Washington State Health Care Authority

Washington Apple Health (Medicaid)

ProviderOne billing and resource guide

June 2024

Washington State Health Care Authority

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Washington State Health Care Authority

About this guide

This guide supersedes all previously published agency ProviderOne Billing and Resource Guides.

Current updates

Reason for change	Page number	Subject	Change
New program addition – Appendix E	109, 112, and 115	Apple Health Expansion (AHE)	AHE description addition and 2 new ACES program codes

HCA accepts only electronic claims for Apple Health (Medicaid) services, except under limited circumstances. Providers may seek approval to submit paper claims if they are in a temporary or long-term situation outside of their control that precludes submission of claims electronically. Go to the ProviderOne Billing and Resource Guide webpage and go to paperless billing at HCA for more information.

Introduction

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

Disclaimer

A contract, known as the Core Provider Agreement (CPA), governs the relationship between HCA and Apple Health (Medicaid) providers. The CPA's terms and conditions incorporate federal laws, rules and regulations, state law, agency rules and regulations, and agency program policies, provider notices, and provider guides, including this guide. Providers must submit a claim in accordance with agency rules, policies, provider notices, and provider billing guides in effect for the date of service.

HCA does not assume responsibility for informing providers of national coding rules. ProviderOne will deny claims billed in conflict with national coding rules. Consult the appropriate coding resources.

Purpose

This guide serves as a resource for providers and billing staff whose duties are to:

- Maintain provider records.
- Schedule client appointments or check in patients on the day they receive services.
- Submit fee for service (FFS) claims to HCA.
- Post and reconcile payments.

This guide assumes familiarity with standard medical billing practices and coding.

> **Note**: This guide does not include billing information for the pharmacy point-of-sale (POS) system. See the Pharmacy information webpage for more information on the POS system or see the Prescription Drug Program provider guide for more information. DSHS social service billers should refer to the ProviderOne for social services webpage for training resources.

Guide topics

This guide consists of the following six sections:

Apple Health (Medicaid) overview

This section explains the Apple Health (Medicaid) programs provided by HCA, how Apple Health compares to other payers, how Medicaid differs from Medicare, how to identify Apple Health clients, the ProviderOne services card, requirements for becoming an Apple Health provider, and links to important policy documents and resources.

Provider enrollment

This section is for general information about becoming an Apple Health provider. Visit the Enroll as a provider webpage for more information.

Client eligibility, Benefit Service Packages, and coverage limits

This section explains how to determine if a client is eligible for Apple Health (Medicaid) services using ProviderOne, if the service you plan to deliver is covered under their Benefit Service Package (BSP), and when prior authorization is needed.

This section also explains how to determine if a client:

- Has enrolled in a managed care plan.
- Has any restriction to a select number of health care providers.
- Has a spenddown balance that may affect eligibility.

Submitting fee for service (FFS) claims

This section prepares you to submit fee for service claims using the ProviderOne Direct Data Entry (DDE) feature, submit electronic backup documentation, check on the progress of a claim, and process Medicare crossover claims. This section also outlines how to resolve errors, submit adjustments, resubmit denied claims, or void a paid claim.

The Remittance Advice (RA)

This section explains how to obtain your Remittance Advice (RA), determine which claims were paid or denied, review claims still in process, and determine the reason for a claim denial.

Requesting prior authorization

This section explains how to determine if a procedure requires authorization and what steps are needed to complete that process.

Apple Health (Medicaid) overview

Apple Health

Medical assistance is the general name for Washington Apple Health programs administered by the Health Care Authority (HCA).

Washington Apple Health includes Medicaid, mental health programs, chemical dependency and prevention treatment programs, the Children's Health Insurance Program (CHIP), family planning programs, and other state-funded children's healthcare programs. Medicaid is the federal entitlement program financed and operated jointly by the states and the federal government.

HCA provides healthcare coverage for low-income residents who meet certain eligibility requirements. Examples of these requirements include age, pregnancy, disability, and blindness. Special rules exist for those living in a nursing home or for those who receive home and community-based services.

Clients receive healthcare services either through enrollment in a managed care program or on a fee for service basis. For managed care, the agency contracts with licensed health insurance carriers to provide a defined set of services to enrolled members. Fee for service care is delivered by licensed or certified health care providers who have a contract with the agency and receive payment through ProviderOne.

Washington Apple Health clients

Washington's Apple Health programs provide healthcare coverage for our most vulnerable residents. Approximately 1.5 million Washington residents, nearly two-thirds of them children, depend on Apple Health (Medicaid) programs for their healthcare.

Apple Health covers one in three children living in Washington State including:

- Children enrolled in foster care.
- Children of working parents unable to afford health care coverage.
- Disabled children

Other clients also include:

- Nursing home residents
- Elderly or disabled individuals
- Low-income pregnant women

The Health Benefit Exchange (HBE), the HCA Medical Eligibility Determination Services (MEDS), as well as the Department of Social and Health Services determine eligibility for medical assistance depending on the client's circumstances.

Apple Health comparison

Washington State has several programs dedicated to providing healthcare coverage to low-income residents. Washington Apple Health is the largest single source for this coverage. However, some Apple Health programs have limited benefits compared to commercial carriers. See Appendix E for more details.

In many ways, Apple Health is like other payers. There are some distinct differences between Apple Health and commercial insurance plans and Medicare. These differences include:

Specific rules a contracted provider must follow regarding billing a client. See WAC 182-502-0160 and form 13-879 for details.

Apple Health is almost always the payer of last resort, which means Medicare and commercial private insurance companies are billed first. For more information on general conditions of payment see WAC 182-502-0100.

Apple Health compared to Medicare

Apple Health and Medicare are very different programs. Medicare is an entitlement program funded entirely at the federal level. It is a health insurance program for people 65 or older, people 65 and younger with certain disabilities, and people of all ages with end stage renal disease.

The Medicare Program provides:

- Medicare Part A, which covers inpatient hospital services.
- Medicare Part B, which covers professional, and vendor services.
- Medicare Part C, which is a managed care version of Medicare, also called a Medicare Advantage Plan, and offered through private insurance companies.
- Medicare Part D, which covers prescription drugs.

Apple Health (Medicaid) is a needs-based program with eligibility determined by income and covers a wider range of healthcare services than Medicare (i.e., dental). Some individuals are eligible for both Medicaid and Medicare. These clients are referred to as "dual-eligible" clients.

For more information on Medicare, you can find extensive material at the Centers for Medicare and Medicaid Services (CMS) website.

Apple Health clients identified

Each Apple Health client receives a plastic services card. The services card is permanent, and each eligible family member receives a separate card with a client identifier assigned for each client. The card contains only the following information about the client:

- First name
- Last name
- ProviderOne client identification number (9 digits followed by WA)
- Date card was issued.

Using the ProviderOne client ID displayed on the front of the card is one way to access a client's eligibility information. The card also features a magnetic strip on

the back and providers may use a magnetic swipe card reader to obtain the most current eligibility information. There are many other ways to verify a client's eligibility if you do not have access to the client's services card. See the eligibility, benefit service packages, and coverage limits section for more information.

Example of a services card:

Apple Health clients as consumers of healthcare services

The agency encourages Medicaid clients to be responsible consumers of healthcare services. New clients receive information to use when obtaining services that cover topics such as:

- Verifying if a provider is contracted to bill Apple Health before obtaining services from a doctor, dentist, clinic, pharmacy, or other provider. Non-contracted providers can bill clients directly.
- How to help the healthcare provider by bringing the services card to all appointments. Clients should always carry the services card with them in case of emergencies.
- Being courteous about appointments and call their provider's office if an appointment will be missed.
- Informing their provider if they have commercial or other medical insurance besides Apple Health.

Provider enrollment

Benefits for enrolled providers

Some benefits for Apple Health providers include:

- ProviderOne pays claims promptly when billed according to agency rules and regulations.
- Providers may determine how many Apple Health patients to allow according to their business needs.
- ProviderOne offers Electronic Funds Transfer (EFT) payments as a convenience.
- Enhanced payments are available for dental providers who provide Access to Baby and Child Dentistry (ABCD) services.
- The satisfaction that Washington's most vulnerable population is receiving healthcare services.

Enrolling as an Apple Health provider

You can enroll as an Apple Health provider using the electronic enrollment option in the ProviderOne system. See the Enroll as a provider webpage for more information.

For enrollment questions contact the Provider Enrollment office at 1-800-562-3022, extension 16137.

Requirements to enroll

To enroll as a provider with the agency, a healthcare professional, healthcare entity, supplier or contractor of a service must, on the date of application:

- Be licensed, certified, accredited, or registered according to Washington State laws and rules.
- Meet the conditions in Chapter 182-502 WAC and other chapters regulating the specific type of provider, program, and/or service.
- To enroll, an eligible provider must sign a Core Provider Agreement (CPA) with the agency according to WAC 182-502-0005.
- Enrollment of a provider applicant is effective no earlier than the date of approval of the provider application.
- The agency does not pay for services provided to clients during the core provider agreement (CPA) application process, regardless of whether the CPA is later approved or denied.

> **Note**: There is an application fee for institutional provider enrollment applications. **This fee does not apply to providers enrolled with Apple Health prior to June 1, 2016**. The provider enrollment application fee is only required for provider types in the institutional setting. Providers that are required to pay the application fee will receive notification of the cost by mail.

For additional information about federal and state regulations related to the provider enrollment application fee, see 42 CFR 455, Subpart E, 42 CFR 455.460 and WAC 182-502-0010 (k).

For questions related to the enrollment application fee, email providerenrollment@hca.wa.gov or call 800-562-3022 and use extension 16137.

Eligible provider types

There are specific rules on who may enroll:

- All performing providers of services to an Apple Health client must be enrolled under the billing provider's CPA.
- The agency does not enroll licensed or unlicensed practitioners not specifically addressed in WAC 182-502-0002, and ineligible providers as listed in WAC 182-502-0003.
- For a list of providers who are eligible to enroll with Apple Health, see WAC 182-502-0002.
- All dental servicing providers must be enrolled in ProviderOne under the dental billing provider NPI (effective July 1, 2014).

Providers required to enroll

See 42 CFR 455.410:

- Any referring, ordering, or prescribing provider must be enrolled with HCA as a fee for service provider.
- The National Provider Identifier (NPI) number of any referring, ordering, or prescribing provider must be listed on any claims for services, supplies, tests, etc. ordered, referred, or prescribed by that provider.
- To comply with the National Uniform Billing Committee (NUBC) guidelines all NPI numbers of attending, operating, and "other" providers must be reported on institutional claims.
- All providers reported on the institutional claim must be enrolled as a Washington State Medicaid Provider.

Provider enrollment policies

Specific policies regarding provider enrollment include:

- You must notify HCA in writing within seven calendar days of ownership or control changes of any kind (see WAC 182-502-0018).
- You may voluntarily terminate your provider agreement by contacting Provider Enrollment at ProviderEnrollment@hca.wa.gov (see WAC 182-502-0040).
- In some situations, the agency may immediately terminate your enrollment/CPA (see WAC 182-502-0030).
- There are a few exceptions to the enrollment effective date (see WAC 182-502-0005).

- See the full text of Chapter 182-502 WAC for additional provider enrollment information.
- To continue to provide services for eligible clients and be paid for services, a provider must:
  - Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental, or physical handicap, or the use of a trained dog guide or service animal by a person with a disability.
  - Provide all services according to federal and state laws and rules, Medicaid agency billing instructions, numbered memoranda issued by the agency, and other written directives from the agency.
  - See the full text of Chapter 182-502-0016 for additional detail on these requirements.

Policies regarding documentation and paper claims

Specific policies regarding documentation and paper claims include:

- The complete list of Healthcare Record Requirements can be found in WAC 182-502-0020.
- Charts and records must be available to the agency, its contractors or designees, and the US Department of Health and Human Services upon request for six years from the date of service, or longer if required specifically by federal or state law regulation.
- As of October 1, 2016, the agency will only accept electronic claims for Apple Health (Medicaid) services, except under limited circumstances. Providers may seek approval to submit paper claims if they are in a temporary or long-term situation outside of their control that precludes submission of claims electronically. See the ProviderOne Billing and Resource Guide webpage for more information.

Out-of-state bordering cities

WAC 182-501-0175

All eligible Washington residents may receive medical care in a recognized out-of-state bordering city on the same basis as in-state care. The only Washington recognized bordering cities are:

- Idaho: Coeur d'Alene, Lewiston, Priest River, Moscow, and Sandpoint
- Oregon: Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles

> **Note**: Washington Apple Health does not cover services provided outside Washington under the Involuntary Treatment Act (ITA) (Chapter 71.05 RCW and Chapter 388-865 WAC), including designated bordering cities.

Out-of-state providers must have a contract with HCA for payment of out-of-state emergency services and may request retroactive enrollment when necessary.

For nonemergency services, use the Out of State Medical Services Request form, HCA 13-787.

Resources

Topic	Contact or link
Where can I find provider guides that explain program-specific billing guidelines, coverage, and limitations?	See the Provider billing guides and fee schedules webpage.
Where can I find fee schedules?	See the Provider billing guides and fee schedules webpage.
Where can I find hospital rates?	See the Hospital reimbursement webpage.
Who do I contact if I have questions about payments, denials, general questions regarding claims processing, or managed care plans?	The Medical Assistance Customer Service Center (MACSC) provider line is available Monday through Friday 7 a.m. to 4:30 p.m. daily (claims line open 8 a.m. – noon, closed noon – 1:30 p.m., and open 1:30 to 3:30 p.m.). The interactive voice response (IVR) phone system is available 24 hours a day, 7 days a week. • 1-800-562-3022 • Email MACSC using the Contact Us link. **Note**: Providers may use HCA's toll free lines for questions regarding its programs; however, HCA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HCA's programs (see Chapter 182-502 WAC).
Where can I get information about becoming an Apple Health provider, submitting a change of address, submitting a change of ownership, or to ask questions about the status of an application?	See the Enroll as a provider webpage. Provider enrollment hours are 7 a.m. to 4:30 p.m. (closed noon to 1 p.m.) Tuesday and Thursday. Closed Mondays, Wednesdays, and Fridays. • 1-800-562-3022 ext. 16137 • Fax: 360-725-2144

Topic	Contact or link
	• Email providerenrollment@hca.wa.gov
Where can I find information about HCA's current rule making activity?	See HCA's Rulemaking webpage.
Where do I find all Washington Administrative Codes (WAC)?	See the Washington Administrative Code (WAC) webpage.
What is the Apple Health web address?	See the Washington Apple Health (Medicaid) coverage webpage.
Where can I find the Washington State Confidentiality Toolkit for Providers?	See the Toolkit and webpage announcement.
Where can I ask questions about private insurance or third-party liability?	For private insurance claims, submit a Contact us email. Choose Medical Provider and use Private Commercial Insurance on the Select Topic dropdown. For casualty-related claims or third-party liability, call the toll free number at 1-800-562-3022 M – F from 8 a.m. – 4:30 p.m.
Where do I ask questions about nonemergency transportation services?	HCA provides access to nonemergency transportation services for clients who need help with transportation to and from their healthcare appointments. For more information, see the Transportation services (nonemergency) webpage or email HCA Transportation.
Where do I ask questions about interpreter services?	For spoken language access providers (LAP), register through Universal Language. Visit the spoken language access provider webpage for more details. For sign language interpretation, visit the sign language interpretation webpage for more details. E-mail: HCA Interpreter Services
Where do I obtain HCA's forms?	See HCA's forms and publications webpage.
Where can I find locations of DSHS Community Service Offices (CSO)?	For more information, see the Online Community Services Office (CSO) webpage on the DSHS website.

Topic	Contact or link
Where do I find locations of DSHS Home and Community Services (HCS)?	For more information, see the Home and Community Services Information for Professionals webpage on the DSHS website.
How do I find out what is included in the nursing facility per diem or general rate?	Contact the DSHS Aging and Long Term Support Administration (ALTSA) website or call 1-800-422-3263.
How do I request authorization?	Visit the Prior authorization webpage for complete step by step instructions on entering prior authorization requests through the direct data entry feature of ProviderOne. Call 1-800-562-3022 using an extension listed below: • Durable medical equipment and supplies, prosthetics and orthotics, and oxygen: 15466 • Dental: 15468 • Pharmacy: 15483 • Medical – Surgical: 52018 • All other medical services/enteral nutrition: 15471 See the program specific billing guide located on the provider billing guides and fee schedules webpage for information on requesting authorization. See Appendix F for instructions on completing the General Authorization Request form, HCA 13-835. • Authorization forms can only be sent by fax to 1-866-668-1214 If you are faxing supporting documentation without the original authorization request form, a cover sheet is required. See Appendix H for more information on cover sheets.
Where can I access provider training materials?	See the ProviderOne resources webpage.
How do I submit backup documentation for electronic claims?	Heath Care Authority RE: Cover sheets and backup documentation PO Box 45535 Olympia, WA 98504-5535 Backup documentation must include a cover sheet as the first page and can be faxed to 1-866-668-1214. See Appendix H for more information on cover sheets.

Important contacts

Section	Contact
Disability Insurance	1-800-562-6074
Fraud Hotline	1-833-794-2345
Home Health/Plan of Treatment	1-360-586-1471
Foster Care	1-800-562-3022 ext. 15480
Hospice Notification	1-360-725-1965 (fax only)
Medical Eligibility Determination Services (MEDS)	1-800-562-3022
Medicare Unit Fax Line	1-360-664-2186
Patient Review and Coordination	1-800-562-3022 ext. 15606
TAKE CHARGE questions	1-800-562-3022
Telecommunication Relay Services (TRS)	711
Managed care plan managers	hcamcprograms@hca.wa.gov
HIPAA help desk	hipaa-help@hca.wa.gov

Eligibility, Benefit Service Packages, and service limits

Getting paid for eligible Apple Health services

HCA denies many claims because the client was not eligible for Apple Health on the date of service. To prevent billing denials, always check the client's eligibility and confirm plan enrollment prior to providing any services. Checking eligibility and coverage takes less time and effort than resolving a denied claim.

Some procedures may require the satisfaction of certain conditions before reimbursement for a service, such as determining whether a service requires prior authorization. Researching these requirements before providing a service will help prevent denied claims.

If the service is not covered and the client chooses to receive and pay for a specific service, providers may be able to bill the client. See the billing a client WAC 182-502-0160 and Agreement to Pay for Healthcare Services form 13-879 for rules on billing a client. For training materials on this topic, see our webinars page.

This section shows how to determine:

- If the client has Apple Health.
- If a service is covered under the client's Benefit Service Package.
- If the client is enrolled in a managed care plan or if they are fee for service.
- If a client has commercial insurance as their primary payer.
- When prior authorization is required.
- When and if a waiver can be used to bill a client.
- If the client has a spenddown balance that may affect eligibility.
- Any special limitations or restrictions.
- If the client has reached their maximum for services with limitations.

Disclaimer

A contract, known as the Core Provider Agreement (CPA), governs the relationship between HCA and Washington Apple Health providers. The CPA's terms and conditions incorporate federal laws, rules and regulations, state law, HCA's rules and regulations, and HCA's program policies, provider notices, and provider guides, including this guide. Providers must submit a claim in accordance with HCA's rules, policies, provider notices, and provider guides in effect at the time they provided the service.

Verifying Apple Health coverage

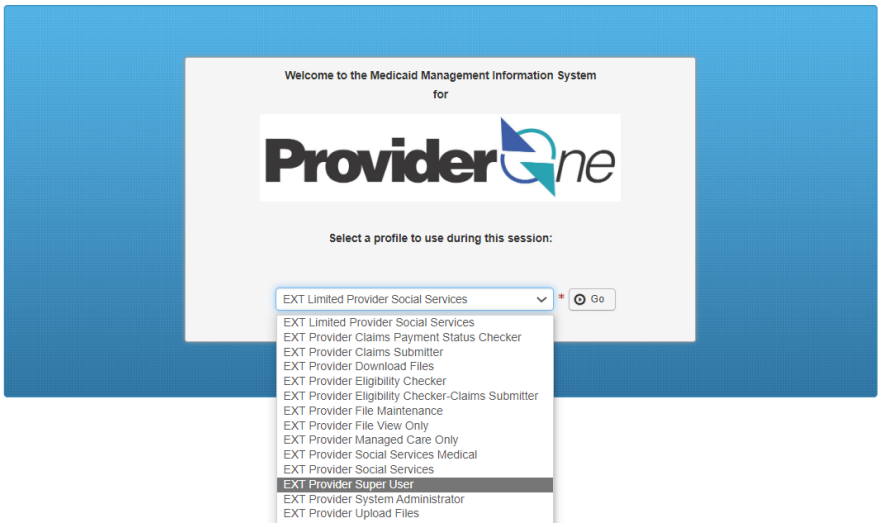
It is your responsibility to verify whether the client has Apple Health coverage for the date of service, and if so, to check the limitations of the client's medical program. Verification helps prevent providing a service that the agency will not pay for. When making an appointment for a client it is important to check

eligibility to determine if the client needs interpreter services for the appointment.

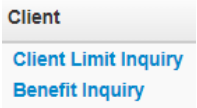
There are many methods to check client eligibility. Most of these methods involve using the ProviderOne system. Use ProviderOne to submit an eligibility inquiry using one of these methods:

- Search for eligibility information using ProviderOne.
- Submit an electronic individual or batch 270/271 inquiry to ProviderOne.
- Swipe the client services card using a magnetic card reader (see Appendix B).
- Use a medical eligibility vendor to access information on your behalf (see Appendix B).
- Call the interactive ProviderOne voice response (IVR) (see Appendix A).
- Submit a request through the Contact Us email link.
- If the client's appointment is within 48 hours, call a customer service representative at 1-800-562-3022.

To search for eligibility information in ProviderOne, log into ProviderOne and select the EXT Provider Eligibility Checker or EXT Provider Super User profile to verify client's eligibility for Apple Health (Medicaid):



Select the **Benefit Inquiry** hyperlink from the provider portal home page menu:



Search by any one of the many combinations available. The inquiry start date will default to the current date. When searching for other dates of service, make sure to enter only the current date or previous dates as ProviderOne cannot search

future eligibility. Information displayed is only valid for the inquiry start and end date. A client's eligibility segment may change if a different date of service is used. The maximum date span for an eligibility inquiry is 2 years.

Close Submit

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

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

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

Client Eligibility Inquiry

ProviderOne Client ID: SSN:
Last Name: First Name:
Date of Birth:
Inquiry Start Date: 09/01/2022 * Inquiry End Date: 09/01/2022 *

Service Type Code

Service Type Code: 30-Health Benefit Plan Coverage

> **Note**: If you aren't sure how to spell the client's name, ProviderOne allows a client eligibility search by using the first 5 letters of the last name and the first 3 letters of the first name. However, if using the name search feature, the date of birth or SSN is required.

If your search was successful, the system then displays the selection criteria you entered, followed by the demographic information. If the demographic information is blank, review the System Response Information to see why ProviderOne could not find the client.

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

Close Submit Another Inquiry Exit Printer Friendly Version

Selection Criteria Entered

Date of Request: 09/01/2022
Time in Request: 10:19:23 AM PDT
Provider ID:
From Date of Service: 09/01/2022
To Date of Service: 09/01/2022
ProviderOne Client ID: 999999998WA
Client Date of Birth:
Client SSN:
Client Last Name:
Client First Name:

Demographic and Response Information

Client Demographic Information:

ProviderOne Client ID: 999999998WA
Client First,Middle,Last Name: JANE DOE
CSO/HCS: 183-HCA SOUTHWEST
County Code: 008-Cowlitz
CSOR: 008-KELSO CSO
Date of Birth: 00/00/0000
Gender: Female
Language: ENG-English
Placement:
ACES Client ID: 00000000
MBI:

System Response Information:

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

Below the Client Demographic Information, successful client searches will display the Client Eligibility Spans with detail on what kind of coverage the client has during the date span you searched:

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	Review End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1203	CNP	09/01/2019	12/31/2999	01/31/2023	N11			

Each column is described below:

- **Insurance type code** – the type of coverage for the client
- **Recipient aid category (RAC)**
- Name of **Benefit service package** (BSP) acronym
- **Eligibility start date** - start date for this eligibility segment.
- **Eligibility end date** - if there is no end date, ProviderOne defaults to 12/31/2999.
- **Review end date** - the date a client may terminate if they don't renew their coverage (renewal notices are sent the month before). If there is no end date, it does not apply to their coverage type.
- **ACES coverage group** - code assigned when eligibility is determined.
- **ACES case number** – case number assigned to client.
- **Retro eligibility** - this reflects the three calendar months before the month the client applied for services (WAC 182-502-0150).
- **Delayed certification** - in some cases the determination of eligibility is delayed. If approved, the delayed certification date will be displayed in this location. The agency can accept claims up to one year past this date (WAC 182-502-0150).

> **Note:** Some providers may need to use the Recipient aid category (RAC) for specific billing purposes or to further determine a client's eligibility in a program. Please reference the applicable program specific provider guide for further details.

If the eligibility inquiry is unsuccessful, the system will display an error message under system response information:

Close | Submit Another Inquiry | Exit

Selection Criteria Entered

Date of Request:	09/01/2022	ProviderOne Client ID:	000000000WA
Time in Request:	01:08:39 PM PDT	Client Date of Birth:	
Provider ID:	200320900	Client SSN:	
From Date of Service:	01/01/2019	Client Last Name:	
To Date of Service:	09/01/2020	Client First Name:	

Demographic and Response Information

Client Demographic Information:		System Response Information:	
ProviderOne Client ID:		Valid Request Indicator:	N
Client First,Middle,Last Name:		Reject Reason Code:	72 - Invalid/Missing Subscriber/Insured ID
CSO/HCS:		Eligibility or Benefit information Code:	
County Code:		Follow-Up Action Code:	C - Please correct data and resubmit
CSOR:			
Date of Birth:			
Gender:			
Language:			
Placement:			
ACES Client ID:			
MBI:			

> **Note**: If your search returns an error, check how you entered the information and correct as needed.

