Submit Social Service Medical Claims

Table of Contents

Definitions

Claims, Dental: Claims submitted for payment of dental services provided by a licensed dental professional.

Claims, Institutional: Claims submitted by facilities, such as hospitals or surgery centers, for payment of costs incurred by the facility for treating the client in outpatient or inpatient settings.

Claims, Professional: Claims submitted for payment of medical services or supplies provided by a licensed professional or vendor.

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

EFT: Electronic Funds Transfer, also called direct deposit. This is an electronic payment sent directly into your bank account on file.

Provider ID: The providers 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.*

Remittance Advice: An explanation of each claim payment including paid claims and amounts, overpayments, denied claims and denial reasons.

Shared Service: A service that is funded partially by DSHS and partially by Health Care Authority. This does not impact the payment you receive.

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

Warrant: A paper check issued for claim payments.

Basic Billing Details

Pay Periods

With ProviderOne, you can determine when and how often you are paid based on when you submit claims. You can enter claims at any time.

ProviderOne pays on Fridays. Claims submitted by 5pm on Tuesdays may be paid as follows:

- If you have EFT (Electronic Funds Transfer/ Direct Deposit) your payment will be in your account on **Friday**.
- If you are paid by warrant, it will be put in the mail on **Friday**.
- When you are paid your Remittance Advice (RA) will be posted in ProviderOne on **Friday**.

Weekly Pay Schedule

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

Deadline is 5pm each Tuesday to submit claims and receive payment the following Friday.

Possible paydays. Refer to your method of payment description for more details.

Note:
Claims successfully entered after the weekly deadline of 5pm on Tuesday will be paid on Friday of the next week.

Holidays may delay receipt of paper warrants dependent on mailing schedules. Check with your local post office for more information about holiday mailing schedules.

Pay Periods

To be paid every <u>two weeks</u>:

- Choose your Friday paydays,
- Submit your claims within the 7 day period ending on Tuesday of the payment week.
- When you are paid, your RA will be posted in ProviderOne on **Friday**.

Note:
Claims successfully entered after the weekly deadline of 5pm on Tuesday will be paid on Friday of the next week.

Holidays may delay receipt of paper warrants dependent on mailing schedules. Check with your local post office for more information about holiday mailing schedules.

Two Week Pay Schedule

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

Deadline is 5pm each Tuesday to submit claims and receive payment the following Friday.

Possible paydays. Refer to your method of payment description for more details.

Pay Periods

To be paid <u>monthly</u>:

- Choose your Friday payday.
- To receive payment the first week of the following month submit your claims within the first 7 day period of that month. (See calendar)
- When you are paid, your RA will be posted in ProviderOne on **Friday**.

Month of service	**First Available Claim Dates of New Month**
5pm Tuesday Deadline	**Pay Date**

Note:
Claims successfully entered after the weekly deadline of 5pm on Tuesday will be paid on Friday of the next week.

Claiming for an entire month will result in varying pay dates throughout the year depending on what day of the week the month ends and its relationship to the first Tuesday and Friday of the new month.

Month Service Was Performed

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	1

Following Month

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Claims submitted before the first available Tuesday will process that evening for payment the following Friday.

You may not bill for future dates. To bill for an entire month, submit clams the first available date of the new month.

Unit Types

Your authorization will have a certain number of units that you are authorized to provide for a given service code and date range. Different service codes can have different types of units, your authorization will also tell you what the unit type is. The possible types of units you may be authorized for are:

1/4 Hour: 1 unit = 15 minutes.

1/2 Hour: 1 unit = 30 minutes.

Hour: 1 unit = 60 minutes.

Each: 1 unit per each occurrence of the service.

Per visit: 1 unit per visit that led to performance of the service. (May have multiple visits on the same day).

Mile: 1 unit per mile driven to provide the service.

Daily: 1 unit = 1 day.

Monthly: 1 unit = 1 month.

Note:
Each service line is a single day, all units of a specific code for the same day should be on the same line. (See Date Range, pg. 9, for daily & monthly unit types)

The number of units provided on each day of service can be more than 1. (Except daily and monthly units)

Date Range

Daily and Monthly date ranges:

Date range from and to dates must be consecutive (in a row with no breaks), within the same calendar month, and use daily or monthly units.

The number of units must equal the number of days in the range for daily unit types or 1 unit for the month within the range for monthly unit types.

When you add service lines, the date range will be a single service line. A note will appear on your billing page telling you that the date range will be broken down into individual daily service lines when the claim is processed.

A date range, or span, can only be used when:

- *Unit Type = daily or monthly.*
- *Days were worked consecutively.*
- *The date range is within the same calendar month.*
- *The number of units match the number of days, for daily units.*
- *For monthly unit types, 1 unit per range. The maximum date range is one calendar month, date ranges of less than a month will be prorated by ProviderOne.*

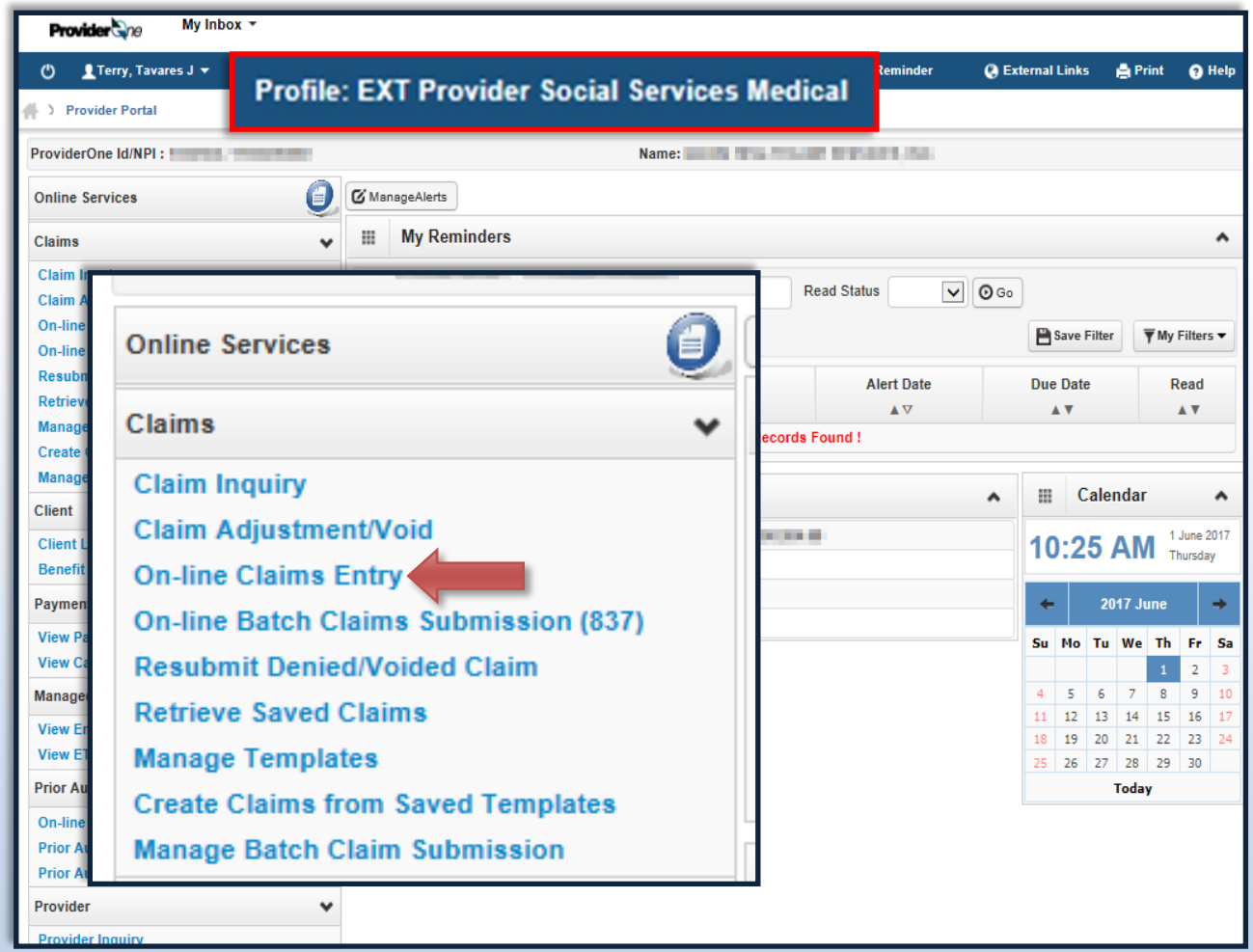
Submit Professional Claim

Submit Professional Claim

This section is on how to submit a professional claim.

This process is direct entry, meaning that you will enter all the needed billing information into a billing form.

The direct entry process is the basis for building and submitting templates and for adjusting claims.



