2015	0: Cannot provide further status electronically.	$60.00	$0.00	John	999999998WA
☐	201600400003944000	01/15/2015	0: Cannot provide further status electronically.	$60.00	$0.00	John	999999998WA

View Page: 1 Go Page Count SaveToXLS **Viewing Page: 1** First Prev Next Last

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.

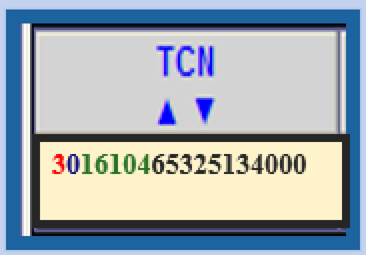
Timely billing

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?

TCN=Transaction Control Number



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

Washington State Health Care Authority

How do I prove timeliness?

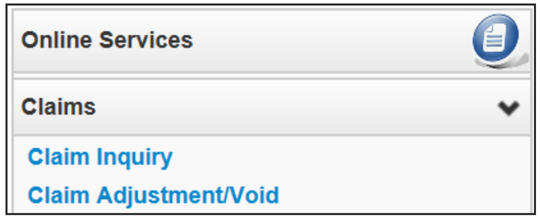
- Direct Data Entry (DDE) Claims
  - Resubmit Original Denied/Voided Claim.
  - ProviderOne will automatically detect the timely claim number as the timely TCN is now attached to the new transaction.

- 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.

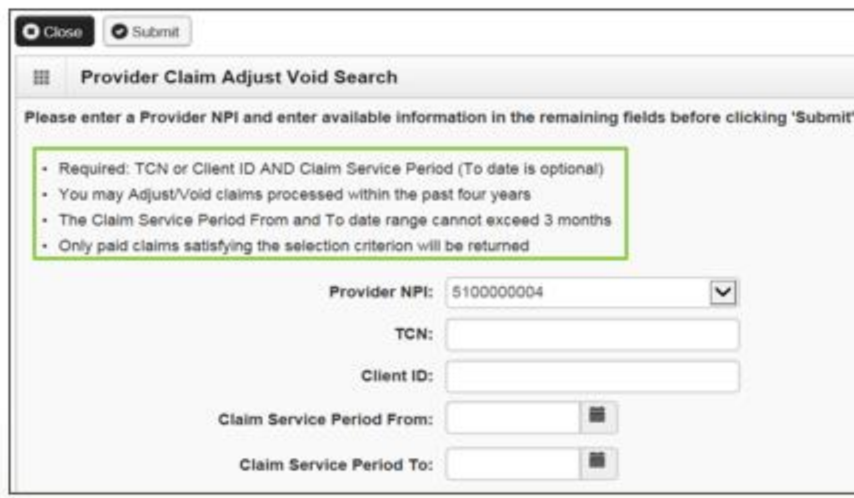
Adjust or void a Claim

Adjust/void a paid claim

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



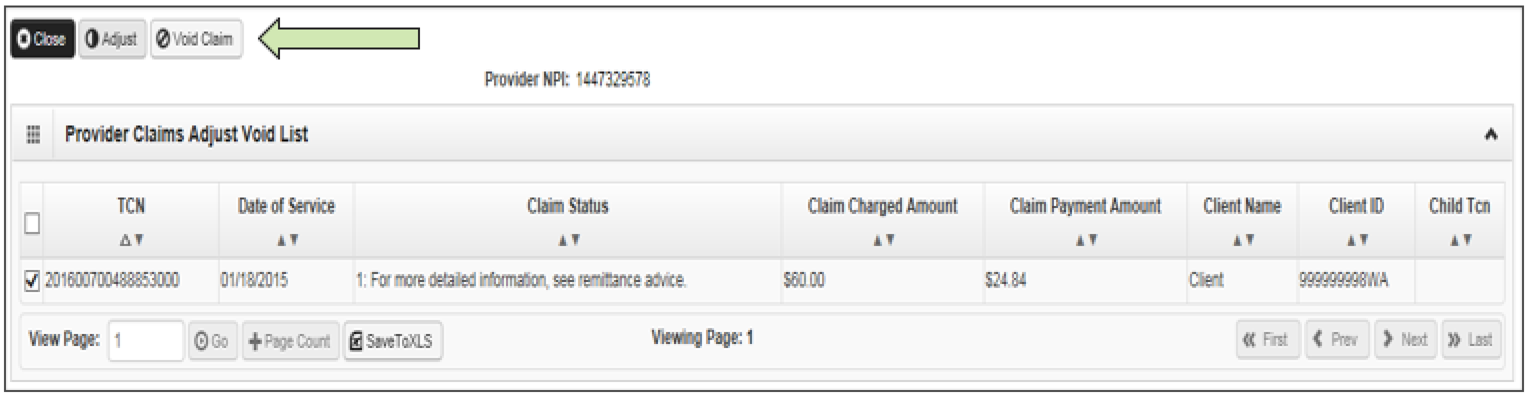
- Enter the **TCN** number if known; or
- Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.



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.

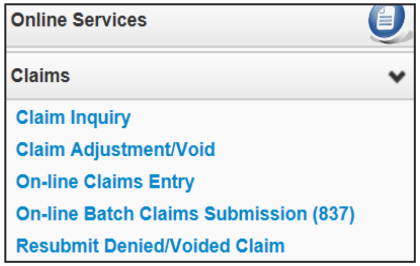


- Check the box of the TCN to adjust/void.
- ProviderOne loads the DDE screen with the claim data.
  - Update the claim information to adjust, then submit.
  - Claim data cannot be changed when doing a void, just submit the void.
  - To resubmit a voided claim, use the credit claim TCN represented by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

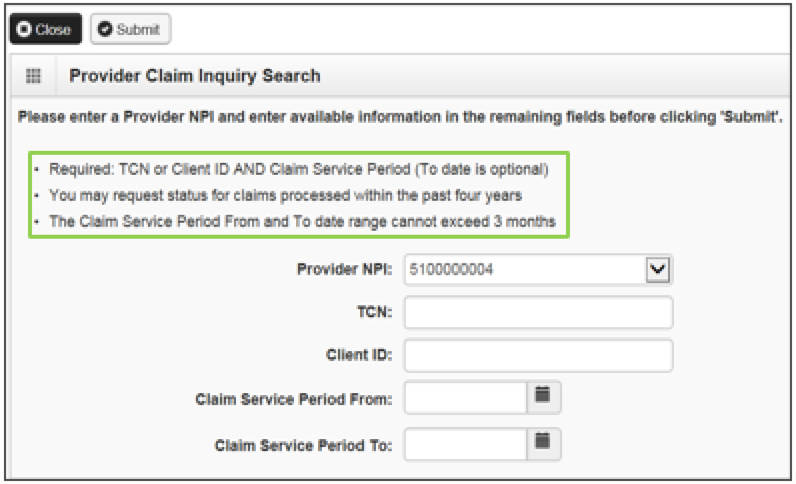
Resubmit denied claims

Resubmit a denied claim

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

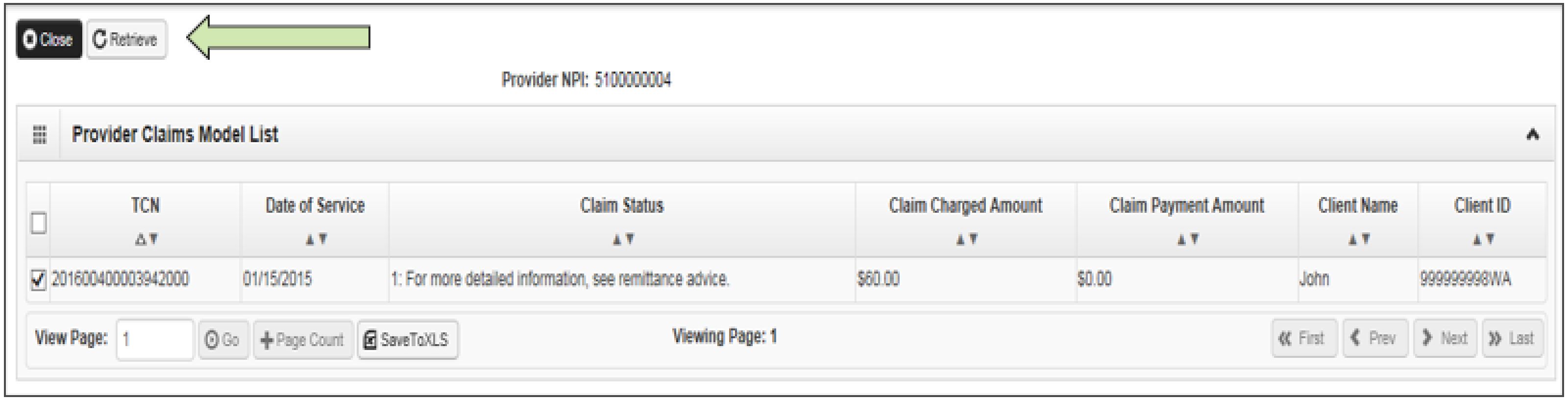


- Enter **TCN**, if known; or
- Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.



