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Please note this information is important and to be used to help you become more familiar with Passport Health Plan. However, this doesn't replace the Provider Manual. The Provider Manual is available on our website and is an extension of your contract with Passport Health Plan.

PROVIDER Kit

support. information. communications.

Welcome to the Passport Health Plan Provider Network

As Vice President and Chief Medical Officer of Passport Health Plan (Passport), I want to take this opportunity to welcome you to our team.

We have created this Provider Kit to help familiarize you with Passport. In this Kit, you will find information about many Passport programs, including Maternity Care Management, Early Periodic Screening Diagnosis and Treatment (EPSDT), and Care Management Programs, along with other information to assist you in caring for Passport members.

Communication is key to good provider relations, and we strive to keep our providers up-to-date with changes that may affect you. Many of these changes are communicated to you through our provider communications.

I also encourage you to access the Provider Center of our web site, **www.passporthealthplan.com**, where you may subscribe to Provider eNews, access recent and archived provider communications, obtain details of our programs and services, and find links to important resources and forms.

Passport has a long history of incorporating input from our providers into our quality improvement, medical management and Utilization Management programs. We have accomplished this through a number of vehicles and one of our most important ones is our committee structure. Please consider joining one of our medical committees to further strengthen Passport Health Plan's programs. We encourage participation from a wide range of providers and there are many avenues for you to provide input. The Quality Medical Management, Pharmacy & Therapeutics Advisory, Women's Health, Credentialing, and Behavioral Health Advisory committees (more information regarding involvement in these committees is enclosed). If you would like to learn more about these committees, or would like to join one, please contact me at (502) 585-8369, and I will be happy to discuss our committee process with you.

If you have any other questions about Passport, please do not hesitate to contact Provider Services, (800) 578-0775. We hope your involvement with Passport will be a long and pleasant one. We look forward to working with you to improve the health and quality of life of our members.

Sincerely,

Stephen J. Houghland, M.D.
Vice President and Chief Medical Officer

All About Benefits

SUMMARY OF BENEFITS FOR PASSPORT MEMBERS

Basic services covered under Passport include, but are not limited to:

- Ambulatory surgical center services.
- Behavioral health services and substance abuse.
- Chiropractic services.
- Community Mental Health Center Services.
- Dental services, including oral surgery, orthodontics, and prosthodontics.
- Durable medical equipment (DME), including prosthetic and orthotic devices and disposable medical supplies.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services.
- End stage renal dialysis services.
- Family planning clinic services in accordance with federal and state law and judicial opinion.
- Hearing services, including hearing aids for members younger than age 21.
- Home health services/ private duty nursing.
- Hospice services.
- Independent laboratory services.
- Inpatient hospital services.
- Inpatient mental health and substance abuse.
- Meals and lodging for appropriate escort of members.
- Medical detoxification as defined in 902 KAR 20:111.
- Medical services, including those provided by physicians, advanced practice registered nurses, physician assistants and Federally Qualified Health Centers (FQHC), primary care centers and rural health clinics (RHC).
- Organ transplant services not considered investigational by the FDA.
- Other laboratory and x-ray services.
- Outpatient hospital services.
- Outpatient mental health services.
- Pharmacy and limited over-the-counter drugs.
- Podiatry services.
- Preventive health services, including those currently provided in public health departments, FQHCs/primary care centers, and rural health clinics.
- Psychiatric Residential Treatment facilities.
- Specialized case management for members with complex chronic illness.
- Specialized children's service clinics.
- Therapeutic evaluation and treatment, including physical therapy, speech therapy, and occupational therapy.
- Transportation to covered services, including emergency and nonemergency ambulance and other stretcher services.
- Urgent and emergency care services.
- Vision care, including vision examinations, services of opticians, optometrists and ophthalmologists, including eyeglasses for members younger than age 21.

Please remember some services/benefits may require a copay or prior authorization.

COST SHARING

Effective January 1, 2019 members may be required to pay a copay for certain services. The Passport Provider Portal will indicate if a member is copay-required. Please check eligibility prior to the member's visit and collect applicable copays as copays will be deducted from provider claim reimbursement. Please note preventative services DO NOT require a copay.

Service or Item	Copayment Amount
Brand Name Drug	$4.00
Generic Drug	$1.00
Brand Name Drug Preferred over Generic	$1.00
Chiropractor	$3.00
Dental	$3.00
Podiatry	$3.00
Optometry	$3.00
General Ophthalmological Services	$3.00
Office visit for care by a physician, physician assistant, APRN, nurse practitioner, nurse midwife or any behavioral health professional	$3.00
Physician Services	$3.00
Visit to RHC, FQHC or Primary Care Center	$3.00
Outpatient hospital service	$4.00
Non-emergent ER visit	$8.00
Inpatient Hospital Admission	$50.00
Physical, Speech, Occupational Therapy	$3.00
DME	$4.00
Ambulatory Surgical Center	$4.00
Laboratory, Diagnostic or x-ray Service	$3.00

For more information about copays please visit www.passporthealthplan.com under the Provider tab and choose 'Member Copays'.

UTILIZATION MANAGEMENT

The Utilization Management (UM) department helps to assure prompt delivery of medically-appropriate health care services to Passport members and subsequently monitors the quality of care.

All participating providers are required to obtain prior authorization from Passport's UM department for inpatient services and specified outpatient services. **Members must be held harmless for denied services.**

To determine which services require prior authorization, please refer to the UM section of our Provider Manual, available on our web site at **www.passporthealthplan.com/provider**. (More information regarding Identifi, Passport's online authorization system, may be found under "Electronic Services" online.)

To determine if a service or supply is considered a benefit exclusion, please contact Provider Services at 1-800-578-0775.

The UM department is available:

Monday & Friday 8:00 am – 6:00pm EST

Tuesday, Wednesday, Thursday 8:00 am – 5:30pm EST

Saturday Urgent Requests 8:00 am – 5:30pm EST

Federal holidays 8:00 am – 5:30pm EST

Department	Phone Number	Fax Number
General Number	(800) 578-0636	(502) 585-7989
Concurrent Review	(502) 585-2077	(502) 213-8997
Retrospective Review	(502) 585-7972	(502) 585-8207
Home Health	(502) 585-7320	(502) 585-8204
DME	(502) 585-7310	(502) 585-7990
Cardiology/Oncology Authorizations (New Century Health)	1(888) 999-7713	https://my.newcenturyhealth.com
Cosmetics	(502) 585-7069	(502) 213-8998
Appeals	(502) 585-7307	(502) 585-8461
High Dollar Radiology (eviCore)	1(888) 693-3211	(888) 693-3210 www.evicore.com

*After hours voicemail is available

Passport invites you to discuss a decision with one of our Medical Directors. To ask questions about a utilization management issue, or to seek information from the nurse reviewer about the UM process and the authorization of care, you can call UM at (800) 578-0636.

PRESCRIPTION MEDICATIONS AND PRIOR AUTHORIZATION

Any health care provider licensed to prescribe medications in the Commonwealth of Kentucky may write a prescription for a Passport Health Plan (PHP) member provided it is within the scope of the provider's medical licensure and the prescriber has a valid, current Kentucky Medicaid license number. The provider's National Provider Identifier (NPI) and Medicaid number must appear on the prescription presented to the member for the prescription to be filled. Pharmacies must include the prescriber's NPI when submitting all

prescriptions for coverage.

Providers are encouraged to use PHP's Preferred Drug List (please see Cost Sharing below). The preferred drug list is updated regularly and can be found on Passport's website www.passporthealthplan.com/pharmacy.

2019 Cost Sharing Requirements
$4 Brand name drugs $1 Generic drugs $1 Preferred drug over non-preferred
Members who meet any of the following conditions do not have a copayment requirement unless they receive a non-preferred medication. • Members 18 years of age and under (depending on category of aid) • Pregnant members • Institutionalized members • American Indians receiving services directly by an American Indian health care provider or through referral under contract health services. • Members in hospice care

e-Prescribing

Benefits of e-prescribing

E-prescribing will allow you to create and send prescriptions online, which will:

- Improve patient safety and quality of care.
- Provide access to your patients' medication history information.
- Reduce time on phone calls to and from pharmacies.
- Increase patient convenience and medication compliance.
- Identify which medications are on the formulary and encourage use of generic medications or lower costing therapeutically equivalent medications.

Provider Action Needed

The formulary file will be refreshed monthly. For most current formulary information, please visit the online searchable formulary at

http://passporthealthplan.com/pharmacy/#drugformulary

When is a Prior Authorization (PA) Required?

PA is necessary for some medications to establish medical necessity and to ensure eligibility for coverage per State and/or Federal regulations. This may be due to specific Food and Drug Administration (FDA) indications, the potential for misuse or overuse, safety limitations, or cost-benefit justifications.

