Updated April 2025

How to view your remittance advice (RA)

The remittance advice (RA) provides a detailed breakdown of paid, denied, adjusted, and in process claims. RAs are available in ProviderOne each Friday. To ensure claim submissions processed correctly, it is very important for providers/billers to review their RAs as soon as they become available in ProviderOne. To view RAs: login to ProviderOne, click on “View Payment”, click on the RA you want to view.

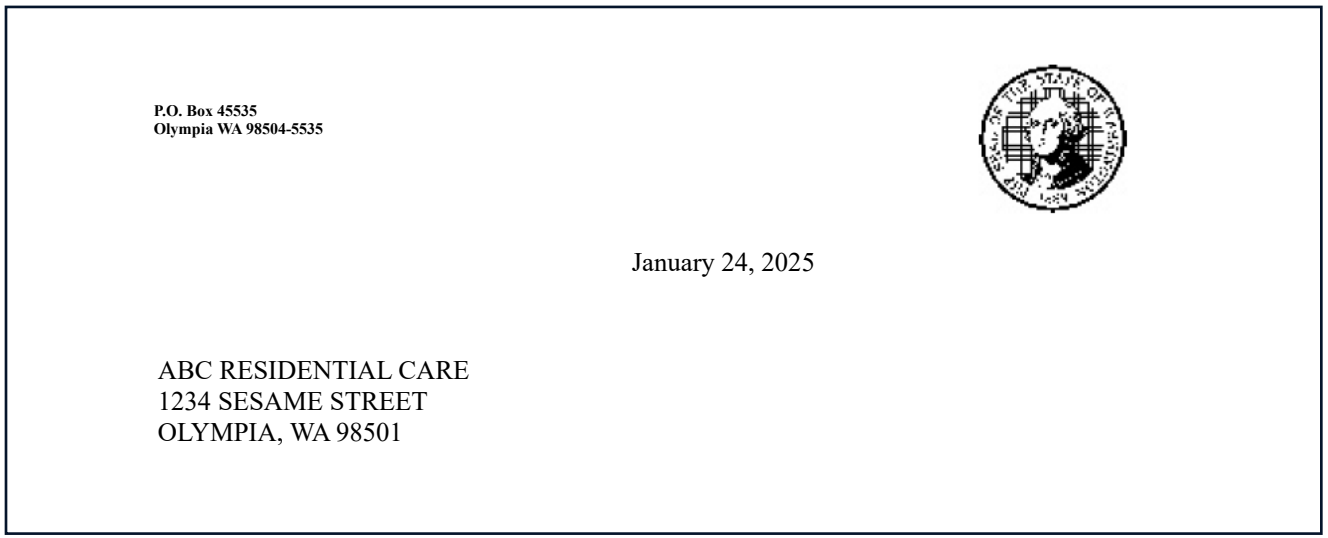
Understanding each section of the RA

The remittance advice is broken into four main sections:

- Section 1: Mailing information
- Section 2: Current RA messages
- Section 3: Payment summary
- Section 4: Payment information

Section 1: Mailing Information

The first page of the RA contains the RA creation date, the provider's name, and the provider's mailing address. If your mailing address has changed, it is important to update that information in ProviderOne:



P.O. Box 45535
Olympia WA 98504-5535

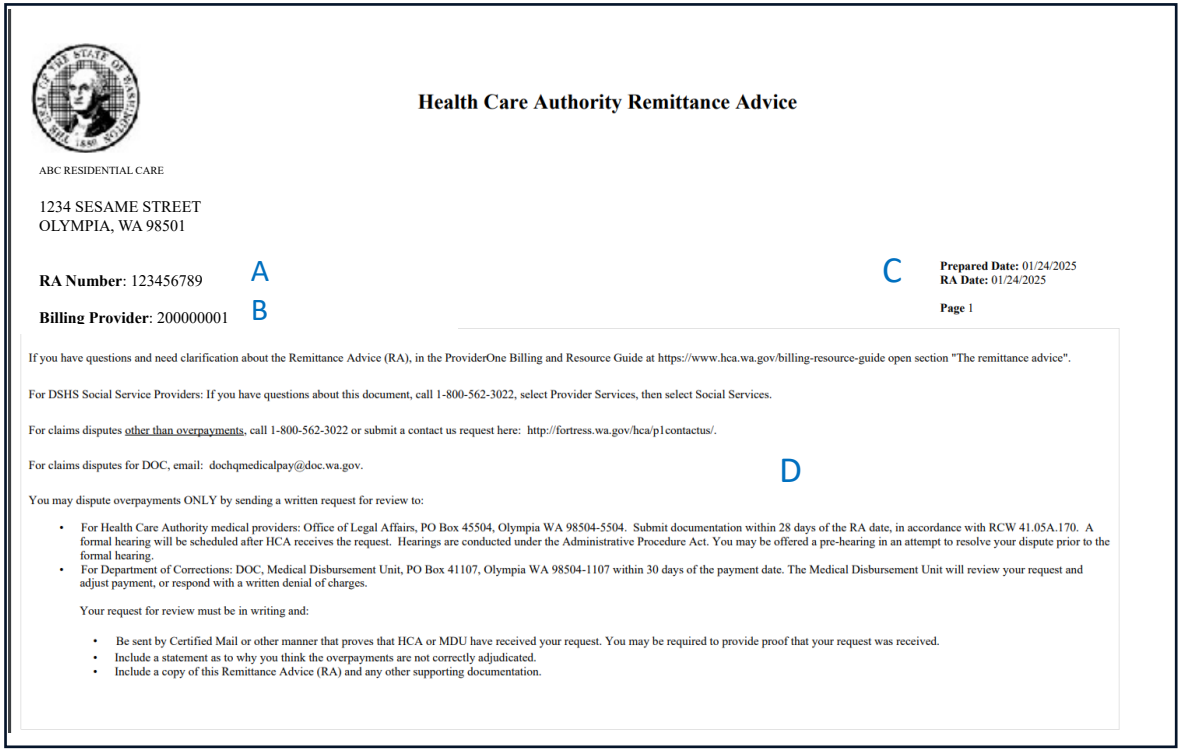
January 24, 2025

ABC RESIDENTIAL CARE
1234 SESAME STREET
OLYMPIA, WA 98501

Section 2: Current RA Messages

In this section we find the:

A. **RA Number**
B. **Billing Provider ID**: This is your ProviderOne ID (also known as your ProviderOne domain).
C. **Prepared date**: Date the RA was prepared & **RA date**: Date payment was released
D. **Key messages:** These are alerts from HCA or DSHS about changes to ProviderOne functions or claims deadlines.



Health Care Authority Remittance Advice

ABC RESIDENTIAL CARE

1234 SESAME STREET
OLYMPIA, WA 98501

RA Number: 123456789 A

Billing Provider: 200000001 B

C **Prepared Date:** 01/24/2025
RA Date: 01/24/2025

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If you have questions and need clarification about the Remittance Advice (RA), in the ProviderOne Billing and Resource Guide at https://www.hca.wa.gov/billing-resource-guide open section "The remittance advice".

For DSHS Social Service Providers: If you have questions about this document, call 1-800-562-3022, select Provider Services, then select Social Services.

For claims disputes other than overpayments, call 1-800-562-3022 or submit a contact us request here: http://fortress.wa.gov/hca/p1contactus/.

For claims disputes for DOC, email: dochqmedicalpay@doc.wa.gov.

D

You may dispute overpayments ONLY by sending a written request for review to:

- For Health Care Authority medical providers: Office of Legal Affairs, PO Box 45504, Olympia WA 98504-5504. Submit documentation within 28 days of the RA date, in accordance with RCW 41.05A.170. A formal hearing will be scheduled after HCA receives the request. Hearings are conducted under the Administrative Procedure Act. You may be offered a pre-hearing in an attempt to resolve your dispute prior to the formal hearing.
- For Department of Corrections: DOC, Medical Disbursement Unit, PO Box 41107, Olympia WA 98504-1107 within 30 days of the payment date. The Medical Disbursement Unit will review your request and adjust payment, or respond with a written denial of charges.

