



Provider Manual

2020

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Section 1.0

Introduction

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1.0 Introduction

1.1 Provider Welcome

We are pleased you are part of the Passport Health Plan (referred to as Passport throughout this document) provider network. As a participant in Passport's network, you have the opportunity to make Passport beneficial for both you and the members you serve. Passport knows providers are essential in delivering high-quality, cost-effective medical services to Medicaid recipients in the Commonwealth. We further recognize that achieving our mission "to improve the health and quality of life of our members" would not be possible without your participation. Passport is committed to earning your ongoing support and looks forward to working with you to provide the best service possible to Passport's members.

This Provider Manual explains the policies and administrative procedures of Passport. You may use it as a guide to answer questions about member benefits, claim submissions, and many other issues. This Provider Manual also outlines day-to-day operational details for you and your staff. It will describe and clarify the requirements identified in the Provider Agreement you hold with Passport. Updates to this Provider Manual will be provided on Passport's website on a periodic basis. As your office receives communications from Passport, it is important that you and/or your office staff read the Provider Alerts, Medical Office Notes, Passport eNews, and other special mailings and retain them with this Provider Manual so you can integrate the changes into your practice. All Passport provider materials, including the Provider Manual and Provider Directory, are available online at www.passporthealthplan.com.

Please note, the term "provider" as used throughout this Provider Manual is inclusive of all practitioners, individual and group affiliated, as well as facilities and ancillary service suppliers, as appropriate.

1.2 Kentucky Medicaid Program

The Kentucky DMS, under the Cabinet for Health and Family Services (CHFS), is responsible for administering the Kentucky Medicaid Program as explained in Section 1.3 below. DMS has contracted with Passport, and other managed care organizations (MCO), to administer Medicaid benefits. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965 and operates according to a state plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint federal and state assistance program that provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of their care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining needed medical care.

As a provider of medical services, please be aware DMS, Passport, and the provider are bound by both federal and state statutes and regulations as well as revisions governing the administration of the

state plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Passport may request a return of any monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program should not be confused with Medicare. Medicare is a federal program, identified as Title XVIII, primarily serving persons 65 years of age and older and some disabled persons under 65 years of age. The Kentucky Medicaid Program and Passport services eligible recipients of all ages.

1.2.1 Department for Medicaid Services

The Kentucky Department for Medicaid Services (DMS), within the CHFS, bears the responsibility for developing, maintaining, and administering the policies and procedures, scope of benefits, and basis for reimbursement for the medical care aspects of the program. As a managed care organization (MCO) for DMS, Passport makes the actual reimbursement to providers for covered services provided to Passport members.

It is important to note Passport does not determine eligibility for Medicaid. Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Community Based Services (DCBS) offices located in each county of the Commonwealth (see Section 18, “Other Important Contact Information” for local offices).

1.2.2 Kentucky Medicaid Member Enrollment and Disenrollment

Kentucky Medicaid members are given the option to participate in an annual open enrollment period, where they may choose to join one of the MCOs contracted by DMS. New members are also given 90 days after the time of enrollment to change MCOs. DMS is responsible for this process, and maintains all member eligibility information in their KyHealth Net online system (see Section 2.4.1).

Although Passport has policies in place for instances where we may request disenrollment of a member, DMS is responsible for disenrolling that member from Passport.

1.3 Overview of Passport

Passport is the operating name for University Health Care, Inc. (UHC), a managed care organization that serves the Medicaid and the Kentucky Children’s Health Insurance Program (KCHIP) populations in the Commonwealth of Kentucky. UHC is a non-profit health maintenance organization (HMO) licensed in the Commonwealth of Kentucky.

Passport is sponsored by the University of Louisville Medical School Practice Association, University Medical Center, Inc., Jewish Heritage Fund for Excellence, Norton Healthcare, and the Louisville/Jefferson County Primary Care Association, which includes the Louisville Metro Department of Health and Welfare and Louisville's two Federally Qualified Health Centers: Family Health Centers and Park DuValle.

The Partnership Council is a broad coalition of consumers and providers, including physicians,

nurses, hospitals, health departments, and ancillary providers who help govern the operations of Passport. If you are interested in volunteering to participate on the Partnership Council or one of our committees, please contact your Provider Relations Specialist.

1.4 Mission and Values

Passport's vision is:

To be the leading model for collaboration and innovation in health care

Passport's mission is:

To improve the health and quality of life of our members

The Organizational Values are:

- *Integrity*
- *Community*
- *Collaboration*
- *Stewardship*

1.5 Important Telephone Numbers

1.5.1 Care Management (877) 903-0082

The Care Management department is available 8:00 a.m. to 6:00 p.m. EST, (7:00 a.m. to 5:00 p.m. CST), Monday through Friday. The Care Management department offers a number of programs that assist members and providers in managing and coordinating services to meet the members' medical and social needs. These programs include:

- Catastrophic Care Management
- Complex Care Management
- Condition Care Management (including Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Coronary Artery Disease (CAD) and Heart Failure)
- Transition Care Management
- Maternity Management
- Foster Care
- Guardianship
- Medically Frail

1.5.2 Compliance Department

Providers are also required to cooperate with the investigation of suspected Fraud and Abuse. 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	Compliance	Hotline:	(855)	512-8500
Medicaid	Fraud	Hotline:	(800)	372-2970
Passport Compliance Email Address: ComplianceHotline@passporthealthplan.com				

1.5.3 EPSDT Program (877) 903-0082

The Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Program is available 8:00 a.m. to 6:00 p.m. EST (7:00 a.m. to 5:00 p.m. CST), Monday through Friday.

1.5.4 Member Services (800) 578-0603

Member Services representatives are available 7:00 a.m. to 7:00 p.m. EST (6:00 a.m. to 6:00 p.m. CST), Monday through Friday. Member Services representatives assist members by answering questions regarding changes, benefits, and grievance issues, or by directing members to other Passport departments as needed, and by sending communication materials to members as needed.

1.5.5 Passport Provider Portal (800) 578-0775

The Passport Provider Portal offers you a secure, real-time online connection between your office and Passport. The Passport Provider Portal can assist your office processes so that you spend less time on the phone or processing paperwork. The Passport Provider Portal's registration and usage is offered free of charge. Services offered include member eligibility verification, claim status inquiry, and referral submission and inquiry.

1.5.6 Other Services

Service	Provider	Telephone	Hours
Behavioral Health (See Section 16)	Beacon Health Strategies, LLC	(855) 834-5651	24 hours/7 days/week
Dental (See Section 18)	Avesis Third Party Administrators, Inc	(866) 909-1083	7 a.m. to 8 p.m. ET 6 a.m. to 7 p.m. CT
Nurse Advice	Axispoint Health	(800) 606-9880	24 hours/7 days/week
Radiology/Outpatient Therapy / Chiro / Pain Management	eviCore Healthcare	(877) 791-4099	8 a.m. to 9 p.m. ET 7 a.m. to 8 p.m. CT
Vision (See Section 19)	Superior Vision Benefit Management, Inc	(800) 243-1401	8 a.m. to 9 p.m. ET 7 a.m. to 8 p.m. CT

1.5.7 Pharmacy Prior Authorization (844)380-8831

Passport's prior authorization department is available 24 hours per day. The following fax number is available to submit requests for drug prior authorizations, (844) 802-1406.

Urgent requests should be reserved for those situations in which applying the standard procedure

may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The use of urgent fax lines for non-urgent requests is not appropriate. Please refer to Section 12 for prior authorization procedural requirements.

1.5.8 Provider Claims Service Unit (800) 578-0775 Option 2

The Provider Claims Service Unit (PCSU) receives providers' calls regarding any issue specific to claims. The PCSU is available Monday through Friday from 8:00 a.m. to 6:00 p.m. EST (7:00 a.m. to 5:00 p.m. CST).

1.5.9 Provider Services (800) 578-0775 Option 3

Provider Services representatives are available Monday through Friday, 8:00 a.m. to 6:00 p.m. EST (7:00 a.m. to 5:00 p.m. CST), to assist providers with questions about policies, procedures, member eligibility, and benefits. Representatives are also available if providers need to request forms or literature, report member noncompliance, or assist members in obtaining ancillary direct access services or other specialty care.

1.5.10 Utilization Management (800) 578-0636

The UM department is available Monday and Friday from 8:00 a.m. to 6:00 p.m., and Tues, Wed, Thurs, Sat and Federal Holidays from 8:00 am to 5:30 pm. All requests for authorization of services may be received during these hours of operation. Weekend requests may be submitted on Monday. After business hours, a provider can fax the request or can leave a message and a representative will return the call the next business day.

1.6 Claim Submission

New and corrected paper claims are to be submitted to the following address:

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

Please refer to Section 15 for additional claims filing instructions.

Claims and correspondence for appeal or recovery are to be submitted to the following address:

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

An active valid Kentucky Medicaid identification number, assigned by DMS, is required to receive any payment for services rendered.

Other Important Contact Information

Department for Medicaid Services MCO Hotline

Toll-free:

(855) 446-1245

Change Healthcare (formerly Emdeon) Business Solutions Client Services

For questions or concerns regarding claim routing or clearinghouse rejections, the provider should be instructed to contact their vendor for support. Change Healthcare will work with the vendor as needed to research and resolve the issue. If the provider is a direct Change Healthcare submitter, he or she should contact Change Healthcare product support (the numbers vary based on the product) or the Change Healthcare Help Desk at 800-845-6592.

The Change Healthcare Help Desk Consultant will assign a case number for tracking the issue. The Change Healthcare Help Desk Consultant owns the issue through resolution.

Toll-free: (800) 845-6592

Web resources:

- Change Healthcare Home Page - <http://www.changehealthcare.com>
- Change Healthcare ON24/7 Portal - <https://client-support.changehealthcare.com>
- Change Healthcare Payer List - www.emdeon.com/payerlists
- Change Healthcare HIPAA Simplified page - Your online resource for HIPAA 5010, NCPDP D.0, ICD-10, and other HIPAA regulations - www.hipaasimplified.com
- EHNAC Accreditation - <http://www.ehnac.org/>
- Change Healthcare Vision Login Page - <https://access.emdeon.com/CIHS/>

InstaMed ERA/EFT Customer Service

Support team

(866) 467-8263
support@instamed.com

Kentucky Medical Ombudsman

Toll-free:

(800) 372-2973

TDD/TTY:

(800) 627-4702

Address:

Kentucky Department for Medicaid
Services
Office of the Ombudsman
275 East Main Street, 1E-B
Frankfort, KY 40621

State Hearing Request

Toll-free:

(800) 635-2570

Address:

Kentucky Department for Medicaid
Services
Division of Program Quality &
Outcomes
275 East Main Street, 6C-C
Frankfort, KY 40621

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Section 2.0

Administrative Procedures

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2.0 Administrative Procedures

2.1 Medicaid Eligibility

Most individuals who meet the DMS eligibility criteria for Medicaid are assigned to an MCO in the region, and include individuals in the following categories:

- A. Temporary Assistance to Needy Families (TANF);
- B. Child and family related;
- C. Aged, blind, and disabled Medicaid only;
- D. Pass through;
- E. Poverty level pregnant women and children, including presumptive eligibility;
- F. Aged, blind and disabled receiving State supplementation;
- G. Aged, blind, and disabled receiving Supplemental Security Income (SSI); or
- H. Under the age of twenty-one (21) years and in an inpatient psychiatric facility.
- I. Foster Care ages 0 – 18 and Former Foster Care ages 18 – 26
- J. ACA Expanded Population ages 18-64
- K. Presumptive Eligibility - Pregnant

DMS does not allow certain categories of Medicaid beneficiaries to participate in managed care. Beneficiaries in the following categories are not eligible for assignment to an MCO:

- A. Individuals who shall spend down to meet eligibility income criteria;
- B. Individuals currently Medicaid eligible and have been in a nursing facility for more than thirty (30) days*;
- C. Individuals determined eligible for Medicaid due to a nursing facility admission including those individuals eligible for institutionalized hospice;
- D. Individuals served under the Supports for Community Living, Michele P, home and community-based, or other 1915(c) Medicaid waivers;
- E. Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBs) or Qualified Disabled Working Individuals (QDWIs);
- F. Timed limited coverage for illegal aliens for emergency medical conditions;
- G. Working Disabled Program;
- H. Individuals in an intermediate care facility for mentally retarded (ICF-MR); and
- I. Individuals who are eligible for the Breast or Cervical Cancer Treatment Program.

* If you have any questions regarding eligibility criteria, contact Provider Services at (800) 578-0775.

2.2 Passport Health Plan Assignment

DMS assigns eligible beneficiaries to Passport when the beneficiary selects Passport on their enrollment application or as part of an automatic assignment process developed by DMS.

Once assigned to Passport, a member receives a welcome kit from Passport, which includes a welcome letter, member identification card, a Health Risk Assessment (HRA), and a Member Handbook.

2.3 Choosing a Primary Care Provider (PCP)

Making sure our members have a medical home is at the heart of Passport's approach to managed care. The PCPs, in their role as the Medical Home, provide our members with primary and preventive care and arrange other medically necessary services for members. Therefore, Passport acts quickly to make sure members are linked to a medical home.

Passport has a multifaceted PCP assignment process that meets all DMS requirements. The process is based on our current Medicaid experience and computer generated assignment of an accessible PCP.

Our plan and process to assign our members a PCP will occur as follows:

- If the member requires assignment, our process will be as follows:
 - Identify members who require a PCP including SSI adult members (the process recognizes the need for longer timeframes for adult SSI members)
 - Review for historical claims data for PCPs
 - Review for prior PCP assignments for member
 - Review for PCPs for other family members

Final step, if no assignment can be made, based on the above criteria, PCP assignment will be based on the member's address.

At the time of assignment, Passport members will be informed of their assigned PCP in the New Member Welcome Kit and their confirmation letter. The member will also be notified at this time of his/her right to change his/her PCP if he/she is not satisfied with our assignment. The member will also receive an ID card with the practice name and phone number printed on the ID card. If the member is not required to have a PCP, he/she will receive an ID card with "No PCP required or Medicare Primary" printed on the card. Members in foster care, disabled children, adults with a state guardian, and Medicare primary members are not required to choose a PCP.

The above processes will be adapted as necessary to effectively assign PCPs to beneficiaries eligible for coverage (and assigned to Passport).

2.3.1 Changing PCPs

Members can change PCPs twice in a 12 month period, and PCP changes are effective on the day the change is requested. To change a PCP, members must call our Member Services department. Upon receiving an existing member's request to change a PCP, our Member Services Representatives (MSRs) will:

- Assist the member in finding a new provider (if requested), using methodologies outlined above,
- Perform the requested change in our system, and

- Advise the member of the effective date of the new PCP assignment.

The member will then receive a new ID card with the PCP practice name and phone number printed on the ID card.

Exceptions to the change of provider rule will apply in cases of provider termination, provider office closing, provider panel limitations and member re-location. In the case of voluntary provider termination, we will notify the member no less than thirty (30) days prior to the effective date of voluntary provider termination. The member will be sent a letter explaining that his/her provider is leaving Passport's network and the member will need to contact Member Services to select a new PCP or to receive assistance selecting a new PCP. If the provider notifies Passport of voluntary termination with less than thirty (30) days from the effective date of voluntary termination, we will notify affected members as soon as Passport receives notification.

Fortunately, due to our long history of superior provider satisfaction, most voluntary terminations are the result of providers retiring or moving out of the service area, not the result of provider dissatisfaction with Passport's administration.

In the case of involuntary provider termination, where Passport has decided to remove a provider from its network, Passport will notify affected members at least fifteen (15) days prior to the effective date of involuntary termination. Affected members will be sent a letter advising them to contact Member Services to select a new PCP or to receive assistance finding a new PCP.

In either of these cases, if the member does not contact us to select a new PCP, Passport will use the auto-assignment process to assign the member to a new PCP.

The goal of Member Services is to always provide satisfactory resolution, but if a request for a change in PCP is denied and the member is dissatisfied, the member will be advised of their appeal rights. The member will receive a written notice of the decision made by Passport.

Passport also reviews member activity related to PCP transfers on an ongoing basis and works in conjunction with Health Management, Quality Improvement, and the Provider Relations Specialists to provide education and assist if any areas of improvement are identified.

Each PCP receives a monthly member panel list of those members who have selected or been assigned to his or her panel. The monthly member panel list is not to be used as a confirmation of eligibility. To confirm eligibility, call Provider Services at (800) 578-0775 option 3.

2.4 Identification Cards

Passport issues an identification card for each family member enrolled. Members are advised to keep the ID card with them at all times.



ID cards contain the following information:

- Member's name and date of birth.
- PCP group name and telephone number (if applicable).
- Passport identification number.
- Kentucky Medicaid identification number.

2.4.1 Member Identification and Eligibility Verification

Passport member eligibility varies by month. Therefore, each participating provider is responsible for verifying member eligibility with Passport before providing services. Providers may verify eligibility using any of the following methods:

- **Online** – check member eligibility by logging into [Passport's Provider Portal](#).
- **KyHealth Net System** - Use the State's website to verify eligibility for all five (5) 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.chfs.ky.gov/dms/kyhealth.htm.
- **Telephone** – you may also check member eligibility by calling our interactive voice response (IVR) system at (800) 578-0775.
- Utilizing Passport's real-time member eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system eligibility verification, including point of service (POS) devices.
- Asking to see the member's Passport ID card and Kentucky Medicaid ID card. **Please note that Passport cards are not returned to Passport when a member becomes ineligible.** Therefore, the presentation of a Passport ID card is not sole proof that a person is currently enrolled in Passport.

Providers should request a picture ID to verify that the person presenting is indeed the person named on the ID card. Services may be refused if the provider suspects the presenting person is not the card owner and no other ID can be provided. If you suspect a non-eligible person is using a member's ID card, please report the occurrence to Passport's Fraud and Abuse Hotline at (855)512-8500 or the Medicaid Fraud Hotline at (800) 372-2970.

2.5 Member Release for Ethical Reasons

A participating provider is not required to perform any treatment or procedure that may be contrary to the provider's conscience, religious beliefs, or ethical principles. If such a situation arises, the provider should contact Provider Services at (800) 578-0775. A Provider Services representative will work with the provider to review the member's needs and transfer or refer the member to another appropriately qualified provider for care.

2.6 Health Education and Special Programs

Passport may refer members to health education classes provided by health agencies and providers or to Passport-provided programs. Providers who identify members who could benefit from education for a specific condition, such as pregnancy, asthma, heart failure or diabetes, for example, may call (877) 903-0082 for class information and schedules. Members also have access to health topics through an audio health library. Pre-recorded messages on topics provide information on preventing illness, identifying warning signs and administering self-care. A member may call the 24-Hour Nurse Advice Line to access the audio health library (see Section 2.6.3).

2.6.1 Language Assistance for Members

Federal law requires providers to ensure that communications are effective.

Providers who render health services, medical services, or social service programs to Passport members benefit from a program that receives federal financial assistance and are, therefore, subject to the requirements of Title VI of the Civil Rights Act of 1964. This act prohibits recipients of benefits from a program receiving federal financial assistance, such as Medicaid, from being prohibited from or refused service on the grounds of race, color, or national origin. The term "on the grounds of national origin" has been interpreted to include persons with limited-English proficiency (LEP).

Title VI requires every Medicaid provider, including Passport providers, to offer members equal access to benefits and services by ensuring that each LEP (limited English proficiency) person can communicate effectively in his or her language of choice. This law also requires providers to take necessary steps to provide language assistance at no cost to Medicaid members, including those enrolled with Passport.

Providers may contact Passport's Cultural & Linguistics Services Program at (502) 585-7303 for additional information and/or questions.

2.6.2 Help for Those with Impaired Vision or Hearing

The Member Handbook is available in alternative formats for members with visual impairments. Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, Passport's TDD/TTY number for Member Services is (800) 691-5566.

2.6.3 24-Hour Nurse Advice Line and Audio Health Library

PCPs can encourage their members to talk with a nurse 24 hours a day, 7 days a week by calling the

24-Hour Nurse Advice Line at (800) 606-9880. Passport wants to make certain that you are aware that through the same number, Passport members may access an audio health library of over 35 categories of health care topics, including:

- Allergies and Immune System
- Blood and Cancer
- Bones, Muscles, and Joints
- Brain and Nervous System
- Cancer
- Heart and Blood Vessels
- Children
- Mouth and Teeth
- Diabetes
- Diet and Exercise
- Digestive System
- Ear, Nose, and Throat
- Eyes
- Foot Problems
- Hormones
- Injuries
- Medicines
- Mental and Behavioral Health
- Men's' Health
- Pain Management
- Physical and Sports Medicine
- Pregnancy
- Preventive Health
- Respiratory and Lung Problems.
- Sexual and Reproductive Health
- Skin
- Sleep Disorders
- Social and Family
- Surgery
- Tests and Diagnostic
- Procedures
- Urinary Problems
- Women's Health

Members with limited English proficiency (LEP) can also access the 24-Hour Nurse Advice Line.

Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, the TDD/TTY number for the 24-hour Nurse Advice Line is (800) 648-6056.

NOTE: The 24-Hour Nurse Advice Line is not meant to take the place of the PCP and may not be used for after-hour coverage. However, it is an effective communication mechanism for dissemination of disease specific educational information as well as an alternative method for receiving information on self-care techniques in clinically appropriate circumstances.

2.7 Credentialing/Re-Credentialing

2.7.1 Initial Application Process

To join the Passport network an application and credentialing process must be take place. This can be initiated by calling our Provider Services department at (800) 578-0775. We will send you a provider application packet and work with you to become credentialed and, if approved, contracted as a Passport network provider. Providers may start the contracting and credentialing process by clicking on <http://passporthealthplan.com/providers/join-provider-network/>.

Passport participates with the Council for Affordable Quality Healthcare (CAQH). Providers who are participating with this common credentialing application database should include their CAQH provider ID number with documents submitted to Passport.

The policies and procedures regarding selection and retention do not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.

2.7.1.1 Practitioners

New practitioner applicants are required to complete their residency program and be eligible to obtain board certification prior to joining Passport. A practitioner is considered hospital based if they practice exclusively in a facility setting. These practitioners undergo a condensed review as it is the responsibility of the facility to verify their full credentials.

Passport enrolls providers in compliance with the "Any Willing Provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270. Passport enrolls providers in the network who are not participating in the Kentucky Medicaid Program as long as provider is deemed by the Department of Medicaid Services (DMS), eligible to enroll with Kentucky Medicaid Program in accordance with the state's Provider Credentialing and Re-credentialing standards. A provider cannot enroll in Passport network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process.

Passport enrolls providers in compliance with the "Any Willing Provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270. Passport enrolls providers in the network who are not participating in the Kentucky Medicaid Program as long as provider is deemed by the Department of Medicaid Services (DMS), eligible to enroll with Kentucky Medicaid Program in accordance with the state's Provider Credentialing and Re-credentialing standards. A provider cannot re-enroll in Passport network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the re-credentialing process.

New practitioners must include the following as applicable:

- A letter adding practitioner to each group.
- Completed Provider Application either a CAQH (Council for Affordable Quality Healthcare) universal credentialing application or the most current version of KAPER1 (Kentucky DMS application), including:
 - Additional copies of pages from the application (as needed);
 - Disclosure questions, as applicable, including but not limited to:
 - Documentation of any malpractice suits or complaints.
 - Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
 - Documentation of any conviction of a criminal offense within the last 10 years (excluding traffic violations); and,
 - The attestation page (including the practitioner signature and current date).
- Original, complete, and signed MAP Forms per the Kentucky DMS provider enrollment web page, <http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm>.
- Copy of current State License Registration Certificate.
- Copy of current Federal Drug Enforcement Agency Registration.
- Copy of CLIA.

- Copy of collaborative agreement between an Advance Practice Registered Nurse and supervising practitioner.
- Copy of MAP 612 Statement of Authorization for Payment signed by both the physician assistant and supervising practitioner.
- Curriculum vitae or a summary specifying month and year, explaining any lapse in time exceeding six months.
- Copy of a W-9 with the legal and doing business name of the entity, Tax Identification Number, and mailing address for all 1099 tax information signed by an authorized agent for the entity.
- Copy of claim history form for each malpractice activity within the past five years.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.
- A copy of Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with your unique Medicare provider identification number and practice location).
- Copy of social security card (If applicant has as social security card stating “valid for work only with DHS/INS Authorization,” please refer to additional requirements at <http://www.chfs.ky.gov/dms/provEnr/>).
- ECFMG (Education Council for Medical Graduates).
- FOX verification documentation for National Provider Identifier (NPI) and Taxonomy Code(s).

2.7.1.2 Organizational Provider

New applicants must submit a completed application, which includes the following as applicable:

- Two signed Participating Provider Agreements.
- Completed facility/ancillary service application including the credentials verification release statement.
- Original, complete, and signed MAP Forms per the Kentucky DMS provider enrollment web page, <http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm>.
- Copy of current State License Registration Certificate.
- Hearing aid dealer current license for specializing in hearing instruments.
- Copy of CLIA, if applicable.
- Copy of a W-9 in the name of the facility/group, including the Tax Identification Number and mailing address for all tax information.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.
- A copy of Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with your unique Medicare provider identification number and practice location), as applicable.
- Copy of current facility accreditation or certification.
- Model Attestation Letter for Psychiatric Residential Treatment Facilities (PRTF).
- DME Accreditation Certificate- exempt organizations need to submit a signed statement attesting to the exemption and documentation from CMS outlining the exemption.

- HME license issued by the KY Board of Pharmacy (per HB 282 and 201 KAR 2:350) (As of September 30, 2012) - exempt providers need to submit a signed statement attesting to the exemption.
- Medicare certification letter less than three years old with effective date of certification and physical location of where DME number is to be used. Medicare requires DME providers to re-enroll every 3 years.
- Independent labs must have a laboratory director, who must satisfy requirements set forth in 907 KAR 1:028 Section 1(8) and KRS 333.090 (1), (2), or (3) and supply documentation thereof.
- If not accredited or certified, a copy of the most recent CMS or state review.
- A copy of the mechanism that the organizational provider uses to monitor and improve patient safety.
- A copy of the transfer policy.
- FOX verification documentation for National Provider Identifier (NPI) and Taxonomy Code(s).

Failure to submit a complete application may result in a delay in Passport's ability to start the initial credentialing process.

Practitioners may contact the Provider Enrollment department at (502) 588-8578 to check the status of their application.

2.7.2 Credentialing Process

Passport assesses practitioner applicants through Passport's credentialing process. With the receipt of all application materials, primary source verification is conducted by Passport's Provider Enrollment department. Following the verification of credentials, Passport's Chief Medical Officer/designated Medical Director and/or Credentialing Committee reviews each application for participation.

Passport will not initiate the credentialing review until a completed and signed application with attachments has been received. The normal processing time is between 60 to 90 days from date of submission of a completed application for medical providers. For behavioral health providers, the enrollment process is complete within 45 days including credentialing.

A provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process.

2.7.3 Reimbursement and the Credentialing Process

Providers seeking participation in the Passport network and in the credentialing process will be reimbursed at the participating provider rate, starting from the date Passport receives a completed and signed application packet and confirmation that the provider has been issued a Kentucky MAID number. If the Credentialing Committee denies participation, any claims paid during the interim will be recouped, and unpaid claims will be denied.

Providers may begin submitting claims for services provided to Passport members once they have been notified of the receipt of their completed application and have been assigned a Provider ID number. Providers are required to submit all claims within 180 days of service, but no payment is made until Passport receives confirmation that the provider has been issued a Kentucky MAID number. Please note, claims submitted without a Kentucky Medicaid Identification (MAID) number will initially deny.

Providers will receive notification from DMS when a MAID number is assigned. Providers are encouraged to notify Passport of receipt of a MAID number assignment.

After Passport receives notification of a provider MAID number assignment, all claims received from the provider will be automatically reprocessed, starting from the date Passport received a completed and signed provider application.

Providers will be considered participating Passport providers once they have met Passport's credentialing requirements. Providers will be notified by Passport when they have been successfully credentialed by Passport. Providers applying for participation are excluded from the *Provider Directory* until the credentialing process has been completed in its entirety.

2.7.4 Providing Services Prior to Becoming a Credentialed Passport Provider

If a provider determines a member must be seen prior to the assignment of a Provider ID number and notification of the receipt of a completed and signed application by Passport, the provider must obtain an authorization from Passport's Utilization Management department in order to receive payment for services. Please note that an authorization for service does not guarantee payment.

2.7.5 Re-credentialing Process

Passport re-credentials its providers, at a minimum, every three years. In addition, Passport conducts ongoing monitoring of Medicare and Medicaid sanctions as well as licensure sanctions or limitations. Practitioners who become participating and subsequently have restrictions placed upon their license will be reviewed by the Credentialing Committee and evaluated on a case-by-case basis, based upon their ability to continue serving Passport's members.

Member complaints and adverse member outcomes are also monitored and Passport will implement actions as necessary to improve trends or address individual incidents. If efforts to improve practitioner performance are not successful, the practitioner may be referred to the Credentialing Committee for review prior to his/her normally scheduled review date.

2.7.5.1 Practitioners

Passport will generate a re-credentialing application on all practitioners with current CAQH applications on file. Practitioners without a CAQH on file will be notified by telephone or letter to submit a re-credentialing application (most current version of the KAPER 1 or CAQH) with the following list of attachments:

- Disclosure questions, as applicable, including but not limited to:
 - Documentation of any malpractice suits or complaints.

- Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
- Documentation of any conviction of a criminal offense within the last 10 years (excluding traffic violations).; and,
- The attestation page (including the practitioner signature and current date).
- Copy of current State License Registration Certificate.
- Copy of current Federal Drug Enforcement Agency Registration - if applicable.
- Copy of current collaborative agreement between an Advance Practice Registered Nurse and supervising practitioner, as applicable.
- Copy of MAP 612 Statement of Authorization for Payment signed by both the physician assistant and supervising practitioner, as applicable.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.

2.7.5.2 Organizational Provider

Passport sends a facility/ancillary service application to the organizational provider for completion. The re-credentialing application must include the following as applicable:

- Completed facility/ancillary service application including the credentials verification release statement.
- Copy of current State License Registration Certificate.
- Copy of CLIA, if applicable.
- Copy of a W-9 in the name of the facility/group, including the Tax Identification Number and mailing address for all tax information.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.
- Copy of claim history form for each malpractice activity within the past five years.
- A copy of Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with your unique Medicare provider identification number and practice location), as applicable.
- Copy of current facility accreditation or certification.
- If not accredited or certified a copy of the most recent CMS or state review.
- A copy of the mechanism that the organizational provider uses to monitor and improve patient safety.
- A copy of the transfer policy.

Failure to return documents in a timely fashion may result in termination. If the termination period is longer than 30 days, the initial credentialing process would need to be completed in order to re-enroll as a participating provider.

Practitioners or providers may contact the Provider Enrollment department at (502)-785-8281.

1. **Press Option 1** to check status of your Passport Network Participation and/or report or check status of practice information changes.

2. **Press Option 2** to check on status of your credentialing application. This will transfer you direct to Aperture.
3. **Press Option 3** if you have spoken with Aperture but would like to speak with a Passport Credentialing Representative.

2.7.5.3 Practitioner Rights

Practitioners have the right to review information obtained from outside sources (e.g., malpractice insurance carriers, state licensing boards) and to correct erroneous outside source information that was used to support your credentialing application.

To request information obtained by outside sources, or should you wish to correct erroneous information, please contact Passport Credentialing Department at (502) 785-8281, press option 3. When requesting a correction of erroneous information, please contact Passport Credentialing Department within seven (7) business days of receipt of the requested outside source information that was used to support your credentialing application.

Should Passport decide to deny or terminate a provider from participation with Passport, the provider will receive notification of the decision. The notification will include the reasons for the denial or termination, the provider's rights to appeal and request a hearing within 30 days of the date of the denial notice, and a summary of the provider's hearing rights.

2.8 Provider Terminations/Changes in Provider Information

2.8.1 Provider Terminations

A provider desiring to terminate his/her participation with Passport must submit a written termination notice, to Provider Enrollment, at least ninety (90) days prior to the desired effective date of the termination.

For terminations by primary care providers, the assigned Provider Relations Specialist will work with Provider and Member Enrollment to coordinate member notification and assignment to another PCP based on the PCP's member panel.

Provider Network Management will send the full list of members impacted by the termination to the Case Management team for review to determine if any members are in active treatment for a medical or surgical condition, including those members receiving obstetrical care in the second or third trimester of pregnancy throughout the postpartum period (six weeks post-delivery).

Upon receipt of the list of identified members, the Provider Network Management sends a notification letter to affected members within fifteen days if provider is a Primary Care Provider (PCP) and within thirty days for any other provider-specialist, of the provider's termination, termination effective date, and instructions. If the terminating provider is a PCP, the letters are sent to members that are assigned to that PCP's panel. If the terminating provider is a specialist, a mailing list is compiled of any member that has been seen by the specialist in the last 6 months from the date the termination notice is received. The list is compiled using claims data for the specialist.

If the terminating provider is an individual Primary Care Provider within a group practice, there is no action needed in regards to reassigning members as they are assigned at the group level and not individual practitioner level. If the terminating provider is a Primary Care Provider group, members will be notified and given the opportunity to choose a new PCP by calling our Member Services department at (800) 578-0603 or they will be automatically assigned to a Primary Care Provider closest to their residence at the end of the 90-day period.

2.8.2 Changes in Provider and Demographic Information

Providers are required to provide a 90-day prior written notice to both Passport's Provider Network Management department and DMS of any changes in information regarding their practice. Such changes include:

- Address changes, including changes for satellite offices.
- Additions/deletions to a group.
- Changes in billing locations, telephone numbers, tax ID numbers.

Reimbursement may be affected if changes are not reported in accordance with Passport policy.

Please note that providers are required by DMS to annually submit a copy of current license and annual disclosure of ownership. If these documents are not provided, the provider's Kentucky Medicaid (MAID) number may be terminated. Your office will receive notice from the DMS when these documents are due for submission. Please respond timely to these requests.

2.8.3 Change in Location

If a provider working in multiple offices discontinues working in one or more locations, written notification must be provided to Passport within 30 days detailing the locations where he/she will no longer see patients, as well as the specific offices where he/she will continue to see patients.

2.8.4 Panel Closings

Passport recognizes that PCPs may occasionally need to limit the number of patients in their practices in order to deliver quality care. Passport will evaluate any requirements for minimal members per practitioner panel. (For additional information regarding member to practitioner ratios, see Section 4.3.)

Once a PCP has accepted the number of Passport members agreed upon in the Primary Care Provider Agreement, a written request must be forwarded to Passport to impose panel restrictions. Please send your request to your Provider Relations Specialist at 5100 Commerce Crossings Drive, Louisville, KY 40229.

Passport requests a 90-day advance written notice to change panel status.

2.8.5 Panel Limitations

Panel limitations and/or removal of panel restrictions must be submitted in writing to the Provider Relations Specialist. Providers are notified by their Provider Relations Specialist of the approval or denial of the request. Approved panel limitations and/or removal of restrictions become effective

the first of the following month after a request is approved by Passport.

2.8.6 Member Dismissals from PCP Practices

Primary care providers (PCP) have the right to request a member's dismissal from their practice and request the member be reassigned to a new PCP for the following circumstances:

- Incompatibility of the PCP/patient relationship;
- Member has not utilized a service within one year of enrollment in the PCPs practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year or;
- Inability to meet the medical needs of the member.

PCPs do not have the right to request a member's dismissal from their practice in the following situations:

- A change in the member's health status or need for treatment.
- The member's utilization of medical services.
- A member's diminished mental capacity.
- A member's disruptive behavior that results from the member's special health care needs unless the behavior impairs the PCP's ability to provide services to the member or others.

Dismissal requests shall not be based on the grounds of race, color, national origin, handicap, age or gender.

Providers should submit a Primary Care Provider Member Dismissal Form

<http://passporthealthplan.com/wp-content/uploads/2019/05/PROV03132-PCP-Member-Dismissal-Form.pdf>. Primary Care Providers must use this form when requesting a member dismissal from their panel. This form takes the place of the previous policy, which required a provider to submit the dismissal request via practice letterhead.

This form allows Passport to receive all necessary information in order to review and process the dismissal request efficiently and timely. Required fields are marked with an asterisk. Incomplete forms will not be accepted and may affect the dismissal timeframe. Please follow the submission information marked on the form.

Dismissal requests forms should be faxed to Passport Network Management, 502-585-6060 and the provider should notify the member, please see Section 2.8.1. Requests must include provider name, provider group ID number, member name, member ID number, reason for dismissal request, and effective date. Members are not dismissed from the PCP's practice until all required information is received. Questions regarding this process may be directed to Provider Services at (800) 578-0775 or contact your Provider Relations Specialist.

Dismissal requests meeting Passport's requirements as stated above are reviewed, determined to be appropriate, and processed within five business days of receipt by Provider Network Management. Following review, Member Enrollment will reassign the member to a new PCP. The dismissal

effective date must be at least 30 days from the request date to allow for the member's transition to a new PCP unless extenuating circumstances necessitate an immediate effective date.

The initial PCP must continue to serve the member until the new PCP assignment becomes effective, barring ethical or legal issues. The member has the right to appeal such a transfer via Passport's formal appeal process.

If a PCP's request does not meet the above stated requirements, the appropriate Provider Relations Specialist will contact the PCP directly to discuss.

Please note this process does not apply to "age-out" dismissals for pediatric practices.

2.8.7 Locum Tenens

According to Passport policy, participating providers may utilize the services of a locum tenens provider, under temporary circumstances, for a maximum period of sixty (60) consecutive days. When locum tenens services are needed, participating providers must register the substitute provider. This process must be completed prior to the provision of any services by a locum tenens provider.

To register a locum tenens provider, the participating Passport provider must complete a one-page *Registration of Locum Tenens Physician* form (available in Section 17 of this Provider Manual). Both the participating Passport provider and the locum tenens provider must sign the form. To complete the registration process, the signed form must be returned to Passport by mail or by fax to:

Mail:

Passport Health Plan
Attn: Provider Relations
5100 Commerce Crossings Drive
Louisville, Kentucky 40229

Fax:

Attn: Provider Relations
(502) 585-6060

Services rendered by a locum tenens provider must be billed utilizing the absent provider's Passport ID number and the Q6 modifier with the applicable procedure code(s). The Q6 modifier signifies that the service was provided by a locum tenens provider. According to the Passport Provider Agreement, the absent provider remains liable and all contractual terms remain effective throughout the employ of a locum tenens provider.

If services by a locum tenens provider remain necessary beyond the period of sixty (60) consecutive days, the locum tenens or substitute provider must apply for participation with Passport and complete the credentialing process and have or apply for a Kentucky Medicaid number. Upon becoming credentialed with Passport, the provider will be assigned a provider ID number for billing purposes.

2.9 Provider Appeals and Grievances

2.9.1 What is Appealable?

Passport providers have the right to file an appeal for any adverse benefit determination which includes:

- Denial of a claim for reimbursement;
- A contractual issue; or
- Denial of a health care service (prior authorization).

Upon the request of a Medicaid provider, Passport will provide at no cost to the provider, all documents, records, and other information relevant to an adverse payment or coverage determination, Passport shall inform a Medicaid provider of the determination with sufficient detail of the reason(s) therefore and the Provider's right to request and receive at no cost to the Provider, all documents, records, and other information related to the determination.

2.9.2 How do Providers File an Appeal?

2.9.2.1 Method of Appeal

All provider appeals must be submitted in writing.

Submit Provider Appeals to:

Type of Appeal	Timing of Appeal	Address
Behavioral Health	Must be submitted within sixty (60) calendar days of the adverse benefit determination.	Passport Health Plan Attn: Beacon Appeals Coordinator P.O. Box 1856 Hicksville, NY 11802-1856 (855) 834-5651 TDD/TTY (866)834-9441
Claims Denial	Must be submitted within 180 days of last process date of claim.	Passport Health Plan Claim Appeals PO Box 7114 London, KY 40742
Contractual Issues	Must be submitted within sixty (60) calendar days of the occurrence of the contractual issue being appealed.	Passport Health Plan Legal Services / Contractual Appeals 5100 Commerce Crossings Drive Louisville, Kentucky 40299
Credentialing Denial or Credentialing or Quality Network Termination	Must be submitted within thirty (30) calendar days of the adverse benefit determination.. Provider may request a hearing.	Passport Health Plan Attn: Credentialing Appeals 5100 Commerce Crossings Drive Louisville, Kentucky 40299
Dental	Must be submitted within thirty (30) calendar days of	Avesis Attn: Appeals Department

Type of Appeal	Timing of Appeal	Address
	adverse benefit determination..	PO Box 7777 Phoenix, AZ 85011-7777 (866) 909-1083
Medical	Must be submitted within sixty (60) calendar days of the adverse benefit determination..	Passport Health Plan Appeals Coordinator 5100 Commerce Crossings Drive Louisville, KY 40229 (502) 585-7307 Fax (502) 585-8461
Overpayment Recovery and Recoupment	Must be submitted within thirty (30) calendar days from postmark date or electronic delivery date of written notice of overpayment recovery request.	Passport Health Plan Attn: Recovery Letter Appeal 5100 Commerce Crossing Drive Louisville, KY 40229
Pharmacy	Must be submitted within sixty (60) calendar days of the adverse benefit determination.	Passport Health Plan Phone: (844) 380-8831 Fax: (844) 802-1406
Radiology	Must be submitted within sixty (60) calendar days of the adverse benefit determination..	eviCore Appeals Department 730 Cool Springs Blvd., Suite 800 Franklin, TN 37067 (877) 791-4099
Outpatient Therapy, Chiropractic, Pain Management	Must be submitted within 60 days (60) calendar days of the adverse benefit determination.	eviCore Healthcare Attn: Clinical Appeals, Mail Stop 600 400 Buckwalter Place Blvd. Bluffton, SC 29910 Phone: (800) 792-8744 option 4
Vision	Must be submitted within thirty (30) calendar days of adverse benefit determination..	Avēsis Third Party Administrators, Inc. Attention: Vision Appeals P.O. Box 38300 Phoenix, AZ 85069-8300

At no time will punitive or retaliatory action be taken against a provider for filing an appeal or a provider for supporting a member appeal.

2.9.2.2 Conduct of the Review

For appeals related to a medical necessity denial, a board-certified physician, who was not involved in the initial denial, will conduct the clinical review. The provider can also request that the reviewing physician have clinical expertise in treating the member's condition or disease. Providers may submit documents in support of the appeal.

2.9.2.3 Resolution of the Appeal

All provider appeals except those related to credentialing denials or terminations, are resolved within thirty (30) calendar days of receipt of the appeal unless the time period is extended by fourteen (14) calendar days upon request of the provider or pursuant to our request. Providers will receive a written notice of the resolution of the appeal. Appeals of credentialing denials or terminations include the right to a hearing before a hearing panel. Passport will work with the provider to schedule the hearing.

