

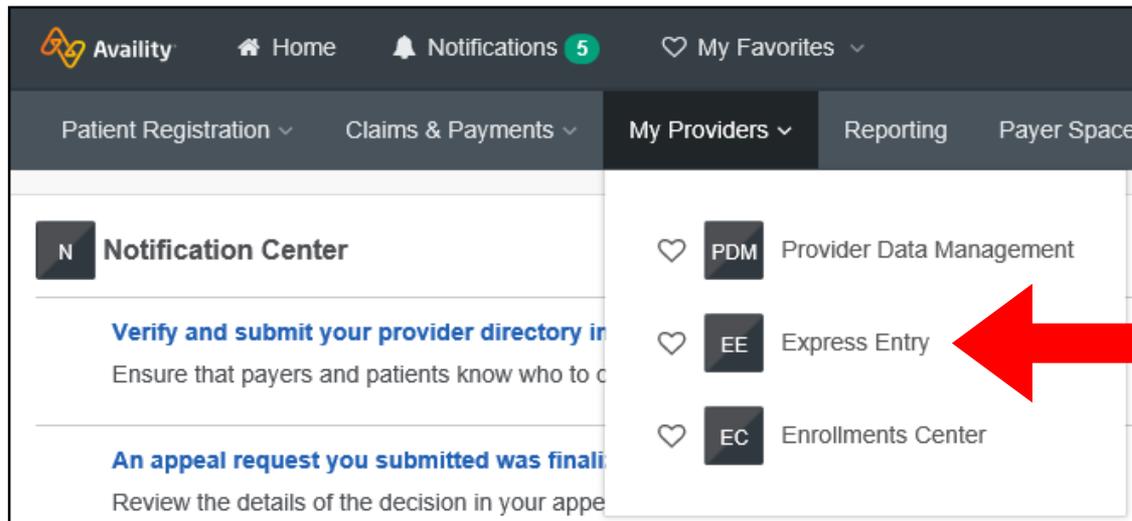


Express Provider Entry setup in Availity

Atypical provider billing process

Express entry set up

- Once logged in to the Availity Portal, select **Express Entry** through *My Providers*.



Express entry set up (cont.)

- Select **Add Provider**.



The screenshot shows a web interface titled "Manage Express Entry". Below the title is a horizontal bar containing a dropdown menu on the left labeled "Select Organization" and a green button on the right labeled "Add Provider" with a white plus sign icon. A large red arrow points from the right side of the image towards the "Add Provider" button.

Express entry set up (cont.)

- In the drop down that appears, choose the arrow next to *Select Organization*. (This is the payer.)
 - Only available options will be listed.
 - If multiple options exist, the provider will be loaded into the selected organization.
- Please note: A separate process exists for copying providers from one organization to another.

Express entry set up (cont.)

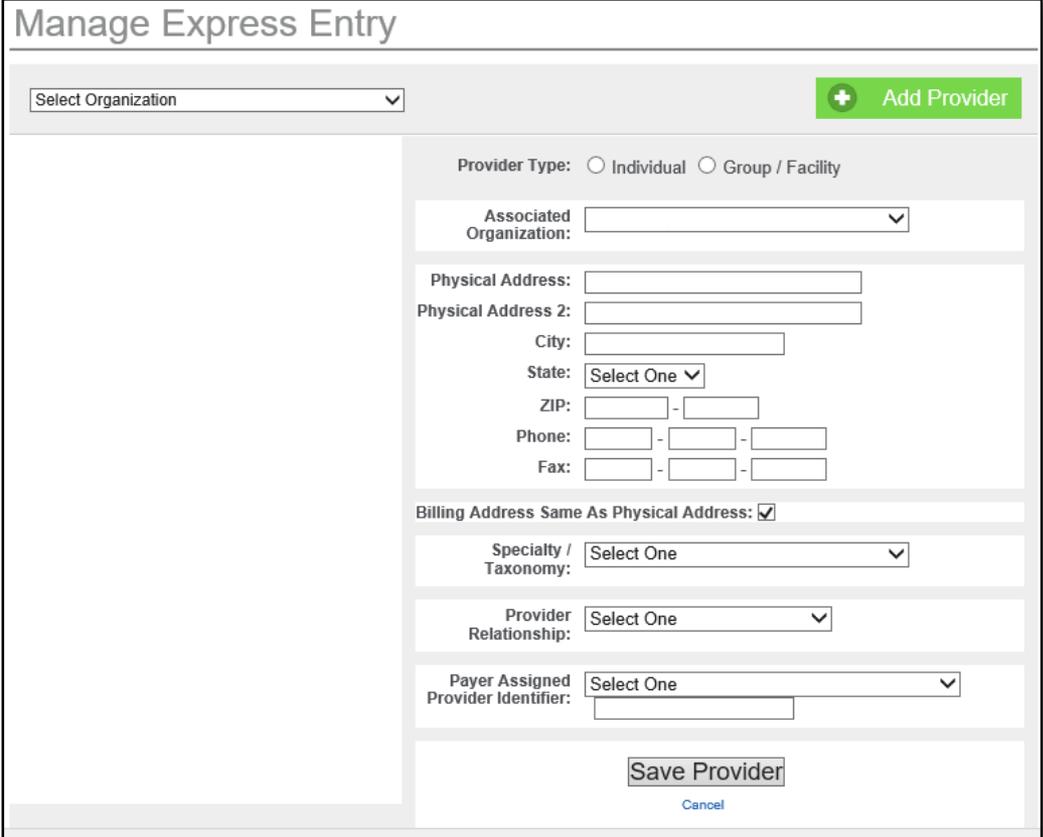
- Once you have selected the organization, select **This provider is not required to have an NPI.**



