# Passport Advantage
# Provider Manual
# Section 2.0
# Administrative Procedures

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# 2.0 Administrative Procedures
## 2. 1 Provider Enrollment

### 2.1.1 Initial Application Process
To begin the application process and join the Passport Advantage provider network, first call our Provider Services Department at (844) 859-6152. We will send you a provider application packet and work with you to become a participating Passport Advantage network provider.

Passport Advantage policies and procedures regarding selection and retention do not discriminate against providers based on a practitioner's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or types of patients including those who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification. Passport Advantage does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.

Passport Advantage has developed a systematic method for assessing practitioner applicants against the health plan's credentialing standards. Passport Advantage enrolls providers in compliance with the "Any Willing Provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270 and in accordance with Center for Medicare & Medicaid Services (CMS) provider eligibility requirements. A practitioner cannot enroll, re-enroll or otherwise remain active in Passport Advantage provider network if:

- The practitioner has active sanctions imposed by Medicare or Medicaid,
- If required licenses and certifications are not current,
- If money is owed to the Medicare or Medicaid Program,
- If practitioner has opted out of Medicare program or
- If the Office of the Attorney General has an active fraud investigation involving the practitioner or
- The practitioner otherwise fails to satisfactorily complete the credentialing process.

### 2.1.2 Medicare Opt-Out
Physicians or other practitioners who have opted out of Medicare are not eligible to participate in Passport Advantage.

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

**Practitioners**
To begin the enrollment process, practitioners must submit the following documents, as applicable:

1. Two signed Participating Provider Agreements
2. Practice Demographic Form
3. Add A Practitioner Form
4. Medicare certification letter with effective date of certification

**Organizational Providers**

To begin the enrollment process, organizational providers must submit a complete application, which includes the following as applicable:

- Two signed Participating Provider Agreements.
- Completed facility/ancillary service application including the credentials verification release statement.
- Medicare certification letter with effective date of certification.

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

Please contact the Provider Services department at (844) 859-6152 to check the status of your application.

## 2.1.5 Credentialing Process

Passport Advantage has developed a systematic method for assessing providers compliance with credentialing standards. Upon receipt of all application materials, we will initiate primary source verification. Following the verification of credentials, Passport's Chief Medical Officer/designated Medical Director and/or Credentialing Committee reviews each application for participation.

Passport Advantage is unable to initiate the credentialing review until we receive a completed and signed application with attachments. Please allow between 45 to 90 days from date a complete application is received.

Should Passport Advantage decide to deny, suspend, or terminate a provider from participation with Passport Advantage, the provider will receive notification of the decision. The notification will include:

- the reasons for the denial, suspension, 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.

Providers who are already credentialed with Passport Health Plan (Kentucky Medicaid) do not need to repeat the credentialing process to participate in the Passport Advantage network.

## 2.1.6 Reimbursement and the Credentialing Process

Providers seeking participation in the Passport Advantage network who have successfully completed contracting and credentialing will be reimbursed at the participating provider rate, starting from the date Passport Advantage received a complete application packet (*clean*

*application date*). However, before rendering services to our members, it is advised providers wait to receive confirmation from Passport Advantage of their completion of the credentialing process, including approval into Passport Advantage network. If the Credentialing Committee denies participation, any claims paid during the interim will be recouped, and unpaid claims will be denied.

Providers can begin submitting claims for services provided to Passport Advantage members once they have been notified of their approval into the Passport Advantage network and have received their assigned Provider ID number. Providers are required to submit all claims within 180 days of service.

### 2.1.7 Providing Services Prior to Becoming a Credentialed Passport Advantage Provider

If a provider determines a member must be seen prior to receiving a Provider ID number, the provider must obtain an authorization from Passport Advantage's Utilization Management department to receive payment for services. Please note that an authorization for service does not guarantee payment.

### 2.1.8 Re-credentialing Process

Passport Advantage re-credentials its practitioners and organizational providers, at a minimum, every three years. Failure to return required re-credentialing documents in a timely fashion can 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 practitioner.

In addition, Passport Advantage conducts ongoing monitoring of Medicare and Medicaid sanctions as well as licensure sanctions or limitations. Providers who become participating and subsequently have restrictions placed upon their license or are sanctioned by a professional licensing board will be reviewed by the Credentialing Committee to determine the provider's continued participation in the Passport Advantage provider network.

