



Provider Manual

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For Provider Use Only. This information
is not a complete description of benefits.

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Section 1: Introduction

1.1 About This Manual

PacificSource Community Health Plans (PacificSource Medicare) 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 Medicare. For the purpose of brevity, we use the term “provider” throughout the manual to refer to physicians and/or providers.

The manual is organized into sections and then into specific topics.

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

Please note the comments at the bottom of some pages. This information gives you quick and easy reference related to physician and provider responsibilities and/or instructions. Updates are announced in provider newsletters and on our website, Medicare.PacificSource.com.

We hope you will find the information in the Provider Manual and on the website to be useful. PacificSource Provider Service Representatives are committed to providing tools that meet the needs of our participating 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.

Notice of Changes

For any change in a PacificSource policy or process to this Provider Manual, we will provide written notice. Notice will be provided by being posted to our website at Medicare.PacificSource.com/Providers, Provider newsletter at Medicare.PacificSource.com/Providers/newsletters, email, or by fax.

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

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.

1.3 PacificSource History

PacificSource was founded in 1933 by a group of 21 physicians who staffed and operated Pacific Christian Hospital in Eugene, Oregon. Within a year, the company covered 600 employees, and in 1935 hired the first full-time manager. That same year Pacific Christian Hospital was sold, making Pacific Hospital Association, the chosen name of the organization, a separate entity.

Slow, steady growth and solid resources made Pacific Hospital Association (PHA) an attractive company in the 1940s, and twice during the first half of the decade the firm rejected offers to merge. By 1945, PHA insured 4,500 working men and women at \$2 per month.

As the country entered the post-war boom of the 1950s, PHA continued its steady growth. The company celebrated its 20th anniversary in 1953 with 10,500 members, 123 business contracts, and 67 physicians. In 1964, the physicians at the Eugene Hospital and Clinic joined PHA as member doctors. Soon after, two major client groups decided to self-insure their employees, and PHA expanded its menu of services by providing administrative services for those clients.

By 1975, PHA had become a major health insurer for Lane County, Oregon, residents. In the early 1980s, the health insurance industry experienced increased utilization, and many carriers raised premiums dramatically in response to large claims losses. Thanks to its selective marketing and conservative underwriting practices, PHA avoided large losses and emerged stronger than ever. In 1985 and 1986, PHA expanded its Oregon marketing area to include Douglas, Linn,

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Coos, and Benton Counties, and in 1987, construction was completed on a company-owned office building in Eugene.

The company grew dramatically in the 1990s as a result of aggressive provider contracting and marketing efforts. In 1992, PHA opened a local office in Portland, Oregon, and in 1994, the company launched its own line of group dental plans. The organization adopted the name PacificSource Health Plans in October 1994 to better reflect its mission as a health insurer. By the late 1990s, PacificSource had become a statewide plan, providing businesses and individuals in all corners of Oregon with flexible health and dental insurance.

To better serve its customers and accommodate enrollment increases, PacificSource opened local offices in Bend in 2000 and in Medford in 2004. The company occupied a newly constructed company-owned headquarters in Springfield, Oregon, in September 2003. That same year, PacificSource enhanced its position as a market leader and source for innovative benefit solutions by acquiring two third-party administrators: Manley Services, an administrator of flexible spending accounts, health reimbursement arrangements, and COBRA benefits; and Select Benefit Administrators, an administrator of self-funded employee benefit plans.

In 2007, PacificSource achieved a key goal of its expansion strategy by entering the Idaho market. It celebrated its 75th anniversary in 2008, ending the year by achieving licensure in the state of Washington. In 2009, PacificSource completed two key acquisitions that increased its dental membership and Idaho market share significantly: it acquired Advantage Dental's commercial dental business, and it acquired Primary Health, Inc. of Idaho, including Primary Health Plan, Riverside Benefit Administrators, and Idaho Physicians Network. PacificSource is now well positioned to continue its goal of providing affordable, quality healthcare and personal service at the local level throughout the Northwest.

In keeping with its vision of becoming the leading community health plan in the region, PacificSource entered the Medicare and Medicaid markets in 2010 through the acquisition of Clear One Health Plans, Inc. This union combined Clear One's expertise in government programs with PacificSource's longstanding leadership as a commercial health plan, providing greater opportunity to collaborate with providers across a broader spectrum of patients to improve healthcare quality and access.

Through the acquisition of Clear One, PacificSource also gained a foothold in the Montana market with 1,500 members and began its expansion in that state. In 2011, PacificSource opened an office in Helena, achieved licensure in Montana, and signed an agreement to purchase a portion of New West Health Services' commercial health insurance business.

Now, as a full-service organization with licensure in four states, PacificSource is well positioned to expand on its role as a

community healthcare asset. Offering healthcare solutions for individuals, small companies, large organizations, and government programs, PacificSource is able to meet the needs of all community members.



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 Medicare contract.

Section 2: Who to Contact

Customer Service

Bend, OR: (541) 385-5315
Springfield, OR: (541) 225-3771
Boise, ID: (208) 433-4612
Toll-free: (888) 863-3637
TTY: (800) 735-2900
Fax: (541) 322-6423
Email: MedicareCS@pacificsource.com

Customer Service is available:

- **October 1–February 14**
8:00 a.m. to 8:00 p.m. local time zone, seven days a week
- **February 15–September 30**
8:00 a.m. to 8:00 p.m. local time zone, Monday–Friday

Contact for:

- Member benefits, eligibility information, or waivers
- Deductible, co-insurance and/or co-pay information
- Explanation of payments/vouchers
- Participating physicians and providers
- Claims inquiries or claim reconsideration questions
- Claim-specific billing and/or coding questions
- Referrals or authorization inquiries

Claims Billing

Mail Medicare claims to:

PacificSource Medicare
PO Box 7068
Springfield, OR 97475-0068

Health Services

Oregon: (541) 330-7304
Idaho: (208) 433-4624
Toll-free: (888) 863-3637
TTY: (800) 735-2900

Oregon

Fax: (541) 382-2952

Idaho Authorization and Referrals

Fax: (208) 395-2697

Idaho Utilization Review

Fax: (208) 395-2696

Contact for:

- Referrals
- Care management
- Utilization review
- Prior authorization
- Out-of-network referral information



Pharmacy Services

(541) 330-4999, toll-free (888) 437-7728
TTY: (800) 735-2900

Contact for:

- Exceptions to standard formulary rules
- Prior authorization for all medications (medically administered and pharmacy)
- Clinical consultation

Provider Contracting/Reporting

(541) 684-5580, (800) 624-6052, ext. 2580
Fax: (541) 225-3643
Email: providercontracting@pacificsource.com

Contact for:

- Contract negotiations
- Contract concerns/clarifications
- Physician/provider contract reports
- Physician/provider utilization reports

Provider Network

Physician/provider support and education
(541) 684-5580, (800) 624-6052, ext. 2580
TTY: (800) 735-2900
Fax: (541) 225-3643
Email: providernet@pacificsource.com

Contact for:

- Physician/provider contract support
- Explanations of medical, administrative, or reimbursement policies

Who to Contact

- General education on proper methods to use for billing and coding
- Questions about web connectivity to PacificSource Medicare
- 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 Medicare and healthcare professionals. Recognizing the needs and perspectives of participating 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 Service 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.
- Develop educational materials for meetings 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.

Section 3: Glossary of Terms

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.

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.

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 service 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 drugs 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 regards to contract termination, as described in the PacificSource Policies and Procedures.

Balance Billing: Sometimes referred as extra billing, 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.

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

Benefit Package: Specific services provided by the insurance carrier.

Benefit Plan: Covered services, co-pays or deductible requirements, limitations, and exclusions contained in the contract between PacificSource Medicare and a member.

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 he/she is 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: The process whereby a healthcare professional supervises the administration of medical or ancillary services to a patient, typically one who has a catastrophic disorder or who is receiving mental health services. Care managers reduce the costs associated with the care of such patients, while providing high-quality medical services.

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

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

Coordinated Care Organization (CCO): A new way to manage physical, mental, and dental healthcare for the Oregon Health Plan (OHP). A CCO is a group of local healthcare providers, hospitals, and health insurance plans. They will provide healthcare and healthcare coverage for people eligible for the Oregon Health Plan.

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.

Co-insurance: 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.

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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.

Co-pay: 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, co-pays or co-insurance 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: Total of insured members.

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

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. PacificSource Medicare plans have no deductible.

Diagnosis: The identification of a disease or condition through examination.

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.

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.

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.

Emergency Medical Condition: A medical emergency is when any prudent layperson with an average knowledge of health and medicine, believe that they have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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.

Emergency Services: 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.

Enrollee: A person eligible for service.

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.

Experimental Procedures: Also called unproved procedures. All healthcare services, supplies, treatments, or drug therapies that PacificSource Medicare 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: PacificSource Medicare's list of covered drugs.

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

Global: All-inclusive.

Grievance: A type of complaint made about a health plan, in-network provider, or pharmacy, including a complaint

concerning the quality of care. This type of complaint does not involve coverage or payment disputes.

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

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

Independent Physician Association (IPA): An independent association of physicians and/or providers that have entered into a contract with PacificSource Medicare to provide certain specific covered services to members.

Individual Practice Association (IPA): An individual practice association of physicians and/or providers that entered into a contract with PacificSource Medicare 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 healthcare, ambulatory care, home care, and long-term care services.

Locum Tenens Provider: A provider, local or visiting, who is not credentialed or contracted with PacificSource Medicare but who is allowed to see and treat members enrolled in our products on behalf of their normal practitioner who may be unavailable for a period of time.

Managed Fee-for-Service Product: Plan in which the insurer pays the cost of covered services after the services have been used. Various managed care tools such as preapproval, 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 you 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 Loss Ratio (MLR): The ratio of a health maintenance organization's actual incurred expenses to total premiums.

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 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. A plan 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 **November 15 and December 7 each year**. Also called Annual Enrollment Period in which an individual enrolls in a Medicare plan or makes plan changes in their Medicare healthcare coverage.

Member (Member of our Plan, or Plan Member): 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 Medicare has selected and contracted with to provide healthcare for its members.

Network Pharmacy: A network pharmacy is 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 Medicare members.

Noncoverage Decisions: PacificSource follows CMS guidelines for NCD (National Coverage Documents) and LCD (Local Coverage Documents). Information can be found at <https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?NCDId=335&ncdver=2&bc=AgAAgAAAAAAAAA%3d%3d&>.

Noncovered Services: Those services excluded from coverage by PacificSource Medicare, may also be called an 'un-covered benefit'.

Non-Emergent Condition: Routine medical care such as diagnostic work-ups for chronic conditions, 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.

Nonformulary Covered Prescriptions: A list of prescription drugs that generally are not covered.

Nurse Practitioner: A registered nurse who has advanced skills, training, and licensure in the assessment of physical and psychosocial health status of individuals, families, and groups.