Pitfalls:

- Relying on eligibility information obtained before the date of service. HCA recommends that providers always verify eligibility the day the service occurs.
- Failing to verify the identity of the cardholder. Apple Health coverage is not transferable. If you suspect that a client has presented a services card belonging to someone else, request to see a photo ID or another form of identification.

Verifying primary payer and program type

Apple Health is almost always the payer of last resort (for exceptions, see WAC 182-502-0100). The agency will not pay claims as primary if there is another payer (such as Medicare or commercial insurance). Most Apple Health clients will be in a managed care plan where the agency pays a monthly premium to that plan for the client's medical needs. If there is no managed care segment on the client's file, they are considered fee for service clients and all billing will be submitted directly to ProviderOne, or through the agency's pharmacy POS (point of sale) system for prescription benefits.

> **Note**: Effective for claims with dates of service on and after January 1, 2017, the Health Care Authority changed the process for managing Apple Health (Medicaid) benefits for clients with other primary health insurance. See the Apple Health Medicaid provider alert dated 11/16/2016 10:09 AM PST.

- Providers billing for fee for service clients with a private commercial insurance, bill ProviderOne as secondary.
- Providers do not have to be part of the client's MCO network to bill for secondary coverage. However, to bill the client's MCO, providers must follow the MCO's billing requirements.

- After billing a client's primary health insurance for a covered service, providers must then bill the MCO or the MCO's pharmacy benefit manager (PBM) to coordinate benefits for copays, deductibles, or other remaining balances. Providers must not bill copays, deductibles, or other remaining balances to the client.
- If a provider bills the client's MCO as a secondary payer, the MCO does not require prior authorization. However, if the client's primary health insurance does not cover the service, the provider must follow the Apple Health MCO requirements, including prior authorization if necessary.

To avoid turning away an individual at check-in, determine the client's primary payer when making an appointment. Some of the reasons a provider might turn clients away include:

- The provider does not accept their managed care plan.
- The provider is not an enrolled Medicare provider.
- The provider is not an enrolled provider with their commercial private insurance.

Client eligibility may change over time, and the primary payer may change as well. For example, a client may enroll in an Apple Health managed care plan.

Nursing home providers must review the Institutional Award Letter. The award letter explains client income and participation amount, medical care eligibility, effective date for care, care level, and other information.

This does not apply to clients with Alternative benefits plan (ABP) benefits, as this population has nursing home coverage without cost sharing, so the institutional award letter is unnecessary.

All other providers that are not nursing homes can follow the instructions below.

This section covers the following:

- How to determine the client is enrolled in an Apple Health managed care plan.
- How to determine the client is eligible for behavioral health services (mental health and substance use disorders).
- Whether or not the client is enrolled with a Primary care case management (PCCM) provider.
- Verifying the client is Medicare eligible.
- How to determine if the client has commercial private insurance, Medicare Part C or D, or military.
- How to verify a client receives services from specific providers.
- Verifying a client is receiving services through a hospice agency.
- How to determine an individual is a client of the Developmental Disabilities Administration (DDA).
- How to verify a client is participating with the Department of Health's Children with Special Health Care Needs (CSHCN) program.

Client with managed care

If the client is enrolled in a Managed Care Organization (MCO), the following segment will be displayed as part of the client benefit inquiry. HCA does not process or pay claims for clients enrolled in an MCO for services provided under the plan's contract. If the service is covered by the MCO, do not bill HCA as a secondary payer. If there is no managed care segment, or there are end dates noted for the managed care plan and the dates you are billing for, the client is fee for service, and you should bill ProviderOne directly.

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	AMG Fully Integrated Managed Care	201599810	(800) 600-4441		03/01/2021	05/31/2037

> **Note**: The benefit inquiry response does not return the primary care provider (PCP) information but does return the PCP clinic name when the information is available.

Contact the managed care plan with any questions regarding authorization and billing. See Appendix C for MCO contact information.

> **Note**: Already saw a client enrolled in an MCO and the provider is not the assigned primary care provider (PCP), or the client does not have a referral? Contact the PCP to get a referral and then call the MCO to see if authorization is required or can be obtained for the service provided. If the office is not contracted with the MCO, call the MCO to see if they have an allowance for a noncontracted provider treating the client.

When a client is enrolled in an MCO upon admit to a hospital stay, then disenrolls from the plan and becomes fee for service (FFS) during the stay, the entire stay and physician services are the responsibility of the plan until the client is discharged.

Integrated managed care

Integrated managed care (IMC) was implemented in 2016 and includes physical and mental health services, and drug and alcohol treatment, all in one health plan. It is now available in all regions of the state with the remaining areas of Thurston-Mason, Great Rivers, and Salish implemented January 1, 2020.

For more information, view a map of the integrated managed care plans available in each region. IMC is represented as fully integrated managed care (FIMC) in ProviderOne:

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	AMG Fully Integrated Managed Care	201599810	(800) 600-4441		03/01/2021	05/31/2037

Clients enrolled in Apple Health Core Connections (AHCC) will have a Healthy Options Foster Care (HOFC) segment for Coordinated Care listed in the managed care section:

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	Coordinated Care Healthy Options Foster Care	201599905	(877) 644-4613		11/01/2021	12/31/2999

Note: Effective for claims with dates of service on and after January 1, 2017, clients with other primary health insurance may be enrolled into an Apple Health managed care plan as a secondary insurance. Remember to always check for other primary payers when verifying eligibility in ProviderOne. See the Apple Health Medicaid provider alert dated 11/16/2016 10:09 AM PST.

If a client has a managed care plan as their secondary insurance, all updates related to their primary payer (terminations, etc.) must be reported through the managed care plan not through the agency's Coordination of Benefits Unit.

Health Home program

The Health Home (HH) program provides patient-centered care coordination services to support Medicaid and dual Medicaid/Medicare eligible clients in accessing appropriate medical and social services. Care Coordinators (CC) work with clients to support their overall health, wellbeing, and self-care. Participation is optional and does not affect Medicaid coverage or other health care benefits the client is currently receiving.

FFS clients enrolled in the HH program will have a segment for "Health Home Only" listed in the managed care section:

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	Northwest Regional Council - Health Home Only	203067601	(800) 585-6749		09/01/2021	12/31/2999

A managed care client enrolled in the HH program will have a Health Home eligibility segment on the benefit inquiry screen in ProviderOne.

Health Home Eligibility

Start Date	End Date
10/01/2013	12/31/2999

Behavioral health services

As of January 1, 2020, the state has fully transitioned all behavioral health organizations into the integrated managed care program (IMC). All behavioral health services (including substance use disorder [SUD]) will go through the client's managed care plan.

Clients who are dual eligible (Medicare as primary) or some clients who are fee for service, will receive behavioral health services through Behavioral Health Services Only program (BHSO).

Clients enrolled in a BHSO will have the following display:

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	CHPW Behavioral Health Services Only	105010110	(800) 440-1561		02/01/2023	12/31/2999

Apple Health clients who are in a program that is not eligible for a BHSO should be referred to the appropriate community resource in their county to see if there are available funds for services.

For more information on IMC and BHSO programs, please visit the Behavioral Health Care and Recovery webpage page.

State-only programs

Some provider groups rely on the ACES program codes to help them determine if the client is on a state only (fee for service) program. Review the ACES Program Codes for assistance.

Primary Care Case Management (PCCM)

Primary Care Case Management (PCCM) is an Apple Health (Medicaid) program where an Indian Health Service (IHS) or tribal clinic serves as the primary care provider (PCP) and manages the client's health care needs, including specialty care. To support coordination of the health care services the client is receiving, the agency requires a referral from the client's assigned PCP.

Clients enrolled in a PCCM will have the following display in the Managed Care Information section:

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	NATIVE PROJECT			NATIVE PROJECT	08/01/2020	10/31/2052

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

- Clients who have a PCCM have Apple Health (Medicaid) coverage without a managed care plan and all claims are billed to ProviderOne fee for service.

- All clients with a PCCM must have a referral from their PCCM for health care services to be paid to an outside provider.
- Bill all services for PCCM clients covered by the referral to Apple Health and indicate the PCCM referral number on the claim.
- Women who have a PCCM provider do not need a referral for OB/GYN, or family planning services provided outside of the PCCM.

The current PCCMs are:

- Lake Roosevelt Community Health Centers
- Inchelium Clinic
- Lower Elwha Health Clinic
- Puyallup Tribal Health Authority
- Seattle Indian Health Board
- Lummi Tribal Health Center
- Roger Saux Health Center - Medical
- Native Project
- Nooksack Community Clinic
- Yakama Health Center
- David C Wynecoop Memorial Clinic
- Colville Indian Health Clinic

Clients with Medicare

The Medicare Eligibility Information screen displays the following segments for clients eligible for Medicare Part A or Part B:

Medicare Eligibility Information

Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MA: Medicare Part A	04/01/2020	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	05/01/2021	12/31/2999

You must bill Medicare as the primary payer if Medicare covers the service. The client's Medicare Beneficiary Identifier (MBI) will be returned on a ProviderOne benefit inquiry screen for billing purposes.

Commercial insurance, Medicare Part C/D, or military benefits

If the client has other coverage, ProviderOne displays the following segments in the Coordination of Benefits Information section of the eligibility results:

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	UMR (800) 826-9781	WU01					09/01/2017	12/31/2999

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 "I am an Apple Health (Medicaid) biller or provider," 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.

- You must bill the commercial private insurance as primary. ProviderOne should be billed only after verification of commercial insurance on the client's file in ProviderOne, and all other commercial insurance claims have been processed.
- The insurance carrier code displayed under the Carrier Code column must be used on the direct data entry (DDE) secondary insurance claims billed to ProviderOne as the insurance company ID number.
- If the private insurance does not cover the service or has denied the service, expand the Other Insurance Information area in the DDE screen and complete all required fields, entering zeros for COB Payer Paid Amount. If you do not have a specific Claim Adjustment Reason Code (CARC) to enter in the Claim Level Adjustment area, you must attach the letter or EOB from the primary payer. By entering the Other Insurance Information, the claim will be manually reviewed with the backup submitted. For assistance submitting backup with your DDE claim, review the submitting backup documentation for a DDE claim section of this guide.
- You must bill the Medicare Part C plan as primary. Bill a secondary crossover claim to the agency after the claim is processed and payment is made by the plan. If the Part C plan did not make a payment, these claims would not be considered crossover claims and will be processed as a standard medical claim in ProviderOne. Include a copy of the Medicare EOB with the denied claim.
- ProviderOne may pay the client liability amount (deductible, co-insurance, or co-pay) according to the agency's payment policy.
- If ProviderOne indicates Medicare Part D (prescription drug coverage) in the Coordination of Benefits section, see the Prescription Drug Program provider guide for specific details.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	COMMUNITY HEALTH PLAN OF WASHINGTON (206) 521-8833	H5826		Med Part D			01/01/2023	12/31/2999

- Refer active-duty military clients who are eligible for benefits with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to use their local military facility. When a client is CHAMPUS eligible, the insurance carrier code is either HI50 or HI00 (see example below).

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	DEERS/TRICARE/CHAMPUS	HI50			PRIME	DEERS	01/01/2009	12/31/2999

- Individuals with Department of Veterans Affairs (VA) eligibility may seek care through their VA primary insurance, but it is not required. When billing HCA as secondary insurance, use the insurance carrier code VE02.

> **Note**: If the client needs to locate a VA medical center, they may call 1-800-827-1000 from any location in the United States and the call routes automatically to the nearest VA regional office.

- Refer clients who have insurance through a commercial Health Maintenance Organization (HMO) to their designated facility or provider. If a client's primary insurance is through an HMO, the insurance carrier code will be HM, HI, or HO.
- Apple Health does not pay for services referred to a provider not contracted with the primary HMO. This is the responsibility of the referring HMO. If the HMO does not cover the service, the agency may be billed for those services if they are covered by Apple Health.

Exception: If a client lives more than 25 miles or 45 minutes away from the nearest primary HMO provider/facility, Apple Health will pay for nonemergency services under the fee for service (per fee schedule) program. These cases are generally determined on an individual basis.

You must complete a Contact Us email to our Coordination of Benefits Unit. 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 information relating to the issue in the **Other Comments** section to include a reference to "out of area network review." The primary HMO may require notification of any emergency services before they make any payment(s).

The Contact Us form can also be used to update a client's file when the commercial insurance is no longer active following the same steps as above. In the Other Comments section enter the following detail:

- Termination date of the private insurance
- Date you spoke to the insurance agent to verify end date.

The agency does not deny the following services for third party coverage unless the third-party liability (TPL) carrier code is HM, HI, or HO:

- Outpatient preventative pediatric care

- Outpatient maternity-related services
- Accident-related claims, if the third party benefits are not available to pay the claims at the time they are filed

> **Note**: If it is determined that there is a possible casualty claim, call the toll-free number at 1-800-562-3022 [e.g., motor vehicle accident, Department of Labor and Industries (L&I) claim, injury diagnosis]. See Appendix D for more information on casualty claims.

Restricted client information

(WAC 182-501-0135)

Some clients are assigned to certain providers. ProviderOne displays the following segment(s) in the Restricted Client Information screen when clients are restricted to specific providers:

Restricted Client Information

Assignment Type	Provider Name	Provider Phone Number	Period Start Date	Period End Date
Primary Care Physician	JANE SMITH, ARNP	(800) 562-3022	01/01/2022	12/31/2999
Primary Care Physician	HCA MEDICAL CLINIC	(800) 562-3022	01/01/2022	12/31/2999
Pharmacy	HCA PHARMACY SERVICES	(800) 562-3022	01/01/2022	12/31/2999

- The Patient Review and Coordination (PRC) program assists clients in using medical services appropriately by assigning them a PCP, pharmacy, and/or a hospital for nonemergency care. The PCP may make referrals for specialty medical care. Some covered services that do not need a referral include, but are not limited to, dental and medical equipment.
- Providers must bill PCP referred services with the PCP's National Provider Identifier (NPI) in the appropriate field on the claim. You may look up an NPI at the National Plan & Provider Enumeration System (NPPES) Registry website. For questions about the PRC program or to report a client for utilization review, call 1-800-562-3022 ext. 15606.

Hospice services

(WAC 182-551-1210)

If the client receives services through a hospice agency, the following segment will be displayed as part of the client benefit inquiry:

Hospice Information

Hospice agency	Hospice Address	Hospice Phone	Hospice Contact	Start date	End date
217487900	10530 19TH AVE SE STE 201, EVERETT, WA 98208-4282	(425) 595-3059		09/20/2021	12/31/2999

See the Hospice Services provider guide for more information.

Developmental Disabilities Administration (DDA)

Clients of DDA will display the following segment in the Developmental Disability Information section of the eligibility results:

Developmental Disability Information

Start Date	End Date
10/06/1982	12/31/2999

Clients of DDA may be eligible for additional medical services. See the program specific provider guides for those additional services.

Children with Special Health Care Needs (CSHCN)

If the client has special health care needs and is enrolled in the CSHCN program, the system displays the following segment in the Children with Special Health Care Needs Information section of the eligibility display:

Children with Special Health Care Needs Information

Start Date	End Date
08/05/2022	08/31/2023

Medicaid suspension

If an existing Apple Health client is incarcerated or committed to a state hospital, their coverage with Apple Health will be suspended and no longer end dated in ProviderOne. If you see the term "suspended when doing an eligibility check, Apple Health would only be covering inpatient services for the time frame during the suspension. All other services during the suspended timeframe would be covered by the jail or state hospital. For more information, visit the Medicaid Suspension webpage:

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1105	CNP	07/17/2022	12/31/2999	S01			
MC: Medicaid	1105	Suspended - Inpatient Hospital Services Only	05/20/2022	07/16/2022	S01			

Pitfalls

- Failing to check the dates on a displayed segment. When reviewing the eligibility record, always make sure the dates on a segment correspond with the actual date of service.
- Billing the agency when there is a primary payer. This delays receipt of payment increasing a provider's workload. Commercial insurance must be added to a client's file prior to submitting a secondary claim to ProviderOne.
- Providing a service to a client who has chosen to obtain care with a PCCM provider, and this provider is not the PCP, or the PCCM provider/PCP did not refer the client. Contact the PCP for a referral.

Benefit Service Package

Benefit Service Packages (BSP) do not cover all services and procedures. Providers should always verify the service provided is a covered benefit under the client's BSP.

View additional information related to programs covered under a specific BSP (e.g., physical therapy, dental, hospital) by clicking on the hyperlink under the heading Benefit Service Package.

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1203	CNP	06/01/2021	12/31/2999	N11			

See Appendix E for an overview of Benefit Service Packages.

Spenddown

Spenddown is a type of client liability, like an insurance deductible. Spenddown liability is the amount of medical expense a client must pay before Limited Casualty Program/Medically Needy Program (LCP/MNP) coverage begins. When the client has paid medical expenses equal to or greater than a predetermined spenddown amount, the provider can submit a claim for the outstanding amount.

Medical coverage does not always begin on the first day of the month. A date of service that is the same as the Medicaid eligibility start date may require the claim to show a spenddown liability amount. See the Provider Spenddown step-by-step fact sheet and Chapter 182-519 WAC for more information on spenddown.

If the client has not accumulated enough financial obligation to obtain medical benefits, the Benefit Service Package displays Pending Spenddown – No Medical:

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1124	Pending Spenddown - No Medical	01/01/2023	12/31/2999	S99			

Spenddown FAQ

Q - How do I find out if our claim was used to meet a client's spenddown liability? How do I find out how much of our claim was assigned to a client's spenddown liability?
A - Call the spenddown inquiry toll free number for providers 1-877-501-2233 and leave a message to request a call back from the specialized Spenddown Unit.

Q - How will my claim be processed if there is a spenddown amount applied to my claim?
A - HCA will deduct the spenddown amount from HCA allowable amount. For more information on provider payments, see WAC 182-519-0110.

Q - How do I know if a claim was denied for spenddown?
A - Check the remittance advice to find the denial code for the claim. Claims

denied for spenddown will show adjustment reason code 125 and remark code N58.

Q - What will happen if I submit a claim when ProviderOne indicates the client is "pending spenddown"?
A - The claim will deny because the client is not eligible.

Q - Can I charge the client when some or my entire bill has been used to meet the client's spenddown liability?
A - Providers may charge the client no more than the spenddown amount that was applied to the claim. See WAC 182-519-0110 for more information.

Q - How do I report spenddown on a claim?
A - See the Provider spenddown step-by-step fact sheet.

Q - What if I see an active Benefit Services Package, such as CNP effective for the same date(s) as a pending spenddown segment?
A - Due to changes in the way eligibility is determined and displayed in ProviderOne, some clients still show pending spenddown segments from the benefit they had prior to Medicaid expansion on 1/1/14; these will not go away until the end of their spenddown period, so until that happens providers will see overlapping eligibility. It is important to note the active segment will always be honored, so in these situations providers can ignore the pending spenddown segment and bill according to the active segment.

Pitfalls

- Failing to check the client's Benefit Service Package. This may result in providing services that are not covered by HCA.

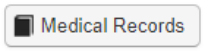
Medical records for clients in Foster Care

ProviderOne now gives the provider access to claims history for children in foster care. The claims history (pharmacy, dental, medical, etc.) will be available when a provider performs an eligibility check in ProviderOne.

Providers may benefit from knowing a foster care client's claims history before treating or prescribing medications for the client.

Log into ProviderOne and select the **Benefit Inquiry** hyperlink to conduct an eligibility check for the client.

Enter the appropriate search criteria to locate the client's eligibility information. If the selected client's medical records are available when the eligibility page displays in ProviderOne, the following "Medical Records" button appears



at the top left of the screen:

Close | Submit Another Inquiry | Medical Records | Exit

Selection Criteria Entered

Date of Request:	09/06/2022	ProviderOne Client ID:	999999998WA
Time in Request:	09:29:37 AM PDT	Client Date of Birth:	
Provider ID:		Client SSN:	
From Date of Service:	09/06/2022	Client Last Name:	
To Date of Service:	09/06/2022	Client First Name:	

Demographic and Response Information

Client Demographic Information:

ProviderOne Client ID:	
Client First,Middle,Last Name:	
CSO/HCS:	076-MEDICAL ELIG DET SVC
County Code:	018-Kitsap
CSOR:	018-BREMERTON CSO
Date of Birth:	01/01/2022
Gender:	Female
Language:	SPA-Spanish; Castilian
Placement:	F
ACES Client ID:	000000000
MBI:	

System Response Information:

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

Note: The placement code (indicated by the arrow in the image above) may allow an enhanced payment to providers for certain E&M codes. See the EPSDT provider guide for the placement code table, plus detailed information about how to bill for the enhancement.

Select **Medical Records** to open the next screen which contains claims information in three separate sections. These sections contain information about paid claims obtained from the ProviderOne claims history database. Two years of data will be returned by default, regardless of the eligibility search begin or end dates.

The three sections include:

- Pharmacy services claims
- Medical services claims (including dental)
- Hospital services claims

The overall screen looks like the example below. Providers may need to use the scroll bar on the right side of the page to see the bottom portion of the screen. This is a "Printer Friendly Version", so the content of this screen is printable by clicking on the blue "Printer Friendly Version" hyperlink at the top center of the screen.

Printer Friendly Version

Close

ProviderOne Client ID: 999999998WA
Name: Jane Doe
Date of Birth: 10/31/2003

Pharmacy

Filter By Period: All Go

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
11/19/2021	SERTRALINE HCL	50 MG	28	28	00		RITE AID PHARMACY 05254	
10/14/2021	SERTRALINE HCL	50 MG	28	28	00		RITE AID PHARMACY 05260	
09/19/2021	SERTRALINE HCL	50 MG	28	28	01		RITE AID PHARMACY 05260	
08/10/2021	SERTRALINE HCL	25 MG	14	14	00		RITE AID PHARMACY 05260	
08/10/2021	DIPHENHYDRAMINE HYDROCHLORIDE	25 MG	56	28	00		RITE AID PHARMACY 05260	

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

SaveToXLS

The first section contains the Pharmacy claim information:

Pharmacy

Filter By Period: All Go

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
11/19/2021	SERTRALINE HCL	50 MG	28	28	00		RITE AID PHARMACY 05254	
10/14/2021	SERTRALINE HCL	50 MG	28	28	00		RITE AID PHARMACY 05260	
09/19/2021	SERTRALINE HCL	50 MG	28	28	01		RITE AID PHARMACY 05260	
08/10/2021	SERTRALINE HCL	25 MG	14	14	00		RITE AID PHARMACY 05260	
08/10/2021	DIPHENHYDRAMINE HYDROCHLORIDE	25 MG	56	28	00		RITE AID PHARMACY 05260	

Some fields could be empty or contain "zero (0)" as a value for the different pharmacy claims if that information is not available for viewing.

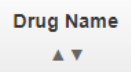
Providers have the option to search the pharmacy list for specific dates of service by using the "Filter By Period" option as seen in the segment below.

Filter By Period: All 1 2 3 Go 4

1. Pick the filter value name (all or a date range) using the drop-down option.
2. If using a date range, in the next box indicate the filter value "from" date of service.
3. Next in the date range, use the second filter box to enter the "to" date of service (all dates entered in ProviderOne must be formatted as mm/dd/ccyy).

4. Click the Go button.

ProviderOne will return the paid claim(s) found for those filter values based on the "from" date. Providers can sort the list of pharmacy claims using the up/down triangles located under each blue column heading.

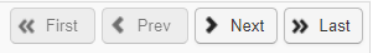


The system only sorts by one column heading at a time; however, it will sort the whole list based on the column heading chosen.

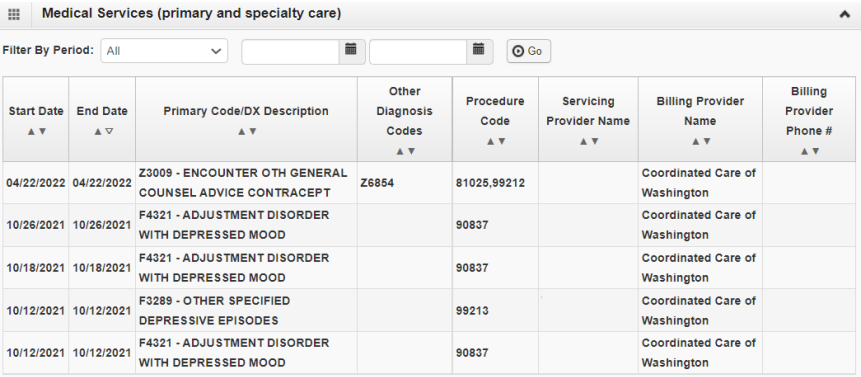
- Clicking on the triangle (caret) on the left causes ProviderOne to sort the list by the oldest, smallest, or in alphabetical order, according to the column specified.
- Clicking on the caret on the right causes ProviderOne to sort the list by the latest, largest, or in reverse alphabetical order, according to the column specified.

> **Note**: The search (Filter By) option and the column sort functions work the same for each specific claim section on this screen.

Providers should keep in mind that each claim history section may have multiple pages. The buttons at the bottom of the page provide the ability to move to the next page if they have black text. If there are no more pages to review, the Next button will be greyed out. In the following screen example, the Next button indicates that more than one page of claims is available to view.



