ProviderOne for Social Services

Viewing Claim Status and Payments Guide

Updated June 2025

INTRODUCTION

This publication takes effect June 2025 and supersedes earlier billing guides for Social Service Providers.

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) or Department of Social & Health Services (DSHS) rule arises, the rule applies.

This guide provides a step-by-step resource to help Social Service Providers and billing staff understand the processes of ensuring clients are eligible for services and to receive timely and accurate payments for covered services.

The purpose of this guide is to serve as a resource for Social Services Providers and billing staff regarding the following items:

- **Overpayments**
  - In this section you will find the difference between offset and non-offset adjustments, how to read overpayments on the Remittance Advice (RA), and how to work with the Office of Financial Recovery (OFR) to repay any overpayments that resulted from a non-offset adjustment.
- **Claim Status Inquiry and Viewing Remittance Advice**
  - Claims Status Inquiry allows providers to look up the status of a claim in ProviderOne
  - The remittance advice (RA) provides a detailed breakdown of paid, denied, adjusted, and in process claims. RAs are available in ProviderOne each Friday. To ensure claim submissions processed correctly, it is important for providers/billers to review their RAs when they become available in ProviderOne.

Note: This billing guide contains attachments. To view these attachments, you must first download and save this guide as a PDF.

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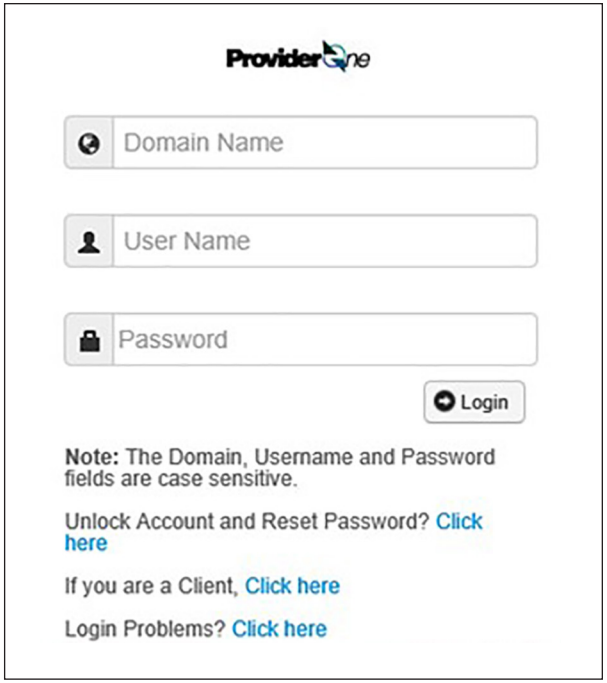
ALL PROVIDERS

GETTING STARTED

Welcome to the *ProviderOne for Social Services: Viewing Claim Status and Payments Guide.* The following section explains the basics of the ProviderOne system, including:



Note:

Please note some screen grabs in this section are from the Social Service Billing side and some are from the Social Service Medical Billing side of ProviderOne. The directions and information provided is applicable to both Provider types.

GENERAL TIPS

General Notes

- "OK" signifies a Yes response and "Cancel" a No Response
- Asterisk (*) denotes required fields
- "%" acts as a wildcard, returning information that corresponds with the current search
    - For example, if searching for authorizations for multiple locations, you could enter your seven digit Provider ID and add % to the end in order to return authorizations for each of your locations
- Make sure your Pop-Up Blockers are turned off on your preferred browser (**i.e.**. Chrome, Edge) you are using to access ProviderOne
    - If the Pop-Up Blockers are not turned off it will result in errors when trying to submit claims.
    - If you chose to turn the pop-up blockers back on when you are not using ProviderOne, remember to turn them back off when you are utilizing ProviderOne.
    - Each specific browser has their own instructions on how to turn off pop-up blockers.
- Clearing your browser history (Cache) regularly will help the overall performance of ProviderOne
    - Clearing browser history will not delete saved favorites, book marks, or passwords
- Columns can be sorted from A-Z or Z-A by using the controls below the name of each column:

Passwords

Passwords and Security Questions:

The first time you log into ProviderOne you will be required to change your temporary password and create a security question. Please note passwords and security questions are case sensitive.

When creating a password for ProviderOne they must contain the following:

- Cannot be the same as your last five passwords
- Must be at least eight characters long
- Must contain at least one letter
- Must contain at least one number
- Must contain at least one of the following special characters:

  !@ # $ % ^ & * ( ) _ + - < >

After three unsuccessful attempts to login, your domain will be locked. You can unlock and reset your password by reaching out to ProviderOne Security here: provideronesecurity@hca.wa.gov

When you update your password, you will be asked if you want to update your secret question. You can change it at this time or select No.

Note:

As an added security measure, ProviderOne passwords must be changed every 90 days.

ACRONYMS & DEFINITIONS

- **AAA -** Area Agency on Aging
- **CARS** - Collections and Accounts Receivable System. The system DSHS's Office of Financial Recovery uses to manage providers' debt (overpayments).
- **CMS** - Center for Medicare and Medicaid Services
- **COFF** - CARS Offset (lien)
- **DDE** - Direct Data Entry
- **Domain** - Also known as your ProviderOne ID.
- **DOS** - Date of Service
- **DSHS** - Department of Social and Health Services. State agency in charge of delivering s a variety of social services, employment supports, safety programs, and court-ordered behavioral health care.
- **EFT** - Electronic Funds Transfer. This is when funds are deposited directly into a banking account for claims payments.
- **HCA** - Health Care Authority. HCA is WA State's Medicaid agency. HCA is in charge of managing the ProviderOne system.
- **HCLA** - Home and Community Living Administration. HCLA is a newly formed administration within DSHS effective May 1, 2025. This administration focuses on coordinating home and community-based services to support clients in their own environments. It was formed by merging key functions from the Developmental Disabilities Administration (DDA) and the Aging and Long-Term Support Administration (ALTSA).
- **HIPAA -** Health Insurance Portability & Accountability Act
- **MOS -** Month of Service
- **NOC -** Non-Offset to CARS
- **NPI -** National Provider Identifier. Most social service vendors are not required to have one.
- **OFIN -** Oracle Financial System
- **OFR -** Office of Financial Recovery
- **PPSU -** Payment Policy & Systems Unit. Housed within DSHS/HCLA, this unit manages the ProviderOne for Social Services webpage, P1 for Social Services billing guides & P1 for Social Services monthly newsletter. PPSU is also in charge of ProviderOne configuration for social service claims and post payment reviews/adjustments.
- **P1OFF -** ProviderOne Offset (claim adjustment)
- **PHI -** Protected Health Information
- **ProviderOne or P1** - ProviderOne is the Medicaid management information system (MMIS) utilized by WA State.
- **ProviderOne ID.** A 7-digit ID assigned to each provider's ProviderOne account. Also known as the Provider Domain ID or Domain Name.
- **RA -** Remittance Advice. RAs provides details about paid, denied, adjusted and in-process claims submitted in ProviderOne.
- **TCN -** Transaction Control Number. A unique tracking number assigned to each claim (also known as the claim number).
- **Warrant –** A paper check issued for claim payments

CONTACT INFORMATION

I need help with ...	Contact ...
• There is no active authorization • The authorization is 'in error' status • The dates, units, or rates on the authorization are wrong	**The client's Case Manager**
• Signing up to receive electronic payments (EFT) • Updating information in ProviderOne (location addresses, email addresses, communication preferences) • Social Service Medical providers only: ○ Updating business license, taxonomy, NPI, or Dept. of Health license in ProviderOne	**Health Care Authority--Provider Enrollment** **Phone**: 1-800-562-3022 ext. 16137 **Phones are open**: Tuesdays and Thursdays from 7:30 a.m. to 4:30 p.m. (Closed from noon to 1 p.m.) **Email**: ProviderEnrollment@hca.wa.gov When emailing Provider Enrollment, you will get you a ticket/incident number. Save this ticket/incident # for future reference as needed.
• Direct Data Entry (DDE) basic billing and claims assistance • Creating claim templates/template batch billing • Payment issues (lost checks) • Basic ProviderOne navigation & questions	**Health Care Authority--Medical Assistance Customer Service Center (MACSC)** **Phone**: 1-800-562-3022, choose "provider services" **Online**: HCA Secure form
• Accessing ProviderOne • Login issues (i.e., password reset, locked out) • Setting up additional users, profiles, or system administrators	**Health Care Authority--ProviderOne Security** **Email:** ProviderOneSecurity@hca.wa.gov **Online**: HCA Secure form

