2018 Provider Manual
Section 1.0 - Introduction

1.1 Provider Welcome
1.2 Overview of Passport Health Plan
1.3 The Passport Advantage Program
1.4 Member Eligibility
1.5 Important Telephone Numbers

Section 2.0 – Administrative Procedures

2.1 Provider Enrollment
2.2 Provider Appeals
2.3 Provider Terminations/Changes in Provider Information
2.4 Member Assignment to a Primary Care Provider (PCP)
2.5 Member Identification Cards
2.6 Member Release for Ethical Reasons
2.7 Members’ Rights and Responsibilities; Passport Advantage Responsibilities
2.8 Member Grievances and Appeals
2.9 Title VI Requirements: Translator and Interpreter Services

Section 3.0 – Provider Roles and Responsibilities

3.1 Confidentiality
3.2 The Role of the Primary Care Provider (PCP)
3.3 The Role of Specialists and Consulting Providers
3.4 Responsibilities of All Providers

Section 4.0 – Office Standards

4.1 Appointment Scheduling Standards
4.2 After-Hours Telephone Coverage
4.3 Member to Practitioner Ratio Maximum
4.4 Provider Office Standards
4.5 Medical-Record-Keeping & Continuity & Coordination of Care Standards
4.6 Hospital Care
4.7 Communication Guidelines

Section 5.0 – Utilization Management
5.1 Utilization Management
5.2 Review Criteria
5.3 Prior Authorization Requirements
5.4 Organization Determinations
5.5 Member Appeals
5.6 Provider Appeals
5.7 Appeal Records
5.8 Special Procedures

Section 6.0 – Referrals
6.1 Referral Process
6.2 Member Self-Referral (Direct Access)
6.2 Referral for Urgent Care

Section 7.0 – Benefit Summary and Exclusions
7.1 Benefit Summary
7.2 Services Covered Outside Passport Advantage
7.3 Non-Covered Services

Section 8.0 – Quality
8.1 Quality Improvement Plan Description
8.2 Clinical Practice Guidelines
8.3 STAR Ratings
8.4 Quality of Care Concerns
8.5 Practitioner Sanctioning Policy

Section 9.0 – Emergency Care
9.1 Emergency Care
9.2 Out-of-Service Area Care
9.3 Urgent Care Services

Section 10.0 – Care Management

10.1 Model of Care
10.2 Medication Therapy Management
10.3 Care Coordination
10.4 Complex Case Management

Section 11.0 – Outpatient Pharmacy Services

11.1 Prescribing Outpatient Medications
11.2 Covered Outpatient Pharmacy Benefits
11.3 Drug Authorization Procedure
11.4 Part D Transition Policy

Section 12.0 – Transitions of Care

12.1 Transitions of Care

Section 13.0 – Provider Billing Manual

13.1 Claim Submissions
13.2 Provider/Claims Specific Guidelines
13.3 Understanding the Remittance Advice
13.4 Denial Reasons and Prevention Practices
13.5 Timely Filing Requirements
13.6 Appeal and/or Refunds

Section 14.0 – Forms

14.1 Provider Network Management
14.2 Claims
14.3 Utilization Management
14.4 Pharmacy

Section 15.0 – Dental Services

15.1 Important Contact Information
15.2 Administrative Procedures
15.3 Standards of Care for Dental Offices
15.4 Dental Benefits
15.5 Care Management and Utilization Management
15.6 Authorization Procedures and Requirements
15.7 Dental Provider Billing Manual

Section 16.0 – Program Integrity

16.1 Program Integrity
16.3 Provider Insight and Training
Passport Advantage
Provider Manual
Section 1.0
Introduction

Table of Contents

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Introduction</td>
</tr>
<tr>
<td>1.2</td>
<td>Provider Welcome</td>
</tr>
<tr>
<td>1.3</td>
<td>Overview of Passport Health Plan</td>
</tr>
<tr>
<td>1.4</td>
<td>The Passport Advantage Program</td>
</tr>
<tr>
<td>1.5</td>
<td>Member Eligibility</td>
</tr>
<tr>
<td>1.6</td>
<td>Important Telephone Numbers</td>
</tr>
</tbody>
</table>
1.0 Introduction
1.1 Provider Welcome
We are pleased you are part of the Passport Advantage (HMO SNP) provider network. As a participant in this network, you have the opportunity to make Passport Advantage beneficial for both you and your patients, our members. We know our network providers are essential to delivering high quality, cost-effective medical services. 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. We are committed to earning your ongoing support and look forward to working with you to provide the best service possible to Passport members.

This Provider Manual explains the policies and administrative procedures of the Passport Advantage program. Please use it as a guide to answer questions about member benefits, claim submission, and other questions you may have. This Provider Manual also outlines operational processes to be used by you and your staff. It will describe and clarify the requirements identified in your Provider Contract. Updates to this Provider Manual will occur on a periodic basis. As your office receives communications from us, it is important that you and/or your office staff read the eNews, Passport News and other special mailings. Please retain these updates with this Provider Manual so you can integrate any changes into your practice. All Passport Advantage provider materials, including the Provider Manual and Provider Directory, are available online at www.passportadvantage.com.

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

1.2 Overview of Passport Health Plan
Passport Health Plan is a non-profit health maintenance organization licensed in the Commonwealth of Kentucky.

Passport offers two managed care health plans, Passport Health Plan (Medicaid) and Passport Advantage (Medicare). Our Medicare Advantage plan serves the four counties of: Jefferson, Bullitt, Hardin and Nelson

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.

Passport’s Organizational Values are:
- Integrity
- Collaboration
- Community
- Stewardship
1.3 The Passport Advantage Program
Passport Advantage is a Medicare Advantage Dual-Eligible - Special Needs Plan (HMO SNP) for active full Medicaid beneficiaries that are also enrolled in Medicare Parts A & B. Passport’s Organizational Values are:

- Integrity
- Collaboration
- Community
- Stewardship

1.4 Passport Advantage Program
Passport Advantage is a Medicare Advantage Dual-Eligible - Special Needs Plan (HMO SNP) for active full Medicaid beneficiaries that are also enrolled in Medicare Parts A & B. At the time of enrollment, Passport Advantage members may qualify for low income subsidy (LIS), otherwise known as "Extra Help."

As a Special Needs Plan, Passport Advantage coordinates both Kentucky Department of Medicaid Services (Medicaid) and The Center for Medicare and Medicaid services (Medicare) benefits for young, disabled, and senior Medicare-eligible members. Passport Advantage covers the following:

Part A = Hospital stays  
Part B = Practitioner office visits  
Part D = Prescription drug benefits

In addition, Passport Advantage works with a member’s Kentucky Medicaid benefits to offer comprehensive benefits. Members are also offered supplemental benefits such as hearing aids, vision benefits for frames and lenses and dentures and monthly Over The Counter (OTC) allowance. The benefit details are outlined in the member’s EOC and Summary of Benefits.

1.5 Member Eligibility
Passport Advantage member eligibility can change on a monthly basis. To join Passport Advantage, persons must meet the following requirements:

- Member must be entitled to Medicare Part A and enrolled in Medicare Part B
- Member must reside in the Passport Advantage service area (counties include: Bullitt, Hardin, Jefferson, Nelson)
- Member must not have End-Stage Renal Disease (ESRD) with limited exceptions, such as if you develop ESRD when you were already a member of a plan that we offer or you were a member of a different plan that was terminated.
- Member must be eligible for Medicare and have full Kentucky Medicaid benefits as determined by Kentucky Medicaid

To confirm eligibility, and member’s PCP assignment, please call Passport Advantage Provider Services.
1.6 Important Telephone Numbers

Provider and Member Services (844) 859-6152 | TTY/TDD 711
Call this number for questions about the status of a claim, member eligibility or other Passport Advantage related questions. Provider Services is available 8:00am-8:00pm Sunday through Saturday October 1-February 15 and Monday through Friday 8:00am-8:00pm February 16-September 30.

Pharmacy (866) 693-4620
Passport Advantage’s Pharmacy Benefit Manager, CVS Caremark, is available 24 hours a day, 7 days a week. Prescribers may request prior authorizations by calling (844) 246-2930, by fax (866) 869-7043 or by mail to:
   Passport Advantage Pharmacy Services
   950 N. Meridian Street, Suite 600
   Indianapolis, IN 46204

Please use the same contact information when submitting appeals.

Utilization Management (UM)
Please call these numbers to request an authorization, retrospective review, or appeals:
- Medical: (866) 813-1721
- Behavioral Health: (866) 816-1722
- Appeals (813)452-2177

For Organizational Determinations, please use the following fax numbers:
- UM Medical Urgent: (844) 602-4628
- UM Medical Non Urgent: (844) 602-4629
- Behavioral Health UM: (844) 602-4630

Utilization Management is available Monday through Friday from 8:00am to 6:00pm.
Passport Advantage
Provider Manual
Section 2.0
Administrative Procedures

Table of Contents

2.1 Provider Enrollment
2.2 Provider Appeals
2.3 Provider Terminations/Changes in Provider Information
2.4 Member assignment to a Primary Care Provider (PCP)
2.5 Member Identification Cards
2.6 Title VI Requirements: Translator and Interpreter Services
2.7 Member Release for Ethical Reasons
2.8 Member Rights and Responsibilities; Passport Advantage Responsibilities
2.9 Member Grievances and Appeals
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 in accordance with The National Committee for Quality Assurance (NCQA) Standards and Guidelines. Passport Advantage credentials against the health plan’s standards in accordance with The National Committee for Quality Assurance (NCQA) Standards and Guidelines.

