Provider Manual

Commercial, Medicaid, Medicare | March 2026

PacificSource

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1. Introduction

1.1 About This Manual

PacificSource has prepared this Provider Manual for our contracted providers. It is 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. For the purpose of brevity, we use the term "provider" throughout the manual to refer to physicians.

Take a moment to look over the sections that relate to your responsibilities. You will find the expanded glossary helpful in becoming familiar with common insurance terminology and, of course, your comments, questions, and/or suggestions are always welcome.

In addition to using this Provider Manual, we suggest you visit our websites, PacificSource.com, CommunitySolutions.PacificSource.com, and Medicare.PacificSource.com. There you will find other useful tools, such as provider directories, formularies, and plan documents.

We hope the information in the Provider Manual and on the web is useful. PacificSource Provider Relations Representatives are committed to providing tools that meet the needs of our in-network physicians and providers. 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.

Thank you for becoming a team member in the partnership between PacificSource, members, and our in-network physicians and providers.

Notice of Change

For any change in a PacificSource policy or process that this manual addresses, we will provide written notice. Notice of the specific policy or process change will be provided by email and may be posted on this web page: PacificSource.com/Providers.

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

PacificSource administers its Medicare Advantage, Medicaid, and commercial products in accordance with applicable federal and state laws, regulations, and sub-regulatory guidance. PacificSource may adopt and apply Centers for Medicare and Medicaid Services (CMS) requirements, billing rules, coverage policies, coding standards, and program integrity methodologies to all product lines, to the extent permitted by law and unless otherwise expressly excluded in the applicable Provider Agreement. Providers agree to comply with such requirements as a condition of participation and payment. In the event of a conflict between CMS regulations and PacificSource policies, CMS regulations shall control Medicare Advantage products. For other lines of business, PacificSource policies shall incorporate CMS standards unless preempted by state law or the applicable Provider Agreement. To the extent that CMS guidance is silent or non-binding for a particular product line, PacificSource may establish internal standards consistent with industry best practices and program integrity principles.

This manual is not intended to be all encompassing of PacificSource provider policies. To request information on a policy that is not included in the Provider Manual, please reach out to your Provider Relations Representative. Not all processes are documented in a formal policy and procedure, and/or are able to be shared externally.

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.

Anti-Discrimination Statement

PacificSource does not discriminate against any provider based on their participation with the plan, reimbursement, or indemnification, who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification. PacificSource does not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment.

2. Who to Contact

TTY: 711. We accept all relay calls.

Commercial Customer Service

Oregon and Washington: 541-684-5582, 888-977-9299
Idaho: 208-333-1596, 800-688-5008
Montana: 406-442-6589, 877-590-1596
Fax: 541-684-5264
Email: CS@PacificSource.com

Call Customer Service Monday through Friday, from 7:00 a.m. to 5:00 p.m., PT

Medicaid Customer Service

Toll-free, all areas: 800-431-4135
Central Oregon and Gorge: 541-382-5920
Marion and Polk Counties: 503-210-2515
Fax: 541-322-6423
Email: CommunitySolutionsCS@PacificSource.com

Call Medicaid Customer Service Monday through Friday, from 8:00 a.m. to 8:00 p.m.

Medicare Customer Service

Bend, OR: 541-385-5315
Springfield, OR: 541-225-3771
Boise, ID: 208-433-4612
Toll-free: 888-863-3637
Fax: 541-322-6423
Email: MedicareCS@PacificSource.com

Call Medicare Customer Service:

October 1–March 31
8:00 a.m. to 8:00 p.m. PT, 7 days a week

April 1–September 30
8:00 a.m. to 8:00 p.m. PT, 7 days a week

Contact for:

- Member benefits, eligibility information, or waivers
- Deductible, coinsurance and/or copay information
- Explanation of payments/vouchers
- In-network physicians and providers and changes
- Claim questions/status
- PCP changes
- Referrals or prior authorization questions
- Appeal process
- Accident information

Claims Billing

Commercial: See the back of the PacificSource member ID card.

Mail Medicaid claims to:
PacificSource Community Solutions
PO Box 7068
Springfield, OR 97475-0068

Mail Medicare claims to:
PacificSource Medicare
PO Box 7068
Springfield, OR 97475-0068

Credentialing

Phone: 541-225-3747
Fax: 541-225-3644
Email: Credentialing@PacificSource.com

Contact for:

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

Contracting

Phone: 541-684-5580
Toll-free: 800-624-6052
Fax: 541-225-3643

Contracting Email, all states:

- ProviderContracting@PacificSource.com

Contact for:

- Direct contracting inquiries
- Direct contracting application status
- Direct contract renewal inquiries

Dental

Commercial Dental Customer Service

Phone: 541-225-1981
Toll-free: 866-373-7053
Fax: 541-255-3655
Email: Dental@PacificSource.com

Monday through Friday, 8:00 a.m. to 5:00 p.m., PT

Medicaid Dental Providers

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

Medicaid Dental Services

Advantage Dental Services: Toll-free 866-268-9631
Capitol Dental Care: Toll-free 800-525-6800
ODS Community Health: Toll-free 800-342-0526

Health Services

Monday through Friday, 8:00 a.m. to 5:00 p.m., PT

After normal business hours, calls to Health Services are forwarded to voice mail. A staff member will return the call the next business day. Any email communication received after hours will be answered the following business day.

Care Management

Commercial

Phone: 541-284-7653; 888-991-1536
Fax: 541-684-5486
Email: MSSTeamCommercial@PacificSource.com

Medicaid

Phone: 541-330-2507; 888-970-2507
Fax: 541-385-3123
Email: MedicaidMSS@PacificSource.com

Medicaid Health Related Services

Phone: 541-284-7964; 888-675-0350
Fax: 541-322-6435
Email: HealthRelatedServices@PacificSource.com

Medicare

Phone: 208-433-4623; 888-862-9725
Fax: 208-433-4625
Email: MedicareMSS@PacificSource.com

Utilization Management

Commercial

Phone:
Oregon and Washington: 541-684-5584, 888-691-8209
Idaho: 208-333-1563, 800-688-5008
Montana: 406-442-6595, 877-570-1563

Fax:
Oregon and Washington: 541-225-3625
Idaho: 208-395-2697
Montana: 406-441-3378

Email:
CS@PacificSource.com

Medicaid

Behavioral Health
Phone: 541-382-5920, 800-431-4135
Fax: 541-330-4910

Prior authorization/Referrals
Phone: 541-330-7301

Utilization Review
Phone: 541-330-7301

Medicare

Phone:
Oregon and Washington: 541-330-7304
Idaho: 208-433-4624
Toll-free: 888-863-3637

Fax:
Oregon and Washington: 541-382-2952
Idaho Authorization and Referrals: 208-395-2697
Idaho Utilization Review: 208-395-2696

Contact for:

- Referrals
- Utilization review
- Prior authorization
- Out-of-network referral information
- Specific medical necessity criteria/guidelines

Pharmacy Services

Commercial/Exchange: 844-877-4803
Medicare: 888-437-7728
Community Solutions (Medicaid): 855-228-6229

Or contact any line of business by email: Pharmacy@PacificSource.com

Contact for:

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

Grievance and Appeals

Medicare and Medicaid

Toll-free: 888-863-3637
Phone: 541-330-4992
Fax: 541-322-6424
Email: NewAppeal@PacificSource.com

Commercial

Phone: 800-624-6052
Fax: 541-225-3632
Email: LC@PacificSource.com

Provider Network Department

Physician/provider support and education

Phone:
Idaho and Montana, Toll-free: 855-247-7579
Oregon and Washington, Toll free: 855-247-7575
Fax: 541-225-3643
Email: ProviderRelationsRep@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
- Provider location changes
- Call share maintenance
- Physician/provider network information
- Limited practice designations
- Demographic updates, including tax identification numbers
- Physician/provider credentialing

The Provider Network department operates as a liaison between PacificSource and healthcare professionals. Recognizing the needs and perspectives of in-network 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 Relations 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.
- Educational materials for meetings, annual site visits 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.
- Ensure providers complete all requested direct or third-party-partner demographics and capacity updates to maintain the online provider directory.

3. Glossary

Access: Ability to obtain medical 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.

Administrative Services Only (ASO) Contract: A contract between an insurance company and a self-funded plan where PacificSource performs administrative services only; for example, claims processing.

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

Alternative Care: Medical care received in lieu of inpatient hospitalization. Examples include outpatient surgery, home healthcare, and skilled nursing facility care. It also may refer to nontraditional care delivered by providers such as acupuncturists.

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 services customarily deemed ancillary to the care furnished by primary care or specialist physicians or providers.

Annual Enrollment Period (AEP): A set time each fall when Medicare members can change their health or drug plans, or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal Process for Terminated Providers: The system for the receipt, handling, and disposition of provider complaints and grievances in regard to contract termination, as described in the PacificSource Policies and Procedures.

Avoidable Errors: Formerly called a "never event," avoidable errors are 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 avoidable errors as "serious, preventable, and costly medical errors."

Balance Billing: Sometimes referred to as extra billing, this is the practice of a healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge. In-network providers cannot balance bill members.

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

Benefit Package/Plan: Specific services provided by the insurance carrier. Covered services, copayments or deductible requirements, limitations, and exclusions contained in the contract between PacificSource and a member or subscriber group.

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 they are 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: A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs. The Care Manager helps identify appropriate providers, facilities, and other resources throughout the continuum of care. Care Managers strive to ensure that available resources are being used in a timely and cost-effective manner in order to obtain optimum value and quality outcomes for both the member and the reimbursement source. At PacificSource, care management is an integral part of Health Services. Care management is composed of clinicians who are registered nurses, licensed clinical social workers, or licensed professional counselors, as well as non-clinical Member Support Specialists (MSS). Our care management programs provide members with custom-tailored support in coordination with their healthcare. Members may be referred to care management in a number of ways, including self-referral, provider or community partner referral, and outreach from PacificSource when it is indicated.

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

Capacity: The patient maximum threshold a primary care provider is assigned to manage their Medicaid-member panel without impacting quality of care.

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 a 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.

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.

Clinical Quality Utilization Management (CQUM) Committee and Pharmacy & Therapeutics Committee: The CQUM Committee promotes quality and oversees performance improvement projects, identifies topics for quality and performance improvement efforts, and oversees and evaluates quality and performance improvement plans. The Pharmacy & Therapeutics Committee (P&T) maintains drug formularies, reviews and approves pharmaceutical coverage policies for all lines of business including PacificSource Health Plans (commercial), PacificSource Community Health Plans (Medicare), and PacificSource Community Solutions (Medicaid).

Closed Grievance (also see Grievance): A decision that has been made which cannot be appealed or is not under appeal by the member.

Coinsurance: A policy provision under which the insured pays or shares part of the medical bill, usually according to a fixed percentage.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A law that requires employers to offer continued health insurance coverage to eligible employees whose health insurance coverage terminates.

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.

Coordinated Care Network (CCN): A network of all types of healthcare providers (physical healthcare, addictions, and mental healthcare) who have agreed to work together in their local communities to serve people who receive healthcare coverage under the Oregon Health Plan (Medicaid).

Coordinated Care Organization (CCO): A network of all types of healthcare providers who have agreed to work together in their local communities for people who receive healthcare coverage under the Oregon Health Plan (Medicaid).

Copay, copayment: The portion of the claim or medical expense that a member (or covered insured) must pay out-of-pocket.

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

Cost Sharing: A general set of financing arrangements via deductibles, copayments, or coinsurance in which a person covered by a health plan must pay some of the cost to receive care.

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

Covered Lives: Insured members.

Covered Services: Healthcare services which a member is entitled to receive from PacificSource.

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.

Deductible: The portion of the member's healthcare expenses that must be paid out-of-pocket before any insurance coverage is applied.

Dependents: Eligible family members of the subscriber covered by a health insurance plan.

Dental care organization (DCO): A corporation or entity that enters into a 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-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.

Distant Site: The physical location of the eligible healthcare provider.

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. Some dual eligibles qualify for our Dual Care (D-SNP) where available.

Dual Option: The choice between two or more different insurance arrangements for medical care (for example, indemnity or a coordinated care organization plan).

Dual Special Needs Plan (D-SNP): D-SNP plans are a type of managed care Medicare Advantage plan that enrolls only Full Benefit Dual Eligible (FBDE) individuals. The primary demographic is individuals who are more likely to be at higher risk for chronic conditions. Part D is always included, and the plan provides $0 cost sharing for all Medicare covered benefits. Integrated care management is also included.

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.

Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT): Formerly called Medicheck, the program offers "well-child" medical exams with referral for medically appropriate comprehensive diagnosis and treatment for all children (birth through age 20) covered by the Oregon Health Plan (OHP) Plus benefit package, and members under age 26 in the Young Adults with Special Health Care Needs (YSHCN) program.

Emergency Dental Condition: Is defined as:

- Manifestation of acute symptoms with sufficient severity, including severe pain or infection, whereby a prudent layperson, who possesses an average knowledge of health and dentistry would reasonably expect that without receiving immediate dental care the following would result:
  - Placing the health of the individual (or with respect to a pregnant individual, the health of the individual or the unborn child) in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

AND

- Any incident involving the teeth and gums that would require immediate treatment to stop ongoing tissue bleeding, alleviate severe and sudden pain or infection, treat unusual swelling of the face or gums, or preserve an avulsed tooth:
  - Emergency dental conditions are based on the presenting symptoms, not the final diagnosis, as perceived by a prudent layperson, rather than a healthcare professional. Emergency dental conditions include cases in which the absence of immediate medical attention would not in fact have had the adverse results.
  - The treatment of an emergency dental condition is limited only to covered services. Some noncovered services may meet the criteria of treatment for an emergency condition. However, PacificSource does not extend coverage to those noncovered services.

Emergency Medical Condition:

- A medical, mental health, or substance use disorder condition manifesting itself by acute symptoms with sufficient severity, including severe pain or emotional distress, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that without receiving immediate medical, mental health, or substance use disorder treatment the following could result in:

  - Placing the health of an individual or the health of a pregnant individual or their unborn child in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part
- With respect to a pregnant individual who is having contractions, for which there is inadequate time to safely transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the individual or the unborn child
- A behavioral health crisis

Emergency Services: Covered services that are required when there is a sudden and unexpected onset of an emergency condition (medical, behavioral, or dental) requiring immediate care for which the member secures immediately after the onset, or as soon thereafter as can be made available, but in any case, no longer than 24 hours after the onset.

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. PacificSource expands the definition as the sudden and unexpected onset of a condition requiring immediate medical or surgical care, which the member secures immediately after the onset, or as soon thereafter as can be made available, but in any case, no longer than 24 hours after the onset.

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.

Enrolled Group (see also Contract Group): A group of persons enrolled in a health plan through their employer or other common organization of which the persons are members.

Enrollee: A person eligible for service as either a subscriber or a dependent.

Enrollment: The process by which an individual becomes a subscriber for coverage in a health plan.

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

Evidence of Coverage (EOC) and Disclosure Information: This document, along with member enrollment form and any other attachments, riders, or other optional coverage selected, which explains member coverage, what we must do, member rights, and what he or she has to do as a member of our plan.

E-visit: Refers to communication between patients and providers through an online patient portal or email, not in real time. Email visits must meet the following criteria: The provider must use encrypted or authenticated email for online medical evaluation visits as described in current CMS criteria.

Standard email is not acceptable, as it is not secure, has no "terms of use" or legal disclaimers in place to protect the patient or provider, and can easily expose patient PHI including email addresses and contents of consultation discussion to unintended third parties.

Experience Rating: Rating system by which a plan determines the capitation rate or premium based on the claims experience of the individual group enrolled.

Experimental Procedures: Also called investigational or unproved procedures. All healthcare services, supplies, treatments, or drug therapies that PacificSource 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: List of covered drugs. The list can vary according to health plan.

Fraud, Waste, and Abuse (FWA): "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to themself or another person. It includes any act that constitutes fraud under applicable federal or state law. Examples include double-billing, forging or altering prescriptions, and billing for more expensive procedures than were actually performed.

"Waste" means to use healthcare benefits or spend healthcare dollars in a careless or needless manner. Examples include duplicative, inappropriate, or unnecessary tests and procedures; preventable hospital readmissions; and medical errors.

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare, Medicaid, or PacificSource. Examples include reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Full Risk: An arrangement where PacificSource 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, and acute hospital and physician services.

Grievance: A complaint submitted by, or on behalf of, a member regarding any of the following: the availability, delivery, or quality of healthcare services; utilization review decisions; claims payment, handling or reimbursement for healthcare services; or the contractual relationship between a member and an insurer.

A member's expression of dissatisfaction to PacificSource, an in-network provider, or the Oregon Health Authority about any matter other than an adverse benefit determination, as defined in OAR 410-120-0000. Grievances may include, but are not limited to the availability, delivery, or quality of healthcare or services provided; aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights, regardless of whether remedial action is requested. A grievance also includes a member's right to dispute an extension of the time proposed by PacificSource to make a decision on a service authorization request.

Health Maintenance Organization (HMO): A Health Maintenance Organization plan is a Medicare Advantage Plan that has a network of contracted providers who have agreed to treat plan members for a specified payment amount. An HMO plan will cover all plan benefits only when they are received from in-network providers, unless noted otherwise.

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

Hospice: A healthcare service that provides supportive care for the terminally ill.

Independent Physician Association or Individual Practice Association (IPA): An individual practice association of physicians and/or providers that have entered into a contract with PacificSource 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.

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

Locum Tenens Provider: A provider who is not credentialed or contracted with PacificSource, but who is allowed to see and treat members enrolled in our products in cases where the member's usual practitioner is unavailable.

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

Managed Care: A system of healthcare delivery developed to manage the cost, quality, and access of care. It is characterized by a contracted panel of physicians and/or providers; use of a primary care provider; limitations on benefits provided by noncontracted physicians and/or providers; and a referral authorization system for obtaining care from someone other than the primary care provider.

Managed Care Coordinator/Committee: An individual and/or committee that receives referral authorization requests and, based on a strict set of criteria, either approves or denies a request for referral authorization.

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.

Managed Fee-for-Service Product: Plan in which the insurer pays the cost of covered services after the services have been performed. Various managed care tools, such as prior authorization, second surgical opinion, and utilization review, are used to control inappropriate utilization.

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 members 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 that are needed for the prevention, diagnosis, or treatment of a medical condition and meet the accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older; some people under age 65 with certain disabilities; and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Advantage Plan, or other Medicare plans.

Medicare Advantage: An alternative to the traditional Medicare program, in which private plans run by health insurance companies provide healthcare benefits that eligible members would otherwise receive directly from the Medicare program.

Sometimes called Medicare Part C, Medicare Advantage plans are offered by a private company that contracts with Medicare to provide Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not billed directly to Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease.

Medicare Advantage Disenrollment Period: A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14.

Medicare Open Enrollment Period: The time period between October 15 and December 7 each year. Also called Annual Enrollment Period, this is the time during which an individual enrolls in a Medicare plan or makes plan changes in their Medicare healthcare coverage.

Member:

- Any PacificSource commercial plan subscriber or dependent as determined by PacificSource.
- A person with Medicaid who is eligible to get covered services, and who has been assigned to the community care organization by the Oregon Health Plan (OHP). For the purposes of appeals and grievances, "member" includes, as appropriate, the member, the member's representative, and the representative of a deceased member's estate. With respect to community care organization notification requirements, a separate notice must be sent to each individual who falls within this definition.
- A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare and Medicaid Services (CMS).

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 has selected and contracted with to provide healthcare for its members.

Network Pharmacy: 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 members.

Network Not Available (NNA): A member does not have reasonable geographic access (determined by PacificSource) to an in-network provider for a medical service or supplies. NNAs will only be approved when there is absolutely no provider to accommodate member care needs. Approval of NNA means that a member's cost share will be subject to any of their applicable in-network level deductible, copays, coinsurance, and out-of-pocket maximums. Members can be balance billed over the allowed amount even with NNA approval.

Noncoverage Decisions: For Medicare, PacificSource follows CMS guidelines for NCD (National Coverage Documents) and LCD (Local Coverage Documents). Information can be found at CMS.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx.

Noncovered Services: Those services excluded from coverage by PacificSource. These may also be called "un-covered benefits."

Non-Emergent Condition: Routine physical or eye examinations, diagnostic work-ups for chronic conditions, routine prenatal care, 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.

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

The Medicare Advantage organization has made an organizational determination when it makes a decision about whether services are covered or how much a member will have to pay for covered services. The Medicare Advantage organization's network provider or facility has also made an organizational 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.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare): Original Medicare is offered by the government, and not private health Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other healthcare providers amounts established by Congress.

Originating Site: The physical location of the patient receiving telemedical health services.

- Office of a qualified healthcare professional
- A hospital (inpatient or outpatient)
- Critical access hospital (CAH)
- Rural health clinic (RHC)
- Federal qualified health center (FQHC)
- A hospital-based or critical access hospital-based renal dialysis center
  - Independent renal dialysis facilities are not eligible originating sites
- Skilled nursing facility (SNF)
- Mobile stroke unit
- Patient home (Commercial and Medicaid)

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

Out-of-Network/Out-of-Panel Physician or Provider: A physician or provider who is not a part of the panel or network, or who has not contracted with PacificSource.

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

Overpayment: Any payment made to a provider by the health plan to which the provider is not entitled to under the Provider Contract, CCO Contract (for Medicaid), or state or federal regulations. Overpayments are also known as improper payments.

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 Plan (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.

Palliative Care: Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering in terminally ill patients.

Panel 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 members.

Part A: A hospital Medicare insurance plan including nursing care and hospital stays.

Part B: Part of Original Medicare. Covers services and supplies deemed medically necessary to treat a health condition including outpatient care, preventive services, ambulance services, and durable medical equipment.

Part C: These are Medicare Advantage Plans including HMO and PPO that administer Medicare Part A and Part B benefits through private insurance plans on behalf of Original Medicare.

Part D: The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

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

Patient-Centered Primary Care Home: A care delivery model where member treatment is coordinated through their primary care provider in a centralized setting.

PCP: See Primary Care Provider.

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-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 to provide specified covered services to members.

Plan Administration: Management of a plan, including accounting, billing, personnel, marketing, legal services, purchasing, and servicing of accounts.

Plan Sponsor: An entity that organizes the group health plan, oversees its facilities, and provides managerial authority.

Point of Service: A health plan that allows members to choose an in-network or out-of-network provider (with or without a referral), with benefit levels that differ depending on whether or not the provider is in the plan's network.

Policyholder: The employer or individual to whom a contract is issued, and in whose name a policy is written. In a plan contracted directly with the individual or family, the policyholder is the individual to whom the contract is issued.

Portability: Access to continuous health coverage such that the insured does not lose insurance coverage due to any change in health or personal status (such as employment, marriage, or divorce).

Poststabilization Care Services: These are covered services when related to an emergency medical, behavioral, or dental care condition and provided after a member is stabilized in order to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition.

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

Pre-Existing Condition: Physical condition of an insured person that existed before the issuance of a policy or enrollment in a plan.

Preferred Provider Organization (PPO): Fee-for-service product where participants have financial incentives to seek care from in-network physicians and providers, but are allowed to go to out-of-network physicians and providers at a reduced benefit.

Premium: The amount paid for health insurance.

Preventive Care: An approach to healthcare emphasizing preventive measures, such as routine physical exams, diagnostic tests (e.g., PAP 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): Physician or provider selected by a member who is given the responsibility of providing initial and primary care, and for referring, supervising, and coordinating the provision of all other covered services to the member. A PCP may be a family physician or provider, general practitioner, internist, pediatrician, obstetrician, gynecologist, or other practitioner or nurse practitioner who has otherwise limited their practice of medicine to general practice, or a specialist practitioner who has agreed to be designated as a primary care provider. Managed Care plans require that each enrollee be assigned to a primary care provider.

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

Program Integrity (PI) Audit: The review of claims for appropriate payment or suspicious aberrancies primarily to:

- Establish evidence that fraud, waste, or abuse has occurred or is likely to occur, or
- Determine whether actions of individuals or entities have the potential to result in an expenditure of health plan funds unintended under the Provider Contract, CCO Contract (for Medicaid), or state or federal regulations.

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; or (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; and
- Their name listed on OHA's Health Care Interpreter (HCI) Registry. More information is available at Apps.Oregon.gov/SOS/LicenseDirectory.

Quality Assurance Program: A program and process that is carried out by PacificSource and contracted physicians and providers to monitor, maintain, and improve the quality of services provided to members as described in PacificSource Policies and Procedures.

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 patients.

Quality Improvement Program (QIP): CMS requires Medicare Advantage plans to conduct a QIP each year. Each project runs a minimum of three years. We strive to improve member outcomes and assist providers with their treatment plans.

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.

The Quality Improvement Program is intended to:

- Ensure access and enhance the quality of healthcare
- Improve customer satisfaction
- Maximize the safety and quality of healthcare delivered to members
- Improve efficiency and effectiveness
- Fulfill quality related reporting requirements

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.

Reinsurance: Insurance purchased by a carrier from another insurance company to protect itself against all or part of the losses that may be incurred by claims for its members (e.g., catastrophic care).

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 or Medicare enrollees 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 and a provider may each agree to share the risk of excessive healthcare cost over budgeted amounts on a 50-50 basis.

Self-Funded: Management in which health services are delivered by physicians and/or providers, but the cost of these services is covered by the member's employer, instead of by the insurance firm.

Service Areas: Geographic areas covered by a PacificSource 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.

Stop-Loss: Risk protection from losses resulting from claims greater than a specific dollar amount per member per year.

Subscriber: The person who is responsible for payment to PacificSource, or whose employment or other status (except for family dependency), is the basis for eligibility for membership with PacificSource.

Another example would be a person who is covered by Medicare and has chosen to get their Medicare healthcare and/or prescription drug coverage through PacificSource Medicare.

Supplemental Medicare: A plan that covers some copayments, deductibles, and other services not covered under traditional Medicare.

Telehealth or Telemedicine: Refers to consultations with a qualified healthcare professional provided in real time over an electronic mechanism. These services are rendered to patients using electronic communications, such as secure email, patient portals, and online audio and/or video.

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 Administrator (TPA): An independent person or corporate entity that administers group benefits, claims, and administration for a self-funded group or insurance company. A TPA does not underwrite risk.

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

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: Care provided to treat a non-emergency, 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 with the cooperation of contracted physicians and providers to authorize and monitor the utilization of covered services provided to subscribers.

Virtual Check-in: An appointment where an established patient has a brief communication with a provider via telephone or other telecommunication devices to determine whether an office visit or other services are needed.

4. Credentialing

4.1 Credentialing

PacificSource credentialing standards follow the guidelines of the National Committee on Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) and state-specific rules. The credentialing process includes meticulous verification of the education, experience, judgment, competence, and licensure of all healthcare providers.

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

Please remember that PacificSource requires all providers rendering services to be individually credentialed before they can be considered an in-network provider under the provider contract.

PacificSource does not allow "incident to" billing for providers that are eligible for credentialing and practicing under their scope of license.

Provider Types to Credential

The following practitioners and organizational providers are eligible to be considered as PacificSource in-network providers, provided they meet credentialing requirements.

Physicians and Dentists

- Dentist
- Doctor of Medicine
- Doctor of Osteopathy
- Oral Surgeon, Doctor of Dental Medicine
- Podiatrist

Allied Healthcare, Mental Health, and Substance Abuse Providers

- Audiologist
- Behavior Analyst or Assistant Behavior Analyst, Board Certified
- Behavior Analyst, Doctorial Level
- Behavior Analyst Interventionist
- Board Certified Behavior Analyst
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- Genetic Counselor
- Electrologist
- Hearing Aid Fitter/Specialist
- Lactation Consultant (License and Certification is state specific)
- Licensed Addictions Counselor
- Licensed Clinical Professional Counselor
- Licensed Clinical Social Worker
- Licensed Dietician
- Licensed Independent Social Worker
- Licensed Marriage and Family Therapist
- Licensed Master Social Worker (Idaho only)
- Licensed Midwife (Washington only)
- Licensed Professional Counselor (also known as Licensed Mental Health Counselor)
- Licensed Psychologist Associate (Not under supervision)
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Pharmacist (billing under a medical benefit)*
- Physical Therapist
- Physician Assistant

- Physician Assistant/Physician Associate
- Psychologist
- Psychologist Associate (practicing without supervision)
- Registered Dental Hygienist
- Speech/Language Pathologist

Please note:
Certified Nurse First Assist, Certified First Assist (CFS), Certified Surgical Technicians, Surgical Assistants, and Registered Nurses must bill under the overseeing doctor's tax identification number.

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 Psychology.

Alternative Care Practitioners

- Acupuncturist
- Chiropractor
- Licensed Massage Therapist
- Naturopath

*Credentialing is required only for pharmacists providing care under medical benefits.

Credentialing is required for telemedicine practitioners who have an independent relationship with PacificSource, and who provide treatment services under PacificSource's medical benefit.

PacificSource does not require credentialing for some types of practitioners. It is the policy of PacificSource to follow the NCQA and CMS guidelines regarding practitioners who do not need to be credentialed.

Practitioners who meet any of the following criteria are not required to be credentialed:

- Practitioners who practice exclusively within the inpatient setting and who provide care for organization members only as a result of members being directed to the hospital or other inpatient setting.
- Practitioners who practice exclusively within freestanding accredited facilities, such as freestanding mammography centers and freestanding ambulatory surgery centers, and who provide care for organization members only as a result of members being directed to the facility.
- Practitioners who enter into a contractual relationship with an employer group outside of PacificSource and provide their own network to support their members, subject to review and approval of the specific circumstances.

Examples of practitioners who may meet the above criteria that do not need to be additionally credentialed by PacificSource include, but are not limited to:

- Pathologists
- Radiologists
- Anesthesiologists
- Neonatologists
- Emergency room physicians
- Behavioral healthcare practitioners
- Hospitalists
- Non-licensed providers (as required by state or federal statute)

Note: Hospitalists or others who occasionally work in the private clinic setting must complete the credentialing process.

Note: Non-licensed providers will be evaluated by the Credentialing Department by the use of a checklist submitted by the organizational facility (on behalf of the provider) prior to participation. The organizational providers will be credentialed through the standard organizational provider credentialing process.

Organizational Providers

- Behavioral Health Facilities (providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting)
- Birthing Centers
- Clinical Laboratories
- Comprehensive Outpatient Rehabilitation Facilities
- Durable Medical Equipment Suppliers
- Eating Disorder Treatment Facilities
- End-Stage Renal Disease Dialysis Centers
- Federally Qualified Health Centers
- Freestanding Ambulatory Surgery Centers
- Home Health Agencies
- Home Infusion
- Hospices
- Hospitals (including longer term acute care (LTAC)
- Independent Diagnostic Testing Facilities
- Medicare Certified Diabetes Prevention Programs
- Portable X-ray Supplies
- Public Health Centers
- Rural Health Clinics
- Skilled Nursing Facilities
- Sleep Study Labs

Examples of practitioners who are often hospital-based but may need to be credentialed because of an independent relationship outside the organization include, but are not limited to:

- Anesthesiologists with pain-management practices
- Cardiologists and other critical care specialists
- Emergency medicine physicians

4.1.1 Initial Credentialing/Validation 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. This process can take up to 90 days upon receipt of complete application. Dental care organizations perform credentialing for dental providers. Refer to DCOs for applications and processing.

Phase 1: Application

Providers are required to submit an application and complete our credentialing process prior to being considered an in-network provider with PacificSource. To begin the process, providers can submit one of the following applications to our Credentialing Department: Oregon Practitioner Credentialing Application, Washington Practitioner Application, Universal Practitioner Application, or the Medicaid Provider Validation Application (for non-licensed providers providing services to members in our Oregon CCOs). CAQH can also be utilized for all providers in all states. Organizational providers must complete PacifcSource's Organizational Provider Credentialing Application. Please note that any new practitioners at your clinic will be considered out-of-network until a credentialing or validation application is approved by our Credentialing Committee or Medical Director. When a provider has an out-of-network status, claims are paid at the out-of-network level, which has a direct effect on your clinic and patients.

Once the credentialing or validation 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 at the time of the credentialing decision, or 365 days at the time of validation decision.

The credentialing applications are available in the Providers section of our websites (PacificSource.com, CommunitySolutions.PacificSource.com, and Medicare.PacificSource.com) or by contacting our Credentialing department at 541-225-3747 or by email at Credentialing@PacificSource.com. The Credentialing department reviews all applications upon receipt, and will communicate any information needed to complete the file. The credentialing process will not begin until all elements are received for a complete application.

Practitioner Credentialing/Validation

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

- Current, unrestricted license or certification to practice
- Current, valid Drug Enforcement Agency (DEA) certificate
- Education and training
- Board certification
- A minimum of five years relevant work history
- Hospital privileges
- Current, adequate professional liability coverage, showing the coverage dates and limits of liability
- All professional liability claims history
- Criminal background information
- Appropriate clinical supervision as required by the licensing or certifying board

Organizational Provider Credentialing

- Current, unrestricted professional licensure, certification and/or registrations specifically required to operate as a healthcare organization
- Current accreditation by a recognized accrediting body, or current CMS/state survey, including corrective action plans for identified deficiencies
- Description of credentialing and clinical staff privileging program
- Appropriate policies regarding patient visitation, patient safety, and the use of restraints and/or seclusion
- Current, adequate professional liability coverage, showing the coverage dates and limits of liability

Phase 2: Review

The PacificSource Credentialing department is responsible for processing credentialing requests for providers requesting to participate in our provider network. The PacificSource Credentialing Committee evaluates provider candidates for credentialing and makes the final determination on credentialing requests. 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. 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. The provider will then be recredentialed at least every three years.

Providers who are not approved or 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 or 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 rules or legal boundaries) whereby claims payments may not be approved. After credentialing is complete, the provider's in-network effective date will be the first day of the following month.

4.1.2 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 one million per claim/three million aggregate amount ($1,000,000/$3,000,000), and is required for all practitioners and organizational providers eligible for credentialing noted in the beginning of the Credentialing section.

