

Section 5: REFERRALS

5.1 Referral Policy

Some PacificSource plans require the selection of a primary care practitioner (PCP) who will be responsible for the member's routine medical care and will coordinate any required specialty care. The PCP is responsible for requesting a referral for specialty care services.

Referrals are requested by the PCP to a managed care/referral coordinator. Referral services may be provided by:

- Physician and/or provider groups contracted with PacificSource
- A subcontracted entity delegated by PacificSource, or a physician and/or provider group
- PacificSource Health Plans

The referral coordinator approves or does not allow referrals based on established criteria. If the referral coordinator is not able to make a decision, further evaluation will be made by a medical director and/or review committee.

PacificSource plans that have PCP and referral requirements stipulate all specialist services (except those listed as "Referral Not Required") must have a PCP referral, and must receive authorization from the referral coordinator and/or committee.

The Referral Request Form is available in the For Providers section of our Web site, www.pacificsource.com (click on Forms). You may also obtain the form by contacting our Referral Coordinator in our Health Services Department by phone (541) 684-5584 or toll-free at (888) 691-8209, or by e-mail at healthservices@pacificsource.com.

Notification process: We communicate our referral decisions in writing to the member, the requesting provider, and the specialist. Notices will be mailed within two working days after we receive the referral request.

PLEASE NOTE: Referral authorization does not imply that services will be covered by the member's policy. It is important that the member contact the PacificSource Customer Service Department for benefit information prior to being seen by the specialist.

5.2 Referral Procedure

When the services of a specialist are necessary, the primary care practitioner (PCP) requests a referral to a panel specialist through a referral coordinator. The referral coordinator approves or does not allow the referral, and communicates the decision to PacificSource. PacificSource requires the following information for processing referrals:

- Date
- Patient's name
- Group and identification number
- Name of PCP
- Name of specialist
- Start date
- Expiration date
- Number of visits
- Managed care office's unique referral number (optional)
- Diagnosis code and description
- Referral plan:
 - Level 1: Consultation only

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- Level 2: Treatment (may state CPT code or CPT range)
- Level 3: Consultation and medical treatment
- Level 4: Consultation and medical treatment including surgical/procedure option

The number of visits requested does not include surgery, unless the surgery is done in the physician's office exam room (not an outpatient surgical suite or facility). Approved specialist services occurring after the global period, but within the time period requested, are still available to the member.

The following restrictions apply:

- Referrals must be made to a specialist on the appropriate panel, unless the specialty services are not available on that panel.
- Referrals must be for a specified period of time.
- Referrals must be for a period no longer than six months.
- Referrals become void if the member changes his/her PCP.
- Referrals should be made for covered diagnoses only. Please call Customer Service for benefit information.

If you have other questions or concerns, contact the Referral Coordinator in our Health Services Department by phone at (541) 684-5584 or toll-free at (888) 691-8209, or by e-mail at healthservices@pacificsource.com.

5.3 Referral Management Entities

Each physician or provider who is contracted for products with referral requirements needs to request referrals through a designated referral authorization entity. The referral management or authorization entity may be a department in a large clinic, an IPA office that represents the physicians and/or providers, or an independent company. In addition, physicians and providers may choose to have PacificSource perform the referral review process.

Referral operations are typically comprised of a managed care coordinator, a medical director, and a committee. The coordinator receives the referral authorization request and, based on an established set of criteria, evaluates the request for approval. If the coordinator is unable to make a determination, the request is referred to the Medical Director and/or committee. Referral determinations are communicated to PacificSource for appropriate data entry into the claims system.

Know who manages your referrals. Check your provider contract provision regarding referrals, or contact our 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.

5.4 Out-of-Panel Referrals

The PCP is responsible for referring the member to a panel physician or provider; however, members occasionally require care that is not available within the panel. When this happens, the PCP may request a referral to an out-of-panel physician or provider.

When a referral management coordinator receives an out-of-panel referral, it is evaluated for medical necessity and/or continuity of care. Further evaluation will ascertain the following:

- Care is not available from a panel member
- The primary consideration of the referral is the patient's care
- Preferably, the referral is to a PacificSource participating physician or provider, or to a physician or provider contracted through the panel.

Communication with the PacificSource Health Services Department may be necessary on a case-by-case basis.

When PacificSource receives an out-of-panel referral from a managed care office, the following procedures apply:

- The referral intake person ensures that the referral management coordinator is aware that the physician or provider is out-of-panel. The referral intake person may need to call the managed care office for clarification.

- Approved referrals to out-of-panel physicians and providers are routed to the PacificSource Health Services Department along with pertinent information, including the patient's name, group and identification number, PCP name, name of specialist, and diagnosis. The Health Services Department may call the referral management coordinator or PCP to discuss the referral. The goal is to attempt to direct a member to a contracted physician or provider.

If your patient requires services not available within the panel or network, please contact our Health Services Department by phone at (541) 684-5584 or toll-free at (888) 691-8209, or by e-mail at healthservices@pacificsource.com.

5.5 Outstanding Referrals

The following PacificSource policies apply to changes in PCPs and outstanding referrals:

- When a member chooses to change primary care practitioners, 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 outstanding referrals.
- When a PCP makes a change that requires 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 of the status of outstanding referrals.

If you have a change in your practice that affects members who have chosen you as their PCP, please contact our 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.

5.6 Referral Not Required

5.6.1 List of Services

The following services do not require a referral:

- Ambulance
- Anesthesia
- Assistant surgeons
- Chemical dependency services
- Diabetic education
- IUD insertion during six- to eight-week postpartum visit. Applies to managed care plans that require referral (Prime) and have a contraception benefit.
- Mental health services
- Obstetric care
- Pharmacy
- Physical, occupational and speech therapy
- Routine annual gynecological exams (see routine gynecologic services)
- Routine vision exams (medical eye services require a referral) and supplies

Diagnostic testing*, including (but not limited to):

- Lab and radiology
- Nerve conduction studies
- Treadmill tests
- Spinal taps
- EKG testing and interpretation

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*Please note: The office call or consultation with a specialist that results in a charge prior to or following these tests **does** require a referral.

5.6.2 Routine Gynecologic Exam

When a member chooses to see a participating women's care specialist for her annual gynecological exam, she may do so without a referral from her primary care practitioner.

If, during the routine annual exam, it is determined that medical treatment is necessary, the specialist may proceed on the same date of service without a referral.

Services not requiring a referral on the same date of service as the routine exam include medically necessary evaluation of gynecologic, obstetric or breast conditions, including lab, radiology, and/or diagnostic procedures.

Claims must be billed with a primary diagnosis of V72.3 to be recognized as a routine gynecological exam.

Claims billed with a medical diagnosis as primary will be subject to referral guidelines.

Medical services deemed necessary at a future date require an approved referral through the PCP.

5.7 Referrals That are Not Approved

When the managed care coordinator and/or committee does not approve referral requests, the PCP is notified. It is the PCPs responsibility to discuss other options with the member. The PCP may appeal the decision by submitting supporting documentation to the managed care coordinator/committee for re-evaluation of the request.

Referrals may not be approved for reasons including, but not limited to, the following:

- Not medically necessary
- Not a covered benefit
- Request for service/visit is included in the global service
- Service is available within the provider panel
- Member has self-referred

Please see "Appeals" under the Providers section for further review of a referral that was not approved.

PCPs are expected to discuss referrals that were not approved with their patients. Members have the right to appeal through PacificSource.