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 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 Appeals 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 form that states 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 the waiver is not received, Passport Advantage will dismiss the appeal and forward the dismissal and documentation to the Independent Review Entity (IRE).

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.

### 2.2.2.1 Standard Appeal 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 appeal 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.

A treating physician may request a standard pre-service appeal 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 an appeal request, Passport Advantage will not verify Member notice. If the appeal 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 appeal, Passport Advantage will make reasonable efforts to confirm the provider has given the Member appropriate notice.

Appeal 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 appeal 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 appeal 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 appeal a reasonable opportunity to present, in person or in writing, evidence and allegations of fact and law related to the issues in dispute.

All appeals 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 appeal is completed within 30 calendar days for a pre-service request and 60 calendar days for post-service request.

For pre-service appeals 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 appeal 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 Appeals of Organization Determinations
An expedited appeal of a non-authorized service may be requested. An expedited appeal 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 appeal will be automatically transferred to the standard appeal process. For denied requests for expedited appeal, 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 appeal;
• 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 appeal;
• Informs the member of the right to resubmit a request for an expedited appeal 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 appeal 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 Appeal 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 appeal has been denied and the case file will be forwarded to the IRE for an appeals review within 24 hours of the determination.

The provider, 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 IRE.

2.2.2.4 Independent Review of the Organization Determination
When Passport Advantage affirms the appeal 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 provider, 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 provider, member and/or representative 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 appeal 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 Part D 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.
2.2.3.1 Part D 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 Part D 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 Part D 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 Part D 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 appeal 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 appeal 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 verbally 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

For Part C Post Service Appeals
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 Appeals (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 Appeals  
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 reassigned 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 MedicareEnrollment@passport.evolenthealth.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 MedicareEnrollment@passport.evolenthealth.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  
(sample below is Passport Medicaid ID card, but member may have a different Managed Care Organization).

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 (855) 512-8500.
2.6 Language Access Requirements: Interpreter Services

2.6.1 Title VI/ Section 1557 for the ACA

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.

American with Disabilities Act: Providers cannot charge patients or other persons with hearing disabilities an extra fee for interpreter services or other communication aids and services. For telephone communications, many people who are deaf or hard of hearing use a teletypewriter (TTY, also known as a TDD) rather than a standard telephone.

Section 1557 of the Affordable Care Act (ACA): The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.

Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

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

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/provider for 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 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](http://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 verbally 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.


*For information regarding Provider Appeals, please refer to Section 2.2 of this manual.
Passport Advantage
Provider Manual
Section 3.0
Provider Roles and Responsibilities

Table of Contents

3.1 Confidentiality
3.2 The Role of the Primary Care Provider (PCP)
3.3 The Role of Specialists and Consulting Providers
3.4 Responsibilities of All Providers
3.0 Provider Roles and Responsibilities

3.1 Confidentiality

Passport Advantage endeavors to ensure both Passport Advantage and any participating providers conduct business in a manner that safeguards patient/member information in accordance with state and federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In accordance with federal and state laws, Passport Advantage has established confidentiality policies and practices for its own operation and to outline expectations to its provider network. To obtain a copy of Passport Advantage’s Notice of Privacy Practices, please visit http://www.passportadvantage.com/

All providers must comply with state and federal laws and regulations and Passport Advantage’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 HIPAA. It is the provider’s responsibility to obtain the member’s written consent to share member health information when required.

Providers are authorized to share members’ protected health information with Passport Advantage for the purpose of treatment, payment, and health care operations.

Passport Advantage and its providers/practitioners 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 Advantage and its providers/practitioners will accept special consent or authorization from persons designated or appointed by the member. Designated persons, such as parents or guardians, can authorize the release of personal health information and can obtain access to information about the member.

Passport Advantage requires only the minimum necessary member information to accomplish its purpose. Passport Advantage can request member information for treatment, payment, or health care operations. When Passport Advantage requests information or medical records, the information should be sent timely in accordance with the request.

Member information transferred from Passport Advantage to another organization as permitted by routine or special consent will be protected and secured according to Passport Advantage’s privacy
policies and procedures.

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.

Passport Advantage members have the right to appeal any Plan decision that involves issues of information confidentiality and privacy.

Passport Advantage 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 state administrative regulations.

### 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 FQHC, 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 primary health care services to individuals twenty-four (24) hours per day, seven (7) days a week.

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 OB/GYN agrees to provide and arrange for all appropriate primary and preventive care. Passport Advantage 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 can function as PCPs. The PCP serves as the member's initial and most important point of contact with Passport Advantage. This role requires a responsibility to both Passport Advantage and the member. Although PCPs are given this responsibility, Passport Advantage will retain the ultimate responsibility for monitoring PCP actions to ensure they comply with Passport Advantage policies and CMS requirements.

Specialty providers can 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, appointed representative, appointed family, the specialist, and Passport’s medical director. The member has the right to appeal such a decision in the formal appeals process.

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

- Maintaining continuity of the member's health care;
• Usage of evidence based clinical practice guidelines recognized by the Plan;
• Adhering to Cultural and Linguistic Standards;
• Participating in Care Coordination of the member. Including but not limited to; encouraging member to complete Health risk Assessment (HRA), collaboration with the member’s Individualized Care Plan (ICP) and involvement with the member’s Interdisciplinary Care Team (ICT) through the Plan;
• Exercising primary responsibility for arranging and coordinating the accessibility 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;
• Following CMS and NCQA’s guidelines for medical record documentation;
• Discussing Advance Medical Directives with all members as appropriate. See Section 3.4.4. Advanced Directives;
• Screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders;
• 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 3.2 ;
• Arranging and/or providing necessary inpatient medical care at participating hospitals.
• Providing health education and information; and,
• Passport Advantage 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 Advantage’s Utilization Management department at (866) 813-1721 to request an authorization for a non-participating specialist.
• Adhering to required annual compliance training

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 Advantage, 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 Advantage 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.

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 at www.passportadvantage.com (beginning September 2018). Even with this verification, there are times when CMS retroactively terminates eligibility for certain members. In these circumstances, Passport Advantage can 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 Advantage members. Members never need a referral for behavioral health services. If you need assistance establishing behavioral health services for a Passport Advantage member, we encourage you to call our Behavioral Health Services, (800) 866-816-1722.

**Member Dismissals from PCP Practices**

Primary care providers (PCP) have the right to request a member's disenrollment 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 disenrollment 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.

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

Disenrollment requests must be submitted to Passport by mail and/or to their assigned provider representative with Passport. Requests must include provider name, provider group ID number, member name, member ID number, reason for disenrollment request, and effective date. Members are not disenrolled 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 Network Management Specialist.

Disenrollment requests meeting Passport’s requirements as stated above are reviewed, determined to be appropriate, and processed within five business days of receipt by Provider Services. The disenrollment 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.
3.3 The Role of Specialists and Consulting Providers

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 Advantage’s Utilization Management department.

Except for Direct Access Services and a few other services (see Section 6.2 “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 for the specialty care provider to communicate 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.

3.4 Responsibilities of All Providers

3.4.1 Professional Manner

The provider must provide services in a manner consistent with professionally recognized standards of care and in a culturally competent manner.

3.4.2 Provider and Member Communications

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

3.4.3 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 Advantage policy. HIPAA privacy and security audits will be performed to assure compliance as required by Passport Advantage’s contract with the CMS.

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

3.4.2 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. Providers must comply with all state and federal laws regarding treatment consent. In accordance with Title VI, all vital documents (i.e. treatment and consent forms) must be translated into patient’s preferred language.

3.4.3 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 42 CFR 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 can make a written living directive that does any or all of the following:

- Directs the withholding or withdrawal of life-prolonging treatment.
- Directs the withholding or withdrawal of artificially provided nutrition or hydration.
- Designates one or more adults as a surrogate or successor surrogate to make health care decisions on his or her behalf.
- Directs the giving of all or any part of his or her body upon death for any of the following reasons: medical or dental education, research, advancement of medical or dental science, therapy, or transplantation.
A living will form is included in KRS 311.625. The form can be reviewed at http://www.lrc.ky.gov/krs/311%2D00/625.pdf.

A copy of the living will can also be obtained through the Office of the Attorney General website at http://ag.ky.gov/civil/consumerprotection/livingwills/Pages/default.aspx. Advance directives can 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 patient 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 patient.
- Spouse of the patient.
- Adult child of the patient (or the majority of the children).
- Parents of the patient.
- 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 Directive 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.

**3.4.4 Sanctions Under Federal Health Programs and State Law**
Participating providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or other Federal Health Care Programs are employed or subcontracted by the participating provider.

As stated in your contract, participating providers must disclose to Passport Advantage whether the provider or any staff member or subcontractor has any prior violation, fine, suspension, termination, or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Kentucky; the federal government, or any public insurer. Participating providers must notify Passport Advantage immediately if any such sanction is imposed on the provider, a staff member, or subcontractor.

The following resources are available to providers to facilitate their compliance with the above requirements:

• The Health and Human Services Office of Inspector General (HHS OIG) List of Excluded Individuals and Entities (LEIE) lists individuals and entities that are excluded from participating in the Medicare, Medicaid, and all other Federal health care programs. The LEIE can be accessed at https://exclusions.oig.hhs.gov/

• The System for Award Management (SAM) web site maintains a list of individuals and entities that have been excluded throughout the U.S. Government from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non-financial assistance and benefits. The Excluded Parties List System (EPLS), housed on the GSA web site is accessible at https://www.sam.gov/portal/SAM/

3.4.5 Suspected Child or Adult and Elder Abuse or Neglect

Cases of suspected child or adult and elder 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, local law enforcement agency, Kentucky State Police, the Commonwealth’s Attorney, or the County Attorney.