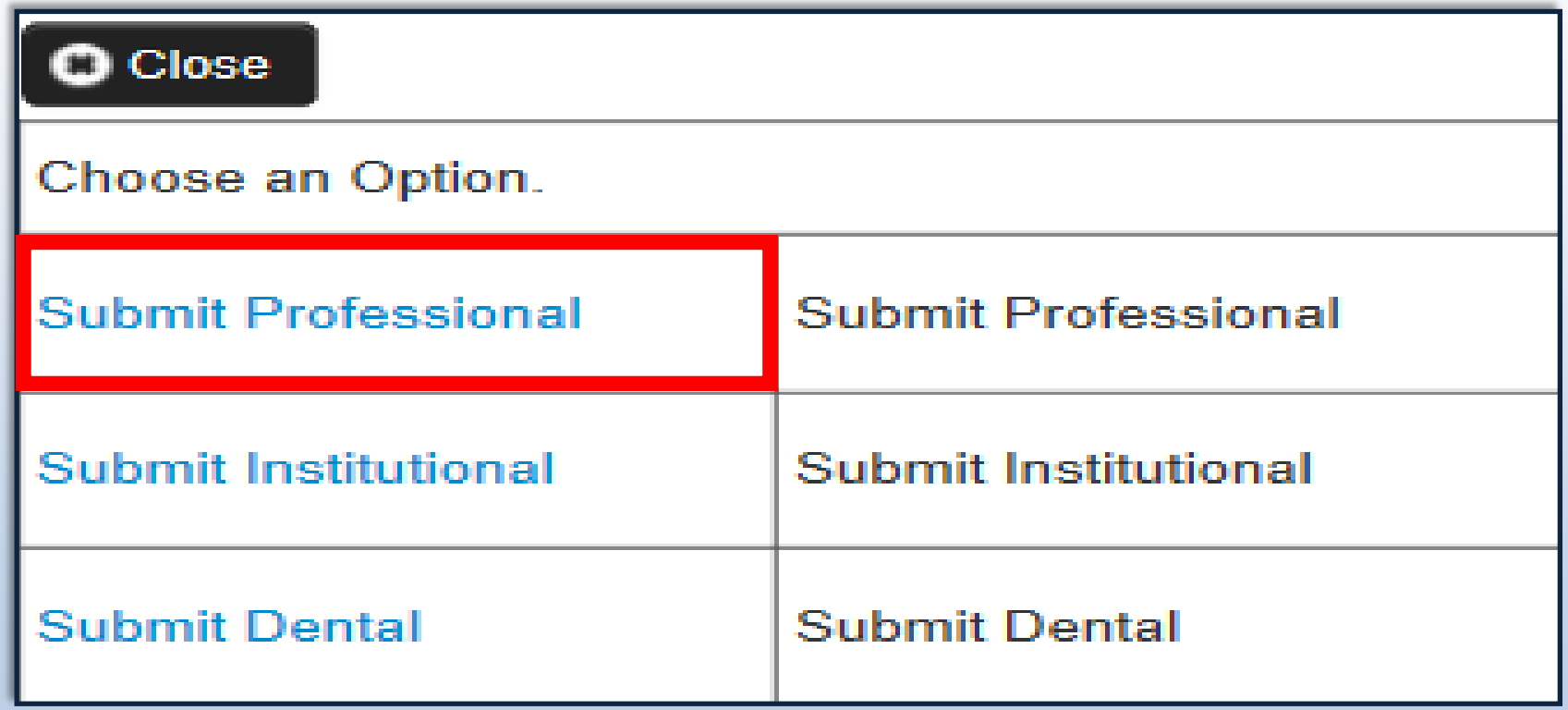
To submit a professional claim:

- Log in to ProviderOne using the 'EXT Provider Social Services Medical' profile,
- Click on 'Online Claims Entry'.

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

Submit Professional Claim

The 'Choose an Option' page appears. Social Service Medical claims will always be professional claims, Social Service Medical providers will choose '**Submit Professional**'.



Submit Professional Claim

The 'Professional Claim' screen appears.

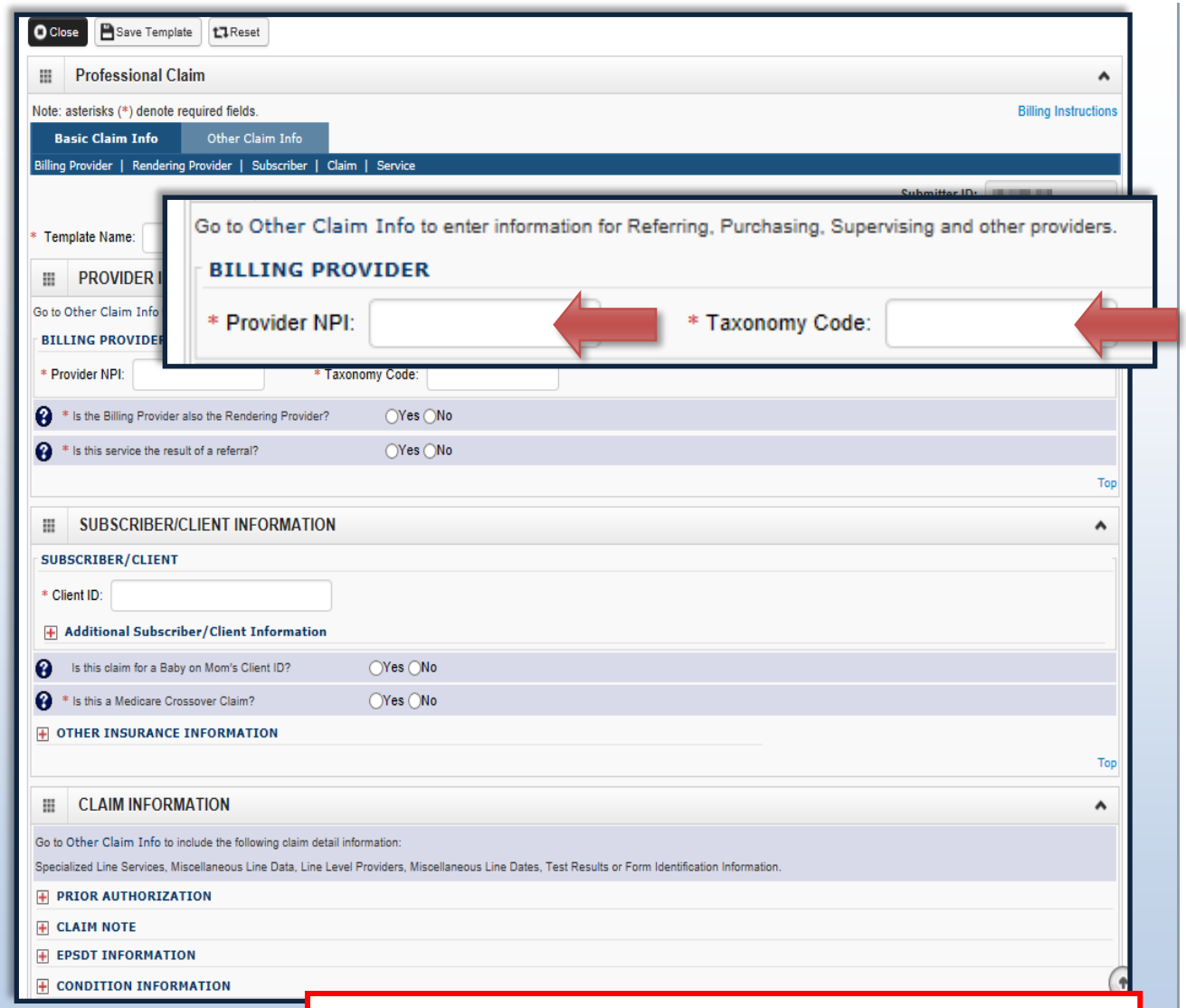
Enter the following information:

- '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.

