Tips and Tricks For Clean Claim Submission

Submitting "clean" claims is one of the best ways to ensure timely payment. Here's why:

Providers' claims are processed and adjudicated by PacificSource. Then the claims are sent to the Oregon Health Authority (OHA) to be encountered. If PacificSource receives pended or rejected encounters from the OHA for a claim, PacificSource may recoup their payment to the provider or facility.

Here are some ways providers can help insure clean claim submission:

Informational-only codes should be billed with $0.01, not $0.00.

Billing with a $0.00 claim line will stop the claim for review.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
1	01	27	19	01	27	19			T1015			0 01	1

Coordination of benefits

NOTE: Please ask your patients about any other coverage that may be in force, and bill accordingly.

If a member is enrolled in PacificSource Medicare and PacificSource Community Solutions (Medicaid) plans, it's not necessary to submit the secondary claim. PacificSource systems will automatically cross over the claim after the primary adjudication has completed. Submitting a secondary claim will cause duplicate claim issues, and slow the process for payment and review. This also applies to situations where the primary plan may be a PacificSource commercial plan.

Please contact your Provider Service Representative or call (855) 896-5208

PacificSource Community Solutions

COBA now allows for direct crossover claims from CMS.

PacificSource now receives Fee for Service Medicare claims directly when a member is also insured under PacificSource Medicaid. There is no need to submit the secondary claim in these scenarios, as the claim will be identified as a duplicate.

Sterilization consent forms

Sterilization consent forms are required for payment on any sterilization procedures billed. The coordinated care organization (CCO) is required to submit the consent forms to the OHA for any sterilization charges received. If the CCO is unable to obtain a valid consent, claims will be denied and/or recouped. This applies to professional and facility claims.

Tips for a valid consent:

- All fields must be filled out.
- The patient must sign the consent form at least 30 days, but no more than 180 days, prior to the procedure
- Any interpreter's statement must be signed and dated the same day as the member/patient signs the consent form.
- The statement of the person obtaining consent must be signed and dated on the same date as the member.
- The physician's statement must be completely filled out, and the physician's signature must be dated on the date of the procedure.

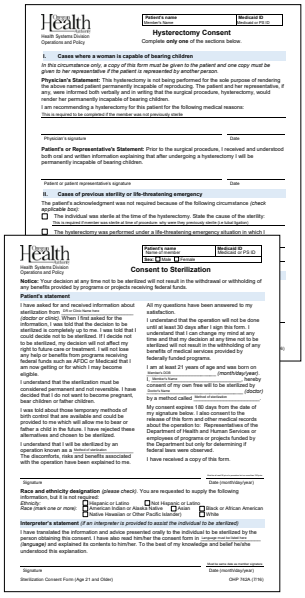
Provider enrollment

Oregon Medicaid requires providers be enrolled with the state to refer, assist, prescribe, render, or bill for services. As a contractor of the OHA, PacificSource is responsible for submitting enrollments for our providers and facilities.

Prior to billing, please verify that all providers on the claim have active Medicaid IDs. If there is a provider who doesn't have an active Medicaid ID, please contact PacificSource. We'll assist with the 3108 enrollment process.

Individual Practitioner

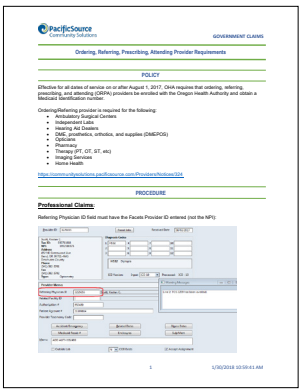
- Completed 3108 form
- W-9 Federal tax form
- Healthcare license
- Copy of associated claim


Hysterectomy Consent

Consent to Sterilization

The Hysterectomy Consent and Consent to Sterilization forms are available from the OHA.

https://www.oregon.gov/oha/HSD/OHP/Pages/Providers.aspx


Ordering, Referring, Prescribing, Attending Provider Requirements

Ordering, Referring, Prescribing, Attending (ORPA) Provider Requirements are available on our website.

https://communitysolutions.pacificsource.com/Providers/DocumentsAndForms

PacificSource Community Solutions

Facility, Ambulance, DME, Lab, Pharmacy, etc.*

- Completed 3108 form
- Completed, signed, and dated 3974 form
- W-9 Federal tax form
- Copy of associated claim
- Healthcare license for organization
  - Can be issued by State Health and Human Services Department or equivalent
  - Can be CMS/Medicare certification

Group of Professionals*

- Completed, signed, and dated 3974 form
- W-9 Federal tax form
- Copy of associated claim

**Nonprofit organizations: 501 (c) Federal tax designation form, issued by the IRS*

Form 3974

- Effective 01/01/2019 – The OHA now requires a completed 3974 in addition to the 3108 to show ownership. This follows CFR and OAR regulations.
- It is possible that there will be multiple 3974 forms for every one 3108 submitted.

