

Section 4: PHYSICIANS AND PROVIDERS

4.1 Eligible Providers

The following physicians and practitioners are eligible to be considered as PacificSource participating providers, provided they meet credentialing requirements.

Physicians & Practitioners	Allied Health Care Practitioners	Alternative Care Practitioners
Doctor of Medicine	Audiologist	Acupuncturist
Doctor of Osteopathy	Certified Nurse Midwife	Chiropractor
Oral Surgeon	Certified Registered Nurse Anesthetist	Naturopath
Podiatrist	Certified Registered Nurse First Assist	
	Clinical Nurse Specialist	
	Licensed Clinical Social Worker	
	Licensed Marriage and Family Therapist	
	Licensed Professional Counselor	
	Nurse Practitioner	
	Occupational Therapist	
	Optometrist	
	Physical Therapist	
	Physicians Assistant	
	Psychologist	
	Psychologist Associate	
	Psychologist Resident	
	Registered Dietician	
	Registered Nurse	
	Speech Therapist	
	Surgical Technician	

4.1.1 Eligible Mental Health and Substance Abuse Professional Providers

- Clinical social workers licensed by a State Board of Clinical Social Workers
- Medical or osteopathic physicians licensed by a State Board of Medical Examiners
- Nurse practitioners registered by a State Board of Nursing
- Psychologists (PhD) licensed by a State Board of Psychologist Examiners
- In Oregon, psychologist associates and the supervising licensed psychologist must have an agreement to provide continued supervision of the professional work of a licensed psychologist associate by the Oregon Board of Psychologist Examiners (we will review eligibility of psychologist associates outside Oregon on a case-by-case basis.)
- In Oregon, psychologist residents with a contract for the supervision of a psychologist resident by Oregon Board of Psychologist Examiners (we will review eligibility of psychologist residents outside Oregon on a case-by-case basis.)
- Licensed Professional Counselors and Licensed Marriage and Family Therapists licensed by the State Board of Licensed Professional Counselors and Licensed Marriage and Family Therapists.

4.2 Credentialing

PacificSource 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 believes the emphasis on credentialing further demonstrates a commitment to qualified healthcare physicians and providers performing services our members require.

4.2.1 Initial Credentialing Process

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

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. **Please note that any new providers at your clinic will be considered nonparticipating providers until the credentialing application is submitted and approved by our Credentialing Committee. When a provider has nonparticipating status, claims are paid at the nonparticipating 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 Web site, www.pacificsource.com (click on Forms), or by contacting our Credentialing Department by phone or e-mail.

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 effective date. The provider will then be recredentialed every three years.

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

If the Credentialing Committee does not approve the provider, the provider may be considered a “nonparticipating provider” and claims may be processed at the nonparticipating benefit level. There may be reasons (e.g., fraud, inappropriate billing practices, other violations of PacificSource rules or legal boundaries) whereby claims payments may not be approved.

4.2.2 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 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** above.

4.2.3 Adequate Professional Liability Coverage

PacificSource requires physicians and providers to procure and maintain appropriate general and professional liability insurance coverage. The minimum acceptable professional liability insurance includes, but is not limited to:

One million/three million (\$1,000,000/\$3,000,000) is required for:

- Acupuncturist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinical Nurse Specialist
- Dentist
- Doctor of Osteopathy
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor
- Medical Doctor
- Naturopath
- Nurse Practitioner
- Oral Surgeon

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- Physician Assistant
- Podiatrist
- Psychologist
- Psychologist Associate

Two hundred thousand/six hundred thousand (\$200,000/\$600,000) is required for:

- Audiologist
- Occupational Therapist
- Optometrist
- Physical Therapist
- Speech Therapist

4.2.4 Providers Not Credentialed

Please note that certain hospital-based providers are not required by the NCQA or PacificSource to be separately credentialed by the health plan.

This exception applies to providers who practice exclusively within the inpatient setting and who provide care for the health plans' members only as a result of members being directed to the hospital or other inpatient setting.