Out-of-Network Provider: A healthcare physician or provider who has not contracted with PacificSource Medicare.

Organizational Determination: The Medicare Advantage organization has made an organization 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 organization 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. Organization determinations are called "coverage decisions" in this manual.

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

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

Out-of-Network Physician or Provider: A physician or provider who is not a part of the network.

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

PacificSource Community Solutions: A healthcare service contractor licensed under state law, Health Plan Management System (HPMS), and the Centers for Medicare and Medicaid Services (CMS) to provide comprehensive healthcare services for Medicaid members enrolled through the Oregon Health Plans (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 and federal 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.

PacificSource Medicare Service Area: The geographic area defined by the boundaries of federal law and the state and of Oregon and Idaho and in certain counties as follows:

Oregon:

- Central, Eastern, and Mid-Columbia Gorge: Crook, Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, Wheeler, and northern parts of Klamath and Lake counties

- Clackamas, Multnomah, and Washington counties
- Lane county
- Coos and Curry counties

Idaho:

- Southwest: Ada, Blaine, Boise, Camas, Canyon, Cassia, Elmore, Gem, Gooding, Jerome, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, and Washington counties
- Northern: Bonner, Boundary, and Kootenai counties
- Eastern: Bannock, Bingham, Bonneville, Jefferson, and Madison counties

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

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.)

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

Part B: Part of original Medicare and 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.

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

PCP: See Primary Care Practitioner.

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: A person duly licensed and qualified to practice medicine in the state where his/her practice is located.

Physician Assistant: A healthcare professional qualified by education, training, experience and personal character to provide medical services under the direction and supervision of

a licensed physician in active practice and in good standing with the Board.

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 Medicare to provide specified covered services to members.

Plan: See PacificSource Medicare.

Policyholder: The individual to which a contract is issued and in whose name a policy is written.

Preapproval: A medical review process prior to the provision of services, usually requested by the physician or provider. Factors determining authorization may be eligibility, benefits of a specific plan, or setting of care.

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

Premium: Rate that is paid for a specific health service.

Preventive Care: An approach to healthcare emphasizing preventive measures, such as routine physical exams, diagnostic tests, and immunizations.

Primary Care Provider (PCP): An in-network healthcare professional who meets state requirements and is trained to give members basic medical care. They can also coordinate member care with other providers. PCPs can be selected from the following specialties: family practice, general practice, internal medicine, or pediatrics. Providers in these specialties may include: Nurse Practitioners (NP), Physicians Assistants (PA), Medical Doctors (MD), or Doctor of Osteopathy (DO).

HMO plans require members to have a PCP.

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; 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.

Quality Assurance Utilization Management Pharmacy Therapeutics (QAUMPT) Committee: The QAUMPT Committee functions to promote quality and oversee performance improvement projects, identify topics for quality and performance improvement efforts, and oversee and evaluate quality and performance improvement plans. The pharmacy and therapeutics function of the committee is tasked

Glossary of Terms

with defining formulary coverage and clinical guidelines for the Medicare population.

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.

Quantity Limits: A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Referral: The process by which the member's primary care practitioner directs the member to seek and obtain covered services from other physicians and providers.

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

Service Areas: Geographic areas covered by a PacificSource Medicare 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.

Special Enrollment Period: A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which an enrollee may be eligible for a Special Enrollment Period include: if an enrollee moves outside the service area, enrollees getting "Extra Help" with prescription drug costs, if enrollees move into a nursing home, or if we violate our contract with the enrollee

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. Please reference the below link for CMS regulation, Chapter 4 Section 20. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>

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.

Subrogation: When healthcare costs of enrollees are the responsibility of an entity other than the insurer, such as workers' compensation, third party negligence liability, or automobile medical coverage.

Subscriber: A person who is covered by Medicare and who has chosen to get their Medicare healthcare and/or prescription drug coverage through PacificSource Medicare.

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 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: Urgently needed care is 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 Medicare with the cooperation of contracted physicians and providers to authorize and monitor the utilization of covered services provided to members.

Section 4: Physicians and Providers

4.1 Credentialing

PacificSource Medicare credentialing standards follow the guidelines of the National Committee on Quality Assurance (NCQA). The credentialing process includes meticulous verification of the education, experience, judgment, competence, and licensure of all healthcare providers.

Although the credentialing process may be lengthy and time-consuming, PacificSource Medicare believes the emphasis on credentialing further demonstrates a commitment to qualified healthcare physicians and providers performing services our members require.

Please remember that PacificSource Medicare requires all providers rendering services to be individually credentialed before they can be considered a participating provider under the provider contract. This includes a nurse practitioner, physician assistant, or other mid-level provider.

PacificSource follows CMS "Incident to" guidelines.

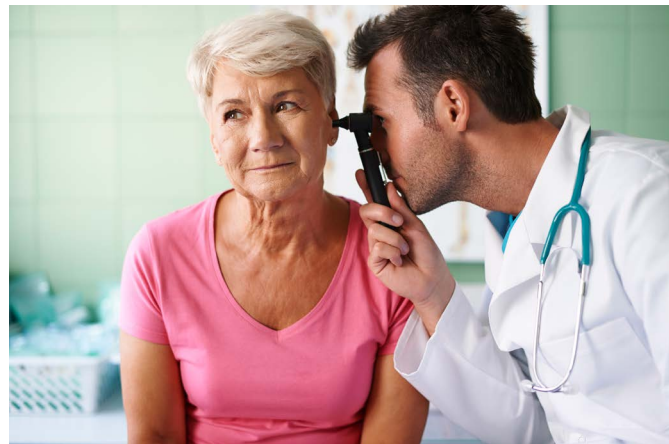
4.1.1 Initial Credentialing Process

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

Phase 1: Application

Providers are required to submit the Practitioner Credentialing Application and complete our credentialing process prior to being considered a participating network provider with PacificSource Medicare. Please note that any new providers at your clinic will be considered out-of-network providers until the credentialing application is submitted and approved by our Credentialing Committee. When a provider has out-of-network status, claims are paid at the out-of-network level, which has a direct effect on your clinic and your patients. Once the credentialing application has been completed, a copy of the application can be used in the future provided no information has changed in the interim. However, signatures and attestation statements must be no more than 180 days old.

The Practitioner Credentialing Application is available in the Providers section of our website, [Medicare.PacificSource.com/Providers/Credentialing](https://www.Medicare.PacificSource.com/Providers/Credentialing) or by contacting our Credentialing department at (541) 225-3771 or email at credentialing@pacificsource.com.



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

- Current, unrestricted Medical License
- Current, valid Drug Enforcement Agency (DEA) certificate, if applicable
- Education and training
- Board certification, if applicable
- A minimum of five years relevant work history
- Hospital privileges, if applicable
- Current, adequate professional liability coverage, showing the coverage limitations and expiration dates
- All professional liability claims history

Phase 2: Review

The PacificSource Credentialing department is responsible for credentialing and recredentialing providers participating in our provider network. The PacificSource Credentialing Committee evaluates provider candidates for credentialing and makes the final determination on credentialing and recredentialing. The Credentialing Committee is also responsible for developing credentialing criteria based on applicable standards, and applying those criteria in a fair and impartial manner.

The Credentialing Committee has the right to make the final determination about which providers participate within the network. If unfavorable information about a specific provider is discovered during the credentialing process (e.g., professional liability settlements, sanctions, erroneous information, or other adverse information), the Committee may choose not to credential the provider. The Credentialing Committee will not accept applications that are incomplete or do not meet our standards for review. Applications that are not accepted are not subject to appeal.

Phase 3: Decision

Upon the Credentialing Committee's approval, the provider will be notified in writing of their acceptance, including an approval date. The provider will then be recredentialed at least every three years.

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

If the Credentialing Committee does not approve the provider, the provider may be considered an "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 Medicare rules or legal boundaries) whereby claims payments may not be approved.

4.1.2 Recredentialing Process

A practitioner recredentialing letter with a link to the online application will be sent to the provider approximately three months prior to the credentialing period expiration date.

Failure to return the information by the due date will result in termination from the PacificSource Medicare network and will affect claims payment. If the provider is reinstated after such termination, the provider will be required to complete the full credentialing process, as deemed necessary by the Credentialing department and/or Medical Director.

The recredentialing process will include verification or review of the following:

- Completed recredentialing application
- Copy of current, unrestricted Medical License
- Copy of current, valid Drug Enforcement Agency (DEA) certificate, if applicable
- Board certification, if applicable
- Hospital privileges, if applicable
- Current, adequate professional liability coverage, showing the coverage limitations and expiration dates
- Claims history since last credentialing
- Quality improvement activities

The decision and notification process for recredentialing is the same as for initial credentialing; please see Phase 3: Decision in previous section.

Locum Tenens Arrangement

A Locum Tenens arrangement is made when a participating physician must leave his or her 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 he or she is replacing.

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.

If a Locum Tenens is providing coverage longer than 60 consecutive days, the provider will be required to complete the applicable practitioner credentialing application. If the Locum Tenens returns to the practice for additional cycle, a new 60-day cycle will be allowed before credentialing is required.

Claims for the covering Locum Tenens billed after 60 days will be denied. The Locum Tenens is required to bill PacificSource Medicare as the service provider after 60 days coverage, and the claim will process according to member's benefits and contractual guidelines.

Exception to the 60-day limitation for locum tenens billing:

- Section 116 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the exception to the 60-day limit on substitute physician billing for physicians being called to active duty in the Armed Forces for services furnished from January 1, 2008, through June 30, 2008. Section 116 of Public Law 110-173 extended the accommodation of physicians ordered to active duty in the Armed Forces, enacted by Public Law 110-54, by striking 'January 1, 2008,' and inserting 'July 1, 2008'.
- Essentially, both legislative acts allow a physician being called to active duty to bill for the services furnished by a substitute physician for longer than the 60-day limitation.

If postoperative services are furnished by the substitute physician, the services cannot be billed with modifier Q6 since the regular physician is paid a global fee.

- If services are provided by a substitute physician over a continuous period of longer than 60 days, the regular physician must bill the first 60 days with modifier Q6.
- The substitute physician must bill for the remainder of the services under his/her own name.
- The regular physician may not bill and receive direct payment for services over the 60-day period.
- A new period of covered visits can begin after the regular physician has returned to work.

For a medical group billing under the locum tenens arrangement, it is assumed that the locum tenens physician is paid by the regular physician.

- The term “regular physician” includes a physician who has left the group and for whom the group has hired the locum tenens physician as a replacement.
- A physician who has left a group, and for whom the group has engaged a locum tenens physician as a temporary replacement, may still be considered a member of the group until a permanent replacement is obtained.

