
Client Eligibility, Benefit Packages, and Coverage Limits

Making Sure You Can Get Paid For Services Covered through Medical Assistance

This Chapter shows how to Determine:

- If the client has Medical Assistance.
- If a service is covered under the client's Benefit Service Package.
- If the client is enrolled in a Medical Assistance Managed Care Plan.
- When prior authorization is required.
- When and if a waiver can be used to bill a client.
- If the client has a spenddown balance that may affect eligibility.
- Any special limitations or restrictions.
- If the client has reached their maximum for services with limitations.
- Who to bill so payment is not delayed.

Why is Checking Eligibility and Benefit Coverage Important?

The Agency denies many claims because the client was not eligible for Medical Assistance on the date of service. To prevent billing denials, please check the client's eligibility **prior** to providing services.

Checking eligibility and coverage limits requires little time compared to the level of effort a providers office staff experience when following up on a denied claim. Denied claims cost provider organizations time spent researching and rebilling denied claims or writing off costs for services that cannot collect on.

Some procedures may require that providers satisfy certain conditions in order to be reimbursed for the service - such as determining whether a service requires prior authorization. Research these requirements before providing a service.

If the service is not covered and the client chooses to receive and pay for a specific service, providers may be able to bill the client. Please see [Memo 10-25](#) or [WAC 182-502-0160](#) for rules on billing a client.

Disclaimer

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

The Key Steps

- 1. Determine if the Client Has Medical Assistance Coverage**
- 2. Identify the Primary Payer**
- 3. Review the Client's Benefit Service Package**
- 4. Review the Foster Care Client's Medical Records History**
- 5. Determine if Medical Assistance Covers the Service and if so, is Prior Authorization (PA) Required**
- 6. Determine if the Client's Benefit Limitations Have Been Met**

Key Step

1

1. Determine if the Client Has Medical Assistance Coverage

Why

The provider is responsible to verify whether the client has Medical Assistance coverage for the date of service, and if so, to check the limitations of the client's medical program. This helps prevent delivering a service the Agency won't pay for.

Providers may also choose to confirm eligibility when making an appointment for a client. This could help avoid turning the client away at check-in. Checking eligibility when making an appointment can also help determine if the client needs [free interpreter services](#) for the appointment.

How

There are many methods to check client eligibility. Most of these methods involve accessing ProviderOne.

- Access ProviderOne to submit an eligibility inquiry using one of these methods:
 - Search for eligibility information via ProviderOne at <https://www.waproviderone.org>.
 - Submit an electronic individual or batch 270/271 inquiry to ProviderOne.
 - Swipe the client services card using a magnetic card reader ([See Appendix A](#)).
 - Use a Medical Eligibility Vendor to access information on your behalf ([See Appendix H](#)).
- Alternative methods for checking eligibility are available:
 - Call the Interactive ProviderOne Voice Response (IVR) ([See Appendix B](#)).
 - Call a customer service representative at 1-800-562-3022.

The remainder of this section provides instructions and screenshots demonstrating how to search for eligibility information via ProviderOne.

Log into ProviderOne and select the **EXT Provider Eligibility Checker** or **EXT Provider Super User** profile to verify client's eligibility for Medical Assistance services.

- Select the Benefit Inquiry hyperlink from the Provider Portal home page Menu

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ProviderOne My Inbox

Welcome Monroe, Gary . You have logged-in with EXT Provider Super User profile. Links: --Select--

Path: Provider Portal
 ProviderOne Id/NPI : 2057403 / 5522336671 Name: MARIO HEALTH CENTER

Provider Portal:

Online Services: Hide/Max

Claims Hide/Max

- Claim Inquiry
- Claim Adjustment/Void
- On-line Claims Entry
- On-line Batch Claims Submission (837)
- Resubmit Denied/Voided Claim
- Retrieve Saved Claims
- Manage Templates
- Create Claims from Saved Templates
- Manage Batch Claim Submission

Client Hide/Max

- Client Limit Inquiry
- Benefit Inquiry

Payments Hide/Max

- View Payment
- View Capitation Payment

Welcome!

The Department of Social and Health Services (DSHS) is an agency that helps people. We do this in partnerships with families, community groups, religious organizations, private providers, other government agencies, and the many thousands of generous foster parents, neighbors, and citizens who make Washington a special place by taking care of each other.

The mission of DSHS is to improve the quality of life for individuals and families in need.

Manage Alerts

My Reminders:

Search by any one of the many combinations available. The inquiry start date will default to today's date. Change this date if it is not the date of service. Information displayed is only valid for the inquiry start and end date. A client's eligibility segment may change for a different date of service search. The max date span for a data return for an eligibility inquiry is 2 years.

Close Submit

To submit an Eligibility Inquiry on a specific client, complete one of the following criteria sets and click 'Submit'.

- ProviderOne Client ID(Client Identification Code) or
- Last Name, First Name AND Date of Birth or
- Last Name, First Name AND SSN or
- SSN AND Date of Birth
- ProviderOne Client ID(Client Identification Code), Last Name, First Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code), Last Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code) AND Last Name

Please contact Customer Service Center at (800) 562-3022

Client Eligibility Inquiry:

ProviderOne Client ID: SSN:

Last Name: First Name:

Date of Birth:

Inquiry Start Date: 12/05/2011 * Inquiry End Date: 12/05/2011 *

Enter one of these search criteria then click on "Submit"

Hint: Don't know how to spell the clients name? ProviderOne now allows a client eligibility search by using the first 5 letters of the last name and the first 3 letters of the first name. However the Date of Birth or the SSN would still be required if using the name search feature.

The system then displays the following eligibility information. Make sure to scroll down the page to view all related eligibility information.

- The first information displayed on the page is the search criteria
- The next section is the Client Demographic Information, name, birth date, etc.

ProviderOne Billing and Resource Guide

- The eligibility information segment is next.

Client Eligibility Spans

Insurance Type Code ▲▼	Recipient Aid Category (RAC) ▲▼	Benefit Service Package ▲▼	Eligibility Start Date ▲▼	Eligibility End Date ▲▼	ACES Coverage Group ▲▼	ACES Case Number ▲▼	Retro Eligibility ▲▼	Delayed Certification ▲▼
MC: Medicaid	1030	CNP	04/01/2011	12/31/2999	F06	019376679		

↑ **A** ↑ **B** ↑ **C** ↑ **D** ↑ **E** ↑ **F** ↑ **G** ↑ **H** ↑ **I**

- A. The type of coverage for the client.
- B. Recipient Aid Category (RAC).
- C. Name of Benefit Service Package (BSP).
- D. Start date for this eligibility segment.
- E. End date for this eligibility segment.
- F. Medical coverage group codes assigned by the Community Service Office (CSO) or the Home and Community Service (HCS) Office when eligibility is determined.
- G. Case number assigned by CSO or HCS.
- H. Retroactive eligibility information. This reflects the three calendar months before the month the client applied for services. ([WAC 182-502-0150](#)).
- I. Delayed certification date. Sometimes a person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. In these cases, the eligibility determination date is after the actual month of service and a date will be displayed in this location. Medical Assistance can accept claims up to one year past this date ([WAC 182-502-0150](#)).