CONTACT INFORMATION *continued*

I need help with ...	Contact ...
• .dat file claim submissions/adjustments	**Health Care Authority--HIPAA Help Desk** **Email:** hipaa-help@hca.wa.gov In the subject line type: "Social Service Batch Upload" In the body of the email include your: • Name • ProviderOne ID/domain • Name of the batch file you are referencing ("SOC.xxxxxxx.20150131xxxxxx.SAMPLE_BATCH.dat") • Description of your issue or what you need help with • Your telephone number if you request a return call
• Overpayment questions	**DSHS--Office of Financial Recovery (OFR)** Phone: 360-664-5700, option 3, 1-800-562-6114, or TTY WA 1-800-833-6388
• Urgent payment issues Note: You should only contact the DSHS ProviderOne payment teams after you have tried resolving your issue through the appropriate channels (i.e., case manager, contract specialist, or HCA) AND client services are impacted.	**DSHS--ALTSA or DDA ProviderOne payment teams** **DSHS ALTSA providers/clients** **Email:** P1_escalation@dshs.wa.gov **DSHS DDA Providers/clients** Contact the DDA resource developer or contractor who will escalate to the regional payment specialist as needed. When emailing DSHS, please include your: • Name (first and last) • Name of your organization • ProviderOne ID (also known as your P1 domain) • The date you emailed HCA and the corresponding HCA Ticket # • A brief description of your issue, who you've tried to contact, and how the issue impacts client services and/or your ability to receive payment

OVERPAYMENTS

This section explains the difference between offset and non-offset adjustments, how to identify an overpayment on the remittance advice (RA), and how to work with the Office of Financial Recovery (OFR) to repay any overpayments that resulted from a non-offset adjustment.

OVERPAYMENTS OVERVIEW

Overpayments can be generated when a paid claim is voided or adjusted.

- When a claim is voided, it will generate an overpayment because the State has paid out money for a claim that is no longer in paid status.
- When adjusting a claim, an overpayment may be generated if the new paid amount is less than the original claim paid amount.

If an overpayment is for a claim that was automatically generated (one-time, repetitive, or individual repetitive payment types), please contact the client's authorizing case manager. They will need to update the authorization and initiate an adjustment of the claim. If you have been overpaid for a claim that you submitted, you can adjust the claim in ProviderOne.

You will see overpayments reflected on page 2 of your remittance advice (RA). You will also receive an overpayment letter, which will identify the payment details for your original paid claim.

There are two options for how an adjustment will be processed: non-offset or offset, which will be discussed on the following pages.

Note:

To find instructions on adjusting Social Service Claims, review pages 96-107 of the Submitting and Adjusting Social Service Claims guide.

To find instructions on adjusting Social Service Medical Claims, review pages 63-77 of the Submitting and Adjusting Social Service Medical Claims guide.

NON-OFFSET

This is the default adjustment option for Social Service providers. When a debt (overpayment) is created as a result of a voided or adjusted claim, the overpayment is sent to the Office of Financial Recovery (OFR). OFR then contacts you, the provider, to address the debt. You will receive Vendor Overpayment Notice from OFR informing you of the debt and how to correct the overpayment, along with your administrative hearing rights.

The notice will list the TCN that was adjusted/voided and there will be a reason code on the notice that gives some information as to why the claim was adjusted or voided.

You should also review your remittance advice (RA) associated with the adjustment to see the specific days or service lines being recouped. The RA will be generated and available on the Friday before the week the overpayment notice is generated.

Below are the most common reason codes, with a description, for adjustments initiated by DSHS:

- **AA - Audit Unit** identified this payment as not being valid.
- **P1 - Goods or services not provided.** This may apply to the entire claim or individual claim lines. Refer to your RA for additional details.
- **P2 - Goods or services authorized in error** means that the payment details originally authorized have changed since you submitted your paid claim. Refer to your RA to see specific dates impacted, and review your authorization list to see any changes made to the authorizations. If you have questions about your authorization please contact the authorizing worker.
- **P3 - Provider not eligible to provide goods or services.** This means that you were not eligible for payment for the dates of service that resulted in the overpayment.
- **P5 - Rate paid was incorrect** means the rate originally paid by the Department for your affected claims is higher than the amount that should have been paid by the Department. This may be caused by a change in the authorized rate or application of client responsibility. If you have questions about a change in the paid rate please contact the authorizing worker.
- **P6 - Multiple payments were made for the same goods or services.** This most often occurs when a duplicate claim is submitted and paid because there was a change to the authorization. Review your claims for the affected dates of service and contact HCA if you need assistance.

OFFSET

To adjust a clam as 'offset', you have to submit an e-mail or call HCA to request the claim be adjusted as offset. With this option, the debt will be deducted from future paid claims within a 6 month window. You can track your offset payments in the summary on page 2 of your RAs.

After 6 months, if the debt is not satisfied, any remaining balance will be sent to OFR for recovery as a non-offset adjustment.

When a claim is adjusted as offset, the overpayment will not be referred to OFR, you will not receive a Vendor Overpayment Notice, and you will not have administrative hearing rights to dispute the overpayment.

Note:
To request your claim be adjusted as offset, contact HCA's Medical Assistance Customer Service Center (MACSC). See Contact Information on pages 4-5.

If you want the debt to be deducted from paid claims as an offset, you can submit a message to HCA. Please provide the following information:

- Your ProviderOne ID/Domain
- TCN (s) that need to be adjusted
- Client's ProviderOne ID
- A note that the claims need to be adjusted as offset
- Why claims need to be adjusted
- Contact info in case HCA has questions

Email example:

Client responsibility was not taken out of TCN 61xxxxxxxxxxxxx000, although I received a letter stating the client has client responsibility. Case manager verified client responsibility was correct in the system. Please adjust the claim as offset to ensure client responsibility is taken out of the claim.

- Provider Number: 11xxxxx01
- TCN: 61xxxxxxxxxxxxx000
- P1 Client ID: 1xxxxxxxxWA
- Contact info: ABCadultfamilyhome@yahoo.com or 360-555-55555

CLAIM STATUS INQUIRY AND VIEWING REMITTANCE ADVICE (RA)

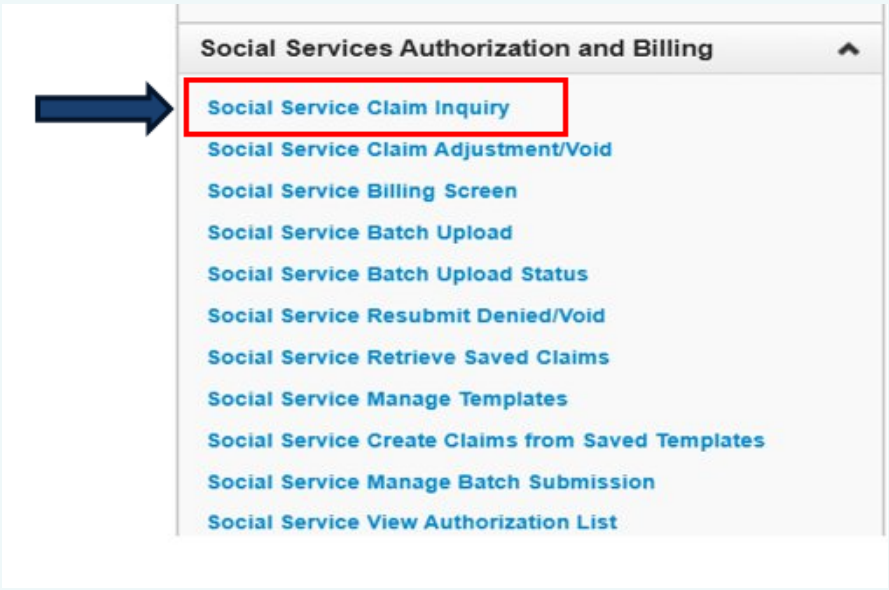
This section explains how to view claim status in ProviderOne as well as how to view the remittance advice (RA).

Providers may need to view the status of a claim in ProviderOne if they can't locate the claim on the RAs.

