Washington State Health Care Authority

Direct Data Entry of an Institutional Claim

2022

Accessing ProviderOne

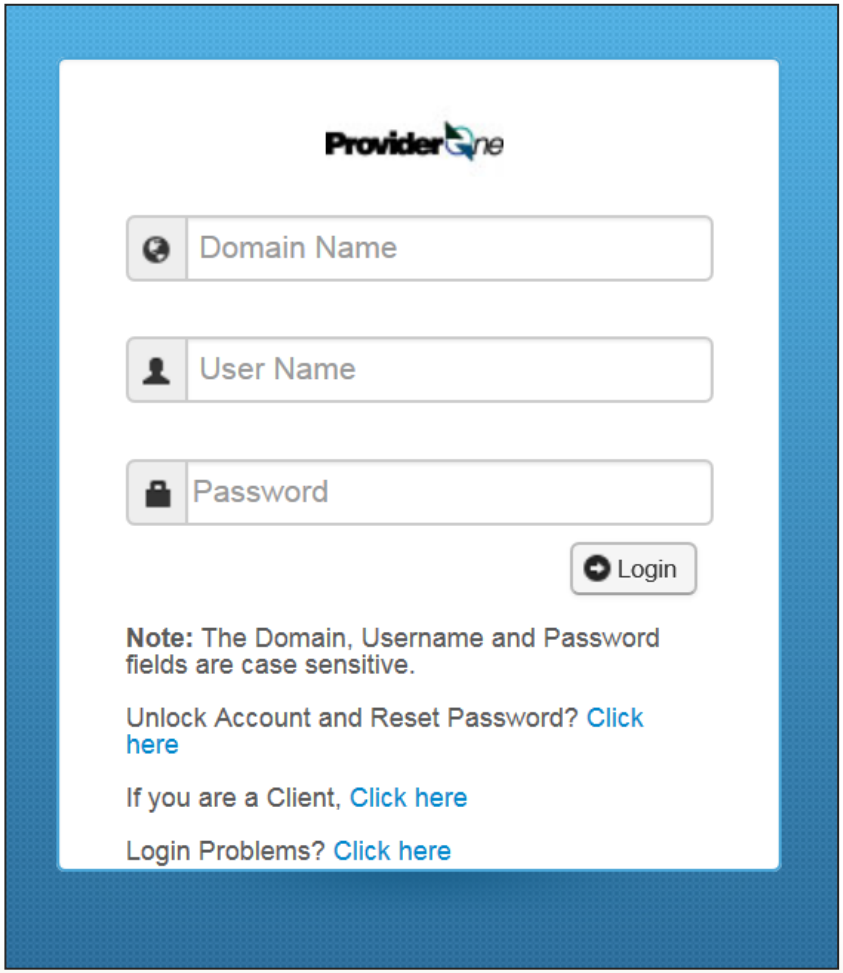
Accessing ProviderOne

- Before logging into ProviderOne:
  - Make sure you are using one of the following and your popup 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

Accessing ProviderOne

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



After this training, you can:

- Submit fee for service DDE claims
- Create and submit TPL and Medicare Crossover claims using DDE
  - With backup
  - Without backup
- Submit claims for clients with both Medicare and commercial insurance

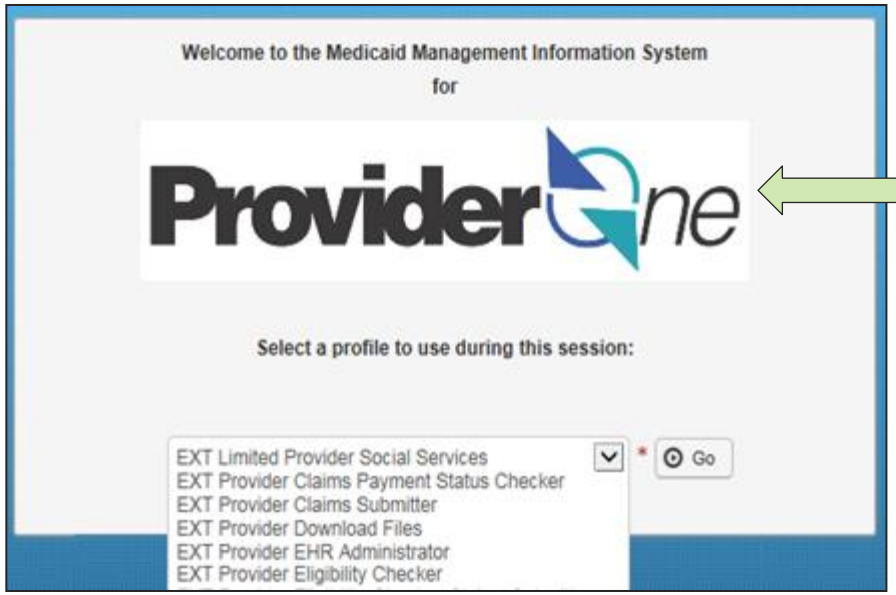
Direct Data Entry (DDE) Claims

- 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.

Determine What Profile to Use

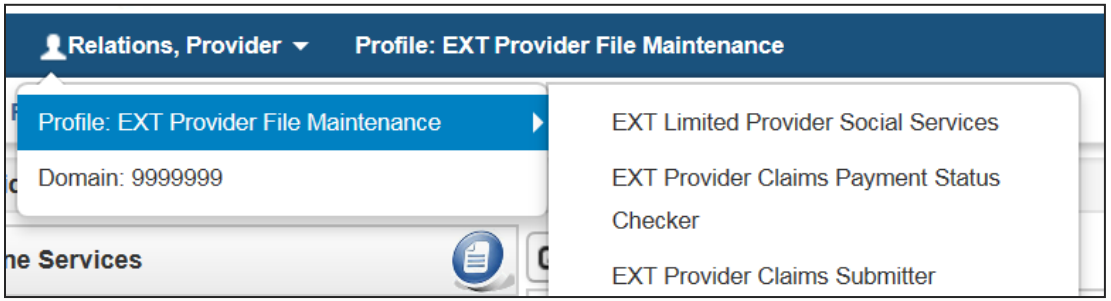
With the upgrade to 3.0, ProviderOne allows you to change your profile in more than one place.

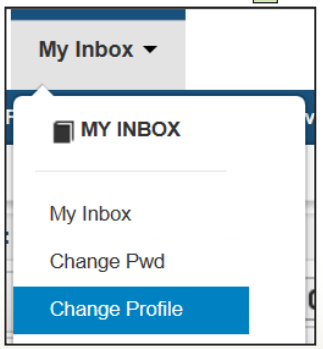
- At initial login:



Note: Using "My Inbox" to change profiles, takes you back to the main profile screen.

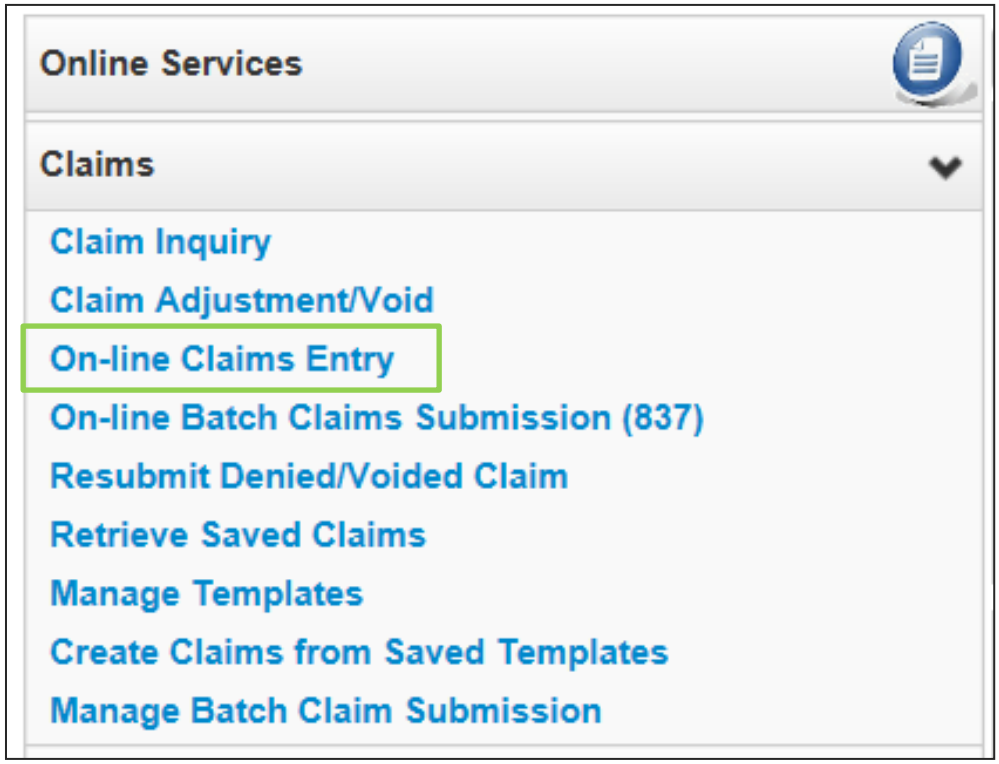
- And in the portal:





