Washington State Health Care Authority

How to Submit SBHS Claims in ProviderOne

School-Based Health Care Services Program

August 2020

Submitting SBHS Claims

This training is intended for self-billing school districts who participate in the SBHS program.

- This training will show self-billing school districts how to submit fee-for-service direct data entry (DDE) claims into the ProviderOne portal.
- In this training, you will learn how to:
  - Create and submit claims for students who are covered by Title XIX Medicaid only
  - Create and submit claims for students who are covered by private insurance (TPL) as primary and Medicaid as secondary
  - Create claim templates to speed-up the claim entry process
  - View, edit, and resubmit denied claims
  - View and read the remittance advice (RA)

Washington State Health Care Authority

Training Overview

- **Submitting SBHS claims:** Slides 4-44
- **Saving and retrieving a claim:** Slides 45-49
- **Claim inquiry:** Slides 50-53
- **Timely billing info:** Slides 54-58
- **Adjust/void a claim:** Slides 59-61
- **Resubmit denied claims:** Slides 62-64
- **Claim templates:** Slides 65-70
- **Reading the remittance advice:** Slides 71-76
- **Contact information:** Slide 77

Logging into ProviderOne

- Before logging into ProviderOne:
  - Make sure your are using one of the following and your pop-up blockers are turned OFF:

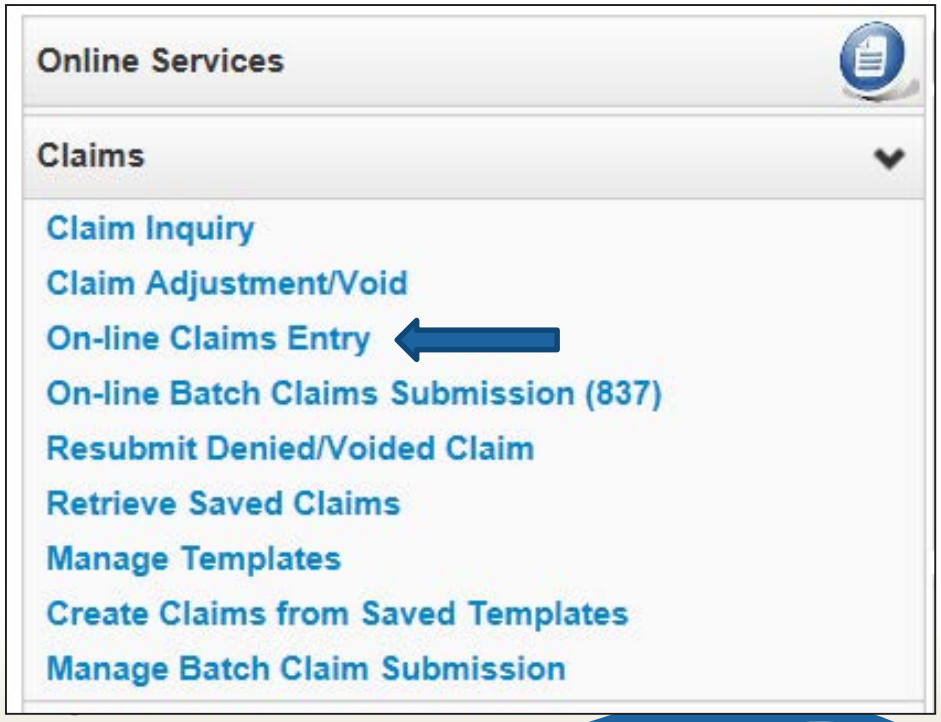
Computer operating systems	Internet browsers
Windows • 10 • 8.1 • 8 • 7	Internet Explorer • 11 • 10
Macintosh • OS 10.12 Sierra • OS X 10.11 El Capitan • OS X 10.10 Yosemite	Google Chrome • 55.0.2883 • 54.0.2840
	Firefox • 50.0.2 • 45.5.1 ESR
	Safari • 10.0.1

Washington State Health Care Authority

Log in to ProviderOne

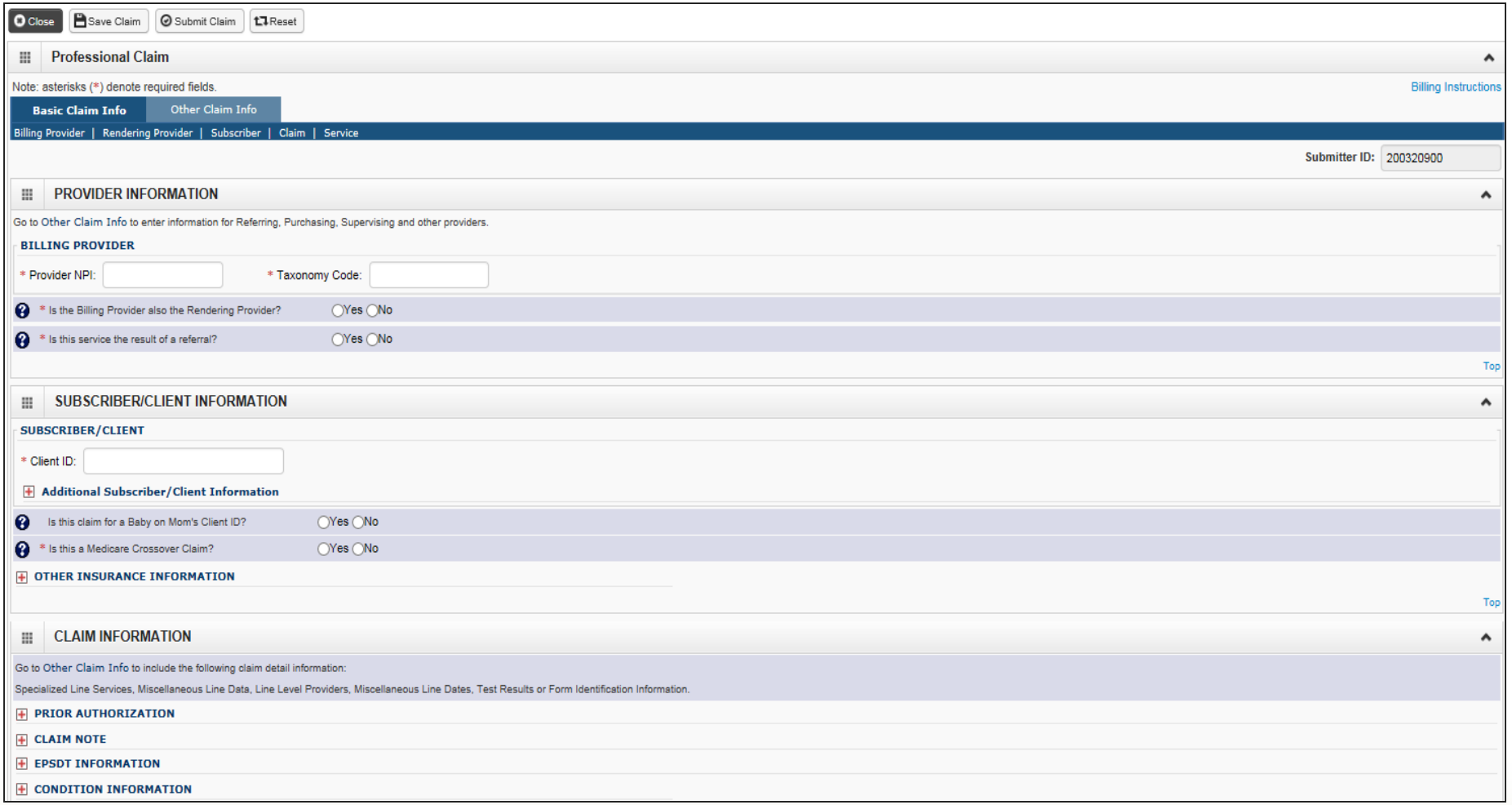
- Log into ProviderOne using the appropriate profile: ***EXT Provider Super User*** or ***EXT Provider Claim Submitter.***

- Once logged in, from the Provider Portal select the **Online Claims Entry** option located under the Claims heading.



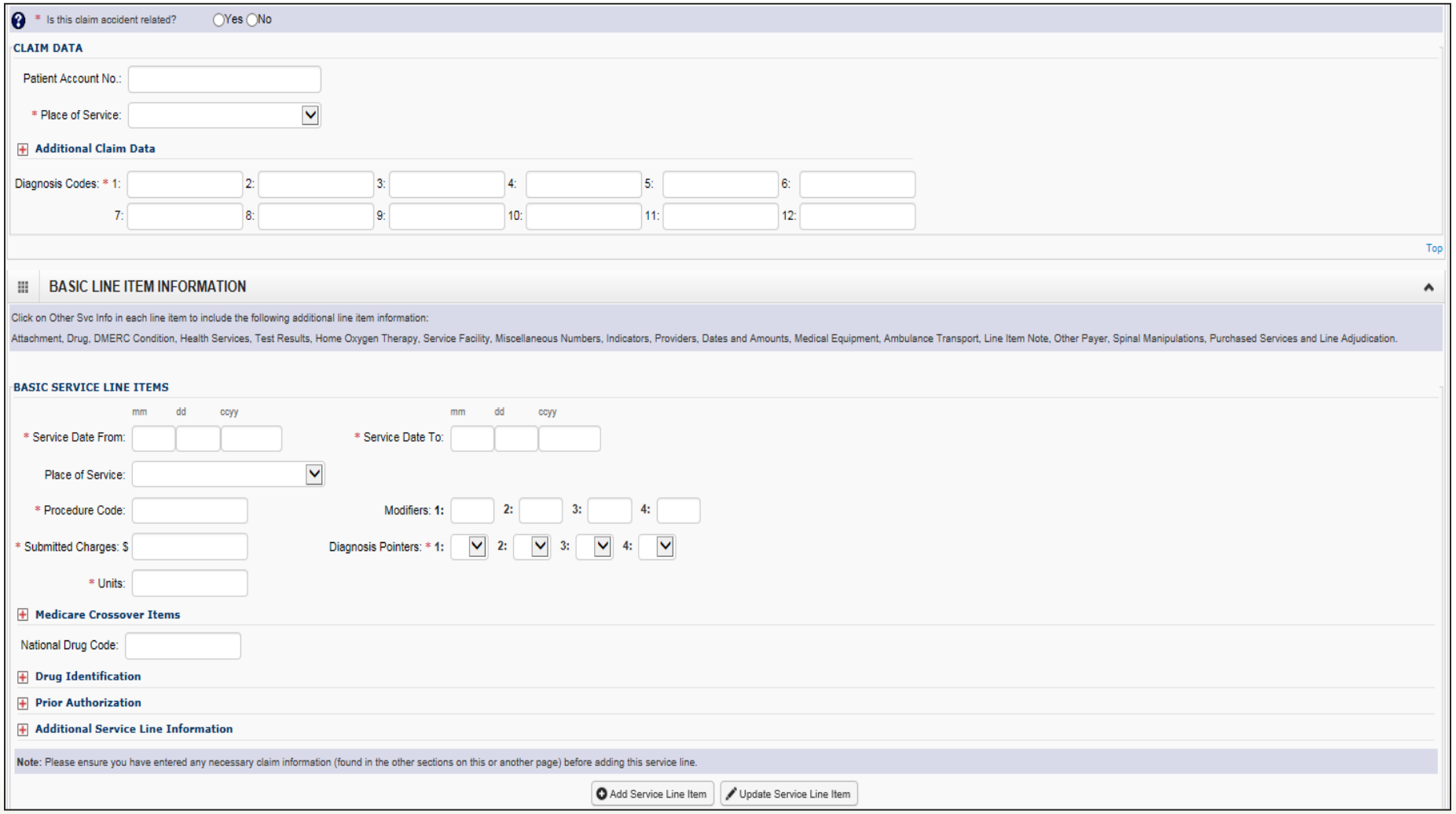
Washington State Health Care Authority

Screenshot of Claim Template



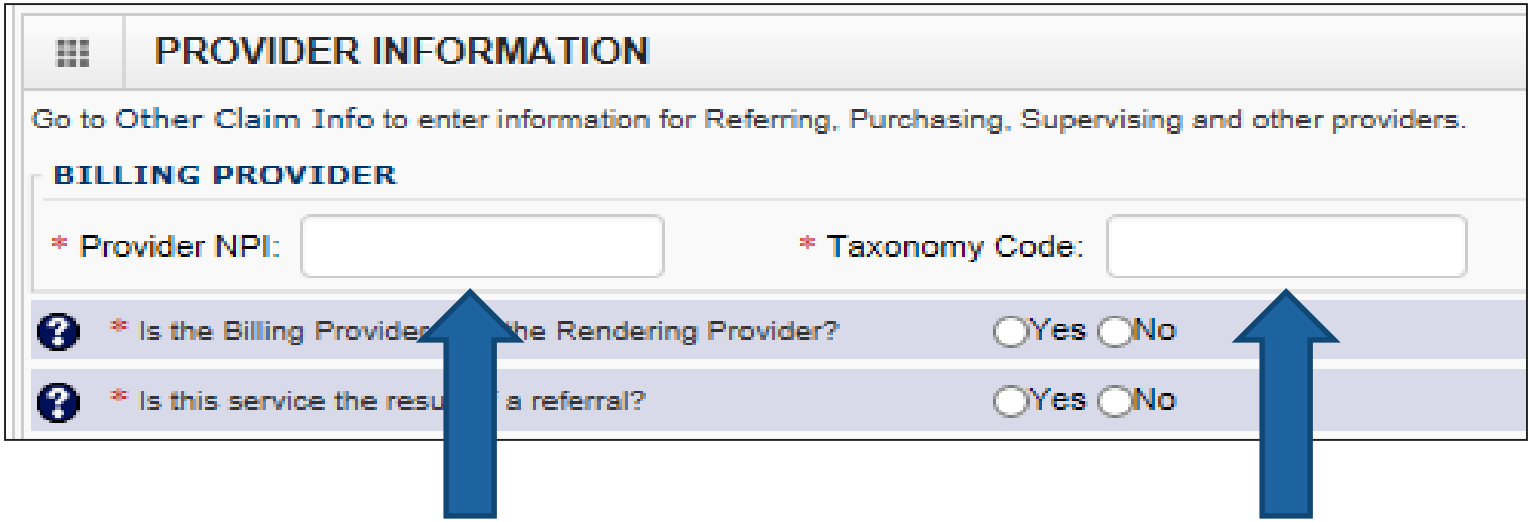
Washington State Health Care Authority

Screenshot of Claim Template, cont.