To facilitate 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 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 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 Balance Billing

As outlined in the Passport Advantage Provider Agreement, and the CMS HPMS Memo dated April 3, 2018, providers are prohibited on collection Medicare Part A and B coinsurance, copayments and deductibles from those enrolled in the Qualified Medicare Beneficiary (QMB) Program, a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B cost-sharing. For all services where a Medicare Part A or Part B coinsurance, copayment or deductible applied to the member, providers are required to bill the member’s secondary insurance provider for the additional payment.

Reference:

Please see CMS Memo: Qualified Medicare Beneficiary Information in Remittance Advice and Explanation of Benefits.
Passport Advantage
Provider Manual
Section 4.0
Office Standards

Table of Contents

4.1 Appointment Scheduling Standards
4.2 After-Hours Telephone Coverage
4.3 Member to Practitioner Ratio Maximum
4.4 Provider Office Standards
4.5 Medical-Record-Keeping, Continuity & Coordination of Care Standards
4.6 Hospital Care
4.7 Communication Guidelines
4.0 Office Standards

PCPs are required to provide coverage for Passport Advantage 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 Advantage Provider Directory, or contact Provider Services with questions regarding which providers participate in the Passport Advantage network.

Passport Advantage will contact providers on a quarterly basis to confirm or update contact information including street address, phone number, office hours and other information that affects provider availability. Providers will be contacted through mail, email and phone calls to collect this information.

Passport Advantage policy requires on-site visits at least annually to ensure compliance with CMS regulations, please see page 11 of Regulations and Guidance. Components of the following office standards will be reviewed during on-site visits to ensure compliance.

4.1 Appointment Scheduling Standards

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

1. Appointments with primary care providers (PCP) and specialists must be scheduled within 30 days for routine care and preventive care visits.

2. Appointment standards for other situations that might confront a PCP or specialist are as follows:
   - Appointments for urgent care services must be scheduled within 48 hours.
   - Non-urgent appointments requiring more immediate attention must be scheduled within 7 days.
   - Appointments for emergency care must be immediately provided.
   - Appointments for laboratory and radiology services must be scheduled within 30 days for routine care and 48 hours for urgent care.

3. Appointments with Behavioral Health Care providers must:
   - Be scheduled within 10 business days for routine care visits.
   - Be scheduled within 6 hours for non-life threatening emergencies.
   - Be scheduled within 48 hours for urgent care visits.

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
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 Advantage
5100 Commerce Crossings Drive
Louisville, KY 40229
Attention: Provider Network Management

Passport Advantage will set the maximum panel size at 1500 members per practitioner. However,
the ratio can be adjusted for practices that employ physician extenders, such as physician assistants.
Passport Advantage 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 Advantage.

4.4 Provider Office Standards

- The provider must not differentiate or discriminate in the treatment of any member
  because of the member’s race, color, national origin, ancestry, religion, health status,
  disability, sex, marital status, age, political beliefs, or source of payment.
- The office waiting time should not exceed 45 minutes.
- Appointments for members should be scheduled at the rate of 6 or less per hour per
  provider.
- Health assessments/general physicals should be scheduled within 30 days.
- Providers should have a “no show” follow-up policy. For example, the provider
  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 can 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 appropriate consent forms, as required by state and federal regulations and laws.

4.5 Medical-Record-Keeping, Continuity & Coordination of Care Standards
Passport Advantage has adopted the following medical-record-keeping standards, which cover confidentiality, organization, documentation, access, and availability of records. These standards are based on the National Committee for Quality Assurance (NCQA) and can be revised as needed to conform to new NCQA and/or federal recommendations. Compliance with these standards will be monitored annually from medical records captured via HEDIS chart review. Sample charts captured from select HEDIS measures will be reviewed for compliance with relevant clinical practice guidelines. Medical record access and confidentiality will monitored during periodic practitioner office site visit form assessment based on Passport Advantage Network policy.

4.5.1 Confidentiality of Records
• Staff receive periodic training in member information confidentiality.
• Records are stored securely and maintained in an area that is only accessible to practitioner office staff.
• 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.

4.5.2 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 non-smearable, non-erasable ink.
• Medication allergies, adverse reactions, and known allergies are prominently noted in the record.
• There is a completed 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, and obstetric histories.
• Documentation of physical examination.
• Documentation of clinical findings and evaluation for each visit.
• All entries in the medical record are signed or initialed and dated and all providers are identified by name, for providers using EMRs, the record include a time and date stamp.
• 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 an examination by a specialist is requested, there is a note from the consultant in the record.
• Consultation, lab, and x-ray reports filed in the chart are initiated 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 Advantage’s Clinical Practice Guidelines. Use of risk assessments, disease maintenance, and preventive health sheets are encouraged (see Section 19, “Forms and Documents,” for samples).
• Copies of consent forms, when applicable, are maintained in the record.
• The medical record also contains an indication of the 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 is documented in the medical record.
• Hospital discharge summaries are included in the medical record.

4.5.3 Access and Availability of Records
• Provider shall maintain a complete and accurate permanent medical record for each member to whom Hospital/Provider renders services. Provider permits Passport Advantage, on request via letter, fax or phone, access to member medical records at no cost, to inspect, review, and copy within ten working 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 Advantage 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 Provider of Choice within ten (10) business days from receipt of request at no cost to Passport or member.

• When releasing records to an entity other than the Passport Advantage, providers are first required to obtain written consent from the member.

• Providers must maintain medical records for ten (10) years.

4.5.4 Continuity and Coordination of Care
While there are some indicators of continuity and coordination of care included within the documentation standards, Passport Advantage will also assess sample 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 and in accordance with Passport Advantage’s Clinical Practice Guidelines.

• 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.

• There is a review for the under- and over-utilization of provider examinations.

• Age or disease-appropriate direct access services 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 provider appointment(s), referrals, directions, and time to return

4.6 Hospital Care
Practitioners must have admitting privileges to a Passport Advantage network hospital or facility for all patient groups for whom they are providing care. With prior written approval from Passport Advantage’s Utilization Management department, a practitioner can arrange for another participating practitioner to provide inpatient coverage.

4.7 Communication Guidelines
As discussed in Section 2.9, Title VI Requirements: Translator & Interpreter Services, federal law
requires providers to ensure that communications are effective. Please review the federal requirements.

Provide effective communication for members who have communication disabilities (i.e., vision, hearing or speech disabilities). See Americans with Disabilities Act (ADA) for Title III entities, https://www.ada.gov/effective-comm.htm.
5.1 Utilization Management
5.2 Review Criteria
5.3 Prior Authorization Requirements
5.4 Organization Determinations
5.5 Member Appeal
5.6 Provider Appeals
5.7 Appeal Records
5.8 Special Procedures
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, 8:00 a.m. to 6:00 p.m. EST (except weekends and designated holidays).
- How to contact the UM Department:

  - **Phone Numbers**
    - (866) 813-1721 Medical Authorization
    - (866) 816-1722 Behavioral Health Authorizations

  - **Fax Numbers**
    - (844) 602-4628 Medical Urgent Fax
    - (844) 602-4629 Medical Non-Urgent Fax
    - (844) 602-4630 Behavioral Health Fax

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:

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeframe for Review Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service, non-urgent</td>
<td>14 calendar days of request</td>
</tr>
<tr>
<td>Pre-service, urgent</td>
<td>72 hours of request</td>
</tr>
<tr>
<td>Concurrent, non-urgent</td>
<td>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).</td>
</tr>
<tr>
<td>Concurrent, urgent (request must be made at least 24 hours before the expiration of the authorization)</td>
<td>24 hours of request</td>
</tr>
<tr>
<td>Concurrent, urgent : request NOT made within 24 hours before expiration</td>
<td>72 hours of request</td>
</tr>
<tr>
<td>Post-service</td>
<td>30 calendar days of request</td>
</tr>
</tbody>
</table>
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 Appeal

Submitting a request for an appeal:
A member can submit a written appeal within sixty (60) calendar days after the initial organization determination notice was issued. The member can also file an appeal 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 appeal.

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

Members can request an expedited appeal of a non-authorized service. An expedited appeal 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 appeal will be automatically transferred to the standard appeal process. For denied requests for expedited appeal, 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 appeal;
- 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 appeal;
- Informs the member of the right to resubmit a request for an expedited appeal 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 appeal decisions will be made by a person(s) not involved in the initial decision. All appeals 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 appeal is completed as expeditiously as the member’s health condition requires, but no later than 72 hours after receiving the request.

A standard appeal 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 for pre-service appeals 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 appeal 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 Appeal Records
Passport Advantage maintains a record of all appeal 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.

Waiver of Liability Form
Appointment of Representative Form
Provider Appeal Form

5.6.1 Provider Appeals and Disputes
A provider appeal is a request for review of a Passport Advantage action related to the medical necessity of service provided and the provider has documented and agreed to waive the right to pursue reimbursement from the member. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously-authorized service; failure to provide services in a timely manner; failure to act within specified timeframes; denial of a request to obtain services outside the network for specific reasons. All appeals must be received in writing. See section 2.2 for additional details.

