Creating Social Service Medical Templates
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Definitions

**Batch:** A mass billing of several claims submitted at once.

**Client ID:** The client’s ProviderOne ID number, 9 digits followed by WA, *ex: 123456789WA*

**Provider ID:** The provider’s ID number for ProviderOne, 7 digits. This is the same as the Domain number. You will see this listed on the authorization with a 2 digit location code such as 01, *ex: 123456701*.

**Provider NPI:** The provider’s National Provider Identifier.

**TCN:** Transaction Control number; also called the claim number. This is an 18 digit number assigned to a claim for tracking purposes.

**Template:** A template is a reusable billing page that automatically fills out certain pieces of information.
Create a Template
Templates can be used when you have repetitive billing; where the claim is the same, or nearly the same, each time you bill. With a template, you create a billing page that is reusable.

Using templates is a great way to save time and make billing easier.

Having templates with previously saved information will help cut down on errors by reducing the amount of data entry for each claim.

To create a social service template, first log in to ProviderOne using the ‘EXT Provider Social Services Medical’ profile. Then select ‘Manage Templates’.

**Note:**
*Creating a template is not the same as submitting a claim.*

*Managing templates is for adding or removing templates. No claims can be submitted from the ‘Manage Templates’ area.*
The ‘Create Claim Template’ page appears.

Here you will see any previously saved templates.

When there are a large number of templates you can use the ‘Filter By’ function to find a template.

Columns can be sorted from A-Z or Z-A by using the controls below the name of each column.

Note: The Social Service Medical ‘Type of Claim’ is “Professional”.
The ‘Create a Social Service Claim Template’ page can be used to do several things:

- Add a new template.
- Edit a saved template.
- View a saved template.
- Delete a saved template.
- Change template name or SaveAs/Copy template.
- Create a template batch.

To create a new template, make sure to choose “Professional” as the claim type and then click on ‘Add’.
The ‘Professional Claim’ screen appears. This page is a Professional Billing page with an added Template Name field.

- Enter a Template Name. This is determined by you and is only used to identify the template.

Note:
ProviderOne will check the following before allowing the template to be saved:
- Provider NPI,
- Taxonomy Code,
- Client ID,
- Authorization Number.
The ‘Professional Claim’ screen appears.

Enter the following information:

- ‘Provider NPI’,
- ‘Taxonomy Code’ associated with the service you are contracted to provide.

**Note:**

_Durable Medical Equipment (DME) providers do not have contracts with DSHS._

Work performed is done so in accordance with their Core Provider Agreement (CPA) with the Health Care Authority.

When entering taxonomy information, use the appropriate assigned taxonomy for the service provided either through your DSHS Contract or the CPA.

**Note:**

You must turn off your pop-up blocker before you begin billing.

Asterisks (*) denote required fields.
Select ‘Yes’ for the question, “Is the Billing Provider also the Rendering Provider?”

Select ‘No’ for the question, “Is this service the result of a referral?”

Note:
Some shared services do require referrals.
If required, select ‘Yes’ for the question “Is this service the result of a referral?”
When answering yes another field will appear asking for the referring provider NPI number. Enter the referring provider NPI and continue submitting your claim.
Under ‘Subscriber/Client Information’:

- Enter the ‘Client ID’ (Client ID ends in WA),
- Click the + next to ‘Additional Subscriber/Client Information’,
- Enter the following information for the client:
  - ‘Last Name’,
  - ‘Date of Birth’,
  - ‘Gender’.

**Note:**
Client last name, DOB, and gender are the only required fields.
Patient is pregnant and Patient Weight fields do not apply.
Under ‘Subscriber/Client Information’:

- Answer ‘No’ to the questions:
  - “Is this claim for a Baby on Mom’s Client ID?”
  - “Is this a Medicare Crossover Claim?”
Under ‘Claim Information’,

Click the \( \pm \) next to ‘Prior Authorization’.

- Enter the approved authorization number for the client.
  
  \( \Rightarrow \) Some claims may require a claim note. If you think a note is required please refer to the program specific billing guide for more information.

  \( \Rightarrow \) If no note is needed, skip this option.

- Answer ‘No’ to the question “Is this claim accident related?”

**Note:**
Claim Note, EPSDT Information and Condition Information are not applicable to these claims.
Under ‘Claim Data’,

Using the dropdown menu, choose the appropriate ‘Place of Service’.

Most social services performed will be in either an office or the client’s home.

If the service is performed outside of those locations, choose the appropriate place of service from the list.

**Note:**
Adult Family Homes, Assisted Living Facilities and Enhanced Service Facilities are residential settings and thus considered to be the client’s home.
Under ‘Claim Data’,

Enter the ‘Diagnosis Codes’,

- Only **ICD-10** diagnosis codes are accepted.
- At least 1 diagnosis code is required for all claims.
- ProviderOne will allow up to 12 **ICD-10** diagnosis codes.
- **Do not enter decimal points in diagnosis codes.** ProviderOne will automatically add any decimals to the code once the claim is submitted.