Billing Provider Information

- Section 1: Enter **Billing Provider NPI** and **Billing Provider Taxonomy**



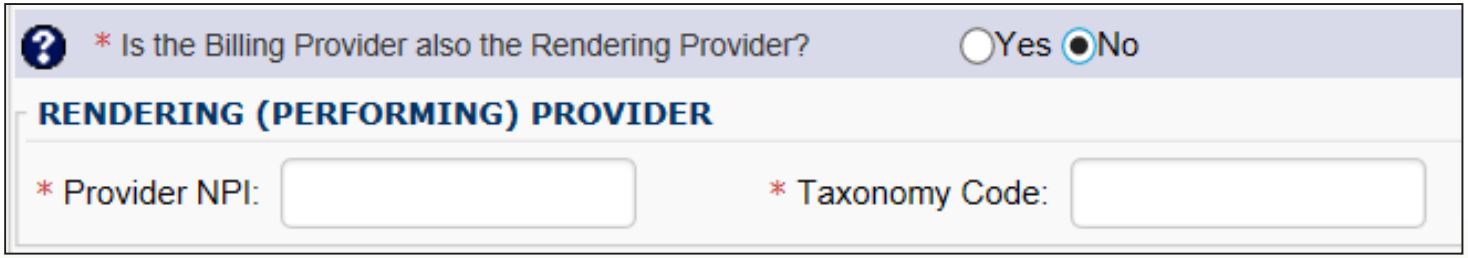
Enter the school district's NPI here.

Enter the SBHS billing provider taxonomy 251300000X here.

Rendering/Servicing Provider Information

- The Rendering Provider is the servicing provider who provided the service to the student. You will choose “No” when asked if the billing provider is also the rendering provider. .

- Enter the Rendering (Performing/Servicing) **Provider NPI** and **Taxonomy Code**. A list of SBHS approved taxonomy codes can be found in the SBHS Billing Guide.

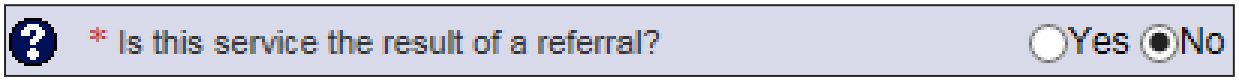


Rendering/Servicing Provider Information

- Reminder: A servicing provider must be enrolled under your school district's ProviderOne account with an SBHS approved taxonomy code before you can submit claims!
- School districts can review the How to Enroll Servicing Providers training for instructions on how to enroll providers.

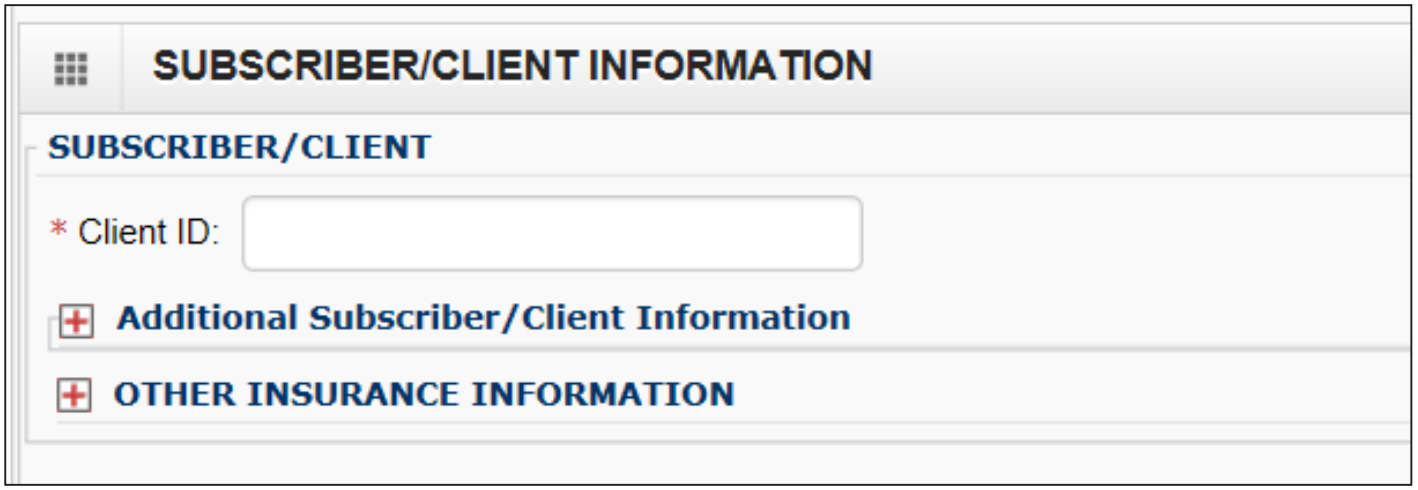
Referring Provider Information

- Answer **No** to this question and continue to the next section.



Subscriber/Client Information

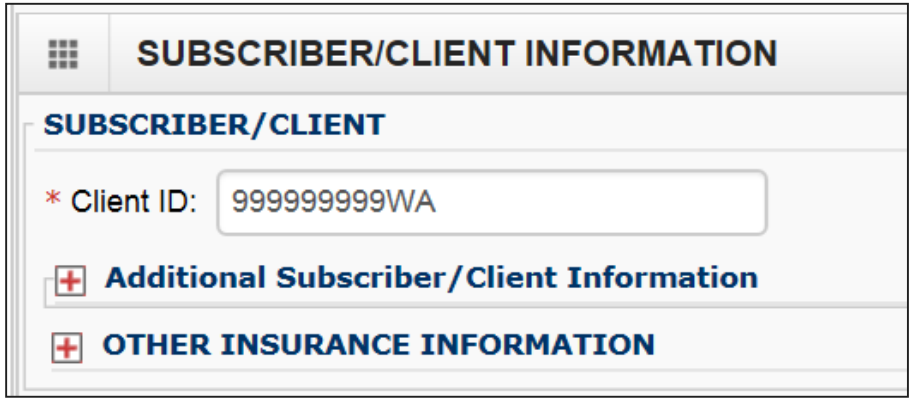
- Section 2: Subscriber/Client Information



- This is where you will enter the student's information.

Subscriber/Client Information

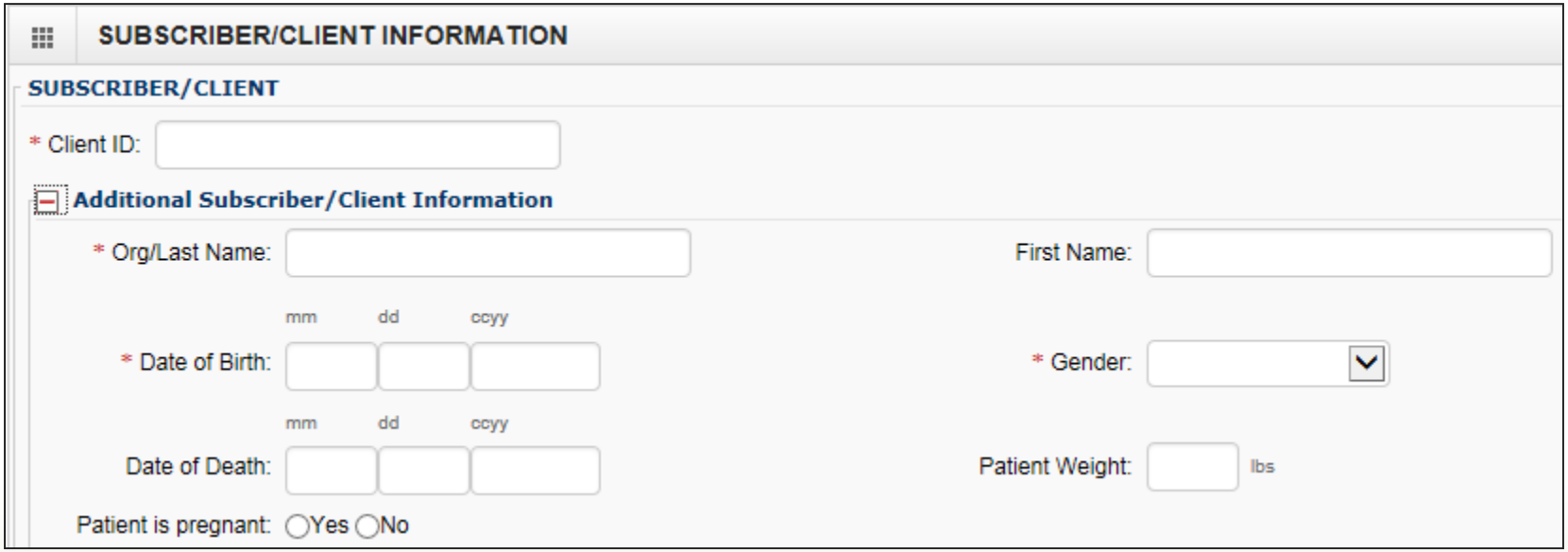
- Enter the **Subscriber/Client ID** found on the WA Medicaid/ProviderOne services card. This ID is a 9-digit number followed by **WA**.
  - Example: **999999999WA**



- 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 **Student's Last Name**, **Date of Birth**, and **Gender**.
  - Date of birth must be in the following format: **MM/DD/YYYY**.
  - The additional information fields are not needed.



Student Covered by Private Insurance

These next few slides provide directions on how to bill for a student who has primary insurance coverage through a third party liability (TPL) such as Regence, Cigna, Tri-Care, etc. with Medicaid as secondary coverage. If a student does not have TPL coverage, skip to Slide 23.

- If a student has private insurance coverage as primary and Medicaid as secondary, it is up to the district whether they choose to seek Medicaid reimbursement for this student (HCA does not require school districts to bill for these students).
- If your district decides to bill HCA for students with TPL, the district must bill TPL prior to billing Medicaid (Medicaid is always the payer of last resort).

Note: View the *Checking Medicaid Eligibility* training to view if a student has private insurance in addition to Medicaid.

Students Covered by Private Insurance

- If your district decides to seek Medicaid reimbursement for a student who is covered by TPL, the district must:
  - Obtain parental consent (per IDEA regulations)
  - Submit at least one claim annually to the private insurance company before billing HCA in order to get a claim denial
- The claim denial letter will contain a “group code” and “remark code”.
- The district must enter the “group code” and “remark code” on the SBHS claim.

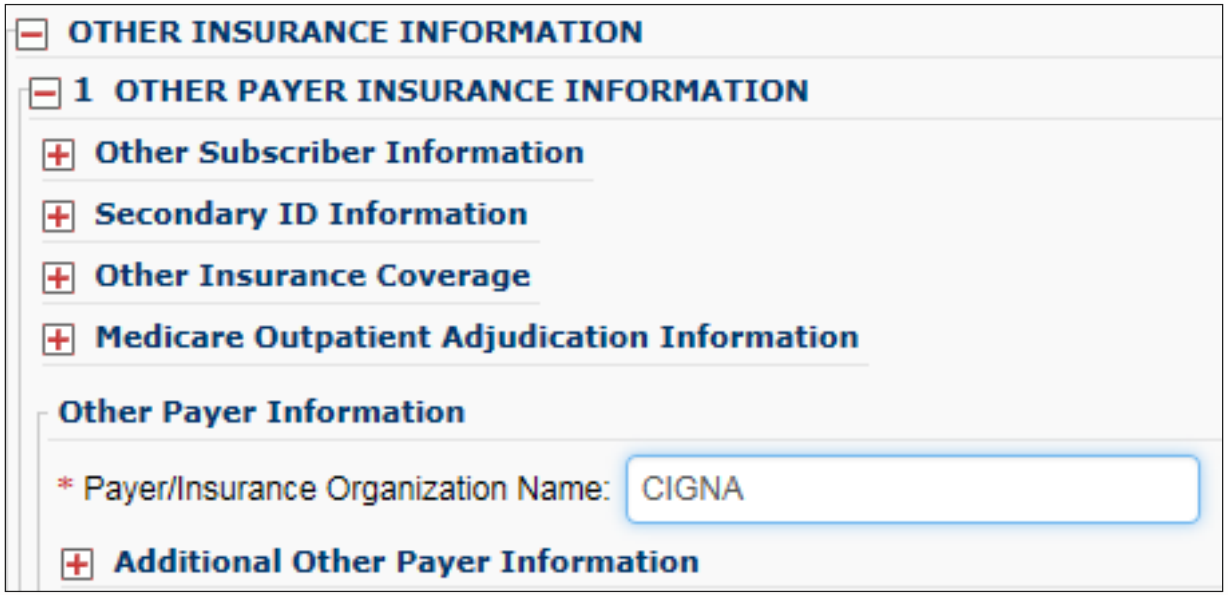
Students Covered by Private Insurance

- If the student 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.

