

Washington Apple Health (Medicaid)

ProviderOne Billing and Resource Guide

October 2020

About this guide

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

What has changed?

REASON FOR CHANGE	PAGE NUMBER	SUBJECT	CHANGE
Updates	Appendix E – page 131	F99 and P99 coverage types	Corrected description on spenddown requirements

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.

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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.

Who will benefit from this guide?

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 please refer to the [ProviderOne for social services webpage](#) for training resources.

What does this guide cover?

This guide consists of the following six sections:

Section 1: 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.

Section 2: Provider enrollment

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

Section 3: 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.

Section 4: 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.

Section 5: 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.

Section 6: Requesting prior authorization

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

Section 1: Apple Health (Medicaid) overview

What is 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.

Who are 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.

How does Apple Health (Medicaid) compare to other payers?

Washington State has a number of 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 similar to 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](#).

How is Apple Health (Medicaid) different from 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 age 65 or older, people age 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](#).

How do I identify an Apple Health client?

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 in the event that you do not have access to the client's services card. See the [Client 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.

Section 2: Provider enrollment

What are some of the benefits of being an Apple Health provider?

- 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.

How do I become 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.

What is required to become an Apple Health (Medicaid) provider?

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 \(k\)](#).

Email questions about the enrollment application fee to providerenrollment@hca.wa.gov. You may also call 800-562-3022, extension 16137.

Who may enroll as an Apple Health provider?

- 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).

Who must enroll as an Apple Health provider?

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.

Understanding policies regarding provider enrollment

- 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 completing and sending a [Medicaid Provider Termination request](#) to the Provider Enrollment unit (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.

Understanding policies regarding documentation and paper claims

- 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.

Which out-of-state bordering cities does Apple Health recognize?

([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

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?	<p>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 p.m. to 3:30 p.m.).</p> <p>The interactive voice response (IVR) phone system is available 24 hours a day, 7 days a week.</p> <ul style="list-style-type: none"> • Providers may contact MACSC at 1-800-562-3022; or • Email MACSC at Contact Us <p>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).</p>
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?	<p>See the Enroll as a provider webpage.</p> <p>1-800-562-3022 ext. 16137</p>
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?	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 ask questions about private insurance or third party liability?	<p>For private insurance claims, submit a Contact us email. Choose Medical Provider and use Private Commercial Insurance on the Select Topic dropdown.</p> <p>For casualty-related claims, call the toll free number at 1-800-562-3022.</p>

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<p>Where do I ask questions about nonemergency transportation services?</p>	<p>HCA provides access to nonemergency transportation services for clients who need help with transportation to and from their healthcare appointments.</p> <p>For more information, see the Transportation services (nonemergency) webpage or email HCA Transportation.</p>
<p>Where do I ask questions about interpreter services?</p>	<p>HCA provides access to interpreter services for clients and applicants, including clients who are deaf, deaf-blind, and hard of hearing, as well as clients with Limited English Proficiency (LEP). Effective July 1, 2018, the new contractor for these services will be provided through Universal Language Service. Please visit the Interpreter services webpage for more information about registering.</p> <p>E-mail: HCA Interpreter Services</p>
<p>Where do I obtain HCA's forms?</p>	<p>See HCA's forms and publications webpage.</p>
<p>Where can I find locations of DSHS Community Service Offices (CSO)?</p>	<p>For more information, see the Online Community Services Office (CSO) webpage on the DSHS website.</p>
<p>Where do I find locations of DSHS Home and Community Services (HCS)?</p>	<p>For more information, see the Home and Community Services Information for Professionals webpage on the DSHS website.</p>
<p>How do I find out what is included in the nursing facility per diem or general rate?</p>	<p>Contact the DSHS Aging and Long Term Support Administration (AL TSA) or call at 1-800-422-3263.</p>

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<p>How do I request authorization?</p>	<p>Visit the Prior authorization webpage for complete step by step instructions on entering prior authorization requests through the direct data entry feature of ProviderOne.</p> <p>Call 1-800-562-3022 using an extension listed below:</p> <ul style="list-style-type: none"> • Durable medical equipment and supplies, prosthetics and orthotics, and oxygen: 15466 • Dental: 15468 • Pharmacy: 15483 • Medical – Surgical: 52018 • All other medical services and enteral nutrition: 15471 <p>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.</p> <p>Authorization forms can be sent by fax or mail:</p> <p>Fax 1-866-668-1214</p> <p>Attn: [enter one of the authorization areas above] AUTHORIZATION SERVICES OFFICE PO BOX 45535 OLYMPIA WA 98504-5535</p> <p>If you are mailing/faxing supporting documentation without the original authorization request form, a cover sheet is required. See Appendix H for more information on cover sheets.</p>
<p>Where can I access provider training materials?</p>	<p>See the ProviderOne resources webpage.</p>
<p>How do I submit backup documentation for electronic claims?</p>	<p>HEATH CARE AUTHORITY RE: COVER SHEETS AND BACKUP DOCUMENTATION PO BOX 45535 OLYMPIA, WA 98504-5535</p> <p>Backup documentation must include a cover sheet as the first page and can be faxed to 1-866-668-1214.</p> <p>See Appendix H for more information on cover sheets.</p>

Important contact information

Disability Insurance	1-800-562-6074
Fraud Hotline	1-800-562-6906
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 email	hipaa-help@hca.wa.gov

Section 3: Eligibility, Benefit Service Packages, and service limits

Making sure you get paid for services covered through Washington Apple Health

Why is checking eligibility and benefit coverage important?

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 Medical Assistance Managed Care Plan.
- 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.

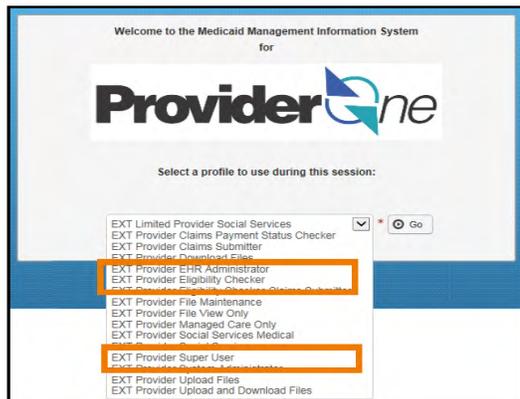
Does the client have Apple Health (Medicaid) coverage?

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.

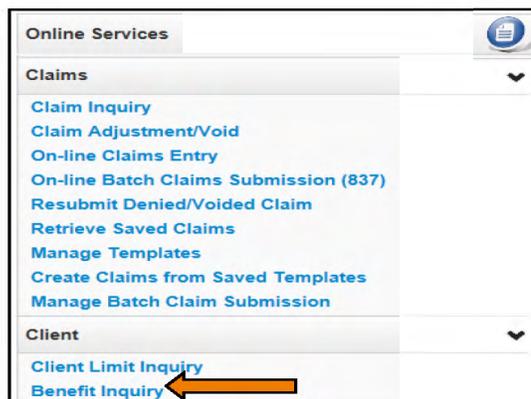
There are many methods to check client eligibility. Most of these methods involve using the ProviderOne system. Use ProviderOne to submit an eligibility inquiry using one of these methods:

- 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):

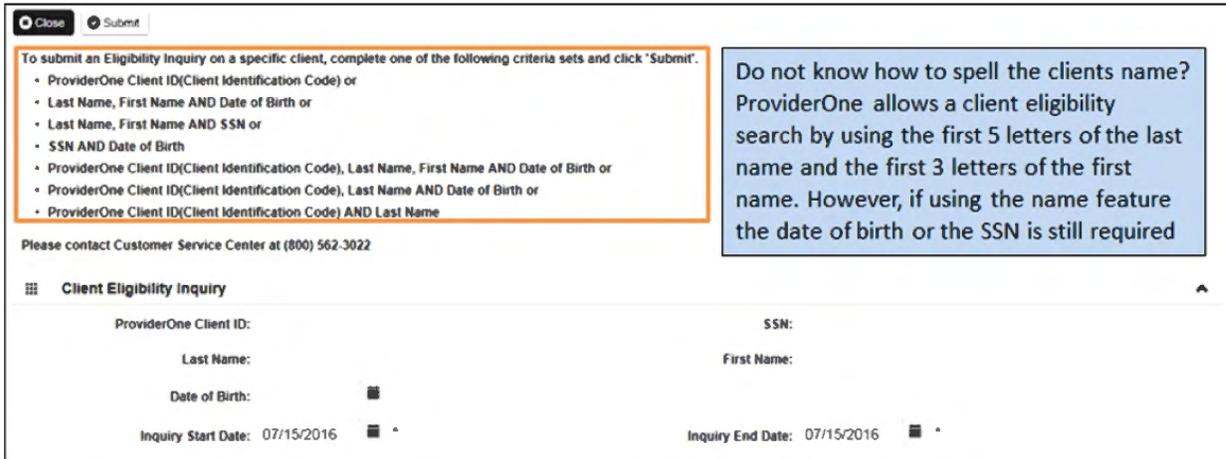


Select the **Benefit Inquiry** hyperlink from the provider portal home page menu:



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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.



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: _____

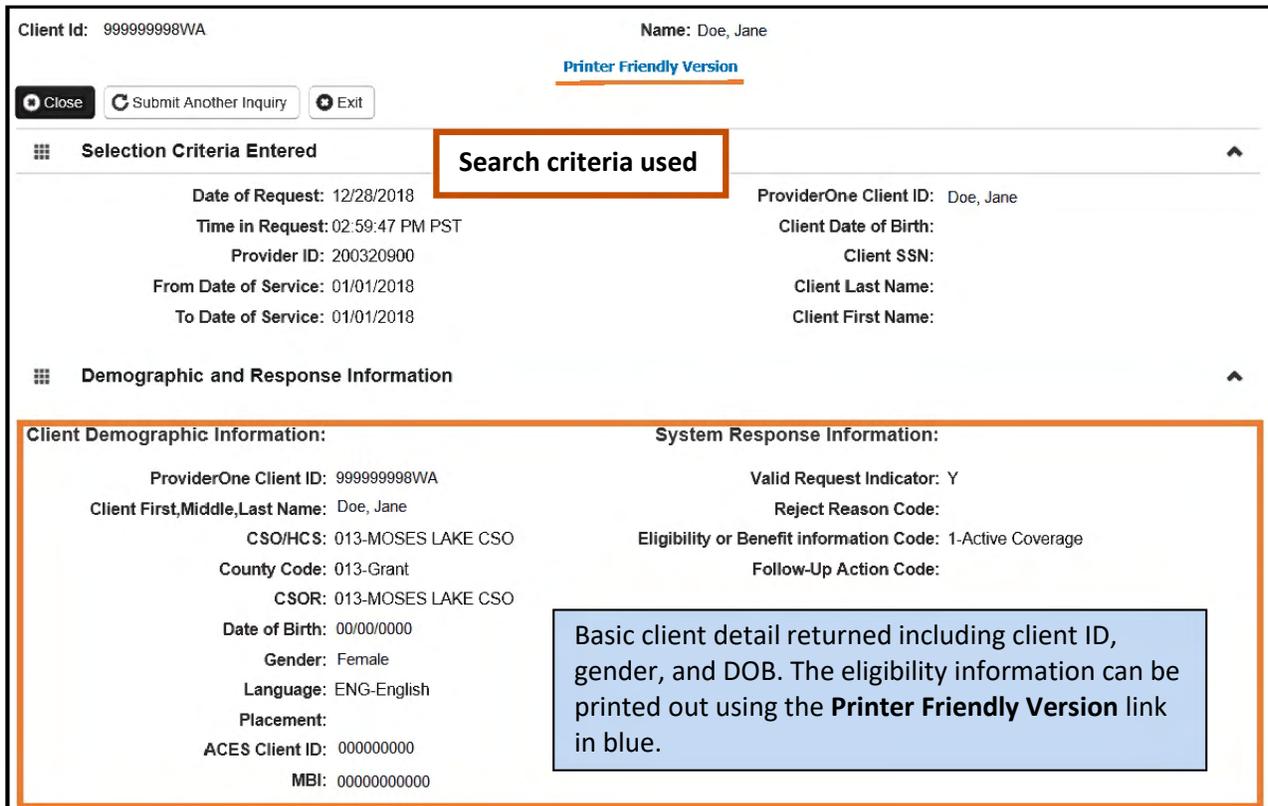
Last Name: _____ First Name: _____

Date of Birth: _____

Inquiry Start Date: 07/15/2016 Inquiry End Date: 07/15/2016

Do not know how to spell the clients 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 feature the date of birth or the SSN is still 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:



Client Id: 99999998WA Name: Doe, Jane

[Printer Friendly Version](#)

