Passport Advantage
Provider Manual
Section 5.0
Utilization Management

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PASSPORT ADVANTAGE (HMO SNP)

5.0 Utilization Management

5.1 Utilization Management

Utilization Management (UM) is the process of influencing the continuum of care by evaluating the appropriateness and medical need of health care services, procedures, and facilities according to evidence-based criteria or guidelines and under the provisions of the available health benefits. All participating providers are required to obtain authorization from Passport Advantage's UM department for inpatient services and specified outpatient services.

Failure to submit an authorization or failure to submit an authorization in a timely manner can result in a denial of services. An authorization is not a guarantee of benefits. Member eligibility should be verified for every request of service.

- UM Department hours of availability:
  - Monday through Friday, 8:00a.m. to 6:00 p.m. EST (except weekends and designated holidays).
- How to contact the UM Department:
  - Phone: (866) 813-1721.
  - Fax: (844) 602-4629.

Passport Advantage provides the opportunity for a provider to discuss a decision with the Medical Director, to ask questions about a UM issue, or to seek information from the nurse reviewer about the UM process and the authorization of care by calling (866) 6813-1721. After business hours or on holidays, a provider can leave a message, and a representative will return the call the next business day.

5.2 Review Criteria

Passport Advantage utilizes InterQual Level of Care Criteria® criteria and medical policies approved by the Chief Medical Officer (CMO) and the Quality Improvement Committee.

Behavioral Health (BH) Clinical Guidelines are developed internally by a panel comprised of board certified physicians, with specialties in adult, child and geriatric psychiatry as well as addictionology and psychology. The BH criteria are developed and applied based on current principles, the local, state and federal delivery system, and processes by the Chief Medical Officer.

These guidelines are only made available as allowed under licensing restrictions, copyright limitations, trademark consideration or materials labeled "for internal use only."

Passport Advantage will abide by Medicare's local and national coverage determinations. At the request of the provider, the UM department Clinical Coordinator or the Senior Medical Director will provide a free copy of the specific review criteria within one (1) business day after a request. If the guidelines are not available for distribution , the practitioner has the option to request the guideline be read over the telephone, or review the guidelines at the Passport Advantage office.

5.3 Prior Authorization Requirements

The assigned authorization number should be provided on the claim form.

The following list of services or procedures require authorization from Passport Advantage UM department:

Service
Advanced Radiology
Bariatric Surgery (inpatient or outpatient)
Cosmetic Surgery (inpatient or outpatient)
DME with E1399 codes
DME: Authorization if billable amount is > $500.00 per line, rent or purchase (All items requiring customization or accessories require prior authorization)
Enterals
Experimental /Investigational
Home Health Services
Home Health Services (Nurse, Aid, SW)
Home Infusion
Hospital Observation
Hyperbaric Therapy
Inpatient Hospitalization / Rehabilitation (initial and concurrent review; acute and scheduled admissions) CMS Inpatient only codes will apply
Inpatient Mental Health and Substance Abuse Rehabilitation (initial and concurrent review; acute and scheduled admissions)
Intensive Cardiac and Pulmonary Rehabilitation Services: inpatient and outpatient
Neuropsychological Testing
Non-participating providers
Orthotics: Authorization if billable amount is > $500.00 per line
Ostomy Supplies
Outpatient Therapy: PT, OT and Speech
Pain Management Injections
Part B medications: Authorization of billable is > $400.00, excluding chemotherapy
Prosthetics : Authorization if billable amount is > $500.00 per line
Psychiatric Residential Treatment Facility
Skilled Nursing Facility (SNF) ; Swing Beds
Stem Cell / Progenitor Retrieval
Substance Abuse Detoxification (in IMD and/or psych unit)
Transplants, excluding cornea

To determine if a service or supply such as a cosmetic procedure are considered benefit exclusions, contact the Passport Advantage UM department.

Time frames for review submission:

- Elective / Scheduled (inpatient or outpatient): Prior to the service date
- Emergent / Urgent Services (inpatient or outpatient): Within one business day of the service or admission

Passport Advantage UM will accept the hospital's or the attending physician's request for prior authorization of elective hospital admissions; however, neither party should assume that the other has obtained prior authorization.

5.4 Organization Determinations

Passport Advantage does not reward any provider or other individuals conducting utilization review for issuing adverse determinations. Utilization Management decisions are based only on appropriateness of care and service and existence of coverage. Passport Advantage does not give a financial reward or incentive to any provider, practitioner, employee or any other individual associated with making utilization decisions for issuing denials or for encouraging inappropriate underutilization of care.