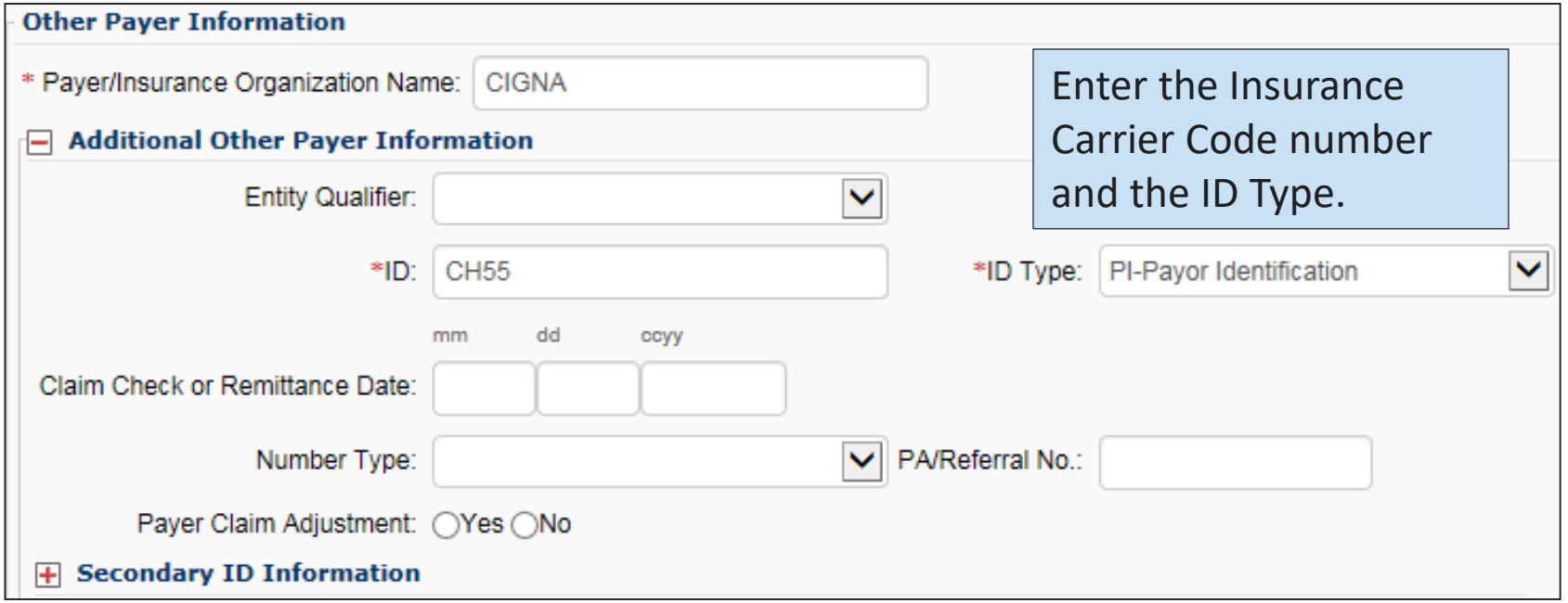
Students Covered by Private Insurance

- Enter the **Payer/Insurance Organization Name**.
- Open up the **Additional Other Payer Information** section by clicking on the red **(+)** expander.



Students Covered by Private Insurance

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



Students Covered by Private Insurance

- 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.

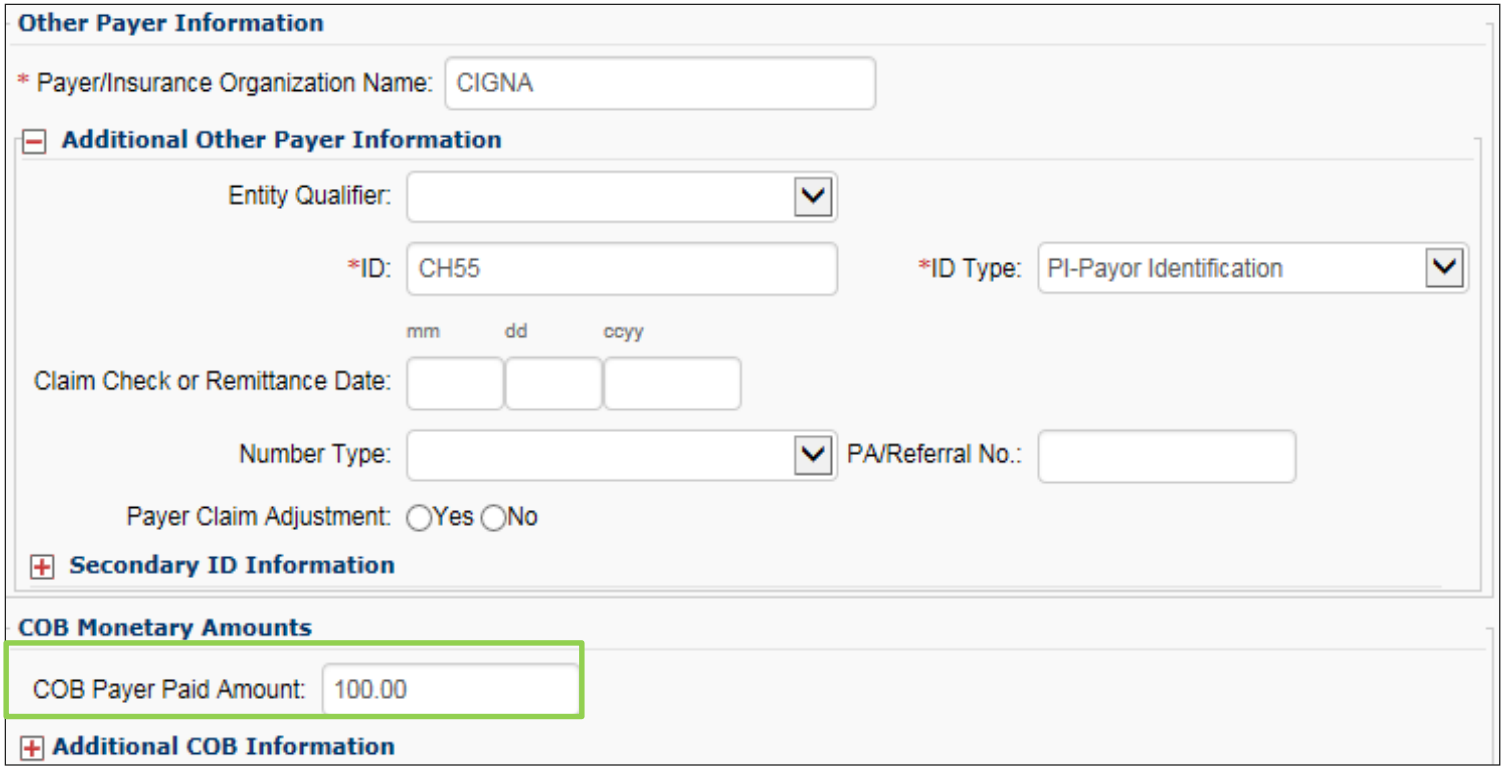
Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA DENTAL	DN18					01/01/2012	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA HEALTHCARE	CH55					01/01/2012	12/31/2999

- To obtain the **Carrier Code**, view the Checking Medicaid Eligibility training to view if a student has private insurance in addition to Medicaid.

Students Covered by Private Insurance

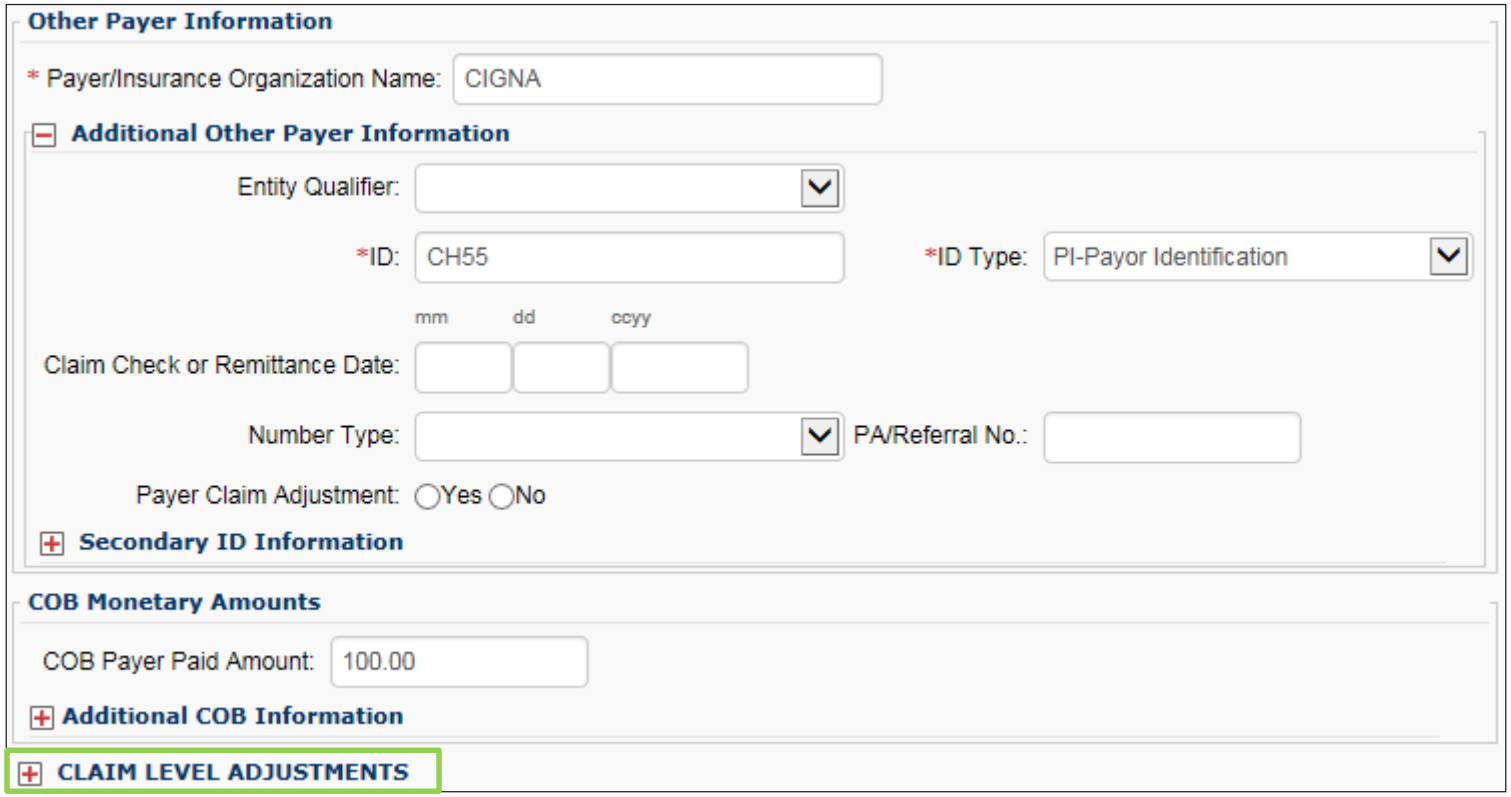
- Enter the total amount paid by the commercial private insurance in the **COB Payer Paid Amount** field.



- Most private insurance companies will not pay for school-based claims. If you receive a denial from the insurance company, enter a "0" here.

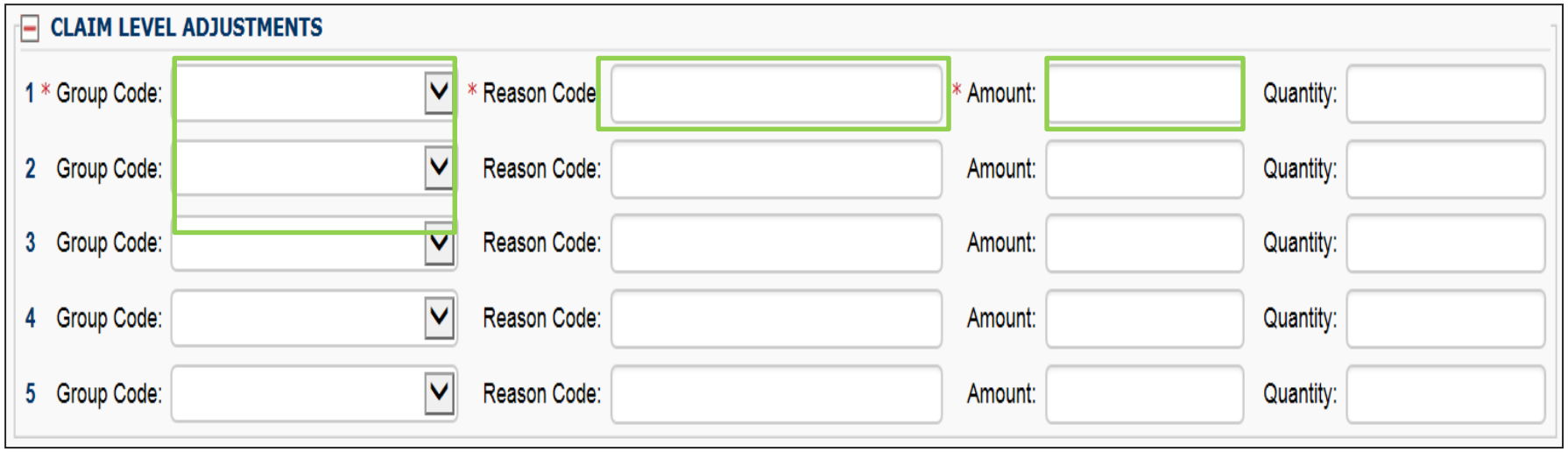
Students Covered by Private Insurance

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



Students Covered by Private Insurance

- Enter the adjustment **Group Code** and **Reason Code** (Number Only) which can be found on the denial letter you received from the insurance company.