Note: Some providers may need to use the Recipient Aid Category (RAC) code for specific billing purposes or to further determine a client's eligibility in a program. Please reference the applicable Medicaid Provider Guide for further details.

- Examine the eligibility segment start and end dates. If no end date is determined, the system defaults to 12/31/2999.

If your eligibility inquiry is unsuccessful, you will see an error message here:

Printer Friendly Version

Selection Criteria Entered:

Date of Request: 09/08/2009 Time in Request: 11:14:03 AM PDT Provider ID: 2657403 From Date of Service: 01/01/2006 To Date of Service: 01/31/2006	ProviderOne Client ID: 001002003WA Client Date of Birth: Client SSN: Client Last Name: Client First Name:
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Client Demographic Information: ProviderOne Client ID: 001002003WA Client First,Middle,Last Name: BETTY S CROCKER CSO/HCS: 088-GENERAL CENTER CSO County Code: 017-King CSOR: 040-KING EAST CSO Date of Birth: 03/23/1978 Gender: Female Language: ENG-English	System Response Information: Valid Request Indicator: N Reject Reason Code: 52 - Service Dates Not Within Provider Plan Enrollment Follow-Up Action Code: C - Please correct data and resubmit
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Note: If your search is unsuccessful, check your keying!

Pitfalls

- **Relying on eligibility information obtained before the date of service. We recommend that providers verify eligibility the day a service occurs.**
- **Failing to verify the identity of the cardholder. Medical Assistance coverage is not transferable. If you suspect that a client has presented a Services Card belonging to someone else, request to see a photo ID or another form of identification.**

Key Step

2

2. Identify the Primary Payer

Why

Medical Assistance is almost always the payer of last resort (for exceptions, see [WAC 182-502-0100](#)). The Agency will not pay claims as primary carrier if there is an alternate primary payer (for example, Medicare or commercial insurance).

To avoid turning away an individual at check-in, determine the client's primary payer when making an appointment. Some of the reasons a provider might turn clients away include:

- The provider does not accept their Managed Care Plan.
- The provider is not an enrolled Medicare provider.
- The provider is not an enrolled provider with their commercial private insurance.

Client eligibility may change over time, and the primary payer may change as well. For example, a client may enroll in a Medical Assistance Managed Care Plan.

How – Nursing Homes Only

Nursing Homes Only: Review the Institutional Award Letter. The award letter explains client income and participation amount, medical care eligibility, effective date for care, care level, and other information.

How – All Other Providers

This section covers the following:

- How to determine if the client is enrolled in a Medical Assistance Managed Care Plan.
- How to determine if the client is eligible for mental health services. (Provided through Regional Support Networks).
- How to determine if the client is enrolled with a Primary Care Case Management (PCCM) provider.
- How to determine if the client is Medicare eligible.
- How to determine if the client has one or more of the following: commercial private insurance, Medicare Part C or D, military, or commercial HMO coverage.
- How to determine if the client must receive services from certain providers.
- How to determine if the client receives services through a Hospice Agency.
- How to determine if the client is a client of the Division of Developmental Disabilities (DDD).
- How to determine if the client is participating with the Department of Health's Children with Special Health Care Needs (CSHCN) program.

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- How to determine if the client is enrolled in a Medical Assistance Managed Care Plan.** If the client is enrolled in Medical Assistance Managed Care Plan, the following segment will be displayed as part of the client benefit inquiry. Some examples include ‘ANH Healthy Options’, ‘CHPW Basic Health Plus’, and ‘MHC State Children Health Insurance Program’. The Agency does not process or pay claims for clients enrolled in a Medical Assistance Managed Care Plan for services provided under the plan’s contract. If the service is covered by the Medical Assistance Managed Care Plan, do not bill the Agency as a secondary payer.

Managed Care Information ←

Insurance Type Code ▲ ▼	PCCM Code ▲ ▼	Plan/PCCM Name ▲ ▼	Plan/PCCM ID ▲ ▼	Plan/PCCM Phone Number ▲ ▼	PCP Clinic Name ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼
HM: Health Maintenance Organization	MC: Capitated	CHPW Healthy Options	105010101	(800) 440-1561		07/01/2012	12/31/2999



Note: The benefit inquiry response does not return the Primary Care Provider (PCP) information but does return the PCP Clinic Name when the information is available.

- Contact the Managed Care Plan if there are questions on authorization and billing. See [Appendix C](#) for Medical Assistance Managed Care Plan contact information.



Note: Already seen a client enrolled in a Managed Care Plan, and the provider is not the assigned Primary Care Provider (PCP) or do not have a referral? Contact the PCP to get a referral then call the Plan to see if authorization is required or can be obtained for the service provided. If the office is not contracted with the Plan, call the Plan to see if they have an allowance for a noncontract provider treating their client.

When a client is enrolled in Healthy Options plan on admit to a hospital stay and then dis-enrolls from the plan and becomes FFS during the stay, the entire stay and physician services are the responsibility of the plan until the client is discharged.

- How to determine if the client is eligible for mental health services (which are provided through a regional Support Network (RSN)).** If a client is eligible for mental health services, their Regional Support Network (RSN) will be displayed under “Managed Care Information”. This is not a medical managed care plan. **The RSN indicator applies to mental health services only.** Refer the client to their RSN to access mental health services. Please do not contact the RSN unless trying to coordinate mental health services for a client. Authorization may be required. For a directory of Regional Support Networks, please visit <http://www.dshs.wa.gov/dbhr/rsn.shtml>.

Managed Care Information

Insurance Type Code ▲ ▼	PCCM Code ▲ ▼	Plan/PCCM Name ▲ ▼	Plan/PCCM ID ▲ ▼	Plan/PCCM Phone Number ▲ ▼	PCP Clinic Name ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼
HM: Health Maintenance Organization	MC: Capitated	CHPW Healthy Options	105010101	(800) 440-1561		07/01/2012	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	SWWA Behavioral Hlth RSN-Mental Hlth Services Only	202342601	(360) 397-8222		01/01/2013	12/31/2999

Note: The ProviderOne system eligibility benefit inquiry now shows the RSN segment with the county RSN name and the phrase “**Mental Health Services Only**”. This information informs providers that the client would get mental health services coordinated through the county organization listed. This segment reflects mental health coverage eligibility ONLY. Also note the RSN is not involved in billing and cannot help with claim denials or other related questions.



Note: If there is **NOT** an RSN listed in this segment for your dates of service, the client is in a state-only funded program. This information can be used by providers (e.g. **Rural Health Clinics** and others) when trying to determine if the client is in a state-only funded program. One exception to this rule is the clients with ACES program code **P04**. The client is primarily state funded even if there is an RSN segment.

