

PacificSource Community Solutions Preapproval Frequently Asked Questions

****For Provider Use Only****

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

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

A “**preapproval**” (PA) is defined as a request for a specific service that requires review to determine medical necessity.

2. When is a preapproval needed?

Services that require preapproval are outlined on our website at CommunitySolutions.PacificSource.com.

Please note: Preapprovals do not supersede other program requirements such as:

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

Our claims payment system will always look for a valid referral to be in place if you will be billing a preapproval with an office visit (E&M code).

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.*

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

- No. Referrals and preapprovals are not required when PacificSource Community Solutions is the secondary payer.
 - Please remember that payment for services is always subject to member eligibility on the date(s) of service, and the member's benefits as defined in their plan conditions, terms, and limitations.

4. Can a specialist submit a preapproval request to PacificSource Community Solutions?

Yes, generally preapproval requests are initiated by the rendering provider. This is because the rendering provider knows which services will be rendered (the associated CPT and/or HCPC codes).

Examples:

- Chiropractic manipulation
- Physical therapy

The preapproval request can be initiated by the specialist via InTouch, our online provider portal.

5. What does a preapproval allow?

A preapproval allows members to see providers for covered services. Payment for these services will be subject to eligibility, funded conditions, medical appropriateness, and established medical criteria. See below for additional detail.

6. What about services that *do not* require a preapproval, is a referral required?

It depends. If you will be billing with an E&M code (office visit), you will need to be sure a valid approval is in place.

Examples:

- A diagnostic procedure that does not require a preapproval, such as 70450 CT Brain.
- ATL diagnosis that pairs with the requested procedure that does not require a preapproval, such as Endometriosis/Adenomyosis and Laparoscopy.

7. What about services that do require a preapproval, is a referral required?

It depends. If you will be billing with an E&M code (office visit), you will need to be sure a valid approval is in place.

Example: ATL diagnosis that pairs with a requested procedure and the procedure requires a preapproval, such as Radiculopathy lumbar region and MRI of the lumbar spine.

8. What about diagnoses that are *both* ATL and BTL?

Submit a preapproval request. These are generally situations that require medical necessity review for determination of coverage.

Examples:

- Medical nutrition therapy for bariatric surgery
- Circumcision

9. Are there certain services that are considered diagnostic that don't require preapproval?

There are certain services that don't require a preapproval because state law considers these to be diagnostic. Please see the Diagnostic Workup File for these:

<https://intouchqa.pha.pacificsource.com/LineFinder/Content/files/DiagnosticWorkupFile.pdf>

These codes typically will not pair with procedure codes (due to being diagnostic).

10. What if the member had a previously scheduled service/procedure before becoming eligible with PacificSource Community Solutions?

A plan approved authorization (preapproval) is still required.

11. Does PacificSource Community Solutions allow retroactive PAs?

Retro-preapprovals are allowed for services 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(s) or initiation of the service(s).

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

12. What if the preapproval request has not been approved at the time of service?

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

13. What information is required when submitting a preapproval request?

- Member name, date of birth, and member ID number.
- Referring provider information and contact information.
- Treating provider or facility name and contact information.
- Diagnosis code(s).
- Start date of request, timeframe, and number of visits (start and end dates must be clearly defined).
- Chart notes are always required for plastic surgery, dermatology, and podiatry referral requests and may be required in additional scenarios (see #12).

14. Is a preapproval limited to the specialist designated by the member's PCP?

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

15. Does preapproval guarantee payment for services?

No. Payment for services is always subject to:

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

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

16. How do I submit a preapproval?

A preapproval must be submitted electronically through InTouch, our online provider portal at CommunitySolutions.PacificSource.com/Providers.

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

17. When will I receive a determination for a preapproval request?

PacificSource Community Solutions responds to standard preapproval requests within 14 calendar days, but usually renders a decision much sooner.

18. How will I know my preapproval request has been approved?

The decision will be visible within InTouch, our online provider portal.

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

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

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