Resubmit a denied claim (cont.)

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



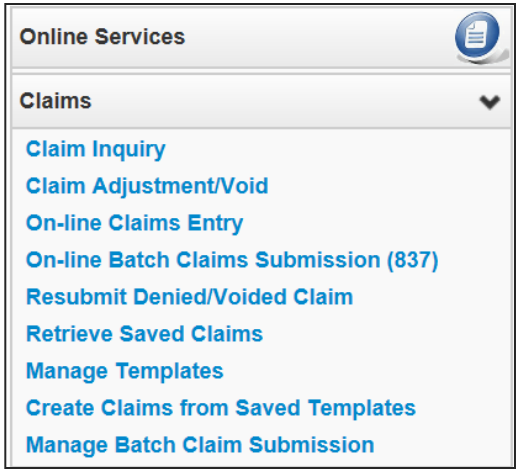
	TCN	Date of Service	Claim Status	Claim Charged Amount	Claim Payment Amount	Client Name	Client ID
☑	201600400003942000	01/15/2015	1: For more detailed information, see remittance advice.	$60.00	$0.00	John	999999998WA

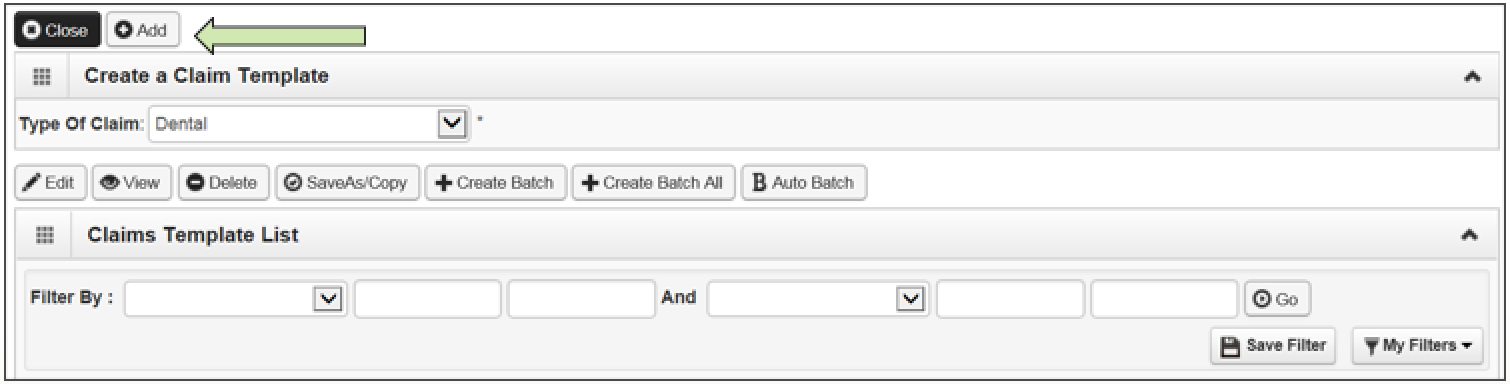
- Check the box of the TCN to resubmit and click **Retrieve**.
- ProviderOne loads the DDE screen with the claim data.
  - Update the claim information that caused the claim to deny, then submit.

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.



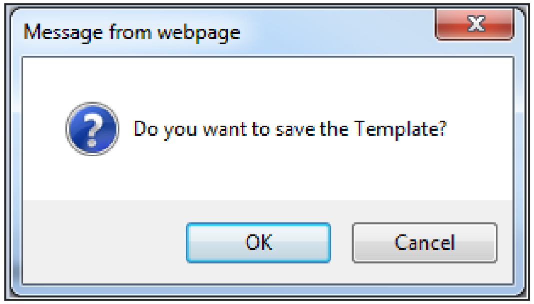


Saving a claim template

- 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.

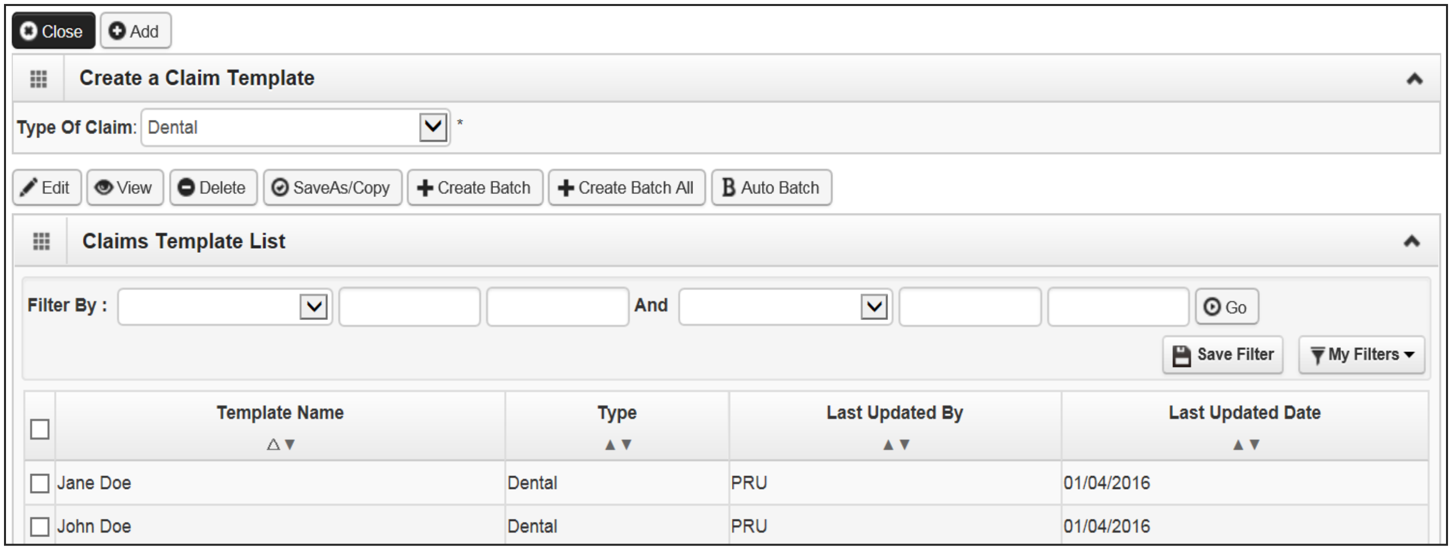


Note: The minimum information required to save a template is the Template Name and answer required questions.