4.1.3 Recredentialing Process

The recredentialing process will be conducted for each in-network provider no less frequently than every three years, or according to applicable standards at the time. A notice that recredentialing is due will be sent to the provider approximately four 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 NCQA and CMS.

At a minimum, the recredentialing process will include verification or review of items noted in the Credentialing/Validation Process section, including quality improvement activities.

The decision process is the same for recredentialing as for initial credentialing (see Phase 3: Decision in the Initial Credentialing/Validation Process section). Providers who are approved for a recredentialing period of less than three years will be notified in writing. Providers who are denied continued participation will be notified in writing via certified mail, and are awarded appeal rights. Providers are notified of these rights and the process to request an appeal at the time of credentialing termination. Appeal rights are not granted for providers terminated for administrative reasons, such as loss of an active license, failure to recredential, and so on.

4.1.4 Medicaid Validation Providers

PacificSource performs validation of the following provider types that are eligible for Medicaid claims reimbursement, but would not otherwise qualify for full credentialing. These providers are only eligible for participation for the PacificSource Medicaid line of business.

- Addictions Counselor (CADC I, II, III)
- Addictions Counselor, Registrant
- Birth Doula
- Community Health Worker
- Professional Counselor Associate
- Family Support Specialist
- Gambling Addiction Providers
- Healthcare Interpreter
- Licensed Psychologist Associate (practicing with supervision)
- Marriage/Family Therapist Associate
- Peer Support Specialist
- Peer Wellness Specialist
- Personal Health Navigator
- Psychologist Associate Resident
- Qualified Mental Health Associate
- Qualified Mental Health Associate, Registrant
- Qualified Mental Health Professional
- Qualified Mental Health Professional, Registrant
- Youth Support Specialist

Please Note: Addictions Counselors (CADC I, II, III), Addictions Counselor Registrants, Community Health Worker, Family Support Specialists, Peer Support Specialists, Peer Wellness Specialists, Personal Health Navigators, Qualified Mental Health Associates, Qualified Mental Health Associate Registrants, Qualified Mental Health Professionals, Qualified Mental Health Professional Registrants, and Youth Support Specialists may be required to be providing care at a location with a Certificate of Approval registered with the Oregon Health Authority.

4.1.5 Practitioner Rights

PacificSource practitioners are afforded certain rights during the credentialing and recredentialing process. These rights include but are not limited to:

- The right to review information submitted to support your credentialing application, including information received from outside sources such as malpractice insurance carriers and state licensing boards. This right does not include the ability to review references, recommendations, or other peer-review protected information.
- The right to correct erroneous information when information submitted with your application varies substantially from information obtained during the credentialing process. The Credentialing department will notify you when such information is identified, with the appropriate timeframes and format to make necessary corrections. PacificSource is not required to reveal the source of the information verified, if federal or state law prohibits disclosure.
- The right to be informed of the status of your credentialing and recredentialing applications, upon reasonable request. The Credentialing department may provide projected timelines for completion, including possible delays, information pending or missing, and substantial variations in information verified during the credentialing process. The Credentialing department will respond within 14 days of receiving such requests, via email, telephone, fax, or mail.

4.2 Locum Tenens

A locum tenens arrangement is made when an in-network provider must leave their 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 they are replacing.

Medicaid: PacificSource requires each eligible practitioner, provider, or supplier of service to appear as the rendering provider in box 31 of the CMS-1500 form. If an in-network provider goes on leave, we require the covering provider to be credentialed prior to being paid under the absent provider's contract.

Medicare: PacificSource Medicare will accept modifier Q5/Q6 claims. The plan will monitor all claims that are submitted with these modifiers to ensure the same locum is not billing for services longer than 60 days. Providers must be fully credentialed if practicing more than 60 days.

Commercial: PacificSource will accept modifier Q5/Q6 locum tenens claims. Our Provider Network department will monitor all claims that come in with Q5 or Q6 modifier to ensure they are within the locum tenens claim guidelines.

A locum tenens provider who provides coverage for an in-network provider for up to 60 consecutive days does not require credentialing with PacificSource. If the locum tenens leaves the practice and then returns to the practice for an additional cycle, a new 60-day cycle will be allowed before credentialing is required. However, if the locum tenens provider provides coverage longer than 60 consecutive days, the applicable practitioner credentialing application is mandatory for claims consideration.

Locum tenens claims billed after the 60-day period without the completion of credentialing will be denied. Claims would need to include the names of the locum tenens or the servicing provider for the claim to pay according to member's benefits and contractual guidelines. Be sure to include the provider's NPI in item 24-K on the CMS-1500 claim form or electronic equivalent.

4.3 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 need a current version of the IRS W9 form, you may download it from the IRS website at IRS.gov/forms-pubs/about-form-w-9.
- 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: 541-225-3644, or mail:

  Attn: Provider Network Department
  PacificSource Health Plans
  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 or by email at ProvNetSup@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, copays, and/or services that are not covered. (See section Availability Practice, Patient Waivers for more detailed information.)
- Physicians and providers will bill their usual and customary charges.
- Practitioners and facilities will cooperate with quality improvement activities to improve the quality of care and services and members' experience. Cooperation includes collection and evaluation of data and participation in PacificSource's Quality Improvement programs. PacificSource may use practitioner and facility performance data for quality improvement activities.
- Providers will not provide incentives to deny, limit, or discontinue medically necessary services to enrollees.
- Physicians and providers will bill PacificSource directly using current CPT procedure, ICD10 diagnostic, HCPCS, and/or DRG coding, and will 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, and benefit administrations. PacificSource 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 or by email at ProvNetSup@PacificSource.com. For dental contracts, please refer to your dental care organization.

4.4.1 PacificSource Medicaid Physician and Provider Contract Provisions

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 Record Submission Guidelines: Medical records are requested when additional information is needed to process a claim. Letters to request this information may be sent via portal, phone, fax, or regular mail. Please include the claim number or a copy of the letter with your submission.
- 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 their 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 Clinical Quality Utilization Management (CQUM) Committee and Pharmacy & Therapeutics Committee on a quarterly basis. If a provider is found to have violated an enrollee's rights, the CQUM Committee will determine appropriate corrective action.

Training Requirements

Providers, provider staff, and subcontractors are required to participate in annual training in each of the fundamental areas listed below. Providers may attest to the provision of this training by reporting the training subject, training title, trainer and trainer qualifications, content outline and materials, learning objectives, target audiences, delivery system, evaluation data, training dates and hours, and training attendance for each training offered. If a provider does not have the capacity to offer training to staff and subcontractors, they may participate in training offered by PacificSource.

Fundamental Areas of training include:

- Cultural Responsivity and Implicit Bias
- Fraud, Waste, and Abuse

In addition to these courses, Behavioral Health Providers must also take training in the areas of:

- Motivational Interviewing
- Foundations of Trauma Informed Care
- Integrated Care

Finally, CMS requires all providers who provide services for members on the PacificSource Dual Care (HMO D-SNP) receive the following annual training:

- D-SNP Model of Care

Find information about training offered by PacificSource at: PacificSource.com/providers/training-and-education. To access courses provided by PacificSource or to attest to training completed, please create an account at PacificSource.MyAbsorb.com.

4.4.2 PacificSource Medicare Physician and Provider Contract Provisions

Privacy and Accuracy Records

Provider agrees to abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information: safeguard the privacy of members' information; maintain records and information in an accurate and timely manner; and ensure timely access by members to the records and information that pertain to them. Medical record information will be disclosed only to those contracted business associates outside of the organization with which PacificSource Medicare retains a valid confidentiality agreement [42 CFRs 422.118 and 422.504 (a)(13)].

Record Retention, Data, and Medical Record

PacificSource Medicare will obtain the risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service. Provider will cooperate with PacificSource Medicare when applicable.

PacificSource Medicare may include in its contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data. Provider will cooperate with PacificSource Medicare when applicable.

PacificSource Medicare and its providers and practitioners will be required to submit a sample of medical records at no cost, unless otherwise specified, for the validation of risk adjustment data as required by CMS. There may be penalties for submission of false data. Provider will cooperate with PacificSource Medicare when applicable.

PacificSource Medicare and provider will maintain books, records, documents, and other evidence of accounting procedures and practices for ten years for the purpose of CMS inspection and audit. PacificSource Medicare and provider will comply with state and federal government auditing, inspection, and evaluation requirements, including maintenance of records, access to facilities and records, and record retention guidelines pursuant to 42 CFR §422.504(d)(e).

PacificSource Medicare's contracts with providers will contain CMS-required provisions pursuant to 42 CFR §422.504(i)(3),(4).

PacificSource Medicare and provider (when applicable) will certify to the accuracy, completeness, and truthfulness of relevant data to CMS pursuant to 42 CFR §422.504(l)(3).

Medical Record Submission Guidelines: Medical records are requested when additional information is needed to process a claim. Letters to request this information will be sent via regular mail. Please include the claim number or a copy of the letter with your submission.

Government Claims: fax: 541-322-6437
Commercial Claims: fax: 541-225-3634
Dental Claims: fax: 541-246-1461

Provider Communication

Each contracted provider receives and has access to the PacificSource Provider Manual. Member rights and the provider's responsibilities to comply with these rights are outlined in this document.

The Provider Network department also communicates these rights to providers through provider meetings and electronic communications.

Provider Incentive Plans

PacificSource Medicare does not utilize physician incentive plans. A physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee. PacificSource Medicare does not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

Provider Monitoring and Corrective Action

Providers will be monitored to ensure they are complying with the member rights listed in the Rights and Responsibilities section of this manual. Monitoring will occur through the Grievance and Appeals process. Any complaint received regarding a possible violation of a member's rights will be logged and tracked as a Member Rights complaint. These complaints will be reviewed by the Quality Medical Management (QMM) Committee on a quarterly basis. If a provider is found to have violated a member's rights, the QMM Committee will determine appropriate corrective action.

4.4.3 Medicare Advantage Contract Addendum

PacificSource Health Plans ("PacificSource") is an Oregon nonprofit corporation and has several wholly owned subsidiaries, including one that is a Medicare Advantage Organization contracted with the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage health insurance products. PacificSource and Contractor have entered into a separate, underlying agreement (the "Agreement") whereby Contractor provides certain covered services to PacificSource members. PacificSource has entered into an agreement with one of its subsidiaries, PacificSource Community Health Plans, that is a Medicare Advantage Organization (the "MA Organization"). This Addendum is intended to apply on behalf of PacificSource and its related subsidiaries to the extent that Contractor provides services to members enrolled in a Medicare Advantage policy through a PacificSource subsidiary organization, or to the fullest extent required by CMS.

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization (or First Tier Entity) and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA").

Definitions

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

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.

Unclean Claim: A claim that is not a clean claim.

Completion of Audit: Completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees, of a Medicare Advantage Organization, Medicare Advantage Organization contractor, or related entity.

Contractor: A healthcare service contractor licensed under state and federal laws that contracts for the provision of comprehensive healthcare services for its members enrolled in various benefit plans.

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: The final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with PacificSource or applicant to provide administrative services or healthcare services for a Medicare eligible individual under the MA Organization program.

Medicare Advantage ("MA"): An alternative to the traditional Medicare program in which private health insurance companies provide healthcare benefits that those eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA Organization"): A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements. For purposes of this Addendum, the MA Organization is PacificSource Community Health Plans.

Member or Enrollee: A Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

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.

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

Required Provisions for Contractor

Contractor agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books,

contracts, computer or other electronic systems (including medical records and documentation) of the first tier, downstream, and entities related to CMS's contract with the MA organization through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. 42 C.F.R. §§ 422.504(i)(2)(i) and (ii).

2. Contractor will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. 42 C.F.R. §§ 422.504(a)(13) and 422.118.
3. Contractor agrees to not hold enrollees liable for payment of any fees that are the legal obligation of the MA organization. 42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i).
4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Contractor will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Contractor may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Contractor will: (1) accept the MA organization's payment as payment in full, or (2) bill the appropriate state source. 42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i). This paragraph does not apply to contractor who is not a provider.
5. Any services or other activity performed in accordance with a contract or written agreement by contractor are consistent and comply with the MA organization's contractual obligations. 42 C.F.R. § 422.504(i)(3)(iii).
6. The MA organization is obligated to pay or deny contractor in accordance to the prompt payment provision for clean claims and unclean claims as contained in the provider agreement. 42 C.F.R. §§ 422.520(b)(1) and (2). This paragraph does not apply to contractor who is not a provider.
7. To the extent that any payment(s) for covered services under the terms of this agreement are based, either in whole or in part, on funds obtained from any state or federal program, of any nature, those payments are subject to modification as a result of any change in state or federal law, rule, regulation, or executive order.
8. Contractor and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. 42 C.F.R. §§ 422.504(i)(4)(v).

   As applicable, if the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

   (i) The MA organization and contractor acknowledge that delegated activities are clearly outlined in the agreement, or a companion agreement specifying specific services that are delegated and the reporting responsibilities.

   (ii) CMS and PacificSource reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or PacificSource determines that such parties have not performed satisfactorily.

   (iii) The MA organization will monitor the performance of the parties on an ongoing basis.

   (iv) The credentials of medical professionals affiliated with the party or parties will be reviewed by PacificSource; or the credentialing process will be reviewed and approved by PacificSource, and PacificSource will audit the credentialing process on an ongoing basis. This paragraph does not apply to contractor who is not a provider.

(v) If PacificSource delegates the selection of providers, contractors, or subcontractor, PacificSource retains the right to approve, suspend, or terminate any such arrangement. 42 C.F.R. §§ 422.504(i)(4) and (5).

9. Contractor must comply with health plan's policies and procedures.
10. Health plan may only delegate activities or functions to contractor in a manner consistent with CMS requirements.
11. Health plan and contractor shall comply with the termination provision contained in the contract, which at a minimum must require both parties to provide a minimum of 60 days written notice to each other before terminating the contract without cause. This paragraph is not applicable if termination without cause is prohibited by the contract.
12. PacificSource advocates for open lines of communication and requires contractor to contact its contract administrator regarding any compliance issues or suspected compliance issues. PacificSource also maintains an anonymous reporting vehicle, which is accessed at: EthicsPoint.com, or toll-free 888-265-4068.

In the event of a conflict between the terms and conditions above and the terms of the underlying agreement, these terms shall control.

4.4.4 Medical Records and Chart Notes Requirements

The purpose of practitioner signatures is to indicate that the services have been accurately and fully documented, reviewed, and authenticated. The individual who ordered and/or provided services must be clearly identified in the medical records to confirm that the provider acknowledges the medical necessity and reasonableness of the service(s) that were rendered.

All medical records, chart notes, procedures, and orders submitted for review must be **signed (including credentials)** and **dated** by the rendering practitioner.

- Medical records must be signed, including credentials, and dated within 30 days of the date the service was rendered.
- Medical records must be signed prior to the submission of a claim for payment. This applies even if a service was rendered within the previous 30 days.
- A medical record that does not contain a valid signature may result in claim denials or recovery of overpayments.
- Signatures added to documentation following a claim denial will not be accepted.

This is modeled after requirements in the Centers for Medicare and Medicaid Services (CMS) *Medicare Program Integrity Manual (MPIM).* Specifically, Section 3.3.2.4 of the MPIM states:

> "For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or an electronic signature. Stamp signatures are not acceptable."

Section 3.3.2.4 of the MPIM also states:

> "Providers should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process."

PacificSource defines a "short delay" as no more than 30 calendar days from the date of service(s).

CMS guidelines state in an "incident to" scenario, the documentation should be signed by the supervising provider with a reference in the notes as to who performed the service or cosigned.

While CMS requirements do not govern commercial health plans, PacificSource has made the business decision to adopt the CMS signature requirements across all lines of business. This standard is recognized as a best practice by professional associations, such as the American Health Information Management Association (AHIMA) and the American Academy of Family Physicians (AAFP).

Acceptable Signatures

- Handwritten signatures must:
  - Appear on each entry (multiple page medical records require one signature at the end of the last page if it is clearly documented to be one encounter)
  - Be legible
  - Include the practitioner's first initial and last name, at minimum
  - Requires the practitioner's credentials (PA, DO, MD, etc.)

  PacificSource may request a signature log with any review of medical records to verify provider's signature or initials.

- Digitized/Electronic signatures:
  - The responsibility for, and authorship of, the digitized or electronic signature should be clearly defined in the record.
  - A "digitized signature" is an electronic image of an individual's handwritten signature. It is typically generated by encrypted software that allows for sole usage by the practitioner.
  - An electronic or digitized signature requires a minimum of a date stamp (preferably includes both date and time notation) along with a printed statement such as "Electronically signed by" or "Verified/reviewed by," followed by the practitioner's name and a professional designation. An example would be:
    - Electronically signed by: John Doe, MD 03/31/2023 08:42 am.

Unacceptable Signatures

- Signature "stamps"
- Missing signature on dictated and/or transcribed documentation
- "Signed but not read" notations
- Illegible lines or marks

Attestations

PacificSource will permit the use of an attestation form when a **signature** and **date** have been inadvertently omitted. However, patterns or consistent use of attestation in place of signed records may lead to further investigation of claims data, denial of claims, audits, overpayment recovery, or escalation of claims for fraud review. This is consistent with the fraud referrals information from CMS Pub 100-08, Medicare Program Integrity.

Amended Medical Records

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum, or a correction to the medical record bears the current date of that entry and is signed by the person making the addition or change.

- Late Entry: A late entry supplies additional information that was omitted from the original entry. The new entry should be identified as a "late entry." The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information, validates the source of additional information as much as possible (where you got the information to write the late entry), and is signed or initialed.
- Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record, and be signed or initialed by the person making the addendum.
- Correction: When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, referring to the original entry.
  - Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change, and initials of person making the correction. When a paper copy is generated from an electronic record, both records must be corrected. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Corrections to the medical record legally amended prior to claims submission and/or review will be considered in determining the validity of services billed. If changes appear in the record following payment determination based on prior review, only the original record will be reviewed in determining payment of services billed to PacificSource.

4.5 Call Share Policy

In-network providers 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. Dental providers can refer to the manual provided by your DCO.

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

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

PacificSource maintains call share group listings. Any changes in call share must be forwarded to the Provider Relations department. If there is any change in a call share group, please call Provider Relations as soon as possible at 541-684-5580 or 800-624-6052.

4.6 Accessibility

PacificSource has established timely access standards of care related to primary care, emergent/urgent care, and behavioral health care. Provider Network may measure compliance with those standards, as further described below, by conducting monthly access surveys and site visits, and monitoring member complaints.

For commercial and Medicare members, the following access standards apply.

4.6.1 Behavioral Health Services

Behavioral health providers will accept behavioral health appointments for:

- Initial visit for routine care within ten working days
- Routine follow-up care within four weeks
- Urgent care services:*
  - Within 48 hours or two business days
  - Within next calendar day (Washington commercial only)
- Non-life-threatening emergency care, contact or referral to emergency services or behavioral crisis unit within six hours*
- After-hours care should include 24-hour phone availability (answering machine or service advising patients of care options)*

*PacificSource members have direct access to behavioral health services by calling your office or going to the emergency room.

4.6.2 Primary Care Provider Services

Primary care providers will accept office appointments for:

- Routine follow-up care (such as annual physicals, immunizations, and annual gynecological exams) within four weeks in Oregon, Idaho, Montana, and Washington
- Routine care (such as colds, rashes, headaches, and joint/muscle pain) within 15 working days
- Urgent care (high fever, vomiting, etc.) within 48 hours
- Emergency care services immediately
- After-hours care should include 24-hour phone availability (answering machine or service advising patients of care options)

4.6.3 Specialty Care Providers

Specialty care providers will accept appointments for:

- Routine care within 30 business days
- Non-urgent care initial visit scheduled within 30 business days of referral, appointment does not need to occur within 15 days (Washington commercial only)
- After-hours care should include 24-hour phone availability (answering machine or service advising patients of care options).

4.6.4 Medicaid Access to Care Standards

PacificSource Community Solutions has established timely access standards of care related to physical health services, behavioral health care services, and oral and dental care services.

Providers participating with PacificSource Community Solutions are required to have the ability to treat all members in person within the standard timeframes below.

The following access standards are specific to availability for all new and established Medicaid members pursuant to OAR to 410-141-3515.

Physical Health Services:

Physical health services for all new and established Medicaid members include primary care services and specialty care unless otherwise specified.

- Wellcare appointments—Within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870 (annual physicals, pediatric/adult immunization, and annual GYN exams)
- Urgent care appointments—Within 72 hours or as indicated in initial screening, in accordance with OAR 410-141-3840 (high fever, vomiting etc.)
- Emergency care services—Immediately, or referred to an emergency department, depending on the member's condition
- After-hours care—24-hour phone available (call share or answering machine/service advising members of care options; see Call Share Policy section for more about call sharing)

Behavioral Healthcare Services:

- Urgent behavioral health care for all populations—Within 24 hours*
- Routine behavioral healthcare for nonpriority populations—Assessment within seven days of the request, with a second appointment occurring as clinically appropriate
- Specialty behavioral healthcare for priority populations:*
  - Pursuant to OAR 309-019-0105 and 410-141-3515. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist, and provided interim services within 72 hours of being placed on the waitlist.
  - Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135 (Entry and Assessment).
  - Pregnant women, veterans and their families, women with children, unpaid caregivers, families and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist.
  - IV drug users, including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must begin within 120 days from placement on a waitlist.
  - Opioid use disorder: Assessment and entry within 72 hours.
  - Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry.
  - Children with serious emotional disturbance as defined in 410-141-3500 (Definitions): Any limits that the Authority may specify in the contract or in sub regulatory guidance.
- After-hours care—24-hour phone available (call share or answering machine/service advising members of care options). See Call Share Policy section for more about call share.

*All PacificSource Community Solutions members have direct access to behavioral health services by calling their provider's office or going to the emergency room.

Oral and Dental Care Services:

- Routine oral care
  - Children and non-pregnant members—Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate
  - Pregnant members—Within four weeks, unless there is a documented special clinical reason that makes a period longer than four weeks appropriate
- Urgent dental care:
  - Children and non-pregnant members—Within two weeks
  - Pregnant members—Within one week
- Emergency oral care—Seen or treated within 24 hours

If a provider must cancel an appointment, the provider must make a good-faith effort to contact the member and reschedule for a later time.

PCPs are encouraged to contact specialty providers directly for urgent patient needs. If a member has an urgent or emergent need and the listed primary care provider is unavailable, alternative treatment access should be made available for the member.

Practitioners are encouraged to maintain several open, same-day appointments for any urgent/ same-day needs.

Provider Network will measure compliance with the above standards by conducting monthly access surveys and site visits, and monitoring member complaints. All measured data is analyzed and reviewed by the QI Committee. 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.

4.7 Providers

4.7.1 Primary Care Providers

When a provider is practicing within a Patient-Centered Primary Care Home and/or chooses to be designated as a primary care provider (PCP) under a benefit plan requiring a PCP, they agree 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.

The primary care provider is also responsible for the following:

- Medicaid plans require PCP designation
- 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
- For Medicaid, the primary care provider will notify once per quarter their Provider Relations Representative of their maximum capacity. (Note: any capacity of 1,000 or more requires supporting documentation to understand how calculations were determined.)

- For Medicaid, provider or provider groups will notify their assigned Provider Relations Representative of any PCP changes that will be occurring. All changes need to be submitted in writing prior to the effective date of the change. These notifications must be received within 30 days of the effective date change. Delayed notices received outside of the date requirements can have an impact on providers or provider groups with Capitated agreements. Provider or provider groups will need to work with their assigned Provider Relations Representative. Delayed notice cases will require Provider Network leadership to review for approval. Delayed case determinations will be communicated by the assigned Provider Relations Representative in writing. Providers with multiple delayed cases are subject to corrective action.
- For D-SNP, providers must complete D-SNP training upon onboarding, then annually thereafter, and participate in Integrated Care Team (ICT) meetings to address member care needs.

Please see the Referrals section for complete referral requirements.

4.7.2 Responsibilities

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 an in-network women's healthcare specialist.
- **Medicaid:** 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.
- **Medicaid:** The PCP or specialist provider must contact PacificSource Community Solutions for prior authorization or referral to an out-of-network specialty provider. To determine if a prior authorization is required, please visit our Provider Authorization Grid and LineFinder tool.
- **Medicaid:** Primary care providers providing EPSDT services shall enter into a signed written agreement with the member or their representative by which the member or their representative agrees for the Provider to be the member's regular source for EPSDT services for a stated period of time, including oral health services as indicated by EPSDT screenings or a referral for such services. Primary care providers providing EPSDT services shall comply with OHA reporting requirements. For additional information on EPSDT services, please visit Oregon Health Authority: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program: Oregon Health Plan: State of Oregon.
- The PCP will coordinate care and share appropriate medical information with PacificSource and any specialty provider to whom they refer their patients.
- **Medicaid and Medicare:** 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.
- **Medicaid:** PacificSource covers second opinions. If a member wants a second opinion about their treatment options and the provider is out-of-network, they will need to consult with their PCP or specialty provider to get an approval (prior authorization). 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 patients' records that an individual has executed an Advance Directive and/or a Declaration of Mental Health Treatment if one exists.
- Provider or provider groups will notify their assigned Provider Relations Representative of any PCP changes that will be occurring. All changes need to be submitted in writing prior to the effective date of the change. These notifications must be received within 30 days of the effective date

change. Delayed notices received outside of the date requirements can have an impact on providers or provider groups with Capitated agreements. Provider or provider groups will need to work with their assigned Provider Relations Representative. Delayed notice cases will require Provider Network leadership to review for approval. Delayed case determinations will be communicated by the assigned Provider Relations Representative in writing. Providers with multiple delayed cases are subject to corrective action.

- **Dual Special Needs Plan (D-SNP)**: All PCP and specialist providers who see D-SNP members must complete training on the Model of Care (MOC) upon onboarding then annually thereafter. This training can be completed through our training platform PacificSource.MyAbsorb.com/?KeyName=DSNPMOC. PacificSource will monitor to ensure all providers seeing D-SNP members have completed this required training.

Also see section on Referrals.

Medicare: Continuity of Care and Monitoring

Referral providers are responsible to ensure that relevant medical, mental health, and/or dental information is sent to the referring primary care provider (including telephone referrals). The referral needs to be documented in the member's clinical record by both the referral provider and referring provider. The PCP is responsible to document denial or acceptance of the referral in the PCP's clinical record for the member.

- The referring provider (PCP) is responsible for reviewing the information sent by the referral provider, and for entering that information into the member's clinical record.
- If a PacificSource Medicare member is seen in an emergency room, the hospital is responsible for sending those ED records to the PCP. The PCP is responsible for ensuring all emergency visit records are entered into the PacificSource Medicare member's PCP's clinical record.
- If a PacificSource Medicare member is hospitalized in an inpatient or outpatient setting for a covered service, the hospital is responsible for immediately notifying the PCP with the reason, date, and expected duration of the hospitalization and discharge date. The PCP is responsible for documenting this information in the PCP's clinical record for the PacificSource Medicare member. This will include follow-up plans, including appointments for provider visits. The hospital is responsible for sending the PCP pertinent reports from the hospitalization. The PCP is responsible for making sure this information is entered into the PCP's clinical record for the PacificSource Medicare member.
- PacificSource Medicare will monitor provider records of our members to ensure information from emergency department visits, hospitalizations, and referral appointments are documented in the member's medical record and reviewed by the referring provider.

Change of Information

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

- Moving practice to a different location
- Moving out of the PacificSource service area
- Closing practice
- No longer participating on the panel/network
- PCP dismisses member from care
- Phone number
- Tax ID number
- Billing address
- Physical office address
- Provider leaving
- MAP, UPIN, 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: ProvNetSup@PacificSource.com

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.

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 their 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 they are an established patient of a physician or provider. In such instances, the insured will be notified by mail and asked to select a new PCP.

Primary care providers 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.

Applicability of State and Federal Laws

As a federal contractor, PacificSource Community Solutions and PacificSource Medicare receive federal funds to provide services to our members. As an in-network provider providing services to PacificSource Community Solutions or Medicare members, you are subject to laws applicable to individuals and entities receiving state funds. In-network providers who treat our members are required to comply with applicable state and federal laws and regulations regarding Medicaid or Medicare.

4.7.3 Medicaid and Medicare: Availability Practice

In-network providers agree to accept new patients unless their practice has closed to new patients. Please notify PacificSource 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, and do not discriminate against Medicaid or Medicare members.

In-network providers agree to provide 24-hour, seven-days-a-week coverage for Medicaid or Medicare members in a culturally competent manner and in a manner consistent with professionally recognized standards of healthcare. The provider or their 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 will make every attempt to communicate to our members any closed or limited practice when notified by the PCP in writing of their 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:

- PacificSource Community Solutions: 541-382-5920 or 800-431-4135
- PacificSource Medicare: 541-385-5315 or 888-863-3637

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.

Medicaid: 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

Medicare: You may call PacificSource Medicare and ask for the PacificSource Medicare Clinical Quality department at 888-863-3637.

If you prefer to write a letter, please mail it to the following address:

PacificSource Medicare
Attention: Clinical Quality Department
PO Box 7469
Bend, OR 97708

Medicare: Continuity of Care Standards

PacificSource Medicare and provider will ensure continuity of care and integration of services through provider medical record review with contracted providers.

Provider Medicare Record Reviews (PMRR) are conducted annually on Medicare providers who are PCPs (general medicine, family medicine, internal medicine who act as PCPs, and pediatrics). Reviews are scheduled the year prior to the provider's recredentialing. One of the elements of the review is the member chart. It must contain evidence of continuity and coordination of care. This can include follow-through from one appointment to another and review or discussion of consult notes or recommendations. The goal of the review is to verify that provider documentation in the member medical record is in accordance with professional standards and CMS regulatory requirements.

Medicare: Marketing

Provider will not distribute any marketing materials to Medicare members unless such materials have been approved by PacificSource Medicare. The provider will comply with all aspects of the CMS marketing requirements, including prohibition on marketing activities.

Medicaid: 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 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.

Medicare and Commercial: 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 properly terminated for any of these reasons:

- 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, the physician must take all of the following steps:

- Give patient reasonable notice of intent to withdraw
- Provide the patient with reasonable time to find alternative care
- Continue to be available 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.

Medicaid: Termination of Patient Care

Provider must send notice to PacificSource Community Solutions 30 days prior to member dismissal.

A member cannot be dismissed by their primary care physician for any of the following reasons:

- Due to a physical, intellectual, developmental, or mental disability
- Due to an adverse change in the member's health
- Due to the member's utilization of services, whether excessive or minimal
- Because the member requests a hearing
- Because the member exercises their right to make medical decisions that the PCP disagrees with
- Due to uncooperative or disruptive behavior resulting from the member's special needs

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 the member 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 on our ability to either terminate the member from our plan or to locate another network provider willing to accept the member as their patient within a 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.

Providers will notify PacificSource in writing of a member's uncooperative or disruptive behavior, describing the behavior, and allow time for appropriate resolution prior to any refusal to provide services. This notification shall be documented by the provider in the member's medical record.

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

Medicaid: Patient Waivers

There are Oregon Administrative Rules, 410-120-1280 (Billing) and 410-141-3540 (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/hsd/ohp/pages/policies.aspx. The Oregon Health Authority (OHA) and PacificSource Community Solutions require that our members receive advance written notification that a specific service is not covered. The OHA prohibits providers from asking OHP members to sign a general waiver.

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 that 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 MAP 3165. This is available at our website.

Advance Directives

Providers shall provide training of their staff on policies and procedures regarding Advance Directives. Information provided will include important information about Advance Directives, that they are designed to enhance an incapacitated individual's control over medical treatment, and will describe applicable state law concerning Advance Directives. All providers will document their educational efforts.

If an enrollee is incapacitated at the time of initial enrollment and unable to receive information due to an incapacitating condition, the provider will give Advance Directive information to the enrollee's family or surrogate.

Once the enrollee is no longer incapacitated, the provider will provide Advance Directive information directly to the enrollee.

Medicaid: 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 (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 Consent to Sterilization Form 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
- Is seeking or obtaining an abortion
- Is under the influence of alcohol or drugs
- Has 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/hsd/ohp/pages/forms.aspx.

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

Medicaid: Hysterectomy Consent Forms

PacificSource Community Solutions requires physicians to obtain a signed MAP Hysterectomy Consent form prior to surgery. There is no required waiting period between signing a MAP Hysterectomy consent form and surgery. Please note, hysterectomies for the sole purpose of sterilization are 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 requiring 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 the physician 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 MAP 741 form can be found in the MAP Medical Surgical Guide (OAR 410-130-0760) or online at Oregon.Gov/OHA/HSD/OHP/Tools/Medical-Surgical%20Services%20Provider%20Guide.pdf.

Contact your Provider Relations Representative at 541-684-5580 or 800-624-6052, for information or questions concerning the above topic.

Advance Directive and Declaration of Mental Health Treatment

These documents allow patients to direct their healthcare 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 PacificSource Customer Service or online:

Advance Directive: Oregon.gov/OHA/PH/ABOUT/Pages/ADAC-Forms.aspx

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

4.7.4 Health Insurance Portability and Accountability Act (HIPAA)

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

PacificSource endeavors 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 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 faxed to PacificSource. PacificSource uses a fax system that is secure and only authorized personnel have access to the information. Email should only be used when information is sent through an encrypted and secure email system.

The Notice of Privacy Practices that is available to all PacificSource members is available on our websites. If you have any questions or concerns, please contact your Provider Relations Representative.

4.8 Traditional Health Worker (THW) Services (Medicaid)

Traditional Health Workers (THW) are available to help connect members to a broad range of services to support their health and wellness. Listed below are different types of THWs accessible to members.

