

# Referral Frequently Asked Questions

## What is the difference between a referral and a prior authorization?

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

Please note: The referral must be submitted directly to PacificSource by the PCP. Referrals do not supersede other program requirements, such as:

- Medical necessity
- Eligibility
- Prior authorization requirements
- Coverage limitations

A "prior authorization" is defined as a request for a specific service that requires a review to determine medical necessity. Services that require prior authorization are outlined on our website at [PacificSource.com/provider/preauthorization](https://www.pacificsource.com/provider/preauthorization).

## When is a referral needed?

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

For more information about referrals to out-of-network providers, please refer to [Provider Manual](#), Referrals, section 5 Out-of-Panel Referrals.

## Are referrals required when PacificSource is the secondary payer?

No. Referrals and prior authorizations are not required when PacificSource is the secondary payer.

## Can a specialist submit a referral to PacificSource?

No, all referrals must be submitted by the member's PCP.

## What does a referral allow?

An approved referral allows members to see an in-network specialty provider for covered services. Without a referral, the member will likely incur more out-of-pocket costs.

**Please note:** Payment for these services will be subject to verification of benefits, eligibility, and other plan provisions at the time of service.

## Can a referral request include surgical services or other procedures?

Yes. Surgery can be counted as one of the referral's authorized visits, regardless of the place of service. Approved specialist services occurring after the procedure's global period, but within the time period requested, are still available to the member. However, some procedures or services may also require prior authorization.

Specialists must submit requests for these services via the prior authorization process.

## What if the member had a previously scheduled office visit before becoming eligible with PacificSource?

In this situation, a referral from the member's PCP is still required.

## Does PacificSource allow retro referrals?

Retro referrals are accepted within 90 days of the date of service. Please verify through Customer Service for your patient, because this is not available on all plans.

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

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

If you see a patient prior to receiving the referral determination, it is recommended you have the patient sign a liability waiver for the specific services and/or procedures rendered, in case the referral request is denied. The member's PCP will need to submit a retro referral request within 90 days of the date of service. Please verify through Customer Service for your patient, as this is not available on all plans.

## What if services are obtained without a referral or a referral request has been denied?

Claims will be paid at the nonparticipating member benefit level, regardless of provider contract. It is the PCP's responsibility to discuss other options with the member.

## How do I submit a referral?

Referrals can be submitted online via the InTouch provider portal. You can access InTouch through [OneHealthPort.com](http://OneHealthPort.com). (For more information about InTouch, please visit [Pacificsource.com/aboutproviderintouch](http://Pacificsource.com/aboutproviderintouch).)

**Please note:** Approvals are usually faster when requests are submitted online via InTouch.

## What information is required when submitting a referral request?

- Member name and PacificSource member ID number
- Ordering provider information (PCP) and contact information
- Treating provider or facility name and contact information
- Diagnosis code(s)
- Start date of request
- With the exception of Pain Management referrals, we no longer request a specific number of visits on the referral and will accept date spans up to a one-year time period.
- Referrals to Pain Management/Physiatrist - limited to 6 visits in a rolling year. Additional visits will require chart notes for clinical review.

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

No. The approved referral covers services from any provider that practices in the same group and has the same specialty as the provider approved on the request.

## Does referral approval guarantee payment for services?

An approved referral does not guarantee PacificSource will cover the services provided by an in-network provider. Covered services are always subject to:

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

## Do all services require a referral?

Referrals are not required for the following. Please note, plan benefit limits and eligibility apply:

- A declaration of disaster or emergency
- Ambulance

- Anesthesia
- Assistant surgeon
- Emergency room care
- Well baby/well child care
- Women's health: Members may self-refer for pregnancy care, annual gynecological (GYN) examinations, and contraceptive care. In addition, any medically necessary follow-up visits resulting from the annual exam do not require referral when performed within three months of the annual exam.

## Is referral information available online via InTouch?

Yes, referral information is available via our InTouch provider portal. The referral/authorization tool is web-based. There is no special software to install. Once you are logged in to InTouch, simply click the "Submit an Authorization" button.

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

## Where is the PacificSource referral form located?

PacificSource encourages referral submission online via InTouch, in lieu of faxing.

## When will I receive a determination for a referral request?

We communicate our referral decisions in writing to the member, the requesting provider, and the specialist. Notices will be faxed or mailed within two business days after we receive the referral request.

## How will I know my referral request has been approved?

Faxed requests: The determination notice will be mailed and/or faxed to the referring provider and specialist.

Online requests: The determination notice will be available via InTouch. Determination notices are also faxed or mailed.

Please contact your Provider Services Representative for questions related to this process.