PA is required for medications that are:

- outside the recommended age, dose or gender limits;
- non-preferred (potential for "step therapy[1]" before approval);
- a duplication in therapy (i.e. another drug currently used within the same class);
- new to the market and not yet reviewed by Passport's Pharmacy & Therapeutics Advisory (P&T) Committee;

- prescribed for off-label use or outside of certain diseases or specialties; or
- prescribed with an approved ICD-10 code when required.

How to Submit and Receive Notification on a PA

STEP 1: Determine if the drug requires PA.
For the PA status of specific covered medications, please refer to our online searchable formulary by visiting www.passporthealthplan.com/pharmacy.

STEP 2: Complete the PA form in its entirety.
The Passport Prior Authorization Form is available at www.passporthealthplan.com/pharmacy/prior-authorizations. A physician, nurse practitioner, or pharmacist may complete this form.

STEP 3: Submit the completed form for review to (800) 229-3928 or complete the online submission form through the Pharmacy portal at www.passporthealthplan.com/pharmacy. If the request is for hospital discharge, check the box on the Universal General Pharmacy PA.

[1] Step therapy is defined as a trial of the safest and/or most cost-effective therapy prior to progressing to other, more costly or recently-approved therapies (i.e. "step protocol").

What Happens During the PA Review Process:

1st review: A pharmacy technician compares all information on the request to Passport's clinical authorization criteria. Passport uses medical criteria developed in collaboration with our Pharmacy Benefits Manager (PBM), the P&T Committee, and the Quality Medical Management Committee. Criteria are derived from one or more of the following:

- Published Food and Drug Administration approval indications for therapy;
- Federal and/or State regulatory requirements;
- Drug compendia such as American Hospital Formulary Service - Drug Information (AHFS-DI), Drugdex or "Facts and Comparisons;"
- Evidence-based guidelines provided by non-biased resources from government agencies, such as the Agency for Healthcare Review and Quality (AHRQ), the American Society of Clinical Oncologists (ASCO), or the American Academy of Pediatrics (AAP); and/or
- Current medical literature and peer-reviewed, non-biased publications, based on appropriate scientifically-designed study protocol with validated outcome endpoints.

2nd review: If the request does not meet the clinical authorization criteria, it is forwarded to a registered pharmacist. Additional information may be requested via fax or telephone from the prescribing provider.

3rd review: If the pharmacist cannot approve the request, the request is forwarded electronically to a Medical Director for a decision.

STEP 4: Receive the response.

You may expect a response within 24 hours after submission.

Your office must have the area code programmed into your fax machine with a Called Subscriber Identification (CSID) number in order to receive fax confirmation of a PA receipt.

**Timeframes are developed in accordance with requirements established by the Kentucky*

Department for Medicaid Services (DMS) and are subject to change. Incomplete or unclear information on the form may delay processing of a PA.

How Providers Are Notified of PA Decisions

A fax will be sent to the requesting provider's submitted fax number with one of the following PA decisions.

Approved	The PA request has been approved for pharmacy reimbursement. Based on the medication and if requested by the prescriber, approvals may be granted for up to twelve (12) months.
Partial Denial	Reimbursement has been approved for a therapeutic alternative or for a different dose than requested.
Deferral	The final PA action was not decided due to the need for additional information. Providers must fax the requested information back to the PBM in order to obtain a final PA decision.
Denial	The PA request was denied. **All PA denials are issued by a licensed physician**. These decisions may be appealed.

Denial rationale is included on every PA denial fax, and, whenever possible, with a recommendation for an alternate preferred medication. However, denials for medications not indicated for clinical use may not include medication alternatives.

THE PASSPORT HEALTH PLAN LOCK-IN PROGRAM

In compliance with DMS regulation 907 KAR 1:677, Passport Health Plan has implemented a Lock-In program. Passport's Lock-In program is designed to encourage better health behaviors, increase personal responsibility in health care, and ensure medical and pharmacy benefits are received at an appropriate frequency and setting, and are medically necessary.

Members must meet the following criteria in two consecutive 6-month periods in order to be placed in either Lock-In program.

Pharmacy Lock-In Criteria:
- Received services from at least five (5) different providers
- Received at least ten (10) different prescription drugs, and
- Received prescriptions from three (3) or more pharmacies

Emergency Room (ER) Lock-In Criteria:
- Four (4) ER visits for a non-emergent diagnosis, or
- Receive services from at least three (3) different hospital emergency departments for a non-emergent diagnosis

Under the Lock-In Program, a member's medical and pharmacy claims history and diagnoses are reviewed for possible over-utilization. Members who meet the Pharmacy Lock-In ER criteria will be locked-in to a specific pharmacy location and controlled substance prescriber. Members who meet the ER criteria will be locked-in to a specific hospital for non-emergency services.

All designated providers (i.e. PCPs, controlled substance prescribers, hospitals and

pharmacies) will receive written notice of the member's lock-in status. All members have the right to appeal.

Initially, a member will be locked-in for a minimum of 24 months. At least annually, members will be reviewed to determine whether to maintain their lock-in status for another 12 month period, or be removed.

Questions?
For general questions regarding the Pharmacy Lock-In program, please contact our Pharmacy Coordinator at (502) 585-7930. For general questions regarding the ER Lock-In program, please contact our ER Lock-In Coordinators at (502) 588-8564

ADDITIONAL INFORMATION

How Do I Check the Status of My Request?
To check on the status of your request, please call CVS, 24 hours, 7 days a week, from 8:30 a.m. to 9:00 p.m. at: (888) 512-8935

Can Members Receive an Emergency Supply Without a PA?
The PA department is not available at all times. Pharmacists may process an emergency supply if, in their clinical judgment, it is in the best interest of the member.

The maximum quantity to be dispensed is a **3-day supply.** This does not apply to narcotic agents or drugs excluded from coverage by state and federal regulations.

How Often Does the Formulary Change?
The Passport online searchable formulary is typically updated each quarter. A downloadable PDF is updated annually.

How Do I Request Additions/Deletions to the Passport Health Plan Formulary?
To request additions or deletions to the PHP Preferred Drug List, visit www.passporthealthplan.com/pharmacy to download the "Request for Drug Review" form. Mail the form to our Pharmacy department to have an addition or deletion considered by our P&T Committee. Requests from pharmaceutical manufacturers will not be accepted.

URGENT CARE SERVICES

Urgent care is covered in an urgent care center, PCP office, or other ambulatory setting. Urgent means care for a condition not likely to cause death or lasting harm, but for which treatment should not wait for a normally scheduled appointment. Members are advised to contact their PCP before seeking medical treatment elsewhere.

PCP Responsibilities
If the member calls prior to going to the urgent care center and care can be administered in the PCP's office, it is the PCP's responsibility to see the member in accordance with Passport access guidelines.

Rights & Responsibilities

MEMBER RIGHTS & RESPONSIBILITIES

Members are informed of their rights and responsibilities through the Member Handbook. Passport Health Plan providers are also expected to respect and honor members' rights.

Passport members have the following rights:

- Be treated with respect and dignity. You have the right to privacy and to not be discriminated against.
- Choose a primary care provider (PCP) and request a change to another PCP.
- Join your providers in making decisions about your health care. You may discuss treatment options, regardless of cost or benefit coverage. You may also refuse treatment.
- Ask questions and receive complete information about your medical condition and treatment options. This may include specialty care.
- Voice grievances (within 30 days) or file an appeal about Passport decisions that affect you. If you do not agree with Passport's appeal decision, you may file a state hearing with DMS.
- Receive timely access to care that does not have any communication or physical barriers.
- Make an advance directive, like a living will.
- Look at and get a free copy of your medical records, as permitted by law.
- Receive timely referrals and access to medically needed specialty care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Receive information about Passport, benefits, services, providers and your rights and responsibilities.
- Make suggestions about your rights and responsibilities.
- Native American members may get services from I/T/U providers (Indian Health Services, Tribally operated facility/program, and Urban Indian clinics) signed up with Passport.

Passport members have the following responsibilities:

- Learn about your rights.
- Follow the policies and procedures of the DMS and Passport.
- Learn about health services and treatment options.
- Take part in personal health care decisions and practice a healthy lifestyle.
- Keep appointments with providers and call to cancel appointments when you cannot be there.
- Provide, to the best of your ability, information that your providers need to give you care.
- Learn about your health problems and follow the orders and care plans that you and your providers have agreed upon.
- Tell us if you suspect fraud or misuse of Passport ID cards or benefits by a member or provider. To report fraud or misuse, please call Passport's Compliance Hotline at 1-855-512-8500 or the Office of the Inspector General (OIG) at 1-800-372-2970.

