Washington State Health Care Authority Medicaid

Medicaid Dental Provider Billing Workshop

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Date: 2012

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Provider Training

Medicaid Overview

- What is Medical Assistance?
- Acronyms
- Eligibility Programs
- Foster Children Claim History
- Life of a Claim

ProviderOne

- Manage ProviderOne users
- Direct Data Entry (DDE) Claims
- Commercial Secondary Claims
- Saving Claims
- Build and Use a Claim Template
- Provider File Maintenance
- Enroll a New Rendering Provider

Billing Processes

- Check Patient Eligibility
- Claim Status Inquiry
- Billing Timely & the TCN
- Adjust or Void a Paid Claim
- Resubmit a Denied Claim
- System Authorization Information
- Authorization Requests
- EPA Eligibility
- Obtain the Remittance Advice

Various Other Billing

Appeals

Spend Down

For Adults – use the flowchart for coverage

Billing the Client

HIPAA

Transactions

Reference Materials

Web Pages

Webinars

Billing Instructions

Discovery Log

Contacts

Resource List

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What is Medical Assistance?

- Washington's Medical Assistance program provides healthcare coverage for low-income residents.
- The Health Care Authority operates Medicaid and coordinates other health and recovery programs.
  - ✓ State's Mental Health programs
  - ✓ Chemical Dependency and prevention treatment
  - ✓ Family Planning
- Clients receive healthcare services through:
  - ✓ A Managed Care Organization
  - ✓ Fee-For-Service

Key Terms and Acronyms

BSP
Benefits Service Package

RHC
Rural Health Center

RSN
Regional Support Network

FQHC
Federally Qualified Health Center

PCCM
Primary Care Case Management

CSO
Community Services Office

Fee for Service
The term used when a client is able to get care from doctors and other medical providers who will accept the client service card.

Managed Care
A prepaid comprehensive system of medical and health care services provided through a designated health care plan that contracts with Medicaid

Spenddown
An expense or portion of an expense which has been determined by the Agency to be client's liability

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Eligibility Programs

Benefit Service Packages (BSP)

CNP

Categorically Needy Program

This program has the largest scope of care.

MNP

Medically Needy Program

This program covers many medical services.

TCFPO

Take Charge-Family Planning Service Only

This program is for both women and men. Covers family planning services.

FPSO

Family Planning Services

This program is for women.

DL

Disability Lifeline

This program covers most of the basic services.

ADATSA

Alcoholism and Drug Addiction Treatment and Support Act

This program covers most of the basic services.

For a complete listing of BSP visit:
http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/Appendix_E.pdf

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Accessing ProviderOne

- Before logging into ProviderOne:
  - ✓ Make sure you are using Microsoft Internet Explorer version 6.0 and above.
  - ✓ You turn **OFF** the Pop Up Blocker.
  - ✓ You are using a PC (MACs are not supported by ProviderOne).

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How Do I Obtain Eligibility In ProviderOne

- Select the proper user profile

1

Welcome
to the
Medicaid Management Information System

Note: There are three different profiles that can be used for checking client eligibility in ProviderOne

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

Select a profile to use during this session: EXT Provider Eligibility Checker * Go

EXT Provider Eligibility Checker-Claims Submitter
EXT Provider Super User

2

Online Services:

Claims Hide/Max
- Claim Inquiry
- Claim Adjustment/Void
- On-line Claims Entry
- On-line Batch Claims Submission (837)
- Resubmit Denied/Voided Claim
- Retrieve Saved Claims
- Manage Templates
- Create Claims from Saved Templates
- Manage Batch Claim Submission

Client Hide/Max
- Client Limit Inquiry
- Benefit Inquiry

Select "Benefit Inquiry" under the "Client" section of the Provider Portal

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How Do I Obtain Eligibility In ProviderOne

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

Close | Submit

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

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

3

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: 12/20/2011 * | Inquiry End Date: 12/20/2011 *

- An unsuccessful check would look like this:

Printer Friendly Version
Close | Submit Another Inquiry | Exit

Search Criteria Used

Selection Criteria Entered:

Date of Request: 12/20/2011
Time in Request: 09:02:28 AM PST
Provider ID: 200320900
From Date of Service: 12/20/2011
To Date of Service: 12/20/2011

ProviderOne Client ID:
Client Date of Birth: 05/16/1973
Client SSN:
Client Last Name: JONES
Client First Name: JOE

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:
HIC:

System Response Information:

Valid Request Indicator: N
Reject Reason Code: 75 - Subscriber/Insured ID Not Found
Follow-Up Action Code: C - Please correct data and resubmit

Unsuccessful eligibility checks will be Returned with an error message here.

- ✓Client is not eligible for your search dates; or
- ✓Check your keying!

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Successful Eligibility Check

Printer Friendly Version

Close | Submit Another Inquiry | Exit

Selection Criteria Entered:

Search Criteria Used

4

Date of Request: 12/20/2011
Time in Request: 10:11:16 AM PST
Provider ID: 110320900
From Date of Service: 12/20/2011
To Date of Service: 12/20/2011

ProviderOne Client ID: 600212788WA
Client Date of Birth:
Client SSN:
Client Last Name:
Client First Name:

Client Demographic Information:

ProviderOne Client ID: 600212788WA
Client First,Middle,Last Name:
CSO/HCS: 133-OAK HARBOR/ISLAND COUNTY HCS
County Code: 015-Island
CSOR: 015-OAK HARBOR CSO
Date of Birth: 06/28/1951
Gender: Female
Language: ENG-English
Placement:
ACES Client ID: 602411160
HIC:

System Response Information:

Valid Request Indicator:
Reject Reason Code:
Follow-Up Action Code:

Basic client information returned including the Client ID, Gender, and Date of Birth

Note: The eligibility information can be printed out using the "**Printer Friendly Version**" link located in the upper left corner.

Successful Eligibility Check

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

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1147	CNP	02/01/2011	12/31/2999	L21			

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Note: Clicking on the "**CNP**" hyperlink will display the "Benefit Service Package" which is a list of covered services for the client.

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Successful Eligibility Check

"Coordination of Benefits Information"

- Will display phone number and any policy or group numbers on file with WA Medicaid for the commercial plans listed.
- For DDE claims the Carrier Code (Ins. ID) is found here.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	KAISER PERMANENTE MED CARE (800) 813-2000	HM10		13482256			09/01/2010	12/31/2999

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"Restricted Client Information"

- Client's may be restricted to specific Hospitals, PCP's, and Pharmacies for care. A referral is required from the PCP for specialized care.

Restricted Client Information

Assignment Type	Provider Name		Provider Phone Number	Period Start Date	Period End Date
Hospital	MULTICARE HEALTH SYSTEM			01/05/2010	12/31/2999
Pharmacy	WALGREEN CO			01/01/2010	12/31/2999
Primary Care Physician	SEA-MAR COMMUNITY HEALTH CENTER			01/01/2010	12/31/2999
Primary Care Physician	DITTMER, STEPHANIE			01/01/2010	12/31/2999

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Successful Eligibility Check
Foster Care Information

- Foster Care Client's Medical Records History is available.
  - ✓ There is an extra button at the top of the eligibility screen.

Printer Friendly Version

Close | Submit Another Inquiry | Medical Records | Exit

Selection Criteria Entered:

Date of Request:	08/18/2011	ProviderOne Client ID:	564532100WA
Time in Request:	07:20:08 AM PDT	Client Date of Birth:	
Provider ID:		Client SSN:	
From Date of Service:	08/18/2011	Client Last Name:	
To Date of Service:	08/18/2011	Client First Name:	

Client Demographic Information:

ProviderOne Client ID:	564532100WA
Client First,Middle,Last Name:	UNCLE SAM
CSO/HCS:	076-MEDS
County Code:	017-King
CSOR:	043-KING SOUTH CSO
Date of Birth:	12/28/2003
Gender:	Male

System Response Information:

Valid Request Indicator:	
Reject Reason Code:	
Follow-Up Action Code:	

  - ✓ Click the button to see:
    - Pharmacy services claims.
    - Medical services claims (**includes dental**).
    - Hospital services claims.
- See the Billing and Resource Guide for complete details. Web address is on the last slide.

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Successful Eligibility Check

Foster Care Information

➢ Foster Care Client's Medical Records History shows claims paid by ProviderOne. Each section looks like:

- ✓ If any field is empty there is no data for it.
- ✓ Sort by using the "diamonds" under each column name: Drug Name ▲▼
- ✓ Search by using the "Filter by Period" boxes.
- ✓ If there is more pages of data use the "Next" or "Previous" buttons: << Prev Viewing Page 1 Next >>
- ✓ If there is no data for the section it will display: No Records Found !

Printer Friendly Version

Close

Pharmacy:

Filter By Period: All Go

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
02/03/2011	VITAMIN D	1000 UNIT	60	30	00	FRANKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/27/2011	POLYETHYLENE GLYCOL 3350	0	527	30	01	FRANKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/18/2011	BACLOFEN	20 MG	90	30	00	FRANKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/12/2011	LANSOPRAZOLE ODT	15 MG	60	30	00	WASHINGTON,GEORGE	BIG RIVER PHARMACY	(509) 555-2323
01/12/2011	IBUPROFEN	400 MG	15	10	01	WASHINGTON,GEORGE	BIG RIVER PHARMACY	(509) 555-2323

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Medical Services (primary and specialty care):

Filter By Period: All Go

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #
02/02/2011	02/02/2011			D1120,D1203,D0150,T1015	HAMILTON, ANDREW	BIG RIVER DENTAL CLINIC	(509) 555-5678
01/24/2011	01/24/2011	3439 - Cerebral palsy NOS	7689,5181	A0425,A0428		MEDICAL AMBULANCE SERVICE	(509) 555-2222
01/24/2011	01/24/2011	78097 - Altered mental status	3481,79091,51881	A0425,A0429		MEDICAL AMBULANCE SERVICE	(206) 535-4444
12/16/2010	01/15/2011	V440 - Tracheostomy status	85400,04112,51889	E0445		HOME NURSING SUPPLY	(509) 555-3333
01/04/2011	01/04/2011	V440 - Tracheostomy status	51889,85400,04112	A7525		HOME NURSING SUPPLY	(509) 555-3333

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Hospital Care:

Filter By Period: All Go

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	ER/Outpatient/Inpatient	DRG Description	Attending Provider Name	Billing Provider Name	Billing Provider Phone #
01/24/2011	01/24/2011	47874 - Stenosis of larynx	3481,V440,3:7775,53081	Outpatient		EAGLECLAW, DAN	CHILDRENS	(206) 535-2167
01/11/2011	01/11/2011	51919 - Trachea & bronch dis NEC		Outpatient		KIDD, CISCO	MEMORIAL HOSPITAL	(509) 555-6789
10/27/2010	10/27/2010	85406 - Brain inj NEC-coma NOS		Outpatient		KIDD, CISCO	MEMORIAL HOSPITAL	(509) 555-6789
09/30/2010	09/30/2010	78720 - Dysphagia NOS	78722	Outpatient		EAGLECLAW, DAN	CHILDRENS	(206) 535-2167
09/21/2010	09/21/2010	47874 - Stenosis of larynx		Outpatient		EAGLECLAW, DAN	CHILDRENS	(206) 535-2167

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Life of a Claim

Paper Claims

Electronic, DDE Claims

PROVIDERONE

- Assigns a TCN
- Scanned information is verified
- E-Claims, DDE information verified

Optical Scanner

- Work Scan Errors

History and Claims Analysis

Suspended Claims

- Authorization
- Eligibility
- Coordination of Benefits
- Program Limitations

Final Claim Disposition

RA , 835 Generated

Warrants printed

EFT deposits

Manage Users

- How to get access into the system.
- How to set up a user.
- How to lock out and unlock a user.
- How to reset a password.
- How to end a user.

How to get access into the system

- Review the ProviderOne Security Manual at http://hrsa.dshs.wa.gov/providerone/documentation/Provider%20System%20User%20Manual/H.%20Maintaining%20ProviderOne%20User%20Accounts.pdf
- New provider and don't have the "form" Email ProviderOne Security at provideronesecurity@hca.wa.gov In the subject line enter "request for Provider Supplemental Information Request Form"

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How to get access into the system

- The Provider Supplemental Information Request form is for a newly enrolled Facility, Clinic, Individual Provider, or a new office administrator.
- Fill it out and fax it in to 360-586-0702 for ProviderOne access.

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IMMEDIATE ACTION REQUIRED

ProviderOne ID:

PROVIDER SUPPLEMENTAL INFORMATION REQUEST

The Health Care Authority has transitioned to its new claims payment system called ProviderOne. Completion of this form is necessary to designate your Security Administrator who will be issued a Username and temporary password to access ProviderOne. Your Security Administrator is responsible for overseeing access to ProviderOne for your staff: setting up additional users and user profiles in your assigned Domain (ProviderOne ID).

PROVIDERONE SECURITY ADMINISTRATION	
Name of Security Administrator (First, Last, Middle Initial)	Physical Address (Street) (City) (State) (Zip)
Security Administrator's Date of Birth	Business Name
Security Administrator's Email Address	National Provider Identifier (NPI)
Security Administrator's Phone Number	Federal Tax ID (FEIN)
Providers must respond within seven (7) days of receiving this request. Fax this form back to HRSA/IT Security at (360) 586-0702, scan and email to provideronesecurity@hca.wa.gov or mail to Provider Enrollment, PO Box 45512, Olympia, WA 98504-5512.	

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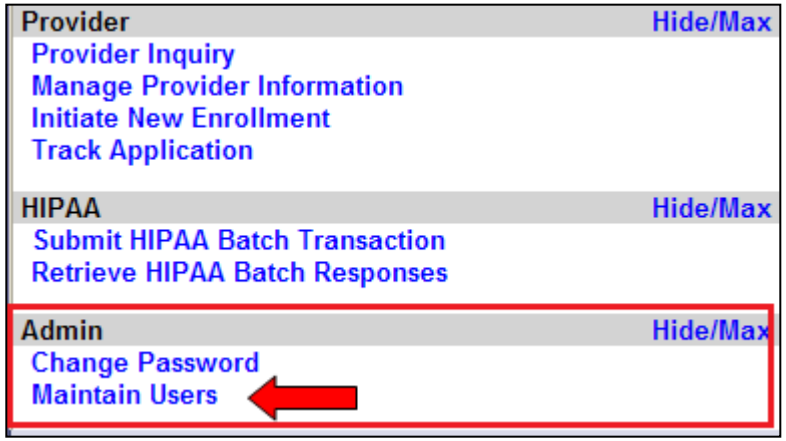
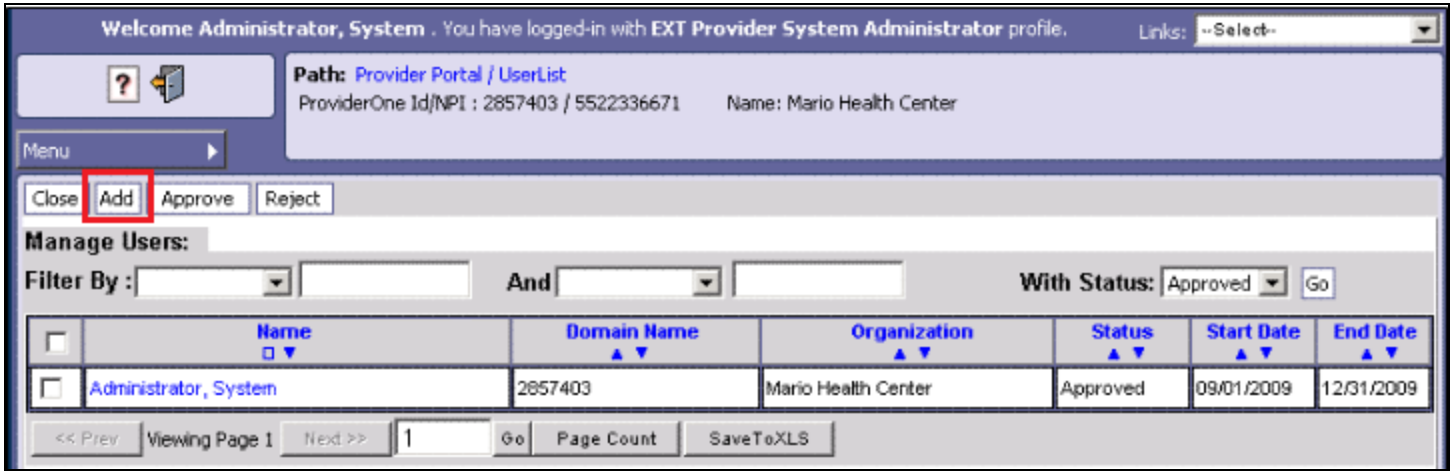
How to set up a user

- Log in with the **System Administrator** Profile
- Click on **Maintain Users**
- The system now displays the "User List" screen
- Click on the "Add" button





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How to set up a user

- Adding a user

Add User - Windows Internet Explorer

Add User

Please enter the following information:

First Name: *
Middle Name:
Last Name: *
User Login ID: *
User Type: Batch User *
Date of Birth: *
EID: *
Domain Name: 2857403
Start Date: 09/10/2009 *
Expiration Date: 12/31/2999 *
Status: In Review
Comments:

Next Cancel

Add User - Windows Internet Explorer

Add User

Please enter the following information:

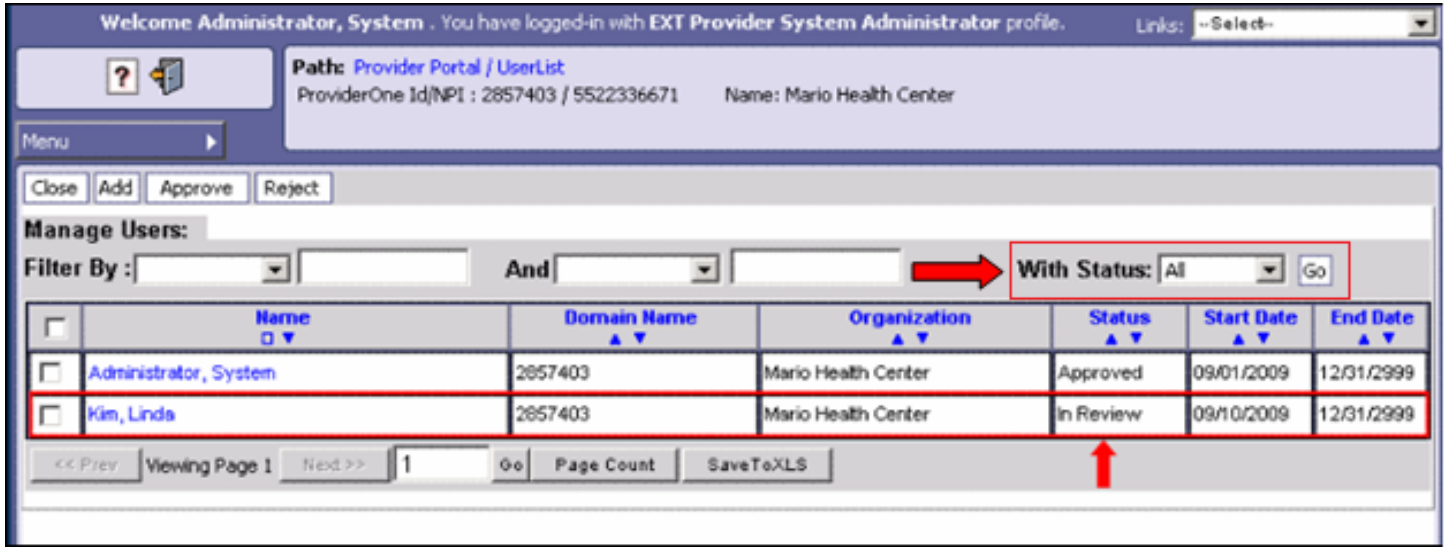
User Login ID: KimL
Domain: 2857403
Password: *
Confirm Password: *
Email: *
Phone Number: *
Pager Number:
Mobile Number:
Address Line 1:
(Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
City/Town:
State/Province:
County:
Country:
Zip Code: -
Address

Back Finish Cancel

- Fill in all required boxes that have an asterisk *
- The address is not needed here

How to set up a user

- Adding a User



- To Display the new user
  - ✓ In the "**With Status**" box display "**All**", then click
  - ✓ The user's name is displayed with "In Review" status.
  - ✓ Click the box left of the user's name, then click the Approve button. User will then be approved.

How to set up a user

- Adding Profiles
  - ✓ Get here by clicking on the users name on the previous screen.

Welcome Administrator, System . You have logged-in with EXT Provider System Administrator profile. Links: --Select--

Path: Provider Portal/ UserList/ UserDetails
User Login Id : KimL Name: Kim, Linda

Menu

Close Save

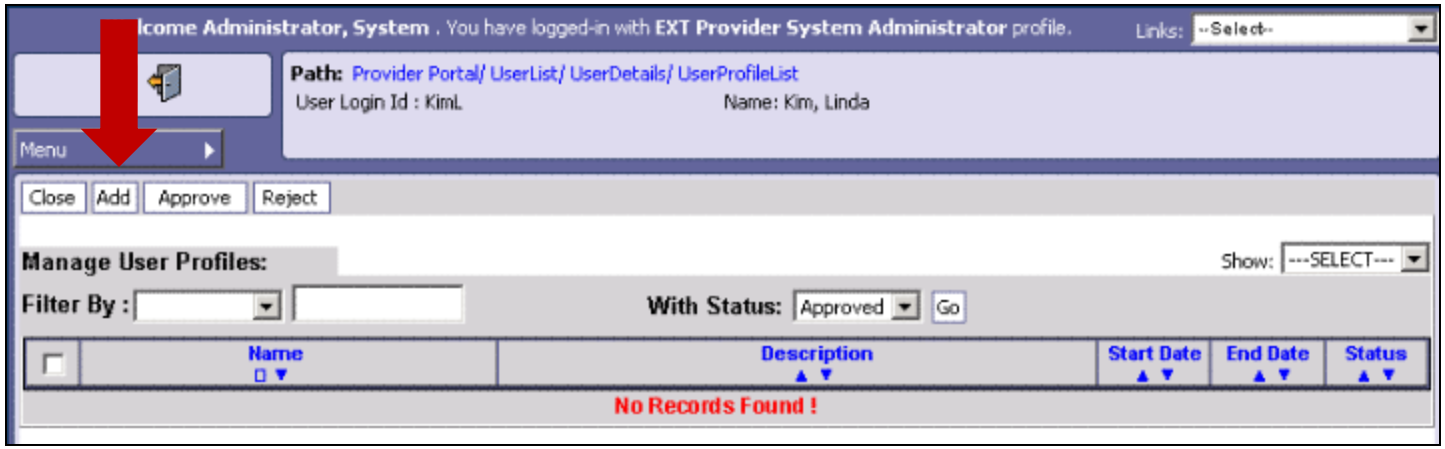
User Details: Show: ---SELECT---
---SELECT---
Associated Profiles
Check List

First Name: Linda
Middle Name:
Last Name: Kim
Lock User:
Date of Birth: 08/13/1975
Domain Name: 2857403
EID: 02376
UserType: NON-PHYSICIAN STAFF
User Name: Linda
Password:
Confirm Password:
Address Line 1:
(Enter Street Address or PO Box Only)
City/Town:
County:
Address Line 3:
Zip Code: - Address
State/Province:
Expiration Date: 12/31/2999

  - ✓ On the "Show" menu click on Associated Profiles.

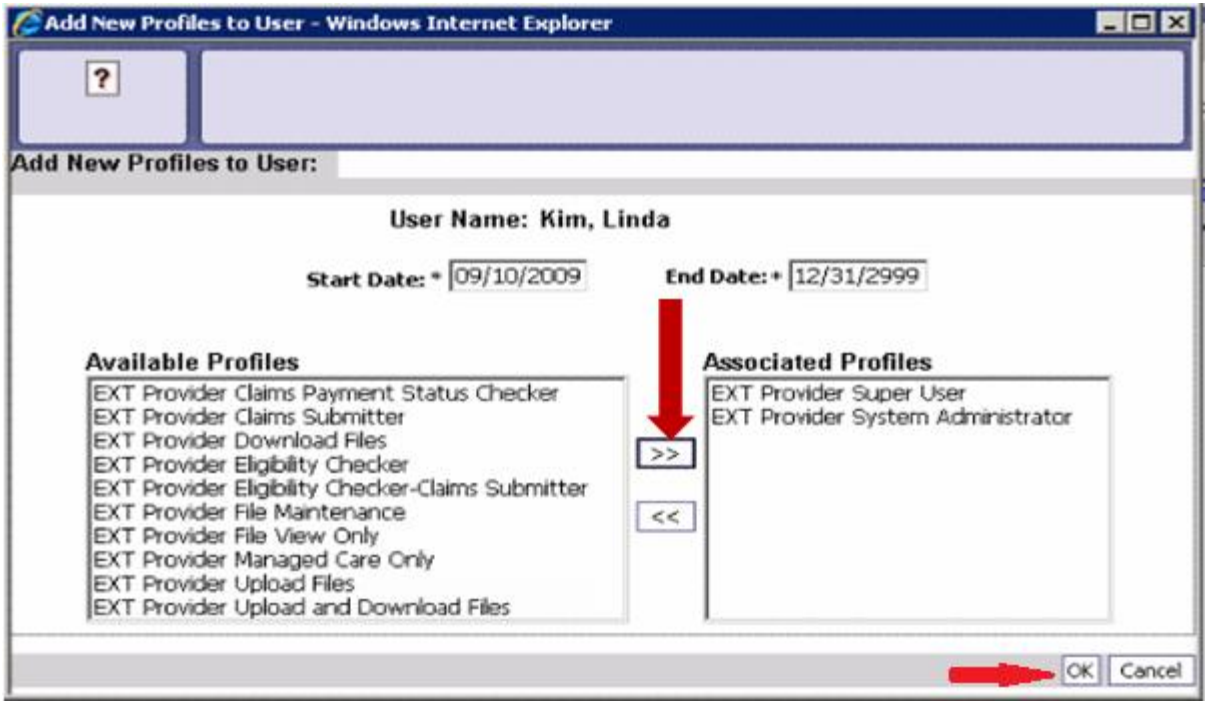
How to set up a user

- Adding Profiles
  - Click on the Add button to select profiles



How to set up a user

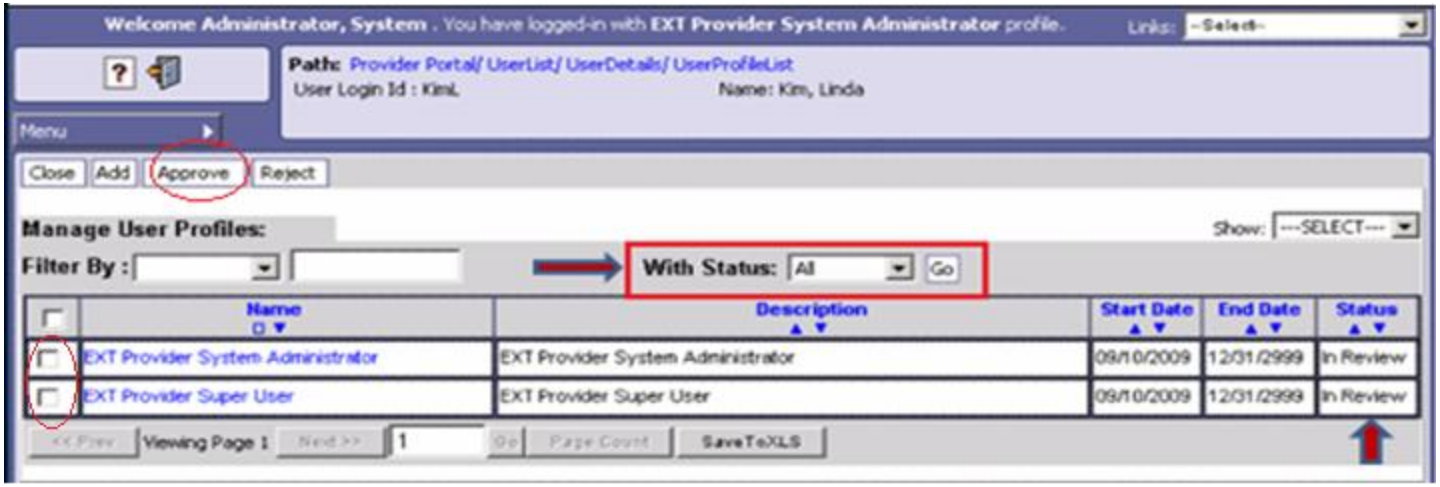
- Adding Profiles



- ✓ Highlight Available Profiles desired and click double arrow and move to Associated Profiles box then click the OK button.

