Provider Manual

Commercial Plans

PacificSource HEALTH PLANS

PRV1_0719_v2

Covered Expenses, General Exclusions, and Limitations

For reference, sample plan policies and handbooks are available online on PacificSource.com. These outline coverage, as well as exclusions and limitations.

Find plan summary pages at Pacificsource.com/plan-summaries and sample plan policies and handbooks for each state and type of plan as follows:

Idaho

2018
Small group plans: https://pacificsource.com/idaho/small-2018/
Large group plans: https://pacificsource.com/idaho/large-2018/

2019
Individual plans: https://pacificsource.com/idaho/individual-2019/
Small group plans: https://pacificsource.com/idaho/small-2019/
Large group plans: https://pacificsource.com/idaho/large-2019/

Montana

2018
Small group plans: https://pacificsource.com/montana/small-2018/
Large group plans: https://pacificsource.com/montana/large-2018/

2019
Individual plans: https://pacificsource.com/montana/individual-2019/
Small group plans: https://pacificsource.com/montana/small-2019/
Large group plans: https://pacificsource.com/montana/large-2019/

Oregon

2018
Small group plans: https://pacificsource.com/oregon/small-2018/
Large group plans: https://pacificsource.com/oregon/large-2018/

2019
Individual plans: https://pacificsource.com/oregon/individual-2019/
Small group plans: https://pacificsource.com/oregon/small-2019/
Large group plans: https://pacificsource.com/oregon/large-2019/

Note these are sample documents, and a patient's actual coverage may vary.
Please be sure to contact us as you normally would to verify benefits or obtain preapproval.

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1.1 About This Manual

The PacificSource Provider Network department assembled this manual to give participating providers helpful and reliable information and guidelines. The manual is organized into sections and then into specific topics.

The PacificSource Physician and Provider Manual is your desktop reference for information about PacificSource commercial policies and procedures and can also be used as a training tool when familiarizing new employees to PacificSource. For the purpose of brevity, we use the term "provider" throughout the manual to refer to physicians and/or providers.

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 The Provider Bulletin newsletter and on our website, PacificSource.com.

Take a moment to look over the sections that relate to your responsibilities. You will find the expanded glossary helpful in becoming familiar with common insurance terminology and, of course, your comments, questions and/or suggestions are always welcome. PacificSource Provider Service Representatives are committed to providing tools that meet the needs of our participating physicians and providers.

Thank you for becoming a team member in the partnership between PacificSource, our employer groups and 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

Serving Lane County, Oregon: 1933–1973

PacificSource was founded in 1933 by a group of 21 physicians who staffed and operated Pacific Christian Hospital in Eugene, Oregon. Within two years the company covered 600 employees, hired the first full-time manager, and took on the name Pacific Hospital Association (PHA).

By 1940, the not-for-profit PHA focused on providing health coverage to mostly wood product companies and government employers, such as Giustina Brothers Lumber Company, Westfir Lumber Company, Lane County, and the City of Eugene. PHA fulfilled the needs of local employers who wanted to ensure their employees could access care if they were sick and would be protected financially.

Slow, steady growth and solid resources made PHA an attractive company, and twice during the early 1940s the firm rejected offers to merge. By 1945 PHA insured 4,500 working men and women at $2 per month. The company celebrated its 20th anniversary in 1953 with 10,500 members, 123 business contracts, and 67 physicians.

Expanding throughout Oregon: 1973–2005

By 1975, PHA had become a major health insurer for Lane County, Oregon, residents. During the financially difficult 1980s, thanks to conservative underwriting practices and measured growth, PHA avoided the large financial losses that plagued many other health insurers and emerged stronger than ever. In 1985 and 1986 PHA expanded its western Oregon marketing area to include Douglas, Linn, Coos, and Benton Counties.

The company grew dramatically in the 1990s thanks to aggressive provider contracting and marketing efforts. In 1992, PHA opened an 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 growing customer base, PacificSource opened offices in Bend in 2000 and in Medford in 2004. In 2003 PacificSource acquired two third-party administrators: Manley Services (renamed PacificSource Administrators), an administrator of flexible spending accounts, health reimbursement arrangements, and COBRA benefits; and Select Benefit Administrators (renamed PacificSource Administrators), an administrator of self-funded employee benefit plans. These new product lines allowed PacificSource to offer a full range of benefit solutions to employers and paved the way for growth beyond Oregon.

From Statewide to Regional: 2005–Present

In 2007, PacificSource achieved a key goal of its expansion strategy by entering the Idaho market and opening a regional office in downtown Boise, Idaho. It celebrated its 75th anniversary in 2008, ending the year with 150,000 covered members and newly acquired licensure in Washington.

In 2009 PacificSource enhanced its Idaho market presence and its dental membership through two acquisitions: Primary Health, Inc., of Idaho, including Primary Health Plan, Riverside Benefit Administrators, and Idaho Physicians Network; and Advantage Dental's commercial dental business. Through this growth PacificSource finished 2009 with 206,000 members.

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.

Customer Service

Oregon: (541) 684-5582, (888) 977-9299
Idaho: (208) 333-1596, (800) 688-5008
Montana: (406) 442-6589, (877) 590-1596
Fax: (541) 684-5264
Email: cs@pacificsource.com

Contact for:

- Benefits
- Explanation of payments/vouchers
- Participating physicians and providers
- Pharmacies and networks
- Claim questions/status
- PCP changes
- Referral status
- Appeal process
- Accident information

Credentialing

(541) 684-5580, (800) 624-6052, ext. 3747
Fax: (541) 225-3644
Email: credentialing@pacificsource.com

Contact for:

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

Dental Customer Service

(541) 225-1981, (866) 373-7053
Fax: (541) 684-5564
Email: dental@pacificsource.com

Health Services

Our Health Services staff is available Monday through Friday, 8:00 a.m. to 5:00 p.m. to answer calls. After normal business hours, calls to Health Services are forwarded to voice mail. A staff member will return the call the next business day. Any email communication received after hours will be answered the following business day.

Oregon: (541) 684-5584, (888) 691-8209, ext. 2584
Idaho: (208) 333-1563, (800) 688-5008
Montana: (406) 442-6595, (877) 570-1563
TTY: (800) 735-2900

Fax numbers
Oregon: (541) 225-3625
Idaho: (208) 395-2697
Montana: (406) 441-3378

Email: healthservices@pacificsource.com

Contact for:

- Referrals
- Case management
- Utilization review
- Preauthorization
- Out-of-panel referral information
- Specific medical necessity criteria/guidelines

Individual Sales Department

Oregon: (541) 684-5585, toll-free (866) 695-8684
Idaho: (208) 333-1559, toll-free (855) 333-1559
Montana: (406) 442-6609, toll-free (888) 684-5585

Fax numbers
Oregon: (541) 225-3646
Idaho: (208) 342-4508

Email: individual@pacificsource.com

Contact for:

- Elect products including Portability
- MediShield/Medicare supplement

Marketing Department

Oregon: (541) 686-1242, (800) 624-6052
Idaho: (208) 908-5801, toll-free (888) 492-2875
Montana: (406) 422-1008
Fax: (541) 225-3645
Email: groupsales@pacificsource.com

Contact for:

- Sales
- Quotes of optional benefits
- Group supply orders
- Group service
- Policy change

Marketing Offices

Contact for:

- Sales
- Quotes of optional benefits
- Group supply orders
- Group service
- Policy change

Portland
(503) 699-6561, (800) 624-6052, ext. 2513
Fax: (503) 697-1075
Email: groupsales@pacificsource.com

Bend
(541) 330-8896, toll-free (888) 877-7996
Fax: (541) 330-8948
Email: groupsales@pacificsource.com

Medford
(541) 858-0381, (800) 899-5866
Fax: (541) 858-0486
Email: groupsales@pacificsource.com

Membership Service

(541) 684-5583, (866) 999-5583
Fax: (541) 225-3642
Email: membership@pacificsource.com

Contact for:

- Enrollment eligibility
- Continuation
- Billing
- Adding and terminating employees
- Member ID cards
- Member address changes

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:
Idaho: IDcontracting@pacificsource.com
Montana: MTcontracting@pacificsource.com
Oregon: ORcontracting@pacificsource.com
Washington: WAcontracting@pacificsource.com
All States: ProviderContracting@pacificsource.com

Contact for:

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

Provider Customer Service

To better serve you, and to reduce on-hold wait times, we've added a new toll-free customer service phone line especially for commercial providers: (855) 896-5208.

Contact for:

- Verify member benefits
- Check the status of referrals
- General questions

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
- Call share maintenance
- Physician/provider panel information
- Limited practice designations
- Demographic updates, including tax ID numbers
- Physician/provider credentialing

2.1 Provider Network Management

The Provider Network department operates as a liaison between PacificSource Health Plans and healthcare professionals. Recognizing the needs and perspectives of participating physicians and providers, Provider Network Management 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.

Provider Service representatives are a division of the Provider Network department. The Provider Network Management staff and 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.

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

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

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

Ambulatory Care: Healthcare services rendered in a hospital's outpatient facility, physician's office, or home healthcare; often used synonymously with the term "outpatient care."

Ancillary Medical Service: Covered service necessary for diagnosis and treatment of members. Includes, but is not limited to, ambulance, ambulatory or day surgery, durable medical equipment, imaging service, laboratory, pharmacy, physical or occupational therapy, urgent or emergency care, and other covered service customarily deemed ancillary to the care furnished by primary care or specialist physicians or providers.

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.

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-payments or deductible requirements, limitations, and exclusions contained in the contract between PacificSource and a member or subscriber group.

Board Certified: A physician who has passed an examination given by a medical specialty board.

Board Eligible: A physician who has graduated from an approved medical school and is eligible to take a specialty board examination.

Call Share: The physicians or providers on whom a practitioner relies for backup coverage during times 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. Under capitation, PacificSource pays a participating physician or provider a fixed amount per month for every PacificSource member he/she takes care of, regardless of the care the member receives.

Carrier: Insurer, underwriter of risk.

Carve Out: An arrangement in which an employer or health plan removes or retains coverage for a specific category of services (for example, mental health, substance abuse, vision care, or prescription drugs), and arranges for coverage through a contract with a separate set of providers. The health plan's contract with these providers may specify certain payment and utilization management arrangements.

Case 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. Case 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.

Clinic: A healthcare facility for providing preventive, diagnostic, and treatment services to patients in an outpatient setting.

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

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

Complaint: An expression of dissatisfaction about a specific problem encountered by a member, or about a decision by the insurer (or agent acting on behalf of the insurer). A complaint must include a request for action to resolve the problem or change the decision.

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

Coordination of Benefits (COB): An insurance provision that allocates responsibility for payment of medical services between carriers if a person is covered by more than one insurance plan.

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

Co-payment: 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-payments, or coinsurance in which a person covered by a health plan must pay some of the cost to receive care.

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

Covered Lives: Total of insured members.

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

Credentialing: A process of screening, selecting, and continuously evaluating individuals who provide independent patient care services based on their licensure, education, training, experience, competence, health status, and judgment.

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

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

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.

Disclaimer: A form supplied by PacificSource for managed care physicians and providers to use when a patient presents for services without a referral to a specialist. It may also be used when a patient accesses services of a primary care practitioner who is not the patient's designated PCP or is not in the PCP's call share group. The patient/subscriber is asked to sign this form indicating that they understand they may be financially responsible for charges incurred during the visit.

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

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 condition that manifests itself by symptoms of sufficient severity to convince a prudent layperson that failure to receive immediate medical attention would place the health of a person (or a fetus in the case of a pregnant woman), in serious jeopardy. Examples include heart attacks, cardiovascular accidents, poisonings, and loss of consciousness or respiration.

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: Healthcare items or services furnished in an emergency department, and ancillary services routinely available to an emergency department, when needed to stabilize a patient. PacificSource expands the definition as the sudden and unexpected onset of a condition requiring immediate medical or surgical care, which the member secures immediately after the onset, or as soon thereafter as can be made available, but in any case no longer than 24 hours after the onset.

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

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

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

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

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

Experimental Procedures: Also called unproved procedures. All healthcare services, supplies, treatments, or drug therapies that PacificSource has determined are not generally accepted by healthcare professionals as effective in treating the illness for which their use is proposed.

Extended Care Facility: A nursing home-type setting that offers skilled, intermediate, or custodial care.

Fee-for-Service: The traditional method of paying for medical services. A doctor charges a fee for each service provided and the insurer pays all or part of that fee.

Fee Schedule: List of fees for specified medical procedures.

Formulary: PacificSource Health Plan's list of approved prescription medications that generally carry a lower co-payment.

Full Risk: An arrangement where PacificSource has given the medical group or provider organization financial responsibility for the comprehensive healthcare needs of the patient. Full risk includes both the institutional and professional components of capitation with no sharing of savings with the health plans and generally includes home health, skilled nursing facilities, ambulance, and acute hospital and physician services.

Gatekeeper: See Primary Care Practitioner.

Global: All-inclusive.

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

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

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

Individual Practice Association (IPA): An individual practice association of physicians and/or providers that entered into a contract with PacificSource to provide certain specific covered services to members.

Inpatient Care: Healthcare provided in a licensed bed in a hospital, nursing home, or other medical or psychiatric institution.

Inquiry: A written request for information or clarification about any matter related to the member's health plan. An inquiry is not a complaint.

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

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

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

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

Managed 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 preauthorization, second surgical opinion, and utilization review are used to control inappropriate utilization.

Medicaid: The federal-state health insurance program for low-income U.S. citizens. Medicaid also covers nursing-home care for the indigent elderly.

Medical Group: A group of physicians and/or providers organized as a single professional entity that is recognized under state law as an entity to practice a medical profession.

Medical Services Contract: A contract to provide medical or mental health services that exists between an insurer, physician or provider, and independent practice association; between an insurer and a physician or provider; between an independent practice association and a provider or organization of providers; between medical or mental health clinics; or between a medical or mental health clinic and a physician or provider. This does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapters 58, 60 or 70, or other similar professional organizations permitted by statute.

Medically Necessary Covered Services: Services that PacificSource determines, through its professional review process, are (i) appropriate for the symptoms and diagnosis or treatment of a member's medical condition, (ii) provided for in the diagnosis or the direct care and treatment of that medical condition, (iii) provided in accordance with standards of good medical practice, (iv) not primarily for the convenience of the member or the member's provider of care, and (v) the most appropriate level of service that can be safely provided to the member.

Medicare: The federal health insurance program for older U.S. citizens and the disabled.

Member: Any PacificSource subscriber or dependent as determined by PacificSource.

Negotiated Discount: Method of reimbursement for contracted physicians and providers that stipulates a specific percentage by which a charge may be reduced if included in the physician's or provider's contract or agreement.

Network: The doctors, clinics, health centers, medical group practices, hospitals, and other providers that PacificSource has selected and contracted with to provide healthcare for its members.

Noncovered Services: Those services excluded from coverage by PacificSource.

Non-Emergent Condition: Routine physical or eye examinations, diagnostic work-ups for chronic conditions, routine prenatal care, elective surgery, and scheduled follow up visits for prior emergency conditions. In these instances, no benefits are payable for service/treatment provided in an emergency room setting.

Nonformulary Covered Prescriptions: A list of prescription drugs that generally carry a higher co-payment.

Nonparticipating Provider: A healthcare physician or provider who has not contracted with PacificSource Health Plans.

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

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

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

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 Policies and Procedures: The terms and conditions adopted by PacificSource for the administration of health benefits.

PacificSource Service Area: The geographic area defined by the boundaries of the states of Oregon and Idaho; the Washington counties of Clark, Cowlitz, Klickitat, Pacific, Skamania, and Wahkiakum; and the Idaho counties of Ada, Boise, Canyon, Elmore, Gem, Owyhee, Payette, and Washington.

Panel Physician or Provider: An individual physician or provider who has entered into an agreement with an IPA, or other association of healthcare practitioners to provide certain contracted services to PacificSource members.

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

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 to provide specified covered services to members.

Plan: See Group Health Plan.

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

Plan Sponsorship: A group that organizes the group health plan, oversees its facilities, and provides managerial authority.

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

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

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

Preauthorization: An approval 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.

Pre-Existing Condition: Physical condition of an insured person that existed before the issuance of a policy or enrollment in a plan. Pre-existing conditions may result in a limitation in the contract on coverage or benefits.

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 (e.g., PAP tests), and immunizations.

Primary Care Practitioner (PCP): Physician or provider selected by a member who shall have the responsibility of providing initial and primary care and for referring, supervising, and coordinating the provision of all other covered services to the member. A PCP may be either a family physician or provider, general practitioner, internist, pediatrician, obstetrician, gynecologist, or other practitioner or nurse practitioner who has otherwise limited his/her practice of medicine to general practice or a specialist practitioner who has agreed to be designated as a primary care practitioner. Managed Care plans require that each enrollee be assigned to a primary care practitioner.

Protocol: Description of a course of treatment or an established practice pattern.

Provider: A person licensed, certified, or otherwise authorized by federal and/or state law to administer medical or mental health services in the ordinary course of business or practice of a profession. PacificSource further defines providers as physicians, dentists, nurses, physician assistants, podiatrists, chiropractors, acupuncturists, naturopaths, optometrists, mental health professionals, physical, speech, and occupational therapists, pharmacists, and other healthcare facilities or entities, including Individual Practice Associations or Medical Groups engaged in the delivery of healthcare services.

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

Quality Improvement: A continuous process that identifies problems in healthcare delivery, tests solutions to those problems, and monitors the solutions for improvement.

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.

Referral Authorization: The process of reviewing and authorizing referrals to specialists by primary care practitioners.

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

Resource-Based Relative Value Scale (RBRVS): A financing mechanism that reimburses healthcare providers on a classification system.

Risk: A possibility that revenues of the insurer will not sufficiently cover expenditures incurred in the delivery of contractual services.

Risk Contract: An arrangement through which a healthcare provider agrees to provide a full range of medical services to a set population of patients for a prepaid sum of money or a predetermined budget. The physician or provider is responsible for managing the care of these patients, and risks losing money if total expenses exceed the predetermined amount of funds.

Risk Pool: A category of services that are subject to some type of projected expense target. Typically, amounts over or under this target are shared with the medical group "at risk" for these services. For example, if the risk pool is set at $25.00 (per member per month) for hospital services and the actual amount comes in at $26.00, the $1.00 over the targeted amount may be deducted from other areas of reimbursement to the medical group.

Risk Sharing: An arrangement in which financial liabilities are apportioned between two or more entities. For example, PacificSource and a provider may each agree to share the risk of excessive healthcare cost over budgeted amounts on a 50-50 basis.

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

Service Areas: Geographic areas covered by a PacificSource insurance plan where direct services are provided.

Skilled Nursing Facility (SNF): A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and/or medical care that is of a lesser intensity than that received in a hospital.

Solo Practice: Individual practice of medicine by a physician or provider who does not practice in a group or share personnel, facilities, or equipment, with other physicians.

Specialist Physician/Provider: A physician or provider whose training and expertise are in a specific area of medicine.

Stabilization: A state in which, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

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

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

Supplemental Medicare: A plan that covers some co-payments, deductibles, and other services not covered under traditional 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 Administrator (TPA): An independent person or corporate entity that administers group benefits, claims, and administration for a self-insured group or insurance company. A TPA does not underwrite risk.

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

Triage: The classification of sick or injured persons, according to severity, in order to direct care and ensure efficient use of medical and nursing staff and facilities.

Urgent Care Clinic: A healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Utilization: The extent to which the members of a covered group use the services or procedures of a particular healthcare benefit plan.

Utilization Review: A set of formal techniques used by (or delegated by) an insurer that are designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of healthcare services, procedures, or settings.

Utilization Management Program: The programs and processes established and carried out by PacificSource with the cooperation of contracted physicians and providers to authorize and monitor the utilization of covered services provided to subscribers.

4.1 Eligible Providers

The following physicians and practitioners are eligible to be considered as PacificSource participating providers, provided they meet credentialing requirements.

Physicians and Practitioners

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

Allied Health Care Practitioners

- Audiologist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist (with concurrent NP, CRNA, or CRNFA licensure only)
- Licensed Clinical Social Worker
- Licensed Dietician
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor (also known as Licensed Mental Health Counselor)
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Physical Therapist
- Physician Assistant
- Psychologist
- Psychologist Associate
- Speech Therapist

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

Alternative Care Practitioners

- Acupuncturist
- Chiropractor
- Licensed Massage Therapist
- Naturopath

4.1.1 Eligible Mental Health and Substance Abuse Professional Providers

- Clinical social workers licensed by a State Board of Clinical Social Workers
- Medical or osteopathic physicians licensed by a State Board of Medical Examiners
- Nurse practitioners registered by a State Board of Nursing
- Psychologists (PhD) licensed by a State Board of Psychologist Examiners
- In Oregon, psychologist associates and the supervising licensed psychologist must have an agreement to provide continued supervision of the professional work of a licensed psychologist associate by the Oregon Board of Psychologist Examiners (we will review eligibility of psychologist associates outside Oregon on a case-by-case basis).
- Licensed Professional Counselors and Licensed Marriage and Family Therapists licensed by the State Board of Licensed Professional Counselors and Licensed Marriage and Family Therapists.