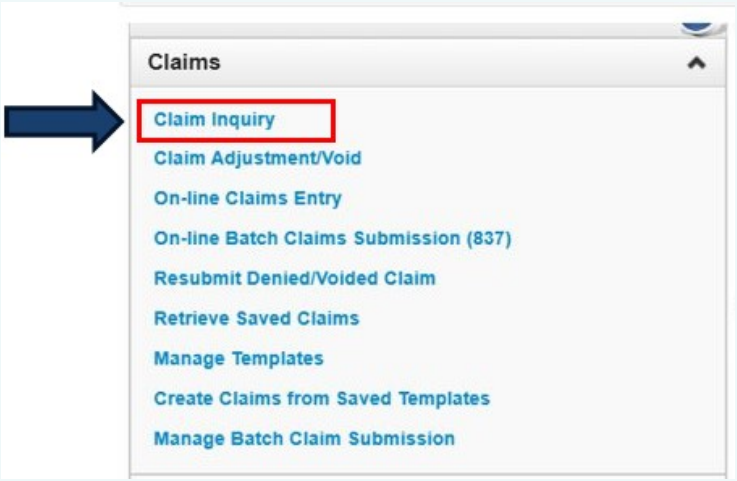
RAs provide a detailed breakdown of paid, denied, adjusted, and in process claims. RAs are available in ProviderOne each Friday. To ensure claim submissions processed correctly, it is important for providers/billers to review their RAs as soon as they become available in ProviderOne.

CLAIM INQUIRY

- **For Social Service (non-medical) claims:**
  - Log in using the **EXT Provider Social Services** profile
  - From the Provider Portal, **click on Social Service Claim Inquiry** (under the Social Services Authorization and Billing section).

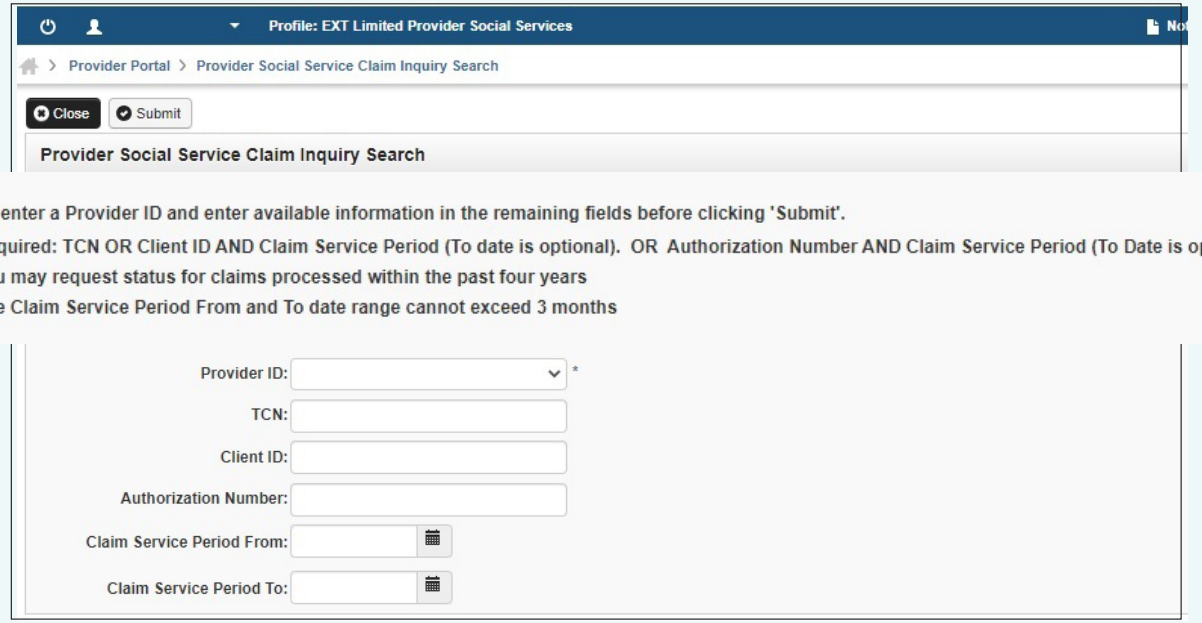


- **For Social Service (medical/professional) claims:**
  - Log in using the EXT Provider Social Services Medical profile
  - From the Provider Portal, c**lick on Claim Inquiry** (under the Claims section)



CLAIM INQUIRY *continued*

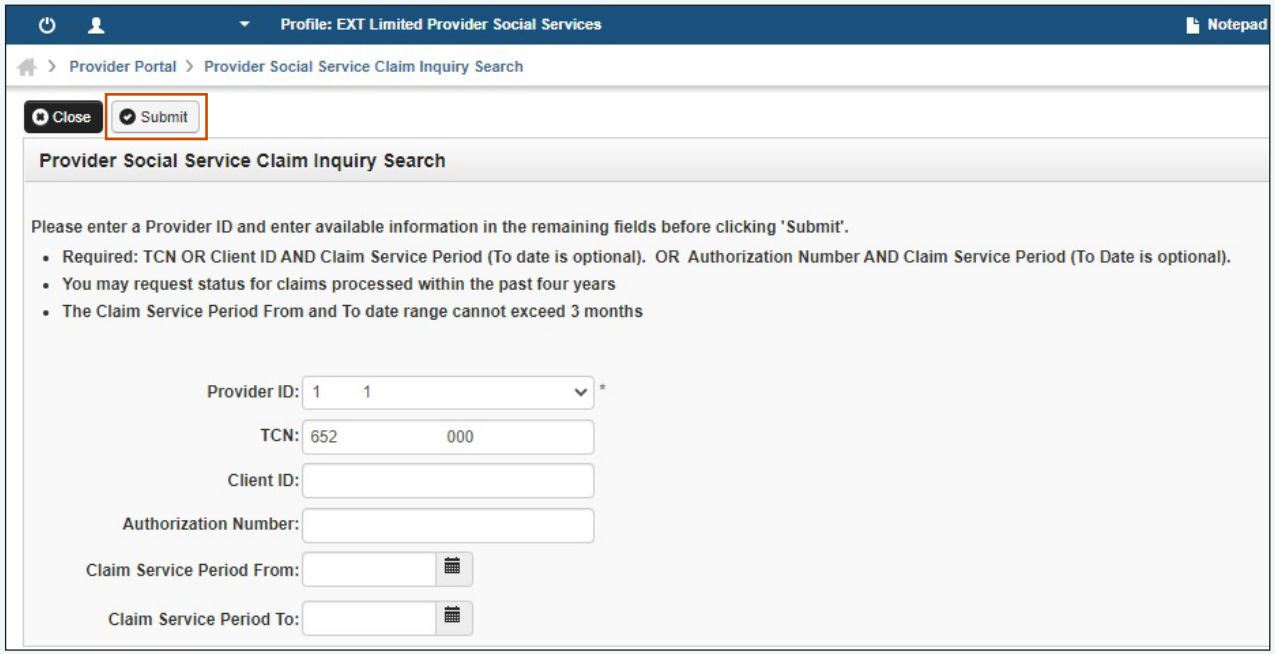
- The Claim Inquiry Search page appears
- Your Provider ID (Domain) should auto-populate in the Provider ID field
- Enter your search criteria to search for a claim. You can search for a claim multiple ways:
  - TCN (claim number), or
  - Client ProviderOne ID and Claim Service Period, or
  - Authorization number and Claim Service period



CLAIM INQUIRY *continued*

Searching by Transaction Control Number (TCN)/Claim number:

- Enter Transaction Control Number (TCN) in the **TCN field**
- Click Submit



CLAIM INQUIRY *continued*

Searching by Client ID or Authorization Number.