A provider dispute occurs when a contracted provider disagrees with the processing of the claims and/or have identified one or more errors related to payment of benefits. If you disagree with the payment amount or the manner in which your claim was processed, you can call Provider Claims Service Unit (PCSU) at (844) 859-6152 to inquire or submit a written request for review. Contracted providers do not have appeal rights, however, can submit a provider dispute. The dispute must be made within two years of the last process date. Non-contracted providers can appeal with a waiver of liability form within 60 days from the date of denial of a claim and/or payment. Providers appealing on behalf of member can submit their appeal in writing with an Appointment of Representative (AOR) form within 60 days from the date of denial of a claim and/or payment.

Provider Appeal Form
Attn: Appeals/Dispute Coordinator
5100 Commerce Crossings Drive Louisville, Kentucky 40229
By Fax: 502-213-8906

5.7 Special Procedures

5.7.1 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.

5.7.2 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.

5.7.3 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.
Table of Contents

6.1 Referral Process
6.2 Member Self-Referral (Direct Access)
6.3 Referral for Urgent Care
6.0 Referrals

6.1 Referral Process

Passport Advantage’s referral requirements are based on the premise that our members are best served with a primary medical home for care and oversight, where the PCP is responsible for coordinating the member’s health care.

Members must receive a referral from their PCP when they see most specialists or when they go to an Urgent Care Center. Referrals are required for urgent care centers EXCEPT: Saturday, Sunday, a national holiday, or a weekday after 4 p.m.

A referral is NOT an authorization and is not used interchangeably. The specialist must be participating with Passport Advantage. If a referral is made to a non-participating provider, an authorization is required and the PCP should verify that the specialist accepts Passport Advantage.

PCP provider’s is required to complete their own enteral process for referrals to specialists. Passport Advantage does still require referrals; just providers are no longer required to complete the Passport Advantage referral form as of 7/1/2018.

Passport Advantage 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 Advantage’s Utilization Management department.

If a referral is made following a phone call with a member, it is the PCP’s responsibility to keep a record of the referral on file. When a verbal referral is made, it is the PCP’s responsibility to follow up with the referral document. Members should not obtain a referral to a specialist when the PCP can perform the services.

6.2 Member Self-Referral (Direct Access)

There are a number of Direct Access provider types covered by Passport Advantage for which members can make appointments to a participating specialist without referrals from their PCP. These include:

- OB / GYN
- Chiropractic care
- Orthopedist
- Oncologist
- Mental health care providers
- Substance abuse providers
- Some vision care services, including diabetic retinal exams and the fitting of eyeglasses provided by ophthalmologists, optometrists, and opticians.
- Routine dental services and oral surgery services and evaluations by orthodontists and prosthodontists
- WINGS Clinic
- Specialist to test for HIV, HIV-related conditions, TB and other communicable diseases
Additional services which do not require referral:
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations
- Kidney dialysis services at a Medicare-certified dialysis facility

6.3 Referral for Urgent Care
A PCP referral is required for all urgent care visits except as indicated below:
- Saturday and Sunday
- A national holiday
- Weekday after 4 p.m.

The referral can be submitted prior to or within five (5) business days of the service.
Passport Advantage
Provider Manual
Section 7.0
Benefits Summary and Exclusions

Table of Contents

7.1 Benefits Summary
7.2 Services Covered Outside Passport Advantage
7.3 Non-Covered Services
7.1 Benefits Summary

- Benefits Summary
- Evidence of Coverage

7.2 Services Covered Outside Passport Advantage

Members can continue to receive certain health services not covered by their Passport Advantage Health Plan but covered by CMS. Members can obtain these services from any Medicare provider by using their Medicare ID number. Members choosing to obtain these services are encouraged to notify their PCP to update their medical records.

Members can find out what is covered by under these services by calling 1-800-MEDICARE (1-800-633-4227) or accessing www.medicare.gov.

7.3 Non-Covered Services

Services that are not covered by the Passport Advantage health plan include but are not limited to:

- Services and supplies that are not medically reasonable or necessary
  - This includes:
    - Hospital services that exceed the Medicare length of stay limitations
    - Therapy or diagnostic procedures that exceed Medicare usage limits.
    - Services not warranted based on the diagnosis of the beneficiary.

- Non-covered items and services
  - This includes:
    - Items and services furnished outside the United States
    - Items and services required as a result of war
    - Personal comfort items and services

- Services and supplies denied as bundled or included in the basis allowance of another service
  - This includes:
    - Indirect prolonged care
    - Physician standby services
    - Case management services

- Items and services reimbursable by other organization or furnished without charge
  - This includes:
    - Services reimbursable under automobile no-fault, or liability insurance, as well as services under worker’s compensation
    - Items and services authorized or paid by a government entity
Passport Advantage
Provider Manual
Section 8.0
Quality Improvement

Table of Contents

8.1 Quality Improvement Program
8.2 Clinical Practice Guidelines
8.3 Star Measures
8.4 Quality of Care Concerns
8.3 Practitioner Sanctioning Policy
8.0 Quality Improvement

8.1 Quality Improvement Plan Description
As part of Quality Improvement (QI), the QI Program is tailored to meet the unique needs of the DSNP population and focuses on our mission to improve the health and quality of life of our members. The QI Program identifies the processes by which Passport Advantage collects, analyzes, and reports on quality performance, including the Model of Care (MOC).

Components of Passport Advantage’s QI Plan include:
- QI Program Description
- QI Program Evaluation
- QI Workplan
- Health outcome measurement by National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) process
- Medicare Health Outcome Survey (HOS) for members
- Member satisfaction measurement by Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Chronic Care Improvement Program (CCIP)
- Quality Improvement Projects (QIP)
- Model of Care (MOC) process
- Quality Committee structure, support, and authority
- NCQA Structure and Process Measure reporting
- CMS Part C reporting
- CMS Part D reporting
- Quality of Care Concerns
- Sentinel Events
- Patient Safety Plan
- Provider Satisfaction
- Continuity and Care Coordination
- Access and Availability of Care
- Delegation Oversight
- Credentialing and Re-credentialing of providers
- Adoption and promotion of preventative health guidelines
- Adoption and promotion of Clinical Practice Guidelines (CPGs)
- Ongoing assessment of the eligible population, including special needs and cultural and linguistic needs
- Risk management

The objectives of the Passport Advantage QI Program include:
- To continually monitor key clinical and service indicators
- To analyze and aggregate data on specific provider trends related to quality of care concerns
and or sentinel events

- To monitor clinical and health management programs
- To develop programs for populations with special needs
- To conduct intervention studies in clinical and service areas that were selected based on review of data
- To perform appropriate oversight of delegated activities
- To coordinate activities related to structure and process with cross-functional areas to improve care and service
- To foster an environment that assists to help providers with improving the safety of their practices
- To evaluate the effectiveness of the QI program
- To establish a Model of Care that promotes care coordination of both physical and behavioral health

Providers can request a copy of Passport Advantage’s “Quality Improvement Program Description” or “Quality Improvement Program Evaluation” by contacting the Provider Network Department.

### 8.2 Clinical Practice Guidelines

Passport Health Plan promotes quality of care and improves the overall health outcomes for patients with chronic illness through implementation of clinical practice guidelines. These guidelines include:

- Acute Bronchitis
- Adult Obesity
- Guide to Clinical Preventive Services
- Chronic Kidney Disease
- Congestive Heart Failure
- COPD
- Diabetes
- Management of High Blood Pressure in Adults
- Substance Use Disorder
- Major Depressive Disorder
- Panic/ Anxiety Disorder
- Schizophrenia
- Substance Use Disorder

Providers may access the guidelines through our website, or request a hard copy of the guidelines by contacting Utilization Management at (571) 385-3921.

### 8.3 Star Measures

The Center for Medicare and Medicaid Services (CMS) Star Rating strategy measurement categories:
- Outcomes focusing on improvement to an enrollee's health as a result of care that is provided
- Patient experience measured from the enrollee's perspective
- Access measures reflect issues that can create barriers to receiving needed care
- Process captures the method by which health care is provided

**Weights Assigned to Individual Performance Measures**

**Table G-1*: Part C Measure Weights**

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Name</th>
<th>Weighting Category</th>
<th>Part C Summary</th>
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Table G-2*: Part D Measure Weights

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For additional information on Medicare Star Ratings: [www.medicare.gov](http://www.medicare.gov) and/or [http://go.cms.gov/partcanddstarratings](http://go.cms.gov/partcanddstarratings)

### 8.4 Quality of Care Concerns (QOCC)

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 through Provider Services at (844) 859-6152.

8.5 Practitioner Sanctioning Policy

In the event Passport Advantage identifies health care services rendered to a Passport Advantage 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 can be subject to sanctions and/or corrective actions. The National Practitioner Data Bank (NPDB) can 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 Advantage will exclude, implement a corrective action plan, and/or penalize a provider under any of the following conditions:

- Passport Advantage 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 (but are not limited to):

- 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.
- Corrective Action Plans
Passport Advantage
Provider Manual
Section 9.0
Emergency Care

Table of Contents

9.1 Emergency Care
9.2 Out-of-Service Area Care
9.3 Urgent Care Services
9.1 Emergency Care
Services for medical emergencies are covered when provided in a hospital, physician’s office or other ambulatory setting.

9.1.1 Definition
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 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; 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 can pose a threat to the health or safety of the woman or the unborn child.