Selection Criteria Entered

Search criteria used

Date of Request: 12/28/2018 ProviderOne Client ID: Doe, Jane
Time in Request: 02:59:47 PM PST Client Date of Birth:
Provider ID: 200320900 Client SSN:
From Date of Service: 01/01/2018 Client Last Name:
To Date of Service: 01/01/2018 Client First Name:

Demographic and Response Information

Client Demographic Information:

ProviderOne Client ID: 99999998WA
Client First,Middle,Last Name: Doe, Jane
CSO/HCS: 013-MOSES LAKE CSO
County Code: 013-Grant
CSOR: 013-MOSES LAKE CSO
Date of Birth: 00/00/0000
Gender: Female
Language: ENG-English
Placement:
ACES Client ID: 000000000
MBI: 0000000000

System Response Information:

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

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

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	Recipient Aid Category	Benefit Service	Eligibility Start	Eligibility End	ACES Coverage	ACES Case	Retro	Delayed
Code	(RAC)	Package	Date	Date	Group	Number	Eligibility	Certification
MC: Medicaid	1201	ABP	02/01/2014	12/31/2999	N05			

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Message(s): This is the Client's eligibility as of this date, based on information available at this time

- A. The type of coverage for the client
- B. Recipient Aid Category (RAC)
- C. Name of Benefit Service Package (BSP)
- D. Start date for this eligibility segment
- E. End date for this eligibility segment - examine the eligibility segment end date. If no end date is determined, the system defaults to 12/31/2999.
- F. Eligibility coverage group codes assigned when eligibility is determined
- G. Assigned case number
- H. Retroactive eligibility information - this reflects the three calendar months before the month the client applied for services ([WAC 182-502-0150](#)).
- I. Delayed certification date - 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:

The screenshot displays the ProviderOne system interface. At the top, there are buttons for 'Close', 'Submit Another Inquiry', and 'Exit'. Below this, the 'Selection Criteria Entered' section is highlighted with an orange box labeled 'Search criteria used'. This section contains the following information:

- Date of Request: 12/28/2018
- Time in Request: 03:23:52 PM PST
- Provider ID: 200320900
- From Date of Service: 12/28/2018
- To Date of Service: 12/28/2018
- ProviderOne Client ID: 000000000WA (highlighted with an orange arrow)
- Client Date of Birth:
- Client SSN:
- Client Last Name:
- Client First Name:

Below the selection criteria is the 'Demographic and Response Information' section. It is divided into two columns:

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

A blue box at the bottom of the system response information section contains the text: 'If your search is unsuccessful, check how the entry was keyed into the system.'

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.

Identifying the client's 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).

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 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.

Is the client enrolled in a managed care plan?

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.

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	MHC Healthy Options				03/01/2015	12/31/2999

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 noncontract 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.

Is the client enrolled in 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 available in all regions of the state with the remaining areas of Thurston-Mason, Great Rivers, and Salish being 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	CHPW Fully Integrated Managed Care				01/01/2016	12/31/2999

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				12/01/2015	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.

Is the client enrolled in a 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.

A FFS client 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	SE WA Aging and LTC - Health Home Only				07/01/2016	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.

Start Date	End Date
08/01/2020	12/31/2999

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Is the client eligible for 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 AI/AN 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:

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	MHC Behavioral Health Services Only				03/01/2016	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 [Integrated Physical and Behavioral Health Care](#) page.

Is the client in a state-only program?

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.

Is the client enrolled with 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

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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	06/01/2020	10/31/2052

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- 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 in order 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:

- 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
- Tulalip Tribes
- Yakama Health Center
- David C Wynecoop Memorial Clinic
- Colville Indian Health Clinic
- Shoalwater Bay Tribal Clinic
- Quileute Health Clinic

Is the client covered by Medicare?

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

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Medicare Eligibility Information			
Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30 Health Benefit Plan Coverage	MA: Medicare Part A	02/01/1997	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	02/01/1997	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.

Does the client have commercial insurance, Medicare Part C or 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	CIGNA DENTAL	DN18					01/01/2012	12/31/2999
30 Health Benefit Plan Coverage	C1 Commercial	CIGNA HEALTHCARE	CH55					01/01/2012	12/31/2999

Please Note: If you know an Apple Health client has a commercial insurance and you do not see a Coordination of Benefits Information segment on their eligibility file in ProviderOne, you must complete a [Contact Us](#) email. Choose the option “I am an Apple Health (Medicaid) biller or provider” and then choose the **Medical Provider** button. On the select topic dropdown, choose **Private Commercial Insurance**. Enter the client’s insurance information in the **Other Comments** section. The agency’s Coordination of Benefits unit will update the client’s file using this information. Check eligibility again in ProviderOne in 3 – 5 business days to verify the update has been made. Only after verification of this information in ProviderOne should you bill the claim to the system.

- 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.

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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	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part D			08/01/2009	12/31/2999
30 Health Benefit Plan Coverage	C1 Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part C			08/01/2009	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.

Is the client restricted to specific providers?

[\(WAC 182-501-0135\)](#)

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
Pharmacy	SAMUEL EASTERN INC		03/21/2011	12/31/2999
Pharmacy	REIDT PHARMACY CORPORATION		03/04/2011	12/31/2999
Primary Care Physician	MINOR AND JAMES MEDICAL PLLC		02/11/2009	12/31/2999
Primary Care Physician	COMM Health Assoc of Spokane		12/01/2009	12/31/2999
Hospital	PROVIDENCE HOLY FAMILY HOSPITA		08/08/2008	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.

Does the client receive services through a hospice agency?

[\(WAC 182-551-1210\)](#)

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	
	PROVIDENCE HOSPICE OF SEAT, 425 PONTIUS AVE N STE 300, SEATTLE, WA 98109-5312			01/04/2016	12/31/2999	

See the [Hospice Services provider guide](#) for more information.

Is the client a client of the 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.

Is the client enrolled in the DOH Children with Special Health Care Needs (CSHCN) program?

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
08/05/2015	08/31/2016

Does the client have a Medicaid suspension due to incarceration or commitment to a state hospital?

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
▲ ▼	▲ ▼	▲ ▼	▲ ▼	▲ ▼	▲ ▼
MC: Medicaid	1201	ABP	06/15/2017	12/31/2999	N05
MC: Medicaid	8500	SBP - Institutionalized Dates	01/01/2017	06/15/2017	
MC: Medicaid	1201	Suspended - Inpatient Hospital Services Only	01/02/2017	06/14/2017	N05
MC: Medicaid	1201	ABP	01/01/2014	01/01/2017	N05

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.

Reviewing the Client’s 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	Recipient Aid Category	Benefit Service	Eligibility Start	Eligibility End	ACES Coverage	ACES Case	Retro	Delayed
Code	(RAC)	Package	Date	Date	Group	Number	Eligibility	Certification
▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
MC: Medicaid	1203	CNP	01/01/2015	12/31/2999	N11			

See [Appendix E](#) for an overview of Benefit Service Packages.

Client spenddown

Spenddown is a type of client liability, similar to 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	Recipient Aid Category	Benefit Service Package	Eligibility Start	Eligibility End	ACES Coverage	ACES Case	Retro	Delayed
Code	(RAC)	Package	Date	Date	Group	Number	Eligibility	Certification
▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
MC: Medicaid	1126	Pending Spenddown - No Medical	11/01/2015	12/31/2999	S99			

If the client has a pending spenddown liability amount, the current balance will be displayed in a segment that looks like this:

Client Eligibility Spans							
Spenddown Information							
RAC Code - 1126							
Base Period - Start: 02/01/2016 End: 07/31/2016							
Total Spenddown	Spenddown Liability	Remaining Spenddown	EMER Liability	Remaining EMER	Spenddown Status	Update Date	Spenddown Start Date
▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
1494.00	1494.00	1494.00	0.00	0.00	Pending	01/06/2016	02/01/2016

Frequently asked questions about spenddown

- 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 request to be transferred to the designated 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.

Reviewing Foster Care clients' medical records history

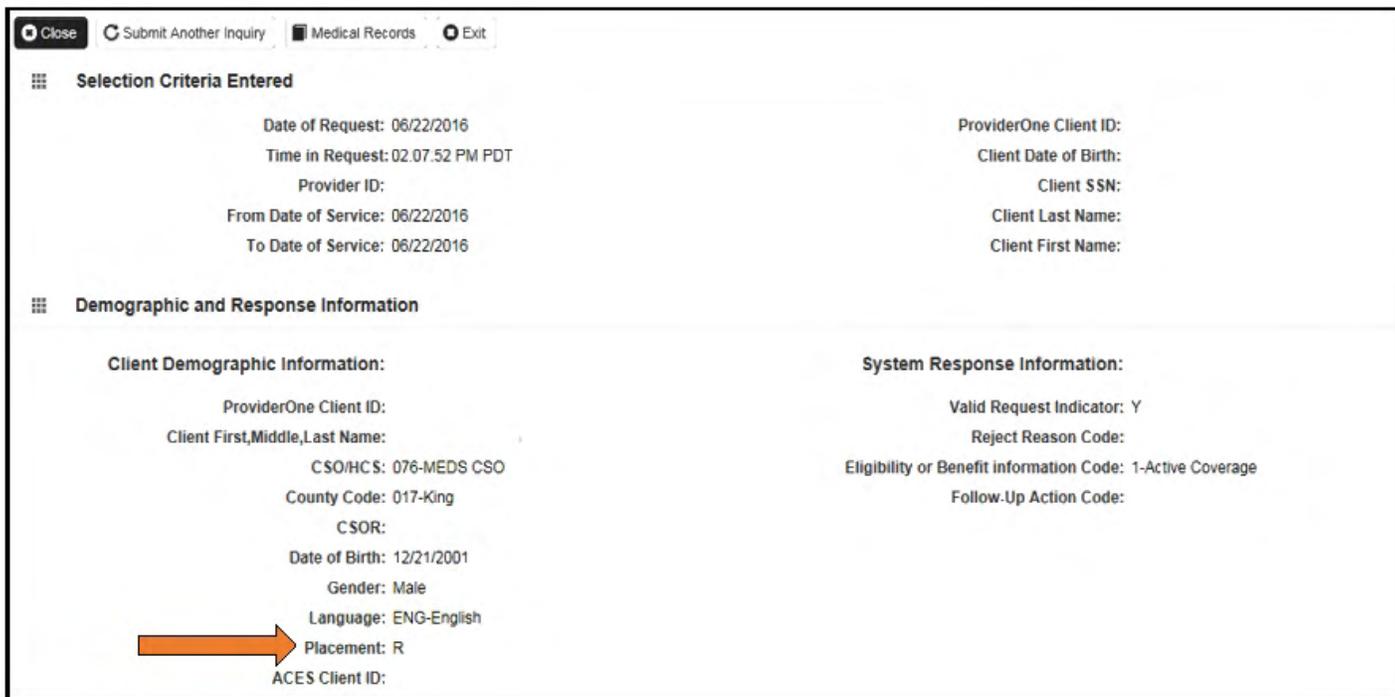
ProviderOne now gives the provider access to claims history for children in foster care. The claims history (pharmacy, dental, medical, etc.) will be available when a provider performs an eligibility check in ProviderOne.

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

Medical Records will appear at the top left of the screen:



Note: The placement code (indicated by the arrow in the image above) may allow a provider billing certain E&M codes to receive an enhanced rate for the service. 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 claim history database. Two years of data will be returned by default, regardless of the eligibility search begin or end dates.

ProviderOne Billing and Resource Guide

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:
Name:
Date of Birth:

Pharmacy

Filter By Period: All

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
04/05/2016	VITAMIN D	50000 UNIT	4	28	01		RITE AID PHARMACY	
03/16/2016	VITAMIN D	50000 UNIT	4	28	00		RITE AID PHARMACY	
03/08/2016	METHYLPHENIDATE HCL ER	20 MG	30	30	00		RITE AID PHARMACY	
01/12/2016	AMPHETAMINE/DEXTRAMPHETAMINE	0	30	30	00		RITE AID PHARMACY	
12/14/2015	AMPHETAMINE/DEXTRAMPHETAMINE	0	30	30	00		RITE AID PHARMACY	

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

Medical Services (primary and specialty care)

Filter By Period: All

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #
------------	----------	-----------------------------	-----------------------	----------------	-------------------------	-----------------------	--------------------------

The first section contains the Pharmacy claim information:

Pharmacy

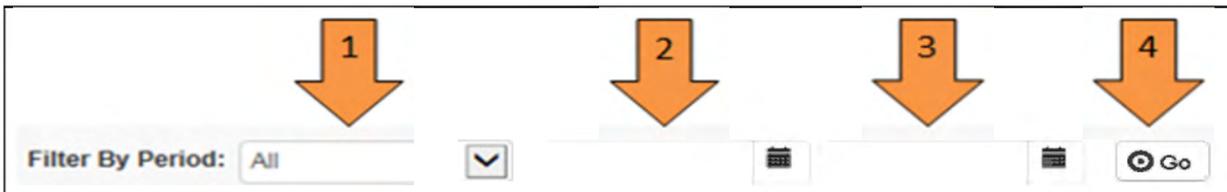
Filter By Period: All

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
04/05/2016	VITAMIN D	50000 UNIT	4	28	01		RITE AID PHARMACY	
03/16/2016	VITAMIN D	50000 UNIT	4	28	00		RITE AID PHARMACY	
03/08/2016	METHYLPHENIDATE HCL ER	20 MG	30	30	00		RITE AID PHARMACY	
01/12/2016	AMPHETAMINE/DEXTRAMPHETAMINE	0	30	30	00		RITE AID PHARMACY	
12/14/2015	AMPHETAMINE/DEXTRAMPHETAMINE	0	30	30	00		RITE AID PHARMACY	

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.