How to set up a user

- Adding Profiles



- To Display the new profiles
  - ✓ In the "**With Status**" box display "**All**", then click Go
  - ✓ The profiles are displayed with "In Review" status.
  - ✓ Click the box left of the profile name, then click the Approve button. Profiles will then be approved.

How to Manage a user

- How to lock and unlock a user

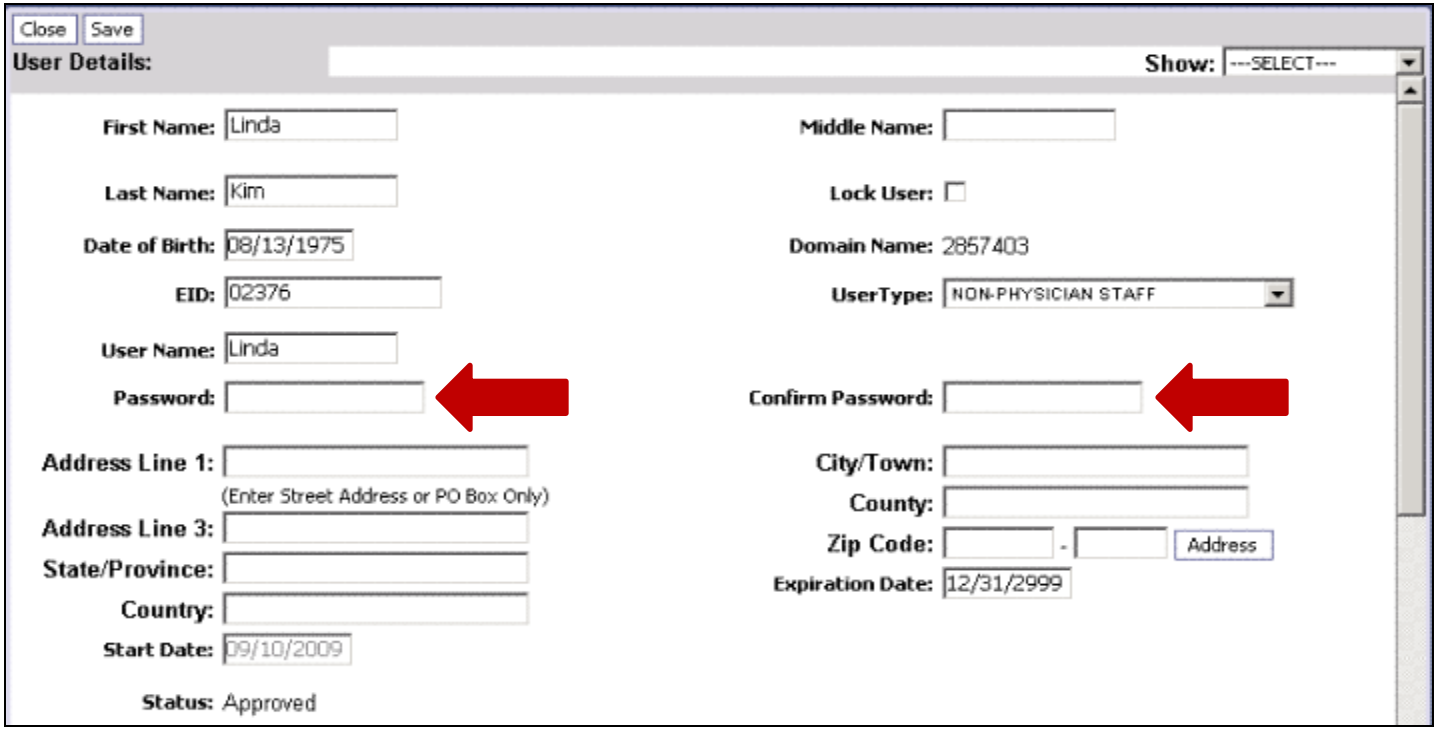
Close Save

User Details: Show: ---SELECT---

First Name: Linda
Middle Name:
Last Name: Kim
Lock User: ☐
Date of Birth: 08/13/1975
Domain Name: 2857403
EID: 02376
UserType: NON-PHYSICIAN STAFF
User Name: Linda
Password:
Confirm Password:
Address Line 1:
(Enter Street Address or PO Box Only)
City/Town:
County:
Address Line 3:
Zip Code: - Address
State/Province:
Expiration Date: 12/31/2999
Country:
Start Date: 09/10/2009
Status: Approved

How to Manage a user

- How to reset a password



- Enter the new temporary password and click "Save"

How to Manage a user

- How to end a user in ProviderOne

Close Save

User Details: Show: ---SELECT---

First Name: Linda
Middle Name:
Last Name: Kim
Lock User: ☐
Date of Birth: 08/13/1975
Domain Name: 2857403
EID: 02376
UserType: NON-PHYSICIAN STAFF
User Name: Linda
Password:
Confirm Password:
Address Line 1:
(Enter Street Address or PO Box Only)
City/Town:
County:
Address Line 3:
Zip Code: - Address
State/Province:
Expiration Date: 12/31/2999
Country:
Start Date: 09/10/2009
Status: Approved

- ✓ Enter the end date and click the save button.
- ✓ The account will be removed from view after the system refreshes overnight.

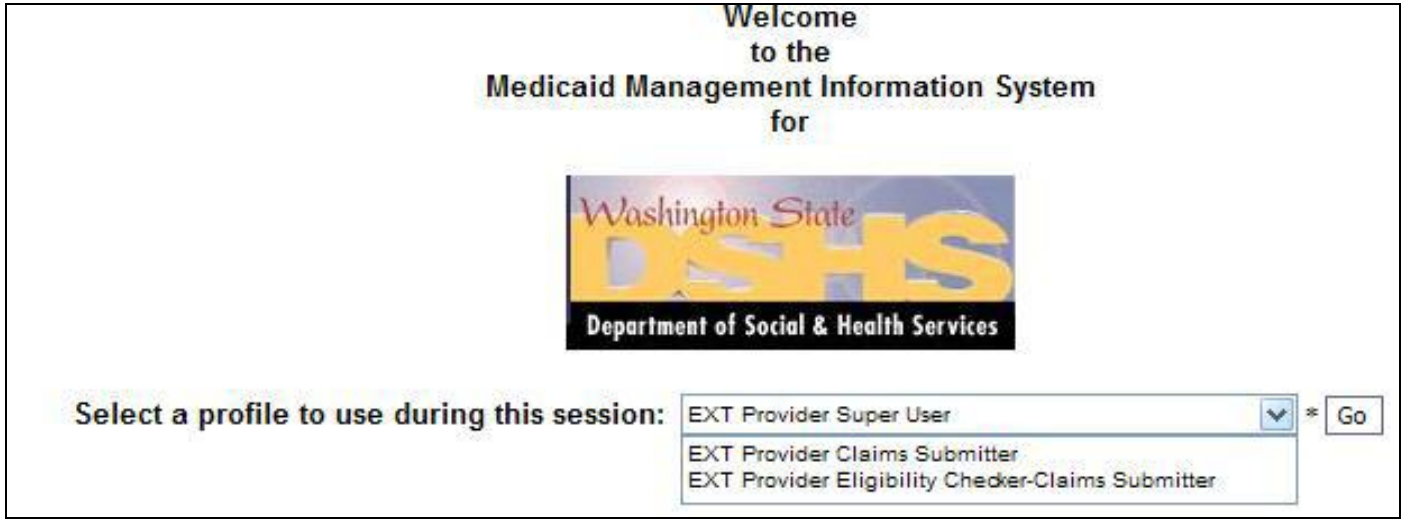
DIRECT DATA ENTRY (DDE) CLAIMS

DIRECT DATA ENTRY (DDE) CLAIMS

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

DIRECT DATA ENTRY (DDE) CLAIMS

- Log into ProviderOne using one of the following profiles:
  - EXT Provider Super User
  - EXT Provider Claims Submitter
  - EXT Provider Eligibility Checker-Claims Submitter

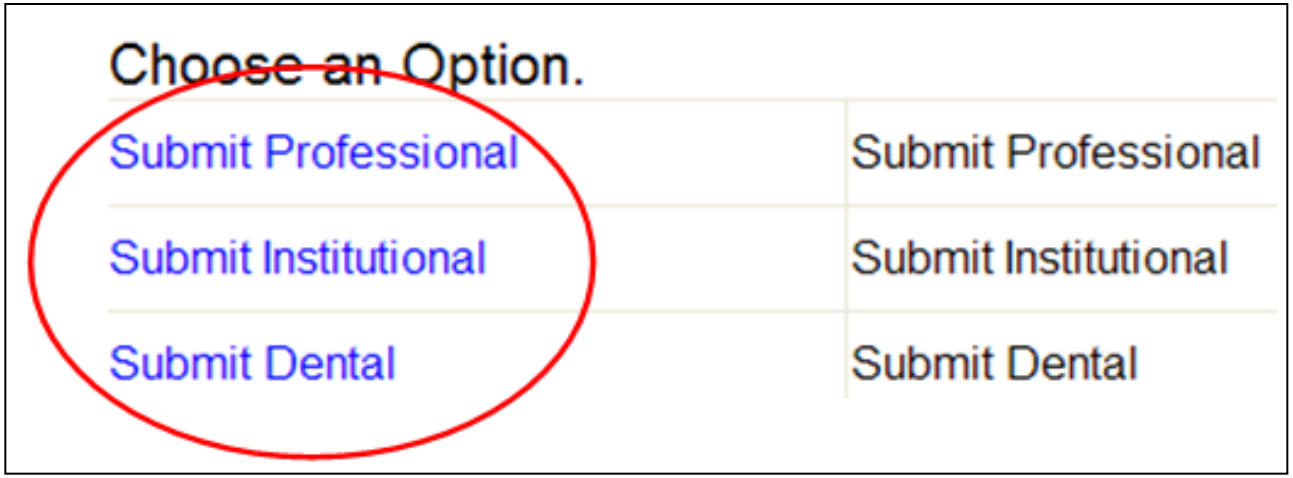


DIRECT DATA ENTRY (DDE) CLAIMS

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

DIRECT DATA ENTRY (DDE) CLAIMS

- Choose the type of claim that you would like to submit:
  - Professional is the CMS 1500
  - Institutional is the UB04
  - Dental is the 2006 ADA form



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DIRECT DATA ENTRY (DDE) CLAIMS

Close | Save Claim | Submit Claim | Reset

Dental Claim:

Note: asterisks (*) denote required fields. Billing Instructions

Basic Claim Info | Other Claim Info

Billing Provider | Subscriber | Claim | Service

Submitter ID: 200320900

PROVIDER INFORMATION

Go to Other Claim Info to enter information for providers other than the Referring provider.

BILLING PROVIDER

* Provider NPI: * Taxonomy Code:

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

Top

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

Additional Subscriber/Client Information

OTHER INSURANCE INFORMATION

Top

CLAIM INFORMATION

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

CLAIM DATA

Patient Account No.:

* Service Date: mm dd ccyy

* Place of Service:

Additional Claim Data

Diagnosis Codes

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DIRECT DATA ENTRY (DDE) CLAIMS

PRIOR AUTHORIZATION

CLAIM NOTE

* Is this claim accident related? ○ Yes ○ No

BASIC LINE ITEM INFORMATION

Click on the Other Svc. Info link associated with each added Service Line Item to enter line item information other than that displayed on this page.

BASIC SERVICE LINE ITEMS

* Procedure Code:

* Submitted Charges: $

Place of Service:

Modifiers: 1: 2: 3: 4:

Diagnosis Pointers

Tooth Information

* Procedure Count/Units: (Billing for anesthesia? Please indicate minutes here.)

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

Appliance Placement Date: mm dd ccyy

Oral Cavity Designation: 1: 2: 3: 4: 5:

Prior Authorization

Additional Service Line Information

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

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 0

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

DIRECT DATA ENTRY (DDE) CLAIMS

- Online step by step instructions for all claim types at: http://hrsa.dshs.wa.gov/provider/webinar.shtml

Washington State Medicaid

Providers home | Training | Fact Sheets | Links | Claims and Billing | New Provider | ProviderOne | ProviderOne Manuals

Programs and Services Directory

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Medicaid State Plan
WACs and Proposed Changes

Webinars

News

All Webinar presentation slides have been updated to reflect the ProviderOne system changes due to the implementation of the HIPAA 5010 system format. The Webinar recordings have not been updated to reflect the 5010 system format changes at this time.

Contract All | Expand All

- **Billing a client webinar**
- **Nursing Home providers webinar**
- **TAG/Provider Open Communication Forum webinar**
- **Interpreting Client Eligibility Information Returned by ProviderOne**
- **Prior authorization**
- **Submit fee for service claims (professional, dental, institutional)**
- **How to Navigate the Interactive Voice Response (IVR) System**

You may also want to visit:

ProviderOne Billing and Resource Guide for billing & detailed authorization information

Receive the latest information in your email. Join the Medicaid list for providers.

Coordination of Benefits

Providers access

Scope of Care client coverage eligible for services

Tribal services information

Contact the Customer Service Center

Saving a Direct Data Entry Claim

Saving a Direct Data Entry Claim

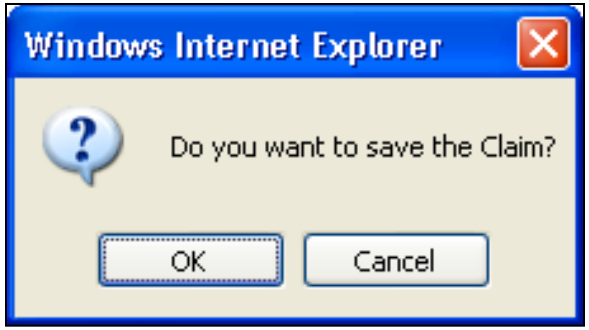
- ProviderOne now allows a provider to save a claim if the provider is interrupted during the process of entering a claim.
- Provider retrieves the saved claim to finish it and submit the claim.
- The following data elements are the minimum required to be completed before a claim can be saved:

Provider Information • Billing Provider NPI • Billing Provider Taxonomy • Question: Is the Billing Provider also the Rendering Provider?	**Subscriber/Client Information** • Client ID number
Claim Information • Question: Is this claim accident related?	**Basic Service Line Items** • Line Items are not required for saving a claim.

Saving a Direct Data Entry Claim

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

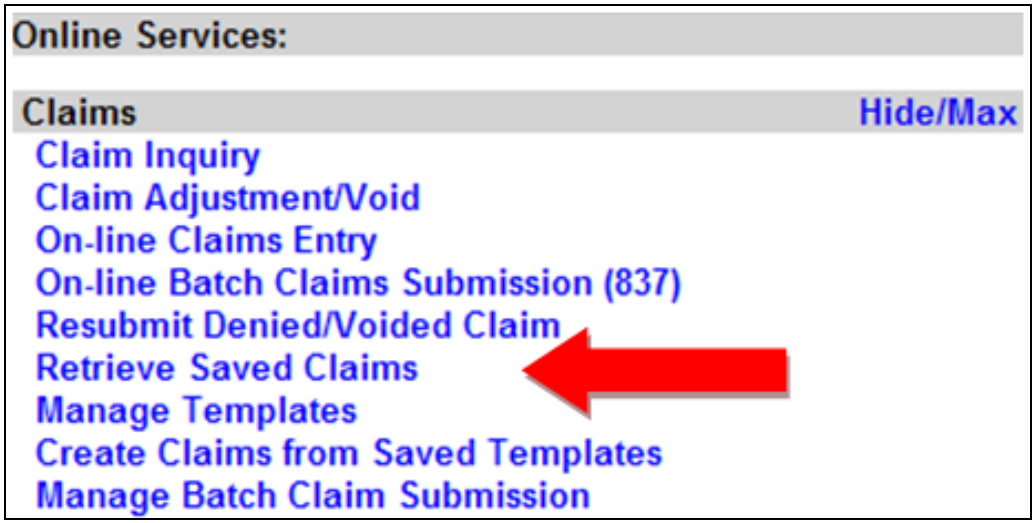
- ProviderOne now displays the following confirmation box:



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

Retrieving a saved Direct Data Entry Claim

- At the Provider Portal, click on the "Retrieve Saved Claims" hyperlink.



Retrieving a Saved Direct Data Entry Claim

- ProviderOne displays the Saved Claims List.
  - Click on the "Link" Icon to retrieve a claim.

Close | Delete

Saved Claims List:

Filter By : **And** Go

	Link	Billing Provider NPI	Client ID	Client Last Name	User Login ID
	▶	552233661	198333777WA		BettyB
	▶	552233661	198333666WA	Rogers	BobS

<< Prev | Viewing Page 1 | Next >> | 3 | Go | Page Count | Save To XLS

- The system loads the saved claim in the correct DDE claim form screen. Continue to enter data, then submit the claim.

- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claim List.

Commercial Insurance Secondary Claims

After this training, you can:

- Create and Submit TPL secondary claims DDE
  - ✓ With backup
  - ✓ Without backup
- Submit TPL secondary claims electronically
  - ✓ Without BU

Accessing ProviderOne

- Use web address https://www.waproviderone.org
- Ensure that your system **"Pop Up Blocker"** is turned **OFF**
- Login using assigned Domain, Username, and Password
- Click on the "Login" button

Determine what profile to use

Welcome
to the
Medicaid Management Information System
for

Washington State DSHS
Department of Social & Health Services

Select a profile to use during this session: EXT Provider Super User * Go

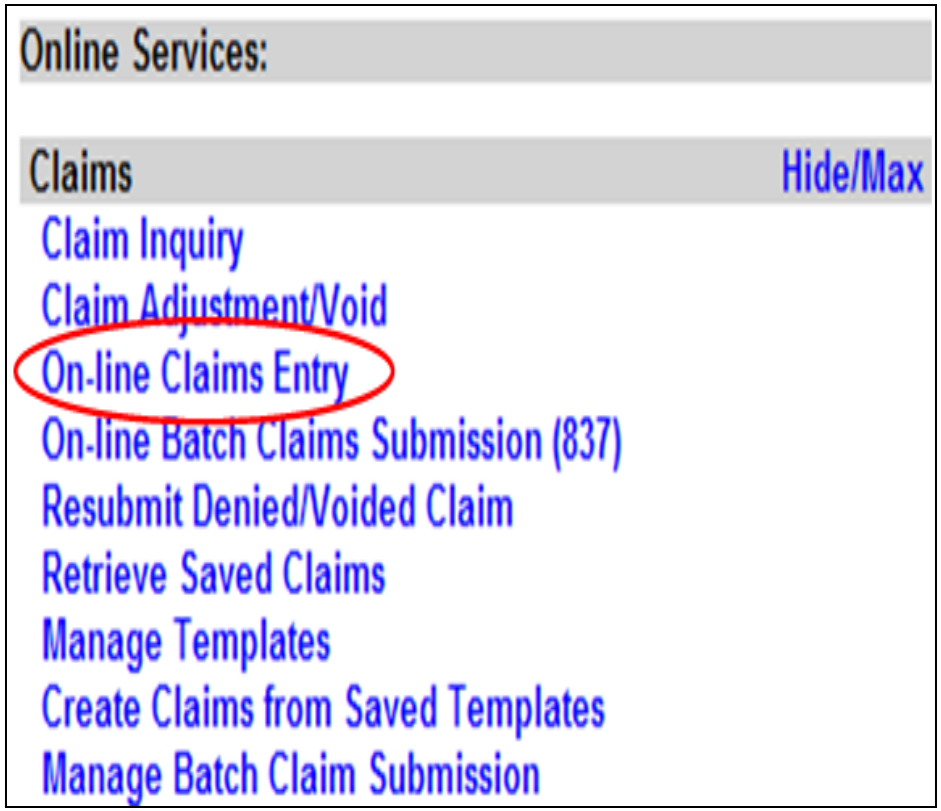
EXT Provider Claims Submitter
EXT Provider Eligibility Checker-Claims Submitter

For claims submission choose one of the following profiles:

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

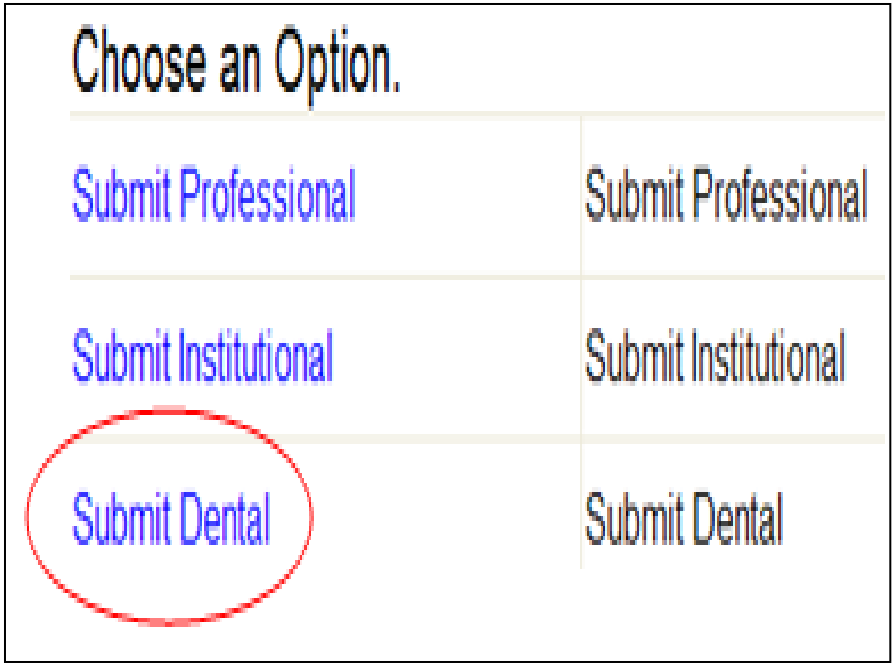
Provider Portal

- From the Provider Portal select the **"Online Claims Entry"** option located under the "Claims" Heading



Provider Portal

- Choose the type of claim that you would like to submit.
  - ✓ Professional is the HCFA 1500
  - ✓ Institutional is the UB04
  - ✓ Dental is the 2006 ADA form



Billing Provider Information

- Section 1: Billing Provider Information of the DDE Dental claim form

Dental Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info | Other Claim Info

Billing Provider | Subscriber | Claim | Service

PROVIDER INFORMATION

Go to Other Claim Info to enter information for providers other than the Referring provider.

BILLING PROVIDER

* Provider NPI: [ ] * Taxonomy Code: [ ]

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

Billing Provider Information

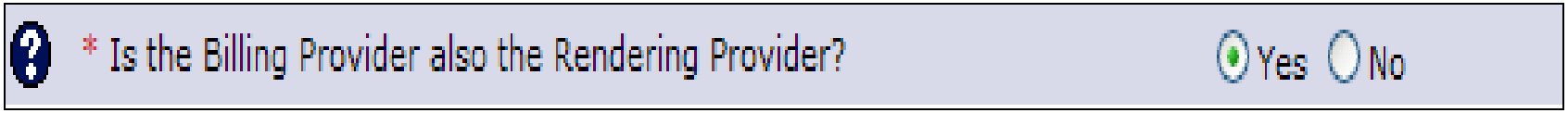
- Enter the Billing Provider NPI and taxonomy code
  - ✓ This will likely be the NPI and Taxonomy Code of the clinic/office where the service was performed and where you would like payment to be received.

BILLING PROVIDER

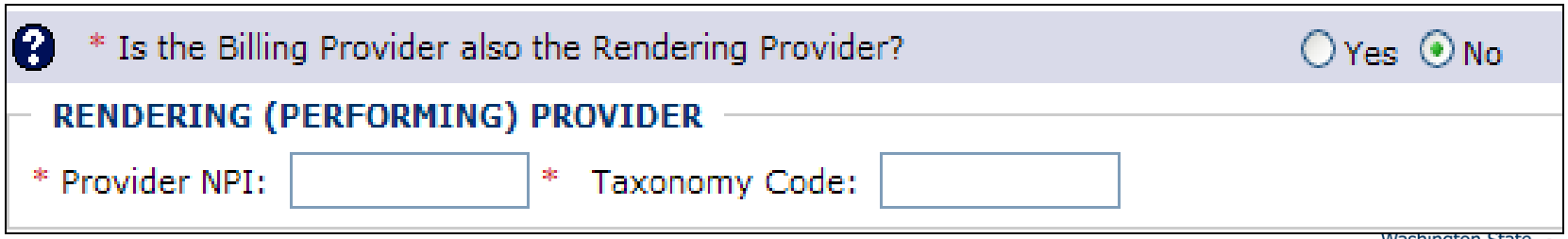
* Provider NPI: [ ] * Taxonomy Code: [ ]

Rendering Provider Information

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



- If the "Rendering Provider" is different than the "Billing Provider" entered in the previous question, answer "**NO**" and enter the "Rendering (Performing) Provider" NPI and Taxonomy Code.



Subscriber/Client Information

- Section 2: Subscriber/Client Information

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

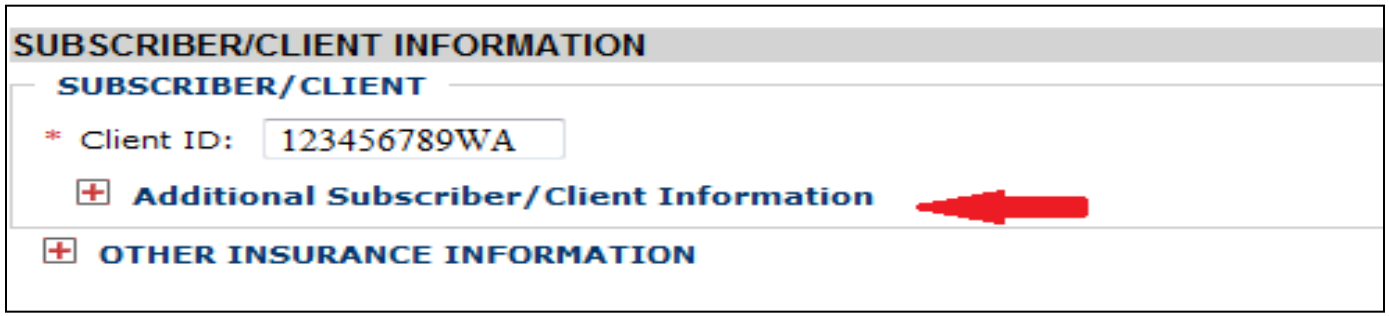
* Client ID:

Additional Subscriber/Client Information

OTHER INSURANCE INFORMATION

Subscriber/Client Information

- Enter the Subscriber/Client ID found on the WA Medicaid medical card. This ID is a 9 digit number followed by a "**WA**"
  - ✓ Example: **123456789WA**



- Click on the red "**+**" to expand the "Additional Subscriber/Client Information" to enter additional required information.