9.1.2 Primary Care Practitioner 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 can help avoid after-office-hours calls or ER visits. Reviewing home treatment for common conditions, such as fever, vomiting, diarrhea, and earaches can 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.

9.2 Out-of-Service-Area Care
9.2.1 Definition
Emergency care as described in Section 10.1.1 is also a covered benefit for Passport Advantage 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.

9.3 Urgent Care Services
9.3.1 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.

Primary Care Practitioner 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, http://passportadvantage.prismisp.com/.

To request a hard copy of this listing, please contact your Provider Relations Specialist or Provider Services at (844) 859-6152
Passport Advantage Provider Manual
Section 10.0 Care Management

Table of Contents

10.1 Model of Care
10.2 Medication Therapy Management
10.3 Care Coordination
10.4 Complex Case Management
**10.0 Care Management**

Passport Advantage is a Dual Special Needs Plan (DSNP) for members eligible for both Medicare and full Medicaid benefits. During analysis of the eligible population, Passport Advantage noted the average age was 57.13 years of age*, members are disabled versus aged, and it includes a larger female population.

*Demographics are subject to change based on membership.

Members are stratified for inclusion in Care Management through the following:

- Completion of the initial Health Risk Assessment (HRA)
- Completion of the annual HRA
- Medical and pharmacy claims
- Internal plan staff referrals
- Provider referrals
- Member and/or caregiver referrals
- Medical Record Review (MRR)
- Hierarchical Condition Category (HCC) that are submitted by providers
- State-of the art stratification tool embedded in the electronic care management system
- Transition of care process

Passport Advantage’s Care Management is targeted at the most vulnerable members such as those with multiple hospitalizations, readmissions within 30 days of inpatient discharge, long-term skilled nursing facility (SNF) residents, poly and/or high risk pharmacy utilization, end of life or advanced illness, and/or members with serious mental illness (SMI).

Care Management’s aim is to promote care coordination of both the physical and behavioral health needs of our members. Passport Advantage utilizes the talents and knowledge of our associates (professional and non-professional), as well as those of our providers within the community to provide an interdisciplinary team approach for our members in order to deliver the highest quality of healthcare.

**10.1 Model of Care (population; ICT; ICP)**

Vulnerable members will be identified during completion of initial and annual HRAs, medical and pharmacy claims, care management referrals, practitioner referrals including the member’s PCP, member and/or caregiver referral, HCC/MRR results, etc. Member identification is supported by a stratification tool and recorded in the electronic care management system. Members are stratified with follow-up interventions based on their acuity level of low/moderate/high. Stratification is based on a number of factors, such as predictive models, clinical practice guidelines, co-morbidities, gaps in care, polypharmacy and/or non-adherence, and/or uncoordinated care, etc. The stratification allows Passport Advantage the ability to continually assess and identify emerging vulnerable populations and to design services to address their specific needs.

An Individualized Care Plan (ICP) is generated for each member using the best available information at the time of completion. Information sources include, but are not limited to: Health Risk Assessment Tool (HRAT), pharmacy and medical claims, member and/or caregiver interactions and preferences, etc. The ICP addresses the following essential components:
<table>
<thead>
<tr>
<th>ICP Components</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History</td>
<td>Assessment of medical, psychosocial and cognitive needs; frailty</td>
</tr>
<tr>
<td>Member Preferences</td>
<td>Language and cultural preferences for health care and communication (mail, phone); Caregiver status; Articulated stressors</td>
</tr>
<tr>
<td>Advance Medical Directive</td>
<td>Articulated member wishes and status of documentation</td>
</tr>
<tr>
<td>Member’s personal high level self-</td>
<td>Articulated goals provided by member and/or caregiver</td>
</tr>
<tr>
<td>Identified problem list and potential barriers</td>
<td>Articulated by member and/or caregiver and augmented by care management staff</td>
</tr>
<tr>
<td>Short and long term goals and interventions by priority and timeframes for reevaluation</td>
<td>Identification of member and care management system generated goals based on health status, medical/behavioral health history, care gaps and social needs as determined by systemic triggers, care manager and Intensive Care Team (ICT). Unmet goals are triggered as interventions and/or alerts to the care management team</td>
</tr>
<tr>
<td>Stratification Level</td>
<td>Determined based on available information, such as HRAT, additional assessments, pharmacy and medical claims, MMR and HCC results, care management interaction</td>
</tr>
<tr>
<td>Notes</td>
<td>Open text notes gathered by the care management team through engagement with the member and/or ICT</td>
</tr>
</tbody>
</table>

Member stratification and subsequent care plan updates are ongoing as changes in a member’s health status and/or care needs are detected. If specific goals are not met within the targeted timeframe, the care management team outreaches to the member. Through a process of discovery and addressing barriers, the care management team works with the member and/or caregiver, the PCP and/or broader ICT to determine appropriate alternative actions, revise and/or modify goals or methods utilized to achieve results. Updates are made to the member’s ICP and redistributed. Data from the Health Risk Assessment Tool, including member preferences, is integrated with other available member information, such as demographics, MMR/enrollment system, pharmacy and medical claims to form the comprehensive assessment used to develop the ICP. Care plan interventions include services and benefits covered under Medicare and Medicaid, as well as relevant community resources, such as food pantries, utility assistance, support groups, etc. Plan of care topics, barriers, goals and interventions are designed by a care manager who is either a nurse or social worker. The care plan is reviewed by other members of the care management team that comprise the Interdisciplinary Care Team (ICT). The internal ICT includes a dedicated care manager (LPN or RN), consulting physicians (medical and behavioral), an RN supervisor, and a behavioral health ICT member (Psychologist, LSW, LCSW), if not already represented by others in the ICT with a behavioral health specialty. The ICT also includes a pharmacist who is responsible for addressing medication reconciliation, adherence and patient education goals.

The member’s PCP is part of their ICT. The ICP is forwarded to the PCP for input and/or
confirmation of the member’s plan of care. The ICP is useful during office visits, so that the PCP can support the member’s goals and preferences.

The care manager discusses goals with the member and whenever possible, integrates the member’s preferences and personal goals as a basis for the ICP. If the care manager is unable to contact the member, a care plan is created based on known information. The ICP is shared with the PCP, so that Passport Advantage can be shared with the member during the next office visit. The PCP can help reinforce the importance of the member’s engagement in the care management process and encourage them to contact their care manager.

Individual care plans initially are developed and shared following a member’s enrollment into Passport Advantage, as part of the HRAT process. The care plan is again updated at the time of HRAT re-assessment, which must be completed within a year. Care plans are also updated when a member experiences a significant change in health care needs/status, and/or a transition of care occurs. Changes to the ICP are reviewed by the ICT.

Sample PCP Letter

| HomeTown Doctors  
| 123 Central Ave.  
| Any City, US 12345 |

Dear HomeTown Doctors:

Your patient, Sample Member, is a member of Our Sample Health Plan’s Model of Care Program, a plan for people with complex medical and social needs. In order to improve the care and coordination of medical services, we prepare a care plan for each member. We hope that these plans will help patients keep track of their own medical issues, improve communications with their doctors, and ultimately improve the quality of their health care.

Please modify the plan and make any revisions that you feel are medically indicated. You are welcome to call 1-123-456-789, Monday through Friday, 9 a.m. to 5 p.m., should you have any questions or comments.

Sincerely,
The ICT is a group of professionals, paraprofessionals and non-professionals who possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the member's needs, identify appropriate services, and design specialized interventions responsive to those needs. The ICT attempts to identify relevant issues, modifies interventions based on previous response, determine subsequent goals and interventions.

Composition of the ICT varies according to the member's individual care needs, which are identified during the HRAT and ICP development process. Additionally, care managers are assigned that can best meet the needs of the member. As an example, an LCSW can be assigned to a member that has a diagnosis of severe mental illness. In addition to the member and/or caregiver and their care manager, the ICT includes internal Plan resources, such as nurses (RN, LPN), psychologist, LSW or LCSW; consulting medical directors, including psychiatrist; pharmacist; and ancillary care management team members, such as care coordinators. ICT external
participants may include contracted physicians, the PCP, specialists and ancillary providers involved in the member’s treatment and community resource staff. ICT composition is determined based on the unique needs of each member and additional team participants added to address specific nuances. As an example, a member that develops cancer could benefit from having their oncologist added to the ICT and have input and review of the ICP.

Members and/or caregivers are involved in ICT activities through participation in ICT meetings and via updates from the care manager. ICT meetings are held as frequently as needed based on the member’s clinical situation and care needs. Meetings are typically conducted via phone..

10.2 Medication Therapy Management Program
Passport Advantage offers a medication therapy management (MTM) program to assist members with complex health needs. Members who qualify can receive a comprehensive medication review (CMR) through a one-on-one consultation with a pharmacist or licensed pharmacy intern under the direct supervision of a pharmacist. During the CMR, the member’s entire medication profile is reviewed (including prescriptions, OTCs, herbal supplements and samples) for appropriateness of therapy. The purpose and direction of each medication are reviewed with the member and documented on the Personal Medication List (PML). Disease-specific goals of therapy and medication-related problems are discussed with the member, as well as any member-specific questions. After the CMR, the member is mailed the standardized post-CMR takeaway letter which includes a Medication Action Plan detailing the conversation with the pharmacist or licensed pharmacy intern and a PML.

