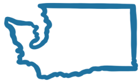

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Please note we have started this Q&A from our first ProviderOne webinar series, and will continue to update. We encourage you to submit more questions to shereice@ltcfwa.org

ProviderOne FAQs

Q: What is the deadline to collect fees for the month?

A: ProviderOne assigns client responsibility (CR) based on what is authorized at the beginning of the month and then it deducts that client responsibility once you submit your claims. You should not collect client responsibly until after the services are delivered in order to ensure the amount you are collecting is correct. Your remittance Advice (RA) will indicate how much CR was deducted from your claim. If there needs to be additional information relating to client responsibility policy or collection, please send that to the adult family home council.

Q: For adult foster homes do you know if there is going to be supplemental COVID authorizations?

A: There is a temporary add-on rate for Covid that is available through 12/31/2020. Refer to MB H20-072 for more information.

Q: How do we get an authorization to claim for transportation to appointments?

A: If you and your client are eligible for a separate transportation service code you would work with the case manager to authorize it.

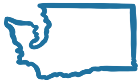
Q: First error date, does it include authorization changes made by case manager that have already been paid? Will it help with auditing for delayed authorization changes?

A: Yes, the first error date will show if something happens retroactively and most often that's a clerical error by the case manager. If you have already been paid for those dates, it is really important to reach out to your case manager as soon as possible.

Q: If I do batch billing can I have my date range include 2 different months or must I submit for each individual month?

A: You can do a batch with multiple templates. You can only submit for one month at a time, but you can do multiple individual months in a single batch.

Q&A continues on next page



Q: I went in to bill today for the month of September. The service code for the pandemic was already gone from the authorization list but I saw it earlier this month. Why does this happen?

A: When you are looking at your authorization list, it will default to only show your authorizations for the current month of service. When looking at the authorization list, there is a filter drop down that you can use to search by client id or date range or search for service code. The authorization is just not in that default view.

Q: How would I charge for an authorization that gets back dated and includes dates I've already billed? Do I just re-submit the claim for that period and let ProviderOne determine the difference between the previous and new authorization amount?

A: If an authorization is updated to reflect a different rate you can adjust previously submitted claims. If new dates are authorized, then you should submit new claims for those dates of service not previously claims. https://www.hca.wa.gov/billers-providers-partners/providerone/providerone-social-services

Q: Can the case manager change the assessment even without assessment or annual assessment without knowledge of provider?

A: Clients typically have their assessments done on an annual basis. Other types of assessments are significant change or interim assessment. A CM does not necessarily have to involve you in the development of the assessment, but they should be sending you a copy of the updated assessment when available. Continue to build the relationship with the CM and let case manager know you would like to be involved in future conversations.

Q: Can you show how to create a sample template?

A: Refer to the social service template billing guide (https://www.hca.wa.gov/billers-providers-partners/providerone/providerone-social-services), it has step by step instructions on how to create a template. If you still need assistance contact the HCA MACSC team (https://www.hca.wa.gov/contact-hca#collapse5).

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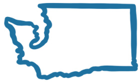

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Q: I often get an email that says there is a new provider one authorization message. When I click on it and open up ProviderOne I have no idea where this message or new information is located. It just opens up to my regular desktop, so I have no idea what the message was.

A: In your ProviderOne profile you can indicate how you would like to receive your notifications, when there are changes in your authorizations. Consider mailing option having a copy of the letter is helpful.

The email references the authorization number, it does not give you any more information than that. Consider ProviderOne mailing option so you can see those changes over time.

Q: Can you explain how batch claim works?

A: Information related to the batch upload process can be found here (https://www.hca.wa.gov/billers-providers-partners/providerone/providerone-social-services). If you need assistance with your batch upload contact HCA's HIPAA Help https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/hipaa-electronic-data-interchange-edi

Q: Does the caseworker file the claims?