The medical, including dental, services section look like the following segment:



Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #
04/22/2022	04/22/2022	Z3009 - ENCOUNTER OTH GENERAL COUNSEL ADVICE CONTRACEPT	Z6854	81025,99212		Coordinated Care of Washington	
10/26/2021	10/26/2021	F4321 - ADJUSTMENT DISORDER WITH DEPRESSED MOOD		90837		Coordinated Care of Washington	
10/18/2021	10/18/2021	F4321 - ADJUSTMENT DISORDER WITH DEPRESSED MOOD		90837		Coordinated Care of Washington	
10/12/2021	10/12/2021	F3289 - OTHER SPECIFIED DEPRESSIVE EPISODES		99213		Coordinated Care of Washington	
10/12/2021	10/12/2021	F4321 - ADJUSTMENT DISORDER WITH DEPRESSED MOOD		90837		Coordinated Care of Washington	

Some fields could be empty when viewing the different professional and dental services because the information did not apply to the service indicated, or the data may not be available. The "filter by" (search) and the column sort features described above work the same on this screen.
The hospital care screen looks like this and is the last section on the page:

Hospital Care

Filter By Period: All Go

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	ER/Outpatient/Inpatient	DRG Description	Attending Provider Name	Billing Provider Name	Billing Provider Phone #
10/28/2015	10/28/2015	Z6221 - CHILD IN WELFARE CUSTODY	F902,Z62812,F1210	Outpatient			Community Health Plan of Washington	
09/24/2014	09/24/2014	60820 - Torsion of testis NOS		Outpatient			Community Health Plan of Washington	
09/18/2014	09/18/2014	60820 - Torsion of testis NOS	6039,4564	Outpatient			Community Health Plan of Washington	
09/14/2014	09/14/2014	60820 - Torsion of testis NOS	60889,6039	ER			Community Health Plan of Washington	

When viewing the hospital claims in this section, some fields may be empty because the information does not apply, or the data is not available. The "filter by" (search feature) and the column sort features work the same as described in the previous section.

> **Note**: If any one of the screens return the message **No Records Found!** the client does not have any claims history for that section.

Covered services and prior authorization

Apple Health does not cover all medical services and some covered services require Prior Authorization (PA). The agency will not pay a claim if a provider fails to obtain a required prior authorization. For additional information on prior authorization, visit the Prior Authorization webpage.

This section describes how to identify a procedure code, how to use that procedure code to determine if Apple Health covers the service, and how to determine if PA is required (as identified in Apple Health's program specific provider guides).

PA indicates providers must obtain prior authorization before providing certain healthcare services, equipment, or supplies to clients. Before approval of a prior authorization request, the provider must prove the service is medically necessary.

For more information, see WAC 182-501-0165, Expedited Prior Authorization (EPA) WAC 182-531-0200, Exception to Rule (ETR) WAC 182-501-0160, and Limitation Extensions (LE) WAC 182-501-0169.

Identify the procedure code which best describes the service provided to the client. Use the following types of codes when billing in ProviderOne:

- American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes
- American Medical Association (AMA) Current Procedural Terminology (CPT) procedure codes (CPT® is a registered trademark of the American Medical Association)

- U.S. Department of Health & Human Services ICD-10 diagnosis codes
- Level II Healthcare Common Procedure Coding System (HCPCS) procedure codes
- National Drug Code (NDC)
- Revenue codes - the National Uniform Billing Committee (NUBC) assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

Procedures performed must match the descriptions and guidelines from the most current CPT, HCPCS, CDT, and ICD-10 manuals for all Apple Health covered services. HCA publishes only the short descriptions of procedure codes due to copyright restrictions. Consult the current manual for full descriptions.

Procedure codes and fee schedules

The fee schedules will provide information about the procedure code and payment rate. HCA updates fee schedules as updates to national codes occur and HCA is notified of the changes.

Code Status Indicat	Code	Modifier	Maximum Allowable NFS	Maximum Allowable FS	Global Days	Assist at Surgery	PA Required
	01991		3 Base	3 Base	XXX	9	
	01992		5 Base	5 Base	XXX	9	
R	01996		$21.94	$21.94	XXX	9	

Covered procedures

Procedure codes that are not listed in the fee schedule for a specific program are not a covered service under that program.

Also review the maximum allowable columns:

- If there is an NC noted, it is a non-covered service.
- If there is a DC noted, a different service code should be billed.
- Consult the legend for each fee schedule for specific detail.

Code Status Indicat	Code	Modifier	Maximum Allowable NFS	Maximum Allowable FS	Global Days	Assist at Surgery	PA Required
	01991		3 Base	3 Base	XXX	9	
	01992		5 Base	5 Base	XXX	9	
R	01996		$21.94	$21.94	XXX	9	
	01999		BR	BR	XXX	9	
	0263T		NC	NC	XXX	0	
	0264T		NC	NC	XXX	0	

Note: You can request an "Exception to Rule" (ETR) authorization for a non-covered service. For more information about ETR, see WAC 182-501-0160.

Prior authorization requirement

The fee schedule may indicate that PA is required.

Code Status Indicat	Code	Modifier	Maximum Allowable NFS	Maximum Allowable FS	Global Days	Assist at Surgery	PA Required	Comments
	00170		5 Base	5 Base	XXX	9		
	00172		6 Base	6 Base	XXX	9		
	00174		6 Base	6 Base	XXX	9		
	00176		7 Base	7 Base	XXX	9		
P	00190		5 Base	5 Base	XXX	9	PA*	*PA is required if related to a TransHealth procedure with an effective date of 1/1/2021

If this is the case, you have two options to submit your prior authorization request:

- Enter the prior authorization request through the direct data entry (DDE) feature in the ProviderOne portal.
  - For complete self-service training materials, click one of the following links depending on your provider type:
    - Medical providers
    - DME providers
    - Dental providers
- Complete the General Information for Authorization form, HCA 13-835. To ensure that the form will be scanned correctly, see the instructions about completing this form in Appendix F and the back of the form.
  - If a provider is faxing supporting documentation without the original authorization request form, print the required cover sheet to ensure association with the correct authorization. For more information see the document submission cover sheets webpage and Appendix H.
- Once a provider has submitted the PA request, check the status using ProviderOne or the IVR. For more information, see Appendix G.

When Medicare is the primary payer and denies a service that is covered by the agency with a prior authorization requirement, the agency waives the "prior" requirement in this circumstance. Submit a request for authorization. Attach the Explanation of Benefits (EOB) to the request for services denied by Medicare.

> **Note**: If the client has TPL, also known as commercial or private insurance, and the service you are billing for requires prior authorization (PA) from the agency, the agency waives the "prior" requirement in this instance. If the commercial insurance denies payment for the service that required the authorization, you must then request authorization and include a copy of the insurance denial EOB with the request. See the Requesting prior authorization section for more information on submitting an authorization request.

For some programs PA is required before providing services regardless of which payer is considered primary. Examples of this are DME supplies, dental/orthodontia, and inpatient hospital stays that require authorization.

If the primary pays the service, then authorization is not required for the secondary claim. Refer to the program specific provider guide applicable to the service provided.

> **Note**: When billing HCA using a "By-Report" (BR) CPT or HCPCS code that requires authorization and the authorization has been approved, a provider must:
>
> - Bill HCA with the amount requested on the authorization form.
> - Do not bill HCA the allowed amount for the (BR) CPT or HCPCS code.
> - Do not include sales tax in the billed amount for the (BR) CPT or HCPCS code.

The fee schedule may indicate "EPA" for expedited prior authorization. The EPA process eliminates the need for prior authorization for selected procedures. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an EPA number when appropriate. Refer to the program specific provider guide for the EPA criteria for specific supplies or services.

EPA guidelines

- Medical justification (criteria) - all medical justification must come from the client's prescribing physician or physical/occupational/speech therapist. HCA does not accept information obtained from the client or from someone on behalf of the client (e.g., family).
- Documentation - the billing provider must keep documentation of the criteria in the client's file. Upon request, a provider must provide documentation to HCA showing how the client's condition met the criteria for EPA. Keep documentation on file for six (6) years.
- Providers must follow EPA criteria exactly. If the exact EPA criteria outlined in the provider guide is not met, the formal PA process must be followed.

> **Note**: HCA may recoup any payment made to a provider if the criteria do not meet the requirements or the wrong code was used on the claim.

For more information on prior authorization and expedited prior authorization, visit the Prior authorization webpage.

Claim payments – professional services

Apple Health publishes fee schedules to communicate to providers the maximum allowed amount for a health care service.

- Use the fee schedule to determine the payment rate for the procedure.
  - Facility setting maximum allowable fee (FS fee) is paid when the provider performs the services in a facility setting (e.g., a hospital or ambulatory

surgery center) and the cost of the resources are the responsibility of the facility.

  - Non-facility setting maximum allowable fee (NFS fee) is paid when the provider performs the service in a non-facility setting (e.g., office or clinic) and typically bears the cost of facility space and resources, such as labor, medical supplies, and medical equipment associated with the service performed.

- Use the fee schedule that covers the date of service on the claim.

> **Note**: HCA does not pay more than the billed amount on a claim regardless of the allowed fee listed in any of the fee schedules. HCA recommends that providers bill their usual and customary charges on their claims. Claims that are underpaid will have to be adjusted by the provider to capture the under billed but allowed amount. (Exceptions are for trauma claims and services that pay a sales tax.)

Claim payments – institutional services

Providers billing on an institutional claim have various payment methods that are much too detailed to cover in this publication. Please see the appropriate fee schedule or provider guide for detailed information about payments.

Claim payments – inpatient hospital services

For payment information on inpatient hospital services, please see the Inpatient hospital services billing guide.

Provider preventable conditions (PPCs)

The agency has established a policy for services provided to Medicaid clients, both FFS and for those enrolled in one of HCA's MCO plans that result in provider preventable conditions. The rule applies to all health care professionals and inpatient hospitals.

Provider preventable conditions is a term used for hospital and non-hospital acquired conditions that are included in two distinct categories:

- Health care-acquired condition (HCAC) is a condition occurring in any inpatient hospital setting (identified as a hospital acquired condition by Medicare). Examples include a foreign object retained after surgery to certain surgical site infections, etc. See the Medicare Hospital-Acquired Conditions HAC list and WAC 182-502-0022.
- Other provider preventable conditions (OPPCs) are an adverse health event that could have been prevented through the application of nationally recognized evidence-based guidelines. Examples of PPCs include surgery on the wrong patient, or medication errors, etc. Also see adverse health events identified by the Department of Health in WAC 246-302-030.

Under the policy, HCA will deny or recoup payments to health care professionals and inpatient hospitals for care related only to the treatment of consequences for HCAC and OPPC conditions.

All hospitals are required to include the present on admission (POA) indicator when submitting inpatient claims for payment. The POA indicator may prompt a claim review when billed with an HCAC diagnosis code according to CMS guidelines. Professional claims will be identified using this claim information.

For professional services performed during an inpatient hospital stay, insert one of the following modifiers to all lines related to the surgical error:

- MX – wrong surgery on patient
- MY – surgery on wrong body part
- MZ – surgery on wrong patient

CMS has created three new HCPCS Level II modifiers for practitioners, ambulatory surgical centers (ASCs), and hospital outpatient facilities to use to report erroneous surgeries. Add one of the following HCPCS Level II modifiers to all lines related to the surgical error:

- PA – surgery wrong body part
- PB – surgery wrong patient
- PC – wrong surgery on patient

Providers must report confirmed PPCs to HCA within 45 calendar days of the incident. Notification must be in writing, addressed to HCA's Chief Medical Officer (CMO) and include the PPC, date of service, client identifier, and the claim number (TCN) for claims submitted in ProviderOne. Hospitals and health care professionals must complete their portion of the "Other provider preventable conditions (OPPC) notification form" 12-200 and send with the notification.

The complete text and details covering a PPC, ProviderOne payment, reporting a PPC, and a provider dispute process can be located in WAC 182-502-0022.

Pitfalls

- Using outdated coding books. This can result in a claim denial.
- Using a procedure code and diagnosis code that do not correspond with each other. This can result in a claim denial.
- Not confirming eligibility on the day of service. PA does not override eligibility.
- Failing to obtain authorization when required will result in a claim denial.
- Handwriting the PA request form. If the PA request is not typed, it will be returned to the provider because it cannot be scanned using "optical character recognition."
- Trying to request authorization without the client ID. If the client ID is unknown, providers can do a client search in ProviderOne.
- Billing claims without the proper PPC modifier or POA indicator could result in a claim review and possible recoupment of the payment.

Client service limits

Apple Health limits certain covered services with respect to quantity, frequency, or duration. For example, HCA covers a routine eye exam for an adult client every two years, or some DME supplies, and dental services may have quantity and frequency limits.

Determine the service needed. Then look in the program specific provider guides to find the quantity, frequency, or duration service limitations. Providers can check client service limits by:

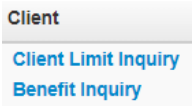
- Using the Client Limit Inquiry feature of ProviderOne, or
- Use the secure contact us form, or
- If the date of service is within 48 hours, call the Customer Service line at 1-800-562-3022 and follow the prompts for provider services. All other requests must utilize the contact us web form.

ProviderOne allows providers to check service limits using claim data stored in ProviderOne. This system functionality is limited to claims previously paid by ProviderOne and does not account for claims received in the system but are still in process or have denied. There is also the possibility that billing has not occurred for provided services.

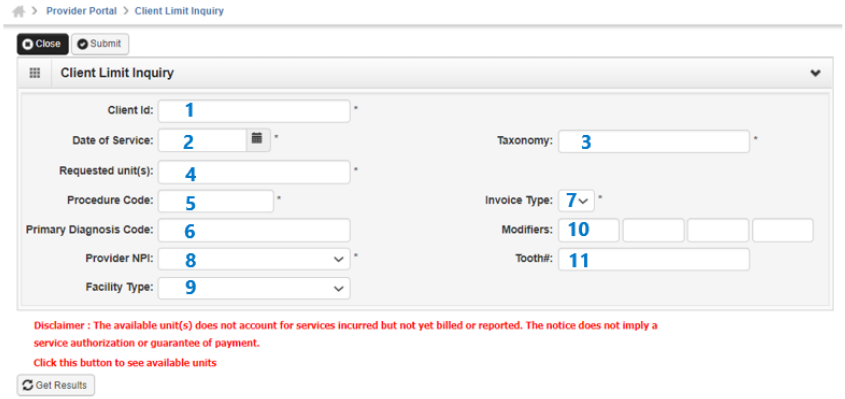
Check for service limits by logging into ProviderOne and selecting one of the following profiles:

- EXT Provider Super User
- EXT Provider Claims Submitter
- EXT Provider Eligibility Checker
- EXT Provider Eligibility Checker-Claims Submitter

Select the **Client Limit Inquiry** hyperlink on the provider portal:

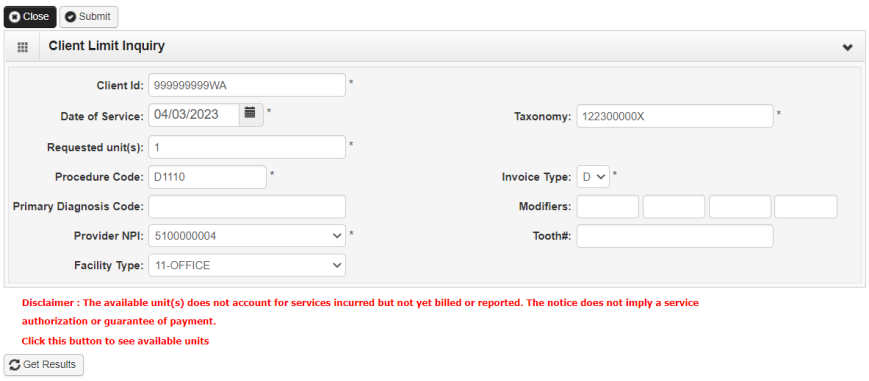


At the Client Limit Inquiry screen fill in the required fields numbered below:

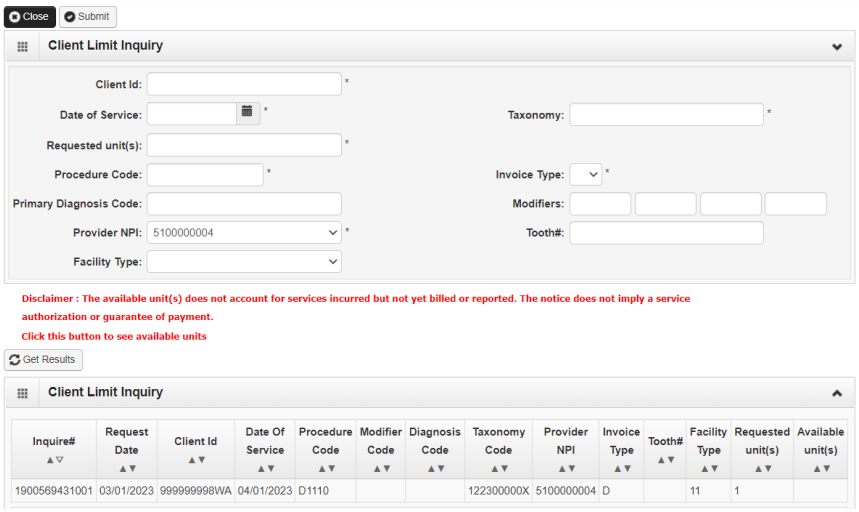


1. Client ID number
2. Date of service (when you are planning a visit/service; future dates accepted)
3. Taxonomy code of the billing provider
4. Requested unit(s) - requires at least one or enter the amount to be supplied.
5. Procedure code
6. Primary diagnosis code (if required) - no decimal point should be used here.
7. Invoice type (claim type)
   - D = dental
   - P = professional
   - I = institutional
8. Provider NPI (pre-populated)
9. Facility type (place of service if procedure code requires)
10. Modifiers (if the service has a specific modifier)
11. Tooth number (if dental service requires a tooth)

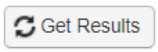
Example request with completed form:



Click the **Submit** button after completing all the required fields. The system clears the data boxes and displays the information entered in the form at the bottom of the client limit inquiry screen.

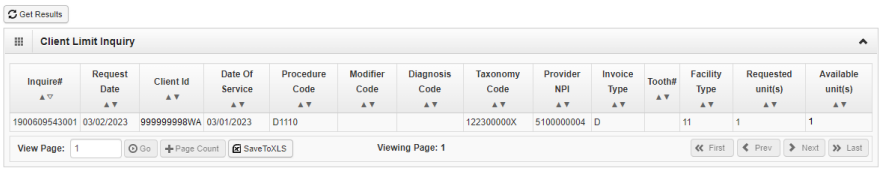


The limit inquiry is processing in the background, so the Available unit(s) box is still empty. Wait a short time then click the **Get Results** button to see the response to the limit inquiry.



> **Note**: If the Available unit(s) box remains empty click on the **Get Results** button again as it may take ProviderOne a few seconds to complete the database inquiry.

Once the inquiry is complete, ProviderOne will display this screen with a value populated in the Available unit (s) field:



If there are available units, the system will display the number of units available.

> **Note**: The available unit(s) does not account for services incurred but not yet billed or reported. The information returned does not imply a service authorization or guarantee of payment.

Both ProviderOne and the HCA toll free phone line rely on the submission of claims for services paid in ProviderOne. If the system finds claims for the service performed within the timeframe of the service limit, it will return a zero value for the Available unit(s) field.

Get Results

Client Limit Inquiry

Inquire#	Request Date	Client Id	Date Of Service	Procedure Code	Modifier Code	Diagnosis Code	Taxonomy Code	Provider NPI	Invoice Type	Tooth#	Facility Type	Requested unit(s)	Available unit(s)
1900569431001	03/01/2023	999999998WA	04/01/2023	D1110			122300000X	5100000004	D		11	1	0

In these cases, the billing provider should review the program specific provider guide to see how to proceed with treatment and check for any PA requirements.

> **Note for vision providers**: Use one of the exam codes or fitting fee codes as the search criteria rather than one of the hardware codes. ProviderOne will not have a record of the history of these codes since hardware is not billed directly to HCA. For questions about hardware benefits, contact Airway Optical at 888-606-7788.

Other reasons ProviderOne may return a zero

- The client is enrolled in a managed care plan, is QMB-Only or covered by Medicare, etc. which may mean that no units are available through Medicaid fee for service.
- The client is currently ineligible.
- The billing provider taxonomy is incorrect for the procedure code and/or the taxonomy used is not listed on the provider's file in ProviderOne.
- The diagnosis code used is incorrect for the procedure (if applicable).
- The modifier used is incorrect for the procedure (if applicable).

ProviderOne will retain the Client Limit Inquiry data line you entered if completing additional limit checks for other codes during the same session.

Pitfalls

- Not checking for service limits. By not checking client eligibility for services that have quantity, frequency, or duration limits of the services, providers risk denial of a claim.
- The results of the search are separate from checking a client's eligibility for any service. It is the responsibility of the provider to verify eligibility for the estimated date of service, in addition to checking service limits.
- Not checking eligibility to verify enrollment of the client in a managed care plan that pays for services outside ProviderOne.

Submitting fee for service claims

Timely and accurate payments

This section shows how to submit claims using the following methods:

- Direct data entry into ProviderOne
- Process online batch submissions (837)

And to perform the following:

- Submit electronic and paper backup documentation on individual claims
- Resolve errors during a claim submission
- Submit commercial insurance secondary claims
- Save claims
- Submit Medicare crossover claims
- Check claim status
- Submit claim adjustments
- Resubmit denied claims
- Void paid claims
- Create template claims
- Submit a template claim or a batch of template claims

When you determine that the client is eligible for Apple Health, the service is covered, Apple Health is the primary payer, and any authorization requirements have been fulfilled (if required), you may bill ProviderOne after rendering the service.

Disclaimer

A contract, known as the Core Provider Agreement (CPA), governs the relationship between HCA and Apple Health providers. The CPA's terms and conditions incorporate federal laws, rules and regulations, state law, HCA rules and regulations, and HCA program policies, numbered memoranda, and provider guides, including this guide. Providers must submit a claim in accordance with HCA rules, policies, provider notices, and provider guides in effect at the time they provided the service.

HCA does not assume responsibility for informing you of national coding rules. ProviderOne denies claims billed in conflict with national coding rules. To correct such errors, consult your coding resources.

Claim submission method

HCA wants you to receive timely payments. Providers usually base their claim submission method decision in part on the volume of claims billed and the level of technology they have available.

Select one of the methods below:

- Direct data entry of individual claims using the ProviderOne portal - ProviderOne enables you to submit new claims, check claim status, submit adjustment claims, correct, and resubmit denied claims, and attach electronic backup documentation to claims. Updates to ProviderOne claim options enable you to create and save template claims, create a claim from the template, and create batches of claims using saved templates.
- Electronic batch claim self-submission - electronic claims you submit directly in ProviderOne using a companion guide to keep your software up to date [electronic batch submitters are required to pass testing with ProviderOne and have a Trading Partner Agreement (TPA)].
- Electronic batch claim submission using a billing agent or clearinghouse - electronically submitted claims to ProviderOne through a billing agent or clearinghouse, who use a companion guide to keep their software up to date [electronic batch submitters are required to pass testing with ProviderOne and have a Trading Partner Agreement (TPA)].

For more information on trading partner agreements, see the HIPAA Electronic Data Interchange (EDI) webpage.

Claim backup

Claims billed in ProviderOne may need backup documents if the client has:

- Commercial private insurance
- Medicare
- A Medicare Advantage plan

You must attach backup documentation to DDE or electronic claims when a specific type of service requires additional information. Examples of these backup documents include:

- Invoices for Acquisition Costs (AC)
- By Report (BR) services
- Operative reports or other documents, if required or requested by HCA

An Explanation of Benefits (EOB) may be needed if there is a primary payer.

- If you are submitting an EOB with a claim, the information on the claim must match the line information billed to the primary payer as reflected on the EOB.

Documentation is needed for some services such as the following:

- Acquisition Cost (AC) and By Report (BR) services are listed in the fee schedules. Review the fee schedules on the fee schedule webpage.

See below for an example from the professionally administered drugs fee schedule, J7699, which has the AC (acquisition cost) indicator in the allowable fee field. Refer to the provider guides to verify if an invoice will be required as backup.

Code Status Indicat	Code	Maximum Allowable Fee	PA Requirec
	J7686	DP	
	J7699	A.C.	
	J7799	A.C.	

Acquisition Cost (AC) indicators

Claims for drugs with an AC indicator in the fee schedule with billed charges of $1,100.00 or greater or claims for supplies with billed charges of $50.00 or greater, require a manufacturer's invoice to be paid. Submit a copy of the invoice by attaching it to the claim and note the quantity given to the client in the comments or billing note section of the claim.

It is not necessary to attach an invoice with claims when procedure codes have an AC indicator in the fee schedule for drugs with billed charges less than $1,100.00, or supplies with billed charges less than $50.00, unless requested by HCA. For claims of this type, bill only one unit of service. See acquisition cost (AC) on the introduction page of the Physician-Related Services/HealthCare Professional Services provider guide for additional information.

By Report (BR) indicators

Services with a BR indicator in the fee schedule with billed charges of $1,100.00 or greater require a detailed report to be paid. Attach the required report describing the nature, extent, time, effort, and/or equipment necessary to deliver the service to the claim.

When the fee schedule contains a BR indicator it is not necessary to attach a report to the claim for services when charges are less than $1,100.00 unless requested by HCA. See the Physician-Related Services/HealthCare Professional Services provider guide for additional information.

ProviderOne may deny a claim and request an operative report to justify medical necessity for services.

Pitfalls

- Failing to include required backup information with the claim. This will result in claim denial.
- Billing services not billed to the primary payer. This will cause the claim to be denied.
- Failing to check eligibility to determine if another payer exists.

Submitting new claims and backup

ProviderOne accepts the following methods for you to submit claims and backup documents:

- Direct data entry into ProviderOne
- Direct data entry commercial insurance secondary professional claim
- Saving a direct data entry claim
- Online batch claims submission

ProviderOne offers several free methods to submit claims to pay for services provided to our clients. HCA encourages billing using electronic methods provided in ProviderOne to optimize payment receipts and to improve resubmission turnaround time in case a claim is denied for a billing error.

This section covers in detail the billing methods available.

Initial claims

Submit claims in the ProviderOne system for assignment of a transaction control number (TCN) within 365 days from any of the following:

- The date the service was furnished to the eligible client.
- The date a final fair hearing decision is entered that impacts a particular claim.
- The date a court orders HCA to cover the service.
- The date HCA certifies a client eligible under delayed certification criteria.