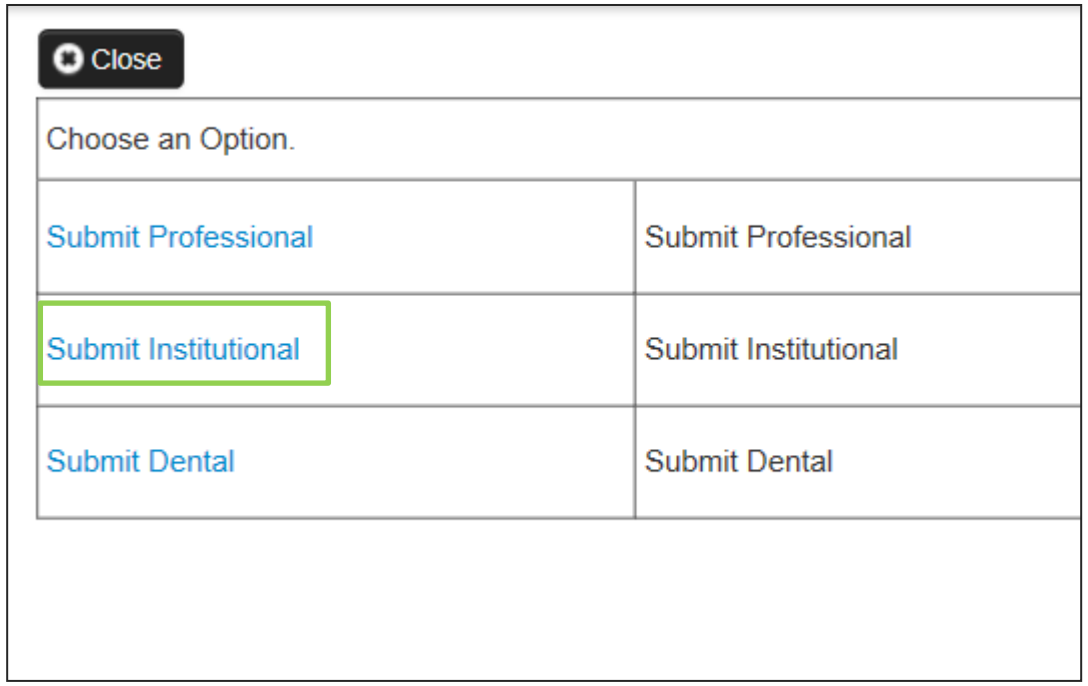
Direct Data Entry (DDE) Claims

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



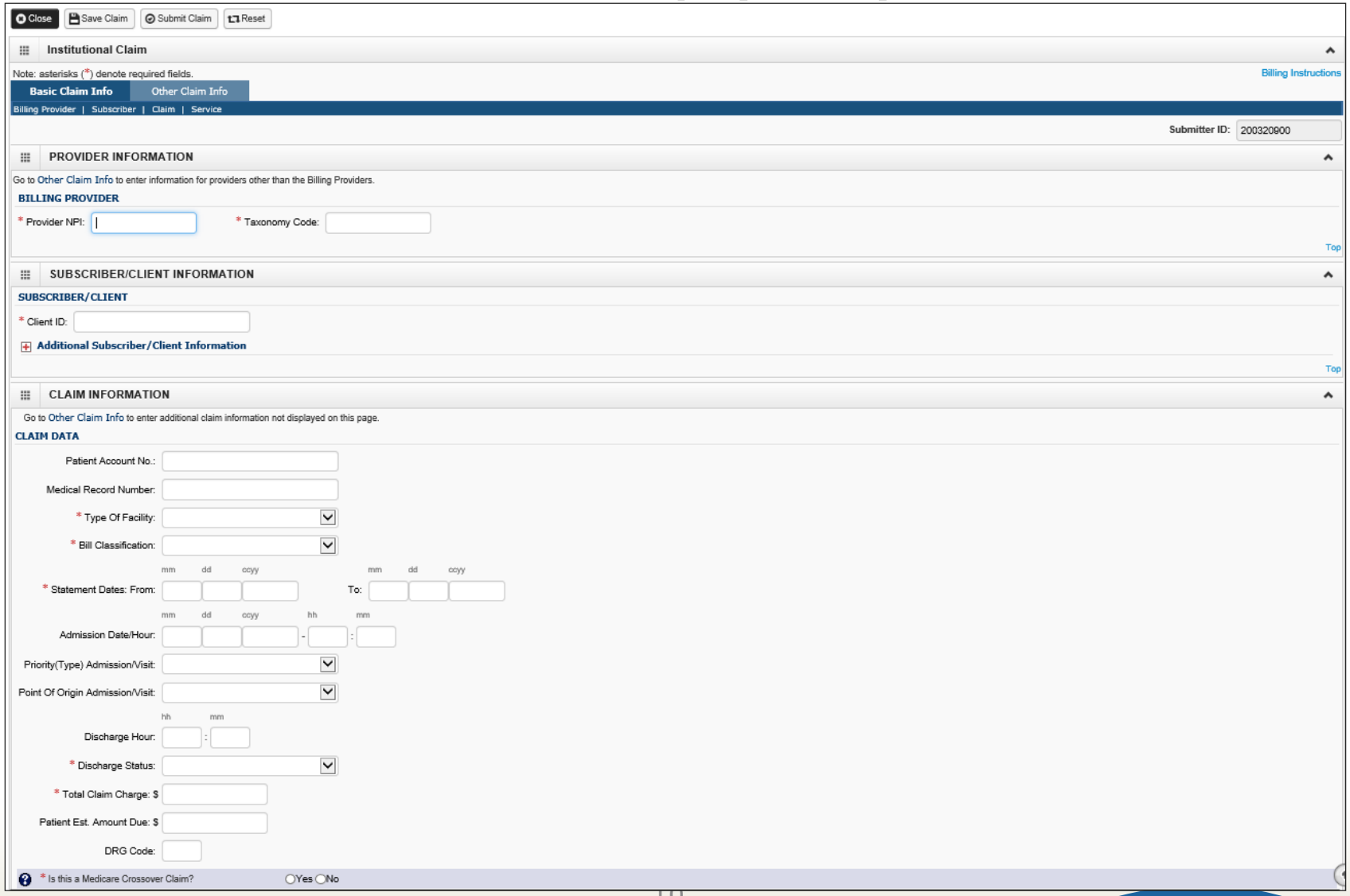
Direct Data Entry (DDE) Claims

- Choose the type of claim that you would like to submit with the appropriate claim form:
  - Professional – CMS 1500
  - Institutional - UB04
  - Dental - 2012 ADA



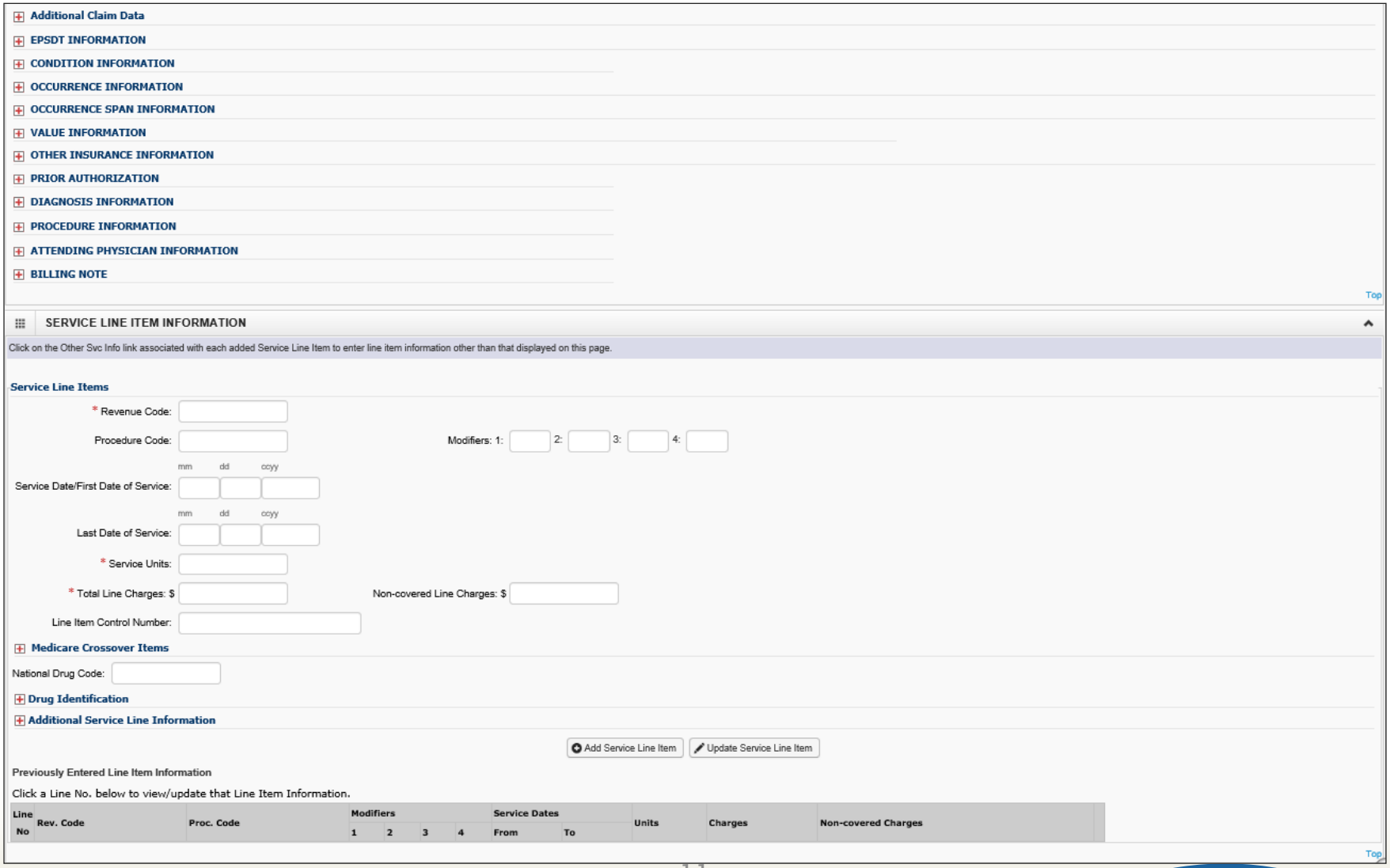
Washington State Health Care Authority

Direct Data Entry (DDE) Claims



Washington State Health Care Authority

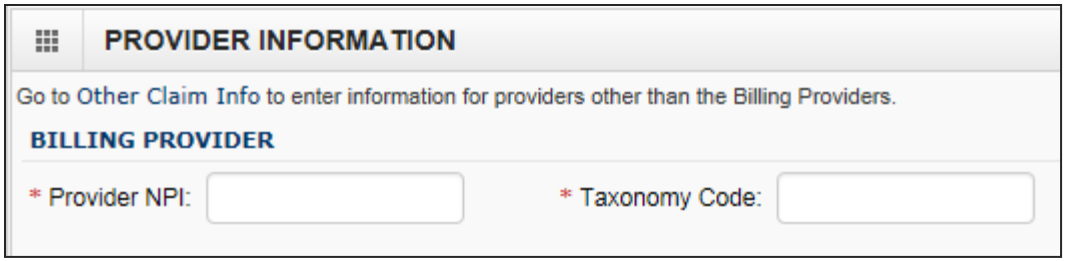
Direct Data Entry (DDE) Claims



Direct Data Entry (DDE) Claims

- Section 1: Billing Provider Information

  - Enter the Billing Provider NPI and Taxonomy Code.

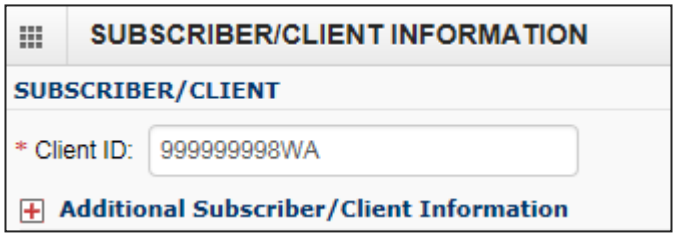


Note: This will be the NPI and taxonomy code of the facility where the service was performed and where you would like payment to be received.

Direct Data Entry (DDE) Claims

- Section 2: Subscriber/Client Information

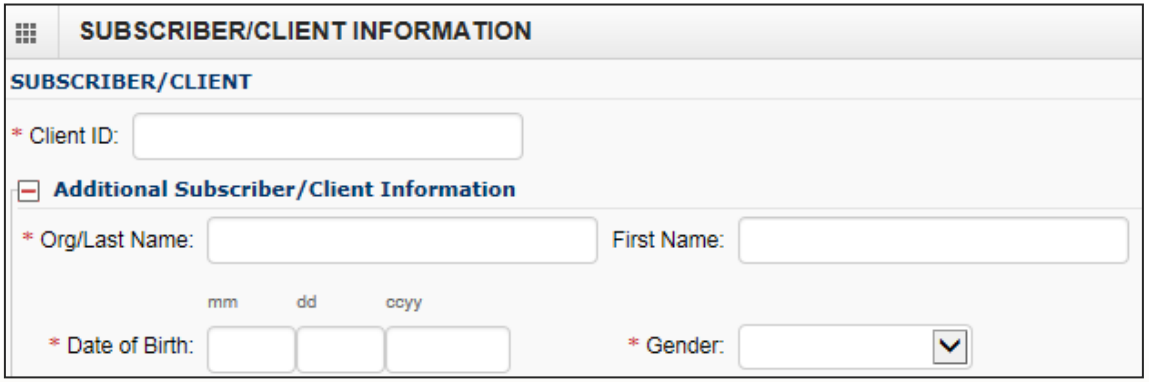
  - Enter the Subscriber/Client ID found on the WA Medicaid services card. This ID is a 9-digit number followed by **WA**.
    - Example: **999999998WA**



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

Direct Data Entry (DDE) Claims

- Section 2: Subscriber/Client Information (continued)
  - 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**.
    - The First Name field is not marked with a red asterisk and is not required.

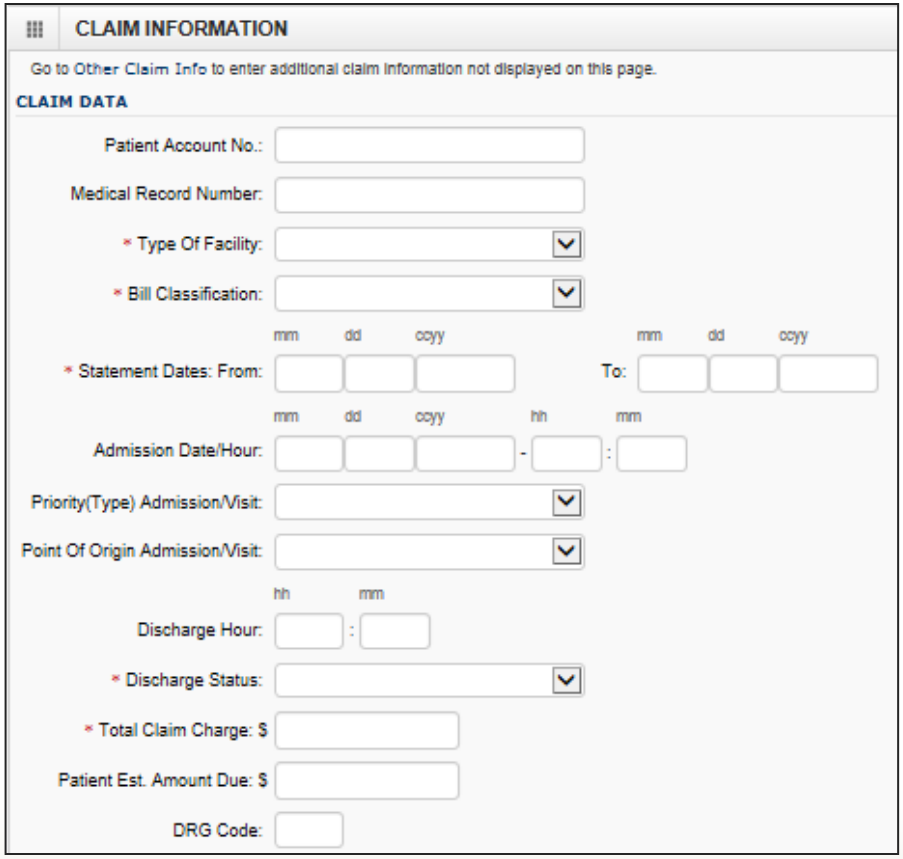


Direct Data Entry (DDE) Claims

➢ Section 3: Claim Information

- The next section is for Claim Information. The next few slides will go over each of these boxes.

Note: Not all information demonstrated here is required on an institutional claim. This will depend on the type of institutional claim you are billing.



