Prior Authorization FAQ

PacificSource Community Solutions

Member eligibility and benefits

Providers must check a member's eligibility and benefits prior to rendering care. A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service.

What is a prior authorization?

A **"prior authorization"** is defined as a request for a specific service that requires review to determine coverage and medical necessity.

What does prior authorization allow?

Prior authorization allows members to see providers for covered services. Payment for these services is subject to eligibility, funded conditions, medical appropriateness, and established medical criteria. See below for additional details.

When is it necessary to submit a prior authorization?

To determine if a service and or medication requires prior authorization, consult AuthGrid.PacificSource.com. If a service requires prior authorization for an in-person visit, then prior authorization is also required when the service is provided via telehealth. For more information, please refer to your provider manual.

How do I know if a service is covered under the Oregon Health Plan (OHP)?

This can be identified by using LineFinder, an online tool to assist providers in determining what is covered by OHP. OHP generally updates the information quarterly. Linefinder: InTouch.PacificSource.com/LineFinder.

Is prior authorization required when PacificSource is the secondary payer?

Yes, it is required if the service provided is not covered by the primary insurance, or if the requested service is indicated as below-the-line (BTL) or not covered based on Oregon Health Authority's Prioritized List of Health Services and PacificSource's Prior Authorization Grid.

Is a prior authorization a guarantee of payment for services?

No. Payment for services is always subject to:

- Member eligibility on the date(s) of service, and
- Member benefits as defined in their plan conditions, terms, and limitations.

To determine if your patient's condition is covered by OHP, please check LineFinder.

Are there services that are considered diagnostic that don't require prior authorization?

There are certain services that don't require a prior authorization because they are considered diagnostic. For a list of these services, please see the Diagnostic Procedure Codes list here.

This list does not guarantee coverage. Please see our prior authorization grid and the Prioritized List of Health Services to determine prior authorization requirements and coverage.

What information is required when submitting a prior authorization request?

- Member name, date of birth, and member ID number
- Referring provider information and contact information
- Treating provider or facility name and contact information
- Diagnosis code(s)
- Number of visits
- Type of service
- Start date of request and timeframe (start and end dates must be clearly defined)
- Chart notes are always required
- Current evaluation, re-evaluation, and/or progress notes
- Alternative Care: Supporting documentation that outlines the type of care being requested (may be from referring provider or primary care provider).

Does PacificSource Community Solutions allow retroactive prior authorizations?

Retroactive approvals are those considered for approval following the initiation or provision of the service(s). Authorization may be given for a past date of service if:

- The member was made retroactively eligible or was retroactively disenrolled from a CCO or PHP on the date of service.
- The provider has not already billed for the service and/or received a denial citing a lack of authorization as the reason. In this case, the provider may submit an appeal for reconsideration.
- The services provided meet all other criteria and Oregon Administrative Rules.
- The request for authorization is received within 90 days of the date of service.
- It is the responsibility of the hospital (e.g., Utilization Review Department) to contact PacificSource Community Solutions with pertinent medical information, including a copy of the admission history, physical, etc.

How do I submit a retroactive request for authorization?

Requests can be sent via InTouch or by fax. Please note that a request for authorization after 90 days from the date of service requires documentation from the provider to indicate authorization could not have been obtained within 90 days of the date of service.

What if a member had a previously-scheduled service/procedure before becoming covered by PacificSource?

A plan-approved prior authorization is still required in these situations.

Below the line diagnoses

Member eligibility and benefit requirements still apply.

Please reference the below guide regarding the different guidelines for primary care and specialty care offices.

- **Primary care office visits:** Primary care claims will be allowed one below-the-line (BTL) office visit every 30 days to confirm a diagnosis. This means that primary care clinics will be paid for the first BTL office visit to confirm a diagnosis. Any additional claims within 30 days showing the same diagnosis will be denied.
- **Specialty care office visits:** PacificSource allows one initial BTL office visit per provider by specialty. This includes allowing providers within the same group as long as they are different specialties.

  At least one above-the-line (ATL) diagnosis is required for claims to process after the one initial BTL office visit has been used within a 12-month lookback. The first five diagnoses are reviewed to determine if they are ATL or appear in the OHA Diagnostic Workup File (DWF). If no ATL or DWF diagnosis is submitted, the claim will be denied if no prior authorization is in place. Prior-authorization requirements remain the same.