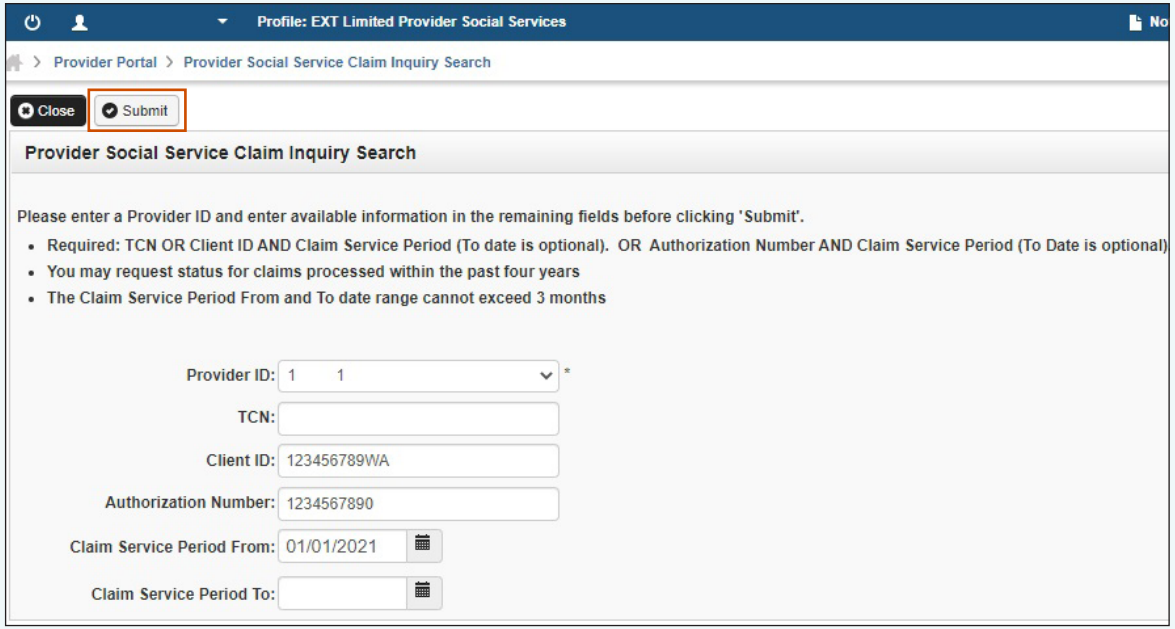
Enter either the:

- Client ID number or
- Authorization number

Next, enter the:

- **Claim Service Period From date (Required)**
- **Claim Service Period To date (optional)**

- **Click Submit**



Note: ProviderOne will only return results when the Header TCN From/To Date are within your searched dates. If the Header TCN date range is outside of your search dates, the claim won't show in search results.

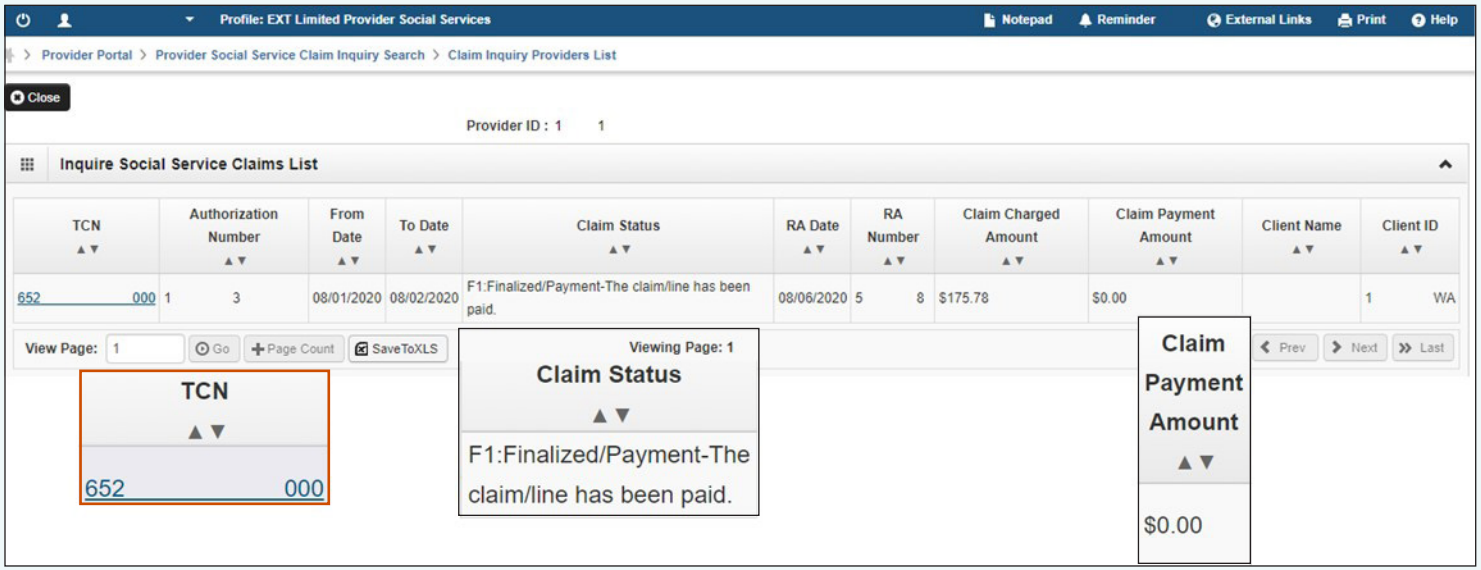
Example: The claim From Date is 4/27/25 & To Date is 5/2/25. If you enter 5/1/25 as the 'Claim Service Period From' date in your search criteria, the claim will not show up in the search results. You must enter 4/27/25 as the 'Claim Service Period From' date.

CLAIM INQUIRY *continued*

Inquire Claims List appears showing search results. Here you can view:

- TCNs
- Claim Status
- Claim Payment Amount

Click on the blue hyperlinked TCN to view more information

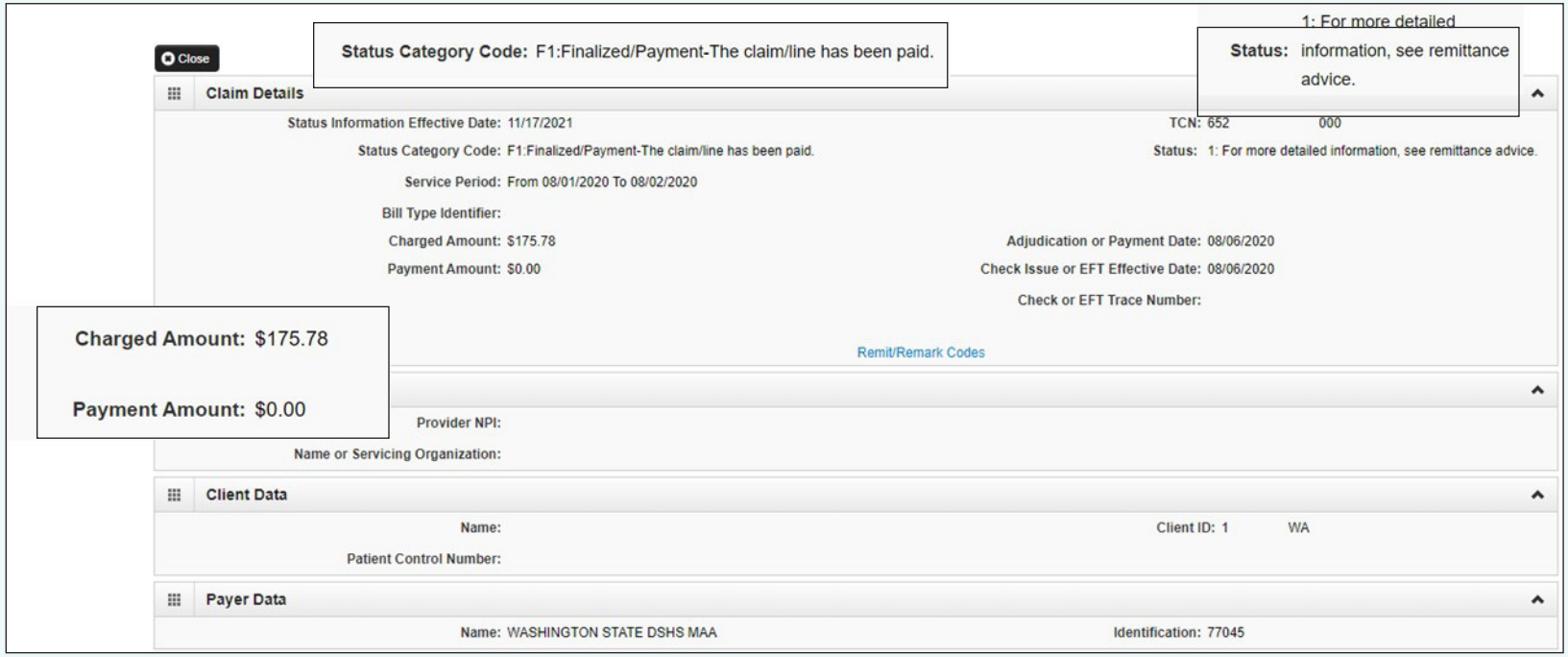


CLAIM INQUIRY *continued*

After clicking on the TCN, Claim Details appears. Here you can view:

- Status Category Code
- Status
- Charge and Payment amounts

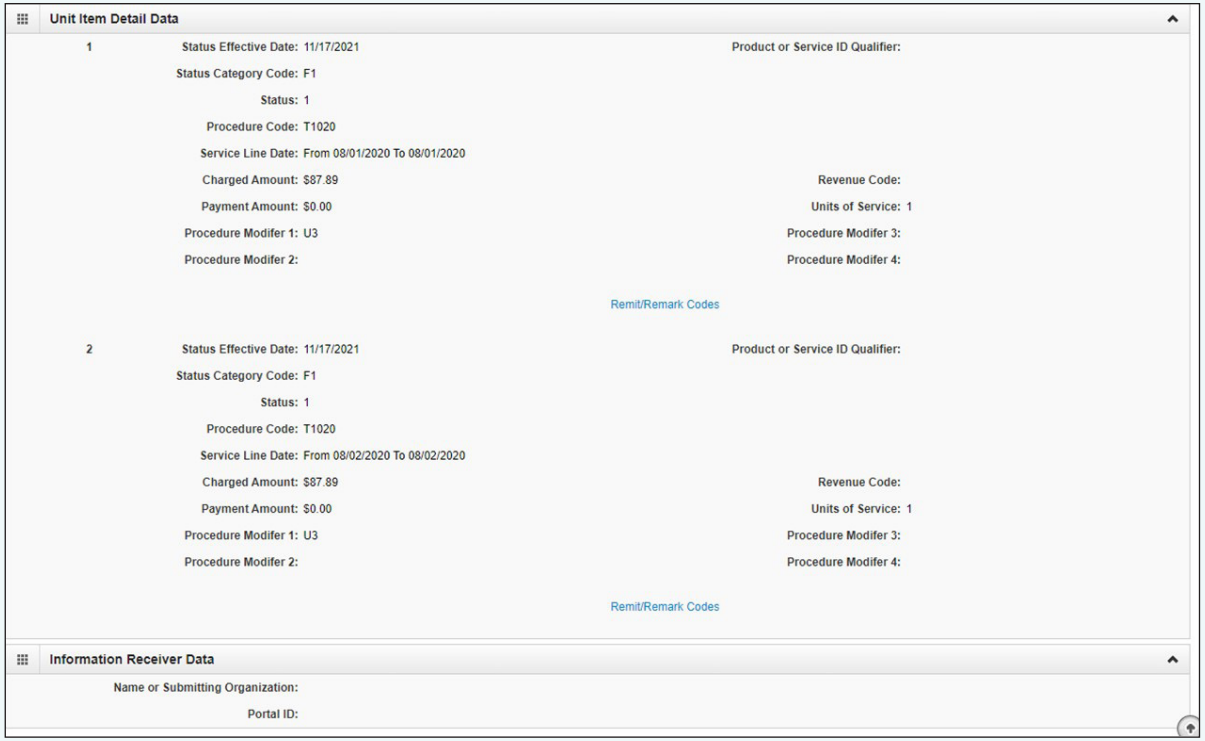
Scroll down to see additional information

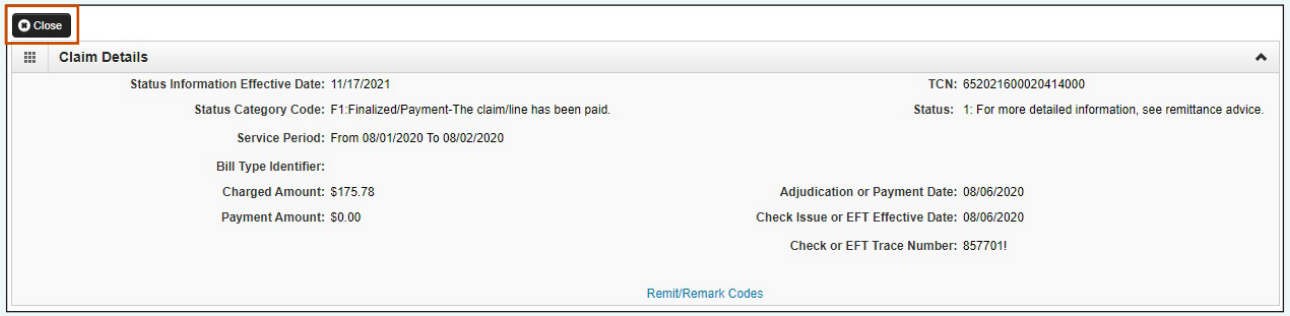


CLAIM INQUIRY *continued*

As you scroll down, you can see Unit Item Detail Data and Information Receiver Data.

To exit this screen, scroll up and hit the Close button in the upper left corner.





Note:

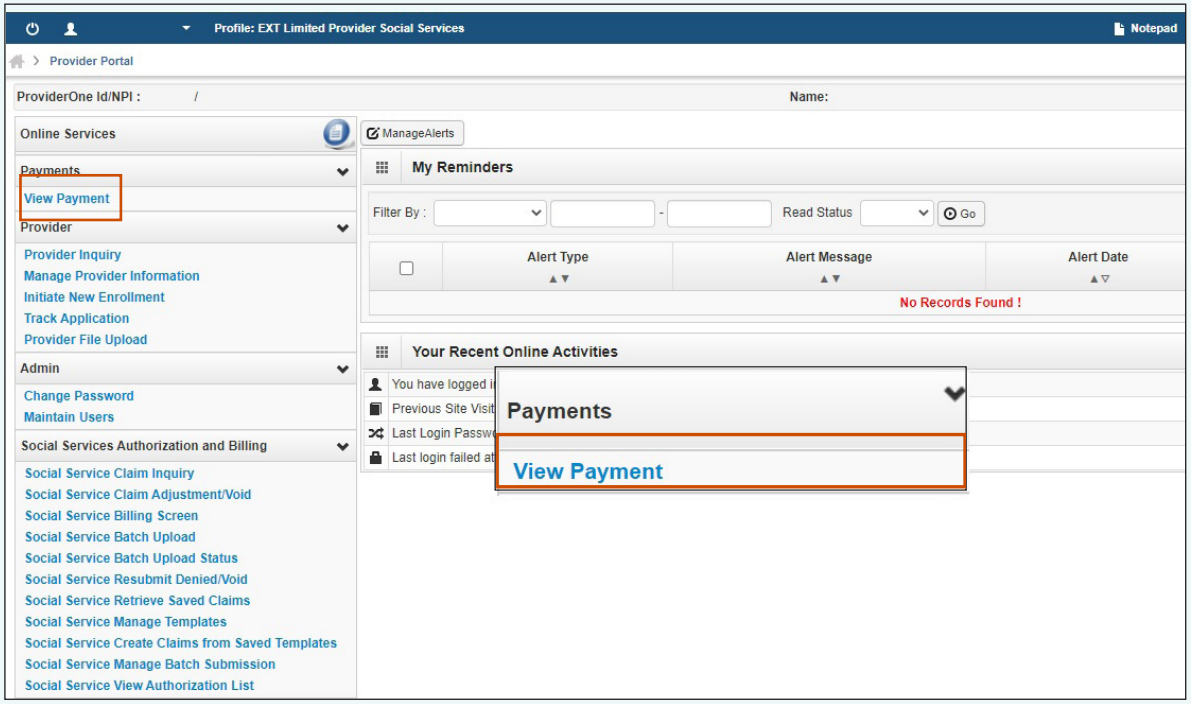
Line item information can also be found on the Remittance Advice.

If a claim has been denied, you can choose to adjust and resubmit the claim after verifying the claim details match the authorization details.

VIEW AND DOWNLOAD RA

This section provides a brief overview of how to view and download the remittance advice (RA).

For an in-depth review of each page of the RA and what to look for in each section, view the *Understanding Each Section of the RA* attachment. For more information on how to view the attachment, click here.



To view your the RAs:

- Login to ProviderOne using the EXT Provider Social Services or EXT Provider Social Services Medical profile.
- From the Provider Portal, Click on View Payment (under the Payments section)

Note:

RAs are retrievable in ProviderOne for up to 4 years. Providers are required to retain records for up to 6 years and are responsible for retaining copies for this purpose.