2.9.2.4 Independent Third Party Review

Pursuant to KRS 205.646 and 907 KAR 17:035, a provider may request an external independent review of an adverse final decision of a denial, in whole or in part, of a health care service regarding medical necessity determinations, whether the service is covered by the Medicaid program, or whether the provider followed Passport's requirements for the covered service. To request an external independent third-party review, a provider must submit a written request to Passport within sixty (60) calendar days of receiving the final appeal decision. Requests must identify each specific issue and dispute related to Passport's adverse final decision and state the basis on which Passport's decision on each issue is believed to be erroneous. The request must include your designated contact information including a name, phone number, mailing address, fax number, and email address. Requests for external independent third party reviews may be sent:

Electronically: ReviewRequests@passporthealthplan.com

By fax: (502) 585-8334

By mail: Attn: Provider Review Requests
Passport Health Plan
5100 Commerce Crossings Drive
Louisville, KY 40229

2.9.2.5 Administrative Hearing

Pursuant to KRS 205.646 and 907 KAR 17:040, a provider who receives an adverse final decision from an independent third party review may appeal that decision by requesting an administrative hearing. Requests for administrative hearings must be sent to DMS within thirty (30) calendar days of receiving the written notice of the right to appeal from DMS.

2.9.3 Provider Grievances

A grievance is defined by federal and state law as an expression of dissatisfaction about any matter other than an adverse **benefit determination**.

Passport providers have the right to file a grievance of any Passport decision that does not involve an adverse **benefit determination**.

2.9.3.1 How do Providers File a Grievance

Timing:

Providers have thirty (30) calendar days from the date of an event causing dissatisfaction to file a grievance.

Method of Filing a Grievance:

Provider grievances may be submitted orally or in writing.

Submit Provider Grievances to:

Type of Grievance	Address
Dental	Avesis Attn: Appeals Department PO Box 7777 Phoenix, AZ 85011-7777 (866) 909-1083
Radiology	eviCore Healthcare Appeals Department 730 Cool Springs Blvd., Suite 800 Franklin, TN 37067 (877) 791-4099
Outpatient, Chiropractic, Pain Management	eviCore healthcare Attn: Clinical Appeals, Mail Stop 600 400 Buckwalter Place Blvd. Bluffton, SC 29910 (800)792-8744 option 4
Vision	Superior Vision 939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090 (800)879-6901

Type of Grievance	Address
Pharmacy	Passport Health Plan 5100 Commerce Crossings Drive Louisville, KY 40229 (800) 578-0775
All Other Provider Grievances	Passport Health Plan 5100 Commerce Crossings Drive Louisville, KY 40229 (800) 578-0775

2.9.3.2 Resolution of the Grievance

All provider grievances are resolved within thirty (30) calendar days of receipt of the grievance unless the time period is extended by fourteen (14) calendar days upon request of the provider or pursuant to our request. For any extension not requested by the Provider, Passport will mail the Provider written notice of the reason for the extension within two (2) business days of the decision to extend the timeframe. Providers will receive a written notice of the resolution of the grievance.

2.10 Members' Rights

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

The rights of our members include, without limitation, the right to:

- A. Be treated with respect and dignity. Have the right to privacy and to not be discriminated against.
- B. Choose a primary care provider (PCP) and request a change to another PCP.
- C. Join providers in making decisions about your health care. You may discuss treatment options, regardless of cost or benefit coverage. You may also refuse treatment.
- D. Ask questions and receive complete information about their medical condition and treatment options. This may include specialty care.
- E. Voice grievances or file an appeal about Passport decisions that affect them. If a member does not agree with Passport's appeal decision, members may file a state hearing with the Department for Medicaid Services (DMS).
- F. Receive timely access to care that does not have any communication or physical barriers.
- G. Make an advance directive, like a living will.
- H. Look at and get a free copy of their medical records, as permitted by law.
- I. Receive timely referrals and access to medically needed specialty care.
- J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- K. Receive information about Passport, benefits, services, providers and their rights and responsibilities.
- L. Make suggestions about their rights and responsibilities.

M. Any Native American (Indian) member may get services from I/T/U providers (Indian Health Services, Tribally operated facility/program, and Urban Indian clinics) signed up with Passport.

The responsibilities of Passport members include the responsibility to:

- A. Become informed about member rights;
- B. Abide by the Contractor's and Department's policies and procedures;
- C. Become informed about service and treatment options;
- D. Actively participate in personal health and care decisions, practice healthy lifestyles;
- E. Report suspected Fraud and Abuse; and
- F. Keep appointments or call to cancel.
- G. Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- H. Follow plans and instructions for care that they have agreed to with their practitioners.
- I. Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

2.11 Member Appeals and Grievances

2.11.1 What is Appealable?

Members have the right to appeal any Passport decision involving an **adverse benefit determination**. An **adverse benefit determination** is defined by federal and state law.

An Adverse benefit determination is as defined in 42 CFR 438.400(b):

- A. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
- B. Reduction, suspension, or termination of a service previously authorized by the Department, its agent or Contractor;
- C. Denial, in whole or in part, of payment for a service;
- D. Failure to provide services in a timely manner, as defined by Department;
- E. Failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 CFR 438.408(b); or
- F. For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside a Contractor's Network; or
- G. Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

No Retaliation for Filing an Appeal

At no time will punitive or retaliatory action be taken against a member for filing an appeal or a provider for supporting a member appeal.

2.11.2 How do Members File an Appeal?

Timing

Members have sixty (60) calendar days from the date of receiving a notice of adverse **benefit determination**, to file an appeal.

Method of Appeal

Member appeals can be either oral or in writing. An oral appeal must be followed by a written appeal, signed by the member and received by us within ten (10) calendar days of the member's oral appeal.

Authorized Representatives of Members May File an Appeal:

An authorized representative may file an appeal on behalf of the member. An authorized representative is a legal guardian of the member for a minor or an incapacitated adult, or a representative of the member as designated in writing by the member to Passport. The personal representative of a deceased member may file an appeal on behalf of the member.

A provider may be an authorized representative for a member only with the member's written consent. The written consent must include a statement that the member is giving the provider the right to appeal and must also include a specific statement of the adverse **benefit determination** that is being appealed. A single written consent shall not qualify as a written consent for more than one:

- a. Hospital admission;
- b. Physician or other provider visit; or
- c. Treatment plan.

Help for Members with Filing an Appeal:

Passport members may call Passport member services for help filing an appeal. For Behavioral Health, Passport members may call Passport Behavioral Health Hotline at (855) 834-5651.

LEP persons will be given interpretation / translation assistance when necessary to navigate the appeals process.

Submit Member Appeals to:

Type of Appeal	Address	To Expedite a Member Appeal
Behavioral Health	Beacon Health Options Appeals Coordinator P.O. Box 1856 Hicksville, NY 11802-1856	(855) 834-5651 TDD/TTY (866) 834-9441

Denial, in whole or in part, of payment for a service	Passport Health Plan Claim Appeals PO Box 7114 London, KY 40742	N/A
Dental	Avesis Attn: Appeals Department PO Box 7777 Phoenix, AZ 85011-7777	(866) 909-1083
Medical	Passport Health Plan Appeals Coordinator 5100 Commerce Crossings Drive Louisville, KY 40229 (502) 585-7307 Fax (502) 585-8461	(502) 585-7307, or (800) 578-0603, option 0, Extension 7307
Pharmacy	Passport Health Plan	(844)380-8831 Fax: (844)802-1406
Radiology	eviCore Healthcare Appeals Department 730 Cool Springs Blvd., Suite 800 Franklin, TN 37067 (877) 791-4099	(877)791-4099 Appeals Department
Outpatient Therapy, Chiropractic, Pain Management	eviCore healthcare Attn: Clinical Appeals, Mail Stop 600 400 Buckwalter Place Blvd. Bluffton, SC 29910	(800)792-8744 option 4
Vision	Superior Vision 939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090 Attn: Member Appeals	(800)879-6901

	(800) 879-6901	
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Acknowledgement of Receipt of the Appeal:

Within five (5) working days of receiving an appeal, we will send the member a written notice that the appeal has been received and the expected date of resolution.

Continuance of Services during an Appeal:

Passport will provide for continuation of services in accordance with 42 CFR, while the appeal is pending; if the member requested a continuation benefits, until one (1) of the following occurs:

- A. The member withdraws the appeal or request for a State Fair Hearing;
- B. The member does not request a State Fair Hearing with continuation of benefits within ten (10) days from the date the Contractor mails an adverse appeal decision; or
- C. A State Fair Hearing decision adverse to the member is made.

Expedited Appeals

An expedited review process is available for a member when the standard resolution time frame could place the Member at risk or seriously compromise the Member's health or well-being seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain or regain maximum function. Expedited appeals are resolved within three (3) working days of receipt of the request. The three (3) working days timeframe will be extended for up to fourteen days if the member requests the extension or we demonstrate to the Department that there is need for additional information and the extension is in the member's interest. If we request the extension, we will give the member written notice of the reason for the extension. If we deny a request for a Member request for an expedited appeal, the appeal will be resolved within thirty (30) calendar days of receipt of the original request for appeal. We will give the Member prompt oral notice of the decision to deny expedition of the appeal. We will follow up with a written notice within two (2) calendar days of the denial.

Conduct of the Review

The review will be conducted by an individual who was not involved in the initial decision. Appeals involving denials for lack of medical necessity, the denial of expedited resolution of the appeal or clinical issues will be conducted by health care professionals who have the appropriate clinical expertise concerning the condition or disease under appeal.

Members shall be given an opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing and will take into account all comment, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

Resolution of the Appeal

All member appeals are resolved within thirty (30) calendar days of receipt of the appeal, unless the time period is extended by fourteen (14) calendar days upon request of the member or a request made by us. If we request the extension, we will provide give the member prompt oral notice and followup with written notice of the extension and the reason for the extension within two (2) working calendar days of the decision to extend. Members will receive a written notice of the resolution of the appeal. The notice will include the right to request a State Fair Hearing.

Member Requests for a State Hearing

If a member is not satisfied with the appeal resolution, the member has the right to request a State Fair Hearing. The member must exhaust the Passport internal appeal process prior to requesting a State Fair Hearing. Requests for a State Fair Hearing must be made in writing postmarked or filed with the Kentucky DMS, within one hundred twenty (120) days of the notice of the appeal decision. Requests for a State Hearing should be forwarded to:

Kentucky Department for Medicaid Services

Division of Program Quality & Outcomes

275 East Main St., 6C-C

Frankfort, KY 40621

(800) 635-2570

TDD/TTY (800) 775-0296

Kentucky Ombudsman

Members may also contact the Kentucky Ombudsman at any time at the following address:

Cabinet for Health and Human Services

Office of Ombudsman

275 East Main St., 1E-B

Frankfort, KY 40601

(800) 372-2973

TDD/TTY (800) 627-4702

What is a Grievance?

A **grievance** is defined by federal and state law as an expression of dissatisfaction about any matter other than an adverse **benefit determination**..

Passport members have the right to file a grievance concerning any Passport decision that does not involve an adverse **benefit determination**..

No Retaliation for Filing a Grievance

At no time will punitive or retaliatory action be taken against a member for filing a grievance or a provider for supporting a member grievance.

How do Member's file a Grievance?

Timing:

Members may file a grievance with Passport at any time.

Method of Filing of Grievance:

Grievances can be submitted either orally or in writing.

Submit Member Grievances to:

Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

(800) 578-0603

Help for Members with filing a Grievance:

Members may call Passport **Member Services at (800) 578-0603** for help filing a grievance. LEP persons will be given interpretation/translation assistance when necessary to navigate the grievance process.

Acknowledgement of Receipt of the Grievance:

Within five (5) working days of receipt of a grievance, we will provide the member with a written notice that the grievance has been received and the expected date of resolution.

Conduct of the Review

The grievance review will be conducted by an individual who was not involved in the initial decision.

Resolution of the Grievance

All member grievances are resolved within thirty (30) calendar days of the date the grievance was received. Members will receive a resolution letter that includes the information considered in investigating the grievance, findings and conclusions based on the investigation and the disposition of the grievance.

Resolution may be extended by up to fourteen (14) calendar days if the member requests the extension, or if we determine there is a need for additional information and the extension is in the member's interest. For any extension not requested by the member, Passport will mail the member written notice of the reason for the extension within two (2) business days of the decision to extend the timeframe.

Member Request for a State Hearing

Passport will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but not later than 72 hours from the date the Passport receives notice reversing the determination, if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse Passport's decision to deny, limit, or delay services. Passport will pay for disputed services received by the Member while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services.

2.12 Title VI Requirements: Translator and Interpreter Services

Title VI of the Civil Rights Act of 1964 is a Federal law 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.

All Passport providers indirectly benefit from Federal financial assistance (via Medicaid). Therefore, under Title VI and the Culturally and Linguistically Appropriate Services (CLAS) Standards 4 - 7, as outlined by the Office of Minority Health, U.S. Department of Health and Human Services (DHHS), **all Passport providers are required by law to:**

- Provide written and oral language assistance at no cost to any patient, including, but not limited to, Passport members with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. **Language access includes the provision of competent language interpreters.**

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation in their preferred language and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

- Provide patients, including Passport members, 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 member 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 in the preferred language or format of patients, including Passport members.

Additionally, under the CLAS Standards, Passport providers are **strongly encouraged** to:

- Provide effective, understandable, and respectful care to all patients, including Passport members, in a manner compatible with his/her 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, including Passport members.
- Routinely document each patient's preferred language or format, such as Braille, audio, or large type, in all medical records.

Potential penalties of non-compliance with Title VI may include:

- Loss of federal and state funding, including future funding (i.e. providers may be prohibited from participating in Medicaid, Medicare, and/or incentive programs such as the Electronic Health Records incentive).
- Legal action against providers from the DHHS, legal service organizations, and private individuals.
- "Informed consent" issues which may also lead to medical malpractice charges.
- Change in participation status with Passport.

Providers may contact Passport's Cultural and Linguistics Services Program Coordinator at (502) 585-8251 or e-mail cals@passporthealthplan.com for additional information or to schedule an on-site training.

2.12.1 Title VI Training/Resources

Passport's Cultural and Linguistics Services (CLSP) Program offers the following training materials and resources. Contact the CLSP Coordinator at (502) 585-8251-, e-mail cals@passporthealthplan.com, or visit our web site, www.passporthealthplan.com/provider/services/cals, for more details.

- **Onsite Trainings/Resources**

Our CLSP staff is a resource for Title VI/CLAS Standards, Cultural Diversity and assists providers in reaching and maintaining compliance. We offer free on-site trainings for office staff, an informative Provider Toolkit, and web-based information and resources.

- **Provider Office Materials**

In addition to the Provider Toolkit and other educational resources, Passport also offers provider office signage to assist office staff in complying with Title VI. These materials are available online or by calling the CLSP coordinator.

- **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 call Member Services for copies.

Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf (TDD), Passport's TDD/TYY number for Member Services is:

Passport - (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 ask for Client Services. It may take 48 to 72 hours to set up an InterpreTalk account to begin receiving interpretive services.

Provider Manual

Section 3.0

Provider Roles and Responsibilities

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3.0 Provider Roles and Responsibilities

3.1 Confidentiality

In accordance with federal and state laws, Passport has established confidentiality policies and practices for its own operation and to outline expectations to our provider network. To obtain a copy of Passport's Notice of Privacy Practices (NPP), please [visit the member section of our website](#).

All providers must comply with state and federal laws and regulations and Passport's policies on the confidential treatment of member information in all settings.

All providers are to treat members' protected health information (PHI), including medical records, confidentially and in compliance with all federal and state laws and regulations, including laws regarding mental health, substance abuse, HIV and AIDS, as well as the Health Insurance Portability and Accountability Act (HIPAA). It is the provider's responsibility to obtain the member's written consent for the purpose of sharing member health information.

Providers are authorized to share members' protected health information with Passport Health Plan for the purposes of treatment, payment, and health care operations, including requesting Passport to process claims and administer reimbursement for the same.

Providers rendering services to Passport members are required to obtain special consent (authorization) from members for any uses or disclosures of protected health information beyond the uses of payment, treatment, and health care operations. Members have the right to specifically approve or deny the release of personal health information for uses other than payment, treatment, and health care operations. Examples of uses and disclosures that require special consent or authorization include data requested for workers' compensation claims, release of information that could result in the member being contacted by another organization for marketing purposes, and data used in research studies.

In cases where consent is required from members who are unable to give it or who lack the capacity to give it, Passport and its providers/practitioners will accept special consent or authorization from persons designated by the member. Designated persons, such as parents or guardians, may authorize the release of personal health information and may obtain access to information about the member.

Member information transferred from Passport Health Plan to another organization as permitted by routine or special consent will be protected and secured according to Passport Health Plan's privacy policies and procedures and in compliance with state and federal privacy laws and regulations.

Provider agrees to cooperate with Passport's Quality Management Program and all other quality management activities, including the use of performance data. Practitioner performance data may include, but is not limited to, medical records, practitioner experience, patient experience, and claims. The data received will be used in the development or improvement of activities and initiatives, credentialing activities, and public reporting to consumers. Passport will use member information for quality studies, health outcomes measurements, and other aspects of health plan operations and will

de-identify the information as dictated by federal privacy legislation.

Passport members are permitted to access, copy, and inspect their medical records upon request. One copy of a member's complete medical record must be made available from the provider upon request at no charge and in accordance with [KRS 422.317](#).

3.2 The Role of the Primary Care Provider (PCP)

A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a Federal Qualified Health Center, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals.

Additionally, an Obstetrician/Gynecologist can serve as a PCP to a member with obstetrical or gynecologic health care needs, disability or chronic illness provided the specialist agrees to provide and arrange for all appropriate primary and preventive care. Passport provides instructional materials that encourage members to seek their PCP's advice before accessing medical care from any other source except for direct access services and emergency services. It is imperative the PCP's staff fosters this idea and develops a relationship with the member that will be conducive to continuity of care.

Primary care physician residents may function as PCPs. The PCP serves as the member's initial and most important point of contact with Passport. This role requires a responsibility to both Passport and the member. Although PCPs are given this responsibility, Passport will retain the ultimate responsibility for monitoring PCP actions to ensure they comply with Passport and DMS policies.

Specialty providers may serve as PCPs under certain circumstances, depending on the member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the member or family, the specialist, and Passport's medical director. The member has the right to appeal such a decision in the formal appeals process.

Passport will monitor the PCP's actions to ensure he/she complies with Passport and DMS policies including but not limited to the following:

- Maintaining continuity of the member's health care;
- Exercising primary responsibility for arranging and coordinating the delivery of medically-necessary health care services to members;
- Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within Passport's network;
- Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services, including periodic preventive and well-care services, and providing appropriate and timely reminders to members when services are due;
- Discussing Advance Medical Directives with all members as appropriate. See Section 3.4.4. Advanced Directives;

- Providing primary and preventative care, recommending or arranging for all necessary preventive health care, and adhering to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule and the Vaccines For Children (VFC) immunization schedule for each Passport member younger than 21 years of age. Documenting all care rendered in a complete and accurate medical record that meets or DMS specifications;
- Screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders (Please see [Screening, Brief Intervention and Referral to Treatment - SBIRT](#));
- Arranging and referring members when clinically appropriate, to behavioral health providers;
- Providing periodic physical examinations as outlined in the Preventive Health Guidelines;
- Providing routine injections and immunizations;
- Providing or arranging 24-hours a day, seven days a week access to medical care. For additional information, see Section 4.0 – Office Standards;
- Arranging and/or providing necessary inpatient medical care at participating hospitals.
- Providing health education and information; and,
- Passport members have the right to a second opinion. If the member requests a second opinion, the PCP should complete a referral to a participating specialist. If there is not a specialist within the network, the PCP must call Passport's Utilization Management department at (502) 578-0636 to request an authorization to a non-participating specialist.

The PCP should perform routine health assessments as appropriate for a member's age and gender and maintain a complete individual medical record of all services provided to the member by the PCP, as well as any specialty or referral services. PCPs are required, with the assistance of Passport, to integrate into the member's medical records any services provided by school-based health services or other external service providers.

It is the responsibility of all PCPs to manage the care of their Passport panel members and direct the members to specialty care services when necessary. It is the responsibility of the specialist practitioner to work closely with the PCP in this process.

Dual eligible members, members who are presumptively eligible - pregnant, disabled children, and foster care children are not required to have a PCP but may request a PCP. All other members either make a selection or have Passport select a PCP for their medical home. The name and telephone number of the PCP or group selected appears on the member's Passport Identification Card. Please see Section 2.4.1 for more information about member eligibility and identification.

Each PCP receives a monthly member panel list of those members who have selected or been assigned to him or her. It is advisable to verify eligibility at, or before, the time of service using one of the online eligibility tools, ([Passport Provider Portal](#) or [KyHealth Net](#)). Even with this verification, there are times when DMS retroactively terminates eligibility for certain members. In these circumstances, Passport may decide to recoup any amounts paid for these patients.

Coordination between Primary Care and Behavioral Health providers is a critical component of promoting health and wellness for Passport members. We encourage primary care providers to review the behavioral health section of this provider manual for more information about the covered

benefits, authorization requirements and other important behavioral health issues. All Passport members are required to have an annual [SBIRT](#) screening from their PCP. Members never need a referral for behavioral health services. If you need assistance establishing behavioral health services for a Passport member, we encourage you to call our 24-hour Behavioral Health Services Hotline at (855) 834-5651.

To support our goal of integrated behavioral and physical health care, we offer a comprehensive prescription drug intervention program designed to alert our primary care providers of sub-optimal dosing, polypharmacy or other key issues for members who are prescribed psychotropic medications.

The incorporation of comprehensive Behavioral and Mental Health Services brings about many changes. Working with the DMS and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Passport will highlight the expectations for screening for behavioral health disorders by PCP's in numerous settings. PCP's may continue to provide any clinically appropriate Behavioral Health Services within the scope of their practice. The training sessions that are offered will review this in greater detail.

New expectations extend to Behavioral Health specialists in that they are expected to communicate to the PCP the initial evaluation. Additionally, they are expected to provide, at minimum, quarterly reports of the member's condition with the consent of the member or their legal guardian.

3.3 The Role of Specialists and Consulting Practitioners

Specialty care practitioners provide care to members referred by their PCP. The specialty care practitioner must coordinate care through the PCP and must obtain necessary prior authorization for hospital admissions or specified diagnostic testing procedures. Refer to Section 5.3, "Authorization Requirements," for a complete listing of procedures requiring prior authorization from Passport's Utilization Management department.

Except for Direct Access Services and a few other services (see Section 6.1, "Member Self-Referral (Direct Access)," all members must obtain a valid referral from the PCP prior to receiving services from most specialty care providers/practitioners.

Specialty practitioners must review the referral section of the PCP referral form to determine which services have been referred. The specialist must contact the PCP if he or she intends to provide services in excess of those initially requested. In these cases, the PCP must generate a second referral to cover the additional services.

It is important that the specialty care provider communicates regularly with the PCP regarding any specialty treatment. Specialists are to report the results of their services to the member's PCP just as they would for any of their patients. The specialist should copy all test results in a written report to the PCP. The PCP is to maintain referrals and specialist reports in the member's central medical record and take steps to ensure that any required follow-up care or referrals are provided.

For electronic referral submission guidelines via [Passport Provider Portal](#), please refer to Section 6.3.

3.4 Responsibilities of All Providers

3.4.1 Provider and Member Communications

It is the provider's responsibility to provide appropriate and adequate medical care to Passport members, and no action of Passport or any entity on the Plan's behalf, in any way, absolves, relieves, or lessens the provider's responsibility and duty to provide appropriate and adequate medical care to all patients under the provider's care. Passport agrees that regardless of the coverage limitations of the Plan, the provider may freely communicate with members regarding available treatment options and that nothing in this Provider Manual shall be construed to limit or prohibit open clinical dialogue between the provider and the member.

3.4.2 Medical Records

Documentation in the medical record shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided to the member. The member record shall be signed by the provider of service.

Medical record confidentiality policies and procedures shall comply with state and federal guidelines, HIPAA and Passport policy. HIPAA privacy and security audits will be performed to assure compliance as required by Passport's contract with the DMS.

If a member were to change PCP's, medical records should be forwarded to the new PCP within ten (10) days' of receipt of a signed request.

See Section 4.5 for additional detail regarding Medical Record Keeping

3.4.3 Treatment Consent Forms

Treatment consent forms for specific procedures must be completed and signed by the member. A copy of the appropriate treatment consent form must be maintained in the member's record. The following original treatment consent forms must be sent to the Plan, along with a copy of the claim, as required by state and federal laws. In accordance with Title VI, all vital documents (i.e. treatment and consent forms) must be translated into patient's preferred language. These treatment consent forms are available from DMS:

MAP-250 Consent for Sterilization

MAP-251 Hysterectomy Consent Form

MAP-235 Certification Form for Induced Abortion or Induced Miscarriage

MAP-236 Certification Form for Induced Premature Birth

For additional information on completion of the above forms, please contact Passport Utilization

Management at (800) 578-0636. Additional information on family planning services is located in Section 14.

3.4.4 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. Matters regarding application of advanced directives and related legal matters are defined in Kentucky Statutes, some of which are outlined in greater detail below; however, these should not be considered exhaustive lists. State and federal laws also provide guidance to these policies. Policies will be updated as soon as possible after guidance from these organizations is received.

A member who is 18 years of age or older and who is of sound mind may make a written advance 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. The form can be reviewed at <http://www.lrc.ky.gov/krs/311%2D00/625.pdf>.

A copy of the living will may also be obtained through the Office of the Attorney General website at <http://ag.ky.gov/civil/consumerprotection/livingwills.htm>. Advance directives may be revoked in writing, by an oral statement, or by tearing up the written living will. The revocation is effective immediately.

Health Care Surrogates. If a health care surrogate is appointed in the advance directive, the surrogate is required to consider the recommendations of the attending physician and to honor the requests made by the grantor in the advance directive.

No Directive. What happens if an adult member does not have decisional capacity and has not executed an advance directive? Kentucky statutes authorize the following persons, in the order given, to make such decisions:

- A judicially-appointed guardian of the member.
- Spouse of the member.
- Adult child of the member (or the majority of the children).
- Parents of the member.
- Nearest living relative.

Conscientious Objections. What happens if the practitioner or health care facility does not want to comply with a member's advance directive because of matters of conscience? The provider/practitioner should notify the member and cooperate with the member in transferring the member, with all his or her medical records, to another provider/practitioner. The provider/practitioner must also clarify any differences between institutional conscientious objections and those that may be raised by individual practitioners. Also, the provider/practitioner must describe the range of medical conditions or procedures affected by the conscientious objection.

Provider's Responsibilities. In addition to reviewing the Kentucky Living Will Directives Act, providers should:

- Discuss the member's wishes regarding advance directives for care and treatment at the first visit, as well as during routine office visits when appropriate;
- Document in the member's medical record the discussion and whether the member has executed an advance directive;
- Provide the member with information about advance directives, if asked;
- File the advance directive in the member's record upon receipt from the member;
- 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.

3.4.5 Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations. Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission or neglect.

If suspected cases are discovered, an oral report should be made immediately, by telephone or otherwise, to a representative of the local Department for Social Services office at (502) 595-4550.

To facilitate the reporting of suspected child abuse and neglect cases, legislation affecting the reporting of child abuse (KRS 620.030) is printed on the reverse of the Child Abuse Reporting Form (DSS-115). These forms may be obtained from the local Department for Social Services office.

Adult abuse is defined by KRS. 209.020 as, "the infliction of physical pain, mental injury, or injury of an adult." The statute describes an adult as, "(a) a person 18 years of age who because of mental or physical dysfunctioning is unable to manage his [her] own resources or carry out the activity of daily living or protect himself [herself] from neglect or a hazardous or abusive situation without assistance from others and who may be in need of protective services; or (b) a person without regard to age who is the victim of abuse and neglect inflicted by a spouse."

3.4.6 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 Acts prohibit 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 in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the claim.

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 and/or Medicare programs.

Passport has developed a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. Our plan includes:

- Enforcement of standards through disciplinary guidelines;
- Provisions for internal monitoring and auditing of the member and provider;
- Provisions for internal monitoring and auditing of subcontractors. Should issues be identified, the subcontractor shall be placed on a corrective action plan (CAP). DMS will be notified of the CAP.
- Processes to collect outstanding debt from providers;
- Procedures for appeals;
- Compliance with the expectations of 42 CFR 455.20 by employing a method of verifying with the member whether the services billed by the provider were received by randomly selecting a minimum sample of 500 Claims on a monthly basis; and,
- Programs that run algorithms and edits on Claims data to identify outliers and patterns and trends.

Passport's Program Integrity Unit (PIU) conducts fraud, waste and abuse investigations for Passport. The PIU is comprised of staff from a broad range of Passport departments. All Passport fraud, waste and abuse activity is reported to the DMS. PIU staff meeting regularly with the state Medicaid Fraud Control Unit (MFCU) which includes representatives from the DMS, the Office of the

Inspector General (OIG) and the Office of the Attorney General (OAG).

Providers are required to cooperate with the investigation of suspected Fraud and Abuse. If you suspect fraud, waste or abuse by a Passport member or provider, it is your responsibility to report this information immediately. Please contact:

Passport Compliance Hotline: (855) 512-8500

3.5 Provider Collection of Co-Pays

Effective January 1, 2019, most members will be required to pay a co-pay at the time of service. Providers will be reimbursed less the co-pay amount.

Providers may refuse service if member cannot pay co-pay unless member is under 100% of Federal Poverty Level. For co-pay information, please see [907 KAR 1:604](#). To check eligibility, co-pay information and exceptions, please login to [KY HealthNet](#).

For more information, please see the [Policy Update](#) and more on the [Cabinet for Family and Health Services website](#).

Provider Manual

Section 4.0

Office Standards

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- 4.2 After-Hours Telephone Coverage**
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- 4.5 Medical-Record-Keeping & Continuity & Coordination of Care Standards**
- 4.6 Hospital Care**
- 4.7 Kentucky Health Information Exchange – KHIE**
- 4.8 Communication Guidelines**



4.0 Office Standards

PCPs are required to provide coverage for Passport members 24 hours a day, seven days a week. 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 their Passport Provider Directory, or contact Provider Services at (800) 578-0775 with questions regarding which providers participate in the Passport network.

4.1 Appointment Scheduling Standards

Providers must adhere to the following appointment scheduling standards to assure timely access to medical care as required by DMS. Compliance with these standards will be audited by periodic on-site review of provider offices and chart sampling.

Primary Care and Specialist Care Providers

Routine Appointments	Within 30 days
Urgent Appointments	Within 48 hours
After Hours/Emergency Care	24 hours a day/7 days per week
Pregnancy in 1 st Trimester – preventive care	Within 14 days
Pregnancy in 2 nd Trimester – preventive care	Within 7 days
Pregnancy in 3 rd Trimester – preventive care	Within 3 days

Behavioral Health Care Providers

Care for non-life-threatening emergency	Within 6 hours
Emergency Care with Crisis Stabilization	Within 24 hours
Urgent Care	Within 48 hours
Services Post-Discharge from Acute Psychiatric Hospital	Within 7 days
An appointment for a routine office visit	Within 10 business days
All Other Services	Within 60 days
Missed Appointment Follow-Up	Within 24 hours to reschedule

Voluntary Family Planning

Appointments for counseling and medical services shall be available as soon as possible with in a maximum of thirty (30) days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within ten (10) days.

4.2 After-Hours Telephone 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.

Unacceptable after-hours telephone coverage in a PCP's office includes:

- No answer after office hours.
- Telephone answered after hours by a recording that tells members to leave a message.
- Telephone answered after hours by a recording that directs members to go to the emergency room for any services needed.
- Not returning calls within 30 minutes

4.3 Member to Practitioner Ratio Maximum

Per DMS regulation 907 KAR 1:705, member to PCP ratios are not to exceed 1500 to 1. If any PCP is concerned about his or her panel size or prefers a ratio smaller than 1500 to 1, he or she should notify Provider Network Management in writing at the following address:

**Passport Health Plan
5100 Commerce Crossings Drive
Louisville, KY 40229
Attention: Provider Network Management**

Passport will set the maximum panel size at 1500 members per practitioner. However, the ratio may be adjusted for practices that employ physician extenders, such as physician assistants. Passport will consider exceptions to the 1500 to 1 ratio upon PCP request. Exceptions will be allowed based on an analysis of the practice capacity and geographic availability of other PCP practices contracted with Passport.

For additional information regarding requests for panel closings and limitations, please see Section 2.8.4.

4.4 Provider 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.

- PCPs 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 Network Management 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 as referenced in Section 3.4.3, “Treatment Consent Forms,” as required by state and federal regulations and laws.

4.5 Medical-Record-Keeping & Continuity & Coordination of Care Standards

Passport has adopted the following 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 the 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 practitioners’ scoring less than 80% through corrective action plans and re-evaluation.

Confidentiality of Records

Medical records are maintained in an area that is only accessible to practitioner office staff. Providers are also required to:

Have policies addressing privacy and confidentiality of member information.

- Ensure that medical records are NOT accessible to those not employed by the practice.
- Post notice of privacy practices (NPP) in a prominent area of the office.
- Ensure that HIPAA policies and procedures are easily accessible for all staff members.
- Provide disclosures of PHI, patient’s right to request restriction of the use of PHI, and include a contact person within the practice.
- Locate copier and fax machines in an area that restricts unauthorized access or viewing.
- Password protect all computer screen savers.
- Protect all staff members’ computer access by requiring unique log-ins and time-limited passwords.
- Ensure that office staff shall send all emails containing PHI marked secured or encrypted.

Organization of Records

- There is only one medical record per patient.
- The medical record is bound or pages fastened to prevent loss of medical information.
- Each and every page in the record contains the member's name or ID number.
- The medical record is organized in chronological order with the most recent information appearing first. The record includes separate sections for progress notes, lab results, x-ray and other imaging studies, hospital records (ER report and discharge summaries), home health nursing reports, physical therapy reports, etc.
- All charts contain flow sheets for health maintenance.

Documentation

- The record is legible.
- Personal data includes date of birth, age, height, gender, home and work addresses, employer, home and work telephone numbers, marital status, emergency contact information, school name and telephone numbers (if no phone contact name and number), race, ethnicity, guardianship/custodial arrangements, and identifies preferred language.
- Entries are done in smudge-proof non-erasable ink.
- Medication allergies, adverse reactions, and no known allergies are prominently noted in the record.
- There is a completed immunization record in all pediatric records and/or appropriate history in all adult records.
- All charts contain a problem list, a medication list, and a treatment plan. Significant illnesses and medical conditions are indicated on the problem list, including working diagnoses.
- Medical history (for members seen three or more times) is easily identified and includes medical, surgical, obstetric histories, and serious accidents. For children and adolescents (18 years of age and younger), medical history includes prenatal care, birth, operations, and childhood illnesses.
- Documentation includes weight recorded at each regular visit.
- All entries in the medical record are signed or initialed and dated and all providers are identified by name.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.
- Documentation will reflect assessment of and counseling for tobacco, alcohol, substance abuse, and risk of sexually transmitted diseases.
- If a consultation is requested, there is a note from the consultant in the record.
- Consultation, lab, and x-ray reports filed in the chart are initialed by the practitioner to indicate review. Consultation and abnormal lab and imaging study results have a specific notation in the record of follow-up plans.
- Emergency care provided is documented in the medical record, as well as follow-up visits provided secondary to reports of emergency room care.
- Evidence of reportable diseases and conditions are documented and reported appropriately to local or state health departments.
- There is evidence that preventive screenings and services are offered in accordance with Passport's Clinical Practice Guidelines. Use of risk assessments, disease maintenance, and preventive health sheets are encouraged (see Section 17, "Forms and Documents" for samples).
- Copies of consent forms, when applicable, are maintained in the record.

- The medical record also contains an indication of whether an adult (over 18 years old) member has executed an advance directive and a copy of the member's advance directive, as applicable.
- Written denials for service and the reason for the denial are documented in the medical record.
- Hospital discharge summaries are included in the medical record.

Access and Availability of Records

- Hospital/Provider shall maintain a complete and accurate permanent medical record for each member to whom Hospital/Provider renders services. Hospital/Provider permits Passport, on request via letter, fax or phone, access to member medical records at no cost, to inspect, review, and copy within 10 business days of receipt of request.
- Members have the right to all information contained in the medical record as required by law. Medical records must be made available to a member upon request at no cost to Passport or the member for first copy.
- When a member changes PCPs, the medical records or copies of medical records shall be forwarded to the new PCP within ten (10) business days from receipt of request at no cost to Passport or member.
- When releasing records to an entity other than Passport, providers are first required to obtain written consent from the member.
- Subject to applicable legal restrictions, Hospital/Provider shall forward to Passport, or its designee, electronically, at no cost, within ten (10) business days or fourteen (14) calendar days of a request, any clinical information or accounting, administrative and medical records maintained by Hospital/Provider, relating to the provision of Covered Services rendered by or through Hospital/Provider to Passport's members, the cost thereof, the amount of any payments received therefor from members or from others on members' behalf, claims by and payments to Hospital/Provider, member appeals and complaints, or coordination of benefits.

Continuity and Coordination of Care

While there are some indicators of continuity and coordination of care included within the documentation standards, Passport will also assess medical records for evidence of continuity and coordination of care using the following criteria:

- The record is legible to someone other than the writer. Any record determined illegible by one reviewer shall be evaluated by a second reviewer.
- At each office visit, the history and the physical performed are documented and reflect appropriate subjective and objective information for presenting complaints, including any relevant psychological and social conditions affecting the patient's medical/behavioral health.
- The working diagnosis is consistent with the clinical findings.
- The plan of action and treatment is consistent with the diagnosis and includes medication history, medications prescribed; including the strength, amount, and directions for use, as well as any therapies or other prescribed regimen.
- Lab and other studies are ordered as appropriate.
- Unresolved problems, referrals, and results from diagnostic tests, including results and/or status of preventive screening services (EPSDT) from previous office visits are addressed in

- subsequent visits.
- There is a review for the under-and over-utilization of consultations.
- Age or disease-appropriate direct access services or referrals must be documented in the medical record, for example: immunizations, diabetic retinal eye exams, family planning, and cancer screening services.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.
- Follow-up plans including consultations, referrals, directions, and time to return.

4.6 Hospital Care

Practitioners must have admitting privileges to a Passport network hospital or facility for all patient groups for whom they are providing care. A practitioner may arrange for another participating practitioner to provide inpatient coverage.

4.7 Electronic Health Records (EHR)

4.7.1 Kentucky Medicaid EHR Incentive Program

The Kentucky Department for Medicaid Services (DMS) runs the Kentucky Medicaid EHR Incentive Program which provides eligible professionals with up to \$21,250 to adopt, install, or upgrade a certified electronic health record system and an additional \$42,500 over the following five years for meaningful use of the system.

In addition to making your practice more efficient with the use of EHRs, you could earn additional monies. For more information, please see the Kentucky Cabinet For Health Services website <https://chfs.ky.gov/agencies/dms/ehr/Pages/default.aspx> as well as the FAQs <https://chfs.ky.gov/agencies/dms/ehr/Pages/faq.aspx>.

4.7.2 Kentucky Health Information Exchange – KHIE

Passport is dedicated to improving the health and quality of life of our members and actively supports the statewide implementation of the Kentucky Health Information Exchange (KHIE). The KHIE is the secure electronic information infrastructure created by the Commonwealth for sharing health information among health care organizations and offers health care providers the functionality to support meaningful use and a high level of patient-centered care.

Passport's participating providers are required to connect to the KHIE through various communication channels such as annual workshops, routine onsite visits, and general provider relations interaction.

KHIE is a secure, interoperable network which participating providers with certified electronic health record (EHR) technology can use to locate and share needed patient information with each other which results in improved coordination of care among physician practices, hospitals, labs, and across the various health systems. Some of the benefits include:

- Real time access to patient health information including:
- Detailed patient summary
- Rx/medication history
- Laboratory results

- Radiology and other transcribed reports
- Clinical reminders/alerts
- Improved patient care quality and safety
- Reduced health care costs by reducing duplication of care
- Improved efforts to reduce health disparities
- Informed medical decisions at the time/place of care.

Please visit <http://khie.ky.gov/cwkhie/Pages/home.aspx> to obtain more information on this program and guidance on how you can make the KHIE connection. A welcome packet with information on submission steps can also be found here:

<https://khie.ky.gov/SiteCollectionDocuments/Combine.pdf>

Hospitals are also required to submit Admission, Discharge, Transfer (ADTs) to KHIE. If providers do not have an electronic record, please sign a [Participation Agreement](#) with KHIE as well as sign up for Direct Secure Messaging services so that clinical information can be shared securely with other providers in your community of care.

4.8 Communication Guidelines

DMS has developed guidance related to member materials and other communication for providers participating in Medicaid managed care organizations in the state. The guidance includes the following:

- Providers are considered **agents** of all managed care organizations (MCOs).
- MCO's must have a system of control over the content, form, and method of marketing and information materials published on its behalf or through its agents.
- Any listing of MCO's in a provider office **must** include all Medicaid plans with which the provider does business.

4.8.1 Approval Process:

- All communication materials referring to Passport must be approved in writing by Passport and by the Kentucky DMS.
- Passport is responsible for submitting provider communication & information materials to the DMS for approval.
- DMS has the same approval authority over provider materials as it has over MCO materials.
- Passport must correct any problems or errors on provider materials identified by DMS.

4.8.2 Distribution of Materials:

- Passport may not distribute marketing materials through its provider network.
- Branded health education materials may be distributed to providers by MCOs including Passport, but distribution must be limited to members of that specific plan.
- Branded materials cannot be left in common areas, such as waiting rooms and lobbies.
- Branded health education materials can not include enrollment or disenrollment information.

Provider Manual

Section 5.0

Utilization Management

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5.0 Utilization Management

5.1 Utilization Management

Utilization Management (UM) is the evaluation of the medical necessity, quality, appropriateness and efficiency of the use of health care services, procedures and facilities under the provisions of the applicable health plan benefits. Medically Necessity is defined under 907 KAR 3:130 or other applicable Kentucky Laws or Regulations and provided in accordance with 42 CFR 440:230, including children's services pursuant to 42 U.S.C. 1396d(r).

Utilization Management decision making is based only on appropriateness of care and service, existence of coverage and available criteria. Passport does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or services and Passport does not encourage decisions that result in under-utilization.

All Passport participating providers are required to obtain prior authorization from the Plan's UM department for inpatient services and specified outpatient services. Failure to submit a request for authorization may result in a denial.