Your request for review must be in writing and:

- Be sent by Certified Mail or other manner that proves that HCA or MDU have received your request. You may be required to provide proof that your request was received.
- Include a statement as to why you think the overpayments are not correctly adjudicated.
- Include a copy of this Remittance Advice (RA) and any other supporting documentation.

Section 3: Payment Summary

The **Payment Summary**, found on Page 2 of your RA, contains a summary of the claim information found in Section 4: Payment Information.

RA Number: 123456789
Warrant/EFT # 555556! A **Warrant/EFT Date: 1/23/2025**
Payment Method: EFT

Prepared Date: 1/24/2025
RA Date: 1/24/2025

Warrant/EFT Amount: $14,501.85 B

Page 2

Claims Summary C

Provider Adjustments D

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total Sales Tax	Total Client Resp Amount	Total Paid	Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type E	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
200000001	Paid	$43629.14	$43629.14	$0.00	$29127.29	$14501.85	200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Invoice	$0.00	$0.00	$799.04
200000001	Denied	$81.00	$0.00	$0.00	$0.00	$0.00	200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Referred CARS	$799.04	$799.04	$0.00
200000001	Adjustments	$0.00	$0.00	$0.00	$0.00	-$799.04							

Total Adjustment Amount: $799.04

- **A.** **RA Number**, **Warrant** (check)/**EFT #**, **Warrant/EFT Date** (date of payment), and **Payment Method** (electronic funds transfer-EFT or warrant)
- **B.** **Warrant/EFT Amount**: Total amount paid to the provider
- **C.** **Claims Summary**: Provides a summary of all claims submitted in the most recent weekly claim cycle
  - *Category*: Paid (original claims in paid status); Denied (claims in denied status); Adjustments (claims that resulted from an adjustment); In Process (claims that were submitted by the deadline but there was a delay in processing payment). A description of each claim category and what to look for in each category can be found on pages 6-10 of this document.
  - *Total Billed Amount*: Dollar amount on the submitted claim.
  - *Total Allowed Amount:* The amount DSHS is allowed to be pay.
  - *Total Client Resp. Amount:* Amount of client responsibility (CR) that will be deducted from the paid claim. The provider collects CR from the client.
  - *Total Paid:* This is the total amount paid by DSHS (allowed amount minus client responsibility).
- **D.** **Provider Adjustments.** Provides a summary of claim adjustments initiated during the previous week that resulted in an overpayment* or are related to an existing overpayment. Claim adjustments can be initiated by the provider or DSHS. Next to each adjusted amount, the adjustment type (**E**) is listed. The adjustment type indicates whether the adjustment was processed as offset or non-offset.**

*See page 4 for more information about overpayments
**See pages 5 and 10-12 for more information about adjustments

Overpayments

Overpayments can be generated when a paid claim is either adjusted or voided. Adjusting a claim in paid status will result in an overpayment when the new paid amount is less than the original paid amount. Voiding a claim will always result in an overpayment because the State (DSHS) has paid out money for a claim that is no longer in paid status. There are two different methods for repaying an overpayment, non-offset or offset. These are described below:

- **Non-offset**: This is the default option for Social Services providers. The debt (overpayment) is sent to the Office of Financial Recovery (OFR). OFR then contacts you, the provider, to address the debt. You will receive a letter from OFR informing you of the debt and how to correct the overpayment, how to pay the overpayment, and your administrative hearing rights if there is any dispute to the information provided.
- **Offset**: For this option, you have to contact HCA via phone at 1-800-562-3022 or online **prior** to adjusting or voiding the claim. You will need to provide the claim number (TCN) and explain that you want the claim adjusted as "offset". HCA will assist you with adjusting the claim as offset and the ProviderOne system will then deduct the debt from all paid claims submitted until the debt is satisfied within a 6-month window. The deduction is reflected in the Payment Summary section on your Remittance Advices (RAs). No overpayment notice is generated. After 6 months, if the debt is not satisfied, any remaining balance will be sent to OFR for recovery as a non-offset adjustment and you will receive an overpayment notice from OFR at that time.