VIEW AND DOWNLOAD RA *continued*

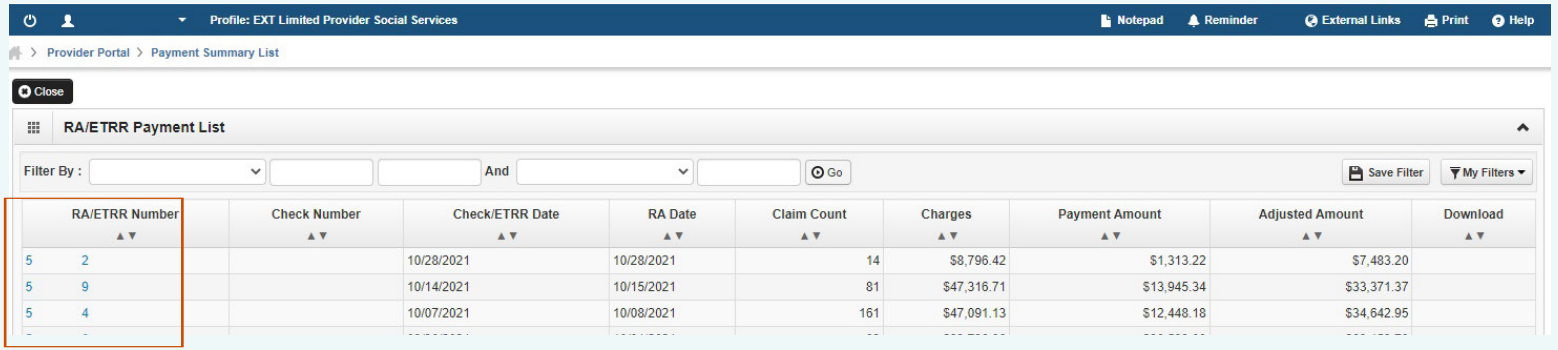
After clicking on View Payment, the RA/ETRR Payment List appears

- You will see a list of your recent RAs. To view more RAs, click the arrows at the bottom of the screen to scroll.
- The RA/ETRR Payment List shows basic information for each RA, but the list should **not** be used to reconcile your payments.
- To reconcile and review all payments, adjustments, and denials, click on the RA you want to review.

Note:

If you have more than 1 location code, each code has its own RA for each time claim period

To view an RA, click on the blue hyperlinked RA/ETRR Number--->



RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
5 2		10/28/2021	10/28/2021	14	$8,796.42	$1,313.22	$7,483.20	
5 9		10/14/2021	10/15/2021	81	$47,316.71	$13,945.34	$33,371.37	
5 4		10/07/2021	10/08/2021	161	$47,091.13	$12,448.18	$34,642.95	

VIEW AND DOWNLOAD RA *continued*

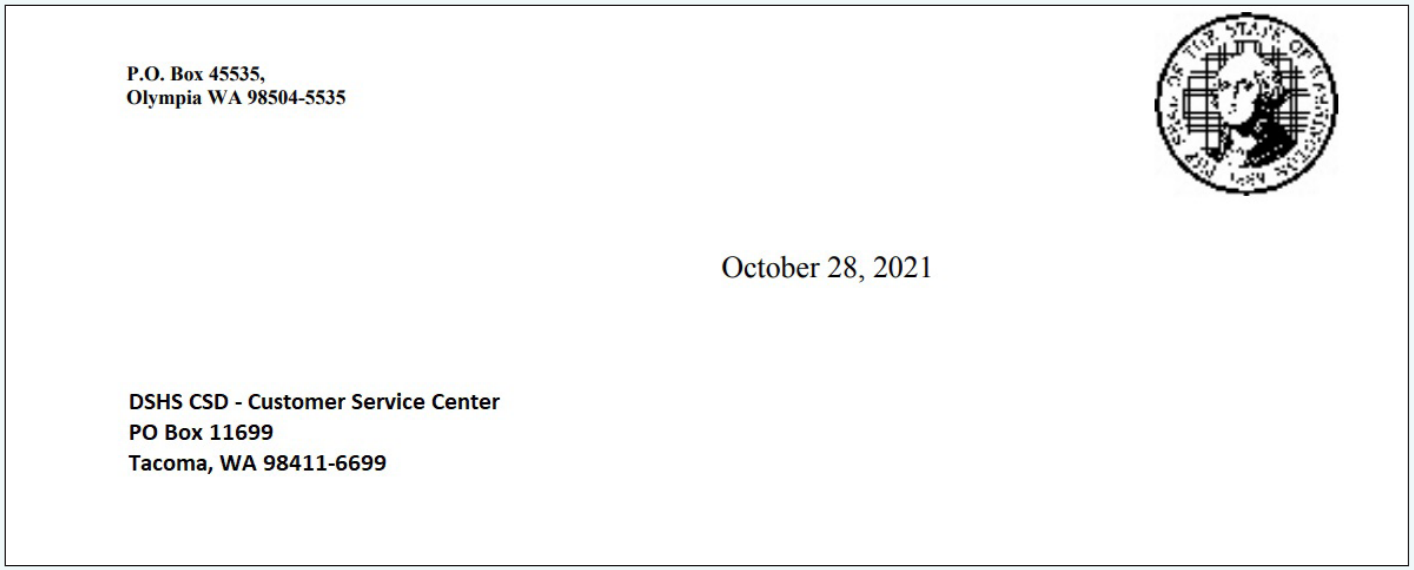
After clicking on a blue hyperlinked RA number, the RA opens. The cover page of the RA includes:

- Provider name and mailing address
- RA creation date

Note:

Providers should retain a copy of each RA for six years. ProviderOne purges RAs after four years.

If your mailing address has changed, it is important to update that information in ProviderOne.



P.O. Box 45535,
Olympia WA 98504-5535

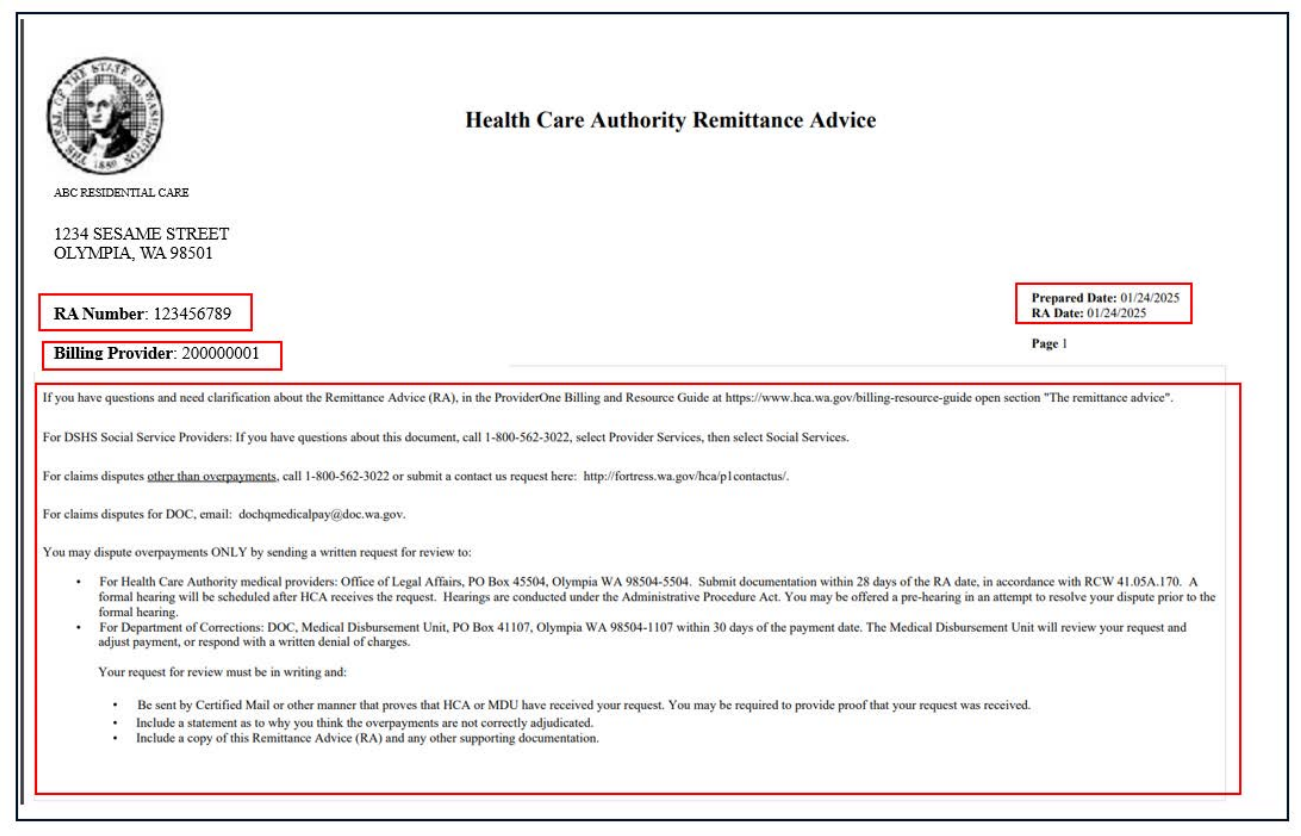
October 28, 2021

DSHS CSD - Customer Service Center
PO Box 11699
Tacoma, WA 98411-6699

VIEW AND DOWNLOAD RA *continued*

Page 1 of the RA contains:

- RA Number
- Billing Provider ID (this is your 7-digit ProviderOne ID + two digit location code for the location the RA is associated with)
- Prepared Date: Date the RA was prepared
- RA Date: Date payment was released
- Key Messages: These are alerts from HCA or DSHS about changes to ProviderOne functions or claims deadlines.