Because of frequent changes in member eligibility for Medicaid coverage, providers should verify continued eligibility via the Plan's web site, www.passporthealthplan.com or by calling Provider Services at (800) 578-0775.

Hours of Operation

The UM department is available Monday and Friday from 8:00 a.m. to 6:00 p.m., and Tues, Wed, Thurs, Sat and Federal Holidays from 8:00 am to 5:30 pm ET. All requests for authorization of services may be received during these hours of operation. Weekend requests may be submitted on Monday. After business hours, a provider can fax the request or can leave a message and a representative will return the call the next business day.

Department	Phone Number	Fax Number
General Number	(800) 578-0636	(502) 585-7989
Concurrent Review	(502) 585-7331	(502) 585-7989
Retrospective Review	(502) 585-7972	(502) 585-8207
Home Health	(502) 585-7320	(502) 585-8204
Home Infusion	(502) 585-8285	(502) 213-8958
DME	(502) 585-7310	(502) 585-7990
Prescribed Pediatric Extended Care (PPEC)	(502) 585-8286	(502) 213-8921
Cosmetics Request can be sent via confidential email to: Passport UMCosmetics@Passporthealthplan.com	(502) 585-7069	(502) 213-8998
Outpatient Physical, Occupational, Speech Therapy (a)	(502) 585-6055	(502) 585-6205
Pain Management Injections	(502) 585-6614	(502) 212-6611

- (a) Authorization is only required for outpatient therapy conducted at a provider office after the 20th visit, per therapy in a calendar year. Authorization for Home Therapy is required from the initial visit.

The following services are administered in partnership with eviCore:

Radiology (b)	(877) 791-4099	(888) 693-3210
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(b) High Tech Radiology ordered by a Cardiologist or Oncologist will require review through New Century Health

The following services are administered in partnership with New Century Health (NCH)

Log onto the NCH Provider Portal at www.mynewcenturyhealth.com to submit a request

Service	Phone	Fax
Oncology Imaging	888-999-7713	833-305-3018
Cardiology Imaging	888-999-7713	833-305-3018
Oncology Medication for office, outpatient or scheduled inpatient admissions	888-999-7713	844-835-6529
Radiation Oncology professional services for office, outpatient or scheduled inpatient admissions	888-999-7713	855-256-8520
Professional services for office, outpatient and scheduled inpatient admissions related to Cardiology Services	888-999-7713	877-622-6879

Passport provides the opportunity for the provider to discuss a decision with the Medical Director, to ask questions about a utilization management issue, or to seek information about the Utilization Management process and the authorization of care by calling the Utilization Management Department at (800) 578-0636.

5.2 Review Criteria

The UM Department utilizes InterQual® Criteria during the review process. In the event InterQual® Criteria is not available for a specific request, the reviewer may use internal medical policies which are reviewed and approved by actively practicing practitioners in the community. The Quality Medical Management Committee (QMMC) approves both the use of InterQual Criteria® and Medical Policies.

Criteria for which a decision was based may be requested by a provider. Criteria are made available as allowed under copyright limitations and trademark considerations. To request the criteria for which a decision was based, you may contact the UM Department at (800) 578-0636.

5.3 Authorization Requirements

Services Requiring Authorization	
All Inpatient Admissions (see exclusions below)	Inpatient Rehabilitation
Prescribed Pediatric Extended Care (PPEC)	DME Rental / Purchase > \$500.00 All E1399 DME Codes
Orthotics / Prosthetics > \$500.00	Enteral Products > \$500.00
Home Infusion / Home I.V. Therapy (IVT)	Home Health Services / Private Duty Nursing (PDN - 2,000 hours per year)
High cost Medications > \$400.00 including Synagis All Chemotherapy, adjunct and supportive medications	Ocular Photodynamic Therapy/with Verteporfin (Visudyne)
Neuropsychological Testing	Stem Cell/Progenitor Cell Retrieval
Radiology: PET, MRA, MRI, CTA, CT, Select Cardiac Imaging (Authorization not required if performed: While Inpatient, In the E.R., Observation)	Outpatient Therapy: Physical, Occupational and Speech (Visits approved in Units; 1 visit – 4 units)
Pain Management Injections	
Outpatient Cardiac / Pulmonary Rehabilitation	Abortion / Termination of Pregnancy
Cosmetic Procedures / Services	EPSDT Special Services
Experimental / Investigational Procedures or Services	Services performed by a non-participating provider including MD office visits
Cardiology / Oncology Services (See NCH Below)	

All requests are subject to coverage, benefits and eligibility

Pain Management CPT Codes requiring authorization

PAIN MANAGEMENT CODES			
20552	62360	64484	64610
20553	62361	64490	64622
27096	62362	64491	64623
62281	63650	64492	64626
62282	63660	64493	64627
62310	63685	64494	64633
62311	63688	64495	64634
62318	64479	64520	64635
62319	64480	64600	64636
62350	64483	64605	

Provider Notification Requirements

Providers must notify the UM department within the required times frames; failure to notify the UM department may result in an administrative denial of the request. An administrative denial may be appealed.

Non-Emergency

- Non-emergency: Prior to the elective / scheduled procedure / service

Emergency:

- Urgent - Emergent Admission and inpatient concurrent review : Within one business day of the admission. Weekend or holiday admissions may be requested on the following business
- Providers are responsible for notifying Passport UM Department of the need for additional inpatient days (concurrent review)

The UM Department will accept the hospital's or the attending physician's request for prior authorization; however, neither party should assume that the other has obtained prior authorization.

Providers may contact the UM Department by phone or fax. Fax forms are available on the Passport Website; requests may be submitted using the Passport fax forms or the Universal Fax form.

Information required for review

When requesting a review, at a minimum, documentation must include:

- The member's name and Passport ID number.
- The diagnosis for which the treatment or testing procedure is being sought.
- Other treatment or testing methods that have been tried, their duration, and any outcomes.
- Additional clinical information as applicable to the requested service.
- Applicable sections of the medical record.

Requests not meeting the established medical necessity criteria will be referred to Passport's Medical Director for further review and evaluation.

Inpatient Authorization Exclusions: Maternity & Newborns

- Normal Vaginal Delivery: If the inpatient stay is less than or equal to 3 days, no authorization is required
- Authorization is required for:
 - All Cesarean Sections
 - All Scheduled inductions
 - All Non-par providers, regardless of delivery type
- An infant born by Normal Vaginal Delivery (NVD) does not require authorization until day four (4). If an infant born via NVD stays ≤ 3 days, authorization is not required.
- An infant born by C-Section does not require authorization until day six (6). If an infant born via C-Section stays ≤ 5 days, authorization is not required.

Observation Stays

Observation at a participating facility does not require authorization. If a member is admitted following an observation stay, the date of the inpatient authorization begins on the date the inpatient order is written.

Durable Medical Equipment (DME)

DME Purchase

DME items with billable charges greater than \$500 require an authorization. Requests for authorization of purchase MUST be received PRIOR to the end of the rental period.

DME Rental

Authorization requirements of rentals are determined by the billable price of the item being rented. Rental charges will be applied to purchase price.

Miscellaneous DME

- All items requiring customization or accessories require prior authorization.
- All mini-nebulizers will be a purchase only item and do not require prior authorization.
- Maintenance, repair, or replacement in excess of \$500 must have prior authorization from the UM department.
- Enteral products with allowable amounts greater than \$500 for a month's supply require an authorization.
- DME that exceeds quantity limits per DMS fee schedule.

Inpatient Only Codes:

In accordance with the Centers for Medicare and Medicaid Services (CMS) billing requirements, select surgical procedures must be performed in the inpatient setting.

Please reference the current Medicare IP Only list for appropriate codes, <https://www.cms.gov/>.

Cardiology and Oncology Services; New Century Health (NCH)

In partnership with New Century Health (NCH), the following services will require authorization through NCH:

Services **ordered** by an **Oncologist** or **Cardiologist** to include:

- Scheduled inpatient admissions at participating facility related to Cardiac / Oncology services
Authorization for emergent admissions conducted by Evolent
- Inpatient / Outpatient Chemotherapy, Hematology adjunct and supportive medication; All infused and oral Chemotherapy, Hormonal Therapeutic Treatment, Supportive Agents and Symptom Management Medications
- High Tech radiology ordered by a Cardiologist / Oncologist
 - Brachytherapy, Conformal IMRT, SBRT, IGRT, PET, CT and MRI
- Treatments for Cardiology Services
 - Clinical Cardiology
 - Cardiac Cath and Interventional Cardiology
 - Vascular Radiology and Interventions
 - Vascular/Endovascular Surgery
 - Thoracic Surgery
 - Electrophysiology
 - Cardiac Surgery

For all other specialties, please see authorization requirements in Table 5.3

For additional information, please contact NCH at 888-999-7713, option 1 for Medical Oncology, option 2 for Radiation Oncology and option 3 for Cardiology

5.4 Retrospective Authorization

Retrospective review of inpatient services is performed when the patient was not a member of Passport prior to or at the time of the service. Outpatient services do not require retrospective review by Utilization Management for members whose eligibility is determined retrospectively. Providers have 60 days from the notification of eligibility on retrospectively enrolled members to submit medical records for review and utilization management authorization request. A decision and written notification is provided within thirty days of receipt of the medical information for the retrospective review request. An administrative denial is issued for retrospective requests when the provider fails to request a utilization management review of the medical record within the timeframe specified.

The provider is notified of all decisions regarding retrospective reviews. In cases of denial, a written notification is provided.

Requests received beyond 60 days from the card issue date or from the provider's documentation of the date when they were aware of the member's eligibility will be administratively denied.

Send requests for retrospective review to:

Utilization Management Retrospective Review
5100 Commerce Crossings Drive
Louisville, KY 40229

The phone number for retrospective review is: (502) 585-7972 or fax to: (502) 585-8207 (for large chart review, please send records via mail).

5.5 Denials

An authorization request for a service may be denied for failure to meet guidelines, protocols, medical policies, or failure to follow administrative procedures outlined in the Provider Contract or this Provider Manual. If pre-authorization criteria are not met resulting in a denied claim, members must be held harmless for denied services.

A Passport Medical Director renders all medical necessity denial decisions. Whenever a denial is issued, Utilization Management provides the name, telephone number, title, and office hours of the Medical Director who rendered the decision. The Passport Medical Director is available to discuss any decision rendered with the attending practitioner.

An administrative denial is issued for those services for which the provider has not followed the requirements set forth in the Provider Contract or this Provider Manual. For example, an administrative denial may be issued for failure to prior authorize a non emergent elective service, procedure, or admission. It may also be issued for failure to notify Utilization Management within one business day of an emergency service, procedure, or admission.

A provider may appeal an administrative denial by submitting the appeal request in writing to:

Clinical Appeals Department
5100 Commerce Crossings Drive
Louisville, KY 40229

To speak with the Medical Director or to the nurse reviewer regarding a denial, please contact Utilization Management at (800) 578-0636.

5.6 Prior Authorization for Members with Medicare / Tricare / Other Carrier

Prior authorization is not required for services listed on the prior authorization list when the member has Medicare or Tricare as the primary payer and benefits under Medicare have not been exhausted. This applies to both inpatient and outpatient services. When benefits are exhausted, or if the service is not a benefit covered under Medicare or Tricare and Passport becomes the primary payer, prior authorization requirements apply for both inpatient and outpatient services. For those members who have exhausted their Medicare Part A inpatient lifetime reserve days, prior authorization of inpatient services must be obtained. If a member's lifetime reserve days are exhausted during an inpatient hospitalization, notification to Passport UM Department must be

made within one business day of the exhaustion of benefits by Medicare.

Authorization is required for members with other carrier as primary except for Medicare / Tricare.

5.7 Inpatient Skilled-Nursing Facility

Passport is not responsible for, nor does it reimburse nursing facility costs, for members at skilled-nursing facilities. Those services are covered by the Kentucky Medicaid Program. Passport is responsible for costs of professional services, such as physician or therapist services that are not part of the routine facility service. After a member is in a nursing facility for 31 days, the disenrollment process begins for that member. Passport's responsibility for those non-facility services continues for any of its members while they are still enrolled with the Plan. After the Kentucky Medicaid Program completes the managed care disenrollment process and reinstates the member in the fee-for-service Medicaid program, the Plan no longer has financial responsibility for any services for that Medicaid recipient. To obtain skilled-nursing facility authorization, please call the DMS-contracted review entity.

Provider Manual

Section 6.0

Referrals

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6.1 Member Self-Referral (Direct Access)

6.2 Referral Requirements

6.3 Distribution of Referrals



6.0 Referrals

6.1 Member Self-Referral (Direct Access)

There are a number of services covered by Passport for which members can make appointments with participating Passport providers without referrals from their PCP. These include:

- Routine vision care services, including diabetic retinal exams and the fitting of eyeglasses provided by ophthalmologists, optometrist, and opticians.
- Routine dental services and oral surgery services and evaluations by orthodontists and prosthodontists (orthodontic and prosthodontic services require prior authorization).
- Maternity care
- Immunizations for all members.
- Screening, evaluation, and treatment for sexually transmitted diseases.
- Screening, evaluation, and treatment for tuberculosis.
- Chiropractic 26 visits per calendar year allowed – Authorization is required.
- Testing for HIV, HIV-related conditions, and other communicable diseases.
- Pap smears and mammograms.
- GYN services, including Pap smears and mammograms.
- Voluntary Family Planning in accordance with federal and state laws and judicial opinion
- Routine outpatient behavioral health services do not require a PCP referral. Please see section 16.5 (Authorization Procedures and Requirements) for those requiring prior authorization.
- Substance Abuse Treatment
- Orthopedic Care
- Members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring as appropriate for the member's condition and identified needs.
 - The following list of diagnoses (when billed in any position on the claim):

ICD-9 Code	ICD-10 Code	DESCRIPTION
ESRD		
585	N18.1 –N18.9	Chronic Kidney Disease (CKD)
586	N19	Renal failure, unspecified
HIV/AIDS		
042	B20	Human immunodeficiency (HIV) disease
079.51	B97.33	Human T-cell lymphotropic virus, type I (HTLV-I)
079.52	B97.34	Human T-cell lymphotropic virus, type II (HTLV-II)
079.53	B97.35	Human immunodeficiency virus, type 2 (HIV-2)
CANCER		
140-208	C00.8 – C95.92	Malignant
230-234.0	D00.00 – D09.9	Carcinoma in situ
235-238	D37.01 – D48.9	Neoplasm of uncertain behavior
239 – 239.9	D49.0 – D49.9	Neoplasm of unspecified behavior
Behavioral Health		

290.xx	F01.50 – F99	Behavioral Health Diagnosis Range
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NOTE: For family planning services, members may self-refer to any participating Medicaid provider. For more information, please refer to Section 17, “Family Planning.”

6.1.1 Additional Referral Exceptions

In addition to the direct access services outlined above, members do not need referrals for the following:

- Services provided by the Commission for Children with Special Health Care Needs or the WINGS Clinic.
- Diabetic retinal exams.
- OB/GYN services
- Perinatologists/geneticists.

The following referral exceptions also apply:

- One lifetime referral is required for each transplant.
- Referrals to specialists are not required for children in foster care or living in out-of-home placements.
- Referrals are not required for participating orthopedists.
- Referrals are not required for members with Medicare or Tricare as the primary payer.

6.2 Referral Requirements

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. Except as outlined in Sections 7.1 and 7.1.1, if the member needs to see a specialist, the PCP will complete and issue a referral to the specialist (identified by Box 17 on the claims form).*

- 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, but a referral must be completed.
- If a PCP wants to refer a member to a non-participating provider, the PCP must request a prior authorization from Passport’s Utilization Management department. The PCP should also verify that the specialist accepts Kentucky Medicaid.
- Requests for retrospective review of inpatient services provided by nonparticipating providers require review and authorization by Utilization Management.
- Cases requiring follow-up visits or treatment by nonparticipating providers that were not prior authorized must be reviewed by Utilization Management.
- Referrals for consultation, diagnostic studies and treatment are valid for one year unless otherwise specified by the member’s PCP.
- The PCP may also designate a visit limit if preferred
- Passport members have the right to a second opinion. If the member requests a second opinion, the PCP should complete a referral to a participating specialist. If there is not a

specialist within the network, the PCP can request an authorization to a non-participating specialist by calling Passport's Utilization Management department at (800) 578-0636.

*An exception occurs when a member is new to Passport (in the first 30 days after enrollment) and has not yet selected or been assigned to a PCP. Under these circumstances, if a member requires specialist care, a participating specialist provider may contact the UM department to request authorization of a one-time visit without a referral.

NOTE: Please refer to the Passport Real-Time Provider Directory on www.passporthealthplan.com to verify participating providers.

Occasionally, a referral will be made following a telephone conversation between the member and the PCP who determines the need for specialty care. When a verbal referral is made, it is the PCP's responsibility to keep a record of the referral. Members may not obtain a referral to a specialist when the PCP can perform the services.

Responsibilities of the specialist or consulting practitioner:

- Retain copy of referral for the member's file.
- Send a copy of the consult report to the PCP.

6.2.1 Referral for Urgent Care

A referral is required for all urgent care visits except as indicated below:

- If it is Saturday, Sunday, a national holiday, or a weekday after 4 p.m., Passport members may go to specified urgent care centers. For the latest listing of participating centers, please reference Passport's website.

6.2.2 Original Medicare Primary Member Referrals

Passport members who are covered by Medicare or TriCare as their primary insurance are not required to have referrals for specialist care and may go to any participating or nonparticipating practitioner, as set forth in this Provider Manual. These members have a Passport identification card with "Medicare Primary" as the PCP. Providers will be paid on a fee-for-service basis for all covered services provided to Passport members who are also covered by Medicare or Tricare. Providers are required to bill Medicare or Tricare first and only submit to Passport the coinsurance and deductible amounts or those amounts not covered by their primary insurance as shown on the EOB.

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Section 7.0

Benefit Summary and Exclusions

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7.3 Non-Covered Services



7.0 Benefit Summary and Exclusions

7.1 Benefit Summary

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

- Alternative birthing center services.
- Ambulatory surgical center services.
- Behavioral Health Services, including:
 - Community Mental Health Services.
 - Inpatient behavioral health services.
 - Outpatient Mental Health Services.
 - Psychiatric Residential Treatment Facilities (Level I and Level II.)
- Chiropractic services.
- Dental services, including oral surgery, orthodontics, and prosthodontics.
- Durable medical equipment (DME), including prosthetic and orthotic devices and disposal 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 (2,000 hours per year)
- Hospice services.
- Independent laboratory services.
- Inpatient hospital services.
- Intensive Case Management.
- Meals and lodging for appropriate escort of members.
- Medical detoxification.
- Medical services, including those provided by physicians, advanced practice registered nurses, physicians assistants and FQHCs/ primary care centers and rural health clinics.
- Organ transplant services not considered investigational by the FDA.
- Other laboratory and x-ray services.
- Outpatient hospital services.
- Pharmacy and limited over-the-counter drugs including mental/behavioral health drugs.
- Podiatry services.
- Preventive health services, including those currently provided in public health departments, FQHCs/primary care centers, and rural health clinics.
- Specialized Case Management Services for Members with Complex, Chronic Illnesses (includes adult and child targeted case management).
- Targeted Case Management.

- Therapeutic evaluation and treatment, including physical therapy, speech therapy, 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.
- Specialized Children's Services Clinics.

NOTE: Some Services require an authorization; refer to section 5 of the Provider Manual for a full list of services that require an authorization

Meals, lodgings and transportation necessary to maintain a member and one designated attendant are covered, if necessary, when the member is accessing approved and necessary medical care at a site, in or outside of Kentucky, which is at a sufficient distance to preclude daily travel to and from the recipient's home. This service requires prior approval with specific maximum rates applicable to standard and high-rate areas.

7.1.1 Allergy Testing and Treatment

Consultation and testing by an allergist is covered for any member with a referral from the member's PCP. Allergy injections may be administered by either an allergist or by the member's PCP.

7.1.2 Behavioral Health Service

Passport has contracted with Beacon Health Options, LLC to administer comprehensive behavioral health benefits for Passport members beginning January 2013.

Section 16 of this provider manual provides comprehensive detail of this service.

7.1.3 Dental Care

Passport has contracted with a dental benefits manager to administer and provide all primary care dental services for all members. A PCP referral is not required for routine dental services. Members may obtain assistance with locating a dental practitioner by calling Member Services at (800) 578-0603. Members may also visit the Plan's web site at www.passporthealthplan.com.

Specialty dental services do not require a referral, for example, orthodontic evaluation (see Section 6.1, "Member Self-Referral (Direct Access)") and are only covered for children younger than age 21.

For more information, please see Section 1, "Important Telephone Numbers," for our dental benefits manager's contact information.

7.1.4 Durable Medical Equipment (DME)

Passport covers medically-necessary durable medical equipment (DME) and supplies that are

covered under the fee-for-service Medicaid program. Members are required to have a practitioner's order to receive the covered DME or supplies (see Section 5.6.3).

DMS requires that an updated Certificate of Medical Necessity (CMN) be signed by the provider for all supplies and equipment and kept on file by the supplier for a period of five years. The only exception is oxygen for which Passport follows Medicare guidelines.

7.1.5 Family Planning Services

Family planning services are meant to prevent or delay pregnancy for individuals of childbearing age. These services include:

- Health education and counseling.
- Limited history and physical exam.
- Laboratory tests as medically necessary.
- Diagnosis and treatment of STDs.
- Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment.
- Follow-up care for complications associated with contraceptive methods issued by a family planning provider.
- Contraceptive prescriptions, devices, supplies.
- Tubal ligation with required consent form completed.
- Vasectomies with required consent form completed.
- Pregnancy testing and counseling.

Passport members may obtain family planning services from any state-approved Medicaid provider. No referral from the PCP is required for routine family planning services.

Some family planning services require authorization. For more information on benefits and/or a list of providers, refer to Section 14, "Family Planning" in this Provider Manual. Please direct members to call our Member Services department at (800) 578-0603.

7.1.6 Home Health Care

When medically appropriate, home health care may be a good alternative to hospitalization. Home health care, including skilled and unskilled nursing, may be medically appropriate at other times as well. Passport's Utilization Management department must prior authorize all home health services. Please see Section 5 for authorization requirements.

7.1.7 Laboratory Services

All laboratory work should be sent to participating laboratories. For assistance locating a participating laboratory, providers may go to our online directory at <http://passport.prismisp.com/>. Choose "Other Services" > Laboratory Services.

Both PCPs and specialists may order lab services. Participating practitioners who cannot perform venipuncture in their office should send members to the nearest participating laboratory.

7.1.8 Prenatal Care

A referral is not necessary to an obstetrical provider, and a member may self-refer to any participating obstetrical provider. The OB provider should confirm eligibility. Providers are no longer required to obtain global authorization for antepartum cases. However, you must submit the initial ACOG or ACOG-like assessment which includes the member's medical and obstetric history within two business days of a member's initial prenatal visit. You can email the completed form to Passport.GlobalAuths@passporthealthplan.com or fax it to (502) 585-7970.

7.1.9 Prescriptions

Prescription benefits are administered for Passport members through a pharmacy benefits manager (PBM). Members must have prescriptions filled at participating pharmacies. For assistance locating a participating pharmacy, members should call Member Services (800) 578-0603 or search the on-line pharmacy directory.

For additional information on the outpatient pharmacy benefits, please refer to Section 14 of this Provider Manual or visit www.passporthealthplan.com.

7.1.10 Presumptive Eligibility

Presumptive Eligibility (PE) is a process in Kentucky which expedites an individual's ability to receive temporary healthcare coverage under Medicaid. There are two ways an individual may be considered presumptively eligible.

- **Pregnant:** Women who are pregnant may receive prenatal care while their eligibility for full Medicaid benefits is determined. This can only be done at a DMS certified provider and will have defined benefits per DMS. Also member will be covered until the last day of the second month or when Medicaid application is filed and approved or denied.
- **Hospital:** Authorized hospital employees may deem any individual presumptively eligible to receive immediate Medicaid coverage until the last day of second month or when Medicaid application is filed and approved or denied. Same benefits as a fully eligible member just shorter time frame.

In both cases, a qualified member will be assigned to an MCO and the information should be available on Ky Health Net the following day. The member may change MCOs and it will be effective the next feasible month. The member will receive a Medicaid card at the time of service. This information is to make Providers aware of this avenue of Medicaid eligibility, but no provider action is necessary.

7.1.11 Skilled-Nursing Facility

Should a member need authorization for admission to a skilled-nursing facility, the PCP should contact DMS. They will coordinate necessary arrangements between the PCP and the skilled-nursing facility in order to provide continuity of the member's care.

Passport covers the costs of health care services that are not part of nursing facility costs for up to 31 days or until the member is disenrolled from Passport by DMS. After the member has been in a skilled nursing facility for 31 days, the disenrollment process begins. After disenrollment, the member is re-enrolled with the fee-for-service Medicaid program except when a member is under the care of Hospice and in a skilled-nursing facility. In this case, Passport will continue to cover services under the hospice benefit even after 31 days.

7.1.12 Transportation

Emergency transportation and stretcher services are covered by Passport.

Members may be eligible for non-emergency transportation services to and from medical appointments. This is a covered benefit by DMS.

Members should call the appropriate transportation broker at least three days ahead of time when scheduling transportation.

The telephone numbers for transportation brokers for each county can be found in Section 20.2, "Other Important Contact Information." Members may also access this information by calling Passport Member Services at (800) 578-0603.

7.1.13 Vision Care

Passport has contracted with a vision benefits manager to administer and provide routine vision care benefits to members. A PCP referral is not required for vision services.

An annual routine eye refraction exam is covered for adult and child members. Eyeglasses are a benefit for children under age 21. Some exceptions apply to KCHIP members.

Members may obtain a list of vision practitioners by calling Member Services at (800) 578-0603 or by checking the provider directory on the Plan's website at www.passporthealthplan.com.

Members requiring vision care because of a medical condition must be referred by their PCP to a participating Passport ophthalmologist. For more information, call Provider Services at (800) 578-0775 or refer to Section 1, "Important Telephone Numbers," for our vision benefits manager's contact information.

7.2 Services Covered Outside Passport Health Plan

Members may continue to receive certain health services not covered by Passport but covered by DMS. Members may obtain these services from any Medicaid provider by using their Medicaid ID. Members choosing to obtain these services are encouraged to notify their PCP to update their medical records. The following services are covered outside Passport:

- Nursing facility services.
- Early-intervention services for children.
- School-based services for any child member younger than the age of 21 with an individualized education plan.
- Waiver services.

- Nonemergency transportation.

Additional information about these services can be obtained from DMS.

7.3 Non-Covered Services

Services that are not covered by Passport or the Kentucky Medicaid Program include:

- Non-medically-necessary services.
- Cosmetic services.
- Custodial, convalescent, or domiciliary care.
- Experimental procedures not approved by Kentucky's Medicaid Program.
- Hysterectomy procedures, if performed for hygienic reasons or sterilization only.
- Infertility treatment (medical or surgical).
- Paternity testing.
- Personal items or services, such as a television or telephone, while the patient is in the hospital.
- Postmortem services.
- Reversal of sterilization services.
- Sex-change procedures.
- Sterilization of a mentally incompetent or institutionalized individual.

The following are services currently not covered by the Kentucky Medicaid Program:

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual providers of any laboratory service;
- Cosmetic procedures or services performed solely to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.);
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Post mortem services;
- Services including, but not limited to, drugs that are investigational, mainly for research purposes or experimental in nature;
- Sex transformation services;
- Sterilization of a mentally incompetent or institutionalized member;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services;
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein; and,
- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.

NOTE: Under EPSDT, some exceptions may be made if a service is medically-necessary.

Provider Manual

Section 8.0

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

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- 8.2 EPSDT Eligibility**
- 8.3 Covered Services**
- 8.4 EPSDT Audits for Screening Elements**
- 8.5 EPSDT Tracking/Member Outreach**
- 8.6 EPSDT Protocols**
- 8.7 EPSDT Reporting/Billing (Preventive Health
Screens/Immunizations)**



8.0 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

8.1 Overview of EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated Medicaid program developed to ensure that the Medicaid population younger than the age of 21 is monitored for preventable and treatable conditions which, if undetected, could result in serious medical conditions and/or costly medical care. Passport must track the progress of all members younger than the age of 21 and perform outreach as needed to encourage members to obtain EPSDT health screens according to the Bright Futures/American Academy of Pediatrics (AAP) Guidelines for screening intervals. Once a condition is detected, treatment may be considered under EPSDT Special/Expanded Services if it is not a current covered benefit under Medicaid, if medical necessity is proven. EPSDT preventive health screens that result in any treatment recommendations must be monitored to ensure follow-up has occurred.

8.2 EPSDT Eligibility

8.2.1 Member Eligibility

Passport members from birth to age 21 are entitled to receive EPSDT services.

8.2.2 Practitioner Eligibility

All Passport PCPs who see children younger than the age of 21 are required to conduct EPSDT screenings and complete all EPSDT billing requirements.

8.3 Covered Services

The following services are covered under the EPSDT preventive care program:

- Comprehensive screening exams according to the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule see https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf
- All Passport eligible members under the age of 21 are entitled to EPSDT services

8.4 EPSDT Audits for Screening Elements

As part of Passport's Quality Improvement Program, the EPSDT/Quality Improvement (QI) department will conduct annual audits of submitted EPSDT claims by providers to review for completion of the age appropriate elements based on the approved Periodicity schedule. A benchmark has been established that each provider score at least 90% on the completion of all critical elements of an age appropriate screen. If a provider scores less than 90%, the EPSDT/QI staff will provide a detailed report of missing elements and education regarding the age appropriate standards. The provider will be reviewed again within six months after the education has been completed. If a provider does not meet the 90% score at that time, the provider must submit a corrective action plan that is to be reviewed and approved by the Chief Medical Officer (CMO) and

Child and Adolescent/Quality Medical Management Committees (C&A/QMMC). Sanctions are to be determined and approved by the CMO and C&A/QMMC. Audit results and any audit material may be used to identify providers who require further examination and referral to the Program Integrity Unit and/or Reimbursement to determine recovery of overpayment to providers.

8.5 EPSDT Tracking/Member Outreach

Tracking begins at enrollment for both newborns and other members and continues periodically thereafter:

- The EPSDT program and the importance of preventive care are outlined in the Member Handbook. EPSDT articles are included in all member newsletters, on Passport's web site, and in Passport's telephone on-hold messages.
- Reports are generated to check for members who are due/overdue for preventive screens. If no documentation from the PCP has been processed, follow-up calls are made or notices are mailed to members.
- Reports are generated for members who cannot be reached through written notification or by telephone. These members are referred for home visit outreach.

8.6 EPSDT Protocols

To complete an EPSDT preventive health screen:

- Verify member's eligibility via KyHealth Net, referencing the PCP monthly panel list, utilizing the EPSDT Eligibility Confirmation Form, or contacting the EPSDT team at (877) 903-0082, ext. 8210.
- For more information about KyHealth Net, or to create an account, visit www.chfs.ky.gov/dms/kyhealth.htm.
- Once eligibility is verified, inform the parent/guardian that the visit will be an EPSDT screening.
- Have the parent or legal guardian sign a consent form authorizing the practitioner to perform screening tests or other assessment procedures pertaining to EPSDT preventive health screens.

To receive reimbursement, **all EPSDT services must be submitted as part of the standard electronic (837) or paper (CMS-1500) claims submission process.**

To submit EPSDT services via claims:

- **Continue to bill using the codes** for comprehensive history and physical exam as used today. These codes must correspond with the member's age.

CPT Code	Modifier	Code Description	Billing Format
99381- 99385	EP	New Patient	837/CMS-1500
99391- 99395	EP	Established Patient	837/CMS-1500

- **Add an "EP" modifier to the physical exam code** only when all components of the appropriate EPSDT screening interval have been completed and documented in the

member's medical record. Do not add the EP modifier to other services being billed (i.e. immunizations).

- **Acknowledge the following health evaluation services have been completed** by submitting the appropriate CPT Category II codes, according to the member's age, as outlined below. CPT II codes must include a nominal charge (i.e. \$.01 or \$1.00 not blank or zero) in order to adjudicate correctly.
- Two years of age and above: 3008F to confirm the BMI has been performed and documented in the member's medical record.
- Nine years of age and above: 2014F to confirm the member's mental status has been assessed and documented in the member's medical record.
- **Note in the appropriate box on the Referral Form that a referral has been made for additional services, related to an EPSDT screening.**

Mail Paper Claims to:

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

8.7 EPSDT Reporting/Billing (Preventive Health Screens/ Immunizations)

Practitioners who perform complete EPSDT health screens according to the recommendations in the Preventive Health Guidelines will be reimbursed a fee-for-service rate. EPSDT health screens must be billed on the standard electronic (837) or paper (CMS-1500) claim form.

Practitioners will be reimbursed an administration fee for recommended childhood and adolescent immunizations. Providers participating in the Vaccines For Children (VFC) program must submit claims with an SL modifier. Providers billing for immunizations outside of the VFC program, will be reimbursed for administration as well as the vaccine serum.

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Section 9.0

Quality Improvement

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- 9.2 Quality of Care Concerns**
- 9.3 Practitioner Sanctioning Policy**
- 9.4 Clinical Practice Guidelines**



9.0 Quality Improvement

9.1 Quality Improvement Program Description

The purpose of the Quality Improvement (QI) Program is to provide the infrastructure for the continuous monitoring, evaluation and improvement in care, safety, and service.

Providers may obtain a copy of Passport's complete "Quality Improvement Program Description," "Quality Improvement Program Evaluation," or "Quality Program Committee Structure" and/or a copy of a summary of its annual evaluation by visiting the Passport website at www.passporthealthplan.com/member/eng/qi-program/index.aspx or by contacting their Provider Relations Specialist.

9.2 Quality of Care Concerns

Quality of Care Concerns may be reported by both internal and external customers such as members, providers, and advocates. All reported concerns are investigated and monitored for trends.

In the event a quality of care concern is reported, Passport requires full cooperation with the investigation of the concern. This includes the timely submission of requested medical records and the implementation of corrective action plans. Providers have the right to respond to reported concerns.

For more information regarding quality of care concerns, please contact the Quality Improvement department at (502) 585-8254.

9.3 Practitioner Sanctioning Policy

In the event Passport identifies health care services rendered to a Passport member by a participating practitioner that are outside the recognized treatment patterns of the organized medical community and quality management and/or credentialing standards, the practitioner may be subject to sanctions. The National Practitioner Data Bank (NPDB) may be notified of all negative outcomes if formal sanctioning proceedings are implemented and if the outcome is to last 30 days or more.

In addition to the above, Passport will exclude and/or penalize a provider under any of the following conditions:

- The Plan has received recommendations to take such actions as a result of an investigation conducted by the Office of the Inspector General or other appropriate state and/or federal agency.
- The provider fails to cooperate with an investigation of alleged fraud and abuse.
- The provider has been listed on the Medicare/Medicaid Sanctions Report.

Possible sanctions for deviation from accepted quality management and/or credentialing standards and program integrity violations include:

- Limiting a PCP's panel, not necessarily limited to freezing new member assignment.
- Termination of participating provider status.
- Withholds from future claims payments of amounts that are improperly paid or reasonable estimates of such amounts.
- Suspension of claims activity.

9.4 Clinical Practice Guidelines

The intent of the guidelines is to support the provider's efforts in the care and education of members and to reduce variation in diagnosis and treatment. The Plan makes every effort to ensure that current scientific data and expert opinion is the basis for each guideline. Each guideline is evaluated as new data becomes available or at a minimum of every two years. For Quality Improvement initiatives, Passport monitors provider compliance and member outcomes related to these clinical guidelines by performing an annual medical record audit. These guidelines are intended to assist the practitioner in clinical decision-making and attempt to define clinical practices that apply to most patients in most circumstances. The treating practitioner should make the ultimate decision regarding the care of a particular patient.

Relevance:

These guidelines are relevant to our Disease Management programs, HEDIS measures, Healthy Kentuckian elements, and NCQA Standards for Accreditation.

Guidelines

These guidelines include:

- Preventative guidelines for children and adults,
- EPSDT Periodicity Schedule,
- Immunization schedules for Adults and Children,
- Guidelines addressing appropriate antibiotic use in adult and children
- Behavioral Health guidelines, and
- Guidelines for Acute / Medical conditions

Providers may [access the guidelines through our website](#), or request a hard copy of the guidelines by contacting the Quality Improvement Nurse at (571) 385-3921.

Provider Manual

Section 10.0

Emergency Care/Urgent Care Services

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10.0 Emergency Care/Urgent Care Services

10.1 Emergency Care

10.1.1 Definition

Services for medical emergencies are covered when provided in a hospital, physician's office or other ambulatory setting. As defined in 42 USC 139dd(e) and 42 CFR 438.114, Emergency Medical Condition means: (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in (i) placing the physical or behavioral health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment of bodily functions, or (iii) serious dysfunction of any bodily organ or part; (iv) serious harm to self or others due to an alcohol or drug abuse emergency, (v) injury to self or bodily harm to others or (B) with respect to a pregnant woman who is having contractions (i) that there is an inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

10.1.2 PCP Responsibilities

If the member calls the primary care practitioner's (PCP) office prior to going to the ER and if the situation can be handled in the PCP's office, it is the PCP's responsibility to comply with Passport's access standards. A referral or authorization is not required for a member to be seen in the emergency room (ER). It is also the responsibility of the PCP, per his or her contract with Passport, to have after-hours call service 7 days a week, 24 hours a day. Use of Passport's 24-Hour Nurse Advice Line is not an acceptable alternative to after-hours call service.

Giving members easily understood instructions during regular office visits may help avoid after-office-hours calls or ER visits. Reviewing home treatment for common conditions, such as fever, vomiting, diarrhea, and earaches may give members or their caregivers more confidence in handling these conditions when they arise. Providing written instructions to be used as a reference may also be helpful.

10.2 Out-of-Service-Area Care

10.2.1 Definition

Emergency care as described in Section 10.1.1 is also a covered benefit for Passport members when they are out of the service area. A referral or prior authorization is not required for out-of-service-area emergency care in the ER. For an out-of-network provider to receive reimbursement a Kentucky Medicaid ID number and Passport Provider ID number is needed.

10.3 Urgent Care Services

10.3.1 Definition

Urgent care may be a covered service in an urgent care center, PCP office, or other ambulatory setting. Urgent care 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 via Passports educational materials to contact their PCP before seeking medical treatment elsewhere.

10.3.2 PCP Responsibilities

If the member calls prior to going to a licensed, credentialed urgent care center and the situation can be handled in the PCP's office, it is the PCP's responsibility to see the member within Passport's access guidelines.

For the current listing of urgent care centers, please visit the Provider Directories section of our web site, www.passporthealthplan.com/provider/resources/directories.

To request a hard copy of this listing, please contact your Provider Relations Specialist or Provider Services at (800) 578-0775.

10.4 Lock-In program

The Passport Lock-In Program is designed to ensure medical and pharmacy benefits are received at an appropriate frequency and are medically necessary. The Lock-In Program is a requirement of the Kentucky DMS.

Inappropriate use or abuse of Medicaid benefits may include:

- Excessive emergency room or practitioner office visits;
- Multiple prescriptions from different prescribers and/or pharmacies; and/or,
- Reports of fraud, abuse, or misuse from law enforcement agencies, practitioners, Office of the Inspector General, pharmacies, and Passport staff.

Under the Lock-In Program, a member's medical and pharmacy claims history and diagnoses are reviewed for possible overutilization. Members who meet the criteria will either be locked-in to a designated hospital for non-emergency services; and/or one prescriber, who may not necessarily be the member's PCP, and one pharmacy for controlled substances.

- Members who receive services from a non-designated or non-referred provider (i.e. via PCP) and are informed of the financial responsibility before the service is provided will be responsible for payment.
- Members who receive services provided in the emergency department of a hospital for a condition that is not determined to be an emergency will also be responsible for payment.

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 within the first 30-days of the Lock-In effective date.

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.

The Lock-In Program is not intended to penalize or punish the member. The program is intended to:

- Connect members with case managers who can identify reasons for over use of medical services and provide education on their health care needs;
- Reduce inappropriate use of health care services;
- Facilitate effective utilization of health care services; and,
- Enhance quality of care by developing a stable patient-physician and patient-pharmacist relationship.

Provider Manual

Section 11.0

Special Programs

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11.0 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 Primary Care Provider (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 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 an 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.

11.0.1 How are Members Identified?

Members are identified for Care Management Programs through many sources, including:

- Enrollment data
- Medical and pharmacy claims
- Health Risk Assessment (HRA)/Patient Questionnaire

- EMR data, when available
- Hospital admission, discharge and transfer feeds
- Laboratory values, as available
- The Utilization Management team
- The Care team staff managing the member in another Evolent Health Population Management Program, such as the Complex and Condition Care, Transition Care
- A discharge planner
- Internal departments, such as Pharmacy
- The 24-hour Nurse Advice Line (health information line), as applicable
- Member, family or caregiver(s), self-referral
- Practitioners, including behavioral health providers
- Ancillary providers, behavioral health managed care organizations, pharmacists, disability management programs, employer groups, or staff from community agencies

11.0.2 How to Request Care Management Services

Providers, as well as members and other interested parties, may request care management services. Providers can complete the Care Management Request Form available online at www.passporthealthplan.com/providers/Forms & Claims Information/Care Management Forms/ and under “Care Management” select “Care Management Request Form”.

11.1 Catastrophic Care Management

11.1.1 Definition

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.

11.1.2 Target Populations

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

- Amyotrophic Lateral Sclerosis
- Severe Cognitive Functional Impairment
- Hemophilia and Coagulation Disorders
- Gauchers 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)

11.1.2 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 supplementing 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 care 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, and partner in the member’s treatment plan to promote improved compliance.

11.1.2.1 Target Populations

A predictive modeling tool developed to identify members most likely to incur a disease-specific adverse event is used to target members for this program. Some of the covariates include: co-existing chronic conditions, prior utilization, change in utilization rates, drugs that indicate disease progression or severity, medical equipment and gaps in care

11.1.3 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.

11.1.3.1 Target Populations

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

- Asthma
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Coronary Artery Disease (CAD)

Please reference Passport's website at www.passporthealthplan.com, under **"Members" and then "Health and Wellness Programs"** for additional information.

11.1.4 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.

11.1.4.1 What we do

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.

11.1.4.2 Contact the Transition Care Management Team

The Transition Care Management Team can be reached at (877) 903-0082 from 8:00 a.m. until 6:00p.m. EST, Monday through Friday. After hours, if members are not sure if they need to see a doctor, the 24/7 Nurse Advice Line is a great place to start. Members can call (800) 606-9880 24 hours a day, seven days a week. There's never any cost.

