PacificSource
Community Solutions

Provider Manual

Revised April 2017

126PRV 042017

Contents

Section 1: Introduction

1.1 About This Manual

This Provider Manual has been prepared by PacificSource Community Solutions (Medicaid) for our contracted providers as a reference tool to provide important information concerning the role of the provider and office staff in the delivery of healthcare to our members and your patients. This manual provides critical information regarding provider and plan responsibilities. This document should be used in conjunction with your contract with PacificSource Community Solutions.

In addition to our Provider Manual, we suggest you visit our website, CommunitySolutions.PacificSource.com to obtain more useful tools, such as: provider directories, formularies, and plan documents.

We hope you will find the information within the Provider Manual and the website to be useful. Please let us know if you have questions about any aspect of this manual, or have suggestions regarding how we can improve this document in the future.

30-Day Notice

For any changes in policy or process, this manual and your Medical Services Agreement require that we give thirty (30) days prior written notice to provider, personally delivered, fax, email, or by first class, registered or certified mail of such proposed amendment. The continued participation by provider without written objection to the proposed amendment within the 30-day period following receipt shall constitute provider's approval of such amendment. (Note: 30-day notice does not apply to dental or behavioral health.)

1.2 PacificSource Mission Statement

The Mission of PacificSource

To provide better health, better care, and better cost to the people and communities we serve.

Provider Network Department Mission

To create and maintain partnerships among internal and external customers resulting in adequate access to quality service in a competitive market

This manual gives you the details about important information concerning the role of provider and office staff in the delivery of healthcare to our members and your patients. It also provides critical information regarding provider and plan responsibilities, and should be used in conjunction with your PacificSource Community Solutions contract.

Section 2: Who to Contact

Customer Service

Toll-free, all areas: (800) 431-4135
Bend area: (541) 382-5920
TTY: (800) 735-2900
Fax: (541) 322-6423
Email: CommunitySolutionsCS@pacificsource.com

Call customer Service Monday to Friday, 8:00 a.m. to 5:00 p.m.

Contact for:

- Member benefits, eligibility information, or waivers
- Deductible, co-insurance, and/or co-pay information
- Explanation of payments and member hold harmless issues
- Participating physicians and providers
- Claims inquiries
- Referral or preapproval inquiries

Behavioral Health

(541) 382-5920, (800) 431-4135
Fax: (541) 330-4910

Claims Billing

Mail Medicaid claims to:

PacificSource Community Solutions
PO Box 7068
Springfield, OR 97475-0068

Dental Providers

Please contact your dental care organization (DCO) for contracting information.

Dental Services

Advantage Dental Services
Toll-free (866) 268-9631, TTY: 711

Capital Dental Care
Toll-free (800) 525-6800, TTY: 711

ODS Community Health
Toll-free (800) 342-0526, TTY: 711

Willamette Dental Group
Toll-free (855) 433-6825, TTY: 711

Grievance and Appeals

(541) 330-4992
Fax: (541) 322-6424

Health Services

Preapproval/Referrals
(541) 330-7301

Intensive Care Management and Care Coordination
(541) 330-2507, toll-free (888) 970-2507

Utilization Review
(541) 330-7301

Pharmacy Services

(541) 330-4999, toll-free (888) 437-7728

Contact for:

- Exceptions to standard formulary rules
- Medication authorization (medically administered and pharmacy)
- Clinical consultation
- Care planning for patients with complex needs

Provider Contracting/Reporting

(541) 684-5580, (800) 624-6052, ext. 2580
Fax: (541) 225-3643
Email: providernet@pacificsource.com

Contact for:

- Contract negotiations
- Contract concerns/clarifications
- Physician/provider contract reports
- Physician/provider utilization reports

Provider Credentialing

(541) 684-5580, (800) 624-6052, ext. 3747
Fax: (541) 225-3644
Email: credentialing@pacificsource.com

Contact for:

- Direct credentialing inquiries
- Direct credentialing application status
- Direct recredentialing inquiries

Provider Network

Physician/provider support and education
(541) 684-5580, (800) 624-6052, ext. 2580
TTY: (800) 735-2900
Fax: (541) 225-3643
Email: providernet@pacificsource.com

Contact for:

- Physician/provider contract support
- Explanations of medical, administrative, or reimbursement policies
- General education on proper methods to use for billing and coding
- Questions about web connectivity to PacificSource Community Solutions
- Provider location changes
- Call share maintenance
- Physician/provider network information
- Limited practice designations
- Demographic updates, including tax ID numbers
- Physician/provider credentialing

The Provider Network Department operates as a liaison between PacificSource Community Solutions and healthcare professionals. Recognizing the needs and perspectives of participating physicians and providers, Provider Network is dedicated to giving our physicians and providers the highest quality service, with a commitment to working with practitioners in a fair, honest, and timely fashion.

In our Provider Network Department, Provider Service Representatives have the following defined purposes and responsibilities:

- Develop and provide support services to new and established contracted physicians and providers for the purpose of contract education, compliance, and problem solving, and to ensure satisfaction with PacificSource.
- Provide liaison support internally for physician and provider-related issues, including questions or concerns regarding contracts and operations.
- Develop educational materials for meetings and/or mailings as needed.
- Develop and maintain a Provider Manual outlining general information about PacificSource policies and procedures applicable to healthcare professionals.
- Present contracted physicians and providers to members via current and accurate provider directories.
- Identify and pursue opportunities for provider network expansion and enhanced member access to healthcare.

CommunitySolutions.PacificSource.com/Providers

InTouch for Providers is our secure website for providers. Through this site, you can access claims, request and check the status of preapprovals, and view member benefit information 24/7. The site is available through OneHealthPort, a web portal that provides access to local secure health plan websites and other provider services with a single user ID and password.

Section 3: Glossary of Terms

Access: Ability to obtain healthcare services.

Accreditation: Accreditation programs give an official authorization or approval to an organization against a set of industry-derived standards.

Actuary: A person in the insurance field who determines insurance policy rates and conducts various other statistical studies.

Adjudication: Processing a claim through a series of edits to determine proper payment.

Allied Health Professional (AHP): All healthcare providers who are not licensed as doctors of medicine or osteopathy; for example, nurse practitioners, physician assistants, behavioral health, and chiropractors.

Ambulatory Care: Healthcare services rendered in a hospital's outpatient facility, physician's office, or home healthcare; often used synonymously with the term "outpatient care."

Ancillary Medical Service: Covered service necessary for diagnosis and treatment of members. Includes, but is not limited to, ambulance, ambulatory or day surgery, durable medical equipment, imaging service, laboratory, pharmacy, physical or occupational therapy, urgent or emergency care, and other covered service customarily deemed ancillary to the care furnished by primary care or specialist physicians or providers.

Behavioral Healthcare: Treatment of mental health and/or substance use disorders.

Benefit Plan: Covered services, limitations, and exclusions contained in the contract between PacificSource Community Solutions and a member.

Board Certified: A physician who has passed an examination given by a medical specialty board.

Board Eligible: A physician who has graduated from an approved medical school and is eligible to take a specialty board examination.

Call Share: The physicians or providers on whom a practitioner relies for backup coverage during times he/she is unavailable.

Call Share Group: A group of providers with similar specialties who have joined together to provide call share services.

Capitation: A method of paying for medical services on a per-person rather than a per-procedure basis.

Carrier: Insurer, underwriter of risk.

Carve Out: Medical services that are specifically identified in a contract and paid under a different arrangement.

Care Management: The process whereby a healthcare professional supervises the administration of medical or ancillary services to a patient, typically one who has a catastrophic disorder or who is receiving mental health services. Care managers reduce the costs associated with the care of such patients, while providing high-quality medical services.

Case Rate: A "package price" for a specific procedure or diagnosis-related group.

Centers for Medicare and Medicaid Services (CMS): The agency within the Department of Health and Human Services that administers the Medicare program.

Certified Interpreter: A person who is certified as competent interpreter by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. This includes passing a standardized national test.

Coordinated Care Organization (CCO): A new way to manage physical, mental, and dental healthcare for the Oregon Health Plan (OHP). A CCO is a group of local healthcare providers, hospitals, and health insurance plans. They will provide healthcare and healthcare coverage for people eligible for the Oregon Health Plan.

Clean Claim: (1) A claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with § 422.310(d)) or particular circumstance requiring special treatment that prevents timely payment; and (2) A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Clinic: A healthcare facility for providing preventive, diagnostic, and treatment services to patients in an outpatient setting.

Coordination of Benefits (COB): An insurance provision that allocates responsibility for payment of medical services between carriers if a person is covered by more than one insurance plan.

Cost Containment: A strategy that aims to reduce healthcare costs and encourages cost-effective use of services.

Coverage: Services or benefits provided through a health insurance plan.

Covered Lives: Total of insured members.

Covered Services: Healthcare services which a member is entitled to receive under their PacificSource Community Solutions insurance.

Credentialing: A process of screening, selecting, and continuously evaluating individuals who provide independent patient care services based on their licensure, education, training, experience, competence, health status, and judgment.

Dental care organization (DCO): A corporation or entity that enters into service agreement with PacificSource Community Solutions for the provision of dental services to PacificSource Community Solutions members. DCOs also maintain the dental provider network.

Diagnosis: The identification of a disease or condition through examination.

Diagnosis Related Groups (DRG): A program in which hospital procedures are rated in terms of cost and intensity of services delivered. A standard rate per procedure is paid, regardless of the cost to the hospital to provide that service.

Disability: Any medical condition that results in functional limitations that interfere with an individual's ability to perform his/her normal work, and results in limitations in major life activities.

Dual Eligible: Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit. PacificSource Dual eligibles are enrolled in the lowest cost PacificSource Medicare Advantage Plan offered in their service area as well as PacificSource Community Solutions.

Durable Medical Equipment (DME): Equipment that can be repeatedly used, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples include hospital beds, wheelchairs and oxygen equipment.

Emergency Medical Condition: A medical emergency is when any prudent layperson with an average knowledge of health and medicine, believe that they have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Medical Screening Exam: The medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency Services: Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Episode of Care: All treatment rendered in a specified time frame for a specific disease.

Experimental Procedures: Also called unproved procedures. All healthcare services, supplies, treatments, or drug therapies that PacificSource Community Solutions has determined are not generally accepted by healthcare professionals as effective in treating the illness for which their use is proposed.

Extended Care Facility: A nursing home-type setting that offers skilled, intermediate, or custodial care.

Fee-for-Service: The traditional method of paying for medical services. A doctor charges a fee for each service provided and the insurer pays all or part of that fee.

Fee Schedule: List of fees for specified medical procedures.

Formulary: Drugs covered by PacificSource Community Solutions (preferred drug list).

Full Risk: An arrangement where PacificSource Community Solutions has given the medical group or provider organization financial responsibility for the comprehensive healthcare needs of the patient. Full risk includes both the institutional and professional components of capitation with no sharing of savings with the health plans and generally includes home health, skilled nursing facilities, ambulance, acute hospital, and physician services.

Global: All-inclusive.

Grievance: A type of complaint made by a member or member's representative to express dissatisfaction to the Coordinated Care Organization about the health plan, in-network provider, or pharmacy, including a complaint concerning the quality of care. This type of complaint does not involve coverage or payment disputes.

Health Risk Assessment (HRA): A health questionnaire, used to provide individuals with an evaluation of their health risks and quality of life.

Independent Physician Association (IPA): An individual practice association of physicians and/or providers that have entered into a contract with PacificSource Community Solutions to provide certain specific covered services to members.

Individual Practice Association (IPA): An individual practice association of physicians and/or providers that entered into a contract with PacificSource Community Solutions to provide certain specific covered services to members.

Inpatient Care: Healthcare provided in a licensed bed in a hospital, nursing home, or other medical or psychiatric institution.

Inquiry: A written request for information or clarification about any matter related to the member's health plan. An inquiry is not a complaint.

Intensive Care Coordination Services (ICCS): A specialized care management service Oregon Health Plan (OHP) managed care plans are mandated to provide to OHP members who are aged 65 or older, blind, disabled or have special healthcare needs.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): A private, nonprofit organization that evaluates and accredits healthcare organizations providing mental healthcare, ambulatory care, home care, and long-term care services.

Locum Tenens Provider: A provider, local or visiting, who is providing coverage for a participating provider for 60 consecutive days or less.

Loss Ratio: The ratio of a health maintenance organization's actual incurred expenses to total premiums.

Managed Care Organization (MCO): A corporation, governmental agency, public corporation or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority to be accountable for care management and to provide integrated and coordinated healthcare for each of the organization's members.

Medicaid: Medicaid is a federal-state health insurance program for low-income U.S. citizens. Medicaid also covers nursing home care for the indigent elderly. Medical assistance is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

Medical Group: A group of physicians and/or providers organized as a single professional entity that is recognized under state law as an entity to practice a medical profession.

Medical Services Contract: A contract to provide medical or mental health services that exists between an insurer, physician or provider, and independent practice association; between an insurer and a physician or provider; between an independent practice association and a provider or organization of providers; between medical or mental health clinics; or between a medical or mental health clinic and a physician or provider. This does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapters 58, 60 or 70, or other similar professional organizations permitted by statute.

Medically Necessary Covered Services: Services, supplies, or drugs received are needed for the prevention, diagnosis, or treatment of a medical condition and meet the accepted standards of medical practice.

Member (Member of Our Plan, or Plan Member): A person with Medicaid who is eligible to get covered services, and who has been assigned to the CCO by the Oregon Health Plan (OHP).

Negotiated Discount: Method of reimbursement for contracted physicians and providers that stipulates a specific percentage by which a charge may be reduced if included in the physician's or provider's contract or agreement.

Network: The doctors, clinics, health centers, medical group practices, hospitals, and other providers that PacificSource Community Solutions has selected and contracted with to provide healthcare for its members.

Network Pharmacy: A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Physician or Provider: An individual physician or provider who has entered into an agreement with an IPA, or other association of healthcare practitioners to provide certain contracted services to PacificSource Community Solutions members.

Never Event: A list of serious medical errors or adverse events (for example, wrong site surgery or hospital-acquired pressure ulcers) that should never happen to a patient. The Centers for Medicare and Medicaid Services (CMS) defines never events as "serious, preventable, and costly medical errors."

Noncovered Services: Those services excluded from coverage by PacificSource Community Solutions.

Non-Emergent Condition: Routine medical care such as diagnostic work-ups for chronic conditions, elective surgery, and scheduled follow up visits for prior emergency conditions. In these instances, no benefits are payable for service/ treatment provided in an emergency room setting.

Non-Emergent Medical Transportation Services (NEMT): Non-Emergent Medical Transport, or NEMT, is how a Medicaid member can get a ride to a covered healthcare appointment. This is for scheduled healthcare appointments, not emergencies.

Nonformulary Covered Prescriptions: A list of prescription drugs that generally are not covered.

Nurse Practitioner: A registered nurse who has advanced skills, training, and licensure in the assessment of physical and psychosocial health status of individuals, families, and groups.

Organizational Determination: The Coordinated Care Organization (CCO) has made an organization determination when it makes a decision about whether services are covered. The CCO's network provider or facility has also made an organization determination when it provides a member with an item or service, or refers a member to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this manual. Oregon Health Authority uses the terms "prior authorization" or "claim" to refer to organizational determination.

Out-of-Area: Any area that is outside the PacificSource Community Solutions service area.

Out-of-Network Physician or Provider: A physician or provider who is not a part of the network.

Out-of-Network Provider: A healthcare physician or provider who has not contracted with PacificSource Community Solutions.

Outpatient Care: Care given to a person not requiring a stay in a licensed hospital or nursing home bed.

PacificSource Community Solutions: A healthcare service contractor licensed under state law and the Centers for Medicare and Medicaid Services (CMS) to provide comprehensive healthcare services for Medicaid members enrolled through the Oregon Health Plans (OHP).

PacificSource Health Plans: A healthcare service contractor licensed under state law that contracts for the provision of comprehensive healthcare services for its members enrolled in various benefit plans.

PacificSource Medicare: A healthcare service contractor licensed under state law and the Centers for Medicare and Medicaid Services (CMS) to provide comprehensive healthcare services for its Medicare members enrolled in various benefit plans.

PacificSource Policies and Procedures: The terms and conditions adopted by PacificSource for the administration of health benefits.

Participating Provider Network: An IPA or other association of physicians and/or providers organized as a single professional entity, which enters into a service agreement with PacificSource Community Solutions for the provision of certain covered services to PacificSource Community Solutions members.

Per Diem: The negotiated daily payment rate for delivery of all inpatient or residential services provided in one day, regardless of the actual services provided. Per diems can also be developed by type of care (for example, one per diem rate for general medical/surgical care and a different rate for intensive care).

Per Member Per Month (PMPM): A negotiated rate of payment per enrollee per month. A fixed amount determined by a negotiated rate between an insurance carrier and physician or provider.

Physician: A person duly licensed and qualified to practice medicine in the state where his/her practice is located.

Physician Assistant: A healthcare professional qualified by education, training, experience and personal character to provide medical services under the direction and supervision of a licensed physician in active practice and in good standing with the Board.

Physician-Hospital Organization (PHO): A healthcare delivery organization including both physicians and providers and a hospital or hospitals, which has entered into a contract with PacificSource Community Solutions to provide specified covered services to members.

Plan: See PacificSource Community Solutions.

Preventive Care: An approach to healthcare emphasizing preventive measures, such as routine physical exams, diagnostic tests, and immunizations.

Primary Care Dentist (PCD): The dentist who a member chooses or is assigned to by the dental care organization. Similar to a PCP, the PCD will provide or help coordinate the member's dental care.

Primary Care Provider (PCP): An in-network healthcare professional who meets state requirements and is trained to give members basic medical care. They can also coordinate member care with other providers. PCPs can be selected from the following specialties: family practice, general practice, internal medicine, or pediatrics. Providers in these specialties may include: Nurse Practitioners (NP), Physicians Assistants (PA), Medical Doctors (MD), or Doctor of Osteopathy (DO). HMO plans require members to have a PCP.

Preapproval: An approval process prior to the provision of services, usually requested by the physician or provider. Factors determining authorization may be eligibility, benefits of a specific plan, or setting of care.