For more information, see WAC 182-502-0150 (3) (4).

HCA may grant exceptions to the timely filing limit when either of the following cause billing delays:

- The client receives retroactive Apple Health coverage, which displays in the eligibility results. The agency allows one year from the date of retroactive eligibility award.
- For various reasons, ProviderOne may recoup premiums to a client's managed care plan, causing the plan to recover payments. Those bills would then need to be submitted fee for service. ProviderOne will allow one year from the date the plan recouped the payment for a given claim if you enter "Managed care recoupment [date]" in the remarks or comments field.
    - Follow the same steps to submit the claim to ProviderOne if a managed care plan paid in error when the service should have been billed fee for service originally.
- The commercial payer recouped their payment as primary. You have one year from the date of the takeback to submit the claim to ProviderOne. Enter the "primary payer" and "recoupment [date]" in the remarks or comments field.
- Providers can prove to the agency that there are extenuating circumstances. To appeal a timely claim denial made by HCA, contact the customer service center by phone.

ProviderOne follows National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote

national correct coding methods. NCCI assists the HCA in controlling improper coding that may lead to inappropriate payment.

HCA coding policies are based on:

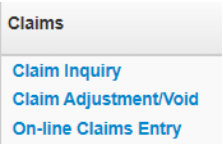
- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

Direct Data Entry (DDE)

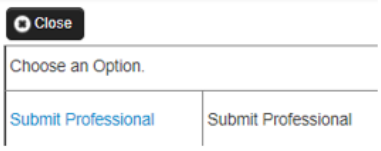
It is extremely important before claims submission to disable any popup blockers on your web browser. The ProviderOne system uses popup windows during the claims process.

Log into ProviderOne and choose the EXT Provider Claims Submitter or EXT Provider Super User profile.

From the Provider Portal, select **On-line Claims Entry**:



To create a new claim, select the appropriate claim type hyperlink in blue. The below information is based on choosing the **Submit Professional**.



> **Note**: For more assistance with DDE for all claim types, visit the ProviderOne resources webinars webpage.

Complete the required data fields marked with a red asterisk and add any optional information needed for ProviderOne to process the claim. If you have questions regarding billing policies, please refer to the appropriate provider specific provider guide for the claim type.

Enter the billing **Provider NPI** number and **Taxonomy Code**. For more information on taxonomy codes, please see Appendix I for more information.

PROVIDER INFORMATION

Go to Other Claim Info to enter information for Referring, Purchasing, Supervising and other providers.

BILLING PROVIDER

* Provider NPI: * Taxonomy Code:

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

* Is this service the result of a referral? Yes No

Answering the "yes/no" questions

There are several routine yes/no questions you need to answer on any DDE claim:

- For a solo practice office, the billing provider is also the rendering provider.
- For a clinic or group practice, the billing provider would not be the rendering provider. Check **No** to this question and fill in the NPI and taxonomy for the provider who rendered the service.
- If the service provided is the result of a referral from another provider, check **Yes** and enter the referring provider's NPI (taxonomy codes are not required for referring providers).

Client information

Enter the ProviderOne **Client ID** and expand the box by selecting the red plus sign to enter the client's name, birthdate, and gender. The client's last name, birth date, and gender are required on all claims. While the first name is optional, if entered the first name also appears on the RA. When billing for a newborn claim using the birthing parent's id, enter the baby's name, baby's birthdate, and the baby's gender in the boxes instead of the birthing parent's information.

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

Additional Subscriber/Client Information

* Org/Last Name: First Name:

mm dd ccyy

* Date of Birth: * Gender:

mm dd ccyy

Date of Death: Patient Weight: lbs

Patient is pregnant: Yes No

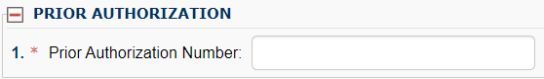
Check **Yes** if indicating the claim is for a baby using the birthing parent's ID:

Is this claim for a Baby on a Birthing Parent's Client ID? Yes No

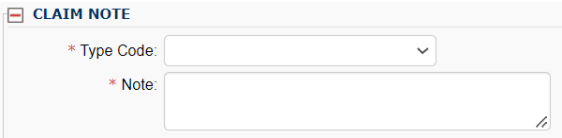
The next data element is a question about Medicare; check **Yes** if indicating this is a Medicare crossover:

* Is this a Medicare Crossover Claim? Yes No

If the claim requires authorization, select the red plus sign to expand the prior authorization number area, and enter the authorization number:



Sometimes a claim needs a claim note added to the claim so that it processes correctly. To add a note, click the red plus sign to expand the note option, and then type in the note information keeping it short.



Some of the reasons to add a note or claim indicator are:

- SCI=B for baby on birthing parent's ID (can only be used the first **60 days of baby's life**)
  - For multiple births use the following:
    - SCI=BA for twin/triplet A
    - SCI=BB for twin/triplet B
    - SCI=BC for triplet C
- SCI=F for enteral nutrition – client not eligible for WIC
- SCI=I for Involuntary Treatment Act (ITA)
- SCI=V for voluntary (psych) treatment

Other examples of claim notes needed to enter on a claim can be found in the agency's program related billing guides.

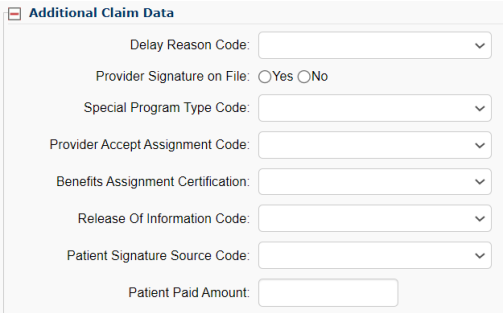
> **Note**: When using Special Claims Indicator (SCI) entries, everything following the "=" symbol will be read as part of your indicator, so do not enter spaces before or after the =.

Always check **No** for the next question, claim adjudication does not use this information:

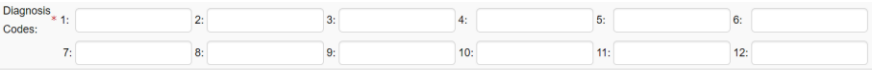
Use the **Patient Account No** field to enter any internal patient account numbers used. This information appears on the remittance advice for your convenience.

Enter the **Place of Service** code number using the drop-down option.

If the client has a spenddown amount, report this on the claim by selecting the red plus sign to expand the **Additional Claim Data** field and enter the spenddown amount into **Patient Paid Amount**.

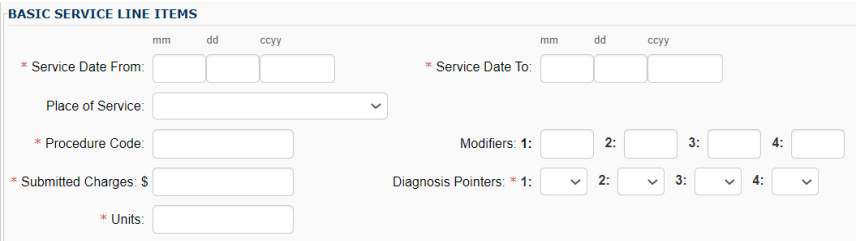


Now enter the **Diagnosis Codes** without the decimal point. ProviderOne adds the decimal point where needed once the claim is submitted. HIPAA allows up to 12 fields for diagnosis codes. Later ProviderOne uses a pointer to indicate which diagnosis code applies to the service line.



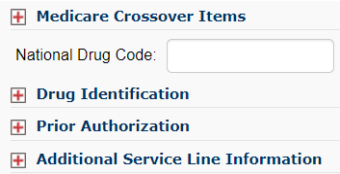
> **Note**: When entering diagnosis codes, do not enter the decimal point. ProviderOne will add the decimal automatically when the claim is submitted.

Next enter the basic line item information for the first service line of the claim:



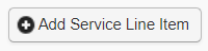
- Enter the **Service Date From** and **To** date(s) of service using date spans for equipment rental, etc.
- Use the dropdown menu to indicate the Place of Service (optional as the place of service has already been entered at the claim level).
- Enter the **Procedure Code** being billed on this service line.
- Enter the **Modifier(s)** if appropriate, then tab through the other boxes.

- Enter the **Submitted Charges** (whole dollar amounts do not need a decimal point).
- Use the **Diagnosis Pointers** dropdown to indicate which diagnosis code(s) from the previous section above will apply to this line.
- Enter the number of **Units** used - at least one unit must be indicated.



- Enter a **National Drug Code** (NDC) only if you are billing a code that requires the NDC in the NDC field. Do not enter the NDC in the Drug Identification section. Skip that area.
- If you have more than one authorization number, expand the Prior Authorization section, and enter the **PA number** for that service line.
- Skip the additional service line Information section.

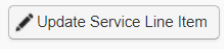
Next, click the **Add Service Line Item** button:



The entered line information will appear under the Previously Entered Line Item Information section. Make sure every line has the correct information and appears under this section before submitting the claim.

Editing lines due to keying errors or coding mistakes

Select the line number of the line to correct and the system will repopulate the service line item boxes. Make the changes as necessary and select the **Update Service Line Item** button:



The system will change the original information to the corrected information.

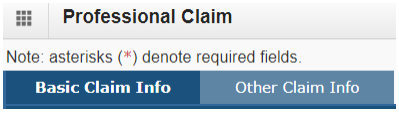
You can use a shortcut when adding more lines to the claim. Use the edit feature of the system to quickly add more lines. Select the line number to repopulate the service line item boxes. Now add the information for the next line by overwriting what is there, only changing what is different. Usually only the procedure code and the billed amount would change, or in some cases the codes are the same, but the date of service has changed. After adding the updated information, select the **Add Service Line Item** button to add the new line. Repeat this process to add line 3 and 4, etc.

Continuous hospital stay information (only if applies)

Clients that are fee for service (FFS) when admitted to a hospital and then later enrolled in a managed care plan during the hospital stay, the entire stay for

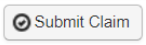
physician services is paid FFS until the client is discharged. Fill out the claim as normal and before submitting a claim for a continuous hospital stay enter the initial hospital admit date and discharge date following the instructions below.

Select **Other Claim Info** at the top of the page:

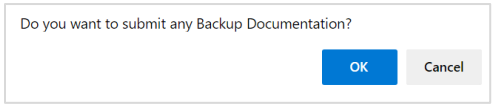


Then select the **Relevant Dates** expander:

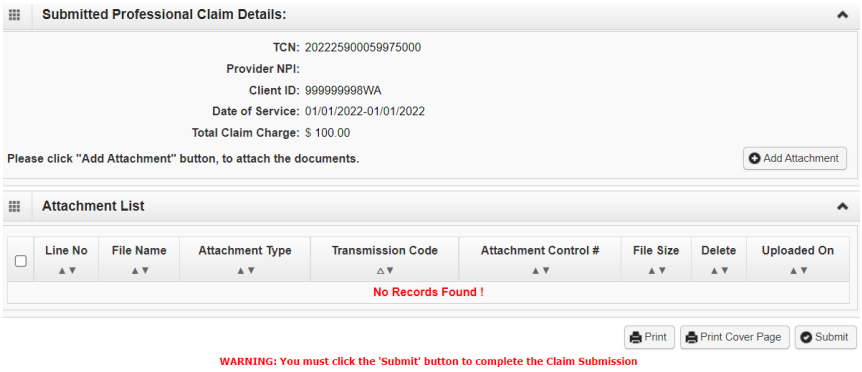
Enter the Admission Date and Discharge Date for the hospital stay. Select **Basic Claim Info** at the top of the page to get back to the first page of the claim screen, and after entering all the claim information, select **Submit Claim** at the top of the screen.



The following popup window message will appear:



If no backup is being submitted, select **Cancel** and the following window appears:



Select **Submit** to send the claim to ProviderOne for processing. The system will return you to a blank claim form ready for your next claim submission.

Submitting backup for a DDE claim

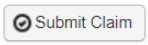
ProviderOne allows the biller to submit backup two ways to a DDE claim:

- Browse files on your computer to attach an electronic file
- Submit paper backup with a cover sheet (by fax or mail)

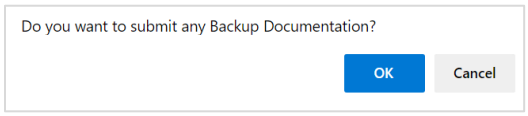
HCA policy specifies how long to hold a claim waiting for backup documentation as follows:

- DDE – held for 3 days
- HIPAA/EDI – held for 21 days

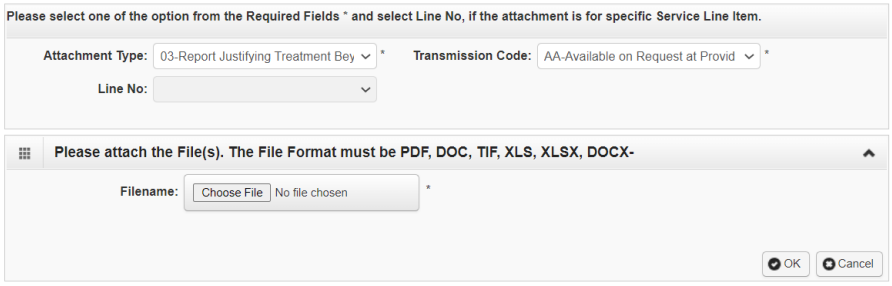
After selecting Submit Claim, a popup will appear asking if you want to submit backup documentation:



Select **OK** to proceed with attaching backup, if/when necessary.



The backup documentation screen tells us about the backup:



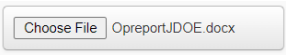
Fill in the following fields:

A. Pick the **Attachment Type** from the drop-down list.

B. The **Transmission Code** is **By Mail** (BM), **Fax** (FX), or **Electronic** (EL).

C. The Line No field is not required.

D. Add an electronic attachment using the **Filename field**. Use the **choose file** button to find the file on your computer to attach to your claim.

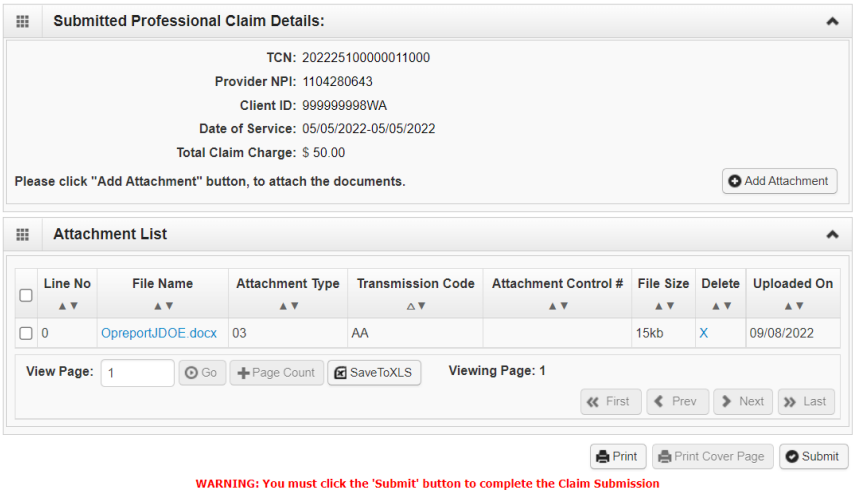


If you receive an error when attaching a file, try changing the name of the document. Do not use special characters or start file names with a number.

Select **OK** when completed.

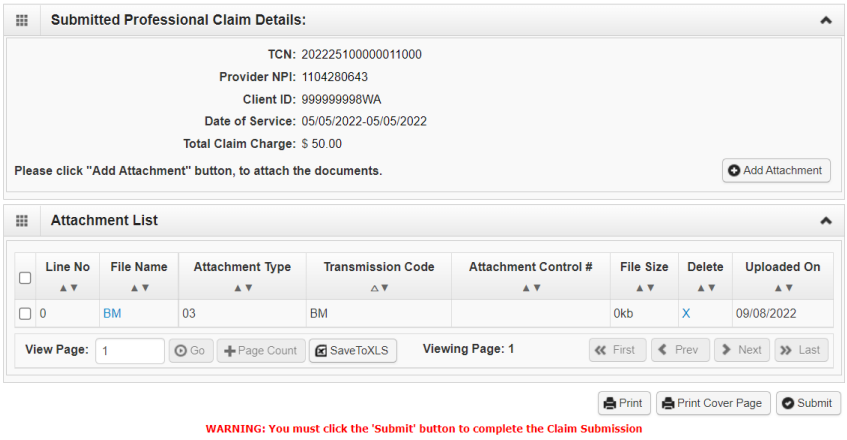
Attaching electronic backup

Electronic backup image files are limited to 2 megabytes in size. The below screenshot shows a sample of an electronic file attached to a claim. Select **Submit** to send your claim to ProviderOne for processing.



Attaching paper backup using mail or fax

Attach paper backup to a DDE claim in two different ways, by mail (BM) or by fax (FX). Write down the TCN number and select **Print Cover Page**:



Below is an example of the cover sheet. Enter in the TCN number captured on the confirmation screen when you submitted the claim. The barcode expands to reflect the data entered once the data field is completed by clicking the enter key or clicking outside the TCN box.

ProviderOne

Claim Attachment Submission Cover Sheet

TCN

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

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet

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

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

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

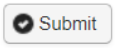
FAX to : 1-866-668-1214.

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

All supporting documentation requires a ProviderOne cover sheet. For more information on cover sheets, see Appendix H. There is one cover sheet for use with claims submitted through ProviderOne regardless of claim type. This cover sheet can be accessed on the document submission cover sheets webpage under claim attachment.

When filling out the cover sheet, only add in the numeric TCN. Do not add a zero, an extra space, or any other characters. Do not save the cover sheet for reuse, as the cover sheet is specific to the claim TCN only. Do not use any software other than Adobe for opening and generating the cover sheet. The barcode used to link documents will not work properly using other software.

When finished attaching backup, select **Submit** to send your claim to ProviderOne for processing.



To send your paper backup for claims entered by DDE, attach a ProviderOne cover sheet to the backup documents and either fax to 1-866-668-1214 or mail using the following address:

Heath Care Authority
RE: Cover sheets and backup documentation
PO Box 45535
Olympia, WA 98504-5535

HCA accepts large amounts of backup by mail only. Mail to the above address and be sure to use a cover sheet for each claim.

Submitting backup through a clearinghouse

You can also easily submit your claims through your clearinghouse, then fax in your backup documents.

Follow these steps:

- Prepare the claim as normal and submit the claim to the clearinghouse. (Reminder: the HIPAA file transaction must include the "Claim Supplemental Information" to notify ProviderOne that backup is being sent. If you have questions on how to include this detail, please discuss with your software vendor or clearinghouse, or have them contact HCA HIPAA staff at HIPAA-help@hca.wa.gov.)
- Wait 48-72 hours to allow the claim to process in ProviderOne and for ProviderOne to assign a TCN number to the claim.

There are two options to get the TCN number for the claim(s):

- Log into the provider portal and select Claim Inquiry, then enter the client ID and the date of service. The system will return all the TCNs that meet the search criteria. Find the newest TCN for your claim (the larger the TCN number the newer the claim).
- Submit a 276 HIPAA transaction and the system will return a 277 transaction with the TCNs for the claims needed. Work with your technical staff for completions of these transactions.

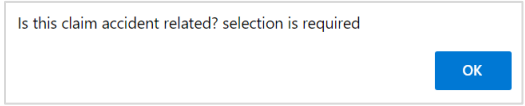
After receiving the TCN number for the claim, go to the document submission cover sheets webpage and select the claim attachment cover sheet. Complete the cover sheet (as first page) by entering the TCN and fax it to the number on the cover sheet. An EDI claim will be held for 21 days waiting for any backup submitted.

Resolving DDE claim errors

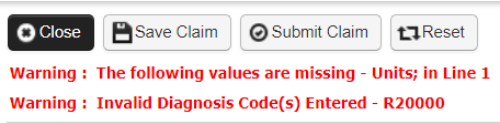
During the process of submitting a DDE claim, ProviderOne does a data check prior to submission to verify the following required entries:

- Fields contain valid entries.
- Fields are completed.
- Questions are answered.

Errors can come in two formats. A popup window:



Or a red text message at the top of the claim screen:



To correct such errors, review the red warnings and review the data previously keyed in for corrections.

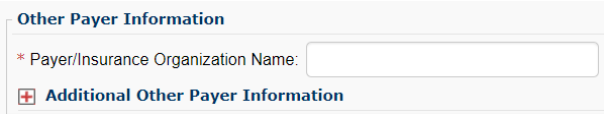
Entering commercial insurance information

Expand the **Other Insurance Information** section using the red plus sign. Then expand the **Other Payer Insurance Information** section for the first insurance.

ProviderOne allows you to enter information for more than one insurance company – note the **1** before **Other Payer Insurance Information** which indicates the first commercial carrier data entered.

Do not enter Medicare or Managed Medicare (Medicare Part C) information here. HCA does not consider them commercial insurance.

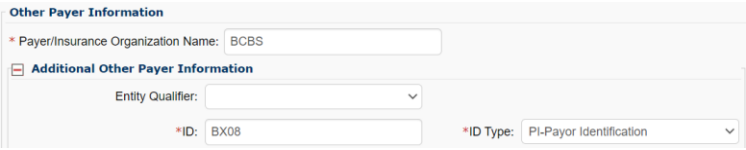
When the Other Insurance Information screen opens, skip directly to **the Other Payer Information** section, and enter the name of the insurance company.



Then select the red plus expander to open the **Additional Other Payer Information** section.

Enter the following:

- Enter the **ID** number as the Carrier Code
- Payer ID Type from the ID Type dropdown (always choose PI-Payor Identification)



Finding the commercial insurance carrier code

ProviderOne requires use of the insurance carrier code found on the client's eligibility file under the Coordination of Benefits section. The carrier code in the example below is BX08.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	BCBS ANTHEM OF OH	BX08	JOHN DOE	000000000			03/01/2014	12/31/2999

Then scroll down to **COB Monetary Amounts** field and enter the amount paid by the insurance:

COB Monetary Amounts

COB Payer Paid Amount: 50

Additional COB Information

> **Note**: If you are attaching the EOB to your claim or mailing or faxing in the backup using the following methods, stop here.

Avoid sending in the insurance EOB with your claim

Expand the Claim Level Adjustments section:

COB Monetary Amounts

COB Payer Paid Amount: 50

Additional COB Information

CLAIM LEVEL ADJUSTMENTS

1	* Group Code:	PR-Patient Responsibility	* Reason Code:	96	* Amount: 50
2	Group Code:		Reason Code:		Amount:
3	Group Code:		Reason Code:		Amount:
4	Group Code:		Reason Code:		Amount:
5	Group Code:		Reason Code:		Amount:

Enter the HIPAA adjustment reason code information from the insurance EOB:

- **Group Code** (choose from the options)
- **Claim Adjustment Reason Code** (CARC - only the HIPAA reason code number is required)
- **Amount** (enter a zero if billing services denied by the insurance company)

Finish filling in the rest of the claim data and submit the claim as outlined above.

You can use this process to submit services denied or paid by the primary insurance company. ProviderOne can process the claims with these data elements:

- The name and carrier code of the insurance company.

- The amount paid by the insurance company (enter zero if no payment).
- The HIPAA adjustment reason codes for non-payment or denials.

The agency is requesting that providers submit both paid and denied lines on the same claim, which can result in more efficient processing. Line level entries of TPL payments and adjustment reason codes can be billed for more accurate payment of commercial insurance claims via DDE. The agency will provide a resource for line level billing through direct data entry if provider's request assistance. For assistance with line level HIPAA/EDI billing for third party claims, please see the Reporting Medicare/Managed Medicare and commercial payer data on an 837 transaction fact sheet.

FQHC's, RHC's, and tribal billers should submit TPL amounts at header only to correctly receive encounter payments.

For more information on billing Medicaid secondary to a commercial insurance, see the "Billing with commercial insurance or Medicare as primary" section on the fact sheets webpage.

Third-Party Liability (TPL) and Prior Authorization

If the client has TPL, also known as commercial insurance or private insurance, and the service you are billing for requires prior authorization (PA) from the agency, the agency waives the "prior" requirement in this instance. However, if the commercial insurance denies payment for the service that required the authorization, you must then request authorization and include a copy of the insurance denial EOB with the request. See Completing the authorization intake process for submitting a request.

For some programs PA is required prior to providing services regardless of the primary payer. Examples of this could be DME supplies, dental/orthodontia, and inpatient hospital stays. Review the specific provider guide for more details. If the primary pays the service, then authorization is not required for the secondary claim.

Saving a DDE claim

If interrupted during the process of entering a claim, ProviderOne allows you to save the claim, and later retrieve the saved claim to finish and submit the claim. Make sure to complete the following data elements before trying to save the claim:

Provider Information

- Billing provider NPI
- Billing provider taxonomy
- Question: Is the billing provider also the rendering provider?
- Question: Is this service the result of a referral?

Subscriber/Client Information

- Client ID number
- Question: Is this a Medicare crossover claim?

Claim Information

- Question: Is this claim accident related?

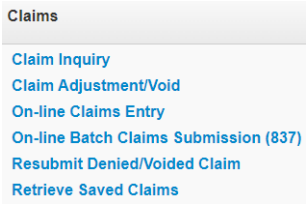
Basic service line items are not required before saving a claim.

Once all the minimum necessary data fields are completed, select **Save Claim**:

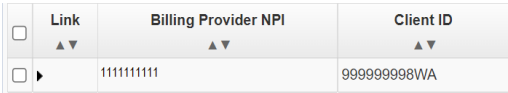
ProviderOne will display the following confirmation box:

Select **OK** to proceed or Cancel to return to the claim. When you select OK, ProviderOne will check the claim to ensure the minimum data fields are completed, and if so will save and close the claim.