- **How to determine if the client is enrolled with a PCCM.** If the client is enrolled with a Primary Care Case Management (PCCM) provider, the following segment will be displayed as part of the client benefit inquiry:

Managed Care Information



Insurance Type Code ▲ ▼	PCCM Code ▲ ▼	Plan/PCCM Name ▲ ▼	Plan/PCCM ID ▲ ▼	Plan/PCCM Phone Number ▲ ▼	PCP Clinic Name ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼
HM: Health Maintenance Organization	MC: Capitated	SEATTLE INDIAN HEALTH BOARD	104367301	(206) 324-9360		12/01/2007	12/31/2999

- All clients enrolled with a Primary Care Case Management (PCCM) provider must have a referral from their PCCM in order for health care services to be paid to an outside provider. Bill all services for PCCM clients covered by the referral to Medical Assistance and indicate the PCCM referral number on the claim form.
- Newborns of clients enrolled with a PCCM provider are fee-for-service until the client chooses a PCCM for the newborn. Bill all services for the newborn to the Agency.
- Women enrolled with a PCCM provider do not need a referral from their PCCM to refer themselves for women’s health care services provided by a clinician outside of the PCCM. Billing for all services does not require a PCCM referral number on the claim.

- **How to determine if the client is Medicare Eligible.** If the client is eligible for Medicare Part A or Part B, the following segment(s) will be displayed as part of the client benefit inquiry:

Medicare Eligibility Information

Service Type Code ▲ ▼	Insurance Type Code ▲ ▼	Eligibility Start Date ▲ ▼	Eligibility End Date ▲ ▼
30: Health Benefit Plan Coverage	MA: Medicare Part A	05/01/1992	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	05/01/1992	12/31/2999

- Providers must bill Medicare as the primary payer if Medicare covers the service provided.
- The client’s Medicare HIC number will be returned on benefit inquiries.

- **How to determine if the client has one or more of the following: commercial private insurance, Medicare Part C or D, military, or commercial HMO coverage.** If the Agency’s records reflect that the client has other coverage, the following segment(s) will be returned as part of the client benefit inquiry:

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	PREMERA BLUE CROSS/BCBS OF AK (800) 722-1471	BC01					10/01/2012	12/31/2999

Message(s): We believe this information to be correct, but you must verify eligibility and coverage with specified payer

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- Providers must bill the commercial private insurance primary to Medical Assistance. Bill the Agency after the claim has been processed by all other commercial insurance. The insurance **carrier code** displayed here is used on the direct data entry (DDE) secondary insurance claims billed to the Agency as the insurance company ID number.
- Medicare Part C information will be returned if the Agency knows the name of the plan. Providers must bill the Medicare Part C Plan (Medicare Advantage HMO) primary to Medical Assistance. Bill the Agency a secondary crossover claim after the claim is processed by the Plan and the Agency may pay the client liability (deductible, co-insurance, co-pay) amount according to the Agency's payment policy.
- If the Client has Medicare Part D, (prescription drug coverage), see the [Prescription Drug Program Medicaid Provider Guides](#) for specific details. Current Medicare Part D plan information may be listed in the Coordination of Benefits Information segment.

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	PACIFICARE OF WASHINGTON, INC.	H5005	UNKNOWN UNKNOWN	Med Part C			02/01/2011	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	PACIFICARE OF WASHINGTON, INC.	H5005		Med Part D			02/01/2011	12/31/2999

Message(s): We believe this information to be correct, but you must verify eligibility and coverage with specified payor

- Refer active duty military clients who are eligible for benefits with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to use their local military facility. When a client is CHAMPUS eligible, the insurance carrier code is either **HI50** or **HI00**. (see example below)

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	DEERS/TRICARE/CHAMPUS (888) 874-8378	HI50			PRIME		01/01/2004	12/31/2999

- Direct clients who are also eligible for benefits with the Department of Veterans Affairs (VA) to the nearest VA medical center. Individuals with VA eligibility are required to seek medical care through their VA providers as their primary insurance. When a Medical Assistance client is also VA eligible, the insurance carrier code is **VE02**.



Note: If the client needs to locate a VA medical center, a call to 1-800-827-1000 from any location in the United States will be automatically routed to the nearest VA regional office.

- Refer clients who have insurance through a Health Maintenance Organization (HMO) to their designated facility or provider. When a client has primary insurance through an HMO, the insurance carrier code is **HM, HI, or HO**.
- Medical Assistance does not pay for services referred to a provider not contracted with the primary HMO. This is the responsibility of the referring HMO. If the primary HMO does not cover the services, Medical Assistance may be billed for those services if they are covered by Medical Assistance.

Exception: If a client lives more than 25 miles or 45 minutes away from the nearest primary HMO provider/facility, Medical Assistance will pay for non-emergency services under the fee-for-service per Fee Schedule. These cases are generally determined on an individual basis. Please call Coordination of Benefits at 1-800-562-3022 ext. 16134 for further assistance. The primary HMO may require notification of any emergency services before they make any payment(s).



Note: When a commercial insurance company terminates a client's private coverage, send the Agency a copy of the termination notice or call the Coordination of Benefits toll-free line at 1-800-562-3022, ext. 16134. The following documents (or photocopies of them) may be used as verification of insurance termination:

- EOB statement from insurance company
- Letter from employer
- Memo from CSOs or insurance company
- Divorce decree
- Court order
- Military discharge papers (DD214)
- Client-specific letter on insurance company letterhead



Note: The Agency does not deny the following services for third-party coverage **unless the third-party liability (TPL) carrier code is HM, HI, or HO:**

- Outpatient preventative pediatric care;
- Outpatient maternity-related services; and
- Accident related claims, if the third-party benefits are not available to pay the claims at the time they are filed.



Note: If you determine there is a possible casualty claim, please call the Casualty Unit at 1-800-562-3022, ext. 15462 (e.g., motor vehicle accident, Department of Labor and Industries (L&I) claim, Injury diagnosis). See [Appendix D](#) for more information on casualty claims.



Note: If providers have additional insurance coverage questions, call the Coordination of Benefits toll-free line at 1-800-562-3022, ext. 16134.