- Birth doulas: Assist women and their families with prenatal, childbirth, and postpartum care.
- Personal Health Navigators (PHN): Provides information, assistance, tools, and support to enable a patient to make the best healthcare decisions.
- Peer Support Specialists (PSS): Including Family Support Specialists, Youth Support Specialists, and Recovery Mentors, focus on recovery from addiction/mental health conditions.
- Peer Wellness Specialists (PWS): Focus on recovery from addiction/mental health and physical conditions.
- Community Health Workers (CHW): Assist individuals and their community to achieve positive health outcomes.

The Member Support Specialist (MSS) Team at PacificSource has Personal Health Navigators (PHN) who are available to help members:

- Understand how PacificSource works
- Answer questions about their medical, dental, and behavioral health benefits
- Connect to community resources
- Connect to healthcare providers to schedule visits
- Assist with transportation to medical visits

If you would like to talk with a Personal Health Navigator, or connect with local community THW services, please call 541-330-2507 or 888-970-2507 (toll-free).

4.9 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. You can submit appeals through the provider portal, InTouch for Providers, and review all related documents in the Documents and Forms section of our website.

4.9.1 Commercial Appeals

PacificSource Health Plans Statement of Principles

PacificSource understands that at times our members, physicians, and providers may have questions or concerns about decisions made by our staff. Our policy is to fully and impartially document, investigate, and resolve concerns, including any issues relating to clinical care, and to notify all affected parties in a timely manner. When a contract dispute arises between a provider and PacificSource, resolution will be attempted by informal meetings and discussions in good faith between appropriate representatives of both parties. This procedure does not apply to grievances about adverse benefit determinations or claim or preclaim issues (Provider Appeals (commercial)), nor does this procedure apply for a termination of a provider contract "for cause." All grievances and appeals will be handled and reviewed in accordance with the written policies and procedures governing PacificSource's Grievance and Appeals process.

PacificSource has two separate procedures for addressing and resolving grievances and appeals. However, prior to filing any grievance, we encourage all providers to call our Customer Service team or their assigned Provider Representative. We are often able to resolve concerns or inquiries over the phone without further action being required.

Procedure 1: Provider Appeal

PacificSource recognizes the right of a provider to file an appeal as it relates to adverse benefit determinations involving medical necessity or procedures or services which are considered by PacificSource to be experimental and/or investigational, or other determinations by PacificSource related to a claim, including but not limited to the amount of payment determined by PacificSource. Providers are entitled to a single level of review. The provider should submit a written appeal to PacificSource which identifies the member, the procedure or service at issue, and specifies the provider's reasoning for requesting PacificSource reverse the determination. Except as expressly provided otherwise in the provider's reimbursement agreement with PacificSource or by applicable law, the provider has 180 days to initiate a first-level appeal of an adverse benefit determination and 365 days to initiate a first-level appeal of any other determination related to a claim. The time to appeal will start on the day the provider receives notice of the subject determination. PacificSource will investigate and respond to the provider, in writing, within 30 days of receipt of the appeal. Failure by the provider to initiate an appeal of a determination by PacificSource, including but not limited to the amount of payment on a claim, in accordance with the foregoing requirements, constitutes the provider's acceptance of the determination.

Procedure 2: Member Appeal

PacificSource provides its members with a two-level internal appeal system. The member may designate an authorized representative (such as a provider, agent, or attorney) to pursue an appeal on their behalf.

First Level of Review

The first level of review starts with a written appeal from the member disputing an adverse benefit determination made by PacificSource, and requesting it be overturned. PacificSource will fully and impartially investigate the appeal, including any aspects of clinical care which may be involved, and will provide the member or the member's authorized representative with a written determination concluding the appeal.

Second Level of Review

The second level of review involves a written appeal of the decision reached by PacificSource at the first level. When a member or authorized representative finds the earlier decision unacceptable, they have the right to appeal. To do so, the member or authorized representative must submit a written statement requesting PacificSource to review and reverse their decision. PacificSource will fully and impartially investigate the appeal, including any aspects of clinical care which may be involved, and will provide the member or the member's authorized representative with a written determination concluding the appeal.

How to Submit Appeals

The member or authorized representative may file an appeal by:

- Writing to PacificSource, Attn: Grievance Review, PO Box 7068, Springfield, OR 97475
- Emailing a message to NewAppeal@PacificSource.com with "Appeal" as the subject
- Faxing a message to 541-225-3628

If you are unsure how to prepare an appeal, please contact our Customer Service department by phone at 888-977-9299, or by email at CS@PacificSource.com. We will help you through the appeal process and answer any questions you may have.

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 appeal process.

4.9.2 Medicaid Appeals

A provider appeal guide is available online at CommunitySolutions.PacificSource.com. For any questions, please contact Appeals & Grievances (A&G) at 541-330-4992. Members have the right to a hearing if a ruling is upheld by Appeals & Grievances.

As an in-network 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., prior authorization 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 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 timeline (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.

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 person
- Contact's phone/fax number
- Claim or prior authorization 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 Appeals & Grievances department via fax at 541-322-6424. Please refer to the Provider Appeal Form for mailing options.

Prior Authorization Appeals

PacificSource Community Solutions will accept timely prior authorization appeals if you believe that additional information 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.

We process prior authorization 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. When the plan accepts a request to expedite a review, a coverage response will be issued within 72 hours of receipt.

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/Providers/DocumentsAndForms or via InTouch. Please fill these out completely, with the following minimum information:

- Member name/identification number
- Provider name and contact person
- Contact phone/fax number
- Prior authorization 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.

We process appeals 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 of your request.

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

Claim Appeals

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

- Member name/identification number
- Provider name and contact person
- Contact phone/fax number
- Claim number
- Date of service
- Reason for the appeal (why you believe the claim 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.

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), the member may file an appeal on their 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 rebill via the appeals process. In these cases, it is more appropriate to contact the Claims Department with a "rebill" or "corrected claim" submission.

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 timeframe may be extended if the reviewer requires additional information to make a determination.

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 that have denied due to timely filing and/or coding reasons, a noncontracted provider may resubmit through the rebill process with supporting documentation, such as a clearinghouse report or corrected claim.

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 their 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.

4.9.3 Medicare Appeals

A provider appeal guide is available online at Medicare.PacificSource.com/Providers/AppealsGuide. For any questions, please contact a Provider Services Representative at 541-684-5580 or 800-624-6052.

As an in-network provider, you agree to adhere to PacificSource Medicare's appeal procedures.

You have the opportunity to request that PacificSource Medicare reconsider a coverage decision that affects you adversely, such as a denial of claim payment, or as a patient advocate for a coverage denial. This is exercised via the Provider Appeal process.

If you fail to submit a complete and timely appeal, PacificSource Medicare will presume that you have accepted our coverage determination and have waived further appeal processes regarding the issue.

All appeals must be received by PacificSource Medicare within 65 calendar days of the coverage determination date (i.e., Explanation of Payment or Denial of Medical Coverage). PacificSource Medicare may consider exceptions to the filing timelines within reasonable limits if you can show "good cause" that prevented timely filing due to circumstances beyond your control. Please provide this information with your appeal.

Untimely appeals without "good cause" are dismissed without review.

Upon receipt, we will send you a notice to acknowledge your appeal. This provides direct contact information should you have any questions or wish to provide additional information during the review process.

Prior Authorization Appeals

If the appeal involves utilization management issues, please note we will only reconsider a noncoverage decision if you provide additional information (not previously reviewed by PacificSource Medicare) that you believe will impact our original decision. Submit your request using the PacificSource Medicare Provider Appeal Form, available online at Medicare.PacificSource.com/Providers/AppealsGuide. Please fill it out completely. It should include the following minimum information:

- Member name/identification number
- Provider name and contact person
- Contact phone/fax number
- Prior authorization number
- Service or item denied
- Reason for the appeal (why you believe the service should be covered in detail)
- Any pertinent clinical information or related documentation that would be of assistance in reviewing the request and supporting the reasons for reversing the noncoverage decision.

The appeal form includes mailing and fax information.

Your appeal should include supporting medical information to support a change in decision. Appeals based on a denial of coverage as experimental/investigational should also include peer-reviewed literature supporting your position. Appeals that indicate disagreement with a coverage decision without providing information to support further review may result in an unchanged decision.

We process appeals as quickly as possible. This may take up to 30 calendar days. A review may be expedited if a physician requests it with clear indication that waiting up to 30 calendar days to receive a coverage decision may place the patient's health in jeopardy. **When PacificSource Medicare accepts a request to expedite a review, a coverage resolution will be issued within 72 hours of receipt of your request.**

If a prior authorization was denied because the PacificSource Medicare reviewer requested additional documentation but did not receive it in a timely manner, please consider submitting a new prior authorization request. With your new request, include the additional information requested and clearly indicate that you request a reopening of your authorization request with new information.

This is the only level of appeal available to providers who are not the member's treating physician. Prior authorization appeals submitted by a member's treating physician on behalf of the member will follow an automatic second-level review process if the noncoverage decision is upheld. The treating physician will be advised via the resolution letter when a second-level review is taking place. If you are a treating physician filing on behalf of the member, CMS requires that you provide notice to the member that you are appealing the noncoverage decision.

Prescription Coverage Appeals

If the appeal involves a Part D prescription issue, please submit your request using the PacificSource Medicare Provider Appeal Form. If you are the prescriber, you can also use the Request for Redetermination of Medicare Prescription Drug Denial Form. Both forms are available online at Medicare.PacificSource.com/Providers/AppealsGuide. Please fill these out completely, with the following minimum information:

- Member name/identification number
- Provider name and contact person
- Contact phone/fax number
- Prior authorization number
- Prescription denied
- Reason for the appeal (why you believe the prescription should be covered in detail)
- 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.

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

When a prior authorization has been denied because PacificSource Medicare requested additional documentation, but did not receive it in a timely manner, please consider submitting a new prior

authorization request instead of an appeal. Include the additional information requested and clearly indicate that you request a reopening of your authorization request with new information.

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

Claim Appeals

If your appeal involves claim nonpayment ($0 payment) issues, please include clear documentation that will help us research the claim in question. You can include a copy of the original claim, the Explanation of Payment, and any records that support your argument for payment. Submit your request using the PacificSource Medicare Provider Appeal Form, which is available online at Medicare.PacificSource.com/Providers/AppealsGuide. Please fill it out completely. It should include the following minimum information:

- Member name/identification number
- Provider name and contact person
- Contact phone/fax number
- Claim number, including date of service
- Service or item denied
- Reason for the appeal (why you believe the service should be covered in detail)
- 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

The appeal form includes mailing and fax information.

Claims denied for reasons such as invalid coding, invalid place of service, duplicate claim, etc., should not be submitted via the appeals process. In these cases, it is more appropriate to contact the Claims department with your reconsideration or "corrected claim" request. PacificSource Medicare makes available our prior authorization requirements via the online Authorization Grid. However, typical claim appeals involve denials based on lack of prior authorization. Examples of appeals that may result in upheld denials include:

- Provider used an incorrect authorization grid, or ignored prior authorization requirements.
- Provider did not confirm member's coverage prior to provision of services, and was unaware of, or did not follow prior authorization requirements.
- Provider's records indicate accurate coverage information. However, staff did not contact PacificSource Medicare to obtain a prior authorization.
- Provider failed to call with utilization review and notification of an inpatient admission.
- The treating provider indicates the referring provider did not obtain a prior authorization. PacificSource Medicare considers that it is the responsibility of both providers to confirm prior authorization.

This is the only level of appeal available to contracted providers.

Appeal Resolutions

Reviewers who were not involved in the initial coverage decision participate in the appeal review. A resolution will be issued in writing within 30 calendar days of receipt of the appeal for preservice appeals; 60 days for postservice (claim) appeals for a standard review; seven calendar days for a Part D

prescription review; and 72 hours for an expedited review. These timeframes may be extended if the reviewer requires additional information to make a determination or if the provider or member requests it.

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

Noncontracted Providers

The Center for Medicare and Medicaid Services (CMS) has provided an avenue by which noncontracted providers may dispute the amount of reimbursement made by the plan for a covered service. These include any decisions where a noncontracted provider contends that the amount paid by PacificSource Medicare for a covered service is less than the amount that would have been paid under Original Medicare. Provider payment disputes also include instances where there is a disagreement between a noncontracted provider and the plan about the plan's decision to pay for a different service than that billed, often referred to as down-coding of claims.

This process is not available to plan-contracted providers.

The Noncontracted Providers Claims Payment Dispute Process is available at Medicare.PacificSource.com/Providers/AppealsGuide.

5. Referrals

5.1 Referral Policy

Commercial Member Referrals

Most PacificSource commercial plans do not require a referral from a primary care physician to see an in-network specialist; however, there are some exceptions. Please refer to the member's health insurance card for verification.

Medicaid Member Referrals

As of January 1, 2021, PacificSource Medicaid plans do not require a referral to see an in-network provider. However, the reason (condition or diagnosis) for the visit must be for a covered service. There are also visit limits if the patient is seen for the same condition or diagnosis; the limit is once every 30 days with a PCP and once every 12 months with a specialist. There may be situations where the patient's condition is not limited to visits.

Referrals for out-of-network providers are considered a prior authorization.

Medicare Member Referrals

PacificSource Medicare Advantage plans do not require a referral to see an in-network provider. Referrals for out-of-network providers are considered a prior authorization.

5.2 Referral Procedure

Please see the prior authorization section for details regarding prior authorization guidelines. When the services of a specialist are necessary, the primary care provider (PCP) requests a referral to a panel specialist through the Health Services department or managed care office. The referral coordinator issues approval or nonapproval for the referral and communicates the decision to the member, PCP, and specialist.

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. 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 800-624-6052 or by email at ProvNetSup@PacificSource.com.

5.4 Out-of-Network Referrals

Requests to see an out-of-network provider, including for second opinions, must be submitted via the prior authorization process and are not considered a referral. For referrals to a noncontracted provider, PacificSource 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)
- Infertility treatment and care
- Some immunizations (shots)

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 email at CS@PacificSource.com.

5.5 Referrals That Are Not Approved

When Health Services or the delegated managed care entity does not approve a referral request, the PCP, specialist, and member are notified by mail or fax. It is the PCP's responsibility to discuss other options with the member. Appeal rights will be included with the determination, and the PCP or member may appeal the decision in writing by submitting supporting documentation 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/network
- Member has self-referred

PCPs are expected to discuss referrals that are not approved with their patients. Members have the right to appeal through PacificSource. Also see Provider Appeal under Appeals Process in the Credentialing section.

5.6 Retroactive Referrals

We realize there are sometimes instances when a referral may not have been in place prior to services being rendered; this should be the exception and not the rule. Please contact your PacificSource Provider Relations Representative in these instances and we will assist you in this process.

6. Medical Management

6.1 Medical Necessity and Coverage

Services must be medically necessary to be eligible for reimbursement. "Medically Necessary" and "Medical Necessity" are terms PacificSource uses to define procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury or disease of its symptoms, and that are:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the convenience of the patient, physician, or other healthcare provider.
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the disease or injury involved and the patient's overall health condition.
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, evaluation, diagnosis, or treatment of the patient's illness, injury, or disease or its symptoms.

A service or supply that is ordered or given by a provider does not in itself make it medically necessary.

Medical necessity determinations are not made arbitrarily. When a PacificSource claims adjudicator reviews a claim, we compare the treatment with the usual treatment provided by physicians and/or providers and hospitals to patients having similar conditions. Services are checked for correlation with the diagnosis or problem.

When the adjudicator cannot match the services with the diagnosis, or when the length of stay seems inappropriate for the diagnosis given, the claim is referred to our Health Services department. A staff of licensed clinicians, under the direction of the Chief Medical Officer will research and review the medical necessity. Chart notes and supporting documentation may be requested to complete the review process. If a discrepancy remains, the issue may be referred to the Medical Director or Assistant Medical Director for review. Members and providers have the right to appeal.

Behavioral Health treatment that is court ordered or required by a third party must also meet medical necessity criteria and will not be approved solely on the basis of court order or third-party requirement.

Culturally, Linguistically, and Medically Appropriate Services

PacificSource Community Solutions covers and coordinates payment for out-of-network services when the CCO is unable to provide covered services that are culturally, linguistically, and medically appropriate. These services will require prior authorization. Please utilize the notes field to indicate the out-of-network service is being requested to meet a need that is unable to be met with an in-network provider.

Medicaid: 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.

Medicaid: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

PacificSource Community Solutions cover the full scope of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, also known as EPSDT. Members under the age of 21 or members of the Young Adults with Special Health Care Needs (YSHCN) program are covered under the EPSDT benefit. EPSDT offers comprehensive and preventive health care services to EPSDT Beneficiaries and includes all services coverable under the Oregon Health Plan (OHP), when EPSDT Medically Necessary and EPSDT Medically Appropriate, regardless of placement on the Prioritized List. Providers should submit documentation supporting medical necessity and medical appropriateness with any request for authorization.

Medicaid: Women's Health Services

Women's health services are organized services to provide healthcare to women. Female members have direct access to an in-network women's health specialist for routine and preventive healthcare services in addition to the member's source of primary care if that source is not a women's health specialist.

This includes but is not limited to:

- Annual exams, including breast and pelvic exams with additional exams covered, when appropriate
- Family planning services, including, contraceptive supplies such as patches, birth control pills, intrauterine devices (IUDs), and emergency contraception
- Sterilization (tubal ligations and vasectomies) – Hysterectomies are not covered as part of family planning
- Diagnostic services: radiology and laboratory testing, including sexually transmitted disease (STD) testing and cancer screenings
- Education and counseling for birth control and STDs, including AIDS and HIV
- Routine and preventive maternity care

Abortion services are covered through OHA (Visit OHA Reproductive Health Client Services — What can I get?)

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 Care Management team.

Complex care management services are provided by PacificSource to members at no additional cost.

Members enrolled in the Complex Care Management program typically have extensive and intensive healthcare needs such as, but not limited to, one or more of the following:

- Spinal cord injury/trauma
- Eating disorders
- Amyotrophic lateral sclerosis (ALS-Lou Gehrig's Disease)
- Acute or chronic conditions requiring specialized treatment programs
- All pediatric cancer cases
- Selected adult cancer
- Cases with frequent ER visits or inpatient hospitalizations
- Inpatient re-admissions (within 30 days)
- 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 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 leads to an Inpatient Admission; or has multiple inpatient stays at the same facility within a year (five or more); or has multiple ED visits at the same facility within a year (four or more)
- Complex medical condition and social determinants of health causing severe obstacles to care

The following commercial members are identified for Complex Care Management (CCM) program participation:

- High-risk members with a primary diagnosis of Diabetes, experiencing three or more chronic conditions and who have had an inpatient stay within the past six months
- High-risk members with multiple conditions and/or barriers to care identified during an inpatient stay and anticipated to require extensive resources CCM Identification List
- High-risk individuals referred through the premanage process and requiring case management services anticipated to last 60 days or greater
- Multiple admissions, readmissions, and emergency department visits, not captured by the premanage process
- Individuals requiring a prior authorization for inpatient services with a behavioral health diagnosis of SPMI
- Individuals requiring a prior authorization for services with a medical diagnosis of ALS.
- Traumatic brain injury, spinal cord injury, or multi trauma identified by an inpatient event anticipated to require extensive rehabilitation

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."

Support Team

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.

Members enrolled in Complex Care Management engage frequently with an assigned clinician who works with the member on a mutually agreed upon set of health-related goals and outcomes.

Care management services are designed to help members who may require assistance with transfers from hospital to home, home health, home infusion, skilled nursing facility, or acute inpatient rehabilitation. They can also help with other questions related to health-related concerns, new diagnoses, finding an appropriate provider, etc.

When care management services are initiated, PacificSource will work with the patient's physician or provider on a case-by-case basis. Care management interventions support the provider-patient relationship, identify and facilitate removal of barriers to good self-management, and promote adherence to the prescribed treatment plan.

PacificSource reserves the right to delegate a third party to assist with, or perform the function of, care management. PacificSource will have final authority in all case management decisions.

Payment of benefits for supplemental services is at the sole discretion of PacificSource and may be made as a substitute for other covered benefits based on PacificSource's evaluation of the member's particular case. PacificSource may limit payment for supplemental services to a specific period of time.

Members may request complex care management services by contacting our Care Management team. To speak with someone regarding care management, please contact us.

Commercial, Medicaid, Medicare

Phone: 888-970-2507
Fax: 541-385-3123
Email: MSS@PacificSource.com

Role of PacificSource Clinician

It is the responsibility of the care manager to:

- Monitor all aspects of care both requested and dispersed.
- Coordinate care in cooperation with the PCP and other plan providers, providing assistance as needed.
- Evaluate alternatives to care.
- Document care information and actions taken.
- Develop a care management problem list.
- Coordinate a member's medical care with community resources.
- Educate members as appropriate about disease processes, procedures and treatments, and appropriate use of plan resources.

Member education is provided on a variety of topics and may include general information about disease processes, an analysis of medication usage for compliance and contraindications, or plan-specific information on routine preventive health screening, as well as screening for disease-related complications. Member education may occur in a variety of settings using a number of different resources, depending on member need and level of understanding:

- Cost-effective, evidence-based educational resources will be utilized on a case-by-case basis.
- Where possible, members will be apprised of disease-specific, community-based educational opportunities. This information will be made available in the quarterly newsletter to members and other sources as developed.
- Disease prevention and disease-specific information will be included in the quarterly newsletter to members.
- One-on-ones will be conducted with clinicians.

Care management is a collaborative process. The PCP relationship with the member is a vital resource necessary to adequately develop a plan of care.

Member Support Specialists

Member Support Specialists work in collaboration with Clinicians, the member's PCP, and community partners. They assist with the member's healthcare needs, identify gaps in care, address social determinants of health, and assist in resolving barriers to access. The Member Support Specialist may make referrals to our internal specialists, such as nurse care managers, pharmacists, and behavioral health staff. They may also directly assist members in areas such as:

- Helping members understand their healthcare plan limits, benefits, and guidelines
- Connecting members with their PCP
- Coordinating community support and social services

Medicaid Care Coordination

Care Management 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 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 services for members that are aged, blind, disabled, or have special healthcare needs. For services, reach out to the Care Management 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 directly
- Community partners engaged directly in coordination of care activities
- Referrals from other internal departments, such as Utilization Management, Customer Service, or Behavioral Health

- Members and member representatives contacting PacificSource directly
- Data analysis to identify high-risk and special-health-needs patients
- State agency referrals

PacificSource Health Plans members may be identified through the completion of a health risk assessment survey (wellness survey) administered after enrollment. The health risk assessment survey 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.

6.3 Quality Improvement and Medical Management

PacificSource relies on the Clinical Quality Utilization Management (CQUM) Committee and Pharmacy & Therapeutics Committee to be its advisory body for quality, utilization, pharmacy, therapeutics, and performance improvement activities. The committees have the responsibility to develop and endorse all clinical policies and formulary coverage decisions. The CQUM committee consists of physicians and pharmacists practicing in the communities we serve. These committee members represent our contracted providers. Evidenced-based guidelines are reviewed and adopted by the CQUM committee. Examples include MCG, Hayes, and Carelon Medical Benefits Management 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 CQUM 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. Providers represented on the CQUM Committee are free of conflict with PacificSource.

Program Overview

High-quality healthcare is a priority at PacificSource Health Plans. 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 and the community. 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 CQUM Committee reviews several sources of data and information available to plans to help identify areas on which to focus improvement efforts.

Consumer assessment of healthcare providers and systems (CAHPS) is an annual survey that CMS requires all health plans to send to its members. The survey asks members to rate their health plan and providers on access to care, coordination of care, customer service, and overall satisfaction. The survey is sent to a random sample of members from March to May.

CCO quality incentive metrics (QIM) for Medicaid: The State has developed 13 quality health metrics to demonstrate how well we are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of healthcare. Each metric has a state baseline (starting point) and state benchmark (goal). For current incentive measures, please refer to Oregon Health Authority (OHA) website.

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

Health outcomes survey (HOS) surveys members about their perceptions of their physical and mental health over a two-year period to assess whether members have maintained or improved their health. It also collects health characteristic information such as chronic conditions and limitations in ADLs.

Healthcare effectiveness data and information set (HEDIS®) measures various aspects, such as Effectiveness of Care, Access/Availability, Use of Services, Cost of Care, and Health Plan Descriptive Information. Examples of HEDIS measures produced from claims data are as follows:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Follow-up After Hospitalization for Mental Illness
- Eye Exam for Patients with Diabetes
- Osteoporosis Management in Women Who had a Fracture
- Pharmacotherapy Management of COPD Exacerbation
- Potentially Harmful Drug-Disease Interactions in the Elderly
- Use of High-Risk Medications in the Elderly
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Plan All-Cause Readmissions

Six of the Effectiveness of Care Measures require that we annually collect information from members' medical records. Unless otherwise noted, copies of medical records will be provided at no cost to the plan.

- Colorectal Cancer Screening—Colonoscopy in the past 10 years, Sigmoidoscopy in the past five years, annual FOBT, or DNA testing every three years
- Hemoglobin A1C Control for Patients with Diabetes—A1C control less than eight (commercial) or less than nine (Medicare) for last A1C result of the year
- Eye Exam for Patients with Diabetes—diabetic eye exam (i.e., retinopathy)
- Controlling High Blood Pressure—Last BP of year less than 140/90
- Transitions of Care: Notice of inpatient admission, Record of Discharge, Patient Engagement, and Medication Reconciliation Post Discharge
- Care of Older Adults—Functional Status Assessment, Pain Assessment, Medication Review and List
- Cervical Cancer Screening—Cervical cytology with result or finding, hrHPV test with result or finding
- Prenatal and Postpartum Care—Prenatal care within first trimester or within 42 days of enrollment and postnatal care between seven and 84 days after delivery

Input from Members and Providers. Providers who participate as members of the CQUM Committee give input into the focus of improvement efforts through participation on that committee. Additionally, members' grievances are monitored and trended for issues of concern. Grievance reports are shared at CQUM.

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 health councils remain 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.

6.3.1 Medicare Advantage Star Ratings

The Centers for Medicare & Medicaid Services (CMS) evaluates the quality of care and customer service of all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a five-star rating system.

The two main types of Star Ratings are:

- An Overall Star Rating that combines all of our plan's scores.
- Summary Star Rating that focuses on our medical or our prescription drug services.

Medicare Advantage plans are assessed on an annual basis and ratings may change from one year to the next. Each plan is assigned a score based on a 1-to-5-star scale:

- Excellent
- Above Average
- Average
- Below Average
- Poor

Star ratings provide Medicare beneficiaries a standardized way to compare plans based on quality and performance. CMS also utilizes star ratings to determine funding for Medicare Advantage plans.

Star Rating Measures

Current star ratings are based on categories including preventive care, managing chronic conditions, member satisfaction, customer service, and pharmacy benefits. The data sources used by CMS to develop star ratings include:

- HEDIS®: Clinical performance indicators (access to care, receipt of preventive services, and management of chronic conditions).
- Consumer Assessment of Healthcare Providers and Systems (CAHPS): Survey to evaluate member satisfaction with providers, health plan, and overall experience.
- Medicare Health Outcomes Survey (HOS): Survey to evaluate physical and mental health and quality of life of Medicare beneficiaries.
- Administrative and Compliance Measures: Call center performance, grievance and appeals, CMS audits, and member complaint tracking.
- Part D (Pharmacy) Measures: Medication adherence and accuracy of drug pricing and member experience.

If you have questions about PacificSource Medicare star ratings and initiatives, please contact your PacificSource Provider Relations Representative at 800-624-6052. For general information about the CMS Star Rating System or to view current Star Ratings for Medicare Advantage and Part D plans, please visit the CMS Consumer website at Medicare.gov.

6.3.2 Quality Improvement and Care Coordination Arrangements, Programs and Initiatives

In support of the goals and strategies outlined above, PacificSource has implemented specific value-based quality improvement and care coordination arrangements, programs and initiatives designed to effectuate measurable care gap closures and improved health outcomes in certain target patient populations. Contracted Providers shall be enrolled and participate in all such PacificSource quality improvement and care coordination arrangements, programs and initiatives to the extent that they are provider type relevant and appropriate, as designated by PacificSource, including without limitation:

PCP/Provider Incentive Programs; CMS initiatives; NCQA activities; HEDIS®; CAHPS®; HOS; RADV; Leapfrog; National Quality Forum; diagnosis code capture and information sharing; and other programs to improve quality, member experience, documentation accuracy, and health outcomes.

Provider shall (a) submit complete and accurate clinical/administrative data—including diagnosis codes, encounter, and supplemental data—in the formats and time frames required by PacificSource; (b) provide secure electronic access to Provider's EHR for quality measurement, risk adjustment, and care management, consistent with applicable law (e.g., HIPAA); and (c) participate in PacificSource's Medicare 5-Star initiatives and related incentive programs, including gap-closure workflows and, as applicable, the provision of Annual Wellness Visits or routine physical examinations for eligible Members.

Enrollment in, and commencement of, a value-based quality improvement and care coordination arrangement, program or initiative will not occur until the terms of such arrangement, program or initiative are set forth in writing by PacificSource. Consistent with the signed Provider Agreement and this Provider Manual, receipt of the written terms of a value-based quality improvement and care coordination arrangement, program or initiative, shall constitute a contracted Provider's acknowledgement, signature, and acceptance of such program and its terms.

Notwithstanding the aforementioned program enrollment and participation, contracted Providers have the option to opt-out of quality improvement and care coordination programs (such as the PCP/Provider Incentive Program), and waive any related incentives, by executing opt-out processes provided by PacificSource.

6.4 Prior Authorization

Prior authorization is the process by which providers verify coverage and receive prior authorization from PacificSource before services or supplies are rendered. Prior authorization establishes covered expenses based on benefits available, medical necessity, appropriate treatment setting, and/or anticipated length of stay. Prior authorization does not guarantee payment. Some in-network medical services are covered only if an in-network provider receives prior authorization from our plan. Lack of prior authorization could result in the member unknowingly becoming responsible for payment to a provider for services or supplies not covered by the plan. Questions or need to obtain a prior authorization? Contact us.

6.4.1 Services Requiring Prior Authorization

The list of services that require prior authorization is available for all lines of business at this website: AuthGrid.PacificSource.com

Following the initial prior authorization, please notify our Health Services department in the event of the following:

- When surgery has been rescheduled
- When there has been a change of facility
- When there has been a change of physician or provider

Drug Prior Authorization

Please see the Pharmacy section of this manual.

6.4.2 Process

PacificSource Health Plans requires prior authorization of certain procedures and services to determine benefit eligibility, benefit availability, and medical necessity. This does not override our claims system clinical edits. PacificSource no longer requires notification of maternity admissions.

Admitting clinical information must be submitted within 48 hours for medical necessity determination and authorization to be completed. Lack of clinical information will result in coverage not being authorized. Initial assessment should include initial treatment plan, discharge plan, and estimated length of stay, and is necessary for facilitation of follow-up appointments.

Physicians and other provider offices may request prior authorization by contacting the PacificSource Health Services department. PacificSource will work with the physician or provider office to determine the following:

- Specific type(s) of services proposed (diagnosis and procedure codes)
- Appropriate treatment setting (inpatient or outpatient)
- Appropriate time of admission (same day or day before)
- Expected length of stay (For commercial members, length of stay is reviewed at the time of admission.)
- Identification of contracted physicians, providers, and/or facilities

In some cases, PacificSource may require more information or request an external review.

If a request is received for a procedure/treatment/device that does not require prior authorization, it will not be reviewed for medical necessity, and a cancellation notice will be issued. To ensure coverage, services not requiring prior authorization must be performed by a contracted provider and are subject to benefit availability, eligibility requirements, and the claims editing process. If you want to submit a request for a service that does not require prior authorization, you can do that by clearly stating on the request that you want to have it reviewed regardless of the requirement. The plan will review those requests like any other request. Additionally, if you receive a cancellation notice and you want your request reviewed, you can contact the Utilization Management team anytime through a secure message on the provider portal, InTouch, or call Monday through Friday, 8 a.m. to 5 p.m. at 541-330-7301.

Our Utilization Management Clinicians use nationally accepted, evidence-based screening criteria, clinical experience, and standardized processes to conduct all utilization review activities, including:

- PacificSource medical criteria and guidelines, which can be found at PacificSource.com/Providers/Medical/Clinical-policies-and-practice-guidelines
- CMS guidelines
- Standard of Practice in your state
- MCG clinical guidelines
- Carelon Medical Benefits Management Guidelines
- ASAM—American Society of Addiction Medicine
- LOCUS / CALLOCUS-CASII—Child and Adolescent Level of Care/Service Intensity Utilization System

Electronic Prior Authorization and Inpatient Notification Process

PacificSource Health Plans strongly encourages prior authorization (PA) and inpatient notification requests to be submitted via our provider portal, InTouch. We will contact your offices to assist you in getting an account created and assist with any training. Medicaid PAs and inpatient notifications are required via electronic submission.

If you do not have access to InTouch, please visit OneHealthPort.com and register. Here is a link with some more information about InTouch as well: PacificSource.com/providers/about-intouch-providers.

In some cases, your billing office may be using it already. If so, you can contact them to find out who your administrator is on the account, and they can contact OneHealthPort to have additional users added. This can include front desk personnel or anyone who needs to submit PAs.

Please contact your Provider Relations Representative should you have any questions. We will be happy to assist you in any training you might need to utilize this portal.

Commercial Process

The PacificSource Health Services department is ready to assist physicians, providers, and office staff with prior authorization services, and is available to answer questions. When all pertinent information needed to make a decision has been received, the prior authorization request will be processed according to the turnaround times established by state laws and regulations.

Commercial prior authorization determinations:

- Idaho and Oregon providers: prior authorization determinations are made within 2 business days for nonurgent preservice requests.
- Montana providers: prior authorization determinations are made within 7 business days for nonurgent preservice requests.
- Washington providers: prior authorization determinations are made within 5 calendar days for nonurgent preservice requests.

Please note that PacificSource has the right to extend prior authorization determination time frames up to 30 days in the event that all necessary clinical information needed to make a determination is not received. To avoid extensions, please submit all necessary clinical information at the time of request.