Adjustment types

A summary of any claim adjustments can be found on the Payment Summary (Page 2) of your RA. Next to each adjusted amount, an adjustment type is listed. The adjustment type is a result of your actions on a claim(s), or an action initiated by DSHS. The most common adjustment types seen on Social Services RAs are listed below. A list of all claim adjustment types can be found in HCA's ProviderOne Billing & Resource Guide.

Adjustment Type	Definition
NOC Referred to CARS	This occurs when a voided claim or an adjusted claim resulted in a non-offset overpayment and the overpayment has been referred to the Office of Financial Recovery's (OFR) Collection and Accounts Receivable System (CARS) for recovery. An overpayment means you were paid too much and you now owe this money back to DSHS.
NOC Invoice	This posts together with a "NOC Referred to CARS" line. This means that the overpayment was referred to OFR and an invoice was created. OFR mails the invoice to you informing you how much you owe.
P1OFF Invoice	This occurs when you owe DSHS due to adjustments exceeding payments. In these cases, DSHS creates an account receivable which is satisfied by either: • Taking payment from a future paid claim, or • Through a receivable sent to OFR to initiate the recovery. The latter only happens if the P1OFF is not satisfied after six months.
P1OFF Recoupment	This identifies the payments used to satisfy the P1OFF receivable. This typically posts immediately following a P1OFF Invoice line.
COFF Invoice	OFR creates a CARS Offset Invoice in OFIN for each request sent to ProviderOne from CARS. Direct all questions about COFF offsets to OFR at 1-800-562-6114.
COFF Recoupment	OFR accepts a receivable to collect, and OFR sends back a request to take other payments for paid claims from you to satisfy the receivable. There should be other paid claims on the RA, and some of those payments go to OFR to help satisfy the debt.
COFF Referred to CARS	ProviderOne tried to recover a dollar amount you owed DSHS but did not have a sufficient total of claim payments post in the last six months to satisfy the debt. The balance owed is sent to OFR for collection.

Legend for above acronyms:

OFR: Office of Financial Recovery
OFIN: Oracle Financial System
CARS: Collections and Accounts Receivable System (OFR recovery)
NOC: Non-Offset to CARS
COFF: CARS Offset (lien)
P1OFF: ProviderOne Offset (claim adjustment)

Section 4: Payment Information

The Payment Information section, which starts on Page 3 of the RA, provides a detailed breakdown of the information found in Section 3: Payment Summary. Depending on how many claims were submitted during the previous week, the Payment Information section may be multiple pages long. The Payment Information section is divided into claim categories. Within each claim category, you will find the following information:

RA Number: 123456789 **Warrant/EFT #: 555556!** **Warrant/EFT Date: 1/23/2025** **Prepared Date: 1/24/2025** **RA Date: 1/24/2025**

Page 3

Category: Paid A **Billing Provider: 20000001**

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/ B	TCN / Claim Type / RX Claim # / Inv # / Auth # C	Line # D	Rendering Provider / RX # / Auth office # E	Service Date(s) F	Svc Code or NDC / Mod / Rev & Class Code G	Total Units or D/S G	Billed Amount H	Allowed Amount H	Sales Tax	TPL Amount I	Client Responsible Amount I	Paid Amount J	Remark Codes K	Adjustment Reason Codes / NCPDP Rejection Codes K
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	1/16/2025 - 1/16/2025	T1020 U1	1.0000	$70.85	$70.85	$0.00		$0.00	$70.85		
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	1/17/2025 - 1/17/2025	T1020 U1	1.0000	$70.85	$70.85	$0.00		$0.00	$70.85		
Document Total: 1/16/2025-1/17/2025						2.0000	$141.70	$141.70			$0.00	$141.70		

