Medicaid billing workshop for fee-for-service (FFS) medical 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

ProviderOne

Eligibility & billing processes

Resources

Topics
Medicaid overview
Medicaid overview

Medicaid is no longer managed by DSHS

Medicaid is managed by the Health Care Authority

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

- Categorically Needy Program (full scope)
- Alternative Benefit Plan (mirrors CNP)
- Medically Needy Program

- Qualified Medicare Beneficiary – Medicare Only
- Take Charge - Family Planning Services Only

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

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

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

➢ 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.
ProviderOne users
How to get access in ProviderOne

➢ Review the ProviderOne Security webpage for detailed instructions on setting up users.

➢ New provider and don’t have the form? Email ProviderOne Security at provideronesecurity@hca.wa.gov (in the subject line enter “Request for ProviderOne User Access Request form”).
How to get access in ProviderOne

➢ The ProviderOne User Access Request Form is for a newly enrolled facility, clinic, individual provider, or a new office administrator.

➢ Complete the form and fax to: 360-507-9019.

➢ If changing system administrators, a letter on office correspondence must also be completed and faxed with the form.
How to set up a user

➢ Log in with the **System Administrator** Profile.
➢ Click on **Maintain Users**.
➢ The system now displays the User List screen.
➢ Click on the **Add** button.
How to set up a user

➢ Adding a user:

➢ Fill in all required boxes that have an asterisk *.

➢ Click the Next button.
How to set up a user

➢ Complete remaining required fields:

Note: It is not necessary to complete the address information.

➢ Click the Finish button.
How to set up a user

➢ To display the new user:
  • In the **With Status** dropdown, select **In Review** and click **Go**.
  • The user’s name is displayed with In Review status.
  • Click the box next to the user’s name, then click the **Approve** button.
How to set up a user

➢ Once approved, a dialogue box will pop up, click Ok.

➢ Once clicked, another window will appear warning you that profiles must be added for this new user. Click Ok or Cancel.
How to set up a user

➢ The user is now in **Approved** status.

➢ Click on the username noted in the **Name** column to access their user account and tell ProviderOne the functions they will perform in the system.
How to set up a user

➢ Adding profiles:

• On the User Details page, click on the username to access User Details.

• Using the Show menu click on **Associated Profiles**.
How to set up a user

➢ Adding profiles:
  • Click on the Add button to select profiles.
How to set up a user

➢ Adding profiles:

- Highlight Available Profiles desired.
- Click double arrow button and move to Associated Profiles box then click the OK button.
How to set up a user

➢ Adding profiles:

To display the new profiles:

• The **With Status** dropdown box should state **All**. Click **Go**.
• The profiles are displayed with **In Review** status.
• Click the box next to the profile name, then click the **Approve** button.
How to set up a user

➢ Once approved a dialogue box will pop up, click Ok.
How to set up a user

➢ The profile statuses are now **Approved**.

![Manage User Profiles](image)

➢ **Click Close** to return to User Details.
How to set up a user

➢ Setting up a user’s password
  • Enter the new temporary password and click **Save** and then **Close**.

Note: Passwords must be changed every 120 days!
How to manage a user

➢ How to lock or end date a user:

- To lock or unlock a User, click this box.
- Users can also be end dated.

➢ Click Save and then Close.
Eligibility & billing processes
How do I check eligibility in ProviderOne?

➢ Select the proper user profile.

- Select **Benefit Inquiry** under the Client area.
How do I check eligibility in ProviderOne?

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

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

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

- After scrolling down the page, the first entry is the **Client Eligibility Spans** which show:
  - The eligibility program (CNP, ABP, etc.).
  - The date span for coverage.

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

Note: Use the benefit service package blue acronym hyperlink to see high level coverage for this program.
Successful eligibility checks

Managed Care Information

- Clients may have more than one of the following managed care programs listed on their eligibility screen. Refer to the ProviderOne Billing and Resource Guide for detailed information on each program.
Successful eligibility checks

➢ Managed Care Information (continued)

Note: Effective for claims with dates of service on and after January 1, 2017, clients with other primary health insurance may be enrolled in an Apple Health managed care plan as their secondary insurance. Remember to always check for other primary payers when verifying eligibility in ProviderOne. See the Apple Health Medicaid provider alert and the ProviderOne Billing and Resource Guide for more detail.
Successful eligibility checks

Managed Care Information

- Primary Care Case Management (PCCM) and Health Homes provide care management for clients only and are not direct payers.
Successful eligibility checks

**Medicare Eligibility Information**

- If client has Medicare Part A or Part B this information will be shown with the Medicare eligibility effective dates of service.

<table>
<thead>
<tr>
<th>Service Type Code</th>
<th>Insurance Type Code</th>
<th>Eligibility Start Date</th>
<th>Eligibility End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>30: Health Benefit Plan Coverage</td>
<td>MA: Medicare Part A</td>
<td>02/01/1997</td>
<td>12/31/2999</td>
</tr>
<tr>
<td>30: Health Benefit Plan Coverage</td>
<td>MB: Medicare Part B</td>
<td>02/01/1997</td>
<td>12/31/2999</td>
</tr>
</tbody>
</table>

- If the client has enrolled in a Medicare Advantage Plan (Part C), if reported it is listed in the **Coordination of Benefits Information** section.

<table>
<thead>
<tr>
<th>Service Type Code</th>
<th>Insurance Type Code</th>
<th>Insurance Co. Name &amp; Contact</th>
<th>Carrier Code</th>
<th>Policy Holder Name</th>
<th>Policy Number</th>
<th>Group Number</th>
<th>Plan Sponsor</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>30: Health Benefit Plan Coverage</td>
<td>C1: Commercial</td>
<td>UNITED HEALTHCARE INSURANCE COMPANY</td>
<td>H5008</td>
<td>Med Part D</td>
<td></td>
<td></td>
<td></td>
<td>08/01/2009</td>
<td>12/31/2999</td>
</tr>
<tr>
<td>30: Health Benefit Plan Coverage</td>
<td>C1: Commercial</td>
<td>UNITED HEALTHCARE INSURANCE COMPANY</td>
<td>H5008</td>
<td>Med Part C</td>
<td></td>
<td></td>
<td></td>
<td>08/01/2009</td>
<td>12/31/2999</td>
</tr>
</tbody>
</table>
Successful eligibility checks

➢ 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.