Prioritized List: The Oregon Health Evidence Review Committee (HERC) ranks healthcare condition and treatment pairs in order of clinical effectiveness and cost effectiveness.

Protocol: Description of a course of treatment or an established practice pattern.

Provider: (1) Any individual who is engaged in the delivery of healthcare services in a state and is licensed or certified by the state to engage in that activity in the state; and (2) any entity that is engaged in the delivery of healthcare services in a state and is licensed or certified to deliver those services if such licensing or certification is required by state law or regulation.

Qualified Interpreter: An individual who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Healthcare. A qualified interpreter will have:

- A high school diploma.

- 60 hours interpreter training approved by the Oregon Health Authority (OHA).
- Proof of language proficiency in English and target language.

Their name listed on OHA's HCI Registry. More information is available at https://apps.Oregon.Gov/SOS/LicenseDirectory.

Quality Assurance Utilization Management Pharmacy and Therapeutics (QAUMPT) Committee: The QAUMPT Committee functions to promote quality and oversee performance improvement projects, identify topics for quality and performance improvement efforts, and oversee and evaluate quality and performance improvement plans. The pharmacy and therapeutics function of the committee is tasked with defining formulary coverage and clinical guidelines for the Medicare and Medicaid population.

Quality Improvement Organization (QIO): A group of practicing doctors and other healthcare experts paid by the federal government to check and improve the care given to Medicare and Medicaid patients.

Quantity Limits: A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Referral: The process by which the member's primary care provider directs the member to seek and obtain covered services from other physicians and providers.

Related Entity: Any entity that is related to the health plan by common ownership or control and (1) performs some of the health plan's management functions under contract or delegation; (2) furnishes services to Medicaid members under an oral or written agreement; or (3) leases real property or sells materials to the health plan at a cost of more than $2,500 during a contract period.

Resource-Based Relative Value Scale (RBRVS): A financing mechanism that reimburses healthcare providers on a classification system.

Risk: A possibility that revenues of the insurer will not sufficiently cover expenditures incurred in the delivery of contractual services.

Risk Contract: An arrangement through which a healthcare provider agrees to provide a full range of medical services to a set population of patients for a prepaid sum of money or a predetermined budget. The physician or provider is responsible for managing the care of these patients, and risks losing money if total expenses exceed the predetermined amount of funds.

Risk Pool: A category of services that are subject to some type of projected expense target. Typically, amounts over or under this target are shared with the medical group "at risk" for these services. For example, if the risk pool is set at $25.00 (per member per month) for hospital services and the actual amount comes in at $26.00, the $1.00 over the targeted amount may be deducted from other areas of reimbursement to the medical group.

Risk Sharing: An arrangement in which financial liabilities are apportioned between two or more entities. For example, PacificSource Community Solutions and a provider may each agree to share the risk of excessive healthcare cost over budgeted amounts on a 50-50 basis.

Service Areas: Geographic areas covered by a PacificSource Community Solutions insurance plan where direct services are provided.

Skilled Nursing Facility (SNF): A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and/or medical care that is of a lesser intensity than that received in a hospital.

Solo Practice: Individual practice of medicine by a physician or provider who does not practice in a group or share personnel, facilities, or equipment with other physicians.

Specialist Physician/Provider: A physician or provider whose training and expertise are in a specific area of medicine.

Stabilization: A state in which, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

Step Therapy: A utilization tool that requires members to first try another drug to treat a medical condition before we will cover the drug a physician may have initially prescribed.

Subrogation: When healthcare costs of enrollees are the responsibility of an entity other than the insurer, such as workers' compensation, third party negligence liability, or automobile medical coverage.

Tertiary Care: Healthcare services that are not available through a community hospital setting. This may include complex cancer procedures, transplants, and neonatal intensive care.

Third Party Payment: Payment for healthcare by a party other than the member.

Transformation Plan: CCO transformation plans establish the foundation for OHA's partnership with CCOs to achieve Oregon's health system goals. Plans also encourage continuous quality improvement, recognizing that transformation is a continuous process and that a CCO's transformation plan will and should evolve over time. As part of the contract process, each CCO was required to develop a transformation plan geared specifically to the needs of the community it serves. Plans demonstrate how the organization will work to improve

health outcomes, increase member satisfaction and reduce overall costs.

Triage: The classification of sick or injured persons, according to severity, in order to direct care and ensure efficient use of medical and nursing staff and facilities.

Urgent Care Clinic: A healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Urgently Needed Care: Urgently needed care is care provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible.

Utilization: The extent to which the members of a covered group use the services or procedures of a particular healthcare benefit plan.

Utilization Review: A set of formal techniques used by (or delegated by) an insurer that are designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of healthcare services, procedures, or settings.

Utilization Management Program: The programs and processes established and carried out by PacificSource Community Solutions with the cooperation of contracted physicians and providers to authorize and monitor the utilization of covered services provided to members.

Section 4: Physicians and Providers

4.1 Credentialing

PacificSource Community Solutions credentialing standards follow the guidelines of the National Committee on Quality Assurance (NCQA). The credentialing process includes meticulous verification of the education, experience, judgment, competence, and licensure of all healthcare providers.

Although the credentialing process may be lengthy and time-consuming, PacificSource Community Solutions believes the emphasis on credentialing further demonstrates a commitment to qualified healthcare physicians and providers performing services our members require.

Please remember that PacificSource Community Solutions requires all providers rendering services to be individually credentialed before they can be considered a participating provider under the provider contract. This includes a nurse practitioner, physician assistant, other mid-level provider, dentist, or dental hygienist. Providers must also be an approved Oregon Health Plan provider.

PacificSource Community Solutions does not accept "incident to" billing.

4.1.1 Initial Credentialing Process

The initial credentialing process at PacificSource Community Solutions involves three basic phases: application, review, and decision. The requirements and details of each phase are described below.

Dental care organizations perform credentialing for all providers. Refer to DCOs for applications and processing.

Phase 1: Application

Providers are required to submit the Practitioner Credentialing Application and complete our credentialing process prior to being considered a participating network provider with PacificSource Community Solutions. Please note that any new providers at your clinic will be considered out-of-network providers until the credentialing application is submitted and approved by our Credentialing Committee. When a provider has out-of-network status, claims are paid at the out-of-network benefit level, which has a direct effect on your clinic and your patients.

Once the credentialing application has been completed, a copy of the application can be used in the future provided no information has changed in the interim. However, signatures and attestation statements must be no more than 180 days old.

The Practitioner Credentialing Application is available in the For Providers section of our website, CommunitySolutions.PacificSource.com, or by contacting our Credentialing department by phone or email.

At a minimum, the Credentialing department will verify the following information with regard to completed applications:

- Current, unrestricted medical license
- Current, valid Drug Enforcement Agency (DEA) certificate, if applicable
- Education and training
- Board certification, if applicable
- A minimum of five years relevant work history
- Hospital privileges, if applicable
- Current, adequate professional liability coverage, showing the coverage limitations and expiration dates
- All professional liability claims history

Phase 2: Review

The PacificSource Credentialing department is responsible for credentialing and recredentialing providers participating in our provider network. The PacificSource Credentialing Committee evaluates provider candidates for credentialing and makes the final determination on credentialing and recredentialing. The Credentialing Committee is also responsible for developing credentialing criteria based on applicable standards, and applying those criteria in a fair and impartial manner.

The Credentialing Committee has the right to make the final determination about which providers participate within the network. If unfavorable information about a specific provider is discovered during the credentialing process (e.g., professional liability settlements, sanctions, erroneous information, or other adverse information), the Committee may choose not to credential the provider. The Credentialing Committee will not accept applications that are incomplete or do not meet our standards for review. Applications that are not accepted are not subject to appeal.

Phase 3: Decision

Upon the Credentialing Committee's approval, the provider will be notified in writing of their acceptance, including an approval date. The provider will then be recredentialed at least every three years.

Providers who do not meet the criteria set forth by the Credentialing Committee will be notified in writing.

If the Credentialing Committee does not approve the provider, the provider may be considered an "out-of-network provider" and claims may be processed at the out-of-network benefit level. There may be reasons (e.g., fraud, inappropriate billing practices, other violations of PacificSource Community Solutions rules or legal boundaries) whereby claims payments may not be approved.

Nonlicensed Providers

Nonlicensed providers cannot be credentialed to NCQA standards. In the case when PacificSource Community Solutions is required to add these types of providers to its network, the plan will require completion of a nonlicensed provider checklist.

The checklist is to be submitted by the facility on behalf of the provider. The checklist must include all applicable education, training, background, and competencies.

The Credentialing team will evaluate the checklist using the standards outlined in OAR 309-019-0125. If the checklist meets the appropriate standards, the providers will then be considered eligible to join the network.

4.1.2 Recredentialing Process

The recredentialing process will be conducted on each participating provider no less frequently than every three years, or according to applicable standards at the time. The Practitioner Recredentialing Application will be sent to the provider approximately three months prior to the credentialing period expiration date.

Failure to return the information by the due date will result in termination from the PacificSource Community Solutions network and will affect claims payment. If the provider is reinstated after such termination, the provider will be required to complete the full credentialing process, as deemed necessary by the Credentialing department and/or Medical Director.

The recredentialing process will include verification or review of the following:

- Completed recredentialing application
- Copy of current, unrestricted medical license
- Copy of current, valid Drug Enforcement Agency (DEA) certificate, if applicable
- Board certification, if applicable
- Hospital privileges, if applicable
- Current, adequate professional liability coverage, showing the coverage limitations and expiration dates
- Claims history since last credentialing
- Quality improvement activities

The decision and notification process for recredentialing is the same as for initial credentialing; please see Phase 3: Decision on previous page.

Locum Tenens Arrangement

PacificSource requires each eligible practitioner, provider or supplier of service appear as the rendering provider in box 31 of the CMS 1500 form. If a participating provider goes on leave, we require the covering provider to be credentialed prior to being paid under the absent providers contract.

A Locum Tenens arrangement is made when a participating provider must leave his or her practice temporarily due to illness, vacation, leave of absence, or any other reasons. The Locum Tenens is a temporary replacement for that provider, usually for a specified amount of time. Typically, the Locum Tenens should possess the same professional credentials, certifications, and privileges as the practitioner he or she is replacing.

A Locum Tenens who is providing coverage for a participating provider for 60 days or less will not need to be fully credentialed. However, PacificSource will require the provider to complete a Locum Tenens information sheet, attestation form, authorization and release of information form, and an attachment A form (if applicable). The provider will also be required to submit a current DEA certificate and documentation of professional liability coverage.

If a Locum Tenens is providing coverage longer than 60 consecutive days, the provider will be required to complete the applicable practitioner credentialing application.

Claims for the covering Locum Tenens provider will be denied as provider write-off if billed prior to credentialing approval.

4.1.3 Practitioner Rights

During the credentialing or recredentialing process, practitioners have the right to:

- Review information submitted to support their credentialing or recredentialing application
- Correct erroneous information
- Receive the status of their credentialing or recredentialing application, upon request

4.2 Taxpayer Identification Numbers

If you have a change in your tax identification number, you are required to notify us immediately. To ensure accurate IRS reporting, the W9 submitted to PacificSource must match the information submitted to the IRS.

When you notify us of a change to your tax identification number (TIN), please follow these steps:

- If you do not have a current version of the IRS W9 form, you may download it from our website, CommunitySolutions.PacificSource.com.
- Complete and sign the W9 form, following instructions exactly as outlined on the form.
- Include the effective date.
- On a separate sheet of paper, tell us the date you want the new number to become effective (when PacificSource Community Solutions should begin using the new number).
- Send the completed form with the effective date by fax: (541) 225-3643, or mail:

  PacificSource Health Plans
  Attn: Provider Network
  PO Box 7068
  Springfield, OR 97475-0068

For your current provider identification numbers, please contact our Provider Network department by phone at (541) 684-5580 or toll-free at (800) 624-6052 ext. 2580, or by email at providernet@pacificsource.com.

4.3 Physician and Provider Contract Provisions

PacificSource Community Solutions physician and provider contract provisions vary regarding lines of business, referrals, medical management, method of payment, and withhold requirements, but several provisions remain the same. The provisions that remain constant:

- Physicians and providers will not attempt to collect from members any amounts in excess of the negotiated rates.
- Physicians and providers may not collect up-front, except for deductibles, co-insurance, co-pays and/or services that are not covered. (See section 4.5.2 Availability Practice, Patient Waivers, for more detailed information)
- Physicians and providers will bill their usual and customary charges.
- Physicians and providers will bill PacificSource Community Solutions directly using current CPT procedure, ICD-10 diagnostic, HCPCS and/or DRG coding, and not ask members to bill PacificSource Community Solutions for their services.
- Physicians and providers will cooperate with PacificSource Community Solutions, to the extent permitted by law, in maintaining medical information with the express written consent of the insured, and in providing medical information requested by PacificSource Community Solutions when necessary to coordinate benefits, quality assurance, utilization review, third party claims, and benefit administrations. PacificSource Community Solutions agrees that such records shall remain confidential unless such records may be legally released or disclosed.

For specific contract provisions, please refer to your direct contract or to the negotiating entity that contracted on your behalf. You are also welcome to contact our Provider Network department by phone at (541) 684-5580 or toll-free at (800) 624-6052, ext. 2580, or by email at providernet@pacificsource.com. For dental contracts, please refer to your dental care organization.

Confidentiality of Records

As required under state and federal law and regulation, providers agree that information from medical records of members and information received by PacificSource Community Solutions pertaining to the provider-patient relationship is confidential and will only be shared as necessary under the Provider Agreement to assure appropriate administration of PacificSource Community Solutions or dental care organization, peer review, quality assurance, and to improve the availability and coordination of covered services to members. Providers agree to adhere to and follow all applicable state and federal privacy standards, including, but not limited to, the requirements under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations enacted by the Department of Health and Human Services at 45 CFR Parts 142, 160-164.

Record Retention, Data, and Medical Record

Providers and their subcontractors shall maintain financial, medical and other records in accordance with prevailing standards for members to whom a provider provides services pursuant to the terms and conditions of the Provider Agreement.

- Medical Records: Medical records, including deceased patients' (adults and minors), shall be kept for a minimum of seven years from the patient's last contact with their provider or per state or federal law, whichever is greater.

- Accounting Records: Accounting records pertinent to the Provider Agreement shall be maintained pursuant to applicable accounting principles for 10 years, or per state or federal law, whichever is greater.

Review of Books, Records, and Papers

Providers shall comply with all reasonable requests by PacificSource Community Solutions or its designee for access to member patient records reasonably necessary for the performance of provider, dental care organization, or PacificSource Community Solutions duties under the Provider Agreement.

Providers acknowledge that, subject to all applicable federal and state statutory and regulatory limitations, PacificSource Community Solutions shall have access at reasonable times upon reasonable demand to the books, records, and papers of providers relating to healthcare services provided to members. Such access shall include, but is not limited to, allowing review by the PacificSource Community Solutions Medical Director and/or his or her designee of a random selection of providers' office charts relating to members for purposes of PacificSource Community Solutions peer review, utilization review, and quality assurance programs.

Provider Communication

Each contracted provider has access to the Provider Manual. Enrollee rights and the provider's responsibilities to comply with these rights are outlined in the Provider Manual. You can access the most current Provider Manual on our website at CommunitySolutions.PacificSource.com.

Dental providers: Please refer to the manual provided by your dental care organization.

Provider Monitoring and Corrective Action

Providers will be monitored to ensure they are complying with the Enrollee Rights. Monitoring will occur through the Grievance and Appeals process. Any complaint received that is regarding a possible violation of an enrollee's rights will be logged and tracked as an enrollee rights complaint. These complaints will be reviewed by the Quality Assurance Utilization Management Pharmacy Therapeutics (QAUMPT) Committee on a quarterly basis. If a provider is found to have violated an enrollee's rights, the QAUMPT Committee will determine appropriate corrective action.

4.4 Call Share Policy

Participating providers will establish call share arrangements with other participating providers when they are unavailable. In such situations, the call share provider may bill PacificSource Community Solutions for the services provided to the patient.

If electronic answering machines are used, messages should include the following:

- Name and telephone number of the on-call provider.
- Instructions on how to contact that provider.

Dental providers: Please refer to the manual provided by your dental care organization.

IMPORTANT NOTE: A tape-recorded telephone message instructing members to call a hospital emergency room is not sufficient for 24-hour coverage.

PacificSource Community Solutions maintains call share group listings. Any changes in call share must be forwarded to the Provider Network department. If there is any change in a call share group, please call Provider Network as soon as possible at (541) 684-5580 or toll-free at (800) 624-6052, ext. 2580.

4.5 Primary Care Providers

4.5.1 Responsibilities

When a provider chooses to be designated as a primary care provider (PCP), he/she agrees to provide and coordinate healthcare services for PacificSource Community Solutions members. PCPs shall refer members to network specialists for services the PCP is unable to provide. The PCP will also be responsible for reviewing the treatment rendered by the specialist.

The primary care provider's responsibility as the manager and coordinator of the member's care is as follows:

- The PCP provides all primary preventive healthcare services, except the annual gynecological exam should the member choose to seek this service from a participating women's healthcare specialist.
- The PCP will complete a culturally and linguistically appropriate health risk assessment (HRA) on all members. This includes screening for chronic disease and risk factors such as alcohol, tobacco use, other substance use, high blood pressure, diabetes, depression, breast, colorectal and cervical cancer, high cholesterol, stress, trauma and other mental health issues with opportunities for education, treatment and follow-up based on results.
- When specialized care is medically necessary, the PCP will facilitate a referral to a specialist or specialty facility.
- The PCP must contact PacificSource Community Solutions to obtain preapproval or a referral to specialty providers, if necessary.
- The PCP will coordinate care and share appropriate medical information with PacificSource Community Solutions and any specialty provider to whom they refer their patients.