11.2 Remote Care Monitoring

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 connected via Bluetooth 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.

11.3 Maternity Care Management

11.3.1 Introduction

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, Infant & Children), smoking cessation programs, substance abuse treatment referrals, or behavioral health counseling referrals.

11.3.2 Purpose of Programs

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.

11.3.3 Interventions

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.

11.3.4 Pregnancy Notification

Providers can complete the Mommy Steps Pregnancy Notification Form available online at [www.passporthealthplan.com/providers/Forms & Claims Information/Care Management Forms/](http://www.passporthealthplan.com/providers/Forms%20&%20Claims%20Information/Care%20Management%20Forms/) and under "Care Management" select "Mommy Steps Pregnancy Notification".

11.3 Specialty Populations Team

The Specialty Populations Team includes Foster Care Specialists, Guardianship Specialists, Care Coordinators, and Social Workers. The Specialty Populations Team focuses on reducing member care gaps and providing care coordination to remove barriers for accessing care.

11.3.1 Foster Care and Guardianship Specialists

The Foster Care and Guardianship Specialists works in collaboration with the Department for Community Based Services (DCBS) and the Department of Aging and Independent Living (DAIL) to provide ongoing Care Coordination Services for foster care and guardianship members. The Foster Care and Guardianship Specialists serves as a primary contact for foster

and adoptive parents, guardians and DCBS/DAIL workers for issues and concerns. Foster Parents/Guardians can call Member Services at (800) 578-0603 and asked to be transferred to the Specialty Populations Team.

Children living in out-of-home placements do not choose a PCP. Participating or non-participating providers with a valid Kentucky Medicaid Identification (MAID) number may provide medical treatment for these children. Children living in out-of-home placements can be treated by specialists without a referral. They require prior authorization for the following services only: inpatient hospital admissions, private duty nursing, home health services, and any non-covered services including EPSDT Expanded Services. To pre-certify these services, contact Utilization Management at (800) 578-0636. In addition, non-participating obstetrical providers are required to obtain authorization for obstetric services.

Children living in out-of-home placements may relocate often and may present for treatment without a card or with a card that is not current. Providers may contact Provider Services at (800) 578-0775 to verify eligibility and out-of-home placement status. Eligibility may also be checked via Passport's Provider Portal at <https://phkyportal.valence.care/>. Foster Parents/Guardians with questions can call Member Services at (800) 578-0603 and asked to be transferred to the Specialty Populations Team.

11.3.2 Homeless Services

Passport provides ongoing face-to-face member/benefits education sessions throughout the year. These sessions are conducted at the various transitional and homeless shelters throughout the state. Special attention is given to those victims of domestic violence residing in emergency shelters.

11.4 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 Relations Specialist that you would like to participate in the Population Health Management program.

Provider Manual

Section 12.0

Outpatient Pharmacy Services

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- 12.2 Covered Outpatient Pharmacy Benefits**
- 12.3 Drug Prior-Authorization Procedure**
- 12.4 Lock-In Program**



12.0 Outpatient Pharmacy Services

12.1 Prescribing Outpatient Medications for Passport Health Plan Members

Any health care provider licensed to prescribe medications in the Commonwealth of Kentucky may write a prescription for a Passport 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.

12.2 Covered Outpatient Pharmacy Benefits

Passport must have available to its members all medications appearing on DMS Drug List; however, Passport may impose additional requirements for medical necessity through the use of prior authorizations. In addition, Passport covers certain diabetic supplies. Passport may also impose quantity limits or day supply limits, and other appropriate edits to promote both safety and evidence-based therapy. The Pharmacy and Therapeutics Committee, comprised of practitioners, pharmacists, and consumer representatives, meets regularly to update the preferred drug list. Working with Passport's pharmacy benefits manager (PBM), the Pharmacy and Therapeutics Committee annually reviews each category of drugs to identify preferred drugs based upon clinical and pharmacoeconomic data to promote cost-effective, evidence-based practices.

Providers are encouraged to use Passport's Preferred Drug List. Providers may view the preferred drug list via Passport's online searchable formulary. Updates to the Preferred Drug List are also distributed via Passport's *Pharmacy News* Bulletin which is also available through your Provider Relations Specialist or Passport's website <http://passporthealthplan.com/pharmacy/pharmacy-communications-2/>.

12.2.1 Categories of Covered Drugs

Three categories of drugs (available on Passport's web site, <http://passporthealthplan.com/pharmacy/drug-formulary-2/>) are covered for Passport members:

- **Preferred medications:** Drugs that have been evaluated by Passport's Pharmacy and Therapeutics Committee and found to provide pharmacoeconomic value, therapeutic benefits, and a history of safe use. Some preferred drugs may have age edits and require step therapy.
- **Prior authorized drugs (PA):** These drugs may require the use of a non-prior authorized drug (step therapy) and/or meet additional medical necessity criteria for approval. Medical necessity criteria may include peer-reviewed criteria, relevant and statistically-appropriate studies, and FDA approvals for drug use.
- **Selected categories of over-the-counter (OTC) drugs:** Covered OTC drugs should be

used in the course of current or ongoing therapy. A valid prescription for these medications is required for dispensing.

Drugs in all three of the above categories may have limits for quantity dispensed, days' supply, and requirements for use to ensure medical necessity.

12.2.2 Categories of Covered Diabetic Supplies

The following diabetic supplies are only covered through the pharmacy with a valid prescription:

- Blood glucose meter
- Blood glucose test strips
- Calibrator solutions
- Insulin syringes
- Blood ketone test or reagent strips
- Urine test or reagent strips
- Lancets
- Lancing devices
- Pen needles

Quantity limits may apply.

12.3 Drug Prior-Authorization Procedure

12.3.1 Prescription Medications and Prior Authorization

12.3.1.1 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” before approval);
- Non-formulary;
- 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 (P&T) Committee;
- Prescribed for off-label use or outside of certain diseases or specialties; or,
- An incorrect ICD-9 before 10/01/15 date of service and ICD-10 after 10/01 code when required.

12.3.1.2 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 on www.passporthealthplan.com/pharmacy.
- A physician, nurse practitioner, or pharmacist may complete this form.

STEP 3: Submit the completed form for review to (844)-380-8831 or complete the online submission form at <http://passporthealthplan.com/pharmacy/pharmacy-portal-2/> and click on “Online Prior Authorization.” If the request is for a hospital discharge, check that box on the form.

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 PA receipt.

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

**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.*

12.3.1.3 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 utilizes medical criteria developed in collaboration with our Pharmacy Benefits Manager (PBM) and the P&T Committee. Criteria are derived from one or more of the following:

- Published American Federal Food and Drug approval indications for Therapy;
- Federal and/or State regulatory requirements;
- Drug compendia such as the American Hospital Formulary Service-Drug Information (AHFS-DI), the Gold Standard Clinical Pharmacology, the 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 Passport's 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 Passport Medical Director for a decision.

12.3.1.4 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.

12.3.1.5 Emergency Supply

Pharmacies may dispense a 72-hour emergency supply of medication if they are unable to contact the prescriber for prior authorization. This does not apply to drugs excluded from coverage by state and federal regulations.

12.3.1.6 Prescription Co-Pays

Beginning January 1, 2014, some Passport members will have a copay for prescriptions. Copay requirements are as follows:

Service or Item	Co-Pay
Preferred and Non-preferred generic drug	\$1.00
Brand name preferred on formulary over generic equivalent	\$1.00
Brand name drug that has a generic version available	\$4.00

Total cost sharing cannot exceed an aggregate of 5% of a family's income per calendar quarter. The pharmacy will be made aware of any copayment responsibility and will collect it from the member when the claim is adjudicated.

A pharmacist may refuse to dispense a prescription to a member who does not pay the cost sharing amount at the time of picking up the prescription (unless the member is under 100% of Federal Poverty Level); however, the pharmacist must dispense a 72-hour supply of the prescribed drug if the member has an emergency condition which requires an emergency supply of the drug.

The following members do not have a copayment requirement unless they receive a non-preferred medication.

- Members 18 years of age and under;
- Pregnant members;
- Institutionalized members;
- Members receiving family planning services and supplies;
- American Indians receiving services directly by an American Indian health care provider or through referral under contract health services;
- Members in hospice care; and,
- Members receiving preventive services.

12.3.2 Denial and Appeal Process

An authorization request for outpatient pharmacy services may be denied for lack of medical necessity, or it may be denied for failure to follow administrative procedures outlined in the Provider Contract or this Provider Manual. Denial letters are generated by Passport to the member and the prescriber. The PBM faxes a denial notification to the prescriber and the pharmacy if fax numbers are available.

Your office must have the area code programmed into your fax machine with a CSID (Called Subscriber Identification) in order to receive fax confirmation of PA receipt with the seven (7) digit transaction number identifier. This 7-digit identifier is required if you call regarding a PA status.

Appeals for pharmacy services are handled by Passport following the same procedure as pre-service appeals (see Section 2.11 for additional information).

12.4 Lock-In Program

The Passport Lock-In Program is designed to ensure medical and pharmacy benefits are received at an appropriate frequency and are medically necessary. The Lock-In Program is a requirement of the Kentucky DMS.

Inappropriate use or abuse of Medicaid benefits may include:

- Excessive emergency room or practitioner office visits;
- Multiple prescriptions from different prescribers and/or pharmacies; and/or
- Reports of fraud, abuse, or misuse from law enforcement agencies, practitioners, Office of the Inspector General, pharmacies, and Passport staff.

Under the Lock-In Program, a member's medical and pharmacy claim history and diagnoses are

reviewed for possible overutilization. Members who meet the criteria will either be locked-in to a designated hospital for non-emergency services; and/or one prescriber, who may not necessarily be the member's PCP, and one pharmacy for controlled substances.

- Members who receive services from a non-designated or non-referred provider (i.e. via PCP) and are informed of the financial responsibility before the service is provided will be responsible for payment.
- Members who receive services provided in the emergency department of a hospital for a condition that is not determined to be an emergency will also be responsible for payment.

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 within the first 30-days of the Lock-In effective date.

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.

The Lock-In Program is not intended to penalize or punish the member. The program is intended to:

- Connect members with case managers who can identify reasons for over use of medical services and provide education on their health care needs;
- Reduce inappropriate use of health care services;
- Facilitate effective utilization of health care services; and
- Enhance quality of care by developing a stable patient-physician and patient-pharmacist relationship.

12.4.1 How to Refer a Member

To refer a member, to determine if a member is part of the Lock-In program, or for general questions regarding the program, please contact the Pharmacy Coordinator for pharmacy or controlled substance prescriber inquiries or the ER Coordinator at (502) 588-8564 for hospital inquiries.

12.4.2 How to Report Fraud and Abuse

If you suspect fraud and/or abuse by a Passport member or provider, it is your responsibility to report this immediately by calling one of the telephone numbers listed below:

Corporate Compliance Hotline: (855) 512-8500

KyHealth Choices Medicaid Fraud Hotline: (800) 372-2970

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Section 13.0

Obstetrical

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13.0 Obstetrical

13.1 Maternity Care Management Program

Passport recognizes that access to effective prenatal and postpartum care provides a strong foundation for the health of women, as well as improving birth outcomes. As a result, Passport's Maternity Care Management, called Mommy Steps, has 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 Women, Infant & Children (WIC) 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 well-being. 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: educational 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.

13.2 How to Contact Us

Perinatal Care Advisors are available to assist members and obstetrical providers with questions. They can be reached at (877) 903-0082 or via fax at (800) 880-6186 Monday through Friday, 8:00a.m. to 6:00 p.m. ET (excluding business approved holidays).

13.3 Member Participation

The Mommy Steps Program utilize an opt-out model. Members identified for the program are considered participating unless they specifically request to opt-out. Members are notified of enrollment by mail and phone contact. Members have the right to decline any or all parts of the program. Member can opt back into the program by calling (877) 903-0082 Monday through Friday, 8:00 a.m. to 6:00 p.m. ET (excluding business approved holidays).

13.4. Member Access and/or Authorization Requirements

All components of obstetrical care are directly accessible by members including testing and prenatal care. Appointment standards must be provided for prenatal care as follows:

- 1st Trimester-within 14 business days of request.
- 2nd Trimester-within 7 business days of request.
- 3rd Trimester-within 3 business days of request.
- High-risk pregnancies-within 1 business day of the identification of a high-risk condition or immediately if an emergency exists.

In addition, authorizations for referrals to Maternal Fetal Medicine specialists, geneticists, and endocrinologists are not required for high risk conditions evaluation and treatment during pregnancy.

Maternity observation stays do not require authorizations. These are defined as a hospital stay of 23 hours or less for the observation of members with medical conditions related to pregnancy.

Only 23-hours of observation is covered at a single encounter. For additional lengths of stay (over 23 hours) to be covered, inpatient stays must be authorized.

For Authorization requirements for scheduled inductions and all Cesarean sections, refer to Provider Manual Section 5.0 Utilization Management Sub-Section 5.3 Authorization Requirements

13.1 Responsibility of Providers

Follow the Passport Clinical Practice Guideline for Perinatal Care which was adopted from the American College of Obstetricians and Gynecologists (ACOG).

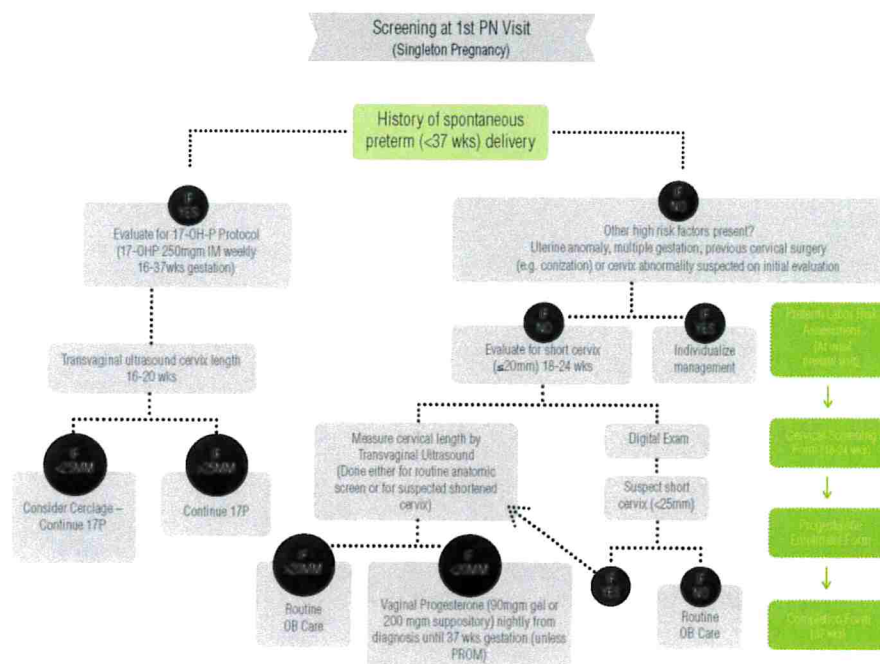
Obstetrical providers should:

- Fax the [Pregnancy Notification Form](#), (available online under Provider Forms then Care Management, select Mommy Steps Pregnancy Notification) to (800) 880-6186 or email to MommySteps@Passport.EvolentHealth.com within seven (7) business days of the initial prenatal visit (or determination of Passport membership/eligibility, whichever is later.)
- Submit the initial prenatal risk assessment/medical and obstetrical history within one week of the initial prenatal visit. An [ACOG](#) (or ACOG like) form containing this information should be faxed to (800) 880-6186 or email to MommySteps@Passport.EvolentHealth.com. It is the responsibility of the provider to confirm that the [ACOG](#) (or ACOG-like) form has been received by the Mommy Steps Program, if they assume the care of a member from another provider. The ACOG (or ACOG-like) form should be received by the Mommy Steps Program within seven (7) business days of the initial evaluation (or determination of Passport membership/eligibility, whichever is later.)
- Birth statistics should be reported for each delivery within seven (7) business days of delivery. This information should include: member name, member Passport ID #,

facility, date of delivery, delivery route, gestational age, birth weight, gender, 1 minute Apgar and 5 minute Apgar, living status: alive/fetal demise, delivering clinician name, delivering clinician NPI#, any complications of pregnancy, delivery, or the postpartum period via fax to (800) 880-6186 or email to MommySteps@Passport.EvolentHealth.com.

- Schedule a postpartum visit for the period of 21-56 days post-delivery. Ideally, scheduling should be done no later than discharge from the hospital following delivery. In addition, for members who are at risk for complications or are post-operative from Cesarean Section, an additional visit should be scheduled for the member to be seen seven (7) to 14 days post-operatively. Submit documentation of the postpartum visit including the member's choice of contraceptive. If the member elects to have a tubal ligation, the surgical permit must be signed 30 days prior to the procedure.
- Providers should contact the Mommy Steps Program if the member's risk status or condition changes in any way during pregnancy, labor and delivery, or postpartum. This information should include: member name, member Passport ID #, provider name, provider NPI#, all risk status or condition changes of pregnancy. Providers can fax this information to (800) 880-6186 or email to MommySteps@Passport.EvolentHealth.com.
- Direct members to their Primary Care Provider (PCP) for the evaluation and treatment of conditions not related to pregnancy.
- Coordinate care with the member's PCP or other treatment providers as appropriate.

PRETERM BIRTH PREVENTION ALGORITHM



Provider Manual

Section 14.0

Family Planning

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14.0 Family Planning

14.1 Services

Family Planning Services includes complete medical history, physical examination, laboratory and clinical test supplies, educational material, counseling and prescribed birth control methods to best suit the patient's needs. Providers must maintain confidentiality for Family Planning Services with members under 18 years of age (Title X, 42 CFR 59.11, and KRS 214.185). Some situations may not guarantee confidentiality, please see KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185 for those exceptions.

Family planning 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.

Termination of Pregnancy**

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

* Requirements for Sterilization:

1. MAP 250 form must be completed (Male and Female sterilization)
2. MAP 250 form must be completed 30 days PRIOR to the scheduled procedure
3. Member must be at least 21 years of age or older
4. Consent expires 180 days from the member's signature
5. Form must be attached to all claims

If the form is not attached or the form is incomplete, the claim may be denied

6. Prior authorization IS NOT required for sterilization

** Requirements for Termination of pregnancy (Induced Abortion or Induced Miscarriage):

1. MAP 235 form must be completed
2. Termination is covered ONLY:
 - A. In cases of Rape or Incest
 - B. If the life of the mother would be endangered if the fetus were carried to term. If the requirements for termination of pregnancy are not met, alternative funding can be located at <http://www.fundabortionnow.org/funds/AFund-Inc>

3. Prior authorization IS required for termination of pregnancy. Medical Record must be submitted for review MAP 235 must be submitted for review.
4. Requests for authorization of services may be received Monday through Friday from 8:00 a.m. to 5:30 p.m. EST, except holidays, by calling (800) 578-0636 or faxing to (502) 585-7989.

Requests submitted without complete medical records and a MAP 235 form will not be able to be processed

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 accessed on the DMS web site, <http://chfs.ky.gov>. Sample forms are located in Section 17 of this Provider Manual. The provider must ensure that non-English speaking, visually impaired and/or hearing-impaired members understand what they are signing.

14.2 Network

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.

14.3 Claims

All family planning claims are to be submitted to the following address:

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

For Sterilization Services: (Tubal ligations, Postpartum tubal ligations, Vasectomies) a completed MAP 250 form must be attached to all claims. Failure to submit the completed form with the claim may result in the claim being denied.

Claims for presumptively eligible (PE) members should be submitted according to the guidelines in Section 15.

Provider Manual

Section 15.0

Provider Billing Manual

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15.0 Provider Billing Manual

15.1 Claim Submission

15.1.1 Procedures for Claim Submission

Passport is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims.

When required data elements are missing or invalid, claims will be rejected by Passport for correction and resubmission.

The provider who performed the service to the Passport member must submit the claim for a billable service.

Claims filed with Passport are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of the referral for specialist or non-primary care physician claims.
- Verification of member eligibility for services under Passport during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the “out-of-network” provider has received authorization to provide services to the eligible member (excluding “self-referral” types of care).
- Verification of whether there is Medicare coverage or any other third party resources and, if so, verification that Passport is the “payer of last resort” on all claims submitted to Passport.
- Verification that an authorization has been given for services that require prior authorization by Passport.
- Verification that the provider is enrolled with Kentucky Medicaid during the claim date of service and that the claim includes the appropriate NPI code and taxonomy code on file with Kentucky Medicaid.

In addition, Passport uses claim edit applications following NCCI, AMA and CMS guidelines:

- Procedure unbundling (billing two or more CPT codes when one CPT code exists for same procedure)
- Incidental procedures (procedures performed at the same time as a more complex procedure but requires little to no additional physician resources or is clinically integral to the performance of the procedure)
- Mutually-exclusive procedures (two or more procedures that should not be performed or billed for the same member on the same date of service)
- Multiple surgical procedures (surgical procedures are ranked according to clinical intensity and are paid following percentage guidelines)
- Multiple Procedure Payment Reduction (MPPR) for selected therapies (applies to multiple procedures and multiple units)
- Duplicate procedures (procedures billed more than once on same date of service)

- Assistant surgeon utilization (reimbursement and coverage determination)
- Evaluation and management service billing (review the billing of services with procedures performed)
- ER evaluation and management services (review the billing for consistency with ACEP guidelines)
- Add on code edits
- Gender and age specific edits
- New vs Established Patients
- Global Surgery guidelines
- Local Coverage Determinations (LCD) and National Coverage Determinations (NCD)

Claims for emergency room services will be subject to review for medical necessity and whether treatment was required for an Emergency Medical Condition as defined in paragraph 10.1.1 of this manual.

Any CPT/HCPCS level 1 or 2 codes that have been denied due to claims editing will be associated with appropriate disposition code on the remittance advice.

As part of the agreement between Passport and the provider, the provider agrees to cooperate with Passport in its efforts to comply with all applicable Federal and State laws, including specifically the provisions of Section 6032 of the Deficit Reduction Act of 2005, PL-019-171, False Claims Act, Federal Remedies for False Claims and Statements Act, and KRS 205.8451, et. Seq. (relating to fraud). Passport also complies with the applicable Prompt-Pay requirements found in KRS 304.17A-700-730, KRS 304.14-135 and KRS 304.99-123.

Passport will provide to each Medicaid provider the opportunity for an in-person meeting with a representative of Passport on any clean claim that remains unpaid in violation of [KRS 304.17A-700 to 304.17A-730](#); and on any claim that remains unpaid for forty-five (45) days or more after the date on which the claim is received by Passport and that individually, or in the aggregate, exceed \$2,500.00.

15.1.2 Lesser of Logic

Unless otherwise specified in writing, it is Passport's policy to reimburse providers the lesser of the billed charge or the contracted reimbursement rate for all services and payment methodologies, including but not limited to bundled services, fee schedule based services, drugs, and per diems.

15.1.3 Rejected and Denied Claims

Rejected claims are defined as claims with invalid or missing data elements (such as the provider tax identification number) that are returned to the provider or EDI source without registration in the claims processing system. Since rejected claims are not registered in the claims processing system, the provider must re-submit corrected claims within 180 calendar days from the date of service. This requirement applies to claims submitted on paper or electronically. Denied claims are different than rejected claims and are registered in the claims processing system but do not meet requirements for payment under Passport guidelines. For more information on denied claims, see Section 15.3 and

15.4 in this Provider Manual.

15.1.4 Claim Mailing Instructions

Passport encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or the Change Healthcare (formerly Emdeon) Provider Support Line at (800) 845-6592 to arrange transmission.

Passport Electronic Payer ID is 61325.

If you choose to utilize paper claims, please submit to Passport at the following address:

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

15.1.5 Claims Status Review

Providers may view claims status using any of the following methods:

- **Online** – check eligibility/claims status by logging into Passport’s Provider Portal at <https://phkypportal.valence.care/>
- **Telephone** – you may also check eligibility and/or claims status by calling our interactive voice response (IVR) system at (800) 578-0775.
- **Real-Time** – depending on your clearinghouse or practice management system, real-time claims status information is available to participating providers. Contact your clearinghouse to access:
 - Change Healthcare Products for claims status transactions.
 - All other clearinghouses: Ask your clearinghouse to access transactions through Change Healthcare.

15.1.6 Notification of Denial via Remittance Advice

When a claim is denied because of missing or invalid mandatory information, the claim should be corrected, marked as a second submission or corrected claim, and resubmitted within two years of the process date electronically or to the general claim address:

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

15.1.7 Claims Adjustment/Appeal Requests

If you believe there was an error made during claims processing or if there is a discrepancy in the payment amount, please call the Provider Claims Service Unit (PCSU) at (800) 578-0775, option 2. Our representatives can help you resolve the issue, process a claim via the phone, and advise whether a corrected claim or a written appeal needs to be submitted. Please submit Claims Issue Forms to P.O. Box above.

15.1.8 Claim Submission for New Providers

New providers with Passport awaiting receipt of their Medicaid Identification (MAID) number are subject to the timely filing guidelines and may begin to submit claims once they are loaded into our system. These claims will initially deny for no MAID number. After Passport receives a provider’s

MAID number, all claims submitted and initially denied will be reprocessed without resubmission.

15.1.9 Claim Forms and Field Requirements

The following charts describe the required fields that must be completed for the standard CMS-1500 or UB-04 claim forms. If the field is required without exception, an “R” (Required) is noted in the “Required or Conditional” box. If completing the field is dependent upon certain circumstances, the requirement is listed as “C” (Conditional) and the relevant conditions are explained in the “Instructions and Comments” box.

The CMS-1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. All claims must be submitted within the required filing deadline of 180 days from the date of service.

Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

15.1.9.1 Claim Data Sets Billed by Providers

To facilitate timely and accurate claim processing, you must assure billing on the correct form for your provider type. The table below outlines the requirements as defined by Kentucky Medicaid:

	CMS-1500	UB-04 (CMS-1450)
Hospital - Acute Care Inpatient		X
Hospital – Outpatient		X
Hospital - Long Term Care		X
Inpatient Rehabilitation Facility		X
Inpatient Psychiatric Facility		X
Home Health Care		X
Skilled Nursing Facility		X
Ambulance (Land and Air)	X	
Ambulatory Surgical Center	X	
Dialysis Facility (Chronic, Outpatient)		X
Durable Medical Equipment	X	
Drugs (Part B)	X	
Laboratory	X	
Physician and Practitioner Services	X	
Federally Qualified Health Centers	X	
Rural Health Clinics	X	

15.1.9.2 CMS-1500 Claim Form and Required Fields

Use of the CMS-1500 form (02/12) was required as of April 1, 2014. Please [see claim form instructions](#). The form includes several fields that accommodate the use of your National Provider Identifier (NPI).

Required Fields for the CMS-1500 Claim Form

NOTE: *Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

CMS 1500 Claim			
Field	Field Description	Instructions and Comments	Required or Conditional*
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicates the payer with whom the claim is being filed. Select "D", other.	R
1A	INSURED I.D. NUMBER	Passport's member identification number as it appears on the member's Passport ID card. EDI details ASC X12 4010A. Subscriber number less than 11 digits. 2010BA, NM108=MI NM109 less than 11 digits. Subscriber is required.	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the member's name as it appears on the member's Passport ID card.	R
3	PATIENT'S BIRTH DATE / SEX	MMDDCCYY / M or F	R
4	INSURED'S NAME (Last Name, First Name, Middle Initial)	Enter the member's name as it appears on the member's Passport ID card, or enter the mother's name when the member is a newborn.	R
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code, and Telephone, Including Area Code)	Enter the member's complete address and telephone number (Do not punctuate the address or phone number).	R
6	PATIENT RELATIONSHIP TO INSURED	Always indicate self.	R
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the member's complete address and telephone number (Do not punctuate the address or phone number).	R
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the member. REQUIRED if member is covered by another insurance plan. Enter the complete name of the insured.	C
9A	OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed.	C

9B	RESERVED FOR NUCC USE		Not Required
9C	RESERVED FOR NUCC USE		Not Required
9D	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if # 9 is completed.	C
10A,B,C	IS PATIENT'S CONDITION RELATED TO:	Indicate Yes or No for each category.	R
10D	CLAIM CODES (Designated by NUCC)	Enter condition codes as approved by the NUCC in this field.	C
11	INSURED'S POLICY GROUP OR FECA NUMBER	Required when other insurance is available. Complete if more than one other medical insurance is available, or if "yes" to field 10 A, B, C.	C
11A	INSURED'S BIRTH DATE / SEX	Complete information if other insurance is listed in field 11.	C
11B	OTHER CLAIM ID (Designated by NUCC)	For worker's compensation or property and casualty enter the qualifier to the left of the vertical dotted line and the identifier number to the right of the vertical dotted line.	C
11C	INSURANCE PLAN NAME OR PROGRAM NAME	Enter name of Health Plan. REQUIRED if field 11 is completed.	C
11D	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Y or N by check box. If yes, complete 9, 9a and 9d.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		Not required
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		Not required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	Enter the three character qualifier to the right of the vertical dotted line to identify which date is being reported.	C

15	OTHER DATE	Enter additional date information about the patient's condition or treatment. Enter the three character qualifier between the vertical dotted lines to identify which date is being reported.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME AND QUALIFIER OF REFERRING PHYSICIAN OR OTHER SOURCE	REQUIRED if a provider other than the member's primary care physician rendered invoiced services. Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply (ies) on the claim. If multiple providers are involved, enter one	C
17A	OTHER I.D. NUMBER OF REFERRING PHYSICIAN AND QUALIFIER	Conditional only if you the Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number	C
17B	NATIONAL PROVIDER IDENTIFIER (NPI)	Enter the NPI number of the referring provider, ordering provider or other source. REQUIRED if field 17 is completed	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	REQUIRED when place of service is inpatient. MMDDYY	C
19	Additional Claim Information (Designed by NUCC)		C
20	OUTSIDE LAB CHARGES	For billing diagnostic tests subject to purchase price limitations.	C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)).	All diagnosis codes must be valid for the date of service. "E" codes are NOT acceptable as a primary diagnosis. List in priority order.	R

22	RESUBMISSION CODE AND ORIGINAL REFERENCE NUMBER	For resubmissions or adjustments, enter the appropriate bill frequency code and the claim ID number of the original claim. Original claim ID is required if claim is a corrected or resubmitted claim.	C
23	PRIOR AUTHORIZATION NUMBER	Enter the referral or authorization number. Refer to Section 18.6 in this Provider Manual to determine if services rendered require an authorization or referral.	C
24A	DATE (S) OF SERVICE	“From” date: MMDDYY. If the service was performed on one day, there is no need to complete the “to” date.	R
24B	PLACE OF SERVICE	Enter the CMS standard place of service code.	R
24C	EMG	This is an emergency indicator field. Enter Y for “Yes” or leave blank for “No” in the bottom (unshaded area of the field).	C
24D	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. NOTE: Modifiers affecting reimbursement must be placed in the 1st position.	R
24E	DIAGNOSIS CODE	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (A-L). All diagnosis codes must be valid for the date of service.	R
24F	CHARGES	Enter charges for each line item. Value entered must be greater than zero (\$0.01)	R
24G	DAYS OR UNITS	Enter quantity for each line item. Value entered must be greater than zero (EDI allows two characters).	R

24H	EPSDT FAMILY PLAN		Not required
24I	ID QUALIFIER	For taxonomy billing, you should put ZZ as the qualifier	R
24J	RENDERING PROVIDER ID	The un-shaded area accommodates the Rendering Provider's NPI and the shaded portion should have the rendering provider's taxonomy.	R
25	FEDERAL TAX I.D. NUMBER SSN/ EIN	Physician or supplier's Federal Tax ID number.	R
26	PATIENT'S ACCOUNT NO.	The provider's billing account number.	R
27	ACCEPT ASSIGNMENT	Always indicate Yes. Refer to the back of the CMS 1500 form for the section pertaining to Medicaid payments.	R
28	TOTAL CHARGE	Enter the total of all charges listed on the claim. Value entered must be greater than zero dollars (\$0.00).	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Passport. Medicaid programs are always the payers of last resort.	C

30	RESERVED FOR NUCC USE		Not Required
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS / DATE	Signature on file, signature stamp, computer generated or actual signature is acceptable.	R
32	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office).	REQUIRED even if field 33 has the same information. Enter the physical location (P.O. Box Numbers are not acceptable here).	R
32A	SERVICE FACILITY NPI NUMBER	Required unless rendering provider is atypical and is not required.	R
32B	SERVICE FACILITY TWO CHARACTER QUALIFIER ID AND CURRENT PROVIDERS ID		R
33	BILLING PROVIDER INFO & TELEPHONE NUMBER	REQUIRED - Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location. P.O. boxes are not acceptable.	R
33A	BILLING PROVIDER NPI NUMBER	REQUIRED	R
33B	PROVIDER'S GROUP TAXONOMY CODE	Populate field with the ZZ qualifier ID and the Group Provider's Primary Taxonomy Code.	R

15.1.9.3 UB-04 Claim Form and Required Fields

Required Fields UB-04 Claim Form

NOTE: *Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

Required fields for the UB-04 Claim Form				
Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
1	Billing Provider Name, Address and Telephone Number	Line A: Enter the complete provider name. Line B: Enter the complete address or post office number. Line C: City, State, and Zip Code Line D: Enter the area code, telephone number. Left justified.	R	R
2	Pay-to Name and Address	Enter the facility Medical Assistance I.D. (MAID) number. Left Justified.	R	R
3A	PATIENT CONTROL NO.	Provider's patient account/control number	R	R
3B	MEDICAL/HEALTH RECORD NUMBER	The number assigned to the member's medical/health record by the provider.	R	R
4	TYPE OF BILL	Enter the appropriate three-digit or four-digit code. 1st position is a leading zero. (Note: Do not include the leading zero on electronic claims.) 2nd position indicates type of facility. 3rd position indicates type of care. 4th position indicates billing sequence.	R	R

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
5	FED. TAX NO.	Enter the number assigned by the federal government for tax reporting purposes.	R	R
6	STATEMENT COVERS PERIOD FROM/ THROUGH	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R
7	UNLABELED	Not used – leave blank.		
8A	PATIENT IDENTIFIER	Patient ID is conditional if the number is different from field 60.	C	C
8B	PATIENT NAME	Last name, first name, and middle initial. Enter the member's name as it appears on the member's Passport ID card. Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should not be reported in this field. No space should be left after the prefix of a name (e.g. McKendrick). Both names should be capitalized and separated by a hyphen (no space). A space should separate a last name and suffix.	R	R
9A-E	PATIENT ADDRESS	Enter the member's complete mailing address. 9A. Street Address 9B. City 9C. State 9D. ZIP Code 9E. Country code (report if other than USA)	R	R
10	BIRTH DATE	Member's Date of Birth MMDDYYYY	R	R
11	SEX	Enter the member's sex as recorded at the time of admission, outpatient service or start of care. Only M and F are acceptable.	R	R

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
12A	ADMISSION 12-15			
12B	ADMISSION DATE	The start date for this episode of care. For inpatient services, this is the date of admission. Right Justified.	R	R
13	ADMISSION HOUR	The code referring to the hour during which the member was admitted for inpatient or outpatient care. Left justified.	R	R
14	ADMISSION TYPE	A code indicating the priority of this admission/visit.	R	Not required
15	ADMISSION SRC (Source of Referral for Admission or Visit)	A code indicating the source of the referral for the admission or visit.	R	C
16	D HR (Discharge Hour)	A code indicating the discharge hour of the member from inpatient care.	R	R
17	Patient Discharge Status	A code indicating the disposition or discharge status of the member at the end service for the period covered on this bill, as reported in field 6.	R	R
18-28	CONDITION CODES (the following is unique to Medicare eligible Nursing Facilities; condition codes should be billed when Medicare Part A does not cover Nursing Facility Services)	A code(s) used to identify conditions or events relating to this bill that may affect processing. Enter one of the following codes in the second column as a Reason Code: <ul style="list-style-type: none"> • 35 if Medicare benefits are exhausted. • 50 if one of the following applies to why Medicare does not cover the services: <ul style="list-style-type: none"> <input type="checkbox"/> No 3-day prior hospital stay; <input type="checkbox"/> Not within 30-days of hospital discharge; <input type="checkbox"/> 100 benefit days are exhausted ; <input type="checkbox"/> No 60 day break in daily skilled care; <input type="checkbox"/> Medical necessity requirements are not met; and/or, 	C	C

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
29	ACCIDENT STATE	The accident state field contains the two digit state abbreviation where the accident occurred. REQUIRED when applicable.	C	C
30	UNLABELED FIELD	Enter DRG on the lower line. REQUIRED when applicable.	C	C
31A, B-34A, B	OCCURRENCE CODES AND DATES	Enter the appropriate occurrence code and date. REQUIRED when applicable.	C	C
35A, B-36A, B	OCCURRENCE SPAN CODES AND DATES	A code and the related dates that identify an event that relates to the payment of the claims. REQUIRED when applicable.	C	C
37A, B	UNLABELED FIELD			
38	RESPONSIBLE PARTY	The name and address of the party responsible for the bill.	C	C
39A, B, C, D-41A, B, C, D	VALUE CODES AND AMOUNTS	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization Value Codes and amounts. If more than one value code applies, list in alphanumeric order. REQUIRED when applicable. NOTE: If a value code is populated, then the value amount must also be populated and vice versa.	C	C
42	REV.CD.	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.	R	R

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
43	DESCRIPTION	The standard abbreviated description of related revenue code categories is included on this bill. See the NUBC instructions for field 42 for a description of each revenue/code category.	R	R
44	HCPCS/RATE S/ HIPPS CODE	<ol style="list-style-type: none"> 1. The Healthcare Common Procedure Coding System (HCPS) is applicable to ancillary services and outpatient bills. 2. The accommodation rate for inpatient bills. 3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. <p>Enter the applicable rate, HCPS or HIPPS code, and modifier based on the bill type of Inpatient or Outpatient.</p>	R	R
45	SERV. DATE	Report line item dates of service for each revenue code or HCPCS/CPT code.	C	R
46	SERV. UNITS	Report units of service. A quantitative measure of service rendered by revenue category to or for the patient to include items such as number of accommodations days, miles, pints of blood, renal dialysis treatments, etc.	R	R
47	TOTAL CHARGES	<p>Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period.</p> <p>Total charges include both covered and non-covered charges. Report grand total of submitted charges. Value entered must be greater than zero dollars (\$0.00).</p>	R	R

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
48	NONCOVERED CHARGES	To reflect the non-coverage charges for the destination payer as it pertains to the related revenue code. REQUIRED when Medicare is primary.	C	C
49	UNLABELED FIELD		Not required	Not required
50	PAYER	Enter the name for each payer being invoiced. When the member has other coverage, list the payers as indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R
51	HEALTH PLAN ID	The number used by the health plan to identify itself. Passport's Payer ID is 61325.	R	R
52	REL. INFO	Release of Information Certification Indicator. This field is required on paper and electronic invoices. Line A refers to the primary payer; B refers to secondary; and C refers to tertiary. It is expected that the provider/practitioner have all necessary release information on file. It is expected that all released invoices contain "Y."	R	R
53	ASG. BEN.	Valid entries are "Y" (yes) and "N" (no).	R	R
54	PRIOR PAYMENTS	The A, B, C indicators refer to the information in Field 50.	R	R
55	EST. AMOUNT DUE	Enter the estimated amount due (the difference between "total charges" and any deductions such as other coverage).	C	C

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
56	NATIONAL PROVIDER IDENTIFIER-BILLING PROVIDER	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier. REQUIRED if the health care provider is a Covered Entity as defined in HIPAA Regulation.	R	R
57A, B C	OTHER (BILLING) PROVIDER IDENTIFIER	A unique identification number assigned by the health plan to the provider submitting the bill. The UB-04 does not use a qualifier to specify the type of Other (Billing) Provider Identifier. Use this field to report other provider identifiers as assigned by the health plan listed in field 50 A, B, C.	C	C
58	INSURED'S NAME	Information refers to the payers listed in field 50. In most cases, this will be the member's name. When other coverage is available, the insured is indicated here.	R	R
59	P. REL	Enter the member's relationship to insured. For Medicaid programs the member is the insured. (Code 01: Patient is Insured)	R	R
60	INSURED'S UNIQUE ID	Enter the member's Passport ID, exactly as it appears on the member's ID card, on line B or C. When other insurance is present, enter the Passport ID on line A.	R	R
61	GROUP NAME	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
62	INSURANCE GROUP NO.	Use this field only when a member has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B refers to secondary; and C refers to tertiary.	C	C
63	TREATMENT AUTHORIZATION CODES	Enter the Passport referral or authorization number. Line A refers to the primary payer; B refers to secondary; and C refers to tertiary.	R	R
64	DCN	Document Control Number. New field. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code (ESC). The ESC field has been eliminated. NOTE: Resubmitted claims must contain the original claim ID.	C	C
65	EMPLOYER NAME	The name of the employer that provides health care coverage for the insured individual identified in field 58. REQUIRED when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B refers to secondary; and C refers to tertiary.	C	C
66	DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION INDICATOR)	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. Not required.	C	C

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
67	PRIN. DIAG. CD. AND PRESENT ON ADMISSION (POA) INDICATOR	The ICD-9-CM codes before 10/01/15 date of service and ICD-10-CM codes after 10/01 describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the member for care). Present on Admission (POA) is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, are considered as POA. The POA Indicator is applied to the principal diagnosis as well as all secondary diagnoses reported.	R	R
67 A-Q	OTHER DIAG. CODES 67A-Q	The ICD-9-CM diagnosis codes before 10/01/15 date of service and ICD-10-CM diagnosis codes after 10/01 corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.	C	C
68	UNLABELED FIELD			
69	ADM. DIAG. CD.	The ICD diagnosis code describing the member's diagnosis at the time of admission. REQUIRED for inpatient admissions. Each diagnosis code must be valid for the date of service.	R	C

70	PATIENT'S REASON FOR VISIT	<p>The ICD-9-CM diagnosis codes before 10/01/15 date of service and ICD-10-CM diagnosis codes after 10/01 describing the member's reason for visit at the time of outpatient registration.</p> <p>REQUIRED for all unscheduled outpatient visits.</p> <p>Up to three ICD-9-CM codes before 10/01/15 date of service and ICD-10-CM codes after 10/01 may be entered in fields A,B, & C.</p>	C	C
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76	ATTENDING PROVIDER NAME AND IDENTIFIERS NPI/QUALIFIER / OTHER ID	<p>Enter the NPI of the physician who has primary responsibility for the member's medical care or treatment in the upper line, and their name in the lower line, last name first.</p> <p>If the attending physician has another unique ID, enter the appropriate descriptive two-digit qualifier followed by the other ID. Enter the last name and first name of the Attending Physician</p>	R	R
77	OPERATING PHYSICIAN NAME AND IDENTIFIERS NPI/QUALIFIERS NPI/QUALIFIER/ OTHER ID	<p>Enter the NPI of the physician who performed surgery on the member in the upper line; enter the physician's name in the lower line. (NOTE: The last name should be entered first.)</p> <p>If the operating physician has another unique ID, enter the appropriate descriptive two-digit qualifier followed by the other ID. Enter the last name and first name of the Attending Physician. REQUIRED when a surgical procedure code is listed</p>	C	C
78-79	OTHER PROVIDER (INDIVIDUAL) NAME AND IDENTIFIERS NPI/QUALIFIER/ OTHER ID	<p>Enter the NPI of any physician, other than the attending physician, who has responsibility for the member's medical care or treatment in the upper line, and their name in the lower line, last name first.</p> <p>If the other physician has another unique ID, enter the appropriate descriptive two-digit qualifier</p>	C	C
80	REMARKS	Area to capture additional information necessary to adjudicate the claim.	C	C

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*

81CC, A-D	CODE-CODE FIELD	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C
Required fields for the UB-04 Claim Form				

15.1.9.4 Electronic Data Interchange (EDI) for Medical and Hospital Claims

15.1.9.5 Procedures for Electronic Submission

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claims submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- **Reduction of overhead and administrative costs.** EDI eliminates the need for paper claims 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.
- **Faster transaction time for claims submitted electronically.** An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- **Validation of data elements on the claim form.** By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- **Faster claim completion.** Claims that do not need additional investigation are generally processed more quickly. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

15.1.9.6 Requirements for Electronic Claim Filing

The following sections describe the procedures for electronic submission for hospital and medical claims, including descriptions of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

15.1.9.7 Hardware/Software Requirements

Providers may use different products to bill electronically. Providers may submit claims electronically as long as their software has the capability to send EDI claims to Change Healthcare (formerly Emdeon) through direct submission or another clearinghouse/vendor.