<table>
<thead>
<tr>
<th>Service Type Code</th>
<th>Insurance Type Code</th>
<th>Insurance Co. Name &amp; Contact</th>
<th>Carrier Code</th>
<th>Policy Holder Name</th>
<th>Policy Number</th>
<th>Group Number</th>
<th>Plan Sponsor</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>30: Health Benefit Plan Coverage</td>
<td>C1: Commercial</td>
<td>CIGNA DENTAL</td>
<td>DN18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>01/01/2012</td>
<td>12/31/2999</td>
</tr>
<tr>
<td>30: Health Benefit Plan Coverage</td>
<td>C1: Commercial</td>
<td>CIGNA HEALTHCARE</td>
<td>CH55</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>01/01/2012</td>
<td>12/31/2999</td>
</tr>
</tbody>
</table>

Please Note: If you know an Apple Health client has a commercial insurance and you do not see a Coordination of Benefits Information segment on their eligibility file in ProviderOne, you must complete a Contact Us email. Choose the option “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 agency’s Coordination of Benefits unit will update the client’s file using this information. Check eligibility again in ProviderOne in 3 – 5 business days to verify the update has been made. Only after verification of this information in ProviderOne should you bill the claim to the system.
Successful eligibility checks

- **Restricted Client Information**
  - Clients may be restricted to specific hospitals, PCP’s, and pharmacies for care. A referral is required from the PCP for specialized care.

<table>
<thead>
<tr>
<th>Assignment Type</th>
<th>Provider Name</th>
<th>Provider Phone Number</th>
<th>Period Start Date</th>
<th>Period End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>SAMUEL EASTERN INC</td>
<td></td>
<td>03/21/2011</td>
<td>12/31/2999</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>REIDT PHARMACY CORPORATION</td>
<td></td>
<td>03/04/2011</td>
<td>12/31/2999</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>MINOR AND JAMES MEDICAL PLLC</td>
<td></td>
<td>02/11/2009</td>
<td>12/31/2999</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>COMM Health Assoc of Spokane</td>
<td></td>
<td>12/01/2009</td>
<td>12/31/2999</td>
</tr>
<tr>
<td>Hospital</td>
<td>PROVIDENCE HOLY FAMILY HOSPITA</td>
<td></td>
<td>08/08/2008</td>
<td>12/31/2999</td>
</tr>
</tbody>
</table>
Successful eligibility checks

➢ **Children with Special Health Care Needs (CSHCN) Information**
  • There may be an eligibility segment stating Children with Special Health Care Needs. These clients could also be enrolled into a managed care plan.
Successful eligibility checks

➢ Hospice Information
  • Client’s may be enrolled in a hospice agency for care:

<table>
<thead>
<tr>
<th>Hospice agency</th>
<th>Hospice Address</th>
<th>Hospice Phone</th>
<th>Hospice Contact</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDENCE HOSPICE OF SEAT, 425 PONTIUS AVE N STE 300, SEATTLE, WA 98109-5312</td>
<td></td>
<td></td>
<td></td>
<td>01/04/2016</td>
<td>12/31/2020</td>
</tr>
</tbody>
</table>

Note: If a client is assigned to a hospice agency, bill the hospice agency for any care related to the client’s terminal illness. WA Medicaid has paid a monthly payment to the agency to cover these services.

Note: If the service is not related to the client’s terminal illness, bill these services to WA Medicaid with a claim note SCI=K.

• The last section of the eligibility check lists the source of the eligibility data.
Successful eligibility checks

➢ 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.

<table>
<thead>
<tr>
<th>Developmental Disability Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start Date</strong></td>
</tr>
<tr>
<td>10/06/1982</td>
</tr>
</tbody>
</table>

Note: If a client has the DD indicator, they may be eligible for expanded benefits.
Successful eligibility checks

➢ 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).
Successful eligibility checks

➢ Foster Care medical records history
  • Shows claims paid by ProviderOne.
  • Sort by using the “diamonds” under each column name.
  • Search by using the “Filter by Period” boxes.
  • If there are more pages of data use the Next or Previous buttons.
  • If there is no data for the section, it will display “no records found.”
Gender and date of birth updates

- Verified with ProviderOne system staff as of 01/27/14:
  - A large number of claims are denied due to a mismatch between the patient’s DOB in the provider's record and the ProviderOne's client eligibility file. Providers can send a secure email to mmishelp@hca.wa.gov with the client's ProviderOne ID, name, and correct DOB. The same is true if providers find a gender mismatch; send the ProviderOne client ID, name, and correct gender to the same email address.
Verifying eligibility

- Coverage status can change at any time
  - Verify coverage for each visit
  - Print the Benefit Inquiry result
  - If eligibility changes after this verification, HCA will honor the printed screen shot
    - **Exception**: Client with commercial insurance carrier that is loaded after you verify eligibility; commercial insurance must be billed first.
Direct Data Entry (DDE) claims

FFS claims and commercial insurance secondary claims
After this training, you can:

➢ Submit fee for service DDE claims

➢ Create and submit TPL secondary claims through DDE
  • With backup
  • Without backup
Direct Data Entry (DDE) claims