Subscriber/Client Information

- Once the field is expanded enter the "Patient's Last Name, Date of Birth, and Gender.
  - ✓Date of birth must be in the following format: MM/DD/CCYY.

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID: 123456789WA

☐ Additional Subscriber/Client Information

* Org/Last Name: SMITH First Name: MC

* Date of Birth: mm 12 dd 01 ccyy 1992 * Gender: M-Male

Insurance Other Than Medicaid

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

- Then open up the "1 Other Payer Insurance Information" section by clicking on the red (+) expander.

Insurance Other Than Medicaid

- Enter the "Payer/Insurance Organization Name" then;

- Open up the "Additional Other Payer Information" section by clicking on the red (+) expander.

Insurance Other Than Medicaid

- In the "Additional Other Payer Information" section fill in the following information:

Other Payer Information

* Payer/Insurance Organization Name: Premera

Additional Other Payer Information

Entity Qualifier:

* ID: BC01 * ID Type: PI-Payor Identification

Claim Check or Remittance Date: mm 12 dd 15 ccyy 2010

Number Type: PA/Referral No.:

Payer Claim Adjustment: Yes No

Secondary ID Information

Enter the Insurance ID number, ID Type, and processing date of the insurance EOB

- The next slide shows where to get the **ID** number.

Insurance Other Than Medicaid

- Use the Insurance Carrier Code found on the client eligibility screen under the "Coordination of Benefits" section as the "**ID**" number for the insurance company, or

- Use the assigned insurance company ID provided on the insurance EOB.

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	PREMERA BLUE CROSS/BCBS OF AK (800) 345-6784	BC01	SMITH , MC	426687BC7			04/01/2007	12/31/2999

Insurance Other Than Medicaid

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

OTHER INSURANCE INFORMATION
1 OTHER PAYER INSURANCE INFORMATION
Other Payer Information
* Payer/Insurance Organization Name: Premera
Additional Other Payer Information
* ID: BC01 * ID Type: PI-Payor Identification
Claim Check or Remittance Date: mm 12 dd 15 ccyy 2010
Number Type:
Secondary ID Information
COB Monetary Amounts
COB Payer Paid Amount: 28.10
Additional COB Information

Note: If the insurance applied to the deductible enter a $0 here.

Note: If the claim is for an insurance denial enter a $0 here.

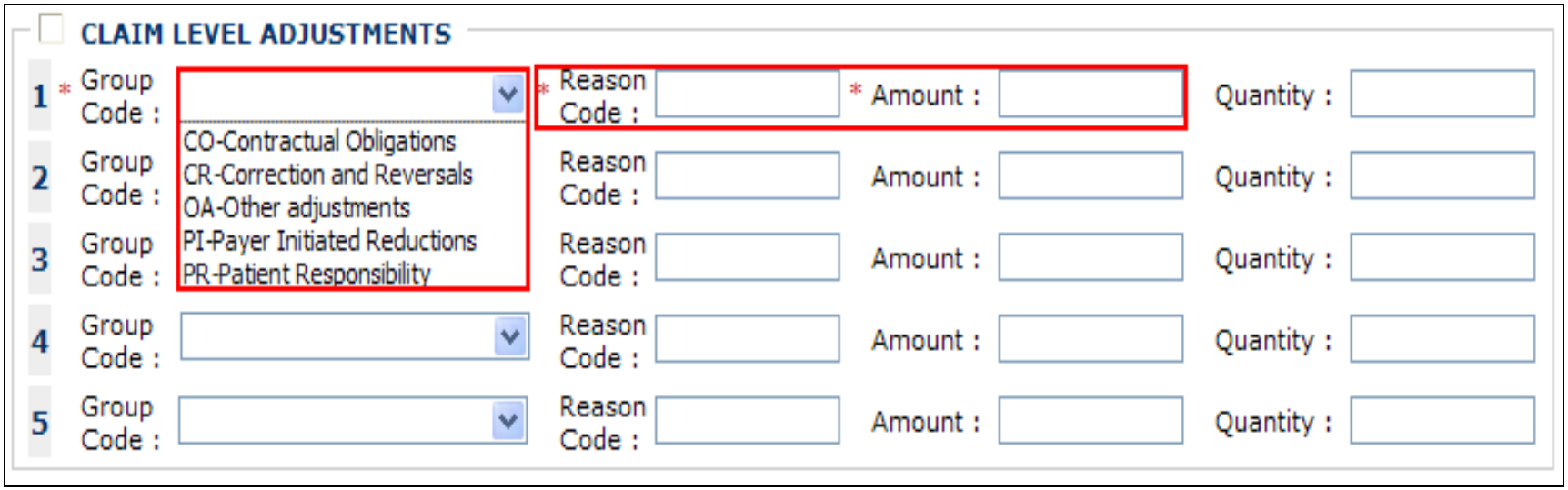
Insurance Other Than Medicaid

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

OTHER INSURANCE INFORMATION
1 OTHER PAYER INSURANCE INFORMATION
Other Payer Information
* Payer/Insurance Organization Name: Premera
Additional Other Payer Information
* ID: BC01 * ID Type: PI-Payor Identification
Claim Check or Remittance Date: mm 12 dd 15 ccyy 2010
Number Type: PA/Referral No.:
Secondary ID Information
COB Monetary Amounts
COB Payer Paid Amount: 28.10
Additional COB Information
OTHER PAYER BILLING PROVIDER
OTHER PAYER ASSISTANT SURGEON
CLAIM LEVEL ADJUSTMENTS
Other Subscriber Information
Other Insurance Coverage

Insurance Other Than Medicaid

- Enter the adjustment "Group Code", "Reason Code" (Number Only), and "Amount."



Note: The Agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the following website: http://www.wpc-edi.com/reference/

Claim Information

- Section 3: Claim Information Section

CLAIM INFORMATION

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

CLAIM DATA

Patient Account No.: 123456

* Service Date: mm 03 dd 10 ccyy 2012

* Place of Service: 11-OFFICE

Additional Claim Data

Diagnosis Codes

PRIOR AUTHORIZATION

CLAIM NOTE

* Is this claim accident related? Yes No

Patient Account Number

- The "Patient Account No." field allows the provider to enter their internal patient account numbers assigned to the patient by their practice management system.

Patient Account No.: 123456

- **Note:** Entering internal patient account numbers may make it easier to reconcile the weekly remittance and status report (RA) as these numbers will be posted on the RA.

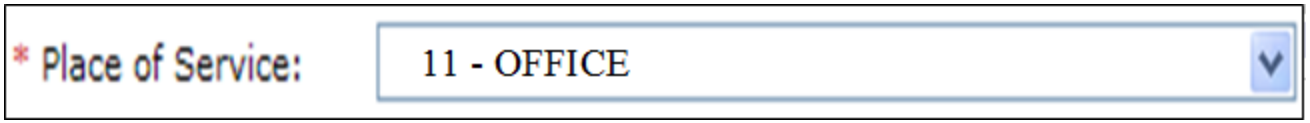
Service Date

- Enter the date of service here. This date will be placed on all lines of the claim.

* Service Date:	mm	dd	ccyy
	03	10	2012

Place of Service

- With 5010 implementation the "Place of Service" box has been added to the main claim section. Choose the appropriate "Place of Service" from the drop down.



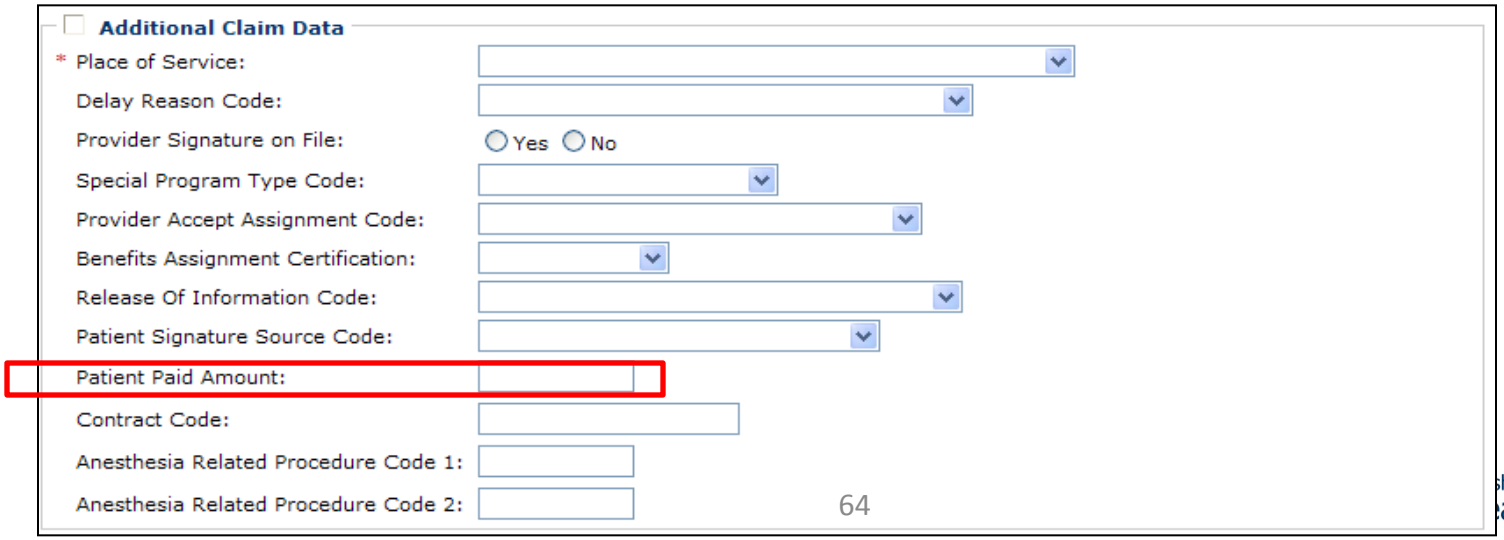
01-PHARMACY
03-SCHOOL
04-HOMELESS SHELTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY
08-TRIBAL 638 PROVIDER-BASED FACILITY
09-PRISON/CORRECTIONAL FACILITY
11-OFFICE
12-Home
13-ASSISTED LIVING FACILITY
14-Group Home
15-MOBILE UNIT
16-TEMPORARY LODGING
17-WALK-IN RETAIL HEALTH CLINIC
20-URGENT CARE FACILITY
21-INPATIENT HOSPITAL
22-OUTPATIENT HOSPITAL
23-EMERGENCY ROOM - HOSPITAL
24-AMBULATORY SURGICAL CENTER
25-BIRTHING CENTER
26-MILITARY TREATMENT FACILITY
31-SKILLED NURSING FACILITY (SNF)
32-NURSING FACILITY
33-CUSTODIAL CARE FACILITY
34-Hospice
41-AMBULANCE - LAND
42-AMBULANCE - AIR OR WATER
49-INDEPENDENT CLINIC
50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
51-INPATIENT PSYCHIATRIC FACILITY
52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
53-COMMUNITY MENTAL HEALTH CENTER
54-INTERMEDIATE CARE FACILITY (ICF/MR)
55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
60-MASS IMMUNIZATION CENTER
61-COMPREHENSIVE INPATIENT REHAB FACILITY
62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
65-END-STAGE RENAL DISEASE TREATMENT FACILITY
71-PUBLIC HEALTH CLINIC
72-RURAL HEALTH CLINIC (RHC)
81-INDEPENDENT LABORATORY
99-OTHER PLACE OF SERVICE

- **Note:** The "Place of Service" is required in this section but can still be added to the line level of the claim. Line level is <u>not</u> required.

Additional Claim Data

- The "Additional Claim Data" red (+) expander will allow the provider to enter the patient's spenddown amount.

- If patient has a spenddown click on the red (+) expander to display the below image. Enter the spenddown amount in the "Patient Paid Amount" box.



Prior Authorization

- If a "Prior Authorization" number needs to be added to the claim, click on the red "**+**" to expand the "Prior Authorization" fields.
- EPA numbers are considered authorization numbers and should be entered here.

PRIOR AUTHORIZATION

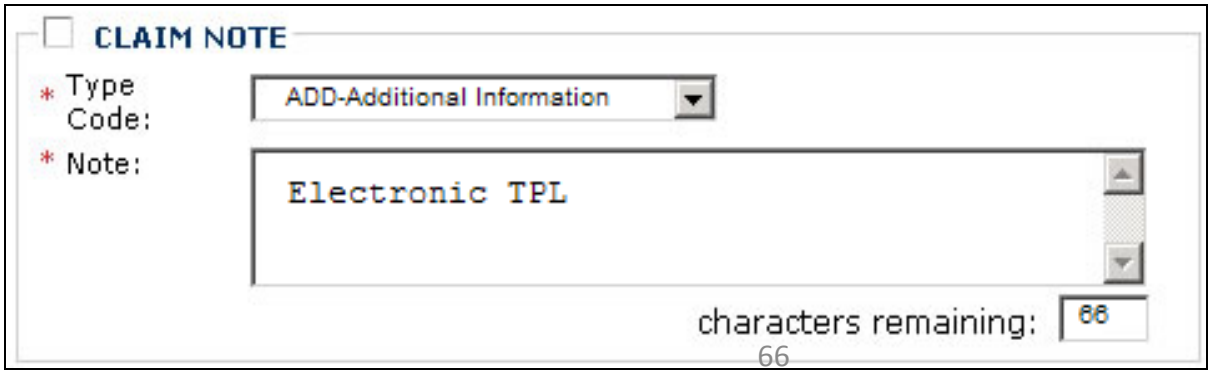
1. * Prior Authorization Number:
2. Prior Authorization Number:

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

Claim Note

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

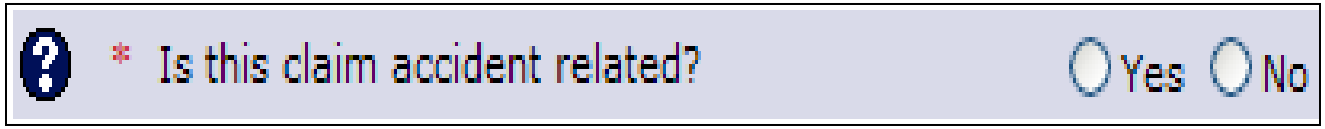
- Click on the red "+" to expand the "Claim Note" section.
  - ✓ Enter the Type Code "ADD-Additional Information".
  - ✓The NOTE must say "**Electronic TPL**" if no EOB is sent.
  - ✓The note could say "Sending ins. EOB" if the EOB is sent
  - ✓ProviderOne allows up to 80 characters.



Is the Claim Accident Related?

- This question will almost always be answered "**NO**" as Washington Medicaid has a specific casualty office that handles claims where another casualty insurance may be primary.

  - ✓ The Casualty office can be reached at 800-562-3022 ext 15462



Basic Service Line Items

- Section 4: Basic Line Item Information

BASIC LINE ITEM INFORMATION

Click on the Other Svc. Info link associated with each added Service Line Item to enter line item information other than that displayed on this page.

BASIC SERVICE LINE ITEMS

* Procedure Code:

* Submitted Charges: $

Place of Service:

Modifiers: 1: 2: 3: 4:

Diagnosis Pointers

Tooth Information

* Procedure Count/Units: (Billing for anesthesia? Please indicate minutes here.)

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

Appliance Placement Date: mm dd ccyy

Oral Cavity Designation: 1: 2: 3: 4: 5:

Prior Authorization

Additional Service Line Information

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

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 0

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

Basic Service Line Items

- Enter the Procedure Code

* Procedure Code:

- **Note:** Use current codes listed in the coding manuals.

- Enter Submitted Charges

* Submitted Charges: $

- **Note:** If dollar amount is a whole number no decimal point is needed.

- **Note:** The Agency request providers to enter their usual and accustom charges here. If providers have billed a Commercial Insurance, please enter the same charges here as billed to the primary. If a provider is billing a service that required prior authorization, please enter the same amount here as was on the authorization request because they must match.

Basic Service Line Items

- Optional "Place of Service Code" (Not required here as already entered).

Place of Service:

- Modifiers are not required on a dental claim
- Diagnosis are not required on a dental claim

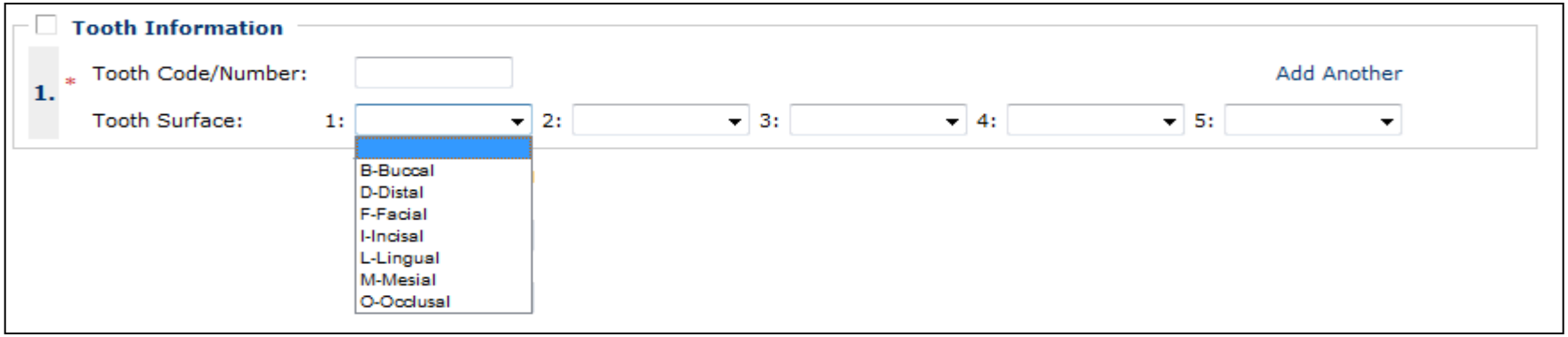
Modifiers: 1: 2: 3: 4:

Diagnosis Pointers

Basic Service Line Items

Tooth Information

- If the service requires tooth information, click on the "+" expander to open.
  - ✓ Enter the tooth number/letter.
  - ✓ Tooth numbers are single digits (unless a supernumerary tooth).
  - ✓ Enter the tooth surface (s) if required.



- Only add one tooth per service line!

Basic Service Line Items

- Enter procedure "Units."
  - ✓ DO NOT enter minutes in this box now.
  - ✓ Old language not removed yet.

* Procedure Count/Units:		(Billing for anesthesia? Please indicate minutes here.)
		Ignore this statement!

- **Note:** At least 1 unit is required.

- If billing two different dates of service on the same claim, enter the second date here (applied to this line only).

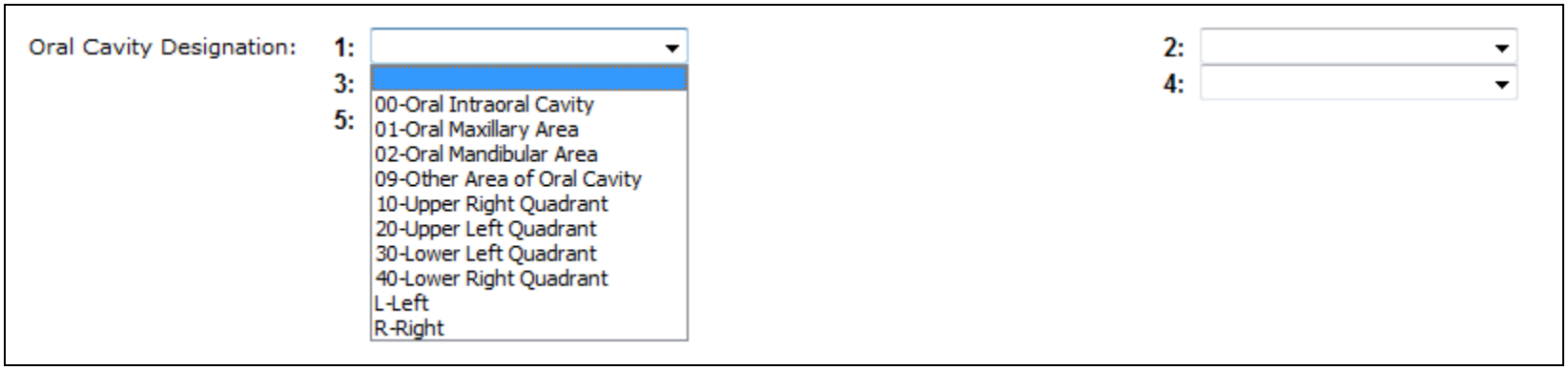
Service Date:	mm	dd	ccyy	(If different from the claim service date)
Appliance Placement Date:	mm	dd	ccyy	

- If billing for Orthodontic services enter the banding date here as the "Appliance Placement Date."

Basic Service Line Items

Oral Cavity Designation

- If the service requires a HIPPA oral area designation:
  - ✓ Click on the appropriated Arch designation; or
  - ✓ Click on the appropriated Quadrant designation.



- Only indicate one oral area per service line.

Basic Service Line Items

- If a "Prior Authorization" number needs to be added to a line level service, click on the red "+" to expand the "Prior Authorization".

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

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

Add Service Line Items

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

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 125

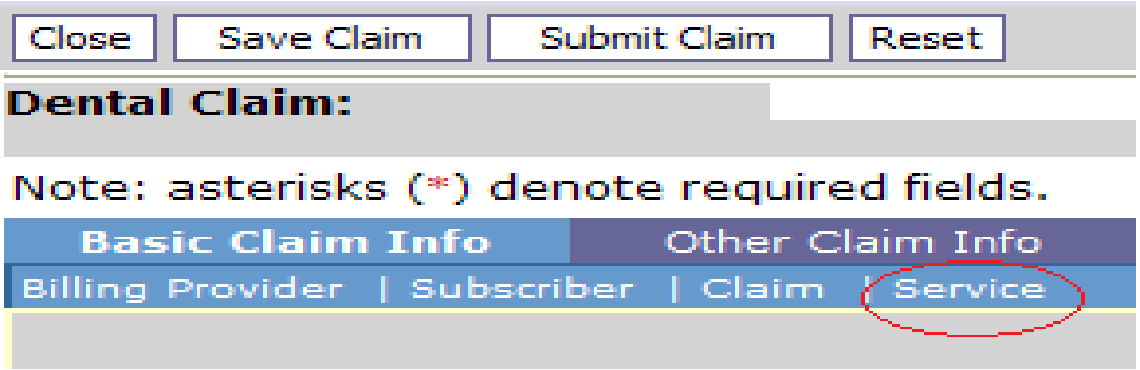
Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	1	2	3	4	5						
1	D0120	125														1					Delete or Other Service Info

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

- **Note:** Once the procedure line item is added, ProviderOne will refresh and return to the top of the claim form.

Add Additional Service Line Items

- If additional service lines need to be added, click on the "**Service**" hyperlink to get quickly back to the "Basic Service Line Items" section.



- Then follow the same procedure as outlined above for entering data for each line.

Update Service Line Items

- Update a previously added service line item by clicking on the line number of line that needs to be updated. This will repopulate the service line item boxes for changes to be made.

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 125

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	1	2	3	4	5						
1	D0120	125														1					Delete or Other Service Info

- **Note:** Once the line number is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the "**Service**" hyperlink to quickly return to the service line item boxes and make corrections.

Update Service Line Items

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

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 420

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	1	2	3	4	5						
1	D0120	125														1					Delete or Other Service Info

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

Delete Service Line Items

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

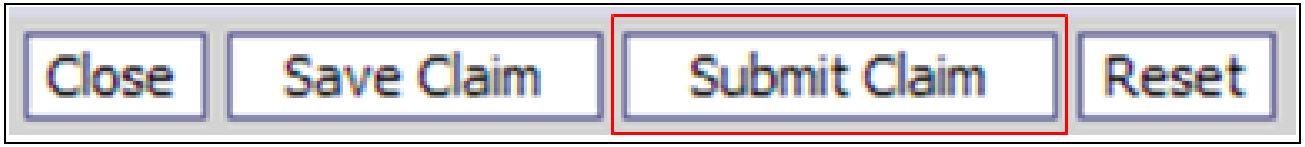
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 420

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	1	2	3	4	5						
1	D0120	125														1					Delete or Other Service Info
2	D0220	25														1					Delete or Other Service Info
3	D0272	20														1					Delete or Other Service Info
4	D1110	250														1					Delete or Other Service Info

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

Submit Claim for Processing

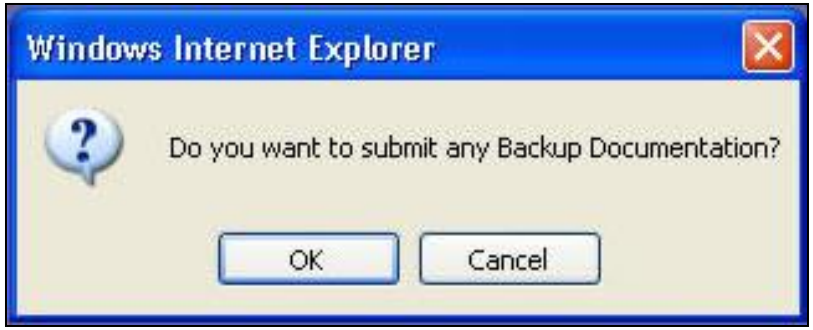
- When the claim is ready for processing, click the "Submit Claim" button at the top of the claim form.



- **Note:** Make sure the browser "**Pop Up Blocker**" is off or your system will not allow the claim to be submitted.

Submit Claim for Processing

- Click on the "Submit Claim" button to submit the claim. ProviderOne should then display this prompt:



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

> **Note:** If all insurance information has been entered on the claim, it is not necessary to send the insurance EOB with the claim.

Submit Claim for Processing – No Backup

- ProviderOne now displays the "Submitted Dental Claim Detail" screen.
- Click on the "**OK**" button to finish submitting the claim!

Claims Submission Final Dialog - Windows Internet Explorer

Submitted Dental Claim Details:

TCN: 200925500000001000
Provider NPI: 5522336671
Client ID: 198333777WA
Date of Service: 9/9/2009 0:0:0-9/9/2009 0:0:0
Total Claim Charge: 1159

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

Attachment List:

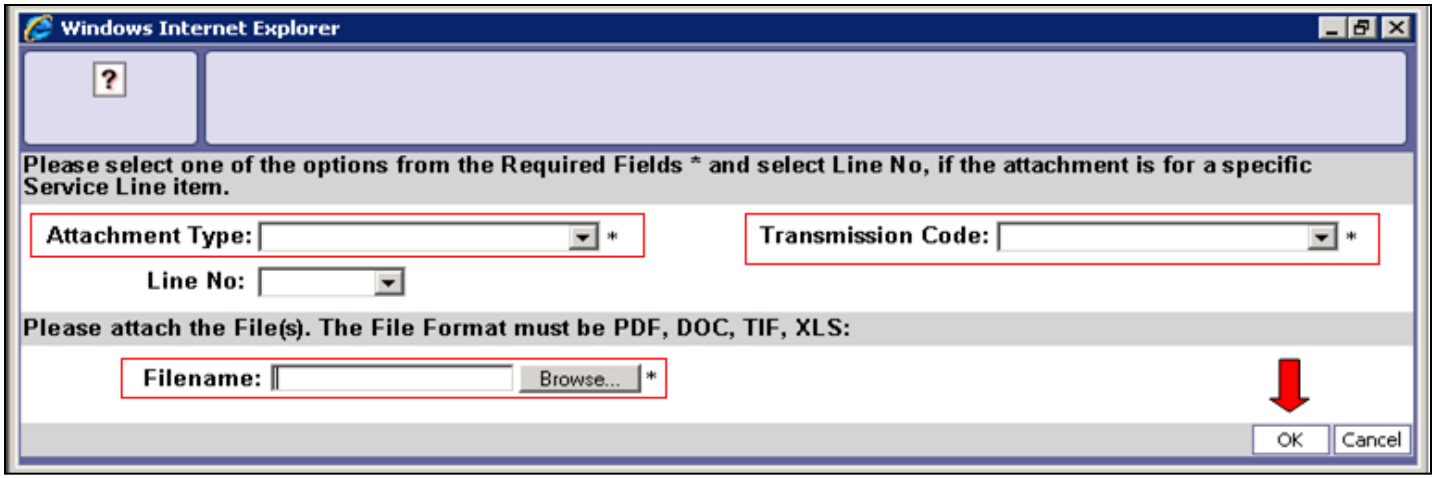
Line No	File Name	Attachment Type	Transmission Code	Attachment Control	File Size	Delete	Uploaded On
No Records Found !							