You may reach the department in one of the following ways:

Phone:
Oregon and Washington: 541-684-5584, toll-free 888-691-8209
Idaho: 208-333-1563, toll-free 800-688-5008
Montana: 406-442-6595, toll-free 877-570-1563

Fax:
Oregon: 541-225-3625
Idaho: 208-333-1597
Montana: 406-441-3378

Address:
PacificSource Health Plans
Health Services Department
PO Box 7068
Springfield, OR 97475

For specific benefit information, please contact our Customer Service department by phone at 541-684-5582 or toll-free at 888-977-9299, or by email at CS@PacificSource.com. Alternatively, you may call our toll-free customer service phone line especially for commercial providers at 855-896-5208 to verify member benefits.

Commercial member MRI, CT, PET scan, and genetic testing prior authorization requests may be submitted through Carelon Medical Benefits Management. Go online to the Carelon Medical Benefits Management web portal at ProviderPortal.com, or submit prior authorization requests via the call center at 877-291-0510.

Medicaid Process

Prior authorization is the process by which providers verify coverage and receive prior authorization from PacificSource Community Solutions before services or supplies are rendered. Prior authorization 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 prior authorization from our plan. The list of services that require prior authorization is available on our website at CommunitySolutions.PacificSource.com.

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

Process

- Medical services that have been identified as high cost, over-utilized, and/or potentially unsafe require prior authorization.
- The prior authorization grid, located on our website at CommunitySolutions.PacificSource.com, details services that require prior authorization.
- A request can come from any source if it supplies information useful in completing the request in an accurate, thorough manner.
- 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 prior authorization. However, notification of all inpatient admissions must be made to PacificSource Community Solutions within two business days from the date of service.

Nonurgent prior authorization requests are processed within 14 days from receipt of the request, with an additional 14 days possible if an extension is granted. Expedited requests are processed within 72 hours, with an additional 14 days possible if an extension is granted.

Beginning January 1st, 2026, nonurgent requests will be processed within seven days of receipt of the request. Expedited requests will continue to be processed within 72 hours. An extension of up to fourteen (14) additional days may be possible for both nonurgent and expedited requests under certain circumstances. Requests for repairs to complex rehabilitation technology will be processed with 72 hours of receipt of the request.

When a PacificSource Community Solutions member's coverage is secondary to PacificSource Medicare, the member may be eligible for PacificSource Community Solutions services. Please submit a prior authorization request if required for PacificSource Community Solutions.

Utilization Management

The PacificSource Utilization Management (UM) Handbook contains additional information on our Medicaid UM functions and requirements, including but not limited to the prior authorization process and minimum health record requirements. You may request a copy of the UM Handbook to be emailed, faxed, or mailed to you by contacting our Health Services team.

Medicare Process

The authorization request should be submitted via InTouch for Medicare Advantage members at Medicare.PacificSource.com/InTouch. Upon completion of the authorization, approved services will be given an authorization number. This number should be included on the claim. The authorization number can also be located online through InTouch.

The prior authorization process is not complete until benefits and eligibility have been verified. The number of days the authorization is valid for is noted online or in the approval letter. An extension to the standard authorization period may be requested.

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

Process

- Medical services that have been identified as high cost, over-utilized, and/or potentially unsafe require prior authorization.
- The prior authorization grid, located on our website, Medicare.PacificSource.com, details services that require prior authorization.
- A request can come from any source if it supplies information useful in completing the request in an accurate thorough manner.
- 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 prior authorization. However, you must notify PacificSource Medicare within two business days from date of admission.

All prior authorization and referral requests will be processed within 14 days from receipt of the request. PacificSource Medicare understands that 14 days can sometimes place an unnecessary burden on the provider and patient. If you require an expedited review, please indicate this on the documentation submitted. We will process expedited requests within 72 hours. Please call our Health Services department to follow up on your expedited request. Phone numbers are listed in the Who to Contact section.

Beginning January 1, 2026, non-urgent requests will be processed within seven days of receipt of the request. Expedited requests will continue to be processed within 72 hours. An extension of up to fourteen (14) additional days may be possible for both non-urgent and expedited requests under certain circumstances.

When a PacificSource Community Solutions member's coverage is secondary to PacificSource Medicare, PacificSource Medicare rules apply. If an authorization 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 authorization requirements.

Incomplete Prior Authorization Requests

Incomplete prior authorization 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.

Carelon Medical Benefits Management

PacificSource has partnered with Carelon Medical Benefits Management to administer prior authorizations for non-emergency advanced diagnostic imaging services and genetic testing, performed in an outpatient setting.

The modalities covered under this program include the following:

- Computed Tomography Scans (CT/CTA)
- Magnetic Resonance Imaging (MRI/MRA/MRS/MRM/fMRI)
- Nuclear Cardiology
- Positron Emission Tomography Scans (PET)
- Genetic testing should be submitted to Carelon Medical Benefits Management for commercial members.

Please note: Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers), or hospital observation do not require prior authorization. Outpatient studies performed for urgent or emergent conditions will be subject to a retrospective clinical claims review by PacificSource.

A complete list of services requiring prior authorization is available on our websites. Services included in the Carelon Medical Benefits Management program are noted in the description field.

To Request Prior Approval through Carelon Medical Benefits Management:

Ordering/referring nonradiological physicians must contact Carelon Medical Benefits Management to obtain an order number before scheduling elective outpatient diagnostic imaging services and genetic testing. In addition, servicing providers should confirm that an order number has been obtained prior to service delivery.

There are two ways to obtain an order number for diagnostic imaging services or for prior authorization submission for genetic testing:

- By calling Carelon Medical Benefits Management toll-free at 877-291-0510.
- By using the Carelon Medical Benefits Management ProviderPortal at ProviderPortal.com. Since many providers already use the ProviderPortal, there is no need to register again. If a provider is new to Carelon Medical Benefits Management, they will need to register at ProviderPortal.com.
- Genetic testing requests must be made by the ordering provider. Requests from testing labs will not be accepted.

6.4.3 Commercial Retrospective Prior Authorizations

PacificSource, through its Health Services department and processes, reviews clinical documentation to ensure the appropriate claims adjudication for certain services that have been provided when coverage of this service was not preauthorized as contractually required. This includes requirements defined in both the member and provider contracts.

Retrospective review determinations will be based solely on the medical information available at the time the service was provided. Results from subsequent testing or procedures cannot be considered.

Retrospective requests for authorization will only be honored when:

- The request is made within 60 days from the date of service.
- The request timing is due to circumstances beyond the provider's control (for example: need for second procedure is identified while performing an approved primary procedure; member is new to the plan and efforts were made to obtain authorization from the prior insurer).
- Request includes documentation of the reason the request for authorization was not requested pre-service. Scheduling or clerical error is not an acceptable reason.
- The provider has not already billed for the service and/or received a denial citing lack of authorization as the reason. In this case, the provider may submit an appeal for reconsideration.

6.5 Medicaid Retroactive Prior Authorization Guidelines

Guideline Overview

Retroactive prior authorization requests are requests submitted after the initiation or provision of the service(s). A retroactive request may be approved when ALL the following criteria are met:

- The member was made retroactively eligible or was retroactively disenrolled from a coordinated care organization or prepaid health plan on the date of service.
- The provider has not already billed for the service and/or received a denial citing a lack of authorization as the reason. In this case, the provider may submit an appeal for reconsideration.
- The services provided meet all other criteria and Oregon Administrative Rules.
- The request for authorization is received within 90 days of the date of service.

Submitting Information for a Retroactive Request for Authorization

Requests can be sent via InTouch or by fax. Providers should submit all pertinent medical information with the request. Please note that a request for authorization after 90 days from the date of service requires documentation from the provider to indicate authorization could not have been obtained within 90 days of the date of service.

Appeals

Please refer to appeals process section.

6.6 Medicare Retroactive Authorization Guidelines

Conditions for Retroactive Authorization Review

PacificSource Medicare will accept retroactive authorization requests. The retroactive authorization request will be processed following the same coverage guidelines and timelines as a standard prior authorization request. Retroactive authorization requests are not subject to an expedited review.

Medicare Noncovered Service Waiver

Original Medicare established Advanced Beneficiary Notices (ABN) in order to allow a Medicare beneficiary the opportunity to determine if a medical service or procedure is covered by Medicare prior to

receiving the service or procedure. However, per the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage plans are not permitted to allow their providers to issue this notice.

If a Medicare provider would like to provide a noncovered service or procedure to a Medicare Advantage member, CMS dictates that the provider must receive written consent before providing any services that are not a covered Medicare benefit.

If the service is not explicitly called out in the Evidence of Coverage (EOC) or other materials distributed to the member as noncovered, the provider must also utilize the pre-service organizational determination process of the plan to determine coverage if there is reasonable doubt the service is not covered.

If the plan determines, pre-service, that the item in question is not a covered benefit, the plan will issue an Integrated Denial Letter to the member and provider. This letter will include information about how the member can appeal the decision.

At this point, the provider can enter into an agreement with the member to provide the service or procedure, if the member would like to proceed, and pay the provider out of the member's pocket. The agreement must follow specific guidelines:

- Only contracted providers are allowed to execute this agreement.
- The agreement cannot specify that it is an "Advanced Beneficiary Notice" or ABN.
- The agreement must be made after the coverage determination and before the service is performed.
- The agreement must identify each noncovered CPT or HCPC code as well as specified pricing.
- After the provider receives the pre-service determination, and the member has signed the waiver and the service is provided, the provider will still bill PacificSource Medicare for the provided service(s).

Note: The –GA modifier must be attached to each noncovered CPT or HCPC line on the claim to indicate all guidelines have been followed. This modifier will allow for the noncovered item to be adjudicated as member liability.

How to request a prior authorization determination:

Prior authorization determinations may be requested by:

- Submitting the request through the online InTouch portal (pharmacy and medical requests).
- By faxing a request to the Plan (Medical requests only). The form and fax information can be found at Medicare.PacificSource.com by choosing the Provider Home Page, selecting Resources from the left navigation, and then selecting the Documents and Forms link.

6.7 Utilization Management

PacificSource's Utilization Review Program, administered by the Chief Medical Officer, entails three different types of utilization review: prospective, concurrent, and retrospective.

We define utilization review as the "evaluation of medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the auspices of the applicable benefit plan."

PacificSource Health Plans reserves the right to delegate a third party to assist with or perform the function of utilization management. PacificSource will have final authority in all utilization management decisions.

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

Criteria may be requested prior to a UM decision, or in the event of a denial, from Health Services in any of the following ways per your request:

Phone:
Call Health Services to request a copy of the criteria at the following numbers per state:
Oregon and Washington: 541-684-5584
Toll free: 888-691-8209
Idaho: 208-333-1563 Toll free: 800-688-5008
Montana: 406-442-6595 Toll free: 877-570-1563
TTY: 711. We accept all relay calls.

Fax:
Oregon and Washington: 541-225-3625
Idaho: 208-333-1597
Montana: 406-441-3378

Mail:
PacificSource Health Plans/Health Services
PO Box 7068
Springfield, OR 97475-0068

Emergency Room Utilization

Emergency care is covered 24 hours a day, seven days a week. PacificSource Health Plans 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.

See Glossary for the definitions of Emergency Medical Condition and Emergency Services.

Observation Room Utilization

Prior authorizations 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. In the event the member requires inpatient admission, the health plan must be notified as described in the Concurrent Review section below.

Concurrent Review

Concurrent review begins when PacificSource has been notified of an inpatient admission authorization, including skilled nursing facility (SNF), long-term acute care (LTAC), behavioral health residential treatment, and partial hospitalization treatment. (See Commercial Retrospective Utilization Review section.) The health plan should be notified within 24 hours (business days only), but no later than 48 hours during normal business days and the next business day if the member is admitting during the weekend.

Eligibility and benefits may be confirmed by contacting Customer Service and the admission should be reported to the Health Services department. Once notified, Health Services will provide a patient-specific, searchable reference number to the facility.

This number is the facility's confirmation that we have recorded the patient's admission and that a PacificSource Utilization Management Clinician will monitor and manage the patient's hospitalization for coverage purposes.

Our Utilization Management Clinicians use nationally accepted, evidence-based screening criteria, clinical experience, and standardized processes to conduct all utilization review activities, including:

- American Society of Addiction Medicine (ASAM) criteria
- PacificSource medical criteria and guidelines (these guidelines may be available to members upon request)
- CMS guidelines
- Standard of practice in your state
- MCG clinical guidelines
- LOCUS / CALLOCUS-CASII—Child and Adolescent Level of Care/Service Intensity Utilization System

Utilization review reports are requested on a case-by-case basis and, if required, PacificSource will notify the case management or utilization review department the same day that a verbal or faxed review is needed. The frequency of concurrent review will vary based on the patient's condition, case complexity, and practice guidelines. The review process may require medical records or review with the facility Case Manager or Social Worker. We also access EMR when available.

Our clinicians review the severity of illness and intensity of services provided during the hospital stay with the facility utilization review or case management staff to confirm need and appropriateness. Our Case Manager provides support to the member by coordinating services, equipment, or alternative placement, as indicated by the discharge plan and physician. Occasionally, the patient will wish to extend their hospitalization beyond that which the attending physician documents as medically necessary. In the case of member request, charges for hospital days and services beyond those determined to be medically necessary will be the patient's responsibility. Only the PacificSource Medical Director or Chief Medical Officer can make decisions to not approve coverage for medical services for reasons of medical necessity.

If a determination is made that the patient no longer meets criteria for continued inpatient stay or the patient's needs may be provided at a lower level of care (e.g., skilled nursing, palliative, or sub-acute setting), this is a non-approval. PacificSource will notify the facility and the attending physician by telephone, fax, or in writing, within one business day of initial requests and within three business days for ongoing requests. All parties are provided with notice of their appeal rights, and a 24- hour grace period may be allowed to coordinate care planning and services for patient discharge.

Charges for late discharge, outside of member's request, will not be the responsibility of the member, nor the health plan.

Retrospective Utilization

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.

Quality Utilization Program

PacificSource's Quality Utilization Program, administered by the Medical Director and the Health Services leadership team, provides a mechanism for systematic, coordinated, and continuous monitoring. The goal is to improve member health and the quality of services.

6.8 Clinical Practice Guidelines

Clinical Practice Guidelines are recommendations for clinicians about the care of patients with specific conditions. They are based on the best available research evidence and practice experience. Guidelines are suggestions for care, not rules. However, most patients do fit guidelines, and this should be reflected in overall practice patterns. Clinical guidelines are available for members to review upon request.

PacificSource adopts guidelines for diseases managed in the Condition Support program, relevant behavioral health conditions, preventive health guidelines for perinatal care through adults 65 years and older, as well as other guidelines relevant to the commercial population.

PacificSource adopted guidelines can be found by visiting the For Providers section of PacificSource.com or by contacting Health Services.

In health plans that include a prescription drug benefit, a comprehensive pharmacy services program is provided that includes drug list management, drug prior authorization, step therapy protocols, drug limitations, and a specialty drug program.

6.9 Commercial: Nonreimbursed Nursing Level Charges During an Acute Care Hospital Stay

Acute care hospital services are those items and services ordinarily furnished by the hospital for the care and treatment of a patient. These must be provided under the direction of a physician with privileges in an institution maintained primarily for treatment and care of patients with medical disorders. Hospital-based care is a key component of the continuum of health services. It provides necessary treatment for a disease or severe episode of illness for a short period of time. The goal is to discharge patients as soon as they are healthy and stable. Acute care hospital services and treatment provided in a hospital setting may include services such as:

- Medical or surgical services
- Room and board
- Observation services
- Nursing services
- Nutritional services
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Speech therapy
- Medical social services
- Intravenous (“IV”) injections or IV fluid administration/monitoring
- Intramuscular (“IM”) and/or subcutaneous (“SQ”) injections
- Nasogastric tube (“NGT”) insertion, and urinary catheter insertion
- Dressings, supplies, appliances, and equipment
- Diagnostic or imaging services

Services That Are Not Separately Reimbursable for In-network Facilities—Nursing Procedures

PacificSource Health Plans will not separately reimburse fees associated with nursing procedures or services including leveled nursing charges provided by facility nursing staff or unlicensed facility personnel (technicians) performed during an inpatient admission. Examples include, but are not limited, to intravenous injections or IV fluid administration/monitoring, intramuscular injections, subcutaneous injections, nasogastric tube insertion, and urinary catheter insertion, venipuncture, or capillary blood draws.

6.10 Medicaid: Mental Health Services

Assertive Community Treatment (ACT)

ACT programs must notify PacificSource within 48 hours of any denials or patient refusals to the ACT program via the InTouch portal. For assistance, please review the InTouch for Providers Resource Guide.

Mental Health Assessment and Treatment Planning

All Medicaid members are entitled to a comprehensive mental health assessment. This assessment can be provided by the member's local Community Mental Health Program (CMHP) or contracted PacificSource Community Solutions 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.

Most of our members are assigned to primary care clinics that now have integrated Behavioral Health Clinicians. Members are not required to get a referral from the PCP to see one of our specialty behavioral health panel providers, but these integrated Behavioral Health Clinicians can help members identify conditions, and coordinate with community behavioral health specialists.

Mental Health Crisis Services

Members in need of emergent and urgent mental healthcare can contact their local CMHPs to assess, stabilize, and determine the next steps to identify an appropriate level of care. All CMHPs 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 PacificSource Community Solutions 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.
- PCPs 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, MD, or Psychiatric Mental Health Nurse Practitioner (recently added by OHA) who has experience or training in the diagnosis of Autism Spectrum Disorder. ABA is covered for the diagnosis of Stereotypic Movement Disorder with Self-Injurious Behavior due to a Neurological Dysfunction (DSM-5 307.3; ICD-10 F98.4) as well as 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	BestCare Treatment Services 1103 NE Elms 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
Marion/Polk CCO			
Marion	Marion County Health Department 1118 Oak St. SE Salem, OR 97301	503-585-4949	503-585-4965
Polk	Polk County Health Department 1520 Plaza St NW #150 Salem, OR 97304	503-623-9289 *Weekdays 8 a.m. – 5 p.m., (excluding holidays)* 503-581-5535 or 800-560-5535 *Outside of regular business hours*	

6.11 Medicaid: Substance Use Disorder (SUD)

Outpatient Treatment

Outpatient SUD treatment services are available by accessing the member's local Community Mental Health Program (CMHP) or a contracted PCS panel provider. Members are not required to get a referral from their PCP or a community mental health program to see one of our specialty behavioral health panel providers for outpatient SUD services.

Residential Treatment

Whenever possible, members are engaged in outpatient services prior to a referral to residential treatment.

6.12 Behavioral Health Navigation Team

The Behavioral Health Navigation team helps our Medicaid members find behavioral health providers to meet their mental health and/or substance use treatment needs. The team was developed to help members overcome barriers to accessing services and is available to all of our current Medicaid CCO regions. The team can be reached directly at 458-240-8018, 8:00 a.m. to 5:00 p.m., PT, Monday through Friday.

7. Health-Related Social Needs (HRSN)

Being healthy requires more than regular check-ups, like having access to non-medical things such as housing, healthy food, and air conditioning, to name a few. Certain OHP members may be eligible for extra non-medical services through a program called health-related social needs (HRSN). This name refers to barriers to health such as housing or food insecurity that may affect well-being. HRSN service providers are community partner organizations that provide HRSN services.

7.1 Eligibility

OHP members may be eligible for some or all HRSN services if they:

- Have a high-risk medical condition
- Are in transition—for example, if they:
  - Are homeless or at risk of becoming homeless
  - Were in a psychiatric facility, jail, or prison in the past year
  - Were ever involved in child welfare services
  - Are becoming eligible for Medicare in the next three months or enrolled in Medicare no more than nine months ago
  - Are a youth with special healthcare needs

Each HRSN service type has its own additional eligibility criteria. Please note that all OHP members can receive outreach and engagement.

7.2 HRSN Services and Supports

Climate Supports

These include supplying no-cost air conditioners, heaters, air-filtration devices, mini-refrigerators, and portable power supply units.

Housing Supports

These include help with rent and utilities for up to six months, storage fees, medically necessary home modifications such as installing wheelchair ramps or grab bars, remediation services such as pest control and heavy-duty cleaning, and related hotel costs.

Nutrition Supports

These include Medically Tailored Meals (with delivery) that align with a member's personal and cultural dietary preferences. Also includes Nutrition Education to help with choosing foods and meal preparation.

Outreach and Engagement

Outreach and engagement helps people find the resources they need. These include HRSN services and other medical and non-medical benefits.

PacificSource is working with Connect Oregon–Unite Us to implement a simple closed loop referral process for HRSN benefits through our HRSN service providers. Connect Oregon will provide training and support for using their platform.

Requests for services can be completed by a member directly or by someone on behalf of a member by applying here: Uniteus.com/networks/oregon/get-help/pacificsource/.

8. Pharmacy

8.1 Drug Lists/Formulary Coverage

PacificSource drug lists can vary by commercial plan and state, Medicaid, and Medicare lines of business. To find out which drug list applies to your patient's pharmacy plan, check their PacificSource member ID card. If no "Drug List" is noted on a commercial member card, use the "PDL" list. Please use the drug lists to prescribe the most clinically appropriate and cost-effective medications for your patient.

Medicaid and Medicare Formulary Coverage

PacificSource Community Solutions and PacificSource Medicare offer comprehensive prescription drug benefits with coverage in all therapeutic classes, as mandated by the Oregon Health Authority and Medicare Part D 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 Medicaid and Medicare members include, but are not limited to:

- Medications where the clinical circumstances do not meet the PacificSource Medicare clinical criteria.
- Medications not on the PacificSource Medicare 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 MAP Prioritized List of Health Services or Medicare Part D rules.
- Most over-the-counter (OTC) medications.
- Medications that have not gone through the FDA approval process, such as Less-than-Effective DESI drugs.
- Medicaid: 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.
- Prior Authorization (PA): Medications that require prior authorization will only be approved when medical record documentation proves the patient's clinical circumstances meet the criteria established by our CQUM 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.

PacificSource Medicare uses the following methods for utilization management:

- Prior authorization: Medications that require prior authorization will only be approved when medical record documentation proves the patient's clinical circumstances meet the criteria established by our CQUM Committee and approved by the Center for Medicare and Medicaid Services (CMS).
- Step Therapy: 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: Medications with quantity limits will generally be limited to encourage dose optimization and limited to the FDA-approved dosing quantities.

Commercial, Medicare, and Medicaid: Using National Drug Codes

The Centers for Medicare & Medicaid Services (CMS) deems that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates. The CMS requirement applies to Medicaid, Medicare/Medicaid dual, and commercial members.

Coverage Determinations and Exceptions

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

PacificSource will provide retrospective notification for medication removed due to availability or safety. For all other formulary medication, PacificSource Medicare will provide member notification at least 60 days prior to implementing a change that may include, but is not limited to:

- Addition of a new coverage policy (PA, ST, QL) to an existing medication
- Moving a medication to a less-favorable tier
- Removal of a previously listed drug
- Generic substitution

To Request Coverage Determination (Prior Authorization) 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 use the phone numbers and email listed under Pharmacy Services in the Who to Contact section of this manual. All PacificSource prior authorization criteria, the applicable formulary, and our Pharmacy Prior Authorization Request form are available on our websites.

When a standard request for a drug benefit has been received, PacificSource provides notification of the determination to the member (and the prescribing physician when appropriate) as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request including weekends and holidays (72 hours after receipt of a Medicare request; approximately one to two business days for commercial requests, and 24 hours for Medicaid requests). All standard determinations are communicated to the requesting prescriber by phone or fax and to members by letter.

If the clinical circumstances warrant an expedited review and the member's health will be jeopardized by the standard review timelines, please indicate that the request is URGENT. All expedited requests will be processed 24 hours from receipt. All expedited determinations are communicated by phone to the member and via fax to the provider.

Pharmacy Network

PacificSource 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 websites.

Drug Prior Authorization and Step Therapy Protocols

Certain drugs require prior authorization or step therapy for members with pharmacy or major medical prescription plans. This process includes an assessment of both your patient's available benefits and medical indications for use. Be sure to get prior authorization for medication when required, to avoid your patient becoming responsible for the full cost of the medication.

We base our prior authorization and step therapy criteria on current medical evidence. We review and update them monthly to accommodate new drugs and changing recommendations. Our Pharmacy & Therapeutics (P&T) Committee must approve all criteria and formulary changes. Voting members consist entirely of providers and pharmacists from the communities we serve. Current Prior Authorization and Step Therapy Policies are available by line of business and available online.

Requesting Prior Authorization

The ordering physician or representative is required to contact our Pharmacy Services department for prior authorization. As a convenience, you can submit your request via InTouch or use the phone numbers and email listed under Pharmacy Services in the Who to Contact section of this manual. Pharmacy Services manages all drugs, whether covered by the pharmacy benefit or the medical benefit.

Electronic Prior Authorization

PacificSource Health Plans strongly encourages prior authorization (PA) and inpatient notification requests to be submitted via our provider portal, InTouch. We will contact your offices to assist you in getting an account created and assist with any training.

For Medicaid, prior authorizations must be submitted via InTouch. If you do not have access to InTouch, please visit OneHealthPort.com and register. Here is a link with some more information about InTouch as well: PacificSource.com/providers/about-intouch-providers.

In some cases, your billing office may be using it already. If so, you can contact them to find out who your administrator is on the account, and they can contact OneHealthPort to have additional users added. This can include front desk personnel or anyone who needs to submit PAs.

Please contact your Provider Relations Representative should you have any questions. We will be happy to assist you in any training you might need to utilize this portal.

Please include relevant chart notes and lab values in all requests for prior authorization.

Please note: A member's contract (policy) determines benefits. Prescription drugs that are contract exclusions will not be approved via notification to the pharmacy at the time of dispensing. Drugs that are not approved may be appealed through our Customer Service department.

Drug Limitations

Quantity limitations are in place for some drugs. These limit drugs to specific quantities over defined time periods. The drug limitations help manage utilization and drug costs, reduce overall healthcare costs, and provide sound, cost-effective options for the choice and utilization of effective drug therapies. It also helps to prevent fraud, waste, and abuse of medications.

The drugs on our lists will have a limit on the quantity allowed in a 30-day period, and we can only consider claims for this limited amount. Limiting quantities helps ensure that our members are using these products appropriately and in a safe manner according to the FDA-approved dosing guidelines.

If you feel that clinical indications warrant a quantity above the limit, please contact our Pharmacy Services department for prior authorization. Please be aware, although your patient may obtain more medication than the specific dispensing limit, they may be responsible for the cost of the additional quantity.

Specialty Drugs

PacificSource offers additional specialty pharmacy options for its members. Please refer to the specific line-of-business website for the specialty pharmacy options.

For PacificSource commercial health plans and self-funded:
PacificSource.com/Members/Individuals/Prescription-drug-information/Find-pharmacy

For PacificSource Medicare:
Medicare.PacificSource.com/Search/Pharmacy

For Medicaid (CCO):
CommunitySolutions.PacificSource.com/Search/Pharmacy

CVS Caremark® Specialty Pharmacy Services provides high-cost medications and biotech drugs. Caremark's pharmacist-led Specialty Care Team provides quality, individual follow-up care and support to our members who are utilizing specialty medications. Please visit our online drug list to determine if a particular medication is considered specialty or not.

The Specialty Care Team provides comprehensive disease education and counseling, assesses patient health status, and offers a supportive environment for patient inquiries. Through our partnership with Caremark, we not only ensure that our members receive strong clinical support, but we also ensure the best drug pricing for these specific medications.

For more information, please contact Caremark at 800-237-2767 or fax 800-323-2445.

Nonformulary Requests

If your patient has tried all formulary drugs available and requires a nonformulary drug, you may request prior authorization through the same process outlined above. If you would like to suggest an addition to the formulary, please mail your written request to:

PacificSource Health Plans
Attn: Pharmacy Services
PO Box 7068
Springfield, OR 97475-0068

The PacificSource Pharmacy & Therapeutics Committee considers requests at their monthly meetings. Once we receive your request, we will notify you of the date your request will be reviewed. After the review, we will notify you of the Committee's decision. There is no guarantee that any change will be made to the drug list.

9. Products

9.1 Product Descriptions

All PacificSource products are designed to contain healthcare costs appropriately. By providing a full spectrum of products, PacificSource is able to offer a broad range of plans with varying flexibility.

9.1.1 Commercial

Product Line	Description
Voyager	PPO plans; plan designs include copay-style or high-deductible health plan-style, which may be paired with a health savings account (HSA)
Navigator	Coordinated care organization style of plans; plans include deductibles with copays on some plans; some plans can be paired with an HSA
SmartAlliance | SAN	Managed care style of plans; plans include deductibles with copays on some plans; some plans can be paired with an HSA

Availability

Network	Idaho	Montana	Oregon
Voyager	✓		✓
Navigator	✓	✓	✓
SmartAlliance | SAN	✓	–	–

Note: Plans and networks may change every year. Please see PacificSource.com for current information.

For more information regarding benefits and eligibility, please contact Customer Service:

Oregon: 541-684-5582 or toll-free 888-977-9299
Idaho: 208-333-1596 or toll-free 800-688-5008
Montana: 406-442-6589 or toll-free 877-590-1596
Email: CS@PacificSource.com

For plan-specific in-network provider directories, please contact our Sales department by phone at 541-686-1242 or 800-624-6052, or visit our website at PacificSource.com.

9.1.2 PacificSource Coordinated Care Organization (Medicaid)

PacificSource Community Solutions has four CCOs: Central Oregon, the Columbia Gorge, and Marion-Polk.

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

Columbia Gorge CCO includes Hood River and Wasco counties

Marion-Polk CCO includes Marion and Polk counties

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

9.1.3 PacificSource Medicare Products

All PacificSource Medicare products are designed to contain healthcare costs appropriately. By providing a full spectrum of products, PacificSource Medicare is able to offer a broad range of plans with varying flexibility.

For more information regarding benefits and eligibility, please call our Customer Service department toll-free at 888-863-3637, email at MedicareCS@PacificSource.com.

For plan-specific in-network provider directories, please call our Customer Service department toll-free at 888-863-3637, email at MedicareCS@PacificSource.com, or visit Medicare.PacificSource.com.

9.1.4 Dual Special Needs Plan (D-SNP)

D-SNP plans are a type of managed care Medicare Advantage plan that enrolls only Full Benefit Dual Eligible (FBDE) individuals. The primary demographic is vulnerable individuals who are more likely to be at higher risk for chronic conditions. Part D is always included and the plan provides $0 cost sharing for all Medicare covered benefits. Integrated care management is also included.

D-SNP Member Care:

- Integrated partnership with providers specialized in care model specific to integrated D-SNP
- Improved access to care and quality while reducing out-of-pocket costs
- Local partnership of network and non-profit health plan
- Highest rating (100%) from NCQA and CMS for the Model of Care
- Interdisciplinary neighborhood care team that resides in the community of our members
- Specialized programs designed specific for the D-SNP populations, and each member receives an individualized care plan based on the member's personalized needs

D-SNP service areas include Central Oregon (Crook, Deschutes, Hood River, Jefferson, Klamath, and Wasco counties), Marion County, and Polk County.

9.2 Plan Features

9.2.1 Commercial Medical Plan Features

Chiropractic or Acupuncture Care

An alternative care benefit, chiropractic manipulation benefit, or alternative care/chiropractic combined benefit is built into **some** of our plan designs, while this benefit must be added by endorsement to other plan designs. When benefits apply, the copayment, coinsurance, and/or deductible may differ between plans. Some services may apply to the outpatient rehabilitation visit limits. For specific benefits, please call our Customer Service department at 541-684-5582 or toll-free at 888-977-9299. Alternatively, you may call our toll-free customer service phone line especially for commercial providers at 855-896-5208 to verify member benefits.

Vision

With PacificSource's vision services network, members may choose from a broad panel of in-network physicians and providers throughout our service area, including ophthalmologists, optometrists, and dispensing opticians.

Vision benefits are built into **some** of our plan designs, while this benefit must be added by endorsement to other plan designs. A variety of vision benefit packages are available as endorsements to our large group health plans. For specific vision benefits, please call our Customer Service department at 541-684-5582 or toll-free at 888-977-9299. Alternatively, you may call our toll-free customer service phone line especially for commercial providers at 855-896-5208 to verify member benefits.

Prenatal Program

PacificSource Health Plans offers the Prenatal program for its pregnant members. The program focuses primarily on reduction of prenatal risk factors through education and early intervention. PacificSource hopes to have a positive effect on both patient health and healthcare costs by decreasing the incidence and severity of low birth weight infant cases. The components of the program are as follows:

- Educational materials
- Risk assessments including depression screening
- Registered Nurse Consultant (available Monday– Friday, 8:00 a.m.–5:00 p.m., PT)

The goals of the program are to:

- Encourage pregnant women to practice good prenatal care
- Help identify individuals who may be at risk for complications

Prenatal Vitamin Program

As part of PacificSource pharmacy benefits, if a member is pregnant or between the ages of 15 and 50, they are eligible to receive licensed provider-prescribed prenatal vitamins at no cost. We offer this benefit to ensure improved access to important vitamins prior to and during pregnancy, to promote healthy fetal development and to optimize healthy baby outcomes. This program is free to our members with pharmacy benefits.

There are nine prescription prenatal vitamins offered under the program.

For questions, contact our Customer Service team at 541-684-5582 or 888-977-9299 (toll-free).

Condition Support Program

Our Condition Support Program is available to all commercial members with medical coverage.

Members with asthma or diabetes (including members age 18 and younger), heart failure, chronic obstructive pulmonary disease, hypertension, Chron's disease, ulcerative colitis, or coronary artery disease may be referred to the program. Effective October 1, 2025, members with rheumatoid arthritis, lupus, and seizures will also be eligible for this program.

The program's interventions are supported by national clinical guidelines and promote a collaborative relationship between the physician and the patient.