A: The case manager creates the social service authorization that tells you the provider what your eligible to be paid for and what the client is eligible to receive. You as the provider go into ProviderOne to submit claim based on the dates of service you actually provide care for. You should verify the authorization details are correct and contact the case manager if the rates, dates, or service code, are not what you agreed to provide.

Q: What other programs would we use to create a batch? When I've created a batch, it also gives an option to upload a batch.

A: There is template batch billing and batch upload. If you are unsure which method would be more beneficial you should review the billing guides, maybe try the different methods and determined which will meet your needs.

Q: How do you recover your ProviderOne Password?

A: If you are unable to recover or reset your password following the link on the login page you can contact ProviderOne Security (https://www.hca.wa.gov/billers-providers-partners/providerone/providerone-security) for additional assistance.

Q&A continues on next page

Q: Can you go over how to add a new client to the billing template?

A: https://www.hca.wa.gov/assets/billers-and-providers/Create-Social-Service-Medical-Template.pdf

Q: How can I sign another person to do our provider one payment?

A: https://www.hca.wa.gov/assets/billers-and-providers/Adding-New-User-and-Profile.pdf

Q: If a client went to hospital late at night and admitted but already claimed to ProviderOne for that day and got paid that week. Social worker entered bed hold for that day. How can we adjust?

A:

- A Medicaid resident's discharge for a short stay in a hospital or SNF must be longer than 24 hours before a bed hold can be authorized.
- According to WAC 388-105-0045 (7), residential facility contractors must notify the Department Case Manager by email, fax or telephone within one working day whenever the resident is discharged from the facility for more than 24 hours on medical leave to a nursing home or hospital.
- Residential providers claim for the for the last full day of service prior to discharge from the residential facility.
    - With this in mind, if the client went to the hospital after midnight, and was admitted, this falls into the next 24 hour period.
    - If the client went to the hospital and was admitted prior to midnight, the residential provider would not claim for that date under normal service code, this would be the first date of bed-hold. Assuming the client is likely to return to the facility within 20 days.
    - If the residential provider has claimed under normal service codes for dates when the client was institutionalized, the fastest way to resolution is to notify the client's case manager. He/she will request that the specific TCN's be reprocessed by HCA, creating an overpayment which will be sent to OFR for debt collection. If appropriate, the case manager will also complete an authorization for bed hold service codes which the residential provider will claim. The funds received for these dates of service will be a 2nd payment and can be utilized to pay down the debt at CARS/OFR.

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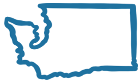

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Q: How do you set up direct deposit into an account, instead of paper checks?

A: https://www.hca.wa.gov/assets/billers-and-providers/Managing-Provider-Data.pdf

Q: Will I still be able to claim the miles that I have not claimed for a year?

A: All new claims for services provided must be claimed within 12 months of service.

Q: I already have the template created for three of my clients and I want to add my new client to the saved template, but it is not allowing me.

A: https://www.hca.wa.gov/assets/billers-and-providers/Create-Social-Service-Medical-Template.pdf

Q: Is it possible to change resident's participation fee for ProviderOne to pay directly if residents do not pay their fees or it needs to be through DSHS?

A: By contract, AFH providers are required to collect C/R from clients. Client Responsibility (C/R) is paid as assessed by each client, as his/her portion of the cost of care. Payment of C/R should occur prior to the state beginning payment on the client's behalf. If you are having difficulty collecting C/R, please work with the client's CM. Payment of assessed C/R is mandatory for participation with LTC services and there are several strategies the CM may be able to assist with.

Q: Can you tell us a little bit more about the first-time enrollment process?

A: https://www.hca.wa.gov/assets/billers-and-providers/Adding-New-User-and-Profile.pdf

Q: My social worker forgot to increase my ECS rate. How do I claim the new rates for July and August?

A: If you have already submitted claims with the old rate then you will need to adjust those claims.