Health Care Authority Remittance Advice

ABC RESIDENTIAL CARE

1234 SESAME STREET
OLYMPIA, WA 98501

RA Number: 123456789

Billing Provider: 200000001

Prepared Date: 01/24/2025
RA Date: 01/24/2025

Page 1

If you have questions and need clarification about the Remittance Advice (RA), in the ProviderOne Billing and Resource Guide at https://www.hca.wa.gov/billing-resource-guide open section "The remittance advice".

For DSHS Social Service Providers: If you have questions about this document, call 1-800-562-3022, select Provider Services, then select Social Services.

For claims disputes other than overpayments, call 1-800-562-3022 or submit a contact us request here: http://fortress.wa.gov/hca/p1contactus/.

For claims disputes for DOC, email: dochqmedicalpay@doc.wa.gov.

You may dispute overpayments ONLY by sending a written request for review to:

- For Health Care Authority medical providers: Office of Legal Affairs, PO Box 45504, Olympia WA 98504-5504. Submit documentation within 28 days of the RA date, in accordance with RCW 41.05A.170. A formal hearing will be scheduled after HCA receives the request. Hearings are conducted under the Administrative Procedure Act. You may be offered a pre-hearing in an attempt to resolve your dispute prior to the formal hearing.
- For Department of Corrections: DOC, Medical Disbursement Unit, PO Box 41107, Olympia WA 98504-1107 within 30 days of the payment date. The Medical Disbursement Unit will review your request and adjust payment, or respond with a written denial of charges.

Your request for review must be in writing and:

- Be sent by Certified Mail or other manner that proves that HCA or MDU have received your request. You may be required to provide proof that your request was received.
- Include a statement as to why you think the overpayments are not correctly adjudicated.
- Include a copy of this Remittance Advice (RA) and any other supporting documentation.

VIEW AND DOWNLOAD RA *continued*

Page 2 contains the **Payment Summary** which includes:

- RA Number
- Warrant/EFT number
- Warrant/EFT date (date of payment)
- Warrant/EFT amount
- Payment Method

RA Number: 123456789
Warrant/EFT # 555556!

Warrant/EFT Amount: $14,501.85

Warrant/EFT Date: 1/23/2025
Payment Method: EFT

Prepared Date: 1/24/2025
RA Date: 1/24/2025

Page 2

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total Sales Tax	Total Client Resp Amount	Total Paid
200000001	Paid	$43629.14	$43629.14	$0.00	$29127.29	$14501.85
200000001	Denied	$81.00	$0.00	$0.00	$0.00	$0.00
200000001	Adjustments	$0.00	$0.00	$0.00	$0.00	-$799.04

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Invoice	$0.00	$0.00	$799.04
200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Referred CARS	$799.04	$799.04	$0.00

Total Adjustment Amount: $799.04

VIEW AND DOWNLOAD RA *continued*

Page 2: Payment Summary *continued*

- **Claims Summary:** Provides a summary of all the claim categories on the RA for claims submitted in the most recent weekly claim cycle.
  - **Category:** There are 4 possible claim categories (Paid, Denied, Adjustments, or In Process). Claims are sorted by category in the payment information section which starts on Page 3 of the RA.
  - **Total Billed Amount:** Dollar amount on the submitted claim.
  - **Total Allowed Amount:** The amount DSHS is allowed to pay.
  - **Total Client Resp. Amount:** Amount of client responsibility (CR) that will be deducted from the paid claim. The provider collects CR from the client.
  - **Total Paid:** This is the total amount paid by DSHS (allowed amount minus client responsibility).
- **Provider Adjustments**: Provides a summary of claim adjustments initiated during the previous week.
  - Claims can be adjusted by the provider or DSHS.
  - Next to each adjusted amount, the adjustment type is listed and indicates whether the adjustment is offset or non-offset and whether the adjustment resulted in an overpayment.

RA Number: 123456789
Warrant/EFT # 555556!
Warrant/EFT Amount: $14,501.85

Warrant/EFT Date: 1/23/2025
Payment Method: EFT

Prepared Date: 1/24/2025
RA Date: 1/24/2025

Page 2

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total Sales Tax	Total Client Resp Amount	Total Paid
200000001	Paid	$43629.14	$43629.14	$0.00	$29127.29	$14501.85
200000001	Denied	$81.00	$0.00	$0.00	$0.00	$0.00
200000001	Adjustments	$0.00	$0.00	$0.00	$0.00	-$799.04

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Invoice	$0.00	$0.00	$799.04
200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Referred CARS	$799.04	$799.04	$0.00

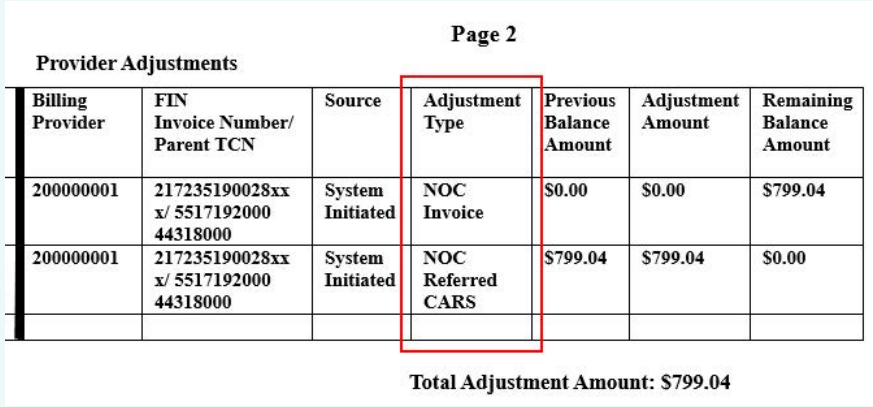
Total Adjustment Amount: $799.04

VIEW AND DOWNLOAD RA *continued*

Page 2: Payment Summary *continued*

Next to each adjustment, an adjustment type is listed. The adjustment type is a result of your action on a claim or an action initiated by DSHS. The most common adjustment types seen on Social Service Provider RAs are listed below:

- **NOC Referred to CARS:** This occurs when a voided claim or an adjusted claim resulted in a non-offset overpayment and the overpayment has been referred to the OFR's Collection and Accounts Receivable System (CARS) for recovery. An overpayment means you were paid too much and you now owe this money back to DSHS.
- **NOC Invoice:** This posts together with a "NOC Referred to CARS" line. This means that the overpayment was referred to OFR and an invoice was created. OFR mails the invoice to you informing you how much you owe.
- **P1OFF Invoice**: This occurs when you owe DSHS due to adjustments exceeding payments. In these cases, DSHS creates an account receivable which is satisfied by either:
  - Taking payment from a future paid claim, or
  - Through a receivable sent to OFR to initiate the recovery; this only happens if the P1OFF is not satisfied after six months.
- **P1OFF Recoupment:** This identifies the payments used to satisfy the P1OFF receivable. This typically posts immediately following a P1OFF Invoice line.
- **COFF Invoice:** OFR creates a CARS Offset Invoice in OFIN for each request sent to ProviderOne from CARS. Direct all questions about COFF offsets to OFR at 1-800-562-6114.
- **COFF Recoupment:** OFR accepts a receivable to collect, and OFR sends back a request to take other payments for paid claims from you to satisfy the receivable. There should be other paid claims on the RA, and some of those payments go to OFR to help satisfy the debt.
- **COFF Referred to CARS:** ProviderOne tried to recover a dollar amount you owed DSHS but did not have a sufficient total of claim payments post in the last six months to satisfy the debt. The balance owed is sent to OFR for collection.



Page 2

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Invoice	$0.00	$0.00	$799.04
200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Referred CARS	$799.04	$799.04	$0.00

Total Adjustment Amount: $799.04

VIEW AND DOWNLOAD RA *continued*

Payment Information

Starting on Page 3 of the RA, you will find detailed information on Paid, Adjusted, Denied, and In Process claims. The next page will provide detailed information about what you will find in each claim category.