The image shows a screenshot of a web form for adding a provider. The form has a light green background and a dark green border. It contains a text input field labeled "Provider's NPI" and a button labeled "Add Provider". Below the input field, there is a link that says "Add multiple providers" and a radio button option labeled "This provider is not required to have an NPI". A red rectangular box highlights the radio button option, and a red arrow points from the right side of the image towards the highlighted option.

Express entry set up (cont.)

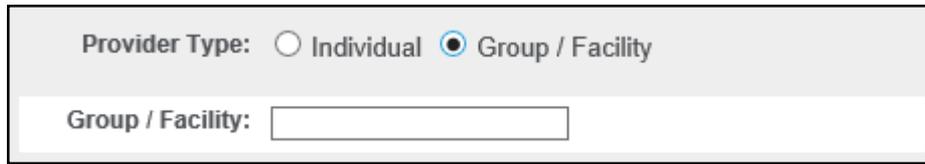
- The *Manage Express Entry* screen will load.
- The following slides highlight some of the important fields to complete.



The screenshot shows the 'Manage Express Entry' form. At the top left is a dropdown menu labeled 'Select Organization'. At the top right is a green button with a plus sign and the text 'Add Provider'. Below these are two radio buttons for 'Provider Type': 'Individual' and 'Group / Facility'. The form is divided into several sections: 'Associated Organization' with a dropdown; 'Physical Address' with a text input; 'Physical Address 2' with a text input; 'City' with a text input; 'State' with a 'Select One' dropdown; 'ZIP' with two text inputs separated by a hyphen; 'Phone' with three text inputs separated by hyphens; and 'Fax' with three text inputs separated by hyphens. Below the address fields is a checkbox labeled 'Billing Address Same As Physical Address:' which is checked. This is followed by 'Specialty / Taxonomy:' with a 'Select One' dropdown, 'Provider Relationship:' with a 'Select One' dropdown, and 'Payer Assigned Provider Identifier:' with a 'Select One' dropdown and a text input. At the bottom are two buttons: 'Save Provider' and 'Cancel'.

Adding a group/facility provider

- Select **Group / Facility** to bring up the option to load the group or facility name of the provider being loaded.



Provider Type: Individual Group / Facility

Group / Facility:

- Select the **Associated Organization** if you didn't select the organization in the previous section.

Adding a group/facility provider (cont.)

- Complete the following required fields:
 - Physical Address
 - City
 - State
 - ZIP
 - Phone
- (Fax is optional.)

Physical Address:	<input type="text"/>
Physical Address 2:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text" value="Select One"/>
ZIP:	<input type="text"/> - <input type="text"/>
Phone:	<input type="text"/> - <input type="text"/> - <input type="text"/>
Fax:	<input type="text"/> - <input type="text"/> - <input type="text"/>

Adding a group/facility provider (cont.)

- If the *Billing Address* is the same as the *Physical Address*, keep the applicable box checked.

Billing Address Same As Physical Address:

- If it is not, uncheck the box and manually enter the billing address in the available fields.

Billing Address Same As Physical Address:

Billing Address:

Billing Address 2:

City:

State:

ZIP: -

Phone: - -

Fax: - -

Adding a group/facility provider (cont.)

- Select the **Specialty / Taxonomy** code from the list of options in the drop-down menu.