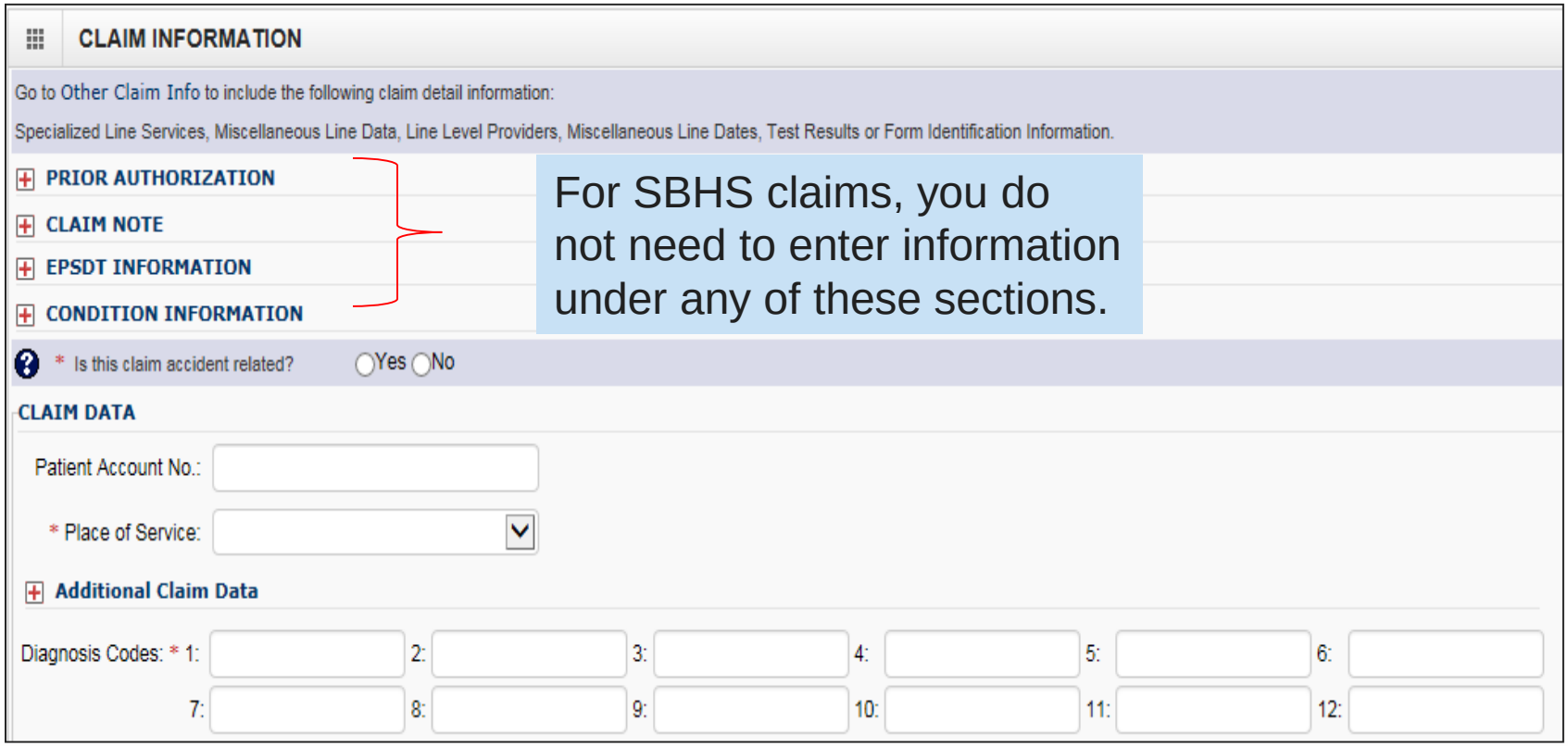


- Under the amount, enter $0.

Note: The agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the Washington Publishing Company's (WPC) website.

Claim Information

- Section 3: Claim Information Section

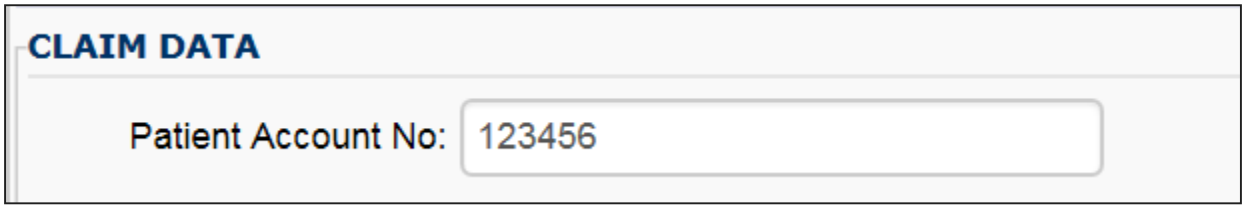


Is the Claim Accident Related?

- This question will always be answered **NO**.

Patient Account Number

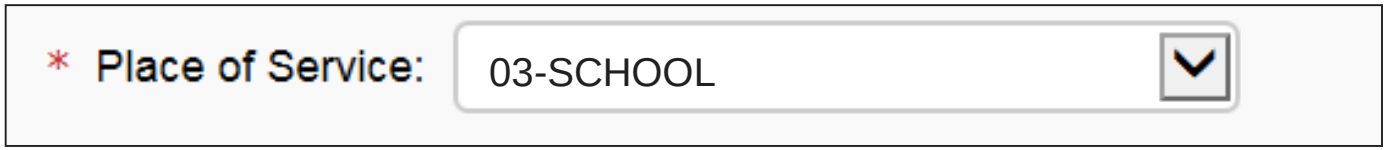
- The **Patient Account No**. field allows the school district to enter their internal student account numbers assigned to the student. This field is optional.



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.

Place of Service

- Choose the appropriate **Place of Service (POS)** from the drop down.
- For SBHS claims, choose the place of service that best matches the location of the student: **POS 03-SCHOOL, POS 12-HOME, or POS 99-OTHER** unless services were provided through telemedicine.
- For services provided through **telemedicine, choose POS "02".**



- Additional directions on how to bill for services provided through telemedicine are available in the SBHS Billing Guide.

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 **NOT** required.

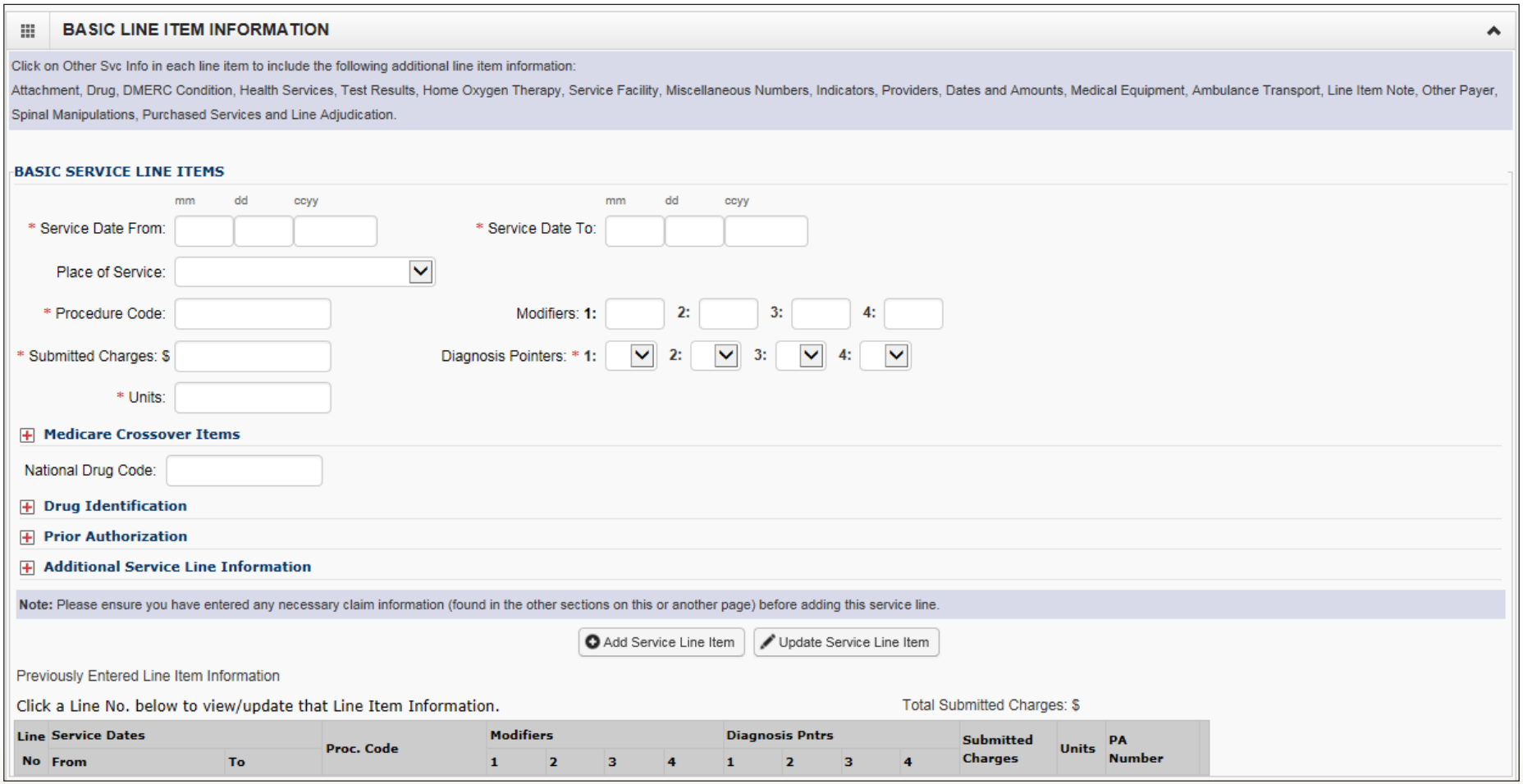
Diagnosis Codes

- Enter the appropriate ICD-10 **Diagnosis Code** or codes.

Note: All SBHS claims use diagnosis code R69 (Illness, unspecified).

Basic Service Line Items

- Section 4: Basic Line Item Information



Basic Service Line Items

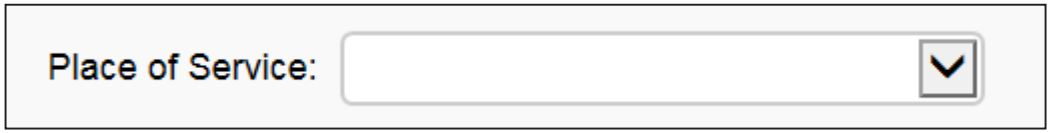
- Enter the **Service Date From**:

- Enter the **Service Date To**:

Note: The dates of service must be in the format of a 2 digit month, 2 digit day, and 4 digit year (e.g. 10/03/2016).

Basic Service Line Items

- The **Place of Service Code** is not required here as it is already entered at the Claim Level. However, you may enter here as well.



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

Basic Service Line Items

- Enter the **Procedure Code**:

Note: Use current codes listed in the SBHS Billing Guide.

- Enter the appropriate procedure **Modifier(s)** if needed.

Note: For the SBHS program, the only time a modifier is required is when services are provided through telemedicine. When services are provided through telemedicine, enter modifier 95 with the corresponding procedure code.

Basic Service Line Items

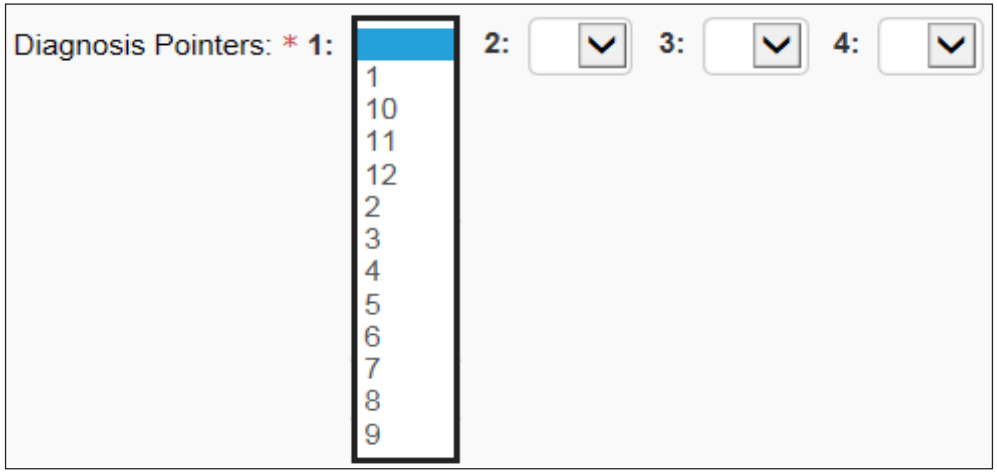
- Enter **Submitted Charges**:

Note: If the dollar amount is a whole number, no decimal point is needed.

Note: Use the current SBHS Fee Schedule to determine the submitted charges. When billing for multiple units, the school district will need to determine the appropriate charge. For example, if the rate of the code is $25 and the provider bills two units, enter $50 as the submitted charge.

Basic Service Line Items

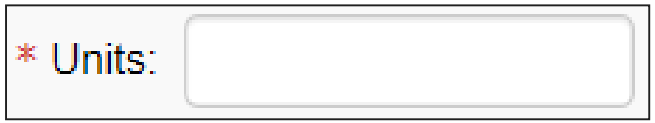
- Enter appropriate **Diagnosis Pointer**:



Note: Because the SBHS program only utilizes one diagnosis code, this will always be “1”.

Basic Service Line Items

- Enter procedure **Units**:



Note: At least 1 unit is required.

Note: To determine the appropriate number of units, school districts can review the section "Using Untimed and Timed Procedure Codes" in the SBHS Billing Guide.