RA Number: 123456789 **Warrant/EFT #: 555556!** **Warrant/EFT Date: 1/23/2025** **Prepared Date: 1/24/2025** **RA Date: 1/24/2025**

Page 3

Category: Paid **Billing Provider: 20000001**

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
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	1/16/2025 - 1/16/2025	T1020 U1	1.0000	$70.85	$70.85	$0.00		$0.00	$70.85		
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	1/17/2025 - 1/17/2025	T1020 U1	1.0000	$70.85	$70.85	$0.00		$0.00	$70.85		
Document Total: 1/16/2025-1/17/2025						2.0000	$141.70	$141.70			$0.00	$141.70		

VIEW AND DOWNLOAD RA *continued*

Reading the RA Payment Information section

The Service Code entered on the claim

This is the amount paid by DSHS.

RA Number: 123456789 **Warrant/EFT #: 555556!** **Warrant/EFT Date: 2/13/2025** **Prepared Date: 2/14/2025** **RA Date: 2/14/2025**

Category: Paid **Billing Provider: 20000001**

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
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/1/2025-2/1/2025	T1019	1.0000	$125.00	$125.00	$0.00		$125.00	$0.00		142 45 94 = $125.00
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/2/2025-2/2/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00	$125.00		
Document Total: 2/1/2025-2/2/2025						2.0000	$250.00	$250.00			$125.00	$125.00		

The RA is divided into client sections.

Each service line of the claim(s) is listed. If you used a date range, the range has been divided into daily lines.

Client Responsibility includes both Participation and Room and Board. It is collected directly from the client.

Adjustment Code and Remarks Code: See next page.

VIEW AND DOWNLOAD RA *continued*

The last page of your RA includes explanations of the Adjustment Reason Codes/NCPDP Rejection Codes and Remark Codes that may be listed throughout the Payment Information section.

A list of common adjustment and denial codes are included on the next page.

Adjustment Reason Codes / NCPDP Rejection Codes
18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) 198 : Precertification/notification/authorization/pre-treatment exceeded.

Remark Codes
N640 : Exceeds number/frequency approved/allowed within time period.

COMMON ADJUSTMENT AND DENIAL CODES

Note:
A printable version of the Common Adjustment and Denial Codes list is available as an attachment. Click here for more information.

Below is a short list of common Adjustment Reason and Remarks Codes you may find on your RA

RA ADJUSTMENT REASON/REMARK CODE/DESCRIPTION	POSSIBLE CAUSES	PROVIDER ACTION
142 – Monthly Medicaid patient liability amount	Client responsibility (participation) applied to the claim	You must collect this amount from the client
198 – Precertification/authorization exceeded	Social Service Authorization Approved Units have already been claimed	Contact your case worker if you question the number of units authorized
16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	1. Claimed dates of service are not within the authorization period 2. The authorization line is in error	1. Contact your case worker if you have questions about the authorization dates 2. Contact your case worker if you have questions about authorization errors
18 – Exact duplicate claim/service	1. Claimed the same units on two different lines for the same day, or 2. Claim is an exact duplicate of one already submitted	1. Adjust the claim and report the number of units on a single claim line 2. No action is needed if duplication was unintended
177 – Patient has not met the required eligibility requirements	The client is not financially eligible	Contact your case worker if you have questions
A1 – Claim/Service denied	The authorization is in cancelled status	Contact your case worker if you have questions
B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service	Your contract may be expired	Contact your contract manager or case worker if you have questions

COMMON ADJUSTMENT AND DENIAL CODES *continued*

Note:

Questions on EVV Claims submissions can be submitted to EVVQuestions@dshs.wa.gov.

Below is a short list of common Adjustment Reason and Remarks Codes you may find on your RA

RA ADJUSTMENT REASON/REMARK CODE/DESCRIPTION	POSSIBLE CAUSES	PROVIDER ACTION
B13 -Previously paid. Payment for this claim/service may have been provided in a previous payment.	Date of Service and Service Code were paid on a previous claim. For Providers with EVV claims: ProviderOne cannot yet distinguish between shifts on the same date of service that are provided by the same caregiver. The claims line(s) denied because same date of service, client, billing ID, and SSSOP ID were claimed.	Review past RAs to see if you have already received payment for this client, date of service & code. Look in ProviderOne to see when/if you received payment. For any questions, contact HCA at 1-800-562-3022. For Providers with EVV Claims: Since shifts should be combined on one line submission when one caregiver works multiple shifts for a single date of service, providers may need to adjust the paid claim for the date of service to combine shifts worked.
N54 – Claim information is inconsistent with pre-certified/authorized services	Authorization line is in error	Contact your case worker if you have questions
N63 – Rebill services on separate claim lines	A separate claim line is required for each date of service for the service/procedure code entered	If you are billing quarter hour units or for each unit types, do not use a date span (example: 1/1/2015 to 1/31/2015) to bill. Adjust the claim to reflect separate claim lines for the date of service for each service provided and resubmit claim
N362 – The number of Days or Units of Service exceeds our acceptable maximum	Too many units claimed. ***Example:*** *Provider billed two units on monthly units or provider billed two units on daily units with one day date span*	Change the number of units to the correct amount and resubmit your claim

RA EXAMPLES

This is an example of what the RA looked like for the original paid claim, notice how the claim details are listed in the Paid category of the RA.

RA Number: [redacted] **Warrant/EFT #:** [redacted] **Warrant/EFT Date:** 01/31/2019 **Prepared Date:** 02/01/2019 **RA Date:** 02/01/2019

Category: Paid **Billing Provider:** [redacted] 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
[redacted]	[redacted]	1	[redacted] $59	01/23/2019-01/23/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	2	[redacted] $59	01/24/2019-01/24/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	3	[redacted] $59	01/22/2019-01/22/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	4	[redacted] $59	01/28/2019-01/28/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
			Document Total:	01/22/2019-01/28/2019		128.0000	$924.16	$924.16	$0.00	$0.00	$0.00	$924.16		

This is an example of what page 2 of the RA looks like when a claim has been adjusted and there is an overpayment.

Prepared Date: 01/02/2020
RA Date: 01/02/2020

RA Number: [redacted]
Warrant/EFT # [redacted] **Warrant/EFT Date:** 01/02/2020

Warrant/EFT Amount: $0.00 **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
[redacted]	Adjustments	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
[redacted]	[redacted]	System Initiated	NOC Invoice	$0.00	$0.00	$231.04
	[redacted]	System Initiated	NOC Referred to CARS	$231.04	$231.04	$0.00

Total Adjustment Amount $231.04

RA EXAMPLES *continued*

This is an example of what the claims look like that resulted from the adjustment of the paid claim, note that the details are in the Adjustments category of your RA.

RA Number: [redacted] Warrant/EFT #: [redacted] Warrant/EFT Date: 01/02/2020 Prepared Date: 01/02/2020 RA Date: 01/02/2020

Category: Adjustments Billing Provider: [redacted] Page 5

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
[redacted]	[redacted]	1	859	01/23/2019-01/23/2019	T1019	32.0000	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04		129 = $0.00
	[redacted]	2	859	01/24/2019-01/24/2019	T1019	32.0000	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04		129 = $0.00
	[redacted]	3	859	01/22/2019-01/22/2019	T1019	32.0000	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04		129 = $0.00
	[redacted]	4	859	01/28/2019-01/28/2019	T1019	32.0000	-$231.04	-$231.04	$0.00	$0.00	$0.00	-$231.04		129 = $0.00
			Document Total:	01/22/2019-01/28/2019		128.0000	-$924.16	-$924.16	$0.00	$0.00	$0.00	-$924.16		
[redacted]	[redacted]	1	859	01/23/2019-01/23/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	2	859	01/22/2019-01/22/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
	[redacted]	3	859	01/28/2019-01/28/2019	T1019	32.0000	$231.04	$231.04	$0.00	$0.00	$0.00	$231.04		
			Document Total:	01/22/2019-01/28/2019		96.0000	$693.12	$693.12	$0.00	$0.00	$0.00	$693.12		

Additional Resources

Visit the ProviderOne for Social Services webpage for more resources:

- Updates and newsletters
- Additional contact information
- Additional ProviderOne for Social Services Billing Guides:
    - Getting Started and Billing Essentials
    - Submitting and Adjusting Social Service Claims
    - Submitting and Adjusting Social Service Medical Claims

For questions, feedback, or suggested changes to this document, please email p1_escalation@dshs.wa.gov.