PROVIDER RESPONSIBILITIES

Provider Access & Availability

PCPs are required to provide coverage for Passport members 24 hours a day, seven days

a week. Practitioner's hours of operation are not less for Medicaid patients than for non-Medicaid patients. When a PCP is unavailable to provide services, the PCP must ensure that he or she has coverage from another participating provider. Hospital emergency rooms or urgent care centers are not substitutes for coverage from another participating provider. Participating providers can consult the Passport Provider Directory, or contact Provider Services at (800) 578-0775 with questions regarding which providers participate in the Passport network.

After Hours Coverage

A PCP's office telephone must be answered in a way that the member can reach the PCP or another medical practitioner whom the practitioner has designated. Their telephone must be:

- Answered by an answering service that can contact the PCP or another designated medical practitioner who can return the call within a maximum of 30 minutes; OR
- Answered by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the practitioner has designated to return the call within a maximum of 30 minutes; OR
- Transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner who will return the call within a maximum of 30 minutes.

Appointment Standards

Routine/preventative appointments with PCPs and specialists must be scheduled within 30 days for routine care and preventive care visits.

Other appointment standards are as follows:

- Appointments for urgent care services must be scheduled within 48 hours.
- Appointments for emergency care must be immediately provided.
- Pregnant women in their first trimester are to be provided preventive care visits within 14 days of request.
- Pregnant women in their second trimester are to be provided preventive care visits within seven days of request.
- Pregnant women in their third trimester are to be provided preventive care visits within three days of request.
- Appointments for laboratory and radiology services must be scheduled within 30 days for routine care and 48 hours for urgent care.

Referrals

Passport's referral requirements are based on the premise that our members are best served with a primary home for care and oversight, thus the PCP is responsible for coordinating the member's health care. If the member needs to see a specialist, the PCP is required to issue a referral to the specialist, with the exception of direct access services.

PCP referrals can only be made to participating specialists, unless the necessary service is not available from participating Passport practitioners. Prior approval by Utilization Management is not required for referrals to participating providers. For referrals to a nonparticipating specialist, the PCP must request prior authorization from Passport's Utilization Management department. The PCP should verify that the specialist accepts Kentucky Medicaid.

Passport no longer requires the Passport referral form; however, PCP's are still required to

issue a referral to a specialist by way of EMR, fax, phone or other means of communication. Specialists must have this documented within the member's chart. Referrals are reported to Passport via box 17 of the claim form.

Direct Access Services do not require a referral from the member's PCP. For more information on direct access services please refer to section 6.1 of the Provider Manual.

Direct access services include:

- Commission for Children with Special Health Care Needs
- WINGS Clinic
- Vision care services, including diabetic retinal exams
- Dental care services
- OB/GYN services
- Orthopedic services
- Pap smears and mammograms
- Immunizations for members younger than 21 years
- Chiropractic services
- Perinatologists/geneticists
- Specialists – for the following members only:
  - Children living in out-of-home placements.
  - Injury or trauma for certain procedure codes (available in the Passport Health Plan Provider Manual)
  - Members with Original Medicare

Referrals to non-participating providers always require prior authorization from Utilization Management.

Office Standards

- Providers must not differentiate or discriminate in the treatment of any member because of the member's race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.
- The office waiting times should not exceed 45 minutes.
- Members should be scheduled at the rate of six or less per hour.
- Health assessments/general physicals should be scheduled within 30 days.
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens for any new enrollee younger than 21 years of age should be scheduled within 30 days of enrollment, unless the child is already under the care of a PCP and the child is current with screens and immunizations.
- EPSDT screens for any new enrollee younger than two years of age should be scheduled within an appropriate time frame so that the child is not out of compliance with any required screenings.
- PCP should have a "no show" follow-up policy. For example, the PCP or specialist might send two notices of missed appointments to the member, followed up by a telephone call to the member. Any actions for missed appointments should be documented in the member's medical record.
- Provider Relations must be notified of all PCP planned and unplanned absences of more than four days from the practice.
- Member medical records must be maintained in an area that is not accessible to persons not employed by the practice. When releasing a member's medical record to another practice or provider, providers are required to first obtain written consent from the member.
- Any provider's office administering care that may have an adverse effect must obtain the

member's signature on a form that describes the treatment and includes the medical indication and the possible adverse effects.
- Providers must complete specific treatment consent forms, such as hospice, sterilization, hysterectomy, or abortion required by State and Federal regulations and laws.

Advance Directives

Living will, living will directive, advance directive, and directive are all terms used to describe a document that provides directions regarding health care to be provided to the person executing the document. In Kentucky, advance directives are governed by the Kentucky Living Will Directive Act codified in KRS 311.621 to 311.643, and as otherwise defined in 42CFR 489.100.

A member who is 18 years of age or older and who is of sound mind may make a written living directive that does any or all of the following:
- Directs the withholding or withdrawal of life-prolonging treatment.
- Directs the withholding or withdrawal of artificially provided nutrition or hydration.
- Designates one or more adults as a surrogate or successor surrogate to make health care decisions on his or her behalf.
- Directs the giving of all or any part of his or her body upon death for any of the following reasons: medical or dental education, research, advancement of medical or dental science, therapy, or transplantation.

A living will form is included in KRS 311.625. Advance directives may be revoked in writing, by an oral statement, or by tearing up the written living will. The revocation is effective immediately.

In addition to reviewing the Kentucky Living Will Directives Act, providers should:
- On the first visit, as well as during routine office visits when appropriate, discuss the member's wishes regarding advance directives for care and treatment;
- Document in the member's medical record the discussion and whether the member has executed an advance directive;
- If asked, provide the member with information about advance directives;
- Upon receipt of an advance directive from the member, file the advance directive in the member's record;
- Not discriminate against a member because he or she has or has not executed an advance directive; and,
- Communicate to the member if the provider has any conscientious objections to the advance directive as indicated above.

Fraud and Abuse

The Federal False Claims Act and the Federal Administrative Remedies for False Claims and Statements Act are specifically incorporated into §6032 of the Deficit Reduction Act. These Acts outline the civil penalties and damages against anyone who knowingly submits, causes the submission, or presents a false claim to any U.S. employee or agency for payment or approval. U. S. agency in this regard means any reimbursement made under Medicare or Medicaid and includes Passport. The False Claims Act prohibits anyone from knowingly making or using a false record or statement to obtain approval of a claim.

Knowingly is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but situations in which the person acts with his eyes shut, in deliberate ignorance of the truth or falsity of the claim, or in reckless disregard of the truth or falsity. The following are some examples of billing and coding issues that can constitute false

claims and high-risk areas under this Act.

- Billing for services not rendered;
- Billing for services that are not medically necessary;
- Billing for services that are not documented;
- Upcoding; and,
- Participation in kickbacks.

Penalties (in addition to amount of damages) may range from $5,000 to $10,000 per false claim, plus three times the amount of money the government is defrauded. In addition to monetary penalties, the provider may be excluded from participation in the Medicaid or Medicare program.

Providers are also required to cooperate with the investigation of suspected Fraud and Abuse. Please provide all requested medical records within 10 business days (as outlined in your provider manual). If you suspect Fraud and Abuse by a Passport member or provider, it is your responsibility to report this immediately by calling one of the telephone numbers listed below:

Passport's Fraud and Abuse Hotline:	(855) 512-8500
KyHealth Choices Medicaid Fraud Hotline:	(800) 372-2970
Passport Health Plan Compliance Department:	(502) 585-8439

Medical-Record-Keeping and Continuity and Coordination of Care Standards

Passport has adopted medical-record-keeping standards, which cover confidentiality, organization, documentation, access, and availability of records. These standards are determined by the National Committee for Quality Assurance (NCQA) and DMS and may be revised as needed to conform to new NCQA or DMS recommendations. Compliance with these standards will be audited by periodic on-site review of practitioners' offices and chart samplings. Practitioners must achieve an average score of 80% or higher on the medical records review. Passport will monitor practitioner's scoring less than 80% through corrective action plans and re-evaluation. For more detailed information regarding our medical-record-keeping standards, please refer to section 4.5 of the Provider Manual.

Provider Resources

ELECTRONIC SERVICES

Real-Time Eligibility

Providers may check eligibility status using any of the following methods:

1. **Ky Health Net System:** Use the State's website to verify eligibility for all four (4) managed care organizations (MCOs) – including Passport – in one central location. Using your Medicaid ID (MAID) number, you may log directly onto this system at https://sso.kymmis.com, or find more information at www.kymmis.com.

2. **Passport Provider Portal:** The Passport Provider Portal offers Passport providers an additional option for accessing member, Plan, administrative information and services such as eligibility inquiries, information on patient third party liability (TPL) and claims status inquiries and reconsideration requests. You can access the portal at https://phkyportal.valence.care/

3. **Real-Time:** depending on your clearinghouse or practice management system, real-time eligibility and claims status information is available to participating providers. Contact your clearinghouse to access:
   - InstaMed Products for member eligibility and claims status transactions.
   - Zirmed Products for member eligibility transactions.
   - All other clearinghouses - ask your clearinghouse to access transactions through Emdeon.