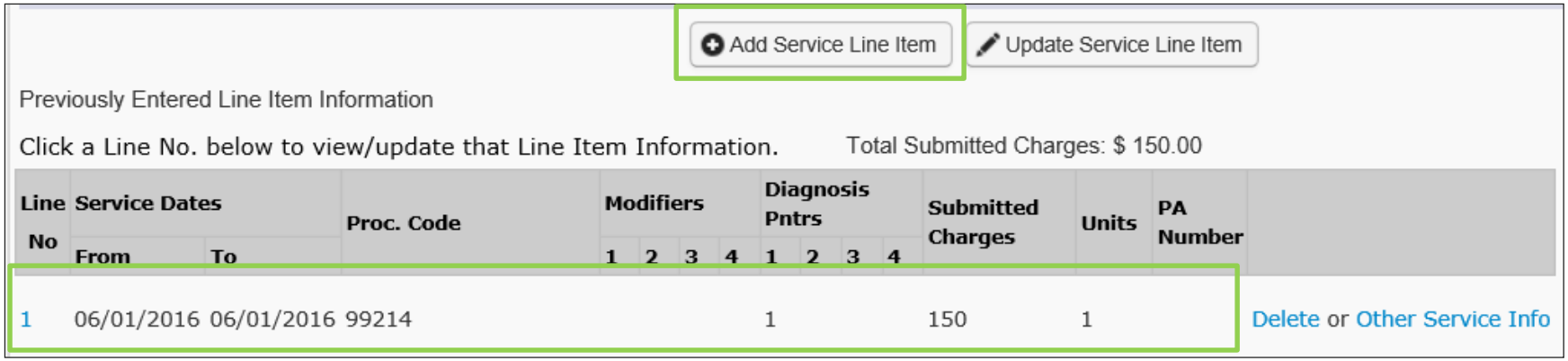
Basic Service Line Items

- SBHS claims do not require prior authorization. Do not enter anything in this section.

- 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.

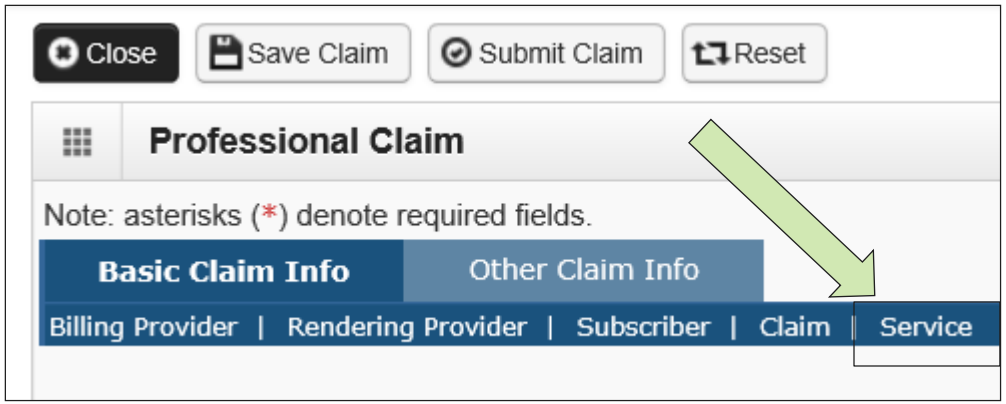


Note: Please ensure all necessary claim information has been entered before clicking the **Add Service Line Item** button to add the service line to the claim.

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

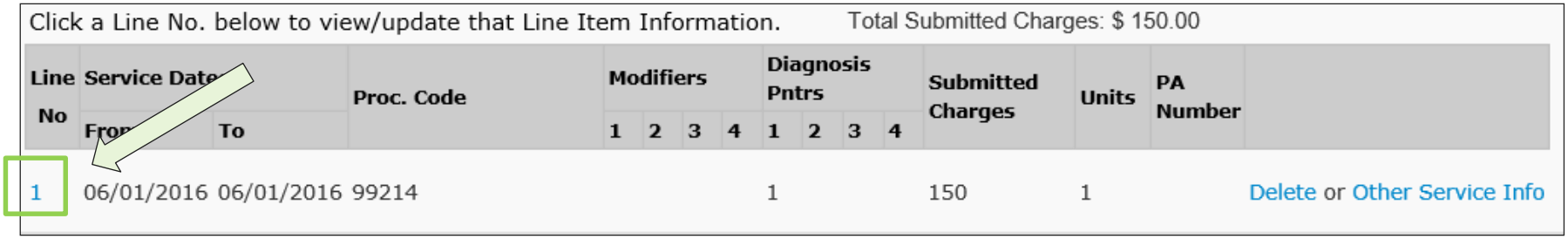
- If additional service lines need to be added, click on the **Service** hyperlink to get quickly back to the **Basic Service Line Items** section.



- 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 No.** of the line that needs to be updated. This will repopulate the service line item boxes for changes to be made.

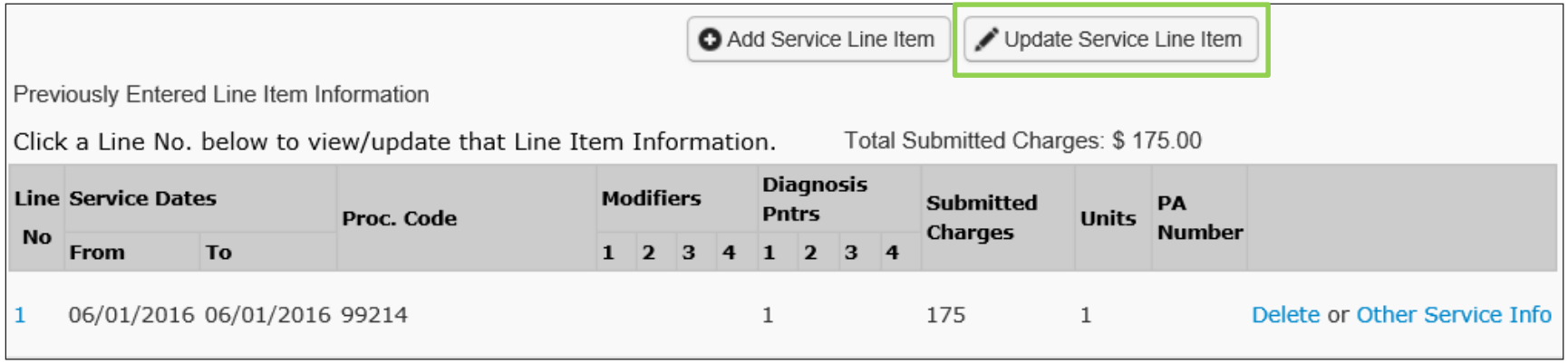

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 150.00

Line No	Service Date From	Service Date To	Proc. Code	Modifiers 1	2	3	4	Diagnosis Pntrs 1	2	3	4	Submitted Charges	Units	PA Number	
1	06/01/2016	06/01/2016	99214					1				150	1		Delete or Other Service Info

Note: Once the line number is chosen, ProviderOne will refresh the 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

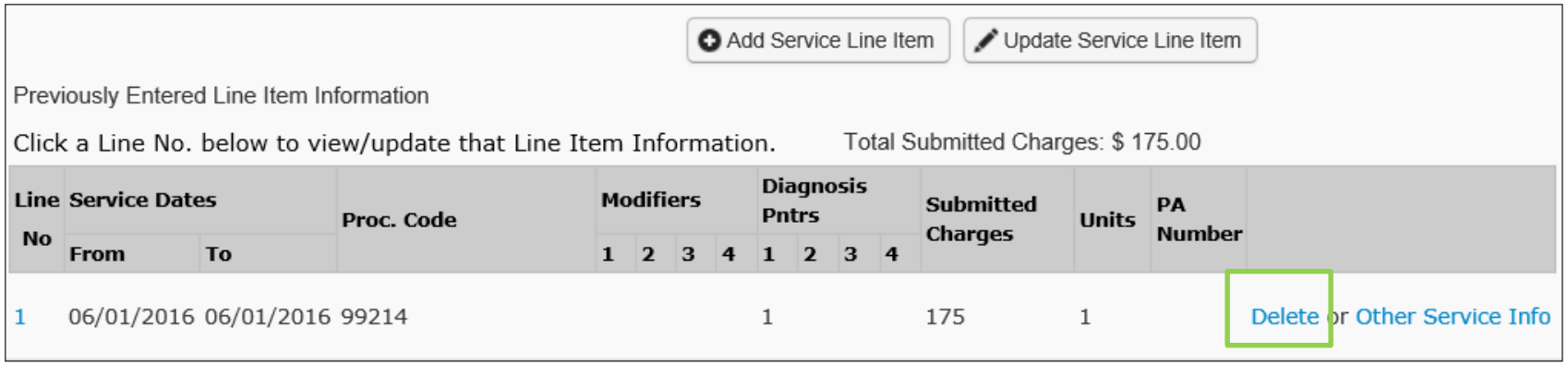
- Once the service line is corrected, click on the **Update Service Line Item** button to add corrected information on claim.



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

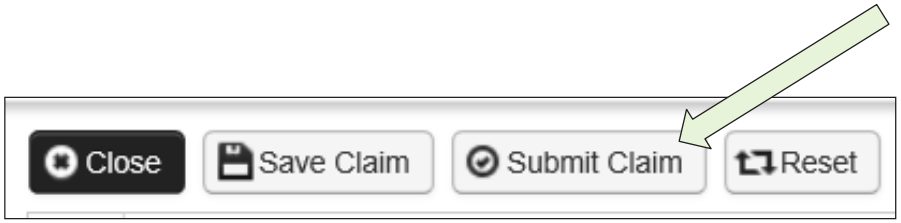
- A service line can easily be deleted from a claim before submission by clicking on the **Delete** option at the end of the added service line.



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

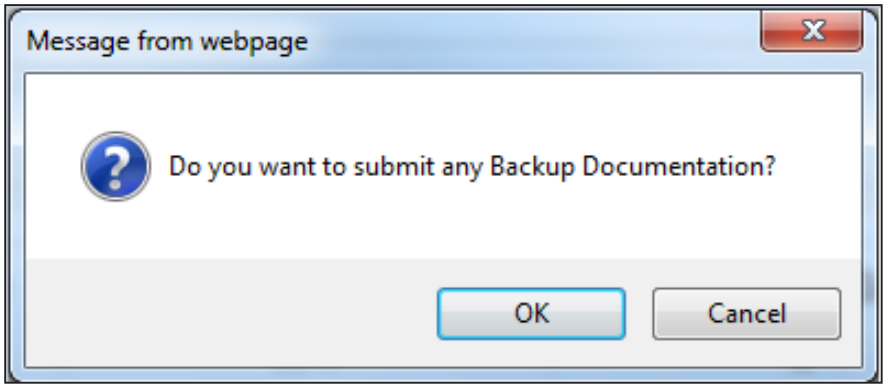
- When the claim is ready for processing, click the **Submit Claim** button at the top of the claim form.



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

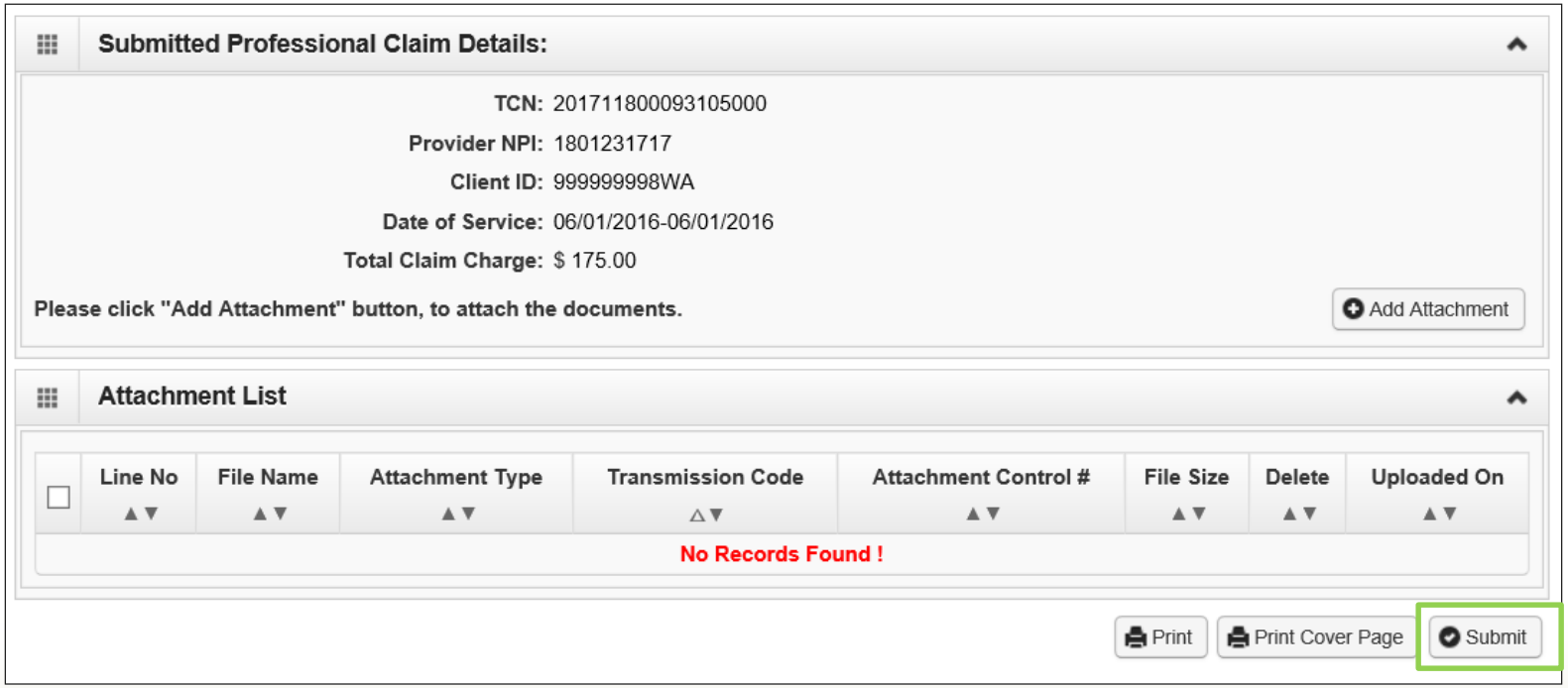
- Click on the **Submit Claim** button to submit the claim. ProviderOne should then display this prompt:



- Click on the **Cancel** button if no backup is to be sent (no backup is required for SBHS claims).

Submit Claim for Processing – No Backup

- ProviderOne now displays the **Submitted Professional Claim Details** screen.
- Click on the **Submit** button to finish submitting the claim.