- ProviderOne allows providers to enter claims directly into the payment system.
- All claim types can be submitted through the DDE system:
  - Professional (CMS 1500)
  - Institutional (UB-04)
  - Dental (ADA Form)
- Providers can CORRECT and RESUBMIT denied or previously voided claims.
- Providers can ADJUST or VOID previously paid claims.
Determine what profile to use

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

- At initial login:

- And in the portal:

Note: Using My Inbox to change profiles, takes you back to the main profile screen.
Direct Data Entry (DDE) claims

➢ From the provider portal select the **Online Claims Entry** option located under the Claims heading.
Choose the type of claim that you would like to submit with the appropriate claim form:

- Professional – CMS 1500
- Institutional - UB04
- Dental - 2012 ADA
Direct Data Entry (DDE) claims
Direct Data Entry (DDE) claims

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### Claim Data

- Patient Account No.: [Field]
- Place of Service: [Dropdown]

### Additional Claim Data

#### Diagnosis Codes

1. [Field]
2. [Field]
3. [Field]
4. [Field]
5. [Field]
6. [Field]
7. [Field]
8. [Field]
9. [Field]
10. [Field]
11. [Field]
12. [Field]

### Basic Line Item Information

Note: Enter the following additional line item information:
- Ambulance Transport
- Line item Notes
- Medicare Crosswalk Items
- National Drug Code
- Prior Authorization
- Drug Identification

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### Basic Service Line Items

- Service Date From: [mm/dd/yyyy]
- Service Date To: [mm/dd/yyyy]
- Procedure Code: [Field]
- Submitted Charges: [$]
- Units: [Field]

#### Modifiers


#### Diagnostic Pointers


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[Add Service Line Item] [Update Service Line Item]
Billing provider information

➢ Section 1: 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.
Rendering provider information

➢ If the rendering provider is the same as the billing provider answer this 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**.
Referring provider information

➢ If the service is the result of a referral, answer Yes to this question and add the referring Provider NPI.

➢ If the service is not the result of a referral, answer this question No and continue to next section.

Note: Only the provider NPI number is required for referring providers.
Subscriber/client information

➢ Section 2: Subscriber/Client Information
Subscriber/client information

➢ 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.
Subscriber/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.
- The additional information fields are not needed.
Baby on birthing parent’s client ID

➢ If claim is for a baby being billed under the Birthing Parent’s Client ID, select Yes; otherwise choose No and continue to next question.

Note: If claim is for a baby using the birthing parent’s ID, use the baby’s last name, the baby’s date of birth, and gender when filling out the Subscriber/Client Information on the previous slide. Be sure to add the claim note SCI=B when billing for a baby using the birthing parent’s ID.
Medicare crossover claim

➢ If the claim is considered a **Medicare Crossover** answer the question **YES**. This includes Managed Medicare Advantage Plans (Medicare Part C).

➢ If Medicare did not make a payment answer the question **NO**.

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Note: Apple Health Medicaid considers a claim as a crossover when Medicare allows the service. If Medicare makes a payment, applies the charges to a deductible, coinsurance, or copayment, you must answer the question Yes to expand the Medicare crossover items and enter those amounts even, if a zero dollar payment.

➢ If Medicare did not make a payment answer the question **NO**.
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.

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

Note: Bill paid and denied lines on the same claim. This will result in more efficient and quicker processing of your TPL claim.
Insurance other than Medicaid

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

➢ Open up the **Additional Other Payer Information** section by clicking on the red (+) expander.
Insurance other than Medicaid

➢ In the **Additional Other Payer Information** section fill in the following:

![Image of form with fields for insurance information]

- Enter the Insurance carrier code number and the ID type.
Insurance other than Medicaid

➢ Use the insurance **Carrier Code** found on the client eligibility screen under the Coordination of Benefits section as the ID number for the insurance company.
Insurance other than Medicaid

➢ Enter the total amount paid by the commercial private insurance in the **COB Payer Paid Amount** field.

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

➢ If the claim is for an insurance denial or insurance applied to the deductible, enter a 0 here.
Insurance other than Medicaid

➢ Click on the red + to expand the Claim Level Adjustments section.
Insurance other than Medicaid

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

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

➢ Section 3: Claim Information

<table>
<thead>
<tr>
<th>CLAIM INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to Other Claim Info to include the following claim detail information:</td>
</tr>
<tr>
<td>Specialized Line Services, Miscellaneous Line Data, Line Level Providers, Miscellaneous Line Dates, Test Results or Form Identification Information.</td>
</tr>
<tr>
<td>➢ PRIOR AUTHORIZATION</td>
</tr>
<tr>
<td>➢ CLAIM NOTE</td>
</tr>
<tr>
<td>➢ EPSDT INFORMATION</td>
</tr>
<tr>
<td>➢ CONDITION INFORMATION</td>
</tr>
<tr>
<td>* Is this claim accident related?</td>
</tr>
<tr>
<td>CLAIM DATA</td>
</tr>
<tr>
<td>Patient Account No.:</td>
</tr>
<tr>
<td>* Place of Service:</td>
</tr>
<tr>
<td>➢ Additional Claim Data</td>
</tr>
<tr>
<td>Diagnosis Codes:</td>
</tr>
</tbody>
</table>
Prior Authorization (PA)

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

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

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

➢ A note may need to be added to the claim to assist in the processing.

➢ Click on the red + to expand the Claim Note section.

➢ 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.
Is the claim accident related?

➢ 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 by dialing 1-800-562-3022.
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 Form]

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.
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*

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.

![Claim Data Image]

➢ 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.

![Additional Claim Data Image]
Diagnosis codes

➢ Enter the appropriate ICD-10 **Diagnosis Code** or codes.