Care Gaps, Immunizations and Screens Due Reports

These tools provide great opportunities for improving both the quality and continuity of care of our members. For additional information or to obtain reports, please contact your Provider Relations Specialists.

If you have questions about the medical information contained within these reports or if you would like to discuss coordination of care for a member, please contact our Care Connectors team at (877) 903-0082.

ONLINE RESOURCES FOR PROVIDERS

Online Searchable Formularies

The Passport formulary is available online in a searchable format that:
- Allows searches via brand name, generic name, or therapeutic class;
- Denotes prior authorization requirements and offers access to authorization criteria (including but not limited to step therapy requirements);
- Displays the class and quantity limits (if applicable) for each medication; and,
- Exhibits all medications within the same class.

We encourage providers and their staff to access this user-friendly searchable formulary by visiting www.passporthealthplan.com/pharmacy.

Passport's Provider eNews

Passport eNews is the free e-mail service for Passport Health Plan providers. It allows you to:

- **Be the first to get important information.**
  - Get the information you want at the speed you need.
- **Get only the most important news.**
  - Claims and Reimbursement.
  - Policy Changes/Updates.
  - State and Federal Laws Affecting Medicaid Providers.
- **Find information easily.**
  - No more accidentally misplaced or discarded paper communications.
- **Keep information electronically for your records.**
  - No more paper files.

As a provider-sponsored plan, we value your time and are committed to sending you only important information. You will never receive non-healthcare-related or spam e-mails from Passport.

Signing up is easy! In just a few moments you can send us your information. Visit www.passporthealthplan.com/provider and click "Provider eNews."

Provider Directories, Manuals and Training Materials

Provider Directories

Providers and office staff may access our Passport Provider Directories online at www.passporthealthplan.com. These real-time provider directories allow providers and members easy access to practitioner and facility information using several search functions.

Provider Manuals

The *Provider Manual* is an extension of your contract with Passport Health Plan.

The *Provider Manual* is available in a convenient electronic format on our web site, www.passporthealthplan.com/provider. Providers may choose to view each section individually, or they may perform a search of the manual in its entirety.

Provider Online Training and Resources Include:

- Claims Forms & Instructions;
- Clinical Practice Guidelines
- Credentialing Quick Reference Guide
- HEDIS 101
- Passport Provider Portal User Guide
- EPSDT
- Training Webinars
- Provider Network Forms

CULTURAL AND LINGUISTICS PROGRAM

Title VI Compliance is Federal Law
Title VI of the Civil Rights Act of 1964 is Federal legislation that requires any organization receiving direct or indirect Federal financial assistance to provide services to all beneficiaries without exclusion based on race, color, or national origin.

What is required by Federal law?
All Passport providers indirectly benefit from Federal financial assistance (via Medicaid and Medicare). Therefore, under Title VI of the Civil Rights Act of 1964 and the Culturally and Linguistically Appropriate Services (CLAS) Standards, as outlined by the Office of Minority Health, U.S. Department of Health and Human Services (DHHS), **all providers are required by law to:**

- Provide written and oral language assistance at no cost to all patients regardless of health insurance type with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. This includes the provision of competent language interpreters, upon request.
- Provide patients verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read patient signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient information forms and treatment consent forms, must be made available, wherever possible, in other languages and formats.
- Provide effective, understandable, and respectful care to all patients in a manner compatible with the patient's cultural health beliefs and practices of preferred language/ format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide interpretive services for patients upon request.
- Routinely document preferred language or format, such as Braille, audio, or large type, in all patient medical records.

Note: The assistance of friends or family is not considered competent, quality interpretation. Friends or family should not be used for interpretation services except where a patient has been made aware of his/her right to receive free interpretation and continues to insist on using a friend or family member for assistance. For more information, please see the section below, "Why not allow friends and family to interpret?"

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA).

The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

Why Not Allow Friends and Family to Interpret?
The use of friends and family members to assist with interpretation may have a negative impact on care. Consider the following potential results and how they may impact your practice and the care you provide:

- Breach of confidentiality.
- Reluctance of the patient to reveal personal information, even information critical to his/her health.
- Incompetent interpretation due to lack of familiarity with medical terminology.
- Miscommunication during medical decision-making or follow-up instructions.

Patients may decline the use of a qualified interpreter, but they must sign a waiver in their preferred language or use a phone-interpreter to record their decline of qualified interpreter services.

Bilingual Staff
The use of bilingual staff can help carry out important Title VI functions (such as staffing an information desk) – but using unqualified employees who are not trained as interpreters is not advisable due to HIPAA regulations and serious health and life threatening consequences.

Qualified interpreters are people who have been tested to determine their level of proficiency in English, their native languages, and their ability to explain pertinent benefits and services. They have also been trained on confidentiality including HIPAA and how to convey messages without adding or removing words or phrases. To determine if your staff is qualified to provide medical interpretation, please see the Office of Minority Health's web site at http://minorityhealth.hhs.gov.

Passport Offers Training and Resources.
Yes, we offer both! To schedule an onsite training, contact Passport's Health Equity Program at (502) 585-8251, e-mail cals@passporthealthplan.com. More information and resources are available online at www.passporthealthplan.com/provider.

- **Onsite Trainings/Resources**
  Our staff is a resource for Title VI/CLAS Standards and assists providers in reaching and maintaining compliance. We offer free trainings for your office staff.

- **Provider Office Materials**
  In addition to our Provider Toolkit and other educational resources, we also offer provider office signage to assist your office staff in complying with Title VI. These materials are available online or by calling the Health Equity Program.

- **Translated Member Materials and TDD/TYY Lines**
  Many member materials, including the Passport Member Handbook, are available in other languages and alternative formats such as Braille, audio, and large type. Members may download these on our web site or call Member Services for copies.

  Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf (TDD), the Plan's TDD/TYY Member Services number is: (800) 691-5566.

- **Discounts for Telephonic and Video Interpretation**
  Passport also contracts with a telephonic and video interpretation vendor, InterpreTalk by Language Services Associates (LSA), to offer our providers a discounted rate. To set up an account and receive InterpreTalk services, please call (800) 305-9673 and select the option 7 for Client Services. It may take 24 to 48 hours to set up your InterpreTalk account so you may begin receiving interpretive services.

Are There Legal Consequences for Non-Compliance?
Yes. The Office for Civil Rights (OCR) enforces anti-discrimination laws. All patients have the right to file complaints if they believe they have been discriminated against.

Patient complaints are evaluated individually by the OCR and may receive further investigation where certain criteria are met (i.e. sufficient information, appropriate jurisdiction, etc.). Patients also have the right to file suit in Federal court, regardless of the OCR's findings.

Penalties of Non-Compliance with Title VI May Include:
- Loss of federal and state funding, including future funding (i.e. you may be prohibited from participating in Medicaid, Medicare, and/or incentive programs such as the Electronic Health Records incentive).
- Legal action against you from the DHHS, legal service organizations, and private individuals.
- "Informed consent" issues which may also lead to medical malpractice charges.

Questions?
For questions about our Health Equity Program, please contact us at (502) 585-8251 or e-mail cals@passporthealthplan.com.

Billing and Reimbursement

PAPER AND ELECTRONIC CLAIM SUBMISSION

Submitting Paper Claims
Paper claims may be submitted on the CMS-1500 or UB-04 forms, or successor forms, to:

Passport Health Plan
P.O. Box 7114
London, KY 40742

Passport encourages all providers to submit claims electronically.

Submitting Electronic Claims
Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports industry efforts to reduce administrative costs.

Benefits of electronic billing include:

- **Reduction of overhead and administrative costs.** EDI eliminates the need for paper claim submission. It has also been proven to reduce claim rework (adjustments).
- **Receipt of reports as proof-of-claim receipt.** This makes it easier to track the status of claims.
- **Shorter transaction time**. An EDI claim averages 24 to 48 hours from the time it is sent to the time it is received.
- **Validation of elements on the claim form.** At the point the claim is transmitted electronically the information needed for processing is present.
- **Faster adjudication.** Claims not requiring additional investigation are processed more quickly.

Many different products may be used to submit claims electronically – you must simply have the capability to send EDI claims to Change Healthcare, either through direct submission or through another clearinghouse/vendor.

If you are interested in submitting claims electronically and do not already have an EDI software vendor, you may choose to:

- Contact Change Healthcare at (866) 817-3813 OR via their website at www.changehealthcare.com
  OR
- Contract with another EDI clearinghouse or vendor

Passport's EDI payer ID is 61325 for submitting claims electronically.