Print | Print Cover Page | Ok

WARNING: You must click the OK button to complete the claims submission.

Submit Claim for Processing – With Backup (Electronic File Attached)

- The "Claims Backup Documentation" page is displayed.



- ✓ Enter the Attachment Type;
- ✓ Pick one of the following Transmission Codes:
  - **EL**-Electronic Only or Electronic file;
  - Then browse to find the file name.
- ✓ Click the "**OK**" button.

Submit Claim for Processing – With Backup (Electronic File Attached)

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

Submitted Dental Claim Details:

TCN: 201201100000004000
Provider NPI: 1760562995
Client ID: 100666385WA
Date of Service: 01/01/2012-01/01/2012
Total Claim Charge: 120

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	10-86.pdf	EB	EL		266kb	X	01/11/2012

<<Prev Viewing Page 1 Next>> 1 Go Page Count SaveToXLS

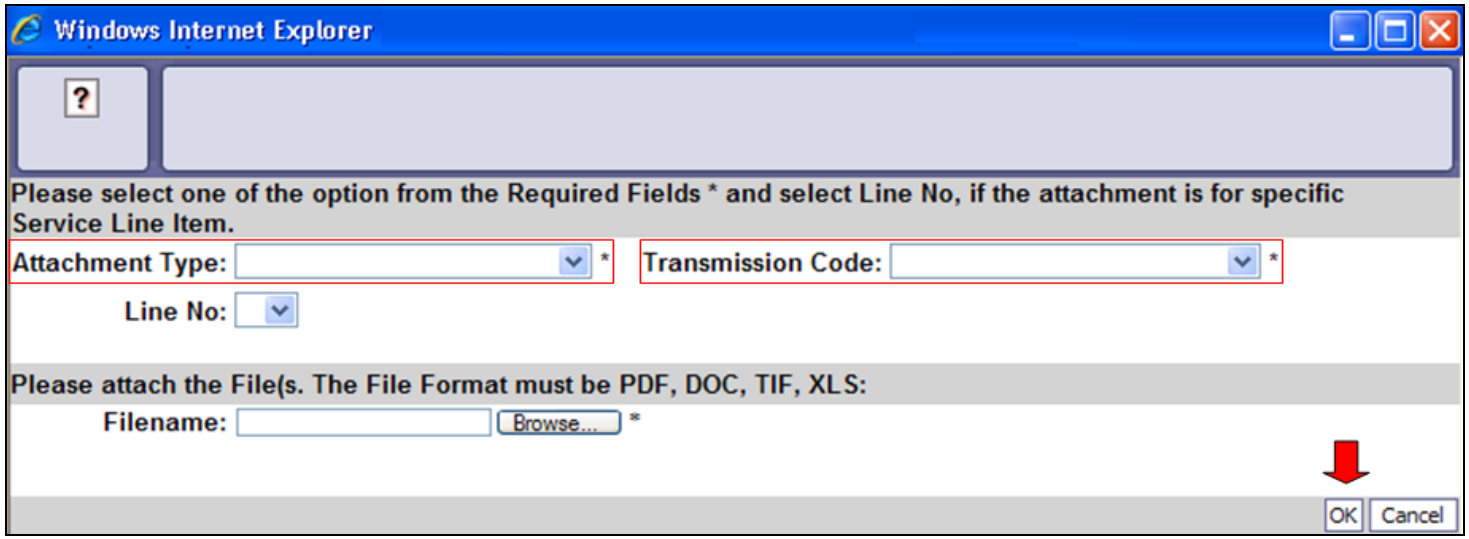
Print Print Cover Page Ok

WARNING: You must click the OK button to complete the claims submission.

- Now push the "**OK**" button to submit the claim!

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- The "Claims Backup Documentation" page is displayed.



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

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- If sending paper documents with the claim, at the "Submitted Dental Claim Details" page click on the "Print cover Page " button.

Submitted Dental Claim Details:

TCN: 201127300000014000
Provider NPI: 1342222999
Client ID: 300655596WA
Date of Service: 10/20/2010-10/20/2010
Total Claim Charge: 75

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	09/30/2011

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Print Print Cover Page Ok

Washington State Health Care Authority
Medicaid

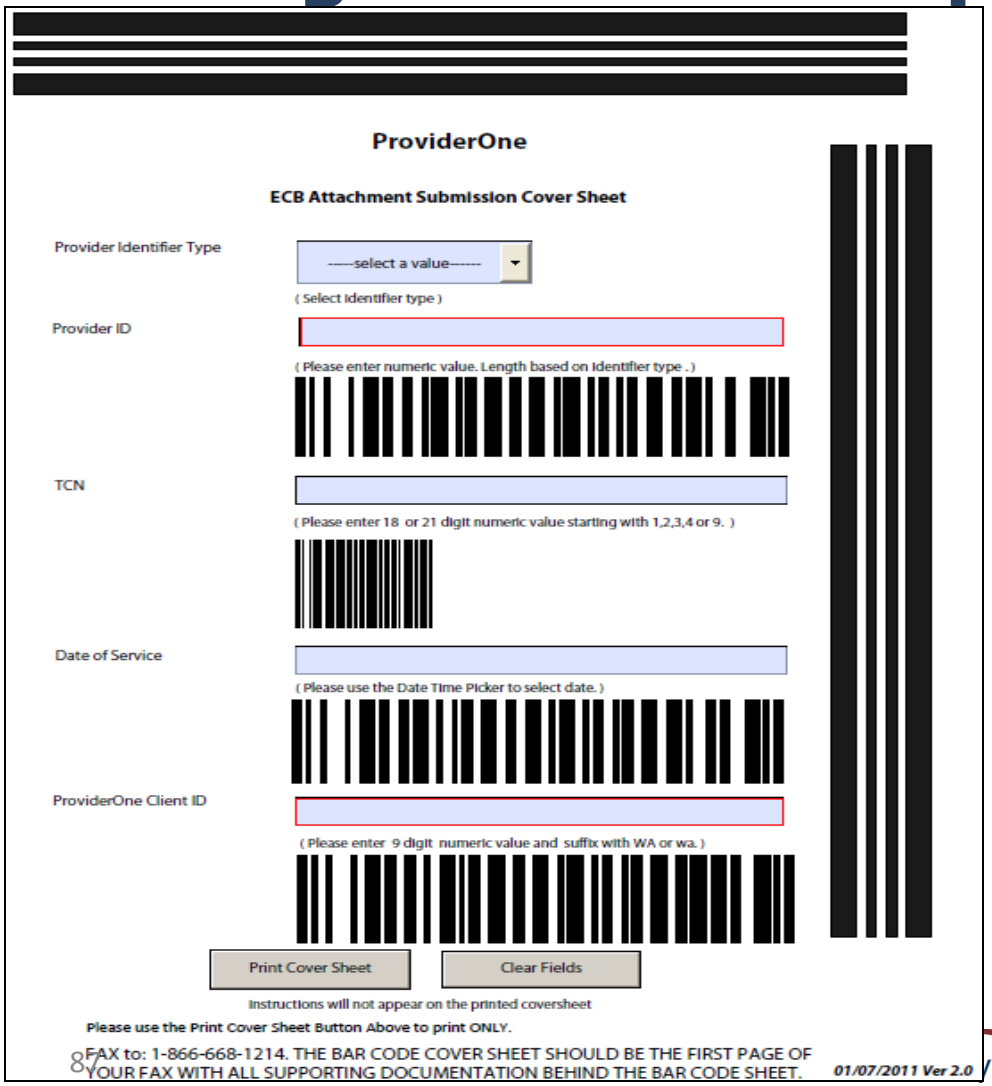
Submit Claim for Processing – With Backup

- Fill in the boxes with the appropriate information.
  - ✓ Tab between fields
  - ✓ Expands the bar code
- When completed click on the "Print Cover Sheet" button and mail to:

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

OR

Fax 1-866-668-1214



ProviderOne

ECB Attachment Submission Cover Sheet

Provider Identifier Type ----select a value------
(Select identifier type)

Provider ID
(Please enter numeric value. Length based on identifier type .)

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

Date of Service
(Please use the Date Time Picker to select date.)

ProviderOne Client ID
(Please enter 9 digit numeric value and suffix with WA or wa.)

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet

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

FAX to: 1-866-668-1214. THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.

01/07/2011 Ver 2.0

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- Now push the "**OK**" button to submit the claim!

Submitted Dental Claim Details:

TCN: 201127300000014000
Provider NPI: 1342222999
Client ID: 300655596WA
Date of Service: 10/20/2010-10/20/2010
Total Claim Charge: 75

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	09/30/2011

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

Print | Print Cover Page | Ok

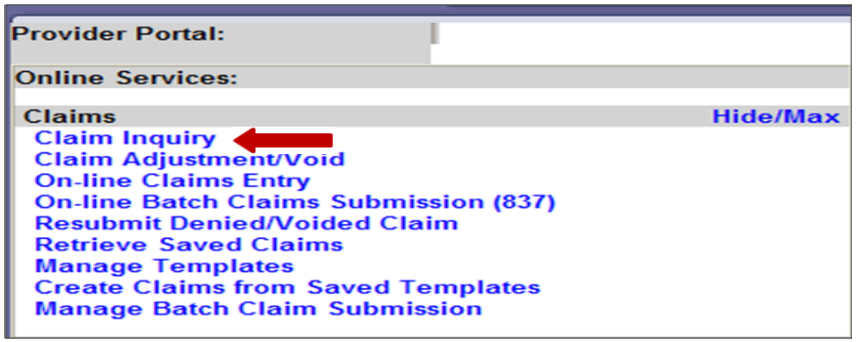
WARNING: You must click the OK button to complete the claims submission.

Batch Secondary Electronic Billing

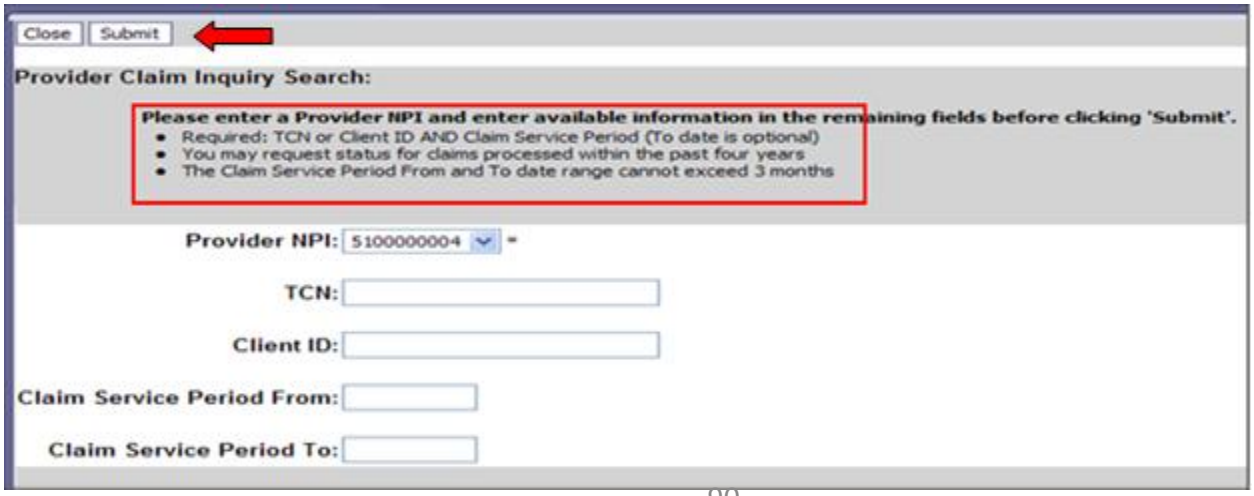
- The Agency is accepting secondary electronic claim billing through a clearinghouse batch or a self submitted HIPAA claim batch.
- Follow the HIPAA companion guides to submit primary payer insurance information:
  - ✓Find at http://hrsa.dshs.wa.gov/dshshipaa/
  - ✓837 Professional
  - ✓837 Institutional
  - ✓837 Dental; and
- Add the required comment "**Electronic TPL**" in Loop 2300, NTE Segment(s).
- Add the required Adjustment Reason Code information (Loop information located in the above companion guides).

Claim Inquiry

- How do I find claims in ProviderOne?
  - ✓ Claim Inquiry



- Enter search data then submit



Claim Inquiry

- Claim TCN's returned
  - ✓ Click on TCN number to view the claim data.
  - ✓ Denied claims will show the denial codes.
  - ✓ Easiest way to find a timely TCN number for re-bills.

Claim Inquiry Providers List:

	TCN	Date of Service	Claim Status	Claim Charged Amount
☐	1030200005720000	10/14/2010	0: Cannot provide further status electronically.	$888.00
☐	1101100018152000	10/14/2010	0: Cannot provide further status electronically.	$888.00
☐	1105400007698000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1106100031712000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1106600001668000	10/14/2010	1: For more detailed information, see remittance advice.	$750.00
☐	1106600003011000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1107500035007000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1108200019887000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1113600005638000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1114400017409000	10/14/2010	1: For more detailed information, see remittance advice.	$750.00

<< Prev Viewing Page 1 Next >> 2 Go Page Count = 2 SaveToXLS

Why can't I pull up my claim?!

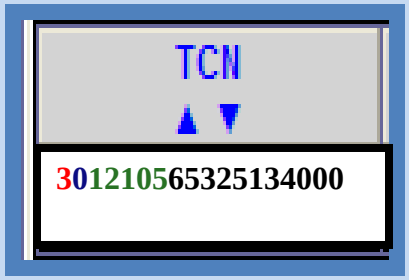
- There are many reasons why you might not be able to retrieve a claim (for any system functions).
  - ✓ It has been Adjusted, you can't retrieve a claim that has already been Adjusted.
  - ✓ It has been replaced by another claim.
  - ✓ It hasn't finished processing.
  - ✓ It was billed under a different domain.
  - ✓ You could be using the wrong profile.
  - ✓ You submitted by batch with more than 1 NDC on a claim line.
  - ✓ Trying to do a Resubmit on a paid claim or an Adjustment to a denied claim.
  - ✓ Claims billed with an NPI not reported in ProviderOne.
  - ✓ Claims billed with an ID only rendering provider NPI number as the pay-to provider.

Billing Timely

- What are the Agency's timeliness guidelines?
  - ✓ The initial billing must occur within 365 days from the date of service on the claim.
  - ✓ Providers are allowed 2 years in total to get a claim paid or adjusted.
  - ✓ For Delayed Certification client eligibility the Agency allows 12 months from the Delayed Cert date to bill.
  - ✓ Recoupment's from other payers-timeliness starts from the date of the recoupment, not the date of service.
  - ✓ Trimester care-determined from the Expected Date of Delivery (EDD), EDD must be noted on the claim.
  - ✓ The Agency uses the Julian calendar for dates.
  - ✓ Crossover and Pharmacy claims have different timeliness guidelines.

What is a TCN?

TCN=Transaction Control Number



18 digit number that ProviderOne assigns to each claim received for processing. TCN numbers are never repeated.

How do I read a TCN?

1st digit-Claim Medium Indicator

- 1-paper
- 2-Direct Data Entry
- 3-electronic, batch submission
- 4-system generated (Credits/Adjustment)

2nd digit-Type of claim

- 0-Medical
- 2-Crossover or Medical

3rd thru 7th digits-date claim was received

- 3rd and 4th digits are the year
- 5th, 6th and 7th digits are the day it was received

Example TCN:30121046532513400 0

3-electronic submission via batch
0-medical claim
12-year claim was received, 2012
104-day claim was received, April 13th

How do I prove timeliness?

- HIPAA batch transaction
  - ✓ Electronic submission- Dental;
    - Enter the timely TCN in the claim note, Loop 2300, segment NTE02=TCN.

- Direct Data Entry (DDE) Claims
  - ✓Resubmit Original Denied/Voided Claim; or
  - ✓Enter timely TCN in the "Claim Note."

- Paper billing-ADA
  - ✓Enter timely TCN in box 35.

Adjust/Void a Paid Claim

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

Provider Claim Adjust Void Search:

Please enter a Provider NPI and enter available information in the remaining fields before clicking 'Submit'.

- Required: TCN or Client ID AND Claim Service Period (To date is optional)
- You may Adjust/Void claims processed within the past four years
- The Claim Service Period From and To date range cannot exceed 3 months
- Only paid claims satisfying the selection criterion will be returned

Provider NPI: 1134178999 *

TCN:

Client ID:

Claim Service Period From:

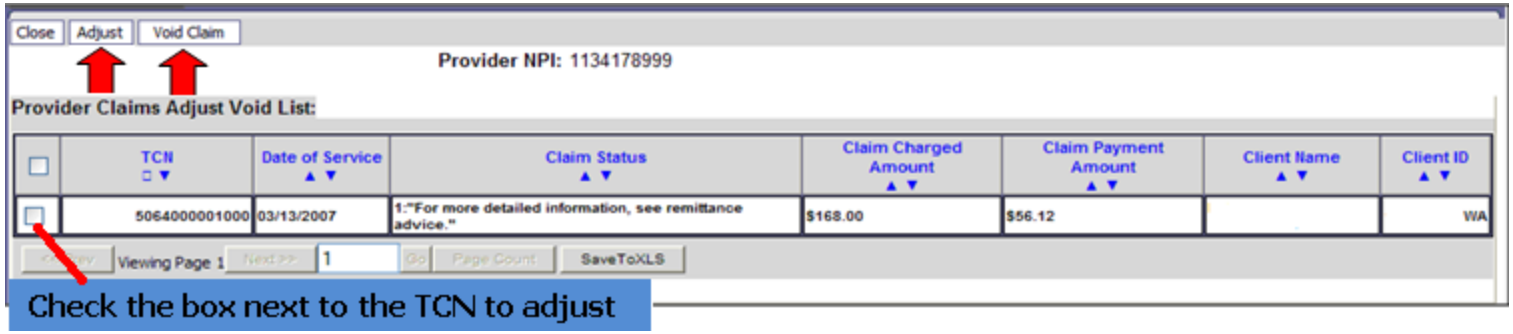
Claim Service Period To:

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.

- Enter the TCN number if known; or
- Enter the Client ID, and the From-To date of service.

Adjust/Void a Paid Claim

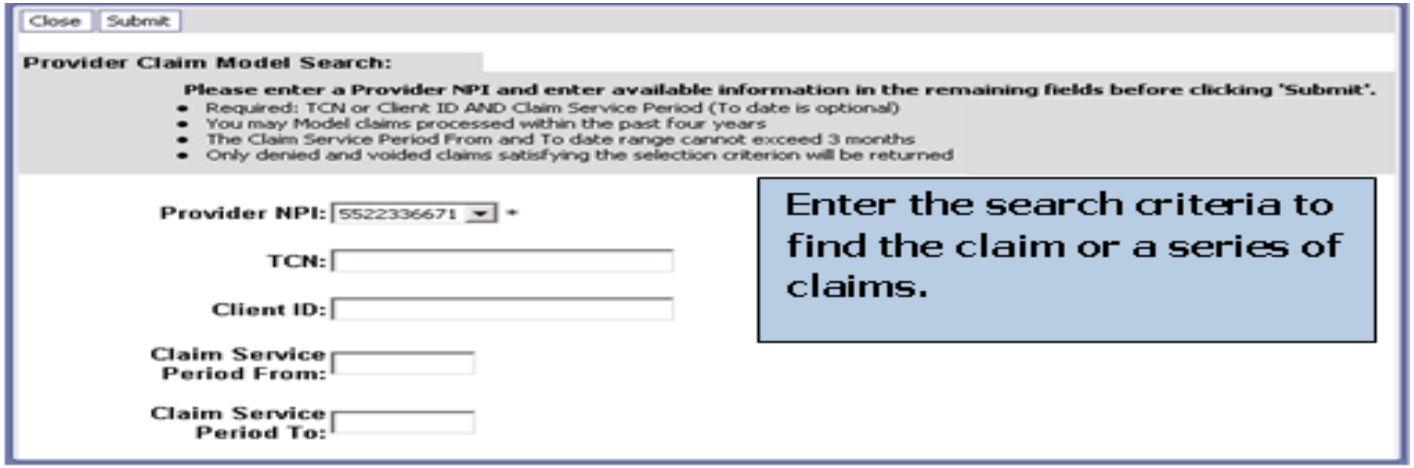
- The system will display the paid claim(s) based on the search criteria.



- Check the box of the TCN to adjust/void.
- ProviderOne loads the DDE screen with the claim data.
  - ✓ Update the claim information to adjust, then submit.
  - ✓ Claim data cannot be changed when doing a void, just submit the void.

Resubmit a Denied Claim

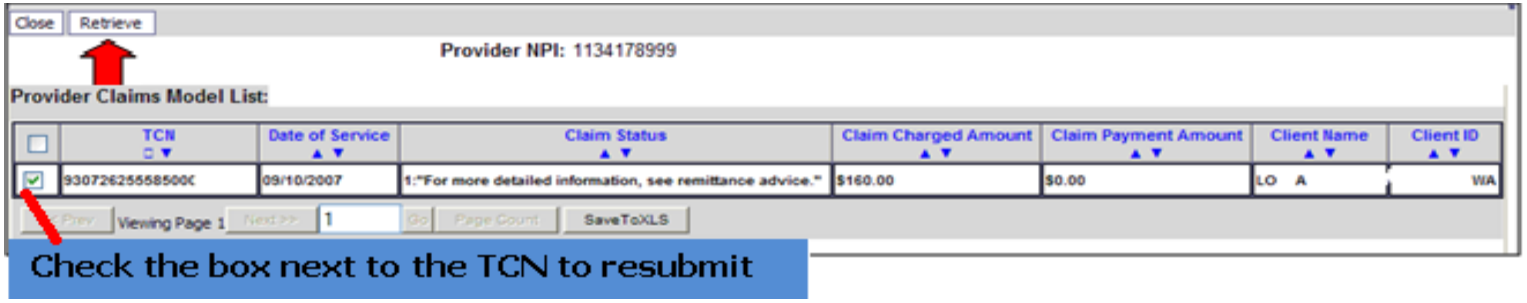
- Select "Resubmit Denied/Voided Claim" from the Provide Portal.



- A TCN will bring up only one claim.
- Enter the Client ID and the From-To dates of service to find all claims billed these dates.

Resubmit a Denied Claim

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

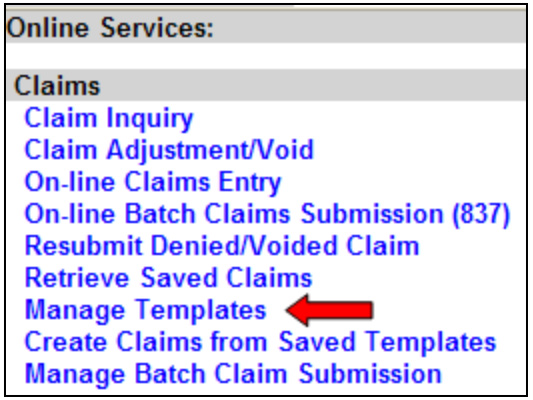


- Check the box of the TCN to resubmit.
- ProviderOne loads the DDE screen with the claim data.
  - ✓ Update the claim information that caused the claim to deny, then submit.

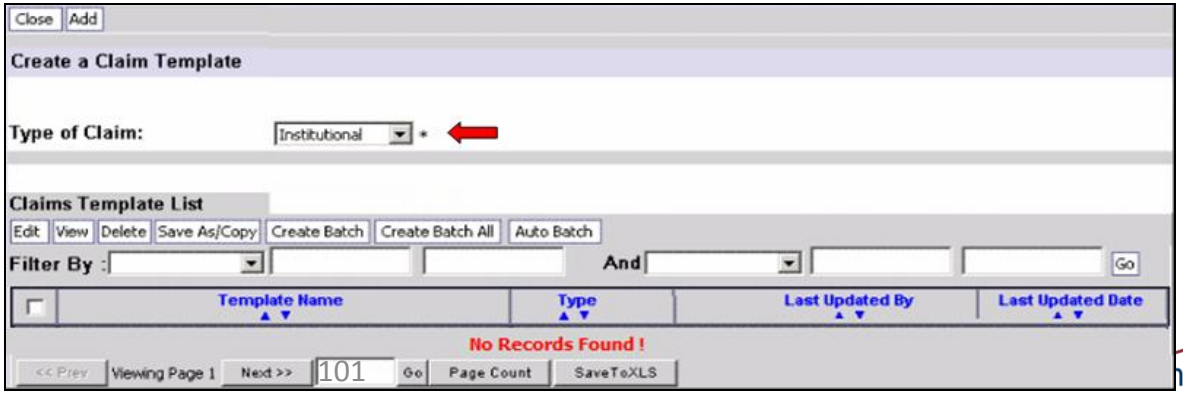
Creating a Claim Template

- ProviderOne allows creating and saving templates.

  - ✓ Log into ProviderOne.
  - ✓ Click on the Manage Templates hyperlink.

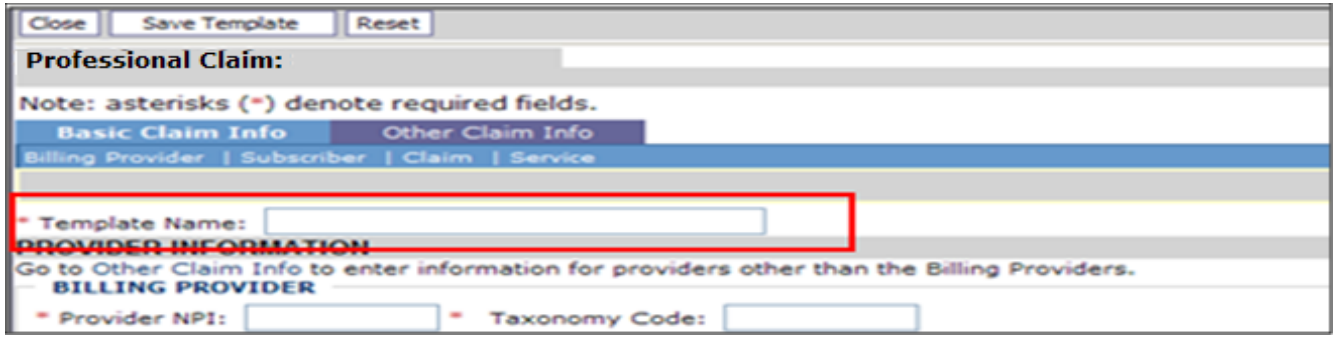


  - ✓ At the Create a Claim Template and list screen click the Type of Claim Option.