- PacificSource Community Solutions covers second opinions. If a member wants a second opinion about their treatment options, they will consult with their PCP about a referral for another opinion. Their PCP will need to contact PacificSource Community Solutions to get approval of the referral (preapproval). If a member wants to see a noncontracted provider; the member or their PCP will need to get PacificSource Community Solutions approval first.
- The PCP may delegate care coordination to another provider if both the member and the other provider agree. This will be clearly documented in the PCP's clinical record. Second opinions for dental services are covered. Dental providers should coordinate with their dental care organization to arrange second opinion visits.
- The PCP will retain the original completed Advance Directive and Declaration of Mental Health Treatment forms and provide a copy to the member. They will also document in a prominent place in their patient's records if an individual has executed an Advance Directive and/or a Declaration of Mental Health Treatment.
- Will notify PacificSource Community Solutions in writing when practice is closed to new patients.
- Will arrange for call sharing with a network physician or provider 24 hours a day, seven days a week.
- Will notify PacificSource Community Solutions of any changes in call share coverage.
- Will notify PacificSource Community Solutions when asking a member to seek treatment elsewhere.

Also see section on Referrals.

Change of Information

Please notify Provider Network if any of the following changes occur within your practice:

- Telephone number
- Tax ID number
- Billing address
- Physical office address
- Closing practice
- Provider leaving
- DMAP or NPI number changes

Submit these changes in writing to:

PacificSource Health Plans
Attn: Provider Network
PO Box 7068
Springfield, OR 97475-0068
Fax: (541) 225-3643
Email: providernet@pacificsource.com

Applicability of State and Federal Laws

As a federal contractor, PacificSource Community Solutions receives federal funds to provide services to our members. As a participating provider providing services to PacificSource Community Solutions members, you are subject to laws applicable to individuals and entities receiving state funds. Participating providers who treat our members are required to comply with applicable state and federal laws and regulations regarding Medicaid.

4.5.2 Availability Practice

Participating providers agree to accept new patients unless his/her practice has closed to new patients. Please notify PacificSource Community Solutions in writing when your practice is closed to new patients and again if the practice reopens.

Providers must ensure that their hours of operation are convenient to the population served under PacificSource Community Solutions and do not discriminate against Medicaid members.

Participating providers agree to provide 24-hour, seven-days-a-week coverage for PacificSource Community Solutions members in a culturally competent manner and in a manner consistent with professionally recognized standards of healthcare. The provider or his/her designated covering provider will be available on a 24-hour basis to provide care personally or to direct members to the setting most appropriate for treatment.

PacificSource Community Solutions will make every attempt to communicate to our members any closed or limited practice when notified by the PCP in writing of his/her intentions. Notations regarding closed or limited practices can be found in the provider directories. Possible notations include:

- Closed as PCP, Open as Specialist
- Practice Has Age Limitations
- Practice Has Demographic Limitations
- Accepting New Patients
- Not Accepting New Patients
- Accepting OB Patients only

Questions regarding PCP selection should be referred to the Customer Service department at (541) 382-5920 or (800) 431-4135. Provider Network will handle questions regarding closed/limited practices.

Provider Reporting of Quality of Care Concerns

Providers are encouraged to report quality of care issues or concerns. You may call PacificSource Community Solutions and ask for the PacificSource Community Solutions Medical

Director at (541) 330-7301. If you prefer to write a letter, please mail it to the following address:

PacificSource Community Solutions
Attention: Quality Assurance Coordinator
PO Box 7469
Bend, OR 97708

Access to Care Standards

PacificSource Community Solutions has established timeliness of access standards of care related to primary care, emergent/urgent care, and behavioral healthcare.

Primary Care Provider Services:

- Preventive Primary Care appointments—30 working days (annual physicals, pediatric/adult immunization, and annual GYN exams)
- Routine Primary care appointments—five working days (chronic conditions, headaches, joint pain)
- Urgent Primary care appointments—within 48 hours (high fever, vomiting etc.)
- Emergency care services—Same day
- After hours care—24-hour phone available (answering machine/service advising members of care options)

Behavioral Healthcare Services:

- Routine office visit appointments—10 working days
- Urgent Care—48 hours*
- Nonlife-threatening emergency care—Contact with patient within six hours*
- Life-threatening emergency care—Immediately*
- After hours care—24 hour phone available (answering machine/service advising members of care options).
- All PacificSource Community Solutions members have direct access to behavioral health services by calling their office or going to the emergency room

Primary Care Dental Services (when dental care is provided by the dental care organization):

- Routine—See within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason that would make 12 weeks or longer appropriate
- Urgent—Within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060
- Emergency—See or treat with 24 hours

Provider Network will measure compliance with the above standards by conducting quarterly access surveys, site visit checklists, and member complaints. All measured data is analyzed and reviewed by the QI Committee at least annually. If there are more than three member complaints about a specific office or provider, then a review will be required and completed by the Provider Network department. Results of any review will possibly identify opportunities for improvement, and corrective actions if necessary.

Reporting Fraud, Waste, and Abuse

You have a contractual and compliance obligation to cooperate with the state and federal governments in their ongoing efforts to combat fraud, waste, and abuse. You should review your current process to ensure that your office staff is aware of the responsibility to respond to requests for information from PacificSource Community Solutions, the state, and CMS in a timely manner.

Disclosure by Providers Related to Business Transactions

Providers agree to furnish to PacificSource or the OHA full and complete information related to the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 in the previous year and any significant business transactions between the provider and any wholly owned supplier or subcontractor during the previous five (5) years. Such information must be disclosed within 35 days of the request. Providers agree to also disclose information related to vendor relations, gifts, gratuities, and other compensations.

Termination of Patient Care

Providers may withdraw from the care of a patient when, in the medical judgment of the provider, it is in the best interest of the patient to do so. The following is a summary of the policy regarding termination of patient care.

Physician Duty
Physicians have a duty to provide medical care to a patient until the proper termination of that relationship. A patient-physician relationship can be successfully terminated by following *any* of the guidelines listed below:

- Mutual consent
- Patient dismissal of the physician
- The lack of need for further medical treatment
- Withdrawal of the physician

When a physician withdraws from a patient who needs continuing care at that time, the physician must take *all* the following steps:

- Give patient reasonable notice of intent to withdraw
- Provide the patient with a reasonable time to find alternative care

- Continue to be available during this time to treat the patient until the date indicated in the notice

Please note: The same rules apply to termination of care for nonpayment of fees.

Reasonable Notice
In most cases, a 30-day notice would be considered reasonable. If the basis for termination of a PacificSource Community Solutions member from your practice is for disruptive behavior and is dangerous to other patients or staff, the period may be shortened to as little as one day. This is dependent upon the seriousness of the threat and our ability to either terminate the member from our plan or to locate another network provider willing to accept the member as his/her patient within the range of one to 30 days. This also takes into consideration both the severity of the patient's condition and the availability of other care in the community within the time period selected. It is not necessary to indicate to the patient why the relationship is being terminated.

Please notify Customer Service at PacificSource Community Solutions of the termination at the same time you notify the patient.

Patient Waivers

There are Oregon Administrative Rules, 410-120-1280 (Billing) and 410-141-3395 (Member Protection Provisions) that outline the waiver requirements for services not covered by the OHP or CCOs. You may find these OARs online at oregon.gov/OHA/healthplan/pages/policies.aspx. The Oregon Health Authority (OHA) and therefore PacificSource Community Solutions, require that our members receive advanced written notification that a specific service is not covered. The OHA prohibits providers from asking OHP members to sign a general waiver or sign one on a routine basis.

OHA and PacificSource Community Solutions require that the following be included in the waiver:

- The specific service being provided
- The date of the service
- A reasonable estimated cost of the service
- A statement indicating the member or member's family is financially responsible for payment for the specific service(s)
- Services that are not supported by a diagnosis or established coding guidelines (i.e., unbundling) may be denied as provider responsibility

If you have a signed waiver on file, you must bill the service with a GA modifier. Without the use of the GA modifier, the service may be denied as provider responsibility. Under these circumstances, the member cannot be billed.

The OHA has provided a standardized waiver that you may use for these purposes, form DMAP 3165. This is made available to you within our website, and at Apps.state.or.us/Forms/Served/oe3165.pdf.

Voluntary Sterilization (Primary and Secondary Coverage):

Voluntary sterilization is a covered service for PacificSource Community Solutions members. In accordance with DMAP rules, PacificSource Community Solutions requires the completion of a DMAP Consent to Sterilization Form (DMAP 742) for all sterilizations. The provider performing the sterilization procedure is responsible for the following even if PacificSource Community Solutions is secondary:

- Obtaining a signed DMAP Consent to Sterilization Form (DMAP 742) from the member age 15 and over (parent or guardian for a child less than 15 years of age), at least 30 days, but not more than 180 days prior to the date of the sterilization except as outlined below.
- In the case of premature delivery by vaginal or cesarean section, the consent form must have been signed at least 72 hours before the sterilization is performed and more than 30 days before the expected date of confinement.
- In cases of emergency abdominal surgery (other than cesarean section), the consent form must have been signed at least 72 hours before the sterilization was performed.

The consent form must be signed and dated by the person obtaining the consent after the client has signed, but before the date of the sterilization. If an interpreter assists the member in completing the form, the interpreter must also sign the consent form.

When a PacificSource Community Solutions member signs a DMAP Consent to Sterilization Form (DMAP 742) it must be an informed choice and they must be legally competent to give informed consent. The consent is invalid if it is signed when the client is:

- In labor
- Seeking or obtaining an abortion
- Under the influence of alcohol or drugs
- Signed less than 30 days prior to procedure

The physician performing the procedure must complete the physician statement in its entirety. The physician must sign and date the consent form on the date of the procedure or on a date following the procedure.

Please submit the consent form to PacificSource Community Solutions either prior to billing or along with the claim.

Consent to Sterilization Forms may be obtained by contacting DMAP, Provider Forms Distribution, PO Box 14090, Salem, OR 97309-4090. You may also download online at Oregon.gov/oha/healthplan/Pages/forms.aspx.

Complete instructions for completing the DMAP 742 form can be found in the DMAP Medical Surgical Guide (OAR 410-130-0580).

Hysterectomy Consent Forms

PacificSource Community Solutions requires physicians to obtain a signed DMAP Hysterectomy Consent form prior to surgery. There is no required waiting period between signing a DMAP Hysterectomy consent form and surgery. Please note, hysterectomies for the sole purpose of sterilization is not covered (OAR 410-130-0580). The method for completing the consent form will vary based on the following circumstances:

When a woman is capable of bearing children:

- The physician must obtain informed consent from the member prior to the surgery being performed. The member must sign and date the consent form prior to the date of surgery.

When a woman is sterile prior to the hysterectomy:

- The physician who performs the hysterectomy must clarify in writing that the woman was already sterile prior to the hysterectomy and state the cause of the sterility.

When there is a life-threatening emergency situation, which requires a hysterectomy in which the physician determines that prior acknowledgement is not possible:

- The physician performing the hysterectomy must clarify in writing that the hysterectomy was performed under a life-threatening emergency in which he or she determined prior acknowledgment was not possible and describe the nature of the emergency.

Please submit the consent form to PacificSource Community Solutions either prior to billing or along with your claim. If submitting prior to billing, forms can be faxed to (541) 322-6437.

Complete instructions for completing the DMAP 741 form can be found in the DMAP Medical Surgical Guide (OAR 410-130-0760) or online at DHSForms.hr.state.or.us/Forms/Served/OE0741.pdf.

Contact your Provider Service Representative at (541) 684-5580 or (800) 624-6052, ext. 2580 for information or questions concerning the above topic.

Advance Directive and Declaration of Mental Health Treatment

These documents allow patients to express and control their healthcare needs at a time when they are unable to make decisions.

Provider Responsibilities:

- Provider will maintain written policies and procedures concerning advance directives and declaration of mental health treatment with respect to all adult individuals receiving medical or mental healthcare.
- Provider will provide written information to those individuals with respect to its written policies and respecting the implementation of those rights. It will include a clear and precise statement of limitation if the provider cannot implement an advance directive or declaration of mental health treatment as a matter of conscience.
- Providers should retain the original and provide a copy of the completed form to the member.

The forms may be obtained from Customer Service or online:

Advance Directive: Oregon.gov/DCBS/insurance/shiba/Documents/advance_directive_form.pdf.

Declaration of Mental Health Treatment: Oregon.gov/oha/amh/pages/services/planning.aspx.

Health Insurance Portability and Accountability Act (HIPAA)

PacificSource Community Solutions continues to ensure that we conduct business in a manner that safeguards member information in accordance with the privacy enacted pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The recently enacted privacy regulations have been fully implemented throughout this organization and we are fully committed to the protection of Personal Health Information (PHI).

PacificSource Community Solutions recognizes to request only the minimum necessary member information to accomplish the task at hand under the HIPAA privacy regulations. However, please note the regulation allows the provision, transfer, and sharing of member information needed by PacificSource Community Solutions in the normal course of business activities to make decisions about care. To make a healthcare determination or resolve a payment issue, the member's medical record may be requested.

Requested information may be uploaded via InTouch for Providers (secure provider portal) or faxed to PacificSource Community Solutions. PacificSource Community Solutions uses a fax system that is secure and only authorized personal have access to the information. Email should only be used when information is sent through an encrypted and secure email system.

The Privacy Notification Statement that is available to all PacificSource Community Solutions members is available on our website at CommunitySolutions.PacificSource.com. If you have any questions or concerns, please contact your Provider Service Representative.

4.6 Provider Appeals Process

A provider appeal guide is available online at CommunitySolutions.PacificSource.com. For any questions, please contact a Grievance & Appeals (G&A) Analyst at (541) 330-4992.

As a participating provider, you agree to adhere to the PacificSource Community Solutions Grievance and Appeals procedures.

You have the opportunity to request that the plan reconsider a coverage action/decision that affects you adversely (e.g., claim denial) or as a patient advocate (i.e., preapproval coverage denial). This should be performed via the Provider Appeal process.

An appeal can be requested via InTouch for Providers (preferred) or by submitting a Provider Appeal Request Form. The form is located at CommunitySolutions.PacificSource.com/Providers/DocumentsAndForms. Appeals must be received by the plan within 60 calendar days of the denial date. To submit an appeal, please fax it to (541) 322-6424 or mail to:

PacificSource Community Solutions
Provider Appeals
2965 NE Conners Avenue
Bend, OR 97701

If you fail to submit a complete and timely appeal, the plan will consider that you have accepted our coverage determination and have waived further appeal processes regarding the issue. Note that the plan may consider an exception to the filing time lines (within reasonable limits) if you can show good cause that prevented timely filing due to circumstances beyond your control. Please include this information as part of your appeal.

Preapproval Appeals

PacificSource Community Solutions will accept timely preapproval appeals if you believe that additional information, not previously reviewed by the plan, will impact the original decision. These types of appeals should include supporting medical information indicating why the original decision should be overturned. Appeals based on a denial of coverage as experimental/investigational should also include peer-reviewed literature supporting your position. Any appeals that do not provide additional information to support further review may not be processed.

The G&A Analysts make every effort to process preapproval appeals as quickly as possible. The plan will consider expediting a decision if a physician requests it, with clear indication that potentially waiting up to 30 calendar days to receive a coverage determination may place the patient's health in jeopardy. For example, the plan may not expedite the review of a MRI coverage appeal because the procedure is scheduled to occur prior to the 30-day time frame. When the plan accepts a request to expedite a review, a coverage response will be issued within 72 hours of receipt.

When preapprovals have been denied because the plan reviewer requested documentation but did not receive it in a timely manner (such as with pharmacy requests), please submit a new preapproval request with the additional information. This is to your benefit, as the process is faster than an appeal.

Appeal Form Requirements

All provider appeal forms must be filled in completely. They must include the following at a minimum:

- Member name/identification number
- Physician/provider name and contact
- Contact's phone/fax number
- Claim or preapproval number being disputed
- Service denied
- Reason for the appeal (why you believe the service should be covered)
- Any pertinent clinical information or related documentation that would be of assistance in reviewing the request, to support the reasons for reversing the noncoverage decision.

These should be submitted to the Grievance and Appeals department, via fax at (541) 322-6424. Please refer to the Provider Appeal Request Form for mailing options.

Prescription Coverage Appeals

If the appeal involves a prescription issue, please submit your request using the PacificSource Community Solutions Provider Appeal Form. The form is available online at CommunitySolutions.PacificSource.com. Please fill these out completely, with the following minimum information:

- Member name/identification number
- Provider name and contact person
- Contact phone/fax number
- Preapproval number
- Prescription denied
- Reason for the appeal (why you believe the prescription should be covered—please be detailed)
- Any pertinent clinical information or related documentation that would be of assistance in reviewing the request

The appeal forms include mailing and fax information.

Your appeal should include supporting medical information indicating why the original decision should be overturned. Appeals that indicate disagreement with a coverage decision,

without providing additional information to support further review, may result in an unchanged decision.

Every effort is made by appeal representatives to process your requests as quickly as possible. For prescription appeals, this may take up to 30 calendar days. We will consider expediting a decision if a physician requests it with a clear indication that waiting up to 30 calendar days to receive a coverage determination may place the patient's health in jeopardy. When PacificSource Community Solutions accepts a request to expedite a review, a coverage resolution will be issued within 72 hours of receipt or your request.

When a preapproval has been denied because PacificSource Community Solutions requested additional documentation, but did not receive it in a timely manner and resulted in a denial of coverage, please consider submitting a new preapproval request instead of an appeal. Include the additional information requested and clearly indicate new information is being provided.

This is the only level of appeal available to providers for prescriptions.

Claim Appeals

Please include comprehensive documentation that will help us investigate the claim in question. This should include, at a minimum, a detailed description of the issue in dispute, the basis for your disagreement, as well as all evidence and documentation supporting your position. Incomplete appeals will be returned for additional information.

In cases where a claim payment denial is considered member responsibility (e.g., instances where the member signed a valid waiver in advance, accepting financial responsibility for the services received), then the member may file an appeal on his/her own behalf, following the member appeals process. This does not prohibit you from also filing an appeal for payment. If you appeal a claim denial where the member has signed a valid waiver and the denial is upheld by the plan as member responsibility, then the member may be billed for the services. However, in cases where a valid waiver was not obtained from the member, then Oregon Health Authority prohibits billing the member, per Oregon Administrative Rule 410-120-1280.