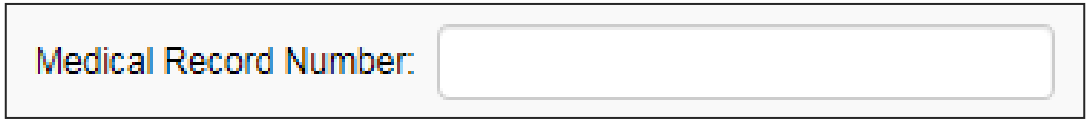
Direct Data Entry (DDE) Claims

- 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.

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.

Direct Data Entry (DDE) Claims

- Medical Record Number
  - The Medical Record Number field allows the provider to enter their internal medical record numbers that have been assigned by their practice management system.



Note: The Medical Record Number is an optional step. If one is not entered continue on to the next question.

Direct Data Entry (DDE) Claims

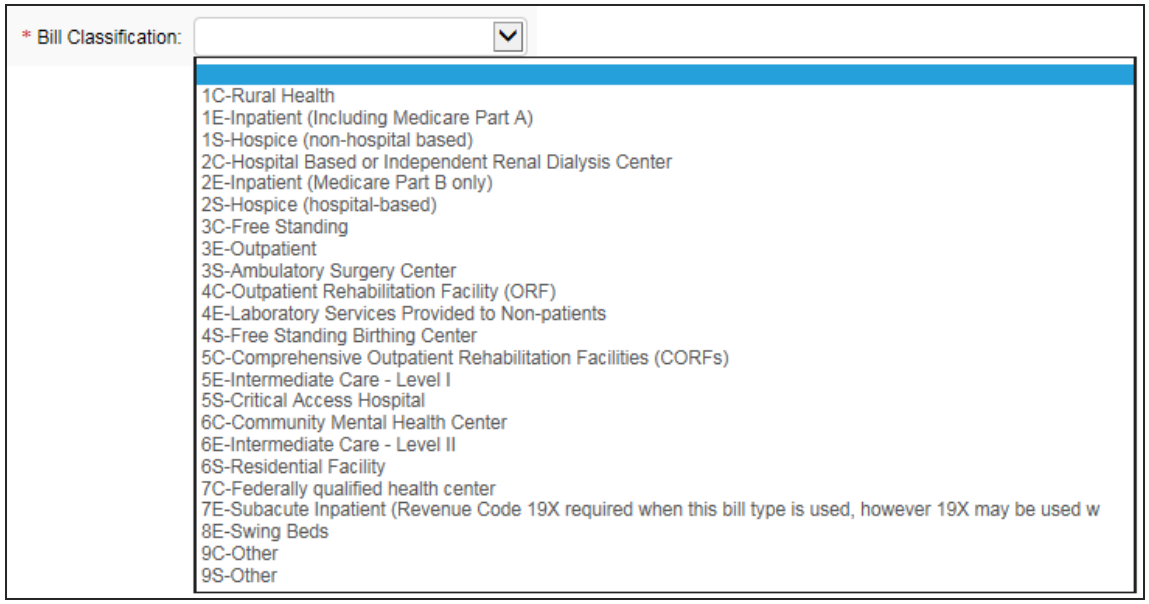
- Type of Facility
  - Enter the Type of Facility using the drop down option.

Note: The Type of Facility is a required field on every institutional claim submitted.

Direct Data Entry (DDE) Claims

➢ Bill Classification

- Enter the Bill Classification using the drop down option.



Note: The Bill Classification is a required field on every institutional claim submitted.

Direct Data Entry (DDE) Claims

- Statement Dates
  - Enter the From and To dates of service.

Note: The date of service must be in the format of a 2 digit month, 2 digit day, and 4 digit year (e.g. 10/01/2016).

Note: Statement Dates is a required field on every institutional claim submitted.

Direct Data Entry (DDE) Claims

- Admission Date/Hour
  - Enter the Admission Date and Admission Hour/Minute.

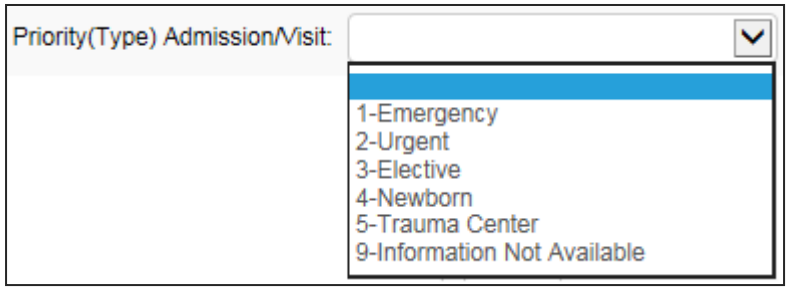
Note: The date of service must be in the format of a 2 digit month, 2 digit day, and 4 digit year (e.g. 10/01/2016).

Note: The hours and minutes must appear in 24 hour time. The format must be in the 2 digit hour and 2 digit minute. For example 3:30 pm in standard time would be 15:30 in 24 hour time.

Note: The Admission Date is a situational field. It is only needed on inpatient claims.

Direct Data Entry (DDE) Claims

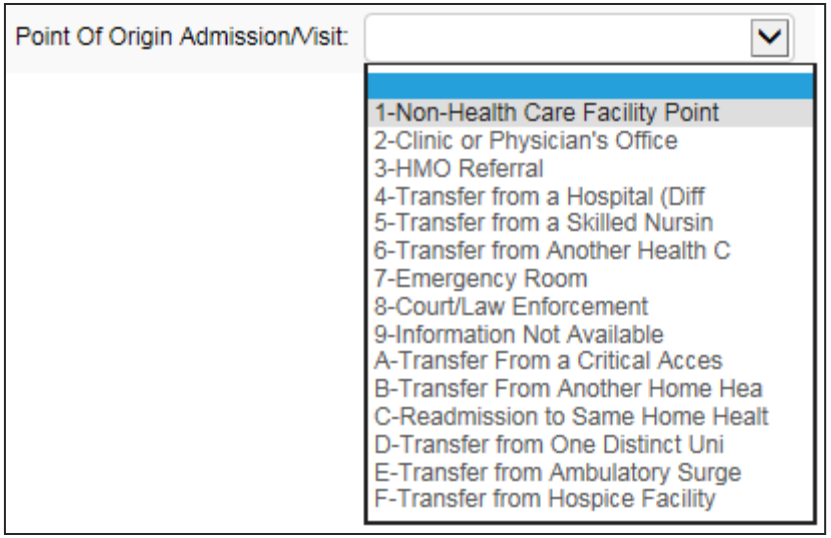
- Priority (Type) Admission/Visit
  - Enter the correct Priority (Type) Admission/Visit from the drop down menu.



Note: This is a situational field. It is only needed on inpatient claims.

Direct Data Entry (DDE) Claims

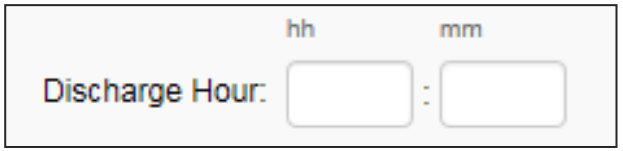
- Point of Origin Admission/Visit
  - Enter the correct Point of Origin Admission/Visit from the drop down menu.



Note: This is a situational field. It is only needed on inpatient claims.

Direct Data Entry (DDE) Claims

- Discharge Hour
  - Enter the correct Discharge Hour and Minute.

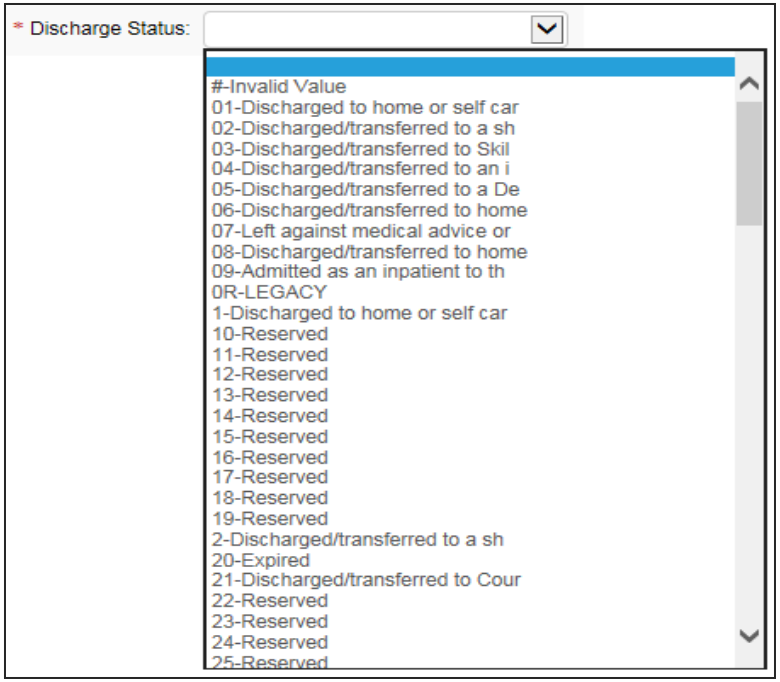


Note: The hours and minutes must appear in 24 hour time. The format must be in the 2 digit hour and 2 digit minute. For example 3:30 pm in standard time would be 15:30 in 24 hour time.

Note: This is a situational field. It is only needed on inpatient claims.

Direct Data Entry (DDE) Claims

- Discharge Status
  - Enter the correct Discharge Status using the drop down menu.



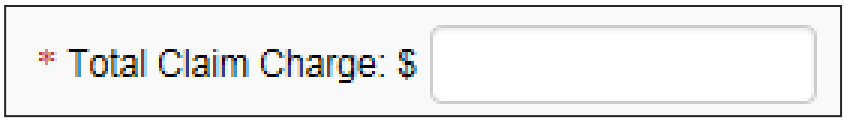
Note: There are more options listed on the drop down than shown on this slide.

Note: This field is required on every institutional claim submitted.

Direct Data Entry (DDE) Claims

- Total Claim Charge

  - Enter the correct Total Claim Charge for the claim.



Note: The total claim charge must match the total of all the service lines on the claim.

Note: This field is required on every institutional claim submitted.

Direct Data Entry (DDE) Claims

- Patient Est. Amount Due

  - Enter the correct Patient Est. Amount Due for the claim.

Note: The Patient Est. Amount due is a situational field on the institutional claim. Do not enter the spenddown amount here as it is entered as a Value Code on the institutional claim. See the Value Code slide below.

Direct Data Entry (DDE) Claims

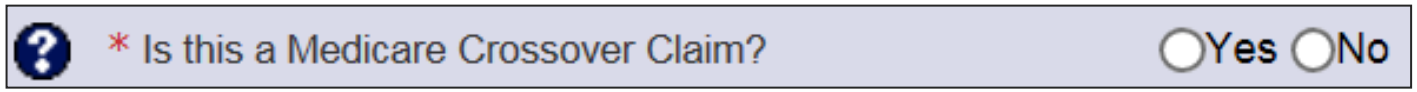
- DRG Code

  - Enter the DRG Code for the claim.

Note: The DRG code is not required to be entered. ProviderOne will determine the correct DRG code to put on the claim by the data that is billed such as diagnosis and procedure codes.

Medicare Crossover Claim

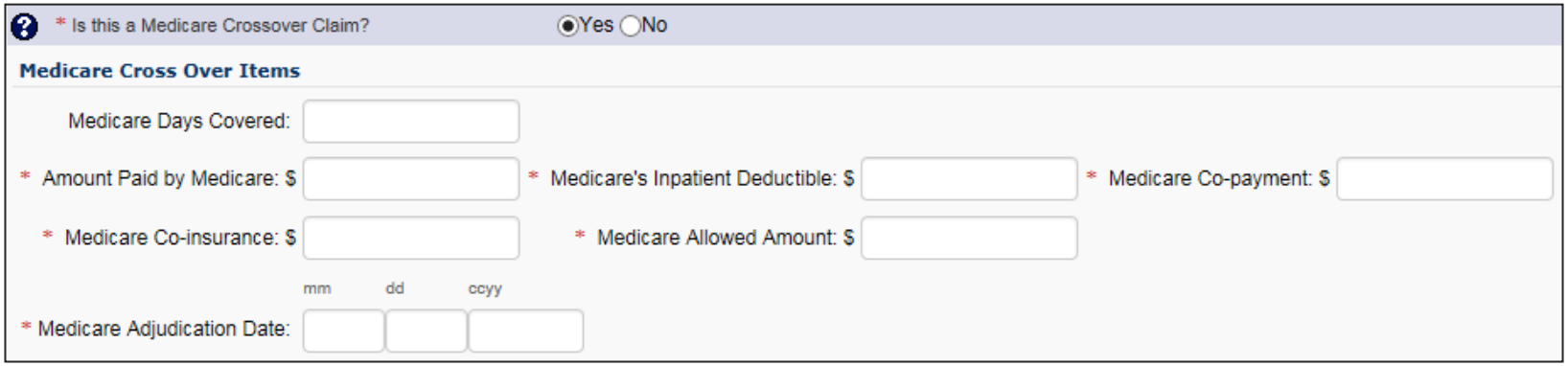
- If Medicare did not make a payment answer the question "**NO**."