Retrieving a saved claim
On the provider portal, select **Retrieve Saved Claims**:



When ProviderOne displays the Saved Claims List, select the **Link icon** to retrieve a claim:

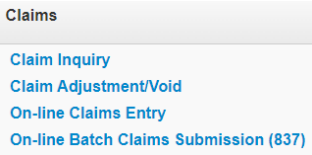


The system loads the saved claim in the professional DDE screens. Continue to complete any required fields and submit the claim.

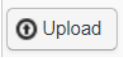
Once a saved claim is retrieved and submitted, the claim no longer appears in the saved claim list.

Submitting online batch claims

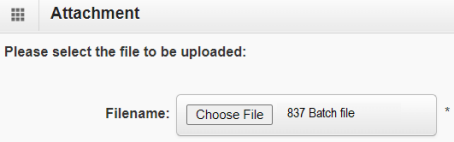
From the homepage, select **Online Batch Claims Submission**. On the provider portal, select **Submit HIPAA Batch Transaction (837)**:



Select the **Upload** button on the next screen:



Select the **Choose File** button and locate the batch file on your computer.



When the file name displays, select **OK**.

If the upload was successful, ProviderOne displays a confirmation page, which you should print out and use for a reference when checking on the batch response (997).

If sending backup documentation for a claim in the batch (a TCN is required to do this) a completed and printed cover sheet is required. Several different types of cover sheets are available on the document submission cover sheets webpage.

For more information on cover sheets, see Appendix H.

Special Claim Indicators (SCI)

ProviderOne has a feature that allows scanning of certain routine comments directly into the system, without the need for manual review. To make any of the following comments, enter "SCI=" and the corresponding **letter** on the list below:

- B – baby on birthing parent's client id (can only be used the first 60 days of baby's life)
- F – enteral nutrition – client not eligible for WIC
- H – children with special healthcare needs
- I – involuntary treatment act (ITA) (legal status)
- K – not related to terminal illness (hospice client)
- V – voluntary treatment (legal status)

When billing Medicaid as the secondary payer using HIPAA batch files, use an 837 transaction to electronically submit the primary payer insurance information to ProviderOne. Please follow the guidelines within the ProviderOne 837 Professional, Institutional and Dental ProviderOne 5010 companion guides.

If you are sending in backup documentation for an EDI claim, HCA holds the claim(s) for 21 days after receiving the electronic file.

Pitfalls

- Failing to use the National Provider Identifier (NPI) that ProviderOne has on file.
- Failure to use a proper taxonomy code.
- Failure to include gender on the claim.
- Failing to indicate the baby's name, birth date and gender on a newborn claim using birthing parent's ID.
- Forgetting to click submit on the bottom of the last popup on the DDE screens, even if a TCN is displayed (the TCN will become invalid if you do not submit it).
- Failure to turn off the popup blocker when using ProviderOne, which is necessary for you to get to the final popup to select submit.
- Forgetting to click the enter key or to click outside any field when filling out the cover sheet, as the cover sheet will not then contain the proper barcodes and the backup will not be attached to the DDE claim in ProviderOne.
- Reusing or saving cover sheets, as each cover sheet has unique coding for the claim the backup document is attached to.

Submitting Medicare crossover claims

Medicare crossover claims are claims for the client's Medicare cost sharing liability (deductible, coinsurance, or copay). This does not apply to claims denied by Medicare, as these are not considered crossover claims.

In most cases, after processing the claim for payment, Medicare will forward the claim electronically to ProviderOne and include a message on the Medicare Explanation of Medicare Benefits (EOMB) stating: "This information is being sent to either a private insurer or Medicaid." In these cases, ProviderOne processes crossover claims without any action on your part.

There are instances where Medicare may not forward claims to ProviderOne (i.e., Managed Medicare) so you may need to bill the crossover claim directly to ProviderOne. HCA recommends billing claims electronically or using ProviderOne DDE for faster processing. If Medicare paid, complete the Medicare fields as shown in this section. If Medicare denied, it would require attaching a copy of the EOMB to the claim.

You will know that Medicare has not forwarded the crossover claim to ProviderOne if:

- It does not show up on the remittance advice (RA).
- The message "This information is being sent to either a private insurer or Medicaid" does not show up on the EOMB from Medicare.

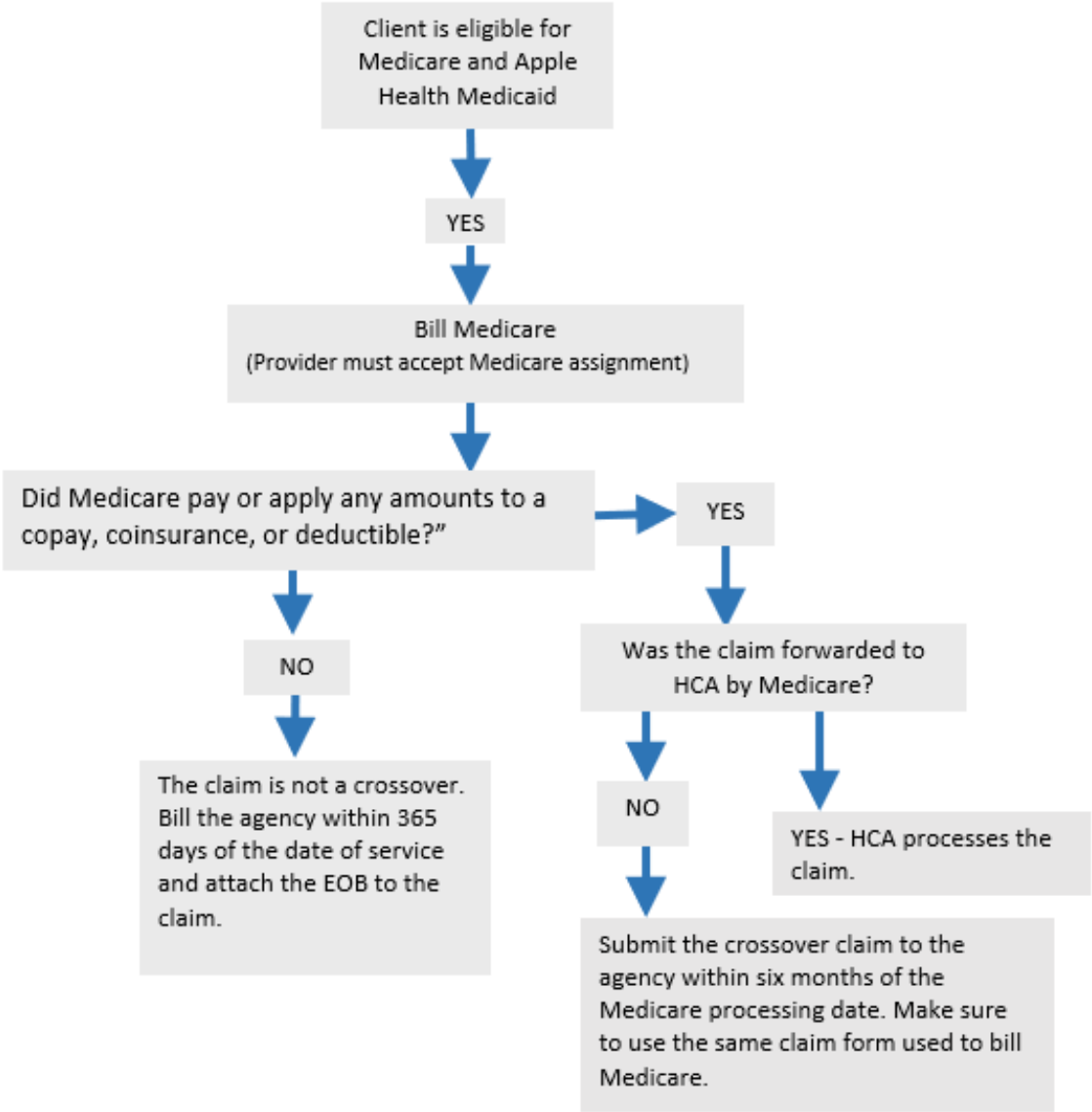
Reasons Medicare may not forward a crossover claim directly to ProviderOne include:

- The patient may be a new Medicare/Medicaid enrollee and Medicare does not yet list them as having Medicaid coverage.
- The provider billed Medicare with an NPI number ProviderOne does not have in the system.

- There are electronic file corruption issues.
- Managed Medicare (Medicare Part C or Medicare Advantage plans) may not forward claims directly to ProviderOne.

See Appendix J for payment methodology information on crossover claims.

Overview of Medicare crossover process



The next section explains how each type of Medicare crossover claim is submitted to the agency if the claim is not automatically forwarded by Medicare. Please see Appendix J for crossover payment methodologies.

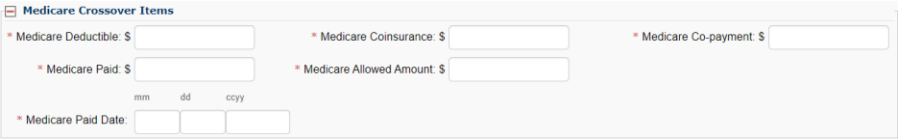
Medicare Part B professional services

To submit crossover claims for professional services:

- If Medicare has paid all lines on the claim, submit the crossover claim to ProviderOne.
- If Medicare has allowed and denied service lines on the claim, do not submit paid lines with denied lines on the same claim form. This could cause a delay in processing the claim. Submit two claims, one crossover for services Medicare paid on and one professional claim for services Medicare denied:
  - If Medicare bundled the service into another paid service line, do not split out or unbundle to bill Medicaid.
  - Attach the EOMB to the claim for services denied by Medicare.
- When Medicare is the primary payer and denies a service that is covered by the agency with a prior authorization requirement, the agency waives the "prior" requirement in this circumstance. Submit a request for authorization. Attach the explanation of benefits (EOB) to the request for services denied by Medicare.
- If Medicare applies to the deductible or makes payment on a service that required PA, then authorization is not required for the service.
- Bill the agency on the same claim format billed to Medicare with the same services and billed amounts.
- Bill Medicare with the appropriate taxonomy code for the claim according to Medicare guidelines. Medicare will then forward the taxonomy on the claim to ProviderOne.
- If billing DME rental codes that require a date span, bill Medicare with the appropriate date span. Medicare will then forward the date span on the claim.

When submitting a DDE professional services crossover claim in ProviderOne, fill out the additional Medicare information at the line level for each service line:

- Select the **Medicare Crossover Items** expander.
- Fill in the required Medicare information.
- The rest of the claim is filled out as normal.



If the Medicare Advantage or Part C Plan indicates an allowed amount for the service but does not make a payment on the service, enter the copayment, coinsurance, or patient responsibility as the deductible if the plan EOB indicates a remark code of copayment for the service. ProviderOne requires a deductible amount in this case to process the claim.

DATES OF SERVICE	SVC PROVIDED/PPS	BILLED AMOUNT	ALLOWED AMOUNT	PAID AMOUNT	PATIENT LIABILITY	DISALLOWED AMOUNT	EOB CODES	
120722-120722	99212	60.00	39.23	0.00	39.23	20.77	3	45
CLAIM TOTAL:		60.00	39.23	0.00	39.23	20.77		
SUMMARY TOTAL:		60.00	39.23	0.00	30.23	20.77		

EXPLANATION OF CODES

3	Co-payment Amount
46	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

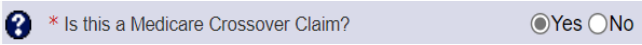
If you bill a crossover electronically or DDE, ProviderOne does not require the EOMB to be uploaded or sent as an attachment, unless Medicare denies the service.

Medicare Part A institutional services

When submitting a DDE institutional crossover claim in ProviderOne, fill out the additional Medicare information at the claim level. DDE claims do not require the EOB.

Select Yes to indicate this claim is a crossover:

- Fill in the required Medicare information in the fields with asterisks indicated.
- The rest of the claim is filled out normally.



While claims for clients that do not have Medicare Part A or Part A benefits are exhausted are not considered crossover claims, we have included how to bill these claims in this section.

Part B only (no Part A), or Part A exhausted prior to stay

Description	DRG	Per diem	RCC	CPE	CAH
Bill Medicare Part B for qualifying services delivered during the hospital stay	Yes	Yes	Yes	Yes	Yes
Bill ProviderOne as primary for hospital stay	Yes	Yes	Yes	Yes	Yes
Show as non-covered in ProviderOne and bill what was billed to Medicare under Part B	No	No	Yes	Yes	Yes
Expect ProviderOne to reduce payment for the hospital stay by what Medicare paid on the Part B bill	Yes	Yes	No	No	No

Description	DRG	Per diem	RCC	CPE	CAH
Expect ProviderOne to recoup payment as secondary on Medicare Part B bill*	Yes	Yes	No*	No*	No*
Report the Part B payment on the claim in the other payer field "Medicare Part B"	Yes	Yes	Yes	Yes	Yes
Attach Medicare Part A & B EOB to claim	Yes	Yes	Yes	Yes	Yes
Include a claim note**	Yes	Yes	Yes	Yes	Yes

ProviderOne pays by the stay (DRG claims) or the day (per diem) on other claims. ProviderOne calculates the payment and then subtracts what Medicare has already paid and recoups what it paid as secondary on the Medicare claim.

* ProviderOne pays line item by line item on some claims (RCC, CPE, and CAH). ProviderOne does not pay for line items that Medicare has already paid.

**The claim note should be one of the following:

- No Part A benefits; or
- Part A benefits exhausted prior to stay

What does the agency pay the hospital?

DRG paid claims pay the allowed amount minus what Medicare paid under Part B. When billing, enter the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

Per Diem paid claims pay the allowed amount minus what Medicare paid under Part B. When billing, enter the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

RCC, CPE and CAH claims pay the allowed amount for line items covered by Apple Health (line items usually covered by Medicare under Part A, if client were eligible).

Medicare begins during hospital stay, or Part A exhausts during stay

To submit a claim in situations where a client's Medicare coverage began during an inpatient stay, or exhausts the Part A benefit during an inpatient stay:

- Bill Medicare - per Medicare PPS Payment Manual, Chapter 3, Section 40A, bullet 3: "The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier payment."
- ProviderOne must have a paid/billed inpatient crossover claim in the system.
- After the inpatient crossover claim is paid, bill ProviderOne the primary claim for the entire stay:
    - If billing RCC, CPE or are a CAH, list the Medicare covered day's charges as non-covered.

  - If billing DRG or per diem, list all services (no non-covered).
- If Part A exhausts during the stay, you must still bill Medicare for the Part B charges.
- ProviderOne may pay something using the following formula:
  - HCA allowed amount for the entire stay, minus Medicare paid, minus HCA crossover payments
- Add the following claim note:
  - "Part A benefits exhausted during stay;" or
  - "Medicare Part A coverage began during the stay;" or
  - Enter the Part A start date, or the date benefits were exhausted in the occurrence fields using occurrence code A3.
- Attach Part A and Part B EOMB.

These claims can be very complex and are addressed on a case-by-case basis and sometimes it is necessary for HCA to contact the biller for additional information.

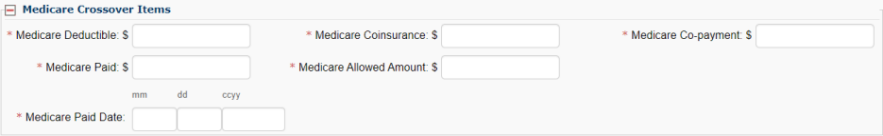
Medicare Advantage plans (Part C)

Some Medicare clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C) and you are required to bill these Medicare Advantage Plans instead of FFS Medicare. The Managed Medicare – Medicare Advantage Plan is the primary payer and HCA does not consider this as commercial insurance.

- To receive payment, it is necessary to follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) plans prior to billing ProviderOne.
- After the Medicare Advantage plan processes the claim, submit the claim to ProviderOne as a Medicare crossover claim.
  - Use the same claim format used to bill the Medicare Advantage plan, unless billing a crossover for an FQHC or RHC, in which case the claim format to use is the institutional format.
  - Make sure the services and billed amounts match what was billed to the Medicare Advantage plan (DDE claims do not require the EOB to be sent with the claim).
- You must submit the Medicare Advantage claim within six months of the Medicare Advantage payment date.
- If Medicare Advantage is the primary payer and denies a service that is covered by the agency with a prior authorization requirement, the agency waives the "prior" requirement in this circumstance. Submit a request for authorization. Attach the EOB to the request for services denied by Medicare.
- If the Medicare Advantage Plan pays the service, then PA is not required.

Billing for managed Medicare – Medicare Advantage (Part C) plans

Providers must submit claims for capitated copayments for the Medicare Part C plan as a crossover claim type (both professional and institutional claims).



If there is not a Medicare (plan) allowed amount, enter the sum of payment + copayment + coinsurance + deductible as the **Medicare Allowed Amount**.

- If there is no amount for an entry, just add together the entries that do have an amount.
- Finish filling in the other amounts (even if these amounts were used to calculate an allowed amount).
- Enter a zero (0) in any other fields without a value.
- If the user entered a zero (0) in the Medicare Paid field, then enter either the Medicare Co-payment or Medicare Deductible amount (whichever is applicable).
- "Managed Medicare" comments are not required on the claim.

Claims with a coinsurance, deductible, or a non-capitated copayment balance due on a claim must be billed as follows:

- **Professional services**
  - Bill the claim paid by the Part C plan as a crossover claim.
  - If the Part C plan lists a copay amount but no coinsurance amount, enter the copay amount in the coinsurance field on the crossover claim submitted to ProviderOne.
  - If the Medicare Advantage or Part C plan indicates an allowed amount for the service but does not make a payment on the service, enter the copayment, coinsurance, or patient responsibility as the deductible if the plan EOB indicates a remark code of copayment for the service.
    - ProviderOne requires a deductible amount in this case to process the claim.
    - If the Medicare Advantage claim includes both allowed and denied service lines on the claim, do not submit paid lines with denied lines to ProviderOne on the same claim; you must submit a crossover claim for services Medicare paid, and a separate claim for services Medicare denied attaching the EOMB to the claim.
  - If Medicare bundled the service into another paid service line, do not split out or unbundle to bill Medicaid.
  - If Medicare Advantage denies a service on a claim, ProviderOne may or may not make a payment on the service, depending on the reason for the Medicare Advantage plan denial.

- **Institutional Services**:
  - Follow the directions above for sending a Part C plan institutional crossover claim, except you cannot split out specific lines denied by the Part C plan to bill a separate claim. Institutional claims are processed as one entire claim.

QMB – Medicare Only clients

QMB – Medicare Only clients have a limited Benefit Service Package which only pays secondary to Medicare and has no independent scope of care.

QMB-only payment methodology is as follows:

- If Medicare or the Medicare Advantage plan and ProviderOne cover the service, ProviderOne pays only the client's cost sharing liability (deductible, and/or coinsurance, and/or copayment) up to the Apple Health allowed amount.
- Payment is based on the ProviderOne allowed amounts minus any prior payment made by Medicare or the Medicare Advantage plan. In these cases, ProviderOne considers the crossover claim paid in full.
- If Apple Health does not cover a service, ProviderOne will use a CMS approved negotiated rate or Medicare's allowed amount in the place of HCA's allowed amount.

Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to Medicare or the Medicare Advantage plan. If Medicare or the Medicare Advantage plan adjusts the payment and the claim has previously been paid, submit an adjustment request to ProviderOne. Submit a new claim if the original claim was denied.

Backup documentation for Medicare crossover claims

For crossover claim billing clarification, HCA has specific requirements for the EOMB submitted with the claim.

Header (claim) level information on the EOMB must include all the following:

- Medicare (or the Part C plan) as the clearly identified payer
- The Medicare claim paid or process date
- The client's name (if not in the column level)
- Medicare reason codes with descriptions
- Text in font size 11 or greater

Column level labels on the EOMB for professional claims must include all the following:

- Client name
- Date of service
- Number of service units (whole numbers only)
- Procedure codes
- Modifiers

- Billed amount
- Allowed amount
- Deductible
- Amount paid by Medicare
- Medicare reason codes with descriptions
- Text that is font size 11 or greater

Column level labels on the EOMB for the institutional claim must include all the following:

- Client name
- From and through dates of service
- Billed amount
- Deductible
- Co-insurance
- Amount paid by Medicare
- Medicare reason codes with descriptions
- Text that is font size 11 or greater
- Rural Health Center (RHC) and Federally Qualified Health Center (FQHC) providers must include their per diem rate

Claims for services denied by Medicare with backup

When Medicare or the Part C plan denies services that can be billed to Medicaid, the above criteria apply to the required EOB sent with the claim.

Medicare Prescription Drug Program

For more information on the Medicare Prescription Drug Program, review the Prescription Drug Program provider guide.

Pitfalls

- Billing Medicare with an NPI that has not been reported to the agency. ProviderOne cannot identify the provider when these claims are forwarded by Medicare.
- The claim billed to Medicare does not match the claim billed to ProviderOne.
- If a Medicare exhaust issue, failing to indicate when the benefit exhausted in the claim note or occurrence code.
- The coding and dollar amount billed on the claim to Medicare does not match the coding and dollar amount on the claim billed to ProviderOne.
- Failing to bill the paid Part C plan claim as a crossover claim type.
- If Medicare denies a service, failing to submit the claim to ProviderOne without the Medicare EOB.

- Sending an EOB with the claim that does not indicate Medicare (or a Part C plan) as the payer or other missing required information.

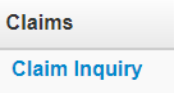
Claim status

ProviderOne allows several options to search for a claim's status. You may want to check a claim because:

- A claim has been submitted and ProviderOne has not responded.
- You are trying to rebill some older claims and need the Transaction Control Number (TCN) to prove timely submission of the original claim.
- You are searching for a claim because your accounts receivable system does not yet show a posted payment.

The easiest method to find claims in ProviderOne is to use the claim inquiry option in the ProviderOne portal.

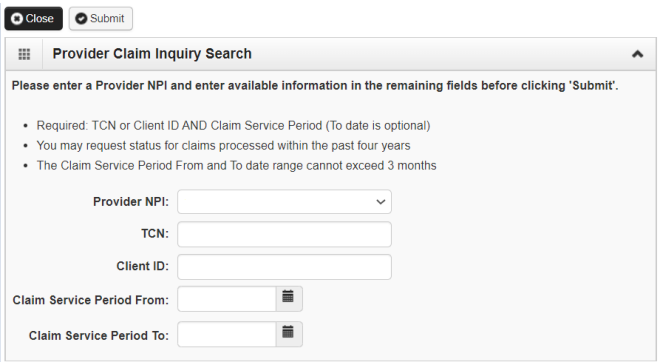
Select the EXT Provider Claims/Payment Status Checker or EXT Provider Super User profile, and select **Claim Inquiry** on the provider portal:



Select the appropriate NPI from the dropdown box and enter available information in the remaining fields before selecting **Submit**. The bullets at the top left of the box describe the various combinations of search criteria you can use to find a claim. The easiest method is to search by TCN.

You may want to record each TCN generated when submitting claims in case you have a need to check the claim using Claim Inquiry later.

- You may request status for claims processed within the past four years.
- The claim service period from and to date range cannot be greater than three months.



To find a claim (or a list of claims) use the client ID and the oldest from date of service on the claim. ProviderOne will display a list of all claims for that date of service.

After selecting **Submit**, select the blue Transaction Control Number (TCN) hyperlink to view the claim:

Claim Inquiry Providers List

TCN	Date of Service
202225800000294000	01/01/2022

See Appendix K for instructions on checking claim status via the Interactive Voice Response (IVR).

Pitfalls

- Calling the HCA Customer Service Center to check on the status of a claim. Providers can easily check on a claim status using ProviderOne or the Interactive Voice Response (IVR) without assistance.

Timeliness

The initial timely filing deadline is 365 days from the date of service, but you may resubmit, modify, or adjust any timely initial claim (except prescription drug claims) for a period of 24 months from the date of service.

Exceptions to this rule are:

- Medicare crossover claims must be submitted initially within six months of the Medicare processing date, and for resubmissions, voids, or adjustments within two years from the "from" date of service.
- Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

For more information, see WAC 182-502-0150.

Adjusting, resubmitting, or voiding a claim

ProviderOne does not process claim appeals. If a claim has any paid amount (i.e., is not in denied status) you must submit an adjustment. If a claim was denied, verify the denial reason(s), and correct the claim for resubmission.

Adjust a paid claim when:

- A billing error was made (e.g., wrong client, billed amount, tooth number, etc.).
- The claim contained multiple surgical procedure codes, and one of the procedure codes denied or paid incorrectly.
- The claim was overpaid (this may be a void claim).

Denied claims can be resubmitted using the ProviderOne resubmit feature and correcting the error that caused your claim to deny. ProviderOne does not post duplicate denials against previously denied claims. ProviderOne will not allow adjusting or voiding of a denied claim.

There are various methods to modify, adjust, or void claims depending on the billing format. If the claim was paid (or partially paid) then you must submit an

adjustment to make any corrections or modifications using the following guidelines:

- For DDE adjustments (regardless of submission method used for the original claim), log into ProviderOne using either the EXT Provider Claims Submitter or EXT Provider Super User profile and use the online Claim Adjustment/Void option.
- For electronic claims, submit a HIPAA batch transaction claim using a frequency 7 to adjust/replace the original claim or a frequency 8 to void the original claim. Follow the ProviderOne companion guide rules for submitting frequency 7 (adjustment) or 8 (void) transactions.

When an adjustment and resubmission of a claim is required after the one-year timely filing rule, ProviderOne requires proof of timely filing to resubmit your claim.

Locate the timely Transaction Control Number (TCN) using the ProviderOne "claim status" search option or the remittance advice, and follow these guidelines:

- For a DDE claim denial, resubmit the original claim using the Resubmit Denied/Voided Claim, which will automatically link the old claim to your new claim to prove timeliness without the need for you to enter a timely TCN.
- For DDE adjustments on paid claims, use the Claim Adjustment/Void function and ProviderOne will similarly link the original timely TCN to your adjustment without the need for you to enter a timely TCN.
- For HIPAA batch claim transactions, see ProviderOne 5010 companion guides for entering the timely TCN number.