In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her NPI number in Item 24k on the CMS-1500 claim form or electronic equivalent. The group must retain a copy of each service provided by the substitute physician, along with the substitute physician's NPI number. This record must be made available to PacificSource Medicare upon request. It is not necessary to provide this information on the claim form.

Physicians should be aware that use of modifier Q6 by the regular physician (or medical group, where applicable) certifies that the covered visit services furnished by the substitute physician are identified in the record of the regular physician which is available for inspection, and are services that the regular physician (or group) is entitled to submit. A physician or other person who falsely certifies any of the above requirements may be subject to possible civil and criminal penalties for fraud.

A patient's regular physician may submit the claim, and (if assignment is accepted) receive the payment, for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, if:

- The regular physician is unavailable to provide the visit services.
- The member has arranged or seeks to receive the visit services from the regular physician.
- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis.
- The substitute physician does not provide the visit services to patients over a continuous period of longer than 60 days.
- The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS code modifier Q6 (service furnished by a locum tenens physician) after the procedure code.

4.1.3 Practitioner Rights

During the credentialing or recredentialing process, practitioners have the right to:

- Review information submitted to support their credentialing or credentialing application
- Correct erroneous information
- Receive the status of their credentialing or recredentialing application, upon request

4.2 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 do not have a current version of the IRS W9 form, you may download it from our website, Medicare. PacificSource.com.
- 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 Medicare should begin using the new number).
- Send the completed form with the effective date by mail, fax, or email:

PacificSource Health Plans
Attn: Provider Network
PO Box 7068
Springfield, OR 97475-0068
Fax: (541) 225-3643
Email: providernet@pacificsource.com

For your current provider identification numbers, please contact our Provider Network department by phone at (541) 684-5580 or (800) 624-6052, ext. 2580, or by email at providernet@pacificsource.com.

4.3 Provider Network Participation Requirements

The following rules of participation (“Rules”) apply to all PacificSource entities that participate in PacificSource’s Medicare Advantage Network(s) as contemplated by 42 CFR §422.202, 204, 205, 206, 220, 752(a)(8); Federal Register: 42 CFR 422, Medicare Program; Changes to the Medicare + Choice Program; Rule (February 17, 1999); Chapter 6: Medicare Managed Care Manual-Relationships with Providers (April 27, 2007)(§30, 60.4) and apply to Providers, Provider groups, independent practice associations, or other Provider organizations (collectively, “Provider”).

PacificSource Rules include the following criteria and/or considerations:

- PacificSource may make determinations as to the number and mix of providers needed in its network(s) at any given time and may choose the manner to achieve it.
- Provider must at all times meet all credentialing and recredentialing standards as outlined in PacificSource’s credentialing and recredentialing policies, as amended from time to time.
- Provider must demonstrate to PacificSource’s satisfaction the ability to meet at all times all obligations set forth in PacificSource’s participation agreement with the provider and acknowledges that all terms of payment are set forth therein.
- Provider must at all times comply with all requirements set forth in PacificSource’s Provider Manual.
- Provider must demonstrate a practice history, which PacificSource deems consistent and compatible with the Rules set forth herein.
- Provider must practice within the applicable service area and geographic territory.
- Provider must meet the Centers for Medicare & Medicaid Services’ (CMS) and PacificSource’s access-to-care requirements applicable to Medicare Advantage members.
- PacificSource may also consider provider performance metrics including, but not limited to, cost efficiency, effectiveness indicators, and patient experience results comparable to benchmarks.

Provider performance metrics may include the following:

- PacificSource may selectively use claims grouper methodologies to analyze the cost efficiency of a broad range of providers and use the resulting “efficiency measurement” to select providers for participation.

- PacificSource may selectively use “effectiveness indicators,” including those developed by emerging industry guidelines and/or by nationally recognized quality organizations.

4.3.1 Medicare Approval

Providers or suppliers, which are types of individuals or entities that can enroll in Medicare in accordance with section 1861 of the Act, must be enrolled in Medicare and be in an approved status in Medicare in order to provide healthcare items or services to a Medicare enrollee who receives his or her Medicare benefit through an MA organization. This requirement applies to all of the following providers and suppliers:

- Network providers and suppliers
- First-tier, downstream, and related entities (FDR)
- Providers and suppliers in Cost HMOs or CMPs, as defined in 42 CFR part 417
- Providers and suppliers participating in demonstration programs
- Providers and suppliers in pilot programs
- Locum tenens suppliers
- Incident-to suppliers

4.4 Physician and Provider Contract Provisions

PacificSource Medicare 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 shall not attempt to collect from members any amounts in excess of the negotiated rates (balance billing).
- Physicians and providers may not collect up-front, except for deductibles, co-insurance, co-pays and/or services that are not covered.
- Physicians and providers shall bill their usual and customary charges.
- Physicians and providers shall bill PacificSource Medicare directly using current CPT procedure, ICD-10 diagnostic, HCPCS and/or DRG coding, and not ask members to bill PacificSource Medicare for their services.
- Physicians and providers will cooperate with PacificSource Medicare, 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 Medicare when necessary to coordinate benefits, quality assurance, utilization review, third party claims, pre-existing condition investigations, and benefit administrations. PacificSource Medicare agrees that such records shall remain confidential unless such records may be legally released or disclosed. Unless otherwise specified, medical records shall be provided at no cost.

- For noncovered services, physicians and providers shall seek payment from the member.
- Unless otherwise specified in your contract, PacificSource Medicare does not pay more than billed charges. The allowable will be based on the lesser of the negotiated rate specified in the physician/provider contract, or the billed amount.

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 (800) 624-6052, ext. 2580, or by email at providernet@pacificsource.com.

4.5 Call Share Policy

Participating providers will establish call share arrangements with other participating providers when they are unavailable. In such situations, the call share provider may bill PacificSource Medicare for the services provided to the patient.

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 Medicare maintains call share group listings. Any changes in call share must be forwarded to the Provider Network department. If there is any change in a call share group, please call Provider Network as soon as possible at (541) 684-5580 or (800) 624-6052, ext. 2580.

4.6 Primary Care Providers

4.6.1 Responsibilities

When a provider chooses to be designated as a primary care practitioner (PCP) under a benefit plan requiring a PCP, he/she agrees to provide and coordinate healthcare services for PacificSource Medicare members. PCPs shall refer members to network specialists for services the PCP is unable to provide.

The PCP will also be responsible for reviewing the treatment rendered by the specialist.

The PCP's responsibility as the manager and coordinator of the member's care is as follows:

- The PCP provides all primary preventative healthcare services, except the annual gynecological exam should the member choose to seek this service from a participating women's healthcare specialist.
- When specialized care is medically necessary, the PCP will facilitate a referral to a specialist or specialty facility.
- The PCP must contact PacificSource Medicare to obtain prior authorization or a referral to specialty providers, if necessary.
- The PCP will coordinate care and share appropriate medical information with PacificSource Medicare and any specialty provider to whom they refer their patients.
- 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.
- The PCP will forward copies of the completed Advance Directive forms for their patient to PacificSource Medicare's Customer Service department. They will also document in a prominent place in their patient's records if an individual has executed an Advance Directive.
- The PCP will adhere to the medical records standards developed and approved by the Ambulatory Record Certification Program of the Oregon Medical Association and Federal regulations.
- Will notify PacificSource Medicare in writing when practice is closed to new patients
- Will arrange for call sharing, as soon as possible, with a network physician or provider 24 hours a day, seven days a week
- Will notify PacificSource Medicare of any changes in call share coverage
- Will notify PacificSource Medicare when asking a member to seek treatment elsewhere

Also, see section on Referrals.

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 your Provider Service Representative, as soon as possible, if any of the following changes occur within your practice:

- Telephone number
- Tax ID number
- Billing address
- Physical office address
- Closing practice
- Provider Leaving
- UPIN or NPI changes

Submit these changes in writing to:

PacificSource Health Plans
Attn: Provider Network
PO Box 7068
Springfield, OR 97475-0068

You may also fax these changes to the attention of Provider Network at (541) 225-3643 or by email to providernet@pacificsource.com.

Applicability of Federal Laws:

As a federal contractor, PacificSource Medicare receives federal funds to provide services to our members. As a participating provider providing services to PacificSource Medicare Advantage members, you are subject to laws applicable to individuals and entities receiving federal funds. Participating providers who treat our members are required to comply with applicable state and federal laws and regulations regarding Medicare.

4.6.2 Availability Practice

Participating providers agree to accept new patients unless his/her practice has closed to new patients from all health plans. Please notify PacificSource Medicare in writing as soon as when your practice is closed to new patients and again if the practice reopens.

Providers must ensure that its hours of operation are convenient to the population served under PacificSource Medicare and do not discriminate against Medicare members.

Participating providers agree to provide coverage for PacificSource Medicare members 24 hours a day, seven days a week in a culturally competent manner and in a manner consistent with professionally recognized standards of healthcare. The provider or his/her 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 Medicare will make every attempt to communicate to our members any closed or limited practice when notified by the PCP in writing of his/her intentions. Notations regarding closed or limited practices can be found in the provider directories. Possible notations include:

- Closed as PCP, Open as Specialist
- Practice Has Age Limitations
- Practice Has Demographic Limitations
- Accepting New Patients
- Not accepting new patients
- Accepting OB Patients only

Questions regarding PCP selection should be referred to the Customer Service department at (541) 385-5315 or toll-free (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. You may call PacificSource Medicare and ask for the PacificSource Medicare Clinical Quality department at toll-free (888) 863-3637. If you prefer to write a letter, please mail it to the following address:

Physicians and Providers

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

Access to Care Standards

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

Primary Care Services:

- Preventive primary care appointments—30 working days (annual physicals, pediatric/adult immunizations, and annual GYN exams)
- Routine primary care appointments—five working days (colds, rashes, headache, joint/muscle pain)
- Urgent primary care appointments—within 48 hours (high fever, vomiting, etc.)
- Emergency care services—same day
- After-hours care—24-hour phone available (answering machine/service advising members of care options)

Behavioral Healthcare Services:

- Routine office visit appointments—10 working days
- Urgent care—within 48 hours*
- Nonlife-threatening emergency care—contact with patient within six hours*
- Life-threatening emergency care—immediately*
- After hours care—24-hour phone available (answering machine/service advising members of care options)

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

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.

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.

NBI MEDIC Prescriber Prescription Verification

You have a contractual and compliance obligation to cooperate with the federal government in its ongoing efforts to combat fraud, waste, and abuse. CMS contracts with the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) to investigate potential fraud, waste, and abuse matters. It relies on providers like you to provide certain information. You should review your current process and ensure that your office staff is aware of the MEDIC's request and be prepared to respond to the MEDIC timely and completely.

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.