Note: Apple Health Medicaid considers a claim as a crossover when Medicare allows the service. If Medicare makes a payment, applies the charges to a deductible, coinsurance, or copayment, you must answer the question Yes to expand the Medicare Cross Over Items and enter those amounts even if a zero dollar payment.

Medicare Crossover Claim

- If the claim is considered a Medicare Crossover, answer the question **Yes**. This includes Managed Medicare Advantage Plans (Medicare Part C). Answering **Yes** will open additional required questions to be filled out. This information will come from the Medicare EOMB.



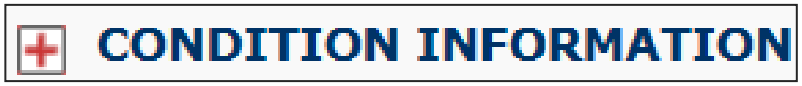
Note: Apple Health Medicaid considers a claim as a crossover when Medicare allows the service. If Medicare makes a payment, applies the charges to a deductible, coinsurance, or copayment, you must answer the question Yes to expand the Medicare Cross Over Items and enter those amounts even if a zero dollar payment.

Additional Claim Data and EPSDT Information

Note: The Additional Claim Data and EPSDT Information red (+) expander is **NOT** needed for institutional claims at this time. You can skip over this and continue on to the next section.

Condition Information

- If the claim requires a Condition Code use the red (+) expander to enter this information. If no Condition Code is needed proceed to the next question.



Note: ProviderOne will allow for more than one Condition Code to be added. Click on the Add Another option and ProviderOne will display additional boxes for entry of this information.

Occurrence Information

- If the claim requires an Occurrence Code use the red (+) expander to enter this information. If no Occurrence Code is needed proceed to the next question.

Note: ProviderOne will allow for more than on Occurrence Code to be added. Click on the Add Another option and ProviderOne will display additional boxes for entry of this information.

Note: The date of service must be in the format of 2 digit month, 2 digit day, and 4 digit year (e.g. 01/01/2016).

Occurrence Span Information

- If the claim requires an Occurrence Code Span use the red (+) expander to enter this information. If no Occurrence Code Span is needed proceed to the next question.

Note: ProviderOne will allow for more than one Occurrence Code Span to be added. Click on the Add Another option and ProviderOne will display additional boxes for entry of this information.

Note: The date of service must be in the format of 2 digit month, 2 digit day, and 4 digit year (e.g. 01/01/2016).

Value Information

- If the claim requires an Value Code and Value Amount use the red (+) expander to enter this information. If no Value Code and Value Amount is needed proceed to the next question.

Note: ProviderOne will allow for more than one Value Code and Value Amount to be added. Click on the Add Another option and ProviderOne will display additional boxes for entry of this information.

Note: This is where a client's spenddown will be reported. Enter the spenddown value code of 66, and then enter the patient participation amount. For patients that have an EMER participation amount, enter that as value code (D3) and then enter the participation amount.

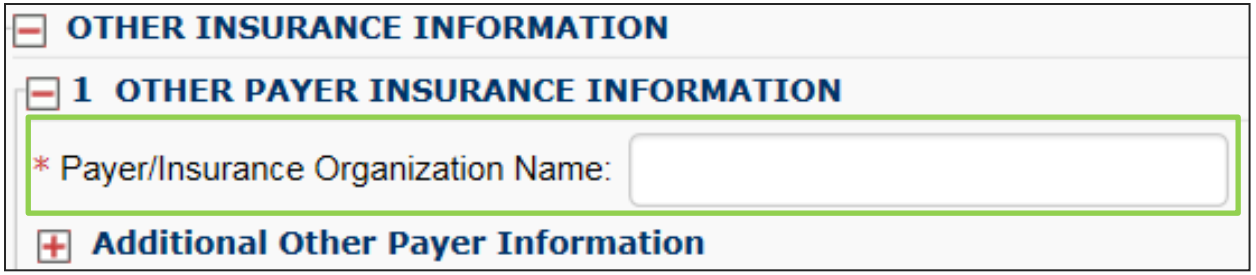
Other Insurance Information

- If the client **ONLY** has Washington Apple Health coverage, continue to the next question.
- If the client **DOES** have insurance other than Washington Apple Health, this information will need to be entered by clicking the red (+) expander for Other Insurance Information.

Please Note: If you know an Apple Health client has a commercial insurance and you do not see a Coordination of Benefits Information segment on their eligibility file in ProviderOne, you must complete a Contact Us email. Choose the option "I am an Apple Health (Medicaid) biller or provider" and then choose the "Medical Provider" button. On the "Select Topic" dropdown, choose "Private Commercial Insurance." Enter the client's insurance information in the "Other Comments" section. The agency's Coordination of Benefits unit will update the client's file using this information. Check eligibility again in ProviderOne in 3 – 5 business days to verify the update has been made. Only after verification of this information in ProviderOne should you bill the claim to the system.

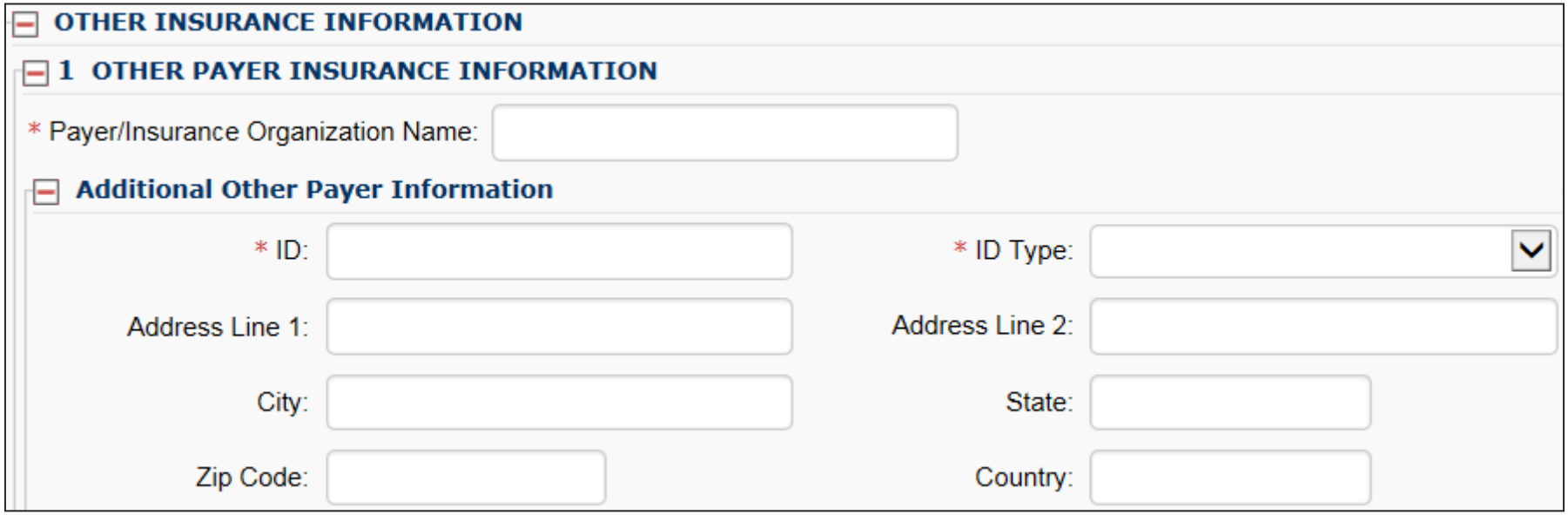
Other Insurance Information

- Click on the red (+) expander titled 1 Other Payer Insurance Information.
- Enter the Payer/Insurance Organization Name.
- Click on the red (+) expander titled Additional Other Payer Information.



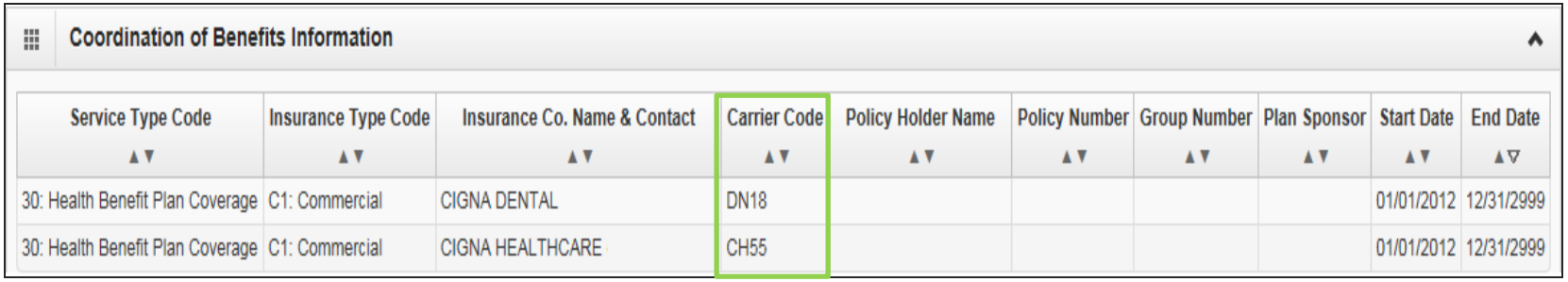
Other Insurance Information

- In the Additional Other Payer Information section fill in the following:
  - ID (carrier code)
  - ID Type



Other Insurance Information

- What ID number do I use in the Additional Other Payer Information section?
  - Use the Insurance Carrier Code found on the client eligibility screen.

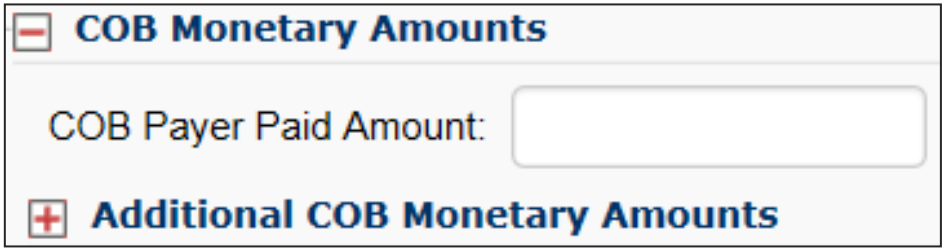


Coordination of Benefits Information

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

Other Insurance Information

- Click on the red (+) expander and open the COB Monetary Amounts section:
  - Enter the amount paid by the commercial insurance company.



Note: If you ARE going to fax or mail in the EOB from the primary insurance, stop after entering the COB Payer Paid Amount.

If you complete the fields as shown on the following slide, you do NOT need to fax or mail in your EOB. The claim will process faster if it does not have to be held waiting for the backup to be received.

Other Insurance Information

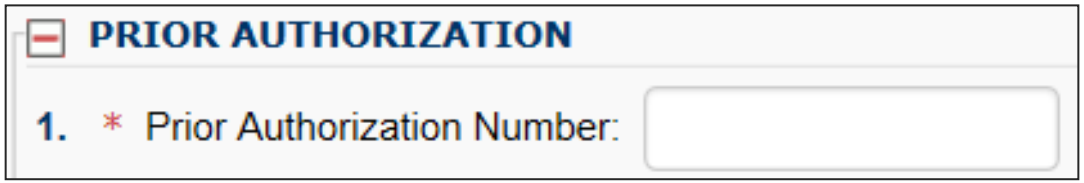
- Click on the red (+) expander and open the Claim Level Adjustments section:
  - Enter at least one each of the following:
    - Group Code
    - Reason Code
    - Amount

Note: If you complete these fields, you do not need to fax or mail in the EOB from the primary payer.

Note: The Agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the X12 organization's website.

Prior Authorization

- If a prior authorization number needs to be added to the claim, click on the red (+) expander and open the Prior Authorization fields.

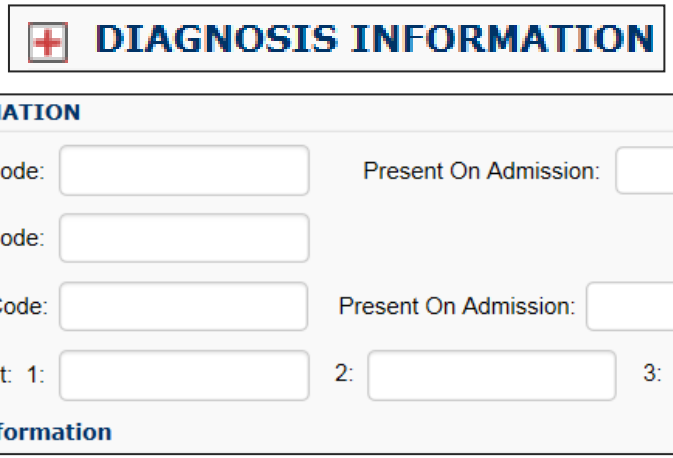


Note: For institutional claims this is the only area to enter an authorization number. If more than one authorization number needs to be added, enter the additional number in the Billing Note section.