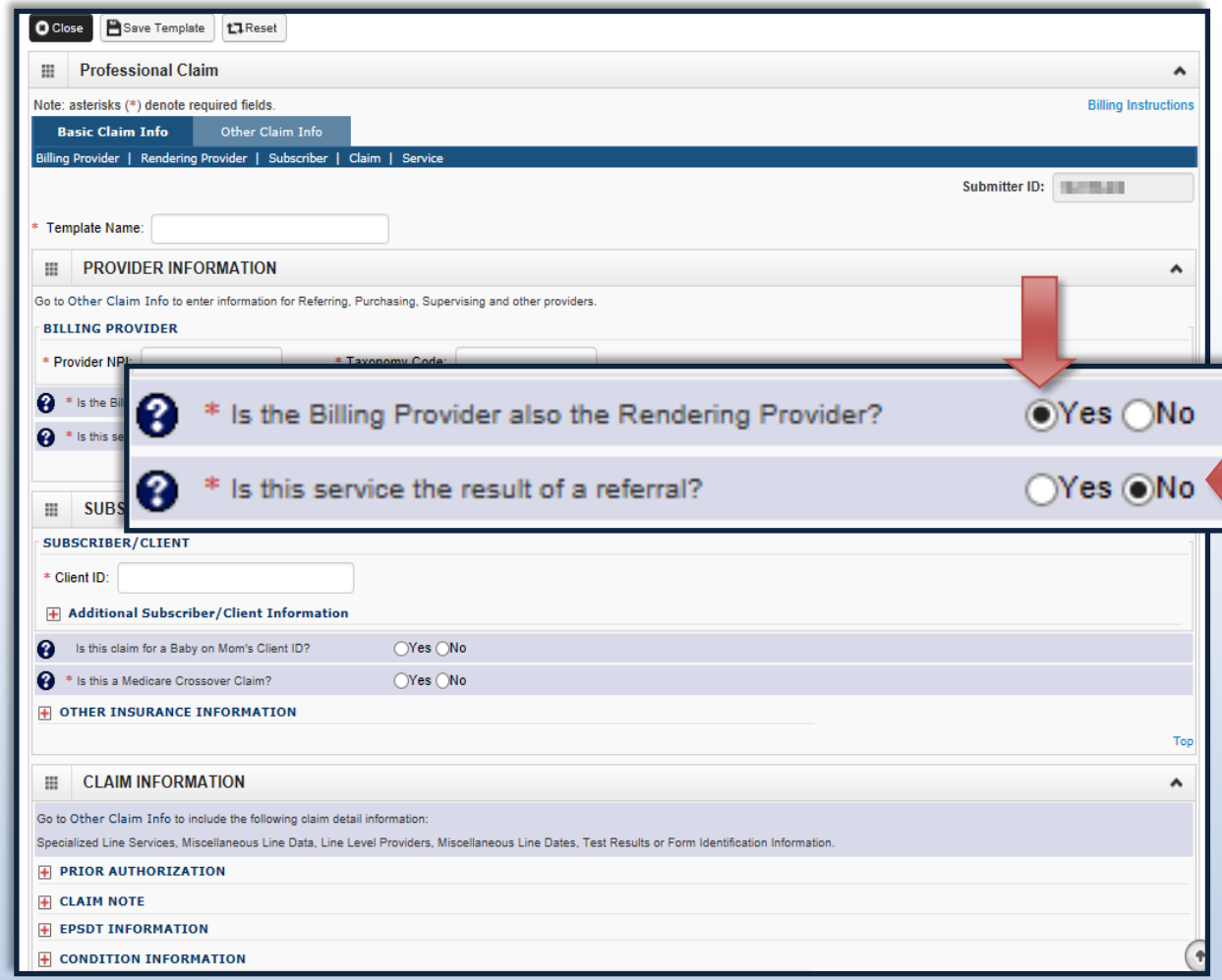
Submit Professional Claim

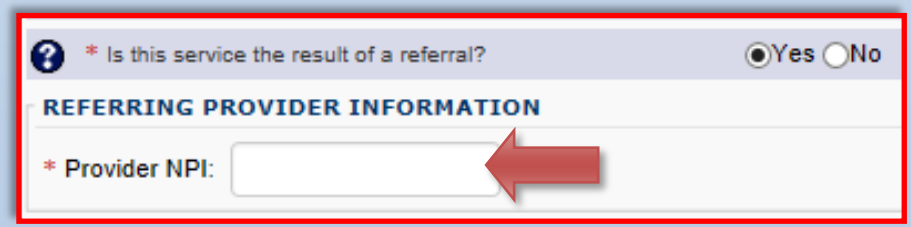
- Select 'Yes' for the question, "***Is the Billing Provider also the Rendering Provider?***"
- Select 'No' for the question, "***Is this service the result of a referral?***"

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.

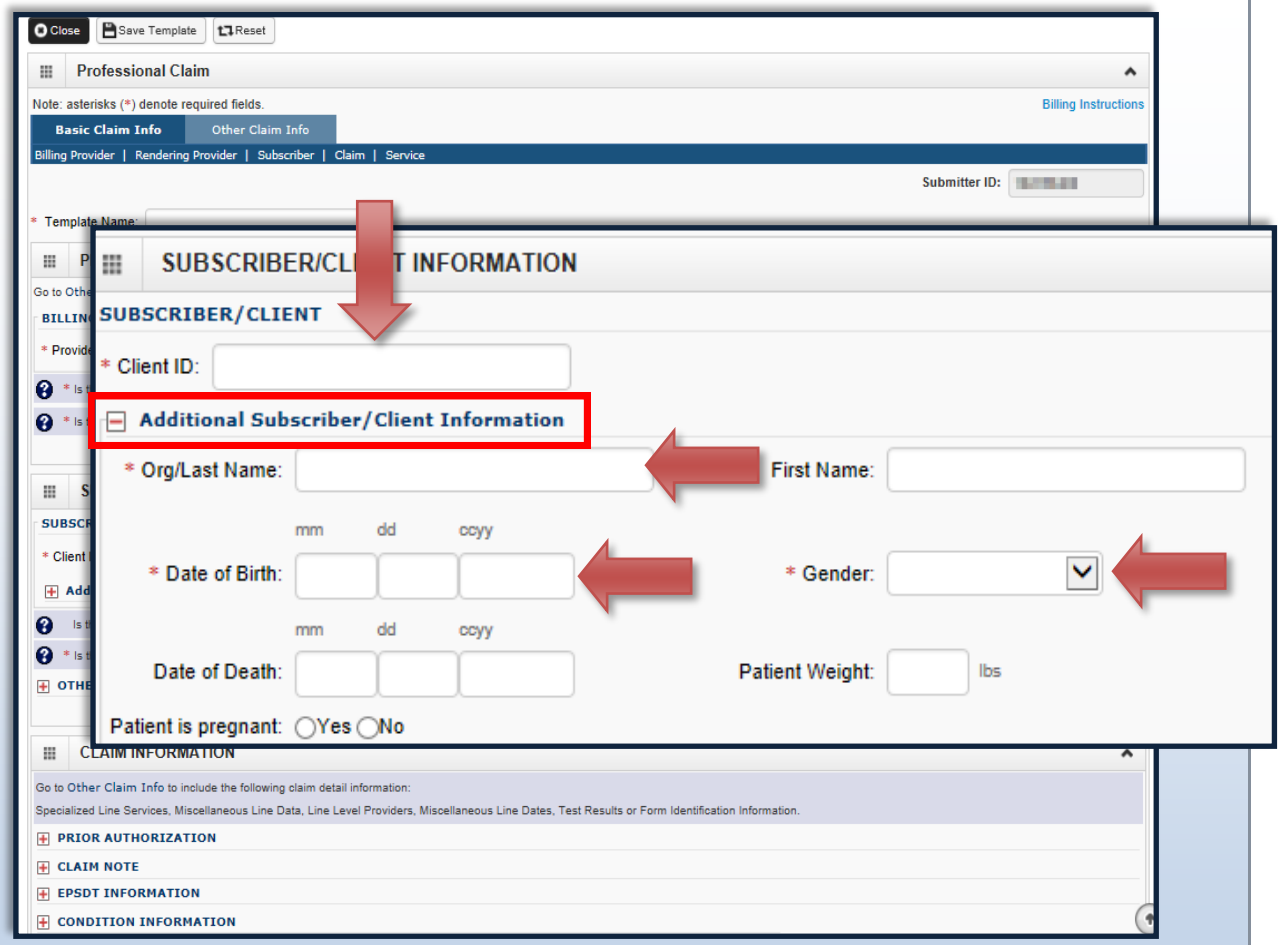




Client Information

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'.



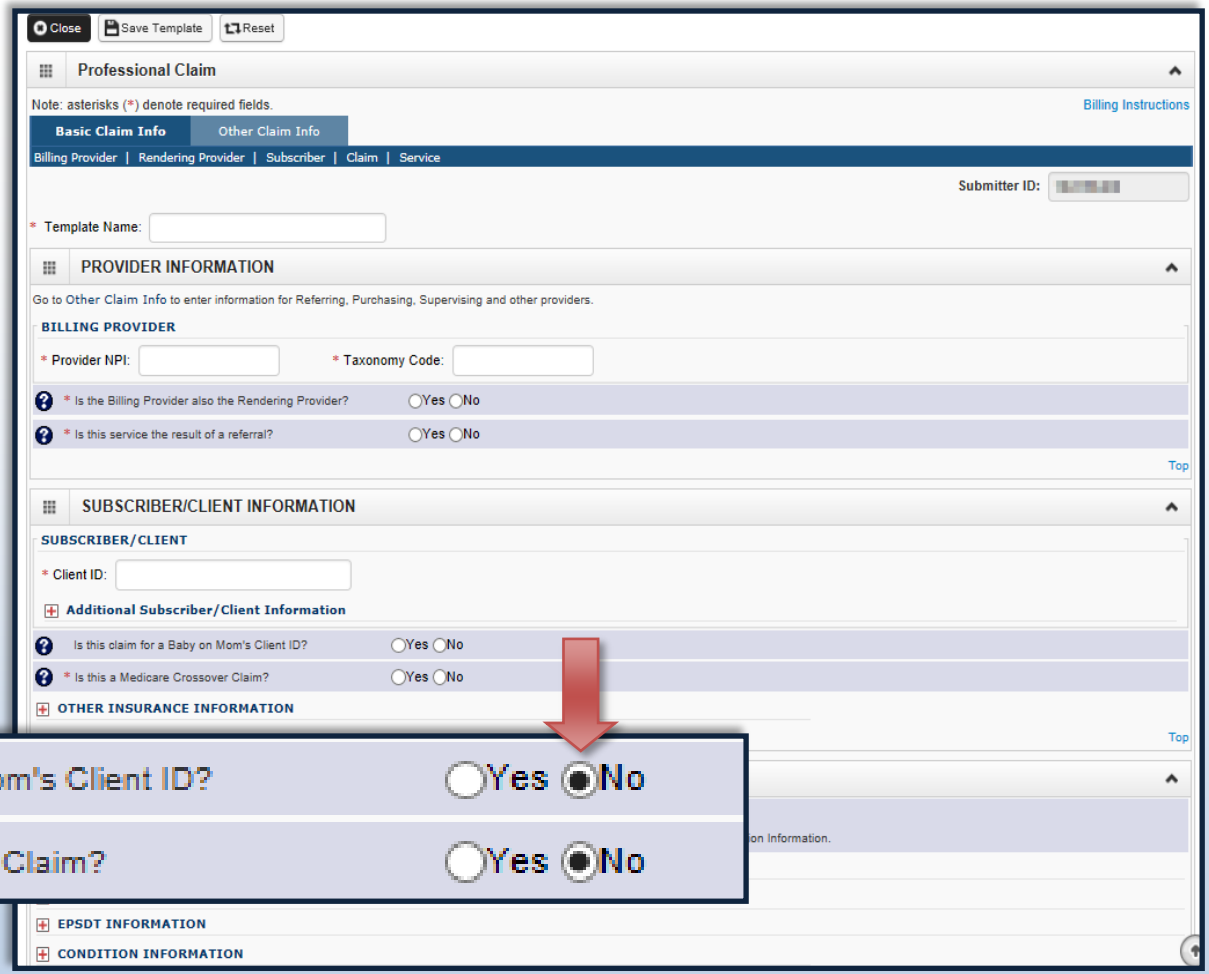
Note:
Client last name, DOB, and gender are the only required fields.