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 successfully terminated by any of following the guidelines listed below:
 - 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 of continuing care at that time, the physician must take *all* the following steps:

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

- Reasonable Notice
- In most cases a 30-day notice would be considered reasonable. If the basis for termination of a PacificSource Medicare member from your practice is for disruptive behavior and is dangerous to other patients or staff, the period may be shortened to as little as one (1) day. This is dependent upon the seriousness of the threat and our ability to either terminate the member from our plan or to locate another network provider willing to accept the member as his/her patient within the range of one (1) 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.

Please notify Customer Service at PacificSource Medicare of the termination at the same time you notify the patient. See the Who to Contact section.

Advance Directive

An Advance Directive is a document that allows patients to express and control their healthcare needs at a time when they are unable to make decisions.

Provider Responsibilities:

- Provider will maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care.
- 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 as a matter of conscience.
- Providers should retain the original and provide a copy of the completed form to the member.

A copy of the Advance Directive form may be obtained from Customer Service or online at Oregon.gov/DCBS/insurance/shiba/Documents/advance_directive_form.pdf.

Health Insurance Portability and Accountability Act (HIPAA)

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

PacificSource Medicare recognizes 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 Medicare 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 Medicare. PacificSource Medicare 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 Privacy Notification Statement that is available to all PacificSource Medicare members is available on our website at Medicare.PacificSource.com. If you have any questions or concerns, please contact your Provider Service Representative.

4.7 Provider Appeals Process

Provider 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, ext. 2580.

As a Participating 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 prior authorization coverage denial. This is exercised via the Provider Appeal process.

If you fail to submit a complete and timely appeal, PacificSource Medicare will consider 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 60 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.

Preapproval 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
- Preapproval 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.

Every effort is made by appeal representatives to process your requests and issue a resolution 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 (i.e., PacificSource Medicare

will not rush the review of a MRI coverage appeal because the procedure is scheduled to occur prior to the 30-day timeframe).

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 preapproval was denied because the PacificSource Medicare reviewer requested additional documentation but did not receive it in a timely manner, please consider submitting a new preapproval request. With your new request, include the additional information requested and clearly indicate that new information is being provided.

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. Please fill these out completely, with the following minimum information:

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

Every effort is made by appeal representatives to process your requests 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 preapproval has been denied because PacificSource Medicare requested additional documentation, but did not receive it in a timely manner and resulted in a denial of coverage, please consider submitting a new prior authorization request instead of an appeal. Include the additional information requested and clearly indicate new information is being provided.

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](https://www.Medicare.PacificSource.com). 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, timely filing, 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 preapproval. Examples of appeals that may result in upheld denials include:

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

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 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](https://www.Medicare.PacificSource.com/Providers/AppealsGuide).

4.8 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 the member's information, and maintain records and information in an accurate and timely manner and to ensure timely access by members to the records and information that pertain to them. Medical record information will only be disclosed to contracted business associates outside of the organization in which PacificSource Medicare retains a valid confidentiality agreement with [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 record, 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).

Provider Communication

Each contracted provider receives and has access to the PacificSource Medicare 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.

Provider Incentive Plans

PacificSource Medicare does 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 chapter 9 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.

4.9 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").

Except as provided herein, all other provisions of the Agreement between PacificSource and Contractor not inconsistent herein shall remain in full force and effect. This amendment shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the PacificSource and Contractor agree as follows:

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: 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.

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 the PacificSource by common ownership or control and (1) performs some of the 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 the 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' 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).
 9. 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 the PacificSource reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the 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 either reviewed by PacificSource or the credentialing process will be reviewed and approved by PacificSource and PacificSource must 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).
 10. Contractor must comply with Health Plan's policies and procedures.
 11. Health Plan may only delegate activities or functions to Contractor in a manner consistent with CMS requirements.
 12. 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.
 13. Contractor shall complete compliance and fraud, waste and abuse training and review and abide by PacificSource's Standards of Conduct and compliance policies and procedures for all of its current employees at least annually and new employees within 90 days of hire.
 14. 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](https://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.

Section 5: Referrals

5.1 Referral Policy

Beginning January 1, 2016, the only plan to require a referral is MyCare Rx 22 (HMO) which is only offered in the Portland area.

A “referral” is the process by which the member’s primary care provider (PCP) directs a member to obtain care for covered services from other health professionals in an office setting. For plan referral requirements please refer to Section 8.1 of this manual.

5.2 Out-of-Network Referrals

Requests to see an out-of-network provider must be submitted via the preapproval process and are not considered a referral.

5.3 Retro-Referrals

Conditions for Retro-referral Review

PacificSource Medicare understands that there are certain circumstances that may prohibit the ability to obtain a referral approval prior to services being rendered. This should be the exception and not the rule. In order to be considered for approval, the referral must be determined to be medically necessary and appropriate.

Retro-referrals will only be reviewed for approval under the following conditions:

- The service was not provided more than 90 days preceding the receipt of the request.
- The service under review has not already been billed and denied. If the claim was denied, a formal appeal will need to be filed.

Contact may be made via InTouch, telephone call, or faxed information.

5.4 Referral Policy for MyCare Rx 22 (HMO) only

Referrals do not supersede other program requirements such as:

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

A “preapproval” is defined as a request for a specific service that requires a review to determine medical necessity. Services



that require preapproval are outlined on our website, Medicare. PacificSource.com.

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.

All referrals must be submitted by the member’s PCP or call share partner.

Please note: Requests to see an out-of-network provider must be submitted via the prior authorization process and are not considered a referral.

Referrals and preapproval are not required when PacificSource Medicare is the secondary payer.

A referral allows members to see an in-network specialty provider for covered services rendered in their office (POS 11). Referrals do not cover services that require preapproval. It is important to note payment for these services will be subject to verification of benefits, eligibility, and other plan provisions at the time of service.

Procedures or services that require prior authorization cannot be included in a referral. Specialists must submit a request for these services via the preapproval process.

If the member had a previously scheduled office visit before becoming eligible with PacificSource Medicare, a referral from the member’s PCP is still required.

5.5 Referral Procedure

A referral can be submitted electronically through our online InTouch provider portal. InTouch can be accessed by visiting Medicare.PacificSource.com/InTouch. Faxed requests must include the PacificSource Medicare referral form and can be faxed to: (541) 382-2952 for Oregon or (208) 395-2697 for Idaho.

Information required when submitting a referral request:

- Member name, date of birth, and member ID number
- Referring provider name and contact information
- Referred to provider or facility name and contact information
- Diagnosis code(s)
- Start date of request.**
- Chart notes required if:
 - office visits for physiatrist/pain management exceed six
 - referral request is longer than one rolling year (after the first six visits, chart notes will be required)

***The number of visits requested is required when submitting a referral for pain management.*

Referral requests do not have a maximum visit limitation (with the exception of pain management). Referrals made to pain management providers may be auto approved for requests up to six visits.

The approved referral covers services from any provider that practices in the same group, is participating with PacificSource Medicare, and has the same specialty as the provider approved on the request.

If the referral request has not been approved at the time of service and 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.

An approved referral does not guarantee PacificSource Medicare 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.

The PacificSource Medicare referral request form is located on our website, Medicare.PacificSource.com.

We respond to referral requests within 14 calendar days, but usually render a decision much sooner. Most requests submitted via InTouch receive a determination within minutes.

A determination notice is sent based on how the request was submitted. Online determination notices will be viewable in InTouch. Faxed determination notices will be mailed and/or faxed to the referring provider and specialist.

5.6 Referral Not Required

Referrals are not required for the following. However, these services are subject to the plan benefits and eligibility:

- A Declaration of Disaster or Emergency
- Emergent ambulance
- Anesthesia
- Assistant surgeon
- Chemical dependency and mental health providers
- Covered chiropractic and alternative care
- Diabetic education providers: *up to 3 hours of diabetic education by a Nurse Practitioner or Diabetic Educator; all other providers will require a referral.*
- Diagnostic testing, including but not limited to lab and radiology services, nerve conduction studies, treadmill tests, ECG testing and interpretation. Consultation with a specialist that results in a charge prior to or following diagnostic testing **does** require a referral. However, some services may require preapproval.
- Durable medical equipment and supplies
- Emergency care
- Lactation counseling
- Mammography screening
- Nutritional counseling with PCP
- Pharmacy
- Physical, occupational, and speech therapy
- Pneumonia and flu vaccinations
- Preventive services
- Routine and diagnostic colonoscopies
- Urgent care
- All vision services
- 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 a referral when performed within three months from the annual exam
- Kidney dialysis (out-of-network): including services rendered at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area

Section 6: Medical Management

6.1 Medical Necessity

PacificSource Medicare provider contracts contain a clause specifying that services must be medically necessary to be eligible for reimbursement. “Medically Necessary” and “Medical Necessity” are terms PacificSource Medicare 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.
- 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.

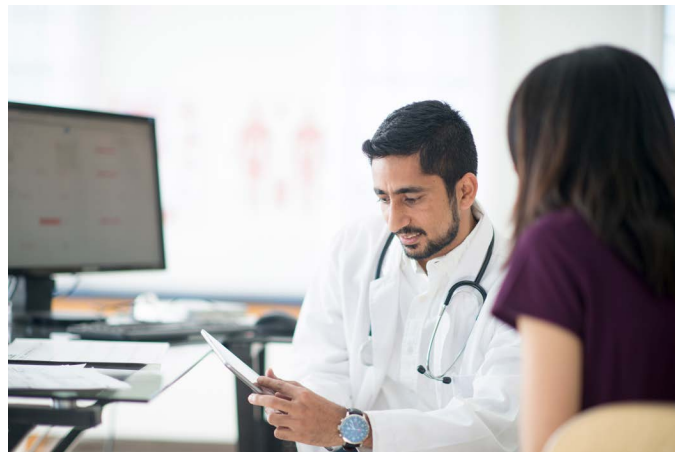
Medical necessity determinations are not made arbitrarily. When a PacificSource Medicare claims adjudicator reviews a claim, we compare the treatment with the usual treatment provided by physicians and/or providers and hospitals to patients having similar conditions. Services are checked for correlation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

6.2 Care Management

Overview of Care Management Program

Care management services are offered as a resource to providers by PacificSource Medicare Nurse Care Managers under the guidance of the Medical Director. They will assist in managing the care of members that have presented as having complex medical and social needs, thereby requiring intensive care coordination. Early identification of these members can



significantly impact the cost associated with their care without sacrificing quality or member satisfaction and often enhances outcomes.

Role of PacificSource Medicare Nurse Care Manager

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.
- Make home visits as needed for needs assessment and evaluation of quality of care.
- 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.

Medical Management

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 Nurse Care Managers

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 Nurse Care Managers, the member's PCP, and community partners. They assist with the member's healthcare needs, identify gaps in care and resolve 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

How Members Are Identified

Care management may be generated under the following terms:

- Contracted providers contacting PacificSource Medicare directly
- Through the clinical review or the preapproval process
- By reviewing emergency or ambulance claims reimbursement requests
- Members contacting PacificSource Medicare directly
- Using data analysis to identify high-risk or high-needs patients

PacificSource Medicare members may be identified through the completion of a Health Assessment Survey (Wellness Survey) administered after enrollment. The Health Assessment tool 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. The Medical Services team will review PacificSource Medicare members' preapprovals and referrals to identify members with critical healthcare needs and, as appropriate, intervene.