Members in the program also receive ongoing Targeted Medication Reviews (TMRs) on at least a quarterly basis. TMRs identify opportunities for interventions based on systematic drug utilization review including cost savings, adherence to national consensus treatment guidelines, adherence to prescribed medication regimens, and safety concerns. TMRs that identify drug therapy problems are categorized and triaged based on the severity of the alert. The member or provider is then contacted via phone, mail, or fax as appropriate for review of potential drug therapy changes.

As a special needs plan, Passport Advantage is required to provide this MTM program that includes quarterly TMRs and annual CMRs. Interventions resulting from these TMRs and CMRs can result in provider contact via fax, phone, or mail, when appropriate. Most provider outreach will occur via fax after a patient intervention. Faxes sent to providers will be related to medication adherence, cost-savings opportunities for members, altering therapy based on treatment guidelines, and other safety concerns.

10.3 Care Coordination
Care Coordination assists members in obtaining and coordinating needed medical and social services. The Case Manager, who is either a Licensed Practical or Registered Nurse or a Licensed Social Worker, contacts members and performs an assessment to identify specific needs. The Case Manager then creates a plan that works in conjunction with the medical plan and the member. The member’s primary care provider receives a copy of the member’s care plan along with the name and telephone number of the assigned Case Manager. Providers can contact the Case Manager with any questions or concerns. Clinical staff manages the entire care coordination program for the SNP population which includes: Health Risk Assessment Tool (HRAT) process, development of the Individualized Care Plan (ICP), facilitation of the Interdisciplinary Care Team (ICT) process,
care coordination services, care transition management and complex case management.

Providers, as well as members and other interested parties, can request care coordination. Providers can contact the Care Coordination department at (844) 859-6152

10.4 Case Management Outreach

Case management utilizes the stratification schema to design the appropriate level of outreach and follow-up. The risk stratification schema takes into account evidence of the member’s ability to successfully self-manage their health status, supports available to the member, and identified barriers to care. The ICP is generated from the assessment(s) and subsequent risk stratification. Stratification occurs on an ongoing basis, as additional information is generated following enrollment, such as pharmacy and medical claims data, interaction between case management and the member, prior authorizations, etc.

<table>
<thead>
<tr>
<th>Stratification Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Level</strong></td>
</tr>
</tbody>
</table>
| Low (Level 1) | • 60-70% of Population  
• General age and gender based needs  
• Minimal Resource needs | • HRA, ICP, ICT, Care Coordination Assessment  
• Care Coordination as needed  
• Management of Care Transitions  
• Annual Follow-up |
| Moderate (Level 2) | • 10-20% of population  
• Requiring low to moderate intervention  
• No extensive issues  
• Some resource needs;  
• guidance on self-efficacy | All of above, plus:  
• Advanced Care Planning (LPN)  
• F/up every 60 days  
• Medical & cognitive behavioral interventions  
• Self-management techniques |
| High (Level 3) | 20-30% of Population  
Significant co-morbid medical & BH needs  
Significant resource needs | All of above, plus:  
Intensive Care Management (RN, LCSW)  
Minimum outreach every 30 days  
Frequent care navigation/coordination |
Passport Advantage
Provider Manual
Section 11.0
Outpatient Pharmacy Services

Table of Contents

11.1 Prescribing Outpatient Medications
11.2 Covered Outpatient Pharmacy Benefits
11.3 Drug Authorization Procedure
11.4 Part D Transition Policy
11.0 Outpatient Pharmacy Services (Part D)
The Passport Advantage outpatient prescription drug program is administered through CVS Caremark, Passport Advantage’s Pharmacy Benefit Manager (PBM).

The PBM Help Desk provides eligibility and technical adjudication assistance to dispensing pharmacists. These services are available 24 hours a day, 7 days a week.

CVS Caremark Pharmacy Services: (866) 693-4620

11.1 Prescribing Outpatient Medications for Passport Advantage Members
Any health care provider who is a Medicare participating provider and licensed to prescribe medicines can write a prescription for a Passport Advantage member, provided it is within the scope of the provider’s medical licensure and within the terms of Passport Advantage benefits.

11.2 Covered Outpatient Pharmacy Benefits
Passport Advantage covers outpatient medications under two separate benefits: the Medicare Part B benefit and the Medicare Part D benefit. Additionally, because Passport Advantage members are eligible for both Medicare and Medicaid, some drugs that are not covered under the Medicare benefit may be covered under Medicaid.

- **Medicare Part B**: Passport Advantage covers outpatient medications under the Medicare Part B benefit according to the same coverage policies and limitations as the Medicare program.

- **Medicare Part D**: Passport Advantage also covers outpatient medications under the Medicare Part D benefit. The Medicare Part D benefit varies from one Part D sponsor to another. The Passport Advantage Part D benefit is described below in Sections 11.2.1 through 11.4.

- **Medicaid**: If an outpatient medication is not covered by Passport Advantage, it may be covered under the member’s Medicaid benefit. The Medicaid benefit varies from one plan to another. Information on Passport Health Plan’s Medicaid benefit and covered drugs can be found at [www.passporthealthplan.com](http://www.passporthealthplan.com).

11.2.1 Formulary
As required by the Medicare program, Passport Advantage has a formulary for outpatient medications covered under Passport Advantage’s Part D benefit. In general, Passport Advantage will only cover drugs on our formulary. The Pharmacy and Therapeutics Committee comprised of physicians, pharmacists, and other qualified health professionals, meets regularly to update the formulary. The Pharmacy and Therapeutics Committee reviews at least annually, each category of drugs to identify preferred drugs based upon clinical and pharmacoeconomic data to promote cost-effective, evidence-based practices.

If Passport Advantage removes drugs from the formulary, adds prior authorizations, quantity limits and/or step therapy restrictions on a drug, providers will be notified via Passport...
Advantage’s website at least 60 days prior to the effective date of the change. Prescribing providers and Passport Advantage pharmacy providers will also be notified verbally and in written form, of new drugs requiring prior authorization for coverage determination. Additionally, the formulary will be updated on Passport Advantage’s website monthly. To view the Passport Advantage formulary, visit our website at www.passportadvantage.com. To request a copy of the formulary, please contact Provider Services at 1-844-859-6152.

11.2.2 Utilization Management
For certain prescription drugs, Passport Advantage has additional requirements for coverage or limits on coverage. These include:

- **Prior Authorization**: Requires authorization from Passport Advantage in order for these drugs to be covered as a benefit.
- **Quantity Limits**: Specifies the amount of a drug Passport Advantage will cover per prescription or for a defined period of time.
- **Step Therapy**: Requires the trial of another medication prior to Passport Advantage covering the requested medication.
- **Generic Substitution**: Generic drugs are available to Passport Advantage members at a lower cost share. Members are required to use the generic version of drugs on Passport Advantage’s formulary, except in cases where the generic version is medically inappropriate, unavailable or otherwise noted on the formulary.

11.2.3 Categories of Covered Drugs
The Passport Advantage formulary includes both brand and generic drugs. Drugs on the Passport Advantage formulary are organized into categories according to the medical conditions used to treat.

Passport Advantage also provides coverage of a number of vaccines under our Part D prescription drug benefit. Other vaccines are considered a medical benefit (and covered under the Part B benefit). Vaccines covered under Part D can be found on Passport Advantage’s formulary. The member may get a Part D vaccine at a network pharmacy or at a provider office.

11.2.4 Member Copayments
Passport Advantage members are subject to low prescription drug copayments based on their level of low-income subsidy, which is determined by the Centers for Medicare & Medicaid Services (CMS).

Copayments for members are determined according to low-income subsidy level and whether a drug is brand or generic. Generic drugs will have the lowest copay and brand drugs may have a higher copay amount.

Once a Passport Advantage member and the Medicare program have paid the “limit on true out-of-pocket costs” toward the member’s drug benefit in a calendar year, the member will not be required to pay additional copayments for the remainder of the calendar year.
11.3 Drug Authorization Procedure

For Medicare, a drug prior authorization is a type of coverage determination. A coverage determination is any decision (i.e., an approval or denial) made by Passport Advantage regarding payment or benefits. The following actions are "coverage determinations":

- A decision to, or not to, provide or pay for a Part D drug that a member believes may be covered by Passport Advantage (including a decision not to pay because the drug is not on Passport Advantage’s formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because Passport Advantage determines the drug is otherwise excluded under section 1862(a) of the Social Security Act);
- A decision concerning an exceptions request for non-formulary drugs;
- A decision on the amount of cost sharing for a drug; or
- A decision whether a member has, or has not, satisfied a prior authorization or other utilization management requirement.

Drugs requiring prior authorization are outlined on Passport Advantage’s regularly updated formulary. A current formulary may be found at www.passportadvantage.com. An authorization request for outpatient pharmacy services can be denied for lack of medical necessity, or it can be denied for failure to follow administrative procedures. Denial notices are sent to the member and provider and will include information regarding the member’s appeal rights.

11.3.1 Prior Authorization Request Procedure

Prior Authorization requests should be submitted directly to Passport Advantage via fax or mail using the fax number or mailing address on the form. Requests must be faxed to (855) 869-7043. A response will be provided within 72 hours. Please see Section 11.3.2 below for information regarding expedited requests.

A copy of the Coverage Determination Form is provided in Section 14. It is imperative that this form be completed in its entirety for Passport Advantage to apply clinical criteria. The prescriber, member or their appointed representative can complete the form. Additional Coverage Determination forms are available by calling Provider Services, (844) 859-6152. The form can also be downloaded from Passport Advantage’s web site, www.passportadvantage.com.