Timely Filing

Initial Submission (clean claim)	Resubmissions/Corrections
180 days from the date of service	2 years from last process date

It is important to indicate corrected claims as such. Corrected claims submitted via paper must be clearly marked corrected. Electronic corrected claims should be submitted with the corrected claim indicator and the original claim number that is being corrected. Please refer to section 15.6 of the provider manual for more information.

Electronic Remittance Advice (ERA/835)

Passport offers providers an Electronic Remittance Advice (ERA) option. If you are interested in receiving an 835 transaction from Passport, you must register with InstaMed by contacting them at (866) 945-7990.

Submitting Third Party Liability Information Electronically

Passport electronic claim submission (837I and 837P) now includes the capability to accept and process secondary claims electronically.

To submit provider-to-payer coordination of benefits (COB) claims via EDI, you must have a system, data entry process, or clearinghouse able to:

- **Create or forward claims directly to EDI in:**
  - » The HIPAA 837 format; or,
  - » A format containing equivalent information.

-AND-

- **Process payment information by:**
  - » Receiving a HIPAA-standard electronic remittance advice (ERA) format from the previous payer; or,
  - » Coding a paper remittance into the electronic claim.

To view technical specifications and guidance for submitting secondary claims via EDI, please visit the "Forms & Claims Information" section under the provider tab on our web site, www.passporthealthplan.com.

If your office does not have web access, please contact your Provider Relations Specialist or Provider Services at (800) 578-0775 to request a hard copy of this information.

ELECTRONIC FUNDS TRANSFER (EFT)

Passport offers direct deposit to our network providers for fee-for-service and capitation payments. Passport partners with InstaMed to bring you EFT. InstaMed ePayment services will streamline the payment process by allowing you to:

- Secure payments quickly and easily;
- Reduce paper processing;
- Maintain your preferred banking partner;
- Simplify your bank connectivity when multiple banks are involved;
- Manage provider enrollment and authentication;
- Eliminate the possibility of checks getting lost or delayed in the mail; and
- View multiple payers in one easy-to-use application.

Providers wishing to enroll in EFT must agree to receive all InstaMed payers' payments electronically.

- **Practices with less than 15 practitioners may enroll online.** Begin the EFT enrollment process by clicking the "**EFT**" link on our web site, www.passporthealthplan.com/provider. This link will connect you to the InstaMed web site, where you will be guided through the quick and easy steps to enroll.

- Practices with more than 15 practitioners may enroll by calling InstaMed at (866) 945-7990.

Once you are enrolled and have received a confirmation e-mail that your EFT account has been activated, you can expect to receive funds electronically within two weeks.

If you choose to enroll in EFT, your paper remittance advice will be automatically discontinued after 90 days. However, you will be able to view and print your remittance advice for free through Change Healthcare's (formerly Emdeon) basic Payment Manager, found at www.instamed.com/eraeft.

You may also want to consider enrolling in InstaMed's Electronic Remittance Advice (ERA) online service, which allows providers to post payments automatically. The online PHP Provider Center includes frequently asked questions (FAQs) about InstaMed, EFT, and ERA. For more information about these services or to enroll in EFT and/or ERA, you may also contact InstaMed directly at www.instamed.com/eraeft or by calling (866) 945-7990.

FAMILY PLANNING CLAIMS

Passport members may obtain family planning services from any participating provider. No referral from the member's primary care practitioner (PCP) is required for family planning services.

Prior Authorization is required for elective or induced abortions.

Family planning services are those services provided to members of childbearing age to prevent or delay pregnancy. Services include but are not limited to:
- Routine OB/GYN exams leading to dispensing of contraceptives.
- Birth control/contraceptives, such as pills, sponges, condoms, jellies.
- Intrauterine devices (IUDs) – implantation and removal.
- Injectable long-acting contraceptives.
- Implantable contraceptive devices.

Sterilization*
- Tubal ligations.
- Postpartum tubal ligations.
- Vasectomies.

Terminations*
- First trimester – up to 12 weeks.
- Second trimester – 12 to 22.5 weeks.

***Note:** The member and the provider must complete and comply with all terms and conditions of DMS consent forms. Consent for Sterilization (MAP 250) and Certification Form for Induced Abortion or Induced Miscarriage (MAP 235) forms may be obtained on the DMS web site, http://chfs.ky/gov. Sample forms are located in Section 19 of this Provider Manual. The provider must ensure that non-English speaking, visually impaired and/or hearing-impaired members understand what they are signing.

All claims must be submitted with the appropriate forms referenced above.

Family Planning claims may be submitted electronically with the exception of those claims which require a patient consent form. The claim along with the consent form must be sent to:

Passport Health Plan
P.O. Box 7114
London, KY 40742

Once you have submitted a family planning claim to Passport, you may review the status of your claim via the Passport Provider Portal. You may include family planning and other services on your claim to Passport.

BILLING FOR EPSDT SERVICES

All EPSDT services must be submitted as part of the standard electronic (837) or paper (CMS-1500) claims submission process, as described below:

1. Continue to bill using the same codes for comprehensive history and physical exam you use today:
   - 99381-99385 – New Patient Series
   - 99391-99395 – Established Patient Series

2. Add an "EP" modifier to the physical exam code when all components of the appropriate EPSDT screening interval have been completed and documented in the member's medical record. As a reminder, do not bill lab codes for testing components individually if they were conducted as part of an EPSDT screening interval.

3. Confirm the following health evaluation services by submitting the appropriate CPT Category II codes, according to the member's age, as outlined below:

Member Age:	CPT Category II Code:	Description:
Two (2) Years and Above	3008F	To confirm the BMI has been performed and documented in the member's medical record.
Nine (9) Years and Above	2014F	To confirm the member's mental status has been assessed and documented in the member's medical record.

Failure to submit these codes as required will result in denial of the EPSDT payment.

EPSDT Screens Include:

- History & Physical exam (including BMI for ages two and above)
- Hearing screening
- Vision screening
- Labs, including Lead Screen, Hgb and/or HCT, and Lipid Profile
- Mental health assessment / Depression Screening (ages 12 and above)

- Anticipatory guidance
- Dental referral
- Immunizations up to date

Each item is based on the American Academy of Pediatrics (AAP)/ Bright Futures Periodicity schedule. For more information on EPSDT Screening Services, please refer to our online EPSDT Provider Orientation Packet at www.passporthealthplan.com/provider.

Other Codes for Capturing Health Status Information

We also encourage you to submit additional CPT Category II codes to describe and report other important health status information. Examples include:

- 1035F – Current Smokeless Tobacco User
- 1039F – Intermittent Asthma
- 1000F – Tobacco Use Assessed (CAD, CAP, COPD, PV, DM)
- 4004F – Patient Screened for Tobacco Use and Received Tobacco Cessation Counseling (if identified as a tobacco user)

Passport accepts all valid CPT Category II codes. These codes are for informational purposes only and do not qualify for reimbursement. Codes will display as denied on the remittance advice with a description stating "non-covered services."

EPSDT Special Services

All claims for EPSDT Special Services must be submitted with an EP modifier in the first position as designated by DMS.

To submit claims for EPSDT Special Services you must:

1. Continue to call Passport's UM department at (800) 578-0636 for prior authorization before rendering special services.
2. Add the "EP" modifier to the claim in the first position.

SUBMISSION OF NDC INFORMATION FOR DRUG CODES

Any claim submitted to Passport with drug codes must include valid national drug code (NDC) numbers and NDC units.

How to Submit Claims

- Paper (CMS-1500) Claims
  - Place NDC information in the shaded portion of field 24, beginning with the qualifier and followed by the NDC number and units. o NOTE: Remember that NDC units do not always match the units for the corresponding HCPCS code billed. If you place the unit for the corresponding HCPCS code in the field which is required for the NDC code, your reimbursement may be impacted.
  - Do not use spaces or hyphens in the qualifier/NDC number/unit combination.
  - To submit multiple NDC numbers for one procedure code, allow three spaces before each additional qualifier/NDC number combination.
- Electronic (837P) Claims

» Place NDC information in segment "2410 – Drug Identification Loop."
» Enter the information in this order: LIN01 – Blank; LIN02 – N4; LIN03 – NDC number.
» You may submit multiple NDC numbers for one procedure code electronically.
» Institutional (837I) Claims - For an Institutional Service Line (SV2), only one NDC number can be submitted.
» Zero "0" is an acceptable value for the Monetary Amount corresponding to that Service Line NDC, which is sent in the CTP segment for the price.

Resources:

DMS Physicians Administered Drug (PAD) List:
http://chfs.ky.gov/agencies/dms/pages/feesrates.aspx

FDA National Drug Code Directory:
www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm

907 KAR 17:020E. Managed care organization service and service coverage requirements and policies. www.lrc.state.ky.us/kar/907/017/020E.htm

907 KAR 10:015. Payments for outpatient hospital services.
www.lrc.state.ky.us/kar/907/010/015.htm

CORRECTED CLAIM SUBMISSION PROCEDURES

You may send in corrected or resubmission of claims electronically. Please enter the appropriate bill frequency code and the claim ID number of the original claim.