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

## 2.2 Provider Appeals

### 2.2.1 Types of Appeals

#### 2.2.1.1 Credentialing Denial, Suspension, or Nonrenewal of Provider Contracts

A provider who is denied participation in the Passport Advantage Network, who is suspended from the network or who has a provider contract that is not renewed may appeal that action in writing within 30 days from the date of the notice advising the provider of the action.

### 2.2.1.2 Payment Disputes for Participating Providers

Participating providers in the Passport Advantage network do not have appeal rights for payment disputes. Please see Section 13.4.3.

### 2.2.1.3 Payment Disputes for Non-participating Providers

A non-participating provider may file a standard appeal of a denial of payment within 60 calendar days from the notification date if the provider completes a waiver of liability statement that states that the provider will not bill the member regardless of the outcome of the appeal.

The timeframe for Passport Advantage to complete the appeal starts when the waiver is received. If Passport Advantage receives an appeal from a non-contracted provider without a waiver, Passport Advantage will attempt to contact the provider to obtain the waiver. If no waiver is received within 60 days of Passport Advantage's receipt of the appeal letter, Passport Advantage will dismiss the appeal and forward the dismissal and documentation to the Independent Review Entity (IRE).

Please submit the waiver of liability to:
Passport Advantage
5100 Commerce Crossings Drive
Lousiville, KY 40229

### 2.2.1.4 Administrative Denials for Timely Notification

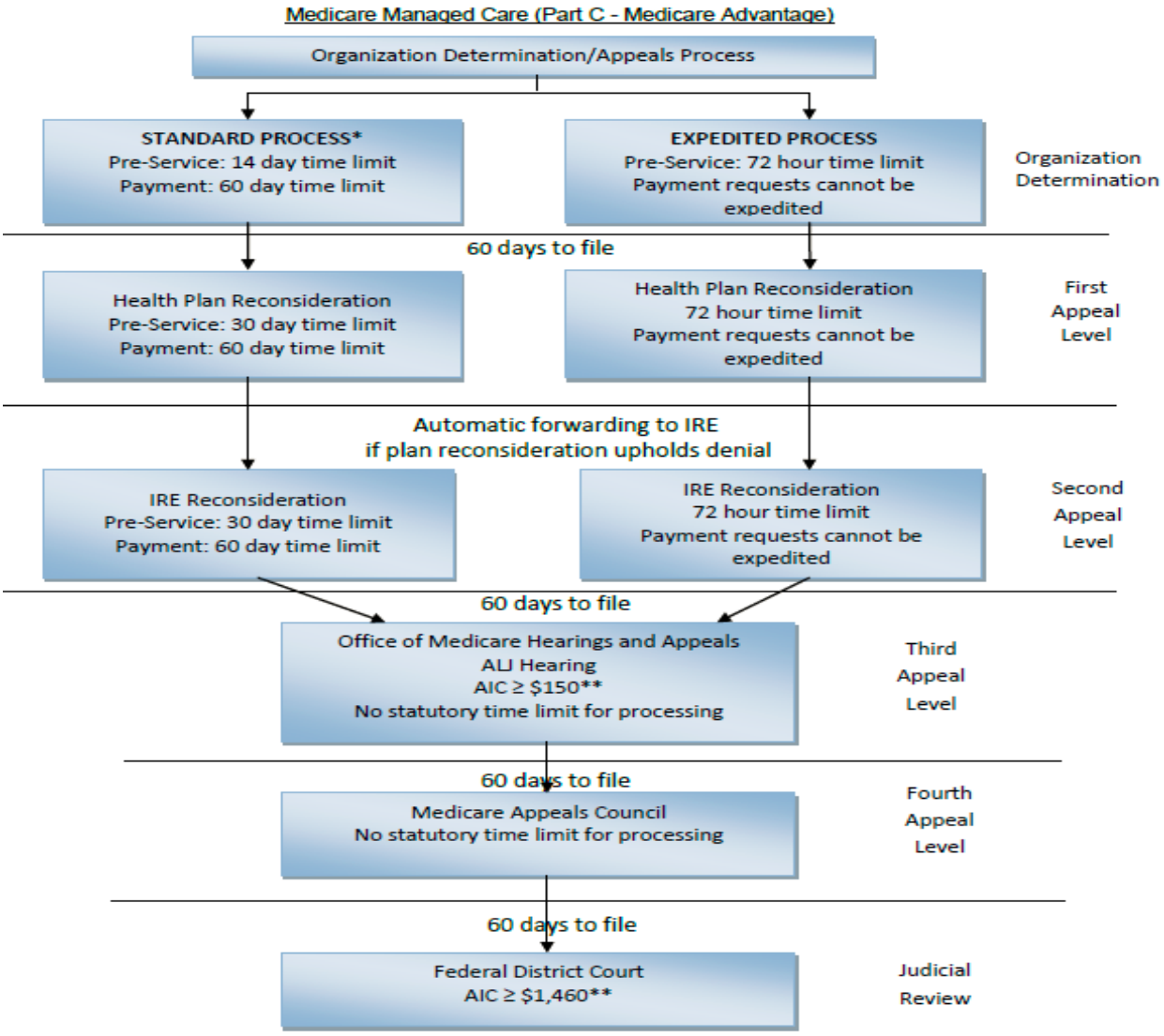
When Passport Advantage denies a request for a clinical service because of untimely notification by the provider, the provider may appeal the denial in writing within 60 calendar days of notice of the denial.