Change Healthcare has the capability to accept electronic data from numerous providers in several standardized EDI formats. Change Healthcare forwards the accepted information to carriers in an agreed upon format.

15.1.9.8 Contracting with Change Healthcare and Other Electronic Vendors

Providers without Change Healthcare EDI capabilities who are interested in electronic claims submission may contact the Change Healthcare Sales Department at (866) 817-3813, option 6.

Providers may also choose to contract with another EDI clearinghouse or vendor who already has EDI capabilities.

15.1.9.9 Certification Requirements

After the registration process is completed and providers have received all certification material, providers must:

- Read over the instructions carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact their system vendor and/or Change Healthcare to initiate electronic submissions to Passport. (Be prepared to inform the vendor of Passport's electronic payer identification number 61325.)

15.1.9.10 Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within Section 18 of this Provider Manual. EDI clearinghouses or vendors may require additional data record requirements.

15.1.9.11 Electronic Claim Flow Description

To send claims electronically to Passport, all EDI claims must first be forwarded to Change Healthcare via a direct submission or through another EDI clearinghouse or vendor.

Upon receipt of the transmitted claims, Change Healthcare validates the submitted information against Change Healthcare's proprietary specifications and Passport specific requirements. Claims not meeting the requirements are immediately rejected and returned to the sender via a Change Healthcare error report. The name of this report may vary based on the provider's contract with its intermediate EDI vendor or Change Healthcare.

Change Healthcare forwards accepted claims to Passport and immediately returns an acceptance report to the sender. Passport immediately validates claims for Change Healthcare for provider identification number requirements. Claims not meeting this requirement are rejected and returned to Change Healthcare. Change Healthcare then forwards this rejection notice to the original sender (i.e. its trading partner, EDI vendor or provider.).

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from Change Healthcare or other contracted vendors must be reviewed and validated against transmittal records daily.

Passport also validates claims containing valid provider identification numbers against member eligibility records before being accepted. If a patient cannot be identified as a member of Passport, a denial letter will be forwarded directly to the provider. This letter is sent to the payment address documented in Passport's provider file. Claims passing eligibility requirements are then passed to the claim processing queues. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid member data.

Since Change Healthcare returns acceptance reports directly to the sender, submitted claims not accepted by Change Healthcare are not transmitted to Passport.

If you would like assistance in resolving submission issues reflected on either the Acceptance or

R059 Plan Acceptance (Claim Status) reports, contact the Change Healthcare Helpdesk at (800) 845-6592 or the EDI Technical Support Hotline at (877) 234-4275

15.1.9.12 Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Passport must first pass Change Healthcare proprietary edits and specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at Passport. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service. It is important for each provider to review the rejection notices (the functional acknowledgements to each transaction set) received from Change Healthcare in order to identify and resubmit these claims correctly. Rejected electronic claims may be resubmitted electronically once the error has been corrected.

15.1.9.13 Plan Specific Electronic Edit Requirements

15.1.9.13.1 Exclusions

Certain claims are excluded from electronic billing. At this time, these claims must be submitted on paper.

- Letters of Agreement (LOA) or Single Case Agreements
- DME requiring invoices (invoice must be attached to claim)
- Sterilization claims accompanied by appropriate MAP forms
- Providers contracted with vendors that are not transmitting through Change Healthcare.

Important: Requests for adjustments may be submitted by telephone to the **Provider Claims Service Unit (PCSU)** at (800) 578-0775, option 2 or by mailing to Passport Health Plan P.O. Box 7114 London, KY 40742.

Common Rejections

Invalid Electronic Claims Records – Common Rejections from Change Healthcare
Claim with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT, HCPCS, ICD-9 before 10/01/15 date of service and ICD-10 after 10/01/15, etc.)
Claims without provider numbers
Claims without member numbers

Important: Also, unique cases are not HIPAA Compliant.

Invalid Electronic Claims Records – Common Rejections from Passport (EDI Edits Within the Claims System)
Claim for providers who are not approved for EDI submission including test claim
Claims received with invalid provider numbers

Important: Provider identification number validation is not performed at Change Healthcare. Change Healthcare will reject claims for provider information only if the provider number fields are empty.

15.1.9.13.2 Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you have specific EDI technical questions ...	Contact EDI Technical Support at: (877) 234-4275
If you have general EDI questions or questions on where to enter required data ...	Contact EDI Technical Support at: (877) 234-4275
If you have questions about your claims transmissions or status reports ...	Contact your System Vendor - call the Change Healthcare Corporation Help Desk at: (800) 845-6592 or access Change Healthcare's www.changehealthcare.com .
If you have questions about your claim status (receipt or completion dates) ...	Contact Provider Claims Service Unit at: (800) 578-0775, option 2
If you have questions about claims that are reported on the Remittance Advice ...	Contact Provider Claims Service Unit at: (800) 578-0775, option 2
If you need to know a provider ID number ...	Contact Provider Services at: (800) 578-0775, option 3
If you would like to update provider, payee, UPIN, tax ID number, or payment address information ... For questions about changing or verifying provider Information.	Notify your Provider Relations Specialist in writing at: Passport Health Plan Provider Network Management 5100 Commerce Crossings Drive Louisville, KY 40229 Fax: (502) 585-6060 Telephone: (502) 585-7943

15.1.9.14 Submitting Member Encounters

As a fiscal agent for DMS, Passport is required to submit encounter data to the Commonwealth of Kentucky. Provider assistance is an essential component of this requirement.

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, including Passport.

Data regarding encounters is also used to fulfill the Centers for Medicare & Medicaid Services (CMS) required reporting in support of the Federal funding of State Medicaid plans.

According to Passport policy, providers must report all member encounters by claims submission either electronically or by mail to Passport.

15.2 Provider/Claim Specific Guidelines

15.2.1 Primary Care Practitioner

15.2.1.1 Allergy Serum

Coverage for Allergy Injections/Serum as well as allergy testing is covered for all members. Authorization of allergy testing and treatment is NOT required.

A referral is required from the PCP to the specialist. Services rendered by a non-participating provider require an authorization. Either an allergist or a PCP may bill the service and serum.

PCPs will be paid based on Passport's fee schedule.

15.2.1.2 Immunization Administration

Immunizations are "Direct Access" services. This means members may go anywhere (i.e. their PCP, their local Department of Health, or another PCP) to receive immunizations.

15.2.1.3 Vaccines Codes and Administration Codes

The immunization and vaccines codes must be billed for the payment of the administration of these services. Practitioners will be reimbursed an administration fee for recommended childhood and adolescent immunizations. For Vaccine For Children (VFC), state-supplied vaccines, providers must append the SL modifier to the CPT codes. For non-VFC vaccines, providers will be reimbursed for administration as well as the vaccine serum. The payment for the administration is actually generated on claim lines billed with the immunization and vaccine codes.

15.2.1.4 Family Planning Claims

Family planning claims must be submitted to:

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

All other services (medical) must be billed as normal to Passport. Please note, combined ancillary charges (e.g. supplies, room use, lab/x-ray) do not need to be separated and may be included in the medical claim billed to Passport.

All claims for sterilization procedures must be submitted with the appropriate Sterilization MAP 250 treatment consent form available on the Kentucky DMS web site, <http://www.chfs.ky.gov>.

Termination requests require an authorization and MAP 235 treatment form available on the Kentucky DMS web site, <http://www.chfs.ky.gov>.

Members and providers must complete and comply with all terms and conditions of the DMS consent forms thirty days prior to a procedure being provided. Providers must also ensure that individuals with limited English proficiency and visually impaired and/or hearing-impaired members understand what

they are signing.

15.2.2 EPSDT

Passport provides all preventive health benefits covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for members from birth to age twenty-one (21).

To submit claims for EPSDT services you must:

1. **Continue to bill using the same codes** for comprehensive history and physical exam you use today. These codes must correspond with the member's age.
 - 99381-99385 – New Patient Series
 - 99391-99395 – Established Patient Series
2. **Add an “EP” modifier to the physical exam code** only when all components of the appropriate EPSDT screening interval have been completed and documented in the member's medical record. Do not add the EP modifier to other service being billed (i.e. immunizations). As a reminder, do not bill lab or testing components individually if they were conducted as part of an EPSDT screening interval.
3. **Acknowledge the following health evaluation services have been completed*** by submitting the appropriate CPT Category II codes, according to the member's age, as outlined below. CPT II codes must include a nominal charge (i.e. \$.01 or \$1.00, not blank or zero) in order to adjudicate correctly.

Member Age:	CPT 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

**Please note this requirement does not apply to EPSDT services rendered prior to October 1, 2010.*

For more information about EPSDT, please see section 9 of this Provider Manual.

15.2.3 Specialists

15.2.3.1 Payment Requirements - Office Related (Place of Service 11)

Services performed in a participating provider's office require a valid referral unless the service is noted as an exception to referral requirements in Section 7 of this Provider Manual. Services performed in a non-participating provider's office require an authorization.

15.2.3.2 Range of Dates on CMS-1500

Date ranges for E/M codes are unacceptable. All days must be submitted separately. For example, if the member receives services ranging from 8/1/12 to 8/5/12, and is being billed with 99232 for \$400.00, bill as follows:

Date	Procedure	Quantity	Requested Amount
8/1/12	99232	1	\$80.00
8/2/12	99232	1	\$80.00
8/3/12	99232	1	\$80.00
8/4/12	99232	1	\$80.00
8/5/12	99232	1	\$80.00

15.2.3.3 Surgeries

If a physician bills an evaluation and management service on the same date of service as a surgical procedure, the surgical procedure is payable and the evaluation and management service is not payable. If more than one surgical procedure is performed, multiple procedures reduction logic will apply.

Many surgeries include a global surgery follow-up period (0, 10 or 90 days). All care provided during the global follow-up period in which a surgery occurred is compensated through the surgical payment.

Visits by the same physician on the same day as the minor surgery or endoscopy are included in the payment for the procedure, unless a separately identifiable service with an unrelated diagnosis is also performed. The appropriate modifier should be used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made upon review against Passport's clinical editing criteria.

The global surgical fee includes payment for hospital observation services unless the criteria for the Appropriate CPT modifiers are met.

15.2.3.4 Obstetrical Services

Referrals are not required for any obstetrical services.

Members may self-refer to any Passport contracted obstetrical practitioner to obtain prenatal care and delivery services; therefore, a referral from the primary care provider is not required.

Submitting the ACOG Form assists Passport in accurately determining a member's risk factors. Upon receipt of the completed ACOG or ACOG-like form, Passport will enroll the member in the Mommy Steps Program. All pregnant members identified will receive educational mailings and, when appropriate, be assigned to a care manager. Participation in the Mommy Steps Program is voluntary, and the member has the right to decline any or all parts of the program.

The Mommy Steps Program hours of operation are Monday through Friday, 8:00 a.m. to 6:00 p.m. EST (except for business-approved holidays).

If a member is seen for a prenatal visit and received diagnostic testing in the participating obstetrical practitioner's office during that visit, the practitioner may bill for both the prenatal visit and the diagnostic test.

No referral or authorization is required for OB ultrasounds done at a participating facility.

For a circumcision to be paid, it MUST be billed under the baby's date of birth. If the claim is billed under the mother's birth date, the claim will deny. Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert "Boy" as the baby's first name; include the baby's last name if it is different than the mother's. Verify that the appropriate last name is recorded for the mother and baby.

15.2.3.5 Delivery and Postpartum Care

For billing of multiple deliveries and/or ultrasounds, payment is made when the designated CPT codes are billed. CPT codes for unique, individual services provided must be billed for all perinatal care, i.e. each prenatal visit, delivery code, and postpartum visit must be billed separately.

15.2.4 Departments of Health (DOHs)

Services conducted by participating Departments of Health are payable without authorizations or referrals.

15.2.5 Chiropractors

Chiropractic services are covered for 26 visits in a calendar year regardless of changes in providers or diagnoses. Please see Section 5 for prior authorization requirements.

15.2.6 Home Health

Home health care is encouraged as an alternative to hospitalization (when medically appropriate), and is utilized for the following types of services:

- Skilled nursing
- Private Duty Nursing
- Occupational therapy
- Infusion therapy
- Social workers
- Physical therapy
- Speech therapy
- Home health aides
- MediPlanner

The Utilization Management Department will coordinate medically necessary home care needs with the PCP, hospital, home care departments, and other providers of home care services.

The home health contract is revenue code based. Claims must be billed with valid revenue and HCPC codes.

15.2.6.1 Nurse Supervision

When home health aides are used, registered nurse (RN) supervision is required at least once every two (2) weeks. This supervised visit is not covered by Passport, as it is considered part of the cost for the home health aides.

15.2.6.2 Services and Visits in Nursing Facilities

Ancillary services (other than room and board charges) billed with POS 31 or 32 are payable for both participating and non-participating providers without an authorization or referral (benefits are not payable for facility charges). Members may be seen by any PCP (regardless of whether the PCP is the member's PCP) and the provider will be reimbursed fee for service.

15.2.6.3 Y1 Indicator (Home Health Services Not Covered by Medicare)

Services not covered by Medicare may be submitted to Passport for payment without submitting to Medicare first. Providers must submit these types of claims with a "Y1" indicator in Field 24 of the UB-04 claim form. An EOB is not required if the "Y1" indicator is on the bill. Passport authorization requirements apply for these services.

15.2.7 Hospice

Payment for hospice care is made at one of four predetermined rates for each day that a member is under the care of hospice. The rates paid for any particular day vary depending on the level of care provided to the member. The four levels of care by which each day is classified are described below.

15.2.7.1 Hospice Routine Home Care

Hospice is paid the routine home care rate for each day the member is under the care of the hospice without receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the member is receiving outpatient hospital care for a condition unrelated to the terminal condition.

15.2.7.2 Hospice Continuous Home Care

Hospice is paid the continuous home care rate when continuous home care is provided. The rate is paid only during a period of crisis and only as necessary to maintain the terminally ill member at home. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to 24 hours a day.

Hospice provides a minimum of eight hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous (i.e. four hours could be provided in the morning and another four hours could be provided in the evening).

The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide services may be provided to supplement the nursing care.

15.2.7.3 Hospice Inpatient Respite Care

Hospice is paid at the inpatient respite care rate for each day the member stays in an approved inpatient facility and receives respite care. Payment for respite care may be made for a maximum of five continuous days at a time (including the date of admission but not counting the date of discharge). Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than five days each) is allowable in a single billing period. If the member dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Please see Section 5 for authorization requirements.

15.2.7.4 Hospice General Inpatient Care

Payment at the inpatient rate is made when general inpatient care is provided.

15.2.8 DME

Referrals are never required for Durable Medical Equipment (DME). The DME authorization requirements are based on total billed charges or monthly quantity of items purchased. For a complete list of benefits requiring authorization by quantity, please refer to Section 5 of this Provider Manual.

If the DME item is not mentioned in this Provider Manual, the authorization requirement is determined by cost as outlined below.

- If the provider's billed charges are greater than \$500 for a supply of the same item, **an authorization is required.**

An authorization is required for all nonparticipating providers unless the service is a Medicare covered service and Medicare is primary or the member is in out-of-home placement.

15.2.8.1 DME Rentals

A modifier "RR" should be used for all rented equipment. All mini-nebulizers must be purchased, with the exception of claims involving coordination of benefits. If Passport is secondary to another carrier who has reimbursed the mini-nebulizer as a rental, the benefits are coordinated as a rental.

15.2.8.2 Enteral Therapy

Enteral therapy does not require an authorization unless the billed amount is greater than \$500 for a month's supply. Claims should be submitted with an NDC number to receive payment.

15.2.9 Home Infusion

All home infusion services, including nursing visits, require an authorization. Catheter maintenance charges are always reimbursed based on the authorization.

15.2.9.1 Medically Billed Drugs

All claims, paper and electronic, submitted to Passport with drug codes must include valid National Drug Code (NDC) numbers and NDC units. Please see [NUCC for NDC formatting requirements \(page 45-46\)](#).

15.2.10 Physician Services in Hospital Setting

Physician services should be billed on the CMS-1500 for paper claims or the 837P for electronic claims using appropriate CPT/HCPCS codes, NDC codes and ICD-10 diagnosis codes.

15.2.10.1 Initial Observation Care

All related evaluation and management services provided by the physician on the same day are included in the admission for hospital observation. Only one physician may report initial observation services. Do not use these observation codes for post-recovery in regard to a

procedure considered to be a global surgical service.

If a member who is admitted to an observation status is subsequently admitted to an inpatient status, only the inpatient service will be paid. Providers may not bill initial observation care codes for services provided on the dates they admit patients on an inpatient status.

15.2.10.2 Observation Care Discharge Service

Observation discharge code 99217 is to be used only when discharge from observation status occurs on a date other than the initial date of observation status.

15.2.10.3 Hospital Inpatient Services

The codes for hospital inpatient services report admissions to a hospital setting, follow-up care provided in a hospital setting, observation or inpatient care for the same day admission and discharge, and hospital discharge day management.

The initial hospital care codes should be used by the admitting physician to report the first hospital inpatient encounter. All evaluation and management services provided by the admitting physician in conjunction with the admission, regardless of the site of the encounter, are included in the initial hospital care service. Services provided in the ER, observation room, physician's office, or nursing facility specifically related to the admission cannot be reported separately.

Codes 99238 and 99239 are for hospital discharge day management, but exclude discharge of the member from observation status. When a physician other than the attending physician provides concurrent care on a discharge day, these services must be billed using the subsequent hospital inpatient or outpatient codes.

15.2.10.4 Consultations

Claims for inpatient consultations and subsequent procedures/treatments are covered without regard to the authorization for the inpatient stay. Consulting physicians must bill both the consultation CPT code and the procedure and/or treatment code to be paid for services rendered during the inpatient stay.

15.2.10.5 Critical Care Services

Critical care codes include evaluation and management of the critically ill or injured member, requiring direct delivery of medical care. Note that 99292 is an add-on code and must be used in conjunction with 99291. Critical care of less than 30 minutes should be reported using an appropriate evaluation and management code. Critical care of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes should not be reported.

15.2.10.6 Identifying Newborn Inpatient Services

Services for newborns are processed under the newborn's Passport member ID number. Effective July 1, 2016, Passport will not pay claims for newborns without a Kentucky Medicaid ID. Claims for newborns will be back-dated to DMS eligibility date.

15.2.11 Free-Standing Facilities

Free-standing radiology facilities who bill with a place of service of 11 (office) do not require a

referral for radiology services.

15.2.12 Ambulance Services

Ambulance services and emergent air transportation do not require authorization for payment. Non-emergent air transportation will require an authorization.

Providers must report an origin and destination modifier for each ambulance trip in accordance with guidelines in the HCPCS manual. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of X, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha equals origin; the second position alpha code equals destination.

15.2.13 Facility Billing for Hospital Services

Facility claims for inpatient services should be submitted on the hospital's standard billing form (UB-04). The prior authorization number issued at the time of admission notification should appear on the claim form. Inpatient claims must be submitted after the services were rendered or compensable items were provided within the timeframe indicated in the Passport Hospital Agreement.

Claims for outpatient services should be submitted on the hospital's standard billing form (UB-04). The Passport prior authorization number for services (if necessary) should be included on the claim form.

15.2.14 Subcontractor Services

Please refer to billing instructions in the following Sections:

- Behavioral Health Provider Billing – Section 16.6
- Dental Claims Submission – Section 18.2.2
- Vision Claims Submission Requirements – Section 19.8

15.3 Understanding the Remittance Advice

15.3.1 Electronic Remittance Advice (ERA/835)

Remittance Advices explain the payment of a claim and/or any adjustments made. For each claim, there is a remittance advice (RA) that lists each line item payment, reduction, and/or denial. Payment for multiple claims may be reported on one transmission of the RA.

Standard adjustment reason codes are used on remittance advices. These codes report the reasons for any claim financial adjustments, and may be used at the claim or line level. Multiple reason codes may be listed as appropriate.

Remark codes are used on an RA to further explain an adjustment or relay informational messages. Please see the end of this section for a sample Passport remittance advice.

15.3.1.1 Receiving the Electronic Remittance Advice (ERA/835)

If you are interested in receiving ERA/EFT, please register with InstaMed. Once registered, you will be able to access ERAs through the InstaMed Provider Portal.

For additional information or questions, please contact InstaMed at (866) 945-7990 or by email at connect@instamed.com.

15.3.1.2 Adjustment/Denial Codes

Description	Benefit/Service Rule	Denial Valid	Denial Invalid
Correct NDC required for consideration.	Required for J code Infusion Therapy drugs.	Submit corrected claim.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Invalid/Deleted code, modifier or description.	The claim was either billed without a procedure code or billed with an invalid procedure code. Compare the codes billed on the CMS 1500 to the codes processed on the remittance advice.	Submit corrected claim.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Itemized Bill/Date of Service/Charges/Invoice required.	Usually required for DME misc. codes and Renal Dialysis Claims. We need the itemized bill in order to know how much to reimburse.	Submit copy of the itemized invoice to correspondence.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Received after filing time limit.	The timely filing deadline is 180 days. If COB related, the deadline is 60 days from the notification date on the primary carrier EOB for CMS submissions and 180 days for UB-04 submissions. Verify that all supporting documentation was included in initial claims submission.	Submit proof of timely filing documentation to Passport correspondence.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Diagnosis invalid/missing/deleted. Requires 4th/5th digit.	The claim was either billed without a DX code or billed with an invalid DX code. Verify that a valid diagnosis code is on the claim.	Submit corrected claim.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Not enrolled on date of service.	Verify that you have copy of the Medicaid card for the date of service.	The member will have to follow up with his/her caseworker.	Mail copy of Medicaid card to Passport correspondence
Resubmit with EOB from primary carrier	System indicates the member has other coverage. Verify if EOB was included with initial claim submission.	Submit primary carrier EOB to Passport correspondence.	Resubmit claim with primary carrier information. *
Carrier of Service - Superior Vision		Submit claim to Superior Vision	Superior Vision Claims & Eligibility at (866) 819-4298 from 9 a.m. to 8 p.m.
Assistant Surgeon Payment	This is a processing explanation code, not a denial.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Combined payment - mother & baby.	This code is used only on claims for a newborn if the facility is paid on a per diem. The newborn claim is written off by the provider, and they receive payment for the mother's delivery claim instead.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Duplicate claim previously paid at correct rate.	Passport has previously processed a claim submitted for the same date of service and from the same provider.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
This is a processing explanation code, not a denial.	Used to signify a payment reduction due to multiple surgical or therapy procedures billed on the same date of service.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Over max procedure/benefit limit.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Payment reflects coordination of benefits, if \$0, max liability met.	COB, secondary payment. If Passport payment is \$0, then the primary carrier paid over the Passport allowable amount.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Same procedure paid to a different provider.	Passport has previously paid a claim submitted with the same procedure code for the same date of service to a different provider.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Service not covered.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Services were not provided.	This rejection code is usually used when the provider has called in to request a payment recoupment.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Submit charges to MA fee for service program.	This claim is considered mental health related.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Administrative approval.	This is a processing explanation code, not a denial code. It is usually used when the Medical Review or Appeals department has overturned a previous processing.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

No PCP referral.	No referral on file. Verify if copy of referral was included with initial claim submission.	Submit copy of referral to Passport correspondence.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Pre-cert/Auth not obtained, denied or invalid.	No authorization on file.	Provider may contact the Utilization Management Department at (800) 578-0636 for retro authorization options.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Duplicate of previously submitted EPSDT screening.	This means that a member has already received an EPSDT screening or checkup for the particular interval or timeframe. Verify this member's periodicity schedule with the EPSDT calculator, then review his/her EPSDT screening history.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Provider wasn't the member's PCP.	This member is showing a different PCP for the date of service.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Charges considered included in inpatient admission.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Inappropriate coding for contract agreement.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Carrier of service - MCNA.		Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Carrier of service - AmeriHealth, Inc.		Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Payment included in other billed services.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 3.
EOB/ Attachments were incomplete/ illegible.	This rejection means that there is a complication with the primary carrier EOB.	Review the primary carrier EOB for any inconsistencies.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Need newborn member number.	Resubmit claim with the ID for the newborn.	Resubmit corrected claim.	Contact Provider Claims Service Unit at (800)
Resubmit to primary carrier for appeals process.	Passport can only coordinate secondary payment with a final processing documented on a primary carrier EOB.	Provider must resubmit claim to primary carrier appeals process.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Attending physician ID/name missing/ invalid.	This occurs most frequently when a hospital bills a UB- 04 without an attending physician's name or ID. Review claim to verify if physician name/ID was included with initial submission.	Provider must resubmit corrected claim with physician ID/name.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Missing place of service.	This claim wasn't billed with a place of service.	Provider must resubmit a corrected claim with POS.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Member's age not valid for procedure code.	<p>This denial code could be used for a variety of claim processing scenarios.</p> <p>Review member's age.</p>	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Member's sex not valid for procedure code.	<p>Review the State system to verify the gender loaded for this member.</p>	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Not covered for presumptive eligibility member.	<p>The particular type of service that is being billed is not a service that is covered for a presumptive eligibility member.</p>	Member will have to contact his/her caseworker for options regarding eligibility reinstatement.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Missing charges/units	<p>This procedure code billed does not include units.</p> <p>Review claim form to verify units billed.</p>	Submit corrected claim.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Inappropriate claim form for professional services.	<p>This occurs when an individual practitioner bills his/her professional services on a UB-04.</p> <p>This mistake most commonly occurs with ER professional fees.</p>	Submit a corrected claim on a CMS-1500 to ACS.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Dates and/or services outside auth.	<p>The information approved on the authorization does not match what was billed on the claim.</p>	Provider may contact the Utilization Management Department at (800) 578-0636 for retro authorization options.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Authorization expired.	The date of service billed is outside the last approved date on the authorization.	Provider may contact the Utilization Management Department at (800) 578-0636 for retro authorization options.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Group ID not payable.	Claims are not paid when group only information is billed. You are required to bill both individual (rendering) provider NPI and taxonomy as well as their group (billing) provider NPI and taxonomy in order for your claim to be considered.	Provider must submit a corrected claim with the individual provider information.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Subset/Incidental Procedure disallow.	The rejected procedure code is considered incidental to another paid procedure code.	Final	Fax in medical records to Provider Claims for medical claim review.
Redundant procedure.	This rejection is very similar to the subset reject.	Final	Fax in medical records to Provider Claims for medical claim review.
Manual Denial.	This is a generic denial code used by adjusters to manually deny a claim. There should be additional denial code information listed explaining the manual denial.	Follow the applicable denial response guideline located on this grid.	Follow the applicable denial response guideline located on this grid.
MAID Missing or Invalid.	Passport does not have the billing provider's Kentucky Medicaid ID (MAID) or the MAID is expired.	Contact your Provider Relations Specialist or Provider Services at (800) 578-0775	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

0000189/



Passport Health Plan
5100 Commerce Crossings Drive
Louisville KY 40229

EXPLANATION OF PAYMENT

Payment Date:

Payee ID:

Tax ID:

Check Number:

Claim Count:

Total Charges:

Total Payment:

Total Provider Adj:

Payment Amount:

0000189 01 SP 0.460 **SNGLP T1 0 1602 40475-795205-C02-P00000-I 234



John Smith, MD
123 Main Street
Anywhere, KY 40229

For further inquiries on this remittance advice contact, please call 1
(800) 578-0775.

Get Paid Faster! Register for ERA/EFT at <https://register.instamed.com/eraeft> and enter Registration Code.

PROVIDER CLAIM SUMMARY

Dates of Service From To	Procedure	No. of Units	Amount Billed	Allowed	Paid	Patient Responsibility	COB	Not Covered	Adjustment Reason	Remarks
Patient:										
Interest: \$0.00										
Total for Claim										

PROVIDER ADJUSTMENTS

Adjustment Reason	Amount
Interest Owed	
Total Adjustments	

Adjustment Reason Codes

Remarks Codes

Code	Description	Code	Description
CO-45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		Consult our contractual agreement for restrictions/billing/payment information related to these charges.

Get Paid Faster! Register for ERA/EFT at <https://register.instamed.com/eraeft> and enter Registration Code: Q2MTKN



Passport Health Plan
5100 Commerce Crossings Drive
Louisville KY 40229

REPUBLIC BANK & TRUST COMPANY
San 601 W Market St
Louisville, KY 40202

VOID VOID VOID

PAY
TO THE
ORDER
OF

15.4 Denial Reasons and Prevention Practices

15.4.1 Billed Charges Missing or Incomplete

A billed charge amount must be included for each service/procedure/supply on the claim form.

15.4.2 Diagnosis Code Missing Digits

Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM manual for addition characters.

15.4.3 Diagnosis, Procedure or Modifier Codes Invalid or Missing

Coding from the most current coding manuals (ICD-9-CM before 10/01/15 date of service and ICD-10-CM on or after 10/01/15, CPT or HCPCS) is required to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.

15.4.4 EPSDT Information Missing or Incomplete

All tests and services listed on the Passport EPSDT Program Periodicity and Screening Schedule must be performed within the indicated time periods.

15.4.5 Illegible Claim Information

Information on the claim form must be legible to avoid delays or inaccuracies in processing. Review billing processes to ensure forms are typed or printed in black ink, no fields are highlighted (this causes information to darken when scanned or filmed), no use of white out and spacing and alignment are appropriate. Handwritten information often causes delays or inaccuracies due to reduced clarity.

15.4.6 Incomplete Forms

All required information must be included on the claim form to ensure prompt and accurate processing.

15.4.7 Newborn Claim Information Missing or Invalid

Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert “Girl” or “Boy” as the baby’s first name; include the baby’s last name if it is different than the mother’s. Verify the appropriate last name is recorded for the mother and baby. Please include the baby’s date of birth.

15.4.8 Payer or Other Insurer Information Missing or Incomplete

Include the name, address and policy number for all insurers covering the Passport member.

15.4.9 Place of Service Code Missing or Invalid

A valid and appropriate two-digit numeric code must be included on the claim form.

15.4.10 Provider Name Missing

The name of the provider of service must be present on the claim form and must match the service provider name and Tax Identification Number (TIN) on file with Passport.

15.4.12 Revenue Codes Missing or Invalid

Facility claims must include a valid revenue code. Refer to UB-04 reference material for a complete list of revenue codes.

15.4.13 Signature Missing

The signature of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Passport. See Section 18.1.12.2 CMS-1500 Claim Form and Required Fields for additional information on acceptable signature formats.

15.4.14 Spanning Dates of Service Do Not Match the Listed Days/Units

Span dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days/unit field.

15.4.15 Tax Identification Number (TIN) Missing or Invalid

The Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with the Passport.

15.4.16 Third Party Liability (TPL) Information Missing or Incomplete

Any information indicating a work related illness/injury, no fault, or other liability condition must be included on the claim form. Additionally, if billing via paper, a copy of the primary insurer's explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

15.4.17 Type of Service Code Missing or Invalid

A valid alpha or numeric code must be included on the claim form.

15.4.18 Billing Bilateral Procedures

Modifier '50' is used to report bilateral procedures performed in the same session. The use of modifier '50' is applicable only to services and/or procedures performed on identical anatomical sites, aspects, or organs. The intent of this modifier is to be appended to the appropriate unilateral code as a one-line entry on the claim form indicating that the procedure was performed bilaterally.

When a procedure code is appended with modifier '50', the units box on the claim form should indicate that "1" unit of service was provided, since one procedure was performed bilaterally.

Placing the procedure on two lines will bill for two charges, and will result in a denial for one of the billed lines. When a procedure code is billed with a '50' modifier and a '1' in the unit field, the code will reimburse at 150% of the allowable amount.

Some CPT codes were developed for unilateral and bilateral procedures, so it may not always be appropriate to append modifier '50' if there is a CPT code to report the bilateral procedure.

15.4.19 Billing with Modifiers '25' and '59'

Use modifier '25' when the E/M service is separate from that required for the procedure and a clearly documented, distinct and significantly identifiable service was rendered, or the procedure performed was above and beyond the usual preoperative and postoperative care. The modifier '25' must be placed on the E/M code to assure appropriate review of your claim.

Modifier '59' is used to indicate a procedure or service was distinct or independent from other services

performed on the same day. When another already established modifier is appropriate it should be used rather than modifier '59'. Only if a more descriptive modifier is not available, and the use of modifier '59' best explains the circumstances, should modifier '59' be used.

15.5 Timely Filing Requirements

Original invoices must be submitted to Passport within 180 calendar days from the date services were rendered or compensable items were provided.

Resubmission of previously processed claims with corrections and/or requests for adjustments must be submitted within two years of the last process date.

Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 180 calendar days from the date of service. Rejected claims are not registered as received in the claims processing system.

15.5.1 Timely Filing Exceptions

- Submission of claims for members retroactively enrolled in Passport by DMS must be submitted within 180 days from the date of notification to Passport of enrollment by DMS.
- Claims with Explanation of Benefits (EOBs) from Medicare Part A must be submitted within 180 days of the date of the Medicare EOB.
- Claims with Explanation of Benefits (EOBs) from primary insurers other than Medicare Part A must be submitted within 60 days of the date of the primary insurer's EOB.
- Out of home placement services are exempt from timely filing guidelines.
- Mommy Steps services are exempt from timely filing guidelines.
- Medicare crossover claims are exempt from timely filing guidelines.

15.6 Reimbursement Issues and/or Refunds and Corrected Claims

If you would like to discuss claims payments, you may call the Provider Claims Services Unit (PCSU) at (800) 578-0775, option 2.

Providers have the right to dispute the reimbursement of a claim. The payment issue must be received within two (2) years of the last process date and include supporting documentation. Passport will respond to the payment issue within thirty (30) days from the receipt date with a determination or status of the review.

The provider will receive written notification of the outcome of the payment issue whether it is upheld or overturned. All upheld determinations will be sent to the provider in a letter with the reason the plan upheld the appeal. Any payment issue overturned by Passport will be reprocessed and the provider will receive an explanation of benefits (EOB) as notification.

Resubmitted claims should be resubmitted on paper when additional documents are needed to reprocess the claim which cannot be submitted electronically (example: invoice, EOB). Corrected claims can be sent electronically. All corrected claims should have the corrected claim indicator (a 7) on the claim and the original claim number that you are correcting:

- Coorrected claims must be submitted within two (2) years of the last process date (Payment Date on remittance advice).
- Claims originally denied for missing/invalid information for inappropriate coding should be submitted as corrected claims. In addition to writing "corrected" on the claim, the corrected information should be circled so that it can be identified.
- Claims originally denied for additional information should be sent as a resubmitted claim. In addition to writing "resubmitted" on the claim, the additional/new information should be attached.
- Corrected and resubmitted paper claims are scanned during reprocessing. Please remember to use blue or black ink only and refrain from using red ink, white out and/or highlighting that could affect the legibility of the scanned claim.

Corrected/Resubmitted paper claims should be sent to:

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

Following these instructions will reduce the probability of erroneous or duplicate claims and timely filing denials on second submissions.

When the need for a refund is identified, the provider should call the PCSU at (800) 578-0775, option 2, to report the over-payment. Claim details will need to be provided such as reason for refund, claim number, member number, dates of service, etc. The claim will be adjusted, the money will be recovered and the transaction will be reported on the Remittance Advice. **There is no need to submit a refund check.**

If Passport recognizes the need for a refund, a letter outlining details will be sent 30 days prior to the recovery occurring. These adjustments will also be reported on the Remittance Advice.

Provider Manual

Section 16.0

Behavioral Health

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- 16.2 Access to Care**
- 16.3 Behavioral Health Benefits**
- 16.4 Authorization Procedures and Requirements**
- 16.5 Quality Improvement**
- 16.6 Behavioral Health Provider Billing Manual**



16.0 Behavioral Health

Passport's behavioral health program provides members with access to a full continuum of recovery and resiliency-focused behavioral health and substance use disorders 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 and substance use disorder services, Passport believes that quality clinical services can help lead to improved health outcomes for our members.

16.1 Administrative Procedures

Passport has partnered with Beacon Health Options, LLC to assist in the coordination of the behavioral health and substance use disorder benefit for our members.

eServices, is a secure web portal, that supports all provider transactions, such as verifying member's eligibility, claims status, and authorization submission and inquiry while saving providers' time, postage expense, billing fees, and reducing paper waste. **eServices** provides important Provider communications and is completely free to Passport contracted providers. Providers may register and access these services through www.beaconhealthoptions.com twenty four hours a day, seven days a week.

Interactive voice recognition (IVR) is available to providers as an alternative to **eServices**. It provides accurate, up-to-date information by telephone, and is available for selected transactions at (888) 210-2018. In order to maintain compliance with HIPAA and all other federal and state confidentiality/privacy requirements, providers must have their practice or organizational tax identification number (TIN), national provider identifier (NPI), as well as the member's full name, Plan ID and date of birth when verifying eligibility.

Electronic data interchange (EDI) is available for claim submission and eligibility verification directly by the provider to Passport or via an intermediary. For information about testing and setup for EDI, download the 837 & 835 companion guides by logging into provider forms and resources at <https://www.beaconhealthoptions.com/providers/login/>.

For technical and business related questions, email options edi.operations@beaconhealthoptions.com. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Change Healthcare, use Change Healthcare Payer ID (43324) and the Passport ID (028).

Electronic Transactions Availability:

Transaction / Capability	Available 24/7 On		
	eServices at www.beaconhealthoptions.com	IVR 888.210.2018	EDI at www.beaconhealthoptions.com
• Verify member eligibility, benefits and copayment	Yes	Yes	Yes (HIPAA 270/271)
• Check number of visits available	Yes	Yes	Yes (HIPAA 270/271)
• Submit authorization requests	Yes		
• View authorization status	Yes	Yes	
• Update practice information	Yes		
• Submit claims	Yes		Yes (HIPAA 837)
• Upload EDI claims for Passport members and view	Yes		Yes (HIPAA 837)
• View claims status and print EOBs	Yes	Yes	Yes (HIPAA 835)
• Print claims reports and graphs	Yes		
• Download electronic remittance advice	Yes		Yes (HIPAA 835)
• EDI acknowledgment & submission reports	Yes		Yes (HIPAA 835)
• Pend authorization requests for internal approval	Yes		
• Access the level-of-care criteria	Yes		

Old Address	Naming Convention	Function	New PO Boxes
500 Unicorn Park Woburn, MA	Woburn Appeals, Grievances & PAT Charts	All Plan Appeals, Grievances & PAT Charts	PO Box 1856 Hicksville, NY 11802
	Woburn Appeals, Grievances & PAT Charts		
	Woburn Claims	Claims, COB Claims EAP	PO Box 1857 Hicksville, NY 11802
	Woburn Member Reimbursement	Member Reimbursement (GIC, NHP & Fallon)	PO Box 1858 Hicksville, NY 11802
	Woburn GIC Appeals	GIC Appeals	PO Box 1859 Hicksville, NY 11802
	Woburn PDIP	PDIP	PO Box 1860 Hicksville, NY 11802
	Woburn Chart Audits	Chart Audits	PO Box 1861 Hicksville, NY 11802
	Woburn General	Correspondence, COB, Questionnaires	PO Box 1866 Hicksville, NY 11802
	Woburn Reconsiderations	Reconsiderations	PO Box 1867 Hicksville, NY 11802

	Woburn Waivers	Waivers	PO Box 1868 Hicksville, NY 11802
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16.2 Access to Care

Passport members may access behavioral health services 24 hours a day, seven days a week by contacting Passport's Behavioral HealthAccess Line, at (855) 834-5651. A behavioral health hotline is also available for members actively in crisis at (844) 231-7496. Members do not need a referral to access behavioral health services and authorization is never required for emergency services.

Emergency Behavioral Health Services or Care means an emergent situation in which the member is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition rendering the member unmanageable and unable to cooperate in treatment.

Passport adheres to State and National Committee for Quality Assurance (NCQA) guidelines for access standards for member appointments. Contracted providers may only provide such behavioral health and physical health services within the scope of their license and must adhere to the following:

Appointment Standards and After Hours Accessibility:

Type of Care	Appointment Availability
Emergency Care with Crisis Stabilization	Within twenty four (24) hours
Urgent Care	Within forty eight (48) hours
Post Discharge from Acute Hospitalization	Within 7 days of discharge
Other routine referrals/appointments	Within ten (10) days

In addition, Passport providers must adhere to the following guidelines to ensure members have adequate access to services:

Service Availability	Hours of Operation:
On-Call	<ul style="list-style-type: none"> 24-hour on-call services for all members in treatment; and, Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations.
Crisis Intervention	<ul style="list-style-type: none"> Services must be available 24 hours per day, 7 days per week; Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours; and After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	<ul style="list-style-type: none"> Outpatient providers should have services available Monday through Friday from 9:00 a.m. to 5:00 p.m. EST at a minimum; and, Evening and/or weekend hours should also be available at least two (2) days per week.