4.2 Credentialing

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

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

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

4.2.1 Initial Credentialing Process

The initial credentialing process at PacificSource involves three basic phases: application, review, and decision. The requirements and details of each phase are described below. This process can take up to 90 days upon receipt of complete application.

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. Please note that any new providers at your clinic will be considered nonparticipating providers until the credentialing application is submitted and approved by our Credentialing Committee. When a provider has nonparticipating status, claims are paid at the nonparticipating 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 For Providers section of our website, PacificSource.com (click on Forms), or by contacting our Credentialing department by phone or email.

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 effective date. The provider will then be recredentialed 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 a "nonparticipating provider" and claims may be processed at the nonparticipating benefit level. There may be reasons (e.g., fraud, inappropriate billing practices, other violations of PacificSource rules or legal boundaries) whereby claims payments may not be approved. After credentialing is complete. Providers participating effective date will be the first day of the following month.

4.2.2 Recredentialing Process

The recredentialing process will be conducted on each participating provider no less frequently than every three years, or according to applicable standards at the time. The Practitioner Recredentialing 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 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 on previous page.

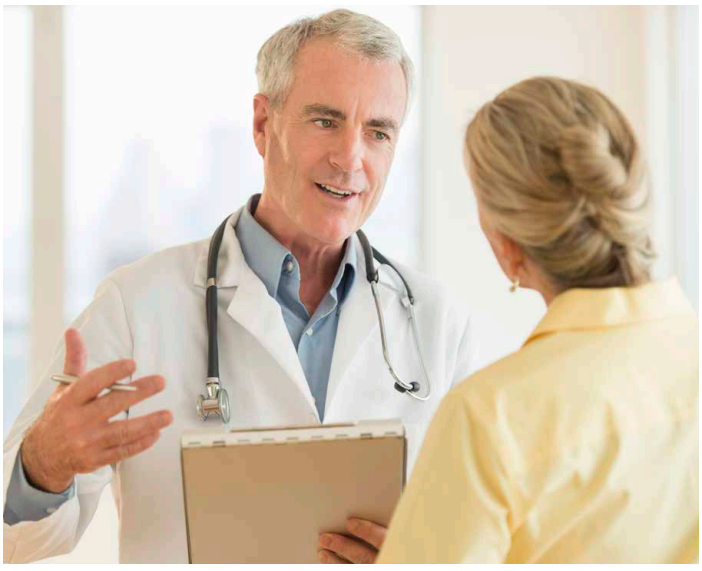
Locum Tenens

A Locum Tenens arrangement is made when a participating provider 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 will now accept modifier Q5/Q6 locum tenens claims. Our Provider Network department will monitor all claims that come in with Q5 or Q6 modifier to ensure they are within the locum tenens claim guidelines.

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

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



4.2.3 Adequate Professional Liability Coverage

PacificSource requires physicians and providers to procure and maintain appropriate general and professional liability insurance coverage. The minimum acceptable professional liability insurance includes, but is not limited to:

One million/three million ($1,000,000/$3,000,000) is required for:

- Acupuncturist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinical Nurse Specialist
- Dentist
- Doctor of Osteopathy
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor
- Medical Doctor
- Naturopath
- Nurse Practitioner
- Oral Surgeon
- Physician Assistant
- Podiatrist
- Psychologist
- Psychologist Associate
- Audiologist
- Occupational Therapist
- Optometrist
- Physical Therapist
- Speech Therapist

4.2.4 Providers not Credentialed

Please note that certain hospital-based providers are not required by the NCQA or PacificSource to be separately credentialed by the health plan.

This exception applies to providers who practice exclusively within the inpatient setting and who provide care for the health plans' members only as a result of members being directed to the hospital or other inpatient setting.

If you have any questions about credentialing, you are welcome to contact the PacificSource Credentialing department, a division of Provider Network Management by phone at (541) 684-5580 or (800) 624-6052, ext. 3747, or by email at credentialing@pacificsource.com.

4.3 Taxpayer Identification Numbers

If you have a change in your tax identification number, you are required to notify us immediately. To ensure accurate IRS reporting, your tax ID number must match the business name you report to both PacificSource and the federal government.

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, PacificSource.com. (Click on For Providers, then on Forms.)
- Complete and sign the W9 form, following instructions exactly as outlined on the form.
- Include the effective date.
- On a separate sheet of paper, tell us the date you want the new number to become effective (when PacificSource should begin using the new number).
- Send the completed form with the effective date by fax: (541) 225-3644, or mail:

  Attn: Provider Network Department
  PacificSource Health Plans
  PO Box 7068
  Springfield OR 97475

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

4.4 Physician and Provider Contract Provisions

PacificSource physician and provider contract provisions vary regarding lines of business, referrals, medical management, method of payment, and withhold requirements, but several provisions remain the same. The provisions that remain constant:

- Physicians and providers will accept the lesser of the billed amount or PacificSource negotiated rates in effect at the time the service or supplies were rendered or provided as payment in full, less deductibles, co-insurance, co-payments, and/or services that are not covered.
- Physicians and providers will not attempt to collect from members any amounts in excess of the negotiated rates.
- Physicians and providers may not collect up-front, except for deductibles, coinsurance, co-payments and/or services that are not covered.
- Physicians and providers will bill their usual and customary charges.
- Physicians and providers will bill PacificSource directly using current CPT procedure, ICD-10 diagnostic, HCPCS and/or DRG coding, and not ask members to bill PacificSource for their services.
- Physicians and providers will cooperate with PacificSource, to the extent permitted by law, in maintaining medical information with the express written consent of the insured, and in providing medical information requested by PacificSource when necessary to coordinate benefits, quality assurance, utilization review, third party claims, pre-existing condition investigations, and benefit administrations. PacificSource 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 will look to the member for payment.
- Provider shall look solely to PacificSource for compensation for Covered Services. Provider, or other designee or agent of Provider, shall not attempt to collect from Members any sums owed to Provider by PacificSource, notwithstanding the fact that either party fails to comply with the terms of this Agreement. Provider further agrees that if PacificSource determines that a Covered Service was not Medically Necessary, or that Covered Services are provided outside of generally accepted treatment protocols, Provider shall not attempt to collect from Member or PacificSource any sums deemed not reimbursable by PacificSource.
- If PacificSource determines that a Covered Service was not Medically Necessary, or that Covered Services are provided outside of generally accepted treatment protocols, Provider shall not attempt to collect from Member or PacificSource any sums deemed not reimbursable by PacificSource, unless the member agreed in writing prior to service(s) being rendered that they were fully aware that said service(s) would be considered not medically necessary and that the member would be responsible for payment.
- Additional agreement assumptions for contracted providers/entities which may be listed in your specific contract or will default and refer to the provider manual:
- Practitioners may communicate freely with members/patients about their treatment plans, regardless of the benefit coverage or limitations to covered services.
- Practitioners/Facilities allow the plan to use practitioner performance data.
- Practitioners/Facilities cooperate with Quality Improvement Activities.
- Practitioners/Facilities maintain the confidentiality of member information and records.

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.

4.4.1 Medical Records and Chart Notes Requirements

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

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

- A medical record that does not contain a valid signature may result in claim denials or recovery of overpayments.
- Signatures added to documentation following a claim denial will not be accepted.

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

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

According to the CMS manual, records should be signed prior to being billed. Section 3.3.2.4 of the MPIM also states:

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

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

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

    PacificSource may request a signature log with any review of medical records to verify provider's signature or initials.
- Digitized/Electronic Signatures:
  - The responsibility for, and authorship of, the digitized or electronic signature should be clearly defined in the record.
  - A "digitized signature" is an electronic image of an individual's handwritten signature. It is typically generated by encrypted software that allows for sole usage by the practitioner.
  - An electronic or digitized signature requires a minimum of a date stamp (preferably includes both date and time notation) along with a printed statement such as, "Electronically signed by," or "Verified/reviewed by," followed by the practitioner's name and a professional designation. An example would be: Electronically signed by: John Doe, MD 03/31/2016 08:42 am.

Unacceptable Signatures

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

Elements of a complete medical record

Per CMS Documentation Guidelines, elements of a complete medical record may include:

- Physician orders and/or certifications of medical necessity
- Patient questionnaires associated with physician services
- Progress notes of another provider that are referenced in your own note
- Treatment logs
- Related professional consultation reports
- Procedure, lab, x-ray and diagnostic reports
- Signature and date

Attestations

Applies to Idaho, Montana, and Oregon.

PacificSource will permit the use of an attestation form when a signature or date is illegible or missing due to an inadvertent omission. The attestation is used to identify the provider of service and authenticate that medical record information is accurate and complete.

Limitations of Attestation

Although the attestation will be accepted regardless of the date it was created, it should not be utilized to "backdate" services relating to orders, plan of care, date records after medical records have been requested, etc.

PacificSource may report a provider for potential fraud if a provider is frequently/regularly using the attestation process rather than to correct the occasional inadvertently missing signature. Patterns or consistent use of attestation in place of signed records may lead to further investigation of claims data, denial of claims, audits, or overpayment recovery. This is consistent with the fraud referrals information from CMS Pub 100-08, Medicare Program Integrity.

We consider the utilization frequency of the attestation process to be acceptable once every 6 months. The submission of the attestation is not in itself a guarantee the claim will be processed if other deficiencies were identified in the medical records.

Attestation Statement

In order to be considered valid for PacificSource documentation review purposes, an attestation statement must:

- Be signed and dated by the author of the medical record entry. Attestation statements will not be accepted if signed by someone other than the author of the medical record.
- Clearly identify the PacificSource member receiving treatment or services and the date services were rendered.

PacificSource neither requires nor instructs providers to use a certain form or format. They may choose to use the following statement or draft:

> "I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed PacificSource member. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Additional Requirements

The attestation statement should be submitted, **within 20 calendar days of audit review,** with:

- PacificSource Corrected Claim Form
- Copy of medical records, even if records have previously been submitted
- Explanation of why the signature was omitted from original medical record

Failure to submit the appropriate documentation within 20 calendar days will result in denial of affected claims.

PacificSource shall *not* consider attestation statements where there is no associated medical record or medical record where the original content has been altered.

Amended Medical Records

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the current

date of that entry and is signed by the person making the addition or change.

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

4.5 Call Share Policy

Primary care providers and specialists agree to make arrangements for coverage when they are unavailable. The call share physician or provider may bill PacificSource for the services provided to the patient, and PacificSource will reimburse the call share provider for noncapitated services.

PacificSource maintains call share group listings. Any changes in call share must be forwarded to the Provider Network department. The listing authorizes the call share providers to provide services, and to receive direct payment for noncapitated services.

If there is any change in a call share group, please call Provider Network Management as soon as possible at (541) 684-5580 or toll-free at (800) 624-6052, ext. 2580.

4.6 Accessibility

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

4.6.1 Behavioral Health Services

Behavioral health providers will accept behavioral health appointments for:

- Routine office visit for behavioral health services within 10 working days
- New patient visit for behavioral health services within 10 working days
- Urgent care services within 48 hours*
- Nonlife-threatening emergency care, contact within six hours*
- Life-threatening emergency care immediately*

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

4.6.2 Primary Care Provider Services

Primary care providers will accept office appointments for:

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

4.6.3 Primary Care Provider

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 members. PCPs shall refer members to panel specialists for services the PCP is unable to provide. The PCP will also be responsible for reviewing the treatment rendered by the specialist.

Please see "Section 5: Referrals" for complete referral requirements.

The primary care practitioner is also responsible for the following:

- Accepts new patients when practice is open to other insurance carriers
- Will notify PacificSource in writing when practice is closed to new patients
- Will arrange for call sharing with a panel physician or provider 24 hours a day, seven days a week
- Will notify PacificSource of any changes in call share coverage
- Will notify PacificSource when asking a member to seek treatment elsewhere

Also see section on Referrals.

4.6.4 Specialty Care Providers

Specialty care providers will accept appointments for:

- Urgent services within 48 hours
- Follow-up visit from emergency room visit within two weeks
- Routine follow-up within four weeks

After hours care should include 24-hour phone availability (answering machine or service advising patients of care options).

4.6.5 PCP Changes

The PCP makes a change, forcing the member to possibly change PCPs. Primary care practitioners may change members for a variety of reasons including, but not limited to, the following:

- Moving practice to a different location
- Moving out of the PacificSource service area
- Closing practice due to retirement, etc.
- No longer participating on the panel
- PCP dismisses member from care

4.6.6 Outstanding Referrals

The following PacificSource policies apply regarding changes in PCPs with regard to outstanding referrals:

- When a member chooses to change PCPs, all outstanding referrals become void effective on the termination date of the referring PCP. A letter will be generated informing the member, new PCP, and specialist of any outstanding referrals.
- When a PCP makes a change forcing a member to choose a new PCP, a 60-day grace period will be in effect for all outstanding referrals. A letter will be generated informing the member, new PCP, and specialist detailing the status of any outstanding referrals.

PCPs must contact the Provider Network department as soon as possible when making any of the above changes. Please call (541) 684-5580 or toll-free (800) 624-6052, ext. 2580.

4.6.7 Limiting or Closing Practice

PacificSource will make every attempt to communicate to our members any closed or limited practice when notified by the PCP in writing of 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

PacificSource enrollment forms ask the insured to indicate whether or not they are an established patient of a physician or provider. Upon enrollment with PacificSource, a Membership Services Representative monitors this information and is prepared to notify the insured when they have selected a PCP whose practice is closed to new patients. In such instances, the insured will be notified by mail and asked to select a new PCP.

Primary care practitioners are sent a monthly report that lists all patients who have chosen them as their PCP. If new patients have chosen their limited or closed practice, the physician or provider can notify the PacificSource Customer Service department and request the patient appoint a different PCP. The insured will be notified by mail and asked to select a different PCP.

Questions regarding PCP selection should be referred to the Customer Service department at (541) 684-5582 or (888) 977-9299. Provider Network Management will handle questions regarding closed/limited practices.

4.7 Appeals Process

PacificSource will make every effort to treat those with whom we do business fairly, honestly, and with recognition of their perspectives and needs.

PacificSource Health Plans Statement of Principles

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

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

Procedure 1: Provider Grievance

PacificSource recognizes the right of a provider to file a grievance as it relates to adverse benefit determinations involving medical necessity or procedures or services which are considered by PacificSource to be experimental and/or investigational. Providers are entitled to a single level of review. The provider should submit a written grievance to PacificSource which identifies the member, the procedure or service at issue, and specifies the provider's reasoning for requesting PacificSource reverse the adverse benefit determination. The provider has 180 days to initiate a first-level appeal of an adverse benefit determination. The time to appeal will start on the day the Provider receives notice of the adverse benefit determination. PacificSource will investigate and respond to the provider, in writing, within thirty (30) days of receipt of the grievance.

Procedure 2: Member Grievance and Appeal

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

First Level of Review

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

Second Level of Review

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

How to Submit Grievances or Appeals

The member or authorized representative may file a grievance or appeal by:

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

If you are unsure how to prepare a grievance, please contact our Customer Service department by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by email at cs@pacificsource.com. We will help you through the grievance process and answer any questions you may have.

PacificSource understands that at times our members, agents, physicians, and providers may have questions or concerns about decisions made by our staff. Our policy is to document, investigate, and resolve concerns, and to notify all affected parties in a timely manner. Fair consideration and timely resolution are the goals of our grievance and appeal process.

5.1 Referral Policy

The member's primary care practitioner (PCP) will be responsible for routine medical care and will coordinate any required specialty care. The PCP, or the PCP call share partner, is responsible for requesting a referral for specialty care services.

Referral requests are made by the PCP to PacificSource Health Plans Health Service department or (if applicable) to a managed care/referral coordinator. Referral services may be provided by:

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

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

PacificSource benefit plans that have PCP and referral requirements stipulate all specialist services (except those listed as "Referral Not Required") must have a PCP referral, and must receive authorization from either the PacificSource Health Services department or the managed care/referral entity.

Referral requests must be submitted via InTouch for Providers at OneHealthPort.com. Once you are logged in to InTouch, simply click "Submit an Authorization." Referrals may be approved immediately through InTouch.

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

Please note: Referral authorization does not imply that services will be covered by the member's policy. In addition to a referral, the member's plan may require a preauthorization for the specific service. It is important that the member contact the PacificSource Customer Service department for benefit information prior to being seen by the specialist.

A Referral Frequently Asked Questions document is available in the For Providers section of our website, PacificSource.com (click on Forms and Materials and then Referral FAQ).

5.2 Retroactive Referrals Policy Change

We realize there are sometimes instances when a referral may not have been in place prior to services being rendered; this should be the exception and not the rule. Retroactive referrals may be eligible up to 90 days of the date of service if determined to be medically necessary and appropriate. Please verify if this is available for your patient through our Customer Service team, as this is not available on all plans.

5.3 Referral Procedure

When the services of a specialist are necessary, the primary care practitioner (PCP) requests a referral to a panel specialist through the Health Services department or managed care office. The referral coordinator issues approval or non approval for the referral and communicates the decision to the member, PCP, and specialist. PacificSource requires the following information for processing referrals:

- Member name and ID number
- Ordering provider information (PCP) and contact information
- Treating provider (or facility name) and contact information
- Diagnosis code(s)
- Start date of request

With the exception of Pain Management referrals, we no longer request a specific number of visits on the referral form. Referral requests up to a total of six visits may be granted automatic approval.

Surgery is counted as one of the referral's authorized visits, regardless of the place of service. Approved specialist services occurring after the procedure's global period, but within the time period requested, are still available to the member.

The following restrictions apply:

- Referrals must be made to a specialist on the appropriate panel, unless the specialty services are not available on that panel.

- Referrals become void if the member changes his/her PCP.
- Referrals should be made for covered diagnoses only.
- Retro referrals may be accepted within 90 days from the date of service. Please verify for your patient through Customer Service, as this is not available for all health plans.

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

If you see a patient prior to receiving the referral determination, you may want to have the patient sign a liability waiver for the specific services and/or procedures rendered, should the referral request be denied. The member's PCP will need to submit a retro referral request within 90 days of the date of service.

Please call Customer Service for benefit information. If you have other questions or concerns, contact the Health Services department by phone at (541) 684-5584 or toll-free at (888) 691-8209, or by email at healthservices@pacificsource.com.

5.4 Referral Management Entities

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

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

Know who manages your referrals. Check your provider contract provision regarding referrals, or contact our Provider Network Management by phone at (541) 684-5580 or (800) 624-6052, ext. 2580, or by email at providernet@pacificsource.com.

5.5 Out-of-panel Referrals

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

When the delegate's referral management coordinator receives an out-of-panel referral, the request and all the pertinent information are forwarded to the PacificSource Health Services department for review by the referral coordinator. The request is evaluated for medical necessity, contract benefit, and/or continuity of care.

The PacificSource referral coordinator will investigate and take under consideration whether or not the service is available from a panel provider while keeping the patient's care a primary consideration.

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

- The referral intake person ensures that the referral management coordinator is aware that the physician or provider is out-of-panel.
- The referral coordinator may contact the delegate or PCP to discuss the referral. The goal is to direct the member to a contracted physician or provider.
- Depending on the results of the coordinator's investigation, the approval or nonapproval of the requested service will be determined.
- PacificSource will inform the delegate's office of the determination by phone if the request is not approved.
- PacificSource will then communicate the determination via fax or mail to the provider, member, delegate entity, and specialist and will include appeal information.

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

5.6 Referral not Required

5.6.1 List of Services

The following services do not require a referral. For a more complete list, please contact Customer Service, as these vary from plan to plan.

- A declaration of disaster or emergency
- Ambulance
- Anesthesia
- Assistant surgeon
- Emergency care
- Well baby/well child care
- 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.

5.7 Referrals That Are not Approved

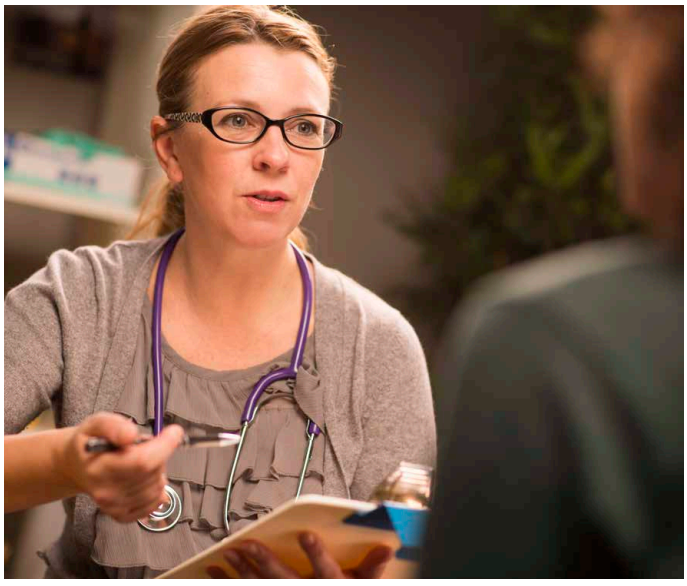
When Health Services or the delegated managed care entity does not approve a referral request, the PCP, specialist, and member are notified by mail or fax. It is the PCP's responsibility to discuss other options with the member. Appeal rights will be included with the determination, and the PCP or member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

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

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

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

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



6.1 Medical Necessity

PacificSource employer contracts contain a clause specifying that services must be medically necessary to be eligible for reimbursement. "Medically Necessary" and "Medical Necessity" are terms PacificSource uses to define services and supplies required for diagnosis or treatment of illness or injury, which, in our judgment, are:

- Consistent with the symptoms or diagnosis and treatment of the condition
- Appropriate with regard to good medical practice
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the disease or injury involved and the patient's overall health condition
- Not for the convenience of the member, a family member, or the physician or provider
- The least costly method of medical service that can be safely provided

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

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

When the adjudicator cannot match the services with the diagnosis, or when the length of stay seems inappropriate for the diagnosis given, the claim is referred to our Health Services department. A staff of 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 Case Management

Complex Case Management and Case Management services are provided by PacificSource to members at no additional cost.