Saving and Retrieving a Direct Data Entry Claim

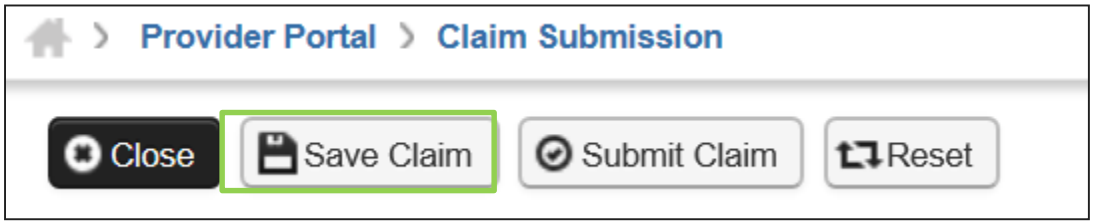
Saving a Direct Data Entry Claim

- ProviderOne allows a provider to save a claim if you are interrupted during the process of entering.
- You can retrieve the saved claim to finish entering the needed information and submit the claim.
- The following data elements are the minimum required to be completed before a claim can be saved:

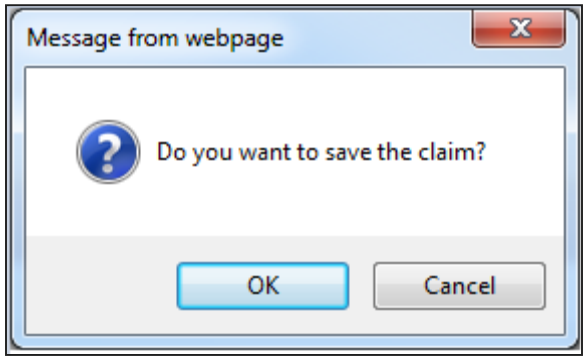
Section 1: Billing Provider Information	Section 2: Subscriber/Client Information	Section 3: Claim Information
Billing Provider NPI	Client ID number	Is this claim accident related?
Billing Provider Taxonomy		
Is the Billing Provider also the Rendering Provider?		

Saving a Direct Data Entry Claim

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



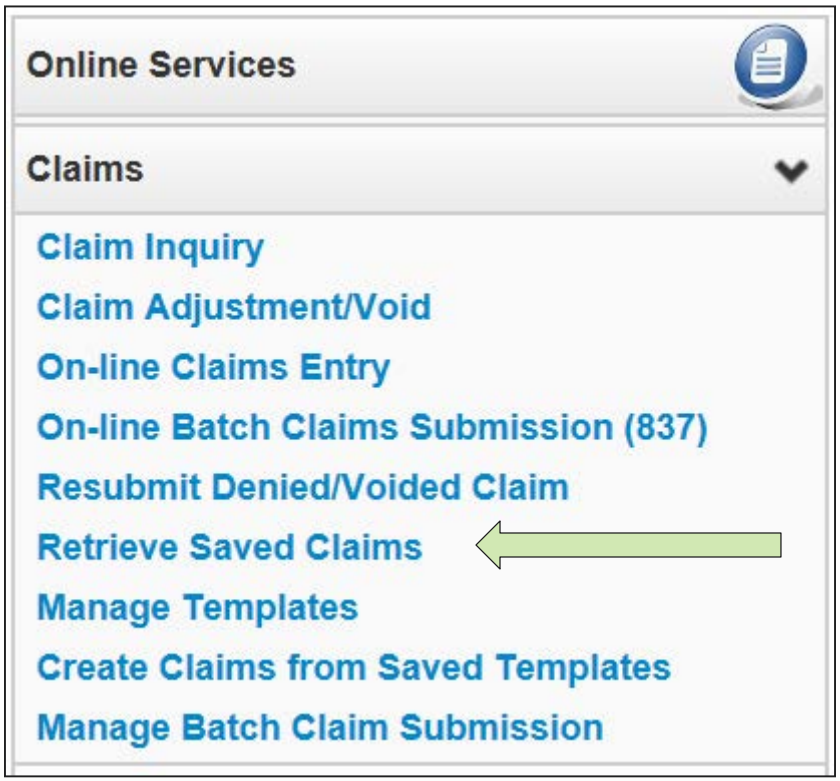
- ProviderOne now displays the following confirmation box:



- 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.

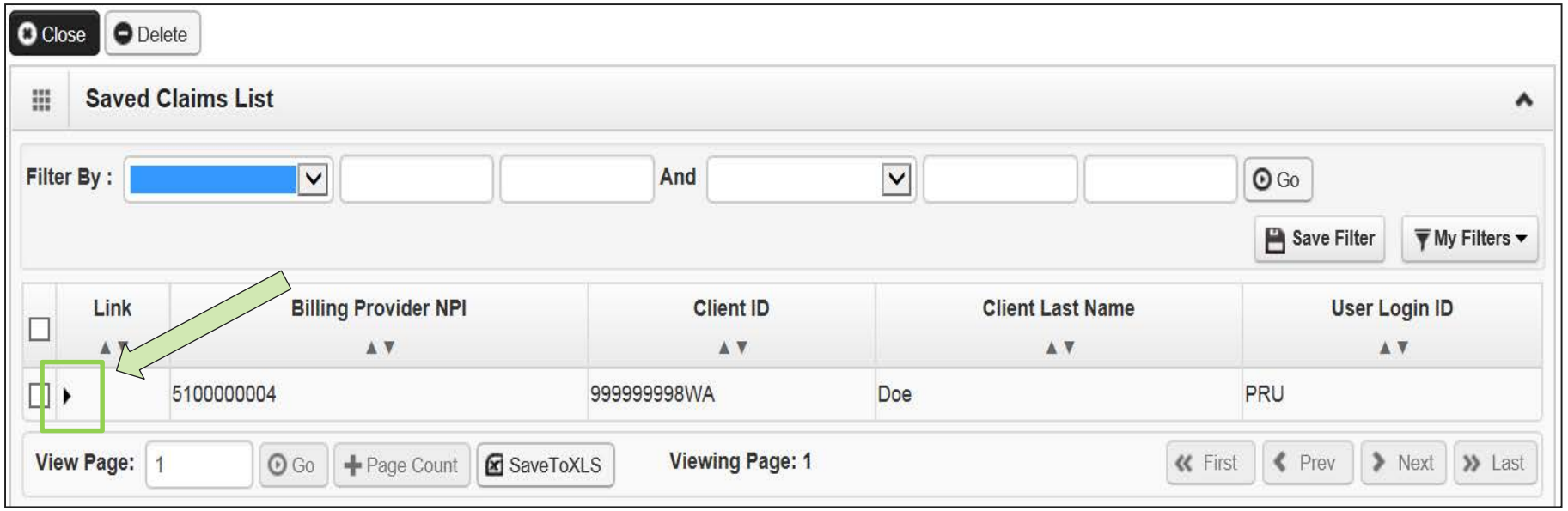
Retrieving a Saved Direct Data Entry Claim

- 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.

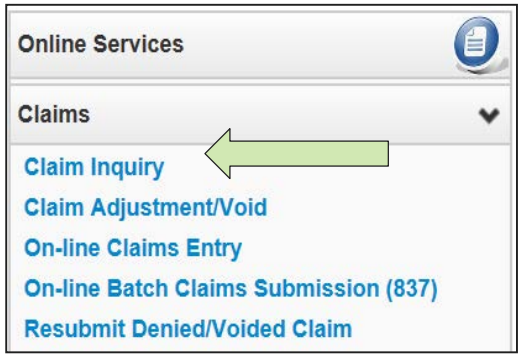


- The system loads the saved claim in the correct DDE claim form screen.
- Continue to enter data, then submit the claim as normal.
- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claims List.

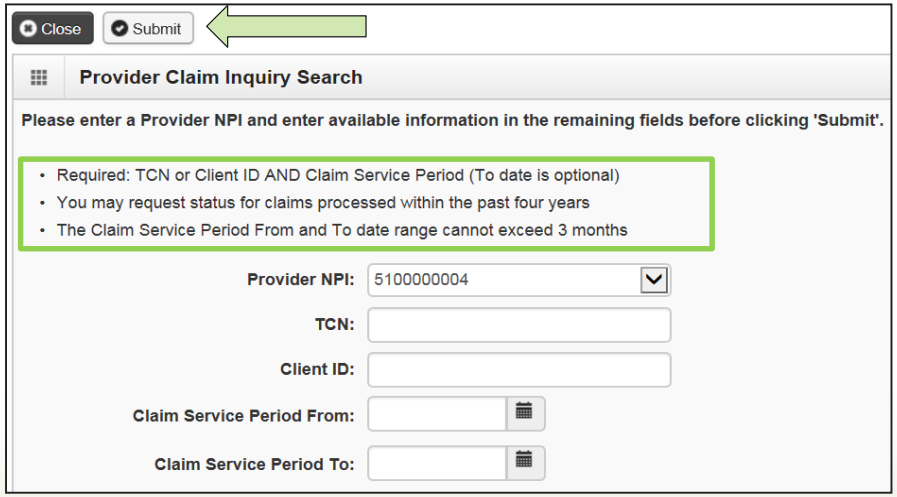
Claim Inquiry

Claim Inquiry

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

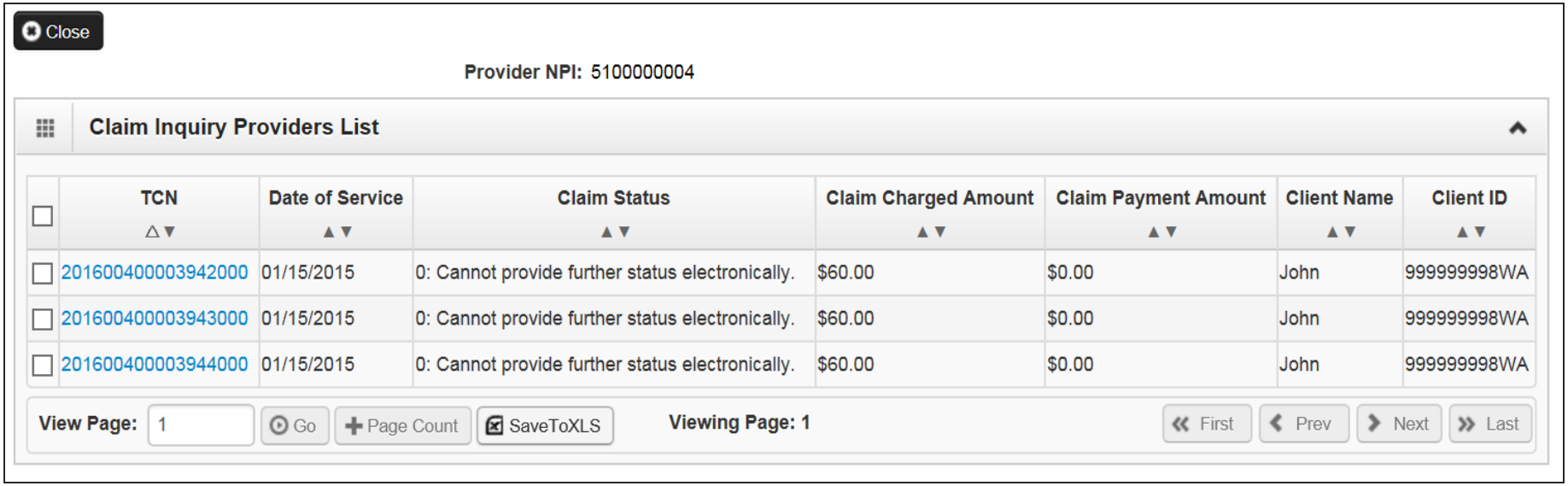


- Enter search data then submit



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-billing.



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.
  - Trying to do a resubmit on a paid claim or an adjustment on a denied claim.
  - Claims you billed with an NPI not reported in ProviderOne.
  - Claims you billed with an ID only rendering provider NPI number as the pay-to provider.

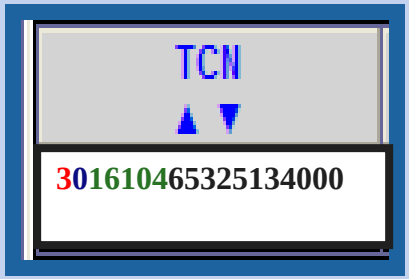
Timely Billing

Timely Billing

- 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 **24 months** years total to resubmit, modify or adjust an initial claim that was previously assigned a TCN.
  - The agency uses the Julian calendar on claim numbers for tracking.

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.

Washington State Health Care Authority

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/Dental
- 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:

30161046532513400 0

3 Electronic submission via batch
0 Medical claim
16 Year claim was received-2016
104 Day claim was received-April 13

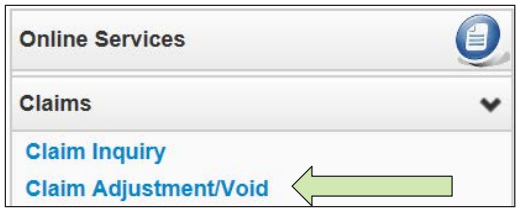
How do I prove timeliness?

- Direct Data Entry (DDE) Claims
  - Resubmit Original Denied/Voided Claim
  - ProviderOne will automatically detect the timely claim number as the timely TCN is now attached to the new transaction.