Washington State Health Care Authority

Claims template list

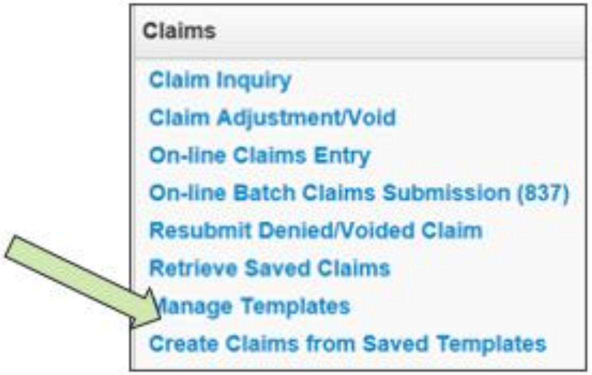
- After the template is saved it is listed on the Claims Template List

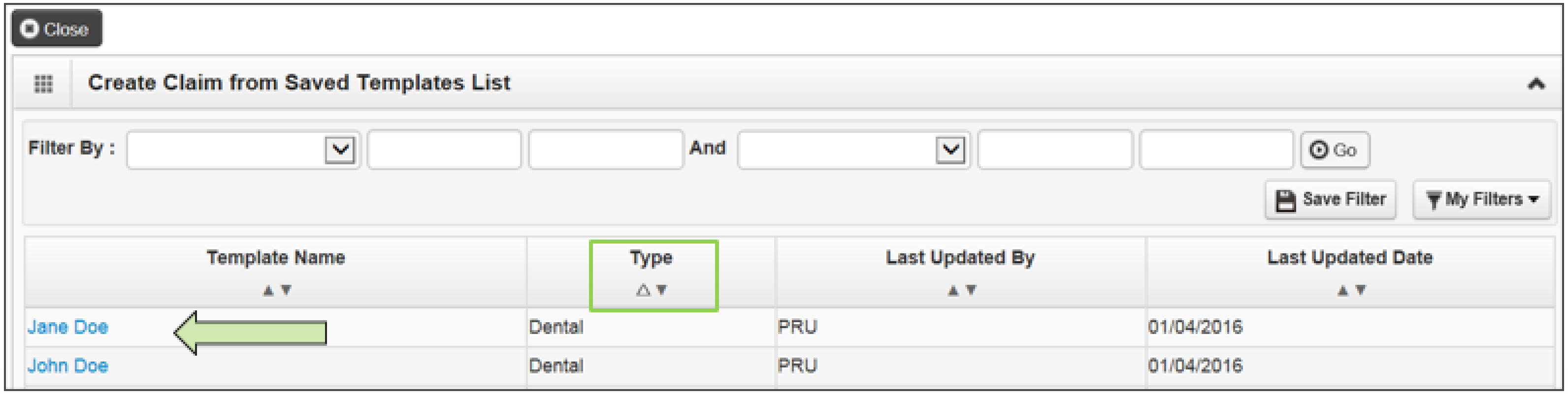


- Additional templates can be created by:
  - Copying a template on the list; or
  - Creating another from scratch.
- Templates can be edited, viewed, and deleted.

Submitting a template claim

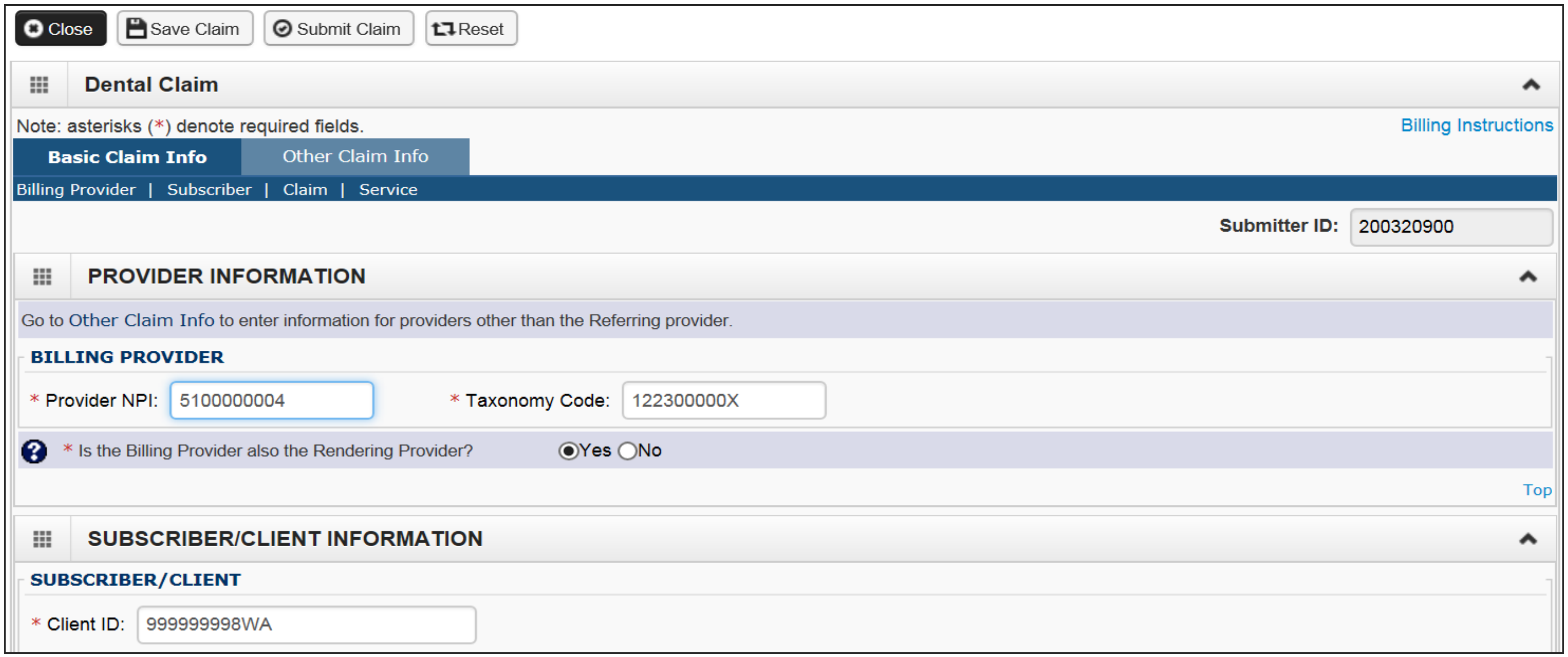
- Claims can be submitted from a Template:
  - Log into ProviderOne
  - Click on the **Create Claims from Saved Templates**.
  - At the Saved Template List find the template to use (sort using the sort tools outlined).





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.

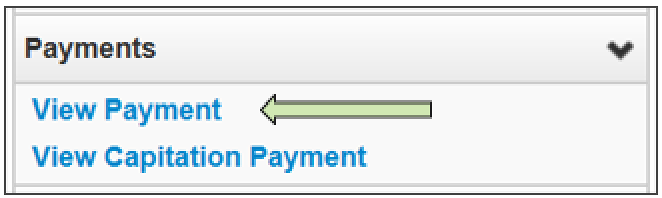
HIPAA transaction assistance

- Where do I get information:
  - HIPAA Electronic Data Interchange (EDI) webpage
- Contact information:
  - hipaa-help@hca.wa.gov

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.

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
500649639			08/06/2015	2	$300.00	$0.00	$300.00	
500955089			12/16/2015	1	$100.00	$0.00	$100.00	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

  - Click on the **RA number** in the first column to open the whole RA.

Washington State Health Care Authority

RA summary page

- 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

Prepared Date: 05/30/2014
RA Date: 05/30/2014

RA Number: 8765432
Warrant/EFT # 852741!

Warrant/EFT Date: 05/29/2014

Warrant/EFT Amount: $9325.93

Payment Method: EFT

Page 2

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Sales Tax	Total Client Resp Amount	Total Paid
1122334455	Paid	$28930.00	$16114.57	$0.00	$0.00	$0.00	$9325.93
1122334455	Denied	$6525.50	$0.00	$0.00	$0.00	$0.00	$0.00
1122334455	Adjustments	-$2981.00	-$3371.87	$0.00	$0.00	$0.00	-$3266.00
1122334455	In Process	$5946.50	$0.00	$0.00	$0.00	$0.00	$0.00

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
1122334455	214148190028/ 40140123456789 0000	System Initiated	NOC Invoice	$0.00	$0.00	$3266.00
1122334455	214148190028/ 40149870123456 0000	System Initiated	NOC Referred to CARS	$3266.00	$3266.00	$0.00

Total Adjustment Amount $3266.00

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.
    - Claims that caused these carry over adjustment amounts can be on previous RAs.
    - 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.
    - 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

RA Number: 500955089 Warrant/EFT #: Warrant/EFT Date: Prepared Date: 12/16/2015 RA Date: 12/16/2015

Category: Denied ler: 5100000004

Page 3

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
Client, Pseudo 999999998WA	201534801403737000 Professional Claim	1		12/01/2015-12/01/2015	96152	3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	N255 N290 N95	170 = $100.00
		Document Total:		12/01/2015-12/01/2015		3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	N255,N290	16,B7
				Category Total:		3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00		
				Billing Provider Total:		3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00		

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.