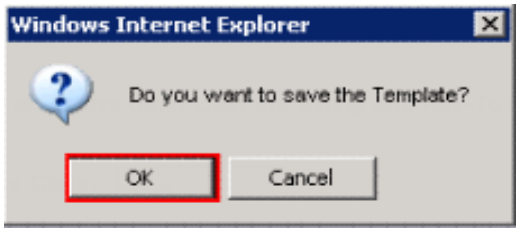
Creating a Claim Template

- Once a template type is picked the system opens in the DDE screen.



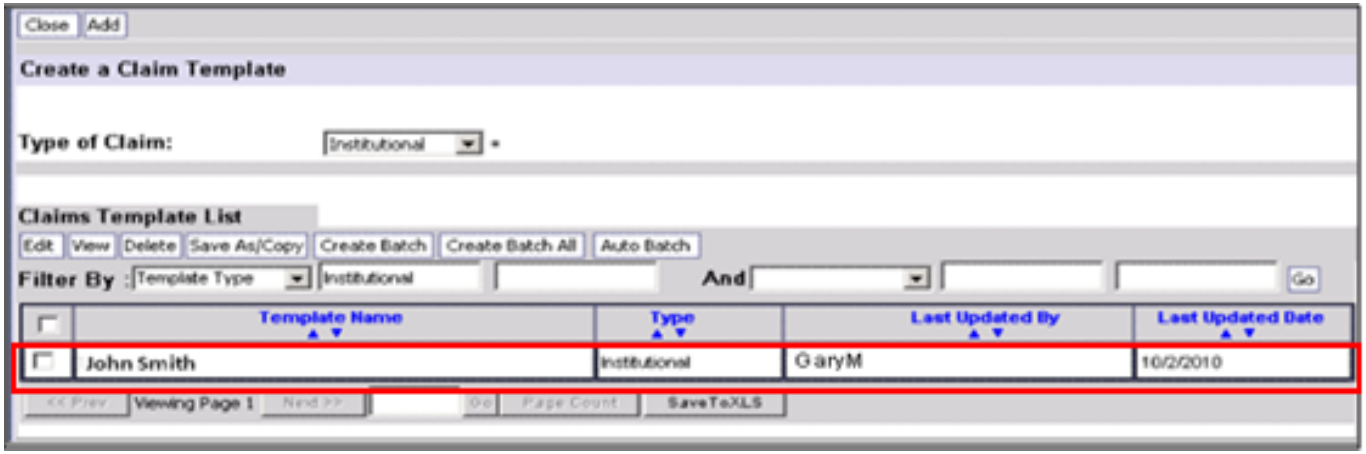
- Name the template then fill in as much data as wanted on the template.

- Click on the "Save Template" button and the system verifies you are saving the template.



Creating a Claim Template

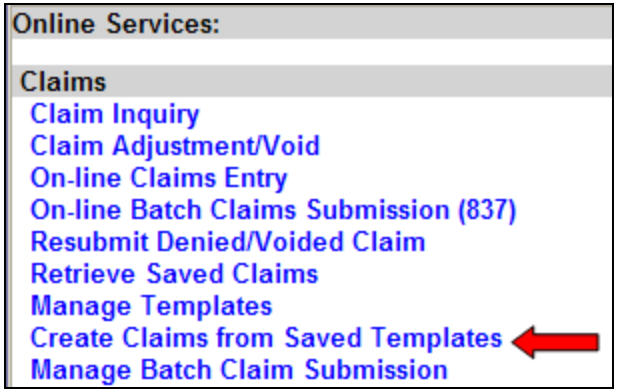
- After the template is saved it is listed on the "Claim Template List".

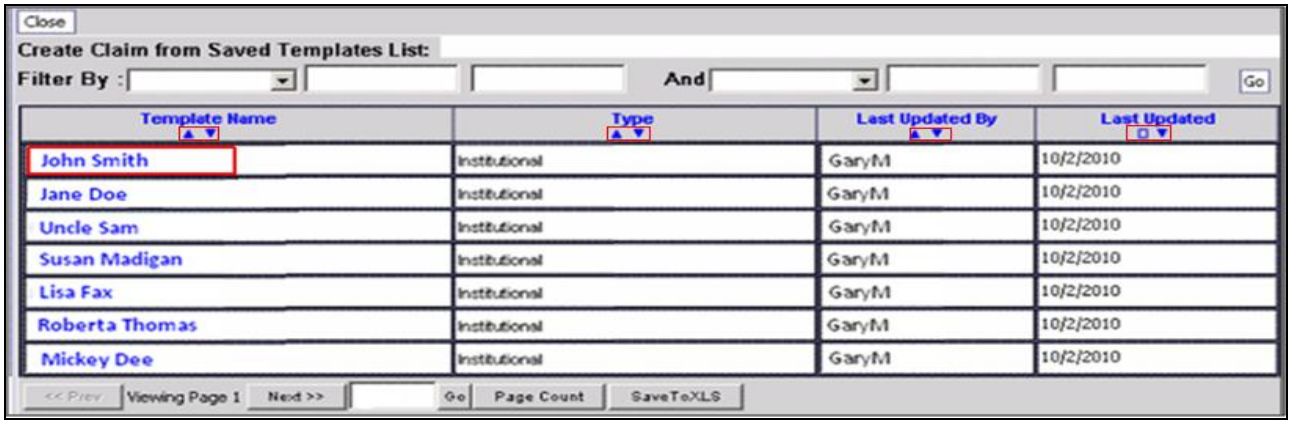


- Additional templates can be created:
  - ✓ Copying a template on the list; or
  - ✓ Creating another from scratch.
- Templates can be edited, viewed, and deleted.

Submitting a Template Claim

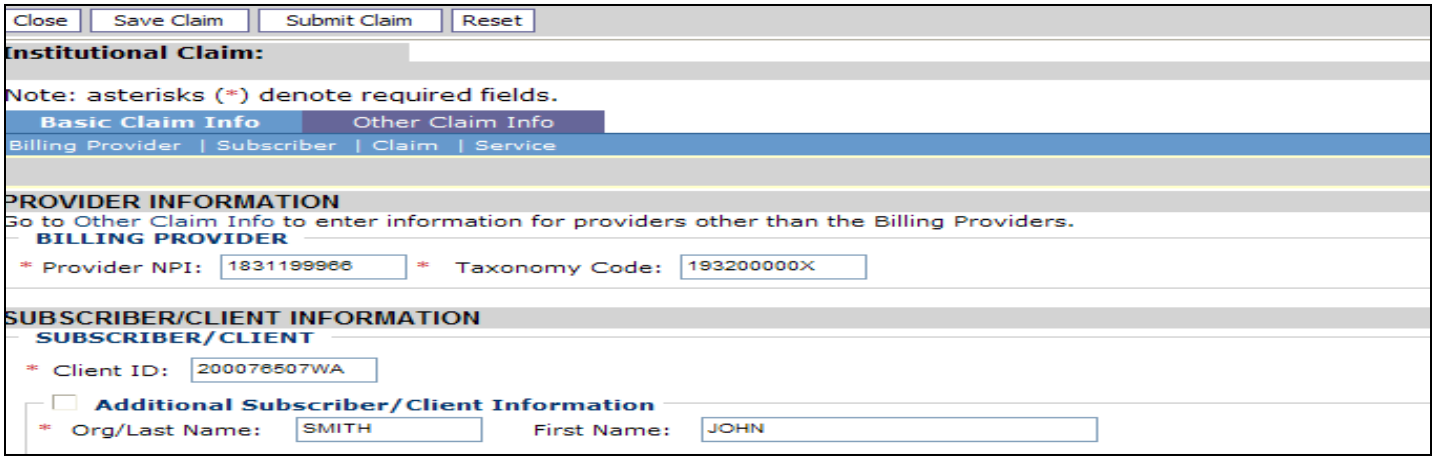
- Claims can be submitted from a Template.
  - ✓ Log into ProviderOne.
  - ✓ Click on the Create Claims from Saved Templates.
  - ✓ At the Saved Template List find the template to use. (sort the list using the sort tools outlined)





Submitting a Template Claim

- Click on the Template name.
- The DDE screen is loaded with the template.



- Enter or update the data for claim submission then submit the claim.
- Batches of Template Claims can be created.
- See the Batch Template webinar at http://hrsa.dshs.wa.gov/provider/webinar.shtml.

Reading the Remittance Advice (RA)

Reading the Remittance Advice (RA)

- How do I retrieve the PDF file for the RA?
  - ✓ Log into ProviderOne with a **Claims/Payment Status Checker, Claims Submitter, or Super User** profile.

✓ At the Portal click on the hyperlink " View Payment."

  - ✓ The system should open your list of RAs.

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
2444447	000777	02/23/2012	02/24/2012	1428	$513,899.73	$62,865.54	$408,607.26	
2443392	000778	02/16/2012	02/17/2012	1538	$484,679.55	$63,959.26	$375,030.04	
2229984	004772	02/09/2012	02/10/2012	1384	$488,482.16	$80,452.68	$408,029.48	

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

Reading the Remittance Advice (RA)

- The Remittance has several sections.
  - ✓ The first page contains the RA newsletter that could contain current provider alerts.

RA Number: 118021
Warrant/EFT #: 4387
Warrant/EFT Date: 08/09/2005

Prepared Date: 08/01/2005
RA Date: 08/08/2005

Warrant/EFT Amount: $2,149.75 **Payment Method: Warrant** **Page:** 002

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Client Resp. Amount	Total Paid
2250186000	Paid	$5418.00	$4638.00	$00.00	$00.00	$4584.25
2250186000	Denied	$11780.00	$00.00	$00.00	$00.00	$00.00
2250186000	Adjustments	$0.00	-$34.50	$00.00	$00.00	-$34.50
2250186000	Suspended	$156.00	$00.00	$00.00	$00.00	$00.00

Provider Adjustments

Billing Provider	FIN Invoice Number	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
2250186000	CM3876	System Initiated	WO: Overpayment Recovery	$1,200.00	$700.00	$500.00
2250186000	398744	HIPAA to System Initiated	LE: IRS Levy	$88,200.00	$1,700.00	$86,500.00

Total Adjustment Amount **$2,400.00**

  - ✓ Page 2 is the Claims Summary page (above).
  - ✓ The following sections could be Paid Claims, Denied Claims, Adjusted Claims, and In-Process Claims.

Reading the Remittance Advice (RA)

- The Summary Page shows:
  - ✓ Number of paid claims and total.
  - ✓ Number of denied claims.
  - ✓ Number of adjusted claims.
  - ✓ Provider Adjustments activity.

RA Number: 118021
Warrant/EFT #: 4387
Warrant/EFT Date: 08/09/2005

Prepared Date: 08/01/2005
RA Date: 08/08/2005

Warrant/EFT Amount: $2,149.75
Payment Method: Warrant
Page: 002

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Client Resp. Amount	Total Paid
2250186000	Paid	$5418.00	$4638.00	$00.00	$00.00	$4584.25
2250186000	Denied	$11780.00	$00.00	$00.00	$00.00	$00.00
2250186000	Adjustments	$0.00	-$34.50	$00.00	$00.00	-$34.50
2250186000	Suspended	$156.00	$00.00	$00.00	$00.00	$00.00

Provider Adjustments

Billing Provider	FIN Invoice Number	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
2250186000	CM3876	System Initiated	WO: Overpayment Recovery	$1,200.00	$700.00	$500.00
2250186000	398744	HIPAA to System Initiated	LE: IRS Levy	$88,200.00	$1,700.00	$86,500.00

Total Adjustment Amount **$2,400.00**

Reading the Remittance Advice (RA)

- Provider Adjustments:
  - ✓ The Number of claims being adjusted (credit) may exceed the Total Paid amount.
  - ✓ Credit balance adjustments are displayed on the right side of the summary page.

Provider Adjustments **Page 3**

Billing Provider	FIN Invoice Number	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
2250188000	[illegible]	Provider Initiated	CASH RECEIVED Invoice	$37.86	$0.00	$37.86
2250188000	[illegible]	Provider Initiated	CASH RECEIVED Invoice	$25.87	$0.00	$25.87
Total Adjustment Amount						

Reading the Remittance Advice (RA)

- Provider Adjustments:
  - ✓ These adjustment amounts can carry over on each weeks RA until reduced by the number of paid claims for that week.
  - ✓ Claims that caused these carry over adjustment amounts can be on previous RAs.
  - ✓ Credit balance RAs have a "check number" that looks like this: **JVAH022334556677800**.
  - ✓ ProviderOne automatically sends credit balance amounts to our finance office after a certain time if the NPI number does not generate claim payments.

Reading the Remittance Advice (RA)

- EOB Codes
  - ✓ The Adjustment Reason Codes; and
  - ✓ The Remark Codes for denied claims & payment adjustments are located on the last page of the RA.

Adjustment Reason Codes / NCPDP Rejection Codes
119 : Benefit maximum for this time period or occurrence has been reached.
125 : Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
16 : Claim/service lacks information which is needed for adjudication. 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.)
204 : This service/equipment/drug is not covered under the patient's current benefit plan
22 : This care may be covered by another payer per coordination of benefits.
24 : Charges are covered under a capitation agreement/managed care plan.
26 : Expenses incurred prior to coverage.
4 : The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
96 : Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
A1 : Claim/Service denied. 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.)

Remark Codes
M47 : Missing/incomplete/invalid internal or document control number.
MA04 : Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
N152 : Missing/incomplete/invalid replacement claim information.
N329 : Missing/incomplete/invalid patient birth date.
N345 : Date range not valid with units submitted.
N362 : The number of Days or Units of Service exceeds our acceptable maximum.
N428 : Not covered when performed in this place of service.

  - ✓ The complete list of Federal codes can be located on **http://www.wpc-edi.com/reference/** .

Authorization

1. Complete Authorization Form 13-835
2. Submit Authorization Request to the Agency with Required Back-up
3. Check the Status of a Request
4. Send in Additional Documentation if Requested by the Agency

Washington State Health Care Authority
Medicaid

Authorization

1. Complete Authorization Form **13-835**
   a) To begin the authorization process providers need to complete HCA Form 13-835. ProviderOne can begin processing the authorization request once the Agency receives this form filled out correctly.
   b) Access the online authorization form 13-835 at http://hrsa.dshs.wa.gov/mpforms.shtml.

Step by step instructions: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/PA_Chapter.pdf

Washington State Health Care Authority

General Information for Authorization

Org	1.	Service Type	2.
Client Information			
Name	3.	Client ID	4.
Living Arrangements	5.	Reference Auth #	6.
Provider Information			
Requesting NPI #	7.	Requesting Fax #	8.
Billing NPI #	9.	Name	10.
Referring NPI #	11.	Referring Fax #	12.
Service Start Date:	13.		14.
Service Request Information			
Description of service being requested: 15.		16.	17.
18. Serial / NEA#		19.	

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

Medical Information			
Diagnosis Code	27.	Diagnosis name	28.
Place of service	29.		
30. Comments:			

http://hrsa.dshs.wa.gov/mpforms.shtml

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

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

HCA 13-835 (8/2011)

Washington State Health Care Authority
Medicaid

Directions for Authorization form 13-835

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

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	Org **(Required)**	Enter the Number that Matches the Program/Unit for the Request 501 - Dental 502 - Durable Medical Equipment (DME)
2	Service Type **(Required)**	Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "501 – **Dental**" for field #1, please select one of the following codes for this field: ASC for ASC; CWN for Crowns; DEN for Dentures; DP for Denture/Partial; ERSO for ERSO-PA; IP for In-Patient; ODC for Orthodontic; OUTP for Out-Patient; PSM for Perio-Scaling/Maintenance; PTL for Partial; RBS for Rebases; RLNS for Relines; MISC for Miscellaneous
3	Name: **(Required)**	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: **(Required)**	Enter the client ID - 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): • You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). • A reference PA will be built with a placeholder client ID. • If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: **(Required)**	The 10 digit number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI #: **(Required)**	The 10 digit number that has been assigned to the billing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: **(Required).**	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).

FIELD	NAME	ACTION
18	Serial/NEA or MEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA/MEA# to access the x-rays/pictures for this request.
20	Code Qualifier: **(Required).**	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S – ICD-9/10 Diagnosis Code
21	National Code: **(Required).**	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: **(Units or $ required).**	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Billing Instructions for the appropriate unit/day designation for the service code entered).
24	$ Amount Requested: **(Units or $ required).**	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00.
25	Part # (DME only): **(Required for all requested codes).**	Enter the manufacturer part # of the item requested.
26	Tooth or Quad#: **(Required for dental requests).**	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-32, A-T, AS-TS, and 51-82
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.

Place of Service Code(s)	Place of Service Name
1	Pharmacy
3	School
4	Homeless Shelter
5	Indian Health Service Free-standing Facility
6	Indian Health Service Provider-based Facility
7	Tribal 638 Free-standing Facility
8	Tribal 638 Provider-based Facility
9	Prison-Correctional Facility
11	Office
12	Home

30	Comments	Enter any free form information you deem necessary.

Washington State Health Care Authority
Medicaid

Example Authorization 13-835

1. Example of a completed Authorization Form **13-835**
   a) Fill (type) in all required fields as indicated on the directions page.
   b) Use the codes listed on in the directions for the required fields.
   c) Add as much other information that may help in approval.
   d) The data on this form is scanned directly into ProviderOne.
   e) Processing begins as soon as a correctly filled out form is received.

Step by step instructions: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/PA_Chapter.pdf

Washington State Health Care Authority

General Information for Authorization

Org	1. 501	Service Type	2. PSM
Client Information			
Name	3. SMITH, JASON	Client ID	4. 445566889
Living Arrangements	5. HOME	Reference Auth #	6.
Provider Information			
Requesting NPI #	7. 1112223334	Requesting Fax #	8. 360-725-9999
Billing NPI #	9. 1473322445	Name	10. DR DENTIST
Referring NPI #	11.	Referring Fax #	12.
Service Start Date:	13. 10/2012		14.
Service Request Information			
Description of service being requested: 15. ADDITIONAL PERIO SCALING		16.	17.
18. Serial/NEA or MEA #		19.	

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. $ Amount Requested	25. Part # (DME Only)	26. Tooth or Quad #
T	D4341		2			10
T	D4341		2			20
T	D4341		2			30
T	D4341		2			40

Medical Information			
Diagnosis Code	27.	Diagnosis name	28.
Place of service	29. 11		

30. Comments: PATIENT HAS EXTREME PERIO PROBLEM; REQURES ADDITIONAL SCALING PER YEAR

http://hrsa.dshs.wa.gov/mpforms.shtml

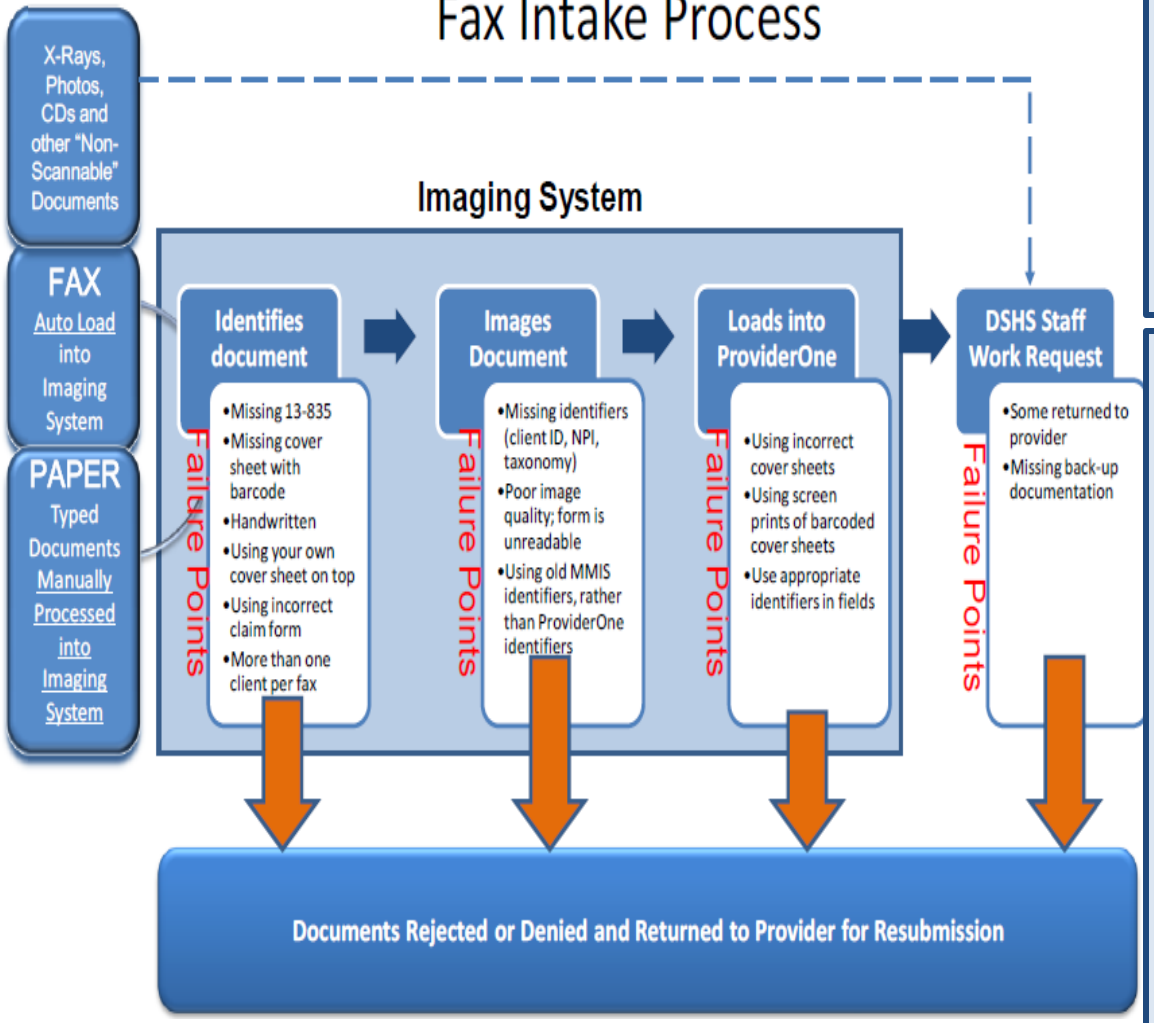
Please Fax this form and any supporting documents to 1-866-668-1214.

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

Washington State Health Care Authority
Medicaid

Authorizations

Fax Intake Process



2. Submit Authorization Request to the Agency with Required Back-up
   a) By Fax
      a) 1-866-668-1214
      b) Form 13-835 must be first
   b) By Mail
      a) Authorization Services Office
         PO Box 45535
         Olympia, WA 98504

Scan larger backup using *FastAttach*

For Dental Providers: (NEA)

Register with NEA by visiting www.nea-fast.com and entering "FastWDSHS" in the blue promotion code box.

Contact NEA at 800-782-5150 ext. 2 with any questions.

For Medical/DME Providers: (MEA)

www.mea-fast.com

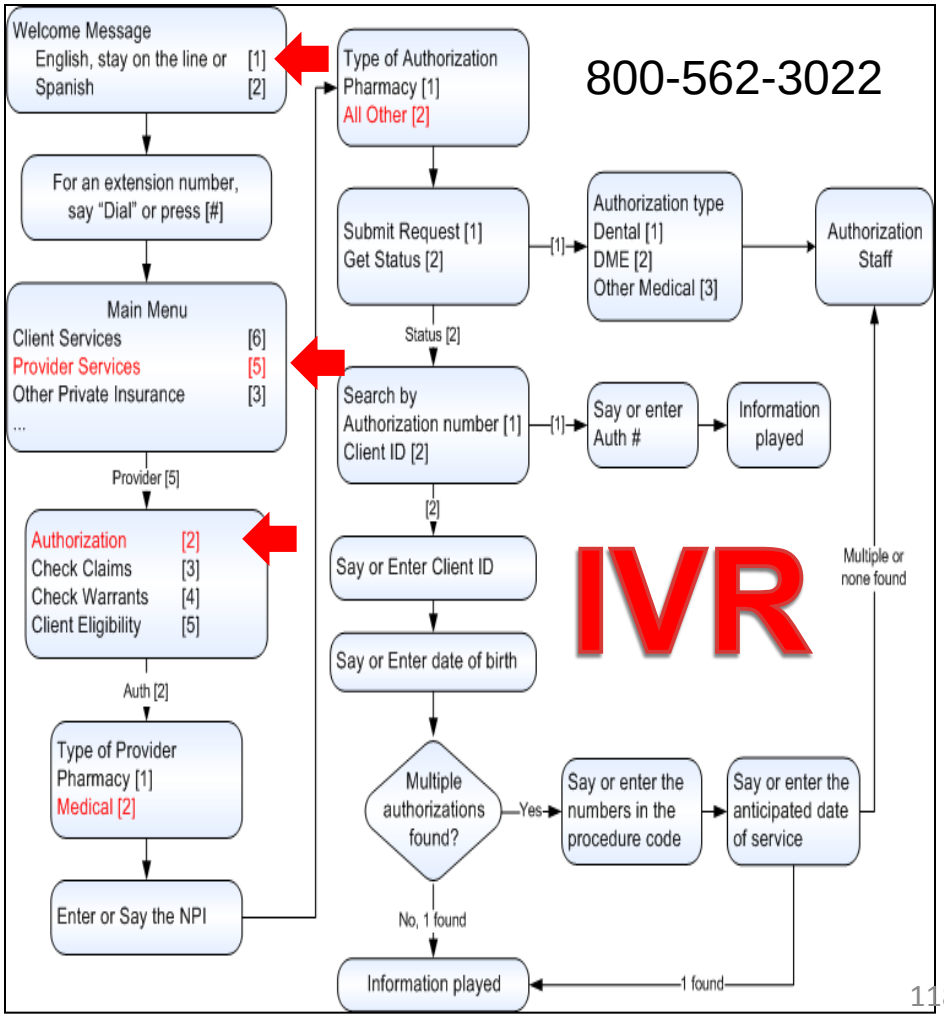
Phone 1-888-329-9988 extension 3.

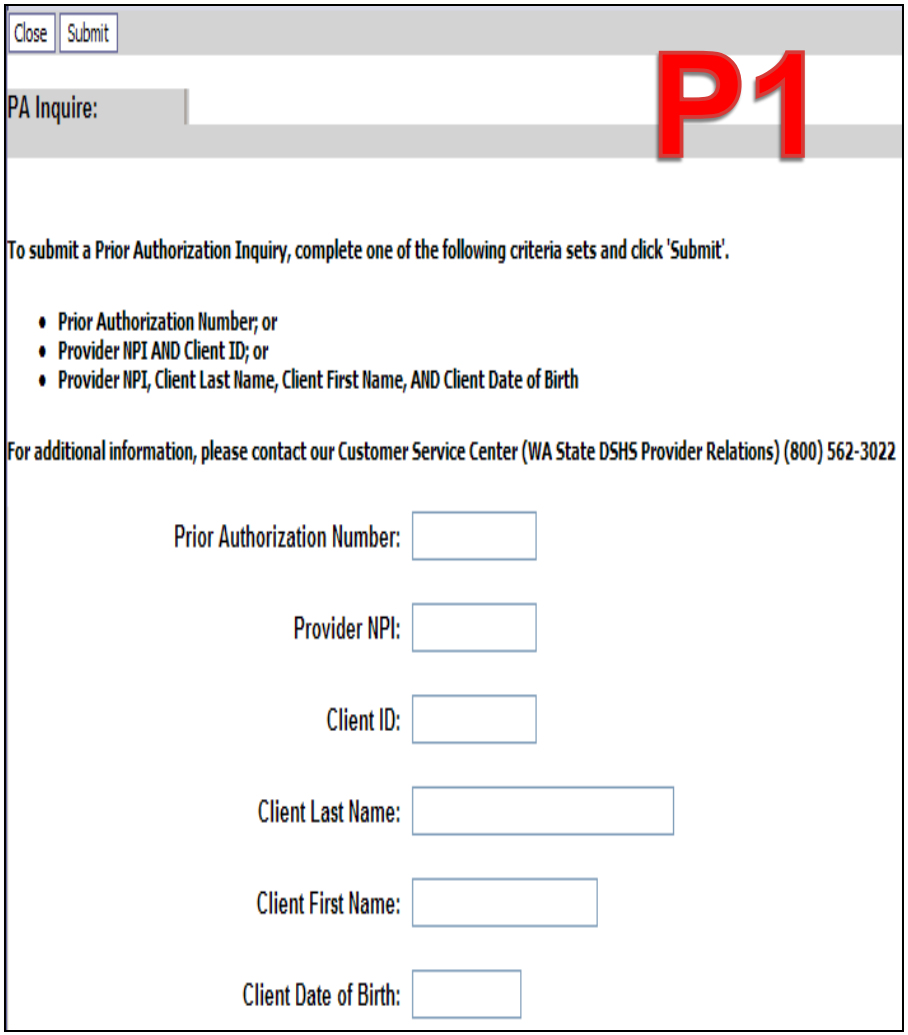
Please identify your office as a participant in the Washington Department of Social and Health Services pilot.