- For more information on prior authorization, visit the Prior authorization webpage!

Diagnosis Information

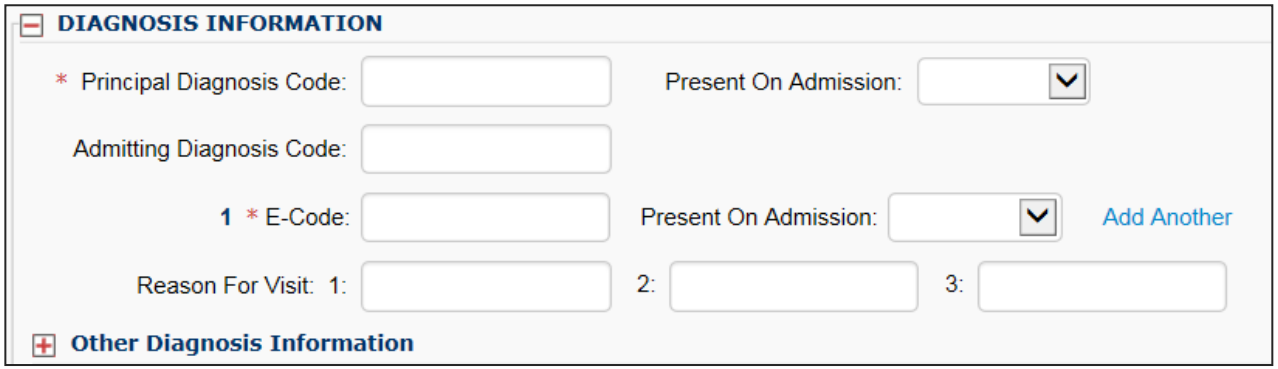
- All institutional claims require a Principle Diagnosis Code and Admitting Diagnosis Code. Click on the red (+) expander and open the Diagnosis Information fields to enter these codes.



- Note: The agency requires present on admission (POA) indicators on all inpatient claims. All inpatient claims will be reviewed for health care acquired conditions (HCAC) and will not receive additional payment related to treatment of the HCAC. For more information, see WAC 182-502-0022.
- Note: E-codes are not required but are situational.

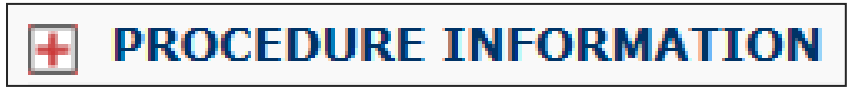
Diagnosis Information

- If more than one diagnosis code needs to be attached to the claim use the red (+) expander titled Other Diagnosis Information to add in these additional codes. Use the Add Another option to continue adding more codes.



Procedure Information

- Enter the applicable procedure codes to be billed on the claim here for inpatient claims. Use the red (+) expander to enter the Procedure Information fields.

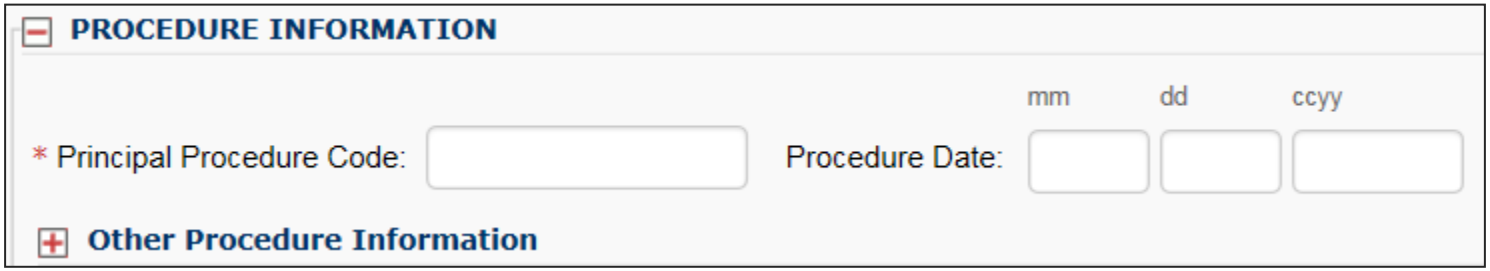


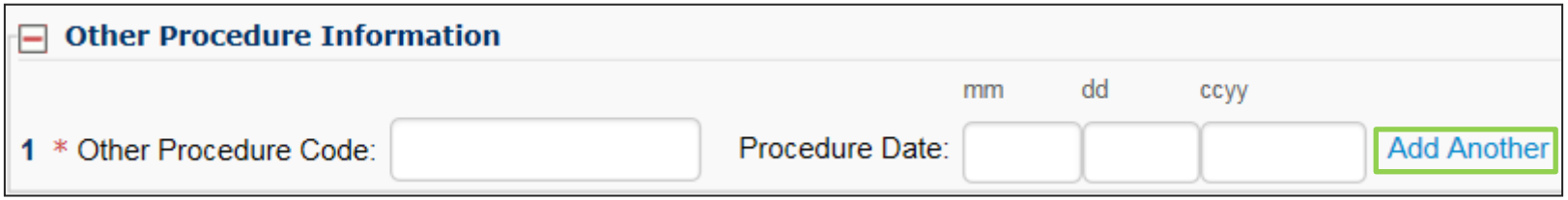
Note: Outpatient procedure codes will be entered at the line level of the claim.

Note: The date of service must be in the format of 2 digit month, 2 digit day, and 4 digit year (e.g. 10/01/2016).

Procedure Information

- Use the Other Procedure Information red (+) expander to enter additional procedure codes.

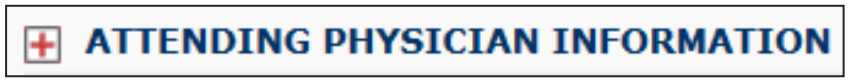


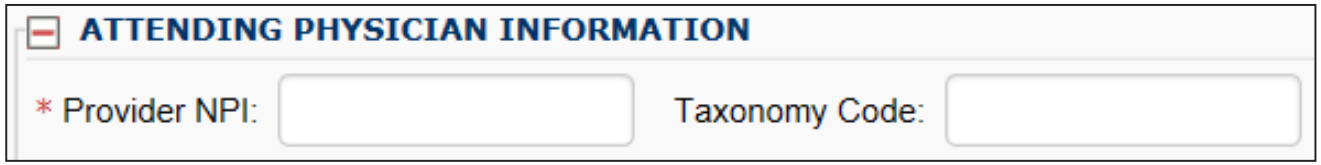


Note: If billing a surgical code it is required to enter the surgery date. To add additional procedure codes click on the **Add Another** option until all procedure codes have been added.

Attending Physician Information

- All institutional claims require an Attending Provider NPI. Click on the red (+) expander to enter the NPI and taxonomy code for the Attending Provider.





Note: The taxonomy of the Attending Physician is not a required field.

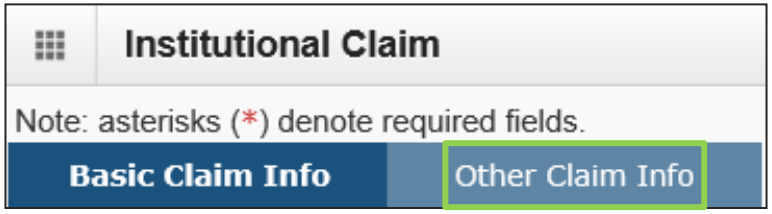
Billing Note

- To add a Billing Note, click on the red (+) expander to open the billing note section.
- Enter the Type Code and Note. ProviderOne will allow up to 80 characters.

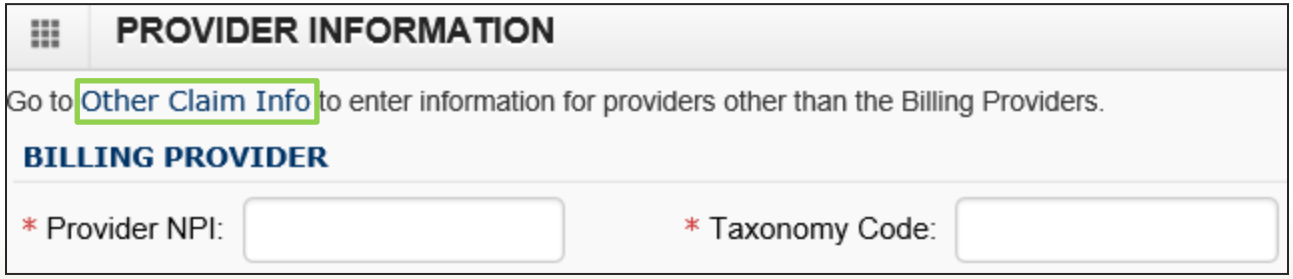
Note: Recent system changes to ProviderOne have changed how claim notes are read. If a specific program or service requires you to enter a claim note as instructed in a program billing guide, they will still be read by the system. If no claim note is needed, skip this option.

Other Claim Info

- The Other Claim Info tab allows entry of other physician information. This is an optional step and is not required, however if there is a need to add additional providers, click on the Other Claim Info tab in the upper left corner of the claim form or the hyperlink above the Billing Provider section.

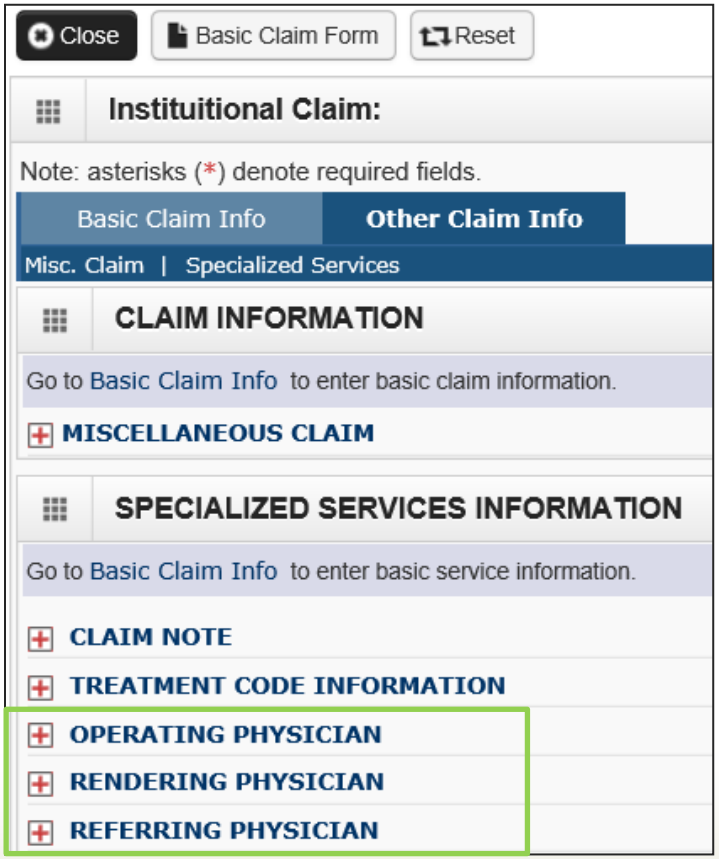


-OR-



Other Claim Info

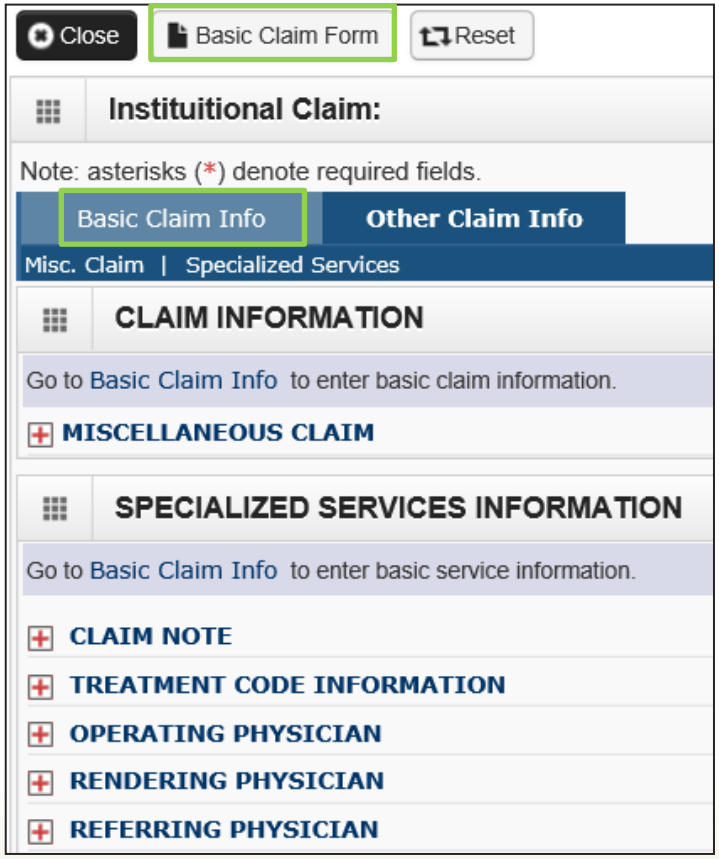
- Enter the appropriate other physician information as needed by clicking on the red (+) expander.