Nurses educate and support recognition and understanding of symptoms, when to seek medical treatment, encourage and support adoption of healthy lifestyle choices utilizing motivational interviewing and health coaching techniques, as well as adherence to the physician-prescribed treatment plan and medication regimen. Condition specific information and newsletters are mailed or emailed.

Some participants in the program receive outbound nurse phone contacts. Your patient may opt-out of the program by phone or email.

Physician collaboration with a Condition Support Registered Nurse regarding your plan of care is encouraged and welcomed so that the program may support the goals you have set with your patient.

If you have any questions about the Condition Support Program, would like to contribute input on your patient's plan of care, or would like to receive any of the program materials, please contact our Health Management department at toll-free at 888-987-5805 or by email at YourSupport@PacificSource.com.

Health Education Classes

Patients can participate in local health education classes and receive reimbursement up to $150 per plan year for eligible health and wellness classes (some limitations apply). We hope that you'll refer your patients to useful classes in your area. Learn more at PacificSource.com/members/healthy-resources/education-reimbursement.

Prescription Discount Program

This value-added program is offered to members at no cost. It allows members to access discounted drug prices through the Caremark pharmacy network by showing their PacificSource ID card. The discount is available on all IRS Section 125-eligible medications, including those excluded from coverage under the health plan.

If there's no prescription drug endorsement in place, the program helps members save money on all their prescription purchases. For members with a PacificSource pharmacy benefit, the discount "wraps around" the health plan's prescription benefits.

Members will receive the discount when they purchase medications that aren't covered by the health plan, such as drugs for smoking cessation or infertility.

The discount program cannot be used in conjunction with an insurance benefit or other prescription discount program. If members purchase prescriptions through a spouse's health plan coverage, for example, they won't receive an additional discount with this program. However, if they are purchasing drugs that aren't covered by the other insurance benefit, they may be able to use this prescription discount program to save money on those medications.

Global Emergency Services

If a PacificSource member experiences a medical emergency when traveling abroad or 100 miles or more away from their primary residence, Assist America® Global Emergency Services can help. Assist America provides a variety of services, including:

- Medical consultation and evaluation
- Medical referrals
- Critical care monitoring
- Evacuation to the nearest facility that can appropriately treat your situation if medically necessary

When the member is ready to be discharged from a hospital and needs assistance to return home (or to a rehabilitation facility), Assist America will arrange transportation and provide an escort, if necessary.

Services arranged by Assist America are provided at no cost to our members. Once under the care of a physician or medical facility, their PacificSource coverage applies.

Note: Assist America is included with most, but not all, PacificSource medical plans.

9.2.2 Medicaid Medical Plan Features

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. PacificSource Community Solutions and Oregon Health Plan (OHP) (Medicaid) help members receive free rides to their covered healthcare appointments. PacificSource Community Solutions is responsible for administering the NEMT benefit to our Medicaid members. The NEMT provider (brokerage) is responsible for providing the services to our Medicaid members. Providers are required to adhere to the guidelines and processes set by the NEMT providers. 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.

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, Columbia Gorge, and Marion/Polk Regions
Modivcare Solutions

Central Oregon Region:
Reservation 855-397-3619
Ride Assist 855-397-3620

Columbia Gorge Region:
Reservation 855-397-3617
Ride Assist 855-397-3618

Marion/Polk Region:
Reservation 844-544-1397
Ride Assist 844-544-1398
Facility: 844-287-6698
Facility Fax: 855-882-5627
TTY: 711. We accept all relay calls.
Hours: 9:00 a.m. – 5:00 p.m., Monday – Friday.

If you are calling from a facility (any region), please use 844-287-6698.

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.

Health-related Services (HRS)

Health-related services are noncovered services under Oregon's Medicaid state plan (OHP) that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. These include flexible services—cost-effective services delivered to an individual OHP member to supplement covered benefits and improve their health and well-being. The flexible services request form and FAQ may be found on our Provider website under documents and forms.

Quit For Life® Program

The Quit For Life® Program is the nation's top tobacco cessation program. It can help members beat their 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 program is free, confidential, and it works.

Call 866-QUIT-4-LIFE, toll-free 866-784-8454, or log on to QuitNow.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.

9.2.3 Medicare Medical Plan Features

Preventive Care

PacificSource Medicare members have a $0 copay for all preventive care received at an in-network provider, including:

- Bone mass screening and diagnostic
- Colorectal screening and diagnostic
- Mammograms
- Pap and pelvic exams
- Prostate cancer screenings, and more

Extra Benefits

PacificSource Medicare plans cover services that Original Medicare does not cover.

- Annual routine physicals ($0 copay with in-network providers)
- Routine vision exams
- Routine hearing exams
- Eyeglasses and contacts
- Home fitness kit ($0 per kit)
- Silver&Fit® Exercise & Healthy Aging Program ($0/year fee)
- TruHearing® hearing aids

Worldwide Coverage for Travelers

Offered on all plans. PacificSource Medicare members are covered during travel anywhere in the U.S. and worldwide for:

- Urgent care
- Emergency room
- Ambulance: ground or air

Other Plan Features

Health Risk Assessments, Health Fairs, Events, and Immunization Programs
We provide health screenings, educational events, immunization programs and health risk assessments, as well as education information about health, wellness, and chronic conditions.

Medication Therapy Management (MTM) Program
Eligible members receive free one-on-one consultations with our contracted clinical pharmacists who identify drug safety issues, potential drug interactions, cost-saving opportunities, and other therapy changes that can improve member health. A clinical pharmacist will work with the member's doctor to make sure they are getting the most out of their prescription drug benefit.

Reminder Program
We want our members to maintain good health and improve it. We believe prevention is the best medicine. Screening can catch chronic disease early so treatment can give the best chance to avoid complications. We also want to catch complications early so they do not get worse. For example, by catching cancer early, less treatment may be needed and there is a better chance for cure. An annual visit with their doctor is very important to maintaining good health. Members will receive reminders for important medical appointments by phone or by mail from our Health Services team.

10. Members

10.1 Enrollment

10.1.1 Commercial Enrollment

All members enrolled in plans requiring the selection of a primary care provider (PCP) must make a selection at the time of enrollment. PCPs are chosen from the primary care provider section of the provider directory associated with the group plan. Each family member must select a PCP that will be responsible for managing that member's healthcare. Family members may choose the same or different PCPs. Not all plans require the selection of a PCP.

Completed enrollment forms are forwarded to PacificSource. When applications are processed, identification cards are sent to the member. PCP selections become active on the effective date of the coverage.

10.1.2 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 PCP when they enroll on the CCO.

A member is auto assigned to a PCP when they enroll on the CCO. Members may change their PCP or dental care organization at any time 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 the Who to Contact section.

10.1.3 Medicare Advantage Enrollment

There are specific times when members can sign up for Medicare Advantage (Part C) and Medicare prescription drug coverage (Part D), or make changes to the coverage they already have. General rules for enrollment:

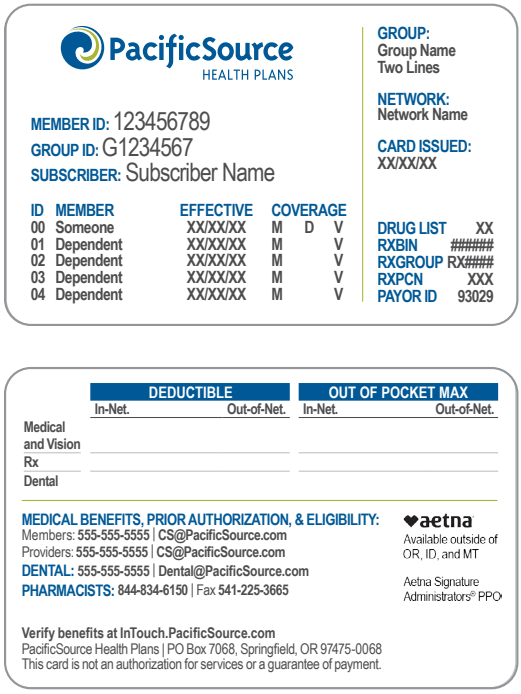
- When first eligible for Medicare or when you turn 65, during your Initial Enrollment Period
  - The seven-month period that starts three months before the month a person turns 65, includes the month a person turns 65, and ends three months after the month the person turns 65
  - The seven-month period that starts three months before a person's 25th month of disability and ends three months after the 25th month of a person's disability
- During the annual open enrollment period from October 15 through December 7. During this time, members have the opportunity to move or change their Medicare plan
- Under certain circumstances that qualify you for a Special Enrollment Period (SEP), such as:
  - A change of residence that is outside current plan service area
  - Member becomes eligible for Medicaid
  - Member qualifies for Extra Help with Medicare prescription drug costs
  - Member getting care in an institution, such as a skilled nursing facility or long-term care hospital

10.2 Member ID Card

Every PacificSource member is either issued a member identification card or has access to the card information through our app, myPacificSource. Identification cards contain information necessary for claims submission (example is for members of commercial plans). If you have questions about a specific member's benefits or eligibility, please contact Customer Service. Accordingly, verification of eligibility is not a guarantee of coverage.

Please ask your patient for their PacificSource member ID card at the time of service. ID cards may include the following important information:

- Member's name
- Member numbers
  (Medicaid members will include OHA number)
- Group name and number (commercial members)
- Network name: The type of network is located below the member number. If a referral is required for the plan, the words "Referral Required" will be seen here.
- Effective dates
- Coverage (medical, vision, and/or dental)
- Pharmacy information and pharmacy identification numbers. If no "Drug List" is noted on their card, use our "PDL" list. Our drug lists are available online at PacificSource.com/find-a-drug.
- Contact information
- Electronic payor ID number
- Out-of-area network information: For members residing or accessing care outside the PacificSource service area
- Provider partners



Members are not required to make payment for services up-front to in-network providers, except for any applicable copayments, coinsurance, deductibles, or noncovered services.

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.

10.3 Rights and Responsibilities

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

PacificSource Health Plans Statement of Principles

In keeping with our commitment to provide the highest quality healthcare service to our members, PacificSource Health Plans 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.

10.3.1 Commercial Member Rights and Responsibilities

PacificSource Health Plans assures our members of the following:

- Members have a right to receive information about PacificSource, our services, our providers, and their rights and responsibilities.
- Members have a right to expect clear explanations of their plan benefits and exclusions.
- Members have a right to be treated with respect and dignity.
- Members have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- Members have a right to honest discussion of appropriate or medically necessary treatment options. Members are entitled to discuss those options regardless of how much the treatment costs or if it is covered by their plan.
- Members have a right to the confidential protection of their medical records and personal information.
- Members have a right to voice complaints about PacificSource or the care they receive, and to appeal decisions they believe are wrong.
- Members have a right to participate with their healthcare provider in decision-making regarding their care.
- Members have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- Members have a right to refuse treatment and be informed of any possible medical consequences.
- Members have a right to refuse to sign any consent form they do not fully understand, or cross out any part they do not want applied to their care.
- Members have a right to change their mind about treatment they previously agreed to.
- Members have a right to make recommendations regarding PacificSource Health Plans' member rights and responsibility policy.

As partners with PacificSource, members are responsible for:

- Reading their policy or handbook and all other communications from PacificSource, and for understanding their policy's benefits. Members are responsible for contacting PacificSource Customer Service if anything is unclear to them.
- Making sure their provider obtains benefit verification for any services that require it before they are treated.
- Providing PacificSource with all the information required to provide benefits under their plan.
- Giving their healthcare provider complete health information to help accurately diagnose and treat them.
- Telling their providers they are covered by PacificSource and showing their ID card when receiving care.
- Being on time for appointments, and calling their provider ahead of time if they need to cancel.
- Any fees the provider charges for late cancellations or "no shows."
- Contacting PacificSource if they believe they are not receiving adequate care.

- Supplying information to the extent possible that PacificSource needs to administer their benefits or their provider needs in order to provide care.
- Following the plans or instructions for care that the member has agreed to with their doctors.
- Understanding their health problems and participating in developing mutually agreed upon goals, to the degree possible.

10.3.2 PacificSource Community Solutions Member Rights

Individuals enrolled in the Oregon Health Plan (OHP) are afforded certain rights under the following rules and regulations:

- Exhibit B of the CCO contract
- OAR 410-141-3590
- Civil rights afforded under Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR Part 80
- Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972
- Titles II and III of the Americans with Disabilities Act
- Section 1557 of the Patient Protection and Affordable Care Act
- ORS Chapter 659 A

Under its contract with the Oregon Health Authority (OHA), PacificSource Community Solutions is responsible for communicating these rights to contracted providers and monitoring their compliance with these policies and procedures. This includes taking corrective action if the contracted provider fails to comply and report findings to the Quality Improvement Committee defined under OAR 410-141-3525.

PacificSource Community Solutions members shall have the following rights:

- For PacificSource Community Solutions to require and cause its network providers to require that members are treated with dignity and respect with due considerations for their dignity and privacy, and the same as nonmembers or other patients who receive services equivalent to covered services.
- To be treated by network 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 healthcare professional from available network providers, including facilities, to the extent possible and appropriate and to change those choices as permitted in PacificSource Community Solutions' administrative policies. For a member in a service area serviced by only one CCO, any limitation PacificSource Community Solutions imposes on a member's freedom to change between a primary care provider (PCP), service site, or to obtain a service from an out-of-network provider if the service or type of provider is not available in PacificSource Community Solutions' network may be no more restrictive than the limitation on disenrollment under Exhibit B, Part 3, Section 6b of the CCO contract.
- To have a sexual abuse exam without prior authorization.
- To refer oneself directly to a traditional health worker, behavioral health, chemical dependency, or for family planning services without getting a referral from a PCP or other network 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 if covered services are to be provided, and to have family involved in the treatment planning.
- To be given information about his/her condition, covered, and noncovered services to allow an informed decision about proposed treatment(s).
- 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 PacificSource Community Solutions develop and provide written information, materials, educational programs, and a mechanism to help members or potential members understand the requirements and benefits of PacificSource Community Solutions consistent with OAR 410-141-3580 and 410-141-3590.
- To receive communications of individually identifiable health information from the Plan by alternative means or at alternative locations per 45 CFR 164.522 if the member provides a written statement that includes:
  - (A) A valid alternative address or other method of contact suitable for enabling the member to receive communications from the Plan (e.g., valid cell phone number, verifiable e-mail address); and
  - (B) If required by the Plan, a clearly stated disclosure that all or part of the protected health information could put the member in danger.
- To obtain covered preventive services.
- To receive referrals to specialty providers for medically appropriate covered coordinated care services in the manner provided in the CCO's referral policy.
- For PacificSource Community Solutions to require its network providers to require that members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language, and ability to understand.
- To participate in decisions regarding their healthcare, including the right to refuse treatment and has the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency or behavioral health treatment, and the right to execute directives and power of attorney for health care established under ORS 127.505 to 127.660 and the OBRA 1990 – Patient Self-determination Act.
- To execute an advance directive and/or a declaration for mental health, a statement of wishes for treatment, including the right to accept or refuse medical, dental, surgical, chemical dependency, or mental health treatment, and to designate 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.
- For PacificSource Community Solutions to ensure and cause its network providers to ensure that each member is free to exercise their rights, and that the exercise of those rights does not adversely affect the way PacificSource Community Solutions, its staff, subcontractors, network providers or OHA, treat the member. For PacificSource Community Solutions to not discriminate in any way against members when those members exercise their rights under the OHP.
- To receive a Certified Interpreter or qualified interpreter services free of charge whether a potential member or a member of PacificSource Community Solutions. This service applies to all non-English languages, not just those that OHA identifies as prevalent. For PacificSource Community Solutions to notify its members and potential members that oral interpretation is available free of charge for any language and that written information is available in prevalent non-English languages in the service area(s) as specified in 42 CFR 438.10(d)(4). For PacificSource Community Solutions to also notify its members on how to access oral interpretation and written translation services.

- To receive a notice of an appointment cancellation in a timely manner.
- To be able to make a complaint or appeal with PacificSource Community Solutions and receive a response.
- To request a contested case hearing.
- To receive notice of PacificSource Community Solutions' nondiscrimination policy and process to report a complaint of discrimination based on 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. A copy of the latest Nondiscrimination Statement can be found here: https://pacificsource.com/media/36621
- To report a complaint of discrimination by contacting PacificSource Community Solutions, OHA, the Bureau of Labor and Industries (BOLI), or the Office of Civil Rights (OCR) and that they are aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A.
- To receive equal access for both males or females identified under 18 years of age to appropriate facilities, services, and treatment under the CCO 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 CCO contract in accordance with 42 CFR 447.50 through 42 CFR 447.60 and with the General Rules. For PacificSource Community Solutions to notify members of their responsibility for paying a copayment for some services as specified in OAR 410-120-1230.
- For PacificSource Community Solutions to ensure that its subcontractors notify members of their responsibility for any cost sharing or payment of copayments authorized in the CCO Contract and OAR.
- For PacificSource Community Solutions to furnish to each of its members the information specified in 42 CFR 438.10(f)(2)-(3) and 42 CFR 438.10(g), if applicable, as specified in the CFR within 30 days after PacificSource Community Solutions receives notice of the member's enrollment from OHA and/or Health Share or for members who are fully Dual eligible, within the time period required by Medicare. To be notified of the right to request and obtain the information described in this bullet at least once a year.
- To be furnished with healthcare services in accordance with § 438.206 through 438.210, which includes making services available, maintaining a sufficient provider network, coordinating care and covering services.
- For PacificSource Community Solutions to ensure:
  - Timely access to all covered services described in the CCO contract.
  - Access to a network of providers that meets the standards developed by the State in accordance with §438.68.
  - Access to a sufficient network of appropriate providers that is maintained, monitored, supported by written agreements, and sufficient to provide adequate access to all services covered under the contract for all enrollees including those with limited English proficiency or physical or mental disabilities.
  - Direct access for female enrollees to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
  - A second opinion from a qualified Provider within the network, or have PacificSource Community Solutions arrange for the member to obtain a qualified provider from outside the network, at no cost to the member.

- If the network is unable to provide necessary services covered under the CCO contract to a particular member, PacificSource Community Solutions must adequately and timely cover these services out-of-network for the member for as long as PacificSource Community Solutions' network is unable to provide them.
- Out-of-network providers coordinate with PacificSource Community Solutions for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network.
- Access to a network of providers credentialed in accordance with 42 CFR §438.214.
- Access to a sufficient network of family planning providers and for PacificSource Community Solutions to ensure timely access to covered services.
- Timely access to a network of providers who:
  - Meet State standards for timely access to care and services, taking into account the urgency of the need for services,
  - Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service (FFS), if the provider serves only Medicaid enrollees,
  - Provide medically necessary services 24 hours a day, seven days a week without prior authorization.
- Access to culturally and linguistically appropriate services and supports, in a culturally competent manner. Includes services and support for those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Service and supports should be made available in a manner that meets the members' unique needs and in locations that are as geographically close to where members reside or seek services as possible. Should offer 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..
- A Network of providers who provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
- Oversight, care coordination, transition, and planning management from PacificSource Community Solutions within the targeted population of the State 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.
- Members have the right to choose a primary care provider and other healthcare professionals, such as Traditional Health Workers, to the extent possible and appropriate.
- Members have the right to work with a care team including healthcare providers and community resources appropriate to the member's needs and have a consistent and stable relationship with a care team that is responsible for comprehensive care management.
- Written materials are explained in a manner that is understandable to the member, and to be educated about the coordinated care approach being used in the community and how to navigate the coordinated healthcare system.
- 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 or qualified interpreters, certified traditional healthcare workers (THW) including, community health workers (CHW), peer support specialists (PSS), doulas, and personal health navigators (PHN) 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 processes affecting the member's care and services.

- An effort is made to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.
- A clinical record is maintained which documents conditions, services received, and referrals made. Documented activities are shared with OHA and other CCO's to prevent the duplication of activities.
- Providers furnishing services to members maintain and share, as appropriate, a member health record in accordance with professional standards, and members have the right to request and receive a copy of their own health record, unless restricted in accordance with ORS 179.505 or other applicable law, and to request that the records be protected, amended or corrected as specified in 45 CFR Part 164. Members also have the right to transfer a copy of his/her clinical record to another provider.
- Members who have been identified by the State as having special healthcare needs (SHCN) or needing long-term services and supports (LTSS) are provided additional services, including:
    - A comprehensive assessment to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring, which utilizes appropriate providers or individuals who meet LTSS service coordination requirements of the State or PacificSource Community Solutions, as appropriate.
    - A treatment or service plan that meets the criteria in §438.208 (c)(3)(i) through (v) for members who require LTSS and/or a treatment or service plan meeting the criteria in paragraphs §438.208 (c)(3)(iii) through (v) for members with special health care needs.
    - Direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.
- Members have the right to receive services in an amount, duration, and scope that is no less than the same services furnished to FFS Medicaid beneficiaries, as set forth in §440.230 and for enrollees under the age of 21, as set forth in subpart B or part 441.
- Each member has access to covered services, which at least equals access available to other persons served by the plan. The plan ensures access through multiple mechanisms, including its Service Authorization policy, which describes the services the plan must cover and any utilization controls.
- Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20.
- Members have access to medically necessary services that are provided in a manner that:
    - Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits (NQTL), as indicated in state statutes and regulations, the State Plan, and other state policy and procedures; and addresses the extent to which PacificSource Community Solutions is responsible for covering services that address: The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.
- The ability for a member to achieve age-appropriate growth and development.
- The ability for a member to attain, maintain, or regain functional capacity.
- The opportunity for a member receiving LTSS, to have access to the benefits of community living, to achieve integrated person-centered goals, and live and work in the setting of their choice.
- Members have the right to have service authorization requests be processed:
    - In a way that ensures PacificSource Community Solutions' review criteria is applied consistently when making authorization decisions,
    - In consultation with the requesting provider, when applicable, and

    - In consideration of a LTSS enrollee's current needs assessment and consistent with the person-centered service plan.
- Members are notified timely and before a denial of, or change in, a drug, benefit or service level is made in an amount, duration, or scope that is less than requested, unless such notice is not required by federal or state regulations. Member notices must meet the requirements in 42 CFR §438.404 and the CCO contract.
- Members have the right to inquire about the compensation of individuals or entities conducting utilization management activities.
- To utilize electronic methods of communications upon request and if available. PacificSource Community Solutions may utilize electronic communications for purposes described only if:
    - The recipient has requested or approved electronic transmittal.
    - The identical information is available in written form upon request.
    - The information does not constitute a direct member notice related to an adverse Action or any portion of a Grievance, Appeals, Contested Case Hearings or any other member rights or member protection process.
    - Language and alternative format accommodations are available; and all HIPAA requirements are satisfied with respect to personal information

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 their 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 choose a Prepaid Health Plan (PHP) or Primary Care Manager (PCM) as permitted in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, a Primary Care Provider (PCP) or service site, and to change those choices as permitted in OAR 410-141-0080, Oregon Health Plan Disenrollment from PHPs, and the PHP's administrative policies.
- To have access to urgent and emergency services 24-hours a day, seven days a week as described in OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services.
- To know how to make a complaint or appeal with the Prepaid Health Plan (PHP) and receive a response as defined in OAR 410-141-0260 to 410-141-0266.
- To receive interpreter services as defined in OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility.

- 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 prior authorization 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 them 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.
- 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.

10.3.3 Medicare Members' Rights and Responsibilities

PacificSource Medicare assures our members of the following:

- To be treated with dignity and respect.
- To impartial access without discrimination or unfair treatment in regard to race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.
- To refer oneself directly to mental health, chemical dependency, or family planning services without getting a referral from a PCP or other in-network 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(s).
- 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 Medicare member.
- To receive necessary and reasonable services to diagnose the presenting condition.
- To receive covered services under the Oregon Health Plan that meet generally accepted standards of practice and is medically appropriate.
- To obtain covered preventive services.
- To receive a referral to specialty practitioners for medically appropriate covered services.
- To have a clinical record maintained which documents conditions, services received, and authorizations made.
- To have access to one's own clinical record, unless restricted by statute.
- To transfer of 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, 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 request an administrative hearing with the Department of Human Services (DHS or Department).
- To receive a notice of an appointment cancellation in a timely manner.

PacificSource Medicare Member Responsibilities

- To keep his/her appointments with providers at the scheduled time and date, or notify the provider when unable to keep the appointment.
- To present the PacificSource Medicare ID card prior to receiving services.
- To provide complete and accurate information about his/her medical conditions and history when seeking medical assistance.

- To follow the care and treatment plan recommended by his/her provider(s) and agreed upon by the member.
- To pay all applicable copays and fees at the time of service, and keep current on his/her monthly premium payments.
- To notify PacificSource Medicare immediately of any changes in his/her address, phone number, or membership status.
- To notify Customer Service about any changes in health insurance coverage from other sources, such as employers, spouse's employer, workers' compensation, Medicaid, or liability claims, such as claims from an automobile accident.

Member Access to Information Regarding Their Rights

Each member is provided an Evidence of Coverage (EOC) that provides detailed information regarding their rights as a member of PacificSource Medicare. Additional information and resources regarding member rights is available to members by calling our Customer Service department.

Interpreter services are available to answer questions from non-English speaking members. We can also give you information in Braille, large print, or other alternate formats if requested. Members eligible for Medicare because of a disability are provided information about the plan's benefits and rights that is accessible and appropriate for their needs.

If members have any trouble getting information from PacificSource Medicare because of problems related to language or a disability, please call Medicare at 800-MEDICARE or 800-633-4227, 24 hours a day, seven days a week, and tell them that you want to file a complaint. TTY users should call 877-486-2048.

10.4 Member Grievance and Appeals Process

PacificSource 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 formal appeals of denied services (claims or service denials).

PacificSource Medicare, PacificSource Community Solutions (Medicaid), and PacificSource Health Plans have different processes. Each process meets any and all guidelines established by the relevant regulatory agency, such as the Centers for Medicare and Medicaid Services (CMS), Oregon Health Authority (OHA), and the Department of Consumer and Business Services (DCBS). For additional details regarding PacificSource Community Solutions' grievance and appeal policies and procedures, refer to the following documents:

- Medicaid Grievance and Appeals System – Grievances, Appeals and Hearings
- Medicaid Grievance and Appeals System – Notice of Adverse Benefit Determination
- Medicaid Grievance and Appeals System – Member Information and Education Requirements

All plan members receive information about their grievance and appeal rights in their Member Handbook/ Evidence of Coverage. If payment of a claim is denied as member responsibility, or coverage of a service is denied on a prior authorization request, members are individually notified in writing of their appeal rights. This notice informs the member of his/her appeal rights and other information regarding the process, including outside review if appropriate. In the case of Medicaid members, they may receive written notice of claim denials even though they are not financially responsible in most situations.

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 Commercial Customer Service

Idaho: 208-333-1596, 800-688-5008
Montana: 406-442-6589, 877-590-1596
Oregon: 541-684-5582, 888-977-9299
Washington: 866-566-1224
TTY: 711. We accept all relay calls.
Fax: 541-684-5264
Email: CS@PacificSource.com

PacificSource Community Solutions Customer Service

Phone: 541-382-5920
Toll-free: 800-431-4135
TTY: 711. We accept all relay calls.

PacificSource Medicare Advantage Customer Service

Bend: 541-385-5315
Boise: 208-433-4612
Springfield: 541-225-3771
Toll-free: 888-863-3637
TTY: 711. We accept all relay calls.

Please note: A provider can file an appeal or grievance on a member's behalf with an appropriate and valid Appointment of Representative (AOR) form.

11. Claims

11.1 Eligibility and Benefits

The PacificSource provider portal, InTouch, is the preferred method and a convenient way for our provider partners to check members' eligibility and benefits. PacificSource also has a dedicated Customer Service team available to assist both you and your patients with questions related to claims' status, benefits, and eligibility. Interpreter services are available to answer questions from non-English speaking members. Information is also available in Braille, large print, or other alternate formats upon request. Call PacificSource Customer Service for:

- Member benefits, eligibility information, or waivers
- Deductible, coinsurance and/or copay information
- Explanation of payments/vouchers
- In-network physicians and providers
- Claims inquiries
- Claim-specific billing and/or coding questions
- Referrals or authorization inquiries

Commercial contacts:

Toll-free: 855-896-5208 or 888-977-9299
TTY: 711. We accept all relay calls.
Fax: 541-684-5264
Email: CS@PacificSource.com

Medicaid contacts:

Toll-free, all areas: 800-431-4135
Bend area: 541-382-5920
TTY: 711. We accept all relay calls.
Fax: 541-322-6423
Email: CommunitySolutionsCS@PacificSource.com

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

Hours: 8:00 a.m. to 5:00 p.m. Monday through Friday

Medicare contacts:

Bend: 541-385-5315
Boise: 208-433-4612
Springfield: 541-225-3771
Toll-free: 888-863-3637
TTY: 711. We accept all relay calls.
Fax: 541-322-6423
Email: MedicareCS@PacificSource.com

Customer Service is available:

- October 1–March 31: 8:00 a.m. to 8:00 p.m., local time zone, seven days a week
- April 1–September 30: 8:00 a.m. to 8:00 p.m., local time zone, Monday–Friday

11.2 HCPCS/CPT/NDC Coding

PacificSource requires current HCPCS coding for durable medical equipment, supplies, and office medication whenever possible. Utilization of this coding system is designed to promote uniform medical services reporting and statistical data collection. The HCPCS Level II code book is prepared for use with Current Procedural Technology (CPT) codes published by the federal government and is the standard for coding these services.

The Centers for Medicare Medicaid Services, (CMS) updates HCPCS codes annually. CMS created this series of codes to supplement CPT coding, which does not include coding for nonphysician procedures, such as durable medical equipment and specific supplies. In addition, more specific codes were created for the administration of injectable drugs. If a compatible CPT code is available, always use the CPT code instead of the HCPCS code.

PacificSource Medicare follows Medicare LCD's/NCD's coding for DME billing. These coding guidelines can be found at CMS.gov/Medicare-coverage-database.

PacificSource uses the following fee schedules for reimbursement of Durable Medical Equipment, orthotics and supplies, and Parenteral and Nutrition (PEN):

- CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule
- MED.NoridianMedicare.com/web/jddme/fees-news/fee-schedules/parenteral-enteral-nutrition

NDC Billing/Claims Requirements:

PacificSource is enforcing this requirement across all lines; commercial, Medicare, and Medicaid to continue alignment through our business. In addition to Medicaid, PacificSource already requires the NDC in some cases within our commercial line, especially if pricing with average wholesale pricing (AWP).

All outpatient claims submitted for reimbursement that contain drug-related codes must include the NDC number, quantity, and unit of measurement to be considered valid. This requirement applies to paper claim forms CMS-1500 and UB-04, and to Electronic Data Interface (EDI) transactions when billed for drug-related HCPC and CPT codes.

What codes require an NDC?

All drug-related HCPCS/CPT codes, including unlisted drug codes

- All J codes
- Drug-related Q codes
- Drug-related S codes
- Drug-related A codes
- Drug-related CPT codes
- Drug-related Rev codes

Is the NDC required for a completed claim?

Yes. Your claim may be rejected if you do not include the current NDC 11-digit number for each drug-related HCPCS/CPT code submitted.

- The NDC number must be entered with the service lines in Box 24 of the CMS-1500 form, Box 43 of the UB-04 or the LIN03 segment of the HIPAA 837P or 837I.

What NDC information is required?

- Valid 11-digit NDC number
- NDC unit of measure (F2, GR, MG, ML, UN)
- NDC units dispensed must be greater than 0

Is the NDC required in addition to HCPCS/CPT codes?

Yes. The NDC must be submitted in addition to the applicable HCPCS/CPT and the number of HCPCS/CPT units.

- A valid HCPCS/CPT code with units of service must continue to be entered on the claim form. Pricing is based on the HCPCS/CPT codes and units of service.

Are the NDC units different from the HCPCS/CPT code units?

Yes. The HCPCS/CPT code units have not changed. You will bill these units as you have in the past.

- NDC units are based on the numeric quantity administered to the patient and unit of measurement (UOM).

The Unit of Measurement (UOM) codes are:

- F2 = International Unit
- GR = Gram
- ME = Milligram
- ML = Milliliter
- UN = Unit

Durable Medical Equipment (DME) and Supplies, Including Orthotics and Prosthetics

- Use the appropriate E, K, or L code to describe durable medical equipment, supplies, orthotics, or prosthetics.
- Prior authorization is required for any durable medical equipment item over $2,500 or as otherwise stated on the PacificSource Authorization Grid. Please see the Medical Management section, Services Requiring Prior Authorization.
- If there is no code, use the appropriate unlisted procedure code and include a description of the item.
- Drug Administration.
- Use the appropriate J code to describe drugs administered, including injectable, oral, and chemotherapy drugs.
- Look closely at the code description for unit or dosage information. If more than the designated unit or dosage amount is used, enter the multiple value in the "Number of Service" area on the CMS 1500 form.
- If there is no code, use the appropriate unlisted procedure code and include a description of the item.
- Sterile Tray: Use HCPCS code A4550.

Special Report

A special report is required when a new, unusual, or variable procedure is provided.

Unlisted Procedures

Use an unlisted procedure code only when the service or supply is not otherwise classified. Claims coded with miscellaneous HCPCS/CPT codes may be subject to review by Health Services, and may require a report.

Modifiers

Under certain situations, a code may require a modifier to indicate that the procedure has been altered by a specific circumstance. In some instances, modified procedures may be subject to review by Health Services. A special report may be required to clarify the use of the modifier.

11.3 Claims and Payment Rules

General Claims Information

PacificSource 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 reserves the right to do retrospective review of claims paid.

PacificSource requires claims to be submitted either on 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 will be billed on the UB-04 using billing rules for PacificSource members to facilitate collection of encounter data.
- Physician claims will be billed on the CMS-1500 using billing rules for PacificSource members to facilitate collection of encounter data.
- All other claims except Pharmacy, DME, Lab/X-ray, Transportation, and Ancillary services will be billed on the CMS-1500 according to billing rules for PacificSource members. PacificSource Medicare will work with in-network providers to ensure they have the necessary guides to ensure proper billing.