Give the technician promotion code MEAFFL.

Washington State Health Care Authority
Medicaid

Check Status of an Authorization Request





Washington State Health Care Authority
Medicaid

Check Status of an Authorization Request

- Select "Provider Authorization Inquiry" from the provider home page.

Search by one of the Options:

✓Prior Authorization number; or
✓Provider NPI and Client ID; or
✓Provider NPI, Client Last & First Name, and the client birth date.

Close | Submit

PA Inquire:

To submit a Prior Authorization Inquiry, complete one of the following criteria sets and click 'Submit'.

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

For additional information, please contact our Customer Service Center (WA State DSHS Provider Relations) (800) 562-3022

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

The system may return the following status information.

PA Utilization:

Authorization #: 870000004
Client ID: 9999999WA
Service: Miscellaneous
Request Date: 12/23/2010
Service Start Date: 1/1/2011
Requestor ID: 8888888897

Authorization Status: Approved
Client Name:
Organization: PA - DENTAL
Last Updated Date: 8/17/2011
Service End Date: 9/30/2011
Requestor Name: Place Holder PA Provider

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	08/17/2011	8888888897	D0120	K-Dental Claim					01/01/2011	09/30/2011	0	99999	0	1	0	0	Approved

Washington State Health Care Authority
Medicaid

Check the Status of a Request

Close

PA Utilization:

Authorization #: 100000226
Client ID: 100149763WA
Service: Partial
Request Date: 5/9/2010
Service Start Date: 6/14/2010
Requestor ID: 1972676971

Authorization Status: Approved
Client Name:
Organization: PA - DENTAL
Last Updated Date: 6/14/2010
Service End Date: 6/14/2011
Requestor Name:

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	06/14/2010	1297174503	D5213	K-Dental Claim				01	06/14/2010	06/14/2010	0	1	0	1	0	0	Approved

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

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

The above example authorization request (number) is in approved status. Other possible status of the authorization request is listed in the table at the left.

Washington State Health Care Authority

Washington State Health Care Authority
Medicaid

4. Send in Additional Documentation if Requested by the Agency

a.) If you are mailing/faxing supporting documentation to an existing PA request, you will need to print and attach the DSHS cover sheet.

ProviderOne

PA Pend Forms Submission Cover Sheet

Authorization Reference # 123456789

(Please enter 9 digit numeric value.)

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet

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

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

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

DO NOT USE FOR PHARMACY RELATED AUTHORIZATION REQUESTS!

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

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

FAX to : 1-866-668-1214.

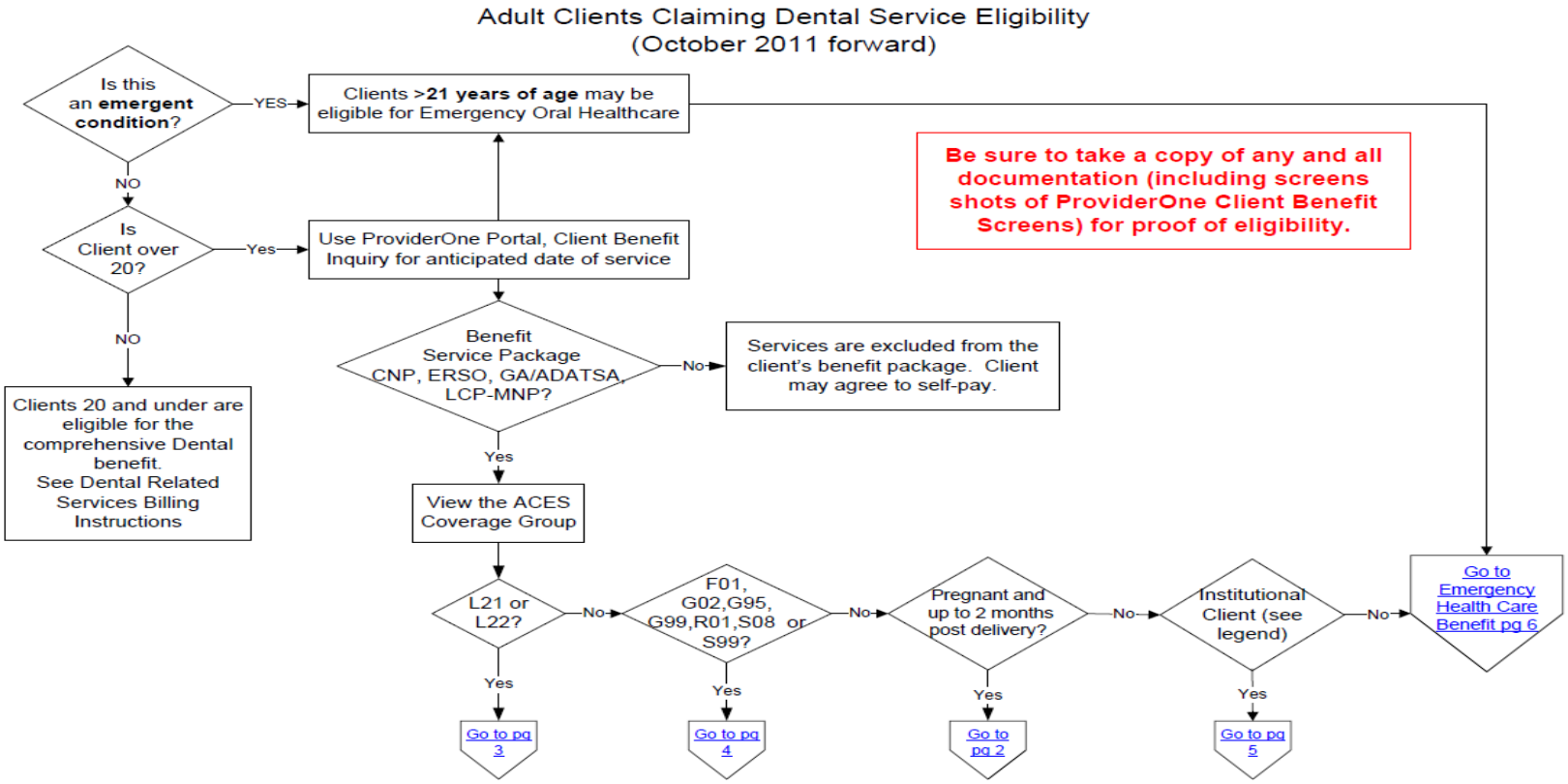
THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.

Cover Sheets can be located at :http://hrsa.dshs.wa.gov/download/document_submission_cover_sheets.html

Washington State Health Care Authority

Eligible for Adult Dental Services?

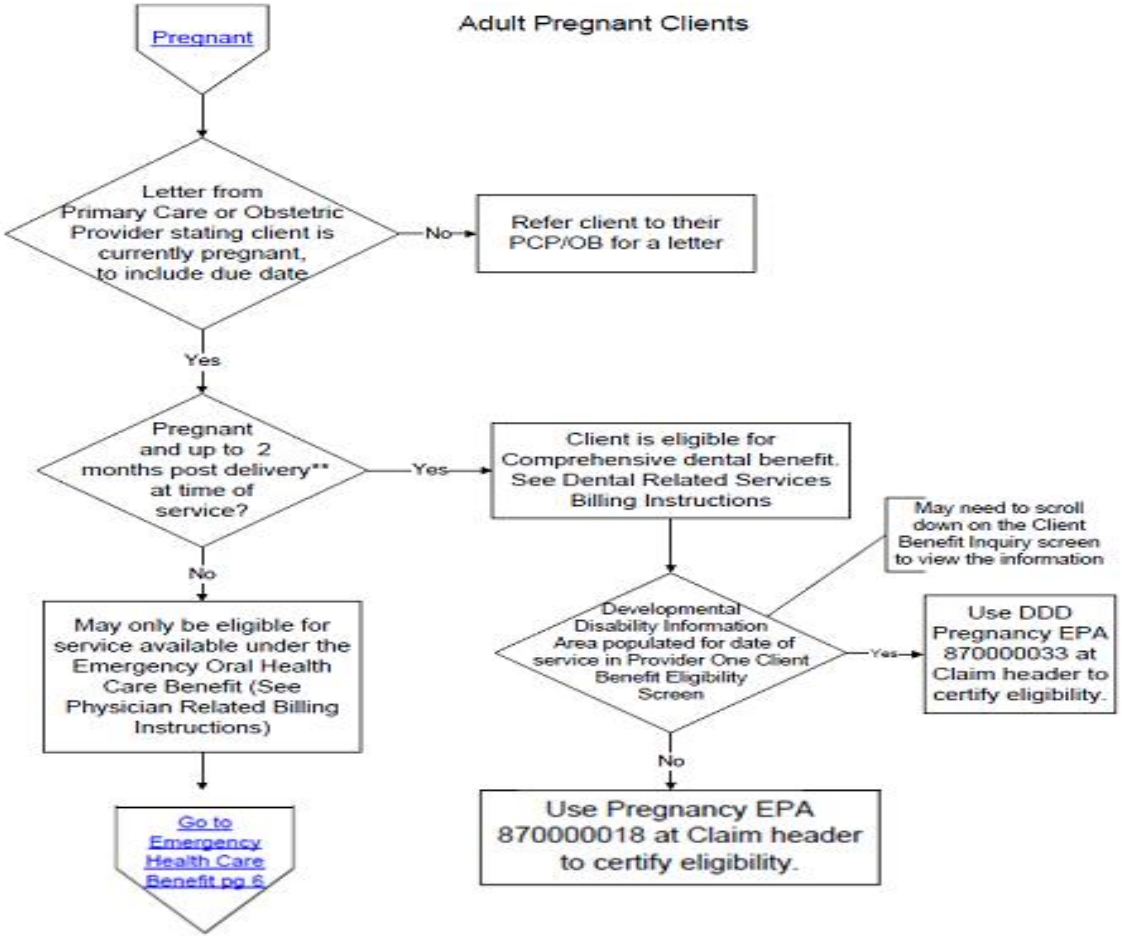
Adult dental services Decision Making Tool flowchart



Find this tool at web page http://hrsa.dshs.wa.gov/DentalProviders/DentalIndex.html

Washington State Health Care Authority
Medicaid

Eligible for Adult Dental Services?

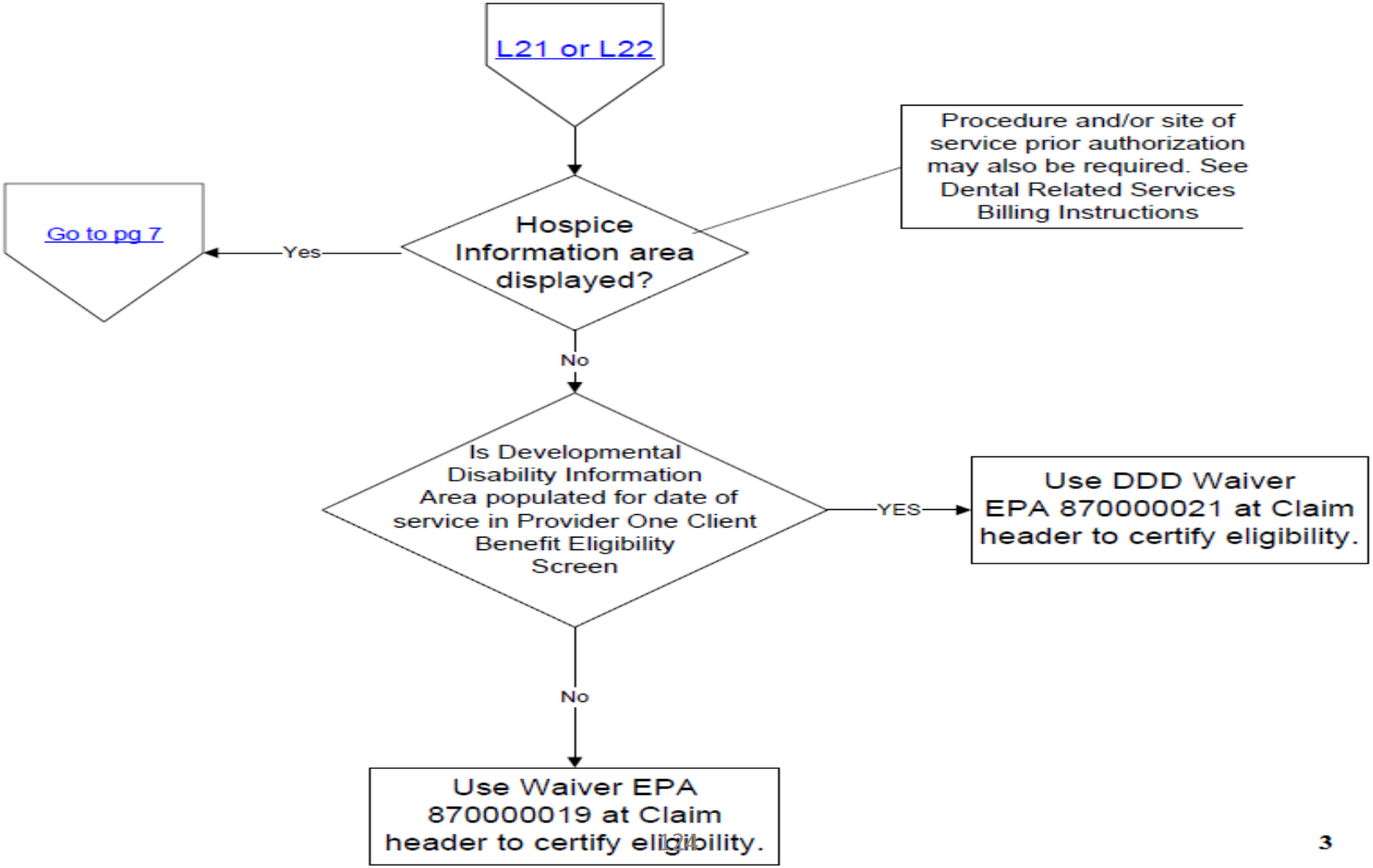


**2 months post delivery = comprehensive dental coverage for women who qualify because they are pregnant, allows continued dental coverage through the end of the month in which the 60th day following the end of the pregnancy falls (e.g., pregnancy ends June 10, medical benefits continue through August 31). This is applicable regardlss of how the pregnancy ends.

Washington State Health Care Authority

Eligible for Adult Dental Services?

Adult Clients Coverage Group L21 or L22



Successful Eligibility Check

- After scrolling down the page the first entry is the "**Client Eligibility Spans**" which shows:
  - ✓ The eligibility program (CNP, MNP, etc).
  - ✓ The date span for coverage.
  - ✓ This client has Coverage Group Code L21

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1147	CNP	08/01/2010	12/31/2999	L21			

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

Note: Continue down the eligibility screen to see if the client is in a Hospice program.

Washington State Health Care Authority
Medicaid

Eligible for Adult Dental Services?

Adult Clients Coverage Group F01,G02,G95, G99,R01,S08 or S99

F01,G02,G95, G99,R01,S08 or S99

Client is ONLY eligible for Comprehensive dental benefit with one of the following: Planned Action Notice OR Waiver/RCL Verification Form"

Procedure and/or site of service prior authorization may also be required. See Dental Related Services Billing Instructions

Note: If PAN states the client is eligible for a service other than one listed below, the client is only eligible for EOHB.

Does Client have a PAN or "Waiver/ RCL Verification form"?

No → If client is HCS or DDD, refer client as indicated

HCS → *For an HCS client, refer to their AAA or HCS office to get replacement PAN from their social worker*

DDD → *For a DDD client: Contact Sue Cabe at (360) 725-3430 or Sue.Cabe@dshs.wa.gov*

May only be eligible for service available under the Emergency Oral Health Care Benefit (See Physician Related Billing Instructions) → Go to Emergency Health Care Benefit pg 6

Yes → Does the program field on the PAN contain "COPES", "MNRW", MNIW", OR "NEW Freedom"?

Yes → Use Waiver EPA 870000019 at Claim header to certify eligibility.

No → Does the client have a "Waiver/RCL verification form" or PAN indicating "Basic", Basic Plus", "Core", "Community Protection" in the program field?

Yes → Use DDD Waiver EPA 870000021 at Claim header to certify eligibility.

No → Does the client have a PAN that indicates "RCL" (Roads to Community Living)?

No → May only be eligible for service available under the Emergency Oral Health Care Benefit (See Physician Related Billing Instructions)

Yes → Is Developmental Disability Information Area populated for date of service in Provider One Client Benefit Eligibility Screen

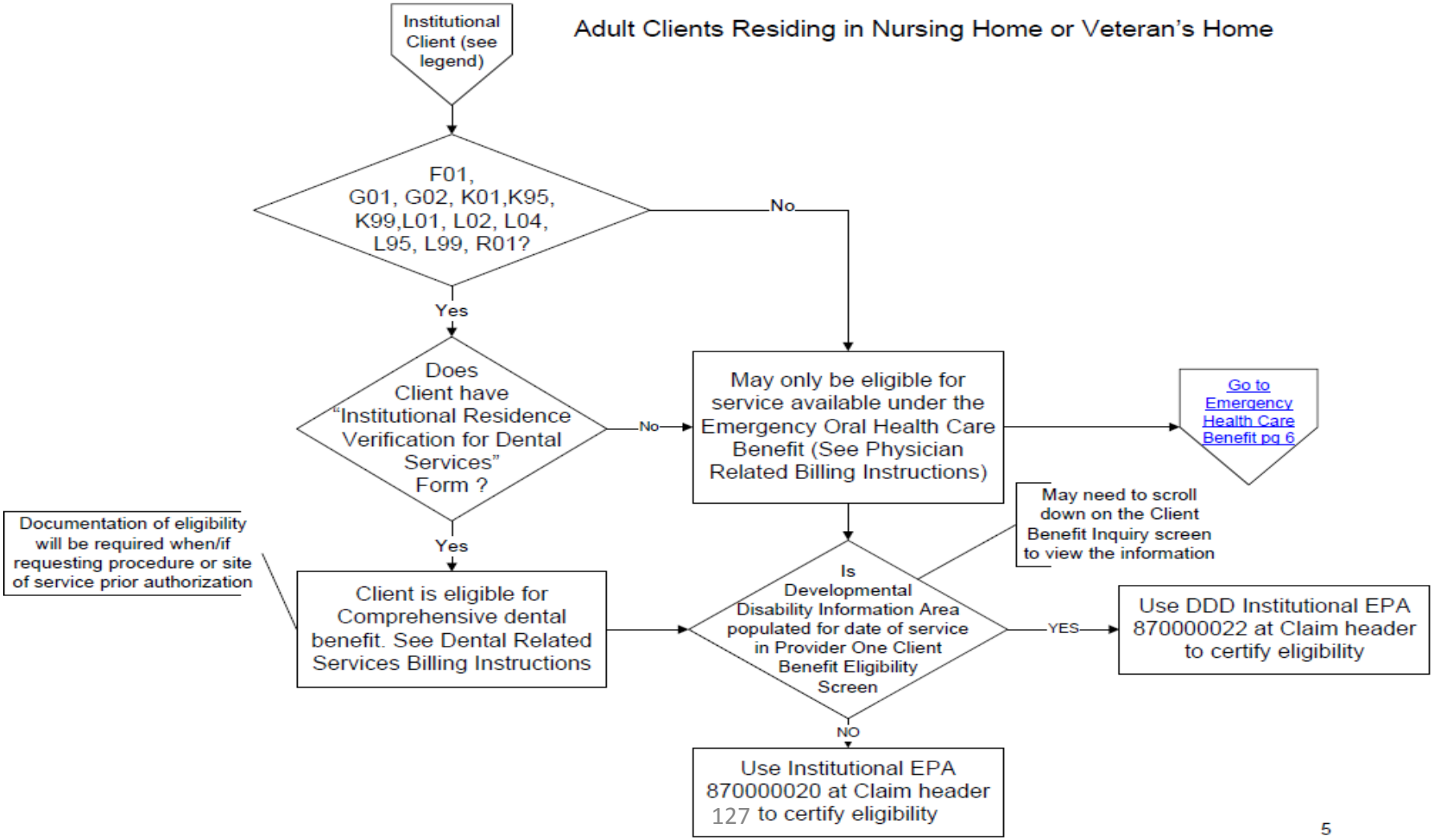
Yes → Use DDD Waiver EPA 870000021 at Claim header to certify eligibility.

No → Use Waiver EPA 870000019 at Claim header to certify eligibility.

4

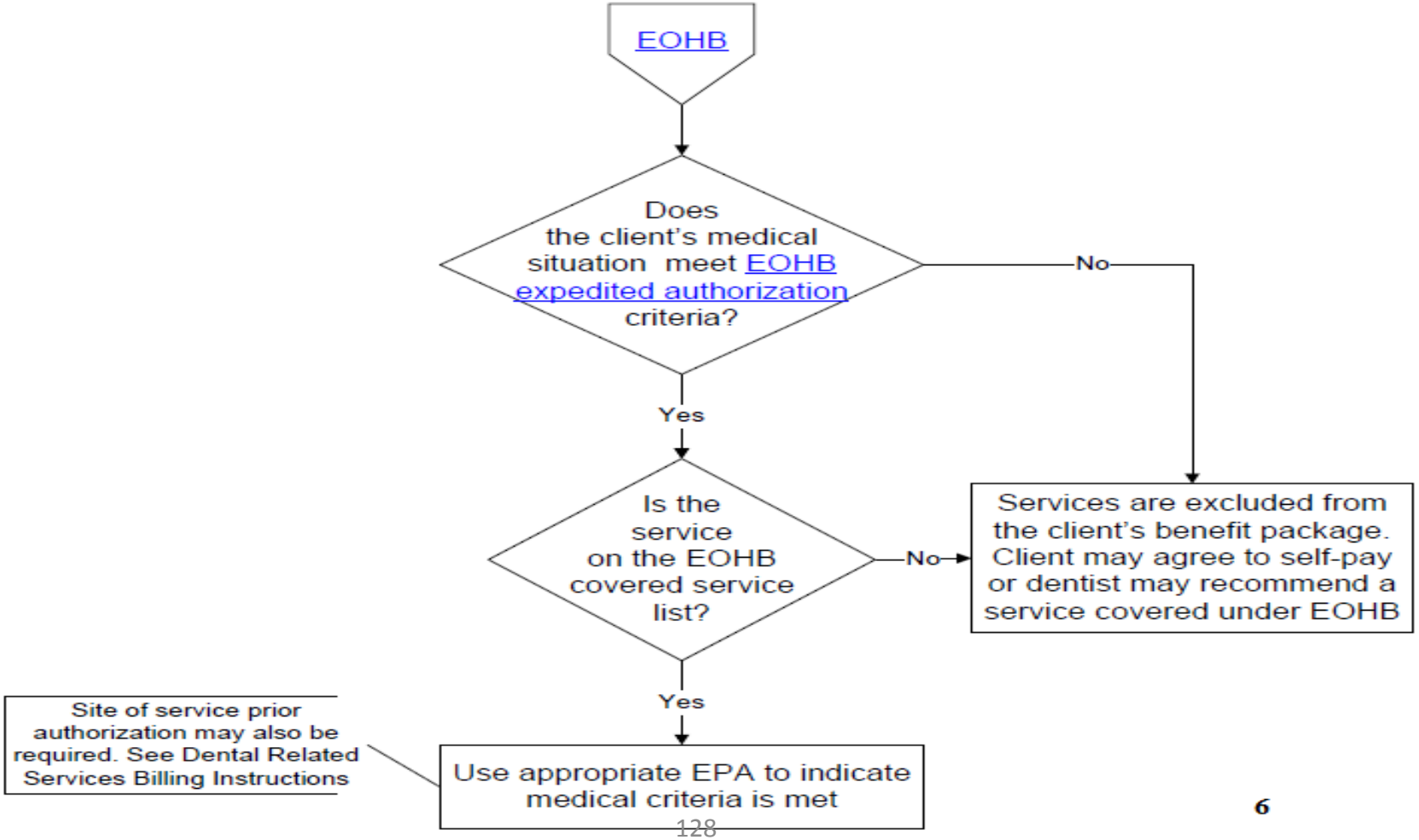
Washington State Health Care Authority
Medicaid

Eligible for Adult Dental Services?



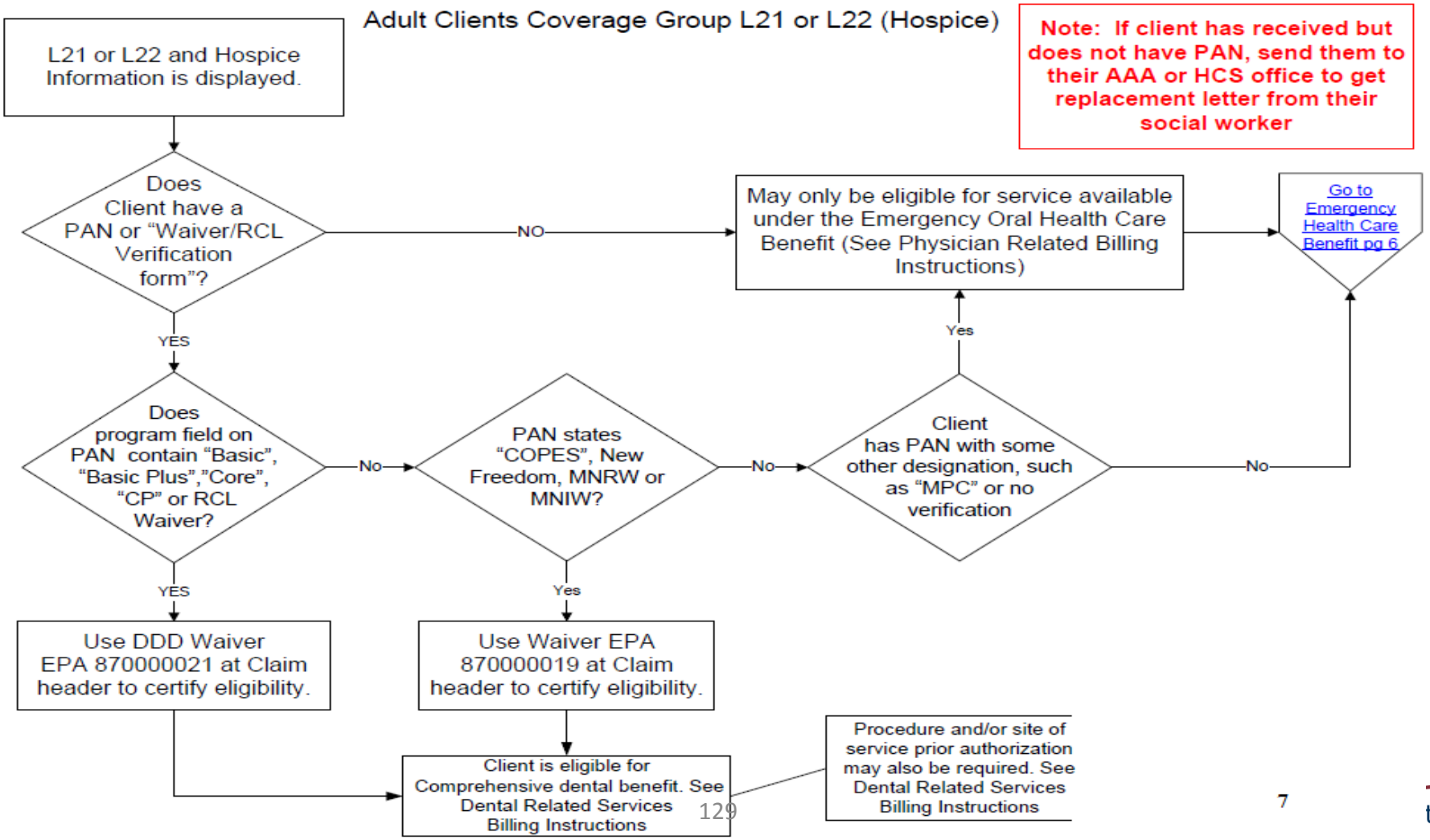
Eligible for Adult Dental Services?