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

- Spinal cord injury/trauma
- Eating disorders
- Amyotrophic lateral sclerosis (ALS-Lou Gehrig's Disease)
- Acute or chronic conditions requiring specialized treatment programs
- All pediatric cancer cases
- Selected adult cancer
- Accordant care cases with frequent ER or inpatient hospitalizations

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

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

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

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

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

Members may request Complex Case Management or Case Management services by contacting our Health Services department. To speak with someone regarding Case Management, please contact our Health Services department:

Telephone

Oregon: (541) 684-5584, toll-free (888) 691-8209, ext. 2584
Idaho: (208) 333-1563, toll-free (800) 688-5008
Montana: (406) 442-6595, toll-free (877) 570-1563

Fax

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

6.3 Preauthorization

Preauthorization is the process by which providers verify coverage and receive authorization from PacificSource before services or supplies are rendered. Preauthorization establishes care based on benefits available, medical necessity, appropriate treatment setting, and/or anticipated length of stay. Failure to preauthorize could result in the member unknowingly becoming responsible for payment to a provider for services or supplies not covered by this group policy. To request preauthorization, please contact the PacificSource Health Services department.

6.3.1 Services Requiring Preauthorization

On our website we maintain a list of procedures and services that require preauthorization. This list can be found in the "For Provider" section, and is subject to revision and updating as PacificSource reviews new technologies and standards of medical practice. Members on plans that require a PCP will need a preauthorization for out-of-area services that are not urgent or emergent.

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

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

Drug Preauthorization

Please see section 7.2.

Mental Health and Substance-Related and Addictive Disorders Services

Mental Health and Substance-Related and Addictive Disorders services are subject to all terms and provisions of the member's specific health plan including limits, deductibles, co-payments and/or benefit percentages shown on the Schedule. Providers must meet the credentialing and eligibility requirements of PacificSource. Only Joint Commission accredited programs are considered to be eligible Mental Health providers by PacificSource Health Plans. Mental Health and Substance-Related and Addictive programs must be licensed by the state in which they operate as a treatment program for the particular type or level of service that is provided or organizationally distinct within a facility.

The following levels of care require preauthorization by PacificSource: inpatient, residential, partial hospitalization, and mental health intensive outpatient services. Substance abuse specific intensive outpatient does not require a preauthorization.

PacificSource expects timely notification—within 24 hours—of admissions requiring preauthorization. Admitting clinical information must be submitted within 48 hours for medical necessity determination and authorization to be completed. Lack of clinical information will result in coverage not being authorized. Initial assessment should include: Initial treatment plan, discharge plan, and estimated length of stay.

PacificSource utilizes MCG, formerly Milliman Care Guidelines' Behavioral Health Guidelines to determine the clinical indications for admission for a primary mental health diagnoses. ASAM—American Society of Addiction Medicine (ASAM PPC-2R) is the clinical guide utilized in the assessment of appropriate levels of patient care for Substance-Related and Addictive Disorders.

Mental Health and Substance-Related and Addictive Disorders are those found in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders classification system with specific exceptions as allowed by state and federal mandates. Currently this is the DSM 5.

The facility and provider must establish, document, and communicate medical necessity for admission, continued stay, and discharge from each level of care and treatment setting. Medical necessity must be met for continued coverage authorization in the treatment setting.

Treatment which is court ordered or required by a third party must also meet medical necessity criteria and will not be approved solely on the basis of court order or third party requirement. Additionally, a therapeutic boarding school or facility that combines a structured psychosocial setting with an academic educational program does not meet medical necessity criteria for this level of care.

PacificSource believes that Mental Health and Substance-Related and Addictive Disorders Services should occur as close as possible to the home area where the patient will be discharged to help facilitate a successful transition to community based services.

Residential Treatment is defined as a 24 hour inpatient level of care that provides a range of diagnostic and therapeutic behavioral services which cannot be provided on an outpatient basis. This level of care must have four or more continuous hours of treatment per day. This treatment occurs in a facility with 7 day a week, 24-hour around-the-clock supervision on a unit that may or may not be locked depending on the specific program's license. Treatment focus is on improving function rather than maintenance of long term gains made in an earlier program. Residential treatment and coverage is not based on a preset number of days. A standardized "program" is not considered reason for medical necessity and continued stay at this level of care. Residential treatment should occur as close as is possible to the home to which the patient will be discharged. If an out of area placement is unavoidable, there must be a family and facility commitment to assure regular family therapy and contact with the patient and the facility.

Partial Hospitalization is defined as a level of care that provides comprehensive behavioral services that are essentially the same in nature and intensity as those which would be provided in a hospital. This level is appropriate for a patient who may present with ongoing, imminent risk of harm to self or others, but is able to develop a plan to maintain safety without 24 hour psychiatric/medical and nursing care. This level of care is typically 5-8 hours per day, 5 days or less per week. This level of care is time-limited, used to stabilize acute symptoms.

Intensive Outpatient (IOP) is defined as a level of care for those patients who are not at imminent risk of harm to self or others. It is an appropriate level of care to generate new coping skills, or reinforce acquired skills that might be lost if the patient returned to a less structured outpatient setting. This level of care is generally 3-4 hours per day or less, 3-5 days per week.

Discharge Guidelines

- Medical necessity and continued stay guidelines are no longer met, or
- Appropriate and timely treatment is available at a less intensive level of care, or
- Maximum program benefits have been achieved and the patient is unlikely to make further positive progress at this level of care

Discharge plans should include:

- Coordination with family, outpatient providers, and community resources
- Timely and appropriate aftercare appointments set prior to discharge
- Prescription for needed medications and medications sufficient to bridge the time between discharge and follow up.

6.3.2 Preauthorization Policy

PacificSource Health Plans requires preauthorization of certain procedures and services to determine benefit eligibility, benefit availability, and medical necessity. Preauthorization is to establish medical necessity, this does not override our system clinical edits. Physicians and other provider offices may request preauthorization by contacting the PacificSource Health Services department. PacificSource will work with the physician or provider office to determine the following:

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

In some cases, PacificSource may require more information or may request a second opinion.

Prior Authorization determinations are made within two business days for nonurgent preservice requests.

Electronic Prior Authorization and Inpatient Notification Process

Effective June 1, 2019, PacificSource Health Plans strongly encourages prior authorization (PA) and inpatient notification requests to be submitted via our provider portal, InTouch. We will contact your offices to assist you in getting an account created and assist with any training.

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

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

Please do not hesitate to contact your Provider Service Representative should you have any questions. We will be happy to assist you in any training you might need to utilize this portal.

6.3.3 Sleep Disorder Treatment

The term "sleep disorders" includes a wide variety of conditions that can be organic such as obstructive sleep apnea (OSA) or upper airway resistance syndrome (UARS), neurological (also called "central sleep apnea") such as narcolepsy or cataplexy, or associated with mental conditions such as insomnia due to anxiety. Mixed sleep apnea is a combination of OAS and central sleep apnea. Most sleep studies are ordered for a suspected diagnosis of sleep apnea or narcolepsy. Treatment for narcolepsy/cataplexy and insomnia is medication. Obstructive Sleep apnea and UARS may be treated medically or surgically.

Types of Sleep Studies

- **Overnight Oximetry** can be done at home or in a hospital setting, and is used primarily to rule out significant sleep apnea in selected patients where the level of suspicion of the diagnosis is relatively low. There can be technical problems with unsupervised testing that can make the test difficult to interpret.
- **Nocturnal Polysomnogram (PSG)** is a detailed study, usually done in a hospital setting with a technician present throughout, and includes monitoring by electroencephalography (EEG), electromyography (EMG), electro-oculography (EOG), oral and nasal airflow, chest movements, oxygen saturation, heart rate and rhythm, and measuring of snoring intensity. This test is considered to gold standard for diagnosing sleep apnea and distinguishing obstructive from nonobstructive sleep apnea.
- **Multiple Sleep Latency Tests (MSLT)** measures the time it takes for the subject to fall asleep and is used primarily in cases of suspected narcolepsy.
- **Actigraphy** is a method of monitoring motor activity with a portable device designed to be used while patients are sleeping. Absence of movement is consistent with sleep. Actigraphy is used either alone or with PSG to diagnose sleep disorders.

- **Home Sleep Study Testing (HST)** is done using unattended portable monitoring devices. While the currently accepted method for definitive diagnosis of OSA is full polysomnography done with a qualified sleep laboratory technician in attendance, home sleep studies using unattended portable devices may be appropriate in patients with suspected OSA when an in-laboratory polysomnogram is not possible by virtue of immobility, safety, or critical illness. Home sleep studies are not considered appropriate for patients with chronic obstructive pulmonary disease or for those suspected of having other sleep complications, such as central apnea, periodic leg movement or narcolepsy.

Criteria: Sleep Studies

Some group contracts require that sleep studies be ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist. Sleep studies may also be ordered by family practice or internal medicine physicians (and nurse practitioners or physicians assistants working with the family or internal medicine physicians) despite not being specified in the contract language.

Preauthorization Requirements

Preauthorization is required for coverage of oral appliances for the treatment of sleep apnea. CPAP/BIPAP devices do not require prior authorization for the initial 3 month rental and convert to purchase. CPAP/BIPAP rental extension, repairs and replacement greater than $800 do require a prior authorization.

Requests for coverage of services for obstructive sleep apnea (OSA) treatment will be reviewed by the criteria below.

Coverage Guidelines: Nonsurgical Treatment of Sleep Disorders

Obstructive sleep apnea can be treated both surgically and nonsurgically.

Nonsurgical treatment options include:

- Continuous positive airway pressure (CPAP)
- Bilevel positive airway pressure (BiPAP)
- Oral appliances

Criteria for Coverage of Nonsurgical Treatment of Sleep Disorders

CPAP and BIPAP includes: Auto-titrating Positive Airway Pressure (APAP) and Adaptive Servo-Ventilation (ASV).

PacificSource considers nonsurgical treatment of sleep disorders to be medically necessary when all of the following are met:

- A PSG or HST sleep study documented AHI or RDI ≥ 10 episodes per hour of sleep OR
- An AHI or RDI between 5 and 9 plus any of the following associated symptoms:
    - Excessive daytime sleepiness, as documented by either a score of ≥ 10 on the Epworth Sleepiness Scale or inappropriate daytime napping (e.g., during driving, conversation, or eating) or sleepiness that interferes with daily activities; OR
    - Impaired cognition OR
    - Mood disorders OR
    - Documented hypertension OR
    - Documented ischemic heart disease OR
    - Documented history of stroke

CPAP or BiPAP trial rental is covered for an initial 3 months to determine tolerance and appropriate utilization before purchase will be approved.

Conversion to purchase of CPAP or BiPAP machine is covered with receipt of the "Request for Purchase" form documenting compliance and efficacy of treatment on the follow-up visit with the specialist. This form is submitted with the claim for purchase. In the case of providers whose billing agent is not at the provider location, the form may be submitted to the Claims department separately. If continued rental (rather than purchase) of CPAP/BiPAP is desired, preauthorization through Health Services is required.

When a participating provider is not available in the members service area, services will be payable at the contracted benefit rate (Use code A36 on preauthorization request).

6.3.4 Preauthorization Procedure

The PacificSource Health Services department is ready to assist physicians, providers, and office staff with preauthorization services, and is available to answer questions. When all pertinent information needed to make a decision has been received, the preauthorization request will be processed according to the turnaround times established by state laws and regulations. You may reach the department in one of the following ways:

Telephone

Oregon: (541) 684-5584, toll-free (888) 691-8209, ext. 2584
Idaho: (208) 333-1563, toll-free (800) 688-5008
Montana: (406) 442-6595, toll-free (877) 570-1563

Fax

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

Address

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

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

Preauthorization requests may be submitted as follows:

- For MRI, CT, and PET scans, through AIM (American Imaging Management). Go online to the AIM web portal at americanimaging.net/goweb, or submit preauthorization requests via the call center at (877) 291-0510.

Electronic Prior Authorization and Inpatient Notification Process

Effective June 1, 2019, PacificSource Health Plans strongly encourages prior authorization (PA) and inpatient notification requests to be submitted via our provider portal, InTouch. We will contact your offices to assist you in getting an account created and assist with any training.

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

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

Please do not hesitate to contact your Provider Service Representative should you have any questions. We will be happy to assist you in any training you might need to utilize this portal.

Please note, preauthorization is to establish medical necessity, this does not override our system clinical edits.

The following information is necessary to complete a request:

- Date
- Patient's name
- Date of birth
- Member number & group number
- CPT/HCPCS code and description
- Durable medical equipment: rental or purchase (if applicable)
- Date of service
- Expected length of stay (if applicable)
- Place of service or vendor name
- Assistant surgeon requested (yes or no, if applicable)
- Prior authorization determinations are made within two business days for nonurgent preservice requests
- Diagnosis codes (ICD-10) and description

- Ordering physician/provider and office location (first and last names please)
- Contact person and telephone number (first and last names please)
- Referring physician (first and last names please)

6.3.5 Retrospective Preauthorizations

Effective August 1, 2013, PacificSource, through its Health Services department and processes, will review clinical documentation to ensure the appropriate claims adjudication for certain services that have been provided when coverage of this service was not preauthorized as contractually required. This includes requirements defined in both the member and provider contracts.

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

All retrospective requests for authorization are completed within 30 calendar days from receipt of all necessary clinical information.

Retrospective requests for authorization will only be honored when:

- The request is received within 60 days of the date of service, or
- Within 60 days of claims notification that an authorization is required.
- A genetic testing request through AIM is received within 90 days of the date of service only.

Requests received outside of this time frame will not be considered for retrospective review.

6.4 Utilization Management

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

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

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

Criteria may be requested prior to a utilization management (UM) decision, or in the event of a denial, from Health Services in any of the following ways:

Telephone

Call Health Services to request a copy of the criteria at the following numbers per state:

Oregon: (541) 684-5584 Toll free: (888) 691-8209, ext. 2584
Idaho: (208) 333-1563 Toll free: (800) 688-5008
Montana: (406) 442-6595 Toll free: (877) 570-1563
TTY: (800) 735-2900

Mail

PacificSource Health Plans/Health Services
110 International Way
Springfield, OR 97477

Email

healthservices@pacificsource.com

FAX

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

Criteria will be provided by mail, email, or fax per your request.

6.4.1 Nonreimbursed Nursing Level Charges During an Acute Care Hospital Stay

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

care hospital services and treatment provided in a hospital setting may include services such as:

- Medical or surgical services
- Room and board
- Observation services
- Nursing services
- Nutritional Services
- Occupational Therapy
- Physical Therapy
- Respiratory Therapy
- Speech Therapy
- Medical Social Services
- intravenous ("IV") injections or IV fluid administration/monitoring
- intramuscular ("IM") and/or subcutaneous ("SQ") injections
- Nasogastric tube ("NGT") insertion, and urinary catheter insertion
- Dressings, supplies, appliances, and equipment
- Diagnostic or Imaging services

Services That Are not Separately Reimbursable for Participating Facilities—Nursing Procedures

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

6.4.2 Concurrent Review

Concurrent review begins when a hospital receives official inpatient admission authorization (see section 6.3.4 Retrospective Preauthorizations). The health plan should be notified within 24 hours (business days only), but no later than 48 hours during normal business days and the next business day if the member is admitting during the weekend. Failure to notify health plan of admission will result in denial of service, and would be the responsibility of the provider.

Eligibility and benefits may be confirmed by contacting Customer Service and the admission should be reported to the Health Services department. Once notified, Health Services will provide a patient-specific, searchable reference number to the facility. This number is the facility's confirmation that we have recorded the patient's admission and that a PacificSource Nurse Case Manager will monitor and manage the patient's hospitalization.

Our Nurse Case Managers use nationally accepted, evidence-based screening criteria, clinical experience, and standardized processes to conduct all utilization review activities, including:

- American Society of Addiction Medicine Criteria
- PacificSource medical criteria and guidelines
- CMS Guidelines
- Standard of practice in your state

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

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

If a determination is made that the patient no longer meets criteria for continued inpatient stay or the

patient's needs may be provided at a lower level of care (e.g., skilled nursing, palliative, or sub-acute setting), PacificSource will notify the facility and the attending physician by telephone, fax, or in writing within one to two business days. All parties are provided with notice of their appeal rights, and a 24-hour grace period may be allowed to coordinate care planning and services for patient discharge.

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

6.4.3 Retrospective Utilization

PacificSource reserves the right to retrospectively review any type of medical service. Requests for retrospective review of hospital admissions, for which we were not notified within two business days, may be reviewed at our discretion. Retrospective utilization may require review of the full medical records and may be reviewed by our Medical Director.

6.5 Quality Utilization Program

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

6.6 Clinical Practice Guidelines

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

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

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

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

7.1 Drug Lists

PacificSource Health Plans uses two base drug lists for their commercial line of business: a state based list (OR, MT, ID) to meet individual state exchange requirements, and our preferred drug list (PDL) which is an open option for large employer groups. Medicaid and Medicare lines of business each have their own drug list and website. Add-on lists are available, including an incentive list and preventive drug list (starting in 2015), which include no co-pay drugs for chronic conditions.

To find out which drug list applies to your patient's pharmacy plan, check their PacificSource member ID card in the lower right corner. If no "Drug List" is noted on their card, use the "PDL" list. Please use the drug lists to prescribe the most clinically appropriate and cost-effective medications for your patient. Generics are generally available for the lowest cost. Preferred brands are available at a higher cost with nonpreferred brands available for the highest cost. Our drug lists are available online at PacificSource.com/drug-list.

7.2 Drug Preauthorization and Step Therapy Protocols

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

We base our preauthorization and step therapy criteria on current medical evidence. We review and update them monthly to accommodate new drugs and changing recommendations. Our Quality Assurance, Utilization Management, Pharmacy and Therapeutics (QAUMPT) Committee must approve all criteria and formulary changes. The QAUMPT voting members consist entirely of providers and pharmacists from the communities we serve. Providers and members can access the current Preauthorization and Step Therapy Policies on our website at PacificSource.com/drug-list.

Requesting Preauthorization

The ordering physician or representative is required to contact our Pharmacy Services department for preauthorization. Pharmacy Services manages all drugs, whether covered by the pharmacy benefit or the medical benefit. Contact Pharmacy Services at (844) 877-4803, fax (541) 225-3665, or email pharmacy@pacificsource.com.

Electronic Prior Authorization/Inpatient Notification 2019

Beginning in 2019, PacificSource Health Plans will no longer be accepting prior authorization (PA) requests via fax or U.S. Mail. Instead, we ask that you submit prior authorization requests via our provider portal, InTouch. We will be making outreach to your offices to assist you in getting an account created, and assist with any training.

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

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

Please do not hesitate to contact your Provider Service Representative should you have any questions. We will be happy to assist you in any training you might need to utilize this portal.