<table>
<thead>
<tr>
<th>Diagnosis Codes: *1:</th>
<th>2:</th>
<th>3:</th>
<th>4:</th>
<th>5:</th>
<th>6:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td>7:</td>
<td>8:</td>
<td>9:</td>
<td>10:</td>
<td>11:</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
- At least 1 diagnosis code is required for all claims.
- ProviderOne will allow up to 12 ICD-10 diagnosis codes.
- Do not enter decimal points in DX codes. ProviderOne will add these in once the claim is submitted.
## Basic Line Item Information

Click on Other Svc Info in each line item to include the following additional line item information:

- Attachment
- Drug
- DMERC Condition
- Health Services
- Test Results
- Home Oxygen Therapy
- Service Facility
- Miscellaneous Numbers
- Indicators
- Providers
- Dates and Amounts
- Medical Equipment
- Ambulance Transport
- Line Item Notes
- Other Payer
- Spinal Manipulations
- Purchased Services
- Line Adjucisation

### Basic Service Line Items

<table>
<thead>
<tr>
<th>Service Date From</th>
<th>Service Date To</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
</tr>
</tbody>
</table>

**Place of Service:**

**Procedure Code:**

**Submitted Charges:**

**Units:**

### Medicare Crossover Items

**National Drug Code:**

### Drug Identification

### Prior Authorization

### Additional Service Line Information

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

### Previously Entered Line Item Information

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

<table>
<thead>
<tr>
<th>Line Service Dates</th>
<th>Proc. Code</th>
<th>Modifiers</th>
<th>Diagnosis Pts</th>
<th>Submitted Charges</th>
<th>Units</th>
<th>PA Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>From</td>
<td>To</td>
<td>Code</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total Submitted Charges: $
Basic service line items

➢ Enter the **Service Date From:**

![Service Date From]

➢ Enter the **Service Date To:**

![Service Date To]

Note: The dates of service must be in the format of a 2 digit month, 2 digit day, and 4 digit year (e.g. 10/03/2016).
Basic service line items

➢ The **Place of Service Code** is not required here as it is already entered at the claim level.

![Place of Service Codes](image)
Enter the **Procedure Code**:  

* Procedure Code:  

Note: Use current codes listed in the coding manuals.  

Enter the appropriate procedure **Modifiers** if needed.  

Modifiers: 1: [ ] 2: [ ] 3: [ ] 4: [ ]  

Note: ProviderOne allows up to 4 modifiers to be added to a single procedure code.
Basic service line items

➢ Enter **Submitted Charges:**

Note: If the dollar amount is a whole number, no decimal point is needed.

Note: The agency requests that providers enter their usual and customary charges here. If providers have billed a commercial insurance or Medicare as primary, please enter the same charges here as billed to the primary. If a provider is billing for DME supplies that required prior authorization, please enter the same amount here as was on the authorization request because they must match.
Basic service line items

➢ Enter appropriate **Diagnosis Pointer**:

Note:

• At least one DX pointer is required.
• Up to 4 DX codes can be added per service line.
• Diagnosis pointer 1 is the primary DX code.
• Diagnosis pointer drop down corresponds with DX codes entered previously.
Basic service line items

➢ Enter procedure **Units:**

* Units:  

**Note:** At least 1 unit is required.
If the claim is a Medicare crossover, complete the following Medicare Crossover Items:

- Medicare Deductible: $
- Medicare Co-insurance: $
- Medicare Co-payment: $
- Medicare Paid: $
- Medicare Allowed Amount: $
- Medicare Paid Date: mm dd ccyy

Note: Entering the line level Medicare information is required here if the previous question concerning Medicare crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.

Note: For complete instructions on how to submit a Medicare crossover claim please view the online fact sheet titled 5010 DDE Medicare Crossover Claims.
Basic service line items

➢ Enter **National Drug Code** (NDC) if billing an injectable procedure code.


```
National Drug Code: 
```

➢ The **Drug Identification** red (+) expander is not needed when billing for injectable procedure codes.


```
Drug Identification
```

Basic service line items

➢ If a PA number needs to be added to a line level procedure code, click on the red + to expand the Prior Authorization option.

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

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

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

Previously Entered Line Item Information

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

<table>
<thead>
<tr>
<th>Line No</th>
<th>Service Dates</th>
<th>Proc. Code</th>
<th>Modifiers</th>
<th>Diagnosis Prnrs</th>
<th>Submitted Charges</th>
<th>Units</th>
<th>PA Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>06/01/2016 06/01/2016 99214</td>
<td>1</td>
<td>150</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Please ensure all necessary claim information has been entered before clicking the **Add Service Line Item** button to add the service line to the claim.

Note: 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.

➢ Then 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.

<table>
<thead>
<tr>
<th>Line No</th>
<th>Service Date</th>
<th>Proc. Code</th>
<th>Modifiers</th>
<th>Diagnosis Pntrs</th>
<th>Submitted Charges</th>
<th>Units</th>
<th>PA Number</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>06/01/2016</td>
<td>06/01/2016</td>
<td>99214</td>
<td>1</td>
<td>150</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Previously Entered Line Item Information

<table>
<thead>
<tr>
<th>Line No</th>
<th>Service Dates</th>
<th>Proc. Code</th>
<th>Modifiers</th>
<th>Diagnosis Pts</th>
<th>Submitted Charges</th>
<th>Units</th>
<th>PA Number</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>06/01/2016 06/01/2016</td>
<td>99214</td>
<td>1 2 3 4</td>
<td>1</td>
<td>175</td>
<td>1</td>
<td></td>
<td>Delete or Other Service Info</td>
</tr>
</tbody>
</table>

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

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

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

➢ 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

➢ After clicking the Submit Claim button to submit the claim, ProviderOne will display this prompt:

![Message from webpage]

Do you want to submit any Backup Documentation?

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

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

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

➢ Click on the **Submit** button to finish submitting the claim.
Submit claim for processing – with backup (attaching electronic file)

➢ 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 – with backup (mailing or faxing backup)

➢ The Claims Backup Documentation page is displayed.