Specialty / Taxonomy: ▼

- Select the **Provider Relationship**:
 - Works in my office
 - Works outside my office

Provider Relationship: ▼

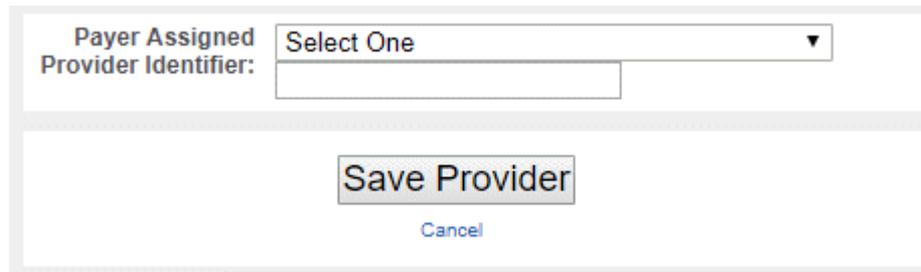
Adding a group/facility provider (cont.)

- Enter the *Tax ID (EIN)* for the provider.

Tax ID (EIN):

Adding a group/facility provider (cont.)

- Atypical providers are required to supply a *Payer Assigned Provider Identifier*.
- Use your assigned Medicaid ID
 - Select **Summit Community Care** in the *Payer Assigned* drop-down.
 - Select **Save Provider** to complete and save the provider.

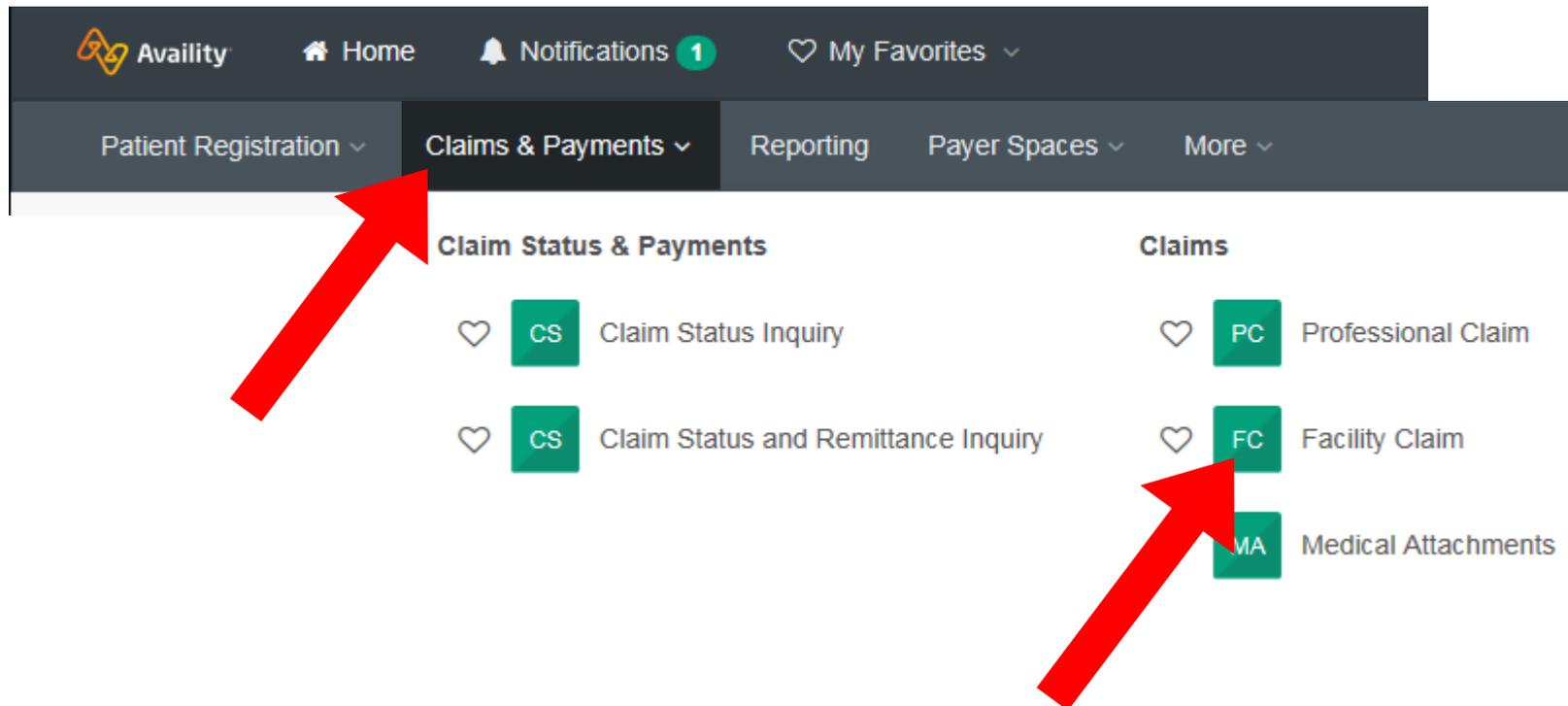


The screenshot shows a web form with the following elements:

- A label "Payer Assigned Provider Identifier:" on the left.
- A dropdown menu on the right with the text "Select One" and a downward arrow.
- An empty text input field below the dropdown menu.
- A "Save Provider" button centered below the input field.
- A "Cancel" link centered below the "Save Provider" button.

Facility claim submission process

- Once an express entry is completed, select **Claims and Payments** and choose **Facility Claim**.



Facility claim submission process (cont.)

- Select your organization in the *Organization* drop-down within the *Facility Health Care Claim* information screen.

Facility Health Care Claim

* indicates a required field

* Payer: ?

* Organization: 

* Facility Type: ?

Responsibility Sequence: ?

* Statement: ? From / /  To / / 
MM DD YYYY MM DD YYYY

Facility claim submission process (cont.)

- Enter any required or applicable patient information.

Patient Information

* Last Name:

* First Name:

Middle Name or Initial:

* Date of Birth: / / 
MM DD YYYY

* Gender: ▼

Country: ? ▼

* Address 1:

Address 2:

* City, State, ZIP Code: ▼

* Relationship to Subscriber: ? ▼

* Patient Status: ▼

Patient Responsibility Amount: ?

Facility claim submission process (cont.)

- Billing Provider Information:
 - Choose your group from the *Express Entry - Billing Provider* drop-down.
 - For atypical providers, enter your Medicaid ID in the *Payer Assigned ID* field. Failure to include the *Payer Assigned ID* will result in claim denials.

Billing Provider Information

Express Entry - Billing Provider: ?

* Organization / Provider Last Name: ?

* Phone Number: ? - - Ext.

Fax Number: - -

E-mail:

Country: ?

* Address 1: ?

Address 2: ?

* City, State, ZIP Code:

* Specialty / Taxonomy:

* Tax ID: ?

Important: Enter the tax ID to which the payment should be paid.

Payer Assigned ID: ? 

Location Number: ?

* Provider Accepts Assignment: ?

* Release of Information Code: ?

This claim has additional provider information...

additional billing provider contact information

a billing provider pay-to address that is different from the billing provider address

a service facility location that is different from the billing provider

Facility claim submission process (cont.)

- Attending Provider Information:
 - Choose your group from the *Express Entry - Attending Provider* drop-down.
 - Copy the *Last Name* into the *First Name* field.

Attending Provider Information

Express Entry - Attending Provider:

* Last Name:

* First Name:

* Specialty / Taxonomy:

Payer Assigned ID: ?

State License Number:

Provider UPIN:

Location Number:

This claim also includes...

a rendering provider that is different from the attending provider

a referring provider that is different from the attending provider

an operating physician

Facility claim submission process (cont.)

- Attending Provider Information (cont.):
 - Re-enter the Medicaid ID in the *Payer Assigned ID* field.
 - Check the box next to “*a referring provider that is different from the attending provider.*”

Attending Provider Information

Express Entry - Attending Provider: ▼

* Last Name:

* First Name:

* Specialty / Taxonomy:

Payer Assigned ID: ?

State License Number:

Provider UPIN:

Location Number:

This claim also includes...

a rendering provider that is different from the attending provider

a referring provider that is different from the attending provider

an operating physician



Facility claim submission process (cont.)

- Referring Provider:
 - The *Referral Number* will be the prior authorization number supplied by Summit Community Care.
 - *First Name, Last Name* and *NPI* are required fields.

Attending Provider Information

Express Entry - Attending Provider:

* Last Name:

* First Name:

* Specialty / Taxonomy:

Payer Assigned ID: ?

State License Number:

Provider UPIN:

Location Number:

This claim also includes...

a rendering provider that is different from the attending provider

a referring provider that is different from the attending provider

an operating physician

Referring Provider

* Referral Number:

Express Entry - Referring Provider:

* Last Name:

* First Name:

* NPI: ?

Payer Assigned ID: ?