The Care Management department and Member Support Specialists are available Monday through Friday, 8:00 a.m.

through 5:00 p.m. local time zone by calling (541) 385-5315 for Oregon, (208) 433-4624 for Idaho or (888) 863-3637 toll-free. Email: Care Management at CaseManagementMedicare@pacificsource.com or Member Support at BoiseMMS@pacificsource.com.

6.3 Quality Improvement and Medical Management

PacificSource Medicare relies on the Quality Assurance Utilization Management Pharmacy & Therapeutics (QAUMPT) Committee to be its advisory body for quality, utilization, pharmacy, therapeutics, and performance improvement activities. The committee has the responsibility to develop and endorse all clinical policies and formulary coverage decisions. The QAUMPT committee consists of physicians and pharmacists practicing in the communities we serve. These committee members represent our contract providers. Evidenced based guidelines are reviewed and adopted by the QAUMPT committee. Examples include, Milliman, Hayes, and AIM 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 QAUMPT committee to their representative groups. Guidelines are also communicated to providers as needed during clinical reviews, through the company website, mailed upon request, and mailed to providers when the guidelines relate to quality improvement or disease management projects. Representation on the QAUMPT Committee includes providers who are free of conflict with PacificSource Medicare and providers who are experts in the care of elderly populations. PacificSource Medicare operates a quality assurance and performance improvement program and has an agreement for external quality review as required by CMS.

Program Overview

High-quality healthcare is a priority at PacificSource Medicare. 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 member experience with healthcare.
- Maximize the safety and quality of healthcare delivered to members.
- Improve efficiency and effectiveness.
- Fulfill quality related reporting requirements.

How do we decide where to focus our improvement efforts?

The QAUMPT Committee reviews several sources of data and information available to Medicare 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 Medicare Advantage 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 random sample of member from March to May.

Access to Care Standards: PacificSource Medicare 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
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis
- Follow-up After Hospitalization for Mental Illness
- Glaucoma Screening in Older Adults
- 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

Four 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.

1. Documentation of Body Mass Index (BMI) once in prior two years

2. Colorectal Cancer Screening—Colonoscopy in the past 10 years, Sigmoidoscopy in the past five years, annual FOBT, and DNA testing every three years.
3. Comprehensive Diabetes Care—A1C screening, A1C control less than 9, LDL screening and control to less than 100, diabetic eye exam (i.e., retinopathy), blood pressure controlled to under 140/90.
4. Controlling High Blood Pressure—Last BP of year less than 150/90.

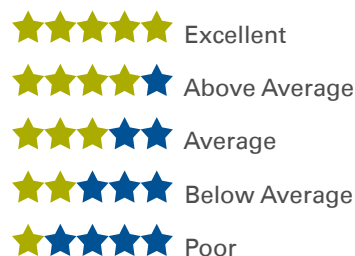
6.3.1 Medicare Advantage Star Ratings

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:



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 Service 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](https://www.cms.gov).

6.4 Medical Preapprovals

Preapproval is the process by which providers verify coverage and receive authorization from PacificSource Medicare before services or supplies are rendered. Preapproval 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 preapproval from our plan. The list of services that require preapproval is available on our website, [Medicare.Pacificsource.com/Search/AuthorizationGrid](https://www.pacificsource.com/Search/AuthorizationGrid).

Preapproval Form

The authorization should be submitted via InTouch for Medicare Advantage members at [Medicare.PacificSource.com/InTouch](https://www.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 preapproval process is not complete until benefits and eligibility have been verified. The number of days the authorization is valid for is noted on line or in the approval letter. An extension to the standard authorization period may be requested.

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

Preapproval Process

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

All preapproval 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.

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.

Required Information for Preapproval

The following minimum information will be requested during the preapproval process:

- Patient Name
- Requesting Provider Name
- Date(s) of Service
- Primary Diagnosis Code (must be a 4–5 digit ICD-10 code)
- Length of Stay (for inpatient prior authorizations)
- Procedure Code, except office visits (must be a CPT 5 digit code)
- Supporting Documentation

If the requested procedure, treatment, or surgery requires clinical review, PacificSource Medicare representatives will forward the request for clinical review. They may ask you for additional information.

If the clinical reviewer determines additional review is needed, the request is referred to the Medical Director for final determination.

The requesting provider is accountable for all referrals of members and expected to enter acceptance or denial into the member's clinical record. PacificSource Medicare will accept supporting clinical data from any source.

Incomplete preapproval and referral requests

Incomplete preapproval and referral 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.

You will find information on our preapproval requirements and copies of PacificSource Medicare forms on our website at Medicare.PacificSource.com.

AIM Specialty HealthSM (AIM)

PacificSource Medicare has partnered with AIM Specialty HealthSM (AIM) to administer prior authorizations for non-emergency advanced diagnostic imaging services 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)

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 preapproval. Outpatient studies performed for urgent or emergent conditions will be subject to a retrospective clinical claims review by PacificSource Medicare.

A complete list of services requiring preapproval is available on our website Medicare.PacificSource.com. Services included in the AIM program are noted in the description field.

To Request Preapproval through AIM:

Ordering/referring nonradiological physicians must contact AIM to obtain an order number before scheduling elective outpatient diagnostic imaging services. 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:

- By calling AIM toll-free at (877) 291-0510.
- By using AIM's ProviderPortal at AimSpecialtyHealth.com/GoWeb. Since many providers already use AIM's ProviderPortal, there is no need to register again. If a provider is new to AIM, they will need to register at AimSpecialtyHealth.com/GoWeb.

6.4.1 Retrospective Review

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.

6.5 Retroactive Authorization Guidelines

Conditions for Retroactive Authorization Review

In order to be considered for approval, the authorization must be determined to be medically necessary and appropriate.

Retroactive authorizations will be reviewed for approval under the following conditions:

- Service is urgent or emergent.
- Hospital Admission is emergent and facility is unable to obtain prior approval from PacificSource Medicare.
- The service was not provided more than 60 days preceding the request.
- The service under review has not been billed and denied. If the claim was denied, a formal appeal will need to be filed.
- Contact may be made via InTouch, telephone call, or faxed information.

Appeals

Please refer to the section on Provider Appeals.

Medical Management

Emergency Room Usage

Emergency Care is covered 24 hours a day, 7 days a week. PacificSource Medicare 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.

Observation Room Utilization

Authorizations are not required for observation room stays. Observation room services for Medicare Advantage are defined as:

PacificSource Medicare follows CMS's "2 midnight" rule for inpatient hospitalizations. 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.

Section 7: Pharmacy

Formulary Coverage

PacificSource Medicare offers a comprehensive prescription drug benefit with coverage in all therapeutic classes, as indicated by the 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 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).
- Medications that are used exclusively for indications that are excluded from coverage under 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.

PacificSource Medicare uses the following methods for utilization management:

Preapproval: Medications that require preapproval will only be approved when medical record documentation proves the patient's clinical circumstances meet the criteria established by our QAUMPT 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.

Coverage Determinations and Exceptions

PacificSource Medicare 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 Medicare 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, QLL) 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 by calling (888) 437-7728 toll-free. All PacificSource Medicare preapproval criteria, the applicable formulary, and our Pharmacy Preapproval Requests form are available on our website, [Medicare.PacificSource.com](https://www.Medicare.PacificSource.com).

When a standard request for a drug benefit has been received, PacificSource Medicare 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. This includes weekends and holidays. 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 Medicare 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 website at [Medicare.PacificSource.com](https://www.Medicare.PacificSource.com).

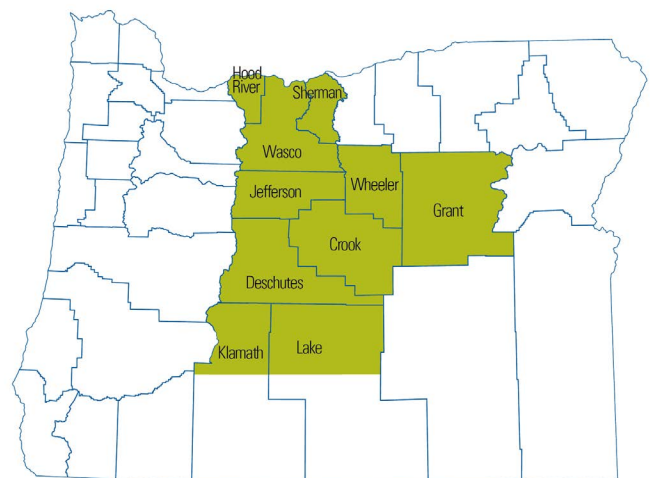
Section 8: Products

8.1 Product Descriptions

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.

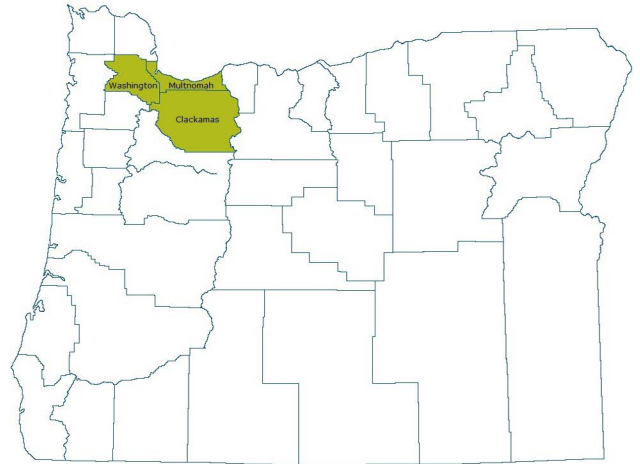
8.1.1 Products Offered in Central, Eastern, and Mid-Columbia Gorge, Oregon

Plan name	PCP required	Referral required	Service area
Essentials Choice Rx 14 HMO-POS	Yes	No	Crook, Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, Wheeler, and northern Klamath and Lake counties
Essentials 2 HMO	Yes	No	Crook, Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, Wheeler, and northern Klamath and Lake counties
Essentials Rx 6 HMO	Yes	No	Crook, Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, Wheeler, and northern Klamath and Lake counties
Essentials Rx 27 HMO	Yes	No	Crook, Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, Wheeler, and northern Klamath and Lake counties