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

➢ If sending paper documents with the claim, at the Submitted Professional Claim Details page click on the **Print Cover Page** button.
Submit claim for processing – with backup (mailing or faxing backup)

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

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

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

OR

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

Push the **Submit** button to submit the claim.
Saving and retrieving a direct data entry claim
Saving a DDE claim

- ProviderOne allows a provider to save a claim if you are interrupted during the process of entering.
- You can retrieve the saved claim to finish entering the needed information and submit the claim.
- The following data elements are the minimum required to be completed before a claim can be saved:

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

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

- ProviderOne now displays the following confirmation box:

  ![Confirmation Box](image)

  - Click the **OK** button to proceed or **Cancel** to return to the claim form.
  - Once the **OK** button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.
  - If all data fields are completed, ProviderOne saves the claim and closes the claim form.
Retrieving a saved DDE claim

➢ At the Provider Portal, click on the **Retrieve Saved Claims** hyperlink.
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 as normal.  
- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claims List.
Medicare crossover
Common terminology

➢ Coinsurance
  • An amount a Medicare client may be required to pay as their share of the cost for services.

➢ Deductible
  • The amount for which a beneficiary is responsible before Medicare starts paying.

➢ Capitated copayment
  • A predetermined set dollar amount a Medicare client may be required to pay as their share of the cost for services.

➢ Non-capitated copayment
  • An amount a Medicare client may be required to pay as their share of the cost for services.
Overview – Medicare crossover

➢ There are 4 types of Medicare coverage:

   • Medicare Part A covers Inpatient hospital services
   • Medicare Part B covers professional and vendor services
   • Medicare Part C is a managed care version of Medicare, a Medicare Advantage Plan
   • Medicare Part D covers prescription drugs

➢ When is a claim a Medicare crossover claim?

   • If Medicare pays or applies to the deductible, the claim billed to HCA is a crossover.
   • The general rule is to bill the Agency after Medicare on the same claim form billed to Medicare.
   • The Agency is not paying Part D co-pays (Part D is not covered in this presentation).
Overview - Medicare crossovers

➢ When is a claim **NOT** a crossover claim?
   • Claims (services) denied by Medicare when billed to us are not crossover claims.
   • We still require the Medicare EOB to demonstrate non-payment.

➢ Sometimes Medicare does **NOT** forward claims automatically to the Agency
   • Can submit DDE or electronically without the EOMB (if Medicare denies the service, the EOMB IS required for electronic billing).
   • The Medicare Advantage Plans do not cross claims over directly so they must be billed separately through DDE or electronically as crossover claims.
Overview - Medicare crossovers

➢ If Medicare denies an Apple Health-covered service that requires PA, the service still requires authorization:
  • You may request it after the service is provided.
  • The agency waives the “prior” requirement in this circumstance.
Medicare eligibility

Eligibility checks may show Medicare as:

- **QMB** – Medicare Only (Qualified Medicare Beneficiary)
  - This program pays for Medicare premiums and may pay deductibles, coinsurance, and copayments according to Medicaid rules.

- **CNP-QMB** (Categorically Needy Program – Qualified Medicare Beneficiary)
  - Client has full Medicaid as well as QMB benefits.
Medicare eligibility

➢ Programs that HCA would not consider for secondary payment after Medicare:

• **SLMB (Special Low Income Medicare Beneficiary)**
  - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.

• **QI-1 (Qualified Individual 1)**
  - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.

• **QDWI (Qualified Disabled Working Individual)** –
  - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.
Medicare eligibility

➢ Determine Medicare eligibility using ProviderOne. Scroll down to the Medicare Eligibility Information area.

<table>
<thead>
<tr>
<th>Medicare Eligibility Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Type Code</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>30: Health Benefit Plan Coverage</td>
</tr>
<tr>
<td>30: Health Benefit Plan Coverage</td>
</tr>
</tbody>
</table>

• The Medicare HIC number is listed under the Client Demographic area.

➢ Medicare Part C information (if loaded) is located under the Coordination of Benefits Information area.

<table>
<thead>
<tr>
<th>Coordination of Benefits Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Type Code</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>30: Health Benefit Plan Coverage</td>
</tr>
<tr>
<td>30: Health Benefit Plan Coverage</td>
</tr>
</tbody>
</table>
Medicare billing Part B
Medicare billing – Part B

➢ DDE Professional, 837P

• If Medicare has paid all lines on your claim and did not forward the claim to Apple Health, submit the crossover claim to the Agency.

• If Medicare has allowed and denied service lines on your claim:
  o You will need to submit TWO claims to the Agency;
    – One crossover claim for services Medicare paid; and
    – One professional claim for services Medicare denied.
Medicare billing – Part B

➢ Bill the Agency using the same service codes and billed amounts sent to Medicare.

➢ Medicare and Medicare Advantage Plans are Medicare:
  • HCA does not consider Medicare as insurance.

➢ When submitting via DDE:
  • Click the Radio button YES to indicate this claim is a crossover.
    * Is this a Medicare Crossover Claim?  
      Yes  No
  • Additional data boxes open to be filled in as required at claim level.

Medicare Cross Over Items

* Amount Paid by Medicare: $                  * Medicare Deductible: $                  * Medicare Co-payment: $                  
* Medicare Co-insurance: $                  * Medicare Allowed Amount: $                  

mm    dd    yyy

* Medicare Adjudication Date:
Medicare billing – Part B

➢ The rest of the claim information is filled out as normal down to the service line information. Expand the Medicare Crossover Items by clicking the red +.

➢ Entering the line level Medicare information is required. The line level Medicare payment amounts must match the claim level Medicare payment total entered.

➢ No EOB is required with the DDE crossover claim.
Tips on billing crossovers

➢ Bill your taxonomy code(s) to Medicare the same as you bill your taxonomy code(s) to Medicaid.