When the Coverage Determination Form is received via fax, the time it is received is auto-stamped on the fax. The information is processed using clinical criteria. Authorization decisions are communicated to the prescriber, member and/or appointed representative.

To check the status of a PA request, you can contact Passport Advantage Pharmacy Resource Desk at 844-246-2930. Prior authorization approvals are valid until at least the end of the plan year (i.e., calendar year for Passport Advantage).

11.3.2 Expedited Drug Prior Authorization Requests

Expedited PA requests, including those related to a hospital discharge, should be marked as “Expedited” or “Urgent” and faxed to (855) 869-7043. A response will be provided within 24 hours if the Coverage Determination Form is complete. Providers can call or the Passport...
Advantage Pharmacy Resource Desk at 844-246-2930 or phpprd@evolenthealth.com for questions regarding a prior authorization Monday – Friday 8 am – 8pm. assistance 24 hours a day, 7 days a week.

 Expedited requests should be reserved for those situations in which applying the standard procedure can seriously jeopardize the member’s life, health or ability to regain maximum function.

11.3.3 Drug Prior Authorization Decisions
The decision outcomes of a drug PA request are as follows:

- **Approval:** If the information is complete and meets criteria, the PA is approved. The approval is faxed to the prescriber within 72 hours for a standard request and within 24 hours for an expedited request. The member is notified via an automated call system and via letter for an expedited request and via letter for standard requests.

- **Denial:** If a PA request does not meet clinical criteria, the request is reviewed and determined by a physician or pharmacist with sufficient medical and other expertise, including knowledge of Medicare coverage criteria. The denial is communicated via fax to the prescriber and via letter to the member.

11.4 Part D Transition Policy
Under certain circumstances, Passport Advantage can offer a temporary supply of a drug that is not on the formulary. Transition fills are not for new prescriptions. Transition fills are for drugs the member was already taking before switching plans or before Passport Advantage changed its coverage.

To be eligible for a temporary supply of medication, Passport Advantage members must meet the two requirements below:

- **The change to the member's drug coverage must be one of the following types of changes:**
  - The drug they have been taking is **no longer on the plan’s formulary.**
  - --or—the drug they have been taking is **now restricted in some way.**

Members must be in one of the situations described below:

- **For those members who are new or who were in Passport Advantage last year and aren't in a long-term care (LTC) facility:**
  Passport Advantage will cover a temporary supply of the member’s drug during the first 90 days of membership in the plan if the member is new and during the first 90 days of the calendar year if the member was in Passport Advantage last year. This temporary supply will be for a maximum of a 30-day supply. If the prescription is written for fewer days, Passport Advantage will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.
• For those members who are new or who were in Passport Advantage last year and reside in a long-term care (LTC) facility:

Passport Advantage will cover a temporary supply of the member’s drug during the first 90 days of membership in Passport Advantage if the member is new and during the first 90 days of the calendar year if the member was in Passport Advantage last year. The total supply will be for a maximum of a 91- to 98-day supply. If the member’s prescription is written for fewer days, Passport Advantage will allow multiple fills to provide up to a maximum of a 91- to 98-day supply of medication.

• For those members who have been in Passport Advantage for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:

Passport Advantage will cover one 31-day supply of a particular drug, or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply.

• Members who have a change in level of care (setting) will be allowed a one-time 31-day transition supply per drug. Such circumstances are:

  • Members who enter long term care (LTC) facilities from hospitals with a discharge list of medications from the hospital formulary with very short-term planning taken into account (i.e., under 8 hours)
  • Members who are discharged from a hospital to a home with very short-term planning taken into account
  • Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary
  • Members who give up hospice status to revert to standard Medicare Part A and B benefits
  • Members who end a long-term care (LTC) facility stay and return to the community
  • Members who are discharged from psychiatric hospitals with drug regimens that are highly individualized
Passport Advantage
Provider Manual
Section 12.0
Transitions of Care

Table of Contents

12.1 Transitions of Care
12.1 Transitions of Care

A care transition is defined as member movement from their usual care setting to another due to a change in health status. Transitions can be planned, such as a scheduled surgery, or unplanned due to an exacerbation of a member’s medical condition, such as an inpatient admission for Diabetes. Passport Advantage staff actively manage each care transition from notification until the member is stable in the lowest possible care setting in order to prevent fragmented and potentially unsafe care.

As part of Passport Advantage’s Model of Care (MOC) requirements an individualized plan of care (ICP) is developed for every member. An ongoing analysis of member level data is conducted to identify any changes in member health status and to proactively identify members, who may be at risk for an unplanned transition in order to update their plan of care, add interventions designed to minimize barriers, facilitate communication between all providers involved in the member’s care, coordinate any changes that need to be made in the treatment plan to hopefully avoid the transition all together.

Passport Advantage may also become aware of care transitions through the Utilization Management (UM) process, or request for authorization, especially for planned services. The UM staff initiates discharge planning upon notification of an admission. This discharge planning includes identification of resources available to support the member’s plan-of-care, organization of those resources, as needed, authorization of the resources, as needed, all in coordination with the facility staff to ensure that the member receives the services necessary for effective transition through the continuum of care and a timely discharge.

As part of transition interventions, Passport Advantage staff:

- Identifying any changes in the member’s health status and careplan.
- Attempted outreach to the member performed within three (3) business days of known admission related to a transition of care. Care plans are updated within one (1) business day of known discharge.
- Notifying the member’s PCP, or usual practitioner, within four (4) business days of plan notification if not directly involved in the transition.
- Facilitating communication among providers and the member and/or caregiver.
- Providing the member and/or caregiver with a case manager within the plan who can assist them through the transition process.
- Coordination of the member’s care plan between the sending and receiving settings within one (1) business day of known discharge.
- Identification of potential problems that may arise during the transition process and taking steps to prevent, minimize, or mitigate those problems.
- Coordinating services for members at high risk of experiencing another transition such as readmission.
- Educating the member and/or caregiver on ways to prevent unplanned transitions.
- Coordinating approval for necessary services.
• Conducting member follow-up post discharge to assess transition status, including medication reconciliation. All members who are discharged home will receive at least three (3) discharge follow-up call attempts at different times of the day within five (5) business days of discharge notification.

• Assessment of changes in care needs and health status is completed post discharge.

• Updating the member’s care plan and ICT, as relevant.

• Distributing the ICP to the member and/or caregiver and ICT participants, including PCP, as relevant.

Continuity of care is particularly important as members move between levels of care such as home to inpatient and/or conversely returning home following a hospitalization.

PHP’s care management team attempts to decrease unplanned care transitions by assessing barriers to care as well as conducting analyses of unplanned care transitions data to identify opportunities to reduce such transitions.
Table of Contents

13.1 Claim Submissions
13.2 Provider/Claims Specific Guidelines
13.3 Understanding the Remittance Advice
13.4 Denial Reasons and Prevention Practices
13.5 Timely Filing Requirements
13.6 Appeal and/or Refunds
13.0 Provider Billing Manual

The Provider Claims Service Unit (PCSU) receives providers’ calls regarding any issues specific to claims. Representatives can also assist providers with questions about policies, procedures, member eligibility and benefits. The PCSU is available Monday through Friday. We are closed on National holidays. Please see Section 1.

13.1 Claims Submission

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.

Primary vs. Secondary Insurance

Primary payers are those that have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries who are not covered by other types of health insurance or coverage.

Medicare is also the primary payer in certain instances, provided several conditions are met. Please see the CMS web site for more information on the Medicare Secondary Payer (MSP) rules- www.cms.gov

If Passport Advantage is not the primary payer, you must bill the primary payer first. You must include the primary payer’s EOB (explanation of Benefits) with the claim. Remaining charges will be reimbursed up to the maximum Passport Advantage allowed amount less the amount paid by the Primary insurance.

Procedures for Claim Submission

Passport Advantage 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 to ensure timely processing of claims.

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

- Claims filed with the Passport Advantage are subject to the following procedures:
- Verification that all required fields are completed on the CMS 1500 (please see instructions) or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under Passport Advantage during the time period in which services were provided.
- Verification that all practitioner or provider information is valid.
- Verification of whether there is any other third party resource and, if so, verification that the appropriate documentation is provided with all claims submitted to Passport Advantage.
- Verification that an authorization has been given for services that require prior authorization by Passport Advantage.
Paper claims should be submitted to the following address:
Passport Advantage (Claims)
PO Box 3805
Scranton, PA 18505

Electronic claims should be submitted to the following:
Payer ID 66008
Record Rejections/Denials

All claim records sent to Passport Advantage must first pass Change Health 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 Advantage. 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 Health in order to identify and resubmit these claims correctly. Rejected electronic claims can be resubmitted electronically once the error has been corrected.

13.2 Provider/Claim Specific Guidelines

Claim Data Sets Billed by Providers

<table>
<thead>
<tr>
<th>Service Type</th>
<th>CMS 1500</th>
<th>UB-04 (CMS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital - acute care inpatient</td>
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</tr>
<tr>
<td>Hospital - outpatient</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hospital - long-term care</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Inpatient rehabilitation facility</td>
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<td>X</td>
</tr>
<tr>
<td>Inpatient psychiatric facility</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Home health care</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
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<td>X</td>
</tr>
<tr>
<td>Ambulance (land and air)</td>
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<td>X</td>
</tr>
<tr>
<td>Ambulatory surgical center</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dialysis facility (chronic, outpatient)</td>
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<td>X</td>
</tr>
<tr>
<td>Durable medical equipment</td>
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<td>X</td>
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<tr>
<td>Drugs (Part B)</td>
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</tr>
<tr>
<td>Laboratory</td>
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<tr>
<td>Physician and practitioner services</td>
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<tr>
<td>Federally Qualified Health Centers</td>
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<td>X</td>
</tr>
<tr>
<td>Rural Health Clinics</td>
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</tr>
</tbody>
</table>


https://passportadvantage.com

13.3 Understanding the Remittance Advice

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 can 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 can be used at the claim or line level. Multiple reason codes can be listed as appropriate.