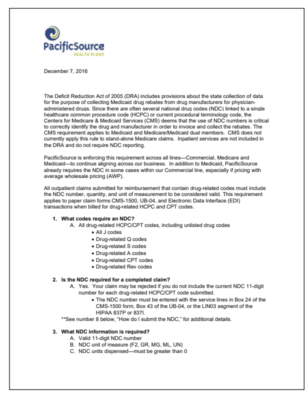
Interpreter Services

Interpreter services are a covered benefit for PacificSource Community Solutions members.

Certified interpreters aren't eligible for Medicaid ID numbers. Their services should be billed on a professional claim form as the rendering provider. This means certified interpreters must be set up in the PacificSource system for timely and accurate payment.

National Drug Codes (NDC)

- NDC codes are required for reimbursement of any drug-related charge submitted as an outpatient service.
- This requirement applies to paper claims and electronic submissions.
- This includes CPT, HCPC, and revenue codes as applicable.
- Codes requiring pairing will be rejected at the front end and/or denied during claims processing.



PacificSource HEALTH PLANS

December 7, 2016

The Deficit Reduction Act of 2005 (DRA) includes provisions about the state collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for physician-administered drugs. Since there are often several national drug codes (NDC) linked to a single healthcare common procedure code (HCPC) or current procedural terminology code, the Centers for Medicare & Medicaid Services (CMS) deems that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates. The CMS requirement applies to Medicaid and Medicare/Medicaid dual members. CMS does not currently apply this rule to stand-alone Medicare claims. Inpatient services are not included in the DRA and do not require NDC reporting.

PacificSource is enforcing this requirement across all lines—Commercial, Medicare and Medicaid—to continue aligning across our business. In addition to Medicaid, PacificSource already requires the NDC in some cases within our Commercial line, especially if pricing with average wholesale pricing (AWP).

All outpatient claims submitted for reimbursement that contain drug-related codes must include the NDC number, quantity, and unit of measurement to be considered valid. This requirement applies to paper claim forms CMS-1500, UB-04, and Electronic Data Interface (EDI) transactions when billed for drug-related HCPC and CPT codes.

1. **What codes require an NDC?**
   A. All drug-related HCPC/CPT codes, including unlisted drug codes
      - All J codes
      - Drug-related Q codes
      - Drug-related S codes
      - Drug-related A codes
      - Drug-related CPT codes
      - Drug-related Rev codes
2. **Is the NDC required for a completed claim?**
   A. Yes. Your claim may be rejected if you do not include the current NDC 11-digit number for each drug-related HCPC/CPT code submitted.
      - The NDC number must be entered with the service lines in Box 24 of the CMS-1500 form, Box 43 of the UB-04, or the LIN03 segment of the HIPAA 837P or 837I.

   **See number 8 below, "How do I submit the NDC," for additional details.
3. **What NDC information is required?**
   A. Valid 11-digit NDC number
   B. NDC unit of measure (F2, GR, MG, ML, UN)
   C. NDC units dispensed—must be greater than 0

The National Drugs Code FAQ can be found on our website.

https://pacificsource.com/provider/forms-and-materials/

PacificSource Community Solutions

Billing multiple lines instead of multiple units may cause delays.

Combine any claim lines that are the same service or drug. Billing duplicate lines will cause the claim to stop for review.

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1	01	27	19	01	27	19			E1028	RR	RT		A	20	00	1
2	01	27	19	01	27	19			E1028	RR	RT		A	20	00	1

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1	01	27	19	01	27	19			E1028	RR	RT		A	40	00	2

There are exceptions to rolling up units.

Providers should check the OHA's Medically Unlikely Edit (MUE) file to determine how many times a service may be performed in a day. If the MUE indicates only one, any units over will need to be billed on separate lines with appropriate modifiers and documentation to support why more than one was performed.

1	01	27	19	01	27	19			H0005							
2	01	27	19	01	27	19			H0005	76						
3	01	27	19	01	27	19			H0005	59						

Same Day Service Modifiers

When billing for a service that occured at multiple times throughout the day, the use of modifiers is critical.

Time of Day Modifier	Description
UF	Services provided in the morning
UG	Services provided in the afternoon
UH	Services provided in the evening
UJ	Services provided in the night

The modifiers XE and 27 may also be used to eliminate or reduce duplicates.

Have Questions?
Please reach out to your Provider Services Representative.

PacificSource Community Solutions