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Referral Frequently Asked Questions for PacificSource Medicare

****For Provider Use Only****

1. **What is the difference between a referral and a prior authorization?**

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

   The PCP must submit the referral directly to **PacificSource Medicare**. Referrals do not supersede other program requirements such as:
   - Medical necessity
   - Eligibility
   - Prior authorization requirements, or
   - Coverage limitations

   A "**prior authorization**" is defined as a request for a specific service that requires a review to determine medical necessity. Services that require prior authorization are outlined on our website, www.Medicare.PacificSource.com.

2. **How can I identify which PacificSource Medicare plans require referrals?**

   Effective January 1, 2016, the MyCare Rx22 plan is the only plan to require a referral and is offered in Clackamas, Multnomah and Washington counties.

   Please refer to the current PacificSource Medicare Provider Manual or the member's ID card. You can download a copy of the Provider Manual from our website, www.Medicare.PacificSource.com/Library/General/Documents/ProviderManual.pdf.

3. **When is a referral needed?**

   Before seeing an in-network specialty provider, a member must obtain a referral from his or her PCP. The PCP is required to notify the plan of the referral. If the member needs additional services from another specialty provider, the PCP will coordinate a referral to the appropriate specialist.

   Requests for members to see an out-of-network provider must be submitted through the prior authorization process via InTouch for Providers.

4. **Are referrals required when PacificSource Medicare is the secondary payer?**

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

5. Can a specialist submit a referral to PacificSource Medicare?

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

6. What does a referral allow?

A referral allows a member to see an in-network specialty provider for covered services rendered in their office (POS 11.) Referrals **do not** cover services that require prior authorization.

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

7. Can a referral request include surgical services or other procedures?

No. Procedures or services that require prior authorization cannot be included in a referral. Specialists must submit a request for these services via the prior authorization process.

8. What 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.

9. Does PacificSource Medicare allow retro-referrals?

We understand 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.

10. What information is 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**

The number of visits is required when submitting a referral for **Pain Management.

11. How many visits are covered by a referral?

- 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.

- 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).

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

No. The approved referral covers services from any provider that practices in the same group, is participating with PacificSource Medicare, and has the same specialty as the provider approved on the request.

13. Does referral approval guarantee payment for services?

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.

14. Do all services require a referral?

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

1. A Declaration of Disaster or Emergency
2. Emergent ambulance
3. Anesthesia
4. Assistant surgeon
5. Chemical dependency and mental health providers
6. Covered chiropractic and alternative care
7. Diabetic education providers:
   a. Up to 3-hours of diabetic education by a Nurse Practitioner or Diabetic Educator, all other providers will require a referral.
8. 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 preauthorization.
9. Durable medical equipment and supplies
10. Emergency care
11. Lactation counseling
12. Mammography screening
13. Nutritional counseling with PCP
14. Pharmacy
15. Physical, occupational, and speech therapy
16. Pneumonia and flu vaccinations
17. Routine and diagnostic colonoscopies
18. Urgent care
19. Visions services
20. Women's health: Members may self-refer for pregnancy care and annual gynecological (GYN) examinations and contraceptive care. In addition, any medically necessary follow-up visits resulting from the annual exam do not require referral when performed within three months of the annual exam.

21. Kidney dialysis (out-of-network): including services rendered at a Medicare-certified dialysis facility when member is temporarily outside the plan's service area.
22. Preventive Services

15. How do I submit a referral?

Referrals should be submitted online via the InTouch provider. You can access InTouch on our website: www.Medicare.PacificSource.com/Providers.

16. Is referral information available online via InTouch?

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

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

17. Where is the PacificSource Medicare referral form located?

The PacificSource Medicare referral request form is located on our website, www.Medicare.PacificSource.com/Partners/Providers/Documents

18. When will I receive a determination for a referral request?

PacificSource Medicare responds to referral requests within 14 calendar days, but usually renders a decision much sooner. Most requests submitted via InTouch receive a determination within minutes.

19. How will I know my referral request has been approved?

Notification method is determined on how the request is submitted. Online determination notices will be viewable in InTouch. Faxed determination notices will be mailed and/or faxed to the referring provider and specialist.

Please contact your PacificSource Provider Service Representative if you have additional questions.