Adjustment Reason Codes / NCPDP Rejection Codes
119 : Benefit maximum for this time period or occurrence has been reached.
15 : The authorization number is missing, invalid, or does not apply to the billed services or provider.
16 : Claim/service lacks information or has submission/billing 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.
18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
35 : Lifetime benefit maximum has been reached.
96 : 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.

Remark Codes
N20 : Service not payable with other service rendered on the same date.
N329 : Missing/incomplete/invalid patient birth date.
N37 : Missing/incomplete/invalid tooth number/letter.
N39 : Procedure code is not compatible with tooth number/letter.

- 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.

Washington State Health Care Authority

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

Washington State Health Care Authority

Completing authorization form

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]()

Washington State Health Care Authority

General Information for Authorization

Org	1. 501	Service Type	2. MISC
Client Information			
Name	3. JOHN DOE	Client ID	4. 999999998WA
Living Arrangements	5.	Reference Auth #	6.
Provider Information			
Requesting NPI #	7. 1122334455	Requesting Fax #	8. 360-777-1111
Billing NPI #	9. 1122334455	Name	10. Dr. Baum
Referring NPI #	11.	Referring Fax #	12.
Service Start Date:	13.		14.
Service Request Information			
Description of service being requested: 15. SURGICAL EXT #9		16.	17.
18. Serial/NEA or MEA #		19.	

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. $ Amount Requested	25. Part # (DME Only)	26. Tooth or Quad #
T	D7241		1			9

Medical Information			
Diagnosis Code	27.	Diagnosis name	28.
Place of Service Code	29.		

30. Comments: SURGICAL EXTRACTION #9 - SEE X-RAY

www.hca.wa.gov/medicaid/forms/Pages/Index.aspx

Please fax this form and any supporting documents to 1-866-668-1214.

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. HIPAA Compliance: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment, or to perform other specific health care operations.

Authorization form instructions part 1

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

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	Org **(Required)**	Enter the Number that Matches the Program/Unit for the Request 501 – Dental 502 – Durable Medical Equipment (DME) 504 – Home Health 505 – Hospice 506 – Inpatient Hospital 508 – Medical 509 – Medical Nutrition 511 – Outpt Proc/Diag 513 – Physical Medicine & Rehabilitation (PM & R) 514 – Aging and Long-Term Support Administration (ALTSA) 518 – LTAC 519 – Respiratory 521 – Maternity Support/Infant Case Management 524 – Concurrent Care 525 – ABA Services 526 – Complex Rehabilitation Technology (CRT) 527 – Chemical-Using Pregnant (CUP) Women Program
2	Service Type **(Required)**	Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "501 – **Dental**" for field #1, please select one of the following codes for this field: ASC for ASC CWN for Crowns DEN for Dentures DP for Denture/Partial EXT for Extractions EXTD for Extractions w/Dentures GA for General Anesthesia GAE for General Anesthesia w/ extractions IP for In-Patient ODC for Orthodontic OUTP for Out-Patient PSM for Perio-Scaling/Maintenance PTL for Partial RBS for Rebases RLNS for Relines TC for Transfer Case MISC for Miscellaneous
		If you selected "502 – **Durable Medical Equipment (DME)**" for field #1, please select one of the following codes for this field: AA for Ambulatory Aids BB for Bath Bench BEM for Bath Equipment (misc.) BGS for Bone Growth Stimulator BP for Breast Pump C for Commode CG for Compression Garments CSC for Commode/Shower Chair DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing) ERSO for ERSO-PA FSFS for Floor Sitter/Feeder Seat GL for Gloves HB for Hospital Beds HC for Hospital Cribs IS for Incontinent Supplies MWH for Manual Wheelchair - Home MWNF for Manual Wheelchair – NF MWR for Manual Wheelchair Repair OS for Orthopedic Shoes OTC for Orthotics OP for Ostomy Products ODME for Other DME OTRR for Other Repairs PL for Patient Lifts PWH for Power Wheelchair - Home PWNF for Power Wheelchair – NF PWR for Power Wheelchair Repair PRS for Prone Standers PROS for Prosthetics RE for Room Equipment SC for Shower Chairs SBS for Specialty "Beds/Surfaces SGD for Speech Generating Devices SF for Standing Frames STND for Standers TU for TENS Units US for Urinary Supplies WDCS for VAC/Wound - decubiti supplies MISC for Miscellaneous

HCA 13-835 (5/15)

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

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
2	Service Type **(Required)** (Continued)	If you selected "504 – **Home Health**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA HH for Home Health MISC for Miscellaneous T for Therapies (PT / OT / ST)
		If you selected "505 – **Hospice**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA HSPC for Hospice MISC for Miscellaneous
		If you selected "506 – **Inpatient Hospital**" for field #1, please select one of the following codes for this field: BS for Bariatric Surgery ERSO for ERSO-PA OOS for Out of State O for Other PAS for PAS RM for Readmission S for Surgery TNP for Transplants VNSS for Vagus Nerve Stimulator MISC for Miscellaneous
		If you selected "508 – **Medical**" for field #1, please select one of the following codes for this field: BSS2 for Bariatric Surgery Stage 2 BTX for Botox CIERP for Cochlear Implant Exterior Replacement Parts CR for Cardiac Rehab ERSO for ERSO-PA HEA for Hearing Aids I for Infusion / Parental Therapy MC for Medications NP for Neuro-Psych OOS for Out of State PSY for Psychotherapy SYN for Synagis T for Therapies (PT/OT/ST) TX for Transportation V for Vision VST for Vest VT for Vision Therapy MISC for Miscellaneous
		If you selected "509 – **Medical Nutrition**" for field #1, please select one of the following codes for this field: EN for Enteral Nutrition MN for Medical Nutrition MISC for Miscellaneous
		If you selected "511 – **Output Proc/Diag**" for field #1, please select one of the following codes for this field: CCTA for Coronary CT Angiogram CI for Cochlear Implants ERSO for ERSO-PA GCK for Gamma/Cyber Knife GT for Genetic Testing HO for Hyperbaric Oxygen HY for Hysterectomy MRI for MRI OOS for Out of State OTRS for Other Surgery PSCN for PET Scan O for Other S for Surgery SCAN for Radiology MISC for Miscellaneous
		If you selected "513 – **Physical Medicine & Rehabilitation (PM & R)**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA PMR for PM and R MISC for Miscellaneous

HCA 13-835 (5/15)

Authorization form instructions part 2

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

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
2	Service Type **(Required)** (Continued)	If you selected "514 – **Aging and Long-Term Support Administration (ALTSA)** for field #1, please select one of the following codes for this field: PDN for Private Duty Nursing MISC for Miscellaneous
		If you selected "518 – **LTAC**" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA LTAC for LTAC O for Other
		If you selected "519 – **Respiratory**" for field #1, please select one of the following codes for this field: CPAP for CPAP/BiPAP ERSO for ERSO-PA NEB for Nebulizer OXM for Oximeter OXY for Oxygen SUP for Supplies VENT for Vent O for Other
		If you selected "521 – **Maternity Support/Infant Case Management (MSS)**" 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 O 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: IH for In Home/Community/Office DAYP for Day Program
		If you selected "526 – **Complex Rehabilitation Technology**" (CRT) for field #1, please select one of the following codes for this field: ERSO for ERSO-PA MWH for Manual Wheelchair - Home MWNF for Manual Wheelchair - NF MWR for Manual Wheelchair Repairs MWS for Manual Wheelchair Supplies PWH for Power Wheelchair - Home PWNF for Power Wheelchair – NF PWR for Power Wheelchair Repairs PWS for Power Wheelchair Supplies
		If you selected "527 – **Chemical-Using Pregnant (CUP) Women Program**" for field #1, please select one of the following codes for this field: DX for Detox DM for Detox/Medical Stabilization MS for Medical Stabilization