➢ If you bill Medicare with an NPI that has not been loaded in ProviderOne, the agency will not be able to identify the provider when these claims are forwarded by Medicare.

➢ The claim format billed to Medicare must match the claim format billed to ProviderOne.

➢ The coding and dollar amount billed must match.

➢ Complete all required fields on the DDE crossover screen.
Claim inquiry
Claim inquiry

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

➢ Enter search data then submit
Claim inquiry

➢ Claim TCN’s returned

- Click on TCN number to view the claim data.
  - Denied claims will show the denial codes.
  - Easiest way to find a timely TCN number for rebilling.

![Claim Inquiry Provider List](image-url)
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):

• It has been 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
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 total to get a claim paid or adjusted.
- For delayed certification client eligibility, the agency allows **12** months from the delayed certification 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 on claim numbers for tracking.
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
How do I prove timeliness?

➢ 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.

➢ DDE claims
  • Resubmit original denied or voided claim
  • ProviderOne will automatically detect the timely claim number because the timely TCN is now attached to the new transaction.
Adjust or void a claim
Adjust or 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 or void a paid claim

➢ 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

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

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

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

➢ Once a template type is picked the system opens the DDE screen:

Once a template type is picked 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.
Creating a claim template

➢ 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 Templates List** find the template to use (sort using the sort tools outlined).
Submitting a template claim

➢ 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.
Reading the Remittance Advice (RA)
Reading the Remittance Advice (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.

- The system will open your list of RAs.

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

- At the Portal click on the hyperlink View Payment.
Reading the Remittance Advice (RA)

➢ The summary page of the RA shows:

• Billed and paid amount for paid claims
• Billed amount of denied claims
• Total amount of adjusted claims
• Provider adjustment activity
Reading the Remittance Advice (RA)

➢ Adjustments:

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

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

➢ Retention Policy:

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

- The RA is sorted into different categories as follows (screen shown is sample of denials):
  - Paid
  - Denied
  - Adjustments
  - In process

<table>
<thead>
<tr>
<th>RA Number</th>
<th>Warrant/EFT #</th>
<th>Warrant/EFT Date</th>
<th>Prepared Date</th>
<th>RA Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>500955089</td>
<td>5100000004</td>
<td>12/16/2015</td>
<td>12/16/2015</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Name / Claim Type</th>
<th>Line</th>
<th>Rendering Provider / RX # / Auth office #</th>
<th>Service Date(s)</th>
<th>Svc Code or NDC / Mod / Rev &amp; Class Code</th>
<th>Total Units or D/S</th>
<th>Billed Amount</th>
<th>Allowed Amount</th>
<th>Sales Tax</th>
<th>TPL Amount</th>
<th>Paid Amount</th>
<th>Client Responsible Amount</th>
<th>Remark Codes / NCPDP Rejection Codes</th>
<th>Adjustment Reason Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client, Pseudo</td>
<td>1</td>
<td>Professional Claim</td>
<td>12/01/2015-12/01/2015</td>
<td>90152</td>
<td>3.0000</td>
<td>$100.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>N255, N290, N95</td>
<td>170 - $100.00</td>
</tr>
<tr>
<td>Document Total</td>
<td></td>
<td></td>
<td>12/01/2015-12/01/2015</td>
<td></td>
<td>3.0000</td>
<td>$100.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>N255, N290</td>
<td>16.67</td>
</tr>
</tbody>
</table>
Reading the Remittance Advice (RA)

➢ EOB codes

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

<table>
<thead>
<tr>
<th>Adjustment Reason Codes / NCPDP Rejection Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>119 : Benefit maximum for this time period or occurrence has been reached.</td>
</tr>
<tr>
<td>15 : The authorization number is missing, invalid, or does not apply to the billed services or provider.</td>
</tr>
<tr>
<td>16 : Claim/service lacks information or has submission/filling 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 335 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REP), if present.</td>
</tr>
<tr>
<td>18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CC)</td>
</tr>
<tr>
<td>25 : Lifetime benefit maximum has been reached.</td>
</tr>
<tr>
<td>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 335 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REP), if present.</td>
</tr>
</tbody>
</table>

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

➢ The complete list of standardized codes can be located at the X12 organization’s [website](http://www.x12.org).
Authorization
Authorization

➢ 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 medical providers

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

1. Complete authorization form 13-835

2. Submit authorization request to the Agency with required backup

3. Check the status of a request

4. Send in additional documentation if requested by the Agency
Authorization

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
Directions for authorization form 13-835