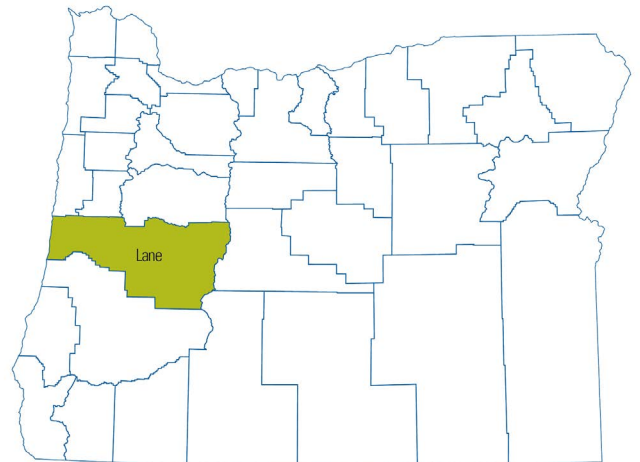
8.1.2 Products Offered in Portland area, Oregon

Plan name	PCP required	Referral required	Service area
MyCare Rx 22 HMO	Yes	Yes	Clackamas, Multnomah, Washington counties



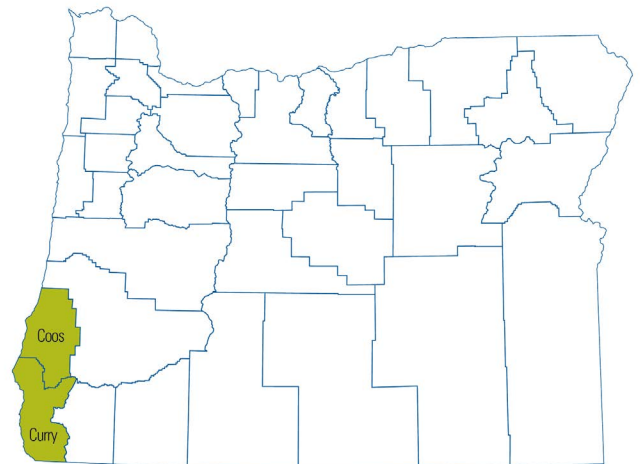
8.1.3 Products Offered in Lane County, Oregon

Plan name	PCP required	Referral required	Service area
Essentials Rx 26 HMO	Yes	No	Lane County
Explorer Rx 4 PPO	No	No	Lane County
Explorer 8 PPO	No	No	Lane County



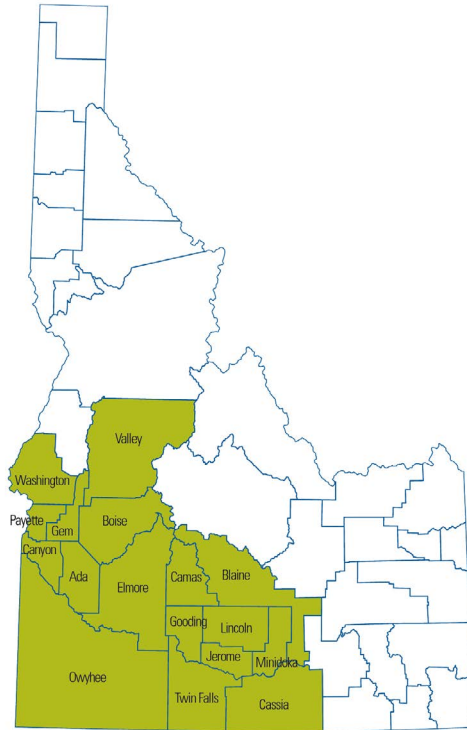
8.1.4 Products Offered in Coos and Curry Counties, Oregon

Plan name	PCP required	Referral required	Service area
Essentials Rx 26 HMO	Yes	No	Coos and Curry counties
Explorer Rx 7 PPO	No	No	Coos and Curry counties
Explorer 8 PPO	No	No	Coos and Curry counties



8.1.5 Products Offered in Southwest Idaho

Plan name	PCP required	Referral required	Service area
Essentials Choice Rx 24 HMO-POS	Yes	No	Ada, Blaine, Boise, Camas, Canyon, Elmore, Gooding, Jerome, Lincoln, Owyhee, Twin Falls, Valley counties
Explorer 6 PPO	No	No	Ada, Blaine, Boise, Camas, Canyon, Cassia, Elmore, Gem, Gooding, Jerome, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, Washington counties
MyCare Rx 23 HMO	Yes	No	Ada, Canyon, Gem, Payette counties



For more information regarding benefits and eligibility, please contact our Customer Service department by phone at (541) 385-5315 (Bend), (541) 225-3771 (Springfield), or (208) 433-4612 (Boise), or toll-free at (888) 863-3637, or by email at MedicareCS@PacificSource.com.

For plan-specific participating provider directories, please contact our Customer Service department by phone at (541) 385-5315 (Bend), (541) 225-3771 (Springfield), or (208) 433-4612 (Boise), or toll-free at (888) 863-3637, by email at MedicareCS@pacificsource.com or on our website at Medicare.PacificSource.com

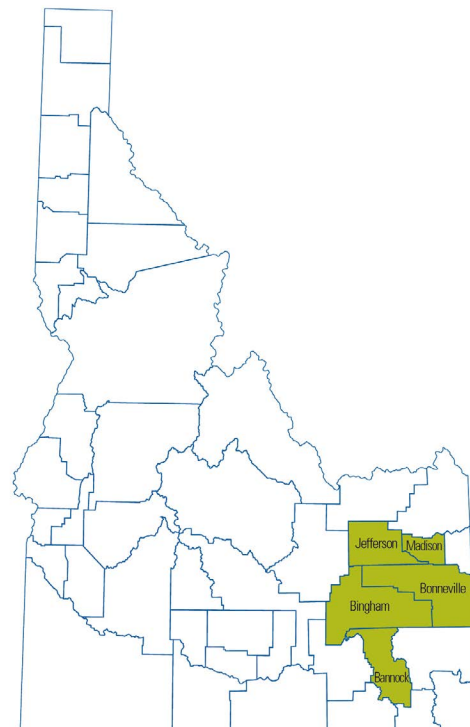
8.1.6 Products Offered in Northern Idaho

Plan name	PCP required	Referral required	Service area
Explorer Rx 11 PPO	No	No	Bonner, Boundary, and Kootenai counties
Explorer 12 PPO	No	No	Bonner, Boundary, and Kootenai counties



8.1.7 Products Offered in Eastern Idaho

Plan name	PCP required	Referral required	Service area
Essentials Rx 21 HMO	Yes	No	Bannock, Bingham, Bonneville, Jefferson, and Madison counties
Explorer Rx 9 PPO	No	No	Bannock, Bingham, Bonneville, Jefferson, and Madison counties
Explorer 12 PPO	No	No	Bannock, Bingham, Bonneville, Jefferson, and Madison counties



8.2 Plan Features

8.2.1 Preventive Care

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

- Bone mass measurement (\$0 co-pay)
- Colorectal screenings (\$0 co-pay)
- Mammograms (\$0 co-pay)
- Pap and pelvic exams (\$0 co-pay)
- Prostate cancer screenings (\$0 co-pay)
- And more

8.2.2 Extra Benefits

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

- Annual routine physicals (\$0 co-pay with in-network providers)
- Routine vision exams (co-pay varies by plan)
- Routine hearing exams (co-pay varies by plan)
- Eyeglasses and contacts (\$200 reimbursement every two calendar years)
- 24-hour NurseLine
- Home fitness kit (\$10 per kit; fee waived for Essentials RX 803 plan)
- Silver&Fit® Exercise & Healthy Aging Program (\$50/year fee)
- TruHearing® hearing aids (\$699/\$999 co-pay per aid)

Note: Not available on Essentials Rx 27.

8.2.3 Worldwide Coverage for Travelers

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

- Urgent care (co-pay varies by plan)
- Emergency room (co-pay varies by plan)
- Ambulance: ground or air (co-pay varies by plan)

Note: Not available on Essentials Rx 27.

8.2.4 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 offense. 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.

Section 9: Members



9.1 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:

1. 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
2. During the annual open enrollment period from November 15 through December 7 each year. During this time, members have the opportunity to move or change their Medicare plan.
3. Under certain circumstances that qualify you for a Special Enrollment Period (SEP), such as the following:
 - 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

9.2 Member Identification

Every PacificSource Medicare member is issued a member identification card. Identification cards contain information necessary for claims submission (please see examples). If you have questions about a specific member's benefits or eligibility, please contact Customer Service at the number listed on the card.

Please note:

- Verification of eligibility is not a guarantee of coverage.
- Providers must inform PacificSource Medicare members of any charges for noncovered services prior to the services being delivered.

ID cards include the following important information:

- Member's name
- Primary care provider's name, if applicable
- Plan name
- Referral required, if applicable
- Pharmacy information and pharmacy identification numbers.
- Preventive dental, if applicable

**The PacificSource Medicare service areas are the geographic areas defined by the boundaries of the state of Oregon and Idaho. Please see Section 8: Products.*



Please submit claims to:

PacificSource Medicare
PO Box 7068
Springfield, OR 97475-0068

Members are not required to make payment for services up-front to participating providers, except for any applicable co-pays, co-insurance, deductibles, or noncovered services (please refer to patient waiver requirements).

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.

9.3 Sample Member ID Card

Plan: Plan Rx 1 (Referral required)
Member Name: Jane L Smith
Member ID #: 112345000
PCP: John L Provider

Rx ID 1234567890
RxBin 004336 RxGroup RX8631 RxPCN MEDDADV
Issue Date 02/01/15 Issuer # 80840 Contract # H3864_014

Medical
Part D Rx
Dental

SHOW THIS CARD TO YOUR PROVIDER EACH TIME YOU RECEIVE CARE.

Customer Service: (541) 385-5315 or (888) 863-3637
TTY Line: (800) 735-2900
Providers: (541) 385-5315 or (888) 863-3637
Pharmacists: (541) 330-4999 or (888) 437-1728

Electronic Claims: Payor ID# 2027
Bill PacificSource Medicare, Inc. (not Original Medicare).
 Some services may require prior authorization. Medicare limiting charges apply. Contact plan for details.

PacificSource Medicare
PO Box 7068, Springfield, OR 97475-0068
Medicare.PacificSource.com
 PACIFICSOURCE COMMUNITY HEALTH PLANS

PacificSource Medicare Member Rights

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 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 Physician (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 refer oneself directly to mental health, chemical dependency, or family planning services without getting a referral from a PCP or other participating 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 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;

9.4 Members' 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 Statement of Principles

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

- To receive a referral to specialty practitioners for medically appropriate covered services;
- To have a clinical record maintained which documents conditions, services received, and referrals 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 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 request an administrative hearing with the Department of Human Services (DHS or Department);
- To receive interpreter services as defined in OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility; and
- 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 co-pays 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, worker's 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.

9.5 Member Grievance and Appeals Process

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

PacificSource Medicare, PacificSource Community Solutions (Medicaid) and Commercial 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) and the Department of Consumer and Business Services (DCBS).