If an original claim was adjusted or replaced and it is necessary to adjust or replace it again, you must use the most recent TCN number in the claim trail. ProviderOne will only allow one adjustment for each TCN. Once a claim has been adjusted or resubmitted, it cannot be adjusted or resubmitted again.

The general adjustment process

The ProviderOne system assigns an 18-digit Transaction Control Number (TCN), also referred to as a claim number, to each claim received. The TCN will also appear on your remittance advice (RA).

Reading the TCN

Each of the 18 digits in the claim number (TCN) has a reserved meaning. The table below describes each (e.g., 202318400000001000):

2 A	0 B	23184 C	0 D	0000001 E	000 F

A: Claim medium indicator

- 0 – Not used
- 1 – Paper
- 2 – Direct data entry (DDE web submission)
- 3 –Electronic (X12)
- 4 – System generated
- 5 – DDE social service claims
- 6 – Non-HIPAA compliant social service electronic batch submission (includes template).
- 7 – Social service repetitive/client payment/adjustments or void
- 8 – Reserved for future use.
- 9 – Represents a claim billed in the legacy (old) payment system (21 digits long).

B: Type of claim

Placeholder number that could be one of the following:

- 0 – Medical
- 1 – Pharmacy
- 2 – Crossover or medical
- 3 – Medical encounter
- 4 – Pharmacy encounter
- 5 – Social services
- 6 – Social service shadow claim type. System generated daily/removed nightly from system. Does not produce payable claim. Provider and staff, please disregard.
- 7 – 9 Reserved for future use.

C: Batch date

- First two digits are the year (23).
- The next 3 numbers are the Julian day of the year with 184 being July 2nd. ProviderOne uses the Julian calendar to record dates claims were received. The Julian calendar is simply a continuous counting of the days of the year from 1 to 365. Leap years add an additional day and use 1-366.

D: Adjustment indicator

- 0 – Original claim
- 1 – Adjustment credit
- 2 – Adjustment debit

E: Claim sequence number

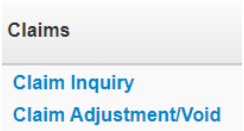
- Sequential counting of claims each day starting with 0000001.
- Allows claim counting to reach almost 10 million (9,999,999) claims daily.

F: Line number

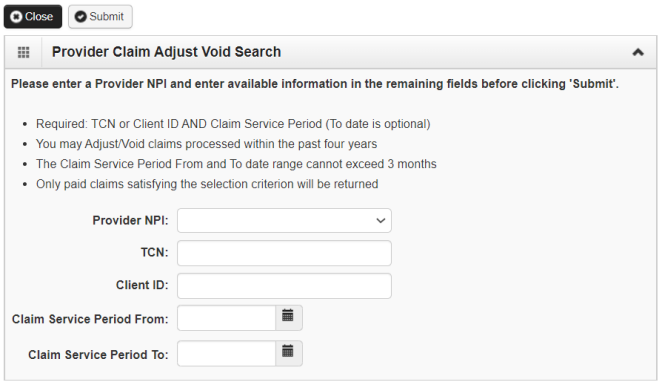
- The claim level number will be 000.
- Each claim line also has a TCN number. The line number will start with 001 sequentially (e.g., 002 for line 2, etc.) for each new claim line (HIPAA Transactions can have up to 999 lines).

Adjusting or Voiding DDE claims

Select **Claim Adjustment/Void** from the Provider Portal:

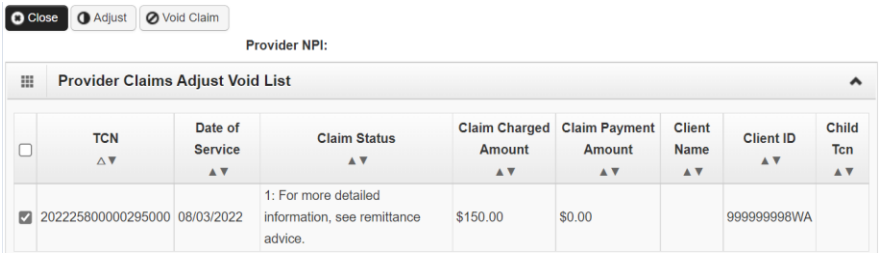


At the search screen enter the required information to find the claim to adjust or void and select **Submit**:



> **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.

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



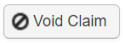
To adjust a paid claim, select the box next to the TCN and click the **Adjust** button in the upper left hand corner. The claim will display in the DDE screen with the values of the selected claim populated. Make the necessary changes then resubmit the adjustment request to ProviderOne for processing. The system will go through the same final steps of a claim submission and will ask if you need to attach backup information.

Remember to select **Submit** on the Submitted Claim Details screen to finish sending in the resubmitted claim. ProviderOne assigns a new TCN to the claim after resubmission. There will be two TCN's associated to the adjustment:

- A TCN with a negative amount representing the takeback of the original payment (credit), and
- A TCN representing the new corrected claim (debit).

The HIPAA adjustment reason code of 129 will appear in the last column on the remittance advice associated with the credit transaction.

ProviderOne allows you to give a payment back by simply voiding a claim. To void a claim, click the **Void Claim** button in the upper left-hand corner of the screen.



ProviderOne displays the claim data on the DDE screen, but all the values are grayed out in the display, meaning no changes can be made.

Select **Submit** and the void will be sent to ProviderOne for processing. The claim will appear as a credit on the remittance advice. There will be one TCN associated to a void – a TCN with a negative amount representing the takeback of the original payment (credit). The HIPAA adjustment reason code of 129 will appear in the last column on the remittance advice associated with the credit transaction.

If a provider is voiding/canceling a claim for an overpayment, there are two options available:

1. Void the claim and the agency will recoup the claim and deduct the excess amount from future payments until the overpayment is satisfied.
2. Issue a refund check payable to the Health Care Authority, attach a copy of the RA showing the paid claim and include a brief explanation for the refund. Mail to:

   THE HEALTH CARE AUTHORITY
   FINANCE DIVISION
   PO BOX 9501
   OLYMPIA WA 98507-9501

The billing time periods do not apply to overpayments that the provider must refund to the agency. After the allotted time periods, a provider may not refund overpayments to the agency by claim adjustment. The provider must refund overpayments to the agency by a negotiable financial instrument such as a bank check (see WAC 182-502-0150 (8)).

The adjusted/replaced claim will appear on the RA in the adjustment claim section as two transactions:

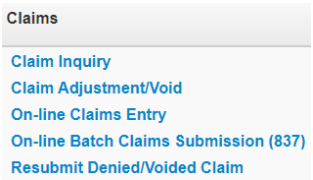
1. The original claim; and
2. The replacement claim

The claim paid amount is adjusted based on the adjustment request and the adjusted amount is reflected in the total payment. See the section on the remittance advice for a complete explanation about the RA.

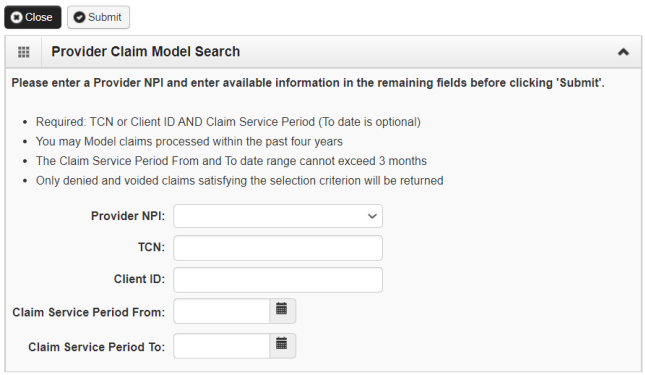
> **Note**: When a claim is voided, the agency will recover the amount originally paid from the next total payment and the voided claim will appear on the RA as only one transaction. Voided claims can be resubmitted by using the credit TCN.

Resubmitting denied or voided DDE claims

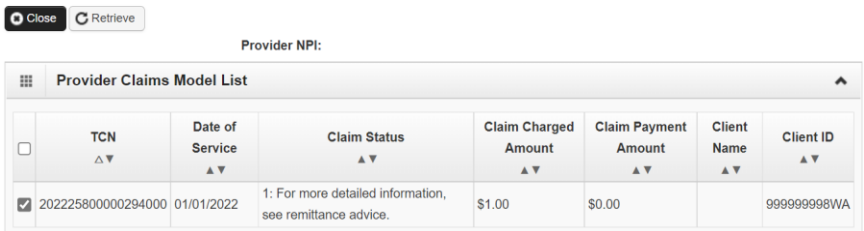
Select **Resubmit Denied/Voided Claim** from the provider portal:



Search for the claim by entering the appropriate information then select **Submit**:



ProviderOne will display the claim list screen. Select the box next to the TCN of the claim to be resubmitted then select **Retrieve** in the upper left-hand corner. The claim will display in the DDE screen with the values of the selected claim in the fields and will indicate the type of claim.



Make any necessary changes to the claim using the same procedure as described above in the Adjusting a Claim section. Upon completing the changes, submit the claim to ProviderOne for processing. The system will go through the same final steps of a claim submission asking if you want to send backup documentation, etc.

Pitfalls

- Adjusting the wrong claim or claim line, which may result in unexpected results with the claim and payment.
- Failing to select Submit on the Submitted Claim Details screen will result in the claim not being sent to ProviderOne for processing.

Claim templates

ProviderOne allows you to create and save a template of a claim for services that you may be billing for a client on a weekly, bi-weekly, or monthly basis. When creating a DDE template, you can add as much claim information to the template as needed, however the system does require a minimum of information to be able to save the template.

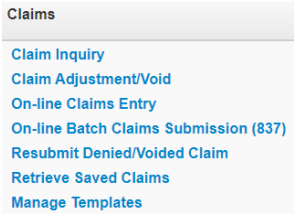
The minimum required information is:

- A template name
- Answers to the questions on the DDE screen; and
- If a data field or section is open or expanded, then additional information may be required.

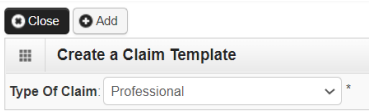
You can use templates repeatedly to create claims. The template can be edited, resaved, or deleted if no longer useful. You can create and save as many templates as needed.

Creating a template

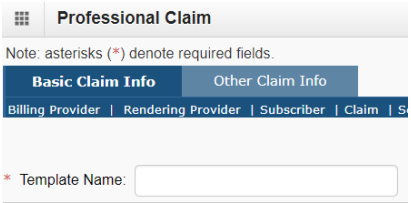
Log into ProviderOne with the EXT Provider Claims Submitter or EXT Provider Super User profile and select **Manage Templates** which will open the following screen:



First, start building a template by choosing which type of template is desired then select **Add**.

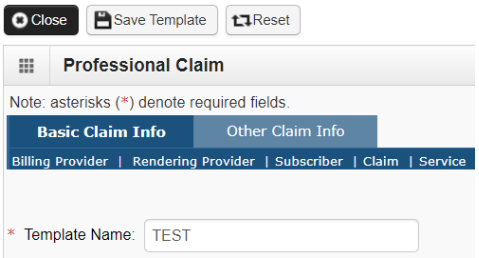


Create a name for the template. Use a name that describes a service or use the client's name. It is best not to use a template name that uses alpha/numeric characters that are common to all templates, which would make the template difficult to sort from a list of many templates.



Fill in as many data fields as possible. If the template is for a client that receives specific services monthly, then fill in all fields except the dates of service. If the template is service-specific, then fill in all the service information and leave off the client information and dates of service. When building and saving a template, ProviderOne will ignore some of the system rules (i.e., not all required fields need data).

Once the template is complete and ready to save, select **Save Template**.



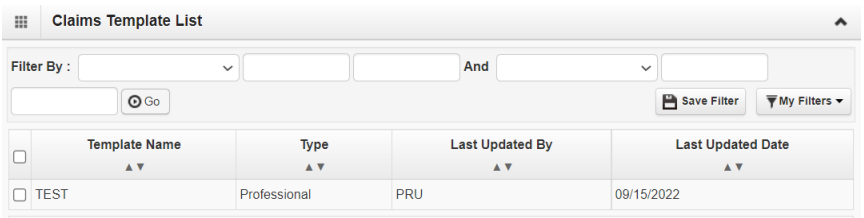
The system will ask to verify saving the template:

ProviderOne may return the message, "Warning: Template Name Already Exists, please enter a unique name". Two things may cause this warning:

- A template has already been created with this name under your domain; or
- ProviderOne found the template name already existed in history.

If the template is truly a new one for the domain, add a number to the end of the template name and attempt to save again.

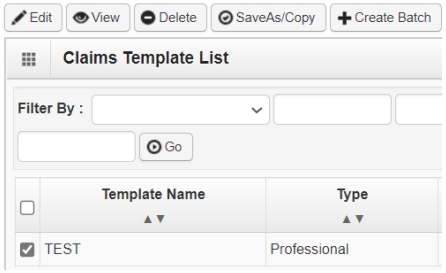
After selecting **OK**, ProviderOne returns to the Create a Claim Template screen adding the template to the list:



Add as many templates as necessary, either by creating new ones using the above method, or copying and editing a saved template.

Copying a template

To copy a template, click on the check box next to the template name and click on **Save As/Copy**:



The system now displays the DDE screen with all the template information except the template name. Name this template and change any data as needed then save the template. Build as many templates as required using this method.

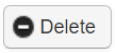
Viewing a template

To view a template, click on the check box next to the template name and click the **View** button:

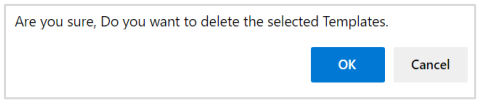
The system now displays the DDE screen with the template information and all the template data will be grayed out and cannot be edited.

Deleting a template

To delete a template, click on the check box next to the template name click the **Delete** button:



A popup will appear asking if you are sure you want to delete the selected record. Click **OK** to delete the template.



Editing a template

To edit a template, click on the check box next to the template name and click the **Edit** button:

The system now displays the DDE screen with the template information available to edit with changes or updates as needed.

Pitfalls

- Choosing the wrong profile after logging into ProviderOne.
- Choosing the wrong claim type for the template.
- Using common starting characters in naming the template. Makes it difficult to sort and find a template on a large list.

Submitting a template claim or batch of template claims

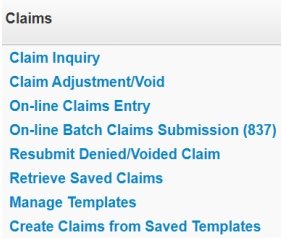
Providers that bill reoccurring services for a client or clients may want to use a claim template to create and submit those claims.

ProviderOne also allows institutional providers to build batches of templates into a batch of claims instead of submitting a single claim template one at a time.

Submitting a single claim from a template

Log in to ProviderOne using either the EXT Provider Claims Submitter or EXT Provider Super User profile.

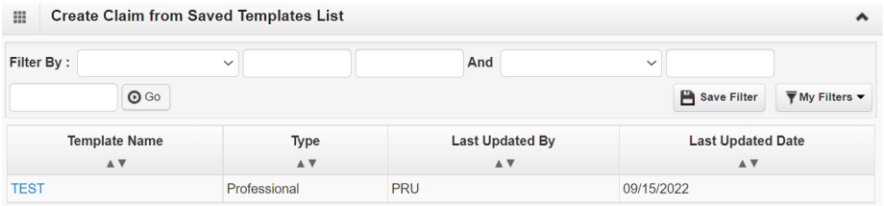
From the provider portal, select **Create Claims from Saved Templates**:



ProviderOne will display the Create Claim from Saved Templates List screen.

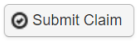
Click on the template name to load the template into the DDE screen.

- If there are several templates listed, use the Filter By boxes to find a specific template, or
- Use the sort tools ▲▼ (little diamonds/carets) under each column heading which sorts from top to bottom or bottom to top.



At the DDE screen finish filling in the claim data. When the data entry is completed, save the claim, or submit the claim to ProviderOne. If submitting the claim, ProviderOne will ask if backup is being sent. Attach backup, if necessary, by clicking Ok, or Cancel if no backup is needed.

Click the **Submit** button to submit the claim.



Go back to the Create Claim from Saved Templates List screen if you want to submit another claim using a template.

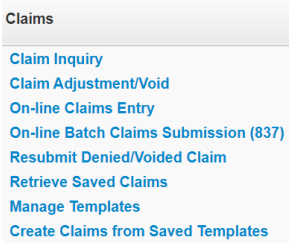
Submitting a batch of template claims

ProviderOne can identify and gather a group of claim templates together to create a batch of templates for submission into the system as a batch of claims. This process has these basic requirements:

- All claim types must be the same in the batch (i.e., professional, dental, or institutional).
- All batch templates will be for the same date of service (or date span).
- The billed amount could be the same on each claim template [based on the date(s) of service].
- Each claim template units will be the same [calculated based on the date(s) of service].

A detailed explanation of the process is beyond the capacity of this publication; however the ProviderOne Managing Claims system manual has a complete overview of the process. Nursing Home providers submitting institutional claims have a detailed webinar and presentation slide show demonstrating the complete process. Other provider types wanting to use the process would follow the same steps; however, they may be using a different claim format.

To submit a batch of template claims, log into ProviderOne and click on **Manage Templates**.



At the Claims Template List screen there are three options to create a batch of claim templates:

- Create Batch
- Create Batch All
- Auto Batch

At the Batch Claim Attributes screen assign the from and to dates of service then build the batch.

Each batch is assigned a batch number.

At the portal page switch to the **Manage Batch Claim Submission** hyperlink.

At the Batch Claim Submission Status List page, check the status of a batch. The status can be:

- Waiting
- In Process
- Failed in Validation
- Passed Validation
- Submitted for Claims Loading

Only template batches that have passed validation can be submitted. Submitted batches are now in Submitted for Claims Loading status. Claims are assigned a TCN and begin processing in ProviderOne. This template batch will be auto purged from the list page.

Pitfalls

- Forgetting to change a data element that needed changing on a template. This could result in a denied claim or an overpaid claim.
- Trying to submit a batch of templates that are different claim types.
- Not keeping track of the batch number for a specific template batch service.
- Trying to submit a batch of templates that have not passed validation.

The remittance advice

Understanding claim status

The Remittance Advice (RA) provides detail about paid, denied, adjusted and in-process claims submitted to ProviderOne.

ProviderOne makes weekly payments every Monday. Claim submission cutoff in the payment system is Tuesday at 5 p.m. Pacific Time to make payment the following Monday for a "clean" claim. Clean claims submitted after cutoff will be paid the following payment cycle on the following Monday. The agency sends out the RA weekly and always follows Monday's payment cycle.

Clean claims are claims that have all the required data elements and do not conflict with Apple Health program policies.

Claims may arrive in the payment system before 5:00 PM on Tuesday but may not process until after the cutoff time. These claims will miss the next Monday payment and be paid the following payment cycle on the following Monday.

The RA is broken down into the following sections:

- RA newsletter
- RA summary
- Paid claims
- Denied claims
- In-process claims
- Adjusted claims

Disclaimer

A contract, known as the Core Provider Agreement (CPA), governs the relationship between HCA and Apple Health providers. The CPA's terms and conditions incorporate federal laws, rules and regulations, state law, Apple Health rules and regulations, and HCA program policies, numbered memoranda, and provider guides, including this guide. You must submit a claim in accordance with HCA rules, policies, numbered memoranda, and provider guides in effect at the time you provided the service.

Retrieving the RA

There are two ways to obtain the Remittance Advice (RA). You will want to select which of the two methods that bests suits your business needs, PDF file or electronic 835. This guide only covers processes related to using the ProviderOne portal, not HIPAA EDI transactions. Please review the HIPAA webpage for the 835 Companion Guide and/or HIPAA help desk contact information.

To retrieve the RA through the ProviderOne portal, log in to ProviderOne and choose the EXT Provider Claims/Payment Status Checker or EXT Provider Super User profile. Select **View Payment** (RHCs and FQHCs select View Capitation Payment to view enhancement/managed care RAs):

Washington State Health Care Authority

Payments

View Payment

The segment below will be displayed.

Select the RA/ETRR Number in the first column to review a PDF of the RA. ProviderOne will hold four years of RAs generated in ProviderOne.

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
999317130	00033S!	3/2/2023	3/2/2023	20	$218,070.25	$280.08	$217,790.17	
999312904	00034S!	2/22/2023	2/22/2023	41	$661,817.84	$340.48	$661,477.36	
999309431	00021S!	2/16/2023	2/16/2023	153	$7,558,492.54	$135.50	$239.50	
999308383	D000000383	2/15/2023	2/15/2023	0	$0.00	$0.00	$0.00	
999304221	99956S!	2/14/2023	2/14/2023	199	$2,512,230.85	$11,463.37	$2,500,767.48	
999301852	D000000852	2/9/2023	2/9/2023	0	$0.00	$0.00	$0.00	

Pitfalls

- Failing to use the correct user profile. This may result in not being able to retrieve the RA in ProviderOne.
- Logging into the wrong domain. This may result in not finding the RA matching your payment.

Reviewing updates and key messages

ProviderOne uses the RA newsletter to communicate changes and new information. Taking the time to review this section will ensure you see the most current and important changes or messages.

Viewing the first page of the RA:

Health Care Authority Remittance Advice

HEALTH CARE AUTHORITY A

PO BOX 45505

OLYMPIA, WA 98504-5505
Phone (800) 562-3022

RA Number: 123456789 B

Billing Provider: 5100000004 C

D **Prepared Date:** 01/13/2023
RA Date: 01/13/2023

Page 1

If you have questions about the Remittance Advice (RA), go to http://www.hca.wa.gov/medicaid/provider/Pages/providerone_billing_and_resource_guide.aspx and then click on "Current Guide".

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

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

E
- For Health Care Authority (HCA) Medical Providers: Office of Legal Affairs at P.O. Box 45504, Olympia, Washington 98504-5504 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): Department of Corrections, Medical Disbursement Unit (MDU) at 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 send a written denial of charges.

Your request for review must be in writing:

- Be sent by Certified Mail (return receipt) or other manner that proves that MDU or HCA have received your request. You may be required to prove that your request was received by MDU or HCA.
- 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.

The following information displays:

A. Provider demographic information

B. The number assigned to the RA.

C. The NPI provider number used in billing ProviderOne.

D. The payment date and the date this RA was prepared.

E. The main body of this RA page is our newsletter with important provider update information (sometimes specific to certain provider groups).

You can call the IVR to check your warrant (check) amount (see Appendix L).

Reviewing the summary page

The summary page lists all claim payments by sections and all other payment and adjustment amounts.

You can find out the total amount of your Electronic Funds Transfer (EFT) or warrant (check) and how ProviderOne determined that amount.

RA Number: 123456789
Warrant/EFT # 123456! A Warrant/EFT Date: 12/08/2022
Prepared Date: 12/09/2022
RA Date: 12/09/2022

Warrant/EFT Amount: $367808.08 B Payment Method: Check

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
9991118882	Paid C	$3,565,979.70	$642,398.02	$850.69	$0.00	$337.65	$396,293.96
9991118882	Denied	$5,692,237.80	$0.00	$0.00	$0.00	$0.00	$0.00
9991118882	Adjustments D	-$187,481.35	-$79,841.70	$0.00	$0.00	$0.00	-$34,060.85
9991118882	In Process	$2,415,404.48	$0.00	$0.00	$0.00	$0.00	$0.00

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
9991118882	2223334445556/ 301436500011122 000	System Initiated	NOC Invoice	$0.00	$0.00	$5,336.57
9991118882	2223334445556/ 301436500011122 000	System Initiated	NOC Referred to CARS	$5,336.57	$5,336.57 E	$0.00
9991118882	3335559996667/ 301437800022299 000	System Initiated	NOC Invoice	$0.00	$0.00	$158.87
9991118882	3335559996667/ 301437800022299 000	System Initiated	NOC Referred to CARS	$158.87	$158.87	$0.00
9991118882	99966885/ 301855500055530 000	System Initiated	P1 Off Recoupment	$72.77	$20.99 F	$51.78
9991118882	99966885/ 301855500055530 000	System Initiated	P1 Off Recoupment	$14.95	$14.95	$0.00

The following information displays:

A. Check number and date of payment.

B. Total payment received on the check (warrant) or EFT.

C. Total of the paid claims on this RA

D. Deduction due to a claim adjustment from the total paid amount.

E. Deduction due to an overpayment (NOC Referred to CARS)

F. Deduction due to a provider adjustment (P1OFF Recoupment)

Adjustment types

The summary page of the RA can show several different adjustment type codes. The adjustment type is a result of your actions on a claim(s), or an action initiated by the ProviderOne system. The following table indicates the adjustment type and explains what they are:

Adjustment type	Definition
P1Off invoice	This occurs when you owe HCA payment due to adjustments exceeding payments. In these cases, HCA creates an account receivable, which is satisfied by either: • Taking payment from a future paid claim, or • Through a receivable sent to CARS (Collections and Accounts Receivable System) to initiate the recovery. The latter only happens if the P1OFF is not satisfied after six months, at which point it becomes an ATC Referred to CARS (see below).
P1Off recoupment	This identifies the payments used to satisfy HCA's accounts receivable. This typically posts immediately following a P1OFF invoice line.
NOC invoice	A Non-Offset receivable is created for transfer to CARS. The creation of this receivable can be a result of voiding a claim or net negatively adjusting a claim. These are caused by: • Adjusting an old claim • Payment Review Program (PRP) recoupment of an old claim • HCA doing a mass adjustment which affects old claims
NOC referred to CARS	A claim is adjusted but ProviderOne will not use paid claims to satisfy the amount owed. Instead, these amounts are referred directly to OFR for recovery.
CASH RECEIVED invoice	HCA has received a check from you and now the claims are adjusted to account for the cash received.
CASH RECEIVED cash application	You sent HCA a check for money owed to the agency which was applied to the receivable in the accounting system.
ATC referred to CARS	ProviderOne tried to recover money you owed HCA but did not have a sufficient total of claim payments post in the last six months to satisfy the debt. At this point the remaining balance is submitted to the OFR for collection.