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

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
3	Name: **(Required)**	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: **(Required)**	Enter the client ID - 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): ▪ You will need to contact HCA at 1-800-562-3022 and the appropriate extension of the Authorization Unit. ▪ A reference PA will be built with a placeholder client ID. ▪ If the PA is approved – once the client ID is known – you will need to contact HCA either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: **(Required)**	The 10 digit number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI #: **(Required)**	The 10 digit number that has been assigned to the billing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: **(Required)**.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA or MEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA/MEA# to access the x-rays/pictures for this request.
20	Code Qualifier: **(Required)**.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S – ICD-9/10 Diagnosis Code
21	National Code: **(Required)**.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: **(Units or $ required)**.	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/day designation for the service code entered).
24	$ Amount Requested: **(Units or $ required)**.	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).
25	Part # (DME only): **(Required for all requested codes)**.	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

FIELD	NAME	ACTION	
		ALL FIELDS MUST BE TYPED.	
26	Tooth or Quad#: **(Required for dental requests).**	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-32, A-T, AS-TS, and 51-82	
27	Diagnosis Code	Enter appropriate diagnosis code for condition.	
28	Diagnosis name	Short description of the diagnosis.	
29	Place of Service	Enter the appropriate two digit place of service code.	
		Place of Service Code(s)	**Place of Service Name**
		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
		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
		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

HCA 13-835 (5/15)

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

FIELD	NAME	ACTION	
		ALL FIELDS MUST BE TYPED.	
29	Place of Service	52	Psychiatric Facility-Partial Hospitalization
		53	Community Mental Health Center
		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 Rehabilitation Facility
		62	Comprehensive Outpatient Rehabilitation Facility
		65	End-Stage Renal Disease Treatment Facility
		71	Public Health Clinic
		72	Rural Health Clinic
		81	Independent Laboratory
		99	Other Place of Service
30	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:
  - Client name
  - Client ProviderOne ID
  - Your NPI
  - Your name
  - Sections the request is for:
    - ❖ Dental or Orthodontic

Another option for submitting photos or x-rays:

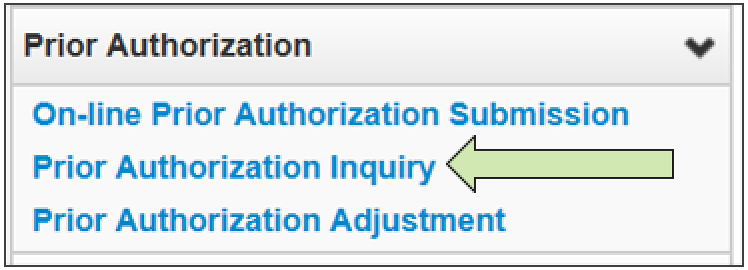
Providers can submit dental photos or x-rays for Prior Authorization by using the FastLook and FastAttach services provided by National Electronic Attachment, Inc. (NEA). Providers may register with NEA by visiting **www.nea-fast.com** and entering "**FASTWDRZ1M**" in the promotion code box for a 0$ 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.

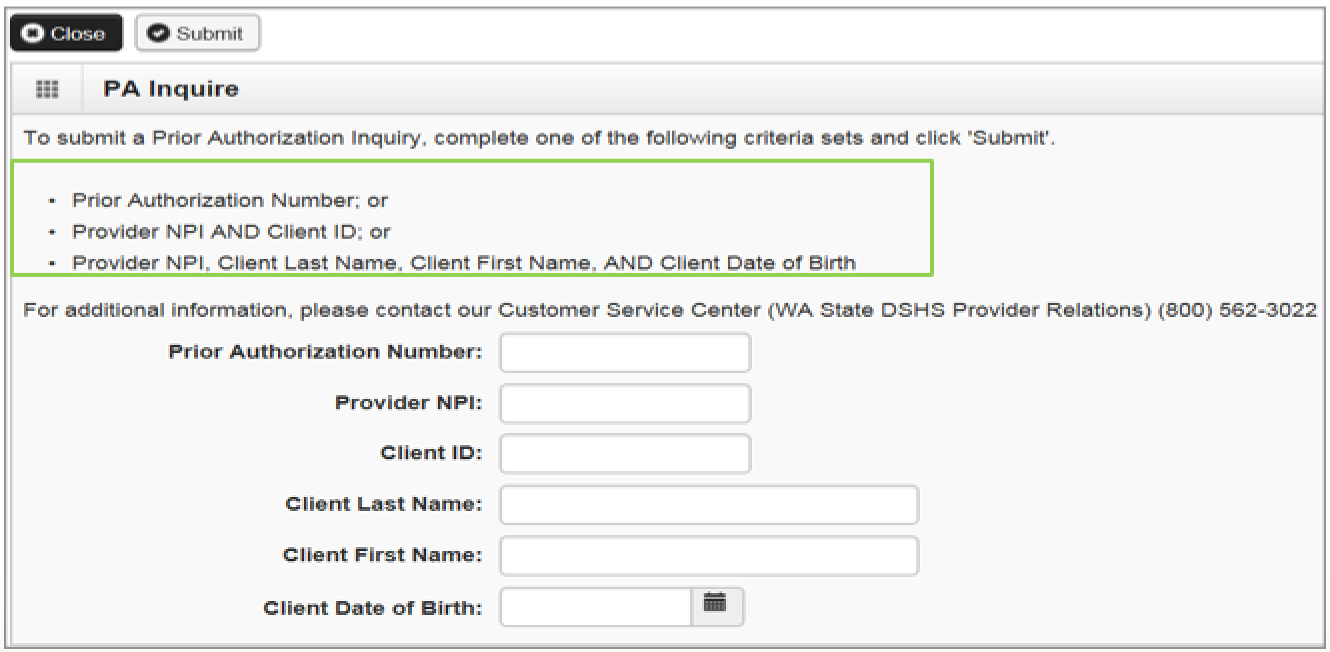


For step-bystep instructions visit the following resources:

- 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.

Close

Auth Search List

	Auth #	Client ID	Status	Org	Requestor ID	Last Updated	Request Date	Service Type
			Rejected	PA - DENTAL		01/05/2016	01/05/2016	Dentures
	1000000000	999999998WA	Approved	PA - DENTAL	1122334455	01/05/2016	01/05/2016	Dentures

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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.

Close

PA Utilization

Authorization #:		Authorization Status:	Approved
Client ID:		Client Name:	
Service:	Dentures	Organization:	PA - DENTAL
Request Date:	2016-01-05	Last Updated Date:	2016-01-05
Service Start Date:	2016-01-05	Service End Date:	2016-04-06
Requestor ID:		Requestor Name:	

Service List

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	01/05/2016	0000000000	D5110	0-All					01/05/2016	04/06/2016	0	1	0	1	0	0	Approved

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Washington State Health Care Authority

List of statuses for authorization requests

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

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.

Submit prior authorization request

ProviderOne

PA Pend Forms Submission Cover Sheet

Authorization Reference # 123456789
(Please enter 9 digit numeric value.)

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet

INSTRUCTIONS:
Click ENTER on your keyboard after typing the number in above.

Please use the **Print Cover Sheet** Button Above to print ONLY.

Use Only ADOBE Reader to generate this coversheet. Other readers will not generate the barcode correctly.

DO NOT USE FOR PHARMACY RELATED AUTHORIZATION REQUESTS!

Privacy Statement:
This material in this facsimile is intended only for the use of the individual who it is addressed and may contain information that is confidential, privileged and exempt from disclosure under applicable law.