ProviderOne Billing and Resource Guide

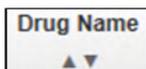
Providers have the option to **search** the pharmacy list for specific dates of service by using the “Filter By Period” option as seen in the segment below:



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.

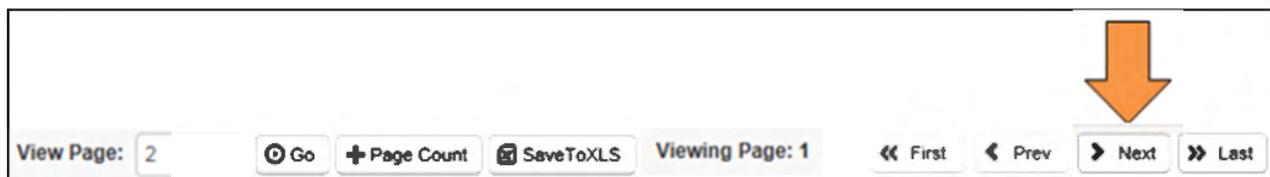
The system only sorts by one column heading at a time, however, it will sort the whole list based on the column heading chosen.



- 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 are available to view.



ProviderOne Billing and Resource Guide

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

Medical Services (primary and specialty care)							
Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #
04/07/2016	04/07/2016			D0274,D0120,D0330,D0230,D0230,T1015		Dental Clinic	
03/25/2016	03/25/2016	F419 - ANXIETY DISORDER UNSPECIFIED	F902	90834		King County	
03/25/2016	03/25/2016	F419 - ANXIETY DISORDER UNSPECIFIED	F902	H2015		King County	
03/18/2016	03/18/2016	F419 - ANXIETY DISORDER UNSPECIFIED	F902	90837		King County	
03/16/2016	03/16/2016	F419 - ANXIETY DISORDER UNSPECIFIED	F902	H0034		King County	

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								
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,” **No Records Found!** the client does not have any claims history for that section.

Does Apple Health cover the service and if so, is Prior Authorization (PA) required?

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.

Looking up the procedure code in the appropriate fee schedule

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.

Procedure code 11954 is not covered.

Procedure code 11970 is covered.

TH	CPT	SI	Description	COV	MAX UNITS	APC 2013	RW 2013	NWR 2013	OPPS Fee	OP Fee
	11952	T	Therapy for contour defects	0 NC	0000	0	0.00			
	11954	T	Therapy for contour defects	0 NC	0000	0	0.00			
	11960	T	Insert tissue expander(s)	1	1 0137	21.1752	1510.07			
	11970	T	Replace tissue expander	1	1 0051	48.2042	3437.59			
	11971	T	Remove tissue expander(s)	1	1 0022	23.2928	1661.08			
	11976	T	Removal of contraceptive cap	1	1 0019	4.717	336.38			
L	11980	X	Implant hormone pellet(s)	1	1 0340	0.6961	49.64			
L	11981	X	Insert drug implant device	1	1 0340	0.6961	49.64			
L	11982	X	Remove drug implant device	1	1 0340	0.6961	49.64			

Determining if the procedure is covered

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 COV column:

- If there is a zero (“0”) in the COV column, it is a non-covered service.
- If there is a one (“1”) in the COV column, it is a covered service.

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](#).

Determining if there is a PA requirement

The fee schedule may indicate that PA is required. 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 mailing/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 [Section 6 Prior Authorization](#) for 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.

Important: 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 does 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.

Important: 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 or 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:

1. 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](#).
2. Other provider preventable conditions (OPPCs) is 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.

Have the client's service limits been met?

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:

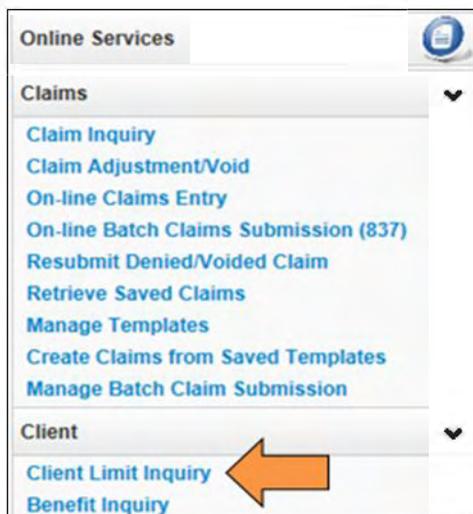
- Using the Client Limit Inquiry feature of ProviderOne, or
- Use the secure [Contact Us](#) form, or
- If the date of service is within 48 hours, call the Customer Service line at 1-800-562-3022 and follow the prompts for provider services. All other requests must utilize the [Contact Us](#) web form.

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:



ProviderOne Billing and Resource Guide

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

The screenshot shows the 'Client Limit Inquiry' form with the following fields and their corresponding numbers:

- Client Id: 1
- Date of Service: 2
- Requested unit(s): 4
- Procedure Code: 5
- Primary Diagnosis Code: 6
- Provider NPI: 8
- Facility Type: 9
- Taxonomy: 3
- Invoice Type: 7
- Modifiers: 10
- Tooth#: 11

Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.
Click this button to see available units

Get Results

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)
No Records Found !													

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:

The screenshot shows the 'Client Limit Inquiry' form with the following fields filled out:

- Client Id: 9999999999WA
- Date of Service: 06/23/2016
- Requested unit(s): 1
- Procedure Code: D1110
- Primary Diagnosis Code:
- Provider NPI: 5100000004
- Facility Type: 11-OFFICE
- Taxonomy: 122300000X
- Invoice Type: D
- Modifiers:
- Tooth#:

Below the form, a red disclaimer reads: "Disclaimer : The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment. Click this button to see available units". A 'Get Results' button is visible.

The results table below is empty, displaying the message "No Records Found !".

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)
No Records Found !													

Click the **Submit** button after completing all of the required data fields:

The screenshot shows the 'Client Limit Inquiry' form with the 'Submit' button highlighted by an orange arrow. The form fields are now populated with the following data:

- Client Id:
- Date of Service:
- Requested unit(s):
- Procedure Code:
- Primary Diagnosis Code:
- Provider NPI: 1447329578
- Facility Type:
- Taxonomy:
- Invoice Type: D
- Modifiers:
- Tooth#:

The disclaimer and 'Get Results' button remain the same.

The results table now contains one record:

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)
1200491258001	06/23/2016	9999999999WA	06/23/2016	D1110			122300000X	5100000004	D		11	1	

At the bottom of the screen, there are navigation controls: 'View Page: 1', 'Go', 'Page Count', 'Save To XLS', 'Viewing Page: 1', and 'First', 'Prev', 'Next', 'Last' buttons.

After the submit button is selected, the system clears the data boxes and displays the information entered in the form at the bottom of the client limit inquiry screen.

The actual 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 results of the limit inquiry.

ProviderOne Billing and Resource Guide

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:

Client Limit Inquiry

Client Id: *

Date of Service: * Taxonomy: *

Requested unit(s): *

Procedure Code: * Invoice Type: *

Primary Diagnosis Code: * Modifiers: *

Provider NPI: 1447320578 * Tooth#: *

Facility Type: *

Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.

Click this button to see available units

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)
1200491280001	06/23/2016	999999999WA	06/23/2016	00150			122300000X	5100000004	D		11	1	1

View Page: 1 Go Page Count Save To XLS Viewing Page: 1 First Prev Next Last

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.

Close
Submit

Client Limit Inquiry

Client Id:

Date of Service: Taxonomy:

Requested unit(s):

Procedure Code: Invoice Type:

Primary Diagnosis Code: Modifiers:

Provider NPI: 1447329578 Tooth#:

Facility Type:

Disclaimer : The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.

Click this button to see available units

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)
1200491258001	06/23/2016	9999999999WA	06/23/2016	D1110			122300000X	5100000004	D		11	1	0

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

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.

Hint 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).

FYI: 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.

Section 4: Submitting fee for service claims

Receive timely and accurate payments for covered services

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.

Determining the 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 [HIPAA Electronic Data Interchange \(EDI\)](#) webpage.

Determining if a claim needs 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 Explanations 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](#).

ProviderOne Billing and Resource Guide

See below for an example from the injectable fee schedule, J7699, which has the **AC** (acquisition cost) indicator in the reimbursement field. Refer to the [provider guides](#) to verify if an invoice will be required as backup.

632		J7681	\$0.01		
633	R	J7682	\$50.77		
634		J7683	\$0.56		
635		J7684	\$0.56		
636		J7686	DP		Outpatient Prescription Drug Program. Billable by pharmacy only
637		J7699	A.C.		
638		J7799	A.C.		
639		J7999	A.C.		Drugs billed under J7999 may require prior authorization.
640		J8498	A.C.		
641		J8499	DP		

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 in order 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 in order 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 decision made by HCA, send a written appeal using the [Contact Us](#) secure mail server (contacting the toll free line is preferred). Include any information relevant to why the claim could not be submitted within the timely filing guidelines.

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:

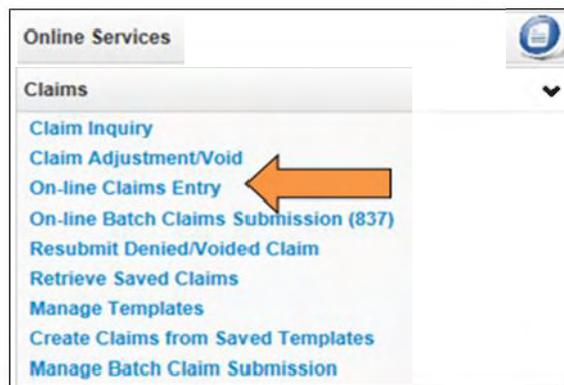
- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

Direct Data Entry (DDE) in ProviderOne

It is extremely important before claims submission to disable any pop up blockers in 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. The below information is based on choosing the **Submit Professional** option.

Choose an Option.	
Submit Professional	Submit Professional
Submit Institutional	Submit Institutional
Submit Dental	Submit Dental

For more assistance with DDE for all claim types, visit the ProviderOne resources [webinars webpage](#).

ProviderOne Billing and Resource Guide

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

Top

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 mom’s id, enter the baby’s name, baby’s birthdate, and the baby’s gender in the boxes instead of mom’s information.

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

+ Additional Subscriber/Client Information

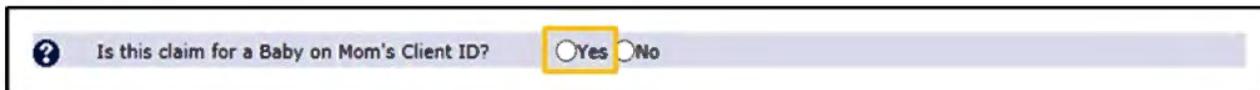
* Org/Last Name: First Name:

Date of Birth: * Gender:

Date of Death: Patient Weight: lbs

Patient is pregnant: Yes No

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



Is this claim for a Baby on Mom'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

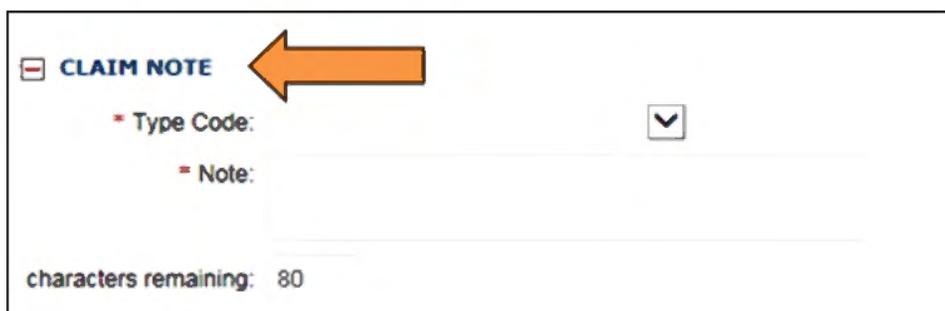
If the claim requires authorization, select the prior authorization expander and enter the authorization number:



PRIOR AUTHORIZATION

1. Prior 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.



CLAIM NOTE

Type Code:

Note:

characters remaining: 80

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

- SCI=B for baby on mom'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 =.