Claims denied for reasons such as invalid coding or invalid place of service, etc., should not be submitted for reconsideration via the appeals process. In these cases, it is more appropriate to contact the Claims Department with a "reconsideration" or "corrected claim" submission. This also applies to disputes related to duplicate claims, eligibility vs. date of service, sterilization consent forms, and timely filing denials.

Appeal Resolutions

Reviewers not involved in the initial coverage determination participate in an appeal resolution, which is issued to the appealing provider in writing (typically via fax) within 30 calendar days of receipt of the appeal. This time frame may be extended if the reviewer requires additional information to make a determination, and this is of benefit to the member or provider.

All appeals are subject to plan benefits, medical necessity, coverage criteria, and member's enrollment status at the time of service.

Noncontracted Providers

The plan does not offer appeal rights to noncontracted providers. For claims denied due to timely filing and coding reasons, a noncontracted provider may resubmit the claim through the Claim Reconsideration process (by resubmitting the claim with corrections or supporting documentation).

Provider acknowledges that subject to all applicable federal and state statutory and regulatory limitations, PacificSource Community Solutions shall have access at reasonable times upon reasonable demand to the books, records, and papers of providers relating to healthcare services provided to members. Such access shall include, but is not limited to, allowing review by the PacificSource Community Solutions Medical Director and/or his or her designee of a random selection of provider's office charts relating to members for purposes of PacificSource Community Solutions peer review, utilization review, and quality assurance programs.

Section 5: Referrals

5.1 Referral Policy

A "referral" is the process by which the member's primary care provider (PCP) directs a member 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.

Dental providers: Please refer to your dental care organization referral policy.

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

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. Requests to see an out-of-network provider must be submitted via the preapproval process and are not considered a referral.

In most cases, referrals must be submitted by the member's PCP. The referral request can be initiated by the specialist in the InTouch portal. However, this referral request must be approved by the PCP. Under special circumstances, a specialist may be granted sub-referral authority. This capability is granted by the PCP and allows specialist to request on-going 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.

A specialist may bypass PCP approval for follow-up appointments after:

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

All PacificSource Community Solution members have access to contracted specialists for second opinions for a medical, dental, or behavioral health condition. A second opinion is another specialist's opinion about treatment for a medical condition diagnosed by the primary specialist. PCPs must submit a referral request to another specialist for a second opinion.

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

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.

Procedures or services that require preapproval cannot be included in a referral. Providers must submit a request for these services via the preapproval process.

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.

Referrals and preapprovals are not required when PacificSource Community Solutions is the secondary payer.

5.2 Referral Procedure

A referral can by submitted electronically through InTouch, our secure, online provider portal. InTouch can be accessed by visiting CommunitySolutions.PacificSource.com/Providers. Information 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, time frame, and number of visits (start and end dates must be clearly defined)
- Chart notes. Please see Table 2 in Section 5.3 for all chart note requirements

The approved referral covers services from any in-network provider that practices in the same group and has the same specialty as the provider indicated on the approved request.

If the referral request has not been approved at the time of service and 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.

Referral approval is, in part, based on the coverage of the diagnosis submitted by the member's PCP.

For specialties listed in Table 1, the **initial** office visit will be allowed with an approved referral. Approval for additional follow-up visits is subject to OHP funding (line placement of diagnosis) and will require medical review.

To determine if your patient's condition is funded by the OHP, LineFinder can be found online at Intouch.PacificSource.com/LineFinder or contact customer service.

For specialties **not** listed on Table 1, all visits are subject to funded conditions, medical appropriateness, and established medical criteria. Documentation will be required for reviewing these specialty requests.

We respond to standard referral requests within 14 calendar days. If the number of requested visits is within the frequency outlined in Table 1, an automatic approval may be processed instantly.

A determination notice is viewable online in InTouch.

5.3 Visits Covered by Referral

Referral requests do not have a maximum visit limitation. However, if the amount of visits requested exceeds the number defined in Table 1, the referring provider must include documentation to support their request.

The amount of visits requested must be a reasonable number and cannot be unlimited. Referral requests that do not exceed the frequency listed in Table 1 may be granted automatic approval if submitted with a covered diagnosis. For specialties listed in Table 1, all referral requests received for **Above the Line (ATL)** conditions will be approved up to the maximum visits listed in the table.

For specialties listed in Table 1, all referral requests received for **Below the Line (BTL)** conditions will be approved for the initial (one) visit only regardless of the number of visits requested.

Please note: If a request has already been submitted within the past rolling year for the same specialty type, these will not be auto-approved.

Table 1. PacificSource Community Solutions Referral Guidelines per rolling year.

Requested Service	Eligible for automatic approval when submitted online with an above-the-line diagnosis
Audiology	Maximum visits: 4
Cardiology	Maximum visits: 6
Cardiovascular Surgery	Maximum visits: 6
Endocrinology	Maximum visits: 6
ENT/Otolaryngology	Maximum visits: 6
Gastroenterology	Maximum visits: 6
General Surgery	Maximum visits: 6
Gynecology Obstetrics	Maximum visits: 6
Hematology/Oncology	Maximum visits: 12
Immunology/Allergy	Maximum visits: 3
Infectious Disease	Maximum visits: 6
MRI follow-up	Maximum visits: 1 (PCP referral requirement is waived)
Neonatology	Maximum visits: 6
Nephrology	Maximum visits: 6
Neurology	Maximum visits: 3
Neurosurgery	Maximum visits: 6
Ophthalmology/Optometry	Maximum visits: 6 if age < = 20; if age > 20 with diabetes or glaucoma diagnosis
Oral/Maxillofacial Surgery	Maximum visits: 3
Orthopedics	Maximum visits: 6
Pediatric Specialist	Maximum visits: 3
Pulmonology	Maximum visits: 6
Radiation Oncology	Maximum visits: 24
Rheumatology	Maximum visits: 6
Urology	Maximum visits: 6

Table 2. PacificSource Community Solutions Referral Guidelines, Documentation Requirements.

Supporting documentation is always required for the following specialties/circumstances:
Any referral type not listed on Table 1 (examples: podiatry and dermatology)
Referral longer than 1 rolling year
Office visits for BTL conditions (initial visit excluded)
Office visits greater than those listed in Table 1
Retroactive requests

5.4 Out-of-Network Referrals

Requests to see an out-of-network provider, including for second opinions, must be submitted via the preapproval process and are not considered a referral. For referrals to a noncontracted provider, PacificSource Community Solutions must approve the service in advance. If the service is not approved, the plan will not pay for it. There are a few exceptions in which a member can see a noncontracted provider without getting an approval in advance. These are:

- Ambulance and Emergency Room Services (for emergencies);
- Family Planning; and
- Some Immunizations (shots).

5.5 Referral Not Required

Referrals are not required for the following. However, these services are subject to the plan benefits and eligibility:

- Annual women's exam
- Anticoagulation office visits
- Certain immunizations (shots) (may be received from any provider)
- Emergency care
- Family planning services (may be given by any provider)
- Health Department services
- Intensive Care Coordination Services (ICCS) (see Section 5.6 Special Considerations below for details)
- Lactation services (help with breastfeeding your baby)
- 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 healthcare
- 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

5.6 Special Considerations

Intensive Coordinated Care Services (ICCS) members have special considerations. 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.

5.7 Retro-Referrals

Retro-referrals are allowed 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 in this process.

Section 6: Medical Management

6.1 Medical Coverage

Medical coverage is determined by the Prioritized List. The Prioritized List emphasizes prevention and patient education. In general:

- Treatments that help prevent illness are ranked higher than services that treat illness after it occurs.
- OHP covers treatments that are ranked on a covered Prioritized List line for the client's reported medical condition.

PacificSource Community Solutions determines medical coverage based on the current published Prioritized List. You can access the Prioritized List on our website at InTouch.PacificSource.com/LineFinder. Select the appropriate PDF file under the "Further Reading" section. This information is directly taken from the Oregon Health Authority (OHA) website and updated as OHA updates.

6.2 Care Management

Overview of Care Management Program

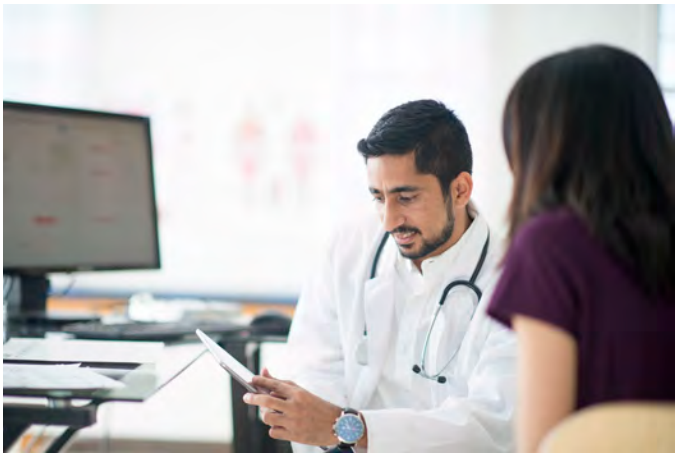
Primary care provider care Homes and other primary care provider (PCP) models are the focal point of coordinated and integrated care, so that members have a consistent and stable relationship with a care team responsible for comprehensive care management.

PacificSource Care Management services are offered as a supplemental resource to the provider care team to assist them in serving members that present them with special healthcare needs, such as obstacles in complex behavioral, medical, dental, and social determinants of health.

When member high-risk and high-utilization issues require intensive care coordination and the creation of an aligned community plan of care, providers may request assistance from the PacificSource Community Solutions Care Management team.

To further define high risk/high utilization special healthcare needs, these categories are utilized:

- Inpatient re-admissions (within 30 days)
- Multiple inpatient stays within a year (five or more)
- EDIE Care Recommendations are not adequate to address community coordination needs
- Co-morbid complex medical and behavioral health conditions that significantly impact care
- High-risk pregnancy (any reason)
- Limited or no engagement with the primary care physician, unless a specialist is acting as a PCP



- Multiple ED visits within a year (four or more)
- Multiple facility ED and/or IP use within a year (three or more)—for instance, goes to two EDs in different towns and one of those lead to an Inpatient Admission
- Complex medical condition and social determinants causing severe obstacles to care

PacificSource uses risk scoring that is derived from report data to prompt case management services, along with the criteria above. Care Management prioritizes risk levels that are stratified as "very high and high."

Utilizing Nurse Care Managers, Member Support Specialists, Behavioral Health Specialists and Pharmacist consultation, when appropriate, and under the guidance of the Medical Director, the PacificSource Community Solutions Care Management team and consultants work with providers and community partners in promoting provider engagement with members and in bridging communication and planning within systems of care.

Care Management is a collaborative process, building from the PCP, PCD, and behavioral health provider's direct relationship with the member.

The Care Management department is available Monday through Friday, from 8:00 a.m. to 5:00 p.m. local time zone by calling: (541) 382-5920 or (800) 431-4135.

Intensive Care Coordination Services (ICCS)

ICCS is a specialized care management service Oregon Health Plan (OHP) managed care plans provide to OHP members who are aged 65 or older, blind, disabled, or have special healthcare needs. PacificSource Community Solutions has staff dedicated to provide ICCS consultation and support services.

ICCS services may include providing assistance to ensure timely access to providers and services; coordination of care to ensure consideration is given to unique needs in treatment

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planning; assistance to providers with coordination of services and discharge planning; coordination of community support and social services, as necessary and appropriate.

Care Management and Coordination staff may collect information to assist in identifying a member's special need and development of a plan. This may include talking to or meeting with members, providers or caretakers, reviewing medical records, and assessing their support systems, communication and transportation.

Care Management and Coordination staff may assist and provide consultation for the primary care team's development and update of service planning, in order to promote member engagement and coordination of all services.

The OHP member's primary care provider is responsible for developing a treatment plan for the member with the member's participation. This should include a consultation with any specialist caring for the member. The treatment plan should be in accordance with any applicable state quality assurance and utilization review standards.

Providers are encouraged to contact PacificSource Community Solutions and request ICCS services for members that are aged, blind, disabled, or have special healthcare needs. Ask for the Intensive Care Management and Coordination team at (541) 330-2507 or toll-free (888) 970-2507.

How Members are Identified

Care management may be generated under the following terms:

- Contracted providers contacting PacificSource Community Solutions directly
- Community partners engaged directly in coordination of care activities
- Referrals from other internal departments, such as Utilization Review, Customer Service, or Behavioral Health
- Members and member representatives contacting PacificSource Community Solutions directly
- Data analysis to identify high-risk and special-health-needs patients
- State agency referrals

PacificSource Community Solutions members may be identified through the completion of a health assessment survey (wellness survey) administered after enrollment. The health assessment tool is completed by the member or their representative. It provides information that allows the care manager to assess the level of need for management and intervention, as well as health and disease education.

The Care Management and Care Coordination Department is available Monday through Friday, 8:00 a.m. to 5:00 p.m. by calling (541) 330-2507 or toll-free (888) 970-2507.

6.3 Quality Improvement and Medical Management

PacificSource Community Solutions relies on the Quality Assurance Utilization Management Pharmacy & Therapeutics (QAUMPT) Committee to be its advisory body for quality, utilization, pharmacy, therapeutics, and performance improvement activities. The committee has the responsibility to develop and endorse all clinical policies and formulary coverage decisions. The QAUMPT committee consists of physicians and pharmacists practicing in the communities we serve. These committee members represent our contracted providers and dental providers. Evidence-based guidelines are reviewed and adopted by the QAUMPT committee. Examples include, Milliman, Hayes, and AIM clinical guidelines. Guidelines are updated on an annual basis or more often in the presence of significant new medical information. Guidelines should be communicated by members of the QAUMPT committee to their representative groups. Guidelines are also communicated to providers as needed during clinical reviews, through the company website, sent upon request, and sent to providers when the guidelines relate to quality improvement or disease management projects. Representation on the QAUMPT Committee includes primary care providers, specialty providers, and pharmacies who are free of conflict with PacificSource Community Solutions and includes experts in the care of elderly populations. PacificSource Community Solutions operates a quality assurance and performance improvement program and participates in for external quality review as required by CMS.

Program Overview

High quality healthcare is a priority at PacificSource Community Solutions. Our Quality Improvement Program is under the direction of our Medical Director and managed by our Quality department. This program works in collaboration with practitioners in our plan network. The program foundation is built on evidence-based guidelines and state and national regulations to achieve the triple aim of providing better health, better care, and better cost to the people and communities we serve.

The Quality Improvement Program Goals:

- Make care safer by reducing harm caused in the delivery of care.
- Strengthen person and family engagement as partners in care.
- Promote effective communication and coordination of care.
- Promote effective prevention and treatment of chronic disease.

- Work with communities to promote best practices of healthy living.
- Make care affordable.

The quality improvement program strategies:

- Eliminate racial and ethnic disparities.
- Strengthen infrastructure and data systems.
- Enable local innovations.
- Foster learning organizations.

How do we decide where to focus our improvement efforts?

The QAUMPT Committee reviews several sources of data and information available to our Medicaid plan to help identify areas on which to focus improvement efforts.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a member survey conducted annually to assess the experiences of members with their health plan and providers.

CCO Transformation Plan calls for fundamental, system-wide changes in our Medicaid healthcare delivery system. This includes important changes that ensure progress toward health, equity, and the elimination of health disparities and inequities that occur disproportionately in communities of color, low-income populations and patients with complex physical and/or mental healthcare needs. We consider the goals of the eight transformation areas in deciding improvement efforts.

- Transformation Area 1: Integration of care
- Transformation Area 2: Patient-centered primary care home (PCPCH)
- Transformation Area 3: Alternative payment methodologies
- Transformation Area 4: Community health assessment and community health improvement plan
- Transformation Area 5: Electronic health record, health information exchange, and meaningful use
- Transformation Area 6: Communications, outreach, and member engagement
- Transformation Area 7: Meeting the culturally diverse needs of members
- Transformation Area 8: Eliminating racial, ethnic, and linguistic disparities

CCO Quality Incentive Metrics. The state is tracking 18 CCO incentive metrics that will help follow progress towards Oregon's goal of better health, better care, and lower costs.

Each metric has a 2011 state baseline (starting point) and state benchmark (goal). The incentive measures are:

1. Adolescent well-care visits (NCQA)
2. Alcohol and drug misuse: screening, brief intervention and referral for treatment (SBIRT) (OHA 001))(temporarily removed from the 2017 metrics)
3. Ambulatory care: outpatient and emergency department utilization. (HEDIS)
4. Assessments for children in DHS custody
5. Access to care: getting care quickly (CAHPS)
6. Satisfaction with care: health plan information and customer service (CAHPS)
7. Childhood immunization status (Combo 2) (HEDIS)
8. Cigarette smoking prevalence (meaningful use)
9. Colorectal cancer screening (HEDIS)
10. Controlling high blood pressure (NQF 0018)
11. Dental sealants on permanent molars for children (EPSDT Form CMS-416) (NQF)
12. Screening for clinical depression and follow-up plan (NQF 0418)
13. Developmental screening in the first 36 months of life (NQF 1448)
14. Diabetes: HbA1c poor control (NQF 0059)
15. Effective contraceptive use (CDC & CMS)
16. Follow up after hospitalization for mental illness (NQF 0576)
17. Patient-centered primary care home (PCPCH) enrollment (OHA 003)
18. Prenatal and postpartum care: timeliness of prenatal care (NQF 1517)

Input from Members and Providers. Providers who participate as members of the QAUMPT Committee give input into the focus of improvement efforts through participation on that committee. The committee also has a public member who provides input on behalf of plan membership. Additionally, members' grievances are monitored for patterns of issues of concern to members and members may provide input by calling Customer Service or the Quality department.

PacificSource Community Solutions has a Community Advisory Council (CAC). Most of the Council members are Oregon Health Plan members. Other members are from government agencies and groups that provide OHP services. The overarching purpose of the CAC is to ensure the COHC remains responsive to consumer and community health needs. The CAC is intended to enable consumers to take an active

role in improving their own health and that of their family and community members.

