PacificSource Community Solutions

Referral Frequently Asked Questions

For Provider Use Only

1. What is the difference between a referral and a preapproval?

A **"referral"** is the process by which the member's primary care provider (PCP) directs them to obtain care for covered services from other health professionals in an office setting.

Please note: the referral must be submitted directly to PacificSource Community Solutions and approved by the PCP. Referrals do not supersede other program requirements such as:

- Medical necessity,
- Eligibility,
- Preapproval requirements, or
- Coverage limitations.

A **"preapproval"** is defined as a request for a specific service that requires review to determine medical necessity. Services that require preapproval are outlined on our website at CommunitySolutions.PacificSource.com.

2. When is a referral needed?

Before seeing an in-network specialty provider*, a member must obtain a referral from his or her PCP. If additional services from another specialty provider are needed, the PCP will coordinate a referral to the appropriate specialist.

A referral is required for all services rendered by a specialist, including office visits, and procedures not listed on the preapproval grid.

Requests to see an out-of-network provider, including second opinion requests, must be submitted via the preapproval process. This type of request is **not considered a referral.*

3. Are referrals required when PacificSource Community Solutions is the secondary payer?

Referrals may be required when PacificSource Community Solutions is the secondary payer. They are required if the service provided is not covered by the primary insurance or if the requested services is indicated as below-the-line (BTL) or not covered based on OHA's Prioritized List of Health Services and PSCS Prior Authorization grid.

4. Can a specialist submit a referral to PacificSource Community Solutions?

In most cases, the member's PCP must submit the referrals. (See "When can a specialist bypass PCP approval?" below for an exception.)

The specialist can initiate the referral request via InTouch, our online provider portal at CommunitySolutions.PacificSource.com/Providers. However, the PCP must approve the referral request. Under special circumstances, a PCP may grant sub-referral authority to a specialist. This capability allows specialists to request ongoing treatment for the member's current condition. This includes the ability to request additional office visits, as well as referrals to other in-network specialists for continued treatment of the initial condition.

Please note: Sub-referral authority is only effective for the timeframe indicated in the original PCP-approved referral.

5. What does a referral allow?

A referral allows members to see an in-network specialty provider for covered services rendered in their office, except services requiring preapproval. Payment for these services will be subject to eligibility, funded conditions, medical appropriateness, and established medical criteria. See the questions below for additional detail.

6. Can a referral request include surgical services or other procedures?

No. Procedures or services that require preapproval cannot be included in a referral. Providers must submit a request for these services via the preapproval process.

7. What about services that do *not* require a preapproval? Is a referral required?

It depends. If you will be billing with an E&M code (office visit), you will need to be sure a valid approval is in place. This includes follow-up office visits related to procedures such as Brain MRIs or CTs.

8. What about services that *do* require a preapproval? Is a referral required?

It depends. If you will be billing with an E&M code (office visit), you will need to be sure a valid approval is in place. This includes follow-up office visits related to procedures such as Brain MRIs or CTs.

9. What if the member had a previously scheduled office visit before becoming eligible with PacificSource Community Solutions?

A referral from the member's PCP is still required in these situations.

10. Does PacificSource Community Solutions allow retro-referrals?

We allow retro-referrals for office visits resulting from urgent/emergent situations only. The provider or facility is expected to contact PacificSource Community Solutions within two business days of date of service or initiation of the service.

However, we realize there are other instances when a referral may not have been in place. This should be the exception and not the rule. Please contact your PacificSource Provider Service Representative in these instances, and we will assist you with this process.

11. What if PacificSource has not approved the referral request at the time of service?

As long as the referral request is submitted on or prior to the treatment date and the referral is approved, the effective date requested on the referral will be granted.

12. When can a specialist bypass PCP approval?

PCP approval is not needed for follow-up appointments after:

- ER/ED visits
- Urgent care visits
- Inpatient stays

Note: ER and urgent care follow-up visits ***for chronic pain conditions*** will require a review for medical necessity.

The specialist can submit these referrals without needing to be approved by the member's PCP only for the initial specialist visit. Please make a *clear note* that the visit is a follow-up from the above list, and *only request one visit.* PacificSource will waive the PCP-approval requirement in these instances. Any subsequent visits will need PCP approval.

Remember, retro-referral guidelines also apply in these instances. (See "Does PacificSource Community Solutions allow retro-referrals?" above for details.)

13. What information is required when submitting a referral 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)
- Start date of request, timeframe, and number of visits (start and end dates must be clearly defined)
- Chart notes are always required for plastic surgery, dermatology, and podiatry referral requests and may be required in additional scenarios (see #12)

14. How many visits are covered by a referral?

Referrals requests do not have a maximum visit limitation, but the timeframe should not exceed 12 months. Please keep in mind that the amount of visits requested must be a reasonable number and cannot be unlimited.

Supporting documentation is always required for office visits with below-the-line conditions (initial visit excluded) and retroactive requests.

PacificSource will approve referral requests for BTL conditions for the initial (one) visit only, regardless of the number of visits requested. we use a 12-month rolling-year timeframe when reviewing the initial BTL visit.

15. Is an approved referral request limited to the specialist designated by the member's PCP?

No. The approved referral covers services from any in-network provider who practices in the same group (call share) and has the same specialty as the provider indicated on the approved request.

16. Does referral approval guarantee payment for services?

No. Payment for services is always subject to:

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

To determine if your patient's condition is covered by OHP, check LineFinder. This tool can be found online at Intouch.PacificSource.com/LineFinder or contact our Customer Service team.

The ***initial*** office visit will be allowed with an approved referral. Approval for additional follow-up visits is subject to OHP coverage (line placement of diagnosis) and will require medical review.

All visits are subject to covered conditions, medical appropriateness, and established medical criteria. Documentation will be required for reviewing specialty requests.

17. Do all services require a referral?

No. Referrals are not required for the following. However, these services are subject to the plan benefits and eligibility (see exceptions noted):

- Annual women's exam (including colposcopies and LEEPs)
- Anticoagulation office visits
- Certain immunizations (shots)—may be given by any provider
- Dialysis
- Emergency care
- Family planning services—may be given by any provider
- Health Department services
- Hospice
- Intensive Care Coordination Services (ICCS) (see additional details in # 19 below)
- Lactation services (help with breastfeeding)
- Maternity care—a referral from the PCP is needed to see a specialist other than the maternity doctor
- Members in a designated special needs rate group (example: HIV)
- Mental health care delivered in a primary care home setting or Community Mental Healthcare Program (CMHP).
- Palliative care
- Routine vision exams (only available to children and pregnant women)
- School-based health center services
- Substance use disorder treatment services (drug and alcohol treatment services)
- Urgent care

18. Do Intensive Coordinated Care Services (ICCS) member have special considerations?

Yes. A referral is not required for an ***initial*** below the line visit to any specialty type to establish an above-the-line condition. If it's determined after the initial visit that the diagnosis is truly below the line, a referral request is necessary.

19. How do I submit a referral?

You can submit a referral electronically through InTouch, our online provider portal at CommunitySolutions.PacificSource.com/Providers.

If you do not have online access to InTouch or need training, please contact your Provider Service Representative for assistance.

20. When will I receive a determination for a referral request?

PacificSource Community Solutions responds to standard referral requests within 14 calendar days.

21. How will I know my referral request has been approved?

The decision and number of approved visits will be visible within InTouch, our online provider portal.

Please contact your PacificSource Provider Service Representative with questions related to this process.

Phone: (800) 624-6052, ext. 2580

Email: providerservicerep@pacificsource.com