## 2.2.2 Organization Determinations

An organization determination is a decision made by Passport Advantage with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

There are five levels of appeal of an organization determination, including judicial review. The following chart, created by CMS, sets forth the time frame for filing and deciding each level of appeal.




AIC = Amount In Controversy / ALJ = Administrative Law Judge / IRE = Independent Review Entity
*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be processed within 60 days.
**The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2015.

### 2.2.2.1 Standard Reconsideration of Organization Determination

Participating providers in the Passport Advantage network do not have the right to appeal an organization determination on their own behalf. Participating and non-participating providers may appeal an organization determination on behalf of the member only. Non-participating providers may appeal an organization determination as a party to the determination if they have an appealable interest in the proceeding. If a non-participating provider seeks a standard reconsideration determination for the purposes of payment only,

the provider must sign a waiver of liability formally agreeing to waive any right to payment from the member. Please see Section 2.5.1.3.

A treating physician may request a standard pre-service reconsideration on behalf of the Member without submitting a representative form if the provider first gives notice to the member. If the Member's PCP submits a reconsideration request, Passport Advantage will not verify Member notice. If the reconsideration request comes from an in-network or non-contract physician and the Member's records reflect that the Member has previously visited that physician, Passport Advantage can choose not to verify Member Notice. If Passport Advantage has no record of a previous relationship between the Member and the provider requesting the reconsideration, Passport Advantage will make reasonable efforts to confirm the provider has given the Member appropriate notice.

Reconsideration of an organization determination must be filed within 60 calendar days from the date of the notice of the organization determination. If a request for reconsideration is made after 60 calendar days and no good cause for late filing is provided, Passport Advantage will forward the request to the IRE for dismissal. Upon written request, Passport Advantage can extend the time frame for filing the request for reconsideration with a showing of good cause for the delay. If Passport Advantage denies a request for a good cause extension, we will forward the case to the IRE.

Passport Advantage will provide the parties to a reconsideration a reasonable opportunity to present, in person or in writing, evidence and allegations of fact and law related to the issues in dispute.

All reconsiderations will be reviewed by someone who was not involved in making the initial decision. If the denial was based on lack of medical necessity, a board-certified physician with expertise in the appropriate medical field who was not involved in the initial denial will conduct the clinical review.

A standard reconsideration is completed within 30 calendar days for a pre-service request and 60 calendar days for post-service request.

Up to a fourteen (14) calendar day extension may be requested by the member, member's representative or Passport Advantage. Passport Advantage will provide prompt written notification regarding Passport Advantage's decision to take up to a fourteen (14) calendar day extension.

The party filing a request for reconsideration may withdraw the request in writing at any time before the decision is mailed. If the withdrawal is received after the case has been forwarded to the IRE, then Passport Advantage will forward the withdrawal request to the IRE.

### 2.2.2.2 Expedited Reconsiderations of Organization Determinations

An expedited reconsideration of a non-authorized service may be requested. An expedited reconsideration is deemed necessary when a member is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, can result in any of the following:

- Placing the health of the member or, with respect to a pregnant woman, the health of the member or the unborn child in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

Denied requests for expedited reconsideration will be automatically transferred to the standard reconsideration process. For denied requests for expedited reconsideration, Passport Advantage will promptly give oral notice of the denial of the request and within three calendar days of the oral notification, send written notification that:

- Explains that Passport Advantage will automatically transfer and process the request using the 30-day time frame for standard reconsideration;
- Informs the member of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the reconsideration;
- Informs the member of the right to resubmit a request for an expedited reconsideration and if the member obtains physician's support indicating that applying the standard time frame for making a determination would seriously jeopardize the member's life, health, or ability to regain maximum function, the request will be expedited automatically;
- Informs the member about the grievance process and time frames

An expedited reconsideration will be completed as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.