6.4 Medical Preapproval

Preapproval is the process by which providers verify coverage and receive preapproval from PacificSource Community Solutions before services or supplies are rendered. Preapproval establishes covered expenses based on benefits available, medical necessity, appropriate treatment setting, and/or anticipated length of stay. Some in-network medical services are covered only if an in-network provider receives preapproval from our plan. The list of services that require preapproval is available on our website at CommunitySolutions.Pacificsource.com.

Dental providers: Please refer to the preapproval policies for your dental care organization.

Preapproval Process

1. Medical services that have been identified as high cost, over-utilized, and/or potentially unsafe require preapproval.
2. The preapproval grid, located on our website at CommunitySolutions.PacificSource.com, details services that require preapproval.
3. A request can come from any source if it supplies information useful in completing the request in an accurate thorough manner.
4. Information will be accepted from specialty offices, facilities, vendors, therapy offices, etc., and should include appropriate clinical information, most current chart notes, and most specific diagnosis or procedure coding.

Emergent and urgent inpatient admissions do not require preapproval. However, you must notify PacificSource Community Solutions within 48 business hours from the date of service.

All preapproval and referral requests will be processed within 14 days from receipt of supporting medical record documentation. If you require an expedited review for urgent or emergent services, please indicate this on the submitted request. Please refer to section 6.5 Retroactive Approval Guidelines for the definition of urgent and emergent situations where an expedited request would be considered. We will process expedited requests within three business days.

When a PacificSource Community Solutions member's coverage is secondary to PacificSource Medicare, PacificSource Medicare rules apply. If a preapproval was not obtained, and it is denied by PacificSource Medicare, it will also be denied by PacificSource Community Solutions.

In other cases where we are secondary, there are no preapproval requirements.

Preapproval Submission

The preapproval should be submitted via InTouch. Upon completion of the preapproval, approved services will be given a preapproval number which will be found within InTouch. This number should be included on the claim.

The preapproval process is not complete until benefits and eligibility have been verified. The number of days the preapproval is valid for is noted with the approval. An extension to the standard approval period may be requested.

Preapproval is not a guarantee of payment and the claims payment will be based on member eligibility at the time of service.

Required information for Preapproval

The following minimum information will be requested during the preapproval process:

- Patient Name
- Requesting Provider Name
- Date(s) of Service
- Primary Diagnosis Code (ICD-10)
- Length of Stay (for inpatient preapprovals)
- Procedure Code, except office visits (must be a CPT 5 digit code)
- Appropriate chart notes that define medical necessity

If the requested procedure, treatment, or surgery requires clinical review, Preapproval/Referral Specialists will forward the request for clinical review. They may ask you for additional information.

If the clinical reviewer determines additional review is needed for medical necessity, the request is referred to the Medical Director for final determination.

Incomplete preapproval and referral requests

Incomplete preapproval and referral requests will be denied. Examples of incomplete requests include:

- Lack of supporting documentation
- Lack of identifying member information
- Missing CPT/HCPC or diagnosis codes
- Provider specialty or facility name not listed

You will find information on our preapproval requirements on our website at CommunitySolutions.PacificSource.com.

6.4.1 Retrospective Review

PacificSource reserves the right to retrospectively review any type of medical service. Requests for retrospective review of hospital admissions for which we were not notified within two business days may be reviewed at our discretion. Retrospective utilization may require review of the full medical records and may be reviewed by our Medical Director.

6.5 Retroactive Approval Guidelines

Guideline Overview

Retroactive approvals are those considered for approval following the initiation or provision, of the service(s). In cases in which the patient's condition was emergent and services were provided outside of the PacificSource Community Solutions available Customer Service hours, the provider or facility is expected to contact PacificSource Community Solutions within two business days of provision or initiation of the service(s). This would include Utilization Review.

For the purposes of retroactive approval, PacificSource Community Solutions defines "Emergent" as a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Serious jeopardy to the health of the individual or if pregnant, to the health of the woman or child
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part

Conditions for Retroactive Approval Review

In order to be considered for approval, the approval must be determined to be medically necessary and appropriate.

Retroactive approvals will be reviewed for approval under the following conditions:

- Service is emergent and provider is unable to obtain preapproval from PacificSource Community Solutions.
- Hospital Admission is emergent and facility is unable to obtain preapproval from PacificSource Community Solutions despite timely attempts to do so. If a claim has already been processed for the service, an appeal must be submitted.
- 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.

Contact may be made via InTouch or faxed information. The request for retroactive approval must be made within two business days of provision of service.

Appeals

Please refer to section 4.6 Provider Appeals Process.

Emergency Room Usage

Emergency care is covered 24 hours a day, seven days a week. PacificSource Community Solutions is responsible for payment of emergency services. An emergency medical condition must have symptoms that are severe (including severe pain). The member must believe their health is in serious danger if they don't get help immediately. This can include the health of their unborn child. The member's symptoms MUST make them believe their health is in danger.

Members should NOT go to the Emergency Room for care that should take place in the provider's office. Routine care for sore throats, colds, flu, back pain, and tension headaches are NOT considered an emergency.

Observation Room Utilization

Preapprovals are not required for observation room stays. Observation room services are defined as:

> A stay in a hospital facility for less than 48 hours not resulting in an inpatient admission, in which documentation of the patient's condition clearly establishes the need for high level observation and monitoring by medical personnel.

6.6 Utilization Management—Subcontractors

PacificSource Community Solutions may give a contractor or dental care organization the ability to perform utilization management functions on its behalf, however, PacificSource Community Solutions retains responsibility for assuring the delegated functions are performed appropriately with consistent regulatory requirements and quality service. Compliance with PacificSource Community Solutions utilization management (UM) standards is assured through ongoing monitoring of the delegate's performance.

6.7 Mental Health Services

Mental Health Assessment and Treatment Planning

All Medicaid members are entitled to a comprehensive mental health assessment. This assessments can be provided by the member's local Community Mental Health Program (CMHP) or contracted PSCS panel provider. The completed assessment will be used to determine medical necessity for treatment, as well as make recommendations for the appropriate level of treatment, which may include: outpatient, individual therapy, group therapy, intensive services, psychiatric support and medication management. Members with complex needs, which require multiple services and/or extensive care coordination, are generally best served by the local CMHP.

Mental Health Crisis Services

Members in need of emergent and urgent mental healthcare can contact their local CMHP's to assess, stabilize, and determine the next steps to identify an appropriate level of care. All CMHP's have a specific crisis phone line that is available 24 hours a day, seven days a week.

Access to Psychiatric Services

Access to psychiatric consultation, stabilization, and medication management occurs through the local CMHP, contracted PSCS panel providers, and approved primary care clinics with behavioral health Integration. These services are available when they are determined medically necessary and part of a collaborative treatment plan, which includes outpatient therapy.

Billing processes for psychiatric medication prescribed to PacificSource Community Solutions members are as follows:

- Prescriptions for medications used to treat mental health diagnoses are billed by pharmacies directly to the Oregon Health Authority (not to PacificSource Community Solutions).
- Prescriptions written by a contracted mental health provider for medications, which are used in conjunction with mental health conditions, are covered by PacificSource Community Solutions.
- PCP's that provide medical management of PacificSource Community Solutions members' mental health conditions (for example, somatic medicine, medication management) should bill PacificSource Community Solutions for reimbursement of these services.

Applied Behavioral Analysis Therapy

Applied Behavioral Analysis Therapy (ABA) is the designed implementation and evaluation of environmental modification to produce socially significant improvement in human behavior. Before an individual can be referred to ABA, they must be evaluated by a licensed psychologist or MD who has experience or training in the diagnosis of Autism Spectrum Disorder. If the individual has not been evaluated by a licensed psychologist or MD, please speak with the member's primary care provider regarding a referral, or contact PacificSource directly.

This table provides a list of Community Mental Health Programs (CMHP) by county.

County	CMHP	Phone	Fax
Columbia Gorge CCO			
Hood River	**Mid-Columbia Center for Living** 1610 Woods Court Hood River, OR 97031	(541) 386-2620 Crisis line: (541) 386-2620	(541) 296-2731
Wasco	**Mid-Columbia Center for Living** 419 East 7th Street The Dalles, OR 97058	(541) 296-5452 Crisis line: (541) 296-5452	(541) 296-2731
Central Oregon CCO			
Crook	**Lutheran Community Services Northwest** 365 NE Court Street Prineville, OR 97754	(541) 323-5330 Crisis line: (866) 638-7103	(541) 447-6694
Deschutes	**Deschutes County Behavioral Health** 2577 NE Courtney Drive Bend, OR 97701	(541) 322-7500 Crisis line: (800) 875-7364	(541) 322-7565
Jefferson	**BestCare Treatment Services** 125 SW C Street Madras, OR 97741	(541) 475-6575 Crisis line: (541) 475-6575	(541) 475-6196

6.8 Substance Use Disorder (SUD)

Outpatient Treatment

Outpatient SUD treatment services are available by accessing the local Community Mental Health Program.

No preapproval is required, when:

- It's the initial assessment.
- A collaborative assessment and treatment plan is developed utilizing American Society of Addiction Medicine (ASAM) placement criteria.
- Treatment is based on ASAM criteria and may include education, intensive treatment, and referral to residential treatment services, then submitted for preappoval to PacificSource Community Solutions.

Residential Treatment

Whenever possible, members are engaged in outpatient services prior to a referral to residential treatment. PacificSource Community Solutions works with Best Care Treatment Services and Rimrock Trails Adolescent Services as the primary residential treatment providers for members.

Agency	Hours	Member	Services Offered
Bend			
Bend Treatment Centers 155 NE Revere Ave., Suite 150 (541) 617-4544	Medication Services: Monday–Friday 5:30–9:30 a.m., Saturday 6:30–8:30 a.m.; Counseling: Monday–Friday 5:30 a.m.–12:00 p.m. (some evening groups available); please call for an appointment	Adult	Outpatient Medication Assisted Treatment for opioid dependence; SUD individual and group counseling
BestCare 461 NE Greenwood Ave., Suite A (541) 617-7365	Monday–Thursday 8:30 a.m.–5:00 p.m.; Friday 8:30 a.m.–12:00 p.m.; walk-ins welcome Mondays, Wednesdays, Thursdays at 8:30 a.m., first come, first served	Adult	SUD Outpatient and Intensive Outpatient (IOP): IOP is based off of individual need, up to 4.5 hours/week
Deschutes County Behavioral Health **Main Office** 2577 NE Courtney Dr. (541) 330-4646 **Downtown Office** 1128 NW Harriman (541) 330-4637	Monday–Friday, 8:00 a.m.–5:00 p.m. Some evening groups and individual sessions available; appointments preferred	Adult	SUD and Mental Health Outpatient: 12 weeks, two-four hours/week—two groups and one individual session
Pfeifer and Associates 23 NW Greenwood Ave. (541) 383-4293	Monday–Friday, 9:00 a.m.–7:00 p.m. Appointments and walk-ins	Adult	SUD Outpatient and Intensive Outpatient (IOP): Individual and group treatment, DUII services, Drug Court programming, meditation, and stress reduction
Rimrock Trails Britta St., Bldg 1 (541) 388-8459	Monday–Friday, 9:00 a.m.–7:00 p.m. Appointments and walk-ins	Youth ages 12–17 and young adults ages 18–24	SUD Outpatient and Intensive Outpatient (IOP): Individualized based on need, approx. 10–16 weeks; groups, individual sessions, family sessions, Self-Management and Recovery Training, and Recovery Mentor services
Serenity Lane 601 NW Harmon Blvd. (541) 383-0844	Monday–Friday, 8:00 a.m.–5:00 p.m. Appointments preferred	Adult	SUD Outpatient and Intensive Outpatient (IOP), nine hours/week for 10 weeks; morning and evening programs offered
La Pine			
Deschutes County Behavioral Health 51340 Highway 97 (541) 322-7146	Monday–Friday, 8:00 a.m.–5:00 p.m. Appointments preferred	Adult	SUD and Mental Health Outpatient

Agency	Hours	Member	Services Offered
Pfeifer and Associates 16440 Finley Butte Rd. (541) 536-8879	Monday–Friday, 9:00 a.m.–7:00 p.m. Appointments and walk-ins	All ages	SUD Outpatient and Intensive Outpatient (IOP): individual and group treatment, DUII services, Drug Court programming, meditation, and stress reduction
Madras			
BestCare 125 SW C St. (541) 475-6575	Monday–Friday, 8:00 a.m.–5:00 p.m. Appointments only	All ages	Mental Health Outpatient, SUD Outpatient and Intensive Outpatient (IOP): IOP meets Monday–Friday, 9:00 a.m.–12:00 p.m. (2-3 groups/day and individual sessions); walk-ins welcome Mondays, Wednesdays, Thursdays at 8:30 a.m., first come, first served
Prineville			
Lutheran Community Services 365 NE Court St. (541) 447-7441	Monday–Friday 8:30–11:30 a.m. and 1:00–3:00 p.m. Appointments and walk-ins	Adults	Mental Health Outpatient, SUD Outpatient and Intensive Outpatient (IOP): 11 groups/week including after hours
Rimrock Trails 1333 NW 9th St. (541) 447-2631	Monday–Friday, 8:00 a.m.–5:00 p.m. Appointments and walk-ins	Youth 12–17 and adults 18–24	SUD Outpatient and Intensive Outpatient (IOP): Individualized based on need; approx. 10–16 weeks; groups, individual, family sessions; Self-Management and Recovery Training, and Recovery Mentor services
Redmond			
BestCare 340 NW 5th St., Suite 202 (541) 504-2218	Monday–Thursday, 9:00 a.m.–12:00 p.m. Friday 8:00 a.m.–12:00 p.m. Walk-ins welcome Mondays, Wednesdays, Thursdays at 8:30 a.m.	Adult	SUD Outpatient and Intensive Outpatient (IOP): Intensive Outpatient includes 2–3 groups/1:1's per week
Deschutes County Behavioral Health 406 West Antler Ave. (541) 322-7414	Monday–Friday, 8:00 a.m.–5:00 p.m. Appointments preferred	Adult	SUD and Mental Health Outpatient
New Priorities 1655 SW Highland Ave., #3 (541) 923-2654	Monday–Friday, 8:00 a.m.–7:00 p.m. Appointments only (unless urgent)	All ages	SUD Outpatient and Intensive Outpatient (IOP): Intensive Outpatient averages 4 sessions/week of family, group, and individual sessions
Pfeifer and Associates 3835 SW 21st St., Suite 103 (541) 504-9326	Monday–Thursday, 9:00 a.m.–7:00 p.m. Appointments and walk-ins	Adult	SUD Outpatient and Intensive Outpatient (IOP): individual and group treatment, DUII services, Drug Court programming, meditation, and stress reduction
Rimrock Trails 850 SW Antler Ave. (541) 316-2041	Monday–Friday, 8:00 a.m.–5:00 p.m. Appointments and walk-ins	Youth 12–17 and adults 18–24	SUD Outpatient and Intensive Outpatient (IOP): Individualized based on need; approx. 10–16 weeks; groups, individual, family sessions; Self-Management and Recovery Training, and Recovery Mentor services

Central Oregon Outpatient Substance Use Disorder Resources

Please note: Oregon Health Plan members are able to choose their preferred facility for these services, within their assigned county, which do not require preapproval or an initial assessment from their assigned Community Mental Health Program. Updated: 2.1.2017

SAMHSA Medication Assisted Treatment (MAT) Physician Locator: samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

6.9 Dental Care Providers

PacificSource Community Solutions has contracted with dental care organizations for members to receive their dental benefits.

- Advantage Dental Services, LLC
- Capitol Dental Care, Inc.
- ODS Community Health, Inc. (MODA)
- Willamette Dental Group, P.C. (Central Oregon only)

Changing Dental Plans

Members may request changes to their dental plan up to two times per enrollment period. To change dental providers, the member must contact their assigned dental care organization.

Access to Dental Care

PacificSource Community Solutions members' dental plan will assign them a primary care dental provider who will oversee their dental care, including specialty care. If a member goes to a provider who is not their dental provider or a provider their dental provider has not referred them to, the member may have to pay for the services received.

Referrals, Claims, and Grievance and Appeals

All referrals, claims, and grievance and appeals are processed by the dental care organizations.

Covered Dental Benefits and Contact Information

Providers and members may call PacificSource Community Solutions Customer Service with any questions or concerns. However, Customer Service may direct providers or members to contact dental care organizations directly.

Advantage Dental Services
Toll-free (866) 268-9631, AdvantageDentalServices.com

Capitol Dental Care
Toll-free (800) 525-6800, CapitolDentalcare.com

ODS Community Health (MODA)
Toll-free (800) 342-0526, ModaHealth.com

Willamette Dental Group (Central Oregon only)
Toll-free (855) 433-6825, WillametteDental.com

TTY users should call 711

Benefit	OHP Supplemental (for pregnant women and members under age 21)	OHP (for all other adults)
Emergency Services		
Emergency Stabilization *Examples:* Extreme pain or infection, bleeding or swelling, injuries to teeth or gum	Yes	Yes
Preventive Services		
Exams	Yes	Yes
Cleaning	Yes	Yes
Flouride Treatment	Yes	Yes
X-rays	Yes	Yes
Sealants	Yes	Not Covered
Restorative Services		
Fillings	Yes	Yes
Partial Dentures	Yes	Limited
Complete Dentures	Limited	Limited
Crowns	Limited	Not Covered
Oral Surgery and Endodontics		
Extractions	Yes	Yes
Root Canal Therapy	Yes	Limited
Prescription Medication		
OHP plan covers required prescription medications ordered by the dental provider		

Section 7: Pharmacy

Formulary Coverage

PacificSource Community Solutions offers a comprehensive prescription drug benefit with coverage in all therapeutic classes, as dictated by the Oregon Health Authority rules and regulations.

Medications that are covered under the pharmacy benefit can be found online by using our formulary. Coverage includes all therapy classes used to treat covered conditions.

Medications excluded from coverage for PacificSource Community Solutions members include, but are not limited to:

- Medications where the clinical circumstances do not meet the PacificSource Community Solutions clinical criteria.
- Medications not on the PacificSource Community Solutions formulary (also known as a List of Covered Drugs).
- If a generic drug is available, we will generally not cover a brand name drug.
- Medications that are used exclusively for indications that are excluded from coverage under the DMAP Prioritized List of Health Services.
- Medications that have not gone through the FDA approval process, such as Less-than-Effective, DESI drugs.
- Medications used to treat mental health conditions are not covered by PacificSource Community Solutions. Patients must access these medications directly through their Fee-For-Service benefit with the Oregon Health Authority.