- **How to determine if the client is restricted and must receive services from certain providers.** ([WAC 182-501-0135](#)) If the client is assigned to certain providers, the following segment(s) will be displayed as part of the client benefit inquiry:

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Restricted Client Information

Assignment Type ▲ ▼	Provider Name ▲ ▼	Provider Phone Number ▲ ▼	Period Start Date ▲ ▼	Period End Date ▲ ▼
Primary Care Physician	SKAGIT VALLEY MEDICAL CENTER	(360) 428-6425	12/12/2007	02/28/2009
Hospital	PUBLIC HOSPITAL DISTRICT 1 SKAG	(360) 424-4111	12/12/2007	02/28/2009
Pharmacy	RITE AID PHARMACY 05245	(360) 424-7958	11/01/2006	02/28/2009

- The Patient Review and Coordination (PRC) program assists clients in using medical services appropriately by assigning them a PCP, pharmacy, and/or a hospital for non-emergency care. The PCP may make referrals for specialty medical care. Some covered services that do not need a referral include, but are not limited to, dental and medical equipment.
 - Providers must bill PCP- referred services with the PCP's National Provider Identifier (NPI) in the appropriate field on the claim form. Look up NPIs at the National Plan & Provider Enumeration System website- <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>. If there are questions about the PRC program or a provider wishes to report a client for utilization review, call 1-800-562-3022 ext. 15606.
- **How to determine if the client receives services through a Hospice Agency.** ([WAC 182-551-1210](#)). If the client receives services through a hospice agency, the following segment(s) will be displayed as part of the client benefit inquiry:

Hospice Information

Hospice agency ▲ ▼	Hospice Address ▲ ▼	Hospice Phone ▲ ▼	Hospice Contact ▲ ▼	Start date ▲ ▼	End date ▲ □
100158500	HOSPICE, SEATTLE , WA 98108	(206) 386-6607	HOME SWEDISH	04/24/2008	12/31/2999

- Please see the [Hospice Services Medicaid Provider Guides](#) for more information.
- **How to determine if the client is a client of the Developmental Disabilities Administration (DDA).** If the client is a client of DDA, the following segment will be displayed as part of the client benefit inquiry:

Developmental Disability Information

Start Date ▲ ▼	End Date ▲ □
01/01/1980	12/31/2999

- Clients of DDA may be eligible for additional medical services. See the [program specific Medicaid Provider Guides](#) for those additional services.
- **How to determine if the client is participating with the Department of Health's Children with Special Health Care Needs (CSHCN) program.** If the client has special health care needs and is enrolled in the CSHCN program, the system displays the following segment as part of the client benefit inquiry:

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Children with Special Health Care Needs Information

Start Date ▲ ▼	End Date ▲ □
01/01/2002	08/31/2014

Pitfalls

- **Failing to check the dates on a displayed segment.** When reviewing the eligibility record, always make sure the dates on a segment correspond with the date of service being checked.
- **Billing the Agency when there is a primary payer.** This will delay receipt of payment and increase a provider's workload.
- **Providing service to a client who has chosen to obtain care with a PCCM provider and this provider is not the PCP, or the client was not referred to the office by the PCCM provider/PCP.** Contact the PCP to get a referral.

Key Step

3

3. Review the Client's Benefit Service Package

Why

Benefit Service Packages do not cover all services and procedures. Providers need to verify the service being provided is a covered benefit under the client's Benefit Service Package.

How

- **Locate the Benefit Service Package returned on the eligibility inquiry.** View additional information related to programs covered under a specific Benefit Service Package (e.g., physical therapy, dental, hospital) by clicking on the hyperlink.

Client Eligibility Spans

Insurance Type Code ▲ ▼	Recipient Aid Category (RAC) ▲ ▼	Benefit Service Package ▲ ▼	Eligibility Start Date ▲ ▼	Eligibility End Date ▲ ▼	ACES Coverage Group ▲ ▼	ACES Case Number ▲ ▼	Retro Eligibility ▲ ▼	Delayed Certification ▲ ▼
MC: Medicaid	1030	CNP	04/01/2011	12/31/2999	F06	019376679		

- See [Appendix E](#) for an overview of Benefit Service Packages.

- **How to determine if the client is pending spenddown eligibility and responsible for a spenddown balance.** Spenddown is a client liability, similar to an insurance deductible. The Agency determines the amount of the spenddown liability and a client must pay or incur medical expenses equal to or greater than this amount before the client is eligible for medical coverage to begin. The Agency does not pay for any services or expenses that were used to meet a client's spenddown liability. The Agency reduces the provider payment amount by any amount that is determined to be a client spenddown liability.

Medical coverage under the Limited Casualty/Medically Needy Program (LCP/MNP) begins on the date the client has incurred enough medical expenses to meet the spenddown liability. Coverage does not always begin on the first day of the month. If billing for a date of service which is equal to the Medicaid eligibility begin date, it is possible that the claim could require a spenddown liability to be reported. Please see [Memo 10-10](#) and [182-519 WAC](#) for more information on spenddown. If the description within the Benefit Service Package above reads "Pending Spenddown-no medical," the following segment will be displayed:

Client Eligibility Spans

Insurance Type Code ▲ ▼	Recipient Aid Category (RAC) ▲ ▼	Benefit Service Package ▲ ▼	Eligibility Start Date ▲ ▼	Eligibility End Date ▲ ▼	ACES Coverage Group ▲ ▼	ACES Case Number ▲ ▼	Retro Eligibility ▲ ▼	Delayed Certification ▲ ▼
MC: Medicaid	1030	Pending Spenddown - No Medical	08/01/2011	12/31/2999	S99			

- If the client has a pending spenddown liability amount, the current balance will be displayed in a segment that looks like this:

Spenddown Information

RAC C  - 1124 Base Period - Start: 08/01/2011 End: 01/31/2012

Total Spenddown ▲ ▼	Spenddown Liability ▲ ▼	Remaining Spenddown ▲ ▼	EMER Liability ▲ ▼	Remaining EMER ▲ ▼	Spenddown Status ▲ ▼	Update Date ▲ ▼	Spenddown Start Date ▲ ▼
2022.00	2022.00	2022.00	0.00	0.00	Pending	08/09/2011	08/01/2011



Note: Emergency Medical Expense Requirement (EMER) liability can only be met with voluntary inpatient psychiatric hospitalization.

Spenddown Frequently Asked Questions

Q. How do I find out if our claim was used to meet a client’s spenddown liability? How do I find out how much of our claim was assigned to a client spenddown liability?

A. Call the Agency toll free customer service call center line at 1-800-394-4571.

Q. How will my claim be processed if there is a spenddown amount applied to my claim?

A. The Agency will deduct the spenddown amount from the Agency allowable amount. For more information on provider payments, see 182-519-0110.

Q. How do I know if a claim was denied for spenddown?

A. Check the Remittance Advice to find the denial code for the claim. Claims denied for spenddown will show adjustment reason code 125 and remark code N58.

Q. What will happen if I submit a claim when ProviderOne indicates the client is ‘pending spenddown’?

A. The claim will deny because the client is not eligible.

Q. Can I charge the client when some or my entire bill has been used to meet the client’s spenddown liability?

A. Providers may charge the client no more than the spenddown amount that was applied to the claim. Please see 182-519-0110 for more information.

Q. How do I report spenddown on a claim?

A. See Numbered Memoranda 10-10 at <http://www.hca.wa.gov/medicaid/billing/documents/memos/10-10.pdf>.

Pitfalls

- **Failing to check the client’s benefit service package. This may result in providing services that are not covered by the Agency.**

Key Step
4

4. Review the Foster Care Client’s Medical Records History

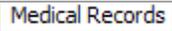
ProviderOne now gives the provider access to claims history for children in foster care. The claims history (pharmacy, dental, medical, etc.) will be available when a provider performs an eligibility check in ProviderOne.

Why

Providers may benefit from knowing a foster care client’s claims history before treating, or prescribing medications for the client.