All members receiving inpatient psychiatric services should be scheduled for outpatient follow-up

and/or continuing treatment prior to discharge. Outpatient treatment must occur within seven (7) days from the date of discharge (note: subject to latest statewide changes). Providers are required to contact members who have missed appointments within twenty-four (24) hours to reschedule appointments.

16.2.1 Out of Network Providers

Out of network behavioral health benefits are limited to those services that are not available in the existing Passport network, emergency services and transition services for members who are currently in treatment with an out of network provider who is either not a part of the network or who is in the process of joining the network.

Out of network providers must have an active Kentucky Medicaid ID number and complete a Behavioral Health single case agreement with Passport. Out of network providers may provide one evaluation visit for Passport members without an authorization upon completion and return of the signed single case agreement. After the first visit, services provided must be authorized.

Authorization requests for outpatient services can be obtained through the electronic outpatient request form (eORF) which can be requested by calling (855)834-5651 or on the website www.beaconhealthoptions.com. If this process is not followed, Passport may administratively deny the services and the out of network provider must hold the member harmless.

Notifications of authorization will be provided within seven (7) days of the request. The member must be eligible at the time of authorization. However, the member's eligibility is subject to change. Out of network providers are encouraged to verify eligibility.

16.3 Behavioral Health Benefits

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

- Inpatient mental health
 - Inpatient Mental Health Services for Adults at Free-Standing Psychiatric Facilities are now included for up to 15 days in a calendar month
- Crisis stabilization – adult and child
- Emergency room visits (Reimbursed through Passport Medical claims billing ONLY)
- Medical detoxification
- Psychiatric Residential Treatment Facilities (PRTF)
- Extended Care Units (ECU)
- Residential substance use disorder rehabilitation
- Outpatient services, such as individual, group, and family therapy, groups, peer support, therapeutic rehabilitation, and targeted case management services, etc.
- Electroconvulsive Therapy (ECT)

- Psychological testing
- Services rendered by Behavioral Health Services Organizations (BHSO)
- Mobile Crisis
- Substance Use Disorder Inpatient (detox, residential) and Outpatient (individual/group/family, intensive outpatient) services
- Partial Hospitalization (BH and SUD)
- IOP (BH and SA)
- Assertive Community Outreach Team (ACT)

Access to behavioral health and substance use disorder treatment is an essential component of a comprehensive health care delivery system. Plan members may access behavioral health and substance use disorder services by self-referring to a network provider, by calling the behavioral health access line, or by referral through acute or emergency room encounters. Members may also access behavioral health and substance use disorder services by referral from their primary care provider (PCP); however, a PCP referral is not required for behavioral health or substance use disorder services. Network providers are expected to coordinate care with a member's primary care and other treating providers whenever possible.

16.4 Authorization Procedures and Requirements

Authorization Procedures and Requirements

This section describes the processes for obtaining authorization for inpatient, diversionary and outpatient levels of care, and for Passport's medical necessity determinations and notifications. In all cases, the treating provider, whether admitting facility or outpatient practitioner, is responsible for following the procedures and requirements presented in order to ensure payment for properly submitted claims.

Administrative denials may be rendered when applicable authorization procedures, including timeframes, are not followed. Members cannot be billed for services that are administratively denied due to a provider not following the requirements listed in this manual.

16.4.1 Member Eligibility Verification

The first step in seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a plan member's eligibility upon admission to, or initiation of treatment, as well as on each subsequent day or date of service to facilitate reimbursement for services.

Member eligibility can change and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check eServices, or by calling their IVR line at (888) 210-2018.

16.4.2 Emergency Services

Definition

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency is listed in your Behavioral Health Services agreement with Passport.

Emergency care will not be denied, however subsequent days do require pre-service authorization. The facility must notify the Behavioral Health Access Line as soon as possible and no later than 24 hours after an emergency admission and/or learning that the member is covered by the health plan. If a provider fails to notify the Behavioral Health Access Line of an admission, any days that are not prior-authorized may be administratively denied.

16.4.2.1 Passport Health Plan Behavioral Health Crisis Line

Our toll-free access line, (855) 834-5651, is available to members and providers and is staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. In the event of a behavioral health emergency, behavioral health professionals are available to assess and triage through the crisis hotline, (844) 231-7496. 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.

16.4.2.2 Emergency Screening and Evaluation

Passport members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, mobile crisis team, or by an emergency service program (ESP). This process allows members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

After the evaluation is completed, the facility or program clinician should call the Behavioral Health Access Line to complete a clinical review, if admission to a level-of-care that requires pre-certification is needed. The facility/program clinician is responsible for locating a bed, but may request assistance. Passport may contact an out-of-network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, Passport will authorize boarding the member on a medical unit until an appropriate placement becomes available.

Disagreement between Behavioral Health Physicians and Attending Physician

For acute services, in the event that the Behavioral Health physician advisor (PA) and the emergency service physician do not agree on the service that the member requires, the emergency service physician's judgment shall prevail and treatment shall be considered appropriate for an emergency medical condition, if such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the member's program of medical assistance or medical benefits. All clinicians are experienced, licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures.

16.4.2.3 Behavioral Health Clinician Availability

All behavioral health clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Clinicians are available 24 hours a day, 7 days a week, to take emergency calls from members, their guardians, and providers.

16.4.2.4 Authorization Requirements

16.4.2.4.1 Outpatient Treatment:

The following table outlines the authorization requirements for each service. Services that indicate “eRegister” will be authorized via the eServices portal. Providers will be asked a series of clinical questions to support medical necessity for the service requested. If sufficient information is provided to support the request, the service will be authorized. If additional information is needed, the provider will be prompted to contact UM staff via phone to continue the request for authorization. While it is preferred that providers make requests via eServices, Health staff will work with providers who do have technical or staffing barriers to requesting authorizations in this way.

Outpatient Services:

Benefit/Service	Authorization Requirements
Psychological Testing	Faxed Prior Authorization Required to (781) 994-7633 if greater than 8 hours will be needed. The first eight (8) hours do not require authorization.
ECT	Telephonic Prior Authorization

Community Based Services:

Benefit/Service	Notification Requirement	Initial Authorization Parameters (All determinations based
Therapeutic Rehabilitation Services (Adult and Child)	eRegister within 2 weeks of initial date of service	Authorization as requested, up to 6 hours daily for initial 30 days. Submit eServices request prior to 30 th day for continued stay review.
Intensive Outpatient	Telephonic Prior Authorization	No authorization required.
Partial Hospitalization	Telephonic Prior Authorization	Initial authorization up to 5 days/per week; routine telephonic continued stay review

Assertive Community Treatment (ACT)	Telephonic Prior Authorization	Initial authorization up to max monthly; routine telephonic continued stay review
Day Treatment	Telephonic Prior Authorization	Initial authorization up to max weekly; routine telephonic continued stay review
Targeted Case Management-Adult with SMI; Children with SED; Targeted Case Management for individuals with Substance Use Disorder and for individuals with co-occurring mental health disorders for chronic or complex physical health conditions	eServices within 2 weeks of initial date of service	Initial authorization for 3 months; submit continued stay request through eServices prior to 90 th day of service.
Emergency Services/Mobile Crisis	No authorization Required	No authorization required
Methadone Medication Assisted Treatment Bundle	Faxed prior authorization or eServices request - Initial Authorization Parameters (all determinations based on medical necessity criteria)	Authorization as requested, up to 8 weeks.
Methodone Induction	Faxed prior authorization or eServices request - Initial Authorization Parameters (all determinations based on medical necessity criteria)	Authorization as requested, up to calendar year max per member.

Authorization decisions are posted on eServices within the decision timeframes outlined below. Providers receive an email message alerting them that a determination has been made. Providers can opt out of receiving paper notices on the eServices portal. All notices clearly specify the number of units (sessions) approved, the timeframe within which the authorization can be used, and explanations of any modifications or denials. All denials can be appealed according to the policies outlined in this Manual.

All forms can be found on this web site under Provider Tools -
<https://www.beaconhealthoptions.com/providers/beacon/forms/>

16.4.2.4.2 Inpatient Services

All inpatient services (including inpatient ECT and inpatient EPSDT special services such as substance use disorder, trauma program and sexually acting out and extended care units) require telephonic prior authorization within one (1) business day of admission. Providers should call the Behavioral Health Access Line at (855) 834-5651 for all inpatient admissions, including detoxification that is provided on a psychiatric floor or in freestanding psychiatric facilities.

Behavioral Health typically authorizes inpatient stays in 2-3 day increments, depending on medical necessity. Continued stay reviews require updated clinical information that demonstrates active treatment. This allows our team to aid in supporting discharge planning and after-care placements/transitions as well. Additional information about what is required during pre-service and concurrent stay reviews is listed below.

UM Review Requirements – Inpatient and Diversionary

Pre-Service Review	Continued Stay (Concurrent) Review	Post-Service Review
<p>The facility clinician making the request needs the following information for a pre-service review:</p> <ul style="list-style-type: none"> • Member's health plan identification number; • Member's name, gender, date of birth, and city or town of residence; Admitting facility name and date of admission; • DSM-5 diagnosis: (A provisional diagnosis is acceptable); • Description of precipitating event and current symptoms requiring inpatient psychiatric care; • Medication history; • Substance use history; • Prior hospitalizations and psychiatric treatment; • Member's and family's general medical and social history; and, • Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment. 	<p>To conduct a continued stay review, call a Utilization Review clinician with the following required information:</p> <ul style="list-style-type: none"> • Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications; • Description of the member's response to treatment since the last concurrent review; • Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan; • Report of any medical care beyond routine is required for coordination of benefits with health plan (Routine medical care is included in the per diem rate). 	<p>Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, contact the Behavioral Health Access Line. If the treatment rendered meets criteria for a post-service review, the Utilization Review clinician will request clinical information from the provider including documentation of presenting symptoms and treatment plan via the member's medical record. The review requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Behavioral Health clinician completes a clinical review of all available information, in order to render a decision.</p>

Authorization determinations are based on the clinical information available at the time the care was provided to the member.

Notice of inpatient authorization is mailed to the admitting facility. Members must be notified of all pre-service and concurrent denial decisions. Members are notified by mail of all acute pre-service and concurrent denial decisions. For members in inpatient settings, the denial letter is mailed to the member and verbal notification is issued to the provider on the day the adverse determination is made. The service is continued without liability to the member until the member has been notified of the adverse determination. The denial notification letter sent to the member or member's guardian, practitioner, and/or provider includes the specific reason for the denial decision, the member's presenting condition, diagnosis and treatment interventions, the reason(s)

why such information does not meet the medical necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by Passport, if any. Based on state and/or federal statutes, an explanation of the member's appeal rights and the appeals process is enclosed with all denial letters. Providers can request additional copies of adverse determination letters by contacting the Behavioral Health Access Line.

16.4.2.4.3 Return of Inadequate or Incomplete Treatment Requests

All requests for authorization must be original and specific to the dates of service requested and tailored to the member's individual needs. Passport reserves the right to reject or return authorization requests that are incomplete, lacking in specificity, or incorrectly filled out. Passport will provide an explanation of action(s) which must be taken by the provider to resubmit the request.

16.4.2.4.4 Notice of Inpatient/Diversionary Approval or Denial

Verbal notification of approval is provided at the time of pre-service or continuing stay review. Notice of admission or continued stay approval is mailed to the member or member's guardian and the requesting facility within the timeframes specified later in this chapter.

If the clinical information available does not support the requested level-of-care, the Utilization Review clinician discusses alternative levels of care that match the member's presenting clinical symptomatology with the requestor. If an alternative setting is agreed to by the requestor, the revised request is approved. If agreement cannot be reached between the behavioral health Utilization Review clinician and the requestor, the Utilization Review clinician consults with a physician advisor. All denial decisions are made by a physician advisor. Utilization Review clinician and/or physician advisor notifies the treating provider of their appeal rights if the request for authorization is denied.

All member notifications include instructions on how to access interpreter services, how to proceed if the notice requires translation or a copy in an alternate format, and toll-free telephone numbers for TDD/TTY capability in established prevalent languages, (Babel Card).

16.4.2.4.5 Termination of Outpatient Care

Passport requires that all outpatient providers set specific termination goals and discharge criteria for members. Providers are encouraged to use the Level Of Care Criteria (accessible through eServices) to determine if the service meets medical necessity for continuing outpatient care.

16.4.2.4.6 Decision and Notification Timeframes

Passport is required by the state, federal government, NCQA and the Utilization Review Accreditation Commission (URAC) to render utilization review decisions in a timely manner to

accommodate the clinical urgency of a situation. Passport has adopted the strictest time frame for all UM decisions in order to comply with the various requirements.

The timeframes below present Passport's internal timeframes for rendering a UM determination, and notifying members of such determination. All timeframes begin at the time of Passport's receipt of the request. Please note, the maximum timeframes may vary from those on the table below on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements that have been established for each line of business.

Decision and Notification Timeframes:

	Type of Decision	Decision Timeframe	Verbal Notification	Written Notification
Pre-Service Review				
Initial Auth for Inpatient Behavioral Health	Urgent	Within One (1) Business Day	Within 24 hours	Within 24 hours
Initial Auth for Other Urgent Behavioral Health Services	Urgent	Within One (1) Business Day	Within 24 hours	Within 24 hours
Initial Auth for Non-Urgent Behavioral Health Services	Standard	Within Two (2) Business Days	Within Two (2) Business Days	Within Two (2) Business Days
Concurrent Review				
Continued Auth for Inpatient and Other Urgent Behavioral Health Services	Urgent/ Expedited	Within 24 hours	Within 24 hours	Within 24 hours
Continued Auth for Non-Urgent Behavioral Health Services	Non-Urgent/ Standard	Within Two (2) Business Days	Within Two (2) Business Days	Within Two (2) Business Days
Post Service				
Authorization for Behavioral Health Services Already Rendered	Non-Urgent/ Standard	Within 30 Business Days	Within 30 Business Days	Within 30 Business Days

When the specified timeframes for standard and expedited prior authorization requests expire before Passport has received any requested information from providers, an adverse **benefit determination**. notice will go out to the member on the date the timeframe expires.

16.5 Quality Improvement

Passport strongly encourages and supports providers in the use of outcome measurement tools for all

members. Outcome data is used to identify potentially high-risk members who may need intensive behavioral health, medical, and/or social care management interventions.

Providers are also required to communicate (with member consent) with Primary Care Providers (PCPs) on a regular basis. Providers are required to send initial and quarterly (or more frequently if clinically indicated) summary reports of a members' behavioral health status to the PCP (with the member's or the member's legal guardian's consent). The purpose of this reporting is to ensure coordination between the PCP and behavioral health provider and improve the quality of member care.

Communication between Behavioral Health Providers and Other Service Providers:

Communication between Outpatient Behavioral Health Providers and PCPs, Other Service Providers	Communication between Inpatient/ Diversionary Providers and PCPs, Other Outpatient Service Providers
<p>Outpatient behavioral health providers are expected to communicate with the member's PCP and other OP behavioral health providers if applicable, as follows:</p> <ul style="list-style-type: none"> • Notice of commencement of outpatient treatment within 4 visits or 2 weeks, whichever occurs first; • Updates at least quarterly during the course of treatment; • Notice of initiation and any subsequent modification of psychotropic medications; and, • Notice of treatment termination within 2 weeks. • Refer for known or suspected and untreated physical health problems or disorders for examination and treatment. Behavioral health providers may use the 	<p>With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within 3 days post-discharge:</p> <ul style="list-style-type: none"> • Date of Discharge; • Diagnosis; • Medications; • Discharge plan; and • Aftercare services for each type, including: <ul style="list-style-type: none"> - Name of provider; - Date of first appointment; - Recommended frequency of appointments; - Treatment plan.

<p>Authorization for Behavioral Health Provider and PCP to Share Information and the Behavioral Health-PCP Communication Form available for initial communication and subsequent updates, in Appendix B, or their own form that includes the following information:</p> <ul style="list-style-type: none"> • Presenting problem/reason for admission; • Date of admission; • Admitting diagnosis; • Preliminary treatment plan; • Currently prescribed medications; • Proposed discharge plan; and • Behavioral health provider contact name and telephone number. <p>Request for PCP response by fax or mail within 3 business days of the request to include the following health information:</p> <ul style="list-style-type: none"> • Status of immunizations; • Date of last visit; • Dates and reasons for any and all hospitalizations; • Ongoing medical illness; • Current medications; • Adverse medication reactions, including sensitivity and allergies; • History of psychopharmacological trials; and, • Any other medically relevant information <p>Outpatient providers' compliance with communication standards is monitored</p>	<p>Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one.</p> <p>Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Passport's member record.</p>
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through requests for authorization submitted by the provider, and through chart reviews.	
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16.5.1 Transitioning Members from one Behavioral Health Provider to Another

If a member transfers from one behavioral health provider to another, the transferring provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health provider to PCP), to the receiving provider.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Passport. Members may be eligible for transitional care within 30 days after joining the health plan, or to ensure that services are culturally and linguistically sensitive, individualized to meet the specific needs of the member, and/or geographically accessible.

16.5.2 Follow Up After Mental Health Hospitalization

Members discharged from inpatient levels of care are assigned an aftercare coordinator/case manager by Passport prior to or on the date of discharge. The Behavioral Health case managers and other behavioral health service providers participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Members being discharged from inpatient levels of care are scheduled for follow up appointments within 7 days of discharge from an acute care setting. Providers are responsible for seeing members within that timeframe and for outreaching members who miss their appointments to reschedule. Behavioral Health case managers and aftercare coordinators work with providers to assist in this process by sending reminders to members; working to remove barriers that may prevent a member from keeping his or her discharge appointment and coordinating with treating providers. Network providers are expected to aid in this process as much as possible to ensure that members have the supports they need to maintain placement in the community and to prevent unnecessary readmissions.

16.5.3 Accessing Medications

Behavioral health service providers will assist member in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

16.6 Behavioral Health Provider Billing Manual

16.6.1 Billing Transactions

This chapter presents all information needed to submit behavioral health claims. Passport strongly encourages providers to rely on electronic submission, either through EDI or **eServices** in order to

achieve the highest success rate of first-submission claims payment.

16.6.2 General Claim Policies

Claims that are for services with a behavioral health primary diagnosis including substance use disorder diagnoses need to be submitted through our behavioral health claims process at Beacon. Please ensure that you have informed your Passport provider representative in advance that you plan to treat members with a behavioral health primary diagnosis so that the proper provider agreement is in place and the provider will be accurately loaded in the Beacon system for claims payment. Likewise, any behavioral health providers that plan to deliver services with a medical primary diagnosis need to inform their provider representative so they are aware that the provider will be delivering these services. Again, the representative will ensure that the proper provider agreement for these services is in place and so the provider will be accurately loaded in the Passport system for claims payment.

Passport requires that providers adhere to the following policies with regard to claims:

16.6.3 Definition of “Clean Claim”

A clean claim, as discussed in this Provider Manual, the provider services agreement, and in other Passport informational materials, is defined as one that has no defect and is complete including required, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

16.6.4 Electronic Billing Requirements

The required edits, minimum submission standards, signature certification form, authorizing agreement and certification form, and data specifications as outlined in this manual must be fulfilled and maintained by all providers and billing agencies submitting electronic medical claims for behavioral health services.

16.6.5 Provider Responsibility

The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to Passport upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies.

16.6.6 Limited Use of Information

All information supplied by Passport or collected internally within the computing and accounting systems of a provider or billing agency (e.g., member files or statistical data) can be used only by the provider in the accurate accounting of claims containing or referencing that information. Any redistributed or dissemination of that information by the provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.

16.6.7 Prohibition of Billing Members

Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding co-payments when appropriate.

16.6.8 Passport's Right to Reject Claims

At any time, Passport can return, reject or disallow any claim, group of claims, or submission received pending correction or explanation.

16.6.9 Recoupments and Adjustments

Passport reserves the right to recoup money from providers due to errors in billing and/or payment, in accordance with Kentucky law and regulations. In that event, Passport applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB with the record identification number (REC.ID) and the provider's patient account number.

16.6.10 Claim Turnaround Time

All clean claims will be adjudicated within thirty (30) days from the date that the claim is received.

16.6.11 Claims for Inpatient Services

- The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date. Refer to authorization notification for correct date ranges.
- Passport accepts claims for interim billing that include the last day to be paid as well as the correct bill type and discharge status code. On bill type X13, where X represents the "type of facility" variable, the last date of service included on the claim will be paid and is not considered the discharge day.
- Providers must obtain authorization from Passport for all ancillary medical services provided while a plan member is hospitalized for a behavioral health condition. Such authorized medical services are billed directly to the health plan.
- Passport's contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.

16.6.12 Coding

When submitting claims through **eServices**, users will be prompted to include appropriate codes in order to complete the submission, and drop-down menus appear for most required codes. See EDI Transactions – 837 Companion Guide on the behavioral health web site

www.beaconhealthoptions.com for placement of codes on the 837 file. Please note the following requirements with regard to coding:

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes HIPAA-compliance revenue, CPT, HCPCS, and ICD-10 codes for dates of service after 10/01/15.
- Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.

- Passport accepts only diagnosis codes listed as approved by CMS and HIPAA ICD-10 after 10/01/15. From 10/1/15 forward, a Primary ICD-10-CM diagnosis code in the range of behavioral health diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.
- Claims for inpatient and institutional services must include the appropriate discharge status code. Table 6-1 lists HIPAA-compliant discharge status codes.
- DSM-5 (or most recent) classification should be used for behavioral health billing.

Table 6-1 Discharge Status Codes

Code	Description
01	Discharged to Home / Self Care
02	Discharged/Transferred to Another Acute Hospital
03	Discharged/Transferred to Skilled Nursing Facility
04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to Another Facility
06	Discharged/Transferred to Home / Home Health Agency
07	Left Against Medical Advice or Discontinued Care
08	Discharged/Transferred Home / IV Therapy
09	Admitted as Inpatient to this Hospital
20	Expired
30	Still a Patient
51	Hospice
65	Discharge/Transferred to Psychiatric Hospital or Psychiatric unit
70	Discharge/Transferred to another Health Care Institute not defined

* All UB04 claims must include the 3-digit bill type codes according to the Table below:

Table 6-2 Bill Type Codes

Type of Facility 1 st Digit	Bill Classification 2 nd Digit	Frequency – 3 rd Digit
1.Hospital	1.Inpatient	1.Admission through Discharge Claim
1.Skilled Nursing Facility	2.Inpatient Professional Component	2.Interim – First Claim
2.Home Health Care	3.Outpatient	3.Interim Continuing Claims
3.Christian Science Hospital	4.Diagnostic Services	4.Interim – Last Claim
5.Christian Science Extended Care Facility	5.Intermediate Care – Level I	5. Late Charge Only
6.Intermediate Care Facility	6.Intermediate Care – Level II	6 – 8. Not Valid

* BHSO –All claims, including residential services, should be submitted on a CMS1500.

16.6.13 Modifiers

Modifiers can reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. Table lists HIPAA-compliant modifiers accepted by Passport.

Table 6-3 Modifiers

Professional Provider Type	Modifier
Psychiatrist	AF
Licensed Psychologist	AH
Licensed Clinical Social Worker	AJ
Physician	AM
Community Support Associate	UC
Licensed Professional Clinical Counselor, Licensed Certified Alcohol and Drug Counselor, Licensed Behavioral Analyst, Licensed Professional Art Therapist	HO
Licensed Marriage and Family Therapist (except CMHC)	U9
Licensed Marriage and Family Therapist (CMHC ONLY)	HO
Per Diem (CMHC ONLY)	U9
Advance Registered Nurse Practitioner	SA
Registered Nurse	TD
Physician Assistant	U1
Psychiatric Registered Nurse (CMHC ONLY)	U2
Psychiatric Resident (CMHC ONLY)	U3
Certified Social Worker, Licensed Professional Counselor Associate, Licensed Psychological Associate, Marriage, Family Therapy Associate, Licensed Certified Alcohol and drug Counselor Associate, Licensed Professional Art Therapist Associate and Licensed Behavioral Analyst Associate	U4
Mental Health Associate (CMHC ONLY)	U5
Certified Alcohol and Drug Counselor	U6
Peer Counselor (CMHC ONLY)	U7

Licensed Psychological Practitioner	U8
The HF modifier is to be utilized when providing Targeted Case Management Services for Individuals with Substance Use Disorders.	HF
The TG modifier is to be utilized when providing Targeted Case Management Services for Individuals with Co-Occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues.	TG
The UA modifier is to be utilized when providing Targeted Case Management Services for Individuals with a Severe Emotional Disability.	UA

16.6.14 Time Limits for Filing Claims

Passport must receive claims for covered services within the designated timely filing limit:

- Within **180** days of the dates of service on outpatient claims, or
- Within **180** days of the date of service on inpatient claims

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the **180**-day timely filing limit will deny unless submitted as a waiver or an appeal request, as described in this chapter.

16.6.15 Coordination of Benefits (COB)

Passport follows a Coordination of Benefits policy when members have other medical insurance including Medicare. Because Passport administers a Medicaid program, it is considered the “payer of last resort” on all claims. All insurance including any automobile (personal protection) coverage or other medical coverage, including Medicare, pays the member’s claims before Passport. These types of coverage are considered “primary” coverage.

In accordance with The National Association of Insurance Commissioners (NAIC) regulations, Passport coordinates benefits for behavioral health and substance use disorder claims when it is determined that a person is covered by more than one health plan, including Medicare:

- When it is determined that Passport is the secondary payer, claims must be submitted with a copy of the primary insurance’s explanation of benefits report and received by Passport within 60 days of the date on the EOB.
- Passport reserves the right of recovery for all claims in which a primary payment was made prior to receiving COB information that deems Passport the secondary payer. Passport applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB.
- Coordination of Benefits claims must be submitted on paper and include a copy of the primary insurance’s explanation. The primary insurance documentation must reflect the following:
 - Member Name
 - Member Demographics (i.e. date of birth, etc.)
 - Provider Information
 - Date of Service

- Procedure Code (preferably with appropriate modifier)
- Primary Payer Information (payer logo or payer name on EOB)
- Amount paid by primary insurer
- Date paid by primary insurer

16.6.16 Claim Inquiries and Resources

Additional information is available through the following resources:

Email Contact

- Provider.relations@beaconhealthoptions.com
- EDI.Operations@beaconhealthoptions.com

Telephone

- **Interactive Voice Recognition (IVR): (888)210-2018**
You will need your practice or organization's tax ID, the member's identification number and date of birth, and the date of service.
- **Behavioral Health Access Line: (855) 834-5651**
Available 24 hours per day.
- **Behavioral Health's Main Telephone Numbers**

EDI	(855)834-5651
TTY	(866)727-9441
Behavioral Health Crisis Hotline	(844) 231-7496

16.6.17 Electronic Media Options

Providers are expected to complete claim transactions electronically through one of the following, where applicable:

- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA- compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Change Healthcare as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
 - Beacon's payor ID is 43324; and
 - Beacon's health plan-specific ID is 028.
- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because much of the required information is available in The behavioral health database, most claim submissions take less than one minute and contain few, if any errors.
- **IVR** provides telephone access to member eligibility, claim status and authorization status.

16.6.18 Claim Transaction Overview

Table 6-4 below, identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for

updates as additional transactions become available on EDI, eServices and IVR.

Table 6-4: Claim Transaction Overview

Transaction	Access on:			Applicable When:	Timeframe for Receipt by Beacon	Other Information
	EDI	eServices	IVR			
Member Eligibility Verification	Y	Y	Y	<ul style="list-style-type: none"> Completing any claim transaction; and Submitting clinical authorization requests 	n/a	n/a
Submit Standard Claim	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Within 180 days after the date of service	n/a
Resubmission of Denied Claim	Y	Y	N	Previous claim was denied for any reason <i>except</i> timely filing	Within 2 years after the date on the EOB.	<ul style="list-style-type: none"> Claims denied for late filing may be resubmitted as corrected claims. Previous claim number and the frequency 7 code is required to indicate that claim is a corrected claim.

180-Day Waiver* (Request for waiver of timely filing limit)	N	N	N	<p>A claim being submitted for the <i>first time</i> will be received by Passport after the original 180-day filing limit, <i>and</i> must include evidence that one of the following conditions is met:</p> <ul style="list-style-type: none"> • Provider is eligible for reimbursement retroactively; or • Member was enrolled in Plan retroactively; or • Services were authorized retroactively. • Third party coverage is available and was billed first. (A copy of the other insurance's explanation of benefits or payment is required); 	<p>Within 180 days from the qualifying event.</p>	<ul style="list-style-type: none"> • Waiver requests will be considered only for these 3 circumstances. A waiver request that presents a reason not listed here will result in a claim denial on a future EOB. • A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as an appeal request. • The waiver determination is reflected on a future EOB with a message of Waiver Approved or Waiver Denied: if waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the denial reason appears.
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Request for review of Timely Filing Limit*	N	Y	N	Claim falls out of all timeframes and requirements for appeal, waiver and adjustment.	Within 180 days from the date of payment or nonpayment.	Future EOB shows “Appeal Approved” or “Appeal Denied” with denial reason.
Request to Void Payment	N	N	N	<ul style="list-style-type: none"> • Claim was paid to provider in error; and, • Provider needs to return the entire paid amount to Passport. 	n/a	Do NOT send a refund check.
Request for Adjustment	Y	Y	N	<ul style="list-style-type: none"> • The amount paid to provider on a claim, was incorrect; • Adjustment may be requested to correct: <ul style="list-style-type: none"> ○ Underpayment (positive request); or, ○ Overpayment (negative request) 	<ul style="list-style-type: none"> • Positive request must be <i>received</i> within 180 days from the date of original payment; • No filing limit applies to negative requests. 	<ul style="list-style-type: none"> • Do NOT send a refund check • A RecID is required to indicate that the claim is an adjustment. • Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount and, if money is owed to provider, re-payment of the claim at the correct amount. • If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment. • Claims that have been denied cannot be adjusted, but may be resubmitted.
Obtain Claim Status	N	Y	Y	Available 24/7 for all claim transactions submitted by provider.	n/a	Claim status is posted within 48 hours after receipt.

View/Print Remittance Advice (RA)	N	Y	N	Available 24/7 for all claim transactions received.	n/a	Printable RA is posted within 48 hours after receipt.
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***Please note that claims are still processed using standard adjudication logic and all other billing and authorization requirements must be met. Accordingly, an approved waiver or appeal of the filing limit does not guarantee payment, since the claim could deny for another reason.**

16.6.19 Paper Claim Transactions

Providers are strongly discouraged from using paper claim transactions where electronic methods are available, and should be aware that processing and payment of paper claims is slower than that of electronically submitted claims. Electronic claim transactions take less time and have a higher rate of approval since most errors are eliminated.

For paper submissions, providers are required to submit clean claims on the National Standard Format CMS1500 or UB04 claim form. No other forms are accepted.

Mail paper claims to:

Passport Health Plan Claims
Attn: Beacon Health Options
P.O. Box 1866
Hicksville, NY 11802-1866

Beacon does not accept claims transmitted by fax.

Passport discourages paper transactions.

**BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS
EARLIER IN THIS CHAPTER.**

Paper submissions have more fields to enter, a higher error rate / lower approval rate, and slower payment.

16.6.20 Professional Services: Instructions for Completing the CMS 1500 and UB04

Please see [Section 15.1.8.2](#) for the CMS 1500 form with a description of the requested information, and indicates which fields are required in order for a claim to process and pay.

Institutional Services: Instructions for Completing the UB04 Form

Passport discourages paper transactions.

BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS
EARLIER IN THIS CHAPTER

Paper submissions have more fields to enter, a higher error rate/ lower approval rate, and slower payment.

Please see [Section 15.1.8.3](#) for the UB-04 claim form, with a description of the requested information and whether that information is required in order for a claim to process and pay.

16.6.21 Paper Resubmission

Passport discourages paper transactions.

BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS
EARLIER IN THIS CHAPTER

Paper submissions have more fields to enter, a higher error rate/ lower approval rate, and slower payment.

- See [Table 6-4](#) for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Passport more than 180 days from the date of service. The REC.ID from the denied claim line is required and may be provided in either of the following ways:
 - Enter the REC.ID in box 64 on the UB04 claim form or in box 19 on the CMS 1500 form.
 - Submit the corrected claim with a copy of the EOB for the corresponding date of service; or
- The REC.ID corresponds with a single claim line on the Passport EOB. Therefore, if a claim has multiple lines there will be multiple REC.ID numbers on the Passport EOB.
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Passport does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Passport within 2 (two) years after the date on the EOB. A claim package postmarked 2 (two) years after the date on the EOB is not valid.
- If the resubmitted claim is received by Passport within 2 (two) years from the date of service, the corrected claim may be resubmitted as an original. A corrected and legible photocopy is also acceptable

16.6.21.1 Paper Submission of 180-Day Waiver

- See [Table 6-4](#) for an explanation of waivers, when a waiver request is applicable, and procedural guidelines;
- Watch for notice of waiver requests becoming available on eServices.
- Download the 180-Day Waiver Form;
- Complete a 180-Day Waiver Form for each claim that includes the denied claim(s), per the

instructions below;

- Attach any supporting documentation;
- Prepare the claim as an original submission with all required elements;
- Send the form, all supporting documentation, claim and brief cover letter to:

Passport Health Plan
Attn: Beacon Health Options
Claim Department / Waivers
P.O. Box 1866
Hicksville, NY 11802-1866

16.6.21.2 Completion of the Waiver Request Form

To ensure proper resolution of your request, complete the 180-Day Waiver Request Form as accurately and legibly as possible.

1. **Provider Name:**
Enter the name of the provider who provided the service(s).
2. **Provider ID Number:**
Enter the provider ID Number of the provider who provided the service(s).
3. **Member Name:**
Enter the member's name.
4. **Passport Health Plan Member ID Number:**
Enter the Plan member ID Number.
5. **Contact Person**
Enter the name of the person to be contacted if there are any questions regarding this request.
6. **Telephone Number**
Enter the telephone number of the contact person.
7. **Reason for Waiver**
Place an "X" on all the line(s) that describe why the waiver is requested.
8. **Provider Signature**
A 180-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Passport will not accept "Signature on file."
9. **Date**
Indicate the date that the form was signed.

16.6.22 Paper Request for Adjustment or Void

Passport discourages paper transactions.

BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS
EARLIER IN THIS CHAPTER

Paper submissions have more fields to enter, a higher error rate/ lower approval rate, and slower payment.

- See [Table 6-4](#) for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines;
- Do not send a refund check to Passport. A provider who has been incorrectly paid by Passport must request an adjustment or void;
- Prepare a new claim as you would like your final payment to be, with all required elements;

- place the REC.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form or;
- Download and complete the Adjustment/Void Request Form per the instructions below;
- Attach a copy of the original claim;
- Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount; Send the form, documentation and claim to:

Passport Health Plan

Attn: Beacon Health Options

Claim Departments – Adjustment Requests

P.O. Box 1866

Hicksville, NY 11802-1866

16.6.22.1 To Complete the Adjustment/Void Request Form

To ensure proper resolution of your request, complete the Adjustment/Void Request form as accurately and legibly as possible and include the attachments specified above.

- 1. Provider Name**
Enter the name of the provider to whom the payment was made.
- 2. Provider ID Number**
Enter the Passport provider ID Number of the provider that was paid for the service. If the claim was paid under an incorrect provider number, the claim must be **voided** and a new claim must be submitted with the correct provider ID Number.
- 3. Member Name**
Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be **voided** and a new claim must be submitted.
- 4. Member Identification Number**
Enter the Plan member ID Number as it appears on the EOB. If a payment was made for the wrong member, the claim must be **voided** and a new claim must be submitted.
- 5. Claim Record ID number**
Enter the record ID number as listed on the EOB.
- 6. Claim Paid Date**
Enter the date the check was cut as listed on the EOB.
- 7. Check Appropriate Line**
Place an "X" on the line that best describes the type of adjustment/void being requested.
- 8. Check All that Apply**
Place an "X" on the line(s) which best describe the reason(s) for requesting the adjustment/void.
If
"Other" is marked, describe the reason for the request.
- 9. Provider Signature**
An adjustment/void request cannot be processed without a typed, signed, stamped, or computer-generated signature. Passport will not accept "Signature on file".
- 10. Date**
List the date that the form is signed.

16.6.23 Provider Education and Outreach

Summary

In an effort to help providers that may be experiencing claims payment issues, Passport runs weekly reports identifying those providers than may benefit from outreach and education. Providers with low approval rates are contacted and offered support and documentation material to assist in reconciliation of any billing issues that are having an adverse financial impact and ensure proper billing practices within documented guidelines.

Passport also provides regular communication about claims and authorization process changes through the use of Passport eNews. Providers are highly encouraged to sign up at <http://passporthealthplan.com/providers/provider-communications/> to receive regular updates about services impacting providers and members.

Clarification on appropriate time-based billing codes and modifiers to use for behavioral health services has been released by the Kentucky DMS and are effective April 1, 2015 for dates of service since August 1, 2014. These changes enable adherence to required NCCI edits.

Passport's goal through regular outreach programs is to assist providers in as many ways as possible to receive payment in full, based upon contracted rates, for all services delivered to members.

16.6.23.1 How the Program Works

- A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.
- All providers below 75% approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.
- An outreach letter is sent to the provider's Billing Director as well as a report indicating the top denial reasons. A contact name is given for any questions or to request further assistance or training.

16.6.24 Grievances

Providers with grievances or concerns should contact the Behavioral Health Access Line at the number provided below and ask to speak with the clinical manager for Passport. All provider complaints are resolved within thirty (30) days of receipt. The Provider or Passport may request up to fourteen (14) day extension for resolution of the grievance or appeal.

If a Passport member complains or expresses concern regarding procedures or services, Plan procedures, covered benefits or services, or any aspect of the member's care received from providers, he or she should be directed to call the Ombudsperson at (855)834-5651 or TTY at (866)727-9441.

16.6.24.1 Appeals and Grievances

Please see Section (2.9) for information concerning provider appeals and grievances. To submit a behavioral health appeal, providers can email Woburn.appeals@beaconhealthoptions.com.

16.6.24.2 Peer Review

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, upon request. Utilization Review clinicians and PAs are available daily to discuss denial cases by phone at (855)834-5651.

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Section 17.0

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Section 18.0

Dental Network

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18.0 Dental

Passport is pleased to partner with Avesis Incorporated (Avesis) for the administration of our Dental Program.

Passport and Avesis recognize the importance of promoting and providing good oral hygiene for Medicaid members in Kentucky. We understand the linkage between good oral health and overall health. By helping to ensure all Passport members receive appropriate and timely dental services, we can continually improve the oral health of members.

The provisions set out in this Section of Passport's Provider Manual supplement the provisions in previous sections as applicable, and include additional information specific to dental providers. Updates to this Dental Section of the Provider Manual will be provided on a periodic basis and available on the below-stated websites. As your office receives communications from Avesis and Passport, it is important that you and/or your office staff read these Dental Network Alerts and other special mailings and retain them with this Provider Manual so you can integrate the changes into your practice. All provider materials, including this Provider Manual and the Provider Directory, are available online at www.passporthealthplan.com and www.avesis.com.

Please take the time to familiarize yourself with this Provider Manual, including this Section. If you have any questions, require clarification regarding the Provider Manual, or need assistance or information that is not included within this Provider Manual, please contact

Provider Services: (866) 909-1083

Monday - Friday 7:00 a.m. to 8:00 p.m. (EST)

All offices will be notified thirty (30) days prior to the effective date of any changes or revisions to this Provider Manual affecting their practice, unless the change is required by law or regulation. Information in this Provider Manual will be updated on the Avesis and Passport websites at www.avesis.com, and www.passporthealthplan.com. It is the provider's responsibility to stay abreast of changes to this Provider Manual.

The Avesis website also contains important information including but not limited to Dental Alerts, eligibility verification, claims submission and claims status. Providers may also visit the Passport website for information on Passport and the Dental Program.

18.1 Important Contact Information

18.1.1 Dental Provider Services Call Center (866) 909-1083

The Dental Provider Services Call Center is available Monday through Friday, 7:00 a.m. to 8:00 p.m. EST to assist providers with questions about policies, procedures, member eligibility, and benefits. Representatives are also available if providers need to request forms or literature, or to report member noncompliance.

A Dental Provider Field Representative can offer orientations and in-service meetings for providers and their staff. This representative can also provide service calls and process any changes in provider status, such as addresses and telephone numbers.

18.1.2 Provider Services and Utilization Management

Provider Services
(866) 909-1083
Monday – Friday, 7:00 a.m. - 8:00 p.m. EST

Utilization Management
(866) 653-5544 (secure fax)
Monday – Friday, 7:00 a.m. - 8:00 p.m. EST

18.1.3 Avesis Chief Dental Officer and State Dental Director

Avesis Chief Dental Officer
Fred L. Sharpe, DDS
fsharp@avesis.com
(800) 522-0258 x 11288

Avesis State Dental Director
Dr. Jerry Caudill
jcaudill@avesis.com
(502) 662-2101

18.1.4 Claims Submission and EFT

Initial Claims Submission:
Avesis Third Party Administrators, Inc.
Attn: Dental Claims
P.O. Box 7777
Phoenix, Arizona 85011-7777

For Claims Correction:
Avesis Third Party Administrators, Inc.
Attn: Corrected Dental Claims
P.O. Box 7777
Phoenix, Arizona 85011-7777

Avesis EFT Contact:
Avesis Third Party Administrators, Inc.
Attn: Finance
P.O. Box 782
Owings Mills, Maryland 21117

18.1.5 Pre-Treatment Estimate and Post Review

Avesis Pre-Treatment Estimate:
Avesis Third Party Administrators, Inc.
Attn: Pre-Treatment Estimate
P.O. Box 7777
Phoenix, Arizona 85011-7777

Avesis Post Review:
Avesis Third Party Administrators, Inc.
Attn: Post Review
P.O. Box 7777
Phoenix, Arizona 85011-7777

18.2 Administrative Procedures

18.2.1 Member Identification and Eligibility Verification

Member eligibility information is detailed in Section 2.0. of the Provider Manual. As noted, Passport member eligibility varies by month. Therefore, each participating provider is responsible for verifying member eligibility before providing services. Dental providers may verify eligibility using any of the methods below. Please be mindful, verification of coverage only is provided, utilization of benefit information is not available when checking eligibility.

IVR (Interactive Voice Response System)

1. Call the IVR at: (866) 234-4806.
2. Enter your Provider PIN number.
3. Enter the member's KY Medicaid Identification number.
4. You will receive a real time response.

Website/Internet

1. Go to www.avesis.com.
2. Enter your User Name and Password.
3. Click "Check Eligibility."
4. Enter the member's KY Medicaid Identification number.
5. You will receive a real time response.