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Org (Required)</td>
<td>Enter the Number that Matches the Program/Unit for the Request: 601 - Dental, 502 - Durable Medical Equipment (DME), 504 - Home Health, 505 - Hospice, 506 - Inpatient Hospital, 508 - Medical, 509 - Medical Nutrition, 511 - Outdoor Proc/Diag, 513 - Physical Medicine &amp; Rehabilitation (PM &amp; R), 514 - Aging and Long-Term Support Administration (ALTSA), 518 - LTAC, 519 - Respiratory, 521 - Maternity Support/Infant Care Management, 524 - Concurrent Care, 525 - ABA Services, 528 - Complex Rehabilitation Technology (CRT), 537 - Chemical-Using Programs (CUP) Warden Program.</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Service Type (Required)</td>
<td>Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected &quot;001 - Dental&quot; for field #1, please select one of the following codes for this field: ASC for ASC, IP for In Patient, OCQ for Orthodontics, OTQ for Orthotics, IPK for Orthopedic Products, PSM for Pain-Scaling/Maintenance, PTL for Partial, RBG for Reimbursement, RLS for Refined, TC for Transfer Case, MISC for Miscellaneous. If you selected &quot;002 - Dental Equipment (DME)&quot; for field #1, please select one of the following codes for this field: AA for Ambulatory Beds, BB for Bath Berths, RMM for Bath Equipment (misc.), RGS for Bone Growth Stimulator, SP for Breast Pump, CG for Compression Garments, CSC for Components/Soother Chair, DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing). If you selected &quot;003 - Medical Nutrition&quot; for field #1, please select one of the following codes for this field: AA for Ambulatory Aids, BB for Bath Berths, RMM for Bath Equipment (misc.), RGS for Bone Growth Stimulator, SP for Breast Pump, CG for Compression Garments, CSC for Components/Soother Chair, DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing).</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Service Type (Required)</td>
<td>If you selected &quot;004 - Home Health&quot; for field #1, please select one of the following codes for this field: ERGO for ERGO-PA, MISC for Miscellaneous, HK for Home Health, T for Therapists (PT/OT/SLT). If you selected &quot;005 - Hospice&quot; for field #1, please select one of the following codes for this field: ERGO for ERGO-PA, MISC for Miscellaneous, HK for Home Health, T for Therapists (PT/OT/SLT). If you selected &quot;006 - Inpatient Hospital&quot; for field #1, please select one of the following codes for this field: 835 for ERGO-PA, MISC for Miscellaneous, HK for Home Health, T for Therapists (PT/OT/SLT). If you selected &quot;008 - Rehabilitation&quot; for field #1, please select one of the following codes for this field: ERGO for ERGO-PA, MISC for Miscellaneous, HK for Home Health, T for Therapists (PT/OT/SLT). If you selected &quot;009 - Medical Nutrition&quot; for field #1, please select one of the following codes for this field: ERGO for ERGO-PA, MISC for Miscellaneous, HK for Home Health, T for Therapists (PT/OT/SLT).</td>
</tr>
</tbody>
</table>

HCA 13-835 (3/13)
Directions for authorization form 13-835

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

<table>
<thead>
<tr>
<th>FIELD</th>
<th>NAME</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| 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:  
|       |     | ERGO for ERGO-PA  
|       |     | LTAC for LTAC  
|       |     | O for Other  
|       |     | If you selected "510 - Respiratory" for field #1, please select one of the following codes for this field:  
|       |     | CPAP for CPAP/BiPAP  
|       |     | OXY for Oxygen  
|       |     | ERGO for ERGO-PA  
|       |     | SUP for Supplies  
|       |     | NEB for Nebulizer  
|       |     | VENT for Vent  
|       |     | OXY for Oxygen  
|       |     | O for Other  
|       |     | If you selected "521 - Maternity Support/Infant Care Management (MSI)" for field #1, please select one of the following codes for this field:  
|       |     | CM 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  
|       |     | HHN for In Home/Community/Office  
|       |     | DAYP for Day Program  
|       |     | If you selected "550 - Complex Rehabilitation Technology (CRT)" for field #1, please select one of the following codes for this field:  
|       |     | ERGO for ERGO-PA  
|       |     | PWH for Power Wheelchair - Home  
|       |     | MWH-N for Manual Wheelchair - Home  
|       |     | MWR for Manual Wheelchair Repairs  
|       |     | MWS for Manual 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  

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 1-800-542-0222 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 #: (Required)  
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).

14 Description of service being requested: (Required)  
A short description of the service you are requesting (examples: manual wheelchair, eyeglasses, hearing aid).

15 General Notes or MIS#: (Required)  
Enter the serial number of the equipment you are requesting repairs or modifications to or the HEAR-MIS# to access the necessary for this request.

20 Code Qualifier: (Required)  
Enter the letter corresponding to the code from below:  
- T - OTC Product  
- G - COP Product  
- D - DRG  
- P - HCPCS Product  
- I - ICD-10 Product  
- R - Raw Code  
- N - NDC-AB Drug Code  
- S - ICD-10 Diagnosis Code

21 National Code: (Required)  
Enter each service code of the item you are requesting authorization that corresponds to the Code Qualifier entered.

22 Modifier  
When appropriate enter a modifier.

23 # Units/Days Requested: (Uninsured or $ needed)  
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: (Uninsured or $ needed)  
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. $40.00 should be entered as 40.00)).

25 Part # (DME only): (Required)  
For all requested codes.
Enter the manufacturer part # of the item requested.
Directions for authorization form 13-835

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Tooth or Quad (Required for dental requests)</td>
<td>Enter the tooth or quad number as listed below:</td>
</tr>
<tr>
<td></td>
<td>QUAD</td>
<td>Enter the tooth or quad number as listed below:</td>
</tr>
<tr>
<td>26</td>
<td>Place of Service</td>
<td>Enter the appropriate two digit place of service code:</td>
</tr>
<tr>
<td>27</td>
<td>Diagnosis Code</td>
<td>Enter appropriate diagnosis code for condition.</td>
</tr>
<tr>
<td>28</td>
<td>Diagnosis Name</td>
<td>Short description of the diagnosis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>Place of Service</td>
<td>Place of Service Name</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>School</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Indian Health Service Free-standing Facility</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Indian Health Service Provider-based Facility</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Tribal Health Free-standing Facility</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Tribal Health Provider-based Facility</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Prison Correctional Facility</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Group Home</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Mobile Unit</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>Temporary Lodging</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>Walk in Retail Health Clinic</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>Emergency Room – Hospital</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>Birthing Center</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td></td>
<td>27</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>Hospice</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>Ambulance – Land</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>Ambulance – Air or Water</td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>Independent Clinic</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
</tbody>
</table>
Check the status of an authorization request

➢ Necessary profiles for checking authorization status:
  • EXT Provider Claims Submitter
  • EXT Provider Eligibility Checker
  • EXT Provider Eligibility Checker-Claims Submitter
  • EXT Provider Super User

➢ Select the Provider Authorization Inquiry

For step-by-step instructions visit the following resources:
  • Prior authorization webpage
  • ProviderOne Billing and Resource Guide
Check the status of an authorization request

➢ Search using one of the following options:
  • Prior authorization number; or
  • Provider NPI and client ID; or
  • Provider NPI, client last name and first name, and the client birth date.
Check the status of an authorization request

The **Auth Search List** screen returns the information requested from the search criteria used:

- Click on the **Auth #** hyperlink to access the PA Utilization screen.
- Do not submit multiple requests for the same client/service.
- Check online 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.
Check the status of an authorization request

- The system returns the following information, with the status of the request noted in the upper right side of the **PA Utilization** screen:
Authorization status

- The following list shows the different statuses you may see on the PA Utilization screen with definitions:

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

For more information, visit the document submission cover sheets webpage or the prior authorization webpage.
Spenddown
What is a Spenddown?