Patient is pregnant and Patient Weight fields do not apply.

Client Information

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?***"

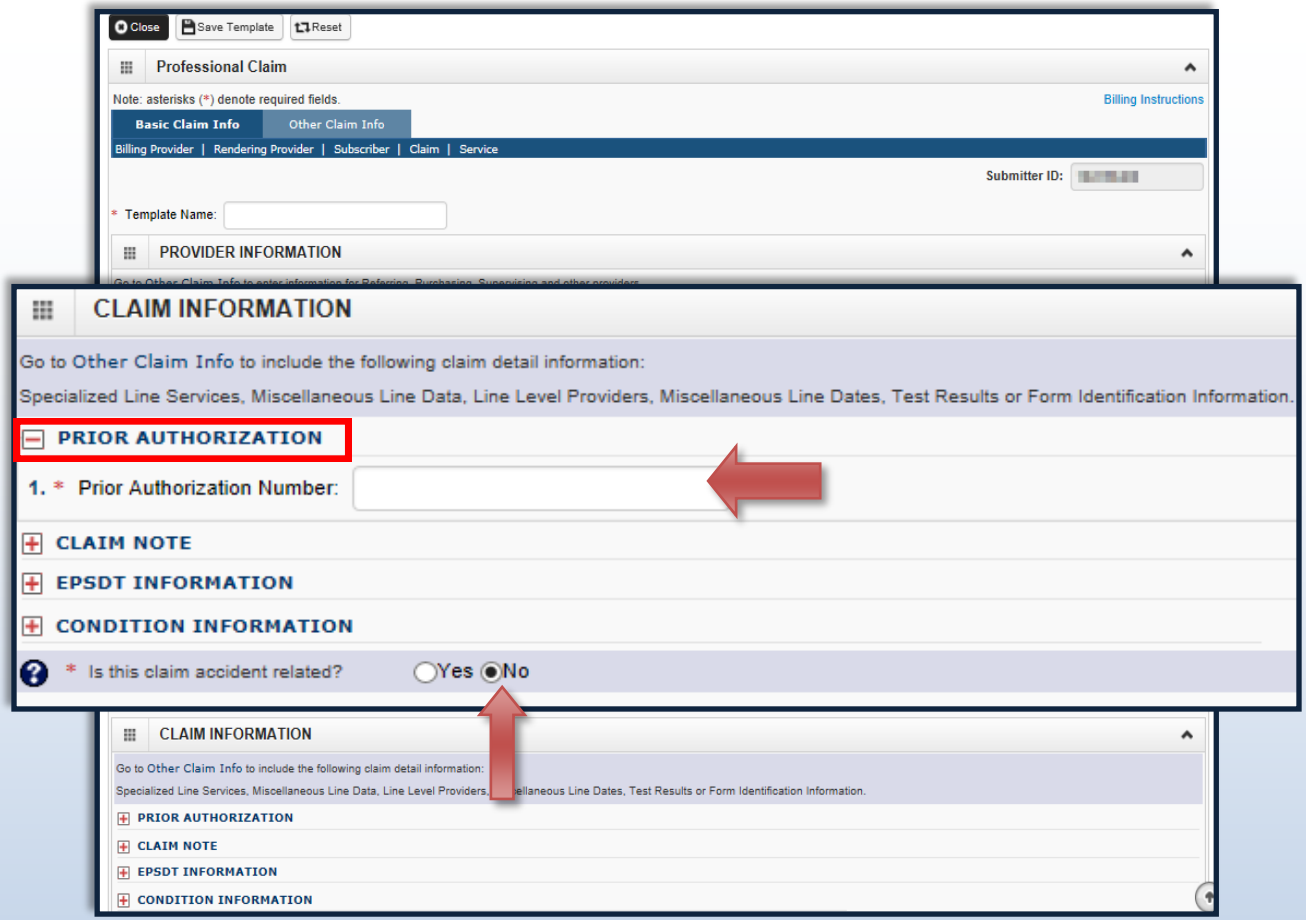


Prior Authorization

Under '**Claim Information**',

Click the ➕ next to '**Prior Authorization**'.

- Enter the approved authorization number for the client.
  - ⇒ 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.
  - ⇒ 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.

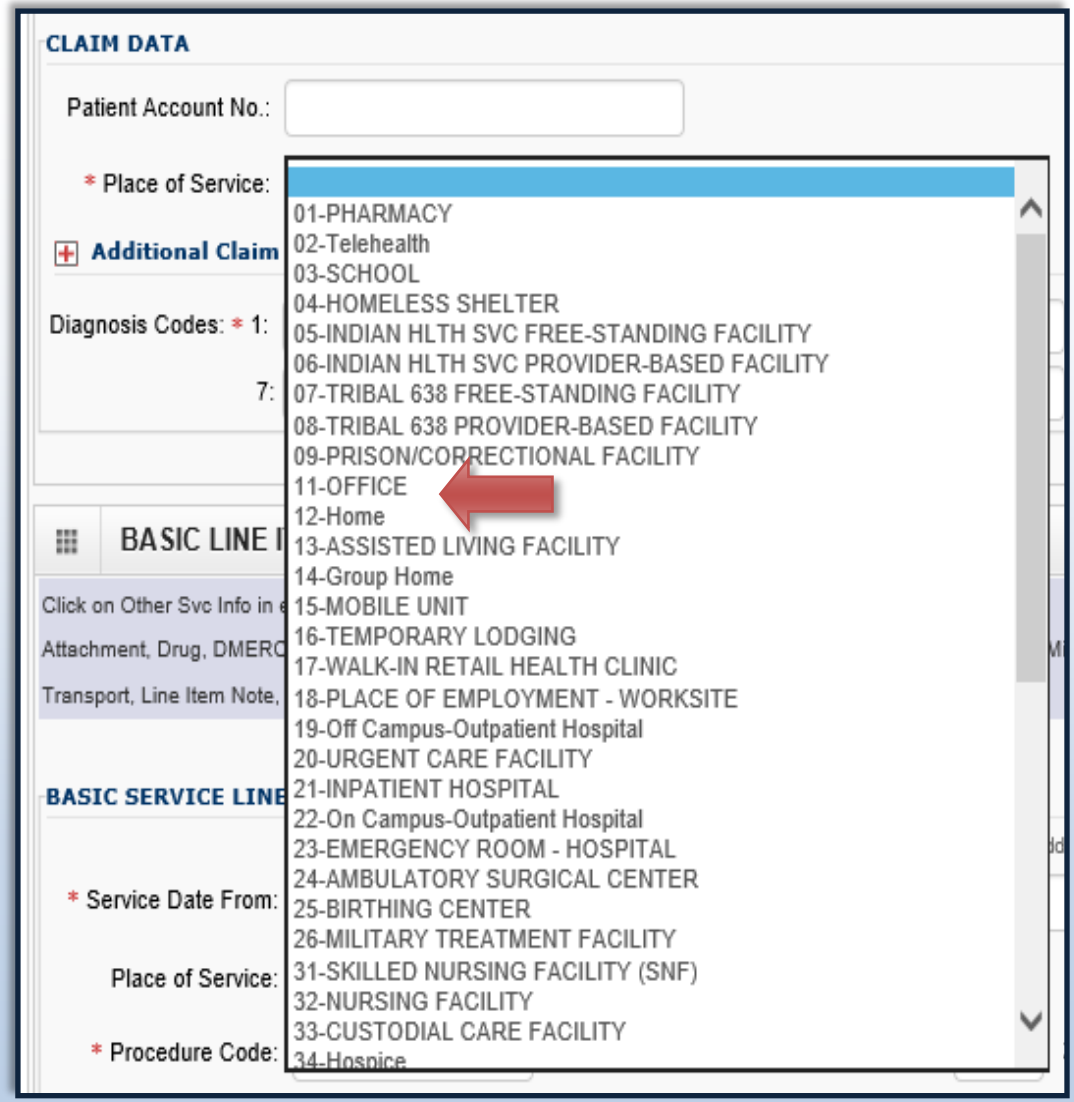
Place of Service

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.