HIPAA Compliance:
Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment to see insurance payment or to perform other specific health care operations.

FAX to : 1-866-668-1214.

THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.

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:

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1113	QMB	06/01/2014	12/31/2999	S03	00[illegible]0000		
MC: Medicaid	1126	Pending Spenddown - No Medical	01/01/2015	05/31/2015	S99	000000000		

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- No longer pending – has MNP coverage:

MC: Medicaid	1124	LCP-MNP		11/01/2014	01/31/2015	S99

What is the spenddown amount?

- The same eligibility check indicates the spenddown amount:

Spenddown Information

RAC Code - 1126 **Base Period - Start: 12/01/2014 End: 05/31/2015**

Total Spenddown	Spenddown Liability	Remaining Spenddown	EMER Liability	Remaining EMER	Spenddown Status	Update Date	Spenddown Start Date
144.00	144.00	144.00	0.00	0.00	Pending	10/27/2014	12/01/2014

View Page: 1 Go Page Count **Viewing Page: 1** First Prev Next Last

- 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
    - 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

Healthcare Service Categories
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 **Benefit Service Package (BSP)**.

Excluded Services
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).

Covered service
A healthcare service contained within a "service category" that is included in a medical assistance BSP as described in WAC 182-501-0060.

Non-covered service
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). **A non-covered service is not an excluded service** (see WAC 182-501-0060). Non-covered services are identified in WAC 182-501-0070 and in specific health-care program rules.

Sample form 13-879

Washington State Health Care Authority

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.

CLIENT'S PRINTED NAME	CLIENT'S ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

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)

Page 1 of 2

Washington State Health Care Authority

Sample form (cont.)

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR/NFJ REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE	
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)

- 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 fro 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 specified 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.	CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE	DATE
I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.	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).

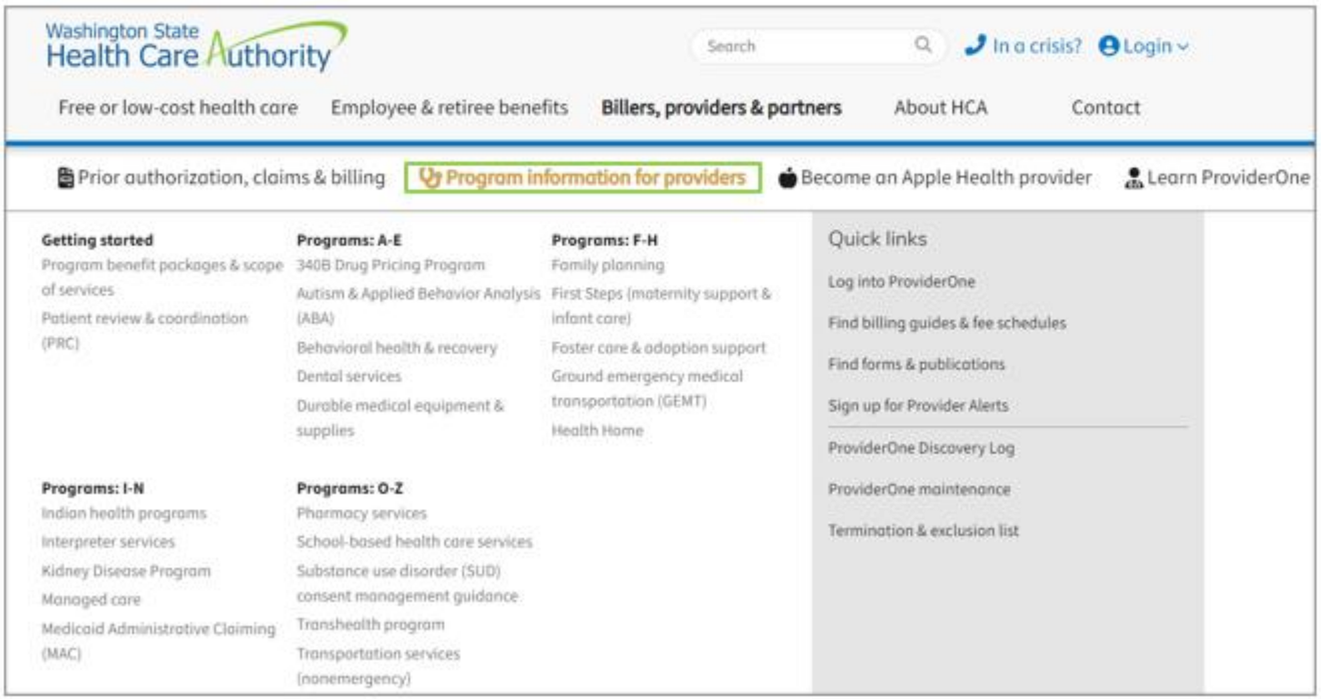
When can a provider **not** bill a client (cont.)?

- 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

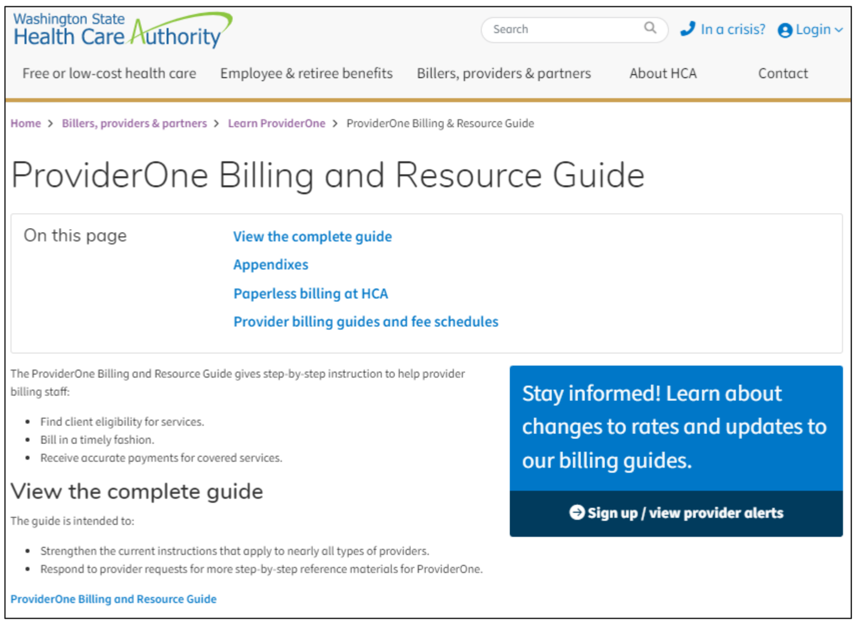
Webpage menus

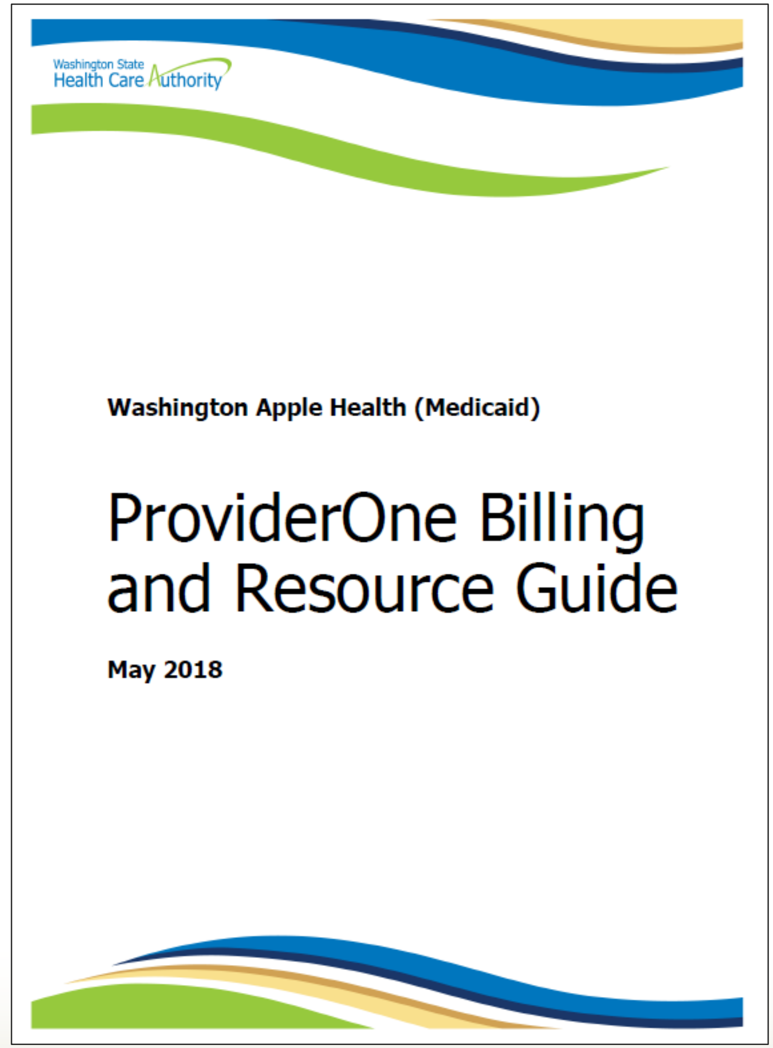
- Apple Health provider homepage
- Hover over a topic to highlight and click to expand the mega menu.