- go to your inquire claims list and search the authorization number and date range
- View the details for the TCNs and verify which TCNs paid the old rate.
- Right down or copy and paste the TCNs that need to be adjusted
- Go to the "social service claim adjustment/void" and adjust each TCN that paid the old rate
- When you do your adjustment, you do not need to make any changes to the claim, just select adjust and then click submit, review the pending claim details then click the final submit button.
- If you have questions about how to adjust your claims reach out to the MACSC team at HCA.

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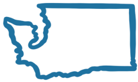

Q: Why is there client responsibility and what does it mean?

A: Client responsibility is the amount that the client has to pay towards their cost of care. It consists of 3 components: Third Party Liability (TPL), Room and Board (R&B), and Participation (Par).

Client Responsibility presentation PowerPoint:
https://dc821f26-f143-4f3a-8ea6-c790161c698c.filesusr.com/ugd/728615_80d03bd9ff3242b7abd876610200cbcf.pdf

Q: What is TCN and how do you find the TCN number?

A: TCN stands for Transaction Control Number. It is a 16 digit claim identifier that you can see on your Inquire Claims List. The Provider Billing and Resource guide has info about how to read a TCN. Open the guide and ctrl+F to search for "How to read a TCN."

https://www.hca.wa.gov/billers-providers-partners/providerone/providerone-billing-and-resource-guide

Q: How do you make a claim for mileage/transportation reimbursements? Do you put the date and the total miles for the dates, or do you do the number of days and miles for the month?

A: You can add a claim line for each date where you drove reimbursable mileage and you should only claim the number of miles driven that day. The mileage authorization is not intended as a stipend but is available to claim as it is used/delivered.

Q: I have heard that clients have SSI pay and Medicaid. How does that work is it two separate checks? Who pays what? Or does it all go through DSHS? As an AFH am I able to take these residents?

A: Clients who receive services through DSHS have both a financial and functional eligibility determination. If you have questions about a client's eligibility or your eligibility to serve them you should discuss those concerns with the Case Manager. If the Case Manager is unable to answer your questions you should ask to speak with a supervisor.

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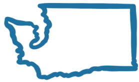

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Q: When creating payments for my Medicare clients in ProviderOne, I made an error and requested to be paid through the check system. How can I change to have EFT payments for claims from DSHS clients in my AFH?

A: You can update your payment preference in ProviderOne by making a change to the specific location details. Information for how to do this can be found in the Managing Provider Data billing guide: https://www.hca.wa.gov/assets/billers-and-providers/Managing-Provider-Data.pdf

Q: What is the time frame of resubmitting a claim?

A: You can submit an original claim within 12 mons of the date of service, you then have an additional 12 months to adjust submitted claims.

Q: When billing for SA0215, (mileage) do I use miles as units?

A: Yes, 1 unit= 1 mile

Q: What is the service code for the $300 that DSHS was supposed to pay each home that got N95 testing?

A: SA603 U1. You can search your authorization list using the filter menus and filter for SA603. If you have more than 10 clients you may want to export your authorization list to excel to view/review to determine whether a client was not included.

Q: What do I do if a client has left my facility, but her case manager and ProviderOne both cannot find her authorization?

A: The authorization is most likely not showing up because the end date is in the past. When you view your authorization list use the search/filter options to look for the client ID. If the case manager can't help, please ask for help from a supervisor.

Q: I have a resident that doesn't have a payee or payee who doesn't answer the phone. What can I do in this situation?

A: There are some services that may be available to help ensure the client is successful in the community by helping them get a payee or other support to manage their finances. If you are having difficulty connecting with the resident you can try to work with the case manager.

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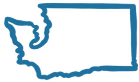

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Bed Hold Authorization FAQs

Q: What is the rate for social leave?

A: Social Leave is claimed using the normal personal care service code and is paid at the client's usual daily rate.

Q: Client are allowed to go spend overnight at a family members home for 18 days out of the year. How would you bill for that if it's not a behold?