Remark codes are used on an RA to further explain an adjustment or relay informational messages.

13.4 Denial Reasons and Prevention Practices

Billed Charges Missing or Incomplete
A billed charge amount must be included for each service/procedure/supply on the claim form.

Diagnosis, Procedure or Modifier Codes Invalid or Missing
Coding from the most current coding manuals (ICD-10-CM, CPT or HCPCS) is required to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed. Passport applies industry guidelines to all adjudicated claims. This includes guidelines implemented by the Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI), Outpatient Code Editor (OCE), American Medical Association (AMA), Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

DRG Codes Missing or Invalid
Hospitals contracted for payment based on DRG codes must include this information on the claim form.

EOBs (Explanation of Benefits)
A copy of the EOB from all third party insurers must be submitted with the original claim form if billing via paper. Include pages with run dates, coding explanation and messages.

13.4.1 Incomplete Forms

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

Payer or Other Insurer Information Missing or Incomplete
Include the name, address and policy number for all insurers covering the Passport Advantage member.

Place of Service Code Missing or Invalid
A valid and appropriate two-digit numeric code must be included on the claim form.

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 Advantage.

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

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.

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.

13.4.2 Type of Service Code Missing or Invalid
A valid alpha or numeric code must be included on the claim form.

Timely Filing Requirements

Original invoices must be submitted to Passport Advantage 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.

13.4.3 Participating Provider Requests for Appeal and/or Refunds If you would like to discuss claims payments, you can call the Provider Claims Services Unit (PCSU) at (844) 859-6152.

Participating providers may have a dispute with a claim. The dispute must be submitted in writing and received within two (2) years of the last process date and include supporting documentation. Passport Advantage will respond to the dispute within sixty (60) days from the receipt date with a determination or status of the review.

The provider will receive written notification of the outcome of the dispute whether it is upheld or overturned. All upheld determinations will be sent to the provider in a letter with the reason the decision has been upheld. Any disputes overturned by Passport Advantage will be reprocessed and the provider will receive an explanation of benefits (EOB) as notification.

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 (844) 859-6152 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 Advantage 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.
Please see Section 2.8 for non-participating provider appeals.

13.5 Timely Filing Requirements

Original claims must be submitted to Passport Advantage 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 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.

13.5.1 Timely Filing Exceptions and Retro Authorization Requests

- Submission of claims for members retroactively enrolled in Passport Advantage must be submitted within 180 days from the date of enrollment notification. Proof of enrollment notification date will be required.
- Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB.
- Requests for retrospective review are received in writing from provider, by fax or mail. The retro request must be received within 14 business days from date of service. If request is received after this timeframe, the provider will be issued a denial. If the provider is non-participating, the claims must be submitted and if denied, provider will have to go through the appeals process. Participating providers may go through the provider dispute process. Payment is not guaranteed.
- Requests must include all necessary documentation to support medical necessity as indicated in the Admission and Concurrent review processes.
- The request is to be reviewed as outlined in the Admission / Concurrent review processes.
- Decisions for a retrospective review are rendered within 45 business days of receipt of the request.
- If retro is appealed, the standard process for appeals will be utilized.

13.6 Corrected Claims

Corrected Claims

A corrected claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates of service, member information, etc.). A corrected claim is not an inquiry or appeal.

**Corrected Claims should be sent to the following:**

**Paper Claims:**

Passport Advantage (Claims)  
PO Box 3805
Instructions for a corrected claim on CMS-1500 or UB 04:

- Professional Claims (CMS-1500): Per industry standards, please include the appropriate frequency code “7” in Box 22 (loop and segment 2300 CLM05-3) on the left-hand side. On the right-hand side, please also include the original claim number in Box 22 (loop and segment 2300 REF02 with an F8 qualifier in the REF01).
- Institutional Claims (UB 04): Please include the frequency code in Box 4 (loop and segment 2300 CLM05-3). Please also include the original claim number in Box 64 (loop and segment 2300 REF02 with an F8 qualifier in the REF01).
Table of Contents

14.1 Provider Network Management
14.2 Claims
14.3 Utilization Management
14.4 Pharmacy
14.1 Provider Network Management
- Add a Practitioner
- Primary Care Provider Panel Change Request
- Provider Termination
- Practice Demographic
- Group/Provider Additional Address
- Provider Tax ID Change Request
- Provider Information Change
- Registration of Locum Tenens Physicians
- Level One Provider Appeal Form

14.2 Claims
- Claims Issue
- Third Party Liability Lead

14.3 Utilization Management
- Medical Prior Authorization Request
- Mental Health/Substance Abuse Outpatient Treatment Review
- Outpatient Treatment Review Applied Behavior Analysis
- Psychological & Neuropsychological Testing Request

14.4 Pharmacy
- Step Therapy Criteria
- Prior Authorization Criteria
- Coverage Determination Form
- Redetermination Form
Passport Advantage
Provider Manual
Section 15.0
Dental Services

Table of Contents

15.1 Medical Emergencies
15.0 Dental
Passport Advantage only covers dentures under this plan as a value added service. Our plan covers one pair of dentures every 60 months within the denture network. Copays may apply. Medical necessity is required.

The medical necessity criteria for the covered dentures in order to meet medical necessity, the criteria have to meet the below standards.

Full dentures

- Existing denture greater than 5 years old and unserviceable
- Remaining teeth do not have adequate bone support or are not restorable

Partial dentures

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding 3rd molars)
- Existing partial denture greater than 5 years old and unserviceable

Remaining teeth have greater than 50% bone support and are restorable

Providers and members can contact our Member Services department at (844) 859-6152 for additional questions.

15.1 Medical Emergencies
All office staff shall be prepared to deal with any medical emergency through the implementation of the following guidelines:

- The dentist and at least one other staff member must have current CPR training.
- The dental office must have a formal medical emergency plan and staff members must understand their individual responsibilities. The emergency plan must include documented emergency procedures, including procedures addressing treatment, evacuation and transportation plans to provide for the safety of members. All emergency numbers must be posted.
- Patients with medical risk shall be identified in advance.
- All dental offices must have a portable source of oxygen with a positive demand valve, blood pressure cuff and stethoscope.
16.0 Program Integrity
Passport Advantage 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:

• Annual Fraud, Waste and Abuse Training;
• Enforcement of standards through disciplinary guidelines;
• Provisions for internal monitoring and auditing of the members and providers;
• Provisions for internal monitoring and auditing of First Tier Downstream and Related Entities (FDR). Should issues be identified, the FDR shall be placed on a corrective action plan (CAP).
• Processes to collect outstanding debt from providers;
• Procedures for appeals;
• Programs that run algorithms and edits on claims data to identify outliers and patterns and trends.

Passport Advantage’s Program Integrity Unit (PIU) monitors and analyzes various types of data to detect patterns of fraud, waste and abuse, to identify for further investigation providers and beneficiaries possibly engaged in such activities. The PIU works with staff from a broad range of Passport Advantage departments. All Passport Advantage fraud and abuse investigation activity is reported to the NBI MEDIC. Providers are required to cooperate with the investigation of suspected Fraud and Abuse. If you suspect fraud, waste or abuse by a Passport Advantage member or provider, it is your responsibility to report this information immediately. Please contact: Passport Advantage Compliance Hotline: (855) 512-8500 or PassportListens@getintouch.com to remain anonymous; or (844) 859-6152 TTY/TDD 711 to speak with an associate.

The Federal False Claims Act (31 U.S.C. §§ 3729 – 3733) and the Federal Administrative Remedies for False Claims and Statements Act (31 U.S.C. § 3802) 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. The U.S. agency in this regard means any reimbursement made under Medicare or Medicaid and includes Passport Advantage. The False Claims Acts also 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) can 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.

**16.1 Provider Oversight and Training**

Passport Advantage’s agreement with CMS requires Passport Advantage to oversee its “first tier entities.” Providers in Passport Advantage’s network are considered first tier entities. All first tier, downstream and related (FDR) entities must comply with all applicable Medicare laws, regulations, and CMS instructions (42 C.F.R. 422.504(l)(4)(v)). Passport Advantage is required to disclose to CMS all information necessary to administer and evaluate the program and to establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. Providers in Passport Advantage’s network must cooperate and provide the information necessary to fulfill these requirements.

Additionally, Passport Advantage is required to ensure that all its FDRs receive general compliance and fraud, waste, and abuse (FWA) training. Passport Advantage must also ensure that its providers receive training on our Model of Care and products. You and all of your employees, including temporary workers and volunteers, must complete the training annually. Any new employees must complete the training within 90 days of initial hire and annually thereafter. Passport Advantage will contact you each year to confirm you and all of your employees have received the required training. It is important that you respond in a timely manner. In the event CMS revises or provide additional training requirements, Passport Advantage will notify you.

You can access CMS’s FWA and General Compliance training module on the Medicare Learning Network website at:

- Under “download” select Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training [ZIP, 2MB]