Note: Only the provider NPI number is needed in these areas.

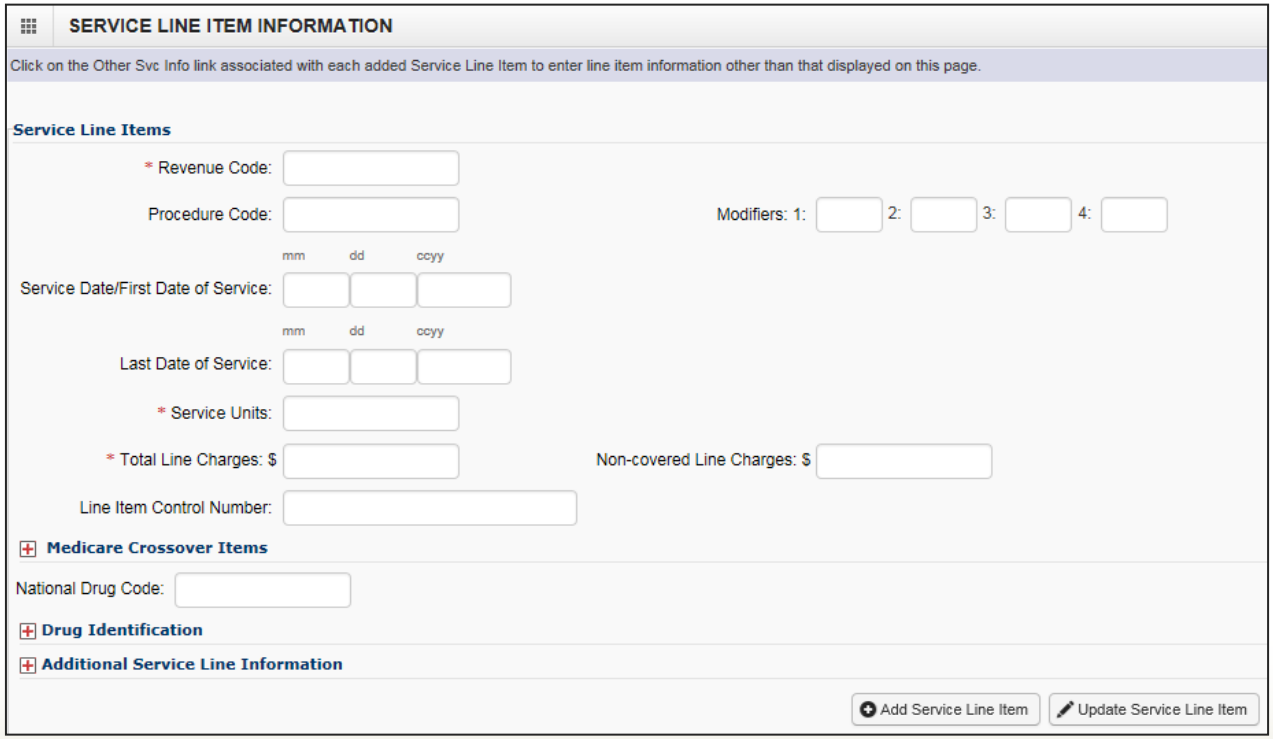
Other Claim Info

- Click on either the Basic Claim Form button or the Basic Claim Info tab to return to the main claim screen.



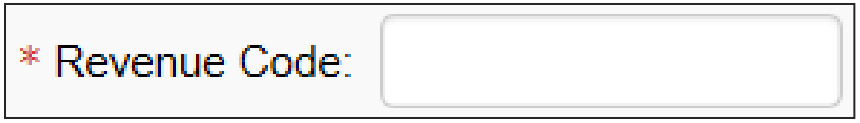
Service Line Item Information

- Section 4: Service Line Item Information
  - The next few slides will show what is needed on the service lines for the institutional claim.



Service Line Item Information

- Revenue Code
  - Enter the appropriate Revenue Code. This should be a four (4) digit number.



Service Line Item Information

- Procedure Code
  - Enter the Procedure Code. This will be used for Outpatient claims only.

Service Line Item Information

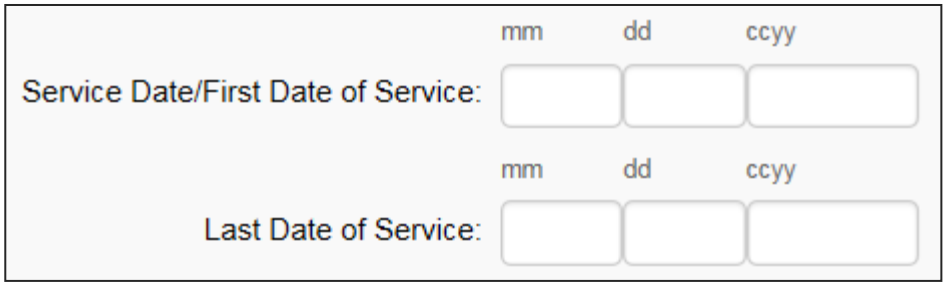
➢Modifiers

- Enter any appropriate Modifiers for outpatient procedures.

Service Line Item Information

➢Service Date

- Enter the appropriate Service Date/First Date of Service and Last Date of Service.



Note: The date of service must be in the format of a 2 digit month, 2 digit day, and 4 digit year (e.g. 01/01/2016).

Service Line Item Information

➢Service Units

- Enter the total Service Units for the procedure.

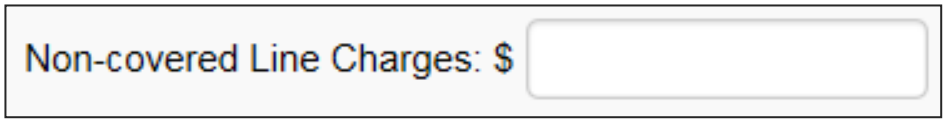
Service Line Item Information

➢Total Line Charges

- Enter the Total Line Charges for the procedure.

Service Line Item Information

- Non-Covered Line Charges
  - Enter any Non-Covered Line Charges for the procedure.



Service Line Item Information

- Line Item Control Number
  - The Line Item Control Number is not needed for submission of an institutional claim.

Service Line Item Information

- Medicare Crossover Items
  - The Medicare Crossover Items does not need to be filled out at the line level.

Service Line Item Information

➢National Drug Code

- Enter the National Drug Code for any injectable procedure.

Service Line Item Information

- Drug Information
  - The Drug Information section is not needed for the submission of the institutional claim.

Service Line Item Information

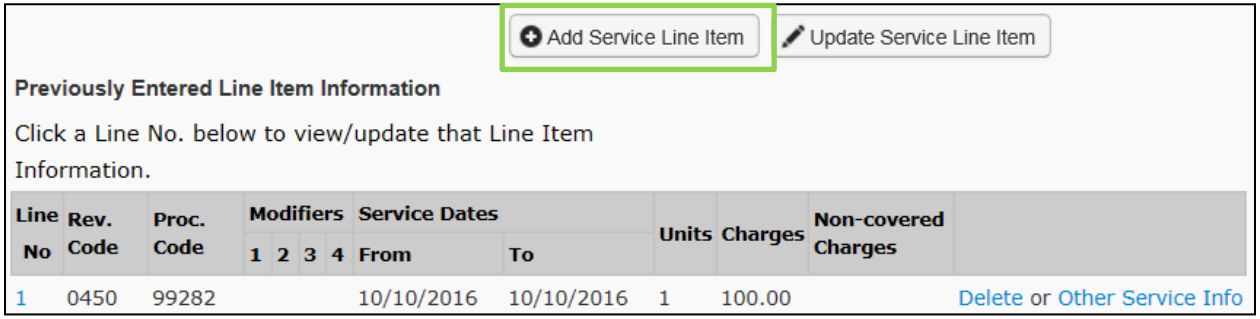
- Additional Service Line Information

  - Additional Service Line Information is not needed for the submission of an institutional claim.

Service Line Item Information

➢Add Service Line Items

- Click on the Add Service Line Item button to add the procedure line onto the claim.



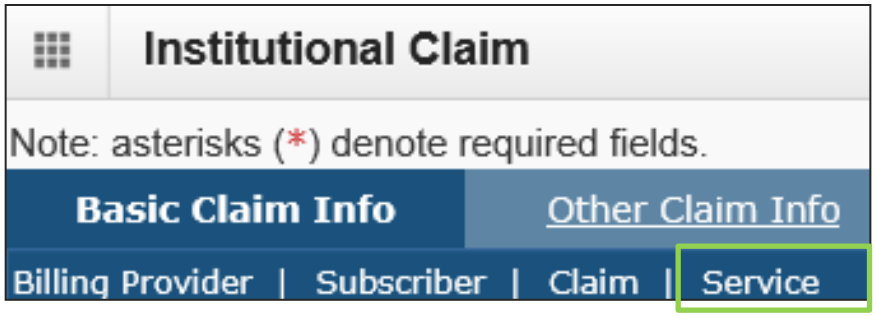
Note: Please ensure you have entered all necessary claim information before clicking the Add Service Line Item button.

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

Service Line Item Information

➢Add Additional Service Line Items

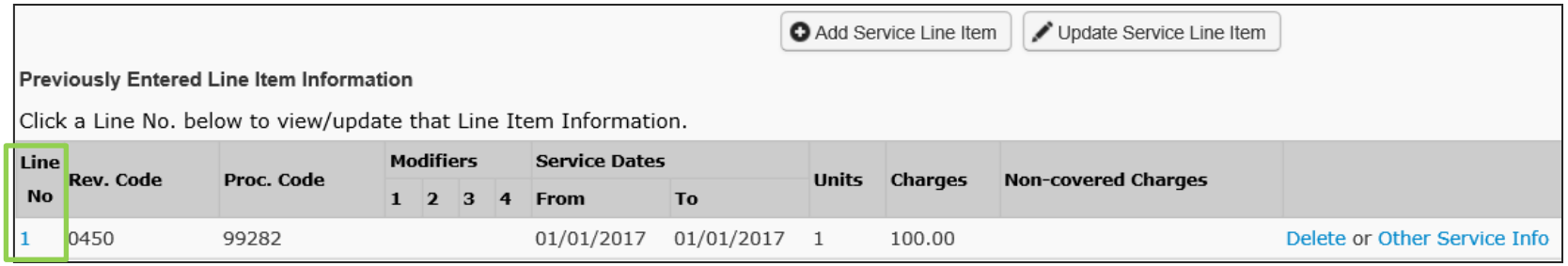
- If additional service lines need to be added, click on the Service hyperlink to get quickly back to the Basic Service Line Items section.
- Follow the same process for entering data for the additional line items.



Service Line Item Information

➢Update Service Line Item

- If you need to correct or update a previously added service line, click the number next to the line that needs to be updated. This will repopulate the service line item boxes for changes to be made.

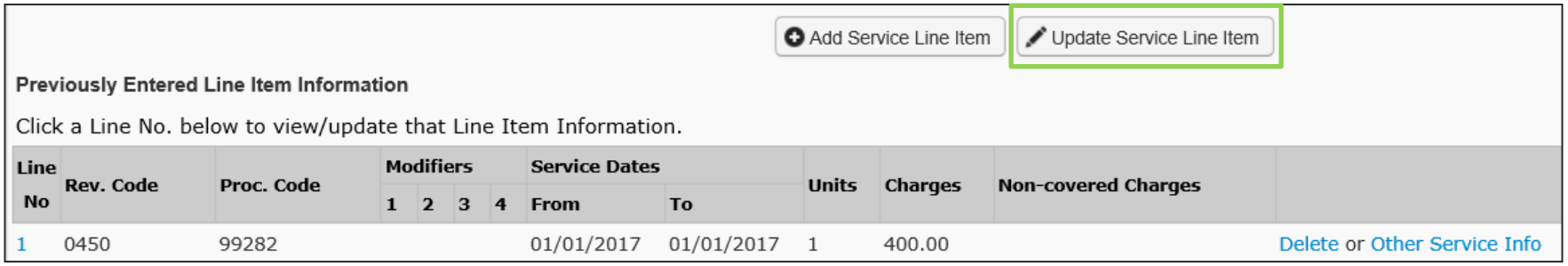


Note: Once the line number is chosen, ProviderOne will refresh the screen and return to the top of the claim form. Use the Service hyperlink to quickly return to the service line item boxes to make corrections.