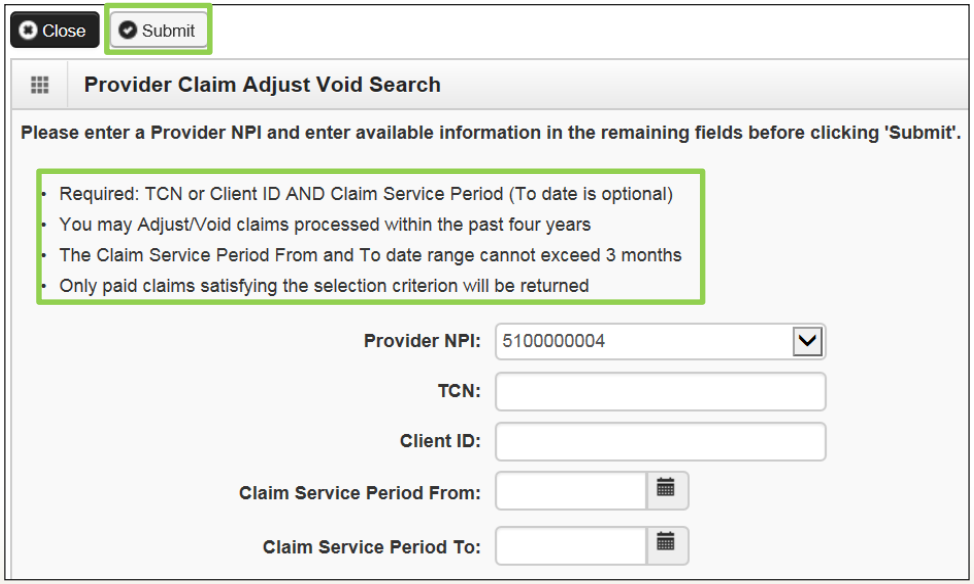
Adjust / Void a Claim

Adjust/Void a Paid Claim

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



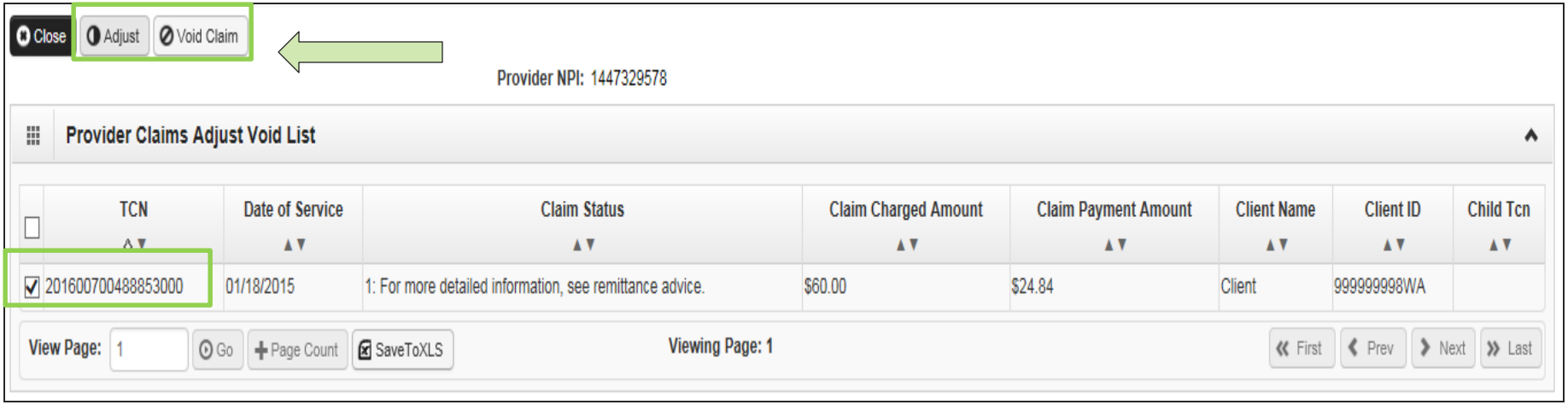
- Enter the **TCN** number if known; or
- Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.



Note: Per WAC 182-502-0150 claims can only be adjusted/voided in ProviderOne 24 months from the date of service.

Adjust/Void a Paid Claim

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

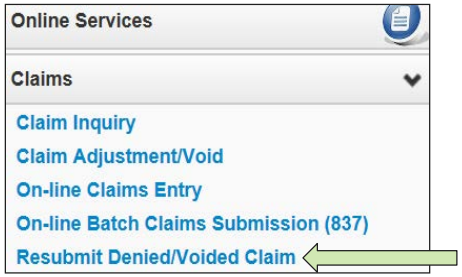


- Check the box of the TCN to adjust/void.
- ProviderOne loads the DDE screen with the claim data.
  - Update the claim information to adjust, then submit.
  - Claim data cannot be changed when doing a void, just submit the void.

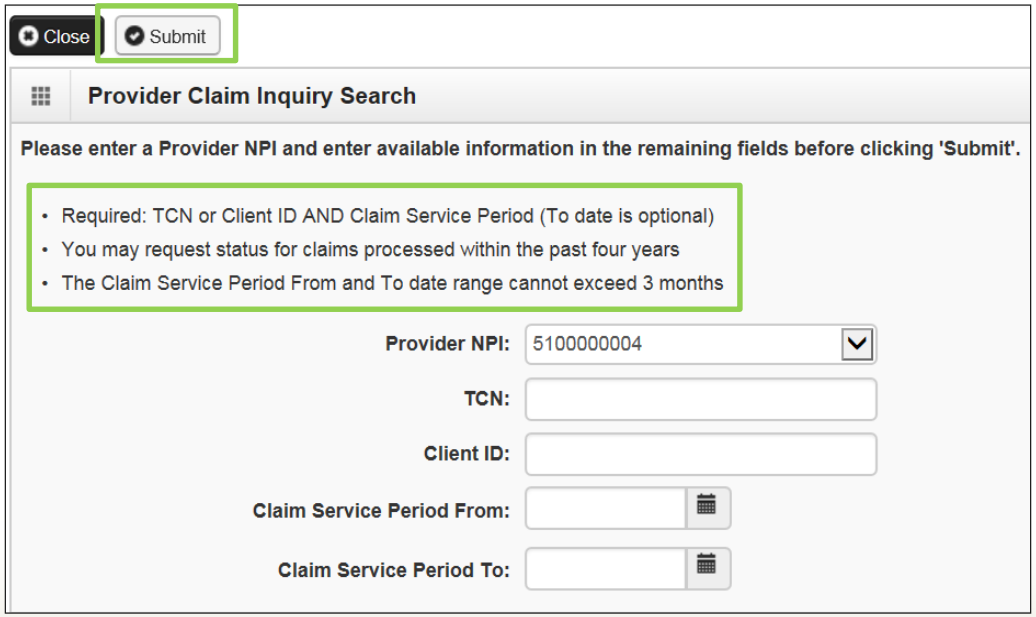
Resubmit Denied Claims

Resubmit a Denied Claim

- Select **Resubmit Denied/Voided** Claim from the Provider Portal.

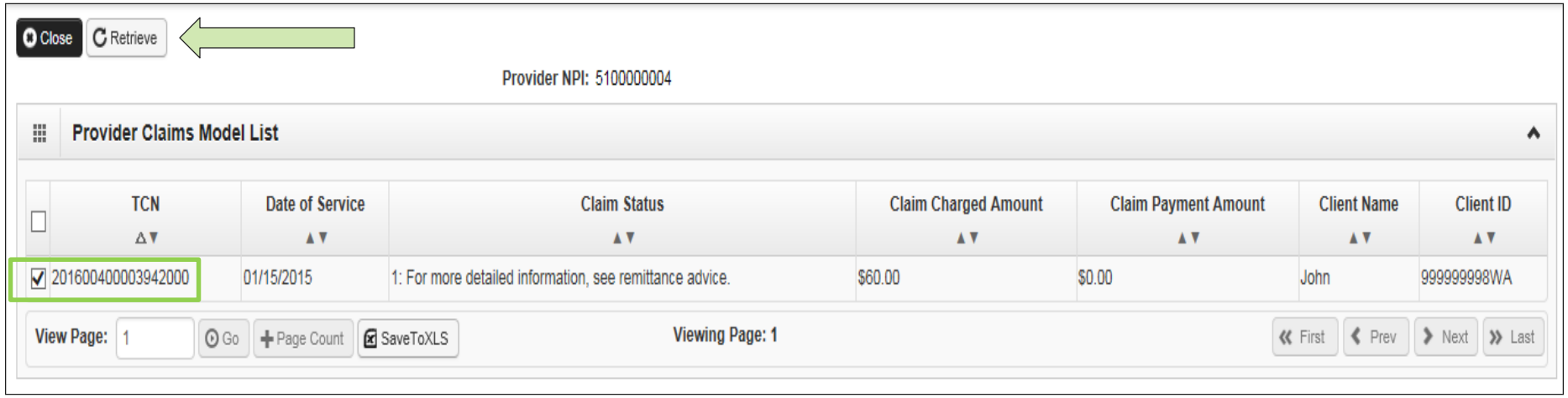


- Enter **TCN**, if known; or
- Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.



Resubmit a Denied Claim

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

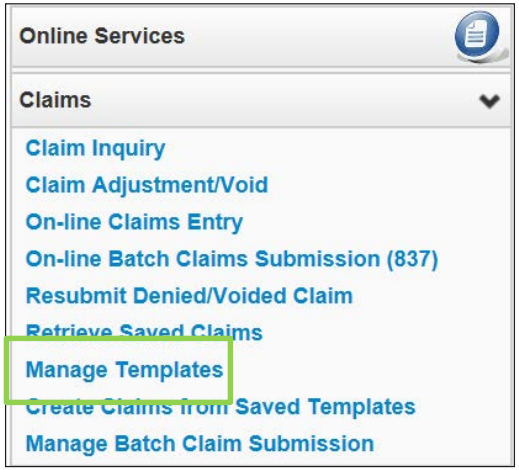


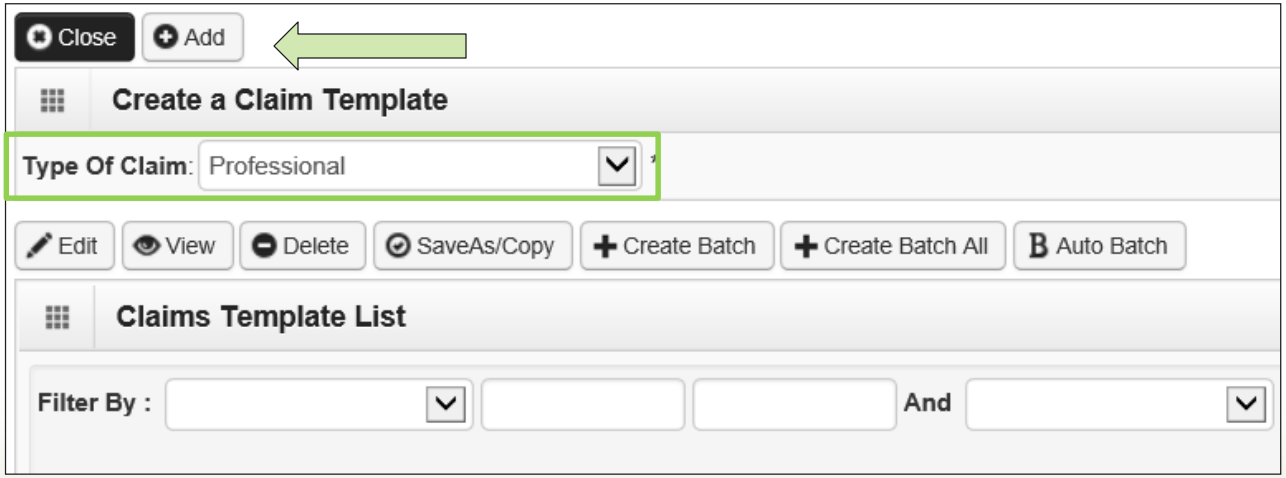
- Check the box of the TCN to resubmit and click **Retrieve**.
- ProviderOne loads the DDE screen with the claim data.
  - Update the claim information that caused the claim to deny, then submit.

Claim Templates

Creating a Claim Template

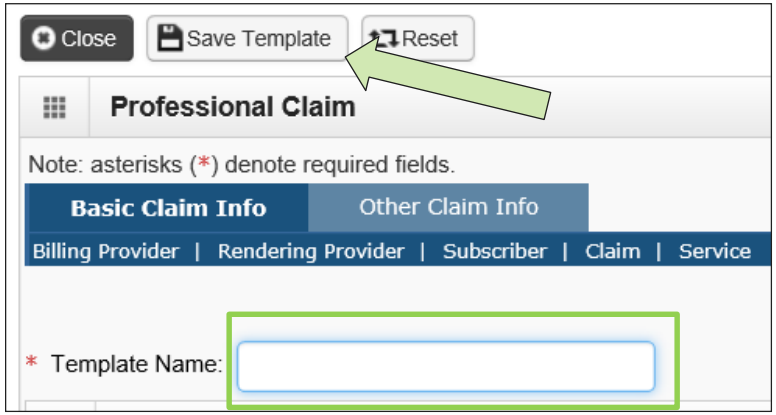
- ProviderOne allows creating and saving templates:
  - Log into ProviderOne.
  - Click on the **Manage Templates** hyperlink
  - At the Create a Claim Template screen, use the dropdown to choose the **Type of Claim**.
  - Click the **Add** button.