State License Number:

Provider UPIN:

an operating physician

Facility claim submission process (cont.)

- Diagnosis Codes:
 - Please be advised that if you do not choose the most accurate diagnosis code, it can cause a denial.

Diagnosis Codes ?

* Principal Diagnosis Code: [ICD-10 Code Verification ?](#)

Present on Admission (POA): ▼

Facility claim submission process (cont.)

- Claim Information:
 - *The Patient Control Number* is a number created by the provider for their records.

Claim Information

* Patient Control Number / Claim Number: ?

Diagnosis Related Group (DRG) Code: ?

Medical Record Number:

* Billing Frequency: ?

this is an HMO claim

Prior Authorization Number: ?

Auto Accident Country:

* Admission Date: / /
MM DD YYYY

* Admission Type:

* Admission Source:

* Patient's Reason for Visit Diagnosis Code 1: [ICD-10 Code Verification ?](#)

Facility claim submission process (cont.)

- Claim Information:
 - *Billing Frequency:*
 - 2: First claim
 - 3: Interim Claim
 - 4: Final Claim
 - 7: Corrected Claim

Claim Information

* Patient Control Number / Claim Number: ?

Diagnosis Related Group (DRG) Code: ?

Medical Record Number:

* Billing Frequency: ?

this is an HMO claim

Prior Authorization Number: ?

Auto Accident Country:

* Admission Date: / /

MM DD YYYY

* Admission Type:

* Admission Source:

* Patient's Reason for Visit Diagnosis Code 1: [ICD-10 Code Verification ?](#)

Facility claim submission process (cont.)

- Claim Information:
 - The *Admission Date* is the date PCA started the patient's care or the date the member enrolled with Summit Community Care.

Claim Information

* Patient Control Number / Claim Number: ?

Diagnosis Related Group (DRG) Code: ?

Medical Record Number:

* Billing Frequency: ?

this is an HMO claim

Prior Authorization Number: ?

Auto Accident Country:

* Admission Date: / /

MM DD YYYY

* Admission Type:

* Admission Source:

* Patient's Reason for Visit Diagnosis Code 1: [ICD-10 Code Verification ?](#)

Facility claim submission process (cont.)

- Claim Information:
 - *Admission Type:*
Elective
 - *Admission Source:*
Clinic or Physician's Office
 - *Patient's Reason for Visit Diagnosis:*
This should match the code in the *Diagnosis Codes* section.

Claim Information

* Patient Control Number / Claim Number: ?

Diagnosis Related Group (DRG) Code: ?

Medical Record Number:

* Billing Frequency: ?

this is an HMO claim

Prior Authorization Number: ?

Auto Accident Country:

* Admission Date: / /
MM DD YYYY

* Admission Type:

* Admission Source:

* Patient's Reason for Visit Diagnosis Code 1: [ICD-10 Code Verification ?](#)

Facility claim submission process (cont.)

- Corrected claim selection:
 - Claims that come on a rejection letter should be entered as new day claims.
 - If a claim is denied on an *EOB*, choose *7 - Replacement of Prior Claim* and enter the old claim number.

Claim Information

* Patient Control Number / Claim Number: ?

Diagnosis Related Group (DRG) Code: ?

Medical Record Number:

* Billing Frequency: ? **7 - Replacement of Prior Claim (a)** ▼

* Payer Control Number (ICN / DCN): ?

this is an HMO claim

Prior Authorization Number: ?

Auto Accident Country: ▼

* Admission Date: / / 
MM DD YYYY

* Admission Type: ▼

* Admission Source: ▼

* Patient's Reason for Visit Diagnosis Code 1: [ICD-10 Code Verification ?](#)

Facility claim submission process (cont.)

- The following boxes do not need to be checked/selected:

This claim also includes...

- an EPSDT referral
- external injury codes
- occurrence span codes
- occurrence information codes
- value codes
- condition codes
- treatment codes

Facility claim submission process (cont.)