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

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

7.3 Drug Limitations

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

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

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

7.4 Specialty Drugs

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

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

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

7.5 Nonformulary Requests

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

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

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

8.1 Product Descriptions

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

8.1.1 Products Offered in Oregon

Product line	Description	PCP required	Referral required	Office calls
PSN	PPO plans; plans include deductibles with co-pays on some plans; some plans can be paired with a health savings account (HSA)	No	No	Plan-specific; could require co-pay or deductible
SmartChoice	Coordinated care organization style of plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	Yes	No	Plan-specific; could require co-pay or deductible
SmartHealth	Coordinated care network style of plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	Yes	No	Plan-specific; could require co-pay or deductible
Legacy	Coordinated care network style of plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	Yes	No	Plan-specific; could require co-pay or deductible
Standard plans	State-mandated plans; they are a part of our PSN line of business	No	No	Plan-specific; could require co-pay or deductible

8.1.2 Oregon Provider Network Descriptions/Product Associations

Network abbreviation	Network name	Region
PSN	PacificSource Network	All of Oregon, Idaho, Montana, and Southwestern Washington
SCN	SmartChoice Network	
SHN	SmartHealth Network	
LHN	Legacy	Oregon

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

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

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

8.1.3 Products Offered in Idaho

Product line	Description	PCP required	Referral required	Office calls
PSN	PPO plans; plans include deductibles with co-pays on some plans; some plans can be paired with a health savings account (HSA)	No	No	Plan-specific; could require co-pay or deductible
SmartChoice	Coordinated care network style of plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	Yes	No	Plan-specific; could require co-pay or deductible
SmartHealth	Coordinated care network style of plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	Yes	No	Plan-specific; could require co-pay or deductible
BrightIdea	Managed care style of plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	Yes	No	Plan-specific; could require co-pay or deductible
SmartAlliance	Managed care style of plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	Yes	No	Plan-specific; could require co-pay or deductible

8.1.4 Idaho Provider Network Descriptions/Product Associations

Network abbreviation	Network name	Region
PSN	PacificSource Network	All of Oregon, Idaho, Montana, and Southwestern Washington
SHN	SmartHealth Network	Eastern Idaho and Northern Idaho
BIN	BrightIdea Network	Eastern and Southwestern Idaho
SAN	SmartAlliance	Southwestern Idaho

8.1.5 Products Offered in Montana

Product line	Description	PCP required	Referral required	Office calls
PSN	PPO plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	No	No	Plan-specific; could require co-pay or deductible
SmartHealth	Coordinated care network style of plans; plans include deductibles with co-pays on some plans; some plans can be paired with a HSA	Yes	No	Plan-specific; could require co-pay or deductible

8.1.6 Montana Provider Network Descriptions/Product Associations

Network abbreviation	Network name	Region
PSN	PacificSource Network (includes Idaho Physician's Network)	All of Oregon, Idaho, Montana, and Southwestern Washington
SHN	SmartHealth Network	All of Montana

8.2 Endorsements/Optional Benefits

8.2.1 Chiropractic or Acupuncture Care

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

Covered Services

- Chiropractic: Services of a licensed chiropractor for medically necessary diagnosis and treatment of illness or injury
- Acupuncturist: Services of a licensed acupuncturist or physician when necessary for diagnosis and treatment of illness or injury

8.2.2 Vision

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

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

8.3 Valued-Added Services

8.3.1 Prenatal Program

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

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

The goals of the program are to:

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

8.3.2 Prenatal Vitamin Program

PacificSource Health Plans offers its pregnant members nine months of prenatal vitamin supplements at no cost (limitations apply). We offer this benefit to pregnant members to promote healthy fetal development and optimize healthy baby outcomes.

There are two prescription prenatal vitamins offered under the program.

To enroll a patient in the prenatal vitamin program, complete the Prenatal Vitamin Home Delivery Order Form found on our web site PacificSource.com. Fax the completed form to (866) 624-5797.

Direct questions about the program to our Customer Service team, (541) 684-5582 or toll-free (888) 977-9299.

8.3.3 Condition Support Program

Our Condition Support Program is available to all commercial members with medical coverage. Members with asthma or diabetes (including members ages 6–18), heart failure, chronic obstructive pulmonary disease, or coronary artery disease may be referred to the program.

The program's interventions are supported by national clinical guidelines and promote a collaborative relationship between the physician and the patient. Nurses educate and support recognition and understanding of symptoms, when to seek medical treatment, encourage and support adoption of healthy lifestyle choices utilizing motivational interviewing and health coaching techniques, as well as adherence to the physician-prescribed treatment plan and medication regimen. Condition specific information and quarterly newsletters are mailed or emailed. Some participants in the program receive outbound nurse phone contacts. Your patient may opt-out of the program by phone or email.

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

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

8.3.4 AccordantCare® Rare Disease Management Program

As an added support to patients with certain chronic, progressive diseases, PacificSource partners with the AccordantCare® Rare Disease Management Program. Accordant Health Services provides support service to patients with the following conditions:

- Seizure disorders
- Rheumatoid arthritis
- Dermatomyositis
- Gaucher disease
- Multiple sclerosis
- Myasthenia gravis
- Parkinson's disease
- Sickle cell disease
- Cystic fibrosis
- Hemophilia
- Scleroderma
- Polymyositis
- Amyotrophic lateral sclerosis (ALS)
- Systemic lupus erythematosus (SLE)
- Chronic inflammatory demyelinating polyneuropathy (CIDP)

Patients in the AccordantCare® Program receive 24-hour support from a team of healthcare professionals specializing in complex, chronic conditions. They also have access to resources at Accordant.com, preventive monitoring, health evaluations, and nurse outreach.

8.3.5 CaféWell

New as of April 2015, we're offering patients access to CaféWell. CaféWell, powered by Welltok, is a secure health engagement portal that offers patients a highly personalized, engaging, and collaborative experience to help individuals reach their health and wellness goals, and be rewarded for making healthy life choices.

- CaféWell offers your patients:
- Custom, personalized health goals
- Communities of health experts, family, and friends
- Helpful tips and articles on health and wellness
- Condition management programs
- Great rewards

Patients can access CaféWell via the PacificSource website. They must first register for InTouch to access the tool. Non-PacificSource members can also access Welltok. More information is available at PacificSource.com/cafewell.

8.3.6 Hospital-based Health Education Classes

Patients can participate in local hospital-based health education classes and receive up to $50 reimbursement per class or class series (up to $150 per PacificSource member per plan year). Hospital-based classes can cover a wide range of health topics, such as pregnancy and parenting, heart health, weight loss, nutrition, and fitness. We hope that you'll refer your patients to useful classes in your area.

Local hospitals can provide a list of offered classes. For more information about reimbursement, visit our website, PacificSource.com. Simply click on For Members, then on the Health & Wellness tab. Some restrictions apply.

8.3.7 Prescription Discount Program

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

If there's no prescription drug endorsement in place, the program helps members save money on all their prescription purchases. For members with a PacificSource pharmacy benefit, the discount "wraps around" the health plan's prescription benefits. Members will receive the discount when they purchase medications that aren't covered by the health plan, such as drugs for smoking cessation or infertility.

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

8.3.8 Chronic Disease Self-management Program

Developed by Stanford Patient Education Research Center, the six-week Chronic Disease Self-Management Program is designed to teach those with chronic diseases how to better manage their condition and live healthier lives. Classes help build patients' skills and confidence through weekly action planning and feedback, modeling of behaviors, group problem solving, and introduction of management techniques. Topics included:

- Techniques to deal with problems such as frustration, fatigue, pain, and isolation
- Appropriate exercise for maintaining and improving strength, flexibility, and endurance
- Communicating effectively with family, friends, and health professionals
- Nutrition
- How to evaluate new treatments

The program does not conflict with other programs or the individual's specific treatment plan. In fact, it enhances patient compliance with treatment regimes and can strengthen disease-specific education processes. For people with more than one chronic condition, this program teaches skills to coordinate the details necessary to manage their health and stay active.

For PacificSource members, the CDSM program cost will be reimbursed up to $25. The cost of the required text, Living a Healthy Life with Chronic Conditions, is not reimbursable.

If you have patients you think would benefit from this program, please share this information with them. PacificSource members may find information about the course (including dates and locations) on the PacificSource website under For Our Members > Health and Wellness Programs > Chronic Disease Self-management. Or they may contact our Health Management Team at (541) 684-5533.

8.3.9 Tobacco Cessation Program

We understand the difficulty of quitting tobacco and are pleased to offer our members the Quit for Life® Program.

The Quit For Life Program, developed by Alere Wellbeing and the American Cancer Society, is a six-month program that consists of phone-based, one-on-one treatment sessions with a professional Quit Coach®. During the initial call, which typically takes 25–30 minutes, the Quit Coach will review your patient's tobacco use history and help them develop a personalized quit plan. If they are not quite ready to quit, the Quit Coach will work with them to get closer to making that decision. Quit For Life's toll-free number offers additional support between scheduled calls.

This benefit is offered to all PacificSource members with medical coverage. There is no charge to participate in the program, and PacificSource covers unlimited quit attempts.

When participants enroll in the Quit for Life Program, they receive:

- One-on-one phone-based sessions.
- Unlimited toll-free telephone access to the Quit Coaches while enrolled in the program.
- Membership to Web Coach, where they can build their own Quitting Plan, track progress, and interact with other participants and Quit Coaches.
- Recommended nicotine replacement products, such as an eight-week supply of nicotine patches or gum (sent directly to you from the program), or the medications bupropion, bupropion SR, or Chantix (when prescribed by their doctor).
- A Quit Kit of materials designed to help them stay on track.

Members are not required to see their doctor to enroll. Doctor visits for tobacco cessation may or may not be covered under a member's plan. Please call Customer Service to verify the benefit. To enroll, they simply call Quit For Life toll-free at (866) QUIT-4-LIFE (784-8454) or enroll online at quitnow.net. After enrolling, everything needed to participate is sent directly to the member's home. A Quit Coach is available 24 hours a day, seven days a week.

If you or your patient has questions about their coverage or Quit for Life, you are welcome to contact our Customer Service department at (541) 684-5582, or toll-free at (888) 977-9299, or email us at cs@pacificsource.com.

The Quit For Life® Program is brought to you by the American Cancer Society® and Alere Wellbeing. The two organizations have 35 years of combined experience in tobacco cessation coaching and have helped more than one million tobacco users. Together they will help millions more make a plan to quit, realizing the American Cancer Society's mission to save lives and create a world with more birthdays.

8.3.10 Global Emergency Services

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

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

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

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

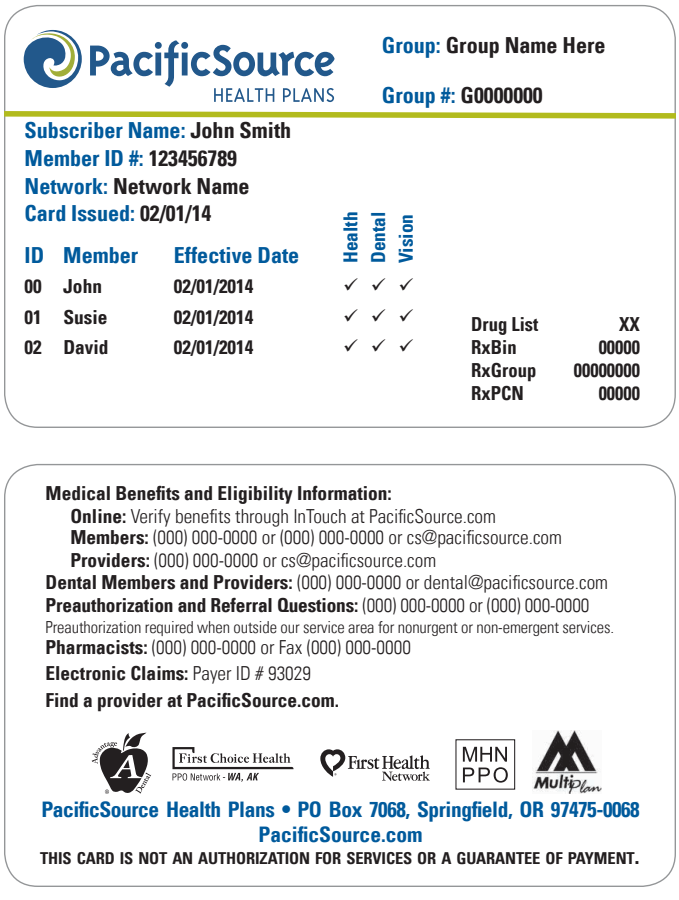
9.1 Enrollment

All members enrolled in plans requiring the selection of a primary care practitioner (PCP) must make a selection at the time of enrollment. PCPs are chosen from the primary care practitioner section of the provider directory associated with the group plan. Each family member must select a PCP that will be responsible for managing that member's healthcare. Family members may choose the same or different PCPs.

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

If the member has not chosen a PCP at enrollment and is issued an identification card, the ID card will say "CALL PACIFICSOURCE." In plans where PCPs and referrals are required, no benefits will be available to the member until a PCP selection is made.

9.2 ID Card



Every PacificSource member, 16 years of age and over, is issued an identification card. Children under age 16 will be identified on the parent or guardian's card. If specific information is needed about a member's coverage or eligibility, please call Customer Service toll-free at (888) 977-9299 or email cs@pacificsource.com. Alternatively, you may call our toll-free customer service phone line especially for commercial providers at (855) 896-5208 to verify member benefits.

Please ask your patient for their PacificSource member ID card at the time of service.

The card front includes the following information:

- Group name and number. A letter code indicates general policy type:
  G = Group
  N = Individual and family
  GE = Group exchange
  NE = Individual and family exchange
- Member's name and ID number
- Network name: The type of network is located below the member number. If a referral is required for the plan, the words "Referral Required" will be seen here.
- Coverage effective date(s)
- Primary care practitioner's or primary care dentist's name for each family member, if applicable to their plan
- Plan Endorsements: If a member has benefits for vision and/or dental, it will be indicated on the card
- Pharmacy: The plan's drug list and pharmacy information is listed in the lower right corner. If no "Drug List" is noted on their card, use our "PDL/VDL" list. Our drug lists are available online at PacificSource.com/drug-list.

The card back includes:

- Out-of-Area Network: For members residing or accessing care outside the PacificSource service area*, instructions and information about the First Health Network and First Choice Health Network is included on the back of the identification card.
- *The PacificSource service area is the geographic area defined by the boundaries of the state of Oregon, Idaho, Montana; the Washington counties of Clark, Cowlitz, Klickitat, Pacific, Skamania, and Wahkiakum.
- VSP Vision network contact information if applicable.
- Other contact information

Please submit claims to:

PacificSource Health Plans
PO Box 7068-0068
Springfield OR 97475

Members are not required to make payment for services up-front to participating providers, except for any applicable co-payments, coinsurance, deductibles, or noncovered services.

We encourage physicians and providers to request to see members' ID cards each time services are accessed. This will help convey to members the importance of the ID card in supplying needed information for proper administration of their benefits and subsequent claims.

9.3 Networks

Participating provider networks vary by plan and location. Often, members have a choice of plans with different provider networks. Your patient's network will be listed on the front of their member ID card. Here are provider networks at a glance:

Idaho

PacificSource Network (PSN)
SmartChoice (SCN)
SmartHealth (SHN)
SmartAlliance (SAN)
BrightIdea (BIN)

Montana

PacificSource Network (PSN)
SmartHealth (SHN)

Oregon

PacificSource Network (PSN)
SmartChoice (SCN)
SmartHealth (SHN)
Legacy Health Network (LHN)

For more information about networks and plans, please see Section 8: Products.

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 Health Plans Statement of Principles

In keeping with our commitment to provide the highest quality healthcare service to our members, PacificSource Health Plans acknowledges the importance of accountability and cooperation. We have ensured a relationship of mutual respect among our members, practitioners, and the health plan by the creation of a partnership of the three parties. Recognition of certain rights and responsibilities of each of the partners is fundamental to this partnership.

PacificSource Health Plans assures our members of the following:

- Members have a right to receive information about PacificSource, our services, our providers, and their rights and responsibilities.
- Members have a right to expect clear explanations of their plan benefits and exclusions.
- Members have a right to be treated with respect and dignity.
- Members have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- Members have a right to honest discussion of appropriate or medically necessary treatment options. Members are entitled to discuss those options regardless of how much the treatment costs or if it is covered by their plan.
- Members have a right to the confidential protection of their medical records and personal information.
- Members have a right to voice complaints about PacificSource or the care they receive, and to appeal decisions they believe are wrong.
- Members have a right to participate with their healthcare provider in decision-making regarding their care.
- Members have a right to know why any tests, procedures, or treatments are performed and any risks involved.

- Members have a right to refuse treatment and be informed of any possible medical consequences.
- Members have a right to refuse to sign any consent form they do not fully understand, or cross out any part they do not want applied to their care.
- Members have a right to change their mind about treatment they previously agreed to.
- Members have a right to make recommendations regarding PacificSource Health Plans' member rights and responsibility policy.

As partners with PacificSource, members are responsible for:

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

10.1 Eligibility and Benefits

PacificSource has a dedicated Customer Service department available to assist both you and your patients with questions related to claims status, benefits, and eligibility.

Customer Service Representatives are available Monday through Friday, 8:00 a.m. to 5:00 p.m. to answer your questions. Spanish-speaking representatives and translation services are also available.

Call PacificSource Customer Service for:

- Claims status
- Deductible, coinsurance, and/or co-payment information
- Information regarding eligibility for PacificSource members
- Benefit questions related to your patient's coverage

You may reach Customer Service by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by email at cs@pacificsource.com. The fax number is (541) 684-5264.

To better serve you, and to reduce on-hold wait times, we've added a new toll-free customer service phone line especially for commercial providers. Please make a note of the new number: (855) 896-5208. You can call this number to verify member benefits, check the status of referrals, or for general questions.

10.2 1500 Health Insurance Claim Form Instructions

PacificSource encourages providers to transmit claims electronically. (Please see Electronic Media Claims under Claims.) Electronic claims result in faster reimbursement, improved accuracy, and reduced costs associated with forms, envelopes, and postage. Paper claims are also accepted, preferably typed, on a 1500 Health Insurance Claim Form. The 1500 is the industry standard for submission of paper claims and is required for optical scanning. Effective April 1, 2014, the New CMS 1500 (Rev 02/12) is required for billing any new or corrected claims to PacificSource.

If you do not wish to file electronically, the 1500 claim form is available in the For Providers section of our website, PacificSource.com (click on Forms). You may also obtain the form by contacting our Provider Network department by phone (541) 684-5580, or toll-free at (800) 624-6052, ext. 2580, or by email at providernet@pacificsource.com.

The preparation of the form in its entirety is encouraged. This will eliminate the need for PacificSource to request additional information, and will enable us to process the bill quickly.

A separate billing form is required for each patient and must be legible. General and specific instructions are listed for assistance in completing the claim form correctly.

Printed in the upper left-hand corner of the 1500 claim form are the name and address of the insurance carrier.

Item 1: Type of Insurance: Mark "Group Health Plan" or "Other" for PacificSource claims

1a: Insured's ID Number.

Item 2: Patient's Name: Must be the patient's full legal name—do not use nicknames.

Item 3: Patient's Date of Birth and Sex: Must be included to correctly identify the member.

Item 4: Insured's Name: Must be the name of the employee or policyholder.

Item 5: Patient's complete address and phone number.

Item 6: Patient Relationship to Insured.

Item 7: Insured's Address.

Item 8: Patient Status.

Item 9 a-d: Other Health Insurance Coverage. It is very important to identify other group coverage for accurate coordination of benefits. If the patient has no other group coverage, please enter "NONE."

Item 10 a-c: Is Patient's Condition Related To: Coverage for employment, auto, or other accident-related claims takes precedence over PacificSource coverage.

Item 11 a-d: Insured's Policy, Group or FECA Number; Insured's DOB; Insured's Name; Other Health Plan.

All members over 16 years of age are issued an identification card, which providers should always ask to see. Children under age 16 will be listed on the parent or guardian's card.

Item 12: Patient's Signature and Date.

Item 13: Insured's Signature.

Item 14: The date of first symptom for current illness, injury, or last menstrual period (LMP) for pregnancy.

Item 15: The date the patient first had the same or a similar illness.

Item 16: Dates Patient Unable to Work in Current Occupation.

Item 17: Name of Referring Physician (if applicable).

17a: ID Number of Referring Physician, i.e., UPIN, Medicaid, Medicare, etc.

17b: NPI.

Item 18: Hospitalization dates related to current services.

Item 20: Outside Lab: Complete this item when billing for purchased services.

Item 21: Enter the patient's diagnosis/condition. ICD Indicator must be filled in or claims will reject. List up to 12 diagnostic codes. Relate lines A–L to the lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this item.

The use of V Codes is encouraged to classify factors influencing health status and contact with health services. V Codes must not be used as the primary diagnosis.

Item 22: Medicaid Resubmission: Only used for Medicaid Claims.

Item 23: Prior Authorization Number.

Item 24: Supplemental Information: The top area of the six service lines is shaded. Use this area for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

24a: Date(s) of Service: Indicate the month, day, and year the service(s) was provided. Grouping services refers to a charge for a series of identical services without listing each date of service.

24b: Place of Service: Indicate if the service was rendered in office, emergency room, hospital inpatient care, etc.

24c: EMG: Not required by PacificSource.

24d: Procedures, Services, or Supplies: Enter the applicable CPT or HCPCS code(s) and modifier(s) from the appropriate code set in effect on the date of service. This item accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description. HCPCS codes may be used to describe services, procedures, and supplies not covered by CPT coding.

24e: Diagnosis Pointer: Enter the diagnosis code reference number (pointer) as shown in Item Number 21.

24f: Charges: Enter the charge for each listed service. A copy of an operative report on all unusual or complicated procedures should be included.

24g: Days or Units.

24h: EPSDT/Family Plan.

24i: ID Qualifier: Enter the qualifier that identifies a non-NPI number in the shaded area.

24j: Rendering Provider ID #: The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area, enter the NPI number in the unshaded area.

Item 25: Federal Tax ID Number: Enter the number used to report income for tax purposes.

Item 26: Patient's Account Number: PacificSource will enter this number (if provided) in the claim record to be printed on EOP.

Item 27: Accept Assignment.

Item 28: Total charges for services.

Item 29: Amount Paid.

Item 30: Balance Due.