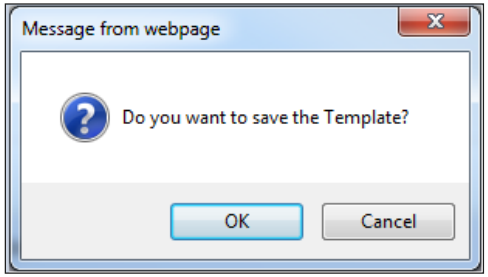
Creating a Claim Template

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



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

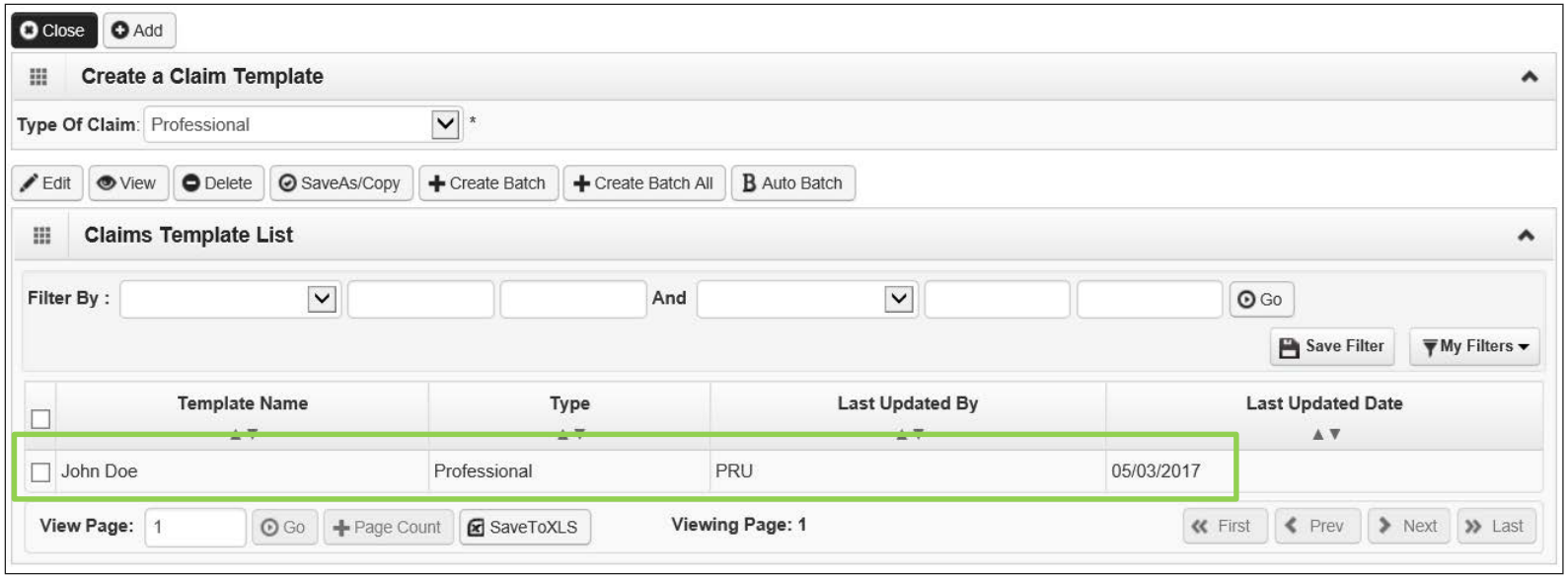
- Click on the **Save Template** button and the system verifies you are saving the template.



Note: The minimum information required to save a template is the **Template Name and answer required questions**.

Creating a Claim Template

- After the template is saved it is listed on the **Claims Template List**.

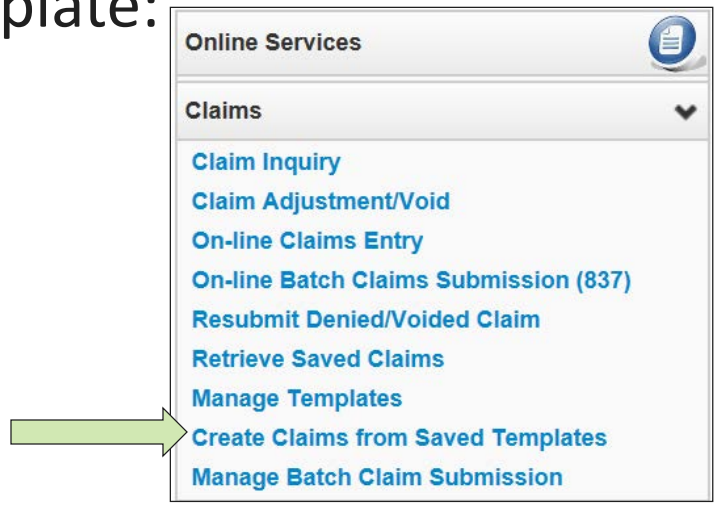


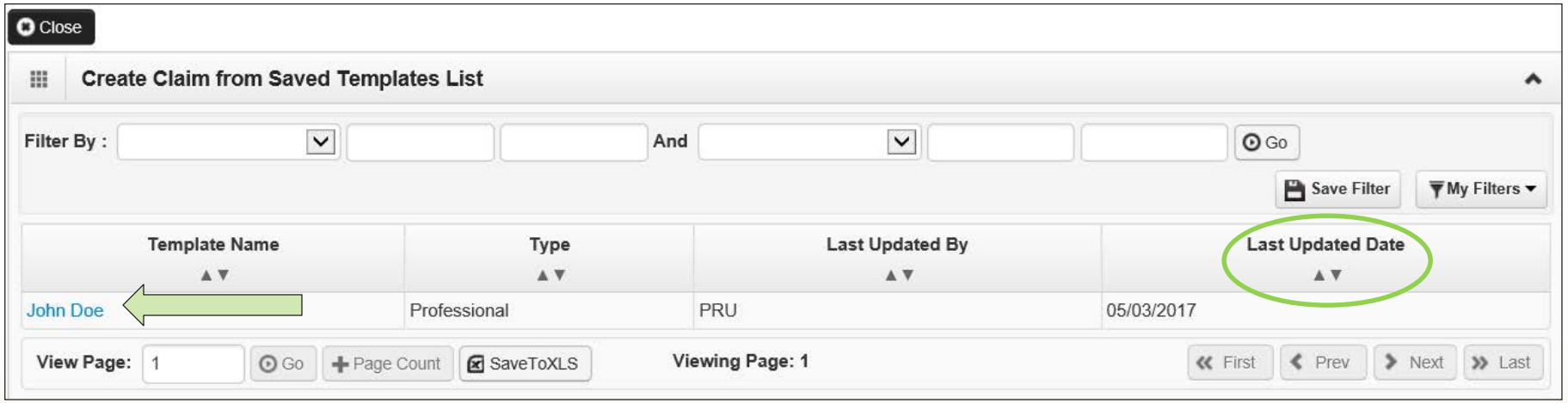
- Additional templates can be created by:
  - Copying a template on the list; or
  - Creating another from scratch.
- Templates can be edited, viewed, and deleted.

Submitting a Template Claim

- Claims can be submitted from a template:

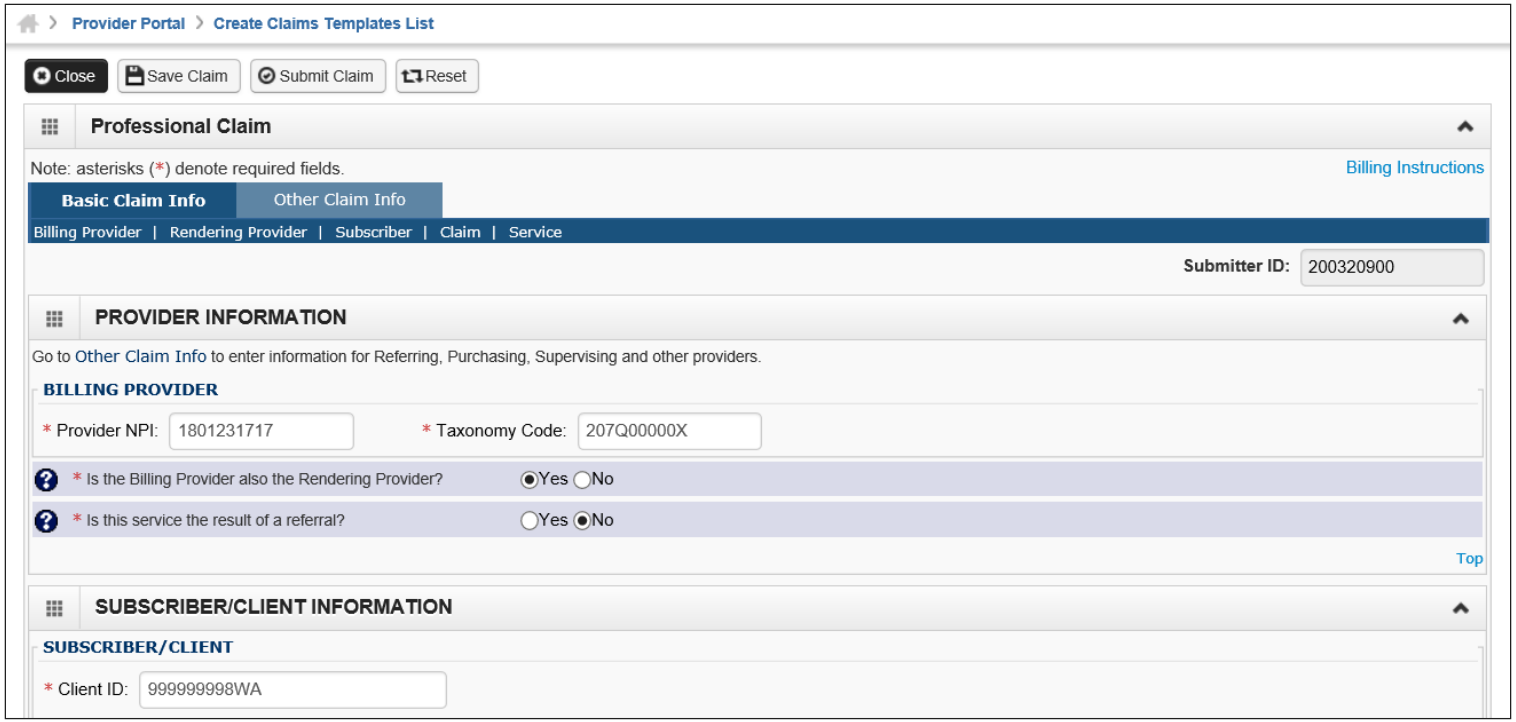
  - Log into ProviderOne.
  - Click on the **Create Claims from Saved Templates.**
  - At the **Saved Templates List** find the template to use (sort using the sort tools outlined).





Submitting a Template Claim

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

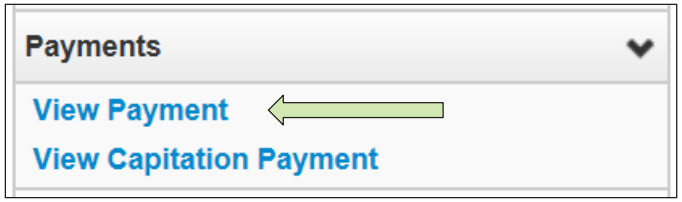


- Enter or update the data for claim submission then submit as normal.

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 will open your list of RAs.

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
500649639			08/06/2015	2	$300.00	$0.00	$300.00	
500955089			12/16/2015	1	$100.00	$0.00	$100.00	

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

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

Reading the Remittance Advice (RA)

- The Summary Page of the RA shows:
  - Billed and paid amount for Paid claims
  - Billed amount of denied claims
  - Total amount of adjusted claims
  - Provider adjustment activity

Prepared Date: 05/30/2014
RA Date: 05/30/2014

RA Number: 8765432
Warrant/EFT # 852741!
Warrant/EFT Date: 05/29/2014

Warrant/EFT Amount: $9325.93
Payment Method: EFT

Page 2

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Sales Tax	Total Client Resp Amount	Total Paid
1122334455	Paid	$28930.00	$16114.57	$0.00	$0.00	$0.00	$9325.93
1122334455	Denied	$6525.50	$0.00	$0.00	$0.00	$0.00	$0.00
1122334455	Adjustments	-$2981.00	-$3371.87	$0.00	$0.00	$0.00	-$3266.00
1122334455	In Process	$5946.50	$0.00	$0.00	$0.00	$0.00	$0.00

Provider Adjustments

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
1122334455	214148190028/ 40140123456789 0000	System Initiated	NOC Invoice	$0.00	$0.00	$3266.00
1122334455	214148190028/ 40149870123456 0000	System Initiated	NOC Referred to CARS	$3266.00	$3266.00	$0.00

Total Adjustment Amount $3266.00

Reading the Remittance Advice (RA)

- Adjustments:
  - P1Off (offset) adjustments: These adjustment amounts can carry over on each week's RA until the amount is paid off or reduced by the amount paid out for claims adjudicated that week.
    - Claims that caused these carry over adjustment amounts can be on previous RAs.
    - Updates to the RA format now provide the parent TCN under the FIN Invoice Number for reference.
  - NOC (non-offset) Referred to CARS: System-generated recoveries or adjustments that are referred to OFR for collection.
    - Updates to the RA format now provide the parent TCN under the FIN Invoice Number for reference.
- Retention Policy:
  - Providers must keep RA's on file for 6 years per Washington Administrative Code (WAC).

Reading the Remittance Advice (RA)

- The RA is sorted into different Categories as follows (screen shown is sample of Denials):
  - Paid
  - Denied
  - Adjustments
  - In Process

RA Number: 500955089 Warrant/EFT #: Warrant/EFT Date: Prepared Date: 12/16/2015 RA Date: 12/16/2015

Category: Denied [illegible]der: 5100000004 Page 3

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
Client, Pseudo 999999998WA	201534801403737000 Professional Claim	1		12/01/2015-12/01/2015	96152	3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	N255 N290 N95	170 = $100.00
Document Total:				12/01/2015-12/01/2015		3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00	N255,N290	16,B7
Category Total:						3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00		
Billing Provider Total:						3.0000	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00		

Reading the Remittance Advice (RA)

- EOB Codes
  - Adjustment Reason Codes and 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. 15 : The authorization number is missing, invalid, or does not apply to the billed services or provider. 16 : Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. 18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) 35 : Lifetime benefit maximum has been reached. 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.

Remark Codes
N20 : Service not payable with other service rendered on the same date. N329 : Missing/incomplete/invalid patient birth date. N37 : Missing/incomplete/invalid tooth number/letter. N39 : Procedure code is not compatible with tooth number/letter.

- The complete list of Federal codes can be located at the Washington Publishing Company's (WPC) website.

Questions?

For assistance with submitting direct data entry SBHS claims, contact Provider Relations at ProviderRelations@hca.wa.gov

For **SBHS policy/program questions**, contact Shanna Muirhead, SBHS Program Manager at:

Email: Shanna.Muirhead@hca.wa.gov

Tel: 360-725-1153

SBHS webpage: https://www.hca.wa.gov/sbhs