A: Clients are allowed Social Leave for up to 18 days per year. These dates are billed using the regular personal care service code. Social Leave is defined as leave that is for recreational or socialization purposes, not for medical, therapeutic or recuperative purposes. Social Leave is permitted under the statutory authority of WAC 388-110-100(2).

Q: How do you discharge a client if they are gone for more than 20 days and there is no more bed hold?

A: A provider isn't able to just discharge a client once they are past the 20 days. Per WAC 388-105-0045 (11), If third-party payment is not available for a bed or unit hold that lasts for twenty-one days or longer, the medicaid resident may return to the first available and appropriate bed or unit at the AFH if he or she continues to meet the admission criteria under chapter 388-106 WAC. However, if the facility believes they can't safely provide ongoing care to the client or other residents due to significant changes in a client's health or needs, the provider will want to follow the process outlined in the RCW 70.129.110 and WAC 388-76-10616.

Q: What happens on day 21 after the bed hold is over?

A: DSHS no longer pays for the bed hold. The provider may seek a third party payment or no longer hold the bed.

Q: Am I entitled to get the participation money if the client goes to hospital at the beginning of the month? If they stay for 20 days, am I entitled to refund the bed hold in this case?

A: Client Responsibility does not apply to dates the client's bed is being held, only dates in which the client is in residence. If a client is out on Bed Hold on the 1st of the month, you are not entitled to Client Responsibility until the client returns and resumes receiving personal care. If the client is out on Bed Hold for 20 days and then returns to your facility, you are entitled to keep the Bed Hold dollars you were paid, as well as the personal care dollars earned after the client's return, and the Client Responsibility deducted from your Department-paid earnings but paid to you by the client.

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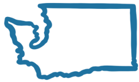

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Q: What is the code for Bed Holds?

A: SA685 (Days 1-7) SA686 (days 8-20)

Q: If the client is admitted mid-day, do I bill that day as a full day, or must it be under bed hold?

A: You may submit a claim for personal care for every date authorized in which the client resides at your facility as of midnight.

Q: Is there a WAC for social leave hold?

A: Yes. WAC 388-110-100 is the statutory authority for Social Leave.

Q: How do you calculate the client's participation to charge during a bed hold period?

A: We don't. Client Responsibility does not get deducted from Bed Hold. The client's Public Benefit Specialist (financial worker) will determine the Client Responsibility amount and needed adjustments for months where the client is in a hospital or SNF.

Q: How far can I go back to submit last year U4 or U3?

A: As per WAC 388-05-0010, providers have one year (366 days) in which to submit claims, and an additional year in which to adjust previously submitted claims. Requests for exceptions must be escalated through the case manager to the ProviderOne Program Manager for consideration.

Q: Can I refuse to offer 20-day bed hold on Medicaid client?

A: Per WAC 388-105-0045 (2), residential facilities (ESF, AFH, ARC, EARC, or AL) are required to hold a client's bed for 20 days when the client is discharged for medical reasons to a nursing home or hospital.

Q: I had an issue billing a bed hold, informed the case manager but it was never resolved. How long do I have to continue to bill for it?

A: If the Case Manager is unable to resolve it then the issue needs to be escalated within their local office (typically to a Supervisor then and Manager). You still have a year from the date of service to resolve the issue but if it takes longer for the CM to update the authorization their office can request assistance from the ALTSA or DDA HQ to review the payment.

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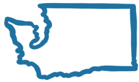

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Q: If Medicaid resident passes, are we allowed to retain any participation money beyond day of death until belongings are removed?

A: No. You can only retain client responsibility up to the amount applied to your social service authorization for that month.

Q: What is the maximum time you can hold a bed?

A: Per WAC 388-105-0045 (2), residential facilities (ESF, AFH, ARC, EARC, or AL) are required to hold a client's bed for 20 days when the client is discharged for medical reasons to a nursing home or hospital. The provider may seek a third party payment or no longer hold the bed after 20 days.

