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PacificSource Community Solutions Referral Frequently Asked Questions

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

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

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

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

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

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

2. When is a referral needed?

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

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

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

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

No. Referrals and preapprovals are not required when PacificSource Community Solutions is the secondary payer.

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

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

The referral request can be initiated by the specialist via InTouch, our online provider portal. However, the 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 specialists to request ongoing treatment for the member's current condition. This includes the ability to request additional office visits, as well as referrals to other in-network specialists for continued treatment of the initial condition.

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

5. What does a referral allow?

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

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

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

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

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

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

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

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

Examples:

- 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
- Chiropractic manipulation billed with an office visit

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

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

10. Does PacificSource Community Solutions allow 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 with this process.

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

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

12. When can a specialist bypass PCP approval?

PCP approval will not be needed for *follow-up* appointments after:

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

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

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

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

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

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

14. How many visits are covered by a referral?

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.

Please keep in mind that the amount of visits requested must be a reasonable number and cannot be unlimited. Referral requests that do not exceed the frequency listed below may be granted automatic approval if submitted with a covered diagnosis. Please see #18 for additional details of coverage.

After the initial BTL visit, documentation may be requested for additional BTL visits.

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: 6
Cardiology	Maximum visits: 8
Cardiovascular Surgery	Maximum visits: 8
Endocrinology	Maximum visits: 8
ENT/Otolaryngology	Maximum visits: 8
Gastroenterology	Maximum visits: 8
General Surgery	Maximum visits: 8
Gynecology Obstetrics	Maximum visits: 8
Hematology/Oncology	Maximum visits: 14
Immunology/Allergy	Maximum visits: 5
Infectious Disease	Maximum visits: 8
MRI Follow-up	Maximum visits: 1 (PCP referral requirement is waived)
Neonatology	Maximum visits: 8
Nephrology	Maximum visits: 8
Neurology	Maximum visits: 5
Neurosurgery	Maximum visits: 8
Ophthalmology/Optometry	Maximum visits: 8 if age <= 20; if age > 20 with diabetes or glaucoma diagnosis
Oral/Maxillofacial Surgery	Maximum visits: 5
Orthopedics	Maximum visits: 8
Pediatric Specialist	Maximum visits: 5
Pulmonology	Maximum visits: 8
Radiation Oncology	Maximum visits: 26
Rheumatology	Maximum visits: 8
Urology	Maximum visits: 8

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* above (examples: podiatry and dermatology)
Referral longer than one rolling year
Office visits for BTL conditions (initial visit excluded)
Office visits greater than the those listed in *Table 1* above
Retroactive request

15. What is the auto-approval process for Table 1 above?

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.

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

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

17. Does referral approval guarantee payment for services?

No. Payment for services is always subject to:

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

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

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.

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.

18. Do all services require a referral?

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

- Annual women's exam (including colposcopies and LEEPs)
- Anticoagulation office visits
- Certain immunizations (shots)
  (these 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 additional details in # 19 below)
- Lactation services (help with breastfeeding)

- Maternity care — a referral from the PCP is needed to see a specialist other than the maternity doctor
- Members in a designated special needs rate group (example: HIV)
- Mental 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

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

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

20. How do I submit a referral?

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

Approval timelines are typically fast when requests are submitted via InTouch as they may qualify for auto-approval. Auto-approval is an instant response.

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

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

PacificSource Community Solutions responds to standard referral requests within 14 calendar days, but usually renders a decision much sooner. If the number of requested visits is within the frequency outlined in *Table 1*, an automatic approval may be processed instantly.

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

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

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

- Phone: (800) 624-6052, ext. 2580
- email: providerservicerep@pacificsource.com