Service Line Item Information

➢Update Service Line Items

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

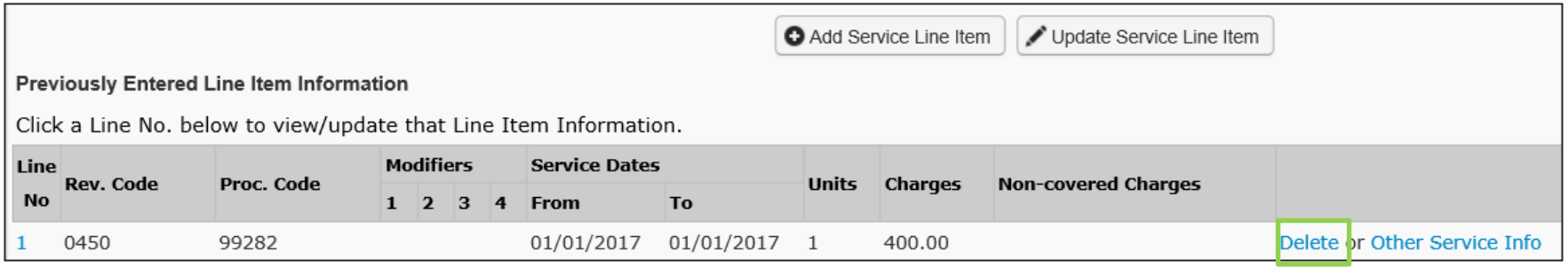


Note: Once the Update Service Line Item is chosen, ProviderOne will refresh the screen and return to the top of the claim form. Use the Service hyperlink to quickly return to the service line item section to view and verify that your changes were completed.

Service Line Item Information

➢Delete Service Line Items

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



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

Submitting the Claim

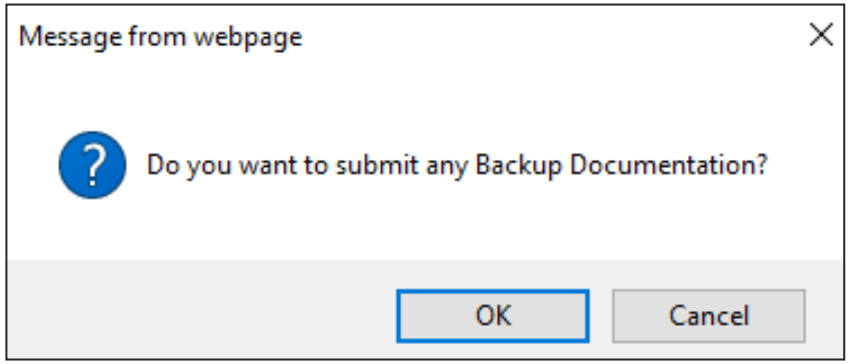
➢Submit Claim for Processing

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

Submitting the Claim

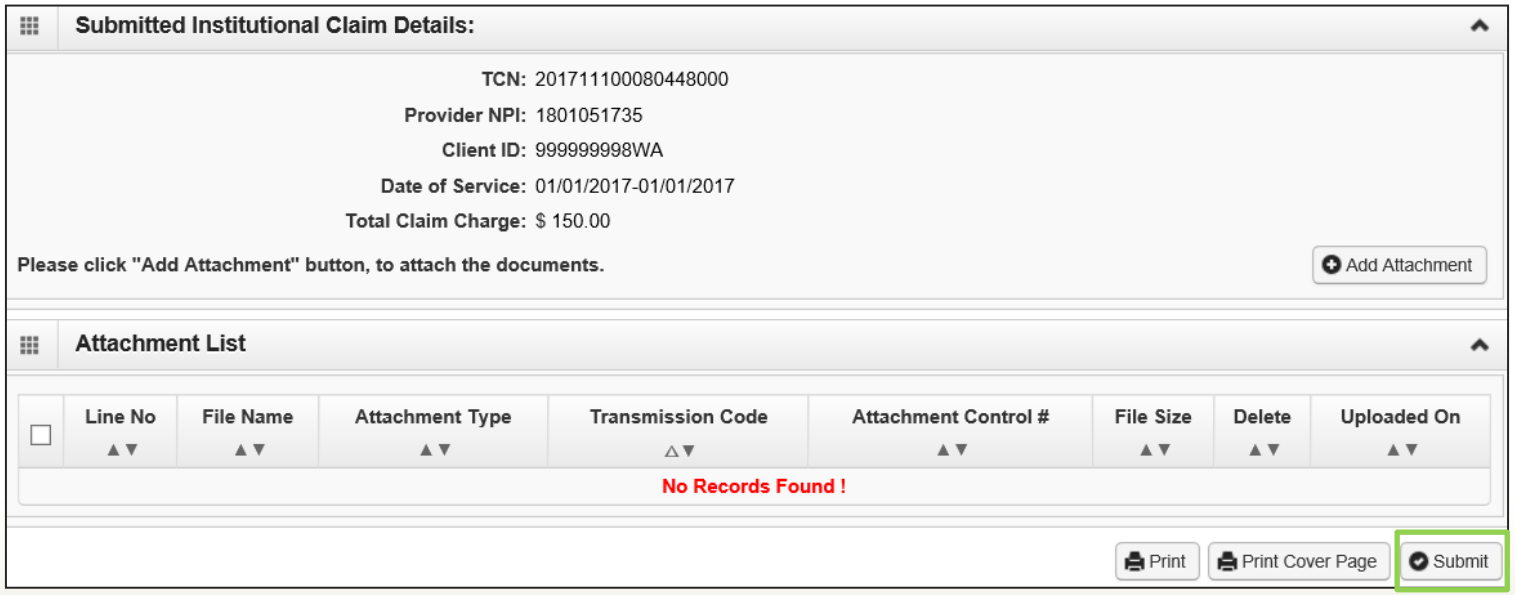
➢Submit Claim for Processing

- Click on the Ok button if you have backup to submit with the claim.
- Click on the Cancel button if no backup needs to be submitted with the claim.



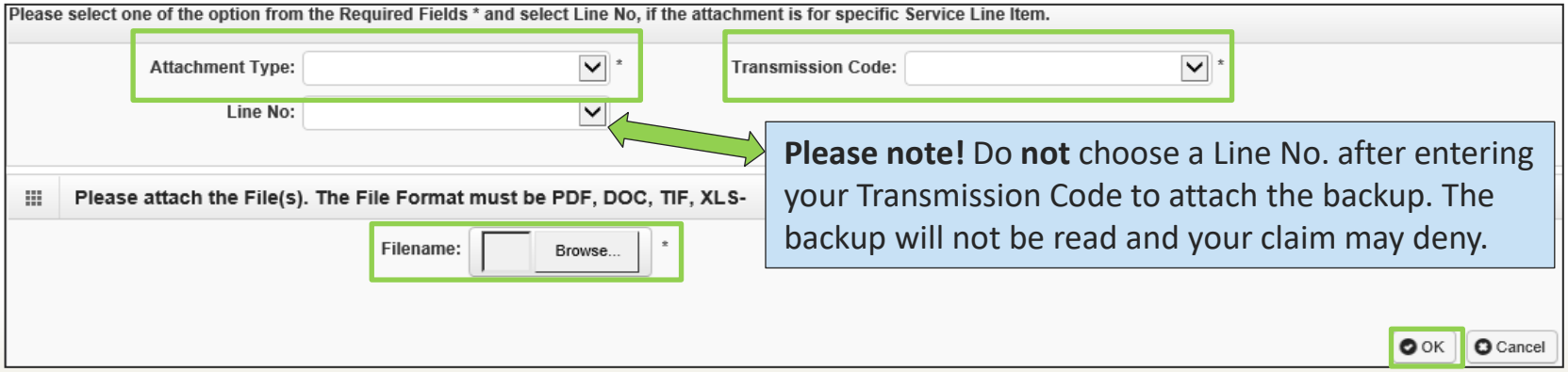
Submitting the Claim

- Submit Claim for Processing – No Backup
  - ProviderOne now displays the Submitted Institutional Claim Detail screen.
  - Click on the Submit button to finalize the submission of the claim.



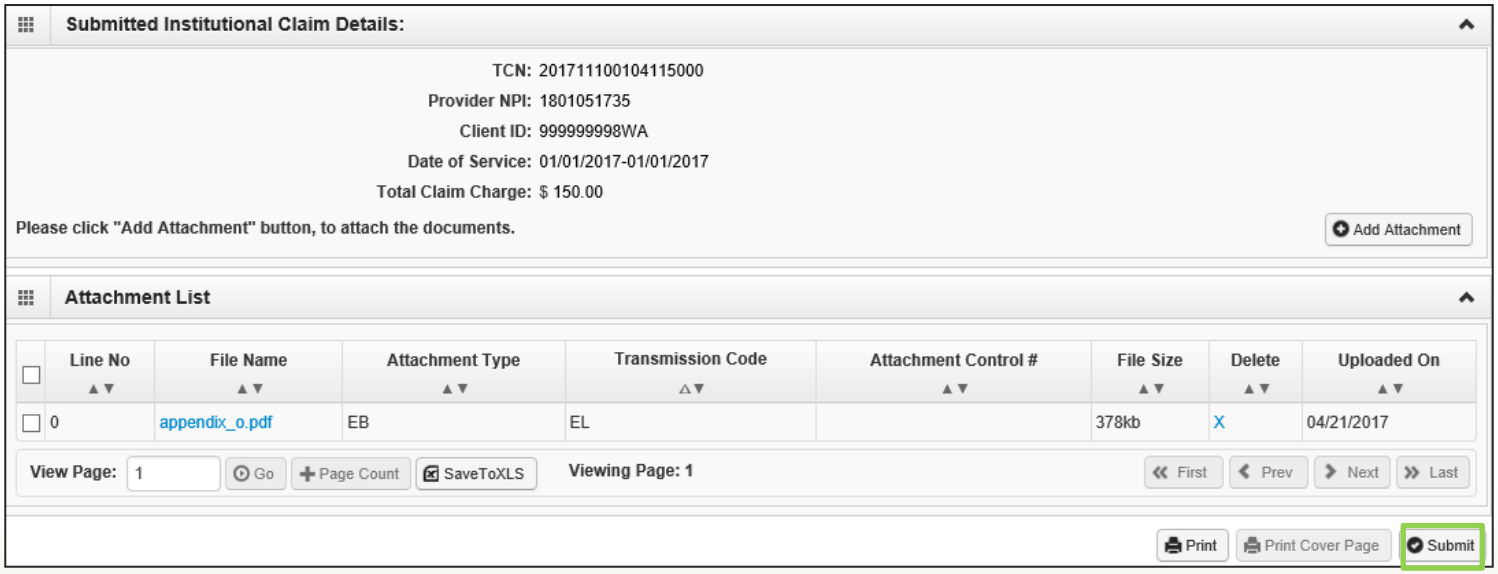
Submitting the Claim

- Submit Claim for Processing – With Backup (Attaching an Electronic File)
  - If you clicked Ok when asked if you want to submit backup documentation:
    - ProviderOne displays the Claims Backup Documentation screen.
    - Enter the Attachment Type from the dropdown.
    - Choose the Transmission Code of EL-Electronically Only.
    - Click on the Browse button to find the electronic file to attach to the claim.
  - Click the OK button.



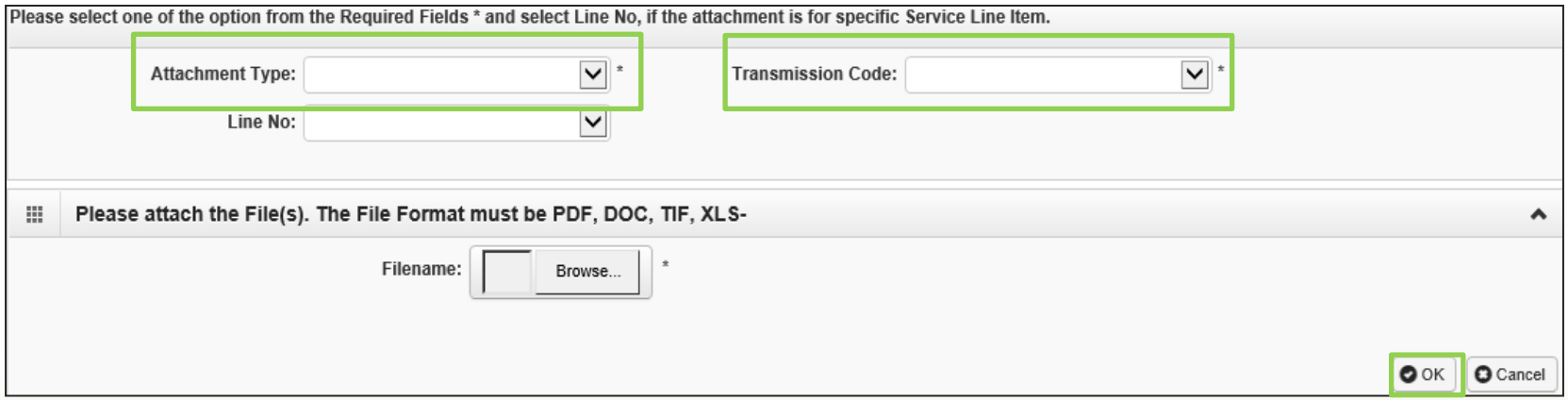
Submitting the Claim

- Submit Claim for Processing – With Backup (Attaching an Electronic File)
  - ProviderOne now displays the Submitted Institutional Claim Detail screen.
  - Click on the Submit button to finalize the submission of the claim.