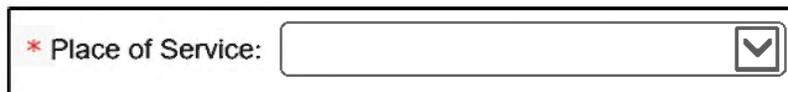
Always check **No** for the next question, claim adjudication does not use this information:



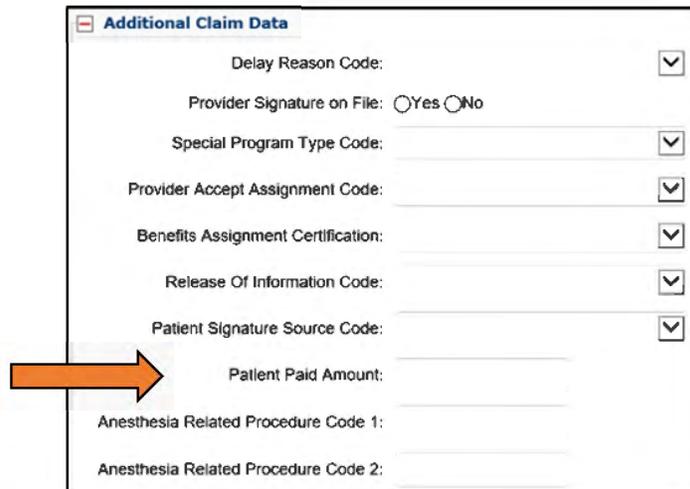
Use the **Patient Account No** field to enter any internal patient account numbers used. This information appears on the remittance advice for your convenience.



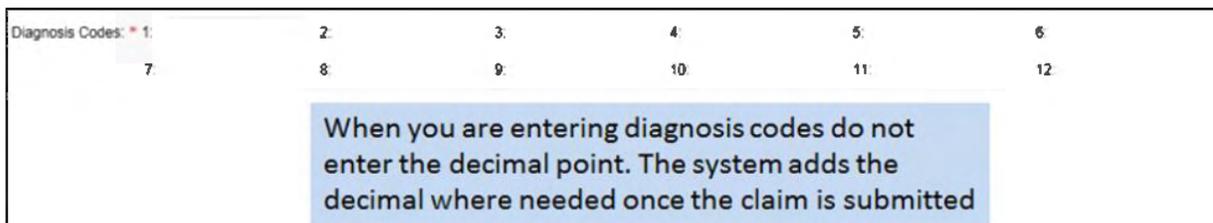
Enter the place of service code number using the drop down option.



If the client has a spenddown amount, report this on the claim by expanding 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.



ProviderOne Billing and Resource Guide

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

BASIC SERVICE LINE ITEMS

* Service Date From: mm dd ccyy * Service Date To: mm dd ccyy

Place of Service:

* Procedure Code: Modifiers: 1: 2: 3: 4:

* Submitted Charges: \$ Diagnosis Pointers: * 1: 2: 3: 4:

* Units:

Medicare Crossover Items

National Drug Code:

Drug Identification

Prior Authorization

Additional Service Line Information

- 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 pointer** number 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 the service you are billing for requires a prior authorization (PA), expand the **Prior Authorization** section and enter the PA number.
- Skip the Additional Service Line Information section

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

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



Previously Entered Line Item Information

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

Line Service Dates		Proc. Code	Modifiers				Diagnosis Pntns				Submitted Charges	Units	PA Number
No	From To		1	2	3	4	1	2	3	4			

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.

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 256.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Ptrs				Submitted Charges	Units	PA Number
	From	To		1	2	3	4	1	2	3	4			
1	06/01/2016	06/01/2016	T1015	HE				1				256.00	1	Delete or Other Service Info

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:



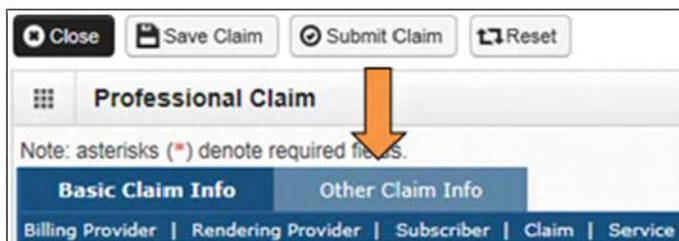
The system will change the original information to the corrected information.

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.

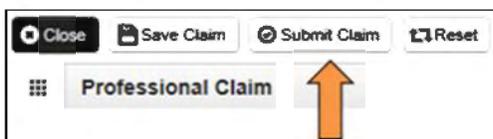
Select **Other Claim Info** at the top of the page, and then select the **Relevant Dates** expander:



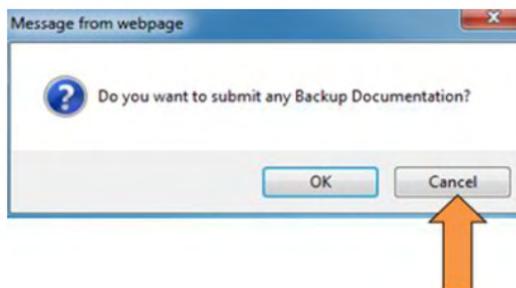
ProviderOne Billing and Resource Guide

The screenshot shows the 'Professional Claim' form. At the top, there are tabs for 'Basic Claim Info' and 'Other Claim Info'. Below the tabs, there is a 'CLAIM INFORMATION' section. The 'RELEVANT DATES' section is highlighted with an orange arrow. It contains several date input fields: 'Date Last Seen', 'Admission Date', 'Discharge Date', 'Assumed Care Date', 'Relinquished Care Date', 'Last Menstrual Date', and 'Onset of Current Illness'. The 'Admission Date' and 'Discharge Date' fields are highlighted with an orange box.

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 pop up 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 documentation for a DDE claim

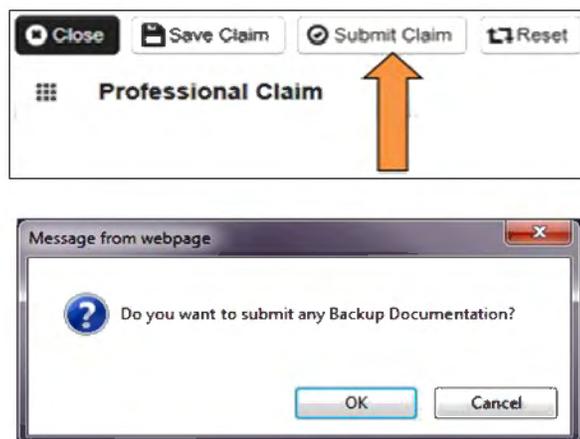
ProviderOne allows the biller to submit backup two ways to a DDE claim:

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

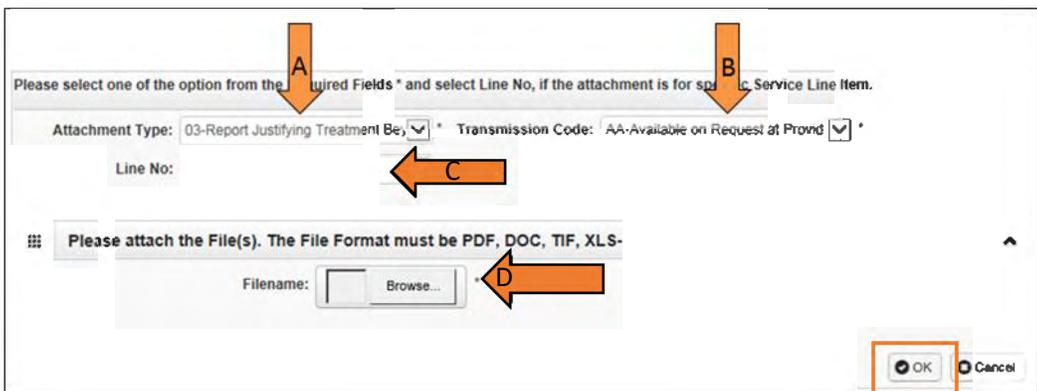
HCA policy specifies how long to hold a claim waiting for backup documentation as follows:

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

After selecting **Submit Claim**, a pop up 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:



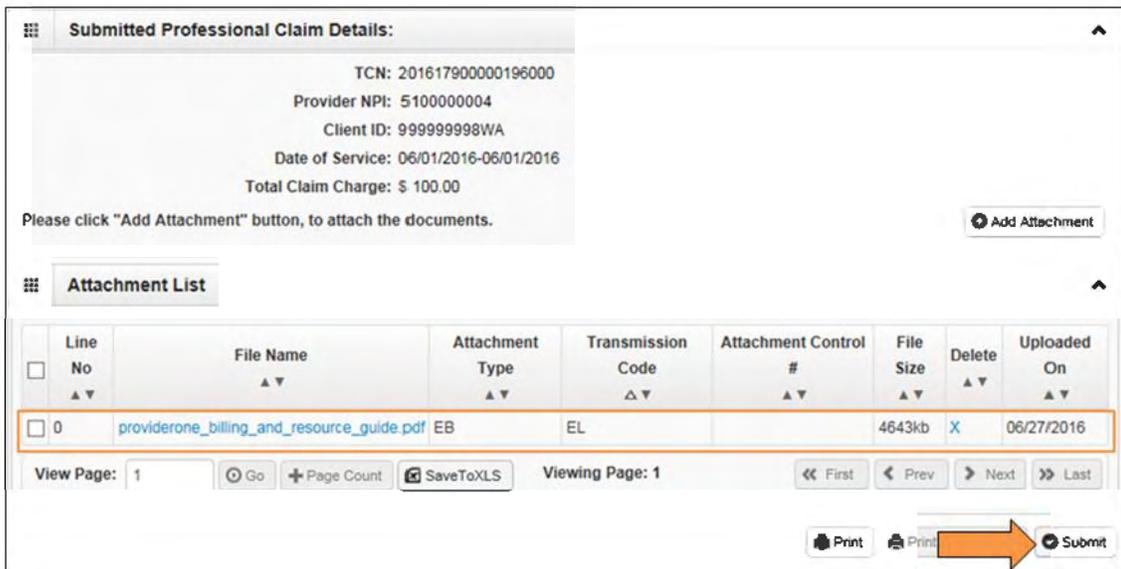
Fill in the following fields:

- 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 **browse button** to find the file on your computer to attach to your claim.
- E. 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 Sheet**:

Submitted Professional Claim Details:

TCN: 20161790000196000
Provider NPI: 510000004
Client ID: 99999998WA
Date of Service: 06/01/2016-06/01/2016
Total Claim Charge: \$ 100.00

Please click "Add Attachment" button, to attach the documents. Add Attachment

Attachment List

Line No	File Name	Attachment Type	Transmission Code	Attachment Control #	File Size	Delete	Uploaded On
0	BM	EB	BM		0kb	X	06/27/2016

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

Print Cover Page Submit

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.

The image shows a screenshot of the 'ProviderOne Claim Attachment Submission Cover Sheet' form. At the top, there are three thick black horizontal bars. Below them, the text 'ProviderOne' is centered, followed by 'Claim Attachment Submission Cover Sheet'. A 'TCN' label is positioned to the left of a light blue input field. Below the input field, a note reads '(Please enter 18 or 21 digit numeric value starting with 1,2,3,4 or 9.)'. A barcode is located below the input field. Underneath the barcode are two buttons: 'Print Cover Sheet' and 'Clear Fields'. Below the buttons, a note states 'Instructions will not appear on the printed coversheet'. The 'INSTRUCTIONS:' section follows, containing three lines of text: 'Click ENTER on your keyboard after typing the number in above.', 'Please use the Print Cover Sheet Button Above to print ONLY.', and 'Use Only ADOBE Reader to generate this coversheet. Other readers will not generate the barcode correctly.'. At the bottom left, the text 'FAX to : 1-866-668-1214.' is displayed. At the bottom center, a note reads 'THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.'. On the right side of the form, there are three thick black vertical bars.

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.

ProviderOne Billing and Resource Guide

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

The screenshot shows a web interface for a submitted professional claim. The top section, titled "Submitted Professional Claim Details:", displays the following information: TCN: 20161810000611000, Provider NPI: 999999998WA, Client ID: 999999998WA, Date of Service: 06/01/2016-06/01/2016, and Total Claim Charge: \$ 100.00. Below this, a message states "Please click 'Add Attachment' button, to attach the documents." and there is an "Add Attachment" button. The middle section, titled "Attachment List:", contains a table with the following data:

Line No	File Name	Attachment Type	Transmission Code	Attachment Control #	File Size	Delete	Uploaded On
0	BM	EB	BM		0kb	X	06/27/2016

Below the table, there are navigation controls including "View Page: 1", "Go", "Page Count", "SaveToXLS", "Viewing Page: 1", and buttons for "First", "Prev", "Next", and "Last". At the bottom right, there are "Print" and "Submit" buttons, with an orange arrow pointing to the "Submit" button.