You may also send in corrected or resubmitted claims on paper.

Send corrected claims to Passport on paper to Passport Health Plan, P.O. Box 7114, London, KY 40742, with one of the following noted, as appropriate:

Situation	Submission Instructions
You are returning claims originally denied for "missing/invalid information" or "inappropriate coding," or previously-submitted claims with incorrect information (i.e. units, date of service, charges)	Write "Corrected Claim" and circle the corrected information.
You are returning claims originally denied for "additional information needed."	Write "Resubmitted" and attach the requested information.

Note: Corrected and resubmitted claims are scanned during reprocessing. Please remember to use blue or black ink only, and refrain from using red ink and/or highlighting that could affect the legibility of the scanned claim.

Questions

If you have any questions or concerns regarding this communication, please contact the Provider Claims Service Unit (PCSU) at (800) 578-0775.

ENCOUNTER SUBMISSION

As a fiscal agent for the Department for Medicaid Services (DMS), Passport is required to submit encounter data to the Commonwealth of Kentucky. The Commonwealth requires complete, accurate, and timely encounter data in order to effectively assess the availability and costs of services rendered to Medicaid members. The data we provide affects the Commonwealth's funding of the Medicaid program. Encounter data is also used to fulfill Federal reporting requirements.

In addition, Passport uses encounter data to analyze physician reimbursement for fee-for-service (FFS), capitated services, and bonus payouts.

According to Passport policy, providers must report all member encounters by claims submission either electronically or by mail to Passport. The following are some tips for encounter submissions:

- Although capitated services are not reimbursed on a fee-for-service basis, it is important to include exact service charges on the claim as you would when billing any other carrier.
- Encounters must be submitted even when Passport is not the primary payer. **Note: The bonus system gives credit for encounters and bonus dollars are earned even when Passport's liability is $0.**
- If you use an automated billing or practice management system, please confirm the system allows for the submission of claims with zero dollar balances, to facilitate the transmission of both capitated and secondary claims.
- PCPs are eligible to receive a monthly encounter bonus payment from Passport for each claim submitted containing only capitated services. To be eligible for the bonus, providers must submit claims within 180 days of the date services were rendered.

THIRD PARTY LIABILITY (TPL)

As an administrator of Kentucky Medicaid benefits, Passport is required to comply with various regulations mandated by the Kentucky Department for Medicaid Services (DMS). This includes regulations regarding third party liability.

Because we are a Kentucky Medicaid plan, Passport will always be considered a payor of last resort. Therefore, Passport continuously evaluates our members for carrying other insurance or when other primary carriers are found. Passport is required to recover any primary payments.

When a member has Medicare as their primary insurance, Passport will initiate recovery activities within 60 days of receiving TPL information from DMS as follows:

- A letter of notification will be sent to affected providers
- Providers will have 60 days to dispute recovery
- After 60 days, the listed claim(s) will be reversed and recovery will occur from future payments; therefore, providers will be asked to not send a check

If a member has primary insurance other than Medicare, HMS will monitor members eligibility with that primary carrier and direct bill for services as necessary.

Providers who find evidence the member did not have other insurance at the time of service may contact our recovery department directly. (Please refer to your original request letter for

contact information.) Passport records will then be updated and recovery efforts will not occur.

If a Medicare insurance policy is identified as the primary insurer:
- The provider must file and obtain a Remittance Advice for the specific claim(s) from the primary carrier.
- Secondary claims must be filed as corrected claims with Passport for coordination of benefits.

Please note:
- Corrected claims contain new information and must be processed through the corrected claim procedure - *Please see Corrected Claims Submission Procedures on page 31.*

Passport is not permitted to consider an original timely filing denial by the primary insurer as a "final denial." In these instances, providers will need to appeal the denial with the primary insurer by attaching a copy of the Passport recovery letter. The letter will serve as evidence they have just been notified of the other carrier liability. Insurance carriers may overturn their denial based on this evidence.

In addition, please note that EPSDT claims should always be submitted to Passport as secondary payer regardless of whether or not payment is due.

As always, we are happy to assist with any questions or concerns you have about TPL. Please call the Passport Provider Claims Service Unit (PCSU) at (800) 578-0775 for assistance.

Special Programs

CARE MANAGEMENT PROGRAMS

Passport is committed to working with providers to keep our members healthy. Our Care Management Programs employ a patient-centric approach that helps members and their caregiver(s) understand and maintain optimal health. The objectives are to:

- Improve care coordination for members in collaboration with their PCP and Specialists.
- Support the PCP/Specialist treatment plan.
- Facilitate and coordinate the transition of the member to the least restrictive setting.
- Optimize chronic condition management by educating members about their diagnoses and self-management.
- Implement personalized care plans.
- Improve medication adherence.
- Address member/caregiver(s) needs regarding adequate support and resources at home.
- Improve adherence to the hospital discharge care plan for member discharged to home.
- Decrease "avoidable" utilization events (e.g., readmissions) and increase the number of members engaged.

Care Management Programs coordinate services for members using a multi-disciplinary care team, led by the member's PCP and Care Advisor or Health Educator. The team-based model focuses on optimizing the health of the member utilizing the broad skills of the PCP, Care Advisor or Health Educator, Registered Dietitian, Licensed Social Worker and Pharmacist, to develop and implement personalized care plans.

Care Management Programs utilize an opt-out model. Members identified for one of the Care Management Programs are considered participating unless they specifically request to opt-out. Members are notified of enrollment by mail and phone contact. Members that decline participation will be re-contacted if they meet criteria again. If the member has communicated that they do not want to be contacted again, they will be placed on a do not call list. The member's provider is alerted when a member engages in or declines care management or if a member opts out of a Care Management Program. The notification can be through letter, telephone, or where available, through the provider practice's electronic medical record (EMR).

Care Connectors alert the Care Management Team when there is a Health Risk Assessment (HRA) with a "positive" result to determine the need for care management or assistance with navigating the Medicaid system. Care Management referrals are also received via the 24/7 Nurse Advice Line (health information line) report.

All Care Management forms can be found online at www.passporthealthplan.com/providers/forms, look for the Care Management Forms section.

CATASTROPHIC CARE MANAGEMENT

The focus for the Catastrophic Care Program is on managing and supporting members and caregiver(s) in instances where a member experiences a significant, potential life-changing event or diagnosis, such as malignant cancer, degenerative neurological disease, respiratory failure, liver diseases, etc. Management and support is provided to members and their caregiver(s) in instances where a member has multiple chronic conditions with other significant comorbidities, or significant diagnoses and barriers, such as serious mental illness, cognitive and/or functional deficits, degenerative neurological diseases, etc.

The majority of these members are identified through the UM authorization process for members admitted with one of the targeted conditions:

- Amyotrophic Lateral Sclerosis
- Severe Cognitive Functional Impairment
- Hemophilia and Coagulation Disorders
- Gaucher's Disease
- Guillain-Barre Syndrome
- Liver Failure
- Cystic Fibrosis
- Respiratory Failure
- Ventilator Dependency
- Burns >20% Total Body Surface Area or 2nd/3rd Degree Burns
- Spinal Cord injuries and "plegias" (mono di para and quadra)
- Sickle Cell Disease
- Malignant Head and Neck Tumors
- Malignant Pulmonary/thoracic tumors (including breast)
- Malignant Gastrointestinal/abdominal tumors (including colorectal)
- Lymphatic and hematopoietic (blood) tumors
- Malignant Genitourinary/pelvic tumors

- Malignant Endocrine Tumors
- Cerebrovascular Accident and Hemorrhage
- Acute and Chronic Osteomyelitis
- Sepsis (all cause)

The primary goal is to support the implementation of the patient's PCP/Specialist treatment plan to prevent avoidable readmissions, reduce unnecessary ER visits, manage the patient's plan and remove barriers that may prevent the patient and his/her caregiver(s) from adhering to his/her treatment plan.

COMPLEX CARE MANAGEMENT

Members with complex medical and/or behavioral health care needs can be very time-consuming for your practice. We are here to help you by enhancing your treatment plan and working to improve member compliance. Care Advisors complete a comprehensive assessment, identify available benefits and resources, and work with all providers involved in the member's care (including the PCP and Specialists) to develop and implement the care management treatment plan. This plan includes establishing both long- and short-term performance goals, identification of barriers to meeting goals, monitoring for compliance, and follow-up. We conduct periodic assessments of progress against plans and goals and make modifications to the plan as needed.