- **A. Category.** The name of the claim category (i.e., paid, denied, adjustments, or in process) is listed at the top of each page. *
- **B. Client Name/Client ID.** The client's name & ProviderOne ID.
- **C. TCN/Claim Type/Auth #.** Claim number (also known as the TCN), the type of claim (ADSA-H=ALTSA or ADSA-D=DDA), & authorization number
- **D. Line #.** The claim line number is listed here and is for each line or date of service on the claim.
  - If the service code is paid per a daily rate and you used a date range when entering your claims, the range is divided into daily lines.
  - If the service code is paid per a monthly rate or one-time payment, you will see the date range that was submitted on the claim.
- **E. Rendering Provider/RX#/Auth office #.** Listed here is the DSHS office (reporting unit) that authorized the service.
- **F. Service Date(s).** This is the service date (i.e., the date services were provided) that the provider or biller entered on the claim in ProviderOne.
- **G. Svc Code/Mod & Total Units.** The service code, modifier, and total units billed for each date of service. In the example below, one unit of service was billed each day for a total of 2 units for the week.
- **H. Billed Amount & Allowed Amount.** The amount that was billed on the claim and the amount allowed per the authorization.
- **I. TPL Amount & Client Responsible Amount**. If the client has private insurance (TPL) or client participation, these amounts will be listed here.
- **J. Paid Amount**. This is the amount DSHS paid towards the claim.
- **K. Remark Codes & Adjustment Reason Codes**. A code will be listed here when client participation is deducted or if a claim is denied or adjusted.

*On the next few pages, we will take a closer look at each claim category. A common mistake made by providers & billers is resubmitting claims that have already paid (possibly resulting in a duplicate payment and/or a denial), or resubmitting denied claims without correcting the claim (which will result in another denial). This can happen when each claim category is not thoroughly reviewed.

Claim category: Paid

The **Paid** claim category shows claims that paid during the previous week. Depending on how many claims were submitted, the paid claim category may be multiple pages long and may contain multiple clients and multiple dates of service. **Note:** Some paid claims may also contain denied service lines. These denied lines will be displayed in the paid claims section within the specific claim that was paid as well as in the denied claims category section. When reviewing the paid claim category, confirm the following information is correct for each client:

- **A. Service Date(s)**. The date the service was provided to the client. These dates should fall within the client's authorized date range.
- **B. Svc Code.** The service code you entered on the claim. This should match what the client is authorized for.
- **C. Total Units or D/S.** The # of units you entered on the claim.
- **D. Billed Amount & Allowed Amount**. The amount that was billed on the claim and the amount allowed per the authorization.
- **E. Client Responsible Amount.** Client responsibility (participation/room & board) amount. The provider must collect this amount from the client. In the example below, we see the client's participation is $125.
- **F. Paid amount.** The amount DSHS paid. In the example below, we see the total claim amount for 2/1/25-2/2/25 was $250. Provider must collect $125 from the client & DSHS pays the remaining $125.
- **G. Remark Codes, Adjustment Reason Codes/NCPDP Rejection Codes**. If a claim line denies, an adjustment reason recode and/or a remark code will be listed. You will also see an adjustment code listed if the client has client participation (as we can see below). A description of any remark code or adjustment reason code listed throughout the RA can be found on the last page of your RA.

RA Number: 123456789 **Warrant/EFT #: 555556!** **Warrant/EFT Date: 2/13/2025** **Prepared Date: 2/14/2025** **RA Date: 2/14/2025**

Category: Paid **Billing Provider: 20000001**

Page 3

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s) A	Svc Code or NDC / Mod / Rev & Class Code B	Total Units or D/S C	Billed Amount D	Allowed Amount D	Sales Tax	TPL Amount	Client Responsible Amount E	Paid Amount F	Remark Codes G	Adjustment Reason Codes / NCPDP Rejection Codes G
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/1/2025-2/1/2025	T1019	1.0000	$125.00	$125.00	$0.00		$125.00	$0.00		142 45 94 = $125.00
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/2/2025-2/2/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00	$125.00		
Document Total:	**2/1/2025-2/2/2025**					2.0000	$250.00	$250.00			$125.00	$125.00		

Total amount of this claim

Amount provider must collect from client

Amount DSHS paid

Note: If information on your paid claims is incorrect, or if a claim line denied, you must login to ProviderOne to correct the claim and resubmit. You should then check future RAs to confirm the claim reprocessed and paid correctly.

Claim category: Denied

If any claims denied during the previous week, you will find the **Denied** claims category directly after the Paid claims category.