To speak with the Medical Director or to the nurse reviewer regarding an organization determination, contact UM at (866) 813-1721.

5.4.1 Organization Determination

An organization determination is any determination 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; or
- Payment for any health services furnished by a provider other than Passport Advantage that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Passport Advantage; **or**
- Passport Advantage'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; **or**
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment; **or**
- Failure of Passport Advantage 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.

5.4.2 Expedited Organization Determinations

An enrollee, an enrollee's representative, or any physician (regardless of whether the physician is affiliated with Passport Advantage) can request that Passport Advantage expedite an organization determination when the member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain

maximum function in serious jeopardy.

5.4.3 Adverse Organization Determination

An adverse organization determination is when Passport Advantage decides not to provide or pay for a requested service, in whole or in part, or if it Passport Advantage discontinues or reduces a service.

A request for an authorization can be denied for failure to meet local and national guidelines, protocols, or medical policies or administrative policies as outlined in the Provider Agreement or in this Provider Manual.

5.4.4 Administrative Adverse Organization Determination

Failure to provide notification within one business day of an emergency admission or observation stay or prior to an elective service can result in an administrative adverse determination (administrative denial) of the requested admission or elective service. An administrative denial can be issued for failure to obtain a prior authorization of an elective service, procedure, or admission. It can also be issued for failure to notify Utilization Management within one business day of an emergency service, procedure, or admission.

5.4.5 Medical Necessity Adverse Determination

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

5.4.6 Timeframes for Organization Determinations

Service	Timeframe for Review Determination
Pre-service, non-urgent	14 calendar days of request
Pre-service, urgent	72 hours of request
Concurrent, non-urgent	If a request to extend a course or treatment beyond the period of time or number of treatments previously approved does not meet the definition of urgent care, the request can be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service or post service).
Concurrent, urgent (request must be made at least 24 hours before the expiration of the authorization)	24 hours of request

Concurrent, urgent : request NOT made within 24 hours before expiration	72 hours of request
Post-service	30 calendar days of request

Time frames can be extended if requests are incomplete.

5.5 Member Appeals

There are five (5) levels of appeals available to Medicare members enrolled in Passport Advantage after an adverse determination has been rendered. These levels are followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity. Dollar threshold can apply at specific appeal levels.

5.5.1 Authorized Representative

A member, a member's representative, or physician (regardless of whether the physician is affiliated with Passport Advantage) are the only parties who can request that a determination be reconsidered.

Providers who represent members can either be appointed or authorized to act on behalf of the member during any of the levels of the appeals process. A member can appoint any individual to act as his or her representative.

For a provider to be appointed by a member, both the member making the appointment and the provider accepting the appointment must sign, date, and complete a representative (CMS-1696 Appointment of Representative) or other equivalent written notice. An "equivalent written notice" is one that:

- Includes the name, address, and telephone number of member;
- Includes the enrollee's HICN or Medicare Identifier (ID) Number;
- Includes the name, address, and telephone number of the individual being appointed;
- Contains a statement that the member is authorizing the representative to act on his or her behalf for the appeal at issue, and a statement authorizing disclosure of individually identifying information to the representative;
- Is signed and dated by the member making the appointment; and
- Is signed and dated by the individual being appointed as representative, and is accompanied by a statement that the individual accepts the appointment.

5.5.2 Steps of the Member Appeals Process

Step 1: Standard and Expedited Reconsideration

Submitting a request for a reconsideration:

A member can submit a written reconsideration within sixty (60) calendar days after the initial organization determination notice was issued. The member can also file a reconsideration if they believe Passport Advantage neglected to furnish them with a written initial organization

determination. Members will receive an acknowledgement letter upon receipt of the reconsideration.

The 60 calendar-day limit may be extended for good cause upon written notification by the member.

Members can request an expedited reconsideration of a non-authorized service. 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

Opportunity to Present Evidence:
Members have an opportunity to present evidence in person or in writing. Any evidence presented will be taken into account when making a decision.

Appropriate Expertise:
Passport Advantage reconsideration decisions will be made by a person(s) not involved in the initial decision. All reconsiderations of adverse organization determinations for lack of medical necessity will be made by a Medical Director with appropriate expertise in the field of medicine appropriate for the service requested.

Review Completion:

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

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 can be requested by the member, member's representative or Passport Advantage. Passport Advantage will provide the member prompt written notification regarding Passport Advantage's decision to take up to a fourteen (14) calendar day extension. All extensions must be well documented.