How

Log into ProviderOne as outlined in Key Step 1 above, and select the “Benefit Inquiry” hyperlink to conduct an eligibility check for the client.

Enter the appropriate search criteria to locate the client’s eligibility information. When the eligibility page is returned, if the selected client’s medical records are available, the following “Medical Records” button  will appear at the top left of the screen:

Printer Friendly Version

Selection Criteria Entered:

Date of Request: 08/18/2011	ProviderOne Client ID: 564532100WA
Time in Request: 07:20:08 AM PDT	Client Date of Birth:
Provider ID:	Client SSN:
From Date of Service: 08/18/2011	Client Last Name:
To Date of Service: 08/18/2011	Client First Name:

Client Demographic Information:	System Response Information:
ProviderOne Client ID: 564532100WA	Valid Request Indicator:
Client First,Middle,Last Name: THOR T HAMMER	Reject Reason Code:
CSO/HCS: 076-MEDS	Follow-Up Action Code:
County Code: 017-King	
CSOR: 043-KING SOUTH CSO	
Date of Birth: 12/28/2003	
Gender: Male	
Language: ENG-English	
Placement: F	

Note: The Placement code (indicated by the arrow) may allow a provider billing certain E&M codes to receive an enhanced rate for the service. Please see the [EPSDT Medicaid Provider Guide](#) for the placement code table plus detailed information about how to bill for the enhancement.

ProviderOne Billing and Resource Guide

Click the **Medical Records** button to open the next screen which contains claims information in three separate sections. These sections contain paid claims information obtained from the ProviderOne claim history database. Two years of data will be returned by default, regardless of the eligibility search begin or end dates. The three sections include:

- Pharmacy services claims
- Medical services claims (includes Dental)
- Hospital services claims

The overall screen looks like the screen picture below. Providers may need to use the scroll bar on the right side of the page to see the bottom portion of the page. This is a “Printer Friendly Version” so the content of this page can be printed.

Printer Friendly Version
Close 

Pharmacy:
Filter By Period: All Go

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
02/03/2011	VITAMIN D	1000 UNIT	60	30	00	FRAIKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/27/2011	POLYETHYLENE GLYCOL 3350	0	527	30	01	FRAIKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/18/2011	BACLOFEN	20 MG	90	30	00	FRAIKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/12/2011	LAN SOPRAZOLE ODT	15 MG	60	30	00	WASHINGTON,GEORGE	BIG RIVER PHARMACY	(509) 555-2323
01/12/2011	IBUPROFEN	400 MG	15	10	01	WASHINGTON,GEORGE	BIG RIVER PHARMACY	(509) 555-2323

<< Prev Viewing Page 1 Next >> 2 Go Page Count SaveToXLS

Medical Services (primary and specialty care):
Filter By Period: All Go

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #
------------	----------	-----------------------------	-----------------------	----------------	-------------------------	-----------------------	--------------------------

The first section contains the Pharmacy claim information:

Pharmacy:
Filter By Period: All Go

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
02/03/2011	VITAMIN D	1000 UNIT	60	30	00	FRAIKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/27/2011	POLYETHYLENE GLYCOL 3350	0	527	30	01	FRAIKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/18/2011	BACLOFEN	20 MG	90	30	00	FRAIKLIN,BEN	BIG RIVER PHARMACY	(509) 555-2323
01/12/2011	LAN SOPRAZOLE ODT	15 MG	60	30	00	WASHINGTON,GEORGE	BIG RIVER PHARMACY	(509) 555-2323
01/12/2011	IBUPROFEN	400 MG	15	10	01	WASHINGTON,GEORGE	BIG RIVER PHARMACY	(509) 555-2323

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Some fields could be empty or contain “zero (0)” as a value for the different pharmacy claims if that information is not available for viewing.

Providers have the option to search the pharmacy list for specific dates of service by using the “Filter By Period” option.





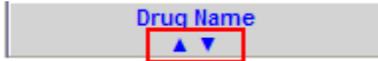

Pharmacy:
Filter By Period: Date Range Go

1. Pick the filter value name (All, or Date Range) using the drop down option
2. Then in the Date Range, in the next box indicate the filter value “From” date of service

ProviderOne Billing and Resource Guide

- Next in the Date Range, in the second filter value box enter the “To” date of service (all dates entered in ProviderOne must be formatted as 06/01/2011)
- Click the “Go”  button

ProviderOne will return the paid claim (s) found for those filter values based on the “From” date. Providers can sort the list of pharmacy claims using the up/down triangles located under each blue column heading. The system only sorts by one column heading at a time, however, it will sort the whole list based on the column heading chosen.

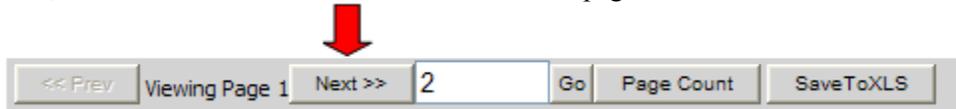


- Clicking on the triangle on the left  causes ProviderOne to sort the list by the oldest, smallest, or in alphabetical order, according to the column specified.
- Clicking on the triangle on the right  causes ProviderOne to sort the list by the latest, largest, or in reverse alphabetical order, according to the column specified.



Note: The search (Filter By) option and the column sort functions work the same for each specific claim section on this screen.

Providers should keep in mind that each claim history section may have multiple pages. If the action buttons at the bottom of the section have black text, they can be used to move to the next page. In this case, the “Next button” indicates that more than one page of claims are available to view.



The Medical (and Dental) Services section looks like this:

Printer Friendly Version

Medical Services (primary and specialty care):

Filter By Period: All Go

Start Date ▲ ▼	End Date ▲ ▼	Primary Code/DX Description ▲ ▼	Other Diagnosis Codes ▲ ▼	Procedure Code ▲ ▼	Servicing Provider Name ▲ ▼	Billing Provider Name ▲ ▼	Billing Provider Phone # ▲ ▼
02/02/2011	02/02/2011			D1120,D1203,D0150,T1015	HAMILTON, ANDREW	BIG RIVER DENTAL CLINIC	(509) 555-5678
01/24/2011	01/24/2011	3439 - Cerebral palsy NOS	7689,5181	A0425,A0428		MEDICAL AMBULANCE SERVICE	(509) 555-2222
01/24/2011	01/24/2011	78097 - Altered mental status	3481,79091,51881	A0425,A0429		MEDICAL AMBULANCE SERVICE	(206) 535-4444
12/16/2010	01/15/2011	V440 - Tracheostomy status	85400,04112,51889	E0445		HOME NURSING SUPPLY	(509) 555-3333
01/04/2011	01/04/2011	V440 - Tracheostomy status	51889,85400,04112	A7525		HOME NURSING SUPPLY	(509) 555-3333

<< Prev Viewing Page 1 Next >> 2 Go Page Count SaveToXLS

Some fields could be empty when viewing the different professional and dental services because the information did not apply to the service indicated, or the data may not be available. The “Filter By” (search) and the column sort features described above work the same in this section.