PacificSource Community Solutions uses the following methods for utilization management:

- **Limited Access (LA):** Drug is available only at certain pharmacies and is limited to a 31-day supply.
- **Partial Fill (PF):** Some types of medications will be dispensed in a limited amount on the first fill only. This acts as a trial period to see if the member is able to tolerate the drug.
- **Preapproval (PA):** Medications that require preapproval will only be approved when medical record documentation proves the patients clinical circumstances meet the criteria established by our QAUMPT committee.
- **Step Therapy (ST):** Medications that require Step Therapy will only be approved when we have documentation that the member has tried and failed our preferred alternative medications or the member's health would be jeopardized by trying our preferred alternative medications first.
- **Quantity Limits (QL):** Medications with quantity limits will generally be limited to the FDA approved dosing quantities.

Coverage Determinations and Exceptions

PacificSource Community Solutions maintains a local Pharmacy Services team. The Pharmacy team is available for clinical consultations with our clinical pharmacist, processing coverage determinations, benefit explanations, and issuing formulary exceptions.

PacificSource Community Solutions will provide notification to participating providers either via email or at CommunitySolutions.PacificSource.com/Providers at least 30 days prior to implementing a change that may include, but is not limited to:

- Addition of a new coverage policy (PA, ST, QLL) to an existing medication.
- Removal of a previously listed drug.

To Request Coverage Determination (Preapproval) or Exception

To request a coverage determination or an exception to our standard formulary coverage or utilization management rules, please contact the Pharmacy Services team using the InTouch for Providers online portal or by calling the phone number listed in the Contact Information section. All PacificSource Community Solutions Preapproval criteria, the applicable formulary and our Pharmacy Preapproval Request forms are available on our website at CommunitySolutions.PacificSource.com.

When a standard request for a drug benefit has been received, PacificSource Community Solutions provides notification of the determination to the member (and the prescribing provider when appropriate) as expeditiously as the member's health condition requires, but no later than 24 hours after receipt of the request. This includes weekends and holidays. All standard determinations are communicated to the requesting prescriber by phone or fax and to members by letter.

Medication Restrictions

The PacificSource Community Solutions Pharmacy Services team is also available to help coordinate medication restrictions for patients taking medication with safety concerns and/or potential for abuse. A medication restriction can limit a patient's access to medications by prescriber and/or pharmacy. To request that a medication restriction be implemented, please contact Pharmacy Services. See the Who to Contact section.

Pharmacy Network

PacificSource Community Solutions contracts with a pharmacy benefit management company to access a nationwide network of pharmacies. For a comprehensive list of in-network pharmacies please visit our website at CommunitySolutions.PacificSource.com.

Medication Synchronization

The PacificSource Community Solutions Pharmacy Services team is available to coordinate medication fills so that members can pick up refills at the same time. This is a service provided to our members taking routine medications that treat chronic conditions but excludes specialty medications and controlled substances. To request for medication synchronization, please contact Pharmacy Services at (541) 330-4999 or toll-free at (888) 437-7728.

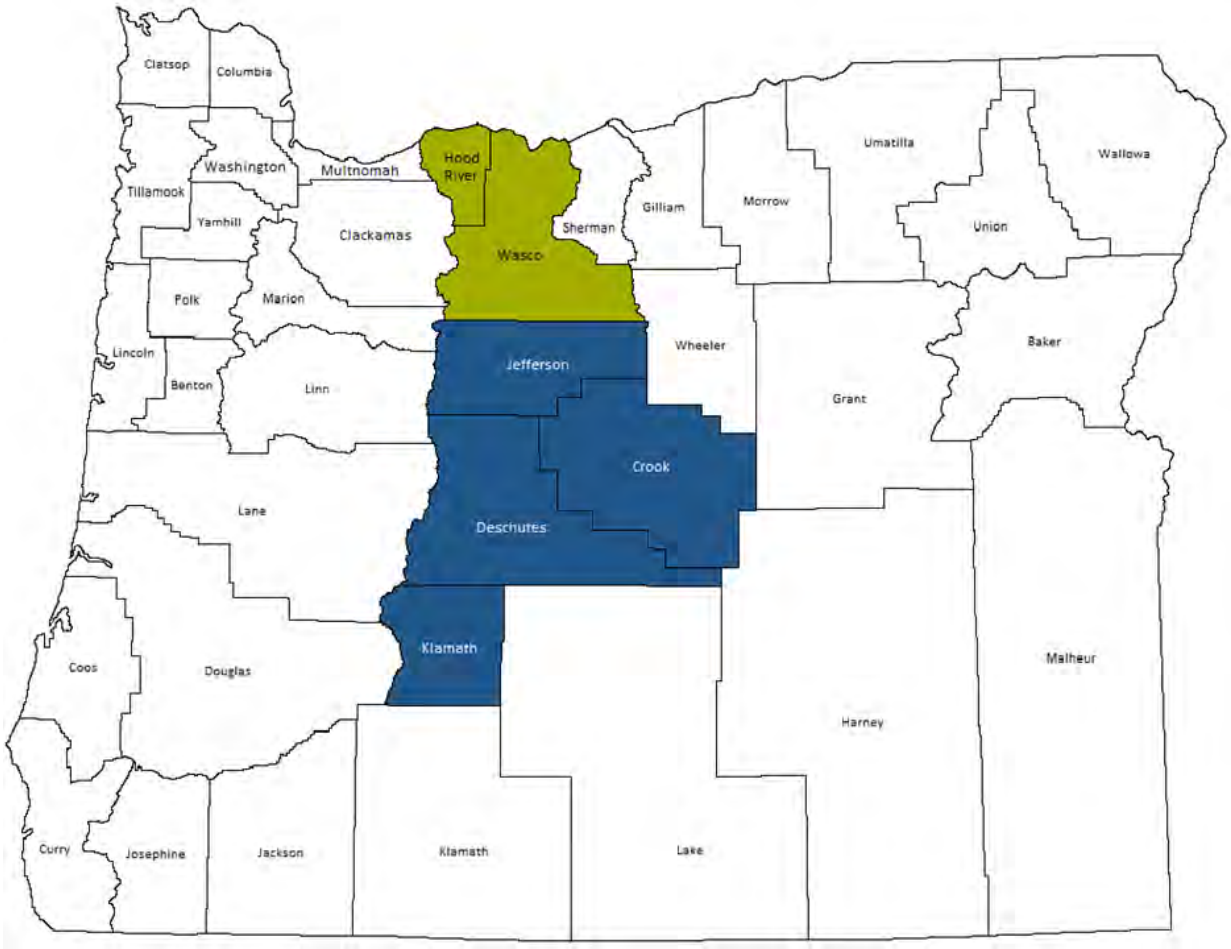
Section 8: PacificSource Coordinated Care Organization (CCO)

PacificSource Community Solutions has two CCO's, Central Oregon and the Columbia Gorge.

Central Oregon CCO includes Deschutes, Crook, Jefferson, and Northern Klamath* counties.

Columbia Gorge CCO includes Hood River and Wasco counties.

**Zip codes include 97731, 97733, 97737, and 97739*



Section 9: Members

9.1 Medicaid Enrollment

When a person enrolls in the Oregon Health Plan (OHP), they are automatically assigned to the Coordinated Care Organization (CCO) responsible for the county in which they live.

Once an OHP enrollee is assigned to PacificSource Community Solutions, they will receive a member welcome packet, which will include information such as their new member ID card and a copy of the member handbook.

A member is auto-assigned to a primary care provider (PCP) when they enroll on the CCO. Once enrolled the member has 30 days to change their PCP or dental care organization. Members may change their PCP or dental care organization up to two times per year. This limit may be extended if a member moves into an area where they cannot continue to seek services from their current PCP or dental care organization. If a member is auto assigned a PCP or dental care organization, this assignment will not count towards the members' twice a year limit.

A member can change their PCP or dental care organization by completing the PCP Change Form or by contacting PacificSource Community Solutions Customer Service. The form can be found on our website at CommunitySolutions.PacificSource.com/Member. Contact phone numbers are listed in section 2, Who to Contact.

9.2 Member Identification

All members enrolled in PacificSource Community Solutions are issued member identification cards. These identification cards contain information necessary for claims submission (please see examples below).

If you have questions about a specific member's benefits or eligibility, please contact the Customer Service Department at the number listed on the card. Accordingly, verification of eligibility is not a guarantee of coverage.

ID cards include the following important information:

- Member's name
- Member numbers (OHP issued and PacificSource issued)
- Primary care provider's name
- Dental plan
- Pharmacy information and pharmacy identification numbers
- Electronic payor ID number

Please submit claims to:

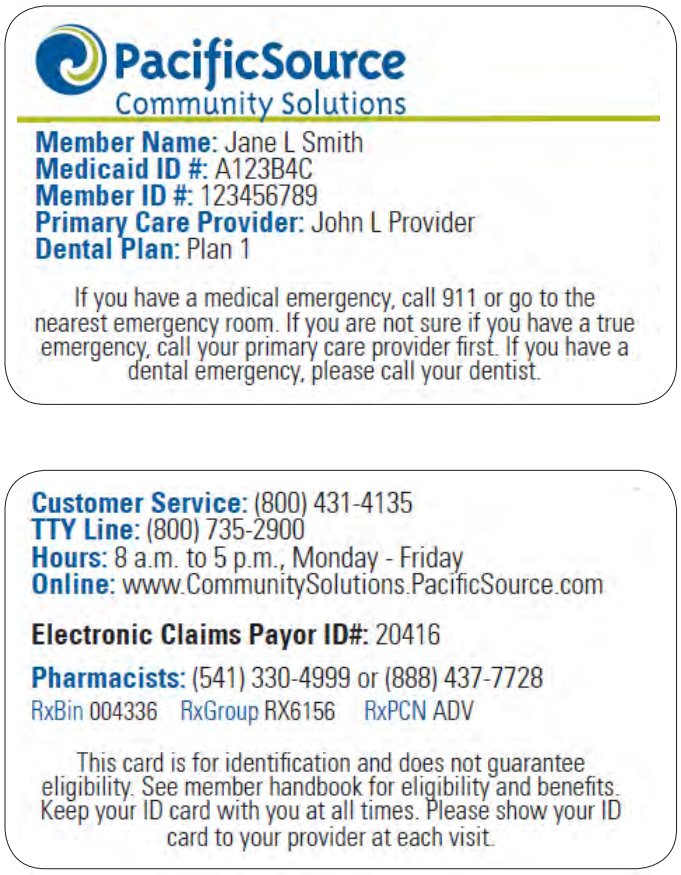
PacificSource Community Solutions
PO Box 7068
Springfield, OR 97475-0068

For information on electronic claims submission, see section 10.2, Filing Claims.

Members are not required to make payment for services up-front to participating providers, except for any applicable co-pays, co-insurance, deductibles, or noncovered services (please refer to patient waiver requirements).

We encourage physicians and providers to request to see members' ID cards each time services are accessed. This will help convey to members the importance of the ID card in supplying needed information for proper administration of their benefits and subsequent claims.

9.3 Sample Member ID Card



9.4 Members' Rights and Responsibilities

PacificSource strives to provide our customers with the highest level of service in the industry. This level of service will be measurable and documented.

PacificSource Statement of Principles

In keeping with our commitment to provide the highest quality healthcare service to our members, PacificSource Community Solutions acknowledges the importance of accountability and cooperation. We have ensured a relationship of mutual respect among our members, practitioners, and the health plan by the creation of a partnership of the three parties. Recognition of certain rights and responsibilities of each of the partners is fundamental to this partnership.

PacificSource Community Solutions Member Rights

- To be treated with dignity and respect.
- To be treated by participating providers the same as other people seeking healthcare benefits to which they are entitled, and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs.
- To choose a primary care physician (PCP) or service site, and to change those choices as permitted in the CCO's administrative policies.
- To refer oneself directly to mental health, chemical dependency, or family planning services without getting a referral from a PCP or other participating provider.
- To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines.
- To be actively involved in the development of his/her treatment plan.
- To be given information about his/her condition and covered and noncovered services to allow an informed decision about proposed treatment.
- To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services.
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency.
- To have written materials explained in a manner that is understandable to the DMAP member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated healthcare system.
- Receive culturally and linguistically appropriate services and support, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.
- Receive oversight, care coordination and transition and planning management from their CCO within the targeted population of AMH to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care.
- To receive necessary and reasonable services to diagnose the presenting condition.

- To receive integrated person centered care and services designed to provide choice independence and dignity and that meet generally accepted standards of practice and are medically appropriate.
- To have consistent and stable relationship with a care team that is responsible for comprehensive care management.
- To receive assistance in navigating the healthcare delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified healthcare interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in presses affecting the member's care and services.
- To obtain covered preventive services.
- To have access to urgent and emergency services 24 hours a day, seven days a week without preapproval.
- To receive a referral to specialty practitioners for medically appropriate covered coordinated care services.
- To have a clinical record maintained which documents conditions, services received, and referrals made.
- To have access to one's own clinical record, unless restricted by statute.
- To request that their clinical record be amended or corrected as specified in 45 CFR Part 164.
- To transfer a copy of his/her clinical record to another provider.
- To execute a statement of wishes for treatment, including the right to accept or refuse medical, dental, surgical, chemical dependency, or mental health treatment and the right to execute directives and powers of attorney for healthcare established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 – Patient Self-Determination Act.
- To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations.
- To be able to make a complaint or appeal with the CCO and receive a response.
- To request a contested case hearing.
- To receive qualified healthcare interpreter services free of charge.
- To receive a notice of an appointment cancellation in a timely manner.
- To receive a second opinion from a qualified healthcare professional within the provider network, or have the health plan arrange for the member to obtain a qualified healthcare professional from outside the provider network, at no cost to the member.
- To report a complaint of discrimination by contacting the health plan, OHA, the Bureau of Labor and Industries (BOLI) or the Office of Civil Rights (OCR).
- To receive notice of the plan's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A.
- To receive equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this contract, consistent with OHA obligations under ORS 417.270.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliations specified in federal regulations on the use of restraints and seclusion.
- To only be responsible for cost sharing authorized under the contract in accordance with 42 CFR 447.50 through 42 CFR 447.60 and with the General Rules.
- To utilize electronic methods of communications upon request and if available.

Behavioral Health Rights

Any member receiving behavioral health services has the following rights in addition to those listed above:

- To be treated with dignity and respect.
- To have all services explained, including expected outcomes and possible risks.
- To confidentiality, and the right to consent to disclosure.
- To view your Individual service record.
- To refuse participation in experimentation.
- To receive medication specific to your diagnosed clinical needs.
- To receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety.
- To be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation.
- To have religious freedom.
- To be free from isolation and restraint, except as regulated in OAR 309-032-1540(9).
- To be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule.

- To be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented.
- To have family and guardian involvement in service planning and delivery.
- To make a declaration for mental health treatment, when legally an adult.
- To file grievances, including appealing decisions resulting from the grievance.
- To exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules.
- To exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority.
- To have all rights described in this section without any form of retaliation or punishment.

Residential Services Rights

In addition to the rights listed above, every individual receiving residential services has the following rights:

- To a safe, secure, and sanitary living environment.
- To a humane service environment that has reasonable protection from harm, reasonable privacy, and daily access to fresh air and the outdoors.
- To keep and use personal clothing and belongings.
- To have an adequate amount of private, secure storage space.
- To express sexual orientation, gender identity and gender presentation.
- To have access to and participate in social, religious, and community activities.
- To private and uncensored communications by mail, telephone, and visitation, subject to the following restrictions:
  - This right may be restricted only if the provider documents in the individual's record that there is a court order to the contrary, or that in the absence of this restriction, significant physical or clinical harm will result to the individual or others. The nature of the harm must be specified in reasonable detail, and any restriction of the right to communicate must be no broader than necessary to prevent this harm.
  - The individual and his or her guardian, if applicable, must be given specific written notice of each restriction of the individual's right to private and uncensored communication. The provider must ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible and allow for confidential communication, and that space is available for visits. Reasonable times for the use of telephones and visits may be established in writing by the provider.
- To communicate privately with public or private rights protection programs or rights advocates, clergy, and legal or medical professionals.
- To have access to and receive available and applicable educational services in the most integrated setting in the community.
- To participate regularly in indoor and outdoor recreation.
- To not be required to perform labor.
- To have access to adequate food and shelter.
- To a reasonable accommodation if, due to a disability, the housing and services are not sufficiently accessible.

PacificSource Community Solutions Member Responsibilities

- To choose, or help with assignment to, a managed care plan (such as PacificSource Community Solutions), to choose a primary care provider (PCP), and to choose or help us assign you to a primary care dentist [PCD] or a behavioral health provider.
- To take your PacificSource Community Solutions Identification (ID) card with you whenever you need care.
- To treat PacificSource Community Solutions staff and health provider staff with respect.
- To be on time for appointments or call in advance to cancel if you are not able to make it or if you are running late.
- To tell your provider of your behavioral health problems.
- To decide about care before it is given.
- To get behavioral health services from contracted providers. You may get services from noncontracted providers only in an emergency.
- To call PacificSource Community Solutions Customer Service to tell us of an emergency within 72 hours.
- To use only your assigned behavioral health provider for your behavioral health needs.
- To seek periodic health exams and preventive services from your providers.
- To have yearly check-ups, wellness visits, and other services to prevent illness and keep you healthy.
- To use your PCP, PCD, or clinic for diagnostic and other care except in an emergency.
- To get a referral from your PCP or PCD before seeking care from a specialist.
- To use urgent and emergency services appropriately.

