

ProviderOne Billing and Resource Guide

Background

The Health Care Authority (the Agency) has replaced its Medicaid Management Information System with a new payment processing system named ProviderOne. When fully operational, ProviderOne will pay about 100,000 providers who serve 1 million people who qualify for healthcare services. That's about one out of every five Washingtonians.

The Agency values our providers who deliver care to our clients. Together, we deliver medically necessary services to our vulnerable citizens. Ensuring that our providers have comprehensive, easy to use reference materials is a high priority.

This Guide replaces a publication known as the “*General Information Booklet*,” which the Agency historically used as its basic set of billing instructions. Providers used the *General Information Booklet* to complement the program specific billing instructions. This Guide supersedes the *General Information Booklet*.

Purpose of the Guide

This Guide provides step-by-step materials to help provider staff through the processes for ensuring clients are eligible for services and receive timely and accurate payments for covered services.

This new “ProviderOne Billing and Resource Guide” is intended to:

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

Disclaimer

A contract, known as the Core Provider Agreement, governs the relationship between the Agency and Medical Assistance providers. The Core Provider Agreement's terms and conditions incorporate federal laws, rules and regulations, state law, Agency rules and regulations, and Agency program policies, numbered memoranda, and billing instructions, including this guide. Providers must submit a claim in accordance with Agency rules, policies, numbered memoranda, and billing instructions in effect at the time they provided the service.

The Agency does not assume responsibility for informing providers of national coding rules. Claims billed in conflict with national coding rules will be denied by the Agency. Please consult the appropriate coding resources.

Who Will Benefit From This Guide?

We hope that this guide will serve as a great tool for providers that are new to serving clients as well as experienced billers using ProviderOne.

This guide is designed for provider staff who:

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

This Guide assumes you are already familiar with standard medical billing practices and coding.



NOTE: This Guide does not include billing in the pharmacy point-of-sale (POS) system. Please refer to <http://hrsa.dshs.wa.gov/pharmacy/> for pharmacy billing instructions.

What is Covered in this Guide?

The ProviderOne Billing and Resource Guide consists of five sections:

Medical Assistance Overview:

Explains the Medical Assistance programs provided by the Agency, how the Agency compares to other payers, how Medicaid differs from Medicare, who our clients are, our client services card, requirements for becoming a provider, and links to important policy documents and resources.

Enroll as a New Provider:

The process to enroll as a new Medicaid provider is beyond the scope of this publication. However for more general information about a Medicaid provider go to the [New Provider](#) web page or review information in this publication on pages 10 and 11. Providers that have decided to enroll as a Medicaid provider can go to the [Provider Enrollment](#) web page for complete enrollment instructions, a list of required documentation and the link to begin the online enrollment process.

Client Eligibility, Benefit Packages, and Coverage Limits:

Explains how to determine if a client has medical assistance available through the Agency, if the service you plan to deliver is covered under their benefit service package, and when prior authorization is needed. This chapter also explains how to determine if a client:

- Is enrolled in a managed care plan.
- Has any restrictions as to which providers they may receive care from.
- Has a spenddown balance that may affect eligibility.

Submit Fee-for-Service Claims to Medical Assistance:

Prepares you to submit fee-for-service (FFS) claims using a variety of methods, submit electronic back up documentation, check on the progress of a claim, and process crossover Medicare claims. This chapter also outlines how to resolve errors, submit adjustments, resubmit denied claims or void a claim paid in error.

The Remittance Advice – Understanding your Claim Status:

Explains how to obtain your remittance advice, determine what claims were paid or denied, review claims in process, and determine why a claim may have been denied.