ProviderOne Billing and Resource Guide

The Hospital Care section looks like this and is the last section on the page.

Hospital Care:								
Filter By Period: All <input type="text"/> <input type="text"/> Go								
Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	ER/Outpatient/Inpatient	DRG Description	Attending Provider Name	Billing Provider Name	Billing Provider Phone #
01/24/2011	01/24/2011	47874 - Stenosis of larynx	3481,V440,37775,53081	Outpatient		EAGLECLAW, DAI	CHILDRENS	(206) 535-2167
01/11/2011	01/11/2011	51919 - Trachea & bronch dis NEC		Outpatient		KIDD, CISCO	MEMORIAL HOSPITAL	(509) 555-6789
10/27/2010	10/27/2010	85406 - Brain inj NEC-coma NOS		Outpatient		KIDD, CISCO	MEMORIAL HOSPITAL	(509) 555-6789
09/30/2010	09/30/2010	78720 - Dysphagia NOS	78722	Outpatient		EAGLECLAW, DAI	CHILDRENS	(206) 535-2167
09/21/2010	09/21/2010	47874 - Stenosis of larynx		Outpatient		EAGLECLAW, DAI	CHILDRENS	(206) 535-2167

Viewing Page 1

When viewing the hospital claims in this section, some fields may be empty because the information does not apply, or the data is not available. The “Filter By” (search feature) and the column sort features work the same as described in the previous section.



Note: If any one of the sections returns the message “No Records Found” **No Records Found!** then the client does not have any claims history for that section.

Key Step

5

5. Determine if Medical Assistance Covers the Service and if so, is Prior Authorization (PA) Required

Why

Medical Assistance does not cover all medical services and some covered services require Prior Authorization (PA). The Agency will not pay the claim if the provider fails to obtain a required PA.

This Key Step describes how to identify a procedure code, how to use that procedure code to determine if Medical Assistance covers the service, and how to determine if the Agency requires PA (as identified in Medical Assistance’s [program-specific Medicaid Provider Guides](#)).

PA is the approval providers must obtain **before** providing certain healthcare services, equipment, or supplies to clients. PA is based on medical necessity and is a precondition for provider payment. For more information on PA, please see [WAC 182-501-0165](#). Expedited Prior Authorization (EPA) [WAC 182-531-0200](#), Exception to Rule (ETR) [WAC 182-501-0160](#), and Limitation Extensions (LE) [WAC 182-501-0169](#) are forms of PA.

How

Identify the procedure code which describes the service that will be provided to the client.

- The following types of codes are used when billing the Agency:
 - American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes;
 - American Medical Association (AMA) Current Procedural Terminology (CPT) procedure codes;
 - U.S. Department of Health & Human Services ICD-9-CM diagnosis codes;
 - Level II Healthcare Common Procedure Coding System (HCPCS) procedure codes;
 - National Drug Code (NDC); and
 - Revenue codes. The National Uniform Billing Committee assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

Procedures performed must match the descriptions and guidelines from the most current CPT, HCPCS, CDT, and ICD-9-CM manuals for all Medical Assistance-covered services. The Agency publishes only the short descriptions of procedure codes due to copyright restrictions. Consult the current manual for full descriptions.

(CPT© is a trademark of the American Medical Association.)

ProviderOne Billing and Resource Guide

- **Look up the procedure code in the appropriate Medical Assistance [Fee Schedule](#).** The Fee Schedule will provide providers with information about the procedure code and payment rate. The Agency updates the Fee Schedules as the national codes are updated. The following is an example of a Fee Schedule:

Procedure code 11954 is not covered.

Procedure code 11970 is covered.

PTH	CPT	SI	Description	COV	MAX UNITS	APC 2013	RW 2013	NWR 2013	OPPS Fee	OP Fee
	11952	T	Therapy for contour defects	0 NC		0000	0	0.00		
	11954	T	Therapy for contour defects	0 NC		0000	0	0.00		
	11960	T	Insert tissue expander(s)	1	1	0137	21.1752	1510.07		
	11970	T	Replace tissue expander	1	1	0051	48.2042	3437.59		
	11971	T	Remove tissue expander(s)	1	1	0022	23.2928	1661.08		
	11976	T	Removal of contraceptive cap	1	1	0019	4.717	336.38		
L	11980	X	Implant hormone pellet(s)	1	1	0340	0.6961	49.64		
L	11981	X	Insert drug implant device	1	1	0340	0.6961	49.64		
L	11982	X	Remove drug implant device	1	1	0340	0.6961	49.64		

- **Determine if the procedure is covered.** If a procedure code is not listed in the Fee Schedule, it is non-covered under that program. Also review the COV column:
 - If there is a zero (“0”) in the COV column, it is non-covered service.
 - If there is a one (“1”), it is a covered service.



Note: You can request an “Exception to Rule” (ETR) authorization for a non-covered service. For more information, please see [WAC 182-501-0160](http://wac.wa.gov/182-501-0160).

- **Determine if there is a PA requirement.** The Fee Schedule may indicate that PA is required.
 - Complete PA form [13-835](#). This form must be typed so that the characters can be scanned correctly. For instructions on completing this form, please see [Appendix F](#).
 - If a provider is mailing/faxing supporting documentation without the original authorization request form, a cover sheet must be printed. Cover sheets can be located at http://hrsa.dshs.wa.gov/download/document_submission_cover_sheets.html. For more information on coversheets, please visit [Appendix G](#).
 - Once a provider has submitted the PA request, he or she can check the status using ProviderOne or the IVR. Please see [Appendix F](#) for details.
 - To use the IVR, a provider will need the NPI, the ProviderOne Client ID, and the client’s date of birth. The IVR will provide the authorization number as well as the status information.
 - ProviderOne allows inquires for authorization numbers and status using defined search criteria... See Appendix F for the steps to use the “Provider Authorization Inquiry” in ProviderOne.



Note: If Medicare denies a Medical Assistance-covered service that requires Prior Authorization, the service still requires authorization, but providers may request it after the service is provided. The Agency waives the “prior” requirement in this circumstance.



Note: If the client has commercial insurance coverage, prior authorization (PA) is not required prior to providing any service requiring PA. However if the commercial insurance denies payment for the service that required PA, providers must then request authorization and include a copy of the insurance denial EOB with the request. See the PA chapter for submitting a request. For some programs PA is required prior to the services being provided regardless who is the primary payer. Examples of this would be DME supplies and Inpatient hospital stays that require authorization.

If the primary pays the service then authorization is not required for the secondary claim. Refer to the program specific [Medicaid Provider Guide](#) applicable to the service intended to be provided.



Note: Authorization for services does not guarantee payment. Providers must meet administrative requirements (e.g., client eligibility, claim timelines, third-party insurance, etc.) before the Agency pays for services.

Important: When billing the Agency for a “By-Report (BR) CPT or HCPCS code that requires authorization and the authorization has been approved, a provider must:

- Bill the Agency with the amount requested on the authorization form.
- Do not bill the Agency the allowed amount for the (BR) CPT or HCPCS code.
- Do not include sales tax in the billed amount for the (BR) CPT or HCPCS code.