Emergency Oral Health Care Benefit (EOHB)



Washington State Health Care Authority
Medicaid

Eligible for Adult Dental Services?



Expedited Prior Authorization (EPA)

1

- The Agency covers certain dental services for eligible adults
- Review the Dental EPA criteria worksheet

2

- Meet the administrative requirements (e.g., eligibility program, claim timelines, third-party insurance, etc.)
- Check the Dental EPA worksheet to determine coverage group

3

- Must meet EPA Guidelines
  - Medical Justification (EPA criteria)
  - Documentation
  - Bill with the associated EPA number and covered coding on the claim

First 5 or 6 digits

Create **9** digit EPA number

870000_ _ _

Last 3 or 4 digits

Find your code assigned to the criteria (must meet all criteria to use)

Enter EPA number on you claim form in the *authorization number field*

EPA	Criteria	Procedure Codes
870000021	**Waiver/DD** Services provided to a client that: 1) Is on CNP; a) Has ACES coverage group L21 or L22 and is not on the hospice program or b) Is a hospice client and Has ACES coverage group L21, L22, F01,G02, R01, S08; and has "***Waiver/RCL Verification* form** **Effective for dates of service October 1, 2011 and after.**	Comprehensive Dental Coverage

Washington State Health Care Authority
Medicaid

Expedited Prior Authorization (EPA)

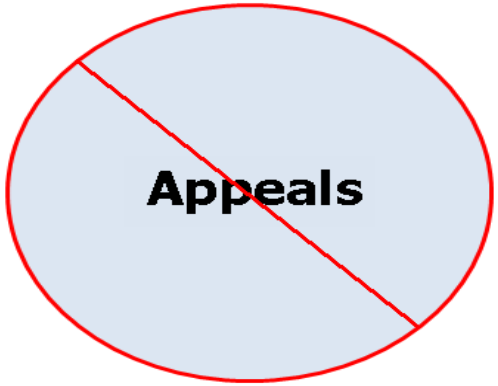
- Eligibility EPA numbers worksheet for Adult Dental

ELIGIBILITY EXPEDITED PRIOR AUTHORIZATION NUMBERS		
EPA	**Criteria**	**Procedure Codes**
870000033	**Pregnant DD–** Services provided to a client that: 1. Is on CNP, 2. Is pregnant or within 2 months** post delivery; and 3. Has a letter from their primary care provider or from their OB/GYN stating that the client is pregnant and the due date. *The letter can be signed by the nurse on behalf of the OB/GYN OR 4. Has Public Health documentation for pregnancy verification that states a positive pregnancy test and due date signed by a Public Health Nurse. OR 5. Has a "***Waiver/RCL Verification*" form** **Effective for dates of service October 1, 2011 and after.**	See "Pregnant/ADSA Adults" column of coverage table.
870000018	**Pregnant –** Services provided to a client that: 1) Is on CNP, ERSO, GA/ADATSA or LCP/MNP; and 2) Is pregnant or within 2 months**post delivery; and 3) Has a letter from their primary care provider or from their OB/GYN stating that the client is pregnant and the due date. *The letter can be signed by the nurse on behalf of the OB/GYN OR 4) Has Public Health documentation for pregnancy verification that states a positive pregnancy test and due date signed by a Public Health Nurse. **Effective for dates of service July 1, 2011 and after.**	See "Pregnant/ADSA Adults" column of coverage table.
870000022	**Institutional/DD client-** Service provided to a client that: 1) Has an active DDD segment in provider One. 2) Is on CNP, GA/ADATSA or LCP/MNP; AND 3) Has ACES coverage group of F01, G01, G02, L01, L02, L95, L99 or R01; and 4) Resides in a nursing home, state veteran's home, veteran's wing of a nursing home, Residential Habilitation Center (RHC) or privately-operated ICF/ID; 5) Presents with an "Institutional Residence Verification" form: **Effective for dates of service Oct 1, 2011 and**	See "Pregnant/ADSA Adults" column of coverage table.
870000020	**Institutional-** Service provided to a client that: 1) Is on CNP, ERSO, GA/ADATSA or LCP/MNP; AND 2) Has ACES coverage group of F01, G01, G02, K01, K95, K99,L01, L02, L04, L95, L99 or R01; and 3) Resides in a nursing home or state veteran's home, or veteran's wing of a nursing home; and 4) Presents with an "Institutional Residence Verification" form. **Effective for dates of service July 1, 2011 and after.**	See "Pregnant/ADSA Adults" column of coverage table.
870000019	**Waiver-** Services provided to a client that: 1) Is on CNP, ERSO, GA/ADATSA or LCP/MNP;	See "Pregnant/ADSA Adults" column of coverage table.
	AND 2) Has ACES coverage group L21 or L22 and a) Is not on the hospice program or b) Is a hospice client and PAN contains the words "COPES","MNIW", "MNRW", "New Freedom", or "RCL" or **3)** Has ACES coverage group F01,G02,G95,G99, R01, S08, or S99; and PAN contains the words "COPES", "New Freedom", or "RCL".**Effective for dates of service July 1, 2011 and after.**	
870000005	**Extractions** that: 1) are performed on or after January 1, 2011 2) did not require authorization in 2010; 3) were allowed in the 2010 dental benefit; 4) were necessary in order to place **dentures** that: a) has an authorization request that was received by the department on or before December 31, 2010 and; b) were authorized by the department.	D7111, D7140, D7210, D7220, D7230, D7240 and D7250
870000002	Services rendered for pain, infection, or trauma. **Effective for dates of service January 1, 2011 and after.**	Any procedure allowed under the Emergency Oral Healthcare Benefit
870000003	Services rendered as part of a cancer treatment regimen*** or part of a pre-transplant/medical protocol* **Effective for dates of service January 1, 2011 and after.**	Any procedure allowed under the Emergency Oral Healthcare Benefit**

- Find the Eligibility EPA at http://hrsa.dshs.wa.gov/DentalProviders/fax/epa.pdf

Washington State Health Care Authority

Claim Appeals



- We don't have an "appeal process" for denied claims.
- Fix the claim error causing claim denial and resubmit the claim.
- If you think the claim(s) were denied in error submit a work ticket online at https://fortress.wa.gov/dshs/p1contactus/.
- Work tickets average 15 days to process. Complex tickets can take longer.

What is a Spenddown?

- An expense or portion of an expense which has been determined by the Agency to be a client liability.
- Expenses which have been assigned to meet a client liability are not reimbursed by the Agency.
- Spenddown liability is deducted from any payment due the provider.
- Call the customer service call center at 1-800-394-4571.

How does a Provider know if a Client has a Spenddown Liability?

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

Client Eligibility Spans

Service Type Code	Insurance Type Code	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group
30: Health Benefit Plan Coverage	MC: Medicaid	Pending Spenddown - No Medical	08/01/2011	12/31/2999	S99

What is the Spenddown amount?

- The same eligibility check indicates the spenddown amount:

Spenddown Information Base Period - Start: 08/01/2011 End: 01/31/2012

Total Spenddown	Spenddown Liability	Remaining Spenddown	EMER Liability	Remaining EMER	Spenddown Status	Update Date	Spenddown Start
2022.00	2022.00	2022.00	0.00	0.00	Pending	08/09/2011	08/01/2011

- The clients "award" letter indicates who the client pays.
- Call the spenddown call center at Call 1-800-394-4571.

How does a provider report the Spenddown amount on a claim?

- Dental paper claim enter the spenddown
  - In field 35, comments.
  - Enter SCI=Y.
  - Then enter the $$ amount.

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Billing a Client

- ***Billing a Client, allowing providers, in limited circumstances, to bill fee-for-service or managed care clients for covered healthcare services, and allowing fee-for-service or managed care clients the option to self-pay for covered healthcare services.***
  - ✓ WAC 388-502-0160

Healthcare Service Categories

The groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's benefits package.

Excluded Services

A set of services that we do not include in the client's benefits package. There is no Exception To Rule (ETR) process available for these services

Covered service

Is a healthcare service contained within a "service category," that is included in a medical assistance benefits package described in WAC 182-501-0060.

Non-covered service

Is a specific healthcare service (for example, Implant services), contained within a service category that is included in a medical assistance benefits package, for which the Agency does not pay without an approved exception to rule (ETR) (see WAC 182-501-0160). **A non-covered service is not an excluded service** (see WAC 182-501-0060).

Non-covered services are identified in WAC 182-501-0070 and in specific health-care program rules

NON-COVERED VS. EXCLUDED

Benefits Package
Healthcare Category of Service

- Included services
  - Covered Service
    - May Require Limitation Extension, Expedited, or Prior Authorization
  - **NON-COVERED** Service
    - ETR process is available
- **EXCLUDED** services
  - ETR process is not available
    - STOP

Note: The examples in today's webinar are based on Benefits Packages effective January 1, 2011.

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NON-COVERED VS. EXCLUDED

Non-Covered	Excluded for Adults* (no funding for these services)
• Implant Services • General dental services are covered, however implants and associated services are not covered under the dental benefits package.	• Adult Dental • Clients participating in the Developmental Disability Program may be exempt.
• Hairpieces or wigs • DME services are covered, however wigs are not covered under the DME benefits package.	• Adult Vision Hardware
• Upright MRI •Diagnostic procedures are covered, but this specific procedure is not covered after a health technology review of its efficacy.	• Adult Hearing Hardware * 21 years of age and older
ETR CAN BE REQUESTED	NO ETR PROCESS AVAILABLE

Note: Examples today are based on Benefits Packages effective January 1, 2011

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

The client is under the Agency's or an Agency-contracted MCO's patient review and coordination (PRC) program (WAC 182-501-0135) and receives nonemergency services from providers or healthcare facilities other than those to whom the client is assigned or referred under the PRC program.

The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the Agency.)

The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program.

The client, the client's legal guardian, or the client's legal representative:

- Was reimbursed for the service directly by a third party; or
- Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.

The service is covered by the Agency with prior authorization, all the requirements for obtaining authorization are completed and was denied, the client completes the administrative hearings process or chooses to forego it or any part of it, and the service remains denied by the Agency as not medically necessary.

The service is covered by the Agency and does not require authorization, but the service is a specific type of treatment, supply, or equipment based on the client's personal preference that the Agency does not pay for. The client completes the administrative hearings process or chooses to forego it or any part of it.

WHEN CAN A PROVIDER BILL A CLIENT <u>WITH</u> FORM 13-879?

If the service is not covered, the provider must inform the client of his or her right to have the provider request an ETR, and the client chooses not to have the provider request an ETR .

The service is not covered by the Agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.

WHEN CAN A PROVIDER NOT BILL A CLIENT?

Services for which the provider did not correctly bill the Agency.

If the Agency returns or denies a claim for correction and resubmission, the client cannot be billed.

Services for which the Agency denied the authorization because the process was placed on hold pending receipt of requested information but the requested information was not received by the Agency. (WAC 182-501-0165(7)(c)(i)). This includes rejected authorizations, when the authorization request is returned due to missing required information.

The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (e.g., a wheelchair with more features; brand name versus generic drugs).

WHEN CAN A PROVIDER NOT BILL A CLIENT?

Providers are not allowed to “balance bill” a client.

Missed, cancelled, or late appointments

Shipping and/or postage charges

"Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care.

Services for which the provider has not received payment from the Agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment; (example: billing using a diagnosis code which is not a primary diagnosis code per ICD-9).

Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to:

Medical/dental charts

Radiological or imaging films

Laboratory or other diagnostic test results

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Agreement to Pay for Healthcare Services

WAC 182-502-0160 ("Billing a Client")

Form 13-879

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

Client - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.
Provider - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

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

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

Directions:

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

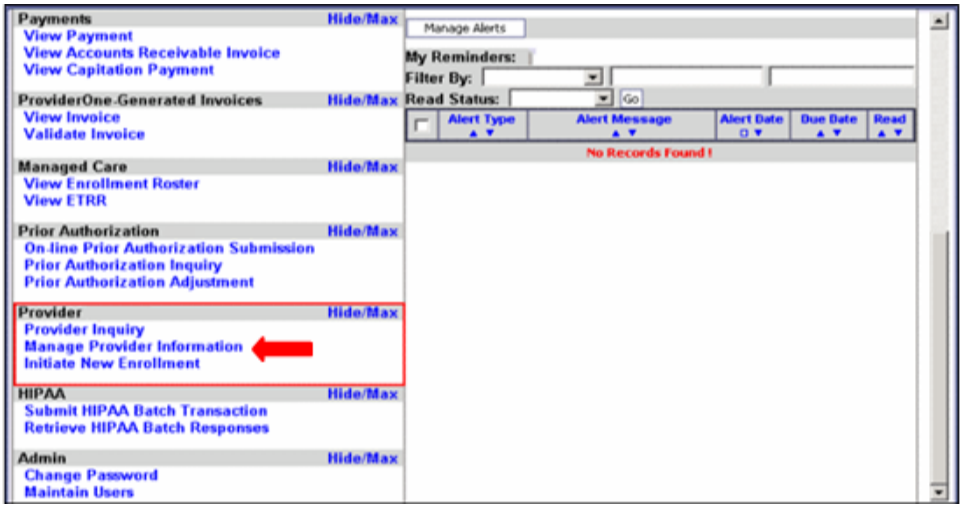
SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED	
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH HCA NOTICE)
					PA REQUEST	PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH HCA NOTICE)
					PA REQUEST	PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH HCA NOTICE)
					PA REQUEST	PA DENIAL (ATTACH HCA NOTICE)

- I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.
- I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; or 2) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.
- I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above.
- I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC.
- ***I agree to pay the provider directly for the specific service(s) listed above.***
- I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form.
- I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care.

I AFFIRM: I understand and agree with this form's content, including the bullet points above.	CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE	DATE
I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.	PROVIDER OF SERVICE(S) SIGNATURE	DATE
I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.	INTERPRETER'S PRINTED NAME AND SIGNATURE	DATE

Provider File Maintenance

- Modifying Provider File Information
  - ✓ Log into ProviderOne with the **Provider File Maintenance** or **Supers User** profile.
  - ✓ Click on the **Manage Provider Information** hyperlink



Provider Types include:
- ✓ Individual
- ✓ Group
- ✓ Tribal
- ✓ Facilities (FAOI)
- ✓ Servicing

- ✓ Go to web page http://hrsa.dshs.wa.gov/provider/provideronemanuals.shtml for the different of provider file update modification manuals.

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Provider File Maintenance

- Modifying Provider File Information
  - ✓ The Business Process Wizard contains the steps for modification. Click on the step hyperlink to modify.

View/Update Provider Data - Group Practice:

Business Process Wizard - Provider Data Modification (Group Practice). In order to finalize submission of your requested changes, you must c

	Step	Required	Last Modification Date	Last Review Date	Status
	Step 1: Basic Information	Required	09/30/2009	09/30/2009	Complete
	Step 2: Locations	Required	09/30/2009	09/30/2009	Complete
	Step 3: Specializations	Required	06/15/2010	07/22/2010	Complete
	Step 4: Ownership Details	Required	09/30/2009	09/30/2009	Complete
	Step 5: Licenses and Certifications	Required	06/15/2010	07/22/2010	Complete
	Step 6: Training and Education	Optional	09/30/2009	09/30/2009	Complete
	Step 7: Identifiers	Optional	09/30/2009	09/30/2009	Complete
	Step 8: Contract Details	Optional	09/30/2009	09/30/2009	Complete
	Step 9: Federal Tax Details	Required	09/30/2009	09/30/2009	Complete
	Step 10: Invoice Details	Optional	09/30/2009	09/30/2009	Complete
	Step 11: EDI Submission Method	Optional	09/30/2009	09/30/2009	Complete
	Step 12: EDI Billing Software Details	Optional	09/30/2009	09/30/2009	Complete
	Step 13: EDI Submitter Details	Required	01/19/2011	01/19/2011	Complete
	Step 14: EDI Contact Information	Optional	05/10/2010	05/10/2010	Complete
	Step 15: Servicing Provider Information	Required	08/31/2011	09/06/2011	Complete
	Step 16: Payment Details	Required	09/30/2009	09/30/2009	Complete
	Step 17: Submit Modification for Review	Required	09/30/2009	09/30/2009	Complete

Provider File Maintenance

➢ Step 3:Specializations (Taxonomy Codes)

Close | Add | Update

Note: Provider Type and Specialty/Subspecialty are your Taxonomy Codes.

Specialty/Subspecialty List:

Filter By : And

Operational Status: Active Go

	Provider Type	Specialty/Subspecialty	Administration	Start Date	End Date	Operational Status	Status
	12-Dental Providers	23-Dentist/00000-Dentist	HRSA	02/23/2009	12/31/2999	Active	Approved
	12-Dental Providers	23-Dentist/G0001-General Practice	HRSA	02/23/2009	12/31/2999	Active	Approved
	12-Dental Providers	23-Dentist/X0400-Orthodontics and Dentofacial Orthopedics	HRSA	02/23/2009	12/31/2999	Active	Approved

- ✓ The first specialization taxonomy code is 12-23-00000 then add a "**X**" to all or 122300000X for a dentist.
- ✓ Be aware of the taxonomy code start date (should be the same as provider start date).
- ✓ Additional taxonomy codes may be added (based on the provider credentialing).

Provider File Maintenance

- Step 11:EDI Submission Method - How are you going to bill?

EDI Submission Details: You may check multiple Modes of Submission. NPI is required for all selections.

If Web Batch and/or FTP Secured Batch are selected, you must complete and mail a new ProviderOne Trading Partner Agreement.

Mode of Submission: ☐ Web Batch ☐ Billing Agent/Clearinghouse ☐ FTP Secured Batch ☐ Web Interactive

Status: In Review

Method	When to Use
Web Batch	For upload/download of files in ProviderOne
Billing Agent/Clearinghouse	For providers who use a 3rd party to bill
FTP Batch	For submitting files via an SFTP site
Web Interactive	For entering (keying) claims directly into ProviderOne

- Your EDI submission method is "Web Batch" if you currently upload and download batch files using WaMedWeb. This method is often used by providers who submit their own HIPAA batch transactions. It allows a maximum file size of 50MB.
- Your EDI submission method is "FTP Secured Batch" if you submit and retrieve batches at a secure web folder assigned to you by DSHS. This method was designed with clearinghouses and billing agents in mind. It allows a maximum file size of 100 MB.

OK Cancel

- ✓ Web Batch – batching claims with your software.
- ✓ Billing Agent/Clearinghouse – submits your claim batches.
- ✓ FTP Secured Batch – used for very large claim batches.
- ✓ Web Interactive – DDE claims directly into ProviderOne.
- ✓ Selection may trigger other steps to become required.

Provider File Maintenance

- Step 11:EDI Submission Method - Updates
  - ✓ Adding a Billing Agent/Clearinghouse.
  - ✓ The next slide shows the actual steps involved.

Close | Add

EDI Submission Method:

Filter By : Status | % | And

And Operational Status: | Go

	EDI Submission Method	Start Date	End Date	Status	Operational Status
	Billing Agent/Clearinghouse, FTP Secured Batch, Web Interactive	05/01/2009	12/31/2999	IN REVIEW	Active

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  - ✓ To see your addition: Filter By: Status then add % and click Go.
  - ✓ Your request is seen and In-Review status.

Provider File Maintenance

- Step 13:EDI Submitter Details – Billing Agent/Clearinghouse
  - ✓ Add the Billing Agent/Clearinghouse ProviderOne ID
    - Get the ID number from the Billing Agent/Clearinghouse; or
    - Go to the HIPAA web site to review the posted list at http://hrsa.dshs.wa.gov/dshshipaa/pdf/bachstatus.pdf

Add Submitter - Windows Internet Explorer

ProviderOne Id/NPI : 2857403 / 5522336671 Name: Mario Health Center

Associate Billing Agent/Clearinghouse:

Billing Agent/Clearinghouse ProviderOne Id: *

Start Date: * End Date:

Status: In Review

Note: In the "Authorized Transaction Responses" section, please select 'yes' for any outbound HIPAA transactions that your clearinghouse acquires on your behalf.

Authorized Transaction Responses:

Transaction Response	Authorized	Start Date	End Date
271-Eligibility Response	No		
277-Claim Status Response	No		
277U-Unsolicited Claims Status Response	No		
278-Prior Authorization Response	No		
820-Premium Payment	No		
834-Benefit Enrollment	No		
835-Healthcare Claim Payment Advice	No		

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OK Cancel

  - ✓ Add the start date with your organization.
  - ✓ Add authorization for any transactions they will do.

Provider File Maintenance

- Step 15: Servicing Provider Information
  - ✓ View the list of providers that work at the clinic.

Welcome Jones, John . You have logged-in with **EXT Provider File Maintenance** profile. Links: --Select--

Path: Provider Portal/ Group Practice Modification
ProviderOne Id/NPI : 2857403 / 5522336671 Name: Mario Health Center

Close Add

Servicing Provider List:

Filter By : **And**

And Operational Status : Active Go

ProviderOne ID	Servicing Provider Name	Servicing Provider NPI	Start Date	End Date	Status	Operational Status	Inactivation Date
3050186	MARIO, ROBERT	5522447783	12/11/2001	12/31/2999	Approved	Active	
2370695	SORENSON, HERMAN	3334445558	07/01/2008	12/31/2999	Approved	Active	
1000092	GOLDEN, MICHAEL	1234567890	07/01/2008	12/31/2999	Approved	Active	

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  - ✓ Adding a new provider is covered later in this presentation.

Provider File Maintenance

- Step 15:Servicing Provider Information – Ending a provider association
  - ✓ Click on the ProviderOne ID on the provider list.

Servicing Provider List:

Filter By : And

And Operational Status : Active Go

	ProviderOne ID	Servicing Provider Name	Servicing Provider NPI	Start Date	End Date	Status	Operational Status	Inactivation Date
	3050186	MARIO, ROBERT	5522447783	12/11/2001	12/31/2999	Approved	Active	
	2370695	SORENSON, HERMAN	3334445558	07/01/2008	12/31/2999	Approved	Active	
	1000092	GOLDEN, MICHAEL	1234567890	07/01/2008	12/31/2999	Approved	Active	

  - ✓ Enter an end date then save the change.

Close Save

Manage Servicing Provider:

ProviderOne ID / NPI: 2370695

Provider Name: SORENSON, HERMAN

Status: Approved

Start Date: 07/01/2008 *

End Date: 12/31/2999

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Provider File Maintenance

➢ Step 15:Servicing Provider Information

✓ Viewing a Servicing Providers taxonomy codes

Servicing Provider List:

Filter By :

And Operational Status : Active Go

	ProviderOne ID	Servicing Provider Name	Servicing Provider NPI
	3050186	MARIO, ROBERT	5522447783
	2370695	SORENSON, HERMAN	3334445558
	1000092	GOLDEN, MICHAEL	1234567890

- ✓ At the provider list page, click on the providers name .
- ✓ ProviderOne opens the individual providers Business Process Wizard.

- ✓ Click on Step 3: Specializations to see the taxonomy code list for your provider.