All PacificSource Medicare members receive information about their grievance and appeal rights in their Member Handbook/ Evidence of Coverage. Every time coverage is denied for a service or request for service, members are also 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 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 timeframe to resolve these issues, your prompt assistance is greatly appreciated.

The grievance and appeal process is outlined in member handbooks. If a member is dissatisfied with the action of PacificSource Medicare, or any of its contracted entities, the member is entitled to file an appeal or grievance. Upon inquiry, please have them contact:

PacificSource Medicare Advantage Customer Service:

Bend: (541) 385-5315
Boise: (208) 433-4612
Springfield: (541) 225-3771
Toll-free: (888) 863-3637
TTY: (800) 735-2900

Section 10: Filing Claims

10.1 Eligibility and Benefits

PacificSource Medicare has a dedicated Customer Service department 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.

Contact PacificSource Medicare Customer Service for:

- Member benefits, eligibility information, or waivers
- Deductible, co-insurance and/or co-pay information
- Explanation of payments/vouchers
- Participating physicians and providers
- Claims inquiries or claim reconsideration questions
- Claim-specific billing and/or coding questions
- Referrals or authorization inquiries

Contact us:

Bend: (541) 385-5315

Boise: (208) 433-4612

Springfield: (541) 225-3771

Toll-free: (888) 863-3637

TTY: (800) 735-2900

Fax: (541) 322-6423

Email: MedicareCS@PacificSource.com

Customer Service is available:

- **October 1–February 14**
8:00 a.m. to 8:00 p.m. local time zone, seven days a week
- **February 15–September 30**
8:00 a.m. to 8:00 p.m. local time zone, Monday–Friday

10.2 HCPCS Coding

PacificSource Medicare follows Medicare LCD's/NCD's coding for DME billing. These coding guidelines can be found at [CMS.gov/Medicare-coverage-database/](https://www.cms.gov/Medicare-coverage-database/).

10.3 Claims and Payment Rules

General Claims Information

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

PacificSource Medicare 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 Medicare billing rules for PacificSource Medicare members to facilitate collection of encounter data.
- Physician claims will be billed on the CMS-1500 using Medicare billing rules for PacificSource Medicare members to facilitate collection of encounter data.
- All other claims except Pharmacy (DME, Lab/X-ray, Transportation, Ancillary services) will be billed on the CMS-1500 according to Medicare billing rules for PacificSource Medicare members. PacificSource Medicare will work with participating 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 Medicare. 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, Fourth Edition (CPT)*
- 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](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html)

Providers are required to use the standard CMS codes for ICD9, 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 and 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 co-pays, co-insurance, and noncovered services.

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](https://www.cms.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).

10.4 Claims Submission Requirements

When to Submit Claims

PacificSource Medicare 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 payer primary liability such as Original Medicare, Medicaid or third-party insurers, or legal action and/or an error by PacificSource Medicare (See Timely Submission of Claims).

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 Medicare 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.

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

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 Medicare 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.

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 payer must be in a Standard 837-5010 format. PacificSource Medicare is currently accepting 837-5010 HIPAA compliant claim transactions either directly from provider offices or through our clearinghouses.

For a list of clearinghouses, visit our website Medicare.PacificSource.com, or contact your Provider Service Representative by phone at (541) 684-5580 or (800) 624-6052, ext. 2580, or by e-mail providerservicerep@pacificsource.com.

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 Service 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, ext. 2251, or by email at info@pacificsource.com.

Common Claim Filing Errors

Proper payment of Medicare Advantage 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 Medicare receives the additional information, the claim is adjusted or corrected.

Payment or Denial of Health Benefit Plan Claims (743.911)

1. 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.
2. 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.

3. 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.
4. This section does not create an assignment of payment to a provider.
5. 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.
6. 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 Medicare claims. [Formerly 743.866]

Hold Harmless/Balance Billing

In the event the insurer fails to pay for healthcare services covered by PacificSource Medicare, 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, co-pay or co-insurance 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 Guidelines

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

- Multiple Procedure Reduction
- 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 Medicare 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 Medicare 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 Medicare 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 Medicare will expect the office/facility to refund all payments related to noncompliance. For more information about PacificSource Medicare's audit policies, refer to the Claims Review Guidelines in Section 10.4 of this manual. This policy provides information on PacificSource Medicare 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)

If a PacificSource Medicare patient has primary coverage with another carrier, the primary carrier should be billed first. We must receive the claim no later than 365 days from the primary carrier's EOB date. Upon receipt of payment from the primary carrier, charges should then be submitted to PacificSource Medicare, accompanied by the primary carrier's Explanation of Benefits.

When PacificSource Medicare is secondary, Coordination of Benefits will be reimbursed according to the contract allowable or charges, whichever is less.

When PacificSource Medicare is the secondary plan, we will calculate the benefits we would have paid on the claim in the absence of other healthcare coverage and apply that calculated amount to the PacificSource Medicare claim. We may pay for all or part of the amount that is unpaid by the primary plan.

PacificSource Medicare will credit to the members benefits, the deductible amounts we would have credited to the member's deductible in the absence of other healthcare coverage.

Claim Review Guidelines

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

Overpayment Recovery

PacificSource Medicare may initiate provider refunds up to one year from the date of payment. In the event that CMS terms (retro-disenrolls) a member, PacificSource Medicare reserves the right to initiate provider refunds for any applicable time period which may be longer than one year from the date of payment.

In response to Oregon Senate Bill 508, PacificSource Medicare has adapted a new refund policy that will apply to all providers regardless of geographic location or network status. This policy will override any contract language. Our refund policy is as follows:

- PacificSource Medicare 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.

To contest a refund, PacificSource Medicare requires the use of our Contested Refund Form, which is available at Medicare. 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

10.5 Corrected Claims Submission

PacificSource Medicare strives to make the claims process as efficient as possible. Therefore, we ask that when you submit a corrected CMS 1500 claim for professional claims you simply append a modifier "cc" to the line that is being altered. For facility claims billed on a UB04, please use a "7" in the type of

bill frequency. This electronic process will help to expedite your request.

If chart notes are needed to help support a correction, we will request those at the time of review.

10.6 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 at 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.

10.7 Explanation of Payment (EOP)

10.7.1 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
- Reason Code
- Deductible Amount
- Co-pay Amount
- Co-insurance 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 by phone:

Bend: (541) 385-5315

Springfield: (541) 225-3771

Boise: (208) 433-4612

Toll-free: (888) 863-3637

We are open:

- **October 1–February 14**
8:00 a.m. to 8:00 p.m. local time zone, seven days a week
- **February 15–September 30**
8:00 a.m. to 8:00 p.m. local time zone, Monday–Friday



PO Box 7489
Bend OR 97708-7489

2015092714
0210 9279

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Explanation of Payment



(DM-)

Forwarding Service Requested

PROVIDER
123 RANDOM STREET
EUGENE OR 97401

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Information

Questions?
Call Customer Service at
(541) 385-5315 or (888) 863-3637
Medicare.PacificSource.com

Payment Summary

Paid To: Provider
Payee Tax #: 123456789
Payment Date: 09/27/2015
Reference #: 2015092710100045

Prior Overpayment: \$0.00
Overpayment Incurred this Period: \$0.00
Recovered this check: \$0.00
Outstanding overpayment: \$0.00

Patient Name: Patient Provider Name: Provider Clinic Name: Provider
Member ID #: 612345678-00 Provider #: 1234567 Product: Explorer Rx 4 (PPO)
Patient Acct #: ABC12345 Claim #: 151234567890 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
09/09/15	99212	1	\$129.00	\$37.60	\$0.05	\$91.40	PXN	\$0.00	\$35.00	\$0.00	\$35.00	\$2.55
Claims Totals:			\$129.00	\$37.60	\$0.05	\$91.40		\$0.00	\$35.00	\$0.00	\$35.00	\$2.55
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												\$2.55

Summary Totals

Billed	Allowed	Risk Withhold	Prov Adjust	Deductible	Co-pay	Co-insurance	Total Patient Responsibility	Interest	Auto-Recovered	Capitated Amount	Net Paid
\$129.00	\$37.60	\$0.05	\$91.40	\$0.00	\$35.00	\$0.00	\$35.00	\$0.00	\$0.00	\$0.00	\$2.55

Reason Code Explanations

Code	Message Description
PXN	Processed at contract benefits
*	Mandatory 2% sequestration reduction effective April 1, 2013

Section 11: Billing Requirements

By using the correct procedure codes when you bill PacificSource Medicare, 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.

11.1 Incident to Billing

PacificSource Medicare requires all eligible providers rendering services to be individually credentialed before they are considered participating under the provider contract. This includes, but is not limited to nurse practitioners, physician assistants, and other mid-level providers.

PacificSource Medicare requires the provider that rendered the service to be indicated in box 31 on the CMS 1500 claim form or electronic claim equivalent. We follow CMS "Incident to" guidelines.

11.2 Global Period

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).

11.3 Surgery

11.3.1 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 1: Bilateral procedures billed as separate charge lines for each procedure with modifier RT/LT on each line.

CPT	Modifier	Description	\$ Charges	Days or units
31238	-RT	Nasal/sinus endoscopy, surgical, with control epistaxis	\$500.00	1
31238	-LT	Nasal/sinus endoscopy, surgical, with control epistaxis	\$500.00	1

Example 2: Billed as one line (2 services) with modifier 50

CPT	Description	# Svcs days or units	Billed amount
31238-50	Nasal/sinus endoscopy, surgical, with control epistaxis	1	\$1,000.00

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.

11.3.2 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 follow these guidelines to ensure correct payment:

- 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.

PacificSource Medicare 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, as our system will make the appropriate cuts.

- Primary procedure: 100% of the fee allowance
- Remaining Procedures: 50% of the fee allowance

11.3.3 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 percent or 25 percent** of the allowed amount, after bilateral adjustment, as appropriate.

1st bilateral procedure = 150 percent of the fee schedule allowance or your billed charge, whichever is less.

2nd bilateral procedure = 150 percent x 50 percent = 75 percent 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.

1. When billing two bilateral procedures:
 - Primary bilateral = 150 percent of the fee schedule allowance for the procedure
 - Secondary bilateral = 75 percent of the fee schedule allowance for the procedure; 150 percent x 50 percent = 75 percent
2. When billing a primary, nonbilateral procedure and a secondary bilateral procedure:
 - Primary procedure = 100 percent of the fee schedule allowance for the procedure
 - Secondary bilateral procedure = 75 percent of the fee schedule allowance for the procedure; 150 percent x 50 percent = 75 percent
3. When billing a primary bilateral procedure and a secondary procedure:
 - Primary bilateral = 150 percent of the fee schedule allowance for the procedure
 - Secondary procedure = 50 percent 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 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.

Please note: The bilateral procedure is not always the primary procedure.