Item 31: PacificSource requires the provider that rendered the service or the supervising provider be indicated in box 31 on the CMS 1500 claim form or the appropriate field on an electronic claim. It is the responsibility of the supervising provider to ensure that the integrity of this policy is being adhered to at all times.

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

Item 32: Service Facility Location Information: Enter the name, address, city, state, and zip code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more then one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier.

32a: NPI number.

32b: Other ID number.

Item 33: Billing Provider Info & Phone #: Enter the provider's or supplier's billing name, address, zip code, and phone number. The phone number is to be entered in the area to the right of the item title.

33a: NPI number.

33b: Other ID number.

Common reasons for returned or not approved claims:

- Print is too light
- Patient cannot be identified as a PacificSource member
- More than one physician, provider, or supplier billing on one claim
- Claims not submitted on the most recent 1500 Health Insurance Claim Form
- Incomplete or inaccurate coding

Please submit claims to the following address:

PacificSource Health Plans
PO Box 7068
Springfield, OR 97475

PacificSource encourages claims submission within 90 days of service. However, we will accept submitted claims for a period of one year from the date of service. Additionally, PacificSource will accept rebillings six months from the date the original claim was processed. Initial bills, rebills, and adjustments that are received after this stated period of time will not be payable by PacificSource or by our member.

PacificSource strives to make the claims process as efficient as possible. We ask that when you submit a corrected claim that it is submitted with our Corrected Claim Form and chart notes, if applicable. This form will help us to more easily assess the reason for the change, resulting in a faster turnaround time. Please do not submit corrected claims without the Corrected Claim Form as these are seen as duplicate submissions and will be denied. At this time we are unable to accept corrected claims in electronic format. You can find the Corrected Claim Form in the Providers > Forms and Materials section of our website, PacificSource.com.

If a claim is not approved, and you believe it is an error, simply resubmit the claims and an explanation to PacificSource for reconsideration, providing time limitations are not exceeded. PacificSource will review the case to determine whether the claim is eligible for payment under the terms of the contract. You will be notified in writing of the determination.

Note: Multiple resubmissions will calculate from the original date the claim was processed.

10.2.1 CMS 1500 Form Implementation

In preparation for ICD-10, the CMS 1500 claim form has been updated to accommodate the new code set. Please be aware of the following time line:

- January 1–March 31, 2014: You can use either the current (08/05) or the revised (02/12) 1500 claim form. Health plans, clearinghouses, and billing vendors will accept and process either version of the form.
- Beginning April 1, 2014: The current (08/05) 1500 claim form will be discontinued; only the revised (02/12) 1500 claim form is to be used. All rebilling of claims will be on the revised (02/12) 1500 claim form from this date forward, even though earlier submissions may have been on the current (08/05) 1500 claim form.

10.3 UB04 Instructions

The UB04 claim form is available in the For Providers–Forms section of our website, PacificSource.com. You may also obtain the form by contacting our Provider Network department by phone (541) 684-5580, or toll-free at (800) 624-6052, ext. 2580, or by email at providernet@pacificsource.com.

The preparation of the form in its entirety is encouraged. This will eliminate the need for PacificSource to request additional information, and will enable us to process the bill quickly. A separate billing form is required for each patient and must be legible. General and specific instructions are listed for assistance in completing the claim form correctly.

FL 1: Provider Name, Address, and Telephone Number. Required

FL 2: Pay-to Name, Address, and Secondary Identification Fields. Situational. Required when the pay-to name and address information is different than the Billing Provider information in FL1.

FL 3a: Patient Control Number. Required. The patient's unique alphanumeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.

FL 3b: Medical/Health Record Number. Situational. The number assigned to the patient's medical/health record by the provider (not FL3a).

FL 4: Type of Bill, 4-digit alphanumeric code.

FL 5: Federal Tax ID Number. Required.

FL 6: Statement Covers Period (From—Through). Required. Enter beginning and ending dates of the period included on this bill.

FL 7: Not used.

FL 8 a–b: Patient's Name. Required. Enter the patient's last name, first name, middle initial, and patient ID (if different than the subscriber/insured's ID).

FL 9 a–e: Patient's Address. Required. Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, state, and ZIP code.

FL 10: Patient's Birth Date. Required.

FL 11: Patient's Sex. Required.

FL 12: Admission Date. Required for Inpatient and Home Health.

FL 13: Admission Hour.

FL 14: Type of Admission/Visit. Required.

FL 15: Source of Admission. Required.

FL 16: Discharge Hour.

FL 17: Patient Status. Required.

FL 18–28: Condition Codes. Situational.

FL 29: Accident State.

FL 30: Not used.

FL 31–34: Occurrence Codes and Dates. Situational.

FL 35–36: Occurrence Span Code and Dates. Required for Inpatient.

FL 37: Not used.

FL 38: Responsible Party Name and Address.

FL 39–41: Value Codes and Amounts. Required.

FL 42: Revenue Code. Required.

FL 43: Revenue Description.

FL 44: HCPCS/Rates/HIPPS Rate Codes. Required.

FL 45: Service Date. Required.

FL 46: Units of Service. Required.

FL 47: Total Charges. Not Applicable for Electronic Billers. Required

FL 48: Noncovered Charges. Required

FL 49: Not used.

FL 50 a–c: Payer Identification. Required

FL 51: Health Plan ID

- a: Required.
- b: Situational.
- c: Situational.

FL 52 a–c: Release of Information Certification Indicator. Required.

FL 53 a–c: Assignment of Benefits Certification Indicator.

FL 54 a–c: Prior Payments. Situational.

FL 55 a–c: Estimated Amount Due From Patient.

FL 57: Other Provider ID. Situational.

FL 58 a–c: Insured's Name. Required.

FL 59 a–c: Patient's Relationship to Insured. Required.

FL 60 a–c: Insured's Unique ID. Required.

FL 61 a–c: Insurance Group Name. Situational (required if known).

FL 62 a–c: Insurance Group Number. Situational (required if known)

FL 63: Treatment Authorization Code. Situational.

FL 64: Document Control Number. Situational.

FL 65: Employer Name. Situational.

FL 66: Diagnosis and Procedure code Qualifier (ICD Version Indicator). Required.

FL 67: Principal Diagnosis Code. Required.

FL 67 a–q: Other Diagnosis Codes. Inpatient Required.

FL 68: Not used.

FL 69: Admitting Diagnosis. Required.

FL 70 a–c: Patient's Reason for Visit. Situational.

FL 71: DRG

FL 72: External Cause of Injury Codes.

FL 73: Not used.

FL 74: Principal Procedure Code and Date. Situational.

FL 74 a–e: Other Procedure Codes and Dates. Situational.

FL 75: Not used.

FL 76: Attending Provider Name and Identifiers (including NPI). Situational.

FL 77: Operating Provider Name and Identifiers (including NPIs).

FL 78–79: Other Provider Name and Identifiers (including NPIs.)

FL 80: Remarks. Situational.

FL 81: Code—Code Field. Situational.

Common reasons for returned or not approved claims:

- Print is too light
- Patient cannot be identified as a PacificSource member
- More than one physician, provider, or supplier billing on one claim
- Claims not submitted on the most recent 1500 Insurance Claim Form or UB04 Form
- Incomplete or inaccurate coding

Please submit claims to the following address:

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

PacificSource encourages claims submission within 90 days of service; however, we will accept submitted claims for a period of one year from the date of service. Claims submitted after the allowable one-year time limit will be processed and not approved. Exceptions will be considered on a case-by-case basis.

If a claim is not approved and you believe it is an error, simply resubmit the claim with an explanation to PacificSource for reconsideration. PacificSource will review the case to determine whether the claim is eligible for payment under the terms of the contract. You will be notified in writing of the determination.

10.4 HCPCS Coding

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

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

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

- Use the appropriate E, K, or L code to describe durable medical equipment, supplies, orthotics, or prosthetics.
- Durable Medical equipment over $800 requires preauthorization. Please see the Medical Management section, 6.3.3—Services Requiring Preauthorization.
- If there is no code, use the appropriate unlisted procedure code and include a description of the item.
- Drug Administration
- Use the appropriate J code to describe drugs administered, including injectable, oral, and chemotherapy drugs.
- Look closely at the code description for unit or dosage information. If more than the designated unit or dosage amount is used, enter the multiple value in the "Number of Service" area on the CMS 1500 form.
- If there is no code, use the appropriate unlisted procedure code and include a description of the item.
- Sterile Tray

Use HCPCS code A4550. Please see Billing Guidelines section, 11.2—Office Surgery, for billing instructions for additional allowance when using office surgery suite.

Special Report

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

Unlisted Procedures

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

Modifiers

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

10.5 Electronic Medical Claims

PacificSource is proactive in moving claims electronically, and we encourage providers to consider electronic billing opportunities.

Some of the benefits providers can realize by transmitting claims electronically are:

- Faster reimbursement. By eliminating the time it takes for mailing, internal routing, and data entry, claims are in our system much faster, and are in line for payment 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.

For a list of clearinghouses, visit our website at PacificSource.com, or contact your Provider Service Representative by phone at (541) 686-1242 or toll-free at (800) 624-6052, or by email providernet@pacificsource.com.

For information on connecting to an electronic clearinghouse, please contact our Information Technology department by phone at (541) 225-3743 or toll-free at (800) 624-6052, ext. 3743, or by email at edisupport@pacificsource.com.

10.6 Explanation of Payment (EOP)

10.6.1 How to Read Your EOP

The PacificSource Explanation of Payment (EOP) is a computer printout sheet that is mailed, along with payment, to physicians and providers on each scheduled payment date. The following information explains how to interpret the PacificSource EOP:

Patient Number: The provider's name and the account number for each patient is listed in the first column of the EOP.

Patient Name and Claim Number: The patient's name and the PacificSource claim number are listed in next two columns of the EOP.

The payment information on the following page is listed under the appropriate headings in the last nine columns of the **EOP: Date of Service, Procedure Number, Billed Amount, Amount Applied to Deductible** (if applicable), **Patient Balance Amount** (patient responsibility), **Withhold Amount** (if applicable), **Write-off** (if applicable), **Paid Amount,** and **Reason Code.**

Explanation of Payment Codes: This information appears at the end of the disbursement section. If further claim status clarification is needed, please contact Customer Service at (541) 684-5582 or toll-free at (888) 977-9299, or by email at cs@pacificsource.com.

Auto Recovery Example #1

1. Claim A was paid at $116.06 when originally processed.
2. Claim A has now been adjusted to show a zero payment due to member ineligibility.
3. This creates an overpayment of $116.06 on claim A.
4. Claim B is paying $64.68.
5. The overpayment on claim A is being deducted from the payment on claim B. This leaves an outstanding overpayment of $51.38 for claim A. This amount will be recovered on the next Explanation of Payment.

Prior Overpayment:	$0.00
Overpayment Incurred this Period:	$116.06
Recovered this check:	$64.68
Outstanding overpayment:	$0.00

A

Patient Name: Member One | Provider Name: Provider One | Clinic Name: Provider
Member ID #: 123456789-01 | Provider #: 1234567 | Product: OR PSN Balance
Patient Acct #: ABC12345678 | Claim #: 157116958901 | 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
04/24/15	99202	1	$120.00	$0.00	$0.00	$120.00	793 6AD	$0.00	$0.00	$0.00	$0.00	$0.00
	Claims Totals:		$120.00	$0.00	$0.00	$120.00		$0.00	$0.00	$0.00	$0.00	$0.00

Interest Amount	$0.00
Refund Requested	$0.00
To be auto-recovered	$116.06
Prior Payment	$116.06
Capitated Amount	$0.00
Payment to Provider	$0.00

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B

Patient Name: Member Two | Provider Name: Provider Two | Clinic Name: Provider
Member ID #: 123456790-00 | Provider #: 1234567 | Product: Preferred CoDeduct Value
Patient Acct #: ABC12345687 | Claim #: 157216339100 | NPI #: 1234567809

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
11/11/15	0306	1	$77.00	$64.68	$0.00	$12.32	793	$0.00	$0.00	$0.00	$0.00	$64.68
	Claims Totals:		$77.00	$64.68	$0.00	$12.32		$0.00	$0.00	$0.00	$0.00	$64.68

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	$64.68

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Summary Totals

Billed	Allowed	Risk Withhold	Prov Adjust	Deductible	Co-pay	Co-insurance	Total Patient Responsibility	Interest	Auto-Recovered	Capitated Amount	Net Paid
$197.00	$64.68	$0.00	$132.32	$0.00	$0.00	$0.00	$0.00	$0.00	$64.68	$0.00	$0.00

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Overpayment Recovery Detail

Adjustment Detail- Retractions could be applied to the net payment

Claim #	Patient Name	Patient Acct #	Date of Service	Original Billed Amount	Original Net Paid	Original Overpay	Previously Recovered	Recovered This Check	Remaining Balance	Original Date Paid	Original Check
157116958900	Member One	ABC12345678	4/24/2015	$120.00	$116.06	$116.06	$0.00	$64.68	$51.38	7/26/2015	EFT

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Reason Code Explanations

2 —

Code	Message Description
6AD	This original Coordination of Benefits (COB) claim was overpaid. Claim adjusted accordingly.

Auto Recovery Example #2

1. Claim C was paid at $212.29 when originally processed.
2. Claim C has now been adjusted to show a corrected payment of $156.10 due to a corrected claim received.
3. This creates an overpayment of $56.19 on claim C.
4. Claim D is paying $1,904.06.
5. The remaining overpayment on Claim A ($51.38) and the new overpayment on claim C are being deducted from the payment on Claim D.
6. This results in a net payment on the Explanation of Payment of $1,796.49.

Prior Overpayment:	$0.00
Overpayment Incurred this Period:	$107.57
Recovered this check:	$107.57
Outstanding overpayment:	$0.00

C

Patient Name: Patient One	Provider Name: Provider	Clinic Name: Provider	
Member ID #: 123456789-00	Provider #: 1234567	Product: ID SmartHealth Balance	
Patient Acct #: ABC123456789	Claim #: 157146154001	NPI #: 1234567809	

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
08/13/15	99396	1	$217.00	$156.10	$0.00	$60.90	793 514 6AG	$0.00	$0.00	$0.00	$0.00	$156.10
08/13/15	8817590	1	$88.00	$0.00	$0.00	$88.00	5AE 6AG	$0.00	$0.00	$0.00	$0.00	$0.00
	Claims Totals:		$305.00	$156.10	$0.00	$148.90		$0.00	$0.00	$0.00	$0.00	$156.10

Interest Amount	$0.00
Refund Requested	$0.00
To be auto-recovered	$56.19
Prior Payment	$212.29
Capitated Amount	$0.00
Payment to Provider	$0.00

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D

Patient Name: Patient Two	Provider Name: Provider	Clinic Name: Provider	
Member ID #: 123456790-00	Provider #: 1234567	Product: ID SmartHealth Value Silver	
Patient Acct #: ABC1234	Claim #: 156019085400	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
10/08/15	0320	1	$785.00	$659.40	$0.00	$125.60	793 PLT	$0.00	$0.00	$0.00	$0.00	$659.40
10/08/15	0360	1	$1,461.00	$1,227.24	$0.00	$233.76	793 PLT	$0.00	$0.00	$0.00	$0.00	$1,227.24
10/08/15	0636	1	$20.74	$17.42	$0.00	$3.32	793 PLT	$0.00	$0.00	$0.00	$0.00	$17.42
	Claims Totals:		$2,266.74	$1,904.06	$0.00	$362.68		$0.00	$0.00	$0.00	$0.00	$1,904.06

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	$1,904.06

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Summary Totals

Billed	Allowed	Risk Withhold	Prov Adjust	Deductible	Co-pay	Co-insurance	Total Patient Responsibility	Interest	Auto-Recovered	Capitated Amount	Net Paid
$2,571.74	$2,060.16	$0.00	$511.58	$0.00	$0.00	$0.00	$0.00	$0.00	$107.57	$0.00	$1,796.49

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Overpayment Recovery Detail

Adjustment Detail- Retractions could be applied to the net payment

Claim #	Patient Name	Patient Acct #	Date of Service	Original Billed Amount	Original Net Paid	Original Overpay	Previously Recovered	Recovered This Check	Remaining Balance	Original Date Paid	Original Check
157146154000	Patient One	ABC123456789	8/13/2015	$305.00	$212.29	$56.19	$0.00	$56.19	$0.00	8/23/2015	EFT
157116958900	Member One	ABC12345678	4/24/2015		$116.06	$116.06	$64.68	$51.38	$0.00	7/26/2015	EFT

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Reason Code Explanations

Code	Message Description
6AS	Claim is being reprocessed per corrected claim and/or documentation received.

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10.7 Prompt Pay Policy

- Effective January 1, 2002, PacificSource will pay or not approve a clean claim not later than 30 days after the date we receive the claim.
- We will begin counting the number of days either on the day PacificSource actually receives the claim, or on the day our representative (who performs claims handling, including pricing, on our behalf) receives the claim—whichever day comes first.
- A clean claim is a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- If additional information is necessary in order to process a claim, we will notify the provider and the enrollee in writing of the delay, and provide an explanation of the additional information required. We will process the claim not later than 30 days after the date we receive the additional information.
    - Provider contracts shall not include any provisions that are contrary to this policy.
    - PacificSource has an established method for informing providers of the necessary information to correctly submit a claim, and will make that information easily accessible.
- If we fail to pay a claim within 30 days of receipt when no additional information is needed, or within 30 days from the receipt of the additional information requested, we will pay simple interest of 12 percent per annum on the unpaid amount of the claim that is due. The interest will accrue from the date after the payment was due until the claim is paid. Interest payments will be limited to those required by state or federal law.
- If the interest is $2.01 or more, the interest will be paid with payment of the claim (we do not pay interest of $2.00 or less).

10.8 Accident Report Policy

Accident information is essential for determining which insurance company has primary responsibility for a claim. There are three main situations that may arise where another insurance carrier could be liable for benefits.

10.8.1 On-the-job Injury

PacificSource policies generally are not responsible for any services or supplies for sickness or injury arising out of, or in the course of, employment for wages or profit where state law requires employers to provide their employees with some type of Workers' Compensation coverage for job related medical bills. This may include situations where a business or employer can elect not to provide such coverage. Determination of actual legal responsibility can delay payments. Depending on the state where the policy was issued, the member may be eligible for interim benefits prior to the determination of actual legal responsibility. Please contact PacificSource Third Party Recovery team for more information.

10.8.2 Motor Vehicle Accident

Any expense which results from a motor vehicle injury and which is payable by a motor vehicle insurance policy without regard to liability will not be a covered expense under a PacificSource policy. This includes, for example, any injury involving an auto including getting into, out of or working on a car.

In Oregon, these types of injuries fall under Personal Injury Protection, Oregon's No Fault Auto Coverage.

In Idaho, health insurance is coordinated with auto insurance under Idaho Coordination of Benefits (COB) rules.

Until it is determined who is legally responsible for an injury, PacificSource may require a subrogation agreement to be signed before we can process any claims related to the injury. Upon receipt of this signed agreement, PacificSource is then able to process claims according to the contract benefits. If it is a payable claim through the third party, PacificSource is then reimbursed on the amount paid on the case.

10.8.3 Third Party Liability

An employee or an eligible dependent may have a legal right to recover the costs of his or her healthcare from a third party that may be responsible for the illness or injury. For example, if a person was injured in a business, the owner may be responsible for the healthcare expenses arising out of the injury under the premise's medical coverage. As another example, a third party's homeowners insurance may be responsible for an injury to someone outside his or her immediate family when an injury is sustained on the homeowner's property.

Depending on the terms of the member's policy, PacificSource may extend benefits while the member is pursuing recovery from the responsible party. Claims would be processed at contract benefits and PacificSource would expect to be reimbursed for any claims paid once settlement is reached.

10.9 Coordination of Benefits

10.9.1 Group Health Insurance Coverage

Usually, group health insurance coverage, in Idaho, Montana, Oregon, and Washington, follows the COB order of benefits indicated below. Self-insured employer groups may not be subject to state insurance regulations and may follow different COB rules. If that is the case, a self-insured and a fully insured Plan may coordinate benefits differently than stated below.

10.9.2 Individual Health Insurance Coverage

In Oregon, the term "Plan" does not include individual or short term health insurance policies. Generally, individual coverage will only pay the amount not covered by any other coverage. This is generally referred to as "nonduplication of benefits" (not COB).

10.9.3 Nondependent or Dependent

The Plan that covers the person other than as a dependent (e.g., employee, member, subscriber, or retiree) is primary.

10.9.4 Dependent Child Whose Parents Live Together

For a dependent child whose parents are married or living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the calendar year is primary.

If both parents have the same birthday, the Plan that has covered the parent longer is primary.

10.9.5 Dependent Child of Divorced or Separated Parents

For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

If a court decree states one parent is responsible for the child's healthcare expense, and the Plan is aware of the decree, the Plan of that parent is primary.

If a court decree states that both parents are responsible for the child's healthcare expense, or assigns joint custody without specifying responsibility, the rule for "Dependent Child Whose Parent Live Together" (above) apply.

If there is not court decree allocating responsibility for the child's healthcare expense, the Plan of the parent that has custody of the child is primary; the Plan of the spouse of the custodial parent is second; the Plan of the noncustodial parent is third; and the Plan of the spouse of the noncustodial parent is fourth.