### 2.2.2.3 Reconsideration Determinations:

If Passport Advantage does not find completely in the member's favor, the Appeals Department will notify the member and/or representative in writing that the reconsideration has been denied and the case file will be forwarded to the IRE for an appeals review within 24 hours of the determination.

The member and/or representative will be notified telephonically immediately with a written notification within 24 hours to explain that the case was forwarded to the contractor.

### 2.2.2.4 Independent Review of the Organization Determination

When Passport Advantage affirms the organization or coverage determination (in whole or in part), a written explanation with the complete case file will be submitted by Passport Advantage to the Independent Review Entity (IRE) within the appropriate timeframes.

The member and/or representative will be informed of how to contact the IRE if they want to submit additional evidence.

If the IRE upholds the Passport Advantage decision, the notice from the IRE will inform the member of their right to a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration

### 2.2.2.5 Administrative Law Judge Review of the Organization

### Determination

If the amount in controversy meets the current threshold requirement, any party to the reconsideration except Passport Advantage may further appeal the case by requesting a hearing with an ALJ. To request a hearing, the member or representative sends the request in writing to the address in the IRE notice letter within 60 calendar days from the letter.

## 2.2.2.6 Medicare Appeals Council (MAC) Review of the Organization Determination

Any party may request a review of the determination after the ALJ ruling by submitting a request to the Medicare Appeals Council within 60 days of receipt of the ALJ decision. The request should identify the parts of the ALJ decision the party disagrees with and state the reasons for the disagreement. Passport Advantage should be notified of any request for a MAC review. The MAC can grant or deny the request for review. If it grants the request, it can either issue a final decision or dismissal, or remand the case to the ALJ with instructions on how to proceed with the case.

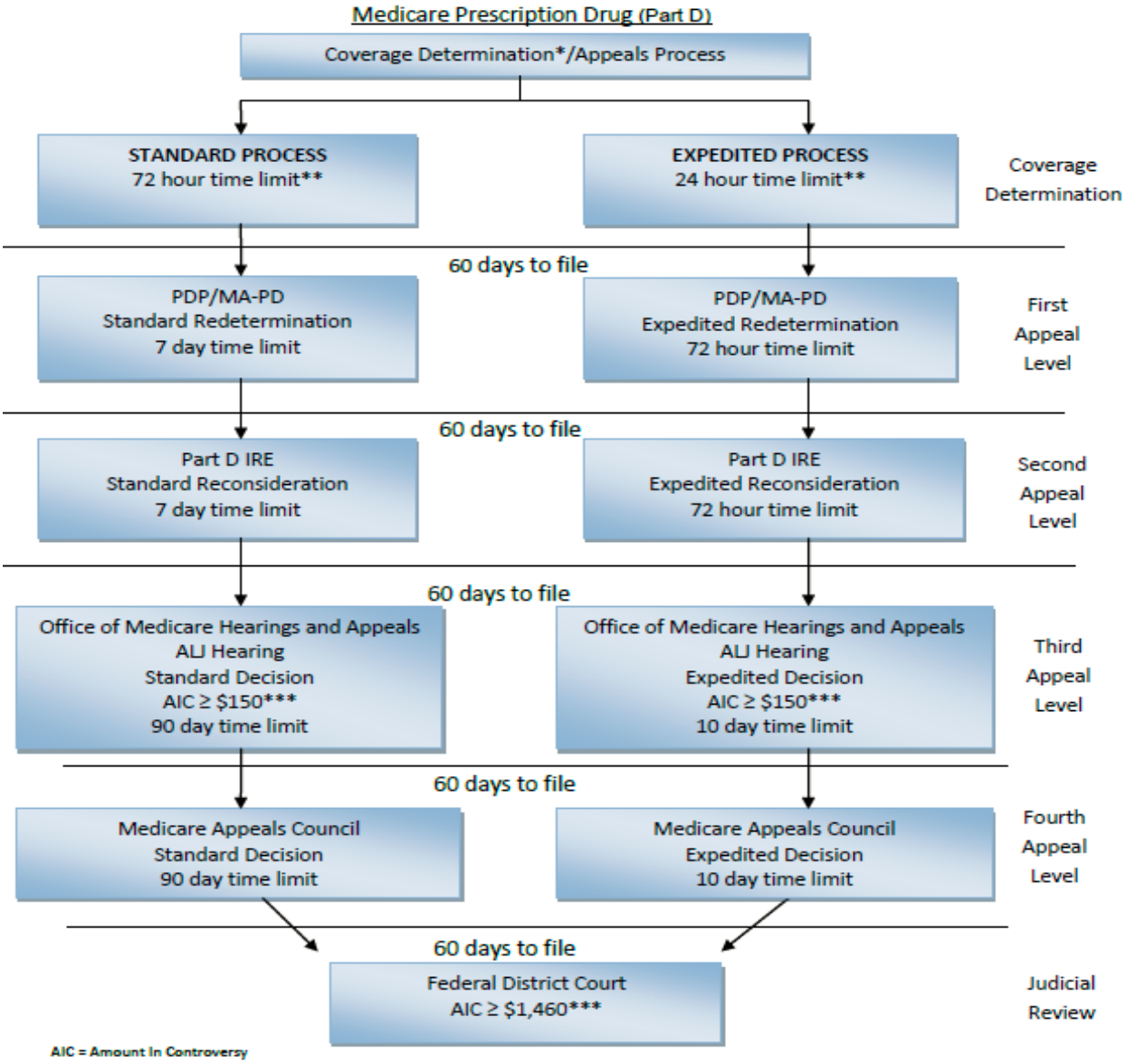
## 2.2.2.7 Judicial Review of the Organization Determination