With the advent of encounter data collection by CMS, health plans doing business with state and federal government (such as PacificSource Medicare) are now required to report to the most specific or fifth ICD-10 digit on all CMS-1500 and UB-04 forms. Not only is coding specificity and accuracy extremely important, but placement of the information in the appropriate box on the forms has become critical. Following is a brief overview of the coding rationale.

First, if offices and hospitals submit claims with accurate coding, it is likely a claim will not be rejected by PacificSource. This will also result in a quicker payment turnaround time. In addition, the need to rebill will be minimized.

Second, CMS (Medicare) uses the "encounter information" captured from the data submitted on CMS-1500's and UB-04's to establish risk scores for members enrolled in the various health plans. CMS reimbursement will be determined from the risk scores. Plans that enroll sicker members will receive better funding to compensate providers for care provided to health plan members. However, risk adjustment works only with complete and accurate data.

General Payment Guidelines

An important element in claims filing is the submission of current and accurate codes to reflect the provider's services.

HIPAA-AS mandates the following code sets:

- The Internal Classification of Disease, Ninth Revision–Clinical Modification (ICD-9-CM) (Effective 10/01/14 ICD-10-CM)
- The Provider's Current Procedural Terminology (CPT), Fourth Edition
- The Healthcare Common Procedure Coding System (HCPCS)
- Modifier reported when appropriate; follow CPT and HCPCS coding guidelines
- Place of Service 2-Digit Place of Service Codes CMS.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Providers are required to use the standard CMS codes for ICD, CPT, and HCPCS services, regardless of the type of submission.

PacificSource Medicare covers the professional and technical components of global CPT procedures. Therefore, the appropriate professional component modifiers and technical component modifiers should be included on the claim form.

Claims processing is subject to change based upon newly promulgated guidelines an rules issued by CMS.

For payment of Medicare claims, PacificSource has adopted all guidelines and rules established by CMS. PacificSource Medicare members may only be billed for their applicable copays, coinsurance, and noncovered services.

PacificSource Community Solutions does not process claims for dental services. Please refer to your Dental Care Organization for claims processes.

Limit to billed charges

Unless expressly stated otherwise elsewhere in the Participating Provider Service Agreement, PacificSource reserves the right to limit allowable amounts to the lesser of the billed amount or PacificSource negotiated rates in effect at the time of service. Consistent with industry accepted methodologies, billed services represented by CPTs, HCPCs, and APCs will limit to billed charges at the line-level. In the event of OPPS APC claims which result in additional Outlier payments, the Outlier payment will also be applied based on the limit to billed charges at line-level provision.

Retroactive rate adjustments

PacificSource loads fee schedules and provider rates from a variety of external sources, including but not limited to, Center for Medicare and Medicaid Services (CMS), Oregon Health Authority (OHA), Optum, American Society of Anesthesiologists (ASA), and Noridian. These published or submitted reimbursement rates are made available to PacificSource via publications, downloads, and supplied directly by providers and facilities.

In cases where the source of retroactive effective dates is external, including websites and provider submissions of Noridian rate sheets, PacificSource will not reprocess claims to accommodate the adjustments. An exception to this policy applies when specific direction on retroactive adjustments comes from a regulatory or governmental agency, when action is needed to address fraud, waste, or abuse, or when PacificSource oversight, delay, or error has occurred. In these cases, affected claims will be reprocessed.

Instructions to complete claim forms

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

- UB-04 (chapter 25)
- CMS-1500 (chapter 26)

Commercial claims submission

Electronic payor ID: 93029

Affiliated clearinghouses:

For a list of clearinghouses, visit our website at PacificSource.com/providers/medical/claims-guidelines, or contact your Provider Relations Representative.

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

Claims mailing address:

PacificSource Health Plans
PO Box 7068
Springfield, OR 97475-0068

Medicaid claims submission

Electronic payor ID: 20416

Affiliated clearinghouses:

For a list of clearinghouses, visit our website at PacificSource.com/providers/medical/claims-guidelines, or contact your Provider Relations Representative.

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

Medicare claims submission

Claims should be submitted in one of the following formats:

- Electronic claims submission
- Electronic payor ID: 20377

UB-04 Form/CMS-1500 Form

Mail to:

PacificSource Medicare
PO Box 7068
Springfield, OR 97475-0068

This section provides information about claims submission, processing, and payment. Providers should submit all claims for PacificSource Medicare members, except for certain services that must be billed to Original Medicare (e.g., certain clinical trial services CMS determines and hospice care). If a provider submits a claim to PacificSource Medicare that should have been submitted to Original Medicare, PacificSource Medicare will return the claim to the provider.

PacificSource Medicare claims should be submitted using Medicare billing guidelines and format (CMS-1500 or UB-04), and the National Provider Identifier (NPI). Additional information is available from CMS at CMS.hhs.gov/Manuals/IOM/list.asp. Search for publication #100-04.

Providers should include the member's complete identification number (ID) when submitting a claim. PacificSource Medicare member ID numbers are 9 digits long and begin with the number 6. PacificSource Medicare cannot process claims with incorrect or incomplete member identification numbers.

Claims submitted without all required information will be returned (paper submission) or denied (electronic submission).

11.4 Claims submission requirements

When to submit claims

PacificSource encourages providers to submit all claims as soon as possible after the date of service to facilitate prompt payment and avoid delays that may result from expiration of timely filing requirements. Exceptions may be made to the timely filing requirements of a claim when situations arise concerning other payor primary liability, such as Original Medicare, Medicaid or third-party insurers, or legal action and/or an error by PacificSource Medicare.

PacificSource Medicare must submit encounter data and medical records to certify completeness and truthfulness of information submitted to CMS, [42 CFR 422.50(a) (8); CFR 422.50(1), (2) and (3)]. In turn, PacificSource Medicare network providers must submit complete and accurately coded claims, and assist PacificSource Medicare in correcting any identified errors or omissions.

PacificSource Medicare reserves the right to do retrospective review of claims paid.

Timely submission of claims

PacificSource abides by CMS Prompt Payment Guidelines. Timely submission is subject to statutory changes. Therefore, claims should be submitted within the timely filing period established by regulatory statute (365 days), unless your contract stipulates something different. Providers should reference their contract with PacificSource Medicare for the stipulated claims submission guidelines. **Note that Medicaid has a different timeline for initial claims submissions (four months).**

When PacificSource Community Solutions is secondary, submit your claim with the primary carrier's Explanation of Payment (EOP) statement. In accordance with OAR 410-141-3565, providers have up to 365 days from the date of payment/denial from the primary carrier to submit to PacificSource Community Solutions.

When PacificSource Health Plans is secondary, submit your claim with the primary carrier's EOP. Providers have up to one year from the date of payment/denial from the primary carrier to submit to PacificSource.

Plan members cannot be billed for services denied due to a lack of timely filing. Claims appealed for timely filing should be submitted with proof along with a copy of the Explanation of Payment (EOP) and the claim.

Acceptable proof of timely filing will be in the form of a registered postal receipt signed by a representative of the plan or a similar receipt from other commercial delivery services.

Electronic Medical Claims

PacificSource 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.

We strongly encourage electronic billing. 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 is currently accepting 837-5010 HIPAA compliant claim transactions either directly from provider offices or through our clearinghouses.

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 Relations 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?

For information on connecting to an electronic clearinghouse, please contact our Information Technology department by phone at 800-624-6052 or by email at Info@PacificSource.com.

Common claim filing errors

Proper payment of claims is a result of efforts of the provider, employee clinicians, and billing personnel, and of adherence to national and local payment policy requirements. This section: (a) describes common claim filing errors that can result in claim rejections or claim denials, (b) includes general requirements for properly resubmitting rejected claims, and (c) discusses the process for appealing a denied claim.

Generally, the common types of errors that result in claim denials are:

- Billing/data entry errors
- Noncompliance with coverage policy
- Billing for services that are not medically necessary
- Incorrect member ID number
- Invalid/missing diagnosis code
- Past timely filing requirements
- Incorrect provider number

- Missing, incorrect, or invalid modifier
- Invalid/missing Healthcare Common Procedure Coding Systems (HCPCS) code
- Missing or incorrect quantity

In some cases, additional documentation may be required in order for the claim to complete adjudication. After PacificSource receives the additional information, the claim is adjusted or corrected.

Payment or denial of health benefit plan claims (743.911)

- 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 a member, the insurer will 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 will notify the member and the provider in writing and give the member and the provider an explanation of the additional information needed to process the claim. The insurer will pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.
- 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.
- An insurer will 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.
- This section does not create an assignment of payment to a provider.
- Each insurer will 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.
- The director will adopt by rule a definition of "clean claim" and will consider the definition of "clean claim" used by the Federal Department of Health and Human Services for the payment of claims (formerly 743.866).

Hold harmless/balance billing

In the event the insurer fails to pay for healthcare services covered by PacificSource, the provider will not bill or otherwise attempt to collect from members for amounts owed by insurers, and members will not be liable to the provider for any sums owed by the insurer. Nothing in this section will be construed to in any manner limit the applicability of ORS 750.095 (2).

Nothing in this section impairs the right of a provider to charge, collect from, attempt to collect from, or maintain a civil action against a member for any of the following:

- Deductible, copay, or coinsurance amounts.
- Healthcare services not covered by the healthcare service contractor.
- Healthcare services rendered after the termination of the contract between the PacificSource Medicare and the provider, unless the healthcare services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract.

Members may seek and accept financial responsibility for noncovered healthcare services from a provider.

PacificSource Medicare does not limit the right of a provider to contract with the member for payment of services not within the scope of the coverage offered by PacificSource Medicare.

Billing Medicaid members

A provider rendering services to a PacificSource Community Solutions member may not bill the member or a financially responsible relative/representative for any **Medicaid-covered services,** except in the following situations:

- The member did not inform the provider of the member's enrollment with the plan at the time of service, and as a result, the provider was unable to bill the plan for any reason—including submitting a timely claim or lacking a pre-approval. (The provider must have documentation of attempts to obtain eligibility/enrollment information.)
- The member received services prior to enrolling in the plan. The member was retroactively enrolled with the plan to be effective on the date of service, but upon retroactive review, did not meet established criteria for coverage of the service provided.
- The member does not have full Oregon Health Plan benefits. For example, members with limited coverage (such as Standard members) may be billed for services that are not benefits of those programs. However, to bill the member under these circumstances, the provider must document that the member was informed in advance of receiving the specific service: 1) that it is not covered, 2) the estimated cost of the service, and 3) that the member/representative is financially responsible for payment of the specific service. The provider must document this in writing and the member/representative must have signed it to knowingly and voluntarily agree to be responsible for payment. Download the OHP Patient Responsibility Form: SharedSystems.DHSOHA.State.OR.US/DHSForms/Served/he3165.pdf

A provider rendering services to a PacificSource Community Solutions member may not bill the member or a financially responsible relative/representative for **non-covered services** except in the following situation:

The service is not covered/has been denied by the plan, and the member was informed in advance of receiving the specific service: 1) that it is not covered, 2) the estimated cost of the service, and 3) that the member/representative is financially responsible for payment of the specific service. The provider must document this in writing, and the member/representative must have signed it to knowingly and voluntarily agree to be responsible for payment. Download the OHP Patient Responsibility Form: SharedSystems.DHSOHA.State.OR.US/DHSForms/Served/he3165.pdf

A provider MAY NOT bill a plan member/representative for:

- Services that have been denied by the plan due to provider error (for example, required documentation not submitted, pre-approval not obtained)
- Missed appointments

Source: Oregon Administrative Rule 410-120-1280:
Secure.SOS.State.OR.US/OARD/viewSingleRule.action?ruleVrsnRsn=291495

Billing guidelines

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

- Assistant surgeon allowances
- Global billing period
- DRG payment criteria
- Eliminating procedure code unbundling

Unbundling occurs when a provider bills in multiple parts for a procedure that would typically be reported under a single comprehensive code. This unethical act reflects improper procedure reporting under CCI

coding requirements. CMS has identified specific code pairs that PacificSource will reject if a provider bills for them for the same patient on the same day. In most unbundling cases, providers cannot bill beneficiaries for amounts Medicare denies due to unbundling. PacificSource has adopted a policy of reviewing claims to ensure correct coding. The plan utilizes a corrective coding re-bundling/unbundling software, which is integrated with our claims payment system. Services that should be bundled and paid under a single procedure code will be subject to review.

Audit and Disclaimer Information

PacificSource reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated. If such an audit determines that the office/facility did not comply with this payment policy, PacificSource will expect the office/facility to refund all payments related to noncompliance. For more information about PacificSource audit policies, refer to the Claims Review Guidelines and Program Integrity (PI) audits in this manual. This policy provides information on PacificSource claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Coordination of benefits (COB)

Coverage, claims submission, and procedures: When scheduling a patient appointment or at patient check-in, be sure to confirm any other coverage your patient may have. If your patient has other coverage, please follow the Coordination of Benefits process described below, as well as the requirements outlined under Eligibility and Benefits and Claims Submission Requirements.

PacificSource lines of business abbreviations	
Commercial:	PacificSource Health Plans/PSHP
Medicare:	PacificSource Community Health Plans/PCHP
Medicaid:	PacificSource Community Solutions/PCS

In general, if a patient has primary coverage with another carrier, and PSHP, PCHP, or PCS insurance as the secondary coverage, the primary carrier should be billed first. PacificSource must receive the claim no later than 365 days from the primary carrier's Explanation of Payment (EOP) date. Upon receipt of payment from the primary insurance carrier, charges should then be submitted to PacificSource, accompanied by the primary insurance carrier's EOP. Also note that when any combination of PSHP, PCHP, and PCS are both the primary and secondary insurance carrier, the secondary claim is automatically processed by PSHP, PCHP, or PCS after the primary claim has been processed. There is no need for the provider to resubmit the secondary claim.

When another carrier is the primary insurance carrier, and PCS is the secondary insurance carrier, providers should submit claims with the primary insurance carrier's EOP statement. Providers have up to 365 days from the date of payment/denial from the primary carrier to submit to PCS. Exceptions to this timely filing guideline can be found in Division 141 of the OARs under the Billing and Payment sections (OAR 410-141-3465).

When PSHP or PCHP is the secondary insurance coverage to any primary commercial insurance, Coordination of Benefits will be reimbursed to the lesser insurance allowable under the primary insurance or the PSHP allowed amount if it had been the primary insurance coverage. The combined benefits of all plans should not exceed the total allowable expense.

When PSHP is secondary insurance coverage to any other Medicare plan, Coordination of Benefits will be reimbursed according to the Medicare allowable.

When PCS is secondary insurance coverage to any primary insurance, Coordination of Benefits will be reimbursed according to the lessor insurance allowable.

Claim review guidelines

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

Overpayment recovery

PacificSource may initiate provider refunds for any overpayment due to noncompliance with billing guidelines and/or regulatory requirements. In the event that CMS terms (retro-disenrolls) a member, PacificSource Medicare reserves the right to initiate provider refunds for any applicable time period.

Network providers are required to report overpayments that they identify to PacificSource. For overpayments made by PacificSource Community Solutions you must return the overpayment within 60 calendar days of the date the overpayment was identified, and notify us in writing with the reason for the overpayment. Mail your written notification and refund of overpayment to PacificSource Community Solutions: PO Box 7469, Bend, OR 97708.

In response to ORS 743B.451, PacificSource has adapted the overpayment policy as detailed below:

PacificSource will send the provider an initial refund request.

- 30 days from the initial request: If we have not received a refund, or the provider has not contested the refund within this timeframe, we will send a reminder (second refund request).
- 60 days after the initial request: If we have still not received the refund, the overpayment will be auto-recovered on the next scheduled payment. Please see EOP examples on the following pages.

  Idaho, Oregon, Montana, and Washington providers may opt-in for immediate auto recovery of overpayment and waive the 60 day waiting period. If you are interested in this process, please complete the Auto-recoupment Enrollment Form at PacificSource.com/resources/documents-and-forms.

  Idaho providers: Refunds due from providers based in Idaho are immediately eligible for auto-recovery. This means that the auto-recovery could be taken in the payment run immediately after the claim adjustment so you may not receive a request letter (if the refund was recovered in full) or may receive a letter requesting only a portion of the total overpayment amount (if partial recovery was made). If auto-recovery cannot be completed within 30 days, we will send a refund request letter, with a follow-up after 45 days. For those providers who wish to opt out of immediate auto-recovery and prefer a refund request letter, please contact your Provider Relations Representative at IDProvNet@PacificSource.com.

To contest a refund, PacificSource requires the use of our Contested Refund Form, which is available at on Medicare.PacificSource.com or PacificSource.com. In addition to the form, supporting documentation is required to contest the refund. Examples of documentation include but not limited to:

- A new primary EOP when coordination of benefits is involved
- Chart notes that support the original payment

11.5 Corrected claims submission

PacificSource strives to make the claims process as efficient as possible. The correct way to submit a claim adjustment request is to include the type of bill frequency code 7 or 8 with the original claim number, also referred to as the Document Control Number (DCN) in Loop 2300 REF02—Payer Claim Control Number with qualifier F8 in REF01.

NOTE: If a charge was left off the original claim, submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.

For facility claims:
When submitting corrected institutional (facility) claims, take note of CLM05-2, the Facility Code Qualifier. In this instance, the CLM05-2 field would require a value of "A" indicating an institutional claim, along with the appropriate frequency code (7) as illustrated in the example below.

CLM*12345678*500***11:A:7*Y*A*Y*I*P~
REF*F8* (Enter the Claim Original Document Control Number)

Note: Providers who are unable to use a clearinghouse to submit a corrected claim will need to drop to paper. Please add "7 or 8" in box 4 TOB and the original claim number in box 64 Document Control Number on the UB04 form.

Note: Effective April 1, 2025, all corrected facility claims must include the appropriate condition codes, regardless of the reason for the correction. Claims submitted without the required condition codes will be rejected.

For professional claims:
For professional claims being billed on a CMS 1500 form, an example of the ANSI CLM segment containing the Claim Frequency Code 7—along with the required REF segment and Qualifier in Loop ID 2300 claim information—is provided below.

CLM*12345678*500***11:B:7*Y*A*Y*I*P~
REF*F8* (Enter the Claim Original Document Control Number)

Note: Providers who are unable to use a clearinghouse for corrected claims submission will need to drop to paper. Please add "7 or 8" along with the original claim number in box 22 of the CMS 1500 form.

Corrected claims submission time frames:

- **Commercial**—six months from the date the original claim was processed
- **Medicare**—twelve months from the date of service or date of last process
- **Medicaid**—180 days from the last claim processing date

If chart notes are needed to help support a correction, we will request those at the time of review. Please do not submit chart notes unless a request has been made.

11.6 Medicare: Special benefits

Hospice care—PacificSource Medicare

You must bill Original Medicare except for benefits that are exclusively covered by PacificSource Medicare. Claims that are not related to the hospice condition should be billed directly to Original Medicare with modifiers such as "GW" and "GV."

Although a member can revoke hospice at any time, claims should continue to be paid by Original Medicare until the first of the month following hospice termination. Please refer to the table below as a quick reference guide.

If the patient:	Submit all claims to:
Enrolls in hospice on the 1st of the month	**Original Medicare**
Revokes their hospice election on or after the 1st of the month	**Original Medicare**
Enrolls in hospice after the 1st of the month	**Original Medicare**
Enrolls in hospice after the 1st of the month and revokes their election the same month	**Original Medicare**
Enrolls in hospice on the 1st of the month, but services billed are not covered by Original Medicare	**Original Medicare is first. Submit Medicare EOB and claim to PacificSource Medicare second.**

11.7 Explanation of payment (EOP)

How to read your EOP

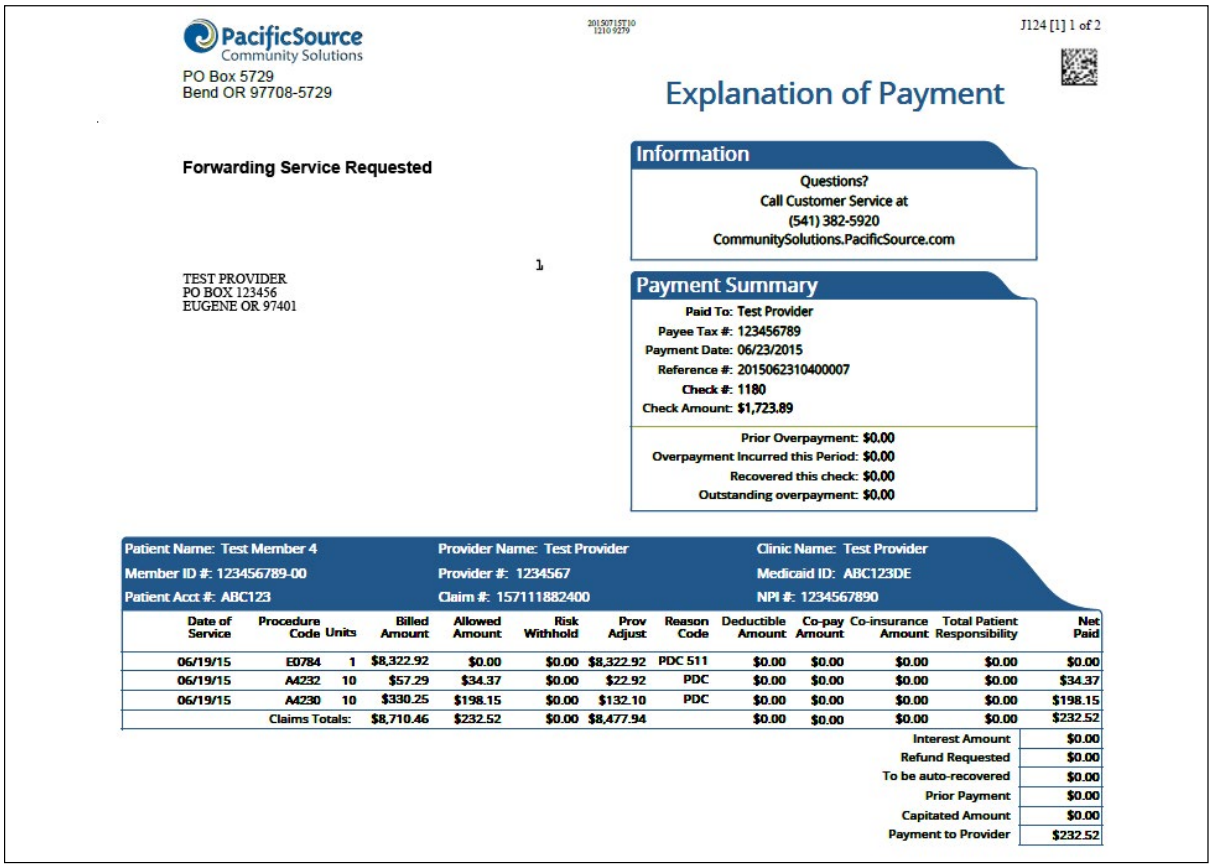
The PacificSource Explanation of Payment (EOP) is a statement that is mailed, along with payment, to physicians and providers on each scheduled payment date. The following information explains how to interpret the PacificSource Medicare EOP:

Patient, plan, and provider information section: The patient name, provider name, and clinic name are listed in the first row. The second row includes the PacificSource Medicare member ID, provider number, and the plan name (product). The third row includes the patient account number assigned by the provider, the PacificSource Medicare claim number, and the provider NPI number.

Claim processing detail section: This section breaks down how PacificSource Medicare processed the claim. The fields include:

- Date of Service
- Procedure Codes
- Units
- Billed Amount
- Allowed Amount
- Risk Withhold
- Provider Adjustment
- Sequestration Amount
- Reason Code
- Deductible Amount
- Copay Amount
- Coinsurance Amount
- Total Patient Responsibility
- Net Paid Amount

Reason Code explanations: This information appears at the end of the disbursement section. If further claim status clarification is needed, please contact our Customer Service department.



PacificSource Community Solutions
PO Box 5729
Bend OR 97708-5729

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Explanation of Payment

Forwarding Service Requested

TEST PROVIDER
PO BOX 123456
EUGENE OR 97401

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 | Provider Name: Test Provider | Clinic Name: Test Provider
Member ID #: 123456789-00 | Provider #: 1234567 | Medicaid ID: ABC123DE
Patient Acct #: ABC123 | Claim #: 157111882400 | 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

11.8 Prompt pay policy

- PacificSource will pay or deny a clean claim not later than 30 days after the date we receive the claim.
- We will begin counting the number of days either on the day PacificSource actually receives the claim, or on the day our representative (who performs claims handling, including pricing, on our behalf) receives the claim—whichever day comes first.
- A clean claim is a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- If additional information is necessary in order to process a claim, we will notify the provider and the enrollee in writing of the delay, and provide an explanation of the additional information required. We will process the claim not later than 30 days after the date we receive the additional information.
  - Provider contracts shall not include any provisions that are contrary to this policy.
  - PacificSource has an established method for informing providers of the necessary information to correctly submit a claim, and will make that information easily accessible.

Commercial

- If we fail to pay a commercial claim within 30 days of receipt when no additional information is needed, or within 30 days from the receipt of the additional information requested, we will pay simple interest based on the CMS interest rate for in-network providers per annum on the unpaid amount of the claim that is due. The interest will accrue from the date after the payment was due until the claim is paid. Interest payments will be limited to those required by state or federal law.

Interest calculations are based on the total claim paid amount (not based on the allowed amount), and rounded up to the nearest cent. Interest rate varies by state:

- Oregon – 12% per annum
  - No interest paid if less than $2.00 calculated interest payment.
- Idaho – 12% per annum
  - No interest paid if less than $4.00 calculated interest payment.
- Montana – 10% per annum
  - No interest paid if less than $5.00 calculated interest payment.
- Washington – 1% per month
  - No minimum calculated interest payment.
  - Interest calculated monthly as simple interest prorated for any portion of a month. **Self-funded groups may have differing policies and Prompt Pay may not apply**. If the interest is $2.01 or more, the interest will be paid with payment of the claim (we do not pay interest of $2.00 or less).

Medicare

PacificSource complies with interest penalty requirements for all clean claims that are not paid within prompt payment timelines for noncontracted providers.

Interest is paid to noncontracted providers on any clean claims not paid within 30 days.

Medicaid

PacificSource does not pay interest on Medicaid claims for in or out-of-network providers.

11.9 Accident and third-party information

Accident information and information indicating the existence of other coverage are essential for determining which insurance company has primary responsibility for a claim. Responsibility for claim payment varies by state and line of business. PacificSource needs accurate and timely accident and other coverage information from providers to properly process claims according to applicable law and plan benefits.

In addition to Coordination of Benefits with other health coverage, there are other situations that may arise where another insurance carrier could be liable for benefits, such as on-the-job injuries; motor vehicle accidents; and other third-party liability situations. Where applicable, such as in Montana, PacificSource will follow the made-whole rule.

Providers should provide notations in claim forms indicating accident and other coverage information to permit PacificSource to properly process all claims. Regardless of ultimate liability for claim payment, PacificSource will extend coverage and only seek reimbursement from the responsible party as required and permitted by applicable law.

11.10 Coordination of benefits

Group Health Insurance Coverage

Usually, group health insurance coverage, in Idaho, Montana, Oregon, and Washington, follows the COB order of benefits indicated below. Self-funded employer groups may not be subject to state insurance regulations and may follow different COB rules. If that is the case, a self-funded and a fully insured Plan may coordinate benefits differently than stated below.

Individual Health Insurance Coverage

In Oregon, the term "Plan" does not include individual or short-term health insurance policies. Generally, individual coverage will only pay the amount not covered by any other coverage. This is generally referred to as "nonduplication of benefits" (not COB).

Nondependent or Dependent

The Plan that covers the person other than as a dependent (e.g., employee, member, subscriber, or retiree) is primary.

Dependent Child Whose Parents Live Together

For a dependent child whose parents are married or living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is primary.
- If both parents have the same birthday, the Plan that has covered the parent longer is primary.

Dependent Child of Divorced or Separated Parents

For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- If a court decree states one parent is responsible for the child's healthcare expense, and the Plan is aware of the decree, the Plan of that parent is primary.
- If a court decree states that both parents are responsible for the child's healthcare expense, or assigns joint custody without specifying responsibility, the rule for "Dependent Child Whose Parents Live Together" (above) apply.
- If there is not court decree allocating responsibility for the child's healthcare expense, the Plan of the parent that has custody of the child is primary; the Plan of the spouse of the custodial parent is second; the Plan of the noncustodial parent is third; and the Plan of the spouse of the noncustodial parent is fourth.

Active/Inactive Employees

The Plan covering the person as an active employee, or dependent of an active employee when none of the above rules apply, is primary.

The Plan covering the person as an inactive employee (e.g., retired or laid-off employee), or dependent of an inactive employee when none of the above rules apply, is secondary.

COBRA or State Continuation Coverage

The Plan covering a person as an employee, member, subscriber, or retiree or the dependent of an employee, member, subscriber, or retiree is primary to a Plan covering the person as a COBRA or state continuation beneficiary.

Longer/Shorter Length of Coverage

If none of the above rules apply, such as when a self-funded and fully insured Plan's COB provisions do not agree, generally the Plan that covered the person the longest will be primary.

Document Imaging

Imaging technology (scanning paper and electronically storing and displaying an image of the paper on screen) has been utilized in business for many years. The secure computer network of PacificSource has made imaging technology a realistic and efficient method for storing paper.

PacificSource began the transition to electronic imaging in March 1998. The first application involves claims entry and retrieval. Claims are sorted into CMS 1500, UB-92, dental and miscellaneous categories and shipped to a service bureau in Portland. The bureau scans the documents, stores the images onto high-volume media and ships them back to PacificSource.

Guidelines for submitting claims for imaging:

- Use the CMS 1500 form
- Printing should be dark and clear
- 10- to 12-point type
- Black or blue print
- No discoloration or smudges
- Information aligned in appropriate box
- Only required claim form information
- Only one code per service line
- Circle specific pertinent information
- Diagnosis appropriate to date of service in box 21(1)
- Box 24(E) diagnosis corresponds to box 21(1)
- Block 25—Federal Tax Identification number
- Block 33—PIN (assigned PacificSource provider/ payee number)

The above guidelines will help ensure the timely processing and payment of claims.

12. Billing Requirements

By using the correct procedure codes when you bill PacificSource, you enable us to process your claims accurately and efficiently. 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.

12.1 "Incident to" Billing

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

PacificSource allows "incident to" billing for providers who are not eligible to be credentialed by PacificSource or a delegated credentialing entity. This allows practices the opportunity to fully utilize their staff appropriately. PacificSource does not allow "incident to" billing for practitioners who are eligible for credentialing.

In order for a service to be considered for payment under the "incident to" billing policy, the modifier SA must be appended to the CPT code. Only claims with the required SA modifier will be considered eligible for "incident to" billing.

In limited situations, PacificSource allows for exceptions to the credentialing and modifier SA requirements. Examples of these exceptions:

- In the event that another policy exists that conflicts with this policy and allows exception to this rule, precedence will be given first to the rules of that policy. For example, PacificSource does allow for licensed behavioral health professionals who are eligible for credentialing to bill under the "incident to" status if the services being rendered are part of an applied behavior analysis (ABA). These services are exempt from the modifier SA requirement.
- The CPT/HCPCS code being billed is inherently considered a collaborative care service, such as G0511 and G0512 for Care Coordination Services or G0502, G0503, G0504, and G0507 for Behavioral Health Integration Services. These codes are exempt from the modifier SA requirement. PacificSource will follow CMS Guidelines in the use and payment of these types of services.

In order to provide care that will be billed to PacificSource using "incident to" status, the provider must be ineligible to be credentialed by PacificSource or its delegated credentialing entity. In addition, if the provider's profession is licensable in the state where services are provided (e.g., nursing, social work), then the provider must hold an active license and be providing services within the scope of that license. If the provider's profession is not licensable in the state where services are provided (e.g., medical assistants, community health workers), then the provider must be working under the license and within the scope of practice of the licensed clinician under whom services are being billed. PacificSource requires strict adherence to the following guidelines, and these criteria must be met in order for services to be billed as "incident to."

Physical Health "Incident to" Billing

PacificSource allows "incident to" billing for physical health only if the following criteria are met:

1. The patient must be established in the practice.
2. Services must be provided under the direct supervision of a qualified provider (e.g., a physician or eligible non-physician provider [NPP]).

3. The qualified provider must perform the initial service, evaluate the patient, and establish the treatment plan.
4. The qualified provider must remain actively involved in the patient's course of care. Care may not be transferred to a non-credentialed provider.
5. The established patient must have a condition that was initially evaluated, and the treatment plan must have been established, by the qualified provider. New conditions cannot be billed "incident to" and should be billed under the qualified provider's NPI.
6. Services must be an integral part of the established patient's treatment plan, and follow-up services must be part of a normal course of treatment.
7. Services must be rendered in a qualified provider's office or clinic (not in an institutional setting).
8. Services rendered under the "incident to" billing policy must be billed under the credentialed, qualified provider.
9. PacificSource will adhere to CPT billing guidelines when processing services billed under the "incident to" billing policy.
10. The rendering provider billing under the qualified provider must be an employee of the practice (i.e., a W-2 employee).
11. Medical records must be authenticated by both the rendering provider and qualified providers.

Behavioral Health "Incident to" Billing:

PacificSource allows "incident to" billing for behavioral health only if the following criteria are met:

1. The patient must be established in the practice.
2. Services must be provided under the general supervision of a qualified provider (e.g., a physician or eligible non-physician provider [NPP]).
3. A qualified provider must perform the initial service, evaluate the patient, and establish the treatment plan.
4. The qualified provider must remain actively involved in the patient's care. Care may not be transferred to a non-credentialed provider.
5. If the patient presents with a new problem, the service cannot be billed "incident to."
6. Services must be medically necessary and normal, integral, though incidental, part of the patient's ongoing course of treatment.
7. Services must be rendered in a qualified provider's office or clinic (not in an institutional setting).
8. Services rendered under "incident to" billing must be billed under the qualified provider.
9. PacificSource will adhere to CPT billing guidelines in the payment of services billed under the "incident to" billing policy.
10. The rendering provider billing under the qualified provider must be an employee of the practice (i.e., a W-2 employee).
11. Medical records must be authenticated by both the rendering provider and qualified providers.