**Note:**
- **ICD-10** diagnosis codes can be found from many online resources.
- **Client case managers and MACSC call center staff cannot supply ICD-10 diagnosis codes.** Please use the online resources available to you to determine the appropriate code(s) based on the client’s diagnosis.
Create a Template

At this point you have entered the minimum required information needed to save a template.

- To save the template, click on ‘Save Template’ in the upper left corner of the screen.

- After choosing to save the template you will be asked, “Do you want to save the Template?”

- Select ‘OK’ to confirm the save of the template. Select ‘Cancel’ if you are not ready to save the template or need to make changes.

Note:
In ProviderOne, ‘OK’ signifies a YES response and ‘Cancel’ a NO response.
You will now be returned to the ‘Create a Claim Template’ page.

Here, you will see the template you have created. You can see the template name, template type, the user who made the last update and the last updated date.

To edit any information on the template, check the box next to the template name and select ‘Edit’. Make the needed edits and save the template.

To view or delete the template, check the box next to the template name and choose the appropriate action button.
Copy a Template
As a way to save time, you can use the template you have just created to make similar templates for other clients.

To do this, you can make a copy of an existing template, change the client information, rename the template, and save.

To Copy a Template:
- Check the box next to the desired template name, then
- Select ‘SaveAs/Copy’.

**Note:**
Creating new templates from a previously saved template can save you time. However, be mindful of the information being entered.

Incorrect authorization numbers, provider IDs or Client IDs will cause the claim submitted with the template to be denied.
After choosing ‘SaveAs/Copy’, the original saved template appears.

To Update the Template:

- Change the Template Name,
- Change the Client ID,
- Open the + next to ‘Additional Subscriber/Client Information’ and change the client’s:
  - Last Name,
  - Date of Birth,
  - Gender.
- Open the + next to ‘Prior Authorization’, change the Authorization Number.
- Change the Diagnosis Code,
- To save the name template, click on ‘Save Template’.

Note: The Provider NPI will remain the same when copying a template.
After choosing to save the template you will be asked, “Do you want to save the Template?”

Select ‘OK’ to confirm the save of the template. Select ‘Cancel’ if you are not ready to save the template or need to make changes.

Note:
In ProviderOne, ‘OK’ signifies a YES response and ‘Cancel’ a NO response.
You will now be returned to the ‘Create a Claim Template’ page.

The new, saved, template will be shown along with the original template.

Repeat the process as many times as needed.

To edit any information on the template, check the box next to the template name and select ‘Edit’. Make the needed edits and save the template.

To view or delete the template, check the box next to the template name and choose the appropriate action button.
Submitting Claims from Saved Templates
As previously mentioned, claims cannot be submitted from the ‘Manage Templates’ field.

To submit claims using the templates you have saved, first log in to ProviderOne using the ‘EXT Provider Social Services Medical’ profile.

From the Provider Portal ‘Create Claims from Saved Templates’.
The ‘Create Claim from Saved Templates List’ appears.

Here you will see the names of all your templates. Take note that the template names are blue hyperlinks. When selected, they will load the information of the saved template.

To continue, click the blue hyperlinked template name.
Submitting Claims from Saved Templates

You will now see the saved information that corresponds to the chosen template.

This will include:

- Provider NPI,
- Taxonomy Code,
- Client ID, Last Name, Date of Birth and Gender,
- Authorization Number,
- Place of Service,
- Diagnosis Code.

**Note:**
If at this point you discover any incorrect information that has been entered, close out of the current screen and return to the ‘Manage Templates’ area to make the needed corrections.
Under ‘**Basic Line Item Information**’ fill out the following information:

- Enter ‘**Service Date From**’ and ‘**Service Date To**’. Unless billing for a daily or monthly unit type, claims are for a single day per line so From and To dates should be the same.

- Enter ‘**Procedure Code**’ and ‘**Modifier**’ (if applicable).

**Note:**
You must turn off your pop-up blocker before you begin billing.

Asterisks (*) denote required fields.
Under ‘Basic Line Item Information’:

- Enter ‘Submitted Charges’ (The provider is responsible for the calculation of submitted charges. Units x Rate = Submitted Charge.),
- Enter the number of ‘Units’,
- Select the corresponding ‘Diagnosis Pointer’ number from the diagnosis pointers dropdown (Data entered into the first diagnosis code box = #1 diagnosis pointer).
Once the service line information has been entered, click ‘Add Service Line Item’.

The ‘Basic Service Line Items’ section clears. This allows entry of any subsequent service lines before submitting your claim, i.e., billing for multiple days in a month.

**Additional service lines must be for the same authorization. Different service codes are allowed if they are from the same authorization.**

A claim service line appears under ‘Previously Entered Line Item Information’. The claim service line will show service dates, service code and modifier, as well as units entered. The total charges submitted will also be available to view.