Any party may request a judicial review of the case if the claim(s) amount is within the dollar threshold. The dollar threshold limit includes the same member claims that the MAC has acted on and must be within the timely limit for all claims or when the MAC denied the parties request for review. A party cannot obtain judicial review unless the MAC has acted on the case, either in response to a request for review or on its own motions.

Judicial review cases must be filed in the District Court of the United States in the judicial district where the member lives or where Passport Advantage has its principal place of business within 60 calendar days from the MAC decision.

## 2.2.3 Coverage Determinations

A coverage determination is any decision made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled. There are also five levels of appeal, including judicial review, of an adverse coverage determination. The following chart, created by CMS, sets forth the timeframes for filing and deciding each level of appeal.




AIC = Amount In Controversy
ALJ = Administrative Law Judge
IRE = Independent Review Entity
MA-PD = Medicare Advantage plan that offers Part D benefits
PDP = Prescription Drug Plan
*A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, by the enrollee's appointed representative or by the enrollee's physician or other prescriber.
**The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.
***The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2015.

### 2.2.3.1 Redetermination of Coverage Determination

A prescribing physician or other prescriber may request a standard or expedited redetermination of a coverage decision on behalf of the member without being appointed as the member's representative. Before requesting a standard request on behalf of the enrollee, the physician or other prescriber must first provide notice to the member that he or she is making the request. If the request is made by the member's PCP or another provider whom

records indicate the member has previously seen, Passport Advantage does not have to verify that the provider notified the member.

### 2.2.3.2 Standard Redetermination

The member, the member's representative or the prescribing physician or other prescriber may request a standard redetermination in writing within 60 calendar days from the date on the written coverage determination denial notice. Passport Advantage can extend the time frame for filing the request based on good cause. A request for extension must be in written and include the reason for the delay. The party who files the request for redetermination may withdraw that request at any time before the decision is mailed.

Passport Advantage will provide the party a reasonable opportunity to present evidence and allegations of fact or law in person or in writing.

All redeterminations will be conducted by someone who was not involved in the initial coverage determination. If the original denial was based on lack of medical necessity, on a determination that insufficient information was received, or on a determination that the drug was not reasonable and necessary, the redetermination will be performed by a physician with expertise in the field of medicine that is appropriate for the issue.

Passport Advantage will make all reasonable and diligent efforts to obtain the necessary medical records and information to make the determination, but if Passport Advantage cannot obtain that information, then Passport Advantage will make its decision based on the available information.

Passport Advantage will provide written notice of a standard redetermination decision as expeditiously as the member's health requires, but not more than 7 calendar days from the date the request was received.

### 2.2.3.3 Expedited Redeterminations

An expedited redetermination may be requested when applying the standard time frame could seriously jeopardize the member's life, health, or ability to regain maximum function. The party must submit an oral or written request for an expedited redetermination of the coverage determination within 60 calendar days from the date of the notice of the coverage determination.