10.9.6 Active/Inactive Employees

The Plan covering the person as an active employee, or dependent of an active employee when none of the above rules apply, is primary.

The Plan covering the person as an inactive employee, (e.g., retired or laid-off employee), or dependent of an inactive employee when none of the above rules apply, is secondary.

10.9.7 COBRA or State Continuation Coverage

The Plan covering a person as an employee, member, subscriber, or retiree or the dependent of an employee, member, subscriber, or retiree is primary to a Plan covering the person as a COBRA or state continuation beneficiary.

10.9.8 Longer/Shorter Length of Coverage

If none of the above rules apply, such as when a self-insured and fully insured Plan's COB provisions do not agree, generally the Plan that covered the person the longest will be primary.

10.10 Document Imaging

Imaging technology (scanning paper and electronically storing and displaying an image of the paper on screen) has been utilized in business for many years. The advent of a computer network within PacificSource and the decreased price of hardware has made imaging technology a realistic and efficient method of storing paper.

PacificSource began the transition to electronic imaging in March 1998. The first application involves claims entry and retrieval. Claims are sorted into CMS 1500, UB-92, dental and miscellaneous categories and shipped to a service bureau in Portland. The bureau scans the documents, stores the images onto high-volume media and ships them back to PacificSource.

Guidelines for submitting claims for imaging:

- Use the CMS 1500 form
- Printing should be dark and clear
- 10- to 12-point type
- Black or blue print
- No discoloration or smudges
- Information aligned in appropriate box
- Only required claim form information
- Only one code per service line
- Circle specific pertinent information
- Diagnosis appropriate to date of service in box 21(1)
- Box 24(E) diagnosis corresponds to box 21(1)
- Block 25—Federal Tax Identification number
- Block 33—PIN (assigned PacificSource provider/payee number)

The above guidelines will help ensure the timely processing and payment of claims.

10.11 Overpayments

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

- PacificSource will send the provider an initial refund request.
- 30 days from the initial request: If we have not received a refund, or the provider has not contested the refund within this time frame, 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 previous pages.

To contest a refund, PacificSource requires the use of our Contested Refund Form, which is available at PacificSource.com under For Providers > Forms and Materials. 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

10.12 Corrected Claims Submission

PacificSource strives to make the claims process as efficient as possible. We ask that when you submit a corrected claim that it is submitted with our corrected claims form and chart notes if applicable. This form will help us to more easily assess the reason for the change, resulting in a speedier turnaround time. Please do not submit corrected claims without the corrected claims form as these are seen as duplicate submissions and will be denied. At this time we are unable to accept corrected claims in electronic format. You can find the corrected claims form in the For Providers > Form section of our website, PacificSource.com.

Have You Tried InTouch?

PacificSource InTouch for Providers is a providers-only area of our website. By logging in with a user name and password, you can access personalized information about your PacificSource patients and their claims 24 hours a day, such as verifying eligibility and checking claims status, EOPs, preauthorizations, referrals, and much more online! Visit PacificSource.com to get started.

By using the correct procedure codes when you bill PacificSource, you enable us to process your claims accurately and efficiently. Our policy regarding billing follows the HCPCS guideline: If a valid CPT code is available, providers must bill with the CPT instead of the HCPC. In efforts to keep administrative costs down and to ensure timely and accurate claims reimbursement, we prefer 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.

Effective January 1, 2017, charges submitted with expired CPT codes will be denied immediately. Note that there is no longer a grace period for changing CPT codes.

11.0 Incident to Billing

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

PacificSource allows "incident to" billing for caregivers who are not eligible to be credentialed by PacificSource or a delegated credentialing entity. This provides practices the opportunity to fully utilize their staff appropriately. PacificSource does NOT allow "incident to" billing for practitioners who are eligible for credentialing.

Effective June 1, 2018, in order for a service to be considered for payment under the "incident to" billing policy, the modifier SA must be appended to the CPT code. Only claims with the required SA modifier, will be considered eligible for "incident to" billing.

In limited situations, PacificSource allows for exceptions to the credentialing and modifier SA requirements. Examples of these exceptions are:

- In the event that another policy exists that conflicts with this policy and allows exception to this rule, precedence will be given first to the rules of that policy. For example, PacificSource does allow for licensed behavioral health professionals who are eligible for credentialing to bill under the "incident to" status if the services being rendered are part of an applied behavior analysis (ABA). These services are exempt from the modifier SA requirement.
- The CPT/HCPCS code being billed is inherently considered a collaborative care service, such as G0511 and G0512 for Care Coordination Services or G0502, G0503, G0504, and G0507 for Behavioral Health Integration Services. These codes are exempt from the modifier SA requirement. PacificSource will follow CMS Guidelines in the use and payment of these types of services.

In order to provide care that will be billed to PacificSource using "incident to" status, the caregiver must be ineligible to be credentialed by PacificSource or its delegated credentialing entity. In addition, if the caregiver's profession is licensable in the state where services are provided (e.g., nursing, social work), then the caregiver must hold an active license and be providing services within the scope of that license. If the caregiver's profession is not licensable in the state where services are provided (e.g., medical assistants, community health workers), then the caregiver must be working under the license and within the scope of practice of the licensed clinician under whom services are being billed. PacificSource requires strict adherence to the following guidelines, and these criteria must be met in order for services to be billed as "incident to."

PacificSource allows "incident to" billing only if the following criteria met:

1. The patient must be established in the practice.
2. The services must be provided under the direct supervision of the physician or credentialed, qualified non-physician practitioner.
3. The supervising provider must actively participate in the continuation of the patient's course of care, with periodic face-to-face encounters. Care may not be transferred to a non-credentialed provider.
4. The original supervising provider, or similarly qualified substitute supervising provider, must be present in the office suite at the time of service delivery and available to provide any necessary assistance.
5. The patient must have a covered condition that was initially diagnosed by the supervising provider.
6. The services must be medically necessary and an integral part of the patient's care.
7. Services must be rendered in a physician's office or clinic (not in an institutional setting).
8. Services rendered under the "incident to" billing policy must be billed under the credentialed, supervising provider.
9. PacificSource will adhere to CPT Billing Guidelines in the payment of services billed under the "incident to" billing policy.
10. The caregiver billing under the supervising provider must be an employee of the practice (i.e., a W-2 employee).

11.1 Osteopathic Manipulation Treatment

Osteopathic Manipulative Treatment CPT Codes 98925–98929

It is PacificSource policy not to allow an evaluation & management service (E&M) on the same date of service as osteopathic manipulative treatment (OMT). Consistent with CPT coding guidelines, E&M services may only be reported if the work provided is above and beyond what is associated with preservice and postservice manipulative treatment.

According to the American Medical Association, E&M services may be reported separately if, and only if, the patient's condition requires significant, separately identifiable E&M service, which may be in connection to a new patient or a second diagnosis. However, the presence of a second diagnosis does not necessarily qualify an E&M service as "separately identifiable".

PacificSource policy for considering a second diagnosis will be as follows:

If a second diagnosis represents a new condition, and requires significant evaluation and management of a separate body system, an E&M code may be reported. Modifier -25 must be attached to the E&M code. PacificSource reserves the right to determine, by chart note evaluation, whether or not an E&M service is warranted.

If a second diagnosis represents a brief recheck of an ongoing, but unrelated condition, an E&M service will be processed to provider write-off.

If a second diagnosis represents the same body system and/or condition, an E&M service will be processed to provider write-off.

Modifier -25—Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service. The physician may need to indicate that on the day he or she performed a CPT code-identified procedure, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided.

11.2 Global Period

"Global period" is defined as the period of time when services must be included in the surgical allowance. PacificSource uses the number of days indicated in the "Global Period" column of the Federal Register as the standard.

PacificSource considers the following services to be included in the global surgical package. These services are not separately reimbursable when billed by the same physician or by another physician within the same Provider Group (same Tax ID number).

Services include:

- Preoperative E&M services after the decision to perform surgery is made, one day prior to major surgery, and on the same day a major or minor surgery is performed;
- Intraoperative services that are a usual and necessary part of the surgical procedure;
- Anesthesia provided by the surgeon (including local infiltration, digital block or topical anesthesia);
- Supplies;
- Normal, uncomplicated follow-up care for the period indicated in the Federal Register Global Period; and
- All additional medical or surgical post-operative services required of the surgeon during the post-operative period due to complications that do not require additional trips to the operating room.

PacificSource considers the following services to be not included in the global surgical package:

- Preoperative services not encompassed in the global period;
- Evaluation and management services unrelated to the primary procedure;
- Services required to stabilize the patient for the primary procedure;
- Procedures required during the immediate preoperative period that are usually not part of the basic surgical procedure (for example, bronchoscopy prior to chest surgery); and
- Treatment by the original physician for a related post-operative complication that requires a return trip to the operating room.

11.3 Obstetric and Gynecology Care Billing Guidelines

11.3.1 Global OB Care

The global maternity allowance is a complete, one-time billing which includes all professional services for routine antepartum care, delivery services, and postpartum care. The fee is reimbursed for all of the member's obstetric care to one provider. If the member is seen four or more times prior to delivery for prenatal care and the provider performs the delivery, the provider must bill the Global OB code, beginning with the date of the initial prenatal visit. Global maternity billing ends with release of care within 42 days after delivery. Global OB care should be billed after the delivery date.

Services Included in Global Maternity Care

- Routine prenatal visits until delivery, after the first three antepartum visits
- Recording of weight, blood pressures and fetal heart tones
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery
- Management of uncomplicated labor
- Vaginal or cesarean section delivery
- Delivery of placenta (see "Billable Services Outside of Global Maternity Care" for examples of when delivery of the placenta may be reimbursed).
- Administration/induction of intravenous oxytocin
- Insertion of cervical dilator on same date as delivery
- Repair of first or second degree lacerations
- Simple removal of cerclage (not under anesthesia)
- Uncomplicated inpatient visits following delivery
- Routine outpatient E/M services provided within 42 days following delivery
- Postpartum care after vaginal or cesarean section delivery

Please use one of the CPT codes listed below when you provide global OB care. Global care includes all obstetrical care for a patient, including delivery, antepartum, and postpartum care. Global OB care should be billed after the delivery date.

59400 Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59510 Routine obstetric care including antepartum care, cesarean delivery and postpartum care

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59618 Routine obstetric care including antepartum care, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery

11.3.2 Partial Services

Nonglobal OB care, or partial services, refers to maternity care not managed by a single provider or group practice. Billing for nonglobal OB care may occur if a member transfers care or is referred to another provider during her pregnancy, a provider from another practice performs the delivery or antepartum care (see the E/M visit info under "Billable Services Outside of Global Maternity Care"), a member terminates or miscarries her pregnancy, or if the member changes insurers during her pregnancy.

If you provide only partial services instead of global OB care, please bill us for that portion of maternity care only. Please use the codes below for billing antepartum-only, postpartum-only, delivery-only, or delivery and postpartum-only services. Only one of the following options should be used, not a combination.

For Antepartum Care Only

- For 1 to 3 visits: Use evaluation and management codes
- For 4 to 6 visits: **59425**
- For 7 or more visits: **59426**

Additional evaluation and management visits during the antepartum period must be billed with modifier -25 to support an evaluation and management service for a medical condition unrelated to the pregnancy. As always, you may bill for ultrasound, amniocentesis, special screening tests for genetic disorders (preauthorization is required for many genetic tests, please refer to the preauthorization list), visits for unrelated conditions, or additional frequent visits due to high risk conditions. You will be reimbursed according to contract benefits.

For Postpartum Care Only

59430

Delivery only

59409 Vaginal delivery only (with or without episiotomy and/or forceps).

59514 Cesarean delivery only

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)

59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Delivery and Postpartum Care Only

59410 Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care

59515 Cesarean delivery only; including postpartum care

59614 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps), including postpartum care

59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Billable Services Outside of Global Maternity Care

- The first three antepartum visits
- Services during the antepartum and postpartum period unrelated to maternity or not in the global period
- Maternal or fetal echography
- Amniocentesis, any method
- Amnioinfusion
- Chorionic villus sampling
- Fetal contraction stress test, and fetal non stress test
- Delivery of the placenta, CPT 59414, is considered integral to a vaginal or cesarean section delivery, this code may be billed if the member delivers vaginally before admission with subsequent delivery of the placenta, or if the placenta is delivered by a provider other than the delivering physician.
- Evaluation and Management (E/M) visits:
  - Additional E/M visits for high risk or complications > 13 antepartum visits
  - E/M visits for conditions unrelated to pregnancy - The diagnosis should clearly identify that the condition is unrelated to pregnancy for the services provided (e.g., appendicitis, bronchitis, cholecystectomy).
  - Maternal Fetal Medicine Specialists seen in addition to the member's regular provider (if the specialist is in the same practice, then use of mod 25 will indicate a significant and separate E/M service).
  - E/M with an OB ultrasound procedure – E/M CPT codes submitted with modifier 25 may be reimbursed with an OB ultrasound on the same date of service. Mod 26 (professional component) is not reimbursed when performed by the same or other health care professional on the same date of service.

11.3.3 Multiple Births

Multiple births should be billed with the appropriate CPTs depending on the delivery method per newborn:

Vaginal delivery CPTs:

- First newborn **59400**, **59409**, **59410**, **59610**, **59612**, or **59614**
- Subsequent newborn(s): **59409** or **59612**

Cesarean delivery CPTs:

- First Newborn: **59510**, **59514**, **59515**, **59618**, **59620**, or **59622**
- Subsequent newborns: **59514** or **59620**

Claim reimbursement: 100% allowance for the delivery method with the highest RVU, and subsequent newborns per the multiple procedure reduction rules and the member's contracted benefit rate.

Midwife Reimbursement

Eligible Certified Nurse Midwives (CNM) will receive reimbursement of services when rendered within the scope of their license.

- Lay midwives, direct-entry midwives, certified midwives (CM), certified professional midwives (CPMs), and doulas will deny in the system as these are ineligible providers.
- Time, services, and medications, are not separately reimbursed as they are part of the global fees.
- Supplies are reimbursed up to $150.00 when billed with the following codes:
  - CPT 99070: Supplies Provided By Physician Over & Above Those Included In The Service (documentation may be required)
  - HCPC S8415: Supplies for home delivery of infant
- If the CNM is unable to perform delivery (another provider delivers), the CNM should only bill for antepartum care.

Increased Procedural Services/Modifier 22

Additional reimbursement may be considered for obstetrical services when the work required to provide a service is substantially greater than typically required, designated by appending modifier 22 (mod 22) to a CPT procedure code. Documentation must support the reason for the additional work (i.e., increased intensity, time, technical difficulty of the procedure, severity of the patient's condition, physical and mental effort required). Mod 22 may not be appended to an E/M code (2013 Professional Edition/CPT manual). Clinical records should be submitted with the claim whenever mod 22 is utilized.

One example of an allowed use of mod 22 for obstetrical services:

> Laceration repairs: 3rd and 4th degree laceration repairs may be billed in addition to the delivery or global OB CPTs by appending modifier 22 to the global OB, delivery only, or delivery plus postpartum care CPTs. The allowable is based on the delivery component alone.

Prolonged Services

Prolonged services, CPT codes 99354 to 99357 for services beyond the usual service provided in an inpatient or outpatient setting, and Prolonged Service without direct patient contact, CPT codes 99358 and 99359 non face-to-face services, are not reimbursed for maternity care services.

Noncovered Service Billed with Global or Nonglobal CPT Codes

Travel time billed by the practitioner is not reimbursed.

Assistant Surgeon

Assistant surgeon fees are reimbursed only with an appropriate modifier for eligible providers using nonglobal cesarean section CPT codes (59514, 59620).

Delivery in Nonhospital Settings

Reimbursement for home delivery, birthing centers, or any nonhospital facility setting is subject to the terms of the PacificSource group and provider contracts, provider eligibility for reimbursement, and provider and facility credentialing

11.3.4 Annual Gynecological Exams

Routine gynecological exams are allowed once each calendar year (or once each benefit year, if plan year).

Any laboratory tests performed are subject to gynecological laboratory benefit. These include:

- Weight and blood pressure check
- Laboratory tests:
  - Occult blood
  - Urinalysis
  - Complete blood count
  - Pap smear
  - Mammography
  - Lab fees CPT 36415, 99000

Any laboratory tests performed, in absence of diagnosis, which are not listed above are subject to the standard preventive laboratory benefits and maximums.

A referral to a women's health care provider is not required for the annual gynecological exam and medically necessary follow-up visits resulting from that examination when performed within ninety (90) days of the annual gynecological exam.

Screening and counseling for sexually transmitted infections, including HIV, and for interpersonal and domestic violence, when provided during a gynecological exam, will be covered at no cost to the member.

This applies to services with participating providers and is effective for PacificSource nongrandfathered group policies and Oregon and Idaho individual policies as they renew (or are effective) on or after August 1, 2012. This is effective for all Montana individual policies effective July 1, 2012, regardless of effective or renewal date.

Any laboratory tests performed in absence of diagnosis are subject to the standard preventive care benefits and maximums.

11.3.5 Screening Papanicolaou Smear HCPCS Code Q0091

PacificSource considers the collection of the pap specimen to be included in the E&M code when services are provided for a gynecological (GYN) exam (CPT codes 99381 through 99397).

- When Q0091 is billed alone with a diagnosis for a GYN exam; the service will be processed as an annual GYN exam.
- If Q0091 is billed in conjunction with an E&M code for the GYN exam, Q0091 will be processed as provider write-off. Allowance for the handling of the specimen using CPT 99000 will be denied as bundled when billed in conjunction with the GYN exam.
- We will consider Q0091 for payment, if billed with an E&M code using a diagnosis other than the GYN exam if modifier -25 is used with the E&M code. Diagnosis and chart notes must support use of the E&M code in conjunction with Q0091.
- If Q0091 is billed with an E&M code without modifier -25, Q0091 will not be approved and will be processed as provider write-off.

11.4 Emergency Services

PacificSource provides coverage without preauthorization for emergency medical conditions. This could include claims within a pre-existing (waiting) exclusion period and/or services not ordinarily covered on the plan.

Coverage includes emergency medical screening exams to determine the nature and extent of an emergency medical condition, emergency services provided in an emergency department and all ancillary services associated with the visit to the extent they are required for the stabilization of the patient.

Routinely, emergency room claims will be processed according to the information provided and benefits available to the member. Claims not approved are subject to automatic review by PacificSource.

See below for current contract definition of an Emergency Service.

"Emergency" shall mean a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

"Emergency Services" shall mean those covered services that are medically necessary to treat emergency conditions.

11.4.1 Emergency Room Claims not Approved

In order to apply "prudent person" determination as mentioned above, all claims for services performed or provided in an emergency room setting (place of service code 23) will be reviewed prior to approval.

PacificSource will thoroughly review billing information for any indication that the member presented in the emergency room with what they perceived to be a medical emergency. If further information is needed, chart notes will be requested. Health Services will be consulted if clinical opinion becomes necessary.

11.4.2 Emergency and After-hours Codes Defined

(including but not limited to)

99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed, such as holidays or weekends.

PacificSource Policy: Claims submitted by an extended hours, urgent care, or immediate care facility must include supporting documentation to be allowed. Claims submitted by an emergency department physician or provider will be processed as provider write-off.

99051 Services provided in the office during regularly scheduled evening, weekend, or holiday office hours.

PacificSource Policy: This CPT code will be denied to provider write-off regardless of documentation.

99053 Services provided between 10:00 p.m. and 8:00 a.m. at a 24-hour facility. This code is only allowed for Emergency departments and should not be billed by any other provider type.

PacificSource Policy: CPT code 99053 will not be approved and will be processed as provider write-off for the following reasons:

To account for the complexity and acute nature of the conditions being seen, the basic emergency room CPT already has a higher level of reimbursement built in as compared to a routine office visit CPT.

The emergency room provider is working his or her regular schedule, and therefore additional reimbursement for a late shift is not appropriate.

The basic facility charge billed with revenue code 450 includes the cost of maintaining a 24-hour facility, which would include staffing of medical providers and support staff.

99056 Services typically provided in-office, provided out of the office at the request of the patient.

PacificSource Policy: This code will not be paid and will be denied as patient responsibility.

99058 Services provided on an emergency basis in and out of the office, which disrupts other scheduled office services, in addition to the basic service.

Criteria: This CPT code will be denied up front. The provider may resubmit claims with documentation. Documentation will be reviewed and payment is not guaranteed.

PacificSource Policy: PacificSource will review any claim with this code to see if the situation falls under our emergency definition (see section 11.4). If so, the claim will be released for payment. If not, the charge will be processed as provider write-off unless supporting documentation is included.

99060 Service provided on an emergency basis out of the office, which disrupts other scheduled office services.

PacificSource Policy: This CPT code will be denied to provider write-off regardless of documentation.

11.5 Surgery

11.5.1 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, using modifier 50 on the second line.

CPT	Modifier	Description	$ Charges	Units
31238		Nasal/sinus endoscopy, surgical, with control epistaxis	$500.00 – units	1
31238	-50	Nasal/sinus endoscopy, surgical, with control epistaxis	$500.00 units	1

Example 2: Billed as one line (two services).