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

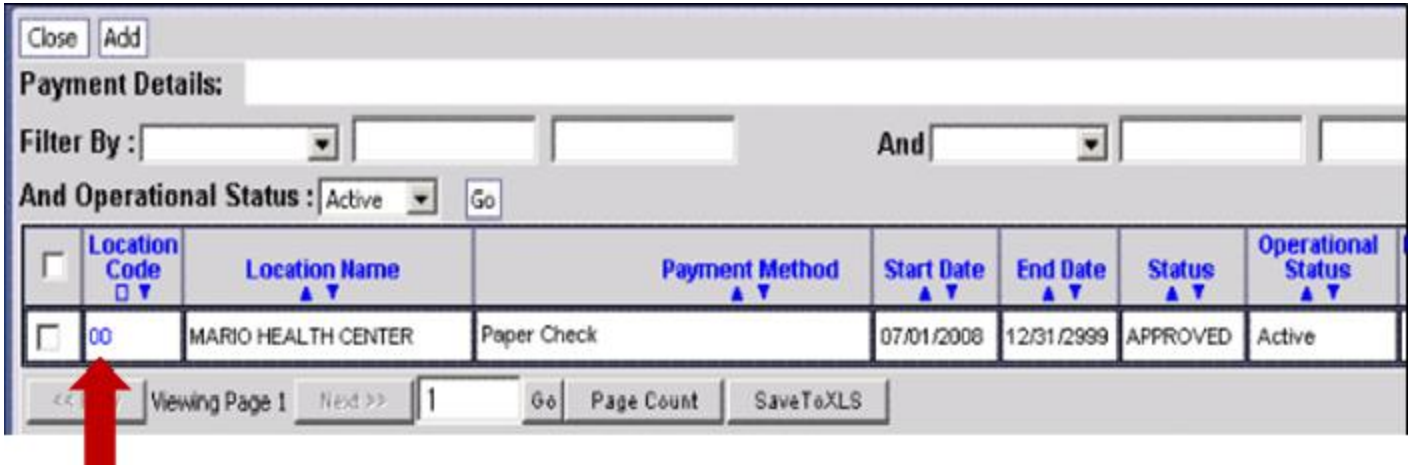
View/Update Provider Data - Individual: **Servicing Provider Business Process Wizard**

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested change

	Step	Required	Last Modification Date	Last Review Date
	Step 1: Basic Information	Required	11/06/2010	11/06/2010
	Step 2: Locations	Not Required	11/06/2010	11/06/2010
	Step 3: Specializations	Required	11/06/2010	11/06/2010
	Step 4: Ownership Details	Not Required	11/06/2010	11/06/2010
	Step 5: Licenses and Certifications	Required	11/06/2010	11/06/2010
	Step 6: Training and Education	Optional	11/06/2010	11/06/2010
	Step 7: Identifiers	Optional	11/06/2010	11/06/2010
	Step 8: Contract Details	Not Required	11/06/2010	11/06/2010

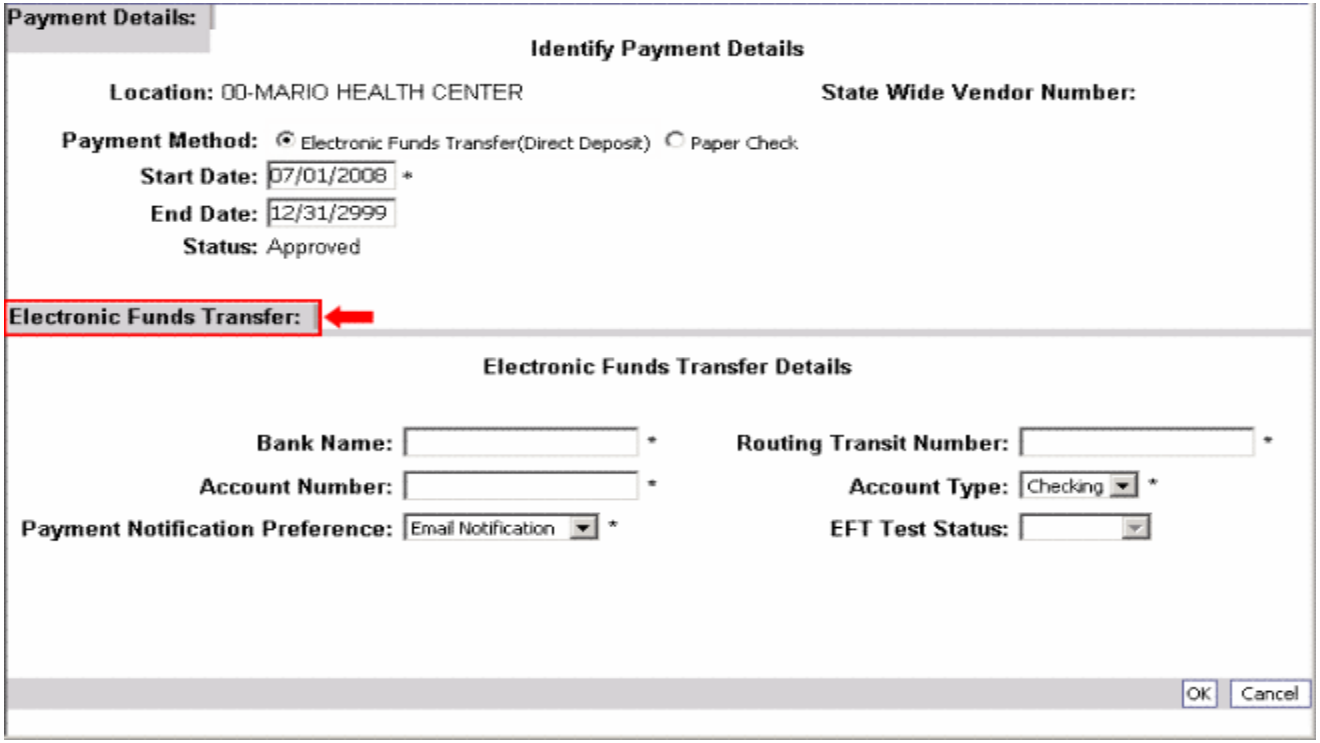
Provider File Maintenance

- Step 16:Payment Details
  - ✓Displayed is current payment information.
  - ✓To modify click on the "**00**".



Provider File Maintenance

- Step 16: Payment Details
  - ✓ Switching to Electronic Funds Transfer (preferred)



  - ✓ Enter your banking information then click "OK"

Provider File Maintenance

- Step 16:Payment Details
  - ✓ Fill out the Authorization Agreement for Electronic Funds Transfer form
  - ✓ Have the form signed
  - ✓ Fax in to 360-725-2144; or
  - ✓ Mail to address on the form
  - ✓ Find the form at http://www.dshs.wa.gov/pdf/ms/forms/18_633.pdf

Provider File Maintenance

- Step 17:Submit Modification for Review

Close | Submit Provider Modification

Final Submission:

ProviderOne ID: 2857403 **Enrollment Type: Group Practice**

The requested modifications submitted shall be verified and reviewed by the DSHS. During this time, you may not make additional changes.

By clicking on the button "Submit Provider Modification", you are agreeing that the information submitted for modification is correct (Privacy and Confidentiality).

Please use your NPI in all the documentation sent to DSHS. If you do not use an NPI please use your ProviderOne ID.

Instructions for submitting documentation:
1. Please click on this link to display the documentation cover sheet.
2. Print the cover sheet.
3. Write the the NPI number or ProviderOne ID number in the Provider ID field on the cover sheet.
4. Include the cover sheet, with the NPI number or ProviderOne ID number, when mailing or faxing documentation to the DSHS.

Application Document Checklist:

Forms/Docs	Special Instructions	Source	Required
Training and Education	Please provide a copy of all required Training and Documentation.		NO
Tax Documents	Please provide a copy of all required Tax Documents.	http://www.irs.gov/	NO
Licenses and Certifications	Please provide a copy of all required Licenses and Certifications.	http://fortress.wa.gov/doh/hpqa1/Application/Credential_Search/profile.asp	NO
EDI Required Documentation	Please provide a copy of all required Trading Partner documents.		NO
Contracts and Agreements	Please provide a copy of all required Contracts and Agreements. Include a copy of the current Core Provider		NO
Business License	Please provide a copy of all business license.	http://dor.wa.gov/content/home/brd/default.aspx	NO

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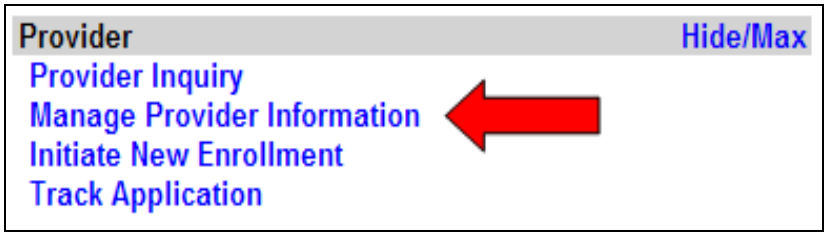
Provider File Maintenance

- More information on provider file maintenance visit this site:
- http://hrsa.dshs.wa.gov/provider/provideronemanuals.shtml
- Find your manual to review.

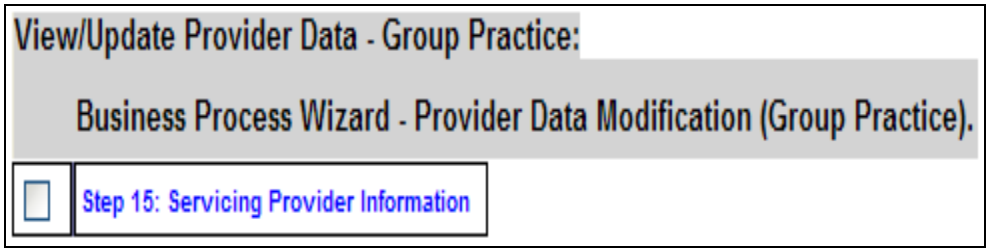
Enroll a New Rendering Provider

Enroll a New Rendering Provider-Existing Provider

- Log into ProviderOne using the File Maintenance or Super User profile.



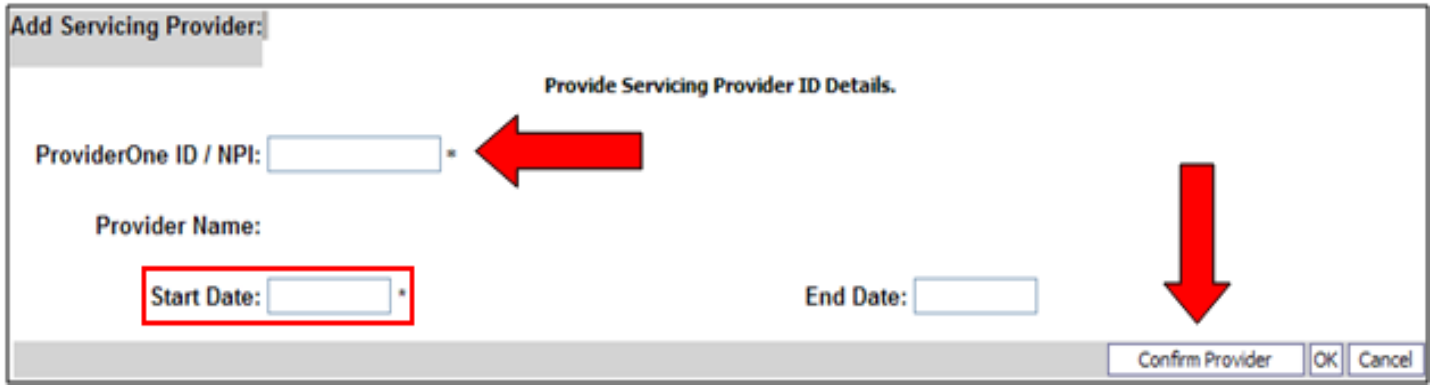
✓ Under Provider click on the hyperlink "Manage Provider Information."



✓ At the Business Process Wizard click on "Step 15: Servicing Provider Information."

Enroll a New Rendering Provider-Existing Provider

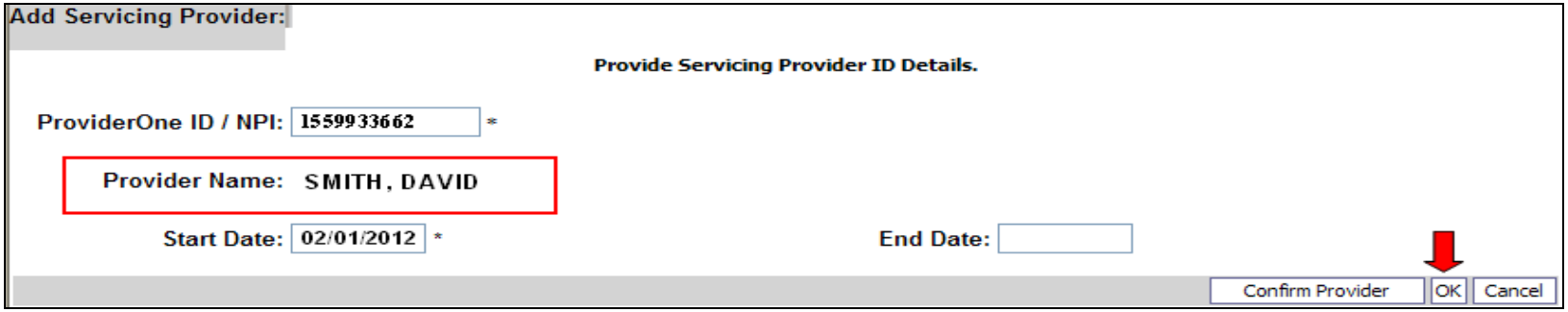
- When the Servicing Provider List opens, click on the "Add" button.



- At the Add screen:
  - ✓ Enter the providers NPI.
  - ✓ Enter their start date at your clinic.
  - ✓ Click on the "Confirm Provider" button.

Enroll a New Rendering Provider-Existing Provider

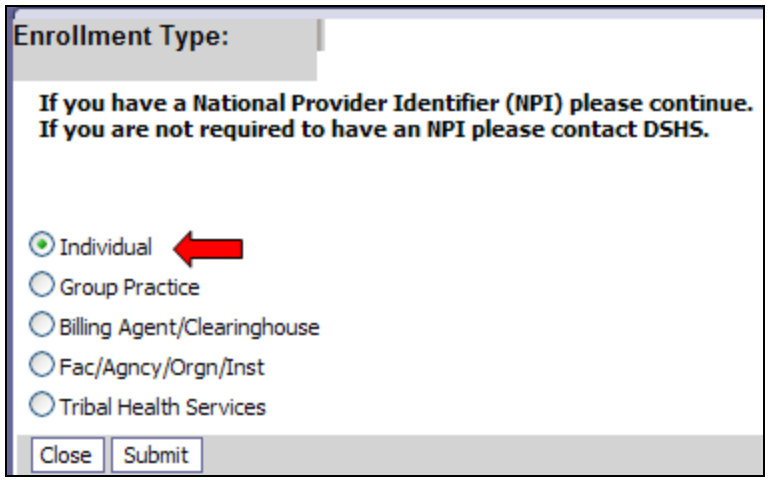
- If the provider is already entered into ProviderOne their name will be confirmed.



- Click the "OK" button to add the provider to your list.
- Remember to click "Step 18: Submit Modification for Review."
- The State will then review your request.

Adding a New Rendering Provider

- There are two ways to add a new provider to your Domain:
  - ✓ Follow the steps above. When you "Confirm" the provider and they are not in the system follow the steps below to enroll them.
  - ✓ At your Portal click on "Initiate New Enrollment" hyperlink.



- ✓ Click on "Individual" to add the rendering/servicing provider to your Domain.

Adding a New Rendering Provider

- At the Basic Information page for the rendering provider enrollment:

Basic Information: If you don't have NPI and if you are Atypical provider then please contact DSHS worker to enroll.

Tax Identifier Type: ○ FEIN ◉ SSN

Organization Name: (as shown on Income Tax Return)
Organization Business Name: FEIN:

First Name: JOHN (as shown on Social Security Card) Middle Name or Middle Initial: L
Last Name: SMITH (as shown on Social Security Card)
Suffix: MD Gender: Male
SSN: 002272012 Title:
Date of Birth: 07/15/1985 Servicing Type: Servicing Only

NPI: 1567890234 * UBI:
W-9 Entity Type: Other * W-9 Entity Type (If Other): SERVICING ONLY
Other Organizational Information: ---SELECT--- Email Address:
Enrollment Effective Date: 02/01/2012
Receive Invoice for Medical Services?: No *

Finish Cancel

- ✓ Most important check the **SSN** radio button!
- ✓ When filling in the rest of the data fields be sure to select "Servicing Only" as the Servicing Type.

Adding a New Rendering Provider

- Once the Basic Information page is filled in click the "Finish" button.
- The basic information on the enrollment application is submitted into ProviderOne which generates the Application number.

Basic Information:

You have successfully completed the basic information on the Enrollment Application This is your Application #: 20227201264480
Please make note of this application number. This number will be emailed to you. This is the number you will be required to use to track the status of your enrollment application. Do not lose this number once you log off.

Ok

- Please to record this application number for use in tracking the status of the enrollment application. Then click "OK."

Adding a New Rendering Provider

- The Business Process Wizard - Step 1 is complete.

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data - Individual:

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested - Su

	Step	Required	Last Modification Date	Last Review Date	Status
	Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
	Step 2: Locations	Not Required			Incomplete
	Step 3: Specializations	Required			Incomplete
	Step 4: Ownership Details	Not Required			Incomplete
	Step 5: Licenses and Certifications	Required			Incomplete
	Step 6: Training and Education	Optional			Incomplete
	Step 7: Identifiers	Optional			Incomplete
	Step 8: Contract Details	Not Required			Incomplete
	Step 9: Federal Tax Details	Optional			Incomplete
	Step 10: Invoice Details	Optional			Incomplete
	Step 11: EDI Submission Method	Optional			Incomplete
	Step 12: EDI Billing Software Details	Optional			Incomplete
	Step 13: EDI Submitter Details	Optional			Incomplete
	Step 14: EDI Contact Information	Optional			Incomplete
	Step 15: Billing Provider Details	Optional			Incomplete
	Step 16: Payment Details	Not Required			Incomplete
	Step 17: View Union Information	Optional			Incomplete
	Step 18: Submit Modification for Review	Required			Incomplete

- ✓ Not all remaining steps are required.

Adding a New Rendering Provider

- The steps with the arrows should be filled out.

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data - Individual:

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested - Su

	Step	Required	Last Modification Date	Last Review Date	Status
☐	Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
☐	Step 2: Locations	Not Required			Incomplete
☐	Step 3: Specializations	Required			Incomplete
☐	Step 4: Ownership Details	Not Required			Incomplete
☐	Step 5: Licenses and Certifications	Required			Incomplete
☐	Step 6: Training and Education	Optional			Incomplete
☐	Step 7: Identifiers	Optional			Incomplete
☐	Step 8: Contract Details	Not Required			Incomplete
☐	Step 9: Federal Tax Details	Optional			Incomplete
☐	Step 10: Invoice Details	Optional			Incomplete
☐	Step 11: EDI Submission Method	Optional			Incomplete
☐	Step 12: EDI Billing Software Details	Optional			Incomplete
☐	Step 13: EDI Submitter Details	Optional			Incomplete
☐	Step 14: EDI Contact Information	Optional			Incomplete
☐	Step 15: Billing Provider Details	Optional			Incomplete
☐	Step 16: Payment Details	Not Required			Incomplete
☐	Step 17: View Union Information	Optional			Incomplete
☐	Step 18: Submit Modification for Review	Required			Incomplete

Adding a New Rendering Provider

- ✓ Step 3: Specializations
  - Add Taxonomy here.
- ✓ Step 5: Licenses and Certifications
  - Enter license/certification issued by the Department of Health.
- ✓ Step 7: Identifiers (DEA number)
- ✓ Step 15: Billing Provider Details
  - Add the NPI and Name of clinic that will bill for this rendering provider's services.
- ✓ Step 18: Submit Modification for Review
  - Open this and click the Submit Button to send to the State for approval.
- ✓ Send in all required supporting documentation (CPA, Certifications, etc.)

HIPAA Transactions

- Who can conduct a Batch submission?
- What kinds of transactions are available?
- Where do I get information?
- Contact information.

HIPAA Transactions

- Who can conduct a Batch submissions?
  - ✓ Anyone can as long as you or your clearinghouse have gone through testing to confirm your software is HIPAA compliant.
  - ✓ Link to HIPAA batch testing site- http://hrsa.dshs.wa.gov/providerone/HIPAAtesting.htm.

HIPAA Transactions

- What kinds of transactions are available?
  - ✓ All the available HIPAA transactions and their description can be found at this site: http://hrsa.dshs.wa.gov/dshshipaa/attachments/pdf/TransactionCodeDescriptions-v1_051704.pdf.

HIPAA Transactions

- Where do I get information
  - http://hrsa.dshs.wa.gov/dshshipaa/

- Contact information
  - Hipaa-help@hca.wa.gov

Washington State Health Care Authority
Medicaid

Dental Web Site

Washington State Health Care Authority
Medicaid

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Dental Services

Services for Clients

For Providers

Important notices and memos for providers:

- Guide for Dental Providers (all ages)
- Dental coverage for pregnant women now includes a post partum period.
- Budget changes access to dental services for some clients
- Provider Memo
- Glossary of Terms
- Emergency Oral Healthcare Benefit (see page B.31 for all clients Age 21 and Older)

Effective October 1, 2011: Changes in coverage for some DDD Medicaid Adults:

- Decision making tool
- Eligibility Expedited Prior Authorization Criteria
- Frequently Asked Questions and Answers for DDD

What's New

Guide for Dental Providers (all ages)

Effective October 1, 2011: Dental Expedited Prior Authorizations

Budget changes access to dental services for some clients.

Update! The General Information for Authorization form (13-835) has been updated to include new Service Types (revised 8/2011). Please use this newest form in Word and PDF!

Reminder: Submission of

http://hrsa.dshs.wa.gov/DentalProviders/DentalIndex.html

Washington State Health Care Authority

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Medicaid

Provider One Stop Shopping

Washington State Medicaid

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Medicaid Providers

News

Proposed Emergency Room changes have been suspended and did not go into effect April 1.

Medicare and Medicaid: Dual eligibles project posted.

HHS-OIG Compliance Training oig.hhs.gov

HIPAA 5010/NCPDP D.O Implemented January 1, 2012 - ProviderOne software was updated for HIPAA 5010 and NCPDP D.0. Technical specification documents are available at our HIPAA/5010 website.

New Registration and Authorization Process (See Advanced Imaging).

News Release: Three-visit limit overturned by judge (November 10, 2011)

September 22, 2011: Health Care Authority Director Doug Porter announces September budget package.

Contract All | Expand All

You may also want to visit:

Budget Cuts how they affect the Medicaid Program

ProviderOne Billing and Resource Guide an overview of Medicaid, billing, and system usage

Join the Medicaid email list for providers to get the latest information specific to your business

ProviderOne Weekly Claims Report
Providers can check their claim statistics by tax ID then NPI

Scope of Care client coverage eligibility for services

Coordination of Benefits

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A Provider link to ProviderOne

Contact the Customer Service Center

http://hrsa.dshs.wa.gov/Provider/

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Training

The **Medicaid Program** offers a variety of learning opportunities for providers. These include live webinars, E-learning lessons, tutorials, and manuals.

Review your **E-Learning** by clicking on the link for:

- Institutional Fee for Service Claims
- Professional Fee for Service Claims
- Dental Fee for Service Claims

ProviderOne manuals are organized into chapters that explain how to use different features of the system.

Webinars

Contract All | Expand All

Professional services and Dental

Basic information about ProviderOne

Enroll and maintain a provider file

Verify client eligibility

Prior authorization

Submit fee for service claims (professional, dental, institutional)

You may also want to visit:

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Webinars

News

All Webinar presentation slides have been updated to reflect the ProviderOne system changes due to the implementation of the HIPAA 5010 system format. The Webinar recordings have not been updated to reflect the 5010 system format changes at this time.

Contract All | Expand All

Each link below is expandable

Billing a client webinar

This webinar covers when a provider may be able to bill a Medicaid client for healthcare services in limited circumstances. It covers the provider's responsibilities and when a provider may need the only acceptable waiver form 13-879 (Agreement to Pay for Healthcare Services) signed by the provider and client before the service date.

- Recorded Webinar
- Presentation
- Review the Questions & Answers from the Webinar

Nursing Home providers webinar

TAG/Provider Open Communication Forum webinar

Interpreting Client Eligibility Information Returned by ProviderOne

Prior authorization

You may also want to visit:

Budget Cuts how they affect the Medicaid Program

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Links Tab Page

Easy to find direct links to Medicaid Programs

Medicaid Provider Services Links

Here are some information links that may be useful to a Medicaid Provider:

- Alien Emergency Medical Program (AEM)
- Authorization Services
- Billing Instructions
- Coordination of Benefits
- Dental Services
- Department of Social and Health Services (DSHS)
- DSHS Division of Behavioral Health & Recovery (DBHR)
- Document Cover Sheets
- Drug Use Assistance
- Durable Medical Equipment
- Electronic Health Record Incentive Program
- Emergency Rooms
- Federal EOB and Taxomony Code list
- Federally Qualified Health Centers and Rural Health Clinics
- Frequently Asked Questions (FAQ)
- Health Care Programs & Services
- Healthy Options (Managed Care)
- HIPAA Home Page
- Hospital Payments
- Interpreter Services
- Kidney Disease Program
- Medicaid News
- Medicaid Rule Making Actions
- Medicaid State Plan
- Mental Health Services
- NPPES
- Numbered Memos
- Pharmacy Information Site
- Professional Services Rates
- ProviderOne Billing and Resource Guide
- Provider Enrollment
- ProviderOne Log-In
- ProviderOne System Manuals
- Patient Review & Coordination Program
- Regional Support Networks (RSN)
- Substance Abuse Help
- Swipe Card Readers
- Tribal Health
- Washington Administrative Code (WAC)

Washington State Health Care Authority
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Discovery Log

Washington State Medicaid

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Claims and Billing

Use the discovery log to learn about known issues in ProviderOne

News

ProviderOne has been updated to the HIPAA 5010 system format. Please check the Discovery Log for new, open, and closed ProviderOne Discoveries.

4th of July holiday will affect ProviderOne Claims Submission Deadline. In order to ensure that payments will be made on the regular schedule, it is necessary to produce the ProviderOne payment file early. The deadline for submission of claims to ProviderOne for the next pay cycle is 6:00 pm, Monday July 2, 2012 because of the 4th of July holiday. Payments and Remittance Advice (RA) documents are unaffected and will process as normal.

The payment for Monday the 9th will include claims submitted through Monday the 2nd at 6:00 pm. The payment for Monday the 16th will include claims submitted from Monday the 2nd at 6:01 pm through 6:00 pm on Tuesday the 10th.

Notice: There is an issue with the storage mechanism of ProviderOne correspondence, this affects your ability to retrieve RAs. Currently we have restored all RAs dated 1/1/2012 to present. We will continue to keep you posted on the progress of the restoration of all historical RAs. Thank you for your patience.

Washington State Medicaid was recently informed that during the transition with Medicare to HIPAA 5010, Medicare will only submit crossover files received from 1/1/2012 up to July 2012 in HIPAA 4010 format. Because Washington State is unable to support multiple HIPAA standards, these 4010 crossover files cannot be loaded and processed in ProviderOne. Since CMS is unable to resubmit these files in the 5010 format, it is important for you to monitor your remittances for expected cross-over claims during this timeframe. If you do not see your claims crossing into ProviderOne, please submit the claim to Medicaid for processing by other means

You may also want to visit:

Budget Cuts how they affect the Medicaid Program

ProviderOne Billing and Resource Guide an overview of Medicaid, billing, and system usage

Join the Medicaid email list for providers to get the latest information specific to your business

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Health Care Authority

ProviderOne Billing and Resource Guide

ProviderOne Billing and Resource Guide

This Guide:

- Provides general information that applies to most Medicaid providers.
- Takes providers through the process for billing the Medicaid Program of the Health Care Authority for covered services delivered to eligible clients.

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

Washington State Health Care Authority
Medicaid

Contact Us!

Washington State Health Care Authority

Medicaid / ProviderOne

Contact Us!

Select one to request more information about Medicaid in Washington State:

If you are looking for more information about eligibility, health plans, services cards or finding a provider click here:	Client
If you are a provider with questions about enrollment, billing policy, a claim denial or service limitations click here:	Provider

- 48 hr turnaround for **Service Limits** checks
  - Be sure to include the Date of Service (DOS)
  - Procedure Code and the date range for search
  - ProviderOne Domain number

Information Request Form for Providers

Your Email Address: *	providerrelations@hca.wa.gov		
Business or Last Name:	Happy DME	FirstName:	Sara
7 digit Provider ID: (Enter NPIs in Comments)	Domain #	Select Topic: *	Service Limits
Client ID	200451235WA	AND: Date of Service (mm/dd/yyyy)	5/18/2012
Procedure Code:	T4525	Type of service:	Incontinence
Other Comments:	Please check Cpt code T4525 for the month of April 2012. Thank you!		

Must include timeframe in comments

Submit Request

* required information

Helpful Links Related to Client Eligibility

For the following Fact Sheets, use the hyperlink listed below:

- Client Services Card Fact Sheet
- Client Eligibility Verification Fact Sheet
- Interactive Voice Response (IVR) Fact Sheet
- Magnetic Card Reader Fact Sheet

http://hrsa.dshs.wa.gov/providerone/Providers/Fact%20Sheets/FactSheets.htm

For the E-Learning Webinar on how to check eligibility in ProviderOne, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/providerone/EEligibility.htm

For the Self-Paced Online Tutorial on how to check eligibility, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/providerone/ProviderTutorials.htm

For the ProviderOne Billing and Resource Guide, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

Questions?

General Information about Medicaid:

- Summarized in the ProviderOne Billing and Resource Guide **http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html**.
- See the Provider Training web site for links to recorded Webinars, E-Learning, and Manuals **http://www.dshs.wa.gov/provider/training.shtml**.
- Find the Dental Medicaid Provider Guide (formerly the billing instructions) at **http://hrsa.dshs.wa.gov/Download/BI.html**.
- Emergency Oral Health Factsheet **http://hrsa.dshs.wa.gov/DentalProviders/FAX/EPA.pdf**.
- Provider Enrollment web page at **http://hrsa.dshs.wa.gov/ProviderEnroll/enroll.shtml#provider**.