The Fee Schedule might indicate “EPA”, Expedited Prior Authorization. The EPA process is designed to eliminate the need for prior authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an EPA number, when appropriate. Refer to the program specific [Medicaid Provider Guide](#) for the EPA criteria for specific supplies or services.

EPA Guidelines:

- Medical Justification (criteria) - All medical justification must come from the client’s prescribing physician or physical/occupational/speech therapist. The Agency does not accept information obtained from the client or from someone on behalf of the client (e.g. family).
- Documentation - The billing provider must keep documentation of the criteria in the client’s file. Upon request, a provider must provide documentation to the Agency showing how the client’s condition met the criteria for EPA. Keep documentation on file for six (6) years.
- EPA criteria must be met exactly. If exact criteria outlined in the Medicaid Provider Guides are not met, the formal PA process must be followed.



Note: The Agency may recoup any payment made to a provider if the criteria were not met or the wrong code was used.

Claim Payments

Professional Services

The Agency uses published Fee Schedules to communicate to providers the allowed amount for a health care service.

- **Use the Fee Schedule to determine the payment rate for the procedure.** If providers want to know the payment rate for a procedure, see the dollar amount listed in the Fee Schedule next to the procedure code.
 - Facility setting maximum allowable fee (FS Fee) is paid when the provider performs the services in a facility setting (e.g., a hospital or ambulatory surgery center) and the cost of the resources are the responsibility of the facility.
 - Non-facility setting maximum allowable fee (NFS Fee) is paid when the provider performs the service in a non-facility setting (e.g., office or clinic) and typically bears the cost of facility space and resources, such as labor, medical supplies, and medical equipment associated with the service performed.
- Access the Fee Schedules at web page <http://www.hca.wa.gov/medicaid/rbrvs/Pages/index.aspx> and click on the letter of the Fee Schedule to be reviewed. Use the Fee Schedule that covers the date of service on the claim.

It is important to note that the Agency does not pay more than the provider billed amount on a claim regardless of the allowed fee listed in any of the Fee Schedules. The Agency recommends providers bill their usual and customary charges on their claims. Claims that are underpaid will have to be adjusted by the provider to capture the under billed but allowed amount. (Exceptions are for trauma claims and services that pay a sales tax.)

Institutional Services

Providers billing on an institutional claim form or 837I have various payment methods and are much too detailed to cover in this publication. Please see the appropriate Fee Schedule or Medicaid Provider Guide for detailed information about payments.

Inpatient Hospital Services

For payment information on inpatient hospital services, please see the [Inpatient Hospital Services Medicaid Provider Guides](#). The Agency established a new payment policy for Provider Preventable Conditions (PPCS) which may cover inpatient hospital, outpatient hospital, ASC, and professional services.

Provider Preventable Conditions (PPCs)

The Agency has established a new payment policy for services provided to Medicaid clients, either FFS or enrolled in one of the Agency's MCO plans that result in Provider

Preventable Conditions. The rule applies to all health care professionals and inpatient hospitals.

Provider Preventable Conditions is an umbrella term for hospital and nonhospital acquired conditions that are included in two distinct categories:

1. Health Care-Acquired Condition (HCAC) is a condition occurring in any inpatient hospital setting (identified as a hospital acquired condition by Medicare). Examples include a foreign object retained after surgery to certain surgical site infections, etc. The Medicare list can be found at web site http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html and in [WAC 182-502-0022](#).
2. Other Provider Preventable Conditions (OPPCs) is an adverse health event that could have reasonably been prevented through the application of nationally recognized evidence based guidelines. Examples include surgery on the wrong patient or wrong site to medication errors, etc. The complete list of adverse health events can be found in the Department of Health [WAC 246-302-030](#).

Under the new policy the Agency will deny or recoup payments to health care professionals and inpatient hospitals for care related only to the treatment of consequences for HCAC and OPPC conditions.

All hospitals are required to include the present on admission (POA) indicator when submitting inpatient claims for payment. The POA indicator may prompt a claim review when billed with an HCAC diagnosis code according to CMS guidelines. Professional claims will be identified using this claim information.

For professional services performed during an inpatient hospital stay, append one of the following modifiers to all lines related to the surgical error:

- MX – Wrong surgery on patient
- MY – Surgery on wrong body part
- MZ – Surgery on wrong patient

CMS has created three new HCPCS Level II modifiers for practitioners, ambulatory surgical centers (ASCs), and hospital outpatient facilities to use to report erroneous surgeries. Append one of the following HCPCS Level II modifiers to all lines related to the surgical error:

- PA – Surgery wrong body part
- PB – Surgery wrong patient
- PC – Wrong surgery on patient

PPCs must be reported to the Agency within forty-five calendar days of the confirmed PPC. Notification must be in writing, addressed to the Agency's Chief Medical Officer (CMO) and include the PPC, date of service, client identifier, and the claim number (TCN) if a claim is submitted to the Agency. Hospitals and health care professionals must complete their portion of the [HCA 12-200](#) form and send with the notification.

The complete text and details covering a PPC, Agency payment, reporting a PPC, and a provider dispute process can be located in [WAC 182-502-0022](#).

Pitfalls

- Using outdated coding books. This can result in the claim being denied.
- Using a procedure code and diagnosis code that do not correspond with each other. This can result in the claim being denied.
- Not confirming eligibility on the day of service. PA does not override eligibility.
- Failing to obtain authorization when required. This will result in the claim being denied.
- Hand writing the PA request form. If is not typed, it will be returned to the provider because it cannot be scanned using “Optical Character Recognition.”
- Not having a client ID when trying to request authorization. If the client ID is unknown, providers can do a client search in ProviderOne.
- Billing claims without the proper PPC modifier or POA indicator could result in a claim review and possible recoupment of the payment.

Key Step

6

6. Determine if the Client’s Benefit Limitations Have Been Met

Why

The Agency limits certain covered services with respect to quantity, frequency, or duration. For example, a routine eye exam is covered for an adult client every two years and some DME supplies and dental services may have quantity and frequency limits.

How

Determine the service being provided and then look in the program specific Medicaid Provider Guides to see if there is any quantity, frequency, or duration limits on that service. Providers can then check on service limits by:

- Using the Client Limit Inquiry feature of ProviderOne or
- Use the secure Contact Medicaid web form at <https://fortress.wa.gov/dshs/plcontactus/> or
- If the date of service is within 48 hours, call the Customer Service line at 1-800-562-3022, provider menu option 4. All other requests must utilize the Contact Medicaid web form.

ProviderOne allows providers to check service limits using claim data stored in ProviderOne. This system functionality is limited to claims that have been paid by ProviderOne and does not account for claims that have been received but are still in process or have been denied. There is also the possibility that services have been incurred but have not been billed yet.