CPT	Modifier	Description	$ Charges	Units
31238-50		Nasal/sinus endoscopy, surgical, with control epistaxis	$1,000.00 units	1

To ensure accurate payment, please make sure you bill the full billed amount, rather than the precut amount. Our system will not recognize if the claim has been precut, and it will cut again according to bilateral surgery guidelines.

11.5.2 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 be aware that this applies to both professional and hospital/facility charges:

- When multiple procedures, other than E&M services, are performed on the same day or at the same session by the same provider, the primary procedure or service should be reported as listed.
- Any additional procedures or services should be ranked in descending Relative Value Unit (RVU) order and identified by the use of modifier -51 on each additional procedure/service.
- Procedure codes that are classified as multiple procedures in the CMS Billing Manual will be processed according to our multiple procedure guidelines. If the code is modifier -51 exempt or an add-on code, it will be processed using 100 percent of the contracted allowed.
- Six or more procedures will require review by PacificSource and chart notes may be requested.

PacificSource uses the following payment structure for multiple procedure claims. Be sure to bill full charges for all services in order to receive the correct payment.

- Primary procedure: 100 percent of the fee allowance
- Second procedure: 50 percent of the fee allowance
- Third through fifth procedures: 25 percent of the fee allowance

Idaho and Montana

PacificSource uses the following payment structure for multiple procedure claims.

- Primary procedure: 100 percent of the fee allowance
- Second procedure: 50 percent of the fee allowance
- Third through fifth procedures: 50 percent of the fee allowance

To ensure accurate payment, please make sure when you are billing for multiple procedures that you submit the full billed amount, rather than the precut amount. Our system will not recognize the claim has been precut and will cut again according to the multiple surgery guidelines.

11.5.3 Multiple and Bilateral Surgical Procedures Performed in the Same Operative Session

Selected bilateral eligible services may also be subject to multiple procedure reductions when billed alone or with other multiple procedure reduction codes. When two or more procedure codes subject to reductions are performed on the same date of service and are subject to reduction as defined in the Federal register, only one of the procedure codes will be considered as the primary procedure, and all the remaining procedures will be considered secondary. The procedure with the highest CMS-based Relative Value Unit or contracted allowance, after the bilateral adjustment, as appropriate, will be considered the primary procedure.

Note: The bilateral procedure is not always the primary procedure. Assistant surgeon fees will be subject to multiple procedure reductions.

Idaho and Montana Examples

First bilateral procedure equals 150 percent of the fee schedule allowance or your billed charge, whichever is less.

Second bilateral procedure equals 75 percent of the fee schedule allowance (150% reduced by half) or your billed charge, whichever is less.

Please note: If the bilateral procedures are billed on two separate lines on the claim, the reduction will be split evenly between both lines.

- 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
- 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
- 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

Procedure	Billed	Contract allowed	Modifier	Considered allowed
31255-50	$4,000.00	$2,100.00	X 150%	$3,150.00
31276-51	$1,100.00	$975.00	X 50%	$487.50
31267-51	$1,100.00	$975.00	X 50%	$487.50

For this 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.

Procedure	Billed	Contract allowed	Modifier	Considered allowed
30140-51, 50	$1,200.00	$500.00	150% X 50%	$375.00
30520	$2,950.00	$2,500.00	Primary @ 100%	$2,500.00
31200-51	$975.00	$900.00	X 50%	$ 450.00

For this 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, 31200, is allowed at 50 percent of the fee schedule allowance.

Oregon Examples

First bilateral procedure equals 150 percent of the fee schedule allowance or your billed charge, whichever is less.

Second bilateral procedure equals 50 percent of the fee schedule allowance (25% X 2) or your billed charge, whichever is less.

Please note: If the bilateral procedures are billed on two separate lines on the claim, the reduction will be split evenly between both lines.

- When billing two bilateral procedures:
  - Primary bilateral = 150 percent of the fee schedule allowance for the procedure
  - Secondary bilateral = 25 percent of the fee schedule allowance for the procedure; 25 percent X 2 = 50 percent
- 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
- When billing a primary bilateral procedure and a secondary procedure:
  - Primary bilateral = 150 percent of the fee schedule allowance for the procedure
  - Secondary procedure = 25 percent of the fee schedule allowance for the procedure

Procedure	Billed	Contract allowed	Modifier	Considered allowed
31255-50	$4,000.00	$2,100.00	X 150%	$3,150.00
31276-51	$1,100.00	$975.00	X 25%	$243.75
31267-51	$1,100.00	$975.00	X 25%	$243.75

For this 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 25 percent of the fee schedule allowance.

Procedure	Billed	Contract allowed	Modifier	Considered allowed
30140-51, 50	$1,200.00	$500.00	150% X 50%	$375.00
30520	$2,950.00	$2,500.00	Primary @ 100%	$2,500.00
29881-51	$975.00	$900.00	X 25%	$ 225.00

For this 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 25 percent of the fee schedule allowance.

11.5.4 Ambulatory Surgery Center Billing Guidelines

Idaho and Montana

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.

Please note: PacificSource requires the use of Modifier SG to expedite processing.

Procedure	Billed	Contract allowed	Modifier	Considered allowed
31255-SG-RT	$1,500	$1,100.00	0%	$1,100.00
31255-51-SG-LT	$1,500	$1,100.00	X 50%	$550.00
30520-51-SG	$1,000	$900.00	X 50%	$450.00
30140-51-SG-RT	$600	$450.00	X 50%	$225.00
30140-51-SG-LT	$600	$450.00	X 50%	$225.00

For this example, the primary procedure is 31255-RT and allowed at 100% 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 see section 11.7 for complete information of ASC Payment Guidelines.

Oregon

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.

Please note: PacificSource requires the use of Modifier SG to expedite processing.

Procedure	Billed	Contract Allowed	Modifier	Considered Allowed
31255-RT	$1,500.00	$1,100.00	100%	$1,100.00
31255-51-LT	$1,500.00	$1,100.00	X 50%	$550.00
30520-51	$1,000.00	$900.00	X 25%	$225.00
30140-51-RT	$600.00	$450.00	X 25%	$112.50
30140-51-LT	$600.00	$450.00	X 25%	$112.50

For this example, the primary procedure is 31255-RT and allowed at 100% of the fee schedule allowance, or billed charges, whichever is less. The second procedure is allowed at 50 percent of the fee schedule allowance, or billed charges, whichever is less. The remaining procedures are allowed at 25 percent of the fee schedule allowance or billed charges, whichever is less.

Please note: For ASCS claims, PacificSource does not recognize Add-on Codes and procedures not subject to the MPR guidelines. All procedures are eligible for MPR.

Please see section 11.7 for complete information of ASC Payment Guidelines.

11.5.5 Surgical Assistant Guidelines

Payment is made only if an assistant surgeon is allowed on the Federal Register.

Modifier 80—Assistant Surgeon (MD, DMD, DDS, DO)

The allowance for modifier 80 is 20 percent of the surgery CPT allowance.

Modifier 81—Minimum Assistant Surgeon (MD, DMD, DDS, DO)

- The allowance for modifier 81 is ten percent of the surgery CPT allowance.
- This modifier is used when the doctor performed minimal assistance.

Modifier AS—Nonphysician Assistant (PA, RN, CRNFA, CST, CNM)

The allowance for modifier AS is ten percent of the surgery CPT allowance.

To ensure accurate payment, please make sure when you are billing assistant surgeon claims that you submit the full billed amount, rather than the precut amount. Our system will not recognize that the claim has been precut (adjusted to show the assistant surgeon payment percentage), and it will be cut again according to the assistant surgeon guidelines.

Please note: Certified Nurse First Assist, Certified First Assist (CFS), Certified Surgical Technicians, Surgical Assistants, and Registered Nurse cannot bill independently. These providers must bill under the overseeing doctor's tax identification number (see section 4.1).

11.5.6 Office Surgery Suites and Fees

PacificSource will allow for the use of an office surgery suite for surgical procedures not requiring hospital outpatient or ambulatory surgery center admission. The allowance for an office surgical suite is calculated according to the relative value of the surgical procedure.

To be eligible for payment, the provider must include office/surgical suite charges when billing the surgery to PacificSource. To expedite these claims, surgical suite should be identified by the use of modifier SU.

For surgical procedures performed in the office, the following table will be used to calculate the PacificSource surgical suite allowance when a provider contract does not state specific surgical suite allowances.

RBRVS surgical relative value unit	% of PacificSource surgical allowance
00.01 through 02.09	Billed
02.10 through 08.75	40%*
08.76 through 14.60	30%*
14.61 and greater RVUs	25%*

**Percentage is based on PacificSource allowance for the surgical procedure(s), not the amount billed.*

The surgical suite allowance includes usage of room, lights, cautery, dressings, sutures, sterile tray, optical or other equipment, and any services of an assistant (e.g., MD, RN, PA). If any of these supplies are billed separately, it will be processed to provider write-off. Surgical Suite reimbursement will only be allowed if there is a dedicated room or space in which surgical procedures are performed. Service done in an exam room or area that is utilized for dual purposes will not be considered a surgical suite and will be denied.

Change effective October 1, 2019: When billed in an office place of service, PacificSource Health Plans will not reimburse any service appended with modifier SU or FF—the costs associated with operating an office, using the facility, and using the equipment for any procedure.

Colonoscopy

Screening colonoscopies: Colonoscopy screenings will be covered at 100 percent for ages 50-75 when billed by a participating provider.

Medical colonoscopies for members under age 50 or when billed with a medical diagnosis will be paid under the surgery benefit. The facility claim will be paid under the outpatient facility or ambulatory surgery center benefit.

CT or MR colonography, also known as "virtual colonoscopy" is not covered and is considered as Experimental/Investigational.

Preauthorization: Colonoscopies do not require prior authorization on group or individual policies.

Colonoscopy with E&M: If a provider bills a colonoscopy with an Evaluation and Management service and the diagnosis is for screening, the E&M service will be denied to provider write-off regardless of participating status.

Visits prior to the diagnostic exam: Previsits prior to a screening colonoscopy are inclusive and are reflected in the RVU for the colonoscopy.

11.5.7 Payment Rules for Multiple Scope Procedures

Related Scope Procedures: Scope surgeries are related procedures (same code family) performed during the same operative session and through the same body orifice/incision on the same day.

The scope with the highest RVU is allowed at 100 percent of the fee allowance.

The second and subsequent procedures are priced by subtracting the fee allowance for the "base" procedure from the code's usual fee allowance.

Unrelated Scope Procedures: When the Scope Procedures are unrelated (not in the same family), multiple surgery rules will apply instead.

Related and Unrelated Scope Procedures on the same day: First, the related scope procedure rule applies, and if the scope is determined to be unrelated then the multiple surgery rule will apply.

Examples of Scope Procedure Families

45378 Base procedure

45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392

Examples of Laparoscopy Families

49320 Base procedure

38570, 49321, 49322, 49323, 58550, 58660, 58661, 58662, 58663, 58670, 58671, 58672, 58673

Example 1: The procedures performed are 45378 (B), 45385, and 45380 and are based on 2009 Fully Implemented Facility RVUs.

CPT	Description	RVUs	Allowed RVUs	RVU minus base	Total RVU
45378 (B)	Colonoscopy	5.87	5.87		9.63
45385	With direct submucosal injection(s), any substance	8.41	2.54	(8.41-5.87)	
45380	With biopsy, single or multiple	7.09	1.22	(7.09-5.87)	

Example 2: The procedures performed are 45380 and 45385 (base code not billed) and are based on 2009 Fully Implemented Facility RVUs.

CPT	Description	RVUs	Allowed RVUs	RVU minus base	Total RVU
45378 (B)	Colonoscopy	5.87			9.36
45385	With direct submucosal injection(s), any substance	8.41	8.41		
45380	With biopsy, single or multiple	7.09	1.22	(7.09-5.87)	

Example 3: The procedures performed are 49320(B), 58660, and 58661, and are based on the 2009 Fully Implemented Facility RVUs.

CPT	Description	RVUs	Allowed RVUs	RVU minus base	Total RVU
49320 (B)	Laparoscopy	8.25	8.25		26.20
58660	Laparoscopy, surgical; with lysis of adhesions	17.62	9.37	(17.62-8.25)	
58661		16.83	8.58	(16.83-8.25)	

Example 4: The procedures performed are 58660 and 58661 (base code not billed) and are based on 2009 Fully Implemented Facility RVUs.

CPT	Description	RVUs	Allowed RVUs	RVU minus base	Total RVU
49320 (B)	Laparoscopy	8.25			26.20
58660	Laparoscopy, surgical; with lysis of adhesions	17.62	17.62		
58661		16.83	8.58	(16.83-8.25)	

If you have further questions about this allowance or need more information about when it is appropriate to bill for these services, 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.

Please note: Multiple Scope payment rules are exempt for Idaho and Montana providers. Idaho and Montana utilize multiple surgery guidelines of 100/50/50 for multiple scope services.

11.6 Evaluation and Management (E&M) Billing Guidelines

11.6.1 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.

PacificSource's Policy for Modifier 25

If the provider provides both a service or procedure and an evaluation and management (E&M) on the same day, it must be significant, separate, and identifiable. Documentation must support both services and show that the E&M was above and beyond the service or procedure provided.

When preventive care codes 99381-99387 or 99391-99397 are billed with office visit codes 99201-99203 or 99211-99213 (with modifier 25 on the office visit code) chart notes are not needed; both codes will be allowed. For all other preventive care & office visit code combinations (or these combinations billed without modifier 25), chart notes are required for consideration of both codes.

When the original claim is received with both preventive services and office visit charges:

- The system will stop the claim for review to allow the adjudicator to determine if chart notes are attached to the claim.
- If there are no chart notes submitted, the charges for the medical office visit will be considered provider write-off. If notes are attached, the notes will be reviewed and, based on the content, a determination will be made whether or not the office visit is appropriate.
- Claims received as rebills with notes will be forwarded to a Claims Research Analyst.

Examples

Examples of when both charges would not be appropriate:

- A patient who has a history of hypertension is scheduled for a routine physical. You make brief mention of the hypertension and refill the patient's prescription.
- During an annual gynecological exam, a patient mentions that she is having hot flashes, and you order blood work to check hormone level.
- A child is seen for a well-child checkup and you note that he has an ear infection and prescribe antibiotics.
- Examples of when both charges would be appropriate:
- A patient is scheduled for a routine physical with a history of hypertension, and upon examination, you discover that the patient's blood pressure is extremely high. The patient says he is having lightheadedness and ringing in the ears. You take measures to reduce the blood pressure and counsel the patient on how to monitor the condition.
- During an annual gynecological exam, you find a lump in a patient's breast and order additional blood work and radiological procedures. You also take additional time to go over treatment options with the patient.

Prolonged Physician Service

If chart notes are not submitted for Prolonged Services, the claim will be processed as provider write-off with the explanation code stating that supporting documentation is required.

PacificSource will reimburse for prolonged physician services with direct face-to-face patient contact that require a minimum of 30 minutes beyond the usual service. "Prolonged services" are limited to include the procedure codes 99354 through 99357.

- Prolonged services charges must be billed with an E/M code in which time is a factor in determining the level of service.
- Prolonged service charges are not reportable with nontime based procedures codes such as surgery or maternity. Other noncovered services include, but are not limited to:
  - Neuropsychological and behavioral testing
  - Intubation
  - Bronchoscopy
  - CPR
  - Infusion/chemo administration
  - Anytime spent performing and documenting separately reportable services
- The time for usual service refers to the typical/average time units associated with the companion evaluation and management (E/M) service.
- Prolonged services cannot be billed if separately reportable services were performed.
- Office visits that consist of 50% or more counseling and exceed the usual time for the E/M must first be billed to the highest level in the given E/M group (new patient, established patient) before the prolonged service can be billed. In this circumstance, time is the deciding factor in choosing the appropriate E/M code.
- Physicians may count only the duration of direct face–to-face contact between the physician and patient, whether the service was continuous or not.
- For inpatient settings, the physician cannot bill prolonged services for the time spent waiting for lab results, reviewing charts, etc.
- Services rendered during the prolonged portion of the visit must be coverable on the member's policy. For example, services for obesity, lifestyle and/or dietary counseling would not be covered unless the member's plan allows for it.
- CPT 99358 and 99359 will not be allowed if the time is spent in medical team conferences, on-line medical evaluations, care plan oversight services, anticoagulation management, or other non-face-to-face services that have more specific codes and no time limit in the CPT code set.

The following is a threshold table from the CMS website that shows the total number of usual face-to-face time (in minutes) and the amount of time needed before prolonged charges can be added:

Threshold Time (in minutes) for Prolonged Visit Codes 99354 and/or 99355 Billed with Office/OP and Consultation Codes:

CPT	Typical time	To bill 99354	To bill 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99241	20	50	95
99242	30	60	105
99243	45	75	120
99244	60	90	135
99245	75	105	150
99324	20	50	95
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

If chart notes are not submitted for Prolonged Services, the claim will be processed as provider write-off with the explanation code stating that supporting documentation is required.

11.6.2 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 section 11.6.4).
- The service must be separated from other services performed on the same day.
- The provider-patient encounter must be face-to-face, not via telephone.

Code 99211 will be accepted only when documentation shows that services meet the minimum requirements for an E&M visit. For example, if the patient receives only a blood pressure check or has blood drawn, 99211 would not be appropriate. All E&M office visits follow the member's office visit benefit; therefore, if another CPT code more accurately describes the service, that code should be reported instead of 99211.

11.6.3 Anticoagulant Management Codes

Anticoagulant services are defined as the outpatient management of warfarin therapy. This includes communication with the patient, International Normalized Ratio (INR) testing (ordering, review, and interpretation), and dosage adjustments as appropriate.

The following codes and guidelines should be applied for anticoagulant management:

- 99363—Initial 90 days of therapy (must include a minimum of eight INR measurements). Submit claim for 99363 after the eighth visit has been completed.
- 99364—Submit claims for 99364 after each additional 90 days of therapy (must include a minimum of three INR measurements).
- Do not bill 99211 with 99363 or 99364 unless a significant, separately identifiable E&M service is performed and documentation can support it. 99211 will be processed to provider write-off when billed in place of 99363 or 99364.

Anticoagulant management work itself is not a basis for an E&M service code or Care Plan Oversight time during the reporting period. Codes 99371—99373 and 0074T do not apply with telephone or online services. However, if a significant, separately identifiable E&M service is performed, report the appropriate E&M service code using modifier 25.

For more information on the use of these codes, please refer to your CPT book.

11.6.4 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.

11.7 Ambulatory Surgery Center (ASC) Payment Guidelines

When contracting directly with an Ambulatory Surgery Center (ASC), PacificSource contracts using various payment methodologies. Please refer to your provider agreement for specifics.

For codes that do not have an ASC allowed amount published by CMS, PacificSource will establish such values for its maximum rate determination.

The SG modifier must be used to bill services provided in an ASC.

11.7.1 Services included in the ASC Facility Payment:

Nursing services, services of technical personnel, and other related services: These services include any nurses, orderlies, technical personnel, and others involved in patient care.

Patient use of the ASC facilities: Use of the operating room, recovery room, patient prep areas, waiting room, and other areas used by the patient or offered for use to the patient's relatives in connection with the procedure are all included within the facility payment.

Drugs and biologicals: These include drugs or biologicals commonly furnished by the ASC in connection with surgical procedures. It is limited to those items that cannot be self-administered.

Surgical dressings: This includes primary surgical dressings applied at the time of the surgery, and therapeutic and protective coverings applied to lesions or openings in the skin that were required for the surgical procedure. (Ace bandages, pressure garments, Spence boots, and similar items are considered secondary dressings.) Surgical dressings for reapplication by the patient or other caregiver obtained on a provider's order from a supplier, i.e., drugstore, are not included in the facility payment and are separately reimbursable to the supplier.

Supplies, splints, and casts: Only those supplies, splints and casts applied at the time of surgery are included in the facility fee. However, such items furnished later are generally furnished "incident to" a physician's service and are not an ASC facility service. Items provided "incident to" a provider's services are subject to other regulations and definitions, and are generally included in the provider fee. Supplies include all those required for the patient or ASC personnel, such as gowns, drapes, masks, and scalpels.

Appliances and equipment: Appliances and equipment used within the surgical procedure are included within the facility payment. However, prosthetics and orthotics (other than IOLs) are not included and will be separately reimbursed. IOLs are included in the facility payment. DME furnished to the patient is separately reimbursable to enrolled DME providers.

Diagnostic or therapeutic items and services: Diagnostic services performed by the ASC may be included in the ASC facility payment. However, if the laboratory of the ASC is not certified, items such as routine simple urinalysis or hemograms should not be billed. Tests performed by a certified ASC laboratory are billed by the laboratory and are separately reimbursable. Similarly, tests performed under an arrangement with an independent or hospital laboratory are billed directly by the provider. Radiology, EKGs, and other preoperative tests are generally not included in the facility payment when used to determine the suitability of an ASC setting. Other diagnostic and therapeutic tests directly connected to the procedure are included in the facility payment.