- To give accurate information that is included in your medical records.
- To help your providers obtain your medical records from other providers, which may include signing an authorization for release of information.
- To ask questions about conditions, treatments, and other issues related to your care that you don't understand.
- To use information to make informed decisions before receiving treatment.
- To be honest with your providers to get the best service possible.
- To help create treatment plans with your provider or behavioral health provider.
- To follow prescribed treatment plans to which you have agreed.
- To tell the provider that you have OHP coverage before receiving services and to show your plan ID card upon request.
- To tell your caseworker if you change your address or phone number.
- To tell your caseworker if you become pregnant, let him or her know when you are no longer pregnant, and/or when your baby is born.
- To tell your caseworker if any family members move in or out of your house.
- To tell your caseworker and providers if you have any other insurance available.
- To pay for services that are not covered by your plan.
- To pay the monthly OHP premium on time, if you have a premium.
- To help the plan in pursuing any third party resources available (such as Workers' Compensation or auto insurance) and to pay the plan the amount of benefits it paid for an injury from any recovery received from that injury.
- To let the plan know of any issues, complaints, or grievances; and
- To sign an authorization for release of healthcare information so that OHP and the plan can get information needed to respond to an administrative hearing request.

9.5 Member Grievance and Appeals Process

PacificSource Community Solutions is responsible for providing a meaningful process for timely resolution of all member complaints. These complaints can be grievances (concerns about the quality of care or access to services) or appeals of denied services (claims or service denials).

PacificSource Community Solutions meets any and all guidelines established by the relevant regulatory agency, such as the Centers for Medicare and Medicaid Services (CMS) and DMAP.

All plan members receive information about their grievance and appeal rights in their Member Handbook. If payment of a claim is denied as member responsibility, or coverage of a service is denied on a preapproval request, members are individually notified in writing of their appeal rights. The "Notice of Action" informs the member of the appeals process and time lines.

In reviewing the grievance or appeal, it may be necessary to obtain additional information from a physician or provider's office. If this is necessary, Grievance/Appeals staff will contact the appropriate office with the request. Because there is an established time frame to resolve these issues, your prompt assistance is greatly appreciated.

The grievance and appeal process is outlined step by step in member handbooks. If a member is dissatisfied with the action of the health plan, or any of its contracted entities, the member is entitled to file an appeal or grievance. Upon inquiry, please have them contact:

PacificSource Community Solutions Customer Service
(541) 382-5920
(800) 431-4135
TTY: (800) 735-2900

Please note: A provider can file an appeal or grievance on a member's behalf.

9.6 Value-Added Services

The following value-added services are available to PacificSource Community Solutions members at no additional cost:

Non-Emergent Medical Transport (NEMT)

NEMT is how members can get a ride to a covered healthcare appointment. This is for scheduled healthcare appointments, not emergencies.

There are many ways we can help members get to their appointment depending on their needs. Examples are:

- Bus pass or taxi service
- A ride from a volunteer driver
- Wheelchair-accessible vehicle service
- Stretcher vehicle or non-emergent ambulance
- Reimbursement for driving themselves (if they tell us before the appointment).

Please note, some rules may apply.

Who can get a ride?
Members are eligible for a free ride to their covered appointment if:

- They are on the Oregon Health Plan and enrolled in a PacificSource CCO.
- Their appointment is for something that the Oregon Health Plan pays for.
- They can't find any other way to get to the appointment.

Children ages 12 and under must travel with a parent or guardian who is at least 18 years old.

When to call?
The member should call as soon as they schedule their medical appointment. PacificSource has contracts with the following NEMT brokerages:

Central Oregon CCO
Cascades East Ride Center (CERC)
(541) 385-8680 or toll-free (866) 385-8680
TTY: 711
Hours: Monday–Friday 7:00 a.m.–5:00 p.m.

Columbia Gorge CCO
Mid-Columbia Council of Governments (MCCOG)
Toll-free: (877) 875-4657
TTY: 711
Hours: Monday–Friday 7:00 a.m.–5:00 p.m.

Living Well with Chronic Conditions

Living Well with Chronic Conditions (the Chronic Disease Self-Management Program, or CDSMP) is a six-week workshop that provides tools for living a healthy life with chronic health conditions, including diabetes, arthritis, asthma, and heart disease. Through weekly sessions, the workshop provides support for continuing normal daily activities and dealing with the emotions that chronic conditions may bring about.

Childhood Immunization Schedule

The schedules list the age or age range when each vaccine or series of shots is recommended. If the child (birth through six years old) or adolescent (age seven through 18 years old) has missed any shots, members can consult the catch-up schedule AND check with their doctor about getting back on track.

Quit For Life® Program

The Quit For Life® Program is the nation's top stop smoking program. It can help members beat your need for tobacco for good. The program uses a mix of tools including telephone and website coaching, and a quit tobacco plan.

Expert coaches help members learn skills and give them tools to quit tobacco for life. The program uses a four-step plan. The chance of quitting is eight times more than if a person tries to quit cold turkey. The program is free, confidential, and it works.

Call (866) QUIT-4-LIFE, toll-free (866) 784-8454, or log on toQuitNow.net for details or to enroll. TTY users should call (877) 777-6534.

Community Assisters

Members can get help filling out a new enrollment application or with renewal paperwork by working with a community assister. Members can find an assister near them by going to the Enrollment Information section of our website, or by calling OHP Customer Service at (800) 699-9075. TTY users should call 711. Someone is there to help you Monday through Friday, from 7:00 a.m. to 6:00 p.m.

Section 10: Claims

10.1 Eligibility and Benefits

PacificSource Community Solutions has a dedicated Customer Service Department available to assist both you and your patients with questions related to claims status, benefits, and eligibility.

Call PacificSource Community Solutions Customer Service for:

- Member benefits, eligibility information, or waivers
- Deductible, co-insurance and/or co-pay information
- Explanation of payments
- Participating physicians and providers
- Claims inquiries
- Referral or preapproval inquiries

You may reach our Customer Service Department, 8:00 a.m. to 5:00 p.m. Monday to Friday, by phone:

Toll-free, all areas: (800) 431-4135
Bend area: (541) 382-5920
TTY: (800) 735-2900
Fax: (541) 322-6423
Email: CommunitySolutionsCS@pacificsource.com

Dental providers may be referred to their DCO for more specific information.

10.2 Filing Claims

PacificSource Community Solutions encourages providers to transmit claims electronically. Submitting electronically will help you get faster reimbursement, reduce costs, increase accuracy. Below is our electronic payor ID and a list of our affiliated clearinghouses.

Please note: PacificSource Community Solutions does not process claims for dental services. Please refer to your dental care organization for claims processes.

Electronic claims submission: Electronic payor ID: 20416

Affiliated clearinghouses:

- inMediata
- Emdeon
- Trizetto Provider Solutions
- HeW (Health E-Web)
- MCPS
- Office Ally
- Payer Connection
- RelayHealth

You may also submit claims via paper submission by mailing the appropriate claim form to the following address.

Claims Mailing Address:
PacificSource Community Solutions
PO Box 7068
Springfield, OR 97475-0068

10.3 Claims and Payment Rules

General Claims Information

PacificSource Community Solutions will process claims in an accurate and timely manner in order to provide quality service to our members and providers and to efficiently manage healthcare premium dollars. PacificSource Community Solutions reserves the right to do retrospective review of claims paid.

PacificSource Community Solutions requires that claims be submitted on either a current standard CMS 1500 claim form or a UB-04 claim form. The following describes the appropriate claim form by type of provider or service.

- Hospital claims shall be billed on the UB-04 using DMAP billing rules for PacificSource Community Solutions members to facilitate collection of encounter data.
- Physician claims shall be billed on the CMS-1500 using Medicare billing rules for PacificSource Community Solutions members to facilitate collection of encounter data.
- All other claims except Pharmacy (DME, Lab/X-ray, Transportation, Ancillary services) shall be billed on the CMS-1500 according to Medicare billing rules for PacificSource Community Solutions members. PacificSource Community Solutions shall work with participating providers to ensure they have the necessary guides to ensure proper billing.

Instructions to complete claim forms

CMS.HHS.gov/Manuals/IOM/list.asp

- UB-04 (chapter 25)
- CMS-1500 (chapter 26)
- PacificSource Community Solutions does not process claims for dental services. Please refer to your dental care organization for claims processes.

Place of Service codes

A complete listing of Place of Service codes can be found online at CMS.gov/Medicare/Coding/Place-of-Service-Codes/Place_of_Service_Code_Set.html.

10.4 Claims Submission Requirements

- PacificSource Community Solutions accepts claims within four months from the date of service.
- Providers have up to four months from the date of process to resubmit claims for reprocessing. The four months is from claims processing date of the original Explanation of Payment (EOP) statement.
- When PacificSource Community Solutions is secondary, submit your claim with the primary carrier's Explanation of Benefits (EOB) statement. Providers have up to four months from the date of payment/denial from the primary carrier to submit to PacificSource Community Solutions.

Exceptions to this timely filing guideline can be found in Division 141 of the OAR under the Billing and Payment section (OAR 410-141-3420) available online at http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_141.html.

Electronic Medical Claims

PacificSource Community Solutions is proactive in moving claims electronically, and we encourage providers to consider electronic billing opportunities. Some of the benefits providers can realize by transmitting claims electronically are:

- Faster reimbursement. By eliminating the time it takes for mailing, internal routing, and data entry, claims are in our system much faster, and are processed sooner.
- Reduced costs. Electronic billing saves providers money by eliminating the cost of forms, postage, and staff time.
- Accuracy. Electronic claims transmittal helps prevent errors and omission of required information, resulting in accurate claims processing.

These benefits can be translated into increased efficiency and productivity, resulting in improved patient relations. Your office will realize greater efficiency through a more streamlined process.

The Health Information Portability and Accountability Act of 1996 (HIPAA) – Transaction and Code Set standards mandates that electronic healthcare claims submitted from a provider to a payor must be in a Standard 837-5010 format. PacificSource Community Solutions is currently accepting 837-5010 HIPAA compliant claim transactions either directly from provider offices or through our clearinghouses.

For a list of clearinghouses, see Section 10.2 of this manual, visit our website CommunitySolutions.PacificSource.com, or contact your Provider Service Representative by phone at (541) 684-5580 or toll-free at (800) 624-6052 ext. 2580, or by email: providerservicerep@pacificsource.com.

What are the technical requirements?

To submit your HIPAA-compliant claim transactions directly to us you must be able to create an 837-5010 Professional or Institutional claim transaction. You must have an Internet connection and a web browser capable of the strongest encryption level available, (currently 128 bit). You also need a printer attached to your system or available through your office network in order to generate your receipts.

Your Provider Service Representative can assist you with questions you may have regarding electronic billing. This applies to both regular submitters or if you would like to begin billing electronically.

Who should I contact to get started or for technical support?

Please call Provider Network at (541) 684-5580 or (800) 624-6052 ext. 2580 for support and assistance.

Dental providers: Please contact your dental care organization for claims support.

Payment or Denial of Health Benefit Plan Claims; rules. (743.911)

1. Except as provided in this subsection, when a claim under a health benefit plan is submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.
2. A contract between an insurer and a provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section and ORS 743.913 or has the effect of relieving either party of their obligations under this section and ORS 743.913.
3. An insurer shall establish a method of communicating to providers the procedures and information necessary to complete claim forms. The procedures and information must be reasonably accessible to providers.
4. This section does not create an assignment of payment to a provider.

5. Each insurer shall report to the Director of the Department of Consumer and Business Services annually on its compliance under this section according to requirements established by the director.

6. The director shall adopt by rule a definition of "clean claim" and shall consider the definition of "clean claim" used by the federal Department of Health and Human Services for the payment of Medicaid claims. [Formerly 743.866]

Hold Harmless/Balance Billing

Please refer to the "Billing of OHP Members" on our website at CommunitySolutions.PacificSource.com/Providers/MemberBilling.

Billing Guidelines

We follow Medicare guidelines for all lines of business. Below are some of the more common ones:

- Multiple Procedure Reduction
- Assistant Surgeon Allowances
- Global Billing Period
- DRG payment Criteria

Coordination of Benefits (COB)

If a PacificSource Community Solutions patient has another PacificSource (commercial/Medicare Advantage) plan as their primary coverage, the claim with automatically crossover within our claims processing system after the primary plan has processed the claim. Do not submit a secondary claim under this circumstance.

If the member has primary coverage with another carrier, the primary carrier should be billed first. We must receive the claim no later than four months from the primary carrier's EOB date. Upon receipt of payment from the primary carrier, charges should then be submitted to PacificSource Community Solutions, accompanied by the primary carrier's Explanation of Benefits.

If the primary carrier's payment equals or exceed PacificSource Community Solutions' allowed reimbursement, the remaining balance will appear on your payment voucher as a provider write off. The patient cannot be billed this amount.

When PacificSource Community Solutions is secondary, Coordination of Benefits will be reimbursed according to the contract allowable or charges, whichever is less.

COB claims will automatically crossover with the exception of claims submitted on a UB that will need to be submitted on a CMS1500 for the state. This includes:

- FQHC (federally qualified health centers).
- Ambulance billed by a hospital.
- Skilled nursing outpatient therapy.

Claim Review Guidelines

PacificSource Community Solutions reserves the right to review any claims submitted for medical necessity, proper coding, or medical appropriateness.

Corrected Claims

PacificSource Community Solutions strives to make the claims process as efficient as possible. We ask that when you submit a corrected CMS 1500 claim that it is submitted with our Corrected Claims form and chart notes if applicable. This form will help us to more easily assess the reason for the change, resulting in a faster turnaround time. Please do not submit corrected claim without the corrected claims form as these are seen as duplicate submissions and will be denied.

The Corrected Claims form is available on our website at CommunitySolutions.PacificSource.com/Providers/DocumentsAndForms.

UB 04 corrected claims can be submitted electronically. A Corrected Claim form is not required. If submitting a corrected UB 04 claim form, please indicate they claim is corrected by using the appropriate bill type (xxx7).

Overpayment Recovery

PacificSource Community Solutions may initiate provider refunds for up to one year from the date of payment. Note that PacificSource Community Solutions will "Punch Credit" after 60 days from initial request if payment is left undisputed.

If the refund request is based upon a PacificSource Community Solutions error, and reprocessing is indicated, provider is not required to resubmit the claim. PacificSource Community Solutions will initiate the process to reprocess the claim.

In the event that OHA terms (retro-disenroll) a member, PacificSource Community Solutions reserves the right to initiate provider refunds for any applicable time period which may be longer than one year from the date of payment.

10.5 Explanation of Payment (EOP)

How to Read Your EOP

The PacificSource Explanation of Payment (EOP) is a computer printout sheet that is mailed, along with payment, to physicians and providers on each scheduled payment date. The following important information will be included on your PacificSource Community Solutions EOP:

- Patient name
- Member ID number (PacificSource issued)
- Patient account number (provider assigned)
- Provider Name & Number
- Claim number
- Clinic Name
- Medicaid ID number (state issued)
- Date of service
- Procedure codes
- Billed amount
- Allowed amount and provider adjustment
- Total patient responsibility (if applicable)
- Paid amount
- Reason code (full description is provided in the Reason Code Explanations section at the end of the disbursement section)

CommunitySolutions.PacificSource.com/Providers

PacificSource InTouch for Providers is a providers-only area of our website. By logging in with a user name and password, you can access personalized information about your PacificSource patients and their claims 24 hours a day.

PacificSource Community Solutions
PO Box 5729
Bend OR 97708-5729

201507157310
1210 9279

J124 [1] 1 of 2

Forwarding Service Requested

TEST PROVIDER
PO BOX 123456
EUGENE OR 97401

1

Explanation of Payment

Information

Questions?
Call Customer Service at
(541) 382-5920
CommunitySolutions.PacificSource.com

Payment Summary

Paid To: Test Provider
Payee Tax #: 123456789
Payment Date: 06/23/2015
Reference #: 2015062310400007
Check #: 1180
Check Amount: $1,723.89

Prior Overpayment: $0.00
Overpayment Incurred this Period: $0.00
Recovered this check: $0.00
Outstanding overpayment: $0.00

Patient Name: Test Member 4
Member ID #: 123456789-00
Patient Acct #: ABC123

Provider Name: Test Provider
Provider #: 1234567
Claim #: 157111882400

Clinic Name: Test Provider
Medicaid ID: ABC123DE
NPI #: 1234567890

Date of Service	Procedure Code	Units	Billed Amount	Allowed Amount	Risk Withhold	Prov Adjust	Reason Code	Deductible Amount	Co-pay Amount	Co-insurance Amount	Total Patient Responsibility	Net Paid
06/19/15	E0784	1	$8,322.92	$0.00	$0.00	$8,322.92	PDC 511	$0.00	$0.00	$0.00	$0.00	$0.00
06/19/15	A4232	10	$57.29	$34.37	$0.00	$22.92	PDC	$0.00	$0.00	$0.00	$0.00	$34.37
06/19/15	A4230	10	$330.25	$198.15	$0.00	$132.10	PDC	$0.00	$0.00	$0.00	$0.00	$198.15
	Claims Totals:		$8,710.46	$232.52	$0.00	$8,477.94		$0.00	$0.00	$0.00	$0.00	$232.52

Interest Amount	$0.00
Refund Requested	$0.00
To be auto-recovered	$0.00
Prior Payment	$0.00
Capitated Amount	$0.00
Payment to Provider	$232.52

Section 11: Billing Requirements

By using the correct procedure codes when you bill PacificSource Community Solutions, you enable us to process your claims accurately and efficiently. (Dental providers should refer to their dental care organization billing requirements.) In efforts to keep administrative costs down and to ensure timely and accurate claims reimbursement, we require that services performed on the same day by the same provider be billed on the same claim form. This will help eliminate reprocessing of claim refund requests.

11.1 Incident to Billing

PacificSource Community Solutions requires all eligible providers rendering services to be individually credentialed before they are considered participating under the provider contract. This includes, but is not limited to nurse practitioners, physician assistants and other mid-level providers.

PacificSource Community Solutions requires the provider that rendered the service to be indicated in box 31 on the CMS 1500 claim form or electronic claim equivalent. We do not accept "Incident To" billing.

11.2 Global Period

A global period is the period of time when services must be included in the surgical allowance; no additional charge may be added. PacificSource Community Solutions uses the number of days indicated in the "Global Period" column of the Federal Register as the standard.