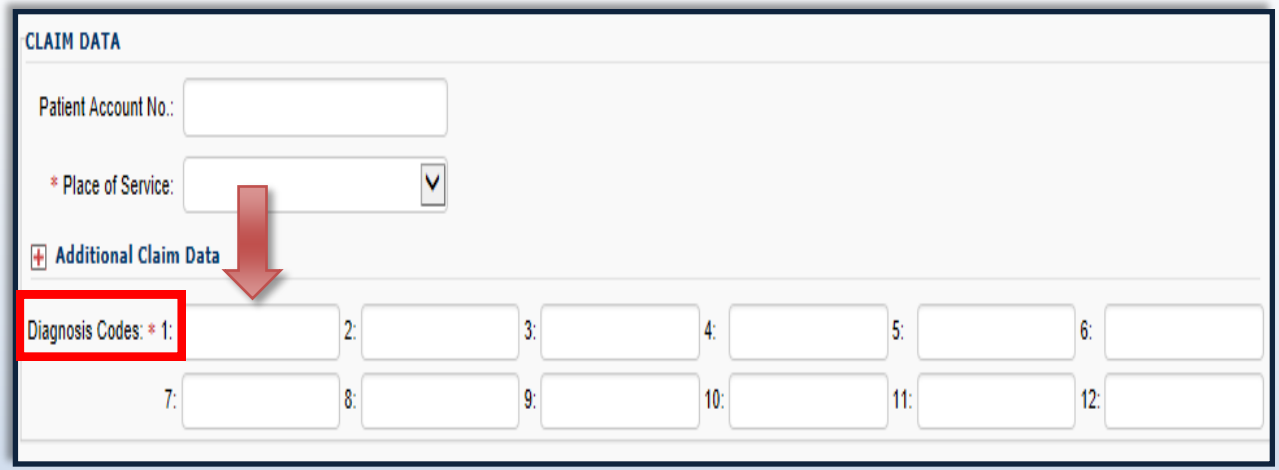
Note:
Adult Family Homes, Assisted Living Facilities and Enhanced Service Facilities are residential settings and thus considered to be the client's home.

Diagnosis Codes

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.



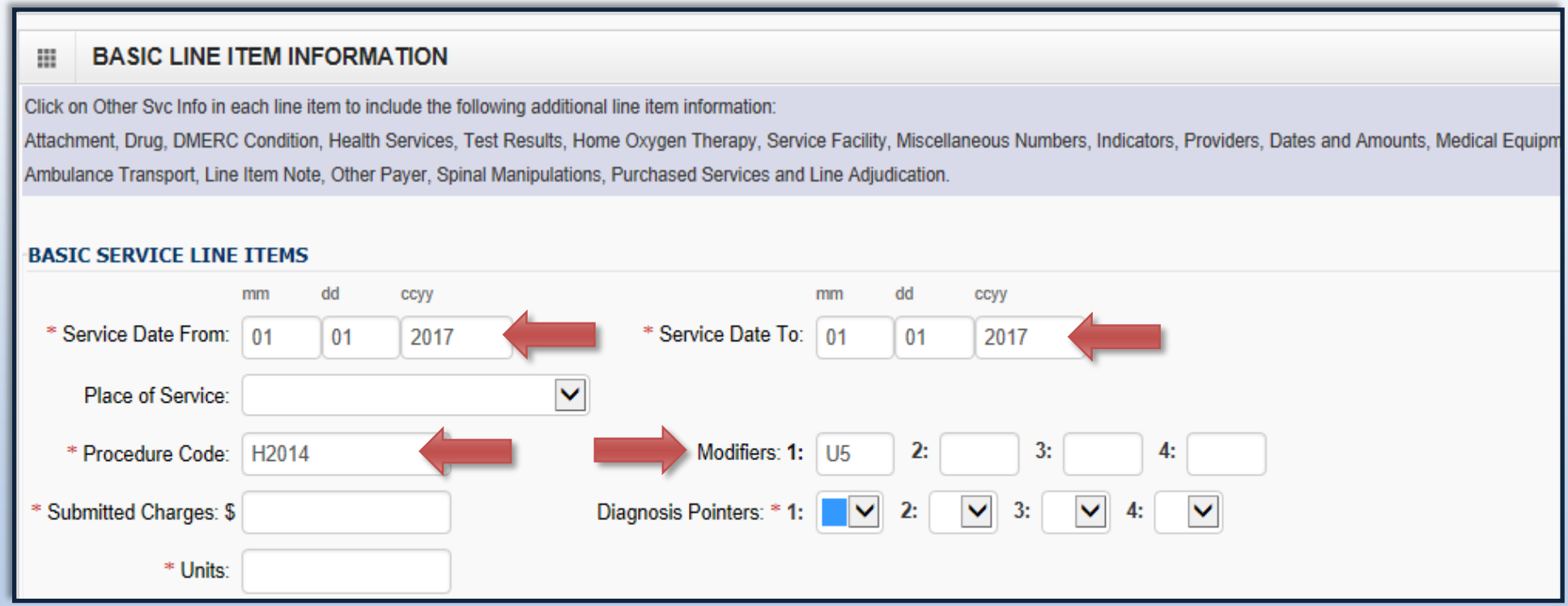
Note:
ICD-10 *diagnosis codes can be found from many online resources.*

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.*

Service Lines

Under '**Basic Line Item Information**':

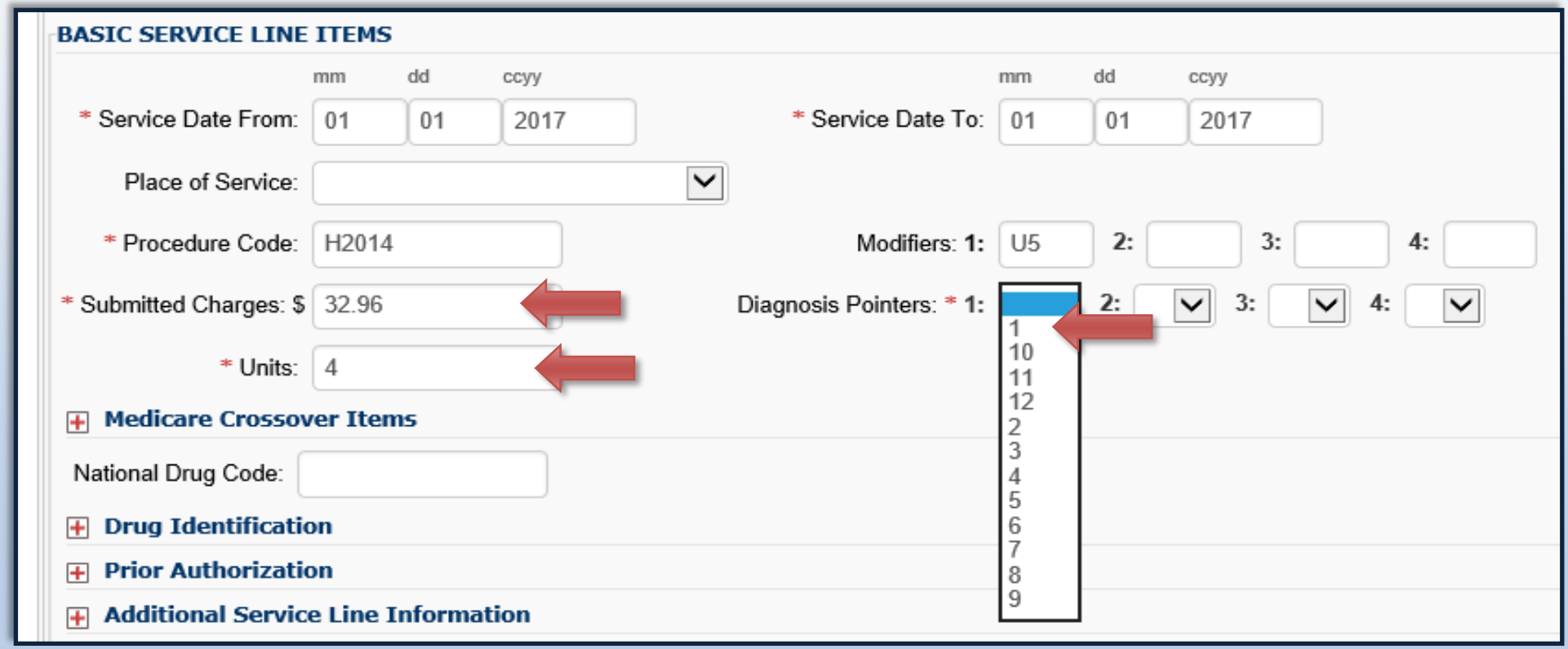
- Enter 'Service Date From' and 'Service Date To'. Unless billing for a daily or monthly unit type, claims are for a single day per line so From and To dates should be the same.
- Enter 'Procedure Code' and 'Modifier' (if applicable).



Service Lines

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).