Commercial: Behavioral Health Provider Types

PacificSource allows "incident to" billing for behavioral health treatment for the following provider types:

- Board-registered associates (does not apply to mental health interns)
- Certified alcohol and drug counselors (CADCs) in Oregon and Idaho
- Substance use disorder professionals in Washington

Medicaid: Behavioral Health Provider Types

All providers operating under a Certificate of Approval (COA) from the Health Systems Division of the Oregon Health Authority (OHA) are eligible for credentialing.

The following provider types may bill only when employed by a COA organization and are not eligible for "incident to" billing at non-COA practices:

- Peer Support Specialists
- Certified alcohol and drug counselors and those working toward certification
- Qualified mental health associates (QMHAs)
- Qualified mental health professionals (QMHPs)
- Mental health interns

Medicaid: Behavioral Health Billing

For providers who bill Medicaid behavioral health (BH) services, a Certificate of Approval (COA) is required when services are rendered by individuals who are not licensed to provide behavioral health services, with the exception of board-registered associates working toward licensure.

A COA is the document issued by the division that identifies and declares provider certification and service delivery rules under OAR Chapter 309, Division 8. The COA outlines the scope of approved services and the locations where those services may be delivered. Primary care or specialty clinics that provide behavioral health services exclusively through board-licensed providers and/or board-registered associates working toward licensure do not need a COA.

All providers who serve Medicaid clients must be enrolled as Medicaid providers and must have an Oregon Medicaid provider number. Claims for behavioral health services (i.e., mental health and substance use disorder services) furnished to Oregon Health Plan (OHP) members must include the rendering provider.

- For nonclinical services delivered in a residential setting, the rendering provider is the same as the billing provider (i.e., the facility).
- For all other behavioral health services, the rendering provider should be the individual practitioner who delivered the service.

12.2 Osteopathic Manipulation Treatment

Osteopathic Manipulative Treatment CPT Codes 98925–98929

It is PacificSource policy not to allow an evaluation & management service (E&M) on the same date of service as osteopathic manipulative treatment (OMT). Consistent with CPT coding guidelines, E&M services may only be reported if the work provided is above and beyond what is associated with preservice and postservice manipulative treatment.

According to the American Medical Association, E&M services may be reported separately if, and only if, the patient's condition requires significant, separately identifiable E&M service, which may be in connection to a new patient or a second diagnosis. However, the presence of a second diagnosis does not necessarily qualify an E&M service as "separately identifiable".

PacificSource policy for considering a second diagnosis will be as follows:

If a second diagnosis represents a new condition, and requires significant evaluation and management of a separate body system, an E&M code may be reported. Modifier -25 must be attached to the E&M

code. PacificSource reserves the right to determine, by chart note evaluation, whether or not an E&M service is warranted.

If a second diagnosis represents a brief recheck of an ongoing, but unrelated condition, an E&M service will be processed to provider write-off.

If a second diagnosis represents the same body system and/or condition, an E&M service will be processed to provider write-off.

Modifier -25—Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service. The physician may need to indicate that on the day he or she performed a CPT code-identified procedure, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided.

12.3 Global Period

Commercial Members

"Global period" is defined as the period of time when services must be included in the surgical allowance. PacificSource uses the number of days indicated in the "Global Period" column of the Federal Register as the standard.

PacificSource considers the following services to be included in the global surgical package. These services are not separately reimbursable when billed by the same physician or by another physician within the same Provider Group (same Tax ID number).

Services include:

- Preoperative E&M services after the decision to perform surgery is made, one day prior to major surgery, and on the same day a major or minor surgery is performed;
- Intraoperative services that are a usual and necessary part of the surgical procedure;
- Anesthesia provided by the surgeon (including local infiltration, digital block, or topical anesthesia);
- Supplies;
- Normal, uncomplicated follow-up care for the period indicated in the Federal Register Global Period; and
- All additional medical or surgical post-operative services required of the surgeon during the post-operative period due to complications that do not require additional trips to the operating room.

PacificSource considers the following services to be not included in the global surgical package:

- Preoperative services not encompassed in the global period;
- Evaluation and management services unrelated to the primary procedure;
- Services required to stabilize the patient for the primary procedure;
- Procedures required during the immediate preoperative period that are usually not part of the basic surgical procedure (for example, bronchoscopy prior to chest surgery); and
- Treatment by the original physician for a related post-operative complication that requires a return trip to the operating room.

Medicaid and Medicare

A global period is the period of time when services must be included in the surgical allowance; no additional charge may be added. PacificSource Medicare 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).

12.4 Commercial: Obstetric and Gynecology Care Billing Guidelines

Global OB Care

The global maternity allowance is a complete, one-time billing which includes all professional services for routine antepartum care, delivery services, and postpartum care. The fee is reimbursed for all of the member's obstetric care to one provider. If the member is seen four or more times prior to delivery for prenatal care and the provider performs the delivery, the provider must bill the Global OB code, beginning with the date of the initial prenatal visit.

Global maternity billing ends with release of care within 42 days after delivery. Global OB care should be billed after the delivery date.

Services Included in Global Maternity Care

- Routine prenatal visits until delivery, after the first three antepartum visits
- Recording of weight, blood pressures, and fetal heart tones
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery
- Management of uncomplicated labor
- Vaginal or cesarean section delivery
- Delivery of placenta (see "Billable Services Outside of Global Maternity Care" for examples of when delivery of the placenta may be reimbursed).
- Administration/induction of intravenous oxytocin
- Insertion of cervical dilator on same date as delivery
- Repair of first- or second-degree lacerations
- Simple removal of cerclage (not under anesthesia)
- Uncomplicated inpatient visits following delivery
- Routine outpatient E/M services provided within 42 days following delivery
- Postpartum care after vaginal or cesarean section delivery

Please use one of the CPT codes listed below when you provide global OB care. Global care includes all obstetrical care for a patient, including delivery, antepartum, and postpartum care. Global OB care should be billed after the delivery date.

59400 Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

59610 Routine obstetric care including antepartum care, vaginal delivery, (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Commercial: Partial Services

Nonglobal OB care, or partial services, refers to maternity care not managed by a single provider or group practice. Billing for nonglobal OB care may occur if a member transfers care or is referred to another provider during her pregnancy, a provider from another practice performs the delivery or antepartum care (see the E/M visit info under "Billable Services Outside of Global Maternity Care"), a member terminates or miscarries her pregnancy, or if the member changes insurers during her pregnancy.

If you provide only partial services instead of global OB care, please bill us for that portion of maternity care only. Please use the codes below for billing antepartum-only, postpartum-only, delivery-only, or delivery and postpartum-only services. Only one of the following options should be used, not a combination.

For Antepartum Care Only

- For 1 to 3 visits: Use evaluation and management codes
- For 4 to 6 visits: **59425**
- For 7 or more visits: **59426**

Additional evaluation and management visits during the antepartum period must be billed with modifier -25 to support an evaluation and management service for a medical condition unrelated to the pregnancy. As always, you may bill for ultrasound, amniocentesis, special screening tests for genetic disorders (prior authorization is required for many genetic tests, please refer to the prior authorization list), visits for unrelated conditions, or additional frequent visits due to high-risk conditions. You will be reimbursed according to contract benefits.

For Postpartum Care Only

59430

Delivery only

- **59409** Vaginal delivery only (with or without episiotomy and/or forceps).
- **59514** Cesarean delivery only
- **59612** Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- **59620** Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Delivery and Postpartum Care Only

- **59410** Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care
- **59515** Cesarean delivery only; including postpartum care
- **59614** Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps), including postpartum care
- **59622** Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Billable Services Outside of Global Maternity Care

- The first three antepartum visits
- Services during the antepartum and postpartum period unrelated to maternity or not in the global period
- Maternal or fetal echography
- Amniocentesis, any method
- Amnioinfusion
- Chorionic villus sampling
- Fetal contraction stress test, and fetal non stress test
- Delivery of the placenta, CPT 59414, is considered integral to a vaginal or cesarean section delivery, this code may be billed if the member delivers vaginally before admission with subsequent delivery of the placenta, or if the placenta is delivered by a provider other than the delivering physician.
- Evaluation and Management (E/M) visits:
  - Additional E/M visits for high risk or complications > 13 antepartum visits
  - E/M visits for conditions unrelated to pregnancy – The diagnosis should clearly identify that the condition is unrelated to pregnancy for the services provided (e.g., appendicitis, bronchitis, cholecystectomy).
  - Maternal Fetal Medicine Specialists seen in addition to the member's regular provider (if the specialist is in the same practice, then use of mod 25 will indicate a significant and separate E/M service).
  - E/M with an OB ultrasound procedure – E/M CPT codes submitted with modifier 25 may be reimbursed with an OB ultrasound on the same date of service. Mod 26 (professional component) is not reimbursed when performed by the same or other health care professional on the same date of service.

Births

Multiple births should be billed with the appropriate CPTs depending on the delivery method per newborn:

Vaginal delivery CPTs:

- First newborn **59400, 59409, 59410, 59610, 59612,** or **59614**
- Subsequent newborn(s): **59409** or **59612**

Claim reimbursement: 100% allowance for the delivery method with the highest RVU, and subsequent newborns per the multiple procedure reduction rules and the member's contracted benefit rate.

Cesarean delivery CPTs:

- First Newborn: **59510, 59514, 59515, 59618, 59620,** or **59622**

- Subsequent newborns: Do not report multiple cesarean delivery codes. Modifier 22 may be appended if the delivery is significantly more difficult. (Supporting documentation is required.)

Midwife Reimbursement
Eligible Certified Nurse Midwives (CNM) will receive reimbursement of services when rendered within the scope of their license.

- Lay midwives, direct-entry midwives, certified midwives (CM), certified professional midwives (CPMs), and doulas will deny in the system as these are ineligible providers.
- Time, services, and medications are not separately reimbursed as they are part of the global fees.
- Supplies are reimbursed up to $150.00 when billed with the following codes:
  - CPT 99070: Supplies Provided by physician over & above those included in the service (documentation may be required)
  - HCPC S8415: Supplies for home delivery of infant
- If the CNM is unable to perform delivery (another provider delivers), the CNM should only bill for antepartum care.

Increased Procedural Services/Modifier 22
Additional reimbursement may be considered for obstetrical services when the work required to provide a service is substantially greater than typically required, designated by appending modifier 22 (mod 22) to a CPT procedure code. Documentation must support the reason for the additional work (i.e., increased intensity, time, technical difficulty of the procedure, severity of the patient's condition, physical and mental effort required). Mod 22 may not be appended to an E/M code (2013 Professional Edition/CPT manual).

Clinical records should be submitted with the claim whenever mod 22 is utilized.

One example of an allowed use of mod 22 for obstetrical services:

- Laceration repairs: 3rd- and 4th-degree laceration repairs may be billed in addition to the delivery or global OB CPTs by appending modifier 22 to the global OB, delivery only, or delivery plus postpartum care CPTs. The allowable is based on the delivery component alone.

Prolonged Services
You can no longer use CPT codes 99354, 99355 in conjunction with E&M codes 99202-99205, 99212-99215, 99415, 99416, 99417.

Prolonged services are only used on the highest-level E&M codes 99205 and 99215 using the new code 99417 and for Medicare G2212.

For additional information, please see your CPT code book under Prolonged Services. CPT codes 99358 and 99359 non-face-to-face services, are not reimbursed for maternity care services.

Noncovered Service Billed with Global or Nonglobal CPT Codes
Travel time billed by the practitioner is not reimbursed.

Assistant Surgeon
Assistant surgeon fees are reimbursed only with an appropriate modifier for eligible providers using nonglobal cesarean section CPT codes (59514, 59620).

Delivery in Nonhospital Settings
Reimbursement for home delivery, birthing centers, or any nonhospital facility setting is subject to the terms of the PacificSource group and provider contracts, provider eligibility for reimbursement, and provider and facility credentialing

Newborn Hearing Screenings

PacificSource does enforce non-coverage of newborn hearing screenings when billed by the rendering professional provider on a CMS 1500 form with location 21 or 22. In accordance with following CMS guidelines, CPT code 92650 is payable to only the facility, when services are performed inpatient (21) or outpatient (22) and billed on a UB-04. Professional charges will be denied with "This code is considered inclusive of the room and board charges or acute admission, not payable separately. Member is not responsible for the balance."

If services are performed in the providers office (location 11), and are part of a routine preventive/well child exam, we will continue to reimburse services subject to the member's benefit plan.

Annual Gynecological Exams

Routine gynecological exams are allowed once each calendar year (or once each benefit year, if plan year).

Any laboratory tests performed are subject to gynecological laboratory benefit. These include:

- Weight and blood pressure check
- Laboratory tests:
  - Occult blood
  - Urinalysis
  - Complete blood count
  - Pap smear
  - Mammography
  - Lab fees CPT 36415

Any laboratory tests performed, in absence of diagnosis, which are not listed above are subject to the standard preventive laboratory benefits and maximums.

A referral to a women's healthcare provider is not required for the annual gynecological exam and medically necessary follow-up visits resulting from that examination when performed within ninety (90) days of the annual gynecological exam.

Screening and counseling for sexually transmitted infections, including HIV, and for interpersonal and domestic violence, when provided during a gynecological exam, will be covered at no cost to the member.

This applies to services with in-network providers and is effective for PacificSource nongrandfathered group policies and Oregon and Idaho individual policies as they renew (or are effective). This is effective for all Montana individual policies, regardless of effective or renewal date.

Any laboratory tests performed in absence of diagnosis are subject to the standard preventive care benefits and maximums.

Screening Papanicolaou Smear HCPCS Code Q0091

PacificSource considers the collection of the pap specimen to be included in the E&M code when services are provided for a gynecological (GYN) exam (CPT codes 99381 through 99397).

- When Q0091 is billed alone with a diagnosis for a GYN exam, the service will be processed as an annual GYN exam.

- If Q0091 is billed in conjunction with an E&M code for the GYN exam, Q0091 will be processed as provider write-off. Allowance for the handling of the specimen using CPT 99000 will be denied as bundled when billed in conjunction with the GYN exam.
- We will consider Q0091 for payment, if billed with an E&M code using a diagnosis other than the GYN exam if modifier -25 is used with the E&M code. Diagnosis and chart notes must support use of the E&M code in conjunction with Q0091.
- If Q0091 is billed with an E&M code without modifier -25, Q0091 will not be approved and will be processed as provider write-off.

12.5 Emergency Services

PacificSource provides coverage without prior authorization for emergency medical conditions. This could include claims and/or services not ordinarily covered on the plan.

Coverage includes emergency medical screening exams to determine the nature and extent of an emergency medical condition, emergency services provided in an emergency department, and all ancillary services associated with the visit to the extent they are required for the stabilization of the patient.

Routinely, emergency room claims will be processed according to the information provided and benefits available to the member. Claims not approved are subject to automatic review by PacificSource.

See below for current contract definition of an Emergency Service.

Emergency Room Claims

In order to apply "prudent person" determination as mentioned above, all claims for services performed or provided in an emergency room setting (place of service code 23) will be reviewed prior to approval.

PacificSource will thoroughly review billing information for any indication that the member presented in the emergency room with what they perceived to be a medical emergency. If further information is needed, chart notes will be requested. Health Services will be consulted if clinical opinion becomes necessary.

Emergency and After-hours Codes Defined

(including but not limited to)

All codes below (99050-99060) are considered provider write-offs and are not considered patient responsibility.

99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed, such as holidays or weekends.

99051 Services provided in the office during regularly scheduled evening, weekend, or holiday office hours.

99053 Services provided between 10:00 p.m. and 8:00 a.m. at a 24-hour facility. This code is only allowed for Emergency departments and should not be billed by any other provider type.

99056 Services typically provided in-office, provided out of the office at the request of the patient.

99058 Services provided on an emergency basis in and out of the office, which disrupts other scheduled office services, in addition to the basic service.

99060 Service provided on an emergency basis out of the office, which disrupts other scheduled office services.

12.6 Surgery

Anesthesia

Commercial

Modifier	Description	Physical Status Units
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

Modifier	Description	Allowed
AA	Anesthesia services personally performed by an anesthesiologist	100%
QK (QA)	Medical direction of two, three or four concurrent anesthesia procedures	50%
QX	Anesthesia, CRNA medically directed by anesthesiologist	50%
QY	Medical direction of one CRNA by an anesthesiologist	50%
QZ	Anesthesia, CRNA without medical direction of anesthesiologist	100%

Government

Modifier	Description	Allowed
AA	Anesthesia services personally performed by an anesthesiologist	100%
QA/QK	Medical direction of two, three or four concurrent anesthesia procedures	50%
QX	Anesthesia, CRNA medically directed by anesthesiologist	50%
QY	Medical direction of one CRNA by an anesthesiologist	50%
QZ	Anesthesia, CRNA without medical direction of anesthesiologist	100%

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 an inherently bilateral (unilateral or bilateral) procedure, the procedure should be reported with modifier 50.

Bilateral procedures should be billed as a separate charge line for each procedure, using a modifier on the second line. However, bilateral procedures may be billed on one line. Please see the examples below.

Example: Billed as one line (two services).

CPT	Modifier	Description	$ Charges	Units
31238-50		Nasal/sinus endoscopy, surgical, with control epistaxis	$1,000.00 units	1

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.

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 be aware that this applies to both professional and hospital/facility charges:

- When multiple procedures, other than 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 Unit (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.
- Six or more procedures will require review by PacificSource, and chart notes may be requested.

PacificSource 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
- Second procedure: 50 percent of the fee allowance
- Third through fifth procedures:
  - Oregon and Washington commercial claims will cut to 25% for the third through fifth procedures; 100/50/25
  - Idaho and Montana commercial claims will cut to 50% for the third through fifth procedures; 100/50/50
  - Medicare and Medicaid will cut to 50% for the third through fifth procedures; 100/50/50

To ensure accurate payment, please make sure when you are billing for multiple procedures that you submit the full billed amount, rather than the precut amount. Our system will not recognize a claim that has been precut and will cut again according to the multiple surgery guidelines.

Multiple and Bilateral Surgical Procedures Performed in the Same Operative Session

Selected bilateral eligible services may also be subject to multiple procedure reductions when billed alone or with other multiple procedure reduction codes. When two or more procedure codes subject to reductions are performed on the same date of service and are subject to reduction as defined in the Federal Register or CMS ASC table, only one of the procedure codes will be considered as the primary procedure, and all the remaining procedures will be considered secondary. The procedure with the highest CMS-based Relative Value Unit or contracted allowance, after the bilateral adjustment, as appropriate, will be considered the primary procedure.

Note: The bilateral procedure is not always the primary procedure. Assistant surgeon fees will be subject to multiple procedure reductions. Below are standard claims processing guidelines. Your specific contract language may call out differences.

Idaho and Montana

First bilateral procedure equals 150 percent of the fee schedule allowance or your billed charge, whichever is less.

Second bilateral procedure equals 75 percent of the fee schedule allowance (150% reduced by half) or your billed charge, whichever is less.

Please note: If the bilateral procedures are billed on two separate lines on the claim, the reduction will be split evenly between both lines.

All commercial except Idaho and Montana

First bilateral procedure equals 150 percent of the fee schedule allowance or your billed charge, whichever is less.

Second bilateral procedure equals 50 percent of the fee schedule allowance (25% X 2) or your billed charge, whichever is less.

Please note: If the bilateral procedures are billed on two separate lines on the claim, the reduction will be split evenly between both lines.

Payment Rules for Multiple Scope Procedures

Related Scope Procedures: Scope surgeries are related procedures (same code family) performed during the same operative session and through the same body orifice/incision on the same day.

The scope with the highest RVU is allowed at 100 percent of the fee allowance.

The second and subsequent procedures are priced by subtracting the fee allowance for the "base" procedure from the code's usual fee allowance.

Unrelated Scope Procedures: When the Scope Procedures are unrelated (not in the same family), multiple surgery rules will apply instead.

Related and Unrelated Scope Procedures on the same day: First, the related scope procedure rule applies, and if the scope is determined to be unrelated then the multiple surgery rule will apply.

Ambulatory Surgery Center (ASC)

Billing Guidelines – Commercial Claims

When contracting directly with an Ambulatory Surgery Center (ASC), PacificSource contracts using various payment methodologies. Please refer to your provider agreement for specifics.

The ASC fee schedule is modeled after the Outpatient Prospective Payment System (OPPS). ASC rules for modifier 50/51 application are different from CPT standard.

When submitting a claim for multiple procedures, submit the primary procedure as the first procedure code. Modifier 51 is informational only, as our claims system will apply the appropriate reduction.

Example: Billed Procedures

- 31255-RT
- 31255-51-LT
- 3052051
- 30140-51-RT
- 30140-51-LT

For the above example, the primary procedure is 31255-RT and allowed at 100 percent of the fee schedule allowance, or billed charges, whichever is less.

Oregon and Washington commercial claims will cut 100/50/25 with succeeding procedures to 25%.

Idaho and Montana commercial claims will cut 100/50/50 with succeeding procedures to 50%.

Billing Guidelines – Medicare and Medicaid

The ASC fee schedule is modeled after the Outpatient Prospective Payment System (OPPS). ASC rules for modifier 50/51 application are different from CPT standard.

When submitting a claim for multiple procedures, submit the primary procedure as the first procedure code. Modifier 51 is informational only, as our claims system will apply the appropriate reduction.

Example: Billed Procedures

- 31255-RT
- 31255-51-LT
- 30520–51
- 30140-51-RT
- 30140-51-LT

For the above example, the primary procedure is 31255-RT and allowed at 100 percent of the fee schedule allowance, or billed charges, whichever is less. All remaining procedures are allowed at 50 percent of the fee schedule allowance.

Services included in the ASC Facility Payment:

Nursing services, services of technical personnel, and other related services: These services include any nurses, orderlies, technical personnel, and others involved in patient care.

Patient use of the ASC facilities: Use of the operating room, recovery room, patient prep areas, waiting room, and other areas used by the patient or offered for use to the patient's relatives in connection with the procedure are all included within the facility payment.

Drugs and biologicals: These include drugs or biologicals commonly furnished by the ASC in connection with surgical procedures. It is limited to those items that cannot be self-administered.

Surgical dressings: This includes primary surgical dressings applied at the time of the surgery, and therapeutic and protective coverings applied to lesions or openings in the skin that were required for the surgical procedure. (Ace bandages, pressure garments, Spence boots, and similar items are considered secondary dressings.) Surgical dressings for reapplication by the patient or other caregiver obtained on a provider's order from a supplier, i.e., drugstore, are not included in the facility payment and are separately reimbursable to the supplier.

Supplies, splints, and casts: Only those supplies, splints, and casts applied at the time of surgery are included in the facility fee. However, such items furnished later are generally furnished "incident to" a physician's service and are not an ASC facility service. Items provided "incident to" a provider's services are subject to other regulations and definitions, and are generally included in the provider fee. Supplies include all those required for the patient or ASC personnel, such as gowns, drapes, masks, and scalpels.

Appliances and equipment: Appliances and equipment used within the surgical procedure are included within the facility payment. However, prosthetics and orthotics (other than IOLs) are not included and

will be separately reimbursed. IOLs are included in the facility payment. DME furnished to the patient is separately reimbursable to enrolled DME providers.

Diagnostic or therapeutic items and services: Diagnostic services performed by the ASC may be included in the ASC facility payment. However, if the laboratory of the ASC is not certified, items such as routine simple urinalysis or hemograms should not be billed. Tests performed by a certified ASC laboratory are billed by the laboratory and are separately reimbursable. Similarly, tests performed under an arrangement with an independent or hospital laboratory are billed directly by the provider. Radiology, EKGs, and other preoperative tests are generally not included in the facility payment when used to determine the suitability of an ASC setting. Other diagnostic and therapeutic tests directly connected to the procedure are included in the facility payment.

Administrative, recordkeeping, and housekeeping items and services: These include administrative functions necessary to run the facility.

Materials for anesthesia: These include any supplies, drugs, or gases are included within the facility payment.

Unless otherwise noted in your agreement, PacificSource will not pay for services or supplies specifically outlined by CMS as included in the Case Rate, or in which CMS has deemed nonreimbursable. These can be found on the CMS Web page at CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html. Refer to your specific payment schedule outlined in your agreement. Procedures that have an "N1" payment indicator listed in Addendum AA will not be reimbursable. Services and supplies outlined in Addendum EE, "Surgical Procedure to be Excluded from Payment," will be reimbursed if prior approved by PacificSource.

Services Not Included in the ASC Facility Payment

- Physician services: This includes services of anesthesiologists administering or supervising the administration of and recovery from anesthesia. Physician services also include any routine pre- or postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services that the individual physician usually includes in a set global fee for a given surgical procedure.
- DME: Includes items for the sale, lease, or rental to ASC patients for use in their home.
- Prosthetic and orthotic devices; and leg, arm, back, and neck braces (except IOLs).
- ASC furnished ambulance services.
- Diagnostic tests performed directly by an ASC.
- Physical and occupational therapy services.

Surgical Assistant Guidelines for Commercial Health Plans

Payment is made only if an assistant surgeon is allowed on the Federal Register.

Modifier 80—Assistant Surgeon (MD, DMD, DDS, DO)

The allowance for modifier 80 is 20 percent of the surgery CPT allowance.

Modifier 81—Minimum Assistant Surgeon (MD, DMD, DDS, DO)

- The allowance for modifier 81 is ten percent of the surgery CPT allowance.
- This modifier is used when the doctor performed minimal assistance.

Modifier 82—Assistant Surgeon:

This modifier is used when a qualified resident surgeon is not available. This is a rare occurrence. The fee allowance is automatically reduced to 20% of the surgical fee allowance as billed by the primary surgeon.

Modifier AS—Nonphysician Assistant (PA, RN, CRNFA, CST, CNM)

The allowance for modifier AS is ten percent of the surgery CPT allowance.

To ensure accurate payment, please make sure when you are billing assistant surgeon claims that you submit the full billed amount, rather than the precut amount. Our system will not recognize that the claim has been precut (adjusted to show the assistant surgeon payment percentage), and it will be cut again according to the assistant surgeon guidelines.

Please note: Certified Nurse First Assist, Certified First Assist (CFS), Certified Surgical Technicians, Surgical Assistants, and Registered Nurse cannot bill independently. These providers must bill under the overseeing doctor's tax identification number (see Taxpayer Identification Numbers section).

Office Surgery Suites and Fees

CMS establishes relative value units (RVU) for CPT and HCPCS codes that include the cost of running an office (e.g. rent, equipment, supplies, and nonphysician staff costs), which are referred to as the practice expense RVU. These expenses should not be separately reported. PacificSource will not reimburse any service appended with modifier SU or FF. Those modifiers will be processed to provider write-off.

The allowance for an office surgical suite is calculated according to the relative value of the surgical procedure.

To be eligible for payment, the provider must include office/surgical suite charges when billing the surgery to PacificSource. To expedite these claims, surgical suite should be identified by the use of modifier SU.

For surgical procedures performed in the office, the following table will be used to calculate the PacificSource surgical suite allowance when a provider contract does not state specific surgical suite allowances.

RBRVS surgical relative value unit	% of PacificSource surgical allowance
00.01 through 02.09	Billed
02.10 through 08.75	40%*
08.76 through 14.60	30%*
14.61 and greater RVUs	25%*

*Percentage is based on PacificSource allowance for the surgical procedure(s), not the amount billed.

The surgical suite allowance includes usage of room, lights, cautery, dressings, sutures, sterile tray, optical or other equipment, and any services of an assistant (e.g., MD, RN, PA). If any of these supplies are billed separately, it will be processed to provider write-off. Surgical Suite reimbursement will only be allowed if there is a dedicated room or space in which surgical procedures are performed. Service done in an exam room or area that is utilized for dual purposes will not be considered a surgical suite and will be denied.

Medicare: Multiple and Bilateral Procedures Performed during the Same Operative Session

When a bilateral procedure code and surgical procedure code(s) are submitted together and both the bilateral and surgical procedure code(s) are eligible for multiple procedure reduction, the bilateral adjustment will be applied first. The surgical procedure code(s) with the highest allowable compensation, after the bilateral adjustment, will be compensated at contract benefit. Other surgical procedure code(s)

subject to reduction logic **as stated above per state and are compensated at either 50% or 25%** of the allowed amount, after bilateral adjustment, as appropriate.

- 1st bilateral procedure = 150% of the fee schedule allowance or your billed charge, whichever is less.
- 2nd bilateral procedure = 150% x 50% = 75% of the fee schedule allowance or your billed charge, whichever is less.

Please note: If the bilateral procedures are billed on two separate lines, the reduction will be split evenly between both lines.

When billing two bilateral procedures:

- Primary bilateral = 150% of the fee schedule allowance for the procedure
- Secondary bilateral = 75% of the fee schedule allowance for the procedure; 150% x 50% = 75%

When billing a primary, nonbilateral procedure and a secondary bilateral procedure:

- Primary procedure = 100% of the fee schedule allowance for the procedure
- Secondary bilateral procedure = 75% of the fee schedule allowance for the procedure; 150% x 50% = 75%

When billing a primary bilateral procedure and a secondary procedure:

- Primary bilateral = 150% of the fee schedule allowance for the procedure
- Secondary procedure = 50% of the fee schedule allowance for the procedure

Example of Billed Procedures:

- 31255-50
- 31276-51
- 31267-51

For the above example, the primary procedure is 31255-50 and allowed at 150% of the fee schedule allowance or billed charges, whichever is less. All remaining procedures are allowed at 50% of the fee schedule allowance.

12.7 Colonoscopy

Screening colonoscopies: Colonoscopy screenings will be covered at 100 percent for ages 45-75 when billed by an in-network provider.

Medical colonoscopies for members under age 45 or when billed with a medical diagnosis will be paid under the surgery benefit. The facility claim will be paid under the outpatient facility or ambulatory surgery center benefit.

CT or MR colonography, also known as "virtual colonoscopy," is not covered and is considered as experimental/investigational.

Prior authorization: Colonoscopies do not require prior authorization on group or individual policies.

Colonoscopy with E&M: If a provider bills a colonoscopy with an Evaluation and Management service and the diagnosis is for screening, the E&M service will be denied to provider write-off regardless of in-network status.

Visits prior to the diagnostic exam: Previsits prior to a screening colonoscopy are inclusive and are reflected in the RVU for the colonoscopy.

12.8 Evaluation and Management (E&M) Billing Guidelines

Preventive Visits and E&M Billed Together

According to the CPT code book, it is appropriate to bill for both preventive services and evaluation and management (E&M) services during the same visit only when significant additional services or counseling are required. Although the following list is not all inclusive and is subject to change, please be aware some specialties, such as: PT/OT, SLP, LMT, LCSW, LPC, PHD, etc., are not eligible to bill for evaluation and management services.

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 evaluation and management 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 evaluation and management (E&M).
- The patient must be established, not new (see Distinction Between New and Established Patients).
- 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. All E&M office visits follow the member's office visit benefit; therefore, if another CPT code more accurately describes the service, that code should be reported instead of 99211.

Anticoagulant Management Codes

Anticoagulant services are defined as the outpatient management of warfarin therapy. This includes communication with the patient, International Normalized Ratio (INR) testing (ordering, review, and interpretation), and dosage adjustments as appropriate.

The following codes and guidelines should be applied for anticoagulant management:

- 99363—Initial 90 days of therapy (must include a minimum of eight INR measurements). Submit claim for 99363 after the eighth visit has been completed.
- 99364—Submit claims for 99364 after each additional 90 days of therapy (must include a minimum of three INR measurements).
- Do not bill 99211 with 99363 or 99364 unless a significant, separately identifiable E&M service is performed and documentation can support it. 99211 will be processed to provider write-off when billed in place of 99363 or 99364.

Anticoagulant management work itself is not a basis for an E&M service code or Care Plan Oversight time during the reporting period. Codes 99371—99373 and 0074T do not apply with telephone or online services. However, if a significant, separately identifiable E&M service is performed, report the appropriate E&M service code using modifier 25.

For more information on the use of these codes, please refer to your CPT book.

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.

Practitioner Service

Chart notes are required for prolonged services. If chart notes are not received, the claim will be processed as provider write-off with the explanation code stating that supporting documentation is required.

See the CMS website for the threshold table.

12.9 Medicare: Annual Wellness Visit

As a result of the Affordable Care Act, CMS extended the preventive focus of Medicare coverage to include an Annual Wellness Visit (AWV) that focuses on establishing a Personalized Prevention Plan.

Who is eligible to receive an AWV?

A Medicare beneficiary who:

- Has been receiving Medicare Part B benefits for at least 12 months, and
- Has not had an Initial Preventive Physical Examination (IPPE) also known as "Welcome to Medicare" exam within the past 12 months

*Please have your staff contact PacificSource Medicare Customer Service at 541-385-5315 to verify eligibility prior to scheduling the patient's AWV.

Who is eligible to provide an AWV?

- A physician who is a doctor of medicine or osteopathy
- A physician assistant, nurse practitioner, or clinical nurse specialist
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner)

What is the patient's responsibility?

There is no cost for this visit. However, a copay or deductible may apply for any additional testing. It is important to note health education and counseling services provided by a referred doctor may not be covered. Please have your patient refer to their member handbook or contact Customer Service to verify coverage.

What does the initial AWV cover?

- Establish or update the patient's medical and family history.
- Record measurements of height, weight, body mass index, blood pressure, and other routine measurements deemed necessary based off the patient's medical/family history.

- Establish a list of current medical providers/suppliers involved in the patient's care.
- Detection of any cognitive impairment.
- Review of potential risk factors for depression.
- Review of functional ability and level of safety based on direct observation or screening questionnaire.
- Establishment of a written screening schedule, such as a checklist for the next five to ten years, in regard to age-appropriate preventive services.