Passport Advantage can extend the timeframe to request an expedited redetermination for good cause. If Passport Advantage denies a request for an expedited appeal, it will automatically transfer the request to a standard redetermination process and provide oral notice of that decision.

If Passport Advantage approves the request to expedite the redetermination, Passport Advantage will complete the expedited redetermination as expeditiously as the member's health condition requires, but no more than 72 hours after receiving the request.

### 2.2.3.4 Redetermination Decisions

Adverse redetermination decisions are not automatically forwarded to the IRE. An enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber on the enrollee's behalf can request an IRE reconsideration of a coverage determination. The request must be submitted in writing to the IRE within 60 calendar days from the date of the notice of the redetermination unless the IRE grants a good cause extension. The party who requests the reconsideration can withdraw the request before the IRE mails the decision. The IRE is final and binding on the member and Passport Advantage unless the member files a request for a hearing before an ALJ.

### 2.2.3.5 Administrative Law Judge

A prescribing physician or other prescriber can only request a hearing with an ALJ on behalf of the member if the provider is the member's representative and submits the proper representation documentation with the request. The request for an ALJ hearing must be submitted in writing to the address identified on the IRE decision letter within 60 days from the date of the IRE decision, unless the ALJ grants a good cause extension.

### 2.2.3.6 Medicare Appeals Council (MAC) Review

A prescribing physician or other prescriber can only request a MAC review on behalf of the member if the provider is the member's representative and submits the proper representation documentation with the request. The member or the member's representative can request a review of the ALJ decision by submitting a request to the Medicare Appeals Council within 60 days of receipt of the ALJ decision. The request should identify the parts of the ALJ decision the party disagrees with and state the reasons for the disagreement. A request for a standard MAC review must be in writing. A review for an expedited MAC review can be submitted orally or in writing.

### 2.2.3.7 Judicial Review

For judicial review, the enrollee must file a civil action in the federal district court in the judicial district where the member lives or where Passport Advantage has its principal place of business within 60 days of receipt of the MAC decision if the amount in controversy meets the threshold amount.

### 2.2.4 Where to Send Appeals/Reconsiderations

Send written appeals to the following address or fax number:

By Mail: Passport Advantage
Attn: Appeals Coordinator
5100 Commerce Crossings Drive
Louisville, Kentucky 40229

By Fax: **(**502)213-8906

**For Part C Preservice and Expedited Reconsiderations (Non- post Service)**

Send to the following address:

Passport Advantage
Attn: Appeals Department
10008 North Dale Mabry Hwy
Tampa, FL 33618

**For Part D Coverage Determinations and Reconsiderations**
Send to the following address:

Passport Advantage Pharmacy Services
950 N. Meridian Street, Suite 600
Indianapolis, IN 46204

# 2.3 Provider Terminations/Changes in Provider Information

## 2.3.1 Provider Terminations

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

For terminations by primary care providers, please indicate on Provider Termination Request Form the provider to whom your members need to be reassigned. If no provider is specified, Passport Advantage will reassign member to another primary care provider in your group. If no group provider is available, the member will be reassigned to a primary care provider nearest the member's residence. A Passport Advantage Provider Relations Specialist will coordinate notification to the member of your intent to termination the network.

If a solo specialist or an entire specialty group decides to terminate the contract, a list of members receiving ongoing health care from the specialist and/or group must be sent to Passport Advantage within 60 days of the termination date for member notification to occur. Within 30 calendar days, the Provider Relations Specialist will work with the specialist to ensure a smooth transition for the members' continued care.

Termination requests need to be submitted using the **Provider Termination Request Form** which can be found on our website @ www.passportadvantage.com. The Provider Termination Request Form can be returned to Passport Advantage via email to passport.credentialing@passporthealthplan.com, by fax to (502) 585-7987 or by mail to ATTN: Provider Enrollment 5100 Commerce Crossing Dr. Louisville, KY 40229.

## 2.3.2 Changes in Provider and Demographic Information

**Providers are required to provide timely written notice to Passport 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 or telephone numbers.

Information changes need to be submitted using the **Provider Information Change Form** which can be found on our website at www. Passportadvantage.com. The Provider Information Change Form can be returned to Passport Advantage via email to passport.credentialing@passporthealthplan.com, by fax to (502) 585-7987 or by mail to ATTN: Provider Enrollment 5100 Commerce Crossing Dr. Louisville, KY 40229.