In addition to traditional telephonic care management, Passport has Care Advisors embedded in certain high-volume provider offices. The purpose of the Embedded Care Advisor is to:

- Engage more members into care coordination activities to reduce care gaps
- Evaluate for and work to eliminate barriers to care
- Promote the most cost effective healthcare delivery by coordinating with all care providers
- Work to reduce inappropriate utilization of the ER
- Partner in the member's treatment plan to promote improved compliance.

CONDITION CARE MANAGEMENT

Members go through a stratification process, considering care gaps, comorbid conditions, and additional factors, to determine the appropriate level of intervention based on identified need and status. When a member has more than one chronic condition, a hierarchy is applied to ensure the member is targeted for the appropriate condition-specific program. The stratification process runs monthly; however, re-stratification may occur anytime in between based on the member's screening or assessment or additional information that becomes available during interactions with the member.
Members are notified of their enrollment in the program after the monthly identification and stratification process or after being referred by their provider, a health professional, or another program.

Passport is pleased to offer the following Condition Care Management Programs to assist both members and providers with their treatment plans:

	Program Goals
Asthma	• Partner with the member, their caregiver and their primary and specialty care practitioners to develop a plan of care (by a nurse care advisor) or action plan (by a health educator). • Improve medication adherence • Facilitate appropriate communication across the entire care team • Optimize asthma management and close relevant gaps in evidence-based care • Educate members on asthma diagnosis and self-management
Heart Failure	• Partner with member, their caregiver and their primary and specialty care practitioners to develop a plan of care by a nurse care advisor • Improve medication adherence • Facilitate appropriate communication across the entire care team • Optimize heart failure management and close relevant gaps in evidence-based care • Educate members on heart failure diagnosis and self-management
Chronic Obstructive Pulmonary Disease (COPD)	• Partner with the member, their caregiver and their primary and specialty care practitioners to develop a plan of care (by a nurse care advisor) or action plan (by a health educator) • Improve medication adherence • Facilitate appropriate communication across the entire care team • Optimize COPD management and close relevant gaps in evidence-based care • Educate members on COPD diagnosis and self-management
Diabetes	• Partner with the member, their caregiver and their primary and specialty care practitioners to develop a plan of care (by a nurse care advisor) or action plan (by a health educator) • Improve medication adherence • Facilitate appropriate communication across the entire care team • Optimize diabetes management and close relevant gaps in evidence-based care • Educate members on diabetes diagnosis and self-management
Coronary Artery Disease (CAD)	• Partner with the member, their caregiver and their primary and specialty care practitioners to develop a plan of care (by a nurse care advisor) or action plan (by a health educator) • Improve medication adherence • Facilitate appropriate communication across the entire care team • Optimize CAD management and close relevant gaps in evidence-based care • Educate members on CAD diagnosis and self-management

Evidence-based medicine and a team approach is used to:

- Empower members
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the provider/member relationship
- Emphasize and reinforce use of clinical practice guidelines

Member Interventions:

- Provider visits and pre-visit planning
- Medication management
- Following a treatment plan
- Adherence to recommended screenings and tests
- Managing other chronic conditions
- Understanding urgent and emergent symptoms and actions
- Addressing psychosocial issues
- Depression and behavioral health screenings
- Understanding/increasing healthy behaviors, including nutrition, smoking cessation and exercise
- Coordinating interventions with member's primary provider
- Providing educational and community resources

Clinical Practice Guidelines (CPGs).

Condition	Guideline
Asthma	Guidelines for the Diagnosis and Management of Asthma: Clinical Practice Guidelines, National Institutes of Health (NIH), National Heart, Lung and Blood Institute
Heart Failure	American College of Cardiology(ACC)/American Heart Association (AHA)/Heart Failure Society of America (HFSA) Focused Update of the 2013 American College of Cardiology Foundation (ACCF/AHA Guideline for the Management of Heart Failure
Chronic Obstructive Pulmonary Disease (COPD)	Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD).
Diabetes	American Diabetes Association (ADA) Standards of Medical Care in Diabetes and ADA Standards of Medical Care in Diabetes and Case Management Society of America, Guidelines for improving patient-centered care for Diabetes
Coronary Artery Disease (CAD)	ACC/AHA Guideline on the Lifestyle Management to Reduce Cardiovascular Risk and ACC/AHA Guideline on the Assessment of Cardiovascular Risk

TRANSITION CARE MANAGEMENT

The Transition Care Program was developed to improve the member's experience and health outcomes as they transition along the health care continuum. By focusing on the member's transition from an acute hospitalization to home, the Transition Care team hopes to lower the member's risk for readmission back to the hospital or emergency department and works toward preventing avoidable hospitalizations.

The Transition Care Program aims to enhance the member and provider experience through a collaborative, multi-disciplinary care management approach, achieve quality outcomes, avoid inappropriate utilization, and manage medical costs. The Transition Care team will collaborate with the Hospital Discharge Planning Team to: ensure appropriate post-discharge resources and services are arranged prior to discharge, educate members about diagnoses and care plan with a specific focus on self-management activities, work to improve medication adherence, address member/caregiver needs, assess for adequate supports and resources at home, and assist in arranging post-discharge outpatient provider appointments, as needed.

CARE FOR YOU 24/7 NURSE ADVICE LINE

If a member or family member becomes sick, hurt or has a health question, the Nurse Advice Line is there for them. Callers will speak to a Registered Nurse who will answer questions and provide guidance. Our nurses help members determine if the condition can be treated at home and, if not, what the appropriate level of care is. Members can call (800) 606-9880 for expert advice any time of the day or night.

Health Information You Can Trust

The Nurse Advice Line is a safe place to get health information. All calls are private. The team of nurses has over 15 years of experience and are supported by doctors. Members can call with questions on topics like:

- Cuts, burns and minor injuries
- Vomiting and diarrhea
- Severe headaches
- Fevers, colds and flu
- Questions about your medicines
- Questions on any general health concern

When members are not sure if they need to see a doctor, the Nurse Advice Line is a great place to start. Members can call us at (800) 606-9880 24 hours a day, seven days a week. There is never any cost.

REMOTE CARE MONITORING PROGRAM

Remote Care Monitoring (RCM) is a supplemental program available to members enrolled in our Care Management Programs who have certain diagnoses. As part of the RCM program, the member receives a kit that includes a tablet that is Bluetooth connected to a scale, blood pressure cuff, and pulse oximeter. The member is asked to take their vitals at least

once daily, as well as answer general questions about their condition-related symptoms. The goal of RCM is to educate members on how to recognize early symptoms of a worsening condition and respond to these symptoms appropriately (such as by contacting their PCP) in hopes of preventing a future ER visit or inpatient admission. RCM is another tool, along with our Care Management Programs, that is geared toward empowering members to take charge of their health.

MATERNITY CARE MANAGEMENT

Passport has a maternity care management program called Mommy Steps with a dedicated team of Perinatal Care Advisors and support staff who work with obstetrical providers, local health departments, home health agencies, and others to identify the psychosocial, nutritional and educational needs of pregnant members. Once these needs are identified, Mommy Steps staff provides coordination of these services for our members. Passport's specialized maternal and newborn nurses work to support the provider's plan of care, which may include additional health education, referrals to WIC (Women, Infants & Children), Smoking Cessation Programs, Substance Abuse Treatment Referrals, or Behavioral Health Counseling Referrals.

Our goal is to empower pregnant women to become more educated and responsible for their health and the decisions that impact their overall wellbeing. By partnering with obstetrical providers and educating members, we can decrease the rate of prematurity, infant mortality, low birth weight and very low birth weight babies.
Each newly identified pregnant member receives a welcome packet to the program that includes: education materials about prenatal care (including coverage for classes conducted by certified prenatal educators), community resources, domestic violence support, dental and vision services, legal assistance contacts, and transportation service contact information. High risk pregnant members receive additional education and guidance from one of our Perinatal Care Advisors.

SPECIALTY POPULATIONS TEAM

The Specialty Populations Team includes Foster Care Specialists and Care Coordinators, Guardianship Specialists, Social Workers who are embedded at key locations in Louisville, and Social Workers who support Care Management by identifying social supports for members. The Specialty Populations Team focuses on reducing member care gaps and providing care coordination to remove barriers for accessing care.

Medically Complex Foster Children are initially enrolled into Care Management (usually Complex Care) and then continue to be followed by a Foster Care Specialist.

POPULATION HEALTH MANAGEMENT

The primary role of the Population Health Management (PHM) team at Passport is to give meaning and action to data that is presented to provider partners. Our goal is to provide a line of sight to information and actionable steps to help providers improve quality outcomes for members. This assistance comes in many forms and includes research into the drivers behind such data points as high cost claims, emergency department use, behavioral health use, pharmacy costs/options, and care gap closure.