Furnish personal health advice and coordinate appropriate referrals and health education, when necessary.

What does the subsequent AWV cover?

- Update the patient's medical and family history.
- Record measurements of height, weight, body mass index, blood pressure, and other routine measurements deemed necessary based off the patient's medical/family history.
- Update the list of current medical providers/suppliers involved in the patient's care.
- Detection of any cognitive impairment.
- Update the written screening schedule.
- Update to the list of risk factors.
- Furnish personal health advice and coordinate appropriate referrals and health education, when necessary.

Is the Annual Wellness Visit the same as an annual physical exam?

The AWV is not an annual physical exam. The AWV is a comprehensive exam, which focuses on preventive care by establishing a Personalized Preventive Plan.

Is the Annual Wellness Visit the same as the Welcome to Medicare Exam?

Both exams are similar in benefits; however, the Welcome to Medicare is only available to those members who are within their first 12 months of being Medicare eligible.

What procedure codes are used to bill for the AWV?

HCPCS codes:

- Initial AWV with PPPS: G0438 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit.
- Subsequent AWV with PPPS: G0439 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit.

Is the Initial AWV Code (G0438) a once in a lifetime benefit?

Yes, the Initial visit code G0438 is for the patient's first AWV only. Submission of G0438 for a patient who has already incurred their initial AWV will result in a denial.

Please verify whether or not the patient has received their initial AWV prior to scheduling their appointment.

Please note subsequent AWV (G0439) visits are payable once every calendar year.

Can a patient select a new healthcare professional to provide their subsequent AWV?

Yes. In the event a patient selects a new healthcare professional for their subsequent AWV, the new healthcare professional must bill the subsequent AWV code G0439.

Remember, the G0438 and G0439 must not be billed within 12 months of a previous billing for the same patient, under the same Tax Identification Number.

How should we bill PacificSource Medicare if the minimum requirement for an AWV is not met? Can we bill with a modifier 52?

If the documentation for the services rendered does not meet criteria to bill G0438 or G0439, please bill with the appropriate CPT/HCPC code that best identifies the service(s) provided.

Also, claims submitted for these services with a modifier 52 appended are not accepted as CMS does not allow the procedure code and modifier combination.

Can a provider bill a medically necessary Evaluation and Management (E&M) service in conjunction with an AWV?

Medicare will allow a significant and separately identifiable evaluation and management (E&M) service on the same date as the AWV when it is reported with a modifier 25. However, CMS recommends against providing nonurgent acute care at the same encounter, as it may detract the intended focus on preventive care. Please note, documentation must support both services.

How do I bill for AWV services on a UB04 form?

Institutional providers need to submit these claims via Types of Bill (TOB) 12X, 13X, 22X, 23X, 71X, 77X, or 85X. Institutional providers will be paid as follows:

- For services performed on a 12X TOB and 13X TOB, hospital inpatient Part B and hospital outpatient, payment shall be made under the MPFS.
- For TOBs 22X and 23X, skilled nursing facilities will be paid based on the MPFS.
- Rural Health Clinics (TOB 71X) and Federally Qualified Health Centers (TOB 77X) will be paid based on the all-inclusive rate.
- For services performed on an 85X TOB, Critical Access Hospital (CAH), pay based on reasonable cost.
- CAHs claims (submitted on TOB 85X with revenue codes 096X, 097X, and 098X) will be paid based on MPFS.

12.10 Ultrasound: Same-day Billing of Transvaginal and Standard

Our claims editing system recommends the denial of payment for transvaginal ultrasound when billed with any pelvic or abdominal ultrasound on the same date of service. After careful review, PacificSource has decided to cover both, but will reduce payment for the transvaginal ultrasound by 50 percent when billed in conjunction with another ultrasound.

12.11 Never Events Policy

PacificSource 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 Medicare 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
- Re-admission 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.

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)

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

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 hyperbilirubinemia 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 bedrails 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.

Environmental 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 an electric shock or elective cardioversion while being cared for in a healthcare facility
- 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
- 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 bedrails 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.

12.12 Routine Venipuncture and/or Collection of Specimens

Venipuncture or phlebotomy is the puncture of a vein with a needle or an IV catheter to withdraw blood. Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures, and is sometimes referred to as a "blood draw." The work of obtaining the specimen sample is an essential part of performing the test.

Reimbursement for the venipuncture is included in the reimbursement for the lab test procedure code.

Collection of capillary blood specimen or a venous blood from an existing line or by venipuncture that does not require a physician's skill or a cutdown is considered "routine venipuncture."

Professional and Clinical Laboratory Services

Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures. The work of obtaining the specimen sample is an essential part of performing the test.

Reimbursement for the venipuncture is included in the reimbursement for the lab test procedure code.

Venipuncture is only eligible to be billed once, even when multiple specimens are drawn or when multiple sites are accessed in order to obtain adequate specimen size for the desired test(s).

PacificSource does not allow separate reimbursement for venipuncture when billed in conjunction with the blood or serum lab procedure performed on the same day and billed by the same provider will be denied as a subset to the lab test procedure.

If some of the blood and/or serum lab procedures are performed by provider and others are sent to an outside lab, venipuncture is not eligible for separate reimbursement.

The use of modifier 59 with venipuncture when blood/serum lab tests are also billed is not a valid use of the modifier. The venipuncture is not a separate procedure in this situation.

PacificSource does allow separate reimbursement for venipuncture when the only other lab services billed for that date by that provider are for specimens not obtained by venipuncture (e.g., urinalysis).

Collection of a capillary blood specimen is designated as a status B code (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file. PacificSource clinical edits will deny a collection of a capillary blood specimen whether it is billed with another code or as the sole service for that date. This edit is not eligible for a modifier bypass.

12.13 Inpatient Hospital Services

A maximum of one collection fee (any procedure code) is allowed per specimen type (venous blood, arterial blood) per date of service, per CMS policy. Specimen collections out of an existing line (arterial line, CVP line, port, etc.) are not separately reimbursable.

12.14 Lab Handling Codes

The following procedure has been updated to follow PacificSource claims editing software:

Lab Handling Codes

- **36415**—Collection of venous blood by venipuncture.
  - Our claims editing system may deny as unbundled when billed with any E&M, lab, or other procedure codes.
- **36416**—Collection of capillary blood specimen.
  - Our claims editing system may deny as unbundled when billed with any E&M, lab, or other procedure codes.
- **99000**—Handling and/or conveyance of specimen for transfer from physician's office to a lab.*
- **99001**—Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory.*
- **99002**—Handling, conveyance, and/or any other service in connection with implementation of an order involving devices (e.g., designing, fitting, packaging, handling, delivering, or mailing) when devices such as orthotics, protectives, or prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician.*

**These codes (99000, 99001, and 99002) will deny as unbundled when billed with an E&M code.*

12.15 Clinical Lab Services

PacificSource Health Plans follows Medicare guidelines for billing of professional, technical, and total components of laboratory tests. Please note, these codes are subject to change based on the National Physician Fee Schedule Relative Value File updates. We will not make separate payment for the pathologist's professional services in the hospital.

12.16 Clinic Editing for Facility and Professional Claims

PacificSource applies clinical edits to claims to align with industry-standard guidance, including but not limited to guidance from CMS's National Correct Coding Initiative (NCCI). PacificSource may utilize claims editing software to promote standardized editing of the claims we receive on behalf of our members.

Clinical editing standards are well researched, clearly defined, and documented in support of transparency requirements. We apply these standards to both in-network and out-of-network providers. Edits made to claims are considered to be provider adjustments and not billable to members.

Sample Edit Criteria

Listed below are some examples and definitions of edits that providers/facilities may encounter. These are strictly for example purposes, are not exhaustive, and are subject to change.

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 in the AMAs CPT Manual, 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 codes using the correct coding edits table and the mutually exclusive edit table.

MUE Hospital: Unlikely number of units billed for services rendered. CMS.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Multiple/Bilateral procedures without modifier: Any instance when a claim is submitted for primary surgery along with additional surgery codes for either multiple procedures and/or bilateral procedures without appropriate modifier.

Unbundling: Procedure code that is a component of the primary procedure code. CMS.gov/Medicare/Coding/NCCI-Coding-Edits

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

Inpatient only procedures: Procedure codes that can only be performed in an inpatient setting.

12.17 Vision—Routine vs. Medical

PacificSource offers routine vision benefits, including hardware, as an endorsement to Group policies. Vision endorsements contain maximum dollar benefits and time limitations. Refer to plan documents for specific benefit limitations.

12.18 Preventive and evaluation and management (E&M) services during the same visit

The CPT code book indicates that this is appropriate only if there are significant additional services or counseling required. When preventive care codes 99381-99387 or 99391-99397 are billed with office visit codes 99202-99203 or 99211-99213 (with modifier 25 on the office visit code) chart notes are not needed; both codes will be allowed. For all other preventive care and office visit code combinations, chart notes are required for consideration of both codes.

When the original claim is received with both preventive services and office visit charges if there are no chart notes submitted, the charges for the medical office visit will be considered provider write-off. If notes are attached, the notes will be reviewed and, based on the content, a determination will be made whether or not the office visit is appropriate.

Claims received as corrected claims or rebills, with chart notes attached, will be reviewed to determine if the office visit is appropriate.

Scenarios when both charges are payable:

- A member with a history of hypertension receives a routine physical, and during the exam their blood pressure is extremely high. The patient says they are having lightheadedness and ringing in ears. The provider takes measures to lower the blood pressure and counsels the patient on monitoring of the condition.
- During an annual gynecological exam, the provider finds a lump in the patient's breast. The provider orders additional blood work and radiological procedures and takes additional time to go over treatment options.

Scenarios when both charges are not payable:

- A member with a history of hypertension comes in for a routine physical. The provider makes a brief mention of the hypertension and refills the patient's prescription.
- During a gynecological exam, a member mentions she is having hot flashes, and the provider orders blood work to check hormone level.
- During a well-child check, the provider notes that the patient has an ear infection and prescribes antibiotics.

12.19 Telehealth or Telemedicine

General Guidelines and Information

- This is a general reference regarding PacificSource's reimbursement policy for the services described and is not intended to address every reimbursement situation.
- PacificSource recognizes federal and state mandates in regard to Telehealth and Telemedicine. Any terms not otherwise defined in this policy is directed by the federal and state mandates.

- Other factors affecting reimbursement may supplement, modify, or supersede this policy which include, but are not limited to the following:
  - Legislative mandates
  - Provider contracts
  - Benefit and coverage documentation
  - Other medical or drug policies
- This policy may not be implemented exactly the same way as written due to system constraints and limitations, however, PacificSource will attempt to limit these discrepancies.
- Services are subject to medical necessity, evidence-based protocols, and member's eligibility and benefit at time of service.
- Providers who are telehealth-only must be able to refer any patients requiring in-person care to a provider who offers in-person services.

Commercial Coverage Criteria:

Criteria for tele-video and telephonic services

Prior authorization to use a telehealth service is not required unless the service requires prior authorization when performed in-person.

Services must meet all of the following in order to qualify for coverage under the health plan:

- Limited to two-way, real-time video and phone communication as defined by state and/or federal mandates.
- Services must be medically necessary and eligible for coverage providers and originating site must be eligible for reimbursement.
- Telemedical video and telephonic communication and other consultation services are subject to all terms and conditions of the plan and member benefit.

Eligible practitioners: PacificSource recognizes the following practitioner types as qualified health professionals eligible for reimbursement for tele-video and telephonic services:

- Naturopath
- Physicians
- Nurse practitioners
- Nurse-midwife
- Physician assistants
- Clinical nurse specialists
- Registered dietitian or nutrition professional
- Clinical psychologists
- Clinical social workers and other mental health providers as outlined in member's benefit
- Certified registered nurse anesthetist
- FQHC and RHC providers
- Clinical psychologists
- Clinical social workers and other mental health providers as outlined in member's benefit
- Certified registered nurse anesthetist
- FQHC and RHC providers
- Speech language pathologists
- Occupational therapists
- Physical therapists

Medicare Coverage Criteria

PacificSource follows the Center for Medicare and Medicaid Services (CMS) for coverage of telehealth and telemedicine services. Please refer to CMS.gov for coverage criteria.

In addition to what is covered under CMS, PacificSource Medicare allows for Licensed Professional Counselors, Licensed Marital and Family Therapists, Licensed Clinical Professional Counselors, Licensed Mental Health Counselors, FQHC, and RHC to be eligible practitioners for tele-video and telephonic services as appropriate with state law.

Medicaid Coverage Criteria

PacificSource Medicaid follows Oregon Health Plan (OHP) per Oregon Administrative Rules (OAR) s 410-130-0610, 410-146-0085, 410-147-0120, and 410-172-0850 for coverage of Telehealth and Telemedicine services. Participating providers must comply with Medicaid Network Access standards as outlined in OAR 410-141-3515

Reimbursement and Claim Information

Reimbursement Information

- All Lines of Business
  - Telehealth visits will be subject to retrospective review, as appropriate.
- Commercial Lines of Business
  - Fees for originating site are ineligible for reimbursement

Claim Information

- Place of Service (POS) code 02 on CMS HCFA 1500 form will be paid at nonfacility RVU for commercial and Medicaid lines of business and Facility RVU for Medicare line of business.
- Place of Service code 11 for telehealth claims is allowed but must be billed with either the GT or 95 modifier.
- Modifier GT or Modifier 95 and additional modifiers may be appended when appropriate to the CPT or HCPCS for telemedicine consultations.

Coding Information

All covered face-to-face services usually done in the office setting, including evaluation and management codes, are eligible to be performed via tele-video and/or telephone when criteria is met. Please see current AMA and CMS coding guidelines.

12.20 Self-treatment or Treatment of Family Members

PacificSource for Medicare, Medicaid, and Commercial medical and dental products exclude coverage for self-treated services and services provided by relatives whether by blood, marriage, or adoption, or other members of your household. A provider may not serve as a primary care physician (PCP) for self, family member, or household member. Physicians cannot order medications without a professional doctor-patient relationship.

13. Publications and Tools

13.1 Websites and Online Resources

Our websites are 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.

Commercial: PacificSource.com

The address of the PacificSource website is PacificSource.com. In the "Providers" section of the site, you'll find:

- News on administrative issues affecting PacificSource providers.
- InTouch for Providers, one of our most popular online tools (see section InTouch for Providers for more details).
- Information about imaging and electronic claims technology.
- A list of services requiring prior authorization.
- From the Home page, providers and PacificSource members can access the online Provider Directory.

Medicaid: CommunitySolutions.PacificSource.com

The address of the PacificSource Community Solutions website is CommunitySolutions.PacificSource.com. 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. See InTouch for Providers section for more details.
- Information about imaging and electronic claims technology.
- Archived issues of newsletters, news blasts, upcoming events, and other important updates.
- A list of services requiring prior authorization.
- From the home page, providers and PacificSource Community Solutions members can access the online Provider Directory, which is updated daily. Users can search for in-network 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.

Medicare: Medicare.PacificSource.com

The address of the PacificSource Medicare website is Medicare.PacificSource.com. In the "Providers" section of the site, you'll find:

- News on administrative issues affecting PacificSource Medicare providers.
- InTouch for Providers, one of our most popular online tools (see section InTouch for Providers for more details).
- Information about imaging and electronic claims technology.

- Archived issues of newsletters, news blasts, upcoming events, and other important updates.
- A list of services requiring prior authorization.
- From the home page, providers and members can access the online Provider Directory, which is updated daily. Users can search for in-network physicians and providers by name, zip code, city, specialty, and/or plan type, and can also print a customized provider directory from the site.

InTouch for Providers

PacificSource InTouch for Providers is a secure, providers-only website. When you log in, 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.
- View member benefits.
- Check to see if a proposed medical treatment has a prior authorization form.
- See if a managed care referral has been submitted for a member.
- Find a patient's claim in our system by Member ID.
- Select an EOP date and get a detailed listing of all claims for your office that were processed on that date.
- Submit referrals and authorizations.
- Submit pharmacy prior authorization requests.
- Submit electronic funds transfers (EFTs) and 835 ERA enrollment forms.
- Use Point of Service Direct to access real-time, accurate, patient liability information and your actual charges for each procedure billed during a visit.
- Submit claims.
- Find a member's assigned dental care organization.

Registering for InTouch:

For your convenience, InTouch is available through the Web portal 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 in the Provider section of our websites.

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

PacificSource members also have access to InTouch for Members, where they can look up claims information, track medical expenses, select a new PCP, and more.

Provider Directories

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

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

Our electronic directories (updated daily) let website visitors search for a PacificSource 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 directory will help them locate one and can even provide a map and driving directions. Members can also create, download, and print their own customized provider directories specific to their benefit plan and their geographic location.

13.2 Email Newsletters and Bulletins

The PacificSource Provider Newsletter is produced quarterly and emailed to all PacificSource in-network physicians and providers. The Provider Newsletter provides general information of interest to medical physicians and providers. PacificSource Provider Bulletins are emailed as needed reflecting policy changes, updates, and relevant pertinent information for our provider partners.

13.3 Medicaid: 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 Relations Representative.

13.4 Material in Alternate Format

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

Interpretation or translation services provided at a provider's location are the responsibility of the provider.

13.5 Healthcare Interpreter (HCI) Services (Medicaid)

PacificSource 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/HSD/OHP/Pages/Prioritized-List.aspx.

Federal and state regulations require Coordinated Care Organizations (CCOs) to provide free certified or qualified interpretation services to their members. This aligns with the goals of better health, better care, and lower costs. It also improves patient safety for the CCO's Limited English Proficiency (LEP) population.

The information below is intended to address questions about interpreter services.

Who pays for the provision of HCI services?

CCOs are responsible for ensuring member access to HCI services. Members and potential members may not be charged. HCI services will be paid by the CCO as long as they support a covered Medicaid service. A list of criteria for covered Medicaid services can be found at the Oregon Health Authority's website: Oregon.gov/OHA**.**

How can a provider arrange and bill for HCI services?

Interpreter services may be arranged by physical health, behavioral health, oral health, and home health providers. If a provider has qualified or certified interpreters on staff, the provider's office may bill the CCO directly, using the HCPC code **T1013.**

The OHA allows an administrative add-on fee for interpreter services at fee-for-service (FFS) healthcare visits (including telehealth visits). PacificSource Community Solutions will continue to allow the add-on fee for interpreter services without an end date. For full billing guidance, please visit Oregon.gov (search "Interpreter Services Fee").

Claims must be billed to the CCO with the certified interpreter staff who rendered the service (not the provider). Providers are not separately reimbursable for interpreter services.

Note: Providers with contracts for interpreter services are not limited to bill under the certified-/qualified-rendering interpreter; providers can bill within the OHA add-on fee for interpreter services (as mentioned above).

HCI vendors will adhere to OHA guidelines and standards set by OHA to render services, including HCI training, certification and qualification requirements, and reporting requirements.

Providers who do not have interpreters on staff may arrange for services through one our contracted language interpreter service providers. These contracted HCI vendors bill PacificSource Community Solutions directly; therefore, neither provider nor member should receive a bill for these services. Providers are encouraged to review our Health Care Interpreter FAQ for an up-to-date list of our contracted language interpreter service providers.

How much notice is required to schedule an interpreter through the CCO?

Generally, 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 them.

What is a "credentialed" interpreter?

The Oregon Health Authority (OHA) Health Care Interpreter Program recognizes two levels of credentialing: **qualification** and **certification.**

- Both are registered by OHA.
- Both must complete an OHA-approved 60-hour training program.
- Both require 24 hours of OHA-approved continuing education (CE) every four years.
- Certified interpreters get their certification by passing a national exam for medical interpreters.

See OHA's side-by-side qualification checklist by going to Oregon.gov: Enter HCI Requirements in the search field.

Note: Bilingual employees who are not trained as either qualified or certified medical interpreters are not eligible for reimbursement. For quality and safety reasons, providers should not use untrained bilingual employees or bilingual patient family members for medical interpretation.

What is the difference between qualified, certified, and bilingual interpreters?

PacificSource Community Solutions is required to pay for qualified or certified interpreters as long as they can provide evidence of training. Providers will be asked to sign an attestation letter to indicate qualifying criteria have been met and evidence of training is available.

- A **certified interpreter** has the highest level of medical interpreter training. Certified interpreters are certified as competent by a professional organization or government entity, through rigorous testing based on appropriate and consistent criteria. This includes passing a standardized national test.
- A **qualified interpreter** 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 Health Care. A qualified interpreter will have:
  - A high school diploma
  - 60 hours of interpreter training approved by the Oregon Health Authority (OHA)
  - Proof of language proficiency in English and target language
  - Their name listed on the OHA's HCI Registry. More information is available at Apps.Oregon.gov/SOS/LicenseDirectory
- A **bilingual individual** is a person who has some degree of proficiency in two languages. Bilingualism does not by itself ensure the ability to interpret. 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 from using bilingual patient family members for interpretation.

Language Proficiency Testing for Providers

Providers who are fluent in a language other than English must take a language proficiency test using an OHA-approved testing vendor. Language proficiency must be demonstrated prior to providing care in a language other than English. If you have completed your proficiency exam, your language(s) can be listed in our Provider Directory. Please send us a copy of the certification, and the directory will be updated. If you have not taken a language proficiency exam, or if it has been more than three years since your last proficiency exam, PacificSource is offering Language Proficiency Testing free of charge for licensed providers in Oregon who are bilingual. If you would like to take this exam, please let us know by completing a short online Language Proficiency Exam survey at PacificSource.myabsorb.com?KeyName=languageproficiency.

What resources are available for learning to work with a medical interpreter?

For guidance on building HCI capacity, as well as best practices for using medical interpreter services, try these pages:

- AAMC.org/system/files/c/2/70338-interpreter-guidelines.pdf
- NCIHC.org/ethics-and-standards-of-practice
- MassGeneral.org/interpreters/working-with-an-interpreter
- Oregon.gov/oha/oei/Pages/hci-training.aspx

Who can providers contact with questions about interpreter services?

Providers may contact our Customer Service Department at **800-431-4135.**

13.6 Language Access Plan, Policies, and Procedures (Medicaid)

We encourage our providers to incorporate the National CLAS Standards as part of their guiding operating principles.

Coordinated Care Organizations (CCO) are required by the Oregon Health Authority to monitor subcontractors to ensure language and disability access consistently across services and settings of care. This ensures compliance with federal and state regulations, including:

- Title VI of the Civil Rights Act of 1964
- Section 1557 of the Affordable Care Act
- Section 504 and the Section 508 Amendment to the Rehabilitation Act of 1973
- Title II and Title III of the Americans with Disabilities Act (1990)
- OAR 410-141-3515 Secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=297150

In accordance with regulations, PacificSource is requiring providers to, at a minimum, have policies and procedures in place for services in a culturally and linguistically appropriate manner to all members, including those with limited English proficiency or other language/communication-related needs. These policies and procedures should be made available for review to PacificSource, upon request. PacificSource has a Language Access Plan (LAP) and encourages providers to consider developing a similar plan to establish consistent access and quality monitoring of language and communication assistance practices. PacificSource's LAP can be found on our PacificSource Community Solutions website under Providers.

14. Health Plan Responsibility

Medicaid

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 copay.

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.

- Members are provided with the telephone numbers and address of PacificSource Community Solutions, Inc., and are instructed to direct all questions 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 the Who to Contact section of this manual.

PacificSource Health Plans shall ensure that all staff who have contact with potential members are fully informed of plan policies, including: enrollment; disenrollment; fraud, waste, and abuse; grievances and appeals; advance directives; and the provision of certified or qualified healthcare interpreter services, including in-network provider offices that have bilingual capacity.

Medicare

Unless otherwise exempted by CMS, PacificSource Medicare may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage plan offered by PacificSource Medicare on the basis of any factor related to health status. This includes, but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of healthcare
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

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

PacificSource Medicare must make timely and reasonable payment to or on behalf of our members for the following services obtained from a provider or supplier that does not contract with PacificSource Medicare where services are covered by PacificSource Medicare:

- Ambulance services dispatched through 911 or its local equivalent.
- Maintenance and post-stabilization care services.
- Services for which coverage has been denied by PacificSource Medicare and found (upon appeal) to be services the member was entitled to have furnished or paid for by PacificSource Medicare.

PacificSource Medicare will cover renal dialysis for those temporarily out of PacificSource Medicare's service area.

PacificSource Medicare will cover influenza and pneumococcal vaccination with no copay if administered in a pharmacy setting. In an office setting, an office-visit copay would still apply.

PacificSource Medicare must provide for continuation of member healthcare benefits for all members, for the duration of the contract period for which CMS payments have been made:

- For members who are hospitalized on the date its contract with CMS terminates or, in the event of an insolvency, through discharge.

PacificSource Medicare will send a written CMS-approved notification of the termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the

termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional will be notified. In meeting these requirements, the provider will cooperate with PacificSource Medicare and assist in complying with these requirements when applicable.

If PacificSource Medicare suspends or terminates an agreement under which the physician provides services to PacificSource Medicare members, PacificSource Medicare will give the affected individual written notice of the following:

- The reasons for the action including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by PacificSource Medicare.
- The affected physician's right to appeal the action and the process and timing for requesting a hearing.
- PacificSource Medicare will ensure that the majority of the hearing network members are peers of the affected physician.
- If PacificSource Medicare suspends or terminates a contract with a physician because of deficiencies in the quality of care, PacificSource Medicare will give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities that include National Practitioner Data Bank and Health Integrity Practitioner Data Bank (NPDB/HIPDB).
- PacificSource Medicare and provider will provide at least 90 days written notice to each other before terminating the contract without cause.

PacificSource Medicare may specify the networks of providers from whom members may obtain services if PacificSource Medicare ensures all covered services, including supplemental services contracted for by (or on behalf of) the Medicare member, are available and accessible under PacificSource Medicare. To accomplish this, PacificSource Medicare must meet the following requirements:

- Maintain and monitor a network of appropriate providers supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served

These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

Neither PacificSource Medicare nor provider may employ or contract with an individual or entity who is excluded from participation in Medicare under section 1128 or 1128A of the Act (or with an entity that employs or contracts with such an excluded individual or entity) for the provision of any of the following:

- Healthcare
- Utilization review
- Medical social work
- Administrative services

PacificSource Medicare will disclose certain CMS-required information to members. PacificSource Medicare will provide in a format using standard terminology specified by CMS, the information necessary to notify current and potential members the information they need to make informed decisions with respect to the available choices for Medicare coverage.

PacificSource Medicare will disclose to CMS all information necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

- The benefits covered under an MA plan;

- The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for PacificSource Medicare;
- Plan quality and performance indicators for the benefits under PacificSource Medicare;
- Disenrollment rates for Medicare members electing to receive benefits through PacificSource Medicare for the previous two years;
- Information on Medicare member satisfaction;
- Information on health outcomes;
- The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;
- The recent record regarding compliance of PacificSource Medicare;
- Other information determined by CMS to be necessary to assist members in making an informed choice among MA plans and traditional Medicare;
- Information about beneficiary appeals and their disposition;
- Information regarding all formal actions, reviews, findings, or other similar actions by states, other regulatory bodies, or any other certifying or accrediting organization; and
- Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program.

In meeting these requirements, the provider will cooperate with PacificSource Medicare and assist in complying with these requirements when applicable.

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

- Member Handbook: This handbook outlines member's benefits, rights and responsibilities, eligibility information, how to use PacificSource Medicare, what to do in cases of emergency, and any limitations of PacificSource Medicare.
- Provider Directory: This directory lists all general and specialty contracted providers that are available to PacificSource Medicare 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.
- Comparison of Benefits: This booklet compares the PacificSource Medicare health plan benefit package to traditional Medicare fee-for-service (FFS).
- PacificSource Medicare Identification Card: Members are instructed to use only the PacificSource Medicare card when accessing medical care.
- An Advance Directive Form, and are asked to review it with their doctor. Members may complete the form if they so desire.
- A Health Assessment form, and are asked to complete it and return it to PacificSource Medicare so members with complex needs can be case managed.
- Telephone numbers and addresses of PacificSource Community Health Plans (PacificSource Medicare), and are instructed to direct all questions they may have about their plan to the PacificSource Medicare Customer Service staff.

Provider offices receiving questions from members concerning benefits, limitations, exclusion, etc., of PacificSource Medicare should direct members to PacificSource Medicare Customer Service. Contact phone numbers are listed in the Who to Contact section.

15. Compliance and Program Integrity

Compliance Program Integrity

We maintain a Compliance and Program Integrity Plan. This plan can be found on our Medicare website at Medicare.PacificSource.com/Compliance, and our Medicaid and Commercial website at PacificSource.com/resources/documents-and-forms. 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.

Disciplinary Standards

We maintain a Code of Conduct 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 the applicable sections in our Compliance and Program Integrity Plan and Code of Conduct for more details. These materials can be found on our Medicare website at Medicare.PacificSource.com/Compliance, and our Medicaid and Commercial website at PacificSource.com/resources/documents-and-forms.

Fraud, Waste, and Abuse and Compliance Reporting

You have contractual and compliance obligations to report known or suspected issues of noncompliance and fraud, waste, and abuse. You must cooperate with PacificSource, the state, and the federal government (such as CMS) in ongoing efforts to combat fraud, waste, and abuse. You should review your current processes to ensure that your office staff is aware of the responsibility to report known or suspected fraud, waste, or abuse and other compliance concerns. Further, to respond to requests for information from PacificSource, the state, and the federal government in a timely and complete manner. Investigators rely on providers like you to provide certain information. Please refer to the applicable sections in our Compliance and Program Integrity Plan for more details.

You can report any fraud, waste, and abuse or compliance concerns directly to your PacificSource Provider Relations Representative, to our Customer Service team, or anonymously by contacting EthicsPoint (a PacificSource vendor):

Provider Relations:

- By phone at 800-624-6052
- By email at ProviderRelationsRep@PacificSource.com

EthicsPoint:

- By phone 24 hours a day/seven days a week at 888-265-4068; or
- Online at Secure.EthicsPoint.com/domain/media/en/gui/16499/index.html

Examples of Fraud, Waste, and Abuse (FWA)

Differences between Fraud, Waste, and Abuse

There are differences between fraud, waste, and abuse. One of the main differences is intent and knowledge. Fraud requires intent to obtain payment or benefit and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the health plan but do not require the same intent and knowledge. Regardless of intent or knowledge, fraud, waste, and abuse are wrong.

Examples of actions that may constitute fraud include, but are not limited to:

- Billing for services that were not provided: Knowingly billing for services not furnished or supplies not provided, including billing for appointments the patient failed to keep or billing for nonexistent prescriptions
- Authorization request and claims schemes: Prior authorization requests or claims from providers with no relationship to the member
- Inflating charges: Intentionally billing more than what would be considered usual and customary for a service
- Electronic funds transfer (EFT) imposter fraud scheme: Requests to change a provider or member's EFT banking information we have on file
- Identity theft: Using another person's health insurance card or identification to obtain healthcare or other services, or to impersonate that individual. Also, using another provider's billing information or identification to divert payments to another account or access patient information
- Phantom billing: Adding otherwise legitimate claim charges for services never performed, or fabricating claims
- Upcoding: Charging for a more expensive service (such as a visit to a specialist when the patient actually received a service from a nurse or intern), or a more expensive item than was provided (such as a wheelchair)
- Doctor shopping: Bouncing from one doctor to another to obtain multiple prescriptions for controlled substances
- Providing unnecessary care, such as unnecessary tests, surgeries, and other procedures
- Misrepresenting services or diagnosis: Performing uncovered services, but billing insurance companies for different services that are covered, i.e., changing the diagnosis to one that would cover the services
- Unbundling: Charging separately for procedures that are actually part of a single procedure in order to increase reimbursement
- Masquerading as healthcare professionals: Delivering healthcare services without proper active licenses or working outside the normal scope of their licensure
- Enrollment fraud: Knowingly misrepresenting health status or dependent status, or purposely not reporting a divorce, marriage of a dependent, or employment status

Examples of actions that may constitute waste include:

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory tests

Examples of actions that may constitute abuse include:

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly charging excessively for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Provider Exclusion and Preclusion

In addition to credentialing and contracting requirements described in this manual, for Medicare and Medicaid, PacificSource will not refer members to, use, contract with, or pay claims to providers who have been precluded, sanctioned, or excluded from participating in Medicare or Medicaid programs, or who have opted-out of the Medicare program. The OIG's List of Excluded Individuals/Entities (LEIE) and GSA's System for Award Management (SAM) search utilizes the government's database for individuals and businesses excluded or sanctioned from participating in Medicare, Medicaid, or other federally funded programs.

For Medicare, CMS has developed a Preclusion List. Providers who are found on the list will be promptly removed from the PacificSource Medicare network. Providers on the Preclusion list are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Prior to being included on the list, CMS will notify providers via an official letter.

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 the applicable sections in our Compliance and Program Integrity Plan for more details.

Program Integrity (PI) Audits

PacificSource reserves the right to audit all claims for appropriate payment, in compliance with the guidelines stated in this Provider Manual, Provider Contracts, our policies, and state and federal regulations. PI audits are one method used to ensure high-value care is provided to our members. These audits include, but are not limited to, a review of a sample of claim encounters for a given time frame against the supporting medical records. If your claims are selected for a PI audit, here are some important points to know about our process:

- Our Program Integrity team will send you a written request for medical records for specific members, services, or a date range of claims.
- Our InTouch for Providers portal is the preferred method for you to supply the records.
- You will have 30 calendar days, from the date of receipt of our request, to supply the records.
- If records are not supplied in a timely way, future claims may be denied and/or payments may be recouped.
- If records do not support audited claims, future claims may be denied and/or payments may be recouped.
- Corrective actions to address any PI audit findings may include, but are not limited to, provider education, recoupment of overpayments, contract termination, and/or reporting to the appropriate regulatory entity or law enforcement agency.

For additional guidance on topics related to PI audits, see the Glossary and Overpayment Recovery section of this manual.