**Reimbursement can be affected if changes are not reported to Passport Advantage in a timely manner**.

## 2.4 Member assignment to a Primary Care Provider

Passport Advantage members select a Primary Care Provider (PCP). The PCP provides Passport Advantage members with primary and preventive care. PCPs also arrange and coordinate other medically necessary services when appropriate.

At the time of enrollment, Passport Advantage members are asked to select a PCP from our list of participating Providers. The member will be advised of their right to change the PCP for various reasons such as, but not limited to:

- The member becomes dissatisfied,
- Moves to a new location, or
- The Provider leaves the office location.

The member can request a change by calling Passport Advantage Member Services. The new PCP will be effective on the date the change is requested.

In the case of voluntary provider termination, providers should complete a Provider Termination form and submit to Passport Advantage's Enrollment department. Passport Advantage will notify the member no less than thirty (30) days prior to the effective date of termination. The member will be sent a letter explaining that his/her provider is leaving the Passport Advantage network, and the member will need to contact Member Services to select a new PCP. In the case of involuntary terminations, or if the Provider fails to provide a 30 day notice, Passport Advantage will notify affected members.

For members that do not contact Passport Advantage to select a new PCP, one will be assigned. If a member's request for a change in PCP that is denied, the member will be advised of their appeal rights. The member will receive a written notice of the final decision made by Passport Advantage.

## 2.5 Member Identification Cards

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


This card is issued by Passport Advantage and allows members to access:
Part A = Hospital stays
Part B = Doctor office visits
Part D = Prescription drugs

In addition to the Passport Advantage ID card, each member is issued a Medicaid ID card by the Kentucky Department for Medicaid Services (DMS).


The Kentucky Medicaid ID card represents eligibility for the Medicaid program and is also used to obtain Medicaid-covered services that are not covered through the Kentucky Medicaid managed care organizations, such as transportation. Members are requested to keep their Kentucky Medicaid ID card along with their Passport Advantage ID card.

### 2.5.1 Member Eligibility Verification

Participating providers are responsible for verifying member eligibility prior to rendering services. To verify member eligibility, please call Passport Advantage's Provider Services.

**Please note: Passport Advantage ID cards are not returned to Passport Advantage when a member becomes ineligible.** Therefore, the presentation of a Passport Advantage ID card is not sole proof that a person is currently enrolled in Passport Advantage.

**Please request a picture ID to verify the person presenting is indeed the person named on the ID card. Services can 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 Advantage's Fraud, Waste and Abuse Hotline at (866) 833-9718.**

# 2.6 Title VI Requirements: Translator and Interpreter Services

## 2.6.1 Title VI

Title VI of the Civil Rights Act (1964) is Federal legislation that requires any organization receiving Federal financial assistance to provide services to all persons without discrimination based on race, color, or national origin.

Under Title VI and EXECUTIVE ORDER 13166 (DHHS), **all Plan providers are required to:**

- Take reasonable steps to ensure meaningful access to your services by Limited English Proficient (LEP) persons.
- Provide oral language assistance at no cost to Plan members with Limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. **This includes providing competent language interpreters, upon request.**

*Note:*
*Friends and family, should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language. The refusal of a qualified interpreter should be noted in the member's record.*

*People who are completely bilingual are fluent in two languages. They are able to conduct the business of the workplace in either of those languages (medical interpreters have been professionally trained). Bilingual staff can assist in meeting the Title VI and Executive Order 13166 requirement for federally-conducted and federally-assisted programs and activities to ensure meaningful access to LEP persons.*

Additionally, under the Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards (HHS Office of Minority Health); the following must be provided:

- Offer language assistance to individuals who have Limited English Proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Providers may contact the Passport's Health Equity Educator at (502) 585-8251 or e-mail clas@passporthealthplan.com for additional information or to schedule an on-site training.

### 2.6.2 Cultural Competencies Training/Resources

Passport Advantage Health Equity Educator offers the following training materials and resources. Contact the Health Equity Educator at (502) 585- 8251, e-mail clas@passporthealthplan.com, or visit our web site, www.passportAdvantage.com/providerfor more details.

**Onsite Trainings/Resources**

Our Health Equity Educator is a resource for Title VI/CLAS Standards and assists providers in reaching and maintaining compliance. We offer free trainings for your office staff.

**Provider Office Materials**

In addition to our Provider mailings, we also offer provider office signage to assist your office staff in complying with Title VI. These materials are available online or by calling the Health Equity Educator.