Determinations:

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

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

Step 2: Independent Review of the Appeal

When Passport Advantage affirms the adverse 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 will inform the member of their right to a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration

Step 3: Administrative Law Judge (ALJ)

The member can further appeal the case by requesting a hearing with an Administrative Law Judge (ALJ). To request a hearing, the member notifies the IRE in writing within 60 calendar days from the letter.

Step 4: Medicare Appeals Council (MAC) Review

Any party can 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 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.

Step 5: Judicial Review

Any party can 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.

5.6 Provider Reconsiderations

Participating providers in the Passport Advantage network do not have appeal rights.

Passport Advantage will allow the following provider reconsiderations:

For standard (non-expedited) pre-service reconsideration, a physician who is providing treatment to a member can, upon providing notice to the member, request a standard reconsideration on the member's behalf without submitting a representative form.

A provider can request a standard reconsideration for an administrative adverse determination within sixty (60) calendar days after the initial organization determination notice was issued. The reconsideration should contain the reason the authorization was not requested within required time-frames.

5.7 Reconsideration Records

Passport Advantage maintains a record of all reconsideration cases for at least ten (10) years. Passport Advantage also complies with the member's request for a free copy of the case file, including but not limited to a copy of supporting medical records and other pertinent information used to support the decision. Passport Advantage abides by all applicable Federal and state laws regarding confidentiality and disclosure of member's health information.

5.8 Special Procedures

5.8.1 Hospital Discharge Decisions

A member who is a hospital in-patient has a right to request an immediate review (fast track appeal) by the Quality Improvement Organization (QIO) when Passport Advantage and/or the hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary. If the member disagrees with the discharge decision, he or she has until midnight on the day of the scheduled discharge to decide to pursue an appeal.

The treating hospital should provide the member both on admission and at discharge the "Important Message from Medicare" notice. This Medicare notice explains that the member has the right:

- To receive Medicare covered services, including necessary hospital services and services the member may require after discharge;
- To be involved in any decisions about their hospital stay;
- To report quality of care concerns to the QIO
- To appeal if the member believes they are being discharged too soon. The notice also explains how to file an appeal.

A member who requests an immediate review of the discharge decision will be provided a Detailed Notice of Discharge. Passport Advantage or the delegated facility will deliver a Detailed Notice of Discharge (the Detailed Notice) to the member as soon as possible, but not later than noon of the day after the QIO's notification. The Detailed Notice provides the member with the clinical and coverage reasons as to why the current level of care is no longer reasonable or medically necessary. It must provide information specific to the member's situation.

The QIO is an organization comprised of practicing doctors and other health care experts under contract to the Federal government. The QIO reviews complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs reviews continued stay denials for members receiving care in acute inpatient hospital.

5.8.2 Notice of Medicare Non-Coverage (NOMNC)

A Medicare provider or health plan must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services not later than two days before the termination of services.

All Passport Advantage Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), Comprehensive Outpatient Rehabilitation Facilities (CORF) and Hospice Providers must deliver the Notice of Medicare Non-Coverage (NOMNC) to Passport Advantage members (or their authorized representative) when the member's Medicare covered service(s) are ending.

The NOMNC form must be provided to the member:

- No later than two (2) days before the proposed end of coverage;
- At the time of admission if the member's covered services are expected to be less than two (2) days in duration.
- Providers should fax the NOMNC to Passport Advantage: (502) 212-6910.

If a member refuses to sign the notice, the provider can annotate the NOMNC to indicate the refusal, and the date of refusal is considered the date of receipt of the notice. If the NOMNC is signed by an authorized representative, Passport Advantage will need documentation from the provider regarding the authorized representative.

5.8.3 Fast Track Appeal

Members have the right to a fast-track appeal when they disagree that their covered skilled nursing facility (SNF), home health agency (HHA), comprehensive outpatient rehabilitation facility (CORF) or Hospice services should end. CMS contracts with Quality Improvement Organizations (QIOs) to conduct fast-track appeals.

The Member shall receive a Notice of Medicare Non-Coverage (NOMNC) at least two days in

advance of the proposed service termination date. The provider is responsible for delivering the NOMNC.

The member can request a fast-track appeal by following the instructions described on the NOMNC. On the day the QIO notifies Passport Advantage of the member's fast-track appeal, Passport Advantage will furnish a Detailed Explanation of Non-coverage (DENC) explaining why services are no longer covered. The review process will generally be completed within less than 48 hours of the member's request for a review.