Category: Denied

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/10/2025-2/10/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00	$0.00		B13=$125.00
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/11/2025-2/11/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00	$0.00		B13=$125.00
Document Total: 2/10/2025-2/11/2025						2.0000	$250.00	$250.00	$0.00		$0.00	$0.00		

When reviewing the Denied claims category:

- Look for the **Remark Codes** and/or **Adjustment Reason Codes** listed in the last two columns. Every denied claim will have an Adjustment Reason Code/NCPDP Rejection Code and some will also have a Remark Code.
    - A description of the adjustment reason code/remark code will be listed on the last page of the RA. Review the description of the codes on the last page to determine why the claim denied.
- After reviewing a description of the adjustment reason codes and remark codes to determine the denial reason, correct the claim in ProviderOne and resubmit (if applicable). You can correct and resubmit a denied claim when:
    - The entire claim is denied.
    - An individual line on a multiple line claim is denied. This line can usually be rebilled as a new claim.
    - The paid claim can be adjusted to correct an error on the denied line of a multiple line claim.
    - More information on how to resubmit denied claims can be found in the ProviderOne billing guides on the ProviderOne for Social Services webpage.
- If you are unable to determine why a claim denied after reviewing the description of the adjustment/remark codes, and/or if you need assistance with correcting and resubmitting the claim, you may contact HCA's Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022 or you can submit an online form for assistance.

Claim category: In Process

In Process claims are claims that are currently in process (i.e., claims haven't paid yet). In Process claims are claims that were submitted by the Tuesday, 5 p.m. deadline but are pending review by HCA claims processing staff. These claims will show up on a future RA as a paid or denied claim. Claims submitted *after* Tuesday, 5 p.m. deadline will *not* show on this week's RA but will show up on a future RA as a paid or denied claim.

Category: In process

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	3	172	2/20/2025-2/20/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00	$125.00		
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	4	172	2/21/2025-2/21/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00	$125.00		
Document Total: 2/20/2025-2/21/2025						2.0000	$250.00	$250.00	$0.00		$0.00	$0.00		

Claim category: Adjustments

The **Adjustments** category shows previously paid claims that have since been adjusted (changed or voided) and reprocessed. Claims can be adjusted by the provider or by DSHS. Claims may be adjusted for a variety of reasons including, but not limited to, the rate or units on an authorization changed after the provider already received payment, the provider received payment when they shouldn't have, etc. When adjusting a claim, an overpayment may be generated if the new paid claim amount is less than the original paid claim amount. An overpayment means the provider owes the previously paid amount back to DSHS.

Category: Adjustments

Every adjusted claim will have a claim adjustment reason code. A description of the code can be found on the last page of the RA. If you are unable to determine why a claim was adjusted, contact HCA at 1-800-562-3022.

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/5/2025-2/5/2025	T1019	1.0000	-$125.00	-$125.00	$0.00		$0.00	-$125.00		119 = $0.00
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/6/2025-2/6/2025	T1019	1.0000	-$125.00	-$125.00	$0.00		$0.00	-$125.00		119 = $0.00
Document Total: 2/5/2025-2/6/2025						2.0000	-$250.00	-$250.00			Credit	-$250.00		
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	**TCN / Claim Type / RX Claim # / Inv # / Auth #**	**Line #**	**Rendering Provider / RX # / Auth office #**	**Service Date(s)**	**Svc Code or NDC / Mod / Rev & Class Code**	**Total Units or D/S**	**Billed Amount**	**Allowed Amount**	**Sales Tax**	**TPL Amount**	**Client Responsible Amount**	**Paid Amount**	**Remark Codes**	**Adjustment Reason Codes / NCPDP Rejection Codes**
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/5/2025-2/5/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00	$0.00		16 = $0.00
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/6/2025-2/6/2025	T1019	1.0000	$125.00	$125.00	$0.00		$0.00	$0.00		16 = $0.00
Document Total: 2/5/2025-2/6/2025						2.0000	$250.00	$250.00			Debit	$0.00		

Adjustments utilize basic accounting principles and will have two transactions displayed on the RA:

- The Credit transaction is a copy of the original claim with the originally paid dollar amounts listed as a negative.
- The Debit transaction displays the new billed and allowed amounts, as a result of the adjustment, and the associated new paid claim dollar amounts.
- **Although a credit & debit transaction are displayed, this <u>does not</u> mean the previously paid amount was taken back by DSHS.** In the example above, we see that the provider was originally paid $250 for dates of service 2/5/25-2/6/25. The provider adjusted their paid claim and removed 2/5/25-2/6/25 after discovering the client was out of the facility and services were not provided on those dates. The new paid amount is $0. Since the provider did not provide services and should never have received payment for 2/5/25-2/6/25, the provider must pay back the $250 to DSHS. This means the provider has a $250 "overpayment". See page 4 for more information about overpayments.

Adjustment reason codes/NCPDP rejection codes and remark codes

On the last page of your RA, you will find a description of any **Adjustment Reason Codes** and **Remark Codes** listed within the claims categories of your RA:

Adjustment Reason Codes / NCPDP Rejection Codes
16 : Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. 18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) 284 : Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services. B13 : Previously paid. Payment for this claim/service may have been provided in a previous payment.

Remark Codes
M79 : Missing/incomplete/invalid charge.

Most common adjustment reason codes/remark codes

Below is a list of the **most common adjustment reason codes/remark codes** you may see on your RA and steps you can take if you see these codes:

Adjustment Reason Code/Remark Code	Possible Causes	Provider Action
16: Claim/service lacks information or has submissions/billing error(s)	1. Claimed dates of services are not within the authorized period, or 2. Authorization line is in error	1. If you claimed the wrong dates, correct the claim and resubmit. 2. If you think the authorization dates are wrong or if you have questions about the authorization dates, contact the client's case manager. 3. If the auth line is in error, contact the client's case manager.
18: Exact duplicate claim/service	1. Claimed the same units on two different lines for the same day, or 2. Claim is an exact duplicate of one already submitted	1. Adjust the paid claim to report the correct # of units on a single claim line 2. Review past RAs to see if you have already received payment for this client, date of service, & code. You can also look in ProviderOne to see when/if you received payment. If you have already been paid, no action is needed. If questions, contact HCA at 1-800-562-3022.
142: Monthly Medicaid patient liability amount (may be listed as "142 45 94" on RA)	Client responsibility (participation)	You must collect this amount from the client
177: Patient has not met the required eligibility requirements	The client is not financially eligible	Contact the client's case manager

198: Precertification/authorization exceeded	Authorized units have already been claimed	1. Review past RAs to see if you have already received payment for this client, date of service, & code. You can also look in ProviderOne to see when/if you received payment. If questions, contact HCA at 1-800-562-3022. 2. If you think the authorized units are incorrect, contact the client's case manager.
A1: Claim/service denied	The authorization is in cancelled or error status	Contact the client's case manager
B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service	Your DSHS contract may be expired	Contact your DSHS contract specialist
B13: Previously paid. Payment for this claim/service may have been provided in a previous payment.	You have already claimed and received payment for this date of service.	Review past RAs to see if you have already received payment for this client, date of service & code. You can also look in ProviderOne to see when/if you received payment. If questions, contact HCA at 1-800-562-3022.
N54: Claim information is inconsistent with pre-certified/authorized services	Authorization line is in error	Contact the client's case manager
N63: Rebill services on separate claim lines	A separate claim line is required for each date of service for the service/procedure code billed.	If you are billing "quarter hour units" or "each unit" code types, do not use a date span when entering the claim (Example--From date: 1/1/2025, To date: 1/31/2025). Modify/adjust the claim and enter separate claim lines for each date of service and resubmit the claim. For assistance, contact HCA at 1-800-562-3022.
N345: Date range not valid with units submitted	Dates entered on claim do not match dates that are authorized.	Confirm you billed for dates within the authorization period and correct/resubmit as needed. Contact the client's case manager if you have questions about the authorized dates.
N362: The number of days or units of service exceeds our acceptable maximum	Too many units claimed (Example: Provider claimed 2 units when only authorized for 1 unit).	Modify the claim to change the # of units to the correct amount and resubmit the claim.