Adjustment type	Definition
COFF invoice	CARS 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 HCA 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 the OFR for collection.

Legend for above acronyms:

- OFR: Office of Financial Recovery
- OFIN: Oracle Financial System
- CARS: Collections and Accounts Receivable System (OFR recovery)
- NOC: Non-Offset to CARS
- ATC: Automatic Transfer to CARS
- COFF: CARS Offset (lien)
- P1OFF: ProviderOne Offset (claim adjustment)

FIN invoice number

Each adjustment type displayed on the RA generates an invoice account. ProviderOne assigns a Financial Invoice Number (FIN) to each account that displays on the RA. Only finance staff have access to these account numbers in the system. Updates to ProviderOne now provide the original TCN/claim number along with the invoice number to help identify the original payment involved in the adjustment. Use this TCN to determine the client ID and the date of service the adjustment occurred on.

Most common adjustment types

The most common adjustment type is the P1OFF which is an offset resulting from a claim (or several claims) being net negatively adjusted or voided.

- A net negative adjustment is when a claim is originally paid then adjusted and the adjusted claim gets denied.
- Adjusting a claim usually creates a “credit,” then a “debit” repays the amount on the same RA and the system does not generate a P1OFF. ProviderOne is

supposed to credit, and debit adjusted claims on the same RA in order not to create unnecessary P1OFF accounts.

- A voided claim will create a P1OFF which may or may not be recouped on the same RA.

Finding P1OFF invoice claim(s)

The original claim number that was involved in the adjustment appears in the FIN Invoice Number column related to the P1OFF. Use this claim number to determine the client and date of service for this adjustment. If there are multiple P1OFFs listed, there is a possibility that they could carry over onto the subsequent weeks' RA, until the debt(s) owed is satisfied.

Satisfying P1OFF adjustments

P1OFF invoices are cleared when enough new claim payments are generated for the RA reporting period. Clearing a P1OFF invoice requires that two transactions display on the summary page:

- The P1OFF – Invoice which is the amount owed the state; and
- The P1OFF – Recoupment which is the amount taken from the new claim payments to satisfy the offset amount.

The RA will display the total recoupment amount as the total adjustment amount at the bottom of the adjustment type list side of the summary page.

Calculating the P1OFF dollar amount

Sometimes the P1OFF recoupment amount is not fully satisfied by the new claim payment amounts so ProviderOne carries the balance forward to the next RA as a new P1OFF invoice amount. The new P1OFF invoice amount does not match any claim paid amount, but the FIN Invoice Number and the associated TCN can be used to track the client and date of service the adjustment is for. This new P1OFF invoice amount will be satisfied with new claim payments generated in the ProviderOne system.

What to do if the dollar amounts still do not match

It can be difficult to track claim payments, P1OFF recoupments, and the actual check generated for the week. If there were a large amount of P1OFF invoices, they could carry over onto several RAs and all those RA summary pages are needed to balance actual payments. All the figures should eventually balance out:

- Claim payment(s) plus
- Positive or negative adjusted claim amounts, total then minus
- Total adjustment amount, equals
- Actual check amount

Cash refunds

You can refund overpaid claims by sending in a check. These show up on the RA as CASH RECEIVED adjustment types.

Other adjustment types

Other adjustment types may occur when ProviderOne recoups claims:

- For non-compliance to program rules

- Overpayments
- A P1OFF – invoice over 6 months old; or
- COFF invoice
- Other adjustment reasons

A letter requesting payment from you usually accompanies these other adjustment types.

Failing to review any payment adjustments, which could be mistaken as an underpayment or an overpayment by the agency.

Pitfalls

Failing to review any payment adjustments, which could be mistaken as an underpayment or an overpayment by the agency.

Reviewing paid claims

The remittance advice shows all claims generated or in process during the previous week, divided into paid, denied, adjusted, and in process claims.

Review the paid claims section(s):

- There may be more than one paid claim section depending upon what services were provided and have been paid. For example, if there were billings for children's Early and Periodic Screening, Diagnosis and Treatment exams (EPSDT) there would be a "Paid claims – EPSDT claims" section that is separate from the "Paid claims – professional claims" section.
- Be aware of the possibility of multiple paid claim sections to ensure that account payments for all paid claims listed on the RA get posted.

Example of professional (physician) paid services:

RA Number: 111222333 Warrant/EFT #: 000001! Warrant/EFT Date: 12/16/2022 Prepared Date: 12/16/2022 RA Date: 12/16/2022
Category: Paid Billing Provider: 5100000004 Page 3

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN /	TCN / Claim Type / RX Claim # / Inv # / Auth # /	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsibility Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
DOE, JOHN 999999997WA	20223450003711500 Professional Claim	1		12102022-12102022	92507	1.000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.41		
Document Total: 12/10/2022-12/10/2022						1.000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.71		
DOE, JANE 999999998WA	20223450003711800 Professional Claim	1		12112022-12112022	92507	1.000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.41		
Document Total: 12/10/2022-12/10/2022						1.000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.71		

Some paid claims may also contain denied service lines. These will also be displayed in the paid claims section within the specific claim that was paid but will have the same remark codes and adjustment reason codes as denials in the denied section.

Pitfalls

- Missing a paid claim section. This may result in an unnecessary call to the Medical Assistance Customer Service Center (MACSC), or a claim rebill that causes extra work for both you and HCA.

Reviewing denied claims

Locate the denied claims section on the RA:

RA Number: 111222333 Warrant/EFT #: 000001! Warrant/EFT Date: 12/16/2022 Prepared Date: 12/16/2022 RA Date: 12/16/2022
Category: Denied Billing Provider: 5100000004 Page 10

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 Responsibility Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
DOE, JOHN 999999997WA	20223450003711500 Professional Claim	1		12102022-12102022	92507	1.000	$47.41	$0.00	$0.00	$0.00	$0.00	$47.41	N288	16 = $47.41
Document Total:				12/10/2022-12/10/2022		1.000	$47.41	$0.00	$0.00	$0.00	$0.00	$0.00	N288	16 = $47.41
DOE, JANE 999999998WA	20223450003711800 Professional Claim	1		12112022-12112022	92507	1.000	$47.41	$0.00	$0.00	$0.00	$0.00	$0.00	N288	16 = $47.41
Document Total:				12/10/2022-12/10/2022		1.000	$47.41	$0.00	$0.00	$0.00	$0.00	$0.00	N288	16 = $47341

Look for the HIPAA adjustment reason and remark codes to determine why the claims denied. Every denied claim will have a claim adjustment reason code. Some will also have a remittance advice remark code for further information. If you are unable to understand the reasons a claim denied, a customer service representative can assist at the Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022. They can assist in reprocessing your claim if ProviderOne denied the claim in error. You can also submit a Contact Us email for assistance on denied claims.

After reviewing the adjustment reason codes and remark codes, determine the denial reason and if the claim can be corrected. Resubmit the claim when:

- The entire claim is denied.
- An individual line on a professional/dental service multiple line claim is denied. This line can usually be rebilled as a new claim.
- The paid professional/dental claim can be adjusted to correct an error on the denied line of a multiple line claim.

You have two years to get the claim rebilled or resubmitted, referencing the original claim number. Medicare crossover claims must be submitted initially within six months of Medicare's process date, with two years from Medicare's "from" date of service for resubmissions.

Pitfalls

- Missing a denied claim section on the RA.
- Overlooking a claim or line that needs to be rebilled or resubmitted and delay payment.
- Overlooking rebilling or resubmitting a claim or line until it is past the timely billing period.
- Overlooking rebilling or resubmitting a claim until it is past the primary payer's timely billing period.

Reviewing adjusted claims

This section of the RA lists claims that have been adjusted or modified after the original submission. You may have sent in an adjustment request to correct a paid claim or ProviderOne initiated an adjustment. Adjusted claims may or may not affect the amount of the payment for services, depending on the changes made.

Page through the RA until the section category labeled "adjustments" is found:

RA Number: 111222333 Warrant/EFT #: 000001! Warrant/EFT Date: 12/16/2022 Prepared Date: 12/16/2022 RA Date: 12/16/2022

Category: Adjustments Billing Provider: 5100000004 Page 6

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 Responsibility Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
DOE, JOHN 999999997WA 302215300164976000	402234500037115000 Professional Claim	1		12102022-12102022	96150 26	1.0000	-$47.41	-$47.41	$0.00	$0.00	$0.00	-$47.41		119 = $0.00
	402234500037115000 Professional Claim	1		12102022-12102022	92101 U7	1.0000	-$10.00	-$10.00	$0.00	$0.00	$0.00	-$10.00		119 = $0.00
Document Total:				12/10/2022-12/10/2022		2.0000	-$57.41	$0.00	$0.00	$0.00	$0.00	-$57.41	CREDIT	0.00
DOE, JOHN 999999997WA 302215300164976000	402233100037711800 Professional Claim	1		12102022-12102022	96150 26	1.0000	$47.41	$47.41	$0.00	$0.00	$0.00	$47.41		
	402233100037118000 Professional Claim	1		12102022-12102022	92101 U7	1.0000	$10.00	$10.00	$0.00	$0.00	$0.00	$10.00		
Document Total:				12/10/2022-12/10/2022		2.0000	$57.41	$57.41	$0.00	$0.00	$0.00	$57.41	DEBIT	
Category Total:						4.0000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		
Billing Provider Total:						11.0000	$200.00	$182.00	$0.00	$0.00	$0.00	$182.00		

- Adjustments to modify or correct claim billing errors utilize these basic accounting principles and will have two transactions displayed on the RA:
  - The Credit transaction is a copy of the original claim with dollar amounts listed as a negative.
  - The Debit transaction is a repayment that displays the modification or corrections made to the original claim and the associated repayment dollar amounts.
  - ProviderOne will then subtract the original payment amount from the adjusted claim payment amount and include this difference in the current payment amount.

The adjustment to the original claim may reduce the adjusted claim payment resulting in a subtraction in the current payment amount. If you owe more money from adjustments to claims than they earned from other paid claims on the current RA, you may be in a "credit balance" situation. HCA will wait until you have been paid enough through subsequent billings to satisfy the "credit balance" before making an actual payment. An RA will be made available weekly in any case.

Pitfalls

- Not reviewing the adjustment section, as there may be paid and denied claims in this section.

Reviewing in process claims

This section of the RA displays claims that are currently in process. These claims are in the payment system but are usually pending review by claims processing staff and will show up on a future RA as a paid or denied claim.

Review the section under the "in process" claims category:

RA Number: 111222333 Warrant/EFT #: 000001! Warrant/EFT Date: 12/16/2022 Prepared Date: 12/16/2022 RA Date: 12/16/2022
Category: In Process Billing Provider: 5100000004 Page 26

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 Responsibility Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
DOE, JOHN 999999997WA	20223450003711500	1		12102022-12102022	92507	1.000	$47.41	$0.00	$0.00	$0.00	$0.00	$47.41		
Document Total: 12/10/2022-12/10/2022						1.000	$47.41	$0.00	$0.00	$0.00	$0.00	$0.00		

Pitfalls

- Rebilling claims because you do not see them in the other sections of the RA; make sure to review the claims "in process" section.

Reviewing EOB codes

There could be many reasons a claim may have denied, or additional information was added to a processed claim. You can find these HIPAA adjustment reason codes and remark codes on the last page of your RA.

Download the PDF file of the remittance advice, locate the claim denial code, and then scroll down to the last page of the RA to find the code and code definition.

Adjustment Reason Codes / NCPDP Rejection Codes
16 : Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remark Codes
N288 : Missing/incomplete/invalid rendering provider taxonomy.

The complete list of standardized adjustment reason and remark codes are located on the X12 organization's website.

Pitfalls

- Not downloading the RA to find the denial codes.
- Not reviewing the adjustment reason code and the remark code if both are on the denied claim.

Requesting prior authorization

The authorization intake process

New functionality was implemented in 2018 to allow providers to enter authorization requests through the direct data entry (DDE) feature in the ProviderOne portal. Since the COVID-19 pandemic, mailed requests will no longer be supported.

The DDE prior authorization process is the agency's preferred method. The requests are received directly in ProviderOne and allow uploading of photos, x-rays, and/or chart notes to support the authorization request. Authorization requests submitted without supporting documentation for medical necessity can cause delays in processing.

Any information related to mailing authorization requests or using the mail for submitting required backup for authorization requests has been removed from this section of the guide.

This section shows how to:

Locate the training materials for entering authorization requests through the DDE process.

- Locate the General Information for Authorization HCA form, 13-835, for fax submission only.
- Fill out the authorization form with the required information.
- Navigate the ProviderOne fax intake process.
- Check the status of your authorization request, using the DDE process.
- Submit additional supporting documentation with HCA cover sheets or the DDE process when needed.

This section does not apply to pharmacy authorization, Long Term Acute Care (LTAC), or Physical Medicine and Rehabilitation (PM&R) admissions. For more information on the prior authorization process and for self-service training materials on entering prior authorizations through the ProviderOne portal, visit the Prior Authorization webpage.

Why is requesting authorization important?

Some Medicaid-covered procedures require prior authorization. If you need to determine if the service requires authorization, please review the section titled Determine if Apple Health covers the service and if so, is prior authorization (PA) required.

Authorization for a service does not guarantee payment. You must meet administrative requirements (e.g., client eligibility, claim timeliness, third party insurance, etc.) before ProviderOne pays for services.

This section will discuss how to submit your authorization request. Doing so according to agency's guidelines will help expedite the authorization process.

DDE prior authorization intake process

There are three resources for step-by-step instructions on submitting authorization requests using the ProviderOne provider portal depending on the type of service you are requesting:

- DDE authorization submission for medical providers
- DDE authorization submission for dental providers
- DDE authorization submission for DME providers

General Information for Authorization form, HCA 13-835

Beginning the authorization process requires downloading and completing the General Information for Authorization form, HCA 13-835. Once completed, fax to 1-866-668-1214.

> **Note**: Always go to HCA forms website to ensure use of the most current form. Do not print the form to copy and use later.

- Find information specific to the most common service types on the back of the General Information for Authorization form, HCA 13-835.
- The General Information for Authorization form 13-835 must be the first page of the fax.
- Do not use a cover sheet when faxing an authorization request.
- A confirmation fax will be returned to the sending fax if the fax number can be identified by caller ID. This fax confirmation does not guarantee that the request has been entered into the ProviderOne system; it just means that HCA has received the fax.

Pitfalls

- Handwriting the authorization request form. Forms that are handwritten will be returned to you.
- Using a cover sheet when faxing in an authorization request; the authorization form must be the first page of the fax, or it will be returned to you.
- Using an NPI that is not on your ProviderOne account (you can confirm you are using the correct NPI by checking Step 1 in your ProviderOne file).
- Using an NPI for a servicing provider in field nine instead of the "pay-to provider". Always use the NPI of the entity that will be paid for the service.

Submitting backup for DDE authorizations

Follow the steps in the linked processes on the Prior Authorization webpage (or links above sorted by category of service) to submit any photos, x-rays, or chart notes required for review of a prior authorization request.

Submitting backup for faxed authorizations (no x-rays)

Prior authorization requests can be faxed to 1-866-668-1214. If the forms are sent correctly, they can be processed and loaded into ProviderOne with very little human intervention. Please follow these instructions when submitting the request:

- Place the General Information for Authorization form, HCA 13-835 as the first page of your fax.
- Do not use your own cover sheets. The first page of the fax must be the General Information for Authorization form 13-835.
- Please make sure the settings on your fax machine are for 8½ x 11 size and photo quality.

Another option for sending dental photos or x-rays for prior authorization is the FastLook and FastAttach services provided by the National Electronic Attachment, Inc. (NEA) (no affiliation with ProviderOne/HCA). You may register with NEA by visiting the NEA website. Contact the NEA at 800-782-5150 extension 1 for questions. Choosing this option, you can fax your request to HCA and indicate the NEA# in the NEA field on the authorization request form.

Pitfalls

- Handwriting the authorization form. Forms that are handwritten cannot be scanned and will be returned to you.
- Using a cover sheet when faxing the authorization form to HCA. The first page of the fax must be the General Information for Authorization form, HCA 13-835.
- Using automated outbound fax technology that has altered the paper size to less than 8 ½ x 11.
- Not having the date stamp on your fax machine current.
- Not setting your fax machine to photo quality images.

Checking PA status

You can verify receipt of your request by HCA using self-service options. You can also check the status of the authorization to see where it is in the review process.

There are two ways you can verify the status of your request, Check the status of an authorization using the ProviderOne provider portal, or using the Medical Assistance Customer Service Center (MACSC) interactive voice response (IVR) system.

Review Appendix G for instructions on using the IVR to check status, using ProviderOne to verify status, and for definitions of the different types of authorization statuses used in processing authorization requests.

Pitfalls

- Calling the Medical Assistance Customer Service Center and waiting on hold to talk with an agent to check status. You can check the status of your request without having to wait to speak with a customer service representative.

Additional documentation requests

Once HCA receives your authorization request, it will proceed through the review process. We may request additional information to process the authorization.

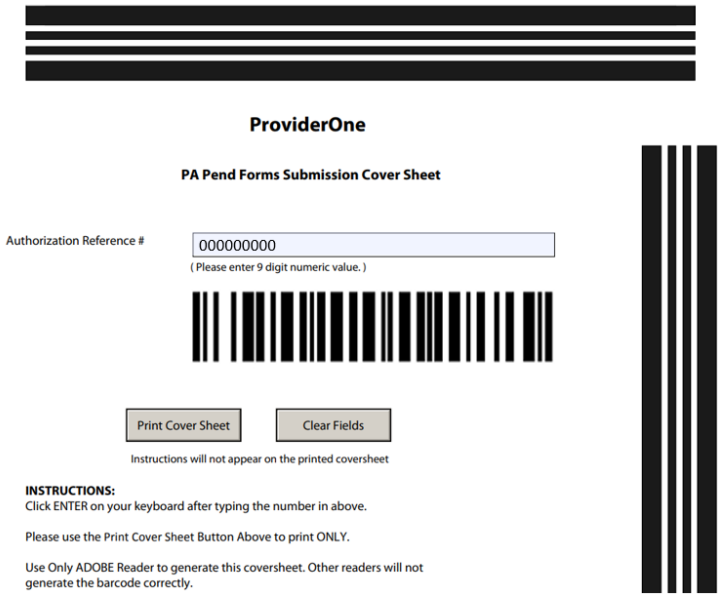
If you receive a request for supporting documentation and your authorization request was submitted through the DDE submission process using the provider portal, follow the instructions for ProviderOne DDE PA pend process to submit the information requested by the agency. You may only submit additional documentation to your online request if the status is "pending".

Use a cover sheet if you are faxing supporting documentation or responding to a request from HCA for additional information.

Cover sheets for many different tasks are available on this webpage. Please use the "Prior Authorization Pend Forms" cover sheet for submitting additional information to an existing authorization request. You will need to know the authorization number to use this cover sheet.

After selecting this form, you will be asked to fill in the "Authorization Reference # field" which is the prior authorization number. Make sure you key in the nine-digit number. Do not copy and paste the PA number into the authorization reference number field.

Once you enter in the number and click enter, a barcode generates on the cover sheet. This bar code enables our scanning system to read the number so that ProviderOne can electronically attach the documentation to your prior authorization request. Print out the completed form and attach it to the supporting documentation.



Cover sheet tips

- Always use the PA pend form when submitting additional information to attach to an existing authorization as requested by the agency.
- Click the enter key or click outside the field after typing in the complete authorization number so the barcode is created. Cover sheets without completed barcodes will be returned to you.
- You must submit a separate cover sheet for each authorization you are submitting backup documentation for.
- You can save the link to the cover sheets webpage as a "Favorite," but do not save completed forms for re-use on future authorization requests.
- If you are creating multiple cover sheets, make sure to select Clear Fields before entering the next authorization number.

Non-scannable cover sheets

It is important that the ProviderOne scanning technology reads the barcode on the cover sheet to properly attach the documentation to your authorization request. If the fax quality is poor or the barcode is incomplete, it will not scan correctly into ProviderOne.

- Avoid handwriting the authorization number.
- Avoid submitting poor quality images with black dots or smudges.
- Set your fax to "photo quality" images to improve readability.
- Cover sheets with incomplete barcodes cannot be scanned.

Pitfalls:

- Not completing the barcode. If you do not click outside the field or press enter after you type in the Authorization Reference #, the barcode will not be created.
- Using the Client ID instead of the authorization reference number. You must enter the prior authorization number on the cover sheet.
- Sending a cover sheet that is a poor quality image; barcodes must be readable by the ProviderOne scanning system.
- Sending an original authorization request form 13-835 when sending in additional information to attach to an existing record.

For more information

- Webinars
- Fact sheets
- Billers and providers webpage
- Health Insurance Portability and Accountability Act (HIPAA) homepage
- Provider guides and fee schedules
- Hospital Finance Rates and Contact Us webpage
- Claims and billing resources

- Enroll as a provider
- Contact Medicaid
- Prior authorization

Appendix A: Verify eligibility with IVR

Client eligibility – use keypad only
Dial 1-800-562-3022
Select 1 for English or stay on the line
"If you have an extension, press 1 now."
Select 2 for self-service provider menu
Select 4 for client eligibility
Enter NPI when prompted
Enter client id – numbers only

What will I hear?

The IVR will play only the information specific to the client. The types of information available are:

- Services card ID number
- Program medical coverage (i.e., CNP)
- Managed care plan name
- Medicare Parts A-D
- Private insurance
- Hospice
- Long term care
- Provider restrictions

More details are available for each of the above options such as beginning and end dates, as well as contact names and phone numbers. After hearing the list, enter the number noted for that selection:

- Medicaid – 1
- Managed care – 2
- Medicare - 3
- Insurance coverage – 4
- Hospice – 5
- Long term care – 6
- Restrictions – 7
- Check coverage for another person - 8

Appendix B: Verify eligibility with magnetic card readers

Magnetic card reader

The option is available to use a magnetic card reader to access eligibility information for clients using the services card. HCA will not provide or sell readers. While swipe card technology gives providers an easy and immediate way to check eligibility, there are other low or no-cost inquiry methods.

- Mini magnetic card readers attach to PC screen and UB connection
  - Provider "swipes" services card
  - Eligibility information is displayed on the PC screen
  - Providers can print the screen

- Desktop magnetic card readers connect directly to the internet
  - Provider "swipes" services card
  - Eligibility information is printed line by line

The Health Care Authority – Washington Apple Health does not favor, endorse, or recommend magnetic card readers over any other inquiry method, and does not favor, endorse, or recommend any magnetic card reader model or vendor over any other model or vendor. HCA and its employees have neither a financial interest, nor any other type of interest, in which inquiry method you choose.

For providers choosing the card reader option, you will need a card reader that is configured appropriately, and you will be subject to a monthly subscription fee to access the secure network that connects to ProviderOne eligibility data. Providers are encouraged to shop for the model and vendor that best meets their needs.

For additional information and configuration questions or assistance, please submit a ticket to HIPAA-Help@hca.wa.gov.

Appendix C: Managed care organizations

Send all claims for services covered under the client's managed care plan to that plan for payment. Managed care plans cover a range of services depending on the program type. For more information about the range of services or covered services in each contract see the Apple Health (managed care) medical programs webpage.

The following are subject to change:

- **Wellpoint, Washington (WLP, formerly Amerigroup)**

  1-833-731-2274

  https://www.provider.wellpoint.com/

- **Community Health Plan of Washington (CHPW)**

  1-800-440-1561

  http://www.chpw.org

- **Coordinated Care of Washington (CCW)**

  1-877-644-4613

  http://www.coordinatedcarehealth.com

- **Molina Healthcare of Washington (MHC)**

  1-800-869-7175

  http://www.molinahealthcare.com

- **United Healthcare Community Plan**

  1-877-542-9231

  http://www.uhccommunityplan.com/health-professionals/wa.html

- **Beacon Health Options**

  1-855-228-6502

  https://www.beaconhealthoptions.com

Appendix D: Casualty and health insurance claims

Casualty claims routinely investigated for possible third-party coverage are:

- Motor vehicle accidents
- Accidents occurring in a place of business, public building, in the home or on the property of another person.
- Litigation involving a malpractice claim.
- Department of Labor and Industries claims.
- Injury diagnoses and services performed in a hospital or physician's office.

While a provider's Apple Health casualty claim is pending investigation, the provider must call HCA using the toll-free number 1-800-562-3022 only if the provider has additional insurance information. When the investigation is completed, HCA makes payment or gives the provider the name and address of the party responsible for payment. If the provider receives payment from an insurance company for services that have been paid by HCA, the provider must immediately refund to HCA either HCA's payment or the insurance payment, whichever is less. If the refund is not made within 30 days, HCA recovers the lesser payment.

Mail refund checks to:

THE HEALTH CARE AUTHORITY

COB CASUALTY UNIT

PO BOX 45561

OLYMPIA WA 98504-5561

Health insurance claims

Third party liability claims other than those for trauma-related injuries are considered health insurance claims. These claims are routinely held for Third Party Resources (TPR) investigation when:

- HCA's records indicate insurance benefits are available through a third party.
- Other resources are indicated on the claim or attachment (name of insurance company, insurance pending, etc.).

Appendix E: Benefit service packages

Categorically Needy Program (CNP)

This program has the largest scope of care. A few of the services are doctors, dentists, physical therapy, eye exams, eyeglasses (children only), mental health, prescriptions, hospitals, and family planning for men, women, and teens. There is limited coverage for maternity case management, orthodontia, private duty nursing, and psychological evaluations. Chiropractic care and nutrition therapy are limited to the Healthy Kids program.