Q: How are the bed hold rates determined?

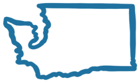
A: Bed Hold rates are defined under the statutory authority of WAC 388-105-0045. The Department makes available what the law allows us to make available.

Q: What if the client has set up with their bank for their client responsibility to auto-pay but they are still in the hospital/skilled center and the provider has received the payment and the bed hold is beyond 20 days and provider is receiving no other compensation?

A: Client Responsibility in excess of what is assigned to the social service authorization for that month should be returned to the client. The Bed Hold is the only compensation to be expected from the Department. After the Client Responsibility is returned to the client, the client may choose to privately pay for their bed to be held after 20 days. That is the client decision, however, and the Client Responsibility should not be held against the client's will.

Q: I accidentally submitted a claim when the resident was in the hospital, I voided it, but the social worker has not given me bed hold authorization and I received a letter saying I owe money what do I do next?

A: You will need to pay back the money associated to the billed and paid personal care. If the CM is not responsive in authorizing the bed hold then the issue should be escalated ot their supervisor to ensure that the bed hold is authorized then you can submit your claims for payment for the bed hold dates. If it has been more than a year ask the Supervisor to escalate the issue to ALTSA or DDA HQ to review for payment.



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Q: How can I see my submitted claims?

A: You can view claims information from your Online Services menu under “Inquire Claims” or on your Remittance Advice from the “View Payment” link.

Q: I signed up for direct deposit, but I received a check. What happened?

A: Once you submit your changes for EFT it may take up to two weeks before you start receiving the direct deposits. If it has been more than two weeks please contact the Health Care Authority so they can verify the status of your change.

Q: If my claims were denied, can I resubmit them after they have been past due?

A: Yes. If you submitted your original claims within a year from the date of service and you resolve the denial reasons after a year then you should be able to resubmit those denied TCNs and they should pay. If they deny only due to the timeliness edit then you can contact the Health Care Authority MACSC team and ask that your denial be reviewed and forced if appropriate.

Q: Is there a deadline to submit claims?

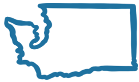
A: Per WAC 388-05-0010 you have 12 months from the date of service to submit a claim.

Q: How can I refund the state and fix my billing error for over payment?

A: If you made a billing error on a PAID claim you can adjust the claim to change specific details or if nothing should have paid on the claim you can void the whole TCN.

Q: If I miss the opportunity to bill for the previous year, can I go back and bill?

A: If you submit a claim that is more than a year past the date of service it will deny due to timeliness. If there were extenuating circumstances that meet criteria per WAC 388-05-0010 please contact the MACSC team at HCA and provide details to the circumstances request that the denial be reviewed and considered to be paid.



Q: When does the clients responsibility (CR) amount change?

A: The total amount that a client may have to pay changes when there is a change to the client's income or rules changes in how the Department calculates the amounts.
The amount of CR that may be applied to your authorization service lines may change when there are changes to the authorization after the affected month has started. If your authorization is modified for past dates of service review the CR application in your authorization list.

Q: Is the client responsibility (CR) and participation fee the same?

A: CR is comprised of Participation, Room and Board, and Third Party Liability

Q: If I billed and forgot to add a billing authorization line code would ProviderOne add it for me?

A: ProviderOne does not have the ability to add lines on your behalf. You will need to review your claims against your authorization and services delivered to ensure you have billed fully.

Q: If I register for direct deposit, where do I confirm that I have completed it correctly?

A: Please contact HCA for assistance with verifying Direct Deposit enrollment.

Q: How do I sign up for ProviderOne alerts and how do I check them?

A: You can change you authorization alert settings of a specific location by:

1. Manage Provider Information
2. Click Step 2: Locations
3. Click the Location ID for the desired facility
4. Update Communication Preference