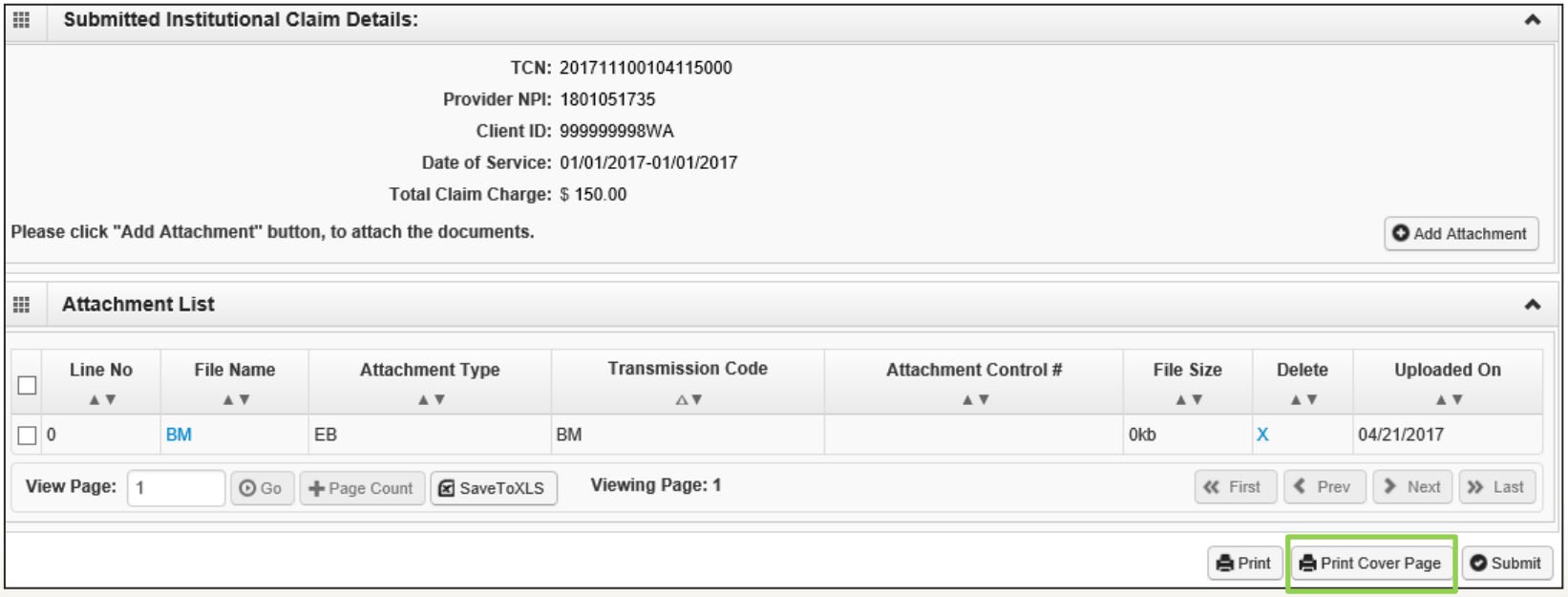
Submitting the Claim

- Submit Claim for Processing – With Backup (Mailing or Faxing)
  - ProviderOne displays the Claims Backup Documentation screen:
    - Enter the Attachment Type from the dropdown.
    - Choose the Transmission Code of BM-By Mail or FX-By Fax.
    - Do **not** choose a Line No.
  - Click the OK button.



Submitting the Claim

- Submit Claim for Processing – With Backup (Mailing or Faxing)
  - If you are sending backup by mail or fax, you must include a cover sheet. At the Submitted Institutional Claim Details page click on the Print Cover Page button.



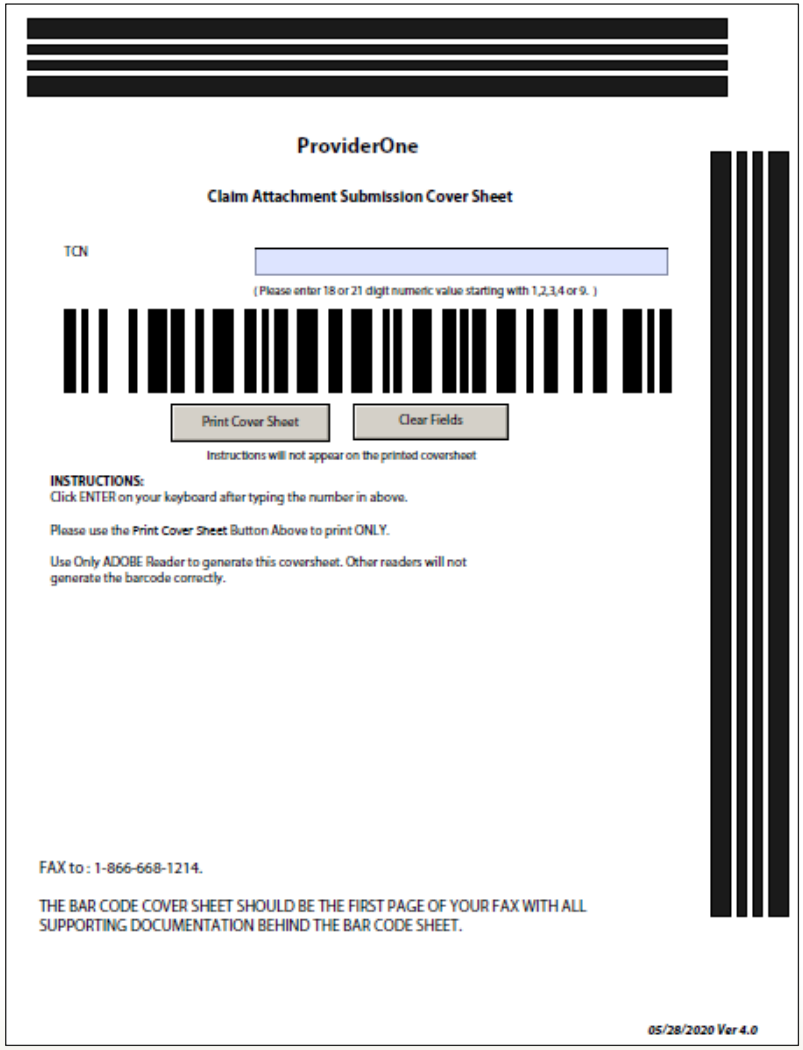
Submit Claim for Processing – With Backup

- Fill in the TCN number received on your claim confirmation screen. Click outside this field or tab to expand the barcode.
- 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

Claim Attachment Submission Cover Sheet

TCN

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

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.

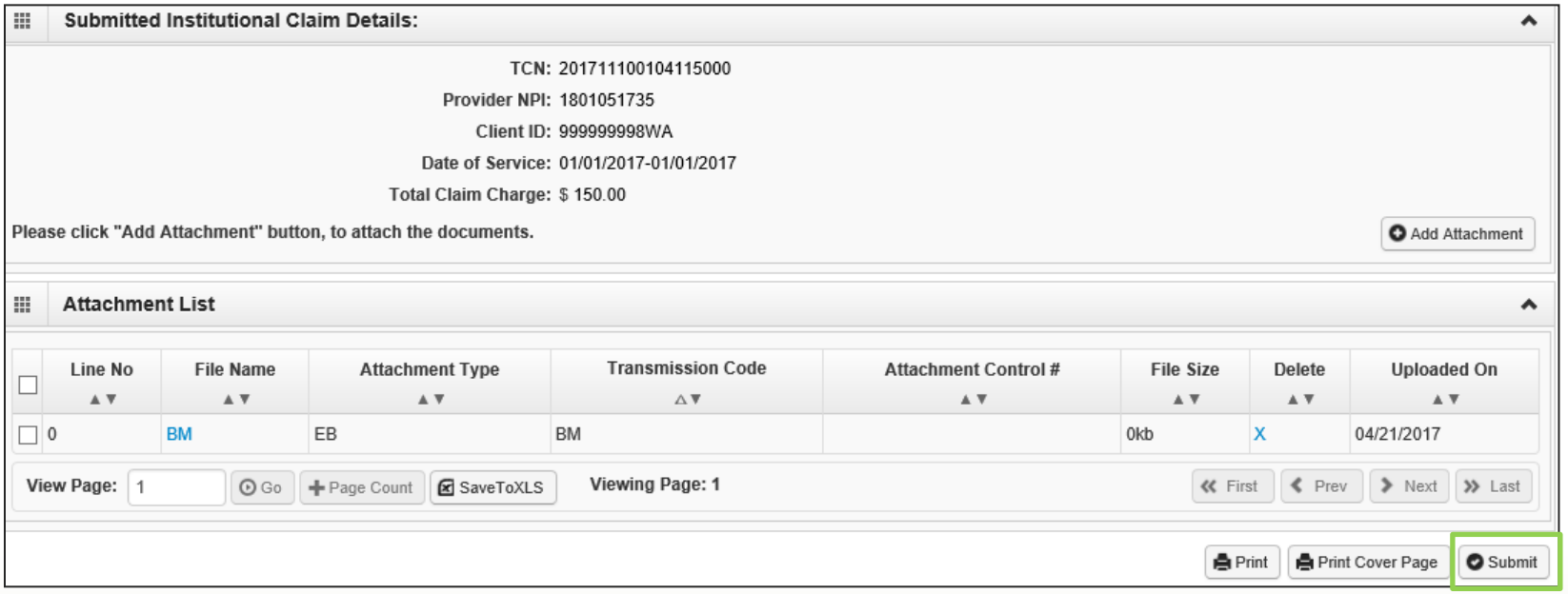
FAX to : 1-866-668-1214.

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

05/28/2020 Ver 4.0

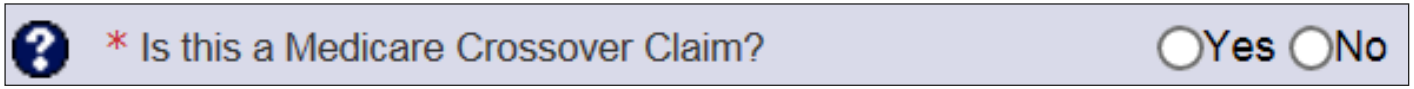
Submitting the Claim

- Submit Claim for Processing – With Backup (Mailing or Faxing)
  - Click on the Submit button to finalize the submission of your claim.

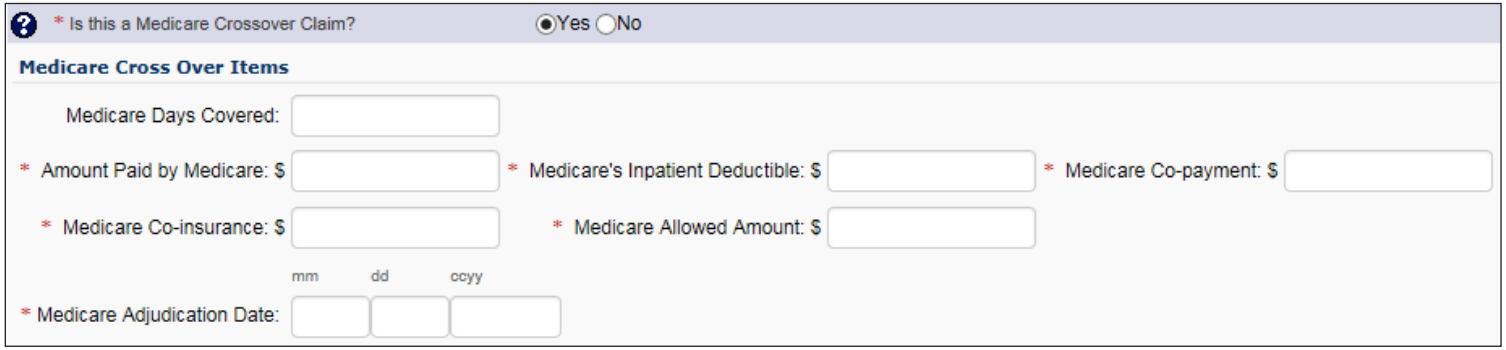


Billing Cross Overs with TPL Information

- If a client has both Medicare and commercial insurance, you can bill a crossover claim through DDE and then add the commercial insurance information on the same claim.
  - On the Institutional DDE claim screen answer “Yes” to the question if Medicare is Primary.



  - Then fill in the Medicare payment information.



  - Complete the commercial insurance information screens as discussed earlier in the presentation.
  - No Medicare EOB is required with this claim.

Online Resources

- Programs and Services information
- Program billing guides and fee schedules
- Hospital rates
- Provider Enrollment webpage and email
- Learn ProviderOne
- HCA Forms webpage
- Washington Administrative Code webpage