- Entering service lines:
 - Each day of service needs to be added separately.
 - Procedure codes are required, for example:
 - T1019
 - T1019 U3
 - 99509 TD

Line Number	Date(s) of Service:		Procedure Code CPT/HCPCS	Modifiers				Revenue Code	Charges	Days or Units
	From	To		1	2	3	4			
No claims entered yet. Enter claim(s) below and click Save to Service Line.										
								Total:	\$0.00	
Line Number: 1										
* Line Item Control Number: ? 1										
* Revenue Code: ? 0570										
* Date of Service: ? From 07 / 01 / 2018 To 07 / 01 / 2018 MM DD YYYY MM DD YYYY										
Procedure Code: ? T1019										
<input type="checkbox"/> non-specific procedure code description										
Modifiers: 1 2 3 4										
* Charges: 41.80										
Non-Covered Charge Amount:										
* Service Unit Count: ? 10 Units										
This service line also includes...										
<input type="checkbox"/> reporting of a national drug code (NDC)										
<input type="checkbox"/> a rendering provider that is different from the attending provider										
<input type="checkbox"/> a referring provider that is different from the attending provider										
<input type="checkbox"/> an operating physician										
Save to Service Line										

Facility claim submission process (cont.)

- Entering service lines:
 - Charges need to be written in **##.##** format.
 - All units need to be entered.
 - Once the information is entered, select **Save to Service Line**.

Line Number	Date(s) of Service:		Procedure Code CPT/HCPCS	Modifiers				Revenue Code	Charges	Days or Units
	From	To		1	2	3	4			
No claims entered yet. Enter claim(s) below and click Save to Service Line.										
								Total:	\$0.00	
Line Number:	1									
* Line Item Control Number: ?	<input type="text" value="1"/>									
* Revenue Code: ?	<input type="text" value="0570"/>									
* Date of Service: ?	From				To					
	<input type="text" value="07"/>	/	<input type="text" value="01"/>	/	<input type="text" value="2018"/>	<input type="text" value="07"/>	/	<input type="text" value="01"/>	/	<input type="text" value="2018"/>
	MM		DD		YYYY	MM		DD		YYYY
Procedure Code: ?	<input type="text" value="T1019"/>									
	<input type="checkbox"/> non-specific procedure code description									
Modifiers:	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>						
	1	2	3	4						
* Charges:	<input type="text" value="41.80"/>									
Non-Covered Charge Amount:	<input type="text"/>									
* Service Unit Count: ?	<input type="text" value="10"/>								Units	▼
This service line also includes...										
<input type="checkbox"/> reporting of a national drug code (NDC)										
<input type="checkbox"/> a rendering provider that is different from the attending provider										
<input type="checkbox"/> a referring provider that is different from the attending provider										
<input type="checkbox"/> an operating physician										
<input type="button" value="Save to Service Line"/>										

Facility claim submission process (cont.)

- Entering service lines:
 - Once all lines are entered that match your date span from the claim information section, select **Submit** at the bottom of the page.
 - Your claim has now been submitted to Summit Community Care for payment.

Line Number	Date(s) of Service:		Procedure Code CPT/HCPCS	Modifiers				Revenue Code	Charges	Days or Units	
	From	To		1	2	3	4				
1	07/01/2018	07/01/2018	T1019					0570	\$41.80	10 Units	Remove
2	07/02/2018	07/02/2018	T1019					0570	\$41.80	10 Units	Remove
3	07/03/2018	07/03/2018	T1019					0570	\$41.80	10 Units	Remove
4	07/04/2018	07/04/2018	T1019					0570	\$41.80	10 Units	Remove
5	07/05/2018	07/05/2018	T1019					0570	\$41.80	10 Units	Remove
6	07/06/2018	07/06/2018	T1019					0570	\$41.80	10 Units	Remove
Z	07/07/2018	07/07/2018	T1019					0570	\$41.80	10 Units	Remove
Total:									\$292.60		

Line Number: 8

* Line Item Control Number: ?

* Revenue Code: ?

* Date of Service: ? From / / To / /
MM DD YYYY MM DD YYYY

Procedure Code: ?

non-specific procedure code description

Modifiers:
1 2 3 4

* Charges:

Non-Covered Charge Amount:

* Service Unit Count: ? Units

This service line also includes...

reporting of a national drug code (NDC)

a rendering provider that is different from the attending provider

a referring provider that is different from the attending provider

an operating physician

[Save to Service Line](#)

Potential billing errors

- Please ensure you are entering accurate information, as the electronic claim system is a very detail-oriented program.
- Specific tips:
 - Make sure you're entering *the Payer Assigned ID* in both *Billing Provider* and *Attending Provider* sections.
 - Make sure you've checked the box for "*a referring provider that is different from the attending provider.*"

Potential billing errors (cont.)

- Specific tips:
 - Enter a revenue code for each line.
 - Ensure the procedure code is correct.
 - Ensure modifiers are added if needed.
 - Enter each date of service accurately and completely.
 - Enter one date for each line.
 - Ensure the charges and service units are accurately and completely entered for the date of service.



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