If you have any questions about credentialing, you are welcome to contact the PacificSource Credentialing Department, a division of Provider Network Management by phone at (541) 684-5580 or toll-free at (800) 624-6052, ext. 2580, or by e-mail at providernet@pacificsource.com.

4.3 Participating Physician & Provider Identification Numbers

Each participating physician and provider is issued a unique identification number immediately following the completion of contract negotiations. This important number links participating physicians and providers to the PacificSource maintenance and claim payment systems.

The PacificSource provider or payee number is a five-character identifier. Individual physicians and providers within a practice are identified by a two-character code following the provider/payee number; e.g., A3500 Healthy Clinic, A3500-04 (or JB624-B5) Dr. Smith at Healthy Clinic.

All claims must indicate the physician or provider in block #33 of the HCFA form, preferably in the space titled PIN.

4.3.1 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, your tax ID number must match the business name you report to both PacificSource and the federal government.

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 Web site, www.pacificsource.com. (Click on For Providers, then on Forms.)
- 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 should begin using the new number).
- Send the completed form with the effective date by fax: (541) 684-5559, or mail:

Attn: Provider Network Department
PacificSource Health Plans
PO Box 7068

Eugene OR 97401

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 e-mail at providernet@pacificsource.com.

4.4 Physician and Provider Contract Provisions

PacificSource 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 accept the lesser of the billed amount or PacificSource negotiated rates in effect at the time the service or supplies were rendered or provided as payment in full, less deductibles, coinsurance, copayments, and/or services that are not covered.
- 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, coinsurance, copayments and/or services that are not covered.
- Physicians and providers will bill their usual and customary charges.
- Physicians and providers will bill PacificSource directly using current CPT procedure, ICD-9 diagnostic, HCPCS and/or DRG coding, and not ask members to bill PacificSource for their services.
- Physicians and providers will cooperate with PacificSource, 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 when necessary to coordinate benefits, quality assurance, utilization review, third party claims, pre-existing condition investigations, and benefit administrations. PacificSource agrees that such records shall remain confidential unless such records may be legally released or disclosed.
- For non-covered services, physicians and providers will look to the member for payment.

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 e-mail at providernet@pacificsource.com.

4.5 Call Share Policy

Primary care providers and specialists agree to make arrangements for coverage when they are unavailable. The call share physician or provider may bill PacificSource for the services provided to the patient, and PacificSource will reimburse the call share provider for noncapitated services.

PacificSource maintains call share group listings. Any changes in call share must be forwarded to the Provider Network Department. The listing authorizes the call share providers to provide services, and to receive direct payment for noncapitated services.

If there is any change in a call share group, please call Provider Network Management as soon as possible at (541) 684-5580 or toll-free at (800) 624-6052, ext. 2580.

4.6 Primary Care Practitioners

4.6.1 Responsibilities

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

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To be eligible for benefits, all services the member receives must be provided or referred by the PCP, except for certain self-referral care (e.g., routine vision exams, annual gynecologic exams, and obstetric care).

The primary care practitioner is also responsible for the following:

- Accepts new patients when practice is open to other insurance carriers
- Will notify PacificSource in writing when practice is closed to new patients
- Will arrange for call sharing with a panel physician or provider 24 hours a day, seven days a week
- Will notify PacificSource of any changes in call share coverage
- Will notify PacificSource when asking a member to seek treatment elsewhere

Also see section on **Referrals**.

4.6.2 PCP Changes

There are two broad categories that may necessitate a change in a member's primary care practitioner (PCP):

- The member chooses to change to a different PCP. PCP changes are allowed once per month; however, the change will not take effect until the first day of the following month. PacificSource will document reasons for changing PCPs for the purpose of monitoring quality assurance and quality improvement.
- The PCP makes a change, forcing the member to possibly change PCPs. Primary care practitioners may change members for a variety of reasons including, but not limited to, the following: Moving practice to a different location
 - Moving out of the PacificSource service area
 - Closing practice due to retirement, etc.
 - No longer participating on the panel
 - PCP dismisses member from care

4.6.3 Outstanding Referrals

The following PacificSource policies apply regarding changes in PCPs with regard to outstanding referrals:

- When a member chooses to change PCPs, all outstanding referrals become void effective on the termination date of the referring PCP. A letter will be generated informing the member, new PCP, and specialist of any outstanding referrals.
- When a PCP makes a change forcing a member to choose a new PCP, a 60-day grace period will be in effect for all outstanding referrals. A letter will be generated informing the member, new PCP, and specialist detailing the status of any outstanding referrals.