**Translated Member Materials and TDD/TYY Lines**

Many member materials, including the *Member Handbook*, are available in Spanish and alternative formats such as Braille, audio, and large type. Members can call Member Services for copies in these formats.

Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf (TDD), the Passport Advantage's TDD/TYY numbers for Member Services is 711.

**Discounts for Telephonic and Video Interpretation**

Passport Advantage also contracts with a telephonic and video interpretation vendor, to offer our providers a discounted rate. Please contact Language Services Associates (800) 305-9673 for more information.

## 2.7 Member Release for Ethical Reasons

A participating provider is not required to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs, or ethical principles. If such a situation arises, the provider should contact Passport Advantage Customer Service at 844-859-6152. A Passport Advantage Medicare Specialist will work with the provider to review the member's needs and refer the member to another appropriately qualified provider for care.

## 2.8 Member Rights and Responsibilities; Passport Advantage Responsibilities

Members are informed of their rights and responsibilities through the Evidence of Coverage (EOC). The EOC is available by visiting Passport Advantage's website at www.passportadvantage.com. Passport Advantage providers are expected to respect and honor members' rights.

### 2.8.1 Passport Advantage members have the following rights:

- To receive information in a way that works for the member (in languages other than English, in Braille, in large print, or other alternate formats)
- To be treated with fairness and respect at all times
- To look at and get a copy of their medical records as permitted by law
- To make an advance directive
- To receive timely access to covered services and drugs
- To choose a PCP
- To have personal health information protected as required by law
- To receive information about Passport Advantage, its network of providers, and covered services
- To receive information about why something is not covered
- To join providers in making decisions about their health care
- To make complaints and to ask us to reconsider decisions we have made
- To report any instances of being treated unfairly or rights not being respected
- To receive more information about member rights

### 2.8.2 Passport Advantage members have the following responsibilities:

- To get familiar with covered services and the rules that must be followed to receive these services
- To report any other health insurance coverage or prescription drug coverage
- To advise their doctor and other health care providers that they are enrolled in Passport Advantage
- To assist their health care providers by giving them information, asking questions, and following through with their care
- To be considerate
- To pay what is owed, if there is a member responsibility remaining
- To report if they move
- To call Passport Advantage Customer Service with questions or concerns

*Members should consult their Evidence of Coverage for more information on their rights and responsibilities.

### 2.8.3 Passport Advantage has the following responsibilities:

- To provide information in a way that works for the member (in languages other than English, in Braille, in large print, or other alternate formats)
- To not discriminate against members based on race, sex, religion, ethnicity, national origin, mental or physical disability, age, sexual orientation, genetic information, or any other basis prohibited by law
- To treat members with fairness and respect at all times
- To ensure members get timely access to covered services and drugs
- To protect the privacy of personal health information

- To provide information about Passport Advantage, its network of providers, and covered services
- To support the members right to make decisions about their care
- To provide members with more information about their rights upon request

# 2.9 Member Grievances and Appeals

## 2.9.1 What is a Grievance?

A Part C grievance is defined by federal law as a complaint or dispute, other than an organization determination, that expresses dissatisfaction about any aspect of the operations, activities, or behavior of a Provider or Medicare Advantage Organization, regardless of whether any remedial action may be taken. Passport Advantage members have the right to file a grievance orally or in writing.

A Part D grievance is any complaint or dispute that isn't a request for coverage or reimbursement for a drug. Passport Advantage members may file a Part D grievance either verbally or in writing.

A Part C or Part D grievance must be filed no later than 60 calendar days after the event / incidence; however, Quality of Care complaints have no time constraints. The only exception to the 60-day requirement is when a member provides good cause please see CMS guidelines (Chapter 13, 70.3).

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.

## 2.9.2 What is an Appeal?

An appeal is a formal way of asking us to review and change an organization determination that Passport Advantage has made. 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.

For more information, please see Section 2.7.

## 2.9.3 Who Can Members Contact about Grievances or Appeals?

Members may call Passport Advantage Customer Service for assistance at 844-859-6152. Members may also contact Medicare directly with their questions and/or concerns at 800-633-4227. If Members want assistance from someone that is not connected with us, members may contact the State Health Insurance Assistance Program (SHIP) at 877-293-7447.

*More information regarding Member Grievances and Appeals is available in the Evidence of Coverage (EOC). You may review by visiting www.passportadvantage.com/coverage.

*For information regarding Provider Appeals, please refer to Section 2.2 of this manual.