To submit 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 submission errors

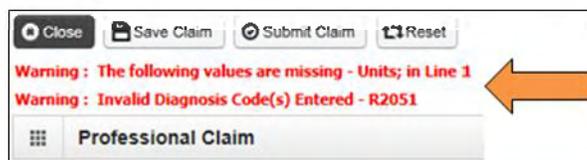
During the process of submitting a DDE claim, ProviderOne does a data check prior to submission to verify the following required entries:

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

Errors can come in two formats. A pop up 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. 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 AD16.

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	AETNA US HEALTHCARE	AD16					01/01/2016	12/31/2999

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

Other Payer Information

Payer/Insurance Organization Name: AETNA

Additional Other Payer Information

Entity Qualifier: [dropdown]

*ID: AD16 *ID Type: PI-Payor Identification [dropdown]

Claim Check or Remittance Date: mm dd yyyy

Number Type: [dropdown] PA/Referral No.: [dropdown]

Payer Claim Adjustment: Yes No

Secondary ID Information

COB Monetary Amounts

COB Payer Paid Amount: 100.00 [input field]

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:

The screenshot shows a form titled "COB Monetary Amounts". At the top, there is a field for "COB Payer Paid Amount" with the value "100.00". Below this is a section for "Additional COB Information" which is currently collapsed, indicated by a plus sign and an orange arrow pointing to the right. Underneath is the "CLAIM LEVEL ADJUSTMENTS" section, which is expanded. It contains a table with five rows. The first row is populated with "1 * Group Code: PR-Patient Responsibility", "Reason Code: 96", "Amount: 100.00", and "Quantity:". The remaining four rows are empty, showing only the column headers: "2 Group Code", "Reason Code:", "Amount:", and "Quantity:".

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 of your TPL claim. 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 in the near future 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

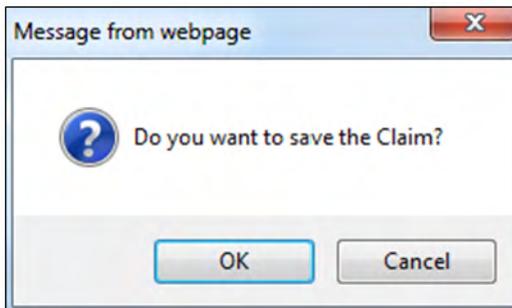
- Question: Is this claim accident related?

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:



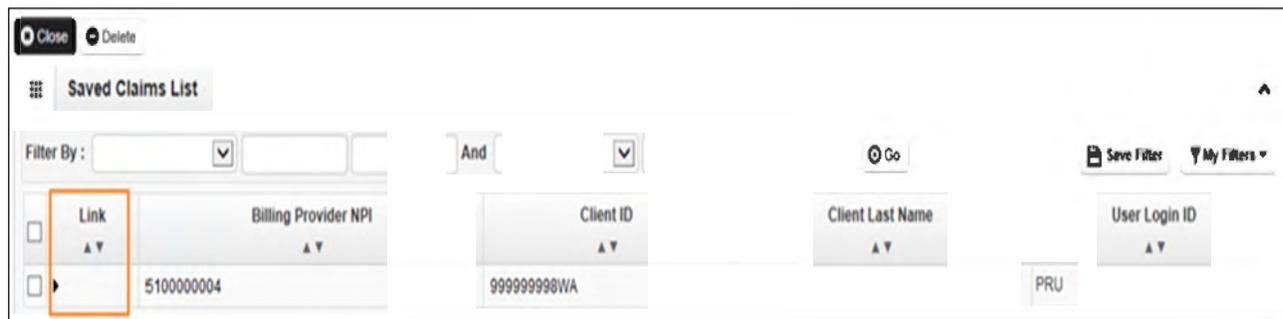
Select **OK** to proceed or **Cancel** to return to the claim. When you select **OK**, ProviderOne will check the claim to ensure the minimum data fields are completed, and if so will save and close the claim.

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:



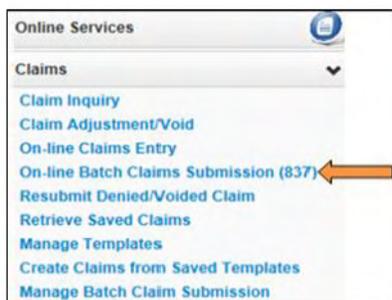
The system loads the saved claim in the professional DDE screens. Continue to complete any required fields and submit the claim.

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**:

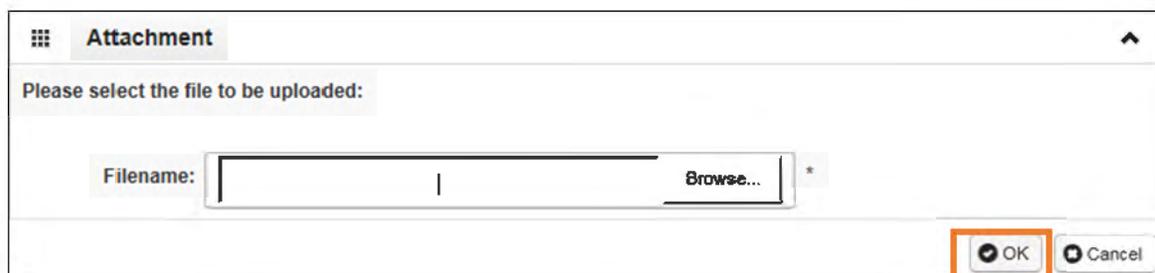
On the provider portal, select **Submit HIPAA Batch Transaction (837)**:



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



Select **Browse** 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](#).

Entering 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 MOMS 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 mom’s ID.
- Forgetting to click submit on the bottom of the last pop up 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 pop up blocker when using ProviderOne, which is necessary for you to get to the final pop up 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:

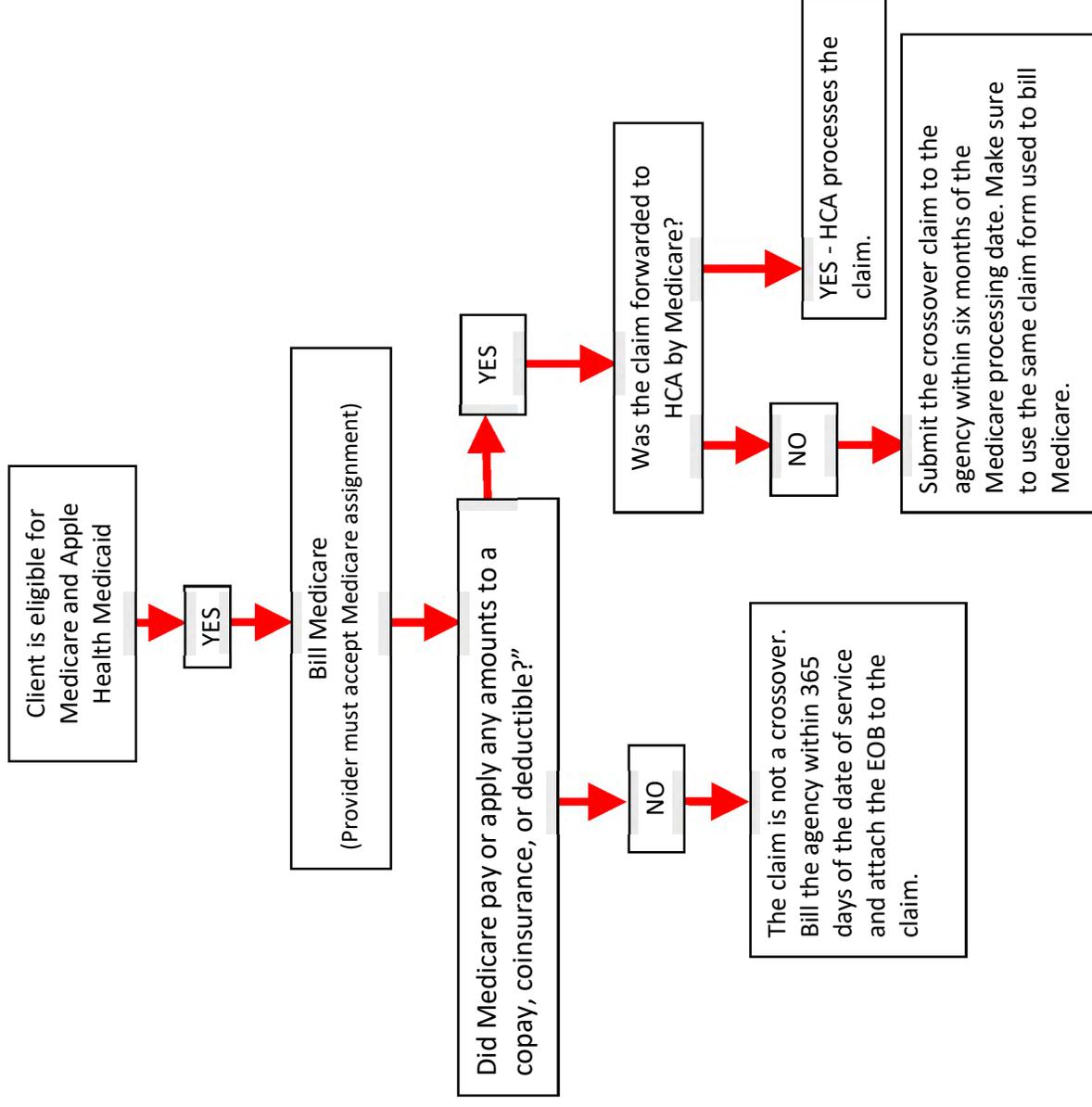
- It does not show up on the remittance advice (RA).
- The message "This information is being sent to either a private insurer or Medicaid" does not show up on the EOMB from Medicare.

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.

The screenshot shows a form titled "Medicare Crossover Items" with a collapse icon on the left. The form contains several input fields with asterisks indicating they are required:

- * Medicare Deductible: \$
- * Medicare Co-insurance: \$
- * Medicare Co-payment: \$
- * Medicare Paid \$
- * Medicare Allowed Amount: \$
- * Medicare Paid Date: (with sub-fields for mm, dd, and yyyy)

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.

Example EOB:

DATES OF SERVICE	SVC PROVIDED/PPS	BILLED AMOUNT	ALLOWED AMOUNT	PAID AMOUNT	PATIENT LIABILITY	DISALLOWED AMOUNT	EOP CODES
120710-120710	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	39.23	20.77	
EXPLANATION OF CODES							
3		Co-payment Amount					
45		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 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.

Billing for clients covered by Medicare Part B only (no Part A), or have exhausted Medicare Part A benefits prior to the 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
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).

Billing for clients whose Medicare coverage began during an inpatient stay, or exhausts Part A during the 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.

- In order 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).

The screenshot shows a form titled "Medicare Crossover Items". It contains the following fields:

- * Medicare Deductible: \$
- * Medicare Paid: \$
- * Medicare Paid Date: (mm dd ccyy)
- * Medicare Co-insurance: \$
- * Medicare Allowed Amount: \$
- * Medicare Co-payment: \$

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 applies 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.