Please note for primary care and specialty care: PacificSource will use the OHA-determined line and the OHA DWF to determine coverage. When a member is new to your office and is presented with a BTL diagnosis, please reference this guide. The DWF contains a number of diagnosis codes that pertain to symptoms. PacificSource is using the DWF to allow providers to make a diagnosis. Please see DWF guide: Data.Oregon.gov/Health-Human-Services/Diagnostic-Workup-File-Code-Group-6032-/etxd-jrnv.

Our system will consider up to five diagnoses on any claim to allow for comorbidities. If any of the first five diagnoses are ATL, the claim will pay pursuant to the applicable contract arrangement. (The claims system will continue to accept more than five diagnoses per claim; this is particularly important for quality reporting purposes.)

Our system will consider DWF when claims are submitted and pay pursuant to the applicable contract arrangement.

What would be required to be included in a prior authorization request for a BTL office visit after our one initial BTL diagnosis exception has been used?

Please reference the above prior authorization section of what would need to be included. The best practice is to include all supporting documentation within the prior authorization process, including referring provider documentation.

Note: If a determination is made that you are not in agreement with, you are able to appeal. For more information regarding our Appeals process, please visit CommunitySolutions.PacificSource.com/Providers/DocumentsAndForms and click on "Provider Manual."

What if a member is presented with a BTL diagnosis office visit? Would I need to put in a prior authorization for the first visit?

Please see the above guidelines for primary care and specialty care offices.

What do I need to know about BTL diagnoses?

- BTL is a noncovered diagnosis; the line applies to all providers for all Medicaid services.
- The line will not apply to laboratory or x-ray services. These services are diagnostic in nature. Please note that some laboratory and x-ray services are excluded by OHP (and were never covered, regardless of line placement).
- ER and urgent care visits will be covered. The existing workflow will remain in place for inpatient stays.
- Our system will consider up to five diagnoses on any claim to allow for comorbidities. If any of the first five diagnoses are ATL, the claim will pay pursuant to the applicable contract arrangement. (The claims system will continue to accept more than five diagnoses per claim; this is particularly important for quality reporting purposes.)
- If none of the first five diagnoses are ATL, the claim will be evaluated as described in the next section.
- PacificSource will use the OHA-determined line and the OHA DWF to determine coverage. (The DWF contains a number of diagnosis codes that pertain to symptoms. PacificSource is using the DWF to allow providers to make a diagnosis.)
- The process described above will also be applied to claims where Medicaid is the secondary payer.

What happens if a diagnosis falls above and below the line?

Some diagnosis codes will show both above and below the line (see below). In these circumstances, a **prior authorization** would be required. A clinician will review and determine which line the diagnosis should fall on. Chart notes will be required to make this determination. Please see "BTL diagnoses" section above regarding guidelines for primary care and specialty providers for initial visit exceptions that fall below the line.

Example: If determined clinically significant, the diagnoses would be above the line (346 and 401) and covered (funded) by OHP. If determined not clinically significant, the diagnoses would fall below the line (527), therefore not covered (non-funded) by OHP.

Alternative care and traditional therapy

Is prior authorization required for alternative care and traditional therapy?

No. Prior authorization is not required for the first 20 physical therapy, occupational therapy, and speech-language therapy visits or the first 10 alternative care provider visits.

What particular information about therapy should I be aware of?

- The U.S. Department of Health and Human Services has deemed that chiropractic services are not appropriate for infants. Some exceptions may apply through a medical diagnosis.
- Children under the age of 14 should not be receiving chiropractic adjustments based on lack of evidence of effectiveness. Some exceptions may apply through a medical diagnosis.
- A STarT Back Tool (SBT) is required beginning at the age of 14 for any back-related condition.
- If a member has used their 20 visits for physical therapy, occupational therapy, and speech-language therapy, and their 10 visits for alternative therapy, they have used their 30 visit total for the calendar year.
- Chiropractors may submit a prior authorization to another therapy, such as acupuncture or massage.
- Massage should not be asked for as a stand-alone service. Stand-alone massage is only covered for a back condition.

Please reach out to our Provider Service team with questions at ORProviderService@PacificSource.com