FAX

1. Complete the Avesis Eligibility Verification Fax Form (included as Attachment D of this Dental Section).
2. Fax toll free to: (866) 332-1632.
3. You will receive a reply to the fax within one (1) business day.

Provider Services

1. Call Dental Provider Services toll free at (866) 909-1083.
2. Provide your Provider PIN number.
3. Provide the member's KY Medicaid Identification number.

Remember: Eligibility verification is not a guarantee of payment. Benefits are determined at the time the claim is received for processing. These options will only provide eligibility information for Passport. Eligibility for other health plans is not provided.

Please note that Passport Health Plan cards are not returned to Passport when a member becomes ineligible. Therefore, the presentation of a Passport ID card is not sole proof that a person is currently enrolled in Passport.

As a way to help prevent Medicaid "card sharing," remember to always ask to see the member's Passport ID card or the member's Kentucky Medicaid ID card and request a picture ID to verify that the person presenting is indeed the person named on the ID card.

Services may be refused if the provider suspects the presenting person is not the card owner and no other ID can be provided. If you suspect a non-eligible person is using a member's ID card, please report the occurrence to the Passport Fraud and Abuse Hotline at (855)-512-8500 or the Medicaid Fraud Hotline at (800) 372-2970.

It is not necessary to refuse treatment to a member who does not present with his/her Passport identification card. Eligibility can be verified 24 hours a day 7 days a week as detailed above. Members may also produce their KY Medicaid ID Card.

18.2.2 Dental Claim Submission

Paper claims and appeals or recovery are to be submitted to the following address:

Avesis Third Party Administrators, Inc.
Attention: Dental Claims
P.O. Box 7777
Phoenix, AZ 85011-7777

To submit claims electronically, register on the Avesis website at www.avesis.com.

An active valid Kentucky Medicaid Provider Identification (MAID) number, assigned by the Kentucky DMS, is required to receive any payment for services rendered.

18.2.3 Statement of Providers' Rights and Responsibilities

Providers shall have the right and responsibility to:

Communicate openly and freely including, but not limited to, support of Provider Services and Customer Services representatives and information on participating providers for the purpose of referrals;

Obtain written parental or guardian consent for treatment to be rendered to members who have not yet reached the age of maturity in accordance with State Dental Board rules or ADA guidelines;

Obtain information regarding claim status and pre-treatment estimates for services to be rendered and re-submit claims with additional information by following the guidelines set forth herein;

Receive prompt payments for clean claims;

Make a complaint or file an appeal on behalf of a member with the member's consent and inform the member of the status of the appeal;

Question policies and/or procedures implemented on behalf of Passport;

Request Pre-Treatment Estimate for services identified herein as requiring pre-treatment estimates;

Refer members to participating specialists for treatment that is outside the provider's normal scope of practice;

Inform Avesis in writing immediately upon notification of any revocation, suspension and/or limitation of your license to practice, certification(s), and/or DEA number by any licensing or certification authority;

Consistent with credentialing and re-credentialing policies, inform Avesis in writing prior to changes in licensure status, tax identification numbers, telephone numbers, addresses, loss or modification of insurance or any other change that would affect status. Failure to notify prior to these changes may result in delays in claims processing and payment;

Consistent with the terms of the Provider Agreement, notice of termination of participation must be submitted at least ninety (90) days prior to the termination effective date;

Maintain an environmentally safe office with equipment in proper working order to comply with city, county, state and federal regulations concerning safety and public hygiene;

Respond promptly to requests for dental records as needed to review appeals and/or quality of care issues; and,

Abide by the rules and regulations set forth under applicable provisions of State or Federal law.

All providers are prohibited from:

Discriminating against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency. Provider agrees to comply with the Americans with Disabilities Act, and the Rehabilitation Act of 1973 and all other applicable laws related to the same. See Title VI Civil Rights Act of 1964, <https://www.justice.gov/crt/fcs/TitleVI-Overview>.

Discriminating against qualified individuals with disabilities for employment purposes;

Discriminating against employees based on race, color, religion, sex, or national origin;

Offering or paying or accepting remuneration to or from other providers for the referral of members for services provided under the Dental Program;

Referring members directly or indirectly to or solicit from other providers for financial consideration;

Referring members to an independent laboratory, pharmacy, radiology or other ancillary service in which the provider or professional corporation has an ownership interest; and,

Billing, charging, or seeking compensation, remuneration, or reimbursement from any member other than for supplemental charges, copayments (example: in 2014, there are no copayments or fees for covered services).

Please refer to Section 3.4 of the Provider Manual for additional information regarding provider responsibilities.

18.2.4 Member Appeals and Grievances

Please refer to Section 2.11 of the Provider Manual.

18.2.5 Provider Appeals and Grievances

Please refer to Section 2.9 of the Provider Manual.

18.3. Credentialing/Re-Credentialing

18.3.1 Initial Application Process

To begin the application process and join Passport, first call Dental Provider Services at (866) 909-1083. A provider application packet will be mailed and Avesis will work with the provider to become credentialed and, if approved, contracted as a Passport dental provider.

Avesis participates with the Council for Affordable Quality Healthcare (CAQH). Providers who are participating with this common credentialing application database should contact Dental Provider Services at (866) 909-1083 and include their CAQH Provider ID number with the documents submitted.

New dental practitioner (hereafter referred to as practitioner) applicants are required to complete all residency and/or training programs prior to joining the network. Practitioners still completing a residency program are required to bill under the attending practitioner.

Applicants must submit a completed application, which includes the following as applicable:

Two Participating Provider Agreements signed by the provider indicating their intent to join the network if approved after being credentialed.

Completed Provider Application, either a CAQH (Council for Affordable Quality Healthcare universal credentialing application) or the most current version of KAPER1 (Kentucky DMS application), including:

- Additional copies of pages from the application (as needed);
- Disclosure questions, as applicable, including but not limited to:
 - Documentation of any malpractice suits or complaints.
 - Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
 - Documentation of any conviction of a criminal offense within the last 10 years (excluding traffic violations).; and,
- The attestation page (including the practitioner signature and current date).

Original, complete, and signed MAP Forms, if a Kentucky Medicaid Provider Identification (MAID) number is needed per the Kentucky DMS provider enrollment web page. If the provider has a current Kentucky MAID number, the provider must include a completed MAP-347 form.

Copy of current State License Registration Certificate.

Copy of current Federal Drug Enforcement Agency Registration - if applicable.

Curriculum vitae or a summary specifying month and year for work history, explaining any lapse in time exceeding six months.

Copy of a completed, dated and signed W-9 in the name of the provider or facility/group, including the Tax Identification Number and mailing address for all tax information.

Copy of claim history form for each malpractice activity within the past five years.

Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.

A letter adding practitioner to each existing group contract, including group ID number(s), if applicable.

Copy of social security card (if applicant has as social security card stating “valid for work only with DHS/INS Authorization,” please refer to additional requirements at <http://www.chfs.ky.gov/dms/provenr/>), if submitted MAP forms for Kentucky MAID numbers

ECFMG (Education Council for Medical Graduates), if applicable.

Failure to submit a complete application may result in a delay of the credentialing process. Practitioners may contact Dental Provider Services at (866) 909-1083 to check the status of their applications.

18.3.2 Credentialing Process

Practitioner applicants are assessed through Passport’s credentialing process. With the receipt of all of the application materials, primary source verification is conducted. Following the verification of credentials, the Chief Dental Officer/designated Dental Director or Credentialing Committee reviews each application for participation. A credentialing review will not be initiated until a completed and signed application with attachments has been received. The normal processing time is between thirty (30) and sixty (60) days from date of submission of a completed application.

18.3.3 Reimbursement and the Credentialing Process

Providers will be considered participating Passport providers once they have met Passport credentialing requirements and have an executed agreement and a Kentucky MAID number. Providers will be notified when they have been credentialed. Providers applying for participation are excluded from the *Provider Directory* until the credentialing process has been completed in its entirety.

Providers will be reimbursed at the participating provider rate, retroactive to the first of the month in which the application is received provided the provider has an active Kentucky Medicaid MAID number and has submitted the MAP 347 form to be linked to Passport. Providers may begin submitting claims for services provided to Passport members once they have been notified of the receipt of their completed application and have been assigned a Kentucky MAID number. Providers are required to submit all claims within 180 days of service, but no payment is made until Passport receives confirmation that the provider has been issued a Kentucky MAID number. Please note, claims submitted without a Kentucky MAID number will be denied. Providers will receive notification from DMS when a MAID number is assigned.

Providers must notify Avesis of receipt of a MAID number assignment.

18.3.4 Providing Services Prior to Becoming a Credentialed Passport Provider

If a provider determines a Passport member must be seen prior to the assignment of a KY MAID number, the provider should see the member and submit for reimbursement under the plan after receiving his/her KY MAID number. As stated previously, the provider will not be eligible for payment until he/she has an executed contract and a KY MAID number. If payment is denied because the provider is not participating or he/she does not have a Kentucky MAID number, the member cannot be held liable.

18.3.5 Re-credentialing and Ongoing Monitoring Process

Passport re-credentials its providers, at a minimum, every 36 months. In addition, Passport conducts ongoing monitoring of Medicare and Medicaid sanctions and sanctions or limitations on licensure. Practitioners who become participating and subsequently have restrictions placed upon their license will be reviewed by the Credentialing Committee and evaluated on a case-by-case basis, based upon their ability to continue serving Passport members.

Member complaints and adverse member outcomes are also monitored and Passport will implement actions as necessary to improve trends or address individual incidents. If efforts to improve practitioner performance are not successful, the practitioner may be referred to the Credentialing Committee for review prior to his/her normally scheduled review date.

A re-credentialing application will be generated on all practitioners with current CAQH applications on file. Practitioners without a CAQH on file will be notified by letter to submit a re-credentialing application (most current version of the KAPER 1 or CAQH) with the following list of attachments:

Disclosure questions, as applicable, including but not limited to:

- Documentation of any malpractice suits or complaints.
- Documentation of any restrictions placed on practitioner by licensing board, or governing agency.
- The attestation page (including the practitioner signature and current date).
- Copy of current State License Registration Certificate.
- Copy of current Federal Drug Enforcement Agency Registration - if applicable.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.

Failure to return documents in a timely fashion may result in a period of non-participation. The initial credentialing process will need to be completed in order to re-enroll as a participating provider. Practitioners may contact the Dental Provider Services at (866) 909-1083 to check the status of their re-credentialing application. Should Passport decide to deny or terminate a provider, the provider will receive notification of the decision. The notification will include the reasons for the denial or termination, the provider's rights to appeal and request a hearing within thirty (30) days of the date of the denial notice, and a summary of the provider's hearing rights.

18.4 Changes in Provider Information

18.4.1 Changes in Provider and Demographic Information

Providers are required to provide a written notice to both the Provider Network Management department and the DMS of any changes in information regarding their practice. Such changes include:

- Address changes, including changes for satellite offices.
- Additions to a group.
- Changes in billing locations, telephone numbers, tax ID numbers.

Reimbursement may be affected if changes are not reported in accordance with Passport policy. Please note that providers are required by DMS to annually submit a copy of current license and annual disclosure of ownership. If these documents are not provided, the provider's Kentucky Medicaid (MAID) number may be terminated. Your office will receive notice from the DMS when these documents are due for submission. Please respond timely to these requests. **Untimely response to this requirement may result in claims denials and/or untimely claims payment.**

18.6 Dental Benefits

18.6.1 Dental Services

Dental services are outlined in 907 KAR 1:026. Coverage shall be limited to services identified in 907 KAR 1:626, Section 3, in the following CDT categories:

- Diagnostic;
- Preventive;
- Restorative;
- Endodontics;
- Periodontics;
- Removable prosthodontics;
- Maxillofacial prosthetics;
- Oral and maxillofacial surgery;
- Orthodontics; and
- Adjunctive general services.

Please see Attachment F - Covered Benefits Schedule for additional information on benefits. Information is also available on the Avesis website at www.avesis.com.

In 2014, there are no copayments or fees for covered services.

18.6.2 Non - Covered Items or Services

Passport will not pay providers for non-covered services. Providers will hold harmless Passport, Avesis and DMS for payment of non-covered dental services.

Non-covered services include investigational items and experimental drugs or procedures not

recognized by the United States Food and Drug Administration, the United States Public Health Service, CMS, and the Avesis Chief Dental Officer and State Dental Director as universally accepted treatment, including but not limited to, positron emission tomography, dual photon absorptiometry, etc.

The member may purchase additional services as non-covered procedure(s) or treatment(s) for an additional charge. Passport requires that the provider and the member complete the Non-Covered Services Disclosure Form (see Attachment B) or a similar form that contains all of the elements of the *Passport Non-Covered Services Disclosure Form* prior to rendering these services. If the member elects to receive the non-covered procedure(s) or treatment(s), the member would pay the provider's usual and customary rate as payment in full for the agreed upon procedure(s) or treatment(s). The member is financially responsible for such services. If the member will be subject to collection action upon failure to make the required payment, the terms of the action must be kept in the member's treatment record. Failure to comply with this procedure will subject the provider to sanctions up to and including termination.

Members may not be billed for any service, with the exception of services in which a *Passport Non-Covered Services Disclosure Form* has been signed, prior to the service being rendered.

18.6.3 Periodicity Schedule

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE

Periodicity and Anticipatory Guidance Recommendations

Dental Health Guidelines – Ages 0-18 Years Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003)

Age	6-12 months	12-24 months	2-6 years	6-12 years	≥12 years
Clinical oral examination ¹	X	X	X	X	X
Assess oral growth and development ²	X	X	X	X	X
Caries-risk assessment ³	X	X	X	X	X
Radiographic assessment ⁴	X	X	X	X	X
Prophylaxis & topical fluoride ^{3,4}	X	X	X	X	X
Fluoride supplementation ⁵	X	X	X	X	X

Age	6-12 months	12-24 months	2-6 years	6-12 years	≥12 years
Anticipatory guidance/ counseling ⁶	X	X	X	X	X
Oral hygiene counseling ⁷	Parent	Parent	Patient/Parent	Patient/Parent	Patient
Dietary counseling ⁸	X	X	X	X	X
Injury prevention counseling ⁹	X	X	X	X	X
Counseling for nonnutritive habits ¹⁰	X	X	X	X	X
Counseling for speech/ language development	X	X	X		
Substance abuse counseling				X	X
Counseling for intraoral/ perioral piercing				X	X
Assessment and treatment of developing malocclusion			X	X	X
Assessment for pit and fissure sealants ¹¹			X	X	X
Assessment and/or removal of third molars					X
Transition to adult dental care					X

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
5. Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing, including the importance of mouth guards.
10. At first, discuss the need for additional sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
11. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

18.8 Authorization Procedures and Requirements

Prior Authorization is a request made in advance for dental services to be performed by the Passport network general/pediatric dentist.

18.8.1 Prior Approval for Non-Emergency Situations

Non-emergency treatment for services requiring prior approval started prior to the granting of prior authorization will be performed at the financial risk of the dental office. If authorization is denied, the dental office or treating provider may not bill the member, Passport, or Avesis. Receipt of authorization or denial of the request for prior approval will be provided within two (2) business days.

Services that require Prior Approval for non-emergency care include

ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED YES / NO
D0330	Panoramic film	All	One per patient per dentist or dental group every 24 months. Part of D8660 for orthodontic patients. Authorization required for ages 0 - 5.	All	Yes for members age 5 and under only
D0340	Cephalometric Film	All	Part of D8660		Yes for members age 5 and under only
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant	All	One per 12 months. A minimum of four (4) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes.	All	Yes--prepayment review
D4211	Gingivectomy or gingivoplasty- one to three contiguous teeth or bounded spaces per quadrant	All	One per 12 months. One (1) to three (3) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes.	All	Yes--prepayment review

D4341	Periodontal scaling and root planing, per quadrant	All	One per 12 months. A minimum of three (3) teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1201. One per 3 months for patients diagnosed with AIDS.	All	Yes-post review since 10/1/12 and prior authorization effective ?
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	All	Covered for pregnant women only. One per pregnancy.	All	Post review to confirm pregnancy
D5820	Interim partial denture (maxillary)	All	One per 12 months per patient.	0-20	Yes
D5821	Interim partial denture (mandibular)	All	One per 12 months per patient.	0-20	Yes
D5913	Nasal prosthesis	All	Covered for Prosthodontists only.	All	Yes
ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED YES / NO
D5914	Auricular prosthesis	All	Covered for Prosthodontists only.	All	Yes
D5919	Facial prosthesis	All	Covered for Prosthodontists only.	All	Yes
D5931	Obturator prosthesis, surgical	All	Covered for Prosthodontists only.	All	Yes
D5932	Obturator prosthesis, definitive	All	Covered for Prosthodontists only.	All	Yes
D5934	Mandibular resection prosthesis	All	Covered for Prosthodontists only.	All	Yes
D5952	Speech aid - pediatric (13 and under)	All	Covered for Prosthodontists only.	0-13	Yes
D5953	Speech aid - adult (14 -20)	All	Covered for Prosthodontists only.	14-20	Yes
D5954	Palatal augmentation prosthesis	All	Covered for Prosthodontists only.	All	Yes
D5955	Palatal lift prosthesis	All	Covered for Prosthodontists only.	All	Yes
D5988	Oral surgical splint	All	Covered for Prosthodontists only.	All	Yes

D5999	Unlisted maxillofacial prosthetic procedure	All	Covered for Prosthodontists only.	All	Yes
D7280	Surgical access of an unerupted tooth	1-32	No Limitations	0-20	Yes-prepayment review
D7880	Occlusal orthotic device, by report	All	Once per lifetime.	0-20	Yes-prior authorization
D8080	Comprehensive orthodontic treatment of the adolescent dentition	All	No Limitations	0-20	Yes
D8210	Removable Appliance Therapy	All	This appliance is not to be used to control harmful habits. Limit of two (D8210, or D8220) per 12 months.	0-20	Yes
D8220	Fixed Appliance Therapy	All	This appliance is not to be used to control harmful habits. Limit of two (D8210, or D8220) per 12 months.	0-20	Yes
ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED YES / NO
D8660	Pre-orthodontic treatment visit	All	Used to pay for records. Final records will be paid only if member is age 20 and under and still eligible for benefits on date of service. Member cannot be billed for final records.	0-20	Yes
D8670	Periodic orthodontic treatment visit(as part of the contract)	All	Quarterly Payment	No limitations	Yes
D8680	Orthodontic Retention(removal of appliances, construction and placement of retainer(s))	All	Final Payment	No limitations	Yes
D8999	Unspecified orthodontic procedure, by report	All	Six month payment.	0-20	Yes

All EPSDT Special Services (aka Expanded Services) require prior authorization.

This list is also available at www.avesis.com.

Form to use: *ADA Claim Form for Pre-Treatment Estimates*. Providers may submit a pre-treatment estimate in one of two ways:

1. Electronic submission, please go to www.avesis.com; or

2. Mail on an ADA claim form to:
Avesis Third Party Administrators, Inc.
P. O. Box 7777
Phoenix, Arizona 85011-7777
Attn: Dental Pre-Treatment Estimate

ADA dental claim forms are not accepted via fax. Because all prior authorization requests for prior approval for non-emergency situations must be submitted electronically on our website or on an ADA dental claim form, the provider must either submit them on the website or mail in an ADA dental claim form with the appropriate box checked indicating the provider is submitting a request for a pre-treatment estimate.

Prior authorization of dental services must be performed as a part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

- pertinent dental history;
- pertinent medical history, if applicable;
- the strategic importance of the tooth;
- the condition of the remaining teeth;
- the existence of all pathological conditions;
- preparatory services performed and completion date(s);
- documentation of all missing teeth in the mouth;
- the general oral hygiene condition of the member;
- all proposed dental work;
- identification of existing crowns, periodontal services, etc.
- identification of the existence of full and/or partial denture(s), with the date of initial insertion, if known;
- the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis;
- identification of abutment teeth by number;
- periodontal services, include a comprehensive periodontal evaluation.

For those situations where dental services are limited to services provided in an inpatient hospital, hospital short procedure unit or ambulatory surgical center, please include a statement identifying where the service will be provided. Please see Sections 19.8.4 and 19.8.5 for information regarding referrals to hospitals and other facilities for dental treatment.

18.8.2 Emergency Care

A dental emergency is a situation where the member has or believes there is a current, acute dental crisis that could be detrimental to his/her health if not treated promptly.

In the event a dental emergency occurs after business hours and the provider cannot treat the member within twenty-four (24) hours, please refer the member to Avesis at (866) 909-1037 for further assistance. Passport requires providers ensure sufficient access to help keep the member from having services rendered in a hospital emergency room.

18.8.2.1 Emergency Access and Authorizations

All Passport provider offices are responsible for the effective response to, and treatment of, dental emergencies. In relation to dental emergencies, there are two types of members:

- 1) Members of record (i.e., members who are routinely treated by the provider); or
- 2) Members who have not been previously seen by the office.

and two situations:

- 1) during regular office hours; or
- 2) after hours.

To confirm whether the situation is a true emergency, the dentist should speak with the member to determine the member's problem and take the necessary actions. If it is determined by the provider and the member that it is a true dental emergency (that is: a situation that cannot be treated simply by medication and, that left untreated, could affect the member's health or the stability of his/her dentition), then the provider may either: A) render services in the dental office to treat the emergency, or B) assist the patient in obtaining proper dental care from another dental provider or a hospital emergency room, if the condition warrants emergency room treatment.

18.8.2.2 Members of Record

If the member telephones with an emergency before 12 noon, the provider must respond to the member the same business day, if possible. If the member telephones after 12 noon, the member must be responded to the same day if possible, but no later than the following business day. If the provider is not treating patients the following business day, then weekend requirements will apply.

For a weekend, holiday, or other "off hour" dental emergency, the provider must make available an answering service or telephone number available for the member of record to contact. The responding dentist should assess the emergency request from the patient and make arrangements to provide appropriate follow-up care. If the situation is determined to be a true dental emergency (a situation that cannot be treated simply by medication and, that left untreated, could affect the member's health or the stability of his/her dentition), the responding dentist must either:

- arrange for the member to come into the office to treat the emergency, or
- assist the member in obtaining proper dental care from another network dental provider.

Passport is committed to providing effective emergency care for patients without the use of hospital emergency rooms, unless absolutely necessary. Members of record shall be required to see their dentist of choice prior to any hospital admission. The dentist must request prior approval from Passport (see Sections 19.8.4 and 5.1).

18.8.2.3 Members Not Previously Treated By Provider

In the case of a Dental Emergency or Urgent dental condition, the provider must make every effort to see the member immediately or see the member on the next business day or sooner, if possible. For weekend Dental Emergencies, the provider must have an answering service or cell phone number available for contact. Passport will permit treatment of all dental services necessary

to address the Dental Emergency for the member without prior authorization. However, elective dental services, not necessary for the relief of pain and/or prevention of immediate damage to dentition, fall under the standard Pre-Treatment/Prior Authorization estimate procedures.

18.8.2.4 Waiver of Pre-Treatment Estimate/Prior Approval for Emergencies

Passport recognizes that in the case of emergency care, the provider may not be able to obtain a Pre-Treatment Estimate / Prior Authorization. In this situation, required documentation must be submitted after treatment along with the provider's ADA claim form including radiographs, narrative, and CDT codes within thirty (30) business days of the date of service. Claims sent without documentation will be denied and the member is not liable for payment. The minimum materials must include:

- Narrative explaining the emergency and treatment rendered;
- Claim form complete with all applicable ADA-CDT codes or medical CPT codes;
- Radiograph(s) of tooth / teeth and any area of treatment, if appropriate;
- Hospital records, if admitted to hospital; and,
- Anesthesia records, if general anesthesia was administered.

The clinical reviewer and/or the State Dental Director or Dental Advisory Board Member will review the claim along with the accompanying documentation submitted. If the claim is found to not be a qualified emergency, the payment may be reduced or denied.

In the event the emergency occurs after business hours and the provider cannot treat the member within twenty-four (24) hours, the provider must contact Avesis at (866) 909-1037 to allow for the arranging of timely emergency care. Although Passport requires dental providers ensure sufficient access so that the provider attempts to limit having services rendered in a hospital emergency room, the provider should refer members to a hospital emergency room when he/she cannot provide or arrange immediate care.

Emergency services shall not include the following:

- Prophylaxis, fluoride and routine examinations.
- Routine restorations, including stainless steel and composite crowns.
- Dentures, partial dentures and denture relines and repair.
- Extraction of any asymptomatic teeth, including 3rd molars.

18.8.3 Specialty Referral Process

A member requiring a referral to a dental specialist can be referred directly to any specialist contracted with Passport without authorization. The dental specialist is responsible for obtaining prior authorization for services. If the provider is unfamiliar with the Passport contracted specialty network or needs assistance locating a certain specialty, please contact the Provider Services department. In addition, members may self-refer to any network provider without authorization. Members have direct access to dental specialists. A referral is not necessary.

19.8.4 Hospital Referral

Hospital referrals will be handled by Passport. If hospitalization of a member for dental services is necessary, the hospital must be authorized using the regular process for Passport. Please refer to Section 5.1 of the Provider Manual.

18.8.5 Participating Ambulatory Surgical Centers (ASC) and Hospitals for Pre-Treatment Estimate/Prior Approval

With Pre-Treatment Estimate/Prior Approval, providers may render services at Passport approved Ambulatory Surgical Centers (ASC), IV Sedation Clinics or hospitals when services are unable to be performed in the dental clinic setting. Please see the following link for a list of Passport ASCs, IV Sedation Clinics and hospitals:

<http://passporthealthplan.com/members/find-a-doctor/>

18.8.6 Second Opinion

The dentist should discuss all aspects of the patient's treatment plan prior to beginning treatment. Make sure all of the member's concerns and questions have been answered. If the patient indicates he/she would like a second opinion, inform the member he/she may do so and that Passport will cover the cost of a second opinion if he/she sees a dentist within the Passport network of participating dentists. The dentist must provide copies of the chart, radiographs and any other information to the dentist performing the second opinion upon request.

18.9 Quality Improvement

Passport strongly encourages and supports providers in the use of outcome measurement tools for all members. Outcome data is used to identify and understand why there are areas of under-utilization. Annual analysis of HEDIS results along with quarterly statistical provider reviews facilitates our efforts and is complemented by on-site surveys and quarterly wait time reviews as described below.

18.9.1 Quarterly Statistical Provider Review

At the end of each quarter, Avesis compiles and reviews total services rendered by all dental providers in the Passport Dental Program. The objective of the utilization review process is intended to provide feedback regarding the demand for dental services and appropriateness of care. Each code will be analyzed against the number of total Passport dental members being treated. The result will be an average frequency of services per 100 recipients treated in the Passport Dental Program. Providers' per member cost will be calculated for the quarter. An average per member cost income will be the result. The following items formulate the basis of the utilization review:

- Average Service Comparison – a summary of the statistical results by ADA code for each provider compared with the state average. An analysis will be performed only if the provider has treated a sufficient number of Passport dental members in that quarter. Providers that qualify must fall within a reasonable range of the state average. Those providers falling outside of the range will be reviewed for over or under-treatment patterns.
- Relative Service Comparison – Certain dental services are typically performed with or after other services. A series of related dental services will be reviewed for appropriate care. Examples of such services are:
 - A root canal on a tooth, D3310 or D3320, followed by the placement of a stainless steel crown, D2930
 - A fluoride treatment for a child being performed at the same appointment as their prophylaxis. These related services would be compared to the averages and to other similarly utilized providers to detect any over or under utilization.

- Total Quarterly Per Member Cost –A calculation of the per member cost for all Passport providers using the services rendered during each quarter. The results shall be compared to all other providers and to previous quarters. Providers may request a summary of their per member cost compared to the state average.
- Accurate Claim Submission – This will be assessed via the following:
 - During the quarterly statistical review, Passport will look for any services that would be impossible due to a tooth being previously extracted or a service done on a tooth that would not require that service (i.e. placing an amalgam on a tooth that already had a stainless steel crown).
 - Compliance with processes.

The goal in the utilization review process is to ensure provider satisfaction along with quality care for members.

18.9.2 On-Site Office Survey

The office site survey has two components: prospective and ongoing for participating offices. Each review highlights essential areas of the office management and dental care delivery. During the site survey (which may or may not be scheduled), the following areas will be evaluated:

- General Information – the name of the practice, address, name of principal owner and associates, license numbers, staffing information, office hours, list of foreign languages spoken in the office, availability of appointments and method of providing twenty-four (24) hour coverage (e.g. answering machine, answering services, etc.) the name of the covering dentist when the office is closed, such as on vacation.
- Practice History – the office provides information regarding malpractice suits, settlements and disciplinary actions, if applicable.
- Office Profile - indicates services they routinely perform.
- Facility Information – includes location, accessibility (including handicap accessibility) description of interior office such as the reception area, operatory and lab, type of infection control, equipment and radiographic equipment.
- Risk Management – includes review of personal protective equipment (such as gloves, masks, handling of waste disposal, sterilization and disinfection methods), training programs for staff, radiographic procedures and safety, occupational hazard control (regarding amalgam, nitrous oxide and hazardous chemicals), medical emergency preparedness training and equipment.
- Recall System – includes review of procedures for assuring patients are scheduled for recall examinations and follow-up treatment.
- Verification that all participating dental providers in a group practice are credentialed.

18.9.3 Quarterly Wait Time Review

In lieu of requiring providers to submit a report of average wait times on a quarterly basis, random and anonymous surveys are performed of provider practices to inquire whether scheduling wait times as well as office wait times are excessive. Providers found to have excessive wait times will be required to implement a corrective action plan.

1. If a member complains to Passport, DMS, CMS or other state or federal agency that wait times in a provider's office were excessive, it is required for us to contact the provider to

advise there was a complaint filed against their office. Once the provider is notified, Passport will work with the provider to formulate a written corrective action plan and follow up to ensure the action has been implemented.

2. If a member complains to Passport, DMS, CMS, or other state or federal agency that it was difficult to make an appointment for routine care, Passport is required to contact the provider's office to advise the provider there was a complaint filed against their office. Once the provider is notified, a written corrective action plan will be formulated and follow up to ensure the action has been implemented.

It is important to note that providers who do not implement a corrective action plan upon request may be subject to termination from the network.

18.9.4 Dental Committees

Passport welcomes involvement from the dentists who participate in the Passport Dental Program. There are currently three active committees that are staffed with dentists who participate in the Passport Dental Program. These committees provide opportunities for feedback from our local dental communities.

The Credentialing Committee helps to ensure the acceptability of new dentists before their entry into the Passport network as well as upon re-credentialing. The committee credentials new network providers and reviews the credentials upon re-credentialing every thirty-six (36) months. In addition, this committee reviews disciplinary information received during the continuous credentialing process on a monthly basis and conducts review of any appeals from dentists who have been sanctioned. Meetings are held every other week.

The Quality Assurance Committee is a multi-disciplinary committee whose critical focus is the review of the statistical summary data to determine the primary areas to focus on for improvement. Committee members review planned efforts toward continuous quality improvement, establish standards for quality review of the Dental Program and provide input toward Passport planning for future planned improvements. Meetings are held on a quarterly basis.

The Complaint Resolution /Peer Review Committee includes the Chief Dental Officer, Advisory Board and up to (3) dentists from the Passport provider network. Its critical focus includes reviewing the complaints received from members and dental network providers to determine the validity of the complaints and the appropriate response to the party bringing the complaint. The committee addresses decisions concerning the appropriate settlement of clinical disputes between providers and patients. Meetings are held quarterly.

The State Dental Director is an employee or contractor with Avesis who serves as the provider's local contact as a dental professional. The State Dental Director represents Avesis at meetings of the local Dental Association and its component societies and at meetings with Passport. The State Dental Director is available for discussion and consultation concerning issues of importance to Passport's dental network providers. Providers may contact Provider Services at (866) 909-1083 to speak with the State Dental Director.

All of Passport Dental Program committees include the Chief Dental Officer as either an active member or as an attendee.

Attachment F

Covered Benefits Schedule

ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED?	ATTACHMENTS REQUIRED
D0140	Limited Oral Evaluation- Problem Focused	All	Not reimbursable on the same day as D0120 and D0150. Trauma related injuries only. May only be billed in conjunction with D0220, D0230, D0270, D0272, D0274, D0330, D2330, D2331, D2332, D2335, D7140, D7130, D7250, D7530, D7910 and D9240.	All	No	Requires a prepayment review
D0120	Periodic Oral Evaluation - established patient	All	Only one exam (D0120 or D0150) every 6 months per patient per dentist or dental group.	All	No	None
D0150	Comprehensive Oral Evaluation	All	One comprehensive exam (D0150) per patient per dentist or dental group every 12 months. Only one exam (D0120 or D0150) every 6 months per patient per dentist or dental group. Cannot be billed on the same day as D0120, D0140, D1510, D1515, D1520, D1525.	All	No	None
D0210	Intraoral - complete series (including bitewings)	All	One per patient per dentist or dental group every 12 months.	All	No	None
D0220	Intraoral - periapical first view	All	Total of 14 (D0220 and D0230) per patient per dentist or dental group every 12 months. Not to be billed in the same 12 months as a D0210.	All	No	None
D0230	Intraoral - periapical each additional film	All	Total of 14 (D0220 and D0230) per patient per dentist or dental group every 12 months. Not to be billed in the same 12 months as a D0210.	All	No	None
D0270	Bitewing - single film	All	Total of 4 bitewing x-rays per patient per dentist or dental group every 12 months. Not to be billed in the same 12 months as a D0210.	All	No	None
D0272	Bitewing - two film	All	Total of 4 bitewing x-rays per patient per dentist or dental group every 12 months. Not to be billed in the same 12	All	No	None

			months as a D0210.			
D0274	Bitewing - four films	All	Total of 4 bitewing x-rays per patient per dentist or dental group every 12 months. Not to be billed in the same 12 months as a D0210.	All	No	None
D0330	Panoramic film	All	One per patient per dentist or dental group every 24 months. Part of D8660 for orthodontic patients. Authorization required for ages 0 - 5.	All	Yes for members age 5 and under only	None
ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED?	ATTACHMENTS REQUIRED
D0340	Cephalometric Film	All	Part of D8660		Yes for members age 5 and under only	None
D1110	Prophylaxis - Adult	All	One per 12 months.	21 and older	No	None
D1120	Prophylaxis - Child (Age 0 to 13)	All	Two per 12 months.	0-20	No	None
D1208	Topical application of fluoride - Child (prophylaxis not included)	All	Two per 12 months. Fluoride must be applied separately from prophylaxis paste.	0-20	No	None
D1351	Sealant - per tooth	All	One per 48 months. Maximum of 3 times. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Repair, replacement or reapplication of the sealant within the four year period is the responsibility	0-20	No	None
D1510	Space maintainer-fixed-unilateral	All	Limit of 2 (D1510, D1515, D1520 or D1525) per 12 months.	0-20	No	None
D1515	Space maintainer-fixed-bilateral	All	Limit of 2 (D1510, D1515, D1520 or D1525) per 12 months.	0-20	No	None
D1520	Space maintainer-removable-unilateral	All	Limit of 2 (D1510, D1515, D1520 or D1525) per 12 months.	0-20	No	None
D1525	Space maintainer-removable-bilateral	All	Limit of 2 (D1510, D1515, D1520 or D1525) per 12 months.	0-20	No	None
D2140	Amalgam-one surface, permanent/primary	All	No Limitations	All	No	None

D2150	Amalgam-two surfaces, permanent/primary	All	No Limitations	All	No	None
D2160	Amalgam-three surfaces, permanent/primary	All	No Limitations	All	No	None
D2161	Amalgam-four surfaces or more, permanent/primary	All	No Limitations	All	No	None
D2330	Resin-based composite - one surface, anterior	Anterior Teeth only	No Limitations	All	No	None
D2331	Resin-based composite - two surfaces, anterior	Anterior Teeth only	No Limitations	All	No	None
D2332	Resin-based composite - three surfaces, anterior	Anterior Teeth only	No Limitations	All	No	None
D2335	Resin-based composite - four or more surfaces, anterior	Anterior Teeth only	No Limitations	All	No	None
D2391	Resin-based composite, 1 surface-posterior primary/permanent	Posterior Teeth only	No Limitations	All	No	None
D2392	Resin-based composite, 2 surfaces-posterior primary/permanent	Posterior Teeth only	No Limitations	All	No	None
ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED?	ATTACHMENTS REQUIRED
D2393	Resin-based composite, 3 surfaces-posterior primary/permanent	Posterior Teeth only	No Limitations	All	No	None
D2394	Resin-based composite, 4+ surfaces-posterior primary/permanent	Posterior Teeth only	No Limitations	0-11	No	None
D2930	Prefabricated stainless steel - primary tooth	Primary Teeth only (A-T)	No Limitations	0-20	No	None
D2931	Prefabricated stainless steel - permanent tooth	Permanent Teeth only (1-32)	No Limitations	0-20	No	None
D2932	Prefabricated Resin crown	Only Anterior teeth 6-11, 22-27, c-h, m-r	No Limitations	0-20	No	None
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth (Stainless steel primary crown with exterior esthetic coating)	Anterior Primary Teeth only(c-h,m-r)	2 per anterior tooth, per member, per lifetime. Anterior primary teeth only (C, D, E, F, G, H, M, N, O, P, Q, R).	0-11	No	None

D2951	Pin retention - per tooth, in addition to restoration	Only for Permanent Molars(1-3,14-16,17-19,30-32)	Limited to permanent molars; used in conjunction with D2160, D2161, D2931, or D2932. Lifetime maximum of two per molar. Limit of one per tooth per date of service.	0-20	No	None
D3110	Pulp cap - direct (excluding final restoration)	All	No Limitations	0-20	No	None
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament.	1-32, A-T	Shall not be billed in conjunction with D3310, D3320, or D3330 on the same day.	0-20	No	None
D3310	Root canal - Anterior (excluding final restoration)	Only for teeth 6-11 and 22-27	Once per lifetime.	0-20	Post review	Pre and Post treatment radiographs showing endodontic fill
D3320	Root canal - Bicuspid (excluding final restoration)	Only for teeth 4, 5, 12, 13, 20, 21, 28, 29	Once per lifetime.	0-20	Post review	Pre and Post treatment radiographs showing endodontic fill
D3330	Root canal - Molar (excluding final restoration)	Only for teeth 1-3, 14-19, 30-32	Once per lifetime.	0-20	Post review	Pre and Post treatment radiographs showing endodontic fill
D3410	Apicoectomy/periradicular surgery - anterior	Only for teeth 6-11, 22-27	Once per lifetime.	All	Post review	1) Pre and Post-Treatment radiographs showing endodontic fill of tooth (teeth) involved. 2) Complete treatment plan.
ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED?	ATTACHMENTS REQUIRED
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	Only for teeth 4, 5, 12, 13, 20, 21, 28, 29	Once per lifetime.	All	Post review	1) Pre and Post-Treatment radiographs showing endodontic fill of tooth (teeth) involved. 2) Complete treatment plan.
D3425	Apicoectomy/periradicular surgery - molar (first root)	Only for teeth 1-3, 14-19, 30-32	Once per lifetime.	All	Post review	1) Pre and Post-Treatment radiographs showing endodontic fill of tooth (teeth) involved. 2) Complete treatment plan.
D3426	Apicoectomy/periradicular surgery (each additional root)	Only for teeth 1-5, 12-21, 28-32	Once per lifetime.	All	Post review	1) Pre and Post-Treatment radiographs showing endodontic fill of tooth (teeth) involved. 2) Complete treatment

						plan.
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant	All	One per 12 months. A minimum of four (4) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes.	All	Yes--prepayment review	1) Comprehensive periodontal evaluation documentation. 2) Narrative documenting necessity. 3) Pre-treatment radiographs 4)Periodontal charting
D4211	Gingivectomy or gingivoplasty- one to three contiguous teeth or bounded spaces per quadrant	All	One per 12 months. One (1) to three (3) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes.	All	Yes--prepayment review	1) Comprehensive periodontal evaluation documentation. 2) Narrative documenting necessity. 3) Pre-treatment radiographs 4)Periodontal charting
D4341	Periodontal scaling and root planing, per quadrant	All	One per 12 months. A minimum of three (3) teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1201. One per 3 months for patients diagnosed with AIDS.	All	Yes-post review since 10/1/12 and prior authorization effective?	1) Periodontal charting. 2) Narrative documenting necessity. 3) Pre-Treatment radiographs. 4) List number of quadrants required on Pre-Treatment/ Prior Approval estimate.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	All	Covered for pregnant women only. One per pregnancy.	All	Post review to confirm pregnancy	None
D5520	Replace missing or broken teeth - complete denture (each tooth)	All	One per 12 months per denture per patient.	0-20	No	None
D5610	Repair resin denture base	All	Three per 12 months per patient.	0-20	No	None
D5620	Repair cast framework	All	Three per 12 months per patient.	0-20	No	None
ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED?	ATTACHMENTS REQUIRED
D5640	Replace broken teeth - per tooth	All	One per 12 months per patient per dentist.	0-20	No	None
D5750	Reline complete maxillary denture (laboratory)	All	One per 12 months per denture per patient. Not covered within 6 months of placement.	0-20	No	None
D5751	Reline complete mandibular denture (laboratory)	All	One per 12 months per denture per patient. Not covered within 6 months of placement.	0-20	No	None
D5820	Interim partial denture	All	One per 12 months per	0-20	Yes	Narrative

	(maxillary)		patient.			
D5821	Interim partial denture (mandibular)	All	One per 12 months per patient.	0-20	Yes	Narrative
D5913	Nasal prosthesis	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5914	Auricular prosthesis	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5919	Facial prosthesis	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5931	Obturator prosthesis, surgical	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5932	Obturator prosthesis, definitive	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5934	Mandibular resection prosthesis	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5952	Speech aid - pediatric (13 and under)	All	Covered for Prosthodontists only.	0-13	Yes	Narrative
D5953	Speech aid - adult (14 - 20)	All	Covered for Prosthodontists only.	14-20	Yes	Narrative
D5954	Palatal augmentation prosthesis	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5955	Palatal lift prosthesis	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5988	Oral surgical splint	All	Covered for Prosthodontists only.	All	Yes	Narrative
D5999	Unlisted maxillofacial prosthetic procedure	All	Covered for Prosthodontists only.	All	Yes	Narrative
D7111	Coronal Remnants - Deciduous tooth	A-T	No Limitations	All	No	None
D7140	Extraction, erupted tooth or exposed root	1 - 32, 51 - 82, A-T, AS-TS	No Limitations	All	No	None
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	1-32, 5 -82, A-T, AS-TS	Includes cutting of gingiva and bone, removal of tooth structure and closure.	All	No	None
D7220	Removal of impacted tooth - soft tissue	1-32, 51-82	No Limitations	All	No	None
D7230	Removal of impacted tooth - partially bony	1-32, 51-82	No Limitations	All	No	None
D7240	Removal of tooth - completely bony	1-32, 51-82	No Limitations	All	No	None