Check for service limits in ProviderOne by:

- Logging into ProviderOne
- Use one of the following profiles
 - **EXT Provider Super User**
 - **EXT Provider Claims Submitter**
 - **EXT Provider Eligibility Checker**
 - **EXT Provider Eligibility Checker-Claims Submitter**
- Select the **Client Limit Inquiry** hyperlink



ProviderOne Billing and Resource Guide

At the Client Limit Inquiry screen fill in the required fields marked with the asterisk *:

Client Limit Inquiry:

Client Id: *

Date of Service: *

Requested unit(s): *

Procedure Code: *

Primary Diagnosis Code:

Provider NPI: *

Facility Type:

Taxonomy: *

Invoice Type:

Modifiers:

Tooth#:

Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.

Click this button to see available units

Client Limit Inquiry:

Inquire#	Request Date	Client Id	Date Of Service	Procedure Code	Modifier Code	Diagnosis Code	Taxonomy Code	Provider NPI	Invoice Type	Tooth#	Facility Type
No Records Found !											

1. Client ID number
2. Date of Service (when you are planning a visit/service; future dates accepted)
3. Taxonomy code of the Billing Provider
4. Requested unit (s) (requires at least one or enter the amount to be supplied)
5. Procedure Code
6. Primary Diagnosis Code (if procedure code requires)
7. Invoice Type (claim form type)
 - D = Dental
 - P = Professional
 - I = Institutional
8. Provider NPI (Prepopulated)
 - Some providers such as a Billing Agent or a Master Submitter may have a drop down option to pick a NPI used in the search.
9. Facility Type (place of service if procedure code requires)
10. Modifiers (if the service has a specific modifier)
11. Tooth Number (if dental service requires a tooth)

Provider NPI: *

Facility Type:

Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.

Click this button to see available units

Client Limit Inquiry:

Inquire#	Request Date	Client Id	Date Of Service	Procedure Code	Modifier Code	Diagnosis Code	Taxonomy Code	Provider NPI	Invoice Type	Tooth#	Facility Type
No Records Found !											

Example request with data fill:

Client Limit Inquiry:

Client Id: *

Date of Service: *

Requested unit(s): *

Procedure Code: *

Primary Diagnosis Code:

Provider NPI: *

Facility Type:

Taxonomy: *

Invoice Type: *

Modifiers:

Tooth#:

Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.

Click this button to see available units

Client Limit Inquiry:

Inquire#	Request Date	Client Id	Date Of Service	Procedure Code	Modifier Code	Diagnosis Code	Taxonomy Code	Provider NPI	Invoice Type	Tooth#	Facility Type
No Records Found !											

ProviderOne Billing and Resource Guide

Click on the “**Submit**” button once the required data fields are filled.

The system clears the data boxes and displays the entries as if a line of code for a claim.

Client Limit Inquiry:

Client Id: *
Date of Service: *
Requested unit(s): *
Procedure Code: *
Primary Diagnosis Code:
Provider NPI: *
Facility Type:

Taxonomy: *
Invoice Type: *
Modifiers:
Tooth#:

Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.

Click this button to see available units

Get Results

Inquire#	Request Date	Client Id	Date Of Service	Procedure Code	Modifier Code	Diagnosis Code	Taxonomy Code	Provider NPI	Invoice Type	Tooth#	Facility Type	Requested unit(s)	Available unit(s)
832061108001	09/19/2012	110088899WA	10/02/2012	D0274			261QF0400X	1999444223	D		11	1	

Navigation: << Prev Viewing Page 1 Next >> 1 Page Count SaveToXLS

The actual limit inquiry is processing in the background so the **Available unit(s)** box is still empty. Wait a short time then click on the **Get Results** button to see the results of the limit inquiry.

Note: If the **Available unit(s)** box remains empty click on the **Get Results** button again as it may take ProviderOne a few seconds to complete the data base inquiry.

Once the inquiry is complete ProviderOne will display this screen with a value populated in the Available unit (s) field:

Client Limit Inquiry:

Client Id: *
Date of Service: *
Requested unit(s): *
Procedure Code: *
Primary Diagnosis Code:
Provider NPI: *
Facility Type:

Taxonomy: *
Invoice Type: *
Modifiers:
Tooth#:

Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.

Click this button to see available units

Get Results

Inquire#	Request Date	Client Id	Date Of Service	Procedure Code	Modifier Code	Diagnosis Code	Taxonomy Code	Provider NPI	Invoice Type	Tooth#	Facility Type	Requested unit(s)	Available unit(s)
832061108001	09/19/2012	1100887098WA	10/02/2012	D0274			261QF0400X	1942358908	D		11	1	1

Navigation: << Prev Viewing Page 1 Next >> 1 Page Count SaveToXLS

If there are available units, the system will display the number of units available.

Note:
Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.

ProviderOne and the toll free phone line relies on a claim/service being paid in ProviderOne. If the service has been done by another provider but not billed or paid yet, Medicaid will not be aware of the service status.

ProviderOne Billing and Resource Guide

If the system finds the service has been done within the timeframe of the service limit it will return a zero value for the “Available unit(s)”.

Client Limit Inquiry:

Client Id: *
Date of Service: *
Requested unit(s): *
Procedure Code: *
Primary Diagnosis Code:
Provider NPI: *
Facility Type:

Taxonomy: *
Invoice Type: *
Modifiers:
Tooth#:

Disclaimer: The available unit(s) does not account for services incurred but not yet billed or reported. The notice does not imply a service authorization or guarantee of payment.
Click this button to see available units
Get Results

Client Limit Inquiry:

Inquire#	Request Date	Client Id	Date Of Service	Procedure Code	Modifier Code	Diagnosis Code	Taxonomy Code	Provider NPI	Invoice Type	Tooth#	Facility Type	Requested unit(s)	Available unit(s)
832061108001	09/19/2012	100887098WA	10/02/2012	D0274			261QF0400X	1942358908	D		11	1	0

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At that point the provider of service would need to review the program specific Medicaid Provider Guide of the service to see how to proceed with treatment and if some form of Prior Authorization is an option.

Hint for Vision Providers: Use one of the exam codes or fitting fee codes as the search criteria not one of the hardware codes.

Other Reasons ProviderOne may return a “zero”:

- The client is enrolled in a Managed Care Plan, is QMB-Only or covered by Medicare, etc. may mean that no units are available through Medicaid fee for service.
- Is the client currently eligible?
- Is the billing provider taxonomy correct for the procedure code and is the taxonomy used listed on this provider’s file in ProviderOne?
- Is the diagnosis code used correct for this procedure (if applicable)?
- Is the modifier used correct for this procedure (if applicable)?

FYI: ProviderOne will retain the Client Limit Inquiry data line if additional limit checks for other codes are done during the same session.

Pitfalls

- **Not checking for service limits. By not checking client eligibility for services that have quantity, frequency, or duration limits and those services are performed, providers risk not getting paid.**
- **The results of the search are separate from checking a client’s eligibility for any service. It is the provider’s responsibility to verify eligibility for the estimated date of service, in addition to checking service limits.**
- **Make sure the client is not enrolled in a managed care plan that pays for services outside ProviderOne.**