PCPs must contact the Provider Network Department as soon as possible when making any of the above changes. Please call (541) 684-5580 or toll-free (800) 624-6052, ext. 2580.

4.6.4 Limiting or Closing Practice

PacificSource 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

PacificSource enrollment forms ask the insured to indicate whether or not they are an established patient of a physician or provider. Upon enrollment with PacificSource, a Membership Services Representative monitors this

information and is prepared to notify the insured when they have selected a PCP whose practice is closed to new patients. In such instances, the insured will be notified by mail and asked to select a new PCP.

Primary care practitioners are sent a monthly report that lists all patients who have chosen them as their PCP. If new patients have chosen their limited or closed practice, the physician or provider can notify the PacificSource Customer Service Department and request the patient appoint a different PCP. The insured will be notified by mail and asked to select a different PCP.

Questions regarding PCP selection should be referred to the Customer Service Department at (541) 684-5582 or (888) 977-9299. Provider Network Management will handle questions regarding closed/limited practices.

4.7 Appeals Process

PacificSource will make every effort to treat those with whom we do business fairly, honestly, and with recognition of their perspectives and needs.

PacificSource Health Plans Statement of Principles

PacificSource understands that at times our members, agents, physicians, and providers may have questions or concerns about decisions made by our staff. Our policy is to document, investigate, and resolve concerns, and to notify all affected parties in a timely manner. Fair consideration and timely resolution are the goals of our grievance and appeal process.

PacificSource has a four-level system for addressing and resolving inquiries, requests, concerns, complaints, and grievances.

Level 1 Response (Informal Review)

Level 1 is an informal process by which PacificSource is made aware of an issue and then acknowledges and responds to that concern, complaint, inquiry, or request. Trained staff members are accessible to PacificSource customers on a daily basis, and are able to answer 98 percent of all inquiries or concerns. Reviews may be requested for contract interpretation, claim payment issues, or second medical or legal opinion.

Level 2 Response (Formal Review)

Level 2 involves a formal, written appeal of a concern, complaint, or request when a decision reached by PacificSource at Level 1 is not acceptable. When a member or authorized representative finds an earlier decision unacceptable, they have the right to appeal the decision by filing a grievance. To do so, the member or authorized representative must submit a written statement requesting PacificSource to review and reverse their decision. All perspectives are investigated following written testimony.

Level 3 Response (Formal Review)

Level 3 involves a formal written appeal of a decision reached by PacificSource at Level 2. When a member or authorized representative finds our decision at Level 2 regarding a grievance unacceptable, they have the right to appeal by submitting a written statement to PacificSource requesting that we review and reverse our decision. Depending on the issues presented, the appeal will be heard by a grievance committee made up of PacificSource staff not involved in the initial grievance decision, a committee primarily consisting of physicians who are not employed by PacificSource, or an independent review organization.

Level 4 Response (Formal review)

Level 4 represents the final level within our system. Members or authorized representatives wishing to appeal a decision beyond Level 3 must submit a written appeal request. The appeal may be reviewed by a committee that includes at least one member of the board of trustees, a committee primarily consisting of physicians who are not employed by PacificSource, or an independent review organization.

How to Submit Grievances or Appeals

The member or authorized representative may file a grievance or appeal by:

- writing to PacificSource, Attn: Grievance Review, PO Box 7068, Eugene OR 97401

- e-mailing a message to lc@pacificsource.com with "Grievance" as the subject
- faxing your message to (541) 431-3806

If you are unsure how to prepare a grievance, please contact our Customer Service Department by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by e-mail at cs@pacificsource.com. We will help you through the grievance process and answer any questions you may have.