ProviderOne billing and resource guide

- [ProviderOne Billing and Resource Guide](#) and webpage



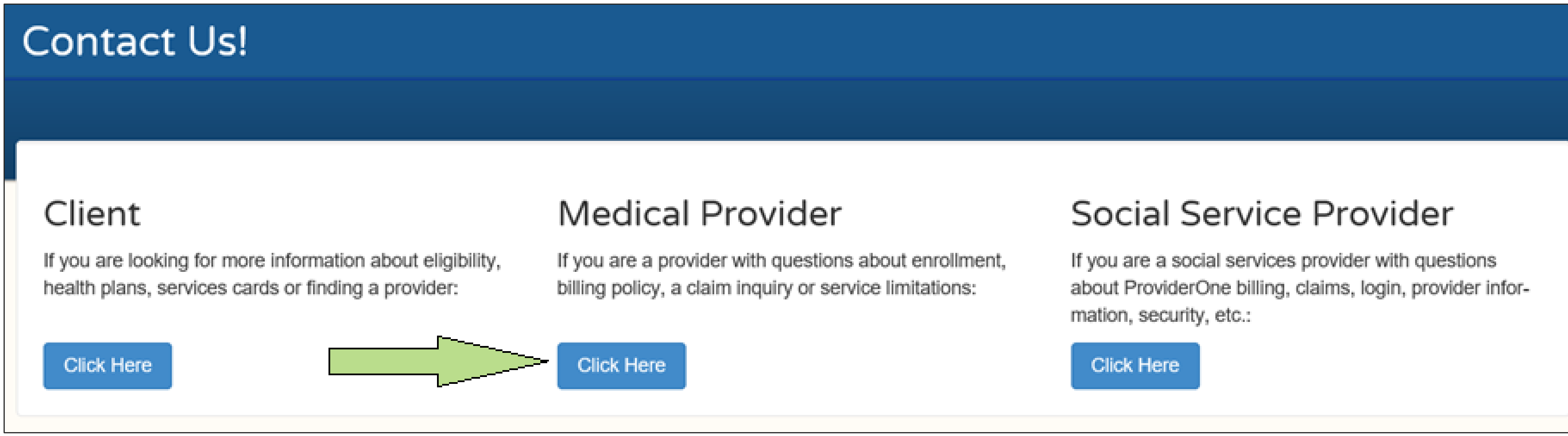


Online resources for authorization

- 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

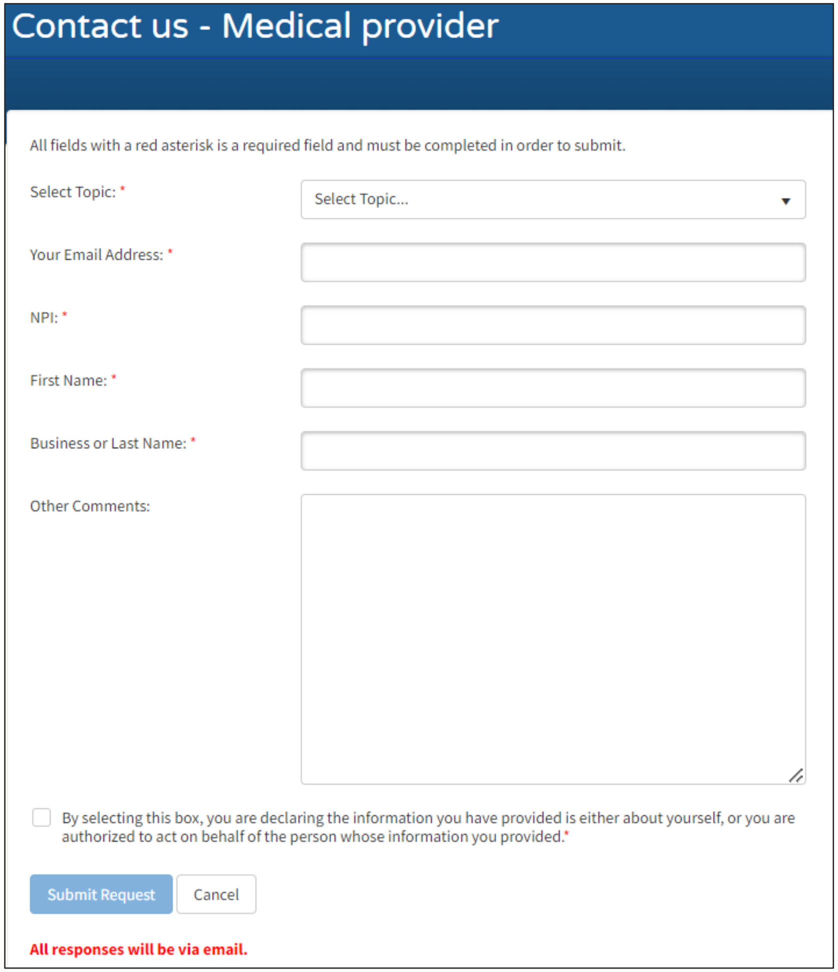
Contact us



Use the Apple Health web form!

Contact us form

- Using the drop down **Select Topic**, choose **Service Limits**:


Contact us - Medical provider

All fields with a red asterisk is a required field and must be completed in order to submit.

Select Topic: * Select Topic...

Your Email Address: *

NPI: *

First Name: *

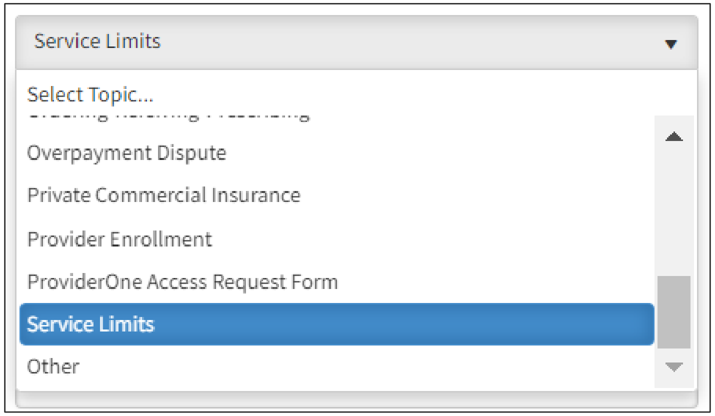
Business or Last Name: *

Other Comments:

By selecting this box, you are declaring the information you have provided is either about yourself, or you are authorized to act on behalf of the person whose information you provided.*

Submit Request | Cancel

All responses will be via email.


Service Limits

Select Topic...