D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	1-32, 51-82	Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.	All	No	None
D7250	Surgical removal of residual tooth roots - cutting procedure	1-32, 51-82, A-T, AS-TS	Will not be paid to the dentists or group that removed the tooth.	All	No	None
ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED?	ATTACHMENTS REQUIRED
D7260	Oroantral fistula closure	All	No Limitations	All	No	None
D7280	Surgical access of an unerupted tooth	1-32	No Limitations	0-20	Yes-prepayment review	Approved orthodontic plan
D7310	Alveoloplasty in conjunction with extractions - per quadrant	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Once per lifetime. Minimum of three extractions in the affected quadrant. Usually in preparation for a prosthesis.	All	No	None
D7320	Alveoloplasty not in conjunction with extractions per quadrant	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Once per lifetime. No extractions performed in an edentulous area.	All	No	None
D7410	Radical excision - lesion diameter up to 1.25 cm	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No Limitations	All	No	None
D7472	Removal of torus palatinus	Upper Arch (01, UA)	Once per lifetime.	All	No	None
D7473	Removal of torus mandibularis	Lower Arch (02, LA)	Once per lifetime.	All	No	None
D7510	Incision and drainage of abscess (intraoral)	All	No Limitations	All	No	None
D7520	Incision and drainage of abscess (extraoral)	All	No Limitations	All	No	None
D7530	Removal of foreign body	All	Shall not pertain to removal of stitches (sutures) or teeth.	All	No	None
D7880	Occlusal orthotic device, by report	All	Once per lifetime.	0-20	Yes-prior authorization	Narrative
D7910	Suture of recent small wounds up to 5 cm	All	Shall not be billed in conjunction with any other surgical procedure. It shall not pertain to repair of surgically induced wounds.	All	No	None
D7960	Frenulectomy	All	Once per lifetime. Limited to one per date of service.	All	No	None

D8080	Comprehensive orthodontic treatment of the adolescent dentition	All	No Limitations	0-20	Yes	1)Cephalometric image with tracing 2)Panoramic or full mouth image 3)Intraoral and extraoral facial frontal and profile pictures 4)Occluded and trimmed models or digital images of models 5)Initial payment is made when treatment is started
D8210	Removable Appliance Therapy	All	This appliance is not to be used to control harmful habits. Limit of two (D8210, or D8220) per 12 months.	0-20	Yes	Arch or quadrant must be indicated on the claim
D8220	Fixed Appliance Therapy	All	This appliance is not to be used to control harmful habits. Limit of two (D8210, or D8220) per 12 months.	0-20	Yes	Arch or quadrant must be indicated on the claim
D8660	Pre-orthodontic treatment visit	All	Used to pay for records. Final records will be paid only if member is age 20 and under and still eligible for benefits on date of service. Member cannot be billed for final records.	0-20	Yes	1)Cephalometric image with tracing 2)Panoramic or full mouth image 3)Intraoral and extraoral facial frontal and profile pictures 4)Occluded and trimmed models or digital images of models 5)Initial payment is made when treatment is started
ADA CODE	DESCRIPTOR	TEETH COVERED	BENEFIT LIMITATIONS	AGE LIMITATIONS	AUTHORIZATION REQUIRED?	ATTACHMENTS REQUIRED
D8670	Periodic orthodontic treatment visit(as part of the contract)	All	Quarterly Payment	No limitations	Yes	Approved orthodontic treatment
D8680	Orthodontic Retention(removal of appliances, construction and placement of retainer(s))	All	Final Payment	No limitations	Yes	Beginning and final records
D8999	Unspecified orthodontic procedure, by report	All	Six month payment.	0-20	Yes	1) Complete narrative describing Member's condition, compliance with and need for treatment, estimated treatment period 2) Study models 3) Radiographs
D9110	Palliative (emergency treatment of dental pain - minor procedure) (Not payable in conjunction with other dental services except radiographs.)	All	Not allowed with any other services other than radiographs. One per patient per dentist or dental group per date of service.	All	No	None

D9241	Intravenous sedation/analgesia - first 30 minutes	All	"This procedure code shall not be used for billing local anesthesia or nitrous oxide." (Kentucky State Dental Manual page 4.11).	0-20	No	1) Narrative detailing medical necessity and dental treatment done or to be done. 2) The person responsible for the administration must have a current valid permit from the Kentucky State Board of Dentistry to do so.
D9420	Hospital call (Requires 24 hour notification after services rendered.)	All	No other procedures may be billed in conjunction with D9420. Not applicable for nursing home visits (D0150 or D9110). One per patient per dentist or dental group per date of service. Cannot bill conjunctively.	All	Yes	Narrative

Provider Manual

Section 19.0

Vision Network

19.1 Quick Reference

19.2 Claims

19.3 Wait Time and Urgent Care

19.4 Provider Appeals

19.5 Provider Responsibilities

19.6 Member Appeals and Grievances

19.7 Claims Submission and Timely Filing

19.8 Covered Services Guidelines

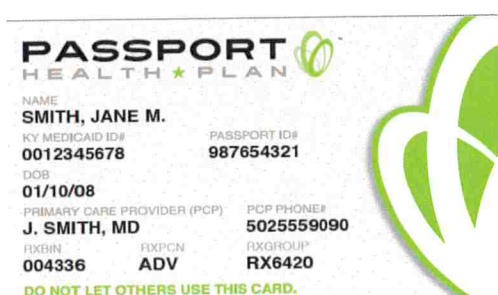
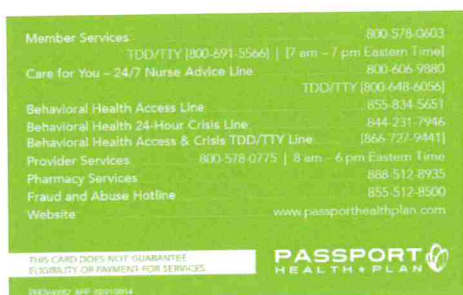
19.9 Eye Medical/Surgical Procedures

19.10 Forms



19.1 Quick Reference and Sample Identification Card

Avēsis Executive Offices 10324 South Dolfield Road Owings Mills, MD 21117-3991 (410) 581-8700 (800) 643-1132	Avēsis Corporate Offices 10400 North 25 th Avenue, Suite 200 Phoenix, AZ 85021-1696 (602) 241-3400 (800) 522-0258
EFT Avēsis Third Party Administrators, Inc. Attention: Finance P.O. Box 316 Owings Mills, MD 21117	Appeals Avēsis Third Party Administrators, Inc. Attention: Vision Appeals P.O. Box 38300 Phoenix, AZ 85069-8300
Pre-Authorization Avēsis Third Party Administrators Attention: Vision Pre-Authorization P.O. Box 38300 Phoenix, AZ 85069-8300	Post Review Avēsis Third Party Administrators Attention: Vision Post Review P.O. Box 38300 Phoenix, AZ 85069-8300
Vision Claims Avēsis Third Party Administrators Attention: Vision Claims P.O. Box 38300 Phoenix, AZ 85069-8300	Corrected Claims Avēsis Third Party Administrators Attention: Vision Corrected Claims P.O. Box 38300 Phoenix, AZ 85069-8300
Provider/Customer Services 844-346-7782 Monday – Friday 7:00 am – 8:00 pm (EST) except observed holidays	Avēsis Provider Portal/Website www.avesis.com Avēsis IVR: 866-234-4806
Avēsis Vision Clinical Director David Worth, O.D dworth@avesis.com	Passport Member Services 800-578-0603 TDD: 800-691-5566 or TTY: 711



Members should present a Passport Health Plan Medicaid identification card. Medical Assistance Members may also present their Medical Assistance card. Providers are responsible for verifying eligibility and benefits prior to an appointment.

Using your Avēsis Provider PIN and the Member's identification number you may:

- Call the Interactive Voice Response (IVR) at (866) 234-4806; or
- Visit www.avesis.com; or
- Call Avēsis Provider Services at 844-346-7782

19.2 Claims

Clean Claims

Clean claims are processed and paid 30 days from date claim was received.

Claims Process

Claims must be received within 180 days from the date of service.

Corrected Claim Process

The Provider has a right to correct information submitted by another party or to correct his/her own information submitted incorrectly. Changes must be made in writing and directed to the Avēsis Claims Manager within 2 years of the last process date and include the original claim number.

Corrected claims must be filed no later than 90 days from the last EOB date after timely filing has expired. Correct Claim must be written on the top of the claim form.

Retrospective Review Process

When a request is submitted for a post review and the services have already been provided, providers can submit a retrospective review for a medical necessity. Providers have 60 days from the card issue date or from the provider's documentation of the date when they were aware of the member's eligibility to submit a retrospective review. Providers should submit all retrospective reviews in writing and clearly marked "Retrospective Review" to:

Avēsis Third Party Administrators, Inc.
Attention: Vision Post Review
P.O. Box 38300
Phoenix, AZ 85069-8300

19.3 Wait Time and Urgent Care

Quarterly Wait Time Review

In lieu of requiring Providers to submit a report of average wait times on a quarterly basis, Avēsis will perform random and anonymous surveys of Provider practices to inquire whether scheduling wait times as well as office wait times are excessive. Providers found to have excessive wait times will be required to implement a corrective action plan.

1. If a Member complains to Passport Health Plan, CMS or appropriate Kentucky that wait times in your office were excessive, Avēsis is required to contact your office to advise you that there was a complaint filed against your office. Once you are notified, Avēsis will work with you to formulate a written corrective action plan and follow up to ensure that the action has been implemented.
2. If a Member complains to Passport Health Plan, CMS or the appropriate Kentucky agency that it was difficult to make an appointment for routine care, Avēsis is required to contact your office to advise you that there was a complaint filed against your office. Once you are notified, Avēsis will work with you to formulate a written corrective action plan and follow up to ensure that the action has been implemented.

Urgent Care

In accordance with Kentucky State Code KRS 311A.165, Urgent Care means health care treatment with respect to which the application of the time periods for making non-urgent determination (a) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (b) in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

Avēsis shall permit treatment of all eye care services necessary to address an eye emergency for a member without prior authorization. In accordance with the Provider Agreement, in the case of an eye emergency or urgent eye condition, you shall make every effort to see the member immediately and within 24 hours. If it is determined by the provider and the member that it is a true eye emergency, then a provider may either:

- render services in the eye care office to treat the emergency; or
- assist the patient in obtaining proper eye care from another optometrist or ophthalmologist or a hospital emergency room, if the condition warrants emergency room treatment.

Provider Approvals for Non-Emergency Situations

Non-emergency treatment started prior to the granting of authorization will be performed at the financial risk of the eye care office. If authorization is denied, the eye care office or treating Provider may not bill the Member, the sponsor or Avēsis.

You will receive an authorization number within 14 calendar days of receipt of the request, if the services are approved. Should the Avēsis Vision Clinical Director determine that the service is not necessary, you will be notified within 14 calendar days of receipt of all required information. If additional documentation is required to decide, you will be notified within 14 calendar days. If we do not receive the additional information within 14 calendar days, the decision to approve or deny the service will be made, based on the available information. Authorization determinations will be communicated in writing within 14 calendar days of the initial communication. Once the determination has been communicated to you, you are responsible for advising the Member of the review decision.

19.4 Provider Appeals

Provider Appeal Process for Denial of Claim(s)

Administrative Appeals – Appeals involving adverse determinations for reasons other than medical necessity (e.g. timeliness of filing, no prior authorizations, etc.)

1. A written request for the claim to be reviewed including the justification for the service to be reimbursed should be submitted within 30 days of the last process date.
2. The Claims Manager will review the appeal within 30 calendar days of receipt. If based upon the information provided it is determined that the claim should be paid, the initial

determination will be reversed, and the claim will be paid within 30 calendar days from received date.

3. If the Claims Manager determines that the claim should not be reimbursed, the Provider will be notified of the decision and advised that administrative appeals are only reviewed one at a time.

Medically Necessary Appeals – Appeals involving adverse determination findings that there was no medically necessary reason to pay the claim.

1. A written notice of appeal to Avēsis should be submitted within 30 days of the last process date. The appeal should include documentation in support of the appeal not previously provided.
2. The Vision Clinical Director will review the appeal and, if necessary, speak directly with the Provider. If the Vision Clinical Director made the initial determination, the appeal will be reviewed by a member of the Avēsis Vision Advisory Board.
3. Within 30 calendar days of the appeal, a decision will be made to either support or reverse the initial determination. If the adverse determination is upheld, the provider will be notified in writing within 30 calendar days of the decision being made. If the decision is to reverse the initial determination, the claim will be processed and paid within 30 days.

Independent Third-Party Review

Pursuant to KRS 205.646 and 907 KAR 17:035, a provider may request an external independent review of an adverse final decision of a denial, in whole or in part, of a health care service regarding medical necessity determinations, whether the service is covered by the Medicaid program, or whether the provider followed Passport's requirements for the covered service. To request an external independent third-party review, a provider must submit a written request to Passport within sixty (60) calendar days of receiving the final appeal decision. Requests must identify each specific issue and dispute related to Passport's adverse final decision and state the basis on which Passport's decision on each issue is believed to be erroneous. The request must include your designated contact information including a name, phone number, mailing address, fax number, and email address. Requests for external independent third-party reviews may be sent:

Electronically: ReviewRequests@passporthealthplan.com

By fax: (502) 585-8334

By mail: Attn: Provider Review Requests
Passport Health Plan
5100 Commerce Crossings Drive
Louisville, KY 40229

Benefit Exception Process

Avēsis requires consideration of written Provider requests for a benefit exception under the EPSDT program if the Member is age 20 or younger. For Members greater than 20 years of age, benefit exceptions may be reviewed by Avēsis on a case-by-case basis.

If a Member or a Provider contacts Avēsis and requests coverage of a non-covered item or service as a benefit exception, the following procedure should be followed:

1. Requests for benefit exceptions must delineate the medical necessity for the exception via a Letter of Medical Necessity from an Avēsis Provider or a physician.
2. Letters of Medical Necessity must be submitted with the benefit exception request to Avēsis Vision Utilization Management at the address listed on page 5.
3. Requests will be reviewed for medical necessity and appropriateness.
4. Avēsis must decide and notify the Provider and Member within 14 calendar days of receipt. If all the information is not available to make a decision, an extension of up to 14 days may be requested and approved if it is in the best interest of the Provider. The Provider must be notified of the extension and the reason. If additional information is requested, the Provider shall be given up to 14 days to submit the additional information.

19.5 Provider Responsibilities

Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations. Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission.

If suspected cases are discovered, an oral report should be made immediately, by telephone or otherwise, to a representative of the local Department of Social Services office or by calling the Kentucky Child/Adult Abuse Hotline at 1-877-597-2331. To facilitate reporting of suspected child abuse and neglect cases, legislation affecting the reporting of child abuse (KRS 620.020) is printed on the reverse side of the Child Abuse Reporting Form (DSS.115). These forms may be obtained from the local Department of Social Services office.

Adult abuse is defined by (KRS. 209.020) as “the infliction of physical pain, mental injury, or injury of an adult.” The statute describes an adult as “(a) person 18 years of age who because of mental or physical dysfunction is unable to manage his [or her] own resources or carry out the activity of daily living or protect himself [or herself] from neglect or a hazardous or abusive situation without assistance from others and who may need protective services; or (b) a person without regard to age who is the victim of abuse and neglect inflicted by a spouse.”

Fraud, Waste and Abuse

The Office of Inspector General, U.S. Department of Health and Human Services has an established hotline to report any person or entity providing services to Medicaid, Medicare, or CHIP beneficiaries anonymously. Visit www.oig.hhs.gov or call:

(800) HHS-TIPS or (800) 447-8477

TTY: (800) 377-4950

Mailing address:

U.S. Department of Health and Human Services
Office of Inspector General

Attn: OIG HOTLINE OPERATIONS

P.O. Box 23489

Washington, Dc 20026

The Kentucky Court of Justice has a state hotline also operated by the Office of Inspector General. Use this hotline to report suspected fraud and abuse for Medicaid recipients anonymously: (800) 372-2970. Providers may also submit a report via e-mail at

It is Passport Health Plan's policy to detect and prevent any activity that may constitute fraud, waste, or abuse, including violations of the Federal False Claims Act or any state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, you may contact our Integrity Program. Reporting fraud, waste, or abuse can be anonymous or not.

Anonymous reporting:

1. Call 855-512-8500 and follow menu options; or
2. Visit <http://passporthealthplan.com/compliance/>

Acceptance of improper payments is a form of Fraud, Waste, and Abuse. This includes payments that should not have been made or were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative or other legally applicable requirements. It includes payment to an ineligible recipient, payments for an ineligible good or service, duplicate payments, payments for a good or service not received (except for such payments where authorized by law) and payments that do not account for credit for applicable discounts (Improper Payments Elimination and Recovery Act [IPERA]).

Examples of Member Fraud, Waste, and/or Abuse:

- Inappropriately using services such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions
- Sharing ID cards
- Non-disclosed other health insurance coverage
- Alteration of prescription forms
- Obtaining unnecessary equipment and supplies
- Members receiving services or picking up prescriptions through identity theft
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.
- Examples of Provider Fraud, Waste, and/or Abuse:
 - Prescribing drugs, equipment, or services that are not medically necessary
 - Failing to provide patients with medically necessary services due to lower reimbursement rates
 - Billing for tests or services not provided
 - Intentionally using improper medical/eye coding to receive a higher reimbursement
 - Purchasing drugs from outside the United States
 - Prescribing high quantities of controlled substances without medical necessity
 - Unbundling services to obtain higher reimbursement
 - Not verifying Member ID resulting in claims submission for non-covered persons
 - Scheduling more frequent return visits than are needed
 - Billing for services outside of your medical/dental qualification

- Using enrollee lists for the purpose for submitting fraudulent claims
- Drugs billed for inpatients as if they were outpatients
- Payments stemming from kickbacks or Stark Violations
- Retaining overpayments made in error by Passport Health Plan and/or Avēsis
- Preventing Members from accessing covered services resulting in underutilization of services offered

The Federal False Claims Act

The Federal False Claims Act allows everyday people to bring “whistleblower” lawsuits on behalf of the government-knows as “qui tam” suits-against businesses or other individuals that defraud the government through programs, agencies, or contracts. Using the False Claims Act, you can help reduce fraud against the federal government.

The False Claims Act, also called the “Lincoln Law” imposes liability on persons and companies who defraud governmental programs. According to the UPDATED OIG Guidelines for Evaluating State False Claims Acts, March 15, 2013 and under section 1909 (b)(1) of the Act, OIG will consider whether the law provides for the following:

1. Liability to the State for false or fraudulent claims with respect to Medicaid program expenditures, including:
 - knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval;
 - knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
 - knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the State; and conspiring to commit any of the violations described above.
2. Definitions for the terms “knowing” and “knowingly” meaning that a person with respect to information: (a) has actual knowledge of the information, (b) acts in deliberate ignorance of the truth or falsity of the information, or (c) acts in reckless disregard of the truth or falsity of the information. In addition, no specific intent to defraud should be required.
3. A definition for the term “claim” meaning, with respect to any Medicaid program expenditure, any request or demand, whether under contract or otherwise, for money or property and whether or not the State has title to the money or property, that (a) is presented to an officer, employee, or agent of the State, or (b) is made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the State’s behalf or to advance a State program or interest and if the State (i) provides or has provided any portion of the money or property requested or demanded or (ii) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.
4. A definition of the term “obligation” meaning an established duty, whether fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship; from a fee-based or similar relationship; from statute or regulation; or from the retention of any overpayment.

5. A definition of the term “material” meaning to have a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

The State of Kentucky does not have a state False Claims Act, but has the following laws regarding fraudulent and false claims:

- KRS 205.211: The Cabinet for Health and Family Services can act to correct Medicaid overpayments.
- KRS 205.8467: A provider who knowingly submitted claims for which they were not entitled to payment shall be liable for:
 - Restitution of payments received in violation, and maximum legal rate on interest from the date of payment
 - A civil fine up to three (3) times the amount of the overpayment
 - A civil fine of \$500 for each false or fraudulent claim submitted
 - Payment of legal fees in investigation and enforcement
 - Removal as a Medicaid provider for two (2) to six (6) months upon the first offense, six (6) months to one (1) year for second offense, and one (1) to five (5) years for a third offense.
- KRS 205.8463: The Cabinet for Health and Family Services can prosecute persons who:
 - Knowingly or wantonly plan or agree to conspire to work together to obtain federal Medicaid payments under false application, claim, report, or documents submitted to the Cabinet (Class A misdemeanor or Class D felony)
 - Intentionally, knowingly, or wantonly makes a false or fraudulent statement or representation of entry in a claim, report, application, or document supporting payment to the Cabinet’s staff (Class A misdemeanor or Class D felony)
 - Knowingly makes, or induces a false statement or false representation of material fact with intent to defraud (Class C felony)
 - Knowingly falsifies, conceals, or covers up a material fact, or makes false or fraudulent statements or representation, or uses false documents when handling payment issues related to Medicaid (Class D felony)

The complete set of Kentucky laws governing Medicaid fraud and abuse may be found in Kentucky Revised Statutes §§205.8451-205.8483.

In addition to federal and state laws, Passport Health Plan’s policy prohibits retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file “whistleblower” lawsuits on behalf of the government. Anyone who believes that he or she has been subject to such retribution or retaliation should also report this to our Special Investigations Unit.

Passport Health Plan is prohibited by its federal and state contracts from knowingly having relationships who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities. Relationships must be terminated with trustees, officers, employees, providers or vendors identified as debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that you or your office management staff possesses a prohibited affiliation, you must notify us immediately utilizing the

contact information in this addendum.

Disclosure of Ownership, Debarment and Criminal Convictions

Before Avēsis enters into or renews an agreement with your practice or corporate entity; you must disclose debarments or suspension status and criminal convictions related to federal health care programs for yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child, or sibling. Please contact us by using the contact information in this addendum.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations (CFR) 42 CFT 455.100-106 for more information and definitions of relevant terms.

19.6 Member Appeals and Grievances

Member Appeals and Grievances

Avēsis is not delegated to resolve Member Appeals and Grievances. If a member wants to file a grievance or appeal, the member should contact the Member Services number listed on the Member ID card. If a member contacts the Avēsis Member Services department, Avēsis will transfer the call to the appropriate member Services department for assistance. While Avēsis is not delegated for this responsibility, we will cooperate and assist Passport Health Plan in resolving member concerns. All appeal and grievance procedures comply with Federal and State regulations and meet appropriate accreditation standards.

Members receive instructions on how to file an appeal or grievance in their Plan documents. Members may contact Member Services number on their ID cards for assistance or access Passport Health Plan's website: <http://passporthealthplan.com/file-appeal/>.

State Fair Hearing Appeal

A member may ask for a State Fair Hearing if he or she is not satisfied with the appeal resolution. The member must exhaust the Passport internal appeal process prior to requesting a State Fair Hearing. A member may request a State Fair Hearing by sending a letter to the Department for Medicaid Services within 120 days from the date of the notice of the appeal decision.

The State Fair Hearing Appeal should be sent to:

**Department for Medicaid Services
Division of Program Quality and Outcomes
275 East Main Street, 6C-C
Frankfort, KY 40621**

19.7 Claims Submission and Timely Filing

Claim Payment/Submission Guidelines

All clean claims submitted will be processed and, when appropriate, paid according to the Avēsis Kentucky Medicaid Fee Schedule. Each claim must include the appropriate line item with your charges and applicable codes.

Claims must be received within 180 days from the earliest date of service on the claim. Submit a clean claim form or file electronically after services and materials have been provided. Missing or incorrect information will cause delays in the processing of your claim. Any and all applicable member copayments will be deducted from billed amounts.

Claims may be submitted in one of the following three formats:

- Avēsis secure web portal:
www.avesis.com
- Through your practice management software using a clearinghouse
 - Change Healthcare (formerly Emdeon)
Payer ID 87098
www.changehealthcare.com
615-932-3000
 - Trizetto
Payer ID 86098
www.trizetto.com
800-569-1222
- CMS-1500 form via first class mail to:
Avēsis Third Party Administrators, Inc.
Attn: Eye Care Claims
P.O. Box 38300
Phoenix, AZ 85069-8300

Avēsis is committed to processing all clean claims as defined by state or federal regulations. Providers shall use the appropriate procedure codes for services provided to the member when billing Avēsis. Eye care services provided to Members are reimbursed per the Avēsis Medicaid fee schedule. The allowable amount is indicated within the fee schedule as:

- The provider's actual cost (including discounts) from the provider's supplier
- The maximum allowable dollar amount
- The reasonable charge for the procedure as determined by Avēsis

Providers are encouraged to visit www.avesis.com to access the current fee schedule.

Note: Members cannot be balance billed for any charges or penalties incurred as a result of late or incorrect submissions.

Timely Filing Guidelines

Timely filing guidelines will be strictly adhered to. Claims received after the filing deadline will be denied. There are no exceptions. The following deadlines will be adhered to unless specified per state/federal guidelines:

Action	Days to File	From Date
Provider to file a claim	180 Days	Date of service
Provider to correct a claim	90 Days	Last EOB date after timely filing has expired
Provider to appeal a claim	30 Days	EOB Date
To pay a clean claim	30 Days	Date claim received
Providers to submit claim with primary EOB	90 Days	Date of primary payer's remittance advice

19.8 Covered Services Guidelines

Examination

Examination includes, but is not limited to: the patient's case history, vision analysis (tonometry and biomicroscopy), refraction (retinoscopy or autorefractor and/or subjective refraction), pupillary reflexes, binocular function, external/internal exams, dilation when professionally indicated, diagnosis and treatment plan, and the prescription of lenses/contacts if necessary. Members are eligible for exam and materials once per benefit year.

Providers must accept Assignment of Benefits for all eligible members and obtain the members signature on such form. Claims can be filed online at www.avesis.com or mailed to Avēsis at P.O. Box 38300, Phoenix AZ 85069.

Eye Medical Benefits

There is a \$0.00 copay for medical exams. Providers must report appropriate CPT II for all diabetic members.

Clinical Protocol Guidelines

Avēsis relies upon approved clinical protocols in the decision-making process to determine medical necessity. These protocols are developed in consideration of the Local Coverage Determination for Kentucky, the American Academy of Ophthalmology Preferred Practice Patterns, and/or the American Optometric Association Clinical Practice Guidelines, which can be found at www.abop.org or www.aoa.org, respectively. Avēsis Clinical Protocols are available online at www.avesis.com inside the provider login. Providers are encouraged to visit the website often to ensure they have the most current information.

Routine Eye Exam Guidelines

The following program standards and requirements shall apply to the routine benefit to be reimbursed for the eye exam portion of the benefit available to Covered Persons.

Eye Examination Standards and Requirements

An eye examination shall be performed in accordance with all current and future state board of optometry and professional standards. All findings and test results shall be recorded, both normal and abnormal, in a clear, legible fashion. An eye examination shall include, at a minimum, the following, whenever possible:

1. Medical/Eye History
 - Chief complaint
 - Age
 - Medications
 - Family history
 - Significant visual changes
2. Visual Acuities
 - Entering, with or without correction, distance and near
 - Best corrected with final Subjective RX, distance and near
3. Cover Test – Findings must be recorded at 20 feet and 16 inches.
4. Versions/Motility Assessment
5. Pupils and Pupillary Reactions
6. Screening Visual Fields – Record all findings including test or instrument used
7. Refraction – To include objective refraction and subjective refraction.
8. External Examination/Biomicroscopy
 - Lid
 - Conjunctiva
 - Cornea
 - Crystalline lens
 - Anterior Chamber Angle Quantification
 - Media Clarity
9. Tonometry/Intraocular Pressure—To include method of obtaining pressures and the time of day
10. Ophthalmoscopy – Direct/Indirect
 - A dilated examination of the retina and the peripheral retina to be performed whenever professionally indicated
 - Document all findings in the vitreous, macula, optic nerve, including numerical C/D ratio, retinal vessels, and grounds
11. Diagnosis and Treatment Plan

Standards for Routine Eye Exam Guidelines

All members up to age 21 have benefits for an annual eye health examination to evaluate a member's ocular health and determine refractive status and eyeglasses that meet certain minimal requirements. Eye examinations are recommended beginning at age three. The member is eligible for one exam every

12 months (from date of service to date of service) and should be conducted in compliance with the Avēsis Eye Examination Standards and Requirements. Coverage includes the examination and the annual dispensing of spectacle frames and lens materials required to correct visual acuity one time every benefit year (1/1 to 12/31). Members ages 21 and over do not have a routine eye exam benefit.

If, in your professional judgment, it is medically necessary for a patient to receive additional eye evaluations and/or replacement materials, you must complete a prior approval form and fax it along with all pertinent clinical data to our secure fax at 855-591-3566.

These requests will be reviewed by our Utilization Management department and will be referred to a peer reviewer for all adverse determinations. You will be notified of the decision in writing from Avēsis within 14 calendar days of receipt of all required documentation. If a decision cannot be rendered by then, you will receive written notification of the need for an extension.

Providers should use the following CPT® codes when billing for the annual comprehensive eye health examination under the routine eye care program:

- 92002/92004: routine ophthalmological examination, including refraction; new patient
- 92012/92014: routine ophthalmological examination, including refraction; established patient

Please note: These services include dilation and determination of refractive state. The provider may not bill separately for dilation or refraction performed on the same date of service.

Material Benefit

Members 21 and Over – Materials benefits are not available for members 21 and over

Members Under 21 – Materials available once every benefit year

Eyeglass and Contact Lens Material Benefit have a refractive requirement of +/- .50 in any of the four meridians or .50 diopters vertical prism or a total of 2.00 diopters of lateral prism. Eyeglasses are covered based on a diagnosed visual condition included in one of the following categories:

- Amblyopia
- Post-surgical eye condition
- Diminished or subnormal vision
- Other diagnosis which indicates the need for prescription eyeglasses

Providers have two options for the fabrication of eyeglasses to eligible members in this program:

- Avēsis Contracted Lab – Providers receive a consignment frame kit from which eligible member select covered eyeglass frames. All orders are placed with Korrekt Optical. Providers are not billed for the eyeglasses but MUST submit a claim to Avēsis for the dispensing fee.
- Fabrication of covered in full eyeglasses for eligible members in-house or utilizing the laboratory of your choice. Providers are responsible for the cost of materials. Avēsis reimbursement is based on the fee schedule.

Each frame dispensed must carry a minimum of a one-year warranty against manufacturer's defect. If a member selects a frame outside the covered frame selection, the member will be responsible for the full cost of the frame. The member/parent/legal guardian's signature MUST be obtained on the Non-

Covered Services Form. This form must be retained in the member's patient file.

Lenses must be available in a complete range of corrective curves. Lenses must meet the requirements of inspection, tolerance, and testing procedures as outlined in the American Standard Prescription Requirements. All lenses shall meet the current FDA standards of impact resistance and MUST be of polycarbonate material with factory scratch coating. The reimbursement includes all lens types and prescriptions.

Exclusions: The following products and services are excluded from this program: Low-Vision Services, tints, plano safety glasses, non-prescription clear or tinted eyeglasses, eyeglasses that do not meet or exceed the minimum refractive requirement of +/- .50 diopters, non-prescription contact lenses.

The following are exempt from copayment responsibilities:

- Foster children
- Children enrolled in Medicaid (Under age 19) (Ages 19 and over may have a copay)
- Pregnant women (includes 60-day period after pregnancy ends)
- Kentucky Medicaid beneficiaries who have reached their cost share limit for the quarter
- Individuals receiving hospice care

Member Buy Up

Avēsis Lab Option Providers:

- When the member elects to purchase an eyeglass frame directly from you, Avēsis makes NO payment for a frame or dispensing and may NOT be billed for these services. You will collect your retail fees directly from the member.
- When the member elects to purchase progressive or any other non-covered lenses directly from you, Avēsis makes NO payment for lenses or dispensing and may NOT be billed for these services. You will collect your retail fees directly from the member.

In-House Fabrication Providers:

- When the member elects to purchase an eyeglass frame directly from you, Avēsis makes NO payment for a frame or dispensing and may NOT be billed for these services. You will collect your retail fees directly from the member.
- When the member elects to purchase progressive lenses directly from you, Avēsis makes NO payment for lenses or dispensing and may NOT be billed for these services. You will collect your retail fees directly from the member.

Eyeglass Replacement

Eligible members up to age 21 are able to receive one pair of replacement eyeglasses per year if their initial pair is lost or broken and their refractive error meets the minimum requirement of +/- .50 in any of the four meridians or .50 diopter vertical prism or a total of 2.00 diopter of lateral prism.

19.9 Eye Medical/Surgical Procedures and Services

Eye medical/surgical procedures are covered when medically necessary and rendered by a Provider duly licensed to practice his/her profession in Kentucky and eligible to participate in the Kentucky Medicaid Program.

Medically Necessary Services are those healthcare services and supplies that are medically appropriate and:

- Necessary to meet the basic health needs of the member
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or healthcare coverage organizations or governmental agencies
- Consistent with the diagnosis of the condition
- Required for means other than convenience of the member or his/her physician
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Of demonstrated value
- Of no more intense level of service than can be safely provided

Surgical Center and Medical Claims

Passport Health Plan will be responsible paying Ambulatory Surgical Center (ASC) and hospital surgical facility costs, in addition to the cost of anesthesia associated with the surgery performed in the surgical facility. Avēsis will facilitate the process of securing surgical facility authorizations for procedures that require professional authorization as well. Please submit the necessary facility information with the request for surgical authorization to Avēsis, and Avēsis will then forward the information to Passport Health Plan upon approval of the request. **It is important to note** that Avēsis is responsible for paying claims for all routine eye care and medical services rendered by the Provider but will not be paying the surgical facility or the associated anesthesia costs. Passport Health Plan is responsible for processing the surgical facility and anesthesia claims.

Should you have:

Eye and medical/surgical and anesthesia claims submission questions, please phone Avēsis' Provider Services at 844-346-7782.

- Surgical facility and anesthesia claims (when the claim is for anesthesia administered in the facility) submission questions, please contact Passport Health Plan

Emergency Care

Providers are responsible for facilitating emergency treatment, as needed. Members may need to be directed to their primary care provider or an eye care specialist or sub-specialist.

Should you require assistance identifying a participating eye care specialist or sub-specialist for a referral, please call the Member Services Department at 800-578-0603. Member Services are available from 7:00 a.m. to 7:00 p.m. (EST), Monday-Friday.

Eye Medical Emergency

An eye medical emergency is a situation where the member has or believes there is a current, acute

crisis involving the eye(s) that could be detrimental to his/her health if not treated promptly.

To confirm whether the situation is a true emergency, you must speak with the member or the member's authorized representative to determine the problem and take the necessary actions. If you and the member determine that it is a true eye care emergency (a situation that cannot be treated simply by medication and, that left untreated, could affect the member's eye health), then you may either: A) render services in the office to treat the emergency, if appropriate, or B) assist the patient in obtaining proper care from another Avēsis participating Provider, outpatient urgent care facility, or hospital emergency room, if the condition warrants emergency room treatment. If the emergency is considered life-threatening, the member should contact 911 or the nearest local emergency services unit.

Once treatment has been rendered, please contact or instruct the member to contact his/her primary care physician or family physician immediately.

19.9 Forms

- Avēsis Locum Tenens Form
- EFT Form
- Mastercard Payments Form

Avēsis Locum Tenens Form

Locum Tenens is a Latin phrase that means: Holding the Place. Locum Tenens arrangements are between providers whereas one provider will temporarily replace another provider for a period of time. After Avēsis receives notification of a Locum Tenens situation, the Participating Provider may submit a claim under his/her name and provider number and receive payment for covered benefits for services provided by the locum tenens provider.

Please complete below:	
Tax Identification Number:	
Provider Name and NPI:	
Locum Tenens Name and NPI:	
Contact Person:	
Contact Phone Number:	
Effective Date for Locum Tenens Relationship:	
Reason for Locum Tenens Relationship:	
Expected Termination Date for Locum Tenens Relationship:	

The following documentation **must** accompany this form:

1. A written notice from the owner of the facility to Avēsis in advance advising of the use of a locum tenens provider. If the use of the locum tenens is due to the incapacitation or death of the Participating Provider, then the letter must be signed by the executor of the estate.
2. Copy of the Locum Tenens provider's license
3. Proof of professional liability of one million dollars per occurrence/three million aggregate minimum

In accordance with the Provider Agreement, the Participating Provider may pay the locum tenens provider for his/her services on a per diem basis or similar fee for time basis.

The locum tenens provider may not provide services to members for a period of time in excess of sixty (60) continuous days within a twelve (12) month period.

Electronic Funds Transfer Agreement

I, _____, as the authorized party, allow Avēsis to deposit funds into my Bank Account using

ACCOUNT REGISTRATION INFORMATION	
Name	Tax ID Number
Address	NPI Number
City, State, Zip Code	
BANK INFORMATION	
Bank Name	<input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other _____
Address	
City, State, Zip Code	
Routing #	Account #

Electronic Funds Transfer. *A voided check is included with this agreement* to facilitate this process. This transfer is for my convenience. All claims filed are in accordance with the terms of the executed Avēsis Agreement and the Avēsis Provider Manual. All funds shall be deposited into my bank account at the banking institution shown above. The bank shall provide to Avēsis the applicant's most current address upon request.

I understand that:

1. The origination of electronic credits to my account must comply with the provisions of United States law.
2. Avēsis and the Bank will share limited account and contract information as necessary to affect these credits.
3. By signing this document, I agree to accept the terms of the Electronic Funds Transfer.
4. This form must be processed by Avēsis before funds will be transferred into my Bank Account.

Printed Name of Account Holder

Signature of Account Holder

Date

Printed Name of Joint Account Holder

Signature of Joint Account Holder

Date

Telephone Number:

Please fax to: 855.828.5654

Avēsis Third Party Administrators, Inc.

Attention: Finance

A VOIDED CHECK MUST BE INCLUDED WITH THIS APPLICATION

Avēsis E-Payment through MasterCard® Enrollment Form

When you sign up, Avēsis will provide your MasterCard® payment transaction notification via email or fax each time your invoices are due.

Return to: Provider E-Payment Enrollment Return fax number: 855-828-5654

Return email to: ProviderEPayment@avesis.com

Enroll Us Now

Enrollment Instructions:

To begin receiving your remittance via email/fax through our MasterCard® payment program, please email or fax the information as requested below and include all fields in the body of the email. You can complete this form and return via the email address or fax shown above.

Practice Name: _____

NPI #: _____

Specialty: ☐ Vision ☐ Dental ☐ Hearing

Accounts Receivable Contact Information:

Contact Name and Title: _____

Contact Phone Number: _____

Preferred method of remittance: ☐ E-mail ☐ Fax

Email Address*: _____

Fax Number*: (_____) _____

*An e-mail address and/or fax number are required for the payment transaction notification. We recommend a central email address, such as accountsreceivable@practicename.com.

Provider Manual

Section 20.0

Acronyms

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Acronym - Definitions



20.0 Acronyms

Acronym	Definition
AAP	American Academy of Pediatrics
ABMS	American Board of Medical Specialties
ACOG	American College of Obstetricians & Gynecologists
ADA	American Dental Association
ADA	American Diabetes Association
AFDC	Aid to Families with Dependent Children
AHFS	American Hospital Formulary System
AIS	Alternative Intermediate Services
AMA	American Medical Association
APRN	Advanced Practice Registered Nurse
CAQH	Council for Affordable Quality Healthcare
CHFS	Cabinet for Health and Family Services
CLAS	Culturally and Linguistically Appropriate Standards
CLIA	Clinical Laboratory Improvement Amendments
COA	Category of Aid
COE	Category of Eligibility
CMS	Center for Medicare and Medicaid Services
DCBS	Department for Community Based Services
DD	Developmental Disabilities
DEA	Drug Enforcement Agency

Acronym	Definition
DME	Durable Medical Equipment
DMS	Department for Medicaid Services
DOS	Date of Service
DRA	Deficit Reduction Act
DRE	Dilated Retinal Exam
DRG	Diagnosis Related Group
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EOB	Explanation of Benefits
EPSDT	Early Periodic, Screening, Diagnosis and Treatment
ER	Emergency Room
ERA	Electronic Remittance Advice
FDA	U.S. Food and Drug Administration
FFS	Fee-for-Service
FFSEs	Fee-for-Service Equivalents
FQHC	Federally Qualified Health Centers
GHAA	Group Health Association of America
HANDS	Health Access Nurturing Developing Services
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services Department
HIPAA	Health Information Portability and Accountability Act
IBNRs	Incurred But Not Reported Claims
ID	Identification Card

Acronym	Definition
ICF	Intermediate Care Facility
IVR	Interactive Voice Response System
KCHIP	Kentucky Children's Health Insurance Program
KHC	Kentucky Health Choices (a.k.a. Ky Health Choices)
KTAP	Child and Family Related Medical Cases
LEP	Limited-English Proficiency
LOS	Length of Stay
LPCC	Licensed Primary Care Center
MAID	Kentucky Medicaid Identification Number
NCCI	National Correct Coding Initiative
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NHLBI	National Heart, Lung and Blood Institute
NIH	National Institute of Health
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
OTC	Over-the-Counter
PA	Prior Authorization
PBM	Pharmacy Benefits Manager
PCC	Primary Care Center
PCP	Primary Care Provider/Practitioner
PCS	Patient Clinical Summary
PCSU	Provider Claims Service Unit

Acronym	Definition
PE	Presumptive Eligibility
PHI	Protected Health Information
PASSPORT	Passport Health Plan
PIC	Program Integrity Coordinator
PMPM	Per Member Per Month
POIS	Passport Online Information Service
PRP	Provider Recognition Program
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assessment Program Improvement
QDWIs	Qualified Disabled Working Individuals
QI	Quality Improvement
QMBs	Qualified Medicare Beneficiaries
RBRVS	Resource Based Relative Value Scale
RHC	Rural Health Center
RN	Registered Nurse
SCMBs	Specified Low Income Medicare Beneficiaries
SOBRA	Sixth Omnibus Budget Reconciliation Act
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TIN	Tax Identification Number
TPA	Third Party Administrator
TPL	Third Party Liability

Acronym	Definition
UHC	University Health Care, Inc.
UM	Utilization Management
UPL	Upper Payment Limit
USP	United States Pharmacopeia
USPDI	United States Pharmacopeia Dispensing Information
VFC	Vaccines for Children
WIC	Women, Infants, and Children