Administrative, recordkeeping, and housekeeping items and services: These include administrative functions necessary to run the facility.

Materials for anesthesia: These include any supplies, drugs, or gases are included within the facility payment.

Unless otherwise noted in your agreement, PacificSource will not pay for services or supplies specifically outlined by CMS as included in the Case Rate, or in which CMS has deemed nonreimbursable. These can be found on the CMS Web page at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html. Refer to your specific payment schedule outlined in your agreement. Procedures that have an "N1" payment indicator listed in Addendum AA will not be reimbursable. Services and supplies outlined in Addendum EE, "Surgical Procedure to be Excluded from Payment," will be reimbursed if prior approved by PacificSource.

11.7.2 Services not Included in the ASC Facility Payment

- Physician services: This includes services of anesthesiologists administering or supervising the administration of and recovery from anesthesia. Physician services also include any routine pre- or postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services that the individual physician usually includes in a set global fee for a given surgical procedure.
- DME: Includes items for the sale, lease, or rental to ASC patients for use in their home.
- Prosthetic and orthotic devices; and leg, arm, back, and neck braces (except IOLs).
- ASC furnished ambulance services.
- Diagnostic tests performed directly by an ASC.
- Physical and occupational therapy services.

11.8 Ultrasound: Same-day Billing of Transvaginal and Standard

Our claims editing system recommends the denial of payment for transvaginal ultrasound when billed with any pelvic or abdominal ultrasound on the same date of service. After careful review, PacificSource has decided to cover both, but will reduce payment the transvaginal ultrasound by 50 percent when billed in conjunction with another ultrasound.

11.9 Never Events Policy

PacificSource has determined that if a healthcare service is deemed a "never event" that neither PacificSource nor the Member will be responsible for payments for said services. Healthcare Facilities and Providers will not seek payment from PacificSource, or its members for additional charges directly resulting from the occurrence of such a "never event" if:

- The event results in a increased length of stay, level of care or significant intervention
- An additional procedure is required to correct an adverse event that occurred in the previous procedure or provision of a healthcare service
- An unintended procedure is performed
- Re-admission is required as a result of an adverse event that occurred in the same facility
- These guidelines do not apply to the entire episode of care, but only the care made necessary by the serious adverse event.

11.9.1 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).

11.9.2 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

11.9.3 Case Management 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 hyperbillirubinemia 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

11.9.4 Environmental Events

Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following events:

- Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility
- Incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a fall while being cared for in a healthcare facility
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

The formulation of this policy is the result of guidelines established by the Centers for Medicare and Medicaid (CMS), Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, and the National Quality Forum.

11.10 Modifiers

22—Increased Procedural Services: Documentation is required when billing with this modifier. A short explanation of why this modifier was applied will also help expedite the processing of claims.

24—Unrelated E&M Service by Same Physician During a Postoperative Period: Used when a physician performs an E&M service during a postoperative period for a reason(s) unrelated to the original procedure.

25—Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service: Used by provider to indicate that on the same date of service, the provider performed two significant, separately identifiable services that are not "unbundled".

26 or PC—Professional Component: Certain procedures are a combination of a physician component and a technical component, and this modifier is used when the physician is providing only the interpretation portion.

TC—Technical Component: Certain procedures are a combination of a provider component and a technical component, and this modifier is used when the provider is performing only the technical portion of a service.

32—Mandated Services: Services related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47—Anesthesia by Surgeon: Regional or general anesthesia provided by a surgeon may be reported by adding this modifier to the surgical procedure. Amount allowed is 25% of the surgical procedure allowance.

50—Bilateral Procedures: Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. Unless otherwise identified, bilateral procedures should be identified with this modifier. A separate procedure code should be billed for each procedure, using modifier -50 on the second one. Refer to Bilateral Procedures 11.5.1 of the Provider Manual.

51—Multiple Procedures: Procedures performed at the same operative session, which significantly increase time. Multiple procedures should be listed according to value. The primary procedure should be of the greatest value and should not have modifier -51 added. Subsequent procedures should be listed using modifier -51 in decreasing value. Refer to Bilateral Procedures 11.5.2 of the Provider Manual.

52—Reduced Services: Allowed amount to be reduced to 80% (cut by 20%), then processed according to the contract benefits.

53—Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Allowed amount will be reduced to 75% (cut by 25%), then processed according to contract benefits.

54—Surgical Care Only: Used with surgery procedure codes with a global surgery period only. Fee allowance is reduced to 70% of the original allowed. See modifiers 55 and 56 below for additional details on pre- and post-op care only.

55—Postoperative Management Only: Reimbursement is limited to the post-op management services only. Used with the surgery CPT code, auto adjudication reduces fee allowance to 30% of the total allowed.

56—Preoperative Management Only: Reimbursement is limited to the preop management services only. Used with the surgery CPT code, auto adjudication reduces fee allowance to 10% of the total allowed.

57—Decision for Surgery: This modifier identifies an E&M service(s) that resulted in the initial decision for surgery and are not included in the "global" surgical package.

59—Distinct Procedural Service: Indicates that a procedure or service was distinct or independent from other services performed on the same day. Example: An E&M service for an ear infection and a surgical code billed for removal of a wart at the same visit.

62—Two Surgeons (MD, DMD, DO): When two surgeons work together as primary surgeons performing distinct part(s) of a single procedure, each surgeon should add modifier 62 to the CPT code. The combined allowable for cosurgeons is 125% of the full CPT allowable. This amount will be split 50-50 between the two surgeons, unless otherwise indicated on the claim form.

63—Procedure Performed on Infants less than 4kg: Documentation is required when billing with this modifier. A short explanation of why this modifier was applied will also help expedite the processing of claims.

66—Surgical Team (MD, DO, PA, CRNFA, RN, SA): When a team of surgeons (two or more) are required to perform a specific procedure, each surgeon bills the procedure with modifier 66. Fee allowance is increased to 120% of the basic fee allowance for the procedure.

76—Repeat Procedure by Same Physician: This modifier is used to indicate that a repeat procedure on the same day was necessary, or a repeat procedure was necessary and it is not a duplicate bill for the original surgery or service.

77—Repeat Procedure by Another Physician: This modifier is used to indicate that a procedure already performed by another physician is being repeated by a different physician. This sometimes occurs on the same date of service.

78—Return to the OR for a Related Procedure During the Post-op Period: Indicates that a surgical procedure was performed during the post-op period of the initial procedure, was related to the first procedure, and required use of the operating room. This modifier also applies to patients returned to the operating room after the initial procedure, for one or more additional procedures as a result of complications. Documentation is required when billing with this modifier.

79—Unrelated Procedure or Service by the Same Physician During the Post-op Period: Indicates that an unrelated procedure was performed by the same physician during the post-op period of the original procedure.

80—Assistant Surgeon (MD, DMD, DO): Only one first assistant may be reimbursed for a CPT code, except for open-heart surgery, where two assistants are allowed. Payment will be allowed only if an assistant surgeon is allowed by our claims editing system. The fee allowance is automatically reduced to 20% of the surgical fee allowance as billed by the primary surgeon. Refer to Surgical Assistant Guidelines 11.5.3 of the Provider Manual.

81—Minimum Assistant Surgeon (MD, DMD, DDS, DO): The allowance for modifier 81 is ten percent of the surgery CPT allowance. This modifier is used when the doctor performed minimal assistance.

82—Assistant Surgeon: This modifier is used when a qualified resident surgeon is not available. This is a rare occurrence. The fee allowance is automatically reduced to 20% of the surgical fee allowance as billed by the primary surgeon.

90—Reference (Outside) Laboratory: This modifier is used when laboratory procedures are performed by a party other than the treating or reporting physician. Allowed should fall to contracted lab fees.

91—Repeat Clinical Diagnostic Laboratory Test: This modifier is used when a provider needs to obtain additional test results to administer or perform the same test(s) on the same day and same patient. It should not be used when the test(s) are rerun due to specimen or equipment error or malfunction. Nor should this code be used when basic procedure code(s) (such as CPT 82951) indicate that a series of test results are to be obtained.

99—Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely describe a service.

Modifier AS—Non-physician Assistant (PA, RN, CRNFA, CST, CNM): The allowance for modifier AS is ten percent of the surgery CPT allowance.

JW—JW Modifier is now billable for single dose medications purchased for a specific patient when a portion must be discarded. Please note that this modifier is very specific and is not to be used for any other types of medications you may need to discard, such as expired medications or multi-dose vials.

SG—Ambulatory Surgery Center: This modifier is used when the services billed were provided at an Ambulatory Surgery Center (ASC).

SU—Procedure performed in physician's office (to denote use of facility and equipment)

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows (effective January 1, 2015):

XE—Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

XS—Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/ Structure

XP—Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

XU—Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

11.11 Place of Service Codes for Professional Claims

Listed below are place of service codes. These codes should be used on professional claims to specify the entity where services were rendered. Place of service descriptions are available on the CMS website at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf. If you would like to comment on a code or description, please email your request to posinfo@cms.hhs.gov.

Place of service code(s)	Place of service name	Facility (F) or nonfacility (NF)
01	Pharmacy	NF
02	Unassigned	
03	School	NF
04	Homeless Shelter	NF
05	Indian Health Services Free-standing Facility	NF
06	Indian Health Services Provider-based Facility	NF
07	Tribal 638 Free-standing Facility	NF
08	Tribal 638 Provider-based Facility	NF
09	Prison/Correctional Facility	NF
10	Unassigned	
11	Office	NF
12	Home	NF
13	Assisted Living Facility	NF
14	Group Home	NF
15	Mobile Unit	NF
16	Temporary Lodging	
17	Walk-in Retail Health Clinic	
18	Unassigned	
19	Off Campus-Outpatient Hospital	
20	Urgent Care Facility	NF
21	Inpatient Hospital	F
22	Outpatient Hospital	F
23	Emergency Room—Hospital	F
24	Ambulatory Surgical Center	F
25	Birthing Center	NF
26	Military Treatment Facility	F
27-30	Unassigned	
31	Skilled Nursing Facility	F
32	Nursing Facility	NF
33	Custodial Care Facility	NF
34	Hospice	F
35-40	Unassigned	
41	Ambulance—Land	F
42	Ambulance—Air or Water	F
43-48	Unassigned	
49	Independent Clinic	NF
50	Federally Qualified Health Center	NF
51	Inpatient Psychiatric Facility	F
52	Psychiatric Facility-Partial Hospitalization	F

Place of service code(s)	Place of service name	Facility (F) or nonfacility (NF)
53	Community Mental Health Center	F
54	Intermediate Care Facility/ Mentally Retarded	NF
55	Residential Substance Abuse Treatment Facility	NF
56	Psychiatric Residential Treatment Center	F
57	Nonresidential Substance Abuse Treatment Facility	NF
58-59	Unassigned	NF
60	Mass Immunization Center	
61	Comprehensive Inpatient Rehabilitation Facility	F
62	Comprehensive Outpatient Rehabilitation Facility	F
63-64	Unassigned	
65	End-Stage Renal Disease Treatment Facility	NF
66-70	Unassigned	
71	Public Health Clinic	NF
72	Rural Health Clinic	NF
73-80	Unassigned	
81	Independent Laboratory	NF
82-98	Unassigned	
99	Other Place of Service	NF

11.12 Routine Venipuncture and/or Collection of Specimens

Venipuncture or phlebotomy is the puncture of a vein with a needle or an IV catheter to withdraw blood. Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures, and is sometimes referred to as a "blood draw." The work of obtaining the specimen sample is an essential part of performing the test. Reimbursement for the venipuncture is included in the reimbursement for the lab test procedure code.

Collection of capillary blood specimen or a venous blood from an existing line or by venipuncture that does not require a physician's skill or a cutdown is considered "routine venipuncture."

Professional and Clinical Laboratory Services

Venipuncture is the most common method used to obtain blood samples for blood or serum lab procedures. The work of obtaining the specimen sample is an essential part of performing the test. Reimbursement for the venipuncture is included in the reimbursement for the lab test procedure code.

Venipuncture is only eligible to be billed once, even when multiple specimens are drawn or when multiple sites are accessed in order to obtain adequate specimen size for the desired test(s).

PacificSource does not allow separate reimbursement for venipuncture when billed in conjunction with the blood or serum lab procedure performed on the same day and billed by the same provider will be denied as a subset to the lab test procedure.

If some of the blood and/or serum lab procedures are performed by provider and others are sent to an outside lab, venipuncture is not eligible for separate reimbursement.

The use of modifier 59 with venipuncture when blood/serum lab tests are also billed is not a valid use of the modifier. The venipuncture is not a separate procedure in this situation.

PacificSource does allow separate reimbursement for venipuncture when the only other lab services billed for that date by that provider are for specimens not obtained by venipuncture (e.g., urinalysis).

Collection of a capillary blood specimen is designated as a status B code (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file. PacificSource clinical edits will deny a collection of a capillary blood specimen whether it is billed with another code or as the sole service for that date. This edit is not eligible for a modifier bypass.

Inpatient Hospital Services

A maximum of one collection fee (any procedure code) is allowed per specimen type (venous blood, arterial blood) per date of service, per CMS policy. Specimen collections out of an existing line (arterial line, CVP line, port, etc.) are not separately reimbursable.

11.13 Lab Handling Codes

The following procedure has been updated to follow PacificSource claims editing software:

Lab Handling Codes

- **36415**—Collection of venous blood by venipuncture.
  - Our claims editing system may deny as unbundled when billed with any E&M, lab or other procedure codes.
- **36416**—Collection of capillary blood specimen.
  - Our claims editing system may deny as unbundled when billed with any E&M, lab or other procedure codes.
- **99000**—Handling and/or conveyance of specimen for transfer from physician's office to a lab.*
- **99001**—Handling and/or conveyance of specimen for transfer from the patient in other than a physicians office to a laboratory.*
- **99002**—Handling, conveyance, and/or any other service in connection with implementation of an order involving devices (e.g., designing, fitting, packaging, handling, delivering, or mailing) when devices such as orthotics, protectives, or prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician.*

**These codes (99000, 99001, and 99002) will deny as unbundled when billed with an E&M code.*

11.14 Clinical Lab Services

PacificSource Health Plans follow Medicare guidelines for billing of professional, technical, and total components of laboratory tests. We will not make separate payment for the pathologist's professional services in the hospital.

PacificSource will no longer allow payment for the following laboratory procedure codes when billed with modifier 26 or TC.

80047–80076	80100–80103	80150–80299
80400–80440	80500–80502	81000–81099
82000–83018	83020–83887	83915–84163
84202–84999	85002–85055	85130–85385
85397–85557	85597–85999	86000–86063
86140–86243	86277–86318	86329–86332
86336–86480	86485–86580	86590–86849
87001–87158	87164–87206	87209–87999

Please note: These codes are subject to change based on the National Physician Fee Schedule Relative Value File updates.

11.15 Editing Software for Facility and Professional Claims

11.15.1 Professional Claims

PacificSource Health Plans has used the OPTUM 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. We apply these guidelines to both participating and nonparticipating professional providers. Edits made to claims are considered to be a provider adjustment and not billable to the member.

11.15.2 Facility Claims

Edits will be applied to both participating and nonparticipating facilities. All claims edited for correct coding will be considered to be a facility adjustment and not billable to the member.

11.15.3 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.

11.15.4 Other Generalized Edits

Age/Gender/Diagnosis/procedure specific conflicts: Age related code development is based on CPT/HCPCS/ICD-9 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.

Hospital High-Dollar Audits: PacificSource contracts with an outside vendor for our high-dollar hospital audits (claims over $20,000). Once the audit is complete, the claim will be reprocessed based on the audited amount and contracted allowance.

11.16 Vision—Routine vs. Medical

PacificSource offers routine vision benefits, including hardware, as an endorsement to Group policies. Vision endorsements contain maximum dollar benefits and time limitations. Refer to plan documents for specific benefit limitations.

The following diagnosis codes are always paid as vision benefits, never as medical:

ICD-10	Description
H5200	Hypermetropia, unspecified eye
H5201	Hypermetropia, right eye
H5202	Hypermetropia, left eye
H5203	Hypermetropia, bilateral
H521	Myopia
H5210	Myopia, unspecified eye
H5211	Myopia, right eye
H5212	Myopia, left eye
H5213	Myopia, bilateral
H52201	Unspecified astigmatism, right eye
H52202	Unspecified astigmatism, left eye
H52203	Unspecified astigmatism, bilateral
H52209	Unspecified astigmatism, unspecified eye
H52211	Irregular astigmatism, right eye
H52212	Irregular astigmatism, left eye
H52213	Irregular astigmatism, bilateral
H52219	Irregular astigmatism, unspecified eye
H52221	Regular astigmatism, right eye

ICD-10	Description
H52222	Regular astigmatism, left eye
H52223	Regular astigmatism, bilateral
H52229	Regular astigmatism, unspecified eye
H5231	Anisometropia
H5232	Aniseikonia
H524	Presbyopia
H52511	Internal ophthalmoplegia (complete) (total), right eye
H52512	Internal ophthalmoplegia (complete) (total), left eye
H52513	Internal ophthalmoplegia (complete) (total), bilateral
H52519	Internal ophthalmoplegia (complete) (total), unspecified eye
H52521	Paresis of accommodation, right eye
H52522	Paresis of accommodation, left eye
H52523	Paresis of accommodation, bilateral
H52529	Paresis of accommodation, unspecified eye
H52531	Spasm of accommodation, right eye
H52532	Spasm of accommodation, left eye
H52533	Spasm of accommodation, bilateral
H52539	Spasm of accommodation, unspecified eye
H526	Other disorders of refraction
H527	Unspecified disorder of refraction
Z0100	Encounter for examination of eyes and vision without abnormal findings
Z0101	Encounter for examination of eyes and vision with abnormal findings
Z460	Encounter for fitting and adjustment of spectacles and contact lenses

For detailed information regarding a member's vision benefits, refer to their Benefit Summary. There are many different plans (calendar year, plan year, dollar limits, rolling accumulators, etc.).

12.1 Provider Directories

PacificSource 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 physician or provider close to their location as well as narrow their search by name, specialty, plan, and other factors. Take, for example, a member looking for an allergist on his plan's panel within five miles of his office. 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.

Our goal is to make a gradual move away from the large, printed provider directories that are standard in our industry. The paper directories are expensive to produce, cumbersome to store and deliver, and out of date as soon as they are printed. With more people linking up to the Internet every day, either at home or at work, we recognize electronic communication as an important tool to reach our members and providers. Our website and electronic provider directory are just the beginning of this change.

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

12.2 Newsletters

The PacificSource Health Plans Provider Bulletin (formerly ProviderSource) is produced quarterly and mailed to all PacificSource participating physicians and providers. The Provider Bulletin provides general information of interest to physicians and providers.

In addition, we produce a Dental Bulletin biannually, which is mailed to providers who participate in the Advantage Dental Network. The Dental Bulletin provides general information of interest to dental providers.

12.3 Website

12.3.1 PacificSource.com

The address of the PacificSource website is PacificSource.com. This site is a convenient way to contact PacificSource 24 hours a day, 7 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 providers
- InTouch for Providers, one of our most popular online tools (see section 12.3.2 below for more details)
- Information about imaging and electronic claims technology
- Archived issues of the Provider Bulletin and Dental Bulletin newsletters
- A list of services requiring preauthorization
- From the Home page, providers and PacificSource members can access the electronic Participating Provider Directory, which is updated nightly. 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 InTouch for Providers

PacificSource InTouch for Providers is a providers-only area of our website. By logging in 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.
- View member benefits.
- Check to see if a proposed medical treatment has been preauthorized by PacificSource.
- See if a managed care referral has been submitted for a member.
- Find a patient's claim in our system by Member ID.
- Select an EOP date and get a detailed listing of all claims for your office that were processed on that date.
- Submit referrals and authorizations.
- Submit pharmacy prior authorization requests.
- Submit electronic funds transfers (EFTs) and 835 ERA enrollment forms.
- Use Point of Service Direct to access real-time, accurate, patient liability information and your actual charges for each procedure billed during a visit.
- Submit claims.

Registering for InTouch:

For your convenience, InTouch is available through the Web portal OneHealthPort. If you are already a registered user of OneHealthPort, you do not need to register to access InTouch.

If you are new to InTouch and OneHealthPort, you will need to register with OneHealthPort in order to access InTouch. Information about this process is available by selecting the Registration Information link under the Provider heading of our InTouch login area on any page of our website, 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 members also have access to InTouch for Members, where they can look up claims information, track medical expenses, select a new PCP, and more.

12.4 Second Language Material

PacificSource provides service to many Spanish-speaking customers who are not fluent in the English Language. As a further service to these customers, we employ several staff members who speak or read Spanish. Two of these staff members are native Spanish speakers who are fluent in both the spoken and written language. These staff members are available to converse with Spanish speaking customers about their coverage and eligibility. We also have employees who speak Japanese and German.

PacificSource has a contract with organizations, Certified Languages International and Passport to Languages, to provide interpretation services to PacificSource member(s) or perspective member(s). Interpretation services can be done in person, by appointment, or by telephone. These services also include sign language services.

Interpretation or translation services provided at a provider's location are the responsibility of the provider.