Overpayment Dispute

Private Commercial Insurance

Provider Enrollment

ProviderOne Access Request Form

Service Limits

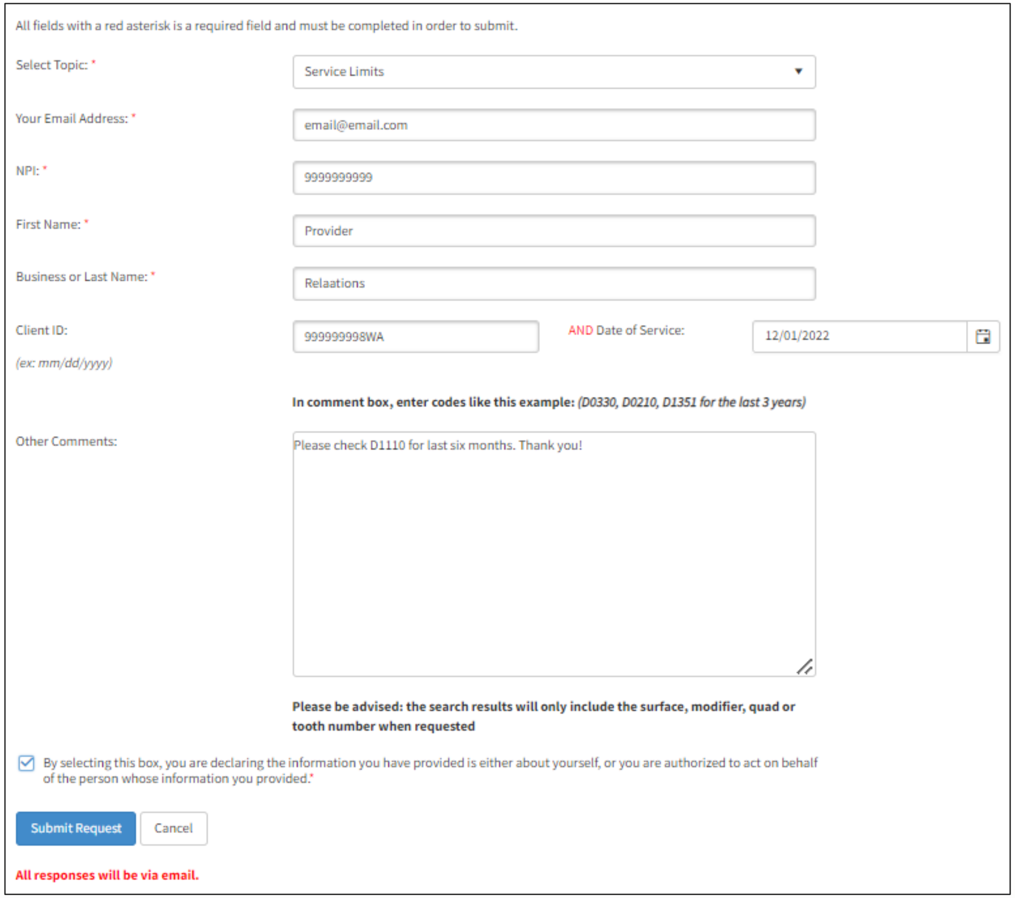
Other

- 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

Washington State Health Care Authority

Contact us – service limit

- Sample request for Service Limit check:


All fields with a red asterisk is a required field and must be completed in order to submit.

Select Topic: * Service Limits

Your Email Address: * email@email.com

NPI: * 9999999999

First Name: * Provider

Business or Last Name: * Relaations

Client ID: 999999998WA AND Date of Service: 12/01/2022

(ex: mm/dd/yyyy)

In comment box, enter codes like this example: ***(D0330, D0210, D1351 for the last 3 years)***

Other Comments: Please check D1110 for last six months. Thank you!

Please be advised: the search results will only include the surface, modifier, quad or tooth number when requested

☑ By selecting this box, you are declaring the information you have provided is either about yourself, or you are authorized to act on behalf of the person whose information you provided.*

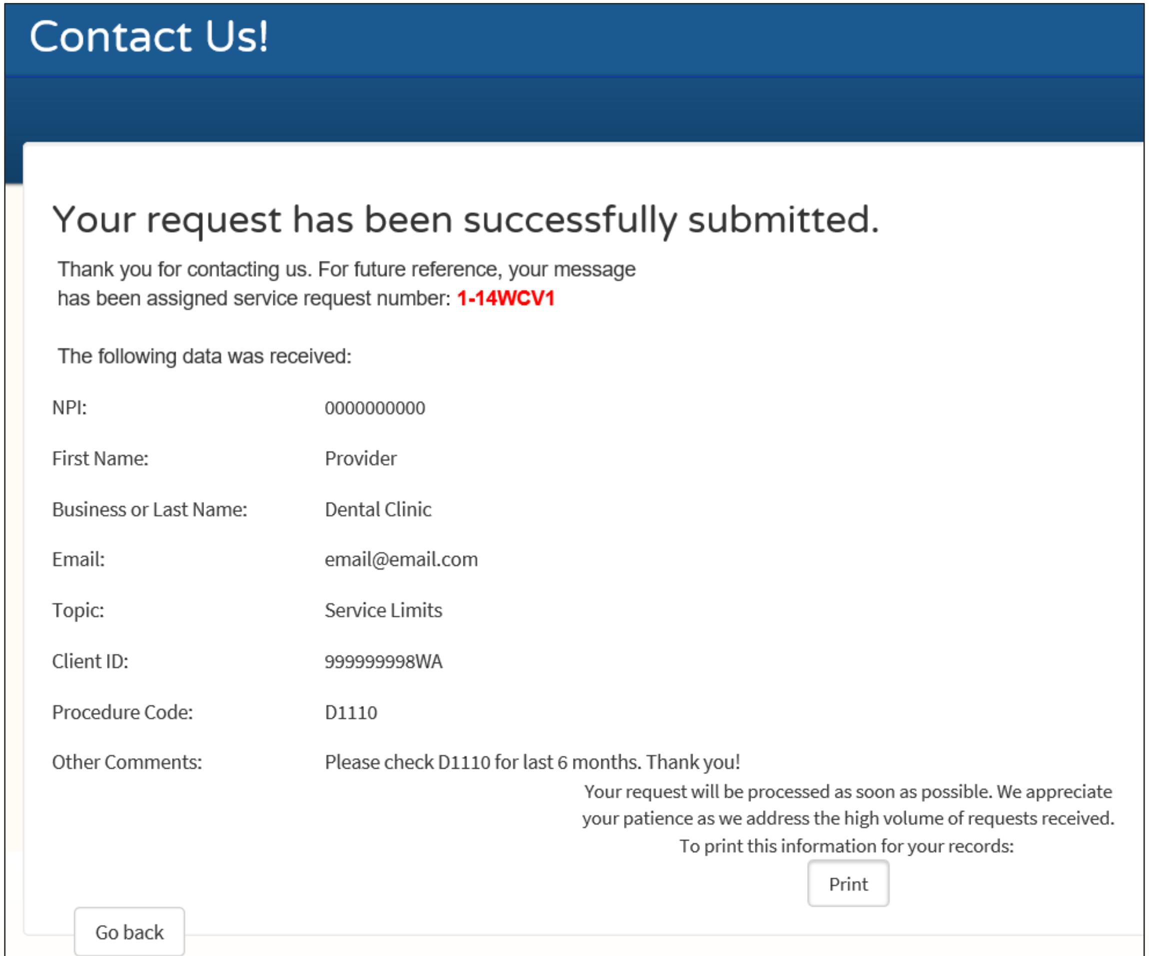
Submit Request Cancel

All responses will be via email.

- 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:



Contact Us!

Your request has been successfully submitted.

Thank you for contacting us. For future reference, your message has been assigned service request number: **1-14WCV1**

The following data was received:

NPI:	0000000000
First Name:	Provider
Business or Last Name:	Dental Clinic
Email:	email@email.com
Topic:	Service Limits
Client ID:	999999998WA
Procedure Code:	D1110
Other Comments:	Please check D1110 for last 6 months. Thank you!

Your request will be processed as soon as possible. We appreciate your patience as we address the high volume of requests received.

To print this information for your records:

Print

Go back

- 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