Service Lines

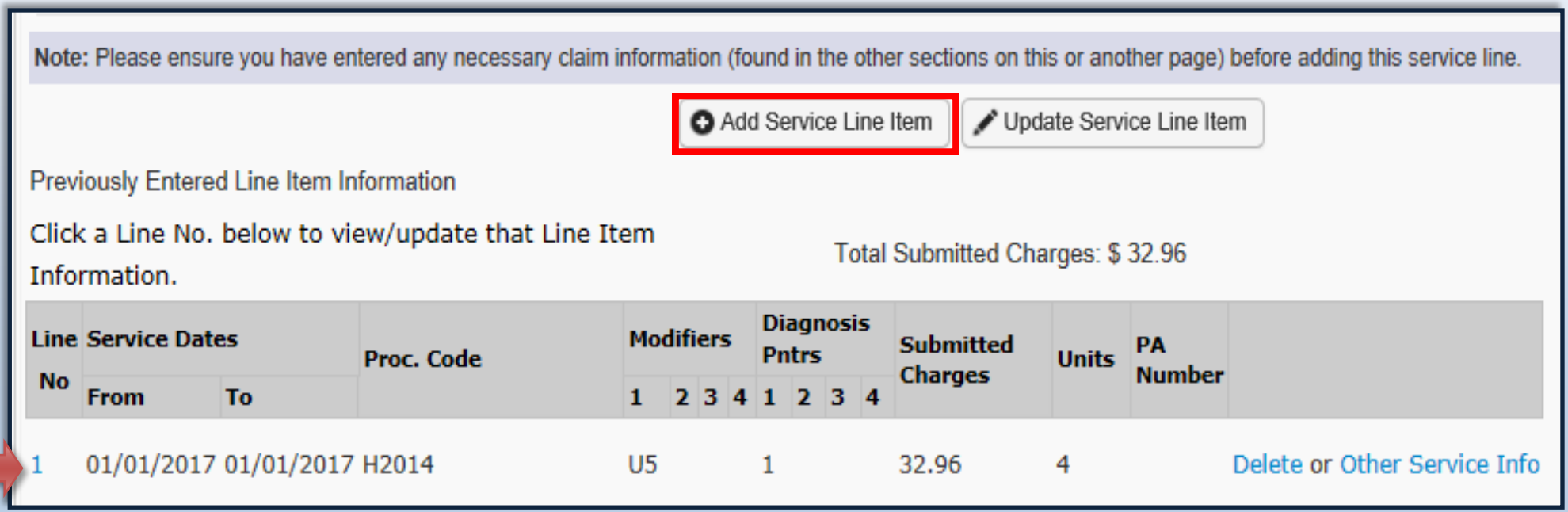
Once the service line information has been entered, click '**Add Service Line Item**'.

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.



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: $ 32.96

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2017	01/01/2017	H2014	U5				1				32.96	4		Delete or Other Service Info

Service Lines

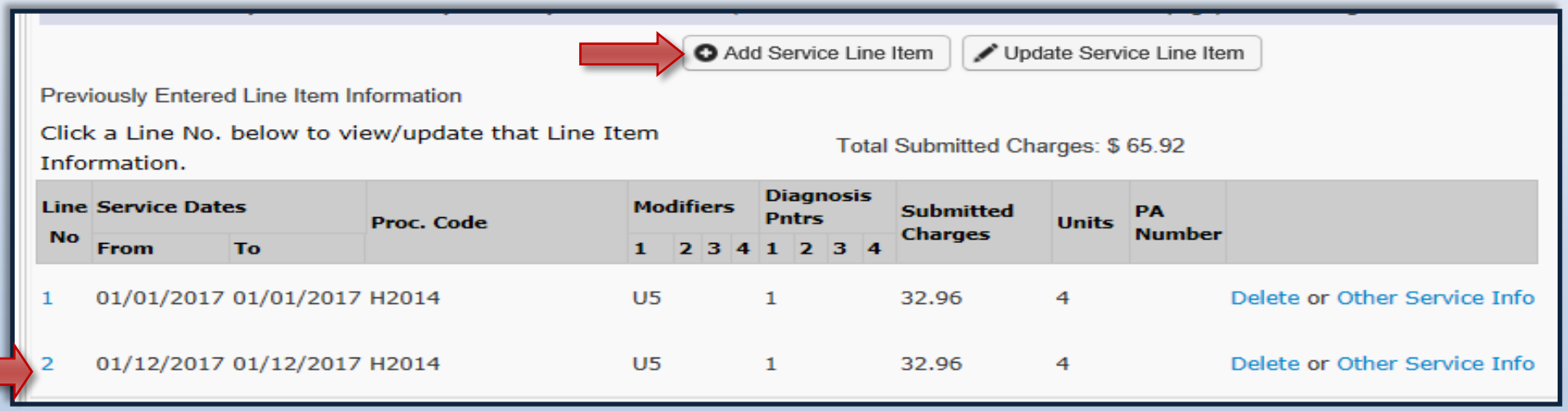
To enter additional service lines there are two options.

Option 1:

- Enter basic service line information in the cleared fields
  - ⇒ Service Date From/To,
  - ⇒ Service Code and Modifier,
  - ⇒ Submitted Charges, Units and Diagnosis Pointer.
- Click on '**Add Service Line Item**'. *(The new service line appears; shown below as line #2.)*

Note:
*Each line must be for the **same authorization number**. Different service codes can be used as long as they are from the same authorization number.*

*You can add up to **50** service lines per claim.*



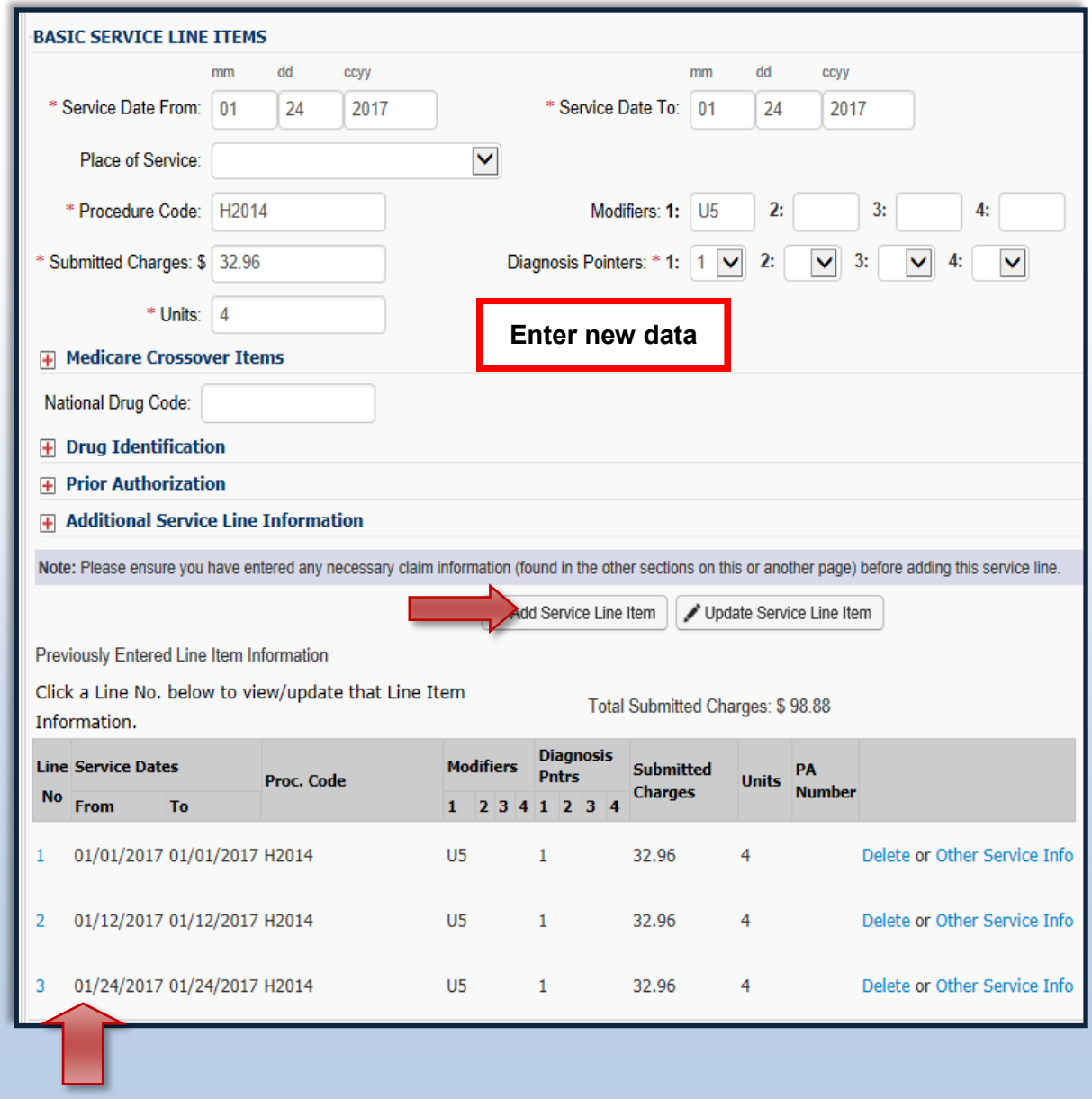
Service Lines

Option 2:

- Click on a service line number,
- The entered service line information populates,
- Replace the information with new data,
- Click on '**Add Service Line Item**'.
- New service line appears. *(Shown as line #3.)*

Note:
*Each line must be for the **same authorization number**. Different service codes can be used as long as they are from the same authorization number.*