Example of Billed Procedures:

- 30140-51, 50
- 30520
- 29881-51

For the above example, the primary procedure is 30520 and allowed at 100 percent of the fee schedule allowance. The secondary procedure is 30140-50 and allowed at 150 percent x 50 percent resulting in a reimbursement of 75 percent of the fee schedule allowance. The third procedure, 29881, is allowed at 50 percent of the fee schedule allowance.

11.3.4 Ambulatory Surgery Center Billing Guidelines

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. Use modifier 51 in the first modifier position and subsequent procedures including exempt and add on codes. If modifier 51 is missing on secondary and subsequent procedures that should be stepped down, PacificSource may deny the claim as billed in error and request a correction or a modifier 51 to be appended to indicate multiple procedures.

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.

11.4 Evaluation and Management (E&M) Billing Guidelines

11.4.1 Preventive Visits and E&M Billed Together

According to the CPT codebook, 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.

11.4.2 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 guidelines below).
- 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. Please remember, all E&M visits require a co-pay/co-insurance from the member; therefore, if another CPT code more accurately describes the service, that code should be reported instead of 99211.

11.4.3 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.

11.5 Annual Wellness Visit (AWV)

As a result of the Affordable Care Act (healthcare reform law), CMS extended the preventive focus of Medicare coverage to include an Annual Wellness Visit that focuses on establishing a Personalized Prevention Plan. The benefit is available as of January 1, 2011.

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 AWW.*

Who is eligible to provide an AWW?

- 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 co-pay 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 AWW 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 regards to age appropriate preventive services.
- Furnish personal health advice and coordinate appropriate referrals and health education, when necessary.

What does the Subsequent AWW 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 AWW is not an annual physical exam. The AWW 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 AWW?

CMS has created two new HCPCS codes effective January 1, 2011:

4. Initial AWW with PPS: G0438 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit.
5. Subsequent AWW with PPS: G0439 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit.

Is the Initial AWW Code (G0438) a once in a lifetime benefit?

Yes, the Initial visit code G0438 is for the patient's first AWW only. Submission of G0438 for a patient who has already incurred their initial AWW will result in a denial.

Please verify whether or not the patient has received their initial AWW prior to scheduling their appointment.

Can a patient select a new healthcare professional to provide their subsequent AWW?

Yes. In the event a patient selects a new healthcare professional for their subsequent AWW, the new healthcare professional must bill the subsequent AWW code G0439.

Remember, the G0438 and G0439 must not be billed within 12 months of a previous billing for the same patient.

How should we bill PacificSource Medicare if the minimum requirement for an AWW 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 AWW?

Medicare will allow a significant and separately identifiable evaluation and management (E&M) service on the same date as the AWW 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 AWW 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.

11.6 Never Events Policy

PacificSource Medicare 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.
- Readmission 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.

11.6.1 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).

11.6.2 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.
- Any 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.

11.6.3 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.

11.7 Editing Software for Facility and Professional Claims

11.7.1 Professional Claims

PacificSource Medicare has used the Ingenix iCES Professional Editing application as the clinical editing solution for professional medical claims for many years. Using claims editing software helps to promote correct coding and standardized editing of the claims we receive on behalf of our members. The coding guidelines contained in the knowledge base are well researched, clearly defined and documented in support of transparency requirements. Editing rules have been established to ensure claims are processing by Medicare guidelines. We apply these guidelines to both participating and out-of-network professional providers. Edits made to claims are considered to be a provider adjustment and not billable to the member.

11.7.2 Facility Claims

Historically, PacificSource Medicare has relied on facility providers to bill us using correct coding methods. To ensure that the facility claims we receive are also properly coded, we have implemented the Ingenix iCES Facility Editing application and will begin applying clinical editing rules to all facility claims. This will align our payment policies on both professional and facility claims and positions us to more closely follow general clinical editing and coding standards within the industry today. Editing rules have been established to ensure claims are processing by Medicare guidelines. Edits will be applied to both participating and out-of-network facilities. All claims edited for correct coding will be considered to be a facility adjustment and not billable to the member.

11.7.3 Sample Edit Criteria

Listed below are some examples and definitions of edits that providers/facilities may encounter:

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 AMA's 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.

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: Includes procedures that are basic steps necessary to complete the primary procedure and are by definition included in the reimbursement of that primary procedure.

Revenue Code requires HCPCS code: Any instance where a revenue code requires the HCPCS code to be billed for payment.

Inpatient only procedures: Any instance of a procedure typically performed in the inpatient setting billed as an outpatient place of service.

11.7.4 Other Generalized Edits

Age/Gender/Diagnosis/procedure specific conflicts: Age related code development is based on CPT/HCPCS/ICD-10 guidelines and/or code descriptions identifying specific ages. Gender-specific procedures are determined by body site, anatomical structure, and description of procedure performed. Diagnosis edits identify inconsistent coding relationships as well as diagnosis codes that are not allowed for reporting alone or as a primary diagnosis.

Provider-Based Office Services

All office services submitted with dates of service on or after May 1, 2017, must be billed under the service provider, in an ANSI 837P format (CMS 1500), and with the "office" place of service (POS).

Effective May 1, 2017, PacificSource will no longer accept provider-based billing of office services, regardless of the office location. We will deny as noncovered any office services billed on a UB claim form, and you will need to resubmit them in the correct format.

Claims in the following formats are not reimbursable:

- Claims billed with revenue codes 0510-0529
- Evaluation and Management codes (CPT 99201-99215 and HCPC G0463) that are billed with revenue codes 0760 through 0769
- Claims with a "PO" modifier

Section 12: Publications and Tools

12.1 Provider Directories

PacificSource Medicare Provider Directories serve as a valuable tool for identifying the participating physicians and providers available for accessing medical services. The directories are designed to be user-friendly, give up-to-date listings of participating physician and provider names, addresses, and telephone numbers.

Directories are uniquely designed to accompany a specific plan design and include participating physicians and other healthcare professionals, such as physical therapists, mental health providers, optometrists, opticians, podiatrists, and healthcare facilities, including participating hospitals.

Our electronic directory (updated daily) lets website visitors search for a PacificSource Medicare 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 new directory will help him locate one and can even provide a map and driving directions. Members will also be able to create, download, and print their own customized provider directories specific to their benefit plan and their geographic location.

For information on this and other future projects, please visit our website at Medicare.PacificSource.com

12.2 Newsletters

Provider Bulletin is the provider newsletter for all lines of business. It is produced quarterly and emailed to PacificSource Medicare participating physicians and providers. It provides general information of interest to Commercial, Medicare and Medicaid physicians and providers. If you are not receiving these newsletters and would like to be included on the distribution list, contact your Provider Service Representative.

12.3 Website

12.3.1 Medicare.PacificSource.com

The address of the PacificSource Medicare website is Medicare.PacificSource.com. This site is 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.

In the "For 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 12.3.2 following 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 preapproval.
- From the home page, providers and PacificSource Medicare members can access the electronic Participating Provider Directory, which is updated daily. Users can search for participating physicians and providers by name, zip code, city, specialty, and/or plan type, and can also print a customized provider directory from the site.

12.3.2 Latest Notices and Updates

The Latest Notices and Updates section of our website is intended to help keep our providers and their staff up-to-date on the latest and upcoming changes, important announcements, and news. The Provider Network team will post notifications of updates to plan policies, preauthorization and formulary changes, and any other initiatives that may impact providers.

The Latest Notices and Updates page will be updated as changes and important news arise, but no more than once per week. There is no login required to view this page. It is located on our public website to allow any individual within your practice or organization access to this information 24 hours a day, 7 days a week.

As our valued partner, we want to make sure you have the tools and resources you need in a timely manner.

See the Latest Notices and Updates page at Medicare. PacificSource.com/Providers.

12.3.3 InTouch for Providers

PacificSource InTouch for Providers is a providers-only area of our website. By logging in via OneHealthPort with a user name and password, 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 Medicare.
- Submit and check status of preapproval or referral requests.
- Check claims status and payment details.
- Select an EOP date and get a detailed listing of all claims for your office that were processed on that date.

- Use Point of Service Direct to access real-time, accurate, patient liability information and your actual charges for each procedure billed during a visit.

Registering for InTouch

For your convenience, InTouch is available through 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 under the Provider heading of our InTouch login area on any page of our website, Medicare.PacificSource.com.

If you have any questions about InTouch or the For Providers section of our website, you're welcome to contact your Provider Service Representative. You can also use the Contact Us form on our website to describe any technical problems.

PacificSource Medicare members also have access to InTouch for Members, where they can look up claims information, track medical expenses, select a new PCP, and more.



[Medicare.PacificSource.com/
Providers/Intouch](https://www.Medicare.PacificSource.com/Providers/Intouch)

Have You Tried InTouch? With InTouch, our secure online portal for Providers, you can verify eligibility and check claims status, EOPs, preapprovals, referrals, and much more!

12.4 Material in Alternate Format

PacificSource Medicare 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.

Section 13: Health Plan Responsibility

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 co-pay.

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:

- Provider network.
- 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

Health Plan Responsibility

- 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 including;
- 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; and
- 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 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.



Your PacificSource Provider Service Representative is available any time you have a question or concern. If you're not sure who your representative is, please visit our Provider Service Staff Directory at [Medicare.PacificSource.com](https://www.Medicare.PacificSource.com).

Section 14: Compliance

Compliance Website

We maintain a compliance website ([Medicare.PacificSource.com/Compliance](https://www.pacificsource.com/Compliance)) that provides information on topics such as provider training and education, examples of compliance and FWA issues, and reporting of these issues.

Compliance Program and Standards of Conduct

We maintain a Compliance Program and Standards of Conduct on our compliance website at [Medicare.PacificSource.com/Compliance](https://www.pacificsource.com/Compliance). 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.

Compliance Training

You and your employees are required to take General Compliance and Fraud, Waste, and Abuse (FWA) Training annually. All new employees must take these trainings as part of their orientation. Please document and retain proof of training records for a period of ten years. If you have met the fraud, waste, and abuse certification requirements through enrollment into the Original Medicare program, you do not have to take the FWA Training.

For your convenience, we have provided a link to the CMS trainings on our compliance website. Please refer to Policy Number C-3 for additional information.

Disciplinary Standards

We maintain a disciplinary action 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 Policy Number C-5 and C-6B for additional information.

Compliance Reporting

If you suspect noncompliance or FWA activities, you must report them to us by calling (800) 624-6052, ext. 2580 or emailing providerservicerep@pacificsource.com. You may also report anonymously by contacting NAVEX Global (a PacificSource vendor) 24 hours a day, seven days a week at toll-free (888) 265-4068. Please refer to Policy Number C-4 for additional information.

Provider Exclusion

PacificSource Medicare will not contract with or pay claims to providers who have been 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 GSAs 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. 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 our Policy Number C-6A for additional information.