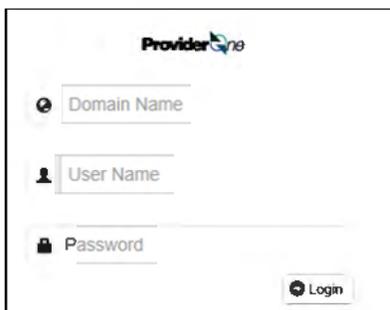
Inquiring about the status of a claim

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

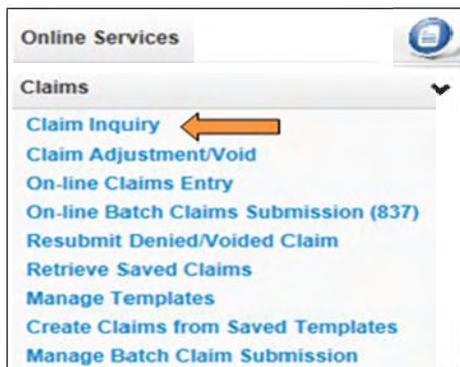
- A claim has been submitted and ProviderOne has not responded.
- You are trying to rebill some older claims and need the Transaction Control Number (TCN) to prove timely submission of the original claim.
- You are searching for a claim because your accounts receivable system does not yet show a posted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

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

Log into ProviderOne:



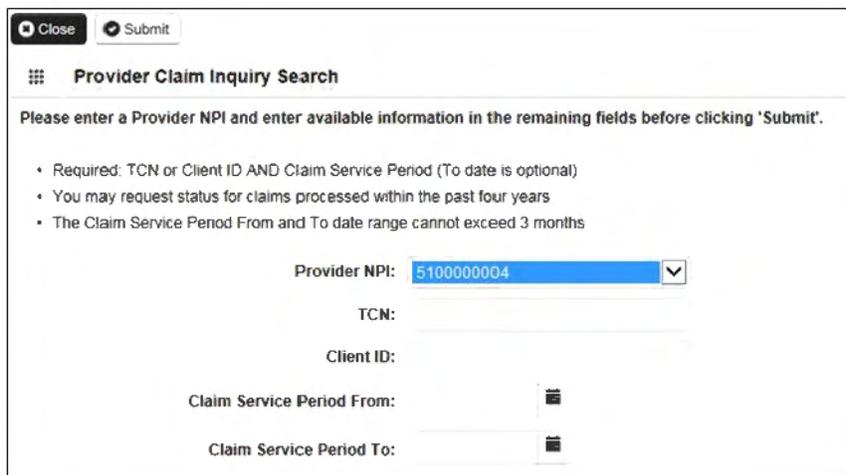
Select the **EXT Provider Claims/Payment Status Checker** or **EXT Provider Super User** profile, and select **Claim Inquiry** on the provider portal:



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	Claim Status	Claim Charged Amount	Claim Payment Amount	Client Name	Client ID
	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/>	20161790000306000	06/01/2016	0: Cannot provide further status electronically.	\$100.00	\$0.00	JANE	99999998WA

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 Medicare's process date, with two years from Medicare's process date for resubmissions, voids, or adjustments (**Note:** Crossover claim timeliness is based on Medicare process date rather than 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 in order 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 has a reserved meaning representing the following:

2	0	16184	0	0000001	000
A	B	C	D	E	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 (16).
- 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

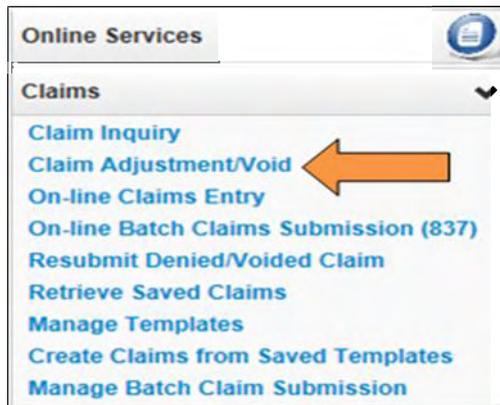
- Sequential counting of claims each day starting with 0000001.
- Allows claim counting to reach almost 10 million (9,999,999) claims daily.

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**:

The screenshot shows a search form titled 'Provider Claim Adjust Void Search'. It includes instructions: 'Please enter a Provider NPI and enter available information in the remaining fields before clicking "Submit".' Below this are fields for 'Provider NPI: 5100000004', 'TCN:', 'Client ID:', 'Claim Service Period From:', and 'Claim Service Period To:'. A search icon is next to the Provider NPI field. A blue note box on the right states: '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:

The screenshot shows a table titled 'Provider Claims Adjust Void List' for Provider NPI: 5100000004. The table has columns for TCN, Date of Service, Claim Status, Claim Charged Amount, Claim Payment Amount, Client Name, Client ID, and Child Tcn. A single row is displayed with the following data:

TCN	Date of Service	Claim Status	Claim Charged Amount	Claim Payment Amount	Client Name	Client ID	Child Tcn
<input type="checkbox"/> 201429200006545000	06/01/2016	1: For more detailed information, see remittance advice	\$160.00	\$87.92	JANE DOE	999999998WA	

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 Billing and Resource Guide

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:

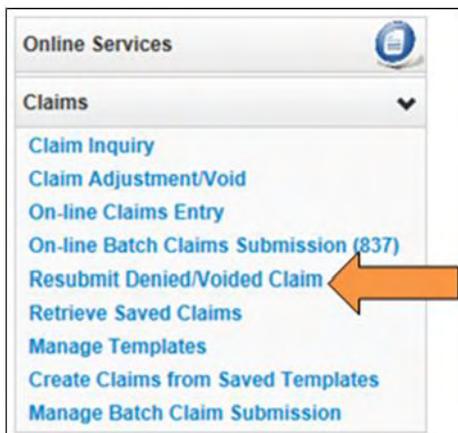
1. The original claim; and
2. The replacement claim.

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.

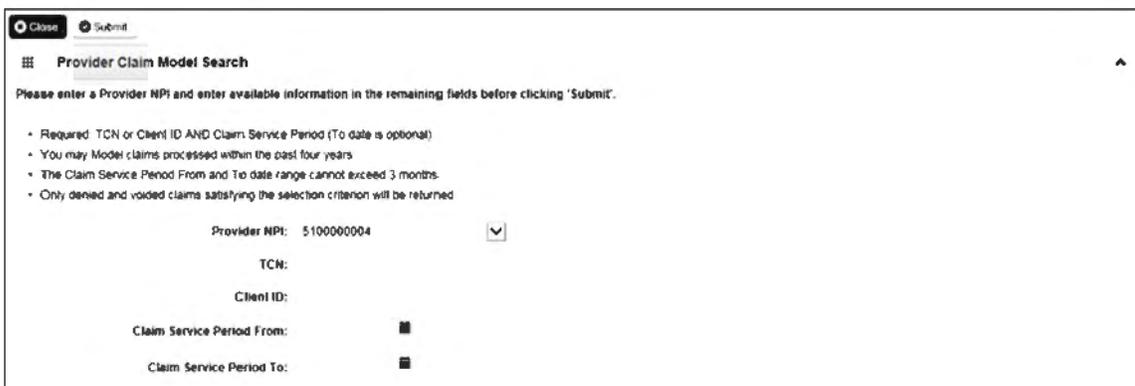
Note: When a claim is voided, the agency will recover the amount originally paid from the next total payment and the voided claim will appear on the RA as only one transaction. Voided claims can be resubmitted by using the credit TCN.

Resubmitting a denied or voided DDE claim

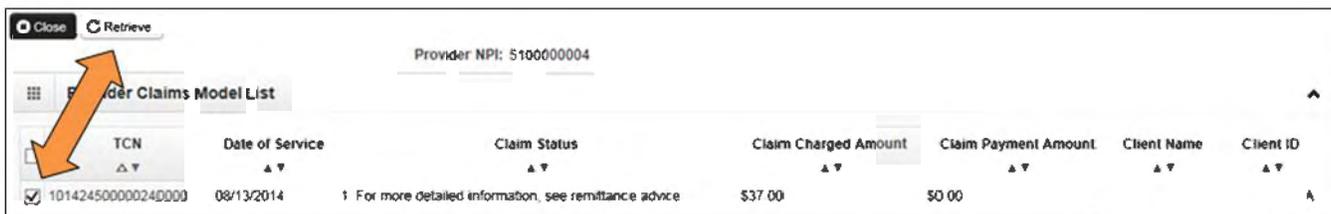
Select **Resubmit Denied/Voided Claim** from the provider portal:



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.

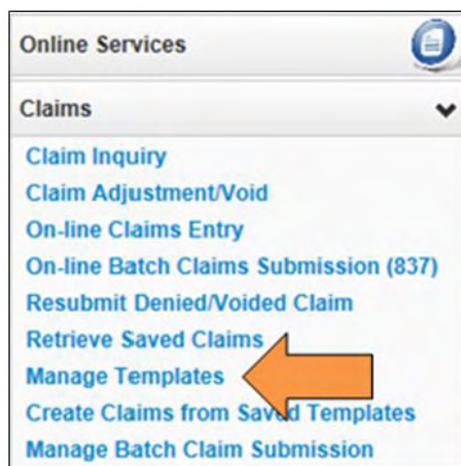
The minimum required information is:

- 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.

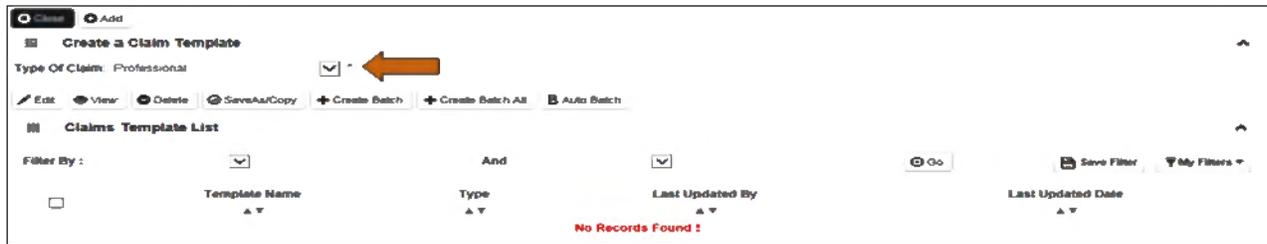
Creating a template

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:



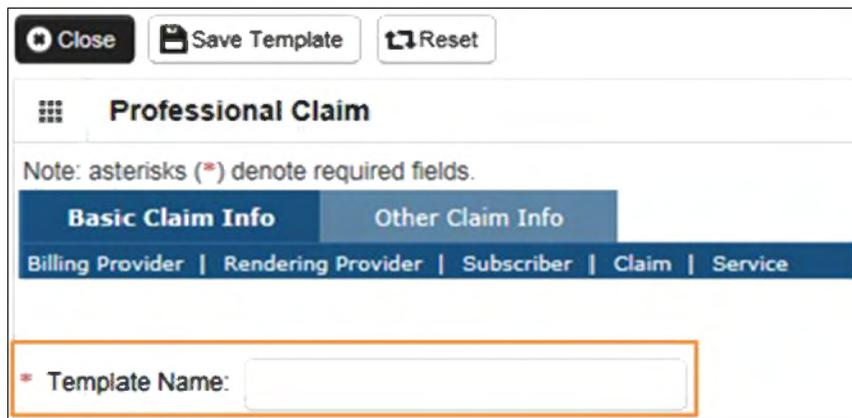
First, start building a template by choosing which type of template is desired then select **Add**.

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.

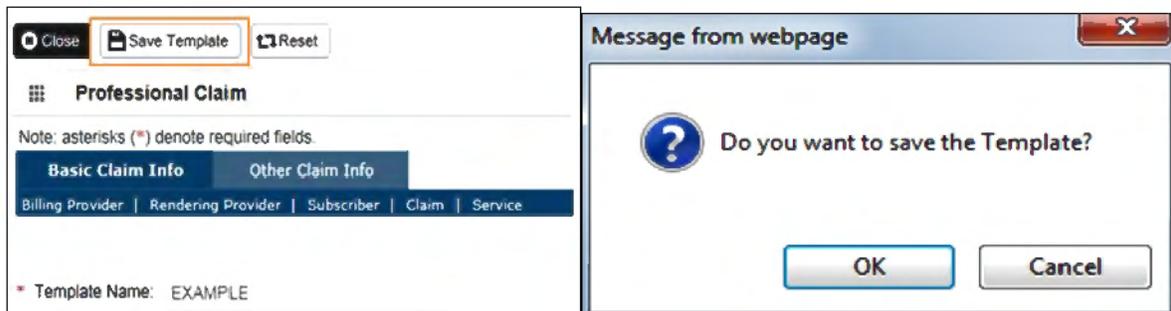


Fill in as many data fields as possible. If the template is for a client that receives specific services monthly, then fill in all fields except the dates of service. If the template is service-specific, then fill in all the service information and leave off the client information and dates of service. 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:

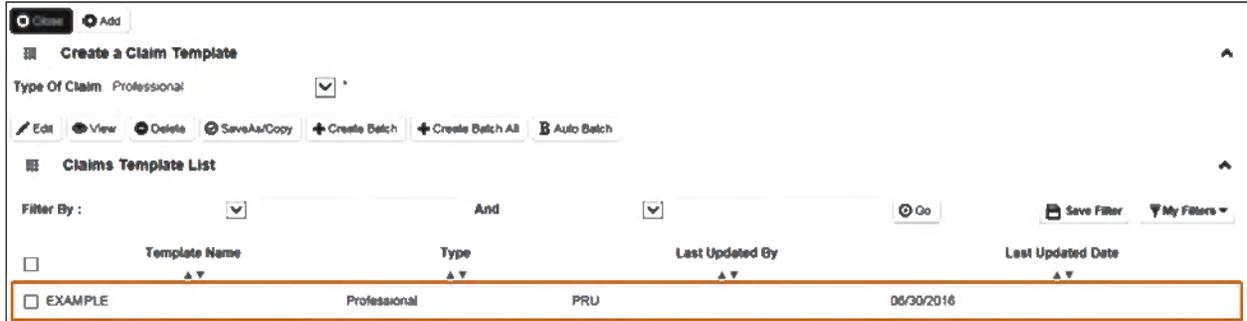


ProviderOne may return the message, “Warning: Template Name Already Exists, please enter a unique name”. Two things may cause this warning:

- 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.