Care Conferences are offered on a regular basis to participating providers. These meetings may include review of member data, discussions around quality initiatives, collaboration around Care Management programs, and other topics related to improving outcomes for both members and provider partners. To request an initial consultation, notify your Provider Network Management Representative that you would like to participate in the PHM program.

Care Management Contact Information	
Care Management Fax Number and Email Address	(800) 983-9160 PassportCM@EvolentHealth.com
Maternity Care Management Fax Number and Email Address	(800) 880-6186 MommySteps@passport.EvolentHealth.com

Behavioral Health

Passport's behavioral health program provides members with access to a full continuum of recovery and resiliency focused behavioral health services through a network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all Passport members receive timely access to clinically appropriate behavioral health care services, Passport believes that quality clinical services can achieve improved health outcomes for our members.

Passport has contracted with Beacon Health Options, LLC to coordinate the delivery of behavioral health services for its members. Beacon's website, www.beaconhealthoptions.com, contains answers to frequently asked questions, Beacon's clinical practice guidelines, clinical articles, links to numerous clinical resources, and important news for providers.

To support our primary care physicians, Passport has established a PCP Psychiatric Decision Support Line to assist with the appropriate and targeted use of psychiatric medications, speed up member access to appropriate care and increate provider comfort with treating behavioral health conditions. Providers can reach the **PCP Psychiatric Decision Support line at (877) 249-6659**.

Passport members may access behavioral health services 24 hours a day, seven days a week by contacting **Passport's Behavioral Health Hotline at (855)834-5651**. Members do not need a referral to access behavioral health services and authorization is never required for emergency services. Behavioral Health Service professionals are available to assess, triage and address behavioral health emergencies through this crisis line. Passport can arrange for emergency and crisis Behavioral Health Services through mobile crisis teams in the member's community. Face-to-face emergency services are available twenty-four (24) hours a day, seven (7) days a week through Passport's behavioral health network.

Level of Care Coordination and Case Management:

1. **Care Coordination**
   Is a short term intervention for members with potential risk due to barriers in services, poor transitional care, and/or co-morbid medical issues that require brief targeted care management interventions.

2. **Case Coordination**
   Consultations are episodic case management interventions aimed at integrating medical and behavioral health care, and improving access to services. Members are typically identified by Medical Case Managers, PCPs or other community providers seeking behavioral health input and information regarding insurance based and community services. Consultations are generally opened and closed within 30 days. They may include member outreach contacts.

3. **Intensive Case Management**
   Intensive Case Management (ICM)

Criteria for intensive case management include but are not limited to:

- Prior history of acute admissions with re-admission within 60 days.
- High lethality.
- Severe, persistent psychiatric symptoms, and lack of family, or social support which puts the member at risk of acute admission.
- Co-morbid medical condition combined with psychiatric and/or substance abuse issues could result in exacerbation of fragile medical status.
- Pregnant, or 90 days post-partum and using substances, or requires acute behavioral health services.
- Child living with significant family dysfunction and instability following discharge from inpatient hospitalization which places the member at risk of requiring acute admission that requires assistance to link family, providers and state agencies

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Passport has adopted the SBIRT practice to identify, reduce, and prevent problematic use, abuse and dependence on alcohol and other substances. SBIRT is provided in a primary care setting to allow opportunities for early intervention with at-risk alcohol and other substance use behavior before more severe consequences occur.

- **Screening** quickly assess the severity of substance use and identifies the appropriate level of treatment.
- **Brief Intervention** focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- **Referral to Treatment** provides those identified as needing more extensive treatment with access to specialty care.

All Passport members age 9 years and above are required to have an annual SBIRT screening. SBIRT may be completed by primary care providers including physicians, nurse practitioners, and physician assistants who have completed SBIRT training.

Current Procedural and Terminology (CPT) code 99409 may be utilized to report the separate and distinct service provision of the SBIRT when the service takes in excess of 30 minutes during the same clinical session as any other Evaluation & Management service. Documentation of the administration and results of the SBIRT including the reason for the extended visit should be recorded in the clinical record.
For more information regarding SBIRT and a complete list of tool and resources please visit www.passporthealtplan.com/providers and click on Behavioral Health. Clinical training is available to your office, for more information please contact your Provider Relations Representative.

Behavioral Health Benefits

Passport covers behavioral health services to members located across the state. Under Passport, the following levels of care are covered, provided that the services are medically necessary, delivered by contracted network providers, and that the authorization procedures outlined in this manual are followed. DSM-5 should be used when assessing members for services and documented in the member's medical record. Covered Services include:

- Inpatient mental health
- Crisis stabilization
- Emergency room visits
- Medical detoxification
- Psychiatric residential treatment facilities (PRTF) for ages 6-21 only
- Extended Care Units (ECU) (EPSDT expanded services through age 21 only)
- Residential substance abuse rehabilitation
- Substance abuse rehabilitation
- Outpatient mental health services
- Outpatient and community based substance abuse services
- Electroconvulsive Therapy (ECT)
- Psychological and neuropsychological testing
- Community Based Outpatient Services, such as therapeutic rehabilitation, targeted case management etc.
- Behavioral health and substance abuse EPSDT special services (through age 21)
- Mobile Crisis
- Community Wrap Around Services
- Residential crisis stabilization
- Assertive community treatment (ACT)
- Peer support
- Parent training
- Wellness recovery support/ Crisis planning
- Crisis intervention outpatient
- Adults are covered on a psych unit affiliated with a hospital, not a free-standing facility.
- Free-standing facilities only cover members under 21 and over 65 years of age.
- Components of Medication Assisted Treatment

Behavioral Health Contact Information	
PCP Psychiatric Decision Support Line	(877) 249-6659
Passport's Behavioral Health Hotline	(855) 834-5651
Passport's Behavioral Health email	passportbehavioralhealth@ passporthealthplan.com
Main fax number	(781) 994-7633
TTY Number (for hearing impaired)	(781) 994-7660 or (866) 727-9441
Claims Hotline	(888) 249-0478
eServices Helpline	(866) 206-6120
IVR	(888) 210-2018
All departments may be reached via Passport's Behavioral Health Hotline	(855) 834-5651

Contact Us!

Real Time Provider Directory, formulary and more information may be found at www.passporthealthplan.com.

Avesis Dental
PH: 1-866-909-1083
www.avesis.com

Avesis Vision
PH: 1-844-346-7782
www.avesis.com

Behavioral Health Claims Hotline
PH: 1-888-249-0478
passportbehavioralhealth@passporthealthplan.com

Beacon eServices Helpline
PH: 1-866-206-6120

Care Management Services
PH: 1-877-903-0082
FAX: 800-983-9160
passportcm@evolenthealth.com

Change Healthcare
PH: 1-866-817-3813
www.changehealthcare.com

Credentialing/Enrollment
PH: 1-502-785-8281
FAX: 1-800-470-8714
ProviderEnrollment@passport.evolenthealth.com

EviCore High-Dollar Radiology Authorizations
PH: 1-888-693-3211
FAX: 1-888-693-3210
www.evicore.com

Guardianship Specialists
502-212-6733

Health Equity Program
PH: 502-585-5281
sandra.duverge@passporthealthplan.com

InstaMed
PH: 1-866-945-7990
www.instamed.com

InterpreTalk (Interpretation Services)
PH: 1-800-305-9673

Maternity Care Management Services
PH: 1-877-903-0082
FAX: 800-880-6186
mommysteps@passport.evolenthealth.com

Member Services
PH: 1-800-578-0603
FAX: 1-888-772-9023

New Century Health Cardiology/Oncology Authorizations
PH: 1-888-999-7713
my.newcenturyhealth.com
Imaging FAX: 702-726-5180
Oncology FAX: 702-726-5181
Radiation Oncology FAX: 702-726-5182
Cardiology FAX: 702-726-5183

Passport Provider Portal
PH: 1-800-578-0775
providerportal@passporthealthplan.com
https://phkyportal.valence.care/

PCP Psychiatric Decision Support Line
PH: 1-877-249-6659

Pharmacy (Caremark)
PH: 1-888-512-8935
www.caremark.com

Provider Claims Service Unit (PCSU)
PH: 1-800-578-0775
FAX: 502-585-8339

Provider Network Management
FAX: 502-585-6060
providerrelations@passporthealthplan.com

Provider Services
PH: 1-800-578-0775
FAX: 1-888-772-9023

Utilization Management

General
PH: 1-800-578-0636
FAX: 502-585-7989

Concurrent Review
PH: 502-585-2077
FAX: 502-213-8997

Retrospective Review
PH: 502-585-7972
FAX: 502-585-8207

Home Health
PH: 502-585-7320
FAX: 502-585-8204

DME
PH: 502-585-7310
FAX: 502-585-7990

Cosmetics
PH: 502-585-7069
FAX: 502-213-8998

Appeals
PH: 502-585-7307
FAX: 502-585-8461