Alternative Benefits Plan (ABP)

This program is available to persons eligible to receive health care coverage under Washington Medicaid's Modified Adjusted Gross Income (MAGI)-based adult coverage. The scope of services available is equivalent to that available to CNP-covered clients with the addition of a benefit for habilitative services. Washington Administrative Code (WAC) program policies are applicable to this new eligibility group, as are the instructions in the ProviderOne Billing & Resource Guide and program-specific provider guides. This client population does not include those eligible for Medicare.

Apple Health Expansion (AHE)

This program covers many of the basic services such as doctor and dental visits, prescriptions, behavioral health, and hospitalizations. However, some services such as long-term care are not included in this coverage. This client population does not include those eligible for federally funded programs.

Emergency Related Services Only (ERSO) – PA may be required

This program has coverage for only specific medical conditions: a qualifying emergency, end stage renal disease on dialysis, cancer actively receiving treatment, or post-transplant status on anti-rejection medications. Prior authorization for some services may be required. Services not related to the medical condition are not covered. HCA determines if the client has a qualifying condition for any of these programs in accordance with the Washington Administrate Code (WAC) criteria. For specific details please see Chapter 182-507 WAC.

Take Charge – Family Planning Service Only (TCFPO)

This program is for both women and men. It covers family planning services such as annual examinations, family planning education and risk reduction counseling, FDA approved contraceptive methods such as birth control pills and IUDs, emergency contraception, and sterilization procedures.

Family Planning Services Only (FPSO)

This program is for women. Services include coverage for all birth control methods, sterilization, OB-GYN exams, and counseling to help with family planning.

Medical Care Services (MCS) - no out of state care

This program covers many of the most basic services such as doctor and dental visits, prescriptions, and hospitalizations. However, some services such as mental health treatment may have restrictions that require prior authorization or may not be covered. This benefit was previously known as General Assistance (GA) and Disability Lifeline (DL).

Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) - no out of state care

This program covered many of the most basic services such as doctor's visits, prescriptions, and hospitalizations. However, some services, such as dental and mental health treatment may have restrictions that require prior authorization or may not be covered. Coverage is equivalent to Medical Care Services (MCS) below, with the addition of treatment for alcohol and drug addiction.

Limited Casualty Program – Medically Needy Program (LCP-MNP)

This program covers many medical services. A few of the services are doctors, dentists, eye exams, eyeglasses (children only), mental health, prescriptions, and hospitals, family planning for men, women, and teens. There are some services that are not covered, such as physical therapy. There are also limited services: maternity case management is one example. Chiropractic care and nutrition therapy are limited to the Healthy Kids program.

Qualified Medicare Beneficiary (QMB) – Medicare Only

This Medicare Savings Program pays for Medicare Part A and B premiums and pays for deductibles, coinsurance, and copayments according to Medicaid rules.

Specified Low-Income Medicare Beneficiary (SLMB)

This Medicare Savings Program only pays for Medicare Part B premiums. Health coverage through Apple Health Medicaid is not covered.

Qualified Individual 1 (QI-1)

This Medicare Savings Program only pays for Medicare Part B premiums. Health coverage through Apple Health Medicaid is not covered.

Qualified Disabled Working Individual (QDWI)

This Medicare Savings Program only pays for Medicare Part A premiums. Health coverage through Apple Health Medicaid is not covered.

Inpatient Psychiatric Care Only (IPCO)

This program covers services given in a psychiatric institution/hospital. Other services are not covered.

For more information, please submit questions to Contact Us.

ACES program codes

Some provider groups rely on the ACES program codes to help them determine if the client is on a state-only program or is on an Apple Health (Medicaid) program to identify their funding sources. The following table lists these program codes.

Category	ACES	Description	BSP
SSI and SSI related, also called Aged/Blind/Disabled (ABD); disability is determined by SSA or by NGMA referral to DDDS	S01	SSI recipients	CNP
	S02	ABD categorically needed	CNP
	S03	QMB Medicare savings program (MSP) Medicare premium and copays	MSP
	S04	QDWI Medicare savings program	MSP
	S05	SLMB Medicare savings program - Medicare premium only	MSP
	S06	QI-1 (SLMB) Medicare savings program	MSP
	S07	Undocumented alien - Emergency related service only	ERSO
	S20	Apple health expansion (AHE)	AHE
	S95	Medically needy no spenddown	MNP
	S99	Medically needy with spenddown	MNP
SSI related healthcare for workers with disability	S08	Healthcare for workers with disability CNP premium based program - substantial gainful activity (SGA) not a factor in disability determination	CNP
SSI related living in an alternate living facility (nonmedical institution), adult family home, boarding home, or DDD group home	G03	Non institutional medical in ALF CNP income under the SIL plus under state rate x 31 days + 38.84	CNP
	G95	Medically needy non-institutional in ALF no spenddown	MNP
	G99	Medically needy non-institutional in ALF with Spenddown	MNP
Institutional HCBS waivers (HCS/DDD) and hospice	L21	DDD/HCS waiver on SSI	CNP
SSI and SSI related	L22	DDD/HCS waiver – gross income under the SIL	CNP

Category	ACES	Description	BSP
	L24	Undocumented alien/non-citizen LTC – residential placement; must be preapproved by ADSA program manager; Emergency related service only (45 slots)	ERSO - CNP
	L31	PACE or hospice on SSI (effective 10/1/2015)	CNP
	L32	PACE or hospice – SSI-related (effective 10/1/2015)	CNP
	L41	Roads to community living on SSI (effective 10/1/2015)	CNP
	L99	Roads to community living – SSI related (effective 10/1/2015)	CNP
Non-institutional community first choice Personal care services in the community	L51	Community first choice (CFC) on SSI (effective 10/1/2015)	CNP
	L52	Community first choice (CFC) – SSI related at home or in an ALF (effective 10/1/2015)	CNP
Institutional SSI - related Residing in a medical institution 30 days or more	L01	SSI recipient in a medical institution - residing in a medical institution 30 days or more	CNP
	L02	SSI related CNP in a medical institution income under the SIL	CNP
	L04	Undocumented alien/non-citizen LTC must be pre-approved by ADSA program manager; Emergency related service only (45 slots)	ERSO - CNP
	L95	SSI related Medically needy no spenddown Income over the SIL; Income under the state rate	MNP
	L99	SSI related Medically needy with spenddown; income over the SIL; income over the state rate but under the private rate; locks into state NF rate	MNP
Institutional family/children TANF related income/resource rules	K01	Categorically needy family in medical institution	CNP

Category	ACES	Description	BSP
	K03	Undocumented alien family in medical institution - Emergency related service only	ERSO
	K95	Family LTC Medically needy no spenddown in medical institution	MNP
	K99	Family LTC Medically needy with spenddown - in medical institution	MNP
Pregnancy	P02	Pregnant 185% of FPL & postpartum extension	CNP
	P04	Undocumented alien pregnant woman	CNP
	P05	Family planning service only	Family planning
	P06	Take charge family planning only	
	P99	Medically needy pregnant spenddown	MNP
Refugee medical assistance	R02	Transitional 4 month extension	CNP
	R03	Refugee Categorically needy	CNP
DCFS/JRA medical foster care	D01	SSI recipient FC/AS/JRA Categorically needy	CNP
	D02	FC/AS/JRA Categorically needy	CNP
	D26	Title IV-E Federal foster care	CNP
Family related medical assistance	F01	TANF cash and Medicaid (ended 9/30/2013)	CNP
	F02	Transitional Medicaid	CNP
	F03	Post TANF child/spousal support (4 months max - ended 12/31/2013)	CNP
	F04	TANF related	CNP
	F05	Newborn	CNP
	F06	Categorically needy medical children (effective 1/1/2009, this may be CNP Medicaid children or CNP State funded children)	CNP
	F07	Children's health insurance program	CNP

Category	ACES	Description	BSP
	F08	Undocumented alien children (this coverage group ended 12/31/2008 and is merged with the F06 group)	CNP
	F09	Undocumented alien – Emergency related service only	ERSO
	F10	Interim Categorically needy (2 months max - ended 12/31/2014)	CNP
	F99	Medically needy children spenddown	MNP
MAGI family related medical assistance	N01	MAGI parent/caretaker Medicaid; adult	CNP
	N02	12-month transitional MAGI parent/caretaker Medicaid; adult	CNP
	N03	MAGI pregnancy	CNP
	N04	After pregnancy	CNP/ABP
	N05	MAGI adult Medicaid; income =<133% (Medicaid expansion)	ABP
	N07	After pregnancy; not Medicaid eligible during pregnancy	CNP
	N10	MAGI newborn medical/birth to one year	CNP
	N11	MAGI children's Medicaid/age under 19	CNP
	N13	MAGI Children's health insurance program (CHIP) children under 19; premium payment program	CNP
	N20	Apple health expansion (AHE)	AHE
	N21	MAGI parents/caretaker; Emergency only; AEM	ERSO
	N23	MAGI pregnancy; not lawfully present	CNP
	N24	After pregnancy; not lawfully present	CNP
	N25	MAGI adult Medicaid; non-citizen - income =<133% (Medicaid expansion) AEM	ERSO

Category	ACES	Description	BSP
	N27	After pregnancy; not lawfully present; not Medicaid eligible during pregnancy	CNP
	N31	MAGI Children's medical; under 19; non-citizen	State funded CNP
	N33	MAGI Children's health insurance program (CHIP): under 19; premium payment program, non-citizen	State funded CNP
ADATSA State program drug & alcohol TX program	W01	ADATSA Medical state funded (ended 12/31/2013)	State funded
	W02	ADATSA Medical state funded (ended 12/31/2013)	State funded
	W03	Detox medical state funded (ended 12/31/2013)	State funded
Medical care services and ABD cash with CN Medicaid	G01	MCS Medical care services (ended 8/31/2014)	State funded
	A01	MCS Medical care services – non-citizen (Aged/Blind/Disabled)	State funded
	A05	MCS Medical care services – non-citizen (under 65, incapacitated)	State funded
	A24	MCS Medical care services – non-citizen SFA for Survivors of certain crimes	State funded
	G02	ABD cash plus either: ABD-X Presumptive SSI Federally funded CN Medicaid (ended 12/31/2013) ABD-A Federally funded CNP - AGED (ended 8/31/2014) ABD-D Federally funded CNP- NGMA disability determination (ended 8/31/2014)	CNP
Mental health institutional	I01	Inpatient psychiatric (mental health - ended 12/31/2013)	CNP
Breast and cervical cancer program	S30	Breast and cervical cancer (Health Department approval)	CNP

Category	ACES	Description	BSP
Take charge	P06	Family planning (Take charge)	Family planning
Psychiatric inpatient	M99	Psychiatric indigent inpatient spenddown (MI prior to 7/2003) Mental health ONLY (ended 12/31/2013)	Inpatient psychiatric hospital only
Tailored supports for older adults (TSOA) HCS maintains TSOA cases	T02	TSOA-**No medical benefits and no Medicaid services card issued** Pre-Medicaid benefit for the caregiver of a person 55 or older to support the caregiver. For those not eligible for a CN or ABP Medicaid program and not needing or eligible for other LTSS services because of resources. Must meet NFLOC.	No medical benefits

For a high-level scope of care table for services covered by these programs see Health Care Coverage Program Benefit Packages and Scope of Service Categories.

Appendix F: Prior authorization process

Authorization for services does not guarantee payment. Providers must meet administrative requirements (client eligibility, claim timeliness, third-party insurance, etc.) before HCA pays for services. For more information on prior authorization and for self-service training materials on entering prior authorization requests through the ProviderOne portal, visit the Prior Authorization webpage.

Download the General Information for Authorization form, HCA 13-835.

> **Note**: See page two of the General Information for Authorization form, HCA 13-835, for complete instructions about completing the authorization form.

When faxing the General Information for Authorization form, HCA 13-835:

- Do not use a cover sheet when faxing an authorization request.
- Make the General Information for Authorization form, HCA 13-835 the first page of the fax.
- Only send one request form at a time.
- Disable the "bundle" setting for multiple fax transmissions when sending to a single fax number. If this function is not disabled, the entire bundle of faxes will be sent under the first cover sheet and cannot be scanned correctly.

A confirmation fax will be returned to the provider if the sending fax number can be identified by caller ID.

Appendix G: Authorization status using the IVR

There are two ways to check the status of a ProviderOne authorization request: using the Interactive Voice Response (IVR) and using the ProviderOne portal.

Checking authorization status using Interactive Voice Response (IVR)

Authorization status – use keypad only
Dial 1-800-562-3022
Select 1 for English or stay on the line
"If you have an extension, press 1 now."
Select 2 for self-service provider menu
Select 1 for authorization
Select 1 for pharmacy authorizations
Select 2 for medical, dental, or other authorizations
Enter NPI when prompted
Select 2 for get status
Choose option 1 to search by authorization number
Choose option 2 to search by client ID/date of birth

What will I hear?

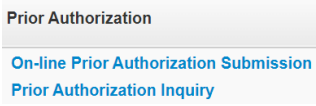
The IVR will play the information only to the provider(s) identified on the authorization. Search by the client's services card number and date of birth, or by the authorization number. If multiple authorization numbers are found, narrow the search with an NDC or service code, as well as an expected date of service. The types of information available are:

- Authorization number
- Status date
- Status, such as:
- Approved
- In review
- Denied

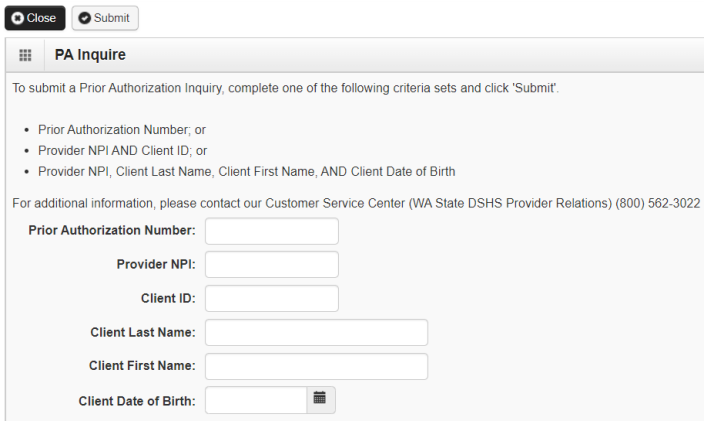
- Referred
- Pending
- Cancelled

Checking authorization status using ProviderOne

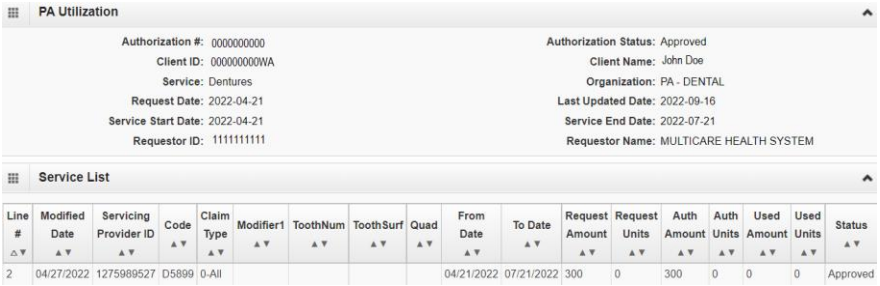
Select **Provider Authorization Inquiry** from the provider home page:



Enter the search criteria using one of the three inquiry options and click on the submit button:



The system will return the authorization status:



Any one of the following may appear in the authorization status field:

Status	Meaning
Error	There is an error in ProviderOne that will be cleared once the request is worked. No action is needed by the provider.

Status	Meaning
Requested	HCA received the requested authorization.
In review	The authorization is in review.
Canceled	The authorization request is canceled.
Pended	Requires additional information to decide on the request.
Referred	Request has been forwarded to a second level reviewer.
Approved/hold	Request approved, but additional information is necessary before the release of authorization for billing.
Approved/denied	Partially approved and some services have been denied.
Rejected	Returned to the provider as incomplete.
Approved	HCA has approved the request.
Denied	HCA has denied the request.

Appendix H: Cover sheets for backup documentation

Use a cover sheet when submitting backup documentation to a claim or an authorization. Cover sheets help HCA quickly match backup documents to claims submitted using Direct Data Entry (DDE) or by batch submission. Backup documentation for claims can be faxed or mailed, however supporting documentation for prior authorization requests must be faxed.

These cover sheets are necessary when submitting backup documentation without the original claim or prior authorization form.

While performing tasks in ProviderOne, the system will sometimes prompt the user to print a cover sheet. For example, when clicking the "submit claim" button while entering a DDE claim, the system will display a popup box asking if you want to send backup documentation. By clicking on the "OK" button, ProviderOne will go directly to the document submission cover sheet page.

On the document submission cover sheet webpage, click on the document hyperlink for the cover sheet you want to use. Below is a list of forms to use and a description of their purpose (forms that apply to pharmacies only are not listed).

Cover sheet name	When would it be used?
Claim attachments	Use this cover sheet when mailing or faxing backup documentation required for a dental, institutional, or professional claim. The TCN from the claim is required to use this form.
Prior authorization pend forms	Use this cover sheet when submitting the supporting documentation for a prior authorization (PA) request in pended status. You must use the authorization number to use this cover sheet. **Backup information to support prior authorization requests must be faxed.**

After choosing the appropriate cover sheet, the provider must fill in pertinent information such as TCN. Once the required information is entered into the form, click "enter" or click outside of the field, and a barcode will be generated. Then print the completed form by clicking on the PRINT button (NOT: File/Print). Do not make any modifications to these forms other than filling out the required information and generating the barcodes. The barcode contains critical information that helps HCA link the supporting documents to the claim or PA request in ProviderOne.

After printing the completed form, attach it to the supporting documentation and submit by fax (only option for prior authorization requests) to 1-866-668-1214 or by mail to:

Heath Care Authority

RE: Cover sheets and backup documentation

PO Box 45535

Olympia, WA 98504-5535

A few tips about cover sheets:

- Submit a separate cover sheet for each claim number (TCN) or client authorization that requires backup.
- If faxing multiple requests, make sure each request has its own cover sheet.
- When mailing multiple sets of documentation for claims, mail in a single envelope with a cover sheet for each.
- Save the link to the cover sheets webpage as a "Favorite", but always use cover sheets printed from the website to make sure you have the most current version. Do not save and re-use them. Each cover sheet has barcodes generated specific to each claim or request.
- Do not use a cover sheet when submitting an initial prior authorization request, if submitting using the 13-835 General Information for Authorization.

Note: When filling out the cover sheet, be sure to fill in all the fields with information:

- Do not add a zero to any field if the information for that field is not available when filling out the cover sheet. Obtain the information, then fill in the fields and print.
- Do not hand write on the cover sheet after printing.
- Do not save the cover sheet for reuse. Each cover sheet is specific to each document sent to the agency.
- Do not use any software other than Adobe for opening and generating the cover sheet. The barcode used to link documents will not work properly using other software.

Appendix I: Taxonomy and ProviderOne

A taxonomy code indicates provider type, specialty, and subspecialty. You will need to use a taxonomy for billing and servicing (if applicable) providers on all claims submitted in ProviderOne.

The general term "taxonomy" refers to a classification system. For medical billing and payment, "provider taxonomy" refers to the national provider classification system defined by the Centers for Medicare and Medicaid Services (CMS). This national classification system is part of the National Provider Identification (NPI) rule of the Health Insurance Portability and Accountability Act (HIPAA).

Apple Health requires taxonomy on Medicare crossovers. You must include taxonomy on Medicare claims when the client is also eligible for Medicaid as a secondary payer. Medicare will pass the taxonomy on these claims to Apple Health. If the taxonomy is missing on Medicare claims passed to Apple Health, these claims will deny. In addition, Apple Health does not receive TPL claims directly from other payers (other than Medicare). When billing the agency directly for TPL coverage, follow Apple Health rules about taxonomy (i.e., make sure the taxonomy is associated with the provider and that the taxonomy description aligns with the service).

There are three steps to using taxonomy in ProviderOne:

1. Verify the taxonomy to be billed is loaded in your ProviderOne account:
    - This information can be found under Manage Provider Information on the Provider Portal.
    - On the Business Process Wizard (BPW) page, taxonomy is referred to as Specializations.
    - There are 2 profiles in ProviderOne that allow the user to edit or add to your account: EXT Provider File Maintenance and EXT Provider Super User (other profiles may only allow viewing of the file).
    - ProviderOne uses subsets of the national taxonomies; there are many more taxonomies available that are not used by the ProviderOne system. Only those taxonomies shown in the drop down list in the provider file are being used.
2. Use the verified taxonomy for billing and rendering/servicing (if applicable) providers on the claim (this is not necessary for referring providers).
3. Make sure the service billed is allowed by the taxonomy:
    - The service on the billed claim must be associated with the taxonomy and be within the scope of licensure for the provider supplying or performing the service. For example, oxygen services require oxygen taxonomy; Durable Medical Equipment (DME) billings require DME taxonomy; dental services require a dental taxonomy, etc.

Appendix J: Medicare crossover claim payment methodology

Professional services

Refer to WAC 182-502-0110 for full details; this guide provides a summary of these rules as follows:

- ProviderOne compares Apple Health's allowed amount to Medicare's allowed amount for the service, selects the lesser amount of the two, and then deducts Medicare's payment from the amount selected.
- If there is a balance due, ProviderOne pays the client's cost sharing liability (deductible, coinsurance, or co-pay) up to the lesser of the allowed amounts.
- If there is no balance due, ProviderOne does not make any crossover claim payment because Medicare's payment exceeds Apple Health's calculated allowed amount.
    - As of 12/20/2015, for QMB clients ProviderOne began paying such claims at $0.00 instead of denying with CARC 23.
- When Apple Health does not cover the service, pricing on QMB clients will use either Medicare's allowed or a Medicaid State Plan rate appropriate to the service, whichever is less; HCA has the option to use a CMS approved negotiated rate instead and will pursue this option over time.

ProviderOne cannot make direct payments to clients to cover the client's cost sharing liability (deductible, coinsurance, or co-pay) amount of a Part B Medicare claim. ProviderOne can pay these costs to you on behalf of the client when:

- You accept assignment; and
- Total reimbursement to you from Medicare and ProviderOne does not exceed the rate in Apple Health's fee schedule.

HCA has revised procedure codes that may be non-covered by Apple Health, but the services are covered. If the service is covered by Apple Health, but the code is not, ProviderOne may pay as follows:

Medicare allowed – Medicare paid = agency payment

ProviderOne payment on crossover claims equals the lesser of the Apple Health allowed amount minus the Medicare or Part C plan payment toward the client's cost sharing liability. Payment from Medicare or the Part C plan and ProviderOne cannot exceed Apple Health's allowed amount for the service.

- The crossover claim payment cannot exceed the client's cost sharing liability.
- No payment will be made if the Medicare or Part C plan payment exceeds Apple Health's allowed amount for the service.

Institutional services

Outpatient hospital

Payment equals the lesser of the Apple Health allowed amount minus the Medicare paid amount up to the client's cost sharing liability (deductible, coinsurance, or co-pay). Total payment to you from Medicare and the agency does not exceed Apple Health's allowed amount.

RHC-Rural health clinic

For RHCs who bill for Medicare encounter services, payment equals the RHC per diem rate on file with the agency, minus the Medicare paid amount. These RHC claims are submitted using type of bill (TOB) 71x and billing provider taxonomy 261QR1300X.

FQHC-Federally Qualified Health Clinic

For Federally Qualified Health Centers (FQHCs) who bill for FQHC Services, payment equals the Medicare coinsurance amount. These FQHCs bill crossover claims using TOB 77x and billing provider taxonomy 261QF0400X.

Inpatient hospital for client with both Medicare Part A and Part B coverage

Payment equals the lesser of the Apple Health allowed amount minus the Medicare paid amount, up to the client's cost sharing liability (deductible, coinsurance, or co-pay).

Dual-eligible clients with a commercial Medicare supplement

ProviderOne will adjust any payment amounts if the client has a commercial Medicare supplement policy and that entity makes a payment after Medicare. In that case the formula is:

> Medicare payment + commercial insurance payment – total Medicaid allowed amount = agency payment

Appendix K: Checking claim status using the IVR

Check claim status – use keypad only
Dial 1-800-562-3022
Select 1 for English or stay on the line
"If you have an extension, press 1 now."
Select 2 for self-service provider menu
Select 2 for claims
Enter NPI when prompted
Enter 1 to search by TCN
Enter 2 to search by client ID
Enter 3 to search by prescription number

What will I hear?

The IVR will play only the information specific to your claims. The type of information available is dependent on the status. In addition to the claim number (TCN), you can also check the following:

- Status of paid:
  - Date paid
  - RA date
  - Amount paid
  - Warrant amount
  - Warrant number
  - RA number
  - Services dates
- Status of denied:
  - Date denied
  - Denial reasons (limited to 5)
- Status of in process:
  - Date received

  - Message if more than 30 days
- Provider menu choices:
  - Authorizations – 1
  - Check claims – 2
  - Check warrants – 3
  - Client eligibility – 4

Searching with data other than the TCN will generate additional questions:

- Client ID:
  - Date of birth
  - Search by specific date or range
- Prescription:
  - Claim more than 2 days old
  - Prescription number
  - Fill date

Appendix L: Checking warrants using the IVR

Check warrants – use keypad only
Dial 1-800-562-3022
Select 1 for English or stay on the line
"If you have an extension, press 1 now."
Select 2 for self-service provider menu
Select 3 for check warrants
Enter NPI when prompted
Enter 1 to search by most recent
Enter 2 to search by a specific date

What will I hear?

The IVR will play only the information specific to the associated provider. The types of information available are:

- Paid date
- Warrant amount (check amount)
- Warrant number (check number)
- RA number

Provider menu choices:

- Authorizations – 1
- Check claims – 2
- Check warrants – 3
- Client eligibility – 4