*You can add up to **50** service lines per claim.*



Service Lines

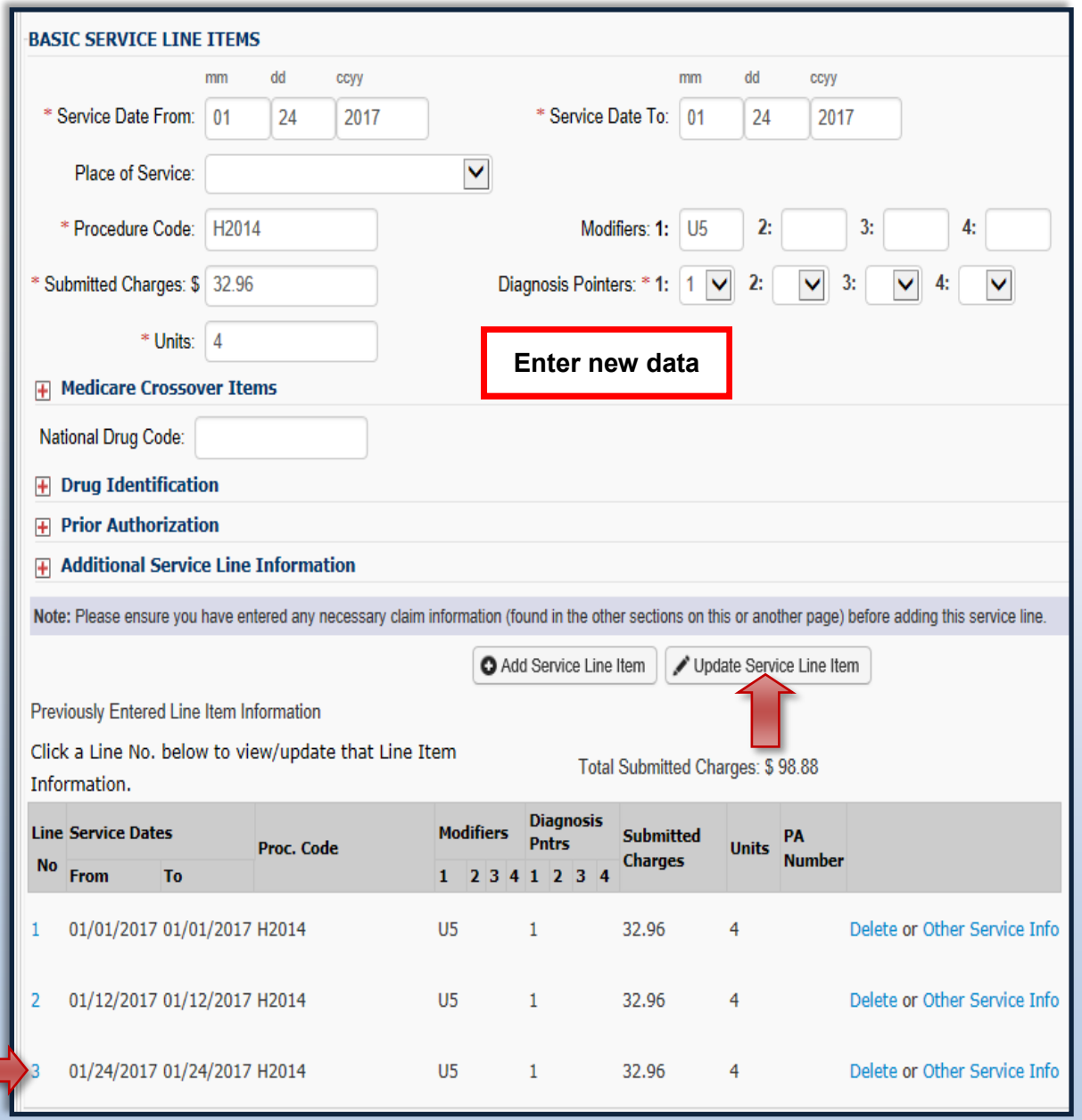
Editing a Service Line:

You may see the information previously entered has an error. To correct the data so that the service line is correct:

- Select the line number you wish to edit,
- The service line data appears,
- Make the needed correction to the service line data,
- Now select '**Update Service Line Item**'.

Note:

The new data you have entered will now be shown on the chosen line. (Shown as line #3.)

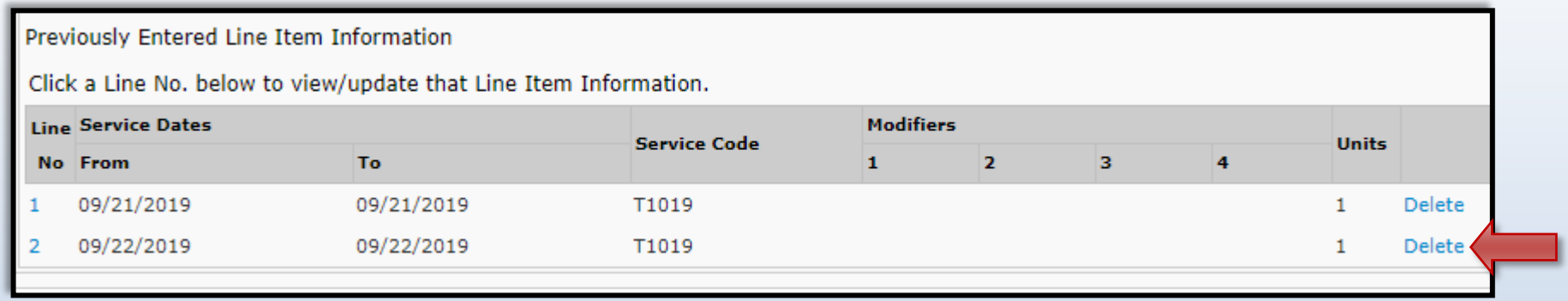


Service Lines

Deleting a Service Line:

You may have need to remove a previously added service line. To remove the service line:

- Determine which line needs to be deleted in the 'Previously Entered Line Item Information' section,
- Click '**Delete**' at the end of the line you wish to remove,

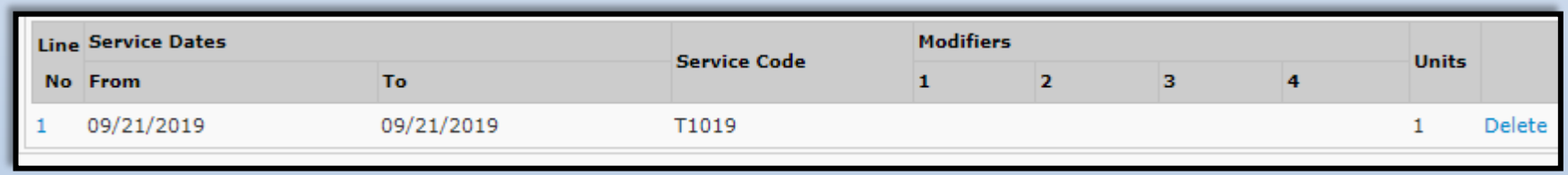


Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Line No	Service Dates From	Service Dates To	Service Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Units	
1	09/21/2019	09/21/2019	T1019					1	Delete
2	09/22/2019	09/22/2019	T1019					1	Delete

- The line disappears from the claim.



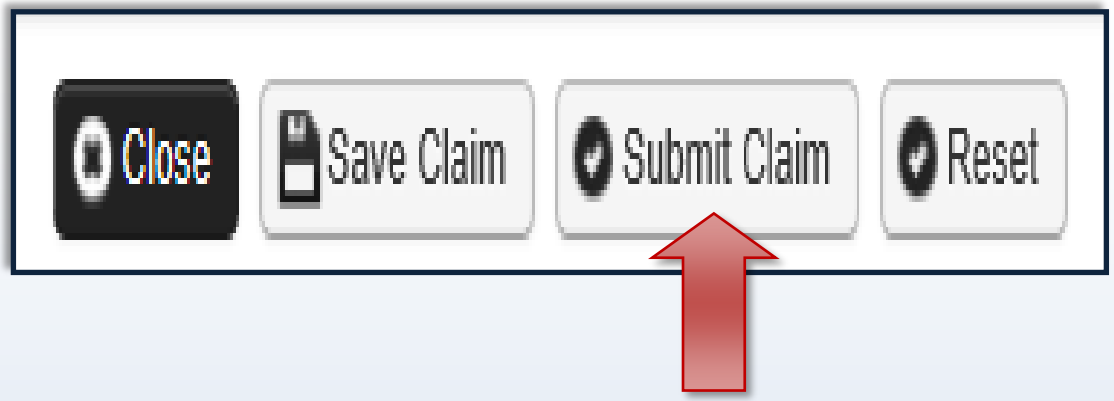
Line No	Service Dates From	Service Dates To	Service Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Units	
1	09/21/2019	09/21/2019	T1019					1	Delete