**Check the line information for accuracy.**
For information on adding, modifying or deleting service lines, please see ‘Submitting Social Service Medical Claims’ on the Health Care Authority’s website.

Once all service line information is entered and checked for accuracy, click ‘Submit Claim’ at the top of the screen.

Your pop-up blockers must be turned off to allow the Claim Detail screen to appear.

If the pop-up blockers are not turned off, the screen will flash and no pop-up will appear, making it impossible to complete billing.

**Note:**

If submitting a claim with the pop-up blockers on, the claim information will remain on the screen. Providers should turn off pop-up blockers before logging in to ProviderOne.

Attempting to click ‘Submit Claim’ again will return an error message that says: The information you are trying to submit has been queried by another user.

To remedy this, log out of ProviderOne, turn off your browser’s pop-up blockers, then log in to ProviderOne again and return to the billing screen to start over.
A message will appear asking, “Do you want to submit any Backup documentation?”

Certain shared services require backup documentation such as a denial from another payer. If required, select ‘Ok’ and upload the needed documentation before continuing to submit the claim.

If no backup documentation is needed, select ‘Cancel’ and continue submitting the claim.
Once you have clicked ‘**Submit Claim**’ the ‘**Submitted Professional Claim Details**’ page appears.

Claim details will include the new **TCN**, **Provider NPI**, **Client ID**, **Date of Service** and **Total Claim Charge**.

**Note:**

‘**No Records Found!**’ refers to attachments such as backup documentation. If you did not attach necessary documents earlier you may do so here by clicking ‘**Add Attachment**’. 
When you see the ‘Submitted Professional Claim Details’ screen you may want to record the information. You may print, print to a file on your machine or record this information in another manner.

***However, your claim has not yet been submitted***

To submit the claim, you must click on the ‘Submit’ button (located in the bottom right corner of the page) to complete the claims submission and send the claim to ProviderOne for processing.
Below is a short list of common Adjustment Reason and Remarks Codes you may find on your Remittance Advice (RA):

<table>
<thead>
<tr>
<th>RA adjustment reason/remark code/description</th>
<th>Possible causes</th>
<th>Provider action</th>
</tr>
</thead>
<tbody>
<tr>
<td>142- Monthly Medicaid patient liability amount.</td>
<td>Client responsibility (participation) applied to the claim</td>
<td>You must collect this amount from the client</td>
</tr>
<tr>
<td>198- Precertification/authorization exceeded</td>
<td>Social Service Authorization Approved Units have already been claimed</td>
<td>Contact your case worker if you question the number of units authorized</td>
</tr>
<tr>
<td>19- Claim/service lacks information or has submission/billing error(s) which is needed for adjudication</td>
<td>1. Claimed dates of service are not within the authorization period &lt;br&gt;2. The authorization line is in error</td>
<td>1. Contact your case worker if you have questions about the authorization dates&lt;br&gt;2. Contact your case worker if you have questions about authorization errors</td>
</tr>
<tr>
<td>18- Exact duplicate claim/service</td>
<td>1. Claimed the same units on two different lines for the same day, or&lt;br&gt;2. Claim is an exact duplicate of one already submitted</td>
<td>1. Adjust the claim and report the number of units on a single claim line&lt;br&gt;2. No action is needed if duplication was unintended.</td>
</tr>
<tr>
<td>177- Patient has not met the required eligibility requirements</td>
<td>The client is not financially eligible</td>
<td>Contact your case worker if you have questions</td>
</tr>
<tr>
<td>A1- Claim/Service denied</td>
<td>The authorization is in cancelled status</td>
<td>Contact your case worker if you have questions</td>
</tr>
<tr>
<td>B1- This provider was not certified/eligible to be paid for this procedure/service on this date of service</td>
<td>Your contract may be expired.</td>
<td>Contact your contract manager or case worker if you have questions</td>
</tr>
<tr>
<td>N54- Claim information is inconsistent with pre-certified/authorized services</td>
<td>Authorization line is in error</td>
<td>Contact your case worker if you have questions</td>
</tr>
<tr>
<td>N63- Rebill services on separate claim lines</td>
<td>A separate claim line is required for each date of service for the service/procedure code entered</td>
<td>If you are billing quarter hour units or for each unit types, do not use a date span (example: 1/1/2015 to 1/31/2015) to bill. Adjust the claim to reflect separate claim lines for the date of service for each service provided and resubmit claim</td>
</tr>
<tr>
<td>N302 : The number of Days or Units of Service exceeds our acceptable maximum</td>
<td>Too many units claimed. Example: Provider billed two units on monthly units or provider billed two units on daily units with one day date span</td>
<td>Change the number of units to the correct amount and resubmit your claim</td>
</tr>
</tbody>
</table>