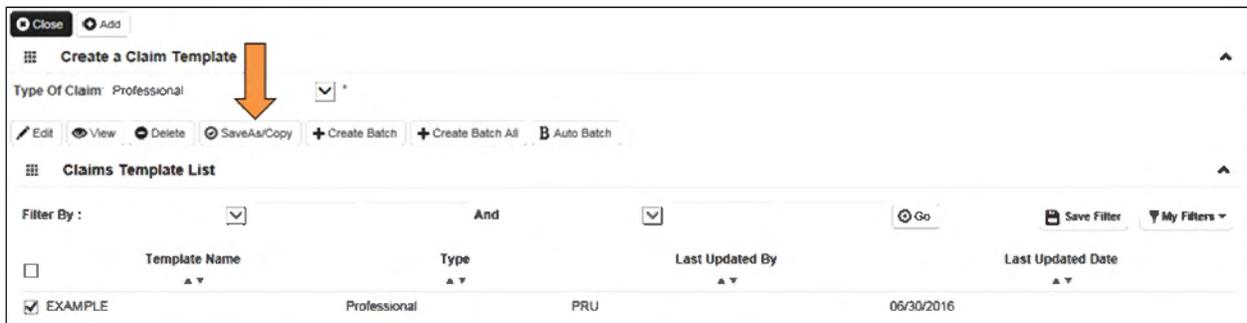
After selecting **OK**, ProviderOne returns to the Create a Claim Template screen adding the template to the list:



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

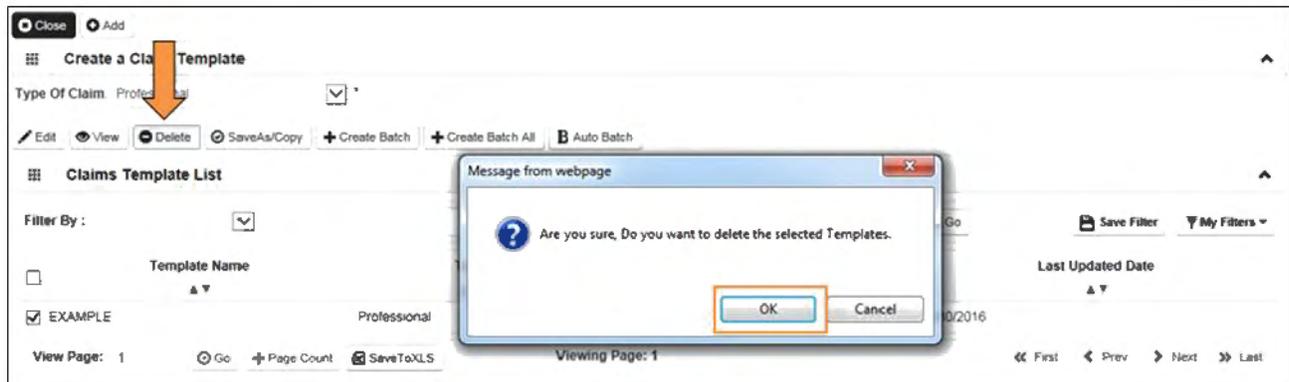
To view a template, click on the check box next to the template name and click the **View** button:



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

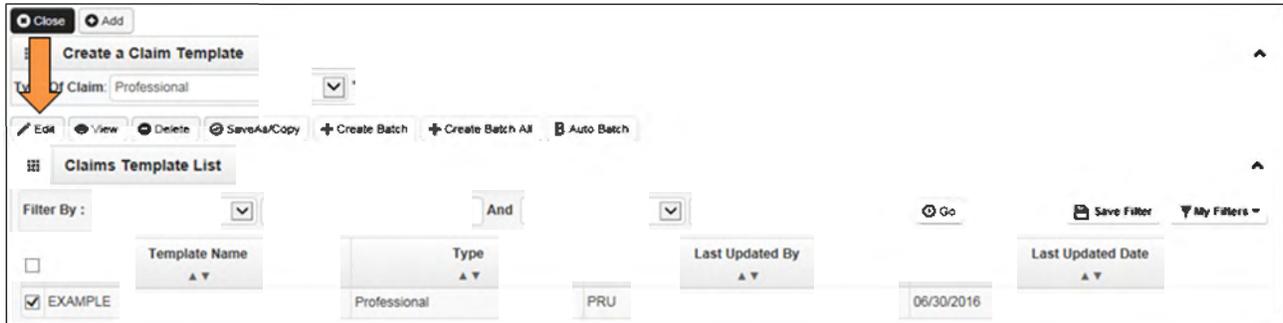
To delete a template, click on the check box next to the template name click the **Delete** button:



A pop up 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

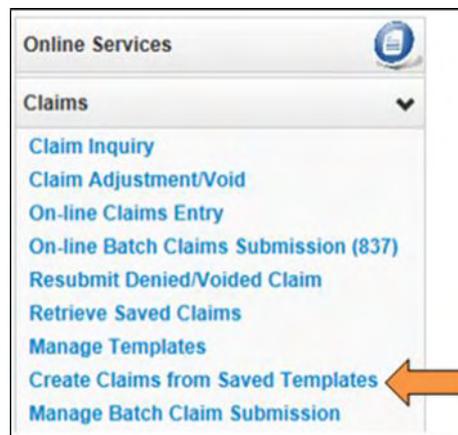
Providers that bill reoccurring services for a client or clients may want to use a claim template to create and submit those claims.

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 has the ability to 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 go to **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. 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 start processing in ProviderOne. This template batch is then 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.

Section 5: 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 of 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 key elements:

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

Each section may be split into multiple parts that could include “Paid claims - physician claims” and “Paid claims - Medicare crossover claims” located on different pages. Be sure to look for possible multiple sections when reconciling your RA.

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.

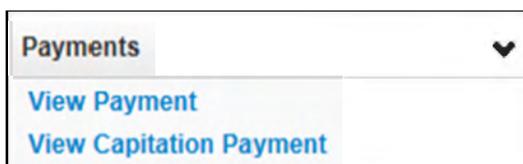
Retrieving the remittance advice

There are two ways to obtain the Remittance Advice (RA). You will want to select which of the two methods that best 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.

Retrieve the RA via the ProviderOne portal:

Log in to ProviderOne.

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):



The segment below will be displayed.

Select **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
123456789		06/24/2016	06/25/2016	1	\$100.00	\$0.00	\$100.00	
111222333		12/02/2015	12/02/2015	5	\$1,410.00	\$512.69	\$897.31	
999888777		06/04/2015	06/05/2015	10	\$3,034.00	\$950.51	\$2,083.49	

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.

View the first page of the RA:

The screenshot shows the first page of a Health Care Authority Remittance Advice (RA) document. The document includes the Health Care Authority logo, contact information, RA Number, Billing Provider, and a main body of text with a list of important changes. Annotations A through E are placed on the document to highlight specific information:

- A**: Points to the Health Care Authority logo and contact information.
- B**: Points to the RA Number: 123456789.
- C**: Points to the Billing Provider: S100000004.
- D**: Points to the Prepared Date: 06/25/2016 and RA Date: 06/25/2016.
- E**: Points to the main body of text, which includes a list of important changes affecting ALL providers as of April 1, 2016.

The following information displays:

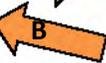
- A. Provider demographic information
- B. The number assigned to the RA
- C. The NPI provider number used in billing ProviderOne
- D. The payment date and the date this RA was prepared
- E. The main body of this RA page is our newsletter with important provider update information (sometimes specific 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: 1591591 Warrant/EFT # 123456!  Warrant/EFT Date: 07/31/2014 Warrant/EFT Amount: \$367808.08  Payment Method: EFT Claims Summary										Prepared Date: 08/01/2014 RA Date: 08/01/2014 Page 2					
										Provider Adjustments					
Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Sales Tax	Total Client Resp Amount	Total Paid	Billing Provider	FN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount	
	18882	Paid	\$3565979.70	\$642398.02	\$850.69	\$0.00	\$337.65	\$396293.96	9991118882	2223334445556/ 30143650001112 2000	System Initiated	NOC Invoice	\$0.00	\$0.00	\$5336.57
	9991118882	Denied	\$5692237.80	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	9991118882	2223334445556/ 30143650001112 2000	System Initiated	NOC Referred to CARS	\$5336.57		\$0.00
	18882	Adjustments	-\$187481.35	-\$79841.70	\$0.00	\$0.00	-\$34060.85		9991118882	3335559996667/ 30143780002229 9000	System Initiated	NOC Invoice	\$0.00	\$0.00	\$158.87
	9991118882	In Process	\$2415404.48	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	9991118882	3335559996667/ 30143780002229 9000	System Initiated	NOC Referred to CARS	\$158.87	\$158.87	\$0.00
	9991118882								99966885/ 30149850005553 0000	Provider Initiated	P1OFF Recoupment	\$72.77		\$51.78	
	9991118882								99966885/ 30149850005553 0000	Provider Initiated	P1OFF 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/several claims or an action initiated by the ProviderOne system. The following table indicates the adjustment type and explains what they are:

P1OFF Invoice	<p>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:</p> <ul style="list-style-type: none"> • Taking payment from a future paid claim, or • Through a receivable sent to CARS (Collections and Accounts Receivable System) to initiate the recovery. <p>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).</p>
P1OFF Recoupment	This identifies the payments used to satisfy HCA’s accounts receivable. This typically posts immediately following a P1OFF invoice line.
NOC Invoice	<p>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:</p> <ul style="list-style-type: none"> • 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 Office of Financial Recovery (OFR) for collection.
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 Office of Financial Recovery (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)

What is the 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 type

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 adjustments types.

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: 06/25/2016		Prepared Date: 06/25/2016		RA Date: 06/25/2016		Page 3				
Category: Paid		Billing Provider: 5100000004												
Client Name / Client ID / Med Record # / Patient Acct # / Original ICN/	ICN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes /NC PDP Rejection Codes
DOE, JOHN 99999997WA	20160990003711500 Professional Claim	1		02/17/2016- 02/17/2016	92507	1.0000	\$47.41	\$47.41	\$0.00	\$0.00	\$0.00	\$47.41		
Document Total: 02/17/2016-02/17/2016						1.0000	\$47.41	\$47.41	\$0.00	\$0.00	\$0.00	\$47.41		
DOE, JANE 99999998WA	20160990003712400 Professional Claim	1		02/24/2016- 02/24/2016	92507	1.0000	\$47.41	\$47.41	\$0.00	\$0.00	\$0.00	\$47.41		
Document Total: 02/24/2016-02/24/2016						1.0000	\$47.41	\$47.41	\$0.00	\$0.00	\$0.00	\$47.41		

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: 11122333		Warrant EFT #: 000001		Warrant EFT Date: 06/25/2016		Prepared Date: 06/25/2016		RA Date: 06/25/2016		Page 10				
Category: Denied		Billing Provider: 5100000004												
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN	TCN / Claim Type / RX Claim # / In # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D'S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Code	Adjustment Reason Code: NCPDP Rejection Code
DOE, JANE 999999995WA	20161250004297800 Professional Claim	1		03/16/2016- 03/16/2016	92507	1.0000	547.41	50.00	50.00	50.00	50.00	50.00	N288	16 = 547.41
Document Total:				03/16/2016-03/16/2016		1.0000	547.41	50.00	50.00	50.00	50.00	50.00	N288	16
DOE, JOHN 999999997WA	20161250004300600 Professional Claim	1		03/23/2016- 03/23/2016	92507	1.0000	547.41	50.00	50.00	50.00	50.00	50.00	N288	16 = 547.41

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 process date for resubmissions (crossover claim timeliness is based on Medicare process date rather than date of service).

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: 06-25-2016		Prepared Date: 06-25-2016		RA Date: 06-25-2016		Page 6				
Category: Adjustments		Billing Provider: 5100000004												
Client Name	TCN	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D-S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Code	Adjustment Reason Codes: NCPDP Rejection Codes
DOE, JANE 99999998WA 301615300164976000	40161631001323500 Professional Claim	1		06-01-2016- 06-01-2016	96150 25	1.0000	-5150.00	-5150.00	\$0.00	\$0.00	\$0.00	-5150.00		119 = \$0.00
	40161631001323500 Professional Claim	2		06-01-2016- 06-01-2016	96101 U7	1.0000	-510.00	-510.00	\$0.00	\$0.00	\$0.00	-510.00		119 = \$0.00
Document Total:				06-01-2016-06-01-2016		2.0000	-5160.00	-5160.00	\$0.00	\$0.00	\$0.00	-5160.00		Credit
DOE, JANE 99999998WA 301615300164976000	40161622001827500 Professional Claim	1		06-01-2016- 06-01-2016	96150 25	1.0000	\$150.00	\$150.00	\$0.00	\$0.00	\$0.00	\$150.00		
	40161622001827500 Professional Claim	2		06-01-2016- 06-01-2016	96101 U7	1.0000	\$10.00	\$10.00	\$0.00	\$0.00	\$0.00	\$10.00		Debit
Document Total:				06-01-2016-06-01-2016		2.0000	\$160.00	\$160.00	\$0.00	\$0.00	\$0.00	\$160.00		
Category Total:						4.0000	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
Billing Provider Total:						31.0000	\$1950.00	\$1820.00	\$0.00	\$0.00	\$0.00	\$1820.00		

- 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 actually 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 #: 0000011		Warrant EFT Date: 06/25/2016		Prepared Date: 06/25/2016		RA Date: 06/25/2016		Page 25				
Category: In Process		Billing Provider: S100000004												
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN /	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D-S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Code:	Adjustment Reason Code: NCPDP Rejection Code:
DOE JANE 999999998WA	20161100022020600	1		03/02/2016- 03/02/2016	92507	1.0000	\$47.41	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
Document Total:				03/02/2016-03/02/2016		1.0000	\$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 the 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 §35 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 the Federal adjustment reason codes and remark codes are located on the [Washington Publishing Company'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.