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

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

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

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

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

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

- The same eligibility check indicates the spenddown amount:

  ![Spenddown Information Table](image)

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

- 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.

- See the Provider Spenddown Step-by-Step fact sheet for more detail and information about where to bill the spenddown amount on claims.
Billing a client
Washington Administrative Code (WAC) 182-502-0160, Billing a Client, allows 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.

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

**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)**.

<table>
<thead>
<tr>
<th>Excluded services</th>
<th>Covered service</th>
</tr>
</thead>
<tbody>
<tr>
<td>A set of services that we do not include in the client’s BSP. There is no Exception To Rule (ETR) process available for these services (e.g., Family Planning Only).</td>
<td>A healthcare service contained within a &quot;service category“ that is included in a medical assistance BSP as described in WAC 182-501-0060.</td>
</tr>
</tbody>
</table>

**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.
Agreement to Pay for Healthcare Services

WAC 182-502-0160 (“Billing a Client”)

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

Client - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.

Provider - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

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

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

<table>
<thead>
<tr>
<th>PROVIDER’S PRINTED NAME</th>
<th>PROVIDER NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Directions:

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

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

Important Note from HCA:

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 182-502-0160 or does not satisfy HCA conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 182-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client’s medical record for 6 years from the date this agreement is signed. Give a copy of this completed, signed agreement to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at http://hrsa.dshs.wa.gov/mpforms.shtml.
<table>
<thead>
<tr>
<th>SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE</th>
<th>CPT/HCPCS CODE (BILLING CODE)</th>
<th>AMOUNT TO BE PAID BY CLIENT</th>
<th>REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)</th>
<th>COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT</th>
<th>DATE(S) ETR/PA REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncovered service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ETR REQUESTED OR WAIVED  ETR DENIAL (ATTACH HCA NOTICE)</td>
</tr>
<tr>
<td>Noncovered service, ETR waived</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PA REQUEST</td>
</tr>
<tr>
<td>Non-formulary drug, NFJ waived</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PA DENIAL (ATTACH HCA NOTICE)</td>
</tr>
<tr>
<td>Covered but denied as not medically necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PA REQUEST</td>
</tr>
<tr>
<td>Covered, but specific type not paid for</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PA DENIAL (ATTACH HCA NOTICE)</td>
</tr>
<tr>
<td>Order, prescribed, or referred by non-enrolled licensed health care professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.
- I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service, 2) submit a Non-Formulary Justification (NFJ) with the help of my prescriber for a non-formulary medication, or 3) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.
- I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the 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
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.

**WHEN CAN A PROVIDER BILL A CLIENT WITHOUT FORM 13-879**

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 chose to receive services from a provider who is not contracted with 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 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.

WHEN CAN A PROVIDER BILL A CLIENT WITH FORM 13-879?

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.
<table>
<thead>
<tr>
<th>WHEN CAN A PROVIDER NOT BILL A CLIENT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for which the provider did not correct bill the agency.</td>
</tr>
<tr>
<td>The cost difference between an authorized service or item and an &quot;upgraded&quot; service or item preferred by the client (e.g., precious metal crown vs. stainless steel).</td>
</tr>
</tbody>
</table>

- 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.
### 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”

### When can a provider **not** bill a client?

- 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 ICD10).
- 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
Provider file maintenance

➢ For the latest information on self-service provider file maintenance activities, please visit the existing Apple Health (Medicaid) providers webpage.

➢ For assistance on adding new or existing servicing or rendering providers, please visit enroll as a health care professional practicing under a group or facility webpage.

➢ Contact information for the Provider Enrollment Unit:
  • 1-800-562-3022 extension 16137
  • Hours of operation Tuesday and Thursday 7:30 am to 4:30 pm
  • Closed Monday, Wednesday, and Friday
  • providerenrollment@hca.wa.gov
Online resources
Online resources

- Apple Health provider [homepage](#)
- Hover over a topic to highlight and click to expand the mega menu.
Online Resources

ProviderOne Billing and Resource Guide and webpage

ProviderOne Billing and Resource Guide

On this page

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

The ProviderOne Billing and Resource Guide gives step-by-step instruction to help provider billing staff:

- Find client eligibility for services.
- Bill in a timely fashion.
- Receive accurate payments for covered services.

View the complete guide

The guide is intended to:

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

Washington Apple Health (Medicaid)

ProviderOne Billing and Resource Guide

May 2018
Online resources

➢ Prior authorization webpage

- Contains step by step instructions
- Links to the most commonly used billing guides for services requiring authorization
- Links to prior authorization forms
- An Expedited Prior Authorization (EPA) Inventory guide
Contact us

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

- **48 hour turnaround for Service Limit checks:**
  - Be sure to include the Date of Service (DOS)
  - Procedure Code and the date range for search
  - NPI number
Sample request for Service Limit check:

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

➢ Sample confirmation screen:

The confirmation screen provides your service request (SR) number.
➢ You can print this page for your records, as needed.
Online resources

➢ Programs and services information
  • Program billing guides and fee schedules
  • Hospital rates
➢ Provider Enrollment webpage and email
➢ Learn ProviderOne webpage
➢ HCA forms