Time periods designated for the following services are considered global:

- Immediate preoperative care beginning when the decision for surgery has been made.
- The surgical procedure (including local infiltration, digital block, or topical anesthesia).
- Normal, uncomplicated follow-up care for the period indicated (refer to Federal Register "Global Period").

Preoperative services not encompassed in the global period include:

- Evaluation and management services unrelated to the primary procedure.
- Services required to stabilize the patient for the primary procedure.
- Procedures provided during the immediate preoperative period that are usually not part of the basic surgical procedure (for example, bronchoscopy prior to chest surgery).

11.3 Surgery

11.3.1 Bilateral Procedures

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The terminology for some procedure codes includes the term "bilateral" or "unilateral or bilateral."

If a procedure is not identified by CPT terminology as bilateral (unilateral or bilateral) procedure, the procedure should be reported with modifier 50. Bilateral procedures may be billed as a separate charge line for each procedure, using a modifier on the second line, or on one line with modifier 50 and "2" in the services.

Example 1: Bilateral procedures billed as separate charge lines for each procedure, using modifier 50 on the second line.

CPT	Modifier	Description	$ Charges	Days or Units
31238	-RT	Nasal/sinus endoscopy, surgical, with control epistaxis	$500.00	1
31238	-LT	Nasal/sinus endoscopy, surgical, with control epistaxis	$500.00	1

Example 2: Billed as one line (2 services)

CPT	Description	# Svcs Days or Units	Billed Amount
31238-50	Nasal/sinus endoscopy, surgical, with control epistaxis	1	$1,000.00

To ensure accurate payment, please **make sure you bill the full billed amount, rather than the precut amount.** Our system will not recognize if the claim has been precut, and it will cut again according to bilateral surgery guidelines.

11.3.2 Multiple Procedures

Multiple surgeries are separate procedures performed during the same operative session or on the same day, for which separate billing is allowed. Please follow these guidelines to ensure correct payment:

- When multiple procedures, other than evaluation and management (E&M) services, are performed on the same day or at the same session by the same provider, the primary procedure or service should be reported as listed.
- Any additional procedures or services should be ranked in descending Relative Value Order (RVU) order and identified by the use of modifier -51 on each additional procedure/service.
- Procedure codes that are classified as multiple procedures in the CMS Billing Manual will be processed according to our multiple procedure guidelines. If the code is modifier -51 exempt or an add-on code, it will be processed using 100 percent of the contracted allowed.

PacificSource Community Solutions uses the following payment structure for multiple procedure claims. Be sure to bill full charges for all services in order to receive the correct payment.

- Primary procedure: 100 percent of the fee allowance
- Remaining procedures: 50 percent of the fee allowance

11.4 Evaluation and Management (E&M) Billing Guidelines

11.4.1 Preventive Visits and E&M Billed Together

According to the CPT code book, it is appropriate to bill for both preventive services and E&M services during the same visit only when significant additional services or counseling is required.

11.4.2 Appropriate Use of CPT Code 99211

Because the appropriate use of CPT code 99211 is often confusing, we offer the following guidelines. According to the CPT Code Book, 99211 is intended for "an office or other outpatient visit for the E&M of an established patient that may not require the presence of a physician." The key points to remember regarding 99211 are:

- The service must be for E&M.
- The patient must be established, not new (see guidelines in next section).
- The service must be separated from other services performed on the same day.
- The provider-patient encounter must be face-to-face, not via telephone.

Code 99211 will be accepted only when documentation shows that services meet the minimum requirements for an E&M visit. For example, if the patient receives only a blood pressure check or has blood drawn, 99211 would not be appropriate. Please remember, all E&M visits require a co-pay/co-insurance from the member; therefore, if another CPT code more accurately describes the service, that code should be reported instead of 99211.

11.4.3 Distinction Between New and Established Patients

The American Medical Association (AMA) defines a new patient as one who has not received professional services from the physician (or another physician of the same specialty who belongs to the same group practice), within the past three years. Conversely, an established patient is one who has received face-to-face professional services within the past three years.

Please be aware of this distinction when billing new patient CPT codes.

11.5 Never Events Policy

PacificSource Community Solutions has determined that if a healthcare service is deemed a "never event" that neither PacificSource nor the member will be responsible for payments for said services.

Healthcare facilities and providers will not seek payment from PacificSource Community Solutions or its members for additional charges directly resulting from the occurrence of such a "never event" if:

- The event results in an increased length of stay, level of care or significant intervention.
- An additional procedure is required to correct an adverse event that occurred in the previous procedure or provision of a healthcare service.
- An unintended procedure is performed.
- Readmission is required as a result of an adverse event that occurred in the same facility.

- These guidelines do not apply to the entire episode of care, but only the care made necessary by the serious adverse event.

11.5.1 Surgical Events

Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following events:

- Surgery performed on the wrong body part.
- Surgery performed on the wrong patient.
- Wrong surgical procedure on a patient.
- Retention of a foreign object in a patient after surgery or other procedure.
- Intraoperative or immediately post-operative death in an otherwise healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologist patient safety initiative).

11.5.2 Product or Device Events

Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following events:

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologicals provided by the healthcare facility.
- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended.
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

11.5.3 Patient Protection Events

Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following events:

- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.
- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
- Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility.
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbillirubinemia in neonates.
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.
- Patient death or serious disability due to spinal manipulation therapy.
- Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility.
- Patient death or serious disability associated with a fall while being cared for in a healthcare facility.
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.
- Patient death or serious disability associated with the use of restraints or bed rails while being cared for in a healthcare facility.

The formulation of this policy is the result of guidelines established by the Centers for Medicare and Medicaid (CMS), Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, and the National Quality Forum.

11.6 Editing Software for Facility and Professional Claims

11.6.1 Professional Claims

PacificSource Community Solutions utilizes the Clinical Integration Manager system to review and edit claims for correct coding practices and guidelines. The coding guidelines contained in the knowledge base are well researched, clearly defined and documented in support of transparency requirements. Editing rules have been established to ensure claims are processing by Medicaid guidelines. We apply these guidelines to both participating and out-of-network professional providers. Edits made to claims are considered to be a provider adjustment and not billable to the member.

11.6.2 Facility Claims

PacificSource Community Solutions utilizes the Clinical Integration Manager edits for facility claims. Editing rules have been established to ensure claims are processing by Medicaid

guidelines. Edits will be applied to both participating and out-of-network facilities. All claims edited for correct coding will be considered to be a facility adjustment and not billable to the member.

11.6.3 Sample Edit Criteria

Listed below are some examples and definitions of edits that providers/facilities may encounter:

Mutually Exclusive: Mutually exclusive codes are those codes that cannot reasonably be done in the same session, or the coding combination represents two methods of performing the same service.

Incidental: Includes procedures that can be performed along with the primary procedure, but are not essential to complete the procedure. They do not typically have a significant impact on the work and time of the primary procedure. Incidental procedures are not separately reimbursable when performed with the primary procedure.

OCE/CCI: Based on coding conventions defined by Medicaid-NCCI, The National Correct Coding Initiative's current standards of medical and surgical coding practice, input from specialty societies, and analyses of current coding practice. Edits always consist of pairs of HCPCS/CPT codes using the correct coding edits table and the mutually exclusive edit table.

MUE Hospital: Unlikely number of units billed for services rendered.

Unbundling: Includes procedures that are basic steps necessary to complete the primary procedure and are by definition included in the reimbursement of that primary procedure.

Revenue Code requires HCPCS code: Any instance where a revenue code requires the HCPCS code to be billed for payment.

Inpatient only procedures: Any instance of a procedure typically performed in the inpatient setting billed as an outpatient place of service.

11.6.4 Other Generalized Edits

Age/Gender/Diagnosis/procedure specific conflicts: Age related code development is based on CPT/HCPCS/ICD guidelines and/or code descriptions identifying specific ages. Gender-specific procedures are determined by body site, anatomical structure, and description of procedure performed. Diagnosis edits identify inconsistent coding relationships as well as diagnosis codes that are not allowed for reporting alone or as a primary diagnosis.

CommunitySolutions.
PacificSource.com/Providers

Have You Tried InTouch? With InTouch for Providers, you can verify eligibility and check claims status, EOPs, preapprovals, referrals, and much more online!

Section 12: Publications and Tools

12.1 Website

CommunitySolutions.PacificSource.com

The address of the PacificSource Community Solutions website is CommunitySolutions.PacificSource.com. This site is a convenient way to contact PacificSource 24 hours a day, seven days a week. It is updated frequently and is a source of accurate information.

In the "For Providers" section of the site, you'll find:

- News on administrative issues affecting PacificSource Community Solutions providers.
- InTouch for Providers— access personalized information about your PacificSource patients and their claims.
- Information about imaging and electronic claims technology.
- Archived issues of newsletters, news blasts, upcoming events, and other important updates.
- A list of services requiring preapproval.
- From the home page, providers and PacificSource Community Solutions members can access the online Participating Provider Directory, which is updated daily. Users can search for participating physicians and providers by name, zip code, city, specialty, and/or plan type, and can print a customized provider directory from the site.
- Links to dental care organization websites.
- Dental provider manuals and dental practice guidelines for each dental care organization.

12.1.2 Notices and Updates

The Notices and Updates section of our website is intended to help keep our providers and their staff up-to-date on the latest and upcoming changes, important announcements, and news. The Provider Network team will post notifications of updates to plan policies, preapproval, and formulary changes, and any other initiatives that may impact providers.

The Latest Notices and Updates page will be updated as changes and important news arise, but no more than once per week. There is no login required to view this page. It is located on our public website to allow any individual within your practice or organization access to this information 24 hours a day, seven days a week.

As our valued partner, we want to make sure you have the tools and resources you need in a timely manner. See the Notices and Updates page: CommunitySolutions.PacificSource.com/Providers.

12.2 InTouch for Providers

PacificSource InTouch for Providers is a providers-only area of our website. By logging in via OneHealthPort with a user name and password, you can access personalized information about your PacificSource patients and their claims 24 hours a day.

Use InTouch to:

- Find out if a patient has coverage with PacificSource Community Solutions.
- Submit and check status of preapproval or referral requests.
- Check claims status and payment details.
- Select an EOP date and get a detailed listing of all claims for your office that were processed on that date.

Registering for InTouch:

For your convenience, InTouch is available through OneHealthPort. If you are already a registered user of OneHealthPort, you do not need to register to access InTouch.

If you are new to InTouch and OneHealthPort, you will need to register with OneHealthPort in order to access InTouch. Information about this process is available by selecting the Registration Information link under the Provider heading of our InTouch login area on any page of our website, CommunitySolutions.PacificSource.com.

If you have any questions about InTouch or the For Providers section of our website, you're welcome to contact your Provider Service Representative. You can also use the Contact Us form on our website to describe any technical problems.

12.3 Provider Directories

PacificSource Community Solutions Provider Directories serve as a valuable tool for identifying the participating physicians and providers available for accessing medical services. The directories are designed to be user-friendly, give up-to-date listings of participating physician and provider names, addresses, and telephone numbers.

Directories are uniquely designed to accompany a specific plan design and include participating physicians and other healthcare professionals, such as physical therapists, mental health providers, optometrists, opticians, podiatrists, and healthcare facilities, including participating hospitals.

Our online directory (updated daily) lets website visitors search for a PacificSource Community Solutions physician or provider by name, or search for a list of providers by specialty or location. Take, for example, a member looking for an allergist on his plan's network within five miles of his home. Our new directory will help him locate one and can even provide a map

and driving directions. Members will also be able to create, download, and print their own customized provider directories specific to their benefit plan and their geographic location.

For information on this and other future projects, please visit our website at CommunitySolutions.PacificSource.com.

12.4 Newsletters

Provider Bulletin is the provider newsletter for all lines of business. It is produced quarterly and emailed to PacificSource Community Solutions participating physicians and providers. It provides general information of interest to Commercial, Medicare and Medicaid physicians and providers. If you are not receiving these newsletters and would like to be included on the distribution list, contact your Provider Service Representative.

12.5 LineFinder

LineFinder is an online tool to assist providers in determining what is covered by the Oregon Health Plan (OHP). OHP generally updates the Line each year, on January 1. PacificSource Community Solutions will update the LineFinder tool as OHP releases updates.

Find our LineFinder tool online at InTouch.PacificSource.com/LineFinder/.

For questions or assistance with the LineFinder tool, please contact your PacificSource Provider Service Representative.

12.6 Healthcare Interpreter (HCI) Services

PacificSource Community Solutions is responsible to ensure that members have access to HCI services. Members and potential members may not be charged. HCI services will be paid by the CCO as long as it supports a covered Medicaid service. Find a list of criteria for covered Medicaid services online at Oregon.gov/oha/healthplan/Pages/priorlist.aspx.

Interpreter services may be arranged by physical health, behavioral health, oral health, and home health providers. If the provider has qualified or certified interpreters on staff, the provider may bill the CCO directly adding HCPC code T1013 to the claim. Please refer to the Glossary of Terms section of this manual for definition of qualified interpreter and certified interpreter.

Please note: A bilingual employee may provide direct services in both languages but, without additional training, is not qualified to serve as an interpreter and therefore not eligible for reimbursement. Providers are discouraged to use bilingual patient family members for interpretation.

If the provider does not have qualified or certified interpreters, they may arrange for services through one of the following HCI organizations. Contracted HCI vendors bill PacificSource Community Solutions directly; therefore, neither provider nor member should receive a bill for these services. PacificSource Community Solutions' contracted HCI vendors include:

Certified Languages: (800) 362-3241

- Offers phone interpreting services only.
- PacificSource's access code: COIHS.
- You will be asked to provide the member name, date of birth, and identification number.

Passport to Languages: (800) 297-2707

- Offers phone, on-site (including sign language), and video interpreter services.
- No access code is required for this vendor. Identify you are calling on behalf of a PacificSource Community Solutions member and provide the member name, date of birth, and identification number.

Bridges to Communications: (541) 385-1238

- Offers on-site services (including sign language).
- Services are offered to PacificSource Community Solutions members in the Central Oregon area only.
- No access code is required for this vendor. Identify you are calling on behalf of a PacificSource Community Solutions member and provide the member name, date of birth, and identification number.

Many HCI companies require at least 48 hours advance notice to arrange for on-site HCI services. Telephonic and video interpretation services are readily available through the organizations that offer those services.

12.7 Material in Alternate Format

PacificSource Community Solutions can provide information and documents in way that works best for our members. We have free language interpreter services available to answer questions for non-English speaking members. We can also provide information in Braille, large print, or other alternate formats if requested.

Section 13: Health Plan Responsibility

Health Plan Responsibilities

PacificSource Community Solutions will cover emergency and urgently needed services from any licensed provider.

PacificSource Community Solutions will cover renal dialysis for those temporarily out of PacificSource Community Solutions service area.

PacificSource Community Solutions will cover influenza and pneumococcal vaccination with no co-pay.

PacificSource Community Solutions will make good faith efforts to notify all affected members of the termination of a provider contract 30 days before the termination by plan or by provider.

Once enrolled in PacificSource Community Solutions, members are sent information regarding PacificSource Community Solutions, how to access their benefits and their rights and responsibilities. All PacificSource Community Solutions members receive the following information upon enrollment:

- Member Handbook: This handbook outlines member's benefits, rights and responsibilities, eligibility information, how to use the plan, what to do in cases of emergency, and any limitations of the plan.
- Member Identification Card: Members are instructed to use only the PacificSource Community Solutions card when accessing medical care.
- Provider Directory: This directory lists all general and specialty contracted providers that are available to PacificSource Community Solutions members. The directory provides them with names, addresses, and telephone numbers of Providers; a list of all contracted specialty providers, denotes whether or not providers are accepting new patients, and lists the providers by city and clinic location.
- The telephone numbers and address of PacificSource Community Solutions, Inc., and are instructed to direct all questions they may have about their plan to the PacificSource Community Solutions Customer Service staff.

Provider offices that receive questions from members concerning benefits, limitations, exclusion, etc., of the plan, should be directed to PacificSource Community Solutions Customer Service at the phone numbers listed in Section 2 of this manual.

Section 14: Compliance

Compliance Website

We maintain a compliance website at CommunitySolutions.PacificSource.com/About/Compliance that provides information on topics such as provider training and education, examples of compliance and FWA issues, and reporting of these issues.

Compliance Program and Standards of Conduct

We maintain a Compliance Program and Standards of Conduct documents on our compliance website at CommunitySolutions.PacificSource.com/About/Compliance. These documents are a series of policies, procedures, and guidance that articulate our expectations of our employees, contractors, providers, and business partners. You are required to read these documents and abide by them.

Compliance Training

You and your employees are required to take General Compliance and Fraud, Waste, and Abuse (FWA) Training annually. All new employees must take these trainings as part of their orientation. Please document and retain proof of training records for a period of ten years. If you have met the FWA certification requirements through enrollment into the Original Medicare program, you do not have to take the FWA Training. If you and your employees have taken the training for other Medicare Advantage or Medicaid health plans, you do not have to take PacificSource's training.

For your convenience, we have provided the training modules on our compliance website. Please refer to policy C-3 for additional information.

Disciplinary Standards

We maintain a disciplinary action policy that you are required to abide by. Failure to comply with our compliance and contractual requirements may result in disciplinary actions, up to and including termination of contract. Please refer to policies C-5 and C-6B for additional information.

Compliance Reporting

If you suspect noncompliance or FWA activities, you must report them to us by calling (800) 624-6052, ext. 2580 or emailing providerservicerep@pacificsource.com. You may also report anonymously by contacting EthicsPoint (a PacificSource vendor) 24 hours a day, seven days a week at toll-free (888) 265-4068. Please refer to policy C-4 for additional information.

Provider Exclusion

PacificSource Community Solutions will not contract with or pay claims to providers who have been sanctioned or excluded from participating Medicaid programs. The OIG's List of Excluded Individuals/Entities and GSA's System for Award Management search utilizes the government's database for individuals and businesses excluded or sanctioned from participating in Medicare, Medicaid, or other federally funded programs. All providers are required to immediately disclose to PacificSource any exclusion or other events that make them ineligible to perform work related directly or indirectly to a government healthcare program. Failure to disclose may result in appropriate corrective actions, up to and including termination of contract. Please refer to our policy C-6A for additional information.