Section 6: Requesting prior authorization

Completing the authorization intake process

This section shows how to:

- Locate the General Information for Authorization HCA form, [13-835](#).
- Fill out the authorization form with the required information.
- Navigate the ProviderOne paper and fax intake process.
- Check the status of your authorization request.
- Submit additional supporting documentation with HCA cover sheets 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.

Completing the 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](#).

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

- Hand writing 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 authorization request with required back-up

ProviderOne uses scanning technology that converts documents received via fax or paper into electronic files. Please make sure to submit the form correctly to ProviderOne. This will ensure your request can be processed and loaded into the system.

Submit prior authorization requests by fax or by mail. Use the specific instructions for each method as follows:

Submitting authorization requests by fax (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.

Submitting authorization requests by mail

Mail prior authorization requests to:

AUTHORIZATION SERVICES OFFICE
PO BOX 45535
OLYMPIA WA 98504-5535

If sending x-rays, photos, CDs, or other non-scannable items:

- Place the items in a large envelope.
- Attach the prior authorization request form to the outside of the envelope.

Write clearly on the outside of the envelope:

- Client name
- ProviderOne client ID
- Your NPI
- Your name
- Sections the request is for [e.g., MEAU (Medical), DME (Durable Medical Equipment), Dental or Ortho]
- Place the envelope inside a larger envelope for mailing

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). You may register with NEA by visiting the [NEA website](#) and entering "FastWDSH" in the blue promotion code box. Contact the NEA at 800-782-5150 extension 2 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

- Hand writing the authorization form. Forms that are handwritten cannot be scanned and will be returned to you.
- Not putting your x-rays, photos, or CDs in a separate envelope with the required information on the outside of the inside envelope; requests will get returned to you if they are not submitted correctly.
- 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 the status of authorization requests

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, using the Medical Assistance Customer Service Center (MACSC) interactive voice response (IVR) system or by using ProviderOne.

See [Appendix G](#) for instructions on using these features 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.

Sending in additional documentation if requested by HCA

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

Use a [cover sheet](#) if you are mailing or 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 in order 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.

Fax the cover sheet and additional supporting information to 1-866-668-1214, or mail to:

AUTHORIZATION SERVICES
PO BOX 45535
OLYMPIA WA 98504-5535

Below shows an example of the prior authorization pend form cover sheet. Upon entering the authorization reference number, click anywhere outside the field so a barcode is generated on the form:

The screenshot shows a web form titled "ProviderOne PA Pend Forms Submission Cover Sheet". At the top, there are three thick horizontal black bars. Below them, the text "ProviderOne" and "PA Pend Forms Submission Cover Sheet" are centered. On the left, the label "Authorization Reference #" is next to a text input field containing "123456789". Below the input field, it says "(Please enter 9 digit numeric value.)". Underneath is a standard 1D barcode. To the right of the barcode, there is a vertical stack of four thick black bars, and a red arrow points from this stack towards the barcode. At the bottom of the form, there are two buttons: "Print Cover Sheet" and "Clear Fields". Below the buttons, it says "Instructions will not appear on the printed coversheet". At the very bottom, under "INSTRUCTIONS:", it says "Click ENTER on your keyboard after typing the number in above."

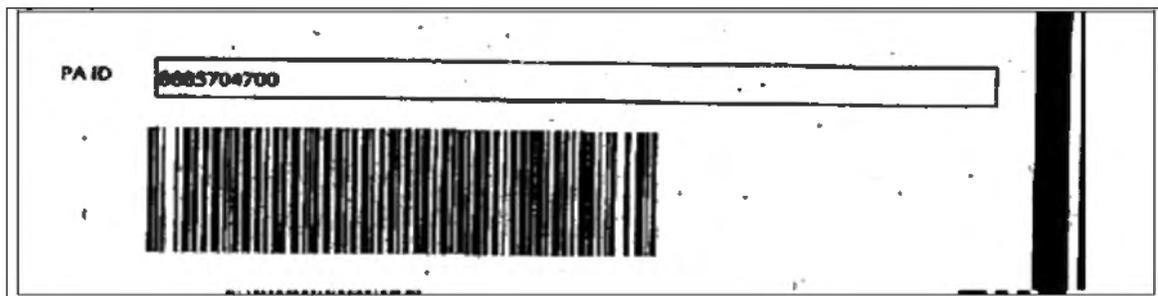
Cover sheet tips

- 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.
- Multiple sets of documentation can be mailed in a single envelope.
- 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.

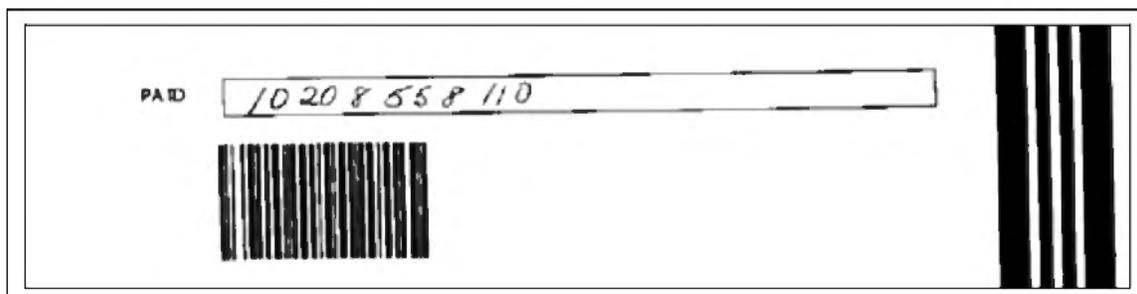
Examples of non-scannable cover sheets

It is important that the ProviderOne scanning technology can read the barcode on the cover sheet. If the fax quality is poor or the barcode is incomplete, it will not scan correctly into ProviderOne.

Below is an example of a poor quality image. The scanner cannot read the barcode below because there are black dots all over the image. You can set your fax to “photo quality image” to improve the image quality.



Handwritten cover sheets are also non-scannable. You can see below that the barcode is incomplete. ProviderOne will not be able to read this cover sheet and attach the submitted documentation to the electronic authorization request.



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 webpage](#)
- [Contact Medicaid webpage](#)
- [Prior authorization](#)

APPENDIX A: Check client eligibility using the 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
<p>What will I hear?</p> <p>The IVR will play only the information specific to the client. The types of information available are:</p> <ul style="list-style-type: none"> • 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 <p>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:</p> <ul style="list-style-type: none"> • 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: Verifying eligibility using a magnetic card reader or MEV service magnetic reader

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:

Amerigroup (AMG)

1-800-600-4441

<https://www.myamerigroup.com/wa/pages/welcome.aspx>

Providers: 1-800-454-3730

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.

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 Administrative 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 visit [Contact Apple Health \(Medicaid\)](#).

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 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 Needy	CNP
	S03	QMB Medicare Savings Program (MSP) Medicare premium and co-pays	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
	S95	Medically Needy no spenddown	MNP
	S99	Medically Needy with spenddown	MNP
SSI related living in an alternate living facility (non-medical 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
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
Institutional HCBS Waivers (HCS/DDD) and Hospice	L21	DDD/HCS Waiver on SSI	CNP
	L22	DDD/HCS Waiver – gross income under the SIL	CNP
	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
SSI and SSI related	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

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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
	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	Family Planning
	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)	CNP

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		children)	
	F07	Children's Health Insurance Program	CNP S-CHIP (Not Medicaid)
	F08	Undocumented alien children (this coverage group ended 12/31/2008 and is merged with the F06 group)	State- funded 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
	N05	MAGI adult Medicaid; income =<133% (Medicaid Expansion)	ABP
	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
	N21	MAGI parents/caretaker; Emergency only; AEM	ERSO
	N23	MAGI pregnancy; not lawfully present	CNP
	N25	MAGI adult Medicaid; non-citizen - income =<133% (Medicaid Expansion) AEM	ERSO
	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 Care-State funded (ended 12/31/2013)	State- funded
	W03	Detox Medical-State funded (ended 12/31/2013)	State- funded

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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
	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
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

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: Completing the General Information for Authorization Request form, HCA 13-835

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: How to check status of an authorization

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
<p>What will I hear?</p> <p>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.</p> <p>The types of information available are:</p> <ul style="list-style-type: none"> • Authorization number • Status date • Status, such as: <ul style="list-style-type: none"> ○ 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 from one of the three inquiry options and click on the **submit** button:

The "PA Inquire" form includes instructions: "To submit a Prior Authorization Inquiry, complete one of the following criteria sets and click 'Submit'." The criteria are:

- Prior Authorization Number; or
- Provider NPI AND Client ID; or
- Provider NPI, Client Last Name, Client First Name, AND Client Date of Birth

 An orange arrow points to these instructions. Below are input fields for:

- Prior Authorization Number: []
- Provider NPI: []
- Client ID: []
- Client Last Name: []
- Client First Name: []
- Client Date of Birth: []

 A "Submit" button is located at the top left of the form area.

The system will return the authorization status:

The "PA Utilization" page displays the following information:

- Authorization #: 1111111111
- Client ID: 9999999990WA
- Service: Other DMAE
- Request Date: 2015-08-03
- Service Start Date: 2015-08-03
- Requestor ID: 5100000004
- Authorization Status: Approved
- Client Name: DOE, JANE
- Organization: PA - DMAE
- Last Updated Date: 2015-10-19
- Service End Date: 2015-12-04
- Requestor Name: ACME MEDICAL CLINIC

The "Service List" table is as follows:

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	Modifier2	Part Number	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	10/19/2015	5100000004	T4526	O-All				09/03/2015	09/01/2015	0	4	0	4	0	0	Approved
2	10/19/2015	5100000004	T4526	O-All				09/02/2015	10/01/2015	0	4	0	4	0	0	Approved
3	10/19/2015	5100000004	T4526	O-All				10/02/2015	10/31/2015	0	4	0	4	0	0	Approved
4	10/19/2015	5100000004	T4526	O-All				11/01/2015	11/30/2015	0	4	0	4	0	0	Approved

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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.
Requested	HCA received the requested authorization.
In review	The authorization is in review.
Cancelled	Authorization request cancelled.
Pended	Requires additional information in order to make a decision 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 provider's request.
Denied	HCA has denied the provider's 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.

These cover sheets are necessary when mailing in 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 pop up 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, and 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 form when submitting the supporting documentation for a prior authorization (PA) request in pended status. You must use the authorization number in order to use this cover sheet.

After choosing the appropriate form, the provider must fill in pertinent information such as TCN or Client ID. 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 originals in ProviderOne.

After printing the completed form, attach it to the supporting documentation and submit by fax (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 or requests, mail in a single envelope with a cover sheet for each.

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- 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 of 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 is revising 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 Rural Health Clinic (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:

$$\text{MEDICAID ALLOWED} - \text{MEDICARE PAID} - \text{TPL} = \text{AGENCY PAYMENT}$$

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
<p>What will I hear?</p> <p>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:</p> <ul style="list-style-type: none"> • Status of paid: <ul style="list-style-type: none"> ○ Date paid ○ RA date ○ Amount paid ○ Warrant amount ○ Warrant number ○ RA number ○ Services dates • Status of denied: <ul style="list-style-type: none"> ○ Date denied ○ Denial reasons (limited to 5) • Status of in process: <ul style="list-style-type: none"> ○ Date received ○ Message if more than 30 days <p>Provider menu choices:</p> <ul style="list-style-type: none"> • 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
<p>What will I hear?</p> <p>The IVR will play only the information specific to the associated provider. The types of information available are:</p> <ul style="list-style-type: none"> • Paid date • Warrant amount (check amount) • Warrant number (check number) • RA number <p>Provider menu choices:</p> <ul style="list-style-type: none"> • Authorizations – 1 • Check claims – 2 • Check warrants – 3 • Client eligibility – 4