Submit Professional Claim

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.*

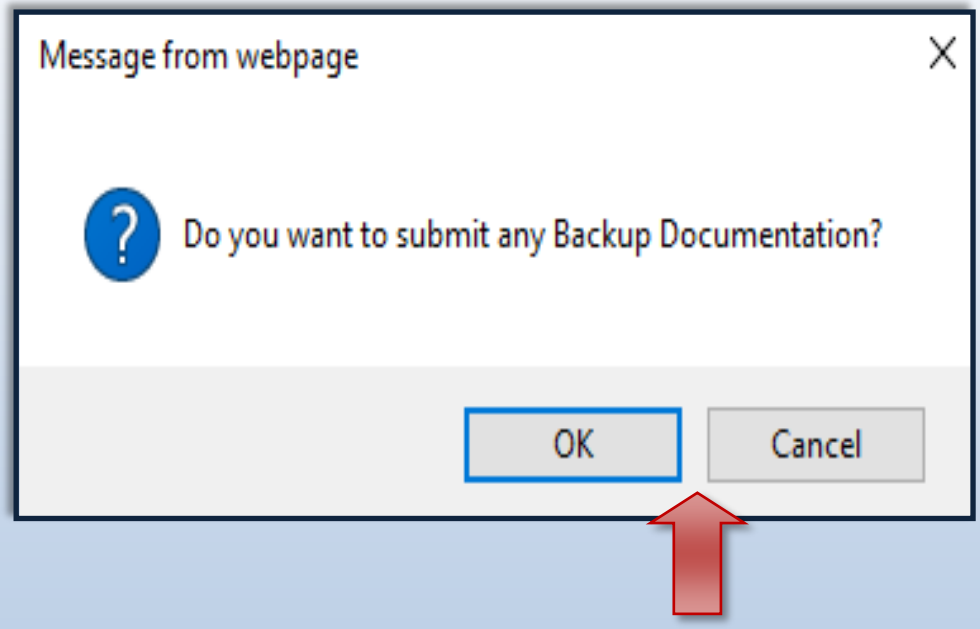
To remedy this, log out of ProviderOne, turn off your browser's pop-up blockers, then log in to ProviderOne again and return to the billing screen to start over.

Submit Professional Claim

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.

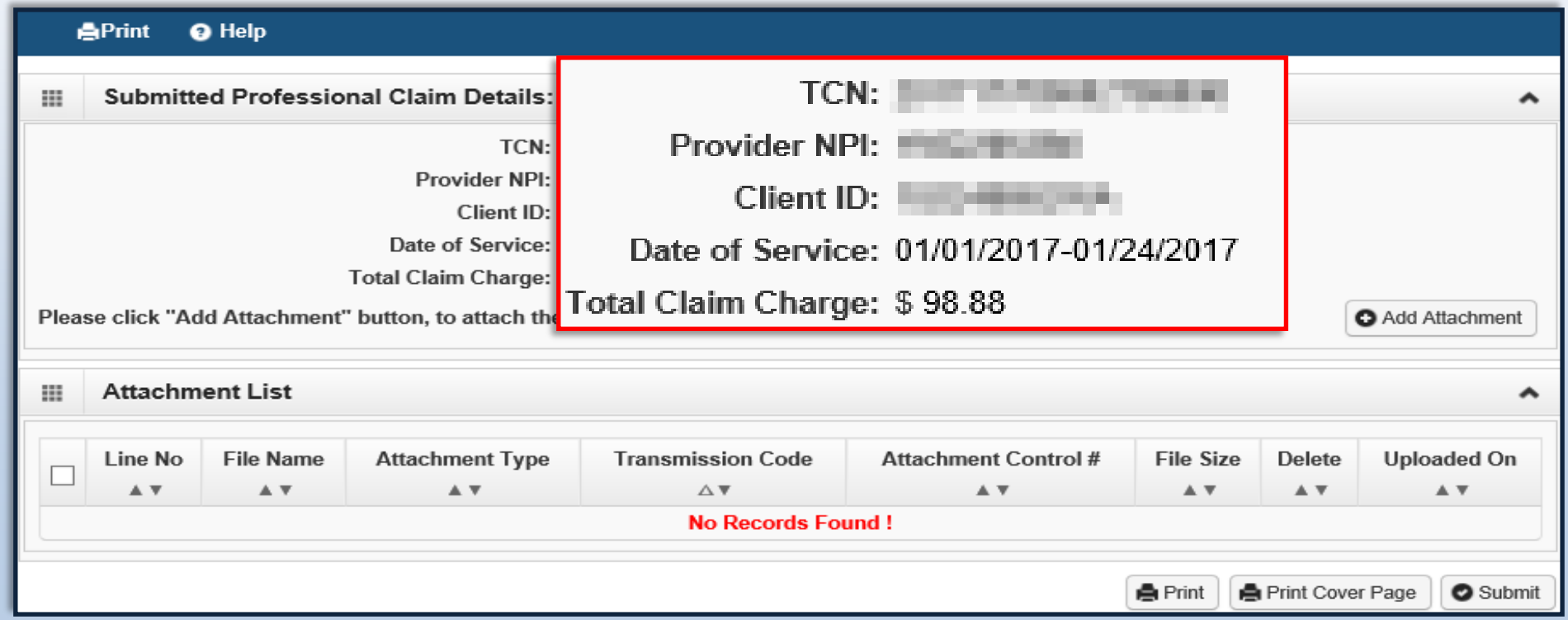


Submit Professional Claim

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**'.*

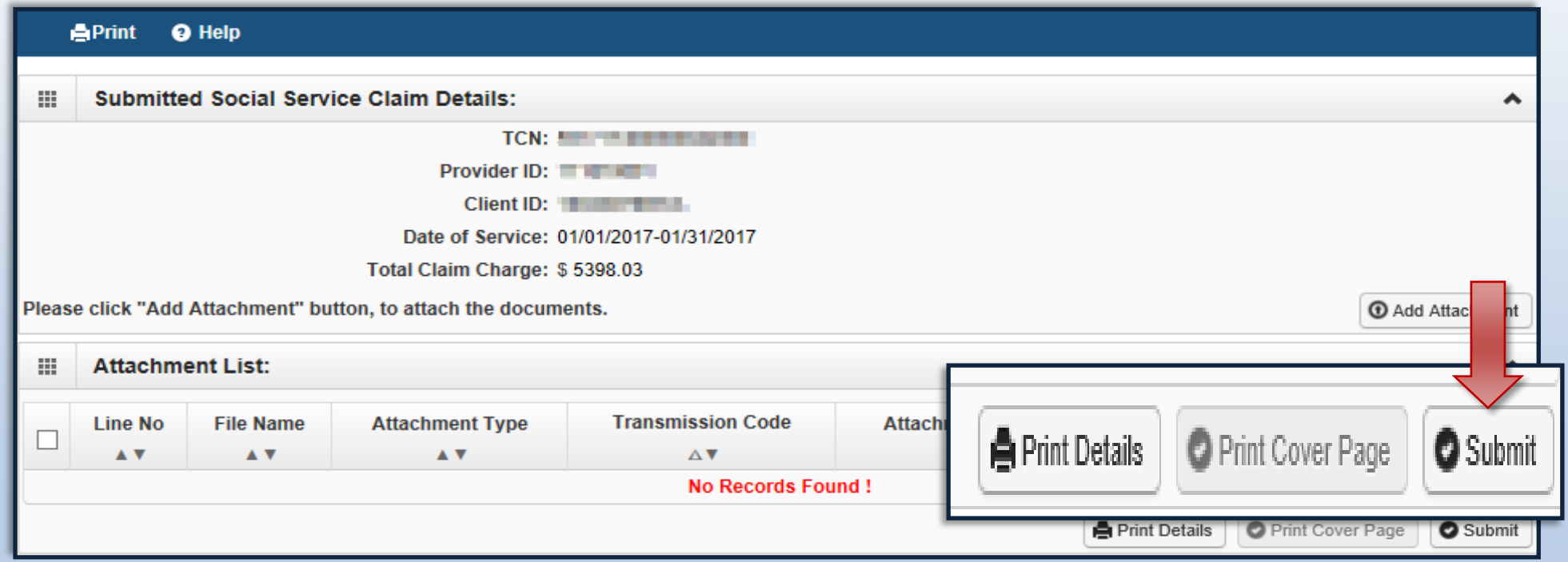


Submit Professional Claim

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.

<u>*However, your claim has not yet been submitted***</u>**

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.



Common Adjustment & Denial Codes

Below is a short list of common Adjustment Reason and Remarks Codes you may find on your Remittance Advice (RA)

RA adjustment reason/remark code/description	Possible causes	Provider action
142- Monthly Medicaid patient liability amount.	Client responsibility (participation) applied to the claim	You must collect this amount from the client
198- Precertification/authorization exceeded	Social Service Authorization Approved Units have already been claimed	Contact your case worker if you question the number of units authorized
16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	1. Claimed dates of service are not within the authorization period 2. The authorization line is in error	1. Contact your case worker if you have questions about the authorization dates 2. Contact your case worker if you have questions about authorization errors
18- Exact duplicate claim/service	1. Claimed the same units on two different lines for the same day, or 2. Claim is an exact duplicate of one already submitted	1. Adjust the claim and report the number of units on a single claim line 2. No action is needed if duplication was unintended.
177-Patient has not met the required eligibility requirements	The client is not financially eligible	Contact your case worker if you have questions
A1-Claim/Service denied	The authorization is in cancelled status	Contact your case worker if you have questions
B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service	Your contract may be expired.	Contact your contract manager or case worker if you have questions
N54-Claim information is inconsistent with pre-certified/authorized services	Authorization line is in error	Contact your case worker if you have questions
N63-Rebill services on separate claim lines	A separate claim line is required for each date of service for the service/procedure code entered	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
N362 : The number of Days or Units of Service exceeds our acceptable maximum	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	Change the number of units to the correct amount and resubmit your claim